

APPENDICES  
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FOR OPENING BRIEF OF  
PETITIONER

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**Appendix 6**  
**Declaration of Murray Twelves**

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

IN RE PERSONAL RESTRAINT )	
) )	
OF )	NO.
) )	
MARIBEL GOMEZ )	DECLARATION OF MURRAY
_____ )	TWELVES

I, Murray Twelves, declare the following:

1. I am over 18 years old and am competent to testify about the statements below, which are based on my own personal knowledge.

**PROFESSIONAL BACKGROUND**

2. I am an intake social worker for the Division of Children and Family Services (DCFS) at the Department of Social and Health Services (DSHS). I have been working at DCFS since October of 1983. I have been employed with DSHS since 1983. I was an intake social worker from 1991-2002. I was a social worker Child Welfare Services (CWS) from September 2002 to September 2003. I resumed my work as an intake social worker for DCFS in 2004 or 2005.

3. During my time as a social worker I was assigned to the case of Rafael Gomez. Rafael was the biological son of Maribel Gomez and José Arechiga. This case, among other cases, was transferred to me after the departure of Olga Gaxiola, another social worker in our department.

4. I received her case in part because of my Spanish-speaking skills. At this same I was assigned to about 10 cases, but I dedicated a considerable amount of time to Rafael's

1 case, because Ms. Gomez called CPS frequently with her concerns, and other providers  
2 called regarding her case when providers were trying to coordinate services to the  
3 Gomez-Arechiga family.

- 4 5. My primary responsibility as a social worker was to facilitate the provisions of DSHS  
5 services to the family the goal of permanently reunifying Rafael with them. My  
6 services included the following: I conducted frequent meetings with the family; I  
7 observed them interact with each other; I ensured that both parents attended required  
8 services and programs; I spoke frequently with them about safety concerns in the home  
9 and parenting skills; I participated in departmental review meetings; and I submitted  
10 regular reports and evaluations of my observations, recommendations and concerns to  
11 the department.

#### 12 INTERACTIONS WITH THE GOMEZ FAMILY

- 13 6. From September 2002 to September 2003 I became well-acquainted with the Gomez  
14 family. I visited the family more than once a month. In addition, I would also visit with  
15 them at our offices in Moses Lake. I had the opportunity to interact with all of the  
16 family members, including all of Ms. Gomez's children and Mr. Arechiga.
- 17 7. Ms. Gomez was a hardworking and loving mother. She would listen to her children,  
18 and take care of all of their needs. She was very proud of her family. Ms. Gomez and  
19 Mr. Arechiga were a close parenting team. Ms. Gomez was very hospitable and always  
20 welcomed me into her home.
- 21 8. Ms. Gomez was the responsible one in the household. Her home was always very well-  
22 kept and she took pride in providing her children and Mr. Arechiga with home cooked  
23 meals. I was always impressed by her ability to juggle many things at once with such  
24 ease and grace. She was always so busy taking care of things.
- 25

1 9. Ms. Gomez was an articulate and strong woman. She knew what she needed and  
2 wanted. Sometimes her personality rubbed people the wrong way. I helped her once  
3 when she was having communication problems with her Drug and Alcohol  
4 Rehabilitation counselor. In the end, I found out that the problem was a language  
5 barrier issue. The only written materials for the Program were the monthly reports,  
6 which were in English, so Ms. Gomez could not read them. We had a meeting with the  
7 Drug and Alcohol counselor where we found out they were being sent to an old  
8 address. There were no program written materials in Spanish.

9 **INTERACTIONS WITH RAFAEL**

- 10 10. The first time I met Rafael was sometime in September 2002. I remember the first time  
11 I met him he was sitting in his father's lap. He seemed so happy and loved. Rafael was  
12 a charming child and had an engaging smile.
- 13 11. Rafael experienced many changes in his short life and the adjustment was difficult for  
14 him. He went back and forth between two very different home environments. His  
15 foster home was bigger, more comfortable, quieter, and had a big back yard. He  
16 received more individualized attention at the foster home. The foster family spoke  
17 English and they consumed a traditional American diet. The Gomez family, on the  
18 other hand, lived in a small apartment with many children. At the Gomez home, there  
19 was a lot more activity in a small space. They were often playing music and visiting  
20 with family and friends. Because there were four other children in the home, Rafael  
21 received less individual attention at home relative to what he was receiving in the  
22 foster home. Additionally, the Gomez family spoke Spanish and cooked Mexican  
23 cuisine. All of these differences brought a lot of frustration to Rafael.
- 24 12. Rafael did not speak much. I only heard him speak once at the foster home when he  
25 said "nana" (i.e. banana).

- 1 13. Rafael displayed some aggressive behavior. Rafael's sister Julieanna once told me that  
2 Rafael hit and scratched her.
- 3 14. I saw Rafael crying twice. When I asked what had happened, Ms. Gomez explained  
4 that he had tantrums. I believed that Rafael had adjustment problems. I personally did  
5 not see any of his behavioral problems. Mr. Moser did not call any of my colleagues  
6 who could speak to family dynamics in the Gomez household.
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8 **INTERACTIONS WITH MS. GOMEZ**

- 9 15. From what I observed, Ms. Gomez was a caring and concerned mother towards Rafael.
- 10 16. Ms. Gomez began reporting behavioral concerns with Rafael around December 2002.  
11 The first report I remember is that she caught Rafael eating feces. Ms. Gomez's reports  
12 of Rafael's behavioral problems increased as he got older. She reported her concerns to  
13 CPS more and more often with time, and asked for more services to assess why Rafael  
14 was behaving the way he was.
- 15 17. After Rafael's injury in December of 2002, Ms. Gomez requested that Rafael undergo  
16 a neurological evaluation because he did not seem to react normally to pain. CPS was  
17 able to get an appointment with a local neurologist, who seemed to conduct a very  
18 rudimentary evaluation, including Rafael's response to a pinprick. I recall that later,  
19 Ms. Gomez took Rafael to another doctor, who was able to put him on the waiting list  
20 for a full neurological assessment at Seattle Children's Hospital.
- 21 18. Ms. Gomez was frustrated at how long it was taking to get a complete neurological  
22 assessment for Rafael.
- 23 19. I never saw any indication of abuse by Ms. Gomez of Rafael. I thought that if Ms.  
24 Gomez was hurting Rafael in any way, he would show fear of her. However, I never  
25

1 noticed him display any fear towards Ms. Gomez. He acted normally towards her in  
2 their home, just like any child would in front of their mother.

3 20. After the December 2002 incident, I saw Rafael in the foster home after he was  
4 released from the hospital. Because CPS suspected abuse, I thought that if Ms. Gomez  
5 had abused Rafael then he would be scared of her at the hospital. I specifically made a  
6 point of asking someone if they had noticed Rafael acting fearful towards Ms. Gomez.  
7 That was something I specifically wanted to know because I thought that if it was  
8 abuse, that Rafael would show fear at that point. That person had not noticed any fear  
9 towards Ms. Gomez.

10 21. I remember speaking with Ms. Gomez on September 9, 2003. Ms. Gomez called me.  
11 She was panicked. Her voice was distorted and paralyzed with terror. She told me  
12 Rafael was unconscious. She told me that she had fed him soup and he wanted more,  
13 and arched his back and threw himself backwards onto the floor, hitting his head. I  
14 asked Ms. Gomez if she had a ride, and she said she did. I advised her to take him  
15 straight to the hospital and not to call the ambulance, because I thought it would be  
16 quicker that way.

17 22. They had recently moved to an apartment with a tile over concrete floor, whereas  
18 before they were living in an apartment with a carpeted wooden floor.

19 **FOSTER FAMILY**

20 23. From December 2002 to March 2003, I also had the chance to observe Rafael in the  
21 foster home. He seemed to be just as comfortable with the foster family as he was at  
22 his family's home.

23 24. The foster mother did not want Rafael to go back to his family.

24 25. Local doctors seemed to be influenced by the foster mother, and were biased by her  
25 interpretations of Rafael's injuries when treating and diagnosing Rafael. The doctor in

1 the hospital where Rafael was being for treated his femur fracture, made a very  
2 different assessment regarding child abuse only after talking with the foster mother,  
3 but citing no additional medical evidence.

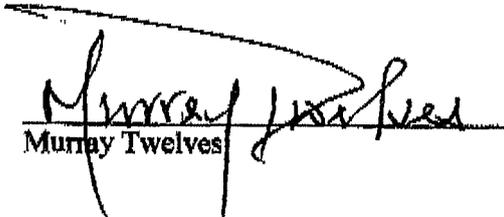
4 **INTERACTIONS WITH ROBERT MOSER**

5 26. Robert Moser ("Mr. Moser"), was Ms. Gomez's attorney at her criminal trial. In my  
6 interactions with Mr. Moser and my observations of him at trial, I was concerned about  
7 Mr. Moser representing Ms. Gomez because Mr. Moser did not call many witnesses  
8 that would bring important information to the case. Some of the important witnesses he  
9 did not call included Jorge Chacon, Jose Vasquez, Linda Turcotte, Gracie Alvarado,  
10 and Tamara Cardwell. However, I did not feel that it was my place to express my  
11 concern to Ms. Gomez or anyone else.

12 27. Mr. Moser did call me as a witness. I only met with Mr. Moser briefly once or twice. I  
13 got the impression that Mr. Moser believed that the prosecution did not have a strong  
14 case against Ms. Gomez. Preparation for testimony brief. We did not go over what I  
15 would be asked and what he was looking for.

16  
17 I DECLARE under the penalty of perjury of the laws of the State of Washington that the  
18 foregoing is true and correct.

19  
20 DATED this 11 day of May, 2010, at Moses Lake, Washington.

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23   
24 Murray Twelves  
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**Appendix 7**  
**Declaration of Jennifer Stutzer**

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1 children. I explained to Ms. Gomez that these were issues for the dependency appeal,  
2 which had already occurred and which did not result in a change to Jacqueline's  
3 placement. However, at Ms. Gomez's insistence, I agreed to re-examine these  
4 dependency issues.

5 5. During my representation of Ms. Gomez, a Spanish language interpreter was essential.  
6 While there is a possibility that we could have conversed in a very limited manner  
7 without an interpreter (such as checking to see if a letter arrived), there is absolutely no  
8 way we could have had a substantive conversation about the relevant legal issues in her  
9 case without a Spanish language interpreter.

10 6. ~~The Office of Public Defense provides funding for interpreters.~~ During my  
11 representation of Ms. Gomez, I used two OPD contracted interpreters to translate  
12 telephone conversations and to translate all letters both to and from Ms. Gomez. Once,  
13 when OPD interpreters were not readily available, I used the interpreting services of a  
14 bilingual guard at the Washington Corrections Center for Women in order to  
15 effectively confirm Ms. Gomez's wish as stated in a letter to withdraw her appeal.  
16 Thus, in my experience, a Spanish language interpreter was necessary in order for Ms.  
17 Gomez and I to effectively communicate, and in order for me to fulfill my professional  
18 and ethical responsibilities as her attorney.

19 7. While examining the record of the dependencies, Ms. Gomez's case caught my  
20 attention because of her attitude and compliance during the dependency of her son  
21 Rafael, which were appreciably different from those of other parents I had represented  
22 in appeals from the termination of parental rights. I reviewed the record of Rafael's  
23 dependency and noted Ms. Gomez's significant participation and progress in services.  
24 Clearly, the dependency court agreed that Ms. Gomez had completed the necessary  
25 services and had shown she had remedied her deficiencies. Her completion of

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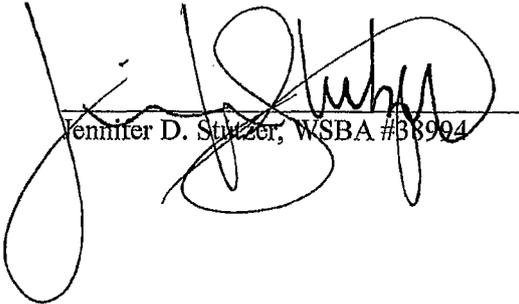
dependency services is the only reason the court would have returned Rafael to Ms. Gomez's care. Accordingly, Rafael was returned to his family home with his siblings and his parents, Ms. Gomez and Mr. Arechiga.

8. After Rafael's death, when the rest of Ms. Gomez's children became dependent, Ms. Gomez's conduct continued to be notable as she fully and thoughtfully participated in the visitations with her children.

9. Simply put, the more I looked into Ms. Gomez's case, and the more I saw what kind of parent she was to her children, the more misgivings I had about the termination of her parental rights. Ms. Gomez's behavior was not typical of the behavior I have seen in the context of termination and dependency cases.

I DECLARE under the penalty of perjury of the laws of the State of Washington that the foregoing is true and correct.

DATED this 11th day of May, 2010, at Seattle, Washington.



Jennifer D. Stutzer, WSBA #38994

## **Appendix 8**

### **Declaration of Douglas Anderson**

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

IN RE PERSONAL RESTRAINT )

OF )

MARIBEL GOMEZ )

NO.

DECLARATION OF Douglas G  
Anderson

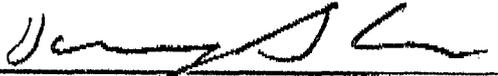
I, Douglas G Anderson, declare the following:

1. I am over 18 years old and am competent to testify about the statements below, which are based on my own personal knowledge.
2. I was the Attorney for Maribel Gomez in the Dependency action in Grant County, Washington for Rafael Gomez and subsequently for her other children.
3. In September of 2003, after the death of Rafael Gomez CPS filed a Dependency Petition as to Ms. Gomez's other children.
4. I was appointed to represent Ms Gomez and Mr. Bobby Moser was appointed to represent Jose Arichega, the father of the youngest child.
5. It has been the long standing policy in Dependency Court in Grant County to have a different attorney appointed to represent each parent, even if they request one attorney, as there is a potential for a conflict of interest.
6. Mr. Arichega and Ms. Gomez were aware that although their legal goals were the same in the dependency case, they each had a different attorney. I was the Dependency Attorney for Maribel Gomez and Mr. Moser was the Dependency Attorney for Mr. Arichega.

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I DECLARE under the penalty of perjury of the laws of the State of Washington that the foregoing is true and correct.

DATED this 10th day of May, 2010, at Ephrata, Washington.

  
Douglas G Anderson

**Appendix 9**

**Declaration of Jorge Chacon**

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

IN RE PERSONAL RESTRAINT )  
OF ) NO.  
MARIBEL GOMEZ ) DECLARATION OF JORGE CHACÓN

I, Jorge Chacón, declare the following:

1. My name is Jorge Chacón. I am over 18 years of age and am competent to testify about the statements below, which are based on my own personal knowledge.

PROFESSIONAL BACKGROUND

2. I am a certified Mental Health Professional, and I have provided mental health services to families for forty years. I currently do a combination of domestic violence perpetrator treatment, anger management, and general family mental health services. I contract with the Department of Social and Health Services (DSHS), Enterprise for Progress in the Community (EPIC), and HeadStart.

3. I studied clinical psychology at Universidad Autonoma de Mexico and Southern California University. I received my doctorate in clinical psychology from Southern California University in 2005. Additionally, I am certified in Domestic Violence Perpetrator Treatment. A copy of my resume is attached and incorporated by reference.

RELATIONSHIP TO MARIBEL GOMEZ

4. I did case management for Maribel Gomez's ("Ms. Gomez") family for approximately six months. I stopped visiting her home after Rafael died in September of 2003, so my

1 work with her family lasted from about March to September of 2003. I worked under  
2 Dr. José Vasquez and the Northwest Family Therapy Institute. Dr. Vasquez obtained a  
3 contract to do Family Reconciliation services with Ms. Gomez and her family, and he  
4 wrote a psycho-social evaluation of Ms. Gomez for DSHS. Family Reconciliation  
5 services are for families who are having any range of problems or who are going  
6 through difficult stages.

7 5. When I visited Ms. Gomez, I would visit for about an hour and a half each time. I  
8 always arrived at Ms. Gomez's home unannounced- I never called beforehand. I  
9 visited her home about once per week. I gave oral reports about my visits at meetings  
10 with DSHS, and I would also submit written reports to Dr. Vasquez.

11 6. When I went on these visits, I would spend time with the family, and I would speak to  
12 Ms. Gomez and to the children. I worked with Ms. Gomez on parenting skills, and I  
13 worked with her on personal issues such as self-esteem. I got to know Ms. Gomez and  
14 her family very well. I also got to know Rafael very well.

15 7. All of the time that I spent with Ms. Gomez and her family was very positive. The  
16 children were not at all fearful of their mother. I noticed a lot of trust and excellent  
17 bonding between Ms. Gomez and her children. Ms. Gomez was a good mom. Her  
18 house and her children were always very clean. Often when I would arrive, Ms. Gomez  
19 would be feeding the children.

20 8. Because of the allegations of child abuse that arose from when Rafael broke his leg, I  
21 was very attentive to possible signs of domestic violence in the home. I never noticed a  
22 single sign of domestic violence.

23 9. All of the disciplining that Ms. Gomez did with her children happened with her voice-  
24 she had a firm voice. I never saw her strike or be physically rough with any of her kids.  
25

1 She would say, "Don't do that." There was never even a real need to put the kids on  
2 time outs, because they listened to Ms. Gomez. They were a very functional family.

3 10. In many Mexican families, it is common for parents to yell and to use a loud tone with  
4 their children. These are dynamics that have been there for generations, and it is very  
5 difficult for them to be shifted or changed. I worked with Ms. Gomez a lot, and I knew  
6 that the firm tone of her voice did not mean that she was an impulsive or an angry  
7 person. Ms. Gomez's main personality traits were cleanliness and stubbornness. But I  
8 would disagree with a characterization of Ms. Gomez as an impulsive or angry person.

9 11. People who are not sensitive to cultural nuances might interpret Ms. Gomez's voice  
10 and behavior as agitated. It was clear to me that Ms. Gomez would get frustrated with  
11 CPS when they were placing many demands on her, and sometimes would raise her  
12 voice with her children. But these frustrations and behaviors were not abnormal, nor  
13 were they irrational or rooted in an anger problem.

14 12. After I visited Ms. Gomez's home, I would intentionally wait outside the home after I  
15 left. I would wait around the side of the house in a place where I could hear what was  
16 going on. I did this in order to be sure that no abuse was taking place in the home, and  
17 that nothing changed in the home, after I left. I never heard anything or noticed  
18 anything suspicious of child abuse during these times I waited outside or during any of  
19 my visits.

20 13. I would take the kids out for walks occasionally, to give Ms. Gomez a break.  
21 Sometimes we would go get ice cream. I would ask them about their mother, and  
22 whether she ever hit or abused any of them. I asked them if she was ever violent, or if  
23 she ever lost control. The kids always said that their mom never did any of those  
24 things. The children were very bonded with their mother, and they never said anything  
25 bad about her.

1 14. Ms. Gomez voiced her concerns about CPS with me. She tried as hard as she could to  
2 do all of the things that CPS asked her to do. This included parenting classes, AA  
3 classes, and appointments to get tested for drugs. She wanted to make every  
4 appointment but sometimes it was too much.

5 15. Ms. Gomez never appeared to be on drugs during any of my visits, all of which were  
6 unannounced.

7 **ALLEGATIONS OF CHILD TARGETING AND ABUSE**

8 16. From my experience working with families, I know that sometimes a child is targeted  
9 within a home. I also am aware that there are certain clues to recognize when a child is  
10 targeted. For example, if a child is doing something around the parent that the child

11 should not be doing, there is a certain quality of the parent's response to the child.

12 Maybe it is just a glance, or a gesture, or some kind of quick reaction that the parent  
13 has to the child that they do not have to other children. Also, in moving towards that  
14 child, there is usually a difference. It is a subtle difference, but it is often noticeable  
15 because the emotions of the parents in these situations are often very powerful and  
16 difficult to mask.

17 17. Ms. Gomez's behavior never triggered me to think that she was targeting or abusing  
18 Rafael. Ms. Gomez was a very tender, very nurturing mother. She would allow Rafael  
19 to do things on his own- she was not completely over-protective all the time. But if he  
20 came to her, she would hug him and talk to him. Ms. Gomez would always try to  
21 comfort Rafael, and she was not abrupt with him. She never approached him with  
22 anger.

23 **OBSERVATIONS OF RAFAEL GOMEZ**

- 1 18. It was obvious to me that Rafael had some psychological or neurological issues. I  
2 knew that when Rafael died, Ms. Gomez was in the process of getting him an  
3 appointment in Seattle or Spokane to look into possible neurological problems.
- 4 19. During my visits, Rafael would pout and throw tantrums. I witnessed him throw  
5 several tantrums. He would jerk his body back and hit himself against a wall, or if  
6 there was not a wall behind him, he would just fall backwards onto the floor. Ms.  
7 Gomez would immediately go to him and hug him and comfort him. They lived in a  
8 one bedroom apartment at the time, and there was carpeting over a wooden floor. I  
9 noticed Rafael throw himself backwards about three times.
- 10 20. Most of the time, it seemed that Rafael's tantrums had to do with food. I frequently  
11 witnessed Ms. Gomez feeding Rafael. When he ate, he would stuff his mouth. Ms.  
12 Gomez would say, Rafael, you are eating too much. But when she stopped giving him  
13 food, he would throw a tantrum.
- 14 21. Rafael would often make sudden arm movements. He seemed to do this when he was  
15 frustrated. He would jerk his arms out to the side suddenly, and sometimes he would  
16 do that while walking around the other children.
- 17 22. Rafael had a tendency to isolate himself from the other children. Ms. Gomez attempted  
18 to keep a balance; she never left him alone or ignored him.
- 19 23. The other kids were wonderful with Rafael. I was always very impressed. They were  
20 very gentle with him. I never saw any of them throw a tantrum or even get angry, even  
21 when Rafael would hit them. When he did that, they would just kind of move away, in  
22 a way that made it seem like they understood that they were not allowed to hit him  
23 even if he hit them.

24 OBSERVATIONS OF JOSÉ ARECHIGA

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1 24. José was a very understanding father. He worked very long hours at a dairy, and most  
2 of the times that I was visiting the home he would be asleep. While he was sleeping,  
3 sometimes the kids would climb on top of him and try to play with him. He would not  
4 yell at them or tell them to stop, he would just kind of curl up and go back to sleep. He  
5 would allow them to do whatever they wanted. His interactions with the children were  
6 always very nurturing- he had a very soft voice.

7 INTERACTIONS WITH ROBERT MOSER

8 25. I was willing and able to testify on behalf of Ms. Gomez during her criminal trial. I  
9 was living in Washington State during the investigation and trial. The State never  
10 called me as a witness.

11 26. Robert Moser, Ms. Gomez's trial attorney, never approached me, which surprised me.  
12 Mr. Moser never interviewed me about my observations of the family, nor did he call  
13 me as a witness for the defense.

14 I DECLARE under the penalty of perjury of the laws of the State of Washington that the  
15 foregoing is true and correct.

17 DATED this 11 day of May, 2010, at Wenatchee, Washington.

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21 \_\_\_\_\_  
22 Jorge Chacón, Mental Health Professional  
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**Appendix 10**

**Declaration of Jennifer Pena**

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1 5. While I lived in that complex, I would visit Maribel's house three times a day or more.  
2 We would hang out, check in on each other, cook together, and raise our kids together.  
3 We did a lot of things together. Because she was such an experienced mother (she  
4 already had four kids), she was a mentor to me when I had my first son in September  
5 2002.

6 6. Maribel was an open hearted, kind person. She was happy and always smiling.

7 **MARIBEL AS A MOTHER**

8 7. Maribel was a really good mother. She loves kids and was really loving towards her  
9 own kids. She was very patient with the children and was able to juggle many things at  
10 once. Her house was always full. There were the kids and her friends would visit.

11 Maribel always took care of everyone. Often when you went to her house, she would  
12 have food ready for you. She was a really good cook.

13 8. Maribel's kids were usually really good. I did see her discipline them, and I never saw  
14 her spank any of them, including Rafita. I would see her discipline them by sitting  
15 them on the couch by themselves or not letting them watch cartoons. The children  
16 were happy - they were always playing and running around. If anything happened to  
17 her kids, she would take care of their needs right away.

18 **RAFITA**

19 9. Maribel's family was really important to her. Maribel was a very good mother to  
20 Rafita. She was devastated whenever Rafita was taken away from her. When Rafita  
21 died, she was so sad, I had never seen her so sad. She didn't leave her house or want to  
22 get ready to go out. She was grieving. She would cry and cry, all day long. She did not  
23 want to talk about it. At Rafita's funeral, she cried hysterically. Rafita's funeral was  
24 two weeks after he died, after the autopsy and investigations. Maribel was more  
25 depressed during this time than I had ever seen her in my life.

1 10. Rafita loved her very much and was close to her. He would cry when he was sent to  
2 the foster home. For example, one time, one of the CPS social workers, Olga Gaxiola,  
3 came to take Rafita to the foster home. He was crying and did not want to go. The  
4 social worker forced Rafita into the car and said that: "he will be okay, he will go to  
5 sleep."

6 11. Rafita was a really sweet kid, but it also seemed like he was sick. Rafita would hurt  
7 himself. He would throw himself back a lot. He would hit his head on the ground or on  
8 the wall when he was having a tantrum.

9 12. When Maribel was feeding Rafita, if he was still hungry he would throw himself back  
10 and pitch a fit when he saw the food was finished. She would tell him to hang on so  
11 that she could serve him more. She would feed him more and he'd be full and then  
12 he'd stop throwing himself back. Once he was full he would relax and go watch tv or  
13 go to the living room. I saw him do that at least three or four times. Sometimes she  
14 would also try feeding him a really big portion and then he wouldn't finish it and he  
15 wouldn't pitch a fit. But sometimes she wasn't able to judge just how much to serve  
16 him and if it was too little, he'd throw himself back and hit his head on the ground to  
17 get more.

18 13. Rafita was always biting and pinching himself. He would bite himself wherever he  
19 could reach, usually on the hand and arms, but I even saw him bite his legs. One time  
20 he pulled a chunk of scabs out of his hand with his teeth. When we saw him do things  
21 like that we would tell him to stop, but he would do it again anyways.

22 14. Rafita wouldn't just act this way when he was angry, but he would act this way a lot.  
23 He always seemed anxious. He was always moving his arms around anxiously. He  
24 acted as if he was always teething.

25

1 15. Maribel would always ask my mom and me for advice on how to deal with Rafita  
2 because my brother has Down Syndrome and he also did unusual things like head  
3 banging when he was little. We always told Maribel to call CPS and tell them how  
4 Rafita was acting so that they would know, and help her.

5 16. CPS was always at Maribel's apartment. Maribel would call them whenever she was  
6 having a problem with Rafita, but they would not do anything about it. For example,  
7 she would complain that when she would call CPS about Rafita's problems, and they  
8 would not call her back for 3-4 days.

9 **ALICIA ESTRADA**

10 17. My family and I lived right across from Maribel when Alicia Estrada lived with her. I  
11 think it was around the spring or early summer of 2002. I had never seen Alicia before  
12 so I asked Maribel and José who she was. Maribel said that Alicia needed a place to  
13 stay. Maribel was a very open-hearted person - if someone needed a place to stay she  
14 would offer her home.

15 18. Alicia was hardly there. I think I saw her once during the day. She might have kept her  
16 stuff there sometimes, but I was over at Maribel's house all the time and Alicia was  
17 hardly ever there during the day.

18 **MARIBEL'S LAWYER**

19 19. I wanted to testify on Maribel's behalf at her criminal trial. I thought her lawyer,  
20 Robert Moser, would call me, but he never called. During the trial, Maribel told me  
21 that she asked him to contact me, so I was waiting for his call. I think she told him to  
22 call me six or seven times, but Mr. Moser never called me. If he did call me, I would  
23 have testified. I regret it very much that I was not able to testify in support of Maribel.  
24  
25

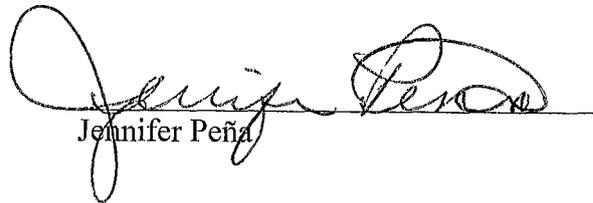
1 **CONCLUSION**

2 20. I know that Maribel loved her kids. She loved Rafita and did everything she could to  
3 help him. She took care of him, she would never hurt him. I saw Rafita bang his head  
4 when he was being fed. She would do the best she could to help him. I do not believe  
5 that Maribel killed her own son.

6 21. It was terrible the way she was portrayed in the newspaper, it made me so angry  
7 because I knew what she was really like. I wish I had had the opportunity to testify at  
8 trial.

9 I DECLARE under the penalty of perjury of the laws of the State of Washington that the  
10 foregoing is true and correct.

11  
12 DATED this 9 day of May, 2010, at Olympia, Washington.

13  
14  
15   
16 Jennifer Peña

**Appendix 11**

**Declaration of Phil Locke**

---



1 HEAD INJURIES

2 5. For many years, it was a commonly held belief in the medical and justice communities  
3 that, absent abusive trauma inflicted by an adult, lethal head injuries in an infant or  
4 toddler would require experiencing the equivalent of an “unrestrained 35 mph. vehicle  
5 crash” or a “fall from a second story.” However, testimony of this nature was never  
6 scientifically supported, and there are now many biomechanical studies and reports  
7 (including a videotaped fatal short fall) confirming that low-level straight falls can also  
8 result in lethal head injury. References are provided below.

9 6. I have attached a diagram (Exhibit A) that presents a mathematical model based upon  
10 the standard equations of motion indicating that a “slip & fall” scenario can result in  
11 skull impact velocities that are, in fact, equivalent to a second story fall.

12 TODDLER “SLIP AND FALL” DIAGRAM (EXHIBIT A)

13 7. The diagram presents the situation of a hypothetical “slip & fall” episode for a toddler.  
14 What is shown is that, if a child slips resulting in a fall, the rotation of the long axis of  
15 the body resulting from the slip imparts a rotational velocity, which translates to a  
16 linear velocity at the skull, and this adds to the straight-fall velocity experienced by the  
17 skull at impact. Definition of variables:

- 18 a.  $d_1$  – distance from impact surface (floor) to impact point on skull (Rafael  
19 Gomez was 33.5” or 2.8’ at the time of death, based on his autopsy).
- 20 b.  $d_2$  – distance from center of gravity of the body to impact point on skull.
- 21 c.  $V_S$  – linear velocity of the bottom of the feet caused by the slip.
- 22 d.  $V_R$  – rotational velocity of the long axis of the body resulting from the slip.
- 23 e.  $V_{RL}$  – linear velocity of the skull impact point resulting from body rotation.
- 24 f.  $V_F$  – linear velocity of the skull impact point resulting from the straight fall  
25 from a height of  $d_1$ .

1 g.  $V_{\text{impact}}$  – skull velocity at impact, which is the sum of the straight-fall and  
2 rotational velocities.

3 8. Estimated representative values of these variables were entered into the equations of  
4 motion, and the resulting skull impact velocity for the ‘slip & fall’ was calculated:

5 a.  $V_{\text{impact}} = 22.4 \text{ ft./sec.}$

6 9. Skull impact velocity from a straight second story fall of 11 feet would be **26 ft./sec.**

7 10. Note that these values are very equivalent. Note also that the rotational velocity  
8 imparted by the act of “slipping” could also be the result of willful body movements on  
9 the part of the child. For example – throwing back the head, or arching the back, or  
10 both.

#### 11 ADDITIONAL CONSIDERATIONS

12 11. The older theories of head injury causation relating to fall height give little or no  
13 consideration to the composition of the impact surface. The root cause mechanism of  
14 injury in skull impact is the level of deceleration experienced by the skull and its  
15 contents at impact (deceleration being negative acceleration). The composition of the  
16 impacting surface will have a significant effect on the peak level of acceleration  
17 experienced by the skull. The impacting surface could be, for example:

18 a. Grassy lawn.

19 b. Padded carpet over plywood.

20 c. Bare hardwood over plywood.

21 d. Tile over plywood.

22 e. Linoleum over concrete.

23 f. Bare concrete.

24 12. Of the above possibilities, bare concrete is by far the most severe. Concrete, as a  
25 material, has essentially no elasticity and has tremendous compressional strength. In

1 other words, there is absolutely no “give” to the concrete surface. Consequently,  
2 concrete results in, by far, the highest peak acceleration (deceleration) in the event of  
3 an impact. Clearly, one would intuitively accept that an impact on padded carpet  
4 would be less severe than the same velocity impact onto concrete.

5 13. Please see the following references for more information:

- 6 a. Duhaime et al, The shaken baby syndrome. A clinical, pathological and  
7 biomechanical study, J. Neurosurg 1987;66(3):409-415;
- 8 b. Plunkett J., Fatal pediatric head injuries caused by short distance falls, Am. J.  
9 Forensic Med Pathol 2001;22(1):1-12 (includes videotaped short fall);
- 10 c. Ommaya et al, Biomechanics and neuropathology of adult and paediatric head  
11 injury, Br J Neurosurg 2002;16(3):220-242;
- 12 d. Prange et al, Anthropomorphic simulations of falls, shakes, and inflicted  
13 impacts in infants, J Neurosurg 2003;99(1):143-150; and
- 14 e. Goldsmith and Plunkett, A biomechanical analysis of the causes of traumatic  
15 brain injury in infants and children, Am J Forensic Med Pathology,  
16 2004;25(2):89-100.

17 I DECLARE under the penalty of perjury of the laws of the State of Washington that the  
18 DATED this 8th day of May, 2010, at Cincinnati, Ohio.

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20  
21 

22 \_\_\_\_\_  
23 Phil Locke  
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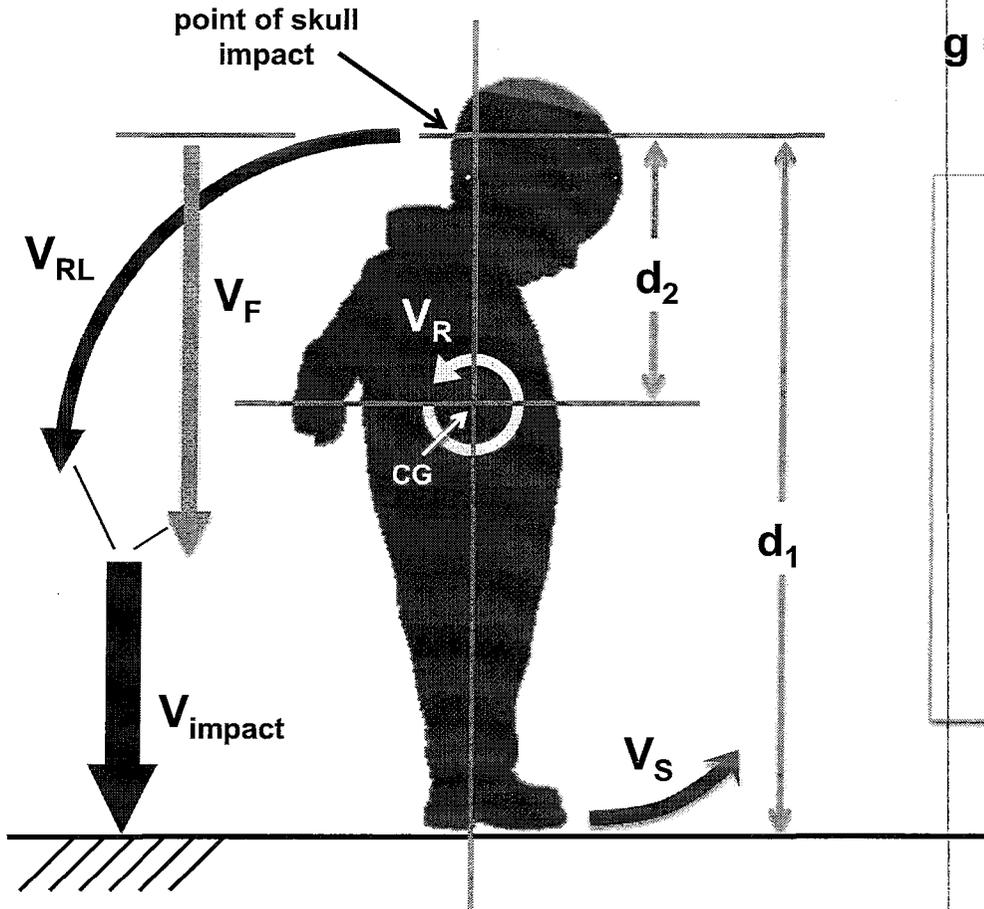
# Slip & Fall Skull Impact Velocity Model

## Exhibit A

$$V_{\text{impact}} = V_F + V_{\text{RL}} \quad V_{\text{RL}} = \frac{d_2}{d_1 - d_2} V_S$$

$$V_F = \sqrt{2 d_1 g}$$

$g = 32 \text{ ft/sec}^2$  (acceleration due to gravity)



If:

$$d_1 = 2.8 \text{ ft.}$$

$$d_2 = 1.2 \text{ ft.}$$

$$V_S = 12 \text{ ft./sec.}$$

$$V_{\text{impact}} = 22.4 \text{ ft./sec.}$$

A straight fall from a second story (11 ft.) would result in

$$V_{\text{impact}} = 26 \text{ ft./sec.}$$

### Assumptions:

- 1) Both feet slip.
- 2) Posture maintained during fall.
- 3) Skull impacts first.

**Appendix 12**

**Declaration of Audra Turner**

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- 1 4. As a visit facilitator for Ms. Gomez, I became very comfortable with her. Ms. Gomez  
2 wanted everyone to feel comfortable on the visits; she wanted me to be sort of a part of  
3 the family. She did not want the kids to feel like they were being watched all the time.
- 4 5. Ms. Gomez always made sure that the visits were fun for all of the kids. She would  
5 play games with them, read to them, and take them to the park. Sometimes they would  
6 go to the lake and go swimming, and would pack a picnic. They would drive to Moses  
7 Lake and pack lunch. Ms. Gomez insisted on getting every single holiday with her  
8 children, so I worked every single holiday.
- 9 6. Ms. Gomez did not miss any of her children's birthdays the entire time that I worked  
10 with her. For birthdays, she always made sure she had presents to give them. And even  
11 though the kids could not keep anything she gave them, she made sure they had  
12 presents that they could play with while they were there on visits.
- 13 7. Ms. Gomez always had meals ready for the kids when they got there. She made sure  
14 they all ate, and that they each had the kind of food that they wanted. Ms. Gomez  
15 would feed them dinner at night before they went back to the foster home.
- 16 8. Ms. Gomez was very attentive and made sure that the kids were always clean. When  
17 they came to visits, she would change their clothes and wash them, and get them into  
18 clean clothes.
- 19 9. The girls had lice for a while, and so for a while, visit after visit, all Ms. Gomez would  
20 do was clean their hair until she got all of the lice out. She asked for boxes of lice  
21 medicine from CPS, and she eventually got rid of all the lice.
- 22 10. Ms. Gomez wanted to help the children with their homework, but she could not read  
23 English, so she would ask me to help the kids with the homework. When the visits  
24 decreased to just Tuesdays and weekends, Ms. Gomez would always make sure that all  
25

1 of the homework was done on Tuesdays. She would go through the kids' backpacks to  
2 see if there were notes from school, and to see what their homework was.

3 11. I observed Ms. Gomez discipline her children. Ms. Gomez never spanked her kids, and  
4 she never yelled at them. She would raise her voice sometimes to discipline them.  
5 Edgar and Julie fought a lot. Edgar always wanted attention, and Ms. Gomez would  
6 give it to him. He was three years old, and he was still drinking juice out of a bottle,  
7 because that is what he wanted so Ms. Gomez gave it to him.

8 12. The day that Ms. Gomez was taken to jail was a visit day. When I went to pick up the  
9 kids and went to Ms. Gomez's house, the house was locked up and nobody was there.  
10 ~~Ms. Gomez had not once missed a visit day, so I thought this was very strange.~~

11 Eventually Mr. Arechiga showed up and said that there was an emergency and that Ms.  
12 Gomez had to miss the visit.

### 13 INTERACTIONS WITH JOSÉ ARECHIGA

14 13. After Ms. Gomez was incarcerated, I still did visits with Mr. Arechiga, but they were  
15 modified to fewer visits. In the beginning in 2004, the visits happened four times a  
16 week, plus weekends. Then the visits were in the CPS office for a while. When the  
17 visits were back in the home again, they were only on Tuesday evenings and  
18 weekends. After Ms. Gomez went to jail, the visits with Mr. Arechiga were only on  
19 Tuesdays and Sundays.

20 14. Mr. Arechiga was nice, but he was not as attentive to the kids as Ms. Gomez was.  
21 Sometimes in the middle of a visit he would just get up and leave. Ms. Gomez said that  
22 he worked a lot, and often during a visit he would just watch TV and fall asleep on the  
23 couch, or if they went to the park he would lie down in the grass and fall asleep for the  
24 entire visit. Ms. Gomez did all of the hygiene with the kids, and all the cooking, and  
25 when Jackie was born Ms. Gomez was the only one that changed her diaper and took

1 care of her. While Ms. Gomez played games and read to the kids, Mr. Arechiga would  
2 watch TV.

3 INTERACTIONS WITH MARIA, JULIO, JULIANNA, AND EDGAR

4 15. Julio was very quiet and well-behaved.

5 16. Towards the last year that I was doing visits, Maria was always on the phone with her  
6 friends in her room. But she helped Ms. Gomez a lot, especially when the youngest,  
7 Jackie, was born. She would help change her, and would look after her. Ms. Gomez let  
8 Maria talk on the phone- she never made her kids do anything that they did not want to  
9 do. Maria would talk to her mom about things that were bothering her at school.

10 ~~17. Julianna (Julie) would cry a lot at the end of the visits, because she did not want to see~~  
11 her mom go.

12 18. Edgar was a handful. He would hit the other kids and spit at them. Ms. Gomez was  
13 very patient with Edgar.

14 FOSTER HOMES

15 19. The kids would tell Ms. Gomez everything that happened in their foster homes, and  
16 Ms. Gomez would write everything down in a journal that she kept. When they were  
17 with Griselda Orozco in the first foster home, the foster parents got divorced and the  
18 mom kept the kids. Ms. Orozco would go on dates and leave the kids alone with her  
19 older kids, who were in their twenties. The kids would complain to Ms. Gomez, “she  
20 left us with the babysitter again.” And Ms. Gomez would write it down.

21 20. Julie especially told Ms. Gomez everything that happened. She told her every time that  
22 she got in trouble at school, and why she got in trouble. Ms. Gomez would write it  
23 down and then go tell Rocky Terry, her caseworker. If they came in with their clothes  
24 torn, or in clothes that did not fit them, Ms. Gomez would make a note.

25

1 RAFAEL

2 21. I only remember one time that Rafael was brought up in conversation. It was when  
3 they were on the way to the park in Ephrata and they walked past the cemetery. Julie  
4 started crying and saying that she missed her brother. Ms. Gomez said that they would  
5 not go that way to the park again, because she did not want to make Julie cry. Ms.  
6 Gomez had pictures of Rafael up in her house. And Edgar, who was very young when  
7 Rafael died, would point to the picture and say, "that's my brother." But other than  
8 that, Ms. Gomez did not want to talk about Rafael because she did not want to upset  
9 the kids. I did not ask, because I did not want Ms. Gomez to feel like I was prying into  
10 her life.

11 22. Once on a visit, it was Rafael's birthday. Ms. Gomez mentioned something to me  
12 really quickly about how they were going to go to the cemetery to put flowers on his  
13 grave, but she did that after the visit was over, because she did not want to make the  
14 kids sad.

15 THE CONVICTION

16 23. I had the impression that Ms. Gomez was completely convinced that she would not be  
17 convicted. She was completely shocked when she went to jail. In the letters she wrote  
18 me from jail, she talked about how shocked she was. She worried about her kids. She  
19 wrote me to look out for Maria and to tell Maria that Ms. Gomez loved her.

20 24. I cannot see the side of Ms. Gomez that was portrayed during trial. I knew Ms. Gomez  
21 to always be so attentive to her kids.

22 INTERACTIONS WITH ROBERT MOSER

23 25. I was willing and able to testify on Ms. Gomez's behalf during her criminal trial. I  
24 expected to get a call from Ms. Gomez's lawyer, Robert Moser, asking me to testify.  
25 Mr. Moser never called me, and I never spoke to him.

1 26. Robert Moser did not call any witnesses who would show the side of Ms. Gomez that  
2 was a loving and caring mother.

3

4 I DECLARE under the penalty of perjury of the laws of the State of Washington that the  
5 foregoing is true and correct.

6

7 DATED this 3 day of May, 2010, at Warden Washington.

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Audra Turner

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**Appendix 13**

**Declaration of Sergio Pena**

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1 6. During the entire time I lived with them, I never saw Maribel or José hurt any of their  
2 children. I saw them discipline their children by making them sit on the couch by  
3 themselves and not watch television, like a 'time out.' They were very loving parents  
4 and their children loved them.

5 7. After we moved out of Maribel and José's house, we moved into another unit of their  
6 apartment complex. The complex was shaped like a horseshoe and we lived directly  
7 across from them. We would see them every day and knew when they had visitors.

8 8. We met one of their visitors, Alicia Estrada, in spring 2002. She needed a place to stay  
9 and Maribel opened her house for her. We were living across the way from Maribel  
10 while Alicia was there. ~~Alicia only stayed for a short time, maybe a few weeks.~~

11 Maribel and José kicked her out of their house after she tried to have sex with José.

12 9. I knew Rafael Gomez throughout his life because I lived across from him and his  
13 family.

14 10. Rafita was a very sweet boy and everyone loved him. But it was clear to me that he  
15 had some mental illness or some problems. He was different from any other child I  
16 knew because he would throw himself back and forth. Whether he was sitting on the  
17 couch or on the floor, he would throw himself forwards and bang his head or throw  
18 himself backwards and bang his head. I even saw him hit his head against the wall  
19 sometimes. He would not typically cry when he banged his head and when any of us  
20 saw him doing this we would run to him and hold him to make him stop.

21 11. I would see him doing this often. Usually, he would throw himself for no apparent  
22 reason. Sometimes, he would throw himself when Maribel was feeding him and then it  
23 was like he was throwing a tantrum. Maribel would always try to comfort him and give  
24 him what he wanted so that he would stop hurting himself. I never saw her hit him or  
25 yell at him. She was always trying to help him. Rafita needed a lot of help.

1 12. I have known Maribel and José for a very long time and I knew them to be very good  
2 people and very good parents. While I lived with them or lived in their building I never  
3 once saw them hurt any of their children, including Rafita. I have raised my own three  
4 children and knew all of Maribel's children and many others, and I knew that Rafita's  
5 behavior was not normal for a child. He would hurt himself by hitting his head on the  
6 floor or the wall, or wherever he was. Maribel and José did everything they could to  
7 help him and comfort him and keep him safe. Maribel would never have hurt him.

8 INTERACTIONS WITH ROBERT MOSER

9 13. I would have spoken at Maribel's trial but her attorney, Robert Moser, never contacted  
10 me.

11 I DECLARE under the penalty of perjury of the laws of the State of Washington that the  
12 foregoing is true and correct.

13  
14 DATED this 9<sup>th</sup> day of May, 2010, at Quincy, Washington.

15  
16  
17 Sergio Peña  
Sergio Peña

**INTERPRETER'S DECLARATION**

I am a certified interpreter or have been found otherwise qualified by the court to interpret in the Spanish language, which the respondent understands, and I have translated The Declaration of Santiago Peña (identify document being translated) for the respondent from English into that language.

The respondent has acknowledged his or her understanding of both the translation and the subject matter of this document. I certify under penalty of perjury under the laws of the state of Washington that the foregoing is true and correct.

DATED: May 09, 2010 Saul C. Castillo  
Interpreter

LOCATION: Quincy, Washington

Saul C. Castillo  
Signature

**Appendix 14**

**Declaration of Dale Lehrman of 11/17/08**

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07-138143

**FILED**

NOV 18 2008

KIMBERLY A. ALLEN  
Grant County Clerk

**JAMI GOMEZ**

IN THE SUPERIOR COURT OF THE STATE OF WASHINGTON  
IN AND FOR THE COUNTY OF GRANT  
JUVENILE DIVISION

In re the Dependency of:

EDGAR ARECHIGA-GOMEZ  
JACQUELINE ARECHIGA-GOMEZ

No. 07-7-00232-9  
07-7-00231-1 ✓

DECLARATION OF DALE L.  
LEHRMAN IN RESPONSE TO  
MOTION TO SET ASIDE  
DEFAULT.

D.O.B. 9/14/02; 4/26/06

I, Dale L. Lehrman, am competent to testify, and have personal knowledge of the following:

1. I am an Assistant Attorney General who represents the State of Washington Department of Social Health Services (Department hereafter). As such, I am familiar with the above files and contents within.

2. I have reviewed the Motion to Set Aside Default filed by attorney Robert Moser. Mr. Moser represents the father, Mr. Arechiga, in the above named childrens' Dependency proceedings (cause numbers 03-7-00134 and 06-7-00136, respectfully).

3. First, the court has not entered an Order of Default as to Mr. Arechiga in either termination cause number.

4. The Department filed termination petitions (regarding both parents) on August 10, 2007. Subsequently, the Department was not able to locate Mr. Arechiga who was deported in June or July of 2007. The father has not been in touch with the Department since his deportation. Mr. Moser's declaration evidences that he has not been in contact with Mr. Moser either.

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1           5.       It does not appear that service was accomplished on Mr. Arechiga at the time of the  
2 initial termination hearing on October 2, 2007. The termination hearings regarding the mother were  
3 continued to dates to be set by the court administrator. A January 3, 2008, Notice of Trial Setting  
4 set out a second set hearing of April 17 and 18, 2008 and a first set hearing of June 19 and 20, 2008  
5 for the mother. On April 15, 2008, an order continuing the termination hearings was entered,  
6 continuing the trials to June 19 and 20, 2008.

7           6.       On May 6, 2008, an ex-parte motion and declaration of caseworker was filed by the  
8 Department requesting an order allowing notice by publication. The court signed the Findings and  
9 Order to Publish Notice and Summons For Termination for Mr. Arechiga and anyone claiming a  
10 paternal interest for the termination hearing on June 19, 2008. An Affidavit Of Publication filed on  
11 June 2, 2008 sets out that publication was accomplished in the Columbia Basin Herald, a  
12 newspaper of general circulation for three consecutive weeks starting May 16, 2008.

13           7.       On June 19, 2008, the date of the termination trial, neither Mr. Arechiga, nor anyone  
14 claiming a paternal interest were present. See attached clerks minutes. The parties agreed to a  
15 continuance based in large part on the mother's attorney having "to seek immediate medical  
16 assistance." Ultimately, the matter was continued to a date to be set by the court administrator. An  
17 order of default was not entered. In September of 2008, the November 20, 2008 termination trial  
18 date was set.

19           8.       Mr. Moser's declaration does not directly indicate whether he is asking to be court  
20 appointed or if he is asking to file a notice of appearance as private counsel. The Department asks  
21 that the court examine whether appointing counsel where there has been no contact with the court  
22 or direct contact with Mr. Moser by Mr. Arechiga is appropriate. The Department also requests that  
23 the court inquire of Mr. Moser whether he is in compliance with any rules of responsibility or other  
24 applicable rules in light of his representation of the mother in her criminal case that gave rise to the  
25 dependency cases.  
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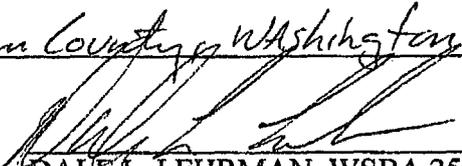
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9. The Department objects to any continuance of the November 20, 2008 termination trial date. The timing of Mr. Moser's motion (within two business days) of the scheduled trial was within his control. The termination petitions were filed over a year ago (8/07).

I declare under penalty of perjury under the laws of the State of Washington that the foregoing is true and correct.

DATED this 17<sup>th</sup> day of November, 2008.

Place (City/State) Wenatchee, Chelan County, Washington

  
DALE L. LEHRMAN, WSBA 25127

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**Appendix 15**

**Declaration of Garth Dano**

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

IN RE PERSONAL RESTRAINT )  
OF )  
MARIBEL GOMEZ )

NO.  
DECLARATION OF GARTH DANO

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I, Garth Dano declare the following:

1. I am over 18 years old and am competent to testify about the statements below, which are based on my own personal knowledge.
2. I have been asked by an Innocence Project staff member to offer a professional opinion concerning the duties and responsibilities of an attorney handling a criminal murder trial.
3. I have been a criminal defense lawyer living in Moses Lake and practicing throughout central Washington in both state and federal court for the past 30 years. My resume is attached (Exhibit A) and incorporated herein by reference.
4. I have been asked to render some opinions concerning *State of Washington v. Gomez*. This was a Grant County murder case which had significant notoriety here in central Washington. I did not review the file or any of the pleadings. I have been asked to comment generally on my approach in handling a case of Homicide by Abuse.
5. Any kind of homicide case is extraordinarily demanding for a lawyer and his staff. It is gut wrenching and not for the faint of heart. A defense attorney must consider every possible avenue of defense. It would be virtually impossible to quantify with any

- 1 degree of certainty the amount of time which would be necessitated in handling such a  
2 case. My opinion would be that homicide cases could easily consume anywhere from  
3 two hundred to a thousand hours of attorney time, not including staff time and costs.
- 4 6. Initial considerations would no doubt consist of immediately seeking co-counsel who  
5 has considerable experience and background handling similar cases. It would be, in my  
6 opinion, legal malpractice to attempt to try a murder case, if you have never tried one  
7 before. I also believe it would be legal malpractice to try your first murder case  
8 without the assistance of a competent co-counsel who has experience trying murder  
9 cases. In addition to having two (2) lawyers on the case, I would no doubt, engage the  
10 services of an investigator; an interpreter, as needed, if the client was Spanish  
11 speaking; and at least one paralegal.
- 12 7. I would move to recuse any judge and perhaps all of the judges of Grant County, who  
13 may have been involved, in any way, presiding or ruling on the dependency or juvenile  
14 cases involving the children of the Defendant prior to the defense of her criminal trial.  
15 I have been advised that one or all of the Grant County judges may have presided over  
16 dependency matters involving the Defendant. This raises the issue an appearance of  
17 fairness problem and a reasonable question as to their predisposition to rule against the  
18 Defendant charged with Homicide by Abuse. The Defendant should be advised of  
19 these concerns and counseled to consider making such a motion. The failure to do so,  
20 in my opinion, would be legal malpractice.
- 21 8. I would definitely move for a change of venue to King, Pierce or Spokane Counties  
22 because of the adverse publicity and notoriety of this case. Stories about this case were  
23 fairly salacious and definitely circulated in the local media. A change of venue would  
24 be prudent due to the extremely negative and widespread press this case generated.  
25 Further, at the time that Ms. Gomez was criminally charged (May 2004), the Grant

1 County Public Defense system was in chaos. Two (2) of the four (4) public defenders  
2 were disbarred or facing disbarment and the County's capacity to defend this kind of  
3 felony was severely compromised at that time. Finally, a change of venue would help  
4 with securing more sophisticated and technical experts and support personnel for the  
5 case.

6 9. In a homicide case, I would never consider waiving a jury. In my opinion, a criminal  
7 defendant would definitely want his or her case to be decided twelve people rather than  
8 one. I absolutely would have advised a criminal defendant charged with such serious  
9 offense to consider filing an affidavit of prejudice against the assigned Grant County  
10 Superior Court Judge.

11 10. Homicide charges, because of the grave nature of the case, necessarily require  
12 extensive investigation. These kinds of cases demand a tremendous amount of legal  
13 and factual preparation. I would, at the very least, do the following:

- 14 a. Consult with other attorneys who have worked on similar charges.
- 15 b. I would consider retaining 1-3 experts; to assist not only in challenging the  
16 State's evidence and experts, but also to review the state's evidence. I would, at  
17 a minimum, research and consider retaining the following categories of  
18 experts:
  - 19 i. A child abuse expert whose credentials could not be impeached to offer  
20 opinions concerning the death of a child caused by intentional versus  
21 accidental trauma; and who could testify as to whether the prior injuries  
22 may be explained as accidental or self-inflicted by the child and not  
23 demonstrate a pattern of abuse by the parent.
  - 24 ii. A forensic pathologist who could complete a review of the medical  
25 record including exploring the possibility of exhuming the body of the

1 child to conduct a complete forensic examination, independent of the  
2 state's expert.

3 iii. A biomechanical engineer who could testify to whether a child could  
4 die from a short fall. I would consult literature about blunt force trauma  
5 and about whether people have thrown themselves back in a way that  
6 could cause death.

7 c. Investigate other possible abusers. I would investigate whether anyone else in  
8 the child's life could have been an abuser. I would inquire as to who my client  
9 lived with and investigate whether they could have been in any way the cause  
10 of the child's death.

11 d. I would fully investigate the father who lived in the house:

12 i. Was he at work during the fatal injury or any prior injuries? Is that  
13 verified by his work records and his employer accounts? If he was not  
14 an abuser, could he corroborate my client's story?

15 ii. Were there other adults (or children) who were left alone with the child  
16 and could have inflicted trauma?

17 e. Contact and speak with any eyewitness who could possibly corroborate the  
18 defendant's version of the case. It would be legal malpractice for an attorney  
19 not to call or speak with any witness suggested by the defendant who could  
20 corroborate or offer an alibi concerning the defendant's version of a key events  
21 or could offer favorable evidence concerning the observations of the defendant  
22 treating the alleged victim in a loving and respectful manner, without being  
23 aware of such observations.

24 f. It would be legal malpractice and reversible error not to subpoena and call a  
25 witness who had exculpatory or first hand knowledge concerning the alleged

1 victim's propensity and known past conduct of self-inflicted trauma, even if the  
2 witness told the lawyer that they did not want to testify or even stated they  
3 refused to testify.

4 g. A criminal defense lawyer must depose/interview all government witnesses  
5 who were assigned to the case and/or had any information, including but not  
6 limited to, CPS workers and police investigators.

7 11. Expert Witnesses. A lawyer should provide all potential defense expert witnesses with  
8 all of the material he or she needed in order to render an opinion in the case well  
9 before the commencement of trial. I would not disclose the name of any expert witness  
10 I consulted until I had received a complete report from the expert witness, setting forth  
11 the opinion he or she reached after reviewing the full record in the case. I would not  
12 allow a defense expert witness to speak with the prosecuting attorney unless I was  
13 present during the prosecutor's interview. I would consult with and spend a substantial  
14 amount of time meeting with and preparing any defense expert witness for his or her  
15 direct examination, as well as for the prosecutor's cross-examination. Failure to  
16 undertake this essential trial preparation, in my opinion, when working with defense  
17 expert witnesses constitutes legal malpractice.

18 12. Lay Witnesses. I would a considerable amount of time preparing a defense lay witness  
19 for his or her direct examination, as well as for the prosecutor's cross-examination. I  
20 have been asked about my opinion concerning having a witness testify, whose ability,  
21 as a percipient witness, maybe compromised by taking various and high powered  
22 prescription medications to deal with serious medical issues. When considering  
23 calling such a witness, a competent attorney should seek to introduce a prior consistent  
24 statement in writing as past recollection recorded rather than have the witness testify at  
25 trial pursuant to ER 612 and 613.

- 1 13. I would counsel my client not to take the stand. A criminal defense attorney should  
2 extensively discuss with their client the risks and drawbacks of testifying at trial. The  
3 decision whether or not to testify is critical, and in my opinion, in the client's best  
4 interest to exercise his or her constitutional right to remain silent. I would ensure that  
5 my client understood the protections of the Fifth Amendment right. Allowing a  
6 criminal defendant to testify, when there is substantial evidence to support the  
7 defendant's theory of the case, is in most cases a serious tactical mistake.
- 8 14. I would prepare jury instructions and motions in limine to exclude all non-relevant and  
9 prejudicial evidence and provide briefing to the court of all procedural and substantive  
10 issues in the case, pre-trial.
- 11 15. I have been advised that the criminal defense lawyer in this case was representing the  
12 father of the siblings of the deceased child, while he was simultaneously representing  
13 the defendant in the Homicide by Abuse case. This, in my opinion, is legal  
14 malpractice and constitutes an absolute conflict of interest which should have  
15 disqualified the attorney from representing the defendant in her murder trial pursuant  
16 to RPC 1.7.
- 17 16. The above would have, in my professional opinion, been the minimum considerations  
18 that a competent attorney should have considered in pursuing a case involving a  
19 Homicide by Abuse charge.

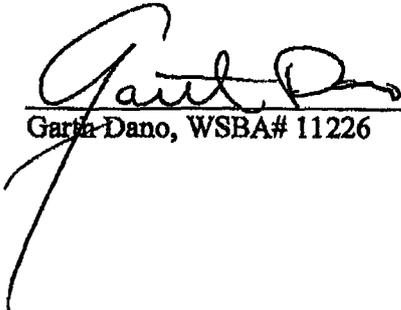
20 I DECLARE under the penalty of perjury of the laws of the State of Washington that  
21 the foregoing is true and correct.

22 DATED this 12<sup>th</sup> day of May, 2010, at Moses Lake, Washington.

23

24

25

  
Garth Dano, WSBA# 11226

**CURRICULUM VITAE FOR GARTH L. DANO**

**CURRENT**

*Principal, Dano Gilbert & Ahrend PLLC, Moses Lake, WA: June 2005 to present. Trial practice of personal injury and criminal law matters.*

**LEGAL EMPLOYMENT HISTORY**

Principal, Garth Dano & Associates, Moses Lake, WA: September 1997 to June 2005.

Principal, Dano Ries & Miller, Moses Lake, WA: 1984 to 1997.

Associate, Dano, Cone, Fraser & Gilreath, Moses Lake, WA: 1980 to 1984

**ADMITTED TO PRACTICE**

State of Washington: 1980.

U.S. District Court, Eastern District of Washington: 1981.

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U.S. Court of Claims: 1981.

U.S. Supreme Court: 1988.

U.S. District Court, Northern District of California: 1991.

**AWARDS**

2006 -- National Crime Victims Law Institute: Victim's Rights Partnership Award

2000 -- Washington Foundation for Criminal Justice: Meritorious Award

2000 -- Washington State Bar Association: Courage Award

1998 -- Washington Association of Criminal Defense Lawyers President's Distinguished Service Award

**OTHER RELEVANT EXPERIENCE**

Trial Lawyers for Public Justice: Member, 2002 to present.

Washington Foundation for Criminal Justice (WFCJ): Original Eastern Washington Member, 2000 to present.

WFCJ/WACDL - Lecturer: Topic - Trial of Case (2001) (2002)

Topic -- Defending DUIs; Pre Trial Motions (2001)

Topic - Jury Selection (criminal)

Dano Vitae  
Page 2 of 3

Topic – Defending Misdemeanor Cases; Ethical  
Issues for the DUI/Misdemeanor  
Practitioner – Defend Zealously, Practice  
Ethically (1998)

National Association of Criminal Defense Lawyers (now known as WSAJ): Member,  
1996 to present.

Washington Association of Criminal Defense Lawyers: Member of Board of Governors,  
1996 to 2002; Vice President-East, 2000 to 2002.

Graduate: Gerry Spence Trial Lawyers College (1996).

Grant County Bar Association: President, 1989 to 1990

Washington State Trial Lawyers Assoc (WSTLA): Member, 1980 to present.

~~WSTLA – Lecturer: \_\_\_\_\_ Topic – Jury Selection (civil) (2002) (2006)~~

Topic – Criminal Law and the Court System (2001)

#### **REPORTED DECISIONS**

*State v. ANJ*, \_\_ P.3d \_\_, 2010 WL 314512 (Wash.)(2010)

*State v. Cerrillo*, 122 Wash. App 341, 93 P.3d 960 (2004).

*State v. Smith*, 113 Wash. App. 846, 55 P.3d 686 (2002).

*State v. Rainey*, 107 Wash. App. 129, 28 P.3d 10 (2001).

*State v. Loukaitis*, 82 Wash. App. 460, 918 P.2d 535 (1996).

*Alvarado v. Standler*, Div III (2004)

*Gugin v. Sonico, Inc.*, 68 Wash.App 826, 846 P.2d 571 (1993).

*Hite v. Public Util. Dist.*, 51 Wn. App. 704, 754 P.2d 1274 (1988), *rev'd*, 112 Wn. 2d  
456, 772 P.2d 481 (1989).

*Kunkel v. Meridian Oil, Inc.*, 114 Wash.2d 896, 792 P.2d 1254 (1990).

*Ginochio v. Hesston Corp.*, 46 Wash.App. 843, 733 P.2d 551 (1987).

*Heidebrink v. Mortwaki*, 104 Wash.2d 392, 706 P.2d 212 (1985).

#### **LEGAL EDUCATION**

Gonzaga University School of Law, Spokane, WA: J.D., 1979.

**Dano Vitae**  
**Page 3 of 3**

**Gerry Spence Trial Lawyers College, Dubois, Wyoming: Graduate, 1996.**

**OTHER EDUCATION**

**Santa Clara University, Santa Clara, CA: B.A., History, 1976.**

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**Appendix 16**

**Declaration of Rosibel Davila**

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- 1 4. I spent about half an hour with Maria and Julio each school day, and I would also see  
2 them outside at recess. To the best of my recollection, Maria was in the 4<sup>th</sup> grade, and  
3 Julio was in the 1<sup>st</sup> grade.
- 4 5. I had a responsibility as a teacher to make sure that all the students were going to  
5 school, were well fed, and were not suffering from any abuse in their homes.
- 6 6. Over the many years I have worked with children, I have developed knowledge about  
7 how to recognize when a child is suffering from abuse at home. When a child is  
8 abused, they will often refuse to look at you, because they are hiding something from  
9 you. They also are unhappy, and they show this unhappiness. If there is abuse in the  
10 home, you will almost always see a difference in behavior before the weekend. The  
11 children will act out before weekends and holidays because they do not want to be at  
12 home; they do not want to be there with the parents. Neither of Maribel's children ever  
13 displayed any of these behaviors.
- 14 7. If a sibling is being abused, it is very difficult for children to hide it. Kids often tell you  
15 everything. They will say, "my little brother is being hit by my mom/ older brother/  
16 older sister." They cannot hide things like that unless they are being threatened, but if  
17 they are personally being threatened then they will show other behaviors like the ones I  
18 mentioned above.
- 19 8. There was never anything that triggered me to assume there was abuse in Maria and  
20 Julio's home.

21 RELATIONSHIP TO MARIBEL GOMEZ

- 22 9. I met Maribel Gomez ("Maribel") because her children Maria and Julio Gomez were  
23 students of mine at Columbia Ridge from 2000-2001. I mainly knew Maribel through  
24 her children, but after Rafael passed away I became friends with her.
- 25

- 1 10. When I met Maribel in 2000, it seemed like she was on some kind of drug. I asked  
2 Maria if her mom ever hit her, yelled at her, screamed at her. Maria said that her mom  
3 never did any of those things- that she fed them and took care of them.
- 4 11. When I noticed Maribel was on drugs, I had to tell the school counselor, Bob Bischoff,  
5 that drugs were being used in the home. Bob told me to speak to the children and find  
6 out whether there were problems in the home. The kids felt more comfortable with me,  
7 which is why Bob asked me to speak to them about it. I talked to them, and I did not  
8 see a single sign of abuse. I reported that to the counselor, Mr. Bischoff.
- 9 12. I saw Maribel through the whole dependency and termination process of losing her  
10 kids.
- 11 13. Maribel would give her life for those kids. When I went to visit Maribel after her kids  
12 were taken away, her house would be completely spotless. I would ask her how she  
13 kept her house so clean. Maribel would respond that she did not have anything else to  
14 do since her kids were taken from her.
- 15 14. Maria and Julio Gomez were my students at Columbia Ridge from 2000-2001. They  
16 were both always very clean. There was never a sign of abuse on either of the kids.  
17 Maria's hair was always done very nicely.

18 OBSERVATIONS OF MARIA GOMEZ

- 19 15. Maria loved her mom so much that she could not stop talking about her.
- 20 16. In the 4<sup>th</sup> grade, Maria was a very loving child. She would run up to me and tell me  
21 that she loved me. She was always talking about Maribel, saying nice things about her.
- 22 17. Maria loved her little brother Rafael, and she was so proud of him. She brought a  
23 picture of him to school. She loved all her siblings, but she was always talking about  
24 Rafael.

25

1 18. One time Maria came to school and she looked sad. I asked Maria why she was sad,  
2 and she said she was not sad. But I said "yes, yes you are," because I spent a lot of  
3 time with her, and I knew her really well. Maria told me that her little brother had  
4 broken his leg after he slipped on the floor. I asked Maria if anyone had pushed him  
5 down, and Maria said that nobody had- that he was just walking. This happened before  
6 Maribel knew that Rafael had a sickness, and that his bones broke easily.

7 19. When they put the kids in foster care after Rafael broke his leg, Maria told me that she  
8 and Julio were not going to come to school anymore because "they are taking us away  
9 from my mom and dad because they think my mom is hurting my brother." But Maria  
10 said her mom would never hurt her brother. I talked to Maria and told her that I knew  
11 Maria was afraid and scared, but that everything was going to be okay. Maria told me  
12 that everything was not going to be okay, because her mom was going to cry every  
13 day.

14 20. After they took Rafael away for the first time, I asked Maria again if her mom or dad  
15 had ever hurt her brother. She said no, that they had never hurt him, but that he had  
16 fallen and gotten hurt that way.

17 21. Maria became kind of like a mom to her siblings because she felt she needed to keep  
18 them all together.

19 OBSERVATIONS OF RAFAEL GOMEZ

20 22. Once Maribel brought Rafael to school, and put him down on the floor to play with  
21 blocks. I saw him throw himself back onto the ground. Maribel picked him up because  
22 he started to cry. Maribel was very careful with him, the way she handled him. Rather  
23 than picking him up like you would pick up a normal child, she picked him up very  
24 slowly and carefully, like she was holding something very fragile. I cannot see any  
25 way that Maribel would have hurt her son.

1 23. Maribel took Rafael to the doctor anytime something was wrong. I knew that she was  
2 always taking Rafael to the doctor because I would talk to Maribel and she would say  
3 that she had taken him to the doctor the night before, or in the morning.

4 INTERACTIONS WITH ROBERT MOSER

5 24. I talked to Mr. Moser a few times because I wanted to know more about what was  
6 going on with Maribel's case. Mr. Moser never had a formal interview with me about  
7 my experiences with Maribel and her children. I told Mr. Moser that I would testify on  
8 Maribel's behalf, but he never called me. He told me the prosecution had not allowed  
9 him to call any more witnesses.

10 25. It was my impression that Mr. Moser seemed very intimidated by the whole trial. The  
11 prosecutors were very aggressive.

12 26. A couple of days before the sentencing, I talked to Mr. Moser. He was so sure that with  
13 the testimony of Ophoven, Maribel would get out of jail. He was really certain that was  
14 going to happen.

15 I DECLARE under the penalty of perjury of the laws of the State of Washington that the  
16 foregoing is true and correct.

17  
18 DATED this 3<sup>rd</sup> day of May, 2010, at Moses Lake, Washington.

19  
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21   
22 Rosibel Davila  
23  
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**Appendix 17**

**Declaration of Maya Sheppard**

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1 4. We contacted a number of medical experts to determine the cause and timing of the  
2 fractures. Each medical expert told us that it is not possible to determine these issues  
3 without reviewing the radiology images from 2002 and 2003. It is my understanding  
4 that the findings in the radiology reports could be fractures (accidental or inflicted);  
5 normal variants; the result of congenital conditions, metabolic abnormalities or vitamin  
6 deficiencies; artifacts from autopsy; or some combination of these factors.

7 5. I have attempted, unsuccessfully thus far, to obtain x-rays and CT-scans taken of  
8 Rafael Gomez.

9 6. I requested x-rays and CT-scans from the following hospitals and radiology labs in  
10 which Rafael Gomez was a patient:

11 a. Central Washington Hospital in Wenatchee, WA.

12 i. I obtained x-ray reports from Central Washington Hospital, but the  
13 Health Information Department informed me that they no longer had  
14 the x-rays.

15 b. Columbia Basin Hospital in Ephrata, WA.

16 i. I received x-ray reports from Columbia Basin, but the Health  
17 Information Department informed me that they no longer had the x-  
18 rays.

19 c. Samaritan Health Care in Moses Lake, WA.

20 i. The Health Information Department informed me they no longer had x-  
21 rays of Rafael Gomez.

22 d. Pacific Medical Imaging Consultants.

23 i. The Health Information Department informed me that they no longer  
24 had the x-rays, and that I should contact Quincy Valley Medical Center.

25 e. Quincy Valley Medical Center in Quincy, WA.

1 i. The Health Information Department informed me that they did not have  
2 x-rays on Rafael Gomez.

3 f. Providence Sacred Heart Medical Center in Spokane, WA.

4 i. The Correspondence Department reported that they were unable to  
5 locate Rafael Gomez in their system.

6 7. I requested the x-rays from Rafael's autopsy from the Spokane County Medical  
7 Examiner.

8 a. Dr. Sally Aiken informed me that they could not locate the hard copy x-rays in  
9 their office. Dr. Aiken contacted Inland Imaging, which is responsible for long-  
10 term storage of x-rays digitally. Inland Imaging cannot locate the digital x-rays.

11 (See Exhibit A).

12 8. I requested the x-rays that were entered as exhibits in State of Washington v.  
13 Maribel Gomez from the Grant County Superior Court. The Court Clerk, Lisa  
14 Ponozzo, informed me that we would need to get a Court Order and make a Notice  
15 of Appearance in order to obtain the x-rays.

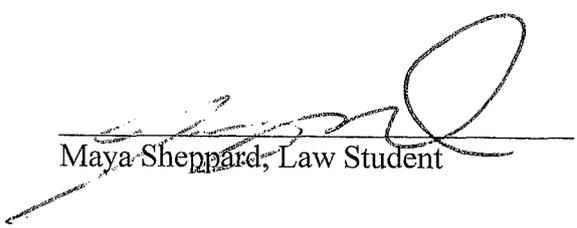
16 a. Kelly Canary, an attorney with Innocence Project Northwest, entered a Motion  
17 for Motion And Memorandum To Release Exhibits P116 Through P119 And X  
18 Rays And CT Scans In The State's Possession To Defense Expert on May 10,  
19 2010.

20 b. On May 12, 2010, the Grant County Superior Court informed Innocence  
21 Project Northwest that they had sent the exhibits back to the Ephrata Police  
22 Department.

23  
24 I DECLARE under the penalty of perjury of the laws of the State of Washington that the  
25 foregoing is true and correct.

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DATED this 13 day of May, 2010, at Seattle, Washington.



Maya Sheppard, Law Student

SPOKANE  COUNTY

OFFICE OF THE  
MEDICAL EXAMINER

MEDICAL EXAMINER  
SALLY S. AIKEN, M.D.  
FORENSIC PATHOLOGIST

MEDICAL EXAMINER  
JOHN D. HOWARD, M.D.  
FORENSIC PATHOLOGIST

April 2, 2010

Maya Sheppard  
Innocence Project Northwest Clinic  
University of Washington School of Law  
William G. Gates Hall, Ste 265  
P.O. Box 85110  
Seattle, WA 98145-1110

RE: RAFAEL ARECHIGA-GOMEZ  
AUTOPSY # 03-0405

Dear Ms. Sheppard,

Enclosed please find the majority of the records regarding decedent Rafael Arechiga-Gomez, which you requested from this office in your letter of 3-19-10. You also requested the x-rays taken during the course of autopsy. The Spokane County Medical Examiner's Office is located in Holy Family Hospital, and the office depends on Inland Imaging to perform x-rays of medical examiner decedents. In most deaths coming under office jurisdiction wherein x-rays are performed, Inland Imaging is responsible for long-term storage of x-rays digitally. The death of Rafael Arechiga-Gomez occurred at a time when Inland Imaging was transitioning between hard-copy x-rays and digital x-rays. We have not been able to locate hard-copy x-rays in our office, and Inland Imaging cannot locate digital x-rays. However, they are still searching for x-rays on this decedent, both via a back-up digital archiving system and in a hard-copy x-ray room which has not been fully cleaned or organized for some time.



Maya Sheppard  
Page 2

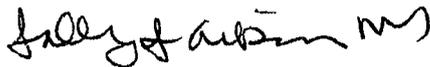
Instead of delaying the remaining items you have requested, those are enclosed. Inland Imaging anticipates that it may take several more weeks for them to complete their search for these x-rays. There is no guarantee that the x-rays will be found.

In the mean time, although you did not request photographs, you should know that the photographs do include photographs of bone injuries. Also, you might check court records to see if x-rays were admitted into evidence during trial.

I apologize for the delay in your receipt of this information. In the unlikely event that autopsy x-rays are discovered in the next few weeks, I will forward them to you as quickly as possible.

Sincerely,

---



Sally S. Aiken, M.D.  
Medical Examiner

SSA/tma  
Enc.

**Appendix 18**

**Letters from Moser to Ophoven 1/25/06 and 1/30/06**

---

# **Robert A. Moser**

Attorney at Law  
110 E. Broadway  
Moses Lake, WA. 98837  
(509) 764-2355 Fax (509) 764-5169

Wednesday, January 25, 2006

Dr. Ophoven:

Per our conference in July 2005, I am sending you documents relating to the birth of Raphael Gomez, the decedent child, documents relating to hospital visits preceding his death, and documents relating to his admittance to the emergency room on Sept. 9, 2003, one day before his death on Sept. 10, 2003.

Cordially,

---

Robert Moser

# **Robert A. Moser**

Attorney at Law

110 E. Broadway

Moses Lake, WA. 98837

(509) 764-2355 Fax (509) 764-5169

Monday, January 30, 2006

Dr. Janice Ophoven  
6494 Crackleberry Trail  
Woodbury, MN 55129

Dr. Ophoven:

Thank you for talking to me before and for taking an interest in this case.

The materials I placed in the mail last week are supplemental to those I sent in June. They complete Rafael's medical history. It is clear that Rafael suffered numerous injuries in the two years of his life which are suspicious for child abuse. I do not think these materials are critical to Maribel's defense. Nonetheless, I believe you wanted a complete understanding of Rafael's history.

Rafael was born addicted to cocaine and methamphetamine. His mother underwent drug treatment and has been clean for several years. Rafael was placed in foster care at birth and remained in foster care for about half his life. He was acknowledged to be hyper-active. He suffered several injuries while in the care of his mother suspicious for child abuse. He did not suffer any serious injuries while in foster care. At the dependency trial two years ago, six neighbors and friends to Maribel testified to her exceptional skills in parenting all of her children. Witnesses from the Department of Children and Family Services also testified to as much. The witnesses did not think Maribel singled Rafael out for abuse. They believed she treated Rafael the same as her other children, though she seemed to keep a "special eye" on him due to his high level of activity.

On September 9, 2003, Maribel was feeding Rafael. When she stopped feeding him, he jumped back in a fit, as he often did when she stopped feeding him. She picked him up and fed him some more to pacify him. He jumped back again and hit his head against the floor. His eyes rolled back in his head and Maribel shortly took him to the hospital.

Much information about this case will not be admissible at trial. Chiefly, Rafael's prior injuries and addiction at birth to cocaine and methamphetamine will not be admitted. The mother's history of drug abuse should also not be admitted.

Maribel's criminal case consists of the facts that Rafael died while in her care and that she has not given an adequate explanation for his death. Dr. Feldman will testify that it is impossible for the child to have died due to a short fall like the mother has explained.

My theory of the case is that Rafael died due to an accident that happened several days before his death. Evidently, Rafael suffered a head injury anywhere from three days to two weeks before he died. This head injury was due to jumping up and down on the bed and landing on the floor on his head. The floor was concrete and covered with a carpet. He had substantial swelling to his forehead, the upper part of his nose, and around his eyes due to this injury.

Maribel Gomez reported this injury immediately to the Department of Children and Family Services. A case worker tells me he remembers her doing so, but is uncertain of the proximity to death. I am trying to obtain records of this report.

I need an expert witness to establish the incidence of papilledema in Rafael. I will also need to establish how many days before his death a prior injury likely occurred, based on the incidence of papilledema.

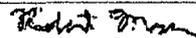
I will need an expert witness to contradict Dr. Feldman's testimony that accidental death from a short fall is not possible. At our dependency hearing, Dr. Feldman testified that he was 100% certain that Rafael died due to abuse. Maribel's defense requires an expert to at least challenge Dr. Feldman's absolute certainty on this point.

I realize as I write this letter that the prior testimonies of Dr. Marco Ross and Dr. Feldman would be helpful. I will send these to you immediately.

If you believe that you can testify to these two issues, I can request the court to appoint you as an expert witness. I believe the court and prosecutor will agree to this.

Cordially,

---



Robert Moser

**Appendix 19**

**Preliminary Report of Ophoven 2/20/07**

---

Janice J. Ophoven, M.D.

6494 Crackleberry Trail  
Woodbury, MN 55129  
651.458.0541  
Fax 651.768.0994  
jophoven@ophovenmd.com

February 20, 2007

Robert Moser  
Attorney at Law  
110 E Broadway  
Moses Lake, Washington 98837

**DRAFT**

**Re: State of Washington V. Maribel Gomez**

Dear Robert Moser

This correspondence is in response to your request for a summary of my opinions regarding the death of Rafael Arechiga-Gomez.

My clinical practice is pediatric forensic pathology. I have completed a residency in pediatrics, pediatric pathology, and a fellowship in forensic pathology. During my career, I have participated in the care of children and young adults in such areas as:

- Pediatric practice in rural and urban settings,
- Management of a clinical laboratory for a children's hospital,
- Diagnosis of solid tumors in children and adolescents,
- Participation in and development of systems to evaluate quality of care [quality assurance]
- Evaluation of medical care with unexpected or negative outcomes to identify areas for improvement [risk management]

I have conducted hundreds of autopsies in children and young adults for the purpose of making a diagnosis of cause and manner of death.

In addition, I have dedicated my clinical practice to research and education in forensic pediatric pathology and have written and taught workshops for a variety of professionals including physicians, coroners and medical examiners, law enforcement, pediatric caregivers, first responders, and members of the legal profession on such issues as:

- Forensic analysis of injuries and death of children
- Death investigation in childhood
- Munchausen's syndrome by proxy
- SIDS and homicidal asphyxia

In preparation of this report I have reviewed the following materials:

**Materials**

- Motion and Affidavit for Arrest and Detention
- Officer's report
- Washington State Patrol police reports
- Ephrata Police Dept reports
- Dept of Social and Health Services reports
- Sacred Heart Medical Center medical reports
- Lab reports
- Radiology reports
- Autopsy photographs-Black and White photo-copied pictures
- Autopsy Report
- Opinion of Dr. Kenneth Feldman-State's chief expert witness
- Columbia Basin Hospital medical records
- Admitting of victim on 9/09/03-unresponsive
- Lab reports

Samaritan Health Care medical records  
Birth records  
Lab reports  
Radiology reports  
Central Washington Hospital medical records  
ER records  
Operative reports  
Consultation report  
X-Ray report  
Wenatchee Valley Clinic Medical records  
Neurological Consultation  
Wenatchee Police Dept records  
Incident report  
Quincy Valley Medical Center medical records  
DCFS request  
Testimony of Dr Kenneth Feldman  
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CD-Gomez Autopsy photos  
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Report by Dr Kenneth Feldman  
Dr-Feldman's testimony  
Dr Feldman's Findings-8/01/06  
Dr Feldman's Findings-2/03/04  
Emergency Room Progress Note-Daniel Sloane  
Sacred Heart Medical Center medical records  
Lab reports  
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Columbia Basin Hospital medical records  
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Pediatric Flow Sheet  
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Discharge Summary  
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Quincy Valley Medical Center  
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Progress Notes  
Radiology reports  
Samaritan Healthcare medical records  
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OB records  
Labor/Delivery  
Physician's Orders  
ER record  
Radiology report  
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Labor Flow sheet

Well child exam  
Neonatal Screening  
Growth Charts  
Moses Lake Community Health Center medical records  
Well visits  
Neurological Consultation-Dr Dickinson-1/16/03 Department of Social and Health Services records  
CPT Minutes  
DCFS record  
Chemical Dependency Assessment  
SER history  
Social Worker evaluation-Mr. Twelves  
Social Worker evaluation-Ms Turcotte  
Intake report for Child Protective Services  
Safety Assessment  
Investigative Assessment  
Black & White photo copied autopsy photos  
LifeLine Ambulance records  
Foster Care Passport Program  
E-mail w/picture attachments  
Ephrata Police Dept records  
Incident reports  
Wenatchee Police Dept records  
Incident reports  
Othello Community Hospital medical records  
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Children's Hospital & Regional Medical Center medical records  
Consultation-Dr Cook  
Consultation-Dr Feldman  
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Evaluation-Jose Vasquez  
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Rockwood Clinics record  
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Neuropathology report Addendums  
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X-Ray Report-Left Hip-Rafael Arechiga  
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X-Ray Report-Osseous Survey Limited-Rafael Arechega-12/07/02  
Samaritan Hospital  
X-Ray Report-Right Tibia & Fibula-Rafael Gomez-9/23/02  
Sacred Heart Medical Center  
CT/CT head Unenhanced, CT Brain-Rafael Arechega-9/09/03  
CT/CT Spine Cervical Unenhanced, CT Cervical Spine-Rafael Arechega-9/09/03  
CT/CT Chest Enhanced, CT/CT Abdomen Enhanced, CT/ CT Pelvis Enhanced-Rafael Arechiga-9/10/03  
Samaritan Healthcare  
Radiology reports-7/24/01  
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Radiology reports-12/11/02  
Pacific Medical Imaging Consultants Inc.  
Radiology report-12/06/02  
Radiology report-9/23/02  
Samaritan Hospital

Radiology report-10/21/02  
Radiology report-9/23/02  
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Pacific Medical Imaging Consultants Inc.  
Radiology report-12/06/02  
Quincy Valley Hospital  
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Problem Oriented Progress notes  
Problem Oriented Progress Notes  
Progress notes  
Well Child visits  
15 mos  
18 mos

### **History and Clinical Findings**

Rafael Arechiga was born 8.7.01 at 37-38 weeks gestation to Maribel Gomez [unmarried 26 year old G4P3]. He was born out of hospital reportedly in a personal vehicle and may not have breathed until paramedics arrived. At the time of his birth, his mother was using cocaine and methamphetamine. The baby was born with positive urine screen-for-cocaine-and-amphetamine. Pregnancy was also complicated by a fall on July 23<sup>rd</sup>, 2001 and Mirabel was hospitalized overnight. Fetal ultrasound was essentially normal, fetal weight estimated at 2700 grams. During the newborn period he had an elevated bilirubin.

Rafael was placed in foster care at birth and later returned to his family. The family has had long-term involvement with DCFS. Rafael lived with his parents and 4 young siblings at the time of his death.

Rafael's family reported that he had problems with developmental delay, hyperactivity and self-injury including biting, pinching and hair pulling as well as behavioral challenges including aggressive and violent behavior and eating problems that involved overstuffing and vomiting.

DCFS LEP Case Document [labeled III pf VIII]; Case name Maribel Gomez includes casework noted on the Gomez family. Linda Turcotte is identified as the Assigned worker. It appears to me that the initial service date is 8.17.2000.

#### **Key elements of the case review include:**

Problems with substance abuse during pregnancy  
Discharge to licensed foster care as a newborn  
Foster parent reports the baby cries constantly and has seen the doctor 'quite a bit'  
Frequent supervised visits  
Activity date 01.22.2002 the child reportedly did not want to eat and was crying more [reportedly discussed with doctor].  
04.04.2002 Doctors visit – Ht 26 ¾”, Wt 20 # [age ~9 months]. Foster parent didn't want him to eat baby food because of vomiting, doctor recommended Maribel go ahead with baby food.

#### **Returned to birth family June 2002 age 10 months]**

September 2002 fractured tibia; nondisplaced right tibial “toddler” fracture. 9.23.2002 crying and complaint of leg pain, right distal tibial spiral fracture. Concerns also raised because of bruises on the child's back and healing lacerations in the nipple area suggesting pinch marks. Fracture was casted.

December 2002 subtrochanteric fracture of the left femur and a skull fracture; infected abrasion to scalp; and burns on hand and tongue- removal to foster care

**Rafael was again reunified with his birth family 3.25.2003 [age ~20 months]. Social worker [SW] visit observed Rafael running and jumping on the furniture, falling over his feet and toys.**

4.02.2003 Maribel raised concerns regarding Rafael's aggressive behavior including hitting and biting. The baby also wanted to be held constantly

4.08.2003 Maribel concerned about baby overstuffing his mouth

4.29.2003 Juliana [Rafael's sister] likes to feed the baby when no one is looking. Wakes up at 1100 hours and goes to bed at 2100 hours.  
5.13.2003 Maribel concerned about Rafael's behavior, biting her, scratching arms, face and legs, sits with his mouth open drooling. SW saw the bites on Maribel.  
5.15.2003 bruise on face  
5.20.2003 pinching himself.  
5.21.2003 SW observed fast eating. Concerns re: pinching, pulling his hair, and biting his mother. Puts him to bed with long socks on hands to prevent scratching  
5.29.2003 Oldest child becoming withdrawn. All of the children fearful that he will hurt himself and they will be taken away. Family requests more help and testing  
5.30.2003 Mother extremely concerned regarding Rafael's behavior. Took him to see Dr. Deleon who reportedly referred the child to Children's Hospital for evaluation.  
6.02.2003 SW visit, child still not awake at 1115 hours  
6.17.2003 Children's Hospital said that Rafael's medical expenses would not be covered  
6.25.2003 SW visit found the residence to be organized and clean..."this mother spares no effort to take care of her children".  
7.08 spitting food, scratching the mattress and crib, continues to hurt and bite his siblings  
7.18 still want to eat until he throws up  
7.24.2003 Report of a phone call from Angie Carlson PCAP worker. She visited with Maribel and Rafael several times. He was asleep most of the time, bit his lip while sleeping. Angie noticed that he sat and stared into space. She indicated that he was being referred for testing as his current doctor thinks he may have a seizure disorder  
8.11.2003 family again raises fears that any injury to Rafael would be interpreted as abuse.  
8.12.2003 Rafael cannot feed himself and doesn't like to be touched.  
8.26.2003 Rafael fell out of the bed.

According to investigative documents Rafael fell 2-3 days prior to his death onto carpet covered cement floor. At that time he suffered swelling to his forehead and face. This event was reported to DCFS.

On 9.9.2004 Rafael was eating and reportedly threw himself backwards onto the floor [uncovered linoleum] bumping the back of his head on the linoleum.

Rafael reportedly vomited and foamed at the mouth, became unresponsive and ceased breathing.

On 9.9.03 his mother transported Rafael to the Colombia Basin Hospital ER in a personal vehicle. He was unresponsive, apneic, and pulseless. CPR was initiated and a pulse was acquired after what was estimated at >25 minutes of pulseless activity. At no time was any activity present to suggest that Rafael had brain function. He was then transferred to Sacred Heart Medical Center, remaining unresponsive and never regaining consciousness. His resuscitation was complicated by problems with adequate airway and during transport to Sacred Heart they reported difficulty ventilating requiring pressure bag-valve oxygenation.

Initial evaluation at Sacred Heart revealed severe cerebral edema, no measurable neurological activity and the presence of DIC [disseminated intravascular coagulation]. Admission diagnosis to Sacred heart Hospital is massive food aspiration with cardiopulmonary arrest [Dr. Mellma]. Physical examination showed small goose egg on the back of the head and slight bruising on the forehead. Dr. Mellma's report also describes problems with airway management and ventilation. During placement of the NG tube, copious food was aspirated from the stomach.

CT scan of the head showed diffuse cerebral edema with **small** extra-axial hemorrhages over the left frontal and frontoparietal convexities. A small area of hemorrhage is seen in the right occipital lobe. Chest x-ray showed severe bilateral central consolidation with air bronchograms. CT scan of the abdomen and pelvis showed shock bowel and possible portal vein thrombosis.

Blood gases at Sacred Heart show profound impairment in lung function.

Rafael had ongoing problems with bleeding and anemia as well as low platelet counts, abnormal coagulation studies and very low white blood cell counts. During the attempts to rescue this young boy he received transfusions because

his blood could not clot. This is a result of DIC, a coagulopathic disorder that results in bleeding throughout the body.

Neurological consultation by Gregory Macdonald confirmed the diagnosis of anoxic encephalopathy with brain death [and confirms that the history is consistent with the child's clinical condition]. His examination of the eyes revealed no retinal hemorrhages in the periphery and there is presence of grade 4 papilledema [choked disc] with peripapillary hemorrhages.

He expired on 9/10/03 at 1000 hours.

Review of diagnostic imaging study reports for Rafael Arechiga:

9.21.2002 Nondisplaced oblique fracture distal right tibial metaphysis

9.23.2002 hairline fracture distal tibial metaphysis; splint in place; soft tissue swelling present

10.04.2002 Fracture right distal tibia; no callus appreciated

10.21.200 Tibial fracture, sclerosis present

12.06.2002 Subtrochanteric fracture left femur with anterior displacement

12.07.2002 Intraoperative AP and lateral left hip showing aligned intertrochanteric/subtrochanteric fracture

12.07.2002 Head CT scan; Lucency traversing the occipital cortex on several images extending to the foramen magnum.

Columbia-Basin-Hospital

9.09.2003 Chest film; diffuse pneumonia or aspiration

9.10.2003 Worsening bilateral infiltrates with complete opacification of the LUL and increased opacification of the RUL, perihilar and infrahilar regions

Sacred Heart

9.09.2003 CT scan: diffuse cerebral edema, small focus of hemorrhage right occipital lobe, small extra-axial collections of blood left frontal and frontoparietal convexities [Hofer]

9.09.2003 CT scan cervical spine; normal

9.09.2003 CT chest, abdomen, pelvis; Extensive consolidation of the lungs bilaterally with involvement of the upper and lower lobes. Distribution is predominantly perihilar with relative peripheral sparing. Impression: Extensive consolidation suggestive of ARDS probably on top of aspiration. Free abdominal fluid; shock bowel; possible L portal venous thrombosis

Dr. M. Ross performed the autopsy on 9/11/03 at 1030 hours: His final autopsy report indicates:

- Blunt force injuries of the head
  - Abrasions of face, right ear, and scalp
  - Subgaleal hemorrhages of occipital scalp and supragaleal hemorrhage of frontal scalp, acute and subacute
  - Occipital skull fractures, acute and chronic
    - Fracture line #1 – sagittally oriented occipital fracture extending from lambdoid suture to the foramen magnum
    - Fracture line #2 – transverse oriented occipital fracture measuring 5 cm.
  - Focal organizing epidural hemorrhage
  - Acute subdural [5-7 ml] and subarachnoid hemorrhages
  - Cerebral edema
  - Focal acute ischemic changes of cerebrum
- Retinal and optic nerve sheath hemorrhages, bilateral
- Contusions of the back (2) and upper extremities (4)
- Periosteal and epiphyseal-metaphyseal injuries, acute and chronic, of the proximal humeri
- Diffuse alveolar damage with multifocal bronchopneumonia
- Pleural effusions, bilateral (100 ml right; 100 ml left)
- Ascites (250 ml)
- Gastroesophageal erosions with chronic gastritis
- Stress involution of thymus

- Meckel's diverticulum
- Growth parameters:
  - Body weight at 75<sup>th</sup> % [31#]
  - Body height between 10<sup>th</sup> and 25<sup>th</sup> percentile
- Metabolic screen
  - Acylcarnitine profile = within normal limits
  - Congenital adrenal hyperplasia = within normal limits
- Toxicology
  - Blood alcohol= negative
  - Urine drug screen
    - Benzodiazepine (EMIT) = Positive
    - Glucose = 500 mg/dl
  - Blood drug screen
    - Acetone = <0.01 g/100ml
    - Midazolam = 0.02 mg/l
    - Lidocaine = positive

Dr. Ross's concludes that the cause of death is blunt force trauma to the head with injuries showing acute-subacute and chronic features. He concludes that the skull fractures are possible refracture superimposed on previous skull injury. He concludes that Rafael had suffered non-accidental trauma and the manner of death is homicide.

My review of the autopsy materials includes the following observations:

- Sections of lung show aspiration pneumonia characterized by foreign material, acute inflammation and hemorrhage. Also present are hyaline membranes characteristic of ARDS.
- Healing [remote] occipital / basilar skull fractures with extensive fibrosis, neovascularization and healing bony deposits on the epidural surfaces of bone and dura. These changes are consistent with the fracture observed on diagnostic imaging in December 2002.
- Acute subdural blood [5-7 ml; approximately 1-1/2 teaspoons of blood]
- Focal subarachnoid blood in some sections of brain
- Diffuse cerebral edema and hypoxic encephalopathy
- Subgaleal bleeding left and right occiput, left frontal – tissue sections of left occiput and left frontal scalp show vital reaction and iron staining in the left frontal scalp suggestive of older injuries.
- Sections of bone identified as L and R humerus shows healing fractures through the growth plate bilaterally with florid periosteal reaction. Section of the left humerus shows hemorrhage and fibrosis.
- Section of eye shows no subdural blood in the optic nerve sheath. There is intradural blood consistent with hypoxia. Absence of subdural blood in the optic nerve sheath is an important finding as it points away from trauma.
- Retinal hemorrhages are present on the histopathology sections

I have reviewed Dr. Feldman's report and testimony.

He was asked to address the nature of Rafael's previous injuries in 2001 and 2002. He concluded that although the constellation of injuries was questionable, he could not conclude definitely that the injuries were due to abuse. In other words, the injuries could have been accidental. These injuries included: skull fractures of differing ages [occipital skull fracture and parietal fracture], a right femur fracture [fracture of the upper bone of the leg], healing and infected skin sores [consistent with scald burns that may have been irritated by the child picking at them] and tibial fracture [the larger bone in the lower leg] characterized as a toddler fracture toddler fracture.

**Opinions:**

The process of forensic review in a case of death of a child requires analysis of the evidence to determine cause as well as manner of death. The analysis demands a review of medical records and autopsy materials, the circumstances of the child's life and medical conditions, as well as the investigation pertaining to the circumstances and activities of the child in the days and hours before presentation to medical attention. The following opinions are based on that analysis and are rendered to a reasonable degree of medical certainty.

Rafael Arechiga was 2 years old at the time of his death. He presented following a prolonged period of cardiopulmonary arrest with no pulse for over 25 minutes. During this time he suffered irreversible brain injury and he arrived to medical attention essentially deceased with a neurological examination that showed fixed dilated pupils, flaccidity [no muscle tone] and complete unresponsiveness.

Dr. Ross performed a comprehensive and scholarly postmortem analysis of Rafael. The report is thorough, and the brain was referred to neuropathology review as would be expected in a case such as this. Rafael died from complications of cardiopulmonary arrest with ischemic injury to the brain, DIC and multisystem organ dysfunction.

**Rafael had evidence at postmortem examination that included the following:**

- At autopsy Rafael showed evidence of bruises on the back of his scalp, fresh subdural blood and severe brain swelling.
- Rafael had remote skull fractures to the occipital bone with extensive reparative bone deposits. Associated with these fractures is epidural injury that has abundant evidence of healing with vital reaction. These fractures are the result of injuries at some time in the past and could have been the result of a single blow.
- There are healing fractures to the growth plate of the humerus bilaterally [the upper bone of the arms] with evidence of significant vital reaction in the tissues indicating the injuries did not occur on the day he collapsed.
- Rafael has evidence of aspiration pneumonia and shock lung. The history of aspiration of gastric contents is confirmed by the event history, the clinical observations of the doctors [Mellman and MacDonald], and the post-mortem examination of the lungs. The lungs show multifocal hemorrhages, acute pneumonia and evidence of foreign debris in the lungs. Superimposed on this is a pattern of hyaline membranes indicative of ARDS [acute respiratory distress syndrome].

Following his cardiac arrest Rafael developed persistent shock with a condition known as third spacing, severe disseminated intravascular coagulopathy [resulting in unclottable blood and bleeding] and unrelenting secondary complications to his brain. These secondary conditions include increased intracranial pressure, reperfusion hemorrhage, retinal hemorrhages and papilledema. His CT scan showed very small areas of extra-axial blood and the predominant abnormality was changes to the brain due to lack of oxygen.

The first chest x-rays at Columbia Basin showed evidence of aspiration of gastric contents which progressed over time. The initial examination of Rafael's eyes showed changes consistent with increased intracranial pressure and papilledema due to hypoxia [MacDonald], not changes due to traumatic injury.

Neuropathology examination demonstrated remote and organizing epidural injury, acute subdural blood and ischemic [lack of oxygen] to the brain. There is no evidence of traumatic injury to the brain structures / parenchyma itself such as contusion, laceration, bleeding, or axonal injury.

There is no question that this boy suffered a severe and in my opinion massive blow to the back of the head at some time in the past. This is evidenced by extensive healing skull fractures and organizing epidural injury.

He also suffered a number of documented additional injuries which include broken femur, broken tibia, and bilateral fractures to his upper arms. These injuries also occurred in the past.

This constellation of traumatic injuries is consistent with a pattern of rough handling or child abuse.

**The question at hand is what happened on or shortly before 9.09.2003 to cause Rafael's death. Was he assaulted or did he choke on his vomit?**

There was a well established history of Rafael overstuffing his mouth when eating. His mother stated that he was eating, overstuffing his mouth, arched backwards hitting his head on the floor and ceased breathing. He has evidence of aspiration of food material into his lungs. There is evidence of impacts to the back of his head that after the onset

of DIC [coagulopathy with ongoing bleeding] could have appeared as they did at postmortem. The initial description of his head was a small goose-egg.

During the period of time between his collapse and the time his pulse was achieved, he underwent aggressive resuscitation. Despite heroic attempts to save his life, he suffered irreversible multisystem organ damage...not just to his brain but his lungs, his bowel, his coagulation system and his heart. Despite the fact that Rafael got a pulse, he had already suffered fatal damage and the fight was lost before it was begun. In addition, because of the arrest and severe metabolic acidosis Rafael developed DIC. This is a coagulopathy that causes bleeding everywhere, into injuries old and new as well as into tissues that aren't even injured. When he arrived at the hospital he had a small amount of subdural blood, by the time he came to autopsy he had substantial bleeding in the subdural area. This blood continued to accumulate even after he came to the hospital. Similarly, Rafael was subjected to aggressive CPR. The fresh bruises to his back area may very well be a secondary effect of cardiac compressions against a backboard.

There is no evidence of shaken baby or rotational whiplash type injuries to Rafael. The neuropathology testing failed to identify any axonal injury to the white matter of the brain.

There is no new fracture to Rafael's skull or bones documented at postmortem.

The retinal hemorrhages present in this case do not indicate a traumatic cause. Retinal hemorrhage is a clinical and pathological finding that continues to elude clear explanation. The mechanism of occurrence of retinal hemorrhage is not well understood and the literature has never suggested that the presence of retinal hemorrhage with or without subdural hemorrhage is diagnostic of inflicted injury. It is well recognized that retinal hemorrhage can occur in a variety of circumstances. Most notably the presence of papilledema is in and of itself is associated with retinal hemorrhages of the pattern seen by Dr. MacDonald. His report indicates very clearly that the hemorrhages did not extend to the periphery when he examined Rafael. Peripheral hemorrhages are more commonly associated with trauma than other patterns. Severe elevation in intracranial pressure and DIC are also conditions that are associated with retinal hemorrhages. The pattern of retinal hemorrhages in Rafael's eyes does not provide useful information to assist in the determination of what happened to the boy when he presented on 9.09.2003.

Subdural hemorrhage and brain swelling can result from a serious hypoxic event.

Papilledema is swelling of the optic disc in the back of the eye. The optic nerve is a continuation of the nerves extending from within the brain substance. Swelling of the optic nerve head is called papilledema. Papilledema does not usually come on all of a sudden, but is a reflection of increased intracranial pressure over time. The presence of papilledema so early in the course suggests that there may have been brain swelling for many, many hours and perhaps days.

The analysis of Rafael's death is complicated. He obviously had serious pre-existing conditions, skull fractures with epidural bleeding, previous injuries suggesting abuse and history of serious behavioral challenges that potentially put him at risk for injury and choking.

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.

I have read the sworn testimony of some of the experts in this case. There are some points I would like to make:

- There is no forensic evidence of shaken baby or rotational injury to Rafael's brain
- The retinal hemorrhages do not indicate traumatic or shaking injury to the brain. There is no subdural optic nerve sheath hemorrhage present.
- Speculation about whether Rafael could have caused injury to his head in the events as described in my opinion is misleading. I agree that Rafael could not have caused his occipital skull fractures by falling backward. However, these skull fractures occurred many months prior. The real question is could he have caused bruises to the back of his head, a goose egg, and the answer is of course.
- The weight of 31 pounds cannot be interpreted at all. With the volumes of fluid and blood that are typically given to a child with severe shock the postmortem weight can increase by 10 or more pounds in a child Rafael's size and age.

Rafael clearly exhibited significantly disordered behaviors that included severe and injurious aggression, feeding dysfunction and self-injurious behavior. Some of these behaviors were documented while he was still in foster care. He was never provided the necessary evaluation to determine the extent of his abnormalities despite repeated requests for assistance on behalf of the family. The factors we do know include documented severe head trauma, intrauterine drug and possible alcohol exposure, possible birth asphyxia as well as signs and even symptoms suggestive of pervasive developmental disorder.

In summary:

Could Rafael have choked and aspirated on his vomit or choked on a mouthful of oatmeal? The answer is of course.

Is there evidence of severe fresh impact injury that is separated from any of his pre-existing and healing injuries?  
No

Could his mother be telling the truth about what happened on that day? Yes

Is Rafael an abused child? Yes

Has that changed since December of 2002? No

There are many factors that must be included in the final analysis of this case that make Rafael's death certification challenging:

- Problems that date back to birth with high risk pregnancy and delivery and possible birth asphyxia
- Complications of intrauterine drug exposure
- Severe behavioral challenges that specifically pertain to eating, overstuffing, history of vomiting with feeding, aggressive and self-harming behaviors.
- Prior abusive head injury with complex occipital skull fracture
- History of possible aspiration followed by cessation of breathing
- Prolonged cardiac arrest with extended resuscitation
- Severe secondary complications of prolonged oxygen starvation, shock and DIC including subdural hemorrhage, retinal hemorrhage and brain swelling.

If you have any additional questions, or should you need additional information, please do not hesitate to contact me.

Sincerely,

Janice Ophoven, M.D.  
Pediatric Forensic Pathologist

**Darla Czech**

---

**From:** HallsOfShambala@aol.com  
**Sent:** Friday, February 23, 2007 10:45 AM  
**To:** dczech@ophovenmd.com  
**Subject:** Dr. Ross's testimony

Dr. Ross was pretty firm in his finding that although the child's brain could also have swelled due to lack of oxygen and that although the brain showed no sign of injury, the child died due to injury to the brain resulting from acute fracture to the occipit. He did not accept that the old occipit injury was more severe than the new injury. He kept referring to the microscopic level -- he said he found the severity of the new injury by examining on the microscopic level. He did not elaborate, but just left that "microscopic" code word as a confirmation of his findings.

Our judge is intelligent, but I think he is going to have a lay impression that evidence of a new fracture is going to be hard to just explain away. A substantial part of our testimony is going to revolve around the nature of the acute re-fracturing and refuting Ross's testimony that it is a severe fracture.

I am working with the court reporter to get Ross's testimony transcribed. Thank you.

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**Darla Czech**

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**From:** HallsOfShambala@aol.com  
**Sent:** Thursday, February 22, 2007 9:59 AM  
**To:** dczech@ophovenmd.com  
**Subject:** yesterday's testimony

Angie Karlson testified -- she visited the home on about 20 occasions. In the Spring and Summer of 2003, Raffy had become very withdrawn. Once she saw his siblings playing in a sprinkler on the lawn and very animated, but he was sitting alone to the side. She saw this detached behavior at least one other time.

Dr. Ross is pretty young, maybe 45. Ross concluded the cause of the child's death was homicide, due to blunt force trauma to the head. For evidence of blunt force trauma, he relied on the acute fracturing or re-fracturing of the occipit and on subdural and sub-arachnoid bleeding.

He testified the mechanism of death was the swelling of the brain. On cross-ex, he agreed the brain would swell from lack of oxygen; that the condition of the child being 8 minutes without breathing could itself lead to this swelling of the brain.

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He believed there was axonal injury, though he could see no sign of it. He believes that a blunt force as severe as in this case must have caused axonal injury and it just wasn't detected. It also takes 24 hours for some signs of axonal injury to develop.

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He believed there was axonal injury, though he could see no sign of it. He believes that a blunt force as severe as in this case must have caused axonal injury and it just wasn't detected. It also takes 24 hours for some signs of axonal injury to develop.

I am trying to get his testimony transcribed. I'll get it to you ASAP. Hopefully by the weekend. Thanks

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**Appendix 20**

**Telephone Interview of Ophoven 4/26/06**

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TELEPHONE INTERVIEW OF DR. JANICE OPHOVEN  
04-1-00312-4 MARIBEL GOMEZ  
APRIL 26, 2006  
PAGE 1

SCOTT: TO SPEED IT UP, THE LAST TIME WE TALKED ABOUT EVERYTHING THAT YOU'D LOOKED AT?

OPHOVEN: YEAH.

SCOTT: AND I JUST WANTED REVIEW IT. IT WAS ALL PROVIDED BY, BOBBY MOSER.

OPHOVEN: YEAH.

SCOTT: AND YOU HAD CD OF THE AUTOPSY PHOTOS?

OPHOVEN: YEP.

---

SCOTT: UH, THE MOTION AND AFFIDAVIT FOR ARREST?

OPHOVEN: OH, HANG ON, YOU KNOW, I'M GONNA HAVE TO PULL THAT PARTICULAR DOC....

SCOTT: THAT WAS IN MY NOTES, THAT USUALLY CONTAINS THE PRIMARY, UH....

OPHOVEN: BUT I HAVE A LITTLE LISTING OF STUFF BECAUSE I KNOW WE WERE GONNA BACK OVER THEM.

SCOTT: OH, OKAY.

OPHOVEN: DARLENE WILL YOU QUICKLY PRINT UP ANOTHER INVENTORY ON THIS CASE FOR ME? THANK YOU. I'M, UM, UH, I'M GONNA JUST HAVE HER...

SCOTT: OKAY.

OPHOVEN: SHE, SHE PREPARES A LIST OF ALL THE THINGS THAT I HAVE, AND I WILL CROSS CHECK AGAINST UH, AGAINST THE LIST YOU'RE READING TO ME.

SCOTT: OKAY. DO YOU WANT ME TO WAIT OR TRY SOMETHING ELSE?

OPHOVEN: LET'S GO TO SOMETHING ELSE AND THEN I'LL, AS SOON AS SHE

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GIVES IT TO ME, I'LL COME BACK.

SCOTT: OKAY, WELL THE OTHER THING I USUALLY START OFF WITH, UH, ASIDE FROM ALL THE UH, MATERIAL THAT YOU REVIEWED, WOULD BE UH, ANY UH, LITERATURE, YOU KNOW (INAUDIBLE) THAT YOU RELIED UPON IN, FOR YOUR OPINION?

OPHOVEN: NOTHING SPECIFIC.

SCOTT: OKAY. AND...UH, LET'S SEE, ARE YOU FAMILIAR WITH UH, ANYTHING THAT DR. FELDMAN HAS DONE?

~~OPHOVEN: SURE. I'VE UH, I'VE READ UM, MANY OF HIS ARTICLES. I'VE READ~~  
MANY OF HIS UM....THE...EXPERT REPORTS AND I HAVE READ MANY OF HIS UM, SWORN TESTIMONIES.

SCOTT: OKAY. AND, NNN, I THINK, CAUSE, HE HAS ONE OF THEM I THOUGHT WAS MISTREATMENT OF CHILDREN, DOES THAT SOUND RIGHT?

OPHOVEN: I DON'T, I DON'T RECALL THAT ONE. THE ONE I REFER TO REGULARLY OF HIS IS TO DO WITH SKULL BURNS. I JUST LOVE THAT ARTICLE.

SCOTT: OH, OKAY.

OPHOVEN: AND SO I USE THAT ONE A LOT. BUT THE REST OF'EM ARE, YOU KNOW, THE FORENSIC PEDIATRICIAN IS SO VAST, THAT I DON'T...KEEP TRACK OF SPECIFIC AUTHORS IN THAT AREA.

SCOTT: OH.

OPHOVEN: I HAVE MY LIST NOW.

SCOTT: OH, OKAY. ALRIGHT. I HAD CD OF AUTOPSY PHOTOS?

OPHOVEN: M, HUH.

SCOTT: A MOTION AND AFFIDAVIT FOR ARREST?

OPHOVEN: M, HUH.

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SCOTT: UH, EPHRATA POLICE DEPARTMENT REPORT? THAT WOULD BE A 14 PAGE REPORT BY DETECTIVE PHILLIPS?

OPHOVEN: M, HUH.

SCOTT: I THINK THAT'S THE PRIMARY REPORT.

OPHOVEN: I HAVE AN OFFICER'S REPORT AND THEN WASHINGTON STATE PATROL POLICE REPORT.

SCOTT: YEAH, IS THAT UH, HUCKSTABLE, LIKE A TWO-PAGE REPORT WITH AN ATTACHED LAYOUT AND LOG?

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OPHOVEN: I HAVE A LAYOUT AND LOG. I DON'T HAVE THEM BY UM, OFFICER'S NAME.

SCOTT: OKAY, IT SHOULD SAY AT THE BOTTOM OF THE FIRST...

OPHOVEN: NO, I JUST HAVE, A LITTLE CONDENSED...

SCOTT: OH, OH, YOU'VE GOT YOUR.

OPHOVEN: ...AND THAT'S WHAT I HAVE...

SCOTT: OKAY.

OPHOVEN: AND IT...

SCOTT: BUT YOU..

OPHOVEN: AND UM, MY CONDENSED VERSION OF WHAT I HAVE DOESN'T HAVE THE OFFICER'S NAME ON IT.

SCOTT: OKAY, BUT YOU'VE GOT ONE WSP REPORT? OKAY. OR OFFICER'S REPORT?

OPHOVEN: I HAVE AN OFFICER'S REPORT, WASHINGTON STATE PATROL POLICE...

SCOTT: YEAH.

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OPHOVEN: ...REPORT, EPHRATA...

SCOTT: THAT'S IT.

OPHOVEN: POLICE DEPARTMENT REPORT.

SCOTT: THAT'S IT. OKAY AND I THINK THOSE ARE THE ONLY LAW  
ENFORCEMENT REPORTS YOU HAVE PER SAY. THEN YOU HAVE  
SACRED HEART RECORDS?

OPHOVEN: M, HUH.

~~SCOTT: YOU, AND DID YOU, UH, HAVE, SEE THE UH, CHEST FILMS AND THE  
CT?~~

OPHOVEN: I HAVE THE REPORTS.

SCOTT: OKAY.

OPHOVEN: I DID NOT RECEIVE THE ACTUAL UM, EXAMS.

SCOTT: OKAY.

OPHOVEN: YEAH.

SCOTT: OKAY AND YOU HAD DSHS REPORTS?

OPHOVEN: YES.

SCOTT: DO YOU KNOW WHICH ONES, THERE'S BUNCHES OF'EM?

OPHOVEN: I DO NOT KNOW SPECIFICALLY.

SCOTT: OKAY. UH,...

OPHOVEN: ...WHICH ONES I HAVE.

SCOTT: WE'VE GOT A COUPLE...

OPHOVEN: ...I HAVE...

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SCOTT: ..FILES FULL.

OPHOVEN: I, YEAH, I HAVE THEM LISTED IN TWO DIFFERENT PLACES.

SCOTT: OKAY AND I HAVEN'T READ THEM ALL MYSELF. SO, YOU HAD SAMARITAN HEALTH CARE? UH, I THINK THAT WAS THE BIRTH RECORDS?

OPHOVEN: BIRTH LAB REPORTS AND RADIOLOGY REPORTS FROM SAMARITAN.

SCOTT: OH, OKAY, SO YOU GOT SAMARITAN, YOU'VE GOT RADIOLOGY AND BIRTH?

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OPHOVEN: SAMARITAN HEALTH MEDICAL RECORDS INCLUDING BIRTH, LAB REPORTS AND RADIOLOGY.

SCOTT: OKAY. AND, YOU HAD I THINK, CBH SEPTEMBER VISIT RECORDS?

OPHOVEN: C-V-H?

SCOTT: THAT'S COLUMBIA BASIN HOSPITAL, IS THAT WENATCHEE FAIR?

OPHOVEN: COLUMBIA BASEMENT, BASIN HOSPITAL...

FAIR: NO...

OPHOVEN: ...HOSPITAL...

FAIR: ..IT'S HERE.

SCOTT: OH, COLUMBIA.

FAIR: IT'S HERE.

OPHOVEN: ..RECORDS FROM....

SCOTT: (LAUGHS)

OPHOVEN: ...SEPTEMBER.

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FAIR: YEAH.

SCOTT: THAT'S HERE. (LAUGHS) OKAY. UH, UH, COLUMBIA BASIN, YEAH.  
YOU HAD CENTRAL WASHINGTON UH, WENATCHEE?

OPHOVEN: I HAVE CENTRAL WASHINGTON AND WEAHATCHEE...WENA..  
.WENATCHEE.

SCOTT: OH, THE WENATCHEE VALLEY CLINIC PROBABLY.

OPHOVEN: THE WENATCHEE VALLEY CLINIC NEUROLOGY?

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SCOTT: RIGHT.

OPHOVEN: AND WENATCHEE POLICE DEPARTMENT.

SCOTT: OH, OH.

OPHOVEN: THAT REPORT.

SCOTT: OH, WENATCHEE POLICE DEPARTMENT REPORTS, OKAY. M.....LET  
ME WRITE THAT DOWN, I DIDN'T CATCH THAT LAST TIME, NOW, BUT  
I REMEMBER, NOW THAT YOU MENTION IT. OKAY. AND, I THINK  
YOU HAD QUINCY VALLEY MEDICAL CENTER?

OPHOVEN: M, HUH.

SCOTT: UH, AND, DCFS REPORT?

OPHOVEN: OH, I DON'T KNOW WHAT THAT IS?

SCOTT: DCFS REQUEST. I HAVE THAT...

OPHOVEN: DCFS REQUEST I HAVE HERE.

SCOTT: YEAH, I HAVE THAT WRITTEN DOWN FROM LAST TIME I TALKED TO  
YOU, OKAY. AND...

OPHOVEN: AND QUINCY VALLEY.

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SCOTT: QUINCY VALLEY, RIGHT. AND THE ONLY OTHER THING I HAVE THAT YOU, UH, WRITTEN DOWN HERE IS YOU HAVE THE TESTIMONY OF FELDMAN AND ROTH AT THE DEPENDENCY HEARING?

OPHOVEN: M, HUH.

SCOTT: OKAY.

OPHOVEN: AND, I HAVE DR. FELDMAN'S EXPERT REPORT.

SCOTT: OH, THAT'S RIGHT.

~~OPHOVEN: AND THE AUTOPSY REPORT.~~

SCOTT: RIGHT. AND FELDMAN'S REPORT IS, IT'S ON LETTERHEAD, WELL YOU DON'T HAVE IT IN FRONT OF YOU, BUT...

OPHOVEN: YEAH, IT'S A LETTER.

SCOTT: YEAH, LIKE...

OPHOVEN: BUT THAT WAS HIS, HIS, REPORT FROM THE PREVIOUS ROUND.

SCOTT: UH, HUH. WELL THE ONE THAT I HAVE IS THE, A LETTER TO DSHS, ONE, TWO, THREE, IT'S LIKE FOUR PAGES?

OPHOVEN: RIGHT, IT WAS, IT WAS WHEN HE WAS TALKING ABOUT THE PREVIOUS EPISODES OF INJURIES.

SCOTT: OKAY. BUT YOU HAVE THE ONE THAT HE DID AS A RESULT OF THIS, OF THE DEATH RIGHT?

OPHOVEN: NO, I DON'T THINK SO.

SCOTT: YEAH, LET'S SEE...

OPHOVEN: I HAVE THE ONE... I HAVE THE ONE THAT HE WROTE UM, HANG ON, YOU KNOW WHAT, I BETTER JUST MAKE SURE, CAUSE I MIGHT BE...

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SCOTT: YEAH, YOU, YOU MUST HAVE THAT...

OPHOVEN: PULLING IT OUT...HERE'S THE ONE THAT I HAVE, IT'S DATED 3/12/03.

SCOTT: 3/12/03 OKAY. UH...

OPHOVEN: THAT IS ON CHILDREN'S LETTERHEAD.

SCOTT: RIGHT.

OPHOVEN: AND, IT IS UM, REGARDING UM.....YEAH, HIS CONCLUSION IS I DO NOT SEE DEFINITIVE EVIDENCE FOR PHYSICAL ABUSE.

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SCOTT: RIGHT. NOW THAT WAS THE ONE UH, THAT WAS HE, HIS PRIOR, A PREVIOUS CONSULT THAT ....

OPHOVEN: RIGHT.

SCOTT: ...HE DID.

OPHOVEN: AND THEN I HAVE HIS UM, I HAVE HIS TESTIMONY AT THE UM, HEARING.

SCOTT: OKAY.

OPHOVEN: AND THEN I HAVE 2/3/04 BUT I'M MISSING THE LAST PAGE.

SCOTT: OH, GEES.

OPHOVEN: YEAH.

SCOTT: OKAY, UH, SO YOU HAVE THREE PAGES?

OPHOVEN: M, HUH.

SCOTT: HOW ABOUT IF I FAX YOU THAT RIGHT NOW?

OPHOVEN: COOL.

SCOTT: BECAUSE THE LAST PAGE IS ONLY A COUPLE SENTENCES.

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OPHOVEN: YEAH, THAT'D BE GOOD TO HAVE.

SCOTT: YEAH, UH, OKAY. LET'S SEE HERE, UH, FAIR, LET'S, LET'S GIVE HER THIS ONE THAT I DON'T NEE.

OPHOVEN: DO YOU HAVE MY NUMBER?

SCOTT: UH...

FAIR: GO AHEAD AND GIVE IT TO US.

SCOTT: YEAH.

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OPHOVEN: 6-5-1-7-6-8-0-9-9-4

SCOTT: 7-6-8-0-9-9-4.

OPHOVEN: YES SIR.

SCOTT: OKAY, AND I CAN READ IT TO YOU BUT YOU MIGHT AS WELL, YOU'RE GONNA NEED IT.

OPHOVEN: WELL, I'D LIKE TO HAVE IT ANYWAY. IS THIS, AM I COMING OUT THERE?

SCOTT: UH...

FAIR: WE DON'T KNOW.

SCOTT: WE'RE NOT CALLING YOU.

FAIR: (LAUGHING)

OPHOVEN: I DIDN'T THINK YOU WOULD, I MEAN...

SCOTT: IT WON'T BE US. (LAUGHS)

OPHOVEN: (INAUDIBLE) GO TO TRIAL?

SCOTT: UH, CURRENTLY SET FOR THE END OF UH...

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FAIR: MAY.

SCOTT: ...MAY. WE'LL FIND OUT DOCTOR, UH, PROBABLY MONDAY. IT IS MONDAY OR TUESDAY.

OPHOVEN: M, HUH.

FAIR: YEAH.

SCOTT: I'LL CALL IT THAT DAY, CAUSE IT'S, IT'S, IT'S ON FOR LIKE A PRE-TRIAL, UH, UH...

OPHOVEN: OKAY.

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SCOTT: ...REVIEW.

OPHOVEN: BECAUSE I THINK I, LAST TIME I TOLD YOU THAT, UH, MY EXAM IS, IS INCOMPLETE AT THIS TIME.

SCOTT: RIGHT.

FAIR: RIGHT.

SCOTT: CAUSE OF THE SLIDES.

FAIR: OF THE SLIDES.

SCOTT: YEAH.

FAIR: YEAH.

SCOTT: OKAY, SO...UH...YEAH, I'M CON, I'M CONSIDERING THE UH, REPORT OF 2/3/04...

OPHOVEN: OKAY.

SCOTT: ....AS KIND OF LIKE HIS BASIC REPORT. ALONG WITH THIS TESTIMONY. UH, AND THAT WAS PRIMARILY THE ONE I WAS GONNA ASK YOU ABOUT. UM...BEFORE WE GET BACK..UM, JUST TO REVIEW, WHAT WAS IT THAT MR. MOSER ASK YOU TO DO?

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OPHOVEN: AN INDEPENDENT FORENSIC REVIEW. AND THIS PARTICULAR CASE IT WAS UM, IT CAME IN AS UM, A QUICK REVIEW.

SCOTT: M, HUH.

OPHOVEN: WHICH IS SOMETHING THAT MY OFFICE DOES FOR FOLKS THAT I HAVE WORKED WITH IN THE PAST.

SCOTT: M, HUH.

OPHOVEN: SO THEY GO AHEAD AND SEND ME A LOT OF THE MATERIAL, AND I GO THROUGH IT AND STILL SPEND THE SAME AMOUNT OF TIME, BUT THE PEOPLE WHO ARE, UM, UH, ASKING FOR MY OPINION, UM, UM, UNDERSTAND THAT, THAT IT WILL BE WITHOUT NECESSARILY HAVING ALL OF THE MATERIALS.

SCOTT: M, HUH.

OPHOVEN: IT'S KIND OF A PRELIMINARY REVIEW.

SCOTT: YEAH.

OPHOVEN: AND CONSULTATION.

SCOTT: OKAY. AND, UH, I KIND OF HAVE IN MY NOTES, WHAT, WHAT YOUR RESULTS WERE, BUT COULD YOU GO AHEAD AND UH, JUST GIVE US A, ...GENERAL, YOUR, YOUR OPINION THAT YOU REACHED?

OPHOVEN: UM, YEAH.. UH..

SCOTT: I ASSUME THAT, YOU..

OPHOVEN: IT WAS MY OPINION THAT THE CHILD HAS SUFFERED FROM UM, UH, I THINK I HAVE THESE, THESE UH, GENERAL STATEMENTS THAT I THOUGHT THE AUTOPSY WAS EXCELLENT AND COMPLETE, WHICH IS TYPICALLY MY EXPERIENCE WITH DR. ROSS.

SCOTT: M, HUH.

OPHOVEN: UM, THAT THE UM, CHILD HAS EVIDENCE OF REPEATED UM, UM,

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INJURIES THAT WERE UM, INADEQUATELY EXPLAINED, SO FELL IN TO THE, INTO THE CATEGORY OF UH, CHRONIC BATTERED CHILD SYNDROME.

SCOTT: M, OKAY. AND THAT WOULD BE...

OPHOVEN: UH, IF YOU STILL USE THAT TERMINOLOGY. SOME STATES DON'T, DON'T LIKE THAT LANGUAGE, SO IT'S THE CHILD IS OBVIOUSLY BEEN THE VICTIM OF, OF RECURRENT BLUNT FORCE TRAUMA, THAT EXCEEDS THE, UM, CLASSIC, UM, INJURY PATTERNS OF UH, CHILDREN OF THAT AGE.

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SCOTT: RIGHT, SO IT'D BE BASICALLY, NON-ACCIDENTAL TRAUMA?

OPHOVEN: YEAH, IT'S THE ALL FIT THE PATTERN OF NON-ACCIDENTAL TRAUMA THAT UM, THAT IT'S MY OPINION THE HEAD BANGING, UM, CERTAINLY CAN CAUSE UH, BRUISES AND SO ON, BUT THAT UH, IT DOESN'T RESULT IN SERIOUS HEAD INJURY OR FRACTURES, OR UH, BRAIN INJURY. AND THAT THE CHILD DIED OF COMPLICATIONS OF BLUNT FORCE TRAUMA TO THE HEAD.

SCOTT: OKAY. UH, I'M GLAD WE'RE RECORDING. (LAUGHS)

FAIR: YEAH. WE CAN'T WRITE AS WELL AS YOU, AS FAST YOU SPEAK.

OPHOVEN: WELL, I'M READING DR. ROSS' REPORT AND IT'S KIND OF, YOU KNOW?

FAIR: YEAH.

SCOTT: YEAH, AND I THINK, UH.

OPHOVEN: THE, THE ONLY THING THAT UH, AND I THINK WE TALKED ABOUT THIS BEFORE, AND, IN, UH, READING THE TESTIMONY PROVIDED BY DR. FELDMAN, UM, I WAS UH, SAILING ALONG JUST FINE TIL WE GOT THE SHAKEN BABY STUFF?

SCOTT: M, HUH.

OPHOVEN: IT'S LIKE, YOU KNOW, THERE'S NO EVIDENCE TO SUPPORT THAT.

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THERE'S NO REASON TO UM, ADD IT. IT'S UH, A CONTROVERSIAL CONCEPT AND THERE'S PLENTY THERE WITH WHAT YOU HAVE.

SCOTT: RIGHT, AND, AND I KNOW YOU'VE DONE, DONE A LOT WITH SHAKEN BABY, RIGHT?

OPHOVEN: WELL, I'VE BEEN RESEARCHING IT FOR YEARS. I HAVE OLD BOOK CHAPTERS THAT JUST GOES IN, YOU KNOW, I LIVE WITH JUST PERFECT WITH DR. FELDMAN, IT'S JUST THE BIO-MECHANICS ARE, THE BIO-MECHANICAL UM, UM, STUFF, WE DIDN'T INVITE THEM TO THE TABLE. UM...IN THE EARLY YEARS OF THIS UH, OF THIS JOURNEY AND STUDYING BLUNT FORCE TRAUMA, OR HEAD ~~INJURIES IN CHILDREN, AND, AND SOMETIME AROUND THE EARLY~~ 80'S UH, SHAKING BECAME SYNONYMOUS WITH ABUSIVE HEAD TRAUMA.

SCOTT: M, HUH.

OPHOVEN: AND SO WHENEVER, WHENEVER WE SAID IT WAS ABUSIVE HEAD TRAUMA, WE USED THE WORD SHAKEN BABY. AND EVERYBODY GOT USE TO IT AND LOVED IT. AND IT WAS JUST VERY HAPPY.

SCOTT: OKAY.

OPHOVEN: AND THEN SOMEBODY FINALLY SAID, WELL, WHAT DOES THAT REALLY MEAN AND WHAT DOES THE EVIDENCE SHOW TO SUPPORT THAT THEORY OF INJURY AND WE ALL KIND OF LOOKED AT EACH OTHER AND SAID, WELL, I DON'T KNOW. AND THEN WE STARTED TALKING THE BIO-MECHANICS AND THEY SAID, WELL, WE'VE BEEN WAITING FOR YOU GUYS BECAUSE THAT'S STUPID THINKING. AND, IT'S YOU KNOW, PEOPLE KILL THERE KIDS BY, FROM HEAD TRAUMA, BUT THE WHOLE SHAKING THING IS KIND OF SHAKY, UPON REVIEW.

SCOTT: OKAY. UH, OKAY YOU KNOW, CAROLYN AND I BOTH, WE'RE KIND OF JUST, YOU KNOW, KEEPING THE CASE GOING, WE MIGHT END UP DOING IT, BUT UH, BECAUSE THE PROSECUTOR'S IN TRIAL, WE COULDN'T FIND WHERE HE REFERRED TO SHAKING, IN LOOKING AT HIS TESTIMONY?

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OPHOVEN: YEAH.

SCOTT: NOW, I KNOW HE, HE TALKS ABOUT...

OPHOVEN: NO, BUT HE GETS, NO HE DOESN'T TALK ABOUT, HE DOESN'T SAY SHAKEN BABY, THE ONLY, BUT WHEN HE'S TALKING ABOUT ACCELERATION AND DECELERATION...?

SCOTT: UH.

OPHOVEN: UM, AND THE, THE UM, AND SOME OF THAT STUFF IS WHERE IT GOT....

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SCOTT: ALRIGHT, I'LL HAVE TO GO BACK AND LOOK FOR THAT...AND....I THINK THAT HELPS ME A LITTLE. UH, I KNOW THAT HE, TALKS ABOUT...A...UH...WHIPLASH MOTION ASSOCIATED WITH...

OPHOVEN: THAT...

SCOTT: ....WITH...

OPHOVEN: THAT'S IT, THAT...

SCOTT: HIM...

OPHOVEN: THAT'S, THAT'S IT.

SCOTT: THAT'S IT?

OPHOVEN: YEAH, THAT'S IT.

SCOTT: GOOD, GOOD. WELL, WHAT, SO WHAT HE SAYS IS, THAT THERE'S BLUNT FORCE TRAUMA TO THE HEAD, AND...UH, THAT THERE WOULD'VE BEEN ASSOCIATED WHIPLASH INJURY...

OPHOVEN: YEAH, JUST DON'T GO THERE.

SCOTT: OKAY. AND, AND HE'S SAYING THAT BECAUSE THE, THE VICTIM'S HEAD WOULDN'T HAVE UH, MOVED IN LINE WITH SOMETHING, BUT WOULD'VE HAD A WHIPLASH MOTION?

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OPHOVEN: YEAH, BUT THE WHOLE WHIPLASH THING IS WHERE YOU GET THIS...

SCOTT: IS THAT JUST TOO GENERAL?

OPHOVEN: ...KIND OF THE...THAT'S KIND OF THE...

SCOTT: TOO...

OPHOVEN: THAT'S KIND OF THE FROSTING THING.

SCOTT: M, HUH.

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OPHOVEN: AND THE WHOLE WHIPLASH, IS THAT KIND OF LAST REFERENCE TO, AND I'M REAL SENSITIVE TO THAT. BECAUSE THE THING THAT, THAT RESULTED IN THE INJURY WAS THE FORCE OF IMPACT.

SCOTT: OKAY, RATHER THAN, OKAY.

OPHOVEN: AND SO, THE WHOLE WOBBLING AROUND ON THE NECK THING?

SCOTT: M, HUH.

OPHOVEN: IS LIKE, YOU KNOW. IF IT'S BAD ENOUGH TO CAUSE UM, TRAUMA TO THE BRAIN, THEN YOU'D EXPECT TO SEE TRAUMA TO THE BRAIN STEM.

SCOTT: YEAH.

OPHOVEN: AND CERVICAL CORD.

SCOTT: OKAY.

OPHOVEN: SO FROM A FORENSIC STAND POINT THIS IS KIND OF WHERE THE FORENSIC PATHOLOGIST GET THEIR HACKLES UP.

SCOTT: M, HUH.

OPHOVEN: WHEN PEOPLE START SWINGING CONCEPTS AROUND THAT ARE, THAT ARE NOT SUPPORTABLE FROM THE AUTOPSY. DR. ROSS HAS DONE A REALLY NICE JOB OF, OF, OF, UH, DOCUMENTING THE

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ACTUAL INJURIES.

SCOTT: OKAY, GOOD. SO I, I, I...

OPHOVEN: HE'S NOT TALKING ABOUT...

SCOTT: ...THINK...

OPHOVEN: ...TALKING ABOUT WHIPLASH AND ACCELERATION AND I THINK WE OUGHT TO JUST STICK WITH, WITH HIS DIAGNOSIS, CAUSE HE'S THE GUY THAT WAS THERE.

~~SCOTT: YEAH. OKAY, BUT THAT DOESN'T IN ANY WAY EFFECT THE CONCLUSION THAT IT WOULD BE, UH, I KNOW DR. FELDMAN SAID, IT WAS A 100% SURE IT WAS NON-ACCIDENTAL TRAUMA?~~

OPHOVEN: WELL, I THINK IT'S ONE OF THOSE SITUATIONS WHERE I HAPPEN TO BELIEVE THAT JURIES ARE THE ONES THAT ULTIMATELY MAKE THE DETERMINATION OF WHAT DID OR DIDN'T HAPPEN IF WE WEREN'T THERE, OKAY?

SCOTT: RIGHT, NO WE WOULDN'T....

OPHOVEN: WHAT I CAN TELL YOU...

SCOTT: ...BE ASKING HIM THAT...

OPHOVEN: ...IS THAT BASED ON THE PATTERN OF INJURIES IN THIS CHILD, IT IS INCONCEIVABLE THAT HE DIED OF AN ACCIDENT.

SCOTT: M, HUH. YEAH AND WE WOULD NEVER ASK YOU OR DR. FELDMAN THAT QUESTION. THAT THEY CAN...

OPHOVEN: YEAH I THINK WHEN YOU SAY, IT IS ABSOLUTELY 100% NON-ACCIDENTAL TRAUMA, THAT'S KIND OF THE SAME.

FAIR: I, I DON'T THINK WE CAN ANYWAY, BECAUSE WE'LL BE INVADING...

SCOTT: YEAH.

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FAIR: ...THE PROBLEMS OF THE JURY, SO...

OPHOVEN: RIGHT. AND THEN, IN THE OLD DAYS, WE USE TO, YOU KNOW,  
PEOPLE USE TO SAY THAT WAS OKAY. YOU KNOW...

SCOTT: YEAH.

OPHOVEN: I KNOW FOR SURE IT HAPPENED IN THE KITCHEN WITH THE PIPE BY  
COLONEL MUSTARD AND WE'RE KIND OF ALL....

SCOTT: YEAH.

OPHOVEN: WE'RE KIND OF BEING TOLD THAT'S... INAPPROPRIATE AND I'VE  
ALWAYS AGREED WITH THAT. SO, THE ISSUE HERE IS, DO YOU  
THINK THIS IS AN ACCIDENT? NO.

SCOTT: RIGHT.

OPHOVEN: IS THERE A HISTORY THAT IS CONSISTENT WITH AN ACCIDENT TO  
EXPLAIN THE FATALITY? NO. UM, THEN IS IT A REASONABLE  
ASSUMPTION TO CONCLUDE THAT IT'S AN ACCIDENT? NO.

SCOTT: M, HUH.

OPHOVEN: DOES THAT MEAN THAT IT'S MOST PROBABLY NOT AN ACCIDENT?  
YEAH. NOW I'M, I'M FINE WITH ALL THAT STUFF.

SCOTT: YEAH, AND THE COURT'S ARE...

OPHOVEN: I WASN'T THERE AND WE, DIDN'T WATCH IT. UM, YOU KNOW, THE,  
THEN, BECAUSE THEN YOU CAN COME BACK OR SOMEBODY ELSE  
CAN COME BACK AND SAY, WELL WHAT ABOUT THE BIG BLACK  
DOG THAT FLEW THROUGH THE WINDOW?

SCOTT: M, HUH.

OPHOVEN: YOU KNOW, THAT YOU DIDN'T KNOW ABOUT. WELL, YEAH, THEN IT  
COULD'VE BEEN AN ACCIDENT.

SCOTT: YEP. NOW ON THE COURT'S ARE TIGHTENING UP ON THE WAY WE

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CAN ASK YOU THAT STUFF ANYWAYS, SO I THINK YOU ON, YOU'RE KIND OF RIGHT ON THE LINE WHERE, RIGHT, UH, IN THE PROPER AREA WHERE WE'D BE. YOU KNOW, WHERE SOMEONE WOULD BE ASKING YOU. OKAY, UH, ALRIGHT THEN NOW THE REPORT OF DR. FELDMAN, THE, THE ONE THAT'S DATED 2/3/04?

SCOTT: IS THAT A COP....

OPHOVEN: WOULD YOU HAND ME THE LAST PAGES OF DR. FELDMAN'S REPORT? I THINK IT JUST CAME OFF? YEAH, WHAT THE HELL IS THAT? OKAY, HERE IT IS.

~~SCOTT: OKAY, UM, THE...UH, IT'S FOUR PAGES, UH, OH THANKS, I'VE GOT THIS ONE. (PAPER SHUFFLING) UM, AND AS FAR AS THE...UH...DR. FELDMAN'S RENDITION OF THE, THE MEDICAL RECORDS AND THE TREATMENT YOU KNOW, PRIOR TO GIVING HIS OPINION?~~

OPHOVEN: I THOUGHT, I THOUGHT HIS, HIS TESTIMONY, UM, WITH THE EXCEPTION ABOUT ALL THE STUFF WITH THE WHIPLASH AND THE WHATEVER, WAS A VERY REASONABLE DISSERTATION OF THE STORY.

SCOTT: M, HUH.

OPHOVEN: OF THE MEDICAL JOURNEY THAT THIS CHILD UNDERWENT.

SCOTT: OKAY.

OPHOVEN: UM, I THOUGHT THAT HIS ORIGINAL REPORT WAS BEYOND FAIR, UM.....NOW, I GUESS...UM...SINCE I'M ON THE RECORD, I'M ON THE RECORD, BUT I SURE AS HELL WOULD'VE.....BEEN, I THINK UH.....IT WOULD'VE BEEN EASIER FOR ME TO SAY THAT THIS CHILD WAS, UH, WAS AT RISK.

SCOTT: YEAH. YEAH.

OPHOVEN: ON THE FIRST ROUND. AND UM, YOU KNOW THAT SAID, THEN, THEN, THEN, THE, THEN HERE WE ARE WITH THE SECOND ROUND AND I THINK IT'S ENTIRELY APPROPRIATE PUTTING ALL OF THE FACTS TOGETHER TO CONCLUDE THIS CHILD DIED UM, UH, AT THE

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HANDS OF ANOTHER.

SCOTT: OKAY, AND AS FAR AS YOU KNOW, HE DOES HIS CONCLUSION, LIKE BEGINNING OF THE LAST PARAGRAPH ON PAGE THREE, UM...BUT UP TO THAT POINT, UH, ARE YOU PRETTY MUCH IN AGREEMENT WITH THE, THE HISTORY HE'S GIVEN?

OPHOVEN: WELL, I THINK, YOU KNOW, AGAIN WHERE HE STARTS TALKING ABOUT THE (INAUDIBLE) SPRAIN INJURY WITH MULTI FOCAL HEMORRHAGE, UM, UH, OR EEE, INDICATIVE OF, OF SEVERE BLUNT INJURY TO THE HEAD, PERIOD.

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SCOTT: M, HUH.

OPHOVEN: NOW THE WHIPLASH ROTATION COMPONENT IS....

SCOTT: YEAH.

OPHOVEN: ....NOT ONLY UNSUPPORTED BY THE FACTS OF THE CASE...

SCOTT: OKAY.

OPHOVEN: ...BUT UNNECESSARY.

SCOTT: OKAY, I GOT YA.

OPHOVEN: AND THAT WOULD BE, AND UM, THAT'S THE WHOLE PLACE WHERE, WHERE DIS, WHERE DISHONEST DEFENSE ATTORNEYS ARE GONNA COME IN AND START MAKING HAY. SO YOU JUST MIGHT AS WELL NOT THROW THAT STUFF IN THERE. NOW I KNOW BOBBY, WON'T BUT, THIS IS WHERE THE, THIS IS WHERE THE B.S. COMES.

SCOTT: YEAH. OKAY.

OPHOVEN: AND I AGREE THE FORCE HAVING BEEN SUFFICIENT TO CAUSE THESE INJURIES, AND...I DON'T BELIEVE THAT HE STOOD AND FELL OVER, AND STOOD AND FELL OVER, AND SPLIT HIS SKULL OPEN.

SCOTT: YEAH. AND THE UH...

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OPHOVEN: I THINK IF SOMEBODY WERE TO ASK DR. ROSS, AND ME, THE QUESTION, IS, IF YOU WHACKED A KIDS HEAD REALLY HARD ON THE CEMENT, AFTER THEY HAD PRE-EXISTING INJURIES OF THIS SEVERITY, COULD YOU HURT OR KILL'EM? THE ANSWER IS, SURE.

SCOTT: M.

OPHOVEN: COULD A CHILD ACCIDENTALLY FALL AND, UM, WHACK THEIR HEAD ON A CEMENT FLOOR, WITH THESE PRE-EXISTING INJURIES AND HURT THEMSELVES, AND DIE? SURE.

SCOTT: M, HUH.

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OPHOVEN: THOSE ARE THE HONEST ANSWERS.

SCOTT: RIGHT.

OPHOVEN: UM.....DO I THINK THAT'S WHAT HAPPENED? UM, THAT'S REALLY SPECULATION, EVERYONE'S GONNA OBJECT.

SCOTT: M, HUH.

OPHOVEN: THERE'S NO EVIDENCE TO SUGGEST THAT'S WHAT HAPPENED.

SCOTT: YEAH, AND I'M JUST MAKING A NOTE HERE...THAT, THAT KIND OF REMINDS ME, I, I, I UH, FROM WHAT I BASICALLY KNOW ABOUT THESE CASES, THE, WHEN YOU ARE TALKING ABOUT FOR EXAMPLE, UH, HAVING A PREVIOUS INJURY AND FALLING, ARE, ARE YOU TALKING...

OPHOVEN: HE IS SO INCREDIBLY MORE vulnerable.

SCOTT: RIGHT.

OPHOVEN: GIVEN THE HORRIBLE, PRE-EXISTING INJURIES HE'S HAD, THAT, YOU KNOW, HE'S A KID THAT SHOULD BE WEARING A HELMET, AND IF HE'S HAD A SOCCER MOM, MOM, YOU KNOW, WE'D ALL BE RUNNING AROUND HOLDING OUR BREATH.

SCOTT: YEAH.

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OPHOVEN: UM, BUT UM, UH, THAT SAID, UM, HE, SPLITTING HIS SKULL OPEN IS STILL GONNA TAKE A HELL OF A FORCE.

SCOTT: YEAH.

OPHOVEN: REGARDLESS.

SCOTT: NOW ARE YOU, ARE YOU OF THE OPINION THAT HE COULD POTENTIALLY, UH, LIKE FALLING ON A CEMENT FLOOR, WITH THAT HISTORY, THERE'D BE A, WHAT THEY CALL A SPONTANEOUS RE-BLEED?

OPHOVEN: WELL, I THINK THERE'S, UM, I'M, I DON'T THINK THAT'S WHERE ANYONE'S GALLING. BUT, BUT IN A, IN A CASE LIKE THIS, THAT, THE, THE SCIENCE WOULD SAY, IF YOU HAVE, IF YOU HAVE A, UH, CHILD WHOSE HEAD HAS BEEN CRACKED WIDE OPEN AND SEVERE SUBDURAL AND BRAIN DAMAGE IN THE PAST?

SCOTT: M, HUH.

OPHOVEN: IF YOU WHACK THEIR HEAD AGAIN, THEIR GONNA BE MORE VULNERABLE TO SUBSEQUENT INJURY AND POTENTIALLY RE-BLEEDING THEN SOMEONE WHO'S STARTING WITH A FRESH HEAD.

SCOTT: OKAY, SO I GUESS THE ANSWER TO THAT, IS IT'S POSSIBLE.

OPHOVEN: POSSIBLE, SURE. AND THE REASON FOR THAT IS THAT IN THE SUBDURAL SPACE, THE, THE UM, MEMBRANE THAT DR. ROSS DESCRIBES IS FULL OF BLOOD VESSELS THAT ARE NEW AND THOSE BLOOD VESSELS SECRETE ANTICOAGULANTS?

SCOTT: M, HUH.

OPHOVEN: UM, SO THAT, SO THERE REALLY IS A RISK FOR RE-BLEEDING INTO THAT SPACE AS LONG AS THERE IS A SPACE OCCUPYING LESION IN THE NEO-MEMBRANE. BUT, RE-BLEEDING INTO AN OLD SUBDURAL ISN'T THE SAME AS RE-CRACKING YOUR HEAD.

SCOTT: RIGHT.

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OPHOVEN: SO THAT BECOMES A, A MOOT POINT.

SCOTT: OKAY.

OPHOVEN: BECAUSE A, A RE-BLEED ISN'T GONNA CAUSE A...NEW SKULL FRACTURE.

SCOTT: RIGHT.

OPHOVEN: SO THEN IT'S KIND OF LIKE, WELL COULD, DID WE HAVE RE-BLEED AND BLUNT FORCE TRAUMA? I DON'T CARE.

SCOTT: YEAH.

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OPHOVEN: IF THERE'S A RE-BLEED.

SCOTT: THAT'S A GOOD WAY TO PUT IT. YEAH, I MEAN, AFTER ALL THE SKULL IS BROKEN AGAIN, SO...

OPHOVEN: YEAH.

SCOTT: BECAUSE TECHNICALLY...

OPHOVEN: WHOLE, YEAH, THAT WHOLE POTENTIAL CONSEQUENCE, WHICH DOES HAPPEN TO SOME POOR GUY'S ACCUSED?

SCOTT: M, HUH.

OPHOVEN: IS YOU GOT AN OLD INJURY IN THERE AND THE KID ACTUALLY DID FALL, AND DID GET A RE-BLEED INTO A, A, AN INJURY THAT PEOPLE DIDN'T KNOW HE HAD AND THEN THE POOR GUY CALLS 9-1-1 GETS ARRESTED. YOU KNOW THAT DOES HAPPEN.

SCOTT: YEAH.

OPHOVEN: BUT THAT HAS NOTHING TO DO WITH THIS CASE.

SCOTT: IN FACT, ISN'T THE, KIND OF THE CLINICAL, OR YOU TELL ME, THE CLINICAL DEFINITION, LIKE OF A RE-BLEED, IS WHEN, WHEN YOU HAVE A RE-BLEED OF A PRE-EXISTING UH, UH, HEMORRHAGE BASED

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A TRIVIAL ACCIDENT, RATHER...?

OPHOVEN: OH, YEAH.

SCOTT: ..THAN A...?

OPHOVEN: IT CAN BE ANY KIND OF ACCIDENT, INCLUDING A BIG ONE.

SCOTT: YEAH.

OPHOVEN: IF IT'S A FALL OFF THE COUCH OR WHATEVER. USUALLY THOSE  
KIDS PRESENT THOUGH WITH A SEIZURE.

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SCOTT: RIGHT.

OPHOVEN: THEY DON'T COME IN DEAD.

SCOTT: YEAH.

OPHOVEN: YOU KNOW THE DON'T JUST LIKE...HAVE A LITTLE RE-BLEED AND  
DIE.

SCOTT: RIGHT, SO YOU'RE BASIC RE-BLEED IS SOMETHING THAT'S UH,  
CONSIDERED TO BE IN CONJUNCTION WITH A TRIVIAL NEW INJURY  
THAT AGGRAVATES A PREVIOUS....?

OPHOVEN: RIGHT, I MEAN I'VE HAD TWO OR THREE OF THESE WHERE THE KIDS  
BEEN DROPPED OFF AFTER A WEEK AT HOME, YOU KNOW, WITH A  
HISTORY OF COLD VOMITING AND WEIGHT LOSS AND THEN HE  
FINALLY GET'S BACK TO THE BABYSITTER HAVING A FUNKY  
MORNING, HAS A SEIZURE, GOES TO THE HOSPITAL AND WE'VE GOT  
THIS SUBDURAL AND EVERYONE THINKS, OKAY, BAD BABYSITTER.  
THEY GET TO THE AUTOPSY AND IT TURNS OUT THAT THAT WEEK  
OF BEING HOME, WITH THE VOMITING AND WEIGHT LOSS WAS  
RECOVERING FROM OUR ORIGINAL INJURY. AND UM, WE LEFT  
SOMEBODY ELSE HOLDING THE BAG. AND THEN WHEN YOU START  
CONJURING SHAKING, WHICH MEANS THAT IT HAD TO HAVE  
HAPPENED RIGHT NOW, THIS MINUTE. UM, IT COULD ONLY BE THE  
BABYSITTER, THAT'S WHERE, THAT'S WHERE PEOPLE LIKE ME GET  
LEGITIMATELY CALLED IN TO DEFEND.

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SCOTT: RIGHT.

OPHOVEN: BUT, NOT, NOT A CASE LIKE THIS.

SCOTT: BUT, AND LIKE, FOR EXAMPLE, AND I THINK YOU WERE TALKING ABOUT ANOTHER CONCEPT WHICH I, I, VAGUELY RECALL, WHICH IS LIKE A, WHAT THEY CALL, A LUCENT INTERVAL?

OPHOVEN: WELL, YEAH, AND AS A MATTER OF FACT, AND I THINK WE TALKED ABOUT THAT, UM, AGAIN, IF YOU HAVE YOUR BRAIN SCRAMBLED FROM UH, A DIFFUSE BRAIN TRAUMA, LIKE YOU SEE IN GROWN UPS WHO HAVE THE TRUE WHIPLASH INJURY WHERE THERE'S NO IMPACT, BUT THEY'RE DEAD?

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SCOTT: M, HUH.

OPHOVEN: UM, THEY'RE NOT GONNA BE CHATTING UP A STORM ON THE WAY TO THE HOSPITAL. THEY'RE DEAD. THEIR BRAINS ARE SCRAMBLED.

SCOTT: M, HUH.

OPHOVEN: IF, HOWEVER, YOU GET A WHACK ON THE HEAD, LIKE THIS KID DID THE FIRST TIME, AND HE GETS A TERRIBLE SKULL FRACTURE. HE MIGHT HAVE A CONCUSSION AND BE UNCONSCIOUS FOR A LITTLE WHILE BUT THEN WAKE UP, OR NOT EVEN BE UNCONSCIOUS. I HAD A KID IN, UH, IN CALIFORNIA WHO THE PARAMEDICS HAD TO RESTRAIN. HE'S 9 MONTHS OLD, THEY HAD TO RESTRAIN HIM AT THE SCENE TO START TREATMENTS. HE HAD THIS GIANT BULGING HEMATOMA ON HIS SKULL. WE GET INTO THE HOSPITAL, HE'S GOT AN EGGHELL FRACTURE OF THE SKULL. THESE LIKE FRAGMENTS ALL OVER THE PLACE. HE GOES ON TO DIE, BUT DURING THE FIRST THREE OR FOUR HOURS AFTER THE IMPACT, THE KID WAS SCREAMING BLOODY MURDER AND THEY HAVE PICTURES OF HIM LOOKING AROUND AND YOU KNOW. SO THIS WHOLE THING ABOUT LUCID INTERVAL AND PEOPLE ARGUING ABOUT WHETHER IT CAN HAPPEN OR NOT, THOSE OF US THAT DEAL WITH REAL HEAD TRAUMA, KNOW THAT YOU JUST TAKE THE CASE AS IT COMES. AND IF THE CHILD PRESENTS WITH A, WITH A, FATAL HEAD INJURY ON IMPACT, UM, AND THE INJURY'S SEVERE ENOUGH SO THAT LIFE STOPS AT THE TIME THAT THE IMPACT OCCURRED, THEN YOU

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KNOW, WHO CARES ABOUT A LUCID INTERVAL. BUT MOST OF'EM, UH, THAT'S NOT HOW IT WORKS. THEY EITHER GET THE DWINDLES, OR THEY GOT A REPEAT INJURY. OR THEY'VE BLED OUT, AND FINALLY GO INTO SHOCK, OR, THERE IS A LOT OF OTHER ELEMENTS TO IT. SO YOU JUST TAKE THEM AT A, YOU KNOW JUST TAKE THEM REALLY CAREFULLY, LOOK AT THE FACTS, LOOK AT THE CHEMISTRIES WHEN THEY ARRIVE AT THE HOSPITAL, AND PUT IT TOGETHER THE BEST YOU CAN. BUT I'VE SEEN KIDS COME IN WITH EGGHELL FRACTURES OF THE SKULL, NEVER HAVING LOST CONSCIOUSNESS AND WITH NO BRAIN INJURY.

SCOTT: WOW, IS THAT MORE COMMON WITH CHILDREN THAN ADULTS?

OPHOVEN: WELL, WE HAVE, WE HAVE YOU KNOW FOLKS FLYING OFF THEIR BICYCLES AND COME IN WITH OBVIOUS BASEL SKULL FRACTURES AND WE JUST SEND THEM HOME. SAY, YOU KNOW, IF YOU GET A REALLY BAD HEADACHE THEN COME BACK. SO, IT, IT'S NOT SPECIFIC TO KIDS OR ADULTS. IT'S JUST SPECIFIC TO A PARTICULAR CASE.

SCOTT: RIGHT.

OPHOVEN: THE THING THAT'S COOL ABOUT THE, THE SKULL FRACTURE CASES, IS THAT A LOT OF TIMES THE FRACTURING DISSIPATES THE FORCE. SO NOW A LOT OF IT ENDS UP GOING INSIDE THE BRAIN. SO YOU CAN HAVE A TERRIBLE SKULL FRACTURE AND NO BRAIN INJURY.

SCOTT: M, HUH.

OPHOVEN: AND YOU CAN ALSO HAVE A TERRIBLE BRAIN INJURY AND NO SKULL FRACTURE.

SCOTT: M, HUH.

OPHOVEN: OR LIKE THIS, YOU CAN HAVE BOTH.

SCOTT: M, OKAY. UM, ALRIGHT, SO I THINK.....WE'RE PRETTY MUCH, UH, IN, IN, PRETTY MUCH WHEN YOU'RE UH, TALKING ABOUT HIS WRITTEN, DR. FELDMAN'S WRITTEN REPORT HERE, IS IT PRETTY MUCH YOUR OPINION THE SAME WITH REGARD TO HIS TESTIMONY AT THE

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DEPOSITION?

OPHOVEN: YEAH, IT'S THE SAME. I THOUGHT HE DID A NICE JOB OF GOING OVER THE FINDINGS AND THEN WHEN WE GOT TO THE WHIPLASH STUFF, I KIND OF JUST CHECKED OUT.

SCOTT: OKAY.

OPHOVEN: I HAVE A LITTLE, LITTLE FROWNING FACE AND SA....

SCOTT: WE'LL TELL DR. FELDMAN.

OPHOVEN: YEAH (ALL LAUGH)

SCOTT: UH...OKAY, AND, AND AGAIN, NOT THAT WE WOULD ASK YOU THIS SPECIFICALLY, BUT, YOU DON'T THINK THESE INJURIES ARE CONSISTENT WITH THE A SHORT FALL?

OPHOVEN: NO.

SCOTT: YEAH, AND...

OPHOVEN: I DON'T.

SCOTT: ...NON-ACCIDENTAL?

OPHOVEN: NOW IF YOU TOLD ME HE WAS STANDING ON THE KITCHEN TABLE AND TO, TOOK A HEADER ONTO A PURE CEMENT FLOOR?

SCOTT: M, HUH.

OPHOVEN: WITH THAT PAS, WITH THESE PAST, YOU KNOW, IF YOU, IF YOU MADE UP A WHOLE NEW SCENARIO?

SCOTT: M, HUH.

OPHOVEN: YOU KNOW, THEN IT WOULD BE A WHOLE NEW SET OF ANSWERS, BUT GIVEN THE INFORMATION AS IT'S BEEN PRESENTED TO ME, UM....IT'S IN, IT'S NOT CONSISTENT.

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SCOTT: RIGHT AND YOU GOT, I THINK IN THIS CASE, WE'VE GOT UH, YOU KNOW THE INTERNAL AND EXTERNAL SCALP BRUISES.

OPHOVEN: OH, YEAH.

SCOTT: THE, THE BRUISES WHAT WITH TO THE EAR AND THE FACE OR WHATEVER, SO IT'S CLEARLY NOT JUST FALLING ON THE BACK...

OPHOVEN: NO. NO, THIS WAS THE, PROBABLY BEST FOR THE KIDS FINALE, REALLY DIFFICULT LIFE.

SCOTT: YEP, YEP AND I THINK THE UH, CAROLYN, DIDN'T THE MOTHER JUST ~~HAVE ANOTHER?~~

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FAIR: YEAH, SHE JUST POPPED OUT ANOTHER ONE LAST WEEK.

OPHOVEN: HOLY MACKEREL.

SCOTT: WHATEVER.

FAIR: YEP, YEP.

OPHOVEN: SO THEN, BUT THEN IT'S NOT... STAYING WITH HER IS IT?

FAIR: NO, I THINK THIS ONE'S ...

SCOTT: NO.

FAIR: ...BEEN TAKING, HER OTHER CHILDREN HAVE BEEN TAKEN AWAY. SHE HAS...

OPHOVEN: OH.

FAIR: ...TWO PROVISIONS. I MEAN, UM, I'M SORRY. SUPERVISED VISITATION.

SCOTT: YEAH.

FAIR: BUT SHE DOESN'T HAVE THE CHILDREN, BUT YEAH SHE JUST HAD ANOTHER BABY AND IT WAS TAKEN AWAY. AND SHE HAD ONE

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YOUNGER THAN RAFFY TOO, WHEN THIS HAPPENED.

OPHOVEN: REALLY.

FAIR: YEAH, SHE HAD A BABY, UH, AFTER THIS ONE.

OPHOVEN: WELL IT JUST CONFOUNDS ME. IT'S ONE OF THOSE PUZZLES OF THE UNIVERSE, YOU KNOW, YOU GET A GLASS, YOU KNOW GET A NICE BOTTLE OF WINE AND SIT AROUND AND TALK ABOUT WHY IN THE HELL IS STUFF GOING ON.

FAIR: I KNOW.

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SCOTT: I KNOW, I KNOW.

FAIR: IT'S SAD.

SCOTT: YEAH.

OPHOVEN: (INAUDIBLE)

SCOTT: ALRIGHT, WELL HEY THE LAST THING I THINK I, UNLESS CAROLYN HAS SOMETHING, THE UM, THE PRIOR INJURIES THAT UH, DR. FELDMAN REFERS TO?

OPHOVEN: M.

SCOTT: THE UH, PROXIMAL, UH, HUMERAL FRACTURES, THAT'S LIKE UPPER ARM, SHOULDER, RIGHT?

OPHOVEN: M, HUH.

SCOTT: AND, DO YOU AGREE WITH HIS CONCLUSION THAT, THEY'RE SEVERAL WEEKS OLD?

OPHOVEN: YEP.

SCOTT: AND, THAT THEY ARE OF THE CHARACTER CAUSED BY SEVERE TRACTION ON THE EX, EXTREMITIES?

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OPHOVEN: YEP.

SCOTT: OKAY AND THEN THE NEXT ONE HE TALKS ABOUT, IS, GLENOID, IS THAT CARTRIDGE, OR CARTILAGE?

OPHOVEN: NO, THE GLENOID IS UH, BONE.

SCOTT: HUM. SO WHAT IS, A GLENOID FRACTURE, HOW IS THAT DIFFERENT FROM A HUMERAL FRACTURE?

OPHOVEN: IT JUST HAS TO DO WITH THE LOCATION.

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SCOTT: OKAY, I, FOR SOME REASON, I THOUGHT IT WAS UH, CARTILAGE...AREA.

OPHOVEN: NO, I DON'T THINK SO.

SCOTT: NO. OKAY, BUT, BUT YOU AGREE THAT THAT'S ALSO UH, AN, UH, NOT A CONTEMPORANEOUS INJURY?

OPHOVEN: RIGHT.

SCOTT: AND ALSO REQUIRES SIMILAR TRACTION FORCES?

OPHOVEN: M, HUH.

SCOTT: OKAY. AND...I GUESS HE CONCLUDES THAT UH, HIS, THE VICTIMS ARMS WOULD'VE HAD TO HAVE BEEN JERKED FAIRLY SEVERE? SEVERELY TO SEPARATE THE BONES FROM, AT THE SHOULDERS?

OPHOVEN: YEAH, I MEAN, I THINK WE'RE TALKING ABOUT THE SA, THE SUBSTANTIAL FORCE, THE WAY THAT I DESCRIBE IT IS, THAT IT EXCEEDS THE, THE, THE UM, TOLERANCES OF THE TISSUES THAT, THAT WOULD BE ATYPICAL FOR UM, UM, UH, A CHILD WITHOUT SOME SUBSTANTIAL ACCIDENTAL FORCE, OTHERWISE, THE ASSUMPTION WOULD BE THAT IT'S, UM, NON-ACCIDENTAL.

SCOTT: OKAY. UM,...AND I THINK..

OPHOVEN: (INAUDIBLE) BONE FRACTURES IS YOU'RE AWARE OR ARE THE

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MOST COMMON IN ACCIDENTAL AND NON-ACCIDENTAL, SO IT BECOMES, IT'S A, THEN IT BECOMES A PATTERN INTERPRETATION. PATHOLOGISTS LIKE PATTERNS AND THAT'S WHY I'M VERY COMFORTABLE WITH CALLING THESE NON-ACCIDENTAL. UM, UM, OTHER SPECIALISTS HAVE DIFFERENT WAYS OF DRAWING CONCLUSIONS ABOUT THINGS, BUT, UM, US PATHOLOGIST HAVE TO LOOK AT, AT PATTERNS IN ORDER TO RENDER OPINIONS ABOUT ANYTHING. AND WHEN YOU GET DOWN TO THINGS LIKE CHILD ABUSE OR CANCER, UH, AGAIN, IT HAS TO DO WITH THE HISTORICAL INTERPRETATION OF PATTERNS. UH, A LOT OF FOLKS ARE ALWAYS SURPRISED WHEN THEY HEAR THAT THE THE, THE AN, THE CORRECT ANSWER TO THE QUESTION OF HOW CAN YOU TELL SOMETHING'S CANCER UNDER THE MICROSCOPE, IS THAT IT LOOKS JUST LIKE STUFF THAT KILLS YOU FROM CANCER.

SCOTT: M.

OPHOVEN: THAT'S THE CORRECT ANSWER.

FAIR: WOW.

OPHOVEN: IT'S GOT THE PATTERN OF MALIGNANCY.

SCOTT: M.

OPHOVEN: AND THAT'S WHAT THIS IS.

SCOTT: YEP, OUR, OUR BOSS UH, SAW THIS THING ABOUT YOU KNOW, HOW DOGS SOMETIMES UH, THEY ACT UP RIGHT BEFORE YOU'RE HAVING A HEART ATTACK?

OPHOVEN: YEP.

SCOTT: HE'S GOT FIVE DOGS, AND HE'S IN A STRESSFUL TRIAL RIGHT NOW.

OPHOVEN: HUH.

SCOTT: AND EVERY TIME HIS DOG COMES UP, AND ONE OF THEM STARTS SNIFFING HIM, HE GETS WORRIED.

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OPHOVEN: OH, GOD.

(ALL LAUGH)

OPHOVEN: WELL, YOU KNOW, I HAVE A FEELING IN A FEW YEARS, WE'RE GONNA BE WALKING INTO THE SPECIAL FLOOR OF THE HOSPITAL WHERE THEY HAVE ALL THE DOGS, CATS, AND (INAUDIBLE).

SCOTT: OH, YEAH.

OPHOVEN: YOU KNOW, AND LET THEM GO OVER US.

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FAIR: (LAUGHS)

SCOTT: AND UH, HEY, DID YOU DO ANY UH, WRITTEN...?

OPHOVEN: NO.

SCOTT: REPORT? OKAY, NO WRITTEN REPORT. AND UH, YOU'LL LET US KNOW IF YOU DO ONE?

OPHOVEN: OH, OF COURSE.

SCOTT: IT, I KIND OF DOUBT BOBBY'S GONNA WANT ONE, UH, BUT WE'LL TALK TO HIM MONDAY. UH, I HAD OTHER, SOME OTHER REAL SPECIFIC STUFF, BUT I THINK YOU'VE GIVEN US PRETTY GOOD GENERAL.

FAIR: YEAH.

SCOTT: ...UH...UH...IDEA, I THINK I LOOKED AT SOME OF THE THINGS FROM THE AUTOPSY. OH, YOU, BASICALLY THE UH, I DID WANT TO ASK YOU ABOUT THE, UM,.....THE UH..... OCCIPITAL FRACTURE?

OPHOVEN: M, HUH.

SCOTT: IS IT, DO YOU KIND OF AGREE WITH THE AUTOPSY REPORT AND DR. FELDMAN, THAT THAT APPARENTLY THAT TAKES QUITE A BIT OF FORCE TO CAUSE THAT TYPE OF FRACTURE?

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OPHOVEN: WELL, OCCIPITAL FRACTURES IN AND OF THEMSELVES, THERE, THESE ARE, THESE ARE THE TOUGH BONES.

SCOTT: M, HUH.

OPHOVEN: I MEAN THERE'S A LOT OF FOLKS THAT'LL TELL YOU THAT ONE, THAT'S PROBABLY THE MO, MOST DIFFICULT BONE TO BREAK. IT DOESN'T MEAN IT'S THE LEAST COMMON, BUT IT'S JUST A BIG, BAD, THICK BONE, UM...UM...BECAUSE OUR BODIES ARE DESIGNED TO, TO UM...BE ABLE TO HANDLE UM TRAUMA BACKWARDS. UM, WE'RE NOT TERRIBLY WELL IN HANDLE TO, TO HAVE TRAUMA FRONTWARDS, BUT UM, THE OCCIPUT IS A VERY, VERY TOUGH BONE.

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SCOTT: RIGHT, THAT'S CAUSE THROUGH EVOLUTION, WE'RE...WE'RE...

OPHOVEN: RIGHT. WE'RE...

SCOTT: WE'RE TRYING TO PROTECT OURSELVES..

OPHOVEN: ..WE DON'T HAVE ANY REFLEXES TO PROTECT US FROM TIPPING OVER BACKWARDS, SO WE'RE BUILT TO, WITH A BIG BUTT AND A NICE THICK BACK OF OUR HEADS. UM, BUT I DON'T THINK THAT IF THE, AND AGAIN, THAT WOULD COME DOWN TO THE QUESTION OF LOOKING AT THE MICROBES, IF THE SKULL FRACTURE, WAS NOT COMPLETELY OCCIFIED UM, IN THE, IN THE HEALING PROCESS, THEN IT'S CERTAINLY IS GONNA BE EASIER TO FRACTURE AGAIN.

SCOTT: OKAY, OKAY, FROM THE UH, THE PRIOR ONE...YEAH, AND I CAN'T, I, I DON'T REMEMBER IF THEY...

OPHOVEN: BUT I CAN'T TELL BECAUSE THEY'RE ALL, THE OCCIPITAL FRACTURES ARE, ARE RED AS ACUTE AND, CHRONIC, SO MY SENSE IS THAT HE MAY, MAY HAVE LAN, YOU KNOW, KNOCKED IT OPEN ON, ON AN UNHEALED SPOT?

SCOTT: M, HUH.

OPHOVEN: SO I THINK THE QUESTION OF WAS THE FORCE FOR THE SECOND FRACTURE NECESSARILY HAVE TO BE AS BAD AS THE FORCE FROM

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THE FIRST ONE. AND THEN I THINK, THE SIMPLE ANSWER WOULD BE NO. HE TALKS ABOUT THERE BEING FIBROSIS AND YOU KNOW, VASCULARITY AND FIBRIN, WHICH MEANS IT WASN'T WELL HEALED AT ALL.

SCOTT: M.

OPHOVEN: AND UM, THE SKULL HEALS VERY DIFFERENTLY THAN OTHER BONES AND SO IT TAKES A LONG TIME FOR SKULL FRACTURES TO ACTUALLY GROW OVER.

SCOTT: UH, WHY'S THAT?

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OPHOVEN: AND SO, I THINK THERE WOULD BE INCREASED VULNERABILITY THERE.

SCOTT: OKAY. IT, IT WOULD IT STILL THOUGH, NORM, NORMALLY CONSIDERED A CONSTELLATION OF UH, INJURIES, UH, IT, IT LOOKS LIKE THIS WAS A FAIRLY SIGNIFICANT IMPACT.

OPHOVEN: WELL, I THIN..IT, IT'S A, I THINK IT, IT IS A FATAL IMPACT. UM, I THINK THE FAIR ANSWER TO THE QUESTION, COULD, COULD A SECOND BLOW, WOULD THE SECOND BLOW, UM, UH, THE SECOND OR THE LIGHTS OUT BLOW TO THE BACK OF HIS HEAD, HAVE TO BE AS SERIOUS OR AS SEVERE AS THE FIRST ONE THAT HE, THAT HE SURVIVED, AND THE ANSWER IS NO.

SCOTT: OKAY. OKAY. AND THEN UH, THE UH.....THE HEMORRHAGING, THE OCCIPITAL UH, IS IT SUBGALIAL?

OPHOVEN: M, HUH.

SCOTT: THAT'S, BUT THAT'S BLEEDING BETWEEN THE LAYERS OF THE...

OPHOVEN: THAT'S BETWEEN THE, THE SUBGALIAL IS BETWEEN THE BOTTOM OF THE SCALP TISSUE...

SCOTT: RIGHT.

OPHOVEN: ...AND THE TOP OF THE BONE.

---

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SCOTT: OKAY.

OPHOVEN: SO IT'S THAT SPACE IN THERE.

SCOTT: RIGHT. UHHHH.....DOES THAT, DOES THAT ALSO HELP YOU IN ANY WAY THE FACT THAT THERE'S HEMORRHAGING AT THAT LOCATIONS?

OPHOVEN: WELL, I THINK THE FACT THAT THERE'S FRESH BLOOD THERE IS, IT SUBSTANTIATES THAT THERE'S BEEN A BLOW.

SCOTT: M, HUH.

---

OPHOVEN: A SECOND BLOW. AGAIN, WE'RE TALKING ABOUT INJURIES ON TOP OF INJURIES.

SCOTT: M, HUH.

OPHOVEN: SO THAT DOES MAKE THE INTERPRETATION OF THE, THE LAST INJURY A LITTLE BIT MORE COMPLICATED, BUT IT'S CLEAR THAT THERE IS FRESH BLOOD, ON TOP OF HEALING TISSUES AND ON TISSUES, HE DESCRIBES VERY NICELY WITH UM, UM, HEMOSIDERIN CELLS, BUT A LOT OF THAT INFLAMATION THAT HE DESCRIBING IS IN PLACES WHERE THE FRESH BLOOD ISN'T.

SCOTT: OH, OKAY.

OPHOVEN: AM I MAKING SENSE THERE? I MEAN THAT'S A VERY LONG, STUPID SENTENCE. LET ME RE-SAY IT. HE TOOK THREE SECTIONS OF THE SCALP. UM, THE FIRST SECTION WAS FROM THE LEFT FRONTAL BLOOD. THE SECOND ONE WAS FROM THE RIGHT OCCIPITAL BLOOD. AND THE LA, THIRD WAS FROM THE LEFT OCCIPITAL BLOOD. UM, ALL THREE OF THEM SHOW, UM...UM...SOME INFLAMATION BUT SLIDES FOUR AND FIVE DEMONSTRATE VERY LITTLE INFLAMATION WHERE AS SLIDE SIX THERE IS A LOT OF INFLAMATION, AND LESS BLOOD.

SCOTT: M. OKAY. AND THE, THE LAST TWO THINGS I WAS JUST KIND OF CURIOUS ABOUT THE AUTOPSY. I'M GONNA PRONOUNCE THIS WRONG, BUT UH...IS IT ISCHEMIA?

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OPHOVEN: ISCHEMIA.

SCOTT: I THINK I KNOW WHAT IT IS. IT'S, IT'S WHEN YOU HAVE A  
DECREASE IN BLOOD SUPPLY DUE TO SOME KIND OF OBSTRUCTION  
OR...

OPHOVEN: YEAH, DECREASED BLOOD SUPPLY THAT RESULTS IN DAMAGE.

SCOTT: OH, OKAY.

OPHOVEN: SO, SO UH, SO ISCHEMIA REFERS TO THE DAMAGE TO THE TISSUE  
FROM INADEQUATE CIRCULATION OF OXYGENATED BLOOD.

---

SCOTT: M, HUH. AND DOES THIS SHOW YOU THAT THERE'S UH, AT LEAST  
AN OBVIOUSLY A RECENT TRAUMA, AS OPPOSED TO...

OPHOVEN: WELL ISCHEMIA REFERS ULTIMATELY TO THE FINAL PATH TO  
DEATH FOR THIS BOY. WHICH IS, UM AT THE END OF THE JOURNEY,  
HE HAD SUCH HIGH BLOOD PRESSURE INSIDE OF HIS HEAD THAT IT,  
IT EXCEEDED THE BLOOD PRESSURE THAT HIS BODY COULD  
CREATE. SO WHEN YOU HAVE A HIGHER BLOOD PRESSURE IN THE  
HEAD, THAN YOU HAVE IN THE BODY, YOU S, THE CIRCULATION  
STOPS.

SCOTT: AH, OKAY. SO THAT'S WHY THEY SAID IN THE REPORT, THAT, AT  
SOME POINT HE DIDN'T HAVE ANY CIRCULATION ABOVE THE  
CORRODED, UH....

OPHOVEN: THAT'S RIGHT AND THAT'S, THAT'S THE, THAT IS THE DE, THAT IS  
ACTUALLY THE DEFINITION OF BRAIN...

SCOTT: AH.

OPHOVEN: ....DEAD.

SCOTT: - OKAY. OKAY. SO THEN....

OPHOVEN: IT'S WHEN THE BLOOD...

SCOTT: AND THAT IS BECAUSE...

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OPHOVEN: ..THE BLOOD PRESSURE UPSTAIRS EXCEEDS THE BLOOD PRESSURE  
DOWNSTAIRS.

SCOTT: I GET YOU, SO NO BLOOD CAN COME UP OR DOWN.

OPHOVEN: YOU'RE TALKING ABOUT A MATTER OF MINUTES BEFORE THE, THE  
BRAIN IS IRREVERSIBLY DONE.

SCOTT: AH.

OPHOVEN: AND WE CAN KEEP THEM ALIVE, THEORETICALLY INDEFINITELY AS  
TERRY SHIVO POINTED OUT.

---

SCOTT: M, HUH.

OPHOVEN: BUT, UM, NO ONE'S HOME.

SCOTT: YEAH, YEAH, THAT WAS. UH, LAST THING, I WASN'T SURE FROM  
THE, UH, AUTOPSY OR THEIR, OR FELDMAN'S UH, THE SIGNIF OF THE  
RETINAL AND OPTIC NERVE SHEATH HEMORRHAGES?

OPHOVEN: THE SIGNIFICANCE OF THE RETINAL AND OPTIC NERVE SHEATH  
hemorrhages...ARE...UM, UH...MUCH LESS THAN THEY USE TO BE. UM,  
IT USE TO BE IF WE HAD RETINAL AND OPTIC NERVE SHEATH  
HEMORRHAGES, WE'D GO, OH, THAT MEANS CHILD ABUSE. NOW, IT  
MEANS, UM, WE HAVE PATHOLOGY IN THE HEAD AND I THINK WE  
ALREADY KNEW THAT.

SCOTT: YEAH. YEAH I THOUGHT I'D READ SOMEWHERE THAT THAT'S  
GIVEN LESS SIGNIFICANCE.

OPHOVEN: THAT'S UH, DR. RANCE, UH A WONDERFUL RESEARCHER FROM UM,  
UM...NORTH CAROLINA ACTUALLY PRESENTED I THINK 750 UM,  
AUTOPSIES THAT HE DID CONSECUTIVELY THAT WHERE HE DID UM,  
WHERE HE DID PHOTOMITOGRAPHRY AND, NO PHOTOGRAPHY  
BEFORE HE DISSECTED THE EYES AND THEN DISSECTED THE EYES  
AND UM, IN (INAUDIBLE) KIDS OF VARYING AGES, WHO DIED OF ALL  
KINDS OF STUFF. AND, AND WHAT WE'VE ALWAYS KNOWN OVER  
THE YEARS IS WE ONLY LOOKED FOR RETINAL HEMORRHAGES AND  
OPTIC-NERVE SHEATH HEMORRHAGES IN PEOPLE THAT WE

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THOUGHT HAD CHILD ABUSE. SO, WE FOUND IT A LOT. UM, NOW, WE'RE LOOKING, THERE'S A FEW INSTITUTIONS THAT ARE LOOKING AT EVERYBODY AND GUESS WHAT? IF SOMETHING'S WRONG IN YOUR HEAD, IT'S GONNA BE REFLECTED IN THE RETINAS AS WELL. SO ALL OF THAT STUFF WE HAD ABOUT BLEEDING OUT TO THE ORTHOTA AND MULTIPLE LAYERS AND YOU KNOW, SHAKING AND ALL THAT STUFF, IT JUST WE NEVER LOOKED AT ANYONE ELSE. SO IT MEANS, IN THIS CASE, THAT THE CHILD HAS REALLY BAD INTRA CRANIAL DEFORMITY.

SCOTT: M, OKAY. ALRIGHT. CAROLYN DO YOU HAVE ANY, MIKE, UH?

FAIR: NO.

SCOTT: ANYTHING ELSE DOCTOR, YOU WANT TO LET US KNOW?

OPHOVEN: NO, I DON'T THINK SO. I, I THINK WE'RE GOOD.

SCOTT: HOW WAS YOUR TRIP TO UH, SEATTLE?

OPHOVEN: OH, IT WAS SOO NICE, I HAVE TWO GRAND BABIES NOW. AND UM, THEY'RE JUST, IT WAS JUST WONDERFUL. AND THEY ARE BEING RAISED IN A LOVELY COMMUNITY AND....

FAIR: NOW ARE THEY IN SEATTLE, OR PORTLAND AREA?

OPHOVEN: NO, THEY'RE IN SEATTLE.

FAIR: OH, OKAY.

OPHOVEN: THEY'RE IN SEATTLE, BUT THAT, THAT UH, I LOVE VISITING THERE, THAT, THAT WHOLE SWING AROUND THE CORNER COMING IN FROM SEA-TAC AND...

FAIR: ISN'T THAT GORGEOUS?

OPHOVEN: THE SOUND IS LIKE, IT NEVER FAILS TO TAKE MY BREATH AWAY.

FAIR: IT IS GORGEOUS.

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SCOTT: YEP, MIKE AND I HAD THE PLEASURE OF BEING OVER IN THE  
MEDICAL EXAMINER'S OFFICE ALL AFTERNOON YESTERDAY.

OPHOVEN: OH, REALLY. OH, HUH.

SCOTT: DIFFERENT CASE.

FAIR: YEAH, DIFFERENT CASE.

SCOTT: (CHUCKLES)

OPHOVEN: YEAH, WELL THEY HAVE A REAL GOOD SYSTEM UP THERE.

---

SCOTT: YEAH.

OPHOVEN: UM, I'VE BEEN, I'VE JUST BEEN SO IMPRESSED WITH UM, THE WORK  
THAT COMES OUT OF WASHINGTON STATE. IT'S REALLY FUN. IT'S,  
IT'S NOT UNIVERSALLY THE CASE, SO.

SCOTT: YEAH, I WAS KIND OF INTERESTED....

OPHOVEN: AND I HOPE YOU PASS ON TO DR. ROSS HOW UM, HOW NICELY LAID  
OUT AND CLEAR AND COMPLETE HIS, UH, POST WAS. IT WAS JUST...

SCOTT: OH, I WILL, YEAH.

OPHOVEN: ANYWAY, UM, I SPECT YOU GUYS'LL TAKE CARE OF BUSINESS ON  
MONDAY OR WHENEVER..

SCOTT: YEAH, WELL REMIND BOBBY TO LET YOU KNOW IF WE CHANGE  
TRIAL DATES OR ANYTHING.

OPHOVEN: (LAUGHS)

SCOTT: AND I'LL TELL BOBBY WE'VE TALKED TO YOU.

OPHOVEN: I'M SURE HE KNOWS. THANKS.

SCOTT: THANK YOU.

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FAIR:           THANK YOU DOCTOR.

OPHOVEN: BYE.

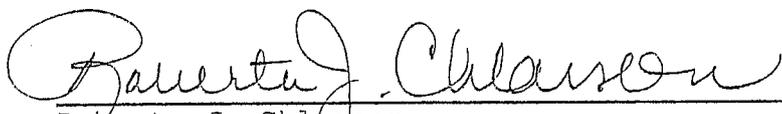
SCOTT:        K. BYE.

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CERTIFICATE OF TRANSCRIPTION

I, Roberta J. Chlarson, a secretary for the Grant County Prosecutor's Office, in and for the County of Grant in the State of Washington, do hereby certify that on the date and at the place herein before set forth; the foregoing proceedings of a compact disc recording of DR. OPHOVEN, taken on April 26, 2006, were duly transcribed by me, and I certify that this is a true and correct transcript of the compact disc recording. I further certify that I am not of relation to either party nor interested in the event of this cause.



Roberta J. Chlarson  
Grant County Prosecutor's Office  
P.O. Box 37  
Ephrata, WA 98823

5-3-06

Dated

**Appendix 21**

**Statement of Maria Gomez**

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EPHRATA POLICE DEPARTMENT

STATEMENT OF: [REDACTED]  
OFFICER: John Phillips  
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CASE NO.: 03EP4159  
CRIME:  
DATE: 9-16-2003

Det. Phillips: This interview is [REDACTED]. Her date of birth is [REDACTED]. She lives at [REDACTED] in Ephrata. Her phone number is [REDACTED]. Speaking is Detective John Phillips. This interview is being conducted at the offices of Child Protective Services in Moses Lake. Also present is Mario Gonzales, with Child Protective Services, and the time is 1342. Uhm, today's date is September 12<sup>th</sup>. Okay, uhm, before we get started [REDACTED], uhm I need to note that you know some rules that when I, that when we talk with kids we have to have certain rules, they're the same rules that we talk to adults but sometimes, the adults don't follow the rules, uhm, but one of them is, do you know the difference between the truth, telling the truth and telling a lie?

[REDACTED] Uh, huh,

Det. Phillips: Okay. If I said Mario's hat is red, is that a truth or is that a lie?

[REDACTED] A lie.

Det. Phillips: Okay, why what color is the hat?

[REDACTED] Blue.

Det. Phillips: Blue, okay. If I said uh, that garbage can is pink, is that a truth or a lie?

[REDACTED] A lie.

Det. Phillips: What color is it?

[REDACTED] Grey.

Det. Phillips: Right. Okay. Now if I said the drawers there are green, yellow, red and blue, is that truth or a lie?

[REDACTED] Truth.

Det. Phillips: Okay. Do you understand the consequences of telling a lie, what happens if you

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STATEMENT OF: [REDACTED]  
OFFICER: John Phillips  
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tell a lie and you get caught?

[REDACTED]: I don't know.

Det. Phillips: You don't know. No one's ever told you that? You think you'd get in trouble?

[REDACTED]: Yeah.

Det. Phillips: Okay, yeah, so what I, what I like to work on is just be truthful with each other okay?

[REDACTED]: Uh, hm.

Det. Phillips: Okay, uhm, and when we're talking, if you don't remember something, just tell me I don't, I don't remember.

[REDACTED]: Uh, hm.

Det. Phillips: Okay. Uhm, and if you don't know something, just let me know you don't know, okay?

[REDACTED]: Uh hm, yeah.

Det. Phillips: Do you know the name of my dog?

[REDACTED]: Uh-uh.

Det. Phillips: No? Why don't you know the name of my dog?

[REDACTED]: Because I don't know your dog.

Det. Phillips: Okay, there you go, now just making sure you understood that rule and uhm, if it's something that you don't want to talk about right then just let me know, I don't want to talk about this right now and we'll talk about something else, okay?

[REDACTED]: (giggling)

Det. Phillips: Where do you go to school at?

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STATEMENT OF: [REDACTED]  
OFFICER: John Phillips  
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[REDACTED] I go to Parkway.

Det. Phillips: Parkway. That's pretty close to the house.

[REDACTED] Uh huh.

Det. Phillips: Right. Who's your teacher this year?

[REDACTED] Uh, Miss (inaudible) and Mrs. Dahl.

Det. Phillips: Do you know Mr. Martell?

[REDACTED] No.

Det. Phillips: He's the principal. I don't know too many of the teachers, but he's I deal with him a lot. He's a pretty nice guy, the principal.

[REDACTED] Is he the Parkway principal?

Det. Phillips: He's kind of an old guy, with grey hair, works in the office. Always looks grumpy,

[REDACTED] Oh, uh I don't know him.

Det. Phillips: kind of stern, but he's not, he's not really too grumpy, not too stern. He likes kids.

[REDACTED] I don't know him.

Det. Phillips: Well that's good, means you haven't been to the principal's office then.

[REDACTED] Uh-uh.

Det. Phillips: Okay. Uhm, how long have you guys lived at [REDACTED]

[REDACTED] Like 3 weeks I think.

Det. Phillips: 3 weeks? So you moved back, moved there in August?

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STATEMENT OF: [REDACTED]  
OFFICER: John Phillips  
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[REDACTED] Uh-huh.

Det. Phillips: Do you remember what day it was?

[REDACTED] Uh, no.

Det. Phillips: Uh, who all lives in the house with you?

[REDACTED] My mom, my brother, and sister, my brother and sisters, me and my dad. He goes and visits sometimes.

Det. Phillips: Uh huh, so you're dad is Jose?

[REDACTED] Yeah.

Det. Phillips: And your brothers are.....who?

[REDACTED]: [REDACTED] (inaudible), [REDACTED] and [REDACTED]

Det. Phillips: Okay, uhm. And you're the oldest?

[REDACTED] Uh-huh.

Det. Phillips: Okay, uhm, do you remember uh, what happened, or what time it was when, when your mom was feeding [REDACTED] and [REDACTED] What were you doing when she was doing that, do you remember?

[REDACTED] Uhm, I was watching tv.

Det. Phillips: Okay. Do you remember what you were watching?

[REDACTED] Sponge Bob.

Det. Phillips: Sponge Bob? Do you like Sponge Bob?

[REDACTED] Uh-hm

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STATEMENT OF: [REDACTED]  
OFFICER: John Phillips  
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Det. Phillips: I was, I seen a deal on the Squidworth.

[REDACTED] Squidwishy? He's mean.

Det. Phillips: You don't like Squidworth. He's kind of funny though?

[REDACTED] Sometimes.

Det. Phillips: I watched him the other day when Squidworth was uh, told Sponge Bob it was opposite day,

[REDACTED] Oh yeah.

Det. Phillips: cause he was trying to sell his house, I don't watch it a lot but I happened to be in the room when that part was on, so.

M. Gonzales: Yeah, yeah, you watch it.

Det. Phillips: (laughing) Do you remember what time Sponge Bob, what channel that was on, is that Nickelodeon?

[REDACTED] Yeah.

Det. Phillips: Do you know what time he comes on?

[REDACTED] Uhm, like about 2, 3, 5, 5, 5. Uh-hm.

Det. Phillips: 5, Uhm, and where was your mom feeding the boys at?

[REDACTED] The living room.

Det. Phillips: In the living room? Where was she, you know, you go in through the front door, there's a

[REDACTED] A couch right here and a couch right here.

Det. Phillips: a couch, a couch to your right and there's one

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STATEMENT OF: [REDACTED]  
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[REDACTED]: the left

Det. Phillips: to your left. She was at the left?

[REDACTED]: Uh-hm.

Det. Phillips: And what, do you remember what she was feeding them?

[REDACTED]: Uh-hm. (inaudible)

Det. Phillips: What was she feeding them?

[REDACTED]: Uhm, noodles.

Det. Phillips: Noodles? I heard somebody say sopa.

[REDACTED]: Sopa

Det. Phillips: Is that Spanish for soup? So what kind of soup was it?

[REDACTED]: It was these curly ones.

Det. Phillips: Oh, okay. Is that what you had for dinner too?

[REDACTED]: Uh huh, no we didn't, we had uhm, what's it called? How do say caldo in English?

M. Gonzalez: stew soup

[REDACTED]: Yeah, we had that. and it was a little bit hot.

Det. Phillips: Oh,

[REDACTED]: so mom made soup for [REDACTED] and [REDACTED]

Det. Phillips: Okay. Cause the soup you had, the stew you had was spicy?

[REDACTED]: Yeah.

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STATEMENT OF: [REDACTED]  
OFFICER: John Phillips  
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Det. Phillips: Oh okay. I had a posada.

[REDACTED] I don't know what that is.

Det. Phillips: Oh, some kind of a with pork, stew like a soup

[REDACTED] Oh.

Det. Phillips: It's got menudo, or uh (inaudible) hominy,

[REDACTED] I never tried that.

Det. Phillips: My cousin's husband made that for her wedding, for their wedding, the reception, that was good, it was spicy. Uhm, so she was feeding, feeding uh, [REDACTED] and [REDACTED], what were they, were they sitting on the floor, or were they standing up, or were they

[REDACTED] They were sitting.

Det. Phillips: Sitting on the floor?

[REDACTED] Uh-huh.

Det. Phillips: Okay. And if your mom's sitting down where were they sitting in conjunction to her, were they sitting, sitting off to the side,

[REDACTED] Right here,

Det. Phillips: Right in front?

[REDACTED] Uh-huh

Det. Phillips: Okay. Both of them?

[REDACTED] No, [REDACTED] was sitting on the couch.

Det. Phillips: Oh, okay. Uhm, and what was, I mean she was just feeding them

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STATEMENT OF: [REDACTED]  
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[REDACTED] And then he was gonna be done and then he started crying, and was hitting himself on the floor, and then my mom said she was gonna give him a little bit more, and he stopped for a little bit, and then when my mom was gonna give him some more, and he saw it was almost over, the second plate, uhm, then he started hitting himself, and then he hit himself really hard, and his eyes went like... that, and then my mom got really scared, and she took him to the neighbors and that's when they took him to the hospital and blah, blah, blah

Det. Phillips: Now there was a, when I was in the house the other day when you guys were there, there's a carpet on the floor and was he sitting on the carpet then?

[REDACTED] No, because my mom had, was mopping, she had finished mopping, and she took the carpet away.

Det. Phillips: Oh, okay. So the carpet wasn't in the living room then?

[REDACTED] Uh-uh.

Det. Phillips: And how many times did he, how did he, he was sitting down when he threw himself backwards then?

[REDACTED] (inaudible)

Det. Phillips: Back,

[REDACTED] Uh hm.

Det. Phillips: Uhm, did he cry?

[REDACTED] A little. He was mad. He was crying because he was mad.

Det. Phillips: Uh huh, so he was crying before he threw himself down.

[REDACTED] Yeah, he was crying because he had finished his food.

Det. Phillips: Okay. Uh, and then uh, when he was laying on the floor, did he bang his head, or did he roll around or do anything?

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[REDACTED] No, he banged himself like that.

Det. Phillips: Threw his head back then?

[REDACTED] Uh huh.

Det. Phillips: Okay. How many times do you remember?

[REDACTED] Like about 10, 8, 9, around there.

Det. Phillips: Okay, and what'd your mom do?

[REDACTED] My mom just got scared, and she was saying [REDACTED] stop, you could just finish this, and I'll give you a little bit more but he wouldn't stop.

Det. Phillips: Okay. And that's, and then that's when his eyes rolled back in his head?

[REDACTED] Yeah.

Det. Phillips: Okay. And what'd your mom do?

[REDACTED] My mom got really scared and she was about to cry and then she just grabbed him and tried to wake him up but he wouldn't wake up, so she took him to the neighbors.

Det. Phillips: Okay. And how did she, how did she go about trying to wake him up, what did she do?

[REDACTED] Well she was just shaking him, saying [REDACTED] but he wasn't waking up or anything. He was like, he like you know how jelly is, he was like that.

Det. Phillips: So he was like real limp or loose?

[REDACTED] Yeah, he was really loose.

Det. Phillips: Okay. Could you tell if he was breathing?

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STATEMENT OF: Maria Gomez  
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[REDACTED] Yeah, he was breathing a little bit, but it was really, but I think it was really hard for him to breathe.

Det. Phillips: Okay. Did he make any noises when he was doing that?

[REDACTED] Uh-uh.

Det. Phillips: And what, so how do you think it was hard for him to breathe?

[REDACTED] Well, I don't know really how he damaged his head or anything but I don't know

Det. Phillips: Okay. Well, and I don't know, I mean I wasn't there so that's why I have to ask. You just said it was hard for him to breathe and I just wondered you know, was he making noises when he was breathing or was he just not breathing,

[REDACTED] He was breathing but I think it was hard for him, pretty hard.

Det. Phillips: And do you remember which neighbor that your mom went to?

[REDACTED] Next door, I think. No, yeah, number 18.

Det. Phillips: Do you know her name?

[REDACTED] No.

Det. Phillips: And who else was home when that happened?

[REDACTED] My brothers and the ladies neighbors kids.

Det. Phillips: Okay. And were they in the living room with you guys, or where were they?

[REDACTED] No, they were in my brother's room playing Nintendo.

Det. Phillips: Oh, okay. Uhm, has uh, [REDACTED] ever, when he gets mad what does he do?

[REDACTED] He hits himself, bites himself, pinch himself

Det. Phillips: Does he do that quite abit?

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STATEMENT OF: [REDACTED]  
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[REDACTED] Only when he finishes his food, so

Det. Phillips: And what happens if he eats too much food?

[REDACTED] He throws up.

Det. Phillips: Does he do that, have you seen him do that before?

[REDACTED] No, only once.

Det. Phillips: Okay. Uh, does your mom normally feed him, or do you help feed him at all?

[REDACTED] I help him feed sometimes, but I don't like to because he bit me once, and I don't like that.

Det. Phillips: Okay.

[REDACTED] And it hurt.

Det. Phillips: Oh, yeah, uhm, now when he, when he plays how does he play?

[REDACTED] Rough, mostly rough.

Det. Phillips: Rough? What kind of stuff does he do?

[REDACTED] He throws the toys, and tries to hit everybody, if he doesn't have a toy he wants he starts hitting himself.

Det. Phillips: Uhm, does he climb up on stuff at all?

[REDACTED] Uhm, yeah, or no, no he doesn't.

Det. Phillips: He doesn't climb up? Okay.

[REDACTED] I've never seen him.

Det. Phillips: Now your mom said uhm, the other day that, that uh, he'd fallen off the bed.

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STATEMENT OF: [REDACTED]  
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[REDACTED] Oh, yeah.

Det. Phillips: Do you remember that?

[REDACTED] No. Cause I was sleeping.

Det. Phillips: Oh, okay. Now where, where do you sleep?

[REDACTED]: In

Det. Phillips: You go down the hallway, there's a bedroom, you sleep in

[REDACTED] The bathroom's right here, and I live sleep, next to the bathroom

Det. Phillips: Okay, so you and Julianna share a room?

[REDACTED] Uh-huh

Det. Phillips: And then there's the big bedroom,

[REDACTED] Yeah.

Det. Phillips: Is that where your dad sleeps?

[REDACTED] My mom and dad,

Det. Phillips: And the baby sleeps in there? And then the other room is where

[REDACTED] and

Det. Phillips: [REDACTED]?

[REDACTED] Yeah, sleep.

Det. Phillips: Okay, so [REDACTED] and [REDACTED] share the one bedroom and then [REDACTED] sleeps with your mom and dad.

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[REDACTED] Um-hm.

Det. Phillips: Which bed does [REDACTED] sleep in? I mean, not [REDACTED] uhm, [REDACTED]

[REDACTED] Well when they, when we were moving and they, we went and cleaned the apartment, they were all done, [REDACTED] uhm crib and so he had to sleep with [REDACTED] but he didn't like that, and he was always mad when we were gonna go to bed. And then uhm, that night, the second night I think, he bounced from the bed, cause he didn't want to be by [REDACTED] he wanted to be in his crib, and he fell.

Det. Phillips: So the crib that's there now wasn't then there?

[REDACTED] Uh-uh.

Det. Phillips: Where'd that crib come from?

[REDACTED] Uhm, the lady from where we pay the rent uhm, she bought it for my brother.

Det. Phillips: Oh, okay.

[REDACTED] Cause my mom told her (inaudible) and that it was her fault.(inaudible)

Det. Phillips: Oh, that was from the first place at 1411?

[REDACTED] Uh-hm.

Det. Phillips: Oh, okay. Uhm, now when, when uh [REDACTED] gets mad, you said he, he hits himself, bites himself, does he throw himself on the ground too?

[REDACTED] Yeah, sometimes he does.

Det. Phillips: How often does he did that, do that?

[REDACTED] He mostly just does it like not every time he gets mad, but sometimes he does do it, not very usually.

Det. Phillips: Okay.

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[REDACTED] Yeah, he does do it sometimes.

Det. Phillips: Okay. Uhm, because, so does he, does [REDACTED] misbehave then? He doesn't, he doesn't, I mean cause he's not being good cause he's throwing stuff at the other kids?

[REDACTED] Uh-hm

Det. Phillips: Does, what does your mom do, if, what happens when he in trouble?

[REDACTED] Uhm, he just goes to the room and my mom talks to him, and he gets really mad and doesn't look at my mom talks to him.

Det. Phillips: What happens when you get in trouble?

[REDACTED] I go inside my room and get grounded.

Det. Phillips: Do you get in trouble very often?

[REDACTED] No, mostly [REDACTED] and [REDACTED] do.

Det. Phillips: Oh, cause they're little kids huh? Yeah, that's usually the way it is. Little kids when they don't catch on that, don't do what you're told and then that's what gets you in trouble.

[REDACTED] Uh-hm.

Det. Phillips: Uhm, do you ever get spanked?

[REDACTED] No.

Det. Phillips: Anybody else in the house get spanked?

[REDACTED] Nobody gets spanked in my house, we don't get spanked.

Det. Phillips: That's good. So, does Jose work quite a bit?

[REDACTED] Normally he works from I think 4 to 12?

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Det. Phillips: 4 to 12. 4 in the afternoon, or

[REDACTED] 4 in the morning.

Det. Phillips: 4 in the morning til noon. So he's working in the

[REDACTED] Dairy. Dairy.

Det. Phillips: Dairy. Yeah, that's early work. Now is he your dad, your real dad?

[REDACTED] No, he's my stepdad.

Det. Phillips: Stepdad. Is he [REDACTED]'s real dad?

[REDACTED] and [REDACTED].

Det. Phillips: And [REDACTED]'s, okay I knew he was [REDACTED] cause [REDACTED] looks a lot like him. Uh, when they sit together, (inaudible) uhm, and how do you like him?

[REDACTED] He, I think he's nicer than my dad.

Det. Phillips: Well that's good then. Uhm, is he nice to you?

[REDACTED] Yeah. He's buys me everything I want.

Det. Phillips: Well that's good I guess. Good for you huh?

[REDACTED] (laughing)

Det. Phillips: So you like living at home then?

[REDACTED] Yeah.

Det. Phillips: No major problems?

[REDACTED] No.

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Det. Phillips: Okay. And do you like, do you like your teachers at school?

[REDACTED] No.

Det. Phillips: No?

[REDACTED] (Laughs) I only like Mrs. Raleigh, cause I'm used to girls, not boys and I think Mr. (inaudible)

Det. Phillips: Oh, I'm sure he probably likes everybody. I don't have anymore questions I don't think Mario, do you have anything to add?

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Mario Gonzales: You know and up to this point, while [REDACTED] has provided a lot of information, she's done really well I think, uhm, I would just, I want to make sure I understood everything, [REDACTED] and I'm gonna repeat a few things that you said and if I repeat it, I'm not repeating it because it's wrong, I just want to make sure I get it right but if I do repeat something wrong will you correct me?

[REDACTED] Uh-hm.

Mario Gonzales: So, you were saying that the day that this happened to the brother that you guys were in the living room. You were in the living room watching tv?

[REDACTED] Me and [REDACTED] and my mom and [REDACTED]

Mario Gonzales: And your mom was sitting at the couch?

[REDACTED] Yes.

Mario Gonzales: Okay, and there wasn't a carpet down, because she'd mopped the floor and it was wet, uhm, [REDACTED] was sitting beside her on the couch and [REDACTED] was sitting or standing in front of her?

[REDACTED] Sitting.

Mario Gonzales: Sitting in front of her on the floor, he was sitting on the floor. And she was feeding him. Now you were saying that he got upset because why?

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[REDACTED] Cause he was about to finish his food, well he did finish his food.

Mario Gonzales: He finished his food, he got upset, what happened when he got upset?

[REDACTED] He started hitting himself.

Mario Gonzales: What do you mean hitting himself?

[REDACTED] Down on the floor, but that was only like 2 times. But, then

Mario Gonzales: Okay, so 2 times, okay.

[REDACTED] But then when my mom served him the second bowl and he uhm, just almost finished it, he started himself like 10 times.

Mario Gonzales: So he was sitting down on the floor, threw himself back and started hitting his head on the floor? And how many times?

[REDACTED] The first time?

Mario Gonzales: The first time you said it was 2.

[REDACTED] Uh-huh.

Mario Gonzales: The second time.

[REDACTED] Like 8.9. 10.

Mario Gonzales: And what was your mom doing when that was going on?

[REDACTED] Feeding him.

Mario Gonzales: No, I mean

[REDACTED] (laughing)

Mario Gonzales: I understand that, I mean he was, I mean that would have taken a lot of time for him to sit there and hit himself 8 or 9 times. Did you try to stop him from doing

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that?

[REDACTED]: I tried to stop him

Mario Gonzales: Did she?

[REDACTED]: My mom tried to stop him, but he just kept on hitting himself.

Mario Gonzales: What did she do to stop him?

[REDACTED]: Well, what do you mean?

Mario Gonzales: I mean,

[REDACTED]: Well actually [REDACTED] stopped by himself, cause then that's when his eyes went back.

Mario Gonzales: So he stopped by himself when,

[REDACTED]: like the 8<sup>th</sup> time

[REDACTED]: when he got hurt.

Maria Gomez: 8<sup>th</sup>, 9<sup>th</sup>

Mario Gonzales: and your mom at this time before you said she was telling him that she was gonna give him more food

[REDACTED]: yeah

Mario Gonzales: So calm down and don't do that, she was telling him, is that right?

[REDACTED]: Yeah, Uh-huh.

Mario Gonzales: Or did she try to grab him to stop him from hitting himself?

[REDACTED]: Well she was telling him that and was going to grab him but [REDACTED] just uhm went like that, so she wouldn't, get her or something like that, yeah.

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Mario Gonzales: So, she was trying to grab but he wouldn't let her.

[REDACTED]: Uh-hm

Mario Gonzales: Okay. And so then I know that you had he kind of he, he, his eyes went like that, you indicated that they rolled to the back of his head and at that time, what did your mommy do?

[REDACTED]: She grabbed him, and tried to wake him up.

Mario Gonzales: And how did she do that?

[REDACTED]: She like shakes him or something, not, not hard like that but yeah.

Mario Gonzales: Right, and then, and how long did she try to do that for him?

[REDACTED]: Like 2 seconds.

Mario Gonzales: 2 seconds? And then what did she do?

[REDACTED]: Uhm, She took him outside to like get some air, and he didn't get more air, so then she came inside from the back door, went from the front door and then went to the neighbors. Then the neighbor wouldn't open the door for her because she was sleeping I think, so my mom just opened the door.

Mario Gonzales: Right, and so you weren't over there when at the neighbors house, you stayed at home with [REDACTED] I guess.

[REDACTED]: Yeah, yeah with [REDACTED], my mom told me to take care of him

Mario Gonzales: Right, and so how long do you think your mom, and I, this has got to be hard for you, it'd probably a hard question for me, did your mom go over to your neighbor's house and then she was gone right away to the hospital, or was she over there for a little while?

[REDACTED]: She was like over there for 1 minute.

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Mario Gonzales: So, she was over there for 1 minute.

[REDACTED] Uh-hum, and then her husband took my mom to the doctor. In emergency.

Mario Gonzales: Okay, and

[REDACTED] And they took quite awhile over there.

Mario Gonzales: When, you, you said you fed your brother before, right?

[REDACTED] Yeah.

Mario Gonzales: And you said you didn't like it because he bit you once. Did he also throw himself around when you were feeding him?

[REDACTED] Ah, no.

Mario Gonzales: Why not.

[REDACTED] I don't know, he just bit me.

Mario Gonzales: And did you only feed him once, or more than once

[REDACTED] No, only once because then I got scared, and (inaudible)

Mario Gonzales: So your mom's the one that usually fed him, not you, you did it one time, but then when he bit you, you decided you weren't gonna do it no more, huh? And so, you were saying that uhm, he does this often?

[REDACTED] Hit himself on the ground?

Mario Gonzales: Uh-huh. And uh, did you guys have a high chair for him?

[REDACTED] No, but my mom had a high chair for him I think, but my mom didn't like the high chair because he would like, move the high chair and my mom was real scared.

Mario Gonzales: He's like, what do you mean?

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[REDACTED] When he was in he would shake the, he would go back and forth really hard, and so the high chair

Mario Gonzales: And she was afraid it might tip over

[REDACTED] Uh-huh.

Mario Gonzales: and he'd fall or something, huh

[REDACTED] Yep.

Mario Gonzales: Oh, okay. Well you know I, I know that the detective asked you a lot of questions, and you answered them all really well and mine too, and I really don't have anymore, but is there anything else you'd like to tell us?

[REDACTED] Not really.

Mario Gonzales: Do you have any questions for us?

[REDACTED] No, oh yeah, when am I gonna go back home?

Mario Gonzales: You know, and I think that's still uh, in the works, I really don't know but I know that until such time that we're gonna make sure that you keep seeing your mom and I'm so glad that all of you guys are together cause I know you kind of watch after your little brother and sisters, or sister and brothers I should say, so I would only say be strong for, for them, and I know this is hard for you, but uh, hopefully it happens soon, but we don't know. Is everything okay in the foster home?

[REDACTED] Uh-hm.

Mario Gonzales: Well I'm glad that that's the case.

[REDACTED] Except [REDACTED] doesn't let me sleep at all.

Mario Gonzales: So then he's sleeping with you?

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[REDACTED]: Yeah, he's sleeping in, in the whats you call it, the playpen? He's sleeping (inaudible) he's sleeping on that.

Mario Gonzales: Okay, (inaudible) he said he doesn't sleep good then?

[REDACTED]: No, he crys and the lady has to get him up, and then he's asleep for fifteen minutes and then (inaudible) he wakes up again and then has to rock him again, and then he doesn't like to sleep.

Mario Gonzales: Okay, uhm, we'll see if we can do something about that, so you can get some rest too. ~~We just hopefully-we're gonna get you started in school real soon, and if you can't sleep then you're not gonna do well in school, you should be there to be helping not be responsible for that okay? So, I'm glad other than that that everything's going well, and, and we'll work on that (inaudible) I don't have any more questions.~~

Det. Phillips: We'll go ahead the interview and it's 1406.

End of statement.

rb

**Appendix 22**

**Affidavit and Preliminary Report of Dr. Peter Stephens**

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medical evidence does not support the conviction. I can also say with certainty that the courts were not provided with accurate and up-to-date medical information on key medical issues.

5. The defense efforts were compromised by the failure to provide the autopsy slides to a forensic pathologist until the trial was underway. This would not allow time for review of these slides in the context of an extremely complicated factual setting. Typically, a reviewing forensic pathologist receives these slides months (sometimes years) in advance of trial.

6. It is also my understanding that the defense did not obtain the radiology images or an independent review of the images even though the radiology reports were the sole basis for the state's claim of ongoing abuse. The next step should be to obtain the images and provide them to Professor Patrick Barnes, Professor of Radiology at Stanford University Medical Center and Chief of Pediatric Neuroradiology at Lucile Salter Packard Childrens Hospital (also affiliated with Stanford). Since this case cannot be adequately investigated without this review, I am recommending referral to Professor Barnes.

7. In its written conclusions, the Court found the following injuries were attributable to assaults by the mother beyond a reasonable doubt:

- a. acute and chronic proximal humeral (shoulder) fractures;
- b. an occipital skull fracture and accompanying epidural hemorrhage which the Court states were sustained in the days immediately before death;
- c. bruised/gouged ear injuries;
- d. lacerated nipples;
- e. death from blunt force injuries to the head.

8. The medical evidence does not support these findings. Since this case is complex and entirely circumstantial, I will briefly review the facts, identify the medical issues, and comment briefly on each of the medical findings.

9. As a preliminary matter, there have been substantial developments in the area of pediatric head injury over the past decade, including major developments since the child's death in 2003 and additional developments as recently as February 2010. Much of the evidence presented at trial reflects medical theories that have been discredited or disproven. This problem was exacerbated by poorly-understood medical terminology. For example, the term "blunt force trauma" refers to hitting any body part on a flat surface, and it does not differentiate between stumbling and hitting one's head on the floor, hitting one's knee on the underside of a table, or being hit with a baseball bat. These technical language issues were further complicated by language and cultural issues. Since the mother and stepfather are Spanish speakers and appear to have only a very rudimentary understanding of English, much of the medical information was obtained through interpretation, with what appears to be varying degrees of accuracy.

## Family Background

10. **Rafael's birth.** Rafael was Maribel Gomez' fourth child. At the time of Rafael's death, the older children were Maria (age 11), Julio (age 7) and Julianna (age 3 ). Mrs. Gomez and her husband, Jose Arechiga, had three children, Rafael (age 2), Edgar (age 1) and Jacqueline (born after Rafael's death).

11.. During her pregnancy with Rafael, Mrs. Gomez used cocaine and amphetamines and drank alcohol. The delivery was precipitous, possibly due to amphetamine use, and Rafael and his mother tested positive for cocaine and amphetamines at his birth. There is some suggestion that the child may have had some oxygen deprivation during or after birth, but this is not well-documented. Based on the drug tests, Rafael was placed in foster care after his birth.

12.. So far as I can determine, the mother's substance addiction was the sole reason for Rafael's removal. Apart from an earlier driving incident (related to alcohol abuse), I do not see any suggestion that any of the other children were abused or neglected.

13.. The records indicate that Mrs. Gomez obtained in-patient care for her substance abuse, likely in early 2002, and that her drug and alcohol tests were uniformly negative after treatment. Apart from a few days in foster care, the other children remained with Mrs. Gomez and Mr. Arechiga until Rafael's collapse in September 2003.

14.. **CPS supervision.** From Rafael's birth on August 7, 2001 and his collapse on September 9, 2003, CPS closely supervised this family, with emphasis on reunification with Rafael. Some records suggest that reunification was possibly compromised by the foster mother's bond with the child and opposition to reunification.

15. The records indicate that this family was under a microscope for nearly two years. I understand that CPS services included scheduled and unscheduled home visits approximately three times a week by CPS caseworkers, a therapist and/or other support staff. This continued from Rafael's return home in June 2002 to his collapse in September 2003 (interrupted by a 4 day return to the foster family in September 2002 and a 3 month return to the foster family in December 2002-March 2003 while CPS investigated two fractures, below). The CPS reports on the family were uniformly positive.

16. This record presents a sharp conflict between the observations of the CPS workers and psychologists, who describe a well-functioning and well-bonded family, and the medical evidence presented to the Court, which describes a pattern of ongoing abuse that was not noticed by the social workers, other family members (including the husband and reasonably articulate children), or family friends. In its findings, the Court explicitly finds that Mr. Arechiga, who was apparently at home for most of the day (ending a dairy shift by approximately noon) was a nurturing man who was apparently unaware of any of the behaviors attributed to his wife.

17. Since the evidence against Mrs. Gomez was circumstantial and based on medical findings, it is essential to conduct a careful review of the medical records and evidence. In this case, the child's death was most likely caused by aspiration pneumonia (in layman's terms, food that went down the wrong tube into the lungs, depriving the child of oxygen), as diagnosed at the first two hospitals. Aspiration is confirmed by the first x-rays of the lungs, the autopsy slides, and the testimony of a state witness (Dr. Fino, a Medical Examiner). It is also consistent with Mrs. Gomez' and her daughter's description of the child's collapse. A "pattern of abuse" by Mrs. Gomez is inconsistent with the CPS reports and is not supported by the medical evidence.

### **Medical evidence**

18. ***Birth.*** Rafael was born with cocaine and amphetamines in his system, prenatal exposure to alcohol, and possible oxygen deprivation at birth. While he was developing well, I would not exclude the possibility of a neurologically-related defect related to the circumstances of his birth.

19. ***Foster care.*** The foster family provided excellent care and bonded closely with the child. Rafael stayed with them from August 2001 to June 2002, with ongoing contact with his parents and siblings. He returned to his family on June 4, 2002.

20. ***Doctor reports.*** Rafael seemed to have developed well despite his difficult beginning.

21. ***CPS supervision.*** After reunification, CPS provided extensive supervision and services, with frequent scheduled and unscheduled in-home visits. The family appeared to be well-functioning and closely-bonded. The child had a few bruises consistent with his age and developmental status but no issues of concern. In the child abuse literature, a common saying is "those who don't cruise don't bruise." The converse is also true: those who cruise *do* bruise. While this dichotomy is overly simplistic, it explains why a child who did not bruise in his first ten months had a normal assortment of bruises after he learned to walk (approximately 11 months).

22. ***September 2002: tibia fracture.*** The first reported incident of concern was a tibia fracture in September 2002, 3 ½ months after Rafael's return home. From the records, the mother gave birth to Edgar on September 16, 2002. On September 21, the mother (and I understand the father) brought Edgar to the emergency room at the local hospital for jaundice. Hospital records indicate that they arrived at approximately 6:45 p.m. The other children, including Rafael, were reportedly left in the care of a paternal uncle. At approximately 10:30, when the mother was still with Edgar, the father, who had apparently returned home, brought Rafael to the hospital with a sore and/or swollen leg. The reports indicate he had fallen over a toy truck or fire engine and fell off a porch or down a few steps. The fracture was a typical "toddler fracture" consistent with this report.

23. The mother, who was still at the hospital with Edgar, joined the father and child in the emergency room. The hospital staff was concerned that the parents were speaking Spanish and could not provide a history for the injury. This appears, however, to be a language problem since the parents appear to have been at the hospital, not at the home, when the injury occurred.

24. Rafael was placed with the original foster family and the other children were placed in foster care while CPS investigated the tibia fracture. They were returned home when Dr. Alan Hendrickson, MD, FAAP confirmed that this was a typical "toddler's fracture" consistent with the explanation.

25. On September 23, the foster mother brought Rafael for a checkup on the tibia fracture. She also reported bruising on his side, variously reported as finger mark or handprint-like, and "lacerations" resembling pinch marks around the nipples were observed. The age of the bruising was consistent with the reported fall. I have not received photographs of the nipples and am uncertain whether any were taken. These marks are consistent with reported incidents of self-injurious behavior by the child, and it is unclear from information I have received whether they occurred while with his biological parents or with the foster family. While the trial court attributed the discolored nipples to Rafael's mother, I do not see any evidence in the record suggesting or confirming this conclusion.

26. Since the CPS investigation did not find any indications of abuse or neglect by the parents, the children returned home.

27. **Bruises.** There is one report of a facial bruise in early October to which the CPS worker did not ascribe much significance. I agree that bruises of this nature are to be expected with active toddlers.

28. **December 2002: femur fracture.** On December 7, 2002, Rafael was taken by his mother and a family friend to the hospital for what turned out to be a femur fracture. Rafael was reportedly running and slid across a wet floor that his mother had just mopped, reportedly hitting his head and ending up in a "splits" position, with one leg twisted. Other injuries included burns on his hand (reportedly from a soup spill); a possible burn on his tongue; a bruise or bruises on his ear; and a small area of infection on his scalp, attributed by one of the doctors to impetigo, a strep infection. X-rays confirmed the femur fracture.

29. In addition, a skeletal x-ray noted a "probable skull fracture," with an alternative explanation noted as "parietal fissure, normal variant." There were "unusual calcifications projecting over the posterior fossa, etiology [cause] and significance unknown." A subsequent CT scan indicated a "lucency transversing the occipital cortex on several images, extending to the region of the foramen magnum" with some images suggesting "a small amount of adjacent soft tissue swelling/thickening." The impression was of a nondisplaced fracture through the left occipital bone with extension to the skull

base. The discharge note indicates that the fracture "was most likely an old skull fracture not associated with the story of a fall related to the femur fracture."

30. Rafael remained in foster care for approximately 3½ months while CPS and law enforcement investigated the femur fracture and other findings. A March 12, 2003 report from Dr. Kenneth Feldman at Children's Hospital, Seattle, WA found the femur fracture to be consistent with the mother's description of the fall. He also noted the mother's reports of odd behavioral patterns. Dr. Feldman felt the parietal (side of the head) fracture showed some healing and was probably older, that the scalp lesion was also older, but that the occipital fracture was potentially caused by the same fall that caused the femur fracture. Dr. Feldman expressed concerns for repetitive injuries that he felt lacked appropriate explanations but did not see any definitive evidence for physical abuse. The CPS reports continued to be positive, and the child returned home.

31. I agree with Dr. Feldman that the femur fracture is consistent with the reported fall. While femur fractures are not common in children, when they do occur, they are commonly associated with accidents rather than abuse. *See, e.g., Schwend et al, Femur shaft fractures in toddlers and young children: rarely from child abuse, J Pediatr Orthop 2000; July-Aug;20(4):475-81* (in walking age group, femur fractures attributed to abuse in only 2.6% of children with femur fractures). Over the past decade, it has also become increasingly clear that no fracture can in and of itself be attributed to abuse but instead reflects multiple factors, including individual susceptibility to fracture. Kemp et al, *Patterns of Skeletal Fractures in Child Abuse: systematic review, British Medical Journal 2008;337* (no fracture on its own can distinguish an abusive from a non-abusive cause).

32. Based on currently available information, it is not possible to determine the cause or timing of the skull fractures. For this, the radiology images must be carefully reviewed by a qualified radiologist with expertise in bone. Skull fractures are not uncommon with children and can be asymptomatic. They can also occur at birth or even *in utero*. In this case, the only conclusion that can be drawn with certainty is that these fractures did not directly contribute to the child's death since the child continued to be in good physical health as reported by the foster mother, biological parents, CPS workers and family doctor.

33. ***Bruises in foster care.*** In February, the foster mother reported that the child fell forward and hit his head on a church pew, resulting in a bruised forehead. There was also one additional report of bruising during this period. Like the earlier October bruise, such incidents are to be expected with toddlers.

34. ***Behavioral issues.*** After the return home in March 2003, the mother reported numerous behavioral issues with the child, including overeating, biting, scratching, pinching, and staring into space. These appear in CPS reports from April-August 2007, are described by the older children in subsequent police interviews, and have more recently been confirmed by others. While the trial court apparently discounted these reports, they suggest a neurological impairment. A neurological impairment could have resulted from the September or December falls, or could have been part of a neurological

process that did not show up until the child became a little older. This is not uncommon with autism, epilepsy, Prader-Willi disease and other genetic or neurological disorders. If any of the child's blood was retained, I would strongly recommend genetic testing.

35. The mother apparently noticed abnormal behavioral patterns before the December fall and insisted on a neurological examination in January 2003. The report of the exam was normal, but it appears to have been limited to sensitivity to pain and did not address the behavioral patterns. The neurologist suggested a follow-up appointment in six months if desired. It appears from the records that the mother instead pursued an appointment at Children's Hospital in Seattle and was still on the waiting list when the child collapsed in September 2003.

36. **March-September 2003.** I do not see any signs of actual or suspected abuse or neglect in the records from March to September 2003. It appears that the mother remained drug free and the CPS workers continued to be very positive in their appraisals. Given that this family was under a microscope in this entire period, it seems unlikely that any significant signs of abuse or neglect would have been unnoticed by these multiple observers.

#### **September collapse**

37. On September 9, 2003, the mother was reportedly feeding soup with noodles to the child, who stood between her legs for feeding. The other children were also at home, as well as some neighbor children. All but the oldest daughter, Maria (age 11) and the youngest child, Edgar (approximately age 1) were in a backroom playing videogames or watching television.

38. Reports by the mother and Maria indicate that Rafael fell backwards onto the floor, which was reportedly linoleum over concrete, hitting his head on the floor when the mother finished feeding him the first bowl of soup. The mother then got a second bowl, and Rafael again threw himself backwards, hitting his head on the floor. This time his eyes rolled back and he had difficulty breathing. Given the language problems, it is difficult to determine when he stopped breathing, but it is clear that he was unresponsive after this.

39. According to reports, the mother took the child to a neighbor's, where the mother sucked food from the child's mouth and attempted to revive the child with alcohol. She also called her CPS worker, who reportedly advised that it would be faster to take the child directly to the hospital rather than call 911, as is often the case.

40. **Columbia Basin Hospital.** The mother and child arrived at Columbia Basin Hospital at approximately 4:55 pm, where the child was intubated with some difficulty. A report by Dr. Alexander Brzezny describes vomitus and suctioning of emesis. The patient continued without pulse or electrical activity for approximately 20 minutes despite CPR efforts and multiple medications. The total downtime was estimated at 25-30 minutes. Since the brain requires a constant flow of oxygen, this downtime would

result in substantial brain damage from oxygen deprivation even after successful resuscitation.

41. Dr. Brzezny's report assesses the likely causation as possible choking. This is consistent with the first x-ray report, which indicates patchy bilateral perihilar opacities consistent with diffuse pneumonia or possibly aspiration, with complete opacification of the left upper lobe and increased opacification of the right upper lobe and perihilar and infrahilar regions. The child was then transferred to Sacred Heart Hospital.
42. **Sacred Heart Hospital.** Apart from the food being described as oatmeal (rather than soup with noodles), a probable translation error, this report is the same as the earlier reports. The Sacred Heart admitting diagnosis was "massive food aspiration with associated cardiopulmonary arrest, now in extremis." It notes poor breath sounds even with ventilation and an x-ray showing "whiteout" of the left lung and continued ventilation difficulties during transport. Aspiration of gastric contents is extremely dangerous. See, e.g., Stewardson and Nyhus, *Pulmonary Aspiration, An Update*, Arch Surg 112:1191-97 (1977) (reported mortality of 40-90% of patients with massive aspiration of gastric contents; 26% of pediatric anesthetic deaths due to aspiration of vomitus or blood).
43. The lab results were highly abnormal and the child developed DIC (disseminated intravascular coagulation, a bleeding disorder) in the hospital. DIC is a primary or secondary condition that causes abnormal clotting, bleeding and/or bruising. DIC can aggravate existing bruising or bleeding or result in spontaneous bleeding. The DIC was treated with transfusions of fresh frozen plasma and Vitamin K, and was further evidenced by bleeding from the nose and other sites.
44. There was slight bruising on the central forehead and under the left eye and a small "goose egg" over the occiput. It was not possible to determine whether retinal hemorrhaging was present due to copious debris on the corneas.
45. A CT scan showed diffuse cerebral edema, very small intracranial hemorrhages, and no skull fractures. A neurological examination confirmed a soft subgaleal hematoma (bruise under the scalp) in the right occipital region without palpable underlying fracture. The fundoscopic examination confirmed grade 4 papilledema (optic disc swelling). One of the chest x-rays identified "an unusual and somewhat shaggy appearance to the bilateral humeral heads" (top of the upper arm bones, closest to the shoulder), of uncertain etiology.
46. The neurologist concluded that the child had "severe anoxic encephalopathy that is well explained by the history given by his parents." Anoxic refers to lack of oxygen; encephalopathy refers to brain damage and/or brain swelling. Deprivation of oxygen from aspirating food or choking, resulting in anoxic encephalopathy, is unfortunately not uncommon in the toddler age group. In this case, Rafael's apparent habit of throwing himself backwards while eating would have placed him at high risk for aspiration.

47. Life support was removed the following day. I do not have records indicating the timing, but it is my understanding that the child spent about 16 hours on life support.

### Autopsy

48. The autopsy found numerous abnormalities. Understanding these abnormalities requires a considerable understanding of the pathology and recent developments in the literature on pediatric head injury. For purposes of this affidavit, I will simply point out some of the more obvious conclusions.

49. ***Abrasions of face, right ear and scalp.*** These are minor and consistent with the child's age, reported behavior and resuscitative efforts. The presence of DIC could have caused bruising or made existing bruises more prominent at autopsy.

50. ***Subgaleal hemorrhages (occipital and frontal scalp, acute and subacute).*** These are bruises that appear under the scalp. In this case, most of these hemorrhages are old, consistent with reported falls. There is also some acute (new) bleeding consistent with DIC, which would cause new bleeding into old hemorrhages. The occipital hemorrhages are consistent with the reports of the child throwing himself backwards onto a linoleum-covered concrete floor.

51. ***Retinal and optic nerve sheath hemorrhages.*** For many years, it was believed that retinal hemorrhages were diagnostic of trauma or abuse. Today, however, there is a long laundry list of causes, including increased intracranial pressure from any source. In this case, these hemorrhages are fully explained by the brain swelling caused by lack of oxygen from aspiration. A recent academic study based on an extensive study undertaken by the Dallas Medical Examiner's Office confirmed that it is not possible to distinguish between accidental, inflicted and natural causes for retinal and optic nerve sheath hemorrhage. Matshes, E., *Retinal and Optic Nerve Sheath Hemorrhages Are Not Pathognomonic of Abusive Head Injury*, American Academy of Forensic Sciences, Seattle WA (Feb. 2010) (retinal and optic nerve sheath hemorrhages not linked to inflicted head trauma but seen in many situations; link appears to be to life support with short-term survival and cerebral edema from any cause, including natural death).

52. ***Occipital skull fractures, acute and chronic.*** Autopsy x-rays indicate that the image of the skull was "nondiagnostic for the presence of fracture." However, fractures were seen at autopsy and in the autopsy slides. The slides 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.

53. The description of the fractures in the autopsy report is remarkably similar to the description of the fractures noted in December 2002. It is not possible to determine based on presently available information whether these fractures are an unusual entity, such as a growing skull fracture, or have spread apart (or even splintered) due to brain swelling. Growing skull fractures are well documented in the literature and are not associated with

abuse. To resolve these issues, all skull x-rays should be reviewed and compared by an experienced pediatric radiologist. 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.

54. ***Contusions of back and upper extremities.*** The only significant finding is a contusion on the mid-back, consistent with the child throwing himself backwards onto a concrete floor. It is also possibly consistent with resuscitation, particularly if the area was already injured by the falls backwards. The appearance of these contusions would be aggravated by DIC, which would make them appear larger and brighter.

55. ***Shoulders.*** The autopsy radiology report identified "abnormal proximal humeral metaphyses bilaterally," suggesting healing fractures. The medical examiner further identified "periosteal and epiphyseal-metaphyseal injuries, acute and chronic, of the proximal humeri." These are unusual findings that I have never seen in a case of child abuse. Possible explanations include vigorous swinging of the child, and/or with congenital abnormalities (e.g., vitamin deficiency, congenital malformation). I cannot determine ageing based on the information presently available, particularly since any acute bleeding would be explained by DIC. The evidence on these findings is confusing and conflicting and the x-rays should be re-read by an experienced radiologist with expertise in bone radiology.

56. ***Lungs.*** The lung findings of diffuse alveolar damage with multifocal bronchopneumonia and bilateral pleural effusions are consistent with the prior x-rays showing extensive damage to the lungs. The autopsy slides show a great deal of inflammation and debris in the lungs. I would not call this diffuse alveolar damage, which is unusual in this age group, but would instead attribute it to a garden variety bacterial or aspiration pneumonia. The lung slides are not consistent with ventilator pneumonia given the severity of the damage and the relatively short time that the child spent on the ventilator. While it is not possible to determine with certainty based on the medical evidence whether this is bacterial or aspiration pneumonia since both produce the same type of inflammation, the history strongly suggests aspiration pneumonia.

57. ***Acute subdural and subarachnoid hemorrhages.*** These are very small hemorrhages that are to be expected given the downtime and subsequent brain swelling. Even at autopsy, the subdural was just 5-7 ml (1-1.4 tsp), which likely would not be symptomatic and could simply reflect choking or gagging. While subdural hemorrhages were previously viewed as diagnostic of trauma or abuse, it is now recognized that they are part of a cascade of events that occur in a wide array of settings, including accidental trauma and natural causes. Hemorrhagic disorders such as DIC are well-recognized causes of such hemorrhages, which are not specific for trauma.

58. ***Epidural hemorrhage.*** The most unusual pathological finding is the epidural hemorrhage that overlies the skull fracture. This is a very old well-organized hemorrhage that may date back to the December 2002 skull fracture. Epidural hemorrhages are rarely associated with nonaccidental trauma. For example, a study by Dr. Feldman and others

found that 47% of children with subdural hematomas were abused (a figure that would probably drop substantially given the alternative causes for subdural hematomas recognized over the past decade) but that only 6% of children with epidural hemorrhages were abused. 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). A small amount of acute hemorrhage, or re-bleed, is to be expected given the increased intracranial pressure caused by brainswelling.

59. **Cerebral edema.** The cerebral edema (brainswelling) noted in the CT scans and at autopsy is an inevitable result of hypoxia, or lack of oxygen to the brain. While other body organs can be “re-started” with resuscitation and life support, the brain cannot be re-oxygenated or re-started after a 30 minute downtime. Instead, following resuscitation, the brain will be injured and will respond by collecting fluid and swelling. While this constitutes “brain damage,” it does not suggest trauma.

60. In this case, a thorough neuropathological examination found hypoxic rather than traumatic damage, consistent with the 30 minute downtime and resuscitation. In abusive head trauma, the theory is that axons are torn by shaking or impact. The older stains did not show damage to the axons unless the patient survived for 48-72 hours after the injury. These stains are referenced in older texts, including the 1998 DiMaio text referenced in the trial testimony. However, a newer stain, the beta amyloid precursor protein (Beta APP) stain, shows damaged or swollen axons approximately 30-90 minutes after injury. An addendum to the neuropathology report states that the Beta APP stain was used and was negative in all blocks, confirming that the injury was hypoxic (*i.e.*, resulting from oxygen deprivation) rather than traumatic in nature, consistent with aspiration rather than trauma. The neuropathology report further states that the neuropathologist discussed the results of these stains with Dr. Marco Ross on July 28, 2006, nearly three years after the child's death.

61. In my opinion, these findings suggest that the medical examiner's conclusion on the manner of death should be changed from “homicide” to “natural” or “undetermined”. My preference would be natural given the mother's report, the x-rays and the lung findings. However, if the backwards fall resulted in aspiration, as is likely, the death could also be considered accidental. By convention, if a cause of death has two or more factors (e.g., natural and accidental), the cause of death is considered to be “undetermined.”

### **Changes in literature**

62. It is not possible to describe in a single affidavit the multiple changes that have occurred in the literature on pediatric head injury over the past decade. Suffice it to say that in the late 1990s-early 2000s, forensic pathologists were routinely diagnosing “shaken baby syndrome” and “abusive head trauma” based on the mistaken belief that

subdural and retinal hemorrhages were diagnostic or even pathognomonic of (*i.e.*, could only be caused by) abuse. This is no longer the case.

63. In forensic pathology, my own specialty, a 2001 paper on “rotational” injuries was published in the journal of the National Association of Medical Examiners (NAME). Case *et al*, *Position Paper on Fatal Abusive Head Injuries in Infants and Young Children*, *Am J For Med and Path* 22(2):112-122 (2001). This paper hypothesized that rotational movement of the brain (*i.e.*, shaking or whiplash forces) caused diffuse axonal injury (disruption of axons throughout the brain), tearing of bridging veins and retinal hemorrhage. The pathological findings of “subdural hemorrhage, subarachnoid hemorrhage and retinal hemorrhages” were therefore offered as “markers” to assist in the recognition of the presence of “shearing brain injury” (*i.e.*, axonal damage) in young children. Although rejected by 4 out of 5 peer reviewers and contrary to existing biomechanical studies, this paper gained a large following in the early 2000s.

64. In 2000-2003, a series of neuropathological studies by Dr. Geddes in the United Kingdom cast considerable doubt on these theories. It is my understanding that there was testimony at trial that Dr. Geddes later “recanted” her findings. In fact, the Geddes research has provided the foundation for a new understanding of pediatric head injury, including the BAPP stains used in this case. See, *e.g.*, Geddes, *Neuropathology of inflicted head injury in children I and II*, *Brain* 124 (1290-1306) (2001); Geddes *et al.*, *Dural haemorrhage in non-traumatized infant deaths: does it explain the bleeding in ‘shaken baby syndrome’?*, *Neuropath and Applied Neurobiology* 29:14-22 (2003).

65. In 2003, NAME published a literature review that found that there was no evidentiary or scientific basis for shaken baby syndrome. Donohue, *Evidence-Based Medicine and Shaken Baby Syndrome – Part I: Literature Review, 1966-1998* (2003). At the October 2006 NAME conference, the 2001 paper was withdrawn by the NAME Board of Directors, and leading presentations had titles such as “Where’s the shaking? Dragons, Elves, the Shaking Baby Syndrome and Other Mythical Entities,” “Conditions That May Mimic or Be Misidentified as Abusive Head Injury in Young Child” and “Use of the Triad of Scant Subdural Hemorrhage, Brain Swelling to Diagnose Non-Accidental Injury is Not Scientifically Valid.” 40<sup>th</sup> Annual NAME Meeting, San Antonio Texas (October 13-18, 2006).

66. Bridging vein theory has undergone a similar metamorphosis. The original theory underlying “shaken baby syndrome” and/or abusive head trauma is that the bridging veins between the brain and the large vein in the dura that drains the brain were ruptured by shaking and/or impact. Now, it is recognized that many “subdural” hemorrhages are actually intradural (*i.e.*, represent leakage in the dural cell border) and are much too small to represent a bridging vein rupture. In this case, the small quantity of the subdural hemorrhage (1-1.4 tsp) *precludes* bridging vein rupture as the bridging veins are large caliber veins that would produce a much larger hemorrhage if ruptured.

67. By 2007, the list of alternative accidental and natural causes for findings previously associated with abusive head trauma included five pages in a paper by one of

the country's leading pediatric neuroradiologists and two entire chapters in a book by pediatricians who are the strongest advocates of child abuse theories. Barnes and Krasnokutsky, *Imaging of the Central Nervous System in Suspected or Alleged Nonaccidental Injury, Including the Mimics*, Top Mag Reson Imaging 18(1):53-74 at 65-70 (2007); *Frasier et al, supra*. These materials emphasize the complicated physiological cascades that occur in cases of hypoxia-ischemia (e.g., choking, respiratory or cardiac arrest) and primary or secondary coagulopathies (bleeding disorders, including DIC) that may be confused with traumatic and/or nonaccidental injury. *Id.* Similar developments have occurred in the timing and biomechanics of head injury. *See, e.g.,* Gilliland, *Interval Duration Between Injury and Severe Symptoms in Nonaccidental Head Trauma in Infants and Young Children*, J For Sciences 723-725 (1998) (intervals between injury and severe symptoms may be 72 hours or more); Duhaime *et al., The shaken baby syndrome: A clinical, pathological, and biomechanical study*, J Neurosurg 66:409-415 (1987) (force of shaking does not meet injury thresholds; force from impact exceeds force from shaking by factor of fifty).

68. At the time of the autopsy in this case (September 2003), the forensic pathology community was in disarray on the implications of medical findings in cases of alleged pediatric abusive head injury. Some of those issues have been resolved; others are ongoing or in the process of being resolved. Thus, for example, while it has long been recognized that there are many nontraumatic causes for retinal and optic nerve sheath hemorrhages, it was not until February 2010 that a formal study confirmed that these hemorrhages do not distinguish between accidental, nonaccidental and natural deaths and are related to cerebral edema and life support with a short survival time, the factors present here, rather than trauma.

68. In many cases, once the diagnosis of abusive head trauma is removed, there is little or no evidence on which to base a finding on the cause of death. In this case, however, a finding of aspiration resulting in anoxic encephalopathy is supported by the history, the initial x-rays, the difficulty of intubation, and the autopsy slides.

### **Court's findings**

69. In this context, it is worthwhile to quickly review the trial court's findings on the cause of death and pattern of abuse. First, while the child doubtlessly had blunt force trauma to the head caused by throwing himself on the floor, head banging or normal toddler falls, there is no evidence that the child died from blunt force trauma to the head. Instead, the findings indicate aspiration pneumonia caused by the passage of food into the lungs, as confirmed by the history, x-rays and autopsy slides.

70. Second, there is no evidence to support the finding that the child suffered an occipital fracture and epidural hemorrhage in the days immediately before death. To the contrary, the autopsy slides and neuropathology reports confirm that this was an old fracture and old epidural hemorrhage, were at minimum weeks old and possibly dated back to December 2002. There is nothing in the records that suggests that the fracture was inflicted.

71. Third, the bruised ear and pinched nipples are consistent with the self-injurious behavior reported by family members and others. I find the police interview of the oldest child, Maria, to be particularly noteworthy. Specifically:

Det.: . . . when [Rafael] gets mad what does he do?  
Maria: he hits himself, bites himself, pinch[es] himself  
Det: Does he do that quite a bit?  
Maria: Only when he finishes his food . . .

Maria: I help him feed sometimes, but I don't like to because he bit me once, and I don't like that.

Det.: Rough? What kind of stuff does he do?  
Maria: He throws the toys, and tries to hit everybody, if he doesn't have a toy he wants he starts hitting himself.

---

Det: ~~. . . when uh Rafael gets mad, you said he, he hits himself, bites himself, does he throw himself on the ground too?~~  
Maria: Yeah, sometimes he does.

Maria Gomez Int. at 10, 11, 13 (9/16/2003) (corrected). A later interview is in accord:

Det: uhm, did anybody ever grab him by the ear or anything like that, do you know?  
Maria: Uh-uh.  
Det: Okay. How do you think he would get bruises on his ear?  
Maria: On his ear?  
Det: Uh-hm.  
Maria: Oh, that, he was pinching it a lot all the time, he was pinching it, my mom said told 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 him and he had like blood so my mom just used a little bit of alcohol.

Maria Gomez Int. at 7 (12/31/2003). Maria also gives an excellent description of the incident that led to Rafael's death. Maria Gomez Int. at 7-10 (describing mother's efforts to feed child, child throwing himself back, repeated head banging on floor, difficulties breathing, etc.) I find it unlikely that the mother inflicted injuries over a period of months, reported them to CPS and sought to obtain help from neurologists while coordinating her reports with her 11 year old daughter and others.

72. As indicated, I do not know the cause of the shoulder fractures or abnormalities. I do not see anything in the history suggesting that they were caused by abuse. In my opinion, swinging the child or other forms of rough play are the most likely explanation, particularly in the presence of congenital susceptibility or abnormalities. Dr. Feldman's

suggestion that a child with these findings will usually develop "pseudo paralysis" and hold the arm close to the body indicates that something else is going on here since there are no reports by CPS workers or others, including Mr. Archiga, of Rafael holding his arm in this manner. For a further review of these findings, I recommend an independent review of the x-rays.

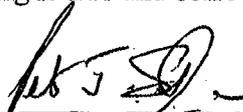
**Conclusion**

73. This case has been complicated by language and cultural difficulties, maternal drug use during pregnancy, behavioral patterns suggestive of a neurological disorder, two short falls resulting in fractures, and a continually evolving and complex literature on pediatric head injury that has changed substantially over the past decade and covers multiple disciplines, including forensic pathology, clinical pathology, neuropathology, radiology, biomechanics and bone development.

74. Based on presently available materials, there is nothing to suggest that this child died from inflicted head trauma or that there was an ongoing pattern of abuse. Instead, it appears that following the child's birth, two families—the biological family and the foster family—did their best by a child who was possibly compromised at birth, who may have had neurological difficulties causing behaviors that placed him at risk of aspiration and possible head injury, and who most likely died from hypoxia caused by damage to the lungs. Other possibilities include seizure or thrombosis, followed by aspiration. There is no medical evidence suggesting that the mother caused the child's death and/or engaged in a pattern or practice of assault.

75. Because the allegations of ongoing abuse are largely based on the imaging findings (radiology), I am urging referral of this case to Professor Patrick Barnes at Stanford, who has extensive experience and numerous publications in cases of this nature. I am also willing to testify on my findings in an evidentiary hearing.

I swear under penalty of perjury that the foregoing is true and correct.



Peter J. Stephens, M.D.  
Board Certified Anatomic, Clinical and  
Forensic Pathology

SUBSCRIBED & SWORN TO BEFORE ME  
THIS 12TH DAY OF MAY, 2010.  
my commission expires 0605

Notary Public  
Yancey County, N.C.



**Appendix 23**

**Letter from Dr. Griebel**

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# Arkansas Children's Hospital

1 Children's Way • Little Rock, AR 72202-3591 • 501/364-1100  
www.archildren.org



## Pediatric Sleep Disorders Center

Office 501/364-1893  
Fax 501/364-6878

Supriya Jambhekar, M.D.  
Assistant Professor, UAMS  
Director, Sleep Disorders

May L. Griebel, M.D. DABSM  
Professor of Pediatrics  
and Neurology, UAMS  
Board Certified Sleep Specialist

Charles Bower, M.D.  
Chief, Pediatric Otolaryngology  
Associate Professor  
Fellowship Director

Gulnur Com, M.D.  
Clinical Instructor, UAMS  
Assistant Professor  
Pediatric Pulmonary

John Carroll, M.D.  
Chief, Pulmonary  
Professor of Pediatrics

Wendy Ward-Begnoche, Ph.D.  
Assistant Professor, UAMS  
Pediatric Psychologist

Marisa N. Guillory, M.D.  
Instructor, UAMS  
Pediatric Pulmonary

Sandy King, RRT, CPFT  
RCA Outpatient Diagnostic  
Manager

Linda K. Moyer, EMT, RPSGT  
Manager

Elizabeth Jones, R.N.  
Specialty Nurse

Frances Knight, R.N.  
Specialty Nurse

3 May, 2010

Ms. Enoka Herat, Law Student  
308 East Republic, # 201  
Seattle, Washington 98102

Dear Ms. Herat:

As you know, you contacted me last week to ask about my involvement with a case related to the supposed wrongful death of a child, Rafael Gomez, who had epilepsy, and the conviction of his mother, Maribel Gomez, for his death

There was apparently a check issued in my name by the court, as requested by Ms. Gomez's attorney of record at the time, Mr. Robert Moser. The check was dated February 15<sup>th</sup>, 2005.

At that time, I had just moved to a part-time position in our sleep disorders center, as my health forced me to relinquish my full-time job in our neurology division, where I ran a large and diverse epilepsy practice, including participating in a nation-wide NIH sponsored pediatric research study.

As my career began many years ago, I made the personal decision that I would not participate in any legal work except as might be part of a patient's care with whom I was closely involved. I had testified in a couple of cases about my personal patients at about the time, and also had gotten a number of phone calls from attorneys nationwide asking me to review cases, give a second opinion, etc. I can recall only one case that I agreed to review, and that case was a child in Arkansas and did not involve the circumstances you described. As it resolved, I actually gave no testimony even in that case.

I do not remember the names of Robert Moser, Rafael Gomez, or Maribel Gomez. I review with my husband virtually any "unusual" situation with which I am involved, and he also does not remember any of those names or such a circumstance. I also checked my income tax and bank deposit records for reported income from 2005, and could find no record of such a check. Sorry I can be of no further help.

Sincerely,

May L. Griebel, MD  
Professor of Neurology and Pediatrics  
Arkansas Children's Hospital and  
The University of Arkansas for Medical Sciences  
One Children's Way  
Little Rock, AR 72202

**Appendix 24**

**Dr. Hendrickson Letter**

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September 25, 2002

400 East Fifth Avenue, P.O. Box 3649  
Spokane, WA 99220-3649  
Phone: (509) 838-2331 / 1-800-776-4048  
Fax: (509) 459-1597  
www.rockwoodclinic.com

Linda Turcotte  
CPS  
Moses Lake DCFS  
1620 S. Pioneer Way Ste A  
Moses Lake WA 98837-2487

RE:  
GOMEZ, RAPHAEL  
999999  
DOB: 01-01-2000

SATELLITE OFFICES  
Cheney Medical Center  
Medical Lake Family Practice  
Rockwood Clinic Cardiology  
Rockwood Clinic Coeur d'Alene Nephrology  
Rockwood Clinic Eye Center  
Rockwood Clinic Gastroenterology  
Rockwood Clinic Moran Prairie  
Rockwood Clinic North  
Rockwood Clinic South  
Valley Rockwood Clinic

Dear Ms. Turcotte:

I have reviewed the records you faxed to me today concerning Raphael, who is a 1-year-old ambulatory child who was seen in the emergency room for fractured distal tibia. The emergency room personnel reported the case for DCFS review because of several factors, including the fact that injury was apparently not witnessed and did have an oblique (or spiral) pattern. Also there was a language problem, and it turned out that mother had had prior concerns with CPS because of cocaine use during this child's pregnancy. There also was some question of bruises on the abdomen, although I am told that that turned out to be not bruises, but Mongolian spots. The fracture that is involved apparently was a nondisplaced injury to the distal tibia which in pediatric parlance is often called "the toddler's fracture." This injury sometimes turns up in the office up to a week after the injury with child limping or not using the leg as appropriate. It can be as a result of abuse, but very commonly is a result of fairly minor trauma where the foot is thought to catch on something, giving some torsion in the process of the fall to that portion of the bone. As to whether it is abusive or not, the decision really needs to be made on the basis of the history and any additional evidence whether the child may<sup>be</sup> abused or neglected. In this case, having read through further investigation reports from the home and caretakers in the home, I believe that this child was very likely injured innocently, as they described, while playing on the porch. Without other evidence of abusive injury or care to this child, I would hope he could be returned to his parent's care as soon as possible.

I will forward to you some supporting information from Paul Klineman's textbook on diagnostic imaging of child abuse for your reference.

Sincerely,



Alan V. Hendrickson, MD, FAAP

8901/J:995444/D:1087758/CL:10  
D: 09/25/2002 11:57:09  
T: 09/25/2002 14:18:00

**Appendix 25**

**Dr Deleon Progress Notes**

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## Family&IM Progress Notes

Page: 1

Name: Arechiga, Rafael

Date Printed: 04/02/10  
ID: 18231-2 SEX:M AGE:8

05/22/03 : ARECHIGA,RAFAEL: 18231-2: 00:00

PROGRESS NOTE

C-D

Patient: ARECHIGA,RAFAEL

Patient Visit Date: 05/22/03

Transcribed Date: 06/02/03

S-----T-----|

**SUBJECTIVE:** The patient is brought in to establish care. He used to be in the foster care system. He was Dr. Verhage's patient also. He was a full-term AGA NSVD. He spent three days in the hospital for possible cocaine withdrawal at birth. The mother used cocaine during pregnancy, smoking and some drinking. Mother thinks that because of all of this there is something wrong with the child. He apparently cries all of the time and at times he hurts himself, bites himself and pulls on his hair. He seems to drool a lot and he seems to eat all of the time.

**SOCIAL HISTORY:** Mother is 29, dad is 30. Has four other siblings, a 10-year-old sister, a 6-year-old brother, a 4-year-old sister and an 8-month-old brother. He lives with the other siblings and the parents. There are no pets.

**FAMILY HISTORY:** Maternal grandmother had heart problems and diabetes mellitus. Maternal grandfather is dead of unknown causes. Paternal grandmother has seizures and arthritis. Paternal grandfather is unknown.

**ALLERGIES:** Unknown but his face swells with an antibiotic.

**MEDICATIONS:** None at this point.

**REVIEW OF SYSTEMS:** As stated above.

### PHYSICAL EXAMINATION:

**Vital Signs:** Weight 29 pounds. Temperature 97.8.

**General:** He was observed during the examination and interview with mom and the caseworker. He was very happy, looking around his surroundings, smiling, laughing. Did not see any outbursts of anger or rage. At this point, I didn't see any sites of mutilation.

**HEENT:** Normocephalic, atraumatic. Extraocular movements are equal and intact. Pupils fundi look OK. Red reflex x 2. Tympanic membranes look unremarkable. Oropharynx is clear.

**Neck:** Supple.

**Lungs:** Clear with good air entry.

**Heart:** First and second sounds are heard with no gallops or murmurs.

**Abdomen:** Soft, nontender, nondistended. Good bowel sounds. No masses.

**Extremities:** Full range of motion x 4. Negative hip click. Good pulses throughout.

**Neurologic:** Cranial nerves 2 through 12 with no focal deficits. Has good sensation, good motor. Seems to have good behavior when I was examining him.

**ASSESSMENT:** Child born to cocaine abuser with cocaine withdrawal in the hospital, with episodes of rage and anger with self mutilation, not observed by me but observed by some family members.

**PLAN:** The patient will be seeing a specialist at Children's Hospital either in Spokane or in Seattle. To come in p.r.n.

# SIGNED BY CONRADO DELEON (C-D)

06/17/03