STATE OF MICHIGAN

COURT OF APPEALS

In the Matter of JD and GD, Minors.

FAMILY INDEPENDENCE AGENCY,

Petitioner-Appellant,

V

CARL DETRYCH and LISA DETRYCH,

Respondents-Appellees.

UNPUBLISHED
June 7, 2002

No. 231322
Wayne Circuit Court
Family Division
LC No. 00-390358

Before: Talbot, P.J., and Smolenski and Wilder, JJ.

PER CURIAM.

Petitioner, the Family Independence Agency, appeals as of right from the family court's order dismissing a petition to terminate the parental rights of respondents to their minor twins under MCL 712A.19b(3)(b)(i) and (k). We reverse and remand for further proceedings consistent with this opinion.

I. Facts and Procedural History

On March 10, 2000, respondent-mother (mother) gave birth to the respondents' twin children, JD and GD. On April 25, 2000, GD (the infant), who was six weeks old, was taken to William Beaumont Hospital for treatment of his right leg. According to respondent-father (father), the infant's leg went limp during a routine diaper change. On arrival at the hospital, the doctors discovered that the infant had fractured his right femur, and subsequent x-rays of the infant also revealed multiple rib fractures, resulting in the doctors suspecting child abuse. On the basis of this suspicion, petitioner was contacted by hospital personnel.

On April 28, 2000, petitioner filed an initial petition in Oakland County on the basis of the alleged physical abuse of the infant, requesting the court to take temporary jurisdiction over the children. On May 2, 2000, following a preliminary hearing, the court authorized the petition and placed the children in the care of mother, requiring father to move out of the marital home, but granting him unlimited visitation under Mother's supervision. The family court later determined that because the minor children and respondents resided in Wayne County, jurisdiction was proper in Wayne County. On June 23, 2000, following the transfer to Wayne Circuit Court, Petitioner filed a supplemental petition seeking termination of respondents'

parental rights pursuant to MCL 712A.19b(3)(b)(i) and (k), and removal of the children from mother's care. On June 26, 2000, respondents filed a motion for an emergency hearing, the children were removed from mother's custody and placed in the care of relatives. Mother then filed a motion for emergency change of placement that was heard on August 4, 2000. Following that hearing, the children were again placed in the care of mother pending the outcome of trial. However, as a condition for the children's return, father was not permitted to reside in the home, and he was restricted to supervised visitation.

The permanent custody hearing commenced on October 18, 2000. At trial, Petitioner alleged that medical examinations established that the infant had suffered child abuse manifested by an unexplained femur fracture and several fractured rib bones. To support this theory petitioner presented the testimony of Dr. Anthony Bonfiglio, an expert in emergency medicine, and one of the treating emergency physicians for the infant on April 25, 2000. Dr. Bonfiglio testified that father informed him that while he was changing the infant's diaper he had felt a "pop."[1] X-rays revealed that the infant had suffered a transverse fracture of the mid-shaft of the right femur. Dr. Bonfiglio also testified that because respondents explanation was inconsistent with the infant's injury, which normally is a blunt force injury, it was his opinion that the infant's injury occurred as a result of child abuse. His testimony also established that a subsequent full skeletal survey revealed that the infant also had sustained several rib fractures and that respondents' explanation of how the infant may have been injured was inconsistent with broken ribs.

On cross examination, Dr. Bonfiglio admitted that there were no indications that the infant had suffered trauma, bruising or redness. He also admitted that the initial skeletal survey was negative, that the infant's dress and hygiene were appropriate, and that respondents had acted appropriately in seeking medical treatment for the infant. He also acknowledged that the initial medical report that had been prepared by a resident had stated that the injury "could have been as Mr. Detrych described," and that he had signed off on the report. However, he clarified that his approval of this report occurred before the rib fractures were known.

Dr. Bonfiglio's testimony also established that the infant had been tested for Osteogenesis Imperfecta[2] (OI), that those tests did not show that the infant suffered from OI, and that the infant did not have blue sclerae,[3] which is a well-known feature of OI sufferers. He also testified that while OI causes bones to fracture easily, it is an inherited disease that is usually present at birth and lasts throughout life. He also acknowledged that if the infant suffered from OI, then father's explanation of the injury would be consistent.

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[1] Father denied this statement, testifying that he never heard a "pop" and that he never told the doctors that he heard a "pop."

[2] "Osteogenesis Imperfecta" is defined as "a condition marked by defective bone formation and, hence, fragility of the bones. Fractures occur without excessive strain or violence, in childhood, infancy, or even before birth." 4 Attorneys' Dictionary of Medicine and Word Finder (2000), p O-117.

[3] "Sclera" is commonly referred to as the "whites of the eyes." Cf. *Random House Webster's College Dictionary* (1995), p 1202.

Petitioner also offered expert testimony from Dr. Alexander Cacciarelli, a pediatric radiologist. Dr. Cacciarelli testified that he had interpreted the infant's x-rays and skeletal surveys, and that they revealed that the infant had suffered acute fractures of seven of the nine left anterior ribs. He also testified that while not all of the rib fractures were visible on the first x-ray, it was evident that the fractures all were the same age and less than ten days old, and opined that the fractures may not have been visible at first because of calcification. His testimony also established that the infant did not suffer from any bone abnormalities, and that there was no evidence of weakened bones, demineralization, Osterporosis, Rickets or OI. He further testified that a person with OI would likely suffer fractures in the future. On cross-examination, Dr. Cacciarelli conceded that a bone density loss of less than 30% would not ordinarily be detected by x-ray, that he had only observed regular x-rays, not computerized topography (CT) or ultrasound, and that, depending on the brittleness of the bones, it was possible for an infant to suffer rib fractures as a result of being hugged, but that it was not within his professional responsibility to determine what caused the infant's injuries.

Dr. Mary Smyth, medical director of Beaumont Hospital's child advocacy and protection team, and an expert qualified in the areas of pediatrics and child abuse assessment also testified on behalf of petitioner. She opined that after reviewing the infant's file in the instant case, there was a "high likelihood" of child abuse. She also opined that because a baby's femur is very strong and would not break as a result of raising the child for a diaper change, respondents' explanation regarding the infant's femur injury was inconsistent, and that nothing in the file suggested that the infant suffered from weakened bones or decreased bone density. However, on cross-examination, she also conceded that she never treated the infant, that the infant did not suffer from external trauma, retinal hemorrhaging or bruising, and that an ordinary x-ray, like those used in the instant case, will not show a bone density loss less than 30%. She further conceded that a collagen test is not one hundred percent effective in detecting OI, that such a test would not detect all forms of OI, and that there were other tests that could have been performed on the infant to ensure that he did not suffer from any type of metabolic bone disease, but that these tests were not conducted.

Respondents asserted that the infant's injuries were not the result of child abuse, and in an attempt to explain the injuries indicated that the infant could have suffered from a bone disease known as "temporary brittle bone disease" ("TBBD"), believed by some to be a separate and distinct, yet controversial, cousin to OI. TBBD is described as a transient occurrence in which children suffer fractures during their first year of age, under certain conditions, as a result of fetal immobilization and intrauterine confinement.

Respondents presented Dr. Marvin Miller, a pediatric geneticist in Dayton, Ohio, and author of the article "Temporary Brittle Bone Disease: Association with Decreased Fetal Movement and Osteopenia," as their TBBD expert. He opined that the infant suffered from TBBD brought on as a result of intrauterine confinement, being a twin, and being born prematurely, and that an infant who suffered from TBBD could fracture their femur by jerking during a diaper change, and that rib fractures could be the result of routine carrying and care. Dr. Miller acknowledged that he arrived at the diagnosis of TBBD without examining the infant. Instead, he relied on his interpretation of the medical evidence presented to him, which included the medical records and x-rays of the infant, mother's medical records, conversations with

respondents, and other medical testing. He also acknowledged that in the absence of TBBD, the explanation given by respondents for the infant's injury would be illogical.

Dr. Miller also indicated during his testimony that the method of analyzing unexplained fractures by examining x-rays is flawed because the x-rays do not provide complete results of a patient's bone density. Thus, while he agreed with Dr. Bonfiglio's assessment regarding the force needed to break the femur, he also testified that Dr. Bonfiglio's assessment was based on an assumption that the infant had normal bone density. Dr. Miller further testified that he agreed with Dr. Cacciarelli's opinion that the infant's skeletal survey did not detect demineralization and that demineralization would only be detected by x-ray if it was in the 33 to 40% range.

Dr. Miller conceded that TBBD was not recognized in the ICD9[4] and that most child abuse experts do not believe that such a disease exists, and also admitted that his study had been rejected by the New England Journal of Medicine, the Journal of Pediatrics, and Pediatrics. However, he also testified that his theory and conclusions had been accepted by those who study bone biology and that those familiar with bone biology support his findings.

Father testified on his own behalf. His testimony established that mother had had a difficult time becoming pregnant, that they had tried to conceive a child for five to six years before the twins were born,[5] and that during the pregnancy mother suffered from preclampsia and hypertension. Father also testified that he and mother shared the child care responsibilities, and that they taken a safety and childcare class at Beaumont Hospital during the pregnancy.

With regard to the events leading up to the infant's leg injury, father testified that at approximately 7:30 am on April 25, 2000, he heard the infant crying, picked him up, placed him on the changing table, and began to change the infant's diaper, holding him by the right leg in order to clean the infant. According to father, the infant then jerked away, causing father to pull him back in order to continue wiping the infant with a baby wipe. After the changing was complete, father looked down and saw that the infant's right leg was limp. Father testified he immediately picked up the infant, sought out mother, and screamed that there was something wrong with the infant's leg. Respondents then took the infant to the emergency room at Beaumont Hospital, where they found out that the infant had a fractured femur. Father also testified that on the next day respondents were asked if the doctors could take more x-rays of the infant, and that the respondents did not object. Father further testified that because he was unaware of any other injury to the infant, he gave no explanation for the infant's injuries besides the diaper change.

On cross-examination father testified that he was left-handed, that he used his left-hand to wipe the infant, and that he used his right hand to pick the infant up without reaching across the infant's body to grab the leg. However, after it was pointed out that father would have had to grab the leg directly in front of his right hand (i.e., the left leg), father then explained and demonstrated to the court that he did reach across the infant to grab and lift the right leg.

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[4] International Classification of Diseases, 9th edition.

[5] Dr. Robert Carter's testimony substantiated father's articulation of respondents' efforts to overcome mother's infertility.

On rebuttal, petitioner called Dr. Wilbur Smith, a radiology professor at Wayne State University Medical School and a pediatric radiologist at Children's Hospital, as an expert witness in pediatrics, pediatric radiology and child abuse. Dr. Smith testified that he had reviewed the infant's medical records and x-rays, and that he concluded from his review that the infant suffered multiple fractures unexplained by any recognized trauma, and that the x-rays provided no evidence of underlying bone disease. As a result, he opined that the infant suffered from non-accidental trauma or child abuse. Dr. Smith also testified that x-rays could reveal bone disease by showing osteopenia, softening, bowing, and abnormal healing patterns, and that generally, conditions such as OI show up on an x-ray by indicating a maldistribution of the outer white part of the bone and the inner part that contains bone marrow. Nonetheless, Dr. Smith did concede that there is one form of OI that would not show up on an x-ray, indicating that it was a very rare disease that affects about one in 1.5 million people. He further testified that a collagen test has about an 85% accuracy rate in diagnosing OI, and that people with OI would repeatedly suffer from fractures, whereas here, the parties stipulated that the infant has not suffered any additional fractures. While Dr. Smith admitted that there are recognized syndromes, abnormalities, and impairments associated with intrauterine confinement, he stated that TBBD is not one of them. Dr. Smith's testimony also established that the medical community had not agreed on the normal bone density for children, and that because there is not "starting point," medical science cannot draw standard deviations.

Dr. Smith testified further that TBBD was not an acceptable clinical theory, that it had been rejected by the American Academy of Pediatrics and was not recognized in the ICD9, and that Dr. Miller's study was not reliable. However, Dr. Smith also admitted that he had never read Dr. Miller's study, and that his conclusion that Dr. Miller's study was not reliable was based on his examination of published reviews critical of Dr. Miller's study contained in professional journals dealing with child abuse. Dr. Smith further conceded that his opinions and conclusions were based on the assumption that the infant had normal bone density, and that he could not rule out the possibility that the infant suffered from OI IV.[6]

At the conclusion of proofs, petitioner requested that the court exclude Dr. Miller's trial testimony, arguing that, under the *Davis-Frye* rule, respondents failed to demonstrate that experts in the medical community have accepted TBBD as a "valid disease." The family court ruled that petitioner was attempting to move in limine to exclude the testimony, but indicated that because she had already heard the testimony, and no objections or motions to exclude the testimony had been made before or during the testimony, petitioner couldn't make the motion at the conclusion of the case, and instructed petitioner that, if it wished, it could discuss the issue as part of closing argument.

Following closing arguments and a recess, the family court ruled from the bench that petitioner had not established by clear and convincing evidence that respondents' parental rights should be terminated under MCL 712A.19b(3)(b)(i) or (k). Therefore, the family court denied the petition and stated:

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[6] OI IV is defined as "[a] form of osteogenesis imperfecta in which the sclerae (whites of eye) are normal. 4 Attorneys' Dictionary of Medicine and Word Finder (2000), p O-118.

The evidence of physical abuse in this case consisted exclusively of the medical evidence of that diagnosis made by numerous physicians at William Beaumont Hospital. Those physicians consistently found child abuse based on the presence of fractures, the unexplained nature of those fractures as it relates to the ribs and, in their view, the inconsistent explanation for those fractures given as it relates to the femur fracture.

The physicians ruled out osteogenesis imperfecta by virtue of a collagen test, although they concede that one type of osteogenesis imperfecta; that is, type four, could not be ruled out by virtue of testing.

Dr. Miller's theory of temporary brittle bone disease did provide medical evidence to this Court based upon his theory of in utero confinement that the accepted methodology for the diagnosis of child abuse fails to take into account the lack of consensus that exists within the medical profession as to what is, quote, normal, end quote, bone density within the medical profession in general. Dr. Miller's testimony raised substantial doubt in this Court's mind as to the accuracy of the child abuse diagnosis made by the William Beaumont Hospital.

Dr. Wilbur Smith's testimony failed to rebut Dr. Miller's testimony. Dr. Wilbur Smith's testimony, particularly his criticisms as to the technique, controls, and methodology, in this Court's judgment were not credible by virtue of Dr. Smith's failure to even read the study he was responding to in court.

More troubling, however, was Dr. Wilbur Smith's testimony concerning the lack of consensus as to what is, quote, normal, end quote, bone density and the problematic nature of the underlying assumption of the diagnosis of child abuse in the first case; that is, all physicians that gave that diagnosis conceded that diagnosis was based on, quote, normal, bone density.

Dr. Wilbur Smith's testimony, in this Court's judgment, undermines the very foundation of the diagnosis in the first place. In addition, Dr. Wilbur Smith's testimony that this issue of, quote, normal, end quote, child bone density is not settled within the medical profession.

The Court found credible the father's testimony. The crossover was not inconsistent, in the Court's judgment. The crossover explanation for how the injury occurred was offered in further clarification of a rather dissembled direct examination by virtue of several different persons asking questions, and in this Court's judgment, the impeachment of how the events occurred in the first place was not accomplished. Again, the Court found the father's testimony credible.

The Court is generally very persuaded by medical testimony. The Court does not believe in this case that Dr. Miller's diagnosis here was adequately rebutted. The Court is not suggesting that I, quote, adopt, end quote, or that I, quote, believe, end quote, that theory. The Court is not a physician, and I rely on medical testimony.

> The medical testimony in this case did not sufficiently rebut an expert when that expert failed even to read it and conceded that the principal [sic] difference between the two theories; that is, whether it was child abuse or whether a medical explanation exists for the injury relied upon the finding of normal bone density, and that assumption is subject to great debate within the medical profession.
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> In addition, the Court notes that the state's awesome power to protect children from abuse is relegated to courts in this state and is not relegated to doctors. . . . the Court did have the opportunity to assess credibility and to determine this issue. If a trial is to mean anything, it means that the Court must make findings of fact and must consider all the evidence.
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> Because the Court has substantial doubt as to the finding of child abuse in this case raised by Mr. [sic] Miller's testimony and because the Court finds the father's testimony to be credible, the Court finds that the Family Independence Agency has not met its burden by clear and convincing evidence to terminate the parental rights of Mr. Detrych.
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> In addition, the Court finds that the Family Independence Agency has not met its burden to demonstrate that this child . . . comes within the jurisdiction of the Court. Therefore, . . . the petition is dismissed.

Petitioner now appeals, arguing that the family court erred in admitting the expert testimony of Dr. Miller, and that the family court also erred when it found that Petitioner had not met its burden of proof by clear and convincing evidence.

III. Preservation of the Issues

A. Expert Opinion Testimony

As previously indicated, Petitioner never sought to exclude Dr. Miller's testimony before or during the testimony, instead only raising the issue at the conclusion of proofs and before closing arguments. MRE 103(a)(1) provides that a party opposing the admission of evidence must timely object at trial and specify the same ground for objection that is asserted on appeal. See also *In re Weiss*, 224 Mich App 37, 39; 568 NW2d 336 (1997). To be timely, an objection should be interposed between the question and answer. *Id*. Therefore, this issue has not been properly preserved. *Id*.; see also *Forest City Enterprises, Inc v Lemon Oil Co*, 228 Mich App 57, 82, n 9; 577 NW2d 150 (1998).

B. Factual Findings and Dismissal of Petition

Petitioner brought the termination petition against respondents, presented evidence in support of its position, and the family court reached the issue of whether there was clear and convincing evidence to terminate respondents parental rights; thus, the issue of whether the family court appropriately dismissed the petition is properly preserved. See *Toth v AutoAlliance International, Inc*, 246 Mich App 732, 740; 635 NW2d 62 (2001), citing *Fast Air, Inc v Knight*, 235 Mich App 541, 549; 599 NW2d 489 (1999).

IV. Standard of Review

A. Expert Opinion Testimony

Because petitioner failed to properly preserve the issue of whether Dr. Miller's expert testimony was properly admitted under *Davis-Frye*, review is only appropriate if manifest injustice will result from our failure to review the issue. *Piccolo v Nix*, 246 Mich App 27, 36, n 6; 630 NW2d 900 (2001), vacated on other grounds ___ Mich ___ entered May 3, 2002 (Docket No. 119778), citing *Winters v Dalton*, 207 Mich App 76, 79; 523 NW2d 636 (1994); see also *People v Turner*, 213 Mich App 558, 583; 540 NW2d 728 (1995), and *Francisco v Manson, Jackson & Kane, Inc*, 145 Mich App 255, 260; 377 NW2d 313 (1985). The determination of what constitutes manifest injustice is contingent on the circumstances of each individual case. *Piccolo, supra*; *Van Pembrook v Zero Mfg Co*, 146 Mich App 87, 94; 380 NW2d 60 (1985).

B. Factual Findings and Dismissal of Petition

We review a trial court's factual findings in a termination proceeding for clear error. MCR 5.974(I); *In re Miller*, 433 Mich 331, 337; 445 NW2d 161 (1989); *In re Vasquez*, 199 Mich App 44, 51; 501 NW2d 231 (1993). A finding of fact is clearly erroneous if, although there is evidence to support it, the reviewing court is left with the definite and firm conviction that a mistake has been made. *In re Miller, supra*. To be clearly erroneous, a decision must be more than maybe or probably wrong. *In re Sours*, 459 Mich 624, 633; 593 NW2d 520 (1999). Deference must be accorded to the trial court's assessment of the credibility of the witnesses before it. MCR 2.613; *In re Newman*, 189 Mich App 61, 65; 472 NW2d 38 (1991).

V. Analysis

The *Davis-Frye* rule, adopted from *People v Davis*, 343 Mich 348; 72 NW2d 269 (1955), and *Frye v United States*, 54 US App DC 46; 293 F 1013 (1923), and now codified in MCL 600.2955(2),[7] provides that novel scientific evidence is admissible only if the proponent of that evidence demonstrates, through disinterested and impartial experts, that it has gained general acceptance in the scientific community. *Stitt v Holland Abundant Life Fellowship (On Remand)*, 243 Mich App 461, 468; 624 NW2d 427 (2000); *Anton v State Farm Mutual Automobile Ins Co*, 238 Mich App 673, 678-679; 607 NW2d 123 (1999); *Kluck v Borland*, 162 Mich App 695, 697; 413 NW2d 90 (1987). In conducting a *Davis-Frye* inquiry, a trial court is not concerned with the ultimate conclusion of an expert, but rather with the method, process, or basis for the expert's conclusion and whether it is generally accepted or recognized. *Anton, supra* at 678-679.

In *Nelson v American Sterilizer Co (On Remand)*, 223 Mich App 485, 491-492; 566 NW2d 671 (1997), this Court explained:

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[7] MCL 600.2955(2) provides:

> A novel methodology or form of scientific evidence may be admitted into evidence only if its proponent establishes that it has achieved general scientific acceptance among impartial and disinterested experts in the field.

> To be derived from recognized scientific knowledge, the proposed testimony must contain inferences or assertions, the source of which rests in an application of scientific methods. Additionally, the inferences or assertions must be supported by appropriate objective and independent validation based on what is known, e.g., scientific and medical literature. This is not to say, however, that the subject of the scientific testimony must be known to a certainty, *Daubert [v Merrell Dow Pharmaceuticals, Inc*, 509 US 579, 590; 113 S Ct 2786; 125 L Ed 2d 469 (1993)]. As long as the basic methodology and principles employed by an expert to reach a conclusion are sound and create a trustworthy foundation for the conclusion reached, the expert testimony is admissible no matter how novel.

Here, Dr. Miller conceded that there were "very, very few" experts who believe in the existence of TBBD, and that TBBD is not generally recognized as a disease, as evidenced by the fact that TBBD is not included in the *International Classification of Diseases* (9th ed). He also conceded that three professional publications, *The New England Journal of Medicine*, *The Journal of Pediatrics*, and *Pediatrics*, had refused to publish his research regarding TBBD, and the trial testimony indicated that the existence of TBBD had also been rejected by the American Academy of Pediatrics.

Further, although Dr. Miller's theory has been published in *Calcified Tissue International*, Dr. Miller's own testimony raised serious questions regarding the research on which that article and his trial testimony was based. Specifically, Dr. Miller testified that his research involved only twenty-six infants, a group which was far too small to produce results of any statistical significance, and conceded that his research was not random, as the infants studied came from homes where the parents were facing either criminal or child protective proceedings, based on accusations of child abuse. In addition, Dr. Miller failed to conduct any follow-up research with regard to the infants studied. These infants had experienced multiple unexplained fractures while in the care of their parents. If Dr. Miller's diagnosis of TBBD regarding those infants were accurate, then the infants should have exhibited fractures even after removal from their parents' care. However, Dr. Miller never inquired whether the children continued to experience fractures. The failure to do so seriously undermines the objectivity and validity of Dr. Miller's conclusion that the infants suffered from a temporary bone condition which lasted throughout the first year of life.

From the above review, we conclude that Dr. Miller's testimony is based on a novel theory which lacks the appropriate objective and independent validation necessary to permit its admissibility at trial. *Id.* Since the petitioner failed to preserve this otherwise valid objection to Dr. Miller's testimony, the trial court erroneously considered Dr. Miller's inadmissible testimony in concluding that petitioner failed to prove by clear and convincing evidence that termination of respondent's parental rights was warranted. The consequences of this error are significant. Because the trial court relied heavily, but not exclusively, on Dr. Miller's testimony when dismissing the termination petition, we are unable to determine whether the trial court would have (or should have) reached the same conclusion based solely on the medical evidence presented by petitioner, and the testimony of the father. For example, while the trial court found the father to be a credible witness, it is unclear how much the father's credibility was bolstered by what appeared to be supporting testimony from Dr. Miller. We find, therefore, that although the issue was not preserved, a manifest injustice would result if we fail to address the erroneous

admission of Dr. Miller's testimony. *Piccolo, supra* at 36, n 6. Accordingly, we conclude that the order dismissing the petition for termination should be reversed, and the matter remanded to the trial court for findings on the merits of the petition. The trial court's findings must be based solely on the evidence properly admitted at trial.

VI. Conclusion

Dr. Miller's testimony was inadmissible under *Davis-Frye* and MCL 600.2955(a). However, because petitioner failed to timely object to this testimony, the trial court erroneously relied on Dr. Miller's testimony in making its findings dismissing the petition. On the facts of this case, such reliance by the trial court results in a manifest injustice. Therefore, we reverse the trial court's order dismissing the petition, and remand to the trial court for findings on the petition based solely on the evidence properly admitted during the trial.

Reversed and remanded for further consideration consistent with our opinion. We do not retain jurisdiction.

/s/ Michael J. Talbot
/s/ Michael R. Smolenski
/s/ Kurtis T. Wilder