)URT OF APPEAL - STATE OF CALIFORNIA

FOURTH APPELLATE DISTRICT

DIVISION II

THE PEOPLE F THE STATE OF CALIFORNIA, Plaintiff/Respondent, v. RYAN CHRI)PHER MICKEY, Defendant/Appellant.	DCA No. E-050646 Case No. SWF-015286 Volume 14 of 16 pp. 2385 - 2499-84

REPORTERS' TRANSCRIPT ON APPEAL

BEFOR THE HONORABLE F. PAUL DICKERSON III, JUDGE PRESIDING

DEPARTMENT S-304

January 11 and 12, 2010

APPE CES:

For Plaintiff and pondent:	OFFICE OF THE ATTORNEY GENERAL 110 West "A" Street, Suite 1100 San Diego, California 92101
For Defendant and ellant:	APPELLATE DEFENDERS, INC. 555 West Beech Street, Suite 300 San Diego, California 92101
Rep d by:	SANDRA C. WALKER, CSR 6977 OLIVIA D. SCHAAF, CSR 11111

SUPERIOR COURT OF CALIFORNIA

COUNTY OF RIVERSIDE

THE PEOPLE OF THE STATE OF CALIFORNIA, Plaintiff, vs. RYAN CHRISTOPHER MICKEY, Defendant.	Case No. SWF-015286 Volume 14 of 16 pp. 2385 - 2499-84

REPORTERS' TRANSCRIPT OF PROCEEDINGS

BEFORE THE HONORABLE F. PAUL DICKERSON III JUDGE PRESIDING

DEPARTMENT S-304

January 11 and 12, 2010

APPEARANCES:

For the People:	OFFICE OF THE DISTRICT ATTORNEY BY: JESS WALSH, Deputy 30755-D Auld Road, Third Floor Murrieta, California 92563
For the Defendant:	LAW OFFICES OF JAMES MATTHEW BROWN BY: JAMES MATTHEW BROWN AND: MARK SIMOWITZ, Attorneys at Law 2044 First Avenue, Suite 200 San Diego, California 92101
Reported by:	SANDRA C. WALKER, CSR NO. 6977 OLIVIA D. SCHAAF, CSR NO. 11111 Official Reporters Riverside Superior Court

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-- MONDAY, JANUARY 11, 2010 - MURRIETA, CALIFORNIA --
-- BEFORE THE HONORABLE F. PAUL DICKERSON III - DEPT. S-304 --
(WITHIN JURY PRESENCE:)

THE COURT: Okay. Let's go on the record in SWF-015286. The parties are present before the court. We're in the presence of the jury.

Good morning, everyone.

THE JURORS (Collectively): "Good morning."

THE COURT: Mr. Brown?

MR. BROWN: Good morning, Your Honor.

THE COURT: Good morning, sir.

MR. BROWN: Mr. Mickey would call Dr. Leestma to the stand, please.

THE COURT: Yes, sir.

THE CLERK: Please remain standing and raise your right hand.

You do solemnly state that the evidence you shall give in this matter shall be the truth, the whole truth, and nothing but the truth, so help you God?

THE WITNESS: I do.

THE CLERK: Thank you. Please have a seat.

Will you please state your full name and spell it for the record.

THE WITNESS: Okay. Jan, J-a-n, Edward, Leestma, L-e-e-s-t-m-a.

THE COURT: Mr. Brown, you may proceed, sir.

MR. BROWN: Thank you, Your Honor.

THE WITNESS: Maybe I can persuade somebody to put a

little water --

THE COURT: Absolutely.

There you go, Doctor.

THE WITNESS: Thank you.

THE COURT: You're welcome.

Mr. Brown?

MR. BROWN: Thank you, sir.

JAN EDWARD LEESTMA,

called as a witness by and on behalf of the Defense, having been first duly sworn, was examined and testified as follows:

DIRECT EXAMINATION

BY MR. BROWN:

Q. Are you okay, Doc?

A. Yes.

Q. All right. Can you help us understand what was wrong with Kerianne Bradley in the days preceding her death?

A. I hope so, yes.

Q. Can you help us understand the cause of her death?

A. Yes.

Q. Can you help us understand the manner of her death?

A. Yes.

Q. Can you help us to understand aging and dating of a process itself?

A. Yes.

Q. Now, before we get to those issues, what I'd like to do is have the jury have a little understanding about who you are. Are you a medical physician?

A. Yes, I am.

Q. All right. And what kind of area or specialty do you have, sir?

A. I'm board-certified in anatomic or general pathology and neuropathology. And I spend most of my time doing neuropathology or the pathology of brain disease.

Q. Would you explain to the jury what a neuropathologist is, please?

A. Sure. This is a recognized medical specialty that deals with the mechanisms and processes of diseases involving the nervous system. And, by that, I mean brain, nerves, spinal cord, eyes to some degree.

And by disease I mean anything that can go wrong with these systems, which would include a tumor, infection, inflammation, physical injury or trauma, that's a disease. And how all these processes work at the tissue level and the organ level, what they look like under the microscope and other techniques we use to get a look at these processes and basically how -- in a sense, it's like being a theoretical -- or a car mechanic that doesn't necessarily fix the car but can tell you what that sound meant and how the process unraveled and why your car doesn't work.

Q. Okay. And, in order to come to that kind of knowledge, I suspect you went to college?

A. Yes.

Q. Where did you go and when did you go?

A. I attended for four years Hope College in Holland, Michigan, graduating in 1960, with a bachelor of arts degree, and then -- that was the undergraduate, and then I went to

medical school, which was the University of Michigan in Ann Arbor, for four years, and graduated in 1964 with an M.D. degree.

And at that point I elected to go into the field of pathology. And to accomplish that I went to the University of Colorado Medical Center in Denver where the first two years of my training there involved learning how to do an autopsy, learning how to look at surgical material that came from the operating room, beginning to learn how to drive an electron microscope and some other research techniques that I was interested in and doing all of these -- these kinds of things for two years.

And then, at the end of that period, I elected to continue on, but specializing on brain disease, or neuropathology, and it involved basically the same things, only involving the brain and its coverings and nerves and so forth. And that took me another year in Colorado.

At the end of that third year I elected to finish up my training at the Albert Einstein College of Medicine in the Bronx, New York, where I went and finished up my training and experience for neuropathology.

So at that point I had satisfied the requirements for -- or most of them for completing my training, and that would have gotten me up to 1968. And at that point I entered the military service, as a captain in the Air Force Medical Corp., and was -- I was going to say sentenced, but I wasn't. I was assigned to the Armed Forces study of pathology in Washington D.C., where I was assigned not to neuropathology, but

to genitourinary pathology, and -- kidneys and so forth, so on.

So I did that for a year and was able to transfer to the neuropathology section of that institute in exchange for an additional year in the service, which I gladly gave. And I finished up my military career in 1971 with the rank of major, U.S. Air Force Medical Corp., and was honorably discharged.

Q. Sir, have you had -- do you have experience doing autopsies?

A. Yes. Short. Certainly in -- all through my pathology residency time, even when I was doing neuropathology, we would rotate on the autopsy service. And I don't know how many autopsies a month I had done, probably several hundred during the four years that I was in Colorado, or the three years that I was in Colorado. And then occasionally afterwards.

Q. Have you had experience with Children's Hospital in performing autopsies?

A. Yes.

Q. Can you explain that to the jury, please?

A. In Colorado the pediatric service at the Colorado General Hospital was still very active. After I left most of these cases went to the Children's Hospital, which expanded. So we -- if a child died for whatever reason, it would be an autopsy done. And if that was a valid permit, I might be assigned to do it. And so I did a number of children's autopsies there.

And when I came to take up my professional career in Chicago, at Northwestern University, there were children's autopsies there that I did. And we were supervised anyway, and

that's happened throughout my career, so it isn't the bulk of the autopsy material that I've done, but I've -- probably have done 100 or plus children's autopsies.

Q. Do you -- I just forgot what I was going to ask you. Must be Monday morning.

Have you taught?

A. Yes.

Q. How to perform autopsies?

A. Sure.

Q. Okay.

A. Yeah, this is part of the job, as I've -- as I left the service, I went to Northwestern University Medical Center as an assistant professor of both pathology and neurology and the chief of neuropathology there, and part of my job was to teach the young residents or participate in that, on how to do an autopsy, and what to look for, and when they were done reading the microscopic slides and generating a report, and I would sign off these autopsies, and that means they come to me and I say, "Tell me about the case," and we got the history. "What did you find, let's look at a microscope together and see what's there."

And I -- it's basically a check -- a check-off to be sure that all the things have been covered and that they did a good job. If they didn't, I say go back and do something more or read some more or do something like that.

So that was my role and I did that as long as I was associated with academia.

Q. Approximately how many brain autopsies have you done, sir?

A. Probably over 20,000 in the course of the career.

Q. And have you received any academic appointments?

A. Sure.

At Northwestern I started as an assistant professor, was fairly promptly promoted to associate professor, and I remained as an associate professor at Northwestern until I left 12 years, 13 years later, something like that, when I went to the University of Chicago as a full professor of pathology and neurology and an associate Dean.

And so I had academic appointments up until probably 1987, at which point I went into a private practice situation that did not have academic ranks, and I don't hold an academic appointment at the present time. I'm basically retired from hospital work.

Q. How about appointments, hospital appointments. Have you had those in your career?

A. Sure.

Every institution I've been at always had an associated hospital, so I would have an academic rank of assistant or associate professor or whatever. And then I'll have -- be an attending physician at hospital, which meant that I could sign reports, be there, do an autopsy. I suppose I could admit patients, but I never did. That isn't what I do.

So that carried with it hospital appointments at Northwestern's affiliate hospitals and Veterans Hospital. And then, at the University of Chicago, the same.

Q. How about honors and awards; have you had any of those?

A. Sure. I was fortunate enough back in the late 70s to

be awarded a teacher of the year award for the basic sciences at Northwestern, pleased about that. And, in 1981 and '82, I was granted a sabbatical leave with pay to go anywhere I wanted to and do what I pleased. So I was fortunate enough to be invited to come to the Karolinska Institute in Stockholm, Sweden, to do research there for a year as a guest visiting researcher. And I completed that in 1982.

Q. And do you lecture from time to time?

A. Yes. Of course during the academic career, teaching medical students, dental students, nurses, residents, and so forth. It was an everyday occurrence. And in the periods of time that -- even in hospitals where I would give conferences and teaching, was just the other regular everyday occurrence relating to items of neuropathology to whatever audience.

Q. And, sir, are you published?

A. Yes.

Q. And would you explain to the jury, or discuss with the jury, the areas in which you've been published and how you've been published?

A. Right.

The majority of my work has been published as journal articles, that is relating to some subject in pathology or neuropathology, and it could reflect the interests that I had or work that I was doing at the time. And this would mean sending a manuscript to a journal and having their editorial board look at it and see if it was acceptable and then publishing or not, as the case may be. Most of them quite successful in getting most everything that I submitted published. And then I wrote

some books, one of which you -- I notice that you have in your hand there.

Q. I do.

A. That's fine. That's recently published in 2009. It's a second edition of a book called Forensic Neuropathology, which basically covers the field of how the field of brain disease and its pathology interfaces the legal system.

Q. And, sir, have you been from time to time called upon to act as an expert in a proceeding such as this?

A. Yes.

Q. Approximately how many times?

A. In terms of testimonies, I think it's between 1- and 200 times, probably 150, something like that.

Q. And have you qualified as an expert in neuropathology in the United States?

A. Yes. In California a number of times and I think in counting up the last I think about 40 states now. In Canada and in the United Kingdom.

Q. And what were you asked to do in this case involving Kerianne Bradley, sir?

A. What are the issues, you mean?

Q. Yes, sir. What were you asked to do?

A. Oh, I see.

Basically, most simplistic way is to say what happened, and when did it happen. And how did this whole process work that brought about the unfortunate death of this child.

Q. And, sir, have you reviewed any records relating to Kerianne Bradley that has helped you focus on those issues and

provide us answers here today?

A. Yes. I was provided -- well, we can take from the most objective or, you know, the stuff that I deal with mostly, would be the autopsy report, autopsy and scene photographs, or photographs of the child in light of some subsidiary photographs of a vehicle, and so forth. The autopsy report, autopsy tissue slides, microscopic glass slides, autopsy photographs, medical records of the two hospitals this child was brought to near the end of her life, a number of interview reports, members of the family and others that were involved with this child. And, yes, I forgot to mention the image studies, the CT scans, and other films, radiologic studies that were performed on this child.

Q. And so there's a box behind you. Does that pretty much contain all the information in it that you --

A. Yeah. I haven't gone through this page by page. I have a duplicate in my briefcase, but I've been a shown that and it looks like it's all the materials I saw.

Q. Now, based on your review of these documents and people's statements, let me ask you, have you read a statement -- well, let me ask you this: Based on your review of these documents that you've articulated for us, and the statements, do you have an understanding, sir, of the physical or mental well-being of Kerianne Bradley in the last 24 to 48 hours prior to her --

A. Yes, I believe I do.

Q. Can you explain those to us, please, what your understanding is --

A. Well, let's take the day going backwards from

February 4th, which -- of 2006, was the date of admission. And then the child was basically dead less than a day later.

From that time forward, or backward, a couple of days before this, which would be February 2nd, my recollection, the child had been vomiting, sick, irritable, and sleeping a lot. And to that end was brought to see a pediatrician. I don't think the pediatrician examined the baby but a nurse practitioner did and concluded that the child had a stomach flu or some sort of virus, possibly, and basically that was -- that was that.

But the child had been sick of that same -- in that same way a couple of days before. So there had been several days prior to the admission on February 4th in which the child just was not her normal self, not eating, irritable, sleeping a lot. And vomiting episodically. So this was a child that was sick in a way and apparently due to a gastrointestinal bug of some sort.

Q. Based on your review of the statements, did you gather an understanding of how the child was on February 3rd of 2006?

A. Yeah, the child apparently at some point was brought to one of the -- well, not the grandparent, but the mother of Mr. Mickey. And the child just was -- I guess you could say a dish rag, I mean, just was not happy, was squirming, and but not crying a great deal apparently, just sort of uncomfortable, and wanted to sleep and in fact wanted to sleep so much that when the baby was brought outside and placed on the ground, or even on the concrete surface, the child crashed out and went to sleep there.

And clearly, for a 16-month-old, 17-month-old child, that would be abnormal behavior. And so -- but that is how the child had been off and on, not feeding, sleeping a lot, and doing those sorts of things.

Q. And how about into the night on February 3rd into the early morning hours of February 4th; do you have an understanding of the child's behavior in that time period?

A. Well, the child, again, I guess would -- awakened and I forgot to mention there was a fever in there at one point measured at 103, so there's no doubt the kid was sick.

Q. How about on the Saturday; do you have an understanding of the child's behavior on Saturday morning, February 4th?

A. Kind of the same thing, lethargic and so forth, not feeing well. Being offered food, but not eating much. And then the event -- there was an event of the child being placed in the car, in a baby seat, and then upon being extracted it's reported that a door -- or a door slammed and hit the child on the head. And at that point then that was treated or attempted to be treated with an ice pack. And not long after that the child began -- was discovered to be not arousable, sleeping but apparently more so. And that resulted ultimately in 9-1-1 calls and action that brought the child to hospital.

Q. Now, on the -- are you familiar with on -- based on the information that you've read, that on that Saturday morning when Jennifer -- do you know who Jennifer Bradley is? Could you tell us who she is, please?

A. Say that again? I'm sorry.

Q. Jennifer Bradley?

A. Yes.

Q. Can you identify your knowledge of her for us, please? Do you know who she is?

A. Yes.

I mean, that would be the mother of -- the grandmother of the -- of the child. Well, Jennifer Bradley is the mother.

Q. Right. And Denise Pou, do you know who she is, based on your review of the records?

A. Yes.

Q. And who is she?

A. And that is, if I remember correctly, is the mother of Mr. Mickey.

Q. That would be Mrs. Mickey, is the mother of --

A. Certain people here I'm not real good at remembering the names, but there was the mother, the grandmother of this baby --

Q. All right.

A. -- and then the mother of Mr. Mickey, who has no biologic relation to the child, but was also involved in supervising the baby briefly.

Q. Now, based on your review of these statements, did you obtain information that, on the way to take Jennifer Bradley to work on Saturday morning, that the child was asleep in the car?

A. Yeah; yes. This child never really what I would say perked up and acted like a normal 16- or 17-month-old child, basically.

MR. WALSH: Excuse me. Object as nonresponsive.

THE COURT: Sustained. The answer is nonresponsive.

Jury is to disregard the entire answer.

Want to re-ask the question, Mr. Brown?

MR. BROWN: I do.

Q. (By Mr. Brown:) Sir, did you gather, based on your review of the statements, gather information that the child was asleep in the car on the way to take Jennifer to work?

A. That was my understanding.

Q. And based on your review of these statements, did you gather information which led you to believe that the child was nonreactive to sunlight coming into the rear door?

A. Anyway, this child was basically out. And it didn't appear that the child reacted to things that one would expect it to.

Q. Now, in your analysis of these issues, you talked to us about vomiting, correct?

A. Correct.

Q. Fever?

A. Yes.

Q. Correct? Lethargy?

A. Yes.

Q. Not eating?

A. Right.

Q. Not reacting to sunlight?

A. Exactly.

Q. And so forth. Are those consistent with symptoms relating to head injury?

A. They can be.

Q. And in your -- based on your skill, training and

education, have you known that lay people such as myself might not have the ability to discern the distinction between a gastrointestinal injury versus a head injury?

A. I wouldn't necessarily expect them to be able to do so unless somebody had some special training or experience.

Q. Now, in your analysis of this case, Doctor, why is it important to have an understanding of the child's physical and mental well-being prior to February 4th of 2006?

A. Well, one of the inherent and important elements in the medical exercise, the diagnostic exercise, whether it's after the fact as a pathologist would be involved or before the fact as a clinician would be is you need to have a background. What's been happening to this person. Because that begins to give you a clue as to something called a differential diagnosis. You start saying well it could be this it could be that, and you start ordering these things in your mind. And the kind of -- the importance of that is it drives you, number one, what to look for in a physical examination, to be attentive to. Then it also may drive what laboratory studies you're going to order to try to help you get there to if you have to interdict some disease process, it helps you get there. And, after the fact, it does the same thing, rather than approach the case as a needle in a hay stack, a total cypher, it gives you places to start looking at things, a checklist to start checking off and looking into.

Q. All right; thank you.

Now, I'd forgotten one thing here in regard to your training. Have you ever acted in the capacity of a coroner?

A. I have performed medical-legal autopsies and exercises on occasion that is generating a death certificate and determining cause and manner of death. I don't normally do that but I have on some occasions. And more commonly in several venues I worked with coroners and medical examiners as their consultant in neuropathology. I was an assistant medical examiner in Cook County, Illinois -- that's the county that encompasses Chicago -- for 11, 12 years, something like that, where I would go and examine brains at the medical examiner's office, sometimes help in autopsies if I was requested to do so, and generate reports that the person who was deputized to do the official reports would use in the determination and the cause and the manner of death.

Q. How about CT scans; are you trained in reading those?

A. And then I would be teaching the trainees and the residents at the coroner's office, the fellows there, and I've participated in training and education exercises relating to forensic issues for a long time.

Q. Now, how about subdural hematomas; are you familiar with those, sir?

A. Very much no?

Q. Can you explain to the jury, please, what a subdural hematoma is?

A. Sure.

A subdural hematoma is, in the way as the name implies, though you do not know medical terms, it is basically a hemorrhage underneath the skull and underneath a membrane called the dura but above the brain. So if you were going to drill a

hole to get to a subdural hematoma, you would have to go through the scalp, through the skull, through the dura, which is a membrane attached to the under side of the skull, and then you would have access to a potential space underneath the dura where blood has accumulated, but over the brain. There's another little membrane underneath that, that looks about like Saran Wrap, and that's called the arachnoid membrane. So that would be a collection of blood over the brain, under the dura.

Q. And how are subdural hematomas caused or formed; can you give us kind of an idea how that happens, sir?

A. Well, there's collective thoughts about that, and it's gotten more complicated in recent years as people have re-examined a bunch of the time-honored concepts, is that the most common cause of the subdural hematoma is head trauma and a physical impact either by a blow or a fall or something else, sufficiently accelerating the head to tear blood vessels over the brain and can produce bleeding into the space. That would be far and away the more common situation, but there are other situations that -- in which trauma is not involved that subdurals occur, for example, in elderly people who are on Cumadin or some blood thinner, are at risk for spontaneous subdural hematoma.

And if they're overmedicated a bit, or have a very minor head attack, you could get a subdural that way. There are other medical conditions, bleeding disorders of one sort or another that can produce that. And so there's lots of ways that you can do it, but physical forces would be the most common one.

Q. And based on your review of the medical evidence that

we have here in this case, CT scans and so forth, are you able to form an opinion as to whether or not Kerianne Bradley indeed had a subdural hematoma?

A. Oh, yes, she did. No question about it.

Q. And can you describe for the jury what type or size of this subdural hematoma, if that's helpful at all, sir?

A. Well, I think we need to look at it in several different time frames because our first glimpses of this process are in the CT scan of the head. And at Rancho -- I forget the name of the hospital, the first local hospital that the child went to, and then on transfer to the San Diego Children's Hospital another CT scan was done.

And it showed the same thing, that is, there's -- there is a white density representing blood over a lot of the brain. And that's the first glimpse of this process. You do have an exhibit which we could look at -- that is your choice -- which would shows that.

Q. I'm going to get to that?

A. Okay.

Q. I just wanted to kind of fill in a couple holes here. What is your training in learning how to read a CT scan?

A. Say that again? It's a little --

Q. Do you have training in learning how to read CT scans?

A. Oh, yes.

Q. Can you describe for us what that is, sir?

A. Well, training, I don't know. Before training occurs you have to learn yourself. Especially with a new technology. And back in the late 70s, early 80s, our hospitals in Chicago

got the first scanners. And the neuroradiologists who preside over this kind of equipment freely said, "I don't know how to read these studies," because we never had the technology before. And, "Would you help us do that." So they would have the scan images on their big celluloid films, and they -- the radiologists would come to the brain cutting conference of pathology, autopsies, and say, "Here is what we looked at in life. Show us in the brain what we -- what is there." And because the way we cut a brain and dissect it is very much like the cuts of a CT scanner, you can put the living -- not the living tissue -- but the actual tissue next to the films and say, "Oh, that's what this looks like." "We didn't see this, how come?" You know. And it was a -- very much of a learning exercise for me, the pathologist, as well as the neuroradiologists, and happily that went on for several years until -- I think we all figured out how to read these things and other people did too.

Q. Now, can a subdural hematoma be aged and dated histologically?

A. Yes, it can.

Q. And when I used the word histologically, people probably know, but would you just explain what histological means in the sense of your specialty, please?

A. Yes; exactly. That's a fancy term for under the microscope.

And so we take a microscopic slide, slice a piece of tissue, in this case dura, and the cloth that goes with it, and I take a look at what's in there. Of course there will be a

slice of dura, which we come in our training to know what it looks like, and I can show you also in an exhibit, and what the blood clot looks like, and what the red blood cells that are in the clot look like.

And they've undergone changes. These are time-dependent. And if there's healing reactions and scarring reactions and other reactions that are part of the body's way of trying to get rid of this blood clot, they appear on a time schedule as well.

So it gives you a chance to, by seeing what's there and what's not there in this blood clot, make estimations of how old it is.

Q. Now, have you reviewed any forensic evidence in this particular case, sir, Kerianne Bradley's case, that would allow you to formulate opinions as to the most likely age and dating histologically of the subdural hemorrhage that she had?

A. Yes, I can and I did.

Q. And what information have you looked at that allowed you to do that, sir?

A. Well, I believe there were two slides prepared and given to me by the ME's office that I was able to examine under my microscope in my office lab, and see what was there. I made photographs of these key elements of that, with a camera that's put on my microscope, and prepared an exhibit or two that shows what is there.

And basically what we have is a spectrum of aging of blood clot. There are recent collections of red blood cells in which red blood cells look like red poker chips under the

microscope. They should be a red brick color, distinct and so forth. I saw those, and that tells me that that kind of blood -- and I like to use the term "recent," because I can't tell microscopically the difference between a red blood cell that came five minutes before the child died to that subdural and was there for two days.

So there's a kind of a black-out period of two days during which I can't really do much in the way of aging and dating other than saying, "This blood clot is two days or less old."

Then the next thing that I observed is red blood cells that are undergoing color changes, that that red brick color begins to fade and becomes more blue, more purple or lavender, and there were clearly red blood cells that were undergoing that change. And that's another couple of days.

So we know that we've got very acute or recent blood, blood that has been there maybe three to four days, and then just sticking on the red cell histology, there are some red blood cells that look -- at the edge that seem to have lost most of the material that was inside of them. So they have kind of a pale pink or lavender appearance.

And those are red blood cells that are probably on the order of five days old. From death. From the time of death.

Q. You're dating all this from the time of Kerianne Bradley's death?

A. When the heart quit and everything stopped.

Now, that's -- the red blood cells. Now I have to begin to look at other things that come up because a blood clot

attracts scavengers, so to speak, and reparative cells that are going to try to take it away. And it takes a few days for those to appear. And there are a few kinds of those cells present at the edge of the blood clot.

Then to -- as this clot sits there for a longer period of time, there's an attempt to try to wall this blood clot off by the formation of scar tissue and new blood vessels and some other things, and I observed some of that too. And that process I make on the order of five to seven days old from death.

Then there are other things, as scavenger cells go to work on blood, blood has iron in it, hemoglobin is bound to hemoglobin. It makes up the hemoglobin molecule. And when a cell comes apart, iron is recycled blood. It's very good at that. So it sends cells in to do that and it concentrates the iron from red blood cells.

Now, those cells -- and there is a chemical reaction that can be performed on the slide itself that identifies iron and it is a very, very sensitive stain.

Q. And did you do that?

A. I didn't do it. They were provided to me. So the ME's office had performed that.

Q. When you say ME, what do you mean?

A. The medical examiner. The coroner.

Q. All right.

A. And so there were some cells that contained iron at the interface between the dura and the clot.

Q. Now, what does that mean, interface between the dura and the clot?

A. Okay. Well, that's where all the action is, at least for the first several weeks in this process, the place where the dura membrane stops and the blood clot is right up against it. The cells that come in and scavenge come from the dura. So that is where some of these iron-containing cells are. They're not deep in the scar tissue, they're not deep into the dura, they're right at that interface. And I have an exhibit to show that. Which tells you the estimate of how long it takes iron to get processed and deposited in these cells is on the order of five to seven days or more.

Now, it's important to think about the "or more" because when a process of bleeding has occurred at the dura or many other places, iron scavenging goes on all the time and when the process is done, some of these iron-containing cells, they'll stay there for some reason or another, and can be present for years after a blood clot or an injury.

So all I can say is it takes about five to seven days for these scavenger cells to process and display iron, and then they hang on for a long time. And I must say there are very few of them there, which makes me think that they are more on the five- to seven-day side of this business than maybe months on the left.

Q. All right. Now, would this be a good time to take a look at the slides you referenced?

A. I think it would. We talked about these things several times. Would probably be worthwhile.

Q. Which ones would you like to start on, the CT scans?

A. Might as well do the sequence, take a look at the CT

scan and --

Q. We'll put up on the ELMO Exhibit JJ. And you have to kind of turn around, Doctor. Could you tell us what this is?

A. Yeah, let's turn it -- let's just rotate it 180 degrees. That's good.

Do we have a pointer?

Q. There's a laser.

A. Oh, good.

Q. I'm going to give this to you. I had to play with it.

A. Just show me which button to push.

Q. (Complies.) Okay; all right.

So what is it we're looking at, sir?

A. Okay. What we're looking at here is a computer-generated, basically a slice of the head just above the ears, can't see the ears here. This is the front of the head, the back of the head, and I claim innocence on this business. The radiologists always switch sides, so things that we see on this side are in fact the right side of the head. I don't know how they manage to get that convention going, but we live --

Q. So left is right and right is left?

A. Left is right, right is left. So this is the left side of the head, front of the head, back of the head. If there were ears, they would be right here.

So this a slice, sort of a hat band of this child's head, Kerianne Bradley, taken at in a study at the San Diego Children's Hospital.

Q. And why is this CT scan important for us?

A. Because it shows us a number of things that give us a

preview of what's going on with this child.

Q. And can you explain what those number of things are for us?

A. Right. Let me get oriented here.

Q. Thank you.

A. What we have here, the white is the skull. And it contains calcium. So that stops the X-rays that are used in the CT process, and make it white. What we see here otherwise is this gray. That's the brain. And it is tight up against the skull. There should be a little group of black material here. There's very, very little of that. And that is cerebral-spinal fluid, or basically water. And there should be a -- probably a quarter inch or more layer of that all the way around the brain. And it tells us there's increased intracranial pressure that has driven out and caused to be absorbed the cerebral-spinal fluid. Which means there's something not good going on here. This brain is swollen and cerebral-spinal fluid has been absorbed to make way for the swelling and try to keep the pressure as low as it can be.

Now what we see in the middle of the brain are these sort of pattern there. These are called the ventricles of the brain. And that's normal. That -- right here is where the cerebral-spinal fluid is produced. Now these -- I guess you'll have to take my word for it -- these are compressed -- these upper part of the ventricles should be about the size of the oval that I'm describing with the laser. They're definitely squeezed down.

Now, the -- the other part is that -- in some parts of

the brain you can begin to see a little convolution here, some of the wiggles and squiggles on the surface, but they're mostly compressed. In some places you can begin to see a little difference in density between the white matter, that's all this stuff down here, and the gray matter which are the -- is where the nerve cells are.

And the fact that you can't see much differentiation there is a bad sign. It means that blood circulation in that brain is essentially nil. And that's a very bad thing. That means that essentially this brain is dead and/or dying, has been deprived of circulation, probably because of pressure that is there, that the blood can't pump against, the heart can't pump against and profuse the brain.

Q. Because the brain has got nowhere to go?

A. Because the brain -- there's pressure inside the head that resists that inflation, or at least the profusion of the blood.

Q. Okay. Now, can I stop you just for a second?

A. Yeah.

Q. Because I know we're throwing a lot of information out here, and I just want to slow down a little bit to have you tell us what you mean by a couple of these terms, okay?

A. Sure.

Q. Now, you used the term intracranial pressure. Now, what do you mean? Can you tell the jury what you mean by that, please?

A. If I were to take basically a tire pressure gauge, or a more sophisticated one, and actually go through the skull and

stick it into the internal environment of the head, there is a small amount of pressure there. It's equivalent to venous pressure, which is between 5 and 10 millimeters of mercury. Your systolic when they take the blood pressure when the heart beats is 120 or something like that. And when it relaxes, if you could just measure venous pressure only, it would be about 5 to 10 millimeters of mercury. So there would be some pressure. And that is the normal environment inside the skull that the brain likes to live in.

Q. Is it important for that pressure to remain constant?

A. Yes, it is.

Q. And what happens when that pressure -- well, is there some kind of -- what happens, I guess maybe the question would be, what happens to the brain when it can no longer maintain that equilibrium of pressure?

A. Well, it interferes, as we have seen here with circulation. It may rise to the place where the blood can't get into the brain or, more critically, at first that blood can get in but it can't get out. And so there is a chain of events that are not good.

And I have some diagrams a little later maybe that we can revisit that talk about this dynamic that it's important to maintain this low level of pressure inside the head and it can be done by regulating the cerebral-spinal fluid. And if it fails, then you end up with problems like respiratory failure, unconsciousness, and brain death, basically, is what I'm talking about.

Q. You just suggested you have a slide in a moment we can

get to explain these things in greater detail?

A. Yes. We can do that in a few minutes, if you like, or whenever you want.

Q. Well, I'd like to do that, but it sounds like what I ought to do then is -- be quiet for a minute and let you explain what it is you were trying do on the CT scan, if you don't mind.

A. I need to show some other things on here.

Now, what we have, there is a membrane part of the dura that infolds and separates the two cerebral-hemisphere from one another. And the term that's been given to that is the falx, f-a-l-x. And what we have are white density along that. You shouldn't see that. That represents that there's some blood attached to that falx, the white imaging inside indicates blood density or basically the iron in the blood. So that represents a dural hemorrhage along this point. It sort of splits in the back.

And then, if we go around this hemisphere over here on the right side, you notice that there's some infoldings and so forth, and that is probably blood. That means there is a subdural hematoma most likely over that portion of the brain. And in some places you can see a little black density underneath it, which represents the surface of the brain and a little bit of spinal fluid that's there. So we have a recent subdural hematoma that's covering a good bit of the right side of the hemisphere here.

So to recapitulate the findings that we have, we have an acute or recent subdural. It's hard to tell exactly how old it is from a CT scan. On the right side of the brain and along

the midline, and probably some collecting back here at the end of the back of the head we have a very, very swollen brain and we have a brain that is not getting the right kind of blood flow to it. So we have cerebral edema, or a brain swelling, subdural hematoma, and profusion failure, if you want to call it that, of the brain.

I have another image which we can just add to that, if you like.

Q. All right. We can move this along.

Would Exhibit KK, is that the other image you're speaking of, sir?

A. Yeah. Let's turn it around, rotate it again the other way.

Good. Now we're kind of losing our -- maybe we can -- just need to zoom it out, because that is kind of -- it's whited out.

Oh, well. Never mind. Basically we've lost the contrast. Now see if you can cut that brightness down a little bit.

There we go there. That's -- and just a little bit.

Q. Doctor, while we're trying to focus this --

A. Yeah, if you can get it back a little bit.

There we go. Stop. Good.

Q. Is that still good?

A. That will do.

Q. All right.

A. What we have here is again the same front of the head, back of the head, right, left. Here along the side we can see a

little more scalp, white, so there's -- the subdural is a little more evident there. We can certainly see that the falx is white. We see the same thing, that the brain is flattened up against the skull. There's very little cerebral-spinal fluid there. So it just shows another view of this process.

So the first view that we have, that this child has, the things that I've said, subdural hematoma, brain swelling, and profusion failure of the brain.

Q. All right. And should we move along then to the next slide?

A. Then we can; uh-huh.

Q. I'm not sure the order of these, sir. We've got --

A. Just the one you -- that's up on top is good.

Q. Subdural clot? This is Exhibit NN.

A. Now let's see what we can do here.

That's probably pretty good. I think we might overshoot again, so -- that's pretty good.

Q. What is this we're looking at?

A. Okay. What we're looking at here is a micro-photograph, or a photo-micrograph of a portion of the subdural blood clot. Now, there's no dura pictured here. This is strictly blood clot.

Q. And is this part of -- you talked to us earlier about some slides that you received from the medical examiner?

A. Yes.

Q. Is this one of those?

A. Yes, it is.

Q. Okay. And how can this slide help us understand this

process that you've been talking about with the dating and aging of the blood?

A. Well, as I indicated before, we need to take a look under the microscope at what's in this clot. What are the character of the red cells and other cells that might be present that can help us with this aging and dating.

Q. Have you done that with this exhibit?

A. Yes.

Q. And would you explain please what it is you did and what the results were?

A. Okay. Well, what we have down here is pretty much a solid portion of the clot. And you can see yourself it has a red brick color. You can't see too many of the red cells, although if I had the microscope here we could go down and see that they are distinct, and all red brick color.

But as we start moving out away from this clot a little bit, we begin to see some changes in color. I hope you can appreciate that, that it isn't all red brick, it's undergoing some color changes.

And those are the things that take three or four days to -- more than two days to occur. So we see it -- a recent blood clot, and I can't -- I'll say it again -- I can't tell you whether these red blood cells got there five minutes before this child's heart quit beating or if it were there for two days.

Q. I understand.

A. Now, in order to get changes like this, it means that some of this blood must have been around three or four days, from the time of death.

Q. And you're telling us -- when you say three or four days from the time of death, you're talking about more of the splotchy type of what we see on this --

A. This stuff up here.

Q. All right. Now, how is it that both of these -- I guess -- how can we -- how is it that both of these can be on the same slide? Does that make sense?

A. As we go further, we can see more spread in aging. It tells us that this process is clearly not a one-shot deal. It tells us that the process, the bleeding process, is incremental, that something happened in the last two days while this child was either in hospital or prehospital, it tells us that there was some bleeding in this general vicinity for a day or two before that.

Q. A day or two before hospitalization?

A. Yes.

Q. So hospitalization is on February 4th of 2006. What portion of Exhibit MM demonstrates blood that existed a day or two before February 4th?

A. Right.

Well, this stuff down here could have been all the day of admission. I don't know. I have no way to tell. Under two days of age, two days from the time of death.

So what you reported one day before hospitalization, possibly. During hospital, most likely too, and then stopping at death.

And then we have other portions of the clot perhaps being elevated by new bleeding underneath it that represent an

older layer of blood that was there. So it clearly shows a time sequence of this process.

Q. And that time sequence is, in your opinion, based on your skill, training and education and background, at least two days prior to the date of admission?

A. Right.

Q. All right. And is that all we can gather from Exhibit MM?

A. That's about all we can go with. That's as far as we can go with this one.

Q. All right. And so how about we take a look at Exhibit NN?

A. Yeah; that's okay. Let's just leave it at that.

Q. All right. What is Exhibit NN?

A. I should mention that the microscopic slide that these things came from, the amount of tissue there is about like that.

MR. BROWN: And, Your Honor, can the --

THE WITNESS: Maybe an inch wide, quarter of an inch deep. And of course has had slices through it. So we're not talking about a little tiny piece, this is -- vast majority of that is blood clot. But part of it is dura, which we can see here, I can point out.

Q. (By Mr. Brown:) Please, can you do that for us?

A. Okay. This is the dural membrane, right here. All this stuff below here. So there's not much going on. It's mostly collagen. Or I won't say scar tissue, because it's normal, but it's dense connected tissue. And above that is part of subdural hematoma.

Now, one of the things that we're interested in is what's going on at that interface because cells like this from the dura are going to be migrating, and we do see a few of them. There a few cells, these darker blue dots are cells that are migrating up there to do their work.

Q. And where are they migrating from, if that makes sense?

A. Well, they're coming from blood vessels and cells and are sitting here waiting to be called, so to speak. There are chemical signals that come from this blood that say, "Wake up now, and come up here and clean this mess up."

So we're beginning to see a few of these at the interface right here and there, and that takes a couple of days for that to begin to occur.

Q. Is there a term that we can associate with that process?

A. Well, it's part of the healing and repair reaction that a subdural gives.

Now, the more important aspect, I mean that's important enough, because it gives us -- these cannot occur in an hour or two or whatever after hematoma. It takes a couple days for these cells to wake up and get there.

Now, what we have above that is a blood clot that -- there's very little brick red in that. A lot of these cells are lavender or pink color. And these are red blood cells that are on the order of three to five days old now.

Q. Now, how do those relate to the -- this slide that we talked about a minute ago, Exhibit MM?

A. Just another immediately adjacent or -- piece of

reaction, so --

Q. Associated with each other?

A. Yeah; sure. It's on the same piece of slide.

Q. All right. So the slides -- when I'm showing you the different exhibits, and putting up on the board, are they from the same slide that you looked at?

A. Yes.

Q. So when the medical examiner went through during autopsy and did the slice of -- what he did is take this basically from the same area of the brain?

A. Well, wherever he took that sample of dura from, and you've got your whole choice, you know, piece as big as my hand where they took them from, and I don't know where that is, physically, but it clearly sampled subdural hematoma. And it's not untypical that at one part of it you'll have more of acute stuff and then right next door maybe half an inch away will be something that's a little bit older, or show something else.

Q. Now, how does that help us in understanding what the ongoing process was with Kerianne Bradley?

A. What is -- ask me that again. I want to be sure.

Q. How does this process help us in understanding what was going on with Kerianne Bradley? And I mean Exhibit MM, as compared to Exhibit NN.

A. Okay. It tells us that we have a sequence of bleeding here over time, and repair, and aging of that blood that's commensurate with that. So it tells us that this is not a one-shot, one-time process, but it's a subdural that has its beginning probably up to five to seven days before this child

died. And we've got a glimpse of that here with early repair cells. They don't get there before a couple of days. Red blood cells that have now lost most of their character. And that's on the four to five days or older time frame.

So we've now documented -- if we want to have a movie, we saw the first several frames of the movie as the under-two-day old blood. Now we have a frame in this movie that says "Oh, we've got blood that's now three to four, five days old," other processes that are in that same time frame. So I think we've done pretty well to show that this is an aging process and probably had peaks and valleys in terms of the bleeding that went on here.

Q. And in your skill, training, education and background, is it your opinion that this child had a subdural hematoma bleeding progress says ongoing prior to February 4th of 2006?

A. Yes.

Q. And what's the basis for that opinion?

A. What we're looking at here, and some subsequent pictures I'm going to show you.

Q. All right. And would Exhibit OO be helpful next in line of slides?

A. Okay. Now, let me point out what we have here. This is a higher power picture, and the dura of course is along like this. And it's all this stuff down below what we have up here is blood clot, and complexity within it.

Now, this one we've got a lot of red brick colored red blood cells, but we also have some lavender colored ones. So we are getting a mixture of recent and older.

More importantly on this one we have a collection of cells that are forming at or close to the dural surface that clearly are -- you have to take my word for it -- they're scavenger cells. And those are cells that have more than three days on them. I mean, this is on the five- to seven-day time frame.

And I hasten to add that subdural hematomas were studied a long time ago in terms of aging and dating, about 60 or 70 years ago. And where they took a number of cases that they knew exactly how old the subdural was and said "What's in it," and that forms the basis for kind of -- that we know what we're doing here.

Q. Now, the Exhibit OO, is it your opinion -- or let me ask you this: Based on what you see, you just described for us in Exhibit OO, do you have an opinion within a reasonable degree of medical probability as to whether or not these lavender blood cells were in existence three to five days before February 4, 2006?

A. Yes, I would say a little more. Well, you know, here again, we have a spectrum of aging that goes probably up to five, six, seven days. Something like that.

Q. And based on your skill, training, experience and education, what is the likely cause of these being there three, four, five days prior to February 4th of 2006?

A. A subdural that has been there that long. Or a portion -- portions of it.

Q. All right. And is there another?

A. Yeah, a couple more. Thank you.

Q. Okay. Exhibit PP. Does that help, sir?

A. Yes.

Well, here we have some color rendition problems, but never mind. We can work our way through it.

We have several pictures here where the dura goes along this way. It might benefit from brightening a little bit. You can try that.

Q. Are we still?

A. That's good. Let's just take it there.

Q. Are you still looking at the same slide?

A. Yes, we're looking at another area from this same slide.

Q. That the medical examiner took?

A. That's right.

Q. And forwarded to you?

A. Exactly.

Now, I didn't -- these represent special stains called an iron stain. The name for it is Prussian blue. And it generates -- wherever iron is, it's a bright blue, that are going to be difficult to see with this projection, but what we have here is the dura going along like so, and right at the interface of this dura are a couple of cells -- I put an arrow there. If we could show them a little different way, it has a blue color, a bright blue color. So it's clearly iron. And the beauty of this stain is there's not much else that's stained. It's one of those very specific things that if it's blue, it's iron. It's nothing else. So --

Q. I've used the term throughout the trial of iron

pigment; is that --

A. Yeah.

Q. Okay.

A. All right. This is material that the cell has ingested that probably has a bit of residue of hemoglobin still with it, but the iron is being concentrated. And, as I say, the importance here is that it's right at the junction between the clot and --

(INTERRUPTION IN PROCEEDINGS.)

THE WITNESS: -- between the dura and the blood clot, and the blood clot here, you can hardly see any red brick color. I think these are totally degenerated red blood cells that have lost everything in them, which puts them out about seven days or so.

Q. (By Mr. Brown:) So based on your skill, training, education and background and the exhibit that we're looking at now, I think it's just -- PP, do you have an opinion within a reasonable degree of medical probability as to whether or not those, that iron pigment that we see there, existed seven days or more prior to --

A. Uh-huh.

Q. -- February 4th of 2006?

A. Exactly.

Q. And what would --

A. Well, February 5, the date of death.

Q. I'm sorry. Thank you; thank you.

And, based on your skill, training, education and background, what would be the likely cause of this iron pigment

in Kerianne Bradley?

A. Subdural hematoma that has -- or bleeding that has been in that area that length of time.

Q. Should I move on?

A. I think we can.

Just -- this other one shows another example of that. I think the importance again, to reiterate, is where these cells are. They're not buried in the dura, they're right up in the interface where the blood clot is. And my conclusion is that they're related to that bleed and not something that may have occurred months or years before.

Q. Related to the bleed that -- can you explain what you mean by that related to that bleed?

A. Related to the bleed that brought this child to a hospital and ultimately participated in her death.

Q. Now, these -- and you say that within a reasonable degree of medical probability?

A. Yes.

Q. All right. Now, can a preexisting subdural hematoma, can it re-bleed?

A. Yes.

Q. How -- can you explain that process to the jury, please?

A. Okay. First of all, in the -- when you have an injury, a bruise, if you traumatize it again or if something else goes on, bleeding can occur in the same cite of injury. It can result from another episode of physical injury much lower in threshold than whatever may have occurred before, medical

conditions such as bleeding disorders, clotting disorders, infection, and other things may cause re-bleeding in the subdural. The fact is, for whatever reason, subdurals re-bleed. And that's a fact that's been known for over 100 years now.

Q. Can -- does the fact of a prior subdural -- subdural hematoma in Kerianne Bradley prior to February 5th of 2006, do you have an opinion within a reasonable degree of medical probability as to whether or not that would make her more susceptible to another bleed?

A. Yes, it would.

Q. How so?

A. First of all, it sort of makes sense that if you've injured something before, that it would take less to produce some further injury at that same spot.

Okay. That's seems a logical proposition. But what proof do we have of that? Well, there's human case material that shows that this is so, where children that have had fluid collections or subdurals over the brain have suffered the kind of an injury that you'd say, "That shouldn't do anything," and yet it did. And there's case material in the literature that talks about that.

So it isn't a crazy idea. The fact is, we don't know how much lower the threshold has been pushed by a prior injury. We can make some estimates about that, but that's all we can do.

Q. Now, I don't want to sound coarse or anything by asking you this question this way, but I mean, is what you're describing now, with a person being more susceptible to a trauma that would cause this to re-bleed, I suspect it would be

difficult to get volunteers to actually undergo testing for that.

A. Right. You really can't do that. You have to use nature's experiments.

Q. So is there any way for anybody to be able to say what kind of force would be necessary in order to -- or trauma, whatever the word may be, from a medical standpoint of things, what would be necessary in order to cause these preexisting subdural hematomas in Kerianne Bradley to bleed again?

A. Well, they can read -- anyone else could read the same case material that's there, and maybe come up with some new cases that could give us better numbers, but I don't think you can do anything better than saying this is the phenomenon, injury thresholds are lowered if you have a prior subdural hematoma. How much? Who knows.

Q. Now, you're familiar -- you talked to us earlier about your understanding of a car door striking a child in this case, correct?

A. Yes.

Q. And what is the basis for your understanding that that occurred here?

A. You're recalling the impact to the car door?

Q. Yes.

A. Yes.

Q. Yes, sir.

A. Well, first of all, we have to say that a car door isn't going to give way too much. It's rigid, and we know you can bump your head on those things, and you probably have all

done it. And so this may represent an analogous impact to a very, very short fall, say about one foot, or something like that.

It could be possible, if you had the proper technology, what model-dome is in computer programs, and all of that, to model this thing out and measure, get some numbers to this particular scenario. But I think it may be appropriate to simply look at what might be some other kind of scenario that would be similar to that. And we do again, in the case material, have instances of children that have had the equivalent of one-foot falls, that have caused re-bleeding i subdurals. Not too many of these are reported, but they're there, so --

Q. Based on your skill, training, education and background, sir, do you have an opinion as to whether or not this car door striking the child could be of sufficient force to cause this preexisting subdural to re-bleed?

A. My answer to that is that this impact scenario is a candidate, a good candidate. I don't know whether it did cause re-bleeding or expansion of what this child already had. All I could say it certainly -- it could. And whether it did or not, I don't know.

Q. And the question that I would think comes out of that is -- I just forgot what that question was. Bear with me just for a second, please. It will come back to me, I'm hoping.

Would it be -- sir, do you have an opinion whether or not it would be the most likely candidate?

A. Well, of all the other circumstances, this is

certainly --

MR. WALSH: Objection; speculation, foundation at this point.

THE COURT: Sustained. The doctor started to answer that question the jury is to disregard it. Next question.

MR. BROWN: Thank you, sir.

Q. (By Mr. Brown:) I'll come back to that as soon as I remember the question.

We were talking about a slide relating to intracranial pressure. Would this be appropriate at this time?

A. We can go to those, if you like, yeah.

Q. Exhibit QQ. Would you explain to the jury what we're looking at here, sir?

A. Yeah, there we go.

Q. What are we looking at there?

A. Okay. We were talking before about the dynamics of -- and mechanisms of so what -- what does a subdural do to you, why does it make you sick, and how does this whole thing work. And I indicated before that -- and we can just walk back through this a little bit, don't get excited about the equations, I'll just walk through that, but this is a diagrammatic depiction of the intracranial environment, and the black is the skull, and there's the brain, and there's the spinal cord. And we might say, "Well, what's inside?" Well, we have the volume of whatever makes up the brain and the spinal cord. There's going to be blood that's in blood vessels. That makes up a volume that's inside there. And then we have the volume of cerebral-spinal fluid in the ventricles and all around through

it. And then, if we have a situation here where there's a subdural hematoma, that represents a volumetric component also.

Now, if any of these things is going to change, like that subdural is going to increase in size, what's going to happen? The pressure will have to go up. It would be like filling this courtroom with as many as people as you think you can get in here, and then four more come. Well, it gets pretty uncomfortable if did you that. And that would be pressure. And that's what would happen inside this space if something came in and there was no way to compensate.

Well, we do have a compensation, and the cerebral-spinal fluid is it. But you have a finite volume. It would be like saying, "Well, okay, we're all going to lose some weight real quick to make room for those four people or more that are going to try come in here," but there's a limit to what you can do, and that limit is the volume of the cerebral-spinal fluid. And a little baby like this maybe has 40 milliliters, 50. And that would be the equivalent of the lower portion of this cup.

Q. Styrofoam cup?

A. Yeah, we've got about our volume in here now but it would be about so much in that cup.

Q. Just for the record?

A. Yeah, or if -- I sometimes bring a beaker, and there's a little beaker about that big around, about this high, and that's 50 milliliters. So when that's gone then you can't compensate anymore. Some of the other things have to leave, which is blood. Not a good thing. And that's what we're seeing

in the radiographs of this -- of this child.

Q. All right.

A. That we have seen the cerebral spinal fluid for the most part gone. Blood is next. And then at that point things are not good. And we -- yeah.

Q. Move on to the next slide?

A. Yeah, we can move on. This just sets the stage for what I'm --

THE COURT: Why don't we take our morning recess, reconvene 15 in minutes.

Please remember the admonition: Please keep an open mind. Don't draw any conclusions about the case. Please don't talk to anyone about the case.

See you back in 15 minutes. Doctor, see you back on the stand in 15 minutes, sir.

(RECESS TAKEN.)

THE COURT: All right. Let's go back on the record in SWF-015286. All parties are present before the Court. We're in the presence of the jury.

Doctor, do you understand you remain under oath?

THE WITNESS: Do I understand what?

THE COURT: You remain under oath.

THE WITNESS: Oh, yes.

THE COURT: Okay; very good.

THE WITNESS: Absolutely.

THE COURT: Mr. Brown?

Q. (By Mr. Brown:) Doctor, we're kind of done with the diagram on the board now?

A. Think we've said what we need to do there. Move on to the next one.

Q. Believe it or not, I just had very short questions for you here. I did remember the question I wanted to ask. Is there any way, from a forensic or scientific or medical evaluation, to correlate the size of or shape of or the look of an external bruise to someone as to what's going on inside her head?

A. That would be a reach. That would be very, very difficult to do.

Q. So have you seen circumstances where someone has had a massive incumbent bruise on their head with no subdural hematoma?

A. Correct.

Q. And have you seen or do you know of circumstances where a person has had quite a small mark on their -- anywhere on their head and actually had a subdural hematoma?

A. Yes.

Q. Okay. So it's not unusual to have that occur?

A. No. The disconnect is I wish it was always one-on-one but it certainly is not.

Q. All right. Now, the other area I wanted to just kind of go back real quickly talk about the iron pigment being there for approximately seven days?

A. Uh-huh.

Q. And I forgot ask you a question about that. In your review of the slides, did you see any kind of scar tissue or scarring around that iron pigment which would cause you to

believe it existed prior to that seven-day time period?

A. As I indicated, it's right at that interface where all the action is taking place regarding healing. And if this were due to a birth-related injury or something months or weeks later, I would expect these cells to be entombed or at least enmeshed by scar tissue in the dura, and they're not.

Q. They do not exist in Kerianne Bradley?

A. No, they're right there.

Q. Now, what could be a likely cause of the subdural hematoma -- or the subdural hematoma which cause this iron pigment to be about seven days old?

A. I would say statistically -- I have to go statistics. I can't go specifics here. I would say some kind of physical impact to the head. A fall would be the most, you know, common situation, but it could be other things as well. I simply don't know.

Q. And you're aware of the fact that some people earlier on in that week prior to February 4th, like on the Sunday or Monday prior to, have suggested that the child seemed to be fine --

A. Yeah.

Q. -- in their opinion. Can you explain to the jury why someone could have a subdural hematoma with this process going on but appear to be fine in --

A. We come back to this and the next exhibit which we're going to have.

Q. All right.

A. It's all a question of volume. How quickly a subdural

hematoma event evolves. If it's going faster than the bilge pumps can keep up, then it may become symptomatic. The majority of these things are -- it's amazing, but they are relatively asymptomatic until they either get too big, or too big too quick and cause symptoms.

Q. So one -- you can have like a waxing and waning kind of a process?

A. It depends, again, how much volume got there and how much cerebral spinal fluid you can have left to compensate. And it is not uncommon to have no symptoms at all, but as the lesion evolves in size, then to have a symptom and then none. Because, again, the compensation is occurring. And we can't compensate anymore, can't absorb, make room for this new change, whatever is there, then you get symptoms and they may be catastrophic.

Q. And based on the slides and your testimony so far, is there any way for anybody to say within a reasonable degree of medical probability that any of these subdural hematomas were intentionally -- were caused by an intentional act by someone?

A. I don't know how anyone could know that.

Q. Let's go to Exhibit RR. I think you said that that would help with the intracranial pressure issue.

A. Okay.

Q. How does that help us, sir?

A. This is just another way of looking at what I've been taking about. And let's not let the graph scare you. Basically what we're doing over here -- maybe we can shift it over a little bit. Anyway, there you go. That's better.

If pressure is zero here, and moving up that way, and

volume is whatever it is, and getting bigger in that axis, somewhere in here is how we all like to operate; that is, we're in the normal range, below ten millimeters of mercury or venous pressure. If the volume changes, then hopefully we can compensate and keep us in this space. And now when we end up with somebody who's operating close to that wire over there, and my analogy for this is imagine you've got $100 in a checking account, and I hope you have more than that, but if you write a $50 check, no problem. The bank will pay it and nobody knows anything. If you start writing some checks and you start getting close to this $100 mark over here, the bank may call you and say your balance is critically low, I want you to know that. That's a symptom. And if that occurs in this kind of situation, a symptom may be irritability, vomiting, sleepiness, stuff like that. A seizure, maybe. And if you can put a couple more bucks into your savings account or into your checking account then you move back into the safe territory and you may be completely without symptoms. The bank is happy, everything like that.

But the trick is, when you're operating close to that line, a very small incremental increase in volume of a subdural or any other volumetric component, water, brain swelling, whatever it happens to be, can get you up here where a very small change results in a lot of things happening, which is what happens if you write a check for $101. All kinds of actions that you don't want to happen.

Q. And that's the area you're talking about where there's no one that can say what kind of force is necessary in order to get to you over the precipice, so to speak?

A. It's all about pressure and involvement. Anything that changes the volume, whether it's a new bleed, a new episode of trauma, some metabolic problems, anything that can change that pressure volume equilibrium, of which there are many components, can get you into trouble if you're operating in close to the wire over here.

Q. Doesn't have to be a punch to the head?

A. Doesn't have to be anything. It can be anything that changes that pressure volume teeter-totter. And it could be trauma, it could be an impact. It could be willful, it might be accidental, might be nothing.

Q. It could just be the natural ongoing process of things?

A. Exactly.

Q. No problem whatsoever?

A. Yeah.

Q. Now, are we done with --

A. Yeah, we're just -- just to illustrate the point of how tippy this teeter-totter is, is -- yeah, that bar graph would be --

Q. We've got -- we're looking at Exhibit SS?

A. Right.

Q. Can you explain to the jury what that means, please?

A. Okay. This represents some experiments that were done on -- probably shouldn't have been done, but were done years ago in which basically a spinal tap was done on an infant and a teenage kid, and water -- not water, but saline solution was put into the spinal sack that -- the equivalent of adding a small amount of cerebral spinal fluid, quickly.

And look here what seems to happen. Two milliliters of fluid added, it pushed this baby here well above the region where some symptoms would occur. 15 millimeters of mercury. And if you went up to four milliliters now here is about two milliliters right here, the end of my finger. Four would be a little bit more than that. The equivalent of a vaccine shot or something that you would get at the doctor.

That's not a whole lot of volume, but it shows that the baby is much more sensitive to this and it gets them into this zone of trouble very easily and very quickly, whereas an older individual is much more capable of absorbing that stuff. But it's probably based on the amount of the total volume of cerebral spinal fluid an adult has versus a baby.

Q. All right. Anything else that this exhibit is helpful for?

A. This just shows that once you get over to that point of decompensation, then it doesn't take much to cause a whole lot of things happening, but before that, you can have a subdural, you can have all these things and maybe have no symptoms at all.

Q. All right. And we'll move on to Exhibit TT. Can you explain to the jury what this is, sir, and how does it help us understand the ongoing process with Kerianne Bradley?

A. The last one base basically shows this whole system collapsing. You have absorbed all of the cerebral spinal fluid that you can, the last remaining reservoir of cerebral spinal fluid is that surrounding your spinal cord, and brain is sort of mushy and squishy and can move around to try to occupy the space, and it tries to go through the hole at the base of the

skull, which is about that big around, and can't get through that. So it's like in the crowded courtroom, somebody opens the door, now let's all leave, we'll all build up at the door, and nobody gets out.

And so that's what happens, the pressure on the base of the brain and brain stem causes loss of consciousness because that's where consciousness resides, respiratory centers are there also, they get squeezed, and they quit. And then all kinds of things happen where the pressure goes way up to the point where the brain can't get the circulation it needs and that makes it even worse because then the brain will swell, making pressure go up even higher.

So you're kind of on a merry-go-round, you can't get off, and it's very, very critical if you were going to intervene in a child like this, or anybody who's in that state of affairs. It's really kind of a flip of a coin whether you're going to be able to go back down that curve and get into good territory or it's gone beyond what you can do.

Q. Well, is that possible for someone to have intervened with this child prior to February 4th in order -- and corrected this increase in pressure?

A. Well, it's all pressure and volume. If you make some of that volume go away, you might have a chance of never reaching that, of the curve going up, and that would -- could be a surgical procedure to take away the subdural, medication to cut down on brain swelling, or a combination of both those things.

Q. But medical science exists in order to accomplish that;

is that true?

A. Yes.

Q. So if someone would have diagnosed perhaps a subdural hematoma in this child on that Wednesday, February 2nd, do you have a within a reasonable degree of medical probability whether or not they would have been able to keep Kerianne Bradley from going over this pressure?

MR. WALSH: Objection; relevance, speculation.

THE COURT: Sustained.

Q. (By Mr. Brown:) Let me ask you these questions, Doctor. You talked to us about the finding of iron pigment in your analysis in relation to the preexisting condition for Kerianne Bradley, correct?

A. Yes.

Q. All right. Is it scientifically or medically acceptable to ignore those findings and analyze what was going on with this child?

A. You mean the iron pigment observed at autopsy or not observed at autopsy?

Q. Well, it was observed?

A. Yeah; it was, right.

Q. Is it scientifically or medical acceptable to ignore that preexisting condition in an analysis of what's going on with this child?

MR. WALSH: Objection; argumentative, relevance.

THE COURT: Sustain the objection; argumentative.

MR. WALSH: Move to strike the answer.

THE COURT: Granted. Jury is to disregard the answer.

Q. (By Mr. Brown:) Is it important for a person trying to analyze what happened or what the prior condition was with this child to consider matters such as iron pigment in the analysis?

A. It's important to consider that because it's something on the table of objective fact and you have to deal with it.

Q. And is it also important, sir, to have an understanding of the child's physical or mental well-being in analyzing what was going on with her?

A. Well, the job of the pathologist that turns out most commonly is to perform what we call clinical pathologic correlation, and clinical or historical, and you can lump the two together, and just say here are events that have been described, do we see anything in pathology that correlates with that or can speak to any of those issues, or answer questions about them. So that's what we do if you end up with something that says chronic, then we may look backwards to history and say is there anything in the history that would, you know, overlap with that. And that's where the historical information of the physical state of the child before she crashed and burned, so to speak, is important.

Q. And have you factored those matters into -- did you take those matters into consideration in your opinions that you provided for the jury today?

A. Yes, we've been talking about that. And I think that

the clinical pathologic correlation speaks for itself.

Q. Now, based on your review of these matters, and your skill, training, education and background, do you have an opinion, Doctor, as to whether or not Kerianne Bradley was suffering from increased cranial pressure prior to February 4th, 2006?

A. My opinion, yes.

Q. And the bases for that, sir?

A. The CT scan clearly shows you don't get a CT scan like that in an hour or two or more. You can't. It takes time to do that. Then we take a look at what kind of symptoms were around, and the aging of the subdural hematoma which we know had to be present, based on the facts that have been presented, before she came to the hospital. Again, the facts speak for themselves there.

Q. All right. And we've heard throughout the trial commentary about this subdural being massive; is that an accurate statement, in your opinion, sir?

A. Well, at autopsy it certainly looks impressively large, but it doesn't look so large on the CT scan at admission. So clearly something was going on, and the bleeding probably continued because the child had a coagulation problem, and meaning that it would bleed more. So at autopsy I think it certainly is significant subdural hematoma. I'm not sure I would use "massive." I don't know, all of these are fluffy terms that need to be defined by whoever uses them.

Q. Can increased cranial pressure cause coagulopathy?

A. That's a good question. Some might -- you could say

yes. It's more often more complicated than that. There are a lot of things can cause coagulopathy. And a child that is in the situation that this one is, comatose and operating with brain -- basically brain death, coagulation problems are very, very, very common, virtually all of the kids will have it.

Now, is that a consequence or a secondary phenomenon to all these other things? Maybe, but this child was also not eating, vomiting, and it appears from the initial lab studies probably was dehydrated when it came in, had a fever. Those are things that can produce coagulopathy or premature clotting, intervascular clotting, in a baby.

So, you know, there's a possibility that these things were leading to coagulopathy, and then were added to, of course, by what happened later.

Q. You've seen the photographs taken at Rancho Springs, correct?

A. Yes.

Q. Have you seen the photographs taken on autopsy?

A. Right.

Q. Now, assuming the child was coagulopathic, would that be an explanation for the differences in the size, shape and the color of these bruises as compared from Rancho Springs and the autopsy?

A. It certainly has to be factored in, if you're coagulopathic, in any place of injury. I don't care if it's on the skin or dura or anyplace else, will have a tendency to bleed and bleed further, so -- and will get bigger. And which is clearly demonstrated, at least the change in size, and so forth,

in a series of photographs that were made of the child. So the subdural probably got bigger on its own, the bruises did the same.

And it doesn't mean that there were new injuries, whatever, it's just part of the difficult process of following an injury such as a bruise through all of the medical problems and ending up on the autopsy table.

Q. And, in your experience, have you come across the term lividity?

A. Yes.

Q. And what is lividity, please?

A. Well, that's just simply when a person dies the blood that's in the capillaries and so forth will follow the law of gravity and go to the lowest part of the body and it will look like a sunburn, kind of, or purple color and that has -- that's a well-known after death postmortem artifact and has no particular significance here.

Q. Would it affect the photographs of these bruises of the child at all?

A. Well, if you had bruises in the area where the lividity is, where there's congestion, you can get postmortem bleeding. The bruises can get bigger that way. That's well-known.

Q. All right. Now, there's also been the term blunt force trauma used throughout the trial. Are you familiar with that term?

A. Yes.

Q. And would you describe for the jury what blunt force trauma means, sir?

A. It's sort of a shorthand term that's very imprecise meaning that some physical force has occurred that is not sharp, not like a knife or an edge that produces a laceration, it's bruise-producing injury, and it doesn't tell you any more than that. It just -- it could be incidental, it could be inflicted, you never know.

Q. So by definition it does not mean that someone intentionally tried to harm this child?

A. No, no.

Q. Now, is there any way to look at these photographs to -- for anyone to be able to arrive at a conclusion that there was an intentional blunt force trauma inflicted on this child?

A. That is a very difficult task that bedevils every forensic pathologist of -- okay, what's the significance of this bruise, that bruise, and so forth. And to understand or find your way through it as best you can, you have to use history, you have to use witness accounts, you have to use any pictures, anything you can have to establish, well, this bruise wasn't there at this time, or it was, but it was very small, now it's bigger here. There's no good, easy formula on trying to find your way through that. And there's a lot of stuff that at first glance at autopsy you might say, "Oh, my goodness, this person must have been in a bar fight," and then you learn that there were four hospitals in between, coagulopathy, all kinds of medical treatment and so forth. And what appeared to be, you know, to your quick eye could be inflicted physical injuries turn out not to be so. That happens all the time and it's very, very difficult to make the determinations on this.

Q. And I would have the same question, sir, by the size or shape of an external bruise. Can anybody say within a reasonable degree of medical probability based on the size or shape of a bruise whether or not someone inflicted that through blunt force trauma intentionally?

A. Again, that should be approached with great caution and conservatism on the part of forensic pathologists. There clearly are examples where fist marks have been matched and probably are true. To go there with any degree of certainty is, as I say, dangerous.

Q. Now, a question that I wanted to ask you is that you're aware that Ryan Mickey was alone with this child for the last hour or so of her life, right?

A. That's what I understand.

Q. Now, what -- or why did the child choose that time to decompensate?

MR. WALSH: Object as vague, relevance, speculation.

THE WITNESS: It's all pressure, volume.

MR. WALSH: Okay. Sorry, Your Honor.

THE COURT: Hold on, Doctor.

I'm going to sustain the objection; speculation.

Q. (By Mr. Brown:) Does intracranial pressure play a role in when someone would decompensate?

A. Yes.

Q. How so?

A. Depends where one is operating in the curve one exhibit

back. If you're close to being able to hang on, so to speak, and match the pressure volume issues that are present, as I said, an incremental change can push you over. And it may be something the person who was the child did, or may not. You simply don't know.

Q. So there's no way to predict?

A. Not really, unless you have historical information that somehow you can evaluate. In this particular case the candidate would be an impact to the car door. That could be serious. Or it might have nothing to do with it. You simply don't know.

Q. Could anybody?

A. Somebody might have an opinion about it, but I don't know how they could, you know, with a reasonable degree of medical and scientific certainly answer that question.

Q. Well, Dr. Swalwell told us he could not say within a reasonable degree of medical probability that the car door striking the child didn't cause the subdural. Do you agree with that?

A. Yeah, I don't know either.

Q. Now, Dr. Swalwell also testified that he would expect to see an inflammatory response; in other words, healing of the brain within four to six hours of the injury. Are you aware of that concept?

A. I'm aware that he said that.

Q. All right. And are you aware of the fact that he didn't see any evidence in the brain of inflammatory response?

A. Correct.

Q. All right. Now, Doctor, if that were true, if it was

true that the healing process would commence within four to six hours of the insult, or the subdural hematoma here, wouldn't that mean that the subdural hematomas he's talking about would have occurred inside the hospital setting itself?

A. Well, if that reasoning holds, then I suppose that's true and that's false. I mean, we know that that's not true. So it's an unfortunate -- or I wouldn't agree with that statement and I think that it speaks for itself.

Q. What about a delay. He also mentions -- Dr. Swalwell mentioned a delay in this healing process because the child was in shock or in a chronic condition. Would that delay this inflammatory process?

A. I would say there's no good medical evidence that that is so. It certainly is something that an experimentalist or a pathologist could say, "I wonder if there is an effect like that." Then what you do, you have to go to a laboratory or some where to test it. If you simply speculate or hypothesize, it isn't good enough. I mean, that's what it is. It's just maybe. I don't find that there's good evidence that the healing process is affected measurably by much of anything.

Q. All right. Now, we had a couple other exhibits here I wanted to direct your attention to.

A. One last one.

Q. Exhibit UU. It's entitled mechanism of retinal on optic sheath, hemorrhages. Are you familiar with retinal hemorrhages, sir?

A. Yes.

Q. Okay. And what does this exhibit do for us insofar as

understanding what was going on with Kerianne Bradley?

A. Again, part of the soul of pathology, and much of medicine, is how does this all work? We see these disease processes, and what's the mechanisms behind them?

There have been observed retinal hemorrhages in the retina of the eye; that is the eye sensing elements in the back of the eye, for a long time. And the significance has been debated endlessly. And in recent years many have imputed that retinal hemorrhages in the eyes of babies means inflicted trauma. Now, if that were true, that's a very, very important observation. But life is usually not like that. We don't have litmus tests that tell us one way or another about things, and that is certainly true here.

It turns out these two authors, Canadians, took the time to go back and study the research work that had been done for almost 50 years on this particular question. Going back to an experiment that was done at the Mayo Clinic where somebody took a monkey and put a balloon under the skull and pumped it up. It's the equivalent of making a subdural hematoma. And, guess what, they were able to produce retinal hemorrhages and hemorrhages around the optic nerve sheath. And then others did a series of other kinds of experiments. These people put it all together by looking at what the anatomy is, and if we look at a diagram, we don't have to look at this, it's the venous drainage of the eye.

But this is the depiction of the retina. It turns out that the blood drains from the retina through a vein called the central retinal vein that goes right down the middle of the

optic nerve. And somewhere on the way to the brain, which is back here, the central retinal vein leaves the optic nerve and collects blood from the surface and then enters into venous channels outside the orbit and the eye.

Think about pressure and volume again. If there's intracranial pressure because there's a sheath here, it communicates directly with the intracranial compartment. So whatever pressure is in the brain is going to be exposed to the optic nerve. And if you think about it for a second, at your doctor's office they pump up a blood pressure cuff, and if you pump that up to the point where it just cut off venous pressure, 10, 15 millimeters of mercury, well, what's your situation. First of all, after a while it's pretty uncomfortable, because blood is coming into your arm and hand, but has no way to leave. So what happens, your hand gets purple, and after a little while, and they made us do this as medical students, you'll get little petechial hemorrhages.

And the same things happens to the eye. The pressure, intracranial pressure, if it's up above 10 or 15 millimeters where is squeezes the optic nerve, and blood gets into the eye but can't get out, and what happens, it backs up, and because the capillaries in the retina are very thin and delicate, they burst, and they bleed. And that's the mechanism behind retinal hemorrhages.

And, in fact, other studies subsidiary to this one pretty well have shown that, that there may be some rare circumstances of other situations, but it's pressure and volume again. And that's where retinal hemorrhages come from.

Q. So is it necessarily an indicator of intentional trauma?

A. No. In fact, other studies have -- when you have a problem like this, of causality, you've got to come at it from every direction you can, because that's science. And somebody, a colleague of mine in North Carolina decided to see, "Well, how common are retinal hemorrhages. And if you don't look, how do you know?"

So he took -- examined over 1,000 autopsies, 2,000 eyes or so, and looked in them, no matter what they have coming to an autopsy, to see who had retinal hemorrhages. He saw about 20 percent. And some of them were head injuries, some of them had brain tumors, some of them had other kinds of stuff.

The final common pathway is virtually everybody who had retinal hemorrhages, except people who had leukemia and things like that, had increased intracranial pressure, for some reason. A blood clot, a tumor, whatever. And that 20 percent was in adults as well as children.

So it turns out to be a fairly common problem. The final common pathway seems to be increased intracranial pressure according to the model of Muller and Deck.

Q. All right. And are you familiar with the term "aspiration"?

A. Laceration?

Q. "Aspiration."

A. Aspiration; yes, of course.

Q. And how does that tie into a subdural hematoma, if at all?

A. Well, it doesn't have any immediate connection except that if your subdural hematoma is interfering with your pressure volume situation, and you're vomiting, then you have the potential for aspirating, that is inhaling, whatever you vomited out, food or stomach contents or whatever.

Q. Bile?

A. And if you have vomited out your gastric contents, maybe some of us have done that when you get really, really sick and you keep vomiting, pretty soon you vomit bile because it's down in your small intestine, then that would be not be a good thin to inhale either.

Q. Is there typically some kind of noise associated with this aspirating process?

A. Well, it can be -- you know, obviously if you're trying to breathe then you're inhaling stuff, and can be noisy, or coughs or chokes or gagging, things like that. Pretty hard to predict exactly how it would sound.

Q. Could it be mistaken by a lay person for matters other than head trauma?

A. Yeah. Yes, it could.

Q. For example, asthma?

A. Of course. The act of aspirating, if somebody has asthma, particular tendencies will set off an asthma attack. I mean, it's irritating stuff. So -- it wouldn't be crazy to imagine that it would sound the same.

Q. Now, are you familiar with liver lacerations?

A. With which?

Q. Liver lacerations?

A. Oh, yes; a little bit, yes.

Q. And have you seen livers be lacerated as a result of improper C.P.R.?

A. Yes, I have encountered that a few times.

Q. How so?

A. In situations where an inexpert person is attempting to do C.P.R., cardiopulmonary resuscitation, and instead of having their hand up on the chest they may drift down to the abdomen, but if it's a small kid, how big is my hand, how big is the trunk of a baby, it is very, very easy to deliver compressions to the abdomen, and under those circumstances the liver can be lacerated. Sometimes the spleen is ruptured, sometimes intestinal injuries will occur.

Q. Do you know that Dr. Murillo -- he was the emergency room physician?

A. Yes.

Q. Do you know that he did not diagnose laceration at Rancho Springs?

A. He said what? I'm sorry.

Q. He did not diagnose laceration --

A. Oh, he did not. Not that I could see from the record.

Q. And there's been some testimony relating to the correlation between the -- well, let me ask it this way: Are you -- do you understand that there's -- on autopsy there was a laceration found in the caudate lobe of the liver and also an issue associated with the adrenal gland?

A. Correct.

Q. All right. Now, there was -- and I just would like you

to explain to the jury based on your skill, training, education and background, the proximity between the caudate lobe of the liver and an adrenal gland in the child of 15 months of age?

A. The liver is a big organ and goes basically past the midline near your stomach all the way around to the other side on the right, and it goes front to back the full dimension of the trunk. On the right side, anyway, the proximity to the kidney and liver and so forth has got to be a matter of an inch, maybe less. On the left side it would be a little farther away, but if the liver were lacerated, and there were slides that showed that it was, and there was hemorrhage in the fatty tissues behind the organs then it has access to where the adrenal glands are so that I don't know that you could impute anything special about it because all of these structures are basically within maybe a three-inch circle.

Q. Less than the size of a palm of an adult male's hand?

A. Right.

Q. All right. Now, Doctor, based on your review of all the records and the reports and the statements and so forth, is it your opinion that Kerianne Bradley was suffering from the effects of a subdural hematoma prior to February 4th of 2006?

A. Yes, she was.

Q. And the basis for that opinion, sir?

MR. WALSH: Your Honor, going to object as asked and answered, Your Honor.

THE COURT: Overruled.

You can answer that, Doctor.

THE WITNESS: Okay. Based first on -- and I like to

take it in the way that I have approached it -- the CT scan clearly shows a subdural to be there. There's some time connected with that.

Then the autopsy and slides clearly show some aging that goes back well before hospitalization. And then we deal with the clinical pathologic correlation that this child was sick and was sick in a way that kids that have an evolving subdural hematoma might behave. So we have, I think, multiple data points that point the way to that conclusion and I think we've discussed those in a number of ways.

Q. And would your opinion be the same insofar as that preexisting subdural hematoma would have made her more susceptible to intracranial pressure becoming out of bounds?

A. Yes.

Q. Through no fault of anybody's?

A. It could be that way.

Q. Thank you.

MR. BROWN: I have nothing else, Your Honor.

Thank you, everybody, for your patience.

THE COURT: Thank you, Mr. Brown.

Mr. Walsh?

MR. WALSH: Thank you, Your Honor.

CROSS-EXAMINATION

BY MR. WALSH:

Q. Good morning, Doctor.

A. Good morning.

Q. You and I had a chance to talk on the phone for a few minutes yesterday while the airport rang in the background

making sure nobody takes your bags?

A. We managed to do it.

Q. I had some questions for you. I do have a number of questions for you. I won't finish before lunch, so let me see how far we can get.

What I want to ask you about a little bit is you said you -- you had reviewed the medical records, the CT scans, the slides, or the cutting that had been presented to you, as well as some witness statements. Did I -- did you say all earlier?

A. Yes, sir; that is correct.

Q. Okay. And as far as witness statements go, did you read police reports attributed to this case?

A. Yeah, I believe I have a list of what these things were, but there were police interviews by several officers. I cannot remember their names.

Q. Okay.

A. But there were --

Q. Okay. No quiz on names; don't worry.

A. Okay.

Q. The -- well, one of the things talked about kind of near the beginning of your testimony is you talked about, and I think it is echoed in your book, one of the important things to do from a neuropathological perspective, first of all you kind of need to get the best history you can about the child; is that fair?

A. Right.

Q. Okay. I mean, I guess let's start from the beginning here. I had a chance to review your resume. You published a

lot of articles. You testified on direct examination that you've conducted 20,000 brain autopsies, right?

A. That's right.

Q. And of those only about 2,000 are children, correct?

A. Yeah. I don't know. I never counted. But it would have to be something like that.

Q. Okay. And you've -- let's see. You're on the board of directors of a company called Naurex, N-a-u-r-e-x; is that right?

A. Uh-huh.

Q. Is that a "yes"?

A. Yes; I'm sorry.

Q. And that's a company that makes antidepressants; is that fair to say?

A. It is a drug development company that deals -- has some products that have to do with depression and post-traumatic stress disorder and neuropathic pain.

Q. Okay. And also in reviewing your resume it looks like and I think you answered this a little bit on direct examination, did you I guess retire from the practice of medicine in 2003?

A. No. I consider what I do every day as practicing medicine, looking at microscopes, doing what I have over done my whole life. I just am not doing that in a hospital setting relating to live patients now.

Q. Okay. And that -- at least that part of your career ended in 2003; is that right?

A. Yes. I think it was maybe -- I retired once, then went

back to the Children's Hospital, because they needed me, and I was there for a couple years, and I think the last was 2005.

Q. You're right; thank you for correcting me. Right, 2003 to 2005 at the Children's Memorial Northwestern University Medical Center?

A. Exactly.

Q. Okay. And so you spent some time talking to us on direct examination about the significance of getting a history?

A. Yeah.

Q. And you talked to us about the -- you gave us some description of your understanding of Kerianne Bradley's last couple days?

A. That's right.

Q. And this morning you talked about the fact that a couple days prior she had a fever, she was vomiting, people had described her as being sleepy. Do you remember talking about that this morning?

A. Correct.

Q. Okay. Now, would you agree with me that some of the statements between witnesses who had access to Kerianne Bradley during the last couple days of her life, would you agree there were some conflicting statements among those witnesses?

A. Yeah, but I mean, there were different recollection problems, some time problems, some descriptions. I think my own view of looking at reports like that is you kind of have to surf over the high spots because you can't, unless you interview people yourself, probably can't find your way out of those problems.

Q. Right; okay. And I guess that brings up another point, and that is you didn't conduct any direct interview in this case, right?

A. No.

Q. And you didn't -- actually, I know this is probably obvious to almost everyone in this courtroom, but you never had access to Kerianne yourself?

A. No.

Q. And when you talked this morning about the last couple days of Kerianne Bradley, one of the things you mentioned was the fact that on the afternoon of February 3rd, that is the day before she went into arrest, there was some information that you have received that Kerianne had simply lied down and gone to sleep on concrete or something like that, right?

A. Yeah; correct.

Q. Okay. Now, that only came from one source, correct? That came from the mother of Ryan Mickey, correct?

A. Yeah.

Q. Okay. And you were aware that in other statements that she gave throughout the investigation, that topic was something that only came up around about the time near the end of her interviews or near the time she testified at preliminary hearing, correct?

A. I'm aware that this wasn't necessarily a consistent statement either elicited or volunteered. I don't know what the story is.

Q. Okay.

A. Yeah.

Q. But would you agree that she was the only source of that information?

A. Yeah; appears so.

Q. Okay. But you -- do you remember the police report where Rosan Mickey that -- do you know who I'm referring to if I say Rosan Mickey?

A. Yes.

Q. The defendant's mother? Mr. Mickey's mother?

A. Correct; yeah.

Q. That -- you are aware that in a police report she's attributed to having said that on February 4th, the day that Kerianne Bradley went into arrest, that she recalls Kerianne Bradley taking and drinking a bit of milk from a bottle while at her house that day?

A. I think so, yes.

Q. Okay. And that was after the car door was alleged to have struck her, correct?

A. I know the feeding was offered and there was some question how much, if any, milk she drank. I can't independently tell you that. I know there's some ambivalence there.

Q. It's unclear, correct?

A. Right. It's unclear.

Q. Get my notes in order for you here. The testimony you gave, you compared Kerianne Bradley to kind of behaving like a dish rag or irritable during the time she was dropped off at Rosan Mickey's house on February 3rd; do you remember saying that?

A. Yes.

Q. Okay. And that's -- is that a comment on how she was, I guess, crying and acting annoyed when her mother left; is that something you remember reading?

A. Yeah, I didn't get the sense that she was crying that much, which is kind of bizarre in a way, because kids, when they're feeling bad, they do that, but -- but that she was just limp and not doing much, and would go to sleep like that.

Q. Okay. You remember reading testimony or information in police reports from roommates of Jennifer Bradley and Ryan Mickey that they heard the child, Kerianne, crying in the late evening, early morning hours between February 3rd and February 4th?

A. That's right, 2:00 o'clock in the morning or something, as I remember. And I think they got up and tried to give the kid a bottle or something, without success, apparently. Somehow the child went back to sleep.

Q. Okay. But that's also an area of, somewhat, dispute. There are conflicting statements on that as well; that is, at some point someone says the child takes a bottle, another point they say something different, right?

A. I can't speak to that. I just know I saw that statement and I don't know how conflictual it was.

Q. Okay. And you recall that a couple of those roommates in the house commented on hearing what was a normal cry; they referred to it as a normal cry? You read that?

A. Boy, I don't remember any comments about that, no.

MR. BROWN: Objection; ambiguous, argumentative.

THE COURT: Going to sustain the objection. It's vague as to time.

MR. WALSH: Okay.

Q. (By Mr. Walsh:) In reference to the negative experience -- do you need more water?

A. No, I'm fine.

Q. Only a few milliliters left?

A. I'm good. When I go dry, I'll tell you.

Q. What I was referring to is the statements by the roommates. There was one male roommate, one female roommate that gave statements to the police in regards to hearing a cry of a child, it was late evening, early morning hours from February 3rd to 4th. Do you remember both those roommates referring to that as being a normal cry?

A. I don't remember that.

Q. Okay.

A. No, I don't.

Q. All right. Do you remember commenting on your -- during you direct testimony about the temperature measuring 103; do you remember talking about that?

A. Yes.

Q. Do you remember where that information came from?

A. Well, it's -- well, let's see, whether that is the medical report -- of course that would be history information. I think this must have come from one of the interviews or transcripts somewhere.

Q. Okay; right. So this is -- you reviewed the records of Dr. Hurwitz's office, right?

A. Yeah.

Q. Okay. And in that -- in that particular appointment or that date of February 2nd, when Kerianne was seen by the nurse practitioner, does that report reflect a temperature of 99.8, correct?

A. I think that the child was mildly febrile at that point, and it may have been in the records somebody said, "We checked it, and it was a 103 last night," or something. I don't remember where that came from.

Q. All right. And did you review or read an interview attributed to Jennifer Bradley, the mother of the child, talking about Kerianne Bradley eating while at the Carrows Restaurant on the evening of February 3rd?

A. There were a number of interview things that involved Jennifer. I'm just trying remember. I don't think I remember that.

Q. Okay.

A. No.

Q. Do you remember anything about her talking about feeding mashed potatoes to Kerianne Bradley and she didn't like the gravy?

A. I think some solid food was attempted, but I don't know how much actually went in. I had the sense that the child was really not eating much at all.

Q. And so part of your opinion is based on the history that depicts the child not eating over the last two days; is that fair to say?

A. Certainly not eating much, in that food was offered but

it all seems to have been rather ineffective.

Q. Okay. Well, Mr. Brown asked you some questions comparing AGE, or acute gastro enteritis, or stomach flu, comparing that to some of the symptoms that you might see from head injury; do you remember talking about that?

A. Yes.

Q. And some of the -- well, isn't it also a symptom of that stomach flu sometimes the child will be unwilling to eat or be uninterested in eating?

A. Sure; of course.

Q. Okay. Now, are you being paid for your testimony here today?

A. Well, I'm paid for my -- I bill by the hour and I have confidence and hope that I will be paid for my time. Being paid for testimony, no, I don't do that. It's -- the facts come out and it's strictly a time deal.

Q. All right. And I didn't realize that. I was just asking if you were paid to be here. I'm not suggesting your opinion is swayed by being paid.

A. No.

Q. The -- so is it -- is it fair to say that -- so you gave us kind of a recitation of the facts of Kerianne's last two days, and those were sleeping all the time -- and I'm paraphrasing, please correct me if I'm paraphrasing wrong -- sleeping excessively, eating very little, irritable at times; is that a pretty fair assessment?

A. That is.

Q. Okay. Now, that is somewhat -- there are contrary

reports to that throughout the information that you've reviewed, correct?

MR. BROWN: Objection; argumentative.

THE COURT: Overruled.

You can answer that, Doctor.

THE WITNESS: Okay. I think there's a question of, you know, was she out all the time, no; that's not my impression, is that she would wake up at some level but then, given the first opportunity, would seem to want to go back to sleep.

Now, what she was doing in between, smiling or, I mean, talking about putting the kid in the playpen to play, I mean, I don't know what the substance of that was. So clearly the kid was not the same the whole time, had some episodes that would approximate, I guess, normal behavior.

Q. (By Mr. Walsh:) Okay.

A. But how much and how long, I can't say.

Q. Okay. There are some limitations in the history that's available in this case, aren't there?

A. Well, the history according to a number of different individuals, and it varies a lot.

Q. Right. You mentioned seeing something about smiling. Did you review the portion of the transcripts --

A. I don't remember who attributed that, but basically the child smiled and then went back to business, so --

Q. Okay. Now, you referred to the vomiting, Kerianne vomited during the last two days of her life. How many times did she vomit?

A. I don't know; no idea.

Q. All right. And would it be -- do you recall reading only that she vomited on Thursday? Or Wednesday?

A. My impression that this was over a couple of days that there was episodes of vomiting, and then precisely how many times, I don't think that was ever mentioned. I certainly didn't get a checklist to keep track of that.

Q. Okay.

A. It wasn't just on one day, I don't think.

Q. All right. And you talked about -- you spent a good deal of time this morning during your testimony referring to your review of these slides of the subdural clotting; do you remember talking about that this morning?

A. Yes.

Q. And you said these were -- all of these exhibits that the defense showed you I think they started at OO and went through MM, NN, OO, PP -- it's your testimony those came from the same, I guess, cutting; is that right?

A. Let me -- yeah, it is. I would like to refer to my notes on that.

Q. Sure.

A. Because I have indicated on which slide I took the photographs.

Q. Okay.

A. And I don't want to misstate.

The -- just for orientation's sake, the -- the autopsy slides have a label on it that say San Diego Medical Examiner.

Q. Okay.

A. And the name Bradley, and the case number and

Dr. Swalwell's name, and on each of these there is a handwritten number identifying which block of tissue it came from. The photographs that I took came from block number six.

Q. Okay.

A. And there are two pieces of dura on there. And it -- I just want to be sure. That may be the only slide of dura, yes, that was made.

Q. Okay.

A. So they all came from a single -- single slide and the single cut and everything else.

Q. Single slide of dura?

A. That's correct.

Q. And you testified on direct examination you don't know where from Kerianne's brain that came from?

A. I don't know which. It had to be where the sub-dura was, which would be the right side. But where that was taken, I don't know.

Q. Okay. Now, there was also a subdural to the back of her brain, correct?

A. Yes. There was some in the posterior on along the falx and from the tissue that I had it didn't look like those were the ones that were sampled.

Q. Okay. But do you stand by your answer -- you have ideas, and you have -- you think know where it came from, but is it fair to say as you sit here today you don't know where from the brain?

A. Physically, topographically, I don't know.

Q. And did I understand your testimony correctly during

direct examination that with -- for example, and I don't know which exhibit this is right now -- okay. This is MM. And I'm putting it back up there.

And I don't know if the color is the same, but you described for us kind of this bottom portion here that the lower solid portion you said that these types of dark areas of all red brick coloring, you say those are the ones that are newer than two days?

A. Correct.

Q. And the ones that are changing in color, I guess north of those on this diagram?

A. Yeah.

Q. When they change in color, they are three to five days old, but they can be older; is that what you said?

A. Well, I think this is the beginning of the change, so they are older than two days, two to four days, something like that.

Q. Okay.

A. And then there are red blood cells that are clearly older. They continue this deterioration process, but in this one slide I would say the time frame was a little closer.

Q. Okay. And so you talked with Mr. Brown about the basis -- and I think he covered just a couple times with you the basis for your conclusions are the fact that you took into consideration the CT scan?

A. Yes.

Q. Which demonstrates the pressure?

A. Yes.

Q. The slides, that is the coloring of the red -- the blood pigment; is that correct?

A. Correct.

Q. And then the history that you received?

A. Yeah.

Q. And those are the things that you used to base -- those are the -- kind of the three big areas that your conclusions are based on?

A. That's right.

Q. Okay. Now, you also talked about -- and I apologize. I'm kind of jumping around a bit, trying to manage my time here. You discussed -- you showed us a chart here near the end of your testimony, S -- is it SS?

A. Uh-huh.

Q. And you were discussing the fact that the -- in this study that was done, albeit in kind of a cruel manner, I guess, in this study doctors noticed during this study that the increased smaller or the same amount of increased intracranial pressure will have a greater effect on smaller children than older kids; is that fair to say?

A. Yeah, the -- a two milliliter additional, quote, cerebral spinal fluid in a baby will result in a much bigger rising in incipient pressure than in an adult.

Q. Okay. And it looks like it increased sort of exponentially?

A. It's pretty impressive, yeah.

Q. Your chart ends at six. Is that because a plus six, they didn't go past that; is that kind of what that study shows?

A. 60 is, I mean, that's almost fatal. That's why -- I don't know how they -- or why they managed to go that way, but somebody with intracranial pressure of 60 probably isn't coming back.

Q. I'm referring to here on the bottom as far as the volume of milliliters.

A. Six milliliters; right.

Q. And that's where their study stops; I assume that's means they didn't --

A. Simply they couldn't do it anymore, I guess. I don't know.

Q. Okay. So fair to say, then, with a smaller child, a small increase, even a small increase of -- I'm going to call it CSF fluid?

A. That's good.

Q. Small increase of CSF fluid can have a greater impact on a child than someone larger?

A. That's right.

Q. Might the child then also suffer the effects more rapidly than an older person?

A. Yeah. I think again, hate to be a broken record, but pressure volume, when you have the pressure, then there are effects from that. And whatever symptoms they are, irritability, lethargy, whatever, would be -- would be visible.

Q. Okay. Did you have any ability within the records of what you reviewed in this case, do you have any idea how much extra or how much -- how that pressure was on Kerianne Bradley's head?

A. I don't think -- it was never measured. I mean, it can be measured, and frequently is, will put a sensor in there.

The effects are that she does have increased intracranial pressure. It's inescapable. How high it came, it must have gotten high enough that arterial pressure was not making headway against it and her brain basically didn't get much blood supply in the last hours anyway. So -- but how high it went, I don't know.

Q. Okay. But from this chart and this study, it would follow that the greater -- the increase of that, that is the greater increased volume of CSF in her head would result in an, I guess, more sick and, again, faster -- I'm going use the word arrest; is that fair to say?

A. Yeah; that's true. And it would be CSF or any volumetric component. It could be the subdural, could be brain swelling, could be all those things.

Q. Right. And I know I didn't go -- this is a QQ -- I didn't go to law school, for math. But I think -- I really didn't. But I think I understand.

So there's a set number of -- let's just say for fun, I'm going to use the number six, okay. And I -- it means nothing right here, but just for the sake of my example.

So let's say volume is always going to be 16. And so let's say each of those others -- well, let's say each of the others are -- well, that's really bad. Going to use 12 now. Going to change it.

I'm sorry. See, this is why I didn't go to law school, for math.

Let's say volume is 12, 12 is the total. 12 is the volume within the brain, or within the head; is that -- are you with me?

A. Well, it would be -- I don't know, the cerebral spinal fluid, or --

Q. The total volume, here in the upper right.

A. Well, the total volume is going to be -- the extreme way we could -- I don't remember what it turned out to be, but I have it.

Q. I know it's not going to be 12; that's just the number I picked.

A. I think -- that will give us some -- about a thousand. A little over a thousand grams. So let's say the total components inside is a little more than a liter. A thousand milliliters or a little more.

Q. Okay.

A. So that's -- that's the total.

Q. So the total -- in this equation, let's use 1,000 instead of 12, so typically it should be maybe 333 of those other three, and then once a subdural comes and interferes, that's what throws off those other numbers; is that basically what that equation means?

A. The volume -- the normal cerebral spinal volume is probably, a kid like this, I'd say 50 milliliters. So that's a small percentage of the total volume that. I mean, I have no idea how much blood is sitting in the vessels, so -- but you've got that component, and you have no subdural, then that's normal.

Q. Okay.

A. So if you have a subdural that's 50 milliliters, then you've used up pretty much all of your cerebral spinal fluid. You still are at a liter, whichever -- which is okay, but once something increases a little bit beyond that, then the pressure goes haywire.

Q. I think what you did, you told me I did it -- kind of understand. You won't let me use my pretend numbers. I want to use 12. I like 12.

Okay. You also spent some time talking to Mr. Brown about whether or not Kerianne had any -- well, you talked to him about coagulopathic?

A. Yeah.

Q. Okay. I can't -- I can't remember all the endings to that word, but I think when I talked to you on the phone yesterday you indicated there's -- you really -- at the point in time you have no idea she was coagulopathic when she first came to Rancho Springs, correct?

A. No, because we don't -- the first lab reports, I don't think they did them at Rancho Springs. They did a coagulation study at San Diego.

Q. Okay.

A. And those were mildly abnormal and got worse.

Q. Right, which is consistent with someone who suffers a head injury that results in this kind of hematoma?

A. The time frame connection to coagulopathy is loose at best, but -- and I don't think that helps us a lot with trying to add some more timing points here. Whether she is

coagulopathic at the time when she was seen at Rancho Springs, who knows? She could have been, I just don't know.

Q. Okay. Now, what we have isn't another indicator of someone being coagulopathic is when other areas of their body are touched or, for example interosseous line is inserted into a part of their body, like a leg, wouldn't that then, versus coagulopathy, wouldn't that result in bruising or some --

A. Well, it certainly can. And if -- you know, there's all kinds of degrees of coagulopathy, so if -- I certainly have seen that and talked about it all the time where blood will ooze around IV lines and any place where a needle is that blood will ooze out. And that can certainly happen, but how often that is, I don't know. Maybe about half the time, I've encountered that.

Q. Okay. But that's an indicator, right?

A. It can be. I mean, if you see it there, it is. It tells you pretty much what's going on.

Q. And do you remember in your review of Dr. Swalwell's autopsy report that he indicated that there were not areas of increased bruising around where the interosseous lines were inserted?

A. No comments were made in that record or the clinical records that there was oozing around the I.V. sites.

Q. Okay. You make a comment in your book about bruising and how the dating of bruising is something that's, I guess, an area of controversy in the medical field; that is, some people want to try to do it, others say we just can't do it?

A. Yeah; that's fair.

Q. Okay. But do you say in your book that really the only

kind of hard and fast rule that really anyone can agree on is the fact that a bruise after 18 hours will begin to yellow; is that in your book?

A. Yeah; that's usually the case. And probably from the outside you would have some confidence about that. You've got yellow, you can say, well, it's got to be somewhere in here.

Q. Okay.

A. But -- not very specific.

Q. Okay. And as far as the other colors, as far as you know, purple, blue, black, those are hard to time; is that fair to say?

A. Those are -- can be very difficult to be accurate about.

Q. But it's fair to say that those are more like -- those are -- to be more recent than 18 hours?

A. Yeah. I mean, they're more likely to be recent than bruises that are yellow, although, oddly enough, there have been some embarrassing studies about that.

Q. Okay. I want to talk to you a little bit about your book. You -- I think before I go into that, it's probably a good time to break, Your Honor. I think it's 11:57.

THE COURT: All right. At this time we'll take our noon recess we'll reconvene at 1:30.

Remember the admonition: Please keep an open mind. Don't draw any conclusions about the case. Please don't talk to anyone about the case.

Doctor, we'll see you back on the stand at 1:30, sir.

THE WITNESS: Very well.

(OUTSIDE JURY PRESENCE:)

THE COURT: Okay. The record should reflect that the jury has left the courtroom.

Mr. Brown, what's your time estimate for your witnesses? Because let me tell you why. As you know, we are dark Monday, we're dark Wednesday. And so I think, because of that, we may just go dark on Tuesday. And this is so -- Monday, Tuesday, Wednesday, come back on Thursday, and that still gives us the entire next week before January 28th.

Mr. Walsh?

MR. WALSH: That would be fine. I -- we were discussing that before you came out. And I don't know where we'll be as far as evidence goes. I prefer not to close on the 21st and send them immediately on a three-day weekend. So if it works the way I'm thinking, I would like to think about closing on the 25th.

THE COURT: All right. I just wanted to let you know that's my tentative plan. That's what I'm going to do. I'll tell them when we get back in, so -- you're going to have Monday and Tuesday and Wednesday, we'll come back on Thursday the 21st next week, then we'll have the entire next week.

MR. BROWN: Um --

THE COURT: Of January.

MR. BROWN: That's fine.

You know, Judge, I was talking to Mr. Walsh about this earlier. I don't have -- we've taken witnesses out of order to try to speed things along. The only thing that's keeping me from resting very quickly is that -- the schedule of these

doctors.

I don't have a lot that I need to go forward on this, on these issues. And I really anticipated right now maybe no witnesses tomorrow. I've got to make a call this afternoon, a couple witnesses on Wednesday, and then we're going to be done for the defense side. So -- we had talked about --

THE COURT: So no witnesses tomorrow, then you have some witnesses on Wednesday? And then you rest on Wednesday?

MR. BROWN: Probably. But I can't commit to no witnesses tomorrow. I've got to make a call and then I can figure that out.

We had talked about your preference on deliberations on a Friday. I don't know if you allow that, or want that to --

THE COURT: I do. But I leave that up to the jury.

My deputy will tell them, if it gets to that point, it's up to you. If you want to deliberate, then they communicate with him and say, you know what, we are, or we're not coming in on a Friday. But we leave that to them. Once they have the case, it's their schedule.

MR. BROWN: Well, here is my -- as clear as I can make a thought right now, sir, is that I think it would be pushing folks, regardless of whether I rested on Wednesday or not, to do closing on Thursday.

THE COURT: You mean this Thursday.

MR. BROWN: Yes, sir. I think it would be pushing it.

THE COURT: Yeah wrong that's going to happen.

MR. BROWN: We still have jury instructions, some things to clear up, exhibits and so forth.

MR. WALSH: Rebuttal.

MR. BROWN: Who knows if he has rebuttal, I don't know. But I -- I would like to -- so that would mean we're -- we would potentially be dark -- well, absolutely dark this Friday -- and then we come back --

THE COURT: Next Thursday.

MR. BROWN: So just take Monday, Tuesday, Wednesday off, and then do the closing on next Thursday, and then have the jury do their thing?

THE COURT: Probably what we would do, listening to you, is do the -- we would go through the instructions on Thursday the 21st?

MR. BROWN: And then argue on --

THE COURT: And then argue on the 25th. And then they would get the case the 25th or the 26th.

So it's conceivable that they're not going to be here at all next week, depending on how we are this week.

But you will not be closing this week. You don't have to worry about that.

MR. BROWN: All right.

THE COURT: Best that we could do would be to start instructions on Thursday. You know, I'm even thinking even if we finish it, if -- Mr. Walsh, your preference is you just want to do the closings on that Monday?

MR. WALSH: Yeah, it would make sense because then they can deliberate for several straight days if they want.

THE COURT: Then we may just go dark and you would have Thursday to -- actually all next week to prepare for your

closing argument.

MR. BROWN: So we're planning on closing on the 21st and --

THE COURT: No, closing on the 25th.

MR. BROWN: I'm sorry; I apologize. And then -- okay. You know, I can live with that.

There's -- the only thing that concerns me is the amount of down time, you know, between the time the parties rest and getting it, but -- there's really not much we can do with the holiday, and then the state --

THE COURT: We're ahead of schedule. I told them the 28th. And that's what matters to me most, so --

MR. BROWN: Okay then.

THE COURT: But we'll see where we're at in terms of your witnesses.

MR. BROWN: Understanding that it's going to be kind of loose tomorrow.

THE COURT: That's fine.

MR. BROWN: Okay.

THE COURT: Yeah, I'll just -- I will explain to the jury like I have before, you know, look, there are issues with some of these individuals when they can testify and this is when they come in.

MR. BROWN: Okay; thank you.

THE COURT: All right. We'll see you at 1:30.

(NOON RECESS.)

THE COURT: All right. Let's go back on the record in SWF-015286. All parties are present before the Court. We're in

the presence of the jury.

Good afternoon, everyone.

JURORS AND COUNSEL (Collectively): "Good afternoon."

THE COURT: And, Doctor, do you understand you remain under oath, sir?

THE WITNESS: You bet; yes.

THE COURT: All right. Mr. Walsh?

MR. WALSH: Thank you, Your Honor.

Q. (By Mr. Walsh:) Good afternoon, Doctor.

A. Hi.

Q. So we left off, and I had asked you a few questions. Going to ask you a few more. Let me talk to you a little bit about your book for a minute. The same one Mr. Brown asked?

A. Yes.

Q. Most recent? 2009, right?

A. That's right.

Q. Okay. Sorry, I have to get myself together here.

Now, you -- just to make sure, in your testimony this morning you talked about some of these blood indicators demonstrated to you that -- some evidence of healing injury that occurred three to five days prior?

A. That's correct.

Q. And within the history that you received in your preparation for testimony and trial, and your evaluation of the physical evidence you had, you had received no history of a head injury that occurred three to five days prior, correct?

A. No, I have not.

Q. And the -- it would have -- the type of subdural

hemorrhage that potentially, in your opinion, that may have been aggravated by the -- I think you said leading candidate was the car door?

A. Right.

Q. The hematoma itself -- or the hemorrhaging itself, I apologize -- but the hemorrhage itself would have to be at least a significant one to be re-aggravated in the way that it was, correct?

A. Something caused it. It's just that we -- or I have no historical information to say what that might have been.

Q. But, in any event, it's your testimony that there's indicators that there was a hemorrhage occurring several days prior to death?

A. Correct.

Q. It was re-aggravated, or re-bled?

A. Right.

Q. Via a possible secondary cause, possibly the car door, that resulted in a pressure change, that eventually caused the arrest and death of this child?

A. Yes.

Q. Okay. So, in any event, this hemorrhaging, the hemorrhage that ultimately, whether it was the first, the second, or a combination of the two, this head injury is what killed Kerianne Bradley, correct?

MR. BROWN: Objection; legal conclusion, speculation.

THE COURT: Overruled.

Doctor, you can answer that, if you have an opinion.

THE WITNESS: Well, if you -- it depends on how you --

there 's a train of events that leads to this unfortunate outcome. And if you have to pick a point where this journey began, yes. There -- you could say that whatever this event was, unspecified, unknown at this point, got this child, or at least contributed to where this child ended up, yes.

Q. (By Mr. Walsh:) Okay. But -- I guess I said that wrongly. I meant to say it was the head injury that caused the arrest that eventually caused the death; is that a better way of saying it?

A. Either way, the result is the same. This child arrested and decompensated and that can be the end of the road for many people who have a subdural hematoma, however they got it.

MR. BROWN: Going to interpose an objection; assumes facts not in evidence.

THE COURT: Overruled. The answer stands.

Next question.

MR. WALSH: Thank you.

Q. (By Mr. Walsh:) Now, some of the charts that we looked at today in court actually come from your book, don't they?

A. Yeah. They've been duplicated. They might be slightly different in the exhibits, but the contents is the same.

Q. All right. And, now, within your book there's a section right around page 466 where you have some discussion of the pathology of an acute and subacute subdural hematoma?

A. Yes.

Q. And, in fact, you have some pictures in your book of similar slides that we have been looking at in court here today,

correct?

A. Yes, analogous ones, but of different ages, and so forth.

Q. Right. Kind of standardized, correct?

A. Yes.

Q. Now, in your book you've told us today that one of the things that you noted that was, I guess, kind of abnormal, or one of the things that you noted as being significant in your review is the fact that there are different colored or different stages of healing red blood cells within the slides that you looked at, correct?

A. Yes.

Q. Okay. And you told us that it wasn't -- I think the word you used, this wasn't a one-shot deal, right?

A. Yeah, I used those words.

Q. All right. Now, in your book, isn't it true that you kind of give a discussion or make a statement that it's not uncommon to find different colors or different stages of red blood cells in and around a subdural hematoma?

A. Absolutely true.

Q. Okay.

A. Yes.

Q. And that this bleeding need not imply repeat trauma but is an inherent part of the character of this lesion?

A. Yes.

Q. Okay. So, in other words, you can have a one-shot subdural hematoma --

A. Right.

Q. -- that may have different colors or different stages of healing red blood cells, correct?

A. Yes. This is like an earthquake. You have the tremor, and then there's aftershocks and things that come that don't necessarily mean that there's been another injury or anything else that has gone on.

Q. Okay. So in your book it says that a subdural hematoma, when viewed, can have these different colors and different stages within it?

A. That's true.

Q. Okay. And that doesn't necessarily mean that there's more than one incident to blame for this head injury?

A. That's also true, yes.

Q. Okay. Now, I was really -- I'm sorry -- I was really proud of myself that I understood some of the words in here. It's heavy duty. And I -- when I got it at the library, it was like, "What am I going to do with that." But -- well, you know.

Did you also state in your book at some point, it's around page 269, that hemorrhages can be a part of the birthing process?

A. Can be a part of what?

Q. The birthing process?

A. Oh, yes; oh, yes, certainly true.

Q. And is it possible for a child to sustain some sort of subdural hematoma during the birthing process that can stay with them for some time in the early part of their life?

A. That is true.

Q. Retinal hemorrhages can also occur during birthing,

correct?

A. Oh, yes.

Q. And basically the chart that you showed us this morning with the retinal hemorrhaging -- I should probably put it up there, instead of just talking about it. This is Defense -- is it U or UU?

MR. BROWN: That is UU.

MR. WALSH: UU. I'm not just stuttering. UU.

THE WITNESS: Yes.

Q. (By Mr. Walsh:) We talked about this a little bit. And basically, if I understand your testimony correctly, it's your testimony that an increase of pressure in the brain, or in the head?

A. Yes.

Q. Can result in retinal hemorrhaging?

A. Yes.

Q. And retinal hemorrhaging was present in Kerianne Bradley?

A. Yes; certainly was.

Q. Okay. And, now, is there any difference between -- I think that Dr. Swalwell in his autopsy report indicated that there was both retinal hemorrhaging and hemorrhaging in the optic nerve. Am I saying that correctly?

A. I believe that's correct; yes.

Q. Is there a difference, or is that significant, the difference in where it's located?

A. It probably isn't significant because in this work the hemorrhages kind of curve along the optic nerve shoot as well as

in the retina and the blood drainage, venous drainage is impeded. It affects the optic nerve and its sheath as well. So it's very common to see them both at the same time.

Q. So the fact that Kerianne Bradley had retinal hemorrhaging occurring both in her retina and in the optic nerve is consistent with the fact that she had an increase of pressure in her head?

A. I don't think it changes anything, yes.

Q. Okay. Now, you -- I think when Mr. Brown asked you a question about the significance of retinal hemorrhaging, I remember -- I think you kind of gave a kind of a fuller answer than you did on some other things. Now, the topic of retinal hemorrhaging is significant in your field, correct?

A. Yes.

Q. Or it's an area of some debate in your field, correct?

A. Oh, certainly there are differences of opinion and belief systems that surround that.

Q. And you've been specifically involved in some of the debate about whether or not retinal hemorrhaging and how it relates to shaken baby syndrome, correct?

A. Yes.

Q. And in fact you've authored articles about the correlations or sometimes lack thereof of retinal hemorrhaging and shaken baby syndrome, correct?

A. I have.

Q. And you've testified in court before in cases, even in California, that retinal hemorrhaging does not indicate abuse when it comes to shaken baby syndrome.

A. I have.

Q. Okay. So as far as we're talking about retinal hemorrhaging in this case, it's only significant in that it relates to the increased head pressure, correct?

A. That's how I interpreted it, yes.

Q. Now, a little bit more about your book. Now, this is -- is this what they call a learned treatise? Or -- what do we call that?

A. I've got to consult my lawyer. I don't know what that means. I think it probably does, would fall under that.

Q. Okay. And this is sort of -- kind of to be a guide for forensic pathologists in their interactions with the legal system?

A. For the most part, that would be the target audience, and then of course other people. And you have a book, and attorneys clearly have some interest in what's in there. It's not a textbook that I would say the average medical student would know anything about.

Q. Okay.

A. So --

Q. So when a medical student such as yourself a few years ago decided you wanted to go into neuropathology, they would consult a different reference than this, correct?

A. There would have been one. There was one under the same title published by Dr. Courville, from Los Angeles, Loma Linda, and -- in the '50s, and it went out of print.

Q. Okay. But as far as --

A. There would have been one available for me to look at.

Q. Understood. But as far as a med student going into neuropathology, this is not specifically a neuropathology textbook, this is kind of, again, an assistance between neuropathologists and the legal system?

A. That's true though increasingly neuropathologists are finding themselves doing forensic work, and many of them would apply that and have bought that book and others.

Q. Okay. In fact, the book includes kind of a chapter near the beginning in describing for the forensic pathologist what might be expected of them when they come to court?

A. Yeah, I think the forensic pathologist would know those things certainly pretty quickly. That chapter has to do more with neuropathologists who might be more comfortable in a hospital setting that might be drawn into a legal case and here's kind of what goes on.

Q. Okay.

A. And that's what that chapter is for.

Q. Right. Well, it begins on page 11 in your book you discuss that if a forensic pathologist is going to come in and testify, or I guess answer questions about the autopsy that was done prior to them -- such as an autopsy done by a medical examiner, it's your suggestion in your book that you speak with the medical examiner before coming in and offering an opinion, whether different or the same, correct?

A. It would -- it would depend what the context was. You know, what the situation might be and would it be appropriate to do that. If it doesn't conflict in some ethical or slight way with the legal proceeding.

Q. Did you contact Dr. Swalwell --
A. No, I did not.
Q. -- before coming in and testifying?
A. No.
Q. Okay. And just for the sake of the court reporter, I notice we were doing great this morning. I know you might know what I'm going to ask, but if you can just wait until I finish my question before you answer.
A. I'm sorry.
Q. It will make things go a lot smoother. I'm trying to go as fast as I can, can't you tell?
Now, basically the section, like pages 11 through 25 of your book discuss what is to be expected of an expert witness and what an expert witness might expect to experience when they come to court, correct?
A. Yes.
Q. Suggests show up on time, present yourself well-groomed, correct?
A. Yes.
Q. And there's some discussion about what will happen, how cross-examination might go, correct?
A. That's right.
Q. Okay. There's a section about the fact that an attorney may cross-examine you and confront you with other documents that are contradictory?
A. Certainly.
Q. Okay. Or other books -- works that are considered to be authoritative?

A. That's right.

Q. And it's your job as the witness to be prepared to explain this controversy, correct?

A. Yes.

Q. And you suggest in your book that this can be done by pointing out that any textbook can be somewhat out of date, calling for delays in writing, publication, correct?

A. Yes, the argument about -- or the issue of authoritative, which I take to mean pure, unvarnished truth, without any mistakes and so forth. So there's probably no other document that would meet that criterion, and that's what I'm pointing out.

Q. All right. Are you okay on water?

A. Including my own book.

Q. I understood. You cite yourself in your book a few times, do you not?

A. Yes.

Q. Your own studies, at least?

A. Right.

Q. Okay. Page 23 of your book, there's a discussion -- and I'm paraphrasing here. Please correct me if I paraphrase it wrong -- that the difference between I guess the legal system and the medical profession is that in the medical profession physicians might be confronted with I guess an injury or a group of symptoms that can be open to different interpretations, correct?

A. Yes; correct.

Q. And sometimes there will be disagreements and the

answer will be unclear, correct?

A. Right.

Q. And you make a discussion about the fact that in court things are a little different in that people kind of want answers; is that true?

A. Obviously I mean answers that are highly specific, sometimes more than can be provided. And that's kind of the context.

Q. Okay. And I want to make sure I get the words right. And it's -- you make the suggestion that experts should answer when kind of giving their opinion about the likelihood of certain explanations, to use terms like more likely than not, or to a reasonable degree of medical certainty, correct?

A. Yes.

Q. And on page 24 you kind of have a discussion of the fact that experts will come in and they'll be asked questions about the fees they're receiving when they come into court, correct?

A. Of course.

Q. And you give a suggestion on how to answer and that is to cite to the fact you're being paid for your time, correct?

A. That's correct.

Q. Now, you have testified a number of times, I think you told Mr. Brown somewhere around 150 times, as an expert witness?

A. That's probably true.

Q. Okay. Has that been exclusively on the topic of neuropathology?

A. No. Usually it is, but occasionally the elements of a

case will center on heart or lungs or something where I'm perfectly qualified to make opinions about and have done that. But the majority of them surround the nervous system and head problems, brain problems.

Q. You testified in 2007 in the County of Los Angeles in the Phil Specter murder trial, did you not?

A. Yes, I did.

Q. Okay. And in that trial you were there to opine about what might have happened as a result of the gunshot wound, correct?

A. That's right.

Q. And you testified in some degree about the probabilities that might come from when a person severs the spinal cord during a gunshot wound, what might happen with the rest of their body afterwards?

A. That's correct.

Q. And one of the bases for your opinion in that case was citing to observations done during the French revolution, the beheadings and activity afterwards?

A. You find information in kind of strange places, but yes.

Q. Okay. One of the first -- well, you can correct me if I'm wrong, but one of the first notable cases of yours in which you testified was 1997 in New England in the case of the -- I guess the English nanny, correct?

A. Correct.

Q. And in that case she was accused of shaking a baby to death, correct?

A. That is -- that was part of the theory of the prosecution, yes.

Q. Okay. And you came in and testified int that trial and cited to slides of blood clots in order to show preexisting injuries on that child, correct?

A. Yes. It centered about some of the same issues that are here, it's very common, what's in the dura and can you age and date them. And there were a lot of controversy surrounding that, and a lot of difficulties.

Q. Okay. In fact, I mean, this whole -- this whole area is difficult, is it not?

A. Excuse me?

Q. This whole area is difficult, is it not, for a neuropathologist to actually look at a deceased person and be able to come to, I guess I'll use the word concrete conclusions, as to what caused their injuries?

A. Sometimes it's like falling off a log, it's very easy, the material that has been collected is adequate, prepared well, and there's just no argument about that.

Many times the quality of the preparations, that is the slide, may be not so good, the staining may be bad, the selection may be bad, so you're trying to -- trying to put things together that have noise in them, and in those cases it can be extremely difficult.

Q. Okay. I spoke to you a little bit about you are fairly involved in the debate over retinal hemorrhaging and shaken baby syndrome?

A. Yes.

Q. You testified in 2002 in San Diego in the Diaz case about a -- the fact that the -- and, again, I'm summarizing here, and correct me if I'm wrong, but --

A. I'm trying to recall the case, but -- I've been to San Diego a number of times. And Diaz, you said?

Q. Yes.

A. D-i-a-z?

Q. A four-month-old, shaken baby allegation. And I believe you came in and testified about the fact that the retinal hemorrhaging was not indicative or it was not your conclusion that that was a direct conclusion?

A. Okay.

Q. There was a -- that that was shaken baby syndrome, correct?

A. Right.

Q. In the Thomas case in -- that was this year, was it not?

A. Which one?

Q. The Thomas case in New York, is that this year?

A. Yes.

Q. Okay.

A. Yeah, that was just not very long ago, a couple months ago.

Q. In the fall, correct?

A. Yeah.

Q. And in that case, the defendant was accused of blunt force trauma, killing a child, correct?

A. As I recall, yes.

Q. And you came in that case and you testified, generally speaking, that there was an old blood infection, it was your opinion?

A. Yes.

Q. That created the death?

A. Right.

Q. Okay. Now, the Mike Peterson trial in North Carolina, 2003, did you testify in that?

A. I did.

Q. And that was an incident in which the government accused the husband of blunt force trauma on the wife in particular, correct?

A. Basically accused him of beating her to death.

Q. And you came in in that trial and opined that the injuries on her head were consistent with a fall down the stairwell?

A. Yeah, and this is a complicated case, but the sum and the substance of it is that a beating probably did not occur, and the injuries, as weird as they were, could be explained by multiple falls backwards down a staircase.

Q. And did you testify in the Waddle [phonetic] case in 2000?

A. Colorado Springs?

Q. Yes, sir.

A. Okay. I think I testified twice there.

Q. Okay.

A. Maybe. I don't know.

Q. And that was a case in which there was an allegation by

the government of blunt force trauma causing injuries, and you came in and testified as to a decreased head injury based on slides again?

A. Those were the facts.

Q. Now, going back to your book, a little bit. The pages are long, so I'm trying to make sure I get the words right.

A. If I need to refer --

Q. Please let me know if there's anything in here that you need to look at.

Now -- and you -- let's see. This is page 563. It's a chapter discussing child abuse and neuropathology perspectives of child abuse. You're familiar with this chapter?

A. Yes.

Q. And you begin a section on child -- pathology of child abuse?

A. Correct.

Q. And in that section you discussed that almost every alleged child abuse case, especially involving young infants, include the possibility of some preexisting brain injury or other condition; do you remember stating that?

A. Yes; that's true.

Q. Possibly emanating from birth or the possibility of inherited acquired disorders of bleeding or coagulation, some other process?

A. That's right.

Q. Okay. So kind of the beginning of your chapter talks about the fact that it's always possible something may have happened prior to the incident that brings the child to the

hospital, correct?

A. That the situation isn't what it seems. It may be something else.

Q. Okay. On page 565 you emphasize the importance of getting a complete history from the parties that were around the child, correct?

A. Right.

Q. And it warns against ignoring some of that history, correct?

A. Say again?

Q. It warns against ignoring history, correct?

A. I think this is in the context of speaking to a forensic pathologist medical examiner whose job is to develop a the cause and manner of death. And so that puts a burden on them. And I'm trying to define what that burden is. That may not necessarily be the burden of an expert as well because they may be focused on certain issues, but to the person who has to satisfy that statutory requirement, then they really do have to roll up their sleeves and get information.

Q. Okay. And if you're going to come in and testify as an expert, or to give your evaluations and your opinions based on a review of the history and the medical evidence, such as you have in this case, it would be important for you to not disregard or ignore any parts of the history that you're presented, correct?

A. It -- this gets tricky because the burden upon someone such as me in this circumstance is not the same as it is to the coroner or medical examiner, and I don't have the resources or the expertise necessary to go and seek witnesses, interview

people, do things like that. I'm not an expert in interviewing. I have no experience of that. And so there is a break point between what an M.E. could and should do, and what I can do and should do. And that's a gray zone, of course. I freely admit that.

Q. Okay. Well, I'll put it this way: In other words -- you had an opportunity to review Dr. Swalwell's report, correct?

A. Of course, yes.

Q. Dr. Kuelb's report?

A. Yes.

Q. And I would imagine that you could tell that some of the police work, some of the investigation went on after both those doctors had written and authored their reports, correct?

A. I'm not sure of what the time frame was for subsequent investigations and so forth. Ultimately that didn't concern me so much that -- I'm interested in staying as close as I can to the objective material, which is -- which can't be changed by anybody, which is the CT scan, and the autopsy slides and pathologist's report and so forth. And the other things provide a context, but not I'm not equipped to really deal with every aspect of that -- of -- you know, weighing one witness against another or attempting to determine who may be complete or incomplete.

Q. Okay. Well, I guess I'll ask it more directly.

A. Yeah.

Q. Whey you're going to come in and give your opinion on a case like where a lot of work has already been done before you come in -- is that a fair assessment?

A. Right.

Q. You shouldn't ignore any pieces of history that are available to you in coming in and giving your opinion, correct?

A. The history is -- provides a context. It doesn't provide me answers so much. I have to start with the objective material that I can deal with, with my specialty. And if historical information comes in, I regard that as being -- sitting here being able to answer questions that may come from that. I can't resolve all of those things. Maybe from the objective information and analysis I can, but it isn't up to me to be the cop, to be the investigator, to deal with the historical information other than in a context from being able to answer questions.

Q. Okay. And I appreciate that, Doctor. What -- I guess what I'm asking you is when you came in initially and spoke with Mr. Brown right now and kind of gave your summary of the history you had about the child, and you were talking about what happened on the 2nd and the 3rd and the 4th, prior to her going into arrest?

A. Right.

Q. Many of the details that you included were those that came were -- those were the details that accentuated, I guess, the sleeping and the lethargy of the child, correct?

A. That's correct.

Q. On page 569 of your book -- I already talked to you a little bit about it -- you told us that the bruises are hard to time, but yellow is generally a pretty good indicator of old, correct?

A. Yes.

Q. Okay. On page 569 you also discussed -- this is a section on dermal and scalp injuries -- you discussed the fact that external injuries that are observed oftentimes won't match with the injuries that are found underneath the skin, correct?

A. That's correct.

Q. Sorry, Doctor. Just a second here. Epidural hemorrhages can be caused with difficult births?

A. Yes; that's true.

Q. Okay. And it can last for some time into the child's life, correct?

A. That's right.

Q. Evidence of these hemorrhages can?

A. They can appear -- not discovered at birth, but then appear later in some context or another.

Q. Okay. And I think that you -- you discussed with Mr. Brown on direct examination a little bit, when you were discussing, for lack of a better word, possibilities. Might have even been more specific consulting the notes for this -- you testified that there was evidence, based on your review of the blood slides, the hematoma -- hemorrhage slides, that there was evidence three to five days that there had been some injury in that time frame; do you remember --

A. Yes, that's what I said.

Q. And then you also said that you didn't know what it was necessarily to either cause that or it could have been any number of things that caused the actual arrest itself, which caused, but you called the car door a candidate?

A. I'm sure there are multiple factors, including major -- one would be increased intracranial pressure, the role of aspiration and -- evolving could certainly be a part of that, and there may be other things as well.

Q. Okay. Isn't it correct in your book that you discuss, after citing your study on hematomas, occur without skull fractures; do you recall that?

A. Okay.

Q. And you also go on to discuss the fact that there is not sufficient information to study on infants or children who sustain hematomas without any sort of trauma; do you remember discussing that?

A. Yeah, there's -- there's circumstances that that's true.

Q. Okay. But there isn't -- there's no study on that, correct?

A. Oh, yeah, there's -- the problem is -- there have been a number of studies that address the issue, okay, we don't have any evidence particularly of trauma, and yet we have a child with subdural hematoma. And once you rule out birth trauma, or move farther away in time, then there's a whole bunch of problems that can potentially do this. The trick is trying to diagnosis and figure out what those things are. But there's a literature on that.

Q. Okay. This isn't what you're referring to when you say "insufficient data or available are available on these comparatively few published cases"?

A. Many times there aren't enough cases in a specific

situation to deal with it. First of all you've got to discover that there is a subdural, and then you do the best you can to try to figure out what caused it. And there have been -- there's literature on that, but in terms of maybe specific questions, it may be deficient.

Q. Okay. And, now, you just talked to us for a moment about the increased intracranial pressure?

A. Yeah.

Q. And you talked to us a little bit while you were on the stand this morning about 40 milliliters, and you showed us your water cup and kind of gave us --

A. Uh-huh.

Q. 40 milliliters. What's an ounce, in milliliters?

A. Oh, gosh I forget how to convert them. I think metrically now, I don't think the other way, but --

Q. It looked about an ounce to me, you were holding up.

A. A couple ounces at most, or you could say a couple shot glasses, I guess.

Q. I'm sorry, that's what came to my mind.

A. I wouldn't normally think about that, of course.

Q. You wouldn't. But unfortunately I already admitted that a couple times here, but it looks sort of like that to me like --

A. I guess if I'm looking, because I have this glass now, maybe a finger's breadth would be about 50 milliliters there.

Q. All right. And you showed us a chart earlier today that demonstrated how -- I guess how quickly or how much of an effect each incremental I guess two -- what was that value in

that chart?

A. Well, I think they had it milliliter by milliliter, or maybe two. I forget now.

Q. It's SS. I'll put it back up for you.

A. They did it in increments of two milliliters each.

Q. So a very insignificant -- well, a very small change in pressure can have a dramatic effect; is that fair to say?

A. It can in an infant, yes.

Q. Okay. And a very small increase in pressure can have both a dramatic and a quick effect, correct?

A. Once you are at that kind of the border zone of compensation, then pressure will rise rather dramatically, and maybe very seriously.

Q. Okay. To follow up on a few answers you gave this morning, I wanted to ask questions about.

A. Uh-huh.

Q. I'm sorry -- excuse me. You showed us a couple of CT scans that were marked by the defense this morning, two of them specifically; do you recall that?

A. Yes.

Q. And I don't know where they are now. The CT scans -- it's actually -- okay. We saw two of them, and you said those are kind of the hat line?

A. That was the first one that was shown.

MR. WALSH: Thank you, Mr. Brown.

MR. BROWN: You're welcome.

Q. (By Mr. Walsh:) Now, there were other CT scans -- I'm putting on the overhead now JJ. There were other CT scans

taken, correct?

A. Yes, there are other images, even from that one, maybe a dozen or more that basically would like it was as if you were taking my band saw, you know, slicing upward in the head and seeing what's in that segment. And I didn't copy those.

Q. Were there other CT scans that showed the -- either the swelling or the hemorrhages --

A. Correct.

Q. -- of more than this?

A. Yes.

Well, the first one, that I didn't make copies of because it was all -- the way they did this printed up a whole bunch of small images on a big film, and it was hard to peel them off. But in terms of looking at them, and that would be the Rancho -- Rancho Springs, okay, the study that was done at the first hospital, essentially it's the same as the one done at the San Diego Children's.

Q. Okay. So there others that show, I guess, more --

A. Same stuff.

Q. Okay. Are there others that show, I guess, looking more significant, or --

A. There really was an incremental, minimal difference between the first scan and, I don't know how many, a couple hours later, the second one.

Q. Okay.

A. And that's my awareness of how many CT, I think there was just two studies done.

Q. Okay. And I guess I -- I had a little -- I had a

couple questions, I had a little trouble understanding. We've -- you said you've reviewed the -- some photographs in this case. Have you reviewed the photographs from the autopsy itself?

A. Yes.

Q. Okay. In fact, the photographs that depict the actual subdural hemorrhages, once the skin is peeled back and --

A. That's correct. There are photographs there of those.

Q. Okay. And those indicated, I guess, several different areas of hemorrhaging, correct?

A. Well, the main one was on the right side and top of the head. And then when the brain was removed, there were some others in the posterior part of brain, and there may have been a couple patchy other ones maybe on the other side. I just don't recall right now.

Q. Okay. I'm putting People's 27 on the overhead. I apologize. I need to ask you some questions about this?

A. Okay.

Q. And we've had testimony this is, I guess, the forehead, or the front of Kerianne Bradley's head as the skin was peeled back from the front of it.

A. I think that that is true, that this is the front of the head, the nose would be under here, and the scalp has been peeled forward, and this would be the right side --

Q. Yes.

A. -- of the forehead.

Q. Yes, that's what's been testified to.

Now, these -- there's different areas, different dark

areas here. I guess maybe one here and in the dead center a little bit to the left there appear to be kind of a bunch up here, and then there's some down here, right, at the bottom of the peeled back skin?

A. Yes.

Q. So this is -- what is the hemorrhage called when it's in that skin? What is that called?

A. Well, it appears to be multifocal, but they tend to have a cluster and sort of a crescent shape, I guess, roughly, if you can think about them. At one point they -- at this point they appear to be separate, and they may or may not actually be that way.

Q. Actually what I was asking is what's the term for these kind of hemorrhages, I forget, the hemorrhages that are in the skin?

A. Oh, I see. I'm sorry. I misconstrued.

Q. Okay.

A. Those would be subgaleal hemorrhages. The galea is the loose connective tissue under the scalp.

Q. And so there appear -- is it fair to say there are multiple subgaleal hemorrhages in this photograph?

A. It appears so, yes.

Q. And could those correlate to multiple areas of impact?

A. It could.

Q. Okay. And it could also not; I understand what you're saying.

A. That's right.

Q. Okay. And then this is 28, this appears to be the back

of Kerianne's head; is that right?

A. Yeah, that would be the peak of the back of the head.

Q. Okay. And is that -- looks like we can see on -- on the actual -- what's the skin that's left around the skull in this picture?

A. This would be the opposite flap that is reflected backwards, which you can see the ear here, this is something right at the back peak of the head.

Q. What would that be called? Is that also a sub --

A. Subgaleal hemorrhage.

Q. Okay. And does this appear to be, I guess, removed by some distance from the other ones?

A. Oh, yeah, it was physically separate.

Q. Okay. And then this is 29, it looks like -- I'm sorry, switching here -- looks like we're looking at the -- this is the lower right of the head?

A. Yes. It maybe something -- it's hard to tell where the shadow is, if there is something back there, but there could well be a subgaleal hemorrhage way in the back, back behind the ear, and the back part of the head.

Q. All right. And do you recall Dr. Swalwell noting that?

A. I believe he did, yes.

Q. All right. Now, this would appear -- again, I'm kind of giving the lay attorney's opinion here, but this would appear to be different areas of hemorrhaging, correct?

A. That's correct.

Q. Okay. And I didn't -- what was your explanation for why she would have different areas of hemorrhaging?

A. Okay. Let us start with the injury scenario that we talked about, about the impact with the car door.

You have to take a look at what the shape of the face is and how the location of various bruises might articulate with a slightly curved surface of a car door or a car door frame. And it may be that there is one impact that, because of the rising point of the cheek, you're going to have a bruise there, because of the rising point of the edge of the orbit, you may have an apparent impact site there. Because of the bulge in the forehead, that may be another point of contact with one surface. So you might have one injury event that could explain all of those things.

As an alternative, you certainly need to consider the idea are there multiple separate dings, so to speak, and I'm not sure how to get at that, to resolve that question.

Now, if you're talking about -- that's a complex of bruises, and so there's both interpretations, one impact to a special surface that touches the protuberant points, or one, two, three, four separate impacts.

Then we deal with the one at the top of the head, those are rather difficult sometimes because when the child is laying in a hospital bed they may be up against the end rails of the bed, they may have not so soft pillows on them, there may be things that are around the head that -- put the oxygen mask and other devices to them, which can produce hemorrhages like that. Especially in a coagulopathic kid. And it can be very challenging and often is to say what is that.

One scenario is it's another impact something or

somebody did, or it's something that occurred incidentally in the course of medical treatment, hospitalization.

Q. Let me show you -- this is People's 90. Not going to put it on the overhead. This has been testified to as Kerianne Bradley in her hospital bed at San Diego Children's Hospital. Is her head up against any rails in that photograph, sir?

A. I have seen that and others like this, yes.

Q. Do you see in that photograph, is her head up against any rails or anything like that?

A. No, except that we see the bed control is right -- very close, there are pipes and other things cascading away from and over the head. They don't appear to be behind the head at the moment, although it's not so clear. And this is a dynamic situation, the kid is being moved and so forth.

Q. Okay.

A. Sometimes these pipes get under and on the skin and sometimes you can actually see photographs where it is, and lo and behold, there's a bruise underneath there, so that's --

Q. Okay.

A. -- part of the confounding problem of interpreting bruises in a child like this.

Q. Okay. Now, Dr. Swalwell in his -- in his report noted -- let me see. I want to find the page here. May not be able to find the page.

But he noted -- he considered these different areas of subgaleal hemorrhaging to be evidence of multiple areas of impact, correct?

A. Well, that was his conclusion, yes.

Q. And that -- and you're acknowledging today that is a possible conclusion, correct?

A. It certainly is. I'm just saying maybe, maybe not. He chose one way, I might say, "I don't know."

Q. Okay. Understood.

And going back to that car door, you mentioned some things about the car door which you refer to as the leading candidate or -- I think that's the word you used.

A. Yes.

Q. Now, you also just opined for us briefly about potential for multiple bruises or impact areas being caused by a car door because it's firm, and --

A. Right.

Q. -- the side of the face is kind of shaped. And, again, I'm paraphrasing.

A. Well, that -- that's correct, that's -- I did talk about how a single impact, depending on the surface, and where -- might appear to give multiple impact sites, which they are multiple, but it's from a single event.

Q. Understood. Now, you talked about I think during your direct examination you talked a little bit about -- I think you analogized this car door candidate as being similar to a one-foot fall; do you remember saying that?

A. Yes. I think -- I think we have to be careful about that, but I think that might be something that you could compare with.

Q. Okay. And I think in your answer -- I know I didn't write it all down, but I wrote it's possible to study -- it

would be possible with the right technology to do a study, but you just have to look at similar studies, and then you analogize to a one-foot fall; is that a fair summary of what you said?

A. Yes.

Q. So, in other words, I take it you didn't do any studies on this particular car door?

A. No.

Q. And I take it, as you sit here today, do you even know how heavy the car door was, or anything like that?

A. No, I don't. I mean, we all know what these things are like. There's a certain amount of folk knowledge of cars that would apply to me as well as anybody. And to go much further and put numbers on that, I'm uncomfortable doing so because I like to stick to the science of the most known, and I can't give you precise numbers about that.

Q. So you -- it sounds like there isn't even necessarily like a study or experiment you could suggest that would simulate these exact situations, correct?

A. Oh, I could suggest an experiment that probably would model that very nicely, except that I don't have the equipment and expertise to do that.

Q. All right. The -- you also made mention that, when I was talking to you about the multiple areas of -- multiple subgaleal hemorrhages, we were just talking about that a minute ago, I just apologize for jumping around, but you mentioned -- I think part of your answer said in a coagulopathic child?

A. Yes.

Q. Now, I thought we covered that this morning. You can't

say whether or not Kerianne Bradley was, prior to these tests that were done at the hospital on the blood, right?

A. Well, that probably didn't begin five seconds after or before they drew the blood, but how far back outside the hospital this child was coagulopathic, I can't say. I don't know. I don't have any data to help me with that.

Q. At the time of her first test, the PT and the PTT levels were only slightly elevated, correct?

A. Yes; that's correct.

Q. So -- so if --

MR. WALSH: Could I just have a moment, Your Honor? I think I'm close to being completed.

THE COURT: That's fine. Take your time.

MR. WALSH: Thank you. Thank you for your patience, Doctor.

Q. (By Mr. Walsh:) Now, the -- I'm going back to this history again.

A. Okay.

Q. The -- and I don't want to get into a debate with you about what the word "fine" means, because when I ask my wife what's wrong and she says she's "fine," I know that's not what she means. But as far as -- you gave us a summary of the days preceding Kerianne's death?

A. Yes. And, again, a summary, and that's it. It's not --

Q. Understood.

A. -- totally particular.

Q. And within the interviews of different people who were

around the child during the last week her of her life, there were people who described her at times during that week as appearance to be -- using the word "fine"; do you recall that?

A. Apparently so, yes.

Q. And you are aware that she saw a doctor -- and we're not going to talk about the reason -- but you were aware she saw a doctor on Monday, the 31st, correct?

A. Okay.

Q. Are you aware of that?

A. Yes, yes. I'm aware of some prior medical history.

Q. All right. And she was in the pediatrician's office to see a certified nurse practitioner on Wednesday -- excuse me -- Thursday the 2nd, correct?

A. That's right.

Q. And there were descriptions of her eating, and there were descriptions of her being awake on the days from the 1st all the way up to the 4th, correct?

A. Eating how much is not totally clear to me. I couldn't get a good picture in my mind about how much she was actually eating. So I can't say what I don't know.

Q. Okay; I understand. But would you agree that some of these symptoms that you've discussed with Mr. Brown this morning, some of the symptoms that she was exhibiting you told us today that some of those are similar to what a person might experience as a result of a head injury?

A. That's correct.

Q. But these are also symptoms that a child would experience when they have a stomach flue or A.G.E.?

A. They can be the same.

Q. And then it was -- and I believe it was your final testimony with Mr. Brown that the opinions you provided us in court today are based on your review of the CT scan demonstrating increased cranial pressure?

A. Yes.

Q. Your review of the pigment of the slides that you reviewed in preparation for your testimony?

A. Correct.

Q. As well as the history and the facts that you received of the days around the child's passing, correct?

A. That's right.

Q. Okay. Is that the extent?

A. Yeah, I mean, the autopsy, autopsy slides, CT scan, photographs, and then a lesser impact, I guess you can say, or veracity, come from the historical accounts, that do vary, and that -- that's that.

Q. Okay; thank you very much, Doctor. I appreciate your time.

A. Thank you.

THE COURT: Thank you, Mr. Walsh. Mr. Brown, any follow-up?

MR. BROWN: I do, Your Honor, briefly. Thank you.

THE COURT: Okay.

REDIRECT EXAMINATION

BY MR. BROWN:

Q. Doctor, I want to direct your attention to this comparison between the gastroenteritis and the head injury

symptoms.

A. Uh-huh.

Q. Okay?

A. Correct.

Q. With A.G.E., acute gastroenteritis, do you typically have blood that can be dated histologically up to three to four days and indicative of prior head trauma?

A. Well, that's a separate process, apples and oranges, and has nothing -- this kid had gastroenteritis which it had that too. It doesn't effect the subdural and the aging and dating process.

Q. I guess what I'm saying is if you have the flu -- excuse me. I guess what I'm saying is that histologically dated blood, between three and five days old and five to seven days old, those are not symptoms of the flu, are they?

A. No.

Q. They're not symptoms of acute gastroenteritis, are they?

A. No, separate processes.

Q. They are symptoms of preexisting head injuries, aren't they?

A. Yes.

Q. Okay. Now, I want to take these back in a different direction, if you don't mind, from the end to the beginning. This coagulopathy issue, which has probably been spent way too much time on, is that an ongoing process?

A. Yes, it's --

Q. In other words --

A. Yeah.

Q. -- when you have a test that shows that someone is coagulopathic, those are the test results at the time when that lab study was taken; isn't that true?

A. That's true. This is a dynamic process that has a beginning, a middle, and an end.

Q. So just because you have a lab study that says that they're coagulopathic, for example, at eight o'clock at night, that does not mean that the child is coagulopathic starting at eight o'clock at night, does it?

A. Well, probably not. It means something was going on before and that's just when you entered the movie theater, that's when you did your test.

Q. So the child has to progress to that coagulopathic area, correct?

A. Yes, but in terms of the consequence of that coagulopathy, like the pressure volume thing, there is a period in which and mechanism by which the body can compensate for something that's failing. And at some point it either doesn't, or intervention does that, or proceeds on to a more serious and complicated pathologic process.

Q. Right.

Now, you were asked some questions about studies associated with this car; do you recall that?

A. Yes.

Q. Okay. Now, if someone would have had that car in their possession, custody and control, based on your skill, training experience and background, could they have conducted a study on

this car door?

A. That's true.

MR. WALSH: Argumentative; speculation, Your Honor.

THE COURT: Overruled. The answer was that's true. The jury can consider that. Next question.

Q. (By Mr. Walsh:) So in order to conduct a study to determine what would be involved in a car door shutting in this child's head, you would have to have the car, correct?

A. Well, or an analogous one. They don't vary that much. You know what the model and year and everything else is, and if you didn't have that car you could certainly get another one. They don't vary that much.

And one could do experiments and measurements and try to duplicate what the circumstances were and have a baby model there hooked up to a computer with sensors on it, and slam the door, and slam the kid in it. And you could do all kinds of different scenarios under those circumstances and make the measurements of how much force that was there, and if those force levels would be consistent for, or capable of producing intracranial injury and bleeding. That could be done.

Q. You would have to have the same or similar type of spring system, springs on the car door, et cetera, wouldn't you?

A. Yeah. Again, probably the variance that would exist within another car of the same year and model, I suppose you could test that, but I'm not sure you would need to. All you need is a simple call to the manufacturer, and say, did you change the design of the door, or springs or latches for that model year, and the answer is no, mostly likely, then you

proceed on and assume whatever car you can find that's close by is going to be very, very similar, if not identical.

Q. Well, let me talk to you about the child and the bruises that --

A. Sure.

Q. -- are you aware that Dr. Kuelbs has testified that the -- what she described as bruises on this child could have been caused by one situation?

MR. WALSH: Object; misstates the testimony.

THE COURT: Sustained.

Q. (By Mr. Brown:) Well, do you have an opinion whether or not it could have been one event or multiple events that caused these bruises?

A. I don't know. There certainly are multiple subgaleal hemorrhages which raises the perfectly logical question how many events were there.

And I attempted to go into why maybe such a simple interpretation is not warranted, namely placement of medical devices, manipulation by personnel, and impact to a particular surface that might produce multiple apparent impacts. And I don't know how to go looking further than raising the possibilities and say, well, there's more than one interpretation here, and certainly it would be appropriate and valid for somebody to say it looks like there are multiple impacts.

Q. Well, in this situation we know that there was C.P.R. performed at the scene, correct?

A. Correct.

Q. We know the child was transported by ambulance to an emergency room, correct?
A. Yes.
Q. We know that the child was treated and handled by folks there at the emergency room, correct?
A. Yes.
Q. We know the child underwent treatment at the emergency room with multiple people, correct?
A. Yes.
Q. We know the child was transported by ambulance or somehow to a life flight, correct?
A. Yes.
Q. And we know more people had hands on the child during that situation.
A. Undoubtedly.
Q. And we know there was more medical intervention with the child through all these processes, correct?
A. Well, intervention, I don't know if tubes were changed or reintubation occurred. I just simply -- a lot of that isn't on the run sheets and so forth. So what other kinds of manipulation may have occurred, I don't know.
Q. Well we know that a lot of different people had access to this child in one way or another, correct?
A. That's a fact.
Q. All right. And then the child get life-flighted to Children's Hospital, correct?
A. Yes.
Q. More people have contact with the child there, correct?

A. Undoubtedly.

Q. And then we have the child being treated at Children's by multiple other people, correct?

A. Yes.

Q. More studies being done?

A. Yes.

Q. And then we have the autopsy, correct?

A. Yes.

Q. All right. So we have multiple different areas where different people are hands-on with the child over the course of a 24-hour period, correct?

A. Yes.

Q. Now, Mr. Walsh had asked you about you should keep an open mind to additional facts or different documents to change your opinion, correct?

A. Yes.

Q. Did by chance he share with you any additional facts which have changed any of your opinions that you have rendered for us this morning?

MR. WALSH: Object as relevance.

THE WITNESS: I haven't -- excuse me.

THE COURT: Overruled. Doctor, was your answer "I haven't"?

THE WITNESS: I have not received any astounding new information since basically I quit working on the case. If something were made available to me, of course, I mean, I would have to re-evaluate that and see if it made any differences in my opinion.

Q. (By Mr. Brown:) But what I'm asking is during your cross-examination by Mr. Walsh, did he suggest any other facts to you which would have changed the opinions that you rendered this morning?

A. No.

MR. WALSH: Objection; relevance.

THE COURT: Overruled.

Q. (By Mr. Brown:) I'm sorry?

A. No.

Q. During the course of your cross-examination by Mr. Walsh, did he show you any documents which would have changed or altered the opinions you shared with us this morning?

A. No.

Q. Now, he did cite to you, I think, three or four of the cases that you had previously testified to; isn't that correct?

A. Yes.

Q. Now, your opinions in those, Doctor, that you rendered in those cases, are they based on forensic evidence that you have similar to the analysis that you've gone through with us today?

MR. WALSH: I'm going to object as vague.

THE COURT: I'm sorry?

MR. WALSH: Vague.

THE COURT: Do you understand the question, Doctor?

THE WITNESS: No, I don't.

THE COURT: Well, then I'll sustain the objection. Because if you don't understand the question --

(LAUGHTER.)

THE COURT: Go ahead, Mr. Brown.

MR. BROWN: Congratulations.

Q. (By Mr. Brown:) Let me ask it this way. Is it your professional practice or reputation to walk into a courtroom and willy-nilly pull opinions out of the sky?

A. Of course not.

Q. And in each of the times that you've testified have you had a forensic basis for your opinions?

A. Absolutely.

Q. And have you done that in all the cases that Mr. Walsh talked about earlier that he cited to you, like in Colorado and different places?

A. In many of these there are stacks of records. Basic information is often very similar, but each one has to be evaluated on its merits. And if they're the same, how else can I do? I have to give the same answer. One and one is two today and tomorrow and the next day. And if there's some other factor involved, then the opinion would have to reflect that.

Q. And you were asked some questions about potential hemorrhaging from an epidural birth; do you recall those?

A. Yes.

Q. Okay. Do you know that this child was -- there wasn't an epidural birth, there was a natural birth involved in Kerianne Bradley?

A. I don't know anything about the birth history. And point of fact, as a 16- or 17-month old child, that's a long ways away. I mean, there could be things that emanated at birth that could still be a problem for a 16- or 17-month-old, but I

frankly didn't see any trail going back to birth that I could do.

Q. What kind of trail would you be talking about to see if you could go back to birth?

A. We would be talking about a child who had very low Apgars, at birth, had asphyxial problems, looked to be a cerebral palsy-type child. Those things trail on for the life time of the child and can have import to some things down the road. I see no evidence of that.

Q. I was going to ask you, any indication that those events were ongoing?

A. None.

Q. Any scarring or any kind of encapsulization to point to, to say that these five- to seven-day or three- to four- to five-day old subdural issues existed back at birth?

A. I don't see any, at this point, any connection to anything relating to the birth.

Q. And if you knew that the child was born naturally, would that eliminate any potential hemorrhaging as a result of --

A. No.

Q. -- an epidural birth?

A. No. Normal childbirth, normal vaginal deliveries, do have incidents of retinal hemorrhages and subdurals and other things like that, and you say how in the world does this happen? It just tell us that birth is a traumatic process.

And in some people significantly you pay your dues later, others, kids get through, thank God, and that's that.

Q. So you would have done the same analysis to go back to see if there was scarring or any trail that you could follow to birth?

A. Sure. I mean, if there was any information, I would say is there anything in the material that I have to look at that could correlate with that. And I didn't see anything there. So --

Q. Did you see anything that would indicate to you that this child had an inherent acquired disorder from birth?

A. No.

Q. And has any information been shown to you by the prosecution to indicate this child had any inherent acquired disorder from birth?

A. I find nothing relating to the birth at all. It appears that the kid was developing, as some kids do, normally, maybe some kids are talking by age 16 months, and my grand-kids were, but so what. That's the way it is. I didn't find that abnormal.

Q. Now, you were asked some questions about this term -- not specifically -- not the term -- was referenced, shaken baby syndrome?

A. Yes.

Q. Doctor, you are aware Dr. Kuelbs has testified this is not a shaken baby case, correct?

A. That's my understanding.

Q. And is that also your opinion?

A. I don't think that that enters into consideration here at all.

Q. Now, you had some discussion with Mr. Walsh about a severed spinal column, and going back to the French wars and the guillotines and so forth?

A. Oh, yes.

Q. I was kind of wondering about that a little bit. When a head is severed, or a spinal cord is severed, I mean, has the body reaction changed much in the last 300, 400, 500 years?

A. Well, that's when you go back to these -- the nasty time during the French revolution in which people had their heads cut off, and an experiment was actually done with the discoverer of oxygen, Dr. Lavoisier -- why someone would be cold-blooded enough to be able to do this -- made arrangements with a friend to shout at him when his head was in the basket, and he would blink or do something, which apparently he did, for up to 10 or 15 seconds, and some say more, after he had been guillotined.

And there's other evidence that suggests that massive injuries like that can sometimes have a period of consciousness relating to them, for 10 or 15 seconds. Basically one circulation time. And that's why that rather morbid and awful business came up.

Q. Now, where I was raised we were taught to stay away from rattlesnakes and such when you had your head cut off [sic] because they could still bite you; is that kind of the same analogy?

A. Yes; yeah.

Q. Okay. Did Dr. Swalwell ever talk to you in this case?

A. No. I think I've met him at a meeting or two. But I

didn't -- I've never talked with him certainly about this case, and I can't recall the last time we might have had a conversation.

Q. Do you know if Dr. Swalwell had the benefit of the history that was shared with this jury about the child and how she was three, four, five days before this February 4th date?

A. It appears that information was not communicated to him, but I can't answer for Dr. Swalwell. I don't know.

Q. I wanted to ask you one other question here. This is -- Mr. Mr. Walsh had talked to you about the intracranial pressure or fluid with the child and how quickly it might react; do you recall that area?

A. Yes, I do.

Q. Can anybody say whether or not that intracranial pressure would have reacted to the extent that the child would decompensate within an hour, two hours, three hours, four hours, five hours from the time when it did actually decompensate?

A. This is something that's totally unpredictable. When a child is in that situation where they're barely able to decompensate, back to the curves again, little events -- little things mean a lot, I guess I could say. And this may occur totally spontaneously, it may occur -- this decompensation in the presence of any number of people who may or may not have had anything to do with it.

And so this is -- it's like why did the bomb go off now. Well, the fuse got short, that's all. And what caused that, then it becomes sort of speculative.

Q. And the fuse is getting short. You have no idea how

fast it is burning, do you?

A. No.

Q. Whether it's a child or adult?

A. Right.

Q. Now, there were some questions asked of you earlier on in Mr. Walsh's examination of you about the amount of slides and so forth that were sent to you; do you recall that area of testimony?

A. Just bring me back to speed on that a little bit.

Q. Well, I didn't really get it too well, but he was asking you, I think, if there was an indication of where the slides came from; do you recall that?

A. The microscopic slides you're speaking of now?

Q. Yes, sir, the slide.

A. Yeah, I looked at all that were provided to me, and tried to compare them with identifications in the autopsy report by Dr. Swalwell. And, as far as I can tell, there's none missing. I don't have anything that he didn't have. I got them from him, so --

Q. So are there two slides?

A. There are -- there are two slides taken of the dura. He mentions that. I went through my documents, and yes, there are two slides, but they're recuts from the same block.

Q. What does that mean, when you say it's two slides but they are recut from the same block?

A. If you have a piece of salami, you make one slice, then you make another one. And in this case the first slide that I looked at was stained with the standard red and blue dye called

HNE, that we all use.

And then there was a slide stain which I showed a picture of, for the iron that required a separate piece of tissue. But there was another cut from the same piece of block that contains tissue.

So there are two slides, but it's not two different slides, it's two cut from the same block, so to speak.

Q. Now, Doctor, one other area I wanted to clean up a little bit, is the -- how is aspiration connected to a head injury?

A. Well, if respiratory difficulty occurs, and symptoms are occurring because of rising intracranial pressure, then the child may vomit, which we know the child did, in which case inhalation of that vomitus can produce an aspiration pneumonia, and its own train of complications that can have an import on how the child does.

But it has to be connected with vomiting and lack of being able to cough stuff out. And if you're lethargic and half sleepy and vomiting, that can be a deadly scenario for inhaling what you've upchucked.

Q. And is that the sound that you were associating with that earlier wheezing and gasping kind of sounds?

A. Yeah, I'm not in the habit of being around when people are dying in this way, but various vocal sounds have been described from choking and coughing to gagging to wheezing, doing other sorts of things. So from that report I can't tell you what is particularly going on at the time other than that the kid is in respiratory distress.

Q. And the respiratory distress, could that be caused by altered loss of consciousness?

A. Yes.

Q. Preventing a child from clearing its airway?

A. That's part of it.

Q. That could cause the child to gasp for breath?

A. Yes.

Q. Could that lead to respiratory failure?

A. All this goes into the fact that the child was not able to perform the normal respiratory functions efficiently, whether it's due to obstructions, asthmatic bronchiospasm, aspiration, or some neurogenic reason why breathing is not working right. All of those things could be present.

Q. And that could stop a child from breathing; isn't that true?

A. Yes.

Q. Thank you.

MR. BROWN: I have nothing else. Thank you, sir. Thank you, Your Honor.

THE COURT: Thank you, Mr. Brown.

MR. BROWN: Thank you, Your Honor.

THE COURT: Mr. Walsh?

MR. WALSH: Just one second, Your Honor. I'll consult with "Dr. Ullrich."

(BRIEF PAUSE IN PROCEEDINGS.)

MR. WALSH: I do just have a couple questions, Your Honor.

THE COURT: Go ahead.

MR. WALSH: I thought long and hard about it.

RECROSS EXAMINATION

BY MR. WALSH:

Q. Your history includes the fact that witnesses who are around the child one hour before her arrest did not see any visible signs of injury, correct?

A. Say that again. I want to be sure I get --

Q. Certainly. Your history includes the fact that witnesses who were around the child approximately one hour before her arrest noted no visible injuries to her with the exception of one mark that has been related to --

A. That is my understanding, yes.

MR. BROWN: And I was going to interpose an objection, this assumes facts not in evidence, misstates the testimony.

THE COURT: Overruled. Answer stands. But the doctor said yes.

MR. WALSH: Thank you.

Q. (By Mr. Walsh:) And the chart that you've shown us about the increased intracranial pressure, well, how does that factor into your evaluation of the child, the fact that witnesses who saw her an hour before she went into arrest saw, at most, a raised area of swelling on her face and shortly thereafter she has what you've seen in these photos?

MR. BROWN: Misstates testimony.

THE COURT: Overruled; go ahead, Doctor.

THE WITNESS: You want me to correlate the bruising on the face with what? The increased intracranial pressure?

Q. (By Mr. Walsh:) No, I'm sorry. I asked the question

poorly.

The doctors who have testified previously in this trial opined that the hemorrhage, the subdural hemorrhaging that they observed in Kerianne's head, could have placed her into arrest very quickly. Would you agree that that's a possibility?

A. In this particular case, I don't think so. I mean, something has been there for a period of time. And maybe it ramped up at the time the child decompensated, maybe due to the car door, maybe due to something else, or nothing.

And an acute subdural hematoma can certainly kill somebody quickly, but generally those are a bigger amount. This all talks about something that was evolving and not just bang, at one time. I'd have to disagree with that interpretation.

Q. Okay. And that's based on your evaluation of the slides from -- as we sit here today, an unknown area of the brain?

A. Yes.

Q. Acknowledging that these slides will -- hematomas will differentiate different colors, and that's to be expected?

A. That's right.

Q. Even from multiple incidents?

A. Right.

Q. Okay. And the -- well, trying to formulate the right way to say this. Can you say with a reasonable degree of medical certainty that injuries sustained upon this child on February 4th were not the cause of her death?

MR. BROWN: Vague and ambiguous as to the term "injuries."

THE COURT: Do you understand the question, Doctor?

THE WITNESS: Yes.

THE COURT: Overruled. You can answer it, if you have an opinion.

THE WITNESS: That's presupposing that injuries did occur on February 4th, which they may have.

But whatever occurred on February 4th was placed on a preexisting condition that was evolving before that. So if -- I don't know what happened on February 4th ultimately.

Clearly there's been some recent bleeding, but did that occur on February 4th or the 3rd or some other time? So I can't answer that question a yes. I have to say I don't know.

Q. (By Mr. Walsh:) Okay. Thank you very much.

MR. WALSH: I have no other questions, Your Honor.

THE COURT: Thank you, Mr. Walsh.

Mr. Brown?

MR. BROWN: No; thank you, Your Honor.

THE WITNESS: Okay.

THE COURT: Doctor, have a good rest of the day.

THE WITNESS: Okay; thank you.

THE COURT: Thank you, sir.

THE WITNESS: I may be excused? Very well.

THE COURT: You are excused.

THE WITNESS: Good. Not that we don't love you madly.

THE COURT: Of course.

THE WITNESS: Okay.

THE COURT: Want to approach sidebar?

MR. BROWN: Please. Thank you, Your Honor.

THE COURT: Okay.

(A DISCUSSION WAS HELD AT SIDEBAR, OFF THE RECORD.)

THE COURT: I had a sidebar conference with counsel. There's a potential witness that the defendant wants to call. May be able to be here tomorrow, may not be.

So this is what we're going to do. I'm trying to make this as easy on all of you as possible.

I will tell you that we're very close to the end of the case. You will be hearing from some witnesses on Wednesday.

And then am I correct, Mr. Brown, then you may be resting at the end of Wednesday?

MR. BROWN: That's our plan, Your Honor, yes.

THE COURT: Okay. So we're well ahead of our January 28th schedule, when I told you that you would get the case.

I will tell you that next Monday is a holiday. Tuesday we're going to be dark, and Wednesday is a furlough day.

So the next day you will be back potentially is next Thursday. But anyway, tomorrow, this is what I would ask you to do. Defense counsel, as you know, has worked with witnesses with the People, and so don't hold it against them. Sometimes you don't know when people can come in.

If all of you could call my clerk -- she will give you the number, or my deputy will -- by 10:00 in the morning. I would say start at about 9:00 o'clock. So between 9:00 and 10:00, all of you call. Very quick call.

She will tell you whether to be here at 1:30 or not. So that's how I'm going to leave it, rather than bring all of

you here at 1:30 and make it a fifty-fifty bet, and then you just leave. I just don't want to do that to you. I'm just not comfortable with that.

And my clerk was the one that suggested it. And I think that's a great suggestion.

You can call her. You've got an hour. And she'll tell you.

Because defense counsel has told me -- and correct me if I'm wrong, Mr. Brown -- that you should know by this evening. Could be late, but you're going to know whether or not your witness is going to be able to testify at 1:30 tomorrow, correct?

MR. BROWN: I'm supposed to know between 8:00 and 11:00 this evening.

THE COURT: And then they will leave a message with my clerk. Then my clerk will know tomorrow morning.

If you're not going to be here tomorrow, we will be in session on Wednesday at 9:00 o'clock. So I'm just letting you know ahead of time, if I don't see you tomorrow, then I'll see you Wednesday at 9:00 o'clock.

So we're done for the day. You don't have any more witnesses; am I correct, Mr. Brown?

MR. BROWN: That's correct, Your Honor.

THE COURT: Okay. Remember the admonition. Please keep an open mind. Don't draw any conclusions about the case.

Please don't talk to anyone about the case. Don't read anything about the case.

But, again, we're very close to the end. And I

appreciate your patience. If I don't see you tomorrow, I'll see you Wednesday at 9:00 o'clock. Have a good evening.

All right. Court is adjourned.

(EVENING ADJOURNMENT.)

MURRIETA, CALIFORNIA; TUESDAY, JANUARY 12, 2010

BEFORE THE HONORABLE F. PAUL DICKERSON, III -- DEPARTMENT S304

(Outside the presence and hearing of the jury.)

THE COURT: SWF015286. Parties are present before the Court. Mr. Mickey's presence is waived. Outside the presence of the jury. Yes.

MR. WALSH: Hi.

THE COURT: Afternoon.

MR. WALSH: Afternoon. We have been talking. We think we can run through the evidence first and then we have discussion to have with the Court about potential stipulations to give to the jury.

THE COURT: Very good. All right.

People's 1, 2, 3, 4, 5, 6, 7, 8, 9 --

MR. BROWN: Objection. Cumulative. Doesn't show any more than what the photographs already show.

THE COURT: I'm showing the drawing of the home.

MR. WALSH: Yes. The floor plan of the downstairs.

THE COURT: That can have some probative value, the drawing of the home. I'll note your objection, though, Mr. Brown.

10?

MR. BROWN: Same.

MR. WALSH: Three-dimensional diagram of the living room and kitchen.

THE COURT: That was shown to the jury and used, so I'll admit that.

11?

MR. BROWN: Same objection.

THE COURT: For the same reasons, I'll allow that. Because, again, it was used. I believe there's probative value in it as well.

12?

MR. WALSH: We need 12. I think we agree it can be admitted, but for -- on the upper right-hand -- this is the Mark Rimmer report. Handwritten in the upper right-hand corner there is a reference to "recent broken arm." With that being redacted, I believe it can come in in its entirety.

Is that correct?

MR. BROWN: Yes.

THE COURT: 12 is modified. Sounds like parties have agreed to the modification. Mr. Walsh will take care of that.

MR. WALSH: I'll have to black it out once, then copy.

THE COURT: That's fine. Just go ahead and work with my clerk on that.

I'm not showing 13 was identified.

Madam Clerk, are you showing it was identified?

THE CLERK: No.

THE COURT: 14, 15, 16 --

MR. WALSH: I'm sorry, your Honor.

THE COURT: Yes?

MR. WALSH: Back to 13. I don't recall if I used it or not. I think they appear in a different photograph. I guess I can withdraw it, if it -- I didn't show it to a witness.

THE COURT: I'm not showing it. My clerk's not either. We try to keep track.

MR. WALSH: If I didn't show it to somebody, I don't get to use it, so --

THE COURT: 14, 15, 16, 17, 18, 19, 20. So, not hearing any objections, People's Exhibit 1 through 8 will be admitted; 9 through 11 are admitted over objection. 12 is admitted as modified. 14 is admitted and 15 through 20 are admitted at this time.

21, 22, 23 --

MR. BROWN: Excuse me.

THE COURT: Yes, sir.

MR. BROWN: 22, I have an objection to the death certificate.

THE COURT: To the death certificate?

MR. BROWN: I know it's a certified copy, but it is -- has legal conclusions on it, and it also has immediate cause of death on it, which is not testified to in this trial. It has uncorroborated legal conclusions, "assaulted by another," on this document. It has immediate cause of death, head and abdominal injuries. These are the very issues that are before the jury for them to decide. This is not for Dr. Swalwell to back door his opinions in front of the jury, to have his opinions, which he was not allowed to testify to in this courtroom, go in by way of certificate. I would object. We stipulate the child has passed, but the reason why she passed is the issue of this trial. This adds nothing.

THE COURT: Mr. Walsh?

MR. WALSH: I disagree. These are all opinions and information that Dr. Swalwell testified to. He testified that

it is his practice to prepare this document, includes these conclusions. This is part of his job and this is an official record. He is the person called upon to make a determination as to the cause of death. He did so. He stated his opinions and the basis for them while he was in court. I understand the defense disagrees with them, but this is what he does and this is how he does it. He did testify the cause of death was head and abdominal injury. He did testify he ruled it to be homicide, which is within his job duties and was based on the evidence that he found; so it's a matter -- what he's supposed to do and what he does, and this is what he made. This reflects his opinions and what he had to say here in court. I understand it's an area of contention for defense, but I believe this is an appropriate document to put in front of the jury.

THE COURT: I agree with that. The other cases I've had, had those, have been admitted. The doctor did testify to these conclusions.

MR. BROWN: He did not testify this was a homicide. He did not testify -- and I objected to that. You sustained my objection. He did not testify that she was assaulted by another. In fact, on cross-examination he said he couldn't tell whether or not the child had been assaulted or not. He couldn't even tell if the injuries were caused by the car door.

THE COURT: Go ahead and hand that to my deputy. Let me look at that.

I've taken a look at this.

I'll note your objection, Mr. Brown.

What I'm going to have Mr. Walsh do is I'm going to

admit the document, note your objection; but I am looking here at Number 124, "assaulted by another." I tend to agree with that. That is an issue for the jury. Obviously, Dr. Swalwell will testify to the cause of death. That will remain because he did testify, "Look, the child died from head and abdominal injuries."

MR. BROWN: I would object to it as being cumulative, because no party is entitled to have documents for an opinion put into evidence. It's cumulative. It's argumentative.

THE COURT: I don't think so. I'll note your objection. I'm going to allow that.

Because here, immediate cause, condition resulting in death, head and abdominal injuries. He testified. Because we had the autopsy photographs and pointing out the subdural hematomas, we talked about the lacerated liver, we talked about the adrenal gland. You had a chance to cross-examine him, and that's Dr. Swalwell's signature on the bottom; but I understand your point about the assault. It's a general nonmedical term that doesn't describe the cause of death, at least in Dr. Swalwell's opinion. So I don't think that really has any probative value and can be prejudicial. But as far as head and abdominal injuries, that's -- that's the whole case for the People, and, obviously, you're contesting that; although, I'm not really sure even that you're contesting that based on the doctor that testified yesterday.

It's almost like there was a prior undiagnosed head injury that was re-injured based on the head injury the child suffered, to wit, the head being hit in the car door. So,

whether it was blunt-force trauma that killed the child within a very short period of time of that occurring or whether or not it was blunt-force trauma by a car door that aggravated prior injuries, it's still head injuries that caused the child's death. We still have subdural hematomas that were pointed out in the pictures.

MR. BROWN: I understand. I appreciate you redacting that.

THE COURT: As far as the assault goes, I understand your point. That's argumentative. It doesn't really further anything, but I am going to allow the "head and abdominal injuries" to remain because he testified to that.

MR. BROWN: I didn't know, your Honor -- I don't know if it actually says "caused" or "conclusion" of homicide.

THE COURT: No. It just says, "Condition resulting in death, head and abdominal injuries."

MR. BROWN: If it doesn't say homicide, I want to make sure I look at that carefully, make sure homicide is not in there, because he was not allowed to testify to that in court. I don't want that in. I would have the same objection as to what you just sustained.

THE COURT: It does have "manner of death" box checked -- natural, accident, homicide, suicide, pending investigation, could not be determined. I'll note your objection; but I'm going to allow that because that's the charge. I mean --

MR. BROWN: But a charge --

THE COURT: Jury knows it's a --

MR. BROWN: There's one issue, if I can, Judge?

THE COURT: On that box; right?

MR. BROWN: Absolutely.

I mean, there's a difference between a charge of homicide, a murder, and then having an expert check a box saying "that's my conclusion" when you didn't allow it during his testimony.

THE COURT: Let me stop you there.

Mr. Walsh?

MR. WALSH: I think you did allow it during testimony. I remember going through that entire form with him when he testified. "Is this the form? How did you fill it out? At the bottom, are you asked to make a conclusion as to the type of death this was? You have choices. Which box did you check?"

"Homicide. Okay. Thank you."

This is the form showed to the jury. This is his job. Job is to look at persons who are deceased, to do an autopsy on them, and to find within one of those categories what type of death. Those are his choices. That's the one he selected based on the opinions he testified to in court, that within this time period, these injuries suffered would place a child into arrest, and the person who was with this child was the defendant. It was his conclusion that is when the injuries occurred; therefore, he ruled it a homicide. The bases for his opinions were testified to, and the box he checked was based on the opinions and information he provided to this jury; so I think it's appropriate.

THE COURT: I agree.

Mr. -- let me stop you there. I'm going to note your objection, but I agree with that. We had testimony it's blunt-force trauma. There were no intervening acts to cause the child's death. Child suffers massive bleeding in the head. The child dies. And Mr. Mickey was the only one with the child. And that was his conclusion. That's going to be the People's case. Obviously, you're going to be arguing that was not the cause of death, but it's a murder case. He had to check a box because he has to make a determination. That's what he testified to.

MR. BROWN: He didn't -- with due respect, your Honor, I don't think he testified it was a homicide. I remember that area of questioning. It was a cursory foundation for an official record. There wasn't a lot of boxes gone over with that. Whether or not this is a homicide is a legal conclusion. It has to be left to this jury.

THE COURT: I'll tell you, I couldn't agree with you more. The jury's going to have to make that determination. But they are going to be basing it on the evidence presented and then argued by Mr. Walsh. Mr. Walsh is not going to say -- because that is not going to carry any weight -- "Look at this document. The box is checked. Find him guilty of murder." He's going to have to show causation beyond a reasonable doubt to prove the first-degree murder charge or a lesser.

MR. BROWN: Under that theory, I could have had Dr. Leestma fill out a document and have him X a box on the bottom of it saying aggravation of preexisting condition, no homicide, and let my people go free, and argue, "Well, there's

this conclusion; therefore, I ought to be able to have the box he prepared in the orange form provided to the jury."

THE COURT: You're talking about the doctor yesterday?

MR. BROWN: Yes, sir.

THE COURT: The doctor testified yesterday, as I recall, he disagreed with the medical examiner's conclusion about the death being so quick after the blunt-force trauma.

MR. BROWN: I ought to be able to have his transcript and that portion of it put out and put in as an instruction and as evidence with a box next to it where he says, "I disagree with Dr. Swalwell, it wasn't this. This is what it was." That evens the playing field.

THE COURT: All right. Well, again, I'm going to note your objection, but I'm going to allow it.

But, Mr. Walsh?

MR. WALSH: Yes, your Honor.

THE COURT: You know what to cross out?

MR. SIMOWITZ: One other point?

THE COURT: Go ahead, Mr. Simowitz.

MR. SIMOWITZ: Same issue came up with Dr. Kuelbs. You wouldn't let her answer the question, "Is this child abuse," because you said that is a determination for the jury. That's an ultimate fact in this case. It's the same thing with Dr. Swalwell testifying to homicide. It was objected to, and you said, "Yeah, you can't ask that ultimate question." So it came up twice with two different doctors. You sustained it then, and now we're getting it back-doored in. It's not fair.

THE COURT: I disagree. I don't think it's being

back-doored. I think he testified to the cause of death. It was blunt-force trauma.

MR. BROWN: But homicide means at the hands of another human being.

THE COURT: Correct.

MR. SIMOWITZ: So, that wouldn't allow even Dr. Kuelbs to say this is child abuse. No, it was blunt-force trauma. So we're facing the same thing. The ultimate decision the jury has to decide, was this a homicide? Now, you've got a legally filed document that the County Recorder's Office -- with a stamp on it saying it's a homicide.

THE COURT: Right. But it's the opinion of the doctor, and you were able to cross-examine the doctor. He's the examiner, has to make a determination as to cause of death. That's what he testified to here.

MR. BROWN: Blunt-force trauma is what he testified to, not classification of it.

THE COURT: But unlawful blunt-force trauma by Mr. Mickey is the reason he's being charged. Again, I'm going to note your objection, but I'm going to allow that with the redaction of the assault.

MR. BROWN: Can I just -- I want to make sure I understand what the Court's saying on this. And the way for me to do that is to repeat what I'm saying. I don't have a problem with the document. That's an official document signed by Swalwell saying in his opinion blunt-force trauma is what happened because that is at issue.

THE COURT: Correct.

MR. BROWN: I have no worries about that because I did cross-examine him on that. Okay. I do have an issue -- you sustained the one on the assault by another. But now, if I understand you, you're going to allow this conclusion that it's a homicide to go in front of the jury. My point on this is that he wasn't allowed to say it was a homicide in front of the jury, just as Dr. Kuelbs is not allowed to testify it was child abuse. You sustained the objection, "assaulted by another." And you had a reasonable basis to do that. Yet, you're saying it's okay to have "homicide" go in. If you say assaulted by another is irrelevant, but you're going to allow it in as homicide -- homicide is by someone else. I mean, the child didn't kill himself (sic). It would have been suicide. So, there really -- the rulings -- I'm not trying to talk you out of the ruling you already sustained. I'm just saying they are very inconsistent to say I'm not going to allow "assaulted by another" to go back, but I'm going to say "killed by another" to go back.

THE COURT: You have a good point.

MR. BROWN: A charge is a charge. I have worries about the charge. He's going to be found innocent, guilty, or not guilty, but to allow that kind of inconsistency to go in front of a jury, I think that's what Mr. Simowitz is saying. It's not fair, and it ought not to be there, because that's an ultimate conclusion that goes to the jury, not for Swalwell to come to a decision on what he wasn't allowed to testify to in court. If he was, I could have gone over this thing in multiple different ways.

THE COURT: Hold on one second, Mr. Brown.

Mr. Walsh, want to be heard?

MR. WALSH: The medical examiner of the County is tasked with accepting dead bodies in unknown or suspicious circumstances. Doing their work, their pathology, to review the body, to do an autopsy, and to make their determination what it was that caused this person to die when that fact is unknown. One of the things they are asked to do at the end of that within their job qualifications, and what they are asked to do thousands of times per year in the County, is to decide, was this suicide, was this accident, was this natural causes, or does this fit into the category of homicide. This doctor, using the information that he had available to him at the time that he performed his autopsy, came to the conclusion this was categorized as a homicide. He came into court. He was presented that form. Asked what box he checked. He indicated the box "homicide." The rest of his direct was, "Why did you classify it as such? Give us your foundation for making that decision." He talked about the injuries, the significance of them, the results of them, his opinion as to when those injuries were inflicted and what they would have caused. At the end of his examination, albeit he was cross-examined quite well by Mr. Brown and, just as Dr. Leestma, did had to say many times, "as a medical expert, I can't say for sure how something happened," but his conclusion, based on his review of all the evidence, was it fit into the category of homicide. That's what he recorded on his form. As the Court correctly pointed out, there's a lot more to it than just me pointing to a box, saying the medical exam anywhere said so, so it must be true. This is

-- he recorded his opinion, noted it on an official record. It was lodged with the County as the type of death this was. That's all it is.

THE COURT: Okay. Again, I'm not going to change my ruling on this. I'm looking at CALCRIM 500. Box checked, it's homicide, and the jury's going to get this instruction, "Homicide is the killing of one human being by another." We have that before -- before the jury now because Mr. Mickey was with the child last. We have testimony that this doctor felt it was blunt-force trauma that killed the child. And, then, it goes on to say, "Murder and manslaughter are types of homicide. The defendant is charged with murder. Manslaughter is a lesser offense to murder." And then it talks about how a homicide can be lawful or unlawful. So, they are going to -- it's not just first-degree murder, first-/second-, manslaughter, but it states here the jury is going to make that determination; so I'm not worried they are going to take the medical form because he has to pick a cause of death. It's an official document. And then the jury's going to advocate their responsibility. They are going to have to make a determination whether it was first-degree murder. They are going to have to look at the premeditation instruction. Then they are going to have to decide whether or not they unanimously agree it's first-degree murder, or, then, if it's a lesser or below that or that the causation issue hasn't been met beyond a reasonable doubt. So I'm not worried that the jury is going to be confused, so I'm going to grant your request on the assault, but I'm going to leave the box, because the doctor did have to make that

determination.

Was that, Mr. Brown, was that People's 21?

MR. WALSH: 22, your Honor.

THE COURT: I'll note your objection to that. I'm going to allow it. It will be admitted.

23, 24 --

MR. BROWN: I do object to the investigative report. It's hearsay. It wasn't testified to. There's no foundation for it.

THE COURT: Is that Number 23, Mr. Brown?

MR. BROWN: It is, your Honor.

THE COURT: Mr. Walsh, I don't have that in front of me.

MR. WALSH: Well, 23 is the first four pages, says "Investigative Report," but it's really the whole thing. The first four pages are investigative report as provided to the medical examiner that came from an investigator. And then the latter, I don't know, probably sixteen pages, are the actual autopsy report itself. I don't imagine the jurors are really going to be able to read what all this stuff means, because I don't know what a lot of it means. So, I think that we can get rid of the first portion of it. However, the last three pages include the doctor's notations of injuries that he observed on the child by mechanism of diagram.

THE COURT: Did the doctor testify to those drawings? I don't recall that.

MR. WALSH: I did not show them to him. What -- I believe the questioning I conducted with him was, "These

injuries we looked at on these photographs, Doctor, are those recorded within your greater autopsy report." And he said, "Yes." I indicated on the charts in that report. I do know that I asked him about that because I was trying to lay the foundation for the report itself. The entirety probably doesn't need to come in, because it might be confusing for the jury to have all that medical information in front of them. But the last three pages that -- the last three pages of the document where he noted the injuries, I believe are significant, and they were also referred to by Dr. Leestma yesterday afternoon when he said he wasn't sure what the doctor's indication was on the rear right-hand portion of Kerianne's neck.

THE COURT: Those were the autopsy photographs?

MR. WALSH: He said he didn't recognize in the autopsy photo. I said, "Dr. Swalwell did note that in the autopsy it was a subdural hematoma in the report."

Yes. And Dr. Leestma acknowledged, yet Dr. Swalwell did note that in the report, so --

THE COURT: You're only requesting the last three pages, Mr. Walsh?

MR. WALSH: Yes, your Honor.

THE COURT: You want to be heard?

MR. BROWN: They were never published. They were never cross-examined on. Dr. Leestma never talked about them. They all were directed to photographs shown on the overhead. I don't think that's appropriate to show to the jury now, to let them extrapolate what they may or may not have been talking --

THE COURT: I tend to agree with that. I don't recall

anything about these diagrams at all being used. Just to talk about diagrams in a report is one thing, but to actually publish it. What I recall during the testimony is not these diagrams but the actual -- the autopsy photographs themselves, where I take it a, well -- C, B, H, B, C, D A -- those are just the markings for the bruises, right, and then underneath we have the subdural hematomas?

MR. WALSH: Yes. I think that's the next page.

THE COURT: Right. I think what you're going to have to use is the photographs. Those were cross-examined on but nothing about this.

MR. WALSH: Just of note, I think I accept the Court's ruling. I did refer the doctor to those as part of a greater document. I don't believe it's correct that Dr. Leestma did not see those, because he did testify he had the entirety of the autopsy report, and that was included in it. I know defense had these, because they showed them to me before I even saw them, so --

THE COURT: This is the doctor yesterday?

MR. WALSH: Yes.

THE COURT: I remember when you asked the doctor, "Well, wait a minute. What about this, the injury behind the head?" And, then, as I recall, you actually showed an autopsy photograph that shows an area that at least, if I recall, was bloodied or bruised.

MR. WALSH: There were two of them -- there were three photos I showed the doctor yesterday. One was at the front, one was at the rear, one was of the right-hand side of Kerianne's

head without the skin on it. There was a portion right by where the skin was folded where it was dark. And the doctor yesterday said, "You know, I can't tell if that was or not. It's dark in the fold of the skin."

I said, "Well, Dr. Swalwell did identify that in his autopsy report as a subdural, did he not?"

He said, "Yes, he did."

THE COURT: Correct.

MR. WALSH: But that could be in a written text of Dr. Swalwell's report. That's fine. We can move on. That's fine.

THE COURT: But I think the point was made, you were asking him about the finding, and he conceded that, and then you showed the picture.

MR. WALSH: Yes. That's fine.

THE COURT: Here you go, Deputy. Thank you.

All right. I agree. This should not be admitted. So, 23 is going to be out.

24?

THE CLERK: 23 is out?

THE COURT: Yes.

24, 25, 26, 27, 28, 29, 30.

MR. BROWN: Were these all published?

THE COURT: I'm showing they were, Mr. Brown.

MR. BROWN: I'm sorry.

MR. SIMOWITZ: 31, the next one, was not published.

THE COURT: I haven't gotten to that one yet, Mr. Simowitz.

THE COURT: 24, 25, 26, 27, 28, 29, 30, 33, 34, 35, 37, 38, 39, 40, 41, 42, 43, any objections to any of those?

Mr. Simowitz?

MR. SIMOWITZ: No, your Honor.

MR. WALSH: Your Honor, I'm sorry to interrupt. 37, we need to make one change to 37. I talked to Mr. Simowitz about this. This is the phone records of the Sprint cell phone. Mr. Simowitz and I agree only the last four pages of that should be given to the jury, because that's the only portion that pertains to the dates we're discussing in this case.

THE COURT: You have an agreement with Mr. Walsh on this?

MR. SIMOWITZ: Yes.

THE COURT: 37 will be admitted as modified.

Anything else, Mr. Walsh, on any of those exhibits?

MR. WALSH: No.

THE COURT: Then, the ones that I have listed, Madam Clerk, would be admitted. 37 as modified.

All right. 44, 45, 46, 47, 48, 49, 50, 51, 52, 53, 54, 56, 57, 58, 59, 60, 61, 62, 63, 64, 65, 66 67, 68, 69, 70, 71, 72.

Mr. Simowitz, any objections?

MR. SIMOWITZ: No.

THE COURT: Any modifications, Mr. Walsh, on any of those?

MR. WALSH: No. They were all fine.

MR. BROWN: Your Honor, I do on 59. I would restate my objections to the photograph, just because they were finding --

just because they are a finding at the home pursuant to a consensual search doesn't make them relevant in a murder trial. I think it overly prejudicial and 352, and they shouldn't be allowed. I stated this objection originally, and I would just restate the objection at this time.

THE COURT: Mr. Walsh?

MR. WALSH: I think we have already tilled this ground.

THE COURT: What's that?

MR. WALSH: I think we already tilled this ground. I thought we discussed this at the time it was introduced. I thought the Court ruled on this.

THE COURT: That's what I thought, too.

MR. BROWN: I just want the record clear I object to it now. Mr. Simowitz didn't voice an objection. I'm not waiving the objection I made earlier. I would restate it now for the record. I'd like that recorded as an official defense position. We object to 59.

THE COURT: All right. I'm going to note the defense's objection to 59. I'm going to admit that over their objection.

Anything else?

MR. BROWN: 60 through 64, computer-generated diagrams, I have the same objection.

THE COURT: Note your objections on 60 through 64. Those would be admitted.

Any others?

MR. BROWN: Not really, other than just the comment that 65 through 78, the photographs --

THE COURT: I haven't gotten to 78 yet. I'm only

going --

MR. BROWN: Through 72.

65 through 72 are all the same as defense's -- that's fine.

THE COURT: Anything else?

MR. BROWN: No, sir.

THE COURT: Madam Clerk, did you get all that?

THE CLERK: Yes, your Honor.

THE COURT: Very good. 73, 74, 75, 76, 77, 78, 80, 81, 82, 83, 84, 85, 86, 87, 88, 89, 90, 91, 92, 93, 94, 95, 96, 97, 98, 99, 100, 101, 101-A, 102, 102-A, 103.

Mr. Simowitz?

Mr. Brown?

MR. BROWN: I would object, your Honor, to Number 84, the abdominal diagram. It's not to scale. In fact, it's argumentative as to how Dr. Kuelbs drew in the adrenal gland. It is not to scale. It's not even of a child. It's got no probative value at all.

THE COURT: All right. Mr. Walsh?

MR. WALSH: You want me just to address 84 or --

THE COURT: Just address 84. It will be easier for my clerk and my reporter, then we will just go on to the next one.

MR. WALSH: I think it should come in. It's what Dr. Kuelbs used to demonstrate where certain things were located within the body. She qualified her answers by describing how it would be different within the child, but this was where she indicated for the jury where certain things were located; so I think it was part of her testimony. I think it gives context to

some of her testimony. I think it should be admitted, because she did reveal how it was different to the child, in what way it would have been.

THE COURT: I agree with that. It was demonstrative evidence. I don't think it was shown to be exact. It's just to show -- look where it's located in general. It's separate from the liver and there was injury to the organ.

I'll note your objection, Mr. Brown, but that will be admitted.

Mr. Brown, next one?

MR. BROWN: 94 through 100, your Honor, the Chevron surveillance photographs. There's no issue -- there's no issue that he bought a beer. There's no issue that he drank a beer. Photographs of somebody doing something that's not an issue is cumulative. It's 352 and ought not to be in front of the jury.

THE COURT: This is another one we discussed. I don't need to hear from you, Mr. Walsh. I'm going to admit those.

MR. BROWN: And, I'm sorry, your Honor. I didn't mean to interrupt you. Time is blocked off. I would restate objection for foundation on the timing.

THE COURT: Right. I'm going to admit those. I think they are probative, and the foundation was laid.

94 through 100 will be admitted.

Any others?

MR. BROWN: 101 through 102-A, I would just restate my objections that I made on the record earlier. I understand the ruling, but I don't want the transcript to reflect I waived those. I'll restate them now.

THE COURT: Okay. I'll note you reserved all your objections. I'll admit those. We did discuss those; but for purposes of any appeal, you're objecting?

MR. BROWN: On Number 103, Dr. Murillo's physician notes, those are irrelevant. They've got no basis.

MR. SIMOWITZ: We discussed that.

THE COURT: Mr. Walsh, you're not moving those in?

MR. WALSH: (Nods head.)

THE COURT: All right. 73 through 76 are admitted.

77 through -- I'm sorry. 77, 78 are admitted.

And 80 through 102 are admitted, and noting the objections we have already discussed.

MR. WALSH: Your Honor, we need two corrections within there, maybe three. 78 should refer to photograph of ice cube. That's what it actually was.

THE COURT: Photograph of ice cube. Okay.

MR. WALSH: Yes, your Honor. 79. I did not show.

THE COURT: That's why I didn't list it.

MR. WALSH: 80 should be described as photo of bed with ice cube.

THE COURT: We have that, Madam Clerk?

THE CLERK: Yes.

THE COURT: Photo of bed with ice cube?

MR. WALSH: Yes, your Honor.

THE CLERK: First one was 78; correct.

THE COURT: 78 was ice cube.

THE CLERK: Okay.

MR. WALSH: Finally, on People's 93, this was the

coagulation studies that were done at Children's Hospital. Only the bottom half of this page was referred to or shown to the jury, so I think myself and Mr. Simowitz agree we'd like to present this to the jury, but only the latter half. The page, the title "Children's Hospital" should remain, but the only medical information that should be contained on it when it goes back to the jury is the coagulation studies we have referred to during the case; is that correct, Mr. Simowitz?

MR. SIMOWITZ: That's correct.

MR. BROWN: I would agree with that right now. I don't know if this is going to be used tomorrow or not.

I would just ask the Court to reserve on this. I don't know if it's -- the upper half is going to necessarily be used tomorrow or --

THE COURT: Mr. Brown, I'm going to ask you -- you to keep track of 93 only, and I'll reserve on that, whether it's going to come in in unmodified or modified.

MR. BROWN: Thank you.

THE COURT: Okay.

Anything else, Mr. Walsh?

MR. WALSH: No.

THE COURT: Tell me when you're ready.

MR. WALSH: Thank you. I'm ready.

THE COURT: Okay. 104, 104-A, 105, 106, 107, 107-A, 108, 108-A, 109, 109-A, 110, 110-A, 111, 112, 112-A, 113, 113-A, 114, 115. I'm going to note, Mr. Brown, your objections on all the interviews.

Am I correct?

MR. BROWN: Yes, your Honor. Interviews and accompanying transcripts and the CDs themselves.

THE COURT: Of course. We have discussed those. I'll note you're reserving on all those.

MR. BROWN: We have. Thank you.

THE COURT: That will cover 104, 104-A, 107, 107-A, 108, 108-A, 109, 110, 110-A, 111, 112-A, 113, 113-A. Those will be admitted over objection.

Any objections on any of the others, Mr. Brown?

Or Mr. Simowitz?

MR. BROWN: Not from my view.

MR. SIMOWITZ: No, your Honor.

THE COURT: Those would be -- the rest would be admitted. 116, 117, 118, 119, 120, 121, 122, 122-A. Same objections are preserved for the record. I'll admit those over objections.

Any objections 116 through 121?

MR. BROWN: Not really.

THE COURT: Mr. Simowitz?

MR. SIMOWITZ: No.

THE COURT: Those will be admitted. That's all I have for the exhibits.

Madam Clerk, did you get all that?

THE CLERK: Yes.

THE COURT: I understand there are other issues.

You wanted to address a stipulation, Mr. Walsh?

MR. WALSH: Yes.

THE COURT: Okay.

MR. WALSH: Sorry. Just a second.

THE COURT: Take your time. While you're doing that, Mr. Walsh.

Mr. Brown, then, are you planning on resting tomorrow?

MR. BROWN: I am. They are going to talk to you about a tape and talk about a stipulation to get around it, and I have -- I'd like to rest tomorrow. I've got three federal hearings on Thursday that I've got nobody to cover; so I'm doing the best I can.

THE COURT: Your plan, then, it looks like you're going to be resting tomorrow.

MR. BROWN: That's my goal. Yes, sir.

THE COURT: Mr. Walsh, are you going to call rebuttal witnesses?

MR. WALSH: At this point, no.

THE COURT: Very good. What we would do if it -- if both sides can have your instructions to me tomorrow, because I do the instructions. I don't require Mr. Walsh to do that. But I need to know what you're requesting, then I would be working on those on Thursday. Because, sounds like we're not going to be in session, and then what would happen is next Thursday you would all be here, and that's when we will actually go over the instructions. And, then, Thursday, we will get both sides finished copies; so then you'll have the weekend to work on your closings, which we will have on Monday.

MR. BROWN: The 25th. I can't -- I can't comply, your Honor, with the jury instructions by tomorrow morning. I don't have any of those books with me here. I've got to tend to

witnesses tomorrow morning that I have to prepare for tonight.

THE COURT: How about Mr. Simowitz?

MR. BROWN: He's going to be helping on some of that, I hope. But the books I have of the jury instructions are not here. They are in San Diego.

THE COURT: Do you have any special instructions that you can think of that you want?

MR. BROWN: I do. I've been talking to Mr. Simowitz about those. Maybe we can address those tonight and get those to you tomorrow. As far as -- standard ones are pretty much going to be the standard.

THE COURT: Mr. Walsh, will you be able to get a copy of yours?

MR. WALSH: I can give the Court that checklist of what I'm requesting. Is that what the Court's asking for?

THE COURT: Yes.

MR. WALSH: I can give it to you tomorrow. Can I give it to you by close of evidence tomorrow? Is that all right?

THE COURT: Yeah. That's fine. Because I'll have all day on Thursday to do it.

MR. WALSH: Actually, I can probably have it for you tomorrow morning. Doesn't take long to check the boxes.

THE COURT: I want to make sure you look at everything. If you want to do it by close -- because we're going to be in session, obviously. I won't be working on it, but I would like to have it by tomorrow afternoon.

MR. WALSH: Sure.

THE COURT: All right. Are you ready?

MR. WALSH: Yes.

THE COURT: Okay.

MR. WALSH: We have -- there is one stipulation that the People prepared that we still would like to have read that I think I got through part of it in front of the jury, but we will finish that whenever its convenient tomorrow. That is about the drug results. I talked with defense counsel. I made one change to that, which specifies the time at which the blood was drawn was approximately 7:00 p.m. So, I guess maybe at the close of defense's case, we can read all these together perhaps.

THE COURT: That's fine. My suggestion, Mr. Walsh, you've been reading them. We might as well just stay with that. Defense counsel will let you know when to read it. You can tell the jury what you've been telling them. This is a stipulation between counsel, and then you can just read it.

MR. WALSH: Okay.

MR. BROWN: I'm sorry to interrupt you. On the stipulations relating to the drug results, I maintain our objection that they are irrelevant and that drug results ought not to be in front of the jury. However, we are stipulating that to save the People time and witnesses that we can go ahead and read these things.

So, what I would like, if you don't mind, your Honor, I would like you to rule on -- present your ruling as to whether or not you believe those things are actually admissible or not, and then we can go forward with the reading of them.

THE COURT: I believe they are admissible. I think we already discussed this. They are probative in the case. We

have discussed alcohol throughout the trial, and I think it goes to Mr. Mickey's veracity. And there's been some discussion about how he acts when he's drinking, so I think they are -- it's highly relevant. I'll note your objection it should be excluded entirely, but I appreciate the fact you're joining in a stipulation. But, for the record, so it's clear, you're objecting to them being admitted at all and have been.

MR. BROWN: Yes, your Honor.

THE COURT: I think you stated that initially in this -- one of the 402s.

MR. BROWN: Character and all the other objections that we raised, but I do want fewer witnesses at this point in time for those kind of procedural things.

THE COURT: You mean you don't want to be here for the next month?

MR. BROWN: I enjoyed my time here immensely, but we don't need to have witnesses come lay foundation for things of that nature.

THE COURT: I agree.

Next one, Mr. Walsh?

MR. WALSH: We have a list of phone numbers and what they correspond to. Mr. Simowitz is going to add one phone number to that. It's about twelve phone numbers. So I think we will just -- I don't know how beneficial it would be to actually read it off to the jury, or maybe I can just say we have got a log for you or a table for you of what phone numbers and what they correspond to.

THE COURT: I'll tell you what. I'll let you work with

Mr. Simowitz on that. I don't have a problem with you putting it up there, saying this is a stipulation, this is the log. If Mr. Simowitz feels it's more conducive to read it, then you can read that. I'll leave that to you.

Next one.

MR. WALSH: We have a stipulation about Detective Schnoor, what he would say if he was called back to testify. The defense has been able to excerpt a couple photos from the videotaped interview between Detective Schnoor and the defendant, and I guess they put their hands up against each other. They were stating that if Detective Schnoor was to come back, he would testify those were photographs of that interview. I'm fine with that. I'm happy to read that to the jury.

THE COURT: Very good.

MR. WALSH: I've shown defense counsel a stipulation in regards to what Detective Failde might testify to, F-a-i-l-d-e, if he was recalled from Texas about his interview with Kristy Martin. He did two interviews with her. We made one corrections and I understand Mr. Brown is fine with that; so we will be reading that.

There's a stipulation that was authored by defense in regards to what Mr. Plumley's testimony was -- if Detective Failde was called to return to talk about his conversation with Jesse Plumley, what he would say. I'm fine with that.

There's a stipulation about some of the phone calls made between the cell phone, the Sprint phone, and 911 and phone calls that came to that phone. I believe Mr. Simowitz has two corrections to make to that, and then we will be reading that.

We have a stipulation as to what will be testified to if a technical-support person from the Samsung Company were called to testify, how that phone works. I've agreed to read that as well.

And, then, I think the only other area of controversy we have as far as stipulations go is the defense -- and I think this came up earlier this week or last week. There are jail recordings that took place, a number of them, that the defendant is on the phone talking. One of these phone calls took place February 5th in the early morning hours, approximately 6:45 in the morning, between the defendant and Rosan Mickey. During this conversation, a number of topics are discussed. I listened to the phone call today. It's about nine minutes. On the phone call, it begins with Mr. Mickey talking about the fact that he's going to get out. He's not going to be charged. He begins listing some of the injuries that he has heard that Kerianne sustained. Some are correct; some are not.

What the defense wants to introduce is a statement by Rosan Mickey that she tells Ryan some of the things she told police. And she tells Ryan that, "I didn't tell police about something," and that something is that when Kerianne came over to the house on the 3rd. I think the statement the defense is particularly concerned with was that she came into the backyard and laid down on the concrete. That was kind of presented both as a consistent and inconsistent statement during the trial.

The defense wants a stipulation to simply that bit of information within the phone call. I would be objecting to that. The entire context of this phone call, especially the

minutes around this statement, include discussion between the defendant and his mother about the fact that the car door is not responsible for this, the fact that neither of them saw any injuries on her face. And Rosan does say something about everything except for that thing on her face.

The defendant says, "I didn't see anything."

She says, "I didn't see anything."

So, I think it's ripe for problems. We're presented with a conversation that took place between a mother and son in a jail phone call. The conversation is dependent on hearsay statements, self-serving hearsay statements by the defendant and his mother's response to those. So I'm disagreeable to this coming in in the way it's been formed.

THE COURT: How do you want it to come in?

MR. WALSH: One last fact, if I can just complete this. This recording, this phone call, took place in February at 6:45 in the morning. These phone calls were not received or garnered by the police until February 16th, approximately ten days later. And I think the questioning suggested that the police had access to a bit of information during the time they were conducting their investigation that they've not said they had, but it's debatable whether they had it or not. Again, I think it's an unreliable statement. I don't know how it should come in, but this is kind of a thorny bit of information in the context in which it was acquired.

THE COURT: Do you have a copy of the stipulation?

MR. WALSH: I have the copy of the stipulation I've written all over, yeah.

MR. SIMOWITZ: I have a clean one.

THE COURT: Mr. Simowitz, let me see yours, because this is the one you want read; am I right?

MR. SIMOWITZ: Yes.

THE COURT: Mr. Simowitz, do you want to be heard?

MR. SIMOWITZ: Yes, your Honor.

That statement was made close in time to the incident. It's a prior consistent statement. Later on that day, she calls Detective Ullrich, and he then paraphrases in his report that "she told me she sat down outside." Here's the exact quote that she later testified to at the preliminary hearing that was read into -- and because of the timing, 6:48 in the morning, the day after the event, it's showing not making up this statement, you know, which is kind of what I think has been intimated here. That's an afterthought. Well, no, it's right here close in time, so it's prior consistent statement made earlier in time to the preliminary testimony. I think that's why it should come in.

THE COURT: All right.

Well, this seems like this statement's taken, then, in a vacuum. I don't know if it's a prior consistent statement when someone says, "Remember, I told you." He would have to get on the stand and testify as to what she told him about what she was saying. That's how the prior consistent statement would work, not what she's reminding him of what she said. So it's not a prior consistent statement. Because she says -- this is in your stipulation, remember. "I told you she was kind of having a little fit when Jennifer dropped her off, but I didn't

say she was having a fit to the police." I said, "Well, she was crying. She was upset that her mother was leaving. I thought that was a good thing." That's a question of fact for the jury to decide, because we have had police officers testify about what she did or did not say in recordings. So, what this is is trying to remind somebody of what she said to them and then what she told the police, so I don't --

MR. SIMOWITZ: I think at the end she says, "I didn't tell them that she laid down." If we can just chop that portion out, perhaps, and that last portion and statement where she says, "I didn't tell them that. She didn't lie down."

THE COURT: The way this is phrased, it seems to me she's trying to tell him, "This is what I remember saying." I don't think this fits within the -- both sides have gone back and forth in terms of whether or not she said that at or near the time of the occurrence. It's a question of fact, but the conversation she's having with her son, and then you take just one phrase --

MR. SIMOWITZ: But the second portion of that is that the police did have that. They had it on February 16th. They could have listened to the tapes that corroborate that she said that, and all we're left with is that afternoon Detective Ullrich paraphrases that she sat down on the sidewalk; so, you know, that's the inference you're getting, that she never said "laid down on the cement," and here they had that information on February 16th. That's still early enough in this investigation.

THE COURT: She got on the stand and said the child laid down on the cement. Mr. Brown, I don't know how many

times, mentioned it. The doctors, the detectives have mentioned it. The only question here is whether or not -- is a question of fact, is whether or not she made that up subsequent to him being arrested to try to support some kind of an argument.

This is what I'm thinking. Some is kind of argument that the child had a preexisting injury that was aggravated because of the car door, but she's testified to that happening and that it was close in time and that -- I don't think this --

Go ahead.

MR. SIMOWITZ: But he pulled out from her prelim transcript that "you hadn't mentioned this earlier about laying down in the cement." And she has, and it was paraphrased by Detective Ullrich; and that's where it gets to be a problem, because he's paraphrasing not recording.

Here, we have a statement that the police have access to that she made that statement, and he wasn't arrested at this time. He wasn't arrested until later that evening. So, the time she's talking to him, he's not under arrest for the murder charge. He was on old -- on a warrant is why the call was recorded; so, he's not under arrest. She's got no reason -- in fact, he says at the beginning of the tape, "They are letting me out," which they were. They were posting his bail, and she wasn't saying out of motive. She's saying, you know, "I didn't tell them about laying down," so it comes, you know, soon after the event occurred before he's arrested.

THE COURT: But the detectives already testified to this. Paraphrased, but the child, you know, she sat the child down and just laid there and just went to sleep.

Am I missing that, Mr. Walsh?

MR. WALSH: No.

MR. SIMOWITZ: That's not what the detective, the paraphrase --

THE COURT: Go ahead, Mr. Walsh.

MR. WALSH: So, our time line is she gives one statement at the house right when the child's being taken away. She gives a statement at the station to Detective Ullrich on the 4th, and then she has a phone interview with Detective Ullrich -- or he's asked by Sergeant Ganley to call her back and receive more information. That interview is not recorded. The detective summarized in his police report -- words he used to summarize were "sat down." She -- I understand what defense is saying.

In the interim, she has a conversation with her son where she says, "I didn't tell the police this, but remember when I told you that she laid down and went to sleep on the concrete." Now, this statement that she's making to her son doesn't change anything about what she said to Detective Ullrich during that phone conversation. The jury's free to believe Detective Ullrich, whether he paraphrased correctly or not. But even if this statement is admitted, it doesn't change what she said to Detective Ullrich. And the only testimony about that is her recollection of the conversation and Detective Ullrich's recollection of the conversation. The jurors have to make a decision about that.

This doesn't change anything that was said to any of the police officers or anything that she said during the

preliminary hearing. This is one statement of her with her son over the phone, while he's arrested, while he's in custody, so I don't -- I don't see how this speaks to any of those other statements.

THE COURT: Let me ask you this. It sounds like you're not -- are you not objecting, then, with the last statement? What she's saying, trying to remind him of what she said is not a consistent or inconsistent statement. But the last statement is, "But the funny thing is, as soon as Jennifer left, she was still acting like -- pushing her back, you know, how she was throwing herself back. I brought her outside. She just laid down on the cement and got real still." Are you objecting to just the last part? A stipulation -- and then saying, "I brought her outside, and she just laid down on the cement and got real still," and then what you would do is put down the date of the conversation and that it was a phone call between herself and her son that was recorded in the jail? Doesn't sound like you're objecting to that.

MR. WALSH: I am.

THE COURT: You are.

MR. WALSH: My first problem with this is the context in which it occurs. It's fraught with peril, in that the conversation before this paragraph, the conversation after this paragraph, are all items of evidence that would never be introduced but are in exact contradiction to this or that are -- this is a full conversation about where he's -- he says things, she says things that are consistent and inconsistent with her testimony. He says things that are consistent and inconsistent

with his statements to the police, and this is made in the context of a mother and a son talking while he's in custody in relation to what happened to this child. That's how he comes into the police hands.

She says, "Remember these things that happened, and I didn't tell police those things."

And then immediately following this, he says, "Well, that's because you're trying to protect yourself; right?"

She says, "No, I'm not trying to protect myself."

Then they continue on another -- I'm not going to go into the rest of the conversation, but it's back and forth with things that are true to what we saw here in court and not true to what we saw here in court. My problem, the greatest problem with it is the context.

Second of all, it speaks to nothing of the issues we have had here. She's saying, "Here are things I didn't tell the police." Then we have her saying what she told the police before and after this conversation. You have Detective Ullrich saying what she said before and after the conversation. Only things relevant to this jury are what she said to people when she was interviewed and what she said here in court. We have all that.

THE COURT: Sounded to me initially maybe you weren't objecting.

MR. WALSH: I am.

THE COURT: And I agree with that. First -- and I've said this before, Mr. Simowitz, the Court is suspicious of the context in which these statements are being made because they

are between the mother and the son, and no one is there when the child is injured and no one except the mother and the son are there when the car door hits the child.

Now, there's some corroborating evidence, but I just -- when the defendant and the mother are talking, and it's a jailhouse interview, and then she's saying or reminding her son of what happened, and then saying, "Oh, this is what I forgot to tell the police," that's not a prior consistent statement or inconsistent statement. The consistent or inconsistent statement is -- Mr. Walsh is correct. It's what was said, not what she forgot to, and then saying, "Oh, this is a consistent statement," because she's telling her son, the defendant, that she forgot to tell the detective this, when, in fact, she did tell the detective that about going out, sitting down, falling asleep. At least that's what I recall.

I'll note your request, specifically that you want all this in, but I'm not going to allow it.

MR. BROWN: Could I have just one quick comment on it?

THE COURT: Yes, sir.

MR. BROWN: I think that the Evidence Code prior consistent statement applies in this particular matter because Mrs. Rosan Mickey talked to Detective Ullrich on the phone and said the child went outside, put it's head down on the patio, and that was the end of it. Detective Ullrich chose to paraphrase it, instead of recording it, or recording it accurately. Prior consistent statement is what she said to her son on the telephone, which corroborates what she said earlier. Rules of Evidence don't require her to have made that same

statement to any detective in a formal or informal or Mirandized or non-Mirandized statement. It could have been made to Joe at the hot dog stand. That's a prior consistent statement which corroborates what she told Detective Ullrich on February 5th. The People are disputing that she said that.

THE COURT: Yes, I agree.

MR. BROWN: And that's what --

THE COURT: I think they are disputing that that happened.

MR. BROWN: Well, that's fine. I'm disputing that it's a homicide and you allowed evidence from the guy checking the box.

THE COURT: I understand. I'm just agreeing there are certain facts disputed. That's one of them.

MR. BROWN: The point of it is that's what prior consistent statements are. They don't have to be said to the police. They don't have to be said to anybody. It's that she made the statement on February 5th. The People are challenging that, and there's a consistent statement earlier. That's prior consistent statement. If that wasn't the Rules of Evidence, then none of these tapes, I would suspect, would ever have gotten in, admitted into evidence over our objection.

MR. WALSH: If Mr. Mickey would like to come in and testify as to his mother's consistent statement, he's welcome to.

MR. BROWN: The consistent statement -- I appreciate that, too. The consistent statement is Rosan Mickey saying that on February -- on February 5th or 4th before she told it to

Detective Ullrich.

THE COURT: Well, I guess I disagree with both of you. This is the absence of the statement. This is not a consistent or inconsistent statement. She's saying, "This is what I forgot to tell the officer." That's not an -- even if he got on the stand to testify to that, I don't think I would allow it, because I don't know if it's consistent or inconsistent when somebody says, "You know what, I forgot to tell somebody ...." What matters is what they actually told somebody. And the detectives already testified she did say that the child went outside, sat down, was lethargic, or went to sleep. I think you're both wrong.

All right. I'm going to note your objection, but I'm not going to allow it. All right.

MR. BROWN: Are we done?

MR. WALSH: No.

THE COURT: We are.

MR. WALSH: Well --

THE COURT: I think.

MR. WALSH: There's another issue.

THE COURT: That's fine. We have plenty of time. It's only 4:05.

Isn't that right, Mr. Brown?

He's, like, "I've got to get out of here."

MR. BROWN: I vote for you. We're done. We're out of here. It is okay.

THE COURT: Okay.

MR. WALSH: Since the beginning of trial, there's been

an area of contention. We spent a grea
about the phone calls to 911 at or abou
went into arrest. The Court has already
defendant's statements on the 911 call a
tape has not been played. The defendant
expressing to the jury Mr. Mickey's level
excitement, freak-outedness, franticness, and I
believe that Mr. Brown and I this afternoon in the time you gave us came to an agreement that we're going to craft a stipulation using the words that were used by the 911 dispatcher to describe Mr. Mickey's demeanor while speaking.

Is that right?

MR. BROWN: Everything he said is right with -- my added thought to it was we could -- because there's some issue -- only issue is how do you really describe how they would suggest his tone was on the phone. I agree with Mr. Walsh that it's this far past, with all the 911 panic calls, they are unlikely to remember this one exactly. So, we can either craft a stipulation and kind of hone in some words we can agree to or just play that one portion of the tape where they are -- Mr. Mickey's not on, but the 911 people are talking back and forth to each other, and they do say he's panicked. "I got a guy on the phone panicked, freaking out," and --

THE COURT: Just put that in a stipulation.

MR. BROWN: "Child's not breathing."

THE COURT: It's already in front the jury when first responders arrived, he was frantic. He was. I don't think -- that hasn't been in dispute, except there were a couple of

statements where they thought he was acting in an unusual manner. But what we have here is a child not breathing. They arrive and they immediately try to resuscitate the child. What people can remember is he was a little odd, he was frantic, but it was chaos, so I think you can stipulate to that.

MR. BROWN: I do. I'm not suggesting that we can't. The only point I'm making is that sometimes when you enter into a word stipulation where either I or Mr. Walsh read it, we read it with no tone to it at all, just put it into evidence. First is actually hearing the 911 operator talking to another 911. We get intonations of the voice. "This guy is freaking." If we can play it, that would be the preferred method.

THE COURT: I don't have a problem with playing the tape. My ruling still remains what he actually said is not going to be admitted, but if you, based on what Mr. Walsh is saying, sounds like you made this agreement, then, go ahead and play the tape. Let the 911 -- let the testimony come in with what the 911 operators are saying so they can describe his tone of voice, and then if you -- but I'm not really sure how probative that is. You know, whether or not the 911 operator is agitated because of what's going on. What matters is, at least for your case, what his state of mind was at the time, not what the 911 operator sounds like.

MR. BROWN: The 911 operator is describing, their words that they use. That's all I'm saying.

THE COURT: Just use their words and put it in a stipulation.

MR. SIMOWITZ: This one tape doesn't have Mr. Mickey on

it at all. It's just a conversation between two or three dispatch people, and they are talking about "he's freaking out." They are talking about -- they are trying to give him information how to do CPR, so --

THE COURT: Mr. Walsh?

MR. WALSH: We're changing topics again.

Okay. Mr. Brown and I talked about getting Mr. Mickey's demeanor in front of the jury by way of stipulation. I'm fine with that. If now we're talking about one tape, that is the defendant calling and screaming, "My baby's not breathing," all these sorts of things, I'm not playing that for the jury.

THE COURT: I've already made my ruling.

MR. WALSH: Right. That would leave us with the recording of dispatchers speaking to each other.

"Hi, this is CHP."

"Hi, this is the Fire Department."

THE REPORTER: Counsel.

THE COURT: Don't irritate my reporter.

MR. WALSH: I don't want to. I think you hear Mr. Brown agreeing.

THE COURT: I'll tell you what. Try to reach a stipulation, Mr. Walsh, on describing it.

MR. WALSH: The reason we're pressing on it today is we're trying to alleviate the need to bring in CHP personnel, who took these phone calls, who won't come in unless they receive a subpoena. They usually demand five days for that. We're trying to avoid that situation. I'm trying to avoid it

while working together with counsel here. I think we're really close.

THE COURT: Good. I have a feeling that you're going to be able to reach a stipulation.

MR. WALSH: Now, there's a secondary issue having to do with the 911 calls that Mr. Simowitz was beginning to discuss. I'm prepared to talk about that, but prefer we deal with one issue at a time.

THE COURT: We have taken care of the demeanor issue.

MR. WALSH: Looks like Mr. Brown is beginning to write it right now.

MR. BROWN: I'm circling the buzz words.

THE COURT: I'll let you do that. It sounds like you're close enough to be able to give and take.

Next issue.

MR. WALSH: I won't read another transcript.

The second issue is Mr. Simowitz brought to my attention I'm aware of the fact that there is radio traffic between three different agencies that got involved in the dispatching of this case, which Sergeant Ganley already testified to -- CHP, CDF, and Murrieta Fire. And there are phone calls between them with each other where they are describing to each other to try to find this house. There was a lot of difficulty in finding this house.

Throughout that conversation, there's reference from one dispatcher to another, "We're trying to give him instructions on CPR, but his phone keeps cutting out. We can't even do that."

There's another reference to looks like they are close to the house. "We have a description of the cars out in front of the house. We're going to try to walk him through CPR," and that's as far as these conversations go.

They tell each other, "We're going to try to give him instructions on CPR," but they are -- and to this point neither of us have heard on these tapes an instance in which a dispatcher gives instruction to Mr. Mickey on how to perform CPR. I believe Mr. Simowitz would like to put in front of the jury by way of playing the recording or by way of transcript somehow the fact that dispatchers were discussing with each other what they intended to do by way of instruction to the defendant.

I would object to that because we have no information from any witness at this point and no documentary information or recording which demonstrates they were ever able to give these instructions to the defendant. That's where we are.

THE COURT: Mr. Simowitz, do you want to be heard?

MR. SIMOWITZ: That's not what I'm saying.

THE COURT: What are you saying?

MR. SIMOWITZ: What -- I want the two transcripts we have right now, take everything out about Mr. Mickey, and let's just listen to the conversations between the people, one another talking about, "We're trying to give him CPR information. We're trying to find the house." These two transcripts, they are real, real short.

There's a third one that just came to light that hasn't been transcribed. We were going to all go listen to it and see

if there's anything in there that we can see what's relevant and put together.

But as far as the two that we have right here, I see no reason why those just shouldn't be played in their entirety after Mr. Mickey gets cut off the line.

THE COURT: What's the probative value of emergency dispatch communicating with one another how they want to tell Mr. Mickey how to give CPR if Mr. Mickey's not on the phone?

MR. SIMOWITZ: They are saying that -- it goes to the whole --

MR. BROWN: It's corroborative of everything we already put in. I agree with Mr. Walsh there's no direct contact with Mr. Mickey about instructions with CPR. It doesn't exist on any tape I've heard. But I think what Mr. Simowitz is trying to suggest to the Court is that there's been a lot of testimony about phones breaking down, reception is bad, that he's frantic, he's freaking out. And these 911 operators are talking about that on the phone. "He's freaking out. The baby's not breathing." He doesn't know -- he's trying to find out where he is. The phone lines keep dropping and such, and there's only one reference on this here. "We're trying to get him CPR."

I agree with Mr. Walsh there's no corroboration they ever did give him CPR. I think that's what Mr. Simowitz is trying to suggest.

THE COURT: I'll admit it on that basis. I do agree with that. I do agree with that, that it's corroborative of the testimony that's been given to the jury, the trier of fact, the phones were cutting out. That's fine.

MR. BROWN: Okay. So, if I understand Mr. Walsh correctly, he would object to the one line saying, "We're trying to get him CPR on the phone"?

MR. SIMOWITZ: I'm sorry.

MR. BROWN: Let Jess make his point.

MR. SIMOWITZ: We already have in evidence the Murrieta report said, "We're walking him through CPR."

THE COURT: Tell you what, because now actually I'm going to have to deal with Mr. Walsh, and now you are arguing with each other, so now I --

MR. BROWN: I just want to get to the point is all I'm saying.

THE COURT: That needs to be deleted because it's not probative of anything, that they intended to give him instructions on CPR. I don't think it's probative of anything. It's excluded, but it can be probative of evidence that's before the jury about the phone cutting out. Jennifer Bradley testified to that, that it was hard to get a connection. So if you want to use it for that purpose, I'll admit it for that purpose.

MR. BROWN: Thank you.

THE COURT: And, then, just if you want to reach a stipulation with Mr. Walsh on that, because that is corroborative, and I think it's admissible.

MR. BROWN: Thank you. So I'll ask, then, I'll share this with Mr. Walsh. I redacted the one sentence relating to CPR. The rest is related to what I suggested.

THE COURT: Okay. Mr. Walsh, anything else?

I want you to hurry. I'll tell you why. Now they are disagreeing with one another. At some point, I don't know who to turn to. Actually, today, only twenty percent of the time I think you've jumped in -- or you jumped in. It may be tension in the defense.

MR. BROWN: We just need Curly here. We've got Larry and Moe and Curly. We're good.

It's just that sometimes I think that, at least from my perspective, I don't want to spend too much time on an issue we don't want to spend time on.

THE COURT: Mr. Walsh?

MR. WALSH: Only goal I have from this conversation was trying to figure out if we're going to need to call witnesses or not. What I'm getting from this conversation, just trying to be clear, is if by some mechanism we can present to the jury the fact that cell phone reception was bad and his state of mind.

THE COURT: Yes. I'll allow -- and what I'm hoping is you can reach a stipulation on his demeanor, how he sounded, and you can pick the words, and then the fact that the phone cuts out, because that's before the jury, and Mr. Brown's offer of proof, I accept that. I think it can be admitted for that purpose.

MR. BROWN: Mr. Simowitz wants the tape played. He wants the record clear he wants these two tapes played that are already transcribed and just redact the one sentence, "We're trying to get CPR on the phone."

THE COURT: If you can reach a stipulation with Mr. Walsh to authenticate the phone call, that's fine. Then he

doesn't -- then he doesn't have to call witnesses.

MR. SIMOWITZ: What's Mr. Walsh's thoughts?

MR. WALSH: We're running in circles. I'm willing to write a stipulation. I'm not willing to play a tape of dispatchers talking to each other about what they'd like to do. I think we can accomplish all that through written stipulation. Every police officer who's testified has been at that house so far stated the cell phone reception problems in that house. There's no dispute that the cell phone disconnected on Mr. Mickey during times he was trying to communicate with 911. I'm willing to stipulate to that.

THE COURT: I've made my ruling. I agree with you, Mr. Brown, I agree with you. I don't want you playing a tape that talks about how emergency responders are -- they are going to try to give CPR to the child.

MR. BROWN: That's not --

THE COURT: But if you can -- but if the tape can be redacted to show somehow that the phone cuts out, that's admissible. I don't know if that's possible. If it's not possible, then I can tell you none of the tape is going to be played. And the reason none of the tape will, then, be played is I agree with Mr. Walsh here. That issue is already before the jury. Actually -- actually, we have heard it a number of times that cell phone reception in that house was difficult, which is why I accept your offer of proof, Mr. Brown. That's an issue, but all this does is reenforce testimony that's already before the jury.

MR. BROWN: Right.

THE COURT: It seems to me the easiest way is to draft a stipulation on that call, but if you don't want to do that, Mr. Simowitz, those statements have to be redacted and then --

MR. SIMOWITZ: Your Honor, it's a three-page statement. The first page and a half should be cut out because Mr. Mickey's in it. Can you look at the balance of it and just say, "Yeah, what's there is fine." Play the tape or not.

THE COURT: I don't need to look at it until -- because it sounds like -- you understand what my ruling is and then you can show it to Mr. Walsh. Mr. Walsh may agree if you show him the rest of it. He may say, "Fine, I can redact that. We can play it." As long as there is a stipulation on who it was from.

MR. SIMOWITZ: Again, it's a page and a half. I think we can resolve it right now.

MR. BROWN: Talk to Jess about it. That's what the judge is telling you.

MR. SIMOWITZ: If he doesn't agree, we're going to need a ruling.

THE COURT: All right. Mr. Walsh, take a look at that.

MR. WALSH: I thought I'd already been really clear so far. You want to play two people talking to each other about him. This is what I just talked about. You want to play -- you want to play, "I have somebody on the phone. He's freaking out. His baby's not breathing. Yeah, we're trying to figure out where he is" --

THE COURT: I don't have a problem with that.

MR. WALSH: Okay.

THE COURT: They already know that.

MR. WALSH: I know.

THE COURT: You can play that. Is that what you wanted?

MR. SIMOWITZ: Like I said, "He said his baby's not breathing. Let me bring him on the line for you. Let me give you a call-back number."

THE REPORTER: Counsel.

THE COURT: I don't want my reporter to break.

MR. SIMOWITZ: And then they gave the number. Okay. "Hello, sir? Whoops. Did he hang up? Well, he must have disconnected somehow. Whoops."

And then there's another call. "Hi, CHP."

"Hi, ma'am."

Regarding -- well, actually that one's irrelevant, so really right to what I read.

THE COURT: What you just read to me, I don't have a problem with that. That's already before the jury. I'm going to let you gentlemen take care of it. Finish it up.

Mr. Walsh, I can tell you what I just heard from Mr. Simowitz, that portion, I don't have a problem with that. We know the baby's not breathing, that he was panicked. That shows -- if you can redact the tape. But, no -- we don't need to call witnesses on the issue. We don't need to call witnesses. All right. Court's adjourned. See you tomorrow morning at 9:00 o'clock.

(Proceedings concluded.)