to intent, implied malice, as well as lack of accident. The jury will be admonished in the 1101(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 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 352 will be denied.

As far as the information is concerned, Mr. Sachs, are you requesting a bifurcation?

MR. SACHS: Yes. As a matter of fact, I believe Mr. Patkins is prepared to not only ask for bifurcation, but waive jury on the issues of the truthfulness of the priors, should that need arise.

THE COURT: At this time, the prior offense as alleged, the serious prior offense, as well as the strike as alleged in the information, will be bifurcated, and the jury will not be advised of those convictions.

MR. SACHS: The Court want to take a jury waiver on that issue right now?

THE COURT: I can.

MR. HUGHES: With respect to that prior, I have to double-check. I believe we may have alleged the sentencing

A I believe he got there near the end of the interview, the first interview.

Q And do you recall approximately how long the break was from the time you said, "All right, we'll take a break," till the time that Detective Masson began interviewing Mr. Patkins?

A It was over an hour, probably closer to two hours.

Q During that time, you said you were searching the house. You videotaped the house.

Did you speak with anyone on the telephone during that time?

A Yes, I did.

Q Who did you speak with on the phone?

A I spoke to -- I believe, I listed her name in the report, but a person from Riverside Community Hospital, and then a person from Loma Linda University Medical Center.

Q Were those people giving you updates on the condition of the baby?

A Yes.

Q What information did you learn during that time about the condition of the baby?

A Um, during the first interview, they indicated there were some -- they had spotted some possible new fractures based on some X-rays taken at Riverside Community Hospital, in addition to the skull fractures, and Loma Linda indicated they didn't find those, but that the child did have the cranial bleeding and such, and his condition was not good.

Q Did you discuss with them, with anyone on the phone

during that break, whether the medical opinion was that Mr. Patkins' story was consistent or inconsistent with the injuries to the baby?

A I believe I discussed with Loma Linda medical personnel.

Q What information did they give you?

A That the injuries sustained by Erik were inconsistent with the situation described by Mr. Patkins.

Q During the interview with Mr. Patkins, there's a point where he discloses to you his prior experience with shaken baby syndrome.

Up until that point of the interview, did you know of Mr. Patkins' criminal history?

A No.

MR. HUGHES: And with the Court's permission, I'm going to play a copy of the videotape, People's 34, I think. In particular, towards the end of the tape, there's a segment that shows the layout where the interview actually took place that I think will be helpful.

THE COURT: Mr. Sachs, have you viewed this tape?

MR. SACHS: I've seen it before.

MR. HUGHES: It doesn't appear the Court's VCR is working. It won't play.

THE COURT: Didn't we have this problem a couple weeks ago?

MR. HUGHES: I hit the "play" button. It won't play. It's not a problem of the connections. The heads, themselves, won't turn.

A Um, I -- yes, I think so.

Q And also two more things that came out of People's Exhibit 30, a one-page document that at the top says, "Rancho Pediatric Associates"?

A Um-hum.

Q Can you see that document?

A Yes, uh-huh.

Q And that pertains to Eric at four and a half months; is that right?

A Yes.

Q Date 3/8/01?

A Yes, uh-huh.

Q Is this the -- why don't you tell us what this is actually?

A Looks like -- Dr. Curtis would write -- he had little -- small little, like, form paper he would -- as you're in the room with him, he would fill out notes for himself on the baby.

Q Give those notes to you?

A Yeah. He would give you a copy, and then he would keep it for himself too to make his notes later.

Q You see the word "healthy" on there?

A Yes.

Q Is that the well-baby visit you had with him?

A Yes.

Q Also out of People's Exhibit 30, a business card on the front says, "Donald D. Curtis, M.D.," is that a card that he gave to you?

father and the paramedics.

Q Now, when you -- when the CT scan was done, did you have a chance to view the results?

A Yes.

Q Did you discuss the results with any other doctors?

A Well, two doctors, one would be the radiologist who actually gives us the report and the second was the trauma surgeon that I had consulted.

Q Who was that?

A A. J. Rogers.

Q Is he a neurological surgeon?

A No, he's actually a thoracic surgeon, but he's a trauma surgeon.

Q Okay. Now, with the CT scan results, what were the results of the CT scan?

A Can I refer to this for a second?

Q Please, if it would refresh your recollection.

A Well, specifically, it showed skull fractures on both sides of the head, broken skull bone on both sides of the head. It had some bleeding underneath the skull between the brain and the skull on the right side, and it had some blood in the fluid around the brain, which is also related to trauma. It showed on the left side what's called subdural hematoma, which suggests there may have been an old injury on the left side of the brain. Then there was an area in the left frontal part of the brain inside the brain substance itself that -- some blood and

was suspicious for an injury of another date.

Q An older injury, you mean?

A Correct.

Q Was there evidence of new -- pardon -- new bleeding within the brain?

A Yes, there was.

Q Where did you see that?

A It was primarily in three places. There was blood, a collection of blood between the brain and the skull. There was a little bit of blood around the whole brain in the fluid that the brain sits in, and then there was blood inside the brain over on the left side.

Q Okay. With respect to some of the new bleeding you're describing generically between the skull and the brain, what levels was the subarachnoid subdural -- what type --

A It's called epidural. Was the blood over here on the right. That's right underneath the skull but outside of what's called the dura, which is the covering over the brain.

Q Did you see subarachnoid hematoma?

A There was subarachnoid hematoma as well. That's the blood that's in the fluid that the brain sits in.

Q Now, did you notice any type of swelling to the brain?

A Yes, there was edema to the brain, which is a response to trauma, and it's what causes the brain substance to swell, and that's -- itself to swell, and

A It would be -- well, I would say most of the time, what we're seeing, there would be a matter of hours rather than days. After two or three days, the blood loses its sort of fresh appearance, but I can't give you anything more specific than that. It would require a radiologist probably to tell you that.

Q Again, showing you Number 36 for identification, the hygroma, was that in the left side of the skull or the right side?

Did you say -- I didn't hear what you said?

A The hygroma was in the left frontal temporal part of the brain in this area [indicating].

Q That's actually in the brain?

A No, it's -- it's subdural, which is below the dura, that membrane between the dura and the brain.

Q Subdura looks like gray in this area here [indicating]?

A That's correct.

Q Subdural. This area here. Frontal lobe area with -- where I'm pointing [indicating]?

A This is a view this way [indicating]. But if -- if the face is this way, yes it would be. It's a little hard for me to describe on this. But it would be about right here underneath the dura but above the brain, outside the brain [indicating].

MR. HUGHES: For the record, your Honor, indicating above the witness' left eye in the forehead area, roughly the hairline area.

Q (By Mr. Sachs:) Is that correct?

A That would be correct; little towards the temporal, front part of the temporal.

MR. SACHS: Depends on what his hairline would be.

MR. HUGHES: His, not mine.

Q (By Mr. Sachs:) Now, that hygroma, that, as I understand, that you thought was consistent with an older injury, is that how I understood that bleeding?

A That was my concern and the radiologist's concern. And read the report. That was not an acute injury but a sign of an older injury.

Q If there is some uncertainty, that can also be a fresh injury?

A That would not be felt to be a fresh injury.

Q Now, the other injury to the, I guess you said, the epidural, where was that epidural injury on the child?

A The epidural injury was on the right side, right temporal area that -- again, remember that dura, that membrane that covers over the brain, the left side was a little under that membrane. The right side is over that membrane, between the membrane and the skull.

Q That's what you call the epidural, I believe you said?

A Epidural. That's on the right temporal side.

Q That was deemed to be fresh bleeding by the CAT scan?

A That's correct.

there's no shift in the bones themselves.

Q So the increased pressure that's building up in the child's brain, would that be the result of the skull fractures?

A No, they would be a result of the brain --

Q The bleeding in the brain?

A Well, the swelling of the substance of the brain itself.

Q Approximately how long was the baby in the care of Riverside Community before it was determined that he needed to be transported to Loma Linda? We talked about less than an hour.

A Before he showed a need to be transferred?

Q Right.

A Less than an hour.

Q Now, you said also something about femur bones, I think, on both?

A Yes.

Q Talking about the bone, where exactly is the femur bone?

A The femurs are the thigh bones that connect from the hip down to the knee, longest bone in the body, and there were signs -- I think they said of periosteal thickening, which is what we see in bones that have been broken and they are starting to heal. That suggests to us the bones have been broken in the shaft and are showing some signs of healing.

Q That's the periosteum is the membrane that covers

the bone?

A That's correct.

Q You're talking about both the left and the right?

A That's correct.

Q That was learned from the Xrays or the CAT scan?

A From the Xrays, survey of Xrays that we did.

Q You were not in a position to estimate the age of the fractures; is that right?

A No.

MR. SACHS: I have no further questions. Thank you.

THE COURT: Mr. Hughes?

REDIRECT EXAMINATION

BY MR. HUGHES:

Q At the time that Eric was transported to Loma Linda University Medical Center, would he have been awake?

A No.

Q Why is that?

A We had put the child on a ventilator. We were breathing for the child; and so to keep him from fighting that tube or to be uncomfortable with that tube in his lungs, we gave him sedating doses of medications.

Q Sedating doses of phenobarbital?

A Phenobarbital.

Q Phenobarbital had previously been given to try to control swelling; is that right?

A It's -- it does two functions. It helps sedate

Q How did he respond?

A He responded with, yes, it was.

Q Did you ask the father to describe how the baby had been injured?

A Yes, I did.

Q Did he do that for you?

A Yes, he did.

Q What did he tell you?

A From what I can recall, he said he was holding the child, began walking up the stairs, approached approximately the third or fourth stair. There was a dog. He said the dog either tripped him up or caused him to fall and ended up dropping the child.

Q Did he actually show you the area of the house where this occurred?

A He showed us the stairs, where the stairs were, stated that's where the child fell.

Q Based on how he was showing you and describing things for you, did you estimate how far the fall would have been based on what Mr. Patkins told you?

A We estimate. Yes, sir. We estimated the fall to be approximately 18 inches.

Q I'm going to show you what's been marked for identification as People's Exhibit 10. Can you show me what that photograph shows or tell me what that photograph shows?

A Shows a staircase going from the first floor to the second floor and the break in the middle, the landing,

checking for, then, is head trauma?

A And no other trauma noted on the line below it. Also we were also checking for -- there's an abbreviation under that also that says DCAP BTLS, which we were checking for, which that's an acronym.

Q Stands for?

A Deformity, contusions, abrasions, penetrations. The BTLS stands for burns, trauma, lacerations, and swelling.

Q How would you -- how did you go about checking for that? Did you remove the clothing from the child?

A We -- typically we would have, but, like I said, I don't remember what the child was dressed as at the time.

Q Exactly how would you go about checking for head trauma and exactly what would you do?

A Typically on a patient this size, we would obviously look at the patient, see if there's anything out of the normal, as far as any bleeding, any swelling, any cuts or abrasions, any active bleeding or bruising. The child was six months; so that was -- that would probably be doing that -- doing a pupil check, probably that and only thing we do do.

Q Would you actually feel the head, see if there's any bumps?

A On a six-month-old, probably not, because they are still a little soft in the head.

Q Do you remember at all if you thought it was okay -- that you said it was actually okay to keep the baby

at the house, and it was Mr. Patkins that suggested he be taken to the hospital?

A Could you repeat that question?

Q Do you remember saying it was okay to leave the baby at the house?

A I don't.

Q Or was it Mr. Patkins that actually suggested the baby be taken to the hospital?

A No. The Fire Department said if -- they felt comfortable asking Mr. Patkins to leave him at the house. I recommended, for safety sake, and like for his lack of -- not having a car, maybe we should take the child in the ambulance.

Q The person that preceded you from the Fire Department thought it might be okay to leave the baby there?

A That's affirmative. Yes, sir.

MR. SACHS: Thank you. I have nothing further.

THE COURT: Mr. Hughes?

REDIRECT EXAMINATION

BY MR. HUGHES:

Q You went ahead and recommended transporting the child?

A Yes, sir.

Q Do you always recommend transporting?

A Yes, sir, I do. From my standpoint, it's less liability to take them to the hospital than leave them on

scene.

Q Afraid if you leave the baby there, somebody might sue you if there's something wrong with the baby?

A Yes, sir.

Q Are you familiar with the term posturing?

A Yes, sir.

Q What?

A Yawning or crying, either turning their limbs inward or outward like a -- like I said, almost like yawning, when you yawn you tighten your muscles up.

Q You described Eric as making that kind of motion?

A That's affirmative to one side.

Q Now, you also said that you thought perhaps Eric was yawning; is that right?

A Yes. The only reason I didn't think it was true posturing is because when he would squeeze his hand inward, when I place my finger in it, he would free it up real quick, seemed like he had real good control of extremities from what can I see.

Q For the record, to describe the motion you made as sort of taking his arm in an outward fashion at about shoulder height, balling up a fist, curling the fist in towards the body?

A Yes, sir, actually two sides were decerebate, which is where you can come inward, and sural posturing, when you kind of have involuntary movement going outward.

MR. HUGHES: Thank you. I have nothing further.

THE COURT: Mr. Sachs?

drain, which is a device that would drain off CSF fluid to help bring that pressure down.

Q An EVD drain?

A External ventricular drain.

Q You said it was to drain off CSF?

A What that is cranial spinal fluid.

Q They are actually putting a hole in the skull and inserting something that is to drain out fluid out of the skull; is that right?

A Right, to relieve pressure there.

Q Is that visible in the photograph?

A I think it's the red like device there coming off there.

Q Out there in the back?

A Right.

Q This is where the fluid would drain out?

A Into a bag that would collect it.

Q Okay.

Now, after the neurosurgeons placed the bolt and the drain, is that when Erik was brought up to pediatric ICU?

A Yes.

Q What was Erik's condition when he came up to the pediatric ICU?

A His blood pressure was stable at that time. There was no real outward bruising on his body. He was intubated, meaning, a breathing machine was helping him breathe. He had no activity, really. His neuro exam was there was no movement. There was no pupil movement. No movement to any

painful stimuli. No gag to protect his airway. Pretty unresponsive child.

Q When they brought him up to you, you actually did a physical examination; is that right?

A Correct.

Q Was he sedated at that point?

A He was sedated, but the sedation that they use could have been wearing off at the time. He -- but it was no sedation -- sedation for the procedures, that was it.

Q Does the hospital -- or do you use levels of illness? Can you characterize his level of illness when he came up?

A He was critically ill.

Q When you looked at his pupils, you indicated that there was no movement; is that right?

A They were tabulation and fixed.

Q Which means what?

A They didn't react to light. Usually a pupil, when you put a bright light, it will go down to one or two millimeters. When you take that light away, they come back open, and his did not do that.

Q You indicated there was no movement in his extremities. Was there any indication of paralysis?

A Not paralysis. It was mostly a flaccid, not a stiff. It wasn't paralysis from drugs. It was no movement because there was no reaction from the brain.

Q Um, after you did your initial physical examination of Erik, did you have an opportunity to review the incoming

medical records --

A Yes.

Q -- from Riverside Community Hospital?

A Uh-huh.

Q Did you request that a child abuse workup be performed?

A Correct.

Q Why is that?

A Because of the history of the fall. Because of the types of injuries that he had. It's just a natural flow of things to make sure that this wasn't something done to this child.

Q Were the injuries suspicious in some way?

A Yes, there were old and new lesions in the brain, and also in his femoral bones, so those needed to be evaluated.

Q And to evaluate that, you consulted with the CAN team; is that correct?

A Yes, CAN team.

Q That's a child abuse and neglect team?

A Uh-huh.

Q Does "uh-huh" mean "yes"?

A Yes, yes, I'm sorry.

Q It's okay.

And when you had had a chance to look at Erik and review the records, did you also get a history of how these injuries were claimed to have occurred?

A Yes. Um, do you want me to answer?

Q Just with "yes" or "no".

A Yes.

Q Did what you saw in the records and your physical examination of Erik seem to be consistent with the history that was given?

A No, it didn't seem consistent.

Q So now, you have gone through this initial evaluation of Erik, and he has the bolt placed and the drain. What are you now trying to do with Erik as you continued with treatment?

A Like it's supportive care from now. After you stabilize the patient, it's supportive care until his body heals. Healing for Erik would be to try to get his ICP, his intracranial pressure, down. We did that through medical management with drugs, sedation, three percent normal saline, and mannitol to try to relieve that pressure.

Q Specifically to relieve the pressure, try to stop the brain from swelling?

A Stop the brain from swelling.

Q Okay.

Now, can you explain for us how the brain swelling increases pressure in the head?

A Well, if you look -- think about a skull, it's kind of a closed system. There's some opening in children that age because there are sutures there and you have some give there. But it's only so much that it will give. When the pressure gets too high, um, that pressure will take the skull and push it downward to relieve that pressure. That's just like a

surgery performed to harvest organs?

A The mother agreed to have SCOPC come and see her child for possible harvesting of his organs for other children.

Q Did they do that surgery?

A Yes.

Q When they do those surgeries, other doctors from -- who are involved with the recipients are actually brought to Loma Linda and they oversee the surgery?

A Yes.

Q That occurred with Erik's case?

A Yes.

Q And, also, if it's a case where homicide is suspected, a coroner attends, as well; is that right?

A Right.

Q And then after the surgery, where organs were harvested, Erik is dead; is that correct?

A Well, he was dead before.

Q That's right.

MR. HUGHES: Okay, thank you. Nothing further.

THE COURT: All right, Mr. Sachs?

MR. SACHS: Thank you.

CROSS EXAMINATION

BY MR. SACHS:

Q Good afternoon, Doctor.

When you first had your opportunity to examine Erik, did you say that he didn't exhibit any kind of activity at all?

A No.

Q Was he posturing at all when you first observed him?

A It was reported that he was posturing in the Riverside Community ER.

Q What about when you received him?

A Not on my exam.

Q Could you explain what posturing is?

A Posturing is something that happens with cerebral injury, either that injury could be done to the cortex, the cerebral cortex, or the cerebellum, and he was posturing in both ways. It's a stiffening of the arms and legs, either inward to the core of the body or outward.

Q Sort of involuntary movement?

A Yes. It could be a seizure, it could be anything. But that's the type of severe brain injury kind of thing that happens.

Q And you flashed some kind of a light in his eyes?

A A bright light, uh-huh.

Q Was there any activity?

A No. As I said, the pupils were fixed.

Q When you were asked earlier about the injuries that you observed on Erik, not consistent with the reported mechanism in which he got in this condition, were you given information that he had taken a few falls from a bed? Is that what information you are talking about?

A No, the information that I was given is that the father was carrying the child up the stairs in his arms and

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fell 12 to 18 feet -- sorry -- onto a carpeted floor.

Q In the record that you reviewed, does it say that the baby has rolled off the bed a few times in the past? Did you write that in your report?

A No, I did write that in my report, but there is a report given to -- I can't remember who wrote it. I think one of the residents talked to the mom, and she said that there was some two or three months prior to this injury that the child had rolled off the bed a couple of times. And then a doctor had seen him at each one of those times.

Q Did you actually prepare a typewritten report of your contact with Erik?

A No.

Q So when you relied on the medical records, some notes that you wrote, I guess, are contained in the records, though?

A Correct, yes.

Q Now, in terms of the drugs that were given to try and control the swelling of the brain, are any of those possibly leading to a drug-induced coma? Is that what they are designed to do?

A They are designed to keep Erik as quiet as possible so that he will use as less energy as possible in his brain. So that if there's talking in the room or movement in the room, that he won't be agitated, which will increase his blood pressure in his brain.

Q So that's what the drugs were designed to do, just limit his complete activity, including brain activity; is that

What do you do for a living?

A Forensic pediatrics.

Q Where do you work?

A Loma Linda University Children's Hospital.

Q What do you do there?

A I am a general pediatrician, as well as a forensic pediatrician. I'm an assistant clinical professor of pediatrics.

Q Can you describe for us your education as it relates to pediatrics?

A Yeah. After under graduate, I went to medical school at Loma Linda University School of Medicine. And then I did a pediatric residency at Loma Linda University Medical Center.

Q When?

A And then --

Q I'm sorry. If I could interrupt?

When? When did you graduate from Loma Linda?

A From medical school, 1989, and I graduated from residency in 1992.

Q What other education have you had since that time?

A Since I trained in doing child abuse exams with Dr. Sheridan, as well as, you know, conferences that we attend every year.

Q Now, you say since that time, since 1992, you have been working with Dr. Sheridan?

A Yes.

Q Do you belong to any professional societies

pertaining to medicine?

A Yes. To the American Professional Society on the Abuse of Children, California Professional Society on the Abuse of Children, Ambulatory Pediatric Association, American Academy of Pediatrics.

Q Now, what type of teaching do you do?

A I do -- supervise students and residents of pediatrics, you know, the students when they are in medical school, they do a rotation in pediatrics. So I would supervise those students and the residents in pediatrics, as well as family practice sometimes.

Q Okay.

Since 1992, when you completed your residency, where have you been working?

A Well, I worked -- I have been working with Loma Linda, but I was -- part of that time, I was doing -- providing the same services at Riverside County Regional Medical Center.

Q What services are those?

A Both general pediatrics and forensic pediatrics.

Q What does forensic pediatrics mean?

A It's a field that deals with child abuse, all the aspects of child abuse, including physical abuse, sexual abuse and neglect.

Q When you say it deals with child abuse --

A Yes.

Q -- in what way does it deal with child abuse?

A Well, we do the exams in children who have been

suspected of being abused, and evaluate all the tests that are done and the history, and come up to a conclusion whether we think that this child has actually been a victim of abuse or if there's any other reason or any other explanation for their injuries.

Q So it's your job, and it has been for the past 10 years, to help determine what causes injuries in children?

A Yes.

Q You said that includes both physical and sexual abuse of children; is that right?

A That's correct.

Q Now, when you were working with Riverside County Regional Medical Center, what positions did you hold there?

A Well, there was a pediatric clinic director, and I was -- part of the time, I was chair of the pediatric department.

Q How long were you chair of the department of pediatrics?

A Three years, I think. Two to three years.

Q Okay.

And were you a member of the child abuse and neglect team there?

A Yes.

Q Was that for that entire period of 1992 to 1999?

A Yes.

Q Now, you said you provided the same services at Loma Linda during that time frame; is that correct?

A Yes. At times, when I was -- when I had to cover

because of doctors at Loma Linda were gone, yes.

Q So during that time frame since 1992, you were primarily at RCRMC?

A Yes.

Q And you would fill in at times at Loma Linda?

A Yes, because there wasn't an association between Loma Linda and Riverside County. The doctors, we would get together and discuss the cases. I would physically go there when there was a need.

Q Was there a time when you moved from RCRMC to Loma Linda University Medical Center?

A In 1999.

Q And what have you been doing since 1999 for Loma Linda?

A I have been doing, again, the child abuse exams, as well as the general pediatrics.

Q Now, are you Board-certified in any specialties?

A Yes, I'm Board-certified in pediatrics.

Q As a result of your job and what you do for a living, the training that you have, do you study the medical research and medical literature concerning injuries to children?

A Yes.

Q Keep current on medical beliefs and medical practices with respect to injured children?

A Yes.

Q Now, can you tell us, generally, what your job duties include there at Loma Linda at this point?

A Yes, of course.

Q What does that term mean?

A It means that there is some injury, some trauma to the brain. And the cause is abuse, if it is someone has actually inflicted the injuries.

Q Are there other terms for abusive head trauma?

A Well, the common term that has been used by -- well, has been used in the medical profession, but it's mostly commonly known in the community, is shaken baby -- shaken baby syndrome.

Q Are there other names for it other than that?

A Well, inflicted traumatic brain injury.

Q How about shaken impact?

A Shaken impact is actually on top of the shaken, an impact or actually blunt force.

Q Will you describe for us how shaking an infant causes injury?

A Um, when an infant is shaken, and we are not talking about playful shaking, that doesn't -- you know, it's a vigorous violently shaken baby. Usually the baby is grabbed by the chest across the ribs, but it can be grabbed by the arms, it can be grabbed by the legs. Grabbed by the neck. There are different ways, but the most common one is the chest. And as a baby is grabbed by the chest, then there's this forward and backward motions where the head goes back and forth.

It's not just back and forwards. Because there's no limitation of that movement, so there is also rotation. As

A The hemorrhage can be severe right away.

Q It can be severe right away?

A Yeah.

Q If it does, if you have a subdural hematoma, you would see the blood under the dura in redness here (indicating)?

A Yes.

Q Between the brain and the dura?

A That's correct.

Q So I'm clear, if it's a subdural hematoma, the blood is between the dura and the arachnoid; is that right?

A Yes.

Q And if it's a subarachnoid hematoma, it's one level further down, and it's between the arachnoid and the brain?

A That's correct.

Q What is an epidural hematoma?

A Epidural means it is above the dura.

Q Between the skull and the dura?

A Skull and dura.

Q Are you familiar with the term axial injury?

A Yes.

Q What does that mean?

A Axial injury, when you have that significant injury, you have bleeding, and not just bleeding, but you have the shearing injury, the tearing in the brain, itself, as it moves back and forth. Then you actually cause damage to the nerves. So if you cause damage to the nerves, there's actually not -- that communicating is like the nerves can't

communicate anymore, translate any information. So you lose your brain controls, everything, but you lose that function of the brain to communicate to the cells and what to do.

Q I'm going to show you what has been marked for identification as People's 43. Can you see the red, the red, squiggly lines? Not the ones with the arrows on it.

A Yeah. Those are the axials, they are also damaged from the shearing force.

Q Those are examples of the nerves that are running through the brain?

A Yes.

Q As the brain moves back and forth or sideways, at a different speed than the skull, you have the same tearing --

A Breakage.

Q -- of those nerves?

A Yes.

Q People's 44 is an example to demonstrate what that tearing is like?

A That's correct.

Q Now, are you familiar with retina hemorrhaging?

A Oh, yes.

Q What is retina hemorrhaging?

A Retina hemorrhaging is actually bleeding into the retina. The retina is the back of your eye. When you go to a doctor and they look with their scope and look at the back of your eye, that's what they are looking at, the retina. The retina has many layers, but it's like that yellow/orangy part that has your optic disk and the vessels that can be visible

by the doctor. And there is bleeding into the retina. That's what retina hemorrhaging is.

Q How is retina hemorrhaging caused?

A How the retina hemorrhaging in child abuse or --

Q Are there various ways it can be caused?

A Well, there are different ways that retinal hemorrhaging can be caused, but there are different types of retinal hemorrhage. If you have a very single dot, retina hemorrhage, it can be associated with certain diseases. You can have retina hemorrhages that are involved with extensive bleeding that are throughout the layers of the retina that are more consistent with abusive head trauma or trauma. So, yes, there are different types of retina hemorrhages.

Q With respect to abusive retina trauma, retina hemorrhaging, how does that work? How do you end up with retina hemorrhaging?

A Well, again, the same, the exact mechanism. There's different theories of how the mechanism for the retina hemorrhage is. They have been really seen in association of 75 to 80 percent of the cases of abusive head trauma or shaken baby have retina hemorrhages. Sometimes unilaterally and sometimes bilaterally.

In this retina hemorrhage in abusive head injury are usually very extensive and they are a different type. They are in more layers of one of the retina, for one thing, and then they are frequently -- just the blood is diffused as opposed to a single dot where you see a little small hemorrhage in a particular area of the retina.

Um, and there is postulate that the same mechanism of shearing of the back and forth causes those, so some tearing of the vessels in the retina. Then there's another mechanism that maybe there is venous obstruction, so there is increased pressure so it can't drain. So there is blood accumulated there. And so the exact mechanism is difficult to tell.

Q Okay.

It's something that medical science hasn't yet determined completely?

A Not to an agreement on exact mechanism. 'Cause it's difficult to say in a live person how exactly you would do that.

Q Do you see retina hemorrhaging in cases of high speed auto accidents?

A Very rarely, and they are usually very small in a particular spot, what we call the postular.

THE REPORTER: Please slow down.

THE WITNESS: -- around the optic disk.

Q (By Mr. Hughes) You said you see retinal hemorrhaging frequently in abusive head trauma cases?

A Yes.

Q Now --

A When we talk about motor vehicle -- I'm sorry, I didn't clarify. It's usually high speeds, not just a rear ending type of accident.

Q Okay.

Now, with respect to abusive head trauma cases or

shaken baby cases, do you see associated rib injuries sometimes?

A Yes. There's frequently associated fractures and commonly is rib fractures, especially posterior rib fractures.

Q Posterior meaning?

A In the back. They grab the chest (indicating), not even in CPR, they happen. Posterior rib fractures, it's just like the way their ribs are made, and you have -- you have the fixed spinal column here, and as they twist, there's this level where the rib goes actually beyond the extent -- the flexibility point, and then it breaks right at that point.

Q You are gesturing with your hands in front of you as though holding a baby.

Let me show you what has been marked for identification as 47. Does that diagram demonstrate what you are describing as far as holding a child in front of you?

A That's correct. You can see the upper part here, the vertebrae. Yeah, right here (indicating). And that rib, as it comes around, and there is a squeezing motion, you can see how it breaks as it joins with the vertebrae, and the posterior side.

Q That's what you are talking about, the motion?

A Right.

Q The point at this part at the top of the diagram, that is the spinal column or vertebrae?

A Yeah. Vertebrae is this whole thing.

Q Back on April 28th of 2001, were you consulted with respect to a baby by the name of Erik Patkins?

ICU room, he was very critical. Very unstable. By the time I got there, he had already a bolt placed, a bolt -- it's a monitor to check on his intracranial pressure, basically the pressure in the brain. As there is injury to the brain, the pressure increases. So they had to check to be able to see what to do, what the course of treatment was going to be, they put in a bolt and they had also put in a brain drain. A drain to decrease the pressure in the brain. They then put in a catheter to drain some of the fluid out to see if the pressure will come down. So he had already a drain and he had also a bolt. And he had central lines, IVs. He was intubated. He had an NG tube, nasal gastric tube, a tube through his nose. And he was basically very sick.

Q All right.

Did you see any physical injuries, external physical injuries?

A No, he didn't have any external physical injuries. Other than he had a little bit of -- just a little bit of blood in the first stools. In the analysis of the first stools.

Q Did you take a look at Erik's eyes?

A Yes, I did.

Q What did you see?

A Well, he had -- when I came to see Erik, actually his pupils were fixed and dilated. If I go into deeper the exam, in looking in head to toe, we look in the eyes, also. We usually have to dilate the eyes to be able to actually see in the eyes. But his pupils were not responsive, and they

A Well, it was -- there was blood into the optic nerve, and just the whole eyeball as they took it, it was obvious there had been a lot of bleeding. It looked kind of brownish, looking blood appearing.

Q The damage to the optic nerve, why is that significant to you?

A Again, as retina hemorrhages are seen with abusive head trauma, so is an optic nerve sheath commonly seen. Those are not something usually we can tell in the general physical exam. Sometimes in MRIs you can tell there is bleeding into the optic nerve, but that's not something I could tell by looking at the eyes. So that is something that is usually noticed by a pathologist at an autopsy.

Q And is the damage to the optic nerve an indicator to you whether this is an inflicted or accidental injury?

A It's contributed to an inflicted injury.

Q Would you expect to see that type of damage to the optic nerve in an accidental case?

A No.

Q Are you aware of any mechanism that would cause that damage that would be accidental?

A Right. There is -- no.

Q And you have already discussed for us how retina hemorrhaging is indicative of a shaking injury, as well; is that right?

A Yes.

Q The retina hemorrhaging that you saw at the autopsy, that confirms your earlier suspicion that this -- did

X-rays, that will show actually that this is a fracture that had happened. It has already gone through some healing, it had happened in the past.

The acute fractures, then you don't see that. You just basically see the fracture line. And you don't see the healing process yet. Plus, the acute fracture sometimes -- not always -- there may be some swelling of the tissues around it.

Q Okay.

Now, why is the hemorrhaging that you saw significant?

A The hemorrhaging in the subdural -- hemorrhaging in the subarachnoid hemorrhaging?

Q Yes.

A Because the subdural hemorrhage is very common in abusive head trauma. And subdural subarachnoid is also very common in abusive head trauma. When you have subdural hemorrhage from an accidental injury, you can have -- you can have subdural from an accidental injury, is not usually as extensive in the history, is clearly compatible with it. Usually if there's a fracture, the subdural hematoma will be at the site of the fracture and not as extensive. And usually when you see the subdural hemorrhage, even between the -- what we call the inner hemisphere fissures in between the two sides of the brain, that is also more indicative of abusive head trauma.

Q Now, how would you characterize the extent of the hemorrhaging in Erik's case?

A Oh, very extensive, because, I mean, it's not just a hemorrhaging. He had a lot of swelling in the brain, you know, from the hemorrhaging and the damage, the injury to the brain difuse axial injury, he had extensive swelling of the brain and increased pressure of the brain.

Q What type of -- let he back up a step.

Would you expect to see fractures from shaking a baby alone?

A No.

Q The fractures are a result of impact of some sort?

A Yes.

Q What type of force would be necessary to cause these fractures and this hemorrhaging?

A A lot of force. I don't know how to quantify it, but it's out of control. It's a person -- the person who was doing the shaking was out of control.

Q Would you expect to see this type of injury in a short fall onto a carpeted surface?

A No.

Q Meaning, a fall of under two feet?

A No. Not at all.

Q Okay.

In proceeding through the autopsy and reviewing the records, were there any additional injuries that were discovered during the autopsy?

A He did have a contusion -- when the scalp was reflected, when the skin is taken back, he did have an area of hemorrhage. I believe it was on the left side. I don't

Q Now, the blood we can see on the left-hand side of this picture, that shows subarachnoid hemorrhaging?

A Yes.

Q Because the arachnoid, is that membrane that encases the brain?

A Yes.

Q There's blood between that membrane and the brain?

A Yes.

Q From looking at this photograph, can you tell --

A It looks more like it's fresh blood.

Q And there was a subdural hematoma, or hemorrhaging, on the left-hand side of the brain; is that right?

A That's correct.

Q Was that old or new hemorrhaging?

A That was old.

Q And the subdural, is that visible in this picture?

A No, the subdural, actually when they take the skull off, it stays more under the dura, under the skull, so I think it's not really clear, not in this picture.

Q Okay.

And the subdural hemorrhaging on the right-hand side of the brain, was that older or new?

A That was new.

Q All right.

Now, you had started to mention a femur fracture. Can you describe for us what was found at the autopsy with respect to a femur fracture?

A Yeah, the distal area, or the farthest area on the

femur, there was a fracture, and it was an older fracture 'cause they could see, again, the new bone formation, a healing, that there was healing.

Q All right.

Now, based on the injuries that you saw to Erik when you were treating him, based on your review of the medical records, and based on your attendance at the autopsy, and review of the autopsy results, and based on your training and your experience, and the thousands of children that you have seen, do you have an opinion as to how these injuries were caused?

A Yes.

Q What is that opinion?

A My opinion is that Erik was a victim of abusive head trauma.

Q And why is that your opinion?

A Because in taking the history, the history does not explain the injuries. The history that is given is definitely very inconsistent with the injuries. There was delay in seeking medical care. The injuries are very extensive, and all of them consistent with abusive head trauma, as is the intracranial bleeding --

THE REPORTER: Please slow down.

THE WITNESS: -- subdural hematoma, the subarachnoid bleeding, there is actually even bleeding into the brain tissue, and there is significant brain swelling in diffuse axial injury. That causes death. He has extensive bilateral retinal hemorrhages. He has multiple skull fractures of

different ages. He has a posterior rib fracture that is acute. He has also a femur fracture that is old.

So this infant is not only a victim of abusive head trauma causing his death that is just recent, he has evidence of on-going abuse or previous abuse.

Q (By Mr. Hughes) The repetitive nature of these injuries that you can see, is that a factor in why you think this is abusive head trauma?

A It's a factor.

Q It's not?

A But it's not the -- the ultimate event that causes death was enough, even without prior injury, is clearly abusive head trauma causing the acute event that caused his death.

Q Based on the history that you received, if you assume that that history is true, that Erik was just fine on April 27th at roughly 6:00 or 6:15, maybe a little bit after that, p.m., when Margie Garifano left for work, and it was the next morning in the neighborhood of 5:30 to 6:30 in the morning that he first started exhibiting symptoms, do you have an opinion as to the timing of these injuries that led to his death?

THE COURT: The acute injuries?

THE WITNESS: The injuries that led to his death that were acute, yeah, it had to have happened after the time mom left to go to work.

Q (By Mr. Hughes) Based on what you saw, all the medical records, everything you saw with Erik and the autopsy,

being shaken by being held by one leg?

A Yes.

Q That type of shaking can result in a subdural hematoma?

A Yes.

Q Can it result in a subdural hematoma without resulting in retina hemorrhaging?

A Yes.

Q Is there -- and I'm going to come back to Erik's case now -- is there anything that you saw in treating him, in attending his autopsy, and reviewing the medical records, that leaves in your mind any doubt whether Erik was shaken and slammed and that's what caused his death?

A Not at all.

MR. HUGHES: Thank you. I have nothing further.

THE COURT: Mr. Sachs?

CROSS EXAMINATION

BY MR. SACHS:

Q Let me turn to Jack for a moment, if I could, Jack Patkins, the records you reviewed, I guess it was yesterday.

A Yes.

Q Now, you mentioned something about a skull fracture; is that correct? Do you recall reading something about that?

A That's correct.

Q There was nothing in the records the skull fracture was an old one; is that true?

A I believe in the report it says a "healing" skull

retinal hemorrhage was observed?

A There were retinal hemorrhages observed.

Q Strictly attributable to a fall?

A They were not diffused like this. And I don't know, because there were not pictures of the retina hemorrhages.

Q And that whole body of literature from Dr. Plunkett says children can die from a fall from a distance of about two feet, correct?

A Yes, he says that.

Q Now, again, with respect to the injuries to Jack, you are saying it's possible that his injuries could have been attributable by a fall, but unlikely. Does that characterize your testimony about Jack's injuries?

A Yes.

Q You can get a subdural hematoma from a fall, can't you?

A Yes, you can.

Q And you can have -- then you would have blood leaking into the subdural space as a result of a fall, correct?

A You can.

Q How about through the subarachnoid area, can that also be caused by a fall?

A Yes.

MR. HUGHES: Objection. Vague as to the distance of the fall.

Q (By Mr. Sachs) A short distance fall, in your

opinion.

A A short distance fall?

Q Can you have bleeding into the subdural area?

A You can have small areas of bleeding.

Q Can you have bleeding to the subdural -- subarachnoid area of the skull?

A Yes, you can.

Q From a short fall?

A Yes.

Q Now, turning to Erik, specifically, when you saw him, I guess you said it was the evening hours of, I guess it would be, the 28th of April; is that right?

A That's correct.

Q He was already paralyzed and heavily sedated; isn't that true?

A Yes.

Q So at that particular point in time, in your estimation, was he already brain dead?

A I couldn't say that. I didn't do a brain dead exam. I couldn't -- if he was sedated. He has to be off medication for it to be done.

Q So -- but he wasn't exhibiting any reflex actions or anything when you observed him, correct?

A Well, you don't do the exam to exhibit reflex actions if he is sedated. So I couldn't tell you whether he had them or not. I couldn't elicit them.

Q Then what was the purpose of your exam when he is basically paralyzed and sedated when you saw him on the 28th?

A You look for external and internal injuries you can observe without having to do a neurological exam to see brain death.

Q So in this particular case, he didn't have any external injuries except for what you said on his nose?

A Right.

Q What kind of an internal examination did you do of him at that point?

A Well, you don't -- if you are talking about an internal examination as a summary, we don't do that. We check it and -- to see if it is soft, listen for bowel sounds. I checked his retina in his eyes and saw the retina hemorrhaging. We looked inside his mouth. And looked for a complete physical exam, other than doing a neurological exam, for the purposes of establishing neurological function.

Q So the pictures that we saw of the retinal bleeding on both the left and right eye, is that what you saw when you looked in his eyes? Is that what you're telling us?

A Yes.

Q Did you use some kind of instrument to observe this?

A I used an opthalmoscope.

Q Now, you are aware that when the baby was first seen by the EMT at about 6:45 in the morning, the baby was basically alert? You are aware of that, right?

A Yes.

Q The baby -- apparently, eyes were showing reactions to light? Are you aware of that?

correct? Moving at different speeds?

A Different speeds, yes.

Q Now, when you talked with Mr. Hughes about the bridging veins that are torn, could you explain what you meant by that?

A Yes, I did.

Q Can you explain again what you meant by that?

A Oh, the bridging veins are the veins that go right under the dura and drain into the major central vein into the subdural sinus. Those veins that are attached to the dura and connect to that are as the brain moves back and forth, they are stretched and torn. They are sheared, so they bleed.

Q So they bleed into the subdural and subarachnoid spaces, is that what you are saying?

A Not subarachnoid, we're talking about subdural.

Q So the bleeding that goes into the subdural, that's not from the bridging veins then?

A I don't understand your question.

Q The bleeding that goes into the subdural, that's from the veins that burst?

A That's correct.

Q What about the bleeding that gets into the subarachnoid space?

A That is bleeding just right under the subarachnoid, not related to the bridging veins.

Q Now, is that mechanism where the bridging veins -- does that sometimes happen as a result of a fall?

A That can happen as a result of a fall.

Q Now, you could certainly have intracranial pressure, or pressure increase, from a fall, I take it; is that true?

A From a major fall, yes, you can.

Q From a short distance fall, can you have intracranial increase?

A You can have increased intracranial pressures.

Q That's basically what caused the death in this case, isn't it? If you cut right to the chase, is the extreme high intracranial pressure basically what caused Erik to become basically brain dead?

A Yes, the mechanisms that caused increased intracranial pressure. As the cause of the intracranial pressure, the intracranial pressure is the ultimate cause of death, but what caused --

Q I think you said, getting back to retina hemorrhaging, there's really not a lot of agreement, even within the medical community, as to how retina hemorrhaging is actually caused. Is that what you said?

A What I said is that there's not as a specific definite agreement as to the mechanism that they are caused, not that they are seeing with abusive head trauma. It is just exactly what happens.

Q And that is basically the veins that burst in the eye, is it?

A Well, that's what I say, there is different theories for the actual mechanism of the retina hemorrhages.

Q And just so it is clear, you do not subscribe to

Q In this particular case, I think you did say there was evidence of some subdural hematomas that looked older; is that correct?

A That's correct.

Q Was that consistent with the old skull fractures that you had observed?

A Well, there were slightly different locations. It was more towards the front. The subdural bleed. And the fracture was more in the middle frontal parietal area. But there can be -- as far as happening about the same time, they could be. I don't know how -- I couldn't date both of those.

Q Can you date either one of them?

A I could just say they are older. Maybe the pathologist could. I don't know.

Q So the subarachnoid, which was on the left side, that was a new bleed?

A I believe that was more new.

Q And that was -- you learned that from what, the CT scan, or actually being at the autopsy, in terms of the ages of these bleedings?

A I think both, if I remember correctly. Most of the bleeding -- well, the CT scan just suggests. Okay?

The autopsy is definitely the definite answer.

Q Okay.

Going to the skull fracture that was on the parietal side, which I think you said is the right rear, which is the more dense bone, I guess, than the parietal -- is that right, the dense part of the skull?

that about right?

A Yeah. Yes.

Q You would certainly -- what was the age of that? Were you able to tell?

A It was older. It was healing. As far as specific how many days, I can't tell you.

Q Was it the membrane, the periosteum, had started healing?

A Right.

Q Can you give us some range in when that would happen, when the healing process would start?

A The pathologist that reviewed it on the microscope could probably give you more estimation of that. I can tell you, usually the X-rays don't show -- on the X-rays, you don't see any evidence of healing until seven or 10 days later. So -- and it was seen on X-rays. So I don't know how old, probably seven, 10, more days. Exactly, I can't tell you.

Q And with your experience, what's the most likely mechanism of a six-month-old to have his femur fractured, by twisting?

A Abuse.

Q Pardon?

A Abuse.

Q How? Slamming a child to the ground? Twisting him?

A Different ways, depending on how the fracture is. Because a six-month-old is not ambulatory, is not a child that should have fractures. And frequently, it could be pulling.

It could be twisting. It could be impact. Different ways femur fractures can happen in a infant.

Q Femurs is like if a child would lift his leg up, some type of mobility?

A Yes.

Q The child would have to use the femur?

A Yes.

Q You would expect some kind of --

A It depends how the fracture is. If it's not transverse or broken through-and-through, we see new bone formation, and it may be a thin cortical fracture, so he could still move his leg. It's not a through-and-through fracture so you can't move the leg. This fracture is more in the length of the femur. It may -- again, is just healing in the X-ray, such a suggestion of a fracture that could be seen at the autopsy.

Q So you are saying you don't know exactly how the femur was fractured?

A I don't know exactly how it was fractured, but it was not a transverse through-and-through fracture.

Q Okay.

You mentioned again it was interhemispheric bleeding, I think, as well?

A That's correct.

Q Was that something apart from the subarachnoid bleeding that you talked about?

A Well, what we are talking about is that there was actually blood, subdural blood, that is actually between the

presence of drugs. It depends on the circumstances whether we do that or not.

When I've got all those reports back, I sit down and dictate all of that into a dictaphone and go over the report, sign the report, and then that report becomes the -- at the end of that report, I give a list of all the injuries or diagnoses. It's either injuries or evidence of surgical procedures or evidence of disease, sort of list those, and, at the very bottom, I give a cause-of-death statement, what I think the cause of death is.

Then the deputy coroner whose case -- whichever investigator's assigned to this case, they fill out the death certificate for the County, and they will use my cause of death under the part of the death certificate where it says cause of death was. They get that from my autopsy protocol.

Q All right. With respect to the external examination of Eric Patkins, what injuries did you find?

A Essentially, it was injuries related to the medical procedures and the organ-recovery procedure.

Q Other than bruising perhaps in the area where an IV would be done?

A He'd had -- he'd had a pressure monitor to monitor the amount of pressure inside the skull. The neurosurgeon had put a bolt. It's called a bolt monitor or pressure monitor, and they also put a drain in to help drain out excess fluid to help control pressure. So those were still there, and the autopsy showed hemorrhage in the

scalp and in the covering of the bone around those procedures, which, because this child survived for four days, essentially, from the time it got to the hospital until the time of the organ recovery, it was about four days. So the amount of hemorrhage would be what I'd expect to see in a child who survived that long.

Q Other than medical-treatment-related injuries, did you note any bruising or other visible external injuries to Eric?

A No.

Q Now, with respect to the internal-body-cavity examination Eric, had had organs harvested; is that right?

A Correct.

Q So in the internal examination, what did you see?

A Well, we saw the effects of, you know, the organs that had been removed. And then, when they do that, the surgeons, you know, they sew up the bowel. After they remove the bowel, they will sew that up, then leave it in place.

So all of the organs that were left, there was no evidence of injury or disease to those. The only evidence of injury that I found on the internal examination of the chest and abdomen was that after I had removed whatever organs were left after that recovery procedure, I then removed the diaphragm, which is a very thin muscle that separates the chest cavity from the abdominal cavity. It's that muscle moving up and down, primarily what we breathe with when -- when we take a deep breath, we are not only

expanding our chest but pushing our diaphragm down. It's the thin muscle that separates the chest from the abdomen. I'll take that back. And remove it. And when I'd done that, back behind the diaphragm on the right side, there were -- there was hemorrhaging around the area of the ninth and tenth ribs on the right side right where the ribs connect to the back bone.

Q So you're able to see some bleeding in the area of the ninth and tenth ribs in the muscle area?

A Right.

Q By those ribs?

A Correct.

Q What does that signify to you?

A Well, I mean, it's basic, most basically, it's bleeding. It's hemorrhaging into -- into tissues. And it's not in an area, like I said, where they put the bolt and they'd done surgical procedures, put in IVs, that sort of thing. You expect hemorrhage as part of, you know, drawing blood and surgical procedures. But this is an area way around in the back, low on the back, that wouldn't be associated with any surgical procedures; so the implication was it was an injury.

Q What do you do when you see that?

A I cut those -- those portions of the ribs out so that I can look at them under microscope. With ribs or with bone, because bone is hard, we have to put it in a solution, a form of acid, which we call it decalcifying solution. It essentially eats all the calcium out of the

bone. Usually takes a couple of weeks to do that, but once that's been done, you can take a scalpel or knife, cut the bone in real thin sections to make those microscopic slides. I cut in the area of suspected injury, decalcified it, and submitted it for microscopic sections.

Q What was the result of the microscopic examination?

A Showed a fracture.

Q And were you able to determine the relative age of that fracture, whether it was acute or whether it was a healing fracture?

A It was acute.

Q How can you tell the difference?

A Well, acute fractures, no matter where they are, have acute hemorrhage associated with them, and that -- it was -- the hemorrhage was the first thing I saw.

If you're looking at ribs -- it applies to all bones, but it's most easily appreciated in ribs or the shafts of long bones. When a fracture starts to heal, it takes essentially -- it heals by forming new bone around the site of the fracture, and it -- the bone healing occurs like a knot. It's like a big lump of bone right around the fracture site. So when you're looking inside a body, usually the ribs are very smooth and sort of thin, curved structures. And you're looking at them and see a big lump in the middle with no hemorrhage around it, that's a healing fracture of, say, a rib. If all you see is the hemorrhage, that's an acute fracture.

The same thing will happen in long bones. When they first crack, there's hemorrhage associated with them, they are swelling. As the hemorrhage and swelling subside and the bone starts to heal, a callus will form, which is the knot of new bone.

And, so, when we take microscopic sections, we're looking for the presence of reaction and healing process. And, generally, with bones, we can -- we can say they are acute if they happen within, like, less than a week, or they may be -- they might be a couple of weeks old or they might be almost healed. So they are several weeks to a month old, but we can't be much more definite about time. We can't really give an exact date when a fracture would have occurred.

Q Which of those three categories did this rib fracture fall into? Less than a week? Couple weeks? Or longer than that?

A Less than a week.

Q And which -- which rib itself was fractured?

A It was the ninth rib on the right side.

Q Counting from the top?

A Top down, yeah.

Q Show you what's been marked for identification as People's Exhibit 48. Doctor, you might need to turn that television on.

Showing you People's Exhibit 48. Is this a representation, a diagram of a rib cage?

A It's a diagram of a rib cage viewed from the

back.

Q Okay. So, the -- the pointy bones in the middle there, that's the spine, the vertebrae?

A Yes.

Q And you said it was the ninth rib down from the top on the right or the left side?

A On the right side.

Q So this being number one?

A That would be two.

Q That there is one, two, three, four, five, six, seven, eight, nine. Is this the rib it would be [indicating]?

A Yes.

Q And where on that rib was the fracture?

A Right --

Q Adjacent to where it connects to the vertebral column? Right here [indicating]?

A Yes.

Q Just going to put a circle in that area.

Did I place the circle properly?

A Yes.

Q Now, did you go through an examination process of Eric's head?

A Yes, I did.

Q Did you notice any injury to his scalp?

A There wasn't an injury to the external scalp as you're just looking at the baby, other than where these drains were put in. A drain and a bolt were put in -- in

the anterior part behind the hairline. But as far as an injury visible externally, no.

Q Okay. Was there any -- any hemorrhaging in the scalp itself?

A Yes.

Q What was that?

A Well, when we -- when we're examining heads, we're going to do the internal examination. An incision is made from behind one ear over the top of the head to behind the other ear. And the scalp, the back part of the scalp is peeled off the skull backwards, and the part is peeled forward. So you're actually looking at the deepest parts of the scalp and you're looking right at the bone and the covering of the bone. There's a really tight membrane that's tightly to the bone periosteum called the skin of the bone, and there was hemorrhage around both of those surgical procedures in the and then sort of on the top in the midline. There was about a one-inch area of hemorrhage within the deeper layers of the scalp.

But even after I'd seen that and I pulled the scalp back to look at that again externally, I couldn't see any external evidence of that hemorrhage.

Q Was that -- in a six-month-old baby, was that a suspicious injury to you?

A Well, it might not be. It depends on the circumstances. If you have -- if you have a bunch of injuries and the other injuries are suspicious, then sort of any new injury is suspicious. It -- if I was doing the

autopsy under different circumstances, it would indicate that there had been some trauma to the top of the head, some sort of a bump or fall. I mean, an infant, a six-month-old infant, generally isn't going to create by themselves a situation -- no, I guess -- I guess I can think of a few situations, as a former pediatrician. Kids who rock themselves, you know, in an infant rocker and flew out of the rocker and landed on the floor. That's -- actually, my oldest son flew right between my wife and I.

Q You didn't see -- you didn't see any injury associated, any bruising associated with that, did you?

A The subdural hemorrhage is a hemorrhage -- you can describe it as a deep bruise, but, by bruise, if you mean something you can see that anybody would have seen just looking at the baby before the baby died, no.

Q Okay. I'm going to show you what's been marked for identification as People's Exhibit 20. Do you recognize these diagrams?

A Yeah, these are diagrams I prepared.

Q I'm going to zoom in on the upper left of the diagram. It's the circular area in the middle of the outline on the top of the head. Is that the area where the subdural hemorrhage was?

A Yes.

Q That would be a view looking down on the top of Eric's head?

A Right to the top of the skin.

Q Now, after you looked at the scalp, you looked

the nerve was the darker blue. The hemorrhage isn't so much in the nerve itself as in the tissue around the nerve.

Q Were you able to see any retinal hemorrhaging with respect to Eric's eyes?

A Not -- not at the time of the autopsy. I made microscopic sections of the eyes and saw -- saw hemorrhaging in the microscopic sections.

Q Is that both eyes?

A Yes.

Q Was the damage to the optic nerve sheath, was that both eyes as well?

A Yes.

Q Now, prior to making the microscopic sections of Eric's eyes, are the eyes themselves actually sliced open?

A The eyes are removed, then they are fixed -- like all the tissue before, we make microscopic sections, put it in formaldehyde -- term for it -- and what the formaldehyde does for most tissue, it makes it firmer, stiffer, so that then when you go to make a cut, it's easier to get a nice thin section in the plane that you're trying to make the section in. And that's true in most tissue.

Q And when the eyes were cut, were you able to, with the naked eye, see the hemorrhaging?

A Yes.

Q Did you notice any injuries to Eric's leg?

A There were no external injuries.

Q How about fractures?

A Well, when we took -- we took Xrays, and the Xrays showed some periosteal reaction, more prominent around the right leg.

Q Okay.

A So then I dissected the leg to look for any evidence of acute injury, which would be hemorrhage, and I didn't see some. But I took a section of the right femur, the bone in the right leg, and microscopically I saw evidence of new bone around the central femur. Symmetrically around it, there was another layer of bone.

Q Was this different than what you saw on the left leg?

A Um, I only looked at the right leg.

Q Did you list the injury that you saw as asymmetric?

A The asymmetry was from the -- I listed it that way, but the asymmetry was more prominent in the right than left was from the Xray.

Q From the Xray, it was different from the left leg?

A Correct.

Q Are you able to determine whether the healing to that right leg is necessarily inflicted injury or not?

A Well, there is a condition where you can get periosteal reaction in growing bones rapidly growing in infants, and it's a normal consequence of rapid bone growth. Usually it's -- in those cases, it's symmetric. When you take the Xrays, you'll see the same amount of

reaction in the right leg as the left leg. And those kids don't have any other injuries. We see them, like, in the -- we do a lot of autopsies for sudden infant deaths, the majority of which end up being sudden infant death syndrome, and we might see this Xray picture in those cases, but that's all there is. There's no other injury. So there is, in this case, it was asymmetric, and this was a child who had other injuries I felt were inflicted; so I thought it's likely this was inflicted, too.

Q Based on the record -- your review of the medical records, your review of the history of how these injuries were claimed to have been inflicted and the autopsy that you performed on Eric Patkins, the microscopic examinations that you did, and your years of experience and training, do you have an opinion as to what caused Eric Patkins' death?

A Yes.

Q What is that opinion?

A Abusive head trauma.

Q Why do you say that?

A Well, because I think the -- the -- the whole picture is -- tells me that these injuries were inflicted. They were not accidental, in the sense of something that the infant did themselves. Six-month-olds generally don't generate that kind of energy.

Q All right. And you reviewed the history that at approximately 6:00 or 6:15 p.m. on April 27th of 2001, Eric Patkins was fine, and the following morning when paramedics got there, he was exhibiting crying; and roughly

an hour later, CT scans show fractures to the skull and hemorrhaging in the brain. And you also are aware of the history that the baby was claimed to have been dropped from a distance of about 18 inches onto carpeted stairs.

Are the injuries that you saw consistent with that history?

A Well, well, no, in two senses. One sense, they were -- they were injuries of different ages; so certainly the older skull fracture didn't occur from a fall on the carpeted stairs on that morning. The rib fracture, the posterior rib fracture, might have occurred at the -- around that same time, and the occipital fracture at the base of the brain might have occurred at the same time as the injury to the brain, but the injury that led to the subdural hemorrhage on the right side and the fatal brain injury, that -- those all could have occurred at the same time, um, but the mechanism of a fairly short fall, 18 inches or even 24 inches, on carpeted stairs, I wouldn't expect to, number one, give this fracture at the base of the skull and, two, cause a significant brain injury associated with it.

In addition, from my review of the records, there appeared to be a delay in calling for medical assistance.

Q Okay.

THE COURT: Mr. Hughes, I think we'll go ahead and take about a ten-minute recess right now.

We'll be in recess.

[Morning recess taken.]

THE COURT: The jury is again seated.

Mr. Hughes.

MR. HUGHES: Thank you.

DIRECT EXAMINATION (Resumed)

BY MR. HUGHES:

Q Dr. Trenkle, you told us what would not cause these injuries, these acute injuries. What would cause these acute injuries?

A Well, by acute injuries, I would say, talking about the fracture at the base of the skull, the right side, the injury to the brain, the subdural hemorrhage, the subarachnoid hemorrhage, and the ninth rib fracture in the back, that's a blunt-force injury.

Blunt force, meaning blunt force applied to the base of the head essentially where the fracture was. And blunt force can be force as applied to a head, a blow to the head, or they can be the head hitting -- a moving head hitting another object like a fall.

So I think the rib fracture, the most common mechanism for posterior rib fracture in the infant, is having the chest squeezed and the rib, sort of the end of the rib leveraging against where it attaches to the back bone and cracking at that point. So, rather than being a blow, it's usually the chest being squeezed, the rib. Otherwise, it's -- they are really pliant and mobile. They are not really stiff and brittle. So severe blow to the back of the head with someone squeezing the ribs would generally mean that the baby is hit against something.

That would be, I think, the easiest explanation for these injuries.

Q All right. How hard would the baby have to be hit against something to cause the injuries that you saw?

A Very hard.

Q Would falling from a height of 18 to 24 inches onto a carpeted stair be hard enough?

A No.

Q One of the things you mentioned previously in talking about blunt-force trauma, you talked about a fall. What type of height of fall are you talking about that would be required to cause this type of injury?

A Well, it's -- there are different factors. Basically, you're not going to get this kind of injury -- a -- your standard accidental falls in infants, which are usually from a parent's arms if you're walking with the child and you stumble or slip on wet linoleum or something like that, and the baby falls, falls off of beds, falls off of changing tables, kitchen counter heights, they rarely cause fractures.

When they cause a fracture, it's usually up in the parietal bone, and there's no -- there's no brain injury associated with it.

So fatal fractures from falls, you know, a height greater than 10 to 20 feet. When you look at children or infants who fall out of windows in cities where they have multiple-story buildings that children fall out of, it's usually not until you get past the second floor that you

get fatal injuries. You may get broken bones falling out of a two-story window, break your arm, break your leg, but you don't start dying from head injury until you get to falls higher than that. The height is one issue.

The other issue is what you fall against. I mean, if you fall -- stunt people jump out of 15-story buildings onto an air bag and then survive; so it's what you land on, is the other thing. So the harder the thing you land on, the more likely you're going to have an injury. And then the shape of if you land on, something that's sharp and sort of pointed, there would be more force applied there. If you land on the ground, the force is spread out over a broader area. There's a lot of different factors that go into it other than just the height of the fall.

Q Got you.

But we're not talking about the type of fall that was described in the history?

A No.

MR. HUGHES: Thank you. I have nothing further.

THE COURT: All right.

Mr. Sachs?

MR. SACHS: Thank you.

CROSS-EXAMINATION

BY MR. SACHS:

Q Morning.

A Morning.

Q You've been involved basically in child abuse

since about at least 1983, I guess; is that fair to say?

A Yes.

Q You were involved with the C.A.N. Team or the team in San Bernardino as a pediatrician, I guess, from 1983 to 1990?

A Correct.

Q Testifying basically for the prosecution at that time in many child-abuse cases; is that fair to say?

A Well, I testified for whoever wanted me to testify. As it turned out, it was 95 percent prosecution.

Q Since you joined the coroner's office in 1990, would it be fair to say in child-death cases, would you testify probably close to a hundred percent for the prosecution? That be fair to say?

A Again, I've had defense attorneys ask me to review cases, and I have and given them an opinion, but I've -- it's never led to testimony. So, again, for all practical purposes, the testimony I've done in child-abuse cases is being called by D.A.'s.

Q Certainly when you see a child death with A multiplicity of injuries like you see here, you sort of suspect some type of child abuse. Would that be fair to say?

A Well, I think it would be fair to say that any physician looking at an infant with multiple injuries, that should be part of their differential diagnosis.

Q But you are, are you not, conditionally fair to say -- or is it fair to say you're sort of conditioned to

look for evidence of child abuse when you look at a child death under suspicious circumstances, where there are suspicious circumstances?

A Well, I mean, it's -- I wouldn't say you're conditioned. You're required to look at everything, and one of the things you're saying, is this child abused? Is this inflicted injury? Or is there another explanation. So you always think of child abuse, but you always say, is there another way that this can be looked at that would reasonably explain what I'm seeing or the whole picture?

Q As a pathologist, when you're called upon to render an opinion as to the cause of death, you basically look at the body and do your normal routine and render an opinion based on evidence you find at the time of the autopsy, isn't that basically for the most part what you do?

A Well, as far as the overt evidence of injury, that's what we see at the autopsy. But in many cases as a forensic pathologist, that's all you have. There is no -- the body is just found somewhere. There is no explanation. There's nobody to give you any background, and then you're left with just looking at the injuries.

In other cases, there are medical records, there are family members, there are -- there's a historical background to the case. And when there is a historical background in the case, I take that into account, too.

Q This report, your protocol, I believe is nine pages. Basically, the first three or four pages are

basically summarizing what happened in this case even before you got involved; isn't that true?

A Yeah. I would say that's -- that's just the way I tend to do things. Other pathologists in our office would be -- might summarize all of the medical records in one page or even a half a page.

Q Even in your protocol you went so far to even talk about statements Mr. Patkins made to various people. You put that in your protocol; correct?

A Correct.

Q And you mentioned right before Mr. Hughes concluded with you, I mean, the alleged delay in reporting Mr. Patkins made with respect to injuries that Eric Patkins had suffered. Is that something you would ordinarily put in a protocol, the statement that the person on trial would have made?

A Well, you're telling me I put it in my protocol and then you're asking me is that something I would put in my protocol. I did so.

Q Why would you put a particular statement of a perpetrator on trial in your protocol when you're asked to determine what the cause of death is?

A Why would I not? I mean --

Q Are you attempting to justify your conclusion by comparing your conclusions to what statements an outsider made, namely, Mr. Patkins?

A I guess I wouldn't categorize as trying to justify my conclusions. That's part of the whole picture

of the injury, is that the history that I'm given, and the history may include statements that people make. You know, I think it would be a mistake to ignore all of that and just look at the injuries themselves and not try and put the injuries into some context of a history. I don't think any reasonable physician does that, and no reasonable pathologist does that.

Q Absent statements that -- exclude for just a moment statements were given to you as to what supposedly happened to Eric at the time. Are you saying you would not have been able to come up with a diagnosis to the cause of child's death?

A No. In this case, no. I would have been able to.

Q So in your protocol that you prepared for San Bernardino County, you routinely summarize police reports in your autopsy protocol? Is that what you're telling us?

A I'm not sure what you mean by "routinely," but I would say that I do it more than anyone else in the office. Everyone else in the office will read the reports, and they will make their decision based on that information. They just won't put it into their history of death the way I do.

Q Okay. I'd like to turn to the rib fracture that you indicated on the ninth, a post -- the ninth posterior rib. Was that a fracture -- a hairline facture? Anyone make any determination on that?

A You might get the fractured rib if you shook the baby, from gripping the baby around the chest, but you're not going to get a fracture of the skull from shaking a baby.

Q So that part of the skull had to meet some kind of a blunt-force trauma? Is that sort of what you're saying?

A Yes.

Q Does the same hold true -- what -- I'm talking about the fracture of parietal regions as well. Those are not caused by shaking a baby? Is that also fair to say?

A That's correct.

Q Now, you're obviously familiar in your work with the concept of shaken-baby syndrome, I assume, Doctor; correct?

A Yes.

Q I'm sure you studied back that -- back in 1983 when working as a pediatrician?

A I started pediatrics in '73. I think it was first described in '71, so --

Q For a while?

A Yeah.

Q When you shake a baby vigorously, and I take it you have to shake a baby vigorously for the shaken-baby syndrome to come into effect. Fair to say?

A Yes.

Q Okay. And certainly a child, six-month-old, they usually don't have well-developed neck muscles; isn't that

true?

A True.

Q Do you normally find in your experience that there is some damage to a child's neck muscles when you are suspecting a shaken-baby syndrome?

A Typically, I guess, by damage, the kind of damage would be hemorrhage or tearing of muscles, and that's not been described in cases of shaken-infant syndrome. I guess it could happen, but it's not something you expect to see, and it's not part of the definition. I mean, you don't have to see damaged occipital muscles in a shaken infant.

Q Are you aware of any medical literature that talks about the neck damage when it comes to shaken-baby syndrome?

A There are a lot of people who are looking more, not so much the damage to the neck muscles but damage to the brain stem and the upper cervical spinal cord as the site where the fatal injury would occur in shaken-infant syndrome.

Again, the shaken-infant syndrome, people who describe that people who got significant central system injury, and that's different than the muscles in your neck, an injury to the muscle in your neck might cause some pain or stiffness, but it's not going to affect your brain. The injury that causes an injury to the muscle might cause an injury to the brain, the upper cervical spine, and that's -- that's what we think happens in shaken-infant. That's where we really think of the pathology, not so much the

muscles.

Q But the head, the phenomenon of shaken-baby syndrome, they are shaking, the skull is going a different speed than the brain, and the head is moving back --

A The idea, because the person doing the shaking is so much more stronger than the baby, that the baby's head is moving back and forth, and it can -- it can lead to subdural hemorrhage or hemorrhage of the upper spine or brain stem. There are reported cases of shaken adults, adults who have been shaken enough to cause the injuries. Again, smaller adults, stronger person doing the shaking; so --

Q You didn't find any evidence of any damage to the child's neck in this case; correct?

A No.

Q There's no hemorrhage attached to the neck muscles or anything of that sort?

A No.

Q Number 19 for identification. This is the healing fracture that you observed on the left parietal area; is that correct?

A That's correct.

Q And were you able to determine some kind of age for that particular fracture?

A Well, I'll tell you only in general terms. It's more consistent with having occurred more than a month prior rather than within a few weeks.

Q Now, let me understand how the bleeding that you

talked about in the actual subdural and subarachnoid areas. As I understood your testimony, there was bleeding into the right of this -- I'm showing Number 22 for identification. This area here is the right side of the diagram. This indicates the subarachnoid area [indicating]?

A Subdural.

Q Subdural. This is recent, then; is that right?

A Yes.

Q Okay. Now, the sub -- subarachnoid that you indicated, it was also on the -- that was on the left side, then; is that right?

A Yes.

Q So the subarachnoid bleeding would have been different than the bleeding here in the subdural?

A That's correct.

Q A different area?

A Well, it's a different side of the brain. The subdural is more on the right midportion of the brain, the subarachnoid is more diffusely over the whole left side of the brain. And if you take the subarachnoid membrane, it's that very thin, tightly adherent to the brain. Subdural is on top of that, and subarachnoid is underneath it. So it's anatomically different part of the layers of the central nervous system. One is on --

Q How does the bleeding go to the subdural into the subarachnoid area?

A Well, it --

Q Just a deeper type of injury, more severe?

A Well, if you have somebody, say, with a ruptured aneurism, you can get hemorrhage in all of those layers. If you have someone with a severe stroke, just blows out part of the brain, you can get bleeding in all of those layers; but generally there are slightly different mechanisms that act for subarachnoid versus subdural hemorrhaging.

Q Are there any recent -- you didn't discover any recent fractures of the brain that would be consistent with the bleeding that you observed into the skull; is that right?

A Could you rephrase that?

Q You talked about some fractures of the brain that you observed both on the parietal and the occipital?

A Well, a fracture only applies to the skull, the bone; so --

Q There wouldn't be any bleeding seeping down below the fractures, then, just talking about the bone itself was fractured?

A The bleeding we're describing in this diagram is not bleeding from a fracture of the skull. This is -- this is -- I think that the bleeding comes from the same trauma. So what caused the fracture of the skull, caused this bleeding, but it's --

Q The occipital-lobe fracture, that was of a recent vintage, I think you told us?

A Occipital-bone fracture is recent.

after the brain is removed, the dura lays against the bone at the bottom of the brain; so this is blood that's visible in the subdural space.

Q This be on both the left and right side?

A That's correct.

Q Now, this is fresh bleeding, as you say?

A Yes.

Q Now, showing Number 22 for identification. You also showed us this was also recent bleeding here on the right side [indicating]?

A Correct.

Q Is that the similar type bleeding of what we saw in the previous picture? Same, just deeper to the region to the brain?

A This -- the subdural blood lies on top of the brain. It doesn't go into the brain substance.

Q Okay. So going back to, again, Number 21. This bleeding that we see here, is it your opinion this is still the result of one traumatic episode, the bleeding we see here as opposed to the epidural bleeding as well [indicating]?

A Yes. I think it's all consistent with one traumatic episode.

THE COURT: When you say, "one traumatic episode," are you talking about more than one blunt-force trauma event?

THE WITNESS: All you would need would be one blunt-force trauma event, but there may have been more than

one. There's only evidence on the skull fracture of one site of blunt-force injury. That's one event, being a blow or a fall, would be sufficient to account for all the damage.

Q (By Mr. Sachs:) That's what I was going to get into next. I'm trying to understand for myself and perhaps for the jury, all the -- what areas of the brain we had evidence of the recent bleeding as opposed to old bleeding you talked about. We start off with the fresh fracture, occipital, that you told us about this morning, that you think sort of started the ball rolling, the fresh fracture?

A Again, the fracture is just a marker of a blunt-force injury.

Q Okay.

A Many, many fractures have no associated brain injury at all.

Q I understand.

A This one did.

Q And best medically -- the most reasonable medical explanation, contact with sharp object?

A Blunt object.

Q Blunt object.

Then, as a result of that, we have the bleeding that we see in Number 22, the subdural bleeding on the right side of the brain, which is fresh; is that right?

A Right.

Q That could be attributable to that same skull fracture you just made reference to; right?

A Again, it's attributable to the same injury that caused the skull fracture could have caused the subdural bleeding.

Q And then we have 21, again, for identification. We have -- the bleeding here could have been attributable to that same?

A Same injury.

Q Same injury.

And then we have -- which is Number -- excuse me -- Number 14 for identification. I think you told us before this is the picture, this area here, the subarachnoid hemorrhaging; is that right?

A The subarachnoid hemorrhaging is over -- the whole hemorrhage is spheric sort of compared -- what -- the way I'm looking at the picture on my left to the right, there's more --

Q From here to here [indicating]?

A -- more dark coloration from side to side.

Q Speaking of this area here [indicating]?

A There are two areas of hemorrhaging showing here. One is older, one that occurred, say, a month ago, and the other is fresher; so just depends on where you put the pinpoint.

Q Is this the more recent [indicating]?

A That's the older one.

Q Over here would be the more recent [indicating]?

A No. The whole left hemisphere, all -- I keep wanting to point to my screen here. I can come down there.

Q Maybe that would be helpful.

A This area here, just -- I am circling with the pen -- is the site of the older injury underneath the parietal fracture that was healing. But this whole hemisphere here, particularly out on the sides here, the sort of reddish-brownish color is -- that's all subarachnoid hemorrhaging on the right side of the brain. You can see individual blood vessels that have blood inside the blood vessel. The blood that appears darker on this -- this side of the brain, although swollen, it doesn't have the subarachnoid hemorrhaging. This side of the brain has more. If you -- if you saw a view from the left side, it would be more dramatic. This is one looking sort of straight down so you can see the top of the left side, top of the right side with the whole left side having more diffuse subarachnoid hemorrhaging.

Q This area here, the more diffuse area, that's clearly recent bleeding?

A Yes, it is.

Q A couple days of the child's death, then; right?

A Yes.

Q Okay. Thank you.

That kind of bleeding you just described, that can also be attributable to the same injury, the fracture to the occipital?

A The same injury that caused the fracture could cause that subarachnoid hemorrhage, the fresher more recent subdural hemorrhage.

instrument; is that fair to say?

A That's correct.

Q If we -- can we just turn real quickly to the femur? I understand you to say -- what kind of fracture was that? Were you able to tell? Was this hairline, through-and-through-type fracture?

A No. This was -- this was a circumferential -- it wasn't really a fracture, but it was as if --

Q You mean --

A Like a break in the bone or crack or hairline. This was an instance where the external layer of the bone, the periosteum, which is usually very tightly inherent to the bone, yet sort of the leg can get twisted, the periosteum is sort of torn off of the bone, creating an injury between the periosteum and the bone. It then heals. When it heals, it gives this Xray appearance of elevated periosteum. And when you take a section of the femur, just cut it in cross-section right through the bone, you can see that whole layer of new bone being formed around it. So it's, I'd say, it's an exuberant periosteal reaction from an injury, but it's not an actual crack of the bone.

Q In terms of your ability to date that, several weeks; is that fair to say?

A Yes, several weeks to, you know, could be six weeks or eight weeks.

Q The most likely way in which that could have been done is by a twisting motion?

A I think, as I described before, if it's inflicted, it's twisting like the leg or whatever, the arm, gripped tightly, and there's some twisting motion so that the periosteum strips.

Another phenomenon I talked about, the rapidly growing bone, where you have very symmetric -- looks the same on the left as it looks on the right -- which we don't -- the medical profession doesn't think that's really an injury. That's probably just a result of very rapid bone growth.

Q That's what you're saying in this case you believe, or you're not sure?

A In this case, because in this case it was asymmetric, much more pronounced, I say more pronounced on the right side than the left side, and there were these other injuries, my inclination is to say this was likely an inflicted injury rather than being the result of rapid bone growth in a six-month-old infant.

Q Did I understand you to say, though, that you didn't X-ray the left femur, though?

A We X-rayed both femurs. What I didn't do is take a section of the left femur to compare it from the section I took from the right.

Q If I could ask you, since we're talking about the femur again, ask you to look at Number 18. If we focus in on the diagram to the far left of this picture, would there be an area on the right knee, right leg, or child where you can tell us with the same green dot where the femur would

have been?

A Well it's the whole -- from the hip to the knee.

Q If you can circle that area for us with the green marker?

A Sure. [Witness complies.]

MR. SACHS: May I approach, your Honor?

THE COURT: Yes.

THE WITNESS: I can -- I can just -- you just want it on the right or both sides?

Q (By Mr. Sachs:) Where you found the evidence of abnormality there?

A I'll draw a long line where the bone would be, and on the right side I'll put a cross where I took the microscopic section.

Q Okay. Showing you 18.

So it looks like you've drawn on the far left picture of this diagram the long straight line that indicates the whole femur bone; is that right?

A Yes.

Q On the right side, you also drew a straight line on the left leg as well. That's also to indicate the femur on the left leg?

A Correct.

Q There's a crossing here like where the area was that you located the, what you thought was possibly a break in the femur?

A The periosteal reaction with a new bone formation.

Q It's a recognized document or piece of literature in your field?

A It's the official journal of the National Association of Medical Examiners, which is basically the American organization of physicians, like myself, forensic pathologists that work in the coroner or medical examiner system.

Q That's a peer-review article as well?

A Yes.

Q Can you explain to the jury what a peer-review article is?

A If you want your article to be published, you write your article, submit it to the editor of the journal, then the editor sends it out to a group of forensic pathologists who agree to reading the articles. They look it over and give -- they may offer criticism or what -- they may say, "This is worthless. Don't publish this," in which case generally the editor won't publish it. So it's basically a group of your peers looked at that article, said this is worthwhile to be published. Then the editor -- then it's his decision whether he's got the room to published it.

Q That article came out about the year 2001; that about right?

A That's about right.

Q Now, did you talk about the optic nerve sheath?

I just want to make reference if you have extensive retinal hemorrhaging like we did in this case,

would you also normally expect to have the optic nerve sheath in the condition you found it as well?

A Yeah, such that they would go together.

Q Finally, when you were talking about your protocol, you diagnosing, listing the various injuries that you found, you have under "abusive head trauma," you have "the right inferior occipital skull fracture, recent." Do you see that?

A Yes, I do.

Q And then further on down, you have "blunt-force head injury explained, remote." You have "the superior left parietal bone fracture, remote"?

A Yes.

Q Can I ask, why do you distinguish one fracture as being blunt-force head injury and the other fracture you describe as abusive head trauma? Is there any particular reason for that?

A Well, it has to do with the -- just the way we -- an evolving way that we have of describing these kinds of injuries in infants.

Q Certainly the right inferior occipital lobe skull fracture could also be described as blunt-force head injury, could it not?

A Certainly. I wouldn't argue with anybody who chose to do it that way.

Q So when you tell us that the cause of death is abusive head trauma, you're basically telling us in your medical opinion this is a nonaccidental death; correct?

A Certainly.

Q That could have come about in a variety of ways, then. Namely, it could have been -- well, had to be preceded in your explanation by some sort of blunt-force trauma that the baby didn't generate itself?

A Right.

Q Could it come about -- a blow to the baby's head by, you know, a board or a hammer or something like that, or baby hitting it's head against a hard surface? That fair to say?

A Yes.

Q And as a result of that blunt-force trauma, then, the inferior bleeding which you've described quite comprehensively for us probably started taking place; correct?

A Correct.

Q So, in your medical opinion, then, this baby is not necessarily a victim of shaken baby, then; is that fair to say?

A Well, I think that's fair to say; and I didn't use that term, the term "shaken baby," I don't think I used anywhere in my report.

MR. SACHS: I don't have anything further.

Thank you, Doctor.

THE COURT: Mr. Hughes?

MR. HUGHES: Thank you.

REDIRECT EXAMINATION

BY MR. HUGHES:

Q Performing your autopsy and reviewing all the records, you're focusing on determining the cause of death; is that right?

A Yes.

Q Okay. In this particular case, death is caused by that blunt-force trauma; is that right?

A Yes.

Q It's also possible that the baby was shaken; is that right?

A The baby may have been, but, um, I think all the injuries can be explained by blunt-force injury. But -- but I can't say the baby, from the autopsy, my review, I cannot say the baby was not shaken.

Q Everything that you've seen with respect to Eric is consistent with shaking, but you know for certain that baby was slammed against something hard enough to fracture it's skull; is that right?

A Yes.

Q Dr. Plunkett came up with 18 cases of death out of 75,000 playground falls; is that right?

A Well, what he did is -- he's a forensic pathologist from Minnesota. And there had been some issue, some controversy, whether a short-distance fall could ever be fatal. Some people who thought, no, cannot, you cannot fall from a short-distance fall [sic]. He thought that that was wrong.

So what he did is go to a national data bank, the name of which is in the beginning of his article. It's

was the youngest, but the majority of them, as I remember that paper, were schoolage kids.

Q Okay. Now, counsel asked, "Are there other mechanisms that can cause diffuse retinal hemorrhaging?" You said, "Yes."

Are there any other mechanisms that can cause diffuse retinal hemorrhaging that you saw in Eric Patkins that came into play in this case?

A Well, no. I think trauma is the best explanation for the diffuse retinal hemorrhages here. Now, here trauma is associated with increased basically brain swelling and increased pressure inside the brain.

And, say, if you have a case of a near drowning where someone, a child, is pulled out of a swimming pool, and they are resuscitated but they've been without oxygen for a significant amount of time so they get hypoxic brain injury. Their brains might swell. If you look at the eyes there, you might see a few scattered retinal hemorrhages in that scenario. Would you say it's not due to trauma because you probably would have gotten Xrays, you've done an exam, you wouldn't find any evidence of trauma, you'd say, in this case, I think these retinal hemorrhages are due to the increased -- the brain swelling. But there's no reason to, in a case like this, to say, well, these -- in this case, the retinal hemorrhaging are only due to the swelling. I mean, from that logic, you can say whatever caused the swelling caused the hemorrhages. Since I think trauma caused the swelling, it caused the hemorrhages,

albeit perhaps indirectly.

Q Okay. And, again, the swelling causes more spotty hemorrhaging than what we see here?

A No, the trauma does.

Q Okay. Now, with respect to the healing parietal fracture, the symptomatology that may have been visible could have been as minimal as the baby being fussy for a few days?

A A combination of fussy and lethargic. And because babies mostly cry and sleep and poop and eat, that's about all a baby does, and they do it in various amounts, and sometimes they are fussier and cry more than other times. They sleep more, you know. Unless you're doing neurologic exams and checking reflexes and shining lights in the eyes and measuring that kind of thing like a doctor would do, a caretaker might not recognize that the sleepiness or fussiness was due to the injury rather than just the normal various infant behavior.

Q You mentioned that you have been consulted at various times by defense counsel to see if you agreed with other coroner's opinions; is that right?

A Well, it's -- I was a -- I was a pediatrician. I would be approached by defense attorneys as a forensic pathologist. I've reviewed records on their behalf.

Q Ever have a difference of opinion with a person who reached a conclusion in the records?

A Yes.

Q You've just never come in to testify about it?

A Right. Either -- well, I mean, you give your opinion. You say this is what I think. This is where I disagree with this person. And then the attorney never calls you back to say, "Will you come to court, say this?" Either they decided not to use it, or they found another way to use that, or the case was settled in some other way. But it's never come to a situation where I testified in court.

Q There are other doctors that do this type of consultation; is that right?

A Many.

Q You've had trials where you testify on one side and another doctor comes in and gives a different opinion than you did?

A Sure.

Q Much was made over the fact that you include a history which includes statements by the caretaker in the history. That's something that's important to you in conducting your evaluation, is it not?

A Yes.

Q Why is it important to you?

A Well, the key to looking at injuries, either fatal injuries or nonfatal injuries, is that one of the key issues is is the mechanism offered for this injury consistent with what you see. So, if a baby comes into your emergency room with multiple bruises and broken bones, but they were pulled from the wreckage of a flattened car that rolled in the desert, you will accept that sort of

trauma should lead to these sorts of injuries. That raises nobody's suspicion.

When a child comes, as they often do, with basically no history of anything, just suddenly stopped breathing, turned blue or had a seizure, then you find skull fractures, subdural hemorrhages, retinal hemorrhages, then you ask the caretaker what happened, and they said, "Nothing," well, that -- that -- those kinds of things don't occur out of the blue; so that's not consistent. And then you get a story from a caretaker what happened.

"Well, this is what happened."

And then you have to make a judgment. Do the injuries you see in the child, that either if they are in the hospital, if it's the hospital doctors that are making those decisions, if the child comes to me, then I'm making them. But I need -- I need some sort of explanation for fatal injuries, not just infants but in adults we see the same thing. People found dead in bed. Then you do an autopsy, find skull fractures, hemorrhages, and then you say, "Well, somebody's not giving me the full story here." That's sort of the bread-and-butter day-to-day casework of forensic pathology. You have the body of a dead person with injuries. Then you say, "What's the explanation for these," and it doesn't fit. Again, when they are pulled out of cars, out from a freeway accident, that fits the -- usually that will fit the injuries.

Sometimes you get a case where bodies pulled out of a car that crashed and there are no injuries at all,

THE COURT: Okay.

And actually, before you go today, I'll read the case, because I know you have to do your jury instructions.

12.40 will be given as to Count III.

All right.

MR. HUGHES: And, obviously, we'll modify 12.40 so it only reads "metal knuckles."

THE COURT: Uh-huh.

Okay, let's talk about lessers under Count I, Mr. Sachs.

MR. SACHS: Yes, I am requesting involuntary manslaughter. And it's not statutory involuntarily manslaughter, it's basically non statutory.

I think the jury could find this is an unlawful killing done without malice and without the intent to kill, and therefore, comes under the umbrella of involuntary manslaughter. There are some cases that talk about involuntary manslaughter as non statutory. And it seems to me that the Court -- the jury could easily find that. Again, this is not an intentional killing and it was not done with malice, and it certainly doesn't fall within the definition of voluntary manslaughter because after Lasco and Blackley, we know you don't have to have an intent to kill for involuntary manslaughter. We don't have heat of passion or self-defense, so we know it wouldn't be voluntary manslaughter. Actually, I think the new instructions under involuntary manslaughter have incorporated the Lasco and Blackley decisions, and I do -- this case falls within that category of case that would

justify an involuntary manslaughter.

THE COURT: Mr. Hughes?

MR. HUGHES: My question would be: What unlawful act, not amounting to a felony, are we talking about that resulted in this death? Or what lawful act that is performed? I'll try to get the language right, what lawful act which involves a high degree of risk of death or great bodily harm was done without due caution and circumspection? There isn't anything that fits within the law of involuntary manslaughter.

I have a case, People versus Evers, and I have a copy for counsel, and the Court -- I cited it in my 1101(b) brief. It's a 1992 case out of the 4th DCA in which the Court, under highly similar facts, did not instruct on voluntary manslaughter, and the 4th DCA said that was appropriate and review was denied.

In that case, there was 1101(b) evidence of a prior shaking of a baby, and in the new case the baby was abused and killed under similar circumstances by the same person. And the Court ruled that giving of an involuntary, under those circumstances, was unnecessary because there was no evidence upon which the jury could reach an involuntary manslaughter.

MR. SACHS: The cases I would like to point out, there's People versus Cameron.

THE COURT: Just one moment, Mr. Sachs.

Let me jot down these citations and take a break and read these cases.

THE COURT: All right, and your cases, Mr. Sachs?

MR. SACHS: Yes, it's People versus Cameron, which is 30

Cal. App. 4th, 591.

THE COURT: 30 Cal. App. 4th --

MR. SACHS: -- 591.

The applicable language is at 604, People versus Morales, 49 Cal. App. 3d., 134.

THE COURT: 134?

MR. SACHS: Yes, at Page 144.

And People versus Burrows, 1984 case, 35 Cal. 3d., 824.

THE COURT: 35 Cal. 3d.

MR. SACHS: Cal. 3d., yes, at 824. Applicable language is 836.

With those cases, basically talks about it's non statutory involuntary manslaughter.

THE COURT: All right, I will be in recess about 20 minutes.

(Recess.)

MR. HUGHES: One brief matter before we take up the lesser. We had mistakenly, I believe, indicated that People's 4, which is the internal photograph of the baby's ribs, would be admitted into evidence. That was a mistake. It was not considered. I would request it be withdrawn and returned to me.

THE COURT: People's 4 will be withdrawn.

I assume there's no objection?

MR. SACHS: That's correct.

THE COURT: People's 4 will be returned to the People.

All right, the Court has read the matter of

Basulta, and it does appear it is a legal lesser, Mr. Hughes.

MR. HUGHES: Okay.

I've stated my position. I don't think there's evidence to support it, and that's the only reason I suggested we not give it.

THE COURT: Well, in evaluating these kinds of issues, I do not weigh the credibility of witnesses. I don't assess the weight of the evidence for one side against the other. But it is a factual issue under 273(a)(b) whether a reasonable person would know that the conduct could result in great bodily injury or death, and it is a factual issue, so I'm certainly not in a position to take that away from the jury, however remote that conclusion might be.

If you are requesting 245(a)(1) as an additional lesser, I will give it, Mr. Sachs.

MR. SACHS: Yes, I would be.

THE COURT: All right.

I've also reviewed several other cases, including the case submitted by the People, People versus Evers. This does raise an interesting legal issue. In the matter of Evers -- and correct me if my recollection is in error -- but in the Evers matter, we had a child, I believe two years of age, living in the home.

And there was 1101(b) evidence, as well, but I don't think that's necessary for purposes of my evaluation, but at any rate, the evening in question, the minor was placed in bed. Mom went to bed, and the next day the child was discovered lying on the floor. And the autopsy results

indicated the child died from non-accidental means. It was the consensus that the child died as a result of abusive head trauma. And basically that was the cause of death.

As far as the circumstances surrounding the cause of death, the actual trial transcript, or the actual evidence, was void of what happened, other than the child was found on the floor basically beaten to death.

And the issue really was who did it? And it was either mom or dad. The defense attorney made some arguments in closing of a non evidentiary matter, but there was really -- there was no theory based upon any evidence that the baby died based upon any kind of negligent handling of the baby or anything else. The baby was just basically beaten to death.

And so the Court in this particular scenario felt that involuntary manslaughter was not based upon any evidence in the transcript at all. I just wanted -- there was one citation I wanted to read.

By reading Evers, the Court basically indicates that involuntary manslaughter would be appropriate if there was any evidence to support it,, but in this particular case there was no evidence to support that theory, which would have caused the child's death, based upon involuntary manslaughter or criminal negligence.

In this particular case, let's assume, Mr. Hughes, that a juror, in evaluating the evidence, believes that it may be possible that the head injury in this case could have resulted from a short range fall. Let's assume a juror

believes that, or believes that that is a reasonable possibility, based upon the testimony from the experts. And I'm not saying that is the most probable conclusion or the most reasonable conclusion, but let's assume a juror drew that conclusion, that he wasn't convinced beyond a reasonable doubt that it wouldn't be possible.

Further conclude that a juror adopts, or believes, the defendant's version, which is in evidence, that he was going up the stairs and he dropped the baby. What crime do we have, if any?

MR. HUGHES: None.

THE COURT: Okay.

Obviously, if it's strictly accidental, then there's no crime. Under the circumstances and evaluating the defendant's prior handling of this baby, a prior head injury is the result of the child hitting its head at some point in time 'cause we have an old skull fracture, and then we have the 1101(b) evidence of mishandling another child, which goes to knowledge. Do we have any evidence here which would suggest an inference that he was criminally negligent in handling the baby as he was going up the stairs?

MR. HUGHES: Not in my opinion, no.

THE COURT: Mr. Sachs?

MR. SACHS: I think we do, Your Honor. I think there's an issue whether he was criminally negligent or whether he exhibited conscious disregard.

THE COURT: And that's the difference.

MR. SACHS: That's the difference. I think that would

be a jury issue. I don't think the Court could take that away, because it is a little uncertain as to how the baby was killed. We don't know that. How the baby received the injury in the occipital region of the skull.

And so, I do think this does fall in a gray area. And I don't think the defense should be in a position of either asking the defendant to be acquitted of murder by virtue of an accident or guilty of murder. I think because of the uncertainties of how the baby met its demise, there is evidence that the jury could find that he was criminally negligent instead of exhibiting this conscious disregard. All the injuries, pre-existing the one he suffered, are not life threatening.

There is no indication that Margie or Mr. Patkins knew he suffered those. Unlike the case in Evers, where the child actually had his feet burned before he was killed, a prior occasion. We don't have that here.

THE COURT: In the Evers case there's no evidence to suggest any other theory, which would have caused death. There was no other theory. There was no accidental theory at all.

MR. SACHS: The cause of death is much more clear-cut in the Evers case than it is here.

THE COURT: I think in Evers that's why the District Court of Appeal took the position that involuntary manslaughter wasn't in the cards, in this case, because there was no theory of the evidence to support that.

MR. SACHS: Right.

THE COURT: Again, Mr. Hughes, it's not my job to evaluate the evidence, or weigh the evidence, or weigh the credibility of the witnesses. If I took this issue away from the trier of fact, I believe it would be error.

So at this time, I will be giving involuntary manslaughter.

And, Mr. Sachs, I would suggest under involuntary manslaughter, the Court would define it as during the commission of an act, ordinarily lawful, which involves a high degree of risk, or death, or great bodily harm without due caution and circumspection, I don't believe, based upon your theory, it was during the commission of an unlawful act.

MR. SACHS: That's correct, yeah.

Do we have to define for the jury what the lawful act is?

THE COURT: No.

MR. HUGHES: No.

THE COURT: We would have to define what the unlawful act is.

MR. SACHS: Excuse me. Okay.

THE COURT: But not the lawful act.

MR. SACHS: Carrying the baby up the stairs is a lawful act. So that's what I would suggest.

THE COURT: Do you concur with Mr. Sachs?

MR. HUGHES: Yes, I think so, that's fine.

THE COURT: So if paragraph number one would be stricken, so "The killing is unlawful, within the meaning of this instruction, if it occurred in the commission of an act

ordinarily lawful, which involves a high degree of risk or great bodily harm without due caution and circumspection."

MR. HUGHES: In which case we should also give 8.46, which defines due caution and circumspection.

THE COURT: I agree.

Can we pull that, Madam Clerk?

THE CLERK: Uh-huh.

MR. SACHS: It was requested.

Did you pull it?

THE CLERK: Yes.

MR. SACHS: I did request it in my packet. I'm sorry, I did not ask for that. I forgot to ask for that.

THE COURT: Then 8.50 --

MR. HUGHES: -- should not be given because 8.50 applies only to a voluntary manslaughter. Maybe 8.51 instead.

THE COURT: Can you pull 8.51, please?

THE CLERK: Uh-huh.

THE COURT: Just for the record, but for the defendant's statement concerning how the child was killed, if he had not made that statement in this particular case, I would not have given involuntary manslaughter.

All right, as far as 8.50, I will not give that. That's rejected.

8.51, gentlemen, I believe the second paragraph would be appropriate.

MR. SACHS: Just to interject, I was thinking about the Court's ruling. Certainly, I concur. I'm wondering if the Court had the chance to read the cases I cited if we really

have to fit this into a lawful act or unlawful act.

It seems like it's a stretch to tell the jury that my client is involved in a lawful act, namely, carrying the baby up the stairs, but that involves a high degree of risk or death or great bodily harm without due caution or circumspection. How would carrying the baby up the stairs?

THE COURT: It would be how he carried it, I guess.

MR. SACHS: I would propose just tell the jury if someone commits an act without malice, and without the intent to kill, then that would be involuntary manslaughter, which I think the cases I cited to the Court support that proposition of law. I don't know if we have -- that seems to be Burrows, the other cases, we don't have to fit an involuntary manslaughter situation immediately into a category defining an act or unlawful act. If it's an intent without malice and without intent to kill, it would be involuntary manslaughter.

THE COURT: Mr. Hughes?

MR. HUGHES: As I read Evers, and it is reference to Burrows, I didn't have an opportunity to read Burrows. They are talking about if there's a commission of a non inherently dangerous felony without knowledge of its danger that results in death, then you could have an involuntary.

Well, Mr. Sachs can't argue that Mr. Patkins was shaking this baby or slamming it's head was abusing the child and didn't realize it was dangerous. I suppose he could, but I'm certain he's not going to. That's the only way we get to that type of involuntary under Burrows.

Counsel, I think, has hit exactly on the head, why

I say there's no way we can get to involuntary because there's no unlawful act here.

MR. SACHS: I agree. I think it applies. I was thinking out loud because I know that's my sense of those cases that you don't have to, you know, again, fit into a neat category. I think there's a non statutory involuntary manslaughter. What I think those cases suggest, what the Court doesn't have to say, whether it was a lawful or unlawful act. Just give definitions of malice and intent to kill. If it doesn't find malice exists or attempt to kill, it would be involuntary manslaughter. I would submit that.

MR. HUGHES: I have a suggestion that might help that might fit within what counsel is suggesting. Using the second page.

MR. SACHS: Of 50?

MR. HUGHES: 851. There are many acts which endanger human life. If a person causes another death by doing an act or engaging in conduct in a criminally negligent manner without realizing the risk involved, he's guilty of involuntary manslaughter. I guess the trouble with that, of course, is that really only implies to him intentionally doing something to the baby.

THE COURT: Well, engaging in an act, doing an act or engaging in an act, in a criminally negligent manner would be handling the baby, carrying the baby, and then dropping it. We're not talking about a situation where he is actually shaking it and pounding it's head against the wall.

MR. HUGHES: Right.

MR. SACHS: I can see the Court's point. The jury could come to the conclusion, if they do believe he tripped over the dog, was carrying the baby too loosely or something should have been more protective, the jury could find ostensibly that he was conducting himself in a criminal manner.

THE COURT: First of all, I'm not giving the first paragraph. It doesn't apply on 8.51.

MR. HUGHES: All right.

THE COURT: Okay. I'm not going to give that.

I will be giving the second paragraph because it is an accurate statement, but what Mr. Hughes is suggesting that we draft a definition of involuntary manslaughter around the second paragraph of 8.51, which basically is, I think, your position, Mr. Sachs.

MR. SACHS: That's fine, yeah.

THE COURT: Think about that. I'll think about it, as well. But I think Mr. Hughes' suggestion was a good one.

MR. SACHS: Yeah, that's fine.

THE COURT: I'll work on that, too.

Okay, 8.46, due caution and circumspection.

8.72. I believe, that's appropriate.

And 9.02 would be appropriate as a lesser under Count II, striking reference to deadly weapons. A person who commits an assault upon the person of another by means of force likely to produce great bodily injury is guilty of a violation of 245(a)(1). Okay.

All right, 17.11, I don't believe that's necessary.

MR. HUGHES: That just pertains to degrees, correct?

The mental state constituting malice aforethought does not necessarily require any ill will or hatred of the person killed.

The word "aforethought" does not imply deliberation or lapse of considerable time. It only means that the required mental state must precede rather than follow the act.

The crime of involuntary manslaughter is a lesser-included offense under Count I.

Every person who unlawfully kills a human being without malice aforethought, which means without an intent to kill and without conscious disregard for human life, is guilty of the crime of involuntary manslaughter in violation of Penal Code Section 192, Subdivision (b).

A killing in conscious disregard for human life occurs when a killing results from an intentional act, the natural consequence of which are dangerous to life, which act was deliberately performed by a person who knows his conduct endangers the life of another and who acts with conscious disregard for human life.

A killing is unlawful within the meaning of this instruction if it occurred in the commission of a lawful act which might produce death in an unlawful manner, or without due caution and circumspection.

In order to prove this crime, each the following elements must be proved:

Number one, a human being was killed; and

Number two, the killing was unlawful.

The term "without due caution and circumspection" refers to a negligent act which is aggravated, reckless, and flagrant, and which is such a departure from what would be the conduct of an ordinarily prudent, careful person under the same circumstances as to be contrary to a proper regard for human life or danger to human life or to constitute indifference to the consequences of such acts.

The fact must be such that the consequences of the negligent act could reasonably have been foreseen. It must also appear that the death or danger to human life was not the result of inattention, mistaken judgment, or misadventure, but the natural and probable result of aggravated, reckless, flagrant, or grossly negligent act.

If an individual is acting without due caution and circumspection, he is acting in a criminally negligent manner.

There are many acts which are lawful but nevertheless endanger human life. If a person causes another's death by doing an act or engaging in conduct in a criminal, negligent manner, without realizing the risk involved, he is guilty of involuntary manslaughter.

If, on the other hand, the person realizes the risk and acted in total disregard of the danger to life involved, malice is implied, and the crime is murder.

If you are convinced beyond a reasonable doubt and unanimously agree that the killing was unlawful but you unanimously agree that you have a reasonable doubt whether the crime is murder or manslaughter, you must give the

defendant the benefit of that doubt and find it to be manslaughter rather than murder.

Before you may return a verdict in this case, you must agree unanimously not only as to whether the defendant is guilty or not guilty, but also if you should find him guilty of an unlawful killing. You must agree unanimously as to whether he was guilty of murder or involuntary manslaughter.

The defendant is accused in Count II of having committed a violation of Section 273 (a)(b) of the Penal Code, a crime.

Every person who, having the care or custody of a child who is under eight years of age, assaults the child by means of force that to a reasonable person would be likely to produce great bodily injury resulting in the child's death, is guilty of a violation of Penal Code Section 273(a)(b), a crime.

Great bodily injury means significant or substantial bodily injury or damage. It does not mean trivial or insignificant injury or moderate harm.

In order to prove this crime, each of the following elements must be proved:

Number one, a person had the care or custody of a child under eight years of age;

Two, that person committed an assault upon the child;

Three, the assault was committed by means of force that to a reasonable person would be likely to

Murderer. That's what there is to say to Mr. Patkins. Murderer.

I was thinking about Eric a lot this weekend, and I was thinking -- I realized he should have been two in a couple weeks. He should have been laughing and smiling, smearing cake frosting on his face; but, instead, we're all here listening to gruesome and heart-wrenching testimony about that man's brutality to a six-month-old boy.

And when you think about this case at its most basic level, that's what it comes down to. Eric wasn't old enough to walk. He couldn't crawl. He couldn't scoot. He couldn't move about to get himself into trouble. And when he was alone in that man's care, he suffered massive head injuries and a rib fracture, and he died from them. That's what happened to Eric Patkins in his care.

And he, after killing his son, lies about it. He tells you folks by talking to a paramedic and by talking to Margie and by talking to the doctor, tries to tell you he fell eighteen inches -- that far [indicating] -- eighteen inches onto household carpet, not the industrial stuff we have here, household carpet -- that far [indicating] -- to fracture his skull at the base of his skull, the thickest part, the hardest part to break. An 18-inch fall onto carpet to cause massive bleeding in his brain at various levels, subdural hematoma, subarachnoid hematoma, to cause extensive retinal hemorrhaging in both eyes, bilateral retinal hemorrhaging, to cause the bilateral optic nerve sheath damage.

Eighteen inches, that's what he told the paramedics, as he was walking up the stairs and tripped over the dog and dropped him onto the stairs. Somehow broke his rib too.

You know that didn't happen. You know that's a lie. Every doctor that saw Eric knew it was a lie.

You heard from Dr. Sonne, Riverside Community Hospital, board certified in emergency medicine, been an emergency room physician for over 20 years. He told you the injuries he saw are inconsistent with what the defendant claimed about falling on the stairs. Inconsistent. He's seen two to three hundred head injuries in children, and he told you he knew right away it was inconsistent with what that guy's trying to claim. That's why he asked for a child-abuse evaluation. That's why the police were called.

Dr. Angela Slaughter, she works at Pediatric ICU at Loma Linda University Medical Center, the primary facility for children in our region. She told you she saw Eric after he'd already had the bolt in place, after the drain was in place. She reviewed his records, and she told you it was inconsistent. Those injuries were inconsistent with a short fall onto carpeted stairs at home.

Dr. Rebeca Piantini, she's a forensic pediatrician. She's also a general pediatrician. She also works at Loma Linda University Medical Center. She was the chair of the Pediatrics Department at R.C.R.M.C. She was in charge of the children -- of the Pediatrics Clinic at

R.C.R.M.C. She sees both normal children with normal illnesses and medical problems, and she's the one they call in when doctors suspect child abuse. Half the time when she's called in, she doesn't find child abuse.

She told you Eric was abused. This was no accident. Eric was abused. The force necessary to break the little boy's skull was far greater than any household fall, far greater than any household fall. She told you this was a classic case of shaking and impact, shaken impact, not a close call.

Dr. Steven Trenkle, forensic pathologist for the County of San Bernardino. He's been doing that since 1990, over a decade. He's board certified in forensic pathology. He's also board certified in pediatrics, because before he switched careers in the field of medicine to become a pathologist, he, himself, was a forensic pediatrician. He worked in pediatrics from 1973 to 1990. He was the former chief of the Division of Adolescent Medicine and Pediatrics at R.C.R.M.C. He used to have Dr. Piantini's job -- actually, Dr. Piantini's boss' job at Loma Linda University Medical Center.

And he told you this was no accident. The force necessary to break Eric's skull back here is the kind of force you'd expect to see in greater than a second-story fall. Remember he was talking about the studies where we see these types of injuries in urban areas where they have high-rises -- Detroit, Chicago, New York -- greater than second-story fall, that's when you start to see these types

of injuries. Greater than a second-story fall. Not eighteen inches, not on the carpet. That's nonsense.

Now, Dr. Trenkle said we saw old and new injuries, were black and blue, again, over here. I apologize. Old injuries, parietal skull fracture healing up on the left top of Eric's head beneath that subdural hematoma and a brain contusion. You can actually see it on that photograph. You can see the area where the brain contusion was. And an old healing leg injury.

Eric's new injuries, occipital fracture to the back of his skull, subdural hematoma on the top right and in the middle, and at the base under the skull under the brain -- excuse me -- subarachnoid hematoma all over the left-hand side of the skull of the brain. Pardon me. Extensive bilateral retinal hemorrhaging, both sides, and that rib fracture.

He told you all about all of that and he took all of that into account and he took the history into account, the claim of falling eighteen inches onto carpeted stairs, when he told you, "No way. That didn't happen. The cause of death was abusive head trauma." He said it was all consistent with shaking, but he didn't need to reach the shaking issue because what caused the death was the impact. Impact with a force greater than that of a two-story fall.

Not a single doctor who saw Eric said otherwise. Not a single doctor who saw Eric was called in to say those four doctors had it wrong.

Now, the defense has no burden of proof. They're not obligated to call any witnesses. I'm not trying to suggest that.

They have the right to call witnesses. And if any of those doctors that treated Eric had felt differently, you better believe you'd have heard from them.

But you know what? Even without those doctors, you know it didn't happen the way he said. You know from your common sense, from your life experience, you know it in your heart of hearts. No baby got those injuries from falling eighteen inches or so. Let's make it an even two feet onto the carpeted stairs. Never happened. You know that.

Why else do you know?

Well, most parents never drop their baby. Most parents never drop a baby that young. Maybe once. Maybe twice. He claims to have dropped his two babies at least four times within a total of nine months. He dropped Eric, so he says, when he's walking up the stairs, and Eric flew out of his arms like a football.

About a month earlier when Margie notices a bump on Eric's head, then he says, "Oh, yeah, he fell off the couch, hit his head on the coffee table." Didn't tell her beforehand. Told her only after she found the injury and only after the baby had rolled off the bed in Margie's care. How's she going to dispute him?

More importantly, he -- move back to 1993 and

Jack. He drops Jack three times in three months. Says he dropped him in the shower on July 1st of 1993. Says he dropped him when he tripped over the bedpost and he flew out of his hands like a dart. And he says he dropped him when he arched his back and forced his way out of his hands and hit his head on the windowsill in Oceanside.

Most parents never drop a baby. Four or five times in nine months? No, absolutely not.

And you know every time one of these boys comes up hurt, he's alone with him. Nobody's there to see otherwise. And he says, "It was an accident."

How else do you know that this didn't happen? Babies bump their heads all the time; right? Especially once they get to the age where you start playing with them a little bit. But mothers frequently carry the baby down a little bit, resting on the hip, go through the doorjamb, and bang. Happens. People have the little babies up on their shoulders, walk through the door. Oops. Bang. Right?

I was playing with my little niece. She likes to run around, hold her under the arms, throw her up in the air. Wasn't paying attention, running right under the doorjamb, bam, hit the doorjamb.

But the babies don't die. You see babies bump their heads all the time. That's why they make the corner guards for our furniture. Baby's fall, hit their heads all the time. They don't get the types of injuries that Eric had.

So, even without the doctors, you know it didn't happen the way he says.

All right. Let's look at the charges. He's charged with three crimes: The first, violation of Penal Code Section 187, murder; the second is violation of Penal Code Section 273(a)(b), assault on a child under eight resulting in death; and the third, a violation of Penal Code Section 12020, possession of metal knuckles.

Talk about the law and the facts with you now. I know it was all abundantly clear when the judge read it to you, but we'll go through it anyway. We'll go in reverse.

12020. What do I have to prove? A person possessed a weapon, and the weapon was commonly known as metal knuckles. That's all I have to prove. There they are. Metal knuckles. It's illegal to possess these.

Now, one thing you noted. You don't have to prove that Mr. Patkins knew they were illegal. Doesn't matter whether he knew or not. I don't have to prove it. It's not a defense if he didn't. Something you may have not known. I don't know, but that's not an issue. The only issue is he possess those knuckles. I don't have to prove he knew it was illegal, because it's no defense he knew it was illegal. Possession. Doesn't have to carry them on his person, just have to have control of these things, right to control them.

They are in on a workbench in the garage. Margie told you she saw them. She was there when he found them and took them home. So that's Count III. I don't think

that's going to be seriously disputed.

Let's look at Count II, assault on a child causing death. A person had the care and custody of a child under eight, the person assaulted the child, and to a reasonable person, the force used would be likely to cause great bodily injury.

Great bodily injury just means significant or substantial injury and the assault resulted in death.

Well, let's look at those.

Mr. Patkins was alone with Eric. He had the care and custody of his six-month-old child. He assaulted the child.

What do we mean by "assault"? That's a very long instruction, but basically it means did he intentionally apply physical force to his baby. If he intentionally applied physical force to the baby, he assaulted the child. That's what that means.

Now, to a reasonable person, would the force used be likely to cause great bodily injury, to a reasonable person, any one of you folks. Would the force equivalent of a three-story fall be likely to produce great bodily injury in a six-month-old? Of course. Of course. Shaking and slamming a child. Everyone knows it.

He knew it from his own unique knowledge. He'd done it before. He knows it. Any reasonable person would know it.

I use the word "slamming." Yep. That's my word. Dr. Trenkle didn't use it in his report, but I can't

think of a different word or a better word for the force of a three-story fall. Maybe you have a different word, but "slamming" certainly fits. And you can look at the nature of the injury to see would that force be likely to cause great bodily injury. Just look at Eric's injuries -- fractured skull, massive brain hemorrhaging, retinal hemorrhaging, optic nerve sheath damage, and a broken rib. That's indisputable. Hitting a kid either with something or hitting the kid against something with that much force to any reasonable person is going to cause great bodily injury. And the assault resulted in Eric's death.

So, you know he's guilty of that crime. Those elements are all met. He's guilty of that crime.

Now, let's look at murder. What is murder? A human being was killed, and the killing was unlawful, which means it wasn't in self-defense or justifiable somehow, and the killing was done with malice aforethought.

Malice aforethought. Lot of times we think of malice as hatred, ill will, anger, something like that. Malice does not equal hatred under the law. Okay. It's a legal term we're going to use. I'll define it further. It doesn't mean he had to hate his baby to have malice.

There's two kinds of malice. There's express malice and there's implied. It can be either. The person was killed, the killing was unlawful, and it was with malice aforethought.

Let's look -- what does express malice mean? A defendant manifests an intention unlawfully to kill a human

being.

What would we mean by that? By words or conduct you can tell that the defendant intended to kill. That's express malice.

There's another way we can get to murder, and that's implied malice. It doesn't have to be both. It can be either/or.

What is implied malice? Well, implied malice -- malice is implied when the killing resulted from an intentional act, the natural consequences of that act are dangerous to human life, and the defendant acted -- or the act was deliberately performed with knowledge of the danger to and conscious disregard for human life.

So, in other words, person commits an intentional act, that act is a danger to human life, and the person disregards that danger. Knows it's dangerous and does it anyway.

All right. Like to give an example to illustrate what we mean with all of this express and implied malice and malice aforethought. Let's say you work in an office building up on the fifth floor. It's an older building. Your window is open. You have potted plants next to the window. It's quarter to 5:00, and you're working away, and it's been a long day. You're tired, but you're concentrating. The phone rings. It startles you. You knock that potted plant off. It falls down five stories and hits your manager who's sneaking out early. It kills your manager. And while the manager lies down there, you

see what you've done, and, you know what? You hate your manager. He's always sneaking out early. He's always making you do his work for him. After that hits him on the head, you say, "I hope you die."

Okay. That would be express malice, but that wouldn't be malice aforethought. That would be malice after the fact. That wouldn't be murder.

Aforethought just means it's before an intentional act.

All right. So let's talk -- change the scenario just a little bit. You're not startled. You see your manager sneaking out early again. You take that plant, loudly proclaim, "I'm going to kill you." You throw it down. You want to kill him. It hits him on the head. He dies by your actions and your words. You've manifested an intent to kill. You've shown your intent to kill. That's express malice.

All right. Let's change it one more time. Talk about implied malice. Now it's your best friend in the office. Your best friend's leaving work early. You've known her for years. She was your maid of honor at your wedding. You love the woman like a sister, and you figure, "I'm going to play a little trick on my friend. I'm going to throw this potted plant down and scare her. I know it's dangerous, but I'm a good enough shot. She always walks straight. I'll miss, and it will be funny. I don't want to kill her. I'll miss. It will be funny."

You throw it down. Of course, that's the one day

she turns left because she's going to go mail something, and it hits her in the head. It kills her. That's implied malice. You did an intentional act that was dangerous to human life, and you consciously disregarded that danger and did it anyway. That's implied malice. Murder. That's murder.

Okay. So that's just kind of an example to talk about what the three different concepts mean.

So what evidence backs up malice then equals murder? Express malice, intent to kill; implied malice, danger disregarded. Either way it's murder.

What evidence do we have of express malice, intent to kill?

Well, you can look at the amount of harm to Eric and you can infer an intent to kill just from the severity of those injuries. You can look at the amount of force it took for that man to break his son's skull and cause massive brain hemorrhaging and all of those injuries. You can, from that alone, say he meant to do what he did. He intended this.

But you have more than that. Because, if you think about murdering your own child, it's a crime of emotion, rage, frustration, anger, despair; and he fits those emotions.

You look at his life. His life is crumbling around him. His relationship with Margie is failing. It's on the rocks. She has asked him to move out a couple different times. She's paid him to move out. The arguing

is getting more frequent, and it's getting worse. He doesn't have any money. He's barely working. He doesn't have the means to support himself. He doesn't have a friend network that he can go to that he can rely on, and his family relationships, by his own definition, his relationship with his father is poor. His world is collapsing around him, and he is jealous of Eric. Eric is getting Margie's love and David is not.

And you look at all of these things together, and you throw in the fact that he knows precisely what he's doing when he injured the child. He's been through it before. He knows how dangerous it is. He knows exactly what he can do that will kill that child. He's been through it. And when you look at that entire picture, you can infer that he intended to kill Eric.

But there's another way you can get to murder. It doesn't have to be express malice. It can be implied malice. And what evidence do we have of implied malice, danger disregarded? This was abusive head trauma. All the doctors told you that, and you know it from your own common sense. And, again, the very nature of the injuries, he had to know what he was doing was dangerous to human life.

Everyone knows that it's dangerous to shake a baby or to slam its head against something or with something with the force of greater than a second-story fall. Everyone knows that. Everyone knows. And he knows it firsthand from his own experience because he's done it before, and he saw firsthand what the injuries were.

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. That's why you get to hear about that kind of evidence. He knows firsthand of the danger.

Little Jack spent, what, eleven days to two weeks in the hospital because of what he did to him, and he lied about it. But ultimately he ended up admitting what he had done. During that time in the hospital, they had to tap Jack's brain four times to relieve fluid build-up, which was causing pressure in his brain. They put a shunt into his head, which stayed there for a year. He knew firsthand what he was doing and how dangerous it was. And he did it anyway. Danger disregarded. That's implied malice. That's murder.

The police, when they interviewed him and Michelle on the telephone, told him Jack has life-threatening injuries, knows firsthand because he did it and lived it. This is dangerous to human life.

All right. Let's talk about lesser offenses. The law says that we have to give juries the option of convicting on lesser offenses. They don't necessarily

apply in every given case, but we have to give juries the option. If they don't find the defendant guilty on the greater offenses, then they have the option of finding the defendant guilty on the lessers. They don't apply here, but the law says we have to give you those options.

Involuntary manslaughter is a lesser to murder. To get to involuntary manslaughter, you have to have a killing, an unlawful killing, without malice aforethought. In other words, if he didn't know what he was doing was dangerous to human life. It doesn't apply here.

Assault by means of force likely to produce great bodily injury is a lesser to assault on a child resulting in death.

Simple assault is an even lesser to that. Again, those don't apply to these facts. And if the defense tries to shoehorn those lessers into these facts, then I'll address them on rebuttal.

But the key, you cannot convict of a lesser offense unless you unanimously agree he's not guilty of the greater offenses. You can't find him guilty of manslaughter unless you unanimously agree he's not guilty of murder.

And if there's an attempt to shoehorn those lessers in here, I'll talk to you more about them on rebuttal.

So what's the defense in this case? Well, these types of cases, there are two possible defenses. First one, it wasn't me. Somebody else did it. Well, that's not

the defense here. Mr. Patkins was alone with his boy, and he chose not to go that way when he talked to his wife on the phone -- or when he talked to Margie on the phone -- and when he talked to the doctors and the paramedics.

He went with the other option in these types of cases. It was an accident. Well, neither one of those fits. We talked a little bit about why neither one of them fits.

Basically, to find him not guilty, you have to believe that a fall that far on these carpeted stairs, household carpeted stairs, caused that type of massive brain injury. That's what you have to believe to believe the defense.

How else do you know it's not an accident?

Well, he'd fallen before from greater than that distance when he was in Margie's care and he rolled off the bed. That bed -- remember Detective Bartholomew testified that was 26 inches off the ground -- rolls off the bed, fell on the carpet, started crying. No injuries whatsoever. No bumps. No bruises. Nothing.

And yet when he supposedly fell eighteen inches onto the stairs, it caused him to die?

How else do you know it's not an accident?

He lies to Michelle and he lies to the police and he delays medical care.

Back in 1993, he claims it was yet another drop, yet another drop, but he ultimately ends up admitting in court he abused Jack on July 1st, 1993, and he personally

inflicted great bodily injury.

And years later, he ends up admitting it to Michelle, he shook Jack by the feet. He delayed that medical care back then. What must he have been thinking? I hope nobody knows. "I hope Michelle won't notice this. Maybe this will just go away."

We also know because the defendant knew more about Eric's condition than the paramedics. The paramedics come. Baby seems fine. C.D.F. even says, "You don't need to transport him. If you want to take him in for a checkup, you can do that." And the AMR guy says, "Go ahead, transport," because he doesn't want to get sued if it turns out, as it did, that the injuries were much worse.

But the defendant knew more than they did, because remember the defendant called Margie before they got there, and he told Margie, "The baby's hurt bad. He hurt his little shoulder. He's favoring one side. You better come home right now."

The defendant knew more than the paramedics did, because the defendant knew what he did to the boy. He told them that the boy fell eighteen inches. They thought, "Well, nothing serious." He knew what he'd done to the boy, and he knew because he'd lived through it before, that Eric was in big, big trouble.

How else do you know it's not an accident? Because we have lightening striking twice, that's why. You get to hear about his past conduct because the more times

he claims the identical accident, the more you know he's lying.

What happens to Jack when he's three months old? He's -- the defendant is in a relationship that's on the rocks. Michelle left him about a month earlier, was gone for a few weeks. He's alone with the baby. The baby suffers a serious life-threatening head injury. He delays medical care. He claims that he dropped the baby, he advises the hospital.

Remember, he was there for, like, five minutes the whole first day. Five minutes he spends at the hospital while his son is almost dying. And then he claims a history of falls and he defines Jack's fall in the bedroom when he tripped as falling like a dart.

Now, we look at what happened to Eric when Eric was six months old. The defendant's in a relationship that's on the rocks. Margie's told him to move out a couple times and has actually paid him to move out. He's alone with the baby. Eric suffers serious life-threatening head injuries. The defendant delays medical care. Thirty to sixty minutes he spends before he calls Margie. Thirty to sixty minutes. He claims he dropped the baby.

He wanted to leave the hospital when Margie was there. Here his baby is dying, and he wants to leave the hospital.

He claims a history of falls for the boy, and he defines Eric falling like a football. You know he's lying. You know Eric was abused.

The Court read you the law regarding consciousness of guilt, and it says, "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."

And if you think about it, it makes perfect common sense. People lie when they are trying to get away with something. They try to cover themselves. They try to hide their misconduct.

The law tells you that when someone lies about the crime for which they are on trial, you can infer that means they know they are guilty. Now, that alone isn't enough. I'm not trying to suggest that to you. We have so much more than just that. But he's got to come up with something.

What's got to be going through his mind? He knows the baby's hurt. He knows Margie is due home within a couple of hours. He knows she's going to know something's up. He knows everyone's going to know he did it. He's got to come up with something. He can't just hope Margie won't notice. He tried that in 1993. He just hoped that Michelle wouldn't notice and maybe it would go away. That didn't work in 1993. He can't do that again. Margie's a nurse. She's going to know something's up. He's got to come up with something.

Okay. The baby fell. He's got to explain why a

healthy man, six feet two inches tall, in his mid-thirties, is going to trip and drop a baby in his own home. Plain, the dog, Scooby did it. He's got to come up with something; so he decides he'll call Margie and tell his story.

The baby fell eighteen inches onto the stairs, only that's not medically possible. He came up with a story that can't possibly explain the injuries that Eric suffered.

And you know why he's lying? Because he abused Eric, because he bashed him on something, and he killed him, and he's trying to avoid responsibility for that.

I said I thought a lot about Eric this weekend. Talked about him a lot to my family and friends. And somebody said, "What a tragedy." And it occurred to me it's not a tragedy. It's an atrocity. This man killed his own son. That's an atrocity.

To find him not guilty, you have to believe that all of the doctors that saw Eric were wrong. You have to believe that falling eighteen inches onto carpet turned this little baby into that little baby. That's what you have to believe to find him not guilty. You know that didn't happen, and you know he's guilty of everything he's charged with.

Thank you.

THE COURT: All right.

Ladies and gentlemen, why don't we go ahead and take a ten-minute recess.

THE COURT: At this time, ladies and gentlemen, we'll take our noon recess until 1:30.

[Lunch recess.].

[In the presence and hearing of the jury.]

THE COURT: Afternoon, ladies and gentlemen.

THE JURY: Afternoon [collectively].

THE COURT: The jury is seated.

Mr. Hughes.

MR. HUGHES: Okay. It's 1:35. I'll finish -- we'll finish today. Just kidding.

I think you folks probably saw the major flaws in the defense argument, but just in case, I have to go through it. If it's things you already saw and know, which it probably is, I apologize, but these are important matters.

So where did eighteen inches come from? Where did that come from? How did Mr. Hughes come up with eighteen inches?

Well, Mr. Patkins gave us that, because Mr. Patkins told the paramedic, Chuck Clements, what had happened to Eric, or a version of what had happened to Eric. And he described it, and he demonstrated it for Mr. Clements, who came in here and told you folks about it, that, based upon the demonstration that Mr. Patkins gave him, the distance the baby fell was about eighteen inches. If you think about it, it makes common sense. It makes good sense that's about the right number.

As Mr. Sachs pointed out, Mr. Patkins would be

holding the baby at, what, four, four and a half feet, if he's holding him here [indicating]. He's walking towards the stairs. He trips. The stairs go up in front of him. They are seven inches tall each, if you remember Detective Bartholomew measured them. If he drops the baby onto the fourth stair, that's twenty-eight inches up. If he's holding the baby up at four feet, that's -- what's that? 20 inches. If he drops him onto the fifth stair, then that's going to be only a foot.

So that eighteen inches is exactly what you would expect. It's exactly what you would expect based on what the defendant demonstrated for Mr. Clements.

I'm not making these numbers up. I'm not coming in here deciding the evidence will be whatever I choose it to be.

Where did three stories come from? Where did Mr. Hughes get three stories? Dr. Trenkle came in and he testified for you, he told you that that's when you start to see death from falls, when you start to see injuries, not when you start to see fractures, but that's when you start to see death, greater than a two-story fall. I'm not making this stuff up. That's what Dr. Trenkle told you.

You probably saw some attempts in the argument to rewrite history or rewrite testimony.

Dr. Trenkle, yes, he testified that all of these injuries could be suffered from a fall. Yes, he did, but that's taken out of context, because he said repeatedly over and over these could not be suffered from this type of

fall. These injuries could not come from a household fall.

He talked about babies falling off changing tables and beds and the kitchen counter, that type of thing, and you don't see these injuries from those types of falls, and you don't see death from those types of falls. So when it's suggested to you it's a reasonable interpretation of the evidence that these injuries were suffered in a fall, that misstates Dr. Trenkle's testimony and it's inconsistent with every other doctor's testimony as well. Every doctor agreed you don't get these types of injuries in that type of fall.

And if you're at all concerned with Dr. Trenkle's context, with what he really meant, all you have to do is think about what did he tell you was the cause of death? Abusive head trauma. That's his opinion, abusive head trauma. He told you you're not going to get this from a fall. This is inflicted injury.

He's pointed out he's never done a fall autopsy. Maybe that's because babies don't usually die from the falls here in Southern California. You start seeing deaths out of high-rises, falls higher than two stories, not household falls.

If a baby died from those types of falls, could our species have survived this long? Absolutely not. Absolutely not.

It's kind of suggested to you that I said that Eric was a victim of ongoing abuse, if all of this abuse is

going on, why didn't Margie see this. I'm not suggesting to you that David was regularly abusing Eric. I used the term he was abused because that's what Dr. Trenkle said, because that's what Dr. Piantini said, because that's what all the other doctors suspected, he was abused. I'm not saying that every day David was out there battering the child. He's not charged with ongoing child abuse. He's charged with the murder, one incident, and that's what I'm talking about.

If you want to talk about the symptoms that Eric would have had when he had that parietal skull fracture, the healing skull fracture, you heard what the doctors said the symptoms would be, maybe nothing more than fussiness, maybe nothing more than sleepiness.

You're right. How could any parent miss a fussy child?

They also said there might well be a bump, and Margie did find the bump. And she asked him what happened, and lo and behold, Eric got that bump when he was alone with the defendant; so she asked him what happened.

And it's suggested to you folks that he got that bump from a fall and that that blows these experts out of the water, because here we have in living color a skull fracture from a short fall. According to whom? According to David Patkins. That's what he says every time the baby gets hurt. "Oh, he fell." He said it repeatedly about baby Jack and now he says it repeatedly about Eric.

The only evidence that that healing skull

fracture came from a short-distance fall is from him. You can't believe that. It would be unreasonable to believe that. He's not trustworthy. He lies repeatedly about these injuries. So his word somehow blows out all the medical testimony, all the established knowledge from the experts in the field?

Let's talk about rewriting the testimony.

Mr. Patkins may have landed on the baby. Really? When did he describe that to anybody? He didn't say that to Margie. He didn't say that to Mr. Clements. He didn't say that to the doctor at the hospital. That's wishful thinking. That's revision of the history.

And the doctor told you that type of rib injury, that's not from a fall. That's from squeezing the baby. Can it be shaking as well? Absolutely.

Let's talk about rewriting things some more.

Intent to kill. Went through all of that evidence that supports intent to kill, and I told you folks you can infer that's what he meant to do. You can infer that. You can reach guilty on murder because you can infer intent to kill from all of the circumstances. But you don't even have to, because we have implied-malice murder.

Implied malice murder is the one thing Mr. Sachs barely touched on, because it fits the facts so perfectly.

Question was asked, where did this delay in reporting come from? Where did that come from? It came from David. He called Margie. He said he called at 6:30, little after, said, "The baby's hurt bad," shoulder

injuries, favoring one side.

And Margie asked him, "When did this happen?"

And he estimated 5:30. Where did we come up with that? Out of his mouth. That's what he told Margie.

Is there a delay in reporting? Yes, there is.

To be charitable to him, could it have been half an hour? Yeah. An hour? That's what he said. If the baby's hurt bad and your spouse, or the woman you're living with, the mother of the child, is a nurse, you're going to wait an hour before even calling her if you didn't do it yourself?

She's working. You pick up the phone. "Oh, my God. The baby's hurt. What should I do?" But he doesn't want medical attention. He wants the baby -- he wants his crime not to be discovered. He wants to be able to hide what he's done. Rewrite things a little bit more.

I suggested that Mr. Patkins knew more than the paramedics. Not that he had more medical knowledge than the paramedics. That's not what I said. I said that he knew what happened to the boy, and when they couldn't see -- see serious injury, he knew the boy was hurt bad because he knew what he'd done to the boy.

He told Margie before the paramedics got there, "He's hurt bad. He's favoring one side. He hurt his shoulder. You need to come home right now." He knew more than the paramedics knew, because he knew what he'd done to the boy.

You'd expect to see some neck damage if this baby

were shaken.

Well, that's contrary to all the evidence. Both doctors said, no, actually you don't expect there to be neck damage. Yes, there can be some, but you don't expect to see it. It's not one of the classic symptoms. Yet it's presented to you as though, wouldn't you expect to see that? Let's rewrite the testimony.

It's suggested to you that Michelle Tubs, now Michelle McFarland, is somehow unreliable because many years later from out of state she calls Mr. Patkins. Imagine the gall of a mother with a nine-year-old boy expecting the father to take some financial responsibility, unmitigated gall of expecting a man to live up to his responsibility. Somehow she's the bad guy in this scenario. It's ridiculous.

Let's say that Michelle is unreliable and, of course, Dr. Piantini's unreliable, because she said that what happened to Jack is consistent with shaking, and she said in her opinion most likely that's what it was, not absolutely for sure. She never saw the boy. She reviewed the medical records. What she saw is consistent with it, and she's somehow unreliable and biased.

Of course, Michelle actually saw Jack shaking the baby -- the baby -- pardon me -- saw David shake the baby, and he admitted to the police that he shakes the baby, and he admitted in court that he had abused his son and personally inflicted great bodily injury. But somehow Dr. Piantini is unreliable because she thinks this baby may

have been shaken.

And then we have the famous Dr. Plunkett and his study, and that blows it all away. That's it. There's your reasonable doubt. One doctor writes one or two studies that refer to eighteen deaths at playground equipment out of 75,000 reported injuries.

Playground falls. These aren't infants. We're not talking about kids the age of Eric or Jack Patkins. These are after the fact from a review of records, and they come up with eighteen deaths out of 75,000.

How many million more falls were there from playground equipment where they were not reported injuries? So with these eighteen deaths onto who knows what surfaces, concrete, hard-packed dirt, who knows, on other bars when they fall, who knows. But out of that, you're supposed to say that -- Dr. Piantini and Dr. Sonne are aware of the study and give it its due weight -- are out to lunch.

I think Dr. Trenkle described it best when he said we're comparing apples and oranges. Now that's playground equipment falls in older children, school-age children onto the playground surfaces. We're not talking about household falls, not talking about infants, pretoddlers.

And then it's suggested that you folks can't convict unless you can tell me what exactly David did to the boy. If you can't tell me he smacked him in the back of the head with a board, you can't convict. But maybe he

smacked his head on the wall or maybe he threw him to the floor as hard as he could. But if you can't say what the act was, you can't convict.

Well, that's not the law. That would be crazy if that were the law. We could never convict in any murder case where there wasn't eyewitness testimony where somebody wasn't there to see the crime. If that were the law, people would be free to kill their children -- not that any sane person would want to do that -- but they would be free to kill their children as long as nobody was there to see it. No jury could ever convict.

You don't have to decide what was the act. You have to decide that he took an intentional act, a deliberate act. You have to decide that he didn't trip and drop his boy eighteen inches onto the carpet.

It's suggested that I'm too emotional about the case. Yeah, it's an emotional case. We come into court. It's a fairly sterile environment. We show you a couple of pictures. We tell you about what happened, and we discuss it all in a very clinical way, a cold way. Doctors take the stand. They describe committing atrocities to this little baby, peeling the dura off his skull, peeling his -- that's horrible. We just describe it. I'm not suggesting to you folks that emotion should be the reason you make your decision. That would be wrong. I'm suggesting exactly the opposite. Don't make your decision based on emotion. But you don't have to sit here and pretend it's not an emotional issue. You don't have to sit here and

ignore the fact this man killed a little baby. You just can't say, "I'm going to vote guilty because I'm outraged." You can be outraged. You just can't vote guilty because you're outraged.

Talk about murder versus manslaughter. Again, malice equals murder. Express malice, intent to kill. Implied malice, danger disregarded.

There's a lesser offense to that. Manslaughter, involuntary manslaughter. The key is you can't convict of involuntary manslaughter unless you unanimously agree he's not guilty of murder. And I think, as both counsel have pointed out, involuntary manslaughter doesn't fit here. It just flatly doesn't fit. So it's not really something that you need to trouble yourself over. I didn't spend time arguing about it. Counsel didn't spend time arguing about it. It doesn't fit these facts.

Let's talk about the lessers to assault on a child resulting in death. One of the lessers is assault by means of force likely to produce great bodily injury. Again, it doesn't fit these facts. You have to somehow assume the baby did, in fact, get hurt in this accidental fashion, which the medical testimony says did not happen. And your own common sense tells us it did not happen. You have to assume that did happen, and then say somehow he was doing this lawful act of carrying the child up the stairs in an unlawful way or in a recklessly or grossly negligent manner. It doesn't fit these facts, but the element for that assault by means of force, assaulted a child by means

of force likely to produce great bodily injury, and that a reasonable person wouldn't know it was likely to cause great bodily injury, that's what you have to believe; that these massive injuries by means of force that a reasonable person wouldn't know would be dangerous or likely to produce great bodily injury. Does not apply.

Talk about expert testimony. What it amounts to -- basically, the defendant is guilty of Counts I and II or he's not guilty of Counts I and II. The lessers, the medical grounds, they don't apply. You folks know that he's guilty.

Talk about the expert testimony. Was there some difference in the testimony between Dr. Trenkle and Dr. Piantini? Yeah, of course. These are two different people. They are not going to agree on every little aspect of every case. They each have their perspectives.

Dr. Trenkle, of course, is focused on determining the cause of death. That's his primary concern, what's the cause of death, and both he and Dr. Piantini agreed that it was abuse.

Was there also shaking? Dr. Piantini says yes. When you look at all of this, the rib fracture, retinal hemorrhaging, skull fracture, subdural hematoma, subarachnoid hematoma, when you look at all that together, that is inconsistent with the history he gave. Yeah, she says, there was shaking. It's a classic shaken-impact case. Dr. Trenkle says I don't have to get to the shaking. I can explain all of this with abusive head

trauma, explain all of this with the impact.

Does that mean that the baby wasn't abused? Of course not. He says, yeah, it may have been shaken, but I don't need to reach that conclusion; so he doesn't. But they both agree it was abuse.

I guess you're supposed to suspect that these doctors are out to get Mr. Patkins just like the 1993 doctors were when Mr. Patkins told the police, "You're all out to get me." Apparently, that's what's going on again.

I've got to ask you, where's the contrary medical evidence? Like I said earlier, he doesn't have to call any witnesses. He has no burden of proof. I do. But he has the right to call witnesses. He didn't call any of the doctors that saw Eric. He didn't call any of the other consultants that are out there who can review the case and come in and say, you know what, Dr. Trenkle is all wet, Dr. Piantini is wrong. He didn't call any witnesses like that. That's why I asked each of them, "There are other doctors that are out there that look at this stuff, aren't there?" And they both said, "Yes."

He didn't call any of those people.

You better believe if some doctor was willing to come in here and say, "You know what, this guy is wrongly accused. This was an accident," you would have heard from them. He has that right.

Reasonable doubt. Reasonable doubt. The instruction was read to you by the Court, by Mr. Sachs, and I'm sure it makes about as much sense to you folks as it

does to me. It's not particularly helpful.

Not a mere possible doubt, because everything relating to human affairs is subject to some imaginary or possible doubt. It's that state of the case, after consideration of all the evidence, that leaves jurors in the state of mind they cannot say they have an abiding conviction of the truth of the charge.

What reasonable doubt is, you consider all of the evidence, not mere possible or imaginary doubt. You use your common sense. You use your logic, not just what if, not just isn't it possible, not just what if there's a little voice in the back of your head asking, gee, what if that's not what reasonable doubt is.

I suggest you approach the subject of reasonable doubt three ways. If you have a doubt, ask yourself, can you articulate it? Can you put it into words in a way other people can understand? Is it based on the evidence? Is it based on the record, what you heard from the witness stand? Is it shared or understood by others?

Now, I don't mean to say if you're the only person that thinks one way, you automatically change your mind. I don't mean that. But if you have a doubt that other people don't seem to share, maybe you need to reevaluate whether it's a reasonable doubt. I'm not saying you have to change your mind, but maybe you need to reevaluate.

Circumstantial evidence. If there are two reasonable interpretations of all of the evidence, one of

them points to innocence and one of them points to guilt, you must adopt the interpretation that points to innocence. That's the presumption of innocence.

It's my burden of proof to overcome that presumption. It makes good sense. However, if no interpretation points to innocence, what are you left with? Guilty. And there is no interpretation that points to innocence. No interpretation of this evidence, no reasonable interpretation of this evidence, points to innocence.

If there's only one reasonable interpretation of all of the evidence, that's the one that points to guilty, you vote guilty. You have to adopt the reasonable, reject the unreasonable. Only reasonable interpretation of the evidence here points to guilty.

Now, why is the defense interpretation unreasonable? Why?

Well, it's contrary to the evidence. It's contrary to every witness who came in here, every doctor who came in here, said that's not right; that can't have happened that way.

Well, if it's contrary to all of the evidence, it's not a reasonable interpretation of the evidence. There's nothing to support it except wishful thinking.

Mr. Sachs can say over and over and over again that Dr. Trenkle admitted the baby could have been hurt in a fall. He can say that as many times as he wants. Doesn't mean he's taking it correctly, taking it in

context. It doesn't make it true.

Dr. Trenkle told you unequivocally over and over again, "Can't have happened from this household fall." You must reject the unreasonable interpretation. It is unreasonable for you to assume that those massive head injuries were caused by that eighteen-inch fall onto carpet. If that's unreasonable, you have to reject it. When you reject this, you're left with, is the defendant guilty.

For the defendant to be not guilty, you've got to believe he's the unluckiest guy in the world. Meets Michelle Tubs, has a child with her. When he's alone with that baby, he repeatedly drops it, causing injuries. When he's alone with that baby, he drops it in the shower causing new injuries that Michelle misinterprets as injuries, when really it's just the flu. And when he's got the high fever for a couple of days, David's so unlucky he doesn't put two and two together, realize, gee, I dropped the baby in the shower, his eyes are bulging, his head is swelling, he's got a fever. No, he never makes that connection because he's so unlucky it never occurs to him.

Of course, we know he has shaken Jack because he admits that to the police and because Michelle saw him do it. But he still never puts two and two together, that maybe I'm hurting the boy. So the cops are out to get him, the doctors are out to get him, and the nurses are out to get him. And he goes to court and he admits his abuse, admits he inflicted great bodily injury. He's just unlucky

and wrongly accused. And years later, Michelle is unfortunate enough to reconcile with him, and he admits -- well, no, I guess he doesn't admit to her. He shook the child. She makes it up. Even years after that, she comes in here and lies because he's again wrongly accused.

He meets Margie, and when Eric, he's in this unlucky man's care, Eric falls off the couch and suffers a head fracture because Mr. Patkins is an unlucky man and he's involved in this rocky relationship. And he's so unlucky he trips over the dog and he drops the baby again. Fifth time a baby's been put in his care. The unluckiest man on earth, and he's so unlucky he gets two completely biased doctors who happen to be very experienced at what they're doing, who happen to work at the premier children's facility in the region, and these biased, unfair doctors come into court and tell lies about him because he's so unlucky. And Margie exaggerates because she never noticed any of these symptoms that he had before, even though she says, yes, she did notice those symptoms.

Michelle lies. The paramedics get it wrong. Mr. Clements gets it wrong. Because Mr. Patkins is so unlucky. Everybody comes in, all the evidence points right at Mr. Patkins being guilty of murdering his own son, and yet he's just unlucky.

You know that didn't happen. You've heard all of the evidence. You've heard from the witnesses. You've seen the photographs. You know what he did to Jack. You know what he did to Eric. You know he's guilty of murder.

THE COURT: This is irrelevant and not within the scope of the evidence.

All right, question number three, and I'll initial the top, "Dr. Sonne versus Dr. Trenkle, broken leg, how many times"?

And then, "Dr. Trenkle, what height could cause this type of damage? What would cause femur breakage"?

And then the last question, "Could occur in household accidents"?

MR. SACHS: I guess answer it the same way. If this is issues of concern, they could have Trenkle's testimony reread. I don't think we are in a position to answer those questions.

MR. HUGHES: I agree.

THE COURT: All right, "if these are issues of concern, the jury can request the testimony of Dr. Sonne and Dr. Trenkle be reread."

MR. SACHS: Yeah.

THE COURT: Okay.

All right, gentlemen, thank you.

MR. SACHS: Thanks.

MR. HUGHES: Okay.

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(Proceedings adjourned.)

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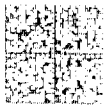

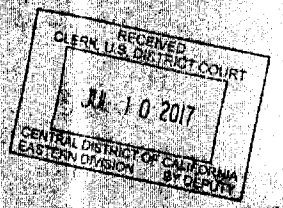

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