Testimony of Dr. Vincent DiMaio

EXAMINATION
12
13 BY MR. TOBY L. SHOOK:
14 Q. Dr. DiMaio, my name is Toby Shook. I
15 just have a few questions for you for this hearing.
16 What opinions have you come to testify
17 for today?
18 A. One, that the injuries incurred by
19 Mrs. Routier are those that would be incurred if one was
20 assaulted with a knife, and are not consistent with
21 self-inflicted wounds. She has shown significant blood
22 loss, and that her hemoglobin dropped two grams. She has
23 evidence of severe blunt trauma to both forearms, more on
24 the right than the left. Let's see.
25 Q. Is that it?
Sandra M. Halsey, CSR, Official Court Reporter
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1 A. Well, you know, I don't know exactly
2 what questions I'm going to be asked, you know, but --
3 Q. Are those the only opinions -- has one
4 of these attorneys gone over your testimony with you and
5 asked you questions about what you are coming to testify
6 to?
7 A. Yes, essentially those questions, I
8 think there were some questions asked about bleeding, you
9 know, how much do you bleed with different wounds, and
10 that sort of thing, only having to do with, again with
11 Mrs. Routier.
12 Q. Okay. The first opinion you said was,
13 that Mrs. Routier's wounds would have been, did you say
14 consistent with an assailant?
15 A. What I'm saying is that, based on the
16 location and direction of the wounds and the nature of
17 the wounds, these are the type of wounds that one would
18 get if one was assaulted, rather than self-inflicted.
19 They are not consistent with self-inflicted wounds.
20 Q. And what facts or data do you rely on
21 for that opinion?
22 A. Essentially, the photographs of the
23 wounds and the medical records. All of my opinions are
24 based on photographs of her and her wounds, the -- and
25 the medical records. So that is about it.
Sandra M. Halsey, CSR, Official Court Reporter

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Q. Okay. And then, the other was an
opinion on blunt trauma to the right arm, primarily, and
then maybe blood loss?
A. You get various evidence of blood
loss, her hemoglobin went down from 11.6 at about 3:30 in
the morning, down to 9.6 the following day.
Q. Okay. Is that, as far as you know,
the extent of the opinion that you have come to testify
for today?
A. Yes, I think I have covered
everything. Let me think a second.
Q. And which attorney did you discuss it
with? Was it Mr. Mulder?
A. Well, my original conversation was
with Mr. Parks when he was originally -- he was the one
who originally retained me, and then I discussed it with
Mr. Mulder as well.
Q. Okay.

THE COURT: All right.
MR. TOBY L. SHOOK: Is that as far as
it goes?
THE COURT: Any objection?
MR. DOUGLAS MULDER: I think so --
that is pretty close, yeah.

MR. TOBY L. SHOOK: That's all then,
Judge.
THE COURT: All right. Any objection?
MR. DOUGLAS MULDER: We have none.
THE COURT: I didn't think so. What
about you, Mr. Shook?
MR. TOBY L. SHOOK: No, sir.
THE COURT: All right. Thank you,
Doctor.
Bring the jury in, please.

(Whereupon, the jury
Was returned to the
Courtroom, and the
Proceedings were
Resumed on the record,
In open court, in the
Presence and hearing
Of the defendant,
As follows:)

THE COURT: All right. Ladies and

23 gentlemen, let the record reflect that all parties from
24 the trial are present and the jury is seated. Ladies and
25 gentlemen of the jury, this witness has been sworn

1 outside of your presence.
2 Mr. Mulder.
3 MR. DOUGLAS MULDER: Yes, sir.
4 THE COURT:
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7
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9 Whereupon,
10
11 DR. VINCENT J. M. DIMAIO,
12
13 was called as a witness, for the Defense, having been
14 first duly sworn by the Court to speak the truth, the
15 whole truth, and nothing but the truth, testified in open
16 court, as follows:
17
18
19 DIRECT EXAMINATION
20
21 BY MR. DOUGLAS MULDER:
22 Q. You are Dr. Vincent DiMaio?
23 A. Yes, sir.
24 Q. And will you tell the jury your
25 profession?

1 A. I am a physician, presently employed
2 as the chief medical examiner for Bexar County.
3 Q. You are a medical doctor?
4 A. Yes, sir. I graduated from medical
5 school in 1965 from the State University of New York,
6 Downstate Medical Center.
7 Q. Dr. DiMaio, do you have a specialty in
8 the field of medicine?
9 A. Yes, sir. I am a specialist in the
10 overall branch of medicine called pathology which is the
11 study and diagnosis of diseases. Then I have a
12 subspecialty in forensic pathology, which is essentially
13 a branch of medicine concerned with the application of
14 all aspects of medical science, the problems and the law.
15 Q. Doctor, are you board certified?
16 A. Yes, I am board certified in

anatomical pathology, clinical pathology and forensic pathology.
Q. Does a pathologist also perform autopsies?
A. Yes, sir.
Q. And will you give the jury some idea of how many autopsies you have performed?
A. I would say that I've performed somewhere over 7,000 autopsies, and supervised maybe

about 21,000, in addition.
Q. For how many years have you been the chief medical examiner for the county of Bexar?
A. Since March the 1st, 1981, so it will be 16 years come the end of February.
Q. And Dr. DiMaio, will you please outline for the jury your education and professional experience for the position that you now hold?
A. Yes, sir. After graduating from medical school and obtaining my M.D. Degree, I spent four years additional training in the fields of anatomical pathology, and clinical pathology at Duke Hospital in Durham, North Carolina, and the King's County Downstate Medical Center, in New York City.
I then spent the fifth year of training in the field of forensic pathology at the Office of the Chief Medical Examiner for the State of Maryland.
Following this, I took my board exams in '70 and '71 and was certified as a specialist in the three fields of anatomical pathology, clinical pathology, and forensic pathology.
I then went into the military, I served two years in the Army, assigned to the Armed Forces Institute of Pathology in Washington, D.C. where I was chief of the medical legal section for one year, and

chief of the wound ballistics for another year. Then I got out of the service, and I moved to Texas. I took the position as a medical examiner in Dallas. I was there from around June the 1st, '72 to, as I said, March the 1st of 1981. I was the medical examiner there and eventually ended up as the Deputy Chief Medical Examiner for Dallas County.
That is about it.
Q. All right. Now, Doctor, there is a magazine or journal in the field of forensics, forensic

11 medicine. Are you familiar with the American Journal of
12 Forensic Medicine and Pathology?
13 A. Yes. The American Journal of Forensic
14 Medicine and Pathology is the only medical journal
15 devoted to the field of forensic pathology published in
16 the United States.
17 Q. Would you tell us who the editor in
18 chief is?
19 A. I am the editor in chief.
20 Q. Okay. How long have you been editor
21 in chief?
22 A. I think this is the 6th year.
23 Q. You have published books in the past,
24 have you not?
25 A. I have published three books. I was

1 the editor of one book on forensic pathology. I wrote a
2 book on gunshot wounds, which has been published. And I
3 am also the co-author with my father, who is the Chief
4 Medical Examiner in New York City, on a book called,
5 Forensic Pathology, which kind of covers all the other
6 areas of forensic pathology except for gunshot wounds,
7 which I covered in the other book.
8 Q. In addition to your father, you have
9 other pathologists in the family, do you not?
10 A. Actually, I -- well, yes, I guess
11 that's right. The older of my three sisters is a
12 pathologist and my son is a pathologist in Houston,
13 hospital pathology, he is not interested in forensics.
14 Q. You also have a sister who is a
15 pediatrics physician?
16 A. No, two sisters in pediatrics.
17 Q. Two, excuse me. Doctor, in addition
18 to the books, you have published 70 or 80 articles, have
19 you not?
20 A. 70 articles, 7 book chapters and 10 or
21 11 professional scientific letters.
22
23
24 (Whereupon, the following
25 mentioned item was

1 marked for
2 identification only as
3 Defendant's Exhibit No. 94,
4 after which time the

5 proceedings were
6 resumed on the record
7 in open court, as
8 follows:)
9
10 BY MR. DOUGLAS D. MULDER:
11 Q. I have marked for identification and
12 record purposes as Defendant's Exhibit 94, your CV, which
13 would acquaint the jurors with your background and
14 qualifications?
15 A. Yes, sir.
16 Q. All right.
17
18 MR. DOUGLAS MULDER: We will offer
19 into evidence what has been marked and identified as
20 Defendant's Exhibit No. 94.
21 MR. TOBY L. SHOOK: No objection.
22 THE COURT: Defendant's Exhibit 94 is
23 admitted.
24
25 (Whereupon, the item

1 Heretofore mentioned
2 Was received in evidence as
3 Defendant's Exhibit No. 94
4 For all purposes,
5 After which time, the
6 Proceedings were resumed
7 As follows:)
8
9
10 (Whereupon, the following
11 mentioned items were
12 marked for
13 identification only
14 as Defendant's Exhibits
15 No. 82, 83, 84, 85, 86,
16 87, 88, 89, 90, 91,
17 92, 93 and 95,
18 after which time the
19 proceedings were
20 resumed on the record
21 in open court, as
22 follows:)
23
24 MR. DOUGLAS MULDER: Your Honor, at
25 this time, I'm going to offer into evidence what has been

1 marked and identified as Defendant's Exhibits 82, 83, 84,
2 85, 86, 87, 88, 89, 90, 91, 92, 93 and 95?
3 THE COURT: Any objection?
4 MR. TOBY L. SHOOK: Wait a minute.
5 What is 93?
6 MR. DOUGLAS MULDER: 93 was Dr. Santos
7 report. I think it was already in. I just couldn't find
8 it.
9 MR. TOBY L. SHOOK: No objection.
10 THE COURT: All right. Defendant's
11 Exhibits 82, 83, 84, 85, 86, 87, 88, 89, 90, 91, 92, 93
12 and 95 are admitted.
13
14 (Whereupon, the above
15 Mentioned items were
16 Received in evidence
17 As Defendant's Exhibits
18 No. 82, 83, 84, 85, 86, 87,
19 88, 89, 90, 91, 92, 93 and 95
20 For all purposes, after
21 Which time, the
22 Proceedings were
23 Resumed on the record,
24 In open court,
25 As follows:)

1
2 BY MR. DOUGLAS MULDER:
3 Q. Doctor, so that we might identify
4 these exhibits, Defendant's Exhibit 93 is an operative
5 record that was dictated by Dr. Patrick Dillawn, and also
6 bears the name of Alex Santos?
7 A. Yes, sir.
8 Q. All right. And you have had that in
9 the past, a copy of that to refer to?
10 A. Yes, I have.
11 Q. Okay. And then Defendant's Exhibit
12 No. 95 is a Polaroid photograph that has been admitted
13 into evidence that is dated 6-6-of 96, at 16:05 hours,
14 which would be, I suspect military time, for 4:05 P.M. of
15 Darlie Routier. This picture was taken June the 6th of
16 1996. I'm sorry. Can you see it now?
17 A. Yes. Okay.
18 Q. Also, you have had occasion to see
19 that, have you not?

A. Yes, I have.
Q. All right. And, could you come up here so that Richard, and John maybe, so we can show the jury the various photographs that we're talking about? Maybe each could hold three or four.

MR. DOUGLAS MULDER: Judge, I just want them generally to be familiar with the photographs that we have here.
THE COURT: I understand. All right. Maybe we could get in line in order so we don't inundate the jury.
MR. RICHARD C. MOSTY: Should I be at the end?
THE COURT: Well, let's put it at the other side. We would never place you at the end.
MR. DOUGLAS MULDER: I said the ones in the hospital are June the 6th, the Polaroid is June the 6th, and the deals where she is standing in clothing other than hospital, are June the 10th.

BY MR. DOUGLAS MULDER:
Q. Dr. DiMaio, in reviewing Defendant's Exhibit No. 93, that is the operative report, did you determine from that report that Darlie Routier had experienced considerable blood loss?
A. The -- yes, sir. That in conjunction with the lab reports. That is, the report by Dr. Santos describes an incised wound, running down the right side of the neck onto the chest, and then a continuation on the left side of the chest.

And, he indicates that the -- he calls it a laceration, it's really an incised wound, a cut -- extend down to the sheath of the carotid artery, and this is almost like a thin, transparent membrane, the best way to think of it, it looks like Saran Wrap, so, that was wrapping the vessel, and it is about a millimeter thick, there may be a little more there.
So, essentially, you are talking about a cut that went down to, virtually, the wall of the carotid artery. And, if it had severed the carotid artery, she would have bled to death, because the blood would have pumped out in a matter of a few minutes and there would have been death.

When you look at the rest of the medical records, they indicate that when she came into the hospital, she had a blood hemoglobin, that is the amount of -- that is kind of a measurement, the amount of hemoglobin that you have in your blood.
A blood hemoglobin level of about 11.6 and this is about 3:30 in the morning. Then by the next day, it had dropped two points, from 11.6 down to 9.6, and what happened was is that she had lost a significant amount of blood from this injury. And -- but it's not initially reflected. That is, what happens is that when you lose blood, your body compensates for it by

mobilizing fluid from outside the bloodstream and pours it in.
In addition, when you go to the hospital, you know, they run those IV's, they are putting in fluids. So what happened is, is that her hemoglobin appeared relatively normal when she came in, because the blood not been diluted by the fluids. The fluids came in, it dropped. And what it meant was, that she had lost a significant amount of blood from these wounds. And in fact, one of the diagnosis was acute posthemorrhagic anemia, which meant she lost a lot of blood.
So this, these wounds were not, you know, that and the other wounds on the arm, caused a drop of two points in her hemoglobin, which is a significant drop.
Q. Okay. Dr. DiMaio, what is your evaluation as regards to the seriousness of that neck wound?
A. About another millimeter or two, and she would have been dead. It would have cut right through the carotid artery.
In theory, you could put pressure on to stop it, but, you know, in a real life situation, people aren't trained like physicians, and she would have bled to death.

It's -- the carotid artery, or the two carotid arteries deliver 75 percent of the blood going to your head. So, she would have lost approximately 40 percent of the blood supply going to her head. And every time her heart beat, there would have been a pulse of blood shooting out the neck, four or five feet, if she had cut the carotid artery. And, the cut was, as I said,

down to the sheath, a millimeter thick, maybe.
Q. Dr. DiMaio, have you had the opportunity to view the photographs taken of Darlie Routier on June the 6th, there in the hospital?
A. Yes, sir.
Q. And, have you also had occasion to review and evaluate the photographs where she is in, not in hospital garb but in regular civilian clothes, shorts, I believe, the photographs that were taken on June the 10th of 1996?
A. Yes, sir.
Q. Okay. Do the bruises on June the 10th of 1996 demonstrate bruising?
A. Yes. I mean, if you look at her arms on the 10th, you can see there is just massive soft tissue hemorrhage.
This is her right arm. And what it is going from the wrist right up to past the elbow and into

the upper arm, so it's going, just sweeping, all the way here on what you would call the plexor surface of the arm, not on the back. And this is extensive hemorrhage.
And it appears to be a few days old, because it's turning, it's a good purple color, and it's indicative of severe, blunt trauma.
This, you know, everyone bumps into something, an edge or something and gets a little bruise, but just think about, if you have gotten one little bruise, how much force must have been generated, must have been put against this arm to cause the whole arm from the wrist past the elbow, to be bruised.
So that is a lot of force. And so there is evidence of really severe injury, and there is like a little, a few little, what appears to be scrapes here, indicating that there was an impact with something.
So, you're talking again of severe force. The left arm -- again, this is the right -- the left arm is not too bad. You can see it's going upward to maybe a third to half a way up the forearm on this surface.
Q. Doctor, you have noted, that no doubt, that there is evidence in the photograph you have in your left hand or just put down there on it, of a line, an arterial line in her left wrist?

A. Yes, sir.
Q. And also, an IV in her, I guess, what is that, the inside of the left elbow?
A. Yes, sir. Right. Yes.
Q. That's what I call it.
A. All right. That is good enough.
Q. All right. At least --
A. At the cubital fossa, let's use the crease.
Q. Is that bruising, in your judgment and experience, is that a result of medical intervention?
A. No. The bruising here -- I mean, I -- at one time I actually treated live people. I started IV's. That was the day before we had disposable needles, and those needles were dull.
I can tell you, I perforated vessels and there was blood, and you did not get this massive hemorrhage into the arms.
And I have had IV's started on me, where they have poked through, and you don't get it. This is blunt force injury, and it's deep, it's deep down into the muscle. And so, it was deep down and then gradually the blood percolates up to the surface underneath the skin.
Q. Doctor, directing your attention to

the right arm, the photographs that depict the right arm?
A. Yes, sir.
Q. And, you will notice two stab wounds in the right forearm?
A. Yes, sir.
Q. One of some two inches in length and the other, of approximately a half inch in length?
A. Yes, sir.
Q. Do you have an opinion with respect to whether or not the bruising associated with the right arm was caused by those two stab wounds?
A. No. Stab wounds in those locations would not produce that massive bleeding into the arm. And in fact, if you even use a little -- if you think about it, look at where they are. They are on the back, and on the back, there is not much bleeding. Where is all of the bleeding? Let's see, excuse me.
There's so many, I have got to juggle these things. It's on the other side. So, these stab wounds have nothing to do with the bleeding in the arm.
Q. All right. Doctor, what sort of

23 instrument caused those injuries?
24 A. The two penetrating wounds in the --
25 Q. No. No. That caused the bruising?

1 A. It would have to be something blunt.
2 By blunt, I mean it doesn't have sharp -- it's not a
3 knife, it's not something with very sharp margins.
4 It could be blows from a fist, because
5 your fist is considered a blunt object. It could be
6 blows from a hard object, people always like baseball
7 bats, things like that.
8 It could be anything that is heavy,
9 that doesn't have any cutting edges and that can be, that
10 could impact hard against the arm, so to cause all this
11 bleeding in this area.
12 Q. Are those injuries consistent and
13 compatible with Darlie Routier having been severely
14 beaten with a blunt, heavy instrument?
15 A. Yes. That is what they are. These
16 are blunt force injuries. Impacting something very hard
17 that produced extensive bleeding into her muscle.
18 Q. Are those injuries consistent and
19 compatible, those shown in the photographs of June the
20 10th, of 1996, are those consistent and compatible, the
21 bruises evidenced in those photographs, with having been
22 received by Darlie Routier during the early morning hours
23 of June the 6th of 1996, some four days or so earlier?
24 A. Yes, sir. The coloration is
25 appropriate, and it is consistent with it.

1 Q. Okay. Dr. DiMaio, are those injuries
2 consistent or inconsistent with having been
3 self-inflicted, the bruising?
4 A. That is -- I would say it's
5 inconsistent. I mean, how do you get blunt force
6 injuries here? I mean, it's easy to get blunt force
7 injuries here, if you want, you know, I can bang my arm
8 against the edge here. But to here? And, also, again,
9 it's very wide spread.
10 I mean this, this, a lot of force.
11 You -- everybody has bumped into something and you get a
12 bruise, but look at this. It's just really severe
13 hemorrhage up and down the arm. This is tremendous
14 force.
15 Q. Doctor, what are defensive wounds?
16 A. Defensive wounds are injuries that you

17 get when you try to ward off an attacker. And, the
18 original description had to do with knives, and it could
19 also be blunt force.
20 In other words, if somebody is
21 swinging something hard at you like a hard object, and
22 you put your arm up like that and you get injuries here
23 and here, then you have what is called defensive wounds,
24 because they are incurred when you try to protect
25 yourself. And people will typically protect the most

1 important part of the body, that is the head. So people
2 tend to raise arms up, if it's a blunt force, and try to
3 protect their face and head.
4 Q. Doctor, I'll ask you to refer to the
5 photographs and see if they don't depict an injury to the
6 neck of Darlie Routier, an injury, a stab wound to the
7 left chest of Darlie Routier, cuts to the left, inside
8 fingers to three of her fingers on her left hand, and two
9 stab wounds in her right forearm?
10 A. Yes, sir.
11 Q. All right. Would you characterize any
12 of those injuries as defensive wounds?
13 A. The wounds that you would consider
14 defensive would be the wounds of the back of the right
15 forearm. This is a close-up in my right hand. This is
16 the type of wound that if somebody was trying to stab at
17 you with a knife, what do you do? You put your am up.
18 And there are two stab wounds here and here.
19 If she had been dead, and I had done
20 an autopsy, I would have called -- I would have put this
21 section down as two penetrating stab wounds of the right
22 forearm, parenthesis, defense wounds. Because this is
23 the location that you get these wounds in, if somebody is
24 going to attack you with a knife. It's typical.
25 That is, people who commit suicide

1 will cut themselves here. Why? Because this is the
2 natural way to do it. Although, they cut the edge, this
3 way. But these are vertically oriented, you know, on the
4 hands in its normal position, and on the back. And this
5 is typical for the defense wounds, when someone is coming
6 at you with a knife and you hold your arm up in the front
7 of you, and this is where you would get the defense
8 wounds.
9 Q. Okay.
10 A. And the other place you get defense

wound are on the hands. In fact, the original
description of defense wounds is on the hands.
Because what happens is someone comes
at you with a knife, you try to ward them off, a lot of
times they try to grab the blade, and you can see there
is a cut going across, a very superficial cut going from
one finger to the other and there. This has the
appearance of one single cut.
All right. I know someone says,
"Well, they don't exactly line up," but you know, your
fingers, you don't walk around with your hand like that,
I mean, you curl them and then maybe down or up. And
this has the appearance, again of a defense wound.
Again, if this was an autopsy case, I
would put, you know, incised wounds of fingers,

parenthesis, defense wounds.
Q. Okay. Dr. DiMaio, have you had
occasion in the past to examine injuries or render an
opinion as regards to whether or not those injuries were
self-inflicted?
A. Yes. The last time I think was about,
just before Christmas. A nurse shot her, I think it was
common-in-law husband, and her defense was is that he
attacked her with a knife. And, you know, they were
obviously self-inflicted wounds.
And my office has had two other -- in
the last three or four years, two other cases where the
defense was, you know, it was self-defense, and I had
to -- I warded off a knife, and these are defense wounds,
you know, these wounds were incurred, but actually they
were incised wounds.
One was, I think, an oral surgeon,
another one, a dentist. And again, I had another case of
a doctor who self-inflicted wounds and was trying to say
he was attacked.
Q. All right. Dr. DiMaio, assume that
Darlie Routier is right-handed, are those injuries that
you observed in the photographs, are they consistent or
inconsistent with self-infliction?
A. They are inconsistent with

self-infliction. Both the wounds, the stab wounds on the
back of the right forearm and the stab wounds on the
neck. Because if you look at the -- really, incised
wounds. When I say incised, I mean a cut.

And, an incised wound is when, you know, the sharp edge of a knife runs across her body, but a stab wound is the tip going into it. And, you can see here and here (demonstrating), then if we go close up, this is a much better close-up.
And what this shows, is that this wound has started on the right side of her neck here, across the midline going in a downward path, and then, there is a gap and then there is a second wound.
So essentially, if you look at me, there is an incised wound going like this, gap, and then there is another knife wound here. And, you know, if you think -- the ruler -- think about this.
If this is a knife and you're right-handed, I mean, you are going to have to be going like this, the edge of the knife, and then skipping a place, like that, then, changing hands and doing two stab wounds here, this way.
And, because, you know, people don't do things the hard way. They do things simple. So, this, you know, try and say, you know, you are going to

cut like this, and then you have to cut like that, and then stab, doesn't make any sense for self-inflicted wounds, for a right-handed person.
And people who are right-handed use their right hand for self-infliction of the wounds, because you don't think about it. If I handed any of you this, you would pick it up with your dominant hand. You wouldn't think anything.
You wouldn't pick it up with your left hand and manipulate it. It's too difficult. And people don't think about that. They are not going to say, "Oh, I'm going to switch hands." Now, like I said, the people I saw were doctors and nurses and they self-inflicted with the right hand, which was their dominant.
The wound on the neck is -- if I may demonstrate on you?
Q. Sure.
THE WITNESS: May I, your Honor?
THE COURT: That is quite all right.
MR. DOUGLAS MULDER: That is why I got the ruler.

(Whereupon, the witness Stepped down from the Witness stand, and

Approached the jury rail
And the proceedings were
Resumed as follows:)

THE WITNESS: As I said, this, and then you have to turn it like this, doesn't make any sense. But that makes sense, or, that make sense. Okay? And, what happens, you notice how he cringed? Well, let's go in slow motion. The knife comes here, and starts to cut, and what will you do, you'll lean back.
And of course, when you lean back, there's a gap, but you stick your chest out and you get here. So it's like this, now lean back and so there is a gap. Stand straight.
MR. DOUGLAS MULDER: Okay.
THE WITNESS: The cut comes down like that, and now you start to go back. And notice how you get a skip, and if you look at these wounds, they line up.

BY MR. DOUGLAS MULDER:
Q. Would that be the same if I were -- could you demonstrate that same thing if I were lying on a sofa?

A. Sure. It's the same thing. Well, it doesn't make everybody horizontal, but it's the same way. If you look at this, this is one wound coming straight down this way. It's coming from here, gap, space. And this is not consistent with someone self-inflicting it with the right hand. I mean, obviously, you can't stab yourself in the back. And people who do self-inflict wounds, will always use their dominant hand, because that is how you are taught to use knives and things.

THE COURT: Thank you, Doctor. All right. We will recess for lunch now. Until 10 minutes after 1:00 o'clock.
All right. Same instructions to the jury as always: Don't discuss the case among yourselves, or with anyone. Do no investigation on your own. If you see any publicity about the case either on radio or T.V., newspapers, please ignore it. Thank you.

20
21 (Whereupon, a short
22 recess was taken, after
23 which time, the
24 proceedings were
25 resumed in open court,

1 in the presence and
2 hearing of the
3 Defendant, being
4 represented by his
5 Attorney, but outside of
6 the presence of the jury
7 as follows:)
8
9 THE COURT: Are both sides ready to
10 bring the jury back in and resume the trial?
11 MR. DOUGLAS D. MULDER: Yes, sir.
12 MR. GREG DAVIS: Yes, sir, the State
13 is ready.
14 THE COURT: All right. Bring the jury
15 in, please.
16 Will the Court come to order, please.
17 THE BAILIFF: Please have a seat.
18
19 (Whereupon, the jury
20 was returned to the
21 courtroom, and the
22 proceedings were
23 resumed on the record,
24 in open court, in the
25 presence and hearing

1 of the defendant,
2 as follows:)
3
4 THE COURT: All right. Let the record
5 reflect that all parties in the trial are present and the
6 jury is seated.
7 Mr. Mulder.
8 MR. DOUGLAS MULDER: Yes, sir.
9
10
11 DIRECT EXAMINATION (Resumed)
12
13 BY MR. DOUGLAS MULDER:

Q. Dr. DiMaio, are you familiar with
blood pattern interpretation?
A. To a certain degree, yes, sir.
Q. And Dr. DiMaio, as a medical doctor,
what aspects and variables from a medical standpoint must
be taken into consideration in blood pattern
interpretation?

MR. TOBY L. SHOOK: Judge -- excuse
me, Doctor -- could we approach the bench for one moment?
THE COURT: You may.

(Whereupon, a short
discussion was held
at the side of the
bench, between the Court,
and the attorneys for
both sides in the case,
off the record, and outside
of the hearing of the
Jury, after which time,
the proceedings were
resumed on the record,
in the presence of
the jury as follows:)

THE COURT: Okay. Thank you. Go
ahead.

BY MR. DOUGLAS MULDER:
Q. Dr. DiMaio, what are the variables
that have to be taken into consideration from a medical
doctor's standpoint in blood pattern interpretation?
A. Okay. Essentially, bleeding is not a
simplistic thing. So, if you have -- some people think,
you know, if you cut yourself or you have a wound,
everybody bleeds the same. But there are a lot of things

that go into how you bleed.
One of the simplest is, it has to do
with what is called, the Langer's lines, the elastic
fibers in your skin.
We all know as we get older, our skin
sags. And what happens is is that in the skin, beneath
the skin, there are elastic fibers and they make the skin

very contract, you know, contractile.
And, they run certain ways through the
body. And, have you ever seen anyone with a vertical
scar on their forehead, you notice how it stands out, but
then you see people who have horizontal scars and it gets
lost in the normal folds.
And plastic surgeons take advantage of
these elastic fibers to hide their scars. And so, if
you -- let's say you have been stabbed. Suppose you get
stabbed, if you get stabbed perpendicular to Langer's
lines, the elastic fibers pull open the wound and you get
a lot of blood coming out, if there is a vessel
underneath that is spurting, it will spurt out.
If you cut along the fibers, the wound
tends to be slit-like and it may not begin bleeding
immediately, or if it does bleed, it will not bleed as
much as the vertical one.
Then you have to take other factors.

Right beneath the skin in most parts of the body, you
have muscle. And everybody has had a muscle cramp, you
know, when the muscle contracts down.
Suppose you get a stab wound in the
chest here, through the muscle. Is the stab wound
parallel or perpendicular to Langer's lines? Then when
it goes in, is it running with the muscle or against it?
If it's running against the muscle, the wound will gape
open.
If it's running with the muscle, it
will be slit-like. And then you are irritating the
muscle, will it go into a cramp and shut down and reduce
the amount of bleeding?
Then, suppose you do have a stab wound
going through here. And then suppose you move your arm
or maybe your arm had already been moved in an unusual
position when you had the wound, and now you moved it
back, the muscle can slide over, and there could be
contraction.
So, a simple stab wound may not be
simple. The amount of bleeding may be determined by
Langer's lines, the elasticity of the skin, whether you
are cutting against the muscle or with the muscle,
whether the muscle contracts down.
And then, when you get into a body

cavity, do you hit a large vessel? Does the bleeding from the large vessel go into the cavity first, and then leak out? Or does it -- is the vessel so close to the surface that it pulsates out?
Then, of course, you have clothing.
You have, say, a shirt like that. You get a stab wound here and then the clothing shifts, or maybe the clothing had been pulled over when you got the stab wound.
Now the clothing shifts over it. And so that affects the way you're bleeding. So the concept people have is you get a wound and the blood comes out in a simple pattern. It is not that simple.
There are a number of factors that can determine how much blood comes out, how fast, and whether it comes out in spurts or kind of dribbles out, and unfortunately, some people don't take that into account in bloodstain interpretation and that is the Achilles heel of bloodstain interpretation.
It makes an assumption that is not true. That all wounds are equal, all wounds bleed the same, and that you can -- you have -- you are starting out with a fixed concept, or fixed concept and then you can interpret, and it doesn't always happen that way.
On top of that, you will actually get certain areas of the body where you will get a wound, you

may not get any bleeding because the initial response to the shock is contraction down of the blood vessels. Even if you have like a major artery, like the carotid artery.
If you cut it, suppose you don't cut it all the way, you only cut it part of the way, and then someone else gets it cut all the way. Which wound is worse?
Actually, it's the wound where you only cut part of the way, because if you cut it completely through, an artery, which is elastic like that, may go into contraction and may actually shut off both ends for a short time before it pulsates.
But if you cut it open, you maintain the open lumen of the vessel and the blood keeps pumping out. So the thing is bleeding and wounds and how the blood comes out is complex and it's not simple, and to try to assume everybody and every wound will bleed the same, doesn't work out. And again, that is the Achilles heel.
Q. So, I guess what you are saying is that, when somebody gets a stab wound or a puncture wound, the body doesn't always bleed like water runs out of faucet, when you turn the faucet on.

23 A. Right. It depends on, again, all of
24 these factors, including clothing, whether it's with the
25 grain, against the grain, whether it's muscle, whether

1 you hit a vessel, there's a whole bunch of things. And
2 you can only generalize, but it may not actually, what
3 you may say, may not apply in this case. But you can
4 just get a general feel.
5 Q. Dr. DiMaio, have you seen many victims
6 of stab wounds?
7 A. Yes. I would say a couple hundred in
8 the last few years.
9 Q. Let me show you what's been marked for
10 identification and record purposes as State's Exhibit No.
11 25.
12 A. Yes, sir.
13 Q. And it has quite a number of holes
14 that are taken for evidence purposes. But it also has a
15 hole here, a defect here, and it has a defect here, and
16 it has a defect here.
17 I was thinking there were four of
18 those defects, but at any rate, here, here and here. Do
19 you routinely find defects in clothing worn by a victim
20 where there is no corresponding stab wound or cut on the
21 body itself?
22 A. All the time.
23 Q. How is that?
24 A. Because essentially, what you are
25 talking in most cases, it's not just somebody sticking a

1 knife in. There is a struggle. And you try to grab
2 people, and most stabbings are close combat.
3 Suppose you grab a shirt like this,
4 and you pull it, and then a knife blade comes toward you,
5 and you pull back, so it cuts the material.
6 But, let's put it this way: I would
7 say that maybe a quarter of all cases, you will find a
8 little tear, you know, of multiple stab wound cases, a
9 little tear, a point where the tip of the knife has gone
10 through, and even a slash, and on the body it doesn't
11 correspond.
12 Because what's happened is, during the
13 struggle the clothing has been pulled away, or it --
14 maybe just hangs down, and so, when someone slashes the
15 knife, it catches the material, but it doesn't go in deep
16 enough to cut the body.

So that's just common, all the time you will find defects in the clothing, and no injury to the underlying body. An examination of the clothing at the time of the autopsy is part of the autopsy.
In my autopsy reports, and every one that comes out of my office, if the person is wearing clothing and we have the clothing, in the autopsy report will not only be a description of the body, but will be a description of the clothing, and whether there are

corresponding defects or noncorresponding defects in that clothing.
MR. DOUGLAS MULDER: Thank you, Doctor.
Mr. Shook will have some questions for you.

CROSS EXAMINATION

BY MR. TOBY SHOOK:
Q. Dr. DiMaio, it's my understanding you are the chief medical examiner of San Antonio?
A. Yes, sir.
Q. Okay. And additionally, you make extra money coming in and testifying at -- out of other jurisdictions?
A. Right. I am not here as -- in my official capacity as chief medical examiner. I am here on my own time, compensatory time, and this is what I do, you know, it's work on the side.
Q. And when you are testifying as an expert, for instance, today, how much -- what is your fee that you charge for that?
A. It depends on how far I have to go and

it depends on how long, it depends on how much time.
Q. In this particular case?
A. I think my total bill, when I submit it, is going to be about fifteen hundred dollars.
Q. Okay. And, you, in recent years testified for, as I said, the defense in cases such as this, haven't you?
A. Yes, most of my testimony is for the prosecution in Bexar County, obviously, because that is where my job is. And then I -- on private, I do about

half the time for the prosecution and half the time for defense. This Friday I was testifying for the prosecution in Florida, and Tuesday I am testifying for the defense.
Q. A medical examiner is not supposed to be biased one way or the other; is that right, Dr. DiMaio?
A. That's correct.
Q. You just, you get the body in and you do the autopsy, and you testify to questions asked about what you found; is that right?
A. Right. And that is what I'm doing here. I am just testifying to my scientific observations of the wounds in this case.
Q. And, you have testified for Mr. Mulder

before, haven't you?
A. When he was a district attorney, yes, and also when he was in private practice.
Q. How many times have you testified for him since he has been in private practice, would you say?
A. Maybe four or five times.
Q. Okay. And have you consulted with him on other cases?
A. Well, he's shown me occasionally a case or two, and I have told him things.
Q. Did you make any report in regards to this case?
A. No, sir.
Q. Any notes in regards to this case?
A. Just this sheet right here. If you want to take a look at it.
Q. And then the -- the only other items you looked at were the photographs?
A. And the medical records.
Q. And the medical records.
A. Yes.
Q. Did you look at all of the medical records?
A. What? Well, on my testimony. I've also -- I also have here some testimony by Dr.

Townsend-Parchman, but I'm not using any of that. Do you want to take a look?
Q. Yes. But you had the Baylor medical records to look at; is that right?

A. Yes, sir.
Q. Okay. And is that -- and then you had some photographs. When is the first time you looked at these photographs?
A. When I was originally given them by -- it was by Mr. Parks.
Q. Okay. You have not interviewed anyone else in regards to your testimony or opinions?
A. No, sir.
Q. Have not talked to Dr. Santos or Dr. Dillawn or any of the nurses at Baylor, have you?
A. No, I have just read his medical records and such, yes.
Q. Okay. And you said that you worked on several cases where people have committed self-inflicted wounds to try to, I guess, what, cover their tracks or throw off blame on them?
A. Yes, sir.
Q. Situations like that?
A. Yes, sir.
Q. So you do see that from time to time,

don't you? People will go to the trouble of actually having a self-inflicted wound to try to shove blame off on them?
A. Yes, sir.
Q. Or point it in another direction?
A. Yes, sir.
Q. I guess, in your line of work, it never ceases to amaze you what people can be capable of?
A. Yes, sir.
Q. Okay. Now, you say that -- well, let me start this way. You talk about --
A. Excuse me.
Q. Yes, sir.
A. Are you through with my material, or do you want to look through it?
Q. Well, I was going to look at here in a second.
A. Okay. That is fine.
Q. Would it be better --
A. No, no, no. Go ahead and look at it.
Q. I'll leave it with you in case you need to refer to it.
A. Okay. My piece of paper.

THE COURT: Can you all hear him okay?

THE JURORS: Yes.
THE COURT: Thank you. All right.

BY MR. TOBY L. SHOOK:
Q. Now, as far as the seriousness of the defendant's wounds, Dr. DiMaio, wouldn't the surgeons who actually performed the surgery on her, be a better judge of how serious those injuries were?
A. Well, yes, sir. And that is why I'm using their description that it went down to the carotid sheath. If you are down to the carotid sheath, you are within one or two millimeters of the carotid artery. And then, of course, the medical records, also -- I'm answering you now -- all the medical records also show the hemoglobin has dropped by two milligrams. So --
Q. But would you agree, Doctor, that the surgeons who actually performed the surgery would be a better judge to how serious their injuries -- or her injuries were?
A. They might be, yes, sir.
Q. Well, they were there, weren't they?
A. Yes, sir, but I don't know what -- but I mean, you know, it's like saying, someone shot at me with a .44 magnum and it missed me, so therefore, it

wasn't very serious.
Q. Doctor, that is not the question I asked you. They were there, weren't they?
A. Right, yes, sir, they were.
Q. Okay. They performed the surgery on her neck, didn't they, Dr. DiMaio?
A. Yes, sir. And I'm basing my opinion on their description of it.
Q. They saw the wound opened and operated on it?
A. Yes, sir.
Q. So wouldn't they be the better judge of just how serious that injury was?
A. Yes, sir.
Q. Okay. Now, as far as your opinion about the defendant self-inflicting these wounds, are you saying that it is impossible, that it couldn't have happened?
A. No. What I'm saying is, that based

upon their location and their path, and the nature of the wounds, it is more probable, the term I used, that it's inflicted by someone else. Anything is possible, but I am saying in this case, it's not probable.
Q. Okay. And as far as the neck wound, you were talking about -- well, how would you describe

the neck wound? Is it -- it's a pretty long wound, I guess, wouldn't you say?
A. It looks to be about three inches or so, the primary wound.
Q. Okay. Have you actually gotten to examine her scar?
A. No.
Q. Okay. Would that help you in some of your opinions, if you got to look close at the scar?
A. It doesn't make any difference because it is pictured in the photographs.
Q. Okay. So those would be fine for you?
A. Yes, sir.
Q. Okay. You said -- do you have any opinion as to how fast that wound would bleed out? You were talking about when Mr. Mulder was finishing these -- what did you call them? Langer's lines?
A. The Langer's lines, yes, sir.
Q. Did that make a difference in this case, or do you have an opinion as to how fast the neck wound might bleed?
A. No, sir. All I know is that, you know, she lost two milligrams -- two grams of hemoglobin.
Q. If that neck was cut, or when it was cut, would you expect it to bleed pretty quickly?

A. It would begin bleeding fairly quickly, within 30 seconds to a minute, yes, sir.
Q. Would a neck wound like that bleed a lot, have a lot of blood coming out of it?
A. Under most conditions, it would bleed a lot, yes, sir.
Q. Okay. And, how would you describe the position of this wound on the neck. Is it -- I mean, let's say, she didn't survive, she had died. How would you describe it in an autopsy?
A. An incised wound.
Q. Okay. And what position would you say it was on the neck?

A. Okay. It's on the -- okay, it would
be an incised wound of the anterior aspect of the neck,
beginning, say, this is -- I'm just throwing numbers out
saying --
Q. Sure.
A. -- 2 inches to the right of the
midline, above -- say an inch or two above the clavicle,
the collarbone and running downward and medially, that is
towards the center of the body, crossing the midline and
extending towards the medial end, that is the inner end
of the left collarbone. And the incised wound extends
down through the muscle, up to the carotid sheath.

Q. Okay. How about the angle? How
severe an angle is the neck wound?
A. What do you mean, how severe an angle?
Q. Well, is it, like, vertical, oblique,
horizontal?
A. It's an oblique. It's running
downward from right to left.
Q. As far as the neck wound goes, would
you say it was a pretty long wound?
A. Well --
Q. I think it's in the medical --
A. It's a couple of inches, right. I
think it says 7.5 centimeters or so. Let me see how long
is this drawing?
Q. I thought I saw nine millimeters.
A. Nine centimeters?
Q. Or centimeters, I'm not sure.
A. Okay. Nine centimeters then would be
approximately four and a half inches. No, let me see,
no. It's three and a half inches, that is what I said.
Okay. It's 2.5 centimeters per inch and 10 centimeters
would be four inches.
Q. Okay.
A. So, it's a little less than four
inches.

Q. A little less then four inches.
A. Yes, sir.
Q. And looking at the photograph here in
28-B, it covers most of the front of the neck, I guess,
wouldn't you say?
A. It begins to the right of the midline,
runs downward onto the upper chest, right. Yes, sir, so

8 that is the primary one.
9 Q. So we're talking about all down the
10 front of the neck? Starting at the top right and going
11 down?
12 A. Yes, sir.
13 Q. Now, you can't say, or maybe you can,
14 if it started here or there? I mean, at which end it
15 starts, the cut? Can you tell us which end, just looking
16 at it?
17 A. No.
18 Q. So it could go this way or that way?
19 A. You could in theory say, it went up
20 this way. But of course, the problem there is if you are
21 trying to say it was self-inflicted, it becomes even more
22 difficult.
23 Q. Now Doctor, are you saying that the
24 defendant could not take this knife --- oh, I think we --
25 she could cut her own neck with this knife, couldn't she?

1 A. Well, I said it's possible, but
2 improbable due to the -- if you look at it, see how it
3 comes down and then skips and then down.
4 Q. Well, that is if you take it through
5 that that is one long, continuous cut, right?
6 A. Yes, sir, and it lines up, and it's
7 consistent with it. Down, then you come, as you're
8 coming, then you come back and put your chest out and
9 then it catches it.
10 Q. Well, I don't want to use this knife
11 on myself, obviously. Let's try to measure it up here.
12 But there is nothing --
13 A. It would settle the problem, how fast
14 the bleeding was, you know.
15 Q. Yeah. All right. Well, I don't think
16 I will be demonstrating it. Maybe Mr. Mulder could come
17 up here and do that.
18
19 MR. DOUGLAS MULDER: Hand me the
20 knife, I'll do it.
21
22 BY MR. TOBY L. SHOOK:
23 Q. But there is nothing -- nothing that
24 would prevent her from taking that knife, if she wanted
25 to, and cutting across here?

A. That's correct. Then she would have to cut again, then she would have to change hands.
Q. Yes. And then do --
A. Turn her arm like that.
Q. Yeah.
A. But, what I'm saying is, it's improbable.
Q. It's improbable?
A. Yes, because people who we've seen and who have had incised, who do try to do that, do the same thing, they always use the dominant hand, the right hand. It's so ingrained that you don't even think about it.
Q. That is what people usually do?
A. Right. These people are, you know --
Q. Okay. But there is nothing preventing the --

MR. DOUGLAS MULDER: Excuse me. Excuse me. If you just will let him answer.
THE WITNESS: These people, no insult to the defendant, but they're a little better -- they were better educated than her and they are familiar with medical things and they may even be familiar with forensics, which I seriously doubt that she is.

BY MR. TOBY L. SHOOK:
Q. But there would be nothing preventing the defendant from -- take the knife with the left hand, stabbing it right there in the right arm. She could do that, couldn't she?
A. That's what I said. I said it's possible, but not probable.
Q. Well, in fact, there were two wounds there on the right arm, aren't there?
A. Right.
Q. One is much smaller?
A. Yes.
Q. Didn't even require any sutures or anything. This wound we're talking about right here?
A. Yes.
Q. And, is this wound kind of right here, Doctor, would you say in the middle of the forearm or near the elbow?
A. It's on -- it's approaching the side of the arm.
Q. Okay. And this other one is right above it?

23 A. Right.
24 Q. Okay.
25 A. It's actually a little further towards

1 the finger.
2 Q. You talk about hesitation wounds, that
3 is when a person might work up enough courage, or testing
4 out, for instance, sometimes you get suicides, they might
5 cut a little bit before they make the big cut. Is that
6 right?
7 A. Hesitation marks are associated with
8 incised wounds, right. Cuts where they start to make a
9 cut and it hurts, and then they start and it hurts, so
10 you will see a number of smaller wounds.
11 Q. This smaller wound we see here could
12 be consistent with sort of a hesitation wound, couldn't
13 it?
14 A. You could say that if you think
15 it's -- if you think they are self-inflicted. Or, if
16 it's not self-inflicted, it's just a small stab wound.
17 Q. Right. It could go either way? But
18 it could be consistent with someone stabbing their arm
19 and then stabbing it with greater force right below it.
20 A. Right. What I am talking about is
21 medical probability. I'm not talking about possibility.
22 Q. And, again, as far as the angle goes,
23 right-handed, I mean, do you think it's real difficult
24 just to do that?
25 A. It actually is.

1 Q. Well, I'm doing it, aren't I?
2 A. Yes, I know.
3 Q. Okay.
4 A. But well, okay. Never mind.
5 Q. Okay.
6 A. It's difficult, but then again, okay,
7 so you do it this way, which is difficult, it's easier
8 just to go this way, and most people would go this way.
9 Why go this way? Why do it difficult?
10 First of all, if you're going to cut
11 yourself and you know it's going to hurt and everything,
12 why do it the hard way? Why not just go that way?
13 You are saying she went that way, then
14 put the knife in her other hand and then stabbed herself.
15 Q. Could do it? Could happen though?
16 A. It could happen, but --

17 Q. Nothing could stop her and it's not
18 physically impossible to do that?
19 A. It's not possible (sic) -- it's not
20 impossible, I said it's not probable.
21 Q. As far as that blunt trauma goes, that
22 is severe blunt trauma; is it not?
23 A. Yes, sir.
24 Q. And the bruising that you see there,
25 you said -- could that be consistent with just being two

1 days old?
2 A. It looks to be a couple of days old.
3 That's all I will say. You can't date it any better.
4 Q. You can't come to dating them real
5 close, can you, Doctor?
6 A. No, sir.
7 Q. If this photograph was taken on the
8 10th, it's possible that injury could have happened on
9 the 8th?
10 A. It's possible, yes, sir.
11 Q. Okay. This bruise is still -- well,
12 somewhat crimson here on this.
13 A. Yes, sir.
14 Q. Which shows it's a more recent bruise;
15 is that right?
16 A. Well, I wouldn't say that. I mean, I
17 have said that it can, so I wouldn't push my luck.
18 Q. Okay.
19 A. Okay. With the coloration.
20 Q. And blunt trauma is caused when
21 something strikes the skin very hard; is that right?
22 A. Yes, sir.
23 Q. Okay. And you have looked at -- it
24 could be like you say, people oftentimes use a bat,
25 right?

1 A. Yeah, I just used it because everyone
2 talks about a bat, but it could be anything hard.
3 Q. Does it look like there might be some
4 kind of pattern to these abrasions?
5 A. The only thing that I saw that
6 suggested a pattern of some sort was those little marks
7 over there, but I'm not going to commit myself.
8 Q. Okay. But this could possibly have a
9 pattern, what you see here, these red --
10 A. It could be something, right.

Q. Okay. And a pattern can be caused
when someone, I don't know, well, you tell the jurors how
a pattern can show up on skin.
A. A pattern indicates that the surface
that -- impacting was not smooth. I mean, there was some
irregularity on it.
Q. A brick, something like that could
leave a pattern?
A. Yes, sir, anything with a little
irregularity on it.
Q. Okay. And wherever it strikes the
skin, it might leave an abrasion to the skin? Or --
A. Well, only if you hit it on the side,
you have to hit the edge.
Q. Okay. And you can see, possibly, you

don't know, but possibly that's what we see here on the
forearm?
A. Yes.
Q. These marks?
A. There's three or four marks there and
I don't know what they are, they may be abrasions and
such, but, it's too slim a thing to hang your hat on, I
mean.
Q. Right.
A. Mix up what I'm saying, but, let's put
it this way, it's there, the significance, I'm not sure.
Q. Well, on Defendant's Exhibit 86, do
you also see maybe a similar-type abrasion?
A. Yes, sir.
Q. Okay. And on, I think, it's 52-E, you
have already pointed out this area.
A. Right.
Q. But also, right along in there, is
there also an area?
A. Well, I'm talking about the same
thing.
Q. All right. All that area. And this
bruising, obviously, goes from here to here?
A. Yes, sir.
Q. More on inside; is that right?

A. Yes, sir.
Q. Again, looking at it from the other
point of view, if you wanted to self-inflict those
wounds, you would just have to take an object and hit the

inside of your arm; is that right?
A. Interesting, it's again, with the non-dominant hand, yes, sir.
Q. If you wanted to do it. Or you could just take your arm against the wall and whack it real hard, couldn't you?
A. Not -- the wall wouldn't work because your hand would hit also.
Q. Your hand would hit? Okay. But you could do it if you wanted to?
A. It's possible. It would be very hard.
Q. But again, like you said, in your line of work you see people do all kinds of things?
A. Occasionally.
Q. You didn't get any information in the medical records that Mrs. Routier had any blunt force trauma to her torso, did you?
A. No.
Q. To her head or face?
A. That's correct. There's photographs of the face and then part of, well, just her upper

extremities, upper chest.
Q. Okay. This -- getting back to the neck wound again, it's almost four inches across and extends across the front of the neck; is that right?
A. No, it four inches long. It begins in the neck and then runs down onto the chest.
Q. Okay. Wouldn't you consider that, as far as a neck wound, a pretty long wound?
A. Four inches is fairly long, yes, sir.
Q. Okay. And is it just one, is it just one wound? The primary one we are talking about on the neck, is that made with one swipe of the knife?
A. The only description says, it says one wound, so that's the only thing. But, it's all been sewed up at that point.
Q. Okay. Well, looking at the photos and what the description is from the medical reports, that's what it shows? It shows one long --
A. It shows a single swipe, yes, sir.
Q. Okay. Now, you gave an example of -- well, usually, when you see someone that has been attacked from the front, frontal attack to the neck with, let's say with a knife or sharp instrument?
A. Yes, sir.
Q. Those wounds inflicted are usually

short, are they not?
A. Yes, sir.
Q. Okay. Here we have a more long, continuous wound?
A. Well, okay.
Q. Is that different?
A. By short, most -- okay, if you are talking about incised wounds of the neck, generally, they run about that size which would probably be about three or four -- three or four inches, you know, three or four inches for a neck wound, could be called short. I mean, they are not going to be one-inch wounds, obviously, they are going to be a couple of inches.
Q. Well, just a moment ago you said you would consider it long, did you not?
A. Yeah, it's long. It's not short -- but when you ask me about short wounds to the neck, I'm talking three or four inches, too. I mean, I'm talking -- a long wound to the neck is when somebody gets someone behind you and runs it completely around, so you are talking about six or seven inches.
But slash wounds of the neck typically run like this, because what happens is they will slash down like this, and so you will see it running about that length. But a long wound would be if you're cutting

someone's throat from ear to ear.
Q. Now, defensive wounds, you said that you usually see those on the palms of the hand, don't you?
A. No, I said the original description of them is on the palms of the hand, but you will get them on the palms of the hands, and on the back of the forearms, even on the back of the other arms. We have had people lying on the ground who have put their legs up and have gotten them actually in their legs.
All that a defense wound means, is that it is a wound incurred, in an extremity, in an attempt to ward off an attacker.
Q. And it's just natural to put your hands up and that kind of thing, to block off blows, knife or blunt trauma?
A. Yes, sir.
Q. And you will often see, for instance, in a knife attack, wounds to the palms of the hand?

20 A. Well, the fingers and palms, yes, sir.
21 Q. And they can be quite deep?
22 A. They can be deep, yes, sir.
23 Q. Cut to the bone often, don't they?
24 A. They can be, yes, sir.
25 Q. Now, this particular wound to Mrs.

1 Routier's hand, that is not a very deep wound, is it?
2 A. No, it's a very superficial -- there's
3 actually three of them, but I think it's probably one
4 swipe, but they're very superficial.
5 Q. Extremely superficial?
6 A. Yes, sir.
7 Q. Okay. Also, many times on your
8 defensive wounds, you see them -- what part of the arm do
9 you call this?
10 A. You talking about plexor surface?
11 Q. I guess so. If that is the word I'm
12 looking for.
13 A. Yes.
14 Q. You put your arm up. You will see
15 cuts across that way in defensive wounds?
16 A. Actually, most defensive wounds from
17 knives are in the back, they are not on this surface.
18 In fact, that's the way you can tell
19 people come in with scars. People come in with scars on
20 this surface, you think they may have tried suicide.
21 This surface, you think they have been in knife fights.
22 So --
23 Q. What's this surface called?
24 A. That would be the posterior aspect,
25 back of the forearm.

1 Q. And what is this surface called?
2 A. Plexus. Okay. It's this surface,
3 plexor surface.
4 Q. And you are saying you don't see
5 defensive wounds on the plexor surface?
6 A. Well, you can see -- what I'm saying
7 is, you're asking me where they usually occur. And they
8 are classically described as being on the back and not
9 here.
10 These suicidal wounds are described as
11 being on this surface. Homicidal, that is where people
12 attack you, on the back.
13 Q. Okay. Usually, in cases of homicide,

the assailant doesn't leave the weapon at the scene, does he?
A. Yeah, that's correct.
Q. Okay. Another area I wanted to ask you: Did you look at the autopsy reports on the two boys?
A. I just briefly went through them, but since I didn't intend to testify in anything about them.
Q. I just had one quick question about that. As far as stab wounds in this case or any other case, the angle, how it goes in the body. Let me show you this one. You see this stab wound number 1?

A. Yes, sir.
Q. It shows the knife coming across this way into the torso. You can't tell from an autopsy if the person was laying on their back and they were being stabbed at this angle, if they were moving around and maybe the knife went in that way; is that right? Do you understand what I am saying?
A. Well, I think so. What you're saying is, that just by examining the stab wound alone, you can't say necessarily whether they are standing up or lying down. Is that the question?
Q. Right.
A. The answer is yes.
Q. And even if they were lying down, they could be moving around during the attack when the knife is going in?
A. Yes, sir.
Q. Okay. And as far as blood on the knife, I think that it's your understanding that three people could have been cut with this knife; is that right?
A. Yes, sir.
Q. Now, if blood of one of the children was not found on this knife, that is not -- you can't say, well, then this knife wasn't used to do the killing,

could you?
A. No.
Q. Oftentimes --
A. It's only significant if you find blood, it means something; if you don't find it, it doesn't mean anything.
Q. When you stab someone in the body,

skin might wipe it off, an organ might wipe it off, that kind of thing?
A. Yes, sir.
Q. Okay. As far as -- here, let me give you your notes back. I don't want to forget those.
A. Okay. Thank you.
Q. The blunt trauma that the defendant received, you wouldn't expect her to sleep through that, would you?
A. No.
Q. Okay. And that is going to hurt when you get hit like that?
A. Yes, sir.
Q. And, is it a natural reaction, would you say, that the person that is getting hit with blunt trauma, they are going to yell out?
A. Well, I would assume -- well, I don't know, I have not beaten anybody, so I can't say. I would

think it would depend on the person, I mean what is going on, I mean, you know.
Q. Okay. Nothing --
A. I think that is outside of my area.
Q. Nothing would prevent a person from yelling out if they were suddenly attacked in their home and someone started hitting them with a stick, brick or whatever?
A. I guess not, no, sir.
Q. And certainly, the defendant, when she is stabbed on the throat, wouldn't sleep through that, would you think?
A. No, sir.
Q. I mean, they are going to wake up when someone starts cutting you with a knife?
A. Well, I think she would have to have been moving by virtue, as I said, of going backward, because I think that is one slice wound.
Q. Okay. And if her children were in the same room and stabbed, you wouldn't expect her to sleep through that either, would you?
A. Well, depends.
Q. Okay.
A. It depends on how violent the attack was and it depends on how hard the person sleeps, but

most -- under most circumstances, you would think that they wouldn't sleep through it.
Q. Well, if you had information that they were a light sleeper and that they had taken amphetamines that day, and the amphetamines in fact, are in their blood when they were taken to the hospital, you wouldn't think they would sleep through that, would you?
A. I would say under most circumstances, right. I think phentermine, not amphetamines.
Q. Well, what is that?
A. Phentermine is a -- the toxicology report, the only drug present being phentermine, not amphetamines. Phentermine is essentially a weight reducing drug.
Q. Okay. It's certainly not something that will put you to sleep though, right?
A. No.
Q. And, if one of your children were about as far from I am to you right now, the one that had all of the stab wounds in the back, Damon, you wouldn't expect her to sleep through that, would you?
A. Again, as I said, under most circumstances, no, sir.
Q. Okay. And if the other child was about from, about this distance, say about five feet, you

wouldn't expect her to sleep through that either, would you?
A. Under most circumstances, no, sir.
Q. Okay. And did you review the wounds that those children received, Dr. DiMaio?
A. I looked, again, as I say, I looked at them, I didn't pay that much attention.
Q. Those were obviously deep, penetrating wounds to the trunk, were they not?
A. Obviously, yes, sir.
Q. Okay. What do you think happened first, the blunt trauma, or the cut to the neck?
A. It would be speculation on my part. I can't answer that.
Q. Okay. And would you say, Dr. DiMaio, that the wounds that the children received, the deep, penetrating wounds to their trunk areas, are extremely different from the type of incised wounds that she received?
A. Well, by definition, a stab wound and an incised wound are different things. And so the incised wound is inflicted from a swipe with a knife,

23 while stab wounds is with the tip end, yes, sir.
24 Q. You have come across, I think, you
25 have, in one of your books that I have looked at, you

1 have a section about children that are killed, homicides?
2 A. Yes, sir.
3 Q. And, you talk about, I think it's in
4 the miscellaneous section, that sometimes children are
5 killed, they are shot or stabbed or things like that?
6 A. Most killed -- most children are
7 murdered within the first two or three years of life --
8 usually, within the first two years of life or the first
9 year.
10 Q. Okay. And again -- well, let me make
11 sure I get the quote right.
12 In talking about these miscellaneous
13 deaths where children are stabbed or clubbed or shot, I
14 believe that you write that, "Homicides are committed by
15 sane individuals, for reasons that may or may not be
16 apparent. There are two groups in this category: First
17 are violent deaths, which while no attempt is made to
18 conceal the cause of death, the perpetrator will attempt
19 to make the death appear to be an accident, or due to
20 another individual. Thus, the perpetrator will relate
21 that a child accidentally drowned in the bathtub or fell
22 in a river. There may be claims that a child was
23 kidnapped by a bearded or masked individual."
24 A. Yes, sir.
25 Q. So you have had -- seen situations

1 where it's a very violent death to a child and the
2 perpetrator might say, well, just try to blame it on
3 someone else?
4 A. Oh, yeah.
5 Q. Okay. I don't know if I caught this
6 right. Did you say people just -- people can commit
7 suicide by cutting their own throat, can't they? You
8 have seen that, haven't you?
9 A. Yes.
10 Q. And when they do that, they do one
11 long continuous cut, don't they?
12 A. Usually what they do is they will
13 start high up on the side and they will cut down this way
14 and then they will stop about here.
15 Q. Okay.
16 A. If they are right-handed, you know.

17 If left-handed, then they will start and they will come
18 down. It will be cut through, it will start up high,
19 below the ear and then cut down this way.
20 Q. Starts up high and then comes down at
21 an angle?
22 A. Yeah, and then loops across the other
23 side.
24 Q. And then all the way across the neck?
25 A. Yes, sir.

1 Q. Okay.
2 A. Well, up to a certain point. Usually,
3 they only get here. Because what happens is, once you
4 get to this point, it becomes difficult to angle the
5 knife.
6 Q. Thank you, Doctor.
7
8 MR. TOBY L. SHOOK: That's all I have.
9 THE COURT: Mr. Mulder?
10
11
12
13 REDIRECT EXAMINATION
14
15 BY MR. DOUGLAS MULDER:
16 Q. Doctor, just a thing or two. Are you
17 familiar with amnesia following a traumatic event?
18
19 MR. TOBY L. SHOOK: Judge --
20 THE COURT: Sustain the objection.
21 705 hearing. The doctor has testified as to what the
22 basis of his testimony is going to be.
23 Move on to the next question.
24 MR. DOUGLAS MULDER: Yes, sir.
25

1 BY MR. DOUGLAS MULDER:
2 Q. Doctor, there is a Polaroid photograph
3 up there, that was taken by a member, I believe it's
4 Beddingfield of the Rowlett Police Department.
5 A. Yes, sir.
6 Q. It has some writing on the back.
7 A. Yes, sir.
8 Q. Do you see anything in that photograph
9 that is dated, I think at 16:05 on June the 6th of '96,
10 do you see anything to indicate bruising of that

particular arm?
A. There is a suggestion of some discoloration below this wound over here. Unfortunately, because it's out of focus, you know, it's difficult to say.
Q. Okay. It would be somewhat unusual to batter someone in an isolated incident, just on the arms, wouldn't it?
A. You mean in defensive?
Q. No, just to -- the bruising here?
A. Um-hum. (Witness nodding head affirmatively.)
Q. It's likely that this occurred at the same time that the stab wounds were inflicted, is it not?
A. Yes, I mean, right, yes. I thought I

had said that. Yes, sir.
Q. Okay.
A. All I said was, I couldn't say whether it occurred immediately before or after. There is no way to say.
Q. And they have quite a sensitive test now, to determine the presence and absence of blood, even though the instrument has been wiped clean, don't they?
A. Right. You can do a test that would identify the blood. You might not be able to type it, but you could say that there was hemoglobin present, or material that tests positive for hemoglobin.
Q. One last thing: You have testified before lunch that, in your opinion, those bruises are consistent with Mrs. Routier having been beat violently with a blunt instrument on or about both of her arms. It would not be unlikely to also receive an injury to the head during that beating, would it?
A. That's correct, yes, sir.

MR. DOUGLAS MULDER: I believe that's all. Thank you.

RECROSS EXAMINATION

BY MR. TOBY L. SHOOK:
Q. But you saw nothing in the medical

records that showed any blunt force injury to the head, did you?
A. No, not to the face. I mean, that also includes the top and back covered by hair and there is no mention in the records, and, of course, I can't see it on any photographs.
Q. And no indication that anywhere in the medical records that she complained about getting her head whacked real hard?
A. That's correct.
Q. Okay. If you are going to get the blunt trauma to the arm that is going to cause that kind of damage, and you got hit in the head anywhere, it would cause a pretty big knot, wouldn't it?
A. It may. I mean, you know, what we're talking about is not a stationary -- it's not like you are hitting a stationary object. You would have to say that -- it's like, what's on one arm that person would be moving trying to avoid it. So, it just depends on how hard the impact is. I wouldn't rule it out, but I mean, I can't say.

Q. Well, if a person got hit on the head, as hard as they did on the arm obviously, that is going to cause an injury, is it not?
A. Right. If that was the case, right. But I'm saying, I can't, you know I cannot discuss something that I don't know if it was there or not and say how much force was used to produce a wound which may or may not be there.
Q. Because you don't have evidence or information that tells you that there was any injury like that?
A. That's correct.

MR. TOBY SHOOK: Okay. That's all we have, Judge.
MR. DOUGLAS MULDER: That's all we have. May he be excused?
THE COURT: Any objection? All right. Doctor, you are excused subject to recall. You are instructed not to discuss your testimony with anybody. If someone tries to talk to you, tell the attorney for the side who called you. And, of course, you are subject to recall.
THE WITNESS: Thank you, your Honor.
THE COURT: All right.

Your next witness.
MR. DOUGLAS MULDER: Dr. Lisa Clayton.
THE COURT: All right.
MR. TOBY SHOOK: Judge, could we approach the bench?

(Whereupon, a short discussion was held at the side of the bench, between the Court, and the attorneys for both sides in the case, off the record, and outside of the hearing of the Jury, after which time, the proceedings were resumed on the record, outside the hearing of the jury as follows:)

THE COURT: All right. Ladies and gentlemen, if you will step back to the jury room, briefly, please.