SUPREME COURT SUPERIOR COURT

NO. S124131 NO. CF-5733

IN THE SUPREME COURT OF THE STATE OF CALIFORNIA

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THE PEOPLE OF THE STATE OF CALIFORNIA, PLAINTIFF AND RESPONDENT, vs. JOSEPH ANTHONY BARRETT, DEFENDANT AND APPELLANT.

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VOLUME 52
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FROM THE SUPERIOR COURT OF IMPERIAL COUNTY

HONORABLE JOSEPH W. ZIMMERMAN, JUDGE

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REPORTERS' TRANSCRIPT ON APPEAL

DECEMBER 8, 2003

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IN THE SUPERIOR COURT, COUNTY OF IMPERIAL

STATE OF CALIFORNIA

CRIMINAL DIVISION, DEPARTMENT 1

JUDGE JOSEPH W. ZIMMERMAN, PRESIDING

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THE PEOPLE OF THE STATE OF CALIFORNIA, PLAINTIFF, VS. JOSEPH A. BARRETT, DEFENDANT.) NO. CF-5733) TRIAL PROCEEDINGS) DAY 41

REPORTER'S TRANSCRIPT

MONDAY, DECEMBER 8, 2003

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I N D E X

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THE COURT: Sometimes you can't avoid that little opening headline. But as long as you don't read the text of it, I think you're okay.

And the other thing that occurred to me is that -- I sure wish I had the authority to march you all over the health department and get you flu shots.

JUROR NO. 6: Are they open at noon? That's my plan.

THE COURT: Good. I got mine Friday. They're running out of vaccine. Apparently this is a really bad strain of flu going on. And I don't want to lose any of you folks. So I appreciate it if you did.

Now, let's see. Dr. Swalwell, could you come on up, sir.

MR. BEAUDIKOFER: Your Honor, could we make a further inquiry to see if anyone talked to them about the contents of that article?

THE COURT: Did anybody talk to you about the article or attempt to discuss the article with you?

(The jury panel answers collectively in the negative.)

THE COURT: Okay. Thank you, ladies and gentlemen.

All right. Doctor, you're still under oath.

And apparently there was a line of questioning that Mr. Robinson neglected or failed or didn't remember to

ask you about Friday. So I'm going to let him reopen on that. Go ahead.

MR. ROBINSON: Thank you very much.

DIRECT EXAMINATION (RESUMED)

BY MR. ROBINSON:

Q. Just briefly, doctor.

Doctor, I would like to give you a hypothetical. Let's assume that there is a weapon approximately eight and a half inches in length, three quarter inches in width at its widest point, and one inch thick at its thickest point. Let's further assume that this weapon was sharpened to a point on one end with a white cloth wrapped around the other end for a handle, and the handle measured approximately two inches in length.

Based upon the injuries or the wounds or the stab wounds that you referred to in your testimony on Friday, would that weapon be consistent with the type of

weapon used to inflict those wounds?

A. Yes.

MR. ROBINSON: Thank you very much.

Nothing further, your Honor.

THE COURT: Okay. Thank you.

Mr. Beaudikofer.

CROSS-EXAMINATION (RESUMED)

BY MR. BEAUDIKOFER:

Q. Good morning, doctor.

To clarify, we spoke a little bit after the close of testimony last week, correct?

A. Yes.

Q. And that was in the presence of at least part of the time with Mr. Robinson.

A. Yes.

Q. Okay. And then we spoke a little bit of the time, I guess you would say, outside of his presence or in private, correct?

A. Yes.

Q. Did you have occasion, since our discussion, in talking with Mr. Robinson about the contents of our conversation?

A. No.

Q. What exactly is it that a forensic pathologist do?

A. Well, we study the pathology of injuries. And generally what we do is autopsy examinations on people who die under various circumstances, as I mentioned before. And part of that is documenting injuries to the extent that we can and determining the cause of death.

Q. And in the process of making examinations and

evaluating injuries, do you occasionally make references to other sources of information, for example, toxicology reports, police reports?

A. Yes.

Q. Okay. And what is the purpose of making reference to the other sources of information?

A. Part of what we do in determining the cause of death is to consider all the information that is available. And sometimes we need that information to be able to tell why somebody died. For instance, if somebody dies from a drug overdose, we obviously need to do drug testing to determine that.

Q. Did you make references to any of the reports in connection with your medical examination in this case?

A. The -- I'm trying to think. I remember seeing the toxicology report. And the other thing I had, as I mentioned before, was the autopsy memo from the coroner's office, which is just a very brief statement.

Q. Do you know what a criminalist is?

A. Yes.

Q. Do you know what a crime scene technician is?

A. Yes.

Q. Do you know what a serologist is?

A. Yes.

Q. Do you know what a blood splatter expert is?

A. Yes.

Q. What is a criminalist?

A. A criminalist is usually someone that -- well, someone that has special training in criminology. And in particular, they're interested in things related to crime scene investigation, evidence collection, and analysis.

Q. And in the case of a homicide involving a sharp instrument, which was apparent in this case, is it common for -- for them to -- for a criminalist to preserve blood stain evidence if it's available?

MR. ROBINSON: Objection, your Honor, beyond the scope of direct examination.

THE COURT: Well, it is. All right. Sustained.

MR. BEAUDIKOFER: So are you going to make us call him back some other day?

THE COURT: I'm going to have to follow the rules. I'm going to turn square corners every chance I get in this case. So if that's what it's going to take, that's what it's going to take.

BY MR. BEAUDIKOFER:

Q. Did you refer to any criminalists' reports in coming to your conclusions?

A. No.

Q. Did you refer to any serologist's report? What is a serologist?

A. A serologist is someone that works in a laboratory dealing with serology, which is an evaluation of certain findings in blood.

Q. Okay. For example?

A. Well, for example, they may be doing D.N.A. testing or testing of blood types or looking for evidence of sex assault like semen.

Q. Did you see any reports concerning that kind of examination?

A. No.

Q. What is a blood stain specialist?

MR. ROBINSON: Again, your Honor, objection, beyond the scope of direct examination.

MR. BEAUDIKOFER: He's referred to his report and common habits of the way he works with people. I want to ask him if he did so in this case. And I want to start by defining what they are so we'll know what he's talking about.

THE COURT: Your objection stands?

MR. ROBINSON: Yes, your Honor.

THE COURT: I believe it is. I'll sustain the objection.

BY MR. BEAUDIKOFER:

Q. Are you familiar with the term "agonal period"?

A. Yes.

Q. What is that referred to?

And how is it spelled, just for the record?

A. A-g-o-n-a-l.

It refers to the period or the time during which somebody is dying or the time around when the death occurs.

Q. So basically it's the time it takes to die from the onset of the injuries?

A. It -- it would include that, yes.

Q. What else would it include?

A. Well, I mean, that's assuming that there are injuries. And not everybody dies from injuries.

Q. All right. As it would apply in this case.

A. Right. I mean, obviously sometimes there is a big delay between the time of injury and when someone dies.

Q. But we're talking about in the case of traumatic injuries, which is the presumed cause of death. We're talking about the time from the receipt of the

injuries to the time the person dies. That would be called the agonal period.

A. It would be if it is a short period of time.

Q. Okay. Can you define short for us in terms of your understanding?

A. Minutes.

Q. Minutes?

A. Or less.

Q. So on the outside, how many minutes are we talking about? I'm talking about general now.

A. There is no -- I mean, there is no defined limit.

Q. So when you said you didn't use hours, you didn't use days.

A. Right.

Q. So I assume there is some parameters. Again, I'm not being case specific.

A. I don't have any set time frame where I would say this is beyond what that is.

Q. But your particular use -- is there a generally accepted term for use of agonal period?

A. Not in terms of numbers, no.

Q. So when you say it was minutes, it could be longer?

A. Well, it could be many minutes, sure.

Q. All right. For example, someone gets poisoned.

From the onset of poison to death could be several hours?

A. Could be, sure.

Q. And that would be referring to the agonal period?

A. It could be.

Q. Why wouldn't it be?

A. Well, obviously, like I said, at some point, you know, if you get brain damage and you die ten years later, you wouldn't consider that ten-year period an agonal period. Agonal just mean the time shortly around the time of death or close to the time of death.

Q. And it could be minutes or many minutes?

A. Yeah.

Q. And does the agonal period -- in your determination, does that provide information as to what the decedent was able to do before his death and have importance on that issue?

A. It could.

Q. For example, a person had three minutes from the onset of injuries to his death, he couldn't write a book presumably, correct?

A. Right.

Q. So there would be limitations on the amount of activity, correct?

A. Right.

Q. Isn't it true that people rarely drop dead immediately from traumatic injury?

A. Well, it really depends on the nature of the injury.

Q. Isn't that "drop dead" immediately usually

confined to devastating central nervous system injuries or deep brain injuries?

A. Yes.

Q. In fact, isn't it true that there is well documented cases in the forensic literature of people actually be shot in the heart across the room and done significant activity?

A. Yeah.

Q. And even people with seemingly major brain injuries may be able to speak out.

A. Yes.

Q. And do other voluntary activity for a considerable period of time.

A. Yes.

Q. Isn't it true that it's difficult to be sure, judging from the body alone -- an examination of the body alone, how long the agonal period may have been and what type of activity a person might be able to do during that period?

A. Yes.

Q. And isn't it true that anatomic abnormality or injuries don't always correlate with the degree or type of impairment the person might suffer?

A. Yes.

Q. Physical factors about a person's agonal

activity, such as location of the injury and the amount of tissue damage, plays a significant role on what the activity might be.

A. It can. Certainly.

Q. And then there is psychological factors that also come into play, correct?

A. Yes.

Q. And they can be unpredictable.

A. Yes.

Q. And so I think we agree that not many injuries occur where incapacitation is immediate except spinal cord and deep brain injuries.

A. Right. And the other thing would be extensive multiple injuries like in some motor vehicle accidents where it's devastating injuries.

Q. And just so we have that in balance, what are we -- what kind of injuries are we talking? There are lots of vehicle accidents where that doesn't occur, correct?

A. Yeah. I'm talking about severe cases where obviously people die right away.

Q. For example, what kind of injuries are we talking about?

A. Multiple fractures, multiple injuries to internal organs.

Q. The determination of when a person can function during the agonal or the extended -- could function during the agonal period might be difficult to address because of the variability among victims and the psychological and physiological makeup?

A. Yes.

Q. Not all people are typical in the way their muscles and nerves are assembled.

A. True.

Q. So categorical statements about anatomic functional relationships are sometimes difficult to make and could be misleading in terms of what the activity might occur during an agonal period.

A. Yes.

Q. Sometimes people have what they call backup mechanism. For example, if a part is injured, there may be some other way to accomplish an activity, even though the normal functioning system has been damaged?

A. Yes.

Q. And isn't it true that people with stab wounds through the heart have run for blocks before collapsing?

A. That can happen, yes.

Q. I don't know if I said that, but people can awaken from a seemingly irreversible coma?

A. Yes.

Q. Another example would be that people shot through the frontal lobes of the brain almost immediately become unconscious, correct? Most people --

A. Yes.

Q. But a few do not.

A. Yes.

Q. And isn't it true that one factor that limits the ability of forensic pathologists to determine the parameters of a voluntary victim activity -- in other words, what a person in the agonal period can or cannot do -- is somewhat limited by the assent of dissection entailed in the normal autopsy?

A. It can be.

Q. Now, did you have an estimate of the agonal period in this particular case, the one involving Inmate Richmond?

A. Only a ballpark figure. Obviously, I don't know for sure.

Q. What was your ballpark figure?

A. I would say it would be several minutes.

Q. You conducted an autopsy of Mr. Richmond, correct?

A. Yes.

Q. Do you have that in front of you?

A. Yes.

Q. The protocol you used or the series of steps you used, could you just give us a quick outline of what that would have been?

A. In terms of -- I'm not quite sure I understand.

Q. What you did first and so on.

A. During the course of the autopsy?

Q. Yes.

A. Well --

Q. I'm talking about in general terms. For example, external examination and then go through the organs.

A. Right, right.

Generally it starts with what we call the external examination, which is the looking at the body from the outside, basically looking at the general features and items that are on the body and, of course, the injuries that are apparent from the outside.

And the second part is the internal examination where we look at the inside of the body, go through the

same thing with the individual organs and the body cavities and looking at -- for diseases and also for injuries.

Q. In your report, you gave an external description of Mr. Richmond, correct?

A. Yes.

Q. And your determination of him was that he was well developed, thin, but muscular, nonembalmed Caucasian, correct?

A. Yes.

Q. What does that mean?

A. Which part?

Q. It's on Page 3 of the report under first sentence under external description.

A. I'm sorry. I didn't quite understand what you're asking.

Q. You describe him as a well developed, thin, but muscular, nonembalmed Caucasian. What does well developed, thin, but muscular mean to you?

A. Well developed means, in terms of his general physique, normal development. He wasn't handicapped in the physical sense that there is something wrong with his arms or legs that is apparent by looking at him, normal body features, and that kind of thing.

Thin, but muscular obviously to some extent is

subjective. But even though he looked thin, he did seem to have well developed musculature.

Q. You stated that rigor was well developed, correct?

A. Yes.

Q. What does that mean?

A. That means that at the time of the autopsy, the rigor mortis was quite firm, probably optimal.

Q. Optimal meaning the maximum it could get?

A. Right.

Q. And that was around 10:46 the 9th, if I recall?

A. Well, the autopsy started at 10:52 in the morning. So it would have been some time shortly thereafter.

Q. The -- did you examine him to see if he had tattoos on him?

A. Yes.

Q. What was the purpose of that?

A. Well, it's part of the general description of the body. As I mentioned, one of the things we do is to document what is there and not there.

Q. And could you tell us, did you discover any tattoos on his body?

A. Yes, yes. Several tattoos.

Q. What were they?

A. On the -- on the left upper arm was a tattoo that included a couple of skulls. That's the tattoo that you could see in some of the photographs because there is one of the stab wounds that was in that area. He had small tattoos on the back of the left hand including a couple of lightning bolts.

Q. Could you show us where that would be on your own hand?

A. It would be somewhere around here in this area.

Q. Pointing on -- why don't you tell --

A. Well, what I call the web, which is kind of the area between the thumb and the index finger.

There is also some letters tattooed on the left forearm.

Q. And what were those?

A. I don't know what letters they were. I couldn't read them. There were the letters "F," "E" on his left thigh.

Q. "F," "E"?

A. And there is another cut, too, on the right upper forearm near the crook of the arm.

Q. That was a letter tattoo?

A. Yes. I don't know what letter it was.

Q. Okay. And then you -- do you know what the significance of the skulls would be?

MR. ROBINSON: Objection, your Honor, beyond the scope of direct examination. And I don't see the relevance of it as well.

MR. BEAUDIKOFER: Your Honor, he did make an examination of the body. He did note that down in the report that he referred to. I would be ask that I can

be --

THE COURT: I'll sustain the objection.

I also don't think that there is a foundation that a medical doctor would know what a tattoo signifies.

MR. BEAUDIKOFER: That may be true. That's why I ask him.

THE COURT: But anyway --

BY MR. BEAUDIKOFER:

Q. Are they important -- let me just go on.

This apparently was important enough to put in your report. And what was the purpose of that?

A. Well, as I mentioned, we document what is on the body. Even if we're not interpreting it, I'm just documenting what is there. It can be helpful sometimes like in an identification. If someone is not identified or someone wants to confirm the identity, tattoos is one way that could be done.

Q. Okay. Just -- you said that there was a couple of small lightning bolts tattooed on the left dorsal web;

is that correct?

MR. ROBINSON: Same objection.

THE COURT: What's that?

MR. ROBINSON: Same objection.

THE COURT: He's already testified to that.

MR. ROBINSON: It's still not relevant.

MR. BEAUDIKOFER: I'm going over his report. I don't think I'm limited to --

THE COURT: I'll overrule the relevance because he already testified to it. There is no sense sustaining an objection at this point.

BY MR. BEAUDIKOFER:

Q. All right. That was -- when you say a couple, just two?

A. Yes.

Q. Now, you made an -- oh, you also noticed that there was a -- well, in the next sentence down, you noticed that there was a scar on the right forearm.

A. Yes.

Q. Could you describe that?

A. On the -- on the front side of the right forearm was a superficial scar that was an inch in length. I don't remember exactly the details of it.

Q. Okay. But it was apparently not related to this incident?

A. No. It was a scar or something. That was all.

Q. Could it have been a stab wound?

A. It could have been at one time.

MR. BEAUDIKOFER: I don't know how we're going to do this, but I'm going to ask the doctor just to -- where I'm going -- he said there were the stab wounds. But

there were other injuries that were noted. I'm going to ask him to put them on the chart so we have an idea of what was involved. Let's see if I can -- I really don't want to stand behind it like Mr. Robinson did.

Q. Was there evidence of external injuries apart from the stab wound that you described on direct examination?

A. Yes. There were a few -- as I mentioned before, some abrasions and some small cuts.

Q. Did you catalogue those?

A. Yes. I described them in my report.

Q. All right. So we can have a balanced view, I've got a red pen for the external injuries. And if you could -- we can go one by one. And if you can -- I don't know if you comfortably can do this. But describe where they were and then place them on the diagram.

A. Okay. Well --

Q. I'll do it one by one, if that will help.

Did you notice that on the right side of the

upper nose, there was an one eighth inch superficial red abrasion?

A. Yes.

Q. Okay. Could you put that on the chart?

A. Actually, I already marked a lot of these injuries on the chart. Do you want me to mark over it?

Q. I think what you put on those was the stab wounds, correct?

A. No. I also put on the other injuries, some of the abrasions and cuts.

Q. All right. Well, let's just -- if it's duplicative, I'll indicate where they are. I don't think there is anything indicating there is an abrasion on the nose.

First of all, what is an abrasion?

A. An abrasion is a scrape of the skin where the superficial layers of the skin gets scraped off.

Q. What does superficial mean?

A. It means it's not deep.

Q. Okay. Is that the general use of superficial? Depth?

A. When I use it, yes. Yes, it's referring to the depth.

Q. All right. When you use it for sure.

A. (Shakes head).

Q. All right. Could you show us where that abrasion was?

A. Okay. I marked it here in blue. I'm going to make it a little bigger, just so you can tell where it is.

Q. I can't see it.

A. Yeah. I know you got to be close to see. It's just on the side of the nose, on the right side, a little -- it actually only measured an eighth of an inch right here.

Q. Could we make -- draw a little line to it and maybe make the letter "A" since that was not numbered? And we'll call it "S," "A" for superficial abrasion.

A. Okay.

MR. ROBINSON: Maybe the size, too, counsel.

BY MR. BEAUDIKOFER:

Q. That would be great. One eighth of an inch.

A. Okay.

Q. And the lateral left cheek near the angle of the jaw has a three sixteenth superficial stab wound which has a diagonal orientation and is about one quarter inch in depth.

Did you write that?

A. Yes. And that refers to this wound here. And if you like, I can label that.

Q. "B," mark it. Just pull it out.

A. (Indicating).

Q. And that would be superficial stab wound?

A. Yes. I did count that as one of the stab wounds, even though it was only three sixteenths of an inch in width. It was a quarter inch in depth. And by

definition, a stab wound is something deeper than it is wide. So even though it's small, technically it is a stab wound.

Q. Do you have an opinion of whether or not this instrument that was described by Mr. Robinson caused that particular injury?

A. It certainly is consistent with that.

Q. Okay. Now, consistent, what does that mean?

A. That means it could have been caused by that.

Q. Okay. But there are other reasonable possibilities?

A. Well, the thing with stab wounds is that they're unlike trying to match a bullet to a gun. You can't match up a stab wound to a particular weapon. All you can say is consistent based on the dimensions and the size. But obviously, there could be lots of kinds of instruments, knives that look very similar and could cause wounds that would appear very similar.

Q. So when you say -- and I've been doing a little

research over the weekend. When you say something is consistent with or diagnostic of -- consistent just means it's one of the reasonable possibilities, correct?

A. Right. I can't say that -- you know, that it's a match.

Q. But that wound could have been caused by other

activities beside the stab wound -- the instrument that Mr. -- that counsel was apparently referring to.

A. Yes. It could have been caused by a different instrument.

Q. The reason I say it, there is some evidence that when the body came to rest, that his mouth was kind of leaning to the left on the edge. Is it possible that -- that something from the nature of that desk could have caused that particular wound?

A. I couldn't say without seeing the desk. It would have to be something sharp that was sticking out.

Q. So superficial means it's shallow, correct?

A. Right.

Q. So can you put "S," "W" as superficial?

A. Sure.

MR. ROBINSON: Maybe the width and the depth of the wound would be nice.

MR. BEAUDIKOFER: Yeah. That's great.

Q. Three sixteenths, quarter inch in depth.

A. Okay.

Q. The left mid back has a very -- "very" is the word -- superficial red-tan one by one half inch scrape abrasion.

A. Yes. That refers to this injury here.

Q. That would be "C."

A. (Indicating).

Q. The dimensions are --

A. One by one half inch.

Q. One by a half inch?

A. Okay.

Q. And we'll call it "S," "S," "A," superficial scrape abrasion.

A. Okay.

Q. What does that mean? Scrape abrasion?

A. Well, it means it's an abrasion caused by friction that is going across the skin as opposed to something that might be a more direct contact.

Q. Across the skin. Does the skin have a grain?

A. Not really.

Q. Okay. So it's a scrape would be the easiest way to describe it.

A. Yes.

Q. The left lower back has a one quarter inch by sixteenth inch superficial red-tan abrasion?

A. Yes. That's referring to this injury here.

THE COURT: Just so everybody is aware, there is some students that are going to come in and view part of trial. So if you see a lot of youngsters come in, that's what that is about.

MR. ROBINSON: Thank you.

BY MR. BEAUDIKOFER:

Q. All right. And that would be "D"?

A. Okay.

Q. And the dimensions are a quarter by sixteenth inch.

A. (Indicating). Okay.

Q. I don't know if we already included this or not. It may have. But the lateral to the left elbow is an irregular one by half inch, red abrasion.

A. That's this one here.

Q. I want to distinguish these other injuries from stab wounds. So if we can put -- did we get the dimensions already?

A. Not yet.

Q. Okay. One and a half by three eighths. No. Strike that. That is incorrect.

It's an irregular one by half inch red abrasion.

A. Okay. Do you want to label this "E"?

Q. Yes, please.

A. Okay.

Q. And within that area was a superficial three eighths inch cut, correct?

A. Yes.

Q. Could you tell us what a cut is as opposed to

an abrasion?

A. A cut is a break in the skin that is made by a sharp object. So it's usually a thin -- you know, like thin line.

Q. All right. So we can that have as "F" since that, you've detailed as separately.

A. Okay.

Q. On the left elbow slightly medially is a quarter inch red abrasion. Could you mark that and tell us what it is?

A. Okay. That would be "G." It's an abrasion, another scrape. That was on the elbow separate from the other one that we just talked about.

Q. On the antero-lateral left upper arm is a very thin horizontal one quarter inch linear scrape, which is appears to be scabbed and older than the other injuries.

A. Yes.

Q. All right. That would be what "F" or "G," I guess.

A. That would be "H."

Q. H. Do you think that should be put there?

Does that appear to have been sustained at some other time than the time of the --

A. Right. That's an older healing injury. So it wouldn't have been related to any of these other ones.

Q. So we'll leave it off then, right?

A. Okay.

Q. The dorsal left thumb extending from the joint to the lateral edge of the nail has an almost vertical three quarter inch superficial linear cut.

A. Yes. That's the one here that we've labeled as a potential -- potentially defensive wound.

Q. Now, I heard you use -- could we -- what -- we have "A," "B," "C," "D," "E," "F," and "G." What would be the next in order?

A. "H."

Q. "H"?

A. (Indicating).

Q. And then you indicate that the palmar surface of the right hand near the web has an ovoid three sixteenth by one eighth inch red denudation.

A. Yes.

Q. Could you show -- indicate where that would be?

A. That's the one over here on the right. I'll

label it "I."

Q. I think that's it for the external. Those are the external injuries that you noticed apart from the stab wounds, correct?

A. Yes.

Q. And you use the word "consistent" with -- as

being a reasonable possibility, correct, in connection with the conclusion?

A. Yes.

Q. All right. But it doesn't necessarily exclude other possibilities that are reasonable.

A. That's correct.

Q. Defense 502 I'm going to hand you and ask you if you can identify that.

A. Yes. This appears to be a photograph of his left hand taken at or around the time of the autopsy.

Q. And that would be where on your chart?

A. Well, the left hand over here. It's a kind of a -- it's kind of a side view of the hand. So you see the thumb and the index finger. It does show that cut that is on the -- on the thumb. And it also shows some of the tattoo -- tattoos.

Q. So that's one that's potentially a defensive wound?

A. Yes.

Q. It would be consistent with the defensive wound?

A. Yes.

Q. Is it a fair assumption in your opinion that those --

I'm sorry the people can't see them more

easily. Maybe we can hold them up.

-- that the abrasions and the superficial injuries that you've described, in addition to the stab wound, are consistent with a fact that a struggle might have occurred during the agonal period?

A. Yes.

Q. So it would be consistent with the findings, say, that death -- with your diagnosis, cause of death, that there was actually a physical struggle before Mr. Richmond was incapacitated.

A. It's consistent with that, yes.

Q. I'm going to go through your report now concerning the stab wounds.

You used the word that there were six stab wounds that were potentially fatal, correct?

A. Yes.

Q. When you say potentially fatal, what are -- what does that mean as opposed to being fatal?

A. Well, if they were fatal, it would mean that

that one wound killed you. Potentially fatal means --
well, in this case, since there were multiple wounds,
it's not one single wound that resulted in the death.
It's the sum of the wounds. But there is six of those
that potentially could have killed him by themselves.
And that's what I mean by that.

Q. In connection with the potentially fatal, counsel asked you if there was evidence of overkill. And you said there was a -- you could say there was an element of overkill.

A. Yes.

Q. Now, overkill -- I've got my medical dictionary. It's an old one. But I couldn't find it in the dictionary. Does that surprise you?

A. No.

Q. Why is that?

A. Because it's -- it's not a medical term.

Q. Now, you define overkill as any wound in excess of what would be necessary to cause death, correct?

A. Yes.

Q. All right. Let me give you an example. Assume an officer is trained to fear for his safety when he's making felony arrests. Okay?

A. Okay.

Q. And he approaches a felony stopping a vehicle.

Okay?

A. Okay.

Q. He sees the suspect reach down apparently underneath his seat. And the suspect, bolting out of the vehicle, charges at him with a knife in hand.

His reaction is to pull his weapon and to fire

five times. One perforates the stomach, and another the liver, the heart, the lungs, and the brain. Five shots, rapid fire.

Under your definition -- well, isn't it true that each of the wounds I've described are potentially enough to kill a person?

A. Yes.

Q. So can we say because there are four wounds in excess of what was necessary to kill him, that this is a case of overkill?

A. From a pathologist's standpoint, I would say that.

Q. Well, these words end up being bandied around the courtroom like they have some big significance. And the fact is isn't overkill, as opposed to a medical term, more of a psychological term?

A. Yes.

Q. And doesn't it in its typical sense refer to events where the number of death blows far and extremely

exceed what is necessary to cause death?

MR. ROBINSON: Objection, your Honor, vague.

THE COURT: I'll sustain that. Could you rephrase that?

MR. BEAUDIKOFER: Yes, I can.

Q. Let me give you another example.

Let's say there are reports from the I.V. Press on an incident that occurred in Imperial County Jail are true. An inmate is found in his cell on his back with multiple stab wounds. In fact, there is about 140 of them, and 114 of which are within a four-inch square of his heart. Would that be evidence of overkill?

MR. ROBINSON: Objection, your Honor. It's not relevant. And it's a based on a hypothetical that has no foundation. So those are my objections.

THE COURT: All right. Well, I think you opened this overkill issue up. So I'll allow that.

MR. ROBINSON: But can't we have a hypothetical based upon the facts in this case as opposed to some case that is not even before the Court?

THE COURT: That's always preferable. But if he wants to analogize things, I think he can do that.

BY MR. BEAUDIKOFER:

Q. Did you do the autopsy on that alleged -- on the inmate that that happened to?

A. No.

Q. Would that be evidence of overkill?

A. I would say so.

Q. In fact, that would be evidence that there was an extreme amount of excessive blows necessary to cause death, correct?

A. Yes.

Q. And overkill, isn't that a term -- a psychological term that usually refers to a rage that is associated with a homicide?

A. I don't know. When I used the term, I used it in a pathologic sense from the standpoint of pathologists.

Q. But you're not surprised it's not in the dictionary.

A. No.

Q. Isn't it a fact that overkill needs to be tempered with an examination of the situation to determine whether or not the use of amount of blows or death blows is excessive?

A. Well, I think that you need to define what you mean by overkill because it may mean something different to me than it does to you than it does to anybody else in this courtroom.

And when I use the term, I was using it looking

at it as a pathologist and looking strictly at the injuries and not looking at the scene. I'm not looking at the psychological profile and so on.

Q. Were you -- I can't remember. Were you given -- were you made reference to one of the exhibits showing the cell, a representation of the cell in this

case? Do you remember that?

A. No.

Q. Well, let me do that.

MR. ROBINSON: Your Honor, now I do believe we're going beyond the direct examination of my questioning of this witness.

MR. BEAUDIKOFER: We're going to use hypotheticals.

THE COURT: Well, wait a minute. You have to stay within the bounds of the direct. So how does that relate to the direct testimony?

MR. BEAUDIKOFER: Because I want to talk about overkill in the situation where the person to whom it applies as being described is in a very small confined space.

THE COURT: Well, I'm worried we're getting beyond the expertise of this witness. I don't know that this is something that he would have training in.

But if you do, then that's fine.

I think you'll need to lay a foundation first.

MR. BEAUDIKOFER: He's used the word and I want to explore it and all of its ramifications.

THE COURT: You might need another type of expert is all I'm telling you.

MR. BEAUDIKOFER: He brought it up.

THE COURT: I know.

MR. BEAUDIKOFER: If it's going to be bandied around by the prosecution, I have --

THE COURT: We've got testimony it's not a medical term. If you want to talk about this situation, you need to lay a foundation.

BY MR. BEAUDIKOFER:

Q. Don't statements of overkill have to be tempered by the situation in which the blows were administered, for example, whether it was a confined space or not?

A. Well, like I said, you have to define it first before you can talk about it. And I've tried to define it in my terms. And in my terms, the answer is no.

Q. So in your terms, any blow in excess of what would be necessary to kill someone would be overkill.

A. It could be, yes.

Q. You were asked some questions on whether or not the decedent experienced pain, correct?

A. Yes.

Q. Were you making medically definitive statements about the amount of pain that Mr. Richmond presumably suffered during the agonal period?

A. I didn't -- I don't remember saying anything about how much pain.

Q. What exactly is pain? I mean, we've all

experienced it. But medically, when you use the word.

A. Well, it's -- it's an unpleasant sensation that is carried by the nervous system to the brain.

Q. An unpleasant sensation.

When you use the word "pain," were you making any statements as to the severity of pain that Mr. Richmond presumably had?

A. No.

Q. It could have been severe?

A. Yes.

Q. It could have been mild?

A. Yes.

Q. Pains are -- the experience of pain is a result of a combination of factors, correct?

A. Yes.

Q. Some of them are physical.

A. Yes.

Q. For example, the number of nerve endings and the location of the wounds, correct?

A. Yes.

Q. Are organs a -- typically densely populated with nerves or sparsely?

A. It's variable.

Q. Pain is sometimes described as acute or diffuse, correct?

A. Yes.

Q. What other descriptions are there for pain?

A. Well, there is a lot of terms that are used you. Can have sharp pain, dull pain, steady pain, throbbing pain.

Q. Can you tell from an examination of Mr. Richmond's body what kind of, if any, pain he suffered?

A. No.

Q. But in order to experience pain, there has to be some consciousness, correct?

A. At least to be aware of the pain, there has to be.

Q. When I say experience it, I guess I mean aware of it.

A. I mean, unconscious people can react to pain.

Q. And that requires that the cerebral -- both hemispheres of the cerebrum be intact, correct?

A. I'm not sure -- I'm not sure about that.

Q. Spinal cord be intact of pathways to the brain.

A. Yes.

Q. And psychological factors might include a person's experience with pain previously.

A. Yes.

Q. The anticipation of pain.

A. Yes.

Q. Whether the person was in fear or enraged.

A. Yes.

Q. And in fact, when people are involved in traumatic situations or receiving traumatic injury, endorphins may be released by the brain, correct?

A. Yes.

Q. What are endorphins?

A. They are naturally occurring substances that are -- react to the nerve endings. And they act like a drug to block the sensations.

Q. An example -- what would be a common example to help us understand what endorphins do?

A. Well, it could be a situation where you're like an athlete who is exerting himself to an extreme degree, but doesn't feel pain from that because of this action.

Q. And that is referred to as analgesic effect.

A. Right. Which is a dulling of pain.

Q. It could even be a high in some instances.

A. Yes.

Q. Is there any way by making an autopsy and a physical examination of that body to detect whether endorphins were released into Mr. Richmond's body during that time in the agonal period?

A. No.

Q. Is there any way to tell by just looking at -- well, first of all, let me strike that.

Fear and rage, they're controlled by the hypothalamus in the limbic system, correct?

A. That's beyond my area of expertise.

Q. Are you familiar with the word "epinephrine"?

A. Yes.

Q. What's that?

A. It's a naturally occurring hormone that is --

Q. That what?

A. Well, it's also known as adrenaline.

Q. Okay.

A. And it's produced like when the body is under stress.

Q. Fight or flight reaction, for example?

A. Yes.

Q. Is there any reliable post mortem measurement of the epinephrine in the individual system?

A. No.

Q. So there is no really way -- reliable way to look at a body and to determine -- to make an assessment of the effects epinephrine might have had during the agonal period, correct?

A. Correct.

Q. Isn't it fair to say that looking at a body

alone, that it is very difficult, if not impossible, for the forensic pathologist to determine from an autopsy whether pain occurred, its type, or its severity?

A. Well, I think that when you look at injuries, you can say that injury would have hurt. Now whether that pain was perceived and how it was perceived, I wouldn't be able to say.

Q. Would it be a safer statement to say that the particular injury is likely to have been accompanied by discomfort?

A. As opposed to pain?

Q. Just from looking at the body.

A. Well, from looking at the stab wounds, to me, they look painful.

Q. Right. We don't need to go through the whole assessment, though, because that's a subjective determination, correct?

A. Well, unless he's paralyzed, I don't see how he would not have pain from the injuries.

Q. All right. But can you tell the severity?

A. No.

Q. Can you tell if it's diffuse?

A. No.

Q. Can you tell if it's acute?

A. Well, by definition it would be acute.

Q. What can you tell about the pain except to say that he probably had it?

A. That's about it.

Q. Right. Because it could be tempered by rage, endorphins, epinephrine, adrenaline.

A. Right.

THE COURT: You know what? We're about ready to take our morning break. And let's do that right now.

Don't discuss the case amongst yourselves or with anybody else or form or express any opinions. Don't do any independent research or investigation on the case.

Ladies and gentlemen, we'll take approximately a 15-minute break.

But let's stay on the record. We've got another media request here. Is somebody here from K.S.W.T. T.V.?

MILROSE BOSCO: (Indicating).

THE COURT: You can step down, by the way, doctor, if you care to.

THE COURT: You're requesting to photograph?

MILROSE BOSCO: Right. Camera inside the courtroom, if possible.

THE COURT: Well, okay. One thing -- this request was supposed to have been presented --

By the way, you can take your break, ladies and

STATE OF CALIFORNIA)

) SS.

COUNTY OF IMPERIAL)

I, SHIELAH D. MORGAN, CSR Number 3763, a duly licensed shorthand reporter in and for the State of California, and official reporter in and for the County of Imperial, do hereby certify:

That I reported in shorthand the proceedings held in the foregoing cause on the 8th day of December, 2003. That the proceedings were reported stenographically by me and later transcribed by computer under my direction. That the foregoing is a full, true and correct transcription of the proceedings taken at that time.

In witness whereof, I have subscribed my name this 13th day of April, 2004.

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SHIELAH D. MORGAN

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C.S.R. Number 3763

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State of California)

) SS.

County of Imperial)

I, Linda Parks, certified shorthand reporter, registered professional reporter, official reporter, County of Imperial, State of California, do hereby certify:

That I reported in shorthand the testimony and proceedings held in the foregoing cause on the 8th day of December, 2003; that the testimony and proceedings were reported stenographically by me and later transcribed by computer under my direction; that the foregoing is a true record of the testimony and proceedings taken at that time.

In witness whereof, I have subscribed my name this 13th day of April, 2004.

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23 Linda Parks

24 C.S.R. No. 9625

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