

**STATE OF MICHIGAN
IN THE MICHIGAN SUPREME COURT**

PEOPLE OF THE STATE OF MICHIGAN,
Plaintiff-Appellee,

v

Supreme Court No.: 159948
Court of Appeals No.: 338431
Trial Court No.: 05-000220-FH

TERRY LEE CEASOR,
Defendant-Appellant.

On Appeal From The Court Of Appeals
James Robert Redford, P.J.; Jane E. Markey, J.; Kirsten Frank Kelley, J.

DEFENDANT-APPELLANT TERRY LEE CEASOR'S APPENDIX

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Michigan Innocence Clinic
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CASE

Judicial Officer	Date Filed	Adjudication	Status
ADAIR, JAMES	1/28/05	FOUND GUILTY - JURY VERDICT 12/19/05	CLOSED 1/18/06
PROSECUTOR: WENDLING, MICHAEL			
CTN: 740400423401 PIN/OCA: SD0423272			
OFFENSE DATE: 10/3/04 DC ARRAIGN DATE: 1/4/05			
LOWER COURT: 04P08897FY 72ND DISTRICT COURT - PORT HURON			
INCARCERATION DATE: 12/23/04 DC PRELIM DATE: 1/25/05			

PARTICIPANTS

DEFENDANT 1	CEASOR, TERRY LEE FILED: 1/28/05 DOB: ***** GENDER: M DLN: MI ***** SSN: ***** RACE: W-WHITE HOME - COOPER STREET CORR. FACILITY 3100 COOPER STREET JACKSON, MI 49201 ATTY: DAVID A. MORAN # 45353 PRIMARY APPOINTED 701 S STATE ST ANN ARBOR, MI 48109-3091 (734) 763-9353
BOND POSTER 1	CALVERT BAIL BONDS FILED: 1/28/05 DOB: ***** DLN: ***** SSN: ***** BUSINESS - 917 PINE GROVE AVE PORT HURON, MI 48060

CHARGES

1	Current Offense	A/S/C	Current Offense Description
	750.136B2		CHILD ABUSE - 1ST DEGREE
DISPOSITION: FOUND GUILTY - JURY VERDICT 12/19/05			

BOND HISTORY

Bond For:	Set Date	Set Amount	Bond Type	Balance	Bond Status
TERRY LEE CEASOR BOND ID: 71067	1/28/05	\$5,000.00	CASH / SURETY	\$0.00	CLOSED
	ACTIONS				
	1/28/05	POSTED NON-MONETARY \$0.00 BY: CALVERT BAIL BONDS			
		RETURNED \$0.00			

RECEIVABLES/PAYMENTS

	AD Name	Assessed	Paid/Adjusted	Balance
DEF 1 TERRY LEE CEASOR	CRIME VICTIMS	\$0.00	\$0.00	\$0.00
	RESTITUTION	\$0.00	\$0.00	\$0.00
	STATE MINIMUM COSTS	\$0.00	\$0.00	\$0.00
	TOTAL		\$0.00	\$0.00

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PAYABLES/DISBURSEMENTS

	AD Name	Assessed	Adjusted	Applied	Balance
DEF 1 TERRY LEE CEASOR	RESTITUTION	\$5,078.41	\$0.00	\$5,078.41	\$0.00
	TOTAL	\$5,078.41	\$0.00	\$5,078.41	\$0.00

CHRONOLOGICAL LIST OF ACTIVITIES

Activity Date	Activity	User	Entry Date
1/25/05	FELONY BIND OVER/TRANSFER AFTER PRELIMINARY EXAMINATION	kab dm-ssis	1/25/05 6/19/15
1/28/05	BOND ID: 71067 POSTED NON-MONETARY (SURETY BOND POSTED) BOND TYPE: CASH / SURETY	\$0.00 kab dm-ssis	1/28/05
	SET AMOUNT: \$5,000.00		
1/28/05	BOND ID: 71067 RETURNED Bond Closed by DM-Data Fix BOND TYPE: CASH / SURETY	\$0.00 dm-44386a □	3/15/16
	SET AMOUNT: \$5,000.00		
2/1/05	ARRAIGNMENT LOC: 3200	SET 2/14/05 1:31 P ced dm-ssis	2/1/05 6/19/15
2/1/05	NOTICE TO APPEAR	kab dm-ssis	2/1/05 6/19/15
2/1/05	NOTICE SENT FOR 02/14/05 01:31P 10029 ARR 3200 AND PRE-TRIAL CONFERENCE	ced dm-32768c	2/1/05 10/19/15
2/4/05	INFORMATION	kab dm-ssis	2/4/05 6/19/15
2/4/05	WITNESS LIST	kab dm-ssis	2/4/05 6/19/15
2/4/05	NOTIFICATION	kab dm-ssis	2/4/05 6/19/15
2/14/05	NOTICE TO APPEAR	kab dm-ssis	2/14/05 6/19/15
2/14/05	ARRAIGNMENT PRE-TRIAL CONFERENCE; WAIVE FORMAL READING; BOND IS CONTINUED HELD PLEAD NOT GUILTY	ced dm-32768c	2/14/05 10/19/15
2/14/05	NOTICE SENT FOR 04/05/05 09:00A 10029 JYT 3200	ced dm-32768c	2/14/05 10/19/15
2/18/05	***TRANS PREL EXAM VOL I *** **TRANS PREL EXAM VOL II ***	kab dm-ssis	2/18/05 6/19/15
2/23/05	STIP /ORDER FOR SUBS OF ATTY	kab dm-ssis	2/23/05 6/19/15
2/24/05	FROM: BLACK,DAVID D., TO: LORD,KENNETH M.,	kab dm-ssis	2/24/05 6/19/15
2/24/05	WITNESS LIST	kab dm-ssis	2/24/05 6/19/15
4/1/05	JURY TRIAL LOC: 3200	SET 5/17/05 9:00 A sjt dm-ssis	4/1/05 6/19/15

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Activity Date	Activity	User	Entry Date
4/1/05	ORDER FOR ADJOURNMENT 04/05/05 09:00A 10029 JYT 3200	sjt dm-ssis	4/1/05 6/19/15
4/1/05	STIP /ORDER TO ADJ JURY TRIAL NTC TO APPEAR	kab dm-ssis	4/1/05 6/19/15
4/1/05	NOTICE SENT FOR 05/17/05 09:00A 10029 JYT 3200 ADJOURNED FROM APRIL 5	sjt dm-32768c	4/1/05 10/19/15
5/5/05	ORDER TO PAY EXPERT WITNESS FEES	kab dm-ssis	5/5/05 6/19/15
5/9/05	MOT TO ADJ JURY TRIAL	kab dm-ssis	5/9/05 6/19/15
5/9/05	PRAECIPE NOTICE 5/16/05 /PROOF	kab dm-ssis	5/9/05 6/19/15
5/10/05	MOTION LOC: 3200	ced dm-ssis	5/10/05 6/19/15
	SET 5/16/05 1:33 P		
5/10/05	PRAECIPE 05/16/05 01:33P 10029 MOH 3200 ADJOURN TRIAL	ced dm-ssis	5/10/05 6/19/15
5/12/05	PEOPLE'S ANS TO DEF'S MOT TO ADJOURN JURY TRIAL /PROOF	kab dm-ssis	5/12/05 6/19/15
5/13/05	AM LIST OF WITENSSES INTENDED TO BE CALLED AT TRIAL /PROOF	kab dm-ssis	5/13/05 6/19/15
5/18/05	NOTICE SENT FOR 06/28/05 09:00A 10029 JYT 3200 ADJ. FROM MAY 17, 2005	ced dm-32768c	5/18/05 10/19/15
5/19/05	NOTICE TO APPEAR	kab dm-ssis	5/19/05 6/19/15
6/1/05	NOTICE TO APPEAR	kab dm-ssis	6/1/05 6/19/15
6/1/05	REMOVE SCHEDULED EVENT 06/28/05 09:00A 10029 JYT 3200	ced dm-32768c	6/1/05 10/19/15
6/1/05	NOTICE SENT FOR 08/02/05 09:00A 10029 JYT 3200 ADJ. FROM JUNE 28, 2005 BY COURT	ced dm-32768c	6/1/05 10/19/15
7/21/05	JURY TRIAL LOC: 3200	ced dm-ssis	7/21/05 6/19/15
	SET 9/13/05 9:00 A		
7/21/05	ORDER FOR ADJOURNMENT 08/02/05 09:00A 10029 JYT 3200	ced dm-ssis	7/21/05 6/19/15
7/21/05	NOTICE SENT FOR 09/13/05 09:00A 10029 JYT 3200 ADJ. FROM AUGUST 2, 2005 BY STIPULATION AND ORDER	ced dm-32768c	7/21/05 10/19/15
7/22/05	STIP /ORDER TO ADJOURN	kab dm-ssis	7/22/05 6/19/15
7/22/05	NOTICE TO APPEAR	kab dm-ssis	7/22/05 6/19/15
9/13/05	JURY TRIAL LOC: 3200	ced dm-ssis	9/13/05 6/19/15
	SET 11/1/05 9:00 A		

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Activity Date	Activity	User	Entry Date
9/13/05	NOTICE TO APPEAR	kab dm-ssis	9/13/05 6/19/15
9/13/05	NOTICE SENT FOR 11/01/05 09:00A 10029 JYT 3200 ADJ. FROM SEPT. 13, 2005	ced dm-32768c	9/13/05 10/19/15
11/1/05	JURY TRIAL LOC: 3200	ced dm-ssis	11/1/05 6/19/15
11/1/05	NOTICE TO APPEAR	kab dm-ssis	11/1/05 6/19/15
11/1/05	NOTICE SENT FOR 12/13/05 09:00A 10029 JYT 3200 ADJ. FROM NOVEMBER 1, 2005	ced dm-32768c	11/1/05 10/19/15
12/13/05	JURY TRIAL WHOLE DAY JURY SELECTED; TO BE CONTINUED DEC. 14, 2005 HELD	ced dm-32768c	12/13/05 10/19/15
12/14/05	JURY TRIAL LOC: 3200	ced dm-ssis	12/14/05 6/19/15
12/14/05	JURY TRIAL LOC: 3200	ced dm-ssis	12/14/05 6/19/15
12/14/05	SET CASE ON CALENDAR 12/14/05 09:30A 10029 JYT 3200 CONTINUED FROM DEC. 13, 2005	ced dm-32768c	12/14/05 10/19/15
12/14/05	JURY TRIAL WHOLE DAY TO BE CONTINUED DECEMBER 15, 2005 HELD	ced dm-32768c	12/14/05 10/19/15
12/14/05	SET CASE ON CALENDAR 12/15/05 09:30A 10029 JYT 3200 CONTINUED FROM DEC. 14, 2005	ced dm-32768c	12/14/05 10/19/15
12/15/05	JURY TRIAL LOC: 3200	ced dm-ssis	12/15/05 6/19/15
12/15/05	SET CASE ON CALENDAR 12/16/05 09:30A 10029 JYT 3200 CONTINUED FROM DEC. 15, 2005	ced dm-32768c	12/15/05 10/19/15
12/15/05	JURY TRIAL WHOLE DAY TO BE CONTINUED DEC. 16, 2005 HELD	ced dm-32768c	12/15/05 10/19/15
12/16/05	JURY TRIAL LOC: 3200	ced dm-ssis	12/16/05 6/19/15
12/16/05	JURY TRIAL WHOLE DAY TO BE CONTINUED DEC. 19, 2005 HELD	ced dm-32768c	12/16/05 10/19/15
12/16/05	SET CASE ON CALENDAR	ced dm-32768c	12/16/05 10/19/15

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	12/19/05 09:30A 10029 JYT 3200 CONTINUED FROM DEC. 16, 2005		
12/19/05	SENTENCE HEARING LOC: 3200	SET 1/17/06 2:00 P ced dm-ssis	12/19/05 6/19/15
12/19/05	NOTICE SENT FOR 01/17/06 02:00P 10029 SEN 3200	ced dm-32768c	12/19/05 10/19/15
12/19/05	JURY TRIAL WHOLE DAY JUDGMENT OF CONVICTION ENTERED REFERRED TO PROBATION DEPT.; BOND IS CONTINUED HELD DISPOSITION: FOUND GUILTY - JURY VERDICT COUNT: 1 CHILD ABUSE - 1ST DEGREE	ced dm-32768c	12/19/05 10/19/15
12/20/05	JUDG OF CONVICTION FORM OF VERDICT NTC TO APPEAR JUROR QUESTIONS REQ FOR INSTRUCTIONS TO THE JURY	kab dm-ssis	12/20/05 6/19/15
1/12/06	RECEIVABLE CRIME VICTIMS SENTENCING DUE DATE: 1/12/06	\$60.00 ced dm-ssis	1/12/06 6/19/15
1/12/06	RECEIVABLE STATE MINIMUM COSTS SENTENCING DUE DATE: 1/12/06	\$60.00 ced dm-ssis	1/12/06 6/19/15
1/17/06	SENTENCE HEARING PAY ADDITIONAL RESTITUTION IF DETERMINED; IF ELIGIBLE, PRISON BOOT CAMP IS RECOMMENDED HELD RESTITUTION \$5,078.41 DUE DATE: 1/12/06 STATE MINIMUM COSTS \$60.00 DUE DATE: 1/12/06 CRIME VICTIMS \$60.00 DUE DATE: 1/12/06 START DATE: 1/17/06 ENHANCED SENTENCING: NO PRISON MIN. TERM: 24 MONTHS MAX TERM: 15 YEARS CREDIT TERM: 1 DAYS	\$5,198.41 ced dm-32768c	1/17/06 10/19/15
1/18/06	FINAL ORDER/JUDGMENT SENTENCING INFORMATION REPORT	kab dm-ssis	1/18/06 6/19/15
1/20/06	PSI REPORT-1/9/06-STOCKWELL	kab dm-ssis	1/20/06 6/19/15
2/7/06	RECEIVABLE RESTITUTION AS ORDERED DUE DATE: 1/12/06	\$5,078.41 ced dm-ssis	2/7/06 6/19/15
2/7/06	REQUEST FOR COURT APPOINTED ATTORNEY AND ORDER CLAIM OF APPEAL AND ORDER APPT COUNSEL--SADO	kab dm-ssis	2/7/06 6/19/15

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2/7/06	FROM: LORD,KENNETH M., TO: PRO-PER	kab dm-ssis	2/7/06 6/19/15
2/7/06	REMOVAL ORDER	kab dm-ssis	2/7/06 6/19/15
2/10/06	AMENDED JUDGMENT CORRESPONDENCE CORRESPONDENCE	kab dm-ssis	2/10/06 6/19/15
2/10/06	ORDER FOR TRANSCRIPT	kab dm-ssis	2/10/06 6/19/15
2/21/06	REQ FOR COPY OF ENTIRE FILE FROM SADO	kab dm-ssis	2/21/06 6/19/15
2/22/06	REMOVAL ORDER ORDER FOR PRODUCTON OF TRANS	kab dm-ssis	2/22/06 6/19/15
2/22/06	MAILED COPY OF ENTIRE FILE TO SADO	kab dm-ssis	2/22/06 6/19/15
2/27/06	ORDER FOR TRANSCRIPT	kab dm-ssis	2/27/06 6/19/15
3/7/06	ORD REGARDING CRT ASSES.	dkf dm-ssis	3/7/06 6/19/15
3/21/06	RECEIVABLE ADJUSTMENT CRIME VICTIMS (\$60.00) PAYMENT 03-21-2006 ADJUSTMENT DECREASE AMOUNT DUE DATE: 1/12/06	dm-fix	3/21/06 7/16/15
3/21/06	RECEIVABLE ADJUSTMENT STATE MINIMUM COSTS (\$60.00) PAYMENT 03-21-2006 ADJUSTMENT DECREASE AMOUNT DUE DATE: 1/12/06	dm-fix	3/21/06 7/16/15
3/23/06	CORRESPONDENCE	kab dm-ssis	3/23/06 6/19/15
4/12/06	MOT TO EXTEND TIME FOR FILING TRANS ON APPEAL	kab dm-ssis	4/12/06 6/19/15
6/5/06	NOTICE OF FILING OF TRANSCRIPT AND AFFIDAVIT OF MAILING ***TRANS ARR &; PRETRIAL *** **TRANS JURY TRIAL VOL 1 *** **TRANS JURY TRIAL VOL 2 *** **TRANS JURY TRIAL VOL 3 *** **TRANS JURY TRIAL VOL 4 *** **TRANS JURY TRIAL VOL 5 *** **TRANS DISPOSITION ***	kab dm-ssis	6/5/06 6/19/15
6/8/06	SUBS /ORDER OF COUNSEL	kab dm-ssis	6/8/06 6/19/15
6/15/06	RECEIVABLE ADJUSTMENT RESTITUTION (\$109.01) PAYMENT 06-15-2006 ADJUSTMENT DECREASE AMOUNT DUE DATE: 1/12/06	dm-fix	6/15/06 7/16/15
6/15/06	PAYABLE RESTITUTION \$5,078.41	dm-ssis	6/15/06 6/19/15
6/27/06	RESTITUTION DISBURSEMENT	aw dm-32768c	6/27/06 10/19/15
6/27/06	DISBURSEMENT: VOUCHER \$109.01 RESTITUTION \$109.01 PAYEE/VENDOR FIRST RECOVERY GROUP LLC,, REFERENCE# 8939	aw dm-ssis	6/27/06 6/19/15

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Activity Date	Activity	User	Entry Date
8/4/06	MOTION LOC: 3200	ced dm-ssis	8/4/06 6/19/15
			SET 8/21/06 1:33 P
8/4/06	PRAECIPE 08/21/06 01:33P 10029 MOH 3200 BOND PENDING APPEAL	ced dm-ssis	8/4/06 6/19/15
8/4/06	PRAECIPE NOTICE 8/21/06 /PROOF MOT FOR BOND PENDING APPEAL AFFID IN SUPPORT BRF IN SUPPORT OF MOT FOR BOND PENDING APPEAL PROOF OF SERVICE	kab dm-ssis	8/4/06 6/19/15
8/10/06	ANS TO MOT FOR BOND ON APPEAL PROOF OF SERVICE	kab dm-ssis	8/10/06 6/19/15
8/21/06	MOTION MOTION FOR BOND PENDING APPEAL DENIED. HELD	jmc dm-32768c	8/21/06 10/19/15
9/14/06	REQ FOR ENTIRE COURT FILE FROM COURT OF APPEALS	kab dm-ssis	9/14/06 6/19/15
10/6/06	MAILED ENTIRE FILE &; 9 TRANS TO COURT OF APPEALS	kab dm-ssis	10/6/06 6/19/15
10/18/06	ORDER DENYING DEF'S MOT FOR BOND PENDING APPEAL	kab dm-ssis	10/18/06 6/19/15
12/8/06	AMENDED JUDGMENT CORRESPONDENCE	kab dm-ssis	12/8/06 6/19/15
12/19/06	RECEIVABLE ADJUSTMENT RESTITUTION PAYMENT 12-19-2006 ADJUSTMENT DECREASE AMOUNT DUE DATE: 1/12/06	dm-fix	12/19/06 7/16/15
			(\$100.17)
1/10/07	CORRESPONDENCE	kab dm-ssis	1/10/07 6/19/15
1/29/07	RESTITUTION DISBURSEMENT	aw dm-32768c	1/29/07 10/19/15
1/29/07	DISBURSEMENT: VOUCHER RESTITUTION \$100.17 PAYEE/VENDOR FIRST RECOVERY GROUP LLC,, REFERENCE# 9706	aw dm-ssis	1/29/07 6/19/15
			\$100.17
2/9/07	RECEIVABLE ADJUSTMENT RESTITUTION PAYMENT 02-09-2007 ADJUSTMENT DECREASE AMOUNT DUE DATE: 1/12/06	dm-fix	2/9/07 7/16/15
			(\$108.95)
2/26/07	RESTITUTION DISBURSEMENT	aw dm-32768c	2/26/07 10/19/15
2/26/07	DISBURSEMENT: VOUCHER RESTITUTION \$108.95 PAYEE/VENDOR FIRST RECOVERY GROUP LLC,, REFERENCE# 9851	aw dm-ssis	2/26/07 6/19/15
			\$108.95
7/11/07	RECEIVABLE ADJUSTMENT RESTITUTION PAYMENT 07-11-2007 ADJUSTMENT DECREASE AMOUNT	dm-fix	7/11/07 7/16/15
			(\$103.91)

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Activity Date	Activity		User	Entry Date
	DUE DATE: 1/12/06			
7/13/07	COURT OF APPEALS OPINION		kab dm-ssis	7/13/07 6/19/15
7/16/07	COURT OF APPEALS OPINION		kab dm-ssis	7/16/07 6/19/15
7/30/07	RESTITUTION DISBURSEMENT		aw dm-32768c	7/30/07 10/19/15
7/30/07	DISBURSEMENT: VOUCHER	\$103.91	aw dm-ssis	7/30/07 6/19/15
	RESTITUTION \$103.91 PAYEE/VENDOR FIRST RECOVERY GROUP LLC,, REFERENCE# 10323			
10/23/07	RECEIVABLE ADJUSTMENT RESTITUTION	(\$103.42)	dm-fix	10/23/07 7/16/15
	PAYMENT 10-23-2007 ADJUSTMENT DECREASE AMOUNT DUE DATE: 1/12/06			
11/2/07	ENTIRE FILE &; 9 TRANS RETURNED FROM MI SUPREME COURT MI SUPREME COURT ORDER		kab dm-ssis	11/2/07 6/19/15
11/19/07	RESTITUTION DISBURSEMENT		aw dm-32768c	11/19/07 10/19/15
11/19/07	DISBURSEMENT: VOUCHER	\$103.42	aw dm-ssis	11/19/07 6/19/15
	RESTITUTION \$103.42 PAYEE/VENDOR FIRST RECOVERY GROUP LLC,, REFERENCE# 10677			
2/25/08	RECEIVABLE ADJUSTMENT RESTITUTION	(\$119.23)	dm-fix	2/25/08 7/16/15
	PAYMENT 02-25-2008 ADJUSTMENT DECREASE AMOUNT DUE DATE: 1/12/06			
3/24/08	RESTITUTION DISBURSEMENT		aw dm-32768c	3/24/08 10/19/15
3/24/08	DISBURSEMENT: VOUCHER	\$119.23	aw dm-ssis	3/24/08 6/19/15
	RESTITUTION \$119.23 PAYEE/VENDOR FIRST RECOVERY GROUP LLC,, REFERENCE# 10960			
6/11/08	CORRESPONDENCE FROM DEFENDANT		kab dm-ssis	6/11/08 6/19/15
6/24/08	PROOF OF SERVICE NTC OF HRG MOT TO CORRECT PSI REPORT SO DEF CAN RECEIVE PROPER EVAL CLASSIFICATION AND PLACEMENT WITHIN MDOC		kab dm-ssis	6/24/08 6/19/15
7/30/08	CORRESPONDENCE FROM DEFENDANT		kab dm-ssis	7/30/08 6/19/15
8/6/08	FROM: LORENCE,GERALD M., TO: PRO-PER		ced dm-ssis	8/6/08 6/19/15
8/6/08	ORDER DENYING MOTION FOR CORRECTION OF PSI REPORT PARTY NOTIFICATION		kab dm-ssis	8/6/08 6/19/15
8/11/08	RECEIVABLE ADJUSTMENT RESTITUTION	(\$246.93)	dm-fix	8/11/08 7/16/15
	PAYMENT 08-11-2008 ADJUSTMENT DECREASE AMOUNT DUE DATE: 1/12/06			
8/26/08	RESTITUTION DISBURSEMENT		kab dm-32768c	8/26/08 10/19/15

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Activity Date	Activity		User	Entry Date
8/26/08	DISBURSEMENT: VOUCHER RESTITUTION \$246.93 PAYEE/VENDOR FIRST RECOVERY GROUP LLC,, REFERENCE# 11585	\$246.93	kab dm-ssis	8/26/08 6/19/15
11/7/08	REQ FOR COPY OF ENTIRE FILE FROM ATTY GENERAL		kab dm-ssis	11/7/08 6/19/15
11/19/08	MAILED COPY OF ENTIRE FILE TO ATTY GENERAL		kab dm-ssis	11/19/08 6/19/15
2/25/09	RECEIVABLE ADJUSTMENT RESTITUTION PAYMENT 02-25-2009 ADJUSTMENT DECREASE AMOUNT DUE DATE: 1/12/06	(\$269.61)	dm-fix	2/25/09 7/16/15
3/31/09	RESTITUTION DISBURSEMENT		aw dm-32768c	3/31/09 10/19/15
3/31/09	DISBURSEMENT: VOUCHER RESTITUTION \$269.61 PAYEE/VENDOR FIRST RECOVERY GROUP LLC,, REFERENCE# 12167	\$269.61	aw dm-ssis	3/31/09 6/19/15
5/26/10	MOT FOR RELIEF FROM JUDGMENT MEMO IN LAW OF SUPPORT OF MOT FOR RELIEF FROM JUDGMENT PROOF OF SERVICE		kab dm-ssis	5/26/10 6/19/15
8/16/10	RECEIVABLE ADJUSTMENT RESTITUTION PAYMENT 08-16-2010 ADJUSTMENT DECREASE AMOUNT DUE DATE: 1/12/06	(\$58.28)	dm-fix	8/16/10 7/16/15
8/26/10	RESTITUTION DISBURSEMENT		aw dm-32768c	8/26/10 10/19/15
8/26/10	DISBURSEMENT: VOUCHER RESTITUTION \$58.28 PAYEE/VENDOR FIRST RECOVERY GROUP LLC,, REFERENCE# 14045	\$58.28	aw dm-ssis	8/26/10 6/19/15
9/15/10	RESTITUTION DISBURSEMENT		aw dm-32768c	9/15/10 10/19/15
9/15/10	DISBURSEMENT: VOUCHER RESTITUTION (\$58.28) PAYEE/VENDOR FIRST RECOVERY GROUP LLC,, REFERENCE# 14045	(\$58.28)	aw dm-ssis	9/15/10 6/19/15
9/23/10	ORDER DIRECTING PROS REPSONSE PARTY NOTIFICATION		kab dm-ssis	9/23/10 6/19/15
9/27/10	RESTITUTION DISBURSEMENT		aw dm-32768c	9/27/10 10/19/15
9/27/10	DISBURSEMENT: VOUCHER RESTITUTION \$58.28 PAYEE/VENDOR FIRST RECOVERY GROUP LLC,, REFERENCE# 14156	\$58.28	aw dm-ssis	9/27/10 6/19/15
10/18/10	RESTITUTION DISBURSEMENT		aw dm-32768c	10/18/10 10/19/15
10/18/10	DISBURSEMENT: VOUCHER RESTITUTION (\$58.28) PAYEE/VENDOR FIRST RECOVERY GROUP LLC,, REFERENCE# 14156	(\$58.28)	aw dm-ssis	10/18/10 6/19/15

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Activity Date	Activity	User	Entry Date
10/28/10	PARTY NOTIFICATION RETURNED-- UNDELIVERABLE	kab dm-ssis	10/28/10 6/19/15
11/12/10	APPEARANCE PROOF OF SERVICE ATTY: BRIDGET M. MCCORMACK # 58537	kab dm-ssis	11/12/10 6/19/15
1/18/11	RECEIVABLE ADJUSTMENT RESTITUTION (\$3,858.90) PAYMENT 01-18-2011 ADJUSTMENT DECREASE AMOUNT DUE DATE: 1/12/06	dm-fix	1/18/11 7/16/15
1/31/11	NTC OF HRG 2/7/2011 MOT FOR TIMELY RESPONSE PROOF OF SERVICE	kab dm-ssis	1/31/11 6/19/15
2/1/11	ANS TO MOT FOR A TIMELY RESPONSE /PROOF	kab dm-ssis	2/1/11 6/19/15
2/4/11	PRAECIPE NOTICE 2/14/2011 /PROOF NTC OF HRG 2/14/2011 MOT FOR TIMELY RESPONSE PROOF OF SERVICE	kab dm-ssis	2/4/11 6/19/15
2/7/11	MOTION SET 2/14/11 1:33 P LOC: 3100	ced dm-ssis	2/7/11 6/19/15
2/7/11	PRAECIPE 02/14/11 01:33P 10029 MOH 3100 TIMELY RESPONSE	ced dm-ssis	2/7/11 6/19/15
2/14/11	COURT'S ORDER GRTG DEF'S MOT FOR TIMELY RESPONSE	kab dm-ssis	2/14/11 6/19/15
2/14/11	MOTION TIMELY RESPONSE IS GRANTED AND TO BE RESPONDED W/I 45 DAYS HELD	ced dm-32768c	2/14/11 10/19/15
3/31/11	ANS TO MOT FOR RELIEF FROM JUDGMENT PROOF OF SERVICE	kab dm-ssis	3/31/11 6/19/15
4/22/11	DEF'S REPLY BRIEF TO PEOPLE'S ANS TO DEF'S MOT FOR RELIEF FROM JUDGMENT PROOF OF SERVICE	kab dm-ssis	4/22/11 6/19/15
5/11/11	ORDER DENYING DEF'S MOT FOR RELIEF FROM JUDGMENT PARTY NOTIFICATION	kab dm-ssis	5/11/11 6/19/15
5/25/11	RESTITUTION DISBURSEMENT	mad dm-32768c	5/25/11 10/19/15
5/25/11	DISBURSEMENT: VOUCHER \$3,917.18 RESTITUTION \$3,917.18 PAYEE/VENDOR FIRST RECOVERY GROUP LLC,, REFERENCE# 14992	mig dm-ssis	5/25/11 6/19/15
5/31/11	DEF'S MOT FOR RECONSIDERATION PROOF OF SERVICE	kab dm-ssis	5/31/11 6/19/15
6/3/11	ORDER DENYING DEF'S MOT FOR RECONSIDERATION PARTY NOTIFICATION	kab dm-ssis	6/3/11 6/19/15
10/11/11	COURT OF APPEALS ORDER	kab dm-ssis	10/11/11 6/19/15
10/12/11	COURT OF APPEALS ORDER	kab dm-ssis	10/12/11 6/19/15
11/9/11	REQ FOR ENTIRE COURT FILE FROM MI SUPREME COURT	kab dm-ssis	11/9/11 6/19/15
12/2/11	MAILED ENTIRE COURT FILE &; 9 TRANS TO MI SUPREME COURT	kab dm-ssis	12/2/11 6/19/15

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Activity Date	Activity	User	Entry Date
12/9/11	REQ FOR ENTIRE COURT FILE FROM MI SUPREME COURT-PREV MAILED ON 12/2/2011	kab dm-ssis	12/9/11 6/19/15
4/24/12	ENTIRE FILE &; 9 TRANS RETURNED FROM MI SUPREME COURT MI SUPREME COURT ORDER	kab dm-ssis	4/24/12 6/19/15
7/5/12	REQ FOR COPY OF ENTIRE COURT FILE FROM ATTY GENERAL	kab dm-ssis	7/5/12 6/19/15
8/14/12	MAILED COPY OF FILE FROM NOV 2008 TO PRESENT TO ATTY GENERAL	kab dm-ssis	8/14/12 6/19/15
7/14/17	LETTER CORRESPONDENCE	kab	7/14/17
7/17/17	MOTION FOR NEW TRIAL	kab	7/17/17
7/17/17	BRIEF IN SUPPORT OF MOTION	kab	7/17/17
7/17/17	PROOF OF SERVICE	kab	7/17/17
7/28/17	MOTION FOR TEMP ADMISSION TO PRACTICE	kab	7/28/17
7/28/17	PROOF OF SERVICE	kab	7/28/17
7/31/17	MOTION FOR NEW TRIAL BEFORE: WEST, MICHAEL LOC: 3100	jmc	7/31/17
		SET 8/7/17 3:00 P	
8/1/17	PRAECIPE	nik	8/1/17
8/4/17	ANSWER TO MOTION FOR NEW TRIAL	kab	8/8/17
8/30/17	PARTY NOTIFICATION	kab	8/31/17
8/30/17	PROOF OF SERVICE	kab	8/31/17
8/30/17	ORDER	kab	8/31/17
9/6/17	EVIDENTIARY HEARING WEST, MICHAEL 34472 LOC: COURT REPORTER: K SCHWEIKART, #3271 HELD	jmc	9/6/17
9/6/17	EVIDENTIARY HEARING BEFORE: WEST, MICHAEL LOC: 3100	jmc	9/6/17
		SET 9/21/17 9:00 A	
9/7/17	NOTICE TO APPEAR	kab	9/7/17
9/21/17	EVIDENTIARY HEARING 9/21/17 9:00 AM WEST, MICHAEL 34472 LOC: 3100 COURT REPORTER: K SCHWEIKART, #3271 HELD;JUDGE TO ISSUE OPINION HELD	jmc	9/21/17
12/19/17	LETTER CORRESPONDENCE	kab	12/20/17
2/1/18	OPINION AND ORDER	kab	2/1/18
2/1/18	PARTY NOTIFICATION	kab	2/1/18
2/1/18	PROOF OF SERVICE	kab	2/1/18
2/20/18	TRANSCRIPT ***EVID HRG (EXCERPT)***	kab	2/21/18
3/7/18	REPORTER/RECORDER CERTIFICATE OF ORDERING TRANSCRIPT ON APPEAL	kab	3/7/18
3/19/18	TRANSCRIPT ***MOTION***	kab	3/19/18
3/21/18	NOTICE OF FILING OF TRANSCRIPT AND AFFIDAVIT OF MAILING	kab	3/21/18
3/21/18	TRANSCRIPT ***EVID HRG***	kab	3/21/18
7/30/18	REQUEST FOR ENTIRE COURT FILE FROM COURT OF APPEALS	kab	7/30/18
8/17/18	COMMENT MAILED ENTIRE FILE & 12 TRANS (1 COPY TRANS) TO COURT OF APPEALS	kab	8/17/18

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Activity Date	Activity	User	Entry Date
8/21/18	REQUEST FOR ENTIRE FILE FROM COURT OF APPEALS PREV MAILED ON 8/17/18	kab	8/21/18
5/23/19	OPINION AND ORDER (FROM APPELLATE COURT)	kab	6/26/19

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Case Search

Case Docket Number Search Results - 338431

Appellate Docket Sheet

COA Case Number: 338431**MSC Case Number: 159948**

PEOPLE OF MI V TERRY LEE CEASOR

1	PEOPLE OF MI Oral Argument: Y Timely: Y	PL-AE	PRS	(66226) GEORGIA HILARY
2	CEASOR TERRY LEE Oral Argument: Y Timely: Y	DF-AT	RET	(45353) MORAN DAVID A

COA Status: Case Concluded; File Open **MSC Status:** Pending on Application

- 05/19/2017 1 Claim of Appeal - Criminal
Proof of Service Date: 05/19/2017
Fee Code: FP
Attorney: 45353 - MORAN DAVID A
Comments: File Opened Per USDC ED 5:08-cv 13641
- 01/17/2006 2 Order Appealed From
From: ST CLAIR CIRCUIT COURT
Case Number: 05-000220-FH
Trial Court Judge: 10029 ADAIR JAMES P
Nature of Case:
Child Abuse
- 05/15/2017 3 Other
Date: 05/12/2017
For Party: 2 CEASOR TERRY LEE DF-AT
Filed By Pro Per
Comments: Attorney General Provided Copy of USDC ED Order Granting Writ Of Habeas Corpus
- 05/19/2017 4 Transcript Complete Per COA Atty
Date: 05/19/2017
Comments: See 268150 for Transcript Entries
- 05/19/2017 5 Correspondence Sent
For Party: 2 CEASOR TERRY LEE DF-AT
Filed By Pro Per
Comments: Chf Clk Advised File Opened Per USDC ED Directive
- 05/22/2017 9 Appearance - Appellant
Date: 05/23/2017
For Party: 2 CEASOR TERRY LEE DF-AT
Attorney: 45353 - MORAN DAVID A
- 05/23/2017 10 Defective Holding File Letter
Attorney: 45353 - MORAN DAVID A
Comments: Letter sent to all parties.
- 05/23/2017 11 Proof of Service - Generic
Date: 05/23/2017

Court of Appeals Docket

- For Party: 2 CEASOR TERRY LEE DF-AT
Attorney: 45353 - MORAN DAVID A
Comments: for appearance
- 05/31/2017 12 Fee - Entry - Defect Cured
Date: 05/31/2017
For Party: 2 CEASOR TERRY LEE DF-AT
Attorney: 45353 - MORAN DAVID A
- 07/12/2017 13 LCt Pleading - Post-Judgment
Date: 07/12/2017
For Party: 2 CEASOR TERRY LEE DF-AT
Attorney: 45353 - MORAN DAVID A
Comments: Motion for new trial
- 07/12/2017 14 Correspondence Sent
Date: 07/12/2017
For Party: 2 CEASOR TERRY LEE DF-AT
Attorney: 45353 - MORAN DAVID A
Comments: PJ letter sent
- 07/19/2017 15 Telephone Contact
For Party: 2 CEASOR TERRY LEE DF-AT
Attorney: 45353 - MORAN DAVID A
Comments: Per Atty Moran, attempting to scheduled status conference w/Judge West; will keep COA posted.
- 07/28/2017 16 Correspondence Received
Date: 07/26/2017
For Party: 2 CEASOR TERRY LEE DF-AT
Attorney: 45353 - MORAN DAVID A
Comments: letter to trial court from Atty Moran explaining history of case and why pj mtn properly before Him
- 12/01/2017 22 Post-judgment Proceedings Overdue - Notice
Attorney: 45353 - MORAN DAVID A
- 12/07/2017 23 Correspondence Received
Date: 12/05/2017
For Party: 2 CEASOR TERRY LEE DF-AT
Attorney: 45353 - MORAN DAVID A
Comments: letter indicating that order re: post-judgment motion has not yet been issued
- 02/13/2018 26 Telephone Contact
For Party: 2 CEASOR TERRY LEE DF-AT
Attorney: 45353 - MORAN DAVID A
Comments: Per AT, motion for new trial denied on 2/1/18; AT will forward trial court order to COA.
- 02/13/2018 27 Telephone Contact
For Party: 2 CEASOR TERRY LEE DF-AT
Attorney: 45353 - MORAN DAVID A
Comments: AT attempting to order two p-j hrg dates from Ct Rptr Schweikart (Rptr #3271) : 8/7/17 & 9/21/17.
- 02/13/2018 28 LCt Order
Date: 09/05/2018
For Party: 2 CEASOR TERRY LEE DF-AT
Attorney: 45353 - MORAN DAVID A
Comments: order re: evidentiary hearing
- 02/13/2018 29 LCt Order - Post Judgment
Date: 02/01/2018
For Party: 2 CEASOR TERRY LEE DF-AT
Attorney: 45353 - MORAN DAVID A
Comments: motion for new trial denied
- 02/13/2018 30 Transcript Requested By Atty Or Party

Court of Appeals Docket

- Date: 02/12/2018
Timely: Y
Reporter: 3000 - REPORTER UNKNOWN
Filed By Attorney: 45353 - MORAN DAVID A
Comments: for post-judgment proceedings
- 02/27/2018 31 Invol Dismissal Warning - No Steno Cert
Attorney: 45353 - MORAN DAVID A
Due Date: 03/20/2018
Comments: No steno cert for post-judgment hearing date(s)
- 03/07/2018 32 Telephone Contact
For Party: 2 CEASOR TERRY LEE DF-AT
Attorney: 45353 - MORAN DAVID A
Comments: AT has obtained steno cert for post-judgment transcript. Will file with COA.
- 03/07/2018 33 Steno Certificate - Tr Request Received
Date: 02/12/2018
Timely: Y
Reporter: 3271 - SCHWEIKART KATHIE A
Filed By Attorney: 45353 - MORAN DAVID A
Hearings:
08/07/2017
09/21/2017
Comments: for post-judgment proceedings
- 03/07/2018 34 Transcript Not Taken By Steno
Date: 03/06/2018
Reporter: 3000 - REPORTER UNKNOWN
Comments: Rptr Schweikart responsible for post-judgment proceedings-see event 33
- 03/09/2018 35 Other
Date: 02/12/2018
Reporter: 3271 - SCHWEIKART KATHIE A
Comments: copy of steno cert in evt 33
- 03/19/2018 36 Notice Of Filing Post-Judgment Transcript
Date: 03/19/2018
Timely: Y
Reporter: 3271 - SCHWEIKART KATHIE A
Hearings:
08/07/2017
09/21/2017
Comments: per St. Clair register of actions-these transcripts filed on 3/19/18
- 03/19/2018 37 Post-Judgment Motion Concluded
Date: 03/19/2018
For Party: 2 CEASOR TERRY LEE DF-AT
Attorney: 45353 - MORAN DAVID A
Comments: transcripts filed on 3/19/18
- 03/20/2018 38 Transcript Filed By Party
Date: 03/20/2018
Reporter: 3271 - SCHWEIKART KATHIE A
Filed By Attorney: 45353 - MORAN DAVID A
Hearings:
08/07/2017
09/21/2017
- 03/21/2018 39 Notice Of Filing Post-Judgment Transcript
Date: 03/19/2018

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Timely: Y
Reporter: 3271 - SCHWEIKART KATHIE A
Filed By Attorney: 45353 - MORAN DAVID A
Comments: no hearing dates listed-indicates complete transcript filed

- 04/27/2018 **40 Brief: Appellant**
Proof of Service Date: 04/27/2018
Oral Argument Requested: Y
Timely Filed: Y
Filed By Attorney: 45353 - MORAN DAVID A
For Party: 2 CEASOR TERRY LEE DF-AT
- 05/04/2018 **41 Stips: Extend Time - AE Brief**
Extend Until: 06/29/2018
Filed By Attorney: 66226 - GEORGIA HILARY
For Party: 1 PEOPLE OF MI PL-AE
- 06/13/2018 **42 Motion: Extend Time - Appellee**
Proof of Service Date: 06/13/2018
Filed By Attorney: 66226 - GEORGIA HILARY
For Party: 1 PEOPLE OF MI PL-AE
Fee Code: EPAY
Requested Extension: 07/27/2018
Answer Due: 06/20/2018
- 06/19/2018 **43 Submitted on Administrative Motion Docket**
Event: 42 Extend Time - Appellee
District: T
- 06/22/2018 **44 Order: Extend Time - Appellee Brief - Grant**
View document in PDF format
Event: 42 Extend Time - Appellee
Panel: CMM
Attorney: 66226 - GEORGIA HILARY
Extension Date: 07/27/2018
- 07/27/2018 **46 Brief: Appellee**
Proof of Service Date: 07/27/2018
Oral Argument Requested: Y
Timely Filed: Y
Filed By Attorney: 66226 - GEORGIA HILARY
For Party: 1 PEOPLE OF MI PL-AE
- 07/28/2018 **45 Noticed**
Record: REQST
Mail Date: 07/30/2018
- 08/13/2018 **47 Brief: Reply**
Proof of Service Date: 08/13/2018
Oral Argument Requested:
Timely Filed: Y
Filed By Attorney: 45353 - MORAN DAVID A
For Party: 2 CEASOR TERRY LEE DF-AT
- 08/21/2018 **48 Record Request**
Mail Date: 08/21/2018
Agency: ST CLAIR CIRCUIT COURT
- 08/21/2018 **49 Record Filed**
File Location:
Comments: 2 LCF ; 12 TRS - St. Clair County
- 04/15/2019 **62 Motion: Oral Argument - Law Student (MCR 8.120)**

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Proof of Service Date: 04/15/2019

Filed By Attorney: 45353 - MORAN DAVID A

For Party: 2 CEASOR TERRY LEE DF-AT

Fee Code: EPAY

Answer Due: 04/22/2019

Comments: Law Students William Chorba & Lena Gankin

- 04/23/2019 63 Submitted on Motion Docket Affecting Call
Event: 62 Oral Argument - Law Student (MCR 8.120)
District: T
- 04/23/2019 64 Order: Oral Argument - Law Student - Grant
View document in PDF format
Event: 62 Oral Argument - Law Student (MCR 8.120)
Event: 63 Submitted on Motion Docket Affecting Call
Panel: JRR,JEM,KFK
Attorney: 45353 - MORAN DAVID A
Comments: William Chorba & Lena Gankin may appear-Atty Moran shall accompany
- 04/23/2019 65 Case Call Update For Panel
Comments: Law Students William Chorba & Lena Gankin may appear-Chorba present Arg I-Gankin present Arg II
- 05/07/2019 60 Submitted on Case Call
District: D
Item #: 3
Panel: JRR,JEM,KFK
- 05/07/2019 66 Oral Argument Audio
- 05/13/2019 68 Oral Argument Recording - Request
Date: 05/09/2019
For Party: 2 CEASOR TERRY LEE DF-AT
Attorney: 45353 - MORAN DAVID A
- 05/15/2019 69 Oral Argument Recording - Sent Temp Link
Date: 05/15/2019
For Party: 2 CEASOR TERRY LEE DF-AT
Attorney: 45353 - MORAN DAVID A
Comments: morand@umich.edu-audio file confirmed/acceptable
- 05/23/2019 73 Opinion - Per Curiam - Unpublished
View document in PDF format
Pages: 11
Panel: JRR,JEM,KFK
Result: L/Ct Judgment/Order Affirmed
- 07/17/2019 74 SCT: Application for Leave to SCT
Supreme Court No: 159948
Answer Due: 08/14/2019
Fee: E-Pay
For Party: 2
Attorney: 45353 - MORAN DAVID A
- 08/06/2019 75 Supreme Court - Record Sent To
File Location:
Comments: sc#159948 2 lcf;12 tr
- 08/06/2019 76 SCT: Trial Court Record Received
12 tr; 2 files
- 10/02/2019 78 SCT Motion: Miscellaneous
Party: 2
Filed by Attorney: 45353 - MORAN DAVID A

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Court of Appeals Docket

Comments: Motion to File Supplemental Authority; Supplemental Authority attached

04/17/2020 80 SCt Order: MOAA -Oral Argument on Lv Appl

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Comments: Grant motion to file supp authority. Chief Justice McCormack not participating.

Case Listing Complete

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1 over.

2 THE COURT: Mr. Black.

3 MR. BLACK: Yes, Judge. I didn't want to upset
4 the Court when I asked any questions, but if the Court
5 will recall, the Court earlier told me if I were to ask
6 one more question possibly a case would not have been
7 bound over, so forgive me for going overboard on that.

8 Judge, I know this case is going to get bound
9 over and so does my client, but there's no eyewitnesses to
10 it. It's going to be expert against expert, and that's
11 why it's very, very important that I get all the
12 information I can when I have an opportunity to talk to
13 witnesses. I hope I didn't make the Court mad at me, but
14 I have a job to do, your Honor, and I'm sorry that it made
15 you mad. I didn't quite get the answer to that question,
16 and I wanted to make sure I got it.

17 THE COURT: Well, Mr. Black, I think that if you
18 get a transcript of this proceeding, which I'm sure you
19 will, you will see that the doctor did, in fact, answer
20 that question. And that's what I was saying was that she
21 had answered the question and you seemed to want to argue
22 with me as to whether she did or didn't.

23 MR. BLACK: I just didn't hear it.

24 THE COURT: And, well, I think if you consult
25 the transcript you will find that she answered that

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1 then for them to --

2 JUROR TEN: Right.

3 THE COURT: Oh.

4 JUROR TEN: My husband works.

5 THE COURT: I see. Okay.

6 JUROR TEN: But I can line somebody up.

7 THE COURT: Um, is --

8 JUROR TEN: I did today, taken care of if we run

9 over. I just want to make a confirmation call to the

10 person.

11 THE COURT: Well, you may want to think about

12 doing that at noon time today. I don't know whether

13 you're going to stay on this jury or not at this stage and

14 I, so I can't give you a whole bunch of warning. And so

15 we just have to go from there for now. Are you

16 comfortable in doing that?

17 JUROR TEN: Yes.

18 THE COURT: Okay. All I can do is promise you I

19 won't forget about you. At this stage that's all I can do

20 is promise you that. You almost finished, Mrs. Deegan?

21 MRS. BERGAN: Yes, and that's what I was going

22 to say, any other reasons like Ms. Moses or Mr. Luke-Gunn

23 that you have some issues? Nothing further.

24 THE COURT: Thank you, Mrs. Deegan.

25 MRS. BERGAN: Thank you.

1 THE COURT: Mr. Lord, you may voir dire this

2 prospective jury.

3 MR. LORD: I get to do it while everybody's

4 thinking about lunch, right.

5 Anybody really know why we're here? Mr. Kane

6 did you ever think about why we're here?

7 JUROR ELEVEN: As a, as a juror.

8 MR. LORD: What, what is our role here?

9 JUROR ELEVEN: I guess our role would be to

10 to decide the, the facts of this, not decide the facts,

11 listen to the, the facts presented.

12 MR. LORD: That's pretty good, though, decide

13 the facts. All right. Because after you hear the facts

14 you have to decide whether they are facts, correct? What

15 if I told you another role in my mind would be to seek

16 justice. Does that make sense?

17 Sometimes we always talk about guilt or

18 innocence and whether somebody did something or, you know

19 when you, when you look at a crime and you hear about

20 child abuse all of us kind of raise the hair on the back

21 of our neck, don't we?

22 Mrs. LaForge, doesn't that bother you? I mean

23 anybody here doesn't like kids? We all like kids, right?

24 And if you hear that somebody's accused of

25 abusing them, doesn't that automatically kind of stand

1 that hair on the back of your neck up, Mr. Shield?

2 Doesn't that bother you a little bit?

3 But if we're here to seek justice and there's

4 just an accusation made, do you see how we have to protect

5 from that happening? Miss Balkwill, does that make sense

6 to you?

7 I mean child abuse. God, that's terrible.

8 Hurting a kid. But what if you didn't do it? Mr. Rivard,

9 what if you didn't do it? Would you want 12, 13 people

10 you don't know making that judgment for you if it were

11 you?

12 JUROR ONE: ... (inaudible) ...

13 MR. LORD: Yeah, but how do you prove it?

14 Mr. Lane, do you think that money can sometimes assist a

15 person? If we have a lot of money to hire expert

16 witnesses and you're wealthy and you bring a bunch of

17 people in here to trumpet out their experts that would

18 help, wouldn't it?

19 JUROR SIX: Probably could.

20 MR. LORD: What if you don't have a lot of

21 money? What if you're like maybe my dad worked 30 years

22 at Chrysler's. He had to come up with \$3,000.00 or

23 \$4,000.00 he wouldn't have it.

24 So, Ms. McDonald, you think about that. People

25 sometimes ever imagine you been a victim of a crime? We

1 can all, the way the news goes we can all imagine

2 ourselves being victims of a crime, can't we? I mean

3 anybody ever imagine when you get up in the morning, oh,

4 might be a Defendant by the end of the day? Doesn't

5 happen, does it?

6 Mr. Schunck, I never should, you probably never

7 thought one of your sons or anybody in your family would

8 be a Defendant by the end of the day, did you?

9 JUROR FOUR: Nope.

10 MR. LORD: And when it happens you go, wow,

11 let's back the truck up, in the words of Tim Allen, what

12 happened here. And now I got to go in front of 12 to 13

13 people who have no idea about me and they're going to make

14 a determination that's going to affect the rest of my

15 life.

16 Mr. Brand, see how you might be worried if that

17 you were over there?

18 JUROR SEVEN: Oh, yeah.

19 MR. LORD: And if that were you over there would

20 you like someone like you on the jury? Everybody see what

21 I'm getting at?

22 We talk about the presumption of innocence and

23 before I went to law school that didn't mean much to me.

24 You know, just a bunch of words. Hear it on TV a lot.

25 Used to watch Perry Mason. The Prosecutor there was

1 Now, I have to tell you a couple of things. It
 2 goes this way: You know however little or however much
 3 about this case now, so when you go through this door, I'm
 4 talking to all of us in here, all of you in here, you may
 5 not discuss this case with anyone. You can go to lunch
 6 together, have lunch, talk about my tie, but don't talk
 7 about this case, please. I don't want you getting
 8 somebody else's ideas about this and about that and, and I
 9 think you understand.

10 It's not kindergarten, this is adult stuff. So
 11 you're excused 'til 1:30 this afternoon and return right
 12 directly to the spot you're in right now.

13 Marsha, we'll go off the record. Thank you.

14
 15 (At 12:08 p.m., proceedings recessed.)
 16 (At 1:33 p.m., proceedings reconvened.)

17
 18 THE COURT: Let's see, was it Mrs. Moses. Were
 19 you able to make some phone calls at noon time today --
 20 JUROR TEN: Yes.
 21 THE COURT: -- Mrs. Moses.
 22 JUROR TEN: I'm all set.
 23 THE COURT: Are you able to help me out anymore
 24 or tell me anything more or --
 25 JUROR TEN: I'm set with babysitting.

1 THE COURT: You're set with babysitting.
 2 JUROR TEN: Yes.
 3 THE COURT: Okay. Okay, well you're still on
 4 mind and I'll get back to you yet before we finally do
 5 this. But okay, thank you very much.
 6 Mr. Lord, you may continue to voir dire this
 7 jury.
 8 MR. LORD: Good afternoon. Everybody full?
 9 Good.
 10 We're talking a little bit about expert
 11 witnesses and opinions and foundation for those opinions.
 12 Mentioned a little bit about if you went to a doctor and
 13 he gave you an opinion and you went and got a second
 14 opinion and the prosecutor brought up whether or not you
 15 would rely upon that. A lot of you shook your heads yes,
 16 right? But you know that medicine is not an exact
 17 science. Would you agree with that, Mrs. LaForge?
 18 And Mrs. Worswick, you know Doctor Gilmer-Hill
 19 or don't know her, but refer people to her, correct?
 20 Medicine sometimes evolves, everybody agree with that?
 21 Sometimes, I don't know how many times we're
 22 told something's bad for us, eggs are bad for us, then
 23 they're good for us, then they're bad for us, then
 24 Saccharine, then Sucrose. These are all based upon
 25 medical opinions and experts, because as science evolves

1 we learn different things, right?
 2 The, everybody hear of the drug Vioxx. That was
 3 prescribed by doctors for people that have arthritic pain
 4 and that sort of things. And it was ... (inaudible) ...
 5 for substantial period of time by doctors who had opinions
 6 based upon medical research, right? And all of a sudden
 7 we find out it's taken off the market because maybe that
 8 research wasn't so good. We, see how that could happen?
 9 You can go to two doctors, present the same
 10 symptoms and get different opinions. Everybody agree that
 11 could happen?
 12 And we also talked about a little bit about
 13 money. My client cannot afford to hire an expert. I can
 14 tell you that right now. The fact that we don't have an
 15 expert, that doesn't mean that you won't listen to the
 16 questions I ask and try to make sense out of what I ask
 17 and see how that fits with your own common sense and
 18 general knowledge, does that make sense to you?
 19 Mr. Rivard, does that seem fair to you?
 20 JUROR EIGHT: Yeah.
 21 MR. LORD: Mostly we see experts in trials like
 22 this when we have like a mental illness and psychiatrists
 23 and, and we'll have one say one thing, another say
 24 another, but it happens in all kinds of trials where we
 25 have experts that differ, have different view points.

1 Everybody see how that can happen?
 2 Is it Luke-Gunn or is it just --
 3 JUROR TWELVE: Legally, yeah, it's Luke, dash,
 4 Gunn, but usually I just go by Anthony GUNN.
 5 MR. LORD: Mr. GUNN.
 6 JUROR TWELVE: Yeah.
 7 MR. LORD: Is it more comfortable if I call you
 8 that then? Okay. You see now how that could happen,
 9 Mr. Gunn? In, in the Vioxx trial where they have Pfizer
 10 on one side and people suing them on behalf of the
 11 families on the other, they have tons of money and expert
 12 on all sides, right?
 13 JUROR TWELVE: Right.
 14 MR. LORD: All I'm asking is as jurors would yo
 15 be fair and listen to what's testified to and what the
 16 evidence shows as to what the opinions are and what
 17 they're based upon? Would you be willing to do that?
 18 Since you refer people to Doctor Gilmer-Hill, I
 19 may have to question her about some things that might mak
 20 her not very pleased with me. Would that bother you?
 21 JUROR TWO: No, I go by my doctor's
 22 recommendations.
 23 MR. LORD: Okay.
 24 THE COURT: Mr. Lord, I actually did not make
 25 your -- very pleased with me, her?

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1 JUROR SEVEN: Yes.

2 MR. LORD: So even with this, the certain

3 syndromes like the shaken baby syndrome or certain

4 medications, opinions change on those things and just

5 because a doctor may say something or that they look for

6 certain criteria doesn't make it true beyond a reasonable

7 doubt. Do you see what I'm saying?

8 JUROR SEVEN: Yes.

9 MR. LORD: That makes sense, doesn't it?

10 JUROR SEVEN: Yes, it does.

11 MR. LORD: Ms. Ruggero.

12 JUROR FOUR: Uh-hum.

13 MR. LORD: Did you ever have any cases that

14 were, where the allegation was shaken baby syndrome?

15 JUROR FOUR: I can't recall any cases, no.

16 MR. LORD: And when they do medical diagnosis,

17 and again a little bit of knowledge I think is sometimes a

18 dangerous thing, especially when I'm the one with the

19 little bit of knowledge. But we can't afford to hire an

20 expert, you understand that?

21 JUROR FOUR: Uh-hum.

22 MR. LORD: Not everybody has that kind of money

23 available. I can, I can take 25 bucks a week from him for

24 the rest of his life, but if we want a doctor we got to

25 pay him up front, you understand that?

1 JUROR FOUR: I understand.

2 MR. LORD: So a lot of my questioning with

3 reference to this doctor will be material that I've had

4 research myself, and not being a doctor I'm probably going

5 to be fighting a battle where the doctor has more

6 information than I do. But there are competing theories

7 out there about shaken baby syndrome, what causes it, what

8 causes the injuries. Do you understand that?

9 JUROR FOUR: Yes.

10 MR. LORD: Your background in social work is

11 going to predispose you one way or another. And I think

12 you, I, I really appreciate your honesty, that that's kind

13 of nice. Just like Mr. McCarty. We, we do as attorneys

14 appreciate that when somebody gets up there and says, you

15 know, you need to know this and I think sometimes if I were

16 on a jury I'd try extra hard to make sure, I'd want them

17 to know my bias, but I, I work my best to put it aside

18 just want to make sure that you in your heart, you can

19 look at me and say listen, I believe in the presumption

20 of innocence, unless this is proved beyond a reasonable doubt

21 then I'm going to say not guilty.

22 JUROR FOUR: No, I don't believe I'm biased, I

23 just believe I'm informing the Court of the questions that

24 were asked.

25 MR. LORD: Okay.

1 JUROR FOUR: And ... (inaudible) ... I can

2 definitely ... (inaudible) ...

3 MR. LORD: All right. And just because a doctor

4 says something are you going to say that that's proof

5 beyond a reasonable doubt?

6 JUROR FOUR: No.

7 MR. LORD: You understand as we've gone over

8 some of the other examples like Vioxx and some of the

9 other things that were once accepted for medical treatment

10 --

11 JUROR FOUR: Certainly.

12 MR. LORD: -- that they change?

13 JUROR FOUR: Certainly.

14 MR. LORD: And do you also agree that, you know,

15 an expert's opinion would be relevant as to how much time

16 they've actually spent with say if they're going to make a

17 diagnosis about a child wouldn't you want them to have

18 spent some time with the child?

19 JUROR FOUR: I would look at their experience,

20 certainly.

21 MR. LORD: Well, experience is one thing, but

22 actually spending, I might have experience blowing up a

23 lot of bridges, but unless I've looked at that particular

24 bridge it's not always good to go based upon what other

25 bridges look like.

1 JUROR FOUR: Certainly I would want to listen to

2 what they have to say.

3 MR. LORD: Okay.

4 JUROR FOUR: Yes.

5 MR. LORD: So if a witness came in and said,

6 well gee, I don't even remember seeing that doctor around

7 my child, that might be something you want to look at,

8 right?

9 JUROR FOUR: Yes.

10 MR. LORD: I have nothing further.

11 THE COURT: Thank you, Mr. Lord.

12 Mrs. Deegan, do you pass this jury for cause?

13 MRS. DEEGAN: I do, your Honor.

14 THE COURT: Mr. Lord, do you pass this jury for

15 cause?

16 For cause, Mr. Lord?

17 MR. LORD: None for cause.

18 THE COURT: You may exercise one or more

19 peremptory challenge.

20 MR. LORD: We're satisfied with the jury.

21 THE COURT: Thank you.

22 Mrs. Deegan, you may exercise one or more

23 peremptory challenge.

24 MRS. DEEGAN: Thank you, your Honor.

25 Your Honor, we'd thank and excuse Mr. McCarty.

Trial: Testimony of Cheryl Genna

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1 Q Had you left either Derian or Brenden with Mr. Ceasor
 2 alone prior to that night?
 3 A Yes, several times.
 4 Q Did you guys stay in that evening then when you got over
 5 there around 7:00? Did you, did you stay at residence or
 6 did you go somewhere else?
 7 A Actually me and my daughter went to Blockbuster Video and
 8 to China Lite.
 9 Q Just you and your daughter?
 10 A Yes.
 11 Q And where were Mr. Ceasor and Brenden?
 12 A At his home.
 13 Q All right. They didn't go with you?
 14 A No.
 15 Q Was there a reason for that?
 16 A Brenden needed to eat and he was getting ready to go to
 17 bed, so --
 18 Q Approximately what time did you get home then Saturday
 19 night?
 20 A Maybe quarter to 8:00, eight o'clock.
 21 Q All right. And had Brenden had any injuries or bruising
 22 that night when you took him over, had he had any bumps or
 23 fallen prior to that evening?
 24 A No.
 25 Q Now, what happened then did, the evening, did you stay

1 overnight at Mr. Ceasor's?
 2 A Yes.
 3 Q Okay. What happened the next day?
 4 A Um, I woke up around 9:30, quarter to 10:00.
 5 Q And were the kids up?
 6 A Well, Terry was getting back in bed and he had said he
 7 went in there and gave Brenden a bottle.
 8 Q All right. And was Derian up then at that time?
 9 A No.
 10 Q No?
 11 A She, I believe she was awake, but she was watching TV.
 12 Q And then what happened after that?
 13 A I went into the bathroom, came out, went and talked to
 14 Derian. Um, she said she was hungry. She asked me if
 15 Brenden was up yet.
 16 Q All right. Did you take care of Brenden then or take
 17 of Derian's breakfast?
 18 A Actually we went to McDonald's, just Derian and I.
 19 Q Okay.
 20 A Around 10:30.
 21 Q And so Mr. Ceasor was left with Brenden again for the run
 22 that you went to McDonald's?
 23 A Yes.
 24 Q When you returned what happened after that?
 25 A Um, I was reading the newspaper. Terry had went in and

1 checked on him a few times. Um, I was going to take
 2 Brenden over to his father's mother's because I was going
 3 to take my daughter swimming.
 4 Q All right. And what time of day was that when you were
 5 starting to think about doing that?
 6 A Um, noon, one o'clock.
 7 Q Okay. And you had set it up then that his paternal
 8 grandma could see Brenden then during the day?
 9 A She had said before to always call Sundays.
 10 Q All right. That would be a good day?
 11 A Yeah.
 12 Q All right. Was Brenden awake during this time at all
 13 when, during the morning?
 14 A No.
 15 Q When was he awake, when you were talking about taking him
 16 over to his paternal grandma's?
 17 A No.
 18 Q All right. Is that unusual for him to sleep that late?
 19 A No.
 20 Q All right. He's a good sleeper?
 21 A Yes.
 22 Q Okay. So what time then did you end up taking him to his
 23 paternal grandmother's?
 24 A I didn't.
 25 Q Okay. What happened after that?

1 A Um, I was watching TV with Derian in Terry's son's room.
 2 Um, he, Terry said he would get him ready so I could take
 3 him. We were in there watching TV and I went to come out
 4 and Terry was going back into the bedroom and he said he'
 5 tired, just let him sleep, go ahead and go, you're only
 6 going to be gone a little bit.
 7 Q All right. So did you agree to have Terry just watch
 8 Brenden for you then?
 9 A Yes.
 10 Q All right. You said that, that you were watching TV with
 11 Derian in, in Terry's son's bedroom. Was Terry's son
 12 there?
 13 A No.
 14 Q Had you been over when Terry's son had been there?
 15 A Yes, several times.
 16 Q You, you know Terry's son?
 17 A Yes.
 18 Q What's his name?
 19 A Cody.
 20 Q All right. And approximately how old was he back last
 21 year?
 22 A Thirteen.
 23 Q Approximately what time then did you think about leaving
 24 with Derian? What time did you leave the house?
 25 A Around 2:30.

Trial: Testimony of Cheryl Genna

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1 Q All right, 2:30.
2 And the only person who, who was the only person
3 home?
4 A Terry.
5 Q And Brenden?
6 A Yes.
7 Q Where did you go when you left?
8 A I actually went to the store down the street.
9 Q All right.
10 A Then I went to my home, got my, my daughter's bathing suit
11 and ran over to my sister's. She lives two doors down and
12 got her bathing suit, and then we went to the Holiday Inn.
13 Q All right. And why the Holiday Inn?
14 A Because I worked there and I could swim free on Sundays.
15 Q All right. So you were working there at that time?
16 A Yes.
17 Q All right. And so were you able to take Derian there
18 swimming?
19 A Yes.
20 Q And so approximately what time did you kind of wrap up the
21 swimming and decide it was time to go?
22 A Right before four o'clock.
23 Q All right. And is the Holiday Inn very far from Terry's
24 house?
25 A About two minutes.

1 Q So you had been there approximately how long then or how
2 away from the house approximately how long?
3 A About an hour and a half.
4 Q All right. What happened when you, where did you go when
5 you left? Where were you going to go?
6 When you left the pool, where were you going
7 to go?
8 A Back to Terry's house.
9 Q On Yeager Street?
10 A Yes.
11 Q And, and when you arrived there, what happened?
12 A I walked in and was taking my shoes off and Terry was
13 standing at the top of the stairs holding Brenden and
14 Brenden fell and hit his head, I can't wake him up. And
15 laughed and looked down, I said whatever, because I
16 thought he was joking.
17 Q All right. You didn't notice Brenden's condition at the
18 time?
19 A No, because he had Brenden. I just seen him holding
20 Brenden.
21 Q Okay. And you didn't feel that it was serious at that
22 time?
23 A No.
24 Q All right. What happened after that?
25 A He said I'm serious, so I ran up there and, and screamed

1 and shouted.
2 Q All right. And how, what did you notice about Brenden
3 when you got up to the top of the stairs?
4 A He was unconscious.
5 Q All right. Were you, what did you do?
6 A Screamed and yelled his name.
7 Q Did he respond?
8 A No.
9 Q All right. What happened after that?
10 A I said we have to take him to the emergency room.
11 Q All right. And how did that come about then?
12 Did you call for an ambulance or --
13 A No.
14 Q -- or what happened?
15 A I knew that I could get him there in a couple minutes.
16 Q All right. Did Brenden arouse himself at all from the
17 time you got in the house to the hospital?
18 A No.
19 Q All right. And how did you get to the hospital, what
20 vehicle did you use?
21 A My vehicle.
22 Q All right. And who went?
23 A Terry, my daughter, my son and myself.
24 Q All right. And who was driving?
25 A Terry.

1 Q Okay. And you said that Brenden didn't get conscious
2 during that time?
3 A Not at all.
4 Q Did you notice anything about him when you, were you
5 holding onto him then in the car?
6 A No, I put him in his car seat.
7 Q You put him in his car seat. Did you notice any injuries
8 on him when you looked at him?
9 A No.
10 Q All right. Did you notice anything about his person that
11 drew your attention? Anything unusual about him?
12 A He was completely, um, he was very, I don't know the word
13 I want to use.
14 Q Not conscious?
15 A Not conscious.
16 Q And was there anything, you said you didn't notice any
17 injuries, but was there anything different about him that
18 you noticed when you looked at him?
19 A His hair was wet.
20 Q All right. Did you know why his hair was wet?
21 A No.
22 Q And how wet was wet?
23 A Wet enough to where it was sticking up. Um, it wasn't
24 drenched wet, but --
25 Q And what part of his head, head was wet?

1 Q All right. And was there a time that you were asked about
2 the incident itself?
3 A Yes.
4 Q And do you recall whether that was at Port Huron or later?
5 A That was Port Huron Hospital.
6 Q All right. And did you give the police a version of what
7 had happened?
8 A Yes.
9 Q What did you tell them?
10 A I told him that I was there --
11 Q That you were there?
12 A -- when my son was injured.
13 Q All right. So you told him you were where?
14 A At the house on Yeager.
15 Q All right. And you told him you were there. What did you
16 tell him about the incident?
17 A I said Brenden fell and I picked him up.
18 Q Did you tell them whether you were present when he fell or
19 whether you saw the fall or not?
20 A Yeah, I didn't say I saw the fall.
21 Q And was that the truth?
22 A No.
23 Q All right. Why didn't you tell the officer that you
24 weren't there when it had happened?
25 A I was afraid, scared.

1 Q And what was making you scared or why, why did you have
2 that fear?
3 A I don't know. I was in shock. I was dealing with my son
4 being injured. I didn't think it through, no.
5 Q All right. You, you say that you were not with the fact
6 of Brenden at the time. You weren't in a relationship
7 with him obviously?
8 A No.
9 Q And was there any kind of problems that were going on
10 between you and him with regard to Brenden?
11 A Yes.
12 Q Okay. And was there a situation where you were having
13 troubles over custody between, with regard to Brenden?
14 A Not with custody, no.
15 Q Okay.
16 A It was support, yes.
17 Q With support.
18 Did you have a more detailed conversation with
19 Mr. Ceasor once you got to the, the Port Huron Hospital
20 about what had happened while you weren't there?
21 A Yes.
22 Q And what did he tell you had happened while you were at
23 the pool?
24 A That he fell.
25 Q And did he describe it in any way?

1 A A little. That he had fallen off the couch when they
2 were, he was on the couch and Terry was in the bathroom.
3 Q And did you relate those facts then to the police?
4 A No.
5 Q All right. You didn't tell them that Terry had been in
6 the bathroom and things like that?
7 A No.
8 Q Okay. When you talked about it with Mr. Ceasor and got
9 some more facts, did he ever tell you not to tell the
10 police that, that you were present at the time?
11 A No.
12 Q So, did he ever encourage you to tell the truth about you
13 not being there?
14 A I don't recall if he did.
15 Q When you went to, in the ambulance down to Children's
16 Hospital were, did you stay down there then with Brenden
17 at that hospital?
18 A Yes.
19 Q And how long was Brenden at that hospital?
20 A From Sunday 'til Friday.
21 Q So, less than seven days, less than a full week?
22 A Yeah.
23 Q On the transport down did, was there any change that you
24 could tell? Not, not being a doctor, but any change in
25 Brenden's condition while you were, he was transported to

1 Children's?
2 A He was throwing up.
3 Q Okay. And were, was the ambulance person treating him?
4 A Yes.
5 Q And once he got down to, to the hospital, were you able to
6 stay right with him the whole time?
7 A Not in the very beginning because he, when they, when he
8 came in they had to do a lot of vital signs, so they made
9 me go into the waiting room.
10 Q Okay. So there's a little period of time that you had to
11 wait for them to do some things with him?
12 A Yes.
13 Q All right. But then were you able to kind of go into his
14 room and stay with him?
15 A Yes.
16 Q All right. And did you pretty much stay there the entire
17 five days that he was --
18 A Yes.
19 Q -- there?
20 Any changes, like I said just not you being a
21 doctor, but any changes that you could tell as he was at
22 Children's about his condition physically?
23 A I did see a mark on the back of his head.
24 Q All right. When did you see that?
25 A I don't recall if it was Port Huron Hospital or Children's

Trial: Testimony of Cheryl Genna

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1 Q And what was making you scared or why, why did you have
 2 that fear?
 3 A I don't know. I was in shock. I was dealing with my son
 4 being injured. I didn't think it through, no.
 5 Q All right. You, you say that you were not with the father
 6 of Brenden at the time. You weren't in a relationship
 7 with him obviously?
 8 A No.
 9 Q And was there any kind of problems that were going on
 10 between you and him with regard to Brenden?
 11 A Yes.
 12 Q Okay. And was there a situation where you were having
 13 troubles over custody between, with regard to Brenden?
 14 A Not with custody, no.
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1 Hospital.

2 Q Can you describe the mark?

3 A Yeah. Um, it was oval, maybe two inches long, two and a

4 half, and it had red dots on it.

5 Q Had you noticed that mark prior to the Sunday when he was

6 at Mr. Ceasor's house? Had you noticed --

7 A No.

8 Q -- that mark earlier in the week or anything prior --

9 A Absolutely.

10 Q -- this incident?

11 A No.

12 Q All right. And you, you said it was red in color?

13 A Yes.

14 Q All right. Did you, were you able to tell any doctor

15 about that mark or any nurse or anything? Do you remember

16 saying, hey, there's a mark on, on Brenden's head?

17 A Yes.

18 Q Okay. Do you recall who you would have related that to?

19 A No, that was at Children's Hospital.

20 Q It was at --

21 A I do not, that I did tell them.

22 Q It was at Children's?

23 A That I told them, yes.

24 Q And was Brenden treated by just one person at Children's?

25 A No, several.

1 Q There was more than one that you were dealing with?

2 A Yes.

3 Q More than one nurse, too?

4 A Yes.

5 Q When you say several, was there a lot of different people

6 how many is several?

7 A Guessing, 30, 50.

8 Q Do you remember everybody that came into contact with you

9 son?

10 A Absolutely not, no.

11 Q Had you been able to get a good night's sleep at all when

12 you were there?

13 A Absolutely not.

14 Q Eating regularly or anything?

15 A No.

16 Q By the time Friday came of that week, was Brenden able to

17 talk and walk and, and was he doing better?

18 A Yes.

19 Q I mean just from your being able to look at him as a man?

20 A Yes.

21 Q All right. And was there anything that you needed to do

22 follow up wise with Brenden when he was released from the

23 hospital? Meaning did he have to meet with any doctor or

24 something further that he needed done?

25 A I believe he did, but I didn't take care of that.

1 Q And do you know if there were any medications that he was

2 to be continued on?

3 A He was released with no medications.

4 Q Any prescriptions --

5 A No.

6 Q -- for medications?

7 A No.

8 Q Someone else had custody of Brenden then for a period of

9 time?

10 A Yes.

11 Q And who was that?

12 A His father.

13 Q And was there a time when you said that you had originally

14 talked to an officer at Port Huron Hospital and told them

15 that you were present at the house. With a, there a time

16 that you reported that you really weren't at the house?

17 A Yes.

18 Q And when did that happen?

19 A Wednesday or Thursday that week.

20 Q Okay. The same week Brenden's at the Children's?

21 A Yes.

22 Q All right. How did you get in touch? What happened, how

23 did you do that, that you changed to that you weren't

24 there?

25 A I talked to a detective on the phone.

1 Q So you, you did it by phone?

2 A Yes.

3 Q Why did you change and tell them that you really weren't

4 at the house?

5 A Because I knew the truth had to be told.

6 Q All right. And you decided on that week to do that?

7 A Yes.

8 Q How long before you could start seeing Brenden again after

9 he was released from the hospital?

10 A Three months.

11 Q You hadn't seen him at all --

12 A No.

13 Q -- during that time?

14 And you're able to see him regularly now,

15 correct?

16 A Yes.

17 Q And at the time that you're seeing him, how is he doing at

18 this stage?

19 A He's doing great.

20 Q Do you see any effects from him being in the hospital --

21 A No, I don't.

22 Q -- from that incident?

23 Do you have to take him into the hospital or do

24 any follow-up with him now that, that you're seeing him

25 regularly?

Trial: Testimony of Cheryl Genna

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1 Q On that occasion, on October 3rd, you had mentioned that
2 you noticed a red mark and you said you did mention that
3 to a doctor?

4 A I believe so, yes.

5 Q Do you recall --

6 A A nurse.

7 Q -- which doctor you would have done that to?

8 A No.

9 Q And do you recall whether that was Port Huron Hospital or
10 Children's Hospital?

11 A Children's.

12 Q Okay. And did you notice any other injuries that you
13 hadn't noticed prior to that date on October 3rd?

14 A Yes.

15 Q What else did you notice?

16 A He had a bite mark on his tongue.

17 Q A bite mark on his tongue?

18 A Yeah.

19 Q Did he have a full set of teeth at that time?

20 A I believe he had four top and four bottom.

21 Q And when did you notice that bite mark?

22 A Port Huron Hospital.

23 Q All right. And did you point that out to someone at Port
24 Huron Hospital?

25 A No.

Trial: Testimony of Cheryl Genna

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1 Q Did you point that out later at the Children's Hospital?

2 A I don't recall.

3 Q And I believe you said there were several different
4 doctors and nurses that were working with your son?

5 A Yes.

6 Q Do you, did you have one in particular that you were
7 working with?

8 A Yes.

9 Q What was that name?

10 A Sherry.

11 Q Sherry. Do you know how to spell that?

12 Was it a doctor or a nurse?

13 A She was a doctor.

14 Q Okay. And would you say that you had spent, had more
15 contact with Sherry than another --

16 A Yes.

17 Q -- doctor. But that doesn't mean that other doctors
18 weren't working on your son, correct?

19 A Well, there were several. She's just the one I remember
20 the most.

21 Q And at the time of this incident, did you leave the
22 hospital at all down in Children's?

23 A Just to get something to eat, sleep.

24 Q Would you drive back to Port Huron then?

25 A No.

Trial: Testimony of Cheryl Genna

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1 A No.

2 Q However, he was there at the hospital with you?

3 A Yes.

4 Q Okay. And you had not gotten any contact from him prior
5 to going home. You didn't get a call from him at the
6 pool?

7 A No.

8 Q When you discussed the incident at the Port Huron Hospital
9 you two were able to discuss what had happened with
10 Brenden --

11 A Yes, I did.

12 Q -- at the hospital?

13 At that time who initiated the version that was
14 told to the police?

15 A I told them that.

16 Q All right. Did, were you interviewed separately by the
17 police?

18 A Yes.

19 Q Had you already talked with Mr. Ceasor prior to talking
20 with the police?

21 A Very briefly.

22 Q And did you have what he had told you, you knew what he
23 had told you already before you talked to the police about
24 what had happened?

25 A Yeah.

Trial: Testimony of Cheryl Genna

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1 MRS. DEEGAN: Nothing further.

2 THE COURT: Thank you.

3 Mr. Lord, you may cross-examine this witness.

4 MR. LORD: Thank you, Judge.

5

6 CROSS-EXAMINATION

7

8 BY MR. LORD:

9 Q Good morning.

10 A Good morning.

11 Q Probably more pleasant places to be.

12 A Pardon?

13 Q I said there's probably more pleasant places to be right
14 now, huh?

15 A Yes.

16 Q You were kind enough to bring Brenden into my office,
17 correct?

18 A Correct.

19 Q Pretty active child, isn't he?

20 A Yes.

21 Q Now, was he that active?

22 A He destroyed your, he destroyed your office.

23 Q Hum?

24 A He destroyed your office, yes.

25 Q Actually he didn't, but he was kind of cute.

Trial: Testimony of Cheryl Genna

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1 He was, you indicated to me he was pretty much
2 that active before the injury, correct?

3 A Yes.

4 Q And he's now that active again, and you've already told
5 the Prosecutor you don't see any signs of any lasting
6 injury to Brenden?

7 A Correct.

8 Q Pretty active child?

9 A Very active.

10 Q He --

11 A The most active I've ever seen, yes.

12 Q He keeps you hopping, right?

13 A Yes.

14 Q Now, on that particular day the Prosecutor were asking you
15 questions. **Mr. Ceasor never told you to tell Detective**
16 **Baker that he wasn't, that you were there, did he?**

17 A **No.**

18 Q And the information you got on the shaken baby syndrome
19 that was brought to you by your sister, didn't you also
20 have some discussion with her that Mr. Ceasor had told her
21 that he was alone with the baby?

22 MRS. DEEGAN: Your Honor --

23 THE WITNESS: That's a different sister.

24 MRS. DEEGAN: That would be hearsay, your Honor.

25 MR. LORD: It's not hearsay, your Honor. It's

Trial: Testimony of Cheryl Genna

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1 A True.

2 Q And that would not have been unusual that Terry would
3 vacuum?

4 A I, I guess not on a Sunday, no.

5 Q Okay.

6 A Yes.

7 Q And when you got to the home Terry was holding Brenden in
8 his arms, true?

9 A Yes.

10 Q You initially, because it would have never, you would have
11 never had any thought that Terry would hurt your child,
12 correct?

13 A Correct.

14 Q That's why you thought he was kidding when he said --

15 A Yes.

16 Q And then he said I'm serious that you knew then that he
17 was serious, true?

18 A Yes.

19 Q He seemed concerned, did he not?

20 A Yes.

21 Q He went to the hospital with you, did he not?

22 A Yes.

23 Q You were probably at that point a little shaken, would
24 have been probably difficult to drive on your own, true?

25 A Yeah, I couldn't, no.

Trial: Testimony of Cheryl Genna

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1 Q But Terry said, Terry didn't say, no, I'm not going, I
2 don't want to be around there. He wanted to go and, and
3 he went into the hospital, true?

4 A True.

5 Q Not just on that particular day that you were with Terry,
6 but at any time that Terry had interacted, you had done
7 other things. You'd gone, had you gone camping --

8 A Yes.

9 Q -- for instance?

10 And the children had went along?

11 A Yes.

12 Q At any time during any of the times that you saw Terry
13 interact with Derian or Brenden, did you ever at any time
14 see him act in any way that caused you any concern about
15 his being left alone with the children?

16 A No.

17 THE COURT: Say that again. I didn't hear you.
18 Say what? What was your answer?

19 THE WITNESS: No.

20 BY MR. LORD:

21 Q Now, you already discussed that Brenden was a very active
22 child.

23 A Yes.

24 Q And on these occasions with camping and when you were over
25 at Terry's house, Brenden when he wasn't sleeping would

1 A He's sitting in the plaid shirt at the Defense table.

2 THE COURT: Record will indicate identification.

3 MRS. DEEGAN: Thank you.

4 BY MRS. DEEGAN:

5 Q In talking with Mr. Ceasor, what was his indication as to
6 what happened?

7 A He stated that he was playing a game with the child on the
8 sofa where the child's running back and forth on the sofa,
9 and he was crawling back and forth behind the sofa.
10 Stated that he then went up to go and use the restroom.
11 He stated he did look at the child before he went into the
12 restroom and had stated looked as if the child had, had
13 it's foot caught in between the seat cushions. But he
14 stated child looked okay and he went in. And then right
15 before he came out he's finishing up and he heard a loud
16 thud in the living room.

17 Q And what did he notice? After he heard the thud, what,
18 what did he tell you happened next?

19 A He came out of the restroom and when he came into the
20 living room he saw Cheryl already kneeling next to the
21 child.

22 Q And did he give you any other information about that
23 incident?

24 A Um, no, I don't believe so at that time.

25 Q All right. Did he tell you what the condition of Brenden

1 acting?
2 A She was quite upset.
3 Q And how was Mr. Ceasor's demeanor?
4 A He was, he was upset as well.
5 Q At the time that you asked to speak with Miss Genna, did
6 she want to speak with you?
7 A No.
8 Q Okay. Did Mr. Ceasor want to speak with you?
9 A Um, yeah, there was no problem. He stepped, stepped aside
10 and spoke with me.
11 Q All right. And in speaking with Miss Genna, did she
12 respond back to her child after speaking with you?
13 A No.
14 Q Where did she go?
15 A She responded out into the waiting room area --
16 Q And --
17 A -- of the hospital.
18 Q And who was, who was out in the waiting room?
19 A Mr. Ceasor was out in the waiting room at that time.
20 MRS. DEEGAN: Just one moment, your Honor.
21 Nothing further, your Honor.
22 THE COURT: Thank you.
23 Mr. Lord, you may cross-examine.
24
25

CROSS-EXAMINATION

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BY MR. LORD:

Q Good morning.

A Good morning.

Q How are you today?

A Feeling okay.

Q You talked to Cheryl Genna, the mother of the child, outside the room that the child was in, correct?

A Yes.

Q And where was Mr. Ceasor at that point?

A I do not, I'm not sure.

Q Wasn't he about ten, ten feet away from where you were talking to Miss Genna?

A Yes, he'd probably, yes, you're, you're correct, he'd probably be in the room with the child.

Q And then after you got done talking with Miss, Miss Genna, then you talked to my client?

A Yes, I believe so.

Q And you indicated that my client seemed willing to talk to you?

A Yes.

Q Basically my client told you that they were playing a game called gotcha?

A Yes.

1 Q And that prior to him going into the bathroom that he was,
2 that it was Mr. Ceasor that was on his hands and knees in
3 front of the couch, true?

4 A I believe it was behind the couch.

5 Q And that Brenden would run along the top of the couch?

6 A The, the sofa cushions.

7 Q Well, did you write in your report the top of the couch?

8 A I, yes, I did write on the top of the couch.

9 Q Were you right?

10 A That would be my mistake, it was the top sofa cushions of
11 the couch.

12 Q And that when he went into the bathroom nothing had
13 happened, correct?

14 A Yes.

15 Q And that when he was in the bathroom he heard a loud thud?

16 A Yes.

17 Q And when he came out the child had fallen between the
18 couch and the coffee table?

19 A Yes.

20 MR. LORD: Nothing further.

21 THE COURT: Thank you.

22 Mrs. Deegan, anything else?

23

24

RE-DIRECT EXAMINATION

25

Trial: Testimony of Deputy Michael Garvin

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1 BY MRS. DEEGAN:

2 Q Was Miss Genna's statement consistent with that?

3 A Yes.

4 MRS. DEEGAN: Nothing further, your Honor.

5 THE COURT: Thank you.

6 Mr. Lord, anything else?

7 MR. LORD: No, your Honor.

8 THE COURT: Thank you, Officer. You may step
9 down.

10

11 (At 10:19 a.m., Deputy Garvin was excused.)

12

13 THE COURT: You may call your next witness,
14 Mrs. Deegan.

15 MRS. DEEGAN: Just one moment, your Honor. He's
16 going to get her from the --

17 THE COURT: Okay.

18 MRS. DEEGAN: -- officer area. Thank you.

19 THE COURT: Who is, who will this witness be
20 Mrs. --

21 MRS. DEEGAN: Deputy Jacob or I'm sorry,
22 Detective Jacobson. She was going to be here at, in the
23 office.

24 THE COURT: Everybody else heard all about
25 Justin yesterday. And I told you if you want to I'll

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the back.

Q All right. So being that you were triage nurse you would have had the first contact then with Brenden Genna --

A Yes.

Q -- on that date.

Who was brought, who was he brought in by on that date?

A Um, his mother and Mr. Ceasor.

Q All right. And you obtained that information when you first made contact with them then?

A Yes.

Q And what was Brenden's condition when you first saw him?

A Um, when he was first brought in he was, um, gray, not breathing very well, um, wouldn't open his eyes, wouldn't react to any stimulus. So I took him immediately in the back room to the trauma room and I called for Doctor Hunt and, um, we laid him on the bed and I gave him a quick look over, checked his pupils. I noted, counted and seen how he was doing, and then I had to return to my post in the front, which I was gone for approximately about five minutes.

Q All right.

A And then I came back to take care of Brenden.

Q All right. So you were only away from him at that very initial stage --

1 Q -- breathe on his own?

2 A Uh-hum.

3 Q You need to say yes or no.

4 A Yes, I'm sorry.

5 Q Thank you.

6 All right. So in the, after the five minutes
7 then someone else was able to take over triage and you
8 were able to respond back to Brenden?

9 A Yes.

10 Q All right. In responding back to Brenden, what is the
11 next step that happens in this?

12 A Um, once we established an airway and noticed that he was
13 coming around a bit more, we did during our initial
14 assessment we noticed that one pupil was vastly larger
15 than the other, um, which is an abnormal sign. So once we
16 see any, it's abnormal neurologic sign, anything to do
17 with the brain. So once we get that we automatically do a
18 CAT scan to see if there's been any trauma to the brain or
19 anything like that.

20 Um, so initially after just making sure that the
21 patient was okay, able to breathe on his own and that we
22 had, um, I.V. access to him, we transported him down to
23 the CAT scan department.

24 Q And this, as you said, the CAT scan is to search for what?

25 A Any kind of brain, um, abnormalities, any brain bleeds,

1 report back from the radiologist to see if, what the
2 extent of the injuries is.

3 Q And would that be the same for whether the person is a
4 child or whether the person's adult?

5 A Yes.

6 Q All right. So in this case do you recall the cervical
7 collar was placed, was kept on Brenden throughout the CAT
8 scan then?

9 A Yes.

10 Q All right. And in dealing with Brenden then he, he
11 obviously was alert at the time of the, at the time of the
12 CAT scan?

13 A Um, he was, he was alert. Um, he wasn't very active,
14 active, but he was breathing on his own. He was looking
15 around. Um, he was, you know, you could hear him cry from
16 periods, but he wasn't extremely, like being a nurse we
17 like to see the babies cry because it just means that
18 they're doing very well.

19 Q All right.

20 A Um, they might be a little upset, but they're, they're
21 doing well.

22 Q And in this case did you feel that he had progressed as
23 you'd seen other children, you said you mentioned he
24 cried?

25 A Yes, that, that was definitely a good sign. Um, he's

1 CAT scan then?

2 A Yes.

3 Q And does Miss Genna also accompany you?

4 A Yes.

5 Q Does Mr. Ceasor go also?

6 A Yes.

7 Q All right. And what, if anything's happening at that
8 stage? What do you recall about that event? Anything,
9 are you speaking with them in any detail or anything to
10 that effect?

11 A Um, generally I try to reassure the parent or the
12 caregiver, you know, that everything's going to be okay.
13 I remember telling them that, you know, he's making good
14 progression, that he's coming, his level of consciousness
15 is coming up slowly, which is to be expected, and that
16 everything is looking better than when he first came in.

17 Um, I, I also noticed that he, Mr. Ceasor and
18 Brenden's mother were very shaken up. Um, they were
19 very, they were holding each other and talking and I,
20 that's about --

21 Q That's what you recall --

22 A Yeah.

23 Q -- about that period of time?

24 A Yeah, it was about five, ten minutes that, that the CAT
25 scan takes. Not very long at all.

1 Q All right. And at, and during then the CAT scan's
2 performed you're waiting to transport Brenden then back to
3 the emergency room?

4 A Yes.

5 Q All right. What happens after that?

6 A Um, then I have Brenden back into the room and that's the
7 time where I get to do my head to toe assessment of
8 everything that's not vital to sustain life. I mean we
9 got, first of all we do the airway, the breathing, the
10 circulation, and then it's followed by my head to toe.
11 And I was looking at him, um, I was inspecting his head,
12 his neck. By the time the doctor had cleared him to take
13 off the C-collar and to take him off the back board so we
14 could move him around and look at the back of his head
15 then, look at the front of his chest and all, um, the
16 remaining of his body.

17 Um, I did notice that I did not find any lumps
18 or any bruises anywhere on the scalp area or his head or
19 anywhere on his face.

20 Q And you're able to, as you said, move him to be able to
21 even look at the back of his head and feel for those type
22 of injuries?

23 A Yes.

24 Q The lumps or look for bruising?

25 A Yes.

1 Q All right. And at that time you did not notice any,
2 anything of that sort?

3 A Yes.

4 Q All right. Did you move further onto his body then and do
5 an assessment of his body?

6 A Yes.

7 Q And was there anything that struck you in going through
8 that you would have noted in your report?

9 A It, there was nothing. It was, it was basically
10 unremarkable. I didn't find any kind of, um, scrapes,
11 bruising, no abnormalities.

12 Q And if you had, you would have indicated them on, on your
13 further assessment?

14 A Yes.

15 Q In, in a sheet in, in your report?

16 A Yes. I'm just going to refer back and --

17 Q Yeah, if you could tell us which sheet is your head to toe
18 assessment then?

19 A Um, it is the Port Huron Hospital Emergency Center Trauma
20 Flow Sheet.

21 Q All right.

22 A And on the bottom right corner it has a head to toe
23 diagram of a person. And if there was any kind of
24 bruising or anything, um, it goes from anywhere from
25 laceration, abrasion, hematoma, bruise, deformity, open

1 A Yes.

2 Q All right. Had any, did you notice any other members of
3 the family at the hospital at that time?

4 A Brenden's father had arrived and I, there was a couple of
5 females that were with the mother also. I wasn't sure of
6 their relationship.

7 Q Did you ever speak with Mr. Ceasor himself at the
8 hospital?

9 A Not just me and Mr. Ceasor. He had came in, um, he was,
10 him and Brenden's mother were always with the patient.
11 Um, they were allowed in the room from the time he came
12 back, um, down to CAT scan like I said. And, um, I, there
13 was no real questions that I had asked him, but I had
14 observed him interacting with the patient and the
15 patient's mother.

16 Q All right. And did you notice any, the demeanor of
17 Mr. Ceasor's then in reacting to the patient?

18 A Initially when we had brought Brenden back he was very,
19 very concerned with, um, he was a bit out of sorts and
20 just wanting to know, you know, is he going to be okay, is
21 he going to be okay. Um, very, very just concerned.

22 Q All right. And you're saying that's initially?

23 A Yes.

24 Q Was there a change in that demeanor?

25 A Um, he had become less, at the very beginning it was very

1 pronounced and he was pacing in front of the, the bed and,
2 you know, wanting to know if he was going to be okay and
3 he's crying and being very, he was very emotional.

4 Q All right. And then that lessened I believe you stated?

5 A Yes. As, as the time had progressed it had lessened.

6 Q And after the removal of the C-collar, the, the cervical
7 collar, did you notice any marks or anything on the back
8 of his head from that collar in any way?

9 A I did not notice any marks.

10 Q Have you noticed with other patients that the collar would
11 produce a mark after it's been on?

12 A It can produce marks. The collar comes to stabilize the
13 neck. It has to, it reaches up to the bone that lies
14 right in the back of your head and it will rest on the
15 bone and right underneath your neck to make a nice secure
16 fitting for the child or the adult, whoever is the
17 patient. And that combined with a back board does produce
18 a lot of pressure to the back of the head. Um, just not
19 so much to where it would cause any difficulties for the
20 patient, but it's very uncomfortable and we try to release
21 the patient as fast as possible from it.

22 Q All right, thank you.

23 I'm just going to show you what's been marked as
24 People's Proposed Exhibit 8, Ms. Roulo, and I want you to
25 take a look through it and see if it applies, if you

1 telling you or asking you what was discussed, but were any
2 of those discussed with you by the doctor?

3 A Yes.

4 Q Which doctor did you discuss those with?

5 A Um, there was two physicians that were, um, maintaining
6 care of, um, Brenden, Doctor Paul and a Doctor Hunt.

7 Q And if I understand you correctly, the patient when he
8 first came in and your form seems to indicate that there
9 was a difference in dilation between the right and left
10 pupil?

11 A Yes.

12 Q Was, that about five, five millimeters?

13 A Yes.

14 Q And the next note that I would see would, I would assume
15 and I, if I'm wrong tell me. After he came back from
16 having the CAT scan your nurse's notes seem to indicate
17 that both his pupils were equal and responsive, is that
18 true?

19 A Yes, they had, they had returned to normal again.

20 Q So within a very short time and that's, and when you're
21 looking at a neurological injury that's one of the things
22 that you look for, you want to make sure the pupils are
23 equal and they dilate, they're responsive to light, true?

24 A Yes.

25 THE COURT: Answer out loud, I didn't --

1 THE WITNESS: Yes.

2 THE COURT: There you go.

3 BY MR. LORD:

4 Q And that did start occurring when he came back from the
5 CAT scan?

6 A Yes.

7 Q And the notes don't seem to indicate anything different
8 during the entire time that he stayed at the hospital with
9 you, is that true?

10 A No.

11 THE CLERK: I didn't get that.

12 THE COURT: Say that again, please.

13 THE WITNESS: True.

14 THE COURT: Thank you.

15 BY MR. LORD:

16 Q You indicated that Mr. Ceasor when the, when Brenden first
17 came in was upset and crying?

18 A Yes.

19 Q The notes seem to indicate emergency physician record and
20 I don't know if, if you did this or not so I'm going to
21 show you the form I'm looking at. Is that your writing
22 there?

23 A No.

24 Q Okay. I wondered, it didn't look the same.

25 Now, that history context, do you know who did

1 A I was.

2 Q All right. And do you recall how you came into contact
3 with Mr., with little Brenden?

4 A Well, I mean I, not the first moment, but I remember, you
5 know, the case. And as I reviewed my notes it certainly
6 came back to me.

7 Q All right.

8 A It was an unresponsive child that was brought into room 16
9 at the hospital.

10 Q All right. And you were paged then to respond --

11 A Absolutely.

12 Q -- to that child?

13 All right. When you made contact with Brenden,
14 what did you do?

15 A Well, I first assessed him.

16 Q And what was your assessment?

17 A Well, I made sure his vitals were stable. He was
18 breathing all right now. But on the assessment I noted
19 his pupils to be unequal and he, he was unresponsive to
20 any kind of, of verbal command or even painful stimuli
21 initially.

22 Q And --

23 A I didn't see any signs of trauma, at least none that I
24 indicated on the chart at all.

25 Q And that's your first, when you're first having contact

1 send him over to a CAT scan was my first thought.

2 Q All right.

3 A I wanted to see if something was going on in his --

4 Q And did you do that in this case?

5 A I did do that.

6 Q All right. And in particular then are you having those,
7 having that CAT scan done and then you're able to review
8 the results at a later time?

9 A Yeah, almost immediately.

10 Q Okay. It's that fast?

11 And were you able to receive the results of the
12 CAT scan in this case?

13 A Correct.

14 Q All right. And what were the results?

15 A It showed a subdural, I mean I have Doctor Clyde, he's the
16 radiologist who read it, but it showed a subdural
17 hematoma, and with some slight mass effect.

18 Q And what does that mean, Doctor?

19 A Well, subdural is blood under the dura, and when you have
20 so much blood it starts to push the brain to the opposite
21 side, so that's called mass effect.

22 Q So it's moved the brain aside and --

23 A It's just putting pressure on the brain if you have, you
24 know, your brain fills up your whole skull just about, so
25 if you start getting too much blood in there then it

1 starts shifting things over kind of squishing the brain a
2 little.

3 Q And that's what you noted in Brenden --

4 A That's what he had.

5 Q -- at that time?

6 A That's what was going on.

7 Q And is that considered serious?

8 A Oh, yeah, sure.

9 Q And what are you doing in response to noting that subdural
10 hematoma then, what are you doing in response?

11 A Well, at that point, first of all we don't take care of
12 that kind of neurosurgical emergency, we send them down to
13 a facility that has a pediatric neurosurgeon, which would
14 be Children's. And we give them at that point some
15 anti-seizure medication and some medicine to keep the
16 pressure down in the brain from continuing to build up or
17 at least hopefully continue to stop it from building and
18 so there would be minimal damage.

19 Q All right.

20 A As little damage as possible.

21 Q So you're not, so Port Huron doesn't have the facilities
22 then to be able to treat --

23 A Correct.

24 Q I'm sorry, with --

25 A Yeah.

1 the collar is. It's got padding around the whole collar,
2 so --

3 Q In dealing with a subdural hematoma, did you notice
4 whether there was any type of seizure-like activity that
5 occurred with Brenden?

6 A I don't recall any seizure-like activity.

7 Q And did the pupils, did they equalize themselves as
8 throughout the course?

9 A I never indicated they did. They may have. Sometimes the
10 documentation in these situations is lacking. I mean
11 we're trying to, you know, documentation comes later.
12 Trying to take the patient at that time so I can't, I
13 don't recall if they equalized or not.

14 Q All right. And another nurse, or a nurse or another
15 physician or a person in the room might be documenting
16 that type of --

17 A Typically the nurse would do a little bit better
18 documentation than we do, at least than I do.

19 Q Are you making the decision then that the patient,
20 Brenden, needed to be transported to Children's?

21 A I was, sure.

22 Q All right. And at that point then the hematoma, did you
23 notice any retinal hemorrhaging?

24 A I did not at that point. No, I didn't. I don't even know
25 as if I really looked into the retinas. Very difficult in

1 a trauma room to see a child's retina.

2 Q Did you have any concerns in this particular case, Doctor,
3 in the treatment, concerns with the patient or the
4 statements that you were getting with regard to the --

5 A Well, I certainly thought it was suspect of possible child
6 abuse. I mean we filled out a 3200 form on him, which is
7 a Child Protective Service form. I don't know if I
8 personally did it, but I documented that it was done, so
9 as long as someone's done it.

10 Q Why, why did you have concerns in this case?

11 A Well, it, 16 month olds don't typically fall. I mean
12 they're not very big and to fall off a couch and hit your
13 head and get a subdural hematoma would be very strange.
14 And the fact that he didn't, if he did get that and he did
15 fall off the couch and get it, why didn't he have any
16 external soft tissue trauma.

17 I, you know, I would have expected had he hit,
18 hit something hard enough to bleed that you'd have been
19 able to see some sort of hematomas on the skin or
20 laceration or something.

21 Q And have you had occasions where you've had to follow-up
22 in some manner because this, you've been concerned about
23 the manner, the injuries were said to have happened?

24 A Sure.

25 Q And do you, in your course of working as a physician and

1 Q Okay, so --

2 A I wouldn't know what the baby looked like either.

3 Q And when you took the initial history it indicates, I
4 believe that's your, the form that --

5 THE COURT: Folks, we may, I promised you that
6 we would take our breaks at noon because of things that go
7 on in this courthouse. But I suspect we're going to go a
8 little bit past 12:00 here, and I worry about that because
9 relying on my promise you may have made some appointments
10 that I'm not aware of. And if that's the case, please
11 tell me about that right now. Don't be afraid to tell me
12 so we can, okay, we can. You may continue, Mr. Lord.

13 BY MR. LORD:

14 Q Doctor, the form that I indicate, indicates that you did
15 your initial assessment, there's certain boxes here.

16 First of all I'll ask you if this is your form.
17 May I approach, your Honor?

18 THE COURT: Yes, you may.

19 BY MR. LORD:

20 Q Is that, in fact, your form?

21 A It is, yes.

22 Q And that form where you check there's a thing called
23 respiratory, is that true?

24 A Yes.

25 Q And you've got a check mark that there's no respiratory

1 distress?

2 A Correct.

3 Q Breathe sounds normal?

4 A Uh-hum.

5 Q Chest non-tender.

6 Under those circumstances there would be no
7 reason to do an intubation, would there?

8 A I, not that I can, not reading that, no.

9 Q Well --

10 A But it's been --

11 Q That's, that was my question. I mean --

12 A Yeah. If that's, if that's all there is it's probably
13 not. But sometimes people will get intubated just
14 prophylactically.

15 Q All right.

16 A To protect the airway.

17 Q You have no independent memory of ever intubating that
18 child, is that true?

19 A I don't, no. It could have occurred, I just don't recall
20 it.

21 Q Well, wouldn't it normally get intubation, wouldn't that
22 normally be recorded somewhere in the medical record, one
23 would hope?

24 A Yeah, it could have, yeah.

25 Q And also if a child with a head trauma has seizure-like

1 looked at the clock or whatever, remembers getting up at
2 9:30 a.m. Sunday morning, and I think he prepared a bottle
3 for the little boy. He said within the next 20, 30
4 minutes the whole household was up, indicating whoever was
5 there at the house at the time, Sunday morning.

6 I kind of asked him was anything special on
7 through the day that occurred, and he just said the day
8 was kind of uneventful. They just went around and did
9 things around the house and played games and uneventful.

10 Q Did he say whether he'd played in particular with Brenden
11 that day?

12 A Yes, he did.

13 Q And what did he say about that?

14 A Well, he, I guess the best time he could remember was 3:30
15 to four o'clock, sometime in there that Cheryl was in the
16 kitchen and he was playing. He used the term gotcha, and
17 he was crawling around on his hands and knees. He kind of
18 described it as in back of the sofa couch, and that the
19 little boy was running back and forth across the cushions
20 on his hands and knees this way, and the boy would go down
21 there and he'd holler gotcha and the boy would run back
22 and they were playing that back and forth.

23 Q All right. And was he able to tell you what happened then
24 leading up to the incident that, that Brenden was taken to
25 the hospital?

1 A He did. With Cheryl being in the, Miss Genna being in the
2 kitchen area, that exercise he worked up the, the desire
3 to go to the bathroom, so he simply got up and he walked
4 from the room, probably ten feet maybe from the couch to a
5 bathroom door which is right off the couch wall. I mean
6 the living room wall, and he walked into the bathroom.
7 Said he was, stood there and he was urinating. He had the
8 door partially closed out of, for privacy, but that he had
9 it opened in case for whatever reason he had it partially
10 open. And while he was just kind of finishing up
11 urinating he heard a thud or a smack and he thought maybe
12 he better go and check on this. So as fast as he could
13 finish up urinating, he had went right out into the living
14 room to see what caused this thud or a smacking sound
15 there by the couch.

16 Q And was he able to tell you what he saw once he got out of
17 the bathroom?

18 A He said as soon as he came out on the living room floor
19 area and right on the end of the couch, and there's
20 photographs there to help explain that if we need them,
21 that Cheryl had come out of the kitchen. She'd heard the
22 thump or the smacking sound and she'd come around the end
23 of the sofa couch. She was in front of the couch down on
24 a knee or two knees and Mr. Ceasor said that when he got
25 up there and looked over the back of the couch Cheryl was

1 A He did.

2 Q All right. What did he say?

3 A This time he said everything else stayed the same. Um, he
4 and the boy were playing gotcha on the couch, but nobody
5 else was in the home. Cheryl was gone, the other little
6 seven or eight year old daughter of Cheryl was gone. He
7 and the little boy were in the house all by themselves and
8 that they were playing this, this gotcha game and he had
9 the, the, the desire to go to the bathroom. He said the
10 boy was standing on the couch when he left and he went
11 into the bathroom and he left the door partially opened
12 and that he was just finishing up when he heard this thud
13 or this smacking sound. That he came right back out and
14 found the boy lying unconscious on the floor between the
15 coffee table and the couch.

16 Q What did he say happened after he found Brenden to be
17 unconscious?

18 A He said he knelt down and picked him up and called out his
19 name and there was no response, that he was completely
20 unresponsive. He might have used the term limp or, or
21 whatever, but it was unresponsive and unconscious. Then
22 he said he shook him gently to try and revive him and that
23 didn't work. Then he said he touched him on the cheek or
24 on the chin and still there was no response at all.

25 He continued to call out his name and there was

1 no response. He took him over to the kitchen sink and
2 splashed some water on his face and on the back of his
3 neck to see if that would revive him and there was no
4 response.

5 Q And did he, did he say whether he was going to contact 911
6 or contact anybody once he realized that the child was
7 unresponsive?

8 A His comment to me was he was just thinking that process,
9 that I guess I better call 911 or I guess I better call
10 somebody. And while he was, while his mind was processing
11 the thought of what to do, Cheryl and the little girl came
12 up the steps having been gone for an hour or so, had just
13 come into the kitchen area to come home.

14 Q And did he tell you what happened once Cheryl got home?

15 A He said that the, he told me that he said to Cheryl the
16 baby fell down or Brenden fell down and he's unconscious.
17 And she didn't believe it at first, she thought it was
18 maybe he was joking or something.

19 MR. LORD: Objection.

20 THE WITNESS: He said I'm not serious.

21 MRS. DEEGAN: That's what he --

22 THE COURT: Well, well --

23 MRS. DEEGAN: Are you relating what he said to
24 you?

25 THE COURT: If he's relating what he said, then

1 infant, usually a child less than two years old. Violent
2 shaking. Not just shaking a child, excuse me, not just
3 shaking a child a little bit to revive them or because
4 they have fainted or something like that, but really
5 violently shaking the child such that the head whips back
6 and forth on the body, which is the axis.

7 The head is larger relative to the body in a
8 child than it is in an adult, and so it causes a, a big
9 lever of force, and it causes severe forces within the
10 head. The brain is not fixed within the skull and it can
11 move. So, the brain slams back and forth inside the
12 skull. The bridging veins between the brain and the skull
13 can tear, which can cause a subdural hemorrhage. They can
14 get bleeding in the back of the eye, which is retinal
15 hemorrhages from the force of the shaking, and usually it
16 involves an aspect of impact, too. Usually the child is
17 struck as well, or slammed down on a, a sofa or a soft
18 surface, even against a wall or thrown up against the
19 ceiling. There are a lot of variations.

20 BY MRS. DEEGAN:

21 Q It doesn't always have to be in your experience a violent
22 shaking of just the body?

23 A No.

24 Q And is this particular syndrome, has it become an accepted
25 syndrome in, in your field?

1 Q All right. Why? Are there any other signs that you've
2 seen in your profession associated with that, that
3 syndrome?

4 A Well, certainly a history that's not consistent with the
5 mechanism of injury. A history that changes frequently,
6 you know. The person gives one story, then gives another,
7 or the story keeps changing as to how the accident, the
8 injuries occurred.

9 We, we sometimes see bruising on the skin, you
10 know, of different ages, but not always. Sometimes you
11 don't see any bruising. Frequently you'll find fractures
12 on chest, x-ray, or on skeletal survey of different ages
13 and varying stages of healing, meaning that there have
14 been repeated episodes of abuse.

15 Q So, would it be fair to say that not every infant or young
16 child, I think you said under the age of two is normally
17 what it's associated with this syndrome --

18 A Yes.

19 Q -- is that correct?

20 Would it be fair to say that not every infant
21 would have the exact same injuries?

22 A Yes. Oh, yes.

23 Q All right. And have you had the occasion then throughout
24 your career to be able to work on infants or toddlers who
25 you have suspected being a victim of shaken baby syndrome?

1 MR. LORD: -- of other people when my client's
2 not present --

3 THE COURT: I sustain the objection.

4 BY MRS. DEEGAN:

5 Q Doctor Gilmer-Hill, when you, when you were talking to a
6 male, were you able to identify whether that was his, the
7 biological father of Brenden --

8 A Yes, he told me --

9 Q -- or another individual?

10 A -- that he was his biological father.

11 Q All right. You said then that you would have done a
12 physical examination of Brenden; is that correct?

13 A Yes.

14 Q Anything that you noticed in that physical examination?

15 A He was, he was alert and he was, you know, awake, and I
16 did not notice any external bruising or swelling of the
17 scalp.

18 Q And you would have noted that if you had, had found any
19 evidence of external bruise, bruising?

20 A Yes.

21 Q All right. And nothing on his person? In particular you
22 didn't notice a mark on the back of his head?

23 A No.

24 Q Would you have examined his mouth in any way or, or done
25 anything to check him out there?

1 A Yes.

2 Q All right. And then what happened after that?

3 A I saw him again on October 6, which is the next day after
4 that.

5 Q All right. And in seeing him on the next day after that,
6 did you notice any change in Brenden's condition?

7 A He was even better. He was quite alert. He was
8 neurologically intact. He was playful. My partner had
9 stopped the Mannitol the day before, and he was starting
10 to eat.

11 Q All right. Did you notice any other injuries in, in
12 dressing and, and seeing Brenden then on that next
13 occasion?

14 A You mean was I aware of any other injuries?

15 Q Yes. Are you aware of any other injuries with regard to
16 Brenden?

17 A By that time he had been seen by ophthalmology and retinal
18 hemorrhages had been found.

19 Q And you were aware of that injury then in, in reading
20 those charts?

21 A And also the ophthalmologist called us when they find
22 retinal hemorrhages, and they found them on both sides.

23 Q And can you describe to the Jury again what a retinal
24 hemorrhage is or what it looks like?

25 A Retinal hemorrhage is, is bleeding in the retina, which is

1 at the back of the eye. It takes a good deal of force to
2 cause that, and the combination of subdural blood with
3 retinal hemorrhage is child abuse. It is patently
4 demonic. Is diagnostic for child abuse.

5 Q And did that draw your attention then when you realized
6 there was retinal hemorrhage, as well as a subdural
7 hematoma?

8 A Yes.

9 Q And when we're talking about retinal hemorrhage in, in
10 Brenden in particular, was it one eye, both eyes, could
11 you describe how, how it is?

12 A It was in both eyes.

13 Q Okay. And the cause of a retinal, excuse me, yes, the
14 cause of a retinal hemorrhage in your professional
15 experience then is, how do you, how do you get a retinal
16 hemorrhage?

17 A By severally being shaken or slammed onto a surface,
18 either hard or soft. Usually repeatedly.

19 Q Are there any tests that can be done to rule out, I mean
20 in your experience retinal hemorrhage is associated with
21 that shaking. Is there anything that can rule out other
22 reasons for causing retinal hemorrhaging or is there
23 anything that other test that were performed on Brenden in
24 this manner?

25 A He had a C.B.C. which is a complete blood count when he

1 first came from Port Huron, which showed actually elevated
2 platelets, not low platelets, elevated. A low platelet
3 count in the blood could cause bleeding. We typically
4 will see bleeding in the brain when a child has, we call
5 thrombocytopenia or, sorry, or low platelet count, but we
6 don't see retinal hemorrhages typically --

7 Q All right.

8 A -- in association with that.

9 Q I want to make sure that I understand --

10 THE COURT: In association with what?

11 THE WITNESS: In association with the bleeding
12 in the brain that you might see.

13 BY MRS. DEEGAN:

14 Q All right. So, in reviewing Brenden's platelet count,
15 that's something you're looking at, and if it had been
16 lowered there might, it could be associated with bleeding
17 in the brain?

18 A Yes.

19 Q That wasn't the result that you saw with regard to --

20 A No.

21 Q -- to Brenden; is that correct?

22 It was actually elevated?

23 A Yes.

24 Q So that's not associated with bleeding in the brain?

25 A That's right.

1 Q All right.

2 Now in this, well, let's go further then.

3 October 6th you would have seen Brenden on that
4 time, and then how long was Brenden kept at your hospital?

5 A I believe he was discharged on the ninth.

6 Q Okay.

7 A October 9.

8 Q And are you seeing him or are your partners seeing him
9 then on a daily basis until the ninth?

10 A Yes.

11 Q And do you have a date of the next time that you would
12 have personally seen Brenden after the sixth?

13 A If I could refer to the chart?

14 Q Sure. You can refresh your recollection?

15 A I didn't see him again as an inpatient. My partners saw
16 him on the seventh, and then he was discharged home on the
17 eighth.

18 Q Okay. So it was actually October 8th --

19 A Yes.

20 Q -- that your notes as, as discharge. Thank you.

21 Now, in your treatment and diagnosis on Brenden,
22 on Brenden, did you have a professional opinion in your
23 training and experience as to whether the injuries that
24 you saw on Brenden were accidental?

25 A No, I don't believe that they were accidental. ✓

1 Q And what are you basing your opinion on?

2 A Well, we did, we weren't given a history that was
3 consistent with the injuries. The history that was given
4 was a fall from a couch onto a carpeted floor, which does
5 not account for these injuries. Um, the accident that
6 could have accounted for brain swelling with bleeding in
7 the brain and shift is a much greater injury than just a
8 fall. It's a, you know, a fall out of a second story
9 window. It's a high speed car accident, and even then we
10 take care of children with those injuries and we don't see
11 retinal hemorrhages in association with the bleeding.

12 So, no, I do not believe this was accidental.

13 Q All right. And, therefore, the fact that the retinal
14 hemorrhage and the subdural hematoma were found together
15 as Brenden's injuries furthered your opinion in this case?

16 A Yes.

17 Q You've mentioned that there has been research or perhaps,
18 perhaps you've had patients where there has been a high
19 speed crash; is that correct?

20 A Yes.

21 Q Where you've seen injuries consistent with that?

22 A Yes.

23 Q All right. Your testimony is, though, normally retinal
24 hemorrhaging does not result from those high speed
25 crashes?

1 A That's right.

2 Q In this case I know in your introduction you had spoken
3 about fractures of different bones or things associated
4 sometimes with shaken baby syndrome. You did not find
5 that in this case with Brenden, did you?

6 A No.

7 Q And upon release from the hospital I believe you said
8 someone else would have seen Brenden on that particular
9 date of his discharge?

10 A Yes.

11 Q Correct. Do you know from reviewing the chart whether
12 there is any follow-up or was any follow-up that needed to
13 be done with regard to Brenden?

14 A He should have followed up with us in neurosurgery as an
15 outpatient. I can't say whether he followed up with one
16 of my partners or not. I don't believe I saw him as an
17 outpatient.

18 Q All right. And were there any prescriptions or anything
19 that he would have needed medication wise that you would
20 have prescribed upon, you or one of your partners would
21 have prescribed after, after he was discharged?

22 A No.

23 Q And the last occasion that you saw him was his, was he
24 doing better?

25 A Yes.

1 Q So your resident, you don't know where your resident got
2 it from?

3 A The resident had talked to the doctor at Port Huron.

4 Q So, you're assuming then that a doctor in Port Huron said
5 that there were seizure-like symptoms?

6 A No, I'm not assuming that. That's what I was told.

7 Q Okay. Well, if the doctor in Port Huron didn't say there
8 was any seizure-like symptoms, would you then have
9 incorrect history?

10 A That's not the case here.

11 Q That's not the case?

12 A No, because he did say that.

13 Q How do you know, you didn't talk to him?

14 A He told us that the pupils were --

15 Q He told you. I want to know about what he told you.

16 A Well, he didn't tell me anything.

17 Q All right. So, you don't know whether the doctor ever
18 stated there were any seizure-like symptoms. You're
19 relying upon other people as you often do in practicing
20 medicine, correct?

21 A Yes.

22 Q Now, in the charts at Children's Medical Hospital does it
23 not indicate, and in the nurse's notes that there's
24 bruising to the forehead of the child?

25 A That's written in one of the nurse's notes, yes.

1 Q Well, wouldn't you rely upon that just like you rely on
2 other information for history?

3 A Not if that's the only place I see it, and I don't see the
4 bruise myself.

5 Q Well, evidently somebody saw a bruise because they wrote
6 it in the report, didn't they?

7 A I saw that note, yes.

8 Q Well, it's in more than one spot, isn't it?

9 A I only saw it in one spot.

10 Q Doctor, are you familiar with this type of document and
11 isn't that a medical record from Children's Hospital in
12 Detroit?

13 A Yes.

14 Q And in that document does it not have an indication of an
15 individual's body?

16 A Yes.

17 Q And if you look closely do you see not a marker there
18 which says for pointing to go the forehead of that
19 individual?

20 A Yes.

21 Q And is it not, not indicative of a bruise?

22 A I'm not sure I can read that.

23 Q Well, do you have something that's readable? This is a
24 copy of the report what was given to me as being the
25 record of Children's Hospital. Can you look and see if

1 you have that document in your file so you can tell me
2 whether or not that says bruise?

3 A I still can't read that. That's pretty small. It's
4 actually fairly blurred, but it is the same page.

5 Q Do you have any standardized numbering system which would
6 indicate on that form what number four normally is?

7 A No.

8 Q No?

9 A No, this is not --

10 Q So --

11 A -- the standardized numbering system. And, in fact,
12 someone looking at this page would not say, oh, there's a
13 bruise on the forehead. They would see a four with an
14 arrow pointing to the forehead.

15 Q Well, then someone might go to the nurse's notes on the
16 next page and it says he has some bruises on forehead,
17 correct?

18 A Yes, I've seen that.

19 Q Which would be consistent if someone were to look at that
20 and think that maybe that says bruise with the page before
21 that, correct?

22 A I'm sorry, what's the question?

23 Q Well, that's consistent with what the diagram shows with
24 the number pointing to it that says four, right? Bruise
25 on the forehead?

1 A If that's what four indicates, yes.

2 Q Well, when we're doing medical records it's important for
3 the hospital to keep accurate medical records, isn't it?

4 A Yes.

5 Q And it's important for the nurse to, say, keep accurate
6 notes, is it not?

7 A Yes.

8 Q And you often rely upon the charts and information
9 provided to you from other medical personnel to make your
10 diagnosis, correct?

11 A Yes.

12 Q So there is indications in the chart that there was
13 bruising to the forehead and there was also indication in
14 the chart that there was some redness in the oral area,
15 correct?

16 A There's an indication that there was a bruise and that
17 there's redness around the mouth, yes.

18 Q Now, I'm assuming if you're going in to look at a patient
19 you review the charts, do you not?

20 A Yes.

21 Q And if you would have noticed that on the chart, wouldn't
22 you have felt obligated as a doctor in treating a patient
23 to make an examination to see if that's consistent with
24 the child?

25 A Yes.

1 Q Did you see that before you went in and talked to the
2 child?

3 A I don't remember whether I saw that note before I talked
4 to the child or not.

5 Q Doctor, how long were you with the child on October 4th?

6 A I would say about 15 minutes.

7 Q And how long are you with the child on October 6th?

8 A I think probably about ten minutes.

9 Q So, in the entire four or five days the child was in the
10 hospital you personally only observed the child for 25
11 minutes?

12 A That's probably true.

13 Q Doctor, is it safe to say you said the shaken baby
14 syndrome, that that is an accepted syndrome, correct?

15 A Yes.

16 Q There is disagreement in the medical field about that
17 syndrome, is there not?

18 A In what way?

19 Q Well, didn't Plunkett do a study in 2001 that indicates
20 that children can receive trauma, in fact, fatal injuries
21 from short falls even on carpeted surfaces?

22 A Yes.

23 Q But you're saying that doesn't occur?

24 A I'm saying I disagree with the study.

25 Q All right. So, in that respect at least some other people

1 Q Several hours. So the child may act normal for several,
2 several hours before receiving that or before showing
3 signs of the bleeding?

4 A Yes.

5 Q So you can't with any certainty say that when the child
6 fell that that child didn't have that subdural hematoma
7 prior to falling, can you?

8 A No.

9 Q In fact, what may have caused that child to fall could
10 have been the fact that the child already had a subdural
11 hematoma, isn't that a possibility?

12 A Yes.

13 Q Doctor, when you review a child's history isn't it
14 important to get that history from someone who is actually
15 there when it occurred?

16 A It's preferable to talk to someone who saw the accident or
17 saw the injury, but most of the time that person is not
18 there.

19 Q Now, Doctor, when we're talking about the biomechanics of
20 the injury, you're not an expert in biomechanics, correct?

21 A No.

22 Q Do you know the relationship between whether or not a,
23 fall from say five feet and smacking the floor has more or
24 less gravitational force in it than the shaking of a
25 child?

1 A Less. Much less.

2 Q Are you sure?

3 A Whether falling from a height of six feet has less force
4 than shaking?

5 Q Yes.

6 A Yes.

7 Q And --

8 A Much less.

9 Q What are you basing that on, Doctor?

10 A From certain things we can base that on, experimental
11 studies have been done --

12 Q Well, just name me one.

13 A -- which show that --

14 Q Name me one.

15 A Oh, well, the series by Duhaime. Ann-Christine Duhaime
16 from the, at the University of Pennsylvania.

17 Q And --

18 A Children's Hospital, Pennsylvania.

19 Q Did you read the Plunkett study?

20 A I have read the Plunkett study.

21 Q Plunkett theorized it can happen and the gravitational
22 force of a fall can be greater than shaking a baby?

23 A It can, but not from six feet.

24 Q Well --

25 A From 20 feet, 30 feet.

1 Q Didn't Plunkett's study indicate that children actually
2 died from falls as small as two to three feet?

3 A Plunkett may have asserted that.

4 Q So, that disagrees with you, you won't say that's not true
5 then, correct?

6 A I will say that that disagrees with the body of evidence
7 that's out there.

8 Q Now, Doctor, other than the 25 minutes that you saw this
9 child, you didn't see the child anymore after that,
10 correct?

11 A Not that I recall.

12 Q Doctor, do you have any memory of what the father of that
13 child looked like?

14 A Biological father, yes.

15 Q And what did he look like?

16 A Sorry.

17 Q What did he look like, the biological father?

18 A He was a young man.

19 Q Well, that's not a very -- color hair, glasses, no
20 glasses, moustache, anything?

21 A I don't think I want to commit to those characteristics
22 considering it was over a year since I seen him.

23 Q Well, you're committing to the characteristics, or
24 characteristics that you know and remembered what that
25 person said.

1 injury could occur at any time within six to 12 hours, six
2 to how many hours?

3 A Six to 12 that same day.

4 Q Six to 12 hours prior to him being brought to the
5 hospital?

6 A Within six to 12 hours.

7 Q And that's your medical opinion?

8 A Yes.

9 Q So you can't say with any medical certainty that that was
10 caused between 3:00 and four o'clock if the child was
11 brought to the hospital at five o'clock, correct?

12 A I can because the child became symptomatic between 3:00
13 and four o'clock.

14 Q Symptomatic. And we've gone over this, Doctor, but you
15 said after an injury occurs a child can remain
16 non-symptomatic for a period of time?

17 A Yes.

18 Q Right?

19 A Well, you said an injury. The lucid interval is described
20 in relation to subdural hematomas, not subdural hematomas
21 with retinal hemorrhages like this.

22 Q Are you saying there's no literature at all, Doctor, that
23 lucid intervals can, lucid intervals can occur after a
24 subdural hematoma? You're not really saying that, are
25 you?

1 was done on October 5th?

2 A No.

3 Q Is October --

4 A That's ophthalmology.

5 Q The first one where they would notice retinal
6 hemorrhaging, when was that done?

7 A Yes, on the October 5th.

8 MR. LORD: All right. I have no further
9 questions. Thank you.

10 THE COURT: Thank you. Mrs. Deegan.

11

12 RE-DIRECT EXAMINATION

13

14 BY MRS. DEEGAN:

15 Q Doctor Gilmer-Hill, before when we talked about unequal
16 pupils, isn't that a seizure-like symptom?

17 A Yes.

18 Q All right. And if that was noted on a chart or told to
19 you or another member of your staff, resident wise or
20 partner wise, if, if the report was that the child had
21 unequal pupils, what would that signify to you?

22 A That he had probably had a seizure.

23 Q And whether or not a chart or a doctor specifically said
24 that, that would be an indicator to you that that was a
25 seizure-like symptom, correct?

Trial: Testimony of Terry Ceasor

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1 Um, he sat there for a little while just kind of like just
2 staring off. So, he hasn't really ate nothing but the
3 bottle that I gave him in the morning. So, I went out to
4 the fridge and I got him a half of jar of bananas. She
5 had a fruit granola bar with fruit in the middle, um, and
6 a couple things of the little, the fruit snacks, and I
7 brought that out. I fed him. Um, I remember coming
8 around with the granola bar, and as soon as he saw the
9 granola bar he was like uh, uh. He was very excited. He
10 knew what the granola bar was. He knew when it came to
11 food what it was. Um, he very much enjoyed those.

12 Um, I gave him that. Um, he ate it with no
13 problem. Um, I gave him a jar of bananas, Gerber bananas,
14 um, and the fruit snacks.

15 After he had finished eating, um, I had ran out
16 to the, well, walked out to the kitchen and put the spoon
17 in the sink, and he was standing up on the couch with his
18 back towards me in the kitchen looking at the TV and
19 that's when I had came up from the kitchen and I crawled
20 on my hands and knees to the back of the couch, and that's
21 when I started playing gotcha.

22 Um, that pursued to where I was going back and
23 forth behind the couch and he was going from cushions to
24 cushions, um, when we were playing that he had got his
25 foot stuck in the cushions.

TAPE NO. 05-223

DATE: 12-15-05
529

TIME:

Trial: Testimony of Terry Ceasor

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1 MRS. DEEGAN: Is there a question here, your
2 Honor? This seems to be --

3 MR. LORD: Well, your Honor --

4 MRS. DEEGAN: -- a narrative.

5 MR. LORD: It is a narrative. And it's what
6 happened that day, and this is the day in question.

7 THE COURT: All right.

8 MR. LORD: I mean I can keep going if the
9 Prosecutor wants what happened next, what happened next,
10 what happened next, I mean.

11 If there's an objection to anything that he's
12 saying, she can stand up and object.

13 THE WITNESS: Can I have a glass of water, sir,
14 please?

15 THE COURT: Yes. It's, it is, it's true it is a
16 narrative, but it is not in a disruptive sort of a way
17 that would cause me to -- overrule the objection, but he's
18 got to be careful about the --

19 MR. LORD: I understand, your Honor.

20 THE COURT: If there is, you know, if it's
21 objectionable testimony, Mrs. Deegan, that does not
22 prevent you from objecting.

23 Yes, you may have a glass of water.

24 THE WITNESS: Thank you.

25 THE COURT: Mr. Lord.

Trial: Testimony of Terry Ceasor

RECEIVED by MSC 6/5/2020 10:20:32 AM

1 THE WITNESS: Now, where did I leave off?

2 BY MR. LORD:

3 Q You were playing gotcha. You were going back and forth, I
4 think be on your hands and knees behind the couch.

5 A Okay, um --

6 Q And he was running on the cushions?

7 A All right, he was.

8 Q That's my memory.

9 A He was running on the cushions. Um, he had got his foot
10 stuck between the cushions a couple of times.

11 Um, see that was the one, or that was the one
12 thing I did want to discuss that the couch that he was up
13 and on I had just got this couch a week, a couple weeks
14 prior to this --

15 MRS. DEEGAN: Is that responsive --

16 THE WITNESS: -- had happened.

17 MRS. DEEGAN: -- to the question, your Honor?

18 He asked --

19 MR. LORD: It's not.

20 MRS. DEEGAN: -- what happened.

21 THE COURT: It's not. Sustain it.

22 BY MR. LORD:

23 Q Let's just talk about what he's doing. We'll go back and
24 cover that.

25 A Um, he was running back and forth on the couch. He had

Trial: Testimony of Terry Ceasor

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1 got his foot caught in the cushions a couple of times, so
2 I had slowed him in his, in his going back and forth so
3 that let me get him. Um, he was laughing. We were having
4 a good time. His sippy cup was down at the end of the
5 couch on a table.

6 Q All right.

7 A And those pictures that they do have do show --

8 Q Just hang on a second.

9 Do you have the photographs that have been
10 admitted into evidence?

11 THE COURT: Okay, Marsha, do you have the
12 exhibits?

13 THE CLERK: No, I don't.

14 BY MR. LORD:

15 Q I'm going to show you what's been marked as People's
16 Proposed Exhibits 4 and 7, and do you recognize what those
17 photographs depict?

18 A Yes, they are pictures of my living room with my couch and
19 tables.

20 Q And can you take whichever photograph you think we can
21 best show the Jury in relationship to where the couch is
22 and the coffee table and, and the sippy cup?

23 A Both pictures show it very well.

24 Q Okay. Well, which one would be easier for you to use?

25 A I would say probably this one here.

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Trial: Testimony of Terry Ceasor

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1 Q I'm going to let the record say People's --

2 A Four.

3 Q -- Exhibit 4. Can you show the Jury the couch area and in
4 relationship to the coffee table and where the sippy cup
5 was located?

6 A Um, this is the couch.

7 THE COURT: Can you see, Mrs. Deegan?

8 THE WITNESS: This here is the couch and this is
9 the table in front of the couch. This is my other table I
10 had at the end of the couch with my phone and his sippy
11 cup on the table. Um, when I was playing gotcha with him
12 he had stopped and got a drink of his sippy cup. I've
13 never stated that I saw his foot --

14 BY MR. LORD:

15 Q No, no, Terry you got to ask --

16 A Okay, I'm sorry.

17 Q -- the question.

18 A Um, when I seen him getting a drink of his sippy cup, that
19 is when I went to the bathroom because I figured he's
20 occupied enough that I can step off for a second and
21 there's not going to be anything done. Um, I go to the
22 bathroom. Um, I'm in the middle of going to the bathroom
23 and I hear a thud. I hear two hits. I come out when this
24 had happened. I was in the middle of urinating. I had, I
25 had, um, urinated on my hand and this is the reason why I

TAPE NO. 05-223

DATE: 12-15-05
533

TIME:

1 had washed off my hands. I never dried my hands.

2 I got out to the living room as fast as I could
3 to find out what had happened. Um, when I had come out to
4 the living room I had noticed that Brenden was in between
5 my couch and my table, kind of wedged a little bit and
6 kind of propped up, and he was just in a position that
7 there's no way that he went down in this position on his
8 own.

9 It wasn't like he was playing in this position.
10 And, um, when I came out and saw him there, his head was,
11 his head was flung back as far as the neck could go. And
12 when I picked up the child he was like, it was like he was
13 dead and he was like limp noodles.

14 Q Okay. What, what did you do?

15 A I picked him up. Um, I tried talking to him. I sprayed
16 some water off my hands that were wet. Um, I touched his
17 head. I, um, I tried everything I could do. I was
18 calling his name. I was on my way to the phone to call,
19 um, 911. Cheryl had came in the house and I told her that
20 Brenden had fallen and he was unconscious. She started
21 smiling and laughing like she thought that I was kidding
22 with her because, um, I'm a person that has a pretty good
23 sense of humor. I like to joke around a little bit.

24 Um, and I told her that I was not joking, that
25 this was serious, um, and I told her that he's barely

1 breathing. It almost sounds like he's snoring. Um, I
2 didn't know what was, what was wrong. I, I did not see, I
3 did not see him fall. I did not, I have no recollection
4 of what did happen. All I can tell you is how I found him
5 and picked him up. She came in, um, she went hysterical.
6 Um, I feel so bad for her. Um --

7 Q She, she said she became hysterical. What did you do
8 after that?

9 A I tried calming her down. Um, tried keeping her daughter
10 Derian calm, and tried to help take control of the
11 situation. She was far too hysterical to drive. There
12 was no way that she could have drove. Um, we loaded
13 Brenden in the Jeep. We surrounded him with blankets and
14 his sister had sat beside him and held his head so we
15 don't have to worry about the head falling, rocking. Um,
16 Cheryl was, Cheryl was, um, beside herself. I, I've never
17 seen her ever to be honest with you, I don't ever want to
18 see her like that again. Um, we took the baby to the Port
19 Huron Hospital. We had walked in the hospital. Um, they
20 took us right back into a room. Um, within a couple
21 minutes Brenden was crying and I can't tell you how, how
22 good that was to hear him cry.

23 THE COURT: Um, sustain, Mrs. Deegan.

24 THE WITNESS: Um, because --

25 BY MR. LORD:

1 was it any different?

2 A No.

3 Q In any way at any time, not just on that particular day,
4 but at any time have you ever grabbed Brenden and shaken
5 Brenden or caused Brenden any physical harm at all?

6 A No, I never even said no to Brenden.

7 Q Was there anything going on at this particular time before
8 this accident occurred that Brenden had made you mad or
9 upset or --

10 A Never.

11 Q At any of the times that you played with Brenden prior to
12 this day had you ever done anything that, had he ever done
13 anything to you, got you mad, upset or anything that you
14 would cause him any harm?

15 A No.

16 Q When this was all over you haven't had a chance to see
17 Brenden?

18 A No, it's been, um, it's been over 14 months since I've got
19 to see him.

20 MR. LORD: I have no further questions.

21 THE COURT: Thank you.

22 Mrs. Deegan, you may cross-examine.

23

24 CROSS-EXAMINATION

25

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Port Huron, Michigan
Friday, December 16, 2005

(Court in session at 10:47 a.m.)

THE COURT: We are on the record.
Counsel, will you approach the bench, please?
If you can gather around up there.

THE BAILIFF: All the jurors are present, your Honor.

THE COURT: Thank you. Be seated, please, ladies and gentlemen.

Good morning, ladies and gentlemen.

JURORS: Good morning.

THE COURT: Excuse me for just half a second.

(At 10:48 a.m., bench conference was held.)

THE COURT: We, we are now on the record, Counsel. And while we were off the record we discussed the question that I'm going to now answer to the Jury. The question, it says may we have the testimony of Doctor Gilmer-Hill. I, I've set this all up. I've had the reporter bring out the tape. She'll start the tape. It will not be on the record, but it will be shown to the

1 jury on the monitor that I've set up.

2 The Court will stop the tape at the point where
3 Mr. Lord has finished his re-direct and just before
4 Mrs. Deegan, or at the time Mrs. Deegan rose when I ruled
5 that at that point the Jury could not consider that
6 request of the Prosecutor or the testimony of the witness
7 Doctor Gilmer-Hill. And I'm, I'm announcing this on the
8 record now so that I get your response. Mrs. Deegan.

9 MRS. DEEGAN: I understand the Court's ruling.
10 That's fine.

11 THE COURT: Mr. Lord.

12 MR. LORD: I don't have any objection.

13 THE COURT: The alternative would be for me to
14 tell the Jury that they should use their collective
15 recollection. But I think under the circumstances it's
16 ten minutes to 11:00, this is about an hour and 20
17 minutes. From my point of view it's more reasonable thing
18 to do. All right, thank you.

19
20 (At 10:49 a.m., bench conference concluded.)

21
22 THE COURT: Now, ladies and gentlemen, are we on
23 the record now, Marsha?

24 THE CLERK: Yes.

25 THE COURT: Can you hear me okay?

1 return Monday morning at 9:30, no later than to continue
2 their deliberations.

3 Ready for the Jury, Mrs. Deegan?

4 MRS. DEEGAN: Yes, your Honor.

5 THE COURT: Ready for the Jury, Mr. Lord?

6 MR. LORD: Yes, your Honor.

7 THE COURT: Please bring the Jury, Len.

8 THE BAILIFF: Yes, sir.

9

10 (At 4:20 p.m., Jurors present.)

11

12 THE BAILIFF: All jurors present, your Honor.

13 THE COURT: Thank you. Be seated, please,
14 ladies and gentlemen.

15 Folks, we're going to go home. We're going to
16 quit for the day and come back, ask you to come back
17 Monday morning at 9:30 in the morning. No later than 9:30
18 tomorrow morning. You know this routine. I have to tell
19 you some of this just to remind you.

20 Do not talk about this case with anyone or let
21 anyone talk with you about this case. In the unlikely
22 event that there may be something in the newspaper or some
23 kind of publication, got to guard against that kind of
24 thing. I said unlikely. I'm just making a guess, I, I
25 don't know whether there will or there wouldn't be. Can't

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make experiments or investigations on your own. Drive very safely, please. I think the roads are pretty good today. It's starting to snow and it's going to snow some more apparently, but a whole bunch according to my forecaster at home. But let's see, okay, that's all then.

You're excused 'til Monday morning at 9:30. Return directly to the jury room no later than that time.

(At 4:21 p.m., Jurors recessed.)

THE COURT: Counsel, I have many, many things on my docket on Monday morning, but I expect that you will be at the ready no later than 9:30 Monday morning.

MRS. DEEGAN: Yes, your Honor.

THE COURT: All right. Marsha, we can go off the record.

(At 4:21 p.m., proceedings recessed.)

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STATE OF MICHIGAN

IN THE CIRCUIT COURT FOR THE COUNTY OF ST. CLAIR

PEOPLE OF THE STATE OF MICHIGAN

v.

Case No. A 05-220 FH

TERRY LEE CEASOR,

Defendant.

_____ /

JURY TRIAL
VOLUME 5

PROCEEDINGS HAD in the above-entitled cause,
before the HONORABLE JAMES P. ADAIR, Judge, 31st Judicial
Circuit, at Courtroom 3200, County Building, Port Huron, St.
Clair County, Michigan, on Monday, December 19, 2005.

APPEARANCES: JENNIFER D. SMITH DEEGAN, P57234
ST. CLAIR COUNTY ASSISTANT PROSECUTOR
201 McMORRAN BOULEVARD, SUITE 3300
PORT HURON, MICHIGAN 48060

On behalf of the People

KENNETH M. LORD, P30339
ATTORNEY AT LAW
1403 JENKS STREET
PORT HURON, MICHIGAN 48060

On behalf of the Defendant
Terry Lee Ceasor

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JUN 07 2006
APPELLATE DEFENDER OFFICE

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I N D E X

PAGE

Playback of Testimony of Holly Gilmer-Hill: 740
Verdict: 767

E X H I B I T S

Marked Received

None offered.

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Port Huron, Michigan
Monday, December 19, 2005

(Court in session at 10:06 a.m.)

THE COURT: We are on the record.

Counsel, I guess I better get on the bench. We have been discussing this note that was received from the Jury this morning, which reads as follows: "May we watch Doctor Gilmer-Hill's testimony from 4:00 to 4:25." In answer to that, which we've already discussed, we have the tape set up. I'll bring the Jury in. I will start the tape. It's all ready to go. It's marked at that spot and I'll turn it off at 4:25.

Any objection, Mrs. Deegan?

MS. DEEGAN: No, your Honor.

THE COURT: Mr. Lord?

MR. LORD: No, your Honor.

THE COURT: Stay right on the record please, Annette.

THE BAILIFF: Do you want those pulled?

THE COURT: Yes. Right. Pull those.

MR. LORD: Your Honor, may --

THE COURT: Yes, you can move. You can go there now, if you'd like.

1 I intended to read Deadlock Jury Instruction CJI 2nd 3.12.

2 Mrs. Deegan, any objection to my reading this
3 instruction?

4 MR. LORD: No, your Honor.

5 THE COURT: Mr. Lord, any objection to, to my
6 reading this instruction?

7 MR. LORD: I have never liked that instruction,
8 but if the Court wishes to read it, I'm --

9 THE COURT: I intend to. They have, in fact,
10 this jury has said would, and would like further
11 instructions. I don't think I have any choice but I'll
12 read this Deadlock Jury Instruction.

13 Charlie, would you bring the Jury.

14

15 (At 3:42 p.m., Jury reconvened.)

16

17 THE BAILIFF: Jury's impaneled, your Honor.

18 THE COURT: Thank you. Please be seated, ladies
19 and gentlemen.

20 Now, ladies and gentlemen, I have this note that
21 I've received from the Jury, and I've already read it to
22 the lawyers. It reads as follows: "We have not come to a
23 unanimous decision and would like further instructions."

24 So, ladies and gentlemen, you've returned from
25 deliberations and indicating that you believe you cannot

Trial: Verdict

RECEIVED by MSC 6/5/2020 10:20:32 AM

1 So with that, please, ladies and gentlemen, will
2 you return to the jury room and continue deliberations.
3 If you have questions, in the usual way write me a note.

4
5 (At 3:44 p.m., Jurors recessed.)

6 Any objections to the way I just read the
7 instruction, Mrs. Deegan?

8 MS. DEEGAN: No, your Honor.

9 THE COURT: Mr. Lord.

10 MR. LORD: No.

11 THE COURT: Thank you. Off the record, please.

12
13 (At 3:45 p.m., proceedings recessed.)

14 (At 4:11 p.m., proceedings reconvened.)

15
16 THE COURT: We are on the record. Counsel, I
17 have a message the Jury's reached a verdict. I'm going to
18 bring the Jury in and we'll inquire of the Jury.
19 Mr. Charlie, please bring the jury.

20
21 (At 4:12 p.m., Jury reconvened.)

22
23 THE BAILIFF: Jury is impaneled.

24 THE COURT: Thank you. Be seated, please,
25 ladies and gentlemen.

Trial: Verdict

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1 I have a message, folks, that the Jury's reached
2 a verdict. I'm going to ask the clerk to inquire of the
3 foreperson.

4 Kim, will you please inquire of this Jury.

5 THE CLERK: In the case of the People of the
6 State of Michigan versus Terry Ceasor, will the foreperson
7 please rise.

8 Has the Jury reached a verdict?

9 FOREPERSON: Yes, we have.

10 THE CLERK: Is the verdict unanimous?

11 FOREPERSON: Yes, it is.

12 THE CLERK: Would you please read your verdict
13 form, starting with Count 1?

14 FOREPERSON: Where, at Count 1?

15 THE COURT: Count 1, Child Abuse, first degree.

16 FOREPERSON: Child Abuse, first degree. We, the
17 Jury, find the Defendant, Terry Lee Ceasor, guilty as
18 charged of Child Abuse, First Degree.

19 THE COURT: Thank you, Charlie. Will you bring
20 me that verdict form, please?

21 Now, folks, the Counsel, I've reviewed the
22 written form of the verdict and compared it with the oral
23 announcement. I find it to compare exactly.

24 Mrs. Deegan, do you ask that this Jury be
25 polled?

STATE OF MICHIGAN
COURT OF APPEALS

PEOPLE OF THE STATE OF MICHIGAN,

Plaintiff-Appellee,

v

TERRY LEE CEASOR,

Defendant-Appellant.

UNPUBLISHED

July 12, 2007

No. 268150

St. Clair Circuit Court

LC No. 05-000220-FH

Before: Meter, P.J., and Talbot and Owens, JJ.

PER CURIAM.

Defendant appeals as of right from his jury trial conviction of first-degree child abuse, MCL 750.136b(2). We affirm.

Defendant first argues that the trial court erred in qualifying Dr. Holly Gilmer-Hill as an expert witness regarding shaken baby syndrome (SBS). Because defendant did not object to the trial court qualifying Gilmer-Hill as an expert witness, this issue is not preserved. *People v Grant*, 445 Mich 535, 546; 520 NW2d 123 (1994). This Court will not reverse a conviction based on an unpreserved issue except for plain error that affected a defendant's substantial rights by resulting in the conviction of an actually innocent person or seriously affecting the integrity, fairness, or public reputation of the judicial proceedings. *People v Jones*, 468 Mich 345, 355-356; 662 NW2d 376 (2003); *People v Carines*, 460 Mich 750, 761, 764-767; 597 NW2d 130 (1999). The admissibility of evidence is within the discretion of the trial court and will not be reversed unless the trial court abused its discretion. *People v McDaniel*, 469 Mich 409, 412; 670 NW2d 659 (2003). "A trial court's decision on a close evidentiary question generally cannot be an abuse of discretion." *People v Meshall*, 265 Mich App 616, 637; 696 NW2d 754 (2005). Interpretation of a court rule is a question of law that is reviewed de novo. *People v Walters*, 266 Mich App 341, 346; 700 NW2d 424 (2005).

Defendant argues that the trial court should not have qualified Gilmer-Hill as an expert on SBS because the theory is not generally accepted in the scientific community. Although defendant cites a few articles to support his position that the diagnosis of SBS is contested in the medical community, the referenced articles are not part of the lower court record and defendant has failed to move to amend the record for inclusion of the documents. As a consequence, we cannot consider the proffered information because it is not properly before us. See *People v Elston*, 462 Mich 751, 759-760; 614 NW2d 595 (2000).

In addition, defendant, citing to *Daubert v Merrell Dow Pharmaceuticals, Inc.*, 509 US 579; 113 S Ct 2786; 125 L Ed 469 (1993), contends that Gilmer-Hill did not qualify as an expert under MRE 702, which provides:

If the court determines that scientific, technical, or other specialized knowledge will assist the trier of fact to understand the evidence or to determine a fact in issue, a witness qualified as an expert by knowledge, skill, experience, training, or education may testify thereto in the form of an opinion or otherwise if (1) the testimony is based on sufficient facts or data, (2) the testimony is the product of reliable principles and methods, and (3) the witness has applied the principles and methods reliably to the facts of the case.

Under MRE 702, which has incorporated the *Daubert* requirements,¹ the proponent of expert witness testimony must establish that the testimony is reliable by showing that “the data underlying the expert’s theories and the methodology by which the expert draws conclusions from the data [are] reliable.” *Gilbert v DaimlerChrysler Corp.*, 470 Mich 749, 789; 685 NW2d 391 (2004).

With respect to the requirement under MRE 702 that an expert’s testimony must be “based on sufficient facts or data,” Gilmer-Hill testified that she physically examined the victim, reviewed his CAT scan, consulted an ophthalmologist who confirmed the existence of retinal hemorrhaging, and spoke to his mother regarding the cause of the injury. In addressing the requirement that an expert’s “testimony is the product of reliable principles and methods,” when asked about the “research, technology, [and] different mechanisms” utilized to study SBS, Gilmer-Hill testified that she was familiar with “several” published studies that examined whether symptoms indicative of SBS could occur accidentally, emphasizing a study, which concluded that only abuse could account for the symptoms traditionally attributed to SBS. Gilmer-Hill offered unrefuted testimony regarding the existence of professional publications pertaining to the diagnosis of SBS in support of the reliability of the underlying methods and principles for her diagnosis. See *Daubert, supra*. Considering her testimony as a whole, Gilmer-Hill adequately demonstrated that the diagnosis of SBS was generally accepted within the medical community.

Defendant argues, however, that because some experts have disputed the SBS diagnosis, the diagnosis is unreliable. Defendant refers to facts that are not matters of record to dispute plaintiff’s theory that SBS is a recognized or reliable diagnosis. Again we do not consider facts cited by defendant that are not part of the record. *Elston, supra*. Further, even if it was appropriate to consider these papers, nothing in MRE 702 or *Daubert* and its progeny suggest that expert testimony should not be admitted if an opponent shows that the theory relied upon is disputed by some experts in the scientific community. The proponent must establish reliability by a preponderance of the evidence, *id.* at 593 n 10, and, even assuming there is *some*

¹ See *Gilbert v DaimlerChrysler Corp.*, 470 Mich 749, 780 n 46; 685 NW2d 391 (2004), and the staff comment to MRE 702.

disagreement regarding SBS, defendant has not shown an abuse of discretion. Similarly, defendant's argument that Gilmer-Hill's theories were unreliable because she disagreed with the studies cited by defense counsel during cross-examination goes to the weight of her testimony, not to its admissibility. *People v England*, 176 Mich App 334, 340; 438 NW2d 908 (1989).

Concerning the requirement under MRE 702 that "the witness has applied the principles and methods reliably to the facts of the case," Gilmer-Hill demonstrated, through her own direct professional experience with SBS and the data she had studied, see *Gilbert, supra*, that the victim's injuries were the result of child abuse, and that a child with the victim's symptoms would "become symptomatic right away." We further note that Gilmer-Hill testified that another indicator of SBS, in addition to the physical symptoms, is that the explanation of the injuries given by caregivers commonly changes. In this instance, defendant initially told police that the victim's mother was present when the alleged fall occurred but later admitted that she was not present and altered details of his recollection of events preceding the child's injury.

Gilmer-Hill's testimony assisted the jury in understanding the evidence and determining whether the injuries were accidental. The trial court did not abuse its discretion in finding that Gilmer-Hill possessed the necessary "knowledge, skill, experience, training, or education" to testify as an expert on SBS. Gilmer-Hill had six years of experience as a neurosurgeon; having attended medical school and completing a residency and fellowships. Gilmer-Hill was licensed in the field of pediatric neurosurgery and demonstrated extensive study of medical literature on SBS. These factors, combined with her direct observation in medical practice of victims of SBS and her previous qualification as an expert witness regarding SBS on numerous occasions supported the trial court's determination of her qualification as an expert witness. *People v Lewis*, 160 Mich App 20, 28; 408 NW2d 94 (1987).

Defendant's reliance on *Daubert* for the proposition that an expert witness must have personally published and conducted research is misplaced. Although publication and peer review of the *theory* proposed by an expert may be relevant to whether the theory is reliable, there is no requirement under *Daubert* or the Michigan Rules of Evidence that an expert must have personally published any materials on the subject matter in issue. See also *In re Noecker*, 472 Mich 1, 11; 691 NW2d 440 (2005) (rejecting an argument that an expert witness must have been "publish[ed], present[ed], or conduct[ed] peer review on the topic in the recent past" when the evidence showed that the proposed expert possessed the requisite education, training, and experience in the field at issue).

Defendant next argues that plaintiff did not comply with MRE 703, which requires that the facts or data upon which the expert relied must be in evidence, because nothing regarding SBS was admitted into evidence, and Gilmer-Hill did not cite the studies that she claimed supported the diagnosis of SBS. Defendant cites no authority for the proposition that the "facts or data," as those terms are used in MRE 703, refer to writings the expert may have studied to become an expert on a given subject, so we need not address defendant's argument in this regard. *People v Albers*, 258 Mich App 578, 584; 672 NW2d 336 (2003). Furthermore, cases addressing the meaning of "facts or data" within the context of MRE 702 and MRE 703 presume that the "facts or data" refer to the facts of the case that would support the expert's opinion, and do not include information or documentation pertaining to the expert's education on the topic.

Defendant also argues that defense counsel was constitutionally ineffective for failing to present an expert witness to rebut the prosecutor's SBS evidence or for failing to convince defendant of the need to hire an expert. Because defendant did not move for a *Ginther*² hearing, this Court's review is limited to errors apparent on the record. *People v Nantelle*, 215 Mich App 77, 87; 544 NW2d 667 (1996). To establish a claim of ineffective assistance of counsel, a defendant must demonstrate that counsel's performance was deficient in that it fell below an objective standard of professional reasonableness, and that it is reasonably probable that but for counsel's ineffective assistance, the result of the proceeding would have been different. *People v Rodgers*, 248 Mich App 702, 714; 645 NW2d 294 (2001). "Defendant must overcome the strong presumption that counsel's performance was sound trial strategy." *People v Dixon*, 263 Mich App 393, 396; 688 NW2d 308 (2004).

Defendant asserts that because defense counsel mentioned articles in medical journals that questioned the prosecution's expert's understanding of SBS during cross-examination, defense counsel could have found an expert witness willing to testify on defendant's behalf. It cannot be said, based on the existing record, that an expert would have been willing to opine that, under the circumstances of this case and given the victim's symptoms, the victim could not have suffered his injuries as a result of being shaken or slammed or that his injuries could have been accidental. Thus, any conclusion that an expert could have successfully challenged Gilmer-Hill's diagnosis is entirely speculative.

Further, the record does not support defendant's contention that his counsel failed to contact or try to procure an expert to support defendant's theory. Specifically, the trial court granted defendant a stipulated adjournment to consult an expert witness, and defendant then received additional adjournments because his counsel had located an expert on SBS willing to review the evidence. Applying the presumption that counsel's decision to not call an expert witness was a matter of sound trial strategy, *Dixon, supra*, defendant cannot overcome the presumption that defense counsel declined to present an expert witness because any expert consulted was unwilling to support defendant's position that the injury was accidental or would not have presented favorable testimony after reviewing the evidence. The fact that SBS may be a disputed diagnosis does not mean that an expert would have found after reviewing the evidence that this victim's injuries resulted from an accident, nor does the existing record support such a conclusion.

Similarly, it cannot be said that defense counsel failed to explain to defendant the importance of hiring an expert. Notably, defendant suggests that defense counsel may have explained to defendant the need to hire an expert, but because no expert was hired, this Court should infer that defense counsel was ineffective because he failed to convince defendant of this need. Plaintiff cites no legal authority in support of his position. In general, "[a]n appellant may not merely announce his position and leave it to this Court to discover and rationalize the basis for his claims, nor may he give only cursory treatment [of an issue] with little or no citation of supporting authority." *People v Matuszak*, 263 Mich App 42, 59; 687 NW2d 342 (2004) (citation and quotations omitted).

² *People v Ginther*, 390 Mich 436; 212 NW2d 922 (1973).

Defendant further argues that the evidence was insufficient to support his conviction. This Court reviews an insufficiency of evidence claim de novo to determine whether the evidence, when viewed in the light most favorable to the prosecution, would justify a rational trier of fact in finding that all the elements of the crime were proven beyond a reasonable doubt. *People v Tombs*, 472 Mich 446, 459; 697 NW2d 494 (2005); *People v Lueth*, 253 Mich App 670, 680; 660 NW2d 322 (2002).

Defendant argues that the evidence fails to show, beyond a reasonable doubt, that defendant specifically intended to harm the victim. Defendant further contends that the idea that experts can determine intent from physical findings is “junk science.” However, “intent generally may be inferred from the facts and circumstances of a case.” *People v Jory*, 443 Mich 403, 419; 505 NW2d 228 (1993). Under MCL 750.136b(2), “A person is guilty of child abuse in the first degree if the person knowingly or intentionally causes serious physical or serious mental harm to a child.” The jury could have properly inferred that defendant knowingly or intentionally harmed the victim from the testimony of Gilmer-Hill, who opined that the injuries did not appear to be accidental and were caused by someone shaking the victim forcefully or slamming him onto a surface. Although Gilmer-Hill acknowledged that a person could suffer a subdural hematoma and not immediately show symptoms, she rejected suggestions that this might have occurred with this victim, stating, “with this injury, with subdural hemorrhage and bleeding within both eyes indicating severe injury, then the child becomes symptomatic right away, the child does not run around asymptomatic . . . for several hours . . .” In addition, the jury heard evidence from which it could have found that the victim had not been left alone with anyone but defendant when the injuries causing his symptoms were incurred.

Defendant next argues, “the expert’s testimony is based purely on speculation and scientific evidence that is not conclusive.” However, expert witnesses can offer opinions, MRE 703, and Gilmer-Hill was properly qualified to offer her opinion on causation. Far from her opinion being based purely on speculation, Gilmer-Hill testified she had examined the victim, considered his CAT scan, and that she had consulted an ophthalmologist. Considerations regarding the weight of the evidence are properly left to the jury. *People v Fletcher*, 260 Mich App 531, 561; 679 NW2d 127 (2004).

Defendant next argues that the evidence was insufficient because defendant testified that the victim had been alone when he fell and that his mother testified that she had noticed a mark on the victim’s head. However, there was evidence that both defendant and the mother lied about the alleged fall when they both claimed that the mother was in the home at the time, but later admitted that she was not present. Further, the health professionals who testified at trial all asserted that they physically examined the victim for external injuries and did not find, recall, or record any external injuries. Considerations of credibility and the weighing of the evidence are properly left to the jury. *Fletcher, supra*. Further, the prosecution is not required to rule out every arguable theory of innocence, but is only required to prove its theory beyond a reasonable doubt. *People v Nowack*, 462 Mich 392, 400; 614 NW2d 78 (2000). Accordingly, considering the evidence in the light most favorable to the prosecutor, *Tombs, supra*, sufficient evidence was presented to support defendant’s conviction.

Finally, defendant argues that the prosecutor committed prosecutorial misconduct when she stated during oral argument that Gilmer-Hill “was able to refute” all of the theories

mentioned during cross-examination to rebut the SBS theory. Because plaintiff did not object to the challenged statement below, this issue is not preserved. *People v Sardy*, 216 Mich App 111, 117-118; 549 NW2d 23 (1996). “[A] defendant’s unpreserved claims of prosecutorial misconduct are reviewed for plain error. In order to avoid forfeiture . . . , the defendant must demonstrate plain error that was outcome determinative.” *People v Watson*, 245 Mich App 572, 586; 629 NW2d 411 (2001) (citation omitted).

The prosecutor’s remarks that Gilmer-Hill refuted all of the challenges to the SBS evidence did not amount to prosecutorial misconduct, or plain error, because the comment comprised a reasonable inference based on the evidence, specifically Gilmer-Hill’s testimony about certain theories and studies. See *People v Ackerman*, 257 Mich App 434, 450; 669 NW2d 818 (2003) (“A prosecutor may not make a statement of fact to the jury that is unsupported by evidence, but she is free to argue the evidence and any reasonable inferences that may arise from the evidence.”)

Affirmed.

/s/ Patrick M. Meter
/s/ Michael J. Talbot
/s/ Donald S. Owens

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**UNITED STATES DISTRICT COURT
EASTERN DISTRICT OF MICHIGAN
SOUTHERN DIVISION**

TERRY CEASOR,

Petitioner,

CASE NO. 08-13641

v.

**HON. JOHN O'MEARA
MAG. PAUL J. KOMIVES**

**JOHN OCWIEJA, Warden
Jackson Cooper Street Facility**

Respondent.

_____ /

Affidavit of Dr. John Plunkett

1. My name is John Plunkett. My address is 13013 Welch Trail, Welch, MN 55089. I am a forensic pathologist and am board certified in forensic, anatomical, and clinical pathology. Forensic pathology is the subspecialty of anatomic pathology that studies the cause of injury and/or death. I graduated from the University of Minnesota Medical School in 1972. I completed my post-graduate training (general internship, residencies in anatomical and clinical pathology, and fellowship in forensic pathology) in 1978.
2. I have practiced forensic, anatomic, and clinical pathology in a hospital setting and as the appointed Coroner (now Medical Examiner) for the area surrounding Hastings, Minnesota. Since retiring from hospital duties in December 2004, I have continued to write, lecture, sponsor continuing medical education courses, and consult on cases involving infant injury. In cases in which the injuries appear to be accidental or nontraumatic rather than abusive, I provide this information and, if necessary, testify on my findings.
3. I developed a particular interest in pediatric head injury in the 1990s and have published several articles on this subject in peer-reviewed journals. These articles include *Fatal Pediatric Head Injuries Caused by Short-Distance Falls* (2001); *A Biomechanical Analysis of the Causes of Traumatic Brain Injury in Infants and Children* (2004), co-authored with Professor Goldsmith, Biomechanical Engineering, University of California at Berkeley; and *Resuscitation Injuries Complicating the Interpretation of Premortem Trauma and Natural*

Disease in Children (2006). I also co-authored an invited editorial for the British Medical Journal with Dr. Jennian Geddes, a leading researcher in the neuropathology of inflicted head trauma. Geddes and Plunkett, *The Evidence Base for Shaken Baby Syndrome: We Need to Question the Diagnostic Criteria* (2004). Complete citations are included in my curriculum vitae, which is attached as Exhibit 1.

Medical review: Brenden Genna

4. I have been asked to review the medical records for Brenden Genna and have done so on a *pro bono* basis. It is my understanding that the defense did not retain an expert to evaluate the State's claim that the child's brain injury (a concussion) was caused by shaking or shaking/impact rather than a fall from a couch onto the floor or coffee table. Since my name was in the defense counsel's file and references to my work were made during trial, I have been asked to summarize the testimony that I would have given had I been asked to review the case and/or testify at trial.
5. If I had been asked to review this case, I would have obtained complete medical records, including hospital records, radiology images, prenatal and birth records, pediatric records and caretaker reports. If I were not able to take the case due to other commitments, I would have provided defense counsel with information on the literature and strongly advised the retention of an expert to advise on the medical and biomechanical issues and, if necessary, to testify at trial.
6. In preparing this report, I have reviewed the following records:
 - Port Huron hospital records dated October 3, 2003, including admission, progress, discharge, radiology, and laboratory reports.
 - Detroit Medical Center (Children's) hospital records dated October 3-8, 2003, including admission, discharge, and progress reports.
 - Police and CPS reports, including interviews with Dr. Hunt and a nurse at Port Huron, Cheryl Genna (the child's mother), Terry Ceasor, and Brenden's biological father.
 - Pediatric records.
 - Testimony by Dr. Christopher Hunt, the E.R. doctor who treated Brenden at Port Huron, and Dr. Holly Gilmer-Hill, a pediatric neurosurgeon at Children's.
7. These records do not include key documents, including the radiology images; scene photographs; and radiology reports, lab reports, ophthalmology reports, and discharge summary from Children's. Prenatal and birth records are unavailable, and the caretaker reports contain little information on the 72 hours before the child's collapse, including a reported fall at daycare two days earlier. Since there is considerable disagreement on the radiology (addressed below), I recommend that the radiology images be re-read by a pediatric neuroradiologist. In addition, the scene photographs should be reviewed by a biomechanical engineer who can reconstruct the incident in light of established injury thresholds.

Conclusion

8. The medical records establish that Brenden Genna had a concussion with temporary loss of consciousness consistent with a fall from a sofa onto the floor and/or coffee table, with recovery within an hour or so of the incident. There is no medical evidence to support the claim that Mr. Ceasor caused the child's collapse by shaking or shaking/impact.
9. Since the State's case was based on the radiology images and the biomechanics of shaking and impact, it would have been critical to review the radiology and the biomechanical and medical literature on concussions and short falls. It is my understanding that trial counsel did not obtain a review of the radiology or medical records prior to trial. It is my further understanding that trial counsel consulted with Professor Faris Bandak, a biomechanical engineer, but did not retain him or any other expert to address the biomechanical issues.
10. A review of the records and expert testimony establishes that Mr. Ceasor's conviction was based on a misunderstanding of the medical and biomechanical literature. For example, Dr. Gilmer-Hill, the State's lead witness, testified that studies by Dr. Duhaime, a neurosurgeon, found that the force from shaking far exceeds the force from a short fall. In fact, the Duhaime study, which was conducted in conjunction with biomechanical engineers at the University of Pennsylvania, found the opposite: in her 1987 study, Dr. Duhaime and her colleagues found that *impact generated forces nearly 50 times the forces generated by shaking*. Dr. Gilmer-Hill's testimony on the medical issues was also inconsistent with the literature. For example, Dr. Gilmer-Hill testified that a CT scan showed that Brenden's subdural hemorrhage was acute and was therefore no more than 6-12 hours old. However, an acute hemorrhage on CT scan may be up to 5-7 days old. Dr. Gilmer-Hill also testified that the child's collapse would have immediately followed injury. However, the medical literature reports time lags of up to 72 hours between injury and collapse.
11. In this affidavit, I summarize the medical reports and expert testimony and briefly describe some of the major changes in the literature on shaking or shaking/impact that have occurred over the past decade, with emphasis on the literature available at the time of Mr. Ceasor's trial in December 2005. I also address the relevant concussion literature.

Medical history

12. *Prenatal and birth records.* I do not have Brenden's prenatal or birth records. However, his pediatric records indicate that it was a vaginal birth and that the child was one week overdue, with a birth weight of 7 lbs 3 oz. The records indicate that he had a low body temperature and heart rate. As of September 20, 2004 (approximately 2 weeks before the incident), a medical exam showed that Brenden was 33 inches tall and weighed 27 pounds, 5 ounces.
13. *Pediatric records.* The May 22, 2003 pediatric report (age one week) shows a head circumference in the 25th percentile. In June and September 2003, his head circumference had increased to the 75th percentile. On September 20, 2004, two weeks before his collapse, his head circumference was in the 85th percentile. This reported increase in head circumference suggests that the child may have had a chronic (old) subdural hemorrhage,

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- possibly birth-related, or benign extraaxial collections of infancy (cerebral spinal fluid or CSF), which would have predisposed him to subdural hemorrhage spontaneously or from minor impact.
14. The pediatric records indicate that the child had plagiocephaly (abnormally flattened skull), possible minor developmental delays (e.g., speech), and a history of cough, runny nose and other respiratory diseases, for which he took Pediacare, a children's cough and cold medicine that contained pseudoephedrine and dextromethorphan. In October 2007, these ingredients were withdrawn for children under age 2 due to an association with sudden death in this age group.
 15. *Caretaker reports.* At the time of Brenden's concussion, Brendan's mother, Cheryl Genna, and Mr. Ceasor had been dating for several months. Ms. Genna had two children, a 6 year old daughter, and Brenden, age 16 months. Mr. Ceasor had custody of his son, who was 11 years old. There are no reported prior concerns with abuse or neglect.
 16. There are virtually no caretaker reports for Brenden for the 72 hours prior to his collapse, but I am told that Ms. Genna testified that Brenden had a fall at daycare two days earlier. This is within the time range in which head injuries may become symptomatic. The concussion literature also makes clear that a second impact that follows a prior impact that has not yet fully resolved may produce a concussion or more serious consequences, even when both impacts are minor.
 17. The records indicate that on the day before hospital admission, Brenden was taking "Tylenol Cold," one of the children's cough and cold medicines that was later removed from the shelves. While his symptoms may have been related to the mastoid (ear/sinus)infection suggested in a CT scan, it is also possible that he was showing nonspecific signs of head injury (e.g., lethargy or irritability), which can be mistaken for a cold or minor illness.
 18. *Day of collapse (Oct. 3, 2003).* According to the police reports, at around 2:45 on October 3, 2003, Ms. Genna took her 6 year old daughter swimming while Brenden stayed with Mr. Ceasor. Mr. Ceasor reported that he was playing "gotcha" with Brenden on the couch, left to go to the bathroom, and heard a thud. He said he found Brenden unresponsive on the floor by the couch and thought he had hit the coffee table, which is described in the police reports as a heavy table with steel legs positioned approximately 12" from the couch. This reportedly occurred between 4 and 4:15.
 19. According to Mr. Ceasor, he was about to call 911 when the mother returned home. They immediately drove the child to Port Huron Hospital, arriving at 4:20.
 20. At the hospital, the mother told the police that she was at home in another room when Brenden apparently fell off the couch. Mr. Ceasor agreed. A few days later, the mother told the police that she was not at home but had said she was at home because she was afraid that child services would remove her children if she had left Brenden alone with a

non-family member. In a subsequent interview, Mr. Ceasor confirmed that he was alone with Brenden at the time of the incident. All other information remained the same.

Hospital records: Port Huron (Oct. 3, 4:20 – 7:28 p.m.)

21. The admission notes indicate that Brenden arrived at Port Huron hospital at 4:20 p.m. On arrival, he was not in respiratory distress and had no obvious head injury, but was unresponsive and had unequal pupils. At 4:35, he was arousable to verbal stimuli but was not following objects. By 5:15, he was alert, tracking objects with his eyes and following simple commands. By then, his pupils were equal and reactive. At 5:45, his Glasgow Coma Scale was 15 (normal).
22. *Laboratory reports.* The laboratory reports from blood drawn at 4:52 p.m. show high glucose, abnormal ALT/AST, a slightly high WBC, high platelets (740), slight microcytosis, and high monos. These results are consistent with stress and/or infection.
23. *CT scan: 5:28 p.m.* The Port Huron radiology report describes a moderate size collection of blood on the right, 5 mm thick, thought to be subdural in nature, with no fractures or soft tissue swelling. The radiologist did not attempt to age this collection. The report indicates that due to plagiocephaly it was hard to determine whether there was a midline shift (shift of the brain to one side due to brain swelling or hemorrhage) but that there was felt to be mild to moderate mass effect (possible swelling within the brain) with some effacement of the right ventricle. There was fluid in the mastoid on the right compatible with infection. There were no noted intraparenchymal abnormalities, *i.e.*, hemorrhages or other abnormalities within the brain tissue.
24. The child was discharged for transport to Children's Hospital at 7:28 p.m.
25. The Port Huron records indicate that Brenden had a concussion with an immediate loss of consciousness that resolved quickly. In children, concussions are typically caused by accidental impact, such as household falls. There is no evidence of abuse or inflicted injury in the Port Huron records.

Hospital records: Children's Hospital

26. *October 3.* The admission records indicate that Brenden arrived at Children's at 9 p.m. and that he had vomited during transport. Vomiting is often associated with concussion. The principal admission diagnosis was subdural hemorrhage after injury, with brief unconsciousness and no open intracranial wound. Secondary diagnoses included convulsions, retinal hemorrhage, and redness around the mouth. The basis for the diagnosis of convulsions is unclear since no convulsions are noted in the hospital records that I have reviewed.
27. A handwritten admission note from Children's indicates that Brenden had a Glasgow Coma Scale (GCS) of 5 at Port Huron, which would indicate coma. However, the only reference to a GCS in the records I have seen indicates that the child had a GCS of 15 (normal)

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- approximately an hour and a half after admission, suggesting that the handwritten note may have been a recording error.
28. October 4. A 5 a.m. progress report notes bruising on the child's forehead with no other marks on the body. The child was awake and alert and had vomited twice. There was no seizure activity. The mother and father (presumably Mr. Ceasor) were cooperative and asked appropriate questions.
 29. A 9:30 a.m. progress note by Dr. Gilmer-Hill, a pediatric neurosurgeon, states that the Port Huron CT scan showed an acute right subdural hemorrhage with midline shift and diffuse edema. This report differs from the Port Huron radiology report on the same CT scan in two respects. First, Dr. Gilmer-Hill dates the subdural collection, describing it as acute, which would indicate that it is likely between 3 hours and 5-7 days old. Second, unlike the Port Huron radiologist, who could not determine whether there was a midline shift due to plagiocephaly and who saw no definite abnormalities within the brain, Dr. Gilmer-Hill describes a midline shift (movement of the brain to one side due to substantial hemorrhage or brainswelling) and diffuse edema (swelling within the brain). In my experience, the child's rapid recovery is inconsistent with diffuse brainswelling and a midline shift. Dr. Gilmer-Hill did not note the fluid in the mastoid.
 30. Dr. Gilmer-Hill's notes indicate that a second CT taken at Children's on the morning of October 4 showed a resolution of the hemorrhage with continued edema. A 10:50 a.m. progress note by another neurosurgeon states that the second CT showed minimal subdural hemorrhage and less mass effect. The Children's radiology reports and images are not available.
 31. A skeletal survey was negative for fractures but showed a fibrotic benign appearing nontraumatic area in the left humerus (upper arm).
 32. At 1 p.m., the ophthalmology exam was postponed when the attending physician instructed that the eyes not be dilated. A 3 p.m. note indicates that the pupils were equal, round and reactive to light. The ophthalmology report and photos are not available.
 33. October 5. Mannitol (a medication for brainswelling) was discontinued early on October 5. At 9:10 a.m., a child protection team note mentions dot/blot/flame retinal hemorrhages. These retinal hemorrhages are nonspecific for cause and timing and generally resolve of their own accord.
 34. A 4:55 p.m. note indicates that child protective services would interview the parents in the morning and petition the court for termination of parental rights. The biological father was in the process of establishing paternity.
 35. October 7. When the hospital told the mother that this was shaken baby syndrome, the mother reported that Mr. Ceasor had been alone with the child (see above). She also reported that she and other family members had seen a red mark about the size of a 50 cent

piece on the back of Brenden's head at the hospital, which may have represented a site at which Brenden hit his head. There does not appear to be any follow-up on this observation.

36. *Laboratory and radiology reports.* The Children's records that I have received contain no laboratory reports and no radiology reports or images. In cases involving hemorrhage, the records should include laboratory tests for bleeding disorders, metabolic disease, and vitamin or nutritional deficiencies that would make the child more prone to hemorrhage. The radiology reports and images should also be included.
37. *October 8: discharge.* The hospital records confirm that Brenden had no significant symptoms at Children's. However, his discharge was postponed pending investigation by the sheriff and child protective services. On October 8, Brenden was discharged with no medications other than over-the-counter Tylenol or ibuprofen, with follow up to be scheduled with a neurosurgeon. I have not received any follow-up reports.
38. The Children's records indicate that Brenden had a short term concussion consistent with a fall from a couch. There is nothing in the hospital records suggesting that he was shaken or abused.

Pre-trial testimony

39. At a pretrial hearing, Dr. Gilmer-Hill confirmed that Brenden was awake, alert and responding appropriately when he arrived at Children's and that he did not require medical treatment. She also confirmed that there were no fractures, contusions, or signs of trauma to the scalp, skull, or brain.
40. *Port Huron CT scan.* Dr. Gilmer-Hill testified that the Port Huron CT scan showed 8-10 mm thick frontal *bilateral* subdural hemorrhages (*i.e., hemorrhages on the left and right*), with some midline shift and soft tissue swelling over the right parietal scalp. This testimony differs from the Port Huron radiology report, which described a 5 mm collection *on the right*, with no noted soft tissue swelling or definite midline shift. Her pretrial testimony differed from her hospital notes, which described a subdural hemorrhage *on the right*, with a midline shift but no soft tissue swelling. These inconsistencies should have been addressed in an independent review of the images prior to trial.
41. *Children's CT scan.* Dr. Gilmer-Hill testified that the CT scan taken at Children's the following morning showed decreased blood, *smaller on the right but very visible on the left*. This is inconsistent with her hospital notes, which indicate that this CT scan showed *a resolution of the hemorrhage*. Her partner's notes indicate that the 2nd CT scan showed minimal subdural hemorrhage and less mass effect. Neither set of notes mentioned soft tissue swelling. However, absence of soft tissue scalp swelling is still consistent with head impact from a fall.
42. It is not possible to resolve the inconsistencies between Port Huron radiology report, the Children's hospital notes and Dr. Gilmer-Hill's pretrial testimony without reviewing the images. These inconsistencies should have alerted defense counsel that it would be

essential to obtain the images and the Children's radiology reports so that they could be reviewed by a pediatric neuroradiologist.

43. Dr. Gilmer-Hill testified that the child had a GCS of 5 (coma) at Port Huron and that the child had had seizures, indicating a more serious injury than falling off a couch. However, the Port Huron records do not mention a GCS of 5, and there are no reported seizures in the hospital records. These inconsistencies should also have been addressed before trial.
44. Dr. Gilmer-Hill testified that a subdural hematoma is a serious injury, that it would be rare to get a subdural hemorrhage from a fall off a couch, and that the mechanism for subdural and retinal hemorrhage is violent shaking, either shaken baby syndrome (SBS) or shaken/impact syndrome. She testified that SBS refers to nonaccidental injury, usually shaking with some impact, such as striking, slamming or throwing, and that at 18 months, injuries are more likely to involve impact, such as a blow or slamming. She acknowledged, however, that the symptoms of shaking do not necessarily differ from any other closed head injury. She said that medical residents see many SBS cases, and that the hallmark is any kind of brain hemorrhaging, typically subdural hemorrhage, frequently with skull fracture and/or seizures and possibly with retinal hemorrhage. She also testified that retinal hemorrhages are diagnostic of shaking or shaking/impact in the absence of a massive accident or coagulopathy (bleeding disorder), which was ruled out by laboratory tests.
45. As discussed in more detail below, there is no evidentiary basis for Dr. Gilmer-Hill's claims that subdural and retinal hemorrhages are serious injuries caused by shaking or intentional impact. The biomechanical and forensic literature makes clear that shaking is an unlikely cause for subdural or retinal hemorrhages; that it is not generally possible to distinguish between accidental and intentional impact; and that subdural and retinal hemorrhages may result from accidental impact or a wide array of natural causes.
46. At the end of the pretrial hearing, Mr. Ceasor's attorney stated that the trial would be "expert against expert." However, it appears that Mr. Ceasor's attorneys did not retain an expert and that no defense expert testified at trial. Instead, the expert evidence consisted entirely of the State's evidence, much of which was contrary to the medical records and literature.

Trial testimony

47. At trial, Dr. Christopher Hunt, the E.R. doctor from Port Huron Hospital, and Dr. Gilmer-Hill testified on behalf of the State.

Testimony by Dr. Hunt

48. Dr. Hunt confirmed that, on admission, Brenden had stable vital signs and was breathing on his own, with no respiratory distress or signs of trauma. He testified that Brenden was initially unresponsive to stimuli but became responsive after the CT scan. He did not recall any seizure-like activity.

49. Dr. Hunt testified that the CT scan showed a subdural hematoma with some slight mass effect, which he attributed to the subdural hemorrhage pushing the brain to one side (*i.e.*, a midline shift). For preventative purposes, Brenden was treated with dilantin (to prevent seizures), mannitol (to reduce pressure on the brain), and intubation (to prevent respiratory difficulties).
50. Dr. Hunt testified that a subdural hematoma is most commonly seen in a fall where you “hit your head.” However, he felt that 16 month olds don’t typically fall, and that it would be very strange for a 16 month old to fall off a couch and get a subdural hematoma without external signs of trauma. He agreed that bruising does not necessarily occur immediately after a fall and did not know that the Children’s notes mentioned bruising on the forehead.
51. Dr. Hunt associated the lack of external bruising with shaken baby syndrome. He mentioned that he had training in shaken baby syndrome, but he did not diagnose it or discuss the advances in this field over the past decade. In an earlier police report, he stated that he was not an expert in this area.
52. I do not agree that it is unusual for a 16 month old to fall off a couch or to get a concussion, with or without subdural hemorrhage, irrespective of whether there are external signs of trauma. In this case, the forehead bruising noted in the hospital chart is consistent with a fall but is not necessary to the diagnosis.
53. Dr. Hunt testified that Mr. Ceasor initially said Brenden had fallen off a couch and hit his head on a table but later said he didn’t know how it occurred. Dr. Hunt viewed this as a change in the story. However, the reports indicate that Mr. Ceasor consistently said that he was out of the room when he heard a thump and that he found the child between the couch and the coffee table, in a position suggesting that he may have hit his head on the coffee table and/or floor. Since no one was in the room at the time, it is not possible for anyone, including Mr. Ceasor, to determine precisely how the fall occurred. However, Brenden’s concussion and subsequent recovery are consistent with a fall from a couch onto a coffee table or floor.

Testimony by Dr. Gilmer-Hill

54. At trial, Dr. Gilmer-Hill confirmed that when she saw Brenden at Children’s at 9:30 a.m. on October 4, he was awake, alert and had no external bruising, scalp swelling, or other outward signs of trauma. On October 5, Dr. Sood, Dr. Gilmer-Hill’s partner, eliminated Mannitol, a medication for brainswelling. When Dr. Gilmer-Hill saw Brenden on October 6, he was alert, neurologically intact, and playful, and did not require treatment.
55. *Port Huron CT scan.* Dr. Gilmer-Hill testified that the Port Huron CT scan showed some blood, brainswelling and a midline shift, indicating a serious injury. She further testified that the blood on the Port Huron CT scan was “fresh” or acute and therefore occurred within 6-12 hours before the scan. CT scans do not, however, date hemorrhages with this degree of precision. Hemorrhages that appear “bright” or acute on CT may be up to 7-10 days old.

56. Dr. Gilmer-Hill testified that while a child may be asymptomatic and act normally for several hours after injury, the time period in this case could be limited to the period between 3 and 4 p.m. since that is when the child became symptomatic. As discussed below, however, a child may not show significant symptoms for up to 72 hours after injury.
57. Dr. Gilmer-Hill testified that the “lucid interval” refers to subdural hematoma, not subdural hematoma *and* retinal hemorrhage. However, there is no literature suggesting that there cannot be a lucid interval after retinal hemorrhages, which are typically asymptomatic and cannot be dated.
58. Dr. Gilmer-Hill testified that subdural hemorrhage, brainswelling and midline shift are seen in accidents such as falls from second story buildings or high speed motor vehicle accidents and cannot be caused by an accidental injury such a fall from a couch onto a carpeted floor. However, one of the cases in my 2001 study is a videotaped recording of a toddler who fell approximately 28” from an indoor play structure onto a carpeted floor. The child initially appeared to be okay, but then collapsed and died from a large subdural hemorrhage. She also had bilateral retinal hemorrhages. Other short falls resulting in subdural hemorrhage and/or concussion are recorded in the literature and replicated in biomechanical studies.
59. Dr. Gilmer-Hill testified that she could not say with certainty that Brenden did not have a subdural hematoma prior to falling off the couch, and that it is possible that the subdural hemorrhage caused the child to fall. She testified that a chronic (old) subdural can spontaneously rebleed from a membrane but that you would then see old and new blood in the subdural. Since, however, CT scans do not distinguish between hemorrhages that are up to 7-10 days old, a CT scan of a child who has had two or more impacts within a week would simply show acute blood.
60. *Retinal hemorrhage.* Dr. Gilmer-Hill testified that ophthalmology exams on October 5 and 6 identified bilateral retinal hemorrhages but that she did not know their ages or size. An Oct. 5 ophthalmology report by Dr. Klein is mentioned but is not available. Dr. Gilmer-Hill testified that it takes a great deal of force to cause retinal hemorrhages and that retinal hemorrhages can only be caused by being shaken or slammed on hard or soft surfaces, usually repeatedly. She also testified that retinal hemorrhages generally involve impact, such as being struck, slammed down on a sofa or soft surface, or thrown against a wall or up against a ceiling.
61. Dr. Gilmer-Hill’s testimony is contrary to the literature, which establishes that there are many causes for retinal hemorrhages, which are found in approximately 35% of newborns. Other causes include hypertension, infection, anemia, glutaric aciduria I, vitamin C deficiency and/or thrombophilia. At autopsy, retinal hemorrhages are found in a wide array of natural deaths. While some believe that abusive head trauma can be inferred from the size and shape of retinal hemorrhages (*e.g.*, multi-layered retinal hemorrhages that extend to the periphery), there is as yet no evidentiary basis for this hypothesis. In this case, there is no claim that Brenden’s retinal hemorrhages were large or multi-layered.

62. *Fractures and bruising.* Dr. Gilmer-Hill confirmed that the radiology showed no fractures, and that the Children's nursing notes and diagram showed bruising to the forehead as well as redness around the mouth.
63. *Lab reports.* Dr. Gilmer-Hill testified that elevated platelets showed that the child did not have a bleeding disorder. Elevated platelets are, however, signs of infection or stress and do not provide any information on congenital or nutritional abnormalities that affect the propensity to bleed. None of the Children's lab reports is contained in the available records.
64. *Seizures.* Dr. Gilmer-Hill testified that her diagnosis of seizures was based on a Port Huron report of unequal pupils. Unequal pupils are, however, also a sign of concussion.
65. *Discharge.* Dr. Gilmer-Hill testified that Brenden did not require any medications after discharge but that there might be long-term sequelae. In most instances, however, children recover from concussions without adverse consequences.
66. *Shaken baby syndrome.* Dr. Gilmer-Hill testified that shaken baby syndrome involves violent shaking of a child, generally under age 2, causing the brain to slam back and forth and a bridging vein to tear, and resulting in a subdural hematoma. She testified that one usually sees SBS in children six months and under who can't support their heads, that one might need more force for a 16 month old, and that one doesn't always see bruising but frequently sees fractures, often in varying stages of healing. In diagnosing shaken baby syndrome, Dr. Gilmer-Hill looks for subdural and retinal hemorrhage with an inconsistent history or changing story.
67. Dr. Gilmer-Hill testified that she had personally seen about 15 SBS cases in 2005 and had testified approximately 30 times (10 times in 2005), all but once on SBS. However, she was not familiar with developments in the literature on shaken baby syndrome and pediatric head injury, which falls within a number of disciplines, including forensic pathology, neuropathology, Neuroradiology, and biomechanics. Instead, she testified that she limits her reading to neurosurgical journals and relies exclusively on the American literature. Even so, she misunderstood the Duhaime study, which is the key American neurosurgical study on shaking.
68. The trial transcript indicates that Dr. Gilmer-Hill's testimony was the sole basis for Mr. Ceasor's conviction. The transcript indicates that the jury played the videotape of this testimony, which was 1 hour and 20 minutes in length, in its entirety, and I understand that they replayed a portion of the tape. The jury therefore heard this testimony three times, with no rebuttal.

History of Shaken Baby Syndrome

69. It is not possible to understand the testimony in this case without understanding the history of shaken baby syndrome (SBS). In the 1970s, shaking was proposed as a mechanism of

injury in children who had subdural hemorrhage, retinal hemorrhage and/or brain swelling with no signs or history of trauma.

70. The first serious challenge to this theory occurred in 1987 with the publication of a study by Dr. Duhaime, a neurosurgeon. In this study, which was published in the Journal of Neurosurgery, Dr. Duhaime and biomechanical engineers at the University of Pennsylvania used models of 1-month-old infants with neck and skull accelerometers that were shaken and impacted against padded surfaces and metal bars. *The forces from shaking fell below established injury thresholds, while the forces from impact spanned the injury thresholds for concussion, subdural hemorrhage and diffuse axonal injury.* Repeated violent shaking produced forces of approximately 1/50 the force of impact against padded or unpadded surfaces. The researchers concluded that “severe head injuries commonly diagnosed as shaking injuries require impact to occur and that shaking alone in an otherwise normal baby is unlikely to cause the shaken baby syndrome.”¹
71. Despite this study, which has been repeatedly replicated by biomechanical engineers, SBS theory remained popular, and many doctors, including pediatricians and emergency room doctors, continued to testify that the “triad” of subdural hemorrhage, retinal hemorrhage and brain swelling was diagnostic (or even pathognomonic) of violent shaking, causing rupture of bridging veins and traumatic injury to the axons in the brain.
72. Forensic pathologists, who specialize in determining the cause of injury, and biomechanical engineers, who look at injuries caused by the application of mechanical forces to living tissue, were more skeptical. Obvious problems with the theory included the failure to meet established injury thresholds and the absence of neck injury in allegedly shaken children.
73. Because of the popularity of this theory, the Board of Directors of the National Association of Medical Examiners (NAME), the professional association for forensic pathologists, commissioned a position paper on shaken baby syndrome in approximately 1998. The paper, which was largely written by Dr. Mary Case, a proponent of shaking theory, was rejected by four out of five peer reviewers due to the lack of scientific support. Because it did not pass peer review, it was published as an individual opinion piece in 2001. Following its publication, leading forensic pathologists, including Michael Baden, Cyril Wecht, Vincent diMaio and John Smialek, continued to question or reject SBS theory.
74. Although doctors often testified that the symptoms of pediatric head injury would be drastic and immediate, the limited evidence available suggested that the timing parameters encompass a period of at least 72 hours.² This is consistent with general head injury guidelines and instructions given by hospitals to parents whose children have experienced minor head injuries.
75. In 2001, my article on short falls questioned another element of the established wisdom on shaken baby syndrome. At that time, many doctors were testifying that short falls (often defined as falls from less than several stories) could not be fatal, did not result in lucid intervals, and did not produce retinal hemorrhages. To examine these hypotheses, I looked at fatal falls reported to the Consumer Protection Safety Commission, including a

videotaped fatal short fall by a toddler who fell from a 28” high plastic indoor play structure onto a carpeted floor. Most of the falls were witnessed, and all of the children had intracranial hemorrhages of a type commonly attributed to shaking or abuse. In addition, many had lucid intervals, and several (including the child who fell from the indoor play structure) had retinal hemorrhages.³

76. At about the same time, in Great Britain, Dr. Jennian Geddes published the first neuropathology studies on abusive head trauma in infants. Prior to these studies, it was widely believed that shaking caused traumatic tearing of axons throughout the brain (diffuse axonal injury, or DAI) and traumatic tearing of bridging veins, causing subdural hemorrhage. Dr. Geddes and her colleagues found that the brains of allegedly shaken or abused babies did not show DAI but instead showed hypoxic-ischemic injury, *i.e.*, lack of oxygen to the brain, which has many causes. They also found that thin subdural hemorrhages of the type often found in allegedly shaken or abused babies were also found in a control group, including newborns that had died natural deaths.⁴
77. By 2002, even the most ardent SBS supporters recognized that there are many alternative diagnoses for medical findings previously attributed to shaken baby syndrome or abusive head trauma. These alternative diagnoses include accidental trauma; medical interventions; prenatal, perinatal and pregnancy-related conditions; birth trauma; metabolic diseases; congenital malformations; genetic, oncologic or infectious disease; autoimmune disorders; clotting disorders; toxins; and other miscellaneous conditions. Rebleeds and second impact injuries were also recognized.⁵
78. By 2003, a review article published in the official NAME journal confirmed that shaken baby syndrome did not meet the standards of evidence-based medicine but was instead based on poor quality evidence, largely anecdotal in nature.⁶ Since then, the differential diagnoses (alternative causations) for subdural and retinal hemorrhages have continued to expand. For example, a 2006 text by leading SBS proponents includes an entire chapter on alternative medical causes for subdural and retinal hemorrhages.⁷ At the same time, biomechanical studies confirmed that the forces of impact, including short falls, are much greater than the forces of shaking, and that shaking is an unlikely cause of subdural and retinal hemorrhages, particularly in the absence of serious neck injury.⁸ It is also now widely acknowledged that retinal hemorrhages can arise from many causes, including natural disease processes.⁹
79. These developments are slowly being reflected in the legal and medical systems. In 2005, the English Court of Appeals ruled that the “triad” of subdural hemorrhage, retinal hemorrhage and brain swelling can no longer be accepted as diagnostic of child abuse.¹⁰ In October 2006, NAME withdrew its position paper on shaken baby syndrome,¹¹ and in January 2008, the Wisconsin Court of Appeals granted a new trial to Audrey Edmunds, who had been convicted of reckless homicide based on shaken baby syndrome, citing developments in the literature on pediatric head injury.¹² Later that year, the Goudge Inquiry in Ontario, Canada found that there was a lack of evidentiary basis (and often clear alternative diagnoses) for many diagnoses of child abuse, including several shaken baby convictions. As a result, the province of Ontario is reviewing all SBS convictions using

international panels of experts.¹³ In May 2009, the American Academy of Pediatrics advised pediatricians to refrain from using the term “shaken baby syndrome” and to look at alternative causes before diagnosing abuse.¹⁴

80. As the history of SBS makes clear, Dr. Gilmer-Hill’s testimony that Brenden’s concussion and minor hemorrhages could only be caused by violent shaking or shaking/impact was contrary to the literature and research in this area.

Concussion literature

81. In this case, the medical records and caretaker reports indicate that Brenden’s concussion followed a fall from a couch onto the floor or coffee table. The applicable literature is therefore the concussion literature, not the shaken baby literature.
82. A review article in the New England Journal of Medicine defines “concussion” as an immediate and transient loss of consciousness after a blow to the head, accompanied by a brief period of amnesia.¹⁵ The article notes that “[t]his event is so common, affecting about 128 people per 100,000 in the United States yearly, that almost all physicians are called on at some time to provide care at the scene or to treat the sequelae of concussion.” Young children have the highest rates of concussion. Under the imaging guidelines, CT or MRIs should be ordered for all children and for all cases involving vomiting and/or “dangerous mechanisms,” including falls from about 3 feet. This article also addresses delayed symptoms and second impacts.
83. The concussion literature identifies grades of brain injury caused by falls or other impact. Under Ommaya’s classification, which has six grades, Brenden had a Grade III concussion (coma less than 6 hours with classic cerebral concussion, minor to moderate head injury, abnormal CT/MRI scans, and diffuse lesions and/or intracranial bleeding, including acute subdural clots). Immediate posttraumatic coma is most commonly associated with falls or motor vehicle accidents. The consequences of a fall depends on the mechanical characteristics of the fall; pre-traumatic factors, including age, physiological characteristics and prior falls; and specific biological responses and systemic interactions.¹⁶ In this case, the child was young and the hemorrhage and brain edema (if present) were small, allowing rapid recovery.
84. I have attached short summaries on concussion from the National Institutes of Health and the American Association of Neurological Surgeons.¹⁷ As noted in these articles, concussions are common and are often caused by falls around the home, especially among toddlers. Symptoms of concussion, which range from minor to severe, include repeated vomiting, unequal pupils, varying levels of consciousness and the inability to wake up (coma). Concussions may be accompanied by intracranial bleeds, even in the absence of external trauma.
85. Brenden Genna’s medical findings and the course of his hospitalization fit all of the criteria set forth in the concussion literature.

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Conclusions

86. The medical records confirm that Brenden Genna had a Grade III concussion with short term loss of consciousness followed by recovery within an hour or so of the incident. His concussion is consistent with a fall from a couch onto a coffee table and/or floor. There is no evidence of shaking or inflicted trauma.
87. I am willing to review the complete medical files when they become available. Given the inconsistencies in the radiology reports, the radiology images should be re-read by Dr. Patrick Barnes, a Professor of Radiology at Stanford University and Chief of Pediatric Neuroradiology at Lucile Salter Packard Children's Hospital. Dr. Barnes has considerable expertise in pediatric head injury and is a member of various child abuse teams and task forces.
88. From a forensic perspective, the failure to retain an expert to review the medical records and to testify on the applicable literature, including the concussion and biomechanical literature, establishes that Mr. Ceasor was not adequately represented at trial.

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

John J. Plunkett, M.D.

Subscribed and sworn to before me this ____ day of _____, 2010.

Notary Public in and for the
State of Minnesota

My commission expires: _____

¹ Duhaime et al, *The shaken baby syndrome: A clinical, pathological and biomechanical study*, J. Neurosurg. 66:409 (1987)

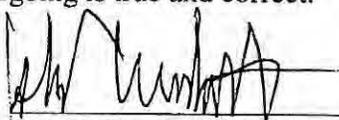
² *Interval Duration between Injury and Severe Symptoms in Non-accidental Head Trauma in Infants and Young Children*, Gilliland, MGF, J. For. Sci. 43(3):723-725 (1998); see also *Delayed Sudden Death in an Infant Following an Accidental Short Fall*, Denton and Mileusnic, Am. J. For. Med. and Path. 24(4):371-376 (2003).

³ Plunkett, J., *Fatal Pediatric Head Injuries Caused by Short-Distance Falls*, Am. J. For. Med. & Path. 22(1):1-12 (2001)

Conclusions

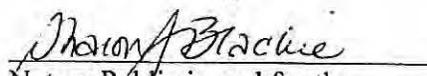
- 86. The medical records confirm that Brenden Genna had a Grade III concussion with short term loss of consciousness followed by recovery within an hour or so of the incident. His concussion is consistent with a fall from a couch onto a coffee table and/or floor. There is no evidence of shaking or inflicted trauma.
- 87. I am willing to review the complete medical files when they become available. Given the inconsistencies in the radiology reports, the radiology images should be re-read by Dr. Patrick Barnes, a Professor of Radiology at Stanford University and Chief of Pediatric Neuroradiology at Lucile Salter Packard Children’s Hospital. Dr. Barnes has considerable expertise in pediatric head injury and is a member of various child abuse teams and task forces.
- 88. From a forensic perspective, the failure to retain an expert to review the medical records and to testify on the applicable literature, including the concussion and biomechanical literature, establishes that Mr. Ceasor was not adequately represented at trial.

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



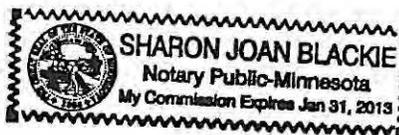
 John J. Plunkett, M.D.

Subscribed and sworn to before me this 26th day of January, 2010.



 Notary Public in and for the
 State of Minnesota

My commission expires: 1/31/13



¹ Duhaime et al, *The shaken baby syndrome: A clinical, pathological and biomechanical study*, J. Neurosurg. 66:409 (1987)

² *Interval Duration between Injury and Severe Symptoms in Non-accidental Head Trauma in Infants and Young Children*, Gilliland, MGF, J. For. Sci. 43(3):723-725 (1998); see also *Delayed Sudden Death in an Infant Following an Accidental Short Fall*, Denton and Mileusnic, Am. J. For. Med. and Path. 24(4):371-376 (2003).

³ Plunkett, J., *Fatal Pediatric Head Injuries Caused by Short-Distance Falls*, Am. J. For. Med. & Path. 22(1):1-12 (2001)

- ⁴ Geddes et al, *Neuropathology of inflicted head injury in children I: Patterns of brain damage*, Brain 124:1290-98 (2001); Geddes et al, *Neuropathology of inflicted head injury in children II: Microscopic brain injury in infants*, Brain 124:1299-1306 (2001).
- ⁵ Hymel et al, *Intracranial Hemorrhage and Rebleeding in Suspected Victims of Abusive Head Trauma: Addressing the Forensic Controversies*, Child Maltreatment 7(4):329-348 (2002); see also Barnes, P, *Ethical Issues in Imaging Nonaccidental Injury: Child Abuse*, Topics in Magnetic Resonance Imaging 13(2):85-93 (2002).
- ⁶ Donohoe, M. *Evidence-Based Medicine and Shaken Baby Syndrome Part I: Literature Review, 1966-1998*, J. For. Med. and Path., 24(3):239-242 (2003); see also Reece and Nicholson, Eds., *Inflicted Childhood Neurotrauma, A Multidisciplinary, Modified, Evidence-Based Conference, sponsored by HHS, NIH, NICHD, ORD and NCMRR* (October 2002) (debate over “shaken baby syndrome” continues to rage in our country; because there is very little scientific experimental or descriptive work, the pathophysiology remains obscure and the relationship to biomechanics even cloudier; the evidence that does exist has not been subjected to evidence-based scrutiny in a multidisciplinary scientific forum).
- ⁷ Frasier et al, *Abusive Head Trauma in Infants and Children: A Medical, Legal and Forensic Reference, Medical disorders that mimic abusive head trauma* (Ch. 14), GW Publishing (2006); see also Barnes and Krasnokutsky, *Imaging of the Central Nervous System in Suspected or Alleged Non-accidental Injury, Including the Mimics*, Topics in Magnetic Resonance Imaging 18:53-74 (2007) (alternative causations) and Rooks et al, *Prevalence and Evolution of Intracranial Hemorrhage in Asymptomatic Term Infants*, Am J Neuroradiology (2008) (subdural hemorrhages found in nearly 50% of asymptomatic newborns)
- ⁸ Ommaya, Goldsmith & Thibault, *Biomechanics and neuropathology of adult and paediatric head injury*, Br. J. Neurosurgery 16(3):220-242 (2002); Goldsmith and Plunkett, *A Biomechanical Analysis of the Causes of Traumatic Brain Injury in Infants and Children*, J., Am. J. For. Med. & Pathol. 25(2):89-100 (2004); Bandak, F., *Shaken baby syndrome: A Biomechanics analysis of injury mechanisms*, For. Sci. Int'l 151:71-79 (2005). The biomechanical studies are consistent with clinical reports. Root, Irving. *Head Injuries from Short Distance Falls.*, *Am. Journal of Forensic Medicine and Pathology*, 13(1): 85-87 (1992); Reiber, Gregory. *Fatal Falls in Childhood: How Far Must Children Fall to Sustain Fatal Head Injury?*, *Am. Journal of Forensic Medicine and Pathology*, 14(3): 201-207, 1993;
- ⁹ Lantz, P., Wake Forest University, Presentations at the Am. Academy of Forensic Sciences, Seattle, WA (2006), San Antonio (2007); Levin, A., *Retinal Haemorrhages 2008: State of the Art*, Seventh North American Conference on Shaken Baby Syndrome (Abusive Head Trauma), Vancouver, B.C. (2008).
- ¹⁰ *R. v Harris et al*, EWCA 1980 (2005).
- ¹¹ National Association of Medical Examiners, Annual Meeting, October 2006.
- ¹² *State v. Edmunds*, 746 N.W.2d 590, 598-599 (Wis. Ct. App. 2008)
- ¹³ The Honorable Steven T. Goudge, *Inquiry into Pediatric Forensic Pathology in Ontario*, Executive Summary (October 1, 2008)
- ¹⁴ Press Release, *ABUSIVE HEAD TRAUMA: A NEW NAME FOR SHAKEN BABY SYNDROME* American Academy of Pediatrics, May 2009, available at: <http://www.aap.org/advocacy/releases/may09headtrauma.htm>
- ¹⁵ Roper, A and Gorson, K, *Concussion*, N Eng J Med 356 (2):166-172 (2007)
- ¹⁶ Ommaya, A.K., *Head Injury Mechanisms and the concept of Preventative Management: A Review and Critical Synthesis*, J. Neurotrauma 12(4):527-546.
- ¹⁷ *Concussion*, MedlinePlus, www.nlm.nih.gov/medlineplus/print/ency/article/000799.htm (2009); *Concussion, What is Neurosurgery*, www.neurosurgerytoday.org/what/patient_e/concussion.asp? (2005).

CURRICULUM VITAE

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PERSONAL:

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Benjamin John (1973)

EDUCATION:

BS, History and Chemistry (1972); University of Minnesota; Minneapolis, Minnesota; 1966 – 1969
MD (1972); University of Minnesota; Minneapolis Minnesota; 1969 – 1972

POSTGRADUATE TRAINING AND EXPERIENCE:

Rotating Internship; Saint Paul Ramsey Medical Center; Saint Paul, Minnesota; 1972 – 1973
Anatomic and Clinical Pathology Residency; Saint Paul Ramsey Medical Center; Saint Paul, Minnesota; 1973 – 1978
Forensic Pathology Fellowship; Hennepin County Medical Examiner's Office; Minneapolis, Minnesota; 1975 – 1976

BOARD CERTIFICATION:

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MEDICAL LICENSURE:

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EMPLOYMENT:

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Hennepin County Assistant Medical Examiner; 1984 – 1985

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Laboratory and Medical Education Director, Regina Medical Center; Hastings, Minnesota; 1978 – 2004

Laboratory Director, Cannon Falls Community Hospital; Cannon Falls, Minnesota; 1981 – 2004

Coroner, Minnesota Regional Coroner's Office; Hastings, Minnesota; 1980 – 1998

Assistant Coroner, Minnesota Regional Coroner's Office; 1999 – 2004

PROFESSIONAL ORGANIZATIONS:

Ramsey County Medical Society

Minnesota Medical Association

American Medical Association

American Society of Clinical Pathologists (Fellow); 1976 – 2004

College of American Pathologists (Fellow)

Minnesota Society of Pathologists; 1978-2001

- Minnesota Medical Association Interspeciality Council Representative; 1991 – 1998
- Member of the MSP Executive Committee

Twin City Society of Pathologists; 1984 – 2001

Minnesota Coroners and Medical Examiners Association; 1974 – 2001

- President, 1981 and 1985)

National Association of Medical Examiners

American Academy of Forensic Sciences

SPECIAL APPOINTMENTS:

College of American Pathologists; Inspector, Laboratory Accreditation Program; 1984 – 1994

Minnesota Coroners and Medical Examiners Association; Executive Committee, 1978 – 1998

Regina Medical Center Operating Board; 1991 – 1996

Regina Medical Center Medical Staff Executive Committee; 1985 - 1994

- President of the Medical Staff; 1987 – 1990

Chairman, Regina Medical Center Infection Control Committee; 1978 – 1990, 1993 – 1999

Minnesota Department of Health, Epidemiology Section, Emerging Infectious Diseases Program (Appointed Member, Hospital-based Physician)

Reviewer, *The Lancet*

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Reviewer, *Forensic Science International*

Reviewer, *Acta Paediatrica*

Reviewer, *Journal of Forensic Sciences*

HOSPITAL STAFF APPOINTMENTS:

Regina Medical Center (Active, 1978 – 2004; Courtesy, 2005 – present)

Cannon Falls Community Hospital (Active, 1980 – 2004)

PUBLICATIONS AND NATIONAL PRESENTATIONS:

1. Tan RE, Noreen JP, Plunkett JJ. Chronic intussusception following intestinal bypass surgery for morbid obesity. *Abdominal Surgery* 1981;23:76-8.
2. Plunkett J. Sudden death and myocardial infarction in Minnesota. *NEJM* 1984;310:1187-9 (letter).
3. Plunkett JJ, Amatuzio JC. Clostridial sepsis and sudden death. Abstract presented at the AAFS National Meeting, February 1985.
4. Plunkett JJ, Amatuzio JC. Sudden infant death: I: Cost analysis of investigative procedures. Abstract presented at the ASCP Fall Meeting, 1985.
5. Plunkett JJ, Amatuzio JC. Sudden infant death: II: Ten years experience in three Minnesota counties. Abstract presented at the ASCP Fall Meeting, 1985.
6. Plunkett JJ, Amatuzio JC. Sudden infant death: III: Sudden non-SIDS natural deaths in infancy. Abstract presented at the AAFS Annual Meeting, February 1986.
7. Amatuzio JC, Plunkett JJ. Hemophilus influenzae sepsis in an asplenic adult. Abstract presented at the AAFS Annual Meeting, February 1985.
8. Plunkett J, Amatuzio JC. Electrical injury and death in three Minnesota counties. Abstract presented at the AAFS Annual Meeting, February 1986.
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 21. Plunkett J. Author's response to fatal pediatric head injuries caused by short distance falls. *Am J Forens Med Pathol* 2002;23:103-04 (letter).
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INVITED LECTURES, PRESENTATIONS, AND CONFERENCES (1989-1994):

1. "Fundamentals of Death Investigation"; Minnesota Bureau of Criminal Apprehension; Brainerd, Minnesota; March 7, 1990 (7 hours, POST approved).
2. "Preleukemia and Dysmyelopoietic Syndromes"; Regina Medical Center Medical and Professional Staff; March 28 and April 4, 1990 (1 hour, AAFP prescribed credit and AMA Category I credit approved).
3. "Arterial Blood Gas Analysis and Monitoring"; Northfield City Hospital Medical and

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- Professional Staff; Northfield, Minnesota; April 18, 1990 (1 hour, AAFP prescribed credit approved).
4. "Cancer Genetics, Epidemiology and Primary Prevention"; American Cancer Society; October 3, 1990 (1.5 hours, Nursing CEU approved).
 5. "Fundamentals of Death Investigation"; Minnesota Bureau of Criminal Apprehension; Saint Paul, Minnesota; October 11, 1990 (7 hours, POST approved).
 6. "Plasma Cell Dyscrasias and Hypercalcemia of Malignancy"; Regina Medical Center Medical and Professional Staff; January 2, 1991 (1 hour, AAFP prescribed credit and AMA Category I credit approved).
 7. "Plasma Cell Dyscrasias and Hypercalcemia of Malignancy"; Northfield City Hospital Medical and Professional Staff; January 8, 1991 (1 hour, AAFP prescribed credit and AMA Category I credit approved).
 8. "A Critical Analysis of Recommendations for Hepatitis Immunization"; Regina Medical Center Medical and Professional Staff; January 10, 1991 (1 hour, AAFP prescribed credit and AMA Category I credit approved).
 9. "A Rational Approach to Evaluation of an Anemic Patient"; Visiting Professor Series, University of Illinois, College of Medicine at Urbana-Champaign; February 21, 1991 (1 hour, AMA Category I credit approved).
 10. "Evaluation of Thyroid Function"; Visiting Professor Series, University of Illinois, College of Medicine at Urbana-Champaign; February 21, 1991 (1 hour, AMA Category I credit approved).
 11. "The Triumph of Hope over Science and Sanity: The Cholesterol Myth"; Visiting Professor Series, University Of Illinois, College of Medicine at Urbana-Champaign; February 22, 1991 (1 hour, AMA Category I credit approved).
 12. "Infant Death Investigation"; Visiting Professor Series, University of Illinois, College of Medicine at Urbana-Champaign; February 22, 1991 (1 hour, AMA Category I, credit approved).
 13. "Infant Death Investigation"; Regina Medical Center Medical and Professional Staff; February 27, 1991 (1 hour, AAFP prescribed credit and AMA Category I credit approved).
 14. "Fundamentals of Death Investigation"; Minnesota Bureau of Criminal Apprehension; Worthington, Minnesota; March 20, 1991 (7 hours, POST approved).
 15. "The Autopsy and the Role of a Pathologist in Wrongful Death Cases"; Minnesota Trial Lawyers Association; Minneapolis, Minnesota; May 2, 1991 (1 hour, CLE approved).
 16. "Death Investigation"; Scott County Law Enforcement; Shakopee, Minnesota; June 6, 1991 (2 hours, POST approved).
 17. "Physiologic Effects of Firearms"; Dakota County Law Enforcement; Rosemount, Minnesota; June 12, 1991 (2 hours, POST approved).
 18. "Fundamentals of Death Investigation"; Minnesota Bureau of Criminal Apprehension; Grand Rapids, Minnesota; August 14, 1991 (7 hours, POST approved).

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19. "Selected Topics in Surgical Pathology"; Regina Medical Center Medical and Professional Staff; September 4, 1991 (1 hour, MFP prescribed credit and AMA Category I credit approved).
20. "How to Examine Medical Experts"; Minnesota State Bar Association; Minneapolis, Minnesota; October 1, 1991 (8 hours, CLE approved).
21. "Implication of Laboratory Test Results for Nursing Personnel"; South Suburban Medical Center Nursing Staff; Farmington, Minnesota; October 29, 1991 (1.5 hours, Nursing CEU approved).
22. "Peripheral Morphology, Bilirubin Determinations and Acute Leukemia"; Regina Medical Center Medical and Professional Staff; October 30, 1991 (1 hour, AAFP prescribed credit and AMA Category I credit approved).
23. "Selected Topics in Laboratory Medicine"; Northfield City Hospital Medical and Professional Staff; November 19, 1991 (1 hour, AAFP prescribed credit approved).
24. "Infant Death Investigation"; Minnesota Bureau of Criminal Apprehension, Advanced Child Abuse Investigations; Rochester, Minnesota; November 20, 1991 (2.5 hours, POST approved).
25. "Death by Natural Causes"; Minnesota Chiefs of Police Association; March 25, 1992 (1 hour, POST approved).
26. "Infant Death Investigation", Minnesota Chiefs of Police Association, March 25, 1992 (1 hour, POST approved).
27. "Infant Death Investigation"; Minnesota Bureau of Criminal Apprehension; Saint Paul, Minnesota; April 1, 1992 (2.5 hours, POST approved).
28. "Cervical Cytology and the Bethesda Classification System"; Regina Medical Center Medical and Professional Staff; May 27, 1992 (1 hour, AAFP prescribed credit and AMA Category I credit approved).
29. "Infant Death Investigation"; Minnesota Bureau of Criminal Apprehension; Alexandria, Minnesota; October 8, 1992 (2.5 hours, POST approved).
30. "Fundamentals of Death Investigation"; Minnesota Bureau of Criminal Apprehension; New Ulm, Minnesota; October 14, 1992 (2.5 hours, POST approved).
31. "The Laboratorian's Role in Forensic Medicine"; Divine Redeemer Memorial Hospital; South Saint Paul, Minnesota; October 2, 1992 (1 hour, AMA Category I credit approved).
32. "Decision Analysis in Laboratory Medicine"; Northfield City Hospital Medical and Professional Staff; December 15, 1992 (1 hour, AAFP prescribed credit approved).
33. "How to Examine Medical Experts"; Minnesota State Bar Association; Minneapolis, Minnesota; March 11, 1993 (8 hours, CLE approved).
34. "Medical Investigation of Motor Vehicle Fatalities"; Minnesota Chiefs of Police Association; March 24, 1993 (2 hours, POST approved).
35. "Infant Death Investigation"; Minnesota Bureau of Criminal Apprehension; Fairmont, Minnesota; May 27, 1993 (2.5 hours, POST approved).

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36. "How to Examine Medical Experts"; Minnesota State Bar Association; Minneapolis, Minnesota; October 14, 1993 (8 hours, CLE approved).
37. Invitational Working Conference, Vulnerable Adult Act Issues; State of Minnesota, Office of the Attorney General; Saint Paul, Minnesota; November 9, 1993.
38. "Time of Death Determinations"; Northfield City Hospital, EMT/Paramedics; March 14, 1994 (1 hour, EMT/Paramedic CEU).
39. "How to Examine Medical Experts"; Minnesota State Bar Association; Minneapolis, Minnesota; March 24, 1994 (8 hours, CLE approved).
40. "Selected Topics in Laboratory Medicine"; Regina Medical Center Medical and Professional Staff; March 30, 1994 (1 hour, AAFP prescribed credit and AMA Category I credit approved).
41. "Decision Analysis in Laboratory Medicine and Pathology"; Minnesota Society of Pathologists; Minneapolis, Minnesota; April 29, 1994 (1 hour, AMA Category I credit approved).

INVITED LECTURES, PRESENTATIONS, AND CONFERENCES (MAY 1994 THROUGH-2005):

I did not maintain a list of lectures, presentations, and conferences during this time. However, I made presentations to several state and local Public Defender organizations; to the Neurosciences Unit at the Radcliffe Infirmary (Oxford, England); and for the American Society of Neuroradiology; among others.

INVITED LECTURES, PRESENTATIONS, AND CONFERENCES (2006-PRESENT):

1. "Differential Diagnoses in Infant Brain Injury"; Eaton Foundation; Royal College of Medicine, London, United Kingdom; May 16, 2006.
2. "Mechanisms, Mimics, and Differential Diagnoses in Infant Brain Injury"; South Carolina Association of Criminal Defense Lawyers; Greenburg, South Carolina; July 14, 2006.
3. "Mechanisms, Mimics, and Differential Diagnoses in Infant Brain Injury"; Ohio Association of Criminal Defense Lawyers; Columbus, Ohio; October 6, 2006.
4. "Infant Injury Evaluation"; Oregon Criminal Defense Lawyers Association; Portland, Oregon; December 2, 2006.
5. "State v. Plunkett: When the State Loses, The Expert Gets Indicted"; Oregon Criminal Defense Lawyers Association; December 2, 2006.
6. "Mechanisms, Mimics, and Differential Diagnoses in Infant Brain Injury"; Los Angeles County Public Defenders Association; Los Angeles, California; September 15, 2007.
7. "Mechanisms, Mimics, and Differential Diagnoses in Infant Brain Injury"; Texas Criminal Defense Lawyers Association; Dallas, Texas; March 4, 2008.
8. "Mechanisms, Mimics, and Differential Diagnoses in Infant Brain Injury"; Wisconsin Criminal Defense Lawyers Association; Milwaukee, Wisconsin; March 14, 2008.

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9. "The Differential Diagnosis for Subdural Hemorrhage in Children Under the Age of Two"; Evidence-Based Medicine and Science Symposium; Denver, Colorado; February 21, 2009.
10. "Infant and Toddler Falls"; Hershey Medical Center Pediatric Abusive Head Trauma Conference; Jackson Hole, Wyoming; June 26, 2009.

SPECIAL INTERESTS:

Decision analysis in laboratory medicine and pathology

Continuing education for the medical and legal profession, law enforcement and the community

Head injury in children

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**UNITED STATES DISTRICT COURT
EASTERN DISTRICT OF MICHIGAN
SOUTHERN DIVISION**

TERRY LEE CEASOR,

Petitioner,

CASE NO. 08-13641

v.

**HON. JOHN O'MEARA
MAG. PAUL J. KOMIVES**

**JOHN OWIEJA, Warden
Jackson Cooper Street Facility**

Respondent.

Affidavit of Peter Stephens

1. My name is Peter J. Stephens. My address is 100 Club Drive, Suite 135, Burnsville NC 28714. I am licensed to practice in Wisconsin and Indiana and am certified by the American Board of Pathology in three areas, Anatomical Pathology, Clinical Pathology, and Forensic Pathology. Forensic pathology is the subspecialty of anatomic pathology that studies the cause of injury and/or death in the context of the legal system.
2. I graduated from McGill University, Montreal, Canada in May 1965 with the degrees of Doctor of Medicine and Master of Surgery (M.D., C.M.). After completing a rotating internship at the Royal Victoria Hospital, Montreal, Canada, I completed residencies in anatomical and clinical pathology at the Medical College of Virginia, Richmond, VA and the University of Western Ontario, London, Ontario, Canada. I was board certified by the American Board of Pathology in November 1970 in anatomic and clinical pathology in November 1970 and in the subspecialty of forensic pathology in May 1984. .
3. I was Acting Iowa State Medical Examiner from 1984-1985 and Deputy Iowa State Medical Examiner from 1985-1995. As such, I testified in cases of child abuse. In 1997, I was consulted in the index case of a series of misdiagnosed alleged "Shaken Baby" cases in Iowa which were subsequently agreed by numerous other forensic pathologists to

be due to non-abuse related causes. I now maintain a consulting practice in forensic pathology. A copy of my CV is attached.

Records Reviewed

4. I was asked to review the medical records of Brenden Genna and the trial testimony given by the state's medical experts in the trial against Terry Ceasor in 2005. I have done so without charging a fee for my review. I understand that Mr. Ceasor did not retain a medical expert to review the records or to testify on his behalf against the allegations that he had shaken or intentionally caused Brenden's head injuries.
5. I have reviewed the Port Huron hospital records for Brenden's stay on October 3, 2003, including admission documents, the E.R. physical, discharge papers, progress notes, and radiology and lab reports. I have also reviewed the Detroit Medical Center (Children's Hospital) records for Brenden's stay from October 3-8, 2003, including admission documents, discharge papers and progress notes. I have also reviewed Brenden's pediatric records; various CPS reports; and police interviews with Dr. Hunt (the E.R. doctor who treated Brenden at Port Huron)/ Ms. Raelo (a Port Huron nurse), Cheryl Genna (Brenden's mother), and Terry Ceasor; and CPS reports. In addition, I reviewed trial testimony by Dr. Hunt and pretrial/trial testimony by Dr. Holly Gilmer-Hill, a pediatric neurosurgeon at Children's Hospital.
6. The materials that I received do not include the several key documents, including the radiology images, lab and consultation reports from Children's. The scene photographs are also missing from the police report. Since there are inconsistencies in the interpretations of the radiology scans, I would advise that the radiology scans be obtained and re-read.
7. The records that I have reviewed indicate that Brenden had a short fall from a sofa onto a coffee table or floor at around 4 or 4:15 p.m. on October 3, became unresponsive, and was taken to the hospital by his mother, Cheryl Genna, and Mr. Ceasor, arriving at 4:20 p.m. The records indicate that at 4:35 pm, he was responsive to verbal stimuli but was not tracking, and that by 5:15 he was alert, tracking and responding appropriately. A CT scan taken at about 5:30 showed a small subdural collection, with no fractures or abnormalities within the brain. He was then transferred to Children's Hospital. The next morning, he was described as alert and playful, and he was kept under observation, with no need for neurosurgical intervention. Subsequent reports note mild bruising on the forehead; retinal hemorrhages; and a small amount of soft tissue swelling on the right parietal scalp. He was discharged several days later, with no apparent concerns.
8. The opinions in this affidavit are given to a reasonable degree of medical certainty. In reaching these conclusions, I have reviewed the scientific literature on head injury suffered as a result of impact.

Conclusion

9. Based on the records, it is my opinion that Brenden Genna suffered an ordinary concussion with temporary loss of consciousness consistent with a fall from a sofa to the floor. There is no medical evidence to support the claim that Mr. Ceasor caused the concussion collapse by shaking or shaking/ impact.
10. In diagnosing abuse, medical professionals look for disparities between the caretakers' accounts. While this approach is valid, it must be done with extreme caution to avoid misinterpreting apparent discrepancies. There is nothing in the records that appears inconsistent with the versions of Brenden's injury given by Terry Ceasor or Cheryl Genna. Brenden's mother. The only changed element in the story told to the hospital and police was whether Cheryl was present when Brenden fell. This change in story was adequately explained when Cheryl admitted that she misled police and CPS on this account due to her fear that her children would be taken away from her. This "inconsistent" element in the explanation of Brenden's injuries should not be used to diagnose Brenden with SBS.
11. The presence of retinal hemorrhage and subdural hematoma is not diagnostic for intentional injury or shaking. Although this theory was widely accepted in the 1990s and into the early 2000's, the literature establishes that these findings also occur from short falls and natural disease processes.

Differential Diagnosis and Shaken Baby Syndrome

12. *Evolution of diagnosis of causation of head injuries traditionally associated with Shaken Baby Syndrome (SBS).* Prior to 1995, most physicians believed that significant injury to an infant or child from a fall was so unusual as to be almost diagnostic of abusive injury, specifically, shaken baby syndrome (SBS). It was widely believed within the medical profession that subdural hematoma, retinal hemorrhages and brain swelling ("the triad") were generally caused by violent shaking or intentional blunt force impact. At the time, it was commonly believed that short distance falls (less than 12 to 15 feet) did not lead to serious injury, that children who suffered head injury were immediately symptomatic, and that natural disease processes rarely if ever produced these symptoms. Given these beliefs, if a caretaker could not describe a motor vehicle accident, fall from a multi-story building or comparable catastrophic event occurring immediately before hospital admission, it was assumed that the caretaker must have intentionally injured the child. In the past decade, these beliefs have been challenged and the core assumptions disproven. Those unfamiliar with the more recent medical literature still hold this belief.
13. In 1993, Dr. Gregory Reiber reviewed short distance falls but did not fully realize the significance of his observations.¹ Since 2000, however, the evidence has established that lethal injury to the infant head can occur from an accidental fall, even of a short distance.

General acceptance of this possibility started in about 1998 at a meeting of the National Association of Medical Examiners when John Plunkett, M.D. showed a videotape made by a relative of a child who sustained a short distance fall and subsequently died. Shortly thereafter, Dr. Plunkett published a series of short distance falls causing death in children occurring in a variety of accidental situations, including the videotaped fall.ⁱⁱ This evidence was compelling and has progressively gained traction.

14. It is now generally accepted that while some higher level falls do not cause severe injury, a small subset of short distance falls result in subdural hematoma and retinal hemorrhaging, skull fractures and occasionally death. Serious, though nonfatal, head injuries have been reported in falls from stairs, bouncy chairs, car seats, shopping carts and high chairs and even from toys dropped on children.^{iii iv v vi vii} Many of these reports are from the pediatric and public health literature, and many public health agencies (such as the US Consumer Product Safety Commission and individual state and city health departments) and hospitals carry cautionary warnings to parents on their web sites. Since 2000, neuropathology studies have also shown that the brain changes in pediatric head injury are generally hypoxic-ischemic (i.e. due to lack of oxygen) rather than traumatic in origin, suggesting a wide range of possible causations, including natural causes.
15. Until approximately 2004, the medical community did embrace the idea that retinal hemorrhages were indicative of abusive injury. Despite the fact that Terson had identified increased intracranial pressure (such as is seen in brain swelling) as a cause retinal hemorrhages approximately 100 years up, this diagnostic belief still exists. However, Patrick Lantz, M.D. of Wake Forest Medical Center has recently studied retinal hemorrhages by examining the eyes of every deceased person in his autopsy room by means of Postmortem Monocular Indirect Ophthalmoscopy. Dr. Lantz found that the only children whose retinas had been examined by an ophthalmologist. At autopsy, Dr. Lantz found retinal hemorrhages in a wide variety of cases, including accidental injuries and natural disease processes including sudden unexpected death in infancy. Dr. Lantz's work has been presented at academic conferences and is in the process of being submitted for publication.
16. As a result of the new learning, the Courts are in some instances beginning to reexamine earlier convictions. For example, in a recent Wisconsin shaken baby case in which I testified, the Wisconsin courts granted post-conviction relief to Audrey Edmunds, holding that she was entitled to a new trial based solely on advances in medical knowledge.^{viii} After reviewing the evidence, the charges were dropped.
17. Internationally, the validity and reliability of diagnoses of pediatric head injury, including shaken baby syndrome and blunt force or abusive head trauma, has similarly been called into question by a series of cases in the United Kingdom and, more recently, by the Goudge Inquiry in Ontario, Canada. On October 1, 2008, following five months of

hearings with testimony by leading international forensic pathologists on misdiagnosed pediatric deaths, including shaken baby cases and one case with an unfounded conviction of sexual assault and murder, Justice Stephen Goudge issued a 1,000 page report finding systemic flawed pathology and misdiagnoses of child deaths, including pediatric head injury. In calling for a review of more than 200 shaken baby and similar pediatric head injury cases in Ontario, Justice Goudge emphasized the advances in medical knowledge since the 1990s and called on judges to act as gatekeepers to protection the legal system from flawed scientific evidence and false convictions.

18. In conclusion, since 2000, there has been broad recognition that many findings previously diagnosed as abuse are consistent with accidental or natural causes, or in some instances fall within the range of normal. In this case, much of the trial testimony reflects the accepted dogma of the late 1990s, much of which is no longer accepted or has been disproven.
19. In this case, the same considerations apply in even greater force since Mr. Ceasor was convicted without the benefit of a medical defense. Such a defense would most certainly have been available prior to Mr. Ceasor's trial in 2005. A proper defense would have addressed the clinical evidence, the advances in neuroradiology, neuropathology and biomechanics, and the alternative diagnoses.
20. *Differential diagnosis.* All medical diagnoses begin with a "differential diagnosis," which is the consideration of all possible entities capable of explaining clinical symptoms. As indicated, one of the most common known causes for subdural and retinal hemorrhages is impact. While shaking is often advanced as a cause for subdural and retinal hemorrhage, this concept is hypothetical and has not been proven. Once an impact has occurred between the head and any other surface, moreover, it is impossible to say whether or not there was shaking before, during, or after that impact. Since the body does not distinguish between accidental and inflicted injury, it can also be difficult or, from a medical standpoint, impossible to determine whether a particular impact was accidental or inflicted. For this, one must look to see if there are pattern injuries (e.g., bruises corresponding to an implement) or longstanding patterns of abuse (e.g., a history of broken bones, bruising or witnessed violence).
21. In addition to impact, there is a long list of natural causes for subdural and retinal hemorrhages, ranging from congenital conditions to infectious disease. In 2000, virtually none of these causes was recognized or understood. By 2006, however, even the most ardent shaken baby advocates acknowledged that medical conditions that "mimic" shaking or abusive head trauma include prenatal, perinatal and pregnancy-related conditions; birth trauma; congenital malformations; childhood stroke; accidental causes; genetic and metabolic disorders; diseases; hematological diseases and coagulation disorders; infectious disease; autoimmune and vasculitis conditions; oncological

conditions; toxins, poison and nutritional deficiencies; and medical and surgical complications. In many cases, one sees a combination of causes. For example, a fall that would be trivial in most children may be devastating or even deadly in a child with preexisting conditions, including prior concussion or chronic subdural hematoma.

22. In addition, it is increasingly recognized that, in addition to the general complexity of the human brain, infant and developing brains have unique characteristics that may make them prone to subdural hematomas, retinal hemorrhage, brain swelling and other physiological cascades, many of which are still poorly understood. One of the features that has been the subject of considerable recent research, and on which doctors on both sides of the controversy are beginning to reach agreement, is the vascularity of the dural border cell layer, which may account for what was believed to be subdural but is more accurately characterized as intradural bleeding in infants and young children. This type of subdural hemorrhage may be a natural response to choking, vomiting or any maneuver that temporarily reduces the venous outflow from the brain.

Trial Testimony

Dr. Hunt's trial testimony

23. Dr. Hunt, the Emergency Room doctor who treated Brenden Genna on arrival at Port Huron Hospital, testified that Brenden was stable and breathing on his own on admission (352) and that he did not see any signs of trauma (354). However, he believed the story he was told regarding Brenden's fall was inconsistent with Brenden's injuries, particularly the subdural hematoma, given the absence of any external signs of trauma (360, 364). Since Brenden did not have external signs of trauma, he felt that the injuries were more consistent with shaken baby syndrome (364:13-15).

Dr. Hunt did not claim that the subdural hematoma was inconsistent with a fall; instead, he claimed that the absence of bruising or other external signs of trauma indicated that impact had not occurred. The nursing notes from Children's indicate, however, that Brenden had bruising on his forehead, consistent with a fall. Since bruising may not develop for some hours after injury, this finding confirms impact consistent with a fall from the couch. The lack of other bruising is inconsistent with shaken baby syndrome since the violence needed to cause this injury to a 16-month old child as large as Brenden, who was 33 inches tall and weighed 27 lbs 5 oz at his last doctor visit, would inevitably have caused external bruises, rib fractures or other marks, none of which were present.

24. Dr. Hunt also testified that 16 month olds don't typically fall and are not very big, and that to fall off a couch, hit one's head, and get a subdural hematoma would be "very strange." (363: 2-16).

In my opinion, having been in practice for more than 30 years, 16 month olds can and do fall, sometimes with serious consequences. Such cases have been reported in many peer-reviewed medical journals. It is not, moreover, unusual to have a subdural hemorrhage from hitting one's head. As established in numerous biomechanical tests, the forces from short distance impact far exceed the forces from shaking.

25. Dr. Hunt testified that in diagnosing shaken baby syndrome he looks for retinal hemorrhage and subdural hematoma. (364:11-16).

As stated above, diagnosing shaken baby syndrome based upon the presence of retinal hemorrhage and subdural hematoma is outdated since it is well understood that these findings also appear in short falls and a wide array of congenital and natural disease processes.

Dr. Gilmer-Hill's pre-trial and trial testimony

26. Dr. Holly Gilmer Hill testified that shaken baby syndrome or shaken impact syndrome refers to non-accidental, intentional injury of a baby or a young child. (Pre-trial exam 20:15-22). The mechanism is usually shaking, but also involves some element of impact, such as striking the child or slamming him or her against a wall, or throwing him or her down "fairly violently." (Pre-trial exam 20:22-25 23:22-23, trial testimony 433:24-434:19, 21-23).

As Dr. Gilmer-Hill recognizes, impact remains the most likely cause for head injury, although natural causes are also increasingly recognized as primary or contributing factors. As set forth above, however, the impact need not be intentional and can result from relatively short falls. Recognizing that shaking is not a proven mechanism for head injury, at least in the absence of serious neck injury, the National Association of Medical Examiners withdrew its position paper on shaking in 2006, and the American Academy of Pediatrics recommended that this term no longer be used in 2009. It is, moreover, unlikely that the violent mechanisms described by Dr. Gilmer-Hill could occur without major bruising, fractures, grip marks, and/or neck injuries, none of which were present. It is equally unlikely that the child would recover quickly and seemingly completely within an hour or so of the incident, with no signs of trauma, if he had been subjected to the violent forces described at trial.

27. Dr. Gilmer-Hill also testified that features used to diagnose shaken baby syndrome are subdural hemorrhage, skull fracture, and retinal hemorrhage. (21:12-23).

Brenden did not, however, have a skull fracture, and the diagnosis of "shaking" based on subdural and retinal hemorrhages is outmoded.

28. Dr. Gilmer-Hill testified that a history that changes frequently as to how the accident occurred is an element in diagnosing shaken baby syndrome. (436: 1-8).

As stated above, the story on the manner in which Brenden's injuries occurred did not change. Instead, it Ms. Genna initially gave an incorrect story because she was afraid she would lose her children. Everything else in the story remained the same.

29. *Retinal hemorrhage as diagnostic for SBS.* Dr. Gilmer-Hill testified that the presence of retinal hemorrhage combined with the presence of subdural hematoma is diagnostic for child abuse and that these types of injuries must be caused by intentional force, whether shaking or otherwise. (Pre-trial exam 22: 17-23, 54: 4-6, Trial Testimony 435: 1-4, 13-28, 494: 18-21, 499: 19-25). She also stated that retinal hemorrhage occurs when one is shaken or slammed onto a surface, usually repeatedly. (453: 13-28).

While retinal hemorrhage can be caused by impact, including short falls, Dr. Gilmer-Hill incorrectly testified that retinal hemorrhages can only be caused by shaking or intentional force. Instead, retinal hemorrhages have many causes, including retinal hemorrhages have many causes including accidental trauma and medical diseases not involving any trauma.

30. *Short falls.* Dr. Gilmer-Hill stated that a fall from a height of the couch (17 inches high) would not result in a subdural hematoma and retinal hemorrhaging. (Pre-trial exam 29:24- 30:5). At trial, she testified that subdural hemorrhage, brain-swelling and midline shift are only seen in accidents such as falls from second story buildings or high speed motor vehicle accidents and cannot be caused by an accidental injury such as a fall from a couch onto a carpeted floor. (456: 1-12, 17-25; 457:1). She also stated that she was aware of American studies that indicate that fatal injuries can be caused by short falls onto a hard surface. (474:20-25, 478:1-10).

As set forth above, the literature – including the Plunkett videotape – confirms that subdural hemorrhages, retinal hemorrhages and brainswelling can occur from short falls. Studies conducted by the federal agencies confirm, moreover, that the carpeting will not generally affect the forces generated by a short fall. In this case, the child minor subdural hemorrhage and nonspecific retinal hemorrhages are consistent with the fall described by Mr. Ceasor.

31. *Neuropathology literature on SBS.* Dr. Gilmer-Hill testified that she was unfamiliar with literature written by Dr. Jennian Geddes, a British neuropathologist, and that she relied exclusively on American neurosurgical literature (474: 4-19, 475: 11-14, 483: 9-25, 484: 1-9).

In 2001-2003, Dr. Geddes and her colleagues published a series of research papers on the neuropathology of allegedly shaken or abused infants. Prior to this research, it was generally believed that the injuries in shaken or abused infants were caused by the traumatic tearing of the axons in the brain, causing instant incapacitation. Using sophisticated testing techniques, Dr. Geddes determined that most of the injury in these brains was hypoxic (i.e., due to lack of oxygen) rather than traumatic in nature. She also found that subdural hemorrhages of a type found in allegedly shaken infants in late term fetuses or newborns who had died natural deaths. These discoveries caused forensic pathologists and others to rethink the etiology of pediatric head injury. Over the years, moreover, it has led to the identification of numerous alternative causes for medical findings previously associated with shaking or other forms of inflicted head trauma.

32. *2001 Short Fall Study by John Plunkett.* Dr. Gilmer-Hill testified that she disagreed with the result of John Plunkett's 2001 study that children can receive significant trauma or die from short falls. (473: 19-24). She testified that Dr. Plunkett's study disagreed with the body of evidence in stating that children could die from falls as small as two to three feet. She asserted that the gravitational force of a fall can be greater than that from shaking a baby only when it was from a height of 20 to 30 feet. (479: 19-15, 480: 1-7). Finally, Dr. Gilmer-Hill stated that Dr. Plunkett's study was not widely accepted in her profession (pediatric neurosurgery). (491: 2-7).

Over the past decade, Dr. Plunkett's study has been increasingly accepted by the medical community since it is very difficult to disagree with a videotaped fall. As discussed below, moreover, it has been known since 1987 that the gravitational force from even a short impact far exceeded the force from shaking. The initial study was, moreover, done by an experienced pediatric neurosurgeon on the faculty of Georgetown University medical school and has written several papers in the American, British, and Japanese literature stating his disbelief in shaking as a cause of pediatric head injury.

33. *Duhaime Study.* In testifying that shaking a child has greater gravitational force than a fall from a height of between five and six feet, Dr. Gilmer-Hill relied on studies out of the University of Pennsylvania by Ann-Christine Duhaime. (478: 22-25, 479: 1-16). She also testified that some of Duhaime's studies involved cats and rats. (Tr. 484:10-15, 285: 1-5).

Dr. Gilmer-Hill misstates the conclusions of the Duhaime study. Dr. Duhaime's 1987 study actually found that shaking did not reach the injury thresholds for concussion or subdural hemorrhage. In contrast, impact on soft surfaces exceeded all injury thresholds and produced forces 50 times greater than shaking.^{ix} To my knowledge, none of Dr. Duhaime's studies involved cats and

rats. Instead, they are based on biomechanical models and early primate studies by A.K. Ommaya and other researchers.

34. Dr. Gilmer-Hill stated that she was unfamiliar with the work of Dr. Reiber, whose 2001 study indicated that children can fall from as little as two to three feet and receive severe brain swelling. (483:9-14). Dr. Gilmer-Hill also testified that she was unfamiliar with the studies of Dr. Root, whose study indicated that short falls can generate the same gravitational forces as long falls (483:15-20).

This testimony establishes that Dr. Gilmer-Hill was unfamiliar with the short fall literature.

35. *External Injuries.* Brenden had no history of broken bones or abuse, no neck injuries, and no marks indicating that someone had vigorously shaken him. (476:15-25, 477:1-3). She further testified that even if she had seen the bruising on his forehead noted on the hospital records, she would have not have changed her diagnosis. (490:17-22).

The Duhaime studies and many others establish that it is physiologically impossible to shake a child, particularly a child of Brenden's size, sufficiently hard to rupture bridging veins and that such injuries would cause neck injury prior to causing head injuries. If moreover, Brenden had been shaken with extreme force, there would have been fractures, bruising or some type of external injury, none of which were present.

Medical history

36. Several features in Brenden's pediatric history suggest that he may have been vulnerable to head injury. The pediatric records report an increasing head size, starting at the 25th percentile at birth, increasing to the 75th percentile in subsequent pediatric visits, and reaching the 85th percentile two weeks before hospitalization. These figures suggest that he may have had a longstanding subdural hematoma or extraaxial collections, which may have made him more susceptible to subdural hemorrhage or concussion.
37. The radiology suggests that Brenden had an ear infection at the time of admission, and the hospital records indicate he had taken a children's cough and cold remedy the previous day. In 2003, the two medications mentioned in his records (Pediocare and Tylenol Cold) contained pseudoephedrine and dextromethorphan, which were subsequently removed from the shelves for children under the age of 2 due to an association with infant death in this age group. Since these medications constrict the blood vessels and increase the heart rate, they increase the pressure on the blood vessels and the possibility of subdural hemorrhage. While the records do not indicate that Brenden took these medications on the day of his collapse, I would not foreclose this

possibility since very little medical investigation was done once the hospital concluded that this was inflicted injury.

38. It is unfortunate that the reported fall at daycare two days earlier, mentioned by Ms. Genna in her testimony (Tr. 262: 15-23), was not more thoroughly investigated since the combination of two minor impacts is known to result in concussion (the so-called "second impact" syndrome).
39. I cannot comment on other possible medical causes for Brenden's collapse since no tests were done. It is, for example, entirely possible that Brenden fell because he suffered a seizure or childhood stroke. It is, however, equally possible that he simply became dizzy from running back and forth on the couch.

Concussion

40. Regardless of etiology, this is a clearcut concussion case, characterized by short term loss of consciousness followed by rapid recovery. It was, however, complicated by a confusion between the concussion literature and the child abuse literature. It has been always been understood that people, including children, can in layman's terms, "knock themselves out" by hitting their heads, either by falling or having something fall on them. In common and medical parlance, this is known as concussion.
41. The concussion literature is distinct from the child abuse literature. The commonest response of the brain to any impact is to develop brain swelling (edema). Brain swelling results in varying degrees of disorientation ranging from "simple fussiness" through frank coma. As the brain recovers from the swelling process it will progressively recover and reset itself similar to rebooting a malfunctioning computer.
42. The records suggest that Brenden may have fallen in daycare a day or two prior to this incident. In that case, the fall from the sofa may have been a second impact. If so, it was critical for him to be kept on bedrest until his brain could completely recover. Cases of children who collapse within 72 hours of an initial relatively minor impact, such as falling off a bed, are also reported in the literature.
43. While the conclusion that Brenden's concussion was caused by violent shaking or shaking/impact is inconsistent with the literature, I agree entirely with the treatment provided by Dr. Gilmer-Hill and her associates, who kept the child in the hospital and under observation for several days following his concussion. Since it can be hard to prevent 16 month olds from having normal tumbles, such as his sofa fall, it is likely that their treatment plan prevented additional injuries and long-term consequences.

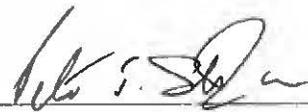
Conclusion

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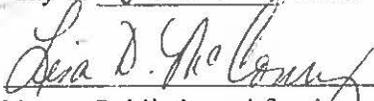
- 44. Brendan’s concussion is consistent with a short fall from a sofa onto a coffee table and/or floor and inconsistent with the violent mechanisms of injury suggested at trial. Given his rapid recovery, it is not possible that he suffered from torn bridging veins or diffuse traumatic axonal injury. Instead, his medical findings and rapid recovery confirm that this was a simple concussion that was appropriately treated with observation and rest.
- 45. I have been asked whether it would be possible to understand the issues or provide an adequate defense without a medical expert. My answer is categorically “no.” This case presents some of the more challenging issues in modern medicine. Even if an individual attorney has sufficient medical knowledge to interpret laboratory reports, it would not be possible to introduce the literature and evidence needed to explain these issues to the jury or the Court without using experts. In this case, the relevant evidence on the change in diagnosing shaken baby syndrome was not presented adequately during trial, presumably because the trial attorney did not understand the significance of such findings for their client. Without such information, it was not possible for Mr. Ceasor to have a fair trial.

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



 Peter J. Stephens, M.D.

Subscribed and sworn to before me this 26th day of June, 2010.



 Notary Public in and for the
 State of North Carolina

My commission expires: 3-28-14

¹ Reiber, GD, *Fatal Falls in Childhood: How Far Must Children Fall to Sustain Fatal Head Injury?* Report of Cases and Review of the Literature, Am. J. Forensic Medicine & Pathology 14(3): 201-207 (1993)

¹¹ Plunkett, J. *Fatal Pediatric Head Injuries Caused by Short-Distance Falls*, Am. J. of Forensic Medicine and Pathology Volume 24, Number 4, Dec. 2003.

¹² Pierce, MC, Bertocci, G, Janosky, JE and Aguel, F *Femur Fractures Resulting from Stair Falls Among Children: An Injury Plausibility Model*, Pediatrics 2005; 115; 1712-1722.

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¹⁶ Wickham, T and Barahamson, E. *Head injuries in infants: the risk of bouncy chairs and car seats* Arch. Dis. Child. 2002; 86: 168-169.

¹⁷ Powell, EC, Jovtis, BA and Tanz, R. *Incidence and description of high chair-related injuries to children*, Ambulatory Pediatrics 2002; 2002; 2: 276-278

¹⁸ Smith, GA AAP Committee on Injury, Violence, and Poison Prevention, *Shopping Cart-Related Injuries to Children*, Pediatrics Volume 118, Number 2, August 2006: 827-840

¹⁹ Blumenthal, I. *Skull fracture – child abuse or an accident*, The Lancet Vol 356 July 15, 2000.

²⁰ *State v. Edmunds*, 746 N.W.2d 590, 598-599 (Wis. Ct. App. 2008)

²¹ Duhaime, Ann-Christine. *Nonaccidental Head Injury in Infants – The “Shaken Baby Syndrome”* New England Journal of Medicine 338(25):1822-1829, June 1998: “More recent biomechanical studies of these injuries show that the magnitude of angular deceleration is 50 times as great when the head of an infant model held by the trunk forcefully strikes a surface as when shaking alone occurs, and it only reaches injury thresholds calculated for infants at the moment of impact.”

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CURRICULUM VITAE

Peter J. Stephens, M.D.

Personal:

Date of Birth: 3 September 1941
Birthplace: Colchester, Essex, England
Marital Status: Married, two children

School Education:

Westminster School, London, England 1954 - 1957

Premedical Education:

McGill University, Montreal, Canada 1957 - 1961 Degree: B.Sc.

Medical Education:

McGill University, Montreal, Canada 1961 - 1965 Degree: M.D., C.M.

Internship:

Royal Victoria Hospital, Montreal, Canada 1965 - 1966

Postgraduate Training:

Medical College of Virginia, Richmond, Virginia:
Junior Asst. Resident & Asst. Resident in Pathology 1966 - 1967
Assistant Resident in Pathology 1967 - 1968
University of Western Ontario, London, Canada:
Assistant Resident in Anatomic Pathology 1968 - 1969
Assistant Resident in Clinical Pathology 1969 - 1970

Board Certification:

American Board of Pathology: (Anatomic & Clinical Pathology) Nov 1970
American Board of Pathology: (Forensic Pathology) June 1984

Continuing Education:

American Acad. of Forensic Sciences, 1988-90, '92, '95, '96, '98, 2003, 2004, 2007, 2008
EBMS Seminar on Head Injury in Childhood, Chicago, May 2007
Mammography Education, Inc. Breast Cancer Control, April 5 - 9, 1995
Workshop on Current approaches in Forensic Toxicology, 2/19/96
Surgical Pathology Course, Harvard Med. School/Mass Gen. Hosp. 11/17-11/21/97
Duke University Medical Center, Pulmonary Pathology Course 8/25/99 - 8/27/99
National Association of Medical Examiners Annual Mtg. October 1999

Preceptorships in Forensic Pathology:

Cuyahoga County Coroner's Office, Cleveland, Ohio, 1983, 1984
Wayne County Med. Examiner's Office, Detroit, Mich, 1983, 1984

Employment:

Regional Medical Labs, P.C., July 1970 to Jan 1977
Battle Creek, Michigan

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Employment (continued):

Quad Cities Pathologists Group, February 1977 to Dec 1989
Davenport, Iowa

Private Practice of Forensic Pathology January 1990 to June 1991
Bettendorf, Iowa

Weland Clinical Laboratory, PC July 1991 to March 2001
Cedar Rapids, Iowa

Miscellaneous Appointments:

Acting Iowa State Medical Examiner 1984
Deputy Iowa State Medical Examiner 1985 - 1995
Deputy Medical Examiner, Scott County, Iowa 1983 - 1991
Inspector, C.A.P. Lab. Accreditation Program 1980 - 2001
Inspector, A.A.B.B. I & A Program: 1978 - 1989

Hospital Staff Memberships:

St. Luke's Hospital, Davenport, Iowa	(Active)	1977 - 1990
Mercy Hospital, Davenport, Iowa	(Active)	1977 - 1991
Muscatine Gen. Hospital, Muscatine, Iowa	(Active)	1977 - March 2001
Illini Hospital, Silvis, IL	(Courtesy)	1990 - 1991
Mercy Hospital, Cedar Rapids, Iowa	(Active)	1991 - March 2001
Sartori Memorial Hospital, Cedar Falls, Iowa	(Active)	1991 - 1995
Guttenberg Municipal Hospital, Guttenberg, IA	(Courtesy)	1991 - March 2001
Peoples Memorial Hospital, Independence, IA	(Courtesy)	1991 - March 2001
Med. Ctr. Of NE Iowa, Manchester, IA	(Courtesy)	1991 - March 2001
Mercy Hospital, Oelwein, IA	(Courtesy)	1991 - March 2001
Community Memorial Hospital, Sumner, IA	(Courtesy)	1991 - March 2001
Palmer Lutheran Health Ctr., West Union, IA	(Courtesy)	1991 - March 2001
Central Community Hospital, Elkader, IA	(Courtesy)	1991 - March 2001
Chief of Staff, Muscatine General Hospital,		1980 - 1982

State Medical Licensure:

Indiana, Wisconsin

Inactive in Ontario (Canada), Illinois, Iowa, Michigan, Minnesota and Vermont.

Memberships in Professional Organizations:

American Medical Association	(Member)	1970-Present
Mitchell-Yancey County (N.C.) Medical Society	(Member)	2002-Present
College of American Pathologists	(Emeritus Fellow)	1970-Present
American Society of Clinical Pathologists	(Fellow)	1970-2001
Iowa Association of Pathologists	(Member)	1977-2001
Iowa Association of Pathologists	(President)	1985-1987
American Academy of Forensic Sciences	(Member)	1985-Present
National Association of Medical Examiners	(Member)	1985-Present

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Clinical Research:

Pathology reviewer, Cedar Rapids Oncology Project, 1991 to March 2001

Publications:

Spontaneous rupture of the spleen in plasma cell leukemia.

Stephens PJ; Hudson P

Can Med Assoc J (Canada), Jan 1969, Vol.100 (1) p31-4

Carcinoma of the breast in childhood.

Oberman HA; Stephens PJ

Cancer (United States), Aug 1972, Vol. 30 (2) p470-4.

The correlation of promotion of tumour growth and of induction of hyperplasia in epidermal two-stage carcinogenesis.

Frei JV; Stephens P

Br J Cancer (England), Mar 1968, Vol. 22 (1) p83-92.

Rectal impaction following concrete enema.

Stephens PJ and Taff ML

Am J For Med and Pathology, June 1987, Vol. 8(2):179-182.

A case of autoerotic asphyxia with multiplex paraphilias

Boglioli LR, Taff ML, Stephens PJ and Money ML

Am J For Med and Pathology. Vol. 20(3):274-276 (1999)

Four Deaths Due to Carbon Monoxide Poisoning in Car Washes

Carson, H.J. & Stephens, P.J. Am J For Med and Pathology. Vol. 12(1):64-73 (1999)

Making allegations without due care is wrong.

Stephens, PJ BMJ. 2005 Jun 25;330(7506):1508. (Invited letter)

Miscellaneous:

Senior Aviation Medical Examiner, Federal Aviation Administration, 1974-1991

U.S. (FAA) Commercial & Instrument Pilot Certificate

Associate Staff, Transportation Safety Institute, Okla. City, OK July 1990

Member, Rotary Club of Davenport, Iowa 11/89 to 6/91

Member, Iowa Medical Delegation to Stavropol, Russia March 1994

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UNITED STATES DISTRICT COURT
EASTERN DISTRICT OF MICHIGAN
SOUTHERN DIVISION

TERRY CEASOR,

Petitioner,

CASE NO. 08-13641

v. HON. JOHN O'MEARA MAG. PAUL J. KOMIVES

JOHN OCWIEJA, Warden Jackson
Cooper Street Facility

Respondent.

Affidavit of Dr. Ronald H. Uscinski

I, Ronald H. Uscinski, state as follows:

Background

My name is Ronald H. Uscinski, and I am a clinical neurosurgeon. My office address is 5530 Wisconsin Ave., Chevy Chase, MD 20815. I am board certified in neurological surgery and am a practicing neurosurgeon. I have been a Clinical Professor at the Georgetown University School of Medicine in both the Department of Surgery (Neurosurgery) and the Department of Pediatrics since 1980. I am also a Professor of Neurological Surgery at the George Washington School of Medicine since 1997.

In my practice, I have operated on children as well as adults, and I have special expertise in the literature surrounding pediatric head injuries, including the so called "Shaken Baby Syndrome". I have published several articles on the topic in peer-reviewed journals, including *The Shaken Baby Syndrome* (Journal of American Physicians & Surgeons, 2004); *The Shaken Baby Syndrome: An Odyssey* (Neurologia medico chirurgica, Tokyo, 2005); and *The Shaken Baby Syndrome: An Odyssey II Origins and Hypothesis* (Neurologia medico chirurgica, Tokyo, 2008). In addition to my teaching responsibilities, I have made numerous presentations to professional organizations and have frequently qualified as an expert on this subject in state courts. The primary focus of my work on "Shaken Baby Syndrome" consists in determining the origin of the theory, tracing its development through the years, and examining and evaluating its scientific basis, and currently, investigating the true origin of the infant subdural hematoma.

Basis of Review

At the request of the University of Michigan Law School Innocence Clinic, I have reviewed this case of Brendan Genna a *pro bono* basis. In so doing, I have reviewed Port Huron hospital records dated October 3, 2003; Detroit

Medical Center (Children's) hospital records dated October 3-8, 2003; pediatric records; and testimony by Dr. Hunt and Dr. Gilmer-Hill.

From a neurosurgical perspective, several key documents are missing from these records. Specifically, I do not have the radiology images from either hospital or the radiology, lab and consultation reports from Children's. If I had been asked to review this case prior to trial, I would have obtained complete medical records, including these critical materials. Given the history of a short fall, I would also have advised counsel to retain a biomechanical engineer to testify on the biomechanical issues.

Conclusion

Based on the available records, Brendan Genna had a small subdural collection that resolved without neurosurgical intervention. There were no fractures or other signs of abuse, and the only available radiology report does not provide information that would allow identification of the nature of this collection (old blood v. new blood vs. CSF) or attempt to age it (chronic v. acute). Mild bruising on the forehead reportedly appeared some hours after hospital admission, and there was some soft tissue swelling on the right scalp. The hospital notes report that the child was behaving appropriately within an hour or so of admission and was alert and playful the following morning. These findings are consistent with an accidental short fall causing concussion. They are inconsistent with violent shaking, and there is nothing in the records suggesting abuse.

At trial, the State's lead expert, Dr. Gilmer-Hill, a neurosurgeon, provided incorrect information on the literature on "shaken baby syndrome." As a threshold matter, it is impossible to acquire a comprehensive understanding of "shaken baby syndrome" while relying only on American neurosurgical literature. The literature on "shaken baby syndrome" spans a number of disciplines, including forensic pathology, neurology, radiology, and injury biomechanics, and includes major contributions by English and Japanese researchers. Dr. Gilmer-Hill's testimony suffered greatly from her exclusion of information outside the American neurosurgery journals.

Because she was unfamiliar with the literature, Dr. Gilmer-Hill provided the jury with incorrect information on the state of SBS literature in 2005. For example:

- Dr. Gilmer-Hill stated that SBS is the violent shaking of a child causing the brain to slam back and forth and the bridging vein to tear, usually accompanied by striking the child or slamming the child down onto a hard or soft surface. (434: 1-18). While

- slamming a child into various surfaces can cause serious injuries, research has shown that shaking does not create the force needed for the generation of subdural hematomas.
- Dr. Gilmer-Hill stated that studies from the University of Pennsylvania in the 1980's and subsequent concluded that that the forces from shaking far exceeded the forces from impact and that only intentional abuse could result in the pattern of injuries observed in Brendan Genna. (478: 22-25, 479: 1-18). Dr. Gilmer-Hill misinterpreted these studies, which established that shaking did not meet the injury threshold for bridging generation of subdural bleeding and that the forces of shaking were approximately 1/50 the forces of impact. The results of these studies have been replicated in subsequent biomechanical experiments.

6. Dr. Gilmer-Hill also provided the jury with inaccurate information on Brenden's injuries. For example:

Dr. Gilmer-Hill stated that the Port Huron CT scan showed that Brendan's subdural hemorrhage was acute, which she defined as no more than 6-12 hours old, and that his collapse would have immediately followed injury. (485: 13-25, 486: 1-13). A solely acute hemorrhage on CT scan may, however, be up to 3-4 days old, and the medical literature reports time lags of up to 3 days between injury and collapse.

Dr. Gilmer-Hill testified that her diagnosis of seizures was based on a Port Huron report of unequal pupils. (459: 14-21). However, unequal pupils simply indicate neurological disturbance, of varying etiology.

Dr. Gilmer-Hill testified that the only mechanism that can result in subdural hematomas and retinal hemorrhaging is abuse or intentional injury. (435: 17-20). However, multiple studies have shown that these findings can also be caused by accidental short falls and/or natural processes, including chronic subdural hematoma.

Clinical Issues

7. While most neurosurgical training is directed towards treatment of neurosurgical problems rather than determining injury causation or timing, neurosurgeons have a unique perspective on head injury, including pediatric head injury. First, those of us who treat adults as well as children often have a more comprehensive understanding of the broad range of possible causes for subdural hemorrhage and other findings that, in adults, are rarely attributed to shaking or other forms of abuse. Many, if not most of these causations are equally applicable to children. Second, because of our surgical experience, we are able to correlate two-dimensional black and white radiology images (CTs, MRIs, etc.) to what is actually present and seen in vivo in the operating room, which is three-dimensional and in color. As a result, we can sometimes identify features that might be overlooked by radiologists. Conversely, by virtue of their own training and experience, radiologists can sometimes identify features that would augment surgical evaluation and treatment. As this suggests, evaluating injuries requires a cooperative effort between several disciplines.
8. In this case, Brendan Genna had a small subdural collection and other findings that did not require surgical intervention, followed by rapid recovery. As a result, the evaluation of his injuries must be based on the radiology images, the hospital records and clinical history, including his rapid recovery, and a comprehensive understanding of the mechanisms and nature of trauma to the nervous system and its surroundings including, in this instance, reference to the so-called "shaken baby syndrome." As a clinician, I agree that the decisions to give initial preventative

medications and to limit subsequent treatment to observation were correct. The diagnosis of "shaking" or "shaking/impact" was, however, incorrect.

The "Shaken Baby Syndrome" Literature

Origins of the "Shaken Baby Syndrome" Hypothesis

9. My involvement in "shaken baby syndrome" began in 1997, when I was asked to review the case of a child who was fatally injured, supposedly by shaking.¹ In conducting my review, I researched the entire body of literature referencing "shaken baby syndrome." As a practicing neurosurgeon and teaching professor, I was startled to discover that there was no scientific support in the literature for this popular and widely-accepted theory, and that key elements of the theory were contradicted by the few studies that were available. Since then, many others have made the same "odyssey" of discovery.

10. The first description of shaking as a mechanism for intracranial injury in infants appeared in 1971 in an article by Norman Guthkelch.² Other authors, including John Caffey, began to publish extensively on this topic in the years following Guthkelch's article.

11. The early papers on "shaken baby syndrome," including those by Caffey and Guthkelch, rely on a 1968 paper by Dr. Ayub Ommaya, a neurosurgeon,³ who was in turn building on work by A. H. Holbourn.⁵ Ommaya and Holbourn were attempting to quantify experimentally the rotational acceleration necessary to cause intracranial whiplash injury in rhesus monkeys.

11. Ommaya's paper is the sole source of experimental data from which the initial hypothetical shaking mechanism was drawn. Significantly, Ommaya never examined whether human beings could shake infants with enough force to produce the acceleration necessary to cause intracranial injury. Instead, his experiments simulated rear-end motor vehicle collisions.

12. The early "shaken baby syndrome" papers seized on this work and hypothesized that manual shaking of human infants could also cause rotational acceleration sufficient to cause intracranial injury, including subdural hemorrhage. However, neither these early

¹ My review led to my testimony in the case of Louise Woodward, a British nanny accused of second degree murder in the shaking death of 8-month old Matthew Eappen.

² Guthkelch AN: Infantile subdural hematoma and its relationship to whiplash injuries. *Br Med J* 2(759):430-431, (1971)

³ Caffey J: On the theory and practice of shaking infants. Its potential residual effects of permanent brain damage and mental retardation. *Am J Dis Child* 124: 161-169, (1972); Caffey J: The whiplash shaken infant syndrome: Manual shaking by the extremities with whiplash induced intracranial and intraocular bleeding, linked with residual permanent brain damage and mental retardation. *Pediatrics* 54: 396-403, (1974)

⁴ Ommaya AK, Faas F, Yarnell P: Whiplash injury and brain damage. *JAMA* 204: 75-79, (1968)

⁵ Holbourn AH: Mechanics of head injuries. *Lancet* 9:438-441, 1943; Holbourn AH: The mechanics of trauma with special reference to herniation of cerebral tissue. *JNeurosurg* 1: 191-200, (1944)

authors nor subsequent investigators took into account critical physiological differences between human infants and rhesus monkeys, particularly in the neck and torso. Nor did they attempt to determine whether manual shaking generated forces equivalent to the forces generated by rear-end motor vehicle collisions.

13. Despite this lack of scientific basis, "shaken baby syndrome" gained immediate acceptance and widespread popularity, ratified primarily on anecdotes and case studies that assumed apparently *a priori* that subdural hemorrhage, retinal hemorrhage and brain swelling in children who had no signs of impact not only *could* be caused by shaking, but *could only be caused by shaking*. For 30 years, the "shaken baby syndrome" theory did not undergo traditional and accepted scientific verification.

14. In 2003, a paper by Mark Donohoe applied the principles of evidence-based medicine to determine the degree of confidence that should accrue to "shaken baby syndrome."⁶ In an article published in the American Journal of Forensic Medicine and Pathology, the official journal for forensic pathologists, Donohoe concluded that, after 32 years, there was "inadequate scientific evidence to come to a firm conclusion on most aspects of causation, diagnosis, treatment, or any other matters relating to SBS" and that "the commonly held opinion that the finding of SDH [subdural hemorrhage] and RH [retinal hemorrhage] in an infant was strong evidence of SBS was unsustainable, at least from the medical literature." This is the same conclusion that I and others had reached previously.

The Shaking Hypothesis Conflicts with Injury Biomechanics

15. In 1943, Holbourn's paper estimated a concept of injury patterns, and intuitively, a concept of injury thresholds based on the involved mass of neural tissue, with the necessary corollary that a smaller mass of tissue would require correspondingly larger rotational acceleration to cause injury.⁷ While Ommaya alluded to this in his paper, Guthkelch, Caffey and others did not recognize its significance.

16. In 1987, Dr. Ann-Christine Duhaime et al attempted to replicate manual shaking in an effort to show that shaking could cause subdural hemorrhage under established injury thresholds. However, the experiments showed the opposite: in these experiments, shaking did not reach the injury thresholds for concussion, subdural hematoma, or diffuse axonal injury. These experiments also showed that the forces from impact were much greater than the forces from shaking. Similar experiments by Dr. Michael Prange, Duhaime et al in 2003 produced the same results. These experiments did not, however, address what injuries could be produced by shaking, nor did they address the potential alternative causes for findings that had previously been attributed to shaking. In 2004, Duhaime and her co-authors acknowledged that they could not "yet answer if shaking can cause

⁶ Donohoe M: Evidence-based medicine and shaken baby syndrome: part I: literature review, 1966-1998. Am J Forensic Med Pathol 24(3): 239-242, (2003)

⁷ Holbourn AH: Mechanics of head injuries. Lancet 9:438-441, (1943)

⁸ Duhaime A, Gennarelli T, Thibault L, Bruce D, Margulies S, Wiser R: The shaken baby syndrome. A clinical, pathological, and biomechanical study. J Neurosurg 66: 409-415, (1987)

⁹ Prange M, Coats B, Duhaime A, Margulies S: Anthropomorphic simulations of falls, shakes, and inflicted impacts in infants. J Neurosurg 99: 143-150, (2003)

intracranial injury in infants, and use of terminology that includes this mechanism should be avoided.”¹⁶

17. In 2005, Dr. Faris Bandak, a biomechanical engineer and research professor in the Department of Neurology at F. Edward Hebert School of Medicine, directly addressed the question of the injuries that might be expected from the type of violent shaking hypothesized in "shaken baby syndrome." Bandak showed that the level of force hypothesized would seriously damage or destroy the infant neck, and that cervical spinal cord or brainstem injury would occur at significantly lower levels of shaking accelerations than intracranial injury.” In other words, if an infant is manually shaken, injury biomechanics confirms that the infant will suffer neck injury well before suffering intracranial injuries, such as subdural hemorrhage. Conversely, the presence of subdural hematomas without neck injury indicates that the hematoma was not caused by manual shaking. This conforms to the everyday experience of most adults, who know instinctively that the neck is a weak link in infant anatomy and therefore the infant head must be supported when carrying or feeding a baby. It also conforms to the experience of automobile passengers who experience whiplash (neck) injuries from low speed auto accidents without subdural hemorrhage or other intracranial injuries.

18. To summarize, the hypotheses of Guthkelch and Caffey, which quickly became widely accepted in the medical community, were based on a misinterpretation of an experiment done for a different purpose (Ommaya) and are contrary to the laws of injury biomechanics (Holbourn, Duhaime and others). As pointed out by many others and confirmed by Bandak, injuries caused by manual shaking of an infant would be very different than those hypothesized by Caffey and Guthkelch and would include neck injuries. Based on biomechanical studies, the hypothesis that subdural hematomas are caused by manual shaking is not only unsupported by scientific evidence but experimentally disproved.

Impact Injuries, Short Falls and Other Causes

19. Short falls, while usually innocuous, have a proven potential for serious injury. As demonstrated by Bandak and simple laws of physics, a three- foot fall onto a hard surface results in impact velocity greater than 9 miles per hour, which generates more than twice the force needed to fracture an infant skull. The various physiological responses to short falls -such as vomiting, aspiration, and seizing -can further complicate the clinical picture, rendering such cases inappropriate for simple generalization. Instead, each case requires careful and individual evaluation.

20. Since biomechanical experiments confirm that short falls can cause subdural and retinal hemorrhage, these findings are not telltale signs of inflicted injury. *Indeed, when an adult presents with these findings, intentional injury is certainly not assumed and rarely considered* There is no scientific basis for assuming otherwise when an infant presents

¹⁶Prange, Coats, Duhaime and Margulies, J Neurosurg, Vol. 100 p. 575 (2004)

¹⁷Bandak FA: Shaken baby syndrome: a biomechanics analysis of injury mechanisms. Forensic Sci Int 151: 71-79, (2005)

with these findings. Instead, one would expect the subdural hemorrhages found in infants to reflect many of the same causes as in adults, and likely more.

21. Strokes are a good example of intracranial injuries that are found in children as well as adults and often present with the same symptoms as "shaken baby syndrome." When adults have strokes, we do not assume that they have been shaken or subjected to violent injury. For years, it was not understood that children also have strokes. The medical literature establishes, however, that childhood stroke is relatively common, with some forms found primarily in infants.¹² In children, however, stroke is often undiagnosed or misdiagnosed as shaking or inflicted injury. Stroke in children is just now beginning to reach the public consciousness, as indicated in a recent feature article in the New York Times.¹³

It is also important to differentiate between acute and chronic subdural hematomas. While acute hematomas can be evidence of recent injury, there are situations wherein differentiation between the two is difficult. For example, it is well known among clinical neurosurgeons operating on patients with chronic subdural hematomas that at surgery fresh blood may be found in addition to old blood in a chronic hematoma. Experiments have confirmed that chronic subdural hematomas can and do rebleed without accompanying trauma, causing an older hematoma to seem acute.¹⁴ Since up to half of children are born with acute subdural hematomas, most of which can and do resolve relatively quickly but some of which become chronic, chronic subdural hematomas should be high on the differential diagnosis for seemingly acute subdural bleeding in infants and children, particularly those who have reported increases in head circumference, as in this case.¹⁵

In reviewing trial testimony, it is important to realize that most clinicians -including pediatricians, E.R. doctors and neurosurgeons -may in fact not be familiar with the research basis for "shaken baby syndrome" and similar theories but are simply repeating what they have

¹² See, e.g., Wasay, M., M.D., F.R.C.Path., et al, Cerebral Venous Sinus Thrombosis in Children.

A Multicenter Cohort from the United States, *J Child Neurol*, 23(1): 26-31 (2008)

Fitzgerald, K., M. Sc, et al., Cerebral Sinovenous Thrombosis .in the Neonate, *Arch Neurol*, 63(3): 405-409 (2006)

Sebire, G., et al., Cerebral Venous Sinus Thrombosis in Children: Risk Factors, Presentation, Diagnosis and Outcome, *Brain*, 128(3):477-489 (2005).

¹³ *Children Don't Have Strokes? Just Ask Jared*, Science Times, The New York Times (January 19, 2010).

¹⁴ Ito H, Komai T, Yamamoto S: Fibrinolytic enzyme in the lining walls of chronic subdural hematoma. *J Neurosurg* 48: 197-200, 1978 *Neurol Med Chir (Tokyo)* 46, (2006);

Ito H, Yamamoto S, Komai T, Mizukoshi H: Role of local hyperfibrinolysis in the etiology of chronic subdural hematoma. *J Neurosurg* 45: 26-31, (1976);

Kawakami K, Chikama M, Tamiya T, Shimamura Y: Coagulation and fibrinolysis in chronic subdural hematoma. *Neurosurgery* 25: 25-29, (1989);

Yamashima T, Yamamoto S, Friede R: The role of endothelial gap junctions in the enlargement of chronic subdural hematomas. *J Neurosurg* 59: 298-303, (1983).

¹⁵ Rooks, V.J., Eaton, J.P., Ruess, L., Petermann, G.W., Keck-Wherley, J., Pedersen, R.C. Prevalence and Evolution of Intracranial Hemorrhage in Asymptomatic Term Infants. *Am. J. Neuroradiol*, 29: 1082-1089 (2008).

been told. Reviewing the literature requires a substantial time commitment, a willingness to read articles outside one's normal areas of expertise, and a willingness to acknowledge that, in this area, much of what has been taught and believed to be true is incorrect. In this context, it is not surprising that the trial testimony in this case did not reflect the state of the literature or of appropriate scientific methodology.

Testimony of Dr. Gilmer-Hill

24. Dr. Gilmer-Hill described SBS as violent shaking of a child, generally under age 2, causing the brain to slam back and forth and a bridging vein to tear, causing a subdural hematoma. (434: 1-18). In apparent recognition of Duhaime's study, she went on onto testify that usually the child is struck as well, or slammed down on a sofa or soft surface, or even against a wall or thrown up against the ceiling. (434: 16-19). She further testified that the only mechanism that could result in subdural hematomas and retinal hemorrhaging was abuse or intentional injury. (435: 17-20).

Comment: Research has shown that abusive style shaking does not result in head accelerations consistent with subdural hematoma generation. In addition to the 1987 article, an article co-authored by Duhaime and published in the Journal of Neurosurgery in 2003 (Prange 2003) showed that maximal exertion manual shaking of an infant sized test device (drastically smaller and easier to shake than a 16 month old) produces head accelerations less than those produced in a 1 foot fall onto carpet. As in the earlier study, the rotational accelerations of shaking were not consistent with subdural hematoma generation. Witnessed and well documented falls, including a videotaped fall reported in a study by Dr. Plunkett in 2001, have confirmed that short falls can result in serious and even fatal head injuries, including subdural and retinal bleeding.

25. Dr. Gilmer-Hill testified about studies from the University of Pennsylvania in the 1980's and 2003 that were "trying to prove these injuries could have happened accidentally." She testified that this work established that the only mechanism that could result in the pattern of injuries associated with shaking baby syndrome was intentional injury. (pg 435:13-20). She also testified that Dr. Duhaime's studies established that shaking has much more force than even a 5'-6' fall. (478: 22-25,479: 1-18).

Comment: Dr. Gilmer-Hill misunderstood the findings of these studies, which were published in the Journal of Neurosurgery. (Duhaime 1987, Prange 2003). These studies established that shaking did not generate sufficient force to cause subdural hemorrhage and that impact - whether accidental or intentional -was required. As Duhaime and her co-authors acknowledged in 1987, "shaking alone in an otherwise normal baby is unlikely to cause the shaken baby syndrome." Subsequent work has established that, in children as in adults, these findings can result from impact (including shortfalls), natural causes, or some combination of the two.

26. Dr. Gilmer-Hill relied only on American neurosurgical literature (474: 4-19,475: 11-14, 483: 9-25, 484: 1-9).

Comment: Dr. Gilmer-Hill's complete reliance on American neurosurgical journals limited her ability to evaluate abusive versus accidental etiologies of injury. Much of the relevant research, including the original Guthkelch theory, is from England, with additional work published in Japan and elsewhere. My own original article on shaken baby syndrome was published as a letter in the British Journal of Neurosurgery.¹⁶ In addition, many key articles have been published in the Journal of Forensic Medicine and Pathology, the official journal for forensic pathologists, who specialize in injury causation. As noted, even the American neurosurgical journals do not support Dr. Gilmer-Hill's testimony. Equally important, by limiting her reading to American neurosurgical literature, she would not have recognized, or overlooked, the major flaws in shaking or shaking/impact theory, or the wide array of alternative causes identified in the pediatric and radiology literature.¹⁷

27. Dr. Gilmer-Hill testified that she could not say with certainty that Brenden did not have a subdural hematoma prior to falling off the couch, and that it is possible that the subdural hemorrhage caused the child to fall. She testified that a chronic (old) subdural can spontaneously rebleed from a membrane but that you would then see old and new blood in the subdural. (478: 5-8,483: 1-8). She also testified that the blood on the Port Huron CT scan was "fresh" or acute and therefore occurred within 6-12 hours before the scan. (477: 15-17,494: 1-8)

Comment: Neurosurgeons are not specifically trained in dating subdural hemorrhages, although we are sometimes in a unique position to do so given the ability to observe membranes surrounding subdural hematomas during surgery. Such membranes typically take a minimum of several weeks to form. In a child who does not have neurosurgery and who survives (eliminating the possibility of examining autopsy slides), CTs and MRIs are the only way to age hemorrhages. However, CT scans are of limited value in dating subdural bleeding, particularly if the lesion in question is chronic and has rebled. Thus, a CT scan of a child who has had two or more impacts within a week would simply show acute blood and possibly obscure older bleeding. MRIs are better at ageing hemorrhages, but they are not uniformly done in cases like this, in which the child recovers fully within a day.

28. Dr. Gilmer-Hill testified that she had personally seen about 15 SBS cases in 2005 and had testified approximately 30 times (ten times in 2005), all but once on SBS.

Comment: Since Dr. Gilmer-Hill was unfamiliar with the lack of scientific basis for shaken baby syndrome and the alternative causes for findings previously associated with shaking or shaking/impact, this testimony raises concern that she was

¹⁶ Uscinski, R., Shaken Baby Syndrome: fundamental questions. For Debate. British Journal of Neurosurgery 16(3): 217-219 (2002).

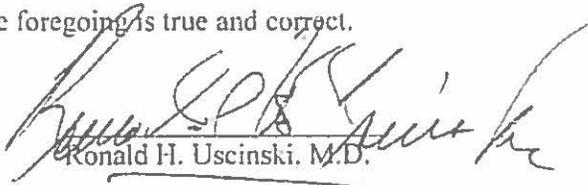
¹⁷ Barnes, P., M.D., & Krasnokutsky, M., M.D., Imaging of the Central Nervous System in Suspected or Alleged Nonaccidental Injury, including the Mimics, Topics in Magnetic Resonance Imaging 18(1): 53-74 (2007)

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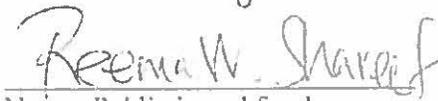
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diagnosing shaking or shaking/impact without exploring alternative causations, including short falls and natural causes.

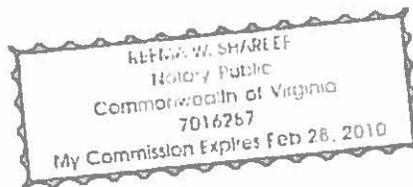
I swear under penalty of perjury that the foregoing is true and correct.


Ronald H. Uscinski, M.D.

Subscribed and sworn to before me this 5th day of February, 2010.


Notary Public in and for the
State of ~~Maryland~~ Virginia

My commission expires: 2/28/2010



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Education:

B.S., Fordham University, New York, NY, 1964

M.D., Georgetown University, Washington, D.C., 1968

Internship, Bronx Municipal Hospital Center, Albert Einstein University College of Medicine, New York, NY, 1968-9

Residency in Neurological Surgery, Georgetown University and affiliated Hospitals, 1971-1975

Military Experience:

Medical Officer, United States Navy; served with United States Marine Corps, Parris Island, South Carolina, and aboard The U. S. S. Thomas A Edison (SSBN 610-B) Atlantic Submarine Force, 1969-1971

Appointments & Positions:

Senior Surgeon, U.S. Public Health Service, Medical Officer, Surgical Neurology Branch, National Institute of Neurological and Communicative Disorders and Stroke, NIH, Bethesda, Maryland, 1975-1976

Instructor in Surgery (neurosurgery) Georgetown University School of Medicine, Washington D.C., 1975-1976

Consultant in Neurosurgery, NIH, Bethesda, Maryland, 1976-1977

Clinical Instructor in Neurosurgery, Medical University of South Carolina, Charleston, South Carolina, 1977-1980

Clinical Assistant Professor, Dept. of Surgery (Neurosurgery), Georgetown University School of Medicine, Washington D.C., 1980-2000

Clinical Associate Professor, 2000-present

Clinical Assistant Professor, Department of Pediatrics, Georgetown University School of Medicine, Washington D.C., 1980-present.

Clinical Assistant Professor, Department of Neurological Surgery, the George Washington University School of Medicine, 1997-2008.

Clinical Associate Professor, 2008-

Adjunct Research Fellow Potomac Institute for Policy Studies, Arlington, Va, 2004-2006.
Senior Adjunct Fellow, 2006-

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Certification

American Board of Neurological Surgery, 1978

Societies:

Congress of Neurological Surgeons, 1975
American Medical Association 1976
South Carolina Medical Society, 1977-1980
American Association of Neurological Surgeons, 1979
American College of Surgeons, 1980
District of Columbia Medical Society, 1981
Polish Society of Neurological Surgeons, corresponding member, 1983
Research Society of Neurological Surgeons, 1989

Publications:

1. Ventricular Septa in the Neonatal Age Group, Diagnostic Considerations of Etiology and Comparison of Sonography and Computed Tomography. Schellinger D, Grant E, Hanz H, Petronca H, Uscinski R. AJHR: volume 7:1085-1071, 1987
2. Periventricular Leukomalacia in Combination with Intraventricular Hemorrhage, Sonographic Features and Sequelae. Grant E, Schellinger D, Smith Y, Uscinski R. AJHR: volume 7: 443-447, 1986
3. The Shaken Baby Syndrome. Uscinski R. Journal of American Physicians & Surgeons: Volume 9, #3; 76-77, 2004
4. The Shaken Baby Syndrome: An Odyssey. Uscinski RH. Neurologia medico-chirurgica (Tokyo) 46, 57-61, 2008
5. The Washington Post, March 9, 2008: B08, Outlook; "The Larger Tragedy in an Unjust Accusation"
6. The Shaken Baby Syndrome: An Odyssey II. Origins and Hypotheses. Uscinski RH, McBride DK. Neurologia medico-chirurgica (Tokyo) 48 (3), 151-155, 2008
7. "I Stand With Humility" Uscinski RH. Neurologia medico-chirurgica (Tokyo) 48 (9), 423-424, 2008

Presentations:

1. Research Society of Neurological Surgeons, "The Repaired Myelomeningocele, and Its Relationship to Tethering of the Spinal Cord" June, 1989
2. National Child Abuse Defense Resource Center, Child Abuse, 2000 and Beyond "Rebleeding and Subdurals and Children," September, 2000
3. National Association of Counsel for Children, 23rd National Children's Law Conference-Improving the Professional Response of Children in the Legal System, Panel Discussant: "Shaken Baby Syndrome" November, 2000
4. Interdisciplinary Problem Solving in Cranial-Maxillofacial Surgery, Panel Participant, Washington D.C., February 2001
5. National Child Abuse Defense Resource Center, "The Shaken Baby Syndrome, an Odyssey" September, 2001

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6. The Polish-American Health Association, Washington D.C., 2001 "The Shaken Baby Syndrome, a Clinical Neurosurgical Perspective" March, 2001
7. Congress of the Polish Society of Neurosurgeons, Rzeszow, Republic of Poland "The Shaken Baby Syndrome, an Odyssey" September, 2001
8. Kings College Hospital, London, UK, "The Shaken Baby Syndrome, an Odyssey," February, 2002
9. Addenbrooke Hospital, Cambridge University, UK; "The Shaken Baby and Newtonian Physics," February, 2002
10. The Radcliffe Infirmary, Oxford University, UK; "The Shaken Baby Syndrome," February, 2002
11. The Neurosurgical Society of the Virginias, 37th Annual Meeting Hot Springs, Virginia, January, 2003; "The Shaken Baby Syndrome, History, Mechanism, and Paradox"
12. American Association of Physicians and Surgeons, Annual Meeting Portland, Oregon, October 2004; "The Shaken Baby Syndrome."
13. Japanese Society for Pediatric Neurosurgery Annual Meeting, Invited Guest Speaker, Nara, Japan, May 2005; "The Shaken Baby Syndrome," "Pediatric Neurotrauma" Ideas from the Arena"
14. National Child Abuse Defense and Resource Council, Annual Meeting, Las Vegas, Nevada, September 2006; "A Primer on Medical Recording."
15. United States Air Force Judge Advocate General School, Maxwell AFB, Montgomery, Alabama, Guest Lecturer, May, 2007; "The Shaken Baby Syndrome"
16. Administrative Office of the Courts, State of Kentucky, September, 2007: "The Shaken Baby Syndrome"
17. King Faisal Hospital, Kigali, Rwanda, Special Lecture, January, 2008: "Neurosurgery, Medicine, and Scientific Methodology"
18. The Neurosurgical society of the Virginias, 43rd Annual Meeting, Hot Springs, West Virginia, January, 2009, "Observations on Primate Birth."

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**UNITED STATES DISTRICT COURT
EASTERN DISTRICT OF MICHIGAN
SOUTHERN DIVISION**

TERRY CEASOR,

Petitioner,

CASE NO. 08-13641

v.

**HON. JOHN O'MEARA
MAG. PAUL J. KOMIVES**

**JOHN OCWIEJA, Warden
Jackson Cooper Street Facility**

Respondent.

Affidavit of Dr. Chris Van Ee

I, Chris A. Van Ee, state as follows:

1. My name is Chris A. Van Ee, Ph.D. I hold a Ph.D. in Biomedical Engineering from Duke University. My academic and scientific research has been focused on determining injury causation and evaluating injury prevention strategies. My work in biomechanics has been well recognized by the scientific community and the published results of my work have received multiple honors and awards. I have served as a grant reviewer for the National Institutes of Health, a program reviewer for the US Army Aeromedical Research Laboratory on Head and Spine Injury, the chairman of the Occupant Protection Committee of the Society of Automotive Engineers, and currently am the chair of the Scientific Program Committee of the Association for the Advancement of Automotive Medicine. I also am an adjunct professor in the Department of Biomedical Engineering at Wayne State University where I am engaged in graduate student training and academic research in impact, orthopedic, and safety biomechanics.
2. I am a biomechanical engineer. Biomechanical engineering is a subdiscipline of biomedical engineering that uses the application of mechanical engineering and physics to quantify the effects of forces on and within the human body, including tolerance levels and injury mechanisms for different age groups.

3. I have particular expertise in the analysis and risk assessment of head injury in the infant and adult populations. I am a co-author on what I believe to be the only peer reviewed publication (Prange et al. 2004) in which the infant head mechanical response to impact was directly measured experimentally and compared to the CRABI-6 infant crash test dummy response. My involvement in head injury research began in 1992 when I joined the impact biomechanics laboratory at Duke University as a PhD graduate student. Since then I have been involved in head injury risk assessments involving helmet testing for sports and transportation, design and development of laboratory experiments quantifying infant and adult head response for a variety of loading conditions ranging from shallow water diving to ballistic studies of skull fractures, and the evaluation of crash dummy head and neck response in relation to the human response. I have performed multiple forensic investigations into infant and adult head injuries in the automotive, marine, industrial, sporting, and domestic environments. I am not an expert in clinical medical care as it concerns the treatment and rehabilitation of the head injured patient. My expertise and training is in identifying and quantifying the mechanisms and risk of traumatic head injury and the evaluation of injury prevention devices and techniques.
4. I have been asked to review information on the alleged head trauma suffered by Brenden Genna. I have reviewed the available medical records from Port Huron Hospital and Detroit Medical Center, the incident report from the Port Huron police and child protective services, and transcripts of the testimony of Dr. Hunt and Dr. Holly Gilmer-Hill. The hospital records are incomplete and do not include radiology images from either hospital or the radiology, laboratory and ophthalmology reports from Childrens Hospital of Michigan (hereinafter "Childrens").
5. In addition to these materials, I am familiar with and have reviewed the historical and current scientific literature on the tolerance of the pediatric head to physical trauma.

Conclusion

6. Based on the records reviewed, the injuries Brenden suffered are consistent with the given history of the short fall off of the sofa as reported by Mr. Ceasor.
7. Dr. Gilmer-Hill's testimony left the jury with incorrect information regarding the injury biomechanics of infant head injury, short distance falls, and abusive shaking.
8. If I had been called to testify at trial, I would have testified Brenden's injuries, including his subdural hematoma and retinal hemorrhaging, were consistent with the short fall off of the sofa. I would also have testified that Brenden's injuries were not indicative of shaking. My testimony would have contradicted Dr. Gilmer

Hill's, which I believe is unsupported by both the current and contemporaneous scientific literature.

Incident history

9. As of September 20, 2004 (approximately 2 weeks before the incident), a medical exam showed that Brenden was 33 inches tall and weighed 27 pounds. 5 ounces.
10. Based on the records reviewed, on October 3 Brenden was in the care of Mr. Ceasor at Mr. Ceasor's residence while Brenden's mother, Cheryl Genna, took his 6 year old sister swimming, leaving at approximately 2:45 p.m. Mr. Ceasor was playing a game with Brenden in which Brenden ran along the couch, with Mr. Ceasor behind the couch. When Mr. Ceasor went to the bathroom, he heard a thud and found that Brenden was on the floor between the couch and the coffee table, in a position suggesting that he had fallen from the sofa onto the floor, possibly impacting the coffee table on the way down. This reportedly occurred between 4 and 4:15 p.m.
11. According to the St. Clair County Sheriff's Incident Report Narrative, the height of the top of the cushions of the couch was approximately 17 inches. A coffee table approximately 18.75 inches high was approximately 12 inches from the couch. The floor was carpeted. Since the reports indicate that the actual fall was not witnessed, there is no testimony regarding the exact fall dynamics, which part of the couch Brenden fell from, whether he struck the table during his fall to the floor, or if his head impacted the coffee table or the floor with significant force.
12. Ms. Genna reportedly arrived home soon after the fall to find Brenden in the arms of Mr. Ceasor (although this conflicts with the first reported history of the events which indicated she was at the residence at the time of the fall). Based on Brenden's condition, Ms. Genna and Mr. Ceasor drove Brenden to Port Huron Hospital, arriving at 4:20 pm.
13. The Port Huron medical reports indicate a right sided subdural collection and possible edema or midline shift with mild to moderate mass effect. Brenden was given preventative medications and transferred to Childrens, leaving at approximately 7:30 p.m.
14. Based on the records and testimony, Brenden was noted to have right sided parietal swelling and bruising on the forehead area in addition to subdural bleeding. Retinal hemorrhages were also reported.

Explanation for Injuries

15. Based on a review of the file, the range of explanations for Brenden's head injury are divided into two main categories: the reported history of the accidental fall off

the couch or an alleged abusive shaking and/or impact scenario. These possibilities can be classified as follows:

- 1) Accidental fall from the couch
- 2) Abuse
 - a) Shaking
 - b) Impacting of Brenden's head onto a soft surface
 - c) Broad impact of another object onto Brenden's head or Brenden's head impacting a broad surfaced object

16. In addition to these considerations, there is the possibility that Brenden's injury was not traumatic in nature. My expertise in head injury is in the evaluation of traumatic head injury risk for different traumatic head exposures. My expertise is not in clinical medicine and the identification of pathological head conditions that are physiologic and/or atraumatic in origin is not an area in which I have expertise. Thus, while there may be non-traumatic medical explanations for some or all of the findings in this case, I do not have evidence or expertise to identify or evaluate such causations. As such, I will be focusing on the proposed physical trauma precipitated mechanisms. If it is shown that the head injuries or pathologies in this case were not predominantly traumatic in nature, than these analyses are of little relevance in the evaluation of this case.

Consideration 1: Accidental Fall off Couch

17. The people closest to the incident, Terry Ceasor and Cheryl Genna, reported an accidental fall. Accordingly, it is deserving of examination. The question is whether a fall from the sofa could have resulted in the head injuries reported for Brenden.
18. Case studies of accidental short falls resulting in serious and even fatal head injury are available in the literature. (Aoki 1984, Hall 1989, Smith 1996, Plunkett 2001, Gardener 2005).
19. Of particular relevance to this case is the Plunkett study of 2001. Plunkett reports case studies of 18 fatally head injured children who suffered their injuries as a result of relatively short-distance falls. As a result of these fatal falls, some of which were witnessed by non-caretakers and one of which was videotaped, the children presented a range of documented injuries, including skull fracture, subdural hematoma, bilateral retinal hemorrhage, vitreous hemorrhage, and papilledema. Of the 6 cases for which a fundoscopic exam was reported, four of the six children exhibited bilateral retinal hemorrhage.
20. Case study #5 in the Plunkett study is of particular relevance. The 23 month old child in that study fell from a play structure to a carpeted floor and suffered an ultimately fatal subdural hematoma with midline shift and bilateral retinal hemorrhage. The grandmother of the child in the study videotaped the fall, so the exact nature of the fall was well documented. I am the lead author of a peer

reviewed scientific publication quantifying the biomechanical exposure the child's head experienced as a result of this fall. (Van Ee et al. 2009). Using the principles of accident reconstruction and state-of-the-art test devices, the mechanics of the fall as observed on the videotape were investigated in the laboratory. The initial height of the top of the child's head prior to falling was approximately 49-51 inches above the floor. The child pivoted and fell head first (arms leading) to a carpeted floor below, resulting in a right-frontal head impact.

21. For comparison purposes, Brenden was approximately 33 inches in height at the time of his reported fall, and the height of the top of the sofa cushions was reported to be 17 inches. If Brenden was standing on top of the sofa at the time of the fall, it is possible that the top of his head was nearly 50 inches in height and was therefore comparable to the fall height of the fatally injured child reported by Plunkett in case study #5. Since no one actually witnessed Brenden's fall, his exact fall dynamics and the nature of his head impact can only be estimated based on available measurements.
22. While Brenden's reported fall was of similar height, it should also be considered that Brenden was seven months younger than the 23 month old child reported by Plunkett. As we mature, the skull fuses, providing a more secure shell around the brain, and the resistance of the head to impact injury increases. Thus, children are more vulnerable to airbag related head injuries than adults, and current motor vehicle standards employ lower injury thresholds for children.
23. In general, a 16 month old child would be at greater risk for head injury for a given exposure than a 23 month old child. It is also unknown how much lower the height would have had to be for the 23 month old child reported in Plunkett #5 to have survived her fall. All we know is that a 49-51" height was enough to result in a fatal head injury. In view of this well documented fall reported by Plunkett and analyzed by myself and my co-authors, the comparable fall reported for Brenden presented a risk of serious or even fatal head injury and cannot be dismissed as a possible and even likely explanation for his head injuries.
24. In addition to Plunkett, other professionals point out that, although rare, low level falls can result in serious or even fatal head trauma, including subdural and retinal hemorrhage. (Aoki 1984, Hall 1989, Smith 1996, Gardener 2005). Hall describes 18 children who died from falls of 3 feet or less. Some of these falls occurred from a parent's arms while others occurred while children were running or when they fell from furniture. Two of these incidents occurred in medical facilities: one child fell while running down the hall in a medical facility and another fell from a doctor's chair.
25. In addition to serious intracranial injury reported in well documented accidental low level falls, in some cases in which the physicians have examined the eyes, bilateral retinal bleeding has been noted. These overlaps in patient presentation

between accidental and abusive injury may make it difficult to differentiate between accident and abuse etiologies. While making the task more difficult, in incidents of unknown etiology, it is imperative that these data be considered in any given case in the interest of justice.

26. Some clinical physicians have been led to believe that short falls do not result in significant linear and angular accelerations. In reality, short falls can result in both significant linear and angular accelerations. As a demonstration, I am attaching a short test video demonstrating a backward fall off a sofa. In this demonstration, a CRABI-12 crash dummy (size of a 1 year old child) is shown falling backward off a sofa and onto a linoleum floor. The fall is videotaped using a high speed video camera at a rate of approximately 500 frames per second (more than 16 times faster than a conventional video camera). When the head first impacts the floor, the head rotates forward in a chin-to-chest direction. The angular accelerations produced in this fall are significant and much larger than those produced in a human shake scenario. The head linear and angular accelerations resulting from the laboratory investigation of this sofa fall were consistent with the production of serious head trauma and far exceeded those produced in maximal shaking.

Consideration 2: Abuse

27. Based on a review of the current scientific data, the hypothesis that shaking without impact is likely to result in injurious levels of angular acceleration/deceleration cannot be supported. It is much more likely that vigorous abusive shaking of a child without impact would result in upper cervical spine or cervical cord injury and gripping style chest injuries.
28. Within the community of impact biomechanics, the statement published by Duhaime et al. in 1987 in the Journal of Neurosurgery is still valid: "It was concluded that severe head injuries commonly diagnosed as shaking injuries require impact to occur and that shaking alone in an otherwise normal baby is unlikely to cause the shaken baby syndrome." Certainly there are medical review articles and hypothesis put forward that contradict this position. However, no reliable scientific data has been documented to refute this finding from 1987. Since 1987, additional research has bolstered the conclusion that shaking alone is unlikely to directly result in angular accelerations consistent with subdural hematoma and diffuse axonal injury. I am also aware of two separate incidents where video tape footage appears to have captured a caregiver shaking a child. In neither case did the child suffer any significant injury.
29. From a biomechanical standpoint, infant anatomy is significantly different than adult anatomy in both proportion and structure. In the adult, the head accounts for approximately 6% of the total body weight. In contrast, the infant head is proportionally larger with respect to the body accounting for nearly 30% of the total body weight at birth. In addition, the skeletal structure changes during the

maturation process. Multiple sections of bone connected by cartilage in a child may become a single bone in a mature skeleton. As the bone sections develop and fuse together, the strength and rigidity of the skeleton increases. These differences affect the injury mechanisms and tolerances of children. Quantifying these effects has been and continues to be the focus of many past and current biomechanical investigations.

30. The current scientific data indicate that human shaking without impact is unlikely to result in subdural hematoma and/or diffuse axonal injury. Further, given the relative weakness of the infant neck and proportionally large head of the infant, violent shaking of an infant by gripping and shaking the chest would likely result in extensive torso and neck injuries prior to subdural hematoma caused by bridging vein rupture.
31. Many in the clinical medical community have been led to believe that manual shaking can give rise to linear and rotational acceleration/deceleration forces that are sufficient to tear bridging veins and that shaking results in greater shear forces than are produced in low level falls. A number of landmark papers have been published quantifying the mechanics of shaking and more recently low level falls and comparing the relative head exposure. (Duhaime et al 1987, Prange et al 2003). Based on Prange *et al* results (shown in Figure 1), the peak rotational accelerations (magnitude proportional to shear forces) for a shake are less than those in a 1 foot fall onto carpet. Thus, comparing the rotational forces or accelerations of a shake to a multistory fall or a high speed motor vehicle accident is without scientific foundation and is wholly misleading.

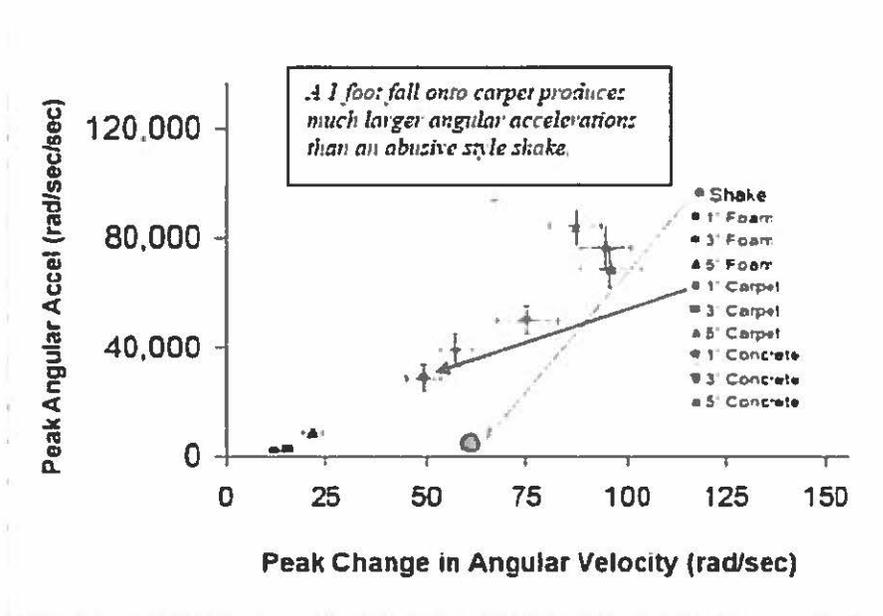


Figure 1: Comparison of the head trauma exposure for short falls onto different surfaces and abusive style shaking. Even a one foot fall onto carpet produces much larger head angular accelerations than shaking does. Figure adapted with permission from M. Prange (*Biomechanics of traumatic brain injury in the infant, Dissertation: University of Pennsylvania, 2002*).

32. Based on the current literature (Prange et al. 2003) and my own research, short falls have the potential to create significantly higher angular accelerations than shaking and would be much more likely to account for the shear related injuries to bridging veins or axons that some physicians associate with shaking.
33. It should be noted that if Brenden’s medical condition was traumatic in nature and a result of abuse, then an intentional direct head impact by an object impacting his head or his head impacting another blunt object would be consistent with his resulting injury. Any exposure resulting in comparable or greater head accelerations than the fall reported by Plunkett could result in significant risk of a severe head injury. However, since at most only minimal bruising or swelling was noted on Brenden’s scalp and no other significant external injury to the head or body was noted in the medical record, any abusive trauma, if it did occur, was likely similar in exposure to that which could occur as the result of a simple fall off the couch.
34. A head injury alone cannot differentiate intent, only level of exposure. The injuries, as noted in the medical record, appear to be consistent with the accidental history provided by Mr. Ceasor and Ms. Genna. I do not see anything in the records that would suggest that the injuries were abusive rather than accidental.

Comments on the Testimony of Dr. Gilmer-Hill

- 35. Dr. Gilmer-Hill, a pediatric neurosurgeon, testified as a witness called by the prosecution on the subject of Shaken Baby Syndrome (SBS).
- 36. Dr. Gilmer-Hill described SBS as violent shaking of a child, generally under age 2, causing the brain to slam back and forth and a bridging vein(s) to tear, resulting in a subdural hematoma. (Tr. 434: 1-18). The doctor went on to testify that the child is usually struck as well, or slammed down on a sofa or soft surface, or even against a wall or thrown up against the ceiling.

Comment: Research has shown that abusive style shaking does not result in head accelerations consistent with bridging vein rupture. Articles published in the Journal of Neurosurgery by Duhaine and colleagues (Duhaine 1987, Prange 2003) have shown that maximal exertion manual shaking of an infant sized test device (smaller and easier to shake than a 16 month old) produces head accelerations less than those produced in a 1 foot fall onto carpet. The rotational accelerations of the shaking exposure was not consistent with the tearing of bridging veins. As shown in Figure 2, these authors' data also shows that slamming the test device onto a soft mattress-like surface resulted in head accelerations less than those produced in a 1 foot fall onto carpet. Clearly, if a child is abused resulting in a high velocity head impact onto a hard surface such as a floor, table, wall, or ceiling, the risk for head injury is great.

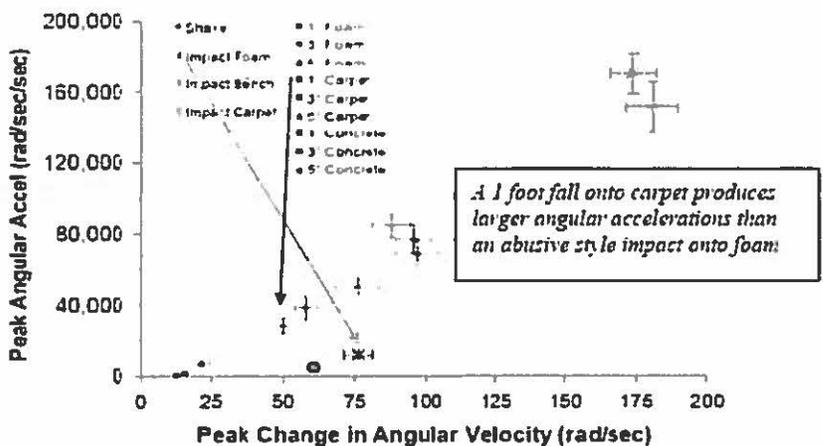


Figure 2: Comparison of the head trauma exposure for short falls onto different surfaces and an inflicted impact onto a soft surface – a foam mattress like surface. Even a one foot fall onto carpet produces much larger head angular accelerations than shaking does. Figure adapted with permission from M. Prange (Biomechanics of traumatic brain injury in the infant, Dissertation: University of Pennsylvania, 2002).

37. Dr. Gilmer-Hill testified that the only mechanism that could result in subdural hematomas and retinal hemorrhaging was abuse or intentional injury. (Tr. 435: 17-20).

Comment: Witnessed and well documented falls, including the Plunkett videotaped fall, have shown that short falls can result in serious and even fatal head injuries including subdural and retinal bleeding. This observation has been confirmed in subsequent biomechanical papers as well as the recent reconstruction of the videotaped fall reported by Dr. Plunkett.

38. Dr. Gilmer-Hill testified that subdural hemorrhage, brain-swelling and midline shift are only seen in accidents such as falls from second story buildings or high speed motor vehicle accidents and cannot be caused by an accidental injury such as a fall from a couch onto a carpeted floor. (Tr. 456: 1-12, 456: 17-25, 457: 1)

Comment: The case studies reported by Plunkett detail head injuries, including subdural hemorrhage, brain swelling, and midline shift, from short distance falls. All these injuries were present in the videotaped fall reported in Plunkett case study #5. Other authors also report these and other injuries resulting from short distance falls.

39. Dr. Gilmer-Hill testified about studies from the University of Pennsylvania in the 1980's and 1990's that were, in her words, "trying to prove these injuries could have happened accidentally". She summarized these findings as showing that shaking or possibly shaking/impact were the only mechanisms that could result in these patterns of injury. (Tr. 435:13-20). Dr. Gilmer-Hill further relied on University of Pennsylvania researcher Ann-Christine Duhaime's studies as her basis for showing that a shaking incident has much more force than even a 5'-6' fall. (Tr. 478: 22-25, 479: 1-18).

Comment: Dr. Gilmer-Hill distorted the findings of Duhaime and colleagues reported in the Journal of Neurosurgery in 1987 and expanded upon in the Journal of Neurosurgery in 2003. Duhaime is an author in both studies. (Duhaime 1987, Prange 2003). As discussed in paragraphs 31 and 32, a 1 foot fall onto carpet produces larger head accelerations than abusive maximal force shaking of an infant sized test device. Further, as set forth above, in Duhaime's 1987 study, the authors concluded that " severe head injuries commonly diagnosed as shaking injuries require impact to occur and that shaking alone in an otherwise normal baby is unlikely to cause the shaken baby syndrome."

40. Dr. Gilmer-Hill relied only on American neurosurgical literature (Tr. 474: 4-19, 475: 11-14, 483: 9-25, 484: 1-9).

Comment: Dr. Gilmer-Hill's complete reliance on American neurosurgical journals and neglect of journals of forensic pathology, neuropathology, biomechanics and pediatrics, as well as all British journals, was detrimental to

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her ability to evaluate abusive versus accidental etiologies of injury. Many of the studies in the broader medical research discuss the occurrence of severe head injury in short distance falls and the factors that must be considered in attempting to differentiate between accidental and abusive causation of head injuries. Even within the literature that she did appear to review, Dr. Gilmer-Hill distorted the findings of Duhaime and her colleagues as reported in the Journal of Neurosurgery in 1987 and 2003. (Duhaime 1987, Prange 2003).

Conclusion

- 41. The injuries noted in the medical records are consistent with the accidental history provided by Mr. Ceasor.
- 42. The testimony provided at trial was contrary to the head injury literature available at the time of Mr. Ceasor's trial in 2005. If I had been asked to testify, I would have provided the information that I provided in this affidavit.

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

Chris Van Ee
Chris A. Van Ee, Ph.D.

Subscribed and sworn to before me this 27th day of January, 2010.

Jennifer Simmons
Notary Public in and for the
State of Michigan

My commission expires: May 3, 2015

JENNIFER SIMMONS
Notary Public, State of Michigan
County of Wayne
My Commission Expires May, 03, 2015
Acting in the County of Washtenaw

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Professional Specialization

Impact biomechanics and accident reconstruction research to identify mechanisms of injury with application to product safety and design. Injury causation is investigated using a combination of computational modeling, laboratory experimental studies, and investigations of real world accidents to define human kinematics, injury mechanisms, interactions with product components and effectiveness of intervention strategies. Specific areas of focus include automotive and marine accidents, child safety, contact sports injuries; industrial machine accidents, and small power hand tool injury investigations.

Past research and product investigations have included adult and pediatric head and neck injury biomechanics, crash induced injuries to the knee, thigh, and hip; crash induced ruptures of the large vessels of the thorax; injury mechanisms and tolerance of the cervical spine; identifying correlations between thoracic loading, skeletal fractures, and internal organ injuries in crash occupants; identifying injury mechanisms to pregnant automobile occupants, evaluating the performance of current and prototype belt restraint systems; evaluating and refining anthropomorphic test device designs and injury reference values; designing assembly machines for increased operator safety; quantifying the protective performance of football, boxing, and motorcycle helmets; evaluating the effectiveness of protective eyewear in small power tool accidents; quantifying the dynamics of circular, miter, and table saw injuries including blade binding, operator error, and the effectiveness of safety interventions; determination of the sufficiency of machine guarding components; and the cause and nature of slip and fall accidents.

Education

Ph.D. (Biomedical Engineering), Duke University, 2000
Advisor: Barry S. Myers M.D. Ph.D.
B.S. (Mechanical Engineering), Dordt College, 1992

Licensure

Professional Engineer: State of Michigan #6201056733

Professional Background

Principal Engineer: Biomedical and Mechanical Engineering

Design Research Engineering, Novi, Michigan
2009 - Present

Adjunct Assistant Professor

Department of Biomedical Engineering, Wayne State University, Detroit, Michigan
2002 - Present

Senior Biomechanical Engineer

Design Research Engineering, Novi, Michigan
2005 - 2009

Project Engineer

Design Research Engineering, Novi, Michigan
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Assistant Research Scientist

University of Michigan Transportation Research Institute, Ann Arbor, Michigan
2000 - 2002

Doctoral Candidate

Department of Biomedical Engineering, Duke University, Durham, North Carolina
1998-2000

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Department of Biomedical Engineering, Duke University, Durham, North Carolina
1992-1998

Custom Design Engineer

Pella Corporation, Pella, Iowa
1991 - 1992

Engineering Technician

Vermeer Manufacturing, Pella, Iowa
1990

Professional Affiliations, Service, Certifications

Scientific Program Committee: Association for the Advancement of Automotive Medicine (2006-Present)

- o Chairman of the Scientific Program Committee (2009-2010)

Society of Automotive Engineers Occupant Protection Committee (2005-Present)

- o Vice-Chairman of the Automobile Body Activity of the Land and Sea Group (2009-2010)
- o Chairman of the Occupant Protection Committee (2008-2009)
- o Vice-Chairman of Occupant Protection Committee (2006-2008)

Organizer of the Occupant Restraints Session: SAE World Congress (2006-Present)

Co-chairperson of the Biomechanics Session: SAE World Congress 2006

Session Organizer: Dynamics and Control of Biomechanical Systems III, 2009 ASME International Mechanical Engineering Congress & Exposition

Editor: 2009 SAE Occupant Protection and Crashworthiness Technology Collection

Traffic Accident Reconstruction, Northwestern University Center for Public Safety

Child Passenger Safety Technician - The National Standardized Child Passenger Safety Training Program (2006-Present)

Review Panel Member: American Institute of Biological Sciences review of United States Army Aeromedical Research Laboratory (February 2008)

Reviewer for American Institute of Biological Sciences review of proposal submitted to US Army Medical Research and Materiel Command

Reviewer and Review Panel Member, National Institutes of Health (NIH) (2003-2008)

- o Special Emphasis Panel/Scientific Review Group ZRG1 MOSS-F, Musculoskeletal, Oral and Skin Sciences
- o Study Section ZRG1 BDCN-K Clinical Neurophysiology, Devices and Neuroprosthetics / Brain Disorders and Clinical Neuroscience
- o Study Section ZRG1-GRM, Geriatrics and Rehabilitation Medicine
- o Study Section MRS, Musculoskeletal Rehabilitation Sciences
- o Study Section ZRG1-SBDD, Rehabilitative Medicine

Reviewer, SAE Congress:

- o Biomechanics
- o Occupant Restraints
- o Side Impact, Rear Impact and Rollover

Reviewer, Accident Analysis and Prevention

Reviewer, Traffic Injury Prevention

Reviewer, ASME: Occupant Protection & Biomechanics

Reviewer, Journal of Biomechanics

Invited Reviewer: Stapp Car Crash Journal 2009

Judge, ASME PhD Student Paper Competition (Summer 2007)

Medical Expert Affidavits

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Member, American Society of Biomechanics (ASB)
Member, American Society of Mechanical Engineers (ASME)
Member, Society of Automotive Engineering Society (SAE)
Member, Association for the Advancement of Automotive Medicine (AAAM)

Honors and Awards

John Paul Stapp Award
Best paper at the 2008 Stapp Car Crash Conference

UMTRI Best Publication Award
University of Michigan Transportation Research Institute best publication award for 2004

UMTRI Best Publication Award
University of Michigan Transportation Research Institute best publication award for 2003

John Paul Stapp Award
Best paper at the 2000 Stapp Car Crash Conference. The paper was voted the most significant contribution in the field of impact biomechanics relating to the reduction of injuries in automotive transportation.

Stapp Association Student Award
Most outstanding student presentation at the 2000 Stapp Car Crash conference.

Ralph H. Isbrandt Automotive Safety Award
Best paper presented to the Society of Automotive Engineers on the subject of Automotive Safety Engineering for the year 1995.

Arnold W. Siegel Award
Society of Automotive Engineers' award for the most outstanding paper presented at the 1995 Stapp Car Crash Conference.

Duke University Research Fellowship
National Science Foundation Fellowship Committee Honorable Mention
Dordt College Merit Scholarship

Publications

"Exploring the Role of Lateral Bending Postures and Asymmetric Loading on Cervical Spine Compression Responses", 2009 ASME International Mechanical Engineering Congress & Exposition, IMECE2009-12911, (with D Toomey, M Mason, W Hardy, K Yang, J Kopacz).

"Evaluation and Refinement of the CRABI-6 Anthropomorphic Test Device Injury Criteria for Skull Fracture", Proceedings 2009 ASME International Mechanical Engineering Congress & Exposition, IMECE2009-12973, (with B Moroski-Browne, D Raymond, K Thibault, W Hardy, J Plunkett).

"Child ATD Reconstruction of a Fatal Pediatric Fall", 2009 ASME International Mechanical Engineering Congress & Exposition, IMECE2009-12994, Accepted (with D Raymond, K Thibault, W Hardy, J Plunkett).

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Chris A. Van Ee, Ph.D.



- "Use of Computational Models in Marine Accident Reconstruction", 2008 TASS Americas MADYMO Users Meeting, April, Detroit, MI (with Robert Taylor).
- "The Effect of Soft Tissue On The Biomechanics Of Skull Fracture Due To Blunt Ballistic Impact: Preliminary Analysis and Findings" (Abstract) 2008 Summer Bioengineering Conference, June 25-29, 2008 (with D. Raymond, G. Crawford, C. Bir).
- "Biomechanics of Temporo-Parietal Skull Fracture From Blunt Ballistic Impact" (Abstract) 2008 Summer Bioengineering Conference, June 25-29, 2008 (with D. Raymond, G. Crawford, C. Bir).
- "Biomechanics of Blunt Ballistic Impacts to the Head and Fracture-Specific Injury Criteria Development" (Abstract) American Academy of Forensic Sciences 60th Annual Meeting, February 18-23, 2008 (with D. Raymond, G. Crawford, and C. Bir).
- "Biomechanics of Blunt Ballistic Impacts to the Forehead and Zygoma" (Abstract-Poster) American Academy of Forensic Sciences 60th Annual Meeting, February 18-23, 2008 (with G. Crawford, D. Raymond, and C. Bir).
- "Head Exposure Levels in Pediatric Falls" (abstract-poster) National Neurotrauma Society Meeting, 2007 (with K. Monson, C. Sparrey, L. Cheng, and G. Manley).
- "Dynamic Biaxial Tissue Properties of the Human Cadaver Aorta," Stapp Car Crash Journal, Vol. 50, November 2006 (with C.S. Shah, W.N. Hardy, M.J. Mason, and K.H. Yang, R. Morgan, and K. Digges).
- "Study of Potential Mechanisms of Traumatic Rupture of the Aorta Using In Situ Experiments," Stapp Car Crash Journal, Vol. 50, November 2006 (W.N. Hardy, C.S. Shah, J.M. Kopacz, K.H. Yang, R. Morgan and K. Digges).
- "Investigation of Potential Mechanisms of Traumatic Rupture of the Aorta" (Abstract #5245) Proceedings of the World Congress of Biomechanics – Munich, Germany August 2006 (with W.N. Hardy, C.S. Shah, M.J. Mason, K.H. Yang, and K. Digges).
- "Safety Restraint System Physical Evidence and Biomechanical Injury Potential Due to Belt Entanglement," SAE Paper 2006-01-1670, 2006 SAE World Congress (with D.E. Toomey and M.E. Klima).
- "High-Speed Biaxial Tissue Properties of the Human Cadaver Aorta," Proceedings of IMECE05 - 2005 ASME International Mechanical Engineering Congress, November 2005. (with C.S. Shah, M.J. Mason, K.H. Yang, W.N. Hardy, R. Morgan, and K. Digges).
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- "Tensile Properties of the Human Muscular and Ligamentous Cervical Spine." Ph.D. Thesis, Duke University, 2000.
- "Quantifying Skeletal Muscle Properties in Cadaveric Test Specimens: Effects of Mechanical Loading, Postmortem Time, and Freezer Storage." *Journal of Biomechanical Engineering*, 122:9-14, February 2000 (with A. L. Chasse, and B. S. Myers).
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- "Tensile Testing of the Ligamentous Cervical Spine: Biomechanical Considerations for a Proposed Testing Methodology." Proceedings: The 27th International Workshop on Human Subjects for Biomechanical Research, 1999 (with R. W. Nightingale, and B. S. Myers).
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- "The Effects of Postmortem Time and Freezer Storage on the Mechanical Properties of Skeletal Muscle." The 8th Injury Prevention Through Biomechanics Symposium Proceedings, Detroit, MI, 1998 (with A.L Chasse, B. S. Myers).
- "Injury Mechanisms in the Pediatric Cervical Spine During Out-of-Position Airbag Deployments." Proceedings of the 42nd Association of the Advancement of Automotive Medicine, 1998 (with R. W. Nightingale, B. A. Winkelstein, and B. S. Myers).
- "The Effects of Postmortem Time and Freezer Storage on the Mechanical Properties of Skeletal Muscle." Society of Automotive Engineers, J. Passenger Cars, SAE Paper #983155, 1998 (with A. L. Chasse, and B. S. Myers).
- "Measurement of Human Neck Muscle Volume Geometry and Physiologic Cross Sectional Area in 5th, 50th and 95th Percentile Subjects using Cadaveric Dissection and MRI." 25th Annual International Workshop for Human Subjects for Biomechanical Research, 1997 (with K. E. Knaub, C. Cheng, B. Poon, C. Spritzer, and B. S. Myers).

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- “On the Structural and Material Properties of Mammalian Skeletal Muscle and its Relevance to Human Cervical Impact Dynamics.” Society of Automotive Engineers, J. Passenger Cars, SAE Paper #952723, 1995 (with B. S. Myers, D. L. A. Camacho, C. T. Woolley, and T. M. Best).
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Presentations

- “Evaluation and Refinement of the CRABI-6 Anthropomorphic Test Device Injury Criteria for Skull Fracture”, 2009 ASME International Mechanical Engineering Congress & Exposition, November 18, 2009.
- “Child ATD Reconstruction of a Fatal Pediatric Fall”, 2009 ASME International Mechanical Engineering Congress & Exposition, November 18, 2009.
- “Use of Computational Models in Marine Accident Reconstruction”, 2008 TASS Americas MADYMO Users Meeting, April, Detroit, MI
- “Pediatric Head Injury: Injury Mechanisms and Injury Tolerance”, Invited Lecturer for BME 7810 – Forensic Bioengineering, Wayne State University, November, 2007.
- “Principles of the Biomechanical Analysis of Infant Brain Injury” and “Case Studies in Infant Brain Injury Analysis,” co-presenter with Kirk Thibault at the EBMS Symposium – An Evidence-Based Analysis of Infant Brain and Skeletal Injury, May 2007.
- “Characterizing Pediatric Head Injury Risk: Automotive Accidents, Falls, and Shaking,” Invited Keynote Speaker: 15th Annual Meeting of the Rachidian Society, Kona, HI, February 2007.
- “Tensile Tolerance of the Cervical Spine” Invited Keynote Speaker: 15th Annual Meeting of the Rachidian Society, Kona, HI, February 2007.
- “Safety Restraint System Physical Evidence and Biomechanical Injury Potential Due to Belt Entanglement,” co-presenter with M. Klima, SAE World Congress, Detroit, MI, April 2006.
- “Biomechanics, Falls, and Shaken Baby Syndrome,” Guest Lecturer for BME 7995 – Forensic Bioengineering, Wayne State University, October, 2005.
- “Trial Techniques and Strategies: Making the Most of Your Experts,” co-presenter with Jeffrey Weiner, Florida Bar Continuing Legal Education Seminar, Miami, FL, January 21, 2005.
- “Use of Computer Models in Forensic Investigations of Human Kinematics: Examples from Alpine Skiing and Marine Accident Reconstruction”, AmeriPAM Nov 3, 2004.
- “Marine Accident Reconstruction: Forensic Engineering and Biomechanics” Wayne State University, June 7, 2004.
- “Biomechanics and Physical Restraint, An Analysis of the Mandt System.” Dallas, TX, April 22, 2004.
- “Rollovers, Neck Injury, and Defining the Role of Lateral Bending in Compressive Neck Injury.” Wayne State University, March 15, 2004.
- “Development of an Experimental Protocol to Quantify the Tolerance of the Hip to Axial Femur Loading.” The 29th International Workshop on Human Subjects for Biomechanical Research. San Antonio, TX, November, 2001.
- “Head and Cervical Spine Geometry in the Automotive Neutral, Flexion, and Extension Postures.” Ford Motor Company, Dearborn, MI, September, 2001.

Medical Expert Affidavits

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- “Tensile Properties of the Human Muscular and Ligamentous Cervical Spine.” 2000 Stapp Car Crash Conference, Atlanta, GA, November, 2000.
- “Development of an Experimental Model of Tensile Neck Injury.” The 27th International Workshop on Human Subjects for Biomechanical Research, San Diego, CA, October, 1999.
- “A Combined Experimental and Computational Study of Tensile Neck Injury.” National Highway Traffic Safety Administration, Durham, NC, July, 1999.
- “Neck Surrogates: A Systematic Experimental and Computational Study Designed to Provide Anthropometric Test Device Injury Reference Values.” National Highway Traffic Safety Administration, Washington, DC, December, 1998.
- “The Effects of Postmortem Time and Freezer Storage on the Mechanical Properties of Skeletal Muscle.” The 42nd Annual Stapp Car Crash Conference, Phoenix, AZ, November 2-4, 1998.
- “The Effects of Postmortem Time and Freezer Storage on the Mechanical Properties of Skeletal Muscle.” The 8th Injury Prevention Through Biomechanics Symposium, Detroit, MI, May 7-8, 1998.
- “Measurement of the Structural and Material Properties of Mammalian Skeletal Muscle.” The 5th Injury Prevention Through Biomechanics Symposium, Detroit, MI, May 4-5, 1995.

Last Update: November 2009

UNITED STATES DISTRICT COURT
EASTERN DISTRICT OF MICHIGAN
SOUTHERN DIVISION

TERRY CEASOR,

Petitioner,

-vs-

JOHN OCWIEJA,

Respondent.

_____ /

CASE NO. 5:08-cv13641
HON. JOHN CORBETT O'MEARA
MAG. R. STEVEN WHALEN

STIPULATED ORDER

The Court finds that an evidentiary hearing in the District Court is unnecessary because the parties stipulate that appellate counsel's deficient performance prejudiced Petitioner because appellate counsel failed to litigate in state court a claim of ineffective assistance of trial counsel that was reasonably likely to succeed. The Court makes no finding on whether the underlying claim of ineffective assistance of trial counsel will ultimately be successful.

Therefore, the writ of habeas corpus is **GRANTED**.

It is further **ORDERED** that the Michigan Court of Appeals shall, within 60 days, grant the Petitioner a new direct appeal of right.

Date: May 12, 2017

s/John Corbett O'Meara
United States District Judge

Approved as to Form and Content by:

*/s/ David A. Moran (w/permission)
Attorney for Petitioner*

*/s/ Andrea Christensen-Brown
Attorney for Respondent*

1 Ackley says that -- states that there -- an expert is
2 necessary for a defense in SBS case because of the
3 disputed medical, the disputed medical position regarding
4 SBS.

5 THE COURT: Well I understand that that's what
6 the Supreme Court has said in that case, but we also had a
7 defendant that had met the requirements of being an
8 indigent defendant. Therefore, everything related to his
9 defense was being paid for by tax dollars and not his own
10 money.

11 You said it would have been an abuse of
12 discretion for Judge Adair not to grant the request, but
13 that's not the same situation as *Ackley*. We have a
14 situation where we have a retained attorney not being
15 represented by court-appointed counsel and you said Judge
16 Adair was basically required to appropriate funds and I
17 wanted to know if there's any authority that supports that
18 position.

19 MS. MILLER: We have, your Honor, we've attached
20 three affidavits to our Motion for New Trial that
21 establish that Mr. Ceasor was indigent despite the fact
22 that he retained his counsel. It -- the affidavits of him
23 and his mother and his uncle all state that Mr. Ceasor
24 used all of his resources and the resources of his mother
25 to pay and retain their attorney Mr. Lord and once they

1 2006 but did it the wrong way and that's why we're back
2 here. And so if there's any reason that the Court is
3 inclined to deny this motion it should do so only after
4 hearing an Evidentiary Hearing at which point we would
5 need to bring in our witnesses and so that there will be,
6 as the Court correctly recognized, there will be
7 scheduling issues but we have some dates that our experts
8 could testify.

9 THE COURT: But at this point -- and I haven't
10 asked Mrs. Georgia and I'll put her on the spot, but my
11 expectation would be that the expert witnesses that you
12 have secured would testify consistently with their
13 affidavits. I don't expect that they're going to come in
14 and tell me anything different than what they have already
15 submitted by way of their written statement.

16 MR. MORAN: I would be shocked if they --

17 THE COURT: And --

18 MR. MORAN: -- if that wasn't true.

19 THE COURT: -- so I would be really surprised
20 that they would come in and say something different and
21 I'm not sure, you know, how big of a contested issue that
22 is but I'm not going to put the People, the Prosecutor on
23 the spot just yet. Let me kind of get back to our
24 discussion, Mr. Moran.

25 Let's assume that your client is indigent and,

1 and that the -- and that fact is going to be resolved one
2 way or the other in your client's favor. The next
3 question then is your position is Mr. Lord was duty bound
4 to then go before Judge Adair my predecessor and request
5 the appropriate funds for an expert and that if the court
6 failed to do that it was -- it would be an abuse of
7 discretion. Mrs. Georgia has cited to me an unpublished
8 case that says that's not necessarily the case. Do you
9 have any authority to the contrary?

10 MR. MORAN: No, there's very little authority on
11 that. That is an unpublished case that apparently deals
12 with a defendant who still had the funds to post bond
13 apparently and what differs from this case is by all
14 accounts including what Mr. Lord said to the court Mr.
15 Ceasor and his mother were tapped out completely by the
16 time that it came time to, to look -- to retain Doctor
17 Bandak and when the 1500 bill in that case came due they
18 didn't have it. So that's a clear distinction between
19 that, that unpublished Court of Appeals case and this
20 case.

21 THE COURT: I know Judge Adair pretty well. I
22 practiced in front of him for the entire time that he was
23 on the Bench 18 years and I would have to say if I had to
24 venture a guess one way or the other as to whether I would
25 be successful or Mr. Lord or anybody else successful in

1 requesting funds for an expert when I was retained counsel
2 and I said: Oh sorry, Judge, we spent all our money and
3 we just don't -- we're tapped out and we need this help
4 now. I'd probably get laughed out of the courtroom. I
5 would be very surprised knowing Judge Adair that he would
6 grant that request and then if he did, my expectation
7 would be that if an amount of funds were appropriated it
8 would probably be a rather meager amount of money.
9 Probably nothing in the \$10,000.00 range that apparently
10 this other doctor that Mr. Lord had contacted was
11 requesting to stay in the case. I just don't see those
12 kinds of funds being available.

13 MR. MORAN: Well --

14 THE COURT: So if the likelihood of those two
15 things the request being granted, number one, is going to
16 be a challenge and then, number two, getting funds that
17 are going to be of a sufficient amount to retain the
18 expert that you need in order to have that true expert
19 battle that was referred to at the exam, don't I have to
20 consider those things as well?

21 MR. MORAN: Well you do but you, you can't rule,
22 your Honor, you believe that the judge would have made a
23 decision that when that decision wouldn't stand up on
24 appeal. And we don't believe that if Judge Adair had said
25 I'm not appropriating enough funds to retain Doctor Bandak

1 for an expert. Cases go in two very different directions
2 depending on whether or not they start out as a retained
3 case or a court-appointed case.

4 I just want to briefly address the idea that
5 Mr. Lord was somehow deficient because he didn't locate a
6 court-appointed expert or, excuse me, a pro bono expert.

7 First of all we haven't heard anything from him
8 about what he did to try to work out fees. So I think to
9 say he didn't try to get an expert at a lower cost isn't
10 really fair to Mr. Lord, but beyond that I think the Court
11 can take notice that this whole idea of experts in shaking
12 baby cases is a movement now and it was not of the same
13 momentum in 2005. So I think the University of Michigan
14 with all of its resources can go out and get the attention
15 of these experts who are happy to jump on for, for the
16 cause but you have to again remember Mr. Lord is
17 practicing in 2005. This was still a contested area but
18 it was not what it is today. So I think again that's a
19 little bit unreasonable for them to put that expectation
20 on him.

21 THE COURT: Where I think I'm going to end up
22 going -- and I'm not making a specific ruling. I, I want
23 to issue a really -- and, and I think it will be very
24 short, a short opinion and Order on this subject and on
25 the first prong only because I think before there's any

1 need to get into the specifics of the expert testimony on
2 prejudice I need to get by the issue of indigency and then
3 whether or not the next claim of ineffectiveness, which is
4 not asking for some help from the court. I think those
5 two things need to be addressed. That probably is going
6 to involve Mr. Lord and some additional evidence or
7 testimony on the indigency question going back and
8 establishing what did or did not exist at that particular
9 time and then whether Mr. Lord had any of that information
10 is probably where this is going to end up at least
11 initially.

12 So I want to give a little bit of thought to
13 that, but I have no trial this week for the first time in
14 a long time. So, I'll try to get something out to you by
15 the end of the week and we'll get some kind of a date set
16 and probably proceed in that direction and then we'll take
17 a look at phase two if we get that far.

18 MRS. GEORGIA: Very good. Thank you, your
19 Honor.

20 MR. MORAN: Your Honor, I am going on vacation
21 Wednesday until August 23rd so I'll be sort of out of
22 communication.

23 THE COURT: Well because this matter is, is now
24 proceeding as a direct appeal and we're dealing with
25 appellate court rules as far as other court rules and

STATE OF MICHIGAN
IN THE CIRCUIT COURT FOR THE COUNTY OF ST. CLAIR

PEOPLE OF THE STATE OF MICHIGAN
Plaintiff,

-vs-

Case No. 05-000220-FH
HON. MICHAEL L. WEST

TERRY LEE CEASOR
Defendant.

ORDER

CIRCUIT COURT FOR THE 31ST JUDICIAL CIRCUIT OF MICHIGAN

On July 17, 2017 Defendant, Terry Ceasor filed a motion for new trial claiming that his trial counsel was constitutionally ineffective for failing to seek funds pursuant to MCL 775.15 from the Court to hire an expert witness. The procedural history of this case is lengthy and has been adequately set forth by the parties in their respective briefs and will not be repeated here.

The parties agree that Defendant's trial counsel recognized the importance of an expert in this case. A defense expert had been consulted and agreed to review the file without prior payment in anticipation of being retained on the file. When it came time to hire the expert, Defendant advised his trial counsel he did not have the necessary funds. Consequently, no expert was retained and Defendant proceeded to trial without a defense expert.

The sole question raised in Defendant's motion is whether Defendant's trial counsels' performance was objectively unreasonable when he did not seek funds from the Court to pay for an expert. That question cannot be answered without additional facts being established regarding the nature and extent of Defendant's retained attorney-client

CIRCUIT COURT FOR THE 31ST JUDICIAL CIRCUIT OF MICHIGAN

relationship and specifically the issue of Defendant's alleged indigence. Defendant's affidavits submitted in support of his motion suggesting he was indigent does not make it so. Even if they did, the issue here is not what Defendant believed about his financial position, but rather what his attorney believed and whether he acted reasonably in connection with that knowledge.

Accordingly, an evidentiary hearing is necessary consistent with *People v Ginther*, 390 Mich 436 (1973) to determine whether trial counsel's failure to request public funds from the Court to pay for an expert witness fell below an objective standard of reasonableness. Until that question is resolved it is premature to consider the prejudice element of *Strickland v Washington* and the same will not be considered by the Court at the evidentiary hearing ordered herein. The parties may contact the Court's assignment clerk within the next seven days regarding a date and time for said hearing.

IT IS SO ORDERED.

August 30, 2017



Michael L. West
Circuit Judge

1 more to weight, this is just the earnings that he has
2 reported to the government, but to that extent I don't
3 have any objection.

4 THE COURT: All right. Well I, I know what the
5 relevant time period is that we need to focus on so that's
6 what I would be looking at. So it will be admitted and I
7 will give it the attention and weight that it deserves.

8
9 (Defendant's Exhibit A admitted at 9:45 a.m.)

10
11 MS. McGRANE: Thank you, your Honor.

12 BY MS. McGRANE:

13 Q Can you take a look at Page 3. What's contained on that
14 page?

15 A My earnings record from 1986 to 2014.

16 Q Okay. And can you please read what your earning record
17 says you earned in 2005 the relative period?

18 A \$15,107.

19 Q Would you like --

20 MS. McGRANE: Your Honor, should I give the
21 exhibit to the clerk or keep it until the end?

22 THE COURT: You can keep them.

23 MS. McGRANE: Okay.

24 BY MS. McGRANE:

25 Q Mr. Ceasor, were you married in 2005?

1 A No.

2 Q Did you have anything that could have been sold for any
3 kind of significant value in 2005?

4 A No.

5 Q Did you have a significant amount of money in the bank at
6 that time?

7 A No.

8 Q I'd like to focus your attention now on your interactions
9 with Mr. Lord. Did you hire him to represent you?

10 A No.

11 Q Who hired him?

12 A My mom.

13 Q And did you personally ever pay him anything?

14 A No.

15 Q Why not?

16 A I never had no money to pay him.

17 Q Who paid Mr. Lord's initial fee?

18 A My mother.

19 Q And how much did she pay him if you know?

20 A \$2,500.00.

21 Q If your mother had not been able to pay Mr. Lord on your
22 behalf, would you have been able to pay him?

23 A No.

24 Q At any point in this process have you yourself hired your
25 own attorney?

1 A No.

2 Q Have you paid an attorney money of your own in connection
3 with this case?

4 A No.

5 Q Before Mr. Lord did you have another attorney?

6 A Yes.

7 Q And who was that?

8 A David Black.

9 Q Who paid Mr. Black's fees?

10 A My mom.

11 Q Why did she do that?

12 A Dave Black's a friend of the family.

13 Q Did you have the funding to pay Mr. Black?

14 A No.

15 Q Did Mr. Black ever discuss with you the need for a medical
16 expert?

17 A Yes.

18 Q And what did he say about that need?

19 A My case solely depends on medical expert's testimony.

20 Q Okay. And did you talk with Mr. Lord about needing to
21 hire a medical expert in your case?

22 A Yes.

23 Q And what did you think about that? Did you think it was
24 important?

25 A My -- everybody told me that everything dealing with my

1 case depends on a medal expert's testimony.

2 Q And did Mr. Lord tell you how much it would cost to hire
3 an expert?

4 A Between 10 to \$20,000.00.

5 Q To your knowledge did Mr. Lord consult with an expert
6 about your case?

7 A Yes.

8 Q And who was that?

9 A Doctor Bandak.

10 Q Did Mr. Lord ask you for any money related to that
11 consultation?

12 A Yes.

13 Q And how much money?

14 A \$1,500.00.

15 Q Did you pay that fee?

16 A No.

17 Q Could you have paid Doctor Bandak's \$1,500.00 consultation
18 fee if you had the advanced notice?

19 A No.

20 Q Do you know if Mr. Lord ever attempted to hire a different
21 medical expert to testify in your behalf?

22 A No, he didn't.

23 Q Do you know why?

24 A Because Doctor Bandak's bill was never paid so he wasn't
25 seeking any other type of expert.

1 Q And how do you know that that was the reason he didn't
2 hire an expert?

3 A Because that's what he told me.

4 Q And did Mr. Lord ever discuss with you any other options
5 for getting a medical expert?

6 A He said there were no other options.

7 Q Were you incarcerated or out on bail during your trial?

8 A I was on bail.

9 Q And if you could have gotten the money together for an
10 expert if you'd had additional time delaying the trial
11 would you have chosen to do that rather than proceed
12 without an expert?

13 A Yes.

14 Q And why would you have made that choice?

15 A That was the only way for me to prove my innocence.

16 Q Could you clarify what you mean when you say that?

17 A The doctor's testimony was the only thing -- the only
18 thing that convicted me on this was the doctor's
19 testimony.

20 MRS. GEORGIA: Your Honor, I'm just going to
21 object to that. I mean he doesn't know what convicted
22 him. He can't be in the minds of the jury. He's arguing
23 to the Court rather than answering the question.

24 THE COURT: I agree. That is something that is
25 outside of the knowledge of this witness. I mean he may

1 Q When you first learned that Terry required a lawyer for
2 his trial, did you think that he would be able to afford
3 one?

4 A No.

5 Q And why didn't you think he would be able to afford one?

6 A Raising his son, paying the rent, car insurance that
7 pretty much took everything he made.

8 Q And who paid to retain Mr. Dave Black as Terry's attorney?

9 A I did.

10 Q And who paid to retain Mr. Ken Lord as Terry's attorney?

11 A I did.

12 Q And how much did you pay each attorney?

13 A Dave Black I paid 1,000 and Ken Lord I paid 2500.

14 MS. HOWE: I have a marked exhibit for
15 Defendant's Proposed Exhibit D. And may I approach the
16 witness, your Honor?

17 THE COURT: You may.

18 BY MS. HOWE:

19 Q I'm handing the witness proposed Exhibit D and,
20 Ms. Hastings, do you recognize this document?

21 A Yes.

22 Q And looking at the first check on the document what is it?

23 A It's a check for \$1,000.00 to Dave Black.

24 Q And the second check?

25 A Is a check for 2,500 for Kenneth Lord.

1 MS. HOWE: Your Honor, I would like to move to
2 admit defense Exhibit D a carbon copy check from Diana
3 Hastings made out to Dave Black for \$1,000.00 and Ken Lord
4 for \$2,500.00.

5 MRS. GEORGIA: May I voir dire the witness as it
6 relates to just the exhibit?

7 THE COURT: Sure.

8

9

VOIR DIRE EXAMINATION

10

11 BY MRS. GEORGIA:

12 Q Ms. Hastings, are these -- these aren't actually checks
13 are they?

14 A No.

15 Q These are like the carbon from your checkbook?

16 A Correct.

17 Q Where's the actual canceled check or a copy of that?

18 A It would be over ten years so they don't keep them after
19 ten years.

20 Q Who doesn't keep them?

21 A The credit union where I have my checking account.

22 Q So, the credit union never sent you the bank statement or
23 copies of your canceled checks at the time?

24 A Bank statements, yes.

25 Q So why do you have this but not bank statements showing

1 for the record.

2 A Alan Wesley Hastings. H-A-S-T-I-N-G-S.

3 Q Mr. Hastings, what is your address?

4 A 7238 Phillips Road, Ruby, Michigan.

5 Q And where are you employed?

6 A I'm the owner of Alan's Expert Auto Body Repair in Port
7 Huron.

8 Q And how do you know Terry Ceasor?

9 A He is my nephew.

10 Q And where was Mr. Ceasor employed in 2005?

11 A With us.

12 Q And how much was he paid?

13 A Terry was on an apprentice salary of 350 a week.

14 Q And did you ever see Mr. Ceasor in possession of expensive
15 property?

16 A No.

17 Q Did you ever see him wearing fancy clothes?

18 A No.

19 Q Did you ever see him wearing expensive jewelry?

20 A No.

21 Q Did he own an expensive car?

22 A No.

23 Q What kind of car did Mr. Ceasor own?

24 A Well, that took a little bit. I believe it was a '96

25 Sable that we ended up getting Terry. Total loss car just

1 Q Yes.

2 A It would be his mother.

3 Q And were expert witnesses ever discussed at these
4 meetings?

5 A I think like the second or third one.

6 Q Did Mr. Lord and Mr. Ceasor agree that Mr. Ceasor needed
7 an expert witness?

8 A Oh yes.

9 Q And did Mr. Lord ever present an estimate about how much
10 an expert witness would cost?

11 A At that point, um, yes, he stated that he had already
12 \$1,500.00 invested and that it could go as high as I
13 believe -- I, I don't know the ceiling, but it seems like,
14 like could have went up to \$10,000.00 that he's going to
15 need.

16 Q And how did Mr. Ceasor react to this?

17 A Well, at that point we're both with no money we're
18 grasping at straws at what we could do.

19 Q And did Mr. Lord and Mr. Ceasor ever discuss how they're
20 going to pay for the expert witness?

21 A Briefly, um, it was mentioned that a vehicle was, um,
22 brung to our shop as a, as a total and we had thought we'd
23 possibly put that together. It was an older car. At best
24 if we fixed it it was only worth \$2,000.00 so, but we
25 could never find parts for it because the car was so old

1 Q So how do you know Mr. Ceasor?

2 A I represented Mr. Ceasor.

3 Q In 2005 in a child abuse case?

4 A I can't give you the date by memory, but if the records
5 say it's 2005.

6 Q Okay. Do you recall how this case came to you?

7 A No.

8 Q Were you aware that there was an earlier lawyer Dave Black
9 on the case?

10 A Not until it was brought to my attention by the check.

11 Q Okay. At some point would it have been your normal
12 procedure to order the Preliminary Exam if, if a different
13 lawyer handled the Preliminary Exam?

14 A Absolutely.

15 Q So you would have ordered the Preliminary Exam and read
16 it?

17 A Yes.

18 Q Now, in that Preliminary Exam which was held -- second
19 volume of the Preliminary Exam held on January 25th, 2005
20 at the very end Mr. Black says: It's going to be expert
21 against expert. Would you, would you -- I'm sorry, your
22 Honor. Will you agree with that? Would you agree with
23 Mr. Black that this case was about expert versus expert?

24 A I agree that experts were extremely critical to the
25 outcome of this case. As far as agreeing with Mr. Black,

1 I prefer not to.

2 Q Okay. But you agree that an expert was needed for the
3 defense in this case?

4 A Absolutely.

5 Q All right. Now, how much were you paid if you recall?

6 A I was originally paid 20 -- I, I don't -- honestly didn't
7 remember until I saw the check. So my, my memory is that,
8 um, my normal, um, attorney fee agreement, which again my
9 file's been destroyed, shredded, I would take a certain
10 amount down and they'd agree to make monthly payments
11 because most of my clients were working class people like
12 myself and my father, didn't have the money to pay me,
13 wanted to have a good legal representation so I work out a
14 payment schedule with them.

15 Q Okay. And do you recall whether you got any additional
16 money on top of the \$2,500.00 that Ms. Hastings paid you
17 up-front?

18 A I don't recall getting any additional money. I do recall
19 the conversation. I don't remember the gentleman being at
20 that conversation, he could have been, where I told Terry
21 don't worry about my payments. I'm more concerned about
22 getting the expert. This had been very -- because he
23 should have been making monthly payments very on in the
24 case that we need to raise money to get an expert and so I
25 didn't take anymore payments.

1 Q So you don't remember whether Mr. Hastings was there. You
2 indicated --

3 A I, --

4 Q -- Mr. Hastings --

5 A -- I don't remember whether or not Mr. Hastings was there.
6 I'm sorry.

7 Q But --

8 A He looks familiar, but he has a friendly face so he just
9 might look familiar.

10 Q But you don't dispute the accuracy of what he said about
11 how what you, you would have said that the expert's more
12 important than your fee?

13 A As far as that, no, I, I don't dispute that. I made that
14 clear to Terry Ceasor right from the outset.

15 Q Okay. Now you did consult with an expert Doctor Bandak;
16 is that right?

17 A I did not remember his name until you called me and, yes,
18 I did. On multiple occasions.

19 Q And we've heard the number \$1,500.00. Was that Mr.
20 Bandak's or Doctor Bandak's fee? Initial consulting fee?

21 A I don't remember it being \$1,500.00. I remember it being
22 approximately \$750.00 to do the initial review and report.
23 And then we had discussed and explained Mr. Ceasor's
24 situation and Mr. Bandak or Doctor Bandak had indicated
25 that he would work with me on the fee.

1 Q Okay. But it was going to be more?

2 A Absolutely.

3 Q And did you ever end up paying Doctor Bandak more?

4 A No.

5 Q Did you ever end up paying him the initial consulting fee?

6 A I probably would have because if I don't pay the experts
7 that I hire then -- so probably would have come out of my
8 pocket, yes.

9 Q So that money came out of your pocket and not Mr. Ceasor's
10 pocket?

11 A Well indirectly. I mean, I got the \$2,500.00 as an
12 initial retainer. That money would have come out of that
13 \$2,500.00 which means we're doing the exam, the motions,
14 the trials, --

15 Q Okay.

16 A -- witness prep. I probably made about \$1,400.

17 Q Okay.

18 A About \$10.00 an hour.

19 Q Ultimately you didn't hire Doctor Bandak; is that fair?

20 A No, I did not.

21 Q And the, the -- you didn't hire any expert for trial?

22 A No, I did not.

23 Q And you did not go to the court and ask for funds to hire
24 Doctor Bandak or another expert?

25 A No, I did not.

1 Q Did you see if you could find any expert who would testify
2 pro bono?

3 A I -- at the time my, my memory serves me that in order to
4 find an expert I, I did two things. I went to SADO.
5 State Appellate Defender's Office. They have an expert
6 witness bank. I contacted them. I got any names of the
7 experts that they would be aware of because they're
8 state-wide. And then I went online, Googled it and got
9 the expert and --

10 Q And that was doctor -- I'm sorry. And that was Doctor
11 Bandak the expert?

12 A Doctor Bandak, yes.

13 Q All right. And did you ever speak to either in person or
14 over the phone with any other expert other than Doctor
15 Bandak?

16 A No.

17 Q Okay. And then the case came to a jury trial and during
18 jury selection you spoke to the jurors?

19 A Yes, I did.

20 Q And I, I've read you some -- over the phone some of the
21 excerpts of what you said to the jurors?

22 A Yes. Yes.

23 Q About how Mr. Ceasor could not afford an expert?

24 A I said those things to the jury, yes.

25 Q Repeatedly; is that fair?

1 I think we all know the answers to them, but can you just
2 give for the record a little bit of your experience with
3 jury trials? Kind of how many have you done over how many
4 years?

5 A The best -- I averaged 15 to 20 jury trials a year for 30
6 years. Sometimes a little more. Seldom less but I, I
7 don't know the number. I, I lost count at three or 400.

8 Q And these are both misdemeanor and felony level cases?

9 A Mostly felony. I did a few misdemeanors, but mostly
10 felony.

11 Q Would you say there have been a number of cases throughout
12 those 30 years where you have involved an expert witness?

13 A Yes.

14 Q Do you sometimes consult with expert witnesses that don't
15 end up testifying at trial?

16 A Yes.

17 Q And you indicated that you had a, a way that you went
18 about finding experts either through SADO or you would
19 search yourself?

20 A Yes.

21 Q Was there any difference in the way you would handle a
22 need for an expert between a retained case or a
23 court-appointed case?

24 A Well, yes, in a court-appointed case your client is
25 already determined that he's indigent and then you would

1 apply to the court prior to the ending of the motion
2 period for court-appointed expert.

3 Q And --

4 A And then, and then you get what the court allows you.

5 Q And as far as retained cases how was that different?

6 A Well, you're not indigent. You don't apply.

7 Q Have you ever sought court-appointed expert funds in a
8 case where you were retained?

9 A Not, not that I can remember ever.

10 Q And that would be because your client wasn't indigent,
11 correct?

12 A Well, also almost all my clients came up with what they
13 promised that they'd come up with.

14 Q If you could describe for the Court -- you've already kind
15 of touched on this, but explain to the Court what you did
16 to engage Mr. Bandak in this case as an expert?

17 A Well, my first was to find an expert. Back in -- my
18 memory of the events is that shaking baby syndrome was --
19 the technology or the, the type of testimony Mr. Bandak
20 was going to -- Doctor Bandak was going to provide was
21 leading edge technology. My research indicated that he
22 was on the forefront of that. There weren't a lot of
23 people willing to come forward and everything. Prior to
24 that it's just been acceptance of the doctors.

25 So I went to SADO. I don't remember if they

1 gave me the name. I went online and I found Doctor
2 Bandak. I called him. Um, I told him my client was going
3 to be raising the money. He asked me to send him copies
4 of the police report and the evidence, the Preliminary
5 Exam transcript and I did. And I had two or three more
6 conversations with him concerning what he thought of the
7 case. He thought that he could help me. He thought
8 that -- I, I believe his degree was in engineering and he
9 had done studies to show that it could actually have
10 occurred the way Mr. Ceasor had said it occurred.

11 During the course of that conversation I talked
12 to him about finances and indication was -- and, and I
13 believe. Again, I can't swear but I believe the initial
14 consultation and all the phone calls I had with him was
15 \$750.00 and I, I told him that Mr. Ceasor did not have a
16 lot of money. That he was possibly going to sell his car.
17 He had indicated buying it from a -- borrowing from his
18 parents or from a relative and based upon that I filed for
19 adjournments. I, I believe I filed a motion to adjourn so
20 that we'd have more time to raise money because Mr. Ceasor
21 was telling me he was going to get more money.

22 At that point I -- Doctor Bandak said that his
23 fee would be approximately \$1,500.00 a day plus expenses
24 and that's where the figure \$3,000.00 came up with. I
25 don't know where the \$10,000.00 is coming from. I've done

1 whole murder trials for less than \$10,000.00.

2 Q If Mr. Bandak had told you that it was going to cost ten
3 to \$20,000 to get involved in this case, would you have
4 pursued his expertise?

5 A I would have. I could -- honestly, I looked. I could not
6 find other experts that were willing to come forward and
7 testify. I, I probably would have been very concerned. I
8 thought Doctor Bandak's rates were reasonable given his
9 expertise in leading technology and, and I thought I had
10 an understanding that the money was going to be raised.

11 Q So his rates as you understood it were 750 for the initial
12 review and then somewhere in the neighborhood of 1500 per
13 day?

14 A Plus expenses.

15 Q Plus expenses.

16 So this ten to \$20,000.00 is not something that,
17 that Bandak told you?

18 A I have never had an expert, um, that was going to testify
19 in one single incident cost that much money. The only
20 other time that I had an expert that cost more than that
21 was an accounting expert where there was two days of
22 testimony and two weeks of preparation and it was
23 \$18,000.00. That's the most I've ever paid for an expert,
24 but never -- even doctors don't charge that much.

25 Q Doctor Bandak appeared interested in becoming involved in

1 this case, correct?

2 A He was very interested. It was why I continued to talk to
3 him even though I hadn't paid his initial fee yet.

4 Q And he was also willing to work with you as far as his
5 rates and potentially a payment arrangement?

6 A Yes, that's when I met with Mr. Ceasor and, again, I don't
7 know if the gentleman was there and said: I'm not worried
8 about my fee. I'm more worried about you and your future.
9 Let's get the money together for the expert. The payments
10 you're suppose to be making me, put them aside. We need
11 an expert.

12 Q Your representation of Mr. Ceasor what did you expect that
13 to cost? I know he paid you 2500 up-front, but what would
14 have typically been his bill at the end of the case?

15 A Jury trial depending on the length of the day and I, I
16 don't remember. This was maybe a two day trial. Figuring
17 \$1,000.00 roughly to \$1,500.00 a day. Probably four or
18 \$5,000.00.

19 Q Okay.

20 A Total bill. It might be less.

21 Q And you made it clear to him don't worry about saving for
22 me to pay me. Save up for your expert?

23 A Yes.

24 Q And did you ever -- I guess I was unclear.

25 Did you ever allocate any of that \$2,500.00 to

1 Doctor Bandak? Did you ever actually pay --

2 A No.

3 Q -- Doctor Bandak or did you just have --

4 A I don't remember.

5 Q You don't remember. Okay.

6 A I think I would have because --

7 Q He wouldn't have kept talking to you otherwise?

8 A No, because I -- you have certain integrity. If you talk
9 to people and they agree to do your services, then you pay
10 them for their services. It was -- I -- when I hired an
11 expert or did any other type of testing that I'd often do
12 prior to proceeding with a client, I paid that so it was
13 an attorney/client work privilege. That way it couldn't
14 be discoverable.

15 Q Okay. So you paid it out of your funds?

16 A It would have been -- if, if I paid him and again I don't
17 remember.

18 Q Okay.

19 A I think I did, but if, if I did it would have been out of
20 my funds.

21 Q Okay. That was your general practice?

22 A That was my practice because then I would -- there had
23 been some case law earlier on that indicated that if the
24 client hired the expert themselves that was not covered by
25 attorney/client work privilege and I never wanted to take

1 that chance so that's the way I did it.

2 Q Okay. Turning to your communication with Mr. Ceasor. I,
3 I don't think there's any dispute here you made it clear
4 to him that he needed this expert?

5 A Yes.

6 Q And did you give him -- what did you represent to him as
7 far as costs? Was it what you've testified to previously?

8 A Yes.

9 Q What did Mr. Ceasor tell you about coming up with this
10 money?

11 A Well Mr. Ceasor told me he was going to try to raise the
12 money, which is why I kept asking for adjournments.
13 Otherwise I wouldn't have represented to the court or
14 filed a motion for adjourn to give my client time to raise
15 the money.

16 Mr. Ceasor to my memory didn't tell me that we
17 weren't going to get the money just shortly before trial
18 after the Motion/Pre-Trial date had -- was cut off and
19 after I had requested numerous times for adjournments and
20 filed a motion to have more time.

21 Q Was seeking adjournments something that you typically did
22 with a case pending or --

23 A No.

24 Q Were those easy to get in this case?

25 A No.

1 I would not make those representations to the
2 court if I didn't believe my client was going to come up
3 with the money. I would not have filed a motion if I
4 didn't believe my client was not going to come up with the
5 money.

6 Q And are you meeting with Mr. Ceasor throughout this time,
7 throughout the Pre-Trial time and is he, is he still
8 telling you: I'm going to get the money. I'm going to
9 get the money?

10 A My memory of events Mr. Ceasor says I'm doing everything I
11 can to get the money. I liked Mr. Ceasor. I was angry
12 with Mr. Ceasor, but I liked him.

13 Q Did you believe Mr. Ceasor when he told you he was going
14 to come up with the money?

15 A Yes.

16 Q As part of your representation of Mr. Ceasor did you get
17 kind of an understanding of his income and his assets?

18 A Yes.

19 Q And his family situation?

20 A Yes.

21 Q Did you believe he was going to come up with that money?

22 A Yes.

23 Q You said you became angry with him. Why was that?

24 A It was a late notification of the fact that he wasn't
25 going to come up with the money.

1 Q Were you passed all of your motion dates as far as the
2 trial docket?

3 A Well passed.

4 Q Do you remember roughly how far in advance of trial he
5 actually came to you and said --

6 A It's an estimate. A couple weeks.

7 Q When he came to you, what did he say? How did he tell you
8 he wasn't going to get this money?

9 A I don't remember word for word, but roughly that -- Mr.
10 Ceasor always maintained his innocence to me. He was very
11 forthright in that, but he also indicated that at that
12 time that he didn't feel that he'd need an expert. That
13 he was a witness and that the jury would believe his
14 testimony. He'd be a good witness.

15 Q When Mr. Ceasor came to you and told you that he wasn't
16 going to come up with the money, what were your options at
17 that point?

18 A Go to trial. I was, I was -- I, I never thought of filing
19 a motion because I did not believe that Mr. Ceasor could
20 not -- honestly, I knew that Mr. Ceasor himself was too
21 poor to have the money, perhaps, but he had indicated he
22 was willing to borrow from his mother and his mother was
23 willing to give it to him. Whether or not that's true I
24 don't know, but that's what he represented. But he felt
25 he didn't want to put his mother in any further debt.

1 Q So, you were aware that Mr. Ceasor did have a job?

2 A Yes.

3 Q He could have made payments to you?

4 A Yes.

5 Q He could have made payments to Doctor Bandak?

6 A I was aware he had a job and had agreed to make payments.

7 Q Okay.

8 A Yes. I, I forego those payments in order for him to get
9 an expert witness.

10 Q And he -- did he ever come to you with even that \$750.00?

11 A No.

12 Q Not, not any money did he ever bring to you for the
13 expert?

14 A No. There were conversations about a car and that he was
15 going to get that and sell it and I believe there was
16 conversations that his employer was working with him and
17 there was a possibility that was going to occur and if it
18 didn't the last resort was going to be borrow from his
19 mother.

20 Q So there was some real concrete plans that Mr. Ceasor had.
21 It wasn't just: Hey, Mr. Lord, I'll come up with the
22 money somehow. I mean, he had some different options in
23 mind?

24 A Yes.

25 Q And he communicated those to you?

1 A Yes.

2 Q In terms of filing a motion with the court for funds for
3 an expert, did you feel that you could file such a motion?

4 A No.

5 Q Did you believe he was actually indigent and would have
6 met the standard?

7 A I believed that Terry felt in his mind he was indigent and
8 would have met the standards.

9 Q Okay. But as far as filing a motion you did not think
10 that that was an appropriate course of action?

11 A Well, there were a lot of factors involved. One is we
12 were well passed the Motion/Pre-Trial date. Two, I made
13 numerous representations based on Mr. Ceasor's
14 representation to me that there was. That close to trial
15 and it was a date certain definite trial I'd not be able
16 to get another adjournment and I never ever had the court
17 on a retained case grant a court-appointed payment for an
18 expert witness fee.

19 Q Did Mr. Ceasor ever tell you that he couldn't come up with
20 the money or was it a choice not to?

21 A My memory of the conversation was he didn't want to have
22 his mother go into debt for the loan. That he was
23 concerned about that. So, it was his choice not to ask
24 his mother for the loan.

25 Q And he brought this to your attention?

1 A A couple weeks before trial.

2 Q Whereas throughout the pendency of the case he had been
3 indicating he'd sell the car, he'd talked to mom, he would
4 come up with it?

5 A Yes. Well, he was trying other options to avoid going to
6 his mother.

7 Q Okay. Were you able to use any of the information that
8 you received from Doctor Bandak in your conversations
9 during trial in this case?

10 A Yes.

11 Q And how did you do that?

12 A I sidestepped scuffle. I used some of the information for
13 basis of cross-examination of the expert witnesses, but I
14 didn't have anything to come back with to backup what my
15 questions were.

16 In other words, I believe I questioned about how
17 do you measure the -- you know, how do we know on the
18 shaking baby syndrome because it's generally two
19 witnesses. The person that -- the victim who's usually
20 too young to testify and the accused. So, how do we know?
21 What kind of testing do you do to say if the baby fell
22 from three feet that they wouldn't receive this injury?
23 And I, I got that from Doctor Bandak and we'd discussed,
24 you know, what type of testing he would have used and what
25 type of testing he would have been brought to the table.

1 concerned because every time it was: Oh, I'm almost this.
2 I'm going to do that. Um, and then at the end I got
3 concerned and then I, you know, I don't know what brought
4 about the initial, um, disagreement. Whether it was me
5 saying: I got to have this money. I got to have it now
6 because I got Bandak on the line and he's ready to come.
7 I got the police report.

8 He was ready because I'd sent him all the
9 information. That's what the initial stuff was for. I
10 just had to make sure he was available for trial and I was
11 getting passed the point where I could have that occur.
12 If he had another trial going, then I would be -- and,
13 again, we were at a date certain now in my mind. Again,
14 I'm not sure it was a date certain. That I would have --
15 I wouldn't be able to get Bandak there because if he
16 was -- had another commitment on a trial I'd be out of
17 luck.

18 Q And when you say "date certain" are you referring to our
19 court's practice of if there have been several
20 adjournments at some point the Assignment Clerk puts it on
21 the docket and says this is a date certain?

22 A After -- yes. There, there came out and I, and I don't --
23 I wasn't involved in that end just from the trial aspect.
24 Trials started going through quicker because courts were
25 told --

1 relationship and one that is court-appointed. And you've
2 described a situation in the court-appointed situations
3 where a determination has already been made by the court
4 that a defendant is indigent. Therefore, a
5 court-appointed counsel is provided and in those
6 situations from time to time depending upon the case a
7 request for funds for an expert witness may be made. So,
8 that's the one situation as a general matter.

9 In the retained attorney/client relationship
10 you've indicated that you personally, if I understood your
11 testimony correctly, have never made a request for expert
12 witness funds claiming that even though I'm a retained
13 lawyer my client has indicated to me that he has no money.
14 He, therefore, qualifies as being an indigent person and
15 he would, therefore, be entitled to consideration for the
16 appointment of or at least the appropriation of funds to
17 go out and hire his own expert. Have you -- you've never
18 done that?

19 THE WITNESS: No.

20 THE COURT: All right.

21 THE WITNESS: I've never done that, your Honor.

22 THE COURT: And, and you practiced criminal law
23 in St. Clair County for upwards of 30 years?

24 THE WITNESS: Pretty close to 31.

25 THE COURT: Are you aware of anyone, any

1 colleague of yours, any other lawyers that you may have
2 observed on a Monday afternoon motion day having made such
3 a request?

4 THE WITNESS: I don't ever remember such a
5 ques -- I'm not saying it didn't happen, but to my
6 knowledge, no.

7 THE COURT: Okay. This may be somewhat of an
8 unfair question in light of the lack of knowledge to the
9 earlier question, but are you aware of the court and in
10 particular this particular court - at that time Judge
11 Adair would have been the presiding judge, my
12 predecessor - are you aware of Judge Adair or any of the
13 other judges in St. Clair County granting such a request?
14 Meaning, we have a retained attorney in a retained
15 attorney/client relationship that is now standing before
16 the court saying my client doesn't have any money. This
17 is a case where we need to hire an expert. I don't feel I
18 can safely proceed to trial without the benefit of an
19 expert. Are you aware of the court ever granting such a
20 request?

21 THE WITNESS: No. Even in court-appointed cases
22 you're limited to the amount of finances. I have been
23 court-appointed and asked for an expert witness is limited
24 to a 500 expenditure.

25 THE COURT: Kind of going -- let's go back to

1 and the medical concerns and things of that sort. Am I
2 hearing that correctly from what your research or contact
3 with SADO may have revealed?

4 THE WITNESS: I was unaware of any experts in
5 this area willing to testify against a doctor from the
6 Detroit area and Children's Hospital. I was unaware of
7 any other experts in that area.

8 And the difficulty quite frankly, your Honor, is
9 if you get a C list expert they can damage your case more
10 than they help it. But at that point I was also -- I
11 would have been reluctant going in front of the court
12 given all the representations I had made saying, you know,
13 we need more time. My client's raised the money. He's
14 going to do this. He's going to do that. Filing a motion
15 for stipulate adjourn. I didn't say: Oh, by the way my
16 client's broke and I knew this for five months. The
17 chances of me granting and having an expert granted were
18 slim to nonexistent. And if I would have then I would
19 have had an adjournment to start over with a new expert
20 because I'd already given him the prep materials to the
21 one I thought we'd agreed on hiring.

22 THE COURT: You anticipated my next question.

23 Knowing as you've testified how the case evolved
24 and the preparation evolved to the point where you
25 believed that funds were going to be available to hire

1 everything --

2 Q All right.

3 A -- in his power to come up with the money including borrow
4 the money from his mother. That was the last resort, Mr.
5 Moran.

6 Q The question --

7 A No, I never believed that Mr. Cesar was lying to me.
8 Never.

9 Q All right. My question is: Did you believe Mr. Ceasor
10 had a lot of money?

11 A No. No.

12 Q So you, you believed him that other people might have
13 money that could help him?

14 A I believed that Mr. Cesar could have put aside -- if he
15 was making 350 a week, he could have put aside 50 to
16 \$100.00 every pay period. We had over five months for him
17 to raise the money.

18 Q Yeah.

19 A I believe he could do that, yes.

20 Q Okay.

21 A I believed he would do that.

22 Q So if, if he puts aside \$50.00 a week for five months that
23 comes out to \$1,000.00; isn't that right?

24 A Yes.

25 Q That's not enough is it?

STATE OF MICHIGAN
IN THE CIRCUIT COURT FOR THE COUNTY OF ST. CLAIR

PEOPLE OF THE STATE OF MICHIGAN
Plaintiff,

-vs-

Case No. 05-000220-FH
HON. MICHAEL L. WEST

TERRY LEE CEASOR
Defendant.

OPINION AND ORDER

This matter is before the court pursuant to Defendant, Terry Lee Ceasor's motion for a new trial. Defendant, Terry Ceasor was convicted by a jury of first degree child abuse on December 17, 2005. He was sentenced by this Court's predecessor, Honorable James P. Adair to 2-15 years in state prison. Defendant appealed his conviction to the Court of Appeals. The Court of Appeals affirmed Defendant's conviction. After exhausting his state court appellate rights, Defendant sought relief in federal court on a writ of habeas corpus. At that time, the People of the State of Michigan were being represented by the Attorney General for the State of Michigan and not the St. Clair County Prosecutor's Office. A stipulation was entered into between the Attorney General and Defendant to grant the writ of habeas corpus and order the Michigan Court of Appeals to grant Defendant a new appeal of right because Defendant's appellate counsel failed to pursue a claim of ineffective assistance of trial counsel that the parties stipulated was likely to be successful. Pursuant to the stipulation, the United States District Court for the Eastern District of Michigan issued the order on May 12, 2017. On May 19, 2017 the Court of Appeals opened

CIRCUIT COURT FOR THE 31ST JUDICIAL CIRCUIT OF MICHIGAN

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CIRCUIT COURT FOR THE 31ST JUDICIAL CIRCUIT OF MICHIGAN

new direct appeal case under Docket No. 338431. Defendant filed the instant motion for a new trial pursuant to MCR. 7.208(B) alleging ineffective assistance of trial counsel.

The ineffective assistance claim

Defendant's claim of ineffective assistance of trial counsel involves the subject of a defense expert. Defendant claims his trial counsel was ineffective because he did not present the testimony of a defense expert to counter the prosecution's expert on the subject of shaken baby syndrome. Defendant relies heavily on the 2015 Supreme Court decision in *People v Ackley*, 497 Mich 381(2015) wherein the Supreme Court held it was ineffective assistance of counsel to proceed to trial in a shaken baby syndrome case without a defense expert. The question here is whether in 2005 trial counsel's failure to procure and present the testimony of a defense expert fell below an objective standard of reasonableness under *Strickland v Washington*, 466 US 668; 104 S Ct 2052 (1984).

The parties agree that Defendant's retained trial counsel recognized the importance of an expert in this case. A defense expert had been consulted and agreed to review the file without payment in anticipation of being retained on the file. After several adjournments of the trial date, Defendant advised his attorney the funds needed would not be available. Consequently, no expert was retained and Defendant proceeded to trial without a defense expert.

The sole question raised in Defendant's motion is whether Defendant's trial counsel's performance was objectively unreasonable when he did not seek funds from the Court to pay for a defense expert pursuant to MCL 775.15. Because that question could not be answered without additional facts, on August 30, 2017 this Court entered an order directing that an evidentiary hearing be conducted consistent with *People v Ginther*, 390

Mich 436(1973) to determine whether the first prong of the *Strickland* standard could be met. If the first prong could be satisfied, further evidence would be needed to decide if the prejudice requirement could also be met.

An evidentiary hearing was conducted on September 21, 2017. The Court heard testimony from four witnesses.

The Ginther Hearing Testimony

Defendant offered the testimony of two witnesses in addition to his own testimony to establish that he was indigent and had limited financial resources in 2005. Despite his claimed indigence in 2005 Defendant did not request court appointed counsel because his mother had retained two different lawyers. His first attorney was Attorney David Black. Mr. Black was retained prior to the preliminary examination and was paid \$1,000 by Defendant's mother, Diana Hastings. Black's services were terminated after the preliminary exam for reasons that are unknown. Defendant then retained the services of Attorney Kenneth Lord. Ms. Hastings testified she paid Mr. Lord a retainer of \$2,500. She testified she paid Mr. Lord not knowing what the scope of the representation would ultimately be.

Ms. Hastings was aware that Defendant and Mr. Lord had been discussing retaining a defense expert in the case. She testified her son told her the defense expert was going to cost \$10,000, but he never asked for money to pay the expert. Ms. Hastings testified that at no time did she suggest to her son that he obtain court appointed counsel. Defendant testified he never asked his mother for the money because she didn't have any more money to give.

Mr. Lord testified that he practiced criminal law for over 30 years and that criminal law represented 95% of his practice. He tried 15-20 jury trial cases per year. He knew the importance of an expert witness and it was discussed at length with Defendant.

Mr. Lord knew that Defendant did not have sufficient resources of his own to hire Dr. Bandak, the expert Mr. Lord had consulted with and who was willing to take the case. Based on his discussions with Dr. Bandak, Lord indicated to the Defendant he was willing to wait for the balance of his fee so the Defendant could focus on raising money for the defense expert. Lord testified Mr. Ceasor said he was going to work on getting the money.

Mr. Lord believes Dr. Bandak's anticipated trial fees were less than the \$10,000 testified to by Defendant's mother. Lord estimated the total fees to be in the \$4,000-\$5,000 range. It broke down as an initial \$750, then \$1,500 per day plus expenses. Mr. Lord testified Defendant kept telling him he was going to try to raise the money. Because of his personal financial situation Lord knew Defending would be likely seeking help from his family.

While these discussions were taking place Defendant's scheduled trial date was fast approaching. Mr. Lord testified that he sought several adjournments of the trial date from the prosecutor and the Court to allow Defendant more time to raise the money. Mr. Lord represented to the Court the adjournments were needed because Defendant was trying to raise funds for the defense expert and needed more time. It was not until approximately two weeks before a date certain trial date that Defendant informed Mr. Lord he couldn't get the money because he didn't want to put his mother in debt. By this time, Lord testified the trial date had been adjourned several times and the motion cut-off date had

long since passed. Lord did not file a motion asking the Court to allocate funds to hire a defense expert.

Lord testified that he also worked as a court appointed defense attorney and in that capacity he had petitioned the Court for funds to hire experts. He said in those situations the question of indigency had already been determined. He testified that when a Defendant had retained counsel he was not considered to be indigent, and you didn't apply. In over 30 years of practice as a criminal defense attorney Lord testified he never filed a motion for the expenditure of public funds to hire an expert on behalf of a client who retained him. Lord further testified that during his career as a defense attorney he is not aware of any of his colleagues filing such a motion or the Court in St. Clair County granting such a motion.

Portions of the Defendant's trial counsel's testimony are important to highlight in order to fully understand the thought processes of trial counsel and the pre-trial and trial strategy employed.

By Mr. Moran:

Q. But you don't dispute the accuracy of what he said about how what you, you would have said that the expert's more important than your fee?

A. As far as that, no, I, I don't dispute that. I made that clear to Terry Ceasor right from the outset.

Q. Okay, Now you did consult with an expert Doctor Bandak; is that right?

A. I did not remember his name until you called me and, yes, I did. On multiple occasions.

Q. And we've heard the number \$1,500.00. Was that Mr. Bandak's or Doctor Bandak's fee? Initial consulting fee?

A. I don't remember it being \$1,500.00. I remember it being approximately \$750.00 to do the initial review and report. And then we had discussed and explained Mr. Ceasor's situation and Mr. Bandak or Doctor Bandak had indicated that he would work with me of the fee.

Q. Okay. But it was going to be more?

A. Absolutely.

Q. And did you ever end up paying Doctor Bandak more?

A. No. (Transcript pg. 7).

By Ms. Georgia:

Q. No. I, I guess I want to start with, with where Mr. Moran left off. He read you a couple portions of the transcript where you indicated to the jury that, that Mr. Ceasor couldn't afford and expert. Why did you do that?

A. Well, there are a couple of reasons. When you're preparing for trial, you develop a trial strategy. Um, and given the nature of what had occurred about the expert witness I was left without what I thought was going to be provided to me and I wanted to do two things. One, I wanted to put -- you know, engender sympathy towards my client. I, I viewed Terry as a hard working individual that would come across to the jury as a hard working individual and often when you're getting a jury especially in an area like in St. Clair County you want them to understand that coming up with money is difficult situation. And that that way we could go after the expert witness without having someone to combat and combat that. So, it was part of my trial strategy. (Transcript pgs. 11, 12).

Q. Was there any difference in the way you would handle a need for an expert between a retained case or a court-appointed case?

A. Well, yes, in a court-appointed case your client is already determined that he's indigent and then you would apply to the court prior to the ending of the motion period for court-appointed expert.

Q. And --

A. And then, and then you get what the court allows you.

Q. And as far as retained cases how was that different?

A. Well, you're not indigent. You don't apply.

Q. Have you ever sought court-appointed expert funds in a case where you were retained?

A. Not, not that I can remember ever.

Q. And that would be because your client wasn't indigent, correct?

A. Well, also almost all my clients came up with what they promised that they'd come up with. (Transcript pgs. 13, 14).

Q. If you could describe for the Court -- you've already kind of touched on this, but explain to the Court what you did to engage Mr. Bandak in this case as an expert?

A. Well, my first was find an expert. Back in -- my memory of the events is that shaking baby syndrome was -- the technology or the, the type of testimony Mr. Bandak was going to -- Doctor Bandak was going to provide was leading edge technology. My research indicated that he was on the forefront of that. There weren't a lot of people willing to come forward and everything. Prior to that it's just been acceptance of the doctors.

So I went to SADO. I don't remember if they gave me the name. I went online and I found Doctor Bandak. I called him. Um, I told him my client was going to be raising the money. He asked me to send him copies of the police report and the evidence, the Preliminary Exam transcript and I did. And I had two or three more conversations with him concerning what he thought of the case. He thought that he could help me. He thought that -- I, I believe his degree was in engineering and he had done studies to show that it could actually have occurred the way Mr. Ceasor had said it occurred.

During the course of that conversation I talked to him about finances and indications was -- and, and I believe. Again, I can't swear but I believe the initial consultation and all the phone calls I had with him was \$750.00 and I, I told him that Mr. Ceasor did not have a lot of money. That he was possibly going to sell his car. He had indicated buying it from a -- borrowing from his parents or from a relative and based upon that I filed for adjournments. I, I believe I filed a motion to adjourn so that we'd have more time to raise money because Mr. Ceasor was telling me he was going to get more money.

At that point I -- Doctor Bandak said that his fee would be approximately \$1,500.00 a day plus expenses that that's where the figure \$3,000.00 is coming from. I've done whole murder trials for less than \$10,000.00. (Transcript pgs. 14, 15).

Q. What did Mr. Ceasor tell you about coming up with this money?

A. Well Mr. Ceasor told me he was going to try to raise the money, which is why I kept asking for adjournments. Otherwise I wouldn't have represented to the court or filed a motion for adjourn to give my client time to raise the money.

Mr. Ceasor to my memory didn't tell me that we weren't going to get the money just shortly before trial after the Motion/Pre-Trial date had -- was cut off and after I had requested numerous times for adjournments and filed a motion to have more time.

Q. Was seeking adjournments something that you typically did with a pending case or --

A. No.

Q. Were those easy to get in this case?

A. No.

Q. Can you tell me why?

A. Yeah.

Q. Not a loaded question.

A. Under oath. I'm I'm not the Prosecutor's Office favorite person. I guess I can be a bit contentious on behalf of my clients at time, but I was able to get the cooperation of the Prosecutor's Office on this particular case.

Q. So you were able to get these adjournments --

A. Yes.

Q. -- under the understanding it was for the Defendant to come up with some money?

A. Yes.

Q. Did you make those kids of representations to the prosecutor and the court?

A. My memory is I actually filed a motion that was, that was the basis for the reason but, yes, I made those representations to the Prosecutor's Office. I made the representations it would have been in chambers with the court when we -- if -- a typical trial roll call might be four or five trials and we'd go in and, and the court would talk with, with us. Any chance of a resolution and I would say, you know, your Honor, we wouldn't mind an adjournment because -- and we need more time to raise money for an expert witness and the court would give it to me.

I would not make those representations to the court if I didn't believe my client was going to come up with the money. I would not have filed a motion if I didn't believe my client was not going to come up with the money.

Q. And are you meeting with Mr. Ceasor throughout this time, throughout the Pre-Trial time and is he, is he still telling you: I'm going to get the money. I'm going to get the money?

A. My memory of events Mr. Ceasor says I'm doing everything I can to get the money. I liked Mr. Ceasor. I was angry with Mr. Ceasor, but I liked him.

Q. Did you believe Mr. Ceasor when he told you he was going to come up with the money?

A. Yes. (Transcript pgs. 18- 21).

Q. You said you became angry with him. Why was that?

A. It was a late notification of the fact that he wasn't going to come up with the money.

Q. Were you passed all of your motion dates as far as the trial docket?

A. Well passed

Q. Do you remember roughly how far in advance of trial he actually came to you and said --

A. It's an estimate. A couple of weeks.

Q. When he came to you, what did he say? How did he tell you he wasn't going to get this money?

A. I don't remember word for word, but roughly that -- Mr. Ceasor always maintained his innocence to me. He was very forthright in that, but he also indicated that at that time that he didn't feel that he'd need an expert. That he was a witness and that the jury would believe his testimony. He'd be a good witness.

Q. When Mr. Ceasor came to you and told you that he wasn't going to come up with the money, what were your options at that point?

A. Go to trial. I was, I was -- I, I never thought of filing a motion because I didn't not believe that Mr. Ceasor could not -- honestly, I knew that Mr. Ceasor himself was too poor to have the money, perhaps, but he had indicated he was willing to borrow from his mother and his mother was willing to give it to him. Whether or not that's true I don't know, but that's what he represented. But he felt he didn't want to put his mother in any further debt. (Transcript pgs. 21, 22).

Q. In terms of filing a motion with the court for funds for an expert, did you feel that you could file such a motion?

A. No.

Q. Did you believe he was actually indigent and would have met the standard?

A. I believe that Terry felt in his mind he was indigent and would have met the standards.

Q. Okay. But as far as filing a motion you did not think that that was an appropriate course of action?

A. Well, there were a lot of factors involved. One is we were well passed the Motion/Pre-Trial date. Two, I made numerous representations based on Mr. Ceasor's representations to be that there was. That close to trial and it was a date certain definite trial I'd not be able to get another adjournment and I never ever had the court on a retained case grant a court-appointed payment for and expert witness fee.

Q. Did Mr. Ceasor ever tell you that he couldn't come up with the money or was it a choice not to?

A. My memory of the conversation was he didn't want to have his mother go into debt for the loan. That he was concerned about that. So, it was his choice not to ask his mother for the loan.(Transcript pgs. 23, 24).

Q. Was there any point prior to that two week mark before the trial when he came to you and said: I am not going to be able to do this. I cannot afford this?

A. No. I would have not gone repeatedly in front of the court nor filed a motion if my client told me he couldn't come up with the money. I, I would lose all integrity with the court and that's where I make my living, or did. (Transcript pg. 27).

By the Court:

You talked about it somewhat and my initial question is really general in scope, but you've talked about the difference between a retained attorney/client relationship and one that is court-appointed. And you've described a situation in the court appointed situations where a determination has already been made by the court that a defendant is indigent. Therefore, a court-appointed counsel is provided in those situations from time to time depending upon the case a request for funds for an expert witness may be made. So, that's the one situation as a general matter.

Is the retained attorney/client relationship you've indicted that you personally, if I understood your testimony correctly, have never made a request for expert witness funds claiming that even though I'm a retained lawyer my client has indicated to me that he has no money. He, therefore, qualifies as being an indigent person and he would, therefore, be entitled to consideration for the appointment of or at least the appropriation of funds to go out and hire his own expert. Have you -- you've never done that?

THE WITNESS: No.

THE COURT: All right.

THE WITNESS: I've never done that, your Honor.

THE COURT: And, you've practiced criminal law in St. Clair County for upwards 30 years?

THE WITNESS: Pretty close to 31.

THE COURT: Are you aware of anyone, any colleague of yours, any other lawyers that you may have observed on a Monday afternoon motion day having made such a request?

THE WITNESS: I don't ever remember such a ques -- I'm not saying it didn't happen, but to my knowledge, no.

THE COURT: Okay. This may be somewhat of an unfair question in light of the lack of knowledge to the earlier question, but are you aware of the court and in particular this particular court -- at that time Judge Adair would have been presiding judge, my predecessor -- are you aware of Judge Adair or any of the other judges in St. Clair County granting such a request? Meaning, we have a retained attorney in a retained attorney/client relationship that is now standing before the court saying my client doesn't have any money. This is a case where we need to hire an expert. I don't feel I can safely proceed to trial

without the benefit of an expert. Are you aware of the court every granting such a request?

THE WITNESS: No. Even in court-appointed cases you're limited to the amount of finances. I have been court-appointed and asked for an expert witness is limited to a 500 expenditure.

THE COURT: Kind of going -- let's go back to that just for a second.

So your, your understanding in a court-appointed situation is even though I have a greater chance or at least I -- because the question of indigency has already been determined by the court at the forefront of the case I -- there's a chance that I might be successful in having some funds appropriated, but it's going to be a limited amount?

THE WITNESS: That's been my experience.

THE COURT: And I guess we could all agree that there are the A list experts, there are B list experts, and there might be a C list experts and maybe on down the line. The expert that you had been in contact with I, I know I've heard it several times, but I'm not sure that I --

THE WITNESS: Doctor Bandak.

THE COURT: Doctor Bandak. Where would you put him in terms of A list, B list, C list, and that kind of thing?

THE WITNESS: He would -- my reading -- again, this is going what I've learned off the Internet and talking to SADO he was A plus. He was cutting edge in a field that's now more fully developed that these injuries can, indeed, occur in the ways that are inconsistent with what the doctors have been testifying to.

THE COURT: Has it been your experience that the A list or the A plus experts, A plus list experts are more expensive than the B, C D, E list experts?

THE WITNESS: Yes

THE COURT: If you were to have been appro -- let's -- assuming that you made the request that the, the Defendant and, and his counsel in this case assert that you should have made to go before the court and ask for public funds to retain your own private expert. Knowing what the typical amount was granted in court-appointed expert -- court-appointed attorney cases, the other relationship, would appropriation as you understand it to typically be would that have been sufficient to retain the services of Doctor Bandak?

THE WITNESS: No. Doctor Bandak's original fee was higher than the \$1,500.00 we talked about spending. Doctor -- I, I really enjoyed talking -- he wasn't like a lot of typical experts I talked to. He actually gave freely of his time and advice and seemed genuinely concerned in the outcome of Mr. Ceasor's trial. So, we did negotiate. Otherwise I think he probably would have been more.

THE COURT: It sounds like the pool of available experts in this particular area was somewhat limited at, at that time simply because of the nature of the issues and the medical concerns and things of that

sort. Am I hearing that correctly from what your research or contact with SADO may be revealed?

THE WITNESS: I was unaware of any experts in this area willing to testify against a doctor from the Detroit area and Children's Hospital. I was unaware of any other experts in that area.

And the difficulty quite frankly, your Honor, is if you get a C list expert they can damage your case more than they help it. But at that point I was also -- I would have been reluctant going in front of the court given all the representations I had made saying, you know, we need more time. My client's raised the money. He's going to do this. He's going to do that. Filing a motion for stipulate adjourn. I didn't say: Oh, by the way my client's broke and I knew this for five months. The chances of me granting and having an expert granted were slim to nonexistent. And if I would have then I would have had an adjournment to start over with a new expert because I'd already given him the prep materials to the one I thought we agreed on hiring. (Transcript pgs. 37-42).

Analysis

The ineffective assistance issue presented here is far more narrow than originally presented in Defendant's motion. The importance of a defense expert is not disputed. Because it is not disputed, Defendant's reliance on *People v Ackely*, 497 Mich 381 (2015) is overstated. However, *Ackely* is still important to the analysis. While it was unclear at the outset of the hearing what the evidence would be regarding Defendant's personal finances, Mr. Lord did not quarrel with Defendant's evidence and believed in 2005 Defendant did not have funds of his own to hire an expert.

In *Ackely* the defendant was indigent and had court appointed counsel. The situational differences presented by a retained attorney client relationship and the implications a motion for allocation of public funds to hire a defense expert present, did not exist in *Ackely*. Moreover, *Ackely* established a minimum or threshold standard of performance for an attorney in a shaken baby syndrome case that did not exist in 2005. These differences must be factored into the analysis of whether Defendant's trial counsel's

performance fell below an objective standard of reasonableness when he did not request public funds to hire an expert.

The testimony of Defendant's trial counsel establishes he was expecting the expert he had consulted would be hired. He testified repeatedly the Defendant told him he was trying to get the money. Based upon those representations trial counsel sought and obtained several adjournments of the scheduled trial dates. The requested adjournments were based on representations to the Court that more time was needed to get the funds to hire the expert. It was not until approximately two weeks before a date certain trial date that Defendant informed his trial counsel he was not going to be able to get the money because he didn't want to put his mother in debt. According to his trial counsel, Defendant further represented they should be okay without an expert, or words to that effect.

Defendant's current counsel is critical of trial counsel because he contends a motion for witness fees still could have been filed pursuant to MCL 775.15 even if it was not likely to be granted. It is not clear whether defense counsel is suggesting a motion should have been filed immediately once the need for an expert had been determined, after some indeterminate period of time passed without funds being raised, or after it became clear funds would not be available. Theoretically, a motion could have been filed at any time. But that is not the question. The question is whether trial counsel, based upon the totality of the circumstances, was constitutionally ineffective for not filing a motion he believed had no chance of being successful.

In this case, trial counsel recognized the importance of a defense expert and expressed that importance to Defendant. Defendant and trial counsel differ on what the expert was going to cost, but it is clear Defendant was looking into raising the money and

talked with his mother about it. Defendant testified she didn't have any more money to give him. Whether Defendant's mother had the money, had some money or was willing to help in getting the money was never established. Defendant was not examined about the extent of his fund raising efforts with his mother or others, or when or how it was determined she had no more money to give him. Defendant's mother, Diana Hastings testified her son told her the expert would cost \$10,000, but she testified he never asked for her for any money. Ms. Hastings never testified that she did not have the money or could not help. This testimony provides credibility and support for Defendant's trial counsel's testimony that he reasonably believed Defendant was trying to raise the money and that he did not inform his attorney it was not going to happen until just before a hard trial date.

The evidence presented during the hearing fails to establish Defendant's trial counsel's performance fell below an objective standard of reasonableness. Those who practice criminal defense law both as court appointed counsel and retained counsel, generally recognize differences when it comes to the availability of public resources to advance a particular strategy or goal. While there is no true presumption of non-indegency simply because one has a retained defense attorney, the perception still exists. Because the perception is real, it is not unreasonable for retained defense counsel to believe they would not be successful in obtaining public funds to retain a defense expert even if the client's indegency could be established. This perception is re-enforced when the history of practice in the local jurisdiction is such that defense counsel have no reasonable expectation to believe such a motion would be successful, or if successful, sufficient in amount. This Court's knowledge of the history of criminal defense practice in St. Clair

County at that time and a request for public funds for defense experts is consistent with Mr. Lord's testimony, both as to the court appointed and retained forms of representation.

This case requires the additional considerations of a stated desire and attempt to secure private funds for a particular expert in a cutting edge field, and a reasonable expectation funds those would be available without the dollar amount limitations typically involved when public funds are appropriated. Trial counsel was in a box when he was informed by Defendant at the 11th hour he would not be able to get the necessary funds, after having secured several adjournments of trial based upon representations more time was needed to get the money. At that point, Defendant stated he was prepared to proceed without an expert, according to Mr. Lord's testimony, and accept the associated risks.

It can be argued that recent decisions of the Michigan Supreme Court and Michigan Court of Appeals are now requiring trial courts to more closely examine the need for a requested defense expert and the payment of reasonable compensation. However, these requests almost universally involve indigent defendants with court appointed attorneys. If this case would have been tried today, the decision in *People v Ackely*, 497 Mich 381 (2015) could likely require a finding of ineffective assistance of trial counsel. It can now be argued a new threshold standard of reasonableness now applies in a shaken baby syndrome case that did not exist in 2005. Because of *Ackely*, courts that might have routinely denied funds for experts for defendants with retained attorneys should now be required to reconsider that position in a shaken baby syndrome case. The distinctions and circumstances that this Court finds fails to support a finding of ineffective assistance of counsel in Defendant's 2005 representation may no longer be considered reasonable

today. But in 2005, trial counsel cannot be charged with the knowledge or expectation that ten years later, in 2015, the Supreme Court would rule as it did in *Ackley*.

For the reason's stated above, Defendant's motion for a new trial is DENIED.

February 1, 2018



Michael L. West
Circuit Judge

CIRCUIT COURT FOR THE 31ST JUDICIAL CIRCUIT OF MICHIGAN

and could have challenged the prosecution's expert. Because trial counsel for the Defendant, Ken Lord, did not ultimately present an expert witness to the jury, the Defendant claims he was denied effective assistance of trial counsel. The Defendant asserts that despite retaining his trial counsel, he was indigent, and therefore his retained attorney should have sought public funds for an expert, or found an expert that would take the case *pro bono*.

There are a few aspects of this case that are not in dispute after the evidentiary hearing held in the trial court. First, the Defendant needed an expert to testify that the victim's injuries could have been caused by something other than abuse. Second, trial counsel consulted with an expert who was willing to assist with the case. Where the parties disagree is the question of whether Mr. Lord's representation should be deemed constitutionally deficient because he did not seek court funding in light of the representations and decisions made by the Defendant and the circumstances surrounding payment of the expert witness.

1. Trial counsel was constitutionally effective in his search for and consultation with an expert witness for the Defendant.

Whether the Defendant was denied effective assistance of counsel requires this Court to evaluate both counsel's decisions, and their effect on the ultimate outcome of the trial. The Defendant must show that: (1) counsel's performance was below an objective standard of reasonableness under professional norms; and (2) there is a reasonable probability that, if not for counsel's errors, the result would have been different and the result that did

Prosecutor's Court of Appeals Brief

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treatises about the medical diagnoses at issue. *Id.* at 386. Counsel's actions (or lack thereof) in *Ackley* are in stark contrast to this case, where Mr. Lord advised the Defendant that he needed an expert. Mr. Lord contacted an expert, and had that expert's cooperation. He would have called him as a witness, but for the fact that the Defendant would not pay for him.

In *Hinton*, the United States Supreme Court held that trial counsel was ineffective for failing to request additional funds to hire a different expert upon learning that the defendant's current expert was inadequate. Counsel in *Hinton* did not realize that he could seek reimbursement under state statute for any expenses reasonably incurred in the defense of the case. The *Hinton* case differs from the case before this Court because, again, the defendant in *Hinton* was indigent and was therefore provided with funding by the state if needed.

There is no dispute in this case that the Defendant's trial counsel recommended an expert witness, and saw the importance of such a witness to the outcome of the case. On April 1, 2005, the parties stipulated to adjourn the trial, then scheduled for April 5, 2005, for the express reason that "defense counsel is currently seeking an independent Medical Expert Witness. . . ." ¹¹⁵ Further, trial counsel sought another adjournment of the trial, now scheduled for May 17, 2005:

Defense counsel has spoken to and forwarded materials to Dr. Faris Bandak, an expert in the field of injury biomechanics, who resides in Potomac, Maryland. Dr. Bandak has been qualified as an expert in shaken baby

¹¹⁵Stipulation and Order of April 1, 2005.

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Prosecutor's Court of Appeals Brief

At any time during this case, the Defendant could have claimed indigency. The People have never questioned that he may have been entitled to proceed as an indigent person. The difficulty in this case is that he never sought to proceed in that manner. The Defendant wanted retained counsel of his choosing throughout the case:

Q Why didn't you apply for a court-appointed attorney?

A 'cause my mom got me a lawyer.

Q Did you talk to your mom about the expense of that and how long this case may take?

A No.

Q What was your understanding of the arrangement with Mr. Black? Was he going to represent you from the beginning of the case all the way through to the end?

A No.

Q Explain to me what your understanding was?

A Um, Dave Black was at court when I went -- when the -- when this first started and he wasn't going to let me go into court without counsel is -- that's what that was.

Q So, what was your agreement with him?

A I had no agreement with Dave Black.

Q So you had no agreement, but your mom paid \$1,000.00?

A My mom paid that with them.

Q So what did she pay it for? She just handed Dave Black --

A No no no. She retained David Black, but I fired David Black.

STATE OF MICHIGAN
COURT OF APPEALS

PEOPLE OF THE STATE OF MICHIGAN,

Plaintiff-Appellee,

v

TERRY LEE CEASOR,

Defendant-Appellant.

UNPUBLISHED
May 23, 2019

No. 338431
St. Clair Circuit Court
LC No. 05-000220-FH

Before: REDFORD, P.J., and MARKEY and K. F. KELLY, JJ.

PER CURIAM.

From an order directing this Court to grant defendant a "new direct appeal" entered by the federal district court in defendant's habeas proceeding, defendant, Terry Lee Ceasor, seeks review of his conviction of first-degree child abuse, MCL 750.136b(2), for which he was sentenced to serve 2 to 15 years' imprisonment. Presently before this Court is a claim that trial counsel provided ineffective assistance by failing to either obtain public funding to hire an expert that would have supported his theory of the case, or alternatively, by failing to find an expert willing to provide services pro bono. For the reasons stated below, we affirm.

I. PROCEDURAL HISTORY

Following defendant's 2006 conviction, he appealed and among other issues asserted that his retained trial counsel, Kenneth Lord, provided ineffective assistance by failing to obtain the testimony of an expert who could have challenged the prosecutor's expert, Dr. Holly Gilmer-Hill, regarding whether the victim's injuries were the result of intentional abuse as opposed to an accidental fall from a short distance. Noting that defendant had not sought an evidentiary hearing¹ to establish a factual record to support his claim, this Court concluded from the available record that defendant's claim failed. *People v Ceasor*, unpublished per curiam opinion

¹ *People v Ginther*, 390 Mich 436; 212 NW2d 922 (1973).

of the Court of Appeals, issued July 12, 2007 (Docket No. 268150). Our Supreme Court denied defendant's application for leave to appeal. *People v Ceasor*, 480 Mich 926 (2007).

Defendant sought a writ of habeas corpus in the federal district court in 2008. That proceeding spanned nearly a decade. The court held the habeas petition in abeyance while defendant sought relief under Subchapter 6.500 of the Michigan Court Rules. After that failed,² defendant returned to the federal district court which initially denied relief but the Sixth Circuit Court of Appeals reversed in 2016. *Ceasor v Ocwieja*, 655 Fed Appx 263 (CA 6, 2016). In a lengthy decision, the court concluded that defendant's appellate counsel's performance was deficient because he (1) did not file a separate motion seeking a remand to the trial court in defendant's direct appeal, (2) did not provide an affidavit or offer of proof in support of such a motion as is required by MCR 7.211(C)(1)(a), and (3) stated in his appellate brief that the question of trial counsel's effectiveness could be decided on the existing record. *Id.* at 279-282. The Sixth Circuit remanded the matter to the federal district court with directions that it hold an evidentiary hearing and decide whether appellate counsel's failures caused defendant prejudice. *Id.* at 290. The Sixth Circuit directed the district court that if it found prejudice it must conditionally grant the writ of habeas corpus "to allow the state courts to consider a new appeal or a renewed request for a *Ginther* hearing" *Id.* at 289-290. If the district court found no prejudice, then it could deny further relief. *Id.* at 290.

On remand to the federal district court, the parties obviated the need for an evidentiary hearing by entering a stipulated order stating that "appellate counsel's deficient performance prejudiced Petitioner because appellate counsel failed to litigate in state court a claim of ineffective assistance of trial counsel that was reasonably likely to succeed." The court "made no finding on whether the underlying claim of ineffective assistance of trial counsel [would] ultimately succeed." The order directed this Court to, "within 60 days, grant the Petitioner a new direct appeal of right."

This Court duly opened the present claim of appeal on May 19, 2017. Defendant then filed a motion for a new trial in the trial court pursuant to MCR 7.208(B)(1). The trial court held an evidentiary hearing and denied the motion, concluding that Lord's representation was not objectively deficient. Defendant now argues that the trial court erred and that Lord provided ineffective assistance for failing to seek public funds to hire an expert witness under MCL 775.15, or alternatively, by failing to seek the assistance of an expert who would have provided services pro bono. We disagree with the defendant. We affirm defendant's conviction and sentence.

² See *People v Ceasor*, unpublished order of the Court of Appeals, entered October 4, 2011 (Docket No. 304703) (denying leave to appeal "for failure to meet the burden of establishing entitlement to relief under MCR 6.508(D)."), and *People v Ceasor*, 491 Mich 908 (2012) (denying leave to appeal for the same reason).

II. ANALYSIS

A. STANDARD OF REVIEW

A claim of ineffective assistance of counsel presents a mixed question of fact and constitutional law. *People v Carll*, 322 Mich App 690, 702; 915 NW2d 387 (2018). The trial court's factual findings are reviewed for clear error, while the ultimate constitutional issue is reviewed de novo. *People v Swain*, 288 Mich App 609, 643; 794 NW2d 92 (2010).

B. BACKGROUND

Defendant's convictions arose out of head injuries sustained by BG, an approximately 17-month-old child on October 3, 2004. On this day, while BG was in the sole care of defendant, BG's mother's boyfriend at the time, BG suffered injuries to his head serious enough to cause him to lose consciousness and require immediate emergency medical attention.

At trial, the court qualified Dr. Gilmer-Hill, as the prosecution's expert in shaken baby syndrome (SBS). She testified that BG's injuries resulted from intentional abuse and would not be consistent with an accidental fall from a short distance. Defendant testified that the child apparently fell during his absence from the room. Defendant presented no expert testimony to contradict Dr. Gilmer-Hill. The jury deliberated for an extended period but eventually convicted defendant.

The record reflects that before defendant's trial, Lord consulted with Dr. Faris Bandak who had a background in engineering. Dr. Bandak reviewed materials sent to him by Lord, and was prepared to testify that the victim's injuries could have occurred as defendant stated. Lord consulted with defendant regarding the importance of Dr. Bandak's testimony. Defendant assured Lord that he would obtain funds to pay Dr. Bandak's fees for trial testimony, but later just before trial informed Lord that he lacked the funds necessary to pay Dr. Bandak's fee, and as a result, defendant went to trial without an expert to support his theory.

Some understanding of the history of SBS, or the now-preferred term, abusive head trauma (AHT), helps to put this matter in context. The debate over SBS/AHT diagnoses has a lengthy history, with experts still coming to differing conclusions regarding whether injuries, such as those sustained by the victim in this case, are unique to intentional abuse. See *Sissoko v State*, 236 Md App 676, 717-725; 182 A3d 874 (2018). As the Maryland Court of Appeals explained in *Sissoko*, "In the latter decades of the 20th century, it became widely accepted in the involved medical communities that shaking was the likely mechanism of brain injury when infants and young children presented with subdural hematomas, retinal hemorrhages, and brain swelling, but without external evidence of trauma or a reported history of a significant traumatic event." *Id.* at 718-719. But "[t]here were some in the biomechanical scientific community who disputed that shaking could produce forces sufficient to cause the injuries seen in shaken baby syndrome cases[.]" *Id.* at 719. These studies were not without their critics. "When scientists altered the models . . . they found that shaking *does* exceed injury thresholds, to the extent those thresholds can be calculated with any precision." *Id.* at 719 n 33. But there were some who "began to consider whether impact on a soft surface, independent of or in combination with shaking, also could be a mechanism for some of the intracranial findings in abuse cases." *Id.* at

720. “It remains the prevailing view within the relevant medical communities that there are some internal findings that are highly correlated with abusive head trauma, even in the absence of external findings; and when those internal findings are coupled with an inconsistent clinical history or one that is inadequate to explain them, and cannot be explained medically, a diagnosis of abusive head trauma is supported.” *Id.* at 722.

The main controversy over abusive head trauma involves a minority of physicians and other scientists who posit that changes in the understanding of the biomechanics of shaking, coupled with evidence that the confluence of subdural hematomas, retinal hemorrhages, and brain swelling is not unique to abusive head trauma, make it impossible to reliably conclude that any particular child’s injuries or death were caused by inflicted (non-accidental) trauma, as opposed to accidental trauma or medical causes, such as clotting disorders. [*Id.* at 725.]

The United States Supreme Court has explained that in the late 1990s and early 2000s, doubt “increased in the medical community over whether infants can be fatally injured through shaking alone.” *Cavazos v Smith*, 565 US 1, 13; 132 S Ct 2; 181 L Ed 2d 311 (2011) (quotation marks and citation omitted). The United States Supreme Court referenced Dr. Bandak’s published 2005 study in which he wrote, “ ‘Head acceleration and velocity levels commonly reported for SBS generate forces that are far too great for the infant neck to withstand injury [A]n SBS diagnosis in an infant . . . without cervical spine or brain stem injury is questionable and other causes of the intracerebral injury must be considered.’ ” *Id.*, quoting Bandak, *Shaken Baby Syndrome: A Biomechanical Analysis of Injury Mechanisms*, 151 *Forensic Sci Int*’1 71, 78 (2005). The Supreme Court noted that several other studies and articles written from 2003 to 2008 concluded that one could not assume that certain types of head injuries were solely indicative of child abuse. *Cavazos*, 565 US at 13-14 (collecting articles).

In this case, Lord contacted Dr. Bandak, whose opinions regarding SBS/AHT supported defendant’s defense theory. Lord explained that at the time it was difficult to even locate such an expert and Dr. Bandak’s position and research on the topic constituted “cutting-edge technology.” Lord could find no other experts willing to challenge the prosecution’s medical expert. Lord negotiated with Dr. Bandak regarding the rate for his services. Lord consulted with defendant, who repeatedly told Lord that he would find the money to secure Dr. Bandak’s testimony at trial. Lord obtained multiple adjournments of trial all based on the representation that defendant needed the time to secure funds to pay Dr. Bandak. Lord testified at the evidentiary hearing that he suspended defendant’s obligation to pay Lord’s own fees so that defendant could save for the cost of hiring Dr. Bandak, and Lord paid Dr. Bandak’s initial consultation fee out of the retainer defendant paid to Lord. Defendant continually represented to Lord that he would secure the money, either by saving his own money and perhaps selling a vehicle, or if all else failed, by borrowing the money from his mother.

Two weeks before the trial date, however, defendant informed Lord that he could not obtain the money himself and that he would not ask his mother for any more financial assistance. A frustrated Lord tried to convince defendant to ask his mother for help, but defendant refused. Instead, defendant told Lord that an expert was not necessary because defendant would be a good witness and the jury would believe him. At that point, Lord prepared for trial with what he had.

Lord discussed with defendant how to present himself to the jury and Lord came up with a strategy aimed at gaining the jury's sympathy, explaining to the jury that defendant, a hard-working individual, lacked the financial resources to afford an expert to combat the expert put forward by the prosecution. Lord also used the knowledge that he had gained from his discussions with Dr. Bandak to cross-examine the prosecution's expert. Lord's strategy clearly had an effect. The jury deliberated for days and reported at one point that it could not reach a unanimous verdict. Ultimately, however, the jury convicted defendant.

Defendant argues that Lord provided him ineffective assistance primarily on the ground that Lord should have sought financial assistance from the court under MCL 775.15. Defendant posits that Lord should have done so at the outset of the case or later when defendant finally informed Lord that he lacked the financial ability to pay Dr. Bandak's fees. Alternatively, defendant argues that Lord should have looked for and obtained the services of another expert who would have provided expert services for free.

On appeal, defendant bears the burden of establishing that defense counsel provided ineffective assistance by showing that "(1) counsel's performance fell below an objective standard of reasonableness and (2) but for counsel's deficient performance, there is a reasonable probability that the outcome would have been different." *People v Trakhtenberg*, 493 Mich 38, 51; 826 NW2d 136 (2012). "A reasonable probability is a probability sufficient to undermine confidence in the outcome." *People v Carbin*, 463 Mich 590, 600; 623 NW2d 884 (2001) (quotation marks and citation omitted). Defendant must overcome a strong presumption that defense counsel provided effective assistance. *People v Seals*, 285 Mich App 1, 17; 776 NW2d 314 (2009). Further, defendant "has the burden of establishing the factual predicate for his claim of ineffective assistance of counsel." *People v Hoag*, 460 Mich 1, 6; 594 NW2d 57 (1999).

Whether Lord's performance fell below an objective standard of reasonableness is measured by examining if his conduct met prevailing professional norms "necessarily linked to the practice and expectations of the legal community . . ." *Padilla v Kentucky*, 559 US 356, 366; 130 S Ct 1473; 176 L Ed 2d 284 (2010) (citation omitted). "[D]efendant must overcome a strong presumption that counsel's performance was born from a sound trial strategy." *Trakhtenberg*, 493 Mich at 52. "This Court does not second-guess counsel on matters of trial strategy, nor does it assess counsel's competence with the benefit of hindsight." *People v Russell*, 297 Mich App 707, 716; 825 NW2d 623 (2012) (citation omitted). "[T]he failure to call witnesses only constitutes ineffective assistance of counsel if it deprives the defendant of a substantial defense." *Id.* An isolated error by counsel may demonstrate that his or her performance was objectively unreasonable if that error is sufficiently egregious. *Harrington v Richter*, 562 US 86, 111; 131 S Ct 770; 178 L Ed 2d 624 (2011). But "it is difficult to establish ineffective assistance when counsel's overall performance indicates active and capable advocacy." *Id.*

The parties acknowledge that there is recent authority holding that the failure to call an expert witness who is willing to assist the defendant in an SBS/AHT case can amount to deficient performance. In *People v Ackley*, 497 Mich 381, 384; 870 NW2d 858 (2015), the prosecutor intended to rely on several experts who would testify that injuries suffered by a child were most likely the result of intentional physical abuse. The defendant's appointed counsel contacted a single expert for assistance who informed counsel that he would not be able to testify

in support of defendant's case. *Id.* at 385. "He also explained to counsel that there was a marked difference of opinion within the medical community about diagnosing injuries that result from falling short distances, on the one hand, and shaken baby syndrome (SBS) or, as it is sometimes termed, abusive head trauma (AHT), on the other hand." *Id.* "Hunter asserted that this divide is 'like a religion' because each expert has deeply held beliefs about when each diagnosis is supported, and the defendant should have the benefit of an expert who, 'in his or her religion, believes this could be a short-fall death.'" *Id.* (brackets omitted). The expert "emphasized to counsel that he was on the wrong side of this debate to be able to assist the defendant." *Id.*

In *Ackley*, the defendant's counsel "called no expert in support of its theory that the child's injuries resulted from an accidental fall, although the court had provided funding for expert assistance." *Id.* at 384. The defendant's counsel apparently never sought out another expert, despite being given the name of another expert by the expert who declined to testify on the defendant's behalf. *Id.* at 385-386. Nor did counsel read medical treatises or other articles on the topic. *Id.* at 386. Instead, the defendant's counsel continued to seek the same expert's assistance, despite his explanation that he could not support defendant's case. *Id.* at 386-387. Our Supreme Court concluded that the defendant's counsel provided ineffective assistance by completely failing to seek the assistance of an expert who could support the defendant's theory and counter the prosecution's experts, and by failing to develop a trial strategy based on familiarity with the readily available journal articles to educate himself on the medical issues at the core of the case. The defendant's counsel's conduct resulted in the presentation of a defense theory that lacked expert testimonial support and a defense counsel insufficiently equipped to challenge the prosecution's expert. *Id.* at 389-394.

In this case, unlike the defendant's counsel in *Ackley*, the record reflects that Lord investigated SBS/AHT and became informed regarding the conflicting scientific studies. He investigated suitable expert witnesses. Lord was an attorney with over 30 years of experience. His practice was 95% related to criminal matters. His practice included both retained and indigent appointed clients. He tried 15-20 jury trials per year. He was well familiar with the assigned trial judge. He found a suitable expert, Dr. Bandak, who could provide expert testimony to rebut the prosecution's expert witness's testimony. Lord testified at the evidentiary hearing that he paid from his own retainer an initial fee required by Dr. Bandak. To testify at trial, however, Dr. Bandak required an additional fee of \$1500 per day plus expenses. Lord testified that he looked for other experts but could find none that were willing to come forward and testify. Lord contacted the State Appellate Defenders Office. Lord did online research. Lord also explained that defendant told him repeatedly that he would pay the required fees for Dr. Bandak to appear and testify at trial. Lord testified that he made clear to defendant the need for expert testimony in his defense and he obtained multiple adjournments of the trial to enable defendant to find funding to pay Dr. Bandak. Defendant made multiple direct and unequivocal representations that he would obtain the funds necessary for retention of an expert. Lord believed defendant's representations that he intended to pay Dr. Bandak's fees by borrowing from his sister or mother. However, two weeks before trial, a trial date which had been adjourned multiple times at the request of Lord, specifically so defendant could obtain the funds he said he would, defendant disclosed to Lord, well after the deadline for filing motions expired that he did not have the money to pay Dr. Bandak's fees and that he chose not to ask his mother for the funds because he did not want her going into debt for him. Lord also testified that

defendant intended to testify on his own behalf and he expressed his belief that he did not need an expert because the jury would find him credible.

Lord also testified at the evidentiary hearing that, with Dr. Bandak's expert assistance, he informed himself of the critical issues to enable him to present a defense theory and cross-examine the prosecution's expert witness regarding the scientific evidence and opinion that conflicted with the prosecution's expert witness's opinions. The trial record reflects that Lord extensively cross-examined Dr. Gilmer-Hill regarding the scientific studies that disagreed with her opinion regarding the cause and origin of the child's injury in this case. Further, in his opening statement and closing argument, Lord presented defendant's defense that the prosecution's expert witness turned a blind eye to scientific studies that contradicted her opinion, and as a result she failed to appropriately analyze the evidence because she relied on a preconceived singular notion of the cause of the child's injury. Lord's opening statement and closing argument reflect a calculated strategy to cast reasonable doubt as to defendant's guilt. Defense counsel's conduct did not deprive defendant of his defense that alternative explanations founded in scientific studies existed to explain the child's injuries that supported defendant's explanation of his innocence. The present case is distinguishable from *Ackley*, where the defendant's counsel did nothing to investigate the availability of a suitable expert and utterly failed to inform himself of the critical issues to enable putting forth a defense. In *Ackley*, the defendant's counsel's ineptitude deprived the defendant of a defense. De novo review of the record establishes that such deficiencies are not present in this case. The record reflects that Lord acted prudently under the circumstances, developed a sound trial strategy, and presented a strong defense for defendant. Accordingly, Lord's conduct did not fall below an objective standard of reasonableness.

Defendant also argues that Lord should have obtained the assistance of another expert who would have provided his or her services to defendant pro bono. "[D]efendant has the burden of establishing the factual predicate for his claim of ineffective assistance of counsel." *People v Hoag*, 460 Mich 1, 6; 594 NW2d 57 (1999). In his motion for a new trial submitted to the trial court, defendant contended that because he has now found experts willing to provide their services pro bono, surely, Lord could have done the same in 2005. The fact that defendant now may have found pro bono experts to support his cause does not establish that suitable experts were available and willing to serve in this case on a pro bono basis in 2005. Lord testified at the evidentiary hearing that he searched for suitable experts other than Dr. Bandak who could testify on defendant's behalf. He found none willing to come forward and testify. The record reflects that Dr. Bandak's theories were based on cutting-edge technology and were not widely accepted in 2005. Given the state of the debate regarding SBS/AHT diagnoses at that time, we are not persuaded that Lord had the ability in 2005 to find a suitable substitute expert as defendant now contends.

Defendant represents in his brief on appeal that the experts who provided him affidavits in support of his motion for a new trial would have testified for free in 2005. The experts' affidavits, however, say nothing of the sort. The experts' affidavits indicate only that they could have provided helpful testimony to defendant in 2005, but none state that he or she would have testified on defendant's behalf for free. Ultimately, defendant has offered no more than speculation that Lord might have been able to find another suitable expert in 2005 who would have provided testimony supporting defendant's theory of the case for free. Further, defendant

has failed to rebut Lord's testimony at the evidentiary hearing that he sought other experts to assist in this case but could not locate a suitable expert and knew of none who would testify for free. Defendant's argument that Lord provided ineffective assistance in this regard lacks merit because he has not established the requisite factual predicate for his claim of ineffective assistance.³

Defendant also asserts that Lord should have sought public funding for Dr. Bandak, or perhaps another expert. Defendant argues that a request for fees should have been made under MCL 775.15. While our Supreme Court has very recently held that this statute does not apply to requests for the appointment of expert witnesses, *People v Kennedy*, 502 Mich 206, 223; 917 NW2d 355 (2018), that is not relevant to our analysis here. At the time of defendant's trial, controlling precedent considered MCL 775.15 as the source for the trial court's authority to provide indigent defendants with funds to hire expert witnesses. See *Kennedy*, 502 Mich at 221-222.

MCL 775.15 states:

If any person accused of any crime or misdemeanor, and about to be tried therefor in any court of record in this state, shall make it appear to the satisfaction of the judge presiding over the court wherein such trial is to be had, by his own oath, or otherwise, that there is a material witness in his favor within the jurisdiction of the court, without whose testimony he cannot safely proceed to a trial, giving the name and place of residence of such witness, *and that such accused person is poor and has not and cannot obtain the means to procure the attendance of such witness at the place of trial*, the judge in his discretion may, at a time when the prosecuting officer of the county is present, make an order that a subpoena be issued from such court for such witness in his favor, and that it be served by the proper officer of the court. And it shall be the duty of such officer to serve such subpoena, and of the witness named therein to attend the trial, and the officer serving such subpoena shall be paid therefor, and the witness therein named shall be paid for attending such trial, in the same manner as if such witness had been subpoenaed in behalf of the people. [Emphasis added.]

Before *Kennedy*, courts interpreted MCL 775.15 to authorize discretionary "payment for an expert witness, provided that an indigent defendant is able to show that there is a material witness in his favor within the jurisdiction of the court, without whose testimony he cannot safely proceed to trial[.]" *People v Carnicom*, 272 Mich App 614, 617; 727 NW2d 399 (2006) (quotation marks and citation omitted). If the defendant made the required showing, the trial court had the discretion to "grant funds for the retention of an expert witness." *Id.* "A trial court [was] not compelled to provide funds for the appointment of an expert on demand." *Id.* (citation omitted).

³ The *Ginther* hearing transcript discloses the strategic analysis undertaken by Lord, based on his three decades of trial experience, respecting the advantages of experts who are exceptionally well qualified and the disadvantages of lesser qualified experts who can actually harm a client's case.

To qualify for funds to pay an expert, defendant would have been required to demonstrate that he was, in fact, indigent at the time he sought funds. Defendant claims on appeal that the trial court concluded that he was indigent in 2005, and that such a finding is unquestionably correct. Defendant, however, misrepresents the trial court's decision. The trial court did not make a finding that defendant was indigent. The trial court simply noted that Lord did not testify that defendant had more financial resources available than defendant had represented to him. Further, Lord relied on defendant's representation that he lacked sufficient cash on hand to pay Dr. Bandak at the time of his trial. That does not conclusively establish indigence, and is not a finding of indigence by the trial court.

The question whether defendant could establish indigent status in 2005 cannot be easily ascertained. No hard-and-fast rule exists for defining indigence. *People v Arquette*, 202 Mich App 227, 230; 507 NW2d 824 (1993). The applicable court rule, MCR 6.005(B), remains the same now as it was in 2005, and established the factors for consideration by the trial court to determine whether a criminal defendant is indigent:

- (1) present employment, earning capacity and living expenses;
- (2) outstanding debts and liabilities, secured and unsecured;
- (3) whether the defendant has qualified for and is receiving any form of public assistance;
- (4) availability and convertibility, without undue financial hardship to the defendant and the defendant's dependents, of any personal or real property owned; and
- (5) any other circumstances that would impair the ability to pay a lawyer's fee as would ordinarily be required to retain competent counsel.

The ability to post bond for pretrial release does not make the defendant ineligible for appointment of a lawyer.

Defendant correctly asserts that an indigent defendant's status does not change simply because his friends or family decide to pay for his legal defense. In *Arquette*, 202 Mich App at 230, this Court explained that "indigence is to be determined by consideration of the defendant's financial ability, not that of his friends and relatives." In this case, whether defendant would have been found indigent is questionable. The record reflects that defendant had regular employment for years, rented a home, and paid utilities. No evidence establishes that he received any form of public assistance. The record reflects that his annual wages in 2005 were at least \$15,000. He also received \$50 a week in child support. Thus, he had an annual income of over \$17,000. While certainly not dispositive, in 2005, the federal poverty level for an individual with one dependent child was \$12,380.⁴ Defendant's income was nearly 140% of the

⁴ See Prior HHS Poverty Guidelines, available at <https://aspe.hhs.gov/prior-hhs-poverty-guidelines-and-federal-register-references>. This Court may take judicial notice of facts that are

federal poverty level in 2005. Defendant has not established that he would have been determined indigent at the time of his trial.

Regardless, the question remains whether Lord's failure to seek funds from the trial court constituted objectively unreasonable conduct. Lord's testimony at the evidentiary hearing establishes that he knew that in the defense of an indigent defendant during 2005, he could turn to the court for funds to hire an expert witness, having done so on other occasions. Lord, however, testified that he had never himself sought such funding for a defendant who had retained him and he also lacked awareness of any other retained attorney who ever sought funding from the court for an expert witness. We cannot fault Lord for failing to advance what would have been a fairly novel position, that an individual in defendant's financial position, and who had twice retained counsel in this case, could nonetheless qualify as an indigent defendant entitled to court funding of an expert witness. See *People v Reed*, 453 Mich 685, 695; 556 NW2d 858 (1996) (counsel cannot be deemed ineffective for failing to advance a novel legal argument).⁵

Even if we assume that the trial court would have deemed defendant indigent, the record reflects that Lord made strategic trial decisions in consultation with his client and consulted with Dr. Bandak to present the defense favorable to defendant. The record indicates that Lord followed his client's direction after fully advising him, prepared his defense, and advocated diligently for defendant at trial. Defendant cannot fault Lord for believing his representations throughout the preparation of his case right up to two weeks before trial that he would pay Dr. Bandak's fees. The record also reflects that, even if Lord requested funds from the trial court, the \$500 customary amount granted by local courts in 2005 would have fallen short of the amount needed for Dr. Bandak's trial preparation and testimony. Therefore, even a successful motion for expert funds likely would have provided defendant no guaranty of the ability to pay for Dr. Bandak's trial testimony. Accordingly, even if we were to find that Lord's conduct fell below an objective standard of reasonableness, we are not convinced that, but for such purported deficient conduct, the outcome would have been different. *Trakhtenberg*, 493 Mich. at 51.

The record establishes that, faced with defendant's late announcement that he could not obtain the funds to pay Dr. Bandak, Lord adjusted the defense strategy and relied on defendant's testimony, as well as, the information he learned from Dr. Bandak, to successfully cross-examine the prosecution's expert. Defendant approved this trial strategy. While Lord was not necessarily bound by defendant's belief that he could prevail without an expert, "[t]he reasonableness of counsel's actions may be determined or substantially influenced by the defendant's own statements or actions." *Strickland v Washington*, 466 US 668, 691; 104 S Ct 2052; 80 L Ed 2d 674 (1984).

"capable of accurate and ready determination by resort to sources whose accuracy cannot reasonably be questioned." MRE 201(b).

⁵ The record from the evidentiary hearing establishes that in 2005, it is highly unlikely that the trial court would have provided public funds for the retention of an expert in a case where defendant was represented by privately retained counsel.

Defendant asks over a decade later that, with the benefit of hindsight and disregard for his own actions in determining his defense, we conclude that Lord provided him ineffective assistance. However, a “fair assessment of attorney performance requires that every effort be made to eliminate the distorting effects of hindsight, to reconstruct the circumstances of counsel’s challenged conduct, and to evaluate the conduct from counsel’s perspective at the time.” *Strickland*, 466 US at 689. As the United States Supreme Court explained in *Harrington*, 562 US at 105:

Even under de novo review, the standard for judging counsel’s representation is a most deferential one. Unlike a later reviewing court, the attorney observed the relevant proceedings, knew of materials outside the record, and interacted with the client, with opposing counsel, and with the judge. It is all too tempting to second-guess counsel’s assistance after conviction or adverse sentence. The question is whether an attorney’s representation amounted to incompetence under prevailing professional norms, not whether it deviated from best practices or most common custom. [Quotation marks and citations omitted.]

De novo review of the record in this case does not support defendant’s claims of ineffective assistance of counsel. Therefore, defendant has failed to establish that Lord’s performance fell below an objective standard of reasonableness under the prevailing norms of competent practice at the time, and defendant cannot establish that but for Lord’s conduct, defendant’s trial would have resulted differently. Accordingly, defendant lacks entitlement to any relief.

Affirmed.

/s/ James Robert Redford
/s/ Jane E. Markey
/s/ Kirsten Frank Kelly

April 17, 2020

159948 & (78)

PEOPLE OF THE STATE OF MICHIGAN,
Plaintiff-Appellee,

v

SC: 159948
COA: 338431
St. Clair CC: 05-000220-FH

TERRY LEE CEASOR,
Defendant-Appellant.

_____ /

On order of the Court, the motion to file supplemental authority is GRANTED. The application for leave to appeal the May 23, 2019 judgment of the Court of Appeals is considered. We direct the Clerk to schedule oral argument on the application. MCR 7.305(H)(1).

The appellant shall file a supplemental brief within 42 days of the date of this order addressing whether he was denied the effective assistance of trial counsel due to counsel's failure to seek funds from the circuit court to hire an expert witness or to otherwise obtain and present the testimony of an expert witness. In addition to the brief, the appellant shall electronically file an appendix conforming to MCR 7.312(D)(2). In the brief, citations to the record must provide the appendix page numbers as required by MCR 7.312(B)(1). The appellee shall file a supplemental brief within 21 days of being served with the appellant's brief. The appellee shall also electronically file an appendix, or in the alternative, stipulate to the use of the appendix filed by the appellant. A reply, if any, must be filed by the appellant within 14 days of being served with the appellee's brief. The parties should not submit mere restatements of their application papers.

MCCORMACK, C.J., not participating because of her prior involvement in this case as counsel for a party.