8:30 and 9:00 a.m.
12-4-78
Preparation for autopsy.
Birth weights of both infants noted in the opposite infant chart for the first time

The following is a synopsis of the investigation of the so called "Baby Swap" case. It was commissioned by Ernest and Regina Twigg and the purpose was to discover how these infants came to be sent home with the wrong families, who caused it to happen, and if appropriate, to forward the results to law enforcement. The children will be referred to by their given names to avoid confusion. Arlena Twigg, who is actually the biological daughter of Robert and Barbara Mays, expired in 1988. Kimberly Mays, who is the biological daughter of Ernest and Regina Twigg, recently celebrated her 15th birthday and still resides with Robert Mays as per order of the trial court. The Twiggs have no visitation rights at the time of this writing and are appealing the most recent court decision denying them parental rights. Attorney John T. Blakely is counsel and has settled the civil claims against Hardee Memorial Hospital and the medical personnel. He is appealing the trial court decision and will submit briefs in the near future. The following is a statement of facts per medical records and sworn testimony of witnesses during depositions:

KIMBERLY MAYS WAS BORN ON 11-29-78, AT 5:31 P.M. PER HER MEDICAL RECORDS. SHE WAS DELIVERED BY C-SECTION BY DR. BLACK BECAUSE OF FETAL DISTRESS. DR. SEDAROS, ATTENDING PEDIATRICIAN, WAS PRESENT AT BIRTH AND GAVE AN APGAR SCORE OF 9-10, WHICH IS A HEALTHY BABY. MEDICAL RECORDS DO NOT REFLECT ANY PHYSICAL ABNORMALITIES

FOR THIS CHILD ALTHOUGH SHE WAS BORN WITH A SEVERE CONGENITAL HEART DEFECT9. DR. SEDAROS CALLED AT 9:00 P.M. TO CHECK ON THE BABY PER NURSE'S NOTES, WHICH IS APPROXIMATELY 3 1/2 HOURS AFTER HER BIRTH. DR. PALMER CONDUCTED A PHYSICAL EXAMINATION AT 10:00 P.M., 4 1/2 HOURS AFTER BIRTH. HE ORDERED HER PUT IN HER CRIB AT THAT TIME AND ESSENTIALLY ASSUMED THE CARE OF THE INFANT FROM DR. SEDAROS UNTIL THE DAY OF DISCHARGE, 12-5-~~93~~.78

ARLENA TWIGG WAS BORN ON 12-2-78 AT APPROXIMATELY 4:10 A.M., VAGINAL DELIVERY,DR. BLACK ATTENDING. HE GAVE AN APGAR SCORE OF 10. DR. PALMER EXAMINED THE INFANT AT 12:00 P.M. AND ORDERED HER FROM INCUBATOR TO CRIB PER NURSE'S NOTES. THERE ARE NO PHYSICAL ABNORMALITIES NOTED IN MEDICAL RECORDS UNTIL DAY OF DISCHARGE. DR. PALMER ASSUMED THE CARE OF THIS INFANT UNTIL THE DAY OF DISCHARGE, 12-5-78.

These infants were switched at some point between 4:10 a.m. on 12-~~2~~4-78 and approximately 9:30 a.m. on 12-5-78. This can be deduced as it was at this time that a heart murmur was detected by Dr. Sedaros. Numerous health care professionals had daily contact with these infants in this 79 hour period. Most have testified at deposition under oath, some more than once, and all have denied any knowledge of how these children came to be sent home with the wrong families. The reader should note that this facility is a small hospital which apparently had one other child of Hispancic heritage in the nursery during this time frame. The Twigg and Mays infants are of caucasian heritage. This would

seem to reduce the probability of confusion among the infants to the 2 caucasians which ultimately were switched.

The identification protocol for newborn infants at that time involved two bands attached to each newborn, one for the wrist and one for the ankle. Foot prints were also taken. Nurse's assistants testified at deposition that they had observed a single band coming off of a newborn during their tenure in the nursery but never both. The bands are to remain on the infant until the time of discharge when they are cut off with a pair of scissors. If protocol was followed in the instance of these two infants, as was testified to under oath, the probability of these 4 bands falling off accidentally and being placed on the wrong infants would seem to be so infinitesimal as to be dismissed out of hand. This alone suggests an intentional act by one or more persons.

There has been a veritable media frenzy surrounding this case from the day it became public knowledge. A movie and book have been produced and published and television and print media have reported on it extensively. Dr. Black was the first medical professional to assert that he believed the switch was intentional, although he declined to name a suspect. A second witness, Nurse's Assistant Patsy Webb, has come forward with what could be characterized as a dying declaration, and stated that she was asked by Dr. Palmer to effect the switch. She states she declined but that when she came to work the next day she noticed

the babies had in fact been switched. The reader should note that Webb has denied under oath on at least 2 prior occasions that she had any knowledge of how this switch came to pass. She states she feared for her job and medical benefits at that time as she had a son with leukemia who required medical treatment. She states that the reason for coming forward at this late date is to clear her conscience before she dies. Her statement is inconsistent with Barbara Mays medical records in that she states "they" knew she was dying of cancer and wanted her to die with a healthy baby. Records indicate that Barbara Mays was not diagnosed until more than a year later with the cancer that ultimately took her life.

The motive for an intentional switch has always been one of the most perplexing problems of this case. Webb's is inconsistent with the medical records and Dr. Black. One witness testified that Webb told her in a Circle-K convenience store that a doctor was paid money to effect the switch. Barbara Mays is alleged to have been trying to have a child for some years unsuccessfully, and when it was discovered that the infant was born with the heart defect, she or her mother decided that they would go home with a healthy baby and took actions to have it so. Her mother is alleged to have considerable financial resources which she used to pay the doctor to effect the switch. Another Nurse's assistant has opined that a Registered nurse effected the switch to please the prominent parents of Barbara Mays. There are problems with all of these theories but they are not so unbelievable as the switch being an accident. An examination of public records and

testimony at deposition by various witnesses suggests the possiblity of deception and lends credence to a financial motive.

The testimony of two physicians might be looked at with a furrowed brow. Dr. Sedaros and Dr. Palmer both testified at length on two occasions about the care they rendered the mothers and infants, respectively. One area that causes concern is what appears to be altered medical records. Dr. Sedaros is listed as attending pediatrician and crossed out and Dr. Palmer handwritten in. There are also instances where records appear to have been whited out. The doctor professes to not recall whether or not he had an agreement to cover for Dr. Palmer's patients. Dr. Sedaros states he doesn't recall why he called to check on the Mays' newborn on the evening of 11-29-93. He also testified he doesn't know why he examined the Twigg newborn on 12-5-78 if it wasn't his patient when he diagnosed the heart murmur and ordered an EKG and test of blood gases.

Dr. Palmer testified he doesn't know why records are whited out, Sedaros's name is crossed out or why he ordered the test of blood gases for the Twigg newborn cancelled. He also testified he doesn't recall if he had an agreement with Dr. Sedaros to cover his patients. In a county as small as Hardee county and a hospital as small as Hardee Memorial it is difficult to accept that practicing physicians would not know with whom they had agreements to cover their patients in their absence if for no

other reason than there is presumably a small number of physicians available to cover them.

These apparent lapses of memory taken by themselves might appear harmless. Then consider that these infants appear quite different physically in photographs taken shortly after birth. Regina Twigg states that around the second day, 12-3-78, she told a nurse that she thought the baby she brought her to feed was not hers. This is verified by Patsy Webb and another Nurse's assistant. Do two trained physicians have another lapse at the same time and not recognize the difference between a healthy infant and one with a major heart defect which reportedly causes a cyanotic appearance? Let's concede this is also possible.

The lapse of memories and inability to recognize the two children takes on a different meaning when considered in combination with a financial motive for effecting the switch. Both physicians were going through foreclosures on their property around 1978. Dr. Palmer's clinic was being foreclosed on and what appears to be Dr. Sedaros' residence also. At this point we have a rather improbable series of coincidences.

We have medical records which are obviously altered and neither physician recalls why. Both doctors can't recall if they had an agreement to cover each others patients in a small rural county medical facility. It is alleged that the switch was done

for financial reasons and both physicians are close to or in the midst of foreclosure on their respective properties. Dr. Sedaros cannot recall why he called at 10:00 p.m. on the night of 11-29-78 to check on Kimberly Mays. He cannot recall why he examined the Twigg newborn on 12-5-78 when he diagnosed the congenital heart defect. Dr. Sedaros, a board certified pediatrician, cannot tell the difference between cyanotic symptomology and a perfectly healthy baby. Dr. Palmer cannot recall why he ordered blood gases not be tested. Dr. Palmer, a family practitioner who has delivered or cared for many newborns, cannot tell the difference between an infant with congenital heart disease and a perfectly healthy one. Patsy Webb states she was asked to switch the babies and recognized the switch the next day. Regina Twigg asked a nurse about having the wrong baby, apparently noticing a physical difference. As the proverb says, some circumstantial evidence is strong, such as a trout in the milk. This series of circumstances defies credulity.