

Appendix 26

Motion for Funds for Expert Witness 2/8/05



04-033935

SANDY MINDER	
BY KENNETH O. KUNES	CLERK DEPUTY
FEB 08 2005	
RECORDED IN _____	PAGE _____
VOLUME _____	PAGE _____

SUPERIOR COURT OF WASHINGTON, GRANT COUNTY

STATE OF WASHINGTON,
 Plaintiff,

Case No. 04-1-00312-4

v.

MOTION FOR FUNDS FOR EXPERT
 WITNESS

MARIBEL GOMEZ,
 Defendant,

Maribel Gomez, the Defendant in the above-captioned matter, requests and moves the court to order funding for consultation with two experts pursuant to CrR 3.1(f). Specifically,

(1) Ms. Gomez requests that the court order funding for consultation with Dr. May Griebel, MD, a pediatric neurologist. Dr. Griebel's billing rate is \$150 / hr. Dr. Griebel will perform an initial review of medical documents to determine if it is plausible that Rafael Gomez, the decedent child, suffered from epilepsy or another neurological disorder.

(2) Ms. Gomez requests that the court order funding for consultation with Dr. Janis Amatuzio, MD, a pediatric forensic pathologist. Dr. Amatuzio's fee for a "quick" review of medical

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documents is \$750. Dr. Amatuzio will perform an initial review to determine if it is plausible that the death of Rafael was accidental.

Whereas:

CrR 3.1(f) provides for court funding of services, other than legal counsel, necessary for the defense of a criminal charge in cases where the defendants are indigent. This rule is interpreted to provide for court funding of defense experts to assist indigent defendants. STATE v. CAROL D., 97 Wn. App. 355 (1999);

Ms. Gomez is indigent;

Ms. Gomez requests funding for a consultation with Dr. Griebel on the basis that consultation with a pediatric neurologist is necessary to the defense of this matter to determine if Rafael suffered from epilepsy or any neurological condition that would dispose him to repeatedly beat his head against the floor or make him susceptible to injury;

Ms. Gomez's request for a consultation with Dr. Griebel is supported by the First Declaration of Robert Moser and the attached affidavit of Dr. Carl Nugent;

Ms. Gomez requests funding for a consultation with Dr. Amatuzio, on the basis that consultation with a pediatric forensic pathologist is necessary to the defense of this matter to determine if it was physically possible for Rafael to sustain the types of injuries he suffered by throwing himself backward or by any other action of his own;

Ms. Gomez's request for a consultation with Dr. Amatuzio is supported by the Second Declaration of Robert Moser and the attached article by Dr. John Plunkett.

Submitted: Feb. 8, 2005

Robert Moser
Robert Moser, WSBA # 32253
Attorney for Maribel Gomez

SANDY MUDER

BY KENNETH O. KENES CLERK DEPUTY
FEB 08 2005
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04-033936

SUPERIOR COURT OF WASHINGTON, GRANT COUNTY

STATE OF WASHINGTON,
Plaintiff,

v.

MARIBEL GOMEZ,
Defendant,

Case No. 04-1-00312-4

FIRST DECLARATION OF ROBERT
MOSER IN SUPPORT OF MOTION
FOR FUNDING OF EXPERT
WITNESSES

I, Robert Moser, declare under penalty of perjury the following:

This affidavit is submitted in support of the Defendant's motion for the court to order funding of a consultation with Dr. May Griebel, MD;

I have discussed the matter of *State v. Maribel Gomez* with Dr. Carl Nugent, MD, over the phone and in person;

Dr. Nugent explained to me that he practiced as a general practitioner;

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Dr. Nugent explained that since his retirement ten years ago, he has taken a particular interest in epilepsy in children and that he has followed several criminal cases in which he thought that epilepsy played a role;

Dr. Nugent's qualifications to render an opinion on the retention of an expert witness are set forth on pages 17-18 of his affidavit;

Dr. Nugent was willing to talk to me about signs of epilepsy in children and the possible implications for this case;

When Dr. Nugent asked what kind of assistance he could provide, I suggested an affidavit stating his credentials and explaining why he thought a consultation with a pediatric neurologist was necessary to the defense of the case;

Dr. Nugent was extremely generous with his time by writing a long and thought-provoking declaration that shows his reasons for suspecting Rafael had epilepsy. Dr. Nugent's affidavit is attached to this First Declaration of Robert Moser as Exhibit 1;

Dr. Nugent noted on page 3 of his affidavit that a child with epilepsy can suffer injuries to multiple parts of the body, leading wrongfully to conclusions of abuse by medical professionals. This suggests the importance of examining the medical records to determine if Rafael Gomez had epilepsy;

Dr. Nugent noted on page 6 of his affidavit that a child can fall during a seizure and right himself so quickly that it appears to be a normal fall. However, the child can suffer serious injuries during such falls, similar to the case of Rafael Gomez. The circumstances of the Rafael's case suggest a possibility of epilepsy;

Dr. Nugent stated on page 4 of his affidavit that he found Maribel Gomez's descriptions of Rafael's falling episodes to be so specific as to suggest a possibility of epilepsy;

Dr. Nugent also notes on page 9 of his affidavit that a child with epilepsy can be susceptible to burns. Burns on multiple parts of Rafael's body was cited by Dr. Feldman of evidence of abuse. Dr. Nugent believes burns on multiple parts of Rafael's body suggest epilepsy.

I spent quite a bit of time looking for a pediatric neurologist, with emphasis on epilepsy, ~~that was available to consult. I was not comfortable retaining an expert-referral-service-if-I-could~~ not talk to the expert first; however, these services did not allow access to their experts before an agreement was signed;

I found Dr. May Griebel by searching the internet. Dr. Griebel teaches at the University of Arkansas for Medical Sciences College of Medicine, Department of Pediatrics, in Little Rock, Arkansas. She practices out of the children's hospital that is connected to the university. Dr. Griebel represented to me that she has been treating children with epilepsy for 20 years. Dr. Griebel's resume is posted at:

<http://www.uams.edu/pediatrics/faculty/Neurology/Griebel,%20May.asp>

Dr. Griebel represented to me that she would not be available to testify. Dr. Griebel was happy to talk to me and enthusiastic about assisting;

Dr. Griebel represented to me that her billing rate for consultations is \$150 per hour.

Sworn to this 8~~th~~ day of February, 2005, in Moses Lake, Wa.

Robert Moser
Robert Moser

Submitted: Feb. 8, 2005,

Robert Moser
Robert Moser, WSBA # 32253
Attorney for Maribel Gomez

Neurology

EXHIBIT 1

	<p>May L. Griebel, MD Associate Professor of Pediatrics Section of Neurology</p>
<p>Contact Information</p>	<p>Arkansas Children's Hospital 800 Marshall Street Little Rock, AR 72202</p> <p>Phone: (501) 364-4416 Fax: (501) 364-6077 GriebelMayL@uams.edu</p>
<p>Education</p>	<p>MD - University of Arkansas for Medical Sciences, 1983</p>
<p>Training</p>	<p>Internship: Pediatrics, University of Arkansas for Medical Sciences, 1983-1984 Residency: Pediatrics, University of Arkansas for Medical Sciences, 1984-1986 Fellowship: Pediatric Neurology, Duke University Medical Center, 1986-1989; Clinical Neurophysiology, Duke University Medical Center, 1989-1990</p>
<p>Board Certification</p>	<p>Pediatrics Neurology Child Neurology Clinical Neurophysiology Sleep Medicine</p>
<p>Hospital Appointments</p>	<p>Arkansas Children's Hospital UAMS</p>
<p>Clinical Interests</p>	<p>Epilepsy and sleep</p>
<p>Research Interests</p>	<p>Epilepsy and sleep</p>

Under the penalties of perjury, I, Carl G. Nugent, M. D., swear and affirm that the following statements are true and correct to the best of my knowledge and belief. It is my firm and unequivocal conviction that Maribel Gomez, of Ephrata, Washington, currently charged with manslaughter in the death of her son, Rafael, cannot hope to obtain a fair trial unless there is consultation by a competent and qualified pediatric neurologist who is thoroughly familiar with is Lennox-Gastaut syndrome and other forms of epilepsy as it presents itself in children under two to three years of age. If, as I assume, she lacks funds to finance such consultation, the State of Washington has an absolute obligation to provide for such consultation at the State's expense. Without it, there can be no possibility of her having a fair trial.

There have been a number of newspaper accounts of this tragedy which have contained statements about Rafael and the troubles which plagued him throughout his short life. I have had no opportunity to review the case in

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detail but there has been enough information in the newspaper accounts to make it mandatory that the question of whether or not he died of epileptic or non-epileptic injury be given the most careful and thorough possible consideration. As far as I can tell from newspaper accounts, the prosecution is totally unaware that this is a question of epileptic or non-epileptic injuries as the cause of death. Apparently they want to make a case of death from “non-accidental” injuries without even dealing with the question of whether or not epileptic injuries are accidental. It is obvious that epileptic injuries are not inflicted injuries and therefore cannot be considered abusive. Furthermore, death from epileptic injuries cannot be considered murder, manslaughter, or any other form of homicide. Most importantly, there is an enormous difference between evidence for abusive injuries and death from non-abusive non-epileptic truly accidental injuries, but sometimes it is extremely difficult to distinguish between epileptic and abusive injuries. Careful study would make it possible to tell the difference in most cases, but it requires that the study be made without allowing any tolerance for expediency to compromise the highest possible standards of integrity, objectivity and dedicated intelligence that can be brought to bear in the investigation. We are not interested in whether or not it is consistent with Motherhood and Apple Pie – we want to know if it is consistent with scientific truth, integrity, and objectivity.

It must be realized that the Appellate Courts are never going to assume that a jury made an honest mistake. In fact, it is my understanding that they are forbidden by law to give any thought to such a consideration. They are allowed to ask one and only one question – DID THE DEFENDANT HAVE A FAIR TRIAL? They will never assume that the jury depended on them to correct any mistakes they might have made. If the jury convicts, the Appellate Courts will assume that they were satisfied of the defendant’s guilt beyond a reasonable doubt and there the matter ends.

The trouble is that the jury is likely to assume that if they acquit a guilty person, someone will get away with murder but if they convict an innocent person, all that person has to do is appeal. I was once naïve enough to believe that myself. The Snohomish County Prosecutor’s Office has done a thorough job of remedying that defect in my education. Can I make that *statement* under the penalties of perjury? Let me be a bit more specific: In January (it might have been February) of 2004, one of the

prosecutors from that office told a San Diego audience “Once you are satisfied that a suspect is guilty, from that point on, every piece of evidence is proof of guilt.” I most certainly am making that statement under the penalties of perjury. I was in the audience at the time – and I can name the prosecutor.

Evidence of abusive injuries versus evidence of epileptic injuries

Child abuse authorities with no understanding of “epilepsy in a nightmare” (otherwise known as the Lennox-Gastaut syndrome) might assume that injuries to multiple body planes constitute irrefutable evidence of abusive injuries. They might be considered evidence of non-accidental injuries if epileptic injuries are considered to be non-accidental but they are most definitely not evidence of non-epileptic injuries. **This requires extreme emphasis: injuries to multiple body planes are absolutely NOT evidence of non-epileptic injury, in spite of anything any child abuse authority may say to the contrary.** They are, however (at the risk of repetition), perfectly genuine evidence of non-accidental injury if epileptic injuries are considered non-accidental. Accidental injuries generally occur one at a time. Epileptic injuries may well be repeated at intervals too short for the bruises to clear between seizures. In fact, in the January 1994 issue of Reader’s Digest, the “News from the World of Medicine” feature states that children afflicted with Lennox-Gastaut syndrome may have up to two hundred seizures per hour. The Reader’s Digest is, of course, not a peer-reviewed medical journal. However, on page 194 in the text by Ernst Niedermeyer we read that, when a child with Lennox-Gastaut syndrome is afflicted with tonic status epilepticus, he may have ten to one hundred seizures per hour. That, of course, is less than two hundred seizures per hour, but it is still one seizure every thirty six seconds – far too short a time period to permit bruises to heal. In fact, seizures six minutes apart would hardly give bruises time to heal. They might not even heal between seizures which were six days apart.

Some of the features of the story of Rafael Gomez seem to represent the hallmarks of a devastating form of epilepsy – one which might even be considered “epilepsy in a night mare” but which is better known to epileptologists as the Lennox-Gastaut syndrome. His mother, Maribel

Gomez, was quoted by the papers as demanding that his peculiar falling episodes be investigated and a search made for the cause. I believe that such an investigation most definitely should have been made during his lifetime. There is no reason why the question of whether or not he actually had Lennox-Gastaut syndrome could not have been definitively resolved had such an investigation been done. Maribel Gomez can most definitely not be blamed for the fact that this investigation was not done. She made her demands (according to stories in the newspaper) and they were persistently ignored by those who undoubtedly were unfamiliar with the features of Lennox-Gastaut syndrome and may have been quite certain that the mother was simply fabricating the stories. I do not think it possible that these features could have been fabricated. Either they represented what she actually saw or they represented she read about in the epilepsy textbooks. I understand that her understanding of the English language was too poor to permit her to have become acquainted with this disease by reading about it in textbooks. Could she have read about them in Spanish translations of standard epilepsy textbooks? If there is any reason to believe she could have had access to any such translations, we could consider the question. My default assumption would be that this is highly improbable. In fact, I doubt that she could have had access to any such works in English. Without access to these professional textbooks there is no way she could have given as good a description of the seizure types and their consequences *unless she had actually observed Rafael when he was "seized" by these convulsions.*

Documentation from the literature

Since the newspaper accounts are in the public records, they can be compared with material from the epileptic (and other professional literature. At this time, I would like to quote some passages from the epilepsy textbooks.

Starting on page 4 in the work edited by Ernst Niedermeyer and Rolf Degan, The Lennox-Gastaut syndrome, Proceedings of a Symposium Held in Bad Kreuznach, Federal Republic of Germany, September 17-19, 1987 Alan R. Liss, Inc., New York, there is a paper by K. Karbowski, of the Department of Neurology, University of Berne, CH-3010 Berne Switzerland. It is titled DEVELOPMENTS IN EPILEPTOLOGY IN THE

18TH AND 19TH CENTURY PRIOR TO THE DELINEATION OF THE LENNOX-GASTAUT SYNDROME. Here is an excerpt from that paper:

In his scripts Jackson (1886) reports on a boy, examined by him in January 1886, who suffered after a succession of epileptic fits on light hemiparesis of the left side. Jackson supposes these fits to be “depending on discharges beginning in parts of the pons Varolii and medulla oblongata” and emphasizes that “the most noteworthy thing in this case is that he “began to fall down” occasionally about a month or six weeks before the first fit, that is, before the first so-called “ordinary epileptic fit”, which occurred at the age of 2 ½ years. Ever since he has been subject to these “fallings” which are really fits also”.

These attacks could sometimes be triggered by unexpected sensoric stimulation – equal to a “startle epilepsy” (Saenz-Lope et al., 1984). Occasionally they were of marked vehemence. In a letter dated March 4, 1886 the boy’s father wrote among other things to Jackson: “He was sitting on my knee whilst I adjusted the band over his eye; in untying the knot, my finger slipped, the vibration caused him a shock, and his eyebrow struck me on the upper lip. Though the fall was only a few inches – say 3 ore (sic) 4 – the blow was so heavy that my lip was cut, and at first, I thought my tooth was broken.” The observation of Jackson was cited 82 years later by Kruse (1968) in the historical introduction of his monograph about “Das Myoklonisch-astatische Petit Mal” (The Myoclonic-astatic minor epilepsy).

Jackson’s report obviously was written before the electroencephalogram was developed, before the syndrome was identified or named, and certainly before the electroencephalographic criteria for making the diagnosis were described. While clinical epileptologists have the luxury of using the EEG criteria, we of the present day are just as handicapped as those of the previous century when it comes to making the diagnosis on a child who dies without ever having any EEG studies done. What we can do, however, is retrace the steps of those pioneers who first determined what the EEG criteria had to be. First, we have to determine the clinical criteria, and then we have to determine what we will always see in the EEG studies on children who do fulfill the clinical criteria. Since I have not had the

opportunity to do a thorough study of the case of Rafael Gomez the way I have done in the case of Kayla Erlandson, I will have to use her as an example. I can make the diagnosis of Lennox-Gastaut syndrome in her case by showing that all children exhibiting the clinical features of her case will fulfill the EEG criteria if there is an opportunity to do the EEG studies while they are still alive.

Mrs. Erlandson has "had her day in court" and the criminal justice system is simply washing its hands regarding her case. Mrs. Gomez has not yet had her day in court. She deserves far more in the way of a fair trial than Mrs. Erlandson ever received. In order to do this, it is mandatory that provision be made for competent input from the field of pediatric neurology and epileptology. We know what went wrong with the Erlandson case. We know what we can do to keep that kind of injustice from being repeated in the Gomez case. We will either do what we have to do or stand accused of permitting an injustice to be repeated.

Another quote is from Penelope Leach in Your Growing Child from Babyhood to Adolescence (1991, Alfred Knopf, New York). (The page in the Leach text was 168.)

Drop Attacks: These are similar to infantile spasms (West Syndrome) but affect children over two years of age. The child falls, often as if violently pushed, either forwards or backwards. Sometimes there is no forward or backward impetus but he simply collapses on the floor without warning.

The child rights himself so rapidly that parents sometimes do not realize that anything other than a normal fall has taken place. Your clue, at least a second time, may be the child's failure to throw his arms up to protect his head or face. Injuries are quite common and have sometimes led to accusations of "battering." Innocent parents' accounts of a child "just suddenly falling" can seem improbable to the inexperienced emergency room doctor.

Can the diagnosis of Lennox-Gastaut syndrome actually be proved by comparing the newspaper accounts of Rafael's seizures with the quotations

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from the epileptic literature? I believe they can be, but the question is moot for two reasons: In the first place there is no reason why we have to depend on newspaper accounts to prove the diagnosis. I have never reviewed the autopsy report. I have never reviewed the actual statements submitted by those who knew Rafael, including his foster parents, the DSHS reports, and other documents that could well furnish some highly pertinent information. It is my firm opinion that **this absolutely must be done**. If there is no way in which input by a competent pediatric neurologist cannot be obtained, I would be more than happy to do it myself. Even if a pediatric neurologist does consult on the case, I still would be willing and happy to do such an investigation, except that I believe that the pediatric neurologist should have the opportunity to interview the mother (Maribel Gomez) before I do.

The other reason why the question is moot is because we, as a society, believe (or pretend to believe) that the prosecution has the burden of proof.

Let me make another quotation from Niedermeyer, this time from page 77. First, let me point out that it is highly technical, and is included not for general information but to provide for a rebuttal to any highly technical attack that may be made against this affidavit. I will put it in fine print but will offer to provide a larger print edition for those really interested in reading it:

Atonic Seizures

These seizures occur **exclusively in conjunction with the LGS (Chapter 7)**. The attacks are most often noted in children but may persist into adolescence and even adulthood. They are also known as atonic-akinetic seizures, atonic drop attacks, atonic absences, and static fits.

Clinical Ictal Features There is a sudden loss of muscle tone, almost generalized, resulting in an abrupt, almost lightning-like fall. Knees buckle and torso and head slump forward; this may lead to head injuries. These attacks may be of a fraction of a second or of a few seconds duration. A subtle myoclonus may initiate the atonia. There is no loss of consciousness, and the patient will pick himself up immediately (Fig. 4-13).

In a sizable number of patients, the myoclonic component is not subtle at all, and the patient may be propelled to the ground with a violent generalized jerk. Matters are even more complicated since a tonic component is also present to a varying degree. This renders the underlying mechanism of atonic attacks quite complex (Nolte et al., 1988). Hence the term "atonic seizure" could be a misnomer in a large number of patients with such falling attacks. Similar conclusions can be derived from the work of Egli et al. (1985).

Ictal EEG The atonic attack is usually accompanied by a generalized burst of spikes, fast polyspikes, and a few slow waves (Gastaut and Broughton, 1972; Oller Daurella and Oller Ferrer-Vidal, 1981).

Prevalence and Frequency These seizures occur in at least 50% of cases of Lennox-Gastaut syndrome and probably in 2%-3% of an epileptic population. The attacks usually do not occur in repetitive salvos.

Postictal Events There are none, except for severe traumatic consequences.

Dangers and Risks Severe trauma is quite common. As a protective measure, the patients wear helmet-like headgear.

Differential Diagnosis The typical atonic drop attacks of the Lennox-Gastaut syndrome must be distinguished from quite similar ictal drop attacks occurring in severe cases of temporal lobe epilepsy of adolescence and adulthood. These patients have unilateral or bilateral anterior temporal EEG spike or sharp wave foci. The fall is either flaccid or rigid; it is a rapid and injurious fall to the ground, with rapid recovery of consciousness. Pazzaglia et al. (1985) assume a frontal origin for such drop attacks, which according to these authors represent an ominous change in the evolution of partial epilepsies. The cases of Pazzaglia et al. (1985) show mainly generalized paroxysmal bursts of spikes and slow spike-wave complexes, which strongly suggest at least some relationship to the Lennox-Gastaut syndrome (although Pazzaglia et al. (1985) favor separation from this syndrome.). It must be reemphasized, however, that pure drop attacks may occur in pure cases of temporal lobe epilepsy.

Outside the domain of epileptic seizure disorders, drop attacks maybe due to rapid syncopal fainting, especially in cases of vertebrobasilar artery insufficiency and acute vestibular dysfunctions ("vestibulocerebral syncope"); Mumenthaler, 1984). Brain tumors and especially colloid cysts of the third ventricle may cause rapid falls. Cataplexy as a sleep disorder also causes drop attacks, usually of a slower and less traumatizing nature.

Perhaps the foregoing need not be considered in evaluating the need for consultation by a pediatric neurologist, but it is important to provide a technical defense against a possible technical attack. Dr. Kenneth Feldman has, according to the papers, made statements at certain hearings in connection with the Gomez case, regarding whether or not Rafael's injuries could have been self-inflicted. I am not familiar with the details, but that should be part of any competent investigation. Suppose he should dispute the assumption that Rafael's falls represented atonic seizures as seen in Lennox-Gastaut syndrome (what I prefer to call "epilepsy in a nightmare"). I would then quote something I heard Dr. Ellsworth Alvord (who was a witness for the prosecution at the Erlandson trial) say at the trial of Michael and Laurinda Jackson in the death of their foster daughter, Breighonna Moore. Dr. Alvord (a witness for the defense at the Jackson trial) was being cross-examined by Prosecutor Rebecca Roe when he answered her question on the possibility that Breighonna might have been conscious after her fatal injury by saying "If Dr. Feldman were to explain why he feels as he does, I

examined Breighonna's brain, I found nothing that would convince me that she could not have been conscious after her injury." I do not have a copy of the transcript, and this does not pretend to be a verbatim account of what he said but I do declare, under the penalties of perjury, that I am not misrepresenting his statement. (Court of Judge Brian Gain, King County Court House, Seattle, WA, May 1994. State of Washington versus Michael and Laurinda Jackson in the death of their foster daughter, Breighonna Moore.) I do not believe that Dr. Alvord (a neuropathologist associated with the University of Washington Hospitals) felt the defendants were innocent, but he was testifying as a witness for the defense regarding the significance of intracellular hemosiderin in Breighonna's subdural hematoma as evidence that the injury was more than 72 hours old. Let me say here that I do not believe that Breighonna Moore had Lennox-Gastaut syndrome.

In addition to saying that, in all probability, Breighonna could not have been conscious after her fatal injury, Dr. Feldman also testified that the presence of injuries on multiple body planes constituted evidence of abuse. As far as Breighonna was concerned, he could well have been correct. I went to that trial for the specific purpose of seeing if I could pick up any evidence of Lennox-Gastaut syndrome and I found none whatsoever. I do not know enough about the autopsy findings to know whether Dr. Alvord or Dr. Feldman was correct about the possibility of consciousness after the injury. I doubt if Dr. Alvord would have overlooked massive diffuse axonal injury in the dorsolateral quadrants of the rostral brain stem, which is one finding that would make a lucid interval after the injury virtually impossible.

I do recall something in the newspaper stories about Rafael Gomez in which Dr. Feldman said that two of Rafael's burns were too far apart to have occurred in a single accident. The same thing I said about bruises applies with at least equal force to burns. In some cultures, epilepsy is referred to as the "burn disease." All it takes to produce a burn in an epileptic child is a seizure occurring when the child is close to something hot.

What about Rafael's leg fracture? That is something I would expect to know more about after reviewing all available records. The myoclonic-atonic seizures of the Lennox-Gastaut syndrome are probably more likely to produce skull fractures than leg fractures, but this would not be the first time that I have heard of a seizure producing a leg fracture in a child with that disease. How old was Rafael when this happened? Was it a mid-shaft fracture? Was it a "classic metaphyseal fracture"? I would hope to know the answers upon completing a thorough review of the case. The child abuse

literature says that leg fractures in a child less than a year old are highly suspicious. This is reinforced by the fact that Lennox-Gastaut syndrome is extremely rare in a child less than a year old. It has, however, been reported in an infant as young as six months. In fact, I have heard of a case in a three-month old infant in whom the correct diagnosis probably was West syndrome. West syndrome, like Lennox-Gastaut syndrome, is associated with a high incidence of progressive mental retardation but I do not believe physical injuries (broken noses, broken teeth, facial injuries, skull injuries) are likely to be as bad. There is a strong association between West syndrome and Lennox-Gastaut syndrome. Anywhere from ten per cent (Niedermeyer) to sixty five per cent (Ikeno) of children with Lennox-Gastaut syndrome have a history of West syndrome and a similar (perhaps slightly smaller) proportion of children with West syndrome will eventually develop Lennox-Gastaut syndrome.

In a conversation I had with Mr. Robert Moser of Moses Lake (who is lawyer for Rafael's mother, Maribel Gomez) on July 6, 2004, he told me that Mrs. Gomez had described Rafael as having seizures in which he would suddenly throw himself backwards. I imagine this could represent one of the more unusual seizure types associated with Lennox-Gastaut syndrome, but, to me, it sounds a lot more like something one would expect to see in West syndrome. What I do not know is how old Rafael was when she noticed these seizures. It could make a difference. To the best of my knowledge, when West syndrome and Lennox-Gastaut syndrome occur in the same child, one would expect the West syndrome to come first. If it truly represents West syndrome, it would constitute powerful *independent* evidence for Lennox-Gastaut syndrome. In fact, one extremely erudite epileptologist once told me that it was improbable that Kayla Erlandson had Lennox-Gastaut syndrome because there was no history of West syndrome. (I hope that expert testifies for the prosecution in the Gomez case. I also hope the defense lawyer is good at cross-examination. I could argue with him about the Erlandson case but I see no need to argue with what he said at that time as it applies to the Gomez case.)

Another source I wish to quote is page 317 in the second edition (1998) of Diagnostic Imaging of Child Abuse edited by Dr. Paul Kleinman of Boston:

Hyperemic swelling. A particularly important cause of diffuse brain swelling in children is a vasoreactive post-traumatic increase in cerebral blood volume (hyperemia).^{2, 42, 82.}

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²²¹ This phenomenon is responsible for the rapid and significant intracranial hypertension that occurs within hours of the trauma and precedes the edema and swelling resulting from other traumatic or posttraumatic insults (Fig. 15-11). The malignant swelling from the increased cerebral blood volume is probably due to cerebrovascular congestion rather than loss of normal autoregulation. Although the condition is potentially reversible with early and aggressive therapy, there is a reported mortality of over 50%.²

I believe that the above represents the final direct cause of death in the case of Kayla Erlandson and may well represent the final direct cause of Rafael's death. In Rafael's case, there is still much work to be done. The reason for submitting this affidavit at this time is to make sure that the need for pediatric neurology expertise is documented before the trial begins. Once the trial is over, the deficiencies will be cast in concrete. I have even heard rumors (which I hope were false) that the United States Supreme Court has gone on record as saying that there is nothing wrong with imposing (and executing) capital punishment on an innocent person as long as he has had a "fair trial." I consider that an oxymoron but I do not believe the Supreme Court is interested in my opinion.

Reference number 42 (in the above quotation) is the 1981 article by Bruce et al. on "Malignant Cerebral Edema." "Hyperemic brain swelling" is a better name for it because the acute episode is the catastrophically sudden developemnt of a situation in which large amounts of blood suddenly enter the brain and, for some reason, cannot get out again. True edema of the brain (interstitial or intracellular fluid accumulation or "water-logging") develops later and more gradually, but the fact that old blood cannot get out of the brain means that fresh blood (carring oxygen and glucose to the brain) cannot get in. Anoxic and hypoglycemic brain damage begins rapidly, leading to true edema, increase in intracranial pressure, and finally, herniation of the brain stem down into the spinal canal with compression of the respiratory centers in the brain stem, exponentially accelerating brain damage and death.

One of several sources of documentation of the fact that the myoclonic- atonic seizures of the Lennox-Gastaut syndrome can produce severe injuries such as skull fractures and subdural hematoma is Tracy Johnson, quoting Dr. Gregory Holmes of the Harvard U Medical School neurology department on page A9, Seattle P-I of April 9, 2001. The Internet access handle is

(http://seattlep-i.nwsource.com/local/17848_crusade09.shtml). I tried it today (August 17, 2004) and was able to satisfy myself that it works just as well from the area of Cleveland, Ohio (where I am currently staying with my sister-in-law following my brother's death) as it does from my home in Seattle.

But Dr. Gregory Holmes, director of the Division of Epilepsy and Clinical Neurophysiology at Children's Hospital Boston, has seen seizures cause serious injuries, including a "subdural hematoma" brain injury like the one Kayla had.

~~Holmes believes a seizure could cause a toddler to fall against a toilet rim with enough force to cause a serious head injury -- and that a mother may have no idea it was a seizure.~~

"It might be tough, initially, for a parent to tell," said Holmes, who is also a professor of neurology at Harvard Medical School. "They're quick. The parent could be standing right next to the child, and all of a sudden, the child is on the ground."

Holmes thinks it's more likely that the head injury killed Kayla than the Valium, though her other injuries make him more circumspect.

He has seen burns on children who have fallen against something hot, and he speculated that a fall against something angular -- like a coffee table -- could cause a liver laceration.

But he pointed to the obvious. There is no way that Lennox-Gastaut Syndrome can cause a bite mark.

As far as the "killer coffee table" is concerned, Dr. Holmes said it -- I didn't. Since, as far as I know, Rafael displayed no bite marks and was never given any Valium (intravenous or otherwise), Dr. Holmes' remarks on those subjects are moot in the Gomez case. They are fascinating subjects which I love to discuss in detail but many people become terribly confused by them. Therefore I should probably discuss them only if a request is made. Dr. Holmes is certainly right if we assume he meant that a bite mark is not a manifestation of Lennox-Gastaut syndrome even if the bite was provoked by an unrecognized seizure. (It certainly can be provoked by a child who "won't stop crying," but that is not considered a legitimate excuse for biting

a child.) Furthermore, Valium was obviously not the direct cause of Kayla's death. (I would insist that a very mild stimulus is all it takes to trigger sudden hyperemic brain swelling several hours after a severe head injury, and Tassinari (1972) has documented that occasionally intravenous Valium can trigger tonic status epilepticus within sixty seconds when given to a child with Lennox-Gastaut syndrome. All this is irrelevant in Rafael's case.)

In the third edition of Aicardi's Epilepsy in Children (Alexis Arzimanoglou, Renzo Guerrini, and Jean Aicardi were the editors.) published by Lippincott, Williams and Wilkins (2004) we find some statistical information about head trauma from tonic or atonic seizures as seen in Lennox-Gastaut syndrome. Like the second edition, it devotes an entire chapter to the Lennox-Gastaut syndrome. In a separate chapter on page 350, it has the paragraph I wish to quote:

Head traumas are more common in some children with atonic or tonic seizures, in whom this may represent a major problem. Skull and face protection is essential in such cases. However, very serious injuries are uncommon. Of the 12,626 seizures associated with falls that were recorded in a center for children and adolescents, 766 resulted in significant head injuries, with 422 requiring simple dressing and 341 requiring sutures. One skull fracture and two intracranial hemorrhages were observed (Russel(sic) -Jones and Shorvon, 1989).

The complete "Russel-Jones" and Shorvon reference is Russell(sic) - Jones DL, and Shorvon SD, 1989. "The frequency and consequences of head injury in epileptic seizures." *J Neurol Neurosurg Psychiatry* 52:659-662. I have not read this article yet. (If I did, maybe I would find out how to "spel" the first author's name.)

This is a very specific documentation of the severity of the injuries which the Lennox-Gastaut syndrome can produce. One thing about that quotation is somewhat misleading. "Twelve thousand six hundred twenty six seizures" seems like a huge number, but, at that rate, a child who was having several dozen seizures per day might well have a skull fracture or subdural hematoma ever few years.

The Gomez Case is Not Quite Without Precedent – Colorado v. Evers
And Evers.

Dr. Harry L. Wilson is a pediatric pathologist who lives in El Paso. He was living in Denver when he and the late Dr. Robert H. Kirschner of Chicago wrote the chapter on the pathology of fatal child abuse in Child Abuse, Medical Diagnosis and Management (1994, Lea & Febiger) edited by Dr. Robert M. Reece of Boston (more recently Norwich, Vermont). After he moved to El Paso, he and Dr. Kirschner wrote a similar chapter for the second edition, edited by Dr. Reece and Dr. Ludwig of Philadelphia (2001, Lippincott, Williams and Wilkins).

In the spring of 1999, I learned of a couple (Dennis and Sandra Evers) who lived in Durango, Colorado, facing homicide charges in the death of their foster daughter, Roberta. The prosecution insisted that they were overly rigid moralists who had applied restraints to Roberta's wrists at bed-time to discourage her from masturbating. During the night she was overcome with vomiting. The restraints, according to the prosecution, prevented her from clearing her throat, and she inhaled massive amounts of vomitus into her lungs and died of pulmonary edema and pneumonia. The cause of death, according to the prosecution, was positional asphyxia, the manner of death was homicide. The defendants countered that the girl was using knives and scissors as phallic substitutes, and they did not feel that their objection to this kind of behavior could be dismissed as pure moralism.

I am still uncertain as to why I was able to base a diagnosis of Lennox-Gastaut syndrome on only that amount of information. I was certain of one thing, however, and that was that I would never be able to sell the diagnosis to a pediatric neurologist.

I was so intrigued that I made a special trip to Durango to see if I could pick up some grist for my mill. (Please bear in mind that Rafael was not even born yet.) My attempt to find supporting evidence for the diagnosis was a total failure. The closest anyone could come to giving me information about anything the least bit like myoclonic-atonic seizures causing traumatic drop-attacks were some reports from the local police. The comments I got from the couple were something like "You know how the police always exaggerate things." (My reply was "Whose side are you on?")

I did learn, however, that the trial had already been held. They had been convicted of non-fatal abuse (for which they served a few months' prison time) but cleared of all homicide charges through the testimony of a certain Dr. Harry L. Wilson of El Paso.

I was a rather slow study. It was a full month after that when I suddenly realized that the defense expert had been none other than Dr. Kirschner's co-author in the writing of the chapter on the pathology of fatal child abuse in the Reece text. (I had already met Dr. Reece and Dr. Kirschner but had not yet met Dr. Wilson.)

~~Dr. Wilson never replied when I wrote to him. However, two and a half~~ years later, Dr. J. Thomas Stocker of Bethesda, Maryland advised me that Dr. Wilson would spend a day at a conference he was presenting which I was already signed up to attend. Dr. Stocker introduced me to Dr. Wilson and I showed him a copy of a manuscript which had been rejected as being too controversial ("We'd get sued if we published anything like that!") in which I expressed amazement that Dr. Wilson would be able to diagnose status epilepticus purely on the basis of aspiration of vomitus. Dr. Wilson looked at my manuscript and said "This is not right." Something told me to refrain from any vituperative reply and simply ask for an explanation. Dr. Wilson then totally flabbergasted me by telling me that Roberta was a known epileptic and a registered patient in an epileptic clinic. He then proceeded to describe her seizures in terms virtually identical to those I quoted from Niedermeyer, Aicardi, and Leach, and, on the basis of those descriptions, I was able to tell Dr. Wilson that Roberta most definitely did have Lennox-Gastaut syndrome – which, of course, Dr. Wilson had never heard of before.

One thing seemed certain: What Dr. Wilson described to me were definitely myoclonic-atonic seizures (see my quote from Niedermeyer and Leach). Nothing he said to me was in any way suggestive of grand mal seizures (the kind one ordinarily thinks of when thinking of epilepsy). Later, I contacted Dennis and Sandra Evers, but they still insisted that there was nothing in her record the least bit suggestive of any kind of epilepsy. I still have not figured it out. I mentioned it to Dr. David Chadwick of San Diego at one of his child abuse conferences. He said he was a good friend of Dr. Wilson and had a very high opinion of his ability. He also said that when abused and molested children are shunted from one foster home to another it is not unusual for some of

their medical records to fail to follow them. Another thing he told me was that children do not aspirate their vomitus just because someone applies restraints to their hands at bed time. They simply do not aspirate their vomitus unless they have some sort of neurological abnormality – such as convulsive status epilepticus.

My background and qualifications.

Mr. Moser (Maribel's lawyer) has requested that I include a curriculum vitae. The authority for my statements is based not on my own erudition but on the quality of the references I have cited. My CV is distinctly unimpressive compared to those of two of the witnesses for the defense in Massachusetts versus Louise Woodward in the death of Matthew Eappen. Dr. Ayub Ommaya and Dr. Jan Leetsma have absolutely fabulous CVs. Nevertheless, I do not believe that Louise Woodward is innocent and neither does Dr. Kenneth Feldman. (Yes, that last statement is part of this affidavit. If Dr. Feldman were to state that he believes that Louise Woodward is innocent that would be evidence of perjury on my part. Of course he may have changed his mind since I last heard him mention the subject, but I doubt it.)

I received my M.D. degree in 1957 from the University of Colorado School of Medicine in Denver. I interned at St. Anthony Hospital in Denver (1957-58) and then served a two-year preceptorship in General Practice at the Group Health Cooperative in Seattle. I then served almost thirty years on the Group Health Medical Staff in the General Practice – Primary Care – Family Practice department until a hypertensive crisis forced a disability retirement in 1987. Our department received rudimentary in-service training in child abuse, and I did initiate one abuse report on a child I saw in the emergency room with suspicious bruises. I once served as an expert witness for the plaintiff in a spousal abuse case, and once as an expert witness for the defense in a Labor and Industry case when my patient was the plaintiff (the defendant, for whom I testified, was the State of Washington). During my years in practice, epilepsy was a very good reason for referring the patient to a neurologist as fast as possible. I believe one of my patients had been afflicted with Lennox-Gastaut syndrome as a child. The neurologist to whom I referred him expressed his gratitude by saying "Hey look, Carl; not every undesirable citizen in the world has a neurological problem." (I now believe that this is part of the general picture of Lennox-Gastaut syndrome.

Farrell of the University of British Columbia states that children with Lennox-Gastaut syndrome are aggressive; they have short attention span

and poor impulse control. They have poor social skills and may have a lot of trouble adjusting to school and social situations. My patient even confessed to me that he had stolen his medical record from Harborview Hospital. Today, that strikes me as consistent with the general Modus Operandi of the disease. If they are more likely to get bitten or otherwise abused than normal children, things like that might suggest the reason.) That was back in the 1960s and I do not believe the Lennox-Gastaut syndrome had even received a name by that time.

In the early 1980s, a pediatrician (Dr. Andrew Biles) and I became involved in the care of a family in whom the infant had Menke's Kinky Hair syndrome. Dr. Biles had initially reported it as a case of severe child abuse with major head injuries, possible blindness, mental retardation, multiple long-bone fractures in different stages of healing with superabundant callus formation. Then one day, he put his hand on the infant's head and noticed that the child had the kinkiest hair he had ever encountered in his career. He started asking the experts if they were aware of any kinky hair syndromes, and was told to draw blood for a serum ceruloplasmin level. The report came back absolutely zero; the child simply did not have any copper at all in his blood. I believe that Dr. Biles' astute observation saved the parents from a murder conviction when the child died. Dr. Biles tells me that, back in those days, Menke's Kinky Hair syndrome was as controversial as Lennox-Gastaut syndrome is today. I do not know if Dr. Feldman has ever heard anything about Lennox-Gastaut syndrome except what he has heard from me, but I am willing to bet he knows everything there is to know about Menke's Kinky Hair syndrome.

The medical journals I read regularly are the American Journal of Forensic Medicine and Pathology (Lippincott Williams and Wilkins with Dr. Vincent DiMaio as editor in chief) and The Quarterly Update (published by the Massachusetts Society for the Prevention of Cruelty to Children, edited by (Executive Editor) Robert M. Reece.) I do read other journals, but usually only when there is a specific article I wish to read. I also do reading in the following textbooks (which are listed in the bibliography):

Engel (Jerome j) and Pedley (Timothy A) editors Epilepsy, a comprehensive textbook 1997, Lippincott-Raven, Philadelphia, New York

Reece & Ludwig (editors) Child Abuse, Medical Diagnosis and Management (2nd ed. 2001 Lippincott, Williams & Wilkins.

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Reece (1st ed)

Niedermeyer, Ernst: The Epilepsies. Diagnosis and Treatment, 1990, Urban & Schwarzenberg)

O'Donohoe

Aicardi (2nd edition)

Aicardi (3rd edition)

Helfer & Kempe - 4th edition

~~Helfer & Kempe, & Krugman, 5th edition~~

Engel & Pedley

Browne and Holmes

Wyllie

J Hume Adams (Greenfield's Neuropathology)

Bibliography, references, and notes:

Adams, J. Hume and Miller, J.D., "Pathophysiology of Raised Intracranial Pressure" Chapter 2 in (Adams & Duchen, editors) Greenfield's Neuropathology Fifth edition, 1992. Oxford University Press, New York.

(On page 84, he describes the complication of "external herniation" which can result when open craniectomy is done for intracranial hypertension. This happened to Kayla Erlandson, only it was not called a "complication!")

Adams, J. Hume "Head Injury" Chapter 3 (Greenfield's Neuropathology, Fifth edition, 1992.) States (page 115 and 142) that apparently trivial injury can produce subdural haematoma and post traumatic convulsions, especially in young children.

Greenfield's Neuropathology See Adams, J. Hume. A sixth edition came out in 1997. It does not have the head injury chapters by Adams and others but does include more about neoplasms of the central nervous system. It also includes about a dozen lines of print on the Lennox-Gastaut syndrome, which the 5th edition did not mention.

Helfer, R.E. and Kempe, R.S. The Battered Child 4th Edition 1987 The University of Chicago Press, Chicago and London

(Brandt F. Steele, "Psychodynamic and Biological Factors in Child Maltreatment") in Mary Edna Helfer/Ruth S. Kempe/Richard D. Krugman (editors) The Battered Child, fifth edition 1997, the University of Chicago Press.

Holmes, Gregory L.
See also Browne
See also Engel & Pedley

Tracy Johnson, quoting Dr. Gregory Holmes of the Harvard U Medical School neurology department on page A9, Seattle P-I of April 9, 2001 (http://seattlep-i.nwsource.com/local/17848_crusade09.shtml).

Hymel (Kent P.), Bandak (Faris A.), Partington, (Michael D.), Winston, (Ken R.). "Abusive Head Trauma? A Biomechanical Approach." Child Maltreatment Vol 3 number 2, May 1998, pp 116-128 (1 1 6 - 1 2 8).

Hymel and Spivak – Chapter one in the second (2001) edition of Child Abuse, Medical Diagnosis and Mangement (Reece and Ludwig)

Ikeno, Tomoyasu; Shigematsu, Hideo; Miyakoshi, Masako; Ohba, Akira; Yagi, Kazuichi; and Seino, Masakazu. "An Analytic Study of Epileptic Falls" in Epilepsia 36(6):612-621 1985 Raven Press, New York. From the National Epilepsy Center, Shizuoka Higashi Hospital, Shizuoka, Japan,

Johnson, see Holmes.

Karbowsky see Niedermeyer, 1987.

Kempe – see Helfer and

Kleinman, Paul K., ed Diagnostic Imaging of Child Abuse second edition 1998 second edition 1998, Mosby. Page 317 in the chapter on head injury by Kleinman and Dr. Patrick Barnes, has an entry on hyperemic brain swelling which I believe was the direct cause of the death of Kayla Erlandson and may well have caused the death of Rafael Gomez.

Krugman, see Helfer and

Leach Penelope Your Growing Child, from Babyhood to Adolescence 1991. Alfred Knopf, New York. This is a new edition of The Child Care Encyclopedia, 1984, also published by Alfred Knopf.

Levin, Alex V. "Ocular Manifestations of Child Abuse" in Chapter 5 Reece, 2001 q.v.

Levin, Alex V. "Retina Haemorrhages and Child Abuse" in David T. :Recent Advances in Paediatrics 2001. 151-219, London: Churchill Livingstone

Dr. Levin occupies a mid-position between those who say that all retinal hemorrhages represent child abuse and those who say that they signify only elevated intracranial pressure and have nothing to do with child abuse. All those involved in questions about child abuse should be familiar with his views regardless of whether or not they agree with them.

I have mailed to Dr. Levin a photocopy of the drawing of Kayla's retinal hemorrhages from her hospital chart (April 25, 1991). He replied that, if there is going to be a new trial, he would appreciate the privilege of presenting his opinions simultaneously to both prosecution and defense so neither side gets blindsided.

My reaction to this is that, if he testifies for the defense, his testimony will probably reflect the two references listed under his name above. If he testifies for the prosecution, I would recommend to the defense lawyer that those references be used for cross-examination.

McQuillen, James B, and McQuillen, Eleanor M. and Morrow, Paul "Trauma, Sport and Malignant Cerebral Edema." in American Journal of Forensic Medicine and Pathology, Vol 9, Number 1, 1988 pages 12 - 15.

(IV valium is not mentioned as a precipitator of malignant cerebral edema but going over moguls in a downhill ski race and running interference in a foot ball game are described.)

Dr. James is a neurologist and neuropathologist. Dr. Eleanor is a forensic pathologist who has served as Chief Medical Examiner for the State of Vermont.)

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I met the McQuillens in San Francisco in 1998. When I told Dr. James McQuillen about Dr. Reece and the subdural hematomata in institutionalized children with apparently non-inflicted head injuries, he replied that he had personally seen it happen in children with Lennox-Gastaut syndrome. Unlike Dr. Reece, he seemed to be quite familiar with that disease. Dr. James B. McQuillen is no longer living but his remarks about subdural hematoma in children with Lennox-Gastaut syndrome are amply confirmed by the quote from Dr. Gregory Holmes in the story by Tracy Johnson. I am not at all sure that I see any conflict between Dr. McQuillen's views on retinal hemorrhages and those of Dr. Alex. Levin.

I met Dr. Paul Morrow in February 2003 at a meeting in Chicago. I showed him the paragraph on "Hyperemic brain swelling" on page 317 of the Kleinman text and asked him if that was the same thing that he and the McQuillens referred to as "Malignant cerebral edema." He answered in the affirmative.

Niedermeyer, Ernst: The Epilepsies, Diagnosis and Treatment, 1990, Urban & Schwarzenberg, Baltimore, Munich

Niedermeyer, Ernst; and Degan, Rolf: The Lennox-Gastaut syndrome, Proceedings of a Symposium Held in Bad Kreuznach, Federal Republic of Germany, September 17-19, 1987, Alan R. Liss, Inc., New York. It is currently out of print but I have a copy.

Prior, P.F., MacLaine, G.N., Scott, D.F., and Laurance, B.M. 1972 "Tonic Status Epilepticus Precipitated by Intravenous Diazepam in a Child with Petit Mal Status". Epilepsia (Amsterdam) 13:467-472. This article has been quoted in every issue of Physicians Desk Reference between 1977 and 2002 inclusive. "Injectable Valium, Roche" did not have an entry for 2003 or 2004. Prior was quite well aware that his patient had Lennox-Gastaut syndrome but PDR never did catch on. No one understands why intravenous Valium can precipitate tonic status epilepticus in children with Lennox-Gastaut syndrome (within sixty seconds, according to Tassinari,) but these reports are quoted in virtually every current textbook of epilepsy. (The O'Donohoe text quotes Bittencourt rather than Tassinari or Prior but, in spite of the fact that we have no idea why it happens, it most definitely does happen. It probably causes death only on rare occasions, but, in the Erlandson case, it appears to have precipitated hyperemic brain swelling which, according to Kleinman and Barnes, carries a fifty per cent mortality rate, unless it is treated with "early and aggressive therapy (Kleinman and Barnes, page 317). Bruce and his associates claim a virtually one hundred per cent success rate (if the child is still talking when admitted to the hospital) using vigorous hyperventilation. In 1981, Bruce was opposed to the use of mannitol which other workers seem to like. He may have changed his mind since then.

Reader's Digest January 1994, "News from the World of Medicine" where we read that a child with Lennox-Gastaut syndrome can have up to 200 seizures per hour and that there are fifty thousand afflicted children in the United States alone.

Steele, Brandt F.: "Psychodynamic and Biological Factors in Child Maltreatment" in Mary Edna Helfer/Ruth S. Kempe/Richard D. Krugman (editors) The Battered Child, fifth edition 1997, the University of Chicago Press.

Tassinari, C.A., Dravet, C., Roger, J., Cano, J.P., and Gastaut, H. 1972. "Tonic Status Epilepticus Precipitated by Intravenous Benzodiazepine in Five Patients with Lennox-Gastaut syndrome." Epilepsia (Amsterdam) 13:421-435 (Diazepam caused the tonic status within 60 seconds in four patients, but Nitrazepam took 11 minutes.) 220 patients, 359 injections (diazepam 4 out of 268, nitrazepam one out of 23).. Kayla had received 6 mg rectal valium at 11:20, some 17 minutes before her first IV valium.

Wyllie, Elaine (ed.): The Treatment of Epilepsy: Principles and Practice 1993 Lea & Febiger, Philadelphia, London) Page 447 - reference to Aicardi syndrome incompatibility with Lennox-Gastaut syndrome.

See also Farrell

Appendix

Denton, Scott and Mileusnic, Darinka. Delayed Sudden Death in an Infant Following an Accidental Fall. (*A Case Report with Review of the Literature*). American Journal of Forensic Medicine and Pathology 2003;24-4:371-376 I was a bit surprised that neither hyperemic brain swelling nor "malignant cerebral edema" was mentioned since I think it rather obvious that this is an example. Perhaps the "doubting Thomases" might claim that there was a second injury inflicted by the mother at the last moment. The child was only 9 months old at the time. Dr. Leetsma might say that was old enough for massive DAI in the dorsolateral quadrants of the rostral brain stem to be diagnosed even if death took place within an hour of the fresh injury (precluding microscopic diagnosis). Dr. Mary E. S. Case might disagree.

I have some more to say about this article. It was discussed at the "Oscars" session at San Diego by Dr. Carole Jenny and Dr. Robert M. Reece. Some of the most highly regarded main-stream child abuse experts in the world were present there. Guess the name of the only person present to suggest that the mother and grandmother who were with the child when the rapidly fatal malignant cerebral edema struck might have been more accomplished liars than they were given credit for being. It happened to be Yours Truly. A number of the True Believers among the child abuse experts expressed their unhappiness at being proved wrong, but the article was so well written that none dared challenge it.

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There are several differences between this case and the Erlandson case. In the first place, the child was so young as to make Lennox-Gastaut syndrome highly improbable (although not quite impossible.). In the second place, Kayla's "lucid interval" after the toilet bowl incident, was not more than 2-3 hours at the outside (although if the subdural hematoma was the result of the water bottle incident of April 10 rather than the toilet bowl incident of April 24, it would have been a two-week lucid interval, during which Kayla was fully as lucid as the child in the Denton article. In the third place, Kayla was not nearly as lucid as the child in the article during this interval. Mrs. Erlandson described her condition (starting shortly after they left the Lipinski-McKinley home) in terms I find impossible to distinguish from Dr. Niedermeyer's description of atypical absence status on page 197 of the 1990 text. This would not have masked total loss of consciousness lasting as long as a few minutes, but concussion manifested by nothing more than confusion and/or amnesia might have been virtually undetectable against the background of atypical absence status. If the Denton-Mileusnic case represents the exception that proves the rule, I would hardly say Kayla's case represents anything significant in the way of an "exception."

I mentioned the article when I was attending a workshop on shaken baby syndrome at the Dallas conference of the American Academy of Forensic Science in February 2004. I was somewhat surprised to discover that both the authors (Denton and Mileusnic) were present at that workshop. Since they had been rather sharply criticized for that article, I think they were both rather grateful for my account of how well that article had been received at San Diego. (I decided not to tell them that I had been its only critic.)

The preceding twenty five pages of text are included in my statement that I declare under the penalties of perjury that they are, without exception, true and correct to the best of my knowledge and belief.

Subscribed and sworn today on this 18th day of August, in the year 2004, city of ~~Anger~~ ^{Olmsted Falls} OH, county of Cuyahoga, State of Ohio.

Carl G. Wugent M.D.

*Signed this 18th day of August, 2004
Susan L. Myers*

SUSAN L. MYERS
Notary Public, State of Ohio
My Commission Expires Nov 13 2005

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EXHIBIT 3

Fatal Pediatric Head Injuries Caused by Short-Distance Falls

John Plunkett, M.D.

Physicians disagree on several issues regarding head injury in infants and children, including the potential lethality of a short-distance fall, a lucid interval in an ultimately fatal head injury, and the specificity of retinal hemorrhage for inflicted trauma. There is scant objective evidence to resolve these questions, and more information is needed. The objective of this study was to determine whether there are witnessed or investigated fatal short-distance falls that were concluded to be accidental. The author reviewed the January 1, 1988 through June 30, 1999 United States Consumer Product Safety Commission database for head injury associated with the use of playground equipment. The author obtained and reviewed the primary source data (hospital and emergency medical services' records, law enforcement reports and coroner or medical examiner records) for all fatalities involving a fall.

The results revealed 18 fall-related head injury fatalities in the database. The youngest child was 12 months old, the oldest 13 years. The falls were from 0.6 to 3 meters (2-10 feet). A noncaretaker witnessed 12 of the 18, and 12 had a lucid interval. Four of the six children in whom funduscopic examination was documented in the medical record had bilateral retinal hemorrhage. The author concludes that an infant or child may suffer a fatal head injury from a fall of less than 3 meters (10 feet). The injury may be associated with a lucid interval and bilateral retinal hemorrhage.

Key Words: Child abuse—Head injury—Lucid interval—Retinal hemorrhage—Subdural hematoma.

Many physicians believe that a simple fall cannot cause serious injury or death (1-9), that a lucid interval does not exist in an ultimately fatal pediatric head injury (7-13), and that retinal hemorrhage is highly suggestive if not diagnostic for inflicted trauma (7,12,14-21). However, several have questioned these conclusions or urged caution when interpreting head injury in a child (15,22-28). This controversy exists because most infant injuries occur in the home (29,30), and if there is history of a fall, it is usually not witnessed or is seen only by the caretaker. Objective data are needed to resolve this dispute. It would be helpful if there were a database of fatal falls that were witnessed or wherein medical and law enforcement investigation unequivocally concluded that the death was an accident.

The United States Consumer Product Safety Commission (CPSC) National Injury Information Clearinghouse uses four computerized data sources (31). The National Electronic Injury Surveillance System (NEISS) file collects current injury data associated with 15,000 categories of consumer products from 101 U.S. hospital emergency departments, including 9 pediatric hospitals. The file is a probability sample and is used to estimate the number and types of consumer product-related injuries each year (32). The Death Certificate (DC) file is a demographic summary created by information provided to the CPSC by selected U.S. State Health Departments. The Injury/Potential Injury Incident (IR) file contains summaries, indexed by consumer product, of reports to the CPSC from consumers, medical examiners and coroners (Medical Examiner and Coroner Alert Project [MECAP]), and newspaper accounts of product-related incidents discovered by local or regional CPSC staff (33). The In-Depth Investigations (AI) file contains summaries of investigations performed by CPSC staff based on reports received from the NEISS, DC or IR files (34). The AI files provide details about the incident from victim and witness interviews, accident reconstruction, and review of law en-

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forcement, health care facility and coroner or medical examiner records (if a death occurred).

METHODS

I reviewed the CPSC, DC, IR, and AI files for all head and neck injuries involving playground equipment recorded by the CPSC from January 1, 1988 through June 30, 1999. There are 323 entries in the playground equipment IR file, 262 in the AI file, 47 in the DC file, and more than 75,000 in the NEISS file. All deaths in the NEISS file generated an IR or AI file. If the file indicated that a death had occurred from a fall, I obtained and reviewed each original source record from law enforcement, hospitals, emergency medical services (EMS), and coroner or medical examiner offices except for one autopsy report. However, I discussed the autopsy findings with the pathologist in this case.

RESULTS

There are 114 deaths in the Clearinghouse database, 18 of which were due to head injury from a fall. The following deaths were excluded from this study: those that involved equipment that broke or collapsed, striking a person on the head or neck (41); those in which a person became entangled in the equipment and suffocated or was strangled (45); those that involved equipment or incidents other than playground (6 [including a 13.7-meter fall from a homemade Ferris wheel and a 3-meter fall from a cyclone fence adjacent to a playground]); and falls in which the death was caused exclusively by neck (carotid vessel, airway or cervical spinal cord) injury (4).

The falls were from horizontal ladders (4), swings (7), stationary platforms (3), a ladder attached to a slide, a "see-saw", a slide, and a retaining wall. Thirteen occurred on a school or public playground, and five occurred at home. The database is not limited to infants and children, but a 13-year-old was the oldest fatality (range, 12 months–13 years; mean, 5.2 years; median, 4.5 years). The distance of the fall, defined as the distance of the closest body part from the ground at the beginning of the fall, could be determined from CPSC or law enforcement reconstruction and actual measurement in 10 cases and was 0.6 to 3.0 meters (mean, 1.3 ± 0.77 ; median, 0.9). The distance could not be accurately determined in the seven fatalities involving swings and one of the falls from a horizontal ladder, and may have been from as little as 0.6 meters to as much as 2.4 meters. The maximum height for a fall from a swing was assumed to be

the highest point of the arc. Twelve of the 18 falls were witnessed by a noncaretaker or were videotaped; 12 of the children had a lucid interval (5 minutes–48 hours); and 4 of the 6 in whom funduscopic examination was performed had bilateral retinal hemorrhage (Table 1).

CASES

Case 1

This 12-month-old was seated on a porch swing between her mother and father when the chain on her mother's side broke and all three fell sideways and backwards 1.5 to 1.8 meters (5-6 feet) onto decorative rocks in front of the porch. The mother fell first, then the child, then her father. It is not known if her father landed on top of her or if she struck only the ground. She was unconscious immediately. EMS was called; she was taken to a local hospital; and was ictal and had decerebrate posturing in the emergency room. She was intubated, hyperventilated, and treated with mannitol. A computed tomography (CT) scan indicated a subgaleal hematoma at the vertex of the skull, a comminuted fracture of the vault, parafalcine subdural hemorrhage, and right parietal subarachnoid hemorrhage. There was also acute cerebral edema with effacement of the right frontal horn and compression of the basal cisterns. She had a cardiopulmonary arrest while the CT scan was being done and could not be resuscitated.

Case 2

A 14-month-old was on a backyard "see-saw" and was being held in place by his grandmother. The grandmother said that she was distracted for a moment and he fell backward, striking the grass-covered ground 0.6 meters (22.5 inches) below the plastic seat. He was conscious but crying, and she carried him into the house. Within 10 to 15 minutes he became lethargic and limp, vomited, and was taken to the local hospital by EMS personnel. He was unconscious but purposefully moving all extremities when evaluated, and results of funduscopic examination were normal. A CT scan indicated an occipital subgaleal hematoma, left-sided cerebral edema with complete obliteration of the left frontal horn, and small punctate hemorrhages in the left frontal lobe. There was no fracture or subdural hematoma. He was treated with mannitol; his level of consciousness rapidly improved; and he was extubated. However, approximately 7 hours after admission he began to have difficulty breathing, both pupils suddenly dilated, and he was re-

TABLE 1. Summary of cases

No.	CPSC No.	Age	Sex	Fall from	Distance M/F	Witnessed	Lucid interval	Retinal hemorrhage	Subdural hemorrhage	Autopsy	Cause of death	FP
1	DC 9108013330	12 mos	F	Swing	1.5-1.8/5.0-6.0	No	No	N/R	Yes +IHF	No	Complex calvarial fracture with edema and contusions	No
2	AI 890208HBC3088	14 mos	M	See-Saw	0.6/2.0	No	10-15 minutes	No	No	No	Malignant cerebral edema with herniation	No
3	IR F9010368A	17 mos	F	Swing	1.5-1.8/5.0-6.0	No	No	N/R	Yes +IHF	Yes	Acute subdural hematoma with secondary cerebral edema	Yes
4	AI 921001HCC2263	20 mos	F	Platform	1.1/3.5	No	5-10 minutes	Bilateral multilayered	Yes +IHF	Limited	Occipital fracture with subdural/subarachnoid hemorrhage progressing to cerebral edema and herniation	Yes
5*	DC 9312060661	23 mos	F	Platform	0.70/2.3	Yes	10 minutes	Bilateral, NOS	Yes	Yes	Acute subdural hematoma	Yes
6	DC 9451016513	26 mos	M	Swing	0.9-1.8/3.0-6.0	Yes	No	Bilateral multilayered	Yes +IHF	Yes	Subdural hematoma with associated cerebral edema	Yes
7*	AI 891215HCC2094	3 yrs	M	Platform	0.9/3.0	Yes	10 minutes	N/R	Yes	No	Acute cerebral edema with herniation	No
8	AI 910515HCC2182	3 yrs	F	Ladder	0.6/2.0	Yes	15 minutes	N/R	Yes (autopsy only)	Yes	Complex calvarial fracture, contusions, cerebral edema with herniation	Yes
9	DC 9253024577	4 yrs	M	Slide	2.1/7.0	Yes	3 hours	N/R	No	Yes	Epidural hematoma	Yes
10	AI 920710HWB4014	5 yrs	M	Horizontal ladder	2.1/7.0	No	No	N/R	Yes	No	Acute subdural hematoma with acute cerebral edema	Yes
11	AI 960517HCC5175	6 yrs	M	Swing	0.6-2.4/2.0-8.0	No	10 minutes	No	Yes +IHF	No	Acute subdural hematoma	Yes
12	AI 970324HCC3040	6 yrs	M	Horizontal ladder	3.0/10.0	Yes	45 minutes	N/R	No	No	Malignant cerebral edema with herniation	Yes
13	AI 881229HCC3070	6 yrs	F	Horizontal ladder	0.9/3.0	Yes	1+ hour	N/R	Yes +IHF	Yes	Subdural and subarachnoid hemorrhage, cerebral infarct, and edema	Yes
14	AI 930930HWE5025	7 yrs	M	Horizontal ladder	1.2-2.4/4.0-8.0	Yes	48 hours	N/R	No	Yes	Cerebral infarct secondary to carotid/vertebral artery thrombosis	Yes
15	AI 970409HCC1096	8 yrs	F	Retaining wall	0.9/3.0	Yes	12+ hours	N/R	Yes (autopsy only)	Yes	Acute subdural hematoma	Yes
16	AI 890621HCC3195	10 yrs	M	Swing	0.9-1.5/3.0-5.0	Yes	10 minutes	Bilateral multilayered	Yes	Yes	Acute subdural hematoma contiguous with an AV malformation	No
17	AI 920428HCC1671	12 yrs	F	Swing	0.9-1.8/3.0-6.0	Yes	No	N/R	No	Yes	Occipital fracture with extensive contra-coup contusions	Yes
18	AI 891016HCC1511	13 yrs	F	Swing	0.6-1.8/2.0-6.0	Yes	No	N/R	Yes +IHF	Yes	Occipital fracture, subdural hemorrhage, cerebral edema	Yes

*The original CT scan for case #7 and the soft tissue CT windows for case #5 could not be located and were unavailable for review.

CPSC, Consumer Products Safety Commission; AI, accident investigation; IR, incident report; DC, death certificate; M, male; F, female; Distance, the distance of the closest body part from the ground at the start of the fall (see text); M/F= meters/feet; Witnessed, witnessed by a noncaretaker or videotaped; N/R, not recorded; IHF, including interhemispheric or falx; FP, forensic pathologist-directed death investigation system

FATAL HEAD INJURIES WITH SHORT-DISTANCE FALLS

intubated. A second CT scan demonstrated progression of the left hemispheric edema despite medical management, and he was removed from life support 22 hours after admission.

Case 3

This 17-month-old had been placed in a baby carrier-type swing attached to an overhead tree limb at a daycare provider's home. A restraining bar held in place by a snap was across her waist. She was being pushed by the daycare provider to an estimated height of 1.5 to 1.8 meters (5-6 feet) when the snap came loose. The child fell from the swing on its downstroke, striking her back and head on the grassy surface. She was immediately unconscious and apneic but then started to breathe spontaneously. EMS took her to a pediatric hospital. A CT scan indicated a large left-sided subdural hematoma with extension to the interhemispheric fissure anteriorly and throughout the length of the falx. The hematoma was surgically evacuated, but she developed malignant cerebral edema and died the following day. A post-mortem examination indicated symmetrical contusions on the buttock and midline posterior thorax, consistent with impact against a flat surface; a small residual left-sided subdural hematoma; cerebral edema with anoxic encephalopathy; and uncal and cerebellar tonsillar herniation. There were no cortical contusions.

Case 4

A 20-month-old was with other family members for a reunion at a public park. She was on the platform portion of a jungle gym when she fell from the side and struck her head on one of the support posts. The platform was 1.7 meters (67 inches) above the ground and 1.1 meters (42 inches) above the top of the support post that she struck. Only her father saw the actual fall, although there were a number of other people in the immediate area. She was initially conscious and talking, but within 5 to 10 minutes became comatose. She was taken to a nearby hospital, then transferred to a tertiary-care facility. A CT scan indicated a right occipital skull fracture with approximately 4-mm of depression and subarachnoid and subdural hemorrhage along the tentorium and posterior falx. Funduscopic examination indicated extensive bilateral retinal and preretinal hemorrhage. She died 2 days later because of uncontrollable increased intracranial pressure. A limited postmortem examination indicated an impact subgaleal hematoma overlying the fracture in the mid occiput.

Case 5

A 23-month-old was playing on a plastic gym set in the garage at her home with her older brother. She had climbed the attached ladder to the top rail above the platform and was straddling the rail, with her feet 0.70 meters (28 inches) above the floor. She lost her balance and fell headfirst onto a 1-cm ($\frac{3}{8}$ -inch) thick piece of plush carpet remnant covering the concrete floor. She struck the carpet first with her outstretched hands, then with the right front side of her forehead, followed by her right shoulder. Her grandmother had been watching the children play and videotaped the fall. She cried after the fall but was alert and talking. Her grandmother walked/carried her into the kitchen, where her mother gave her a baby analgesic with some water, which she drank. However, approximately 5 minutes later she vomited and became stuporous. EMS personnel airlifted her to a tertiary-care university hospital. A CT scan indicated a large right-sided subdural hematoma with effacement of the right lateral ventricle and minimal subfalcine herniation. (The soft tissue windows for the scan could not be located and were unavailable for review.) The hematoma was immediately evacuated. She remained comatose postoperatively, developed cerebral edema with herniation, and was removed from life support 36 hours after the fall. Bilateral retinal hemorrhage, not further described, was documented in a funduscopic examination performed 24 hours after admission. A postmortem examination confirmed the right frontal scalp impact injury. There was a small residual right subdural hematoma, a right parietal lobe contusion (secondary to the surgical intervention), and cerebral edema with cerebellar tonsillar herniation.

Case 6

A 26-month-old was on a playground swing being pushed by a 13-year-old cousin when he fell backward 0.9 to 1.8 meters (3-6 feet), striking his head on hard-packed soil. The 13-year-old and several other children saw the fall. He was immediately unconscious and was taken to a local emergency room, then transferred to a pediatric hospital. A CT scan indicated acute cerebral edema and a small subdural hematoma adjacent to the anterior interhemispheric falx. A funduscopic examination performed 4 hours after admission indicated extensive bilateral retinal hemorrhage, vitreous hemorrhage in the left eye, and papilledema. He had a subsequent cardiopulmonary arrest and could not be resuscitated. A postmortem examination confirmed the retinal hemorrhage and indicated a right parietal scalp impact injury but no calvarial frac-

ture, a "film" of bilateral subdural hemorrhage, cerebral edema with herniation, and focal hemorrhage in the right posterior midbrain and pons.

Case 7

This 3-year-old with a history of TAR (thrombocytopenia-absent radius) syndrome was playing with other children on playground equipment at his school when he stepped through an opening in a platform. He fell 0.9 meters (3 feet) to the hard-packed ground, striking his face. A teacher witnessed the incident. He was initially conscious and able to walk. However, approximately 10 minutes later he had projectile vomiting and became comatose, was taken to a local hospital, and subsequently transferred to a pediatric hospital. A CT scan indicated a small subdural hematoma and diffuse cerebral edema with uncal herniation, according to the admission history and physical examination. (The original CT report and scan could not be located and were unavailable for review.) His platelet count was 24,000/mm³, and he was treated empirically with platelet transfusions, although he had no evidence for an expanding extra-axial mass. Resuscitation was discontinued in the emergency room.

Case 8

This 3-year-old was at a city park with an adult neighbor and four other children, ages 6 to 10. She was standing on the third step of a slide ladder 0.6 meters (22 inches) above the ground when she fell forward onto compact dirt, striking her head. The other children but not the adult saw the fall. She was crying but did not appear to be seriously injured, and the neighbor picked her up and brought her to her parents' home. Approximately 15 minutes later she began to vomit, and her mother called EMS. She was taken to a local emergency room, then transferred to a pediatric hospital. She was initially lethargic but responded to hyperventilation and mannitol; she began to open her eyes with stimulation and to spontaneously move all extremities and was extubated. However, she developed malignant cerebral edema on the second hospital day and was reintubated and hyperventilated but died the following day. A postmortem examination indicated a subgaleal hematoma at the vertex of the skull associated with a complex fracture involving the left frontal bone and bilateral temporal bones. There were small epidural and subdural hematomas (not identifiable on the CT scan), bilateral "contrecoup" contusions of the inferior surfaces of the frontal and temporal lobes, and marked cerebral edema with uncal herniation.

Case 9

A 4-year-old fell approximately 2.1 meters (7 feet) from a playground slide at a state park, landing on the dirt ground on his buttock, then falling to his left side, striking his head. There was no loss of consciousness, but his family took him to a local emergency facility, where an evaluation was normal. However, he began vomiting and complained of left neck and head pain approximately 3 hours later. He was taken to a second hospital, where a CT scan indicated a large left parietal epidural hematoma with a midline shift. He was transferred to a pediatric hospital and the hematoma was evacuated, but he developed malignant cerebral edema with right occipital and left parietal infarcts and was removed from the respirator 10 days later. A postmortem examination indicated a small residual epidural hematoma, marked cerebral edema, bilateral cerebellar tonsillar and uncal herniation, and hypoxic encephalopathy. There was no identifiable skull fracture.

Case 10

A 5-year-old was apparently walking across the horizontal ladder of a "monkey bar", part of an interconnecting system of home-made playground equipment in his front yard, when his mother looked out one of the windows and saw him laying face down on the ground and not moving. The horizontal ladder was 2.1 meters (7 feet) above compacted dirt. EMS were called, he was taken to a local hospital, and then transferred to a pediatric hospital. A CT scan indicated a right posterior temporal linear fracture with a small underlying epidural hematoma, a 5-mm thick acute subdural hematoma along the right temporal and parietal lobes, and marked right-sided edema with a 10-mm midline shift. He was hyperventilated and treated with mannitol, but the hematoma continued to enlarge and was surgically evacuated. However, he developed uncontrollable cerebral edema and was removed from life support 10 days after the fall.

Case 11

A 6-year-old was on a playground swing at a private lodge with his 14-year-old sister. His sister heard a "thump", turned around, and saw him on the grass-covered packed earth beneath the swing. The actual fall was not witnessed. The seat of the swing was 0.6 meters (2 feet) above the ground, and the fall distance could have been from as high as 2.4 meters (8 feet). He was initially conscious and talking but within 10 minutes became comatose and was taken to a local emergency room, then transferred to a tertiary-care hospital. A CT scan

indicated a large left frontoparietal subdural hematoma with extension into the anterior interhemispheric fissure and a significant midline shift with obliteration of the left lateral ventricle. There were no retinal hemorrhages. He was treated aggressively with dexamethazone and hyperventilation, but there was no surgical intervention. He died the following day.

Case 12

This 6-year-old was at school and was sitting on the top crossbar of a "monkey bar" approximately 3 meters (10 feet) above compacted clay soil when an unrelated non-caretaker adult saw him fall from the crossbar to the ground. He landed flat on his back and initially appeared to have the wind knocked out of him but was conscious and alert. He was taken to the school nurse who applied an ice pack to a contusion on the back of his head. He rested for approximately 30 minutes in the nurse's office and was being escorted back to class when he suddenly collapsed. EMS was called, and he was transported to a pediatric hospital. He was comatose on admission, the fundi could not be visualized, and a head CT scan was interpreted as normal. However, a CT scan performed the following morning approximately 20 hours after the fall indicated diffuse cerebral edema with effacement of the basilar cisterns and 4th ventricle. There was no identifiable subdural hemorrhage or calvarial fracture. He developed transtentorial herniation and died 48 hours after the fall.

Case 13

This 6-year-old was playing on a school playground with a 5th grade student/friend. She was hand-over-hand traversing the crossbar of a "monkey bar" 2.4 meters (7 feet 10 inches) above the ground with her feet approximately 1 meter (40 inches) above the surface. She attempted to slide down the pole when she reached the end of the crossbar but lost her grip and slid quickly to the ground, striking the compacted dirt first with her feet, then her buttock and back, and finally her head. The friend informed the school principal of the incident, but the child seemed fine and there was no intervention. She went to a relative's home for after-school care approximately 30 minutes after the fall, watched TV for a while, then complained of a headache and laid down for a nap. When her parents arrived at the home later that evening, 6 hours after the incident, they discovered that she was incoherent and "drooling". EMS transported her to a tertiary-care medical center. A CT scan indicated a right parieto-occipital skull

fracture, subdural and subarachnoid hemorrhage, and a right cerebral hemisphere infarct. The infarct included the posterior cerebral territory and was thought most consistent with thrombosis or dissection of a right carotid artery that had a persistent fetal origin of the posterior cerebral artery. She remained comatose and was removed from the respirator 6 days after admission. A postmortem examination indicated superficial abrasions and contusions over the scapula, a prominent right parieto-temporal subgaleal hematoma, and a right parietal skull fracture. She had a 50-ml subdural hematoma and cerebral edema with global hypoxic or ischemic injury ("respirator brain"), but the carotid vessels were normal.

Case 14

A 7-year-old was on the playground during school hours playing on the horizontal ladder of a "monkey bar" when he slipped and fell 1.2 to 2.4 meters (4-8 feet). According to one witness, he struck his forehead on the bars of the vertical ladder; according to another eyewitness he struck the rubber pad covering of the asphalt ground. There are conflicting stories as to whether he had an initial loss of consciousness. However, he walked back to the school, and EMS was called because of the history of the fall. He was taken to a local hospital, where evaluation indicated a Glasgow coma score of 15 and a normal CT scan except for an occipital subgaleal hematoma. He was kept overnight for observation because of the possible loss of consciousness but was released the following day. He was doing homework at home 2 days after the fall when his grandmother noticed that he was stumbling and had slurred speech, and she took him back to the hospital. A second CT scan indicated a left carotid artery occlusion and left temporal and parietal lobe infarcts. The infarcts and subsequent edema progressed; he had brainstem herniation, and he was removed from life support 3 days later (5 days after the initial fall). A postmortem examination indicated ischemic infarcts of the left parietal, temporal, and occipital lobes, acute cerebral edema with herniation, and thrombosis of the left vertebral artery. Occlusion of the carotid artery, suspected premortem, could not be confirmed.

Case 15

This 8-year-old was at a public playground near her home with several friends her age. She was hanging by her hands from the horizontal ladder of a "monkey bar" with her feet approximately 1.1 meters (3.5 feet) above the ground when she attempted to swing from the bars to a nearby 0.9-

meter (34-inch) retaining wall. She landed on the top of the wall but then lost her balance and fell to the ground, either to a hard-packed surface (one witness) or to a 5.1-cm (2-inch) thick resilient rubber mat (a second witness), striking her back and head. She initially cried and complained of a headache but continued playing, then later went home. Her mother said that she seemed normal and went to bed at her usual time. However, when her mother tried to awaken her at approximately 8:30 the following morning (12 hours after the fall) she complained of a headache and went back to sleep. She awoke at 11 a.m. and complained of a severe headache then became unresponsive and had a seizure. EMS took her to a nearby hospital, but she died in the emergency room. A postmortem examination indicated a right temporoparietal subdural hematoma, extending to the base of the brain in the middle and posterior fossae, with flattening of the gyri and narrowing of the sulci. (The presence or absence of herniation is not described in the autopsy report.) There was no calvarial fracture, and there was no identifiable injury in the scalp or galea.

Case 16

A 10-year-old was swinging on a swing at his school's playground during recess when the seat detached from the chain and he fell 0.9 to 1.5 meters (3-5 feet) to the asphalt surface, striking the back of his head. The other students but not the three adult playground supervisors saw him fall. He remained conscious although groggy and was carried to the school nurse's office, where an ice pack was placed on an occipital contusion. He suddenly lost consciousness approximately 10 minutes later, and EMS took him to a local hospital. He had decerebrate posturing when initially evaluated. Fundoscopic examination indicated extensive bilateral confluent and stellate, posterior and peripheral preretinal and subhyaloid hemorrhage. A CT scan showed a large acute right frontoparietal subdural hematoma with transtentorial herniation. The hematoma was surgically removed, but he developed malignant cerebral edema and died 6 days later. A postmortem examination indicated a right parietal subarachnoid AV malformation, contiguous with a small amount of residual subdural hemorrhage, and cerebral edema with anoxic encephalopathy and herniation. There was no calvarial fracture.

Case 17

A 12-year-old was at a public playground with a sister and another friend and was standing on the seat of a swing when the swing began to twist. She

lost her balance and fell 0.9 to 1.8 meters (3-6 feet) to the asphalt surface, striking her posterior thorax and occipital scalp. She was immediately unconscious and was taken to a tertiary-care hospital emergency room, where she was pronounced dead. A postmortem examination indicated an occipital impact injury associated with an extensive comminuted occipital fracture extending into both middle cranial fossa and "contra-coup" contusions of both inferior frontal and temporal lobes.

Case 18

This 13-year-old was at a public playground with a friend. She was standing on the seat of a swing with her friend seated between her legs when she lost her grip and fell backwards 0.6 to 1.8 meters (2-6 feet), striking either a concrete retaining wall adjacent to the playground or a resilient 5.1-cm (2-inch) thick rubber mat covering the ground. She was immediately unconscious and was given emergency first aid by a physician who was nearby when the fall occurred. She was taken to a nearby hospital and was purposefully moving all extremities and had reactive pupils when initially evaluated. A CT scan indicated interhemispheric subdural hemorrhage and generalized cerebral edema, which progressed rapidly to brain death. A postmortem examination indicated a linear nondepressed midline occipital skull fracture, subdural hemorrhage extending to the occiput, contusion of the left cerebellar hemisphere, bifrontal "contra-coup" contusions, and cerebral edema.

DISCUSSION

General

Traumatic brain injury (TBI) is caused by a force resulting in either strain (deformation/unit length) or stress (force/original cross-sectional area) of the scalp, skull, and brain (35-37). The extent of injury depends not only on the level and duration of force but also on the specific mechanical and geometric properties of the cranial system under loading (38-40). Different parts of the skull and brain have distinct biophysical characteristics, and calculating deformation and stress is complex. However, an applied force causes the skull and brain to move, and acceleration, the time required to reach peak acceleration, and the duration of acceleration may be measured at specific locations (36,41). These kinematic parameters do not cause the actual brain damage but are useful for analyzing TBI because they are easy to quantify. Research in TBI using physical models and animal experiments has shown that a force resulting in angular acceleration pro-

duces primarily diffuse brain damage, whereas a force causing exclusively translational acceleration produces only focal brain damage (36). A fall from a countertop or table is often considered to be exclusively translational and therefore assumed incapable of producing serious injury (3,7-9). However, sudden impact deceleration *must* have an angular vector unless the force is applied only through the center of mass (COM), and deformation of the skull during impact *must* be accompanied by a volume change (cavitation) in the subdural "space" tangential to the applied force (41). The angular and deformation factors produce tensile strains on the surface veins and mechanical distortions of the brain during impact and may cause a subdural hematoma without deep white matter injury or even unconsciousness (42-44).

Many authors state that a fall from less than 3 meters (10 feet) is rarely if ever fatal, especially if the distance is less than 1.5 meters (5 feet) (1-6,8,9). The few studies concluding that a short distance fall may be fatal (22-24,26,27) have been criticized because the fall was not witnessed or was seen only by the caretaker. However, isolated reports of observed fatal falls and biomechanical analysis using experimental animals, adult human volunteers, and models indicate the potential for serious head injury or death from as little as a 0.6-meter (2-foot) fall (48-52). There are limited experimental studies on infants (cadaver skull fracture) (53,54) and none on living subadult nonhuman primates, but the adult data have been extrapolated to youngsters and used to develop the Hybrid II/III and Child Restraint-Air Bag Interaction (CRABI) models (55) and to propose standards for playground equipment (56,63). We simply do not know either kinematic or nonkinematic limits in the pediatric population (57,58).

Each of the falls in this study exceeded established adult kinematic thresholds for traumatic brain injury (41,48-52). Casual analysis of the falls suggests that most were primarily translational. However, deformation and *internal* angular acceleration of the skull and brain *caused by the impact* produce the injury. What happens during the impact, not during the fall, determines the outcome.

Subdural hemorrhage

A "high strain" impact (short pulse duration and high rate for deceleration onset) typical for a fall is more likely to cause subdural hemorrhage than a "low strain" impact (long pulse duration and low rate for deceleration onset) that is typical of a motor vehicle accident (42,61). The duration of deceleration for a head-impact fall against a nonyielding

surface is usually less than 5 milliseconds (39,59-61). Experimentally, impact duration longer than 5 milliseconds will not cause a subdural hematoma unless the level of angular acceleration is above $1.75 \times 10^5 \text{ rad/s}^2$ (61). A body in motion with an angular acceleration of $1.75 \times 10^5 \text{ rad/s}^2$ has a tangential acceleration of $17,500 \text{ m/s}^2$ at 0.1 meters (the distance from the midneck axis of rotation to the midbrain COM in the Duhaime model). A human cannot produce this level of acceleration by impulse ("shake") loading (62).

An injury resulting in a subdural hematoma in an infant may be caused by an accidental fall (43,44,64). A recent report documented the findings in seven children seen in a pediatric hospital emergency room after an accidental fall of 0.6 to 1.5 meters who had subdural hemorrhage, no loss of consciousness, and no symptoms (44). The characteristics of the hemorrhage, especially extension into the posterior interhemispheric fissure, have been used to suggest if not confirm that the injury was non-accidental (9,62,65-68). The hemorrhage extended into the posterior interhemispheric fissure in 5 of the 10 children in this study (in whom the blood was identifiable on CT or magnetic resonance scans and the scans were available for review) and along the anterior falx or anterior interhemispheric fissure in an additional 2 of the 10.

Lucid Interval

Disruption of the diencephalic and midbrain portions of the reticular activating system (RAS) causes unconsciousness (36,69,70). "Shearing" or "diffuse axonal" injury (DAI) is thought to be the primary biophysical mechanism for immediate traumatic unconsciousness (36,71). Axonal injury has been confirmed at autopsy in persons who had a brief loss of consciousness after a head injury and who later died from other causes such as coronary artery disease (72). However, if unconsciousness is momentary or brief ("concussion") subsequent deterioration *must* be due to a mechanism other than DAI. Apnea and catecholamine release have been suggested as significant factors in the outcome following head injury (73,74). In addition, the centripetal theory of traumatic unconsciousness states that primary disruption of the RAS will not occur in isolation and that structural brainstem damage from inertial (impulse) or impact (contact) loading *must* be accompanied by evidence for cortical and subcortical damage (36). This theory has been validated by magnetic resonance imaging and CT scans in adults and children (75,76). Only one of the children in this study (case 6) had evidence for any component of DAI. This child had focal hemor-

rhage in the posterior midbrain and pons, thought by the pathologist to be primary, although there was no skull fracture, only "a film" of subdural hemorrhage, no tears in the corpus callosum, and no lacerations of the cerebral white matter (grossly or microscopically).

The usual cause for delayed deterioration in infants and children is cerebral edema, whereas in adults it is an expanding extra-axial hematoma (77). If the mechanism for delayed deterioration (except for an expanding extra-axial mass) is venospasm, cerebral edema may be the only morphologic marker. The "talk and die or deteriorate (TADD)" syndrome is well characterized in adults (78). Two reports in the pediatric literature discuss TADD, documenting 4 fatalities among 105 children who had a lucid interval after head injury and subsequently deteriorated (77,79). Many physicians believe that a lucid interval in an ultimately fatal pediatric head injury is extremely unlikely or does not occur unless there is an epidural hematoma (7,8,11). Twelve children in this study had a lucid interval. A noncaretaker witnessed 9 of these 12 falls. One child had an epidural hematoma.

Retinal hemorrhage

The majority of published studies conclude that retinal hemorrhage, especially if bilateral and posterior or associated with retinoschisis, is highly suggestive of, if not diagnostic for, nonaccidental injury (9,14-21). Rarely, retinal hemorrhage has been associated with an accidental head injury, but in these cases the bleeding was unilateral (80). It is also stated that traumatic retinal hemorrhage may be the direct mechanical effect of violent shaking (15). However, retinal hemorrhage may be caused experimentally either by ligating the central retinal vein or its tributaries or by suddenly increasing intracranial pressure (81,82); retinoschisis is the result of breakthrough bleeding and venous stasis not "violent shaking" (15,83). Any sudden increase in intracranial pressure may cause retinal hemorrhage (84-87). Deformation of the skull coincident to an impact non-selectively increases intracranial pressure. Venospasm secondary to traumatic brain injury selectively increases venous pressure. Either mechanism may cause retinal hemorrhage irrespective of whether the trauma was accidental or inflicted. Further, retinal and optic nerve sheath hemorrhages associated with a ruptured vascular malformation are due to an increase in venous pressure not extension of blood along extravascular spaces (81-83,88). Dilated eye examination with an indirect ophthalmoscope is thought to be more sensitive for detecting retinal bleeding than routine exami-

nation and has been recommended as part of the evaluation of any pediatric patient with head trauma (89). None of the children in this study had a formal retinal evaluation, and only six had funduscopic examination documented in the medical record. Four of the six had bilateral retinal hemorrhage.

Pre-existing conditions

One of these children (case 16) had a subarachnoid AV malformation that contributed to development of the subdural hematoma, causing his death. One (case 7) had TAR syndrome (90), but his death was thought to be caused by malignant cerebral edema not an expanding extra-axial mass.

Cerebrovascular thrombosis

Thrombosis or dissection of carotid or vertebral arteries as a cause of delayed deterioration after head or neck injuries is documented in both adults and children (91,92). Case 14 is the first report of a death due to traumatic cerebrovascular thrombosis in an infant or child. Internal carotid artery thrombosis was suggested radiographically in an additional death (case 13) but could not be confirmed at autopsy. However, this child died 6 days after admission to the hospital, and fibrinolysis may have removed any evidence for thrombosis at the time the autopsy was performed.

Limitations

1. Six of the 18 falls were not witnessed or were seen only by the adult caretaker, and it is possible that another person caused the nonobserved injuries.
2. The exact height of the fall could be determined in only 10 cases. The others (7 swing and 1 stationary platform) could have been from as little as 0.6 meters (2 feet) to as much as 2.4 meters (8 feet).
3. A minimum impact velocity sufficient to cause fatal brain injury cannot be inferred from this study. Likewise, the probability that an individual fall will have a fatal outcome cannot be stated because the database depends on voluntary reporting and contractual agreements with selected U.S. state agencies. The NEISS summaries for the study years estimated that there were more than 250 deaths due to head and neck injuries associated with playground equipment, but there are only 114 in the files. Further, this study does not include other nonplayground equipment-related fatal falls, witnessed or not witnessed, in the CPSC database (32).

CONCLUSIONS

1. Every fall is a complex event. There must be a biomechanical analysis for any incident in which the severity of the injury appears to be inconsistent with the history. The question is not "Can an infant or child be seriously injured or killed from a short-distance fall?" but rather "If a child falls (x) meters and strikes his or her head on a nonyielding surface, what will happen?"
2. Retinal hemorrhage may occur whenever intracranial pressure exceeds venous pressure or whenever there is venous obstruction. The characteristic of the bleeding cannot be used to determine the ultimate cause.
3. Axonal damage is unlikely to be the mechanism for lethal injury in a low-velocity impact such as from a fall.
4. Cerebrovascular thrombosis or dissection must be considered in any injury with apparent delayed deterioration, and especially in one with a cerebral infarct or an unusual distribution for cerebral edema.
5. A fall from less than 3 meters (10 feet) in an infant or child may cause fatal head injury and may not cause immediate symptoms. The injury may be associated with bilateral retinal hemorrhage, and an associated subdural hematoma may extend into the interhemispheric fissure. A history by the caretaker that the child may have fallen cannot be dismissed.

Acknowledgments: The author thanks the law enforcement, emergency medical services, and medical professionals who willingly helped him obtain the original source records and investigations; Ida Harper-Brown (Technical Information Specialist) and Jean Kennedy (Senior Compliance Officer) from the U.S. CPSC whose enthusiastic assistance made this study possible; Ayub K. Ommaya, M.D., and Werner Goldsmith, Ph.D. for critically reviewing the manuscript; Jan E. Leestma, M.D., and Faris A. Bandak, Ph.D. for helpful comments; Mark E. Myers, M.D., and Michael B. Plunkett, M.D. for review of the medical imaging studies; Jeanne Reuter and Kathy Goranowski for patience, humor, and completing the manuscript; and all the families who shared the stories of their sons and daughters, and for whom this work is dedicated.

APPENDIX

Newtonian mechanics involving constant acceleration may be used to determine the impact velocity in a gravitational fall. However, constant acceleration formulas cannot be used to calculate the relations among velocity, acceleration and distance traveled during an impact since the deceleration is

not uniform (45). This analysis requires awareness of the shape of the deceleration curve, knowledge of the mechanical properties and geometry of the cranial system, and comprehension of the stress and strain characteristics for the specific part of the skull and brain that strikes the ground. A purely translational fall requires that the body is rigid and that the external forces acting on the body pass only through the COM, i.e., there is no rotational component. A 1-meter tall 3-year-old hanging by her knees from a horizontal ladder with the vertex of her skull 0.5 meters above hard-packed earth approximates this model. If she loses her grip and falls, striking the occipital scalp, her impact velocity is 3.1 m/second. An exclusively angular fall also requires that the body is rigid. In addition, the rotation must be about a fixed axis or a given point internal or external to the body, and the applied moment and the inertial moment must be at the identical point or axis. If this same child has a 0.5-meter COM and has a "match-stick" fall while standing on the ground, again striking her occiput, her angular velocity is 5.42 rad/second and tangential velocity 5.42 m/second at impact. The impact velocity is higher than predicted for an exclusively translational or external-axis angular fall when the applied moment and the inertial moment are at a different fixed point (slip and fall) or when the initial velocity is not zero (walking or running, then trip and fall), and the vectors are additive. However, the head, neck, limbs, and torso do not move uniformly during a fall since relative motion occurs with different velocities and accelerations for each component. Calculation of the impact velocity for an actual fall requires solutions of differential equations for each simultaneous translational and rotational motion (45). Further, inertial or impulse loading (whiplash) may cause head acceleration more than twice that of the midbody input force and may be important in a fall where the initial impact is to the feet, buttock, back or shoulder, and the final impact is to the head (46-47).

The translational motion of a rigid body at constant gravitational acceleration (9.8 m/s^2) is calculated from:

$$F = ma \quad v^2 = 2as \quad v = at$$

where F = the sum of all forces acting on the body (newton), m = mass (kg), a = acceleration (m/s^2), v = velocity (m/s), s = distance (m) and t = time (s).

The angular motion of a rigid body about a fixed axis at a given point of the body under constant gravitational acceleration (9.8 m/s^2) is calculated from:

$$M = I\alpha \quad \omega = v'/r \quad \alpha = a'/r$$

where M = the applied moment about the COM or about the fixed point where the axis of rotation is located, I = the inertial moment about this same COM or fixed point, α = angular acceleration (rad/s^2), ω = angular velocity (rad/s), r = radius (m), v = tangential velocity (m/s) and a = tangential acceleration (m/s^2).

The angular velocity ω for a rigid body of length L rotating about a fixed point is calculated from:

$$\frac{1}{2}I_0\omega^2 = maL/2 \quad I_0 = (1/3) mL^2$$

where I_0 = the initial inertial moment, ω = angular velocity (rad/s), m = mass (kg), a = gravitational acceleration (9.8m/s^2) and L = length.

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Addendum

This death was reported to and investigated by the CPSC after submission of the manuscript.

Case 19. A 7 year old boy was playing at a school playground, hanging by his hands from the gymnastic rings of a wooden play structure with his feet approximately 30 inches above the ground. Another child grabbed him by the legs, forcing him to let go, and he fell face-first onto 7 inches of wood mulch, which had been placed on the playground surface the day before. The fall was witnessed by several other children and adults. He seemed uninjured and continued playing. However, 10-15 minutes later he complained of a headache and went to the school nurse's office to lay down. He had a seizure and lost consciousness while in the office, was transported to a local hospital, then transferred to a tertiary care children's hospital. A CT scan indicated acute occipito-parietal subdural hemorrhage, extending along the tentorium and posterior interhemispheric fissure. The hematoma was emergently evacuated, but he had a cardiopulmonary arrest in the operating room and could not be resuscitated. A postmortem examination indicated residual subdural hemorrhage at the base of the skull. He had no impact injury in his scalp, consistent with the history of a face-first fall, and had no identifiable facial lacerations or abrasions. ~~The neck and cervical spinal cord examination were normal. The eyes~~
were not examined.

John Plunkett, M.D.
September 12, 2000

000102

Is gene therapy ready for HIV/Ebola virus-derived viral vectors?

In 1999, an investigation into the death of Jesse Gelsinger, who died while participating in a gene therapy trial, severely criticised James Wilson, director of the Institute of Gene Therapy at the University of Pennsylvania (Philadelphia, PA, USA). The controversy is revisited this month with the publication of a paper by Wilson's laboratory reporting the development of an HIV-based viral vector that carries envelope proteins from the Ebola virus.

The group suggest that the new vector, EboZ, which efficiently transduces intact airway epithelium in vitro and in vivo, may form the basis of an effective gene therapy for cystic fibrosis. "At a time when gene therapists, the FDA, and many others in the field are struggling for restoration of public confidence in gene therapy, one might question the approach of creating a 'strange bug' instead of optimising the known viral or even nonviral transfer technologies", says Wolfgang Walther (Max-Delbrück-Center for Molecular Medicine, Berlin, Germany).

Wilson's team created vectors that incorporated various viral envelope proteins and

showed that a vector containing envelope proteins from the Zaire strain of Ebola virus was the most effective transducer of cultured apical airway cells in culture. Further in-vitro experiments on excised sections of healthy human trachea demonstrated transduction of tracheal epithelial cells by the EboZ vector. This was followed up by in-vivo experiments in which the vector was introduced into the tracheas of immunocompetent young mice—the animals had high-levels of vector expression by day 28, that persisted until at least day 63 (*Nat Biotech* 2001; 19: 225–30).

"The EboZ vector construct serves as a research tool and provides the means to ask if there is a single epitope in the Ebola virus envelope that is critical for binding the receptors on a respiratory epithelial cell", stresses Nelson A Wivel, deputy director of the Institute of Gene Therapy in Philadelphia. "The idea of employing

Ebola envelopes to achieve transduction of airway epithelium—the natural target of Ebola infection—is intriguing", agrees Walther, but he warns that safety concerns are under-represented in the study. "At least one experiment should have investigated whether cell types other than epithelial cells can be infected by the new vector", he says. A scenario of efficient but unwanted infection of other tissues could rule out use of the vector for human gene therapy, he adds.

Gaetano Romano (Thomas Jefferson University, Philadelphia, PA, USA) also warns that a major drawback of HIV-based vectors is the seroconversion to HIV. He also points out that insertion of the viral vector into the genome of human cells and possible recombination between retroviridae-based vectors and human endogenous retroviruses need to be considered. Insertional mutagenesis could be avoided by engineering self-inactivating vectors but Romano notes that "the transfer vector used by Wilson belongs to the early generations of HIV-based vectors, which are not self-inactivating." "Obviously, many more studies need to be done and the question of a clinical trial is very remote in our thinking at this juncture", says Wivel.

Kathryn Senior

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Using Ebola envelope proteins

Science Photo Library

Accident or murder in children?

In 1998, there were several well-publicised trials of child carers who were accused of killing children in their care by shaking them. Experts for the prosecution gave evidence that there were features of the fatal event, and physical signs in the children, that were diagnostic of inflicted injury, although the evidence underlying their assertions was slight. Many observers, including *The Lancet* (1998; 352: 335), expressed concern at this deficiency.

John Plunkett from the Regina Medical Center, Hastings MN, USA, examined the records of the United States Consumer Products Safety Commission between January, 1988, and June, 1999, to find the records of children who died after short falls (0.6–3 m) from playground equipment (*Am J Forensic Med Pathol* 2001; 22: 1–12). 18 children were identified, aged 12 months to 13 years. Legal investigations concluded that death was accidental in

all cases. A non-caretaker witnessed 12 of the accidents, and in the 13th the fall was videotaped by the child's grandmother.

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Kerim Karimov/Medphoto

Is retinal haemorrhage diagnostic?

"Many physicians believe that . . . a lucid interval does not exist in an ultimately fatal paediatric head injury", says Plunkett, yet 12 of the 18 children who died had a lucid interval lasting from 5 min to 48 h. Four of the six children whose fundi were examined had bilateral retinal

haemorrhages, which contradicts the assumption, "that retinal haemorrhage is highly suggestive, if not diagnostic, of inflicted trauma".

The author's conclusion that, "a history by the caretaker that the child may have fallen cannot be dismissed", is likely to echo through courtrooms for many years to come. He is more forthright in person about the issue: "I am genuinely distressed at what medicine has done in the arena of child abuse. Even a cursory understanding of the biomechanics of brain trauma would have predicted the results I was fortunately able to document . . . It [the publication] has already been 'trashed' by many paediatricians and ophthalmologists, and the journal was not mailed until last Friday [Feb 23]! It has even been suggested that the videotape of the fatal short-distance fall was fabricated."

John Bignell

Appendix 27

Declaration Regarding Addition of Homicide by Abuse Charge



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SUPERIOR COURT OF WASHINGTON, GRANT COUNTY

STATE OF WASHINGTON,

Plaintiff,

v.

MARIBEL GOMEZ,

Defendant,

Case No. 04-1-00312-4

DECLARATION OF ROBERT
MOSER

STATEMENT OF FACTS

On September 10, 2003, Rafael Gomez died at Sacred Heart Hospital in Spokane. Following parallel dependency proceedings in Grant County Superior Court, the prosecutor ultimately charged Maribel Gomez with Manslaughter 1 in May 2004.

The State now seeks to amend the information in this matter to include a charge of Homicide by Abuse. RCW § 9.94A.515 ranks Manslaughter 1 as XI seriousness level. Homicide by Abuse is ranked XV seriousness level, the same rank as Murder 1. With Ms. Gomez's

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offender score of zero, the standard sentencing range for Manslaughter 1 is 78 - 102 months; and for Homicide by Abuse it is 240 - 320 months.

DISCUSSION

DEFENDANT OBJECTS TO AMENDMENT OF INFORMATION ON THE BASIS
THAT IT WILL PREJUDICE HER DEFENSE

The defendant will be prejudiced by an amendment of the information because the evidence necessary to an adequate defense is no longer available. The State will seek to establish, and the defendant will need to defend against, allegations of abuse. An adequate defense will require highly specific evidence of observations by people who saw the mother and child together.

Amendment of the information changes the complexion of the case. Adding a charge of Homicide by Abuse introduces as an element that the defendant "previously engaged in a pattern or practice of assault or torture of said child ..." RCW § 9A.32.055. The cause of death is no longer the only issue. The entire course of the relationship between mother and child is now at issue.

Amendment of the information expands the amount of evidence at issue. Rafael Gomez was a dependent of the State his entire life. The Department of Children and Family Services was suspicious of a number of injuries sustained by Rafael. However, the Department affirmed the safe environment of Maribel's home and sent the child home twice. Putting the entire

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dependency and actions of the Department at issue suggests an increase of weeks at trial of debating evidence.

The evidence necessary to adequately defend a charge of Homicide by Abuse has been lost. A child abuse expert, which the defense has yet to retain, will interview the decedent's siblings, family friends, and state and local agents who observed the mother with the child. The expert will seek highly specific information as to mannerisms, reactions, and spoken words. As yet, these witnesses have not been advised that they will be required to remember this information. Rafael lived from five to three years ago. The memories of these witnesses will be incomplete. The memories of witnesses will be incomplete to the point that the defense will not have access to evidence it would have had access to at the time of Rafael's death. The parties will be limited to records made by the Department of Children and Family Services. The defendant does not believe that an adequate defense can be prepared from this single source.

Submitted: April 28, 2006

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Appendix 28

~~OPD Parents Representation Program Standards of Representation~~

Washington State Office of Public Defense Parent's Representation Program

Parents Representation Program Standards Of Representation

2009

"Change is possible when parents get the support they need"



Mission Statement

As an independent judicial branch agency, the Office of Public Defense's mission is to implement the constitutional and statutory guarantees of counsel and to ensure effective and efficient delivery of indigent defense services funded by the state of Washington. The OPD administers all state funded public defense programs including representation of indigent parents who qualify for appointed counsel in dependency and termination cases, as provided in RCW 13.34.090 and 13.34.092.

Vision

The OPD Parents Representation Program seeks to provide high quality, effective representation to indigent parents involved in dependency and termination of parental rights proceedings. As both a counselor at law and advocate, the attorney strives to inform and advise the parent, protect the parents' legal rights, including the rights to family autonomy, remedial services and visitation and ardently pursue the case goals and outcomes as identified by the parent.

"The fundamental liberty interest of natural parents in the care, custody, and management of their child does not evaporate simply because they have not been model parents or have lost temporary custody of their child to the State. Even when blood relationships are strained, parents retain a vital interest in preventing the irretrievable destruction of their family life."

Supreme Court of the United States, Santosky v. Kramer, 455 U.S. 745 (1982).

Description of the OPD Parents Representation Program

The OPD Parents Representation Program contracts with private attorneys, law firms and public defender agencies in program counties, to provide defense services to indigent parents involved in dependency and termination of parental rights proceedings. Contract parent representation attorneys are not employees of the OPD or the state of Washington and the OPD does not direct an attorney's actions, conduct or case strategies, as long as the attorney's conduct is consistent with the terms of the contract, court rules, state law and professional rules and standards. The OPD sets manageable caseload limits, implements professional standards of practice and provides access to expert services, independent social workers and case support services, so that program attorneys can better assist their clients. The OPD Parents Representation Program is established in 25 counties.

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1 General Duties

1.1 Role of Parent's Counsel

The paramount obligation of dependency counsel is to provide effective and quality representation to indigent parents at all stages of the dependency process. Counsel shall advocate for the client's goals and empower the client to direct the representation and make informed decisions based on thorough legal counseling. Counsel shall not substitute counsel's judgment or opinions in those decisions that are the responsibility of the client. Counsel shall also protect the parent's rights including the right to services, visitation and information and decision making while the child is in foster care.

1.2 Education, Training & Experience

Counsel must acquire sufficient working knowledge of all relevant federal and state laws, regulations, policies, and rules. Understand child development principles, particularly the ~~importance of attachment and bonding and the effects of parental separation on young~~ children; and have knowledge of the types of experts who can consult with attorneys and/or testify on parenting, remedial services and child welfare issues. Counsel should be familiar with the child welfare and family preservation services available in the community and the problems the services are designed to address. Counsel should also have a thorough understanding of the role and authority of the Division of Children and Family Services and both public and private organizations within the child welfare system. Counsel shall participate in trainings offered by OPD.

1.3 Continuity of Representation

It is expected that counsel of record shall continue to represent the client from the initial court proceeding through all subsequent dependency and/or termination proceedings until resolution and the case is closed.

1.4 Caseloads

The OPD caseload standard is 80 active cases at any given time, for a full time parents' representation attorney. A program attorney should assure that adequate time is dedicated to each case and that professional time spent on parent representation cases is commensurate with the percent of a full time caseload. If counsel works for the Parent Representation Program on a part-time basis, counsel must ensure that other cases do not interfere with counsel's obligation and commitment to Parent Representation Program cases.

2 Relationship with the Client

Counsel should be aware of unique issues facing each client, such as incarceration, mental health status, poverty, domestic violence and substance abuse and take appropriate steps to assure that these issues do not interfere with effective representation.

Counsel must be alert to and avoid potential conflicts of interest or the appearance of a conflict of interest that would interfere with the competent representation of the client. Counsel shall not represent two or more individuals involved in a dependency or termination proceeding.

3 Client Communication

In all cases counsel must maintain sufficient contact with the client to establish and maintain an attorney-client relationship that will enable counsel to understand the client's interests and needs, as well as the client's position on issues or questions in the case. Client communication should include the following elements-:

- Provide the client with contact information in writing and establish a message system that allows regular attorney-client contact.
- Meet and communicate regularly with the client. Substantial in office meetings should take place between shelter care and the services conference, and well before any court proceedings. At these meetings, counsel should listen to the client's factual descriptions of the case and fully answer the client's questions. Counsel should also advise the client about all legal matters related to the case, including specific allegations against the client, the service plan, the client's rights and potential consequences in the pending proceeding, any orders entered against the client and the potential consequences of failing to obey court orders or cooperate with service plans. Adhere to all laws and ethical obligations concerning confidentiality.
- Work with the client to develop a case timeline and calendar system that informs the client of significant case events and court hearings and sets a timeframe describing when specific case requirements (such as services) should be completed.
- Provide the client with copies of all petitions, court orders, service plans, and other relevant case documents, including reports regarding the child except when expressly prohibited by law, rule or court order.
- Take diligent steps to locate and communicate with a missing parent and decide representation strategies based on that communication.

4 Communication with Other Professionals

Child welfare cases require parents' counsel to communicate regularly with numerous professionals involved in the client's case. Some of these individuals are parties to the proceeding and represented by counsel, while many others are not. Counsel should communicate regularly with other parties and professionals involved in their client's case as required to obtain current information regarding the case. While dependency proceedings may at times appear informal, it is important that all counsel fully respect the attorney-client relationship and abide by the RPC's governing communication with other parties to the proceeding, and communications with third parties.

5 Discovery & Court Preparation

Counsel shall conduct a thorough and independent investigation at every stage of the proceeding and when appropriate utilize OPD social worker and OPD expert services as needed. Counsel shall review the child welfare agency case file and obtain all necessary documents, including copies of all pleadings and relevant notices filed by other parties, and information from the caseworker and providers. When needed, use formal discovery methods to obtain information. Effective court preparation includes the following:

- Interview the client and potential witnesses such as school personnel, neighbors, relatives, foster parents, medical professionals, etc.
- Obtain necessary authorizations for releases of information.
- Develop a case theory and strategy to follow at hearings and negotiations.
- Timely file all pleadings, motions, and briefs. Research applicable legal issues and advance legal arguments when appropriate.
- Engage in case planning and advocate for appropriate social services.
- Aggressively advocate for services to remedy circumstances that led to out of home placement and that services be provided in a manner that is accessible to the client.
- Aggressively advocate for regular visitation in a family-friendly setting.
- With the client's permission, and when appropriate, engage in settlement negotiations and mediation to resolve the case.
- Thoroughly prepare the client and all witnesses to testify at the hearing.
- Identify, secure, prepare and qualify expert witness when needed. When permissible, interview opposing counsel's experts.

6 Pre-Trial/Hearing Actions

Counsel shall attend the case conference to develop a written voluntary services plan. Services plans should meet the individual needs of each client and be designed to facilitate reunification. Additionally, counsel should participate in case staffings, settlement conferences, multi-disciplinary team reviews, family team decision making meetings and other conferences held to negotiate, develop and implement case plans.

7 Advocacy for Services

Consistent with the client's goals, counsel shall thoroughly discuss with the client the advantages of early engagement in services and advocate for timely provision of services appropriate to meet the needs of the individual client. Parents often see themselves as passive recipients of services rather than as a part of the process of determining what services are necessary to resolve the problem. Attorneys should assist them in taking a more active role in the process and representing their own views. Attorneys should help clients obtain not only services deemed necessary by the department, but also those that the family considers essential to its survival.

Advocacy for services should occur at every stage of the proceeding, beginning with the initial shelter care hearing and shall also include out-of-court case events such as: case conferences; family team decision making meetings; and multi-disciplinary team (CPT) staffing. Counsel should identify and address barriers that may prevent or limit the client's ability to successfully engage in services. Counsel should assure that court orders specify each party's duties and responsibilities regarding service referrals, payment for services, transportation issues and a realistic timeline for commencing and completing services. Counsel's efforts to advocate for services include the following principles:

- The department has a duty to make reasonable efforts to unify the family;
- The department must develop treatment plans for the individual needs of the client in a manner that minimizes the number of contacts the client is required to make;
- The department case worker should solicit the parent's active participation in the development of this individualized service plan;
- The court order should specify who is responsible for attaining services and by what time;
- The department must coordinate within the department and with contracted service providers, to ensure that parents in dependency proceedings receive priority access to remedial services;
- Remedial services include: individual, group, and family counseling; substance abuse treatment services; mental health services; assistance to address domestic violence;

services designed to provide temporary child care and therapeutic services for families; and transportation to or from any of the above services and activities;

- The department shall provide funds for remedial services if the parent is unable to pay for such services; and
- Required services must be related to the parental deficiencies or circumstances that led to the child's removal from the home

8 Advocacy for Visitation

Counsel recognizes that parent-child contact is essential to the welfare of the child and the successful resolution of the client's case and advocates for frequent, consistent visits in the least restrictive setting possible. Counsel's advocacy efforts include the following principles:

- Visitation is the right of the family;
- Early, consistent, and frequent visitation is crucial for maintaining parent-child relationships and making it possible for parents and children to safely reunify;
- The department must encourage the maximum parent and child and sibling contact possible, when it is in the best interest of the child;
- Visitation plans should allow for make-up visits in the event that a child is not available for a visit or when a parent, for good cause cannot attend a scheduled visit; and
- Visitation shall not be limited as a sanction for a parent's failure to comply with court orders or services and may only be limited or denied when necessary to protect the child's health, safety, or welfare

9 Hearings

Counsel has a professional duty to diligently represent their client. This includes the following:

- Prepare and make all appropriate motions and evidentiary objections.
- Present and cross-examine witnesses, prepare and present exhibits.
- Request the opportunity to make opening and closing arguments.
- Prepare proposed findings of fact, conclusions of law and orders when they will be used in the court's decision or may otherwise benefit the client.
- Avoid continuances (or reduce empty adjournments) and work to reduce delays in court proceedings unless there is a strategic benefit for the client.

10 Post Hearings/Appeals

Counsel is obligated to ensure that each client understands and is able to exercise their rights to appeal, discretionary review and post hearing relief.

- Review court orders to ensure accuracy and clarity and review with client.
- Take reasonable steps to ensure the client complies with court orders and to determine whether the case needs to be brought back to court.
- Consider and discuss the possibility of appeal with the client.
- If the client decides to appeal, timely and thoroughly file the necessary post-hearing motions and paperwork related to the appeal and closely follow the Rules of Appellate Procedure.
- ~~Request an expedited appeal, when feasible, and file all necessary paperwork while the appeal is pending. Coordinate with appellate counsel to assure that appropriate steps are taken (such as a motion to stay) to protect the client's interests while the appeal is pending.~~
- Communicate the results of the appeal and its implications to the client.

11 Withdrawal and Termination of Representation

11.1 Withdrawal Upon Resolution of Case

Counsel shall close case and withdraw from representation in a timely manner when a final resolution of the case has been achieved and counsel's responsibilities to the client have been completed. In general, counsel should close the case and withdraw from representation within 30 days of entry of a final order.

11.2 Withdrawal Prior to Resolution of Case

If circumstances necessitate counsel's withdrawal prior to resolution of the case, counsel shall obtain a court order allowing withdrawal and substitution of attorney. Counsel must serve client and all parties with notice of intent to withdraw and date and time of motion.

If motion to withdraw is granted, counsel shall take reasonable steps to protect the client's interests and arrange for the orderly transfer of the client's file and discovery to substituting counsel.

12 Involvement in Child Welfare System Improvement Efforts

In addition to the individual case responsibilities described in these standards, Parent Representation Program attorneys are also actively involved in efforts to improve the child welfare system. Court Improvement projects, reasonable efforts symposiums, juvenile court administrative meetings, and similar activities all provide an opportunity for counsel to have a positive impact on developments within the child welfare system and protect the rights and interest of parents and families.

Appendix 29
Dependency Hearing Transcripts

Court of Appeals No. 22935-1-III

IN THE SUPERIOR COURT OF THE STATE OF WASHINGTON

IN AND FOR THE COUNTY OF GRANT

In re dependencies of

E.A., J.G., J.G. and M.G.,
minors,

STATE OF WASHINGTON,

Petitioner,

and

MARIBELLE GOMEZ and JOSE
ARECHIGA,

Respondents.

No. 03-7-00131-1, 132-0,
133-8, 134-6

Hon. Evan Sperline

February 19, 2004

VERBATIM TRANSCRIPT OF PROCEEDINGS
From Electronic Recording

VOLUME I - Pages 1-144
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DEPENDENCY FACT-FINDING
February 19, 2004

MR. CABALLERO: --representing the Department of Social and Health Services, the matter before the court four files, Edgar Arechiga, 03-7-00134-6, Julio Gomez, 03-7-00132-0, Julianna Gomez, 03-7-00131-1, and Maria Gomez, 03-7-00133-8. These matters are on for contested dependency fact-finding trials. Present in court, Maribelle Gomez, she is the mother of all four children, and her attorney Doug Anderson; Jose Arechiga, who is the father of Edgar Arechiga, and he is here with -- with his attorney Robert Moser. Interpreting for the parents is Saul Castillo. Also present is Mario Gonzalez, who is the agency social worker, Terry Cullen, who is the guardian ad litem, and Tamara Cardwell, who is the guardian ad litem program coordinator. The Department is ready to proceed.

THE COURT: Are counsel ready to proceed?

MR. ANDERSON: Yes, your Honor.

MR. MOSER: Yes, your Honor.

THE COURT: And are parents ready to proceed?

INTERPRETER: Yes.

THE COURT: Opening statement, Mr. Caballero?

Counsel for petitioner made opening

Counsel for father made opening

THE COURT: Do either of the parents want to be heard independently of your lawyer?

INTERPRETER: I don't understand. What do you mean?

THE COURT: You have -- You have the right to speak to the judge directly, in addition to being -- having your lawyer speak on your behalf. So at any time either of you wants to speak to the court directly you -- let me know that.

MR. ARECHIGA (through interpreter): I want to speak. I don't know why these people are saying that

it's abuse. We are good parents. (Inaudible) we asked them for assistance. They -- never gave us the assistance that we needed for my son. And now that my son is dead they want to wash their hands (inaudible) with us. And now they want to charge us and the responsible ones are them. They -- always I want to let you know that Mr. (Inaudible) keeps telling her that they're not going to give us the children, and I don't know why he keeps threatening (inaudible). I think he's -- he is not the one that should decide that. And the one I think that should decide that is the judge.

And that's all I wanted to say.

THE COURT: Thank you.

MS. GOMEZ (through interpreter): I want to say a little bit.

THE COURT: Go ahead.

MS. GOMEZ: Yes, your Honor. I also want to say -- (inaudible) it's true. I was two or three days a week at the CPS office asking for assistance, reporting -- I reported everything that my son did, because I needed for them to pay attention to what was happening with my son. One time -- (inaudible) one time -- supervisor yelled at me (inaudible) that I had (inaudible) without so much assistance that I was asking for the child, that they didn't have the money -- (inaudible). And told me that the child was not a normal child and that I had to adapt myself to (inaudible) future with him.

When I found out that there was no -- I couldn't get a solution (inaudible) solution with them and I (inaudible) I would periodic (inaudible) to keep Raphael (inaudible), and I would like to ask the judge if he can (inaudible) the court and if you could have (inaudible) come to court Mary--

INTERPRETER: I'm sorry; the interpreter did not catch that last name--

MS. GOMEZ: --(Inaudible), Jorge Chacon, (inaudible) that made home visits and (inaudible) every Tuesday. And I would like for you to call on the court so that the judge will see that what I'm saying is the truth.

THE COURT: Okay. Thank you.

MS. GOMEZ: Thank you.

THE COURT: Does either counsel for parent have an intent to present the testimony of Graciella Alvarado or Jorge Chacon?

MR. MOSER: Yes, your Honor. In fact we've all (inaudible) preparing (inaudible), although the Department (inaudible) as well, (inaudible).

THE COURT: Thank you.

One other question, since I don't have any background in these cases, what is the role or participation of the biological father of the other three children?

MR. CABALLERO: Your Honor, at this point in time the court does not have jurisdiction. The Department will -- publish -- as to the father for purposes of bringing him into court.

THE COURT: Thank you.

You may call your first witness.

MR. CABALLERO: Yes, your Honor. The Department would call Maribelle Gomez to the stand.

THE COURT: Please raise your right hand.
Do you solemnly affirm that the testimony you
give in this matter will be the truth, under penalty
of perjury?

THE WITNESS (through interpreter): Yes.

THE COURT: Please be seated.

MR. CABALLERO: Your Honor, may I approach the
witness just (inaudible)?

THE COURT: Sure.

THE WITNESS: Thank you.

DIRECT EXAMINATION

BY MR. CABALLERO:

Q Ms. Gomez, would you please state your full name?

A Maribelle Gomez (Inaudible).

THE COURT: Just a moment.

Q What is your address?

A (Inaudible) Court, Apartment 24, Ephrata.

Q Who lives at that residence?

A At this moment Jose and myself.

Q What is your relationship to Edgar Arechiga, Julio
Gomez, Julianna Gomez and Maria Gomez?

A They are my children.

Q Who is the father of Edgar?

A ~~Jose Arechiga.~~

Q And who is the father of Julio?

A Julio Orosco (ph.).

Q And who is the father of Julianna?

A Julio Orosco.

Q And the father of Maria?

A David Rivera.

INTERPRETER: Your Honor, could you instruct
the witness to wait until I finish interpreting the
question, or would you--

THE COURT: Yes. Ms. Gomez, please wait until
Mr. Castillo finishes his interpreting before you
begin your answer.

Would you repeat, please, who is the father of
Maria?

THE WITNESS: David Rivera.

THE COURT: Could you spell the last name?

THE WITNESS: R-i-v-e-r-a.

THE COURT: Thank you.

Q When was Edgar born?

A September 14, 2002.

Q And Edgar is approximately 17 months of age?

A He was a year old in September.

Q Julianna, what is her birth date?

A December 4th, 099.

Q And what is Julio's birth date?

A September 10th, 096.

Q And what about Maria's birthday?

A July 27th, 092.

Q On August 7, 2001 did you give birth to Raphael
Arechiga Gomez?

A Yes.

Q Is Raphael deceased?

A Yes.

Q To the best of your recollection, when did Raphael
die?

A The 10th of September.

Q And that is of the year 2003?

A Yes.

Q Was Raphael a dependent child of the State of Washington as of September 11, 2001?

A Yes.

Q And, Ms. Gomez, I understand that these are difficult questions. If you need a break please let the court know or let me know and we can discuss that. Okay?

A Okay.

Q What is your understanding as to why Child Protective Services, or CPS, became involved with you and your child Raphael?

A Because I was using drugs.

Q And that was while you were carrying Raphael in your womb, correct?

A Yes.

Q The drugs in question were cocaine and amphetamines?

A Okay. I (inaudible) cocaine but I don't know why they said that other thing.

Q Was Raphael placed in a foster home shortly after his birth?

A Yes.

Q And at that point in time the agency social worker that was working with your family was Linda Turcotte?

A Well, Linda Turcotte started but then followed by Olga.

Q And when you say "Olga" do you mean the Department social worker Olga Gaxiola?

A Olga Cabriola or something.

Q Do you recall being offered services by the Department social workers to address your drug use?

A Yes.

Q Were you offered -- strike that. Were you provided inpatient treatment?

A Yes.

Q And you completed that?

A Of course.

Q Were you also provided with random urinalysis testing?

A Yes.

Q Did you undergo a psychological evaluation?

A Yes.

Q And were you also working with a volunteer with the P-CAP program?

A I don't understand the question.

Q Do you recall receiving home support services?

A Such as--?

Q A person visiting your home.

A (Inaudible) counselor (inaudible).

Q Do you recall who that was?

A Yes.

Q And who was that?

A Jorge Chacon.

Q Were you also visiting with Raphael?

A Is that what you're saying, that Ralph was going to the house to -- for visits? I don't understand.

Q I'll rephrase.

As -- when the dependency was in the initial stages, prior to Raphael being returned into your home, you were having visits with Raphael.

A Yes.

Q And those visits were initially supervised visits, correct?

A Yes.

Q And there was then a transition in 2002 to unsupervised visits.

A Yes.

Q In May of 2002 you began having Raphael over into your home for overnight visits?

A Yes.

Q Was Raphael returned to your care and to live in your home on or about June 11, 2002?

A I don't remember the date.

Q Was it approximately mid-year of 2002?

A I don't remember. The only thing I know that -- returned -- I know that he was returned and he was not taken out of the home until -- Edgar (inaudible) been born.

Q Okay. When Edgar was born he was still living -- he was living in your home--

THE COURT: Do you mean Raphael was?

Q I'm sorry. When Edgar was born Raphael was still living in your home?

A Yes.

Q And Edgar was born September 14 of 2002?

A Yes.

Q Was Raphael temporarily removed from your home in September of 2002?

A Yes.

Q And was that due to an investigation by CPS involving an injury to Raphael's right leg?

A Yes.

Q Were you present when Raphael injured his leg in September of 2002?

A No.

Q And do you recall where you were when you found out that Raphael had injured his right leg?

A Yes.

Q And where were you?

A We had -- Edgar was (inaudible) Samaritan Hospital.

Q And when you say "we," who do you mean?

A Jose and myself.

Q How long -- pursuant to that investigation by CPS for the right leg injury to your child, how long was he kept out of your home?

A Five days.

Q And he was then returned to the care -- to your care?

A Yes.

Q Do you recall approximately when that occurred, what date?

A No, I don't remember exactly.

Q Was it still September of 2002 or thereabouts?

A Yes.

Q Do you recall an injury to Raphael's left leg that occurred on December 7, 2002?

A Yes.

Q And were you present when Raphael injured his left leg?

A I was in the home but at the moment that he broke his leg I did not see (inaudible).

Q Who else was in the home when Raphael injured his left leg?

A My children and a friend who had gone to have supper with (inaudible).

Q And who was that friend?

A Lucinda (Inaudible).

Q Would you describe the events on that day that resulted in -- in Raphael injuring his leg?

A Yes. I had invited my friend over to have supper with

us. We had prepared supper. We were waiting for Jose to get home from work so we could have supper -- all together. And my children were in their room, watching -- (inaudible). And so was Raphael.

But Raphael wanted to break the TV with a shoe. And my children told me to get him out of the room. I got him out (inaudible). After that the child Raphael was with myself and Lucinda in the living room, and I told my friend that I was going to clean the kitchen, and -- said okay.

And I had to (inaudible) whenever I mopped my kitchen I would (inaudible) water, soap and Clorox. I sprinkled it (inaudible) kitchen. There was (inaudible). I went to the bathroom to put it in the toilet bowl. And I was pouring it down the toilet, I heard something loudly and Raphael scream. And then I went -- ran out and then I saw that Raphael was with his legs opened and towards the (inaudible).

Q If I could stop you there. When you say that his legs were opened and that they were back could you describe what Raphael's legs looked like?

THE COURT: Please pause before you answer.

The record may be confused at this point. In her previous answer the witness said the child's legs were apart. And that he was back. But when she said he was back she gestured backward with her head. The interpreter obviously did not -- did not state the physical gesture that accompanied her testimony. Perhaps counsel could clarify.

Q Ms. Gomez, when you first saw Raphael, what was the position of his legs?

A One was put in back and one was put in front.

Q Was it similar to a split of the legs?

INTERPRETER: (Interpreter) -- split--.

MR. CABALLERO: I will rephrase.

INTERPRETER: I'm sorry. I cannot find a word for "split."

THE COURT: Counsel will rephrase.

Q One leg was then pointing forward of the child, correct?

A Yes.

Q And one leg was -- the other leg was pointing backwards?

A Yes.

Q And what -- what was occurring with the child's upper torso?

A It was toward the back.

Q And what do you mean by that? If you could describe that--.

A Okay. But it's from the stomach up was also on the floor.

Q Did it appear that he had hit his head to you?

A Yes.

Q Now, if you could describe the layout of -- of your home, with -- specifically the relationship between the kitchen, where Raphael fell, and the bathroom where you were located.

A Okay. The kitchen is like where -- Mario is--

Q If I could stop there for a moment, because we -- we record these, so--

THE COURT: Counsel, I can make a record.

MR. CABALLERO: Sure.

THE COURT: The witness is referring to Mr.

Gonzalez, seated about eight to ten feet directly in front of her.

Go on with your answer, please.

A And, (inaudible) to the side. But you couldn't see like where -- we're all seeing each other here. There was a wall in between.

Q When you heard Raphael scream, were you inside the bathroom?

A Yes. I was pouring the water.

Q And did you -- when you exit the door of the bathroom does this wall that you've described, did that interfere with your ability to see your child?

A I had to -- can't see just -- I had to walk the steps to be able to see.

Q Would it be correct to state that from the time that you heard Raphael scream to the time that you were actually able to see him on the floor in the kitchen, that there were at least a couple of seconds elapsed?

A I couldn't tell.

Q Would it be correct to state that you did not see Raphael hit his head on the kitchen floor?

A I didn't but my friend did.

Q And that is Ms. Garcés?

A Yes.

~~Q Where was she in the house when -- when Raphael fell?~~

A She was on the sofa.

Q And the sofa is located where?

A In the living room.

Q From the living room where she was seated on the sofa could you see the kitchen floor?

A Yes.

Q And at the time of Raphael's -- Raphael falling down was the father of -- strike that -- was Jose Arechiga present?

A --his son (inaudible) talking about? No.

Q Let me -- let me ask for clarification. When Raphael fell in December of 2002 and injured his leg, had Jose Arechiga arrived at -- was he already at the home?

A No. We were waiting for him to have supper.

Q And when you found Raphael in this condition was he crying?

A No.

Q What did you do after finding Raphael?

A I ran to pick him up. And to check see if something had happened to him.

Q And what -- what did you (inaudible)?

A I (inaudible) he had (inaudible).

Q And how could you notice that, (inaudible)?

A Because I could see it.

Q Was there a bump?

A Not a bump, but a scrape.

Q And where was the scrape located on his head?

A I don't know how to say words. If you want me to show you--

Q would you do that.

THE COURT: Just a moment. As she answered the witness pointed to the middle of the back of her skull.

A Around here. I don't remember exactly, but it was around here.

THE COURT: Again as she answered the witness pointed to a location on the middle of the back of her skull.

Q Did you seek medical attention -- strike that.
Was there anything else that you noticed about
the child's condition at that point in time?

A At that -- moment, (inaudible) I only noticed that.

Q And was there a point -- a later point in time that
you noticed any further concerns regarding the child's
physical condition?

A I had him in my arms, (inaudible) when I saw him there
I ran, picked him up and I had him -- I noticed that
he had that, and so I picked him up and had him in my
arms.

okay. And then for me to continue --
(inaudible) the kitchen as I tried to put him on the
floor because, well, I never -- never thought that
there was any fracture.

Q And, did you notice anything of concern regarding your
child when you put him on the floor?

A At first his leg, -- couldn't -- step on it, right,
and I check his leg.

Q And what did you observe?

A The first thing that I noticed that he -- he couldn't
place it on the floor firmly.

Q And then, then what else?

A And that it was -- little bit loose.

INTERPRETER: Excuse me, your Honor. The
interpreter just -- for the record, I don't know if
(inaudible) interpreted (inaudible) that she picked up
the child and that she didn't realize that there was a
fracture. Whether the interpreter mentioned that she
did, because he was not crying.

THE COURT: Thank you.

INTERPRETER: (Inaudible). Sorry.

Q What do you mean by his leg being loose?

A I don't understand.

Q Could you describe what -- what it was -- about the
leg that -- Could you describe what you were observing
in terms of the condition of the leg?

A Okay. That he couldn't place it firmly on the floor,
that he -- like the other leg.

Q Did you seek medical attention for your child?

A Of course.

Q And where did you go?

A To Quincy.

Q Who went to the Quincy -- when you say "Quincy," where
in Quincy?

A (Inaudible) Quincy.

Q And who went there with you?

A At that moment I called Jose -- work to come home. He
came home and Jose, myself, and -- (inaudible).

Q When Raphael was seen in Quincy by medical
professionals on December 7, 2002, in addition to the
injured leg did he have other injuries that you can
recall?

A Yes. (Inaudible) he had (inaudible).

Q What was -- what was that injury?

A He had -- himself on an iron chair, metal chair at the
laundromat.

Q And where was that injury located?

A At the same spot where I -- where I showed you before,
previously, and that's why it was -- (inaudible), and
back again for the second time (inaudible).

Q Would it be correct then to state that the fall on the
wet kitchen floor resulted in the child re-injuring a

prior head wound that he had received earlier at the laundromat?

A Yes.

Q How much earlier had the injury at the laundromat occurred?

A I don't remember exactly but it hadn't been that long.

Q Was it a matter of -- was it more than a week?

A I don't remember.

Q And could you describe what Raphael was doing when he injured himself at the laundromat?

A He wouldn't stop. He was playing around (inaudible) get out of the machines.

Q And what happened?

A He got under the chairs (inaudible) there's a row of chairs -- hard metal there at the laundromat. And he went -- gone under to look for the ball.

Q And what did he do?

A I heard -- well, because when he got under the chair -- (inaudible) get out and when he got his ball he -- the ball he tried to get up but he was under the chair.

Q And he hit himself on the chair?

A Yes.

Q And what type of injury did this cause on his head?

A ~~It split a little bit.~~

Q Did he bleed?

A A little bit.

Q And did you seek medical attention for that injury?

A No.

Q As of December 7, 2002, based upon your observation, and prior to Raphael falling on the kitchen floor, did it appear to you that that injury that he had suffered at the laundromat was healing?

A Yes.

Q On December 7, 2002 did Raphael also have some burns on one of his hands?

A He had one burn, not burns.

Q And where was that burn located?

A In his hand -- on his hand--

THE COURT: Just a moment.

For the record, as she answered the witness gestured to the back of her hand in the area of the axis of thumb and forefinger. She pointed to her left hand.

Q Ms. Gomez, was the burn to Raphael's hand on the left hand?

A I don't remember.

Q It could have been either?

A I don't remember which hand--.

Q And how did that burn on his hand occur?

A Okay. At that time we were all sick with the flu and cough. We had tonsillitis. And I couldn't get up to cook. And then my friend Lucinda Garces made a chicken soup with rice and vegetables and she took (inaudible) my illness. I got up (inaudible) plates to serve and the only one that was around there was Raphael because he was the only one that was not ill. I served the plates and I put them on the table. And Raphael -- one of the plates, that (inaudible) plate, and it fell on (inaudible).

Q The entire plate of soup then fell on one of his hands, correct?

A He pulled the plate and it -- fell over and the food

got on his hand.

Q This soup was very hot?

A Yes.

Q And what did you do when you -- when you realized that Raphael had burned himself with the soup?

A Remove him from there and cleaned up his hand, and I (inaudible) ointment on there because -- so many I always keep ointments and stuff for burns and cuts (inaudible) that ointment (inaudible).

Q Then you did not seek medical attention for that burn?

A No.

Q Do you recall being confronted by medical professionals at the Quincy clinic regarding a pinch mark on Raphael's ear?

A Yes. But I --- that was not a pinch mark. Because the only thing that the child had prior to that (inaudible) injured his leg was that injury (inaudible).

Q Is it your understanding that due to Raphael's slipping on your kitchen floor that he actually broke his leg?

A Yeah, I imagine so. Because he was running around (inaudible) fine, and then after he fell then he couldn't -- okay. Yeah. He fell, and then when I tried to stand him up I noticed that (inaudible) be firm.

Q At the time of the December 2002 injury to his leg did Department social worker Linda Turcotte investigate the injury?

A Yes.

THE COURT: Excuse me, counsel. Let's recess until 11:00.
Recess

MR. CABALLERO: And Dr. Verhage, can you hear me?

THE WITNESS: Yes.

MR. CABALLERO: Your Honor, I have Dr. Larry Verhage on the phone. He -- I scheduled him to testify at 11:00. And I would like to take his testimony out of turn at this point.

THE COURT: Any objection, Mr. Anderson, to interrupting the testimony of Ms. Gomez?

MR. ANDERSON: No, your Honor.

THE COURT: Mr. Moser?

MR. MOSER: No, your Honor.

THE COURT: Dr. Verhage, this is Judge Sperline.

THE WITNESS: Yes.

THE COURT: We are proceeding with the use of a language interpreter--

THE WITNESS: Okay.

THE COURT: So it's necessary that after a question you pause momentarily to allow the question to be interpreted, and then similarly after your answer there'll be a pause.

Also, if your answer is going to be longer than a single phrase or two you need to break it up into shorter portions so that it can be interpreted.

THE WITNESS: Understood.

THE COURT: Do you solemnly affirm that the testimony you give in this matter will be the truth under penalty of perjury?

THE WITNESS: I do.

MR. CABALLERO: And, your Honor, may I approach the phone?

THE COURT: Yes.

MR. CABALLERO: Thank you.

DIRECT EXAMINATION

BY MR. CABALLERO:

Q Dr. Verhage, this is Tom Caballero with the attorney general's office. Good morning.

A Good morning.

Q I'm going to identify who's present in court. Judge Evan Sperline is presiding. Terry Cullen is the guardian ad litem. Tamara Cardwell is a guardian ad litem program administrator. Mario Gonzales is present; he's the agency social worker. The mother, Maribelle Gomez is present with her attorney Doug Anderson. The father, Jose Arechiga, is present with his attorney Robert Moser. And there is a interpreter as the court previously indicated, in addition to the court clerk and court personnel.

A Okay.

Q Dr. Verhage, would you please state your full name and spell your last name for the record.

A It's Larry William Verhage, V-e-r-h-a-g-e.

~~Q What is your professional occupation?~~

A Family practice physician.

Q And what is your business address?

A 605 Coolidge, Moses Lake, Washington, 98837.

Q Are you licensed to practice medicine in the state of Washington?

A Yes.

Q And when were you licensed?

A 1997.

Q Would you describe your pre-medical and medical training, starting with your undergraduate studies?

A I got my bachelor of arts at Trinity Christian College in Palos Heights, Illinois. I then did my medical school at the University of Illinois at Chicago, and I did my family practice residency at the University of Iowa program in Waterloo, Iowa, and did a fellowship in obstetrics in -- at the University of Mississippi.

Q Are you board certified in any area?

A In family medicine.

Q And what does it mean to be board certified?

A It requires that you complete approved residency program which last three years, and that you pass board certification testing and continue to keep your continuing medical education up to date with recertifications every seven years.

Q Is board certification something above and beyond the license to practice medicine?

A Yes.

Q As part of your licensure are you required to complete continuing education?

A Yes.

Q Do you belong to any medical associations?

A The American Academy of Family Medicine.

Q And would you briefly describe what your medical practice consists of?

A We do -- I do general family medicine, with an emphasis on obstetrical care.

Q Are you familiar with Maribelle Gomez?

A Yes, I am.

Q And what about -- were you familiar with Raphael Gomez?

A Yes.

Q And how are you familiar with Maribelle Gomez and -- how are you familiar with Maribelle Gomez and her child Raphael Gomez?

A Maribelle has been a patient at our clinic for her last two pregnancies, one of which was Raphael Gomez.

Q And was the other one involving Edgar Arechiga?

A Yes.

Q Do you recall having occasion in December of 2002 to see Raphael Gomez?

A Yes, I do.

Q And when did that visit occur?

A It occurred on the 20th of December 2002.

Q What was the purpose of that visit?

A It was a visit to follow up a hospitalization and care that was given in Wenatchee, Washington for which the patient had been treated for multiple -- bruises and a femur fracture.

Q And the femur fracture, do you recall, was that of the left extremity?

A Yes.

Q And was surgery performed to repair that femur fracture?

A Yes.

Q And who performed that surgery?

A Dr. Brownlee.

Q Is he an orthopedic surgeon?

A Yes.

Q On December 20, 2002 as part of the visit did you examine the child?

A Yes.

Q And what was the child's condition on December 20th, 2002?

A The patient's condition was that he had -- was in a case for a left femur fracture -- This was a cast that went up to the abdomen. He also had burns of the hand that I noted, and an area in the -- on the back of the head that had abrasions as well.

Q Was it your understanding that the abrasion to the back of the head had been previously infected?

A I am not aware specifically of that.

Q And could you describe what hand the child had burns on?

A Both hands had burns on them. And was on the palmar aspect.

Q What does the palmar aspect mean?

A The contact point of the hand, not the back of the hand.

Q Given the child's medical condition as you examined him on December 20, 2002, were you concerned regarding the etiology of the multiple injuries?

A Yes.

Q And what was your concern?

A My concern was that with this injury, the burns and the injury to the scalp on the back of the head, that there was concern about the home environment that abuse might have been the etiology.

Q Do you recall--

MR. ANDERSON: Your Honor, I'm going to have to object to the last statement of the witness. I just want to make it clear that he's not testifying as an

expert -- concludes that maybe there was some abuse going on at home. I think that area's squarely outside of his expertise, (inaudible).

THE COURT: The objection is noted and overruled. The witness testified only to what his concern was at that time.

Q As part of your follow-up in the care of Raphael Gomez, did you seek a neurological consult with Dr. Richard Dixon in January of 2003?

A Yes, I did.

Q And is Dr. Dixon a neurologist?

A Yes.

Q Why did you request the neurological consult?

A Due to the hospitalization that Raphael Gomez had for his femur fracture and due to reading through the discharge summary that Dr. Brownlee -- did as well as Dr. Cook, I felt it was important to determine a baseline for this child after these incidents had happened, to know whether there was any neurologic problem with the child, and to confirm whether or not the child was doing well or not.

Q Did you receive a report from Dr. Richard Dixon regarding the neurological consult?

A Yes, I did.

Q ~~And do physicians typically rely upon reports from other physicians pertaining to a patient when formulating their opinions about the patient's medical condition?~~

A Yes, they do.

Q And do you as a physician typically rely upon such reports from other physicians pertaining to your patients when formulating your opinions regarding your patients's medical condition?

A Yes. I do.

Q What were the findings of then neurological examination performed by Dr. Dixon?

A Briefly in a sentence, he reflected that Raphael presents with what appears to be a fairly normal neurologic exam today, for an infant that was 17 months old at the time of that exam.

Q Were there any findings by Dr. Dixon that would have suggested any abnormalities of the central or peripheral nervous system?

A No. He said "seems to have a normally developing central nervous system by history, and physical examination; no ongoing neurologic problems."

Q Was a pinprick test conducted on the -- on Raphael's finger?

A Let me consult my records.

Yes.

Q And, what were the -- why is a pinprick test given as part of a neurological examination?

A To determine correct functioning of the sensory endings in the finger.

Q And what was Raphael's response upon medical finding -- his response to a -- to the pinprick test?

A He withdrew his hand.

Q Is that a normal response?

A Yes.

Q Okay. Was Raphael's response to the pinprick test indicative of his ability to feel pain?

A Yes.

MR. CABALLERO: I don't have further questions.

Thank you, Dr. Verhage. The other attorneys may have questions.

THE COURT: Cross examination, Mr. Anderson?

MR. ANDERSON: Thank you, your Honor.

CROSS EXAMINATION

BY MR. ANDERSON:

Q Good morning, Dr. Verhage.

A Good morning.

Q Do you know, is Dr. Dixon, is he a pediatric neurologist?

A I do not believe he is pediatric neurology; he is a general neurologist.

Q Okay.

MR. ANDERSON: Thank you. I think that's the only question that I had.

THE COURT: Cross examination, Mr. Moser?

CROSS EXAMINATION

BY MR. MOSER:

Q Dr. Verhage, were you the primary physician or -- for Maribelle in the birth of Raphael, and Edgar?

A I was the primary physician for Maribelle during both pregnancies.

Q And was Raphael born with a condition? Was he addicted to cocaine at birth?

A Raphael was -- exposed to cocaine intra-uterine, and did have some withdrawal features. "Addicted" is a different term.

Q Okay. I'm not a doctor, so--

A No, no; I understand.

Q I use a lot of inaccurate questions.

What -- And, what effects -- what effects were there of that condition on him?

A The immediate effects of withdrawal from exposure to drug after delivery is usually an increased jitteriness, and often times all it requires is monitoring a child for a little longer period of time than you would a normal newborn. And subsequently then neurologic exam can be completely normal.

Q Does it -- would it cause a child to be hyperactive in infancy?

A Yes. That agitation can go beyond the first several days of life and can be a more long-term problem.

Q And like I said, I'm not -- not too sophisticated on everything you've already testified to, but when you said his neurological exam was completely normal, are you saying that there were no signs of this influence of cocaine on him?

A At the time of his examination at 17 months with Dr. Dixon he for all intents appeared to be a normal child neurologically.

Q Had you had a chance to see Raphael between -- between the 17 months and the time he was born?

A Yes.

Q How many times have you seen him?

A I couldn't tell you the exact number of dates that we saw him, but we did see him for routine well child checks, which would have been at two, four, six, nine, twelve months, and again another one at 15 months. We saw him for another fracture earlier, and some intermittent acute visits for infections, colds, et cetera.

Q During any of these other visits, you indicated the routine visits, did you observe injuries, any injuries to Raphael during that time?

A Yes. There was a visit on October 21st, 2002, at which time we saw him to have his cast removed due to a right distal tibia fracture, a break in the lower leg on the bone called the tibia.

Q Now, were you able to determine that any of these injuries were non-accidental?

THE COURT: Excuse me. What do you mean by "these injuries?"

Q Doctor, you've referred to -- to several injuries, and I would ask if you were able to determine if any of them that you've testified about, if you could determine if they were non-accidental.

A There are features about fractures that indicate an increased likelihood for non-accidental. Those are determinations that Dr. Brownlee, looking at fractures, is probably better suited to answer. We look at patterns. And -- But unless you're in the room when something occurs to a patient specifically, there's no way to say for sure. But we look at patterns and likelihood.

Q Okay. Okay. And I think you've indicated that maybe ~~this -- some of this might be outside your area, and I should probably wait for the doctor who specializes in fractures.~~

MR. MOSER: Okay. That's all the questions I have, your Honor.

THE COURT: Redirect?

MR. CABALLERO: No.

THE COURT: May this witness be excused?

MR. CABALLERO: Yes, your Honor.

MR. ANDERSON: No objection.

THE COURT: Does either parent wish to ask a question of this witness?

INTERPRETER: --question such as--.

THE COURT: Any questions from this witness as to -- strike that.

As I told you before, you have the right to be independently heard. If you believe that some additional questions should be asked of Dr. Verhage, you can do that.

I'm not -- Just a moment.

I'm not suggesting you should. I'm just giving you an opportunity.

MS. GOMEZ: I just want to ask one question.

THE COURT: I think you're going to have to come to the phone, Mr. Castillo.

MS. GOMEZ: I'm Maribelle Gomez. I have a question for you.

You saw some of my other children during consultation.

THE WITNESS: Yes.

MS. GOMEZ: Okay. Did you see any abuse in any of them?

THE WITNESS: By my recollection, not having the chart in front of me, no, I do not remember seeing any abuse.

MS. GOMEZ: Did you notice or see a continued the drugs or did you see something similar in Edgar's -- during Edgar's pregnancy as you saw it in Raphael's?

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THE WITNESS: I would say that I know we did urine drug screens, and I do not know the specific results of those drug screens; I have not reviewed the chart for that. But by my recollection that was not a significant problem during Edgar's -- pregnancy.

MS. GOMEZ: That was it. Thank you.

THE WITNESS: You bet.

THE COURT: Mr. Arechiga, you -- any questions? Anything further of this witness?

MR. CABALLERO: No, your Honor.

THE COURT: Thank you, Dr. Verhage. We'll terminate the call.

THE WITNESS: Thank you.

MR. ANDERSON: Thank you, Dr. Verhage.

MR. CABALLERO: And, your Honor, if we could continue with the testimony of Maribelle Gomez.

THE COURT: Please be seated.

DIRECT EXAMINATION

(continued)

BY MR. CABALLERO:

Q Ms. Gomez, when we left off with your testimony this morning you had indicated that there was a Child Protective Services investigation initiated by social worker Linda Turcotte following your son's leg injury in December, 2002, correct?

A Yes.

Q And as part of her investigation Ms. Turcotte interviewed you, correct?

A I don't remember.

Q Do you recall talking to either Ms. Turcotte or Mr. Murray Twelves regarding difficulties that you were seeing in Raphael's behaviors on or about December of 2002?

A Yes.

Q What types of behavioral problems were you seeing in Raphael?

A He couldn't stop eating. He couldn't be standing still anywhere; he would have to be running, jumping, doing things to himself, biting himself, injuring himself, pulling his hair. He would stick two fingers in his nostrils until he bled. And if we told him, "No," that's when he would throw himself. He would stick his fingers in his eyes and he would (inaudible) with them. And what he did all the time was hit himself also. If we didn't allow him to do what he wanted to he would kick himself, bite himself. And I don't -- it was -- I don't know, like -- was the defense if we didn't let him do what he wanted.

Q These behaviors that you were observing in Raphael, if we could talk them a little bit more specifically--

what do you mean by he would throw himself?

A --finished eating and he -- noticed that, you know, the food on the plate was finished off and he would throw himself.

Q How would he throw himself?

A Whichever way he (inaudible).

Q And these were behaviors that you were not seeing in your three older children, correct?

A Yes. And that's why I was worried, because I by myself had raised the other three children and I had never seen any similar behavior.

Q In regards to the behaviors that you were seeing in

Raphael, were you also concerned that he didn't seem to have a normal sense of pain?

A Yes.

Q And how would you observe that?

A Well, like I told you, when he broke his little leg, he wasn't crying.

Q What about eating his fecal matter? Did you ever observe him doing that?

A Yes. And I reported that, also.

Q Would you pick at the scabs on his hands?

A Yes.

Q Would you do that until he would bleed?

A Yes.

Q And what would he do with the scabs?

A He would eat them.

Q Would you try to -- what would you do to try to stop him from doing the scab eating behavior?

A No, I told him, "No," that that was (inaudible), and that that wasn't food.

Q When you say "fuchi," does that word mean in Spanish that something is gross?

INTERPRETER: Excuse me. The interpreter (inaudible).

A Yeah. It is "fuchi," and it like Americans say, you know, that's gross, dirty.

Q And when you would do that how would Raphael react to you?

A He would yell at me, pull my hair.

Q Would he hide to continue engaging in the scab-eating behavior?

A All the time.

Q Was that frustrating to you?

A It was very sad. And that's why I wanted help, because I didn't like seeing (inaudible).

Q When you say that you wanted help, are you talking about getting medical professionals involved to try to find out what was wrong with your child?

A Yes.

Q Is it correct to state that Raphael's behavior was causing stress in your life?

A I don't know. I had -- dedicated myself more to him than the other children, but I was never angry because of that.

Q Do you recall telling -- Did you tell Ms. Turcotte in December of 2002, as she was investigating the injury to your child's leg, that you were having feelings of stress due to Raphael's behavior?

A No.

Q Were you feeling anxious about Raphael's behaviors?

A Worried, worried all the time.

Q Were you worried that you would be blamed by the Department or others if Raphael accidentally hurt himself?

A That worried me some, but I was more worried about what might happen to the child -- Excuse me -- what could happen to the child.

Q Were you also worried about how Raphael's behaviors were affecting your other children?

A Yes.

Q And in what way was Raphael's behavior affecting your other children?

A Julianna -- she noticed that we gave -- we would give (Inaudible) whatever he wanted so that he wouldn't

throw himself. She wanted to do the same thing now.
I saw that my daughter Maria was having a lot
of stress, and the same for Julio.

Q Stress? What do you mean by that?

A Worry, (inaudible). She was always saying, "Mommy,
why was my little brother born that way? We're not
like that."

Q And this was Maria?

A Yes.

Q At the time that -- that Raphael injured his leg in
December of 2002 were you trying to get the Department
to investigate what effects, if any, your having
exposed Raphael to drugs in your womb, what effect
that could have had on his behaviors?

THE COURT: Excuse me. Rephrase, please.

MR. CABALLERO: Yes.

Q When you were talking to the social workers for the
Department, and asking them to help you with Raphael's
behaviors, were you trying to seek an understanding
about whether or not Raphael's exposure to drugs
prenatally could explain the misbehaviors that you
previously described?

A Yes.

Q And your -- what is your understanding of the
Department's response -- Specifically, what was Murray
Twelve's response to -- to your requests for help?

A He always told me that he was going to speak to his
supervisor.

Q As part of the Child Protective Services investigation
in December of 2002 was Raphael removed from your
care?

A Excuse me?

Q I'll repeat. Was Raphael -- Actually, I will
rephrase.

Was Raphael removed from your care as a parent
and placed into foster care in December of 2002?

A They removed him only two times.

Q Did the Department remove him when he broke his leg in
December of 2002?

A Oh. Yes.

Q And how long -- when was he -- was he returned back to
your care eventually?

A Yes.

Q Okay. And approximately when was Raphael returned to
your care?

A I don't remember exactly.

Q Was it several months later?

A It was 11 months.

Q And, once he was returned to your care, several months
after the December 2002 investigation, did he remain
in your home until his death in September of 2003?

A Until the 10th of September, not the 20th.

Q But he remained in your home until he died?

A Yes.

Q Did Raphael sustain an injury on September 9, 2003?

A Yes.

Q And would you explain for the court what occurred on
that day?

A Yes.

Q And what was it that happened?

A That day I was feeding him. I -- like I'm sitting
here now, and he was in front of me. And Edgar, the
smaller child, was to the side. And I started feeding

him, and everything was fine.

Q If I could stop you a moment. When you indicate that you were sitting what you were doing now, you were sitting on a chair?

A Yes.

Q And then Raphael was standing on the floor?

A Yes.

Q And was he standing close to or between your legs as you were feeding him?

A In front of me.

Q And then, Edgar was sitting where?

A No. He was standing by my side.

Q Okay. Please continue.

THE COURT: Excuse me. In what room of the house were you feeding Raphael?

THE WITNESS: In the kitchen.

THE COURT: Thank you.

A I served a plate of sopa--

INTERPRETER: Your Honor, sopa could be either a soup or a rice -- dry rice or something like that.

So, I don't know if it makes any difference whether it's a soup or maybe rice or something like that. But it's referred to as a "sopa," same thing; it could be -- it could be dry or it could be a liquid. So I

(inaudible).

THE COURT: Were you feeding Raphael dry food or liquid soup?

THE WITNESS: Okay. It was a soup -- It was -- You know, I do use sort of like vermicelli (inaudible), but this one does have liquid, so it is a soup with liquid, yes; pasta and liquid.

Q And how were -- how were you feeding him -- how were you feeding Raphael the soup?

A With a spoon.

Q And were you feeding both boys at the same time?

A Edgar was just in there. He wasn't really eating.

Q And the soup was contained in a bowl?

A Yes.

Q And what occurred next?

A Okay. I was feeding him, and when he saw that it had finished he threw himself, whole body, toward -- back. And even when he was laying there on the floor there he kept raising his head and hitting himself on the floor.

Q Now, did you stop him from doing that?

A Yes. I said, "(Inaudible), I'm going to feed you more; I'll give you more," because I knew that was -- his way of getting more.

Q When he threw himself back did he throw himself backwards?

A Yes.

Q And when he threw himself backwards did his -- did you notice whether or not his head hit the floor?

A Yes. He threw his whole body back.

Q What was the floor material? What was the floor made of?

A It's a hard, hard floor like the one that's in the waiting room out there.

Q Is it a linoleum?

A No.

Q Is it a cement?

A Yes. It's like cement. I don't -- I don't know exactly what it is because I don't know about

materials.

Q And -- but when he threw himself backward, hit himself on the hard floor, he continued to hit his head again against the floor, correct?

A Yes.

Q How many times did he hit his head against the floor?

A About three, four times. But -- (inaudible).

Q And what were you doing while he was hitting his head on the floor three or four times?

A Okay. I was trying to pick him up, and saying, "No, no," "that's an owee," and that I was going to give him more food.

Q Did he stop hitting his head at that point in time?

A Yes.

Q And the entire time that he was hitting his head on the floor he was lying on the floor on his back?

A How's that?

Q Was he laying down on the floor with his back to the floor?

A Yes.

Q And was he hitting, then, the back of his head -- I'm sorry for doing that -- was he then hitting the back of his head?

A Yes.

Q Approximately where on his head was he hitting himself?

A I couldn't tell you exactly because I was seeing him -- You know, I was seeing his front; I wasn't seeing the back of his head.

Q And what -- once he had stopped hitting himself on the head what did you do?

A I hugged him, I held him close to me, for him to calm down a little bit. I rubbed his little head. And I went to serve him more food, because I told him that I was going to give him more food.

Q When you were rubbing his head did you feel any lump?

A Yes.

Q And where was that bump?

A Back of his head.

Q Would you indicate where on the back of his head?

A Here. (Inaudible) but around here.

Q And would that be--

THE COURT: Excuse me. As she answered the witness hand gestured to the middle of the back of her head, perhaps slightly below the middle.

Q And what did you do once you got more food?

A I continued feeding him.

Q And what occurred next?

A When he saw again that the food was finishing off I gave him the last spoonful, because I was feeding him the soup with a spoon. I had just removed the spoon from his mouth and he threw himself again.

Q And when you say he threw himself again, how did he do that?

A The same.

Q The same as the time before?

A Yes.

Q Were you feeding him in the same manner?

A Yes.

Q And so this second time that you were feeding him, you were once again in the chair?

A Everything the same.

Q And he was standing in front of you?

And is that a yes?

A Yes.

Q And, -- did you make any attempt to -- to make the feeding environment safer for your child?

A I don't understand.

Q Did you think to -- Did you put a pillow for your child in case he threw himself -- back again?

A No.

Q Did -- did anything go through your head after the first time he threw himself back to try to prevent him from doing the same thing the second time you were feeding him?

A No, because with Raphael nothing worked any more.

THE COURT: We'll need to take the noon recess. You can step down, Ms. Gomez.

I understand we have arraignments at 1:00, here in this room. So will everyone involved in this case -- will everyone involved in this case be present outside but not come in until the arraignments are completed.

MR. ANDERSON: Your Honor, the parents do have one, I guess, concern. They are allowed one visit per week, (inaudible) Thursdays.

THE COURT: What do you mean, "up here?"

~~MR. ANDERSON: (Inaudible) secure facility, so~~
the Department has (inaudible) here -- 3:30. I guess they are asking the court's indulgence to perhaps cease -- (inaudible) hearing (inaudible) Thursday (inaudible) visit.

THE COURT: From the number of witnesses that you've indicated, I think we're going to be hard-pressed to complete this hearing in three trial days. For that reason I'm not inclined to terminate the hearing early, but certainly I would think that the timing of the visit could be modified to, say, 4:30, to allow the parents to have that visit completed. So I'll ask folks to work on that.

We'll be in recess until 1:00.

Recess

AFTERNOON SESSION
February 19, 2004

THE COURT: Good afternoon.

MR. CABALLERO: Are we back on the record?

THE COURT: We are. Resuming direct examination.

MR. CABALLERO: And at this point in time, your Honor, I have another medical witness that I need to take out of turn. That's Dr. Andrew -- who I scheduled to testify at 1:30.

THE COURT: Any objection?

MR. MOSER: No, your Honor.

MR. ANDERSON: No.

(Inaudible). MR. CABALLERO: It's actually Alexander

THE COURT: Would you step down. Thank you.

MS. GOMEZ: Uh-huh.

THE COURT: What's the name, again?

MR. CABALLERO: Alexander Brzezny, B-r-z-e-z-n-y--

THE COURT: Thank you--

MR. CABALLERO: --spell that (inaudible).

witness reached by phone

MR. CABALLERO: Dr. Brzezny, can you hear me?

THE WITNESS: Yes, I can hear you.

MR. CABALLERO: Okay. We are in open court in Grant County Superior Court Juvenile Division, doctor -- Judge Evan Sperline is presiding. And I would ask that he swear you in.

THE WITNESS: Good afternoon.

THE COURT: Hello. Sir, do you solemnly affirm that the testimony you give in this matter will be the truth under penalty of perjury?

THE WITNESS: Yes, I do.

THE COURT: Dr. Brzezny, we're using the services of an interpreter in this proceeding. Would you be sure to allow small pauses between question and answer.

THE WITNESS: I will. I will try to.

THE COURT: Thank you.

MR. CABALLERO: And, Dr. Brzezny, to identify the persons who are in court, Terry Cullen and Tamara Cardwell are here; they are with the guardian ad litem program. Mario Gonzalez is here; he is an agency social worker with the Department of Social and Health Services. Maribelle Gomez and Jose Arechiga are present, and their attorneys, Doug Anderson and Robert Moser, are present. And in addition there is a court clerk, the judge, myself, and there should be a juvenile court person coming in shortly.

And I'm going to start asking you questions.

THE WITNESS: Hello to them.

DIRECT EXAMINATION

BY MR. CABALLERO:

Q And, Doctor, would you please state your name and spell your last name for the record?

A Yes. My name is Alexander Brzezny. It's spelled B-r-z-e-z-n-y.

Q And, what is your professional occupation?

A I am a physician. I'm currently with Columbia Basin Hospital in Ephrata.

Q And what is your business address?

A We are at 200 Southeast Boulevard, Ephrata, Washington, 98823.

Q Are you licensed to practice medicine in the state of Washington?

A Yes, I am. I'm duly licensed by the Department of Health.

Q And what year were you licensed?

A I was first licensed in 2001.

Q Would you briefly describe your medical training?

A I have graduated from accredited medical school, that -- after that I spent two years as a visiting physician at University of Kansas. I have followed with three years of training in family medicine at the University of Texas. And additionally to that I have also completed the master's of public health program at University of Kansas, at January of 2004 -- Actually, that's December 2003.

I have a degree in medicine, a doctor of medicine or M.D. I'm also a master of public health, M.P.H.

Q Are you board certified in any area?

A I am board certified in family medicine.

Q As part of your licensure requirements are you required to complete continuing medical education?

A Yes, I am.

Q Do you belong to any medical associations?

A Yes, I do. I (inaudible) American Academy of Family Practice, and American Public Health Association.

Q Would you briefly describe your medical practice?

A I see patients at the clinic Monday through Friday. I also cover emergency room, predominantly one day a week and one weekend a month. Sometimes more than that.

Q On or about September 9, 2003 were you discharging your duties in the emergency room?

A Yes. At that time I was -- I completed my day in the clinic and I went to see a patient that I was attending to at the emergency room. And I believe that was in the p.m. hours, I believe, after 5:00, when I would usually go home if there was no patient, however at that time we had a patient in the emergency room, so I decided to see him there.

Q And on that day did you have occasion to provide medical services to the child Raphael Arechiga Gomez?

A Yes, I have.

Q And how did Raphael's medical needs come to your attention on September 9, 2003?

A I will try to speak slowly. I was attending to the patient I was mentioning, at a treatment room. That treatment room has two beds. The room is called a trauma room, where patients with higher degree of need are attended to. I was -- at one of the beds, and at that time a distraught nurse was carrying a child in her arms and sought my attention immediately, stating that the -- the child is not breathing. I placed the child on the room, in that -- on the bed in that trauma room, and I have immediately become -- began to attend to the patient, ceased attending to the patient that I was at that time attending to.

Q And at that point in time you directed your attention to the child Raphael Arechiga Gomez?

A 100 percent.

Q What was your understanding of the child's subjective condition when he first came to your attention?

A It was pretty obvious that the child had no signs of life at that time. The patient has no spontaneous respiration, and when we attempted to feel for the pulses no pulses were felt.

Q Was there any vomit present on or about the child's facial area?

A The very brief assessment that at that time -- just to maybe redirect your attention to the fact that at that time a physician is dealing with a patient that has no signs of life, predominant attention goes to, of course, trying to restoring that. But I do recall that the patient had at that time signs of the vomit at the mouth and also on his cheeks. I would say one of the cheeks for sure.

Q Were lifesaving efforts commenced immediately?

A Immediately after patient was ascertained as without any signs of life. We have began compressions, to his chest, and have first attempted to restore his respirations with providing oxygen and -- highly concentrated oxygen and air mixture through a hand-driven ventilation device.

Q Would that be a type of bag?

A Yes. The device is often referred to as ambu-bag, a-m-b-u, ambu-bag, which is a plastic self-retracting bag that allows a hand to squeeze the air out of the bag into the patient's mouth and lungs -- over a -- through a mask that's attached to patient's face.

Q Was -- were ventilation efforts eventually continued through intubation of the child?

A Yes. Immediately after we -- since we naturally didn't intubate immediately, in an effort not to delay any possible lifesaving effort, we soon after, within the first minute or two, were able to ascertain the necessary equipment, which is placed in the trauma room, I would say within several feet of each of the beds, so that so-called CPR cart was opened, pediatric intubation set was -- was made available to me, and we have proceeded with intubation as soon as we have all in place, I'll say within the first minute or two.

Q And where is the--

THE COURT: --pause--.

Q And where--

INTERPRETER: Excuse me. The word "intubation" is -- that -- Is the interpreter hearing correctly--

THE COURT: Yes.

INTERPRETER: "Intubation."

THE COURT: Inserting a tube.

INTERPRETER: Yeah. (Inaudible).

THE COURT: Mr. Castillo, is the witness's pace -- Are you able to do your work?

INTERPRETER: It's difficult. If he could slow down a little bit more.

THE COURT: All right. Dr. Brzezny, if you'd please slow down a little.

THE WITNESS: I will slow down. I apologize.

Q What -- where is this tube placed inside the child?

A The tube is placed directly to the trachea, which is the tube that connects the lungs with the mouth, in order for us to ventilate appropriately and to ventilate correctly. It is almost always necessary that such a tube be placed soon or -- soon as possible during the resuscitation efforts. We place the tube into the mouth and visualize placement of the tube through the throat, through the vocal chords, into the trachea, or windpipe, which is the -- which then would allow direct provision of the ventilation mixture into the lungs themselves.

Q And is the ambu-bag then attached to the tube?

A The only time the tube would function correctly would be with, yes, with attachment of such a -- of an ambu-bag to the tube, after which we continue to squeeze the bag, periodically or regularly, to provide the oxygen-air mixture into the lungs directly.

Q As part of the lifesaving efforts how do you go about measuring the child's electric activity or pulse?

A The priority of the resuscitation effort could be summarized into the three steps. Step A is to provide airways, and in this case we already saw some vomit on outside, and we felt that we of course needed immediately to intubate or put the tube into the windpipe, and that we have established an adequate airway.

B is breathing; it's the second step. That is to squeeze the ambu-bag regularly and provide for the

breathing.

C is circulation. And in order for us to see how well we are circulating we feel for pulses as we squeeze the heart, that is not beating spontaneously. We want to verify how the heart is going with a -- a so-called cardiac monitor, which is a device that has two electrodes that are placed at the chest, and they measure what the heart is doing at that time.

So we have, immediately after establishing A, airway, B, breathing, and circulation with the compressions of the heart, we have then of course applied the electrodes to see what the rhythm of the heart was in. As I was alluding at the beginning, we couldn't hear the heartbeat, we couldn't feel the pulse. But sometimes there still is heart activity. Based on that activity on the electric monitor -- In other words, looking how the electric charges in the heart look on the monitor -- we then determine what type of treatment needs to be administered to the patient.

Q And what was Raphael's condition as visualized on the monitor?

A Raphael's heart continued to have electric activity. However, that electric activity did not equal or did not provide enough squeezing force of the heart to feel the pulses or to maintain blood pressure. The activity is called -- or, the finding is called PEA, or pulseless electric activity. Speaks for itself. Pulseless, can't feel any pulses; but there's electric activity of the heart. So the heart still has some erratic, sometimes even regular activity.

I would compare this to maybe an engine that is still running but provides no power to the -- to the whole -- the whole car, and that in itself is faulty. And one would have to work for that. And in our area of expertise, having had a pulseless electric activity in this patient led us to directing our treatment towards making that activity more regular. And before that can happen continue the compression of the heart, because, again, that activity is considered insufficient for a functional human organism.

Q And is this pulseless electric activity condition in a child a reversible condition?

A It is usually a reversible condition. The pulseless electric activity, unless for example, (inaudible) where there is no activity whatsoever, indicates that our chances of improving patient's conditions are greater. Pulseless electric activity is common in conditions that -- that are resulting from, for example, low blood pressure, low temperature, possibly a drug overdose and several other conditions. At that time we didn't know which condition that was, but we knew that we had pulseless electric activity, thus we continued in our resuscitation effort.

Q And what was the next -- Actually, let me wait for the interpreter to finish.

What was the next step in the resuscitation efforts?

A The next step, as soon as we identified what was the cardiac activity -- And we are talking still first three or four minutes of the -- of the whole process, so we are very soon in the -- into the resuscitation effort -- we administered medications that are used

for pulseless electric activity. Since we are already providing respirations and airways, and we were breathing for the patient, we were squeezing the heart for the patient, the next effort is to use medications that could turn such pulseless electric activity in to pulseful electric activity, if you will.

We used medication called epinephrine, and administered that medication into the -- into the tube, since we at that time did not have intravenous access as this was obtained all simultaneously. It is appropriate to administer epinephrine into the tube while the intravenous access is being established.

Q Were you -- were you able to obtain intravenous access at a subsequent point in time?

A Within, I believe -- to the best of my recollection for the subsequent medication administration. We have administered epinephrine two more times. We had IV access and medication was administered into the vein. So I believe shortly after that first medication was administered into the tube.

Q Can you provide a time line -- at this point in time, when you're administering medication, how much time has elapsed since you began the lifesaving procedures?

A I'll maybe track back. I'll tell you that at the

time, as we have attended to the patient with 100 percent of the time; I believe we were told that the patient may have been (inaudible) already for eight minutes. That in itself was a negative prognostic value. Patient without resuscitation efforts for eight minutes is certainly in itself a gravely ill if not the deadly ill patient. At the same time the efforts have started and continued, and since we have seen pulseless electric activity we continued, I would estimate that the first epinephrine administration took place within approximately three to four minutes. I would say that the second and the third epinephrine administration took place three -- three to five minutes later. That's the recommended time when they should be administered, according to advanced cardiac life support and pediatric advanced life support manuals, and I am naturally certified by both.

I have followed, then, and I would say that -- I would say that probably -- for me to administer all three epinephrine medications plus one atropine, which was additional medication that was used, and a third medication called bicarbonate, I believe took place within 25 -- I'm sorry -- within about 18- to 20-minute span.

Q And why was the bicarbonate administered?

A Bicarbonate was administered as one of the last medications, just before or -- I'm sorry -- just around the time when we were actually successful in returning to pulseful electric activity, simply because the patient was deemed to have been down for eight minutes, which means the body was without adequate blood flow and perfusion into the tissue, which leads into condition called acidosis, meaning the flowing blood or the blood in their blood vessels is much more acid. One of the conditions that pulseless electric activity is caused by is indeed hyper-acidosis, or acidosis; you could say too much acid flowing into the -- flowing at the time in the blood vessels.

We administer bicarbonate in an effort to reverse that acidity. Bicarbonate is a functioning of a base for that acid; in other words, reversing the acidity to a point. And it's a, I would say, an effort that -- this was done in an effort to purely try everything that we haven't tried yet, because at that time we have been down for many minutes and still not being too successful.

Q In regards to your third administration of epinephrine, did I understand you correctly that following that third administration you were able to obtain a -- a spontaneous pulse from the child?

A It was again to my best recollection, and -- that after the third epinephrine administration, which I believe was followed shortly by the bicarbonate administration -- I believe those two orders were issued in close -- in close sequence -- but I believe more in response to the epinephrine we have seen return to now full pulse -- I'm sorry -- to full -- to full cardiac activity, that was verified by listening to the heart that now had heart sound, meaning that the blood flow was taking place, and also feeling for the pulses on the neck, carotid arteries, and in the groin, femoral arteries, or arteries of the legs, where we verified that the heart activity was now sufficient to actually give us a pulse.

We also verified that by checking patient's blood pressure, and blood pressure was at that time measurable, meaning the heart function has returned.

Q And what was the blood pressure?

A The blood pressure was in the range of 80 systolic over 40 diastolic, which means -- systolic is the blood pressure generated by the squeezing force of the heart; diastolic is the blood pressure when the heart is in so-called diastole, that is, not squeezing, resting blood pressure level. It is considered -- For this patient it would be considered still relatively low blood pressure.

Q Was it a blood pressure that the child was able to maintain through the -- through the beating of his heart?

A The blood pressure was maintained for, I would say, tens of minutes, maybe ten to 15 minutes. However, that blood pressure had not stayed. It began to again come down and decrease, which led us to introduction of a fourth medication that we at that time administered through a continuous dripping into the vein, medication called dopamine. That was used to maintain the blood pressure at that time.

Q Once you were able to obtain a pulse and verify blood pressure in the child, what does this mean in terms of the child's ability to survive the -- to be able to survive?

A I would say that you would probably be able to reproduce my answer from other physicians, and even though I am not an expert in forensic pathology or forensic medicine I will tell you that any patient that has not had resuscitation effort for eight minutes is seriously ill patient, and the prognosis for this -- for a patient like that is relatively poor. I am sure there are studies that one could review and see what survival rate like that is, but I do not believe it exceeds 20 percent of all patients

that present like that. Matter of fact, I think it's less.

At the same time, having had -- let's remember that the resuscitation effort continued for additional 20 minutes or so, after which we were able to have the heart back in rhythm. That suggests about 28 or 30 minutes -- 30-minute effort without normal heartbeat. In itself that again represents a somewhat, even though positive finding at the end, still continues to not change the prognosis from grave and rather unfavorable.

I have at that time had an opportunity to inform the parent that the prognosis continues to be critical and grave, at the same time next 24 hours would be when, shall we say, (inaudible) would be broken, and prognosis could be -- could be discussed in more detail.

Q Were arrangements made to transfer Raphael to Sacred Heart Hospital?

A Immediately after we have established a spontaneous heart rate -- And one would need to know that a patient would not be transferred to another facility while a resuscitation effort would be ongoing. We would only transfer a patient that has demonstrated at least a -- a least degree of -- of self-sustained heart and -- heart or breathing activity, in this case heart activity. And so immediately after we have established pulses, spontaneous heart activity and verified that by blood pressure, naturally we have immediately contacted MedStar, which is a company providing transportation via helicopter to a chosen facility. At that time this was a Sacred Heart intensive -- pediatric intensive care unit.

Q And do you recall approximately at what time the child was handed over to MedStar for transport to Sacred Heart Hospital?

A I do not have that for sure, but I will tell you that they were within a 30-minute range. I believe the child has spent total of about -- best of my recollection about an hour or maybe hour and some in our facility, and then was transferred. Transfer would take approximately 45 minutes to Spokane, or less.

Q Okay.

A So, I'm estimating that at best child spent approximately hour, -- I'd say hour, 15 minutes, hour, 30 minutes, in our facility. And you subtract about 30 minutes of resuscitation effort, you will get about an hour after the resuscitation.

Q Were you able to conduct a urine drug screen?

A We were able to obtain a series of blood tests and also to obtain a urine test on the patient in order to help us verify what was his condition. And -- since I alluded to the fact that pulseless electric activity has as one of its condition drug overdose, we have conducted a drug screen and we have ascertained negative result from that.

Q And--

A Ruling out an overdose with a street drug or similar.

Q And were you -- did you obtain a chest x-rays of the child?

A Yes. In order to verify positioning of the -- of the chest tube -- I should say endotracheal or windpipe

tube that's placed into the windpipe to help breathing, we have obtained chest -- chest x-ray which was followed by a second x-ray, so total of two x-rays of the chest were obtained.

Q How -- how much force is applied to the child's chest when you are doing the compressions?

A The compression -- compressions are usually done by another member of a team, a resuscitation team. You would say that the compression -- is -- it's (inaudible) be as much as consistent about applying adequate force, frequently exceeding one to two inches in depth.

Q One to two inches in depth from the chest--

A From the chest against the surface, so squeezing the heart between the chest bone and the spinal column.

Q And would -- would those resuscitation efforts possibly result in bruising of the chest area, as the resuscitation efforts are ongoing?

A Yes. I would say that more often than not do resuscitation efforts result not only in bruising at the chest and possibly even heart or lungs, but sometimes even in fractures of the ribs at the front of the chest. Fracture meaning breaking the ribs at the front of the chest, simply as a result of the compressions. Especially if adequate.

MR. CABALLERO: I don't have further questions. The other attorneys may. Thank you, Dr. Brzezny.

THE WITNESS: Thank you.

THE COURT: Mr. Anderson, cross examination?

MR. ANDERSON: Thank you, your Honor.

CROSS EXAMINATION

BY MR. ANDERSON:

Q Good afternoon, Dr. Brzezny.

A Hello.

Q Your only -- your contact with Raphael Gomez was from when he was brought into the hospital emergency room until he was resuscitated and then medivaced out to Sacred Heart; is that correct?

A That's correct.

Q You've had no earlier contact with him?

A I was trying to remember, at that day, and even now I am trying to, and I can't recall that I've ever seen Raphael before, best of my recollection.

Q Okay. And you -- you had no contact with him after he was airlifted out to Sacred Heart?

A No, I have not.

MR. ANDERSON: Okay. Thank you. I have no further questions.

THE COURT: Mr. Moser, cross examination?

CROSS EXAMINATION

BY MR. MOSER:

Q Dr. Brzezny, were you able to form an opinion as to the cause of death?

A At the time when patient left the -- left the -- our facility, for all practical purposes he was alive.

Q Okay. Now, you indicated that he was not breathing when you first came into contact with him; is that right?

A True.

Q And what physical manifestations would that have that would show up in an autopsy?

A It is a question that you will need to clarify for me a little bit. You are asking for a autopsy finding in a individual that would not breath; that basically would be an autopsy finding in an individual that would be -- that would be dead, and that's -- you would find no unusual findings of not breathing on arrival.

Yet I will tell you that should the cause of not breathing be, for example, an aspiration, you would find that aspirate inside of the lung. In this case we knew that patient had -- some vomitus at the face. And that means that patient might have vomited prior to arrival to our facility, and that may mean that some of the vomitus would trickle down into the lungs, and that would then show on the autopsy finding, if that indeed was one of the possibilities. At the same time, I could not verify that aspiration took place other than having an x-ray that did identify a possibility of such a process in the left lung.

Q Okay. Okay. And as clear as my question was, you've made the best effort in answering. And that's -- this is what I'm trying to find out.

~~If a patient has -- or child has suffocated and~~
died due to that suffocation, or was -- was having substantial trouble breathing up until the time of death, how would that manifest itself?

A Here I will tell you that my information to you will be limited, and I would refer you to a forensic pathologist to help you there. At the same time, if a patient suffocates as a result of, say, obstruction in the throat or in the higher airways, you would probably see some effort at -- you would probably not find much in the lung -- in the lung histological sample, or on the autopsy sample from the lung. But you could find findings elsewhere, for example, in the retina of the -- of the eye, or blood vessels at the periphery of the hands. There could be a burst blood vessel from the effort to try to expire or exhale or cough it out. There might be little burst marks, which -- I will correct myself now. There could be little burst marks on the sides from the lung if that was a sole -- sole -- reason or sole cause for the -- for the -- for the actual -- the sole reason for the cardiopulmonary arrest.

At the same time, I would refer -- or maybe express a position that a simple choking -- Well, I will retract that. I -- I guess that's my best -- the best I can answer your question, unless you maybe clarify it a little better for me.

Q Okay. And I would like to let you know that, you know, we will be talking to forensic pathologist--

A Okay.

Q It's just that I'm trying to clarify from what we hear from them, what things they say could be due to -- to other causes--

A Okay.

Q And so, so I'm going to ask -- (inaudible) drag you through again, a child who's -- who had no blood pressure, who had no pulse, how would that -- And then died thereafter or shortly thereafter, how would that manifest itself physically in that -- in the decedent's body?

A You would find -- If you ask me whether I could find a -- whether a simple not breathing and not having heartbeat, without any other findings -- And I mean any other findings anywhere else -- whether I would identify the cause of death from just simply not breathing and not having heart activity, I guess if we did find anything else one would be looking for what else have we found. One would be interested in what does the heart tissue looks like; was there any heart disease, congenital heart disease. Was there any heart attack that happened around that time. Was there a pure hypoxia to the tissue that happened. And there again, the pathologist would have to help you in identifying what that hypoxia or lack of oxygen mean.

Is there any other findings anywhere else? Is there any evidence of trauma to the stomach? Has there been any bleeding inside of the cavities, be the skull or be it inside of the -- be it inside of the -- of the stomach cavity? Abdominal cavity. Because naturally there will be a cause for -- for what has happened, and if one identifies nothing anywhere else in any other tissue, no other evidence of any other trauma anywhere else, and one identifies a simple -- identified nothing inside of the lung tissue, one ~~could then say that nothing else has happened but,~~ for example, choking from -- And there there would probably be an evidence to that effect also (inaudible) from burst blood vessels--

Q --pause for a second, please, Doctor?

A Sorry.

Q --sorry.

THE COURT: I didn't mean to cut him off.

Dr. Brzezny, this is Judge Sperline. I want to try to help here a bit. Your answer is focusing on autopsy findings which might identify a cause for a failure of respiration or circulation. And counsel is asking you not what findings might help you identify a cause, but what findings might be the effects of a sustained period of loss of respiration. I think what he's asking is, would we see such things as cellular changes, burst vessels, or any other sign that would distinguish a person whose death was preceded by a substantial period of loss of respiration from a person whose death was not preceded by a substantial period of loss of respiration.

THE WITNESS: I'm sorry to say that I don't feel qualified to really answer that.

THE COURT: Thank you.

MR. MOSER: Okay. Thank you.

And thank you, your Honor. That was exactly what I was trying to ask. And thanks, Doctor, for -- being patient.

Q Dr. Brzezny, do you have experience that a person who has lost circulation does bruise more easily?

A You are -- you would say that if person has lost circulation for a prolonged period of time you would find something that could look like bruising, I guess, (inaudible) pooling at the back of the -- if the patient is laid on the back.

If you're referring to bruising as a result of some process in the blood stream, then you would say that any resuscitation effort, in a patient that is, like I was alluding to, critically ill, from either

what we were experiencing in the emergency room at that time or any other event, bruising conditions or lack of clotting conditions are common in patients that sustain burns, that sustain resuscitation, or any other trauma.

So, conditions of lack of clotting or increased bruising, or increased bleeding from the intravenous access, all these things are very possible in all resuscitation patients.

I will say that at the time when patient was in our emergency room we have not experienced that (inaudible) would be bruising -- bleeding from the intravenous access lines or elsewhere.

Q Are you saying then that you were not able to observe any particular bruising from this--

A No, I did not see any excess bruising, no.

MR. MOSER: Okay. Thank you. That's all I have.

MR. CABALLERO: No further questions.

THE COURT: Mr. Anderson, any follow-up?

MR. ANDERSON: No, your Honor.

THE COURT: Ms. Gomez, do you want to ask any questions directly of the doctor?

Mr. Arechiga?

All right. If you'll please approach the speaker phone with the interpreter.

MR. ARECHIGA: Doctor, my name is Jose Arechiga.

I want to know if when Raphael initially got to the hospital if he was bruised.

THE WITNESS: I'm sorry; I missed the end of your question.

MR. ARECHIGA: Was he -- Did he have bruises on his body?

THE WITNESS: I do not recall.

MR. ARECHIGA: Because the attorney here for CPS says that he had bruises.

MR. CABALLERO: I'm going to object--

THE COURT: That statement is stricken. This is limited to your questions to the witness.

MR. ARECHIGA: And the people from CPS said that he did have bruises?

THE COURT: That's not a question. That is stricken.

MR. ARECHIGA: Because they said my son had bruises.

THE COURT: Mr. Arechiga, you're making statements. Those aren't questions to this witness.

Do you have any other questions for Dr. Brzezny?

MR. ARECHIGA: No; that was my only question--

THE COURT: Thank you. Anything else, counsel?

MR. CABALLERO: Just one additional question.

THE COURT: Redirect?

REDIRECT EXAMINATION

BY MR. CABALLERO:

Q Dr. Brzezny--

A Yes.

Q When -- when you are undertaking resuscitation efforts of a lifeless, pulseless child, how much time are you spending in doing a thorough medical examination of the child?

A I'm sorry; who is asking?

Q I'm sorry. This is Tom Caballero, the attorney for the Department.

Did you understand the--

A Yes, I did understand the question.

The situation -- that the patient found himself in at that time was immediately life-threatening. It was documented by lack of respiration and lack of heart activity. It is only through absolute attention to airways, breathing, circulation and return to normal as soon as possible that we are able -- are ever able to make any difference in bringing patient back to life. That's why physician's attention at that extremely stressful moment in the patient's and the physician's and the team's life is directed towards airways, breathing and circulation. And whenever those are established, only then do we find ourselves to be able to do an exam and observation that we consider detailed.

I will tell you to best of my recollection I have -- Again, I'll maybe retract. And that's why, to answer your question, I feel that the only time you can make such a -- to make a determination and be able to answer some of your questions would be to have luxury of not having threat of airways, breathing and circulation. ~~And that's why I would feel that better to answer that question would be maybe even the receiving team on the -- after patient has been stabilized to the extent that he was able to survive a transportation, and then observed under less-stressful and unthreatening circumstances.~~

MR. CABALLERO: Thank you. You've answered my question, Doctor.

THE COURT: Mr. Anderson?

MR. ANDERSON: No other questions, your Honor.

THE COURT: Mr. Moser?

RE CROSS EXAMINATION

BY MR. MOSER:

Q Doctor, this is the attorney for the father again.

I just wanted to clarify your answer to Mr. Arechiga, that when the baby was brought in to you, you were not -- or, you did not observe any bruises to that baby?

A I do not recollect that I observed any distinct bruises that caught my attention at the time. When I was paying attention more to airways, breathing, circulation. I did then re-examine the patient when we were able then to have the heart -- the heart -- spontaneous heart, and we were more stable. I have consulted with the medical records and I have not found statements to that effect. And simply because I do not recall from there, and I did not find something to help me with that recollection, I had to answer I do not recall.

Q And that is -- that is -- As far as I know that's exactly what you testified to, is what you remember.

Did you notice any injuries to the back of the baby's head?

A I again have consulted with the medical record and have not at that time.

MR. MOSER: Okay. Thank you.

MR. CABALLERO: No redirect.

THE COURT: Does either parent wish to ask

further questions?

May this witness be excused?

MR. CABALLERO: Yes, your Honor.

MR. ANDERSON: No objection, your Honor.

THE COURT: Thank you, Dr. Brzezny. We'll end

the call.

THE WITNESS: Thank you.

witness to present before we continue with the
mother's testimony.

THE COURT: Any objection, counsel?

MR. ANDERSON: No.

THE COURT: Hello.

require an interpreter to testify.

THE COURT: Is -- is another interpreter

present?

Inaudible crosstalk

THE COURT: He can assist the witness. He's--.

If he's available.

THE WITNESS: I can speak English enough of --

(inaudible) nervous. (Inaudible) whatever, you know.

THE COURT: The record should reflect that Mr.

Arnold Garza has been requested to assist the witness.

Mr. Garza has previously been determined to be
qualified as a Spanish language interpreter. To the
best of my knowledge he is not as yet certified. No
other certified interpreter is available to the court
at this time.

Can we close the record for a moment, please.

Break in recording -

For the record I have reversed the position of
the interpreters. Mr. Castillo, who is a certified
interpreter, will assist the witness. Mr. Garza, who
is a qualified interpreter, will assist parents.

Please raise your right hand.

Do you solemnly affirm that the testimony you
give in this matter will be the truth under penalty of
perjury?

THE WITNESS: Yes.

to my entire question--

THE WITNESS: Okay.

translated into Spanish, and then for you to answer in
Spanish, so that it can be translated--.

DIRECT EXAMINATION

BY MR. CABALLERO:

Q Would you please state your full name and spell your
name?

A Alicia C. Estrada--

INTERPRETER: A-l-i -- I can't spell it in
spanish.

Q Well, then, is it spelled "Alicia," A-l-i-c-i-a?

A Uh-huh.

Q And I would ask that you answer yes or no.

A Yes.

Q And is your last name Estrada, spelled E-s-t-r-a-d-a?

A Yes.

Q And--

THE COURT: I'm sorry. I've been clumsy about
this arrangement. Mr. Garza, I don't think it's

necessary for you to provide a second translation because Mr. Castillo is speaking the Spanish equivalents aloud. For that reason, if you would simply assist either of the parents if they want to communicate with their attorney while the process is taking place.

Q What city and state do you live in?

A Moses Lake, Washington.

Q Do you know Maribelle Gomez and Jose Arechiga?

A Yes. They are there.

Q And how is it that you know them?

A When I went to an alcoholic treatment in Moses Lake -- (inaudible) introduced (inaudible) and since I was ill she told me she was very good, she was very nice, and I was there with her in her home for a while.

Q Did you actually reside in the Gomez-Arechiga home for a period of time?

A Yes.

Q And approximately how long did you live with -- within the Gomez-Arechiga household?

A About two months or a month and a half. I don't remember exactly.

Q And do you recall what year you lived with the Gomez-Arechiga family?

A 2002.

Q Was Raphael Gomez residing in the home with Maribelle Gomez and Jose Arechiga?

A Yes.

Q At the time that you were living with Ms. Gomez and Mr. Arechiga were you friends with Maribelle Gomez?

A Yes.

Q During the -- during the period of time -- strike that.

Were you able to observe the interactions between Maribelle Gomez and Raphael Gomez in the home?

A Yes.

Q And, were there any behaviors by Ms. Gomez towards Raphael Gomez that caused you concern?

A Yes.

Q What was it that you observed?

A Well, (inaudible).

Q Did you -- were you ever in a position to observe Ms. Gomez disciplining her child through the use of corporal punishment?

A Yes.

Q Would you describe what it was that you observed?

A One time after (inaudible)--

THE COURT: Pause--

A --after--

INTERPRETER: May I have that repeated?

THE COURT: Please repeat.

A After he left for work the child would cry. And she would -- throw him -- with -- from this height, like this, here, would throw him with her leg -- with her foot, from like -- from here to there where they parked the truck.

Q Was the child on the ground?

A And there was a bicycle there, and that day I wanted to pick him up and she didn't want--.

Q And what, when you were testifying you were indicating a movement with your foot. Was that a kicking movement?

A Yes--

THE COURT: Wait.

A Yes.

Q And how -- when you observed the mother kicking Raphael Gomez, how would Raphael react?

A He was crying, but -- rocks in his mouth.

Q Was this inside or outside the house.

A I'm sorry.

Q What about spankings? Were you -- were you ever in a position to observe the mother spank Raphael?

A Yes. Many times.

Q Was the father present when she would do this--

A No.

Q And let me remind you, let me ask you the question and he'll interpret it for you. Is that okay?

A Thank you. Yes.

Q Was there any situation that you observed where the mother would have hit the child in the facial area?

A One time--

Q And what did you observe?

A I saw that she hit him here -- kind of -- strong.

THE COURT: AS the witness answered she gestured to her left cheek.

Q Did -- did the mother on that occasion hit the child on the cheek area?

A Yes.

Q And how did Raphael react to that?

A He cried a lot.

Q What was it that Raphael was doing when you saw the -- did you see what Raphael was doing when the mom slapped the child?

A He wanted to eat what we ate and he wanted to play with the other children and she wouldn't let him.

Q On the particular day that she hit him on the -- on the cheek, what was it that Raphael was doing -- prior to being slapped?

A We were sitting on the sofa. We were eating grapes, and like -- you know, all the -- like usual, the kids (inaudible), "Aha, you want some grape," and well, for me, kids are everything, you know, and I wanted to give him some, but she -- Okay. And you know, that -- told me not to do it, that she wanted to do it her way, that he was too disciplined--

Or, what--

--Cause they were too -- he was too different, with the other mother that they have now -- foster--

INTERPRETER: I don't know what you call it. I don't know how to say it.

Q Was that more disciplined when the child was with the foster parent?

A Okay. No, that -- that she -- that he was -- used to doing it -- she wanted to do it her way, that he was used to doing it -- getting -- his way, that -- wanted to do it the way--

INTERPRETER: I'm sorry--

Q Let me ask a question.

THE COURT: Pardon me. Ms. Estrada, answer in short phrases.

THE WITNESS: Okay.

THE COURT: Make sure you finish your answer,--

THE WITNESS: Okay.

THE COURT: --but do it in pieces.

THE WITNESS: Okay.

Q And, when -- when the mother was indicating that she

wanted to do things her way, was it in comparison to what the mother saw in the child because of the foster parents way of doing things?

MR. ANDERSON: Your Honor, I'm going to have to--

THE COURT: Sustained.

MR. CABALLERO: Let me rephrase.

Q Did the mother at any point in time express dissatisfaction to you about the child being spoiled by the foster parents?

A Yes. That was it.

Q In regards to the slap in the face that you observed, you were indicating that there were some grapes that were being shared. And what was it that occurred with Raphael that led the mom to slap him in the face?

A Okay. That -- that not -- we were eating, that he not be eating with us; that he would have his time when it was his meal time to eat then and not for him to be eating all the time.

Q And on that occasion what was it that led the mom -- what was Raphael doing that the mom then ended up slapping him?

A Just because he cried because he wanted.

Q He wanted what?

A Grape.

Q What about any type of behavior by the mother -- Strike that. (Inaudible).

Did you ever observe the mother spray the child with water?

A Yes.

Q Would you describe what it was that you observed in that regard?

A (Inaudible), you know, all the time when the -- Mr. left work, you know, the child would cry. And so that he would try to get him and then put him in the sink and for him to stop crying she would -- put him in the sink and pour cold water on.

Q And where would she pour cold water on?

A From the sink there on his back, and then would bathe him all.

Q Did you ever observe any behavior from Mr. Jose Arechiga that would cause you concern about Raphael?

A He was never bad toward him. He (inaudible) a lot because she (inaudible).

Q Did Ms. Gomez exhibit these corporal punishment behaviors towards her other children?

A Yes, but not -- the same as towards Raphael.

Q And, you indicated that you lived in the Arechiga-Gomez home for approximately a month to a month and a half--

THE COURT: She testified a month and a half to two months--

Q Why did you -- So, what -- Let's strike the question. Why did you leave the Gomez-Arechiga home after -- after living there for a month and a half to two months?

A Because a lot of people go and visit them, for example, the social workers, and I told one, I told another one -- and she found out that I had told them that so she sort of ran me off and at the same time I left on my own because I could see that their -- the faces they were making.

Q And when you say that they were making faces, who were

making the faces?

A Well, see, they didn't treat me the same as when I got there, you know.

Q And they being Maribelle Gomez and Jose Arechiga?

A Just him. He never got involved in anything.

Q Just him or just her?

INTERPRETER: Oh. Excuse me. The interpreter said--.

A Just her. I mean, he never got involved in anything.

INTERPRETER: Sorry. The interpreter must have misinterpreted.

Q Did--

MR. CABALLERO: Or I may have mis-heard it.

Q Did you -- did Ms. Gomez ever tell you that she had found out that you had told social workers about her behavior?

A Well, more or less, yes.

Q What do you mean, "more or less?"

A She was -- she told me that I was a gossip.

MR. CABALLERO: I don't have further questions. The other attorneys will have questions.

THE COURT: Cross examination, Mr. Anderson?

MR. ANDERSON: Thank you, your Honor.

CROSS EXAMINATION

BY MR. ANDERSON:

Q Ms. Estrada, you spoke about a time when you saw Maribelle Gomez -- she kicked Raphael -- threw him with her foot, I think you actually said. Do you recall what incident we're talking about?

A Yes.

Q Do you remember when this was? Was this towards the beginning of your stay with them? Towards the middle? Towards the end?

A At the beginning (inaudible).

Q All right. Did you tell any of the social workers that came over -- about that particular incident?

A Not -- not in those days, no.

Q Okay. So you didn't say anything about that particular incident?

A Not until after I left, and -- after I left (inaudible).

Q Was there a reason why you didn't say anything about it earlier?

A Okay. Because one day Olga went (inaudible) told her that there was mark, that she had slapped him, and she said that -- it was nothing, that it was nothing. They never believed anything.

Q Okay.

A Believed of me anything -- of me.

Q When you did tell somebody about that incident, do you recall who you spoke with?

A Yes.

Q And who as that?

A With Olga. With Dave, the social worker, welfare.

With -- (inaudible) -- Okay. With people -- Dave gave me a whole bunch of phone numbers, and I called over there, and -- to them and they said, you know, "Make arrangements" -- "She's got her social worker over there; you take it up with her social worker over there." They -- (inaudible).

Q Okay. Was this before you left their home, or after you left their home?

A Before.

Q Okay. You stated that -- towards the end there you thought that they were getting angry at you, because you were talking with the social workers.

A Yes.

Q So you just decided to leave at that time?

A Yes.

Q So it's your testimony that they -- that they did not ask you to leave, that you left on your own?

A Yes.

Q And, where did you go after you left them, (inaudible)? Where did you go after you left their home?

A With a friend, Anna. She lived on Cascade.

Q Is that in Moses Lake?

A Yes.

Q Okay. (Inaudible) trying to get an idea of -- of what you said to the social worker, social workers, and what they -- what their response was. You had testified already that you told Olga about a mark that he, that Raphael had on his face, and she said, "Don't worry about it."

A Yes.

Q You also said that you called somebody about the -- the time that Maribelle threw Raphael with her foot--

A Yes.

Q --and they told you just to talk with her social worker, who was Olga, correct?

A Yes.

Q And, what was her response to that?

A Nothing.

Q Did she ever have any -- any other responses to your concerns that you raised other than to say, "Don't worry about it?"

A That she told me? Or--

Q Yes.

A --me, myself? Or--

Q When you came to her with your concerns, did she ever take any other attitude besides, "Oh, don't worry about that?"

A Would she always say the same thing, said, "Don't worry; the child (inaudible)."

Q Okay. I think you may have answered this question but I'm not sure (inaudible) full answer. You -- you (inaudible) Maribelle (inaudible) about one and a half or two months, some time in 2002. Do you recall when in 2002 was it? (Inaudible)? Summer? Spring?

A June or July. It was after my surgeries.

MR. ANDERSON: Thank you. I don't think I have any more questions at this point.

THE COURT: Ms. Gomez, I think I made a mistake earlier in inviting you to ask questions of witnesses directly.

Break in recording

THE COURT: You have the right to address the court, but probably not the right to ask questions of witnesses. So if you have any other questions that you want to ask, will you let Mr. Anderson know?

THE WITNESS: Can I include something?

THE COURT: Just a moment.

MR. ANDERSON: Your Honor, (inaudible) questions.

THE COURT: Thank you. Mr. Moser, cross

examination?

MR. MOSER: (Inaudible).

THE COURT: After Mr. Moser finishes, then if you have any other questions that you want him to ask, let Mr. Moser know.

CROSS EXAMINATION

BY MR. MOSER:

Q Ms. Estrada, do you have any children?

A Three.

Q How old are they?

A I have one that's 28, one that's 29, one -- I don't know. One's from '73, '72 and '86.

Q Do they have children?

A No.

Q Do you have contact with any state agencies?

A No.

Q Do you receive welfare?

MR. CABALLERO: Objection. Relevance.

THE COURT: Relevance?

MR. MOSER: Relevance, your Honor -- Actually let me -- why don't I go ahead and ask that after I ask a question or two.

THE COURT: The question is withdrawn.

Q Have you ever had any contact with Child Protective Services?

A What part? From mine, or their part? Or--

Q Yes, for your part.

A Yes.

Q What kind of contact?

A Tell him I don't want to answer that because it's no relevancy. I don't want them to -- interrogate me--

MR. CABALLERO: Your Honor, I -- I'm also going to object to that question as to relevancy -- focuses on (inaudible) Gomez-Arechiga family.

THE COURT: What's the relevance?

MR. MOSER: The relevance, your Honor, is that she's trying to cooperate as much as possible with the state in hope that it -- that it will have some benefit to her.

THE COURT: You can inquire as to whether or not there's a current proceeding, but the details of that proceeding would be irrelevant.

Q Ms. Estrada, who asked you to testify here today?

A A -- I don't know what's his name--

MR. CABALLERO: --your Honor--

THE COURT: Just a moment. Answer if you can.

A I don't know (inaudible) asking him to--

THE COURT: Just a minute.

It's not a test. If you don't remember a name, or don't know, that's your answer. Don't ask someone else.

A Just the policeman went to my home. That's all -- and then he went and -- that's it.

Q Ms. Estrada, when you say "he," who do you mean? Mr. Gonzalez?

THE COURT: Yes or no.

A Yes.

THE COURT: Thank you.

Q Have you ever had any other contact with Mr. Gonzalez before -- before this case?

A No, I never had the pleasure.

Q And have you had contact with CPS in Moses Lake?

A No.
Q Ms. Estrada, why did you go live with Jose and Maribelle?
A (Inaudible), tell you the truth I don't even know myself after -- introduced us and said, you know, "Come and stay with us," (inaudible). I can sleep on the floor.
Q Ms. Estrada, did you have somewhere else to stay at that time?
A Yes.
Q Ms. Estrada, weren't you looking for somewhere to stay?
A No, because I was paying my rent.
Q Why would you go live with strangers if you could live at your own house?
A Maybe it was because God took me there to see how she treated the child. I don't know.
Q Where do you live right now?
A At 4278 Grape Drive.
Q Do you live with other people there?
A No.
Q How long have you lived there?
A Two years.
~~MR. MOSER: I'm going to go ahead and renew my question as to whether she receives welfare, and of course the prosecutor may object.~~
THE COURT: What's the relevance of it?
MR. MOSER: The relevance is that she has a motivation to ingratiate herself with state agencies.
THE COURT: Is there--
MR. CABALLERO: I'm going to object, because there's no--
THE COURT: Just a moment.
The objection is sustained.
Q Ms. Estrada, I think it's when Mr. Anderson was cross examining you, you testified -- what the interpreter said you said -- you testified "they never believed anything I said."
A No--
THE COURT: Just wait.
What is your question?
Q When you said "they never believed anything," do you mean CPS?
A Yes.
Q How many times did you report injuries to CPS?
A Many times.
Q Ms. Estrada, you testified that Maribelle told you -- told you you were a gossip?
A Yes.
Q Has anyone else ever called you a gossip?
question. It's irrelevant.
MR. CABALLERO: Object to the form of the question. It's irrelevant.
THE COURT: Sustained.
MR. MOSER: All right. I don't have any more questions, your Honor.
THE COURT: Mr. Arechiga, is there -- do you want any further questions of this witness?
MR. ARECHIGA: Okay. (Inaudible)--
THE COURT: Tell Mr. Moser.
Inaudible crosstalk
Q Ms. Estrada, did you ever bring alcohol to the house of Maribelle and Jose?
A Yes, because she asked me to.

Q When you say that Maribelle ran you off, what do you mean by that?

A I didn't say that she ran me off.

Q You're right; you didn't say she ran you off. What you said was that she kind of at the same time she ran you off you were deciding maybe you would leave at that time, and (inaudible) happened at the same time.

A Yes.

Q Now, what do you mean by that?

A Because I couldn't bear the treatment that she was giving her child. And him also; she treated him badly also.

Q Ms. Estrada, what do you mean when you say that Maribelle took actions to try to get you out of her house?

MR. CABALLERO: I'm going to object to the form of the question. I believe that her -- it misrepresents her testimony. Her testimony was that the mother was giving faces to her and that -- and that more or less she took it that she didn't want her be around, not that there were actions taken.

MR. MOSER: That was--

THE COURT: Your objection goes to the weight. This is cross. It's appropriate.

Can you answer the question?

THE WITNESS: Could you make the question again, please?

Q What actions did Maribelle take to pressure you to leave the house?

A She called Olga and told her that I had an arrest warrant and that I couldn't be in her home.

Q Isn't it true that it was Jose who was pressuring you to leave the house?

A No. No.

Q You never felt that Jose took any actions to attempt to get you to leave?

A No.

Q Ms. Estrada, were you talking to the neighbors about what was going on inside of the house of Maribelle and Jose?

A No.

MR. MOSER: Okay. No more questions, your Honor.

THE COURT: Before I call on counsel for any other questions, I have a few questions for you, Ms. Estrada.

INTERROGATION

BY THE COURT:

Q Did you ever see Raphael throw a tantrum?

A No.

Q Did you ever see him hit himself?

A No.

Q Did you see him pull his own hair?

A No.

Q Did you ever see him pitch or throw himself against an object or on the floor?

A No. Never. I loved him a lot.

Q When you were living in the Gomez-Arechiga home were you working?

A No.

Q Did you spend your day generally in the home?

A Yes, all day.

Q Did you ever discuss with Mrs. Gomez your concerns about how she treated Raphael?

A Yes.

Q What did she say about that?

A They were (inaudible) her children and she (inaudible) them whichever way she wanted.

Q Can you tell me what you saw that led you to think Ms. Gomez treated Raphael different than the other children?

A Because she -- told me that she hated him, that she didn't know why she hated him so much.

Q Did you ever hear Ms. Gomez say such a thing to any of the other children?

A Just to the little one. I don't remember what the name is, the little one.

Q Girl?

A (Inaudible) really hit him hard on the head with the hair brush.

Q Who hit whom hard?

A Maribelle hit the little girl.

Q Did you see any difference in the way that Ms. Gomez treated the children comparing the time when Mr. Arechiga was away and the time when he was present in the home?

A Yes. She treated them differently, especially little Raphie. (Inaudible) outside -- it was different a lot of things. When he was there she was different with them. And then he would ask her, "why are you that way with my son," and (inaudible) get away, you know, leave, and (inaudible).

THE COURT: That's all the questions I have. Redirect or follow-up?

MR. CABALLERO: Not from the Department.

THE COURT: Mr. Anderson, on behalf of mother?

MR. ANDERSON: Yeah, I just have one follow-up.

RE-CROSS EXAMINATION

BY MR. ANDERSON:

Q When the -- when the judge was questioning you, you stated that Maribelle always said that she hated him, referring to Raphael, and she didn't know why she hated him so much. Do you ever recall her making any of those statements in front of anybody else, such as another neighbor, (inaudible)?

A No. No, because she was always telling the neighbors that the children were crying because they missed their dad, and it wasn't true; they were crying because she hit them.

Q Okay. Well, I -- That doesn't really answer my question. My question was, did she ever state that she hated any of her children in front of the neighbors?

A That I would have heard, no.

Q Okay. So she just said this to you when (inaudible) alone?

A No, she didn't tell me. She would tell the child.

MR. ANDERSON: Okay. Thank you. I have nothing further.

THE COURT: Recross, Mr. Moser?

MR. MOSER: No, your Honor.

THE COURT: If either parent has an additional question let your attorney know.

Just a moment.

Through your lawyer, please.

THE WITNESS: Could I say something?

THE COURT: No. It isn't necessary.

THE WITNESS: --something about -- and I'm
overhearing what they're saying--

THE COURT: Oh. But I'm not.

THE WITNESS: Okay. Thank you, Judge.

(Inaudible).

THE COURT: Anything else?

MR. MOSER: I just -- I just have -- I have one
question, your Honor.

THE COURT: Go ahead.

RE-CROSS EXAMINATION

BY MR. MOSER:

Q Mrs. Estrada, what did happen to your children? Or,
who did raise them?

MR. CABALLERO: Object -- Object, form of the
question. Relevance.

THE COURT: The question is compound. The
objection is sustained. You can restate.

MR. MOSER: Okay.

Q Mrs. Estrada, who raised your children?

A Me.

MR. CABALLERO: And, your Honor, objection
regarding the form of the question, and -- actually
not the form of the question; the relevancy of the
question.

THE COURT: Overruled. The witness has
answered. Her answer can remain.

Q Mrs. Estrada, did CPS ever take your kids away from
you?

MR. CABALLERO: Objection--

THE COURT: Stop. Stop.

MR. CABALLERO: Objection. Relevancy.

THE COURT: The objection is sustained.

MR. MOSER: Your Honor, for the record, the
relevance -- is that she has -- she's seeking an
object to deal with her own personal issues.

THE COURT: I've said before, you could ask her
if there is a presently pending case. But that's not
your question.

MR. MOSER: Okay. Thank you, your Honor.

No more questions.

THE COURT: Anything else? Mr. Caballero?

MR. CABALLERO: No, your Honor--

THE COURT: May this witness be excused?

MR. CABALLERO: Yes, your Honor.

MR. ANDERSON: Yes, your Honor.

THE WITNESS: Thank you.

THE COURT: Thank you--

THE WITNESS: Thank you, Judge.

THE COURT: You can step down--

THE WITNESS: Thank you.

THE COURT: You're free to stay or leave.

THE WITNESS: Thank you, Judge.

THE COURT: Let's take a brief recess until

3:30, please.

Recess

MR. CABALLERO: Your Honor, the Department's
next scheduled witness is Murray Twelves. He is
present in court and ready to testify. His testimony
should be fairly brief.

THE COURT: Any objection to further interrupting the testimony of Ms. Gomez?

MR. ANDERSON: No, your Honor.

MR. MOSER: No.

THE COURT: Mr. Twelves?

Do you solemnly affirm that the testimony you give in this matter will be the truth under penalty of perjury?

THE WITNESS: I do.

THE COURT: Please be seated.

DIRECT EXAMINATION

BY MR. CABALLERO:

Q Mr. Twelves, would you please state your full name for the record?

A Charles Murray Twelves.

Q And what is your occupation?

A I'm a Social Worker III for the Division of Children and Family Services.

Q And what is your business address?

A 1620 South Pioneer Way, Suite A, in Moses Lake.

Q What are your present duties as a social worker for the Department?

A I do intake where I receive reports of child abuse and neglect, requests for family reconciliation services, requests for placement, licensing complaints and licensing CPS.

Q Would you very briefly describe your education that's relevant to your role as a social worker?

A I have a bachelor of arts from the University of Washington. The equivalent of the academy was brand new when I started about 20 years ago, so I did that. And I also got the basic training that they had before that, that hadn't yet been phased out. I've had numerous trainings offered by the state over the last 20 years, both required and optional.

Q And have you been a social worker for the state for the last 20 years--

A Yes.

Q Prior to your current duties as an intake social worker, did you carry a case management type caseload with the Department?

A Yes. I had a CWS load for a year.

Q And during that year was the case of Raphael Gomez-Arechiga previously on your caseload?

A Yes.

Q Is Raphael Gomez a deceased child?

A Yes.

Q And what is your understanding as to when Raphael died?

A It was on September 10th, 2003.

Q Approximately when did you receive Raphael's case into your caseload?

A It's when I first went into CWS, would have been early September of 2002.

Q Who transferred the case to you?

A Olga Gaxiola.

Q And how do you spell Gaxiola for the record?

A G-a-x-i-o-l-a.

Q Where was Raphael placed when you received the case?

A He had been in in-home placement for three months.

Q Was -- was Ms. Gaxiola the social worker that was actively managing the case when Raphael was returned

to the family's care?

A Yes.

Q Would you -- To the best of your recollection would you please briefly describe the history of Raphael Gomez's placements during the period of time that you had the case?

A Like a chronology of them?

Q Yes.

A Okay. In September, shortly after the baby Edgar was born, Raphael had an accident when an uncle was watching him. He's reported to have fallen off a toy and got a fracture -- I think it was in the -- it was in the lower leg, anyway. And the physician who examined it -- or examined the medical records said that it was a -- a toddler's fracture. All of the children were removed from the home and Raphael and his siblings were returned home after five days.

December 7th I think is when the second incident took place, where he broke the femur of his other leg. And that resulted in four months of out-of-home placement -- Or, he went home around March 26th.

Q So he injured his femur in December of 2002?

A 2002, and went home the end of March 2003.

Q ~~During the periods of time that Raphael Gomez was in foster care, --~~ Strike the question.

Where was he placed when he wasn't in the parents' home?

A In foster care.

Q And during those periods of time that Raphael Gomez was in foster care was Raphael receiving routine medical care?

A Yes.

Q Was he also being -- was he also being followed from December of 2002 through March 25, 2003 for post-femur fracture repair?

A The foster parents kept all his medical appointments. I believe the parents went to some of those, also.

Q When you received the case from Ms. Gaxiola did you review the file?

A I didn't read through the whole file. I talked with Ms. Gaxiola and my supervisor and basically, if there was some doubt usually I talked with them about what had happened.

Q During the periods of -- of time that Raphael was in foster care placement did you receive any reports from medical providers or any referrant that Raphael had suffered any injuries?

A Well, of course we had the medical reports related to -- You mean, in addition to the injuries that caused the placements?

Q Let me rephrase the question. During the periods of foster care placement, while Raphael was in foster care--

A Uh-huh.

Q --did you receive any reports pertaining to injuries that would have been sustained while Raphie was in foster care?

A I didn't get any reports from doctors. The foster mother called once when he had fallen at church, and got a bruise on his head, I think.

Q Okay. And when was that, approximately?

A Approximately February.

Q February of--

A of 2003.

Q Do you recall receiving a phone call from Maribelle Gomez on September 9, 2003 regarding Raphael's physical condition?

A Yes.

Q And what is your recollection -- Strike that. what was the substance of your conversation with Ms. Gomez?

A She called shortly before five o'clock. She was--

Q When you say five o'clock, is that in the morning or in the afternoon?

A In the afternoon.

Q Please continue.

A She was -- was very upset, upset enough that I didn't recognize her voice and had some difficulty understanding her. And she said my name a couple times, and -- and I asked her what happened, and I didn't understand a word that she used at the time but she told me that he had thrown himself down. I didn't understand that he wasn't breathing but I understood that he wasn't conscious. And she said this happened while she was feeding him.

I asked her if she had any way to get him to the hospital immediately and she said she did. And I ~~felt that would be faster than calling 9-1-1, if she~~ did have somebody that would take them directly there. So she said she had somebody who would take them. And I said then -- "Then take him immediately." And the last thing she said was, "Don't take my child."

Q Was -- was the mother expressing concern to you regarding the possibility of being misunderstood at the hospital?

A Well, they'd had him taken away -- or, taken out of their care the last two hospitalizations, so, yes, I think -- at that time what was far more real to her was losing him to CPS than losing him to death.

Q Did she ask that you go with her to the hospital?

A Yes.

Q Do you recall what was the last statement that the mother made to you during the conversation?

A During that conversation?

Q Yes.

A "Don't take my child."

Q As part of your ongoing duties as a social worker were you able to observe the mother interacting with Raphael?

A Yes.

Q And what was -- what was your observations about her interactions with the child when you were watching?

A I thought her interaction was very appropriate. She seemed able to attend to all her children and whatever seemed to come up at once.

Q What type of settings were you able to observe the mother interacting with her children?

A Mainly in the family home. Possibly -- Well, I saw them first a couple times at the office but it was mostly in the family home.

Q Was she affectionate towards Raphael?

A Yes.

Q Did she appear loving towards the child?

A I thought so.

Q And, what about in regards to her other four children? Were you able to observe her level of affection for

those children?

A Yeah. I think she was affectionate with all of the children. She was -- was a person basically that made sure everything, you know, that needed to be done was done. So she was very attentive to their needs, and--. In whatever -- pretty much whatever she felt needed to be done she would do.

Q During the December 2002 removal of Raphael due to the femur fracture, did you have occasion to talk to Maribelle Gomez about how Raphael's repeated injuries were affecting her?

A I didn't ask her that.

Q Was she raising concerns with you regarding Raphael's behaviors?

A She did right about that time. She had called me, oh, a few days before that and said "Can you come over and see us soon;" I think it was like a Thursday or a Friday and I said, "Will it be soon enough if I come next week, early next week," and she said, "Yeah, that should be fine." So I was set to go the next week. And I -- And the injury took place in between when I would have gone and when she originally called.

She said afterwards that the reason she had called was that they were starting to observe unusual behaviors, that had them really concerned, that they couldn't really explain and they wanted help dealing with.

Q Did she explain to you what the behaviors that they were observing, what those were?

A That he would eat until he threw up if allowed to. She caught him one time eating his own feces.

Q Was she concerned about the child's high level of activity? (Inaudible)--

A I don't recall that it -- at that time.

Q Did that later become an issue?

A When he came -- It was more of an issue after he came back from foster care. He never seemed to quite fit in like he had before.

Q When he came back from foster care when?

A In March of 2003.

Q Did you explore what she meant by Raphael not fitting in as before?

A Oh, she didn't say that. That was more my observation, that he seems to be -- or, he seemed to be bonding and finding his place in the family at the time he was removed; when he came back he had much more difficulty settling in, back in, in that way.

Q How would Raphael demonstrate behaviorally this difficulty in fitting in?

A Some of it would be he was not used to having anyone in his face, so being back in a small home with all the people who were in that small apartment, and just the -- that the other children were used to being physically close to them if -- like his little sister got up really close to his face he would lash out at her aggressively.

Q What do you mean by that, lashing out aggressively?

A He'd hit her or pull her hair. I think he might have bitten. I know he bit his mother when she told him that he had -- that he had finished his meal.

Q Did you observe that, the hitting (inaudible)?

A No, I didn't see it myself.

Q Was that reported by -- who?

A That was reported by the parents. One time the little girl came up to tattle on him and told me that.

Q When you observed Raphael in the home, did you observe him throwing himself back onto the floor with force?

A I didn't actually see that.

Q Did you ever see him hitting himself?

A No.

Q What about pulling his own hair?

Is that a "no?"

A No. Correct.

Q In terms of your observations of Raphael's level of activity, when you were in the home observing what was his activity like?

A I didn't see that high a level of activity. My very presence there would change, often, the dynamic of what's going on, because everyone's behaving a little differently knowing there's an outsider.

Q Would Raphael be excited to see you?

A Not necessarily. I mean, sometimes he would seem -- you know, he would smile or something like that. And the other kids did, too. Sometimes he was in another room playing with the kids, (inaudible) talked to his mother. Sometimes he played with them all right, sometimes he didn't. And a lot of the behaviors that caused concern were around meal time.

Q Were you present during meal times?

A No.

Q And so, the--

A I think I was there once or twice when she was feeding him some cereal, or something.

Q And do you have a recollection as to how Raphael was behaving during those feedings?

A It wasn't unusual on those occasions.

Q Did you ever observe Raphael throw a temper tantrum around the mother?

A No, I didn't.

The home support specialist and CPS worker, Linda Turcotte, I think witnessed a little bit. I think the home support specialist told me that she witnessed something along the lines of a tantrum once when the mother got him up early -- early being -- he would stay awake all night and then wouldn't -- then would want to sleep until noon, and so if she got him up early then he would protest. And the home support specialist, Gracie Alvarado, witnessed that.

Linda Turcotte said she saw him arch and throw himself back once, but he was on the sofa at the time she saw that.

Q As part of the investigation into--

MR. CABALLERO: Actually, if I could have--.

Q Let me rephrase the question.

As part of the investigation into either the tibia fracture that occurred in September of 2002 or the femur fracture that occurred in December of 2002 did the Department obtain skeletal surveys of the older children?

A Yes. I believe -- I believe it was as a result of the December incident, December 2002 incident. I know all the children got skeletal x-rays, but I think it was as a result of the December 2002 incident that they got them.

Q And were any findings consistent with abuse as to those -- the older siblings of Raphael, were there any

findings that would have been consistent with abuse?

A I didn't study that report, but from talking with the CPS worker who investigated it, as I recall the x-rays did not show past injuries.

Q And Ms. Turcotte would be the person that would know -- that would have consulted with medical professionals regarding the -- the findings -- on the bone -- on the skeletal surveys?

A Correct.

MR. CABALLERO: I don't have further questions for Mr. Twelves.

THE COURT: Cross examination, Mr. Anderson?

MR. ANDERSON: Thank you, your Honor.

CROSS EXAMINATION

BY MR. ANDERSON:

Q Mr. Twelves, you stated that there was, just shortly before the December fracture incident, that Maribelle Gomez (inaudible) -- "concerns that I have with Raphael," is the way you put it. That--

A She didn't specify that. She just said, "There's some things we need to talk to you about."

Q Okay. And you subsequently -- subsequently disclosed to you that these were concerns she had about his behavior? Is that--

A Yes.

Q --accurate? Did she -- After he was returned home in March, 2003, did she call you back (inaudible) other times expressing concerns -- about his behavior, (inaudible)?

A Many times. We talked about it a lot. That's why we pursued the -- the neurological assessment through Children's Hospital. The difficulty was that a preliminary neurological assessment had been done in January, but was very -- very preliminary, was not what we'd hoped, and that doctor recommended a return examination in maybe six months. So the challenge was to get a doctor who would -- who would make a referral to Children's. And they found a doctor who -- who had actually seen Mr. Arechiga for -- regarding injuries in an accident, and he observe Raphael and said something didn't look right. So they took him back to that doctor and he made the referral, probably about May of 2003. And at the time of -- of the child's death they were still on a waiting list--

Q Okay.

A --for that.

Q Mr. Caballero went through a kind of laundry list of behaviors that he asked if you observed Raphael, I think all which (inaudible) you said, "No, (inaudible)." were there any behaviors that you observed in Raphael that you would consider somewhat out of the ordinary for a child of his age?

A That I actually observed first-hand?

Q Yeah, (inaudible).

A I'm not sure I actually did.

Q Fair enough.

(Inaudible) one other question -- You may or may not remember the incident at this point. Do you recall an incident when you went to the Gomez-Arechiga home and that Raphael was upset, (inaudible) crying and -- you comforted him, or got him to calm down?

A Yeah, I remember one time, you--

Q And, -- But, when you got there was he just -- at that point was he just crying, or was he exhibiting behaviors? Or do you recall?

A I think it was like at the end of the incident, could still see like some tear tracks. I knew that he had been upset.

Q Okay. Okay. So -- you didn't see anything that -- where he exhibited his being upset, or--

A No.

Q --other than (inaudible)?

A Uh-huh. Correct.

MR. ANDERSON: Okay. Thank you. I don't believe I have any further questions--.

THE COURT: Mr. Moser?

CROSS EXAMINATION

BY MR. MOSER:

Q Mr. Twelves, have you had any contact with the Ephrata Police Department or any other law enforcement in regard to this case?

A Yes.

Q And when was the last time you had contact with them?

A Probably briefly -- end of January or beginning of February. The detective stopped by briefly.

~~Q What about the prosecutor's office? Had any contact with them?~~

A No.

Q Have you been subpoenaed to testify at any motions or criminal trials?

A No.

Q Do you have knowledge of any ongoing criminal prosecution?

A There were a couple things right around that time, September 2003, old charges that came up regarding Ms. Gomez that they were working on straightening out. I'd gone to court once or twice with them on that. I don't know if there's anything still going on.

Q All right. Mr. Twelves, did Ms. Gomez make Raphael a target of abuse?

MR. ANDERSON: I'm going to object as to this witness's foundation to answer that question.

THE COURT: The objection is overruled, but your answer is limited to your personal observations, your personal knowledge.

A I never observed anything that would indicate such.

Q Did you ever observe her make him a focus of discipline? Above the other children?

A No.

Q Mr. Twelves, up to the time, September of last year, did the other children appear to you to be at any risk from the parents?

A No.

Q Were you the -- I still don't know all the lingo. Were you the primary caseworker with -- Raphael Arechiga?

A Yes. I was -- what we call the child welfare services caseworker, or like the foster care or the dependency caseworker, when during that time new allegations of child abuse and neglect came up, such as those two hospitalizations and injuries--

Q Uh-huh.

A At that point those incidents are investigated by a Child Protective Services social worker. And that was

done separately from my services, and independently of my services.

Q Okay. You're the ongoing caseworker?

A Yes.

Q And, how many services have been required of Ms. -- had been required of Maribelle up to the time of September last year?

A One of the main ones was outpatient drug and alcohol treatment -- Both parents had that. We did psychosocial evaluations. That's what comes readily to mind that we required of them. And of course they participated in visits and such when -- when the child was in out-of-home placement.

Q Parenting skills? Was there any development of parenting skills?

A We had a home support specialist who worked -- oh, probably six to nine months with them, which was to work on parenting skills and that sort of thing. Also we had a Family Preservation Services therapist. That same therapist started out with follow-up counseling to the psychosocial evaluation, according to the recommendations of that evaluation, and then when we got close to the time for the child to return home we ~~changed his services from the follow-up counseling to~~ Family Preservation Services. So the Family Preservation Services counseling and the home support specialist were both around parenting skills and family dynamics.

Q Had Maribelle completed most or all of these services?

A She was anticipated to complete the -- She completed everything except the drug and alcohol treatment, which we anticipated she would complete later that same month, September 2003.

Q And in September 2003 it was anticipated that Raphael's dependency would be terminated momentarily, (inaudible)?

A Yes.

MR. MOSER: Your Honor -- Actually let me ask -- If I can confer with my client for a second.

THE COURT: Sure.

MR. MOSER: No more questions, your Honor.

THE COURT: Redirect?

MR. CABALLERO: No further questions, your Honor.

THE COURT: Mr. Anderson?

May this witness be excused?

MR. CABALLERO: Yes.

MR. ANDERSON: No objection, your Honor.

MR. MOSER: Yes.

THE COURT: Thank you, Mr. Twelves. You can step down.

MR. CABALLERO: If we could continue with the mother's testimony.

THE COURT: Ms. Gomez.

THE CLERK: Plaintiff's Exhibit 1 and 2 have been marked for identification.

THE COURT: You're still bound by your oath.

MR. CABALLERO: I just realized something, your Honor. If we are tape recording then perhaps a microphone should be with the interpreter--

THE COURT: It is.

MR. CABALLERO: Oh, he has a microphone-- okay.

DIRECT EXAMINATION

(continued)

BY MR. CABALLERO:

Q Ms. Gomez, when we left off you had indicated that when you were feeding Raphael the second time that you had not changed the feeding environment at all, correct?

A Yes.

Q Were you concerned, given that he had already thrown himself backwards and hit himself hard against the hard floor, that he might do that again, especially given that you were feeding him in the same manner?

A Of course, yes.

Q What precautions did you take to prevent injury to your child on this second -- during the feeding of the second bowl of soup?

A I was -- ready to grab him to (inaudible) but I was just removing the spoon from his mouth when he (inaudible) himself (inaudible).

Q And what happened when he fell the second time? Can you describe--?

A He threw himself as he thrown himself the first time. This time (inaudible) sounded different.

Q How did it sound different?

A I don't know how to explain the -- what sound is heard.

Q Was it louder?

A Yes.

Q And, what did you do once you realized that he had thrown himself again and hit himself again in the head?

A Quickly I saw this his eyes had turned backward.

Q Did his eyes roll back?

A I just saw that -- turned them back. (Inaudible) to say exactly in detail. I can't--.

Q And what did you do?

A I picked him up. I was -- I was (inaudible) and speaking to him, and I would call him, "Raphie," "Raphie."

Q Was he responding?

Do you need a break, Ma'am?

MR. ARECHIGA: Is it necessary to go through this and keep repeating it every time?

THE COURT: It is.

MR. CABALLERO: While the mother composes herself, your Honor, I just wanted to offer and explanation, if I could. That -- to the father, and also to the mother, that the court's decision is based upon the evidence that is presented today. That is why it is necessary for me to ask these questions of the mother again, so that the court can hear the information. It is not being done to in any way offend or hurt your family.

MR. ARECHIGA: But she is being hurt.

MR. CABALLERO: And I apologize (inaudible).

MR. ARECHIGA: Because it wasn't an animal that died.

THE COURT: I hope that no one feels that anyone's questions or comments are disrespectful. The death of a child is a great sadness, no matter how it happens. There is no way to make it an insignificant or pleasant thing to talk about. It's difficult, and

it's going to be difficult, and no one expects otherwise.

So if -- if the process is too emotional we can always take a break. All you need to do, Ms. Gomez, if you want to take a break, is request it.

THE WITNESS: And yes, I understand the process, and I know that the questions have to be asked. And I'm -- willing -- I'm just asking that you have patience with me because it really does affect my heart.

THE COURT: Okay.

Q What was the child doing when you were throwing him up?

A Nothing. He (inaudible) respond.

Q Was his body limp?

A Yes.

Q And, what did you do?

A And I was throwing him up, and (inaudible) he wouldn't respond. I immediately went to the neighbor. I didn't know what to do.

Q To clarify the record, when you say that you were throwing the child up, what do you mean by that?

A (Inaudible), we Mexicans have this habit of when -- when the children are (inaudible) the child's eyes had gone back like that because maybe he had food stuck -- and that's why I was picking him up like that, because he (inaudible) like that, you know, and they -- they react, and it's over with.

Q And, how were you holding the baby when you were throwing him up?

A I was bending him from here.

THE COURT: As she said "from here" the witness gestured to the sides of her torso.

A (Inaudible) stomach, you know, (inaudible) little stomach -- and back and front.

THE COURT: Witness gesturing to her stomach and sides.

Q What neighbor -- Who were the neighbors that you went to?

A Their last name is (Inaudible), I believe. But I don't remember their names.

Q Was it Amalezio (Inaudible)--

A Malezio is Armela's husband.

Q Prior to taking it to the neighbors did you try taking your child outside to give him some air, to see if that would revive him?

A Yes. Yes. When I was throwing him up and he wasn't responding then I went to the front door, unlocked it and -- you know, so he could get some air. And then when I see that he wasn't reacting I ran to the neighbor's.

Q And you estimate how much time had elapsed from the time that you -- that he threw himself and hit himself on the head to the point in time that you went to your neighbor's house?

A No, but it was quickly. I don't feel (inaudible) any time (inaudible).

Q And what occurred at the Pichardo's residence?

A I went to the door and I knocked at the door and at the same time I opened the door, because I wanted somebody to help me quickly.

Q And what occurred next?

A Okay. I asked my neighbor to help me. I said

(inaudible) child was ill, and she quickly got out the alcohol and we -- some alcohol, and then, -- he wouldn't react.

Q What was this? Rubbing the child with rubbing-type alcohol?

A I put some on my hand and I pass it in front of his nose -- see if he would respond.

Q And Raphael was not responsive?

A No.

Q At that point in time what -- what occurred next?

A At that -- I asked the lady to -- if she would loan me the phone to call my worker -- at that time was Murray.

Q And did you call Murray?

A Yes.

Q Did you think to call an ambulance?

A No. Never.

Q And, -- and why is that?

A I don't know. I -- forgot that the phone existed. I don't know. It all happened so quickly.

Q Why was it that you were calling Mr. Twelves?

A Because I wanted him to go with me to the hospital.

Q And why is that?

A Because they already had me traumatized because they would always take my child away.

Q Whenever the child is being -- the child being taken away whenever he was brought to the hospital for medical care?

A Yes. The two times that he broke his little leg, we had nothing to do with it, (inaudible) and they took him away.

Q Do you recall Mr. Twelves asking you if you had a way to get to the hospital?

A Yes.

Q And, -- and did Mr. Twelves indicate to you that you should take him to the hospital?

A Yes. I was going to take him anyway, and whatever happened (inaudible). But that's why I was calling him and asking him to show up at the hospital. But I was going to take him (inaudible) I was going to take him to the hospital.

Q Did you take him to the hospital?

A Yes.

Q And what hospital did you take him to?

A I don't remember. It's the one going up there toward Wal-Mart.

Q Is it the Columbia Basin Medical Center?

A --I don't know what the name of it is.

Q Have any of your other children ever suffered -- bone fractures while in your care?

A No.

Q Do you recall Julianna having a femur fracture on her left leg on or about December 29, 1999?

A I remember one time that she fell from the little chair where she was eating. She did not break it; she splintered--.

Q Could you explain for the court in detail how it is that -- that that occurred?

A Yes.

Q Would you do--?

A I had Julianna feeding in her little chair. And I don't know if -- I don't know. I was serving at the stove, and she fell from the little chair. There was

an older girl there, or lady, that was visiting (inaudible), and she fell -- with -- chair, along with the chair.

Q How big was the chair?

A A normal chair where children--.

Q Was it a chair sized for a child or was it a normal adult-sized chair?

A It's one of those chairs for children, the ones they sell, you know, for children to eat on.

Q And at this point in time Julianna would have been how old?

A (Inaudible) I don't remember. I don't know. Maybe a year; maybe less than a year. But not to lie to you, I really don't.

Q And there was no other force -- strike that question. She fell -- she toppled over in the chair? Would that be fair to say?

A I didn't see how it happened. I just went and picked her up.

Q And how did you realize that she had a -- had injured her leg?

A Because she wouldn't stop crying. And since she was so little, you know, she didn't know how to (inaudible).

Q And you took her for medical care?

A Of course.

Q Where did you take her to medical care?

A I believe, although I hardly remember, but I think yes, it was in Quincy.

THE COURT: We're at the point where we should conclude our day.

(inaudible). MR. CABALLERO: I just have one last thing,

THE COURT: Go ahead.

MR. CABALLERO: May I approach the witness, your Honor?

THE COURT: You may.

Q Ms. Gomez, I'm handing you what's been pre-marked as Exhibit No. 1. There is a hand -- what is it, first of all?

A When he got burned with the soup.

Q Is that a picture of Raphael's left hand?

A I can't see his face. And a lot of the children's hands could be the same.

Q So is that -- are those the burns -- Does that picture accurately represent the condition of Raphael's hands when he burned -- the way that they were burned with the soup on or about December of 2002?

A These burns (inaudible) look like that, but I can't -- like I said, I can't say "Yes, this is Raphael's (inaudible)."

Q What about Exhibit No. 2? Is that your -- the back of your son's head?

A Yes, it looks like (inaudible), but -- yeah, that's (inaudible) happened at the (inaudible) -- laundromat. And was re-injured when he broke his -- leg the second time.

Q And does that picture accurately represent the abrasion to Raphael's head as it existed in December of 2002?

A I believe so, I think so. (Inaudible) similar (inaudible) -- (inaudible) that is correct.

Q That's fine.

(inaudible).

MR. CABALLERO: And I have no further

THE COURT: We'll be in recess until tomorrow--

THE WITNESS: Thank you.

THE COURT: Can we take up at nine o'clock?

MR. CABALLERO: At nine o'clock? I actually --

I was told by Ms. Finke not to schedule anything until 9:30. So my first witness is scheduled for 9:30. We could start with the mother at nine o'clock--

MR. ANDERSON: (Inaudible)--

THE COURT: Well, probably Ms. Finke knows best because I may have something that I have to hear on the civil docket before the judge who's hearing that docket takes up. So, let's leave our -- leave it at 9:30.

We'll be in recess until that time.

MR. CABALLERO: Thank you.

Recess

I certify that the foregoing is a correct transcript from the electronic sound recording of the proceedings in the above-entitled matter.

July 26, 2004

Kenneth C. Beck, Transcriber

KENNETH C. BECK, TRANSCRIBER

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Court of Appeals No. 22935-1-III

IN THE SUPERIOR COURT OF THE STATE OF WASHINGTON

IN AND FOR THE COUNTY OF GRANT

In re dependencies of

E.A., J.G., J.G. and M.G.,
minors,

STATE OF WASHINGTON,

Petitioner,

and

MARIBELLE GOMEZ and JOSE
ARECHIGA,

Respondents.

No. 03-7-00131-1, 132-0,
133-8, 134-6

Hon. Evan Sperline

February 20, 2004

VERBATIM TRANSCRIPT OF PROCEEDINGS
From Electronic Recording

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DEPENDENCY FACT-FINDING
 (continued)
 February 20, 2004

THE COURT: Good morning.

MR. CABALLERO: Re-calling the matter of Edgar Arechiga, Julio Gomez, Julianna Gomez and Maria Gomez, respective cause numbers 03-7-00134-6, 03-7-00132-0, 03-7-00131-1, and 03-7-00133-8, on for continuing contested fact-finding.

Your Honor, the -- present in court, Maribelle Gomez, the mother, with her attorney Doug Anderson, Jose Arechiga, the father of Edgar Arechiga, with his attorney Robert Moser, Saul Castillo the interpreter is present, interpreting for the parents, Mario Gonzalez for the Department, Terry Cullen, Tamara Cardwell for the guardian ad litem program.

The Department is ready to proceed with the testimony of Dr. David Cook. That would be by telephone.

THE COURT: Is there any objection to further interrupting the testimony of Ms. Gomez?

MR. ANDERSON: No, your Honor. In fact, I anticipate actually calling the mother to the stand during our case in chief, (inaudible).

THE COURT: Mr. Moser?

MR. MOSER: No objection, your Honor. I probably will not wait until the defendant's case in chief to examine her, but no objection at this time.

THE COURT: All right.

MR. CABALLERO: Judge, I -- I typically initiate these phone calls with my SCAN card but I have lost my wallet and my SCAN card--

THE COURT: Yow!

Mr. Caballero, did you say "K-u-c-h?"

MR. CABALLERO: C-o-o-k.

THE COURT: Oh. All right.

Witness reached by telephone

MR. CABALLERO: Dr. Cook, can you hear me?

THE WITNESS: I can.

MR. CABALLERO: We are in Grant County Superior Court, Juvenile Division, with the Hon. Judge Evan Sperline presiding. I'm going to ask Judge Sperline to swear you in for your testimony.

THE WITNESS: Okay.

THE COURT: Dr. Cook, do you solemnly affirm that the testimony you give in this matter will be the truth under penalty of perjury?

THE WITNESS: Yes, I do.

THE COURT: Doctor, we're proceeding here with the use of a Spanish language interpreter. Will you keep that in mind in keeping the pace of your testimony relatively relaxed and allowing pauses when it feels appropriate to do that.

THE WITNESS: Sure. That is not a problem.

MR. CABALLERO: And, Dr. Cook, I wanted to identify who is present in court for you. Judge Sperline is presiding. Maribelle Gomez, the mother of Raphael Gomez, is present with her attorney Doug Anderson. Jose Arechiga, the father, is present with his attorney Robert Moser. Saul Castillo, who is an interpreter, is interpreting for the parents. Mario Gonzalez is present; he is the agency social worker. Terry Cullen is present; she's the guardian ad litem, and Tamara Cardwell who is the guardian ad litem program administrator.

And I'm going to start with my question now, Doctor.

THE WITNESS: Okay.

DIRECT EXAMINATION

BY MR. CABALLERO:

Q I would ask that you state your name and that you spell your last name for the record.

A Dr. David Cook, C-o-o-k.

Q And what is your profession?

A Pediatrician.

Q What is your business address?

A Nine -- It's Columbia Pediatrics, 933 Red Apple Road in Wenatchee.

Q Are you licensed to practice medicine in the state of Washington?

A Yes, I am.

Q And when were you licensed?

A It would be July of 1986. And I've had continued licenses since then.

Q Would you describe your pre-medical and medical training starting with your undergraduate studies?

A Undergraduate studies were in the Midwest at the University of Wisconsin at Eau Claire, (inaudible) known as Eau Claire State. Eau Claire is E-a-u, C-l-a-i-r-e. That was for five years. From 1974 to 1979. And then medical school at the Medical College of

Wisconsin from 1979 to 1983. And then pediatric internship and residency at the University of Iowa from 1983 to 1986. And then private practice here in Wenatchee since then.

Q What does it mean to be a physician that specializes in pediatrics?

A A physician who takes care of children's problems from birth to -- most people describe age 21 as the upper limit.

Q Are you board certified in pediatrics?

A Yes, I am.

Q And who certifies you?

A That would be the American -- I'm not sure of the exact title, but it's the American Board of Examiners, I believe.

Q What does it mean to be board certified?

A Board certified means that you have met the criteria of maximum education for a pediatrician, which includes medical school and residency, and also have passed all the board certification examinations that run through medical school and residency and actually one more final test in private practice. That was, I think I believe I did that last test about two years after I started private practice.

Q Are you also required to complete continuing medical education as part of your licensing requirements?

A Yes, I am.

Q Do you belong to any medical associations?

A The American Academy of Pediatrics.

Q Are you familiar with the child Raphael Arechiga, or Raphael Arechiga-Gomez?

A Yes, I am.

Q And when did you first become aware of Raphael Arechiga-Gomez?

A That was when I saw him in pediatric consultation at Central Washington Hospital. I believe the first date was December 7th, 2002.

Q Do you recall who requested the consultation?

A That was requested by Dr. Brownlee, orthopedist, at Central Washington Hospital.

Q And what was the purpose of the consultation?

A To review the child's status regarding injuries that the child had sustained.

Q In your preparation for the pediatric consult, what were the injuries that were noted in the -- in regards to this child?

A What I knew ahead of time just on verbal report was a -- prominently a left femur fracture.

Q And what about injuries noted in the emergency room?

A I'd have to look at my notes to see what was noted at that time. In my notes, the ER staff noted a bruise on his ear, an abrasion of the back of his head, and a burn of his hand.

Q Did you proceed to perform a physical examination of the child?

A Yes, I did.

Q And what were your findings?

A My findings at that time were -- my general assessment is that of multiple injuries, including -- Again I'm referring to my notes from that day -- left femur fracture, -- had a pinch-like bruise on his right ear. He has an abrasion and what appeared to be a little bit of infection over the back of his head. And,

there was also a dressing over the top of his left hand, which I report that it was -- mother reported to me that that was a previous burn that he had suffered.

Q In regards to the abrasion that appeared on the back of the child's head, were you able to determine whether or not that abrasion appeared older in time than the left femur fracture that has been testified to occurred on December 7, 2002?

A I believe, based on my exam, that it had occurred earlier, because I noted that there was secondary infection over the area, and that usually in the scheme of things, from an injury to an infection usually takes at least, I would think, several days or longer for that to develop.

Q In preparation for today's testimony have you reviewed any x-ray reports of radiographic studies taken on or about December 7, 2002?

A Yes, I have.

Q would you briefly describe what x-ray reports you've reviewed?

A Well, I've reviewed the report of the skeletal survey, the report of the hip and femur exam that was done, and also a report of a head CT scan.

Q And what is a CT scan?

A A CAT scan, otherwise known as a CAT scan -- Most people know it commonly as a CAT scan -- is a special x-ray looking at internal structures of the body, as compared to just the bones alone with a plain x-ray.

Q what were the findings on x-ray regarding the left hip and femur?

A The findings were that of a proximal left femur fracture, and -- the findings of the -- Did you say skeletal survey? I'm sorry.

Q No. Just of the left hip and femur x-ray. what were the findings?

A The findings were that of a proximal left femur fracture.

Q which -- what is the femur?

A The femur is the main bone of the thigh.

Q And where in relation to the -- the location of the femur would a proximal fracture be located?

A The proximal would indicate that it would be in the first, most likely, third of the femur, the thigh bone, going down from the hip towards the knee.

Q would that be, then, closer to the hip than to the knee?

A Yes. Closer to the hip joint than the knee joint.

Q And what were the findings of the CAT scan, the head CAT scan?

A The findings of the CAT scan were that of a -- If I can find the reading. The radiologist's findings was that of the fracture through the occipital bone of the skull with extension to the skull base, which basically is the back of the head with extension down towards the neck.

Q And, what were the findings of the bone survey?

A And the skeletal survey, again, showed the left femur fracture and also the suspicion -- At that time there was a suspicion on the skeletal survey of a skull fracture, which was confirmed with the CAT scan.

Q what type of scenario--

A what -- If I might add one more thing?

Q In regards to the findings?

A Yes.

Q Yes. Please continue.

A One more thing about the findings of the skull fracture that there wasn't any significant swelling of the tissues, the soft tissues, basically the scalp, around the skull fracture, which would indicate that this was not an acute injury, that it might have been sustained at the same time of the hip fracture. So this was felt to be -- my opinion is that of an old injury that's not timed coincidentally with the acute injury of the femur fracture.

Q What type of scenario or scenarios would you expect would result in a proximal femur fracture in a child Raphael's age?

A I would expect that a fracture of the femur close to the hip would have to be related to -- a very severe force. It wouldn't be a fracture that I would expect a child to be sustained on his own, unless he fell a great distance or was thrown potentially forcefully or hit forcefully in that area. But running and falling, with a proximal femur fracture, a child that -- I believe Raphael was 16 months at that age -- would be highly unlikely.

Q ~~What about a child that is running and slips on~~ onto a hard floor in a split position with one leg pointing forward and the other leg pointing backward? Would that be the type of scenario that you would expect would cause a proximal femur fracture?

A I would expect that that would be, although not impossible it would be unlikely. Unless the child was -- If the child was walking or running at his own velocity at that age, unlikely. If he potentially was thrown or dropped from -- either thrown at a great velocity or dropped at a significant height, I could see that happening. But it -- most likely unlikely to be related to the child's own ambulation. That would be my opinion.

Q would -- would this type of injury, the femur fracture, in combination with the -- skull fracture, be suspicious to you for inflicted non-accidental trauma?

A Yes, it would be highly suspicious for that.

Q And why is that?

A Because they are too unusual fractures for a child his age to have sustained on his own, and they are also, by medical evidence, fractures that have been sustained at different times. And so that would be also more suspicious for non-accidental trauma.

Q On -- Did you prepare a discharge summary regarding Raphael Arechiga on or about December 9, 2002?

A Yes, I did.

Q And, were there significant concerns in your mind regarding his hospital course, on discharge?

A Yes. I stated in my summary that it was my opinion, with the multiple injuries that the child was noted to have, that the child's injuries raises serious concern of child abuse, and I stated "leaves no doubt in my mind that this child has been physically abused."

Q In -- You've testified regarding the left femur fracture, the occipital skull fracture. In terms of that opinion were you also considering other injuries that you had seen in this child?

A Yes. The burn on the hand, the bruise on the ear, the

abrasion of the scalp, and also what was not noted that I actually missed on my initial physical examination but picked up on a subsequent examination was there appeared to be a burn mark on the tip of his tongue as well. And I believe the reason I missed that was because of the tongue blade blocking my view when I examined the child's mouth.

Q As part of the workup was a metabolic panel done?

A Yes. A blood test looking for internal problems such as mineral metabolism problems, internal organ problem, looking for blood coagulation problem, and also anemia, was all done and was all normal.

Q One moment, Doctor.

These combination of injuries that you noted on your discharge diagnoses, are these the types of injuries that you would expect a child Raphael's age would typically sustain in the normal course of activity during a child's daily life?

A No, it would not be.

MR. CABALLERO: I have no further questions for this witness. The other attorneys may have questions, Dr. Cook.

THE WITNESS: Okay. Thank you.

~~THE COURT: Mr. Anderson, cross-examination?~~

MR. ANDERSON: Thank you, your Honor.

CROSS EXAMINATION

BY MR. ANDERSON:

Q Good morning, Dr. Cook.

A Good morning.

Q My name is Doug Anderson. I represent Maribelle Gomez. I just have a couple questions.

Based upon your examination of the -- of the x-rays and the CAT scan, did you form an opinion as to how old the fracture to the skull was?

A No, I cannot. Otherwise -- Other than knowing that it was not -- most likely sustained within the last, I would say, probably three to potentially seven days prior to admission. And that reason is because there was no significant soft tissue swelling related to the skull fracture. And in my experience when a child sustains a skull fracture they have bad amount of swelling for at least a period of time. But (inaudible) otherwise more specifically beyond that period of time would be difficult.

Q Okay. How about the -- the burns to the hand? Any -- were you able to estimate with any degree of medical certainty as to how old they were?

A They would have to be somewhere, I would think, within seven to ten days of the time that I saw the child.

Q Okay.

A Or sooner.

Q And I'm just checking my notes for a moment, here.

MR. ANDERSON: I don't believe I have any further questions at this time. Thank you.

THE COURT: Mr. Moser, cross?

CROSS EXAMINATION

BY MR. MOSER:

Q Hi, Dr. Cook.

A Good morning.

Q I think my questions are going to relate primarily to muscle development; that's going to be a particular

interest of mine in this case. How -- how do children's muscles develop differently from adults?

A I'm not sure in what respect that you're asking the question.

Q Well, let me go ahead and ask, how does a child develop muscles? If they use those muscles regularly, or what? Do they develop--

A They -- They are first born with all the muscles that they need, and then develop over time with use and activity, and attainment of motor skills. And they will grow generally as the child grows as well.

Q What age do they start developing their leg muscles, to make them strong enough to walk?

A The average age for walking is actually 13 months, and -- but some children I've seen walk as soon as nine months of age, and as late as 18 months of age, in a normal scenario.

Q And when they walk I expect their leg muscles get stronger through that process?

A Yes.

Q And their leg muscles have to be a certain strength for them to start walking?

A Sure. There has to be a critical strength for them to remain upright, to sustain a gain, and to sustain a walking upright posture.

Q Do the legs develop relatively late in most children compared to their other muscles?

A They -- I guess the best way I can answer that is that they attain their skills with their extremities, especially the legs, later than they might attain their skills or strengths such as their central musculature, like their trunk, their neck and their proximal, like shoulder muscles and back muscles.

Q Okay. And that is what I'm asking. They develop their legs later than a lot of their other muscle systems?

A I guess that would be -- I guess that would be a correct general statement.

Q Is a child able to develop particular muscles out of proportion to the rest of the muscles in their body?

A In a -- aspects of normal development of a child who's physically normal, there is certainly a progression of when you attain your strength and abilities with those muscles and coordinating abilities or strength abilities. But if you had abnormal development of certain muscles, in my experience the only time that would -- in relationship to your other muscles, is if you had something wrong or something abnormal about your physical development.

Q Okay. So let's say a child does something on a regular basis that other children don't do, that uses a certain muscle, he would develop that muscle beyond what other children do, wouldn't he?

A Yeah. Such as an example in my mind would be the child was a toe-walker, not walking with a normal, flat-footed gait, they might develop their calf muscles in -- out of proportion to the rest of their muscles. That would be an easy example.

Q Okay. Now, most children at age two -- And I think that you said that 13 months is the mean age, or the average age, for -- begin walking. Children at age two, their leg muscles are still relatively weak, aren't they?

A I would -- I would not say that. I would say that they have been ambulating for quite some time, almost a year. Their leg muscles, in proportion to the rest of their strength, would still be good. I think in general if you look at an adult, and a child who has been ambulating, your strongest muscles are your leg muscles, especially your thigh muscles. So I wouldn't necessarily say that a child's muscles at two years of age is -- of the legs is weak compared to the rest of their -- their body.

Q Okay. I'm thinking of in proportions of adult strength. I think what you just said is that a child's thigh muscles are -- some of the strongest muscles in their body, when they're two years of age?

A Yes, I think that would hold true for any child at any age that's ambulating. The size of the muscle group, the work that it has to do, the overall strength of the muscles would be, like an adult, stronger than other muscles.

Q All right. A child who is known to jump into the air on a regular basis, would that be unusual?

A From on the ground, or off of things? Or--

Q From the ground.

A Ground? I guess I would expect in the normal course of a child's development that they would explore jumping. And they certainly do that, even jumping off of things at times.

Q Jumping into the air from the ground would be a way of exercising the leg muscles, wouldn't it?

A Sure.

Q And a child who did that on a regular basis would have -- definitely have strong, or stronger than normal children's legs?

A I think if a child was doing a repetitive action for some reason more than other children, yes, those muscles most likely would develop more than the other children would.

Q Now, Doctor, you've made -- you made several conclusions, and I'm not sure that you meant them to be conclusions; I'm just characterizing them as--. Under direct you said you would not expect a child to receive the kind of fracture to the femur by accident, and you would not expect a child to sustain these injuries by accident. These conclusions are referencing a typical child, aren't they?

A I'm -- Could you repeat that question? I had trouble hearing you.

Q Okay. Okay. On direct examination you made a few statements about the injuries to Raphael--

A Right.

Q --saying that they -- you would not expect a child to receive those by accident?

A I believe I stated that in the normal course of a child's ambulation and play I would not expect those kind of fractures, yes.

Q Okay. And your expectation is referencing a child of normal muscle development, right?

A I would reference that, yes, with a normal average child at his age.

MR. MOSER: Okay. That's all. Thanks.

THE COURT: Redirect?

MR. CABALLERO: Yes.

REDIRECT EXAMINATION

BY MR. CABALLERO:

Q And Dr. Cook, this is again Tom Caballero with the attorney general's office--

THE COURT: Excuse me, Mr. Caballero.

Parents, if either of you have questions that you want your lawyer to ask of the witness will you please mention that to your lawyer.

Go ahead, Mr. Caballero.

Q Dr. Cook, assuming a 16-month old child at the extreme of activity, a child that actively jumps and actively runs at 16 months -- And once again I'm asking you to assume at the high end of activity for that child -- in that child would you expect a 16-month-old, a very active 16-month old who jumps and runs constantly, to be able to generate enough force to sustain a left proximal femur fracture?

A The only scenario I could think of that happening would be a child who climbed to a significant height, potentially four feet, five feet, six feet, and then jumped off of something onto a firm surface. But in the normal course of running, unless a child ran and jumped on something of significant height, running on the floor, slipping and falling would be unusual in my mind for that kind of a fracture.

Q And, Doctor, finally, the opinions that you have offered today, are those on a more probable than not and to a reasonable degree of medical certainty?

A Yes.

MR. CABALLERO: Objection. I think that's a legal conclusion.

THE COURT: Overruled.

MR. CABALLERO: I have no further questions.

THE COURT: Mr. Anderson, further cross on behalf of the mother?

RECROSS EXAMINATION

BY MR. ANDERSON:

Q Doctor, I just have one more question. You may have already have answered this, but hypothetically, if you have a very active child who was running on a -- a hard floor that had just been washed, was still -- still likely wet, and was slippery, would it be possible for that child to accidentally sustain a proximal femur fracture?

A Would it be possible? I could say that it would not be -- completely impossible. Would it be probable? In my opinion, no. I would expect a child in that scenario to -- since children are more top-heavy, their head being a significant weight, I would think if a child slipped and fell on a floor it would be -- the usual type of injury would be other than the femur; it would be a head injury, or potentially an outreached arm to brace the fall, not -- I would not think that it would be highly probable that a proximal femur fracture would be sustained.

Q And is this because with a proximal femur fracture it's so close to the -- to the hip?

A Yes. I think the -- in my opinion, although I'm not an orthopedic surgeon, the closer you are to a joint, the higher the force of injury sustained, and therefore it would be less likely that the child sustained that type of injury, because of the location

of it, in that situation.

MR. ANDERSON: Okay. Thank you. I don't believe I have any further questions at this time.

THE WITNESS: Thank you.

THE COURT: Mr. Moser, Recross on behalf of father?

RE CROSS EXAMINATION

BY MR. MOSER:

Q Dr. Cook, I have one question and it's -- I forgot to ask you before, again, in my previous line of questioning.

Could you please describe how a child falls down, I mean, what happens to their -- what happens to their legs that cause them to fall down?

A I think there would be a number of scenarios that could happen. Typically most children at that age either slip on something that's slippery, or they commonly trip on things that they don't pay attention to that's in their pathway of running or walking. And so usually it's a process of their legs being stopped or -- or slipped out from underneath them that leads to the fall.

Q Okay. It sounds -- To me it sounds exactly like how an adult falls. Does a child's legs just -- does a child's legs give out from under them?

A No, they typically don't. They -- If the child has had practice walk and ambulation for a significant time then there would be no reason for a child to suddenly have their legs give out. It would have to be something that stopped their ambulation or allowed them -- not providing adequate traction on a surface, or potentially I could see a scenario where a child sustained an injury and then fell because of pain, such as stepping on a tack or something sharp of that nature, and then having the legs give out as a protective reflex.

MR. MOSER: Okay. Thanks, Doctor.

THE WITNESS: You're welcome.

THE COURT: Anything further?

MR. CABALLERO: No, your Honor.

THE COURT: Dr. Cook, this is Judge Sperline. I have question or two.

INTERROGATION

BY THE COURT:

Q I'd like you to focus on the skull fracture that you observed, and I'm interested in the force, the amount of force likely necessary to cause that fracture. I'm--

A I have seen in my practice, and knowing generally from a pediatric point of view, that a fall from a significant height, or a child who might fall backwards unprotected onto a hard surface, can sustain a fracture of that nature. The scenario where that was presented to me that the child slipped and fell on a wet floor, when we initially talked about the femur fracture, that could be a likely scenario to sustain a skull fracture, in the child's normal course of running and falling, or walking and falling.

Q I'd like you to assume a different scenario, and then I intend to ask you if you have an opinion regarding the likelihood of the injury that you saw arising from

this different scenario.

Assume that the child of the size and age and weight of Raphael Gomez was playing with a small ball, that the ball rolled under a metal chair, an industrial type heavy metal chair, and that when the child retrieved the ball he, from under the chair he, in an attempt to stand up, didn't realize that he was still under the chair and banged his head on the underside of the metal chair, in the process of standing.

would -- Do you have an opinion, on a more probable than not basis, based on reasonable medical probability, as to whether or not that -- conduct would likely cause the type of skull fracture that you observed on -- on your examination of the child?

A No, that would be highly unlikely. If the child was in a stooped position underneath a chair and voluntarily came up and hit his head, to have that kind of fracture, and the extent of it, would be very unlikely. I could see a possible bruise or maybe abrasion of the head, but not a skull fracture. A skull fracture has to be sustained from a much greater velocity type of trauma.

~~THE COURT: Thank you. Any follow-up, Mr. Caballero?~~

MR. CABALLERO: No, your Honor.

THE COURT: Mr. Anderson?

MR. ANDERSON: Yes, your Honor. Just one.

RE-CROSS EXAMINATION

BY MR. ANDERSON:

Q Dr. Cook, I'd like you to imagine the same fact pattern the judge just said, where you have a child crawling underneath a hard metal chair, and brings his head up suddenly. Could that cause an abrasion such as you observe on Raphael?

A Yes.

MR. ANDERSON: Okay. Thank you.

I have no further questions, your Honor.

THE COURT: Mr. Moser, follow-up?

MR. MOSER: No.

THE COURT: May this witness be excused?

MR. CABALLERO: Yes, your Honor.

MR. MOSER: No objection.

THE COURT: Thank you, Dr. Cook. That will end your testimony.

THE WITNESS: Thank you.

MR. CABALLERO: And, your Honor, I canceled the rest of the morning witnesses so that we could complete the mother's testimony without further interruption.

THE COURT: Thank you.

Ms. Gomez, would you be good enough to resume the stand?

MR. CABALLERO: And, your Honor, I think when we left off I had finished asking Ms. Gomez questions, but I do have some more questions, so rather than recalling her I would like to finish up the testimony prior to the -- leading to cross examination.

THE COURT: Please be seated. You are still bound by your oath.

DIRECT EXAMINATION

(continued)

BY MR. CABALLERO:

Q Good morning, Ms. Gomez.

A Good morning.

Q I wanted to revisit the injury to Julianna's leg. When you testified that she was in a child's chair, what type of chair were you describing?

A Normal chair for the children.

Q Is it a high chair or a low child chair?

A High. But I want to say something.

Q Sure.

A (Inaudible)--

THE COURT: Stop. Stop.

State your answer again. I need to have this be successive -- or, consecutive, if you would.

Go ahead and state your answer again.

A We're dealing with Raphael's case. Not Julianna.

Okay? And if you need to know (inaudible) agreement,

I talk about what I can remember. There's no problem.

Q And I would ask you simply to talk about what you remember.

A Okay.

THE COURT: I also want to clarify something for you, Ms. Gomez.

I mean no disrespect. You are actually exactly wrong. We are not talking about Raphael's case. These cases do in fact relate to Edgar, Julio, Maria and Julianna.

THE WITNESS: Okay.

THE COURT: Okay.

Q When Julianna was on the high chair she was sitting, correct?

A Yes.

Q Approximately how high was the seat of the chair compared to the floor?

A I couldn't tell you exactly, because it was a chair for children, but it was high.

Q Can you estimate?

A No. Not really. I couldn't say exactly how high.

Q Was she more than one foot off the ground?

A How much is -- I don't know exactly how much.

MR. CABALLERO: May I approach the witness, your Honor?

THE COURT: Counsel, this seems not very productive. She's unable to estimate in number.

She's described a couple of times a typical child's high chair. You want to approach, why?

MR. CABALLERO: Just to show a visual distance as opposed to (inaudible).

THE COURT: Ms. Gomez, are you able to stand on the floor and hold your hand about the height of the seat of Julianna's high chair?

THE WITNESS: I would say about here, more or less.

THE COURT: The witness is holding her right arm at her side, the upper arm hanging straight down, the hand held out with the forearm roughly parallel to the floor, and thus indicating a distance of perhaps three feet.

Is that a fair characterization?

MR. CABALLERO: It would be -- Department.

MR. ANDERSON: I believe so, your Honor.

(Inaudible).

THE COURT: Thank you.

MR. CABALLERO: And I don't have further questions. Thank you, Ms. Gomez.

THE COURT: Mr. Anderson, do you wish to cross at this time or defer?

MR. ANDERSON: Your Honor, I have just a few questions that (inaudible) now.

THE COURT: Go ahead.

MR. ANDERSON: Thank you.

CROSS EXAMINATION

BY MR. ANDERSON:

Q I just have a couple questions for you regarding Alicia Estrada.

Was there a time when Ms. Estrada was living in your home with you and your family?

A Yes.

Q And how did she come to live in your home with you?

A I was taking part in the program, alcohol and drug, that CPS had sent me to.

Q Okay.

A We met each other there. She told me, crying, if I would give her permission to live in my home, that the lady where she was staying at had run her out and she had her things out in the street. I told her I had to talk to Jose about it. Okay, I spoke to Jose and -- the situation that she had told me, and okay, (inaudible), you know, poor thing, she doesn't have a place to stay; okay.

Q Okay. About how long did she live with you in your home?

A A month and a half.

Q And, what ended her living there? Why did she leave?

A She left because Jose ran her off, because she would sneak in beer through one of the -- into the room through one of the windows, and I told Jose and Jose said that that home did not drink beer, and supposed to be a decent person and a decent person shouldn't be abusing (inaudible).

And also because she was -- going into the homes of all the neighbors and she was causing problems there and none of them could stand her, and I had to call my social worker--

MR. CABALLERO: I'm going to object and move to strike that portion of the answer. It's speculative, and lack of the witness's foundation to know how the neighbors (inaudible).

MR. ANDERSON: Your Honor--

THE COURT: Just a minute.

The objection is overruled. You need to wait until the interpreter completes the interpretation before stating an objection.

MR. CABALLERO: I believe we have a portion of the answer. I understand Spanish, so I know where she finished and I saw where he finished, and so--

THE COURT: Okay.

MR. CABALLERO: Maybe--

THE COURT: Okay. Thank you. I don't understand Spanish, so it sounded to me like she talked a lot longer than you did.

INTERPRETER: We had gotten to the -- to the end--

THE COURT: Thank you.

INTERPRETER: He was right -- right at the end, though, (inaudible) had finished.

THE COURT: Okay. Well done. All right.

MR. CABALLERO: I apologize. And if I could have a ruling on the objection?

THE COURT: It's overruled.

MR. CABALLERO: Okay.

Q Yesterday Ms. Estrada stated that the reason she (inaudible) home (inaudible). Is that true?

A False.

Q At that time you stated that you met her through the drug and alcohol treatment you were going through as part of your case with Child Protective Services, with CPS, correct?

A Correct.

Q During that portion, were you participating in UAs or urinalysis where they would check your urine to see if you were consuming alcohol or taking drugs?

A Of course, yes.

Q And are you aware if any of those came back testing positive for the presence of alcohol in your system?

A Negative all the time.

MR. ANDERSON: Thank you.

~~MR. CABALLERO: And, your Honor, I'm going to object and move to strike that answer -- question, due to this witness's foundation, as to the results.~~

And the question asked for her awareness of any positive UAs for alcohol. I don't have an objection to an answer to that question.

THE COURT: The objection is overruled.

MR. ANDERSON: I don't believe I have any further questions on cross examination (inaudible) direct (inaudible).

THE COURT: Cross examination, Mr. Moser?

MR. MOSER: Maribelle, I also wanted to ask you--

THE COURT: I'm sorry. Counsel, use surname, please.

MR. MOSER: Excuse me.

CROSS EXAMINATION

BY MR. MOSER:

Q Ms. Gomez, I also wanted to ask you about Ms. Estrada. In the time that she lived with you did she have any medical conditions you were aware of?

A No.

Q Did she take any medications?

A All the time.

Q What medications did she take that you were aware of?

A I never checked her things because I like to respect other people's (inaudible), but I saw that she took -- about approximately five pills.

MR. CABALLERO: I'm going to object and move to strike as to relevancy, given that there's no indication of what the medication was, or this witness's foundation to understand the effects of medication on a person.

THE COURT: The objection is overruled, as far as the answer went.

Q Ms. Gomez, do you know what Ms. Estrada was in treatment for when you met her?

A Well, she commented to me that she had been in a hospital receiving -- at a psychiatric hospital.

Q Ms. Gomez, when she was living with you in your house did she ever drink to the point of intoxication?

A Sometimes she was out all day, she wouldn't get in until 4:00 or 5:00 a.m. and she would arrive inebriated, or very inebriated.

Q Ms. Gomez, did you ever have concerns about Ms. Estrada's ability to think clearly?

A Yes.

Q What caused you to have those concerns?

A Okay. Sometimes when we were asleep, because Jose works early dawn hours, (inaudible) sleep and sometimes she would get up and -- and frequently (inaudible), sometimes 15 times.

MR. CABALLERO: Object. Move to strike. Relevancy and this witness's foundation, and tie-in to Ms. Estrada thinking clearly, based upon bathing (inaudible).

THE COURT: The objection is sustained; the motion to strike is granted. That testimony is stricken.

MR. MOSER: I'm sorry. I don't understand (inaudible) something wrong (inaudible)--

THE COURT: Obsessive bathing is not relevant.

~~Q Ms. Gomez, was there anything besides her bathing that caused you to have concerns about her ability to think clearly?~~

A Okay. She told me that her son -- son had killed himself, and she would be laughing, and I couldn't understand how a mother -- (inaudible) son died could be laughing from -- when telling the story.

MR. MOSER: No more questions, your Honor.

THE COURT: Redirect?

MR. CABALLERO: Yes.

REDIRECT EXAMINATION

BY MR. CABALLERO:

Q Ms. Gomez, in regards to Ms. Estrada's drinking, when she was inebriated, when did that start? In relation to the period of time that she was living in your home.

A Okay. That day was -- that's the day Jose ran her off, so that was toward the final part of the time that she was with us.

Q And did you disclose that information, the drinking until inebriation by Ms. Estrada and her bringing of year into your household to your agency social work Olga Gaxiola?

A Yes, I commented that.

Q Ms. Estrada's comment to you that she was in a psychiatric hospital, when was that made in relation to her living in your household?

A Almost toward the end. Almost.

Q And, her comment about her son dying and her laughter about that, when was -- when did that occur?

A Okay. All that happened in days -- (inaudible) days -- started to suspect that she wasn't right in the head--

THE COURT: Instruct the witness, please.

A Okay. Yes, those comments were all those -- it all started to run together.

Q And -- and at that point in time the decision was made to have her leave your residence?

A Yes,--

MR. CABALLERO: Keep going.

A --because -- hidden from me. Okay. We took that decision, Jose and myself, because we took that decision because more than anything because it was a danger to the children.

Q And you disclosed this information regarding Ms. Estrada's disclosure to you about psychiatric hospitalization to Ms. Gaxiola?

A Yes. I commented to my worker Olga that she had commented to me that she had been in a psychiatric hospital.

Q And did you disclose to Ms. Gaxiola that -- your concerns about Ms. Estrada laughing while talking about her son dying?

A No, that I did not comment--.

MR. CABALLERO: No further questions. Thank you.

THE COURT: Will you have Recross?

MR. ANDERSON: No, your Honor. Thanks--

THE COURT: Mr. Moser?

MR. MOSER: I don't -- I think -- I think I'll wait.

THE COURT: Thank you. You can step down.

~~We'll be in recess until eleven o'clock.~~

Recess

MR. CABALLERO: Your Honor, the Department would next call Jose Arechiga.

THE COURT: Do you solemnly affirm that the testimony you give in this matter will be the truth under penalty of perjury?

THE WITNESS: Yes.

THE COURT: Please be seated.

DIRECT EXAMINATION

BY MR. CABALLERO:

Q Would you please state your full name for the record.

A (Witness answers in Spanish).

Q And where do you live?

THE COURT: Just a moment, please.

MR. CABALLERO: Oh, I'm sorry.

A Jose Ramon Arechiga. Saltero.

Q Where do you live?

A With Maribelle. I really don't know addresses, but there in the house with Maribelle.

Q And what is your relationship to Maribelle Gomez?

A She's my wife.

Q Are you the father of Edgar Arechiga?

A Yes.

Q And was he born on September 14, 2002?

A Yes.

Q And what was your relationship to the deceased child, Raphael Arechiga-Gomez?

A He's my son.

Q The testimony indicates that Raphael died on September 10, 2003. Were you present -- Actually, strike that.

Were you present at the house when Raphael was injured on September 9, 2003?

A No.

Q How did you find out that Raphael was injured on September 9, 2003?

A A lady from the hospital -- well, she called my boss.

Q And your boss gave you the information?

And is that a "yes?"

A Yes.

Q Were you present at the house when Raphael injured his leg in December of 2002?

A No.

Q During the time that Raphael Gomez was in your care and by "your" I mean your family's care -- who was the primary caregiver for the child?

A When I was at home I (inaudible).

Q Did Maribelle Gomez work?

A No.

Q And were you working?

A Yes.

Q And when you were working was Maribelle Gomez taking care of the child?

A All the time. She's taking care of him all the time -- very well.

Q Have you ever observed Maribelle Gomez -- Let me rephrase.

Did you ever observe Maribelle Gomez hit Raphael in any manner to discipline him?

A No.

Q Did you ever observe her hit him for any purpose?

A No.

Q Was Maribelle Gomez a good caretaker for your child Raphael when you observed her interacting with the child?

A Yes. When I was there also.

Q Could you describe how Maribelle Gomez would interact with your son Raphael?

A She would play with him.

Q Was she loving towards your -- towards Raphael?

A Yes.

Q When Raphael came back into your home was he more difficult to control than the other children that were in the home?

THE COURT: Pardon me. Would you restate your question to orient the witness to what you mean by "when he came back into the home?"

Q When Raphael was originally placed into your home in June of 2002, was he more difficult to control than your other -- than Maribelle Gomez's other children?

A Yes.

Q And what was it that you observed that leads you to believe that he was more difficult to control?

A Because he had just arrived at the home.

Q And what was he doing that concerned you?

A He would bite the children.

Q Anything else?

A He would pull the little girl's hair, Julianna.

Q Raphael was removed from your care in -- very briefly in September of 2002 for a leg injury; is that correct?

A Yes.

Q And when he was returned to your home following that brief removal what were his behaviors like?

A The same.

Q Maribelle Gomez and you were having difficulty controlling him?

A No.

Q When you say that he was the same, what do you mean?

A The child was with us (inaudible) time.

Q He was -- he was a short time with you? And what was

it that you were observing in his behavior?

A That my son was not right.

Q Is this -- what do you mean by your son was not right?

A One time we took him to the doctor -- Okay. Excuse me. I went for my appointment to the doctor, with Dr. DeLeon. The appointment was for me. And he saw him and he told us that our son was not right. Just upon looking at him.

MR. CABALLERO: Your Honor, I'm -- I'm going to -- move to strike the comments by Dr. Leon; they're not responsive to the question on what he observed in his child. They're also hearsay.

THE COURT: The statements are not offered for the truth of the assertion but for an explanation for this witness's opinion. As such they're appropriate. The objection is overruled.

Q My next question is, what was it that you were seeing in your child's behaviors that led you to believe that he was not right?

A What he did.

Q Can you describe what he did?

A He would pinch himself.

Q Go on. Anything else?

A ~~He would eat the scab off his hand, burn (inaudible).~~
He would pull his hair. And he did a lot of things that, well, we saw that it wasn't right.

Q Is your testimony, then, that despite these behaviors that you felt that you and Maribelle Gomez were able to control your child's behavior?

A No, because we asked CPS for assistance but they never gave us the assistance my son needed.

Q What assistance did you want?

A To see if we could help our son more, because he did things that were not -- were not right.

Q Your son was receiving medical attention while he was in your care from attending physicians, correct?

A Yes, but those doctors never gave us the help, either.

Q As a father, you were -- were you trying to find out some type of underlying condition that would explain your -- your child's behaviors?

A Yes.

Q Do you believe that Maribelle Gomez could have injured Raphael intentionally?

A No.

Q And if you could describe for the court why not.

A Because he was the one she took -- took the most care of (inaudible)--

INTERPRETER: (Inaudible) translation.

Q When you say that she was the one that took the most care of, what do you mean?

A He was the one he took the most care of -- Okay, he took care of all of them but paid -- she paid more attention to (inaudible).

Q And in your mind and in your belief, do you -- do you think that the injuries -- injury or injuries that Raphael suffered in September of 2003, that those injuries were accidental?

A Yes.

Q What if there is medical evidence that is presented by licensed physicians that -- that show that Raphael died as a result of non-accidental trauma? Would that change your opinion?

A Would you repeat?

Q I will do that.

What is medical evidence -- was presented at this hearing by licensed physicians that showed that Raphael's death was as a result of non-accidental injuries?

Would that change your opinion about Raphael's death being accidental?

A Yes -- No. That was an accident.

Q Because of that opinion that you hold, would it be correct to state that you do not believe that Maribelle Gomez would present any danger towards your child, Edgar Arechiga?

A No.

Q And--

THE COURT: I'm going to take the witness's answer to be that he does not believe Maribelle would be a danger.

I say that because I think--

THE WITNESS: No.

THE COURT: --the question actually was, "Would it be your opinion that she is not a danger."

MR. CABALLERO: And I'll try to clarify--

Q Is Maribelle Gomez in any way a danger to your child Edgar Arechiga?

A No.

Q Are there any conditions that you think would be appropriate to protect your child Edgar Arechiga from Ms. Gomez?

A No.

MR. CABALLERO: I don't have further questions. Thank you, Mr. Arechiga.

THE COURT: Cross examination, Mr. Anderson?

MR. ANDERSON: Thank you, your Honor.

CROSS EXAMINATION

BY MR. ANDERSON:

Q Mr. Arechiga, you stated that you do not feel that Maribelle Gomez would be (inaudible) Edgar, correct?

A Correct.

Q Are you aware of any (inaudible) injuries that Edgar has sustained (inaudible)?

A No.

Q Are you aware of any injuries, whether they be explained or unexplained, (inaudible)?

A No.

MR. ANDERSON: Thank you. (Inaudible).

THE COURT: Cross examination, Mr. Moser?

CROSS EXAMINATION

BY MR. MOSER:

Q Mr. Arechiga, who took care of the children while you were at work?

A Maribelle.

Q Did she seem -- did she seem able to take care of the other four children, other than Raphael?

A Yes.

Q Did she ever seem unable to take care of the other four children?

A No.

Q What kind of a mother was she?

A A good mom.

MR. MOSER: (Inaudible).

THE COURT: Redirect?

MR. CABALLERO: (Inaudible).
THE COURT: Mr. Arechiga, I have one question

for you.

INTERROGATION

BY THE COURT:

Q What did you observe regarding the feelings of your other children, or Ms. Gomez's other children, toward -- Raphael?

A Well, the truth, my son did things that I saw that -- that I thought weren't right.

Q Did he do those things to the other children?

A Yes, he would bite them.

Q How did the other children seem to react to Raphael?

A They didn't want to get close to him.

THE COURT: Counsel, I need to ask, just so I don't go down a mistaken factual path, here. My recollection is that when Raphael suffered the first femur -- or, tibial fracture, that all five children were removed for a brief time, like five days, and then returned to the home. Then when the December 02 left femur fracture occurred, only Raphael was removed, and that was for a period of some -- three or four months?

MR. CABALLERO: (Inaudible) have the records (inaudible). But -- the child -- Raphael I know was removed from December of 2002 until March 25, 2003; that's what the testimony has established.

THE COURT: Right.

MR. CABALLERO: But I don't know about the other--

MR. ANDERSON: I don't believe they were, (inaudible) court.

THE COURT: Okay. Thank you. I think that's -- I think you're right. So let me ask this question:

Q After Raphael suffered the broken left leg, he was placed in foster care for a period of about four months; is that correct?

A Yes.

Q During that four-month period did the other children remain in your home?

A Yes.

Q During that time while Raphael was in foster care did the other children have an opportunity to visit him?

A Yes.

Q My recollection is that after a while Raphael was permitted to stay over night in your home, before he was actually returned home for good.

A Yes.

Q Okay. When -- when Raphael began to return to your home for overnight visits, or when he finally returned for good in late March, what did you observe about the reaction of your -- of the other children to his return?

A They were happy.

Q Did you see anything that would suggest resentment or jealousy on the part of the other children?

A Yes.

Q What did you see?

A (Inaudible) older children, see, they're not my children but I've raised them. And Julianna was jealous.

Q Did you see resentment or jealousy toward Raphael from

any of the other children?

A No, -- they were happy because he was back, because they were taking him away from us all the time.

Q Does that description include Julianna?

A Yes, but -- I raised (inaudible) she was little.

Q In the period of about five and a half months from Raphael's return to your home until his very

unfortunate death, did he suffer any other injuries?

A The blow that he suffered at the laundromat.

Q Anything else?

A That's when he burned his hand.

Q Anything else?

A And the blow when he -- you know, when he fell and he broke his leg and then he re-injured that (inaudible) head.

Q Okay. I may have misled you. I understand the broken leg was in December of 2002. I want to move ahead from that time to late March of the following year when he returned, beginning then with his return to your home. For the following five or six months until the great sadness of his death, did he suffer other injuries during that time?

A The first time that -- that he was at home.

~~Q What injuries did he suffer?~~

A That's when he -- his (inaudible) fractured.

Q Mr. Arechiga, I'm still concerned that you aren't talking about the same time that I am. We know that your son died in early September of 2003. During the six months just before his death, beginning with his return from foster care after his broken left leg, during that last five or six months of his life, did he suffer any other injuries?

A No.

Q Were you present at either the time of the injury in the laundromat or at the time of his burning his hand?

A No. I was working.

Q Okay. Where do you work, by the way?

A I work at a dairy.

Q How did you find out how those injuries occurred?

A Because she and the children told me.

MR. CABALLERO: Follow-up, Mr. Caballero?

MR. CABALLERO: (Inaudible).

THE COURT: Mr. Anderson?

MR. ANDERSON: No, your Honor.

THE COURT: Mr. Moser?

MR. MOSER: Nothing right now, your Honor.

(Inaudible).

THE COURT: Thank you. Mr. Arechiga, you can step down.

MR. CABALLERO: Thank you, Mr. Arechiga.

Your Honor, to conclude the morning testimony, there is a stipulation that the parties have agreed to in lieu of testimony regarding Dr. (Inaudible). Let me check with the guardian ad litem to make sure (inaudible) stipulation--.

And, your Honor, the parties have agreed to stipulate to the following evidence in lieu of Dr. James (Inaudible) testifying at trial.

THE COURT: Spell the name, please.

MR. CABALLERO: M-e-l-l-e-m-a.

THE COURT: Go ahead.

MR. CABALLERO: If called to testify the following evidence would be adduced:

Dr. James Mellema is a duly licensed medical doctor in the state of Washington. His specialty is in pediatrics. He is a critical care specialist at the pediatric intensive care unit at Sacred Heart Medical Center.

That on September 9, 2003 Raphael Gomez was transported by MedStar to Sacred Heart Medical Center, and was admitted to Dr. Mellema's care. That efforts to resuscitate Raphael failed and he died on September 10, 2003. And that Raphael's body was then released to the Spokane Medical Examiner's office for autopsy.

That is the extent of the stipulation.

THE COURT: Is it so stipulated?

MR. ANDERSON: It is, your Honor.

MR. MOSER: (Inaudible).

THE COURT: Thank you.

MR. CABALLERO: I don't have further witnesses for the morning. It's my understanding that there is a criminal matter that needs to be addressed.

THE COURT: Okay. Thank you. This matter will be in recess until one o'clock.

MR. CABALLERO: Your Honor, my next witness is at 1:30. (Inaudible) 1:30--.

~~THE COURT: Any problem?~~

MR. ANDERSON: (Inaudible) half hour.

THE COURT: It's a good time to demand that we start at 1:00, Mr. Moser, because you'll come off as looking like a very hard-working lawyer.

All right. One-thirty, then.

Recess

AFTERNOON SESSION
February 20, 2004

THE COURT: Call your next witness, please.

MR. CABALLERO: Yes, your Honor. Returning on the matters of Edgar Arechiga, Julio, Julianna and Maria Gomez, the Department's next witness is Linda Turcotte. But before I do that, to clarify the record, there are two exhibits that have been marked for identification Exhibits 1 and 2. The Department will not be offering those exhibits and would ask that they be withdrawn (inaudible).

THE COURT: They may be withdrawn.

MR. CABALLERO: And the Department will call Linda Turcotte to the stand.

THE COURT: Do you solemnly affirm that the testimony you give in this matter will be the truth, under penalty of perjury?

THE WITNESS: I do.

THE COURT: Please be seated.

DIRECT EXAMINATION

BY MR. CABALLERO:

Q Ms. Turcotte, would you please state your full name for the record?

A Linda Turcotte.

Q And how do you spell your last name?

A T-u-r-c-o-t-t-e.

Q What is your occupation?

A I'm a social worker with the Division of Children and Family Services.

Q What is your business address?

A 1620 South Pioneer Way, Moses Lake, Washington.

Q What are your present duties as a social worker for the Department?

A I presently work for Child Welfare Services.

Q How long have you been with Child Welfare Services?

A Three months.

Q Prior to your current duties as a Child Welfare Services social worker, were you with the Child Protective Services unit?

A I was.

Q And for how long?

A Seven years.

Q How does Child Welfare Services differ from Child Protective Services?

A Child Protective Services is the investigating unit. They investigate reports that come in alleging child abuse and neglect. They determine -- short term, whether a child is in imminent danger or not, make decisions on placement out of the home or remaining in the home of the child. They also determine whether there should be legal intervention.

Child Welfare Services, on the other hand, case manages services for families of children who are dependent already. ~~Those children can be placed in the home with the parent or outside of the home, like in foster care.~~ So it's a longer-term working with the family.

Q What is your education relevant to your role as a social worker?

A I have a bachelors of art in social work from Eastern Washington University.

Q And what training have you had to prepare as a social worker?

A I've completed all the DCFS required mandatory training, to do CPS investigations, and Child Welfare Services. I've completed all the trainings required by the national accreditation. And I've taken other trainings by choice.

Q Are you required to participate in continuing education?

A I don't know that we're required. There's certain mandatory trainings that you need to take initially, and then later on after so many years you're required to take advanced courses. And I've completed those.

Q And typically what are the topics that you train in?

A Well, for Child Protective Services I completed a requirement -- a required training from Harborview Hospital to conduct sexual abuse investigations. I've completed trainings in crisis intervention, families, investigations, risk assessment, child development, working with difficult families, neglect issues.

Q When you were with the Child Protective Services unit did you have the occasion to work with Raphael Gomez and his parents Maribelle Gomez and Jose Ramon Arechiga?

A I did.

Q Did you file the dependency petition involving Raphael Gomez on or about August 10, 2001?

A I did.

Q Prior to filing the dependency petition were you able to investigate the need for dependency?

A I did.

Q The testimony has established that Raphael was born on

August 7, 2001. Was he placed into foster care shortly after birth?

A Yes. He was placed in foster care from -- being discharged from the hospital.

Q And when was he discharged, approximately, from the hospital?

A I believe August 12th.

Q Of 2001?

A Uh-huh.

Q And is that a yes?

A Yes.

Q Was a dependency order entered as to Raphael declaring him a dependent child on September 11, 2001?

A Yes.

Q Would you briefly summarize what facts you felt as a social worker supported a finding of dependency, as presented in your dependency petition?

A Initially a report had come in a month before Raphael's birth alleging that Maribelle was in her third trimester of pregnancy and that she had tested positive for cocaine at the ER hospital. I conducted an investigation on that report and I met with Maribelle in her home -- actually, her relative's home. ~~She denied using -- Actually, she admitted she used at one time but denied continued use of cocaine.~~ She declined any kinds of services through the Department, in assisting her, facilitating in completing a substance abuse eval -- evaluation, in facilitating with prenatal care services.

Q In addition to a dependency order was a disposition order entered on September 11, 2001, as to Raphael?

A Yes.

Q Once a dependency is established do you keep the case on your caseload?

A I do not.

Q Who is it -- who would you transfer the case to?

A The case is then transferred to a Child Welfare Services caseworker.

Q And is that for case management?

A Yes.

Q Do you recall who the Gomez case was transferred to?

A Yes.

Q And who was that?

A Olga Castillo.

Q Is Olga Castillo also known as Olga Gaxiola?

A Yes.

Q At the time that you -- Strike that.

Do you sometimes transfer a case to Child welfare services prior to the establishment of dependency? Can that also happen?

A Yes.

Q Okay. And when a case is transferred from Child Protective Services to Child welfare Services does the Child Protective Services social worker consult with the Child welfare Services social worker?

A Yes.

of transfer-- THE COURT: Did your question mean at the time

MR. CABALLERO: Yes.

THE COURT: --or thereafter?

MR. CABALLERO: At the time of transfer.

THE WITNESS: Yes.

Q Do you recall when you transferred the case to Ms.

Castillo or Ms. Gaxiola?

A I believe it was the early part of September.

Q And when the case was transferred to the CWS or child welfare Services unit where was the child placed?

A In foster care.

Q During the period of time from approximately August 12, 2001 to the early part of September of 2001 when you initially had the case, were there any reports of injury to the child while he was in foster care?

A No.

Q And was Raphael receiving routine medical care during that period of time? If you can recall.

A I believe foster mother did follow up by taking Raphael to the doctor for his initial checkups, yes.

Q Were there subsequent circumstances that required your intervention as a Child Protective Services worker in the Gomez family?

A Following--?

Q Following the September 2001 transfer to -- Ms. Gaxiola.

A Yes.

Q And what -- when did you next become involved in the case?

~~A Can I refer to my notes, to look at a date?~~

THE COURT: Are you able to answer without referring to your notes?

THE WITNESS: I believe so.

THE COURT: Go ahead.

THE WITNESS: Okay.

A The next time I recall being involved with the Gomez case is when a second referral came in alleging that both Jose and Maribelle had completed a scheduled UA at a medical clinic and they both had tested positive and had been observed driving off in the car with two young children.

Q And did you investigate that referral?

A I did.

Q Did that referral result in any Child Protective Services action against the family?

A No.

Q When did you next become involved with the case?

A That would be when Raphael was taken to the hospital by his father, and there was a right leg fracture.

Q The testimony has been that this occurred in September of 2002. Would that be correct to the best of your recollection?

A Yes.

Q Was Raphael removed from the parents' care at that time?

A Yes.

Q How about the other children?

A They were also removed.

Q And for how long? Approximately.

A A week. The infant, the newborn, was not removed from the family; he remained with the mother and father.

Q And the infant is Edgar Arechiga?

A Yes.

Q During that one-week period of removal in September of 2002 where was the child placed?

A In foster care.

Q Were all the children placed in foster care?

A Yes.

Q In regards to Raphael Gomez during this period of

removal in september of 2002, were there any reports that you received of injury to the child while he was in foster care?

A No.

Q And, were you assigned to investigate the September 2002 leg fracture?

A Yes.

Q As part of your investigation, were you able to rule out the mother's involvement in that leg fracture?

A Yes.

Q Do you recall how it was that you ruled out the mother's involvement?

A Yes.

Q And how was that?

A First of all the medical staff at the hospital confirmed that she was in the hospital with her infant child. Also the uncle who was caring for the children confirmed that she was not at the home when the child -- fell and broke his leg.

Q Were you also able to rule out the father's involvement in this leg fracture?

A Yes.

Q And was that based upon the information provided by the relative?

A Yes.

Q Were there subsequent circumstances that required Child Protective Services intervention in this matter -- in the Gomez matter?

A Are you asking me if there was additional investigations? Or--

Q Let me rephrase.

A Okay.

Q Following the return of the child into the parents' care one week after the removal in September of 2002,--

A Uh-huh.

Q --did you become involved in the case again?

A Yes.

Q And when was that?

A December, I believe it was -- It's when Raphael was taken to the hospital -- second time -- for his left leg being fractured.

Q And was this in December of 2002?

A Yes.

Q Was Raphael removed from the parents' care at that time?

A Yes.

Q And where was the child placed?

A In foster care.

Q As part of the investigation into the December 2002 leg fracture, did you interview the mother regarding what had occurred?

A I did.

Q And do you recall -- can you summarize -- strike that. Did the mother provide an explanation as to how the child had injured their leg -- his leg?

A She did.

Q Can you summarize for the court briefly what information you obtained from the mother?

A Yes. Maribelle reported to me that following dinner she was at home, the children were there, she was mopping the floor, the floor was wet in the kitchen. Raphael came running from the back bedroom into the

kitchen, slipped, fell, and basically was in a splits position.

Q Did she explain to you what she meant by a splits position?

A Yes, she did.

Q And what was that?

A That one leg was completely straight forward in front of him and his other leg was straight back behind him.

Q Did the mother offer -- There's been testimony that in December of 2002 there was also a scalp abrasion to the back of the child's head. Did -- were you able to inquire as to how that scalp abrasion occurred?

A Yes.

Q And do you recall what information the mother provided?

A Yes.

Q And what was that?

A When I asked the mother about that injury she stated that she believed it had happened from a prior injury where he had fallen -- Actually, he had hit his head under a table, and she believed that when he had had the fall in the kitchen that hitting his head again, it may have caused that injury to -- skin to reopen. ~~So it would be an old injury, is basically what she was saying.~~

Q In terms of that old injury to the scalp, do you recall if the mother specifically said a table, or -- is that a specific recollection of yours?

A My specific recollection of what she said to me was that they were at a laundrymat [sic] and Raphael had went to get a ball that was under the table and while under that table he lifted his head and had hit his head pretty bad, and -- where there was blood and -- it didn't require any medical attention but that he had injured the back of his head.

Q When you were talking to the mother during your investigation of December 2002 leg fracture, was the mother raising concerns with you regarding difficulties that she was having in -- in caring for Raphael?

A Yes. I recall her expressing concerns as to his behavior, not so much as to how to care for him.

Q Then let me rephrase the question. Was -- what concerns was the mother raising regarding Raphael's behaviors?

A She stated that she -- had been noticing Raphael's behavior -- of not -- She explained that Raphael had no ability to -- to know when he was -- after he ate a meal, that he was full; he would continue to eat and eat until he would just vomit his food out. She said that was ongoing.

She stated that they had observed Raphael to not have a normal sense of pain, as other children would. He would drink very hot liquid, he would throw himself, hit -- land on the floor very hard and he still did not seem to be affected by it.

Maribelle was very concerned as to a burn that he had had on his hand, and that he would not allow to heal. The scab would start getting dry on his hand and he would pick at it and pick at it and no matter what she would do to try to make him understand that that was not something he should do, and it was a bad thing, he wouldn't -- Then she explained that he

started having like secretive behavior, where she would find him alone in a room, or behind, you know, a chair, and he would be picking at that scab and pulling it off, and then he would eat it.

Q Did the mother disclose any feelings of being in a stressful situation because of Raphael's behaviors?

A She did.

Q And what did she disclose in that regard?

A She felt very stressed because he continued to have these accidents, so she said. She felt that -- that she and her husband and family would be blamed for the accidents, and -- she -- I believe she was stressed because she felt that Raphael's behavior, his -- the concerning behavior was due to her having used drugs during her pregnancy with Raphael.

Q Was Raphael returned to the mother and father's care in March of 2003? Do you recall?

A I don't believe I had the case March 2003.

Q That's fine.

Were you able to observe Maribelle Gomez interacting with her child Raphael Gomez?

A Yes.

Q And could you explain for the court under what types of circumstances you were able to observe Ms. Gomez interacting with her child?

A When I was involved in the case doing the investigations I would -- Part of the -- Part of my work was investigating and finding out, getting information from the parents as to what took place. The other part I would conduct unannounced home visits to find out how the family was really behaving, who was there, to get a sense of how they were functioning in a more unannounced setting.

And they always opened their door, every time I would come. They always welcomed me. I would spend up to 30 minutes in their home. I would see the children, the other children, Raphael, interacting very normally. Maribelle had a very good sense and ability to manage that many young children in a very, very small home.

Raphael looked happy. The other children looked happy. I never observed any kind of behavior that would lead me to believe that the children were being physically abused.

Q Was the mother affectionate towards the children?

A Yes.

Q And, did she appear -- were you able to see the mother with Raphael in the home in addition to the other siblings?

A Yes.

Q Did she appear to treat the children differently in any respect, especially Raphael being treated differently from any of the other children?

A Yes.

Q And how was that?

A She kept a special eye on him. We -- Even when she would be talking with me or another child she seemed to always have her eye on him, and -- like she would see him if he was doing something, and she would stop what she was saying to me and go and take care of what she needed to do with Raphael.

Q Were you able to observe the interaction between Raphael and his older siblings?

A Yes.

Q And, what did you see in that regards?

A There was quite a bit of sibling rivalry. And -- most of it was between Raphael and Julianna, the younger ones. It was nothing dangerous.

Q How was it expressed?

A In Raphael wanting something that she had, and him going out to get it, and pulling it and taking it. The older child, Maria, would be usually the -- would be there kind of refereeing, when it was the group of the kids together.

Q Would the mother intervene in those circumstances?

A She would, verbally.

Q While you were in the home observing Raphael and the family did you ever see Raphael hitting himself?

A No.

Q Did you ever observe Raphael pulling his hair, his own hair?

A No.

Q Did the parents ever have Raphael's hair really long?

A I don't recall Raphael's hair being any longer than a little boy's haircut. No, it wasn't long.

Q Did you ever observe Raphael -- hitting his head into

~~into objects, seemingly in a purposeful manner?~~

Let me rephrase that. (Inaudible).

Did you ever observe him running into objects

head-first?

A No.

Q Was he an active child?

A He was active, yeah.

Q And what do you mean by that?

A What I observed in the home is him being just as active as the other children, in playing -- I didn't see him as overly active. I've seen other children who just will not stay still. I don't feel that that was Raphael.

MR. CABALLERO: I don't have further questions. Thank you, Ms. Turcotte.

THE COURT: Before I ask for cross examination, Mr. Caballero was asking you about some specific things that you may or may not have seen in Raphael. Did you ever -- did you yourself ever get to see any of the unusual behaviors that were complained of by Mom?

THE WITNESS: No.

THE COURT: Okay. Cross, Mr. Anderson?

CROSS EXAMINATION

BY MR. ANDERSON:

Counsel's microphone inoperative

Q Taking that one (inaudible) one step further, did you ever see any behaviors in Raphael, whether they were reported to you by Mom or otherwise that seemed a bit odd or unusual to you (inaudible)?

A No.

Q Going back to -- August, September of 2001, when the dependency on Raphael was first filed, I think you stated that the reason for your involvement was the fact that the mother Maribelle Gomez tested positive for cocaine during the final trimester of her pregnancy, and that she was refusing services the Department offered; is that correct?

A Yes.

Q Did you -- Prior to turning the case over to the CFS caseworker did you formulate any sort of -- ISSP or individual service and safety plan (inaudible) services that the Department wanted the mother to engage in?

A Yes.

Q Do you recall what the nature of those services were?

A I recall some of them, not the entire list, but--

Q Can you give a general idea of what (inaudible)?

A She would have to complete a substance abuse evaluation, follow through with all recommended treatment, have scheduled, monitored UAs, complete a parenting education program. Those are the two that I would -- that I remember being the most important ones.

Q Other than the obvious harm that could come to a child who is exposed to drugs while in the womb, was there any other indications you had that Maribelle had abused or neglected Raphael or any of the children?

A My concern was with, in being involved in Maribelle's case with Raphael, was that not only did she test positive at third trimester, she again tested positive at the birth of Raphael.

~~Q Okay. Other than the drug use~~

A Uh-huh.

Q --were there any other concerns you had -- specifically the concerns here is allegation that she was physically abusing any of the other children?

A No.

Q Were there any indications that you had that she had an anger management problem?

A No.

Q How long were you involved in the -- with the Gomez-Arechiga family -- around the December time when the -- femur fracture (inaudible)? How long were you involved in the case at that time?

A Probably about 30 days.

Q Okay. And, were all of the children removed from the home in December? Or,--

A No.

Q --just Raphael--

A Just Raphael.

Q This may seem like an odd question, but there -- the dependency on Raphael was still active and ongoing at that time; is that not correct?

A Yes.

Q why then was CPS -- (inaudible) into the case if there was already a CWS case ongoing?

A Because it was a new injury and he was a dependent child.

MR. ANDERSON: Thank you. I don't believe I have any further questions.

THE COURT: Mr. Moser?

CROSS EXAMINATION

BY MR. MOSER:

Q Ms. Turcotte, in your -- in your contact with Maribelle Gomez did you get a chance to observe her parenting skills?

A Briefly.

Q What did you observe?

A While in the home I observed Maribelle to -- to manage her children quite well, being that they were four of

them, they were young. She was a stay-at-home mom, so she was with them every day. She kept her home very -- very neat. There was always something cooking on -- on the stove when I would come in, even at unannounced visits there was always -- she always had a meal for her children there, ready.

Q Ms. Turcotte, did you say you've -- your career has been about seven years long, or you've been with the Department seven years; (inaudible)?

A Yes.

Q And, mothers with five kids, one with special needs, would you say, Ms. Gomez was a relatively good mother in that situation?

THE COURT: Stop for a moment, please.

I think that at the time that Ms. Turcotte is describing there were four children, and not five.

MR. MOSER: If I could modify the question just -- just (inaudible).

Q Would you say she was a good mother relative to other mothers in that situation?

A The brief time that I spent in the home, I observed her to do -- to take care of her children well, yes.

Q Was she able to care for Raphael?

A ~~The short time that I would be in the home observing~~ Mom with the children, I never actually saw her changing him or actually feeding him. But I would see her taking care of her children in more of a group setting, so not individually.

Q As far as you are aware did she ever ask the Department for assistance in caring for Raphael?

A When you say "assistance," like respite care?

Q Maybe extra beyond what you -- what the Department was (inaudible) providing.

A The one thing I can recall Maribelle asking me is that she wanted help from the Department to have Raphael tested. She felt that he may have a neurological disorder, more of a -- some kind of disorder that was causing him to behave in -- in -- in what she believed was difficult at the eating, the -- not having the normal sense of pain as other children did.

Q And what was the response of the Department to that request?

A There were recommendations made that that take place.

Q And it didn't take place, right?

A I don't know.

Q What kind of services can the Department provide -- mothers with infant children?

A Well, -- you know, thinking of it in the CWS department basically takes care of that part of the case. And in Maribelle's case I don't know what was actually done for -- initiated. So I really can't answer that.

Q Okay. So that's not your end of the case?

A Right.

Q And I think you testified to one injury, but were you -- were you made aware of the injuries that occurred out of the presence of the mother? Injuries to Raphael?

A No.

Q Except for the one where the mother (inaudible) hospital (inaudible)?

A Yes.

Q All right. Were you made aware of any injury that

occurred to Raphael when he was in foster care?

A No.

Q The injury that incurred [sic] to Raphael when the mother was in the hospital (inaudible), was that suspected to be non-accidental?

A Initially, yes.

Q Why is that?

A Well, when Raphael was taken to the hospital by his father, the medical staff made the report to CPS and were suspicious from the explanation that Dad had given as to the injury. So it was investigated as a suspicious injury, initially.

Q And what was the conclusion after the investigation?

A That it was accidental.

Q Ms. Turcotte, (inaudible) testify some about your visits to the Gomez-Arechiga household. Could you tell if the children altered their behavior when you were present?

A No, I couldn't tell.

Q Okay.

MR. MOSER: Okay. That's all I have.

THE COURT: Redirect?

MR. CABALLERO: Yes.

REDIRECT EXAMINATION

BY MR. CABALLERO:

Q Ms. Turcotte, in -- in terms of the mother requesting a neurological assessment of the child, was she asking for that in December of 2002 following the femur fracture?

A Yes.

Q And in regards to the determination that Child Protective Services made that the September 2002 tibial fracture was accidental, were you able to consult with a medical professional regarding that particular injury?

A Yes.

Q And was that Dr. Alan Hendrickson of the Rockwood Clinic?

A Yes, it was.

Q And did Dr. Hendrickson provide you with a letter opinion regarding this type of fracture, the tibial fracture?

A Yes.

Q Did Dr. Hendrickson also provide you with an article explaining those types of fractures?

A Yes.

Q Do you know, Ms. Turcotte, if there is -- if there is another term that can be used to describe a tibial fracture, based upon your review of Dr. Hendrickson's material?

A Yes.

Q And what is that?

A I believe -- I believe he called it a toddler -- I don't know if it's a toddler fracture or a toddler -- It's a common injury that children of that age -- that are active, jump, that they get. It's commonly seen.

Q Okay.

MR. CABALLERO: I don't have further redirect.

Thank you, Ms. Turcotte.

THE COURT: Recross?

MR. ANDERSON: Yes.

RE CROSS EXAMINATION

BY MR. ANDERSON:

Q Ms. Turcotte, Mr. Caballero just asked you (inaudible) questions ago or so if the mother's request to you to have Raphael get a neurological exam was made after the December (inaudible), and you said yes, it was.

A Yes.

Q If she had had concerns about that before and had made a request to the Department, is it likely that you would have known about that, seeing as the case was under CWS caseload at that point?

Do you understand the question--

A Yeah.

Q --(inaudible) rephrase it.

A You can rephrase it.

Q Okay. If she had made a request of her CWS caseworker (inaudible), would you necessarily have known about that request?

A Yes, because when we investigate cases that are already open, that we have a dependency, it's common practice that the investigator will talk with the CWS worker as to how the case is coming along, are there any issues right now that are of concern. So it would be possible that the worker would have shared that part.

Q And do you recall if the -- (inaudible) if the CWS caseworker shared (inaudible) information with you?

A I recall that she didn't.

Q Okay.

THE COURT: I think I need to just ask, to clarify. You say it would be possible that the CWS caseworker would mention that. Would it also be possible if there was a request from Mother to CWS caseworker that the caseworker would not mention it to you?

THE WITNESS: Yes, that's possible.

THE COURT: Okay. Thank you.

Q You may have already answered this question, (inaudible), but -- during the times that you were involved in the case -- So, in August-September of 2001, (inaudible) time in September, 2002, and then December, 2002, did you have the opportunity to observe visits between Maribelle Gomez and Raphael Gomez, and also between the mother Maribelle Gomez and her other children?

A Yes.

Q And (inaudible) did you ever see her act in -- untoward towards her kids or (inaudible) children?

A No.

MR. ANDERSON: Thank you.

THE COURT: Cross examination, Mr. Moser?

RE CROSS EXAMINATION

BY MR. MOSER:

Q Ms. Turcotte, was the foster mother instructed not to discuss this case with any outsiders?

MR. CABALLERO: I'm going to object as to the form of the question. One, its relevancy. And two, it goes beyond the scope of direct and redirect.

THE COURT: The objection is sustained.

MR. MOSER: No more questions, your Honor.

THE COURT: Redirect?

MR. CABALLERO: None, your Honor.

THE COURT: May the witness be excused?

MR. CABALLERO: Yes.

MR. ANDERSON: No objection, your Honor.

MR. MOSER: That's fine.

THE COURT: Thank you, Ms. Turcotte. You can step down.

MR. CABALLERO: And, your Honor, the Department's next witness is Dr. Marco Ross, and he could not testify until 3:00 p.m. due to his duties. So I would ask that there be a recess until 3:00 p.m. (inaudible).

THE COURT: Any objection?

MR. ANDERSON: No, your Honor.

MR. MOSER: (Inaudible) no one else. That's fine.

THE COURT: We'll be in recess until 3:00.

Recess

MR. CABALLERO: The Department's next witness is forensic pathologist Marco Ross. He will be testifying by telephone.

THE COURT: Very well.

Witness reached by phone

MR. CABALLERO: Dr. Ross, can you hear me?

~~THE WITNESS: Yes, I can.~~

MR. CABALLERO: We are in open court at Grant County Superior Court Juvenile Division. Judge Evan Sperline is presiding. And we are ready to take your testimony. Is that all right?

THE WITNESS: Sure.

MR. CABALLERO: And I'm going to ask that Judge Sperline put you under oath.

THE WITNESS: Okay.

THE COURT: Do you solemnly affirm that the testimony you give in this matter will be the truth under penalty of perjury?

THE WITNESS: I do.

THE COURT: Dr. Ross, our hearing is being conducted with the assistance of an interpreter. For that reason I'll ask your cooperation in using a perhaps more relaxed pace for your testimony than you might otherwise.

MR. CABALLERO: And Dr. Ross, I wanted to identify the participants today in court for you.

THE WITNESS: Okay.

MR. CABALLERO: In addition to Judge Sperline, Terry Cullen and Tamara Cardwell are here; they are with the guardian ad litem program. Mario Gonzalez, who is the agency social worker, Maribelle Gomez, who is the mother of Raphael Arechiga-Gomez with her attorney Doug Anderson, Jose Arechiga who is the father of Raphael Arechiga-Gomez and his attorney Robert Moser. In addition there is an interpreter, Saul Castillo.

THE WITNESS: Okay.

DIRECT EXAMINATION

BY MR. CABALLERO:

Q Dr. Ross, would you please state your name and spell your last name for the record?

A Marco A. Ross, R-o-s-s.

Q What is your profession?

A Forensic pathologist.

Q And what is your business address?

A 5901 North Lidgerwood, L-i-d-g-e-r-w-o-o-d, Street, Suite 24-B. That's at the Spokane County Medical Examiner's office in Spokane, Washington, 99208.

Q Are you a licensed physician in the state of Washington?

A Yes, I am.

Q And when were you licensed?

A I believe I received my initial license in -- either -- November, I believe, of 2002.

Q Would you describe briefly your pre-medical and medical training starting with your undergraduate studies?

A I was an undergraduate at Purdue University in West Lafayette, Indiana, followed by four years of medical school at Tulane University in New Orleans. I then completed a six-year residency in general surgery at the University of South Carolina in Columbia, South Carolina. That was followed by four years of active duty in the United States Navy as a general surgeon, followed by a four-year residency in general anatomic and clinical pathology at the University of Vermont in Burlington, Vermont. Then I did a one-year forensic pathology fellowship with the Office of the Chief Medical Examiner in Chapel Hill, North Carolina. Then I spent approximately two and a half years as a medical examiner for Maricopa County in Phoenix, Arizona, before I started working as a medical examiner here in Spokane in December of 2002.

Q What is it that a forensic pathologist does?

A A forensic pathologist is trained to examine the deceased and to perform examinations and investigation into that to assist in determining what the cause of death is.

Q As part of your duties, then, do you perform autopsies with the Spokane Medical Examiner's office?

A Yes, I do.

Q Did you perform the autopsy of Raphael Arechiga?

A Yes, I did.

Q Do you recall on what date and at what time you performed the autopsy?

A That was done on September 11 of 2003, at 10:30 in the morning.

Q What was your understanding regarding the circumstances of Raphael Arechiga's death?

A That he had had a previous femur fracture, that he had become unresponsive at his residence where he was transported to Columbia Basin Hospital, and when he was there at the hospital he was found to be unresponsive, not breathing and pulseless. They started cardiopulmonary resuscitation, and a blood pressure and a pulse were obtained. And he was then transferred to Sacred Heart Medical Center here in Spokane, where he remained unresponsive and never regained consciousness.

He had severe cerebral edema and he expired on the 10th of September, I believe, at approximately ten o'clock.

Q And what is severe edema?

A Severe edema means swelling. Edema is -- is -- excessive fluid in a tissue and causes it to swell, so severe cerebral edema just refers to swelling of the brain.

Q How is it that you identify a body of a decedent?

A How do we identify the body?

Q Yes.

A Generally when the body comes from a hospital it's identified with some identification bands that are attached to the body. And that's usually how we identify bodies from -- from a hospital.

Q And how was Raphael Arechiga's body identified?

A He was identified by a hospital identification band on his right ankle, which had his name, Arechiga, Raphael. In addition he had a purple identification band that is placed on -- on bodies that we transport from one facility to our -- to our morgue. And that name, Raphael Arechiga, was also placed on that particular identification band.

Q Was there any clothing or personal effects?

A Let's see. There was a disposable diaper with the body as well as a white blanket with some cartoon characters, folded across the front of the body.

Q And were there any effects contained inside the body pouch?

A There was a separate plastic bag that had a sample of blood and a sample of urine in it.

Q Were you able to -- strike that.

~~Was there evidence of medical intervention?~~

A Yes, there was. There was an endotracheal tube, which is breathing tube, that entered the mouth and went into the trachea, which is the windpipe. There was also an oral gastric tube, which is a tube used to help suck stomach contents out and keep -- keep excessive fluids from building up on the stomach.

There was a Foley catheter, which is a catheter or small flexible tube that is inserted through the urethra into the bladder, to help drain urine, keep track of urine. There was a triple lumen catheter, which is a type of intravenous catheter, a small tube that goes into -- into a blood vessel in order to administer medications and fluid, and that was in the left groin region, so it was probably going into his femoral vein in that -- in that area.

He had some gauze bandages taped on the tops of his right hand and in the right groin area. These are probably areas where there had been previous needle -- needle punctures of one sort or another, either from IVs, or for blood sampling.

He also had a lot of -- Let's see -- needle puncture sites in the -- in the (inaudible). These are the areas in the arms between the -- between the forearm and the upper arm; it's an area where they routinely draw a lot of blood. And also on the underside of the -- of the left wrist, and on the dorsal aspects of the tops of both feet.

Q As part of the autopsy did you conduct a general external examination of the body?

A Yes. The autopsy begins with a general external examination.

Q Would you summarize your findings upon external examination?

A Okay. That he had a weight of 31 pounds; he was 33-1/2 inches in length. On his right parietal scalp, which is on the right side of his head, he had a 3/4 by 1/8 inch abrasion, or a scrape. And the right side of the back of his scalp, the right posterior occipital scalp, had a slightly thickened feel to it.

Inside the left eye, the white of the eye on the outside part had an area of bleeding or hemorrhage. Also at the corner of the left eye on the skin there was actually a small 3/8 by 1/8 inch abrasion at that area.

The left malar prominence, which is basically where the cheek bone is, had a -- a 1 by 1/4 inch abrasion.

On the right side of his lower lip he had a 3/16 by 1/8 inch contusion or small bruise.

On his right ear, the ear lobe had a scrape or an abrasion that was 3/16 inch by 1/16 inch. And on the outside part of the right ear he also had a half by 1/16 inch abrasion or scrape.

On his -- on his trunk area, the left upper part of his abdomen had a 1-1/2 by 1/2 inch contusion or bruise. The left side of the abdomen had a 1 by 1/2 inch bruise.

And then on his arms, on his right forearm on the top -- the bottom side of his right forearm he had a 1/2 by 3/8 inch bruise.

And on -- on the outside part of his left middle finger he had a 1/8 by 1/16 inch abrasion or scrape.

And on the back side of the left upper arm he had a 1 by 1/2 inch bruise. And around his left elbow he had two bruises ranging from 1/2 to 3/4 inches in size.

And then on the -- on his upper back in the middle he had a 2-1/4 inch by 1-3/4 inch bruise.

Q Did you also perform an internal examination?

A Yes. Next we performed an internal examination where we open up both the chest and the abdominal cavities, as well as the head, and examine the internal organs.

Q Would you summarize your findings upon internal examination?

A Inside the chest he had about 100 ml. of (inaudible) fluid. It's a clear fluid inside -- inside the chest cavity. Normally there's probably only about 5 or 10 ml., 5 ml. being about a teaspoon worth. But he had 100 ml. of this fluid present in each pleural cavity.

In addition he had 250 ml. of clear fluid in his abdominal cavity.

In addition there was a lot of this edema or swelling of many of the tissues in the -- in the abdominal cavity and in the chest cavity.

The heart itself essentially was -- was normal. There were no abnormalities noted on the -- on the heart itself, or in the major blood vessels around the heart.

The lungs themselves were rather heavy, and they also had this edema or fluid, and they appeared to be very congested. Normally the lungs are very spongy, but these lungs were very firm in their -- in their texture, and they had a lot of this edema or fluid in them.

The stomach itself had an abnormality in the area where the esophagus joins the stomach. There were these -- a few of these superficial erosions; they're like tiny -- sort of like little scrapes. They're defects from mini-ulcers, almost, of the -- of the inside surface of the stomach, right where the stomach joins the esophagus or the swallowing tube.

He also happened to have what's termed a mecho-diverticulum (ph.); it's sort of like, almost an appendix-like structure attached to part of his small intestine. Otherwise the rest of his intestine and the pancreas and the liver appeared normal.

His kidneys appeared normal. The bladder did not have any urine in it.

His thymus was unusual in that it was small and shrunken. The thymus is normally an organ which is quite large in infants and children and it can actually increase in size until about puberty, and then after puberty it begins to shrink, and by the time you reach your, you know, 18 or 20 years old, it's pretty much shrunken up to almost nothing. But in his case it had certainly shrunken quite a bit for someone of his age; it was abnormally small and what we would term atrophic or shrunken.

We did an examination of the neck, didn't see any injuries or abnormalities of the neck itself.

In addition to the bruise that I mentioned on the back when we examined him internally we found an additional bruise of the back in the middle but it was kind of lower down, sort of just above the buttocks area, in an area that we call the lumbar regions or sort of in the lower back.

We also examined the bones of the upper arms just below the shoulder joints. The reason we did was we had obtained x-rays during the -- during the autopsy, and these x-rays revealed some abnormalities of the bones at those joint areas. So we looked at those bones, and it turned out that the abnormalities were due to elevation of the periosteum, and what that is, is, the periosteum is a covering of tissue that is directly on the bone, and it is actually the tissue that is -- helps and is responsible for helping the bone to grow. But what had happened in this case is that this layer of tissue had sort of been rubbed off the surface of the bone and there was bleeding between this periosteal tissue and between the bone itself.

In addition, you know, both of these bones at this area, as do -- most -- in all the joints of the body, particularly in someone of this age, have what are called growth plates. There's -- it's an area in the bone that also helps to allow the bone to grow in length and is responsible for one of the primary reasons why we're able to grow in height after we're born is these growth plates are there and allow us to grow in height.

Well, he had an injury to the growth plate in the -- in the bone, or the -- of the left upper arm, that is, the humerus, just below the shoulder joint, and there was a tear in it. It's also something that sometimes can be seen on x-ray and called -- what's called a bucket handle fracture of the -- of the growth plate.

When we examined his head he had an area of what's called subgaleal hemorrhage, essentially bleeding into or just underneath the galea. The galea is a layer of tissue between the skin of the scalp and the skull and it's what helps to hold the scalp down onto the skull. And you can get bleeding or hemorrhage above or below this galeal tissue. And he had an area of hemorrhage beneath this tissue in his

-- on the back of his head in two areas, one on the right side and one on the left side of the back of his head.

He also had an area on the left front side of the head, the left frontal scalp, that had areas of hemorrhage above this galeal tissue layer.

In addition the skull itself had two fractures, on the left side of the back -- the bone or the left occipital bone, which is the back region of the -- of the skull. One of these fractures had what's termed a sagittal orientation, sort of ran a little bit sort of in an up and down direction, between the back of the skull, and went all the way to the foramen magnum. The foramen magnum is the -- is the hole at the bottom of the skull where the -- where the brain connects to the spinal cord and the spinal cord goes on down into the spine. So there was a fracture all the way down the occipital bone into that -- into the foramen magnum.

In addition there was a fracture that was oriented transversely, meaning crosswise, from -- sort of going from left to right, also across the -- the back of the skull.

~~Underneath the -- the fracture site there was~~
an area of bleeding called epidural hemorrhage. The dura is a layer of tissue that's between the skull and the brain and you can get bleeding above this layer, and that's called epidural hemorrhage, and you can get bleeding below that, that's called subdural hemorrhage. And in his case he had an area of bleeding above that -- that tissue layer and beneath the skull called -- called epidural hemorrhage.

In addition, underneath that layer of tissue, the dura, and covering the top of the brain, he had bleeding covering the left side of the brain, the left cerebral hemisphere, about five to seven ml. of hemorrhage overlying that. In addition he had some what are called subarytenoid hemorrhages on the right side of the brain. The arytenoid is a very thin layer of tissue that's very tightly adherent to the actual surface of the brain itself and you can get bleeding underneath that layer of tissue. That would be called subarytenoid hemorrhage. He had that.

And then the brain itself was very -- very soft and swollen, and essentially edematous, severe cerebral edema.

We also did an examination of the -- of the eyes, to look for hemorrhage in the eyes, what are called retinal hemorrhages, and we found multiple sites of bleeding in the retinas of both eyes.

Q Dr. Ross, in regards to the -- the skull fracture, did it -- were these two separate skull fractures that you were observing? Or could they be part of -- of one skull fracture?

A Well, they were -- they were two separate fractures, but they -- but because they were oriented in two different directions. But they could have been the result of one single impact to that area.

Q In addition to the examination of the body, were toxicology specimens taken -- and analyzed?

A Yes. Yes. We took some samples from the body, but because there was survival time in the hospital we actually utilized blood samples obtained from the

hospitals and submitted those for -- for toxicology analysis.

Q Were any of the results of the toxicology specimens significant?

A No, no significant findings. They basically just showed evidence of drugs that were consistent with -- with medical intervention.

Q Are microscopic samples of the body obtained for analysis?

A Yes. Yeah, we do a microscopic evaluation of the tissues. And that allows us to examine the -- some of the abnormalities in more detail. In addition it allows us some time to see some abnormalities microscopically that we don't see as well grossly or with the naked eye.

Q Would you describe any findings upon microscopic examination that you found significant?

A What microscopic examination showed was in the -- in the lungs there were some areas of inflammation and early pneumonia formation. And there were changes that what we call diffuse alveolar damage. It's a type of reaction that the lung has to any number of conditions. You can see it with severe infection, you can see it with head injuries, you can see it after various kinds of trauma. You can see it after other types of conditions where the lungs will fail for one reason or another. Frequently you'll see it in individuals who have to be intubated or put on a ventilator. And when that happens it will -- the lungs can have this response to being in that condition or state, and they'll develop this diffuse alveolar damage and then as part of that they'll usually get some infection on top of it, which is the (inaudible) pneumonia that we saw.

Did an examination of those erosions, those very superficial ulcerated areas that I mentioned previously in the stomach, and it did look like there was some what's called chronic gastritis, some inflammation in the stomach that had -- was chronic in nature, so it wasn't anything that had occurred acutely but had been there some time, some mild -- some very mild, low-level type of inflammation or gastritis in the stomach.

We looked at the thymus. The thymus showed a lot of thinning of the thymus and this atrophy that I mentioned before, that in summary the microscopic findings of the thymus are that of what we call stress involution, and it's seen in children who are under different kinds of stress for prolonged periods, will -- it will cause some overtaxing of their immune system. And it can be stress of various kinds; it can -- generally it's some type of physical or physiologic stress, anything ranging from chronic problems with severe infection to -- to trauma, to injuries, to starvation, things like that, are examples of things that can cause stress involution or shrinking of the thymus gland, which he had evidence of both grossly and microscopically.

Looked at the areas of hemorrhage in the -- in the scalp, as well as in the skull, and looked to see what kinds of bleeding and inflammation are in the tissues of these -- of the scalp as well as the skull. And it showed that both in the scalp and skull

injuries that they had features indicating that they were both acute or very recent as well as subacute or chronic, basically meaning that there were features to suggest that these injuries were of varying and different ages; they didn't all occur at one time but occurred at different points in time.

There was actually some things to suggest that in the skull itself that there was a re-fracturing of a previously fractured area.

We looked at the -- the microscopic areas of the -- of the bones I mentioned before in the upper arms where he had the -- the tears in the growth plate and the -- that periosteal elevation that I mentioned, and again it confirmed what was seen grossly and showed that there was evidence both of very recent or acute injury as well as older injuries to those -- to those areas. And the way one gets those areas is really quite specific; one almost has to grab the arm and twist it quite severely, or shake rather forcibly, in order to generate those kinds of -- of injuries in the joints like he had.

We looked at the bruising on the -- in the arms as well as on the back, again to try to determine if they could give us an idea as to whether or not they had been there for some time or had occurred more acutely, and it appeared that the -- on the -- the bruises that were on the upper and lower back were acute, so they had occurred quite recently, whereas the one in his -- in his right forearm and his left upper arm had a little bit of inflammation to suggest that maybe they were a little bit -- a little bit older than that.

We looked at the hemorrhages in the eyes, and one of the things that helps us to determine the significance of the hemorrhages in the eyes is -- is in addition to seeing how far and how -- what their distribution is on the eye grossly, microscopically we can see if they are in different layers of the retina. And indeed we found that there was evidence of hemorrhage in multiple layers of the -- of the retina, as well as what are termed dome-shaped pre-retinal hemorrhages, and these are kinds of hemorrhages that you, again, with this distribution in these areas, with hemorrhage at these various levels in the -- in the eye, these are hemorrhages that you see only with some type of either severe blunt force impact to the head or with -- with shaking of the -- of the child.

We looked at the -- the dura, which is the layer of tissue between the skull and the brain, mainly actually to look at the area of hemorrhage underneath to see if it looked like that area of -- of hemorrhage on top of the surface of the brain, if it had been there for some time, or -- or not. And what it showed was that it was acute; it had not been -- just -- it was a very recent hemorrhage, and had not -- had not been there for some time.

Now, a more detailed examination of the -- of the brain itself was actually performed by a neuropathology consultant, a -- a Dr. Dario Coccomo (ph.) in Sacramento, California. We will on occasion consult him for a neuropathology examination. And although I did not look at the microscopic section of the tissues from the brain itself, he did, and

according to his report there -- the most significant thing, I believe, that he found was what would be termed some anoxic ischemic changes of the -- of the brain, at least locally; there were some areas where the -- the brain cells showed evidence of -- of -- of starvation of oxygen. And of course this can occur when the -- when the brain gets very swollen, as I saw grossly, with a swollen brain like that it actually squeezes the blood vessels of the brain, and with that squeezing of the -- of the blood vessels in the brain it reduces the amount of oxygen that the brain tissue gets, and in turn then that causes what are called these ischemic changes or anoxic changes, which actually are a sign of oxygen starvation of the -- of the tissues of the brain.

And that in turn -- and then you sort of start getting a vicious cycle where that can actually cause the brain to swell even more. And then of course more brain swelling causes even less blood flow to get to the brain, and -- and so on, and so forth.

Dr. Coccomio's examination also included an evaluation of the dura as well, and for the subdural hemorrhage he also saw that it was acute.

~~In addition he examined the -- what I termed~~ that epidural hemorrhage, that area of bleeding between the skull and the dura. And that actually showed that that was an older area that there was some area of -- of organization in there, so -- which indicated that it was -- one that had not occurred as recently as the bleeding underneath the brain. So, again it -- it's indicative of injuries of different ages occurring to the -- to the head area.

Q Following your examination of the body, externally, internally and microscopically, and also following the consultation regarding the brain tissue, were you able to achieve -- or to arrive at pathologic diagnoses?

A Yes. Uh-huh.

Q And if you could indicate what diagnoses you arrived at.

A Okay. First of all, that there were blunt force injuries of the head, or evidence of blunt force impact to the head. The abrasions or scrapes of the face, the right ear and scalp are certainly indicative of some type of blunt object impacting the -- the head in those particular areas.

In addition, the subgaleal and supergaleal hemorrhages of the -- of the scalp that I mentioned previously are basically really bruises of the scalp, if you will; they're just bruises that you don't necessarily see on the skin surface but are definitely there underneath. And these bruises or contusions are, again, are also the result of some impact. And it would indicate at least a two if not three, minimum, separate (inaudible) of impact to the -- to the head in order to cause just those particular hemorrhages.

Q Doctor, if I could stop you for a second--

A Yes.

Q In regards to the -- you've testified regarding the supergaleal hemorrhage to the frontal scalp?

A Yes.

Q Would that type of injury be expected -- would that type of hemorrhage be expected when a child falls

backwards and his the back of his head?

A No.

Q And please continue with your assessment of the blunt force injuries of the head.

A Okay.

In addition, I mentioned the occipital skull fractures with both had acute and chronic features, so indications that the fractures had been there previously and were healing and then were more recently re-fractured.

In addition, there was this -- this epidural hemorrhage or hemorrhage between the fracture site and the dura, which is the layer of tissue between the skull and the brain, and that showed some organization, and meaning that it was an older, more chronic area of bleeding.

And then, inside the dura and covering the surface of the brain were the subdural and subarachnoid hemorrhages which are acute areas of hemorrhage. These occurred very recently, as opposed to being the older -- older lesions. In addition, of course, there was the brain swelling and these ischemic changes of the cerebrum.

~~So all of these things that I've just mentioned~~
sort of come under the heading of blunt force injury of the head. All of these are either directly the result of or secondarily the result of some type of blunt force impact or a blow to the head, or in this case actually it's more than one blow.

In addition there were retinal and optic nerve (inaudible) hemorrhages. I had not mentioned the optic nerve (inaudible) hemorrhages but both the gross and microscopic examination showed that the -- the nerve that connects the eye to the brain, essentially, the optic nerve, had some hemorrhage around it. Now, some of this hemorrhage can be a result of -- of the hemorrhage in the brain itself that I mentioned before, this subdural and subarachnoid hemorrhage can track out along the nerve, and that's where it shows up out there. But then you get these additional retinal hemorrhages that I mentioned before.

At the contusions or bruises of the back as well as his upper arms--

Q And Doctor, if I could interrupt again--

A Yes.

Q In regards to the retinal and optic hemorrhages that you observed, were those bilaterally observed?

A Yes. It was present in both eyes.

Q And would you please continue regarding the diagnosis regarding the contusions that you observed.

A Okay. He had contusions of his back, the two that I mentioned, one in his upper back and one in the lower back. And he also had bruises or contusions of his -- his upper arms -- say upper extremities which includes both the upper arms and forearms.

He had -- Then he had these injuries of the -- of the bone itself, of the upper arm bone just below the shoulders, or of the humerus bone. He had them on both sides. They were what I termed periosteal and epiphyseal metaphyseal (ph.) injuries of the proximal humeri, basically again meaning these are injuries to the growth plate regions of the -- of the upper arm bones, just below the shoulder. And these showed

features both of being some recent injury as well as some older injury.

THE COURT: Would you pause, please.

THE WITNESS: Excuse me?

THE COURT: Pause? Excuse me. Pause just a moment.

MR. ARECHIGA: He keeps repeating the same thing and the same thing.

THE COURT: Oh. Oh, this -- You were trying to communicate with counsel?

MR. ARECHIGA: Yeah.

THE COURT: Okay.

Doctor, while we've paused here for a minute could I ask you to relax your pace just a little--

THE WITNESS: Okay.

THE COURT: And then, if you could help us follow, you had originally, when asked about pathologic diagnoses--

THE WITNESS: Excuse me one second. I need to close a nearby door where I'm getting a little extra noise. Just one moment, please.

THE COURT: Sure.

THE WITNESS: Okay. I'm sorry. I'm back.

THE COURT: Okay. I want to get oriented once again to your testimony. You had indicated one diagnosis to be a blunt force impact to the head, and you had listed a number of findings which I took to be supportive of that diagnosis.

THE WITNESS: Correct.

THE COURT: Then you began to mention some other things including the retinal and optic nerve sheet hemorrhages, contusions on the back and arms, and the older fracture to the growth plates. Are these separate diagnoses or are these things that are indicative of a different diagnosis than the blunt force impact to the head?

THE WITNESS: The -- the retinal and optic nerve sheet hemorrhages is part of the blunt force injury of the head, or certainly can be attributed to either a blunt force impact or a shaking type of injury. So, it's -- it's listed, although separately from blunt force injuries of the head, is in essence sort of a part of that.

The bruises or the contusions of the back and the upper arms are -- are indicative of blunt force to those particular areas, not to the head, but would be indicative of -- of a blunt force impact to the back or to the arms themselves. And the injuries of the -- of the growth plates themselves, of the growth plates of the upper arms, are very -- quite specific injuries indicative of a -- a -- force that would require someone to grab the arms and twist them forcefully or to grab and shake the individual forcefully.

THE COURT: Thank you.

Q What was your next pathologic diagnosis, Doctor?

A The next pathologic diagnosis after the growth plate injuries was diffuse alveolar damage with multi-focal bronchial pneumonia. This is, again, I mentioned, is a type of what sometimes is called respiratory distress syndrome. It's a change that the lung goes through. It's not very specific, but it occurs in situations where there has been either some type of severe trauma, severe infection, or some other severe

condition in which an individual may have had some type of cardiac or respiratory arrest and then been resuscitated, or may simply present to the hospital and in very extreme, dire straits and most of the time this diagnosis is made in individuals who end up in the intensive care unit on a ventilator. And so it's usually related to a number of factors that ultimately terminate in some type of -- microscopic damage to the lung, that then ultimately causes what's called this diffuse alveolar damage.

Additional diagnoses that in essence are somewhat a part of this but also indicative of part of the resuscitation that was done are the pleural effusions I mentioned, that fluid that was present in the chest cavity. So he had bilateral pleural effusion, and then the fluid in the abdominal cavity. This is yet a separate diagnosis, but I called (inaudible). Both of those diagnoses, the pleural effusions and the (inaudible) are generally a result of the very aggressive resuscitation that was done on -- on Raphael as part of an attempt to try to resuscitate him, where he was given a lot of intravenous fluids.

~~Another diagnosis is that of gastroesophageal~~
erosions, with chronic gastritis. And the -- You know, what that refers to are again the little superficial shallow ulcers that I saw in the stomach near where they join the esophagus as well as some underlying chronic inflammation of the stomach.

Q And, Doctor, what would cause a child Raphael's age to have these gastroesophageal erosions with chronic gastritis?

A Well, the erosions themselves can be due to a number of causes. Sometimes drugs of various kinds can cause them. Infections of various kinds can cause it. Or stress of various kinds, particularly stress associated with head injuries or head injuries themselves can sometimes cause these gastric lesions to occur, although -- the chronic gastritis, that kind of inflammation itself is usually more of a chemical problem with the stomach or a -- an infectious problem with the stomach, some type of an infection, or -- or even viral infection can cause this chronic gastritis. But when you sort of get the erosions on top of it, it -- it indicates some additional factor that was also causing these erosions to occur, and in that setting sometimes actually -- actually the stress itself or head injuries can sometimes associated with the development of ulcers in the stomach can be attributed to actually to head injuries.

So, -- And other kinds of trauma, as a matter of fact, have been associated with these erosions or ulcers. Burn victims, for example, also are prone to develop these lesions in their stomach.

Q And what was your next diagnosis?

A The next diagnosis is stress involution of the thymus. That refers to the shrinking or atrophy of the thymus gland, which in this case was due to some form of stress that had caused it to shrink.

The next diagnosis was a Meckel's diverticulum. That refers to the appendix-like structure that he had on his small intestine. Usually in the setting where we usually see it as part of an autopsy that we do,

almost invariably it's what's called an incidental finding; it just happens to be there and it's not doing anything.

A Meckel's diverticulum can be a source of illness in kids, and sometimes will present sort of like an appendicitis. And if it is so then it will -- usually they'll see it at the time of surgery and remove it. But his showed no evidence that it had ever been a source of problems for him.

The next diagnosis are the growth parameters, where I just simply indicate that according to a standard growth chart -- There are standard growth charts published by the National Institute of Health where children are charted according to their age and according -- well, for their age, what is their weight and what is their height. And for a given age of a child there is a range of -- of heights and weights that are determined as sort of being normal for children of that age. And it's broken down into percentages. And they're called percentiles. So that -- in other words, if you -- in his case, his body weight was at the 75th percentile, which is sort of like a percentage thing; what it basically means is that his weight was actually greater or at the line where three fourths of other kids his age would actually be -- weigh less than he did. That's what that would mean.

However, his height indicated that he was actually short, because his height was somewhere between the 10th and 25th percentile, so that meaning only somewhere between 10 and 25 percent of kids his age would be -- would be shorter than he was, and the majority, therefore, would be taller than he was.

So, normally we look at these growth parameters. Generally speaking it's a way of just sort of charting how well a child has grown. And sometimes if one has a starting point it's what they were at when they were born, and, you know, where they are at any given point in time, you can sort of see where they've gone. In this particular case all that we list them without really knowing what his percentiles were when he was born and what they were over time I really don't know if what significance these have. I mean, if they're -- for example, if the height is low, well, if he was small when he was born he could have just remained at that percentile, up to this point. On the other hand, sometimes if they start out high and they end up in the lower percentile later on, it can be indicative of them being a little bit malnourished or having some type of stress. On the other hand, if they start out low and end up on the high side, it may actually indicate over-feeding.

The next diagnosis that I listed is metabolic screening. It's a standard test that we do as part of autopsies on infants and children where we send the blood to a laboratory to be analyzed for evidence of metabolic disorders that can cause growth abnormalities, sudden death, and so we look for that to make sure that there aren't any problems with that. And the profile that they run in this particular laboratory, (inaudible) profile, which actually looks at a number of different types of metabolic conditions, showed that all of that was normal, that

there was no evidence of a -- of a metabolic condition, at least as described in their (inaudible) profile.

In addition they do a test for this what's called congenital adrenal hyperplasia, and this can sometimes be a cause of sudden unexpected death in infants and children. It's related to a growth abnormality of the adrenal gland, which are glands that sit on the top of the kidney. Usually children who have a problem with congenital adrenal hyperplasia will have abnormal adrenal glands at the time of autopsy. His looked normal.

In addition, microscopically they were normal. And the testing, the metabolic screening test they did for that, showed that he did not have any evidence of that particular disease.

And then the last diagnosis I listed were the -- were the toxicology results, which showed that his blood alcohol was negative. They did do a urine drug screen which showed that there was a benzodiazepine, which is a Valium-type drug, in his -- in his system. In addition, they measured a glucose level of 500 mg. per deciliter. It's not at all unusual for glucose to be released into the urine, particularly in any kind of a stressful situation such as the condition resulting in Raphael's hospitalization alone would be sufficient to account for that.

They -- Benzodiazepine in his urine is probably a result of drugs given to him initially at the first hospital where he was, and during part of his resuscitation, and probably once he was -- once he was intubated they can give these drugs -- sort of helps sedate and relax these individuals a little bit to keep them from what's termed fighting the ventilator. Individuals who are not sedated properly once they're put on a ventilator can actually cause problems if they're not sedated properly. So, they're given medications to assist with this. And what the blood drug screen showed was that actually that drug was called Medazolan. It's a type of drug and -- that -- that is used to help patients -- calm them, sedate them, once they have been put on the ventilator, and that explained the benzodiazepine in his urine.

In addition he had some Lydocaine in his blood, which again is part of the resuscitation, particularly when he presented to the hospital initially, essentially in cardiac arrest, this is a routine standard drug that's given as part of that resuscitation mechanism.

He did have a little acetone in his urine. The body normally makes a small amount of acetone anyway, although under various levels of stress it can make a little bit more. It's most significant when it becomes significantly higher than what's listed here -- this level is -- is, you know, slightly higher than might be what is normally produced, but it's probably indicative of just, again, some baseline underlying stress. When you see exceedingly high levels it can certainly be an indication of a condition known as ketoacidosis, which you can see with severe starvation or with -- with diabetes, but he didn't have an acetone level to indicate -- any of that.

Q And based upon your diagnoses, Doctor, were you able

to formulate an opinion regarding the cause of death?

A Yes. Based on -- on the autopsy findings, my conclusion is that Raphael Arechiga died as a result of blunt force injuries of the head.

Q And, -- are these findings consistent with accidental trauma?

A No. No. These injuries are consistent with non-accidental injury, or inflicted trauma, and therefore the manner of death in this case is a homicide.

Q In regards to the occipital skull fractures that you observed, more specifically the acute occipital skull fracture that was observed, would a child falling from a standing position onto his back and hitting his head on a hard floor, on two occasions very close in time, do you have an opinion as to whether the amount of force that would be generated by that fall would be sufficient to cause the occipital skull fracture that you observe in autopsy?

A No. No. It would require a more significant force than that. Yeah, there's been a number of -- of clinical summaries of children that have fallen in situations such as this, and about the only fracture that occurs, and even then it's rare, is what's called a lineal parietal skull fracture -- This is a fracture on the side of the head where the bone is much thinner -- and generally tend to be a simple linear fracture.

When you have a more complex fracture such as what Raphael had, and particularly in the location of the occipital bone, where it's thicker, that's a type of fracture that can occur in a fall from a standing height but is much more indicative of much greater force having been impacted to the head.

Q What about if a child Raphael's age were to throw himself back and in throwing himself back, from a standing position, once again, he would hit his head on a hard floor? Would that cause the type of skull fractures that were observed on autopsy?

A I still don't believe that that -- that a child could forcibly throw themselves back hard enough to be able to cause a complex fracture of the occipital bone, which again is probably the thickest bone -- thickest bone area of the -- of the skull.

Q Doctor, is the focus of the -- of the diagnosis of non-accidental trauma -- Strike that -- of the findings -- of your opinion that it is non-accidental trauma, is the focus on the -- on the -- blunt force injuries to the head, then?

A Well, that's -- that's the primary cause of death. And certainly in the absence of anything else those skull fractures alone would be -- would be indicative of a -- of a non-accidental event causing those fractures. But certainly when you add onto it the retinal hemorrhages, that is something that makes it even more indicative of a -- of a non-accidental type of nature, as it takes a considerable shaking or blunt force to -- to cause the -- the retinal hemorrhages. So again, it's something that indicates that this was an inflicted injury.

And finally, the -- those growth plate injuries that I mentioned, those are, again, rather specific for non-accidental injury, and are -- indicate that about the only way someone could get those kinds of injuries would be for someone to have grabbed Raphael

by the arms and forcibly twisted his arms or shaken him while holding him from that position.

Q Now, in your testimony you've indicated that some of the findings -- or, some of the diagnoses that you've achieved could be consistent with life-saving or resuscitation efforts, correct?

A Correct.

Q In regards to the findings and diagnoses involving the blunt force injuries to the head, would those be findings and diagnoses that could be explained by the -- by an aggressive resuscitation effort at an intensive care unit?

A Are you asking if the blunt force injuries of the head were a result of aggressive resuscitation measures?

Q Yes.

A No.

Q And what about the retinal and optic nerve sheet hemorrhages that you observed on autopsies? Could those be explained by an aggressive resuscitation effort of a child?

A Not the particular ones that he had. Although retinal hemorrhages have been described with resuscitation in children, they are rare, and when they do occur they tend to be only a few in number, two or three, say, located in a spot, area right around the back of the retina. But his were scattered over the entire surface of the -- of the retina, all the way out to the area almost near where the iris is, what's called the ora serrata.

In addition, with resuscitative type hemorrhages you only get those usually in one layer of the retina. His hemorrhages were in multiple layers of the retina. In addition he had what we call these dome-shaped hemorrhages, and these are actually a result of where the most superficial layer of the retina is almost torn off of the back layers of the retina. And that's -- that can only occur when there is some type of sheer force which is a result either from -- from shaking or a blunt force impact.

So, in summary, these particular hemorrhages that I saw in him were not the result of resuscitation.

Q And in regards to the injuries to the growth plate region, would those be typically explained by an aggressive resuscitation effort of a child?

A No.

Q In terms of that opinion, was it your testimony that some of those injuries were -- were chronic and non-acute?

A Correct.

Q And would the chronic and non-acute -- would the chronic and non-acute nature of part of the injury to the growth plate make it much less likely that the injury to the growth plate occurred during any type of resuscitation effort?

A Absolutely. Yeah. I mean, it's -- it's definitely -- the -- both the acute and the chronic nature of many of the injuries kind of fits the pattern of what has been termed by clinicians as a battered child. When you have different ages, or have wounds -- or injuries in different locations of varying ages, both acute as well as chronic.

have further questions. The other attorneys may have questions for you.

THE COURT: Mr. Anderson, cross on behalf of the mother?

MR. ANDERSON: Thank you, your Honor.

CROSS EXAMINATION

BY MR. ANDERSON:

Q Dr. Ross, how are you this afternoon?

A Fine, thanks.

Q My name is Doug Anderson. I represent the mother, Maribelle Gomez, in this particular action. I just have a few questions for you.

Can you describe what is a blunt force trauma or blunt force injury?

A A blunt force refers to an impact of an object onto the body or the body onto an object that has what would be termed a blunt surface, as opposed to a sharp. We usually call blunt force as opposed to distinguish it from a sharp force which -- a sharp force would refer to a knife or other type of sharp object would cause a sharp force injury. But just about anything else other than a sharp-edged instrument, device or edge would -- would probably constitute what's called a surface capable of imparting a blunt force to the -- to the body.

Q Okay. So (inaudible) sharp force injury or sharp object injury will be (inaudible) like a cut or a stab wound--

A Right.

Q --or a laceration?

A Right. Whereas blunt force can cause a number of things. You can get anything ranging from abrasions or scrapes to bruises or contusions, or what are called lacerations. Lacerations are where the skin or tissue will actually split open and so it -- essentially it's not a sharp force cut but it -- sort of almost like what you might want to think of as a blunt force cut, but where, you know, someone might actually split open their skin, a blunt force can do that.

And then of course, fractures are the other thing that's attributed to blunt force.

So those are the sort of the four main kinds of things that you can get from a blunt force injury, abrasions, contusion, lacerations, or -- or fractures.

Q Okay. Based upon your examination of Raphael, were you able to form any conclusions as to what sort of an object caused the blunt force injuries to the occipital bone?

A No, not specifically. It's one of those things where I think any number of things could have -- could have done it. And sometimes injuries can have what are called certain patterns to them that are more specific of one type of object or another as having caused it. But there was nothing real specific to indicate any particular kind of blunt surface that may have caused this injury.

Q Okay. I believe when Mr. Caballero was questioning you about whether or not in your opinion a child would be able to throw himself back hard enough to -- to cause a fracture of the type that Raphael suffered, you said, "No, I don't believe the child hit

themselves hard enough to fracture the occipital bone." Correct? Is that a correct restatement of your opinion?

A Yes.

Q would a -- would a person older than a child, a teenager, an adult, perhaps, in your opinion, have the strength to throw himself, throw his head back, strike an object hard enough to fracture the occipital bone?

A Adults -- adults can. But a lot of that is really a reflection of the height that an individual falls. You know, an adult which has a heavier skull and a heavier head, falling a greater distance is going to definitely impact on the ground with much greater force. So certainly they are capable of causing an occipital skull fracture if they fall directly backwards, was what -- called an unmitigated fall, and strike the back of their head, if nothing stops them on the way down.

Children, however, the height that they are at, and the height at which they're -- in the size of their heads, and generally the flexibility of their heads, because of the pliability of the bones, it's rare for children to get fractures when they fall and -- from a standing height, and hit their -- and hit their head. And in the rare cases when they do get fractures almost invariably they are what are called these parietal skull fractures, they're fractures on the sides of the skull, you know, in the skull underlying the sides of the head, and they tend to be linear fractures, that the bone there tends to be thinner. And when they do occur, there is virtually never any severe underlying brain injury associated with that.

So, when you have not simply just an occipital skull fracture but you compound with it on top of that the fact that there's underlying hemorrhage in the brain indicative of -- of injury to the brain as well, then -- then you've got a combination of things here that points to definitely nothing that a child could do themselves in terms of falling, you know, from a standing height to create that kind of an injury.

Q Okay. I guess one question that I had, not necessarily saying that the child fell, but would a child be able to throw his head back -- Let's say he was already on the ground and just threw his head back or his body back -- So we're not -- we're not necessarily taking into account gravity, bringing the body down -- do you think there could be enough force there to cause any type of a--

A Again, I don't believe children are going to have enough muscle mass to generate the kind of forces necessary to be able to fracture their head in that manner. Particularly to cause what -- a more complicated fracture. Again, if they did, I'd -- it would be a rare fracture and would probably be, again, be just like falling, with a parietal fracture. But to cause a, you know, a complex fracture such as he had of the occipital bone, combined with the underlying hemorrhage that he had on the surface of the brain, that indicates a degree of force greater than what the -- what a child would be capable of doing to themselves.

Q Okay. You talked about the -- if it was the -- the

hemorrhages to the -- the retinal -- the retinas, and possibly the -- the injury to the growth plate--

A Right.

Q --could be caused either by blunt force trauma or by -- I wrote down severe shaking of the child.

A Right.

Q Is it -- From your findings is it possible that the mother could have picked the unconscious child up and in attempt -- her own attempt to try to revive him, shook him to see if she could get him to wake up or respond, and caused -- any of these particular hemorrhages or other damage?

A In an attempt to revive an individual, shaking that, you know, (inaudible) to a -- to an attempt just sort of, like, enough shaking to try to wake an individual is not the kind of shaking force that would be sufficient to cause these. This is very forcibly shaking. I mean, this is -- this is extreme shaking we're talking about, to cause the kinds of injuries to the arms that he had, as well as the -- the retinal hemorrhages.

And particularly I might add, you know, with the arms, of course, you know, what -- the injuries he had were not indicative of one severe shaking event.

He had more than one. Because he had injuries there that indicated that there was both acute as well as chronic stuff. So he had hemorrhage in there indicating that there was very recent, acute shaking, but there was also evidence of some healing, indicating that there was previous injury to those areas, indicating that there had either been forcible twisting or shaking in the past as well.

And I believe that the amount of shaking that an individual would do just to sort of see if someone is alive and try to get them to respond is not the kind of shaking we're talking about to cause these kinds of injuries. This is very forcible shaking, to do that. And I don't believe that -- that anyone who was trying to revive an individual would be shaking them so hard to cause those kinds of injuries.

Q Okay. The -- the chronic injuries to the growth (inaudible) that you've described, is there any way -- is there any way for you to tell how old the older injuries were?

A Well, let's take a quick look at my description on--.

That's -- It's hard to be extremely precise. The fact that -- Let's see -- I would say in the -- in the region of just several weeks to months, somewhere in that -- in that time frame, that they were. Probably a minimum, I would say, of -- a minimum of probably ten days to two weeks, to get some of those chronic things, so I would say that minimally those chronic injuries are a result of something that had to be ten days to two weeks or possibly out even further than that.

You know, once you kind of get beyond that two-week range it's very hard to age those things unless -- what's termed the inflammation goes away. I mean, he had, you know, this inflammation as well as the -- the fibrosis. And when those are combined you sort of have a -- again something that sort of puts you in the ten-day to two-week range to start, but then it can be anywhere up to several more weeks older than that.

Q Okay. Thank you.
MR. ANDERSON: I don't believe I have any further questions. Thank you.
THE COURT: Thank you, Mr. Anderson. Mr. Moser, cross on behalf of father?

CROSS EXAMINATION

BY MR. MOSER:

Q Hi, Dr. Ross.

A Hi.

Q Doctor, when you say that the injury is not consistent with accidental -- with accident, I believe that you're referring to the -- the force that must have caused the injury?

A That's correct.

Q I think I understand that you did not determine that it's -- that it's from some sort of outside source like a -- like a hand or a -- or a stick or something like that; it's just -- it's just the force of the injury--

A Right.

Q --the force (inaudible) to cause the injury--

A Right.

Q --Okay. Let's see. And I think you said just now when Mr. Anderson was examining you, you said you do not believe that children have the muscle mass capable of inflicting this kind of injury to themselves?

A Right. I don't think they have the strength to be able to do that, no.

Q You're not a pediatrician, right?

A No, I am not.

Q Okay. And you said that there have been some studies done on children falling?

A Well, what they are basically, clinical reviews, if you will, that have looked at fractures in children or just injuries in children that have had accidental falls either from a standing height or from something like a couch or a bed or something like that. And overwhelmingly these studies show that the most injury that a child will sustain is a linear skull fracture of the parietal bone, and that's usually the worst of it, and even then that's rare; in most cases the most they'll suffer are -- are bruises or abrasions of the -- of the scalp itself.

Q Okay. Now, I was an economics major, and maybe I can draw -- maybe I can understand or draw a parallel. Won't -- won't unusual cases be pulled out as a sample in a statistical study, like what you're talking about?

A They can be, yeah. It kind of depends upon what the design of the study is. But again, in most of these cases they -- they will usually look at all comers, so -- And if there is an outlier, or something that -- that's unusual, then there will be -- they will attempt to arrive at an explanation for it. And I believe that the -- the conventional thought on this, based upon a number of these, you know, shows that -- that, you know, when there is a severe injury it can be attributed to something more than just a fall, so that something else did occur.

So it's not like they're throwing it out. They -- they go back and they look at it and see, "well, how come this injury wasn't here," and often-times

with more investigation and analysis of it they find out that indeed this was not just a simple fall, that there was more to it than this, and -- and that in all likelihood the -- the cases where something more severe occurred that has been attributed to a fall initially, is believed actually to have probably been due to some form of non-accidental inflicted injury.

Q Do you remember in any of these studies if they covered children addicted to cocaine or hyperactive due to any sort of chemical condition, anything like that?

A No. I'm not aware if they did or didn't. They may have or they may not have; that I don't know.

Q Do you remember if any studies covered children who were particularly hyperactive?

A No. I don't recall. They may or may not have.

Q Our two attorneys before me took you through some examples of a child jumping up in the air, throwing himself back. We actually have a child here where there has been testimony introduced that this child jumps and arches themselves back, and lands on his head. And would that affect your testimony at all as to whether you think a child could -- would have the force to cause this kind of injury to himself?

A I don't think so, particularly in combination with everything else that was there. I think the injuries are still more severe than could be inflicted by that type of behavior.

Q Okay. Let me -- The scrapes to the head and the face, in direct testimony, direct examination by Mr. Caballero, you said that you could tell that the scrapes to the head and the face were caused by blunt force -- by a blunt object. How could you tell that they -- it was a blunt object and not a sharp object?

A Well, again, sharp -- well, what this again is referred to by blunt force also can refer to a blunt direction of force. For example, if you take a knife, which is a sharp object, granted, but you scrape it across the skin so that the width of the blade is kind of going across the skin, and you sort of drag it across so that it's almost -- it's not really the sharp edge of the knife that's cutting into the skin but it's just simply dragging width-wise across the skin, and you're causing it to do a scrape, that in essence is a form of blunt force.

So, yeah, a blunt force even could be like a scrape caused by, say, a fingernail, is actually something that if you get an abrasion or a scratch or a scrape from a fingernail, that would be considered actually a blunt force injury. Even something that's relatively sharp but if it doesn't actually cut into the skin but just scrapes along the surface of the skin, then that would be considered an abrasion; that would still be classified as a blunt force injury.

Q As a blunt force. Okay. When you examined Raphael were you advised that this child's breathing had stopped hours before he was pronounced dead?

A Yes, uh-huh.

Q And were you advised that he -- his circulation had all but stopped?

A Yes.

Q Hours before?

A Yes.

Q And, let's see. I think that the -- the -- the opinion of the neurologist from Sacramento, that the brain cells indicated starvation of oxygen in those brain cells?

A Correct.

Q Could that have been due to the lack of respiration and -- before death?

A Yes, uh-huh.

Q Okay. And some of the bruising around the body, could that have been due to the lack of circulation?

A Bruising? No. That's not from lack of circulation.

Q Now, Mr. Caballero asked you a question that was like -- and it was toward the end of his examination. And he asked, could the injury to the head have been due to any sort of life-saving effort. And you responded, "No?"

A Right.

Q I'm not asking about the injury to the head, but your opinion about life-saving efforts, that's -- that's based on your knowledge of professionals performing professional life-saving services, right?

A Yes.

Q A person who is not trained in that way could -- could attempt to do quite a few other things, maybe, that are -- that you would not define as a life-saving effort?

Does that make any sense?

A Well, I mean, I'm not familiar with the different ways that -- that non-professionals have tried to attempt resuscitation.

Q Okay. Okay. I just want to make sure that -- when you say that -- that an injury could not have been due to a life-saving effort, you just mean a professional's life-saving--

A Correct.

Q --professional effort.

And I think I just want to clarify something that Mr. Anderson asked. When you're able to determine that the child died due to the blunt force trauma to his head, you're not able to determine or even suggest a source; is that right?

A Correct.

Q And, Dr. Ross, I think that Mr. Anderson asked you if a -- if an adult could injure themselves the way that Raphael was injured, and I believe you said yes, due to several factors such as the height that they fall from--

A Yes. And the size of their head, just, you know, considerably--

Q Size of--

A --larger and heavier than a child.

Q And again, your opinion is based on referencing a typical child?

A Correct.

MR. MOSER: Okay. Thank you. That's all.

MR. CABALLERO: No redirect.

THE COURT: Dr. Ross, this is Judge Sperline.

I actually just have one question for you.

INTERROGATION

BY THE COURT:

Q Was there anything about the process that you went through that would cause you to note any unusual

development of musculature in -- in the child? That is, muscles of any -- or any muscle groups that developed beyond expectations for a child of that age?

A No.

Q And, I asked such a long question; I'm not sure what "No" is. You wouldn't have noted? Or you didn't -- you noted that there was none?

A I noted that there was none.

THE COURT: Okay. Thank you.

Any follow-up?

MR. CABALLERO: No, your Honor.

MR. ANDERSON: Just one question, your Honor.

THE COURT: Go ahead.

RE CROSS EXAMINATION

BY MR. ANDERSON:

Q Dr. Ross, this is Doug Anderson again. Just following up on the question that Judge Sperline asked you, I noticed that when you were -- you were talking about the growth parameters, and you -- discussing the pathological diagnoses--

A Uh-huh.

Q And you stated that the weight fell within the 75th percentile.

A Right.

Q Did you notice an unusually large amount of fatty tissue on Raphael? Or was this due to -- to -- more muscle, or was there -- was there any finding that you made that could tell you why it was such a high percentile of weight?

A No -- well, actually, although that's there, that's probably an artificial elevation due to resuscitation, the fact that he was resuscitated and had the edema of the tissues and the swelling of the tissues and the excess fluid in the chest and in the abdomen. That actually probably accounts for -- for a significant part of that weight, and which is why his -- his percentile is probably high. My -- my guess is, is that without the excess fluid of resuscitation in his body he'd probably be closer to the 50th percentile, which would be a normal, you know, more -- And even 75th is still technically within the normal growth parameters; you know, he's not abnormally large, he's just -- sort of at the high end of what kids of that age would be for -- for their -- for their -- for their weight. But when one considers the resuscitation that was done, I think you can actually subtract some of that out.

Q Okay. Can you also take into account the fact that -- height-wise, his -- in the 10 to 25th percentile, could that also be taken into account to say on a -- I guess, a -- ratio type basis, that he was still probably a bit -- weighed a bit more per inch, I guess, than the average child would?

A Yeah, probably a little bit more.

MR. ANDERSON: Okay. Thank you.

THE COURT: Any follow-up, Mr. Moser?

RE CROSS EXAMINATION

BY MR. MOSER:

Q Dr. Ross, when you're doing the autopsy, I notice that you're -- you're being fairly comprehensive and you're covering a lot of things. Are you checking for muscle

development?

A Well, it's part of the overall examination. I mean, you know, if there were abnormally excessive muscle development I think that's something that would be apparent. And particularly in autopsies like this where often-times our autopsies where we limit our evaluation of muscle development, just sort of an external evaluation of the -- of the structures, of the limbs overall, but in addition, you know, we do a -- you know, in this case, you know, in evaluating for injuries of the extremities it did require sort of an internal examination of the -- of the extremities as well, to the extent that -- and if he had abnormally large muscle masses I think that would have been apparent, and I certainly did not notice that.

Q Okay. So, so you would have checked for large thighs, is one thing (inaudible)?

A Well, I mean, we don't -- (Inaudible) I'm not specifically thinking at the beginning of the autopsy, "Let's see if this kid has large thighs," no. I don't approach it that way. I basically, based upon having, you know, done a certain number of autopsies in kids, and just sort of knowing in my mind's eye what is normal and what is abnormal, and I didn't recognize that his muscle mass appeared to be abnormally larger than I would have expected for a child of this size.

Q I think what you've just said is that you did not notice any abnormal muscle development?

A Right.

MR. MOSER: Okay. Thanks.

THE COURT: Anything else?

MR. CABALLERO: No.

MR. ANDERSON: No, your Honor.

THE COURT: Thank you, Dr. Cook. That will close your testimony and we'll hang up.

THE WITNESS: Okay. Thank you.

MR. CABALLERO: No further witnesses today.

The matter (inaudible) adjourned until February 26, 2004 at 9:30 a.m.

THE COURT: Okay. We'll be in recess until Thursday, the 26th.

MR. CABALLERO: And just for -- there are two additional witnesses, Dr. Feldman and -- Kenneth Feldman, and then Mario Gonzalez.

THE COURT: Okay.

MR. CABALLERO: So I expect to be done by 11:00 or so on the 26th.

THE COURT: That's helpful, I'm sure, to counsel.

MR. ANDERSON: Thank you.

THE COURT: Do you think there's a -- reasonable likelihood that we'll need a day beyond the 26th?

MR. ANDERSON: (Inaudible) say "reasonable" (inaudible). I (inaudible) beyond that. I don't (inaudible -- At the most we'll take one more -- one more day.

THE COURT: Okay. Well, we'll have -- I'll ask the court administrator to have a Plan B that would have us here the following day as well.

MR. ANDERSON: Thank you, your Honor.

THE COURT: Thank you. We're in recess.

Recess

I certify that the foregoing is a correct transcript from the electronic sound recording of the proceedings in the above-entitled matter.

August 1, 2004

Kenneth C. Beck, Transcriber

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