APPENDIX

Supreme Court of the State of New York
Appellate Division, First Judicial Department

Webber, J.P., Friedman, Singh, Scarpulla, Rodriguez, JJ.

42	THE PEOPLE OF THE STATE OF NEW YORK, Respondent, -against- EVAN WALD, Defendant-Appellant.	Ind. No. 2399/17 Case No. 2019-03872

Mark W. Zeno, Center for Appellate Litigation, New York (Jan Hoth of counsel), for appellant.

Alvin L. Bragg, Jr., District Attorney, New York (Philip V. Tisne of counsel), for respondent.

Judgment, Supreme Court, New York County (Gilbert C. Hong, J.), rendered July 8, 2019, convicting defendant, after a jury trial, or murder in the second degree, and sentencing him to a term of 25 years to life, unanimously affirmed.

Supreme Court properly denied defendant's motion to dismiss the indictment on the ground of preindictment delay (*see People v Singer*, 44 NY2d 241 [1978]; *People v Taranovich*, 37 NY2d 442, 445 [1975]). Preliminarily, we note that the majority of defendant's arguments are similar to arguments this Court previously considered and rejected on the codefendant's appeal (*People v Pilmar*, 193 AD3d 467 [1st Dept 2021], *lv denied* 37 NY3d 967 [2021]). We have considered those arguments that are specific to defendant and find no basis to reach a different result.

Although the 21–year delay was significant, it was not due to bad faith or to gain a tactical advantage. Instead, it was the result of the prosecutor's efforts to acquire

additional evidence to prove defendant's guilt beyond a reasonable doubt. The investigative delays were satisfactorily explained and were permissible exercises of prosecutorial discretion (*see People v Decker*, 13 NY3d 12, 14 [2009]).

The People's delay here is readily distinguishable from the delay recently addressed by the Court of Appeals in *People v Regan*, _NY3d_, 2023 NY Slip Op 01353 [2023]). There, the Court found that the four-year preindictment delay on charges of sexual assault was unreasonable. The Court noted that the People had amassed the majority of the evidence, save for obtaining a DNA sample from the defendant, early in the investigation of the case. The People apparently conceded that their failure to take the necessary steps for 38 months, to secure a DNA sample from the defendant was based in part on their incompetence. In contrast, here, the record demonstrates that the People delayed commencement of the prosecution of this homicide to obtain additional evidence to strengthen their case, which consisted almost entirely of circumstantial evidence. In the ensuing years, the record indicates that reasonable investigative steps were taken to gather evidence for an indictment, including reinterviewing witnesses and conducting additional forensic testing. Once this new information was obtained, including information concerning the whereabouts of the codefendant prior to and after the homicide, as well as a possible motive for the crime, the People sought an indictment.

Defendant's right of confrontation was not violated when the autopsy report prepared by a nontestifying medical examiner was introduced through the testimony of another medical examiner. While the Confrontation Clause bars admission of "testimonial statements" of a witness who does not appear at trial (*see Crawford v Washington*, 541 US 36, 53-54 [2004]), this Court has held that the factual statements

in an autopsy report are nontestimonial, and their admission at trial without in-court testimony from the person who prepared the report does not violate the Confrontation Clause (*see People v John*, 27 NY3d 294, 315 [2016]; *People v Freycinet*, 11 NY3d 38, 42 [2008]; *People v Fuller*, 210 AD3d 597, 599 [1st Dept 2022]; *People v Ortega*, 202 AD3d 489, 491-492 [1st Dept 2022], *lv granted* 38 NY3d 1073 [2022]).

The verdict was not against the weight of the evidence (*see People v Danielson*, 9 NY3d 342, 348–349 [2007]). There is no basis for disturbing the jury's credibility determinations, or its evaluation of the extensive circumstantial evidence establishing defendant's guilt.

We perceive no basis for reducing the sentence.

THIS CONSTITUTES THE DECISION AND ORDER
OF THE SUPREME COURT, APPELLATE DIVISION, FIRST DEPARTMENT.

ENTERED: April 18, 2023

Susanna Molina Rojas
Clerk of the Court

State of New York
Court of Appeals

BEFORE: HON. SHIRLEY TROUTMAN,
Associate Judge

THE PEOPLE OF THE STATE OF NEW YORK,

Respondent,

-against-

ORDER DENYING LEAVE

EVAN WALD,

Appellant.

Appellant having applied for leave to appeal to this Court pursuant to Criminal Procedure Law § 460.20 from an order in the above-captioned case;*

UPON the papers filed and due deliberation, it is

ORDERED that the application is denied.

Dated: 5/21/2024

at Buffalo, New York

SHIRLEY TROUTMAN
Associate Judge

*Description of Order: Order of the Supreme Court, Appellate Division, First Department, entered April 18, 2023, affirming a judgment of the Supreme Court, New York County, rendered July 8, 2019.

asking the doctor what she can say based on her scientific training and educational background and what she can't say. We have voir dired this jury on the television shows they see and if the witness is going to say, you know, I am not able to tell a time of death by what is in the stomach of the deceased, the jury should know that because that is what reality is and they are accustomed to television shows. And when she says that she can't tell whether the assailant was right-handed or left-handed, that is information the jury's entitled to know. There is nothing inflammatory about it. It is a fact, it is part of what she does and what she can and can't say in her autopsy.

THE COURT: Okay, I would agree with that. I mean, I don't think it cuts either way, so I don't think it makes a difference.

MR. CROCE: Understood, Judge. I wanted the Court to be aware of what our expectation of the testimony was and anything that would deviate from that would be very much a problem.

And I know this has been an issue litigated, and there is quite a bit of case law on it, but at this time I am going to renew our, raise the objection to the introduction of the autopsy report as a business record or otherwise. I understand that the Courts have said that autopsy reports are non-testimonial in nature, that they are

created in the ordinary course of business, that they recite facts which future experts are permitted to rely upon. However, Judge, I would like to, in the context of this case, specifically with respect to the autopsy of Howard Pilmar, this autopsy occurred 23 years ago. The factual recitation, the factual notations in that report were made 23 years ago. The arrest in this case occurred 21 years after the homicide. So it is impossible for the defense to do, to challenge those factual specifications in that autopsy. It is impossible for us to challenge the information, the factual information which the doctor is relying upon and, along with our due process, speedy trial motion, Judge, I am again reiterating the fact that it is our position that our client's due process constitutional speedy trial rights are violated by the introduction of this evidence as it is impossible for us to controvert those factual allegations contained in the report in which the doctor will rely on.

MR. TALKIN: Ms. Pilmar joins in that application.

MS. LEDERER: Your Honor, I find it unbelievable that we have been litigating this case for a year and a half and today I hear for the first time, when they have known all along the medical examiner was going to testify, that now they are raising due process violations and that this autopsy report is not admissible. It is admissible under

the case law. It is way too late to be making this motion on the date that the witness is sitting in the witness room about to testify. The law and the courts have ruled that it is admissible and whether the autopsy was a hundred years ago or 23 years ago or last week, the observations of the doctor who did it and the photographs -- if you'd like, we will put all 100 photographs in and then you can have exact photographs of the injuries if that makes it easier for you to do your examination. I really, I don't understand how the defense can blindside the People with an application like this at that point in time.

MR. CROCE: I don't believe it is blindsiding. I don't know if, I believe it is Dr. Goldman --

MS. LEDERER: Greenbaum.

MR. CROCE: -- if Dr. Greenbaum is otherwise unavailable to the People. I think, based on Dr. Greenbaum's testimony in the grand jury, he was at the Chief Medical Examiner 23 years ago and went on to practice elsewhere, so I have no understanding or reason to believe Greenbaum is available. Dr. Smiddy is offered as a witness and that is really a convenience to the prosecution and the government. I am preserving these issues because I do believe there is quite a bit of discrepancy between the different courts and the different circuits and this may be an issue, if necessary, on appeal and I want to preserve

that issue for my client.

MS. LEDERER: The autopsy is not testimonial. There is no right of confrontation. The case law makes plain, the autopsy and the testimony of this witness are admissible at this trial.

THE COURT: All right, two things.

One, I agree with the People. This is an untimely motion that should have been done a while ago. Nevertheless, the case law does side squarely in the People's favor. Accordingly, the motion's denied.

Is there anything else before we bring out the jury?

MS. LEDERER: No, Your Honor.

MR. CROCE: No, Your Honor.

THE COURT: And just so I am clear, Mr. Croce, you are going to go first on cross?

MR. CROCE: I am, Your Honor.

THE COURT: All right.

Let's bring out the jury.

(WHEREUPON, THE JURY ENTERED THE COURTROOM)

COURT CLERK: Good morning, jurors. Please be seated.

Do both parties stipulate the jury's present and properly seated?

MR. GOTLIN: Yes.

MS. LEDERER: Yes.

MR. TALKIN: Yes.

THE COURT: All right.

Good morning, members of the jury.

THE JURY: Good morning.

THE COURT: It certainly is.

We are going to continue now with the People's case.

MS. LEDERER: People call Dr. Monica Smiddy.

M O N I C A S M I D D Y,

Called as a witness by and on behalf of the People at the trial, having been first duly sworn, testified as follows:

COURT OFFICER: Have a seat.

State your name, spelling your last name.

THE WITNESS: My name is Dr. Monica Smiddy, S-M-I-D-D-Y.

COURT OFFICER: And your county of residence.

THE WITNESS: Manhattan.

THE COURT: Okay, People, you may inquire.

DIRECT EXAMINATION

BY MS. LEDERER:

Q Dr. Smiddy, what is your occupation?

A I am a forensic pathologist and I work at the Office of Chief Medical Examiner here in New York City and I am a senior

city medical examiner.

Q Please tell the members of the jury what your educational background is.

A I have an undergraduate degree from Wellesley College in Wellesley, Massachusetts.

I attended Boston University School of Medicine in Boston, Massachusetts.

Following medical school I did a residency in pathology at George Washington University Medical Center.

And then, following residency, I came to New York City where I did very specialized training, a fellowship in forensic pathology.

Q Do you have a masters degree?

A Yes, I do.

Q And what is that degree in?

A I have a masters degree in global public health from New York University.

Q Do you do any teaching?

A Yes, I do.

Q Where do you teach?

A Well, we have a very active fellowship training program, so we have doctors in training who rotate through our office for one year. We also have a number of residents, pathology residents who rotate through our office. We have many medical students, we have students from John Jay College of

Criminal Justice, we have anthropology students and physician assistant students who all rotate through our office.

Q And do you participate in teaching some of those students that come through?

A Yes, I do, on a daily basis.

Q As the, as a city medical examiner II, what are your responsibilities?

A My primary responsibilities include the performance of autopsy in order to certify the cause and manner of death.

As a senior medical examiner, I am also responsible to supervise and teach our fellows in training.

Q How long have you been employed by the OCME, the Office of the City Medical Examiner?

A Close to 26 years.

Q Please tell the members of the jury what an autopsy is.

A An autopsy begins with an external examination. The decedent will do a head to toe examination -- excuse me. The doctor will do a head to toe examination of the decedent as the decedent is lying on the autopsy table. The doctor will make note whether there is clothing, what type of clothing, whether it is bloodstained or not, whether there are defects in the clothing.

Q When you say defects, can you tell the jury what you mean.

A Defects could be the clothing is torn or perforated from some type of instrument. Could be torn from resuscitative efforts. So the doctor will make note whether the clothing is intact or not. The doctor will make note of whether it is bloodstained or not. Following that, the clothing will be photographed --

Q If I could just interrupt you for a moment.

I just want to go back to a general overview of what the purpose of an autopsy is and under what circumstances is an autopsy performed?

A Well, the autopsy is performed to certify the cause and manner of death. The cause is the disease or injury responsible for the death. The manner of death has more to do with the circumstances surrounding the death.

Q Is an autopsy done on every person who dies?

A No.

Q When is it done?

A In violent cases, cases of suicide, accident and, in some cases, of natural disease.

Q Have you ever performed an autopsy or assisted in performance of an autopsy?

A Yes.

Q And approximately how many times?

A I have personally performed well over a thousand autopsies and, in my senior capacity, have supervised at least

two or three times that number.

Q Have you ever testified as an expert in the field of forensic pathology?

A Yes.

Q And what is forensic pathology?

A Pathology is the study of disease. The general pathologist works in the hospital, they examine tissues under the microscope to make a diagnosis of benign or malignant. They may run the hospital laboratory. The forensic pathologist has specialized training in the performance of autopsies, the classification of injuries and the certification of death.

Q Have you ever testified as an expert in the field of forensic pathology?

A Yes.

Q Have you testified in the grand jury?

A Yes.

Q And in the Supreme Court of New York State?

A Yes.

Q Have you ever been denied expert status?

A No.

MS. LEDERER: At this time, I ask that the Court recognize Dr. Monica Smiddy as an expert in the field of forensic pathology.

MR. CROCE: No objection.

MR. TALKIN: No objection.

THE COURT: The witness will be deemed an expert in forensic pathology.

Q Dr. Smiddy, I interrupted you earlier. I wanted to ask you if you would now explain to the jury when a diseased person is brought to the morgue or to the Medical Examiner's Office, can you describe what the steps are that are performed in an autopsy?

A The doctor will examine the decedent on the autopsy table, make any notes of clothing that may be on the body. Measurements are taken, the height and the weight. Evidence may be collected from the body. Following that, the clothing will be removed, any medical or surgical intervention, catheters, will be removed.

Once evidence is collected from the body, the body will be washed and the doctor will make note -- at that point in time, following photographs, the doctor will make note of all the injuries on the body, making measurements from the top of the head to the right or left of midline.

The decedent is then turned over and the posterior aspect of the body is examined in a systematic fashion, again making note of any injuries, the anatomic location and the measurement from head, from the top of the head, right or left of midline, and then classify the injuries.

Q And are samples of the body taken for toxicology tests?

A Yes.

Q What is toxicology?

A Toxicology is a laboratory test and in all of our autopsies we collect specimens at the autopsy table. Blood; bile, if it's available; urine, if it's available; some solid organs; and vitreous humour, which is eyeball fluid. Those samples are collected and sent to our toxicology lab where the chemist will analyze those specimens for the presence of alcohol, drugs of abuse, prescription medications, and over-the-counter medications like Tylenol or aspirin.

Q And the visual observations and the measurements of the injuries that you spoke of a few moments ago, are those recorded in diagrams that are part of the autopsy report?

A Yes.

Q Are fingernail scrapings taken by the medical examiner?

A Yes.

Q And can you tell the jury how that is done and how they are preserved?

A The fingernail scrapings are done usually with some type of sharp object in order to scrape and clip the nails. They are preserved in a paper envelope. They are dried in some cases and then they are sent to our Forensic Biology Laboratory.

Q At the conclusion of the autopsy, is the body released to the family?

A Yes, it is.

Q I'd like to direct your attention now to the autopsy of Howard Pilmar.

Did you do that autopsy?

A I did not.

Q Do you know who did it?

A Yes.

Q Who was that?

A Dr. Jordan Greenbaum.

Q And do you know where Dr. Greenbaum is now?

A Yes.

Q Where?

A She is practicing in Georgia.

Q She is no longer with the OCME?

A Correct.

Q Before coming to court, did you review the autopsy report and the notes made by Dr. Greenbaum?

A Yes.

Q And did you review the relevant toxicology reports, the identification of the body by a police officer who was first on the scene?

A Yes.

Q And did you also review an identification of the body by a family member?

A Yes.

Q And the death certificate in this case?

A Yes.

Q The file on the investigation into the death of Howard Pilmar that is maintained by the Officer of the Chief Medical Examiner, does that also include the diagrams and rough notes made by Dr. Greenbaum?

A Yes.

Q I'd like to show you People's Exhibit 19 for identification.

(HANDING)

Q Have you had a chance to review People's 19 for identification prior to coming to court today?

A Yes.

Q Is this a complete copy of the OCME's file relating to the investigation into the death of Howard Pilmar?

A Yes.

Q Are these records made in the regular course of business of the OCME?

A Yes.

Q And is it the regular course of business of the Office of the Medical Examiner to make and keep these records?

A Yes.

Q Are photographs part of the record that you examined before coming to court today?

A Yes.

Q Are those photographs made in the course of the

autopsy?

A Yes.

Q Are the employees of the Medical Examiner's Office under a business duty to make the entries to these records at or about the transaction they record?

A Yes.

Q And are they under a business duty to make the entries accurately?

A Yes.

MS. LEDERER: People offer 19 for identification into evidence.

THE COURT: Any objection?

MR. CROCE: Can I see it, Judge?

THE COURT: I am sorry?

MR. CROCE: Can I see it, please?

THE COURT: Yes, of course.

(SHOWING TO THE DEFENSE)

MR. CROCE: Your Honor, can we have a brief sidebar?

THE COURT: Yes.

(THE FOLLOWING TAKES PLACE AT SIDEBAR, OUT OF THE HEARING OF OPEN COURT, AMONG THE COURT AND COUNSEL)

MR. CROCE: Judge, I have no real objection to this coming into evidence except there are some, there is

some hearsay in here from others that I think should, might need to be redacted and I would like to just confer with the People before this is turned over to the jury to discuss whether or not certain redactions are necessary, but, other than that, we have no objection.

MS. LEDERER: I'd like to know what it is because if I have the medical examiner refer to it or read from it, I don't want --

MR. TALKIN: The death certificate.

MS. LEDERER: The death certificate is in evidence. That is part of the autopsy report.

MR. TALKIN: But that is -- it is not part -- it is not part of the autopsy report. It is separate.

MS. LEDERER: No, but this is not the autopsy report, this is the ME's investigation into the death of Howard Pilmar.

MR. TALKIN: But that is different.

MS. LEDERER: The autopsy report is the scientific findings but the other things that she uses to refer, this is the entire file that they keep.

MR. TALKIN: I understand. So, in other words, the autopsy report we don't have a problem with, that is easy. Then you have investigative notes --

MS. LEDERER: That absolutely is part of the investigative notes from the medical examiner employee who

goes to the scene as part of the autopsy. They use that.

MR. TALKIN: Well, they use it, but that doesn't mean that comes in as part of the autopsy report. She can say I relied upon information that I got, but that doesn't mean it is part of the report. We are not talking about -- we are just talking about what comes in in front of the jury as far as physical documents.

MS. LEDERER: She is going to talk about information she had from the investigator and if you tell me that you are having somebody come and testify and they are not referring to this information, I'd be really surprised.

MR. TALKIN: I don't think we are having anyone testify about that.

MS. LEDERER: It is not your expert but you are having an expert to talk about reconstruction. They are not going to refer to notes by the investigator, Mr. Croce?

MR. CROCE: I am sorry, I missed that. I didn't hear you. I didn't hear you, I am sorry.

MS. HINDMAN: The business record exception hearsay applies to the entire OCME file and it is the entirety of the file upon which the final determinations by the doctor are made.

THE COURT: That is how I understand it unless we are talking about double hearsay. This witness wasn't there, she didn't do the autopsy, she is relying on the

notes and people who had any business record, their notes, and if the examiner is separate from the person who committed the autopsy but they are under the same business duty, then it follows the exception.

MR. TALKIN: Okay, if that is the Court's ruling, but it should be brought out they should be -- it is -- it is -- so far we just have the autopsy report. It should be also --

MS. LEDERER: No, I introduced it as the complete file kept by the Office of the Chief Medical Examiner of New York for their investigation into the death of Howard Pilmar, that is how it was offered.

THE COURT: I was under the assumption that you were talking about some sort of double hearsay and that somebody in there refers to something someone said. In that case I might understand a redaction is necessary. But since the whole thing is hearsay but it is under a business record exception, I don't see why it wouldn't come in.

MR. CROCE: Okay.

MR. TALKIN: All right.

(WHEREUPON, THE FOLLOWING TAKES PLACE BACK IN THE HEARING OF OPEN COURT)

MR. TALKIN: There is no objection.

THE COURT: People's 19 is admitted without objection.

MS. LEDERER: I ask that the witness please be shown People's 19A, B and C.

(SHOWING TO THE WITNESS)

Q Have you had occasion to see People's 19A, B and C prior to coming to court today?

A Yes.

Q Do you recognize those diagrams?

A Yes.

Q What do you recognize them to be?

A These are the three body diagrams that Dr. Greenbaum used to make her notes. On these diagrams she has identified the location and the size of the injuries and the types of injuries.

Q And are those three exhibits enlargements of pages that are included within People's 19 in evidence?

A Yes.

MS. LEDERER: At this time, People offer 19A, B and C in evidence.

THE COURT: Any objection?

MR. CROCE: No objection.

MR. GOTLIN: No.

MR. TALKIN: No.

THE COURT: 19A, B and C are admitted without objection.

Q At the time that Howard Pilmar's autopsy was conducted,

were photographs taken?

A Yes.

Q And when are they taken in the course of an autopsy?

A They are taken at the beginning of the autopsy and during the autopsy and at the end of the autopsy.

Q Did you review the photographs that were taken in the autopsy of Howard Pilmar before you came to court today?

A Yes.

Q I am gonna show you People's 20A through V for identification.

(HANDING)

Q Are these some of the photographs that were taken during the autopsy of Howard Pilmar?

A Yes.

Q And are they fair and accurate depictions of the autopsy?

A Yes.

Q Were they made during the course of the autopsy?

A Yes.

Q And the persons taking those photographs were under a business duty to take accurate photographs?

A Yes.

Q And they are made at or about the time of the autopsy?

A Yes.

Q Are they kept and maintained in the course of the

business of the Office of the Chief Medical Examiner?

A Yes.

MS. LEDERER: People offer 20A through V in evidence.

MR. CROCE: No objection.

MR. TALKIN: No objection.

THE COURT: Okay, 20A through V is admitted without objection.

Q On what date was Howard Pilmar's autopsy performed?

A The autopsy was performed on March 23, 1996.

Q I am going to ask you about the injuries and wounds that you saw in the records that you have reviewed pertaining to the autopsy.

Prior to asking you to go through each of the injuries, I am going to ask you if you have a -- can you tell the members of the jury what the cause of death was in the homicide of Howard Pilmar?

A The cause of death, incised and stab wounds of the neck and of the torso with injuries of the lungs, the heart and the airway.

Q What were the observations of Howard Pilmar's body when he was brought into the morgue?

A The decedent was fully clad, he had a suit jacket, shirt and tie, trousers and belt, socks and shoes.

Q And underwear?

A Yes.
Q And what was the height of the deceased?
A He measured approximately 5'10" in length.
Q And what was his weight?
A Approximately 175 pounds.
Q And can you describe what his build was, in a general way?
A Yes. He was a moderately-built man.
Q Were any photographs taken when Howard Pilmar was first brought in of his clothing or himself in his clothing?
A Yes.

MS. LEDERER: I am going to ask that the witness be shown People's 20A and 20B.

(WHEREUPON, THE EXHIBIT IS BEING PUBLISHED TO THE JURY)

Q What is shown in People's 20A, the photograph that is on display now?
A This is the back of the decedent and he is lying on the autopsy table. And the outer garment is a blue suit jacket and there are defects in the outer garment that are consistent with stab wounds of the body. It is bloodstained.
Q And People's 20B, what is depicted in 20B?

(WHEREUPON, THE EXHIBIT IS BEING PUBLISHED TO THE JURY)

A This is a close-up of the decedent's jacket just

demonstrating, at a higher power, all of the defects in the garment.

Q And that is just a portion of the garment, is that right?

A Yes.

Q All right.

I'd like to ask you about the exam of Howard Pilmar's body and I'd like to ask you to turn your attention to page 10, paragraph 0.

MS. LEDERER: At the same time, I am going to ask that 19A be displayed for the jury and the witness.

(WHEREUPON, THE EXHIBIT IS BEING PUBLISHED TO THE JURY)

MS. LEDERER: And I am going to ask that the witness and the jury be shown photo 20C in evidence.

(WHEREUPON, THE EXHIBIT IS BEING PUBLISHED TO THE JURY)

Q If you turn your attention to 20C, can you tell the members of the jury what the injuries are that you see on Howard Pilmar's face and what significance they have to you as the medical examiner?

A There are blunt impact injuries on the face and these blunt impact injuries consist of abrasions.

An abrasion is a scraping of the skin.

And the location of the abrasions are on the left side of

the forehead, on the left side of the eye, the left cheek and the left side of the nose.

Q You talked about an abrasion. What causes an abrasion?

A An abrasion is a scraping of the skin and it may be somebody who is scraping against a hard surface, it may result from someone being impacted with an object.

Q And blunt trauma, what does that mean?

A Blunt trauma is an injury from being struck with an object or from being in contact with a rough surface.

Q As this photograph is displayed and you refer to the right side and the left side, can you explain are you referring to the right side of Howard Pilmar from your perspective or from his perspective?

A I am describing the decedent's right and left side.

Q So it would be the right side for the decedent?

A Yes.

Q So where you see the abrasion on the cheek, what side is that?

A That is the left side of the face.

Q And do you have any medical opinion about how that abrasion might have come to be there?

A No.

MS. LEDERER: And now People's 20D.

(WHEREUPON, THE EXHIBIT IS BEING PUBLISHED TO THE JURY)

Q Can you describe what is depicted in 20D?
A Next to the lateral corner of the lips on the left side of the face is an incised wound.
Q Can you point to what you are discussing?
Is that --
A Yes.
Q That is blocked a little bit by the black mark on the bottom of the screen?
A Yes.
Q And what is an incised wound?
A An incised wound is a sharp force injury and the incised wound is a cutting wound. It is generally longer on the skin surface than it is deep as compared to a stab wound which is deeper into a body cavity or organ.
So in this case, it is an incised wound. It cuts the skin's surface and the underlying soft tissue, but there is, there are no injuries to the inner aspect of the mouth or the teeth.
Q In terms of injuries to the face or injuries to the torso, are there -- where are the vital organs of a human that control whether or not they are alive? Are those contained in the face or the torso?
A They are contained in the torso.
Q Are there any life threatening injuries that you see to the face in these two photographs?
A No. These are minor injuries.

Q I'd like to turn your attention now, please, to page 4A, to the neck.

MS. LEDERER: And for that I'd ask that 20E be displayed.

(WHEREUPON, THE EXHIBIT IS BEING PUBLISHED TO THE JURY)

Q Can you tell the members of the jury, please, about the injuries that you see in People's E, 20E?

A In this photograph the decedent's right profile is demonstrated. This is the decedent's right side of the face, the right ear and the right side of the neck. And what is shown in this photograph are sharp force injuries; stab wounds and incised wounds on the right side of the neck.

Q Can you explain when you say stab wounds and incised wounds, is this one continuous wound or is it more than one wound in the neck?

A It is more than one wound in the neck. There are two stab wounds on the right side of the neck and one very long incised wound that crosses from the right to the left side of the neck.

Q Can you tell us anything about the wound track that is displayed in this photograph?

A The incised wound most likely goes from the right side to the left side of the neck where it trails off.

Q And when you say most likely, on what do you base that

opinion?

A On the right side of the neck the wound is deeper as compared to the left side of the neck.

Q And how deep is it on the right side?

A On the right side of the neck it is approximately one inch in depth, on the midline of the neck it is approximately two inches in depth and on the left side of the neck it is very superficial.

Q Okay.

MS. LEDERER: I am going to ask that photo 20E, F and G be displayed.

(WHEREUPON, THE EXHIBIT IS BEING PUBLISHED TO THE JURY)

MS. HINDMAN: This is 20F.

Q What does that show?

A This demonstrates the two stab wounds on the right side of the neck and the incised wound that travels across the front of the neck.

Q How deep is that wound that goes across the front of the neck and what are we looking at as we look at that photograph?

A In this photograph you can see hemorrhage. These are gaping wounds. You can see hemorrhage or bleeding into the soft tissues. So there is cutting of the skin surface, the underlying fatty layer; there is cutting of the strap muscles,

those are the skeletal muscles that support the neck and protect the airway; and in this photo you can see the part of the larynx, which is the voice box, which has been cut.

Q What is the consequence of the voice box being cut?

A Whenever there is injury to the voice box, the individual cannot make sound.

Q And the blood that we see in this photograph, when that kind of an injury is inflicted, does the blood go anywhere else in the body?

A Yes, the blood goes into the airway.

Q What does that mean?

A It is called aspiration of blood. Individuals, as they breathe in air, they are also breathing in blood, a liquid that ends up in the upper airway, travels to the lower airway, which is part of the trachea and bronchi, and then enter the lungs.

Q And what would that sensation be for the person who suffers that injury?

MR. CROCE: Objection.

THE COURT: I will allow it.

A Any individual who is breathing in liquid, that is similar to drowning.

Q I am gonna ask that you look at 20G in evidence.

(WHEREUPON, THE EXHIBIT IS BEING PUBLISHED TO THE JURY)

Q Can you tell the members of the jury what is in 20G?

A This is a photograph of the left side of the neck. It is below the left ear. This is the left side of the large incised wound that goes across the front of the neck and here it trails off and it is cutting just the skin's surface.

Q Is the -- on the right side you described two separate cuts and then the beginning of an incised wound. From where the incised wound starts on the right side to where it trails off here on the left side, is that one cut?

A Yes.

Q Thank you.

Turning to page five, paragraph C, and photo H in evidence.

(WHEREUPON, THE EXHIBIT IS BEING PUBLISHED TO THE JURY)

Q Can you tell the members of the jury what that is?

A This is the decedent as he is lying on the autopsy table. There are three stab wounds on the back of the neck.

Q Can you tell us about those injuries?

A The three stab wounds are clustered on the back of the neck. They measure about one inch on the skin's surface. The depth of penetration is one to two inches and one of these stab wounds actually penetrates the cervical vertebra.

Q What does that mean?

A The cervical refers to neck, the vertebra are bones in the neck that protect the underlying spinal cord.

Q And what is the significance of that, of that injury to

the deceased?

A Bleeding and there is a possibility, if there is any injury to the underlying spinal cord, the individual --

MR. CROCE: Objection.

A -- will not be able to move.

MR. CROCE: Objection.

THE COURT: Overruled.

Q The injuries that we have been talking about to the face and the head, are those all contained on the diagram that is on the easel there 20A in evidence?

A Yes.

Q I am sorry, 19A.

And those markings and those writings, were those part of the autopsy notes made by Dr. Greenbaum?

A Yes.

Q When entries are made on a diagram to indicate the location and the depth of a wound, are there coordinates that are used to describe where an injury is and how, how does that, how is that designated on the exhibit?

A The doctor will take a ruler and measure each injury and the coordinates are from the top of the head to the right or left of midline. And then the doctor will measure each stab or incised wound, the length on the skin's surface and the depth within the body, the soft tissues, body cavities or organs.

MS. LEDERER: And I'd ask, please, that the

witness be shown People's 20I.

(WHEREUPON, THE EXHIBIT IS BEING PUBLISHED TO THE JURY)

Q Is that a close-up of the stab wounds that you were describing to the back of the neck?

A Yes.

Q Can you tell us, what is the purpose of the white partial ruler at the bottom of the diagram, photograph?

A That is a label that the photographer will use to identify the injury. It is labeled with the medical, a unique medical examiner case number and it also has a scale on it in inches.

MS. LEDERER: I'd like to exchange this easel for 19B.

Q And I'd like to direct your attention, please, to paragraph D on page six, a stab wound to the upper left torso.

(WHEREUPON, THE EXHIBIT IS BEING PUBLISHED TO THE JURY)

MS. HINDMAN: This is photo 20J.

(WHEREUPON, THE EXHIBIT IS BEING PUBLISHED TO THE JURY)

Q Can you tell us about the injuries that you see in this photograph, 20J?

A This is the decedent's left side of the head, neck and chest.

Q Okay.

And if you look at what's been marked as 20K --

MS. LEDERER: If we can just highlight an injury that you can see just a little bit above the arm and now switch to 20K in evidence.

(WHEREUPON, THE EXHIBIT IS BEING PUBLISHED TO THE JURY)

Q Can you tell the members of the jury about this injury?

A This is a stab wound and it is located just below the left axilla or armpit. It is about two inches in length on the skin's surface and it is approximately two to four inches in depth. It involves the skin's surface, the underlying muscles, penetrates the left rib cage into the left thoracic cavity and penetrates the left lung.

Q What is the thoracic cavity?

A It is the rib cage. It protects the lungs.

Q And were there, was there any blood located in the pleural cavity as a result of this injury?

A Yes.

Q How much?

A About 15 cc's.

Q And tell the members of the jury what the significance of that is.

A It means that there is bleeding from the blood vessels that have been injured, blood vessels traveling between the ribs

as well as blood escaping from the injured lung.

Q Would you describe, please, the direction of penetration and the angle of the injury?

A The penetration goes from the left to the right side of the body slightly down.

Q And is there any sort of vertical -- is there any vertical deviation?

A No.

Q And what does that mean?

A It means that the instrument was plunged inside of the body cavity.

MS. LEDERER: Now I'd like to go back to the 20J.

(WHEREUPON, THE EXHIBIT IS BEING PUBLISHED TO THE JURY)

Q I ask you to look at the paragraph E on page six and i ask you to describe that wound, please.

A This is a large incised wound on the left side of the chest.

Q Can I ask you, are you speaking about the one that has, this one that is illuminated or the one above it?

A The one that is illuminated with the tail extending from it.

Q Okay. Please continue.

A This is a gaping incised wound and it measures approximately six inches in length. This wound is about one to

two inches in depth.

The injuries associated with this wound involved penetration of the pericardial sac, that is a connective tissue covering protecting the heart, and the heart itself, the apex or the bottom of the heart.

Q And what happens when the heart is penetrated that way?

A The heart will stop beating.

Q Can you tell the members of the jury, please, about the direction and the angle of the penetration?

A This is directed from front to back, from left to right.

Q Now turning your attention to the wound above that.

A This is a large incised wound across the midline to the left side of the chest and it is about six inches in length. It involves the skin's surface and the underlying fatty tissue. It does not penetrate a body cavity.

Q In some places in the autopsy report the language "with the edges reapproximated" appears. What does that mean?

A It is a more accurate way to measure the length on the skin's surface. The doctor will just pinch the edges together and remeasure the wound because many of them are gaping.

Q Okay.

MS. LEDERER: Can we go to the next photograph, please?

(WHEREUPON, THE EXHIBIT IS BEING PUBLISHED TO THE JURY)

Q Sorry, I am going to ask you to look at 20L, referring to paragraph H on page seven. Can you tell us the significance of this photograph and this injury and where it is located?

A This is an incised wound. This has a different shape. It has a V shape. And it is located right over the sternum, which is the breast bone, on the midline of the chest. It involves the skin's surface and underlying connective and fatty tissue.

Q Looking now at 20M.

(WHEREUPON, THE EXHIBIT IS BEING PUBLISHED TO THE JURY)

Q Is that a different photograph of the same wound?

A This is the same incised wound I just described and here the doctor is reapproximating the edges of the wound so she can measure it more accurately.

Q And what is the significance to you as an expert in forensic pathology when you see a wound that is in that configuration or in that shape?

A It generally implies that the victim is moving during the attack and or it could be the perpetrator moving the instrument or his or her upper extremity during the attack. So we know that some movement occurred.

Q Direct your attention to paragraph I on page seven,

which is photograph 20N.

(WHEREUPON, THE EXHIBIT IS BEING PUBLISHED TO THE JURY)

Q Can you tell us about the injuries here, where they are located on the body and what, what information you know about these wounds?

A This is the decedent's right side of the chest and we see the right nipple in this photograph. And medial to the right nipple is a stab wound. And this stab wound, it measures about two inches in length on the skin's surface. The depth of penetration is four to six inches.

The injuries associated with this stab wound include penetration of the right lung, the heart and the aorta. And the aorta is the major blood vessel that comes off of the heart, sends branches to all parts of the body. It is under a tremendous amount of pressure.

Q Would this injury, in and of itself, be fatal?

A Absolutely.

Q Did this injury leave any clotted blood in the right pleural cavity?

A Yes.

Q And, again, what is the significance of that?

A It is bleeding into the soft tissues. We know that there are injuries, cutting injuries to the blood vessels.

Q And can you describe the direction of the penetration

of this wound?

A This goes from the right to the left side of the body and front to back slightly upward.

Q And to the right of the injury that you just described that is by the nipple, what is the significance and what is the information that you know about that next injury?

A This is an incised wound that goes from the right side of the chest to the midline. It involves the skin's surface and the underlying soft tissue. It also cuts the superior outer aspect of the sternum, which is the breast bone.

Q I am going to ask that you look at page eight, paragraph K, and, with that, look at the photograph we have already seen, 20H.

(WHEREUPON, THE EXHIBIT IS BEING PUBLISHED TO THE JURY)

Q Can you tell us about the complex stab wound in the upper region of the back near the midline? Is that the largest of the stab wounds that appear that is now illuminated?

A Yes.

Q Can you tell us what information you know about that injury?

A This is a gaping incised wound of the midline of the back and it measures approximately five inches in length and it is approximately one-half inch in depth. So this is cutting of the skin's surface, the underlying fatty layer and the muscles

of the back. There is no penetration of the thoracic cavities and there is no injury to the underlying spinal cord or vertebra.

Q In some of the injuries that we are looking at there appears to be something of a, I think you referred to it earlier as a tail. Do you see that in this injury?

A Yes.

Q Can you tell us what causes that and what information that tells you about the stab?

A I don't understand the question.

Q Is that a sign -- withdrawn.

Does that have any significance to you when you see it at the injury to the neck? What significance is it when you see it in that wound that you described earlier?

A It may tell you something about direction.

Q In what sense?

A In the direction of the individual who is doing the stabbing or cutting, whether it is coming from the right side or the left side, whether it is coming up or down.

Q Turning your attention to page eight, paragraph L, and looking at People's H. Can you tell us about the other injuries that you can see on the back, please?

A On the left side of the back there are five stab wounds which are clustered on the midback. They all measure approximately one to two inches in length on the skin's surface

and the depth of penetration is one to two inches. All five of these wounds penetrate the lining of the thoracic cavity, two of them penetrate the left lung.

Q Is there anything -- you used the word cluster. Can you tell us what you mean by that and is there any significance to you in the fact that they are clustered?

A Wounds that are clustered in this way are very close together. Multiple wounds that are close together that are linear generally mean that the individual is no longer moving.

Q And when you say linear, referring to the two that are just below, those two that are right there, is that what you are talking about when you say linear?

A Yes.

Q And in the stab wounds that are on the right side of the back above that, are those also linear?

A Yes, they are.

Q And clustered?

A Yes.

Q Can you tell us now about the wounds to the right on the back?

A On the right side of the back there are six stab wounds and they measure approximately one-half inch to one to two inches in length and they are approximately two or three inches in depth. Two of these stab wounds penetrate the right lung.

Q Looking at 20P.

(WHEREUPON, THE EXHIBIT IS BEING PUBLISHED TO THE JURY)

Q Are these the six wounds that you were describing?

A Yes.

Q Can you tell us which ones penetrate the lung?

A No.

Q The injuries that you see to the back, and with this I want to go back to the overview of the injuries on the back.

(WHEREUPON, THE EXHIBIT IS BEING PUBLISHED TO THE JURY)

MS. HINDMAN: That is 20H.

Q 20H. Is there anything that you observe in these injuries that helps you place the time of the infliction of the injuries, whether they are pre-mortem or post-mortem and what those terms mean?

A When we say pre-mortem or anti-mortem, that is before death. Peri-mortem is around the time of death. Post-mortem means after death, after the heart has stopped beating.

The wounds on the back, the way they are clustered and their appearance and the relative lack of acute bleeding or hemorrhage into the soft tissue implies that these injuries occurred post-mortem, after the decedent stopped moving and the heart stopped pumping.

Q If you can take this pointer? Would you mind stepping down from the witness stand, with the Court's permission, and

show the members of the jury specifically which wounds look different to you and what the difference is that makes you think it is post-mortem?

A These two wounds on the back of the neck, if you look at them they are pink/white, they are not bright red.

There is a comparison here. There is some blood in this soft tissue, but it is minimal. And you look at the color, it is a dark purple.

These stab wounds, if you look at the edge what you can see here is the underlying connective tissue and it is a white, white/pale pink. That tells me there is no acute bleeding or hemorrhage into the wound. And when I look deeper into the wound what I am seeing is bright yellow. That is the fatty protective layer underneath the skin.

And it is the same thing with some of these other wounds. If you look at the underlying soft tissue, it is a pink/white, it is not a bright purple/red.

Q And what does that mean to you?

A It means that the heart had stopped pumping and it is most likely inflicted post-mortem, after the heart stops pumping, after death.

Q Thank you.

The diagram that is 19B that is on the easel over there, the descriptions of the wounds that you have given, are those included in the writing on that exhibit?

A Yes.
Q And when a wound is described, is it identified in location by a horizontal and a vertical marker?
A Yes.
Q And for the vertical marker, how is it described?
A It is described in inches to the right or left -- excuse me. It is described in inches from the top of the head.
Q And for horizontal?
A For the horizontal, again, described in inches from the right or the left midline of the decedent's body.
Q Okay.
I am going to ask you if you could turn your attention to the wounds that were seen on the forearms of the deceased, of Howard Pilmar.
Tell the members of the jury about injuries to the right forearm. That is page nine, paragraph K.
A There is a stab wound --
MR. GOTLIN: Judge, I just have one objection. Can we take these down if we are not using them?
THE COURT: Are you referring to this photo?
MS. LEDERER: No.
THE COURT: Okay.
Q Please tell us about the injuries to the forearm.
A On the right forearm there is a stab wound just above

the right wrist and it is approximately one inch, one-half inch to one inch in length on the skin's surface. It does penetrate the soft tissues and the tendons.

Q Dr. Smiddy, we don't have a photograph. Can I ask you to use the pointer and step down and use the diagram that is on the easel, with the Court's permission?

So tell the members of the jury and indicate the right forearm injury.

A This is the right hand, this is the right wrist and this is the right forearm. The forearm is from the elbow to the wrist and here, just above the right wrist, is a one-half-inch-long stab wound.

Q All right.

And turning your attention to the left forearm.

A On the left forearm there is -- on the back of the left forearm closer to the elbow is an incised wound about a half an inch in length on the skin's surface. And this just cuts the skin's surface, which is why it is described as a scratch.

Q Thank you. If you could retake the witness stand, please.

I am going to ask you some questions about Howard Pilmar's hands.

Before I get to the hands, let me ask you about injuries that you observed on his legs, if any.

A He had blunt impact injuries on his knees.

(WHEREUPON, THE EXHIBIT IS BEING PUBLISHED TO THE JURY)

A These are --

MS. LEDERER: This is 20K.

MS. HINDMAN: 20Q.

MS. LEDERER: Q, excuse me.

A These are blunt impact injuries. They are minor injuries. They are called abrasions and it implies that the skin on the knees has been scraped.

Q And what might have caused it -- withdrawn.

Can you say what caused the scraping?

A No.

Q And now I'd like to turn to 20R to look -- we are going to switch the exhibits on the easel. This is 19C, but I am going to ask you to look at 20R.

(WHEREUPON, THE EXHIBIT IS BEING PUBLISHED TO THE JURY)

Q Can you describe the injuries and what part of the body we are looking at?

A This is the decedent's left hand and we are looking at the back of the hand, the fingers.

Q What injuries do you observe on the back of the left hand?

A On the back of the left hand there were three incised

wounds; the index finger and the fourth finger.

Q And now we are going to look at 20S.

(WHEREUPON, THE EXHIBIT IS BEING PUBLISHED TO THE JURY)

Q Please tell the jury about this photograph.

A There is the left hand. It is the palm of the hand and a photograph of the fingers and there were nine incised wounds of the palm of the left hand.

Q And now looking at the right hand.

(WHEREUPON, THE EXHIBIT IS BEING PUBLISHED TO THE JURY)

Q Page 10, paragraph N.

A This is a photograph of the right hand and we see the thumb and the index finger on the back of the right hand there were three incised wounds, one involving the thumb and two involving the index finger.

Q And 20U.

(WHEREUPON, THE EXHIBIT IS BEING PUBLISHED TO THE JURY)

A This shows the right hand, the back of the hand where there were three incised wounds on the fingers.

Q And 20V.

(WHEREUPON, THE EXHIBIT IS BEING PUBLISHED TO THE JURY)

A This is the decedent's right thumb where, and the

incised wound at the tip of the thumb is being photographed.

Q Thank you.

I'd like to turn your attention now to the other portions of the examination that were done in the course of the autopsy.

Were tissues taken to send to toxicology?

A Yes.

Q And what tissues were taken?

A Blood, bile and vitreous humour, and that is the eyeball fluid.

Q And were those fluids tested for the presence of alcohol and drugs?

A The blood was tested.

Q And what was the finding?

A The results were negative, there was no alcohol in his system, no drugs of abuse, no prescription medications and no over-the-counter medications.

Q And in the course of the injuries that we have just discussed and that you have described to us, how many stabs or cuts were inflicted on the body overall?

A There were 48 sharp force injuries.

Q And of those injuries, can you tell the members of the jury how many in and of themselves could have been fatal?

A About five.

Q I'd like to ask you a few questions about what you can

say to a scientific certainty about the instrument used to inflict these injuries.

Can you tell us what was used, what the weapon was?

A No.

Q What is the closest description that you can give?

A Well, it is an instrument that has a sharp cutting edge.

Q Is that consistent with a knife?

A Yes.

MR. GOTLIN: Objection.

THE COURT: I will allow it.

Q Is it consistent with a straight-edged knife or with a serrated knife?

MR. CROCE: Objection.

THE COURT: If you can say?

THE WITNESS: I can.

THE COURT: I will allow it.

A The appearance of all of the stab wounds is most consistent with a single-edged knife that has a smooth edge, not a serrated knife.

Q Why do you say that?

A Well, a serrated knife will leave a distinctive pattern on the skin's surface. A serrated knife, if you look at the blade, it is a little bit scalloped and that scalloping will be seen on the skin's surface and incised and stab wounds. And in

all of these wounds the margins are smooth, there is no scalloping to suggest a serrated blade.

Q Are you able to say anything to a reasonable degree of scientific certainty about the length of the blade used to inflict the injuries?

A Given the depth of penetration, the blade would have to be at least four to six inches in length.

Q And why do you say that?

A The doctor will measure the depth of penetration during her internal examination and in this case the deepest depth of penetration within a body cavity is four to six inches, so the blade must be at least four to six inches in length.

Q Are you able to say whether one or more weapons was used?

A No.

Q Are you able to say whether there was one or more assailants?

A No.

Q Are you able to say whether the assailant or assailants were right-handed or left-handed?

A No.

Q What information are you able to conclude from this autopsy as to the time of death of Howard Pilmar?

A Can you rephrase the question?

Q Are you able to make a determination as to the time of

death?

A No.

Q Is there anything about contents of the stomach that would help you make that determination?

A No.

Q Can you tell the members of the jury about rigor mortis, what that means and whether you observed anything in the body, in the autopsy report for Howard Pilmar?

A Rigor mortis is a post-mortem finding.

After the decedent -- when the decedent dies, the skeletal muscles over time will become rigid. That is where the rigor comes in; rigor mortis, rigidity after death. And the skeletal muscles will become stiff over time.

The individual who examines the body will describe the degree of rigor mortis, whether the body is in full rigor mortis or not. We do have some rough estimates of when rigor mortis, full rigor mortis occurs, but it is only a rough estimate.

Q You described injuries to the hands and the forearms. Are those anti-mortem or post-mortem?

A These are anti-mortem, before death.

Q And why do you know that?

A Because these injuries occurred, it is a normal reflex --

MR. CROCE: Objection.

THE COURT: I will allow it.

A When an individual is being threatened or assaulted, the reflex is to draw the hands up to protect the body. So, in this case, the individual was attempting to protect himself and he was still alive at the time.

Q And are you able to tell the members of the jury the order in which these injuries were inflicted, other than what you have already described as post-mortem injuries?

A No.

MS. LEDERER: I have nothing further of this witness. Thank you.

THE COURT: All right, ladies and gentlemen, why don't we take our morning break and then we will continue with the cross examination.

(WHEREUPON, THE JURY EXITS THE COURTROOM)

(WHEREUPON, THE WITNESS STEPS DOWN FROM THE WITNESS STAND)

(WHEREUPON, OFFICIAL COURT REPORTER DAWN CANDELLA WAS RELIEVED BY OFFICIAL COURT REPORTER LISA KRAMSKY)

THE COURT: All right.

Let's get going. Let's get the jury.

THE COURT OFFICER: Do you want the witness first?

THE COURT: Yes, that would be faster. Let's get the witness in here.

THE COURT OFFICER: Witness entering.

(The witness, Dr. Monica Smiddy, enters the courtroom and resumed the witness stand.)

****

THE COURT OFFICER: All rise. Jury entering.

(Jury enters.)

****

THE CLERK: Please be seated.

Do both parties stipulate the jury is present and properly seated?

MS. LEDERER: Yes.

MR. TALKIN: Yes.

MR. GOTLIN: Yes.

MR. CROCE: Yes.

THE COURT: All right. Ladies and gentlemen, one of the toughest parts of my job is to make sure that the temperature in the place is right.

So we have closed most of the windows so hopefully it will warm up and by this afternoon it will be completely warm.

Now we will begin our cross-examination. Mr. Croce.

MR. CROCE: Thank you, your Honor.

****

CROSS-EXAMINATION

BY MR. CROCE:

Q Good still morning, Doctor.

A Good morning.

Q Doctor, in 1996 you weren't working with the Chief Medical Examiner's office, is that correct, in New York State?

A Yes.

Q Oh, you were working?

A Yes.

Q Were you in the room when this autopsy was being performed?

A No.

Q Did you speak with Dr. Greenbaum about this autopsy at any point?

A I don't remember.

Q Since you were asked to testify with respect to this case, did you ever reach out to speak to Dr. Greenbaum about this autopsy and her findings?

A No.

Q Have you stayed in touch with Dr. Greenbaum over the years?

A No.
Q Now, with respect to testifying in this case, when was the first time you became aware that you were going to be asked to testify as an expert in this case?
A A couple of years ago.
Q And at that time, is that when you testified or shortly before you testified in the Grand Jury in this matter?
A Yes.
Q And you indicated that the Chief Medical Examiner's office maintains a file with respect to the autopsies that are performed and investigations that they conducted; is that a fair and accurate statement?
A Yes.
Q So with respect to the autopsy of Mr. Howard Pilmar, you reviewed that file; correct?
A Yes.
Q And I believe that file is now in evidence. But as part of that file, did you also review x-rays?
A No.
Q Were x-rays taken with respect to this case?
A Yes.
Q When medical examiners take x-rays during the course of an autopsy, why do they do that?
A The medical examiner will look for evidence of broken bones or metal objects within the body.

Q And you did not think it was something that was worth doing as part of your review of this case?

A Could you rephrase the question.

Q Well, why didn't you do it as part of your review for this case?

A Because in 1996 we were still taking the old fashioned x-rays on the large pieces of film and then they are stored so they have been -- somehow they've been stored for years in some warehouse.

Today we have different technology. Today we're doing digital photos that can be stored on the computer.

Q So my question though is, Doctor, were those x-rays available to you to review if you wanted to review them?

A No.

Q Why not?

A Because they are in storage somewhere.

Q So did you ever make a request to have those x-rays provided for you?

A No.

Q Now, when you take x-rays, what do they take x-rays of?

A In this case or any case?

Q Well, let's talk about in general?

A In general, it depends upon the nature of the case. Sometimes they just do the head, sometimes they will just do the torso.

They may just do the extremities or in some cases they may do full body.

Q In this particular case, what x-rays were taken, if you know?

A Most likely the head and the torso and the upper extremities.

Q Now, you say most likely, why is it that you say most likely as opposed to what was actually done?

A Because there are incised wounds, sharp force injuries of the head, the torso and the upper extremities.

Q Again, does the file reflect anywhere at the office of the Chief Medical Examiner what x-rays would have been taken on this case particularly?

A No.

Q So there is no way for you to know how many x-rays and what x-rays would have been taken?

A Correct.

Q But we do know that x-rays were taken; correct?

A Yes.

Q Now, with respect to your examination of the file in this case, you had an opportunity to review the factual findings of Dr. Greenbaum; correct?

A Yes.

Q In other words, when I say factual findings, I'm talking about what -- those things that she physically observed

when she conducted this autopsy back in March of 1996. Is that a fair statement?

A I don't know what you mean by physically observed.

Q Her personal observations that were recorded in the report that you reviewed?

A Yes.

Q You also had an opportunity to review photographs. Correct?

A Yes.

Q Now, some of the photographs that we saw that were taken, I think you testified on direct examination that photos are taken throughout the course of the autopsy process. Correct?

A Yes.

Q And they are taken at the beginning, when the body is first brought into the room and is placed on the table and is examined; a fair statement?

A Yes.

Q And I believe you were showing us early on there was a photograph of a suit jacket, of clothing that Mr. Pilmar was wearing.

That would have been one of those photographs taken at the beginning or before the autopsy had begun; correct?

A Yes.

Q And then you said that there were photographs taken

during the course of the autopsy, you said before and after the body is washed?

A Yes.

Q What does it mean to wash the body?

(Pause.)

****

Q And I know that seems like a ridiculous question, but please tell the jury what you actually do when you wash the body?

A The decedent is on the autopsy table, and there were hoses and a sink connected with the autopsy table.

And a cloth is used to wash the body, and then it's hosed to clean the body, to clean the skin surface.

Q Now, with respect to some of the photographs that you were shown during the course of your testimony earlier this morning, can you tell which of those photographs were taken before the body was washed versus after the body was washed?

A Yes.

Q With respect to the photograph of Mr. Pilmar's back where we saw those clustered wounds on the back and in the neck, do you recall if that photograph was taken before the body was washed or after the body was washed?

A After the body was washed.

Q And again, by washed you mean hosed and rubbed down with a cloth; correct?

A Yes.
Q Now, can that process -- can that alter some of the physical observations, some of the physical findings that might have been present before the washing was conducted?
A No.
Q So, in other words, when they take that cloth and they hose it down, they are -- it's impossible for blood clots or blood to be removed from those wounds?
A It will be removed, yes.
Q Okay. So what you are looking at when you were talking about postmortem wounds and you were relying on the fact that you saw no clotting or bleeding, none of that would have been removed during the washing process if there had been clotting or bleeding?
A Within the superficial skin, no.
Q When you say superficial skin, what are you referring to?
A The outer layer and the inner layer of the skin and the underlying fatty layer.
Q So you would have seen specific bleeding in that area that you did not see?
A Yes.
Q I want to ask you about a term that you referenced several times during the course of your testimony, gaping wound. What does that mean?

A It means when you look at the wound, it's wide open.

Q Now, is there a physical reason why those wounds manifest themselves in that manner when you are observing them later on as a forensic examiner conducting an autopsy?

A Yes.

Q Why does that happen?

A Because there are elastic fibers within the layers of the skin and once those elastic fibers are cut, the wound opens up.

Q So, for example, there was a wound that was visualized in the back and it was -- you described it as a stabbing gaping wound.

Correct?

A I don't remember.

Q Okay. I apologize. There was a wound, though, below the neck, kind of midline on the body. It was a very open wound.

Does that indicate by looking at that wound that the item that was used or the object that was used to create that wound was that size, was that large when it created that injury?

A No.

Q So the body, the skin on the body would actually cause the wound, the skin to retract making the hole larger; correct?

A The elastic fibers.

Q Also this autopsy was conducted on March 23rd.

Correct?

A I'm just referring to the report --

Q Certainly.

A -- for accuracy.

Q At any time, Doctor, please.

(Pause.)

****

A The autopsy was conducted on March 23rd, 1996.

Q And does Dr. Greenbaum indicate whether or not the body is in a state of rigor mortise at the time of the autopsy?

A Yes, she does indicate that the body is in rigor mortise.

Q Is it full rigor or some other type of condition?

A Well, she describes it as rigor mortise is symmetric in the arms and the legs.

Q What does that mean to you?

A It means that the arms and the legs are rigid.

Q And what about the remainder of the body?

A She does not comment on that.

Q When a person dies and their body naturally goes into a state of rigor mortise, does the body remain in that state?

A No.

Q Tell the jury about that process, please?

A The body becomes rigid over time and then until it becomes full rigor mortise, what's described as full rigor

mortise and then the body slowly -- the rigor mortise will dissipate until the body becomes flaccid or floppy.

Q Are there different stages of rigor mortise?

A I don't know.

Q What is it, based upon your experience and expertise, is it that a body can be expected to begin the rigor mortise process?

A Well, rigor mortise begins right after death. It's a process that evolves over time.

Q So again, if you have an opinion, if you are aware, how long would it take for a body to develop full rigor mortise, to be stiff completely after a person's death?

A The general rule is about twelve hours.

Q And can a person determine whether a body is in rigor mortise simply by looking at it without touching it?

A Sometimes.

Q And how is that?

A If -- by looking at the extremities.

Q What would it -- what would you see in the extremities that would indicate that it is in rigor mortise?

A Well, if the extremities are in an awkward position, if they are reaching up.

Q So --

A Defying gravity.

Q Okay. So, for example, if a person was on their back

and their arm was extended above them without any other support or problem, then you would presume that the arm -- that the body is beginning in a state of rigor mortise; correct?

A Yes.

Q But other than that, other than observing some type of violation of the natural laws of gravity, would you be able to determine whether a person is in rigor mortise without physically touching it?

A You may be able to.

Q How else?

A Just by observing them on the autopsy table.

If somebody is not in rigor mortise, they are going to be floppy.

Q I understand. Okay.

So you would have to observe them being moved to know that their body is floppy; correct?

A That's generally the way that -- one of the assessments that we make in determining rigor mortise.

Q Now, with respect to the office of the Chief Medical Examiner, in order for you to prepare to testify today, you had to review a number of different reports, among those were the physical findings or observations of Dr. Greenbaum.

Correct?

A Yes.

Q You also had available to you information from an

investigator from the Chief Medical Examiner's office. Do you recall reviewing that as well?

A Yes.

Q And can you tell the jury about why or what the function of the Chief Medical Examiner's office investigator is?

A The medical/legal investigator is a physician assistant, a licensed physician assistant who also has forensic investigative training.

So in this case, one of our medical/legal investigators went out to the scene.

Q Now, that may be the case today. Do you know if that was the case back in 1996 that the medical/legal investigators were physician's assistants?

A Yes, they went out to the scene.

Q No, but were they -- did they have certificates or trainings as physician's assistants?

A I believe they did.

Q Do you know, do you recall the name or does the file refresh your recollection as to the name of the investigator from the Medical Examiner's office who responded to the scene?

A It was Mr. Savino.

Q Now, Mr. Savino is physically present at the scene where the body is.

Correct?

A Yes.
Q And he provides certain information about his observations that are useful to the person who performs the autopsy.
Is that also correct?
A Yes.
Q Is one of the pieces of information that the medical/legal investigator provides the body temperature at the scene?
A They may or may not provide the body temperature.
Q Well, as part of their job don't they prepare a report that becomes part of the medical examiner's file?
A Yes.
Q And doesn't that -- as part of that file, do they document where the scene was?
A Yes.
Q And do they document who was on the scene when they arrived?
A Yes.
Q With respect to this particular case, do you know who the first officer would have been at the scene?
A No.
Q Would the file refresh your recollection?
A It might.
Q Can you take a look at it and see if it tells you?

A Yes, the first officer is written here. I am having trouble. It's handwritten.

I am having trouble with the name.

Q Would the name also be on the identification tag, the body identification tag?

A I don't know.

Q Can you take a look and see if that refreshes your recollection, it makes it easier?

A May I see the document you are referring to. I'm not sure I have it in this binder.

Q Certainly.

(Handed to the witness.)

****

A I do see the name.

Q Is the body identification tag prepared by the medical legal investigator at the scene when they are preparing the body for transport back to the Chief Medical Examiner's office?

A Yes.

Q And is that document that you are looking at consistent with that, by identification tag that I'm referencing?

A Yes.

Q So does that refresh your recollection as to the name of the first officer?

MS. LEDERER: Can I see what you are referring to?

MR. CROCE: Yes, sure. May I have that back,

please.

(Handed.)

(Shown to the District Attorneys.)

****

MS. LEDERER: Thank you.

MR. CROCE: Okay.

Q Does that refresh your recollection as to the name of the first officer?

A Yes.

Q What was the name?

A It looks like May Rose.

Q Police Officer May Rose?

A Yes, if I'm reading it correctly.

Q Thank you. And also as part of the report, are you advised as to who performs the police identification of the body?

A Yes.

Q Now, why is there police identification of the body performed?

A The police officer will come to the Medical Examiner's office and look at the decedent and sign a form stating that this is the decedent that he or she observed at the scene. It's part of our protocol.

Q And who was the officer that performed that function with respect to Mr. Pilmar?

A Again, may I see the document you are referring to, I'm not sure that it is in here.

MR. CROCE: Certainly.

(Shown to the District Attorneys and then handed to the witness.)

****

A It appears to be a Police Officer Scollard.

Q Thank you.

MR. CROCE: May I have that document back, please.

(Handed.)

****

Q And can you just also tell the jury, was a subsequent identification done by a family member?

A Yes.

Q And who did that identification?

A Roslyn Pilmar.

Q Thank you very much.

Now, with respect to the temperature of the body when it was at the scene, as part of that investigator's report, isn't there a place on that report where the investigator notes the body temperature at the scene?

A Yes.

Q And was that done in this case?

A No.

Q What was done with respect to the body temperature of

Mr. Pilmar?

A In this case, the investigator made note that the decedent was cold to the touch and in rigor mortise.

Q And that would have been at what time?

A He notes that this is at 8:30 a.m.

Q On what day?

A 3/22/1996.

Q So with respect to the temperature, cold to the touch, is it impossible to take the body temperature of an individual who was deceased?

A No. But it's not relevant.

Q Why is it not relevant?

A Because the person has already been dead for awhile.

Q What affects the temperature of a body postmortem?

A The garments the individual is wearing, whether there are layers or not, the type of garments, the temperature of the room, the underlying illness or infection that the decedent may have will all alter the temperature of the body.

Q What about the ambient room temperature, will that affect the body temperature at the time of discovery?

A Yes. And that's the temperature of the room or the environment.

Q Was that reported or reflected anywhere in the report?

A No.

Q The fact that there was a significant loss of blood,

does that impact body temperature?

A No.

Q Now, at the time that the autopsy is provided, does the physician have any knowledge about the position of the body when it was discovered?

A The doctor may or may not know the position of the decedent at the time of discovery.

Q Do you know if Dr. Greenbaum knew?

A I don't know.

Q With respect to the fingernail scrapings that we talked about earlier on direct examination, what is the purpose of taking fingernail scrapings?

A To collect any evidence that may be there, that may have occurred during an assault.

Q And how were those fingernail scrapings taken?

A They are taken with a sharp object.

Q And please take us through it.

What is it that you do?

A Each fingernail is clipped and/or scraped.

Q And what did you do with the scrapings?

A They were put in an envelope, a paper envelope. They are labeled. They are sealed. And then they are sent to our forensic biology laboratory.

Q And with respect to the clothing, is the same thing done or is anything done with the clothing of the decedent?

A Yes. The clothing is photographed. It is dried. And then it is put in a paper bag and sealed, and labeled and sent to our Evidence Unit.

Q Does the physician performing the autopsy do anything with respect to the clothing to take forensic samples?

A They may or may not.

Q Do you know if that was done in this case?

A I don't know.

Q Would the report refresh your recollection?

A No.

Q Well, what would refresh your recollection?

A I don't know if evidence was removed from the clothing or not.

Q So is there any indication of it in the report itself?

A No.

Q With respect to the injuries in the neck that you testified to earlier, you indicated that the object perforated the neck and that it struck the spinal discs or vertebrae. Correct?

A Yes.

Q Is that one of the areas that you would have expected x-rays to have been taken?

A Yes.

Q And with respect to the vertebrae's themselves, were any -- were they ever visually examined by Dr. Greenbaum?

A No.
Q Did anyone look to see whether there were any markings on those vertebrae that could tell you something about the instrument that caused the wound?
A The doctor reports that there was injury to a disc between two of the cervical vertebrae.
Q But anything else with respect to visual observations of those vertebrae about, that describes that wound to the vertebrae?
A No.
Q You were also asked earlier about whether or not that injury would have any physical affect on the individual. Do you recall talking about that?
I believe you testified that if it struck the spinal column it could cause some type of paralysis?
A It may.
Q In this particular case, do you know if the spinal column was indeed perforated or struck by any instrument?
A The spinal cord was not injured.
Q So in this case, you know that Mr. Pilmar was not -- at least he did not suffer a spinal cord injury.
Correct?
A Correct.
Q If a wound of the type that you described to the neck was caused while the heart was beating, while it was pumping,

can you give us an opinion as to what would happen with respect to the blood in that area of the neck?

A The blood will escape into the surrounding soft tissues because there are injuries to the blood vessels. There is a lot of blood vessels in the neck.

Q Won't that blood also escape outside of the body as well?

A Yes, that's called exsanguination.

Q And with respect to a number of the injuries here, for example, the injuries that caused perforation of the lungs, those would have created -- those would have resulted in a lot of bleeding as well.

Correct?

A Yes.

MR. CROCE: Your Honor, could I just have a moment, please?

THE COURT: Yes, of course.

(Defense counsel conferring.)

****

Q Just a couple final questions, Doctor, and then I will let you get back.

Doctor, back in 1996, did the Chief Medical Examiner's office have a DNA lab?

A Yes, we did.

Q And were they conducting DNA testing at that time?

A Yes.

Q Were officers -- well, withdrawn.

Do you know if the office of the Chief Medical Examiner's of New York was training law enforcement with respect to collection of DNA?

A Oh, I don't know that.

Q Are there specific methods in which DNA evidence should be collected to preserve it, if you know?

MS. LEDERER: Objection, beyond the scope.

THE COURT: I will allow it. Back in 1996.

THE WITNESS: I don't know.

Q Well, with respect to the DNA scrapings that you collected, were those being collected for any particular type of testing?

Not that you collected, that Dr. Greenbaum collected?

A I don't know, counselor, I'm not a DNA person.

I'm not a DNA scientist or, I don't work in the forensic biology lab.

Q I appreciate that, thank you.

And just a couple of other questions with respect to rigor mortise.

Is rigor mortise and the way that it affects the body the same for every individual or does it differ?

A No, it's usually the same for all individuals.

Q So all individuals that die, they would begin to start

with the rigor mortise process immediately after death?

A Yes, again it evolves slowly over time.

Q So can you give us an idea of, in your experience, the range of time that it would take for a body to go from death to, let's say, full rigor mortise?

A Well, it's hours.

And Dr. Greenbaum did the autopsy the next day and the body was still in rigor mortise.

Q So rigor mortise could extend for quite a period of time; correct?

A Yes, it can.

Q Thank you.

MR. CROCE: Nothing further.

THE COURT: Mr. Talkin?

MR. TALKIN: Thank you, your Honor.

(Pause.)

****

MR. TALKIN: No questions?

THE COURT: Okay. Any redirect?

MS. LEDERER: Yes, your Honor.

Just a few.

*****

REDIRECT EXAMINATION

BY MS. LEDERER:

Q We were talking about rigor mortise.

Can you tell the members of the jury some of the things that would affect when a body or how quickly a body will go into rigor mortise?

A Rigor mortise is very subjective, depending upon who is doing the examination.

Things that can cause accelerated rigor mortise, an individual who is overly excited; some type of muscular activity; over exertion of muscles can also cause an acceleration of rigor mortise.

Q When you say acceleration of rigor mortise, what do you mean?

A It means that the body -- excuse me, that the muscles will become stiff quicker.

Q So if the person who then dies and goes into rigor mortise was in a fight before his death, would that have an impact on how soon rigor mortise would set in?

A Yes.

Q And if that person had been working out at a gym, would that have an affect?

A Yes.

Q And would the temperature where the body was have an affect on how quickly it would go into rigor mortise?

A I don't know.

Q When you say that rigor mortise is subjective, what does that mean?

A It's subjective depending upon the individual whose doing the assessment, how experienced are they.

Are they able to move all parts of the body?

Do they know what rigor mortise is?

Are they talking about rigor mortise in the jaw or are they referring to rigor mortise on the torso or the extremities?

Q Does rigor mortise set in at a different time with respect to the jaw or the extremities or the body?

A It does. Rigor mortise sets in after death.

But it's appreciated differently in different muscles of the body.

Q Does rigor mortise in the case that we are here about today, the death of Howard Pilmar, does the information that you have from rigor mortise, from either the investigator at the scene or Dr. Greenbaum, give you information about the time of death of Howard Pilmar?

A No.

MS. LEDERER: Thank you.

THE COURT: Any recross?

MR. CROCE: Just very briefly, Judge.

****

RECROSS-EXAMINATION

BY MR. CROCE:

Q So Doctor, there are circumstances that affect rigor mortise between different individuals; correct?

A Yes.
Q It's not the same for every body; correct?
A Correct.
Q And in a case of an individual who was involved in a fight, who was very athletic, it would not surprise you to find out that rigor mortise would set in quicker with that individual.
Correct?
A Correct.
MR. CROCE: Nothing further.
MS. LEDERER: Thank you.
Nothing further.
THE COURT: Thank you very much, Dr. Smiddy. Thank you for coming.
Have a nice day.
THE WITNESS: Thank you.
(Witness excused.)
****
THE COURT: All right. Ladies and gentlemen, it's that time.
It's lunch time. So we will break here, and we will come back at 2:15, please.
Have a great lunch.
THE COURT OFFICER: All rise as the jury exits.
(Jury exits.)

The City of New York

DEPARTMENT OF HEALTH
OFFICE OF CHIEF MEDICAL EXAMINER
520 FIRST AVENUE, NEW YORK, N.Y. 10016-6402

CHARLES S. HIRSCH, M.D., Chief Medical Examiner

RECORDS DEPARTMENT

Telephone: 212 447-2064 Fax: 212 447-2716

NAME: Howard PILMAR M.E.# M 96 1957

SENT TO DISTRICT ATTORNEY FOR COUNTY OF: New York

DATE SENT: July 8 19 96

BY: J-R CELSI

	ITEM:		ITEM:
✓	Autopsy Report		Wound Chart
✓	Toxicology Report	✓	Autopsy Notes/Diagram
	Bio/Serology Report	✓	Case Worksheet
	Ballistic Receipt		Pending Death Certificate
	Neuropath. Consult Report		Amended Death Certificate
✓	Family Identification		Dental Consult Report
✓	ID Survey Form		Microbiology Lab Report
✓	Police Identification		Anesthesia Consult Report
	ID by Fingerprint Report		Anthropology Consult Rpt
	Confirmation of ID		X Ray Consult Report
	Hospital Report	✓	Autopsy Report Draft
✓	Tel. Notice of Death		Neuro Consult Draft
	Supplemental Report (Investigation)	✓	Toe Tag
✓	Scene Investigation Report		Micro. Report
✓	Supplemental Reports (other)		Other:

Photographs, X Rays and Audio tapes must be separately requested. Gastric laboratory data must be specifically requested after a case conference. Microscopic slides and retained tissues can be reviewed at the Office of Chief Medical Examiner as long as appropriate authorization is obtained.

CHECKLIST.FRM

OFFICE OF CHIEF MEDICAL EXAMINER
CITY OF NEW YORK

REPORT OF AUTOPSY

Name of Decedent: Howard Pilmar M.E. Case #: M96-1957

Autopsy Performed by: Dr. V. Jordan Greenbaum Date of Autopsy: March 23, 1996

FINAL DIAGNOSES

I. STAB WOUNDS OF NECK (FIVE), WITH:
   A. PENETRATIONS OF SOFT TISSUE, MUSCLES, SPINOUS PROCESS OF C2 AND CERVICAL INTERVERTEBRAL SPACE.

II. INCISED WOUND OF NECK, WITH:
   A. PENETRATIONS OF SOFT TISSUE AND MUSCLE AND PERFORATION OF UPPER AIRWAY.
   B. ASPIRATION OF BLOOD.

III. STAB AND INCISED WOUNDS OF ANTERIOR AND LATERAL CHEST (EIGHT), WITH:
   A. PENETRATIONS OF LEFT VENTRICLE, LEFT ATRIUM AND LEFT LUNG.
   B. PERFORATIONS OF RIGHT LUNG, PERICARDIAL SAC, RIGHT ATRIUM AND AORTA.
   C. HEMOTHORAX (APPROXIMATELY 15 CC RIGHT AND 15 CC LEFT PLEURAL CAVITIES) AND HEMOPERICARDIUM (APPROXIMATELY 5 CC).

IV. STAB WOUNDS OF BACK (TWELVE), WITH:
   A. PENETRATIONS OF SOFT TISSUE, MUSCLE AND LUNGS

V. STAB WOUND OF RIGHT FOREARM, WITH:
   A. PENETRATIONS OF SOFT TISSUE AND MUSCLE.

VI. INCISED WOUNDS OF FOREARMS AND HANDS, WITH:
A. PENETRATIONS OF SOFT TISSUE AND MUSCLE.

VII. INCISED WOUND AND BLUNT IMPACT TO FACE, WITH:
A. PENETRATION OF SOFT TISSUE.
B. ABRASIONS.

VIII. BLUNT IMPACT TO KNEES.
A. ABRASIONS.

CAUSE OF DEATH: STAB AND INCISED WOUNDS TO NECK AND CHEST WITH PENETRATIONS OF LUNGS, HEART AND TRACHEA, AND PERFORATIONS OF LUNG AND AORTA.

MANNER OF DEATH: HOMICIDE (STABBED AND CUT BY OTHER(S)).

OFFICE OF CHIEF MEDICAL EXAMINER
CITY OF NEW YORK

REPORT OF AUTOPSY

CASE NO. M96-1957

I hereby certify that I, V. Jordan Greenbaum, M.D., City Medical Examiner-I, have performed an autopsy on the body of Howard Pilmar, on the 23rd day of March, 1996, commencing at 9:00 AM, in the Manhattan Mortuary of the Office of Chief Medical Examiner of the City of New York. This autopsy was performed in the presence of Drs. Flomenbaum and Seijo.

EXTERNAL EXAMINATION:

The body is of a well developed, well nourished, 5'10", 175 lb, light brown-skinned male whose appearance is consistent with the given age of 40 years.

The thick brown scalp hair measures 2-1/2". There is no moustache or beard. The eyes have brown irides and clear conjunctivae without petechiae, confluent hemorrhage or jaundice. The oral cavity contains natural teeth and has an atraumatic mucosa.

The chest has a normal anteroposterior diameter and the abdomen is soft. The genitalia are of a normal adult circumcised male. There are no scars overlying the course of subcutaneous veins on any of the extremities and none on the flexor aspect of the wrists.

POST-MORTEM CHANGES:

Rigor mortis is symmetric in the arms and legs; the body is cold.

THERAPEUTIC PROCEDURES:

None.

CLOTHING:

The body is clad in the following: a pair of markedly blood-stained blue trousers with a black leather belt in the loops; a pair of white briefs which are blood-stained on the anterior aspect; a pair of blue socks; a pair of black loafers; a markedly blood-stained white dress shirt; a blood-stained tie and a blood-stained blue suit jacket of the same material as the trousers. The dress

shirt has incised defects of the torso and sleeves which reproduce those described below in location and size. The suit jacket has many incised defects which outnumber those found on the body. There are defects clustered on the posterior aspect near the bottom, on the right and left and at the superior aspect of the back, right of midline. There are additional defects over the right shoulder, near the bottom of the right sleeve, in the left sleeve, mid level and on the front. The left front of the jacket has four irregular defects and the right front has one vertical defect. The lining of the jacket is extensively torn and incised in a vertical orientation on the anterior and posterior aspects. The clothing is photographed, dried and submitted to Evidence.

KNIFE AND HAMMER:

Examined in the Evidence office are the following: a single-edged, serrated knife with a 7 3/4 x 7/8 x 1/16" blade, a white handle and no associated blood; a hammer with a 1 1/2" round rubber end containing multiple nicks and irregularities, and a slightly larger, steel opposite end.

INJURIES, INTERNAL AND EXTERNAL:

There are five stab and one large incised wound of the neck, eight stab and incised wounds of the anterior and lateral aspects of the torso; and 12 stab wounds of the back. Multiple blunt impact injuries and a single incised wound are on the face and additional blunt impact injuries are on the anterior aspects of the knees. The hands have multiple linear and irregular incised wounds and the forearms have two incised and one stab wound. These injuries are lettered for descriptive purposes only; no sequence is implied.

A. TWO STAB WOUNDS TO RIGHT LATERAL ASPECT OF NECK:

A stab wound is located 6-3/4" below the top of the head, 2-3/4" right of midline and 1" below the right ear. With the edges reapproximated, the wound measures 1-1/8" in length on the skin surface and 1/16" in width. The wound is nearly transversely oriented and both angles are sharp. The margins are slightly uneven and there are focal abrasions on the superior aspect.

After perforating the skin, the wound track continues downward through the soft tissue, before joining the wound track of the large incised wound described below.

A second stab wound is located 7-1/2" below the top of the head, 2-1/4" right of midline and slightly anterior and inferior to the wound described above. Reapproximating the edges yields a slightly obliquely oriented 1" skin defect with a sharp angle directed toward the occiput and a blunt angle directed toward the chin. A 1/4" extension at the posterior aspect extends downward to join the incised wound described below.

After perforating the skin, the wound track continues downward through the subcutaneous tissue to join the wound track of the incised defect.

B. INCISED WOUND OF NECK:

A gaping incised wound of the neck extends from 2" below the right ear, across the right lateral, anterior and left lateral aspects of the neck to 1/2" behind the left ear, at a level 2-1/4" below the left ear. On the right border a 3/4" scratch continues posterior to the right ear and a 1/4" tail extends downward (this tail may represent an extension from the second stab wound described above). At the left lateral aspect of the wound, there is a 3-1/4" scratch continuing beyond the border of the incised wound to curve upward along the posterior aspect of the neck, nearing the scalp and terminating 1" left of midline.

The incised wound reaches its maximum depth of approximately 2" in the central, anterior aspect of the neck where the wound track extends through the sternohyoid and thyrohyoid muscles and perforates the anterior wall of the upper airway, above the thyroid cartilage. Laterally, the wound track is more superficial and does not transect any major vessels, or the sternocleidomastoid muscles.

There is a moderate amount of associated soft tissue hemorrhage. Sectioning of the lungs reveals patchy regions of aspirated blood, consisting of small scattered parenchymal hemorrhages most prominent in the right middle and lower lobes.

C. THREE STAB WOUNDS TO POSTERIOR NECK:

In a 2 x 1" area of the upper posterior aspect of the neck, right of midline are three transverse to slightly oblique stab wounds which range from 5/8 to 1" in length when the edges are reapproximated. The medial wound has one blunt angle directed medially; the remaining two wounds have only sharp angles. One wound has a 1/4" slightly angulated tail directed superiorly.

The superior wound track extends into the spinous process of C2 approximately 1" before ending in the intervertebral space between C2 and C3. The track extends from right to left, back to front and downward to a total depth of 1 to 2". There is no associated epidural or subdural hemorrhage and no trauma to the external aspect of the cervical spinal cord.

The remaining two wound tracks extend through soft tissue into muscle, to a depth of 1 to 2". The medial wound follows a right to left, back to front and slightly downward direction.

D. STAB WOUND TO LEFT UPPER TORSO:

A stab wound is centered 16" below the top of the head and 6" left of midline, below the left axilla. With the edges reapproximated the wound is transversely oriented and 2" in length with a blunt angle directed medially.

After perforating the skin and muscle of the chest wall, the wound track continues through the fourth intercostal space, enters the left pleural cavity, and penetrates the upper lobe of the left lung.

The direction of the penetration is left to right, back to front without vertical deviation. The estimated depth of penetration is 2-1/4 to 4".

There is approximately 15 cc of clotted blood in the left pleural cavity.

E. STAB WOUND TO LOWER LEFT TORSO:

A stab wound is centered 20-1/2" below the top of the head, 6" left of midline and 2-1/2" anterior to the mid coronal plane. With the edges reapproximated, the skin defect is nearly transversely oriented and measures 2-1/2" in length, with two sharp angles. There is a 3" tail extending posteriorly which varies from a superficial scratch to a defect exposing subcutaneous fat.

After perforating the skin and muscle of the chest wall, the wound track continues through the left seventh intercostal space, perforates the base of the pericardial sac and penetrates approximately 1/8" into the posterior wall of the left ventricle, without entering the chamber.

The direction of the penetration is left to right, back to front and upward. The estimated depth of penetration is 1 to 2".

There is approximately 5 cc of clotted blood in the pericardial sac.

F. INCISED WOUND OF LEFT CHEST:

An incised wound is centered 20-1/2" below the top of the head and extends across the left anterior and lateral aspects of the chest. The medial border is 3/4" left of midline. With the edges reapproximated, the wound is transversely oriented and 6-1/2" in length; the depth of penetration is approximately 1/2". The wound track exposes subcutaneous fat and muscle without extending through the chest wall into the left pleural cavity.

G. SMALL INCISED WOUND OF LEFT CHEST:

Immediately below the medial aspect of the incised wound described above is a 1/2" obliquely oriented incised wound which penetrates to a depth of 1/4". One sharp angle of the wound is directed toward the left axilla and the opposite sharp angle is directed toward the right hand.

H. INCISED WOUND OF ANTERIOR CHEST AT MIDLINE:

Centered 17" below the top of the head, between the nipples in the midline is a triangular, swallow-tailed, slice-like incised wound which has edges measuring 1" and 3/4" when the margins are reapproximated. The superior borders are sharp and there are focal abrasions of the lower borders measuring up to 1/8".

The wound track penetrates approximately 1/4" to the underlying muscle with 1-1/2" of tissue undermining superiorly.

The direction of the wound track is upward.

A linear 1-3/4" scratch is obliquely oriented and inferior to the triangular wound, right of midline.

I. STAB WOUND ADJACENT TO RIGHT NIPPLE:

Centered 18" below the top of the head, 3-1/2" right of midline, immediately medial to the right nipple is a slightly oblique stab wound which has two sharp angles. Reapproximation of the edges yields a wound measuring 2-1/16" in length.

After perforating the skin and underlying subcutaneous tissue, the wound track continues through the muscle of the right fourth intercostal space, enters the right pleural cavity, perforates the lower lobe of the right lung, the pericardial sac, the right atrium, the aorta and penetrates the left atrium. There is approximately 15 cc of clotted blood in the right pleural cavity.

The direction of the penetration is right to left, upward and front to back. The estimated depth of penetration is 4 to 6-1/2".

J. INCISED WOUND OF RIGHT LOWER CHEST:

Centered 20-1/4" below the top of the head on the lower aspect of the chest, right of midline is an obliquely oriented incised wound which measures 2-3/8" in length when the edges are reapproximated. The angles are sharp and are directed toward the left hip and right axilla. There is focal abrasion of the inferior border. The lateral aspect gives rise

to a linear, slightly superiorly directed 5" tail which scratches the skin.

The wound track extends into the soft tissue and muscle of the chest and it leaves an impression on the cartilage of the sternum. The estimated depth of penetration is approximately 1/2". The wound does not enter the pleural cavity.

K. **COMPLEX WOUND OF UPPER BACK:**

A complex stab wound is located in the upper region of the back, near the midline. The total area measures 5-1/2". The inferior 1-1/4" consists of a slightly oblique stab wound centered 15" below the top of the head and 1" right of midline. The inferior edge is blunt and directed towards the medial aspect of the left buttock. At the superior border there is a slight change in angle with a near vertical orientation as the wound continues superiorly. The superior aspect is a shallow abrasion with an obliquely directed superior scratch. An abrasion is on the right border.

The inferior aspect has an associated wound track which extends downward and back to front while the superior aspect extends right to left and downward, toward the left scapula. The wound track extends parallel to the rib cage and does not enter a pleural cavity. While the depth of penetration is approximately 1/2", the length of the wound track is at least 6" in the lateral plane.

L. **FIVE STAB WOUNDS OF LEFT BACK:**

In a 4 x 3" region of the left aspect of the back, at the level of, and inferior to, the left scapula, and extending to the midline, are five clustered stab wounds which are vertically and slightly obliquely oriented. The angled wounds are generally directed from the left shoulder to the right hip. With reapproximation of the edges the wound lengths range from 5/8 to 1-1/4". Two of the wounds are in the midline and run in a parallel direction at approximately 30 to 40 degrees from the vertical. The superior of these two wounds has a blunt angle at its right inferior aspect. The four remaining wounds have two sharp angles. The wound located furthest from the midline has a 1/16" abrasion on the lateral aspect.

The five wounds enter the left pleural cavity. Two of the wound tracks enter the posterior aspect of the left lower lobe to a maximum depth of 1".

The direction of the penetrations is generally back to front without vertical or transverse deviation. The maximum depth of penetration is 1-1/2 to 3".

J. SIX STAB WOUNDS OF RIGHT BACK:

In a 4-1/2 x 3-1/4" area of the mid back, right of midline are six stab wounds which are generally slightly obliquely oriented, with the greatest angle of orientation being approximately 30 degrees from the vertical. The wounds range from 1/2 to 1-3/16" in length and 1/16" in width. A few have blunt angles which are all directed inferiorly.

The wound tracks range from soft tissue penetration of approximately 1/4" to perforation of the chest wall and penetration of the right lung. Three of the wounds enter the right pleural cavity and two enter the posterior aspect of the right lower lobe.

The general direction of the wound tracks is back to front without vertical or transverse deviation. The maximum depth of penetration is 2 to 3-1/2".

K. STAB WOUND OF RIGHT FOREARM:

On the flexor aspect of the distal right forearm is a nearly transverse 1/2" stab wound with a lateral blunt angle and medial sharp angle.

The wound track continues through the skin, subcutaneous fat and into the underlying muscle without perforating tendons or major blood vessels. There is minor soft tissue hemorrhage.

The direction of the wound track is front to back, without vertical or transverse deviation. The estimated depth of penetration is 3/4".

L. INCISED WOUNDS OF FOREARMS:

On the extensor aspect of the right forearm, there is an obliquely oriented 1/2" scratch and on the extensor aspect of the left forearm, below the elbow is a transversely oriented 1" scratch.

M. INCISED WOUNDS OF LEFT HAND:

On the extensor aspect of the second middle phalanx (index finger) is an obliquely oriented 5/8" scratch. A 1" curvilinear incised wound of the fourth finger involves the nail and the flexor aspect of the distal phalanx. It penetrates to a depth of 1/4". Immediately proximal to this is a 1/4" triangular incision. At the base of the index finger, on the flexor aspect is a 1-3/8" incised wound which extends 1/4" into the underlying tissue with exposure of uninjured tendon. A 3/4" scratch is on the flexor aspect of the second proximal phalanx. On the flexor aspect of the second middle phalanx is a V-shaped incised wound with 1/4 and 1/2" branches. The wound exposes the underlying dermis. On the flexor aspect of the third proximal phalanx is a

curvilinear 7/8 x 1/8" incised wound exposing subcutaneous tissue. Proximal to this is a 1/4" linear scratch exposing the underlying dermis. On the flexor aspect of the third middle phalanx is a 3/4 x 1/4" triangular incised wound exposing subcutaneous tissue. On the flexor aspect of the distal third phalanx is a V-shaped incised wound with branches measuring 1/4 and 3/8". Adjacent to this is a linear 1/2" incised wound with parallel tiny faint scratches of the surrounding skin. On the flexor aspect of the fourth finger, over the proximal and middle phalanges is an irregular, V-shaped incised wound with branches measuring 3/4 and 1/2". There is exposure of subcutaneous tissue down to the fascia overlying the tendon. The depth of penetration is approximately 1/4". There is undermining of the proximal tissue.

N. **INCISED WOUNDS OF RIGHT HAND:**

A 1/4" incised wound is on the distal aspect of the fourth fingernail. On the extensor aspect of the third middle phalanx is a linear 1/2" scratch and at the base of the second (index) finger on the dorsum of the hand is a 1/4" abrasion. A 1-1/8" incised wound extends over the flexor aspect of the proximal and distal phalanges of the thumb, with exposed subcutaneous tissue. The tip of the thumb has a 1/8" shallow incision. On the lateral aspect of the second distal phalanx is a 1/4" incised wound.

Both hands are covered by brown paper bags which are secured with yellow evidence tape.

O. **INCISED WOUND OF FACE:**

A curvilinear 1" incised wound is located left of the mouth. It has a notched lateral border and extends approximately 1/4" into the underlying tissue.

P. **BLUNT IMPACT TO FACE:**

On the left aspect of the forehead is a 1/4" abrasion. Above and slightly lateral to the left eyebrow is a 1 x 1/2" dry red abrasion and lateral to the left eye, with involvement of the skin immediately adjacent to the eye, is a 2 x 1-3/4" geographic red-brown abrasion. A 1/4" abrasion is on the left side of the nose near the left eye and over the bridge of the nose is a 1/2 x 1/2" dry red-brown abrasion. At the tip of the nose is a 1/4" abrasion. There is no palpable fracture of the nose.

There are no subscalpular or subgaleal hemorrhages, no skull fractures, no epidural, subdural or subarachnoid hemorrhages. The external surface of the brain is free of trauma.

Q. BLUNT IMPACT TO KNEES:

Three round and irregular dry red abrasions are over the anterior aspect of the right knee and these range from 3/4" to 1-1/4" in greatest dimension. There are no palpable underlying fractures. Over the anterior aspect of the left knee is a circular 1/2" dry slightly depressed abrasion and medial to this is an irregular 1/2" abrasion. Slightly above the left knee is a 1/2" abrasion. There are no palpable underlying fractures.

These injuries, having been described, will not be repeated.

INTERNAL EXAMINATION:

Because of religious objections, the internal examination of organs is limited to in situ examination, palpation and limited incisions.

HEAD: The dura mater is pink-tan, thin and uniform without brown discoloration. The brain has a normal external appearance with symmetric cerebral hemispheres and unremarkable sulci and gyri. The leptomeninges are thin and glistening.

NECK: The thyroid and cricoid cartilages are intact. The soft tissues of the neck are described above.

BODY CAVITIES: The pleural and pericardial fluid accumulations are described above. The peritoneal cavity is free of fluid. The organs are in their normal situs without fibrous adhesions.

CARDIOVASCULAR SYSTEM: The heart is normal size without chamber dilatation or ventricular hypertrophy. The coronary arteries are free of atherosclerosis. The epicardium is smooth and glistening. The myocardium is red-brown.

RESPIRATORY SYSTEM: The lungs are of normal size and configuration with aerated pink parenchyma and minimal anthracosis. There are no areas of consolidation. The pleural surfaces are smooth and glistening.

LIVER, GALLBLADDER, PANCREAS: The liver is normal size, with a smooth, intact capsule and homogeneous brown smooth parenchyma. The gallbladder contains less than 10 cc of bile without gallstones. The pancreas is normal size, color and texture without focal lesions.

HEMIC AND LYMPHATIC SYSTEMS: The spleen is normal size and has a smooth, intact capsule and soft red parenchyma with conspicuous white pulp. The lymph nodes are not enlarged and the thymus is not identified.

GENITOURINARY SYSTEM: Each kidney is normal size, with a smooth subcapsular surface and pale red-brown parenchyma with a slightly blurred corticomedullary junction. The ureters are normal caliber. The bladder is empty.

The testes are unremarkable.

ENDOCRINE SYSTEM: The adrenal glands are normal size, color and consistency. The thyroid gland is not dissected.

DIGESTIVE SYSTEM: The stomach contains approximately 30 cc of dark brown partially digested food with identifiable vegetable fragments and soft tan material (? potato). No pills or capsules are identified. The gastric mucosa is intact and unremarkable. The small and large intestines are normal caliber and color without obstruction. The appendix is present.

MUSCULOSKELETAL SYSTEM: The muscles are well developed and unremarkable. No bony abnormalities are noted.

6-25-96

V. Jordan Greenbaum, M.D.
City Medical Examiner - I

VJG:cti
6/3/96:km
6/12/96:pc

OFFICE OF CHIEF MEDICAL EXAMINER
CITY OF NEW YORK

AUTOPSY NOTES

NAME OF DECEASED: Howard Gilmore M.E.# M 96 1957

WDAWN: HEIGHT: 5 FT 10 IN WEIGHT: 175 LB SKIN COLOR: lt br (♂) ♀ AGE: 47

HAIR: TXTR kink CLR br 3 1/2 IN M ___ IN B ___ IN EYES: IRIDES br CONJ [illegible] TEETH/ORAL [illegible]

TORSO: ANT ___ POST ___ EXTREMITIES: UPPER ___ LOWER ___ GENITALIA: [illegible]

RIGOR MORTIS: [illegible] All LIVOR MORTIS: F/B ___ TEMPERATURE: cold

SCARS:

TATTOOS:

CLOTHING: tie, blue trousers (+ bld) c̄ [illegible] leather belt in [illegible], [illegible] + bld, white dress shirt (+ bld), blue suit jacket, blue socks, bk loafers.

THERAPEUTIC PROCEDURES: [illegible] — defects torso well represented, reproduced → + bld, back many xtra defects R + L near bottom, R top, lining extensively slashed vertical ant/post, defects R shoulder, R sleeve near bottom, Front - 4 irreg L, 1 vertical R [illegible], L arm midway

INJURIES: hands bagged

HEAD

BRAIN [illegible] GM

NECK

CAVITIES

HEART ___ GM without [illegible]

L.V. ___ CM

R-LUNG NL GM

L-LUNG NL GM

LIVER NL GM

BILE [illegible] ML

PANCREAS [illegible]

SPLEEN NL GM soft

LYMPH NODES

THYMUS: Y/N

R-KIDNEY [illegible] GM

L-KIDNEY ___ GM [illegible]

URINE [illegible] ML

GONADS testes ok

ENDOCRINE

DIGESTIVE TRACT

GASTRIC [illegible] ML

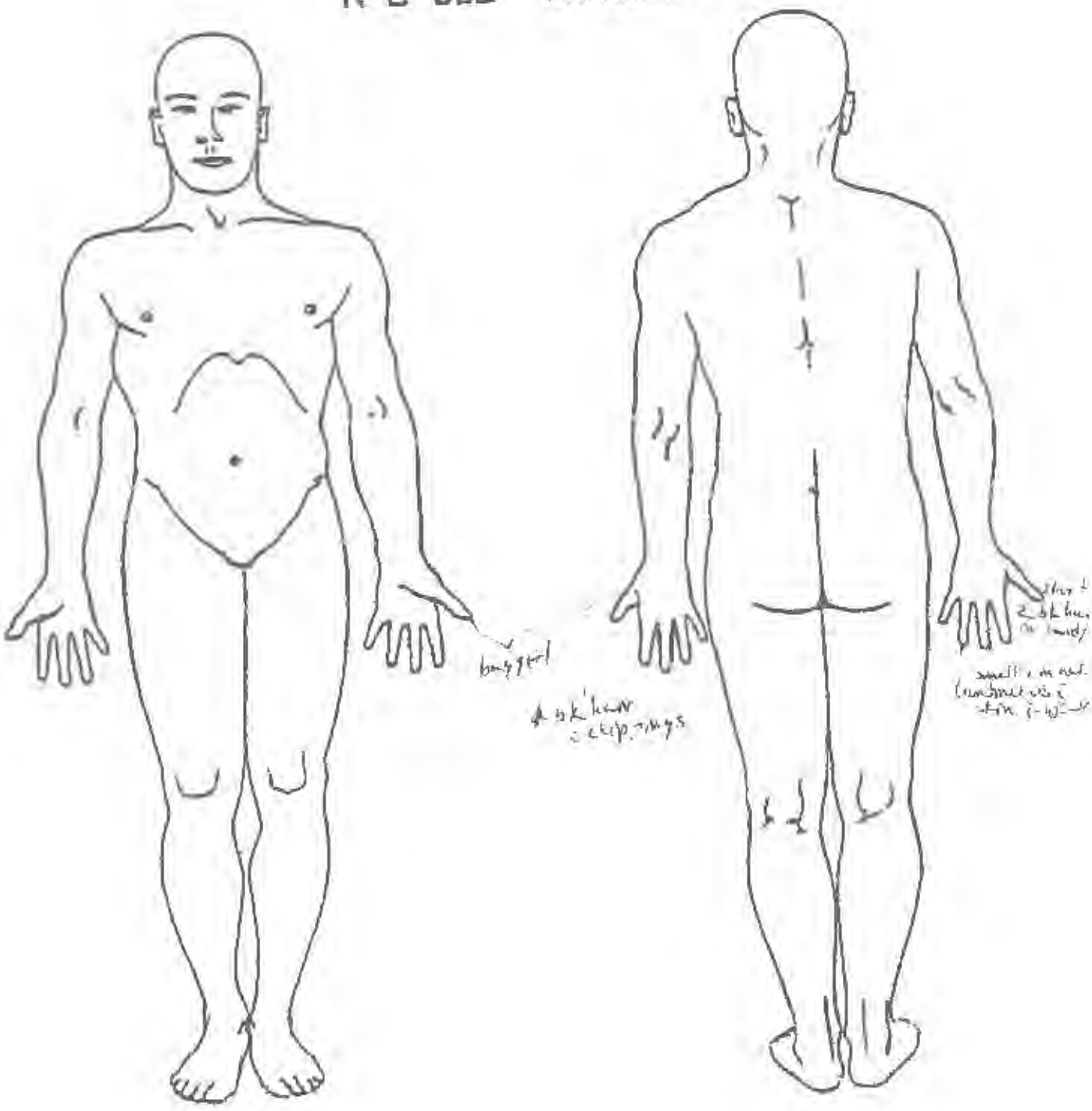
APP: Y/N

MUSC-SKEL

NL organs ... [illegible]

DIAGNOSES:

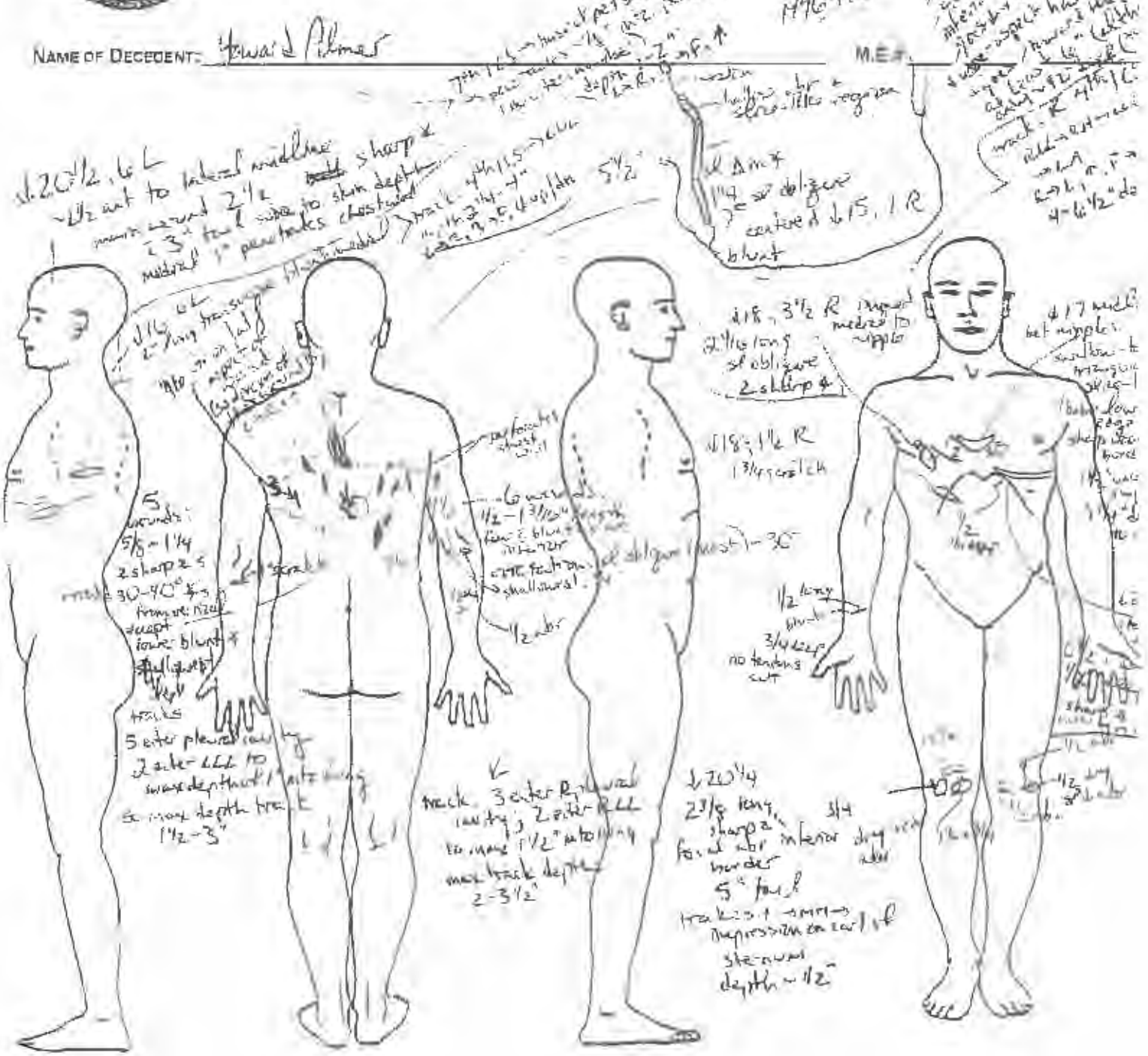
EXAMINED BY: [signature] M.D. DATE: 3 / 23 / 96



OFFICE OF CHIEF MEDICAL EXAMINER
THE CITY OF NEW YORK

ADDITIONAL AUTOPSY NOTES

NAME OF DECEDENT: Howard Palmer M.E.#



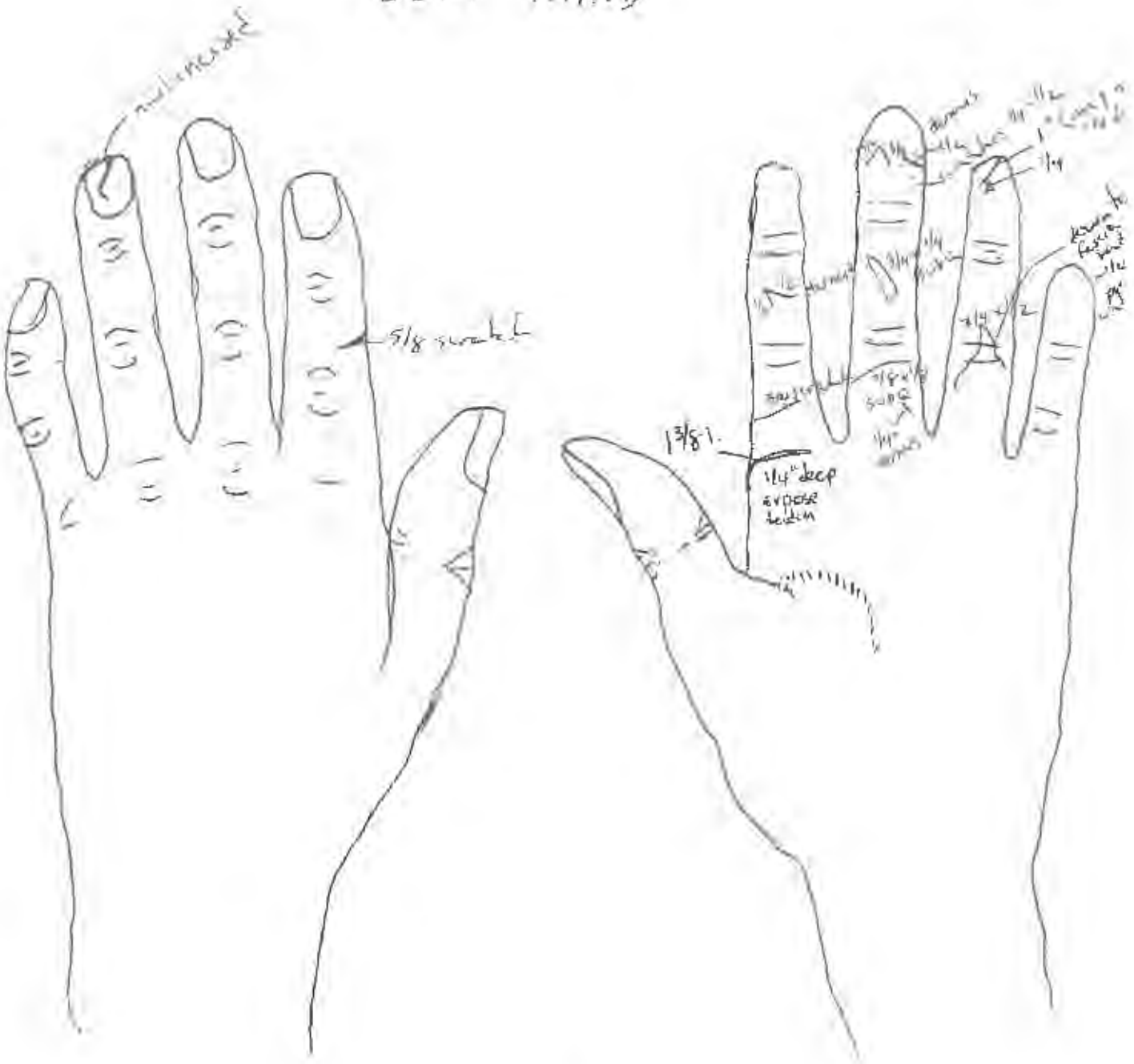
EXAMINED BY: _____ DATE: ____/____/____

OFFICE OF CHIEF MEDICAL EXAMINER
City of New York

ADDITIONAL AUTOPSY NOTES

NAME OF DECEASED: Edmund Palmer M.E.# M-96-1957

LEFT HAND



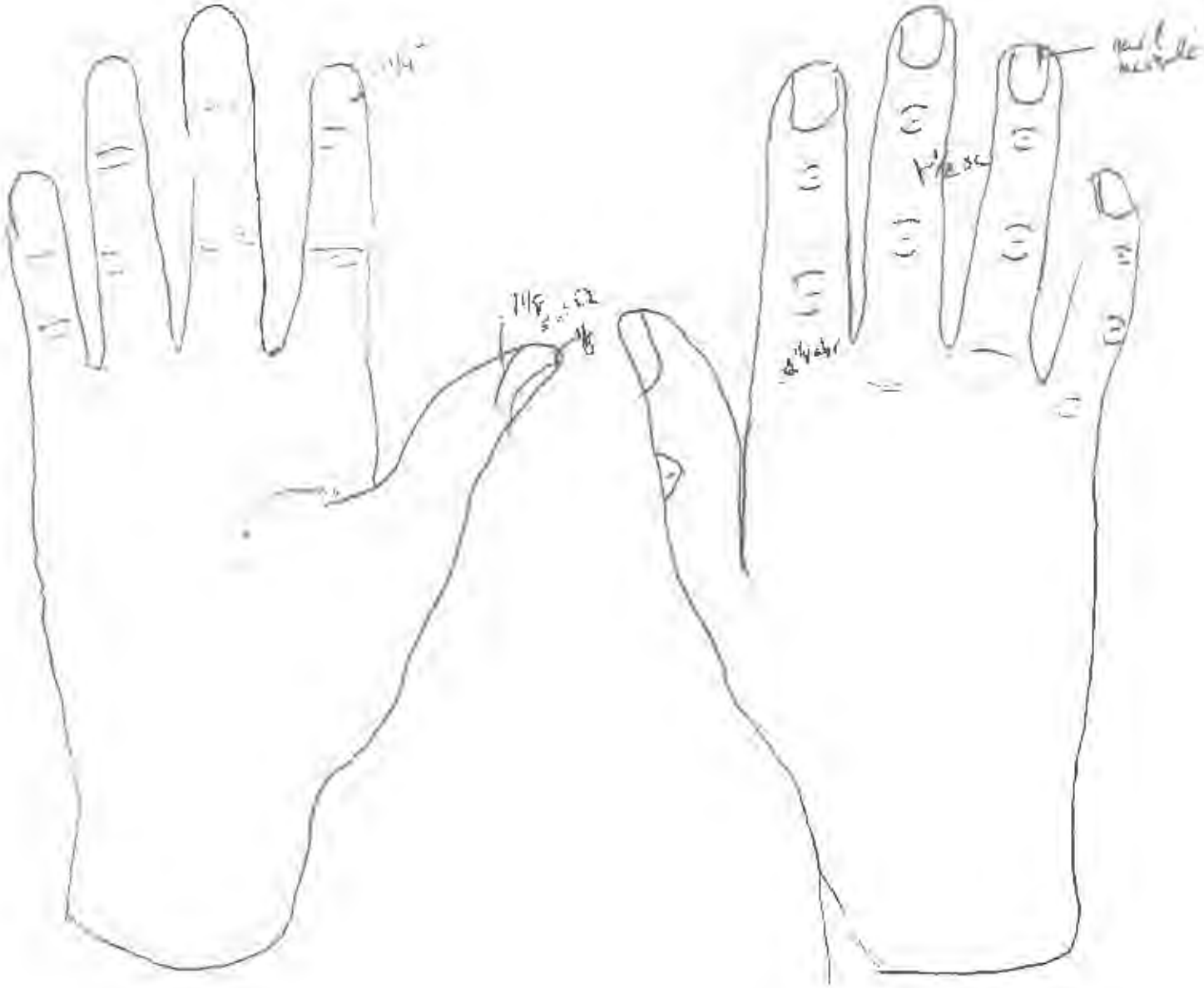
EXAMINED BY: DATE: 5-25-96

OFFICE OF CHIEF MEDICAL EXAMINER
City of New York

ADDITIONAL AUTOPSY NOTES

NAME OF DECEASED: _____ M.E # ____ / ____ / _____

RIGHT HAND

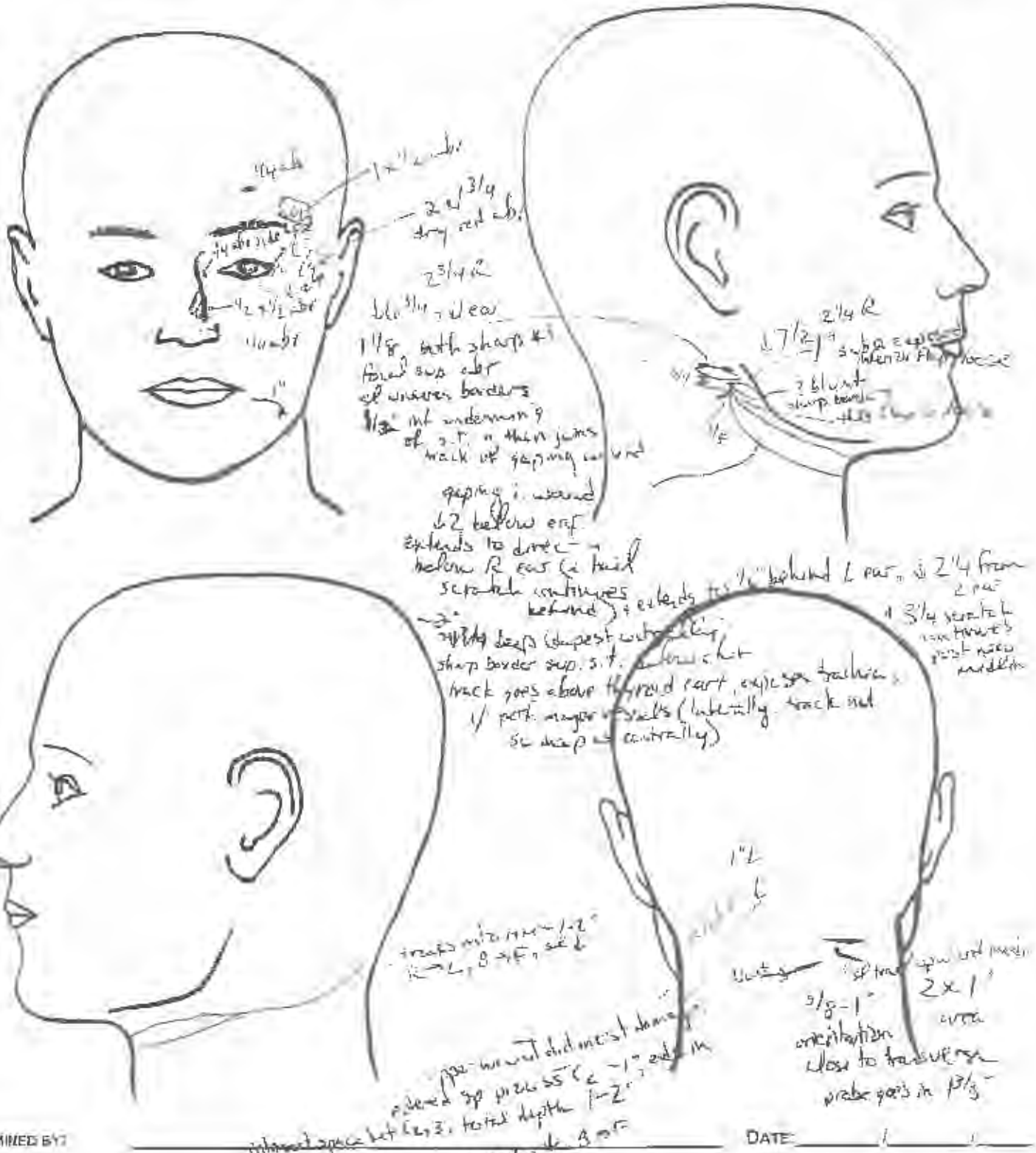


EXAMINED BY: _____ DATE: _____

OFFICE OF CHIEF MEDICAL EXAMINER
THE CITY OF NEW YORK

ADDITIONAL AUTOPSY NOTES

NAME OF DECEDENT: Howard Pilmer M.E.# M-196-1957



EXAMINED BY: _____ DATE: ____/____/____

Dx's

I. Stab wounds to neck, c
A. Penetration of s.t., MM, & spinous process of C_2 & TVs (cervical)

II. I. wound of neck, c
A. Penetration of s.t., MM & trachea
B. Asp of blood

III. Stab & incised wounds of ant & lateral chest (8), c
A. Penetration of LV, LA, L lung
B. Perf. of R lung, PA, aorta
C. Hemothorax (~15cc R & L cavities) & hemopericardium (~5cc)

IV. Stab wounds to back (12), c
A. Penetration of s.t., MM, lungs

V. I. wound of R forearm c
A. Penetration of s.t., MM

-- I. wounds of forearms & hands, c
A. Perf. of s.t., MM

VII I. wound & B.I. to face, c
A. Perf. of s.t.
B. Abr's

VIII B.I. to knees.
A. Abr's.

CASE WORKSHEET

M.E. CASE #: M96-1957

NAME OF DECEDENT	AGE	RACE	SEX	AUTOPSY
Howard Filmer	40	W	M	AUTOPSY (Exam) / NO AUTOPSY PURSUANT TO LAW

MEDICAL EXAMINER DR: Greenbaum

DATE: 3-23-96 TIME: 9:00 AM / PM

PART 1: DEATH WAS CAUSED BY:

a. Immediate cause: MURDER Stab and incised wounds to neck and chest with

b. ~~Due to or as a consequence of~~ penetrations of lungs, heart, ~~aorta~~, and trachea and perforations of lung and aorta.

c. Due to or as a consequence of

PART 2: Other significant conditions contributing to death but not resulting in the underlying cause given in part 1:

d.

MANNER OF DEATH:

☐ PENDING STUDIES ☐ NATURAL ☐ THERAPEUTIC COMPLICATION ☐ ACCIDENT ☐ SUICIDE ☒ HOMICIDE ☐ UNDETERMINED

PLACE OF DEATH: *(Name of hospital or facility or street address)*: 14 E 33rd st

IF HOSPITAL: Admission Date and Time: DOA Emergency Room Inpatient Outpatient

DATE AND HOUR OF DEATH: MONTH / DAY / YEAR: 3-22-96 TIME: 5ish AM / PM

INJURY: Date: Unk. Time: Unk AM / PM	AT WORK: ☒ YES ☐ NO	TYPE OF PLACE: *(Home, Street, etc.)*: Office

LOCATION: 14 E. 33rd St

HOW INJURY OCCURRED: Stabbed and Cut by other (s).

INFANT UNDER 1 YEAR: Name and address of hospital or other place of birth:

OPERATION: ☐ YES ☐ NO DATE:	PROCEDURE:
TYPE OF ANESTHESIA:	MAJOR FINDINGS:

PREGNANCY: *In last twelve months (Female under 54)* ☐ YES ☐ NO DATE OF OUTCOME:

Outcome: ☐ Live Birth ☐ Spontaneous Termination ☐ Induced Termination ☐ None

TRANSFER: If death in institution, was decedent transferred from another institution? ☐ YES ☐ NO

Specify name and address of transferring institution:

M96-1957 C

WORKSHEET

ME-2010 (REV. 7/94)

NAME OF DECEDENT: Howard [illegible] M.E. CASE #: M96-1957
MEDICAL EXAMINER: DR. Greenbaum DATE OF DEATH: 3-22
☒ HOMICIDE ☐ PRISONER ☐ OTHER RUSH TODAY'S DATE: 3-23 [illegible]

COMPONENTS OF MEDICOLEGAL CASE RECORD NEEDED	FOR CERTIFICATION	FOR FILE COMPLETION
TOXICOLOGY REPORT		X
HISTOLOGY SLIDES		
NEUROPATHOLOGY REPORT		
REPORTS(S): ☒ POLICE ☐ FIRE MARSHAL ☐ MLI		X
CULTURES: ☐ BLOOD ☐ TB ☐ OTHER:		
CONSULTANTS: ☐ ANTHRO ☒ RADIOLOGY ☐ OTHER: [illegible]		[illegible]
HOSPITAL OR MEDICAL RECORDS		
SCENE INVESTIGATION FOR SUSPECTED S.I.D.S.		
OTHER:		

AUTOPSY INVENTORY

NEUROPATH: ☐ YES ☒ NO X-RAYS: ☒ YES ☐ NO PHOTOS: ☒ YES ☐ NO

HISTOLOGY: STOCKBOTTLES: 1 2 3 4 BOTTLE(S) REQUESTING SLIDES: ☐ YES ☒ NO 1 2 3

MICROBIOLOGY: ☐ YES ☒ NO SPECIMEN SOURCE:

EVIDENCE: ☒ YES ☐ NO (CLOTHING) BALLISTICS TRACE OTHER:

FORENSIC BIOLOGY: (BLOOD) (HAIR: SCALP) PUBIC RAPE-KIT SWABS: ORAL ANAL VAGINAL (NAILS) OTHER:

TOXICOLOGY: (BLOOD) (BILE) URINE GASTRIC CONTENTS BRAIN LIVER (VITREOUS HUMOR) SUBDURAL BLOOD OTHER

INDICATED ☒ YES ☐ NO Pleural cavities

If death may be a suicide or the result of a motor vehicle accident or a fire indicate below.
If death may be due to chemical agents or if toxicology is needed to exclude other causes of death indicate below.

COMMENTS: 46 yo M/W c̄ multiple stab wounds
Orthodox Jewish objection so autopsy limited

DURATION OF MEDICAL THERAPY OR RESUSCITATION: —

M96-01957
C
INVENTORY

[signature]
SIGNATURE OF MEDICAL EXAMINER

Jordan
Excellent job on a difficult case
I made a couple of
notes. CH

OFFICE OF CHIEF MEDICAL EXAMINER
CITY OF NEW YORK

REPORT OF AUTOPSY

Name of Decedent: Howard Pilmar M.E. Case #: M96-1957

Autopsy Performed by: Dr. V. Jordan Greenbaum Date of Autopsy: March 23, 1996

FINAL DIAGNOSES

I. STAB WOUNDS TO NECK, WITH:

A. PENETRATIONS OF SOFT TISSUE, MUSCLES, SPINOUS PROCESS OF C2 AND CERVICAL INTERVERTEBRAL SPACE.

II. INCISED WOUND OF NECK, WITH:

A. PENETRATION OF SOFT TISSUE, and MUSCLE AND ~~TRACHEA~~. perforation of upper airway

B. ASPIRATION OF BLOOD.

III. STAB AND INCISED WOUNDS OF ANTERIOR AND LATERAL CHEST (EIGHT), WITH:

A. PENETRATIONS OF LEFT VENTRICLE, LEFT ATRIUM AND LEFT LUNG

B. PERFORATION OF RIGHT LUNG, PERICARDIAL SAC, RIGHT ATRIUM AND AORTA.

C. HEMOTHORAX (APPROXIMATELY 15 CC RIGHT AND 15 CC LEFT PLEURAL CAVITIES) AND HEMOPERICARDIUM (APPROXIMATELY 5 CC).

IV. STAB WOUNDS OF TO BACK (TWELVE), WITH:

A. PENETRATION OF SOFT TISSUE, MUSCLE AND LUNGS

V STAB WOUND OF RIGHT FOREARM, WITH:

A. PENETRATION OF SOFT TISSUE AND MUSCLE.

VI. INCISED WOUNDS OF FOREARMS AND HANDS, WITH:

A. PENETRATION OF SOFT TISSUE AND MUSCLE.

VII. INCISED WOUND AND BLUNT IMPACT TO FACE, WITH:

A. PENETRATION OF SOFT TISSUE.

B. ABRASIONS.

VIII. BLUNT IMPACT TO KNEES.

A. ABRASIONS.

CAUSE OF DEATH: STAB AND INCISED WOUNDS TO NECK AND CHEST WITH PENETRATIONS OF LUNGS, HEART AND TRACHEA, AND PERFORATIONS OF LUNG AND AORTA.

MANNER OF DEATH: HOMICIDE (STABBED AND CUT BY OTHER(S)).

OFFICE OF CHIEF MEDICAL EXAMINER

CITY OF NEW YORK

REPORT OF AUTOPSY

CASE NO. M96-1957

I hereby certify that I, V. Jordan Greenbaum, M.D., City Medical Examiner-I, have performed an autopsy on the body of Howard Filmar, on the 23rd day of March, 1996, commencing at 9:00 AM, in the Manhattan Mortuary of the Office of Chief Medical Examiner of the City of New York. This autopsy was performed in the presence of Drs. Flomenbaum and Seijo.

EXTERNAL EXAMINATION:

The body is of a well developed, well nourished, 5'10", 175 lb, light brown-skinned male whose appearance is consistent with the given age of 40 years.

The thick brown scalp hair measures 2-1/2". There is no moustache or beard. The eyes have brown irides and clear conjunctivae without petechiae, confluent hemorrhage or jaundice. The oral cavity contains natural teeth and has an atraumatic mucosa.

The chest has a normal anteroposterior diameter and the abdomen is soft. The genitalia are of a normal adult circumcised male. There are no scars overlying the course of subcutaneous veins on any of the extremities and none on the flexor aspect of the wrists.

POST-MORTEM CHANGES:

Rigor mortis is symmetric in the arms and legs; the body is cold.

THERAPEUTIC PROCEDURES:

None.

CLOTHING:

The body is clad in the following: a pair of markedly blood-stained blue trousers with a black leather belt in the loops; a pair of white briefs which are blood-stained on the anterior aspect; a pair of blue socks; a pair of black loafers; a markedly blood-stained white dress shirt; a blood-stained tie and a blood-stained blue suit jacket of the same material as the trousers. The dress shirt has incised defects of the torso and sleeves which reproduce those described below in

location and size. The suit jacket has many incised defects which outnumber those found on the body. There are defects clustered on the posterior aspect near the bottom, on the right and left and at the superior aspect of the back, right of midline. There are additional defects over the right shoulder, near the bottom of the right sleeve, in the left sleeve, mid level and on the front ~~of the skirt~~. The left front of the jacket has four irregular defects and the right front has one vertical defect. The lining of the jacket is extensively torn and incised in a vertical orientation on the anterior and posterior aspects. The clothing is photographed, dried and submitted to Evidence.

Knife and Hammer Examined in Evidence (5th) are the following: a single-edged knife with a 7 3/4 x 7/8 x 1/16" blade, a plastic handle and no associated sheath; a hammer with a 1 1/2" round rubber end containing multiple nails and irregularities and a slightly longer steel opposite end

INJURIES, INTERNAL AND EXTERNAL:

Excellent eyewitness statement.

There are five stab and one large incised wound of the neck; six (right) stab and incised wounds of the anterior and lateral aspects of the torso; and 12 stab wounds of the back. Multiple blunt impact injuries and a single incised wound are on the face and additional blunt impact injuries are on the anterior aspects of the knees. The hands have multiple linear and irregular incised wounds and the forearms have two incised and one stab wounds. These injuries are listed (lettered) for descriptive purposes only; no sequence is implied.

A. (Two) STAB WOUNDS TO RIGHT LATERAL ASPECT OF NECK:

A stab wound is located 6-3/4" below the top of the head, 2-3/4" right of midline and

1" below the right ear. With the edges reapproximated, the wound measures 1-1/8" in length on the skin surface and 1/16" in width. The wound is nearly transversely oriented and both angles are sharp. The margins are slightly uneven and there are focal abrasions on the superior aspect.

After perforating the skin, the wound track continues downward through the soft tissue, before joining the wound track of the large incised wound described below.

A second stab wound is located 7-1/2" below the top of the head, 2-1/4" right of midline and slightly anterior and inferior to the wound described above. Reapproximating the edges yields a slightly obliquely oriented 1" skin defect with a sharp angle directed toward the occiput and a ~~possibly blunt edge~~ angle directed toward the chin. A 1/4" extension at the posterior aspect extends downward to join the incised wound described below.

After perforating the skin, the wound track continues downward through the subcutaneous tissue to join the wound track of the incised defect.

B. INCISED WOUND OF NECK:

A gaping incised wound of the neck extends from 2" below the right ear, across the right lateral, anterior and left lateral aspects of the neck to 1/2" behind the left ear, at a level 2-1/4" below the left ear. On the right border a 3/4" scratch continues behind the right

ear and a 1/4" tail extends downward (this tail may represent an extension from the second stab wound described above). At the left lateral aspect of the wound, there is a 3-1/4" scratch continuing beyond the border of the incised wound to curve upward along the posterior aspect of the neck, nearing the scalp and terminating 1" left of midline.

The incised wound reaches its maximum depth of approximately 2" in the central, anterior aspect of the neck where the wound track extends ~~above the thyroid cartilage,~~ through the thyrohyoid ~~muscle and anterior wall of the trachea~~. Laterally, the wound track is more superficial and does not transect any ~~other~~ major vessels, or the sternocleidomastoid muscles.

There is a moderate amount of associated soft tissue hemorrhage. Sectioning of the lungs reveals patchy regions of aspirated blood, consisting of small scattered parenchymal hemorrhages most prominent in the right middle and lower lobes.

C. THREE STAB WOUNDS TO POSTERIOR NECK:

In a 2 x 1" area of the upper posterior neck, right of midline are three transverse to slightly oblique stab wounds which range from 5/8 to 1" in length when the edges are reapproximated. The medial wound has one blunt angle directed medially; the remaining two wounds have only sharp angles. One wound has a 1/4" slightly angulated tail directed superiorly.

The superior wound track extends into the spinous process of C2 approximately 1" before ending in the intervertebral space between C2 and C3. The track extends from right to left, back to front and downward to a total depth of 1 to 2".

The remaining two wound tracks extend through soft tissue into muscle only, to a depth of 1 to 2". The medial wound follows a right to left, back to front and slightly downward direction.

D. STAB WOUND TO LEFT UPPER TORSO:

A stab wound is centered 16" below the top of the head and 6" left of midline, below the left axilla. With the edges reapproximated the wound is transversely oriented and 2" in length with a blunt angle directed medially.

After perforating the skin and muscle of the chest wall, the wound track continues through the fourth intercostal space, enters the left pleural cavity, and penetrates the upper lobe of the left lung.

The direction of the penetration is left to right, back to front without vertical deviation. The estimated depth of penetration is 2-1/4 to 4".

There is approximately 15 cc of clotted blood in the left pleural cavity.

E. STAB WOUND TO LOWER LEFT TORSO:

A stab wound is centered 20-1/2" below the top of the head, 6" left of midline and 2-1/2" anterior to the mid coronal plane. With the edges reapproximated, the skin defect is nearly transversely oriented and measures 2-1/2" in length, with two sharp angles. There is a 3" tail extending posteriorly which varies from a superficial scratch to a defect exposing subcutaneous fat.

After perforating the skin and muscle of the chest wall, the wound track continues through the seventh left intercostal space, perforates the base of the pericardial sac and penetrates approximately 1/8" into the posterior wall of the left ventricle, without entering the chamber.

The direction of the penetration is left to right, back to front and upward. The estimated depth of penetration is 1 to 2".

There is approximately 5 cc of clotted blood in the pericardial sac.

F. INCISED WOUND OF LEFT CHEST:

An incised wound is centered 20-1/2" below the top of the head and extends across the left anterior and lateral aspects of the chest. The medial border is 3/4" left of midline.

With the edges reapproximated, the wound is transversely oriented and 8-1/2" in length with penetration of approximately 1/2". The wound track exposes subcutaneous fat and muscle without extending through the wall into the left pleural cavity.

G. SMALL INCISED WOUND OF LEFT CHEST:

Immediately below the medial aspect of the incised wound described above is a 1/2" obliquely oriented incised wound which penetrates to a depth of 1/4". One sharp angle of the wound is directed toward the left axilla and the opposite sharp angle is directed toward the right hand.

H. INCISED WOUND TO ANTERIOR CHEST AT MIDLINE:

Centered 17" below the top of the head, between the nipples in the midline is a triangular, swallow-tailed, slice-like incised wound which has edges measuring 1" and 3/4" when the margins are reapproximated. The superior borders are sharp and there are focal abrasions of the lower borders measuring up to 1/8"

The wound track penetrates approximately 1/4" to the underlying muscle with 1-1/2" of tissue undermining superiorly.

The direction of the wound track is upward.

A linear 1-3/4" scratch is obliquely oriented and inferior to the triangular wound, right of midline.

I. STAB WOUND ADJACENT TO RIGHT NIPPLE:

Centered 18" below the top of the head, 3-1/2" right of midline, immediately medial to the right nipple is a slightly oblique stab wound which has two sharp angles. Reapproximation of the edges yields a wound measuring 2-1/16" in length.

After perforating the skin and underlying subcutaneous tissue, the wound track continues through the muscle of the right fourth intercostal space, enters the right pleural cavity, perforates the lower lobe of the right lung, the pericardial sac, the right atrium, the aorta and penetrates the left atrium. There is approximately 15 cc of clotted blood in the right pleural cavity.

The direction of the penetration is right to left, upward and front to back. The estimated depth of penetration is 4 to 6-1/2".

J. INCISED WOUND OF RIGHT LOWER CHEST:

Centered 20-1/4" below the top of the head on the lower aspect of the chest, right at midline is an obliquely oriented incised wound which measures 2-3/8" in length when the

edges are reapproximated. The angles are sharp and are directed toward the left hip and right axilla. There is focal abrasion of the inferior border. The lateral aspect gives rise to a linear, slightly superiorly directed 5" tail which scratches the skin.

The wound track extends into the soft tissue and muscle of the chest and it leaves an impression on the cartilage of the sternum. The estimated depth of penetration is approximately 1/2". The wound does not enter the pleural cavity.

K. COMPLEX WOUND OF UPPER BACK:

A complex stab wound is located in the upper ~~back~~ region near the midline. The total area measures 5-1/2". The inferior 1-1/4" consists of a slightly oblique stab wound centered 15" below the top of the head and 1" right of midline. The inferior edge is blunt and directed towards the medial aspect of the left buttock. At the superior border there is a slight change in angle with a near vertical orientation as the wound continues superiorly. The superior aspect is a shallow abrasion with a obliquely directed superior scratch. An abrasion is on the right border.

The inferior aspect has an associated wound track which extends downward and back to front while the superior aspect extends right to left and downward, toward the left scapula. ~~This~~ The wound track extends parallel to the rib cage and does not enter a pleural cavity. While the depth of penetration is approximately 1/2", the length of the wound

track is at least 6" in the lateral plane.

I. FIVE STAB WOUNDS OF LEFT BACK:

In a 4 x 3" region of the left aspect of the back, at the level of, and inferior to, the left scapula, and extending to the midline, are five clustered stab wounds which are vertically and slightly obliquely oriented. The angled wounds are generally directed from the left shoulder to the right hip. With reapproximation of the edges the wound lengths range from 5/8 to 1-1/4". Two of the wounds are in the midline and run in a parallel direction at approximately 30 to 40 degrees from the vertical. The superior of these two wounds has a blunt angle at its right inferior aspect. The four remaining wounds have two sharp angles. The wound located furthest from the midline has a 1/16" abrasion on the lateral aspect.

The five wounds enter the left pleural cavity. Two of the wound tracks enter the posterior aspect of the left lower lobe to a maximum depth of 1".

The direction of the penetrations is generally back to front without vertical or transverse deviation. The maximum depth of penetration is 1-1/2 to 3".

J. SIX STAB WOUNDS OF RIGHT BACK:

In a 4-1/2 x 3-1/4" area of the mid back, right of midline are six stab wounds which are generally slightly obliquely oriented, with the greatest angle of orientation being approximately 30 degrees from the vertical. The wounds range from 1/2 to 1-3/16" in length and 1/16" in width. A few have blunt angles which are all directed inferiorly.

The wound tracks range from soft tissue penetration of approximately 1/4" to perforation of the chest wall and penetration of the right lung. Three of the wounds enter the right pleural cavity and two enter the posterior aspect of the right lower lobe ~~to a maximum of 1-1/2" into the lung parenchyma.~~

The general direction of the wound tracks is back to front without vertical or transverse deviation. The maximum ~~track~~ depth (penetration) is 2 to 3-1/2".

K. STAB WOUND TO RIGHT FOREARM:

On the flexor aspect of the distal right forearm is a nearly transverse 1/2" stab wound with a lateral blunt edge (angle) and medial sharp angle.

The wound track continues through the skin, subcutaneous fat and into the underlying muscle without perforating tendons or major blood vessels. There is minor soft tissue hemorrhage.

The direction of the wound track is front to back, slightly to the left in transverse deviation. The estimated depth of penetration is 3/4".

L. INCISED WOUNDS OF FOREARMS:

On the extensor aspect of the right forearm, there is an obliquely oriented 1/2" scratch and on the extensor aspect of the left forearm, below the elbow is a transversely oriented 1" scratch.

M. INCISED WOUND OF LEFT HAND:

On the extensor aspect of the second middle phalanx (index finger) is an obliquely oriented 5/8" scratch. A 1" curvilinear incised wound extends into the nail of the flexor aspect of the distal phalanx. It penetrates to a depth of 1/4". Immediately proximal to this is a 1/4" triangular incision. At the base of the index finger, on the flexor aspect is a 1-3/8" incised wound which extends 1/4" into the underlying tissue with exposure of uninjured tendon. A 3/4" scratch is on the flexor aspect of the second proximal phalanx. On the flexor aspect of the second middle phalanx is a V-shaped incised wound with 1/4 and 1/2" branches. The wound exposes the underlying dermis. On the flexor aspect of the third proximal phalanx is a curvilinear 7/8 x 1/8" incised wound exposing subcutaneous tissue. Proximal to this is a 1/4" linear scratch exposing the underlying dermis. On the flexor aspect of the third middle phalanx is a 3/4 x 1/4" triangular incised wound exposing subcutaneous tissue. On the flexor aspect of the distal third phalanx is a V-shaped incised wound with branches measuring 1/4 and 3/8". Adjacent to this is a linear 1/2" incised wound with parallel tiny faint scratches of the

surrounding skin. On the flexor aspect of the fourth finger, over the proximal middle phalanges is a irregular, V-shaped incised wound with branches measuring 3/4 and 1/2". There is exposure of ~~underlying~~ subcutaneous tissue down to the fascia overlying the tendon. The depth of penetration is approximately 1/4". There is undermining of the proximal tissue.

N. **INCISED WOUNDS OF RIGHT HAND:**

A 1/4" incised wound is on the distal aspect of the fourth fingernail. On the extensor aspect of the third middle phalanx is a linear 1/2" scratch and at the base of the second (index) finger on the dorsum of the hand is a 1/4" abrasion. A 1-1/8" incised wound extends over the flexor aspect of the proximal and distal phalanges of the thumb, with exposed subcutaneous tissue. The tip of the thumb has a 1/8" shallow incision. On the lateral aspect of the second distal phalanx is a 1/4" incised wound.

Both hands are covered by brown paper bags which are secured with yellow evidence tape.

O. **INCISED WOUND OF FACE:**

A curvilinear 1" incised wound is located left of the mouth. It has a notched lateral border and extends approximately 1/4" into the underlying tissue.

P. BLUNT IMPACT TO FACE:

On the left aspect of the forehead is a 1/4" abrasion. Above and slightly lateral to the left eyebrow is a 1 x 1/2" dry red abrasion and lateral to the left eye, with involvement of the skin immediately adjacent to the eye, is a 2 x 1-3/4" geographic red-brown abrasion. The 1/4" abrasion is on the left side of the nose near the left eye and over the bridge of the nose is a 1/2 x 1/2" dry red-brown abrasion. At the tip of the nose is a 1/4" abrasion. There is no palpable fracture of the nose.

There are no subscalpular or subgaleal hemorrhages, no skull fractures, no epidural, subdural or subarachnoid hemorrhages. The external surface of the brain is free of trauma.

Q. BLUNT IMPACT TO KNEES:

Three round and irregular dry red abrasions are over the anterior aspect of the right knee and these range from 3/4" to 1-1/4" in greatest dimension. There are no palpable underlying fractures. Over the anterior aspect of the left knee is a circular 1/2" dry slightly depressed abrasion and medial to this is an irregular 1/2" abrasion. Slightly above the left knee is a 1/2" abrasion. There are no palpable underlying fractures.

These injuries, having been described, will not be repeated.

INTERNAL EXAMINATION:

Because of religious objections, the internal examination of organs is limited to in situ examination, palpation and limited incisions.

HEAD: The dura mater is pink-tan, thin and uniform without brown discoloration. The brain has a normal external appearance with symmetric cerebral hemispheres and unremarkable sulci and gyri. The leptomeninges are thin and glistening.

NECK: The thyroid and cricoid cartilages are intact. The soft tissues of the neck are described above.

BODY CAVITIES: The pleural and pericardial fluid accumulations are described above. The peritoneal cavity is free of fluid. The organs are in their normal situs without fibrous adhesions.

CARDIOVASCULAR SYSTEM: The heart is normal size without chamber dilatation or ventricular hypertrophy. The coronary arteries are free of atherosclerosis. The epicardium is smooth and glistening. The myocardium is red-brown.

RESPIRATORY SYSTEM: The lungs are of normal size and configuration with aerated pink parenchyma and minimal anthracosis. There are no areas of consolidation. The pleural surfaces

are smooth and glistening.

LIVER, GALLBLADDER, PANCREAS: The liver is normal size, with a smooth, intact capsule and homogeneous brown smooth parenchyma. The gallbladder contains less than 10 cc of bile without gallstones. The pancreas is normal size, color and texture without focal lesions.

HEMIC AND LYMPHATIC SYSTEMS: The spleen is of normal size and has a smooth, intact capsule and soft red parenchyma with conspicuous white pulp. The lymph nodes are not enlarged and the thymus is not identified.

GENITOURINARY SYSTEM: Each kidney is normal size, with a smooth subcapsular surface and pale red-brown parenchyma with a slightly blurred corticomedullary junction. The ureters are normal caliber. The bladder is empty.

The testes are unremarkable.

ENDOCRINE SYSTEM: The adrenals are normal size, color and consistency. The thyroid is not dissected.

DIGESTIVE SYSTEM: The stomach contains approximately 30 cc of dark brown partially digested food with identifiable vegetable fragments and soft tan material (? potato). No pills or capsules are identified. The gastric mucosa is intact and unremarkable. The small and large

intestines are normal caliber in color without obstruction. The appendix is present.

MUSCULOSKELETAL SYSTEM: The muscles are well developed and unremarkable. No bony abnormalities are noted.

V. Jordan Greenbaum, M.D.

City Medical Examiner - I

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