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**TRUTH OR CONSEQUENCES, NM 000452**

**2019 APA Child Abuse Project National Conference on Child Abuse**

**Hypothetical Defense “Expert” Report**

**For purposes of the presentation, assume that Dr. X offered testimony that mirrored this report during the trial**

To: Defense Attorney

Date: Whenever you need it

PRELIMINARY REPORT

As one of the world’s leading experts in reviewing the cause of injuries to young children, I was requested by you to review medical records relating to injuries allegedly suffered by 5 month-old V, who suffered an ultimately fatal hypoxic/ischemic brain injury as a result of an accident. I have been able to review all the material that you sent me concerning V’s unfortunate situation. My review has also included the criminal complaint filed against the boyfriend of the child’s mother, the police reports relating to the case and, most interestingly, the expert witness report prepared by Dr. \_\_\_\_\_, the State’s primary expert witness, and Dr. \_\_\_\_\_\_\_, the pathologist who performed the autopsy and death investigation relating to V. As you know from my CV which is attached, I am an emergency room physician who has spent thousands of hours attending to the emergent injuries of both adults and children over my 25 year career. In that capacity, I have witnessed just about every type of injury anyone could imagine and likely have more hours spent with patients than most other physicians, including the two doctors called as expert witnesses by the prosecution in this case.

Relying upon my extensive history in assessing the cause of injuries to children, and testifying as an expert witness in courts all over the country, I’m quite concerned that there was a “rush to judgment” by all physicians who examined V. at the Children’s Hospital. Because the child was found to have the classic “triad” of symptoms associated with the so-called “shaken baby syndrome”, virtually every person who dealt with her case instantly concluded that this was a case of non-accidental trauma intentionally inflicted upon her by her caretaker, many of them specifically invoking the “shaken baby syndrome” as their diagnosis. It further appears that because V. was last in the care of mother’s boyfriend, assumptions have been made by others that he must have been the person who intentionally caused those injuries to V. As is tragically the case with so many cases recently, all medical personnel jumped to faulty and unscientific conclusions based solely on the fact that V. was found to have bleeding over the outer covering of her brain, retinal hemorrhages, and injury to her brain. As has been shown through recent research and articles written by some of the most eminent medical professionals in the field, each of those injuries may have innocent explanations and in V’s case, did in fact have plausible explanations which rule out the possibility of child abuse.

Further review of V’s medical history shows that she was born premature and that there were complications of the delivery that account for many of the medical findings documented prior to her death. It is well known that premature infants are more susceptible to such things as retinal hemorrhages and subdural hemorrhages from birth, especially where, as in this case, there were complications noted during the delivery process. I was disappointed not to find any reference to these possible causes of V’s head and eye injuries in the Children’s Hospital reports. I have also been informed that V’s family has had several members who have suffered from bleeding disorders, manifested by easy bruising. Although cursory laboratory examinations were done at the Children’s Hospital, there was no further genetic testing to rule out various possible coagulopathies. In the absence of that testing, there is no way for anyone to know for sure what the cause of her bruises may have been. Children who have metabolic bleeding disorders from a variety of causes may be bruised from normal daily handling. In my experience, such causes of injuries cannot be ruled out without a full series of genetic tests and a full examination of the entire family history. As I examined photographs of the bruises, it wasn’t clear to me that they were all bruises and none were indicative of child abuse as an exclusive cause. While it is rare for non-mobile infants to have bruises from accidental causes, it does occur and that wasn’t even considered by the prosecution experts in this case. It is my opinion that the bruises were the result of normal daily handling in the milieu of a metabolic coagulopathy.

Next, it was found that V. had a so-called “classic metaphyseal lesion” of the right distal radius and an oblique fracture of the left humerus. Apparently none of the prosecution’s witnesses considered that V.’s mother was found by an independent expert who is preeminent in his field to have Ehlers-Danlos syndrome, which has been shown by that expert and others to be often inherited by the offspring of the mother. It is well-known that individuals with Ehlers-Danlos syndrome can suffer fractures from normal daily interactions which have nothing to do with intentional child abuse. In addition, none of the prosecution’s experts apparently considered the likelihood that because V.’s mother was vitamin D deficient at the time of V.’s birth, it is highly likely that condition was passed on to V. and that such vitamin D deficiency at birth caused brittle bones through rickets. It has been proven by another preeminent expert that healing rickets is often the cause of fractures in young infants who are suspected of having been abused by their caretakers. Finally, none of the prosecution’s experts, nor indeed any of the physicians who treated V. at any time prior to her unfortunate death as a result of hypoxic ischemic injury to her brain ever considered that the fractures may have been caused by temporary brittle bone disease, a condition that has been proven to exist in young children by another expert in the field of radiology. Given all of these conditions which were not even considered by the treating physicians or the prosecution’s testifying experts, it is my opinion that in the context of all the other injuries V.’s fractures were caused by normal daily handling by the infant’s caretakers, who could not have known they were causing fractures to their child.

It has been well-documented that there are several problems with the original hypothesis which later evolved into the medical theory of the shaken baby syndrome. A large and growing number of well-respected experts in their field have shown repeatedly that the existence of intracranial bleeding, retinal hemorrhage and brain injury is *not pathognomonic* for shaking as the sole cause, yet pediatricians and others continue to claim that in courtrooms, as they have in this case. Several articles in the peer-reviewed medical literature have challenged the foundation of the shaken baby syndrome, which is now referred to as “abusive head trauma”, and have shown scientifically that there is no evidence-based support for this diagnosis. Despite this ongoing controversy in the field of medical science, a small group of physicians continue to cling to the “dogma” that the triad of injuries can *only* be caused by violent shaking of a baby or toddler. These physicians continue to ignore the clear change in opinion among mainstream medical scientists about the validity of the diagnosis of SBS/AHT. This has resulted in the tragedy of many falsely-accused caretakers and parents being wrongly convicted and incarcerated for acts that never happened.

It was documented that V. had thin-film subdural hemorrhages over the convexities of the cortex, along the falx membrane and layered over the tentorium. Initial radiology reports indicated these hemorrhages were of differing age. In at least one radiology report, V. was noted to have thrombosis of the superior saggital sinus. She also had retinal hemorrhages in both eyes, which the Pediatric Ophthalmologist claimed were from “non-accidental trauma” because they were too numerous to count and extended from the back of the eye toward the front of the eye.

As to V’s subdural hemorrhages, it is clear from a review of all the radiological records that there appeared to be more than one age of bleeding under the dura. There was clearly a membrane in the early stages of formation in the left parietal region of V’s brain, which was distinct from the acute subdural blood. I agree with the impression that there was acute or fresh subdural blood, however, it has been well documented that once a young child has older or chronic subdural hematomas, the normal and natural process of healing may involve rebleeding into the subdural space and that can be the result of minor trauma or can even occur spontaneously. In the presence of such clear evidence of multiple ages of subdural bleeding, it is nothing less than irresponsible for the Children’s Hospital physicians to have concluded that these subdurals were caused by shaking or other inflicted trauma without any further corroborating evidence. Given the history in this case that V. was found on the floor unresponsive after having choked on crackers, the likelihood is that this act of severe choking caused the subdural hemorrhages and started the process which led to her inability to breathe. Also, the boyfriend’s statement that V squirmed out of the high chair and fell to the floor could have caused the chronic subdural hematoma to rebleed, triggering the cascade of negative and ultimately fatal medical findings. Thus, the accidental explanation for the head injuries is a sufficient cause.

V’s retinal hemorrhages are not a surprising finding when one considers the finding of the Medical Examiner that V. suffered from cortical venous thrombosis. Obstruction of the saggital sinus, which could have occurred as a result of the re-bleed of subdural blood, could easily account for the retinal hemorrhages since it would result in a sudden increase in intracranial pressure. Although many of those who are prone to diagnose “shaken baby syndrome” without a full and complete effort to rule out other differential diagnoses express opinions that retinal hemorrhages are “diagnostic” of the syndrome or at least of intentionally inflicted injury, I strongly disagree and believe in this case there is a valid and credible alternative explanation that was not even considered by the other medical personnel who were involved with diagnosis of V.’s injuries. In addition, there was clear evidence in the clinical records that V.’s brain continued to swell and it is well documented in the medical literature that sudden increase in intracranial pressure is a common cause of retinal hemorrhages, regardless of the cause of that increase in pressure. It has also been established through current medical literature that there is no particular pattern of retinal hemorrhages that in and of itself is diagnostic of child abuse as the cause.

In addition, it has been conclusively shown in a variety of ways that it is not possible to cause subdural hemorrhage or brain injury through shaking of a baby’s or toddler’s head without first causing a catastrophic failure of the child’s neck. Although there were some non-specific findings in the cervical spinal cord of V., as well as some abnormality and bleeding in the thoracolumbar spine, these findings were found to be “most likely related to ischemia/infarct.” In other words, these findings were not the type of neck injury that would be inevitably present prior to a severe and fatal head injury through shaking, as documented in the medical literature.

V. clearly had a preexisting superior saggital sinus and left transverse sinus venous thrombosis, which accounted for her acute subdural and subarachnoid hemorrhages. Because treating physicians concluded that all of V.’s injuries were caused by inflicted trauma, no further testing was done to determine if V. had a clotting disorder and essential tests to answer the question of the cause of the thromboses were not conducted. Such thromboses could easily have contributed to the rapid increase in intracranial pressure that likely resulted in her retinal hemorrhages and the brain edema which ultimately became fatal. The fact that the child choked on crackers, creating a life-threatening lack of oxygen for at least a several-minute interval may have exacerbated her preexisting thrombosis, triggering a seizure and the entire and the descending spiral of injuries which resulted in her death. The boyfriend may be guilty of simple negligence, but his actions do not support the criminal charges of homicide and intentional child abuse.

There is no question this unfortunate child suffered numerous problems in her short life, however, as has been documented recently through multiple media reports, too many people are being accused of child abuse and child murder and convicted of those crimes by testimony of so-called “expert” witnesses who have not performed sufficient testing or who are not qualified to offer such opinions. Further, there is a pervasive lack of neutrality among those who regularly jump to conclusions without a full and thorough investigation of all possible medical explanations for the conditions of a child. Although all in the medical profession are ethically required to consider all possible causes of a patient’s condition, and to carefully rule out each possible cause in the “differential diagnosis”, it has been my experience in the hundreds of cases upon which I’ve consulted that full and complete medical investigations are very rare among those who offer testimony in support of convicting parents and other caregivers. The rush to judgment reflected in a case like this causes great concern about the potential for an unjust conviction of an innocent person.

If I may be of further assistance in this case, please contact me. The opinions reflected in this preliminary report are based upon review of the material you have provided to me and if more information is presented, including future testimony by expert witnesses, I would be glad to review that and comment further.

DATED THIS \_\_\_\_ DAY OF \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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DR. X