the courthouse.)

BY MR. HARPER: Judge, apparently, Dr. Patterson is in route and should be here shortly. We have the coroner here. If it please the Court, we'll go ahead and call him now. I don't think --

BY THE COURT: Is that what you desire to do?

BY MR. HARPER: Yes, sir. We'll just go ahead and call him at this point and she should be here --

BY THE COURT: James Lee.

BY MR. HARPER: Yes, sir. James Lee. She's here now, Your Honor. Let us just go ahead and call her. I apologize to the Court. I hate to keep her waiting now that I've got her rushed up here. I think she worked last night and woke her up to get her down here.

BY THE COURT: Come forward and be sworn, please.

DR. LAURIE PATTERSON,

having been duly and legally sworn, answered questions on her oath as follows, to-wit:

BY MR. ROSENBLATT: May I proceed?

BY THE COURT: Yes, sir.

DIRECT EXAMINATION

BY MR. ROSENBLATT:

Q. Dr. Patterson, thank for being here with us today. Would you tell this jury where you work and what you do, please, ma'am.

A. I am an emergency room physician at Natchez Community Hospital.

Q. And how long have you been there?
A. Since 1999.
Q. Dr. Patterson, you were working last --
(The witness adjusts the microphone.)
Q. You were working last February; were you not?
A. Yes, I was.
Q. Do you recall the night of February 21st when Chloe Madison Britt was brought to the emergency room?
A. Yes, I do.
Q. Would you tell us what your involvement in that case was, please, ma'am.
A. I was the emergency room physician on duty there that night.
Q. How did you first hear that something was wrong or something was happening?
A. One of the phlebotomists from the lab came running into the emergency room holding a baby saying that there was a code.
Q. So what did you do?
A. I was sitting at the desk at that time. So we jumped up and ran to the back to find -- room five was considered our trauma room, and it was open, and that's the room we carried the baby to.
Q. What steps did you all take?
A. Basically when the baby was placed onto the gurney at that time, my assessments are all head to toe, head to toe, head to toe type of assessments, and initially when the baby was placed on the gurney, the assessment was airway -- you know -- and in a child that

age that's not breathing, one of the first things you think is aspiration of some toy or something perhaps or something respiratory. Her airway was open. Breathing, she was not. Circulation, there was none. There were no heart tones, and, you know, it was all new and it was a baby. So we had to call respiratory. Of course, a lot of it, my nurses were starting. They were doing their thing while I am doing mine, but I did CPR as far as doing mouth to mouth resuscitation until I could get respiratory there to do some bagging for me. We placed an oral airway and started to breath with a bag for the baby, and do you basically just want me to tell everything that --

Q. If you would, please.

A. That took place that night.

Q. When you first saw the baby, Dr. Patterson, you said head to toe, head to toe. What do you mean by that? Did you do a pretty good look over?

A. Your first examine is airway, breathing, and circulation. One of the first things I noticed about the baby and for whatever reason that it jumped out at me. There were some bruises on her forehead. That kind of struck me as odd, and it's kind of -- I guess it was prominent enough that you would notice it even during a time like that. That was one of the first things I noticed.

Q. Okay. I show you Exhibit Number 6, Dr. Patterson, and ask you to show that to the jury if that's what you were talking about the bruising.

A. Yes.

Q. Point it out to them, please.

A. Noticed the finger marks -- or I don't know what they were, but the pad type marks on the child's forehead.

Q. You observed that when you first began your treatment?

A. Yes.

Q. At what point did you begin to suspect something more than perhaps a clogged area?

A. Well, there was nothing visible in the airway, and, with bagging, I was able to bag and hear bilateral breath sounds. We were putting air through to her lungs. So that tells me it's not obstructed basically by something. If there was something lodged in there, when I bagged her, I would not have gotten breath sounds on both sides. We noted a torn frenulum.

Q. And, again, if I may, Dr. Patterson, I don't wish to interrupt you, but Exhibit 7 and 8, would you show the jury what you mean by the torn frenulum, please.

A. The frenulum is the little piece of meat that connects that upper lip to the gum there. The little piece that you could pinch like that. That's pretty remarkable in a child this age. I do see it in the ER because it scares parents when it happens. It bleeds, and everything about the face is very vascular. Lots of vessels. So if a child that's toddling around hits a coffee table or falls and hits something like that, then they'll tear that occasionally. That frenulum. It's not usual, but it scares mom and dad to death because it

bleeds so much.

Q. You see that a lot in infants that can't walk?

A. No, you don't see that in infants because they're pretty much carried wherever they do. It takes a pretty good -- you're looking at a blunt type thing usually to cause a tear in frenulum. I did notice that.

Q. Did you ever receive any history from anyone to indicate that the baby had suffered an injury?

A. No. One of the nurses went out to talk to the mom.

Q. But you never got any information about an injury?

A. There was no -- no known injury as far as they were concerned.

Q. Did you ever observe anything that would indicate to you that there had indeed been an injury?

A. Well, in trying to get her breathing, doing CPR, doing chest compressions, and bagging, breathing for the baby. One of the nurses -- one of the things you do is in an infant is a rectal temp, and at that point, one of the nurses that were there said, "Dr. Patterson," and I looked, and one of the most prominent things, I guess, of the whole deal for this child was the anal opening.

Q. What about the anal opening?

A. I would say it was open about the size of a quarter.

Q. Is that typical?

A. No. If you ever -- as one of my nurses says, it's a one way only route there. It's like a pucker, and

we take rectal temps on all our babies in the ER up to a certain age because it's more indicative of what's really going on, but the probe you use to take a rectal temp is smaller that my little finger. It's a -- put KY and you're able to get it in there without any problem because they're able to pass a bowel movement, but that's because your sphincter or your tone there, those muscles there open up and let the stool out. Otherwise, it's stays puckered shut, and her anal opening was about the size of a quarter and open. Very flaccid, like there was no tone there, and there was a little tear there. There was some oozing from her rectum. It was not solid stool anyway. It was just more of a thin, liquidy, just kind of drainage from the rectal opening.

Q. Dr. Patterson, let me -- if I may show you Exhibit Number 5 which purports to be a picture taken of the baby's anus shortly after death and ask you to explain that in relation to what you saw?

A. Uh, doesn't do it justice.

Q. What do you mean by that?

A. I guess because the length of time that she's been dead at this point. You can definitely see -- it's, say, that wide of an opening there or it's still length wise open, but it's become more of an elongated thing than what we saw that night, but you still see -- the opening is so long, and you can see the small tear there.

Q. Is that normal, Doctor?

A. Which one?

Q. The way that anus looks, is that normal?

A. No.

Q. Is what you saw normal?

A. No, not at all.

Q. Is what you saw indicative of sexual penetration?

A. Yes. Or penetration of some sort. Yes.

Q. And the injuries to the baby's mouth, is that suggestive of some sort of penetration with a large object also?

A. Very likely. Something that caused a pushing, a shearing type effect to the mouth would cause a torn frenulum in a baby.

Q. Dr. Patterson, I am just thinking especially in emergency room of all the practices, you've probably seen some pretty horrible victims come in.

A. True.

Q. Is what you saw on this child, does that suggest to you sexual penetration?

A. Yes.

Q. The life threatening injuries to the baby apart from the sexual penetration, would you describe to the jury as to what you actually found out was wrong with this child. In other words, what led to this child's death?

A. She had retinal hemorrhaging.

Q. I am sorry. Again, for laymen, when you say retinal hemorrhage --

A. When you looked into her eyes, it's like you're seeing little patches of blood back in there, deep inside the eyes. Retinal hemorrhaging is indicative in that age

group of something like a shaken baby type thing where you actually caused so much force that you're able to tear those vessels there that you see those plaques or pools of blood deep in the eyes. That's the majority of the time that you see retinal hemorrhaging in a baby. Trauma of some sort.

Q. As you all continued your treatment of Chloe, what steps did you take toward the last of what finally made it all futile.

A. She was intubated. In other words, a tube was put down to breath in her lungs so that she could be properly ventilated. CPR was done until -- her heart actually did start to beat on its own for a period of time, and we were able to stop the compressions and her heart did maintain itself for a period of time. She was receiving IV fluids. We had hoped to take her for a CT scan to see if we could find out -- you know -- more of what was going on in her head that would have caused this or be causing this, and we thought we had her stable there enough for a few minutes to do that. But her final death, you know, that's the pathologist to tell you what her final cause of death was, but what I saw, it was like a -- she just started to swell. Literally swell. Her face, her head, everything just -- it was like it blew out from the inside out and it just caused this actual visual swelling of her head. At that point, we lost everything. There was nothing left, and it was shortly after that the code was called.

Q. Which is another way of telling us what?

A. We pronounced her dead.

BY MR. ROSENBLATT: I tender this witness, Your Honor. Dr. Patterson, answer any questions the defense lawyers have.

BY THE COURT: Cross-examination.

CROSS-EXAMINATION

BY MR. SERMOS:

Q. Yes. Dr. Patterson, when you were talking about the torn frenulum you talked about -- I think you said a lot of times especially in children that a fall will cause that to happen?

A. Uh-hum. Yes.

Q. Well, even though this child wasn't walking, if this child had fallen from a height of, say, three feet onto a hard surface that could cause that frenulum to burst or bleed; isn't that correct?

A. Yes. Anything that would cause -- you know -- something, a force type of effect, yes.

Q. Like a porcelain toilet top or something like that. Some solid object like that.

A. If she fell on to it with her mouth.

Q. Okay. As far as the -- the other records, of course, you talked about the retinal hemorrhaging, things like that, and then you also talked about the rectum and her anus. That injury in and of itself -- I mean, I know it's hard to separate when you have a patient come in like that. That injury itself or whatever caused that to the rectum, that itself would not be a life threatening or life taking injury, would it?

A. The dilation of the rectum?
Q. Right.
A. It would not be a life threatening injury unless something had penetrated it to -- or caused that opening so far that it caused internal damage as far as her abdominal cavity is concerned.
Q. You don't know that any of that happened, do you?
A. No, I do not.
Q. And as far as -- you did state I believe earlier. I want to make sure I understand that. Some type of sexual abuse or sexual assault, but didn't you also say even some kind of object could have caused that wound?
A. Which wound --
Q. The wound on her rectum or the -- you saw that was torn or a tear in the rectum or the anus?
A. Penetration with some object. I would have --
Q. All right. And when you use the word "tear," is that the same word in your language as a contusion?
A. No. A contusion is more just what we call a bruise is a contusion. A tear is more the skin itself and whatever tissue depth it might go. It's actually torn.
Q. So would you be surprised if the medical examiner had called that a contusion instead of a tear?
A. Yes. I guess I would because there was some fluid that was oozing from that sight also.
BY MR. SERMOS: Nothing further, Your Honor.
BY THE COURT: Any redirect of this witness?

BY MR. ROSENBLATT: Briefly, Your Honor.

REDIRECT EXAMINATION

BY MR. ROSENBLATT:

Q. Dr. Patterson, Mr. Sermos indicated that if this baby were dropped just right could have caused that mouth injury?

A. Right.

Q. Do you agree that's a possibility?

BY MR. SERMOS: Objection, Your Honor. He's going into he could have gone into that on direct.

BY MR. HARPER: It's redirect of what he asked him.

BY THE COURT: I overrule the objection at this point. You may proceed, Mr. Rosenblatt.

BY MR. ROSENBLATT:

Q. How would dropping the baby to cause that gaping anal opening?

BY THE COURT: I sustain the objection to that. Any other questions? You may step down. Will Dr. Patterson be excused by both sides?

BY MR. ROSENBLATT: Yes, Your Honor.

BY THE COURT: You'll be released under your subpoena.

BY MR. SERMOS: We excuse her also, Your Honor.

(Witness steps down.)

BY THE COURT: All right. Who does the State call as your next witness?

BY MR. HARPER: We call Dr. Dar, Your Honor.

DR. AYESHA DAR,