LODGED

FILED
2017 JUL 10 PM 4:06
CLERK U.S. DISTRICT COURT
CENTRAL DIST. OF CALIF.
RIVERSIDE
BY

AO 241 (Rev. 5/85)

PETITION UNDER 28 USC § 2254 FOR WRIT OF HABEAS CORPUS BY A PERSON IN STATE CUSTODY

2017 JUL 10 PM 1:20
CLERK U.S. DISTRICT COURT
CENTRAL DIST. OF CALIF.
RIVERSIDE

United States District Court CENTRAL DISTRICT

Name DAVID C. PATKINS Prisoner No. T-73612 Case No. ED CV17-01376 DMG (FFM)

Place of Confinement CORRECTIONAL ~~TRAINING FACILITY~~
P. O. BOX 705
SOLEDAD, CA. 93960

Name of Petitioner (include name under which convicted) Name of Respondent (authorized person having custody of petitioner)

DAVID C. PATKINS V. SHAWN HATTON, WARDEN,

The Attorney General of the State of:
CALIFORNIA, P.O. BOX 85266, SAN DIEGO, CA. 92186-5266

PETITION

1. Name and location of court which entered the judgment of conviction under attack SUPERIOR COURT OF CALIFORNIA, COUNTY OF RIVERSIDE, 4100 MAIN ST., RIVERSIDE, CA. 92501

2. Date of judgment of conviction OCT. 9, 2002

3. Length of sentence 59 YEARS TO LIFE (ATT. 1).

4. Nature of offense involved (all counts) CALIFORNIA PENAL CODE §§ 187, 273ab, 12020 (A).

fee Due 530

5. What was your plea? (Check one)
(a) Not guilty ☑
(b) Guilty ☐
(c) Nolo contendere ☐
If you entered a guilty plea to one count or indictment, and a not guilty plea to another count or indictment, give details:

6. If you pleaded not guilty, what kind of trial did you have? (Check one)
(a) Jury ☑
(b) Judge only ☐

7. Did you testify at the trial?
Yes ☐ No ☑

8. Did you appeal from the judgment of conviction?
Yes ☑ No ☐

9. If you did appeal, answer the following:

(a) Name of court CA. COURT OF APPEALS, 4TH APP. DISTRICT, DIVISION 2

(b) Result DENIED, CASE NO. E032757

(c) Date of result and citation, if known

(d) Grounds raised INSTRUCTION ERROR; ERROR IN ADMITTING PRIOR ACTS; INCORRECT ABSTRACT OF JUDGMENT.

(e) If you sought further review of the decision on appeal by a higher state court, please answer the following:

(1) Name of court CALIFORNIA SUPREME COURT

(2) Result DENIED, CASE NO. S 121700

(3) Date of result and citation, if known FEB. 4, 2004

(4) Grounds raised INSTRUCTION ERROR; ERROR IN ADMITTING PRIOR ACTS

(f) If you filed a petition for certiorari in the United States Supreme Court, please answer the following with respect to each direct appeal:

(1) Name of court

(2) Result

(3) Date of result and citation, if known

(4) Grounds raised

10. Other than a direct appeal from the judgment of conviction and sentence, have you previously filed any petitions, applications, or motions with respect to this judgment in any court, state or federal?

Yes ☑ No ☐

11. If your answer to 10 was "yes," give the following information:

(a) (1) Name of court UNITED STATES COURT, CENTRAL DIST. OF CALIFORNIA

(2) Nature of proceeding HABEAS CORPUS CASE NO. EDCV-07-1124 DMG (FFM).

(3) Grounds raised INEFFECTIVE ASSISTANCE OF TRIAL COUNSEL; PROSECUTORIAL MISCONDUCT; FAILURE TO PROPERLY INSTRUCT; INSUFFICENT

EVIDENCE; ERROR IN ADMITTING PRIOR BAD ACTS; INSTRUCTION ERROR (CALJIC NO. 2.03); CUMULATIVE ERRORS.

(4) Did you receive an evidentiary hearing on your petition, application or motion?
Yes ☐ No ☑

(5) Result DENIED

(6) Date of result 4-14-2011

(b) As to any second petition, application or motion give the same information:

(1) Name of court

(2) Nature of proceeding

(3) Grounds raised

(4) Did you receive an evidentiary hearing on your petition, application or motion?
Yes ☐ No ☐

(5) Result

(6) Date of result

(c) Did you appeal to the highest state court having jurisdiction the result of action taken on any petition, application or motion?

(1) First petition, etc. Yes ☐ No ☐

(2) Second petition, Yes ☐ No ☐

(d) If you did *not* appeal from the adverse action on any petition, application or motion, explain briefly why you did not:

12. State *concisely* every ground on which you claim that you are being held unlawfully. Summarize *briefly* the *facts* supporting each ground. If necessary, you may attach pages stating additional grounds and *facts* supporting same.

CAUTION: In order to proceed in the federal court, you must ordinarily first exhaust your available state court remedies as to each ground on which you request action by the federal court. If you fail to set forth all grounds in this petition, you may be barred from presenting additional grounds at a later date.

For your information, the following is a list of the most frequently raised grounds for relief in habeas corpus proceedings. Each statement preceded by a letter constitutes a separate ground for possible relief. You may raise any grounds which you may have other than those listed if you have exhausted your state court remedies with respect to them. However, *you should raise in this petition all available grounds* (relating to this conviction) on which you base your allegations that you are being held in custody unlawfully.

Do not check any of these listed grounds. If you select one or more of these grounds for relief, you must allege facts. The petition will be returned to you if you merely check (a) through (j) or any one of these grounds.

(a) Conviction obtained by plea of guilty which was unlawfully induced or not made voluntarily with understanding of the nature of the charge and the consequences of the plea.
(b) Conviction obtained by use of coerced confession.
(c) Conviction obtained by use of evidence gained pursuant to an unconstitutional search and seizure.
(d) Conviction obtained by use of evidence obtained pursuant to an unlawful arrest.
(e) Conviction obtained by a violation of the privilege against self-incrimination.
(f) Conviction obtained by the unconstitutional failure of the prosecution to disclose to the defendant evidence favorable to the defendant.
(g) Conviction obtained by a violation of the protection against double jeopardy.
(h) Conviction obtained by action of a grand or petit jury which was unconstitutionally selected and impaneled.
(I) Denial of effective assistance of counsel.
(j) Denial of right of appeal.

A. Ground one: ACTUAL INNOCENCE CLAIM (- AGAINST ERRORS DUE TO INEFFECTIVE ASSISTANCE OF COUNSEL)

Supporting FACTS (state *briefly* without citing cases or law)

SEE ATTACHED: PETITIONER WAS CONVICTED BY UNRELIABLE EXPERT DIAGNOSIS FOR INFLICTION OF SHAKING BABY SYNDROME (SBS) CAUSE OF DEATH. THE JURY WAS NOT PRESENTED EVIDENCE THAT THE EVIDENCE RELIED BY UNQUALIFIED EXPERT TO MAKE A VALID SBS DIAGNOSIS DOES NOT EXIST ON AUTOPY BY NEUROLOGICAL EXPERT WHOM PERFORMED AUTOPSY.

B. Ground two: ACTUAL INNOCENCE CLAIM (- AGAINST PROSECUTORIAL USE OF FALSE EVIDENCE BY EXPERT)

Supporting FACTS (state *briefly* without citing cases or law):

SEE ATTACHED: PETITIONER WAS CONVICTED BY UNRELIABLE EXPERT DIAGNOSIS FOR INFLICTION OF SHAKING BABY SYNDROME (SBS) CAUSE OF DEATH. THE JURY WAS NOT PRESENTED EVIDENCE THAT THE EVIDENCE RELIED BY UNQUALIFIED EXPERT TO MAKE A VALID SBS DIAGNOSIS DOES NOT EXIST ON AUTOPSY BY NEUROLOGICAL PATHOLOGIST WHOM PERFORMED THE AUTOPSY.

C. Ground three:

Supporting FACTS (state *briefly* without citing cases or law):

D. Ground four:

Supporting FACTS (state *briefly* without citing cases or law):

13. If any of the grounds listed in 12A, B, C, and D were not previously presented in any other court, state or federal, state *briefly* what grounds were not so presented, and give your reasons for not presenting them:

ACTUAL INNOCENCE CLAIM: PETITIONER DID NOT DISCOVER FALSEHOOD OF BRAIN CORTEX INJURY (I.E., DIFFUSE AXIAL INJURY). THE JURY WAS NOT PRESENTED RECENT DISCOVERY USED TO VALIDATE SBS DIAGNOSIS/DEATH.

14. Do you have any petition or appeal now pending in any court, either state or federal, as to the judgment under attack?
Yes ☐ No ☑

15. Give the name and address, if known, of each attorney who represented you in the following stages of the judgment attacked herein:
(a) At preliminary hearing STUART SACHS, 4200 ORANGE ST., RIVERSIDE, CA. 92501

(b) At arraignment and plea SAME

(c) At trial SAME

(d) At sentencing SAME

(e) On appeal SHARON JONES (#138137), P.O. BOX 1663, VENTURA, CA. 93002

(f) In any post-conviction proceeding NONE

(g) On appeal from any adverse ruling in a post-conviction proceeding NONE

16. Were you sentenced on more than one count of an indictment, or on more than one indictment, in the same court and at the same time?
Yes ☑ No ☐

17. Do you have any future sentence to serve after you complete the sentence imposed by the judgment under attack?
Yes ☐ No ☑
(a) If so, give name and location of court which imposed sentence to be served in the future:

(b) Give date and length of the above sentence:

(c) Have you filed, or do you contemplate filing, any petition attacking the judgment which imposed the sentence to be served in the future?
Yes ☐ No ☐

Wherefore, petitioner prays that the Court grant petitioner relief to which he may be entitled in this proceeding.

Signature of Attorney (if any)

I declare under penalty of perjury that the foregoing is true and correct. Executed

7-4-17
(date)

Signature of Petitioner

TABLE OF CONTENTS

TABLE OF CONTENTS

I

STATEMENT OF FACTS

A

SINGLE EVENT, BLUNT-FORCE FALL

ON 4-28-01, ABOUT 6:15 A.M., PETITIONER, WHILE HOLDING HIS BIOLOGICAL SON, ERIK PATKINS, WAS WALKING "TOWARDS" THE STAIRS (GOING UP) (C.T. 000041; R.T. 650), TRIPPED ON THE EDGE OF THE FIRST STEP, AND FELL. ERIK FELL, HITTING THE OCCIPITAL BONE, OR BACK OF HIS HEAD AT THE UPWARD FIFTH STEP EDGE.

MAKING A CASE FOR SHAKING BABY SYNDROME

PETITIONER'S HISTORY IS THE SAME TO THIS DAY, AND NEVER ACCUSED AS CHANGED, OR ALTERED, BY POLICE OR DEPUTY DISTRICT ATTORNEY (DDA), CHARLES HUGHES; BUT, AT TRIAL WAS VOUCHED TO BE DISCREDITED AS AS LIE BASED ON THE PROSECUTIONS MISUSE OF:

- A FALSE CEREBRAL DIFFUSE AXIAL INJURY;
- 1993 PRIOR EXTRINSIC/BAD ACTS'; AND
- A JURY INSTRUCTION — CALJIC NO. 2.03 — THE LIAR INSTRUCTION ALLOWING JURY TO PRESUME A GUILTY MENTAL STATE (R.T. 614).

ABOUT 9:30 A.M. ON 4-28-01, POLICE, AND DDA, HUGHES TAPE RE-CORDED, AND WERE INFORMED THAT PETITIONER, IN A PRIOR (1993) RELATIONSHIP, HAD SHAKEN HIS THEN SON, JACK PATKINS, WHICH RESULTED IN A FIVE YEAR CONVICTION/PLEA BARGAIN FOR CHILD CRUELTY (C.T. 000109-118).

ABOUT 3:30 P.M. ON 4-28-01, ERIK'S BIOLOGICAL MOTHER, MARGIE

GAROFANO WAS QUESTIONED BY DDA, HUGHES TO EVER WITNESSING PETITIONER SHAKING ERIK (EXH. 6, Pg 77-83), OR IF ERIK WAS EMOTIONALLY DISTRESSED AROUND PETITIONER – NOT SLEEPING OR IN CONSTANT ANXIETY (EXH. 6, Pg 31, 98-100).
NO ABUSE TOWARDS ERIK, OR ABNORMAL DISTRESS WAS WITNESSED BY MARGIE (EXH. 6, Pg 22-23, 85-87).

PRE-AUTOPSY CT SCANS SUGGEST A CEREBRAL DIFFUSE AXIAL INJURY

ON 4-28 TO 5-1-01 CT SCANS WERE PERFORMED AT TWO HOSPITALS – RIVERSIDE COMMUNITY, AND LOMA LINDA UNIVERSITY.
RADIOLOGIST IMPRESSIONS, REPEATEDLY, SUGGEST NEW BLOOD IN THE CEREBRAL CORTEX, OTHERWISE TERMED, FN 1:

- A "PORENCEPHALIC" LESION (EXH. 10, Pg 1; EXH 18, Pg 2); OR
- "NEW INTRAPARENCHYMAL" (EXH 42, Pg 2-3; EXH 16, Pg 3); OR
- "PARENCHYMAL" (EXH 42, Pg 2); OR
- A "DIFFUSE AXIAL INJURY" (D.A.I) (R.T. 333-334, 357), FN 2, AT THE LEFT FRONTAL CORTEX (SEE EXH 23, Pg 17).

FOOTNOTE 1

SEE STEDMAN'S MEDICAL DICTIONARY, 28TH EDITION (2006) AT:

PARENCHYMA: THE DISTINGUISHING OR SPECIFIC CELLS OF A GLAND OR ORGAN, CONTAINED IN AND SUPPORTED BY THE CONNECTIVE TISSUE FRAMEWORK (Pg. 1424).

INTRA: INSIDE, WITHIN (Pg 993).

PORENCEPHALY: THE OCCURRENCE OF CAVITIES IN THE BRAIN SUBSTANCE (Pg 1542).

LESION: A WOUND OR INJURY (Pg 1070).

CORTEX: THE OUTER PORTION OF AN ORGAN... (CEREBRAL) THE GRAY CELLULAR MANTLE (1-4 MM THICK) COVERING THE ENTIRE

SURFACE OF THE CEREBRAL HEMISPHERE (Pg 447; SEE EXH 23, Pg 17).

AXON: THE SINGLE PROCESS OF A NERVE CELL THAT UNDER NORMAL CONDITIONS CONDUCTS NERVOUS IMPULSES AWAY FROM THE CELL BODY AND ITS REMAINING PROCESSES (DENDRITES) (Pg 191).

FOOTNOTE 2

SEE RUPPLE V KUCANIN 2011 U.S. DIST. LEXIS 67503: BRAIN INJURY IS DIFFUSE OR FOCAL. "A FOCAL INJURY IS A LOCALIZED INJURY, SUCH AS THAT CAUSED BY A STROKE, A DIRECT BLOW TO THE HEAD, OR AN ANEURYSM, AND IS TYPICALLY A CONTUSION ON THE SURFACE OF THE BRAIN, VISIBLE BY CONVENTIONAL SCANNING.

A DIFFUSE AXONAL INJURY INVOLVES SCATTERED DAMAGE TO THE BRAIN SUBSTANCE, PARTICULARLY THE WHITE MATTER THAT IS COMPRISED OF AXON FIBERS."

END FOOTNOTES 1 AND 2

A DIFFUSE AXIAL INJURY VALIDATES A SHAKING BABY SYNDROME DIAGNOSIS

GENERAL PEDIATRICIAN (GP), REBECCA PIANTINI WAS HIRED ON Y-28-01 TO FIND INFLICTED ABUSE ON ERIK (C.T. 000030-31). THE PRE-AUTOPSY CT SCAN SUGGESTIONS OF A CEREBRAL CORTEX LESION IN THE LEFT FRONTAL LOBE — A D.A.I. — IS A FOUNDATION INJURY IN THE MEDICAL COMMUNITY VALIDATING A SHAKING BABY SYNDROME (S.B.S.) DIAGNOSIS.

FOR TRIAL, SBS WAS TERMED "ABUSIVE HEAD TRAUMA" (A.H.T.) ACCORDING TO GP, PIANTINI (R.T. 327; SEE C.T. 000031, 39-40; EXH 2, Pg 3; EXH 16, Pg 3; EXH. 16A, Pg 4).

IN OTHER WORDS, ACCORDING TO GP, PIANTINI, S.B.S, TERMED AHT, IS THE CAUSE OF ERIK'S DEATH (C.T. 000040-41, 51; R.T. 363, 371).

LICENSED QUALIFICATIONS OF GP, PIANTINI

AS A NINE YEAR GENERAL PEDIATRICIAN (R.T. 320-323), GP, PIANTINI CONCEDES

HER LACK OF LICENSED (NO. G69929) QUALIFICATIONS AGAINST NEUROLOGICAL EXPERT, FORENSIC PATHOLOGIST (FP), STEVEN TRENKLE, AND 5-2-01 AUTOPSY FINDINGS AND DIAGNOSIS (R.T. 384); YET BASED HER TRIAL OPINION ON (CONFLICTING) AUTOPSY AND PRE-AUTOPSY MEDICAL RECORDS (C.T. 000031-32, 39-40; R.T. 363, 371).

5-2-2001 AUTOPSY – A FOCAL INJURY VERSUS A DIFFUSE AXIAL INJURY

GP, PIANTINI, AND DDA, HUGHES, ATTENDED THE 5-2-01 AUTOPSY (EXH 23, Pg 10; C.T. 000037-38), KNOWING FIRSTHAND THE RESULTS OF PRIOR CT SCANS/MEDICAL RECORDS, AND, SPECIFICALLY, THE IMPRESSIONS SUGGESTING A D.A.I.

ON AUTOPSY, FP, TRENKLE FOUND FALSE PRE-AUTOPSY CT SCAN IMPRESSIONS OF BLOOD INSIDE THE FRONTAL CORTEX OF THE BRAIN, OTHERWISE TERMED:

- A PORENCEPHALIC LESION;
- NEW INTRAPARENCHYMAL;
- PARENCHYMAL; OR
- A DIFFUSE AXIAL INJURY,

RECORDING, UNDER MICROSCOPIC EXAMINATION: "SECTIONS OF THE FRONTAL CORTEX SHOW ONLY SUPERFICIAL SUBARACHNOID HEMORRHAGING AND EDEMA" (EXH 23, Pg 9, 16).

THE ONLY INJURY FOUND, BEING ALSO WITHIN A MEMBRANE ABOVE THE BRAIN CORTEX (SEE EXH 23, Pg 17). AT THE LEFT FRONTAL LOBE, IS A "MONTH OLD" SUBDURAL SPACE CONTUSION – A HEAD BRUISE (R.T. 463; EXH. 23, Pg 7, PARA 2 – "3x2 cm."; Pg 10 AT IV, C.; Pg 16 AT "CONTUSION")

ON AUTOPSY, AND BASED ON THE "ONLY EVIDENCE" FOUND, FP, TRENKLE DIAGNOSED THAT A SINGLE, BLUNT-FORCE EVENT, "BEING A BLOW OR A FALL", IS SUFFICIENT TO ACCOUNT FOR ALL 4-28-01 CRANIAL/INTRA-

CRANIAL DAMAGE AND IS THE CAUSE OF DEATH (R.T. 461-464, 476-477) — A FOCAL INJURY (ANTE, Pg 3, FN. 2).

GP, PIANTINI'S UNPROFESSIONAL CONDUCT

POST-AUTOPSY, GP, PIANTINI CONCEALED INCOMPETENCE, AND COMMITTED FRAUD, WHEN, OUTSIDE OF LICENSED QUALIFICATIONS, SHE INTENTIONALLY MISREPRESENTED FP, TRENKLE'S FOCAL INJURY NEUROLOGICAL FINDINGS, AND ONLY EVIDENCE DIAGNOSIS, ASSERTING — BASED ON DIFFUSE AXIAL INJURY — THAT SBS/AHT, AND A HEAD SLAMMING, FN 3 — MULTIPLE EVENTS, FN 4 — IS THE AUTOPSY CAUSE OF DEATH (C.T. 000040, 41, 49, 51; R.T. 333-334, 357, 364, 371).

FOOTNOTE 3

AS A SECOND EVENT ACCORDING TO GP, PIANTINI'S NEUROLOGICAL REPRESENTATIONS, DDA, HUGHES ASSERTED FACTS NOT IN EVIDENCE, THAT ERIK SUFFERED A HEAD "SLAMMING" FORCE GREATER THAN "A THREE STORY FALL" (R.T. 603-604).

DIRECT EVIDENCE IS CLEAR, ERIK SUFFERED NO EXTERNAL HEAD (R.T. 417-418, 422), OR BODY (R.T. 301, 340, 417-418) INJURY/BRUISING TO SUPPORT THE FORCE OF A 3, 2, NOR 1 STORY FALL.

FOOTNOTE 4

AUTOPSY RULES-OUT AN SBS DIAGNOSIS: FP, TRENKLE DOES NOT RULE-IN A SECOND EVENT (R.T. 476-478); IN FACT, FP, TRENKLE OUTLINED WHAT THE "PATHOLOGY" REQUIRES TO VALIDATE AN SBS DIAGNOSIS, THAT IS, DAMAGE OR "HEMORRHAGE OF THE UPPER CERVICAL SPINE OR BRAIN STEM" — EVIDENCE NOT FOUND IN ERIK, EVEN FAILING TO MANIFEST 4 DAYS AFTER THE FALL (R.T. 452-453; EXH 23, Pg 7-NECK; CONTRAST DDA, HUGHES ON CLOSING, R.T. 654-655).

END FOOTNOTES 3 AND 4

PROSECUTORIAL USE OF FALSE EVIDENCE; INSUFFICIENT EVIDENCE TO UPHOLD CHARGES

FROM ATTENDING AUTOPSY, DDA HUGHES KNEW (OR SHOULD HAVE KNOWN) A DAI AT THE FRONTAL CORTEX WAS FALSE, AND, RATHER SUBARACHNOID HEMORRHAGING, EDEMA, AND A MONTH OLD SUBDURAL CONTUSION WERE THE ONLY FINDINGS AT THE FRONTAL LOBES (EXH 23, PP 16,17). TO THIS DAY, PETITIONER IS INCARCERATED FOR INFLICTING SBS/ MULTIPLE EVENTS BASED ON D.A.I. — FALSE EVIDENCE.

ON 9-23-02 DDA, HUGHES MOTIONED, AND WAS GRANTED TRIAL USE OF 1993 BAD ACTS — SHAKING JACK — AND, BASED ON STRIKING SIMILARITY OF SBS IN 2001, ESTABLISHING ELEMENT PROOF ON THE 2001 CHARGES, THAT IS, SUBJECTIVE KNOWLEDGE FOR MALICE MURDER, INTENT TO KILL, AND LACK OF ACCIDENT, FN5 (R.T. 10-13).

FOOTNOTE 5 ———————————————————

LACK OF ACCIDENT IS NOT A REQUIRED STATUTORY ELEMENT (SEE U.S. V. BROWN (9TH 1989) 880 F.2d 1012, 1016; U.S. V. MERRIWEATHER (6TH 1996) 78 F.3d 1070, 1077).

THE FACT A DAI IS FALSE, SUBSEQUENTLY, INVALIDATES GP, PIANTINI'S PRE-AUTOPSY SBS DIAGNOSIS BASED ON A DAI; AND, ACCORDING TO LAW (CAL. EVID. CODE 1101; 352 ; ACCORD FED. R. EVID. 404; 403), MAKES IRRELEVANT 1993 BAD ACTS FOR ELEMENT PROOF BASED ON SBS (R.T. 10-13) — REQUIRING SIMILARITY AND A CLEAR AND LOGICAL CONNECTION TO A FACT OF CONSEQUENCE.

DDA, HUGHES NEVER-THE-LESS USED 1993 EXTRINSIC ACTS AS CHILD ABUSER PROOF, I.E., UNFAIR "DISPOSITION EVIDENCE" (R.T. 13), SO, OBVIOUSLY, THE JURY "KNOWS THIS WAS NO ACCIDENT" BECAUSE "HE DID IT BEFORE, AND HE DID IT AGAIN" (SEE CLOSINGS AT R.T. 600 601, 603, 608-609, 611-

615, 652-653, 655-656, 663-664).

END FOOTNOTE 5

EVIDENTIARY TRIAL ERRORS INFECTING THE PROCEEDINGS

ALSO, BY THE FALSEHOOD OF A CEREBRAL DAI, VALIDATING SBS, PETITIONER'S 4-28-01 HISTORY WAS PRONOUNCED MEDICALLY "IN-CONSISTENT" BY UNCALLED DOCTORS, AND PROSECUTION WITNESSES (SEE C.T. 000041-42; R.T. 303-304, 363. 597-599, 659; 62-63; EXH 3, Pg 8; EXH. 2, Pg 3).

BUT, BASED ON THE "ONLY EVIDENCE" FOUND AT 5-2-01 AUTOPSY, PETITIONER'S HISTORY — A SINGLE EVENT, BLUNT-FORCE FALL — IS CONSISTENT WITH FP, TRENKLE'S BLUNT FORCE INJURY DIAGNOSIS, "THAT'S ONE EVENT, BEING A BLOW OR A FALL" (R.T. 962).

THE JURY WAS DEPRIVED FROM TRUTHFUL MEDICAL EVIDENCE, AND DECIDING WHETHER SAID "ONLY EVIDENCE" IS THE RESULT OF "A BLOW OR A FALL" (R.T. 962)

THE LIAR INSTRUCTION HAVING INJURIOUS INFLUENCE ON THE JURY'S VERDICT

REGARDLESS THAT PETITIONER'S HISTORY IS, IN FACT AND CIRCUMSTANCES, CONSISTENT WITH THE AUTOPSY DIAGNOSIS, DDA. HUGHES WAS GRANTED USE OF JURY INSTRUCTION, CALJIC NO. 2.03 — THE LIAR INSTRUCTION — ALLOWING JURY TO PRESUME EVIDENCE PETITIONER HAS A GUILTY MENTAL STATE, SUBSTANTIATING THE CHARGES (R.T. 614). ON CLOSINGS, DDA. HUGHES GAVE THE JURY ULTIMATUMS, THAT IS, TO BELIEVE UNCALLED, AND PROSECUTION DOCTORS OR BELIEVE PETITIONER (R.T. 598, LN 26 — 600, LN 7; 615, LN 18-19; 660; 663-664), WHO LIED, REPEATEDLY, IN 1993, FN 6., AND WHO'S 2001 "HISTORY" IS A LIE, BEING MEDICALLY "INCONSISTENT" BASED ON A DAI (SEE EXH 2, Pg 3, 7-8 — GP, PIANTINI'S SBS ASSERTIONS "ASSISTED THE TRIER OF FACT").

FOOTNOTE 6 ——————————

DDA, HUGHES CONCEDES 1993 EXTRINSIC ACTS WERE ADMITTED TO SHOW "DISPOSITION EVIDENCE" (R.T. 13) — HIS LIES OF 1993 MAKE IT "THE MORE OBVIOUS THAT HE'S LYING" NOW (R.T. 609, 601); IN 1993 HE LIED, THEN "ADMITTED IT" . . . "YOU KNOW HE'S LYING" NOW (R.T. 611-613, 655); HE LIED "REPEATEDLY" IN 1993, AND SAYS IT "REPEATEDLY" NOW. "HE'S NOT TRUSTWORTHY. HE LIES REPEATEDLY" (R.T. 652-653). MOREOVER, HAD AUTOPSY CONFIRMED A D.A.I. TRUE, THIS WOULD NOT ONLY VALIDATE SBS BUT MAKE PETITIONER'S SINGLE EVENT, STAIR FALL HISTORY INCONSISTENT WITH MEDICAL EVIDENCE.

END FOOTNOTE 6 ——————————

INEFFECTIVE ASSISTANCE OF COUNSEL

IN CHRONOLOGICAL ORDER, DEFENSE COUNSEL (DC), STUART SACHS' DEFICIENCIES PREJUDICED THE DEFENSE A REASONABLE INVESTIGATION AGAINST SBS AND ITS BASIS — A D.A.I. — AND DENIED THE JURY FROM HEARING THE TOTALITY OF AFOREMENTIONED MATERIAL EVIDENCE THAT ALSO RESULTED IN THE PROSECUTIONS COMPOUNDING FALSE INFERENCES, AND/OR TRIAL LIES ON TOP OF LIES BASED ON EVIDENTIARY ERRORS:

- THE MISUSE OF 1993 BAD ACTS, USING FALSE EVIDENCE — SBS — FOR ELEMENT SATISFACTION =
  - ASSAULT / MURDER BASED ON GENERAL INTENT (P.C. § 273ab), I.E., A REASONABLE PERSON (STANDARD) WOULD FIND SBS A FORCE THAT CAUSED DEATH;
  - CONSCIOUS DISREGARD (P.C. § 187);
  - AN INTENTIONAL ACT (P.C. § 187);
  - SUBJECTIVE KNOWLEDGE (P.C. § 187), AND
- THE LIAR INSTRUCTION — CALJIC NO. 2.03 — TO VOUCH THE CREDIBILITY OF DOCTORS BASED ON FALSE EVIDENCE — DAI / SBS —

AND TO DISCREDIT PETITIONER'S 2001 HISTORY AS NOT ONLY MEDICALLY INCONSISTENT BUT BECAUSE HE WAS A LIAR IN 1993. ALL SAID BEGINNING NOT ONLY AT THE PROSECUTIONS NEUROLOGICAL DISREGARD OF FP, TRENKLE'S AUTOPSY FORENSICS AND CAUSE OF DEATH BUT AT GP, PIANTINI'S FIDUCIARY DECEIT TO CONCEAL INCOMPETENCE AND INTENTIONALLY MISREPRESENT THE ONLY EVIDENCE ON AUTOPSY, TO MISLEAD THE JURY A DAI/SBS/MULTIPLE EVENTS WAS DIAGNOSED ON AUTOPSY.

B.

AGGRAVATING FACTORS OF OTHER ALLEGED INJURIES TO OBTAIN CONVICTION, AND GOOD CAUSE FOR DISCOVERY PURSUANT RULES GOVERNING SECTION 2254 CASES, RULE 6.

DIRECT APPEAL/CALIFORNIA COURT OF APPEALS STATEMENT OF FACTS

THE AUTOPSY CONFIRMED FALSEHOOD OF DAI/SBS ALTERNATIVELY MADE ITS WAY AS A STATEMENT OF MATERIAL FACT, AND USED TO SUBSTANTIATE THE GOVERNMENTS UPHOLDING CONVICTION, I.E., "BLOOD INSIDE THE FRONTAL CORTEX OF THE BRAIN . . . AND THE LESION IN ERIK'S BRAIN WAS INCONSISTENT WITH THE HISTORY OF THE INJURY GIVEN BY PETITIONER".
AND, "AUTOPSY INDICATED A SHAKING INJURY . . . AND A MORE RECENT FRACTURE TO ERIK'S RIB ALSO INDICATED ERIK HAD BEEN SHAKEN". (EXH 2, Pg 3; EXH 4. Pgs 5, 14).

AGAIN, AUTOPSY WAS CLEAR AND CONVINCING, THE "ONLY EVIDENCE" — A FOCAL INJURY (ANTE, Pg 3, FN.2) — FP, TRENKLE DIAGNOSED WAS RESULT OF A SINGLE BLUNT FORCE EVENT TO "ACCOUNT FOR ALL [4-28-01]

DAMAGE" (R.T. 461-464), AND IS THE CAUSE OF DEATH (R.T. 476-477). FP, TRENKLE DID OPINE HE "FELT" IT WAS NON-ACCIDENTAL (R.T. 439-440).

INCOMPLETE DISCOVERY ON APPEAL

ON PRE-TRIAL DISCOVERY (EVEN POST-TRIAL REQUESTS), PETITIONER IS DENIED A COMPLETE AUTOPSY REPORT — ATTACHMENTS, PHOTOS, SUPPLEMENTS, ETC.; PEOPLE'S EXHIBIT 4; AND PEOPLE'S EXHIBIT 14.

NINTH RIB

WITHHELD AUTOPSY PHOTO(S), AND/OR PEOPLE'S EXHIBIT 4 WERE USED DURING TRIAL BY THE PROSECUTION AS MATERIAL EVIDENCE A NINTH RIB FRACTURE, WHERE "IT JOINS WITH THE VERTEBRAE" WAS INFLICTED ON 4-28-01 (R.T. 337, 441-442).

NO MEDICAL RECORD/X-RAYS EXIST TO REVEAL REQUIRED PHYSICAL EVIDENCE A NINTH RIB FRACTURE OCCURRED ON 4-28-01, AND 4-29-01, PRIOR TO LUMBAR SURGICAL PROCEDURES (EXH. 10, Pg 4-6; EXH 18, Pg 2). ON 4-29-01 LUMBAR SURGICAL PROCEDURES WERE PERFORMED "9 CM. ABOVE THE UPPER GLUTEAL CLEFT" (EXH 23, Pg 6; Pg 4, PARA 7; Pg 5, AT "MID-LOWER BACK").

THE JURY DEPRIVED MATERIAL EVIDENCE, AND ACCORDING TO PEOPLE'S EXHIBIT 4 (— DEPICTING A SINGLE HEMORRHAGE SPOT), IS THAT:

- AT THE EXACT LOCATION OF ACCUSED T-9 VERTEBRAL BODY FRACTURE OCCURRING ON 4-28-01, LUMBAR SURGERY WAS PERFORMED ON 4-29-01 (EXH. 42, Pg 5), WITH CATHETAR, AND LINES, PLACEMENT AT "THE LEVEL OF T9-T10" VERTEBRAL BODY (EXH. 42, Pg 7), AND
- PRIOR TO 4-29-01 LUMBAR PROCEDURES, NO NATURAL, PHYSICAL EVIDENCE MANIFEST (SEE R.T. 420-421 — "HEMORRHAGING" AND "SWELLING") ON MULTIPLE X-RAYS, E.G., THE SINGLE HEMORRHAGE SPOT ON PEOPLE'S

EXHIBIT Y, TO SUBSTANTIATE ABUSE AS OPPOSED TO Y-29-01 T9-T10 VERTEBRAL BODY SURGICAL PROCEDURES PRODUCING THE HEMORRHAGE SPOT, AND FRACTURE AT THE T-9 VERTEBRAL BODY (ACCORD EXH. 10, Pg Y; EXH 18, Pg 2; EXH. 42).

ON 10-2-02 FP, TRENKLE ASSURED THAT "ACUTE FRACTURES, NO MATTER WHERE THEY ARE HAVE ACUTE HEMORRHAGE ASSOCIATED WITH THEM - - - WHEN THEY FIRST CRACK, THERE'S HEMORRHAGE AND THEY ARE SWELLING" (R.T. 420-421; ACCORD NATURAL, PHYSICAL EVIDENCE AT LOPEZ V. SCHIRO (9TH 2007) 491 F.3d 1029, AT 1034 - ABUSE OCCURRED ABOUT 10:00 A.M., AND DEATH ABOUT 3:30 P.M., REVEALING DEFINITE HEMORRHAGE AND SWELLING AT 10TH/11TH RIBS ON AUTOPSY).

ON 10-2-02 FP, TRENKLE, RELYING ON THE HEMORRHAGE SPOT ON PEOPLE'S EXHIBIT Y, MISLED THE JURY THAT NO SURGICAL PROCEDURES OCCURRED "LOW ON THE BACK" (R.T 419), AND THAT HEMORRHAGE SPOT IS DUE TO CHILD ABUSE ON Y-28-01, I.E., "SQUEEZING" (R.T. YY1)

THE JURY WAS DENIED DEFENSE EVIDENCE ON CAUSE OF A T9 VERTEBRAL BODY FRACTURE:

- THE SINGLE HEMORRHAGE SPOT ON PEOPLES EXHIBIT Y DID NOT EXIST ON X-RAYS ON Y-28, AND Y-29-01, PRIOR TO LUMBAR PROCEDURES, AND
- THERE'S A CATHETAR, AND LINES PLACED AT THE T9 VERTEBRAL BODY (- IN FACT, CATHETAR PLACEMENT WAS PERFORMED TWICE DUE TO SURGICAL ERROR, EXH.19), AT THE EXACT LOCATION OF A FRACTURE AT THE T9 VERTEBRAL BODY.

ON 10-3-02 DDA, HUGHES WITHDREW PEOPLES EXHIBIT Y (C.T. 000133; R.T. 8-9, 546).

PEOPLES EXHIBIT Y - THE AUTOPSY PHOTO(S) - WERE WITHHELD FROM PETITIONER'S AUTOPSY REPORT, AND TRIAL DISCOVERY.

DDA, HUGHES CAPITALIZED ON AN UNCHALLENGED NINTH RIB FRACTURE ACCUSED AS INFLICTED ABUSE TO BOLSTER GP, PIANTINI'S DAI/SBS/ MULTIPLE EVENTS CAUSE OF DEATH (C.T. 000040, 45; R.T. 653, 659).

A COMPLETE AUTOPSY REPORT, ON REQUEST FOR DISCOVERY, WILL SUBSTANTIATE PETITIONER'S AFOREMENTIONED ARGUMENT ON ACTUAL INNOCENCE CLAIM.

RIGHT FEMUR

ON 10-1-02 GP, PIANTINI TESTIFIED THAT AUTOPSY DIAGNOSED A "CORTICAL FRACTURE" AT THE "DISTAL AREA" OF THE RIGHT FEMUR, AND THAT CHILD "ABUSE" IS THE ONLY CAUSE (R.T. 362-363, 386-387; EXH 42, Pg 8).
PRE-AUTOPSY MEDICAL RECORDS/X-RAYS ASSERT "NO OBVIOUS FRACTURE" EXISTS ON EITHER FEMUR (EXH 21, Pg 2).
X-RAYS REVEAL "BOTH" FEMURS, BILATERALLY, GOING THROUGH PERIOSTEAL REACTIVE CHANGES (EXH 10, Pg 3), I.E., "EPIPHYSES", FN 7.

FOOTNOTE 7 ——————————————————————

SEE STEDMAN'S MEDICAL DICTIONARY, 28TH EDITION (2006) AT:

EPIPHYSIS: PL. EPIPHYSES; A PART OF A LONG BONE DEVELOPED FROM A SECONDARY CENTER OF OSSIFICATION, DISTINCT FROM THAT OF THE SHAFT, AND SEPARATED AT FIRST FROM THE LATTER BY A LAYER OF CARTILAGE. EPI – UPON, + PHYSIS – GROWTH (Pg 657).

END FOOTNOTE 7 ——————————————————————

ON AUTOPSY – MICROSCOPIC EXAMINATION – FP, TRENKLE CONFIRMED

THERE'S "NO ACTUAL CRACK OF THE BONE" (R.T. 467; EXH 23, Pg 5).
AT THE DISTAL AREA, FN8, OR EXACT LOCATION OF EPIPHYSES (— THAT'S OCCURRING TO BOTH FEMURS, EXH 10, Pg 3), AND "SYMMETRICALLY" ON TOP, ON THE RIGHT FEMUR, THE PERIOSTEUM APPEARED "MORE PROMINENT" (R.T. 438), OR "MORE PRONOUNCED" — ASYMMETRIC — TO THAT OF THE LEFT FEMUR (R.T. 468; EXH 23, Pg 5).

FOOTNOTE 8 ——————————

SEE STEDMAN'S MEDICAL DICTIONARY, 28TH EDITION (2006) AT:
EPIPHYSIAL CARTILAGE: PARTICULAR TYPE OF NEW CARTILAGE PRODUCED BY THE EPIPHYSIS OF A GROWING LONG BONE; LOCATED ON THE EPIPHYSIAL (DISTAL) SIDE OF THE ZONE OF GROWTH CARTILAGE (Pg 319).

END FOOTNOTE 8 ——————————

ON 10-2-02 FP, TRENKLE "FELT" (R.T. 439), OR HAD AN "INCLINATION", I.E., PERSONALLY SPECULATED (— OFFERING NO SCIENTIFIC REASONING), THE RIGHT FEMUR PROMINENCE WAS AN "INFLICTED" INJURY (R.T. 467-469) BECAUSE HE "FELT" THE OTHER INJURIES WERE INFLICTED (R.T. 439, 467-469; EXH 23, Pg 8, 10, AT III.).
FP, TRENKLE AGED THE PROMINENCE AT "SIX" OR "EIGHT" WEEKS PRIOR TO 5-2-01 AUTOPSY (R.T. 467).
FP, TRENKLE ASSERTED, "IF IT'S INFLICTED", IT'S FROM BEING "GRIPPED" AND "TWISTED"; WHOMEVER GRIPPED THE RIGHT FEMUR, TORE THE PERIOSTEUM "OFF THE BONE" (R.T. 467).
BUT, THE HYPOTHESIS IS IN MATERIAL CONFLICT WITH THE EVIDENCE; THE PERIOSTEUM WAS NEVER 'TORN OFF THE BONE' BECAUSE THE PROMINENCE IS SYMMETRICALLY "ON TOP" (R.T. 438), OR ONE AND THE SAME (— ON THE RIGHT) WITH THE NATURAL EPIPHYSES THAT'S OCCURRING, BILATERALLY,

AT THE DISTAL AREA OF BOTH FEMURS IN THE FIRST PLACE (EXH 42, Pg 7). IN OTHER WORDS (QUESTIONING), HOW DOES SPECULATION OF AN INFLICTED INJURY ONLY OCCUR, OR IS CONFINED, SOLELY ON TOP OF, AND SYMMETRICALLY AROUND, THE NATURAL EPIPHYSES PROCESS ONLY? IT'S UNREASONABLE IT'S INFLICTED.

MOREOVER, NO EVIDENCE EXISTS, NOR WITNESSED (E.G., FROM THE MOTHER, OR AT REGULAR WELL-BABY PEDIATRIC VISITS; SEE R.T. 122), OF "SIX", OR "EIGHT" WEEK OLD (R.T. 467) EXTERNAL LEG INJURIES / BRUISING, SUCH FROM BEING "GRIPPED" AND "TWISTED" BY FORCE TO TO ACCOMPLISHING A TEARING OF PERIOSTEUM "OFF THE BONE" (R.T. 467-468).

THE JURY WAS NEVER PRESENTED A DEFENSE, AND INVESTIGATIVE QUESTIONING BASED ON SAID EVIDENCE AND DEDUCTION OF FACTS.

ON CLOSINGS, DDA, HUGHES CONCEDES THE FALSE TESTIMONY OF A RIGHT FEMUR FRACTURE, INSTEAD MIMICKING SPECULATION OF "AN OLD HEALING LEG INJURY" (R.T. 599).

ON DELIBERATIONS, THE JURY'S CONCERN WAS TO KNOW "HOW MANY" FEMUR FRACTURES EXISTED (R.T. 676; — DOCTOR SONNE ASSERTED TWO, R.T. 208-209).

ON DELIBERATIONS, THE JURY FELT AN INJURY WAS STILL BREAKAGE, EVEN ON BOTH FEMURS WHEN SEEKING TO RESOLVE A "HOUSEHOLD ACCIDENT" DEFENSE (R.T. 676).

<u>DIRECT APPEAL / CALIFORNIA COURT OF APPEALS STATEMENT OF FACTS</u>

THE STATEMENT OF FACTS, RELIED BY THE CALIFORNIA COURT OF APPEALS, MISREPRESENTS MATERIAL FACTS, ASSERTING GP, PIANTINI'S EMOTIONAL BIAS, AND FEMUR FRACTURE ABUSE, TO UPHOLD CONVICTION, I.E., "AUTOPSY REVEALED... AN OLDER FRACTURE TO ERIK'S FEMUR" (EXH 2, Pg 3; EXH 4, Pg 5, 14),

II

MEMORANDUM OF POINTS AND AUTHORITIES

ACTUAL INNOCENCE GATEWAY

"TO BE CREDIBLE, AN ACTUAL INNOCENCE CLAIM REQUIRES PETITIONER TO SUPPORT HIS ALLEGATIONS OF CONSTITUTIONAL ERROR WITH NEW RELIABLE EVIDENCE -- WHETHER IT BE EXCULPATORY SCIENTIFIC EVIDENCE, TRUST-WORTHY EYEWITNESS ACCOUNTS, OR CRITCAL PHYSICAL EVIDENCE -- THAT WAS NOT PRESENTED AT TRIAL" (GRIFFEN V. JOHNSON (9TH 2003) 350 F.3d 956, 961; ACCORD 28 U.S.C. § 2244 (b)(2)(B)(ii)).

"AS WE HAVE PREVIOUSLY SAID, WHERE POST CONVICTION EVIDENCE CASTS DOUBT ON THE CONVICTION BY UNDERCUTTING RELIABILITY OF THE PROOF OF GUILT, BUT NOT AFFIRMATIVELY PROVING INNOCENCE, THAT CAN BE ENOUGH TO PASS THROUGH THE SCHLUP [V. DELO, 513 U.S. 298 (1995)] GATEWAY TO ALLOW CONSIDERATION OF OTHERWISE BARRED CLAIMS" (SOULIOTES V. HEDPETH 2011 U.S. DIST. LEXIS 130476 AT *4).

INEFFECTIVE ASSISTANCE OF COUNSEL

"TO ESTABLISH INEFFECTIVE ASSISTANCE OF COUNSEL, A PETITIONER MUST DEMONSTRATE THAT (1) COUNSELS REPRESENTATION WAS DEFICIENT IN FALLING BELOW AN OBJECTIVE STANDARD OF REASONABLENESS UNDER PREVAILING PROFESSIONAL NORMS, AND (2) COUNSELS DEFICIENT REPRESENTATION SUBJECTED THE PETITIONER TO PREJUDICE, I.E., THERE IS A REASONABLE PROBABILITY THAT, BUT FOR COUNSELS FAILINGS, THE RESULT WOULD HAVE BEEN MORE FAVORABLE TO THE PETITIONER" (STRICKLAND V. WASHINGTON (1984) 466 U.S. 668, 687).

"A REASONABLE PROBABILITY IS A PROBABILITY SUFFICIENT TO UNDERMINE CONFIDENCE IN THE OUTCOME" (STRICKLAND, 466 U.S. AT

694).

CALIFORNIA PENAL CODE, SECTION 273 ab

§ 273 ab (— ASSAULT BY FORCE RESULTING IN DEATH) IS A GENERAL INTENT OFFENSE, REQUIRING EVIDENCE THAT THE DEFENDANT ACTED "WITH AWARENESS OF FACTS THAT WOULD LEAD A REASONABLE PERSON TO REALIZE THAT GREAT BODILY INJURY WOULD DIRECTLY, NATURALLY AND PROBABLY RESULT FROM HIS ACT" (PEOPLE V. WYATT (2012) 148 CAL. RPTR. 3d 508, 514), e.g., 585.

INVOLUNTARY MANSLAUGHTER

IT IS READILY CLEAR THE STATUTORY ELEMENTS OF INVOLUNTARY MANSLAUGHTER DO NOT NECESSARILY INCLUDE ALL OF THE STATUTORY ELEMENTS OF AGGRAVATED ASSAULT. AGGRAVATED ASSAULT REQUIRES AN ACT THAT BY ITS NATURE WILL DIRECTLY AND PROBABLY RESULT IN THE APPLICATION OF FORCE TO A PERSON. INVOLUNTARY MANSLAUGHTER REQUIRES EITHER AN UNLAWFUL ACT OR "THE COMMISSION OF A LAWFUL ACT WHICH MIGHT PRODUCE DEATH IN AN UNLAWFUL MANNER, OR WITHOUT DUE CAUTION AND CIRCUMSPECTION" (PENAL CODE § 192(b)). IT IS NOT NECESSARY FOR MANSLAUGHTER THAT THE ACT BE SUCH AS WOULD DIRECTLY AND PROBABLY RESULT IN THE APPLICATION OF FORCE TO THE VICTIM. AGGRAVATED ASSAULT ALSO REQUIRES KNOWLEDGE OF "FACTS THAT WOULD LEAD A REASONABLE PERSON TO REALIZE THAT A BATTERY WOULD DIRECTLY, NATURALLY AND PROBABLY RESULT FROM HIS CONDUCT" (PEOPLE V. WILLIAMS (2001) 111 CAL. RPTR. 2d 114, 121). INVOLUNTARY MANSLAUGHTER MAY BE BASED ON THE COMMISSION OF A LAWFUL ACT THAT MIGHT PRODUCE DEATH (SEE ORLINA V. SUPERIOR COURT (1999) 86 CAL. RPTR. 2d 384, 385-386 — "WHEN WE COMPARE THE SECOND

ALTERNATIVE FOR INVOLUNTARY MANSLAUGHTER WITH CALIFORNIA PENAL CODE § 273ab, WE FIND A DISTINCTION BETWEEN "FORCE THAT TO A REASONABLE PERSON WOULD BE LIKELY TO PRODUCE GREAT BODILY INJURY" AND AN "ACT WHICH MIGHT PRODUCE DEATH . . . WITHOUT DUE CAUTION." § 273ab IS PREDICATED ON A PROBABILITY OF GREAT BODILY INJURY TO THE VICTIM (SEE PEOPLE V. PRELLER (1997) 62 CAL. RPTR. 2d 507, 509-510) WHILE THE SECOND DEFINITION OF INVOLUNTARY IS BASED ON THE POSSIBILITY OF DEATH TO THE VICTIM. § 273ab SPEAKS TO RECKLESS CONDUCT ("LIKELY TO PRODUCE" INJURY) WHILE THE SECOND DEFINITION OF INVOLUNTARY MANSLAUGHTER ENCOMPASSES CARELESS OR NEGLIGENT CONDUCT ("WITHOUT DUE CAUTION AND CIRCUMSPECTION")...").

SBS IS RECKLESS CONDUCT, AND FALSE EVIDENCE OF SBS IS PREJUDICIAL TO A JURY FINDING OF CRIMINAL NEGLIGENCE.

IMPLIED MALICE MURDER | PENAL CODE, SECTION 187

THE ESSENTIAL DIFFERENCE BETWEEN INVOLUNTARY MANSLAUGHTER AND IMPLIED MALICE MURDER IS THAT ONLY IMPLIED MALICE REQUIRES A SUBJECTIVE OR MENTAL COMPONENT. "A FINDING OF IMPLIED MALICE DEPENDS UPON A DETERMINATION THAT THE DEFENDANT ACTUALLY APPRECIATED THE RISK INVOLVED, I.E., A SUBJECTIVE STANDARD". THUS, IMPLIED MALICE MAY BE DISTINGUISHED FROM GROSS NEGLIGENCE BY BOTH THE HIGHER DEGREE OF RISK INVOLVED, AND BY THE REQUIREMENT THAT THE RISK BE SUBJECTIVELY APPRECIATED RATHER THAN MERELY OBJECTIVELY APPARENT (PEOPLE V. NOEL (2005) 28 CAL. RPTR. 3d 349, 411).

EVIDENTIARY TRIAL ERRORS

IT IS WELL SETTLED THAT FEDERAL HABEAS RELIEF DOES NOT LIE FOR ERRORS OF STATE LAW (ESTELLE V. McGUIRE (1991) 502 U.S. 62, 72), BUT HABEAS RELIEF IS WARRANTED IF THE ADMISSION OF EVIDENCE SO FATALLY INFECTED THE STATE COURT PROCEEDINGS AS TO RENDER THEM FUNDAMENTALLY UNFAIR (id). IN SUCH A CASE, "THE PRESENCE OR ABSENSE OF A STATE LAW VIOLATION IS LARGELY BESIDE THE POINT" (JAMMAL V. VAN DE KAMP (9TH 1991) 926 F.2d 918, 919).

INSUFFICIENT EVIDENCE

JACKSON V. VIRGINIA (1979) 443 U.S. 307 MAKES CLEAR THAT CASES CANNOT CONSTITUTIONALLY STAND IF THE EVIDENCE WAS INSUFFICIENT "TO CONVINCE A TRIER OF FACT BEYOND A REASONABLE DOUBT OF THE EXISTENCE OF EVERY ELEMENT OF THE OFFENSE" (AT 316), AND VERSUS SUCH SEVERE STANDARD AS APPLIED IN THOMPSON V. LOUISVILLE (1960) 362 U.S. 199, WHICH HELD IT TO BE A VIOLATION OF DUE PROCESS TO CONVICT ON NO EVIDENCE, JACKSON MAKES CLEAR THAT A CONVICTION IS UNCONSTITUTIONAL EVEN IF THERE IS SOME EVIDENCE OF GUILT WHEN ALL THE EVIDENCE, VIEWED IN THE LIGHT MOST FAVORABLE TO THE PROSECUTION, DOES NOT PERMIT ANY RATIONAL FACT-FINDER TO FIND GUILT BEYOND A REASONABLE DOUBT (JACKSON, 443 U.S. AT 314-319).

CALIFORNIA EVIDENCE CODE, SECTION 801

UNDER 801(b) (COMPARE FED. R. EVID. 702) EXPERT OPINION IS LIMITED TO SUCH OPINION AS IS . . . "BASED ON MATTER THAT IS OF A TYPE THAT REASONABLY MAY BE RELIED UPON BY AN EXPERT . . .".

III

ARGUMENT

UNRELIABLE EXPERT OPINION BASED ON FALSE EVIDENCE

NEUROLOGICAL EXPERT, FP, TRENKLE DID NOT FIND EVIDENCE OF, NOR RELY ON A DIFFUSE AXIAL INJURY, OR BASE THE SINGLE EVENT ONLY EVIDENCE ON AUTOPSY TO AN SBS DIAGNOSIS.

GP, PIANTINI'S GENERAL PEDIATRICIAN OPINION ON NEUROLOGICAL MATTER (– A D.A.I. / S.B.S.) IS NOT "REASONABLY . . . RELIED" UPON BY THE NEUROLOGICAL EXPERT PERFORMING AUTOPSY (CAL. EVID. CODE, § 801(b); FED. R. EVID. 702).

INEFFECTIVE ASSISTANCE OF COUNSEL / INSUFFICIENT EVIDENCE ON CHARGED ELEMENTS

DC, SACHS, IN FAILING TO CHALLENGE GP, PIANTINI ON A D.A.I, AND S.B.S. REPRESENTATION AS FOUNDED ON AUTOPSY, FAILED TO CONDUCT A PRE-TRIAL AUTOPSY INVESTIGATION WITH FP, TRENKLE ON:

- THE ONLY EVIDENCE CAUSE OF DEATH;
- A FOCAL INJURY VERSUS A DIFFUSE AXIAL INJURY; AND
- A SUBDURAL ARTERIAL BREAK AT THE POSTERIOR FALX, TENTORIUM (OCCIPITAL LOBES) AREA, WITH VENTRICULAR / INTRAVENTRICULAR COMMUNICATION PRODUCING SUBARACHNOID HEMORRHAGING.

DC, SACHS ALSO FAILED TO INTERVIEW GP, PIANTINI ON:

- FACTS CONCLUDING CHILD ABUSE BASED ON A D.A.I., THAT IS, A PORENCEPHALIC LESION (EXH 10, P91), OR NEW INTRAPARENCHYMAL (EXH 16, P93);
- EVIDENCE OF MULTIPLE INTRACRANIAL INFLICTIONS ACCORDING TO AUTOPSY (C.T. 000041-42 – "ITS NOT JUST ONE EVENT").

DC, SACHS' DEFICIENCIES ALLOWED, WITHOUT SCIENTIFIC CHALLENGE (R.T. 10-13), THE PROSECUTION TO INTRODUCE INFECTUOUS AND PREJUDICIAL MATTER THROUGH 1993 EXTRINSIC ACTS (ESTELLE, 502 U.S. AT 72), ALLOWING 2001 FALSE ELEMENT FINDINGS BASED ON ALLEGED SIMILARITY EVIDENCE OF S.B.S., AND USE OF SAID TO OBTAIN A FALSE CONVICTION FOR:

- CAL. P.C. § 187 – (1) AN INTENTIONAL ACT, (2) A SUBJECTIVE KNOWLEDGE, AND (3) A CONSCIOUS DISREGARD FOR HUMAN LIFE; AND
- CAL. P.C. § 273 ab — ASSAULT BY FORCE RESULTING IN MURDER BASED ON A GENERAL INTENT THROUGH FALSE EVIDENCE OF A D.A.I / SBS DIAGNOSIS (ACCORD, EXH. 4, PP 6-7, 13-14).

DC, SACHS PREJUDICED THE DEFENSE – A SINGLE EVENT BLUNT FORCE FALL, AND 2001 SURROUNDING CIRCUMSTANCES – REVEALING AT MOST CRIMINAL NEGLIGENCE / NON-STATUTORY INVOLUNTARY MANSLAUGHTER (SEE R.T. 544, 554 LN 23-28) TO SUCH REASONABLE PROBABILITY UNDERMINING CONFIDENCE IN THE OUTCOME OF THE PROCEEDINGS (STRICKLAND, 466 U.S. AT 694).

PROSECUTORIAL USE OF FALSE EVIDENCE

4-28-01 THROUGH 5-1-01

IT MAY BE TRUE ALL "MEDICAL RECORDS" RELIED ON BY GP, PIANTINI (ACCORD C.T. 000031, 37) PRIOR 5-2-01 AUTOPSY SUGGEST "BLOOD INSIDE THE FRONTAL CORTEX OF THE BRAIN" (SEE EXH 4, PP 13), OTHERWISE TERMED, A "PORENCEPHALIC" CESION (EXH 10, PP 1), OR "NEW INTRAPARENCHYMAL AT THE LEFT FRONTAL LOBE" (EXH 16, PP 3; EXH 42, PP 2-4) – A DIFFUSE AXIAL INJURY (R.T. 333-334).

IT MAY BE TRUE PER GP, PIANTINI'S MISSION TO FIND CHILD ABUSE (C.T. 000031), PRE-AUTOPSY MEDICAL RECORDS RELIANCE, AND ALLEGED

SPECIALIST "CONSULTATIONS" (C.T. 000031; R.T. 327) THAT GP, PIANTINI FELT JUSTIFIED TO CONCLUDE CHILD ABUSE, DIAGNOSED S.B.S., AND TERMED IT "AHT" FOR THE PROSECUTION (EXH 16A, Pg 4; EXH 16, Pg 3).

IT ALSO MAY BE TRUE THAT SAID NEW INTRAPARENCHYMAL (EXH 16, Pg 3; EXH Y2, Pg 2-3) — A D.A.I. (R.T. 333-334, 357) — "CONTRADICTED", OR IS "INCONSISTENT" TO THE SINGLE EVENT BLUNT-FORCE STAIR FALL HISTORY PROVIDED BY PETITIONER, AND WARRANTED ARREST ON 4-28-01 (EXH. 3, Pg 8; R.T. 62-63; SEE R.T. 363; EXH 2, Pg 3);

AND, HAD A D.A.I. RATHER THAN A FOCAL INJURY BEEN TRUE ON AUTOPSY (CF. C.T. 000037-38), IT MAY HAVE BEEN TRUE THAT PETITIONER "DID IT BEFORE AND DID IT AGAIN" (SEE PROSECUTORIAL CLOSINGS, R.T. 600-601, 603, 608-609, 611-615, 652-653, 660, 663-664) WARRANTING EVIDENCE ADMISSION OF SIMILAR ACTS IN 1993 TO BE USED AS 2001 ELEMENT PROOF OF INTENT, SUBJECTIVE KNOWLEDGE, AND LACK OF ACCIDENT TO SECURE CONVICTION (R.T. 10-13; EXH 4, Pg 11-12).

GP, PIANTINI'S CONTEMPT OF AUTOPSY ONLY EVIDENCE AND DIAGNOSIS

5-2-01 AUTOPSY

BUT, WHEN DDA, HUGHES AND GP, PIANTINI ATTENDED THE 5-2-01 AUTOPSY (— SURELY SEEKING TO CONFIRM A D.A.I., AND VALIDATE SUCH SIGNIFICANT DIAGNOSIS OF SBS (SEE C.T. 000031-32, 39-40)), DDA HUGHES, GP, PIANTINI, AND DC, SACHS KNEW, OR SHOULD HAVE KNOWN, THAT AUTOPSY/FP, TRENKLE CONFIRMED FALSE CAT SCAN IMPRESSIONS OF A D.A.I. (EXH 23, Pg 9, PARA 5, AT "FRONTAL CORTEX"), THUS INVALIDATING CHILD ABUSE BY AN SBS/AHT REPRESENTATION.

AT THE FRONTAL LOBES, ABOVE THE BRAIN CORTEX, THAT IS, WITHIN THE "CONNECTIVE TISSUE FRAMEWORK" (ANTE, Pg 2, FN. 1 AT PARENCHYMA), AUTOPSY/FP, TRENKLE EVIDENTIALLY RECORDS:

- AT THE SUBARACHNOID SPACE, "SECTIONS OF FRONTAL CORTEX SHOW SUPERFICIAL SUBARACHNOID HEMORRHAGE AND EDEMA" (EXH 23, Pg 9, Pg 16 AT "DIFFUSE SAH LEFT SIDE"); AND
- AT THE SUBDURAL SPACE, AND REFERRING TO PEOPLE'S EXHIBIT 14, FP, TRENKLE DIAGNOSED "A MONTH" OLD CONTUSION - A HEAD BRUISE - AT THE LEFT FRONTAL LOBE (R.T. 463; EXH 23, Pg 7 (PARA 2), Pg 16 AT "FOCAL OLD BROWN-YELLOW SDH CONTUSION" ...

GP, PIANTINI'S UNPROFESSIONAL CONDUCT

IT IS SAID MONTH OLD SUBDURAL CONTUSION (EXH 23, Pg 10 AT IV, C.) - A "FOCAL" INJURY (EXH 23, Pg 16; ANTE, Pg 3, FN 2) — THAT, POST-AUTOPSY, GP, PIANTINI PREJUDICED THE TRIAL BY INTENTIONAL CONCEALMENT OF INCOMPETENCE, OR ACTING AS A NEUROLOGIST (CF. R.T. 320-323) TO MISLEAD NON-EXISTENT PRE-AUTOPSY CAT SCAN IMPRESSION OF A D.A.I., OR "BLOOD INSIDE THE FRONTAL CORTEX" (EXH 2, Pg 3, PARA 5; EXH 4, Pg 5, 13), "ITSELF" (R.T. 333-334; COMPARE PORENCEPHALIC "IN THE LEFT FRONTAL LOBE" (EXH 10, Pg 1), NEW INTRAPARENCHYMAL "IN THE LEFT FRONTAL LOBE" (EXH 16, Pg 3; EXH 42, Pg 3) WAS INFLICTED ON 4-28-01), AND THAT SAID MONTH OLD CONTUSION (OR FALSEHOOD OF A D.A.I.) VALIDATES SBS, FN 9, AND AUTOPSY EVIDENCE OF MULTIPLE EVENTS OF INTRACRANIAL INFLICTION AS THE CAUSE OF DEATH (C.T. 000041, LN 26; C.T. 000048, LN 12; R.T. R.T. 357, 371), UNDER THE TERM "AHT" (C.T. 000040, 41; R.T. 363; SEE DDA, HUGHES ON CLOSINGS, R.T. 598, LN 9; R.T. 593, LN 21-22; R.T. 603 - "SHAKING AND SLAMMING"; R.T. 608, 659-660).

IN OTHER WORDS, GP, PIANTINI DID NOTHING UNDER A FIDUCIARY OBLIGATION TO CORRECT ALL PREVIOUS CHILD ABUSE/SBS ASSESSMENTS BUILT UPON THE AUTOPSY EXPOSED FALSEHOOD OF PRIOR CT SCAN SUGGESTIONS OF A DIFFUSE AXIAL INJURY IN THE LEFT FRONTAL CORTEX.

FOOTNOTE 9 ———————————————————————————————

MATERIAL MISREPRESENTATION OF AUTOPSY EVIDENCE =

ON CLOSINGS, DDA, HUGHES MISLED TO FACTS NOT IN EVIDENCE. REPEATEDLY, DDA, HUGHES FAILED TO CITE A D.A.I. AS A Y-28-01 INJURY (R.T. 596, 599, 604, 659), YET MISREPRESENTED THAT FP, TRENKLE VOUCHED THE Y-28-01 INTRACRANIAL ONLY EVIDENCE IS "CONSISTENT" WITH SBS BUT CHOSE NOT TO REACH "THE SHAKING ISSUE" (R.T. 599), OR "CONCLUSION" (R.T. 659-660).

THE RECORD IS VOID FP, TRENKLE DIAGNOSED EVIDENCE OF MULTIPLE EVENTS, S.B.S. OR A D.A.I. FINDING (ACCORD, R.T. 961-964, 976-978, 650 LN 25 - 651; EXH 23, Pg 10).

AT R.T. 978, AND ACCORDING TO DDA, HUGHES, S.B.S. / MULTIPLE EVENTS WENT FROM A "POSSIB[ILITY]" TO A MATERIAL INJECTION AS "CONSISTENT" WITH THE ONLY EVIDENCE DIAGNOSTIC ON AUTOPSY.

DDA, HUGHES MISLED THE JURY (R.T. 599, 659-660) BY TAKING SPECULATION OF A POSSIBILITY (- THAT WAS REJECTED BY FP, TRENKLE AS EVIDENCE), AND INJECTED S.B.S. AS MULTIPLE EVENTS TO FP, TRENKLE'S SINGLE EVENT BLUNT-FORCE DIAGNOSIS / CAUSE OF DEATH (R.T. 962-964); AND, IN DOING SO, IMPROPERLY BOLSTERED GP, PIANTINI'S CT SCAN OPINION AS AUTOPSY BASED, MISCHARACTERIZING A FOCAL INJURY TO A DIFFUSE AXIAL.

FP, TRENKLE WAS CLEAR, "THE TERM "SHAKEN BABY," I DON'T THINK I USED ANYWHERE IN MY REPORT" (R.T. 977).

END FOOTNOTE 9 ———————————————————————————————

INEFFECTIVE ASSISTANCE OF COUNSEL

AGAIN, THE "ONLY EVIDENCE" (R.T. 961-964) DIAGNOSTIC ON AUTOPSY - A SINGLE EVENT BLUNT FORCE — IS CONSISTENT WITH PETITIONER'S SINGLE EVENT STAIR FALL HISTORY, AND EVEN MORE SO WHERE ERIK HAD NO EXTERNAL INJURY / BRUISING (R.T. 340, 377, 417-418, 422).

DC, SACHS WAS DEFICIENT IN PERFORMANCE NOT ONLY BY THE FAILURE TO CONDUCT AN AUTOPSY CONSISTENT STAIR FALL INVESTIGATION BUT BY "THE FAILURE TO CHALLENGE EXPERT TESTIMONY - - - RENDERING COUNSEL'S ASSISTANCE INEFFECTIVE BECAUSE IT DEPRIVED THE DEFENDANT of A SUBSTANTIAL ARGUMENT AND SET UP AN UNCHALLENGED FACTUAL PREDICATE FOR THE STATES MAIN ARGUMENT - - TO THE FACTS OF THE CASE" (ACCORD, DRAUGHON V. DRETKE (5TH 2005) 427 F.3d 286, 296)

MALICIOUS DISREGARD OF AUTOPSY EVIDENCE AND DIAGNOSIS TO CONCEAL INCOMPETENCE

THE "ONLY EVIDENCE" ON AUTOPSY AND DIAGNOSIS BY FP, TRENKLE WAS, IN FACT, MATERIALLY DISREGARDED BY GP, PIANTINI — "THAT'S ONE EVENT, BEING A BLOW OR A FALL, WOULD BE SUFFICIENT TO ACCOUNT FOR ALL [4-28-01 INTRACRANIAL] DAMAGE" (R.T. 462); THE FRACTURE TO THE OCCIPITAL BONE, "CAUSED THAT SUBARACHNOID HEMORRHAGE, THE FRESHER MORE RECENT SUBDURAL HEMORRHAGE" (R.T. 464; ACCORD EXH 23, Pg 14, 16).

BY DECEIT, MALICE, AND FRAUD, GP, PIANTINI MISLED THE JURY, INTENTIONALLY CONCEALING INCOMPETENCE WHEN MISREPRESENTING THE ONLY EVIDENCE ON AUTOPSY, AND USING AUTOPSY/FP, TRENKLE AS A RUSE TO OFFER A FALSE NEUROLOGICAL DIAGNOSIS (— S.B.S.) BASED ON AN AUTOPSY CONFIRMED NON-EXISTANT INJURY (— D.A.I.) FOR THE PROSECUTION.

THE PREJUDICED AND/OR FUNDAMENTALLY UNFAIR PROCEEDINGS

INVOLUNTARY MANSLAUGHTER — CRIMINAL NEGLIGENCE

PETITIONER AND JURY WERE DENIED A FAIR HEARING AND PREVENTED FROM FULL UNDERSTANDING OF MEDICAL EVIDENCE ACTUALLY BASED ON AUTOPSY/FP, TRENKLE NOT ONLY CONFIRMING PRIOR CAT SCAN IMPRESSIONS OF A D.A.I. FALSE, AND INVALIDATING AN S.B.S. DIAGNOSIS BUT BY FP, TRENKLE'S DIAGNOSIS BEING EVIDENTIALLY CONSISTENT WITH PETITIONER'S 4-28-2001 HISTORY, AND

SURROUNDING CIRCUMSTANCES (e.g., AS A RESULT OF THE SHORT DISTANCE STAIR FALL (C.T. 000041), ERIK SUFFERED NO EXTERNAL HEAD (R.T. 417-418, 422), OR BODY (R.T. 301, 340, 417-418) INTURY / BRUISING (CONTRAST, DDA, HUGHES' THREE-STORY FORCE, "SLAMMING" ARGUMENT, R.T. 603-604)). SAID CONCEALMENT (— AUTOPSY CONFIRMING A D.A.I. / S.B.S NON-EXISTANT), AND PREJUDICIAL MISUSES OF EVIDENCE (— CALJIC NO. 2.03, AND 1993 EXTRINSIC ACTS) DEPRIVED THE JURY FROM RENDERING AN INVOLUNTARY MANSLAUGHTER, FN 10, (— OR ACCIDENT) VERDICT.

FOOTNOTE 10 —

UNDENIABLY, SBS IS AN ASSAULT BY FORCE (CAL P.C. § 273 ab), AN INTENTIONAL ACT (CAL. P.C. § 187) FOR MURDER (R.T. 603-604). A FAIR TRIAL WITHOUT NEUROLOGICAL FALSEHOOD OF S.B.S. WOULD LEAVE THE JURY TO FIND EVIDENCE A "BLOW" RATHER THAN A "FALL" OCCURRED — "THAT'S ONE EVENT" (R.T. 462)

DDA, HUGHES OPPOSED INVOLUNTARY MANSLAUGHTER AS A LESSER, ARGUING HE DID IT BEFORE, HE DID IT AGAIN, I.E., S.B.S. (R.T. 545, 549, 553-554). THE LESSER WAS GRANTED BY THE COURT (R.T. 551, 583-590).

PETITIONER WAS PREJUDICED WHEN JURY WAS DEPRIVED FROM FINDING "CRIMINAL NEGLIGENCE" (SEE R.T. 554 LN 23-28 — "HANDLING", "CARRYING" AND "DROPPING" ERIK) BY PROSECUTORIAL PRESENTATION OF GP, PIANTINI'S D.A.I. / S.B.S. MISCONDUCT, FALSELY SHOWING PETITIONER EXHIBITED "CONSCIOUS DISREGARD;" AND SUBJECTIVE KNOWLEDGE ELEMENTS FOR MURDER THROUGH ADMISSION OF 1993 EXTRINSIC BAD ACTS (R.T. 549-550, 553 554, 610 LN 6-10; SEE EXH. 4, Pg 6-7, 11, 12-13), AND, AS DC, SACHS SAT IDLY BY, WERE, RATHER, MISUSED AS "DISPOSITION EVIDENCE" (R.T. 13; SEE EXH 4, Pg 9) — TO SHOW PETITIONER IS A PAST CHILD ABUSER WHO LIED THEN, SO, OBVIOUSLY, HE ABUSED AGAIN, AND IS LYING ABOUT IT NOW (R.T. 600 LN 28 - 602; R.T. 609, 611 LN 23; R.T 612 LN 26 - 613; R.T. 652 LN 21 - 653; R.T. 663 LN 10 - 664).

END FOOTNOTE 10 —

CONCLUSION

DENIED A FUNDAMENTALLY FAIR TRIAL, PETITIONER IS INCARCERATED 59 YEARS TO LIFE FOR COMMITTING, (1) A RIGHT FEMUR FRACTURE, (2) A NINTH RIB FRACTURE, AND (3) S.B.S. / MULTIPLE EVENTS OF INTRACRANIAL INFLICTION BASED ON A D.A.I. THAT DOES NOT EXIST ON AUTOPSY. MAY PETITIONER PASS THROUGH THE SCHLUP GATEWAY WITH "NEW RELIABLE EVIDENCE . . . THAT WAS NOT PRESENTED AT TRIAL . . . [AS] "ACTUAL INNOCENCE" REVIEW MUST INCORPORATE ALL EVIDENCE" (GRIFFIN, 350 F.3d AT 961).

VERIFICATION

I am the petitioner in this matter. I have read the allegations contained in the petition and know them to be true by my own personal knowledge.

I declare under penalty of perjury under the laws of the United States of America that the forgoing is true and correct.

Executed on this 4TH day of JULY, 2017.

DAVID C. PATKINS
(PRINT NAME)

(SIGNATURE)

//

//

//

//

//

//

//

//

//

PROOF OF SERVICE
BY PERSON IN STATE CUSTODY
(C.P. §§ 1013 (A), 2015.5; F.R.C.P.5; 28 U.S.C. § 1746)

I. DAVID C. PATKINS, declare:

I am over 18 years of age, and am a party to this action. I am a resident of the Correctional Training Facility Prison in the County of Monterey, State of California. My prison address is:

CDCR #: T-73612

Correctional Training Facility
P.O. Box 705 Housing: SA 245 UP
Soledad, CA. 93960-0705

On 7-4-17, I served the attached:
ACTUAL INNOCENCE CLAIM ON PETITION FOR WRIT OF HABEAS CORPUS

On the parties herein by placing true, and correct copies thereof, enclosed in a sealed envelope, with postage fully paid, **verified by, and given to prison staff *, pursuant to 15 CCR § 3142 (d).** for deposit in the United States Mail provided at the above named correctional institution in which I am presently confined.

The envelope was addressed as follows:

U.S. DISTRICT COURTHOUSE
CENTRAL DIST. OF CALIFORNIA
3470 TWELFTH ST.
RIVERSIDE, CA. 92501

ATTORNEY GENERAL
P.O. BOX 85266
SAN DIEGO, CA.
92186-5266

I declare under penalty of perjury under the laws of the United States of America that the foregoing is true, and correct.

Executed on: 7-4-17

(Declarant's Signature)

* Please, note that according to the prison mailbox rule, the document(s) mentioned herein is considered filed the day it is handed o to prison authorities for mailing to the court. See Huizar v. Carey (9th Cir. 2001) 273 F. 3d 1220, 1221; Moore v. Twomey (20 120 Cal. App. 4th 910, 913-918.

ATTACHMENT 1

000281

ABSTRACT OF JUDGMENT - PRISON COMMITMENT INDETERMINATE SENTENCE

FORM CR 292

☒ SUPERIOR ☐ MUNICIPAL ☐ JUSTICE

COURT OF CALIFORNIA, COUNTY OF RIVERSIDE

COURT (I.D.) 133110100

BRANCH OR JUDICIAL DISTRICT: RIVERSIDE

FILED
SUPERIOR COURT OF CALIFORNIA
COUNTY OF RIVERSIDE
NOV 15 2002

PEOPLE OF THE STATE OF CALIFORNIA versus
DEFENDANT: DAVID CHARLES PATKINS
AKA:

☒ PRESENT ☐ NOT PRESENT

RIF096844 - A
- B
- C
- D
- E

COMMITMENT TO STATE PRISON
ABSTRACT OF JUDGMENT

AMENDED ABSTRACT ☐

DATE OF HEARING (MO) (DAY) (YR)	DEPT. NO.	JUDGE	CLERK
11/14/02	52	PATRICK F. MAGERS	W.ROGERS

REPORTER	COUNSEL FOR PEOPLE	COUNSEL FOR DEFENDANT	PROBATION NO. OR PROBATION OFFICER
D.O'LEARY	CHARLES HUGHES	DPD-STUART SACHS	

1. DEFENDANT WAS CONVICTED OF THE COMMISSION OF THE FOLLOWING FELONIES:
☐ ADDITIONAL COUNTS ARE LISTED ON ATTACHMENT 1 (NUMBER OF PAGES)

COUNT	CODE	SECTION NUMBER	CRIME	YEAR CRIME COMMITTED	DATE OF CONVICTION MO	DAY	YEAR	CONVICTED BY JURY TRIAL	COURT TRIAL	PLEA	CONCURRENT	CONSECUTIVE	654 STAY
1	PC	187	2ND MURDER	01	10	09	02					X	
2	PC	273AB	ASSAULT ON CHILD W/RESU	01	10	09	02			PRINCIPAL			

2. **ENHANCEMENTS** charged and found true **TIED TO SPECIFIC COUNTS** (mainly in the § 12022-series) including WEAPONS, INJURY, LARGE AMOUNTS OF CONTROLLED SUBSTANCES, BAIL STATUS, ETC.: For each count list enhancements horizontally. Enter time imposed for each or "S" for stayed or stricken. DO NOT LIST enhancements charged but not found true or stricken under § 1385. Add up time for enhancements on each line and enter line total in right-hand column.

Count	Enhancement	Yrs. or "S"	Enhancement	Yrs. or "S"	Enhancement	Yrs. or "S"	Enhancement	Yrs. or "S"	Enhancement	Yrs. or "S"	Total

3. **ENHANCEMENTS** charged and found true **FOR PRIOR CONVICTIONS OR PRIOR PRISON TERMS** (mainly § 667-series) and OTHER:
List all enhancements based on prior convictions or prior prison terms charged and found true. If 2 or more under the same section, repeat it for each enhancement (e.g., if 2 non-violent prior prison terms under § 667.5(b), list § 667.5(b) 2 times). Enter time imposed for each or "S" for stayed or stricken. DO NOT LIST enhancements charged but not found true or stricken under § 1385. Add time for these enhancements and enter total in right-hand column. Also enter here any other enhancement not provided for in space 2.

Enhancement	Yrs. or "S"	Enhancement	Yrs. or "S"	Enhancement	Yrs. or "S"	Enhancement	Yrs. or "S"	Enhancement	Yrs. or "S"	Total
Enhancement	Yrs. or "S"	Enhancement	Yrs. or "S"	Enhancement	Yrs. or "S"	Enhancement	Yrs. or "S"	Enhancement	Yrs. or "S"	Total

4. Defendant was sentenced to State Prison for an indeterminate term:
A. ☐ For LIFE WITHOUT THE POSSIBILITY OF PAROLE on counts _____.
B. ☐ For LIFE WITH POSSIBILITY OF PAROLE on counts _____.
C. ☒ For 15 30 years to life, WITH POSSIBILITY OF PAROLE on counts 1.
D. ☒ For 25 50 years to life, WITH POSSIBILITY OF PAROLE on counts 2.
E. ☐ For other term prescribed by law on counts _____. *(Specify term on separate sheet if necessary.)*

PLUS enhancement time shown above.

5. ☐ Indeterminate sentence shown on this abstract to be served ☒ consecutive to ☐ concurrent with any prior incompleted sentence(s).

6. Other Orders: *(List all consecutive/concurrent sentence relationships, fines, etc. if not shown above)*

SENTENCED TO STATE PRISON FOR A TOTAL INDETERMINATE SENTENCE OF 9 YEARS PLUS 80 YEARS TO LIFE. PAY RESTITUTION FINE PURST TO 1202.4(B)PC. PURST TO SECTION 2085.5 PC, DEPT OF CORRECTION IS AUTHORIZED TO COLLECT RESTITUTION OBLIGATIONS. SUBMIT THUMB & PALM PRINTS,SPECIMENS OF BLOOD & SALIVA TO CDC FOR DNA TESTS PURST TO 296 PC, RESULTS TO BE FORWD TO COURT FOR DISTRIBUTION.

(Use an additional page if necessary.)

7. ☐ The Court advised the defendant of all appeal rights in accordance with rule 470, California Rules of Court. (AFTER TRIAL ONLY)

8. EXECUTION OF SENTENCE IMPOSED:
A. ☒ AT INITIAL SENTENCING HEARING B. ☐ AT RESENTENCING PURSUANT TO DECISION ON APPEAL C. ☐ AFTER REVOCATION OF PROBATION D. ☐ AT RESENTENCING PURSUANT TO RECALL OF COMMITMENT (PC § 1170(d)) E. ☐ OTHER _____

9. DATE OF SENTENCE PRONOUNCED (MO) (DAY) (YR)	CREDIT FOR TIME SPENT IN CUSTODY	TOTAL DAYS INCLUDING:	ACTUAL LOCAL TIME	LOCAL CONDUCT CREDITS	STATE INSTITUTIONS
11/14/02	566		0	0	☐ DMH ☐ CDC

10. DEFENDANT IS REMANDED TO THE CUSTODY OF THE SHERIFF, TO BE DELIVERED:
☒ FORTHWITH
☐ AFTER 48 HOURS, EXCLUDING SATURDAYS, SUNDAYS AND HOLIDAYS
INTO THE CUSTODY OF THE DIRECTOR OF CORRECTIONS AT THE RECEPTION-GUIDANCE CENTER LOCATED AT:
☐ CALIF. INSTITUTION FOR WOMEN—FRONTERA ☐ CCWF—CHOWCHILLA ☐ CALIF. INSTITUTIONS FOR MEN—CHINO ☐ DEUEL VOC. INST.
☐ WASCO ☐ SAN QUENTIN ☐ R.J. DONAVAN
☒ OTHER (SPECIFY) SOUTHERN RECEPTION

CLERK OF THE COURT

I hereby certify the foregoing to be a correct abstract of the judgment made in this action.

DEPUTY'S SIGNATURE _____ DATE 11/15/02

This form is prescribed under Penal Code § 1213.5 to satisfy the requirements of § 1213 for indeterminate sentences. Attachments may be used but must be referred to in this document.

Form Approved by the Judicial Council of California Effective January 1, 1993

ABSTRACT OF JUDGMENT - PRISON COMMITMENT - INDETERMINATE CR 292

Pen. C. § 1213.5

DISTRIBUTION PINK COPY—COURT FILE YELLOW COPY—DEPARTMENT OF CORRECTIONS

000282

FORM DSL 290

ABSTRACT OF JUDGMENT - PRISON COMMITMENT

FILED
SUPERIOR COURT OF CALIFORNIA
COUNTY OF RIVERSIDE
NOV 15 2002

SUPERIOR COURT OF CALIFORNIA, COUNTY OF Riverside
BRANCH RIVERSIDE

COURT I.D. 33100

CASE NUMBER (S): RIF096844 - A

PEOPLE OF THE STATE OF CALIFORNIA versus
DEFENDANT: DAVID CHARLES PATKINS
AKA:

[X] PRESENT [ ] NOT PRESENT

COMMITMENT TO STATE PRISON
ABSTRACT OF JUDGMENT

AMENDED ABSTRACT [ ]

DATE OF HEARING (MO) (DAY) (YR)	DEPT. NO	JUDGE	CLERK
111402	52	PATRICK F. MAGERS	W. Rogers

REPORTER	COUNSEL FOR PEOPLE	COUNSEL FOR DEFENDANT	PROBATION NO. OR PROBATION OFFICER
D. O'Leary	Charles Hughes	DPD-Stuart Sachs	

1. DEFENDANT WAS CONVICTED OF THE COMMISSION OF THE FOLLOWING FELONIES (OR ALTERNATE FELONY / MISDEMEANORS):

[ ] ADDITIONAL COUNTS ARE LISTED ON ATTACHMENT _____ (NUMBER OF PAGES)

COUNT	CODE	SECTION NUMBER	CRIME	YEAR CRIME COMMITTED	DATE OF CONVICTION MO	DAY	YEAR	CONVICTED BY JURY TRIAL	COURT TRIAL	PLEA	SENTENCE RELATION TERM (L,M,U)	CONCURRENT	CONSECUTIVE 1/3 MIDDLE TERM	CONSECUTIVE 1/3 NON-VIOL.	CONSECUTIVE FULL TERM	INCOMPLETE SENTENCE(S) CONSEC.	654 STAY	PRINCIPAL OR CONSECUTIVE TIME IMPOSED YEARS	MONTHS
3	PC	12020(A)	Manuf, import, s	01	10	09	02	X			M				X			4	

2. ENHANCEMENTS charged and found true TIED TO SPECIFIC COUNTS (mainly in the § 12022-series) including WEAPONS, INJURY, LARGE AMOUNTS OF CONTROLLED SUBSTANCES, BAIL STATUS, ETC.:
For each count list enhancements horizontially. Enter time imposed for each or 'S' for stayed or stricken. DO NOT LIST enhancements charged but not found true or stricken under § 1385.
Add up time for enhancements on each line and enter line total in right-hand column.

Count	Enhancement	Yrs or 'S'	Enhancement	Yrs or 'S'	Enhancement	Yrs or 'S'	Enhancement	Yrs or 'S'	Enhancement	Yrs or 'S'	Total

3. ENHANCEMENTS charged and found true FOR PRIOR CONVICTIONS OR PRIOR PRISON TERMS (mainly § 667-series) and OTHER.
List all enhancements based on prior convictions or prior prison terms charged and found true. If 2 or more under the same section, repeat it for each enhancement (e.g., If 2 non-violent prior prison terms under § 667.5(l
list § 667.5(b) 2 times). Enter time imposed for each or 'S' for stayed or stricken. DO NOT LIST enhancements charged but not found true or stricken under §1385. Add time to these enhancements and enter total in right-har
column. Also enter here any other enhancement not provided for in space 2.

Enhancement	Yrs or 'S'	Enhancement	Yrs or 'S'	Enhancement	Yrs or 'S'	Enhancement	Yrs or 'S'	Enhancement	Yrs or 'S'	Total
667(A)	5									5
Enhancement	Yrs or 'S'	Enhancement	Yrs or 'S'	Enhancement	Yrs or 'S'	Enhancement	Yrs or 'S'	Enhancement	Yrs or 'S'	Total

4. INCOMPLETED SENTENCE(S) CONSECUTIVE:

COUNTY	CASE NUMBER	CREDIT FOR TIME SERVED

5. OTHER ORDERS
Pay Restitution Fine pursuant to 1202.4(
Pursuant to section 2085.5 PC, Departmen
See attachment page
Use additional sheets of plain paper if necessary.

6. TOTAL TIME IMPOSED ON ALL ATTACHMENT PAGES (FORM DSL 290-A):

7. TIME STAYED TO COMPLY WITH 5-YEAR OR 10-YEAR LIMIT ON SUBORDINATE TERMS, DOUBLE-BASED-TERM LIMIT, ETC. (Do not include § 654 stays or discretionary stays of term for enhancements.) 9

8. TOTAL TERM IMPOSED:

9. EXECUTION OF SENTENCE IMPOSED:
A. [X] AT INITIAL SENTENCING HEARING
B. [ ] AT RESENTENCING PURSUANT TO DECISION ON APPEAL
C. [ ] AFTER REVOCATION OF PROBATION
D. [ ] AT RESENTENCING PURSUANT TO RECALL OF COMMITMENT (PC §1170(d)
E. [ ] OTHER _____

10. DATE OF SENTENCE PRONOUNCED (MO) (DAY) (YR)	CREDIT FOR TIME SPENT IN CUSTODY	TOTAL DAYS	INCLUDING	ACTUAL LOCAL TIME	LOCAL CONDUCT CREDITS	STATE INSTITUTIONS	
11 14 02		566		566		[ ] DMH	[ ] CDC

11. DEFENDANT IS REMANDED TO THE CUSTODY OF THE SHERIFF, TO BE DELIVERED:

[X] FORTHWITH
[ ] AFTER 48 HOURS, EXCLUDING SATURDAYS, SUNDAYS AND HOLIDAYS
INTO THE CUSTODY OF THE DIRECTOR OF CORRECTIONS AT THE RECEPTION-GUIDANCE CENTER LOCATED AT:
[ ] CALIF. INSTITUTION FOR WOMEN - FRONTERA
[ ] CALIF. MEDICAL FACILITY - VACAVILLE
[ ] SAN QUENTIN
[ ] CALIF. INSTITUTION FOR MEN - CHINO
[ ] DEUEL VOC. INST.
[X] OTHER (SPECIFY) Southern Reception

CLERK OF THE SUPERIOR COURT

I hereby certify the foregoing to be a correct abstract of the judgment made in the above entitled cause.

DEPUTY'S SIGNATURE _____ DATE 11/15/02

SUPERIOR COURT OF CALIFORNIA COUNTY OF RIVERSIDE

This form is prescribed under Penal Code § 1213.5 to satisfy the requirements of § 1213 for determinate sentences. Attachments may be used but must be referred to in this document.

ABSTRACT OF JUDGMENT - PRISON COMMITMENT

Pen C 12

Form Adopted by the Judicial Council of California Effective January 1, 1990

DISTRIBUTION PINK COPY-COURT FILE YELLOW COPY-DEPARTMENT OF CORRECTIONS WHITE COPY-ADMINISTRATIVE OFFICE OF THE COURT

ATTACHMENT 2

2011 U.S. Dist. LEXIS 104750, *

DAVID C. PATKINS, Petitioner, v. RICHARD J. SUBIA, Warden, Respondent.

CASE NO. EDCV 07-1124-DMG (FFM)

UNITED STATES DISTRICT COURT FOR THE CENTRAL DISTRICT OF CALIFORNIA

2011 U.S. Dist. LEXIS 104750

April 14, 2011, Decided
April 14, 2011, Filed

SUBSEQUENT HISTORY: Adopted by, Writ of habeas corpus denied, Dismissed by, Judgment entered by Patkins v. Subia, 2011 U.S. Dist. LEXIS 104740 (C.D. Cal., Sept. 14, 2011)

PRIOR HISTORY: People v. Patkins, 2004 Cal. LEXIS 1163 (Cal., Feb. 4, 2004)

CORE TERMS: prosecutor, child abuse, trial counsel, degree murder, trauma, medical expert, abusive, accidental, stairs, guilt, prosecutorial misconduct, misconduct, cumulative, federal law, brass knuckles, fair trial, brain, doctor, serious felony, medical evidence, federal habeas, bodily injury, prejudicial, instructing, fracture, shaking, shaken, malice, died, trial counsel

COUNSEL: [*1] David C Patkins, Petitioner, Pro se, Ione, CA.

For Richard J Subia, Warden, Respondent: Garrett Beaumont, LEAD ATTORNEY, CAAG Office of Attorney General of California, San Diego, CA.

JUDGES: FREDERICK F. MUMM, United States Magistrate Judge.

OPINION BY: FREDERICK F. MUMM

OPINION

REPORT AND RECOMMENDATION OF UNITED STATES MAGISTRATE JUDGE

This Report and Recommendation is submitted to the Honorable Dolly M. Gee, United States District Judge, pursuant

to 28 U.S.C. § 636 and General Order 05-07 of the United States District Court for the Central District of California. For the reasons discussed below, it is recommended that the petition be denied and the action be dismissed with prejudice.

I. PROCEEDINGS

Petitioner David C. Patkins, a state prisoner in the custody of the California Department of Corrections, filed a Petition for Writ of Habeas Corpus by a Person in State Custody pursuant to 28 U.S.C. § 2254 on September 5, 2007. Thereafter, on January 28, 2008, Respondent Richard J. Subia filed an answer to the Petition. On July 31, 2009, Petitioner filed a memorandum of points and authorities in opposition to Respondent's answer. The matter, thus, stands submitted and ready for decision. For the reasons that follow, the [*2] Court recommends that the petition be denied and that this action be dismissed with prejudice.

II. PROCEDURAL HISTORY

On October 8, 2002, a jury found Petitioner guilty of second degree murder (Cal. Pen.Code § 187), child abuse resulting in death (Cal Penal Code § 273a), and possession of brass knuckles (Cal. Penal Code § 12020(a)). (Clerk's Transcript 236-38.) The trial court thereafter found true that Petitioner had previously been convicted of a serious and/or violent felony (Cal. Penal Code §§ 667(a)-(e), 1170.12). (CT 245.) Petitioner was sentenced to a total term of 59 years to life in state prison. (CT 281-82; Reporter's Transcript ["RT"] 689-90.)

Petitioner appealed his conviction. (Lodged Doc. No. 3.) On November 19, 2003, the California Court of Appeal filed an unpublished opinion affirming Petitioner's conviction. (Lodged Doc. No. 6.) Thereafter, Petitioner filed a petition for review in the California Supreme Court, which denied the petition on February 4, 2004. (Lodged Doc. No. 8.) Petitioner then filed a petition for writ of habeas corpus in the California Supreme Court, which denied the petition on August 8, 2007. (Lodged Doc. No. 10.)

III. FACTUAL BACKGROUND

The following [*3] facts were taken verbatim from the California Court of Appeal's opinion affirming Petitioner's conviction:

In February 2000, after impregnating his girlfriend, Margie Garofano, [Petitioner] moved into her house. On October 25, 2000, Margie gave birth to their son, Erik. After Margie's maternity leave expired, she went back to work, working the night shift three nights a week from 7:00 p.m. until 7:00 a.m. as a critical care nurse. [Petitioner] worked occasionally as a handyman and painter, providing about 10 percent of the family income.

[Petitioner] became impatient with Erik when he cried. He also grew jealous of the attention Margie gave Erik. In March 2001, a few days before Erik's four month well-baby checkup with his doctor, Margie noticed a bump on the back of Erik's head. When she asked [Petitioner] what happened, he said Erik hit his head on the coffee table when he rolled off the couch. During the well-baby appointment, after Margie described the way [Petitioner] sometimes flipped Erik on his forearm, the doctor told [Petitioner] that was a dangerous way to hold the baby. Margie obtained some pamphlets from the doctor about "shaken baby syndrome" and left them out for [Petitioner] [*4] to read.

[Petitioner] and Margie, who never married, began to argue about Margie's concern that [Petitioner] did not contribute financially to the family. As time went on, the arguments became more heated, and Margie asked [Petitioner] to move out two or three times. [Petitioner] said that he would move out if she gave him $6,000 so he could get his life back together. Margie did not have that much money, but she gave [Petitioner] a check for $2,000 in early April.

On April 27, 2001, when Margie left for work about 6:20 p.m., Erik was healthy. Margie worked all night. About 6:30 a.m. the following morning, [Petitioner] telephoned Margie and asked her to come home from work right away because Erik was hurt. When Margie asked [Petitioner] what happened, [Petitioner] said Erik injured his shoulder around 5:30 a.m., when [Petitioner] tripped and fell on the carpeted stairs while he was holding the baby. Margie asked [Petitioner] if he called 911, and [Petitioner] replied that he had not yet done so. Margie then told [Petitioner] to call 911 and get Erik to the hospital. Although [Petitioner] seemed reluctant to do so, he called 911. After Margie hung up the telephone with [Petitioner], she [*5] went home immediately.

Responding paramedics found [Petitioner] and Erik in an upstairs bedroom. A paramedic observed the baby lying on the bed, looking somewhat drowsy, with a weak cry but no external injuries. When the paramedic asked [Petitioner] what happened, [Petitioner] said that he dropped the baby while climbing the stairs when the dog got in his way. The paramedic estimated an 18-inch drop after examining the stairs. The stairs were each seven inches high and three feet wide. [Petitioner] agreed to accompany Erik to the hospital.

After Margie arrived at the hospital, she unsuccessfully attempted to waken Erik by calling his name and touching his chest. When Margie manually lifted Erik's eyelids, one pupil looked down and the other looked straight ahead. This alarmed Margie because, as a trained nurse, she knew that this was a sign of a head injury. Erik then awoke, arched his head back, and began kicking his legs and crying. Margie noticed, however, that Erik could not move his eyes.

After Margie found a doctor, the doctor asked [Petitioner] what happened. [Petitioner] stated that Erik hit his head on the stairs when [Petitioner] dropped him. Erik was then taken to be treated. [*6] While they waited for the results of the examination, Margie again asked [Petitioner] how Erik got hurt. [Petitioner] said it was an accident.

Dr. Sonne, the emergency room doctor who attended to Erik, ordered a CT scan of Erik's brain after noting that Erik was "posturing" with one arm stiff near his side, that his eyes were staring in a fixed position, and that he had a high pitched cry, all indicators of abnormal brain functions. The CT scan showed skull fractures on both sides of Erik's head, bleeding between the brain and left skull, a subdural hematoma on the left side of the brain, and blood inside the frontal cortex of the brain. Erik's brain was swollen, indicating trauma. X-rays of Erik's body also revealed a healing fracture of Erik's femur. Dr. Sonne opined that the CT scan and lesions in Erik's brain were inconsistent with the history of the injury given by [Petitioner]. The doctor suspected child abuse and recommended that a child abuse workup be performed.

Erik was then transferred to Loma Linda Hospital for intensive care treatment. The treating doctor concluded Erik's condition was critical and ordered a child abuse workup. After reviewing the child abuse evaluation, [*7] the doctor concluded Erik's injuries contradicted the history provided by [Petitioner]. An eye examination revealed extensive bilateral retinal hemorrhaging. The examination suggested abusive head trauma as a result of being shaken.

Erik died three days later, on May 1, 2001, after unsuccessful efforts to relieve the swelling in his brain to keep him alive. An autopsy revealed optic nerve bleeding, which, like the retinal hemorrhaging, indicated a shaking injury. An older fracture to Erik's femur and a more recent fracture to Erik's rib also indicated Erik had been shaken. The skull fractures and subdural hemorrhaging indicated abusive head trauma. The extent of the injuries, particularly the skull fractures, stemmed from an impact greater than that which would occur from a fall to a carpeted floor. Abusive head trauma, rather than an accidental fall, caused Erik's injuries.

A pair of brass knuckles were found by police on April 28, 2001, inside a drawer in Margie's garage. [Petitioner] had found them at a park and kept them in the garage.

(Lodged Doc. No. 6 at 2-6.)

'V. PETITIONER'S CLAIMS

1. Trial counsel deprived Petitioner of his Sixth Amendment right to effective assistance of counsel [*8] by committing the following prejudicial errors:

(a) failing to move to suppress brass knuckles that police recovered during a search of Petitioner's home;

(b) failing to object to the State's expert witness testimony;

(c) failing to investigate the injuries to the victim and to explore alternative causes of those injuries;

(d) conceding that Petitioner was guilty of murder;

(e) failing to challenge the evidence that Petitioner suffered a prior serious felony that was used to impose a sentencing enhancement; (f) failing to call an available medical expert to rebut the state's medical experts; and

(g) failing to object to numerous instances of alleged prosecutorial misconduct.

2. The prosecutor deprived Petitioner of his right to a fair trial by committing the following acts of misconduct:

(a) knowingly presenting false evidence to the jury;

(b) misleading the jury about the content of a witness's testimony;

(c) misleading the jury during closing arguments and making inflammatory arguments;

(d) suppressing exculpatory material;

(e) vouching for prosecution witnesses; and

(f) improperly "profiling" Petitioner as a murderer.

3. The trial court erred in instructing the jury on the requisite state of [*9] mind to support a guilty verdict for second degree murder.

4. The prosecutor failed to introduce sufficient evidence to prove that Petitioner committed child abuse resulting in death and second degree murder.

5. The trial court abused its discretion by allowing the prosecutor to introduce evidence regarding Petitioner's prior conviction involving child abuse against another one his children and the facts underlying that conviction.

6. The trial court erred in instructing the jury with CALJIC 2.03 because that instruction incorrectly implied to the jury

that Petitioner had made false statements about the crime and permitted the jury to convict Petitioner based solely on the fact that he made false statements about the crime.

7. The cumulative impact of the purported trial errors set forth in the foregoing claims for relief rendered Petitioner's trial fundamentally unfair.

V. STANDARD OF REVIEW

The standard of review applicable to Petitioner's claims herein is set forth in 28 U.S.C. § 2254(d), as amended by the Antiterrorism and Effective Death Penalty Act of 1996 ("AEDPA") (Pub. L. No. 104-132, 110 Stat. 1214 (1996)). See 28 U.S.C. § 2254(d); see also Lindh v. Murphy, 521 U.S. 320, 336, 117 S. Ct. 2059, 138 L. Ed. 2d 481 (1997). [*10] Under AEDPA, a federal court may not grant habeas relief on a claim adjudicated on its merits in state court unless that adjudication "resulted in a decision that was contrary to, or involved an unreasonable application of, clearly established Federal law, as determined by the Supreme Court of the United States," or "resulted in a decision that was based on an unreasonable determination of the facts in light of the evidence presented in the State court proceeding." 1 28 U.S.C. § 2254(d); see Williams v. Taylor, 529 U.S. 362, 402, 120 S. Ct. 1495, 146 L. Ed. 2d 389 (2000).

FOOTNOTES

1 In addition, under 28 U.S.C. § 2254(e)(1), factual determinations by a state court "shall be presumed to be correct" unless the petitioner rebuts the presumption "by clear and convincing evidence."

The phrase "clearly established Federal law" means "the governing legal principle or principles set forth by the Supreme Court at the time the state court renders its decision." 2 Lockyer v. Andrade, 538 U.S. 63, 71-72, 123 S. Ct. 1166, 155 L. Ed. 2d 144 (2003). However, a state court need not cite the controlling Supreme Court cases in its own decision, "so long as neither the reasoning nor the result of the state-court [*11] decision contradicts" relevant Supreme Court precedent which may pertain to a particular claim for relief. Early v. Packer, 537 U.S. 3, 8, 123 S. Ct. 362, 154 L. Ed. 2d 263 (2002) (per curiam).

FOOTNOTES

2 Under AEDPA, the only definitive source of clearly established federal law is set forth in a holding (as opposed to dicta) of the Supreme Court. See Williams, 529 U.S. at 412; see also Yarborough v. Alvarado, 541 U.S. 652, 660-61, 124 S. Ct. 2140, 158 L. Ed. 2d 938 (2004). Thus, while circuit law may be "persuasive authority" in analyzing whether a state court decision was an unreasonable application of Supreme Court law, "only the Supreme Court's holdings are binding on the state courts and only those holdings need be reasonably applied." Clark v. Murphy, 331 F.3d 1062, 1069 (9th Cir. 2003).

A state court decision is "contrary to" clearly established federal law if the decision applies a rule that contradicts the governing Supreme Court law or reaches a result that differs from a result the Supreme Court reached on "materially indistinguishable" facts. Williams, 529 U.S. at 405-06. A decision involves an "unreasonable application" of federal law if "the state court identifies the correct governing [*12] legal principle from [Supreme Court] decisions but unreasonably applies that principle to the facts of the prisoner's case." Id. at 413. A federal habeas court may not overrule a state court decision based on the federal court's independent determination that the state court's application of governing law was incorrect, erroneous, or even "clear error." Lockyer, 538 U.S. at 75. Rather, a decision may be rejected only if

the state court's application of Supreme Court law was "objectively unreasonable." Id.

The standard of unreasonableness that applies in determining the "unreasonable application" of federal law under Section 2254(d)(1) also applies in determining the "unreasonable determination of facts in light of the evidence" under Section 2254(d)(2). Taylor v. Maddox, 366 F.3d 992, 999 (9th Cir. 2004). Accordingly, "a federal court may not second-guess a state court's fact-finding process unless, after review of the state-court record, it determines that the state court was not merely wrong, but actually unreasonable." Id.

Where more than one state court has adjudicated the petitioner's claims, the federal habeas court analyzes the last reasoned decision. Barker v. Fleming, 423 F.3d 1085, 1091 (9th Cir. 2005) [*13] (citing Ylst v. Nunnemaker, 501 U.S. 797, 803, 111 S. Ct. 2590, 115 L. Ed. 2d 706 (1991) for presumption that later unexplained orders, upholding judgment or rejecting same claim, rest upon same ground as the prior order). Thus, a federal habeas court looks through ambiguous or unexplained state court decisions to the last reasoned decision in order to determine whether that decision was contrary to or an unreasonable application of clearly established federal law. Bailey v. Rae, 339 F.3d 1107, 1112-13 (9th Cir. 2003).

Here, Petitioner raised his current fifth and sixth claims for relief in his direct appeal to the California Court of Appeal, which issued a reasoned decision rejecting those claims. The California Supreme Court denied Petitioner's subsequent petition for review without commenting on the merits on Petitioner's claims. Accordingly, the California Court of Appeal's decision denying Petitioner's claims stands as the relevant reasoned decision regarding those claims. By contrast, no reasoned opinion exists as to Petitioner's other claims. Accordingly, the Court shall conduct an independent review of the record to ascertain whether the state courts' rejection of those claims [*14] was either contrary to, or resulted in an unreasonable application of, clearly established federal law. Harrington v. Richter, U.S. , 131 S. Ct. 770, 784, 178 L. Ed. 2d 624 (2011).

VI. DISCUSSION

A. Trial Counsel's Performance

In his first claim for relief, Petitioner contends that his trial counsel committed a host of errors that, either alone or in combination, deprived Petitioner of his Sixth Amendment right to effective assistance of counsel. In particular, Petitioner faults his trial counsel for committing the following errors: (1) failing to move to suppress brass knuckles that police recovered during a search of Petitioner's home; (2) failing to object to the State's expert witness testimony; (3) failing to investigate the injuries to the victim and to explore alternative causes of those injuries; (4) conceding that Petitioner was guilty of murder; (5) failing to challenge the evidence that Petitioner suffered a prior serious felony that was used to impose a sentencing enhancement; (6) failing to call an available medical expert to rebut the state's medical experts; and (7) failing to object to numerous instances of alleged prosecutorial misconduct.

A two-step analysis governs [*15] Petitioner's ineffective assistance of counsel claims for relief. Strickland v. Washington, 466 U.S. 668, 687, 104 S. Ct. 2052, 80 L. Ed. 2d 674 (1984). First, Petitioner' must prove that his attorney's representation fell below an objective standard of reasonableness. Id. at 687-88, 690. To establish deficient performance, Petitioner must show his counsel "made errors so serious that counsel was not functioning as the 'counsel' guaranteed the defendant by the Sixth Amendment." Id. at 687; Williams, 529 U.S. 362, 391, 120 S. Ct. 1495, 146 L. Ed. 2d 389 (2000). In reviewing trial counsel's performance, however, courts "strongly presume[] [that counsel] rendered adequate assistance and made all significant decisions in the exercise of reasonable professional judgment." Strickland, 466 U.S. at 690; Yarborough v. Gentry, 540 U.S. 1, 8, 124 S. Ct. 1, 157 L. Ed. 2d 1 (2003). Only if counsel's acts and

omissions, examined within the context of all the surrounding circumstances, were outside the "wide range" of professionally competent assistance, will Petitioner' meet this initial burden. Kimmelman v. Morrison, 477 U.S. 365, 386, 106 S. Ct. 2574, 91 L. Ed. 2d 305 (1986); Strickland, 466 U.S. at 690.

Second, [*16] Petitioner must show that he was prejudiced by demonstrating a reasonable probability that, but for his counsel's errors, the result would have been different. Strickland, 466 U.S. at 694. The errors must not merely undermine confidence in the outcome of the trial, but must result in a proceeding that was fundamentally unfair. Williams, 529 U.S. at 393 n.17; Lockhart, 506 U.S. at 369. Petitioner must prove both deficient performance and prejudice. A court need not, however, determine whether counsel's performance was deficient before determining whether the petitioner suffered prejudice as the result of the alleged deficiencies. Strickland, 466 U.S. at 697.

Here, Petitioner cannot meet his burden to show deficient performance and resulting prejudice with respect to any of his allegations of attorney error. First, counsel did not err in failing to move to suppress the brass knuckles recovered during the search of Petitioner's residence because there was no basis upon which to suppress the evidence. As the testimony revealed, Margie Garofano, who was the primary resident of the home where the search occurred, gave the police permission to search the home. (RT 143, 230.) Accordingly, the [*17] police obtained valid consent to search the residence. See Illinois v. Rodriguez, 497 U.S. 177, 110 S. Ct. 2793, 111 L. Ed. 2d 148 (1990) (observing that Fourth Amendment's prohibition on warrantless searches do not apply "to situations in which voluntary consent has been obtained, either from the individual whose property is searched or from a third party who possesses common authority over the premises") (citations omitted); United States v. Matlock, 415 U.S. 164, 170, 94 S. Ct. 988, 39 L. Ed. 2d 242 (1974) (holding that "the consent of one who possesses common authority over premises or effects is valid as against the absent, nonconsenting person with whom that authority is shared"). Moreover, the brass knuckles were recovered from the garage, a common area of the house. As such, trial counsel could not have performed deficiently in failing to move to suppress the evidence recovered during the search because any such motion was doomed to failure. See Kimmelman v. Morrison, 477 U.S. 365, 375, 106 S. Ct. 2574, 91 L. Ed. 2d 305 (1986); Boag v. Raines, 769 F.2d 1341, 1344 (9th Cir. 1985) (counsel's failure to raise meritless argument does not constitute ineffective assistance). 3

FOOTNOTES

3 In [*18] his Answer, Respondent contends that Petitioner is challenging his trial counsel's failure to move to suppress statements that Petitioner made to investigating officers. (Answer 8-24.) Petitioner, however, raises no such claim and states as much in his Traverse. (Traverse at 4 ("Petitioner/Petition did not raise issue to [sic] suppression of statements - audio tape."). Regardless, the Court notes that, even if such a claim had been raised, it would have failed because Petitioner suffered no prejudice as a result of his counsel's failure to move to suppress the statements. Petitioner's statements to the investigating officer were not introduced into evidence. Moreover, the substance of Petitioner's statements to the officer were introduced through the testimony of other witnesses. Regardless, the substance of Petitioner's statements to the officers was largely inconsequential in light of the other evidence establishing that Petitioner abused his victim. (See infra.) Finally, a review of the transcripts and exhibits shows that, contrary to his assertions, Petitioner was not in custody when he was questioned by police. (See, e.g., Petition, Points and Auth., Exh. 36 at p.3, Exh. 32 at [*19] 53, Exh. 32 53-65, 84-85.); see also California v. Beheler, 463 U.S. 1121, 1125, 103 S. Ct. 3517, 77 L. Ed. 2d 1275 (1983).

Second, trial counsel did not perform unreasonably in failing to object to the testimony of Rebecca Piantini, M.D., who opined that the victim's injuries were caused by the victim being shaken. Although Petitioner insists that Dr. Piantini's opinion regarding shaken baby syndrome was "pure guesswork," there was nevertheless no valid basis upon which to

object to Dr. Piantini's testimony. The testimony assisted the jury in understanding the meaning of the victim's injuries and related to a subject beyond the common experience of the jurors - namely, how the victim's brain injuries may have resulted from being shaken. See Cal. Evid. Code § 801(a); People v. Mayfield, 14 Cal. 4th 668, 766, 60 Cal. Rptr. 2d 1, 928 P.2d 485 (1997). The same is true regarding Dr. Piantini's opinions concerning the cause of the injuries suffered by Petitioner's 1993 victim. 4 (See RT 366-72.) Moreover, Petitioner was offered the opportunity to cross-examine, and in fact cross-examined, each of the State's medical experts. In so doing, Petitioner, through his trial counsel, was able to [*20] explore any shortcomings in the opinions of the testifying experts. 5 See, e.g., Perry v. Leeke, 488 U.S. 272, 283 n.7, 109 S. Ct. 594, 102 L. Ed. 2d 624 (1989) (citing with approval case law and commentators extolling virtues of cross-examination in the truth finding process) (citations omitted); Penn. v. Ritchie, 480 U.S. 39, 51, 107 S. Ct. 989, 94 L. Ed. 2d 40 (1987) (noting that, through cross-examination, witness can be shown to be biased or that witnesses testimony is exaggerated or unbelievable); see also Crawford v. Washington, 541 U.S. 36, 41, 124 S. Ct. 1354, 158 L. Ed. 2d 177 (2004) (explaining that reliability of evidence should be assessed "by testing in the crucible of cross-examination"). Given these facts, Petitioner can show neither that counsel's performance was deficient nor that Petitioner suffered prejudice from counsel's performance.

FOOTNOTES

4 Petitioner contends that Dr. Piantini's opinion regarding the cause of the injuries suffered by Petitioner's 1993 victim lacked any evidentiary basis. (Petition at 16, Points and Auth. at 16.) [*21] However, the trial testimony is clear that Dr Piantini reviewed the records regarding those injuries before opining as to their cause. (RT 366-70.)

5 Further, the jury was instructed that any expert's opinion was "only as good as the facts and reasons on which it [was] based" and that the jury could "disregard any opinion" it found unreasonable. (CT 174; RT 583.)

Third, Petitioner is not entitled to relief based on his allegation that his trial counsel failed to adequately investigate the causes and import of the victim's injuries. As the transcript of trial counsel's cross-examinations of the medical experts show, trial counsel was adequately prepared to explore weaknesses in the State's experts' opinions and to suggest alternative theories to those of the experts to explain the extent and significance of the victim's injuries. And even assuming, as Petitioner insists, that trial counsel failed to adequately investigate the basis for the experts' opinions, Petitioner fails to cite any evidence that trial counsel could have uncovered that would have made the jury more likely than not to have reached a different verdict. 6 Although Petitioner notes that some evidence may have suggested [*22] that the victim's injuries may not have been caused by shaking, the jury was keenly aware that the State's medical experts did not necessarily agree on the precise cause of the victim's injuries. Nevertheless, all agreed that the victim died from abusive head trauma. Nothing that Petitioner cites (and faults his counsel for failing to uncover) would lead a reasonable juror to doubt this conclusion. 7

FOOTNOTES

6 The same is true with respect to Petitioner's claims that trial counsel erred in failing to conduct adequate pre-trial interviews with various law enforcement officials and paramedics. (See, e.g., Petition, Points and Auth. at 29.)

7 In connection with his ineffective assistance of counsel claims, Petitioner asserts that the Reporter's Transcript was somehow altered so as to omit Dr. Trenkle's testimony that changes in the victim's femurs were due to natural growth spurts, rather than to an abuse inflicted fracture. (Petition at 31.) There is no evidence to support Petitioner's assertion that the transcript was altered. But putting that aside, there is no reason to believe that the alteration or counsel's

failure to object to it, assuming it occurred, impacted the proceedings. Irrespective [*23] of the cause of the changes to the victim's femur, Dr. Trenkle opined that the victim died as a result of abusive head trauma. (RT 439.) This opinion was echoed by Dr. Piantini, who likewise concluded that the victim died of abusive head trauma. (RT 342, 364.) Moreover, both medical experts, as well as the physician who attended to the victim, opined that the extent of the victim's injuries and symptoms was incompatible with Petitioner's account of how the victim had been injured. (RT 303-04, 342, 440.) Indeed, Dr. Piantini flatly testified that, given all of the victim's symptoms, it was "medically impossible" that those symptoms resulted from the fall that Petitioner described. (RT 397.) Additionally, the evidence showed that Petitioner had previously inflicted great bodily injury on an infant, only to later claim that the resulting injuries stemmed from an accidental fall. This evidence further served to decrease any likelihood that Dr. Trenkle's purported testimony about the victim's femur would have impacted the jury's verdict.

Fourth, contrary to Petitioner's contentions, trial counsel did not concede Petitioner's guilt at trial. On the contrary, trial counsel adamantly argued [*24] that the evidence showed that the victim's injuries were the result of an accidental fall. (See, e.g., RT 620-21; see also id. at 645-46 ("Mr. Patkins has told you, and the evidence is consistent with the accidental dropping of a child. . . . [¶] You have explanations, reasonable explanations given, that this child could have suffered injuries in an accidental fashion.").) And rather than ignoring medical evidence offered against Petitioner, trial counsel argued that the evidence comported with Petitioner's account of how the victim was injured. (Id.) Moreover, it makes no difference that, at a pretrial hearing, trial counsel may have stated that shaking caused the victim's death. (See RT 30-31.) As an initial matter, Petitioner takes trial counsel's statement out of context. In proper context, trial counsel was arguing that the prosecutor be prohibited from arguing that Petitioner's 1993 assault on his then-infant son resulted in the child's current developmental disability. (Id.) In making this argument, trial counsel twice acknowledged that the prosecutor's theory of the case was that the death of Petitioner's current victim was attributable to shaking. Trial counsel did not, however, [*25] concede Petitioner's defense that the victim's death resulted from an accidental fall. (See id.) Regardless, even assuming error, Petitioner could not show prejudice because trial counsel's statements were never heard by the jury.

Fifth, trial counsel did not perform unreasonably in failing to challenge the evidentiary support for the trial court's finding that Petitioner suffered a prior, serious felony. Referencing a complaint attached as an exhibit to his petition, 8 Petitioner insists that the trial court's finding was unsupported because the complaint references assault with a deadly weapon. 9 However, that complaint was superceded by an information alleging that Petitioner committed child abuse with great bodily injury, and Petitioner pleaded guilty to that allegation. (CT 58; RT 14-16; see also Supp. CT 10.) As such, the conviction was a "serious" felony under California law. See Cal. Penal Code § 1192.7(c)(8) (identifying any felony in which the defendant personally inflicts great bodily injury on a person other than an accomplice as a serious felony); Cal. Penal Code § 667.5(c)(8) (same). Consequently, there was no basis upon which trial counsel could have successfully challenged [*26] the evidentiary basis for the trial court's finding that Petitioner suffered a prior, serious felony. 10

FOOTNOTES

8 Petition, Exh. 31.

9 Presumably, Petitioner believes that assault with a deadly weapon does not qualify as a serious felony because assault can be committed in a way that does not render the resulting conviction a "serious felony" under California law. Compare People v. Delgado, 43 Cal. 4th 1059, 1065, 77 Cal. Rptr. 3d 259, 183 P.3d 1226 (2008) (holding that abstract of judgment with notation "Asslt w DWpn" was sufficient for a trial court to find that the defendant's conviction for assault under California Penal Code § 245(a)(1) was serious felony because notation showed that petitioner used deadly

weapon in committing assault), with People v. Rodriguez, 17 Cal. 4th 253, 261-62, 70 Cal. Rptr. 2d 334, 949 P.2d 31 (1998) (abstract of judgment of assault under California Penal Code 245(a)(1) insufficient to show conviction was "serious" felony because crime could have been committed in ways that did and did not constitute "serious" felony and abstract did not indicate way in which defendant committed crime).

10 The Court notes that Petitioner knowingly and voluntarily waived his state statutory right to have the [*27] jury determine the truth of his prior conviction. (RT 14-15.) And in so doing, he acknowledged that the prior conviction, if found to be true, would constitute a serious felony under California law.

Sixth, Petitioner is not entitled to relief with respect to his claim that his counsel failed to call an available medical expert to testify to rebut the medical expert testimony offered by the prosecutor. In support of this claim, Petitioner cites an opinion from Thomas Schweller, M.D., in which Dr. Schweller, citing a study by Dr. John Plunkett, concludes that the victim's cause of death was consistent with a fall from eighteen inches. Dr. Schweller's proposed testimony, however, would not have led to a different result because the jury was already aware of Dr. Plunkett's study and his conclusions about how short falls led to fatal head injuries in 18 out of approximately 75,000 cases. (RT 374-75, 392-94, 474-75, 636-37, 640-41.) Specifically, trial counsel questioned the medical experts about Dr. Plunkett's study in an effort to undermine the expert's conclusions about the victim's cause of death. (Id. at 374-75, 392-94, 474-75.) The jury's verdict, however, shows that the jury believed [*28] that, in Petitioner's case, the victim's injuries did not result from an accidental fall. 11

FOOTNOTES

11 Petitioner also references a coroner's investigation report authored by Deputy Coroner Investigator Glenn Miller in connection with Petitioner's challenge to counsel's failure to call available witnesses. (Petition, Exh. 17). Miller's testimony, however, would not have benefitted Petitioner because, like the medical experts who testified, Miller concluded that the victim died of abusive head trauma. (Id.)

Finally, Petitioner is not entitled to habeas relief based on his trial counsel's failure to object to the prosecutor's alleged misconduct. As explained in connection with Petitioner's separate prosecutorial misconduct claim (Claim Two), none of Petitioner's many allegations of prosecutorial misconduct has merit. (See infra.) Accordingly, trial counsel did not perform unreasonably in electing not to object to conduct that was neither improper nor prejudicial.

B. Prosecutorial Misconduct

In his second claim for relief, Petitioner contends that the prosecutor committed various acts of misconduct. Although Petitioner challenges numerous actions on the prosecutor's part, each of those challenges [*29] falls into one of the following categories: (1) knowingly presenting false evidence to the jury; (2) misleading the jury about the content of a witness's testimony; (3) misleading the jury during closing arguments and making inflammatory arguments; (4) suppressing exculpatory material; (5) vouching for prosecution witnesses; and (6) improperly "profiling" Petitioner as a murderer.

Prosecutorial misconduct does not rise to the level of a constitutional violation unless it "so infected the trial with unfairness as to make the resulting conviction a denial of due process." Darden v. Wainwright, 477 U.S. 168, 181, 106 S. Ct. 2464, 91 L. Ed. 2d 144 (1986) (quoting Donnelly v. DeChristoforo, 416 U.S. 637, 643, 94 S. Ct. 1868, 40 L. Ed. 2d 431

(1974)); Comer v. Schriro, 480 F.3d 960, 988 (9th Cir. 2007). "[T]he touchstone of due process analysis in cases of alleged prosecutorial misconduct is the fairness of the trial, not the culpability of the prosecutor." Smith v. Phillips, 455 U.S. 209, 219, 102 S. Ct. 940, 71 L. Ed. 2d 78 (1982); see also Estelle v. Williams, 425 U.S. 501, 503, 96 S. Ct. 1691, 48 L. Ed. 2d 126 (1976) ("The right to a fair trial is a fundamental liberty secured by the Fourteenth Amendment."). [*30] As explained below, each of Petitioner's prosecutorial misconduct allegations lacks merit.

First, the prosecutor did not knowingly present false evidence. The knowing use of false evidence by the state, or the failure to correct false evidence, violates due process. Napue v. Illinois, 360 U.S. 264, 269, 79 S.Ct. 1173, 3 L. Ed. 2d 1217 (1959). In Napue, the Supreme Court made clear that this prohibition against using false testimony applies even when the testimony in question is relevant only to a witness's credibility. Id. at 269. A claim under Napue will succeed when "(1) the testimony (or evidence) was actually false, (2) the prosecution knew or should have known that the testimony was actually false, and (3) the false testimony was material.'" Jackson v. Brown, 513 F.3d 1057, 1071-72 (9th Cir. 2008), quoting Hayes v. Brown, 399 F.3d 972, 984 (9th Cir. 2005) (en banc).

Here, Petitioner has not shown that the prosecutor knowingly presented false testimony. Instead, Petitioner, for the most part, merely disagrees with the medical testimony the prosecutor elicited regarding the victim's injuries and their implications. Petitioner was given a full opportunity to cross-examine, and in fact [*31] cross-examined, each of the medical witnesses about their respective opinions and to exploit any perceived weaknesses in those opinions. Likewise, nothing suggests that the prosecutor knowingly introduced false testimony from Margie Garofano, the victim's mother, or from any other witness. Rather, at best, Petitioner points out minor inconsistencies in the testimony. These inconsistencies, assuming they were in fact inconsistent, could just as easily be explained by the witnesses' faulty memories about the events, as opposed to intentional lying. In any event, the mere existence of inconsistencies in a witness's account does not prove or even suggest that the prosecutor was aware or should have been aware that any of the witnesses were fabricating their testimony. Accordingly, Petitioner's claim fails. 12

FOOTNOTES

12 Petitioner notes that there was conflicting testimony about whether Petitioner said he dropped his victim while walking up the stairs or walking down the stairs. (Petition, Points and Authorities at 72-73). Even assuming that some of this testimony was false, it had no impact on the jury's verdict because the medical evidence showed that the victim's wounds were not compatible with [*32] being dropped on the stairs. Additionally, there is no merit to Petitioner's suggestion that the prosecutor elicited false testimony regarding the estimated distance that victim would have fallen if, as Petitioner contended, the victim was dropped while Petitioner was ascending the stairs. The responding paramedic testified that he estimated that the fall Petitioner described would have been about eighteen inches. (See RT 218.) Although Petitioner questions the accuracy of this estimate, he offers no reason to believe that the person who made the estimate was being untruthful in doing so.

Second, the prosecutor did not deprive Petitioner of a fair trial by allegedly misrepresenting the testimony of Garofano. During trial, Garofano testified that Petitioner kept his brass knuckles (of which he was ultimately convicted of possessing) "in" a work bench in the garage. (RT 151.) Immediately after Garofano said this, the prosecutor attempted to parrot back her response, but stated that the knuckles were "on" the work bench, rather than "in" the work bench. (Id.) Petitioner claims that the prosecutor did this intentionally to increase the likelihood that the jury would convict Petitioner of [*33] possessing brass knuckles. This claim is meritless because it made no difference whether the knuckles were in or on the work bench; the only matter of significance was whether Petitioner possessed them. And on that point, Garofano's testimony established that the brass knuckles belonged to Petitioner. (Id.) As such, even assuming, as

Petitioner maintains, that the prosecutor engaged in misconduct, the misconduct had no impact on the jury's verdict. See Shaw v. Terhune, 380 F.3d 473, 478 (9th Cir. 2004) (stating that "[p]rosecutorial misconduct which rises to the level f a due process violation may provide the grounds for granting a habeas petition only if that misconduct is deemed prejudicial under the 'harmless error' test. . . ."); Brecht v. Abrahamson, 507 U.S. 619, 637-38, 113 S. Ct. 1710, 123 L. Ed. 2d 353 (1993) (constitutional trial error will not warrant federal habeas relief unless error had substantial and injurious impact on jury's verdict).

Third, the prosecutor did not assert facts in his closing argument that were untrue. A prosecutor does not commit misconduct by asking the jury in closing arguments to make reasonable inferences from the evidence at trial, even if the [*34] defendant disputes those inferences. See United States v. Cabrera, 201 F.3d 1243, 1250 (9th Cir. 2000). Indeed, "[c]ounsel are given latitude in the presentation of their closing arguments, and courts must allow the prosecution to strike hard blows based on the evidence presented and all reasonable inferences therefrom." Ceja v. Stewart, 97 F.3d 1246, 1253-54 (9th Cir. 1996); see Duckett v. Godinez, 67 F.3d 734, 742 (9th Cir. 1995) (prosecutor's argument that murder victims specifically identified defendant by crying out "Tony" was reasonable though no other witnesses could confirm that "Tony" referred to defendant, as opposed to someone else with same first name). Here, the prosecutor merely asked the jury to infer that the injuries to the victim were the result of being intentionally abused, rather than of accidental causes. This inference was reasonable in light of the uncontroverted medical evidence that the victim died of abusive head trauma and Petitioner's history of assaulting his then-infant son. 13

FOOTNOTES

13 In connection with his claim that the prosecutor misrepresented facts to the jury, Petitioner faults the prosecutor for failing to acknowledge that Dr. Trenkle, one of the State's [*35] medical experts, recanted his testimony regarding the type of fall necessary to cause the injuries observed on the victim. (Petition, Points and Auth. at 76-80.) However, a review of the record reveals that Dr. Trenkle never recanted his testimony on this point. (See RT 442-43, 472-73.)

Moreover, assuming the prosecutor made some misstatements about the evidence admitted at trial, there is no reason to believe that those misstatements deprived Petitioner of a fair trial. As discussed above, the prosecutor introduced compelling medical evidence showing that the victim suffered abusive head trauma. (See supra at n.7.) And, as discussed in more detail below, the prosecutor introduced evidence that Petitioner had previously inflicted great bodily injury on a different infant and, thereafter, attempted to attribute that victim's injuries to an accident. (See infra.) Finally, assuming the prosecutor's comments conflicted with the evidence, the prosecutor's comments were unlikely to have been credited because the jury was explicitly instructed that arguments of counsel were not evidence. (CT 152; RT 574.)

Third, the prosecutor did not withhold exculpatory information. See Brady v. Maryland, 373 U.S. 83, 87, 83 S. Ct. 1194, 10 L. Ed. 2d 215 (1963) [*36] (Due Process Clause requires prosecution to disclose any evidence that is material either t guilt or to punishment); Kyles v. Whitley, 514 U.S. 419, 433, 115 S. Ct. 1555, 131 L. Ed. 2d 490 (1995). Although Petitioner maintains that the prosecutor withheld evidence that a testifying expert had ruled out shaking as a cause of the victim's injury, the record shows that defense counsel questioned the expert about the facts that Petitioner claims were withheld. (RT 456-57; Petition, Points and Auth. at 81). And in any event, the allegedly withheld material was not exculpatory because, contrary to Petitioner's assertions, the expert in question did not rule out shaking as the cause o some of the victim's injuries; rather, the expert concluded that the skull fracture leading to the victim's death was caused by blunt force. (See RT 456-57.) Notwithstanding this conclusion, the expert testified that shaking may have occurred in addition to the use of blunt force. (RT 457.) There is likewise no merit to Petitioner's suggestion that the allegedly exculpatory medical evidence was withheld in order to ensure that the trial court would allow the prosecut

to introduce evidence about Petitioner's [*37] 1993 conviction, particularly in light of the other medical evidence that suggested that shaking was the cause of many of the victim's injuries. 14

rOOTNOTES

14 The Court further disagrees with Petitioner's premise that his 1993 child abuse conviction was admissible only because of the medical evidence suggesting that his current victim had been shaken. Irrespective of whether the baby had been shaken, the medical experts agreed that the victim had suffered abusive head trauma. In other words, the medical experts agreed that the victim's wounds and injuries were intentional, not accidental. Given that fact, there is no reason to believe that the trial court would have excluded the 1993 conviction, as that conviction would still have been relevant to show Petitioner's lack of mistake and to his knowledge of the danger posed by his actions.

Regardless, the expert in question opined that the victim died as a result of abusive head trauma and that the victim's injuries and symptoms were inconsistent with Petitioner's account that he had accidentally dropped the victim a few feet while ascending the stairs. Accordingly, nothing suggests that the purportedly suppressed evidence impacted the jury's verdict. [*38] See Kyles, 514 U.S. at 433-34 (stating that evidence is "material," in terms of prosecutor's discover obligations, "if there is a reasonable probability that, had the evidence been disclosed to the defense, the result of the proceeding would have been different").

Fourth, the prosecutor did not vouch for any witness's credibility. A prosecutor is permitted to argue reasonable inferences from the evidence (see, e.g., Duckett v. Godinez, 67 F.3d 734, 742 (9th Cir. 1995); Ceja v. Stewart, 97 F.3d 1246, 1253-54 (9th Cir. 1996)) and to label a witness's testimony as lies or fabrication. See, e.g., Turner v. Marshall, 63 F.3d 807, 818 (9th Cir. 1995), overruled on other grounds, Tolbert v. Page, 182 F.3d 677 (9th Cir. 1999). A prosecutor may not, however, vouch for the credibility of a prosecution witness. See, e.g., United States v. Young, 470 U.S. 1, 18-19, 105 S. Ct. 1038, 84 L. Ed. 2d 1 (1985); United States v. Jackson, 84 F.3d 1154, 1158 (9th Cir. 1996). "Vouching may occur in two ways: the prosecution may place the prestige of the government behind the witness or may indicate that information not presented to the jury supports the witness's testimony." United States v. Roberts, 618 F.2d 530, 533 (9th Cir. 1980) [*39] (citing Lawn v. United States, 355 U.S. 339, 359-60 n.15, 78 S. Ct. 311, 2 L. Ed. 2d 321 (1958); United States v. Lamerson, 457 F.2d 371 (5th Cir. 1972)); United States v. Weatherspoon, 410 F.3d 1142, 1146 (9th Cir. 2005).

Here, none of the prosecutor's comments constituted improper vouching. Rather, the transcript of the prosecutor's closing argument reveals that the prosecutor did nothing more than urge the jury to make reasonable inferences based on the evidence presented to it. Although the prosecutor cited the expert medical testimony against Petitioner to argue that Petitioner was guilty, the prosecutor did not use the prestige of the government to bolster either that testimony or the credibility of the witnesses who provided it. Compare Hein v. Sullivan, 601 F.3d 897, 913 (9th Cir. 2010) (holding that prosecutor improperly vouched for witness's credibility where prosecutor argued, among other things, that witness "was painfully honest" and that witness's testimony incriminating petitioner was "honest" despite that witness revealed embarrassing things about himself); United States v. Weatherspoon, 410 F.3d 1142, 1146 (9th Cir. 2005) (prosecutor improperly vouched for testifying [*40] officers by arguing that they had no reason to lie and that, if they lied, they would risk being prosecuted for perjury). Rather, the prosecutor simply highlighted certain parts of the witnesses' testimony in an effort to argue that Petitioner was guilty as charged. In doing so, the prosecutor did no more than ask the jury to make reasonable inferences supported by the evidence adduced at trial.

Fifth, the prosecutor did not deprive Petitioner of his right to a fair trial by improperly "profiling" Petitioner. Instead, the prosecutor argued that Petitioner had lied about his actions and labeled him a murderer. As to accusing Petitioner of

lying, such accusations were warranted by the evidence suggesting that Petitioner had lied to cover up his actions. Likewise, the prosecutor committed no error in citing evidence to show that Petitioner's emotions were in line with those of a murder, as that was at least a reasonable inference from Garofano's testimony about Petitioner demeanor and situation in the period preceding the victim's death. Regardless, the prosecutor's comments, even if improper, did not approximate the type of statements that have been found insufficient to establish a due [*41] process violation based on prosecutorial misconduct. See Darden, 477 U.S. at 180 n.10-12 (prosecutor did not deprive defendant of right to fair trial where prosecutor urged jury to impose death penalty by arguing that "as far as I am concerned, . . . [the defendant is] an animal," and "I wish [the decedent] had a shotgun in his hand . . . and blown [the defendant's] face off. I wish that I could see him sitting here with no face, blown away by a shotgun"); Comer v. Schriro, 480 F.3d 960, 988 (9th Cir. 2007) (prosecutor did not deprive defendant of right to fair trial despite labeling petitioner "monster," "filth," and "reincarnation of the devil").

Finally, the prosecutor's comments could not have deprived Petitioner of a fair trial in light of the evidence presented against him. See Hein, 601 F.3d at 916 (denying habeas relief despite prosecutor's improper vouching for witness, in part, because evidence against petitioner was strong). The uncontroverted medical evidence establishing that the victim died of abusive head trauma was overwhelming and compelling. (RT 342, 439.) That same evidence undermined Petitioner's claim that the victim's injuries resulted from an accidental fall on [*42] the stairs. (RT 304, 342, 440.) Moreover, Petitioner's claim that the victim had suffered an accidental fall was further undercut by the evidence regarding Petitioner's past child abuse conviction and his previous attempt to explain away the resulting injuries to his then-infant son by conjuring up an accident. Compare United States v. Rudberg, 122 F.3d 1199, 1206 (9th Cir. 1997) (reversing conspiracy conviction against defendant based entirely on testimony of vouched witnesses where defendant denied participating in conspiracy, vouched witnesses were subject to credibility attacks, and defendant was able to corroborate his testimony denying participation).

In short, the state courts' rejection of Petitioner's prosecutorial misconduct claim was neither contrary to, nor an unreasonable application of, clearly established federal law. Accordingly, Petitioner is not entitled to habeas relief on this claim.

C. Second Degree Murder Instructions

Next, Petitioner contends that the trial court erred in instructing the jury on the requisite state of mind Petitioner had to have to support a guilty verdict for second degree murder. It appears that Petitioner's challenge to the trial court's second [*43] degree murder instructions takes three forms. First, Petitioner contends that the trial court should have provided additional instructions regarding the specific intent to kill. Second, Petitioner maintains that the existing instructions were inadequate because they allowed the jury to convict Petitioner of second degree murder based only on the fact that Petitioner had suffered a 1993 conviction for inflicting great bodily injury on an infant. Third, Petitioner asserts that the trial court erred in instructing the jury that the requisite malice for malice aforethought could be either express or implied. Allowing the jury these alternative routes to reach a guilty verdict, according to Petitioner, was likely to confuse the jury and allowed the jury to convict Petitioner of second degree murder without finding that he harbored the specific intent to kill.

A claim that a trial court erred by omitting an instruction is cognizable only if the petitioner can show the omission so infected the entire trial that the resulting conviction violated due process. See Estelle v. McGuire, 502 U.S. 62, 72, 112 S. Ct. 475, 116 L. Ed. 2d 385 (1991); Henderson v. Kibbe, 431 U.S. 145, 154, 97 S. Ct. 1730, 52 L. Ed. 2d 203 (1977); [*44] Cupp v. Naughten, 414 U.S. 141, 147, 94 S. Ct. 396, 38 L. Ed. 2d 368 (1973). The significance of the omitted instruction should be evaluated by comparing it to the instructions that were given. See Estelle, 502 U.S. at 72; Henderson, 431 U.S.

at 156. An omission or an incomplete jury instruction is less likely to be prejudicial than a misstatement of the law. Henderson, 431 U.S. at 154 (observing that "[a]n omission, or an incomplete instruction, is less likely to be prejudicial than a misstatement of the law"). Consequently, where, as here, a habeas petitioner's claim involves the failure to give a particular instruction, the petitioner bears an "especially heavy" burden to establish a due process violation. Id. at 147, 154.

Here, Petitioner cannot meet that heavy burden. The jury was properly instructed on the elements of second degree murder and on the prosecution's burden to prove each element beyond a reasonable doubt. (See CT 178; RT 585 (instructing jury regarding presumption of innocence and prosecutor's burden to prove guilt beyond reasonable doubt); CT 185; RT 587 (setting forth elements of second degree murder).) Furthermore, the jury was instructed that it could not reach [*45] a guilty verdict as to second degree murder unless it found that Petitioner harbored express or implied malice aforethought. (CT 186; RT 587.) And although Petitioner contends that the jury should have been instructed further on specific intent, no additional instruction was constitutionally required because the jury was already instructed that a finding of express malice required the prosecutor to prove that Petitioner "manifested an intention unlawfully to kill a human being." (CT 186; RT 587.) These instructions made clear that the jury could not find Petitioner guilty of second degree murder under an express malice theory unless the jury believed that Petitioner intended to kill the victim.

Moreover, there is no merit to Petitioner's assertion the trial court erred in instructing the jury on both implied malice and express malice. (See Petition, Points and Auth. at 123.) California law is clear that both instructions are proper when a defendant is charged with second degree murder. See, e.g., People v. Nieto Benitez, 4 Cal. 4th 91, 102-03, 13 Cal. Rptr. 2d 864, 840 P.2d 969 (1992) (stating that "malice," for purposes of second degree murder, may be either express or implied).

Furthermore, [*46] there is no merit to Petitioner's attempt to conflate the trial court's decision to admit his 1993 conviction with his allegations of instructional error. (See Petition, Points and Auth. at 121-22.) Although Petitioner asserts that the 1993 conviction was the only evidence supporting his conviction for second degree murder, this assertion ignores the substantial medical evidence showing that the victim's death was caused by abusive head trauma. That same medical evidence showed that the victim's injuries were incompatible with Petitioner's account of how the victim was injured. And, as discussed in connection with Petitioner's direct challenge to the admissibility of the facts underlying his 1993 conviction, the jury was repeatedly admonished of the limited purposes for which it could consider those facts. (See infra.)

Finally, even assuming that the trial court erred in instructing the jury, the error did not have a substantial and injurious impact on the jury's verdict. See Brecht, 507 U.S. at 637-38 (constitutional trial error does not warrant habeas relief unless error had substantial and injurious impact on jury's verdict). As discussed above, the uncontroverted medical evidence [*47] showed that the victim did not die from being accidentally dropped, but rather from abusive head trauma. Indeed, as one expert testified, it was "not medically possible" that the victim's multiple symptoms resulted from the accidental fall described by Petitioner. (RT 397.) Furthermore, Petitioner's claim that an accidental fall caused the victim's injuries was unbelievable in light of both the extent of the injuries and the evidence regarding Petitioner's prior conviction for inflicting great bodily injury on another infant. Given this evidence, there is no reason to think that the jury would have reached a different verdict had the jury been instructed as Petitioner insists it should have been.

D. The Evidence Supporting Petitioner's Conviction

In his next claim for relief, Petitioner contends that the prosecutor failed to introduce sufficient evidence to prove that

he committed child abuse resulting in death and second degree murder. To review the sufficiency of evidence in a habeas corpus proceeding, the Court must determine whether "'any rational trier of fact could have found the essential elements of the crime beyond a reasonable doubt.'" Lewis v. Jeffers, 497 U.S. 764, 781, 110 S. Ct. 3092, 111 L. Ed. 2d 606 (1990) [*48] (citation omitted); Jackson v. Virginia, 443 U.S. 307, 319, 99 S. Ct. 2781, 61 L. Ed. 2d 560 (1979). All evidence must be considered in the light most favorable to the prosecution. Jeffers, 497 U.S. at 782; Jackson, 443 U.S. at 319. Accordingly, if the facts support conflicting inferences, reviewing courts "must presume - even if it does not affirmatively appear in the record - that the trier of fact resolved any such conflicts in favor of the prosecution, and must defer to that resolution." Jackson, 443 U.S. at 326; Bruce v. Terhune, 376 F.3d 950, 957 (9th Cir. 2004) (per curiam); Turner v. Calderon, 281 F.3d 851, 882 (9th Cir. 2002). Furthermore, under AEDPA, federal courts must "apply the standards of Jackson with an additional layer of deference." Juan H. v. Allen, 408 F.3d 1262, 1274 (9th Cir. 2005); Smith v. Mitchell, 624 F.3d 1235, 1239 (9th Cir. Oct. 29, 2010) (observing that AEDPA combined with Jackson standard requires "double layer of deference").

Here, the prosecutor introduced ample evidence supporting Petitioner's conviction. As an initial mater, there was no question that the victim was injured while alone in Petitioner's care. And, as set forth in the court of appeal's [*49] opinion, the prosecutor introduced substantial medical evidence - in the form of expert testimony, CT scans, and autopsy results - showing that the victim was not injured in the manner described by Petitioner, but rather as a result of having suffered abusive head trauma. (See, e.g., RT 342, 397, 439-40.) In addition, the prosecutor introduced evidence that Petitioner had been convicted of inflicting great bodily injury on another of his infant sons. The prosecutor also introduced evidence showing that Petitioner had fabricated an accident to explain away the abuse he had inflicted on his earlier victim. Given that evidence and the medical evidence contradicting Petitioner's account of the incident leading to the current charge, the jury could have reasonably and rationally concluded that Petitioner - understanding the danger posed by his actions - assaulted his victim and, thereafter, fabricated a story to explain away the victim's injuries. Cf. Smith, 624 F.3d at 1238-40 (holding that evidence was insufficient to prove that petitioner assaulted child resulting in death where uncontroverted evidence showed that petitioner was loving grandmother with no history of child abuse and where [*50] objective medical evidence did not demonstrate that infant's death was caused by abuse).

E. Admission of Prior Bad Acts

In his next claim for relief, Petitioner contends that the trial court abused its discretion by allowing the prosecutor to introduce evidence regarding Petitioner's prior conviction involving child abuse against another one his children and the facts underlying that conviction. The prior conviction arose from a 1993 incident that resulted in Petitioner pleading guilty to abusing his infant son and to inflicting great bodily injury. According to Petitioner, this evidence should not have been admitted at trial because it was overwhelmingly prejudicial and inflammatory.

The court of appeal rejected Petitioner's challenge to the admission of his prior instance of child abuse. In doing so, the court of appeal reasoned that the challenged evidence was relevant to show that Petitioner understood the danger stemming from his actions, that his actions were not the result of mistake or accident, and that he intended to commit the charged offenses. Having concluded that the evidence was admissible under state law for several permissible purposes, the court of appeal then turned [*51] to whether the probative value of the evidence outweighed it potentially prejudicial effect. The court of appeal observed that Petitioner's prior instance of chid abuse was strikingly similar to the acts of which Petitioner was accused. According to the court of appeal, the similarity of the two incidents served to underscore the relevance of the prior incident. The court of appeal also noted that the prior incident, though preceding the current incident by several years, was not likely to be unduly inflammatory because it resulted in a conviction and because the prior incident was not more serious than the current charge. With these considerations in mind, the court of appeal concluded that the trial court committed no error in admitting the challenged evidence. As

explained below, the court of appeal did not commit constitutional error in so concluding.

State evidentiary rulings are not cognizable in a federal habeas proceeding, unless the admission of the evidence violated the petitioner's due process right to a fair trial. Estelle v. McGuire, 502 U.S. 62, 68, 112 S. Ct. 475, 116 L. Ed. 2d 385 (1991); Gordon v. Duran, 895 F.2d 610, 613 (9th Cir. 1990). In order to prevail, the petitioner [*52] must show that the court's ruling was so prejudicial that it rendered his trial fundamentally unfair. See Estelle, 502 U.S. at 68; Jammal v. Van de Kamp, 926 F.2d 918, 920 (9th Cir. 1991); see also McKinney v. Rees, 993 F.2d 1378, 1380 (9th Cir. 1993). Thus, if Petitioner merely contends that the trial court abused its discretion under state law, he has not stated a cognizable claim for federal habeas relief.

Moreover, assuming Petitioner has stated a cognizable claim for relief based on the admission of his prior bad acts, his claim nevertheless fails on its merits. The introduction of evidence violates a petitioner's due process rights only if there is no permissible inference the jury can draw from the challenged evidence and the evidence is "of such quality as necessarily prevents a fair trial." Jammal, 926 F.2d at 920; see Estelle, 502 U.S. at 70 (testimony does not violate due process if it is relevant); McKinney, 993 F.2d at 1380, 1381 (same). Here, as the court of appeal explained, the evidence was relevant to support several permissible inferences, including Petitioner's intent, his awareness of the danger of his actions, and his lack of mistake or accident.

Furthermore, the [*53] trial court took steps to ensure that the challenged evidence was used only for the limited purposes for which it was admitted. Specifically, the trial court instructed the jury that it could not consider the prior bad act evidence to prove that Petitioner was a person of bad character or to show that he was predisposed to commit the charged crime. (CT 166; RT 581.) The trial court further admonished the jury that it could consider the challenged evidence only to show that Petitioner had the requisite intent to commit the charged crime or to show that he had the necessary knowledge to commit the charged crime. (Id.) This admonishment was echoed by the prosecutor, who, during his closing argument, stated:

I want to be really clear. When I say he's done it before, I'm not suggesting to you folks, "Okay, he did it before, we're going to convict him regardless." That would be wrong. I mean it. I'm not suggesting he's a bad guy; therefore, he did it this time. That's not why you get to hear that evidence. You get to hear that evidence because it shows he knew what he was doing was dangerous. And the more accidents he makes up, the more obvious it is that he's lying about it being an accident. [*54] That's why you get to hear about the kind of evidence. He knows firsthand of the danger.

(RT 609.) 15

FOOTNOTES

15 In connection with his prosecutorial misconduct claim (Claim Two), Petitioner appears to allege that the prosecutor committed misconduct in presenting evidence of, or making arguments regarding, Petitioner's 1993 child abuse conviction. This claim is meritless in the light of the foregoing analysis. Equally meritless is Petitioner's suggestion that the prosecutor argued that the jury consider Petitioner's prior bad acts to show Petitioner's propensity to commit the charged act of child abuse. Although the prosecutor urged the jury to consider Petitioner's prior bad act, the prosecutor admonished the jury not to consider that evidence to show Petitioner's bad character or propensity to engage in child abuse.

In short, the challenged evidence was relevant, and the record shows that the jury was well aware that it could not consider the evidence for any improper purpose. As such, the admission of the challenged evidence did not deprive

Petitioner of a fair trial. Consequently, the state courts' decision rejecting Petitioner's challenge to the admission of his prior bad acts was neither [*55] contrary to, nor an unreasonable application of, clearly established federal law.

. . CALJIC 2.03

In his next claim for relief, Petitioner contends that the trial court erred in instructing the jury with CALJIC 2.03, which states the following:

If you find that before this trial the defendant made a willfully false or deliberately misleading statement concerning the crime for which he is now being tried, you may consider that statement as a circumstance tending to prove a consciousness of guilt. However, that conduct is not sufficient by itself to prove guilt, and its weight and significance, if any, are for you to decide.

(CT 158; RT 577-78.) This instruction, according to Petitioner, strongly suggested that he had made false statements about the his role in the crime. Moreover, he maintains that the way in which CALJIC 2.03 is worded likely caused the jury to infer his guilt based solely on the fact that he made false statements about the crime.

If Petitioner merely claims that the jury instructions were incorrect under state law, such a claim would provide Petitioner no basis for federal habeas relief. Estelle v. McGuire, 502 U.S. 62, 71-72, 112 S. Ct. 475, 116 L. Ed. 2d 385 (1991); see [*56] also Lewis v. Jeffers, 497 U.S. 764, 780, 110 S. Ct. 3092, 111 L. Ed. 2d 606 (1990) ("[F]ederal habeas corpus relief does not lie for errors of state law."). Rather, the question on habeas review is whether an alleged instructional error "by itself so infected the entire trial that the resulting conviction violates due process." Estelle, 502 U.S. at 71-72 (quoting Cupp v. Naughten, 414 U.S. 141, 147, 94 S. Ct. 396, 38 L. Ed. 2d 368 (1973)).

Where a habeas claim rests on an alleged constitutional error arising from a jury instruction, the challenged instruction "may not be judged in artificial isolation, but must be viewed in the context of the overall charge." Cupp, 414 U.S. at 146-147; see Middleton v. McNeil, 541 U.S. 433, 437, 124 S.Ct. 1830, 158 L.Ed.2d 701 (2004) (per curiam) ("If the charge as a whole is ambiguous, the question is whether there is a reasonable likelihood that the jury has applied the challenged instruction in a way that violates the Constitution.") (citations and internal quotation marks omitted). Moreover, even if instructional error is found to rise to the level of a constitutional violation under this standard, federal habeas relief is unavailable without further [*57] inquiry to determine whether the error was harmless. "The court must find that the error, in the whole context of the particular case, had a substantial and injurious effect or influence on the jury's verdict." Calderon v. Coleman, 525 U.S. 141, 147, 119 S. Ct. 500, 142 L. Ed. 2d 521 (1998) (citing Brecht, 507 U.S. at 637).

The Due Process Clause protects an accused against conviction except upon proof beyond a reasonable doubt of every fact necessary to constitute the charged crime. In re Winship, 397 U.S. 358, 364, 90 S. Ct. 1068, 25 L. Ed. 2d 368 (1970). The State, therefore, may not use evidentiary presumptions in a jury charge that effectively relieve the prosecution of its burden to prove every essential element of the crime beyond a reasonable doubt. See Francis v. Franklin, 471 U.S. 307, 313, 105 S. Ct. 1965, 85 L. Ed. 2d 344 (1985); Sandstrom v. Montana, 442 U.S. 510, 520-24, 99 S. Ct. 2450, 61 L. Ed. 2d 39 (1979).

Nevertheless, permissive inference instructions, such as the instruction challenged here, are constitutional if the conclusion the instructions suggest can be justified by reason and common sense in light of the proven facts before the jury. Francis, 471 U.S. at 314-15; [*58] Hanna v. Riveland, 87 F.3d 1034, 1037 (9th Cir. 1996); United States v. Warren, 25 F.3d 890, 897 (9th Cir. 1994). Permissive inference instructions do not affect the application of the "beyond a reasonable doubt" proof standard unless there is no rational way the jury could make the connection permitted by the inference.

Ulster County Court v. Allen, 442 U.S. 140, 157, 99 S. Ct. 2213, 60 L. Ed. 2d 777 (1979) ("Because [a] permissive inference instruction leaves the trier of fact free to credit or reject the inference and does not shift the burden of proof, it affects the application of the 'beyond a reasonable doubt' standard only if, under the facts of the case, there is no rational way the trier [of fact] could make the connection permitted by the inference."); Warren, 25 F.3d at 897 n.4.

The Ninth Circuit has found that CALJIC 2.03 is constitutional. Turner v. Marshall, 63 F.3d 807, 819-20 (9th Cir. 1995), overruled on other grounds by Tolbert v. Page, 182 F.3d 677 (9th Cir. 1999) (en banc). In Turner, the Ninth Circuit explained that CALJIC 2.03 comports with the Constitution "[s]o long as the instruction does not state that inconsistent statements constitute evidence of guilt, [*59] but merely states that the jury may consider them as indicating a consciousness of guilt. 63 F.3d at 820.

Here, Turner forecloses Petitioner's challenge to CALJIC 2.03. Petitioner's jury was instructed that, if it found that Petitioner had made willfully false or deliberately misleading statements before trial, the jury could, but was not required to, consider that as evidence tending to show a consciousness of guilt. Accordingly, CALJIC 2.03 did not improperly relieve the State of its burden of proof or require the jury to infer guilt or even consciousness of guilt. On the contrary, CALJIC 2.03 admonished the jury that it could not reach a guilty verdict based only on a finding that Petitioner made a willfully false statement about the crime. Moreover, as the court of appeal observed, the prosecutor introduced ample evidence - including uncontroverted medical testimony - establishing the falsity of Petitioner's account of how his victim was injured. (Lodged Doc. No. 6 at 13-14.)

Consequently, Petitioner is not entitled to habeas relief with respect to this claim.

G. Cumulative Error

In his final claim for relief, Petitioner contends that the cumulative impact of the purported trial errors [*60] set forth in Petitioner's various claims for relief rendered his trial fundamentally unfair. The Supreme Court has found that the combined effect of multiple trial court errors violates due process where it renders the resulting criminal trial fundamentally unfair. Chambers v. Mississippi, 410 U.S. 284, 298, 93 S. Ct. 1038, 35 L. Ed. 2d 297 (1973) (combined effect of individual errors "denied [Chambers] a trial in accord with traditional and fundamental standards of due process" and "deprived Chambers of a fair trial"); Montana v. Egelhoff, 518 U.S. 37, 53, 116 S. Ct. 2013, 135 L. Ed. 2d 361 (1996) (stating that Chambers held that "erroneous evidentiary rulings can, in combination, rise to the level of a due process violation"); Taylor v. Kentucky, 436 U.S. 478, 487 n.15, 98 S. Ct. 1930, 56 L. Ed. 2d 468 (1978) ("[T]he cumulative effect of the potentially damaging circumstances of this case violated the due process guarantee of fundamental fairness. . . .").

According to the Ninth Circuit, these Supreme Court cases show that the "cumulative effect doctrine" is "clearly established." Parle v. Runnels, 505 F.3d 922, 927 (9th Cir. 2007). Thus, in the Ninth Circuit, "the cumulative effect [*61] of multiple errors can violate due process even where no single error rises to the level of a constitutional violation or would independently warrant reversal." Id. (citing Chambers, 410 U.S. at 290 n.3).

Cumulative error, however, does not warrant habeas relief unless the errors have "'so infected the trial with unfairness as to make the resulting conviction a denial of due process.'" Parle, 505 F.3d at 927 (quoting Donnelly v. DeChristoforo, 416 U.S. 637, 643, 94 S. Ct. 1868, 40 L. Ed. 2d 431 (1974)). This standard can be met only if the "combined effect of the errors had a 'substantial and injurious effect or influence on the jury's verdict.'" Parle, 505 F.3d at 927 (quoting Brecht, 507 U.S. at 637). "In simpler terms, where the combined effect of individually harmless errors renders a criminal defense "far less persuasive than it might [otherwise] have been," the resulting conviction violates due process. Parle, 505 F.3d

at 927 (quoting Chambers, 410 U.S. at 294, 302-03).

Here, Petitioner's cumulative error claim does not warrant habeas relief. Because this Court has found no merit to any of Petitioner's claims, Petitioner has not shown his petition should be reversed for cumulative [*62] error. Mancuso v. Olivarez, 292 F.3d 939, 957 (9th Cir. 2002) ("Because there is no single constitutional error in this case, there is nothing to accumulate to a level of a constitutional violation."); Rupe v. Wood, 93 F.3d 1434, 1445 (9th Cir. 1996) (same).

As such, the state court's rejection of Petitioner's cumulative error claim was neither contrary to, nor an unreasonable application of, clearly established federal law. Consequently, habeas relief is not warranted.

VII. RECOMMENDATION

The Magistrate Judge therefore recommends that the Court issue an order: (1) approving and adopting this Report and Recommendation; and (2) directing that judgment be entered denying the Petition on the merits with prejudice.

DATED: April 14, 2011

/s/ FREDERICK F. MUMM

FREDERICK F. MUMM

United States Magistrate Judge

NOTICE

Reports and Recommendations are not appealable to the Court of Appeals, but are subject to the right of any party to timely file Objections as provided in the Local Rules Governing the Duties of the Magistrate Judges, and review by the District Judge whose initials appear in the docket number. No Notice of Appeal pursuant to the Federal Rules of Appellate Procedure should be filed until [*63] entry of the Judgment of the District Court.

Top of Form

Bottom of Form

UNITED STATES DISTRICT COURT

CENTRAL DISTRICT OF CALIFORNIA

WESTERN DIVISION

DAVID V. PATKINS,

Petitioner,

v.

RICHARD J. SUBIA, Warden,

Respondent.

CASE NO. CV 07-1124 DMG (FFM)

ORDER ADOPTING FINDINGS, CONCLUSIONS AND RECOMMENDATIONS OF UNITED STATES MAGISTRATE JUDGE

Pursuant to 28 U.S.C. § 636, the Court has reviewed the entire record in this action, the attached Report and Recommendation of United States Magistrate Judge ("Report"), and the objections thereto. Good cause appearing, the Court concurs with and adopts the findings of fact, conclusions of law, and recommendations contained in the Report after having made a *de novo* determination of the portions to which objections were directed.

IT IS ORDERED that judgment be entered denying the Petition on the merits with prejudice.

DATED: September 14, 2011

DOLLY M. GEE
United States District Judge

UNITED STATES DISTRICT COURT

CENTRAL DISTRICT OF CALIFORNIA

WESTERN DIVISION

DAVID V. PATKINS, Petitioner, v. RICHARD J. SUBIA, Warden, Respondent.	NO. EDCV 07-1124 DMG (FFM) ORDER DENYING CERTIFICATE OF APPEALABILITY

Effective December 1, 2009, Rule 11(a) of the Rules Governing § 2254 Actions provides:

> (a) Certificate of Appealability. The district court must issue or deny a certificate of appealability when it enters a final order adverse to the applicant. Before entering the final order, the court may direct the parties to submit arguments on whether a certificate should issue. If the court issues a certificate, the court must state the specific issue or issues that satisfy the showing required by 28 U.S.C. § 2253(c)(2). If the court denies a certificate, the parties may not appeal the denial but may seek a certificate from the court of appeals under Federal Rule of Appellate Procedure 22. A motion to reconsider a denial does not extend the time to appeal.

///

///

Here, given the Court's ruling on settled legal issues, the Court does not require any arguments from the parties on whether a certificate of appealability ("COA") should issue.

Under 28 U.S.C. § 2253(c)(2), a COA may issue "only if the applicant has made a substantial showing of the denial of a constitutional right." Here, the Court dismissed the petition on the merits. Thus, the Court's determination of whether a COA should issue here is governed by the Supreme Court's decision in *Slack v. McDaniel*, 529 U.S. 473, 120 S.Ct. 1595, 146 L. Ed. 2d 542 (2000), where the Supreme Court held that the showing required to satisfy section 2253(c) after a habeas petition is denied on the merits is as follows:

> The petitioner must demonstrate that reasonable jurists would find the district court's assessments of the constitutional claims debatable or wrong.

529 U.S. at 484.

Here, the Court finds that reasonable jurists would not find the district court's decision debatable or wrong.

Accordingly, a COA is not appropriate with respect to the judgment entered herein and is DENIED.

Dated: September 14, 2011

DOLLY M. GEE
United States District Judge

Presented by:

/S/ FREDERICK F. MUMM
FREDERICK F. MUMM
United States Magistrate Judge

UNITED STATES COURT OF APPEALS

FOR THE NINTH CIRCUIT

DAVID C. PATKINS, Petitioner - Appellant, v. RICHARD J. SUBIA, Warden, Respondent - Appellee.	No. 11-56680 D.C. No. 5:07-cv-01124-DMG-FFM Central District of California, Riverside ORDER

Before: SCHROEDER and M. SMITH, Circuit Judges.

The request for a certificate of appealability is denied. *See* 28 U.S.C. § 2253(c)(2). All pending motions, if any, are denied as moot.

UNITED STATES COURT OF APPEALS

FOR THE NINTH CIRCUIT

DAVID C. PATKINS, Petitioner - Appellant, v. RICHARD J. SUBIA, Warden, Respondent - Appellee.	No. 11-56680 D.C. No. 5:07-cv-01124-DMG-FFM Central District of California, Riverside ORDER

Before: SCHROEDER and MURGUIA, Circuit Judges.

Appellant's (1) motion for an extension of time to file a motion for reconsideration and (2) motion to file an extended motion for reconsideration are granted. Appellant's motion for reconsideration is denied. *See* 9th Cir. R. 27-10.

No further filings will be entertained in this closed case.

Supreme Court of the United States
Office of the Clerk
Washington, DC 20543-0001

Scott S. Harris
Clerk of the Court
(202) 479-3011

February 11, 2014

Mr. David C. Patkins
Prisoner ID T-73612
P. O. Box 705
Soledad, CA 93960

Re: David C. Patkins
v. Richard J. Subia, Warden
No. 13-8654

Dear Mr. Patkins:

The petition for a writ of certiorari in the above entitled case was filed on February 3, 2014 and placed on the docket February 11, 2014 as No. 13-8654.

A form is enclosed for notifying opposing counsel that the case was docketed.

Sincerely,

Scott S. Harris, Clerk

by

Redmond K. Barnes
Case Analyst

Enclosures

Supreme Court of the United States
Office of the Clerk
Washington, DC 20543-0001

Scott S. Harris
Clerk of the Court
(202) 479-3011

April 21, 2014

Mr. David C. Patkins
Prisoner ID T-73612
P. O. Box 705
Soledad, CA 93960

Re: David C. Patkins
v. Richard J. Subia, Warden
No. 13-8654

Dear Mr. Patkins:

The Court today entered the following order in the above-entitled case:

The petition for a writ of certiorari is denied.

Sincerely,

Scott S. Harris

Scott S. Harris, Clerk

ATTACHMENT 3

Riverside Police Department
CA0331300

SUPPLEMENTAL REPORT

Date Prepared: 04-29-01

1. Original File No.	2.	3. Off. ID	4. Dist.	5. Crime-Ct.	6. Crime-Ct.	7. Crime-Ct.	8. Date / Time Occurred	9. Day
P3-01-118-065		626	G08				04-28-01 / 0600	7

10. Date / Time Assigned	11. Date / Time Inv. Start	12. Date / Time Inv. Term.	13. Type Clr.	14. Type Cont.	15. Additional Adults Arr.	16. Additional
28-01 / 0920	/	/			0	0

Address of Occurrence (Street No. - Name - City - Zip): 1370 Via Vista Dr., Riverside

18. Type of Place: Residence

For ID USE: V = Victim, I = Informant, W = Witness, O = Other

19. ID:	20. Last Name - First - Middle (Firm Name if Business)	21. Race - Sex	22. DOB
V	Patkins, Erik James	W - M	10-25-00

23. Residence Address	24. Business or School Address	25. Home Phone	26. Bus. Phone
1370 Via Vista Dr., RV 92506	N/A	(909) 780-2401	

27. ID:	28. Last Name - First - Middle (Firm Name if Business)	29. Race - Sex	30. DOB
P1	Garofano, Margie Ann	W - F	09-13-59

31. Residence Address	32. Business or School Address	33. Home Phone	34. Bus. Phone
1370 Via Vista Dr., RV 92506	San Antonio Community Hospital, Upland	(909) 780-2401	(909) 985-2811

SUSPECT

35. Last Name - First - Middle	36. Race - Sex	37. Age	38. Ht.	39. Wt.	40. Hr.	41. Eyes	42. DOB or ID	43. Arrested
Patkins, David Charles	W - M	36	6-02	220	BRN	BRN	03-24-65	Yes ☒ No ☐

44. Address - Clothing - Other Marks or Identifying Characteristics: 1370 Via Vista Dr., RV 92506 BKG #200114482

45. Juv: Other Disp: Juris. ( ) 2 | Juv. Ct. Prob. ( ) 5 | Within Dept. ( ) 6 | Detained ( ) 1 | Not Detained ( ) 2

SUSPECT

46. Last Name - First - Middle	47. Race - Sex	48. Age	49. Ht.	50. Wt.	51. Hr.	52. Eyes	53. DOB or ID	54. Arrested
								Yes ☐ No ☐

55. Address - Clothing - Other Marks or Identifying Characteristics:

56. Juv: Other Disp: Juris. ( ) 2 | Juv. Ct. Prob. ( ) 5 | Within Dept. ( ) 6 | Detained ( ) 1 | Not Detained ( ) 2

ORIGINALLY REPORTED DOLLAR VALUES ARE CHANGED AS SHOWN BELOW

Cat.	A Currency Notes	B Jewelry Prec. Met.	C Clothing Furs	E Office Equip.	F T.V. - Radio Cameras	G Firearms	H Household Goods	I Consum. Goods	J Livestock	K Misc.
PS	$	$	$	$	$	$	$	$	$	$
PR	$	$	$	$	$	$	$	$	$	$

60. Originally Reported Offenses (Code - Crime)	61. Original Offenses Changed to (Code - Crime)
(1) Incident Report	(1) 273a(a) PC
(2)	(2)

58. Stolen Auto Value ASP

59. Recovered Auto Value A2

Reporting Officer: M. Bartholomew

Reviewed By

COPIES TO

62. Narrative of Supplemental Report

FOR FURTHER, SEE PAGE 2

VCLO ( )

ACTIONS

APB Sent

APB Cancld

APR Sent

APR Cancld

DOJ - NCIC Entered

Cancld.

ENTERED

STATS	ARBK	ANI

After the photographs, Det. Masson conducted a search of the residence and collected several items of evidence (see his supplemental report for details).

I took measurements of the lower portion of the stairs, the crib, the master bedroom bed, the office bed, and the chair in the baby's room. All measurements were taken with a standard tape measure.

Stairs:

The lower portion of the stairway between the ground floor and upper floor consisted of seven steps, including the middle landing. Each step was approximately 7" in height and between 10 ½ " and 11" in width. The landing (step 7) was 3'2 ¼" in width. The height of the lower portion of the stairwell was 5' (from floor to landing). Steps 1 through 6 were approximately 3' wide. The stairwell appeared to be carpeted with the same carpet as the rest of the house (off-white pile carpeting).

Master Bedroom Bed:

The bed, what appears to be a standard king size bed, was 6' side by 6'11" long; the total height of the bed from the top of the mattress to the floor was 26". The bed, which has a wood frame, had an approximately 5" gap at the foot of the bed between the mattress and the end board; there was a 2" gap between the mattress and the wood headboard. The bed was approximately 9" from the wooded dresser located on the right side of the bed.

Crib:

The crib (possibly "Franklin" brand) was wood-colored. It stands 3'6" tall as measured from the floor to the top of the headboard and is 4'6" in length. The sliding rail on the crib is 2'3 ½" in height and consists of eleven slats. There is an approximately 3 ¼" gap between each slat. The interior of the crib was 4'5" in length by 2'4" in width. The distance between the top of the sliding rail (raised) to the top of the mattress pad was found to be about 11".

Chair near crib:

The blue upholstered chair in V-Erik's room was 39" tall, 28" wide (from front of the seat to the back rest, and the seat was 17" from the floor.

Office Bed:

The bed found in the upstairs office measured 3'6" wide by 6'2" long by 28" tall. It had a standard medal frame with no head or footboard. A baby pad/play toy was lying on the top of the bed.

Follow-up:

Prior to the end of the search, I received a message to call Riverside Community Hospital. "Yolanda" advised me that a radiologist had reviewed V-Erik's X-rays and found what was thought to be a fracture in each femur.

I was also asked to call Loma Linda University Medical Center Pediatrics ER. I spoke with an ER doctor who told me they did not believe the fractures did exist based on their x-rays. I was told that new CT scans had revealed increased pressure in V-Erik's brain; a tube was going to be inserted in an attempt to relieve the pressure. Some type of old diffusion (old injury) was seen in the CT scan also, which is consistent with past bleeding due to an older injury. No obvious trauma to the head was observed; all the multiple injuries were observed inside V-Erik's head. The injuries were unlikely to be consistent with the story provided by S-David of the circumstances of the injury.

Based on the medical information, and the inspection of the scene, it was determined that the injuries sustained by V-Erik were consistent with abuse. As S-David was the primary caregiver at the time of the injury, he was arrested for the listed charges and booked into RCJ (see Ofc. Dorado's supplemental report).

Det. Masson, Sgt. DeLaRosa, D.D.A. Hughes, and I went to LLUMC to check the status of V-Erik and to contact P1-Margie. She was interviewed in the family consultation room in the Pediatric ICU (Unit 5700). For further, refer to Det. Masson's supplemental report.

Disposition:

Case to be referred to the Riverside County District Attorney's Office for filing consideration.

ATTACHMENT 4

NOT TO BE PUBLISHED IN OFFICIAL REPORTS

IN THE COURT OF APPEAL OF THE STATE OF CALIFORNIA

FOURTH APPELLATE DISTRICT

DIVISION TWO

THE PEOPLE, Plaintiff and Respondent, v. DAVID CHARLES PATKINS, Defendant and Appellant.	E032757 (Super.Ct.No. RIF096844) **OPINION**

APPEAL from the Superior Court of Riverside County. Patrick F. Magers, Judge. Affirmed with directions.

Sharon M. Jones, under appointment by the Court of Appeal, for Defendant and Appellant.

Bill Lockyer, Attorney General, Robert R. Anderson, Chief Assistant Attorney General, Gary W. Schons, Senior Assistant Attorney General, Gil P. Gonzalez, Supervising Deputy Attorney General, and Garrett Beaumont, Senior Deputy Attorney General, for Plaintiff and Respondent.

A jury found defendant guilty of second degree murder (Pen. Code, § 187)[1] (count 1), child abuse resulting in death (§ 273a) (count 2), and possession of brass knuckles (§ 12020, subd. (a)). The trial court thereafter found true that defendant had previously been convicted of a serious and/or violent felony (§§ 667, subds. (a)-(e), 1170.12). As a result, defendant was sentenced to a total term of 59 years to life in state prison. On appeal, defendant contends (1) the trial court abused its discretion in admitting his prior child abuse offense, (2) the trial court erred in instructing the jury with the consciousness of guilt (CALJIC No. 2.03) instruction, and (3) the abstract of judgment must be corrected to reflect the oral pronouncement of judgment. We agree the abstract of judgment must be amended but reject defendant's remaining contentions.

I

FACTUAL BACKGROUND

In February 2000, after impregnating his girlfriend, Margie Garofano, defendant moved into her house. On October 25, 2000, Margie gave birth to their son, Erik. After Margie's maternity leave expired, she went back to work, working the night shift three nights a week from 7:00 p.m. until 7:00 a.m. as a critical care nurse. Defendant worked occasionally as a handyman and painter, providing about 10 percent of the family income.

---

1 All future statutory references are to the Penal Code unless otherwise stated.

Defendant became impatient with Erik when he cried. He also grew jealous of the attention Margie gave Erik. In March 2001, a few days before Erik's four month well-baby checkup with his doctor, Margie noticed a bump on the back of Erik's head. When she asked defendant what happened, he said Erik hit his head on the coffee table when he rolled off the couch. During the well-baby appointment, after Margie described the way defendant sometimes flipped Erik on his forearm, the doctor told defendant that was a dangerous way to hold the baby. Margie obtained some pamphlets from the doctor about "shaken baby syndrome" and left them out for defendant to read.

Defendant and Margie, who never married, began to argue about Margie's concern that defendant did not contribute financially to the family. As time went on, the arguments became more heated, and Margie asked defendant to move out two or three times. Defendant said that he would move out if she gave him $6,000 so he could get his life back together. Margie did not have that much money, but she gave defendant a check for $2,000 in early April.

On April 27, 2001, when Margie left for work about 6:20 p.m., Erik was healthy. Margie worked all night. About 6:30 a.m. the following morning, defendant telephoned Margie and asked her to come home from work right away because Erik was hurt. When Margie asked defendant what happened, defendant said Erik injured his shoulder around 5:30 a.m., when defendant tripped and fell on the carpeted stairs while he was holding the baby. Margie asked defendant if he called 911, and defendant replied that he had not yet done so. Margie then told defendant to call 911 and get Erik to the hospital. Although

defendant seemed reluctant to do so, he called 911. After Margie hung up the telephone with defendant, she went home immediately.

Responding paramedics found defendant and Erik in an upstairs bedroom. A paramedic observed the baby lying on the bed, looking somewhat drowsy, with a weak cry but no external injuries. When the paramedic asked defendant what happened, defendant said that he dropped the baby while climbing the stairs when the dog got in his way. The paramedic estimated an 18-inch drop after examining the stairs. The stairs were each seven inches high and three feet wide. Defendant agreed to accompany Erik to the hospital.

After Margie arrived at the hospital, she unsuccessfully attempted to waken Erik by calling his name and touching his chest. When Margie manually lifted Erik's eyelids, one pupil looked down and the other looked straight ahead. This alarmed Margie because, as a trained nurse, she knew that this was a sign of a head injury. Erik then awoke, arched his head back, and began kicking his legs and crying. Margie noticed, however, that Erik could not move his eyes.

After Margie found a doctor, the doctor asked defendant what happened. Defendant stated that Erik hit his head on the stairs when defendant dropped him. Erik was then taken to be treated. While they waited for the results of the examination, Margie again asked defendant how Erik got hurt. Defendant said it was an accident.

Dr. Sonne, the emergency room doctor who attended to Erik, ordered a CT scan of Erik's brain after noting that Erik was "posturing" with one arm stiff near his side, that

his eyes were staring in a fixed position, and that he had a high pitched cry, all indicators of abnormal brain functions. The CT scan showed skull fractures on both sides of Erik's head, bleeding between the brain and left skull, a subdural hematoma on the left side of the brain, and blood inside the frontal cortex of the brain. Erik's brain was swollen, indicating trauma. X-rays of Erik's body also revealed a healing fracture of Erik's femur. Dr. Sonne opined that the CT scan and lesions in Erik's brain were inconsistent with the history of the injury given by defendant. The doctor suspected child abuse and recommended that a child abuse workup be performed.

Erik was then transferred to Loma Linda Hospital for intensive care treatment. The treating doctor concluded Erik's condition was critical and ordered a child abuse workup. After reviewing the child abuse evaluation, the doctor concluded Erik's injuries contradicted the history provided by defendant. An eye examination revealed extensive bilateral retinal hemorrhaging. The examination suggested abusive head trauma as a result of being shaken.

Erik died three days later, on May 1, 2001, after unsuccessful efforts to relieve the swelling in his brain to keep him alive. An autopsy revealed optic nerve bleeding, which, like the retinal hemorrhaging, indicated a shaking injury. An older fracture to Erik's femur and a more recent fracture to Erik's rib also indicated Erik had been shaken. The skull fractures and subdural hemorrhaging indicated abusive head trauma. The extent of the injuries, particularly the skull fractures, stemmed from an impact greater than that

which would occur from a fall to a carpeted floor. Abusive head trauma, rather than an accidental fall, caused Erik's injuries.

A pair of brass knuckles were found by police on April 28, 2001, inside a drawer in Margie's garage. Defendant had found them at a park and kept them in the garage.

II

DISCUSSION

A. *Admission of Prior Child Abuse Offense*

Defendant contends the trial court abused its discretion in admitting evidence of his prior 1993 offense of child abuse (§ 273, subd. (a)(1)) inflicting great bodily injury (§ 11022.7). Specifically, he claims that, while the evidence was probative, it was nevertheless "so overwhelmingly prejudicial and inflammatory" that its admission requires reversal of the judgment. We disagree.

Prior to trial, the prosecutor sought to admit specific instances of prior conduct by defendant toward another son, Jack, in 1993, which resulted in defendant's conviction by guilty plea of child abuse inflicting great bodily injury. The prosecutor argued the evidence was admissible under Evidence Code section 1101, subdivision (b) to prove defendant's intent, knowledge of the danger in shaking a baby, lack of mistake, and lack of accident in the instant charged offenses of second degree murder and child abuse. Defense counsel asserted evidence of defendant's prior conduct and conviction were "extremely" prejudicial, "overkill," and improper propensity evidence.

The trial court admitted the evidence, finding: "As far as the [Evidence Code section] 1101[, subdivision](b) evidence, I believe it's highly probative in this kind of case. It clearly goes to intent, implied malice, as well as lack of accident. The jury will be admonished in the [Evidence Code section] 1101[, subdivision](b) instruction that they cannot consider this for disposition evidence, and if the People argue disposition evidence, obviously that would be prosecutorial misconduct, and this matter would be subject to a mistrial if that should occur. [¶] The jury will be advised that this evidence is to be considered only as it relates to the issue of intent and lack of accident or mistake. [¶] Under [Evidence Code section] 352, balancing the probative value of this evidence against the possible prejudicial effect, I feel that it weighs in favor of its admissibility. And for the challenge, therefore, the challenge under [Evidence Code section] 352 will be denied."

The admitted evidence showed that defendant lived with and impregnated another girlfriend, Michelle McFarland, who gave birth to their baby, Jack, in March of 1993. In May 1993, Michelle saw defendant shake Jack, hard, for several seconds. The following day, Michelle took Jack and moved to Iowa, where she stayed for about two weeks until defendant contacted her and coaxed her into returning to California. Sometime later, when Michelle noticed a red mark on the back of the baby's head, defendant said the baby hit his head on the windowsill while defendant was holding him.

On July 1, 1993, Michelle and defendant had an argument while they were in the car with Jack. Michelle got out of the car and walked home. When Michelle got home,

she noted that Jack's crying seemed unusual. The next morning Jack had a fever, and Michelle called the doctor to arrange for an appointment. Defendant, however, did not want to take Jack to the doctor. Defendant continued to resist taking Jack to the doctor, even though Jack's condition worsened over the next few days.

Michelle finally took Jack to the hospital on July 3, 1993. A CT scan revealed a skull fracture. When Michelle relayed this information to defendant, defendant said he dropped the baby while bathing in the shower that morning. The following day, when defendant was interviewed by a police officer investigating the cause of Jack's injuries, defendant again stated that Jack slipped from his hands when he was bathing Jack in the shower. Defendant also told the officer that a month earlier Jack had fallen to the floor when defendant "clipped" the bedpost while carrying him.

In August 1993, defendant pleaded guilty to child abuse (§ 273, subd. (a)(1)) and admitted that he inflicted great bodily injury on the baby (§ 12027). Several years later, defendant admitted to Michelle that he held Jack upside down by the feet while shaking him.

There was also testimony from Dr. Rebecca Piantini, a forensic pediatrician who examined Jack's medical records relating to his injuries. Although Dr. Piantini neither spoke with any of Jack's treating doctors nor examined any X-rays or CT scans in Jack's case, she opined that Jack's injuries were likely to have been abusive injuries and unlikely to have been caused by a fall from defendant's arms in the shower.

Defendant claims the trial court abused its discretion in admitting the foregoing evidence because it was inflammatory, it confused the issues, it involved conduct remote in time, and it consumed an undue amount of trial time. We find no abuse.

"Character evidence is inadmissible when offered to prove conduct on a specified occasion. (Evid. Code, § 1101, subd. (a).) The purpose of this rule is to avoid placing an accused in the position of defending against crimes for which he [or she] has not been charged and to avoid having a jury convict him [or her] on prejudicial character evidence alone. [Citation.]" (*Blackburn v. Superior Court* (1993) 21 Cal.App.4th 414, 430; accord, *People v. Ewoldt* (1994) 7 Cal.4th 380, 393 (*Ewoldt*).)

Under Evidence Code section 1101, subdivision (b), evidence that a defendant committed other crimes, civil wrongs, or other acts is admissible under Evidence Code section 1101 if it is relevant to prove a fact (e.g., motive, intent, knowledge, absence of mistake or accident, or common plan or design) other than the defendant's disposition to commit the charged crime. (*Ewoldt, supra*, 7 Cal.4th at p. 393.)

The admissibility of such evidence "depends upon three principal factors: (1) the materiality of the fact sought to be proved or disproved; (2) the tendency of the uncharged crime to prove or disprove the material fact; and (3) the existence of any rule or policy requiring the exclusion of relevant evidence." (*People v. Thompson* (1980) 27 Cal.3d 303, 315, italics omitted, disapproved on another ground in *People v. Williams* (1988) 44 Cal.3d 883, 907, fn. 7.)

In determining whether evidence of other crimes has a tendency to prove a material fact in dispute, the court must first determine whether or not the uncharged offense serves "'"logically, naturally, and by reasonable inference"' to establish that fact." (*People v. Thompson, supra*, 27 Cal.3d at p. 316.) Moreover, "[e]vidence of uncharged offenses 'is so prejudicial that its admission requires extremely careful analysis. [Citations.]' [Citations.] 'Since "substantial prejudicial effect [is] inherent in [such] evidence," uncharged offenses are admissible only if they have substantial probative value.' [Citation.]" (*Ewoldt, supra*, 7 Cal.4th at p. 404, italics omitted.)

"The least degree of similarity (between the uncharged act and the charged offense) is required in order to prove intent. [Citation.] '[T]he recurrence of a similar result . . . tends (increasingly with each instance) to negative accident or inadvertence or self-defense or good faith or other innocent mental state, and tends to establish . . . the presence of the normal, i.e., criminal intent accompanying such an act . . . .' [Citation.] In order to be admissible to prove intent, the uncharged misconduct must be sufficiently similar to support the inference that the defendant '"probably harbor[ed] the same intent in each instance." [Citations.]' [Citation.]" (*Ewoldt, supra*, 7 Cal.4th at p. 402; see also *People v. Yeoman* (2003) 31 Cal.4th 93, 121-122.)

Even where evidence is not required to be excluded under Evidence Code section 1101, a further inquiry under Evidence Code section 352 is required. (*People v. Balcom* (1994) 7 Cal.4th 414, 426-427.) In other words, for other crimes evidence to be admissible, the trial court not only must find that the probative value of that evidence is

substantial but also must determine whether that probative value "is 'substantially outweighed by the probability that its admission [would] . . . create substantial danger of undue prejudice, of confusing the issues, or of misleading the jury.' [Citation.]" (*Ewoldt, supra*, 7 Cal.4th at p. 404, quoting Evid. Code, § 352.) On appeal, we review the trial court's rulings on both questions for abuse of discretion. (*People v. Lewis* (2001) 25 Cal.4th 610, 637; *People v. Daniels* (1991) 52 Cal.3d 815, 858.)

In the present matter, the trial court did not abuse its discretion in admitting the prior act evidence on counts 1 (second degree murder) and 2 (child abuse resulting in death) for the purposes of showing that defendant had knowledge of danger, lack of mistake or accident, and intent to commit the charged offenses. The prior act was strikingly similar to the charged offenses in counts 1 and 2. Indeed, defendant concedes the evidence was probative.

We next must address the principal question of whether the probative value of the prior crime evidence "is 'substantially outweighed by the probability that its admission [would] . . . create substantial danger of undue prejudice, of confusing the issues, or of misleading the jury.' [Citation.]" (*Ewoldt, supra*, 7 Cal.4th at p. 404, quoting Evid. Code, § 352.) As stated above, the prior act and conviction evidence was highly probative. The prejudicial effect of that evidence, on the other hand, was minimal.

Factors to consider in assessing prejudice include whether the defendant was convicted of the prior offense, which eliminates the danger that the jury would feel compelled to do so in the current case and also eliminates the need for the jury to decide

if the prior crime actually occurred, which could potentially confuse the issues. (*Ewoldt, supra*, 7 Cal.4th at p. 405.) Defendant was convicted of child abuse inflicting great bodily injury in 1993, and therefore the noted concerns do not come into play. In addition, cases have held that long distances in time do not render other crimes evidence irrelevant per se if the incidents are extremely similar, and the myriad similarities of Jack's and Erik's experiences present such a case. (See, e.g., *People v. Burns* (1987) 189 Cal.App.3d 734, 738-739; *People v. Waples* (2000) 79 Cal.App.4th 1389, 1393-1396 [this court determined extremely similar crimes committed 18 to 25 years before the present crime were relevant and admissible]; but see *People v. Harris* (1998) 60 Cal.App.4th 727, 739.)

Testimony regarding the prior crime was not inflammatory, or no more inflammatory than the charged offenses, another factor to consider in assessing whether the probative value of the evidence substantially outweighed its potential for prejudice. (*People v. Burns, supra,* 189 Cal.App.3d at pp. 738-739.) In arguing otherwise, defendant asserts that the prior crime evidence showed nothing more than defendant's propensity to commit crimes and had no other probative value. As discussed previously, the evidence was relevant to prove defendant's knowledge of the danger of shaking a baby, lack of mistake or accident, and intent to commit the charged offenses, and therefore we reject defendant's contrary claim.

The prejudice defendant complains of is the type that naturally flows from relevant, highly probative evidence. And, as noted above, the evidence of the prior act

was so highly relevant to the issues in the present case that there was very little danger the jury would have used it for an improper purpose. Moreover, the trial court limited any prejudicial impact of the prior conviction by instructing the jury, in the language of CALJIC No. 2.50, that such evidence could not be considered to prove defendant was a person of bad character or that he had a disposition to commit crimes. Considering all of the relevant factors, we conclude the trial court did not abuse its discretion in finding that the probative value of the evidence was not substantially outweighed by the probability that it would create substantial danger of undue prejudice, of confusing the issues, or of misleading the jury.

Notwithstanding the above, even if we were to assume that the trial court abused its discretion in allowing the admission of the prior crime evidence, we are unable to find that defendant was prejudiced. Even if testimony concerning the prior offense had not been admissible, we would have concluded that its introduction was harmless error under any standard. (*Chapman v. California* (1967) 386 U.S. 18, 24; *People v. Watson* (1956) 46 Cal.2d 818. 836.) There was overwhelming physical and testimonial evidence here to find that defendant killed Erik and that he committed child abuse resulting in death. The CT scan of Erik's brain showed that Erik's brain was abnormally functioning. It also showed skull fractures on both sides of Erik's head, bleeding between the brain and left skull, a subdural hematoma on the left side of the brain, and blood inside the frontal cortex of the brain. Erik's swollen brain indicated trauma. The child abuse workup, the CT scan, the lesions in Erik's brain, and an eye examination all contradicted the history

given by defendant as to Erik's injuries. Erik's complete medical examination revealed abusive head trauma as a result of being shaken. An autopsy of Erik's body showed optic nerve bleeding, which, like the retinal hemorrhaging, indicated a shaking injury. An older fracture of Erik's femur and a more recent fracture to Erik's rib also showed Erik had been shaken. There was overwhelming evidence here to indicate that Erik died as a result of abusive head trauma rather than an accidental fall.

Defendant also claims admission of the prior offense evidence violated his constitutional right to due process under the federal and state Constitutions. Substantially similar arguments recently were rejected by our Supreme Court in *People v. Yeoman*, *supra*, 31 Cal.4th at pages 122-123. As the court explained, "[w]e reject the argument because the trial court's decision to admit the evidence was correct under state law (Evid. Code, §§ 352, 1101, subd. (b); see *People v. Ewoldt*, *supra*, 7 Cal.4th 380, 402-403), was neither arbitrary nor fundamentally unfair . . . ." (*Id.* at p. 123; see also *People v. Falsetta* (1999) 21 Cal.4th 903, 917 [high court held that Evid. Code, § 1108, which permits evidence of a defendant's uncharged sex offenses to show his propensity to commit offenses of the same type, did not violate due process, reasoning that the trial court's discretion to exclude unduly prejudicial evidence under Evid. Code, § 352 saved § 1108 from the defendant's due process challenge]; see also *People v. Hoover* (2000) 77 Cal.App.4th 1020, 1025-1029 [this court held Evid. Code § 1109, which permits admission of a defendant's prior acts of domestic violence to show the defendant had a propensity to commit one or more charged offenses involving domestic violence, does not

offend due process]; *People v. Escobar* (2000) 82 Cal.App.4th 1085, 1095-1096 [same]; *People v. James* (2000) 81 Cal.App.4th 1343, 1353 [same]; *People v. Jennings* (2000) 81 Cal.App.4th 1301, 1309-1310 [same]; *People v. Brown* (2000) 77 Cal.App.4th 1324, 1331-1334 [same]; *People v. Johnson* (2000) 77 Cal.App.4th 410, 416-419 [same].) For the same reasons, Evidence Code section 1101 does not offend due process.

B. *CALJIC No. 2.03*

Defendant also argues the trial court erred in instructing the jury with the consciousness of guilt instruction (CALJIC No. 2.03). Specifically, he claims the instruction was improper because it "strongly" suggested that the defense was fabricated and the jury might therefore infer his guilt from this fabrication, and because it was an improper pinpoint instruction. We disagree.

CALJIC No. 2.03, as given to the jury, states: "If you find that before this trial the defendant made a willfully false or deliberately misleading statement concerning the crimes for which he is now being tried, you may consider that statement as a circumstance tending to prove a consciousness of guilt. However, that conduct is not sufficient by itself to prove guilt, and its weight and significance, if any, are for you to decide."

"The giving of CALJIC No. 2.03 is justified when there exists evidence that the defendant prefabricated a story to explain his conduct. The falsity of a defendant's pretrial statement may be shown by other evidence even when the pretrial statement is not inconsistent with defendant's testimony at trial." (*People v. Edwards* (1992)

8 Cal.App.4th 1092, 1103.) Prior statements, if false, may constitute evidence of consciousness of guilt even when they are exculpatory in form. (*People v. Cooper* (1970) 7 Cal.App.3d 200, 204-205.) Furthermore, false reasons for one's conduct may be circumstantial evidence of an ulterior, unspoken, and illicit motivation. (See, e.g., *People v. Osslo* (1958) 50 Cal.2d 75, 93; see also *People v. Rankin* (1992) 9 Cal.App.4th 430, 436 [CALJIC No. 2.03 should be given if defendant makes a false statement for the purpose of deflecting suspicion].)

If the defendant's pretrial statements contradict physical evidence or the testimony of trustworthy witnesses, the jury may view the making of those statements as demonstrating consciousness of guilt. (*People v. Kimble* (1988) 44 Cal.3d 480, 496, 498.) Here, there was both physical evidence (photographs of Erik's injuries and of the stairs in the house) and the testimony of trustworthy witnesses, i.e., the paramedic and the doctor, that contradicted defendant's pretrial claim that he accidentally dropped Erik while on the stairs. Accordingly, it can be a proper evidentiary basis for giving CALJIC No. 2.03.

Defendant, however, contends the instruction was improper because it suggested to the jury that he made false statements, and therefore the jury inferred his guilt from this fabrication. To the contrary, the Supreme Court has repeatedly held that the consciousness of guilt instructions (see also CALJIC Nos. 2.04 [efforts by defendant to fabricate evidence] and 2.06 [efforts by defendant to suppress evidence]) do not properly relate to mental state. In *People v. Crandell* (1988) 46 Cal.3d 833 (disapproved on

another ground in *People v. Crayton* (2002) 28 Cal.4th 346), the defendant claimed that the consciousness of guilt instructions violated due process by permitting an unfounded inference, arguing that the jury might "view 'consciousness of guilt' as equivalent to a confession, establishing all elements of the charged murder offenses, including premeditation and deliberation, though defendant might be conscious only of having committed some form of unlawful homicide." (*Crandell*, at p. 871.) The *Crandell* court rejected this argument, concluding: "Defendant's fear that the jury might have confused the psychological and legal meanings of 'guilt' is unwarranted. A reasonable juror would understand 'consciousness of guilt' to mean 'consciousness of some wrongdoing' rather than 'consciousness of having committed the specific offense charged.' The instructions advise the jury to determine what significance, if any, should be given to evidence of consciousness of guilt, and caution that such evidence is not sufficient to establish guilt, thereby clearly implying that the evidence is not the equivalent of a confession and is to be evaluated with reason and common sense. The instructions do not address the defendant's mental state at the time of the offense and do not direct or compel the drawing of impermissible inferences in regard thereto." (*Ibid.*; see also *People v. Jackson* (1996) 13 Cal.4th 1164, 1224 [unnecessary to limit the instruction by advising jury that consciousness of guilt is not probative of mental state]; *People v. Breaux* (1991) 1 Cal.4th 281, 304.) In *People v. Ashmus* (1991) 54 Cal.3d 932 (disapproved on another ground in *People v. Yeoman*, *supra*, 31 Cal.4th 93), the defendant similarly argued that the consciousness of guilt instructions violated due process by improperly implying that if he

lied about attacking a murder victim it might be inferred that he acted with intent to kill. (*Ashmus*, at p. 977.) The *Ashmus* court concluded that the instruction did not permit such an inference: "A reasonable juror simply could not have taken the words of the instruction to mean that lies by defendant supported an inference of intent to kill on his part." (*Id.* at p. 978; see also *People v. Clark* (1993) 5 Cal.4th 950, 1022.) Thus, the consciousness of guilt instructions are actually less appropriate in cases where intent is the primary issue. The rationale in *Crandell* and other California Supreme Court cases dealing with the instant issue is applicable to this case.

Defendant relies on *People v. Rubio* (1977) 71 Cal.App.3d 757, 758, where the appellate court disagreed with the giving of CALJIC No. 2.03 when the only proof that a defendant's pretrial statements are false is that they conflict with the prosecution's evidence at trial. The court reasoned: "The giving of CALJIC No. 2.03 is justified only if there exists evidence that defendant prefabricated a story to explain his conduct. This instruction is *not* applicable in the situation where a defendant makes an explanation of behavior to the police which is *consistent* with his self-serving testimony at trial that conflicts with the prosecution's evidence before the jury. In such a case, the instruction of necessity casts specific doubt on a defendant's credibility as a witness and singles out *defendant's testimony* as subject to more particular scrutiny than that attached to prosecution witnesses." (*Rubio*, at p. 769.)

In *People v. Kimble, supra*, 44 Cal.3d 480, the Supreme Court examined whether the general rule allowing admission of pretrial false statement applies only when the

"'falsity' is demonstrated by the fact that they are contrary to the defendant's own trial testimony." (*Id.* at p. 496.) The court held that such a restriction is not applicable to pretrial false statements. The court disagreed with the line of cases holding otherwise. In *People v. Bacigalupo* (1991) 1 Cal.4th 103, the Supreme Court found that the instruction did not suggest to the jurors that they could infer any mental state or degree of culpability from consciousness of guilt. It held the instruction was not biased or argumentative but was a proper instruction advising the jury of inferences that could rationally be drawn from the evidence. (*Id.* at p. 128.) In *People v. Kelly* (1991) 1 Cal.4th 495, the Supreme Court again rejected a defendant's argument that CALJIC No. 2.03 was favorable to the prosecution. (*Kelly*, at p. 531.)

Hence, in light of *Kimble*, *Bacigalupo*, and *Kelly*, it is clear that *Rubio* is no longer a correct statement of the law. (See *People v. Edwards* (1992) 8 Cal.App.4th 1092, 1103-1104; *People v. Williams* (1995) 33 Cal.App.4th 467, 478.)

Defendant further argues that CALJIC No. 2.03 constituted an impermissibly argumentative pinpoint instruction that drew an inference favorable to the prosecution. We again disagree. As the People point out, this contention has repeatedly been rejected by our Supreme Court. (*People v. Boyette* (2002) 29 Cal.4th 381, 438-439; *People v. Kipp* (1998) 18 Cal.4th 349, 375; *People v. Jackson, supra*, 13 Cal.4th 1164, 1223-1224; *People v. Kelly, supra*, 1 Cal.4th 495, 532.)

We conclude that the trial court did not err by giving CALJIC No. 2. 03.

Even if we assume the challenged instruction was inapplicable here, applying the more stringent *Chapman*[2] standard, we find any error to be harmless beyond a reasonable doubt. As stated in section II.A, *ante*, there was overwhelming physical and testimonial evidence here to find that defendant abused and killed Erik and that he gave a false explanation regarding Erik's injuries to the paramedic, the doctor, and his girlfriend. Based on the foregoing evidence, any error in instructing the jury with CALJIC No. 2.03 was harmless beyond a reasonable doubt.

C. *Correction of Abstract of Judgment*

Lastly, defendant contends, and the People agree, that the abstract of judgment must be corrected to reflect the oral pronouncement of judgment. Because the abstract of judgment erroneously indicates the 30-years-to-life sentence on count 1 (15 years doubled pursuant to the three strikes law) runs consecutively to the 50-years-to-life sentence on count 2 (25 years doubled pursuant to the three strikes), and the trial court stayed the sentence on count 1 pursuant to section 654, we agree with the parties that the abstract of judgment must be corrected accordingly.

III

DISPOSITION

The trial court is directed to amend the abstract of judgment to reflect the sentence on count 1 (second degree murder) was stayed and to forward a copy of the amended

---

2 *Chapman v. California, supra*, 386 U.S. 18, 24.

abstract to the Department of Corrections. (§§ 1213, 1216.) In all other respects, the judgment is affirmed.

NOT TO BE PUBLISHED IN OFFICIAL REPORTS

RICHLI
J.

We concur:

HOLLENHORST
Acting P.J.

McKINSTER
J.

ATTACHMENT 5

ATTACHMENT 6

him about it because it was to the point cause it was gonna get him all riled up, so, I, I knew he--

MASSON: And what do you think--

GAROFANO: --he's a person who wants--

MASSON: --would of happened?

GAROFANO: --he is his son, you know, and obviously--

MASSON: What do you think would of happened if he got riled up?

GAROFANO: Oh, he, he, he is very boisterous and ..... and--

MASSON: Did you ever see him do anything else, throw things?

GAROFANO: He threw maybe something across the room like a telephone book once, and you know, things like that, but, but kinda of out of frustration no I'm upset ..... and then, you know, threw it over there. Yeah, that kind of thing.

MASSON: How is, how is David with the baby?

GAROFANO: He seems to .....him, because I always think the baby, most of the time he's .... love to carry it, play with him, call him cuddle puddles, and things like that and um, you know, he seems very happy about the baby, and uh, if he's busy he'll put him in the swing so he's

fine. His swings are nice little safe seat thing, you know, we have and--

MASSON: You work how many hours?

GAROFANO: I work 12-hour shifts, night shift.

MASSON: For how many hours?

GAROFANO: Uh.

MASSON: I mean for how many days?

GAROFANO: Uh four days a week. I work one day a week extra for extra money.

MASSON: To make up the hours.

GAROFANO: Yeah. Just for the extra money cause we get paid extra money for the extra day.

MASSON: Okay.

GAROFANO: You know.

MASSON: So-o--

GAROFANO: I've been doing that for years though.

MASSON: --and, and what time do you go on?

GAROFANO: It's, I leave the house at 6:00 be at work by 7:00. About 6:15 and work by 7:00.

MASSON: 7:00--

GAROFANO: p.m.

MASSON: p.m?

MASSON: Okay, and you work where?

GAROFANO: San Antonio Community Hospital.

GAROFANO: I, I he's feeding him um rice cereal mixed with different kinds of baby foods--

MASSON: Uh-hum (affirmative)

GAROFANO: --and breast milk.

MASSON: And breast milk? Okay.

GAROFANO: Yeah I breast feed him.

MASSON: So you pump it and--

MASSON: Yeah, I pump it at work at night, just at night, to have some in the bottle at home, so he mixes his food--

MASSON: Okay.

GAROFANO: --and David will feed him. We're trying to get him to go back to the bottle now. We're trying to do the weaning thing.

MASSON: Right. How's the baby's appetite lately?

GAROFANO: Very good, and he eats great. I mean ..... whenever I give him ..... I was remarking to the doctor, I surprised because the very first time I gave him a spoon of food he went right for it like a, like he, oh he, I mean he's, he, even the doctor commented he seemed advanced for his age.

MASSON: Okay.

GAROFANO: I don't know why he, you know, isn't that weird it was in our park and I saw it.

HUGHES: ..... about uh the, the thing you saw on, on Eric's nose?

GAROFANO: Yeah.

HUGHES: ..... you described it is that it's like an indentation and--

GAROFANO: It was like uh--

HUGHES: --and then it blistered?

GAROFANO: --it was like a pressure sore. You know how you get pressure sores and it, when he was a little baby he had rolled over on that side of his face--

HUGHES: Okay.

GAROFANO: --and it was a pressure sore.

HUGHES: But then it did blister before?

GAROFANO: Yeah, it, it, well it half of the skin will blister and then it, and then it, he, well, he, he'd rubbed it then, you know, it broke and then it scabbed and it bled.

HUGHES: Is this something that you told you him that you've seen then .....

GAROFANO: I've seen that kind of thing in the hospital. Yeah, and I showed the doctor and the doctor said not to worry about it, and, it will be, and that's why,

cause all the kids that come out with flat heads because they telling them to stay on their backs, don't turn them yet.

HUGHES: So it's not, it wasn't like a burn perhaps?

GAROFANO: No. No, no, no. Cause--

HUGHES: ..... might--

GAROFANO: --I, I, no.

HUGHES: --just may be a drop of hot water.

GAROFANO: No, no, no it's not that. I, I thought about, it was not, and I know the difference. It was not, it was a pressure sore. And it definitely makes sense to me.

MASSON: Has he ever rough housed with the child?

GAROFANO: There was a time when the baby was crying early on, and he would, he, he would do like this upside thing you know for a few seconds, and you know, and I, at first I didn't notice it, then I saw he, he walked, he was walking the baby, you know how you, you hold the baby, he's crying, just walk around the house, you're cuddling him you know, and I walked into the den or wherever he was and I saw him with the baby he looked like a dippsy thing, like this. I said "What are you doing?" "Oh, this helps stop him from crying and it works." I said

"No, you don't do that." And, it was like he was just, he was holding him like this. You know I said "No, you don't--

MASSON: What kind of motion was it?

GAROFANO: The, the baby's in your arms, here's his head, here's his body and he just, he, supported the baby the whole time doing this.

MASSON: Was it a quick motion or jerky motion or?

GAROFANO: Like um.

MASSON: Or smooth motion?

GAROFANO: Some times smooth, some times a little bit of a jerk like that, but he had uh the hand, his whole arm against his back and head.

MASSON: So the head wasn't falling .....?

GAROFANO: No, no, I watched it. Yeah. And I said "Were you" and I didn't like that. And I, I sa and I said "Don't," I, I, it took me several times and I told him "Don't do that." And so in the office with the doctor I think I remember asking him, you know, tell, tell him, tell David "You don't do upside down with the baby things." ..... he went over that with him.

MASSON: How often did he do that?

GAROFANO: Jus', uh, just on occasion, off and on. But then I told him I didn't like it and I finally got really--that's when some arguments were starting, you know, beginning of arguments. Cause I said--

MASSON: Did you--

GAROFANO: --"I don't like that, don't do that."

MASSON: Did you happen to bring home any kind of pamphlets--

GAROFANO: Yes I did.

MASSON: --regarding to shaking .....

GAROFANO: I picked it up doctor's office and I left it out on the baby's thing, for, so it's always there when I was gone. I did it purposely.

MASSON: Okay. .....

GAROFANO: Yeah.

BARTHOLOMEW: As a result of that?

GAROFANO: Uh.

BARTHOLOMEW: ..... or before that?

GAROFANO: Well, it came with the baby from the doctor's office. It's a package thing. It was all, so, so I, I, it ..... office, I just left it out so it would be visible, so he'll, you know, he'd see it. But then, after I .....

MASSON: You, you left it out so he wouldn't do that anymore?

GAROFANO: I just left it out in the baby's room. I talked to him about it. Yeah. You know, about the shaking baby thing, you know. Yeah, because we talked about that. He didn't do that, he just, this is all I saw him do this dipping thing. That's all I ever saw.

MASSON: Where did he ..... to him.

GAROFANO: I don't know. I, I, I asked him "What is that?" "Oh, it's nothing, it's ....." It, it, it's just, you know, it's white is white, he used to say, say "So what" all the time, said "So what, it's, you don't do that" is what I said. You don't, you know?

HUGHES: How long ago did he do that?

GAROFANO: Um, around January when I saw it.

HUGHES: Did he .....

GAROFANO: Yeah, Uh-huh (affirmative).

HUGHES: Is David familiar with the shaking baby syndrome?

GAROFANO: Yeah.

HUGHES: .....

GAROFANO: And, the doctor pointed it right out to him.

HUGHES: .....

GAROFANO: Um, I don't know.

HUGHES: ..... did he say anything?

GAROFANO: Uh, gosh, ... possibly knew. I don't know ..... he knew, but I think he was aware of it. But, I, I don't know, he didn't exactly, you know, talk about it, cause I learned most of the stuff around Christmas time.

BARTHOLOMEW: ..... Christmas is when you first learned about his prior .....

GAROFANO: Um, just

BARTHOLOMEW: --inquiring about the--

GAROFANO: Yeah, I think most of it, cause I, I learned about it in pieces over time. I didn't know, there's little tidbits. You know we had this, you know, we get ..... and you know things would happen. And, and it's tidbits and I never got the whole picture at one time. It was over time I found out the picture. And after I was involved.

HUGHES: Now that you know the picture what do you think?

GAROFANO: Well, I'm thinking wu, I got myself into a mess. I'm thinking--

HUGHES: ..... used to be.

GAROFANO: Oh, after hearing that it, it definitely struck uh, a chord in myself. You know, wondering, but then

he's shown me how he um ..... while he was in prison and

(End of Tape 1)

(Start Tape 2, Side A)

GAROFANO: ..... he wanted to give into, therefore he got in trouble therefore he got put in jail. She over reacted, cause after the fact they, she wanted to get back together, she did get back together with her son and they did live again together. So here's, why would someone want to get back together if something like that so terrible happened to her son, and why is she again calling and acting so pleasant. I said everything's fine. Which makes me wonder that this makes sense either. So, it made me wonder if she was really true or if he was really true. I didn't really know who I could believe anymore to be honest.

MASSON: Did you get pregnant after he moved in?

GAROFANO: No, just before.

MASSON: Just before he moved in with you?

GAROFANO: Yeah.

MASSON: Was that a--

GAROFANO: Two months before.

MASSON: --was that a factor, or uh or did you guys already plan on him moving in?

GAROFANO: I didn't plan on him moving in at first, and then I got pregnant and he, little by little, you know, coming over doing things. It sound like, you know, I thought "Well," and, and at the time there he was very pleasant, very calm, very nice. Um, I watched my house which was very neglected for years, become little by little a beautiful place. Things were getting done, things were being fixed and you know, it felt good to have that done, so I started thinking "Well, here I am mommy dusting things and think well maybe this'll be okay, so he won't make a lot of money." In fact you know, maybe that's not all you have to have in life. I started thinking "Well, he's got, potentially he's got talent. He, you know, I could help direct him into his field of when he does" you know, "painting and what have you." He did the tile work in my bathroom, you know, the marble flooring. He's, the first time ever, he did a great job. In fact he did two other friend's jobs. Everyone he did work for at my, at hospital, supervisors, and came over, he did a good job. David love, they liked the job he did. They're

impressed. ..... he's very particular. So, he's very good at, at, so, so I thought he's got a potential in his life, you know.

MASSON: What do you think happened to uh Eric?

GAROFANO: I really don't know. I don't know. I, I have uh, it, this whole thing goes like a nightmare. I don't know because I never see it happen. I never, it's never in my view, it's never happened in front of me. It's never happened, it's like you're living in a bubble or, you're, you know, everything's fine. You go off to work, who knows what's going on at home. It could be like doctor Jeckle and Mr. Hyde for all I know. I don't know.

MASSON: Do you think David could of hurt Eric?

GAROFANO: Yes.

MASSON: And why do you think that?

GAROFANO: Based on everything you know, everything I've said. I mean, you know, you put things together, it's possible. But, what's weird is that he seems, in my presence to be so in love with the baby. So, it's very, just takes care of him. Help, ... have a bath in the morning, he brings him to me and I sit in the tub and I wash him, and then he takes him from me back to the crib and

dries him so he won't ..... in and out of the tub thing you know. I, I go and I shower, I sit down, while he hands me the baby and I hold him in my arms and then I wash him and I rinse him and then hand him back to him and he puts him back in the crib, he dries him, put's you know his diaper on, and he gets some warm blankets until I get out of the shower, and then breast feed him and we watch TV, and the baby's happy, he's pleasant and happy. I,

BARTHOLOMEW: You said he gets impatient?

GAROFANO: Yes.

BARTHOLOMEW: Kinda has a problem with being impatient?

GAROFANO: At times. Not, not all the time.

BARTHOLOMEW: Have you ever seen him become impatient with, with Eric, when he's crying or fussy or not wanting to do something?

GAROFANO: Oh, su, on occasion he would sit, he'd talk to him verbally would say "Alright," you know, like you know "Wait, for mommy" or he'd start talking to him when he is, he doesn't understand what all that means. You know, I understand what he's trying to convey to the child, but he's talking across the room to the child like, you know, "Yeah, yeah,

wait, whoa, whoa," you know. "Hey Eric, wait, mommy's still busy, mom's trying to get ready" the baby's crying cause he wants to be in my arms all the time. As soon as I start getting ready and put down, I guess he's getting a little bit spoiled, he wants to be with me and I just love being with him, you know.

MASSON: When uh, when you first got the phone call, ... had been hurt, and you're driving home, was there a gut reaction where you were skeptical that ..... the baby? .....

GAROFANO: Yeah. Um, yeah, maybe for a flash. I guess if I, to be honest, I just kinda went numb, and I just wanted to not think of anything horrible, and I had this long drive home and I thought, all I have to do, I ..... to "call 911, call 911, call 911" and just kinda like "Oh please, I don't, I don't wanna even think the terrible," and I thought, maybe it's just little something, okay, and he's being and doing the right thing like I told him, "Call me," but he's supposed to call 911 first if it's something more, but, then I thought he doesn't know the judgement like my level of judgement, so maybe he didn't know--I thought maybe

MASSON: Right.

GAROFANO: Right, right.

HUGHES: Has there ever been a period of a couple of days where, where Eric seemed to really be in distress or uh, much more normal, uh, much more than normal crying, uh irritable, um anything like that, that you noticed, even the past week?

GAROFANO: ..... if I walk out of the room he gets upset. ..... wanting to be with me, and um, he's, as long he has eye contact with me he's content as a bug, but if, if I walk out of the room for a moment he realizes I'm gone, the doctor told me about separation anxiety, but I was thinking that maybe that's, you know, the mommy thing, but I noticed he gets, he uh a few times he, he cries more than usual. Like, he'd just cry like until as if uh for me to, until I picked him up. And then, and then he, he, he, then he would cry, I play with him and he would like .... "I wanna be with you don't you understand what I'm ....." he says "Cause he's crying." I thought "Well," you know I don't wanna pick him up every single time, so I thought I, I'd let it go for a few moments and like, like

cry a little bit, before I always could grab him all the time, you know, thinking that he's geting a little older now, more aware, so I didn't wanna, you know, I was thinking that in my mimd. But, I would go pick him up finally, I'd go "Oh, come here honey" or pick him up and cuddle him, then he'd, give him about one or two minutes and he'd calm down. Like I just pick him up in my arms and just walk around the room and then, and he, and he, then he'd calm, you know, rather rapidly.

MASSON: I just mean he was like this a day or two where you'd--

GAROFANO: No.

MASSON: --he'd come home from work, you're home from work, and for whatever reason he won't go to sleep all day, and he's crying and he's agitated or irritable all day, and the baby kept you awake .....

GAROFANO: There was a day that was like that. He was, Eric, David was gone most of the day doing errands, and he was crying and I didn't sleep good that day, a full day, ... and I thought he was just growing up and being more active .....

MASSON: ..... and I'm not ..... but-

GAROFANO: Yeah.

MASSON: .....

GAROFANO: It was, it was, there was a couple of days like that this past week or so, but he, I, I just thought, because you know why I know, uh how I thought that, cause if I sat up in bed and then set him in my lap and then he's all bright, like ..... something then he stopped, and he's like u-u-u-u- ..... this time his toys and looking around and he's happy. As soon as I did that, that was ah-h-h, you know, I kept him in bed like a ..... You know older ..... can't do that. Laying in bed, you know, mommy thing.

MASSON: Right.

GAROFANO: Now we're transen, transcending to the next level where he gotta have more activity time. And I know, it's coming you know. I have uh um a playpen my doctor said, I said "Should I put him in the playpen now for an hour in the morning and an hour in the afternoon." Haven't quite done that yet, cause he has .... I didn't want any, ... knew he'd just be all emotional he likes being with me, so, I just

ATTACHMENT 10

Riverside Community Hospital
4445 Magnolia Ave
Riverside, CA 92501

PHONE #: 909-788-3400
FAX #: 909-788-3194

NAME: PATKINS,ERIC
PHYS: Sonne,Alan C
DOB: 10/25/2000 AGE: 6M 3D SEX: M
ACCT: AD0203105879 LOC: AD.ED
EXAM DATE: 04/28/2001 STATUS: DEP ER
RADIOLOGY NO:
UNIT NO: AD01105349

EXAMS: 000224422 CT BRAIN WO CONTRAST

CT OF THE BRAIN WITHOUT CONTRAST:

HISTORY: Trauma.

PROCEDURE:

Contiguous 5 mm slices were make with the GE HiSpeed Advantage CT scanner.

FINDINGS:

There are fractures of the right temporal (NEW) and left parietal (OLD) lobes without significant depression. A 3 mm thick collection of blood along the inner table of the skull in the right frontotemporal region is consistent with an epidural hematoma. A small left frontotemporal low density fluid collection is noted along the inner table of the skull. (EDEMA)

There is a 2 x 1 cm low density lesion in the left frontal lobe (CONTUSION) with a tiny amount of high density material along its dependent portion, consistent with blood. No midline shift is defined.

Some (SAH) increased density material is noted along the tentorium and posterior falx. Irregular zones of diminished density are noted in the cerebral hemispheres bilaterally, particularly the occipital lobes. Diminished density is also noted in the cerebellum.

IMPRESSION:

1. ***SMALL RIGHT TEMPORAL EPIDURAL HEMATOMA.***
2. ***BILATERAL NONDEPRESSED SKULL FRACTURES.***
3. ***SUBARACHNOID BLOOD NOTED ALONG THE POSTERIOR FALX AND TENTORIUM.***
4. ***SMALL LEFT FRONTOTEMPORAL SUBDURAL HYGROMA.***
5. ***A 2 X 1 CM PORENCEPHALIC DENSITY IN THE LEFT FRONTAL LOBE, CONTAINING A SMALL AMOUNT OF BLOOD.*** (CONTUSION)

Riverside Community Hospital
4445 Magnolia Ave
Riverside, CA 92501

PHONE #: 909-788-3400
FAX #: 909-788-3194

NAME: PATKINS,ERIC
PHYS: Sonne,Alan C
DOB: 10/25/2000 AGE: 6M 3D SEX: M
ACCT: AD0203105879 LOC: AD.ED
EXAM DATE: 04/28/2001 STATUS: DEP ER
RADIOLOGY NO:
UNIT NO: AD01105349

EXAMS: 000224422 CT BRAIN WO CONTRAST
<Continued>

6. *IRREGULAR ZONES OF DIMINISHED DENSITY IN THE CEREBRAL AND CEREBELLAR HEMISPHERES BILATERALLY CONSISTENT WITH EDEMA.*

7. *NO MIDLINE SHIFT WITH SMALL BUT NOT COMPLETELY EFFACED VENTRICLES, SULCI, FISSURES AND CISTERNS.*

THE MULTIPLICITY AND CHARACTER OF THESE VARIOUS ABNORMALITIES CERTAINLY RAISES THE POSSIBILITY OF REPEATED EPISODES OF HEAD TRAUMA OVER A PROLONGED TIME PERIOD. CLINICAL CORRELATION IS RECOMMENDED.

** Electronically Signed by Raymond P. Sakover M.D. **
** on 04/28/2001 at 1155 **
Reported and Signed by: Raymond P. Sakover, M.D.

CC: CALIFORNIA EMERGENCY PHYS GRP; Alan C. Sonne, M.D.

TECHNOLOGIST: Mark Enomoto, CRT
TRANSCRIBED DATE/TIME: 04/28/2001 (1109)
TRANSCRIPTIONIST: ADHIMMK
PRINTED DATE/TIME: 05/01/2001 (1020) BATCH NO: 5495

Riverside Community Hospital
4445 Magnolia Ave
Riverside, CA 92501

PHONE #: 909-788-3400
FAX #: 909-788-3194

NAME: PATKINS,ERIC
PHYS: CALIFORNIA EMERGENCY PHYS GRP
DOB: 10/25/2000 AGE: 6M 3D SEX: M
ACCT: AD0203105879 LOC: AD.ED
EXAM DATE: 04/28/2001 STATUS: DEP ER
RADIOLOGY NO:
UNIT NO: AD01105349

EXAMS: 000224430 ABDOMEN 1V / KUB

PORTABLE KUB:

The bowel gas pattern is not remarkable. No suspicious soft tissue density is defined.

Incidentally noted are zones of periosteal reaction of the femoral shafts bilaterally consistent with prior trauma.

IMPRESSION:

SUBACUTE TO CHRONIC PERIOSTEAL REACTIVE CHANGES OF BOTH FEMURS PROBABLY RELATED TO PRIOR TRAUMA.

** Electronically Signed by Raymond P. Sakover M.D. **
** on 04/28/2001 at 1324 **
Reported and Signed by: Raymond P. Sakover, M.D.

CC: CALIFORNIA EMERGENCY PHYS GRP

TECHNOLOGIST: Alecia Curtis, CRT
TRANSCRIBED DATE/TIME: 04/28/2001 (1207)
TRANSCRIPTIONIST: ADHIMDMD
PRINTED DATE/TIME: 05/01/2001 (1020) BATCH NO: 5495

Riverside Community Hospital
4445 Magnolia Ave
Riverside, CA 92501

PHONE #: 909-788-3400
FAX #: 909-788-3194

NAME: PATKINS,ERIC
PHYS: Sonne,Alan C
DOB: 10/25/2000 AGE: 6M 3D SEX: M
ACCT: AD0203105879 LOC: AD.ED
EXAM DATE: 04/28/2001 STATUS: DEP ER
RADIOLOGY NO:
UNIT NO: AD01105349

EXAMS: 000224424 CERVICAL SPINE 1V LATERAL

PORTABLE CERVICAL SPINE, LATERAL PROJECTION:

There is no definitive sign of fracture, displacement nor bone destruction. There is mild adenoid hypertrophy. The soft tissues of the neck are not optimally demonstrated, but there is a suggestion of prevertebral swelling.

IMPRESSION:

NO DEMONSTRABLE ABNORMALITY. A COMPLETE CERVICAL SPINE SERIES IS RECOMMENDED WHEN THE PATIENT IS BETTER ABLE TO COOPERATE.

** Electronically Signed by Raymond P. Sakover M.D. **
** on 04/28/2001 at 1324 **
Reported and Signed by: Raymond P. Sakover, M.D.

CC: CALIFORNIA EMERGENCY PHYS GRP; Alan C. Sonne, M.D.

TECHNOLOGIST: Alecia Curtis, CRT
TRANSCRIBED DATE/TIME: 04/28/2001 (1205)
TRANSCRIPTIONIST: ADHIMDMD
PRINTED DATE/TIME: 05/01/2001 (1020) BATCH NO: 5495

Signed Report Printed From PCI

Riverside Community Hospital
4445 Magnolia Ave
Riverside, CA 92501

PHONE #: 909-788-3400
FAX #: 909-788-3194

NAME: PATKINS,ERIC
PHYS: Sonne,Alan C
DOB: 10/25/2000 AGE: 6M 3D SEX: M
ACCT: AD0203105879 LOC: AD.ED
EXAM DATE: 04/28/2001 STATUS: DEP ER
RADIOLOGY NO:
UNIT NO: AD01105349

EXAMS: 000224423 CHEST 1 VIEW

PORTABLE CHEST, SUPINE:

A frontal view of the chest reveals the appearance of the heart and mediastinum to be within normal limits for this portable technique.

The lungs are clear. Pulmonary vascular markings are essentially normal. There is no major abnormality of bone structures for the patient's age, although this image is not a detailed examination of thoracic skeletal architecture.

IMPRESSION:

NO ACUTE CARDIOPULMONARY PATHOLOGY IS DETECTED ON PORTABLE CHEST RADIOGRAPHY.

** Electronically Signed by Raymond P. Sakover M.D. **
** on 04/28/2001 at 1324 **
Reported and Signed by: Raymond P. Sakover, M.D.

CC: CALIFORNIA EMERGENCY PHYS GRP; Alan C. Sonne, M.D.

TECHNOLOGIST: Alecia Curtis, CRT
TRANSCRIBED DATE/TIME: 04/28/2001 (1203)
TRANSCRIPTIONIST: ADHIMDMD
PRINTED DATE/TIME: 05/01/2001 (1021) BATCH NO: 5495

Riverside Community Hospital
4445 Magnolia Ave
Riverside, CA 92501

PHONE #: 909-788-3400
FAX #: 909-788-3194

NAME: PATKINS,ERIC
PHYS: Sonne,Alan C
DOB: 10/25/2000 AGE: 6M 3D SEX: M
ACCT: AD0203105879 LOC: AD.ED
EXAM DATE: 04/28/2001 STATUS: DEP ER
RADIOLOGY NO:
UNIT NO: AD01105349

EXAMS: 000224436 CHEST 1 VIEW

CHEST, SINGLE VIEW - 04/28/2001:

The lungs are clear. The costophrenic sulci are free of fluid. The pulmonary vessels are normally distributed. The cardiothymic silhouette is normal.

IMPRESSION:

NORMAL CHEST RADIOGRAPH.

** Electronically Signed by Donald R. Massee M.D. **
** on 05/06/2001 at 1046 **
Reported and Signed by: Donald R. Massee, M.D.

CC: CALIFORNIA EMERGENCY PHYS GRP; Alan C. Sonne, M.D.

TECHNOLOGIST: Alecia Curtis, CRT
TRANSCRIBED DATE/TIME: 05/04/2001 (1132)
TRANSCRIPTIONIST: ADHIMMK
PRINTED DATE/TIME: 05/06/2001 (1130) BATCH NO: 5662

CHART COPY

ATTACHMENT 16

LOMA LINDA UNIVERSITY CHILDREN'S HOSPITAL

11234 Anderson Street
Loma Linda, California 92354
(909) 825-KIDS (5437)

PATIENT: **PATKINS, Eric**

DOB: 10-25-2000

MR: 155 43 25

DATE OF CONSULTATION: 4-28-01

REFERRING PHYSICIAN: Dr. Slaughter

CONSULTING PHYSICIAN: Rebeca Piantini, MD

PATIENT IDENTIFICATION:

This is a six month old male who was transferred to LLUCH from Riverside Community Hospital on 4-28-2001 with closed head injury and altered level of consciousness.

HISTORY OF PRESENT ILLNESS:

The history is obtained from the chart. The patient was under the care of his father while mother was at work. The father's history to paramedics and referring hospital is that he was walking up the stairs with the patient and tripped and the patient fell from his arms and rolled down the stairs. This happened about 5:30 to 6:00 AM. The stairs are reported to be carpeted. Father called the mother at work, said that he needed to call 911. Paramedics received a call about 6:38 AM and arrived at the home at about 6:46 AM. They arrived at Riverside Community Hospital at 7:15 AM. Paramedics reported that the patient was alert and crying when they arrived but was agitated upon arrival at Riverside Community Hospital. On their exam, the patient was posturing with eyes deviated downward bilaterally and the right arm was twitching. The patient was intubated and started on phenobarbital, Dilantin and Valium. Head CT done at Community Hospital showed new right epidural and subdural hematoma, interhemispheric subdural hematoma and evidence of chronic subdural versus hyperacute, and there were bilateral parietal skull fractures, per preliminary report. The patient was then transferred to LLUCH for a higher level of care.

PAST MEDICAL HISTORY:

Patient was born full term vaginally to a 41 year old G1 P0. Birth weight was 10 pounds 10 ounces. Suction and forceps were used on delivery. There was meconium, however, patient did well and went home with mother. Development: Patient has started sitting. There are no known medications. There were no medications at home. There have been no reported drug allergies, no illness or hospitalizations. Patient has fallen off the bed a couple of times and was seen by a primary physician after the incidents were reported by mom. Immunizations: Patient has received two and four month immunizations. Family history: There is no family history of seizures or significant disease. Mother reported that, on one occasion, she noted a small bruise on the jawline and asked father what had happened and he said the patient had fallen from the bed.

PRINTED BY: padikuon DATE 09/15/2004

PSYCHOSOCIAL HISTORY:

Mother is 41 years old, is an RN and works at San Antonio Community Hospital. Father is 36 years old and is a painter. The parents live together and are not married.

PHYSICAL EXAMINATION:

Temperature 96, pulse 163, respirations 20, blood pressure 123/57, intercranial pressure 60, estimated weight 7 kg (25th percentile), length 70.5 cm (75th percentile) and head circumference 45 cm (around the 80th percentile). In general, the patient is intubated, sedated. There is an intracranial pressure monitor in the right frontal area. There is an external ventricular drain catheter in the left parietal area and EEG leads on the scalp. Head: Anterior fontanel is bulging and tense with an intracranial pressure monitor bolt on the right side and EDV on the left. There is dried blood on the scalp with some Betadine over the area where the monitor bolt and drains were placed. Head appears macrocephalic. Eyes: Pupils are fixed and about 3 mm. There are bilateral extensive retinal hemorrhages. Sclera is white. Ears: Tympanic membranes are clear. There is no hemotympanum and no bruises. Nose: There are small abrasions around the nares. There is an NG tube in place. Mouth: The lips are dry and cracked. There is an endotracheal tube in place. Upper and lower frenulums are intact. Neck: There is no crepitus or bruising. Lungs are clear to auscultation and ventilator sounds with symmetric air movement. Heart is regular rhythm. He is tachycardiac. There are no murmurs. Abdomen is soft. Bowel sounds are present. There is no abdominal distention, no hepatosplenomegaly and no masses. There is no abdominal bruising. Extremities: There are femoral lines bilaterally for IV access. There is a bruise on the left wrist secondary to IV access attempt. Pulses are 2+ and equal. Genitalia: Patient is circumcised Tanner stage 1 with testes descended bilaterally. Anus is within normal limits. Skin: There is a small amount of hemorrhage on the nails of the first toes bilaterally. There is a small bruise on the left wrist from the IV attempt. There are no other bruises appreciated. The skin is not hyperelastic. There is a slightly red area on the right lower quadrant of the abdomen where tape has been placed for dressing of the right femoral line. Neurological exam: Patient is sedated.

DIAGNOSTIC DATA:

WBC 19,000, hemoglobin 10.4, hematocrit 29.1, neutrophils 80, lymphocytes 15, platelet count 433,000, sodium 144, potassium 3.8, chloride 116, CO2 18, BUN 4, creatinine 0.3, glucose 121, alkaline phosphatase 398, AST 74, ALT 34. UA noted specific gravity 1.025, no leukocytes, trace protein, 500 glucose and small ketones.

April 28, 2001
RE: **PATKINS, Eric**
MR: 155 43 25

April 28: Head CT done at LLUCH was status post left frontal approach ventriculostomy placement with decompression of the ventricles. There is air and hemorrhage along the shunt tract and new intraparenchymal hemorrhage in the left frontal lobe. There was persistent low density consistent with extensive cerebral edema and/or infarction, bilateral cerebellar hemispheres, right greater than left and cerebellum. Intraventricular hemorrhage, right subdural hemorrhage, and right parafalcine hemorrhage. There is a downward transtentorial herniation.

April 30: Bone survey showed fracture of the posterior superior region of the parietal bone and periosteal reaction indicating probable fracture of the right femur.

April 30: Brain scan vascular flow/CBF study noted abnormal cerebral blood flow consistent with absent cerebral blood flow.

SUMMARY OF INJURIES:

1. Closed head injuries, subdural hematoma with significant cerebral edema.
2. Altered level of consciousness.
3. Skull fractures bilaterally.
4. Bilateral retinal hemorrhages.

IMPRESSION:

This is a six-month-old male with abusive head trauma that resulted in death.

RECOMMENDATIONS:

1. Ophthalmology consult and photographs to document retinal hemorrhages.
2. Law Enforcement is involved.
3. Mother wishes organ donation.

Rebeca Piantini, MD
Division of Forensic Pediatrics

RP/ale/5-14

ATTACHMENT
16A

REQUESTED BY ATTENDING PHYSICIAN	CONSULTING SERVICE:
Dr. A Slaughter	CAN.
REASON FOR REQUEST: CHI, ALOC - Poss NAT.	

DATE	TIME
4/28/01	2230

FD 6 mo old male transferred from RCH for CHI & ALOC.

HPI. Hx obtained from chart
pt. was under the care of his father
while mother was at work.
Father, per hx, tripped & pt fell down
& rolled down the stairs; (~5:30 AM or 6:00 AM)
stairs are carpeted. Father called mother. 911 called.
Paramedics received call @ 6:38 - arrived at ~~RCH~~
the house @ 6:46 - arrived @ RCH at 7:15.
Paramedics reported pt was alert & crying when
agitated. On arrival to RCH pt was posturing ~~[illegible]~~
c eyes deviated downward & intub R arm stiffening.
~~Intubated~~ - [illegible] / dilantin / loading given

PMH. FT born vag to a 41 y.o. G1 PO
(suction & forceps delivery (+) meconium ~~[illegible]~~.)
BW 10 ~~lbs~~ 10 oz.

Dev. sitting, 1'

NKDA.
Illnesses / hosp - has rolled off bed few times in
past - seen by PMD s incidents (per mom).

M.D. PLEASE PRINT NAME (RESIDENT)

M.D. PLEASE PRINT NAME (CONSULTING PHYSICIAN)

RESIDENT'S SIGNATURE

5725 CONSULTING PHYSICIAN'S SIGNATURE

LOMA LINDA UNIVERSITY MEDICAL CENTER

CONSULTATION REPORT

PATIENT IDENTIFICATION LAUGHTER, A
PATKINS, ERIC
AD 042801 FC 60 01554325
000101288819 ADTANAA

PRINTED BY: padikuon DATE 09/15/2004 23-0048 (12/96)

0048

2/4

REQUESTED BY ATTENDING PHYSICIAN	CONSULTING SERVICE:
REASON FOR REQUEST:	

DATE	TIME

IZ. received 2 ¢ 4mo Drg..
meds ¢.
Fam hx. ¢ Seizures.
Soc. hx.
M-41 - RN.
F-36 - painter.
Living together.

PE: BP 123/57. ICP 60
TO 96.7 P-163 R 20 HC 45cm.
wt 7kg (estimated) Lt 70.5
Gen: Intubated sedated. bolt ̄ (R) frontal area EVD ̄ (L) parietal. EEG leads ̄
H: AF bulging / dense - bolt on (R) mid EVD left. Dry blood on scalp ̄ betadine (2° to bolt & EVD placement) Macrocephalic
E: Pupils are fixed - 3mm bilat, bilat R H, scleral-white
E: TM's clear, ¢ hemotympanum.
N: small abrasions (4) around nares.
M: Dry / cracked lips upper & lower frenum intact

M.D. M.D.

PLEASE PRINT NAME (RESIDENT) PLEASE PRINT NAME (CONSULTING PHYSICIAN)

RESIDENT'S SIGNATURE CONSULTING PHYSICIAN'S SIGNATURE 10/25/000

SLAUGHTER, A

LOMA LINDA UNIVERSITY MEDICAL CENTER

CONSULTATION REPORT

PATIENT IDENTIFICATION
PAIKINS, ERIC
AD 042801 FC 60 01554325
000101288819 ADTANAA

PRINTED BY: padikuon DATE 09/15/2004

3/4

0048

REQUESTED BY ATTENDING PHYSICIAN	CONSULTING SERVICE:
REASON FOR REQUEST:	

DATE	TIME

neck - ∅ crepitus, ∅ bruises
lung. CTA
heart RRR tachycardic, ∅ ...
abd soft, ⊕ BS, ND, ∅ HSM, ∅ masses, ∅ bruises
Ext. femoral lines bilat.
bruise ~ (L) wrist (2° to IV).
pulses 2+ equal
genitalia circ. TSI testes bilat. Anus WNL.
skin. small amount of hemorrhage on nails of 1st toes bilat. bruise ~ (L) wrist (from IV.) ∅ hyperelastic ∅ other bruises at this time

neuro -> sedated.

Diagnostic data N 80 L 15
amylase 8
lipase <10
19 > 10.4 / 29.1 < 433
ALKP 398
AST 74
ALT 34
144 | 116 | 4 / 3.8 | 18 | 0.3 < 121

UA 1.025 | 5 | ⊖ leuk.
trace protein.
500 glucose
small ketones.

Head CT prelim. Diffuse cerebral edema ~ mass effect. R 3-4 mm midline shift & mild to mod dilatation of 3rd ventricle. Mild dilatation of lat ventricle. Prob. blood layering along tentorium. fracture (L) parietal temporal.

M.D.
PLEASE PRINT NAME (RESIDENT)

M.D.
PLEASE PRINT NAME (CONSULTING PHYSICIAN)

RESIDENT'S SIGNATURE

CONSULTING PHYSICIAN'S SIGNATURE

LOMA LINDA UNIVERSITY MEDICAL CENTER

CONSULTATION REPORT

PATIENT IDENTIFICATION 10/25/000
01554325 0001 SLAUGHTER, A
PATKINS, ERIC
AD 042801 FC 60 01554325
000101288819 ADTAHAA

PRINTED BY: padikuon DATE 09/15/2004
23-INHH (1296)

0048

4/4 -

REQUESTED BY ATTENDING PHYSICIAN	CONSULTING SERVICE:
REASON FOR REQUEST:	
DATE	TIME

Head CT @ RCH now (1) EDH SAH - (1) Subdural vs SDH. Interhemispheric
hyphaema. (B) parietal fx.

Summary of injuries:
1) CHI → EDH, SDH, cerebral edema
2) ALOC.
3) Skull fxs bilat.
4) Retinal hemorrhages.
5)

Pedi surg: 6mo old male with abusive head trauma ? child abuse

Rec: Bone survey.
Ophthalmology consult -
Head MRI / MRS. , Chest & Knees MRI
Abd CT -
Urine drug screen -
Pictures
PT/OT/Neurology consult -
(per child abuse protocol)

Rebecca Piantini M.D.
PLEASE PRINT NAME (CONSULTING PHYSICIAN)

M.D.
PLEASE PRINT NAME (RESIDENT)

RPiantini MD
CONSULTING PHYSICIAN'S SIGNATURE

RESIDENT'S SIGNATURE

LOMA LINDA UNIVERSITY MEDICAL CENTER

CONSULTATION REPORT

PATIENT IDENTIFICATION 10/25/000
01554325 0001 SLAUGHTER, A
PATKINS, ERIC
AD 042801 FC 60 01554325
000101288819 ADTAHAA

PRINTED BY: padikuon DATE 09/15/2004

23-10110 (12/96)

ATTACHMENT 18

PATKINS, ERIC 015543250000 HISTORY AND PHYSICAL 07950

D:04/29/2001 T:04/30/2001 #431795

DATE OF ADMISSION: 04/29/2001

HISTORY OF THE PRESENT ILLNESS: This is a 6-month-old boy who reportedly fell down the stairs after his father tripped over a dog. He was transferred from Riverside. He was intubated at Riverside after showing decerebrate and decorticate posturing. The patient was beginning to have seizures and was given phenobarbital and Dilantin. A CT scan was done that showed evidence of an intracranial injury and the patient was transferred here for further evaluation.

REVIEW OF SYSTEMS: NEUROLOGICAL: No known previous focal weakness or seizures. CARDIOVASCULAR: No hypertension or arrhythmia. RESPIRATORY: No dyspnea or cough. GI: No vomiting or diarrhea. The remainder of the review of systems is negative as far as is known.

PAST MEDICAL HISTORY: Negative.

PAST SURGICAL HISTORY: Negative.

MEDICATIONS: None.

ALLERGIES: NONE KNOWN.

SOCIAL HISTORY: Unknown at this point.

PHYSICAL EXAMINATION:

VITAL SIGNS: Temperature is 98.4, blood pressure 120/74, heart rate 100 and weight is 7.2 kg.

HEENT: Normocephalic. The fontanelles are closed. Eyes, pupils are equal, round and reactive to light. The EOMs are intact. No scleral icterus. Ears, the tympanic membranes are clear bilaterally. No CSF otorrhea. No hemotympanum. Face, no step offs or lacerations.

NECK: No masses or thyromegaly.

CHEST: Heart sounds are clear and equal bilaterally. No chest wall deformity.

HEART: Regular rate and rhythm. No murmur. Normal PMI.

EXTREMITIES: The patient moves all 4 extremities bilaterally. Apparently normal sensation in all 4 extremities.

ABDOMEN: Soft. No distension. No evidence of tenderness. Intact bowel sounds.

PELVIS: Stable.

EXTREMITIES: Lower extremities, no edema and no deformity.

Upper extremities, no edema and no deformity.
No tenderness or blood.
No petechiae or rashes.

RECTAL:
SKIN:

DIAGNOSTIC DATA: The hemoglobin is 10.1, white blood cell count 14.5 thousand. The cervical spine x-ray showed no evidence of fracture or dislocation on preliminary reading. The chest x-ray was normal with no pneumothorax or rib fractures on preliminary evaluation. The CT scan of the head showed a small right epidural hematoma and a left parietal skull fracture. There was evidence of an old left subdural hematoma and left parietal skull fracture.

ASSESSMENT AND PLAN:
This is a 6-month-old boy with a concern for a non accidental trauma with old and new intracranial injuries. Bilateral skull fractures. Right epidural hematoma. Old left subdural hematoma. Left porencephaly. There is no evidence of an intraabdominal injury, but during the abdominal CT scan the patient became unstable due to increased intracranial pressure. Will plan for a Neurosurgery consultation and admission to the Intensive Care Unit. Abdominal/pelvis CT if he is clinically stable. Consult with the Child Abuse and Neglect Team. Formal review of the spinal x-ray with the Pediatric radiologist.

GERALD GOLLIN, M.D. r/72
ATTENDING PHYSICIAN

Pri:01
Authenticated by Gerald Gollin, M.D. On 05-22-2001 at 7:48 am

ATTACHMENT 19

PATKINS, ERIC 015543250001 OP/PROCEDURE REPORTS

D:04/29/2001 T:04/30/2001 #432083

DATE OF SURGERY: 04/29/2001

OPERATING SURGEON: JOHN J. COLLINS, M.D.
FIRST ASSISTANT: MANUEL R. SACAPANO, M.D.
TEACHING ASSISTANT: JASON I. LIFSHUTZ, M.D.

POSTOPERATIVE DIAGNOSIS: Intracranial hypertension.

OPERATION PERFORMED: Placement of lumbar drain.

ANESTHESIA: Local.

FINDINGS: Opening pressure of 27.

PROCEDURE IN DETAIL: After obtaining informed consent and identifying the patient was Eric Patkins, the patient was placed in the right lateral recumbent position and sterilely prepped and draped in the standard surgical fashion over the L2-L3 lumbar space.

After identifying proper landmarks, a needle was gently placed into position, and clear CSF was identified. A catheter was placed through the needle with the assistance of a guide wire, and the guide wire was withdrawn after the needle was withdrawn. Clear CSF was confirmed to continue to flow. After connecting the tube to the drain, it was found, however, that the catheter no longer was patent. At this time, it was decided to perform the procedure again.

Therefore, the catheter tube was withdrawn, and a needle was once again placed into the same position. CSF was identified, and the catheter once again was threaded through the needle. At this time, after connecting to the drain, CSF was able to be aspirated. Therefore, the drain was secured into position using Tegaderms.

The patient's intracranial pressure went from 67 to the low 50s. and the lumbar drain was dripping with CSF.

ESTIMATED BLOOD LOSS: Less than 2 cc.
COMPLICATIONS: None.

MANUEL R. SACAPANO, M.D. (H)/r72 JOHN J. COLLINS, M.D.
OPERATING SURGEON

Pri:02
Authenticated by John J. Collins, M.D. On 05-15-2001 at 12:15 pm

ATTACHMENT 21

D:04/29/2001 T:04/29/2001 #432058

DATE OF VISIT: 04/28/2001

IDENTIFICATION: This is a 6-month-old Caucasian male.

CHIEF COMPLAINT: The child was dropped on a set of stairs per the father.

HISTORY OF PRESENT ILLNESS: The patient presents with a history of being transferred by the Pediatric Intensive Unit Transport Team from an outside facility for head trauma. The patient arrived from the referring facility, intubated and sedated, no paralytics apparently on board.

History from the referring facility available, please see accompanying history as there are no parents at this time to take history from.

REVIEW OF SYSTEMS: Negative, except as above.

PAST MEDICAL HISTORY: Unknown.

ALLERGIES: UNKNOWN.

MEDICATIONS GIVEN: The patient received Versed, Norcuron, Dilantin and phenobarbital prior to arrival in our Emergency Department along with 1 mg of Valium.

PHYSICAL EXAMINATION: GENERAL: The patient is sedated and intubated. There is response to pain on examination. The patient has a firm anterior fontanele. Pupils are 3 to 2 bilaterally. Glasgow Coma Scale is 8. HEENT: TMs are clear bilaterally. HEART: Regular rate and rhythm. No murmur. LUNGS: Clear to auscultation bilaterally. ABDOMEN: Benign. EXTREMITIES: Warm with brisk capillary refill.

EMERGENCY DEPARTMENT COURSE: The patient arrived as a level B activation and Trauma Surgery was at the bedside. Neurosurgery was called to the bedside and to examine the patient and was able to obtain an exam and recommended a CT of the head for evaluation of the patient's intracranial injuries.

Reports from the referring facility were of intracranial hemorrhage on CT. The patient was placed on cardiac monitor as well as blood pressure and pulse oximetry. The patient had a Foley and an NG placed and was placed with seizure precautions as well as spine precautions. A CBC, electrolytes, amylase, lipase and a UDS were obtained as well as the aforementioned CT of the head, abdomen and pelvis being performed at the recommendation of Trauma Surgery for the abdomen and pelvis.

While in the Emergency Department and due to the nature of the injuries, a bolt was placed by Neurosurgery, please see accompanying Neurosurgery consult. Initial pressures were approximately 45, at one point during his stay in the Emergency Department, the patient had an increase in intracranial pressure to 90 at which time with Dr. Collins, the attending neurosurgeon present and en route to repeat CT, thiopental

8 mg/kg was given as the recommended dose per the pharmacist working today. The patient was also given mannitol 7 gram. During this time, the patient was also being hyperventilated.

Prior to this episode an x-ray of the bilateral femurs, a single-view was obtained due to the history of reported significant old fractures bilaterally. Review of the x-rays by myself, although, not complete films in their nature, showed no obvious fractures.

From the second CT, the patient was taken immediately to the Pediatric ICU for placement of ventriculostomy due to increasing hydrocephalus.

CLINICAL IMPRESSIONS:
1. Closed head injury.
2. Intracranial hemorrhage.
3. Cerebral edema.

PLAN: The patient is to be admitted to the Pediatric Intensive Care Unit under the care of the attending Intensivists as well as Dr. Collins, Pediatric neurosurgeon. Ultimate care and disposition of the patient in the hands in these physicians. Currently laboratory studies are pending and abdomen and pelvis CT were not able to be obtained at this time due to the patient's critical nature.

D. SHELTON CHAPMAN, M.D. /r72
ATTENDING PHYSICIAN

Pri:07
Authenticated by D. Shelton Chapman, M.D. On 05-03-2001 at 4:34 am

ATTACHMENT 23

Division of Medical Examiner

175 South Lena Road
San Bernardino, CA 92415-0037
(909) 387-2561

Brian McCormick
San Bernardino County Coroner

Frank Sheridan, M.D.
Chief Medical Examiner
Nenita Duazo, M.D., Deputy M.E.
Edward Yaeger, M.D., Deputy M.E.
Steven Trenkle, M.D., Deputy M.E.

Autopsy Protocol

Coroner's Case Number: 01-3075GM **Autopsy Number:** A-230-01

Name: Eric Patkins D.O.B. 10/25/00 **Age:** 6 months, 6 days **Sex:** Male
Time of Death: Reported 0745 hours, May 1, 2001 **Race:** Caucasian
Time of Autopsy: 1000 hours, May 2, 2001
Place of Autopsy: San Bernardino County Coroner's Facility **Deputy:** Miller

HISTORY OF DEATH: According to the deputy coroner investigator's report, from information received from hospital and SCOPC personnel, this 6 month, 6 day old resident of Riverside was admitted to Loma Linda University Medical Center on April 28, 2001, at 1030 hours, with a diagnosis of traumatic brain injuries. The baby lived with his father and mother at home in Riverside. The parents are not married.

On April 28, 2001, the father stated that at about 0530 hours he was carrying the baby up some stairs and tripped over a dog. He dropped the baby who landed on his head on a carpeted step of the stairway. The father became concerned and finally called his wife who works as a registered nurse at San Antonio Community Hospital in Upland. The wife told the father to call 911. The father called 911 at 0638 hours to report the baby was acting strangely.

When paramedics arrived at 0646 hours, they found the baby on the father's bed crying. The baby seemed aware of his surroundings and there was no visible trauma. They arrived at Riverside Community Hospital at 0715 hours. In the emergency room, the baby began having difficulty breathing and was intubated. A CT scan of the head revealed cerebral edema, as well as old and new injuries. The baby was transferred to Loma Linda University Medical Center, arriving on April 28, 2001, at 1030 hours. He was still moving his extremities at that time. Another CT scan was done at Loma Linda University Medical Center, which also showed old and new injuries.

An intracranial pressure monitor was placed and sedatives were administered. An ophthalmologist examined the baby and found severe bilateral retinal hemorrhage, consistent with traumatic brain injury. The baby's neurologic status deteriorated with persistent cerebral edema leading to brain death. The second brain death pronouncement was on May 1, 2001, at 0745 hours.

Reportedly, Riverside police detectives stated that the 36-year-old father has a history of conviction for a shaken baby death in 1993. He was released from prison with less than 5 years served. He is currently living with a girlfriend who is the mother of Eric. The father has been arrested in regards to this incident.

The father reportedly told police that Eric had previously fallen off of the bed twice, landing on the carpeted floor.

Family has given consent to multiple organ donation procedures and I, the undersigned, also gave permission. I, the undersigned, attended the organ donation procedures, examined the baby prior to surgery and visualized the organs when removed.

Medical records are reviewed. The Riverside paramedics' run sheets stated they arrived on scene at 0646 hours and found the baby lying supine on the father's bed. The baby was alert and crying. According to the father, there was no loss of consciousness. The father stated there was an approximately 18 inch fall to stairs. The dad was holding the baby while going upstairs.

An emergency room record from Riverside Community Hospital states the father was walking down the stairs when he tripped over a dog and dropped the baby. He thought the baby hit the stairs, which were carpeted. The time frame was unclear. The father denies any previous significant injuries. Physical examination showed a baby that was posturing, with a stiff left leg and rhythmic kicking of the right leg and hyperextension of both arms, with a high pitch cry. The eyes were deviated to the right, they were 5 mm., and poorly reactive. No obvious bruising was seen. Lateral C-spine and chest, pelvis and abdomen radiographs appeared negative to the emergency room physician's review. A CT scan showed abnormalities including fresh epidural, bilateral skull fractures, possible old chronic subdural blood and other chronic changes suggestive of repetitive injuries. The child was given phenobarbital and Dilantin and arrangements were made to transfer the baby to Loma Linda University Medical Center. The impression was closed head injury with evidence of epidural, acute and chronic injuries, bilateral skull fractures, and suspicion of child abuse.

The white count was 19,000, hemoglobin 10.4, and hematocrit 29.1. The platelets were 433,000. A urinalysis showed a specific gravity of 1.0 to 5.

The dictated report from the CT scan at Riverside Community Hospital gave an impression of a small right temporal epidural hematoma, bilateral non-depressed skull fractures, subarachnoid blood noted along posterior falx and tentorium, small left fronto-temporal subdural hygroma, a 2 cm. x 1 cm. porencephalic density in the left frontal lobe containing a small amount of blood, irregular zones of diminished density in the cerebral and cerebellar hemispheres bilaterally, consistent with edema, no midline shift with small but not completely effaced ventricles, sulci, fissures and cisterns. The multiplicity and character of these various abnormalities certainly raises the possibility of repeated episodes of head trauma.

A radiologist's impression of x-rays of the legs was periosteal reaction in the femoral shafts bilaterally, suggestive of prior trauma. A chest x-ray was felt to be normal.

The Loma Linda University Medical Center transport team history states that the baby had rolled off of the bed a few times in the past. Mom states pediatrician saw baby after these incidences. Immunizations reportedly up to date. The mother is aged 41, father 36. When transport team arrived, they noted the baby was both decerebrate and decorticate posturing with diffuse hyperreflexia. The initial emergency room examination stated the fontanelle was closed. There was no external injuries described or deformities. The pupils were 3 mm. to 2 mm. The initial pH was 7.4.

A social worker note dated April 28, 2001, states that the father has two other sons, aged 11 and 9 years old that live in Iowa. The patient's mother was at work and the patient was under the care of the father. The mother denied any other accidents or falls, except baby rolled off of the bed a couple of times. A hospital physician's note dated April 28, 2001, states the urine toxicology is negative. The PT was 14.6 and PTT 23.5 (these are normal values). A physician's consult from the Child Abuse and Neglect Team was conducted at 2230 hours on April 28, 2001.

The exam showed a head circumference of 45 cm. and a length of 70.5 cm. The baby was intubated, sedated, with a bolt in the right frontal area. The pupils were fixed. There were small abrasions noted around the nares. The mouth showed dried cracked lips. The upper and lower frenula were intact. The genitalia and anus appeared normal. Impression was closed head injury, bilateral skull fractures, and retinal hemorrhages, trauma consistent with abusive injury.

A physician's note dated April 30, 2001 states a head CT showed global ischemic changes. A pediatric neurology consult done April 30, 2001 confirmed the above history. Ophthalmic exam revealed bilateral retinal hemorrhages.

Pediatric cardiology consult on May 1, 2001 included a normal EKG and normal echocardiogram with normal anatomy and function. No evidence of cardiac compromise. An ophthalmology exam dated April 30, 2001 noted severe bilateral retinal hemorrhages with right preretinal heme, optic disk edema of right eye, and many white centered hemorrhages. A pediatric neurology examination on April 30 was consistent with brain death. A cerebral blow flow study on May 1, 2001 showed no cerebral blood flow. Second brain death pronouncement was on May 1, 2001.

The Riverside police report is reviewed. According to the report, the father stated he had been the only one present with the baby at the time of the injury. The father said he tripped over their dog while carrying the baby up the stairs. When he fell, the baby fell out of his arms and his head struck the stairs. The father first called the baby's mother and then called 911. Detectives drove the father back to the residence. The father stated that he and the wife slept in the master bedroom while the baby had his own room across the hallway. The baby had been sleeping through the night for the past few weeks, although would wake up in the night approximately once a week. On the morning of April 28, 2001, the baby and the father got up sometime between 5:30 a.m. and 6:00 a.m. The father wrapped the baby in a blanket and carried him downstairs. When they got to the bottom of the stairs, he realized the baby's diaper needed to be changed so he turned around to go up. At that point, the dog got in the way and caused the father to trip on the first step. The father was carrying the baby in his left arm so that the baby faced the father's shoulder, tried to catch himself but fell onto the stairs. As he fell, "the baby shot right out of my arms into the steps", according to the father. The father said the baby struck the carpeted portion of the fourth or fifth step from the bottom. The baby did not strike the wood banister or metal railing. The father could not remember if he fell on top of the baby. The baby seemed shocked immediately after the fall. The father picked him up and took him upstairs. The baby began to cry in a "shocked cry". The father stated. "I didn't know what to do, I was scared". He put the baby on the bed in the master bedroom. He realized one side of the baby's body had "frozen up" and the baby was definitely favoring one side. The father said, "I thought he broke his little neck". He was unsure what to do, but after about 10-15 minutes, he called the baby's mother at her work. He told the mother that there had been an accident and the mother told him to call 911. The father then called 911 and told them to send someone over, "My baby is hurting".

When asked if the baby had been hurt before, the father said "He, he had a couple of accidents. One with me where he fell off of the bed close to 3 weeks, maybe 1 month ago. He gets to moving around and the next thing I know he is between the bed and the cabinet there. I guess previously a couple weeks before it happened with her, "the mother". The father described the baby as an active body who did not crawl but rolled and "slams" things down with his hands. He can sit up on his own but will fall over if distracted.

When asked if he ever gets frustrated when he can't stop the baby crying, the father began to stutter his answer. When asked if he had ever shaken the baby, the father said no, not after he understood "the Shaken Baby Syndrome". He has heard of that from pamphlets brought home

by the mother and from "just knowing from the past". At this point, it was found that the father had shaken his oldest son, now 7 years old, in the past. He had been arrested, charged and convicted of child cruelty. This took place in Upland, California. The father spent "about 4 years of my life in prison" for this attempt and was released in 1996. After his release, he and the child's mother got back together and had another child who is now 3 years old. The mother of those two children moved to Iowa. The father said that this was "all done and cleared" and that he is received counseling for the incident. Pg 10, IA

Medical records from a private pediatrician are evaluated. There is a visit dated October 1, 2000, aged 7 days, 1 week visit. The birth weight was 10 pounds and 10 ounces and a birth length of 21-1/2 inches. Exam showed a healthy child. There is a visit dated January 5, 2001, at aged 2-1/4 months – the baby continued to be breastfed. There was an abrasion noted to nose 2 days ago, rubbing on terry cloth with rough texture. There was a healing dry abrasion on the nose. Ex 46, Pg

There is another visit dated March 8, 2001, at 4-1/4 months, 4 month check-up. It was noted the baby sleeps 8:00 p.m. to 5:00 a.m., occasionally up at 12 midnight for feeding. The mother describes laughs, plays with hands, lifts head in prone position. Physical examination is normal.

None of the records reviewed from the pediatrician recorded a visit for evaluation of falling off the bed.

Birth records show the baby was born October 25, 2000, expected date of confinement October 11, 2000. The mother was gravida 1, para 0. Labor lasted 13 hours and 38 minutes. Only labor complication was bleeding. Forceps were used. It was a vaginal delivery. Apgar scores were 8 at 1 minute, 9 at 5 minutes. There was 10 cc. of thick, green material suctioned. The weight was 10 pounds, 10 ounces (4830 grams); the length was 21.5 inches, head circumference 14 inches, chest circumference 14.5 inches. Diagnosis was term, large for gestational age, newborn male infant. Mom 41, gravida 1, para 1. None of these records indicate a visit for falling off bed.

Also refer to Coroner's Investigative Report #01-3075GM.

2100 hours – May 1, 2001

The baby, identified as Eric Patkins, (hospital #01554325) was examined in the operating room by the undersigned prior to prepping for the organ donation surgery. The following therapeutic appliances are present. There is an endotracheal tube secured to the mouth. There is a nasogastric tube in the left nostril. There is an intracranial bolt in the right frontal portion of the scalp. There is a pulse oximeter on the right great toe. There is a drain in the left mid parietal scalp, and there are multiport intravenous lines in both right and left groin. There is also a drain in the lower spine.

There is no overt external trauma on the scalp or face. There is diffuse edema of the soft tissues of the face. The chest and abdomen appear symmetric, warm and pink. There is no evidence of injury such as subcutaneous hemorrhage. The upper and lower extremities are symmetric without overt swelling, hemorrhage or evidence of injury. The back is not fully examined prior to surgery, but a brief examination as both shoulders are turned show no acute injuries.

Intraoperative observations reveal no apparent injury to the anterior chest or abdominal wall. There is no hemorrhage within the peritoneal cavity. The liver appears intact without injury and. in particular, no midline areas of hemorrhage or injury.

The thymus appears of normal size and shape for an infant of this size and age. There are no apparent contusions, areas of hemorrhage or injury.

Intraoperative discussions with both the heart recovery team and the abdominal organ recovery team confirmed they found no injury in the chest or abdominal walls, the pericardial sac, thymus, great arch vessels or any intraperitoneal organs.

EXTERNAL EXAMINATION: This is the nude body of a well-developed and well-nourished young male infant appearing consistent with the stated age of 6 months. The body is identified by a coroner's tag as "Eric Patkins", case "01-3075". The body is not embalmed.

Clothing:

The clothing has been removed.

Evidence of Medical Intervention:

There are bilateral intravenous lines in both right and left femoral areas. There is a catheter in the bladder. There is an endotracheal tube taped to the mouth. There is a nasogastric tube in the left nostril. There is an intracranial pressure bolt monitor in the right frontal area and an intracranial drain in the left mid parietal area. There is a sutured incision in the left frontal area. There is a sutured organ donation incision from the sternal notch down to the symphysis pubis. There is a drain in the mid lower back, apparently at the epidural or subdural space. There are multiple EKG monitor pads.

Measurements:

The following measurements are taken: the length is 70 cm. (27-1/2 inches) (75th percentile for age), the weight is 7.365 kilograms (just above 25th percentile for age), head circumference 45.5 cm., chest circumference 42 cm., crown/rump length 47 cm.

Radiographs:

Multiple radiographs are obtained. A lateral radiograph of the skull shows at least one parietal fracture. Anterior-posterior radiographs of the chest show no evidence of bone deformity. Anterior-posterior radiographs of the long bones of the upper extremities show no fractures or periosteal injuries. Anterior-posterior radiographs of the long bones of the lower extremities show bilateral asymmetric periosteal reaction that appears more prominent on the right side.

Examination:

The head shows diffuse edema of the scalp, as well as the face, eyelids, mouth and lips. There is no definite injury. There is a 1 cm. sutured incision in the left frontal scalp that is centered 6 cm. above the mid left eyebrow and 2 cm. to the left of the anterior midline of the head. There is a drain in the top left parietal portion of the head. This is 2 cm. left of the anterior midline and 9 cm. behind the level of the left eyebrow. The ears appear normally formed and situated. There is diffuse edema of the eyelids and moderate edema of the sclerae. The sclerae are white. There are no petechial or confluent hemorrhages. The nose is midline. The nares are patent. There is no intraoral injury. There is moderate edema of the lips. The frenula of the upper and lower lips are intact. There are no erupted teeth.

The chest and abdomen are symmetric without acute injury. The abdomen is somewhat scaphoid following the organ donation procedures. The external genitalia are normal male. The penis is circumcised. There is no evidence of injury.

The upper extremities are symmetric. The right upper extremity is well formed and muscled without fracture deformity. There is minimal hemorrhage in the antecubital fossa and the back of the right hand, consistent with therapeutic maneuvers. The digits of the right hand are intact without apparent injury.

The left upper extremity is well formed and muscled without evidence of acute injury. There is hemorrhage in the antecubital fossa and over the radial artery in the left wrist, consistent with therapeutic maneuvers. There is moderate edema of the soft tissue of the hand.

The lower extremities are symmetric. The right lower extremity appears well formed and muscled without fracture deformity.

The back shows no evidence of injury. There is no unusual dermal pigmentation or skin tufts. There is a catheter in the midline of the back, 9 cm. above the upper gluteal cleft.

INTERNAL EXAMINATION:

HEAD: When the scalp is reflected, there is minimal focal scalp and subgaleal hemorrhage at the site of the surgical procedures where the intracranial drain and the pressure bolt were placed. In the midline top of the mid parietal skull is an approximately 3.5 cm. x 2 cm. area of red hemorrhage extending into the subgalea. There is no associated visible contusion in the skin overlying this area, and there is no periosteal hemorrhage adjacent to the area of scalp hemorrhage. Extended anterior reflection and deep posterior occipital reflection of the scalp does not reveal any further areas of injury.

The skull shows separation of the coronal lambdoid and sagittal sutures. When the dura is reflected, there is a healing, older fracture of the mid left parietal bone. The fracture is situated at a 90-degree angle to the sagittal suture and is not well seen from the external table of the skull until all of the periosteum has been removed. On the inner table of the skull. the left parietal old fracture is seen as an area of fixed dural attachments extending for approximately 5 cm. in length. This fracture line overlies the area of old contusion and subdural hemorrhage in the mid left superior parietal lobe. No definite fractures can be seen in the right temporal bone, although there is moderate laxity of the sutures.

Because of marked cerebral edema and tight adherence of the dura to the inner table of the skull, brain extraction is undertaken with difficulty. Markedly softened brain oozes from the cut portions of the dura. No definite epidural hemorrhage is appreciated as the brain and skullcap are removed. After the brain and dura have been separated from the skull and the dural membrane is reflected, there is approximately 10-15 cc. of blood and blood clot in the subdural space on the inner aspect of the mid right cerebral hemisphere, with much of the blood clot present in the interhemispheric fissure but extending up and over the superior midline convexity. The blood and blood clot are adherent to the inner dural membrane in an approximately 6 cm. x 3 cm. area. There is extensive subarachnoid hemorrhage over the entire left cerebral hemisphere, present both over the superior convexities and on the lateral and inferior portions of the left frontal and temporal lobes. This subarachnoid hemorrhage is patchy in areas. Over the left cerebral hemisphere, there is a very thin layer of subdural blood. but no clot or organized blood comparable to that seen in the right side. There is approximately 5 cc. of subdural hemorrhage on the inferior base of the right temporal bone, adherent to the dura in an approximately 3 cm. x

4 cm. area. There is a smaller 2-3 cc. portion of subdural hemorrhage minimally over the inferior left temporal lobe. There is marked edema and softening of the cerebellar hemispheres and upper brainstem so that as the brain is removed, this portion of the brain is quite friable and literally falls apart during gentle removal of the brain.

After the dura is removed, there is an approximately 3 cm. x 2 cm. area of older brownish, firm, organizing subdural hemorrhage over the left midline anterior parietal lobe adjacent to the sagittal suture. When this area is incised, there is a thick, firm membrane associated with it.

The soft friable brain is not weighed.

After the dura is stripped from the base of the skull, there is a visible basilar right occipital bone fracture line extending in a sagittal plane from the inferior occipital lobe suture, midway between the sinus and the foramen magnum. When the scalp is reflected and the external table of the occipital skull is examined, the fracture line can be seen. There is no associated grossly identifiable hemorrhage in the associated posterior neck muscles.

The tip of the drain placed in the lower lumbar area is found at the level of the cervical cord. The only hemorrhage seen in the region of the cord is at the lumbar insertion of this drain. The spinal cord is removed through a posterior approach. There is no evidence of trauma. The only soft tissue hemorrhage is at the sites of the surgical placement of the lower lumbar drain.

The eyes are removed through the orbital roof. There is no external hemorrhage in the globe of the eyes or hemorrhage in the extraocular muscles. There is extensive hemorrhage in both right and left optic nerve sheaths.

After formalin fixation, the brain is re-examined. There is diffuse patchy subarachnoid hemorrhage still present, especially over the left cerebral hemisphere. When the brain is serially sectioned through the coronal plane, there is poor penetration of the formalin with the central areas of the brain remaining pink and soft. There is diffuse ischemic change bilaterally. The area of old injury of the left parietal lobe shows thinning of the cortex with a golden brown coloration of resolving hemorrhage. To a lesser degree there is a golden brown coloration on the superomedial mid right temporal lobe.

NECK: There is no hemorrhage or injury to the anterior muscles of the neck. The hyoid bone and thyroid cartilage are intact. The endotracheal tube is adequately placed with the tip approximately 1 cm. above the carina. There is no injury to the epiglottis or tracheal mucosa.

BODY CAVITIES: There is residual free blood in both chest and peritoneal cavities following the organ donation procedures.

CARDIOVASCULAR SYSTEM: The pericardial sac is empty. The heart was removed in the organ donation procedure.

RESPIRATORY TRACT: The right and left lungs are normally formed and lobated. The right lung weighs 59 grams (expected weight for length 69-80 grams). The left lung weighs 49 grams (expected weight for length 57-65 grams). The proximal airways are patent. There is no foreign material. There is no evidence of injury or blood aspiration. Sectioning reveals a firm, moderately well aerated parenchyma. There are no masses or thromboemboli. There are no definite areas of consolidation.

GASTROINTESTINAL TRACT: The esophagus is intact throughout. The stomach contains approximately 50 cc. of a mixture of thin, green fluid and mucus. There is no particulate matter or food. The gastric mucosa shows normal rugal folds. There are no focal lesions or ulcerations. The pancreas and duodenum were removed in the organ donation procedure. The remaining small and large intestines are unremarkable. The unremarkable appendix arises from the cecum. The intraluminal contents of the small and large intestines are normal. There are no strictures or masses.

PANCREAS: The pancreas was removed in the organ donation procedure.

HEPATOBILIARY SYSTEM: The liver and gallbladder are surgically absent.

GENITOURINARY TRACT: The right and left kidneys and adrenals are surgically absent. The distal ureters and bladder are unremarkable. The bladder is empty. The prostate is firm, light tan-brown. Both testes show firm, pale tan-brown, seminiferous tubules.

ENDOCRINE SYSTEM: The thyroid is symmetric with light tan-brown colloid. The left and right adrenals are surgically absent. The pituitary is unremarkable.

MUSCULOSKELETAL SYSTEM: There are skull fractures, as described above. Dissection of the posterior soft tissues of the back, buttocks and legs show no areas of acute or chronic injuries or hemorrhage. Both femurs are dissected down to the periosteum. No acute hemorrhage is seen. When the posterior peritoneal and chest walls are reviewed, there is focal hemorrhage adjacent to the posterior right ninth and tenth ribs behind the liver, suggesting possible fracture.

MICROSCOPIC EXAMINATION:

RESPIRATORY TRACT: Sections of lungs show focal pneumonia with alveoli filled with combinations of neutrophils and macrophages. There are multifocal areas of consolidation. Also, there is evidence of bronchitis with sections showing neutrophils within bronchi. Sections of trachea show submucosal inflammation. These findings are consistent with the presence of an endotracheal tube and survival in the Pediatric Intensive Care Unit for four days.

GASTROINTESTINAL TRACT: Sections of esophagus show minimal submucosal inflammation. The stomach is unremarkable. Multiple sections of bowel are unremarkable, other than some prominence of submucosal eosinophils.

MUSCULOSKELETAL SYSTEM: Sections of diaphragm are unremarkable. Sections of bone marrow show 60-70% cellularity with normal hematopoiesis. There is minimal stress effect.

Sections of the healing left parietal skull fracture show a healing fracture site with chronic fibrosis. Iron stains are negative.

Sections from the hemorrhagic posterior right ninth rib show acute hemorrhage, as well as an acute fracture site.

Cross sections of the right femur taken from areas of x-ray periosteal reaction show a layer of subperiosteal new bone formation consistent with previous inflicted trauma.

GENITOURINARY TRACT: Sections of bladder show submucosal inflammation and focal submucosal hemorrhage, consistent with the presence of a bladder catheter for several days. Sections of testes are unremarkable.

GENITOURINARY TRACT: Sections of bladder show submucosal inflammation and focal submucosal hemorrhage, consistent with the presence of a bladder catheter for several days. Sections of testes are unremarkable.

ENDOCRINE SYSTEM: Sections of thyroid are unremarkable. Sections of pituitary show focal micronecrosis.

CENTRAL NERVOUS SYSTEM: Multiple sections of central nervous system show diffuse hypoxic changes with pink-stained neurons and cerebral edema. Sections of cerebellum show extensive hemorrhage. Sections of the dura from the left side show acute hemorrhage. There are hemosiderin-laden macrophages seen on iron stain. Sections from the subdural hemorrhage of the right inferior temporal lobe show acute hemorrhage within the dural antemortem clots. Iron stain is negative.

Sections of subdural hemorrhage from the region of the interhemispheric fistula show antemortem hemorrhage with lines of Zahn. It is not adherent to the falx. Iron stain is negative.

Sections from the older left parietal lobe injury show extensive gliosis and many hemosiderin-laden macrophages. Iron stain is markedly positive. Sections from the right parietal lobe opposite to the grossly evident left parietal lobe injury also shows an extensive cortical hemorrhage, gliosis and many hemosiderin-laden macrophages of the iron stain. Sections of frontal cortex show superficial subarachnoid hemorrhage and edema. Sections from the lower spinal cord show hemorrhage into the dura with a few scattered hemosiderin-laden macrophages.

Sections of both eyes show multifocal areas of subretinal hemorrhage and marked perioptic nerve sheath hemorrhage. Iron stains of both eyes, including retina and optic nerves, are negative.

DIAGNOSIS:

I. Abusive head trauma.
   A. History of fall from father's arms to carpeted stairs insufficient to explain severity of injuries.
      1. Delay in calling for emergency services.
      2. Father has history of previous conviction for Shaken Infant Syndrome, per Riverside police investigation.
   B. Right inferior occipital skull fracture, recent.
   C. Right subdural hematoma.
   D. Bilateral basilar temporal lobe subdural hematomas.
   E. Extensive left cerebral hemisphere subarachnoid hemorrhage.
   F. Extensive bilateral cerebral edema.
      1. Diffuse spreading of cranial sutures.
   G. Bilateral extensive retinal hemorrhage (clinical and histopathologic).
   H. Marked bilateral optic nerve sheath hemorrhage.
   I. Survival in Intensive Care Unit for several days on respirator.
      1. Mucosal inflammation of trachea.
      2. Bilateral pneumonitis.

II. Acute fracture, posterior right ~~ninth~~ rib.

III. Inflicted injury, right femur, remote
   A. Subperiosteal new bone formation.

IV. Blunt force head injury, unexplained, remote.
   A. Superior left parietal bone fracture, remote.
   B. Left superior bilateral mid parietal cerebral contusions, remote.
   C. Left subdural hematoma, remote.

V. Status post organ donation procedure including:
   A. Heart.
   B. Liver.
   C. Kidneys.
   D. Pancreas.
   E. No evidence of traumatic injuries or dysfunctions of above organs.
   F. No evidence of intrapleural or intraperitoneal injuries seen at time of organ donation procedure.

CAUSE OF DEATH: Abusive head trauma. days.

WITNESSES PRESENT: Deputy D.A. Hughes, Deputy D.A. Sara L. Danville, Deputy D.A. George Masson, Deputy D.A. Robert A. Spira (Riverside District Attorney's Office), Detective Tim Ellis, Riverside Police Department.

Autopsy Completed 1500 hours, May 2, 2001.

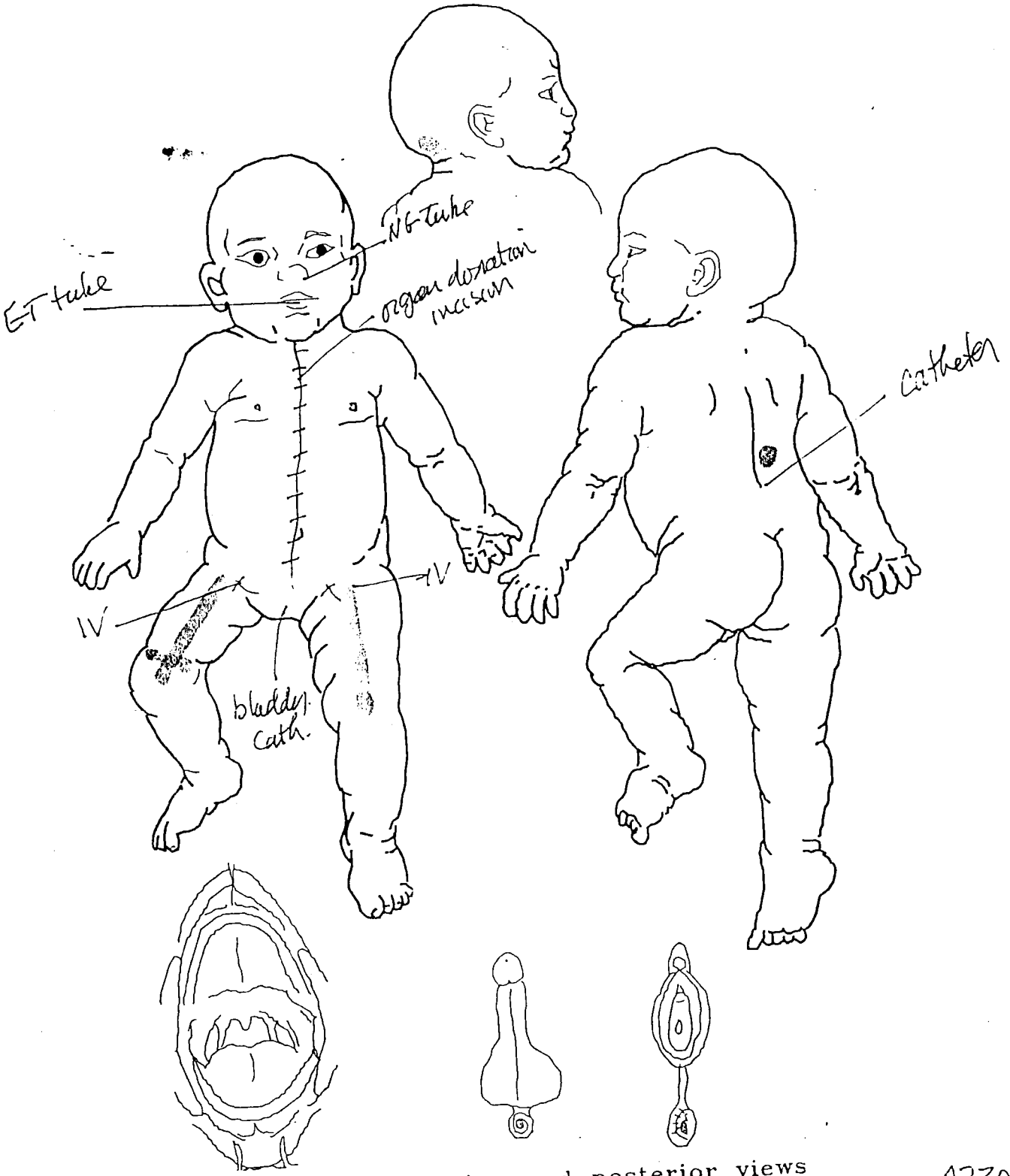
Steven Trenkle

Steven Trenkle, M.D.
Pathologist

Date: 9-5-01

ST:pm

San Bernardino County Coroner
Brian McCormick, Coroner



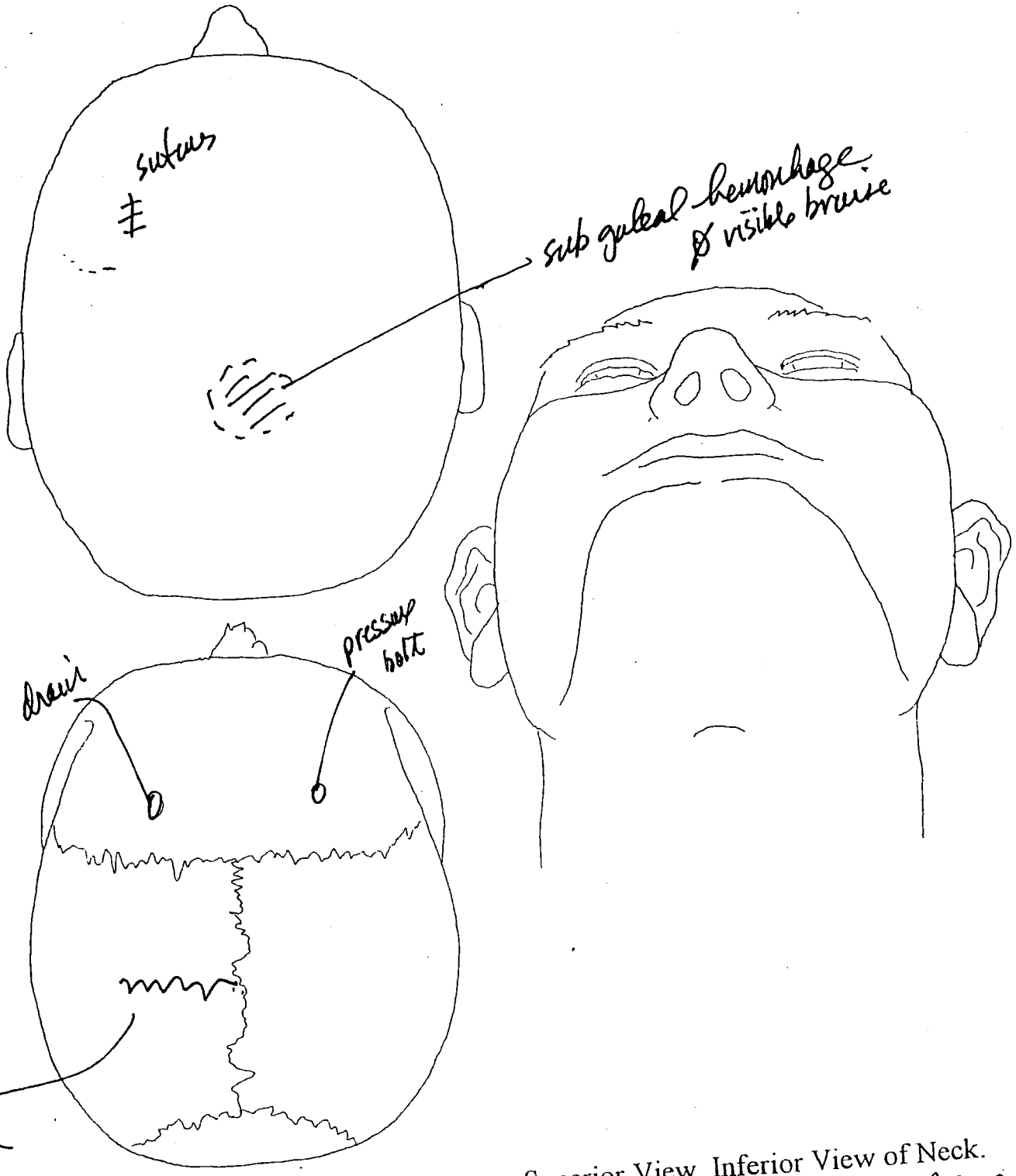
Infant, anterior and posterior views

Name Eric Partida Coroner's Case No. 01-3075 Autopsy No. A230-01

Age 6 mo Race C Sex M Date 5-2-01

Brian McCormick, Coroner

PEOPLES EXHIBIT 20

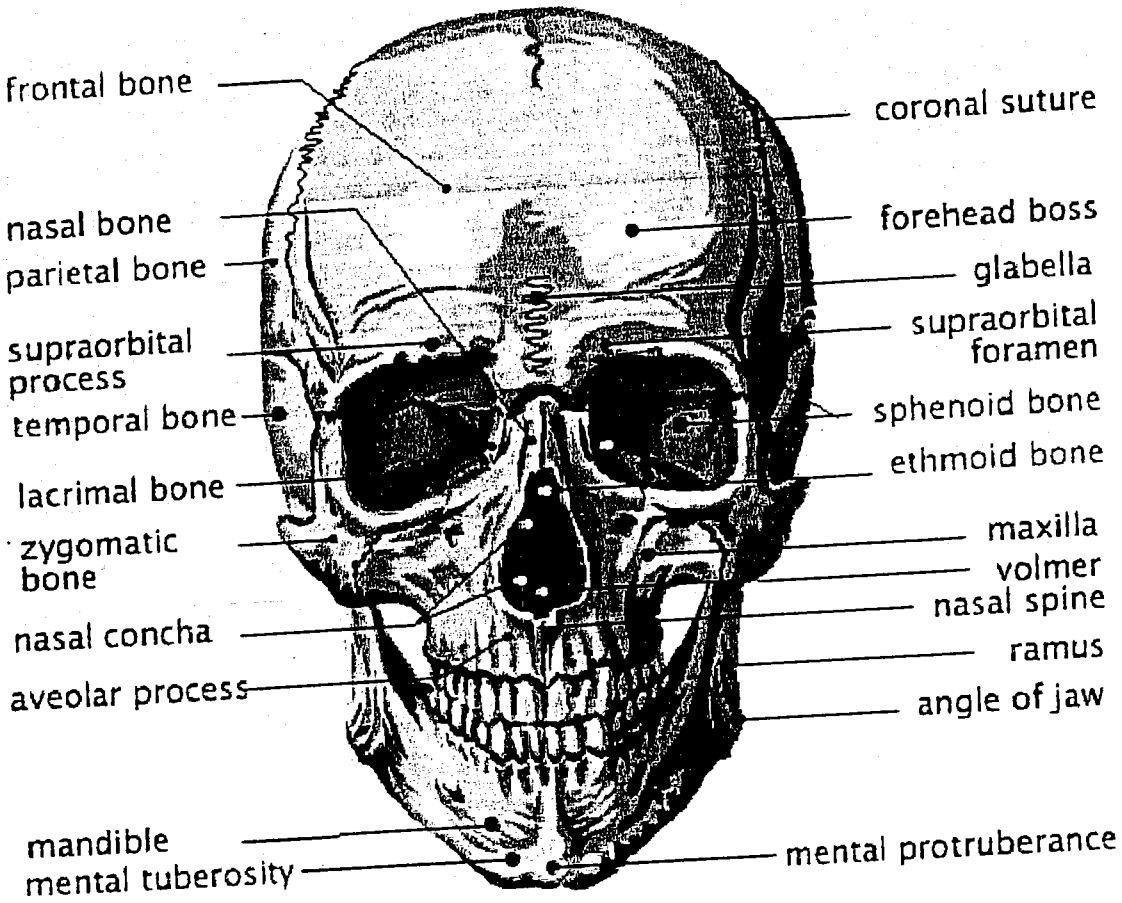


Head Surface & Skeletal Anatomy, Superior View, Inferior View of Neck.

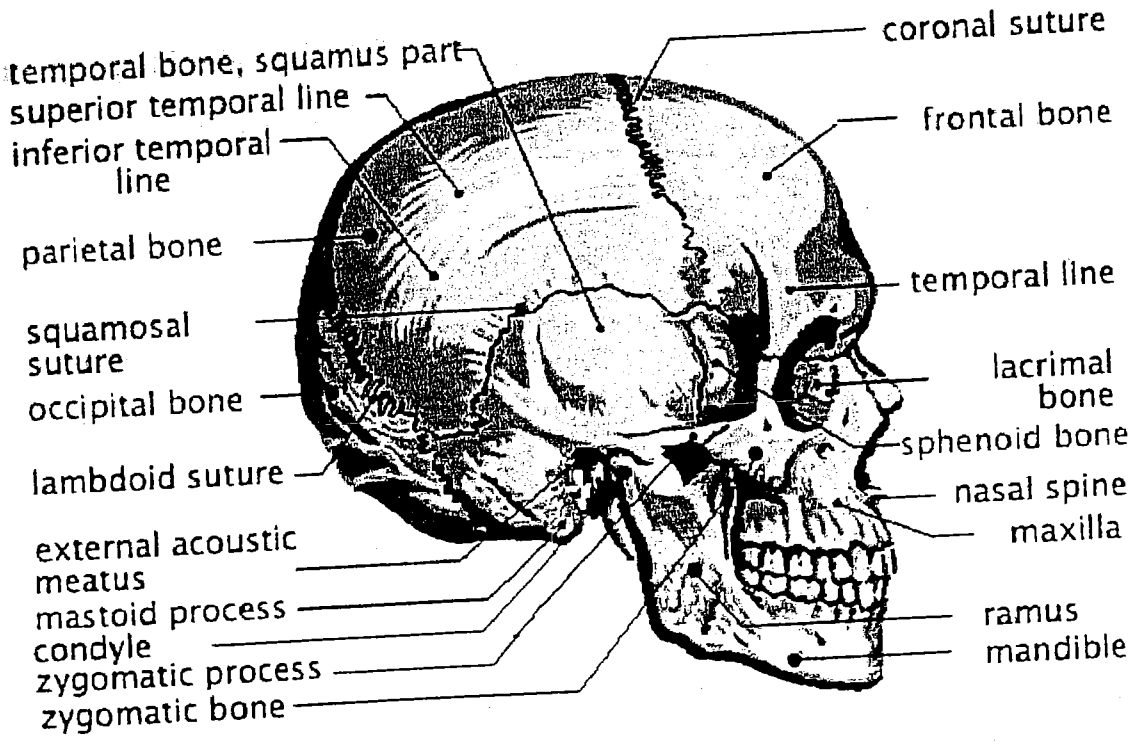
ame Eric Patkins Coroner's Case # 01-3075 Autopsy No. A230-01

Age 6 mo Race C Sex M Date 5-2-01

80



Page 1 of 1



http://face-and-emotion.com/dataface/physiognomy/media/cranium_front.jpg

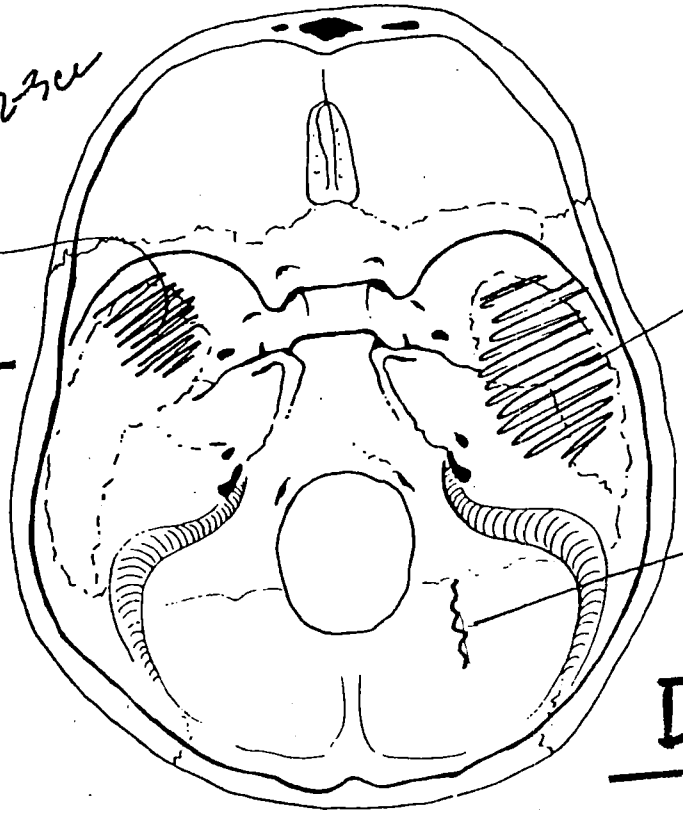
8/13/2004

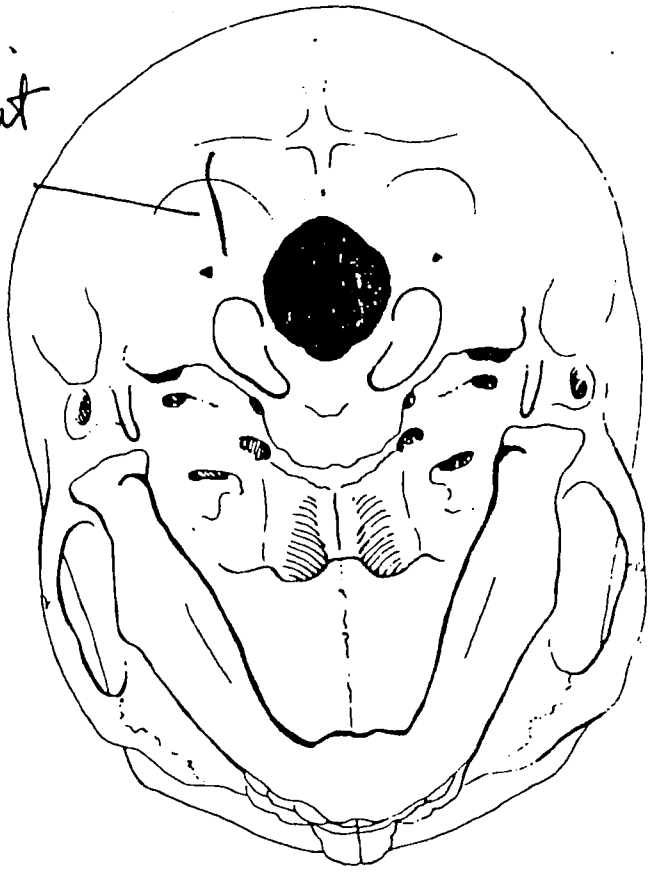
Skull, base, inferior and superior views (plus calvarium).

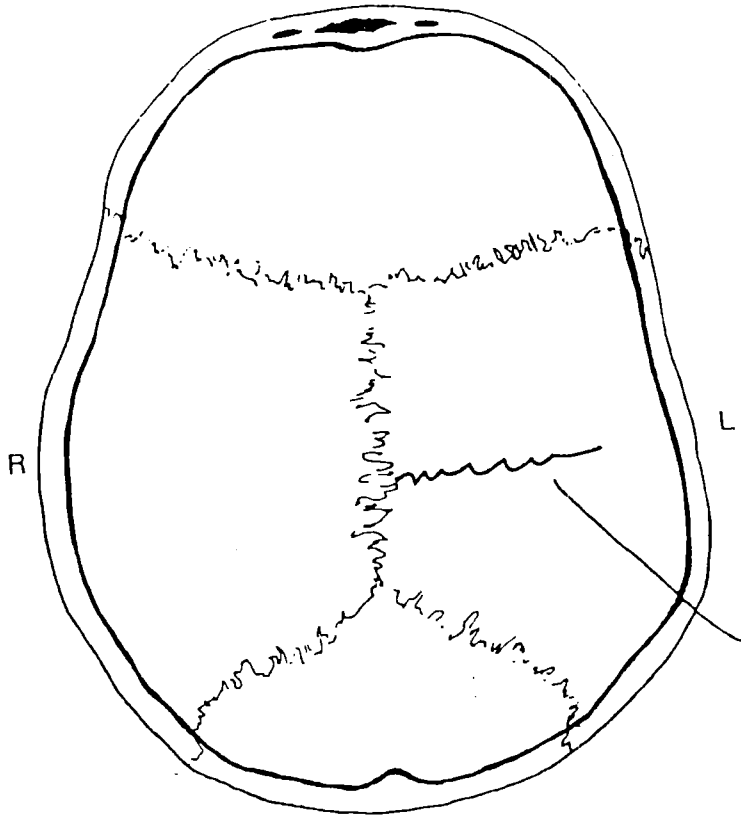
Name Eric Patkus Autopsy No. A230-01

Age 6mo Race C Sex M Date 5/2/01 (F)

NUMBER 21

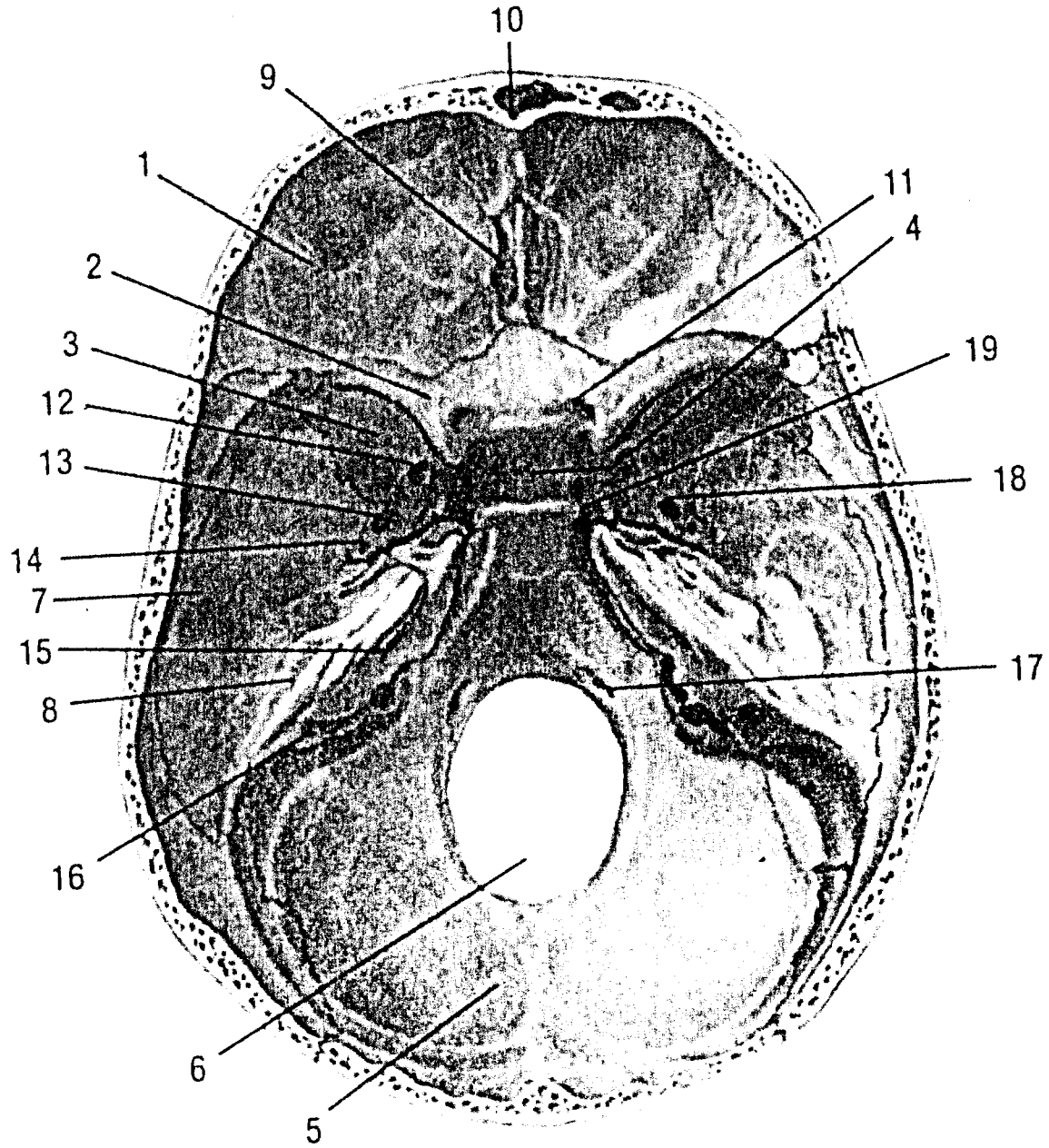






INNER VIEW OF SKULL

Cat. No. 44-1-017.00



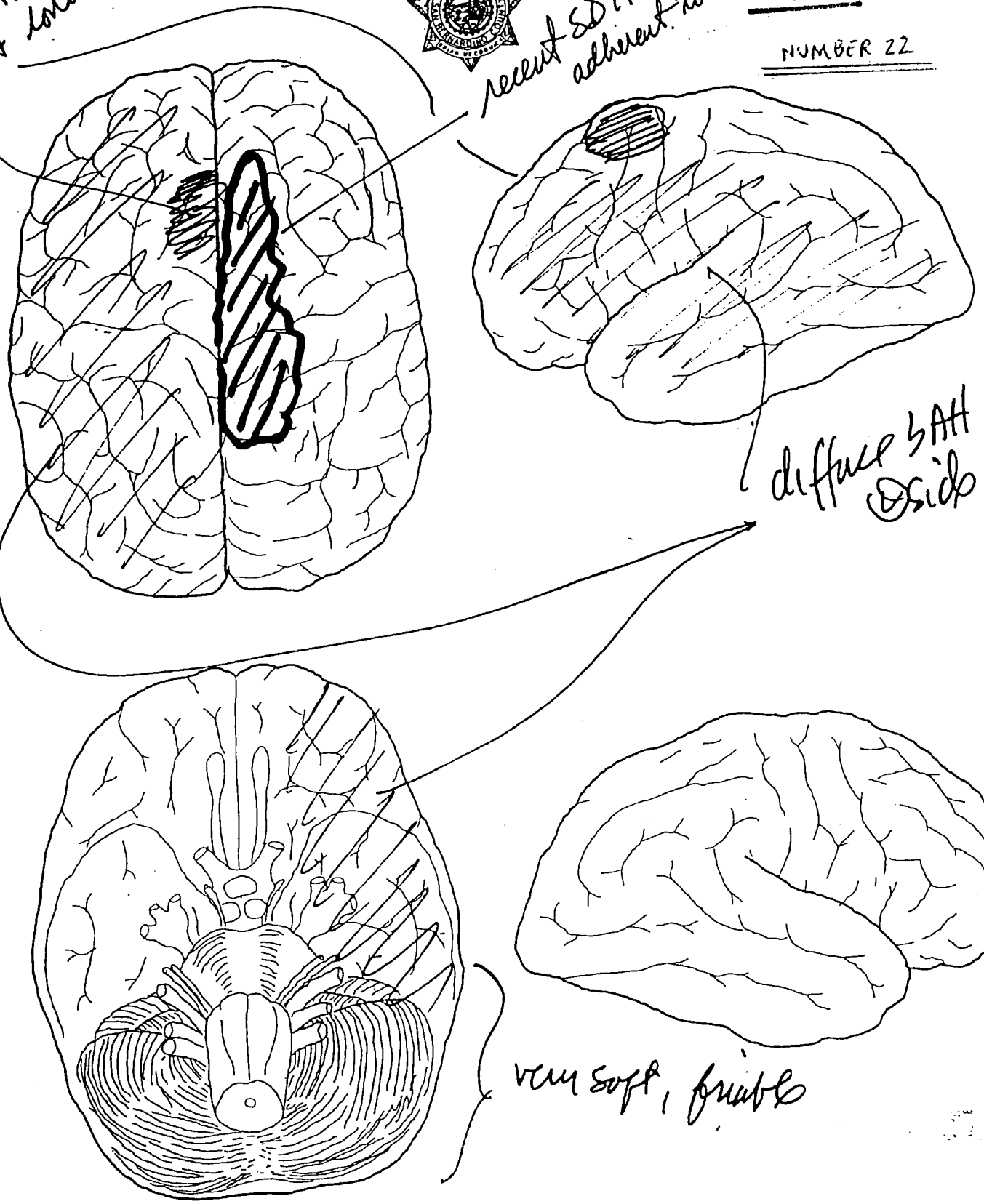
skull: internal view of base

1 frontal bone
2 lesser wing of sphenoid bone
3 greater wing of sphenoid bone
4 sella turcica
5 occipital bone
6 foramen magnum
7 temporal bone
8 petrous portion of temporal bone
9 cribriform plate of ethmoid bone
10 frontal sinus
11 optic canal
12 foramen rotundum
13 foramen ovale
14 foramen spinosum
15 internal acoustic meatus
16 jugular foramen
17 hypoglossal canal
18 foramen ovale
19 cavernous groove

San Bernardino County Coroner
Brian McCormick, Coroner

A.

NUMBER 22



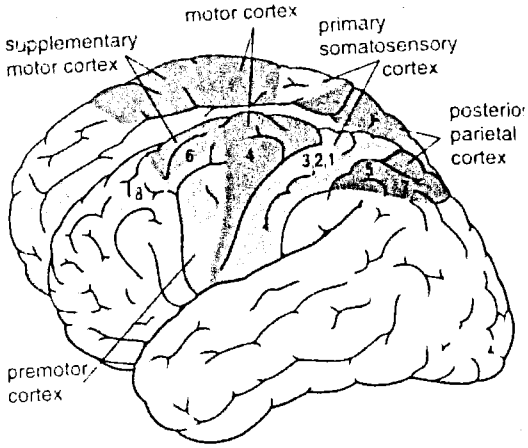
Brain, superior, inferior, and lateral views.

Name Eric Patkins Coroner's Case No. 01-3075 Autopsy No. A230

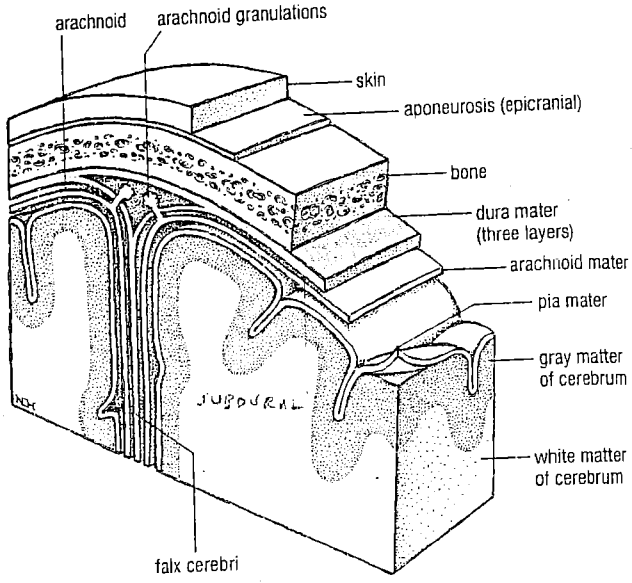
Race C Sex M Date 5-2-01

cerebral cortex **frontal c.**, c. of the frontal lobe of the cerebral hemisphere; (1) originally, the entire cortical expanse anterior to the central sulcus, including the agranular motor and premotor c. (Brodmann's areas 4 and 6), the dysgranular c. (area 8), and the granular frontal (prefrontal) c. anterior to the latter; (2) now more often refers to the granular frontal (prefrontal) c. SYN frontal area.

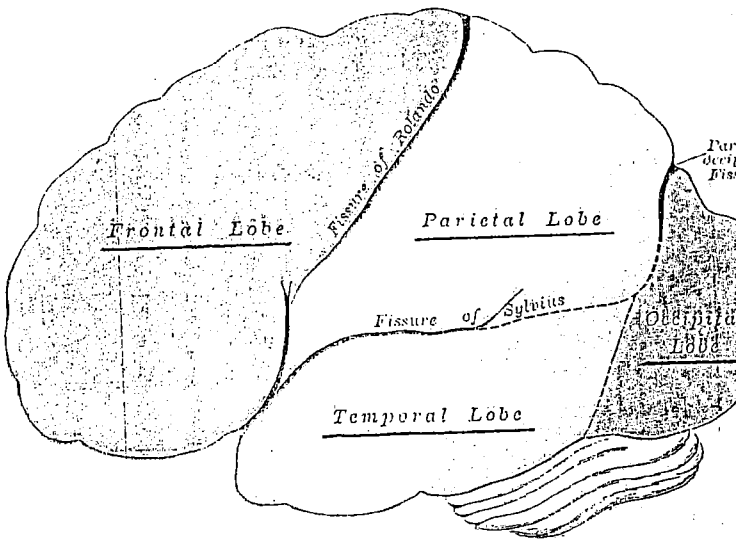
The cortex is made up of nerve-cells which vary in size and shape, and of nerve-fibres, which are either medullated or naked axis-cylinders, embedded in a matrix of neuroglia.



du·ra mat·er (dū′ră mā′tĕr) [TA]. Pachymeninx (as distinguished from leptomeninx, the combined pia mater and arachnoid); a tough, fibrous membrane forming the outer covering of the central nervous system, consisting of periosteal and meningeal dura layer and an inner part, the dural border cell layer, continuous with the arachnoid barrier cell layer. See this page. SYN dura [TA], pachymeninx [TA]. [L. hard mother, mistransl. of Ar. *umm al-jāfīyah*, tough protector or covering]



dura mater: and associated structures of the scalp, skull, and meninges (frontal section)



d. m. of brain, SYN **cranial d. m.** [TA], the intracranial d. m., consisting of two layers: the outer *periosteal layer* that normally always adheres to the periosteum of the bones of the cranial vault; and the inner *meningeal layer* that in most places is fused with the outer. The two layers separate to accommodate meningeal vessels and large venous (dural) sinuses. The meningeal layer is also involved in the formation of the various dural folds, such as the falx cerebri and tentorium cerebelli and is comparable to and continuous with the dural mater of the spinal cord. The cranial epidural space is then an artifactual space between the bone and the combined periosteum/periosteal layer of the d. m. realized only as a result of pathologic or traumatic processes and is neither continuous with or comparable to the vertebral epidural space. SYN dura mater cranialis [TA], d. m. encephali☆, cerebral part of dura mater, d. m. of brain.

ATTACHMENT 24

THOMAS A. SCHWELLER, M.D.

DIPLOMATE: AMERICAN BOARD OF PSYCHIATRY & NEUROLOGY

3200 FOURTH AVENUE, SUITE 100
SAN DIEGO CA 92103
(619)291-2022

Gentlepersons: It has been my opportunity to review medical records concerning injuries to Eric Patkins. This six month six day old boy was reported to have been dropped by his father David Patkins onto a carpeted step at 5:30 AM on 4/28/01. The fall was from a height of 18 inches. Father observed an arm to freeze and was concerned that the child had broken his neck. The father called paramedics and the child was noted at 6:46 AM to be lying on a bed crying. At 7:15 AM at Riverside Hospital ER the child was having trouble breathing and was intubated. A CT of the brain showed cerebral edema, a left parietal skull fracture. At 10:30 AM the child was moving his extremities. A CT of the brain reported a right sided epidural bleed and a small subarachnoid bleed. The child eventually died from pressure on the life sustaining areas of the brainstem secondary to increased intracranial pressure. At autopsy there is reported a small left fronto-temporal subdural hygroma . There is also a report of periosteal reaction in the femoral shafts suggesting prior trauma. The autopsy diagnosis was right inferior occipital skull fracture,right subdural hematoma,bilateral basal temporal subdural, extensive left cerebral subarachnoid hemorrhage,cerebral edema, spreading sutures, and bilateral retinal hemorrhages.

The cause of death is consistent with a fall of 18 inches leading to skull fracture with acute cerebral edema and retinal hemorrhages. This has been studied by Dr. John Plunkett, a forensic pathologist from Minnesota.His study of 12 children with lucid intervals followed by unconsciousness and death show that fatal brain injury may be the result of a short-distance fall. Any sudden increase in intracranial pressure may cause retinal hemorrhages and thus is not diagnostic of any specific mechanism of injury. What needs to be addressed is the accuracy of two diagnoses: 1) An old right femur fracture with subpereosteal bone formation and 2) a remote left parietal skull fracture with a left fronto-temporal hygroma. If these diagnoses are correct then they suggest a pattern of injury at different times. A review by a pediatric radiologist would be able to confirm or dispute this conclusion. The report of an acute fracture of the posterior right ninth rib supports a backward fall as does a right inferior occipital skull fracture. A forensic pathologist such as Dr. Plunkett who is familiar with the potential brain injury from short falls would be able to confirm the reliability of the "old" left parietal skull fracture and the "old" left parietal lobe gliosis that suggests a prior brain injury.

Thomas A Schweller MD

THOMAS A. SCHWELLER, M.D.
DIPLOMATE: AMERICAN BOARD OF PSYCHIATRY & NEUROLOGY

3200 FOURTH AVENUE, SUITE 100
SAN DIEGO, CA 92103
(619) 291-2022

May 28, 2004

Mr. David Patkins
73612 Salinas Valley State Prison A5-240
P. O. Box 1030
Soledad, California 93960-1030

Dear Mr. Patkins:

I received your letter dated May 9, 2004 concerning the details of your trial and its relationship to my review of your case. It is my understanding that this was a defense that was made by a public defender. It has been my experience that these often are subject to inadequate funds and inadequate experience in the process of trying to defend against alleged child abuse.

Upon my review of the records, in the report provided to you, I suggested that consultations be made, particularly with a pathologist who is familiar with the mechanics and details of head injuries and can express the potential accidental nature of this particular injury. I am not certain at this point in time why certain individual were not consulted and why I was not asked to testify at trial. Again, this is often due to time constraints where an individual is placed on trial and is expected to proceed despite having inadequate information and experts available to present the point of view of the defendant. There has been a significant overwhelming child advocacy system that is consulted by the prosecution and often this provides inadequate information.

I have been in contact with a family in the San Diego area that has had a similar experience several years ago and has published a website with information and experts for individuals who have been wrongly accused of child abuse. It is of great importance that individuals who have been wrongly convicted of child abuse be in contact with experienced and capable attorneys who know the controversies that have arisen in the prosecution of child abuse.

The defender is Ken Marsh. The website is freekenmarsh.com. His attorney is Tracey Emblem, 205 West Fifth Avenue, Suite 105, Escondido, CA 92025.

It is my hope that you will receive some comfort and hope from this information.

Sincerely,

Thomas A Schweller, MD

THOMAS A. SCHWELLER, M.D.
Board Certified Neurologist

TAS:ds

ATTACHMENT 42

CAT Scan Reports

Order # 04-221-11392 Exam date/time: 04/29/2001 18:34:51
Exam: Head /wo Contrast

Radiology Report

ORDER: 2111392, EXAM: 2308670, .

CASE: 015543250002

VERIFIED RESULT

NONCONTRAST HEAD CT, April 29, 2001:

COMPARISON: Noncontrast head CT with April 28, 2001.

CLINICAL HISTORY: This is a six-month-old male with a history of severe NAT and elevated intracranial pressure.

PROCEDURE: Utilizing the GE HiSpeed CT/i scanner, 3.0 mm slices at 7.0 mm intervals were obtained through the posterior fossa followed by serial 7.0 mm slices at 10.0 mm intervals through the remainder of the cranium to the vertex in an EMI plane without injection of contrast material. Soft tissue and bone windows were reviewed on PACS.

FINDINGS: This study is compared with the previous head CT dated April 28, 2001. There is stable position of a left frontal approach ventriculostomy tube which terminates near midline, coursing through the left lateral ventricle. There is significant metallic susceptibility artifact from a halo. Stable position is seen of a right frontal intracranial pressure monitor bolt. A small focus of metallic artifact is seen in the right foramen magnum as well as a small amount of pneumocephalus in the foramen magnum which may be related to recent intervention. This is not noted on the previous study. There is severe diffuse low density change within the entire cerebellum with effacement of the fourth ventricle. The basilar cisterns also are effaced. The lateral ventricles are nearly completely effaced, smaller than on the prior study with hemorrhage layering in both occipital horns. There is persistent right to left midline shift, which is estimated at at least 12 mm. Diffuse areas of low density are seen in the entire right cerebral hemisphere and also in the left parieto-occipital lobes. The previously-described focus of hyperdense hemorrhage in the left frontoparietal area is again seen and measures about 13 x 8 mm in dimension. There appears to be hemorrhage along the tentorium, however this is difficult to evaluate due to artifact and severe low density changes within the cerebrum and cerebellum. Other findings are essentially unchanged.

IMPRESSION: Severely limited due to metallic streak artifacts. Stable position of a left frontal approach ventriculostomy tube. Severe diffuse cerebral edema and swelling of the cerebellum with upward transtentorial herniation. Low density changes in the cerebral hemispheres and cerebellum is compatible with infarction and/or edema. The ventricles appear collapsed. Small foreign body in the foramen

CAT Scan Reports

Order # 04-221-11392 Exam date/time: 04/29/2001 18:34:51
Exam: Head /wo Contrast

magnum with a small amount of pneumocephalus may be related to recent procedure. Please correlate clinically. Essentially stable appearance of the left frontoparietal parenchymal hemorrhage. Worsening right to left midline shift since the prior study. Other findings as previously described.

JRT/MRC72 05/01/2001 05/01/2001
Dictated By : BRONWYN HAMILTON MD

I Reviewed Images Personally and Agree With Interpretation.
Signed By : JOSEPH THOMPSON MD
**** end of result ****

Order # 04-221-11044 Exam date/time: 04/28/2001 17:13:38
Exam: Head /wo Contrast

Radiology Report

ORDER: 2111044, EXAM: 2308171, .

CASE: 015543250002

VERIFIED RESULT

CT OF THE HEAD WITHOUT CONTRAST-04/28/01:

HISTORY: Six-month-old with increased intracranial pressure.

PROCEDURE: Utilizing the GE HiSpeed scanner, multiple contiguous 5 mm axial images were obtained and viewed on PACS in bone and soft tissue windows.

COMPARISON: Compared with CT of the head obtained earlier on 4/28/01.

FINDINGS: There is now a right frontal approach intracranial pressure monitor bolt. There is a left frontal approach ventriculostomy catheter. The tip is near the foramen of Monro. There is air and hemorrhage along the shunt tract. There is redemonstration of the previously described confluent extensive hypodensities throughout the entire right cerebral hemisphere and the left frontal and temporal lobes as well as the posterior fossa. This is compatible with edema and/or infarction and appears more sharply marginated suggesting interval maturation. The gray white matter differentiation is poor throughout. There is a left frontal intraparenchymal hemorrhage just lateral to the frontal horn of the left ventricle, this appears new. There is redemonstration of the right parafalcine subdural hematoma anteriorly which appears stable. The right frontotemporal subdural hematoma also appears stable. There is increased density along the tentorium which appears unchanged and there is intraventricular hemorrhage within the occipital horn of the left lateral ventricle. The ventricles are smaller in size and the

CAT Scan Reports

Order # 04-221-11044 Exam date/time: 04/28/2001 17:13:38
Exam: Head /wo Contrast

basal cisterns remain effaced.

IMPRESSION: Status post left frontal approach ventriculostomy placement with decompression of the ventricles. There is air and hemorrhage along the shunt tract and new intraparenchymal hemorrhage in the left frontal lobe. Persistent low density consistent with extensive cerebral edema and/or infarction, bilateral cerebellar hemispheres, right greater than left and cerebellum. Intraventricular hemorrhage, right subdural hemorrhage, and right parafalcine hemorrhage. Downward transtentorial herniation. NDW/MRC72 04/29/2001
04/30/2001
Dictated By : KEVIN KROEGER MD

I Reviewed Images Personally and Agree With Interpretation.
Signed By : NATHNIEL WYCLIFFE MD
**** end of result ****

Order # 04-221-10969 Exam date/time: 04/28/2001 12:29:50
Exam: Head /wo Contrast

Radiology Report

ORDER: 2110969, EXAM: 2308064, .

CASE: 015543250002

VERIFIED RESULT

CT OF THE HEAD WITHOUT CONTRAST-04/28/01:

HISTORY: Six-month-old with head trauma.

COMPARISON: None.

PROCEDURE: Utilizing the GE HiSpeed scanner, 5 mm contiguous axial images of the head were obtained and viewed on PACS in bone and soft tissue windows.

FINDINGS: There is a left parietal skull fracture. There is a right frontal approach intracranial pressure monitor bolt near the vertex. The gray white matter differentiation is diminished throughout which probably represents diffuse cerebral edema. There are large areas of hypodensity noted throughout the right cerebral hemisphere including the frontal, parietal, temporal, and occipital lobes. This confluent low density involves both the gray and white matter. There is also involvement of the left occipital and parietal lobes as well as the inferior frontal lobe on the left. There is diffuse hypodensity throughout the cerebellum. There is intraventricular hemorrhage. There is a focus of hyperdensity in the left frontal lobe probably within the sulcus. This may represent subarachnoid or

CAT Scan Reports

Order # 04-221-10969 Exam date/time: 04/28/2001 12:29:50
Exam: Head /wo Contrast

intraparenchymal hemorrhage. There is a small right subdural hemorrhage along the right frontal convexity measuring 2 mm. There is increased density along the tentorium which may represent subdural hemorrhage or subarachnoid hemorrhage. There is a small right parafalcine subdural hemorrhage which is relatively well localized anteriorly measuring 5 mm in width. There is hemorrhage within the left Sylvian fissure. The basal cisterns are effaced. The lateral and third ventricles are slightly dilated.

IMPRESSION: Extensive brain edema and/or infarction involving both cerebral hemispheres, right greater than left and the posterior fossa. MRI with diffusion imaging would be helpful for further evaluation. Intraventricular hemorrhage, possible subarachnoid hemorrhage, and intraparenchymal hemorrhage right frontal lobe. Small right frontal subdural hemorrhage. Small right parafalcine subdural hemorrhage anteriorly. NDW/MRC72 04/29/2001 04/30/2001
Dictated By : KEVIN KROEGER MD

I Reviewed Images Personally and Agree With Interpretation.
Signed By : NATHNIEL WYCLIFFE MD
**** end of result ****

Diagnostic Radiology Reports

Order #: 04-221-12109 Exam date/time: 04/30/2001 18:16:09
Exam: Bone Survey II

Radiology Report

ORDER: 2112109, EXAM: 2309677, .

CASE: 015543250002

VERIFIED RESULT

April 30, 2001, BONE SURVEY:

HISTORY: Nonaccidental trauma.

COMPARISON: None.

FINDINGS: This exam consists of a AP and lateral view of the skull; AP and lateral views of the chest, abdomen, and pelvis; single AP views of both arms; single AP views of both hands; single AP views of both legs; and single AP views of both feet.

There is a fracture in the posterosuperior region of the parietal bone seen on the lateral view. There is periosteal reaction in the inferior region of the right femoral shaft indicating probable underlying fracture. The remaining osseous margins are well corticated without disruptions.

There is an endotracheal tube with the tip midway between the thoracic inlet and the carina. There is an NG tube with the tip coiled in the stomach and then extending into the third portion of the duodenum. There is a right femoral central line with the tip extending to the level of the T9 vertebral body. There is a shunt extending into the region of the left lateral ventricle.

IMPRESSION: Fracture of the posterior superior region of the parietal bone. Periosteal reaction indicating probable fracture of the right femur. Numerous lines and tubes as described. LWY/MRC72 05/01/2001
05/02/2001
Dictated By : SHANE BALL MD

I Reviewed Images Personally and Agree With Interpretation.
Signed By : LIONEL YOUNG MD
**** end of result ****

Order #: 04-221-12991 Exam date/time: 05/01/2001 16:47:24
Exam: Chest 1V

Radiology Report

Diagnostic Radiology Reports

Order #: 04-221-12991 Exam date/time: 05/01/2001 16:47:24
Exam: Chest 1V

ORDER: 2112991, EXAM: 2310909, .

CASE: 015543250002

VERIFIED RESULT

CHEST SINGLE VIEW ON MAY 1, 2001

HISTORY: Pneumonia.

COMPARISON: Chest single view dated April 20, 2001.

FINDINGS: This exam consists of a single portable supine frontal view of the chest. There is an endotracheal tube with the tip 0.5 cm above the carina. There is a nasogastric tube with the tip coiled in the stomach. There is a small amount of contrast in the stomach. The heart size is within normal limits. There are scattered patchy densities in the right upper lobe and left lower lobe. The sulci are sharp. There is no pneumothorax.

IMPRESSION: Endotracheal tube and nasogastric tube in acceptable position.
Subsegmental atelectasis in the right upper and left lower lobes.
LWY/MRC72 05/02/2001 05/03/2001
Dictated By : SHANE BALL MD

I Reviewed Images Personally and Agree With Interpretation.
Signed By : LIONEL YOUNG MD
**** end of result ****

Order #: 04-221-11023 Exam date/time: 04/28/2001 15:23:07
Exam: Chest 1V

Radiology Report

ORDER: 2111023, EXAM: 2308147, .

CASE: 015543250002

VERIFIED RESULT

CHEST SINGLE VIEW 4/28/01

HISTORY: Line placement.

COMPARISON: None available.

Diagnostic Radiology Reports

Order #: 04-221-11023 Exam date/time: 04/28/2001 15:23:07
Exam: Chest 1V

FINDINGS: An AP supine film of the chest was obtained at 1520 hours. The cardiothymic silhouette is somewhat prominent presumably related to supine positioning of the patient. The lungs are well expanded and clear. There is an endotracheal tube with the tip 8 mm above the carina. There is a nasogastric tube which is coiled in the stomach and then probably extends through the gastric outlet into the duodenum. There is a line projecting in the abdomen on the right, presumably within the inferior vena cava with the tip at the level of T9-10. A large amount of gas and fecal material is noted in the transverse colon.

IMPRESSION: Essentially normal study of the chest with tubes and a line present as described. IBK/MRC72 04/29/2001 05/01/2001
Dictated By: INGRID KJELLIN MD

Signed By : INGRID KJELLIN MD
**** end of result ****
Order #: 04-221-12755 Exam date/time: 05/01/2001 11:51:59
Exam: Femur, Left

Radiology Report

ORDER: 2112755, EXAM: 2310543. .

CASE: 015543250002

VERIFIED RESULT

LEFT FEMUR:

HISTORY: NAT.

FINDINGS: Single view of the left femur demonstrates normal osseous and soft tissue structures. There is no cortical irregularity or periosteal reaction.

IMPRESSION: Normal left femur without fracture.

LWY/MRC72 05/10/2001 05/10/2001
Dictated By : FRED SHU MD

I Reviewed Images Personally and Agree With Interpretation.
Signed By : LIONEL YOUNG MD
**** end of result ****
Order #: 04-221-12755 Exam date/time: 05/01/2001 11:51:44
Exam: Femur, Right

Diagnostic Radiology Reports

Order #: 04-221-12755. Exam date/time: 05/01/2001 11:51:44
Exam: Femur, Right

Radiology Report

ORDER: 2112755, EXAM: 2310542, .

CASE: 015543250002

VERIFIED RESULT

RIGHT FEMUR-05/01/01:

HISTORY: NAT.

FINDINGS: Single AP view of the right femur demonstrates right periosteal new bone formation along the lateral margin of the right femur. There is also cortical buckling or irregularity along the distal metaphysis of the right femur.

IMPRESSION: Distal metaphyseal fracture of the right femur, probably subacute, with evidence of periosteal new bone formation. LWY/MRC72
05/10/2001 05/10/2001
Dictated By : FRED SHU MD

I Reviewed Images Personally and Agree With Interpretation.
Signed By : LIONEL YOUNG MD
**** end of result ****

Nuclear Medicine Reports

Order #: 04-221-12135
Exam: Brain Scan Vas Flow/CBF
Exam date/time: 04/30/2001 16:44:33

Radiology Report

ORDER: 2112135, EXAM: 2309713, .

CASE: 015543250002

VERIFIED RESULT

HISTORY: This is a 6 month old male with history of possible non-accidental trauma.

PROCEDURE: 15.84 mCi Tc99m was bolus injected IV.

FINDINGS: Serial anterior images of the cerebral blood flow were obtained for 60 seconds with immediate blood pool images.

FINDINGS: Abormal arterial and venus flow is seen. There is no evidence of arterial or venous cerebral blood flow.

IMPRESSION: ABNORMAL CEREBRAL BLOOD FLOW CONSISTENT WITH ABSENT CEREBRAL BLOOD FLOW.
Dictated By : BENJAMIN CHEN MD

I Reviewed Images Personally and Agree With Interpretation.
Signed By : GERALD KIRK MD
**** end of result ****

CLERKS AND TRIAL TRANSCRIPTS

IN THE SUPERIOR COURT

OF THE STATE OF CALIFORNIA

PEOPLE OF THE STATE OF CALIFORNIA,

Plaintiff,

vs.

DAVID CHARLES PATKINS,

Defendant.

RSC NO. RIF-096844

PRELIMINARY HEARING

BEFORE THE HONORABLE W. CHARLES MORGAN, JUDGE PRESIDING
DEPARTMENT 32

MARCH 22, 2002

APPEARANCES:

For the People:

OFFICE OF THE DISTRICT ATTORNEY
BY: CHARLES HUGHES, Deputy
4075 Main Street, 7th Floor
Riverside, California 92501

For the Defendant:

OFFICE OF THE PUBLIC DEFENDER
BY: STUART SACHS, Deputy
4200 Orange Street
Riverside, California 92501

ORIGINAL

Reported by:

CONNIE McCUTCHEN, CSR 7027
Official Court Reporter
Riverside Superior Court

INDEX

---oOo---

REBECA PIANTINI,

called as a witness by the People, having been duly sworn, was examined and testified as follows:

DIRECT EXAMINATION

BY MR. HUGHES:

Q. Good morning, Doctor.

A. Good morning.

Q. What do you do for a living?

A. I'm a pediatrician.

Q. Okay. Can you tell us what type of training and experience you have that qualifies you to be a pediatrician.

A. I did medical school at Loma Linda University, School of Medicine. Then I did a pediatric residency at Loma Linda University Medical Center. Then I got extra training to do forensic pediatrics with Dr. Clare Sheridan. And I also attend yearly conferences and meetings for forensic pediatricians.

Q. What does it mean to be a forensic pediatrician?

A. It's a pediatrician who does exams on children that have been abused.

Q. How long have you been doing these types of exams?

A. Almost 10 years.

Q. And can you give us a ballpark figure of how many examinations of kids you've seen that have had injuries?

A. Oh, hundreds.

Q. Okay. Back in April 2001, were you involved in or consulted in the treatment of six-month-old Erik Patkins?

A. Yes, I was.

Q. And what was your role in the treatment and diagnosis

of Erik Patkins?

A. Erik Patkins had suffered from head trauma, and we were consulted because it was a possibility of him being abused; his head trauma being the result of abusive head trauma.

Q. When you're consulted, what do you do -- in this particular case, what did you do with respect to Erik Patkins?

A. Well, when we're consulted, we take a history. We do a thorough history, review medical records, do a complete medical exam, review the diagnostic tests that have been done. And I continue to follow the patient while they're in the hospital, follow their treatment, and then make an opinion as to whether we think the child has been abused or not.

Q. Okay. Do you -- as part of your consultation role, do you advise the treating physicians who are trying to help the injured child?

A. We advise them on what diagnostic tests to get, to try to sort out whether this is an abusive injury or not, and the immediate treatment of. Everybody just helps in what is their area of expertise to see the extent of what's going to be the in acute management of trying to support life and stuff.

Q. You mentioned you review medical reports. Have you reviewed the Loma Linda University medical records pertaining to Erik Patkins?

A. Yes.

Q. And did you also review autopsy and -- autopsy records from San Bernardino County Coroner's Office?

A. Yes.

Q. And you, in fact, attended the autopsy of Erik Patkins;

is that right?

A. Yes, I did.

Q. When was it that you were first consulted with respect to Erik Patkins?

A. I consulted on him that same day he was admitted, on April 28th of 2001.

Q. Okay. He came to Loma Linda from Riverside Community Hospital; is that right?

A. Yes.

Q. Can you just briefly summarize for us the course that Erik Patkins' condition took while he was there at Loma Linda University.

A. What he was -- he came to Loma Linda University by a transport team. That means that a physician went to get him at Loma -- at Riverside Community Hospital. He was transported already intubated, and he had been given medication for seizures and was sedated and was brought to Loma Linda.

When he got to Loma Linda, they felt like his condition was very unstable. He was already doing movements with his arms and legs that were very abnormal, and they thought that he had a significant injury.

MR. SACHS: I'd interpose an objection as hearsay as to what they say. Vague and also hearsay.

THE COURT: Well, I'm not --

If you'd just -- Doctor, let us know whether or not you were told information or you observed the information, and if --

THE WITNESS: This is information from the medical

records as to what happened before I got to see him.

THE COURT: Okay. And if that status were to change, you'd let us know when it's something you have observed or --

THE WITNESS: Correct.

THE COURT: -- you were told by another party, for instance.

THE WITNESS: Correct.

THE COURT: And you used this information in forming your opinion; is that correct?

THE WITNESS: That's correct.

THE COURT: You may continue.

THE WITNESS: Okay.

So in the emergency room he was noted to have increased intracranial pressure and unstable condition. They felt it was important -- the neurosurgeons had to put in an intercranial pressure monitor just as -- to see what the pressure in the head was. So they placed that, and his pressure was still very high. It was in the 90s, which is extremely high. And then they -- again it was necessary to put in a drain to drain some of the fluid to see if the pressure will decrease in the brain, so they put in a drain on his left side. They put in the monitor on the right side. They put in a drain on his left side. His pressures were still high. They came down. Later they again put in a lumbar drain and catheter in the lumbar spine again to try to decrease the pressure.

Q. (By Mr. Hughes) So his brain is swelling?

A. His brain is very swollen. There is increased intracranial pressure. The pressure is so high that he cannot

profuse his body, because it cannot profuse. He cannot get oxygen and blood to his brain because the pressure in the brain is higher than the normal -- than the blood pressure. So they had to also give him medication for the blood pressure, to keep his blood pressure up -- higher doses, you know, the maximum doses, multiple medications. He was placed in a barbitural coma with phenobarbital, again to keep his intracranial condition -- to try to stabilize it and decrease the intracranial pressure.

Q. He was actually placed in a barbitural coma; is that right?

A. Yes.

Q. That's to stop brain activity or limit it as much as possible?

A. So that it doesn't consume the oxygen -- that limited oxygen that you have. So they put the brain basically at rest as much as possible to try to decrease the pressure and to try to decrease the oxygen consumption so that you can do with a minimum that you can, you know, to try to bring things back to -- to try to save, you know, the child.

At the time that I saw him, he had already had all the drains. He was sedated and he was basically paralyzed. And I saw him just later that day. His external condition -- he didn't have apparent bruises other than a couple of bruises in the nails of his toes. He didn't -- of course, he was on a ventilator with a tube to help him breathe. He had the drains. He had the monitor. He had a catheter to collect his urine. He had femoral lines for I.V. access. And his pupils were very

fixed and dilated. That means they don't respond to light. When you shine the light, they don't respond. His pressures were in the 90s. At this time he has an intracranial vault and his intercranial pressure was over 60, 60s to 90s at times, fluctuating. He got medication to bring it down, what we call mannitol or diuretic to try to bring it down. He didn't respond. We wanted the pressure to be always less than 20, and this -- obviously higher than -- 60 to 90, it's extremely high for a child.

Q. Were any of the treatment measures that the physicians at Loma Linda University Medical Center took successful?

A. No. He even got transfusions to bring his hemoglobin up because, of course, he was losing blood and he was bleeding in his head, and to -- trying to keep more oxygen -- depositing more. But that -- nothing really helped. His condition continued to deteriorate.

Q. Are you familiar with the term "brain death"?

A. Yes.

Q. What does that mean?

A. It means that although we can keep the heart going, because we have medications to keep it going, and we have a ventilator to keep the breathing going, and the breathing is only going because of a ventilator. Because once you're brain-dead, you can't breathe, because that's a brain reflex. Basically means your brain isn't working, so you're dead.

Q. All right. Did Erik Patkins reach brain death?

A. Yes.

Q. When did that happen?

A. He was declared -- his first exam for brain death was actually done on the 30th, and he was basically brain-dead by physician's exam, and then we usually repeat the exam like 24 hours later. And then maybe the 1st is when he was -- actually the second exam was done and he was declared brain-dead.

Q. Is brain death fatal?

A. It's death. Yeah, it's fatal.

Q. Once you're brain-dead, you're no longer going to be alive?

A. That's correct.

Q. You can keep perhaps the heart beating and lungs pumping from the machines, but you'll never recover from that; is that correct?

A. That's correct. Only the machine's doing it.

Q. When Erik Patkins was declared to be brain-dead, were there surgical procedures done to harvest organs?

A. Yes.

Q. Whose decision was that, whether or not to harvest organs?

A. It's the family's decision. It's the mother's decision. When the organs are felt to be in good condition, then we call the transplant coordinator and the team and see if -- then they speak to the mother and offer the possibility. I believe the mom actually brought it up even before they spoke to her, saying that she --

Q. Okay. So Margie Garofano agreed to organ harvesting?

A. Yes.

Q. And following that, Erik Patkins expired; is that correct?

A. Yes.

Q. Did you attend the autopsy?

A. Yes.

Q. Who was that performed by?

A. Dr. Steve Trenkel.

Q. And Dr. Trenkel was a forensic pediatrician before he became a pathologist; is that correct?

A. That's correct.

Q. In fact, he trained Dr. Clare Sheridan, who then trained you?

A. That's correct.

Q. How long has Dr. Trenkle been a medical examiner?

A. I don't know. Eight or nine years. Something like that.

Q. When you went to the autopsy, did you actually see what types of physical injuries Erik Patkins had suffered?

A. Yes.

Q. Let's talk about the new injuries that Erik Patkins suffered. What types of injuries to his head did you see as a result of viewing the autopsy?

A. Well, the most fatal injury and the injuries that were very acute, he had what we call subdural hematoma, which is bleeding into the covering layer, which is a thick covering layer that goes over the brain in between the brain and the skull, if you want to -- and there was a lot of bleeding, extensive bleeding. And the most acute was mostly on the

right. It was to the back of the head, and it was in between RT 356
the two hemispheres in the fissure there. Had a lot of
bleeding there.

He had also extensive retinal hemorrhages, 50, 47 which were
also seen before the autopsy. I was able to see that on my
medical exam, and the ophthalmologist was able to see the
retinal hemorrhages. They were very extensive. They were
confirmed on the autopsy. What was also seen on the autopsy
was that he had optic nerve sheath hemorrhage, which -- this is
only seen when -- at autopsy, because it's not something that
can be seen if the child survives. Has to be in --

Q. So -- I'm sorry.

A. Then he had also skull fracture. He had an occipital
skull fracture. It's a skull fracture in the back of the head
on the right side. And when they did a microscopic
examination, they also found that he had ninth rib acute
fracture.

Q. So he had a fracture on his ninth rib. You count from
the top or the bottom?

A. From the top.

Q. So the ninth rib down, counting down from the top.
Right side or left side?

A. On the right side.

Q. Right side. All right. Were there any old injuries
that were found?

A. Yes. Oh. And one other new injury was subarachnoid
hemorrhage. That means bleeding kind of like more deeper into
the brain.

Q. All right.

A. Okay. And the old injuries, he again had old subdural hematomas. And they know they were old because of the appearance of the blood and also the stain. When they do the microscopic examination, they stain it and they see the by-products of the hemoglobin. So they can tell that it's an old injury.

Q. Okay. Now, you had described the new hematoma as extensive bleeding. With respect to the old one, by comparison, was it as extensive?

A. Not as extensive. It was -- the old one was more on the left side.

Q. So on the other side?

A. Right.

Q. All right.

A. And then he had an old left parietal fracture. That's, again, another fracture on the head, but it's on the left side and more in this area of the head (indicating) as opposed to the back.

Q. How can they tell that's old?

A. Well, because they show already the healing process of the fracture.

Q. All right. Were there any other old injuries noted?

A. Yeah. And then he had a right femur fracture. And that, again, they can tell by the healing process of the fracture.

Q. Based on your review of the medical records, your actual consultation, and following of the course of treatment

of Erik Patkins and your attendance at the autopsy and review of the autopsy records, do you have an opinion as to the cause of those new injuries that you've discussed?

A. Yeah. The -- there's -- new injuries were clearly a cause of abusive head trauma or what we commonly know as shaken baby syndrome.

Q. How is shaken -- what is done to a baby in shaken baby syndrome to result in these types of injuries?

A. What happens is a baby is shaken vigorously. It's an acceleration-deceleration, so it's a forward and back movement (indicating) of the head that causes the brain to go back and forth and causes a lot of intracranial bleeding, a lot of bleeding in the head, causes bleeding in the eyes. They can frequently have a fracture, depending on where the child is grabbed, how he's held. And then, obviously, depending on the degree of it, they can go into a level of unconsciousness, coma, and death.

Q. You indicated there can be a fracture from the shaking and you're making a motion with your hands together as though holding something in front of you; is that correct?

A. Right. Because frequently they're held by the chest (indicating), so we frequently see rib fractures associated with it.

Q. Again you're indicating with your hands in front of you as though holding something the size of a baby; is that correct?

A. Right.

Q. Right. Do you have an opinion as to the timing of when

these injuries were inflicted upon Erik Patkins?

A. It clearly had to have happened just --

MR. SACHS: I think I'm going to interpose an objection. Lack of foundation again, unless she's talking about some other doctor --

THE COURT: Overruled. Overruled.

THE WITNESS: And I did take a history from the mom. And the child was fine when she left for work the night before, was acting normal. And the baby then has an acute event, who ends up in death, is clearly within a few hours from the time of presentation to the hospital.

Q. (By Mr. Hughes) All right. And is it your opinion that these injuries that you've described to us as resulting from abusive head trauma resulted in the death of Erik Patkins?

A. Yes.

Q. Finally, do you have an opinion whether these injuries could possibly have been caused by a man approximately 6 feet 2 inches tall walking towards a set of carpeted stairs, tripping while holding the baby up at shoulder level, and dropping the baby onto the fourth or fifth stair up onto a carpeted surface?

A. Absolutely not.

Q. Why do you say that?

A. I've seen many, many children. I also do general peds who fall a whole flight of stairs and don't have this constellation of symptoms. It's not just one event. And if they have a fatal event, or something like falling down stairs -- which is usually cement, which rarely happens -- it's

from a different finding you have something fatal. It is not this whole constellation of symptoms that are found not only in a clinical exam but also at autopsy.

Q. You'd expect to see different injuries for that mechanism of death?

A. Yes.

MR. HUGHES: Nothing further.

THE COURT: Cross?

CROSS-EXAMINATION

BY MR. SACHS:

Q. What kind of injuries -- just touching on your last response -- you'd expect to see, for example, if dropping the baby would be the cause of death as opposed to what you're testifying to this morning?

A. Very rarely. Again, especially on a carpeted floor. If we are talking about a child that ends up with a -- is a fatality, that falls on cement stairs headfirst, it's usually what we call an epidermal hematoma, and it's an arterial bleed. And, again, most of the time it's because it's not recognized and it's not taken to surgery in time, because it's something that usually surgery can correct. And, again, it's very rare.

And here we have a constellation of findings. We have the extensive bleed through the brain in the areas that are not seen with an accidental fall into a stair. And we have the retinal hemorrhages, and we have a fracture, and we have also subarachnoid hemorrhage, and we have rib fractures. Then we have old injuries as well.

Q. Could you distinguish -- you said the subdural --

subdural hematoma is bleeding inside the brain, I guess. Is that right?

A. It's bleeding right under the brain. There's a covering membrane that's called a dura that goes over -- right over the arachnoid, which is the membrane that -- it's really the thin membrane that's going right -- right over the brain. And that dura under has like veins -- reaching veins. And when there is this motion, these veins kind of sheer up. They tear up and cause all this bleeding. 9934, 21,

Q. Now, you also said there's subarachnoid hematoma. Is that bleeding into a deeper region of the brain?

A. Yes. That is right under the arachnoids. That's right onto the brain tissue.

Q. That's more extensive bleeding than subdural hematoma?

A. They're both very extensive bleeding. The subdural hematoma is very classic. And when you have subdural and subarachnoid, it's very, very commonly seen with shaken baby syndrome.

Q. Subdural -- subdural hematoma is such that -- an injury that you would expect the baby to manifest some symptomology; isn't that fair to say?

A. It's depending on the degree of the subdural hematoma.

Q. So there are some --

A. Well -- huh?

Q. I'm trying to understand your testimony, Doctor. Because you said you found evidence of an old subdural hematoma; is that correct?

A. Right.

Q. And yet -- you reviewed the records. The baby had never been brought in before for any type of hospitalizations as a result of a head injury; correct?

A. Right.

Q. So are you telling us all subdural hematomas are not necessarily life-threatening situations?

A. That's correct.

Q. But you would expect a baby to at least be crying vigorously or showing some evidence of some type of a head injury, wouldn't you?

A. Usually the babies do cry, but it -- we find out most of the time that fussiness that -- or depending on what it was they are thought to be -- colic -- they're thought that the baby is just fussy for that. And, obviously, if it's not very extensive bleeding and doesn't have the other manifestations -- not all subdural leads to death. And not all subdural leads to being even admitted to the hospital.

Q. Are you able to give a time frame as to the old hematoma, as to whether that would have taken place in relationship --

A. No. All we can tell is that it's old. And, again, that was done by the pathologist.

Q. I'm sorry?

A. That's what the pathologist determined on the autopsy by doing the microscopic. That's --

Q. Is that where they find -- by some type of staining, they determine it's an old hematoma?

A. Right. Although in the CT, it looked like it's

suspicious. You can't confirm it until -- you know, at autopsy it was confirmed.

Q. Now, the rib fracture that you made reference to in the ninth rib, you said that was already in the process of healing?

A. No. The rib fracture was acute.

Q. So what you mean, it was recent?

A. It was recent.

Q. It was recent?

A. Right.

Q. Could have been contemporaneous with the injury to the head?

A. Right.

Q. And can a baby suffer a rib fracture by falling and hitting their rib in that particular location?

A. Babies that have rib fractures -- if there's not an adequate history to explain the fracture -- yeah, you can get a rib fracture, depending on the location of the rib, from a fall. But that's clearly identified, a fall, as the cause of it. The mechanism has to be studied. It's not unusual. But those rib fractures are due to shaking."

THE COURT: Just a moment, Mr. Sachs. Just a moment. I have to take a call here. Just will be two minutes.

(Brief pause in proceedings.)

THE COURT: I thank you for that, Mr. Sachs. You may continue, sir.

MR. SACHS: Thanks.

THE COURT: Thank you.

Q. (By Mr. Sachs) I'm sorry. You said that was the ninth

rib that was fractured, Doctor; is that right?

A. That's correct.

Q. What side was that again?

A. The right -- on the right side.

Q. The right side?

A. Yeah.

Q. Now, the presence of retinal hemorrhaging is, in fact, something that's consistent with shaken babies; is that right?

A. That's correct.

Q. As a matter of fact, most doctors, when they see the presence of retinal hemorrhaging, automatically assume there's a shaken baby. Isn't that fair to say?

A. Well, in the absence of a lot of other conditions, yes.

Q. But there are other conditions that can cause retinal hemorrhaging?

A. There are other conditions, but they look different too.

Q. Are they consistent with a fall? After, could a child suffer retinal hemorrhaging?

A. Not consistent with a fall, no.

Q. Basically, the presence of retinal hemorrhaging is -- just increased pressure within the brain causes that; isn't that fair to say?

A. No.

Q. What --

A. You can have increased pressure and not have retinal hemorrhages.

Q. And you can have increased pressure and not have

retinal hemorrhages? Is that what you're saying?

A. That's correct.

Q. Frequently, if you do have increased cranial pressure, that does cause it?

A. No. Only certain mechanisms. A lot of people die from motor vehicle accidents and have increased pressure and no retinal hemorrhages.

Q. What mechanisms are you speaking about?

A. There's occulusion of the venous return, of the venous outflow, that causes a lot of retinal hemorrhages. And, again, the retinal hemorrhages, depending on what they're caused from -- but in this case they're suspected to be -- the mechanism is not clearly understood, what causes -- what specific mechanism it is that causes retinal hemorrhages. But they've clearly been seen -- that retinal hemorrhages are associated with shaken baby and are very rarely seen in motor vehicle accidents. The mechanism seen in motor vehicle, there's high speed. With this, there's a history. There's a report of all this. It's not just a rear-end. It's not a high-speed motor vehicle accident.

Q. You had an opportunity to physically examine the baby before the baby was declared brain-dead, I guess?

A. Yes.

Q. And there were no -- would it be fair to say there were no visible injuries to the child?

THE COURT: External?

MR. SACHS: External.

THE WITNESS: No external, other than the two little

areas of hemorrhage that I described on his toenails.

Q. (By Mr. Sachs) There was no redness or bruising on the child. Is that fair to say?

A. No. He just had an abrasion on -- abrasions.

Q. And frequently when you see bruised children, do you not see the presence of either bruising or sometimes extensive external injuries?

A. Sometimes we do; sometimes we don't.

Q. Now, there is -- a short -- a short fall of a child can, in fact, under certain circumstances, cause the kind of fatal injury we have had here; isn't that true?

A. Not the kind of fatal injuries we have here, no.

Q. What specific injuries are you talking about that would preclude -- strike that.

You are aware of a body of literature that talks about short falls can cause fatal injuries in children, are you not?

A. Yes.

Q. By a Dr. Plunkett, a study on short falls. Are you familiar with that study?

A. Yes.

Q. What particular injuries here are you talking about that would allow the possibility of a fall causing these injuries to a child?

A. The injuries that this child has are extensive: subdural, subarachnoid, interhemispheric pressure. He has also extensive retinal hemorrhages and optic nerve sheath hemorrhage. And he also has a posterior rib fracture, acute fracture. He has a combination -- whole lot of symptoms that

are not explained by just falling from a father holding the child, into a carpeted stair.

Q. The skull fracture that you talked about, the new one, I think you said it was in the right parietal region. Is that right?

A. No. The skull fracture that is a new one is in the back of the head in the occipital area.

Q. The occipital area. Is that fracture caused normally by blunt force? Is that caused by shaking as well?

A. No. It -- it's caused by impact, having the head hit against a hard surface. It's what we call frequently -- could be shaken impact syndrome. Most of the shaken babies are not just shaken and put down gently on the bed. A lot of them are shaken, then dropped or hit against something.

Q. So in your opinion, it would cause a sufficient -- have to be a sufficient impact to cause this type of skull fracture, then; is that right?

A. Yes.

Q. And shaking the baby alone doesn't cause this type of fracture, as I understand it?

A. Right.

Q. Now, is -- the old injury, the left -- one to the left parietal area, I believe, is that also the same type of thing? It would have to be some impact to that part of the head with a hard surface?

A. But -- yeah. But the parietal area is less -- the occipital is more significant, in that it requires more force and that it's very, very difficult to break the back of your

head. It's easier to break this area (indicating). The parietal is on the side. And the parietal area is an area that can break easier.

Q. And again --

A. But it's impact. Has to have an impact.

Q. So, again, shaking is not going to cause a parietal fracture either, I take it?

A. Shaken impact will, but not shaken alone, yes.

Q. And was there any attempt to date the age of the parietal fracture?

A. You can't really date fractures on the skull. All you can say is that they were already healing; that they're not just recent. But you can't say they're one week, two weeks. I can't say that.

Q. Does it have calcification --

A. They have periosteal healing of the bone.

Q. Would you expect to have some symptomatology from the fracture to the parietal to the child?

A. Usually, but they can be very minimal. Symptomatology, they may just be fussy, cry, or it may not be very -- again, some shaken babies are very mild, and they don't -- they don't exhibit the symptoms that will bring the child always to a doctor or bring the child into an intensive care unit. They may just be fussy or may be throwing up. They may be sleeping more. There are different things that the people may just not think is that serious for a short period of time.

Q. Well, in your opinion, is it the shaking of the baby or is it the hard impact that caused the occipital skull fracture,

for example, that causes the intercranial pressure to go all the way up from 60 to 90, or is it a combination of both?

A. Probably a combination of both. But definitely the motion of the shaking caused the most fatal injuries.

Q. The motion of shaking, you're saying, as opposed to the impact? Is that what you're saying?

A. Yes. Because usually an impact alone, if you just have a fracture, doesn't kill the baby. A fracture does not kill them. It's the other injuries that kill them.

Q. And the most -- in your opinion, the most likely mechanism to increase the pressure, the intercranial pressure, is by shaking them; is that correct?

A. In this case, yes.

MR. SACHS: If I may just have a minute, please?

THE COURT: You may.

Q. (By Mr. Sachs) Are you familiar with the term of rebleeding from existing hematomas?

A. Yes.

Q. Okay. That's a situation where you don't necessarily have to have a new trauma, but an old hematoma can start bleeding again?

A. No. This is not absolutely what happens. That's -- rebleeding, if you have a space occupying a lesion already, have blood, you can bleed into that area easier. It does usually require trauma. And if the bleeding is minimal and doesn't cause a fatality or a death with the other symptoms, it's just almost like a microbleed.

Q. But it is bleeding that comes from an existing

PATKINS: No big deal. Yeah.

BARTHOLOMEW: OK. Uuh--

DELAROSA: I stepped out when I ask you about you getting frustrated at all when he cries.

PATKINS: Mu-huh (affirmative)

DELAROSA: What'd you do?

PATKINS: Uuh--

DELAROSA: Does, he was making you frustrated when he's crying?

PATKINS: No. Not at all. Sometimes I, well, you know, I mean, you wanna do something. You wanna help. But like get mad, you know, no. No, no, no. No, that's not the answer. That's not the answer, that's not the right way.

DELAROSA: Have you ever spanked him?

PATKINS: No. No. Her, nor the baby. Maybe the dog's got it a couple of times.

DELAROSA: You ever shake him or anything?

PATKINS: No.

DELAROSA: Get mad?

PATKINS: No.

DELAROSA: Frustrated?

PATKINS: No. Not at all. No not after, uuh, understanding about the shaken baby syndrome.

BARTHOLOMEW: How did you hear about that?

PATKINS: Uuh, well she had pamphlets and, uuh, you know, just from the past.

BARTHOLOMEW: What's past?

PATKINS: Just, just, just knowing it from the past.

BARTHOLOMEW: You said you had two other kids, uuh, what a three-year old and a seven-year old?

PATKINS: Mu-huh (affirmative)

BARTHOLOMEW: Did you ever have any problems with them?

PATKINS: Mu-huh (affirmative)

BARTHOLOMEW: Like what?

PATKINS: (laughs) the shaken baby syndrome.

BARTHOLOMEW: You shake the kids then?

PATKINS: The, the, one, my, my oldest son, yeah.

BARTHOLOMEW: Your oldest son? Did you ever get charged with that?

PATKINS: Mu-huh (affirmative)

BARTHOLOMEW: Did you get convicted of that?

PATKINS: Mu-huh (affirmative)

BARTHOLOMEW: What'd they convict you of?

PATKINS: Uuh, they called it child cruelty.

BARTHOLOMEW: OK. Did you do any time?

PATKINS: Mu-huh (affirmative)

BARTHOLOMEW: How much time did you do?

PATKINS: I did, uuh, I did in the, in there, in prison, I did about, uuh, four years of my life.

BARTHOLOMEW: Four years? When did you get out?

PATKINS: I got out in, uuh, 1996

BARTHOLOMEW: So you had, your three-year-old, you've had since then?

PATKINS: Uuh, uuh, yeah. Well, what happened was, uuh, uuh, I got together back with the lady that, uuh, and, uuh, and then, and then we had, uuh, uuh, the next one after that, and, uuh, and, uuh, and then, uuh, well she left to Iowa.

BARTHOLOMEW: Is this all back in Iowa then?

PATKINS: No.

BARTHOLOMEW: No. This, is this in, in the Upland area--

PATKINS: Mu-huh (affirmative)

BARTHOLOMEW: --like you said.

DELAROSA: Are you still on parole?

PATKINS: No.

DELAROSA: Did you do all your time or you get paroled at all?

PATKINS: Mu-huh (affirmative). I have, it's all done and cleared and, you know, counseling and, uuh, and everything, I did everything that--

DELAROSA: Does Margie know this?

PATKINS: Yes, she does.

DELAROSA: That you were arrested for that and did time for it?

PATKINS: Yes.

DELAROSA: So you know all about it right?

PATKINS: Uuh, I, I don't know, you know what's, what's happening right now.

DELAROSA: No, you know all about shaken baby and--

PATKINS: Oh, right, right.

DELAROSA: --being frustrated and doing things to kids you shouldn't be doing.

PATKINS: Yeah, yeah. Right, like I say shaken baby syndrome or, you know, yeah.

BARTHOLOMEW: Did you ever hit Erik?

PATKINS: No.

BARTHOLOMEW: Did you ever push him down?

PATKINS: Uuh, there's, uuh, I, no. Push him down? No.

BARTHOLOMEW: I don't, I'm looking at that bed and I'm looking at the, at the floor and everything, David--

PATKINS: Mu-huh (affirmative)

BARTHOLOMEW: --and I really don't think he, he got his skull fractures from falling off the bed, and I don't think you believe that either.

PATKINS: I, I don't know. Uuh, I just know that, that we had a, that he fell off the bed.

BARTHOLOMEW: What happened, why'd he fall off the bed?

PATKINS: Uuh, he just, uuh, he's just a little rambunctious little boy and he, and he, he just did his little play thing and he, he fell off the bed. I don't know. I don't know.

BARTHOLOMEW: So if I go, when I go to Loma Linda today, are they gonna tell me, I don't think they're gonna tell me that it was natural that, that, I think the way the injuries are described to me that I've heard of so far, I mean, are, it's not from falling off the bed, hitting your head on the side.

PATKINS: I don't know ..(unintelligible)..

BARTHOLOMEW: What happened?

DELAROSA: You do know because you've done time for, for injuring a child before.

PATKINS: Right. But I've changed my life.

DELAROSA: And I'm sure it's part, it's part of your counseling, it's part of what happened back then. You know what it takes to hurt a baby. It takes a lot more than falling off the bed to get a skull fracture.

PATKINS: I don't know.

DELAROSA: These stairs are padded and carpeted.

PATKINS: Right.

DELAROSA: OK. And now he's got bleeding, and he's got, you know, some bilateral skull fractures.

BARTHOLOMEW: The, the only way to help him and to get him the treatment that he needs today--

PATKINS: I told you what happened.

BARTHOLOMEW: --is the truth.

PATKINS: I told you what happened.

BARTHOLOMEW: I think it's, yeah, he probably did fall but what happ--, more had to have happened, David.

PATKINS: There is nothing more. I told you what happened. I did my time. I changed my life. I changed my life.

BARTHOLOMEW: I think--

PATKINS: I told you what happened.

BARTHOLOMEW: --I think you get frustrated because all of a sudden you got a good relationship going--

PATKINS: Yeah.

BARTHOLOMEW: --with Margie.

PATKINS: Right.

BARTHOLOMEW: All of a sudden Erik's in the picture now. She's not giving you the time you want. She's harping on you to get a good job--

PATKINS: She's ..(unintelligible)..

BARTHOLOMEW: --and stuff like that. Right? And you get frust--, I think you get, you get frustrated with that?

PATKINS: No.

BARTHOLOMEW: I think you have been. Who wouldn't? You want a little bit of time. We need to know the truth.

PATKINS: I just told you the truth.

BARTHOLOMEW: What else happened? How did he get the other skull fractures?

PATKINS: I don't know. I don't know. I don't know what, I don't know. I just told you.

BARTHOLOMEW: What--

PATKINS: Anything that, that--

BARTHOLOMEW: --how do you think, why do you think--

PATKINS: --that I would think that would be helpful--

BARTHOLOMEW: --how do you think he got the skull fractures?

PATKINS: From, I don't know. From the stairs? From the cabinets?

BARTHOLOMEW: Has he fallen down the stairs before?

PATKINS: No. Not that I know of, no.

BARTHOLOMEW: So you knew going into this that this wasn't gonna look good for you, didn't you?

PATKINS: I, I'm scared. I'm scared.

BARTHOLOMEW: Is that why you kind of hesitated on calling to get him help this morning?

PATKINS: Uuh, what do you mean hesitated?

BARTHOLOMEW: Well, you, you kind of, you said, "Oh, my god, he's injured," you knew he was hurt.

PATKINS: And I called Margie direct, yes.

BARTHOLOMEW: Well, you took--

PATKINS: And then she hung up and I called 911.

BARTHOLOMEW: --there was some time, why'd you call, if you knew he was hurt, why, why didn't you call 911 and then call Margie?

PATKINS: I don't know.

BARTHOLOMEW: Were you scared?

PATKINS: Yeah.

BARTHOLOMEW: Scared of--

PATKINS: For him.

BARTHOLOMEW: For him or, or what might happen to you?

PATKINS: I, I didn't have a thought about what would happen to me. I was looking at my little baby.

BARTHOLOMEW: I don't know, I don't, my, my impression would be, no offense but, I've been convicted for child abuse before, I'd done, I've served time in prison on a child abuse case, my kid gets hurt in the morning, I know he's hurt, he's in pain and that's obvious, and I'm sitting there looking at him and, my first, no, yeah, I'm gonna care about the kid but, shoot, what's gonna happen to me? That's kind of, you

cannot tell me that didn't go through your mind. I don't buy that.

PATKINS: Well, it did go through my mind.

BARTHOLOMEW: OK.

PATKINS: But does it have to go through my mind right then? It did go through my mind. I've been thinking about that, yeah.

BARTHOLOMEW: You said you got up, you told her in the morning that you woke up at 5:30.

PATKINS: Uuh, I just guessed. I don't know, I don't know. I just guessed. It was around that time. When she corrected me and said I called her at 6:20, well, then I had to just think back from there. It's within that time, it's within that time.

BARTHOLOMEW: Mu-huh (affirmative). As you know, that time period can have an affect.

(talking in background)

BARTHOLOMEW: We'll take a break, alright, David?

MASSON: ..(unintelligible).. Erik's father and you have every right to know that, uuh, uuh, Erik is in critical condition. And, uuh, the injury is life threatening. You understand that? OK. I, I wanna talk to you about what happened. And we're gonna go ahead and read you your rights but the most

important thing here is obviously that we need to know what happened because of poor Erik. And what we might be able to do for him medically. You understand that?

PATKINS: I told you guys everything.

MASSON: OK. Well, maybe there's something that you might've forgotten that could help us out here. Again, his injuries are, are, are so that we need to know everything so that maybe they can make a decision when it comes down to a certain treatment or something.

PATKINS: I told, I told you guys everything. I told you everything. I told you everything that happened.

MASSON: Well, let me, let me go through this again and, and maybe, maybe something will, will spring your memory or something like that, OK? Uuh, obviously it's, it's real important that we get all the facts. Alright. You have the absolute right to remain silent. Anything you say can and will be used against you in a court of law. You have the right to talk to a lawyer and have a lawyer present before and during questioning. If you cannot afford to hire a lawyer, one will be appointed to

Case Number : RIF096844 People vs. DAVID PATKINS

Argument heard By both sides, Matter is submitted.
Motion Granted.
Count 1 reduced to 2nd degree.
Court and Counsel Confer regarding: Jury Instructions.
People's Exhibit(s) 4 is/are Withdrawn.
People's exhibit(s) 4 returned to the People. R.T. 8-9, C.T. 000233, R.T. 546
Court and Counsel Confer regarding: Jury Instructions and lessers.
Jury TRIAL IN-PROGRESS is adjourned to 10/07/2002 at 9:30 in Department 52.
Defendant ordered to return.
Remains remanded to custody of Riverside Sheriff.
Bail To Remain as fixed.
Defendant to be dressed out for trial.
Minute Order printed to Robert Presley Detention Center.
MINUTE ORDER OF COURT PROCEEDING

Dispo

ALPHABETICAL INDEX OF WITNESSES

ALPHABETICAL INDEX OF WITNESSES

(CONTINUED)

photograph, the small one.

MR. HUGHES: I will do that.

With the Court's permission, what I will do is just go ahead and cut the photograph in half and have it remarked as 29A, just the top picture.

THE COURT: Miss Rogers can do that. The bottom photograph will be returned to the People as excluded.

THE CLERK: Okay.

MR. SACHS: The only other picture I have, and I guess the Court might have to wait until we actually have testimony from the physician in this, is number 4. I guess this is a picture of Eric's rib cage. I'm not sure it is even positioned the correct way for the Court to look at.

R.T. 596, C.T. 000133

MR. HUGHES: It is.

MR. SACHS: Apparently shows some kind of bruising or hemorrhaging or something in the rib cage of the child, and it looks like it's a pretty gory picture, to say the least. I'm not necessarily sure how probative it would be for the jury to look at that picture. I would impose 352, I -- right now, although the Court hasn't heard the essence of the pathology, if the Court wishes to wait until such time? This picture does concern me.

THE COURT: Mr. Hughes?

MR. HUGHES: By way of offer of proof, the baby had a rib fracture in the back next to his spine. The way it's discovered is during the autopsy, the pathologist sees hemorrhaging and bruising in this area here. The vertical matter in the center of the photograph is the baby's spine.

When the pathologist sees this type of hemorrhaging, it alerts him that there is damage to this rib. He then cuts out that section of rib and looks at it under a microscope and finds the fracture. So that's the reason that I proposed this photograph, is it is what keys the coroner in that there may well be a rib fracture.

THE COURT: Mr. Sachs?

MR. SACHS: I'd submit on that under 352, I'd ask the Court to exclude it. I don't know how probative it will be for the jury to see this picture. I think it could be adequately described by the pathologist.

THE COURT: I'll take the 352 ruling under submission on this issue.

And, Mr. Hughes, please don't show it to the jury during opening.

MR. HUGHES: I will not.

MR. SACHS: And I'd also -- perhaps the Court could do the same ruling with respect to photographs 13 and 15. 13 being at the top of the screen and 15 being below. I better do them separately. One apparently is the right eye. It's written on the right eye, and I don't know exactly what this would show. Perhaps retina hemorrhaging, which I fail to see from this picture, but I think that's pretty prejudicial to have pictures of the child's right eye to have displayed for the jury.

THE COURT: For the record, it appears that the eye has been --

MR. SACHS: Cut open.

THE COURT: -- sliced in half.

MR. SACHS: Yes. And the number 15 is virtually the same type of picture with writing on the left eye, apparently also sliced open.

So, again, if the Court wishes to defer that that's fine, but at this point, I would ask these pictures not be shown to the jury unless the relevance is clearly tied in by the pathologist.

MR. HUGHES: These are exactly what counsel has described, which is extreme retina hemorrhaging. That is a classic symptom of what Mr. Patkins is accused to having done to his son. To my knowledge, we do not have the type of photographs that sometimes they have of retina hemorrhaging, which a victim survives, which is by jamming equipment behind the eye and photographing it. What we have to show, the retina hemorrhaging, are these photographs. So that's why they are offered.

THE COURT: All right.

Same ruling. Mr. Sachs, I'll take that under submission at this time.

MR. SACHS: I think that concludes the objections to any photographs, Your Honor.

THE COURT: We have the People's motion to admit the 1101(b) evidence. And I've reviewed the trial brief submitted by Mr. Hughes.

And, Mr. Sachs, would you like to respond?

MR. SACHS: Just -- well, just briefly, Your Honor. I'm basically prepared to submit it. I do believe that the -- it

is still prejudicial to allow the 1993 incident to be admitted. I'm not sure if Mr. Patkins' statements to the police, that he dropped the child or the child hit its head on the carpet, should bring up, necessarily, the 1993 incident.

I think it's pretty much common sense that shaking a baby is, in fact, a dangerous condition. And Mr. Hughes seems to believe that because, you know, this incident may have happened in '93, that somehow Mr. Patkins would not have known that it was dangerous to drop a child. I think he admitted to the police if those statements did come in, that he was aware that shaking a child would be dangerous. I think that's fairly common sense that fathers would know shaking a baby violently would, in fact, be a potentially dangerous situation.

So to bring up the fact that he pled guilty to an offense of abusing a child in '93, I think, is sort of overkill and extremely prejudicial to Mr. Patkins. It is preceding a fair trial in the instant case. I think it would be difficult for the jury to not regard this as propensity evidence and say, well, if he did it before, he's likely to have done it again and have most of the issues with respect to Mr. Patkins', vis-a-vis, error. Really be subject to what happened to Erik with respect to the prior incident involving his son, Jack. I'm thinking the incident being introduced with Jack, it would be imposing the fact to that he did the same thing to Erik.

Beyond that, I would submit it. I think it's the 352 issue pretty clearly.

THE COURT: Mr. Hughes?

MR. HUGHES: Well, it's being offered for more than just his knowledge of whether or not this is dangerous. That's one of the reasons it's being offered. And that most people, out of common knowledge, know that's dangerous, is not a reason to exclude the evidence. It's extremely probative in that sense.

Someone who has been through this precise scenario has inflicted himself great bodily injury, has far more knowledge than the average person that, gee, we know it's not good to shake a baby, or we know it's dangerous to shake a baby. He has lived it firsthand. He has caused it firsthand. It's offered for knowledge. It's offered to show his intent, when he is shaking the baby, that his intent is to harm the baby, if not kill. That this was not a mistake or accident, which is what he is claiming to the police. So it comes in for all of those reasons.

Those are the central issues in the case, which makes his prior conduct extremely probative as to the truth of his claim in this case.

So the probative value being very high is not substantially outweighed by the potential prejudice to Mr. Patkins. So it should be admissible under 1101(b) and 352.

THE COURT: All right, anything further, Mr. Sachs?

MR. SACHS: No, Your Honor.

THE COURT: As far as the 1101(b) evidence, I believe it's highly probative in this kind of case. It clearly goes