2016 IL App (2d) 130894U
No. 2-13-0894
Order filed March 28, 2016

IN THE

APPELLATE COURT OF ILLINOIS

SECOND DISTRICT

THE PEOPLE OF THE STATE OF ILLINOIS,	)	Appeal from the Circuit Court of Du Page County.
Plaintiff-Appellant,	)	
v.	)	No. 02-CF-654
RANDY LIEBICH,	)	Honorable John J. Kinsella,
Defendant-Appellee.	)	Judge, Presiding.

JUSTICE HUDSON delivered the judgment of the court.
Justices McLaren and Spence concurred in the judgment.

ORDER

¶ 1 *Held*: The trial court erred in dismissing defendant's postconviction claims of ineffective assistance of counsel concerning the handling of medical evidence and related evidence from fact witnesses; trial court did not err in dismissing actual-innocence claim, ineffective assistance claims pertaining to failing to file a motion to suppress, to seek a plea agreement, and appellate counsel's performance; trial court did not err in rejecting, after an evidentiary hearing, defendant's claim that counsel prevented him from testifying; State did not violate defendant's right to due process by prosecuting him while possessing alleged evidence of his innocence, as evidence was conflicting; and appellate court would not direct trial court to assign case to new judge.

¶ 2 I. INTRODUCTION

¶ 3 Following a bench trial, defendant,[1] Randy Liebich, was convicted of first-degree murder (see 720 ILCS 5/9--1 (West 2002)) and sentenced to 65 years' imprisonment. He was convicted of killing Steven Quinn, who was two years old at the time. He previously appealed this conviction, and we affirmed. See *People v. Liebich*, No. 2-04-1238, slip op. (December 12, 2007) (unpublished order under Illinois Supreme Court Rule 23 (eff. July 1, 1994)).

¶ 4 Defendant filed a postconviction petition (see 725 ILCS 5/122-1 *et seq.* (West 2012)) raising a number of issues. First, he argued that newly discovered evidence established his innocence. Second, he asserted the trial counsel was ineffective for a number of reasons (failure to: (1) elicit exculpatory testimony; (2) allow him to testify; (3) present exculpatory evidence; (4) file a motion to suppress; and (5) communicate plea offers to defendant). Third, he alleged appellate counsel was ineffective for failing to raise any issues that we determined were waived in that they could have been raised following defendant's direct appeal. Fourth, he claimed a due process violation where the State prosecuted him despite being in possession of evidence

[1] Though technically not the defendant in this collateral proceeding, we will refer to Mr. Liebich as "defendant," the same term we used in his first appeal, to facilitate reference to our earlier disposition, to which the reader is directed if he or she desires a detailed discussion of the evidence presented in defendant's original trial. To facilitate an understanding of what follows, Munoz was the neurosurgeon who operated upon Steven. Boykin, Green, and Severin were also treating physicians. Mileusnic was the medical examiner who performed an autopsy on Steven, testified for the State in defendant's trial, and now has submitted an affidavit supporting defendant's postconviction petition. Teas testified on defendant's behalf in his trial, and she has also submitted an affidavit in this case. The remainder of the doctors were not involved in this matter prior to submitting an affidavit here.

showing he could not have committed the offense. Fifth, he alleged that the cumulative effect of these errors was to deprive him of a fair trial. All claims were dismissed at the second stage of postconviction proceedings except one: whether his attorneys were ineffective for not advising him he had a right to testify. After an evidentiary hearing, the trial court denied this claim on its merits. He now appeals from those rulings, and, for the reasons that follow, we affirm in part, reverse in part, and remand.

¶ 5 II. BACKGROUND

¶ 6 The evidence presented at trial was set forth in great detail during defendant's first appeal (see *People v. Liebich*, No. 2-04-1238, slip op. (December 12, 2007)), and we will not restate it here. Defendant has proffered a significant amount of additional material in support of his petition. We summarize that material here. According to defendant, this material constitutes newly discovered evidence that "demonstrated that Steven's head trauma was a secondary result of an abdominal injury sustained days before Steven's death." This would mean that the injury occurred at a time defendant could not have inflicted it. He explains, the "abdominal injury led to peritonitis (inflammation of tissue lining the abdomen), which led to pancreatitis (pancreatic inflammation), which led to a lack of oxygen in Steven's brain, which ultimately caused brain swelling, bleeding, and death."

¶ 7 Defendant submitted nine affidavits from medical experts and a number of affidavits from fact witnesses in support of his petition. These included one from Dr. Shaku Teas, who testified for defendant in his trial, and Dr. Darinka Mileusnic-Polchan, who testified for the State during defendant's trial. Before turning to the medical experts, we will summarize defendant's own affidavit.

¶ 8 Initially, defendant denies harming Steven. He states that the only unusual event that occurred on February 8, 2002 (the day Steven was taken to the hospital for the injuries at issue here), was that Steven choked on a hotdog and bit defendant's finger as defendant attempted to determine if his airway was clear. A few hours later, he and Kenyatta Brown (defendant's fiancée and Steven's mother) took Steven to the hospital, as he was "breathing oddly."

¶ 9 Defendant further avers that he wished to testify but his "attorney refused to put [him] on the stand." He states that "there were a lot of errors in the testimony that were not corrected, and a lot of evidence that didn't get into the trial, including medical evidence that Steven was sick before February 8." Defendant stated his attorney believed he could "get in some of this evidence" through other witnesses, but was ultimately unsuccessful in doing so.

¶ 10 He and Kenyatta had a relationship for about two years. Kenyatta ran away from home when she was 15 because her stepfather beat her. Defendant did not like how Kenyatta treated Steven. He states, "She often hit him, sometimes cuffing him on the head, hitting him with broken plastic hangers, pushing or throwing him, or poking him in the head or stomach with her fingers." He also describes an incident of violence perpetrated by Kenyatta against his mother. He denies he ever hit Steven for any reason.

¶ 11 The week prior to his hospitalization and death, Steven was quieter than usual. Defendant believed it was because they had brought a new baby home and Steven was jealous. He noted that Steven "whined and cried more than usual that week, often for no reason." He was moving slower than usual, and he would not eat unless Kenyatta "almost made him." On February 6, 2002, they visited defendant's cousin Frank. At the end of the visit, Kenyatta shook or hit Steven because he was crying or whining. Steven refused to eat his dinner on February 7.

¶ 12 On the morning of February 8, Kenyatta went to work at about 10 a.m. Kenyatta put some cereal in a bowl for Steven, but he did not want to eat. Defendant encouraged him to eat, and Steven ate the cereal but left the milk. Defendant described the choking incident:

> "Around 3 p.m., I fixed Steven a hot dog. I cut it up for him and put it on a plate with ketchup. I had to coax him to eat. He drank some orange juice and ate a little of the hot dog, but then wanted more to drink. I gave him water but he started choking. When I put my finger in his mouth to see if he had some hot dog caught in his throat, he bit down on my finger. I told him to let go. When he didn't let go, I slapped him on the cheek to get him to let go. I did not hit him hard, just light slaps. I also patted him on the back to dislodge any food that might be stuck."

He added:

> "When Steven let go of my finger, there was a little bite mark on my finger and some vomit in Steven's mouth. I cleaned him up and he seemed a bit dazed but more or less okay, so we watched a bit of Jurassic Park and he went to sleep."

Kenyatta returned from work at about 4 p.m., and they took Steven to the hospital. Defendant's affidavit goes on to detail his version of what took place after they arrived at the hospital, during his interrogation by the police, and during, at, and after trial. We will set forth any additional material as needed in our discussion of the issues defendant raises.

¶ 13 Turning to the medical experts, defendant submitted the affidavit of Dr. Patrick Barnes. Barnes is a pediatric neurologist and is board certified in diagnostic radiology and neuroradiology. He is a professor of radiology at Stanford and is the chief of pediatric neuroradiology at the children's hospital at Stanford. Barnes reviewed Steven's medical records, including various imaging scans, as well as trial transcripts and police reports.

¶ 14 He opined that a CT scan taken shortly after Steven's admission to Mount Sinai hospital showed "the beginning of a hypoxic-ischemic brain"—that is, a brain lacking oxygen. No "fractures, soft tissue swelling or other abnormalities suggest head trauma." He continued, "The CT Findings are likely secondary to abdominal injury/infection, possibly aggravated by choking." He reviewed the written reports regarding the CT scan generated at Mount Sinai. He opined that the reports "do not describe a subdural hemorrhage of significant size." The hemorrhages do not cause "a mass effect or midline shift." Barnes noted sinusitis ("bilateral maxillary sinus and ethmoid air cell opacities"). Barnes stated that it was not possible to ascertain from the CT scan what caused Steven's brain to swell (cerebral edema) or when it began.

¶ 15 Barnes further explained that, "*[s]ince 2000*, the pediatric literature has identified many causes for medical findings previously viewed as diagnostic of non-accidental trauma." (Emphasis added.) He added, "The differential diagnosis for subdural hemorrhage and other findings previously attributed to shaken baby syndrome or inflicted trauma *in a 2002 article* by leading forensic pediatricians includes trauma (accidental or non-accidental); medical or surgical interventions; metabolic, genetic, oncologic or infectious diseases; congenital malformations; autoimmune disorders; clotting disorders; and other miscellaneous conditions." (Emphasis added.) According to Barnes, a "2006 text" contained "a more complete discussion of alternative diagnoses," and he mentioned an article he authored in 2007. He also relied on a 2001 neuropathological study, as well as more recent studies. He opined, "In this case, the high densities along the dural venous sinuses seen on CT suggest thrombosis of the major sinuses, which would explain the CT findings." The presence of the abdominal infection complicated this case, as abdominal injuries are hard to diagnose and may progress slowly. He stated that it

was now (the affidavit was executed in 2012) "well understood" that the classic triad of finding formerly used to diagnose abuse could be caused by many other things.

¶ 16 Barnes opined that Steven's "pediatric records appear[ed] normal," except for some "possibly abnormal weight gain and a possible weight loss of nearly 5 pounds between" November 6, 2001, and February 8, 2002. He also noted indications of lethargy and "possible cold symptoms" on February 8. A blood draw at Mount Sinai confirmed pancreatitis. Medical records document "numerous lines and other marks" appearing after Steven arrived at the hospital. Some are described as "horizontal rope marks." Dr. Green (the attending emergency room doctor) did not initially observe signs of trauma. She testified, at the original trial, that ischemia can cause severe brain damage and bleeding. Dr. Boykin testified that it was unlikely a patient would die suddenly from a subdural hemorrhage, and she confirmed that severe abdominal injuries could cause "problems for the brain and other organs." According to Barnes, laboratory testing at Rush Hospital "confirmed pancreatitis and liver dysfunction." Surgery revealed no subdural hematoma. However, it did reveal "a severely swollen brain with a large amount of subarachnoid hemorrhage and a small thin subdural hematoma." A Cullen's sign[2] appeared on the morning after Steven's admission, which is an indication of pancreatitis. Medical records continually reference new lines and marks appearing during the hospitalization, which were "often characterized as bruises, whip marks or lash marks."

¶ 17 At the autopsy, Barnes stated, Dr. Mileusnic noted a perforated bowel, peritonitis, pancreatitis, and a liver injury. Steven's brain was severely damaged, and there were numerous contusion lines on his body. Mileusnic also noted deep bruising, inconsistent with normal

[2] A Cullen's sign is darkening around the umbilical area resulting from internal bleeding. See Steadman's Medical Dictionary, 1636 (27th ed. 2000).

corporal punishment. Mileusnic testified that "there can be a lucid interval following head trauma, with symptoms and deterioration occurring 24-48 hours after [an] injury." Steven had "early traumatic pancreatitis, which can occur from a natural disease process or from the breaking of the cell membranes from impact in the area of the pancreas." Mileusnic stated that "inconsolable crying, finicky eating, loss of appetite, lethargy and sleeping for a long period can be symptoms of abdominal or head trauma." However, she also testified that she found it unlikely that a child with injuries of this magnitude could eat breakfast without complaining.

¶ 18 Barnes noted that Dr. Shaku Teas testified that Steven's abdominal injury appeared to be a crush injury (caused by hitting, punching or pushing) from the back side. Teas explained that subdural hemorrhages are caused by tearing of the bridging veins, and she stated that a lucid interval can occur. Teas agreed that Steven had suffered a severe beating and that some of the marks on his body were consistent with a belt or clothes hanger. During closing argument, defense counsel asserted that Teas testified that it was not impossible that Steven's injuries occurred on February 8.

¶ 19 Barnes opined that defendant's conviction rests on a misinterpretation of the initial CT scan as showing a large subdural hemorrhage, "poor communication between the doctors, and a great deal of outdated medical literature, some of which was outdated by the time of trial and much of which has become outdated in the decade since Steven's death." Barnes explained that Steven's death occurred less than a year after research that reflected that brain swelling in infants indicates hypoxia and ischemia rather than traumatically torn axons. Barnes stated, "By the time of trial in 2004, several of the prosecution witnesses, including Dr. Mileusnic, Dr. Green and Dr. Boykin, were aware of this shift in the literature." He continued, since 2004, the child abuse

literature has increasingly recognized that there are many natural and accidental causes for these findings and that there can be lucid intervals of up to 72 hours."

¶ 20 Barnes opined that the CT scan did not suggest head trauma. He stated that there is no scientific basis for timing an injury based on the color of the blood observed or concluding that lucid intervals could not occur. He agreed with Munoz that the condition of Steven's brain was a recent development at the time Munoz observed it; however, he believed that it was "likely secondary to pre-existing abdominal injuries/infection rather than head trauma." No radiological evidence of trauma exists. Similarly, he agreed with Severin that Steven would not have been able to walk or eat once he developed pancreatitis and a hypoxic-ischemic brain, however, he believed that these conditions were caused by an earlier injury or infection. He acknowledged that he had not reviewed the autopsy or hospital photographs and could not comment on the marks and lines that appeared during Steven's hospitalization. However, he stated they "may reflect a secondary coagulopathy such as disseminated intravascular coagulation rather than trauma occurring shortly before admission." The choking incident described by defendant "was likely a symptom of the abdominal injury/infection and may have triggered an accelerated collapse."

¶ 21 Defendant also submitted an affidavit from Dr. Michael Laposata, a professor of pathology and medicine at the Vanderbilt School of Medicine. He averred that he had particular expertise in coagulation. Children with coagulopathies are sometimes misdiagnosed as being victims of abuse. Lab results indicated pancreatic damage, though they did not indicate its cause. Other test results indicated infection or inflammation. Moreover, lab tests indicated low amounts of acetaminophen and salicylate, "suggesting that he had been given pain medication." A decreasing platelet count indicated that platelets were being rapidly consumed and that Steven

had disseminated intravascular coagulation (DIC). Laposata opined that Steven's "illness likely began with an ischemic bowel." As the walls of the bowel deteriorated, "the contents leaked into the peritoneal cavity, affecting the surrounding organs, including the pancreas." As inflammation spread, the body responded by producing additional platelets, which would have been consumed in the process called DIC. He continued, "A child in DIC may bruise spontaneously or for minor trauma." According to Laposata, it is not possible to tell if a bruise was caused by trauma or a coagulopathy by visual inspection. DIC causes thrombosis, which can affect blood supply and cause ischemia. If it occurs in the arteries or veins servicing the brain, a hypoxic-ischemic brain results. He believed that, in Steven's case, an ischemic bowel progressed to peritonitis and pancreatitis and then on to the final stage of severe pancreatitis and a hypoxic-ischemic brain. Prior to the final stage, Steven "may have been only mildly symptomatic (lethargy, cold symptoms, refusal of food, *etc*.)." Laposata identified a number of possible nontraumatic causes for an ischemic bowel, a number of which might not be apparent during an autopsy. It could also result from trauma, which, according to Laposata, "is more likely when the child presents with a history of trauma, abrasions, patterned injuries or the like." If Steven's condition was the result of trauma, Laposata believed it would have occurred at least a day before his hospitalization. He "would not expect this entire process (ischemic bowel, peritonitis, pancreatitis, liver inflammation and DIC) to occur within approximately eight hours of hospitalization."

¶ 22 An affidavit from Mileusnic was also submitted by defendant. Mileusnic, formerly of the Cook County Medical Examiner's Officer, is an assistant professor in the department of pathology at the University of Tennessee Medical School. She performed the autopsy on Steven on February 12, 2002. In February 2012, Mileusnic reports, she reviewed the autopsy slides and

Steven's medical records, including the surgical report that indicated that the purported massive cerebral hemorrhage that was to be evacuated at Rush Hospital did not exist. She reviewed laboratory testing confirming pancreatitis shortly after Steven's admission to Mount Sinai, and autopsy slides that show that Steven's injuries preceded February 8.

¶ 23 According to Mileusnic, autopsy slides show that Steven had myocarditis, which is damage to his heart. This would have impaired blood circulation and made him vulnerable to trauma and infection. She characterized this as "a new finding that has not been previously addressed." The slides also showed "a healing hematoma outside the pancreas" that was between 10 and 21 days old. She did not believe this was addressed at defendant's original trial. She continued: "The slides, including the new stains, confirm that the remaining abdominal injuries occurred before February 8. Since myocarditis and the peripancreatic hematoma would have made the child susceptible to trauma or infection, these injuries would not require major trauma and are consistent with a push, shove or inappropriate punishment." She opined that the conditions for which Steven was taken to the hospital—pancreatitis and a hypoxic-ischemic brain—were the "natural progression" of earlier injuries. She believed the marks that appeared while Steven was hospitalized were the result of pancreatitis and DIC, with the exception of the bruising on his back, "which is likely associated with the earlier abdominal injuries."

¶ 24 During the autopsy, Mileusnic noted an older bruise to Steven's head, a subgaleal hemorrhage, a subdural hemorrhage along the spinal cord, a subdural hemorrhage on the left side, and a diffuse subarachnoid hemorrhage. His brain was severely swollen and "[t]he base of the brain was almost completely necrotic." She noted "many marks (lines and contusions)." Mileusnic opined that Steven's injuries occurred five days or more before the removal of life

support, which would place them between noon on February 6 and noon on February 7, at the latest.

¶ 25 Mileusnic averred that she spoke with Teas prior to trial and they agreed that their findings were consistent that Steven's injuries occurred at least five days before Steven's death. Mileusnic told Teas it was unlikely that they occurred three days before his death. Mileusnic states that in preparing for the original trial, she did not have an opportunity to review slides, photographs, or medical records before testifying, because she had to leave for a new job in Tennessee. Further, she avers:

> "When I returned to Illinois for the trial, the prosecutor urged me to place the injuries three days before death or to testify that this was possible. I made clear that this was very improbable given the stage of healing and made clear that my best estimate of timing was five days or slightly longer. The prosecutor understood my position and did not question me on the timing of the injuries."

Some photographs showed marks that had disappeared by the time of the autopsy, which "suggests that some of the marks may have been associated with DIC." She opined that it was "improbable that any of the injuries occurred on February 8." Rather, Steven's "collapse appeared to be the end result of a process that began days earlier."

¶ 26 A section of Mileusnic's affidavit is titled "New information." In it, she states that she received additional information in February 2012, including medical records and stained slides. She explained that her original opinion "was based largely on the investigative report" and the existence of a massive subdural hemorrhage. She did not learn this was incorrect until February 2012, when she found out that the purported massive hematoma was not found when Munoz opened Steven's skull. Furthermore, Mileusnic was "quite certain" that she had not seen

laboratory reports which, she says, confirmed Steven had pancreatitis on admission. Lab reports show Steven's platelet levels dropping rapidly, indicating his body was attempting to repair damage. Once the platelet supply is depleted, the body loses its ability to form clots and regulate bleedings, resulting in easy bruising and hemorrhages. This process is called DIC. Mileusnic opined that most of the marks on Steven's body resulted from DIC, with the exception of marks on Steven's back and side, which she believed were associated with older abdominal injuries.

¶ 27 Mileusnic conducted an extensive examination of the slides generated during Steven's autopsy. She stated that this was new information, and included slides "that had been stained with iron or Masson stains after trial." She stated that the presence of fresh blood does not establish the age of the injury. Mileusnic noted that in addition to a pancreatic injury that was at least 10 days old, there was also evidence of a traumatic event approximately 5 days before the removal of life support; however, nothing indicated a traumatic event occurring on the day of Steven's admission to Mount Sinai.

¶ 28 Mileusnic included her observations regarding 19 slides taken from Steven's brain. Her observations included the following. Several slides show a hypoxic-ischemic brain. She states that observed damage is "consistent with the 2/8 collapse and life support." She observed "hypoxia with red neurons, advanced edema and breakdown around the blood vessels" which was likely caused by poor oxygenation and circulation. She noted that "[n]o visible axonal spheroids [were present] that would suggest trauma." Further, "granular cells [had] died, which takes at least 3 days." Fresh thrombosis, that is, abnormal clotting, is consistent with DIC. Regarding a slide taken from the cortex, Mileusnic observed that it showed a "substantial hemorrhage." Given the presence of a certain proportion of macrophages and neutrophils (cells that assist in healing), Mileusnic opined that the injury was closer to five days old than to three

days old. She acknowledged that "this slide was initially a candidate for trauma," however she now believed it was not possible to determine if it represented a contusion (externally caused) or infarction (internally caused). Other slides showed a hypoxic-ischemic brain and DIC. Another showed a subdural hemorrhage with no neutrophils, some lymphocytes, many macrophages, some fibroblasts and beginning fibrin, indicating that it was five to seven days old. Yet another showed a "thrombosed superior sagittal sinus," with, *inter alia*, a "significant number of neutrophils" suggesting it was at least three days old; Mileusnic pointed out that the presence of fibrin indicated it could be older. In sum, Mileusnic opined, "[t]he slides show a hypoxic ischemic brain consistent with the 2/8 collapse, respirator brain and/or DIC, with no indicators of head trauma."

¶ 29 On slides taken from Steven's heart, Mileusnic noted myocarditis (damaged heart cells) that was at least a week old. She stated that she "would have no hesitation signing this out as a death from myocarditis if this were the child's only finding." Myocarditis can cause ischemia in other areas of the body, including the bowel. A slide taken from Steven's bowel indicated injuries that were about five days old, including considerable hemorrhaging but only limited ischemia. Slides taken from his pancreas shows some inflammatory cells, but most of the pancreas remained intact. There was no suggestion of trauma. However, a slide taken from the area where Steven's bowel had perforated showed "necrosis involving the entire wall." She opined that "[t]he oldest part of the damage appears to be approximately 5 days old." However, the "picture is clouded by myocarditis." It was not possible to tell from the slide whether the perforation was caused by infection, ischemia, or external force. Hemorrhaging around the diaphragm was consistent with a traumatic injury occurring five days prior to Steven's death. A slide from the dura showed a "thin intradural/subdural hemorrhage," occurring three days prior

to death, which "coincides with surgical intervention." Thrombosed vessels, likely occurring three days prior to death, indicated DIC but not trauma. Mileusnic explained that is was not possible to tell what damage to the bowel was caused by trauma and what by DIC "since the original findings are overrun and obscured by DIC." The adrenal gland showed thrombosis, suggesting DIC, but no hemorrhage, suggesting Steven was not septic. A slide from the testicle showed no hemorrhage or trauma.

¶ 30 Defendant presented an affidavit from Dr. Shaku Teas, who had testified for defendant during his trial. She is board certified in clinical, anatomic, and forensic pathology. In this affidavit, Teas explained that in defendant's case, she agreed with the Cook County Medical Examiner's Office (*i.e.*, Mileusnic) that Steven's death resulted from injuries occurring five days earlier and, since this was before the period during which defendant cared for Steven, she agreed to testify for the defense.

¶ 31 Teas initially notes that Steven was kept alive for 66 hours after being admitted to the hospital, though he was, "[f]or most of this period, *** brain dead and on life support." She acknowledges that "[t]hese factors complicate the assessment of the precise course of events that led to his death and the relationship between the various medical findings." Three types of injuries were identified during the autopsy: abdominal, head, and bruising. As injuries sometimes rebleed or expand, one must look to the oldest signs of healing to ascertain when the injury occurred. The presence of fresh blood does not mean that an injury is necessarily new, as rebleeding can occur. Her initial review of the slides taken at the autopsy led her to believe that Steven's injuries occurred five days before he was removed from life support on February 11, which would mean they occurred on February 6, two days before defendant was alleged to have inflicted them. Some injuries appear to be seven days old.

¶ 32 Teas obtained Mileusnic's notes, and found that they were in agreement. Teas also spoke with Mileusnic and confirmed this. Teas received a telephone call from the prosecutor, and she pointed out to him where Mileusnic had opined that Steven's injuries occurred five days before his death. Teas states, "At the time, it was my impression that [the prosecutor] had not been aware that the medical examiner had timed the injuries to a period before [defendant] cared for the child." She advised defendant's attorneys to "thoroughly understand how pathological timing is done" and told them to review the slides with Mileusnic. Teas explained, this would allow them to understand the basis for Mileusnic's opinion and "would also refresh [Mileusnic's] memory since she had left the Cook County Medical Examiner's Office and would not have access to the slides or other materials." She asked defendant's attorneys to subpoena Steven's medical records directly from the hospitals, since the copies she received were, in some cases, illegible. Teas also advised that the attorneys establish that Steven had been symptomatic in the days leading to his collapse (as evidenced by weight loss and acetaminophen in his system) because the court could not adequately assess these issues without this information.

¶ 33 Teas explained that the trial court misconstrued her opinion by stating that she believed that an injury could have occurred during the period defendant cared for Steven. She averred that this was not the case. Moreover, Teas took issue with defense counsel's closing argument where he stated that Teas was unsure whether she saw older injuries. She stated that it was not surprising that Munoz encountered fresh blood during surgery; however, she did not believe this was an acceptable way to date an injury. She also agreed that Steven would not have been able to eat, drink, or behave normally in the condition he was in at the time he was brought to the hospital. However, she asserted that this does not indicate when this process started. She also disputed the trial court's finding that the injuries to Steven's bowel, pancreas, and liver "represented a straight line of force."

¶ 34 Her affidavit, too, contains a section titled "New information." Teas first states that "[s]ince the court's verdict was contrary to [her] review of the slides, [she] immediately double checked [her] work." She states: "I first took photomicrographs of the slides to a professional conference and asked several other forensic pathologists to review the slides and date the injuries. All of the reviewing pathologists found that the key injuries were at least five days old, with some suggesting that they were even older."

¶ 35 Teas had some unstained slides that she had not tested before trial, as she and the State's pathologist (Mileusnic) agreed on timing. She ordered additional testing, specifically iron stains and Masson stains. Irons stains show the breakdown of red blood cells; Masson stains make collagen easier to see, which is significant because collagen indicates scarring has begun. These stains, which Teas paid for herself, confirm that Steven's injuries were at least five days old and some were older. Teas then identified several slides (including the bowel, liver, and pancreas) where iron and Masson staining confirms that the injuries occurred about five days prior to Steven's death.

¶ 36 Given that Steven was experiencing DIC—as confirmed by Laposata—he was subject to spontaneous bruising from trivial trauma, which would include medical intervention. Outside of the marks on Steven's back, Teas opined, the rest were attributable to DIC or pancreatitis. She explained, "The only marks that are concerning to me as an indicator of trauma are the bruises on the lower part of the child's back, which could represent a push or shove, resulting in a crush injury." DIC could also explain the small subdural hemorrhage and the subarachnoid hemorrhage. Teas opined, "Based on currently available information, it appears that the child had an ischemic bowel beginning at least five days before death, leading to peritonitis,

pancreatitis, a small perforation and DIC, with rapid deterioration shortly before presentation to the hospital."

¶ 37 Teas then set forth changes in the medical literature taking place after Steven's death in 2002 and the trial in 2004. At about the time of these events, it was "widely believed that swollen brains were caused by the traumatic tearing of axons (the nerve fibers that connect the cells of the brain) throughout the brain and that subdural hemorrhages were caused by the traumatic rupture of the bridging veins that connect the brain to the superior sagittal sinus (the large vein that drains the brain)." It was also believed that such tearing would require significant force. Teas explained that while the instant case is not a shaken-baby case, the experts that testified "relied heavily on the underpinnings of this theory." After the publication of an article suggesting violent shaking was the force that caused these phenomena, a number of papers critical of this hypothesis were published from 2001 to 2003. Teas averred that "[t]he current consensus is that there are numerous accidental and natural causes for the medical findings previously attributed to shaking or abuse, and that such findings may be secondary to other injuries or illnesses." Moreover, she continued, "There is also considerable consensus that children may have lucid intervals (periods of normality or relative normality) of up to 72 hours after a head injury that ultimately proves fatal."

¶ 38 She further explained that, in 2006, a paper titled "The Use of the Triad of Scant Subdural Hemorrhage, Brain Swelling, and Retinal Hemorrhage to Diagnose Non-Accidental Injury is not Scientifically Valid" was published in the Journal of the National Association of Medical Examiners. Research in 2009 and 2010 indicated that "small subdurals seen in allegedly abused children are too small to represent traumatic bridging vein rupture [] and that

retinal hemorrhages are related to brain swelling and life support, rather than the traumatic rupture of retinal veins."

¶ 39 Teas further noted that the trial court, in its ruling, found that there was no concept similar to a lucid interval when an abdominal injury is at issue. However, she stated, "This is a well-known phenomenon in children who hit the handlebars of bicycles or are impacted by a seatbelt and who present with abdominal injuries a day or more after the event." Leading textbooks on child abuse in 2006 and 2009 stated that abdominal injuries may progress slowly. Teas concluded her affidavit stating:

> "The microscopic slides, including the new stains, establish that the abdominal injuries were five days old or older, putting them outside the period that Mr. Liebich cared for the child. Based on newly available information, including the new literature, it is likely that the small intracranial hemorrhage, the hypoxic-ischemic brain and many of the marks and bruises identified at autopsy were secondary to hypoxia, septicemia, peritonitis (abdominal infection/inflammation) and DIC rather than trauma."

¶ 40 Defendant submitted an affidavit from Dr. George R. Nichols, who was the chief medical examiner for Kentucky for 20 years and is currently a professor of forensic pathology at the University of Louisville School of Medicine. He reviewed the medical examiner's report, including the autopsy; 61 autopsy slides; Steven's medical records; hospital and autopsy photographs; DCFS records; police reports; Teas' report; and the report of Dr. Elizabeth Gilles. He concluded that Steven "had [an] intra-abdominal blunt force injury that was present *at least* 5 days prior to death" (emphasis in original); that Steven had a hypoxic-ischemic brain and intracranial hemorrhages of undetermined significance, by history and radiologic examination,

with extensive operative trauma and resulting anatomic distortion; and that Steven had cutaneous traumatic injuries of differing ages. Regarding Steven's abdominal injuries, Nichols found:

> "There is acute inflammation in the pancreas associated with hemorrhage in the mesentery occurring at least five days before the removal of life support. The area of necrosis (dead tissue) in the small bowel occurred 5-7 days before removal of life support (slide 33). Other slides show healing responses of 5 days or longer. It is my opinion that the abdominal injuries were caused by blunt force trauma occurring at least 5-7 days before removal of life support."

He believed the condition of Steven's brain was "a delayed reaction to the abdominal injuries and have no independent significance given the extent of the surgery and the time on life support (respirator brain)." The marks on Steven's back are consistent with some sort of trauma, and the other marks on his body "appear consistent with normal childhood bruising, abdominal infection, hospital interventions and/or a secondary coagulopathy." His ultimate conclusion was that Steven "died from abdominal injuries inflicted at least five days before the removal of life support." He added, "Based on the histology, it is not possible that the injuries were inflicted three days before the removal of life support."

¶ 41 Defendant submitted the affidavit of Dr. Peter J. Stephens. Stephens is a board-certified forensic pathologist. He has over 30 years experience in clinical and forensic pathology. He was the acting Iowa State Medical Examiner in 1984 and 1985, and he served as Deputy Iowa State Medical Examiner form 1985 to 1995. Stephens states that, "In 1997[,] I was consulted in the index case of a series of misdiagnosed alleged 'Shaken Baby' cases in Iowa which were subsequently agreed by numerous other forensic pathologists to be due to non-abuse related causes." He reviewed, *inter alia*, the autopsy report, including slides, of the autopsy of Steven;

hospital records and photographs; Steven's pediatric records; pregnancy records of Steven's half sister; trial testimony; and police and DCFS records.

¶ 42 Stephens states that the "medical records confirm that Steven had a severe abdominal infection (peritonitis), leading to systemic inflammatory response (SIRS), sepsis, septic shock and multi-organ failure involving the pulmonary, gastrointestinal, cardiovascular and central nervous systems." Stephens continued, "He also had hypoxic-ischemic encephalopathy, probably secondary to the abdominal infection." In young children, abdominal infections are "generally associated with impact," either accidental or inflicted. Stephens opined:

> "Regardless of cause, the pathology establishes that the abdominal infection was present at least 7-10 days before death (4-7 days before collapse and hospital admission). It is not possible that it began as late as February 8, 2002. This infection progressed until the child's collapse on February 8 and continued after hospitalization."

Furthermore, "As determined at autopsy, the injuries to the brain were hypoxic-ischemic in nature *(i.e.,* due to lack of oxygen). This likely represented a natural progression of the abdominal infection." The choking incident with the hotdog—as described by defendant—could have triggered or aggravated the condition of Steven's brain. It "may have set off a chain of interacting hypoxic/ischemic events involving the abdomen and the brain."

¶ 43 Stephens did not see "significant signs of trauma in the hospital or autopsy photographs." He stated that "[m]any of the signs interpreted as trauma are well-known indicia of abdominal injuries or artifactual." He added:

> "The only significant marks are a series of marks down the child's spine that were small at the first hospital but that grew in size at the second hospital. These cannot be definitively identified as to causality but may have been caused by a fall, accidental or

> from a push, or other types of pressure. They may also represent hemorrhage from the pre-existing abdominal infection."

Furthermore, Steven's reluctance to eat and the incident reported by defendant where Steven choked on a hot dog are consistent with a pre-existing abdominal infection.

¶ 44 Steven's medical records indicate that he weighed 35.5 pounds on November 6, 2001, and 30.8 pounds when he was admitted to Mount Sinai on February 8, 2002. Stephens stated that loss of nearly five pounds indicated that Steven was "severely dehydrated and/or ill for some time prior to hospital admission" on February 8, 2002. Abdominal injuries may have no symptoms or nonspecific symptoms, such as lethargy and loss of appetite, "for a substantial period of time prior to diagnosis or collapse." Abdominal slides indicate an infection beginning no later than February 6, "and probably much earlier."

¶ 45 Stephens stated, "A 1980 report in the Journal of the American Medical Association found that half of the fatalities of children who choked on food were attributable to choking on hot dogs." Stephens stated that the choking incident may have "set off a spiral of hypoxic/ischemic damage to the brain and other organs." Steven's abdominal injuries were of the type that typically arises from trauma. Abdominal injuries may not be symptomatic initially. An abdominal injury might not be symptomatic until "the release of toxic substances into the abdominal cavity"; "pancreatitis may have non-specific symptoms for weeks or months." Stephens noted high glucose levels in Steven's blood, indicating that it was likely he was in hyperglycemic shock.

¶ 46 Based on his review of the medical records, Stephens had the following comments:

> "Once the CT scan was misread, all signs of pancreatitis and sepsis were misinterpreted as traumatic bruising. With pancreatitis, bloody exudates seeping from the pancreas

> cause apparent bruising, sometimes dramatic in nature, on various body-parts. As indicated, in the absence of CT scan and/or lab results, both retroperitoneal infection and pancreatitis may be diagnosed from swollen discolored testicles (Bryant's sign), -bruising on the abdomen in the umbilical area (Cullens [sic] sign), bruising of the flanks (Turner's sign), and/or bruising of the thighs (Fox's sign). In this case, the Bryant sign [*sic*] (discolored swollen testicles) was misinterpreted throughout the entire hospital stay, beginning when the trauma doctor at Mt. Sinai told Steven's mother that the child had been "kicked in the balls." The Cullens [sic] sign was correctly interpreted by one of the doctors at Rush but was repeatedly misinterpreted as trauma by other medical staff."

Stephens pointed out that the admitting diagnosis after Steven was transported to Rush Hospital was head trauma, and there was no mention of abdominal injury. However, "The operative report confirms that the original diagnosis of a large subdural hemorrhage and traumatic head injury was incorrect." Nevertheless, "The original misinterpretation of the CT scan persists throughout the medical records, with repeated references to a large subdural hemorrhage that did not exist."

¶ 47 Regarding the marks on Steven's back, Stephens opined:

> "The marks of primary interest are the series of round marks down the spine, most of which appear to be the bony prominences. This suggests that they were caused by a fall or pressure on the back, possibly caused during transport to or from Mt. Sinai, during the CT scan (which would have required restraints), or during surgery. Bruising is common with sepsis. It is also possible that these marks represent retroperitoneal hemorrhage from the abdominal infection."

He later added that "[t]he appearance and disappearance of red marks in multiple locations throughout child's hospital stay suggests that these were related to sepsis (infection), rather than abuse."

¶ 48 As for the medical examiner's conclusions Stephens observed:

> "[I]t appears that the medical examiner received an incomplete history and information. Specifically, it appears that the medical examiner was not told that no significant subdural hemorrhage was found at surgery, suggesting that the head injuries were secondary to the abdominal infection rather than traumatic. It also appears that the medical examiner was not given the hospital photographs, which showed different markings than seen at autopsy, suggesting that many marks reflected abdominal infection or hospital interventions, rather than inflicted trauma."

¶ 49 Stephens noted that Dr. Green (the emergency room doctor at Mount Sinai) initially thought Steven was suffering from a metabolic condition rather than trauma. He comments: "Dr. Green was on the right track in her initial diagnoses and treatment plan. However, the misread-of the head-CT scan resulted in cancellation of the abdominal CT scan and postponement of the evaluation or treatment of the abdominal infection." However, the CT scan "has no specific indicators of trauma, such as skull fracture or soft tissue swelling, and is consistent with hypoxia/ischemia." Stephens took issue with Munoz's attempt to date the cause of Steven's condition by visually observing the blood on his brain.

¶ 50 Stephens explained that over the last decade (his affidavit was executed in March 2009), the science about shaken-baby syndrome has changed dramatically. Ten years ago it was believed that subdural hemorrhaging, retinal hemorrhaging, and cerebral edema (the "triad") were diagnostic of shaking and that children suffering this sort of injury were immediately

symptomatic. However, according to Stephens, "[t]oday, it is well-understood that the triad is also found in accidental injuries and a wide array of natural disease processes." Moreover, the notion that no lucid intervals occur has been questioned. A 1999 study "found intervals of 72 hours or more between head injury and collapse, often with nonspecific symptoms, such as lethargy." Further, "in 2003, Denton and Mileusnic reported a child who initially appeared alright after a short fall but became symptomatic and died three days later."

¶ 51 A 2002 article by "leading child abuse pediatricians" identified numerous alternative diagnoses for the symptoms previously identified with abusive head trauma. Stephens added, "Reviews of the shaken baby literature in 2003 and later have established that existing theories of pediatric head injury, including shaken baby syndrome, are not supported by reliable evidence."

¶ 52 In the instant case, Stephens charged, "much of the trial testimony reflects the accepted dogma of the late 1990s, much of which is no longer accepted or had been disproven." Further, "a premature diagnosis of child abuse led to a failure to adequately consider the objective medical data or investigate the relevant time period." Preliminary diagnoses were never adjusted to reflect new evidence, notably, that Munoz did not find the large subdural hemorrhage purportedly shown on the CT scan during surgery and doctors testified that Steven's abdominal injuries occurred within an hour of his hospitalization despite the pathology slides (as read by both Mileusnic and Teas) showing they were at least five days old.

¶ 53 In sum, Stephens opined that Steven's abdominal injuries were five to seven days old; it was not possible to determine whether they were accidental or abusive in origin; the condition of his brain was secondary to his abdominal infection; the marks on Steven's body that appeared at the hospital were related to his abdominal infection, sepsis, and medical interventions; and there

is no medical evidence that any of Steven's injuries occurred on the day he was admitted to the hospital.

¶ 54 Defendant also submitted the affidavit of Dr. Waney Squier, a neuropathologist and lecturer at the University of Oxford. She is a fellow of the Royal College of Physicians and the Royal College of Pathologists. She reviewed 20 slides of Steven's brain tissue and dura. She was provided with a history of Steven's hospitalization. She noted timing was difficult based on the information she had and stated that the injuries could have occurred 66 hours prior to death. She observed no evidence of "primary traumatic change," but explained that her findings were "consistent with the history of choking [on the hot dog] and subsequent resuscitation and ventilation."

¶ 55 Defendant submitted an affidavit from Dr. Ronald Uscinski. Uscinski is a professor in the Department of Neurological Surgery at Georgetown University, and he maintains an active surgical practice as well. He conducted a "blind review (*i.e.*, a review without access to any significant history)" of the CT scan taken of Steven's brain on February 8, 2002. He concluded:

> "The CT shows findings indicating an anoxic insult to the brain *(i.e* ., a brain that has been deprived of oxygen, with a breakdown of grey white differentiation), more on the left. There is some subdural hemorrhage along the cerebellum and the occipital poles, very thin on the right side. There is subarachnoid hemorrhage and possible blood in the ventricles. These findings indicate that there has been an anoxic insult to the brain that is likely irreversible and nonrecoverable. There are no indicators of trauma (fractures, tissue swelling, etc.)."

He stated that he observed "insufficient hemorrhage to drain surgically." The CT scan was "consistent with any process that deprives the brain of oxygen." After conducting his initial

review, he was told the details of Steven's condition, and he opined that "[t]he CT scan is consistent with the history of pre-existing abdominal injuries/infection, possibly aggravated by choking with critical oxygen deprivation to the brain."

¶ 56 Defendant also submitted the affidavit of Nathan Felix, an Army medic. As a medic, his duties were similar to that of a physician's assistant. He reviewed Steven's lab results and noted that his glucose level was "extremely high," indicating Steven was "likely in hyperglycemic shock." Amylase and lipase levels were "extraordinarily high," which indicated "pancreatitis or a severe endocrine problem." The linear marks on Steven's body were too thin for a belt and were consistent with IV tubes or a hanger. However, that they appeared while Steven was in the hospital as well as the fact that some of the lines appear to be in different places in different pictures was not consistent with an earlier beating.

¶ 57 In addition to affidavits from medical experts, defendant also submitted an affidavit of his own (discussed above) and a number of fact witnesses, including Dion Liebich (defendant's cousin), Marlene Szafranski (his aunt), Denise Foster (defendant's sister), Debra Minucciani (defendant's aunt), and Roger Lily (an investigator for the Du Page County Public Defender's Office). Dion averred that he was present during the conversation between defendant and Robert Liebich (the Roselle police officer who testified for the State in the original trial). Dion stated that defendant consistently maintained his innocence and never related doing anything that could have hurt Steven. Dion also described incidents of violence between Kenyatta and Steven as well as Kenyatta and defendant's mother. Defendant's attorneys never spoke with Dion about his version of the conversation between defendant and Robert. Szafranski, Foster, and Minucciani also described incidents of violence involving Kenyatta. Minucciani and Foster also

averred that they visited defendant sometime after January 27, 2002. They offered Steven food from McDonald's, and Steven refused to eat it.

¶ 58 Lily averred that he interviewed Kenyatta on February 9, 2012. Kenyatta told Lily that defendant had never babysat Steven before February 8, 2002. She also told Lily that two or three days prior to February 8, 2002, Steven had been complaining of stomach pain. On February 7, Steven was crying for no apparent reason. She admitted that she spanked Steven on February 7 in an effort to get him to stop crying. Kenyatta told Lily that she never saw defendant hit Steven.

¶ 59 Ricky Holman, one of defendant's attorneys, averred that he did not "remember advising, nor did [he] remember Mr. Casey advising, [defendant] of his right to testify at trial." Holman further stated, "I have reviewed my notes concerning the representation of [defendant] and nowhere do they reflect that he was advised of his right to testify." John Casey, defendant's other attorney, also averred that he did not recall advising defendant of his right to testify.

¶ 60 III. ANALYSIS

¶ 61 On appeal, defendant challenges all of the trial court's rulings regarding his postconviction petition. He asserts that the trial court erred in finding he was not entitled to advance to the third stage of postconviction proceedings regarding (1) his actual innocence claim; (2) his claims that counsel was ineffective for failing to elicit and present exculpatory evidence, file a motion to suppress, and communicate plea offers; (3) his argument that the State violated due process by prosecuting him while having in its possession evidence that established his innocence; and (4) his conditional claim regarding appellate counsel's possible ineffectiveness and his derivative claim regarding cumulative error. He also challenges the third-stage denial of his assertion that counsel did not advise him of his right to testify.

¶ 62 The Postconviction Hearing Act (Act) (725 ILCS 5/122-1 *et seq.* (West 2012)) provides an avenue for a person to challenge a conviction that he or she believes is the result of a substantial denial of that person's constitutional rights. *People v. Edwards*, 197 Ill. 2d 239, 243-44 (2001). An actual innocence claim may be raised in a postconviction petition. *People v. Johnson*, 205 Ill. 2d 381, 392 (2002). At the first stage, the trial court conducts independent review of the petition to determine whether it is frivolous or patently lacking merit. *Edwards*, 197 Ill. 2d at 244. This case has already passed the first stage. At the second stage, counsel may be appointed for a defendant and the petition may be amended. *People v. Marshall*, 375 Ill. App. 3d 670, 674 (2007). The State may move to dismiss the petition or file an answer. *People v. Clark*, 2011 IL App (2d) 100188, ¶ 15. If the State moves to dismiss, we must take all well-pleaded allegations as true. *People v. Pendleton*, 223 Ill. 2d 458, 473 (2006). To survive dismissal, the defendant must make a substantial showing of a constitutional violation. *Clark*, 2011 IL App (2d) 100188, ¶ 16. Appellate review following a second-stage dismissal is *de novo* (this standard applies to the majority of defendant's arguments here). *Pendleton*, 223 Ill. 2d at 473. If the trial court does not dismiss the petition during second-stage proceedings, it moves to the third stage, where an evidentiary hearing is had and the trial court may make credibility determinations and resolve questions of fact. *Id*. Review following third-stage proceedings is conducted using the manifestly-erroneous standard (this standard applies to defendant's argument concerning not being advised of his right to testify). *Id*. With these standards in mind, we turn to the substance of defendant's arguments.

¶ 63 A. ACTUAL INNOCENCE

¶ 64 Defendant first argues that he is innocent, as shown by newly discovered evidence. To succeed on such a claim, a defendant must present new, material, noncumulative evidence that is

so conclusive it would likely change the result on retrial. *People v. Washington*, 171 Ill. 2d 475, 489 (1996). Evidence is new if it was discovered after trial and it could not have been discovered before trial through the exercise of due diligence. *People v. Coleman*, 2013 IL 113307, ¶ 96. It is material if it is relevant and probative of the defendant's innocence. *Id*. If the evidence adds to what the trier of fact heard at the original trial, it is noncumulative. *Id*. "Conclusive" means that "the evidence, when considered along with the trial evidence, would probably lead to a different result." Id. This may include an assessment of the likely effect of the new evidence on the credibility of witnesses. See *People v. Ortiz*, 2013 IL 113307, ¶ 113-14. It is not our task to reassess defendant's guilt; rather, '[p]robability, not certainty, is the key as [we] in effect predict[] what another jury would likely do, considering all the evidence, both new and old, together." *Coleman*, 2013 IL 113307, ¶ 97. That is, we must determine whether defendant had adequately alleged that "all of the facts and surrounding circumstances *** should be scrutinized more closely to determine [his] guilt or innocence." *People v. Molstad*, 101 Ill. 2d 128, 136 (1984).

¶ 65 First, we turn to the question as to whether defendant has adequately alleged that the evidence he now presents is new. Clearly, the affidavits representing the opinions of experts who examined Steven's medical records and the histological slides did not exist until after the trial and therefore were discovered after the trial. The more difficult question is whether such (or similar) opinions could have been discovered by the time of the trial through the exercise of due diligence. If they could have, these opinions do not represent new evidence, as contemplated by the case law. *Coleman*, 2013 IL 113307, ¶ 96.

¶ 66 The State asserts that they are not new because "[e]verything reviewed by these experts existed and was available at the time of trial." Undoubtedly this is true; however, it is also true

where subsequent DNA testing of an item of evidence establishes a defendant's innocence. Obviously, such testing is usually performed on an item of evidence that existed at the time of the trial. See, *e.g.*, *People v. Brown*, 2013 IL App (1st) 091009, ¶ 54 (DNA testing of, *inter alia*, vaginal swab taken by medical examiner). Thus, the fact that the evidence upon which the experts now base their opinions existed at the time of the trial is immaterial. Rather, the question is whether the opinions themselves existed, or could have been obtained through the exercise of due diligence, by the time of defendant's trial. In this case, we must consider whether the science had advanced sufficiently that defendant could have obtained such opinions at the time of his trial.

¶ 67 In ascertaining whether defendant could have obtained experts to render opinions such as these at the time of his trial, the trial testimony of Dr. Teas provides insight into the state of the science at the time. Thus, we will set out her testimony in some detail. Teas opined that the cause of Steven's death was blunt-trauma injuries to the abdomen and head. There could be a delay in the manifestation of symptoms, and a person might be able to eat for a while after the injury. The lack of a midline shift indicated that "[t]his wasn't just one localized area." She believed either the head or abdominal injury could have led to death independently. Histological slides showed no injury to the scrotum. She explained that the apparent bruising of the scrotum was attributable to blood "trickl[ing] down in that area."

¶ 68 She described the healing process on a cellular level, identifying the different types of cells that respond to an injury, including the order in which they arrived. Histology, though imprecise, is the best way to assess the timing of an injury. To do so, one observes signs of healing. Timing is possible only in 24-hour intervals; assessing the occurrence of an injury to a 4 to 6 hour period is not possible. On the second day after an injury, lymphocytes are present; on

the third, fibroblasts arrive; after four to five days, one can observe three to five layers of fibroblasts; and after day seven, capillaries form. She referred to the initial formation of capillaries as granulation. Teas described the content of several histology slides and explained why they supported her opinion as to timing, pointing to, *inter alia*, evidence of granulation and layers of fibroblasts.

¶ 69 Regarding the timing of Steven's injuries, Teas opined:

> "They were about five days old. They could have been six. If somebody would argue, could they be four, I would say, yeah, it could be, but, you know, I would put it more towards five or six days, rather than – I certainly wouldn't put it in the three days and less category because there was enough healing"

She noted that, while children heal faster than adults, being on a respirator slows healing.

¶ 70 Teas further testified that she was familiar with the concept of a lucid interval. She opined that a person could suffer a head injury like Steven's and remain conscious for a while. While a systematic study had not been performed, lucid intervals had been "documented in the literature" and "there are case reports out." In fact, Mileusnic had authored one. She noted that while there are a "few forensic pathologists who believe" no lucid interval is possible, "there are a lot of forensic pathologists who don't agree with that." She attended a conference of the National Association of Medical Examiners the February before the trial, and lucid intervals were "one of the hottest issues that [was] discussed." She also testified that some of the linear marks on Steven's body could have come from tubes and cuffs used at the hospital.

¶ 71 Using Teas' testimony as a baseline, we must now examine the purportedly new material presented by defendant and determine whether, accepting defendant's allegations as true, it could have been discovered through an exercise of due diligence.

¶ 72 Defendant asserts that at trial, he "was only able to present a few pieces of evidence to support his theory that Steven was injured before he was in [defendant's] care," namely, "Steven's runny nose and cough" and "Teas' testimony that Steven's injuries were from an earlier time period." However, Teas' testimony was extensive. She provided a detailed explanation of the basis for her opinion, including a description of various histological slides. Defendant claims that this "limited evidence would be viewed differently, as would the testimony about the timing of Steven's injuries," in light of the "advancements" in the science surrounding abusive head trauma.

¶ 73 However, given Teas' testimony, it is clear to us that these "advancements" already existed by the time of defendant's trial. Teas' testimony regarding how she determined when Steven's injuries occurred was based on the histological slides. There is nothing in any of the affidavits submitted by defendant to indicate that there have been any new developments in histology relevant to this trial. Indeed, the conclusion advocated by defendant—that the injuries occurred five days before Steven's death—is precisely the conclusion derived by Teas using the methodology available to her prior to the trial.

¶ 74 We note two areas of particular significance to defendant's trial. First is whether a person with a head injury similar to Steven's can experience a lucid interval. This is a possibility to which Teas testified at trial. Further, Mileusnic acknowledged that there was a difference of opinion in her field as to whether children sometimes experience a lucid interval following a traumatic head injury prior to becoming symptomatic. Indeed, she had authored a case study on the subject. Dr. Boykin also testified to the possibility of a lucid interval. Indeed, in his petition, defendant cites a 1998 study by a Dr. Gilliland which "found that in approximately 25% of alleged abuse cases, there was an interval of more than 24 hours (and sometimes more than 72

hours) between the alleged abuse and the onset of severe symptoms." In his petition, defendant states, "Since 2004, the child abuse literature has recognized that there are many natural and accidental causes for these findings and that there can be lucid intervals of up to 72 hours." This may be true; however, given the testimony of these three witnesses (as well as the study cited by defendant), it is apparent that such evidence could have been discovered through the exercise of due diligence at the time of the trial.

¶ 75 The second such area is whether the sort of head injury suffered by Steven could occur in the absence of trauma. In other words, could the head injury have been secondary to Steven's abdominal injuries. Defendant asserts that at the time of his trial, the orthodox view was that brain swelling and hemorrhage was only caused by trauma (shaking, in particular). Defendant contends that "[t]he doctors who testified that Steven's head injuries were caused by trauma were relying on [this] old medical understanding[]." This, however, is not the question—the State likely still could find experts to testify who subscribed to the orthodox view. Rather, the issue is whether defendant could have secured his own witnesses to controvert this position at the time of the trial.

¶ 76 Initially, we note Teas' testimony that "even if the child didn't have any head injury, the child could have become unconscious, once peritonitis sets in and he had septicemia." Further, we note the foundations of shaken-baby-syndrome theory, upon which the notion that edema and subdural hemorrhaging is always indicative of trauma depends, were being questioned well before defendant's trial. In his petition, defendant identifies several studies predating his trial, including: (1) a 1987 University of Pennsylvania study that concluded that "the force of shaking fell far below established injury thresholds"; (2) the 1998 study mentioned above; (3) a 1998 editorial in *The Lancet*, 352 The Lancet 335 (1998), stating that doctors were undecided about

the syndrome; (4) a 1999 article positing external hydrocephalus as a non-abusive-trauma related cause of the classic triad of symptoms of shaken-baby syndrome; (5) a 2001 publication by Dr. Geddes finding that brain swelling in infants was often hypoxic, that scientific evidence for the proposition that the triad was caused by trauma was "scanty", and that subdural hemorrhages and edema in babies who died of natural causes were virtually indistinguishable from those found in allegedly abused infants; (6) a 2001 article by Dr. John Plunkett describing witnessed short falls that resulted in some or all of the symptoms known as the triad; (7) a 2002 article in the British Journal of Neurosurgery that concluded that shaking likely would not produce the symptoms known as the triad; (8) a 2002 article by Dr. Barnes (who submitted an affidavit in this case) questioning the evidence upon which shaken-baby theory is based and cautioning that radiologists must be made aware of possible conditions that mimic symptoms of abuse; (9) a 2003 article by Dr. Mark Donohoe reviewing the evidence underlying the theory and concluding it was of poor quality and insufficient to support diagnostic assessment; and (10) a 2003 case study involving a short fall and collapse where the child had been asymptomatic in the interim. At a minimum, as alleged by defendant, all of this existed prior to his trial. Further, Barnes averred that "*[s]ince 2000*, the pediatric literature has identified many causes for medical findings previously viewed as diagnostic of non-accidental trauma." (Emphasis added.) As such, it is difficult to discern why defendant could not have made a credible challenge to the notion that all instances of edema and subdural hemorrhage were caused by trauma. In other words, the evidence that defendant alleges is new could have been discovered through the exercise of due diligence prior to trial. Indeed, defendant posits, "2001 was both the peak of the [shaken-baby syndrome] hypothesis *and the beginning of its unraveling*." (Emphasis added.)

¶ 77 We note other similar items of proffered evidence. For example, Barnes testified that an injury could not be dated based on the color of blood a surgeon observes during surgery, directly contrary to Munoz's testimony. Nothing indicates that Barnes is basing this opinion on any new scientific developments, so it appears such testimony could have been presented in the original trial. In any event, having reviewed defendant's submissions, it does appear to us that defendant could have sufficiently raised such issues at his original trial. As noted above, evidence is new if it was discovered after trial and it could not have been discovered before trial through the exercise of due diligence. *People v. Coleman*, 2013 IL 113307, ¶ 96. While much of defendant's evidence was new in the sense that the affidavits he now presents did not exist at the time of the trial, these (or similar) opinions could have been obtained and presented at trial, so defendant has not adequately alleged that he could not have discovered such evidence through the exercise of due diligence. As this is a necessary element of defendant's claim, it necessarily fails. We need not, therefore, address other aspects of defendant's claim.

¶ 78 Defendant also asserts, "In the event this [c]ourt concludes that [defendant's] trial attorneys had some ability to raise these issues, then his counsel was ineffective." This brings us, then, to the question of the adequacy of his representation at trial.

¶ 79 B. ASSISTANCE OF COUNSEL

¶ 80 Defendant claims he did not receive the effective assistance of counsel at his trial for several reasons. Most notably, he argues counsel failed to understand and present exculpatory medical evidence as well as related testimony from fact witnesses that would provide support to the expert testimony. He also claims counsel was ineffective for failing to seek a plea bargain and failing to file a motion to suppress.

¶ 81 When a defendant in a criminal case contends he or she received ineffective assistance from trial counsel, the familiar standards first set forth in *Strickland v. Washington*, 466 U.S. 668 (1984), control. To prevail on such a claim, the defendant must show that counsel's performance fell below an objective standard of reasonableness and that, but for counsel's substandard performance, there is a reasonable probability that the outcome of the proceedings would have been different. *People v., Houston*, 226 Ill. 2d 135, 144 (2007). Regarding the first prong, a defendant must overcome the presumption the counsel's actions were the result of trial strategy. *Id*. As for the second prong, a reasonable probability is a probability sufficient to undermine confidence in the outcome of the trial. *Id*.

¶ 82 The failure to understand and adequately present expert and scientific testimony can constitute the ineffective assistance of counsel. The United States Supreme Court has observed, "Criminal cases will arise where the only reasonable and available defense strategy requires consultation with experts or introduction of expert evidence, whether pretrial, at trial, or both." *Harrington v. Richter*, 562 U.S. 86, 106 (2011). In this case, the dispositive issue was narrow. At trial, all expert medical witnesses believed Steven died as the result of blunt-force trauma to the head and abdomen. The outcome of the case turned on whether this trauma was inflicted on February 8, 2002, while defendant had exclusive access to Steven, or at some earlier time, when defendant did not. The evidence indicating that the injuries were inflicted on February 8 consisted primarily of the testimony of the medical personnel who attended to Steven following his admission to the hospital. The only way to rebut this testimony was to introduce countervailing scientific evidence.

¶ 83 Though neither we nor the parties have identified an Illinois case that is directly on point, it is nevertheless clear that the failure to adequately understand and present scientific testimony

in certain circumstances may constitute the ineffective assistance of counsel. In *People v. Luna*, 2013 IL App (1st) 072253, ¶ 116-119, the reviewing court, in rejecting the defendant's claim that trial counsel was ineffective for failing to seek a *Frye* hearing concerning certain DNA evidence, emphasized the *adequacy* of defense counsels' handling of the issue. Similarly, in *People v. McVay*, 170 Ill. App. 3d 443, 451-52 (1988) (quoting *People v. Van Ostran*, 168 Ill. App. 3d 517, 522 (1988)), the court rejected an ineffectiveness claim where counsel failed to interview the pathologist that performed the autopsy on prejudice prong because "[e]ven a professionally unreasonable error does not warrant setting aside the judgment in a criminal case if the error had no prejudicial effect on the judgment." In both of these cases, the court considered the skill (or lack thereof) with which defense counsel handled scientific evidence.

¶ 84 Defendant calls our attention to *Richey v. Bradshaw*, 498 F.3d 344, 364 (6th Cir. 2007), where the court concluded, "Confronted with evidence debunking the State's scientific conclusions, the trial court might have had a reasonable doubt about Richey's guilt." Thus, the *Richey* court flatly held that the failure to adequately address scientific issues was a sufficient basis to find trial counsel ineffective. Defendant also cites *Dugas v. Coplan*, 428 F. 3d 317, 328 (1st Cir. 2005), which found defense counsel ineffective where he "did not consult an expert in arson investigation or learn how to effectively use the terminology and techniques of arson investigation from his own research." In essence, the *Dugas* court concluded that defense counsel had inadequately understood and presented relevant scientific evidence. Though these federal cases are not binding on this court (*People v. Stansberry*, 47 Ill. 2d 541, 545 (1971)), we nonetheless find them persuasive.

¶ 85 Synthesizing the affidavits summarized above, a number of salient points emerge that would have been helpful to defendant at trial. First, the consensus of the experts presented by

defendant is that Steven's brain injury was secondary to his abdominal injury. For example, Barnes opined that the CT scan taken shortly after Steven's admission to Mount Sinai showed the beginning of an oxygen-deprived brain. He expressly opined that the CT findings were secondary to the abdominal injury and were possibly exacerbated by the choking incident described by defendant. Laposata opined that Steven's ischemic bowel progressed to peritonitis and pancreatitis and then to severe pancreatitis and a hypoxic-ischemic brain. Mileusnic—who had testified for the State at defendant's trial—opined that Steven's pancreatitis and hypoxic-ischemic brain were the "natural progression" of earlier injuries. Nichols opined that Steven's brain injury was "a delayed reaction to the abdominal injuries." Stephens believed that Steven had "hypoxic-ischemic encephalopathy, probably secondary to the abdominal infection." He added that the condition of Steven's brain was likely the natural progression of the abdominal infection. Uscinski opined that the CT scan showed a brain that had been deprived of oxygen. Thus, the affidavits submitted by defendant support the theory that Steven's hypoxic-ischemic brain was solely the result of the progression of his abdominal injuries.

¶ 86 Second, the affidavits also support the proposition that Steven had no traumatic injury to his head. Barnes stated that there were no signs of soft tissue injuries that would indicate head trauma. In a histological slide taken from Steven's brain, Mileusnic observed "[n]o visible axonal spheroids [were present] that would suggest trauma." Squire, who examined 20 slides of Steven's brain tissue and dura, observed no signs of trauma. Uscinski averred that that there were no signs of trauma. Recall here that at trial, even Teas believed Steven had suffered a blunt trauma injury to his head, so these opinions present a very different mechanism of injury.

¶ 87 Thus, these experts explain a process of how Steven's brain injury could have occurred solely as a consequence of an abdominal injury occurring about five days before his death. They

provide considerable histological evidence to support this timing determination. Moreover, they also provide a basis for rejecting the conclusion that Steven suffered head trauma on February 8.

¶ 88 A third significant area is the detailed explanation provided in the affidavits of how the marks that kept appearing while Steven was in the hospital were caused by something other than a beating. Barnes stated that the marks "may reflect a secondary coagulopathy such as disseminated intravascular coagulation rather than trauma occurring shortly before admission." Nichols believed this was a possibility as well. Laposata explained that "[A] child in DIC may bruise spontaneously or for minor trauma." Stephens stated that "[m]any of the signs interpreted as trauma are well-known indicia of abdominal injuries or artifactual." While the possibility that some of the marks appearing on Steven's body were artifactual was raised at trial, it was never explained how this could have been the natural progression of the abdominal injury, which resulted in DIC and manifested as several classic symptoms (*i.e.*, the Cullen's sign and the Turner's sign) that could be misinterpreted as bruising (as explained by Stephens).

¶ 89 Additionally, in light of this theory, other evidence takes on added significance. The incident described by defendant where Steven purportedly choked on a hot dog appeared at trial to be a less-than-credible attempt to cover up the real cause of Steven's injuries (particularly given the testimony of the treating doctors concerning Steven choking on a hot dog). However, the choking incident is consistent with the theory that Steven's head injury was secondary to his abdominal injury. Barnes averred that the incident "was likely a symptom of the abdominal injury/infection and may have triggered an accelerated collapse." Stephens and Uscinski offered similar opinions. Had such testimony been admitted at trial, the trial court may have concluded that defendant's statement that Steven had choked on a hot dog actually weighed in favor of his innocence.

¶ 90 Similarly, while there was some evidence that Steven was reluctant to eat in the days leading up February 8, 2002, its significance was not apparent. In light of the expert opinions defendant has submitted in support of his petition, his fussiness and reluctance to eat may be viewed as evidence of an abdominal condition that was not yet fully symptomatic. Stephens opined that Steven's reluctance was consistent with a pre-existing abdominal infection. Moreover, there was evidence that Steven had been given Tylenol and aspirin, indicating something was amiss. Defendant's affidavits from fact witnesses provide additional information of a similar nature.

¶ 91 Furthermore, there was testimony at trial that Kenyatta was violent toward Steven. Affidavits from fact witnesses allege additional violence toward Steven and other members of her household. If the scientific evidence is not viewed as conclusively establishing that the injuries all occurred on February 8, when only defendant had unfettered access to Steven, this evidence takes on added significance.

¶ 92 We also note defense counsel's closing argument that "Teas is not going to say it's impossible, it could have occurred on the 8th." Teas states, in her affidavit:

> I also just learned that [defense counsel] suggested in his closing argument that I was not sure whether I saw older injuries, *i.e.*, injuries occurring before February 8. This was not my testimony. While pathological timing is not precise and in medicine one can rarely say "never," my testimony was that the healing and reaction seen in the slides represented injuries that occurred on or before the morning of February 7. This testimony was based on established pathological principles.

This supports a further inference that counsel did not understand or properly present the scientific evidence available at the time of trial. This is particularly significant in that the trial

court expressly relied on Teas in finding that "the injuries [occurred] anywhere, according to Dr. Teas, as early as the 4th and as late as the 8th," and, "[d]epending on another analysis of those dates, it is from the 5th to the 9th."

¶ 93 In sum, taking defendant's allegations as true (as we are required to do at this stage), his attorneys failed to either investigate, comprehend, or present the aforementioned scientific evidence (as well as corroborating evidence from fact witnesses) that a reasonable exercise of diligence would have made available for defendant's defense. Not doing so was patently unreasonable, and we have no difficulty in concluding (again, accepting defendant's allegations) that it undermines our confidence in the outcome of the trial. As such, defendant's petition adequately alleges he received ineffective assistance of counsel at trial, and this issue must be remanded for stage three postconviction proceedings. To be clear, this remand encompasses defendant's allegations that counsel was ineffective with respect to both expert and fact witnesses, as the fact witnesses statements are intertwined with and substantiate portions of the expert opinions.

¶ 94 Before leaving this section of our disposition, we note the State's argument that the fact that we addressed Teas' post-trial, *ex parte* letter in our earlier order in this case is *res judicata* as to defendant's ineffective assistance of counsel claim. We held that Teas' letter would primarily serve to impeach Severin on the issue of timing and that there was "no reasonable probability that undermining a portion of the basis of Severin's opinion would have led to a different result at trial." *People v. Liebich*, No. 2-04-1238, slip op. at 67 (December 12, 2007) (unpublished order under Illinois Supreme Court Rule 23 (eff. July 1, 1994)). Of course, in proceedings under the Act, "Any issues that could have been raised on direct appeal, but were not, are procedurally defaulted, and any issues that have previously been decided by a reviewing court are barred by

res judicata." *People v. Harris*, 224 Ill. 2d 115, 124-25 (2007). As we read the theory encompassed by the expert affidavits accompanying defendant's petition, it is sufficiently different from Teas' letter and trial testimony so as not to be barred by *res judicata*. Notably, Teas' trial testimony still contemplated head trauma and her letter does not state anything to the contrary. Conversely, the affidavits posit a scenario where Steven's head injuries were secondary to his abdominal injuries with no associated head trauma. Moreover, we also found that the fact that "Steven had taken a pain killer at some point (we do not know when) certainly does not support an inference that Steven had sustained these massive injuries at an earlier time than is indicated by the weight of the evidence." *People v. Liebich*, No. 2-04-1238, slip op. at 67 (December 12, 2007) (unpublished order under Illinois Supreme Court Rule 23 (eff. July 1, 1994)). However, as noted above, evidence that Steven had taken Tylenol and aspirin takes on new significance in light of the theory, supported by the affidavits, that Steven was suffering from an injury that occurred before February 8, 2002. In short, though there is some overlap between Teas' testimony and letter and the content of the affidavits defendant now submits, it is sufficiently different that we cannot say that this claim has been previously litigated such that *res judicata* applies. Indeed, it is well established that "[r]ules of waiver and *res judicata* will be relaxed where the facts relating to the issue of counsel's incompetency do not appear on the face of the record." *People v. Orange*, 168 Ill. 2d 138, 167 (1995). If we were to find that this issue could have been raised earlier, but was not, additional questions regarding the quality of the representation defendant received at trial and on appeal would arise.

¶ 95 Defendant also argues that counsel was ineffective for failing to file a motion to suppress his conversation with his cousin, police officer Robert Liebich. Defendant and another cousin, Dion, went to the Roselle police station to speak with Robert about the case. They spoke in a

small room with a closed door. The conversation was heated, and, according to Dion, a lot of anger was directed at defendant. Defendant avers that Robert "put Dion and me in an interrogation room" and "questioned me for about an hour." Defendant does not aver that he did not feel free to leave. Failing to bring a motion that has no reasonable chance at succeeding does not constitute ineffective assistance of counsel. *People v. Velez*, 388 Ill. App. 3d 493, 504 (2009). Defendant cites no case where a suspect was found to be in custody under similar circumstances, *i.e.*, where a suspect went voluntarily to a police station to speak with a relative while another relative was present. Defendant has not adequately alleged that this so-called interrogation was custodial. As such, defendant's allegations do not establish that it was necessary to read defendant his *Miranda* rights. *People v. Gorman*, 207 Ill. App. 3d 461, 470 (1991). As this motion would have been futile, counsel was not ineffective for failing to make it. *Velez*, 388 Ill. App. 3d at 504.

¶ 96 Defendant contends, in the alternative, that his attorneys were ineffective for failing to pursue a plea agreement. Defendant notes that one of his attorneys stated during posttrial proceedings that he declined the State's invitations to discuss a plea deal. This attorney further stated it was defendant's desire to go to trial, as he was innocent. Defendant does not set forth anything from which we could conclude that the State would have made an offer that was more favorable to defendant than the sentence he ultimately received (or one that he would have accepted). As such, defendant's argument is simply speculative and insufficient to warrant third-stage proceedings under the Act. See *People v. Eggleston*, 363 Ill. App. 3d 220, 229 (2006) (holding that speculation as to what a witness might testify to is insufficient to support a claim of ineffective assistance of counsel). Defendant has not adequately alleged counsel was ineffective in this respect.

¶ 97 In sum, regarding counsel's alleged ineffectiveness, we conclude that defendant's claims that counsel was ineffective for failing to investigate, comprehend, or present expert testimony and the testimony of additional fact witnesses should proceed to stage three proceedings. His claims that counsel was ineffective for failing to file a motion to suppress or pursue a plea deal were properly dismissed by the trial court.

¶ 98 C. EVIDENTIARY HEARING

¶ 99 Defendant also argues that the trial court erred in determining, after an evidentiary hearing, that counsel did not prevent him from testifying. To succeed on this claim, defendant must show that the trial court's ruling was manifestly erroneous. *Pendleton*, 223 Ill. 2d at 473. On this subject, the trial court made several factual findings. It found that defendant did not assert his right to testify. It found defendant's attorney credible and defendant to lack credibility on this issue. Further, the trial court found that despite the fact that neither counsel nor the judge that presided over defendant's trial discussed with defendant his right to testify, defendant did know that he possessed this right. It based this finding on defendant's previous involvement in the criminal justice system, including "his recent admonishments by Judge Dockery and a more detailed explanation" from the attorney who represented him in those earlier cases. Defendant now asserts that we "must take his unrebutted and unimpeached testimony as true, as here there were no witnesses who rebutted [defendant's] testimony that he did not recall and did not understand any admonishments he received in 1999 or 2002." Defendant contends that unrebutted testimony must be accepted unless it is inherently improbable or beyond the bounds of human belief. See *Bucktown Partners v. Johnson*, 119 Ill. App. 3d 346, 353-55 (1983). However, defendant acknowledged recalling Judge Dockery's admonishments (the trial court certainly did not have to accept defendant's self-serving denial of understanding the

admonishment), so it cannot truly be said that defendant's testimony was "unrebutted and unimpeached." Under such circumstances, we cannot say that the trial court's findings are manifestly erroneous.

¶ 100 D. OTHER ISSUES

¶ 101 Defendant raises three additional issues. First, we need not address defendant's contention that appellate counsel was ineffective because he only raised it in the alternative in the event we determined an issue was waived for failure to develop it on direct appeal. We have not made such a determination. Second, defendant asks that, if we determine that any of the errors he raised in his petition were not sufficiently prejudicial in themselves, we consider their cumulative effect. Given the disposition of the issues discussed above, we need not address this issue either.

¶ 102 Third, defendant contends that the State's prosecution of him in the absence of "clear evidence of his guilt" violated his right to due process. Defendant details the evidence that supports his innocence in support. However, we note that the State was able to muster considerable evidence in the form of the testimony of several doctors and health care providers (Munoz, Severin, Boykin, and Green) in support of its position. Thus, while the evidence was conflicting, there was certainly evidence of defendant's guilt presented, and the mere fact that there was evidence to the contrary does not rise to the level of a due-process violation. The cases defendant cites in support involve an unnecessarily suggestive line up and prosecutorial misconduct (see *Foster v. California*, 394 U.S. 440 (1969); *Ex Parte Bradley*, 781 S.W.2d 886 (Tex. Crim. App. 1989)) and thus provide only tangential support to defendant's argument. We do not find this argument well founded.

¶ 103 Defendant also asks that when we remand this case, we direct that it be assigned to a different judge. Defendant cites Illinois Supreme Court Rule 63(C)(1)(a) (eff. January 1, 2016), which states, "A judge shall disqualify himself or herself in a proceeding in which the judge's impartiality might reasonably be questioned, including but not limited to instances where *** the judge has a personal bias or prejudice concerning a party or a party's lawyer, or personal knowledge of disputed evidentiary facts concerning the proceeding." However, defendant is alleging the trial judge should be disqualified due to his former position in the State's Attorney's office rather than any personal bias or prejudice. Therefore, subsection (C)(1)(b) is more germane: "A judge shall disqualify himself or herself in a proceeding in which the judge's impartiality might reasonably be questioned, including but not limited to instances where *** *the judge served as a lawyer in the matter in controversy,* or a lawyer with whom the judge previously practiced law served during such association as a lawyer concerning the matter, or the judge has been a material witness concerning it." (Emphasis added.)

¶ 104 Acting in a supervisory capacity in the State's Attorney's office has been held to be outside the scope of the rule. *People v. Thomas*, 199 Ill. App. 3d 79, 91-92 (1990); see also *People v. Burnett*, 73 Ill. App. 3d 750, 754-55 (1979) (construing an earlier, similar rule). Thus, the mere fact that the trial judge had been a supervisor in the State's Attorney's office does not require that he be disqualified from the instant proceeding. As defendant has shown no actual personal bias, prejudice, or knowledge of the case, subsection (C)(1)(a) also does not apply. As such, we deny defendant's request that we direct this case be remanded with instructions to assign it to a different judge.

¶ 105 In sum, none of these additional issues merit any relief.

¶ 106 IV. CONCLUSION

¶ 107 Before closing, we note that there is a certain interrelatedness to some of defendant's arguments. We have held that the material contained in the affidavits submitted by defendant concerning medical issues is not new for the purposes of an actual-innocence argument and that counsel was ineffective for failing to present such evidence. If we had concluded that counsel's failure to develop the theory encompassed by the affidavits because the science was insufficiently developed to support a theory that Steven's head injuries were secondary to his abdominal injuries, that would provide a basis to conclude that such evidence was new within the meaning of the actual-innocence analysis and we might have come to a different result regarding that argument.

¶ 108 In light of the foregoing, we reverse the trial court's dismissal of the defendant's allegations that he received ineffective assistance of counsel with respect to the medical issues, which includes evidence from both fact and expert witnesses, and we otherwise affirm. We deny defendant's request to direct that the case be assigned to a different judge (though defendant remains free to make any motions to that effect in the trial court). We remand this cause so that the trial court can conduct stage three proceedings regarding the allegations of ineffectiveness that we find the trial court erroneously dismissed.

¶ 109 Affirmed in part; reversed in part: cause remanded.