

**Report on the Death of Daniel Lemons**

**DOD : May 9, 1999.**

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## Introduction

I am a physician licensed in the State of California. I hold degrees in medicine, law, medical law, and public administration. I am Board Certified by the American Board of Pathology in anatomic and forensic pathology and a Fellow of the College of American Pathologists, and I hold similar certifications in Australasia where I am a Fellow of the Royal College of Pathologists of Australasia. I am a member of the Specialist Register of the General Medical Council of the United Kingdom in the medical specialty of histopathology. I have been admitted and have testified as an expert witness in the field of forensic pathology in the United States, Australasia and Europe. I have been in practice as a forensic pathologist for more than twenty years. I reside in Northern California where I am self employed as medicolegal consultant.

In relation to the death of Daniel Lemons, I have reviewed the autopsy report dated May 10, 1999 authored by Patricia Moore DO and co-signed by Joye Carter MD, Chief Medical Examiner of Harris County, Houston, Texas, various medical records from Texas Children's Hospital and East Houston Regional Medical Centre dated from 3/10/1999 to 3/19/1999 and from 5/2/99 to 5/7/99, including various x-ray and other laboratory reports, and approximately 88 photographs taken at the time of the autopsy. I have also reviewed a report authored by Dr Matthias Okoye, dated February 18 2004, and a report authored by Dr Jan Leestma, dated October 1, 2003, regarding the death of Daniel Lemons.

In so far as I express opinions regarding the death of Daniel Lemons in this report, I hold these opinions to be true to a high degree of medical certainty.

## Background of the Case

The decedent is described as a 2 month old caucasian male. He was pronounced dead on May 9 1999 at 5.20 pm in Texas Children's Hospital, Houston, Texas after being admitted on May 2 1999 at 10pm, with a two day history of dyspnoea and nasal congestion.

The child was born by caesarian section, and had a past medical history of recurrent urinary tract infections with E. Coli bacteremia (i.e. bacteria in the blood) due to persistent vesicoureteral reflux. (Vesicoureteral reflux is a condition which is well recognised as predisposing to urinary tract infection, particularly in childhood<sup>1</sup>). Blood and urine cultures were both positive for E. Coli on that earlier admission. (East Houston Medical Record dated 3/10/99). According to the medical records<sup>2</sup> he had a history of 'frequent illnesses during the first two months of life'.

His admitting diagnosis was hypoxia (i.e. lack of oxygen supply to the brain) of unknown causation, complicated by the fact that on initial admission the endotracheal tube which was intended to assist in supplying oxygen was mistakenly inserted into the esophagus (i.e. the tube leading from the mouth to the stomach) instead of into the trachea (i.e. the tube leading from the mouth to the lungs).

The result of those two events, the hypoxia of unknown origin which caused his admission, and the misplacing of the endotracheal tube, was that he developed 'anoxic ischemic injury to the brain' (per Marvin Fishman MD medical record dated 5/3/99) - i.e. he suffered injury to his brain due to a prolonged period of lack of oxygen supply to his brain.

A report from David Coats MD, also dated 5/3/99 in the medical records,

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<sup>1</sup> Pathologic Basis of Disease, 6<sup>th</sup> Edition. Cotran, Kumar & Collins. W.B Saunders & Co. 1999. p975

<sup>2</sup> Texas Children's Hospital dated 5/7/99 per Robert S. Zeller MD

noted that the child had 'severe, intraretinal hemorrhages. There is also bruising about the nose.....In this setting, non accidental trauma (i.e. shaking injury) should be strongly considered'.

Following his death on May 9, 1999, the case was referred to the Houston County Medical Examiner for investigation as a suspicious death.

An autopsy was duly performed on May 10 1999 by Associate Medical Examiner Patricia Moore DO. Dr Moore attributed the death to 'Craniocerebral Trauma' (i.e head injuries), and listed various findings which she opined supported this opinion. These included subdural and retinal hemorrhage as the primary indications of injury. She also noted 'early bronchopneumonia' (i.e. infection in the lungs) and 'disseminated intravascular coagulation'(i.e. an abnormality of the blood which can be caused by many things and is associated with generalised bleeding and defects in the body's natural clotting mechanisms<sup>3</sup>).

Cultures of blood and brain performed on post mortem tissue samples revealed infection by Pseudomonas, an organism which, like E.Coli. is well recognised as a cause of urinary tract infection, bronchopneumonia, and septicemia<sup>4</sup>

Based on her findings and trial testimony, Brandy Briggs, Daniel's mother, was charged with and convicted of his murder.

#### Opinion.

I am attaching and incorporating into this report an article entitled :

'Patterns of presentation of the shaken baby syndrome - Subdural and retinal

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<sup>3</sup> Pathologic Basis of Disease, 6<sup>th</sup> Edition. Cotran, Kumar & Collins. W.B Saunders & Co. 1999. p640

<sup>4</sup> Ibid at n334

hemorrhages are not necessarily signs of abuse'<sup>5</sup> .

and

various pages from the textbook 'Medicolegal Investigation of Death'<sup>6</sup>

and

various pages from the textbook 'Pathologic Basis of Disease'<sup>7</sup>

In my opinion, the views expressed and summarised in this article together with its cited references and the views expressed in these textbooks represent an accurate and reliable account of current medical and scientific opinion regarding the relevant issues raised by the death of Daniel Lemons, and I agree with those views since they are in accordance with my own experience and training.

The finding that Daniel sustained craniocerebral trauma cannot be sustained for the following reasons :

1. There is no evidence that he suffered craniocerebral trauma.

The original statement by Dr Coats that the signs he observed - retinal hemorrhages and 'bruising' of the nose - indicate a strong possibility of 'non accidental trauma' is totally erroneous. The 'bruising' of the nose he observed is a normal finding in any patient who has received resuscitative therapy in a hospital or emergency setting, and is due to the insertion of a naso-gastric tube or the insertion of an artificial airway via the nose as part of emergency medical therapy.

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<sup>5</sup> Patterns of Presentation of the Shaken Baby Syndrome - Subdural and Subarachnoid haemorrhages are not necessarily signs of abuse. LeFanu J., Edwards-Brown R. BMJ 2004;328:767-769

<sup>6</sup> Medicolegal Investigation of Death. Spitz Werner U, Fisher Russell S. 3<sup>rd</sup> Edition. 1993. Charles C. Thomas Publisher

<sup>7</sup> Pathologic Basis of Disease. 6<sup>th</sup> Edition Cotran Kumar & Collins W B Saunders & Co 1999

In addition, retinal hemorrhages are not pathognomonic of non accidental trauma, or 'shaken baby' syndrome. There are numerous alternative non-traumatic causes for such hemorrhages, many of which are outlined in the article cited above<sup>8</sup>, and which include hypoxic(non traumatic) injury to the brain from any cause, including disseminated intravascular coagulation and sepsis (infection in the bloodstream).. Dr Moore, who performed the autopsy, seems to be unaware of those other causes. Spitz and Fisher, for example, state that<sup>9</sup> :

'Not all cases of retinal hemorrhage are due to trauma. Retinal hemorrhage may be found in cases of subacute bacterial endocarditis....disseminated intravascular coagulopathy ....'

Accurate aging of bronchopneumonia is also 'extremely difficult'<sup>10</sup> and although Dr Moore states that Daniel had 'early bronchopneumonia', the duration of this condition cannot be accurately estimated, and it may have been present on admission and this would explain the child's history of two days of dyspnoea.

In addition, the child was diagnosed as suffering from disseminated intravascular coagulation, a condition which is well recognised as causing 'dyspnoea, cyanosis and extreme respiratory difficulties'<sup>11</sup> and 'In the central nervous system, microinfarcts may be caused...occasionally complicated by simultaneous fresh hemorrhage'<sup>12</sup>.

Thus it appears that the appearance of injury in the form of bleeding and necrosis in the brain and retinal hemorrhages can readily be explained by natural

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<sup>8</sup> Patterns of Presentation of the Shaken Baby Syndrome - Subdural and Subarachnoid haemorrhages are not necessarily signs of abuse. LeFanu J., Edwards-Brown R. BMJ 2004;328:767-769

<sup>9</sup> Medicolegal Investigation of Death. Spitz Werner U, Fisher Russell S. 3<sup>rd</sup> Edition. 1993. Charles C. Thomas Publisher p 710.

<sup>10</sup> Ibid at p 661

<sup>11</sup> Pathologic Basis of Disease, 6<sup>th</sup> Edition. Cotran, Kumar & Collins. W.B Saunders & Co. 1999 p 642

<sup>12</sup> Ibid

causes which are well recognised, non controversial and well established in medical and scientific theory.

Daniel had a previous history of septicemia (bacteria in the bloodstream) and laboratory studies at the time of his death established that this had recurred.

It is well established that septicemia may cause septic shock and widespread hypoxic injury to all of the body's organs, including the brain due to 'irreversible tissue injury'<sup>13</sup>. The fatality rate from the condition of septic shock is estimated as 25 to 75%<sup>14</sup>

2. The Rib Fractures are not a Sign of Child Abuse.

The rib fractures observed are healing and appear to be of an age which would be consistent with an injury occurring at birth caused during the birth process and not due to any form of child abuse.

Conclusion : It could reasonably be concluded to a high degree of medical certainty that Daniel Lemons died of natural causes, and that the cause of his death was complications of septicemia which probably had its origins in a chronic urinary tract infection. These complications included septic shock and disseminated intravascular coagulation which produced conditions which simulated and were mistaken for physical injuries.

This conclusion is consistent with Daniel's past medical history, his

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<sup>13</sup> Pathologic Basis of Disease, 6<sup>th</sup> Edition. Cotran, Kumar & Collins. W.B Saunders & Co. 1999 p 134

<sup>14</sup> Ibid

history and clinical findings on admission to hospital at the time of his demise, and the autopsy findings viewed in their proper light. Daniel Lemons was not the victim of any form of physical abuse and his death was not caused by any form of trauma.

I hold these opinions to be true to a high degree of medical certainty.

Date: 14th March, 2004

A handwritten signature in black ink, appearing to read 'James D. Dibdin', is written above a horizontal dashed line.

James D. Dibdin MD, LLB,LLM,MPA,FCAP,FRCPA.