STATE OF ILLINOIS)
) SS.
COUNTY OF WILL)

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CLERK, CIRCUIT COURT
WILL COUNTY, IL

IN THE CIRCUIT COURT OF THE TWELFTH JUDICIAL CIRCUIT
WILL COUNTY, ILLINOIS

PEOPLE OF THE STATE OF ILLINOIS Plaintiff,	)	
	)	NO. 03 CF 199
vs.	)	
	)	The Honorable Carmen Goodman,
JENNIFER DEL PRETE, Defendant.	)	Judge Presiding

NOTICE OF FILING

To: Elisabeth Wang, Loevy and Loevy, 311 N. Aberdeen, Chicago, Illinois 60607

Please take notice that the People of the State of Illinois, Plaintiff, in the above-entitled cause, by James W. Glasgow, State's Attorney of Will County, Illinois, through Colleen M. Griffin, have filed a response to defendant's petition for certificate of innocence.

JAMES W. GLASGOW
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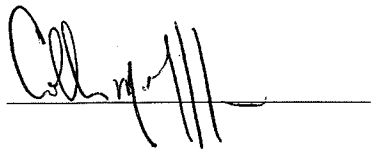
AFFIDAVIT AS PROOF OF SERVICE

Under penalties as provided by law pursuant to section 1-109 of the Code of Civil Procedure (735 ILCS 5/1-109), I certify that a copy of the notice of filing as well as Response, was served by United States mail on the party(ies) listed below on August 8. 2024.



Elisabeth Wang, Loevy and Loevy, 311 N. Aberdeen, Chicago, Illinois 60607

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PEOPLE OF THE STATE OF ILLINOIS,	)	
Respondent,	)	
	)	
v.	)	**03 CF 199**
	)	
JENNIFER DEL PRETE,	)	**The Honorable**
Petitioner.	)	**Carmen Goodman,**
	)	**Judge Presiding.**

RESPONSE TO PETITIONER'S PETITION FOR CERTIFICATE OF INNOCENCE

The People of the State of Illinois, by James W. Glasgow, Will County State's Attorney, through his assistant, Colleen M. Griffin, respond and object to Petitioner's petition for Certificate of Innocence. In support thereof, the People state as follows:

1. After a bench trial, defendant was convicted of first degree murder (720 ILCS 5/9-1(a)(2)(West 2004)) and sentenced to 20 years' imprisonment. Defendant appealed her conviction to the Illinois Appellate Court, Third Judicial District asserting that the evidence was insufficient to prove her guilty beyond a reasonable doubt. The appellate court affirmed. *People v. Del Prete*, No. 3-05-0868 (unpublished order under Supreme Court Rule 23). Defendant filed a petition for leave to appeal which was denied on September 26, 2007. *People v. Del Prete*, 225 Ill.2d 646 (2007).

2, Defendant filed her initial post-conviction petition on March 24, 2008. This Court summarily dismissed the petition as frivolous and patently without merit and the appellate court

affirmed that determination. *People v. Del Prete*, 3-08-0431 (unpublished order under Supreme Court Rule 23). Defendant filed a petition for leave to appeal, which was denied on November 25, 2009. *People v. Del Prete*, 234 Ill.2d 531 (2009).

3. Defendant subsequently filed a petition for writ of habeas corpus in the United States District Court for the Northern District of Illinois. In the federal habeas petition, defendant raised three issues. Defendant's third issue was never raised in the Illinois state court and was therefore procedurally defaulted for federal habeas corpus purposes. However, defendant argued to the federal court that it should consider her claim despite her default on the ground that she had evidence demonstrating she is actually innocent of the underlying charge, and asked the court for an evidentiary hearing to develop that claim. The federal court found that defendant had presented a facially plausible claim of actual innocence, and ordered a hearing to permit further development of this claim as an excuse for defendant's procedural default.

Following the conclusion of the hearing in the district court, but before the district court ruled on the petition, the "Kroll" letter was discovered by counsel. The district court granted the motion to reopen the actual innocence hearing, which was held on June 21, 2013. On January 27, 2014, the federal court held that the defendant had established actual innocence in order to overcome her procedural default; finding that no reasonable jury could find her guilty beyond a reasonable doubt. *Del Prete v. Thompson*, 10 F.Supp. 3d 907 (N.D. Ill. Jan. 27, 2014 (Kennelly, J.). As a result of a then pending motion for leave to file a successive post-conviction petition before this Court, the federal court stayed the federal habeas corpus proceedings and released defendant on bond.

4. On January 2, 2014, this Court denied defendant's motion for leave to file a successive post-conviction petition. Defendant appealed, and on April 1, 2015, the appellate court reversed,

finding that defendant had demonstrated "cause and prejudice" such that a successive post-conviction petition could be filed. *People v. Del Prete*, 2015 IL App (3d) 140007-U (April 1, 2105). Following an evidentiary hearing, this Court determined that defendant should be granted a new trial. The State appealed, and the appellate court affirmed the grant of the new trial. Subsequently, the State nolle prossed the charges against the defendant, specifically stating the State did not believe defendant was actually innocent, but asserting it could not longer go forward on the charges.

5. Defendant has filed a petition for certificate of innocence before this Court. Her petition checks off boxes 3 and 4 which assert that her indictment or information was dismissed or she was acquitted, and she is filing the petition within two years of the dismissal, and that she is likely to succeed at trial in proving that she is innocent of the offenses charged in the indictment. She then attaches a memorandum to the petition, which basically simply asserts the evidence that was presented by the *defense* at the federal hearing, and says that that evidence shows that she is innocent.

6. The People believe defendant has not met her burden under 735 ILCS 5/2/702, and objects to the certificate of innocence being issued.

II. 735 ILCS 5/2-702

735 ILCS 5/2-702 states in pertinent part:

> (a) The General Assembly finds and declares that innocent persons who have been wrongly convicted of crimes in Illinois and subsequently imprisoned have been frustrated in seeking legal redress due to a variety of substantive and technical obstacles in the law and that such persons should have an available avenue to obtain a finding of innocence so that they may obtain relief through a petition in the Court

of Claims. The General Assembly further finds misleading the current legal nomenclature which compels an innocent person to seek a pardon for being wrongly incarcerated. It is the intent of the General Assembly that the court, in exercising its discretion as permitted by law regarding the weight and admissibility of evidence submitted pursuant to this Section, shall, in the interest of justice, give due consideration to difficulties of proof caused by the passage of time, the death or unavailability of witnesses, the destruction of evidence or other factors not caused by such persons or those acting on their behalf.

As such, a person who was wrongly convicted can file a petition for certificate of innocence to seek compensation in the Court of Claims. *People v. Dumas*, 2013 Il App (2d) 120561, ¶ 16. In fact, a court has found that, under a similar federal statute, a certificate of innocence serves no purpose other than to permit its bearer to sue the government for damages. *See Betts v. United States*, 10 F.3d 1278, 1283 (7th Cir. 1993). The People submit it was not meant as an avenue for a defendant who receives a benefit by the State dismissing crimes in exchange for a plea which is later found unconstitutional, to then receive a monetary windfall by suing the State as someone "wrongfully incarcerated." The State's position here as set forth below finds support in the Act's legislative history. It was never the General Assembly's intent that everyone who had his conviction overturned be entitled to a COI. To be sure, there are people who are entitled to a COI under the law and to financial damages for wrongful convictions or malicious prosecutions. But the bill's sponsor was clear that not every person whose conviction cannot stand is entitled to such relief:

> [T]hat's not the nature of this legislation. This legislation is about men and women who have been wrongfully convicted of a crime; they never should have been in jail in the first place. And in the absence of the Governor pardoning them, they cannot

> get what's rightfully theirs because their name is not cleared. They cannot get a job and they cannot get the rightful compensation that they truly deserve because the pardon is not there.

See Ill. Gen. Assem., House Proceedings, May 18, 2007 (statement of Representative Flowers). The General Assembly recognized that the COI statute carried significant financial consequences for Illinois counties. When § 2-702 was enacted in 2008, Representative Reboletti expressed concern "that you have a situation where the inmate will get a COI and then use that as additional evidence at at 1983 hearing in federal court. Most of the counties are self-insured and basically it's going to cost them millions and millions of dollars." Ill. Gen. Assemb,. House Proceedings, May 18, 2007 (statements of Representative Reboletti). The defendant here does not meet the criteria necessary to receive such a certificate.

In order to obtain a certificate of innocence the petitioner must prove by a preponderance of evidence that:

(1) the petitioner was convicted of one or more felonies by the State of Illinois and subsequently sentenced to a term of imprisonment, and has served all or any part of the sentence;

(2)(A) the judgment of conviction was reversed or vacated, and the indictment or information dismissed or, if a new trial was ordered, either the petitioner was found not guilty at the new trial or the petitioner was not retried and the indictment or information dismissed; or (B) the statute, or application thereof, on which the indictment or information was based violated the Constitution of the United States or the State of Illinois;

(3) the petitioner is innocent of the offenses charged in the indictment or information or his or her acts charged in the indictment or information did not constitute a felony or misdemeanor against the State; and

(4) the petitioner did not by his or her own conduct voluntarily cause or bring about his or her conviction. 735 ILCS 5/2-702.

Whether a person is entitled to a certificate of innocence is committed to the sound discretion of the circuit court and won't be overturned on appeal absent a finding that the court abused it discretion or the findings underlying the court's decision were clearly erroneous. *Rudy v. People*, 2013 IL App (1st) 113449, ¶ 11. Petitioner bears the burden of proof in these civil proceedings. Defendant must prove by a preponderance of the evidence not only that his conviction was vacated and that the charge was dismissed, but also that he "is innocent of the offenses charged in the indictment" and that he "did not by her . . . own conduct voluntarily cause or bring about his . . . conviction." 735 ILCS 5/2-702(g)(1)-(4). The question for this Court is whether, in light of all the evidence, it "is satisfied from the record before it that petitioner is altogether innocent." *United States v. Keegan*, 71 F.Supp. 623, 636 (S.D.N.Y. 1947).

7. Beside for the testimony for the defense in the federal hearing, which defendant sets forth in her petition as her claim for actual innocence, the following was presented by the respondent State, which is not included in defendant's petition for certificate of innocence.

8. Dr. Gary Hedlund (neuroradiologist testifying for respondent)

Dr. Gary Hedlund, a neuroradiologist from Primary Children's Medical Center in Salt Lake City, testified on behalf of respondent. Hedlund also works as part of the hospital's child protection services team.

Hedlund testified that his review of I.Z.'s case included a review of all I.Z.'s medical records and her imaging studies in the weeks following her collapse. Hedlund stated that he also reviewed the reports by the experts testifying on Del Prete's behalf.

Based on his review, Hedlund made a number of findings. First, he concluded that I.Z.'s imaging studies indicated that she had both acute and chronic subdural hemorrhages in various locations. Consistent with the testimony by Dr. Barnes, Hedlund stated that there were chronic subdural hemorrhages that already existed as of December 27, 2002 and that were at least two weeks and perhaps as much as three weeks old, or older, at that point. Hedlund testified that the acute hemorrhages ranged in age from a few hours to three days old. He stated that the imaging studies showed a number of hemorrhages of varying ages throughout I.Z.'s head in the subdural space, which he opined was indicative of abusive head trauma. Hedlund stated further that the chronic subdural collections were indicative of prior trauma, separate from the trauma that caused the acute subdural hemorrhages. He testified that the chronic hemorrhages could not have been caused by birth-related trauma, because subdural hemorrhages resulting from birth resolve within the first month of an infant's life.

Hedlund further testified that the imaging studies showed that I.Z. had multiple hemorrhages near the top of her head. He said this strongly suggested ruptured bridging veins. Hedlund testified that ruptured bridging veins are a further indication of abusive head trauma. He described the continuity between cortical veins and bridging veins, stating that cortical veins come together to form bridging veins, which eventually dump venous blood into the even larger sinuses. Hedlund opined that I.Z.'s hemorrhages were the result of injury to the bridging veins, rather than the smaller cortical veins. Hedlund disagreed with Barnes's conclusion that ruptured bridging veins would create larger areas of hemorrhage than were visible on I.Z.'s imaging studies. He opined that ruptured bridging veins do not necessarily cause large hemorrhages but can instead cause several sites of bleeding throughout the subdural space.

Hedlund next testified that he believed that both I.Z.'s CT scan from December 27 and her MRI from January 7 showed evidence of a retroclival epidural hematoma. Hedlund explained that a retroclival epidural hematoma is a collection of blood on the dura mater in the central skull base. He opined that a retroclival epidural hematoma is a proxy for trauma to the neck, because neck injuries are difficult to identify on imaging. He estimated that this injury was one to two weeks old as of January 7 and between a few hours and seven days old as of December 27, though he conceded that making an aging estimate is imprecise. Hedlund stated that he did not believe that what he was seeing on the image was an "artifact" (i.e. that it did not represent something that was actually present). Hrg. Tr. at 271–72. He agreed, however, that retroclival hemorrhages are "a challenging diagnosis" because of the amount of bone in the space, particularly with a 2003–vintage MRI scan like the one he had reviewed.

Hedlund stated that I.Z.'s chronic subdural collections increased in size after December 27, but he opined that at the time of her collapse, the collections were not large enough to have caused her collapse. He also testified that a metabolic disorder could not have caused the collapse, because metabolic problems are typically accompanied by changes that are reflected in the imaging studies, which were not present in I.Z.'s case. Hedlund also stated that I.Z.'s collapse could not have been caused by an infection, because imaging showed that there was no middle ear or mastoid infection in December 2002. Hedlund conceded that fluid had appeared in I.Z.'s ears by January 3, 2003 but stated that fluid commonly appears in patients following a period of hospitalization. In sum, Hedlund opined, I.Z.'s imaging studies were indicative of abusive head trauma.

On cross examination, Hedlund conceded that the full-body x-rays taken of I.Z. (referred to as skeletal surveys) did not indicate any swelling or injury to I.Z.'s neck and that no clinician who

examined I.Z. had found any abnormalities in the neck area. He also agreed that none of the other examining radiologists had found a retroclival epidural hemorrhage as of December 27. Hedlund testified, however, that the retroclival area was deep within the tissue and likely would be invisible to a clinician. He acknowledged that adults can sometimes develop retroclival epidural hemorrhages spontaneously, though he said he has never seen this occur in children. Hedlund testified that it was possible, though unlikely, that a retroclival epidural hemorrhage could be caused by a lumbar puncture, but he also admitted that retroclival epidural hemorrhages are rarely diagnosed in general. Finally, he agreed that most reports of retroclival epidural hemorrhages are from automobile and automobile-vs.-pedestrian collisions.

Hedlund admitted that the white area of acute activity that he observed in images at the right frontal area of I.Z.'s brain could be a thrombosed cortical vein. He further testified that cerebral venous thrombosis (of which cortical venous thrombosis is a type) can cause seizures, which in turn can cause apnea—cessation of breathing—and temporary heart failure. He agreed that a person with cortical venous thrombosis can present with seizures or drowsiness and that a common underlying condition is an infection. Finally, Hedlund admitted that cerebral venous thrombosis can be difficult to diagnose.

Regarding the chronic collections seen in the images of I.Z.'s brain, Hedlund testified that the chronic hemorrhages could have been three weeks old or older as of December 27. He repeated that in his view, these were the result of previously inflicted abusive head trauma. He further stated that the chronic collections were just as big as the acute collections, and he characterized both types of collections as small. He stated that although he believed the chronic hemorrhages could not themselves have caused I.Z. to collapse on December 27, they could have contributed to her collapse.

Finally, Hedlund testified, consistently with Dr. Barnes, that he found no evidence of lacerations orcontusions to I.Z.'s brains based on her imaging studies.

9 Dr. Nagarajan Rangarajan (biomechanical engineer testifying for respondent)

Respondent presented the testimony Dr. Nagarajan Rangarajan, a biomechanical engineer and an associate professor in the Neurosciences Research Laboratory at the Medical College of Wisconsin. Rangarajan opined that the science of biomechanics cannot determine the cause of I.Z.'s injury and cannot yet determine the threshold necessary to produce head injuries in infants. He said that animal experiments have been done but that mass scaling, which takes differences in mass into account when extrapolating data, does not sufficiently account for other differences in material properties that exist between animals and infants or between adults and infants. He also stated that infant brains are anatomically different than adult brains, and thus simply adjusting for the differences in mass would not produce reliable injury threshold results. Rangarajan also stated that human cadaver experiments likewise are inadequate, because the brain of a dead person has different properties from that of a living person.

Rangarajan also noted that the animal experiments that Dr. Prange relied upon in determining the injury threshold for head injury subjected the animals to a single whiplash-type event. Rangarajan stated that he did not believe these experiments reliably establish the injury threshold sufficient for head injury in infants as a result of shaking back and forth multiple times. He therefore opined that there is no reliable, well-accepted injury threshold for head injury to an infant as a result of rotational acceleration (i.e., shaking back and forth). Rangarajan also testified that there similarly was no reliable, well-accepted injury threshold established for neck injury in an infant.

On cross examination, Rangarajan testified that mass scaling is an appropriate method of extrapolation, provided that appropriately comparable subjects are used. He stated, however, that he did not believe infant brains could be appropriately compared to either animal or adult brains. He also agreed, of course, that live human testing of infants is not possible.

Finally, Rangarajan stated that Dr. Flaherty, the prosecution's expert at Del Prete's criminal trial, was wrong when she testified that a fall could not produce levels of acceleration as great as shaking alone.

10. Dr. Brian Forbes (ophthalmologist testifying for respondent regarding retinal hemorrhages). Respondent called Dr. Brian Forbes, a pediatric ophthalmologist at the Children's Hospital of Philadelphia who also teaches as the Pennsylvania School of Medicine. He reviewed I.Z.'s medical records, the police reports, excerpts of the testimony at Del Prete's trial, and the reports from other experts who testified at the evidentiary hearing. Based on his review, he concluded that there were no reports of any problems with I.Z.'s eyes prior to December 27.

Forbes testified that the day after I.Z.'s collapse, three different ophthalmologists at the UIC Medical Center examined I.Z.'s eyes using an indirect ophthalmoscope, a device used to get a three-dimensional view of the retina in an eye. All three doctors noted numerous retinal hemorrhages, including intraretinal, preretinal, and vitreous hemorrhages. Preretinal hemorrhages are located on top of the retina and are the biggest in size, and intraretinal hemorrhages are located deep within the tissue of the retina and typically appear in the shape of dots and flames. Forbes testified that subretinal hemorrhages may also occur, but they can be very hard to detect if the retina is bloody. Forbes stated that two of the ophthalmologists indicated trauma as the most likely cause.

Forbes testified that although I.Z.'s eyes were examined on December 28, the photographs (referred to as fundoscopic photographs) depicting her retinal hemorrhages were not taken until December 30. He stated that the fundoscopic photographs from December 30 showed that I.Z. had retinal hemorrhages too numerous to *932 count, including both preretinal and intraretinal hemorrhages. Forbes further stated that the hemorrhages extended all the way to the ora serrata—the foremost part of the retina nearest the lens. He testified that by January 13, 2003, the date the next set of fundoscopic photographs were taken, all but the preretinal hemorrhages had resolved in I.Z.'s eyes. Forbes concluded that he agreed with the ophthalmologists at the UIC Medical Center that abusive head trauma was the most likely cause of I.Z.'s retinal hemorrhages.

Forbes opined that cortical venous thrombosis did not cause I.Z.'s retinal hemorrhages. He stated that he had never heard of cortical venous thrombosis causing retinal hemorrhages and that he has examined twenty-four children with cortical venous thrombosis and found no retinal hemorrhaging in any of them. He admitted that there have been reports of children with cortical venous thrombosis with a few hemorrhages near the optic nerve (called peripapillary hemorrhages), but he had never heard of cortical venous thrombosis causing the extent of retinal hemorrhaging documented in I.Z.'s eyes. Forbes also opined that the severe retinal hemorrhages present in I.Z.'s eyes on December 28 could not have been the result of CPR, a seizure, or hypoxia. He agreed that an infection can cause retinal hemorrhaging, but to cause hemorrhaging this severe, he said, there would have to be a very serious infection like meningitis, which I.Z. did not have.

Forbes further opined that retinal hemorrhaging can be severe at birth, but the hemorrhages are almost always intraretinal (not preretinal), and they typically resolve within seven to ten days. He stated that if I.Z. had retinal hemorrhaging at birth, the blood would have cleared before

December 27. Finally, he testified that disorders associated with bleeding abnormalities can also cause retinal hemorrhaging, but only those disorders that cause a tendency to bleed too easily. Forbes opined that a clotting disorder (for which I.Z. was not tested) could not cause spontaneous retinal hemorrhaging.

On cross examination, Forbes admitted that ophthalmologists cannot identify the precise mechanism in the body that causes retinal hemorrhaging and that medicine has not established a causative relationship between abusive head trauma and retinal hemorrhages. He hypothesized that the hemorrhages may be the result of the vitreous pulling back and forth against the retina as the baby is being shaken, but he admitted that this hypothesis would not explain retinal hemorrhages from other causes, such as blunt force trauma. Forbes admitted that ophthalmologists have not yet identified any mechanism to explain why or how motor vehicle accidents could cause retinal hemorrhages that extend to the ora serrata.

Forbes testified that he could not identify the specific timing of I.Z.'s hemorrhages. He stated that the intraretinal hemorrhages could have been present in I.Z.'s eyes for up to two weeks before the fundoscopic photographs were taken on December 28, and that the preretinal hemorrhages could have been present for four to six weeks before I.Z. collapsed. Forbes agreed that I.Z. did not have any perimacular folds or retinoschisis, which he agreed are also highly associated with abusive head trauma.

Finally, like Dr. Barnes, Forbes testified that prosecution expert Dr. Flaherty was incorrect when she testified at Del Prete's trial that hemorrhages to the ora serrate are caused only by acceleration or deceleration forces.

11. Dr. Carole Jenny (child abuse pediatric physician testifying for respondent)

Respondent called Dr. Carole Jenny to testify. Given the extensiveness of Jenny's testimony, the Court has organized the following discussion by subject matter.

Jenny is the director of the child protection program at Hasbro Children's Hospital and a professor of pediatrics at Brown Medical School in Providence, Rhode Island. She edits a textbook that she considers to be the "definitive text" on child abuse. Hrg. Tr. at 1044.

Jenny concluded, based on her review of the medical records, imaging studies, and the autopsy, that I.Z. suffered an episode of abusive head trauma at Del Prete's hands on December 27 that led to cardiorespiratory arrest and severe brain damage and eventually to her death. She said there was no other viable explanation for I.Z.'s collapse.

Jenny stated that when an infant has suffered abusive head trauma, she experiences primary injuries—including brain contusions, torn bridging veins, and axonal injury—from the forces applied to the head, and those primary injuries cause secondary injuries like hypoxia-ischemia and metabolic collapse. She stated that brain edema begins "[i]n the short term" after an episode of abusive head trauma, but then the brain returns to normal size and eventually contracts, though the process of shrinkage does not show up on imaging studies for days to weeks afterward. Hrg. Tr. at 1047–48. She later stated, however, that the onset of brain edema is not always immediate but rather is "really quite variable" and that it begins to develop between two hours to one to two days after the injury. Hrg. Tr. at 1077–78.

Jenny was asked about the absence of external injuries. She stated, in contrast to Dr. Scheller, that shaking an infant often does not leave external injuries. Referencing a 2004 article by Dr. Rorke-Adams (another witness for respondent), Jenny testified that there are four specific injuries that result from "violent shaking: 1. subdural hematoma, typically between the two cerebral

hemispheres; 2. retinal and optic nerve sheath hemorrhages; 3. tears of cerebral white matter, especially corpus callosum; and 4. tears and hemorrhages of cervical or more caudal spinal *937 cord and/or nerve roots." Hrg. Tr. at 1062–63 (quoting Resp.'s Ex. Jenny 3 at 29).

On cross-examination, Jenny conceded—though with some initial reluctance—that a chapter in the textbook she edits that she characterized as "one of the best chapters in the book," Hrg. Tr. at 1179, states that no one has marshalled a coherent argument to support shaking alone as a causal mechanism for abusive head injury, and that the only evidence basis for this proposition consists of perpetrator confessions. See Hrg. Tr. at 1179–80. She conceded that she was not aware of the circumstances of confessions relied on in this regard or the tactics used to elicit them. Jenny also stated, however, that parents have made admissions to her and her colleagues of shaking followed by immediate symptoms, though she conceded she did not know whether these parents had tried to minimize by saying they had done nothing more than shake their children.

Regarding the issue of neck injury, Jenny testified that doctors frequently fail to recognize neck (cervical) injuries in cases of abusive head trauma because of the manner in which autopsies typically are done. According to Jenny, around 2009, Dr. Rorke-Adams and others at the Children's Hospital in Philadelphia began to remove both the brain and the attached spinal cord as a single unit when doing an autopsy. Jenny stated that Rorke-Adams concluded that about 70 percent of the children who had suffered abusive head trauma had bleeding in the cervical spinal cord or the nerve roots surrounding it. Rorke-Adams's article also noted that "MR imaging failed to identify the cervical injuries among inpatients." Resp.'s Ex. 4 at 237. Jenny also said that if such injuries occurred in a patient who survived for another eleven months, the injuries likely would heal in the

interim and would not be observable on autopsy. Jenny conceded on cross-examination, however, that Rorke-Adams's findings have not been validated by other studies.

Regarding retinal hemorrhages, Jenny opined that severe multi-layered retinal hemorrhages—like those seen in I.Z. in the days following her collapse—are typically associated only with severe trauma, sepsis, coagulopathy (which she defined as a tendency to clot too little, not to clot too much or too quickly), or a combination of those conditions. Jenny also stated that seizures cannot by themselves, without some underlying medical condition, cause a child to develop retinal hemorrhages.

Jenny opined that in severe cases, abusive head trauma can result in immediate neurological collapse. She referenced a 2004 study which found that of the 57 cases of suspected abusive head trauma where caretakers described the onset of symptoms, 91 percent of them described the symptoms as occurring immediately after the trauma. Jenny testified that according to Del Prete's statements to police, I.Z. fed normally between 8 a.m. and 10 a.m. on the morning of December 27. She stated that infants need coordination in order to suck and swallow, and she would not expect a child who had already suffered a near-fatal brain injury to be able to perform those functions.

On cross-examination, Jenny testified, initially, that she believes that an infant does not have a "lucid interval" following *938 an episode of abusive head trauma. Hrg. Tr. at 1178. She agreed that if there can be a lucid interval of more than four or five hours after abusive head trauma, then Del Prete was not the only possible perpetrator. Upon further questioning, Jenny conceded that symptoms appear more slowly in some victims, though she said that an infant would not appear "normal" after a serious brain injury. She agreed, however, that "not normal" does not necessarily mean immediate loss of consciousness or cessation of breathing, but rather can involve listlessness,

sleeping a lot, irritability, or vomiting. See also Hrg. Tr. at 1197 ("[M]ost pediatricians would say that after an abusive head trauma episode ..., you'll see vomiting, irritability in the absence of fever and increased sleepiness and lethargy as signs of trauma."). The Court notes that these are signs that Del Prete told the police that I.Z. had shown on December 27. Jenny said that these sorts of signs could be mistaken as the result of "colic," acid reflux, or a stomach virus, and she agreed that there was some evidence from daycare workers other than Del Prete that I.Z. had displayed these signs prior to December 27. Jenny also agreed that quivering lips (another sign reported by Del Prete) can be a sign of a seizure. She stated, however, that although symptoms can progress slowly, this means over a matter of hours, not over days, "[i]n an injury that's as devastating as this one." Hrg. Tr. at 1193. That said, Jenny agreed that more recent studies have indicated that there can be a lucid interval after abusive head trauma in which a baby does not appear perfectly normal but yet does not crash.4 She also agreed that this makes it harder to pinpoint the timing of the trauma. Significantly, she also agreed that one can no longer accurately say that the head trauma must have been caused by the last person to see the baby conscious.

Regarding I.Z.'s subdural hemorrhages, Jenny agreed that the CT scans of I.Z.'s head ordered at Provena St. Joseph Hospital showed both acute and chronic subdural hemorrhages. On cross-examination (and again on recross), Jenny stated that she believed that I.Z.'s chronic subdural hemorrhages were caused by a prior episode of abusive head trauma that had ruptured I.Z.'s bridging veins, at some point before December 27. When asked if she agreed with Dr. Hedlund that the chronic subdural hemorrhage was at least two weeks old or more at the time of I.Z.'s hospital admission, she said, "I would leave that to the radiologists," and she stated (contrary to respondent's

expert Dr. Rorke–Adams, see infra) that pediatricians generally rely on what radiologists say in this regard. Hrg. Tr. 1155.

Jenny also said that I.Z.'s chronic hemorrhage was too small to compress her brain sufficiently to cause her collapse sooner. She conceded, however, that the chronic hemorrhage was larger than the acute subdural hemorrhages and that the increasing size of the chronic hemorrhage eventually (post-hospitalization) required surgery to relieve intracranial pressure.

Jenny stated that subdural hemorrhages are typically a marker of trauma, rather than themselves the cause of brain injury. She opined that most infants who suffer from abusive head trauma do not die because of their subdural hemorrhages. Rather, they die because the brain edema compromises the blood's ability to circulate throughout the brain, and brain tissue dies as a result. She explained that the hypoxia-ischemia that kills brain tissue is a secondary injury that results from brain edema, which is the direct result of abusive head trauma.

Jenny agreed that if a chronic subdural hemorrhage is of significant size, it can cause other veins to stretch and rupture with additional trauma, including minor, unintentional trauma. She testified, however, that I.Z.'s acute hemorrhages could not have resulted from a rebleed of the chronic subdural hemorrhages, because the acute hemorrhages were also found in the falx and tentorium, whereas the chronic hemorrhages were found only in I.Z.'s frontal lobe. Jenny also opined that a rebleeding hemorrhage could not produce the amount of hemorrhage documented in I.Z.'s imaging studies. Instead, she stated, rebleeds in hemorrhages appear on imaging as small outlines around the outside of the chronic hemorrhage. She further opined that rebleeding hemorrhages do not cause infants to suffer brain injury or to deteriorate and that I.Z.'s chronic hemorrhage could not have caused her to collapse. The chronic hemorrhage, Jenny stated, was not particularly large and thus did

not, in her view, cause increased intracranial pressure. "Another event," Jenny stated, "would have had to precipitate the failure of her brain." Hrg. Tr. at 1150. She stated that ruptured bridging veins, which carry significantly more blood than a capillary found in a membrane of a chronic hemorrhage, were more likely to have caused the amount of bleeding documented on I.Z.'s imaging. She clarified, however, that a ruptured bridging vein would not necessarily "cause so much bleeding that the child needs emergency surgery." Hrg. Tr. at 1117.

There were also questions that concerned attempting to date I.Z.'s chronic subdural hemorrhage. Jenny agreed that a chronic subdural hemorrhage can manifest itself externally through an increase in head circumference. On direct examination, she testified that I.Z.'s head circumference started at the 50th percentile, increased to the 90th percentile over her first month-and-a-half, and then grew at that level through late December. She initially characterized this as a stable growth pattern and stated that I.Z.'s head grew a total of 41/2 centimeters over the course of six weeks, which she said was similar to the average gain of two centimeters per month.5 On cross-examination, however, Jenny conceded, after further examination of the data, that I.Z.'s head circumference actually may have increased more quickly than she had testified on direct examination, as compared to a normal infant's head growth. Jenny also agreed that I.Z.'s head grew just under 4 centimeters between birth and her one-month examination and that this is greater than average growth.

Jenny testified, however, that she could not determine "one way or the other" whether this indicated that I.Z. may have developed the chronic subdural hematoma during that period of more rapid head growth. Hrg. Tr. at 1170. She testified that I.Z.'s anterior fontanelle—the soft spot at the top of an infant's head—was described as soft and flat each time she was examined before her

collapse, which indicated that there was no increased intracranial pressure and thus the increased head circumference was no cause for concern. She stated that doctors did note that her fontanelle was bulging on December 28, the day after her collapse. According to Jenny, this timeline indicated that I.Z.'s brain was not under unusual pressure until "the final event" occurred. Hrg. Tr. at 1284. She admitted, however, that an infant may have a subdural hematoma and nonetheless have a fontanelle that appears normal. In summary, however, Jenny said that the head circumference increase did not assist in pinpointing the date when I.Z.'s chronic subdural hemorrhage first appeared.

Jenny rejected the possibility that I.Z.'s condition could have resulted from birth trauma. She testified that the medical records reflected that I.Z. had a normal childbirth without any labor complications. She noted that I.Z. was given oxygen but stated that most newborns receive oxygen for a short period to "pink[ ] them up." Hrg. Tr. at 1090. According to Jenny, the cephalohematoma and occipital caput that I.Z. had at birth are very common and are caused by traction on the skull during the birth process. She stated that I.Z.'s high Apgar scores showed a strong transition to extrauterine life and that I.Z.'s two-day stay in the hospital without any visit to the neonatal intensive care unit was a further indication that she did not suffer any trauma from birth. Jenny noted that I.Z. was discharged from the hospital as a "[n]ormal newborn" and was described as "healthy" in both her one-month and two-month evaluation. E.R. 1091–93. Jenny also agreed that subdural hemorrhage can result from birth but stated that in that event, the hemorrhage is typically located in the tentorium, not the frontal lobe where I.Z.'s was found.

Jenny testified that although I.Z. was admitted to the hospital for a fever on October 23, 2002, the hospital tested her blood and urine and found no infections and therefore discharged her. She described this visit as "routine conservative care." Hrg. Tr. at 1094. Jenny acknowledged that I.Z.

had an elevated platelet count documented during this hospital stay but stated that this condition, thrombocytosis, is common in infants who have a fever. She opined that I.Z.'s thrombocytosis was secondary, not primary (though she declined to rule out that the increased platelet count was associated with the prior abusive head trauma that she believed caused the chronic hemorrhage). Jenny stated that because I.Z.'s thrombocytosis was reactive, it could not have caused clotting problems, even when her platelet levels increased to over a million platelets per drop of blood. She acknowledged some support in the literature for an association of "thrombotic complications" with reactive thrombocytosis but interpreted the literature as indicating this occurs in children with an underlying serious illness.

Jenny agreed that I.Z. had highly elevated platelet counts at certain points but interpreted this as a response to stress or trauma. In particular, she testified that the thrombocytosis documented in I.Z.'s medical records on December 27 meant "that she was very stressed and her body was responding vigorously." Hrg. Tr. at 1113. Jenny stated that the fact that I.Z.'s platelet count returned to normal by the time she arrived at Children's Memorial Hospital in January 2003 further indicated that her thrombocytosis was secondary, rather than primary, and that her platelet level decreased once the stress to her system was removed. According to Jenny, I.Z.'s platelet level remained within the normal range for most of the remainder of her life. In addition, she opined that if I.Z. had thrombophilia, one would have expected to see abnormal clots throughout her body, and not just in her head.

Jenny rejected seizures as a possible cause of I.Z.'s collapse. She stated that none of the electroencephalograms (EEGs) done on I.Z. at Provena St. Joseph Hospital, *941 UIC Hospital, and Children's Memorial Hospital showed any seizures.

Jenny also rejected the possibility that cortical venous thrombosis could have caused I.Z. to collapse. She stated that cortical venous thrombosis is typically associated in young children with illness and severe dehydration, and it rarely occurs in the absence of severe vomiting and diarrhea (which causes the dehydration). She agreed with Dr. Scheller that an infection can cause cortical venous thrombosis, but she opined that if that were the case, the thrombosis would be located near the site of the infection, rather than diffuse around the brain. Jenny stated that Dr. Leestma's finding of recent fibrin platelet thrombi in several small cortical veins within the cerebrum (see infra) did not, in her view, indicate that I.Z. previously had cortical venous thrombosis. Instead, she opined that those thrombi could have been caused by the fact that I.Z. was brain dead in the 24 to 36 hours preceding her death and thus would not have had good circulation throughout her brain.

12. Dr. Lucy Rorke-Adams (pediatric neuropathologist testifying for respondent)

Respondent called Dr. Lucy Rorke-Adams, a pediatric neuropathologist currently serving as a consultant for the Medical Examiner's Office in Philadelphia, Pennsylvania. Rorke-Adams reviewed all of the medical reports, police and paramedic reports, the autopsy report and photographs, microscopic slides of I.Z.'s brain prepared in July 2012, trial testimony, and the reports by Dr. Teas, Dr. Hedlund, and Dr. Forbes.

Rorke-Adams testified that the photographs of I.Z.'s brain taken at the autopsy in (which slowed the sectioned slices of brain laid out on an examination table) indicated that I.Z. had hardly any residual *943 tissue on the bottom surface of her frontal lobe. Rorke-Adams stated that the photograph of the sliced coronal sections of I.Z.'s brain showed that the frontal part of the brain, which she concluded was placed near the middle of the table at the bottom, was severely damaged, "falling to pieces," and was "hardly recognizable as brain." Hrg. Tr. at 697. The section of the brain

immediately posterior to the frontal section was also damaged and showed an area of tissue that was missing from the brain.

Rorke-Adams also testified about her review of microscopic slides prepared by Dr. Leestma along with Dr. Tourtellotte and Dr. Teas. Rorke-Adams stated that she believed that one of the slides had been mislabeled. Specifically, she testified that slide 16, labeled the "Periventricular Posterior Cortex and White Matter," an area located toward the back of the brain, did not have "the anatomical configuration of what [she] would expect the brain to look like in that region." Hrg. Tr. at 712. Based upon that observation, she believed that the slide actually depicted the gyrus rectus, which is located toward the front of the brain, on the underside of the frontal lobe. According to Rorke-Adams, the gyrus rectus is a common site of injury in infants who suffer from abusive head trauma because it is located just above a very rough bone that forms the floor of the skull. When an infant's soft brain tissue is forced across that surface, she testified, the brain tissue suffers contusions and lacerations. Rorke-Adams testified that slide 16 showed that I.Z.'s gyrus rectus had been injured severely. Specifically, she stated that the outer layer of cerebral cortex had been "practically totally destroyed," Hrg. Tr. at 719, and that the staining of the tissue, a process used to show the presence of any reactive cells responding to injury, was irregular. Rorke-Adams concluded that irregular staining was indicative of severely damaged tissue of varying degrees. She also testified that the presence of iron within that tissue, as shown by the staining, indicated that the damage must have appeared before death, because the breakdown of blood sufficient for iron to appear microscopically takes some time. She further opined that the microscopic slides depicting I.Z.'s corpus callosum—the band of fibers connecting the two hemispheres of the brain—showed signs of scarring and degeneration. Rorke-Adams concluded that the scarring in the corpus callosum indicated a previous injury, and she

testified that trauma is the most common cause of damage to the corpus callosum. She opined that although hypoxia-ischemia can cause necrosis and scarring in the outer cerebral cortex of the brain, it was less likely to cause damage to the corpus callosum, located within the white matter of the brain, because of its low vulnerability to lack of oxygen. Rorke-Adams thus concluded that the damage to the corpus callosum was likely the result of trauma rather than hypoxia-ischemia.

Rorke-Adams disagreed with Dr. Leestma's conclusion in his report that one of the slides depicted thrombosed cortical veins that had thrombosed prior to I.Z.'s death. She opined that the clots pictured in the slide were quite recent and had not yet undergone organization. She also stated that these were small, isolated thromboses that had no pathological significance and did not indicate any sort of coagulopathy. She explained that this type of thrombosis can occur when there is a breakdown of normal circulation of the blood.

Instead, Rorke-Adams concluded that I.Z.'s brain suffered a number of injuries. First, she concluded I.Z. had subdural hematomas. She stated that these were chronic (old) at the time of her death but that they did exist prior to December 27, 2002. (In this regard, Rorke-Adams differed from every other witness on both sides who testified on this topic.) Second, she concluded that I.Z. had a fronto-orbital contusion (the claimed injury to the gyrus rectus she had previously referenced). Third, she determined that I.Z. had multiple areas where tissue from both the outer cerebral cortex and the internal white matter had begun to die or scar as a result of the cardiorespiratory arrest she experienced at the time of the injury on December 27. Fourth, she concluded that I.Z. had a site of chronic damage to the cerebellum, which Rorke-Adams also attributed to the cardiorespiratory arrest that I.Z. suffered on the day of her collapse. Fifth, she concluded that I.Z. had suffered injury in an

area of her brain stem that Rorke-Adams opined was particularly susceptible to injury following a period of cardiac arrest.6

Rorke-Adams concluded that all of these injuries were the result of abusive head trauma, more specifically, a single incident of abusive head trauma that took place on December 27, 2002. See Hrg. Tr. at 754. Her conclusion was based on part on contusions and lacerations that she claimed to have observed in the autopsy photographs of the sectioned brain. See Hrg. Tr. at 727–28. She stated that the single incident of trauma caused I.Z. bilateral subdural hematomas, contusions, and lacerations on her brain and eventually led to cardiorespiratory arrest.

Rorke-Adams opined that I.Z. was subjected to abusive head trauma by shaking, and that "[t]here may have been an impact associated with the attack.". Hrg. Tr. at 754. She acknowledged that there was no evidence of impact but justified this aspect of her conclusion by stating, "this is a phenomenon which may occur at the time of the shaking and show no evidence of impact because the impact is against a soft surface." Hrg. Tr. at 756. After being pressed further on the issue of impact, however, Rorke-Adams backed off, saying that impact was not part of her diagnosis, and she agreed, "we can throw it out." Hrg. Tr. at 758.

Rorke-Adams rejected alternative explanations for I.Z.'s injuries, including cortical venous thrombosis, birth trauma, or an infection complicated by hypoxia-ischemia. She stated that if I.Z.'s condition had been caused by cortical venous thrombosis, the pattern of damage to her brain would have been different from what was observed. Regarding birth trauma, Rorke-Adams said there was no indication of significant birth trauma, Regarding hypoxia-ischemia, she stated that although some of I.Z.'s injuries were related to hypoxia-ischemia, that could not account for the contusions and lacerations or the subdural hematoma.

Rorke-Adams also rejected the idea that I.Z.'s collapse could have been caused by rebleeding from a previously existing chronic subdural hemorrhage. In this regard, she opined, as noted above, that I.Z. did not have a chronic subdural hemorrhage prior to December 27, 2002. She rejected the conclusions by both sides' radiologists to the contrary,7 explaining this by stating that "radiologists agree with each other." Hrg. Tr. at 733. She testified *945 on redirect that the reason she rejected the radiologists' conclusion that I.Z. had a chronic subdural hematoma is that subdural hematomas contain both cerebrospinal fluid and blood, which makes the hematoma hard to distinguish in terms of chronicity based on imaging alone.

Rorke-Adams testified that even if I.Z. did have a chronic subdural hematoma prior to her collapse, that would not change her opinions because, she said, "it was asymptomatic," Hrg. Tr. at 734, and small chronic subdural hematomas are not problematic in infants. She admitted, however, that she had not examined I.Z.'s imaging studies to assess the size of the chronic subdural hematoma. She stated that any chronic hematoma must have been small, because there was "no clinical manifestation of central nervous system dysfunction" prior to her collapse. Hrg. Tr. at 738. Rorke-Adams further testified that minor trauma could have caused any of the chronic subdural hematomas. She admitted, however, that if the acute subdural hemorrhages were the same size as the chronic ones, the same type of minor trauma theoretically could have caused the acute subdural hemorrhages.

Rorke-Adams appeared to agree with Dr. Leestma's conclusion that I.Z.'s dura contained multiple layers of neomembranes, and she stated that this could indicate multiple incidents of hemorrhage. She agreed that the dura is a vascular structure that can easily bleed without any

inflicted trauma. She testified on redirect, however, that intradural bleeding is not uncommon for infants and would have no clinical significance.

On the question of cortical venous thrombosis, Rorke-Adams stated, again in contrast to experts on both sides (including respondent's expert Dr. Hedlund), that this condition is easy to diagnose, and that the fact that it had not been diagnosed in I.Z. is why she believed it was clear that she did not have that condition. See Hrg. Tr. at 743. Rorke-Adams testified that she based her view about ease of diagnosis on the fact that clinicians at the hospital where she works diagnose children with cerebral vein thrombosis "not infrequently ...," Hrg. Tr. at 747, though she acknowledged that she had no way to tell how often the diagnosis is missed. Rorke-Adams disagreed with published reports stating that cortical venous thrombosis can be difficult to diagnose. She also said that if it were the case that imaging showed I.Z. had a thrombosed cortical vein, this would not affect her opinion. See Hrg. Tr. at 749. She admitted that cortical venous thrombosis can cause a child to seize, which in turn can cause a child to stop breathing and cause cardiac arrest. She also agreed that if I.Z. had cortical venous thrombosis prior to December 27, abuse would not even have been suspected. See, e.g., Hrg. Tr. at 749. She said, however, that patients with cortical venous thrombosis do not present with bilateral subdural hematomas. Rorke-Adams also said that if I.Z. had suffered from significant cortical venous thrombosis that caused her clinical picture, she would have had large areas of hemorrhage through the cerebral cortex and white matter of the brain due to the back-up of the veins, which she did not have.

Regarding her testimony that there were contusions and lacerations on I.Z.'s brain, Rorke-Adams acknowledged that no other expert on either side had reached this conclusion. She also acknowledged that the Dr. Harkey, the medical examiner who conducted the autopsy, had not

reported any contusions or lacerations on the brain, and she agreed that medical examiners who conduct autopsies are well-trained in looking for contusions and lacerations.

Upon further questioning, Rorke-Adams acknowledged that what she considered to be trauma-caused damage to the frontal part of I.Z.'s brain was the same on the top and bottom, even though only the bottom (underside) of the frontal lobe has the potential to scrape against rough bone as she described. Asked to explain this, Rorke-Adams said, somewhat vaguely, that "there must have been so much force in the movement of the brain that something interfered with the—all of the tissue...." Hrg. Tr. at 837. She characterized the damage to I.Z.'s brain as "horrible," even as compared to other trauma-damaged brains she has seen in her work. Id.

Rorke-Adams stated that in her opinion, the conditions that she considered to be contusions and lacerations on I.Z.'s brain could not have occurred when the medical examiner removed the brain during the autopsy. She stated that medical examiners are generally well-trained in removing the brain without causing damage. She disagreed with the finding by Dr. Harkey, the medical examiner who conducted the autopsy, the whole brain was soft and mushy. (There was no real attempt to reconcile Rorke-Adams's statement that a medical examiner like Harkey is generally good at extracting a brain from a skull without damaging it with her apparent conclusion that he was completely deficient in recognizing brain lacerations and contusions.) Rorke-Adams agreed that a "respirator brain" is mushy overall and will "fritter[ ] away when you try to handle it." Hrg. Tr. at 803. She stated on redirect, however, that the rest of I.Z.'s brain did not "look like a respirator brain" and repeated that she believed the frontal lobes showed severe damage. Hrg. Tr. at 821.

Rorke-Adams conceded that she could not date the contusions and lacerations she claimed to see, other than to say they were "months" old at the time of I.Z.'s death in November 2003. She

could not put an outer limit on the age of these injuries, saying they conceivably could date back to her birth. See Hrg. Tr. at 804. Finally, she testified that I.Z. did not have a left frontal contusion, and that Dr. Flaherty, the prosecution's expert at Del Prete's criminal trial, was wrong when she testified to the contrary.

It was apparent from Rorke-Adams's testimony that her claim that I.Z. had brain contusions and lacerations was largely dependent on her understanding of how the brain sections were laid out on the autopsy photo she reviewed and her claim that the aforementioned microscopic slide prepared by Dr. Leestma under the supervision of Dr. Tourtellotte and Dr. Teas had been mislabeled. On the latter point, Rorke-Adams disagreed with the participants' own statements regarding how they had prepared the slides. See Hrg. Tr. 771–72. Rorke-Adams's testimony on these points was, the Court finds, completely unbelievable and unreliable. Her own testimony and later questioning of Dr. Teas showed that she had viewed the autopsy photo of the brain sections upsidedown and had drawn erroneous and unwarranted conclusions from this, and that she did not take into account other factors that accounted for the physical damage she observed, specifically the mushy condition of the brain at autopsy and the likelihood of damage that occurred in removing it. And the testimony of Dr. Leestma, discussed earlier, established to the Court beyond peradventure that the microscopic slide that Rorke-Adams interpreted as showing damage in the gyrus rectus was, contrary to her testimony, correctly labeled. Dr. Rorke-Adams drew an erroneous conclusion about the part of the brain that the slide depicted.

Del Prete v. Thompson, 10 F. Supp. 3d 907, 926–50 (N.D. Ill. 2014).

13. As such, there was evidence presented at the evidentiary hearing that showed petitioner had committed this crime. This is in conjunction with the fact that at the time the police interviewed

defendant, she admitted to slightly shaking the child. The only finding by the federal court was that the defendant had established actual innocence sufficient to allow her to overcome her procedural default in federal court, and that found the answer to the question, "whether any reasonable juror who heard all of [the evidence, old and new], could find Del Prete guilty beyond a reasonable doubt," was a "rather resounding no." However, the federal court did not exonerate defendant and did not vacate her conviction at that time. Evidence that a federal court made findings in the context of a collateral proceeding is not relevant to the issue involved here, whether petitioner is actually innocent. The district court judge made its ruling in determining whether defendant had excused a procedural default, or as a "gateway actual innocence claim," to allow her to raise a different constitutional claim, not as a "freestanding actual innocence claim." The federal courts distinguish between freestanding and gateway claims of actual innocence. In *Schlup v. Delo*, 513 U.S. 298 (1995), the Court held that to obtain habeas relief on a gateway actual-innocence claim, a defendant must show that "it is more likely than not that no reasonable juror would have convicted him in the light of the new evidence." *Id.* at 327. Although the United State's Supreme Court has not recognized the viability of a freestanding actual-innocence claim, and, consequently, has not decided which standard would apply to such a claim, it has speculated that such a standard would theoretically require more convincing proof. *See House v. Bell*, 547 U.S. 518, 555 (2006). *People v. Coleman*, 2013 IL 113307, ¶ 86.

14. Because evidence was presented that petitioner did in fact commit this crime, reasonable minds can differ. As such, petitioner has not established her actual innocence, and is not entitled to a certificate of innocence in this case.

WHEREFORE, the State asks this Court to deny petitioner petition for certificate of innocence.

Respectfully Submitted,

By: _____
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