

STATE OF SOUTH CAROLINA
IN THE SUPREME COURT

Certiorari to Spartanburg County
Honorable J. Derham Cole, Circuit Court Judge

RECEIVED

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S.C. SUPREME COURT

ANDRES ANTONIO TORRES,

PETITIONER

V.

STATE OF SOUTH CAROLINA,

RESPONDENT

APPELLATE CASE NO. 2020-000842

APPENDIX

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INDEX**VOLUME I**

INDEX	i
TRANSCRIPT OF PRE-TRIAL HEARING HELD JUNE 15, 2007	1
TRANSCRIPT OF PRE-TRIAL HEARING HELD DECEMBER 20, 2007	8
TRANSCRIPT OF PRE-TRIAL HEARING HELD AUGUST 18, 2008.....	37
TRANSCRIPT OF PRE-TRIAL HEARING HELD SEPTEMBER 24, 2008.....	61
TRANSCRIPT OF PRE-TRIAL HEARING HELD OCTOBER 8, 2008	78
TRANSCRIPT OF TRIAL HELD OCTOBER 13-23, 2008.....	114
ARRAIGNMENT	163
MOTION TO AMEND INDICTMENT.....	171
COURT'S RULING	171
JURY QUALIFICATION	175
INDIVIDUAL JUROR QUALIFICATION	326

VOLUME II

CONTINUED - TRANSCRIPT OF TRIAL HELD OCTOBER 13-23, 2008.....	501
INDIVIDUAL JUROR QUALIFICATION (CONTINUED)	501

VOLUME III

CONTINUED - TRANSCRIPT OF TRIAL HELD OCTOBER 13-23, 2008.....	1001
INDIVIDUAL JUROR QUALIFICATION (CONTINUED)	1001

VOLUME IV

CONTINUED - TRANSCRIPT OF TRIAL HELD OCTOBER 13-23, 2008.....	1501
INDIVIDUAL JUROR QUALIFICATION (CONTINUED)	1501

JURY SELECTION.....	1545
MOTION TO EXCLUDE THIRD PARTY GUILT EVIDENCE	1555
MOTION TO SEQUESTER ALL WITNESSES.....	1566
COURT’S RULING	1566
PROFFERED TESTIMONY	
TAMMY HUGHEY	
Direct Examination by Mr. Reckenbeil	1568
Cross-examination by Ms. Crick	1580
Re-direct Examination by Mr. Reckenbeil	1588
Re-cross Examination by Ms. Crick	1590
MANDY MCKINNISH	
Direct Examination by Mr. Reckenbeil	1592
Cross-examination by Mr. Gowdy.....	1596
<u>JACKSON V. DENNO HEARING.....</u>	1602
TESTIMONY	
REID LINDSEY	
Direct Examination by Mr. Barnette.....	1607
Cross-examination by Mrs. Hodges.....	1615
JASON BRYANT	
Direct Examination by Mr. Gowdy	1632
Cross-examination by Mr. Allen.....	1644
DEFENSE’S ARGUMENT BY MRS. HODGES.....	1665
STATE’S ARGUMENT BY MR. GOWDY	1670
REPLY ARGUMENT BY MRS. HODGES	1671
MOTION TO SUPPRESS CLOTHING EVIDENCE.....	1677
PROFFERED TESTIMONY CONTINUED	
DOMINICK BAIRD	
Direct Examination by Mr. Gowdy	1682
Cross-examination by Mr. Reckenbeil	1684

COURT’S RULING ON MOTION TO SUPPRESS CLOTHING EVIDENCE.....	1689
COURT’S RULING ON <u>JACKSON V. DENNO</u> HEARING.....	1689
COURT’S RULING ON MOTION TO EXCLUDE THIRD PARTY GUILT EVIDENCE	1690
OPENING STATEMENT BY MS. CRICK.....	1709
OPENING STATEMENT BY MRS. HODGES	1716
TESTIMONY	
DANNY JONES	
Direct Examination by Mr. Gowdy	1722
Cross-examination by Mr. Allen.....	1731
JEFF VALENTINE	
Direct Examination by Mr. Gowdy	1739
Cross-examination by Mr. Allen.....	1752
JOSEPH STEWARD	
Direct Examination by Mr. Gowdy	1763
Cross-examination by Mr. Allen.....	1767
Re-direct Examination by Mr. Gowdy.....	1771
MICHELLE BURGESS	
Direct Examination by Mr. Gowdy	1773
Cross-examination by Mr. Reckenbeil	1782
Re-direct Examination by Mr. Gowdy.....	1785
STEPHEN JONES	
Direct Examination by Mr. Barnette.....	1786
JAMES VINSON	
Direct Examination by Ms. Crick	1791
Cross-examination by Mr. Reckenbeil	1797
HENRY RICHARDSON	
Direct Examination by Mr. Gowdy	1801
Cross-examination by Mr. Reckenbeil	1812
WILLIAM GARY	
Direct Examination by Mr. Gowdy	1816
Cross-examination by Mr. Reckenbeil	1826

RANDY BOGAN

Direct Examination by Mr. Barnette.....	1827
Cross-examination by Mr. Reckenbeil	1859
Re-direct Examination by Mr. Barnette.....	1864

GREG TURNER

Direct Examination by Mr. Barnette.....	1869

CRYSTAL WILLIAMSON

Direct Examination by Ms. Crick	1871

DOCTOR JOHN DAVID WREN

Direct Examination by Mr. Gowdy	1886
Cross-examination by Mr. Reckenbeil	1915
Re-direct Examination by Mr. Gowdy.....	1915

DAVID HOGSED

Direct Examination by Mr. Barnette.....	1917
Cross-examination by Mr. Reckenbeil	1920

RANDALL JOHNSON

Direct Examination by Mr. Barnette.....	1925

HUGH MURPHY

Direct Examination by Mr. Barnette.....	1929
Cross-examination by Mr. Reckenbeil	1937

PHIL EASLER

Direct Examination by Ms. Crick	1940
Cross-examination by Mrs. Hodges.....	1961

ROGER MEANS

Direct Examination by Ms. Crick	1968
Cross-examination by Mrs. Hodges.....	1976

ROBERT TALANGES

Direct Examination by Mr. Barnette.....	1997

VOLUME V

CONTINUED - TRANSCRIPT OF TRIAL HELD OCTOBER 13-23, 2008.....	2001

TESTIMONY CONTINUED

ROBERT TALANGES (CONTINUED)

Direct Examination by Mr. Barnette (Continued)	2001
Cross-examination by Mrs. Hodges.....	2020

DOMINICK BAIRD

Direct Examination by Mr. Gowdy	2026
Cross-examination by Mrs. Hodges.....	2054

JASON BRYANT

Direct Examination by Mr. Gowdy	2063

PHILLIP CHAPPEL

Direct Examination by Mrs. Crick.....	2068
Cross-examination by Mr. Allen.....	2073

SHAWN NIX

Direct Examination by Mr. Gowdy	2075
Cross-examination by Mrs. Hodges.....	2096
Re-direct Examination by Mr. Gowdy.....	2099

ASHLEY HARRIS

Direct Examination by Ms. Crick.....	2100
Cross-examination by Mrs. Hodges.....	2112

MARGARET GREER

Direct Examination by Mr. Barnette.....	2117

JACK WESTMORELAND

Direct Examination by Mr. Barnette.....	2122

JAN BRYSON

Direct Examination by Mr. Barnette.....	2124
Cross-examination by Mrs. Hodges.....	2136

VICKI HALLMAN

Direct Examination by Mr. Barnette.....	2143
Cross-examination by Mr. Reckenbeil	2161
Re-direct Examination by Mr. Barnette.....	2163

MATT FITTS

Direct Examination by Ms. Crick	2165
Cross-examination by Mr. Allen.....	2197
Re-direct Examination by Ms. Crick	2213
Re-cross Examination by Mr. Allen	2217

THE STATE RESTS	2221
MOTION FOR A DIRECTED VERDICT	2221
COURT’S RULING	2222
COLLOQUY WITH DEFENDANT ON HIS RIGHT TO TESTIFY	2223
RENEWED MOTION TO PRESENT EVIDENCE OF THIRD-PARTY GUILT	2225
COURT’S RULING	2226
THE DEFENSE RESTS	2227
RENEWED PREVIOUS MOTIONS AND RENEWED MOTION FOR A DIRECTED VERDICT	2227
COURT’S RULING	2227
REQUEST TO CHARGE LARCENY	2228
COURT’S RULING	2231
REQUEST TO CHARGE MERE PRESENCE.....	2231
COURT’S RULING	2232
COLLOQUY WITH DEFENDANT ON HIS RIGHT TO PARTICIPATE IN CLOSING ARGUMENTS	2233
CLOSING ARGUMENT BY MR. GOWDY	2236
CLOSING ARGUMENT BY MR. RECKENBEIL.....	2247
JURY CHARGE	2257
EXCEPTIONS TO JURY CHARGE	2281
COURT’S RULING	2281
MOTION TO REMOVE JUROR.....	2292
NOTE FROM THE JURY	2292
COURT’S RULING ON MOTION TO REMOVE JUROR.....	2299

NOTE FROM THE JURY	2303
VERDICT	2307
MOTION FOR A NEW TRIAL	2310
COURT'S RULING	2310
PENALTY PHASE OF TRIAL	2315
MOTION TO EXCLUDE TESTIMONY AND VIDEO EVIDENCE REGARDING JAIL INCIDENT	2317
OPENING STATEMENT BY MR. BARNETTE	2327
OPENING STATEMENT BY MR. ALLEN	2331
MOTION TO MOVE ALL EVIDENCE FROM GUILT PHASE INTO SENTENCING PHASE	2334
COURT'S RULING	2334
TESTIMONY	
CHARLENA TINSLEY	
Direct Examination by Mr. Barnette	2335
Cross-examination by Mr. Reckenbeil	2352
Re-direct Examination by Mr. Barnette	2357
JASON BRYANT	
Direct Examination by Mr. Gowdy	2360
ASHLEY HARLEY	
Direct Examination by Ms. Crick	2362
Cross-examination by Mr. Reckenbeil	2374
PHYLLIS WHITE	
Direct Examination by Mr. Gowdy	2376
PROFFERED TESTIMONY	
ALAN FREEMAN	
Direct Examination by Mr. Gowdy	2388
Cross-examination by Mr. Reckenbeil	2390
Re-direct Examination by Mr. Gowdy	2393

COURT’S RULING ON TESTIMONY AND VIDEO EVIDENCE REGARDING JAIL INCIDENT	2396

TESTIMONY CONTINUED

ANTHONY MARTINEZ

Direct Examination by Mr. Gowdy	2398
Cross-examination by Mr. Allen.....	2410
Re-direct Examination by Mr. Gowdy.....	2418

RANDY GAULT

Direct Examination by Ms. Crick	2422

BRANDY DHERS

Direct Examination by Ms. Crick	2428
Cross-examination by Mr. Allen.....	2433

ANDREW TOMLINSON

Direct Examination by Mr. Barnette.....	2435
Cross-examination by Mr. Allen.....	2439
Re-direct Examination by Mr. Barnette.....	2443

MARK WILLIAMSON

Direct Examination by Mr. Gowdy	2444

CRYSTAL WILLIAMSON

Direct Examination by Ms. Crick	2450

DOCTOR JOHN DAVID WREN

Direct Examination by Mr. Barnette.....	2466

DOMINICK BAIRD

Direct Examination by Mr. Gowdy	2479

THE STATE RESTS	2482

RENEWED MOTION TO PRESENT EVIDENCE OF THIRD-PARTY GUILT	2487

COURT’S RULING	2488

DEFENSE TESTIMONY

JOHN SHACKELFORD

Direct Examination by Mr. Allen	2489

VOLUME VI

CONTINUED - TRANSCRIPT OF TRIAL HELD OCTOBER 13-23, 2008.....	2501

DEFENSE TESTIMONY

JOHN SHACKELFORD (CONTINUED)

Direct Examination by Mr. Allen (Continued)	2501
Cross-examination by Ms. Crick	2515
Re-direct Examination by Mr. Allen	2523

LISA LAMB

Direct Examination by Mr. Allen	2536
Cross-examination by Mr. Gowdy.....	2575

PAM GORDON

Direct Examination by Mr. Allen	2586
Cross-examination by Mr. Gowdy.....	2590

DOCTOR ALEX MORTON

Direct Examination by Mrs. Hodges	2594
Cross-examination by Ms. Crick	2640
Re-direct Examination by Mrs. Hodges.....	2654

MOTION TO EXCLUDE GENOGRAM	2658

TESTIMONY CONTINUED

DOCTOR DONNA SCHWARTZ-WATTS

Direct Examination by Mr. Allen	2663
Cross-examination by Mr. Gowdy.....	2707

PROFFERED TESTIMONY

DOCTOR MARTI LORING

Direct Examination by Mr. Allen	2732
Cross-examination by Mr. Gowdy.....	2743

COURT'S RULING ON MOTION TO EXCLUDE GENOGRAM	2748

TESTIMONY CONTINUED

DOCTOR MARTI LORING

Direct Examination by Mr. Allen	2752
Cross-examination by Ms. Crick	2793

JAMES AIKEN	
Direct Examination by Mr. Allen	2808
Cross-examination by Mr. Barnette	2817
THE DEFENSE RESTS	2824
CHARGE CONFERENCE ON AGGRAVATING AND MITIGATING CIRCUMSTANCES	2825
CLOSING ARGUMENT BY MR. GOWDY	2831
CLOSING ARGUMENT BY MR. ALLEN.....	2851
CLOSING ARGUMENT BY DEFENDANT	2858
JURY CHARGE	2860
VERDICT	2886
MOTION FOR A NEW TRIAL AND A NEW SENTENCING TRIAL AND ALL MOTIONS RENEWED.....	2891
COURT’S RULING	2892
SENTENCING	2893
FINAL BRIEF OF APPELLANT	2897
FINAL BRIEF OF RESPONDENT	2913
<u>STATE V. ANDRES ANTONIO TORRES</u> , OP. NO. 26904 (S.C. SUP. CT. FILED DEC. 13, 2010)	2938
APPLICATION FOR POST-CONVICTION RELIEF (FILED APRIL 22, 2011)	2942
RETURN AND MEMORANDUM OF LAW IN SUPPORT OF MOTION TO DISMISS (FILED MAY 19, 2011)	2951
FIRST AMENDED APPLICATION FOR POST-CONVICTION RELIEF (DATED JULY 6, 2012).....	2977
FINAL AMENDED APPLICATION FOR POST-CONVICTION RELIEF (FILED APRIL 7, 2014)	2991

VOLUME VII

CONTINUED - FINAL AMENDED APPLICATION FOR POST-CONVICTION RELIEF (FILED APRIL 7, 2014)	3001
TRANSCRIPT OF APPOINTMENT OF COUNSEL HEARING DATED MARCH 10, 2011	3011
TRANSCRIPT OF POST-CONVICTION RELIEF HEARING DATED APRIL 14-16, 21-25, 30, 2014, AND JUNE 30, 2015	3020
MOTION FOR SUMMARY JUDGEMENT	3031
COURT’S RULING	3046
TESTIMONY	
REID LINDSEY	
Direct Examination by Mr. Ehlies	3047
Cross-examination by Ms. Brown	3081
Re-direct Examination by Mr. Ehlies	3097
Re-cross Examination by Ms. Brown	3099
Final Re-direct Examination by Mr. Ehlies	3103
CHARLES RUSSELL CLEVINGER	
Direct Examination by Mr. Ehlies	3104
Cross-examination by Ms. Brown	3125
CRYSTAL WILLIAMSON	
Direct Examination by Mr. Ehlies	3128
Cross-examination by Ms. Brown	3146
Re-direct Examination by Mr. Ehlies	3151
PHYLLIS WHITE	
Direct Examination by Mr. Schoen	3155
Cross-examination by Ms. Brown	3161
Re-direct Examination by Mr. Schoen.....	3164
MEGAN WILLIAMSON	
Direct Examination by Mr. Tessier.....	3165
Cross-examination by Ms. Brown	3173
Re-direct Examination by Mr. Tessier.....	3176

JESSICA HUGHEY HINSON

Direct Examination by Mr. Schoen	3178
Cross-examination by Ms. Brown	3189
Re-direct Examination by Mr. Schoen.....	3193
Re-cross Examination by Ms. Brown	3198
Final Re-direct Examination by Mr. Schoen	3204
Final Re-cross Examination by Ms. Brown.....	3205

MARY DARLENE PRICE

Direct Examination by Mr. Tessier.....	3206
Cross-examination by Ms. Brown	3212
Re-direct Examination by Mr. Tessier.....	3213

MEGAN MCKINNISH

Direct Examination by Mr. Schoen	3214
Cross-examination by Ms. Brown	3217

TAMMY BULL HUGHEY

Direct Examination by Mr. Tessier.....	3219
Cross-examination by Ms. Brown	3269
Re-direct Examination by Mr. Tessier.....	3291
Re-cross Examination by Ms. Brown	3297

ROGER KIRBY

Direct Examination by Mr. Tessier.....	3299
Cross-examination by Mr. Zelenka.....	3325
Re-direct Examination by Mr. Tessier.....	3365

KEVIN BIGGERSTAFF

Direct Examination by Mr. Schoen	3369
Cross-examination by Mr. Zelenka.....	3398
Re-direct Examination by Mr. Schoen.....	3411

DOCTOR JACK M. RARY

Direct Examination by Mr. Tessier.....	3418
Cross-examination by Ms. Timmons.....	3474
Re-direct Examination by Mr. Tessier.....	3495

JENNIFER ANN MONDONEDO

Direct Examination by Mr. Schoen	3499

VOLUME VIII

CONTINUED - TRANSCRIPT OF POST-CONVICTION RELIEF

HEARING DATED APRIL 14-16, 21-25, 30, 2014, AND JUNE 30, 2015	3501

TESTIMONY CONTINUED

JENNIFER ANN MONDONEDO (CONTINUED)

Direct Examination by Mr. Schoen (Continued)	3501
Cross-examination by Ms. Brown	3506
Re-direct Examination by Mr. Schoen.....	3512

DOCTOR JONATHAN JOSEPH LIPMAN

Direct Examination by Mr. Tessier.....	3515
Cross-examination by Ms. Brown	3574
Re-direct Examination by Mr. Tessier.....	3612

DOCTOR THOMAS EDWARD SCHACHT

Direct Examination by Mr. Schoen	3614
Cross-examination by Mr. Zelenka.....	3712
Re-direct Examination by Mr. Schoen.....	3746
Re-cross Examination by Mr. Zelenka	3755

KATHLEEN J. HODGES

Direct Examination by Mr. Ehliès	3756
Cross-examination by Ms. Brown	3851
Re-direct Examination by Mr. Ehliès	3872
Re-cross Examination by Ms. Brown	3877
Final Re-direct Examination by Mr. Ehliès	3878

DOCTOR STACEY WOOD

Direct Examination by Mr. Tessier.....	3880
Cross-examination by Mr. Zelenka.....	3948
Re-direct Examination by Mr. Tessier.....	3960

DOCTOR GEORGE WOODS

Direct Examination by Mr. Ehliès	3962

VOLUME IX

CONTINUED - TRANSCRIPT OF POST-CONVICTION RELIEF

HEARING DATED APRIL 14-16, 21-25, 30, 2014, AND JUNE 30, 2015	4001

TESTIMONY CONTINUED

DOCTOR GEORGE WOODS (CONTINUED)

Direct Examination by Mr. Ehliès (Continued).....	4001
Cross-examination by Mr. Zelenka.....	4041
Re-direct Examination by Mr. Ehliès	4062

JOHN G. RECKENBEIL

Direct Examination by Mr. Ehlies	4064
Cross-examination by Ms. Brown	4148
Re-direct Examination by Mr. Ehlies	4201
Re-cross Examination by Ms. Brown	4220

CLAY T. ALLEN

Direct Examination by Mr. Ehlies	4221
Cross-examination by Ms. Brown	4365
Re-direct Examination by Mr. Ehlies	4431

APPLICANT RESTS.....	4440

MOTION FOR ADDITIONAL TIME TO PREPARE BY RESPONDENT	4441

COURT’S RULING, GRANTING MOTION	4444

PROCEEDINGS RESUMED ON JUNE 30, 2015	4446

RESPONDENT’S WITNESS

DOCTOR JOHN EDWARD SPENCE

Direct Examination by Ms. Timmons.....	4446
Cross-examination by Mr. Tessier.....	4467
Re-direct Examination by Ms. Timmons.....	4490

RESPONDENT RESTS.....	4493

APPLICANT’S EXHIBIT #2 (VOLUNTARY STATEMENT OF CHARLES DONALD EMORY DATED 5/11/07).....	4497

APPLICANT’S EXHIBIT #3 (VOLUNTARY STATEMENT OF CHARLES DONALD EMORY DATED 5/11/07).....	4500

VOLUME X

CONTINUED - APPLICANT’S EXHIBIT #3 (VOLUNTARY STATEMENT OF CHARLES DONALD EMORY DATED 5/11/07).....	4501

APPLICANT’S EXHIBIT #4 (AFFIDAVIT OF JESSICA HUGHEY DATED 8/15/08)	4505

APPLICANT’S EXHIBIT #5 (VOLUNTARY STATEMENT OF JESSICA HUGHEY DATED 5/11/07)	4508

APPLICANT’S EXHIBIT #6 (AFFIDAVIT OF TAMMY HUGHEY DATED 8/13/08)	4511
APPLICANT’S EXHIBIT #7 (SUPPLEMENTAL AFFIDAVIT OF TAMMY HUGHEY DATED 8/15/08)	4516
APPLICANT’S EXHIBIT #9 (VOLUNTARY STATEMENT OF KEVIN BIGGERSTAFF DATED 5/16/07)	4517
APPLICANT’S EXHIBIT #10 (INVESTIGATIVE REPORT OF ALLEN WOOD DATED 5/13/07)	4519
APPLICANT’S EXHIBIT #11 (CORONER’S INVESTIGATIVE NOTES DATED 5/11/07).....	4521
APPLICANT’S EXHIBIT #12 (CORONER’S INVESTIGATIVE NOTES DATED 5/11/07).....	4524
APPLICANT’S EXHIBIT #13 (CURRICULUM VITAE OF DR. JACK M. RARY).....	4528
APPLICANT’S EXHIBIT #16 (REPORT FROM LABCORP DATED 3/21/14)	4536
APPLICANT’S EXHIBIT #17 (DNA REPORT OF DR. JACK M. RARY).....	4537
APPLICANT’S EXHIBIT #18 (REPORT FROM THE GREAT PLAINS LABORATORY, INC.).....	4552
APPLICANT’S EXHIBIT #19 (CURRICULUM VITAE OF JONATHAN JOSEPH LIPMAN, PH.D., MSB., FACN)	4559
APPLICANT’S EXHIBIT #20 (REPORT FROM YOUSCRIPT DATED MAY 24, 2013)	4572
APPLICANT’S EXHIBIT #21 (CURRICULUM VITAE OF THOMAS EDWARD SCHACHT, PSYD, ABPP).....	4573
APPLICANT’S EXHIBIT #22 (CURRICULUM VITAE OF STACEY WOOD, PH.D.)	4592
APPLICANT’S EXHIBIT #23 (NEUROPSYCHOLOGICAL EVALUATION SUMMARY OF STACEY WOOD, PH.D. DATED 1/18/2013).....	4610
APPLICANT’S EXHIBIT #24 (CURRICULUM VITAE OF GEORGE W. WOODS, JR., M.D.).....	4614

APPLICANT’S EXHIBIT #25 (THIRD-PARTY GUILT LIST)	4629
APPLICANT’S EXHIBIT #26 (MEDICAL RECORDS OF THE APPLICANT).....	4633
APPLICANT’S EXHIBIT #27 (PSYCHIATRIC EVALUATION OF APPLICANT DATED 10/16/08 OF DONNA SCHWARTZ-WATTS, M.D. AND ATTACHED DOCUMENTS).....	4749
APPLICANT’S EXHIBIT #28 (MEDICAL RECORDS OF LISA B. TORRES).....	4776
APPLICANT’S EXHIBIT #29 (PSYCHIATRIC HISTORY AND MENTAL STATUS EXAMINATION DATED 10/23/94 OF APPLICANT)	4939
APPLICANT’S EXHIBIT #30 (SUMMARY OF MITIGATION CASE PRESENTED AT TRIAL)	4944
APPLICANT’S EXHIBIT #31 (COPY OF COVER PAGE OF DEPOSITION OF H. WAYNE TOBIN, M.D. DATED 4/2/14, AND COPY OF DEPOSITION OF H. WAYNE TOBIN, M.D. DATED 7/23/14; ORIGINAL OF 4/2/14 DEPOSITION WAS UNOPENED IN THE CLERK’S OFFICE)	4945
APPLICANT’S EXHIBIT #32 (NEWSPAPER ARTICLE FROM SPARTANBURG HERALD DATED 5/13/07).....	4980
APPLICANT’S EXHIBIT #33 (COPY OF DEPOSITION OF JOHN EDWARD SPENCE, M.D. DATED 3/26/15; ORIGINAL WAS UNOPENED IN CLERK’S OFFICE).....	4983

VOLUME XI

CONTINUED - APPLICANT’S EXHIBIT #33 (COPY OF DEPOSITION OF JOHN EDWARD SPENCE, M.D. DATED 3/26/15; ORIGINAL WAS UNOPENED IN CLERK’S OFFICE).....	5001
APPLICANT’S EXHIBIT #34 (LETTER DATED APRIL 7, 2015)	5025
STATE’S EXHIBIT #1 (VOLUNTARY STATEMENT OF TAMMY BELL HUGHEY DATED 5/11/07)	5056
STATE’S EXHIBIT #2 (VOLUNTARY STATEMENT OF TAMMY HUGHEY DATED 5/11/07)	5059
STATE’S EXHIBIT #4 (VOLUNTARY STATEMENT OF JESSICA HUGHEY DATED 5/11/07)	5061

STATE’S EXHIBIT #5 (STIPULATION #1 FROM TRIAL).....	5062
STATE’S EXHIBIT #6 (BILLING STATEMENT FROM SKIDMORE AND ASSOCIATES DATED 10/6/2008).....	5065
STATE’S EXHIBIT #9 (FINAL DISCHARGE SUMMARY).....	5069
STATE’S EXHIBIT #10 (TIMELINE).....	5071
STATE’S EXHIBIT #11 (TONY TORRES’ LIVING SITUATIONS).....	5072
STATE’S EXHIBIT #12 (C.V. OF DR. JOHN EDWARD SPENCE).....	5073
STATE’S EXHIBIT #13 (PRADER-WILLI PRINTOUT).....	5087
STATE’S EXHIBIT #14 (22Q11 DELETION PRINTOUT)	5123
COURT’S EXHIBIT #1 (COPY OF DEPOSITION OF ROGER KIRBY DATED 2/20/14; ORIGINAL WAS UNOPENED IN CLERK’S OFFICE).....	5152
COURT’S EXHIBIT #2 (NOTICE OF DEPOSITION OF ROGER ALLEN KIRBY DATED 2/4/14)	5239
COURT’S EXHIBIT #3 (COPY OF DEPOSITION OF CHRISTOPHER KEVIN BIGGERSTAFF DATED 2/21/14; ORIGINAL WAS UNOPENED IN CLERK’S OFFICE)	5240
ORDER DENYING POST-CONVICTION RELIEF (DATED DECEMBER 9, 2019).....	5294
NOTICE AND MOTION PURSUANT TO SCRCP 59 (DATED DECEMBER 18, 2019).....	5343
RETURN TO MOTION PURSUANT TO SCRCP 59 (DATED JANUARY 2, 2020).....	5353
FORM 4 DECISION BY THE COURT DENYING APPLICANT’S SCRCP 59 MOTION (DATED MAY 8, 2020).....	5364
INDICTMENTS	5365

THE FOLLOWING DOCUMENTS ARE ON FILE WITH THIS COURT:

APPLICANT'S EXHIBIT #1 (PHOTOGRAPHS), APPLICANT'S EXHIBIT #8 (PHOTOGRAPHS), APPLICANT'S EXHIBIT #14 (PHOTOGRAPHS OF THE APPLICANT), APPLICANT'S EXHIBIT #15 (PHOTOGRAPHS OF THE APPLICANT'S BODY), APPLICANT'S EXHIBIT #31 (DEPOSITIONS OF H. WAYNE TOBIN, M.D., DATED 4/2/14 AND 7/23/14; ORIGINAL OF THE 4/2/14 DEPOSITION WAS UNOPENED IN THE CLERK'S OFFICE), APPLICANT'S EXHIBIT #33 (DEPOSITION OF JOHN EDWARD SPENCE, M.D. DATED 3/26/15; ORIGINAL WAS UNOPENED IN CLERK'S OFFICE), STATE'S EXHIBIT #3 (PHOTOGRAPH—S-366 TRIAL EXHIBIT), STATE'S EXHIBIT #7 (PHOTOGRAPH—S-327 TRIAL EXHIBIT), STATE'S EXHIBIT #8 (PHOTOGRAPH—S-328 TRIAL EXHIBIT), COURT'S EXHIBIT #1 (DEPOSITION OF ROGER KIRBY DATED 2/20/14; ORIGINAL WAS UNOPENED IN CLERK'S OFFICE), AND COURT'S EXHIBIT #3 (DEPOSITION OF CHRISTOPHER KEVIN BIGGERSTAFF DATED 2/21/14; ORIGINAL WAS UNOPENED IN CLERK'S OFFICE)

Jennifer Ann Mondonedo
Direct examination by Mr. Schoen

1 Q And what time was that?

2 A In between the -- between midnight and about 3:00 or
3 4:00 in the morning.

4 Q So you were calling all the way between midnight --

5 A Yes.

6 Q -- and 3:00 and 4:00 in the morning?

7 A Yes.

8 Q Can you tell us whether you ever got anyone to answer
9 that phone?

10 A Yeah. I talked to Ray on the phone.

11 Q Somewhere between midnight and 3:00 in the morning you
12 talked to Ray Emery.

13 A Yes.

14 Q How did you know it was Ray Emery?

15 A Because he -- I asked for Chuck, and he said that Chuck
16 was still outside. He told me. And I said that he needed
17 to -- well, that I was worried about him. Actually, about
18 both of them.

19 Q Did -- did you have an opportunity to call back later
20 in the night?

21 A Huh?

22 Q Did you have an opportunity to call the house back
23 later?

24 A Yes, I did. I called from Jonathan's mom's house
25 phone.

Jennifer Ann Mondoneda
Direct examination by Mr. Schoen

1 Q And did you get any answer when you called back later?

2

3 A No, no, I didn't get an answer when I called back.

4 Q Around what time was that?

5 A That was about 3:00 o'clock.

6 Q Now, did you ever have an opportunity to talk with
7 Chuck Emery about the telephone call at 3:00 o'clock you
8 placed to his house?

9 A Yes, I did.

10 Q What did Chuck Emery say when you said you placed a
11 telephone call to his house at 3:00 in the morning?

12 A He said that if he knew it was me he would have
13 answered. He was outside.

14 Q Chuck Emery said he was outside his parents' house at
15 3:00 in the morning.

16 A Yeah.

17 Q Have you talked with Chuck Emery a number of times in
18 your life?

19 A Yes, I have.

20 Q Would you recognize his voice?

21 A Yes, I would.

22 Q You talked to Ray Emery before he passed away. Did you
23 talk to him a number of times?

24 A Yes. Not a number of times. His father and I haven't
25 talked to -- that much.

Jennifer Ann Mondonede
Direct examination by Mr. Schoen

1 Q Would you -- had you talked to him enough times to be
2 able to recognize his voice if you heard it on the phone?

3 A Yeah. I would.

4 Q Now, were you ever approached by anyone from Tony
5 Torres' defense team, any of his lawyers back when he was
6 being tried?

7 A From his -- no.

8 Q You never talked to them.

9 A No. From his side, no.

10 Q And if those lawyers had come to you --

11 A Uh-huh.

12 Q -- would you have told them the same thing that you've
13 told us today in court under oath?

14 A Yes, I would have.

15 Q And if they had asked you to testify in his trial would
16 you have told the jury the same thing that you've told us
17 today?

18 A Yes.

19 Q One last set of questions.

20 Can you tell us whether you talked to Chuck Emery about
21 the conversations that you had with Ms. Glass?

22 A Yes.

23 Q And do you recognize Ms. Glass?

24 A Yes.

25 Q Is she -- do you know her as the mitigation specialist

Jennifer Ann Mondoneda
Direct examination by Mr. Schoen

1 for Mr. Torres?

2 A Yes.

3 Q And what did Chuck Emery say to you when you told him
4 that you had spoken with Ms. Glass?

5 A He --

6 MS. BROWN: Objection. Irrelevant, hearsay.

7 THE COURT: Sustained.

8 MR. SCHOEN: Your Honor, can I proffer the evidence?

9 THE COURT: Sure.

10 Q What did Chuck Emery say to you?

11 A He said that -- I had told him that she had was asking
12 to speak to me, and he said that he had spoke to her too and
13 that to make sure that I -- I mean, it's not like Jonathan
14 wasn't playing with any carjacks or anything like that.

15 Q What did that mean to you?

16 A It meant that, you know, just watch out, I mean.

17 Q What happened to Jonathan Howard?

18 A He was ran over by a car and pinned underneath one for
19 several hours.

20 Q Is he alive today?

21 A No.

22 MR. SCHOEN: Court's indulgence.

23 (Pause.)

24 Q Were you contacted by the prosecution in Tony Torres'
25 case?

Jennifer Ann Mondoneda
Direct examination by Mr. Schoen

1 A The prosecution, no.

2 Q The solicitor?

3 A Oh, yes, I was.

4 Q You were. Were you under subpoena at his trial?

5 A Yes, I was, but I didn't get called to come and
6 testify.

7 Q Did you ever talk to anyone in the solicitor's office,
8 ever have an interview with anyone there?

9 A Yes. Mr. Gowdy.

10 Q What was the --

11 A Well, actually it was a lady that I was speaking to.
12 Mr. Gowdy just stood out by the door the whole time.

13 Q What did -- did you talk to the lady about?

14 A It was about -- exactly, it wasn't more or less about
15 the child or anything like that. It was about what kind of
16 character or what kind of person Tony was.

17 Q What did you tell them about the kind of person Tony
18 was?

19 A I told them that as far as I knew he was a good person
20 except for the one time, you know, he got drunk and there
21 was an empty shotgun but there was nothing in it and it
22 scared me a little bit but it -- yeah.

23 MR. SCHOEN: No further questions.

24

25

Jennifer Ann Mondoneda
Cross-examination by Ms. Brown

1 CROSS-EXAMINATION

2 BY MS. BROWN

3 Q Good afternoon.

4 A Hi.

5 Q I'm Melody Brown. I'm with the attorney general's
6 office. I have to ask you a few questions.

7 You had said in your direct testimony that you had
8 heard about a fight between Jonathan and Chuck and that's
9 why you were calling?

10 A No. I was looking for Jonathan because he had my -- my
11 phone, and me and him were staying with each other at the
12 time. Actually, there was argument between Chuck and Tony.
13 I don't know this. I don't -- I don't still to this day,
14 don't know what it was about, but I knew that they were
15 arguing.

16 Q Okay. Help me a little bit with the timeframe if you
17 will. You started calling after midnight?

18 A Well, no. I started calling Jonathan and Tony's phone
19 way, way, way before midnight because Jonathan -- me and him
20 got in an argument, and I hung up the phone. And I kept
21 calling Tony to see if he would get Jonathan to speak to me
22 because that was who I was living with at the time.

23 Q Okay. Did you ever speak to Tony?

24 A On the phone, yes.

25 Q You did? How did he sound to you?

Jennifer Ann Mondonede
Cross-examination by Ms. Brown

- 1 A He -- aggravated.
- 2 Q Intoxicated at all?
- 3 A A little bit, yeah.
- 4 Q Angry?
- 5 A Yeah, because I kept calling his phone.
- 6 Q Okay. Has he gotten angry with you before?
- 7 A No.
- 8 Q Have you seen any violence or been scared of him?
- 9 A Not other than the time I just said, no.
- 10 Q And why did he have a shotgun the time that you just
- 11 described?
- 12 A It was -- no, no, no. It was nothing. It was -- I was
- 13 young at the time. It was empty. There was nothing in it
- 14 and --
- 15 Q He held that shotgun and you were scared of him because
- 16 he was holding that shotgun?
- 17 A Yeah. I mean, it was just out of the blue he grabbed
- 18 the gun and then -- but it was nothing major.
- 19 Q Okay. Now, let's go back to the time you started
- 20 calling around. Let's say between midnight and 3:00. About
- 21 how many times did you call different people between
- 22 midnight and 3:00?
- 23 A How many? About six or seven different.
- 24 Q Okay. And one of these calls you actually --
- 25 A I called Chuck, Tony, Jonathan. I actually called

Jennifer Ann Mondonedo
Cross-examination by Ms. Brown

1 Jonathan's mom's house, but that was before I got there. My
2 mom and Ray -- yeah.

3 Q Okay. And when you talked to Mr. Ray Emery --

4 A Uh-huh.

5 Q -- he said Chuck was outside, correct?

6 A Yes, arguing with --

7 Q Arguing with Tony.

8 A Tony and Holly.

9 Q And did he express concern about the argument?

10 A Yeah, he did. He was --

11 Q And what was that?

12 A -- worried about getting his son off drugs and clean,
13 you know.

14 Q Okay. You had said that you talked to Chuck --

15 A Yeah.

16 Q -- and he said something about the carjack, that sort
17 of thing. Can you explain that a bit?

18 A No, I can't explain it. I don't understand it other
19 than, you know, be careful. What's what I took it as.

20 Q Okay. It didn't mean anything particularly ominous to
21 you, threatening to you?

22 A Yeah, it did.

23 Q It did. Why is that?

24 A Because, I mean, a friend of mine who is dead, I mean,
25 he might not have been a very good friend, but, you know,

Jennifer Ann Mondonedo
Cross-examination by Ms. Brown

1 he's dead for, what, attempting to do the same thing I am?

2 Yeah. That's threatening.

3 Q Has he threatened you before?

4 A No.

5 Q Have you ever seen him with a gun before?

6 A No, I have not.

7 Q Have you ever seen him beat up anyone before?

8 A Yeah. But that was a long time ago.

9 Q And that was with a fist or one hit, or what did you
10 see?

11 A That was one hit, yeah.

12 Q Okay. Okay.

13 MS. BROWN: Court's indulgence, please.

14 (Pause.)

15 Q When was the first time you talked about calling the
16 Emerys' home?

17 A When I found -- when Chuck wasn't answering the phone
18 any more for me.

19 Q Okay.

20 A And I was worried about because him and Holly got in an
21 argument, and him and Chuck were fighting, Tony and Chuck
22 were fighting. So, yeah. I was worried and I started
23 calling the house phone.

24 Q Okay. And when did you talk to Chuck about calling and
25 speaking to his father?

Jennifer Ann Mondonedo
Cross-examination by Ms. Brown

1 A When did I call him? Am I supposed to have permission
2 to speak to his father? Was I supposed to?

3 Q I assume that you do have permission to call. I was
4 just asking something a little bit different though. Let's
5 back up a bit.

6 A Okay.

7 Q When you called and you said you talked to Mr. Emery,
8 right, was around midnight to 3:00?

9 A Uh-huh.

10 Q Somewhere in that range.

11 A Yes.

12 Q And Chuck is outside.

13 A Yes.

14 Q Okay. And as I understood -- and you correct me if I'm
15 wrong -- but as I understand your testimony you said later
16 on you had tried to call and no one answered.

17 A That was later on that night, the answering machine,
18 yes.

19 Q Okay. And when did you talk to Chuck about calling
20 later and not getting that answer?

21 A It was probably a few years later.

22 Q A few years?

23 A Yeah.

24 Q Okay. Let me ask you this too. Just so I get the time
25 right in my mind, when was the next time you talked to Chuck

Jennifer Ann Mondoneda
Cross-examination by Ms. Brown

1 Emery after that night?

2 A The next time I talked to him after that night?

3 Q Yes, ma'am.

4 A Goodness gracious. It'd have to be -- we were going --
5 well, no, because that was way after. It would have to be
6 about 2011.

7 Q 2011?

8 A Uh-huh.

9 Q Let me ask you something.

10 A Yeah.

11 Q I'm just trying to get this straight. Now, you said
12 that you talked to Mr. Ray Emery, and Mr. Ray Emery at that
13 time said Chuck was outside.

14 A Yes.

15 Q Is it possible when you talked to Chuck these many
16 years later and you're taking about this phone call he could
17 have thought that you meant when you called Mr. Ray Emery
18 and talked to him that he could have perhaps come inside
19 then?

20 A No. This was when nobody answered, because, I mean,
21 me -- and we both know -- me -- Mr. Emery and Chuck knew
22 that I was -- I had already called the house phone previous
23 because I had talked to Chuck.

24 Q Okay. Ma'am, how sure are you of the time?

25 A That was before he smashed his phone, yeah.

Jennifer Ann Mondonedo
Redirect examination by Mr. Schoen

1 Q And who smashed his phone?

2 A Chuck smashed his phone.

3 Q Chuck.

4 A Yeah.

5 Q Were you aware that Tony had smashed a phone at one
6 time?

7 A No.

8 Q No. You didn't know anything about the fight, or did
9 you know that Tony had actually threatened to call Chuck's
10 parents?

11 A No, I didn't.

12 Q Thank you, ma'am. I appreciate it.

13 MS. BROWN: No further questions, Your Honor.

14 MR. SCHOEN: Brief redirect, Your Honor.

15 REDIRECT EXAMINATION

16 BY MR. SCHOEN

17 Q I want to make sure that I understand your testimony.

18 A Uh-huh.

19 Q Were you at the Emerys' house the day after the murders
20 when they were found?

21 A Yes. I came and I saw Chuck.

22 Q So actually it wasn't -- the first time you saw him
23 between the night --

24 A He didn't say anything to me then.

25 Q Did -- were you talking to a police officer at that

Jennifer Ann Mondoneda
Redirect examination by Mr. Schoen

1 point?

2 A I had spoke to Detective Lindsey, yes.

3 Q And when you were talking to Detective Lindsey about
4 the phone conversation that you had did Chuck --

5 A He didn't really put too much information. I mean,
6 they didn't really ask me to many questions about it. It
7 was not about that. It was more or less more of the
8 whole -- of Tony's character. It wasn't what -- about the
9 official murder itself, you know.

10 Q When you were talking to the police the night after the
11 murder --

12 A Uh-huh.

13 Q -- did you tell any of the police officers that you had
14 called at 3:00 in the morning?

15 A Yes, I did.

16 Q When you said that did Chuck Emery at that point ask
17 you or say if I had known it was you I would have answered
18 the phone?

19 A No.

20 Q He didn't?

21 A He wasn't there.

22 Q Okay.

23 MR. SCHOEN: No further questions.

24 THE COURT: You may step down.

25 MR. TESSIER: Your Honor, we're okay with releasing

1 this witness.

2 THE COURT: Okay. Take him back to California Avenue.
3 (Whereupon, the witness was excused.)

4 MR. TESSIER: Your Honor, our next -- our next witness
5 will be an expert witness. We actually have two expert
6 witnesses that we would like to present to the Court.

7 The ideal scenario would be to present his testimony
8 in one block. It will take more than the time we have
9 remaining to do that.

10 In addition, it would be very helpful to us to be able
11 to talk to him tonight about what he heard from Dr. Rary
12 because he may well use some of that in his testimony.

13 So we're wondering if it's okay to just start with him
14 first thing in the morning and do two right in a row and
15 get them both done tomorrow.

16 THE COURT: Any problem with that?

17 MS. BROWN: No, sir. No objection to that.

18 THE COURT: Okay. We'll start in the morning at 9:30.
19 Court's in recess until then.

20 END OF PROCEEDINGS APRIL 21, 2014

21

22

23

24

25

Dr. Jonathan Lipman
Direct examination by Mr. Tessier

1 (Proceedings April 22, 2014)

2 THE COURT: Good morning. Are we ready to begin?

3 MR. EHLIES: Yes, sir.

4 THE COURT: Okay.

5 MR. TESSIER: Your Honor, the applicant calls Dr.
6 Jonathan Lipman.

7 DR. JONATHAN LIPMAN, having
8 been first duly sworn, testified as follows:

9 THE COURT: Your name is what?

10 THE WITNESS: Jonathan Joseph Lipman, L-I-P-M-A-N.

11 THE COURT: Thank you.

12 DIRECT EXAMINATION BY MR. TESSIER

13 Q Good morning, Dr. Lipman.

14 A Good morning.

15 Q I want to start off --

16 MR. TESSIER: If I may approach, Your Honor.

17 Q -- by showing you what's been marked as Applicant's
18 Exhibit No. 19 just to see if you can identify what that is
19 for us.

20 A That's a copy of my curriculum vitae as of January of
21 2013.

22 Q Okay. And was that -- are the contents of the C.V.
23 accurate as of that date?

24 A Yes, they are.

25 Q Would you please help us out by going over your

Dr. Jonathan Lipman
Direct examination by Mr. Tessier

1 educational background and training? You were educated in
2 England?

3 A Yes, sir.

4 Q So you may need to help us a little bit about that.

5 A Well, Britain.

6 Q Britain. Start with that. Tell us if you would how is
7 the schooling process, college education and beyond work
8 there. What is your educational background?

9 A Right. The educational process is -- is quite
10 radically different in England. I can start out by
11 explaining a professional degree is a bachelor's degree. So
12 you would be a bachelor of the law; a physician would be a
13 bachelor of medicine and so on.

14 However, as to my history, I obtained my advanced level
15 certificates of education at Kitson College of Science and
16 Technology in Leeds, England. That's in Yorkshire.

17 I went on to do my professional degree at Hatfield
18 Polytechnic which is in Hertfordshire. It's now known as
19 Hertfordshire University. My major was in pharmacology and
20 biochemistry.

21 I went on then to do my externship at the National
22 Hospital for Nervous Diseases in Queens Square, London. And
23 during the course of that externship became state certified
24 as a biomedical scientist, which is is a clinical
25 qualification in Europe.

Dr. Jonathan Lipman
Direct examination by Mr. Tessier

1 I went on to do my doctorate at the University of Wales
2 Center for the Health Sciences in the field of
3 neuropharmacology. Wales is part of Britain.

4 I -- when I obtained my Ph.D. I went on to do a
5 fellowship, a postdoctoral fellowship, at the University of
6 Tennessee Center for Health Sciences in Memphis. This was a
7 joint appointment between the anesthesiology department, the
8 biochemistry department and the Faculty Medical Practice
9 Pain Clinic. And I held that post which was a faculty post
10 for three years before going on to Vanderbilt University
11 Medical School where I had a faculty post in the departments
12 of medicine and the department of -- department of surgery
13 and over those years obtained additional qualifications and
14 board certifications in a number of areas including forensic
15 examination and in two subspecialty areas of the American
16 Board of Psychological Specialties. This was in substance
17 abuse and psychopharmacology.

18 I also became certified as a senior disability analyst
19 by the American Board of Disability Analysts.

20 I went on from Vanderbilt to join industry and for the
21 next ten years served in Chicago area as the head of the
22 pharmacology department for a pharmaceutical company,
23 Molecular Geriatrics, researching and developing drawings
24 that can be used to prevent dementia. My particular focus
25 was on drugs that have a phenothiazine structure to them

Dr. Jonathan Lipman
Direct examination by Mr. Tessier

1 otherwise used for antipsychotics.

2 The period that I was in the Chicago area I was also
3 founder of and head of two medical research development
4 companies, device development companies, Neuroscience
5 Toolworks and Medical Toolworks.

6 And after ten years in the Chicago area I moved to East
7 Tennessee where I am now to take up an appointment at East
8 Tennessee State University and to function as a consulting
9 neuropharmacologist through my own company, Neuroscience
10 Consulting.

11 Q So your current position at East Tennessee State
12 University is what?

13 A Clinical associate professor of psychiatry.

14 Q And about how long have you been in that position?

15 A A little over ten years. I actually took that position
16 once I was still in Chicago, and so for the first few years
17 of my appointment I was based in Chicago and conducting
18 research at East Tennessee State University, research on
19 pain patients.

20 Q And tell us just so we're clear, what degrees do you
21 actually hold and in what field?

22 A Bachelor of science with honors.

23 Q Okay.

24 A In applied biology with a concentration in pharmacology
25 and biochemistry and a Ph.D., a doctor -- doctoral degree in

Dr. Jonathan Lipman
Direct examination by Mr. Tessier

1 neuropharmacology from the University of Wales.

2 Q And you've given the court a number of your board
3 certifications and licenses. Are there any other board
4 certification and licenses that you think are particularly
5 relevant to your work in this case that we have before us?

6 A Well, there isn't a licensure as such in
7 neuropharmacology. There are board certifications. I have
8 a number of other board certifications, but I'm not sure
9 that they are of core relevance to what I'm opining on
10 today.

11 Q And the primary board certification for
12 neuropharmacologist would be what?

13 A There isn't a single board certification. There is
14 certifications within the areas of neuropharmacology that
15 one specializes, and I specialize in forensics, the American
16 Board of Forensic Examiners as a subspeciality board in
17 neuropharmacology.

18 Q And are you certified before both of those boards?

19 A Yes.

20 Q And what does it take to become certified in those
21 boards?

22 A Well, first of all, it involves you have to have a
23 doctoral degree. As far as I know you certainly have to be
24 professionally qualified.

25 You have to have a history of supervised work in the

Dr. Jonathan Lipman
Direct examination by Mr. Tessier

1 field. And that history is reviewed by a board of peers.

2 You have an examination that you study for, and in the
3 area of forensic examination -- this is a forensic ethics
4 and forensic procedures examination.

5 And you have to -- at least when I -- when I became
6 boarded, you have to deliver a presentation to the annual
7 meeting.

8 Q And do you have to do anything, Dr. Lipman, to maintain
9 your education or otherwise continue to be board certified
10 over the course of your career?

11 A Yes. You have to acquire continuing education units, a
12 certain number per year, and submit these for approval.

13 Q Your career responsibilities after you received your
14 Ph.D., did they relate primarily to neuropharmacology or at
15 least some related field?

16 A Yes.

17 Q And you said you do some consulting work as well. For
18 whom do you do consulting work today?

19 A A proportion is clinical consulting where a prescriber
20 or sometimes a pharmacist will call me into a case that
21 involves an adverse drug reaction or combination of drugs
22 and foods, or drugs and drugs, or drugs and underlying
23 conditions and ask for an opinion regarding what the drug
24 prescribed should be or what could be done masticate the
25 adverse effects. That occupies a proportion of my time.

Dr. Jonathan Lipman
Direct examination by Mr. Tessier

1 I also do consulting for disability evaluations,
2 workman's compensation injuries, traffic accidents, other,
3 insurance-referred cases where drugs that act on the brain
4 are relevant to the issue at -- at bar.

5 I do civil consultations, cases that involve adverse
6 drug reactions, medical malpractice practice, poisoning,
7 intoxications, whether a civil consequence is to the effects
8 of drug on the brain or, in quite a few cases, the absence
9 of the drug that should have been given which can have
10 catastrophic consequences.

11 In criminal cases I'm consulted by prosecution
12 regarding drug interventions, drug-alcohol interactions. A
13 lot of those have to do with things like D.U.I. cases or an
14 injury that has been sustained by a person intoxicated.

15 Sometimes they have to do with whether a drug -- this
16 is true less in the federal than in the state -- whether a
17 drug that a person has been arrested with is, in fact, a
18 controlled drug or not, and, if so, how would it affect
19 them. That's becoming increasingly common as the market
20 floods with designer drugs that are headed to unknown.

21 Defense criminal cases involve the behavior of people
22 under the influence of drugs, both drugs of abuse and drugs
23 that are therapeutically prescribed, the combination of
24 those two which is a very common consultation and
25 competence, particularly a competence to be executed,

Dr. Jonathan Lipman
Direct examination by Mr. Tessier

1 competence to be tried.

2 Sometimes the question has to do with the idiosyncratic
3 vulnerability of the individual. This is true particularly
4 of the very old who have sometimes bizarre effects to drugs
5 prescribed. I think that probably covered a survey of the
6 consultations.

7 Q And have you in your consultation practice, have you
8 consulted with both the prosecution side and the defense
9 side in criminal cases?

10 A Yes.

11 Q And have you consulted with the government as well more
12 generally?

13 A Yes. That's typically the case in military cases,
14 military trials where the appointment is not by the defense
15 or the prosecution but by the Court. It's called by the --

16 Q Convening authority?

17 A Convening authority, yeah.

18 Q As a neuropharmacologist then in general terms what you
19 are doing in the forensic context is reviewing drugs that
20 are given to or even not given to a particular individual in
21 evaluating the effects of those drugs on the individual. Is
22 that one fair way to characterize what you do?

23 A Yes, it is.

24 Q Now, you understand that we are here to ask you some
25 questions about Mr. Torres in particular and his individual

Dr. Jonathan Lipman
Direct examination by Mr. Tessier

1 susceptibility to the effects of certain drugs and
2 susceptibility to certain psychological impairment. Do you
3 understand that that's what we're here talk to about?

4 A Yes, sir.

5 Q And we're going to ask you some other questions about
6 Mr. Torres and his own drug treatment history. Would you
7 say that your expertise is particularly appropriate in
8 answering these types of questions?

9 A Yes.

10 MR. TESSIER: Your Honor, at this time we offer Dr.
11 Lipman as an expert in the field of neuropharmacology.

12 MS. BROWN: Without voir dire or objection, Your
13 Honor.

14 THE COURT: He is so qualified.

15 MR. TESSIER: And we would offer for the record
16 Exhibit 19 into evidence. That's the C.V.

17 MS. BROWN: No objection.

18 THE COURT: It's admitted.

19 (Curriculum vitae of Jonathan Joseph Lipman, Ph.D.,
20 marked Applicant's Exhibit No. 19.)

21 Q As I understand it, Dr. Lipman, we have a PowerPoint
22 presentation that you believe will assist you in presenting
23 your testimony here today, is that correct?

24 A Yes, sir.

25 Q If I can, I'm going to have you help us out basically

Dr. Jonathan Lipman
Direct examination by Mr. Tessier

1 with some -- start with some definitions if you will.

2 Now, I'm going to put the slides on the board, but you
3 feel free to tell us.

4 MR. TESSIER: Your Honor, can you see okay or shall I
5 move this?

6 THE COURT: That's fine.

7 Q So if you would, please, just start with telling us
8 some of the basic definitions that you work with on a daily
9 basis as a neuropharmacologist.

10 A Well, pharmacology as a field is that field --
11 academic, scientific, industrial, medical field -- dealing
12 with the mechanism of actions of drugs on living tissue.
13 And drugs interact with living tissue by virtue of their
14 mimicking certain endogenous chemicals, natural chemical,s,
15 either by facilitating those endogenous chemicals or
16 blocking those endogenous chemicals or altering the rate of
17 stimulation of those endogenous chemicals. So you can't
18 study pharmacology without understanding how the tissues,
19 the brain, the nerves work.

20 Q Okay. And so that's -- that's the general field of
21 pharmacology.

22 A Yes.

23 Q And then within pharmacology you have some additional
24 definitions that you thought would be helpful to the Court
25 in understanding. And I'll show you the next one,

Dr. Jonathan Lipman
Direct examination by Mr. Tessier

1 autopharmacology. In a minute I'll show you.

2 A Autopharmacology is the name that we pharmacologists
3 give to the tissues owned, transmitted functions within the
4 body, the ones that the drug will be acting upon.

5 The chemicals that communicate one tissue to another in
6 the body behave in a sense like drugs. And our drugs
7 interfere with the autopharmacological molecules.

8 Q Okay. And then neuropharmacology specifically is
9 another, is a subfield within pharmacology, is that fair?

10 A Yes. Neuropharmacology deals with the effects of drugs
11 on nerve, brain and behavior. And neuropharmacological
12 drugs are used by psychiatrists, used by neurologists.
13 Actually they're used by all practitioners.

14 There isn't really a major difference between
15 neuropharmacological drugs and others, but we study how
16 those drugs affect nerve, brain and behavior.

17 It can also include toxicities, for instance, nerve
18 gases on neuropharmacological agents although that is like
19 that to kill. Likewise in sex. It's a neuropharmacological
20 agent designed to kill.

21 Q And do they all -- do they all depend on a certain
22 structure within the brain in order to work?

23 A Yes. The vast majority act as the communicational gap
24 between nerves. It might be easier if I could draw this for
25 the judge.

Dr. Jonathan Lipman
Direct examination by Mr. Tessier

1 THE COURT: Certainly. Your Honor, if you would
2 permit it.

3 THE COURT: Sure.

4 (Whereupon, the witness left the stand.)

5 Q You have to speak up a little bit louder, Dr. Lipman,
6 without the benefit of your microphone.

7 A Right. The nerve, the nervous system, it's often
8 analogized to wires moving through the -- through the body
9 and the brain. But, in fact, it's not electrical as it
10 communicates.

11 where one nerve ends and another nerve begins the
12 signal is transmitted across the gap between those
13 chemically.

14 And if I could draw that, at the end of one nerve there
15 is a bottom ending. And where it comes close to it, it does
16 not touch the next nerve in the chain.

17 Electrical signals pass down this nerve, and they cause
18 the release of chemicals which signal the next nerve in the
19 chain.

20 These chemicals are called neurotransmitters. There
21 are a number of them relevant to today's proceedings, but
22 for the purpose of just generally explaining how a nerve
23 works, the neurotransmissions are made -- monoamine
24 neurotransmitters are made from amino acids. An example is
25 your tyrosine. Another be would tryptophan. Some of these

Dr. Jonathan Lipman
Direct examination by Mr. Tessier

1 are dietary; some of them we make ourselves. And they are
2 reconfigured and built in the body in the nerve.

3 Neurotransmissions which are within the pre -- we call
4 this the presynaptic call because it is before the synaptic
5 gap. And we call the next nerve in the chain the
6 postsynaptic nerve.

7 So the neurotransmitters in the presynaptic nerve are
8 intravesicals, bundles. And when a signal comes down the
9 axon, the nerve, it causes the vesicle -- fuses with the
10 presynaptic membrane and to release the neurotransmitter
11 into the gap, and the neurotransmitter acts as a receptor on
12 the postsynaptic membrane. It is a very specific molecular
13 match. The neurotransmitter has an affect on the receptor
14 the way that a key has an affect on a lock. And once it is
15 stimulated the receptor, and causes a reaction in the
16 postsynaptic membrane and the nerve has been either
17 inhibited or excited, depending upon what the nerve
18 transmitter is.

19 This neurotransmitter must be inactivated immediately
20 or the signal will continue to run. So there are enzyme
21 systems. One of them is catapult. That means I'll transfer
22 it. There are others, monaray [sic] and oxidate. That will
23 break down in other transmitters.

24 THE COURT: Excuse me just a minute.

25 The court reporter is having some difficulty in

Dr. Jonathan Lipman
Direct examination by Mr. Tessier

1 understanding you, because when you turn your face toward
2 the chart she can't hear or see what you're saying.

3 THE WITNESS: I'll try drawing left-handed.

4 THE COURT: Okay.

5 THE WITNESS: It may not be good.

6 THE COURT: It'll probably work just as well.

7 A So the neurotransmitter is released across the synapse,
8 across the synaptic cleft where it acts on the postsynaptic
9 membrane.

10 It must then be inactivated. It's inactivated either
11 by an enzyme in the cleft or it is taken back up into the
12 presynaptic neuron to be reused. And that process of taking
13 it back up uses a transport molecule like a little truck
14 that carries it and redeposits it inside the presynaptic
15 neuron.

16 The activity, the excitability of this neuron, is
17 controlled not only by the electrical signal coming down but
18 receptors on the presynaptic neuron of themselves stimulated
19 or inhibited by other neurotransmitters. Examples relevant
20 to the present case, for instance, could be glutamate, which
21 is a -- an excitatory neurotransmitter. Another also
22 relevant to the present is gamma-aminobutyric acid -- GABA.
23 And that is inhibitory.

24 So when the signal arrives and passes through to the
25 next nerve on the chain this happens at blindingly fast

Dr. Jonathan Lipman
Direct examination by Mr. Tessier

1 speed, nanoseconds. The whole thing is shockingly fast.
2 And the process of recycling, inactivating stimulation or
3 inhibiting the process must also happen shockingly fast.

4 Because this is how nerves conduct and because the
5 brain is made up of these gaps, it gives us places where
6 drugs can act. Some drugs -- an example may be the S.S.R.
7 antidepressants -- act by blocking this reuptake
8 transporter.

9 Some drugs act by forcing the release of the
10 neurotransmitter. Some drugs -- many of them -- and drugs
11 relevant to today's understanding block the receptor on the
12 postsynaptic membrane. Some drugs block the release of
13 neurotransmitters.

14 Each of these control steps therefore is the meat of
15 what a neuropharmacologist designs drugs to do, to interfere
16 with. And I would say that this is in general -- I don't
17 want to get into much detail, but this is in general a
18 simplified overview of how nerves work and where many
19 neuropharmacological drugs act.

20 Q Thank you. Doctor, if you want to, return to the
21 witness stand.

22 (Whereupon, the witness returned to the stand.)

23 Q Now, I'm not -- I'm not going to even pretend to try to
24 explain back what you just told us in detailed terms, but I
25 will ask you a couple of questions about this process.

Dr. Jonathan Lipman
Direct examination by Mr. Tessier

1 This is a process that occurs in human beings, and
2 other animals probably. But for our purposes this a process
3 that happens within human beings in their nerves.

4 A In -- in all animals, yes, and insects, slod --
5 seaslodes [sic] applies here, yes.

6 Q And just to -- just to clarify, I guess, not all humans
7 have it. It doesn't work the same way for all humans
8 depending on their preexisting condition and/or their
9 particular sensitivity to certain either drugs or enate
10 characteristics, is that fair?

11 A Yes, yes.

12 Q Let me finish if I can.

13 The last slide that you had on definitions, I think
14 it's called pharmacogenetics. And if you could, just
15 explain. What is pharmacogenetics within the field of
16 pharmacology?

17 A There are various genetic factors unique to an
18 individual that determine what a drug will do in that
19 individual. And these can be different between people.
20 Partly these pharmacogenetic factors influence the
21 sensitivity of the receptor. Some people are born with
22 missing receptors, in fact, if the case isn't -- degenerate
23 receptors. That's the case in diseases like Myasthenia
24 Gravis. And that will affect drugs that affect the
25 connotation in a system. Some are born with -- have an excess

Dr. Jonathan Lipman
Direct examination by Mr. Tessier

1 or a lack of the ability to manufacture a neurotransmitter.
2 And these can be genetic.

3 Some are born with defects and the drug metabolized in
4 the -- pharmacological metabolizing agents such as the
5 catapult ameth [sic] transfers his dopamine that breaks down
6 a neurotransmitter or the morionoxidates [sic] which brakes
7 down the neurotransmitter.

8 These enzymes are coded for genetically individuals and
9 individuals, certain individuals, can have defective either
10 overactive or underactive enzymes that interfere with the
11 transmission of the neurotransmitter.

12 where the drug acts at the nerve we have what's called
13 a pharmacokinetic profile. That is you take the drug, the
14 drug level rises in blood. The body then deals with the
15 drug, detoxifies it, metabolizes it, gets rid of it. That's
16 a pretty normal process. But it is under the control of
17 enzymes which are themselves genetically determined. And
18 those enzyme activities will therefore determine how
19 individual drugs are dealt with by the body. Some people
20 cannot deal with certain drugs. And these are, again,
21 genetically determined.

22 So there are a number of places from the taking of a
23 drug, to the blood level that the drug forms, to the effect
24 that the drug produces that are at least in part all -- all
25 influenced by genetic factors. And we call the field of

Dr. Jonathan Lipman
Direct examination by Mr. Tessier

1 that influence of genetics on the drug pharmacogenetics.

2 Q Then I want to show you the next slide that you had.

3 Dr. Lipman, in talking about determinants of drug
4 effect -- I guess as a more general proposition -- you just
5 explained, you know, the genetic side of the equation, that
6 genetics can influence your ability to process certain
7 drugs.

8 what about this slide, determine the drug affect more
9 generally? How is that important to you as a
10 neuropharmacologist?

11 A well, in its most general sense the effect of the drugs
12 depends on the set and the setting of the drug use. The set
13 includes the metabolic factors, the history of drug use, an
14 example being that if you, for instance, let's say,
15 chronically abuse alcohol. Your body will change to more
16 efficiently metabolize alcohol. And chronic alcoholics can
17 metabolize alcohol much more rapidly than normal people. so
18 the history of drug use.

19 The presence of underlying diseases or abnormalities
20 that will influence the affect of drug, these are all part
21 of set and determine how the drug acts, what levels it will
22 reach.

23 If the drug is a neuropharmacological agent acting on
24 the brain, then very important to interpreting how the drug
25 will behave is whether there are any underlying psychiatric

Dr. Jonathan Lipman
Direct examination by Mr. Tessier

1 or neurological or psychological illnesses.

2 And of course in the therapeutic arena that's exactly
3 why we give drugs, to treat neurological psychological
4 illnesses.

5 So the presence or absence of these underlying
6 illnesses is a major determinant on what a drug does in the
7 body.

8 As just a crude example, antidepressant drugs, for
9 instance, are the S.S.R.I. class. They are not mood
10 elevating. They will not make a normal person happy, not at
11 all. In fact, you'll probably feel bad.

12 But when acting on the underlying psychiatric illness
13 of depression they can counter the defect that is the
14 biochemistry of that depression.

15 So you cannot generalize about what a drug does to an
16 individual without addressing what it does to their
17 particular vulnerabilities. And those are all part of what
18 we call the set.

19 The setting is the circumstance under which the drug is
20 used. And those can be environmental, situational, salience
21 and so on.

22 Q And all of those factors are important as a
23 neuropharmacologist to help you determine and understand how
24 a particular individual is going to be affected by any use
25 of drugs whether licit or illicit, is that fair?

Dr. Jonathan Lipman
Direct examination by Mr. Tessier

1 A That's correct. They have to be taken into account.

2 Q Now, I want to ask you real quick. I was going to ask
3 you about some opinions that you hold in this particular
4 case, and then I'm going to back up and go through how you
5 came to form those opinions.

6 So, Dr. Lipman, do you have an opinion to a reasonable
7 degree of certainty as a neuropharmacologist as to whether
8 there are immuosenocratic [sic] factors unique to Mr. Torres
9 that relate to the action of drugs on him?

10 A I do.

11 Q And what is your opinion with respect to Mr. Torres?

12 A I have several. Firstly, Torres cannot properly
13 metabolize imipramine, which is a drug that he was treated
14 with as a child. Because he suffered an adverse reaction to
15 imipramine which was catastrophic. He was never again given
16 an antidepressant drug. So that experience determined in
17 part his future treatment.

18 He was given instead a drug that is more appropriately
19 called a chemical restraint, which is thioridazine. And he
20 was given that during his major developmental years, years
21 during which the brain was undergoing maturation pruden
22 [sic], should have been undergoing development. And the
23 drug would have and has interfered with that development.

24 Q Are there other underlying genetic factors that in your
25 opinion as a neuropharmacologist also influence Mr. Torres

Dr. Jonathan Lipman
Direct examination by Mr. Tessier

1 in his ability to accept and process certain types of drugs?

2 A Yes.

3 Q And what are they? what are they of relevance to you
4 in your work of Mr. Torres?

5 A If I understand the question right, the drug
6 metabolizing enzymes, for instance, there's one example.
7 The ones that breakdown drugs is in the -- in the liver
8 mostly.

9 There are 54 of them that we know about at the moment.
10 And different drugs are broken down by different of these.
11 And we call them Cytochrome P450. That's the name of these
12 drug metabolizing, drug oxidizing enzymes. And they are
13 what causes the drug to be converted to its metabolite. As
14 I said earlier, there are 54 that we know about right now.

15 These are genetically determined, and the genes' code
16 for them, are genetically polymorphous. The activity of a
17 particular genetic P450 can be -- you're born with this --
18 either high activity or intermediate activity or low
19 activity. And depending on what the activity level of that
20 P450 is you will be able to rapidly metabolize a drug,
21 normally metabolize a drug or not able to metabolize a drug
22 properly.

23 In that regard Mr. Torres has a defective, a low,
24 activity, Cytochrome P450 2C19. And that means that he
25 cannot properly metabolize imipramine, the tricyclic

Dr. Jonathan Lipman
Direct examination by Mr. Tessier

1 antidepressant he was given as a child. That means that the
2 drug if given to him would increase the toxic levels and
3 would have adverse behavioral outcomes.

4 Q So that is a genetic precondition with Mr. Torres
5 specifically, is that fair?

6 A Yes.

7 Q So he was born that way.

8 A Yes, he was born that way.

9 Q Are there other genetic preconditions? You heard
10 Dr. Rary's testimony yesterday. Are there other genetic
11 issues going with Mr. Torres that influence his ability to
12 handle drugs?

13 A Well, that relate to what drugs could or could not be
14 given to him, or should or should not benefit him?

15 Q Correct.

16 A Yes. His genetic deletion on chromosome 22q11 is
17 important because people with that condition are on a
18 spectrum from mild to severe. But what they have in common
19 is that they have a mood disorder and they have unstable
20 mood and they suffer from anxiety.

21 They are known to respond beneficially to S.S.R.I.
22 drugs, drugs of the Prozac family, for instance, or the
23 Paxil family better still because it has antianxiety
24 effects.

25 He also has Prader-Willi Syndrome, and this puts him in

Dr. Jonathan Lipman
Direct examination by Mr. Tessier

1 a class of people who have an impulse control disorder, who
2 are developmentally impaired in a number of ways and who
3 need pharmacological and behavioral assistance to get
4 through life.

5 Q So these items that you've mentioned -- the 22q11
6 deletion syndrome, Prader-Willi Syndrome and Mr. Torres'
7 inability to process imipramine, those are all genetic
8 preconditions that exist for Mr. Torres specifically, is
9 that fair?

10 A Yes. They are part of the set.

11 Q Okay. So nothing about those items can be changed, is
12 that fair?

13 A That's correct.

14 Q He's that way for his entire life.

15 A Yes. He's not going to get any taller.

16 Q Is there any -- is there any way a person can develop a
17 better ability to metabolize a drug that their genetic
18 precondition predisposes them not to be able to metabolize?

19 A Typically, we would do it by adjusting the dose, but,
20 no, you can't change the genetic, what we call potency, of
21 the P450 enzymes. Those you are born with and those you
22 have throughout your life at that activity.

23 Q So I think we've covered some of the determinants of
24 drug action that you believe are at issue with Mr. Torres in
25 general terms -- and I think we've got them on this slide

Dr. Jonathan Lipman
Direct examination by Mr. Tessier

1 right here. You hit 22q11 deletion, Prader-Willi, his low
2 activity on 2c19, which was the imipramine, and then we're
3 going to talk a little bit about what you believe to be
4 inappropriate thioridazine treatment, which was the drug
5 Mellaril by name.

6 A Thioridazine.

7 Q Thioridazine.

8 A No. Thioridazine.

9 Q Thioridazine.

10 A Yes.

11 Q And now I'd like to just break them into pieces and hit
12 22q11 first and have you elaborate if I may on the
13 significance of 22q11 in particular.

14 Did you -- do you agree? You heard Dr. Rary yesterday.
15 Do you agree with his opinion that Tony suffers from 22q11
16 deletion syndrome?

17 A Yes. It's -- it's certain.

18 Q And what is it based on?

19 A It's based on microarray assay that I requested. And
20 when the result was obtained I asked that it be repeated.

21 Q Okay.

22 MR. TESSIER: May I -- may I approach, the witness,
23 Your Honor?

24 Q What I'm going to do, Dr. Lipman, I'm going to show
25 you. I'm going to actually give you two things now so I

Dr. Jonathan Lipman
Direct examination by Mr. Tessier

1 don't have to repeat the trip.

2 This is Applicant's Exhibit 17, and here's Applicant's
3 Exhibit 18. Applicant's Exhibit 17, is that the microarray
4 you're talking about that detected the deletion?

5 A Yes. This is the output from the equipment that
6 detected the microarray deletion.

7 Q Okay.

8 A The -- in chromosome 22.

9 Q And was there any further testing that was done to
10 confirm that part of Tony Torres' particular deletion
11 encompassed the P.R.O.D.H. gene region?

12 A Yes. The part 22q11 in the region of 22q11 that he is
13 missing contains a number of very, very important genes.
14 Some of them we -- we know how to test for the gene
15 products.

16 The proline dehydrogenase, the PRODH, is a -- that gene
17 enzyme codes for the enzyme, dehydrogenase enzyme, that
18 breaks down proline which an amino acid in the body. It's a
19 marker for this activity of 22q11. It's not the only thing
20 within that region. But if indeed we were correct that the
21 22q11 was deleted and shown again on repetition to be
22 deleted, then it follows that he should have subeffective
23 proline dehydrogenase enzymes in his body. And a test for
24 that would be to measure his serum proline levels.

25 If the serum proline levels are higher than normal,

Dr. Jonathan Lipman
Direct examination by Mr. Tessier

1 thehn that is reflecting the deletion of the proline
2 dehydrogenase gene. It's what happens when proline
3 dehydrogenase isn't working properly.

4 And so to be absolutely doubly sure, not just repeating
5 the test as we did, I also requested or with Dr. Rary
6 requested an amino acid test for proline in his blood.

7 It wasn't possible to ask for just proline. You have
8 to buy a package of amino acid analysis. So we got a lot
9 more data than we actually asked for. But the testing
10 confirmed that his levels of proline are higher than normal,
11 as you would expect if 22q11 was deleted.

12 That wasn't the only region within 22q11 that was
13 deleted. The adjacent -- the area of the gene sequence next
14 to proline dehydrogenase is what's called the DiGeorge
15 critical region which Dr. Rary spoke of yesterday.

16 That's a region which if it was completely missing
17 would have massive effects on the heart and bones of
18 Mr. Torres. And it clearly isn't completely missing. He
19 might not have survived it in childhood. But it's
20 significantly missing according to the microarray assay.
21 There's a good piece of it that isn't there, and that is
22 relevant. The -- I could go on to say more, but I think
23 I've answered your question.

24 Q Yeah. And on the -- on that piece about the DiGeorge
25 critical region if you recall Dr. Rary's testimony he said

Dr. Jonathan Lipman
Direct examination by Mr. Tessier

1 that the entire PRODH gene is only about 3,000 or so base
2 pairs --

3 A Yes.

4 Q -- in its entirety. So of the 91,000 base pair
5 deletion that Mr. Torres has the vast majority of that has
6 to be in the DiGeorge region.

7 A Yes. That's what's next to it.

8 Q what I'd like to do is show the next slide but ask you
9 from a neuropharmacological perspective what is the
10 significance of the 22q11 deletion syndrome for Tony Torres.

11 A well, the significance for him is that 22q11 deletion
12 syndrome is associated with psychiatric illness.

13 There is in people who have this, a large proportion
14 suffer from mood disorders. A large proportion suffer from
15 what we call schizoaffective symptoms. A proportion suffer
16 anxiety. That's actually a major proportion. And they're
17 incapable of properly regulating their mood and -- yeah,
18 their mood.

19 Q And so children -- to summarize that, children then
20 born with 22q11 deletion syndrome, would it be fair to say
21 that they are more susceptible to certain psychiatric
22 conditions like the ones you just described?

23 A Yes. Seventy-nine percent of them have more than one
24 DSM diagnosis, four times higher than a controlled group.
25 Forty-eight percent have transient psychotic experiences

Dr. Jonathan Lipman
Direct examination by Mr. Tessier

1 including thought broadcast. These are transient. We're
2 not talking about a lifetime diagnosis schizophrenia. And
3 about 40 percent have inappropriate emotionality and
4 emotional outbursts frequently. So this goes along with
5 22q11.

6 Q In -- in the literature in your experience is the -- is
7 it typical that a person born with 22q11 deletion syndrome
8 will suffer from chronic psychosis?

9 A No, that isn't typical of the condition.

10 Q What you see is more transient psychotic features, is
11 that fair?

12 A Yes, maybe related to their anxiety, their inability to
13 handle emotional overload.

14 Q And is there a pharmacological treatment available for
15 the various psychiatrist disorders that are common in
16 children with 22q11 deletion syndrome?

17 A What's currently recommended is to treat the underlying
18 anxiety and mood disorder, and that is best done with
19 selective serotonin reuptake inhibited drug of the Paxil
20 class.

21 Q And help us out. Is that -- is it -- an SSRI drug,
22 generally speaking, an antidepressant?

23 A Yes. It blocks the transporter -- can I go back to the
24 picture?

25 (Whereupon, the witness left the stand.)

Dr. Jonathan Lipman
Direct examination by Mr. Tessier

1 A In a --

2 Q You might want to stand on this side.

3 A In a serotonin producing nerve where serotonin is the
4 neurotransmitter that crosses the gap and strikes the
5 serotonin receptor the inactivation of this is done by
6 reuptake. And the carry-on, if you want, it's called the
7 serotonin transporter and it is -- actually it's another
8 genetically coded transporter.

9 I didn't mention it, but, in fact, Mr. Torres'
10 transporter was not fully active. It was not detective, but
11 it doesn't have the highest activity. I mentioned that only
12 incidental.

13 The SSRI drugs block this transporter so serotonin
14 accumulates in the gap and increases the serotonin
15 stimulation postsynaptically and presynaptically, and it
16 takes longer for the serotonin to be broken down. And this
17 is a good thing because under the hypothesis that led us to
18 design this drug or drugs of this class depression can be
19 alleviated and anxiety can be alleviated by elevating brain
20 serotonin activity. And that's how those -- that class of
21 drugs work, Paxil more so than Prozac, for instance, works
22 more on the antianxiety end. But all of them act at the
23 serotonin reactor transporter. I've forgotten your
24 question. I'm sorry.

25 (Whereupon, the witness returned to the stand.)

Dr. Jonathan Lipman
Direct examination by Mr. Tessier

1 Q No. You've answered it. So the -- the point is that
2 the child with 22q11 deletion syndrome who may be much more
3 susceptible to developing some of these psychiatric
4 disorders will still be treatable with drugs like SSRI
5 antidepressants.

6 A Not alone.

7 Q Right.

8 A Because they still have the emotional instability.

9 Q Okay.

10 A And the way that we approach this, whether they're
11 depressed or not, is to give them a -- an anticonvulsant
12 drug.

13 Now, those -- those have somehow acquired the name mood
14 stabilizers because they're also used in people with bipolar
15 disorder, but they're not specific to bipolar disorder.
16 They're actually developed to treat epilepsy, which
17 Mr. Torres doesn't have, and neither do people who have
18 bipolar disorder.

19 But what they do is they stabilize the membrane either
20 by an action on GABA, the neurotransmitter that is
21 inhibitory that I drew on the left or by interfering with
22 the sodium pore on the glutamate stimulatory neuro --
23 neurotransmitter.

24 So you -- you do both. You address the mood and you
25 address the emotional instability. The outbursts are calmed

Dr. Jonathan Lipman
Direct examination by Mr. Tessier

1 by -- I'm going to call them anticonvulsant drugs.

2 Q Okay. And let me ask you now. You've talked about the
3 impact on Mr. Torres of the fact that he has 22q11 deletion
4 syndrome. I'd like to draw your attention to the fact that
5 he has also Prader-Willi syndrome.

6 A Yes, sir.

7 Q And that is something you would agree with Dr. Rary,
8 would you not, that it is a genetic condition?

9 A Yes.

10 Q So it's not something that Mr. Torres had any choice
11 about.

12 A No. He was born with it.

13 Q From a neuropharmacological perspective what you would
14 say is the significance of Prader-Willi syndrome for Tony
15 Torres?

16 A Actually, as far as pharmacology is concerned, we can't
17 really do more for them than address the -- the anxiety and
18 the mood instability.

19 The -- I would say that the main effort at modifying
20 the development of a person with either of these conditions
21 forced [sic] the developmental psychologist. But to the
22 extent that the pharmacologist can add anything to their --
23 the mitigation of their -- their illness we address the
24 anxiety and we address the instability of mood which leads
25 to the outbursts.

Dr. Jonathan Lipman
Direct examination by Mr. Tessier

1 Q So is it the case in your opinion that a person born
2 with Prader-Willi syndrome, like a person born with 22q11
3 deletion syndrome, is more susceptible to certain
4 psychiatric conditions?

5 A Yes. As I mentioned for the 22q11, they have a much
6 higher incidence of DSM diagnoses, almost 80 percent. And
7 they have a much higher incidence of transient psychotic
8 episodes and of inappropriate emotionality and frequent
9 outbursts. These are all neurological disorders that have
10 psychiatric consequences.

11 Q And so is it fair to say based on your description that
12 someone born with Prader-Willi syndrome just like someone
13 born with 22q11 deletion, either one standing alone makes
14 that person more susceptible to very similar types of
15 psychiatrist disorders?

16 A Yes, and misbehaviors that result therefrom.

17 Q And so either one standing alone could cause these
18 problems, or if you have both together I assume you're even
19 more likely to fall into that category of having psychiatric
20 conditions.

21 A Yes.

22 Q And you mentioned it already, but with the Prader-Willi
23 syndrome much like 22q11 deletion syndrome, are they -- are
24 they likely to develop chronic psychosis?

25 A No, not -- this is an organic condition. Typically,

Dr. Jonathan Lipman
Direct examination by Mr. Tessier

1 when you use words like schizophrenia or bipolar psychosis
2 you're talking about something that is primarily a psychotic
3 illness.

4 They don't develop those as a rule, or at least I don't
5 know of any examples that have. There may be some in the
6 literature. But what they do develop are transient episodes
7 of psychosis.

8 Q And those transient episodes are believed to be
9 stemming from the underlying mood disorder?

10 A And anxiety. And I don't think you could separate them
11 because they're related neurochemically, you see, at the
12 GABA receptor or the Glutamate receptor and the serotonin
13 receptor and it -- it's -- you can't really pull them apart.

14 Q The anxiety and the mood disorder.

15 A And the emotional instability they are related
16 chemically at the level of the brain.

17 Q Either way, whether you develop the psychiatric
18 disorder that you're talking about from Prader-Willi
19 syndrome or 22q11 deletion syndrome, there is a way
20 pharmacologically to try to treat those psychiatric
21 conditions.

22 A In part. Again, I would say the major effort is to be
23 put forth by the developmental psychologist, but to the
24 extent that we can contribute to the treatment of an
25 individual with these problems these are the roots that we

Dr. Jonathan Lipman
Direct examination by Mr. Tessier

1 would use.

2 Q So what I'm hearing you say is you can't treat those
3 psychiatric conditions exclusively by medication.

4 A Absolutely not.

5 Q They must also be coupled with behavioral therapies.

6 A Yeah, but let me add that when this is occurring in a
7 child the brain is in a condition that is constantly
8 changing, developing new neurons, sprouting and -- and
9 pruning neurons. It is a very dynamic thing.

10 A child's brain from one week to the next is almost a
11 different thing. So we focus in child development on
12 maximizing the development of that brain.

13 And that isn't done by medication. We can -- we can
14 mitigate the adverse effects of the condition with the
15 medication, but we can't cure anything with it.

16 Q And certainly you cannot cure Prader-Willi syndrome
17 itself or 20q -- 22q11 deletion syndrome itself with drugs.

18 A Right. You can't. That's genetic and effects -- no.

19 Q And what you're trying to do is treat pharmacologically
20 and behaviorally -- not you personally -- but the treatment
21 pattern for these individuals is to treat psychiatric
22 conditions that result.

23 A Yes.

24 Q What about Tony Torres specifically? In your review of
25 his records did you come to any conclusions about specific

Dr. Jonathan Lipman
Direct examination by Mr. Tessier

1 psychiatric conditions that Tony Torres suffered from from
2 an early age?

3 A Well, diagnosis was not a major part of his record.
4 None of these genetic disorders were recognized apparently.

5 I would have to say that he was described more in
6 behavioral terms. At some point during his development it
7 began -- because he responded to anticonvulsant drugs --
8 these are the antiepileptic drugs that I mentioned that
9 would be helpful and are the ones that I said that are also
10 used in bipolar disorder -- because he responded well to
11 Lithium and at a certain point in his childhood history to
12 carbamazepine, which is another anticonvulsant drug, I think
13 because he responded well to those at some point he acquired
14 the level of bipolar disorder. I wouldn't necessarily
15 dispute that it looks like bipolar disorder. But depression
16 was clearly an early observation.

17 Q Now, you mentioned earlier -- and I want to bring you
18 back to it -- this drug metabolism in general -- can you
19 explain for the Court the basic process of how drug
20 metabolism occurs within the human body? And I think
21 you have a slide for it.

22 A It's a 2-step process. And at the body's ostensive
23 intention -- if you can speak of intentions -- is to get rid
24 of the drug.

25 The first step oxidizes the drug to make it more water

Dr. Jonathan Lipman
Direct examination by Mr. Tessier

1 soluble, and the second step called Phase 2 Metabolism
2 combines it with a molecule that is more easily water
3 excreted so that it can be passed out in the urine or the
4 stool.

5 It's, as I said, a 2-step process. The first is under
6 the control of the P450 enzymes that I mentioned earlier.
7 The second, Phase 2, it's a glucurone addiction reaction
8 that is more common to drugs of different classes. We have
9 less -- I know of 57 Phase 1 enzymes. I only know of
10 actually two or three involving the second step.

11 So once the drug has gone through its first step
12 metabolism they enter a narrower range of Step 2 excreting
13 metabolisms.

14 Q And for the purpose of your work with respect to Tony
15 Torres' case, was it the first phase of metabolization that
16 was important to you?

17 A Yes. If the drug doesn't pass through -- well, the
18 blood level of a drug is determined very much by the rate at
19 which it is being removed.

20 When you swallow a drug -- any kind, alcohol, for
21 instance -- as the drug is absorbed your blood level rises;
22 as the drug is excreted your blood level falls.

23 With the drug such as a therapeutic drug that you're
24 taking four times a day, if you're not getting rid of that
25 drug it accumulates in your body and you suffer from

Dr. Jonathan Lipman
Direct examination by Mr. Tessier

1 toxicity -- overdose as it were -- even though you perhaps
2 are taking it, let's say, as prescribed. It's not being
3 removed, and you will become toxic. And so the Phase 1
4 metabolism is the most important of all.

5 Q And that's the P450 system as you described.

6 A Right. I didn't just look at that with him. I -- I
7 looked at several P450 enzymes. And in my view was simply
8 to see if there anything about his P450 enzymes that tells
9 us anything about any of the drugs that he was -- he was
10 given.

11 I had no apriority assumptions about this, but I found
12 that his -- his P450 2c19 was a very low activity. And that
13 was relevant to his history.

14 Q Dr. Lipman, as a neuropharmacologist when you are
15 taking on pretty much any case in which you are trying to
16 determine a patient's ability to metabolize drugs is it
17 important for you to know this kind of background
18 information on the individual person you're dealing with?

19 A Yes. If I can't actually get a blood level following
20 the drug being administered this is -- well, actually I do
21 this anyway. But that's the next best thing.

22 Q And are there tests that you are able to run to check
23 for this ability to metabolize drugs?

24 A Yes, there are.

25 Q What type of test? How could you describe the test?

Dr. Jonathan Lipman
Direct examination by Mr. Tessier

1 A There are genetic polymorphism tests.

2 Q And did you conduct such a test with respect to
3 Mr. Torres?

4 A Yes, I did.

5 MR. TESSIER: May I approach, Your Honor?

6 Q I am going to show -- I'm going to show you, Dr.
7 Lipman, Applicant's Exhibit No. 20 which I think you've just
8 referred to, but tell us if you would what Applicant's
9 Exhibit No. 20 reflects.

10 A Okay. Well, my record is more extensive than this, but
11 if I could introduce Exhibit No. 20, first, by telling you
12 that I tested for cytochrome P450 2c19. Cytochrome P450 2c9
13 and the meka R C1 genetic basis of the metabolizing enzymes,
14 one of them, this one P450 2c19, keyed out as a poor
15 metabolizer. And this is the report on what that would do
16 to Imipramine, a drug that he was given when he was three
17 years and seven months of age.

18 Q And so that is the result for Mr. Torres for 2c19
19 specifically.

20 A It's a result for 2c19 as it would effect Imipramine
21 metabolism.

22 MR. TESSIER: Your Honor, at this time we would offer
23 Exhibit No. 20 into evidence.

24 MS. BROWN: No objection.

25 THE COURT: It's admitted.

Dr. Jonathan Lipman
Direct examination by Mr. Tessier

1 (DNA report of Dr. Rary marked Applicant's Exhibit No.
2 20.)

3 Q Dr. Lipman, you mentioned you ran the test for a few
4 different types of enzymes.

5 Is there any particular method by which you select the
6 various enzymes that you personally want to test for as a
7 neuropharmacologist?

8 A Well, I always test for these four -- five actually,
9 because I include the serotonin transporter.

10 If I'm just looking at the commonest ones, if I have a
11 specific drug in mind, then I might direct the lab to look
12 specifically for that. But these are the ones that I do
13 pretty much on everyone where I'm doing a gene polymorphism
14 study.

15 Q So, Dr. Lipman, with this particular test is there
16 any -- is this -- would you characterize this as an
17 objective, an objective measure of Tony Torres' ability to
18 metabolize Imipramine?

19 A Yes.

20 Q And is this a pretty standard test among
21 neuropharmacologists and other medical professionals?

22 A It's not as common as I would like it to be. Frankly,
23 I -- I think every physician who is prescribing any drug at
24 all should do this test.

25 Q Before they prescribe it?

Dr. Jonathan Lipman
Direct examination by Mr. Tessier

1 A Before they prescribe the drug. And the beauty of it
2 is that like knowing what your blood group is, this is yours
3 for life. So there's no reason why we shouldn't all have
4 this on our driver's licenses really, this information.

5 Q Some drugs are effectively poison to certain people.

6 A Absolutely.

7 Q Was this test that you did to determine that Mr. Torres
8 has an inability to process Imipramine or metabolize
9 Imipramine like normal people do, was that test available
10 for someone to run on Tony Torres' blood sample back in 2007
11 and 2008?

12 A Yes, it was available.

13 Q And if someone had asked for such a test to be run on
14 Mr. Torres before his murder trial in 2008 would they have
15 discovered this inability to metabolize Imipramine back
16 then?

17 A Yes.

18 Q Now, I'd like for you to talk about the pharmacological
19 relevance of all of the various determinants that you have
20 found for Mr. Torres in terms of his actual record
21 treatment.

22 I know you've touched on it a bit because it appears to
23 you in looking at the records that he was treated or
24 attempted to be treated for what looked like some bipolar
25 issues and/or depression issues.

Dr. Jonathan Lipman
Direct examination by Mr. Tessier

1 A Yes. And of course his impulsivity and aggression.

2 Q And what jumped out to you as significant as a
3 neuropharmacologist about the attempted treatment of Mr.
4 Torres as a child?

5 A What jumped out at me, screaming at me, was his
6 experience at age three years and seven months when he was
7 trialed on -- he was given the trial Imipramine. And his
8 mother's words to the doctor as I read it in the record, he
9 went bonkers. This massively increased his problems. He
10 was -- he became violent.

11 Q And could you tell in the record -- and just to make
12 sure we're clear on this -- Imipramine is an antidepressant.

13 A It's a tricyclic antidepressant, quite different from
14 the SSRIs.

15 Q There are multiple classes of antidepressants. Is that
16 fair?

17 A Yes.

18 Q And the one that was attempted -- the one that you saw
19 in the records that was tried on Mr. Torres was Imipramine,
20 which is a different class than the SSRIs?

21 A Yes. Just to put it mechanistically, since you know
22 how the SSRI was based on my illustration, the tricyclics,
23 they -- they do block the serotonin uptake, but they also
24 block dopamine uptake, Norepinephrine uptake, and they
25 stimulate acetylcholine [sic] receptors.

Dr. Jonathan Lipman
Direct examination by Mr. Tessier

1 So they have acetylcholine cholinergic side effects,
2 and/or they act at acetylcholine receptors, I should say --
3 excuse me. And they have cholinergic side effects. And
4 therefore in overdose they block so many things that the
5 toxicity state that results can be quite unpleasant. And
6 that's distinct from the SSRIs which are -- the word is
7 selective serotonin reuptake inhibitor, a distinctive
8 mechanism and in effect both therapeutic and in toxicity.

9 Q Did you see any evidence in the record for Tony Torres
10 that he was ever attempted on any other antidepressant drug
11 besides Imipramine?

12 A No. The later records, the later narratives, by other
13 physicians who saw him made reference to his having an
14 adverse reaction to Imipramine, and there was no further
15 attempt throughout his childhood to put him back on any
16 antidepressant.

17 Q Now, and, Dr. Lipman, do you have an opinion to a
18 reasonable degree of certainty as an expert in the field of
19 neuropharmacology as to whether there existed a
20 pharmacological treatment program that would have
21 therapeutically treated Mr. Torres in his particular
22 psychiatric disorders from the age of two to adulthood?

23 A I do.

24 Q And what is your opinion on whether there is -- what is
25 your opinion on appropriate pharmacological treatment?

Dr. Jonathan Lipman
Direct examination by Mr. Tessier

1 A An SSRI with a mood stabilizer such as he is presently
2 being well treated on, and well controlled.

3 Q And do you know the actual drugs he is currently being
4 treated with?

5 A Paroxetine, Paxil and the mood stabilizer is
6 Gabapentin.

7 Q And those -- those drugs were not attempted as far as
8 you can tell from Tony Torres' childhood medical records.

9 A No.

10 Q Or that combination.

11 A That combination. Various types of anti --
12 antiepileptic drug were given to him over the years but not
13 in combination with an SSI type antidepressant. SSI's
14 antidepressants are the preferred treatment for people with
15 22q11.

16 Q So the appropriate treatment that you believe should
17 have been given to Mr. Torres was not given.

18 A Not at all. He was given the Lithium and carbamazepine
19 at various times and responded apparently well to it, but at
20 that time he was not being given an antidepressant of the
21 SSRI class.

22 Q Now I want to talk to you about any of Mr. Torres'
23 records, not about what was not given to him as a child but
24 what was given to him as a child instead of the
25 antidepressant.

Dr. Jonathan Lipman
Direct examination by Mr. Tessier

1 Did you see a drug in Mr. Torres' record from ages two
2 to 11 that troubled you when you saw it as a treatment for
3 Mr. Torres in particular?

4 A Yes. The drug was thioridazine. The trade name is
5 Mellaril. And he was given this -- this is antipsychotic
6 drug, an extremely powerful antipsychotic drug normally used
7 to control schizophrenic psychotic symptoms in adults. And
8 he was given this at age -- on and off until age 19
9 months -- 19 months.

10 Q He began being treated with Mellaril at the age of 19
11 months?

12 A Yes. That's what the records say.

13 Q Is there any -- to your knowledge as a
14 neuropharmacologist is there any acceptable prescribed
15 treatment dosage of Mellaril in a child that age?

16 A No. The Food and Drug Administration indications for
17 the use of actually very low doses of Mellaril for use in
18 children are only for the age of seven and after, and that's
19 when it is appropriate to children.

20 Q What is -- what's the basic history of antipsychotic
21 drugs?

22 A Let me say seven years, because we put 19 months here.

23 Q Okay. So you're saying that the -- what you see as
24 prescription levels from seven years of age and older.

25 A In the literature, yes.

Dr. Jonathan Lipman
Direct examination by Mr. Tessier

1 Q But not younger than seven years of age.

2 A And certainly not 19 months.

3 Q Tell us if you would a little bit about the history of
4 antipsychotics and their use. What are they designed to be
5 used for?

6 A They were developed in the 1950s as major
7 tranquilizers. When they were initially introduced to tell
8 you the truth this is long before the Food and Drug
9 Administration came into existence, long before its
10 equivalent in other countries came into existence. And
11 there wasn't much control of what a physician could do with
12 drugs. So it was new. It was the second type of
13 antipsychotic drug to be developed. The first was called
14 promazine. That's not involved in this story. Thioridazine
15 was the next wave. And these are neuroleptic drugs. They
16 block dopamine receptors. They are chemically stunning. If
17 you've seen the movie "One Flew Over the Cuckoo's Nest" and
18 you see the zombie like behavior of the character, the
19 chief, that's how neuroleptics work.

20 And the side effects are profound. It causes this
21 zombie like movement, for instance. Originally, we did not
22 know. This was before my time. But we didn't know
23 precisely how to use these drugs or that it would be useful
24 in schizophrenia. But in the early days they were given for
25 a number of other things such as protracted hiccups. Well,

Dr. Jonathan Lipman
Direct examination by Mr. Tessier

1 that sounds ridiculous now. And gastric ulcers. I know
2 that sounds equally ridiculous. But because they were we
3 could see that the side effects that the neuroleptic drugs
4 produced in schizophrenics were also produced in people who
5 did haven't schizophrenia and therefore by this -- by this
6 method we could tell what the adverse effects of the drug
7 are as distinct from schizophrenic illness itself. And they
8 produced some profound and in some cases permanent adverse
9 effects.

10 Q And can you describe what some of those adverse effects
11 are on the human brain, for example?

12 A Okay. Some of them are due to the persistent change in
13 the brain's dopamine receptors. These are the ones that
14 control mood in the mesocorticolimbic circuits of the brain.
15 Dopamine is the brain's pleasure molecule. It's what gives
16 us a sense of joy in seeing a beautiful sunset, a sense of
17 elation at being presented with food or a good meal when you
18 are hungry -- dopamine immediate sensation, the neuroleptic
19 block, dopamine.

20 The dopamine in addition to its role in the
21 mesocorticolimbic circuits which connect the front lobes of
22 the brain that we -- that is relevant to this particular
23 individual, in addition they are also involved in motor
24 control.

25 And we know from the history of people who have been

Dr. Jonathan Lipman
Direct examination by Mr. Tessier

1 treated with neuroleptic drugs that after a protracted use
2 they can develop a condition that resembles Parkinson's
3 disease. And it's purely caused by chronic use of the drug.

4 In some cases that goes away and they get better when
5 the drug is withdrawn. In other cases weeks or even months
6 after the drug is withdrawn the affected areas of fine motor
7 control are still deranged, and the person weeks and months
8 after the drug is withdrawn then develops what looks like
9 Parkinson's disease, and it's permanent, and it's for the
10 rest of their life, and the drug caused it because it
11 damaged the extraperineal parts of the brain.

12 Now, ironically, the only way to control those symptoms
13 is to put them back on the drug and the -- possibly that is
14 an acceptable solution if a person is schizophrenic, but if
15 they were given the drug for hiccups there's not an
16 acceptable solution. Can't keep them on this canonical
17 carsh [sic] for the rest of their lives.

18 So neuroleptic drugs are not used lightly. They have
19 potentially adverse consequences that can be life long. And
20 I have mentioned a mood disorder, but when I described the
21 affects on mood, the blunting effect by blocking the
22 mesocorticolimbic dopamine circuits, the ones that -- the
23 frontal lobe, long losing effects can be produced there as
24 well, effects that don't actually emerge until the drug is
25 withdrawn. And these are mood disorder. It's called

Dr. Jonathan Lipman
Direct examination by Mr. Tessier

1 Tardive dysphrenia, and it can involve agitation. That's
2 called Tardive Akathisia. The word Tardive means late,
3 meaning late after the drug is withdrawn. So the drug
4 leaves branding on the brain, and that's why we don't use it
5 lightly and why it should be reserved for serious things
6 like schizophrenia, people who are abducted by aliens or
7 believe that minds are possessed by animals. It shouldn't
8 be used lightly.

9 Q And is it -- as a neuropharmacologist can you say that
10 the use of Mellaril or an antipsychotic drug like Mellaril
11 is actually contraindicated when you have only transient
12 psychotic episodes like Mr. Torres would have?

13 A I don't think you could justify it on those grounds.
14 The -- the fact is that the drug is so stunning -- I would
15 refer you back to that movie again -- that it can be used as
16 a kind of chemical shackle. And that's probably not
17 ethical, but it's sometimes done.

18 Q And for Mr. Torres -- and I think you have some notes
19 about the records you saw -- he was placed on Mellaril as
20 early as the age of 19 months and continued with some
21 Mellaril as part of his medications through what age?

22 A I believe age 14, but that's only because I don't have
23 records between 14 and 17.

24 Q Okay.

25 A And I have no reason to believe it stopped. It's just

Dr. Jonathan Lipman
Direct examination by Mr. Tessier

1 that I'm lacking the records for that period of time.

2 Q But at least for a multiyear period during his key
3 developmental years he was on this antipsychotic drug.

4 A Did I say 14? I meant 11. Excuse me.

5 Q So that's about nine years on and off he was on
6 Mellaril.

7 A Nine years of critical brain development period.

8 Q And do you -- are -- is the use of antipsychotics known
9 to cause damage or atrophy to the frontal lobes of the brain
10 as well?

11 A Yes.

12 Q And why is that significant?

13 A The frontal lobes are the areas of the brain that in
14 part are responsible for self regulation and judgment and
15 self control. And when these are damaged -- the classic
16 case was a case called Phineas Gage who had a railroad rod
17 jagged through the frontal lobes of the brain.

18 when the frontal lobes are damaged the personality
19 becomes changed. The person has less ability to plan, to --
20 to reason, to judge, to control impulses. And the frontal
21 lobes need to be developed, and development is something
22 that should happen throughout childhood.

23 Q Do you have an opinion then based on what you've seen
24 or the actual treatment provided to Mr. Torres
25 pharmacologically, that is -- do you have an opinion to a

Dr. Jonathan Lipman
Direct examination by Mr. Tessier

1 reasonable degree of certainty as an expert in the field of
2 neuropharmacology as to whether the treatment Mr. Torres
3 received with the use of the mood stabilizer or
4 anticonvulsant, coupled with Mellaril, was an appropriate
5 pharmacological treatment for him from ages two to at least
6 11?

7 A I have no criticism of the Lithium or the Tegretol or
8 the other anticonvulsants. I think those are probably
9 appropriate.

10 What I think was inappropriate was the use of this
11 major neuroleptic antipsychotic drug through that time
12 period, not only because it has the possibility of producing
13 long-lasting damage -- and it certainly shrinks the brain --
14 but because there are other things that could have been done
15 that weren't.

16 Q And that's the SSRIs, among others?

17 A Yes.

18 Q Is it -- in your opinion is it at all possible that
19 Tony Torres would be unaffected in his later life by this
20 course of treatment of Mellaril for such an extended period
21 of time?

22 A I don't think it would be reasonable. I think he must
23 have been effected.

24 Q In your opinion as a neuropharmacologist is there
25 anything about Tony's preexisting conditions that we've

Dr. Jonathan Lipman
Direct examination by Mr. Tessier

1 talked about today -- Prader-Willi syndrome, 22q11 deletion
2 syndrome, inappropriate pharmacological treatment that he
3 received -- is there anything about those preexisting
4 conditions for Tony Torres that make him more susceptible to
5 the psychotoxic effects of methamphetamine abuse or alcohol
6 abuse?

7 A Yes, both for different reasons.

8 Q And how would that manifest?

9 A Okay. Chronic amphetamine abuse and its affects
10 differs from acute amphetamine -- methamphetamine -- use.
11 And I need to distinguish those first.

12 Methamphetamine when it is used acutely, when you first
13 use it, is a mood elevator. And to a person that is
14 depressed the world will become brighter, their emotions
15 more ebullient. They will feel as though this is wonderful,
16 this must be how I'm supposed to feel, this must be how
17 other people feel. And this is not an illusion, because
18 actually methamphetamine is an antidepressant. And it used
19 to be prescribed for that purpose. And it's a good one.
20 It's just not suitable for chronic use.

21 But the effects of a person -- on a person who has
22 depression is like magic. And to be introduced -- to be
23 depressed and to be introduced to methamphetamine is to find
24 what seems to be the solution to your problems.

25 It will make you feel more complete. The blackness

Dr. Jonathan Lipman
Direct examination by Mr. Tessier

1 will lift. The heaviness, the pain of the world, will lift.
2 And you will feel good possibly for the first time in a long
3 time.

4 For that reason of course when a depressed person comes
5 across illicit methamphetamine they're tempted to repeat the
6 experience. And because this is not supervised they are
7 tempted to take large doses. And large doses produce a
8 sensation of competence and power and euphoria and
9 aloofness. And these are not illusions. You really are
10 more alert.

11 It banishes hunger, and in a person with Prader-Willi
12 syndrome -- Prader-Willi syndrome who has outrageous
13 hunger -- and I should mention that on interviewing
14 Mr. Torres the other day he had mentioned that his hunger
15 throughout his life has been so outrageous that he has
16 actually eaten -- taken frozen food out of the freezer and
17 eaten it frozen. That's hyperphagia. That's not an
18 appetite. That's an illness. But, in fact, methamphetamine
19 will quench that. And when you look at his arrest photos,
20 he'd lost weight.

21 I will add that we used to use methamphetamine -- and
22 it is still on the books -- as prescribable for weight loss.
23 Obviously, it has some long-term consequences that are
24 undesirable.

25 However, when you use methamphetamine at abuse -- abuse

Dr. Jonathan Lipman
Direct examination by Mr. Tessier

1 doses the elation and the alertness and the fact that it
2 vanishes appetite and it banishes sleep -- you cannot sleep
3 under the influence, not properly. In fact, that's why we
4 give it to soldiers even in the U.S. and airmen in the Air
5 Force, in the Navy Air Force -- so that they can fly 24-hour
6 missions without sleep. Probably not advisable, but we do
7 do that.

8 when you're abusing the drugs you can be without sleep
9 for days and days and days, and of course sleeplessness,
10 protracted sleeplessness, has really psychotoxic effect on
11 the brain.

12 when the drug is used acutely to contrast it with the
13 chronic effects, the elation, the euphoria, the energy, the
14 confidence, the competence, these are all good. But there
15 is an edge to the experience that is anxious and
16 hypervigilant. And there's a reason for that. It's because
17 the brain areas responsible for what we call the
18 fight-or-flight response are being activated.

19 Normally in you and me these are activated when, for
20 instance, if you were dropped in a jungle where you knew
21 what type it is and you were having to walk to the edge of
22 the jungle, you would be alert for every broken twig, every
23 movement of a leave. You would -- you would be
24 hypervigilant and suspicious of everything -- and you had
25 good reason to be because there are tigers there. This is a

Dr. Jonathan Lipman
Direct examination by Mr. Tessier

1 neuroantipren [sic] circuit in a brain and body that
2 connects the adrenal glands, the hypothalamus, the nerve
3 system and high doses of amphetamine activate it. So the
4 person who is using large doses of methamphetamine has
5 activated this fight-or-flight reaction, and it produces, as
6 I say, this anxiety and agitation.

7 Now, the problem that occurs when you use the drug
8 chronically and you're going without sleep and you're not
9 eating is that although repeated use of the drug causes less
10 and less euphoria -- and we call that tolerance -- the
11 adverse effects of the drugs become more and more severe.
12 You don't get tolerant to those. It's called reverse
13 tolerance or sensitization. So the anxiety flowers, the
14 fear flowers, the hypervigilance becomes more intense, and
15 you start to see things, threatening things, because this is
16 a flight-or-fight response. You start to see things that
17 are threatening.

18 And there are some characteristics things that people
19 who abuse large doses of amphetamine for a while, for a week
20 or two, always report to me that they say see. These are
21 shadow people. They believe that they are under
22 surveillance, but the surveillance is delusional. And you
23 can use usually tell that by asking them, well, how is the
24 surveillance.

25 An example of one case just to show you that it is a

Dr. Jonathan Lipman
Direct examination by Mr. Tessier

1 delusion is that I was told by one methamphetamine abuser
2 that he was being followed by a helicopter with red and
3 green lights that was trailing an instrument could count the
4 money his wallet.

5 Now, I don't believe that. Okay. I don't think there
6 is such a machine. And that's a delusion. It has to be.
7 But when I spoke to the witness to this behavior and I asked
8 him -- I asked the witness what did you see when you went to
9 his yard. He said, well -- his name was John. John was out
10 there with an S.K.S. rifle blasting away at the sky. And I
11 said to him, "John, what you are shooting at?" And he said
12 F'ing helicopters counting the money in my wallet. And the
13 witness told me. But there were no helicopters. It's a
14 hallucination. John didn't know it. But there were no
15 helicopters.

16 So, ultimately, a person who is in this chronic
17 methamphetamine condition is, frankly, psychotic. And the
18 condition can look like an acute schizophrenic episode.

19 I mentioned in terms of Mr. Torres' depression the
20 reason why he would find methamphetamine attractive. But
21 there is another reason that his background, his genetics,
22 should be taken into account, and that is that in the
23 population of people who abuse methamphetamine there seem to
24 be one of two ways that the -- the psycho-toxicity can go.

25 Most people develop a mood disorder wherein their mood

Dr. Jonathan Lipman
Direct examination by Mr. Tessier

1 crashes catastrophically into depression as the drug level
2 falls. Those people may or may not develop psychotic
3 symptoms of hallucinations.

4 The other end of the spectrum of the people who had the
5 mood disorder and they have psychosis, they are hearing
6 things that aren't there, threatening things they are
7 seeing, things that aren't there. They are believing things
8 that are not possible. But they believe them.

9 And what seems to be distinguish these two categories
10 is that the ones that become most readily psychotic have a
11 predisposition to psychosis. And in the normal
12 population -- not the Prader-Willies, not the 11, the
13 22q11's -- people like you and me -- the presence of a
14 history, a family history, of psychotic vulnerability -- a
15 mother who is bipolar, a father who is schizophrenic or who
16 has borderline syndrome -- these are inherited
17 vulnerabilities to developing this psychotic end of the
18 spectrum under the influence of methamphetamine. And they
19 are not protected.

20 The other end of the spectrum, people that don't
21 develop psychosis, they have the mood disorder eventually.
22 They don't have that familial inheritance. So a lot of this
23 vulnerability to the adverse effects of -- of
24 methamphetamine come from your genes and your inheritance.
25 Some of the genes, of course, you don't inherit. They're

Dr. Jonathan Lipman
Direct examination by Mr. Tessier

1 accidents at birth, and that's of course the case here. But
2 some of it is inherited, and that's also the case here.

3 Now, you'd asked me about alcohol as well. There are
4 two factors that are relevant to alcohol with regard to a
5 person having these syndromic characteristics.

6 Anxiety, I mentioned, is one of the things that we try
7 to treat therapeutically, and that's why SSRIs are also
8 addressed anxiety such as a Paxil, paroxetine, which he's
9 presently treated with. That's why those are effective, or
10 at least as effective as you can be when they're combined
11 with a mood stabilizer. But the endogenous processes of
12 anxiety reside in the hypo -- in the hippocampus or the
13 brain in the limbic circuits and particularly in the
14 amygdala. And we know that -- we know from studying people
15 with PTSD that there is abnormal electrical excitability in
16 those areas that is associated with and, in fact, actually
17 is the basis of anxiety.

18 You can quench that anxiety with either an
19 benzodiazepine drug, which I do not recommend because
20 they're addictive, or with alcohol. And anxious people
21 self-medicate with alcohol and it meets their needs.

22 They can overcome social anxieties. They can do things
23 they wouldn't ordinarily be able to do. And it's acting in
24 that way because they have this anxious predisposition or
25 predilection. That is true when the anxiety is also caused

Dr. Jonathan Lipman
Direct examination by Mr. Tessier

1 by a traumatic brain injury. They are in a sense
2 self-medicating.

3 Now, when you have both drugs on board --
4 methamphetamine and alcohol -- you have a sort of condition
5 that I consider a part of the speed bowl passing.

6 The anxiety caused by methamphetamine can in part be
7 relieved by taking a depressant such as alcohol. It's
8 not -- it's no cure but, it will take the edge off. So in a
9 sense there is a relationship between these two drugs of
10 abuse, neither of which would be attractive if you didn't
11 have these underlying idiosyncratic vulnerabilities. I
12 think I've answered your question.

13 Q The underlying idiosyncratic vulnerabilities you
14 described also describe Mr. Torres.

15 A Yes.

16 MR. TESSIER: If I may beg your indulgence, Your
17 Honor.

18 (Pause.)

19 Q Dr. Lipman, a lot of the work you did was premised upon
20 your knowledge that Mr. Torres suffers from at least two
21 different genetic syndromes, Prader-Willi and 22q11 deletion
22 syndrome and your learning that he also cannot properly
23 metabolize certain enzymes, which in this case would affect
24 his ability to take imipramine.

25 A Correct.

Dr. Jonathan Lipman
Direct examination by Mr. Tessier

1 Q All of the information you needed to learn those things
2 was available back in 2007 and 2008, was it not?

3 A Yes, it was.

4 Q And if a -- if a trial defense lawyer for Mr. Torres
5 prior to his murder trial in 2008 had come to you or another
6 neuropharmacologist like you and discovered that same
7 information could you not have provided the same kind of
8 testimony that you just provided today at his murder trial?

9 A Yes.

10 Q Thank you. Please answer any questions the government
11 may have.

12 THE COURT: We're going to take a short break before
13 we do that.

14 Let me ask the witness if you'll step down. Don't
15 discuss your testimony during the break.

16 We'll resume with the cross-examination after the
17 break.

18 We'll be at ease for 15 minutes.

19 (Whereupon, a recess was taken.)

20 THE COURT: All right. We will resume with the
21 cross-examination.

22 MS. BROWN: May it please the Court.

23 THE COURT: Yes, ma'am.

24

25

Dr. Jonathan Lipman
Cross-examination by Ms. Brown

1 CROSS-EXAMINATION

2 BY MS. BROWN

3 Q Good morning, Dr. Lipman. My name is Melody Brown.
4 I'm with the attorney general's office.

5 A Good morning.

6 Q I thought I'd just start back at the beginning because
7 you were telling us a little bit in your direct testimony
8 about definitions. And you're qualified as an expert in
9 neuropharmacology as I understand it, correct?

10 A Correct.

11 Q And that study specializes in the drug induced changes
12 in cell function in the body, correct?

13 A No. It's brain and behavior.

14 Q And behavior. Okay. Well, that's kind of what I'm
15 going to ask you a little bit about, because you also
16 mentioned psychopharmacology. I believe you studied
17 psychopharmacology.

18 A Yes. That section in American Too [sic], it refers to
19 neuropharmacological agents to be used therapeutically. We
20 don't use that in England.

21 Q Okay. As far as the study of how the drug affects the
22 body though, that's shared, correct?

23 A There really is no difference. Psychopharmacology is
24 an American term that addresses therapeutic drug effects but
25 doesn't deal with things like nerve gasses, poisons, carbon

Dr. Jonathan Lipman
Cross-examination by Ms. Brown

1 monoxide toxicities and things of that sort.

2 Psychopharmacologists in the states tend to restrict
3 themselves to therapeutic drugs. But it's a subdivision
4 within neuropharmacology.

5 Q Okay. But you're not a medical doctor, correct?

6 A No. I am a neuropharmacologist.

7 Q And do you routinely work with medical doctors?

8 A Yes.

9 Q Okay. And that would include psychiatrists?

10 A Yes.

11 Q Neurologists?

12 A Yes.

13 Q How about neuropsychologist? Do you routinely work
14 with a neuropsychologist?

15 A I do.

16 Q Okay. And I see on your C.V. several entries regarding
17 pain management.

18 A Yes.

19 Q Is that a specialty of yours?

20 A Yes. Pain management. And my focus in pain management
21 is drugs that are used in pain management.

22 Q Okay. And how much of your time is actually spent on
23 pain management issues independent of psychiatric
24 conditions? Just pain management.

25 A This last three years, very little. But could I

Dr. Jonathan Lipman
Cross-examination by Ms. Brown

1 qualify that?

2 Q Yes, sir.

3 A You see, drugs that are used in pain management have
4 affects on the brain. And frequently I'm consulted in a
5 case by typically a neuropsychologist who is evaluating a
6 person for an injury. They are in pain and they're being
7 evaluated for an injury.

8 The question for the neuropsychologist is how much of
9 their present inability to performing tests is due to their
10 brain injury or the drugs they're on, this being a pain
11 patient being evaluated for, say, a disability evaluation.
12 So you can't really separate drugs that act in pain from
13 drugs that act on nerves or pain-relieving drugs act on the
14 brain.

15 Q Okay. Okay. And I also noticed on your C.V. that you
16 lectured at a 2012 Capital Habeas Unit presentation for the
17 federal defender and two other such seminars in 2012 and
18 then a paper on profiles on violent offenders and -- and I'm
19 quoting from your C.V. -- "Personality Drugs Abuse and
20 Murder".

21 A Yes.

22 Q Does that sound correct? Just serious. Is there a
23 reason for your focus on murderers?

24 A It's actually not a choice of mine. It just seems to
25 be the -- maybe in capital crimes funding is available for

Dr. Jonathan Lipman
Cross-examination by Ms. Brown

1 experts. I'm guessing. I don't really know. But I also
2 deal with nonmurder cases. They're just not very worthy of
3 writing about.

4 Q Okay. I see that there's a lull between 1992 and 2012
5 when you started doing more capital litigation lectures.
6 And I was just wondering. You seem to focus more on pain
7 treatment according to the C.V. entries. Is that fair, that
8 you sort of left maybe murder cases and moved more toward
9 pain management during that time, that was your specialty?

10 A You -- you might -- might be referring to my
11 publications. It can take me a decade to accumulate the
12 data for a publication. So when I publish something it may
13 reflect something that -- a study that began years before.

14 Q Okay. Well, you talked a little bit about your website
15 and help on different cases, civil and criminal.

16 Can you kind of give us an idea of how you divide your
17 time between the university and clinics and cases, one more
18 than the other?

19 A Right. My responsibilities at the university are not
20 onerous. I don't ground ground [sic] and I serve on the
21 control -- this is in pain management -- seminar series
22 committee. So I design those seminars.

23 I do some resident teaching. I don't do medical school
24 students -- medical students. I do collaborate with the
25 researchers and their publications.

Dr. Jonathan Lipman
Cross-examination by Ms. Brown

1 I would say majority of my time is spent on forensic
2 matters. I would divide that probably a majority civil,
3 minority criminal. That changes over the years though.

4 Q Okay. Well, we also heard in your testimony that you
5 consulted Dr. Rary. I believe you mentioned that yesterday.
6 But I want to take a step back. Can you tell me how you
7 were contacted for this case?

8 A Yes. I was contacted by a forensic psychologist, Dr.
9 Schacht, who told me that he was reviewing a case that
10 involved the use of potent drugs in a very small child and
11 he would like some expertise assistance on this.

12 Q Okay. And you are not a geneticist correct?

13 A No, no.

14 Q But you brought Dr. Rary in. And you made that
15 decision that you needed a geneticist at that time.

16 A Yes.

17 Q Okay. And why did you feel the need to consult with a
18 geneticist at that point?

19 A I wanted measurements of his catacall [sic] amotheth
20 [sic] transferees, his dopamine transporter and his moleding
21 [sic] oxidos [sic] genes which are all relevant to
22 metabolism of drugs.

23 I had arranged through a lab that I typically use --
24 Generex -- to do the P450 assays, but they don't do those
25 other assays.

Dr. Jonathan Lipman
Cross-examination by Ms. Brown

1 In the course of arranging that with Dr. Rary we
2 decided that we would use a particular test that he has as a
3 routine in his lab, and as a result of that we discovered
4 the 22q11.

5 Q Okay. Okay. So as I understand it, you had several
6 tests that you actually ran. And some of those tests were
7 negative, correct?

8 A No. I asked for them. Actually, they couldn't be
9 done. They were not done. They still -- I do have a
10 source, but there hasn't been time to do them before this --
11 this hearing.

12 Q And some of the results though that were the tests were
13 accomplished and results were given to your team. Some of
14 those were negative results, weren't they?

15 A What are you talking about if you'd remind me?

16 Q Sure. The methylation I believe.

17 A Oh, right.

18 Q Wasn't that negative?

19 A The methylation was, yes.

20 Q And I believe you said in your direct that you asked
21 for certain tests to be repeated. That was your word, I
22 believe.

23 A Yes. That's what Dr. Rary reported on yesterday.

24 Q Okay. So you were getting some negative results, but
25 you were still testing.

Dr. Jonathan Lipman
Cross-examination by Ms. Brown

1 A No. You misunderstood.

2 Q Okay.

3 A There was nothing negative about the first assay for
4 22q11. I wanted it repeated to see if it happened in the
5 second test for certainty and forensic confirmation.

6 Q Okay. But if there is a test that does show, for
7 instance, a negative result and Dr. Rary would have
8 diagnosed a genetic condition anyway would that have
9 affected your opinion in this case?

10 A I don't understand your question.

11 Q Okay. Let's approach it this way. Let's say there's a
12 negative result on at least one test.

13 A Well, there was in a sense.

14 Q Okay.

15 A For instance, one of the tests that I ordered was for
16 the 5HT transporter. There are three levels of activity in
17 the 5HT transporter, and the one that is most serious from
18 an ability to respond to an SSRI antidepressant is to have
19 two short alleles on that gene. That would have been a
20 negative result. Actually, what Mr. Torres has is an
21 intermediate condition. So I suppose you could say that was
22 a negative result for 5HT transporter failure.

23 Q Okay. Okay. And the treatment or your -- let's see.
24 Let me back up. Your use of this information goes only to
25 how the cells or how the nerves are working, correct?

Dr. Jonathan Lipman
Cross-examination by Ms. Brown

1 Regardless of the label of any condition you're interested
2 in the actual workings involved, correct?

3 A Only insofar as they affect nerve, brain and behavior.

4 Q Okay. Okay. And --

5 A We neuro -- pharmacologists -- maybe I should have
6 explained this at the beginning. We are the people in the
7 industry -- as I mentioned, I spent ten years in the
8 pharmaceutical industry. We research and develop drugs that
9 are used in the medical environment by physicians, by
10 psychiatrists they have prescribed. We are the people who
11 develop those. And in order to develop them we have to
12 understand the condition upon which they're going to act.

13 You'll remember there is a book that the physician
14 looks at called the P.D.R. which has the product labels in
15 there, the description of how the drug works and how it's to
16 be used. Those are written by neuropharmacologists. So of
17 course we have to understand that the cellular level, how
18 the drugs works, but our purpose is in the outcome of the
19 drugs actually, the effect of the drug.

20 Q And certainly, certainly, I can be wrong, so I will
21 leave it to you to explain this a little better and maybe
22 even help with me with a question. But here's what I'm
23 getting at.

24 You're looking more at the function. It doesn't matter
25 about the label or the cause, why that is dysfunctional.

Dr. Jonathan Lipman
Cross-examination by Ms. Brown

1 You're looking at the dysfunction itself, would that be
2 fair?

3 A I can't help you with that question.

4 Q Okay. That's fair enough.

5 A I don't understand it. I'm sorry.

6 Q Okay. Let's look at it this way.

7 If you have symptoms that arise from bipolar, for
8 instance --

9 A Okay.

10 Q -- you're looking to see if there's some kind of
11 medication that can be used to control those symptoms,
12 correct?

13 A Correct.

14 Q If those symptoms are also shared with another
15 diagnosis -- maybe schizophrenia -- you're still using the
16 same medication to treat the symptoms because the symptoms
17 are what you're focusing on, not the label of what may make
18 those symptoms occur, is that fair?

19 A It's -- it's almost fair.

20 Q All right.

21 A You're getting -- you're getting very close.

22 Q Okay.

23 A Yes. To the extent that mood instability is a feature
24 of both of those conditions --

25 Q Uh-huh.

Dr. Jonathan Lipman
Cross-examination by Ms. Brown

1 A -- then we would certainly develop a drug that
2 addressed the mood and stability. However, mood and
3 stability in the condition you're talking about where there
4 is instability in the face of what looks like schizophrenia
5 is a condition that's actually called schizoaffective
6 disorder. It is classically in the 22 11 q [sic]
7 population. That is what they -- many of them have.

8 And you have to address. In those cases you have to
9 address the instability before you can address their
10 psychosis. Does that answer your question? And that might
11 be a different drug.

12 In the case of a bipolar individual where what you have
13 is ultimating depression and mania, the condition as it
14 develops from childhood does not start that way. It starts
15 out as periods of depression separated by normality of mood
16 or apparent normality. And then as the child gets older --
17 actually as they approach about 19, 20 or 21, the periods
18 between the depressions don't go back to normal. They start
19 to go above normal to hypomania agitation, sleeplessness,
20 and the cycles then increase.

21 That you can blunt with a mood stabilizer. But what
22 you do not do if confronted by such a person who is
23 depressed is give them an antidepressant because that would
24 provoke mania.

25 That's why a person who prescribes for a bipolar --

Dr. Jonathan Lipman
Cross-examination by Ms. Brown

1 sort of a depressed person, someone who comes in depressed
2 to the clinic -- you have to be absolutely sure before you
3 give them an antidepressant that you're not just seeing the
4 depressed phasal [sic] bipolar condition.

5 Q And some of the conditions you're talking about and the
6 symptoms that you're talking about that's -- that comes from
7 your work with psychiatrists who diagnosed these symptoms.
8 And you can see patterns based on what psychiatry has done,
9 is that correct?

10 A We learn from their mistakes.

11 Q Okay. And you support them. You support the treatment
12 by helping them with medication.

13 A Yes, and also --

14 Q Psychiatrists are always going to diagnose.

15 A Psychiatrists, psychologists diagnose, neurologists
16 diagnose. In many of these cases -- particularly in the
17 ones that are developmental -- an endocrinologist is
18 involved.

19 Q Okay. And let's go back to the genetic anomalies. Do
20 you usually see patients with multiple genetic anomalies?

21 A I don't, no.

22 Q No. All right.

23 A That's just a feature of -- by population.

24 Q Okay. And --

25 A I know that they're not uncommon. If you --

1 Q Okay.

2 A If -- Dr. Rary probably has seen lots. That's his job.

3 Q Okay. You suspected Prader-Willi syndrome. Have you
4 worked with other individuals with a diagnosis or
5 determination of the Prader-Willi syndrome before?

6 A I don't suspect Prader-Willi syndrome.

7 Q You don't?

8 A I did not.

9 Q You did not. Okay. How did that come about? Was that
10 from Dr. Rary? Was that from Dr. Schacht or --

11 A Dr. Rary identified it as a probable, as you heard in
12 his testimony, from the photographs which he asked for when
13 we were doing the 22q11 study.

14 Q Okay.

15 A 22q11's also have a dysmorphology which you can't -- I
16 diagnose it from a photograph, but you can see if it's not
17 there. And so we requested photographs.

18 Q Okay.

19 A I requested them to show to Dr. Rary.

20 Q And I believe in your -- your slide presentation you
21 said Prader-Willi syndrome will correlate with a
22 predisposition for mood disorders.

23 A Mood disorders and instability of mood. And a
24 percentage of cases have other -- other psychiatric
25 illnesses. And a proportion of the Prader-Willises -- their

Dr. Jonathan Lipman
Cross-examination by Ms. Brown

1 condition's not just psychiatric. It's serious defamation,
2 cranial-facial.

3 Q Okay. And bipolar is a mood disorder, isn't it? You
4 have bipolar mood disorder, right?

5 A Yes.

6 Q That's what it is. Okay. And bipolar mood disorder
7 can arise independent of Prader-Willi.

8 A Yes. As I mentioned earlier, typically it emerges in
9 adolescence, late adolescence.

10 Q Okay. And I think you said before you can't treat
11 Prader-Willi syndrome with medication.

12 A No. You can only address the symptoms.

13 Q Okay. All right.

14 A And you can't cure bipolar.

15 Q Okay. And you can't treat the 22q11 deletion syndrome
16 with medication either.

17 A No.

18 Q Same kind of thing. You're not going to be able to
19 cure it with medication.

20 Okay. The reverse is also true I believe that
21 Prader-Willi is not drug induced, correct? That's a genetic
22 condition.

23 A That's true, that's correct.

24 Q Prader-Willi can't be treated, but the symptoms can.
25 22q11 can't be cured. Symptoms can be addressed. So how

Dr. Jonathan Lipman
Cross-examination by Ms. Brown

1 does this differ from any other psychiatric diagnosis?

2 A It differs in a number of ways.

3 Q Okay.

4 A Most important is in the present case that he had a
5 developmental disorder from birth through infancy, through
6 the period of brain maturation, as the brain is of interest
7 to me. And during that period of time he was not getting
8 the appropriate behavioral therapy and he was not getting
9 all of the appropriate pharmacotherapy.

10 Q Okay. And I think that you've said that the medication
11 is driven by symptoms and not the diagnosis, but is it
12 uncommon for psychiatrists to try different drugs in caring
13 for their patients?

14 A Very common.

15 Q It's very common. And some patients tolerate drugs
16 better than others, right?

17 A For the reasons I have described, yes.

18 Q And there's often a sort of an adjustment to it, right?

19 A Correct.

20 Q And there may be side some effects that are -- that
21 will show up in one particular patient that wouldn't show up
22 in another, different from patient to patient.

23 A Yes. Let me just -- I don't want to agree with the
24 word side effects. Let me just qualify that.

25 You see, drugs don't really have side effects. The

Dr. Jonathan Lipman
Cross-examination by Ms. Brown

1 drugs have multiple effects. And whether the thing you're
2 looking is a side effect or not depends on what it is you
3 are hoping to achieve.

4 For instance, aspirin prevents blood clotting. As a
5 complete side effect it may solve the problem of your
6 headache, but that's a side effect when you're using it to
7 provide blood clotting.

8 Likewise, if you are using it for a headache any affect
9 it has on blood clotting is a complete side effect. So it's
10 not the drug that has side effects. That's a question of
11 how you're looking at it.

12 Q Okay. We're going back to the symptoms themselves and
13 what you're trying to treat.

14 A Right. In the case, for instance, of Imipramine I
15 mentioned that it has anticoagulant effects like antripy
16 [sic] and like effects. This will dry your mouth, dry your
17 eyes, make it impossible to pee. Those are awful side
18 effects. However, if you suffer from urinary incontinence a
19 tiny dose of Imipramine can be used to treat that, and any
20 affect it has on your mood is a side effect. So drugs have
21 many effects. Some of them are the ones you want; some of
22 them are not. And depending on your individual
23 vulnerability you may respond well to the one that you want
24 or badly to the one that you want, or you may respond badly
25 to the side effect or not at all to the side effect. What

Dr. Jonathan Lipman
Cross-examination by Ms. Brown

1 we're calling a side effect, the undesired effect.

2 Q Okay. Now, you just mentioned a little bit about other
3 things that Imipramine is used for. It's also given to
4 prevent bedwetting in children, right?

5 A That's what I just referred to, Yes.

6 Q And that's what you were referencing.

7 A Yeah.

8 Q Okay. So this is a drug that is given for different
9 purposes, and it has been at least in the past very
10 regularly given for either bedwetting or some kind of mood
11 disorder, correct?

12 A Yes, yes.

13 Q Okay. And you have identified that he was given,
14 Mr. Torres was given, this drug at about three years old,
15 right?

16 A Yes, when he had the adverse response to it.

17 Q And how long did he take it?

18 A That's not entirely clear. I don't have the pharmacy
19 dispensing records. I should have explained on direct.

20 Q Would you agree that you have the most devastating
21 effects from a drug that you will react to if you were
22 taking it for a longer period of time?

23 A That's not true with the antidepressants.

24 Q Okay.

25 A With the antidepressants the greatest danger period is

Dr. Jonathan Lipman
Cross-examination by Ms. Brown

1 the first three weeks. This is when adults suicide, for
2 instance, or commit homicide when they're depressed and
3 they're given an antidepressant.

4 The next greatest danger period is when the drug is
5 discontinued, and that's when the brain -- it breaks
6 suddenly off -- has to readjust to the absence of the drugs.

7 Q And this is the -- the Tardive dysphrenia. Am I
8 pronouncing that time correctly?

9 A Well, actually I was referring now to the withdrawal
10 syndrome, and I was speaking of Imipramine. But when the
11 drug is first used, danger period, if you look in the P.D.R.
12 you'll see it's actually a black box warning. And if and
13 when the drug is discontinued another danger period
14 behaviorally due you to the withdrawal syndrome.

15 As far as we know the Tardive dysphrenia -- Tardive
16 Akathisia -- is something that doesn't happen -- well, we
17 know that it happens with the neuroleptic drugs. There is
18 some growing evidence that it also happens with the
19 antidepressants. And that's very troublesome. It's just
20 that once you've been treated with an antidepressant you may
21 have to continue to be treated with antidepressant to
22 prevent depression that was caused by the previous treatment
23 with the antidepressant. But having said that, that is not
24 generally accepted. Yet we're still collecting the
25 information on that.

Dr. Jonathan Lipman
Cross-examination by Ms. Brown

1 Q Okay. Wasn't it true that a basic rule before you can
2 actually say Tardive dysphrenia is present, that you have to
3 show in the records that there was an antipsychotic
4 medication used for at least three full months?

5 A Oh, this was used continuously for years.

6 Q But you don't have records that would support that?

7 A I didn't say that. I have the physician's records
8 describing the dose that he's on, how many times a day he
9 takes it. I have -- of course in the course of the records
10 the doses increased 25 mg, 50 mg and then 50 mg four times a
11 day. And then it's reduced. And then he's put on Lithium,
12 and then it's reduced.

13 So the physician is recording what he is ordering.
14 What I'm-- there are two things that I'm missing from the
15 record. One is the pharmacy dispensing record which would
16 give me the refill dates and the numbers of the medications.
17 And that tells me about the period between the visits to the
18 doctor. So I don't have that. And actually that's the main
19 thing that I'm missing.

20 But the second thing that, as I said, I'm missing is
21 that at the end of the record that I have the last entry
22 regarding drugs is at age 11. And then I have no medical
23 records, even though I note through -- I think it was --
24 excuse me -- I think it was age 14. I may be -- I don't
25 want to run through here. But I don't have records up to

Dr. Jonathan Lipman
Cross-examination by Ms. Brown

1 the time that he was discharged from children -- department
2 of children's services. I know where he was, but I don't
3 have his medical records. So I don't know whether he was or
4 wasn't still on the Mellaril.

5 Q Okay. And you told us that Mr. Torres is currently on
6 Paxil.

7 A And Neurontin, yes.

8 Q Okay. Let's just concentrate on Paxil for a moment.
9 Is it fair to say that that treats symptoms of
10 depression?

11 A Yes. It's actually SSRI.

12 Q Okay. And it works to sort of equalize chemical
13 reactions or chemical imbalances, is that correct?

14 A Only in the serotonin system as relates to depression.
15 It can actually make mania worse.

16 Q Okay.

17 A So it normalizes what we believe is the defect in
18 depressed mood.

19 Q Okay.

20 A And you mentioned by bipolar, and in a bipolar person
21 if one was you wouldn't want to normalize their depressed
22 mood unless you had first stabilized the person with an
23 anticonvulsant which could be Depakote such as we was
24 prescribed or Lithium such as he was prescribed or Tegretol
25 such as he was prescribed one he was institutional custody.

Dr. Jonathan Lipman
Cross-examination by Ms. Brown

1 Q So do you agree with the observation that Mr. Torres
2 was not properly diagnosed and was not properly medicated in
3 his growing-up years? would you agree with that, that it's
4 a correct statement?

5 A No one claimed that he was psychotic except a
6 transient -- transient moments in his record.

7 Mellaril is an antipsychotic medication. If he had
8 been diagnosed with schizophrenic, I would say yes, of
9 course he has to take an antipsychotic drug. But that was
10 never described as far as I could see in the record.

11 Q So is that you would agree that he was not given the
12 proper medication for what he needed?

13 A He was not, yes.

14 Q Okay.

15 A Yes.

16 Q Okay. And you were -- you've told us he's on Paxil now
17 and that seems to be working.

18 A With the Neurontin -- with the Neurontin. The
19 Neurontin is actually being -- well, he thinks it's being
20 given to him because he has diabetic peripheral neuropathy,
21 and it may well be. But it happens to also be a mood
22 stabilizer, and we use it for that reason in chronic pain.

23 Q And it's often used to treat nerve pain, correct?

24 A Oh, yes.

25 Q And that would be diabetic pain as well.

Dr. Jonathan Lipman
Cross-examination by Ms. Brown

1 A Yes.

2 Q That's diabetic nerve pain, correct?

3 A Yes.

4 Q And you know that Mr. Torres is treated or has a
5 description for insulin.

6 A Yes.

7 Q Okay.

8 A Yeah. As I said, he -- he believes that is the reason
9 why it's given to him. I'm mentioning that what he may not
10 know -- but he does -- is that it is -- also has a mood
11 stabilizing effect.

12 Q And it's often used to treat bipolar disorder, is that
13 correct?

14 A That's -- yes. We're saying the same thing, yes.

15 Q Okay. What's Mr. Torres' current psychiatric
16 diagnosis?

17 A I don't know.

18 MS. BROWN: May we have a short break, Your Honor?

19 THE COURT: Sure.

20 (Pause for water spilled.)

21 MS. BROWN: May it please the Court.

22 THE COURT: Yes, ma'am.

23 Q It would not surprise you -- well, let me ask it this
24 way. You've read the transcript from the sentencing phase
25 of the capital trial of Mr. Torres.

Dr. Jonathan Lipman
Cross-examination by Ms. Brown

1 A I don't think I have actually.

2 Q Okay. Have you read any portion or summary of the
3 testimony of Dr. Donna Schwartz-Watz?

4 A I have records of that, yes.

5 Q Okay. Would it surprise you that Dr. Schwartz-Watz
6 diagnosed Mr. Torres as bipolar?

7 A No. I wouldn't disagree with it.

8 Q And it's consistent with the medication that he is
9 responding favorably to right now.

10 A Correct.

11 Q And would you agree that -- would you agree with
12 testimony from Dr. Watz that Mr. Torres' condition, whole
13 condition, if treated properly would result in a good
14 prognosis? It can be treated.

15 A He can be treated. Well, some of it can be treated.
16 There's nothing we can do to address the other aspects of
17 his genetic disorders.

18 Q But to control the symptoms he has to take the
19 medication.

20 A To control the mood disorder?

21 Q Yes, sir.

22 A The emotional impulse -- the emotion lability and
23 impulsiveness. The medication would take care of that, yes.

24 Q Okay.

25 A To some extent. Nothing is a hundred percent.

Dr. Jonathan Lipman
Cross-examination by Ms. Brown

1 Q And he could become aggressive if he fails to take this
2 medication to manage his bipolar, correct?

3 A That's possible, yes.

4 Q Okay. And he's shown other times in his history where
5 he can be or his symptoms can be fairly well managed,
6 correct? I believe you mentioned Lithium in your direct.

7 A Yes. Let me just qualify my previous answer. Most
8 people who have bipolar disorder don't have these underlying
9 genetic and developmental anomalies, and the symptomatology
10 of bipolar disorder can occur in the context of their having
11 an organic origin.

12 That doesn't mean that it is not necessarily bipolar.
13 But it is not the same thing as a person like you or me
14 developing bipolar disorder. We don't have those genetic
15 vulnerabilities -- damage. We don't have that shake. We
16 don't have the -- the other. The dysmorphology that you see
17 in this gentleman is present also in his brain and other
18 organs including his metabolism.

19 Q Doctor, are you suggesting that he may be hotwired for
20 aggression?

21 A No. He's probably hardwired -- not hotwired. He's
22 probably developed frontal lobe deficits partly as a result
23 of his genetics and partly as a result of his developmental
24 trajectory that make him more up impulsive. We know that
25 people with his condition have more anxiety. Anxiety and

Dr. Jonathan Lipman
Cross-examination by Ms. Brown

1 impulsiveness can be a problem.

2 Q And it's probably more of a problem for Mr. Torres from
3 what you've seen.

4 A From his history, but not under current treatment.

5 Q Okay. And you mentioned frontal lobe damage. Do you
6 have any tests or anything that indicates some damage --
7 reduced brain volume, something connected with the frontal
8 lobe?

9 A I don't have the notes of my telephone conversation
10 with the neuropsychologist in this case, but that is one
11 thing that I recall being a conclusion of neuropsychological
12 dysfunction -- frontal lobe, orbital frontal actually.

13 Q Okay. Would there be a difference in just medication
14 alone or why he would test normally at one time in
15 neuropsychological testing and abnormal in another time?

16 A There could be. I'd have to look at the test results
17 on the medication.

18 Q Would he be more likely to have abnormal test results
19 while he's on correct medication?

20 A I -- I -- it depends on the tests that with were done
21 and on the medications.

22 Q Now, back in 1991 to 1994 you'll recall in his history
23 he was on Lithium, and the results were very favorable. He
24 was described as intelligent, doing well in school, working
25 well with others. So he didn't have a problem accepting

Dr. Jonathan Lipman
Cross-examination by Ms. Brown

1 that particular drug at that time, metabolizing it and his
2 body using it to control the symptoms, correct?

3 A Correct.

4 Q Okay. So there's no -- from what you can tell from the
5 treatment with Lithium there's nothing that says, oh, no
6 medication will probably work. So even -- what I'm saying
7 if I can try this a different way, even as a younger child
8 he didn't show permanent deficiency in the ability to
9 metabolize drugs that would aid in controlling his symptoms,
10 is that correct?

11 A Oh, I see what you're saying. No. At any time that he
12 is given a drug that's metabolized through the C19 angelo
13 [sic] system -- there are quite a few of them. He's going
14 to become toxic. It should be part of his record, and
15 hopefully now it will be so that no one tries that again.

16 Q Okay.

17 A Lithium is not metabolized that way. And Paxil, the
18 drug that he is taking now, is metabolized through a
19 different P450 system, which in his case is normal -- 2d6.

20 Q Okay.

21 A And 3A4.

22 Q And probably -- you've probably already told us this
23 before, but let me see if I got this right. Genetics at the
24 very, very base of the discussion are just instructions for
25 our bodies. So there could be a genetic cause for anything,

Dr. Jonathan Lipman
Cross-examination by Ms. Brown

1 correct?

2 A I don't know how to answer that question.

3 Q Okay. Genetics determine whether we're going to be
4 tall; genetics determine our eye color, right? Genetics are
5 instructions for our body, correct?

6 A That's correct, yes.

7 Q Okay. So isn't it possible that someone who doesn't
8 have a pronounced syndrome -- 22q11 or Prader-willie or any
9 other genetic syndrome -- could still not metabolize things
10 correctly or still may have psychotic symptoms? There is a
11 correlation, but there's not a cause and effect, correct?

12 A You're confusing two things. Maybe I misled you.

13 His P450 polymorphism has absolutely nothing to do with
14 either the 22q11 deletion syndrome or the Prader-willi,
15 nothing at all. It's a separate and individual use
16 in cractic [sic] genetic polymorphism.

17 Does that change your question?

18 Q Not exactly, but let me look at it this way.

19 We've probably already said this before, but different
20 people react different ways, and it is because of the way
21 that our bodies are. That's your -- that's what you were
22 saying is the setting. Setting is environment, and then the
23 set is the person, the whole person.

24 A Yes. Well, other way around, but, yes, the set is the
25 body.

Dr. Jonathan Lipman
Cross-examination by Ms. Brown

1 Q Excuse me. Thank you, sir. Appreciate it.

2 Let's look at some of the psychosis-inducing medicines
3 that you were talking about.

4 Meth use, chronic meth use, antidepressant. You said
5 it's like magic. And then when you add alcohol with the
6 meth use it rather levels out, is that correct?

7 A It levels out -- or sorry. It tranquilizes the
8 anxiety. It doesn't do anything to mitigate the psychotic
9 effects.

10 Q How about Klonopin?

11 A Klonopin acts in an alcohol-like way. He's been
12 treated with that in the past. That is very much like an
13 extremely long-acting alcohol. And it's used for that
14 reason prescribed for anxiety. Someone like him would find
15 that it met his needs. I could well imagine that he could
16 be a potential user or abuser of Klonopin.

17 Q Okay. And --

18 A He has been prescribed that in the past.

19 Q If an individual was using methamphetamine and drinking
20 alcohol and taking Klonopin at the same time that could
21 cause a great deal of aggression and violent tendencies,
22 correct?

23 A It can under some circumstances. The alcohol,
24 Klonopin -- and I don't know that this applies to him
25 because I know nothing of that period. I have not read any

Dr. Jonathan Lipman
Cross-examination by Ms. Brown

1 records. But are you asking me a hypothetical?

2 Q Well, I'm asking what those -- how those drugs react
3 together on an individual, what normal reaction would be.

4 A Right. Depends on how long they've been using them, as
5 I mentioned. If he had used -- let's say if the person had
6 used amphetamine one time for the first time and then drank
7 and took a Klonopin, you would get a completely different
8 effect from the effect you would get if you were chronically
9 using amphetamine, chronically using Klonopin, chronically
10 using alcohol.

11 But I can summarize some of it this way. The adverse
12 psychotropic effects of methamphetamine can be subjectively
13 relieved in the anxiety domain by either Klonopin or
14 alcohol, and the combination between Klonopin and alcohol is
15 potentiating. Both of them will -- although they are
16 antianxiety drugs a rule, they will disinhibit the frontal
17 lobes. People will do things that they wouldn't ordinarily
18 do. And this is of course why alcohol plus a benzo is the
19 classic date rape combination. You give the benzo --
20 Rohypnol, Klonopin, Xanax -- to someone who's drinking and
21 they'll go home with you. They will regret it. They will
22 claim that they didn't do it voluntarily. And they may not
23 even remember it because the drug also produces amnesia.
24 But that combination will let people do things that they
25 wouldn't ordinarily do.

Dr. Jonathan Lipman
Cross-examination by Ms. Brown

1 Now, as to whether that is aggressive or not, that is
2 usually a matter of set, setting, the circumstances that
3 they're in, and there is a feature of set. I'll tell you
4 about that.

5 Some people, about 5 percent of benzo users including
6 those who are prescribed it -- we usually think of it as a
7 smaller percentage -- actually become enraged by benzo use.
8 They are a minority and they are very probably the same
9 people who become enraged when they drink, the fighting
10 Irish phenotype if you like. Most people just get tranquil
11 when they drink. Some people get aggressive. And that is
12 true also of the benzos. A minority of people have no idea
13 whether Torres is one, so because I have not interviewed him
14 or evaluated his history from that point of view.

15 But to answer your question as a hypothetical it can
16 increase -- it's called benzodiazepine RH. It can
17 increase aggressiveness and disinhibit the normal impulse --
18 the normal resistance to impulse in certain people if they
19 have that history. I don't know about his history --

20 Q Okay.

21 A -- in that regard. I would be speculating.

22 Q What, if anything, in your professional opinion would
23 you take away from the report that someone didn't feel any
24 results from the use of methamphetamine?

25 A I'd have to know how they were using it. I really

Dr. Jonathan Lipman
Cross-examination by Ms. Brown

1 would.

2 Q Okay.

3 A Yeah. I don't know what else to say other than that.

4 Q And how many times have you met with Mr. Torres? You
5 said you didn't interview him. Have you met with him at
6 all?

7 A I met with him to do a physical exam with Dr. Rary.

8 Q Did you talk to him about his crime?

9 A No.

10 Q Or what he was taking at the time of the crime?

11 A No. It was a physical-exam interview. I asked him
12 what medications he's taking at the moment, and I
13 photographed him.

14 Q Do you know the circumstances of the crime here?

15 A Only what I've gathered from conversations here. No.
16 I haven't read the records.

17 Q Okay.

18 A I was asked not to.

19 Q You were asked not to?

20 A It was told my instruction, my specific referral
21 question, related to the effect of drugs on his childhood
22 and development.

23 Q Okay. You mentioned a little bit just a few minutes
24 ago about there could be rage, there could be psychotic
25 episodes -- I believe or psychotic-like episodes with a

Dr. Jonathan Lipman
Cross-examination by Ms. Brown

1 combination of street drugs and alcohol and Klonopin.

2 A The psychosis doesn't come from the alcohol or the
3 Klonopin. In the example I gave you it comes from chronic
4 high-dose meth use, methamphetamine use. I don't know if
5 Mr. Torres was a chronic high-dose methamphetamine abuser.
6 I do not know.

7 Q Okay. Well, if an individual has used meth for a
8 significant amount of time and he's drinking as well and
9 he's taking multiple pills -- Klonopin -- and he goes into a
10 rage is he capable of great violent conduct?

11 A Yes.

12 Q Being under the influence of drugs, whether
13 prescription or street drugs, does not necessarily mean that
14 you could not intentionally plan a criminal act and carry
15 out that criminal act, does it?

16 A Well, the wider answer is it depends on the underlying
17 circumstances, the underlying individual. But in people,
18 for instance, who are not mentally retarded, who are not
19 psychotic, you know, I'd have -- I'd have to say it depends
20 on the circumstances.

21 Q Okay.

22 A In many cases it's the absence of the drug that leads
23 to the misbehavior.

24 Q Okay. And you had mentioned that there may be
25 according to some drug combinations -- perhaps alcohol

Dr. Jonathan Lipman
Cross-examination by Ms. Brown

1 combinations -- an inability to remember a criminal act.

2 A That's classically true of very high-dose alcohol and
3 the benzodiazepine such as Klonopin. It produces an
4 amateur-grade amnesia unlike the amnesia that comes from a
5 concussion, head injury, and proceeds forward in time
6 actually through the time where you're doing things that you
7 will not like to remember.

8 Q And you said you do not like to remember. How can you
9 tell whether this is some type of amnesia or someone who
10 doesn't want to recall his criminal acts?

11 A Very difficult. There are ways using a functional
12 M.R.I. study that I've seen published because people will --
13 well, there are ways, but it's very difficult.

14 Q Okay.

15 A And there are interview techniques that can be used and
16 there are some tests that can be used, but I haven't done
17 those.

18 Q Okay. Would you expect someone to go into this rage
19 and get to a point because of drug and alcohol use and maybe
20 other conditions to be able to plan out a crime and cover --
21 create a cover story and go many hours without detection?

22 A You know, this would so depend on the circumstances and
23 the dose on the level of intoxications, I'm not sure how to
24 answer the question. Could you speculate about the dose or
25 the drug?

Dr. Jonathan Lipman
Cross-examination by Ms. Brown

1 Q Sure.

2 A You see, when you're under the influence of a benzo, as
3 an example, or alcohol, plus usually it's a combination, you
4 can do things that you normally do, procedural memory.

5 For instance, you ill advisably may drive home on a
6 familiar route and have absolutely no problems.

7 If you take a wrong turn you're in a real mess. You
8 can't navigate. You can be dangerous. So it depends on
9 setting as much as the dose and the underlying condition.

10 Q Let's go back to the amnesia.

11 You said there are certain interviewing techniques and
12 certain ways to make an educated determination of whether
13 that is actual amnesia or someone who doesn't want to admit
14 to a criminal act, correct?

15 A There are. That's not my specialty.

16 Q Okay.

17 A But I have attended lectures on the subject.

18 Q Okay. So you're somewhat familiar with that.

19 A Yes.

20 Q If I were to tell you that Mr. Torres gave a statement
21 to law enforcement and mentioned that the two victims in
22 this case had been beaten to death when that information was
23 not released to the public, how would you perceive that in
24 reviewing whether this was some medically induced, drug
25 induced amnesia or someone who doesn't want to talk about

Dr. Jonathan Lipman
Cross-examination by Ms. Brown

1 the crime?

2 A I think the most we could say would be that he had
3 knowledge of the means of death.

4 Q Dr. Lipman, you cannot divorce the voluntary ingestion
5 of street drugs and alcohol from medical conditions or
6 limitations that Mr. Torres had, correct?

7 A I cannot.

8 Q And regardless of a misdiagnosis as a child or
9 ineffective medication as a child the facts of the murders
10 do not change at all, do they?

11 A The -- the occurrence of the murder is the same. The
12 facts, that might be a legal question.

13 MS. BROWN: Court's indulgence.

14 (Pause.)

15 Q Dr. Lipman, just to give you some hope, I'm almost
16 done, but I've got a few more questions for you.

17 A I'm almost dry. Just keep going another five minutes,
18 please.

19 Q I wanted to ask you. When you were looking over
20 Mr. Torres' record and there were some reports of
21 methamphetamine use and alcohol use and Klonopin use, what
22 about L.S.D.

23 A Could I look at my record, my notes? I'm sorry.

24 Q Absolutely. And while you're looking I would offer I'm
25 going in this direction if it would help you.

Dr. Jonathan Lipman
Cross-examination by Ms. Brown

1 How would you effect -- how would you in your opinion
2 describe the effects that L.S.D. should have on someone with
3 Mr. Torres' genetic background and psychiatric background?

4 A I can answer that without actually looking it up.

5 Q Okay.

6 A People who have a predisposition to transient psychosis
7 are vulnerable to experiencing the more intense and
8 frightening psycho and magic effects on L.S.D., pyschomagic
9 meaning that they resemble a schizophrenia type and
10 delusions and hallucinations.

11 Q And just so we understand, are you saying that L.S.D.
12 would increase the negative effects of this drug?

13 A No. The negative effect of it -- okay. We use the
14 word negative effect in a different way.

15 There would -- he is more like -- not everyone
16 hallucinates on L.S.D. you may not know that. Some people
17 don't.

18 The -- the fact that he is vulnerable to experiencing
19 transient psychosis based on history under certain
20 circumstances, probably under the circumstances of a parent,
21 inescapable emotional stress over overwhelming anxiety he's
22 being very transient. He's more likely to meet those
23 circumstances if he's under the influence of L.S.D., which
24 is a very stimulating drug that provokes visual
25 hallucinations and tractile hallucinations. And it's a

Dr. Jonathan Lipman
Cross-examination by Ms. Brown

1 condition that at least for a few hours can resemble
2 somewhat acute paranoid schizophrenia.

3 Q And I think you mentioned that the methamphetamine is a
4 joyful experience for the user in certain circumstances.

5 A When first used.

6 Q When first used.

7 A It doesn't become joyful at all when chronically used.
8 They're using it at that point to escape the crushing
9 depression that comes from its absence. They do not achieve
10 that high again. They will, in effect, tell you I'm always
11 looking for that high.

12 Q And when you combine methamphetamine and L.S.D. what
13 are the results?

14 A That's a very interesting question. To some extent
15 they potentiate each other. To some extent they don't.
16 That is such an unusual combination that I'm not aware of
17 any literature on the subject.

18 Q Okay. And a hypothetical. If an individual has used
19 within a 24-hour period 3 to 4 grams of methamphetamine, a
20 12-pack, ingested a 12-pack of alcohol or beer, one liter of
21 vodka and 19 to 25 mg of Klonopin, what would you think the
22 results would be on the person?

23 A They would be demonstrably and obviously intoxicated in
24 a way that looked like alcohol.

25 That is an outrageously large amount of Klonopin, and

Dr. Jonathan Lipman
Cross-examination by Ms. Brown

1 those things are made in .25 mg tablets. Six mgs is a
2 maximum dose for a person who is chronically using it. I
3 would expect them to be unconscious actually.

4 Q And if they're not could they be in a rage from all of
5 this together, taken together?

6 A I would expect their thinking to be completely
7 incoherent. That -- that combination in a drug such as
8 Klonopin which has such a very long half life would produce
9 almost an anesthetized state. I'm not sure you would be
10 able to think at all.

11 Q And if you recalled threats against families and using
12 a telephone at a certain time or even able to drive a car,
13 would that change your analysis of the effect on the body?

14 A I would have to ask if this was -- I'm assuming this is
15 the first time the person took this sort of dose.

16 Q No, sir. It's been a chronic use of street drugs and
17 alcohol.

18 A I'm very -- no. I mean that -- that amount of
19 Klonopin.

20 Q No, sir.

21 A Okay. I would be unable to move, completely unable to
22 move. I couldn't drive a car. I might actually face death.

23 It's difficult to imagine someone who had taken all of
24 those doses behaving at all and difficult to imagine that
25 they would remember anything.

Dr. Jonathan Lipman
Cross-examination by Ms. Brown

1 Now, to some extent there is -- in a chronic user on
2 benzos, particularly, they become tolerant to the
3 discoordinated effect. They do not become tolerant to the
4 cognitively impaired effects, the neuro behavioral effects.
5 The effects oln memory, particularly short term memory are
6 profound.

7 Honestly, I would be surprised if such a person could
8 function at all, but they certainly wouldn't remember what
9 they had done. I would question whether that's really the
10 dose taken.

11 Q Okay. But that's the kind of information you would
12 need to make an informed decision on what a person would be
13 capable of doing at any particular time, what drugs he took
14 and what amount, right?

15 A More important than that is the history of drug use.

16 Q The history of drug use?

17 A Yes.

18 Q And the recorded acts that he was able to perform,
19 whether he was talking with people, whether he had threats,
20 whether he was using the telephone. Those are facts that
21 would make it a better, more informed decision for you to
22 talk about what these drugs did to that individual, isn't
23 that correct?

24 A That's correct.

25 Q But you were asked not to look at any facts of the

Dr. Jonathan Lipman
Cross-examination by Ms. Brown

1 crime here.

2 A well, I -- I was told to focus on his developmental
3 period.

4 Q But were you asked not to look at anything about the
5 facts of the brutal murder of two individuals?

6 A My recollection is I was told not to, not to waste any
7 time on that, or something to that effect.

8 Q Thank you, sir. I appreciate that.

9 MS. BROWN: No further questions, Your Honor.

10 REDIRECT EXAMINATION

11 BY MR. TESSIER

12 Q Dr. Lipman, not much on redirect, but I did want to ask
13 as you were being questioned about some of the facts that
14 might be helpful for you to determine the effect on someone
15 at the time of a crime. I'm just going to expand that
16 question way beyond the time of the crime or anything else.
17 But you said the pharmacologist in general, the gist of what
18 I heard you talking about on direct examination was that for
19 a neuropharmacologist to do his or her job you must not only
20 know the drugs taken by the individual but you must, now all
21 of the underlying predispositions, genetic and otherwise,
22 that affect that person's ability to process the drug.

23 A And affect their vulnerability to the effects of the
24 drug.

25 Q And so for a neuropharmacologist at Mr. Torres' trial

Dr. Jonathan Lipman
Redirect examination by Mr. Tessier

1 to discuss medications given to him for bipolar disorder or
2 drugs taken at the time of the crime, as a neuro
3 pharmacologist wouldn't you agree that it is absolutely
4 essential for such a person testifying at Mr. Torres' trial
5 to understand his underlying genetic precondition?

6 A Genetic, medical, psychological, metabolic. All of
7 these are the ind -- are the facets of the individual that
8 the drug acts through and acts on and you cannot make -- you
9 cannot understand the effect of the drug simply knowing the
10 name of the drug.

11 Q You have to understand the person who's going to be
12 taking it.

13 A That's correct.

14 Q And in Mr. Torres' case you and Dr. Rary discovered
15 that he had two preexisting genetic conditions --
16 Prader-Willi syndrome and 22q11 deletion syndrome -- and you
17 discovered through your P450 testing that he has an
18 inability, genetically predisposed condition, that does not
19 allow him to process Imipramine.

20 A Right. As a result of which his levels would increase
21 catastrophically according to the lab possibly as much as
22 200 fold, 200 percent. Dangerous.

23 Q Thank you, Dr. Lipman. I appreciate your testimony.

24 MR. TESSIER: And we can release the witness from our
25 perspective, Your Honor.

Dr. Thomas Edward Schacht
Direct examination by Mr. Schoen

1 THE COURT: Any objection?

2 MS. BROWN: No objection, Your Honor.

3 THE COURT: All right. You're excused. Thank you.
4 we'll take lunch. we'll resume at 2:00 o'clock this
5 afternoon.

6 (Whereupon, a recess was taken.)

7 THE COURT: All right. Next witness.

8 MR. SCHOEN: Applicant calls Dr. Schacht to the stand.

9 DR. THOMAS EDWARD SCHACHT,
10 having been first duly sworn, testified as follows:

11 DIRECT EXAMINATION BY MR. SCHOEN

12 MR. SCHOEN: May it please the Court.

13 THE COURT: Yes, sir.

14 Q Good afternoon.

15 A Good afternoon.

16 Q would you please introduce yourself to the Court? And
17 spell your last name for the court reporter.

18 A Yes. My name is Thomas Edward Schacht. The last name
19 is spelled S-C-H-A-C-H-T.

20 Q Dr. Schacht, what is your occupation?

21 A I'm a professor in the department of psychiatry and
22 behavioral sciences at the College of Medicine at East
23 Tennessee State University.

24 MR. SCHOEN: Permission to approach the witness.

25 THE COURT: Yes, sir.

Dr. Thomas Edward Schacht
Direct examination by Mr. Schoen

1 MR. SCHOEN: Let the record reflection I'm...

2 (Curriculum vitae of Thomas Edward Schacht marked
3 Applicant's Exhibit No. 21 for Identification.)

4 MR. SCHOEN: Let the record reflect that I'm handing
5 the witness a copy of Applicant's Exhibit 21.

6 Q Dr. Schacht, do you recognize the document I just
7 handed you?

8 A Yes. It's a copy of a C.V. that I provided to your
9 office.

10 Q Does it appear to be accurate to you?

11 A It was accurate and complete at the time I provided it.
12 There may have been some additions since then.

13 MR. SCHOEN: Applicant moves Applicant's Exhibit 21
14 into evidence.

15 MR. ZELENKA: No objection, Your Honor.

16 THE COURT: It's admitted.

17 (Curriculum vitae of Thomas Edward Schacht marked
18 Applicant's Exhibit No. 21.)

19 Q Dr. Schacht, where did you get your undergraduate
20 education?

21 A I attended Connecticut College for a bachelor's degree
22 in psychology.

23 Q And where did you receive your graduate education?

24 A I earned a doctoral degree in clinical psychology from
25 Rutgers University Graduate School in Applied and

Dr. Thomas Edward Schacht
Direct examination by Mr. Schoen

1 Professional Psychology.

2 Q And what have you done since earning your doctorate?

3 A Well, in connection with it, as well as since that
4 time, I completed an internship at the School of Medicine,
5 Department of Medical Psychology of the Oregon Health
6 Sciences University in Portland, Oregon, and also completed
7 a postdoctoral fellowship at the same institution at a
8 division called -- at that time it was called the crippled
9 children's division.

10 It was a fellowship specializing in developmental
11 disabilities. And that was a multidisciplinary program that
12 provided clinical service as well as research and training
13 for developmentally disabled people in the State of Oregon
14 and a good portion of the State of Washington.

15 Q As a part of that particular program what were your
16 responsibilities?

17 A I was a postdoctoral fellow, so it was a training
18 program for me.

19 My job was to learn as much as I could about
20 developmental disabilities. That included carrying a case
21 load. It included participating in didactic portions of the
22 fellowship. And it also included service on a
23 multidisciplinary team.

24 The standard of practice for developmental disabilities
25 is that because the problems are so complicated and cross so

Dr. Thomas Edward Schacht
Direct examination by Mr. Schoen

1 many functional systems and professions that proper
2 evaluation and intervention often is deferred to
3 multidisciplinary teams.

4 That's why there was this one center that served the
5 entire State of Oregon and a good portion of Washington,
6 because to get all of those professionals together in one
7 place is not something you're going to do in every
8 community.

9 Q What did you do after you finished that postdoctorate
10 fellowship?

11 A I then moved to Nashville, Tennessee, where I did
12 another postdoctoral fellowship. This was two years at
13 Vanderbilt University under the sponsorship of the National
14 Institute of Mental Health in psychosocial treatment
15 research.

16 Following the completion of that fellowship I joined
17 the faculty of Vanderbilt, research faculty, and worked on a
18 research grant that had been submitted and funded during
19 that period of time.

20 Q What did you do after you left Vanderbilt, and how long
21 were you at Vanderbilt I should ask.

22 A Well, I was at Vanderbilt full time -- excuse me -- for
23 about a year and a half and then remained part time for the
24 better part of the next decade.

25 What happened was that I was dealing with two careers

Dr. Thomas Edward Schacht
Direct examination by Mr. Schoen

1 in my family. My wife wanted to attend medical school. She
2 got in at East Tennessee. East Tennessee offered me a
3 faculty position and allowed me to continue to commute back
4 and forth between E.T.S.U. and Vanderbilt to continue the
5 research program. So for about a decade I did both.

6 Q How about after that decade?

7 A After that I remained at E.T.S.U.

8 Q And did you remain there up until the current time?

9 A I am currently there now as a tenured full professor.

10 Q Doctor, do you hold any certifications?

11 A I am licensed as a clinical psychologist in the State
12 of Tennessee. I am board certified by the American Board of
13 Professional Psychology in both clinical psychology and in
14 forensic psychology.

15 Q Could you describe for us the field of clinical
16 psychology?

17 A Clinical psychology is an applied discipline within
18 psychology that focuses on mental abnormalities including
19 basic science research into the nature of those
20 abnormalities, a professional practice in the form of
21 treatment or diagnostic evaluation, and research into
22 treatments.

23 Q And what about forensic psychology?

24 A Forensic psychology is another applied branch of
25 professional psychology that focuses on the intersection or

Dr. Thomas Edward Schacht
Direct examination by Mr. Schoen

1 the interface between the legal system and behavioral
2 science. So when there are questions of importance to a
3 legal system, forensic psychology is the discipline that
4 attempts to deal with those. There's also a research
5 component to forensic psychology as well.

6 Q would you please describe your experience in the field
7 of clinical psychology?

8 A well, as a medical school faculty member in contrast to
9 if I were an arts and sciences' faculty member, it's been
10 expected from the beginning that I would maintain a
11 professional practice.

12 Medical school is a professional program. You are
13 teaching people practical skills. So there is a
14 professional-practice plan connected with E.T.S.U. that I've
15 been a part of since I was there.

16 Prior to that when I was at Vanderbilt I had a small
17 part-time private practice in addition to what I was doing
18 for the university. It's been a continuous professional
19 activity in one form or other. It's been a continuous
20 activity for the entire time I've been at E.T.S.U. I'm now
21 on my 30th year.

22 Q And what about forensic psychology? Can you describe
23 your experience in that field?

24 A well, it began during my training. At that time it was
25 focused on sort of the basic things you would want to know

Dr. Thomas Edward Schacht
Direct examination by Mr. Schoen

1 as a practicing professional about how the legal system
2 interfaces with your profession.

3 I did some work in child abuse and child abuse
4 intervention through the Department of Human Services in
5 Oregon that had a referral arrangement with the program
6 where I trained.

7 When I came to Tennessee my very first involvement in
8 any forensic work began as a result of a lecture that I gave
9 at Vanderbilt on the psychology of memory. And in part I
10 was drawing on research on certain factors that affect the
11 accuracy or fallibility of memory. And afterwards an
12 attorney in the office -- in the audience approached me and
13 said he had a case involving an eye witness and would I
14 consult with him on that.

15 Q Have you gone on to consult in other circumstances for
16 various courts?

17 A Yes. Beginning around 1986 I accepted a role as a
18 consultant to the Social Security Administration Office of
19 Disability Adjudication and Review.

20 My job there was to review medical records on behalf of
21 requesting federal administrative law judges and then to
22 listen to testimony and testify in disability hearings that
23 were being contested by claimants who have their
24 applications denied.

25 Q How many of those cases have you handled?

Dr. Thomas Edward Schacht
Direct examination by Mr. Schoen

1 A well, I did that for 25 years. At the peak I was doing
2 several hundred of those a year. And I would estimate that
3 there was probably north of 7,000 cases I've done in my
4 career.

5 Q what other experience do you have as a testifying
6 expert?

7 A well, because the medical school I am located is in a
8 small community there's not a high density of people doing
9 forensic work. And so I've been asked to do a lot of
10 things, and I've had to stretch professionally to acquire
11 lots of different kinds of capabilities.

12 I do both civil and criminal work. About the only
13 thing that I try to stay away from are sex offenders. I
14 don't -- I don't have much knowledge or experience with that
15 group.

16 currently, I consult with a court clinic funded by a
17 grant from the Tennessee Administrative Office of the Courts
18 that handles domestic referrals from judges in the First
19 Judicial District. When they have a domestic case they want
20 expertise they ask us to get involved and answer questions
21 for them. That keeps me involved with families and children
22 in that way.

23 when I was doing the disability work for social
24 security it involved both children and adults. And in the
25 case of criminal cases it's been just about every kind of

Dr. Thomas Edward Schacht
Direct examination by Mr. Schoen

1 issue you can imagine for both prosecution and defense.

2 Q Can you tell us whether you've testified in capital
3 cases before?

4 A Yes, I have.

5 Q And can you tell us whether you've testified or which
6 side you testified for in those capital cases?

7 A Both.

8 Q Do you currently have --

9 A Well, not both in the same case but --

10 Q Very good then.

11 A But I've been retained by both prosecution and defense.
12 I'm currently retained on this case, as well as two
13 cases for the prosecution in Nashville.

14 Q Doctor, if you -- you described a very wide range of
15 experience. But if you had an area of expertise, a
16 particular specialty or area that you focus on, what would
17 that area be?

18 A Well, again, I completed a fellowship in developmental
19 disability. So that's always been an area of focus for me.
20 That's not a common training. And so I've been somebody,
21 kind of a go-to person, for consultation in that area in my
22 department.

23 Q Will you define for the Court? What -- when you say
24 developmental disability, what are we talking about there?

25 A Sure. Developmental disabilities, the term, covers the

Dr. Thomas Edward Schacht
Direct examination by Mr. Schoen

1 entire range of problems that an individual may experience
2 as part of the developmental process.

3 So beginning with genetic issues that may occur, you
4 know, from conception and going through the period of early
5 childhood through maturation there is a range of issues that
6 affect the normal process of development -- they're not --
7 as contrasted to the situation where you have an individual
8 who's developing normally but something happens to them to
9 cause an acute illness.

10 So the classic example of a developmental disability
11 would be mental retardation, which is now called
12 intellectual disability. But there are many, many different
13 developmental disabilities.

14 MR. SCHOEN: We tender Dr. Schacht as an expert in the
15 field of clinical psychology and forensic psychology and
16 developmental psychology.

17 MR. ZELENKA: No objection.

18 THE COURT: He is so qualified.

19 BY MR. SCHOEN

20 Q Dr. Schacht, how did you become involved in today's
21 case?

22 A I was contacted by Mr. Ehliess who explained that he had
23 obtained -- he explained that he was working on a capital
24 post conviction matter and that he had obtained some
25 material related to very early psychiatric treatment of

Dr. Thomas Edward Schacht
Direct examination by Mr. Schoen

1 Mr. Torres and he needed some help reviewing and
2 understanding what that might mean for a proceeding such as
3 this.

4 Q In preparation for this case what, if anything, did you
5 review?

6 A I reviewed a box of records which I brought up here in
7 case I need to review it or refer to it while I'm here.

8 That included some legal documents related to the case,
9 included a psychiatric evaluation by Dr. Schwartz-Watz --
10 was a forensic psychiatrist who testified in the original
11 trial.

12 There were some birth records, some childhood photos,
13 some illegible -- some of which were illegible in terms of
14 the birth records.

15 There were psychiatric records from the Medical
16 University of South Carolina, also from the Spartanburg
17 Mental Health Center.

18 There were records from a private psychiatrist,
19 Dr. Chris Caston, who treated Mr. Torres when he was very
20 young.

21 There were records of multiple psychiatric admissions
22 to Spartanburg General Hospital and Patrick B. Harris
23 Psychiatric Hospital and William S. Hall Psychiatric
24 Hospital.

25 There was a copy of Mr. Torres' rap sheet.

Dr. Thomas Edward Schacht
Direct examination by Mr. Schoen

1 And then I also had some miscellaneous other documents
2 that really weren't relevant to mental health.

3 And then I had some excerpts from the trial testimony
4 of several witnesses including Dr. Loring, Dr. Morton, Dr.
5 Wren, Dr. Schwartz-Watz and a counselor whose name I can't
6 recall at the moment who had been involved with Mr. Torres
7 when he was in a residential program.

8 Q Dr. Schacht, can you tell us whether you reviewed any
9 additional literature in connection with this case?

10 A Yes, yes. Once I had gone through the records and
11 identified what seemed to be potential issues for the Court,
12 I then did as I routinely do.

13 I went to the library and consulted the literature in
14 this case with a particular understanding that because we're
15 dealing with a post conviction proceeding it was important
16 to talk about what would have -- could have been known in
17 2008 when the original trial was held.

18 Q Are these materials that you've mentioned the type that
19 are reasonably relied upon by experts in the field of
20 clinical psychology, forensic psychology and developmental
21 psychology?

22 A Oh, yeah. This is -- this is, you know, standard
23 reference works that in the university's library.

24 Q Can you tell us whether you have ever met with
25 Mr. Torres prior to today?

Dr. Thomas Edward Schacht
Direct examination by Mr. Schoen

1 A My understanding of my task in this case was to
2 primarily focus on the state of records. So I have not
3 performed an evaluation of Mr. Torres, but I did attend Dr.
4 Rary's examination of him at the jail and chatted briefly
5 with Mr. Torres at that time.

6 Q Were you able to formulate any opinions with regard to
7 this case?

8 A Yes.

9 Q Did you hold those opinions to a reasonable degree of
10 certainty?

11 A Yes.

12 Q What is your opinion in this case?

13 A There are multiple overlapping factors in this case
14 that converge to create a very severe situation with respect
15 to developmental disability.

16 Q Let's talk about the basis of that opinion.

17 Do you have anything with you that would assist the
18 Court in understanding your testimony?

19 A I prepared a PowerPoint presentation that I hope will
20 be useful.

21 Q Dr. Schacht, I have a -- there's a clicker right there
22 if you want to control the PowerPoint, or you can ask.

23 A Okay. And push to the right to advance it, left to --
24 okay. What does the red one do? That's a laser pointer.
25 Okay. Fine.

Dr. Thomas Edward Schacht
Direct examination by Mr. Schoen

1 Q Doctor, when -- when you conduct an evaluation of
2 someone like Mr. Torres what are the various factors that
3 you consider?

4 A Well, again, I did not evaluate Mr. Torres. I
5 evaluated his history.

6 Q When you evaluate his history what are you looking for?

7 A Well, development occurs along various lines. Okay.
8 So there's motor development, there's cognitive development,
9 social development and so forth. And so as I'm going
10 through the record I'm looking for information that bears on
11 his developmental status as well as threats to development
12 in -- along those various lines.

13 And in this case I broke it down into, first of all, a
14 list of potential causes that could be relevant to
15 Mr. Torres' development and then areas in which affects of
16 those causes might be manifest.

17 So in his case because his difficulties began so very,
18 very early in life, extraordinarily early, that raised an
19 immediate threshold concern for the possibility that there
20 was a strong genetic contribution to what was going on here.

21 Then there was concern raised by some other information
22 about the fetal environment, what was going on when he was
23 in his mother's womb.

24 There were indications in the record that raised
25 questions about physical and psychological trauma. Trauma

Dr. Thomas Edward Schacht
Direct examination by Mr. Schoen

1 is something that is known to have the potential to create
2 longterm and even permanent effects on developing organism.

3 And then finally there were issues related to his
4 treatment. The term iatrogenic means medically caused, and
5 parenting speaks for itself. So that was the range of
6 causal factors that drew my attention.

7 And then with respect to effects there were concerns
8 about the development of his nervous system, about the
9 development of social and interpersonal capacities,
10 development of emotional functioning, development of his
11 ability to process information, which is what the term
12 cognition means, and then of particular importance to a
13 proceeding like this the development of the capacity for
14 self-regulation and self-control.

15 Q How do you define self-regulation?

16 A Well, self-regulation can be defined as the ability to
17 override one response, one thought, one emotion and one
18 behavior and replace it with another one.

19 It requires -- it can occur continuum, you know,
20 ranging from a very simple substitution of a behavior all
21 the way up to something that requires extensive reflection
22 and deliberation. So self-regulation is not just one
23 process. And it looks different at different points in time
24 in a developmental cycle. But basically it's the ability to
25 replace one behavior or thought or emotion with another.

Dr. Thomas Edward Schacht
Direct examination by Mr. Schoen

1 Q And if you were to summarize what you observed about
2 self-regulation, self-regulatory abilities of Mr. Torres,
3 what would that summary include?

4 A What the early development history shows is a really
5 profound impairment in capacity for self-regulation.

6 Q When did that impairment begin?

7 A As early as we have any records.

8 Q Doctor, I'd like to -- to talk about these causes one
9 at a time starting with genetics. What can you tell us
10 about the genetic factors that may have affected Mr. Torres?

11 A Well, first of all, in addition to the genetic approach
12 taken by Dr. Rary and Dr. Lipman in their testing there's
13 also another approach that is used clinically, and that is
14 to simply look at family history.

15 It's known that many mental disorders are heritable.
16 We may not know the exact genetic basis for it, which means
17 a geneticist can't test for it. But we know from looking at
18 the relative incidence of illnesses among family members
19 that they are inherited.

20 There are other kinds of studies, for example,
21 comparing incidents of illnesses in identical twins versus
22 fraternal twins and so forth that also allow these things to
23 be teased apart.

24 And in this case I started by looking at just the
25 family history of mental illness as a way of trying to gauge

Dr. Thomas Edward Schacht
Direct examination by Mr. Schoen

1 to what extent Mr. Torres might have carried a burden from
2 that.

3 what I found was that there was a multigenerational
4 history of mental illness. According to the records
5 available to me, his maternal grandmother had a history of
6 being mentally ill, of psychiatric hospitalization and of
7 receiving electroconvulsive therapy.

8 Based on the time period when she was ill, based on her
9 age, the most likely indication for electroconvulsive
10 therapy would have been a mood disorder, probably very
11 severe depression. But there were some points in history
12 when electroconvulsive therapy was being used for other
13 purposes. So it's possible there was some other diagnosis
14 as well. Without her records I can't tell anything beyond
15 that.

16 There's information in Tony's own psychiatric records
17 about family history that was provided by his mother about
18 the mental illness in the family. And she described her
19 siblings as characterizing -- what's up there in quotes is
20 actually a quote from the record -- as characterized by
21 explosive or rational outbursts of anger that cannot be
22 managed verbal reasoning. So that's mother describing her
23 siblings.

24 There was also in the family history given there that
25 the maternal grand-stepfather was alcoholic and abusive.

Dr. Thomas Edward Schacht
Direct examination by Mr. Schoen

1 Tony's mother herself was psychiatrically hospitalized
2 as an adolescent. And I've reviewed those records, and she
3 was given a diagnosis of borderline schizophrenia. I'll talk
4 more about that later on.

5 And then there was also references in the record to
6 substance abuse by Tony's father. I couldn't tell always
7 from the record whether they were talking about stepfather,
8 which would be more of an environmental influence, or
9 whether they were talking about paternal father, which would
10 be a genetic issue, or both.

11 Q Let me ask you, Doctor.

12 You've written down that there are -- there are -- that
13 you need to consider both the genetic and psychological
14 pathways. What do you mean by -- by these two different
15 pathways?

16 A Well, mental illness to the extent that it has a
17 genetic component in the cascade of causes, that genetic
18 component can be expressed physically.

19 Then that genetic component can also be expressed in
20 interaction with the environment. So there are -- for
21 example, genes are not just on or off. Certain things can
22 happen in a person's life that will turn genes on or off.
23 And so the expression of a gene can depend on experience to
24 some extent.

25 And then finally the psycho -- the purely psychological

Dr. Thomas Edward Schacht
Direct examination by Mr. Schoen

1 pathway occurs because people who are suffering from mental
2 illness often have difficulty functioning satisfactorily or
3 adequately as parents and as caretakers. And so problem
4 behaviors in a parent can be reflected in inadequate
5 nurturing and other parenting behaviors with the child and
6 pass on difficulties in that way.

7 Q Doctor, let's back up one slide, because you had in
8 addition to family history a couple of other conditions
9 listed. What are these conditions?

10 A Well, as Dr. Rary indicated, Prader-Willi syndrome is a
11 factor in this case and the 22q11 deletion issue is also a
12 factor in this case.

13 Prader-Willi syndrome from a psychological point of
14 view -- and I'm going to go ahead now -- has several major
15 categories of dysfunction for which individuals with
16 Prader-Willi are at elevated risk.

17 Q Let's start with the psychological disfunction.
18 What -- what are those areas of risk?

19 A Well, you have cognitive impairment here. Sometimes in
20 Prader-Willi syndrome, but not always, this can be manifest
21 in a global cognitive impairment.

22 When you have this global impairment, particularly in
23 areas that are important for academic functioning, you'll
24 see it in a lowered I.Q. Sometimes it will be lowered into
25 the range of mental retardation. Other times no.

Dr. Thomas Edward Schacht
Direct examination by Mr. Schoen

1 Many individuals with Prader-Willi syndrome have I.Q.s
2 above the retarded range.

3 Then there are also deficits in processing information
4 that go beyond the kinds of things that are typically
5 captured by I.Q. tests. So there can be deficits in what
6 are called executive functions. This involves the same sort
7 of things that Dr. Lipman talked about -- judgment,
8 planning, sequencing, carrying out the steps and remembering
9 the steps to do something.

10 Interpersonal intelligence and emotional intelligence
11 are also separate areas of information processing that are
12 different from I.Q. but that can be the subject of
13 impairment and significant adaptive difficulty when those
14 areas are low.

15 So, for example, you can have an individual who has
16 difficulty recognizing facial expressions in other people.
17 That means you can't tell what other people are feeling in a
18 reliable way. Or you may have an individual who can't
19 develop an accurate what's called theory-of-mind.

20 Whenever one person observes another person acting,
21 part of what we do is we develop in our own mind a picture
22 of what's in their mind when they're acting as a way of
23 making sense out of that person's behavior.

24 Individuals with some developmental disabilities
25 including autism -- and to some extent the research

Dr. Thomas Edward Schacht
Direct examination by Mr. Schoen

1 indicates Prader-Willi -- have difficulty developing an
2 accurate theory of mind. So they may see people behaving
3 but not have an accurate picture of why they're doing it or
4 how their behavior makes sense. It's just out there
5 happening for them.

6 Many of the deficits that are seen in Prader-Willi
7 syndrome have been attributed in the literature to
8 impairments in functions that are known to be supported by
9 the orbital frontal cortex of the brain, which has been
10 mentioned by some of other witnesses as well.

11 Q And when you've got that type of an impairment, what
12 type of behavioral -- how does that manifest itself in
13 behavior?

14 A Well, the most important thing about the orbital
15 frontal cortex for purposes of my testimony is its
16 relationship to self-regulation.

17 The orbital frontal cortex has tracks that connect to
18 lower emotional centers of the brain that can exert a
19 controlling or inhibitory effect on what is being driven by
20 emotion. When the orbital frontal cortex is either
21 undeveloped or damaged in adulthood that connection
22 disappears.

23 To put it in more common terms, the orbital frontal
24 cortex and the lower emotion centers represent the poles of
25 reason and emotion, and having an intact relationship

Dr. Thomas Edward Schacht
Direct examination by Mr. Schoen

1 between the two speaks to the relationship between reason
2 and emotion in an individual's life.

3 when the orbital frontal cortex is dysfunctional either
4 for developmental reasons or because it was damaged later in
5 life you get an individual whose behavior can be dominated
6 by emotion.

7 And, in fact, that's what, you know, psychological
8 evaluators were saying about Tony when he was a child.
9 There's one evaluator when he was about seven who described
10 him as -- described his behavior as governed by, quote, raw
11 affect, meaning unmodulated by the kinds of processes that
12 the orbital frontal lobe would introduce into it.

13 Q Doctor, I want to -- want to distinguish Prader-Willi
14 syndrome from something like bipolar or some other type of
15 mental illness.

16 I believe there was testimony that -- that having
17 Prader-Willi syndrome might put you at a higher risk for
18 some of these conditions. Is that correct?

19 A Yes. Well, yes and no.

20 It's clear from the literature on psychopathology and
21 Prader-Willi syndrome that mood disorders and things like
22 that look like bipolar disorder are to be expected. They're
23 pretty common in the Prader-Willi population.

24 Now, the theoretical question is when you have
25 something that looks like bipolar disorder in the company of

Dr. Thomas Edward Schacht
Direct examination by Mr. Schoen

1 Prader-Willi is it still bipolar disorder in the way we
2 usually think about bipolar disorder.

3 It may be on the surface because there are
4 similarities, but ordinarily, for example, bipolar disorder
5 does not occur in people who have all the other deficits of
6 Prader-Willi syndrome.

7 So it's a much more complicated picture. It would be
8 an error in thinking in my opinion to simply say, well,
9 you've got Prader-Willi and you've got bipolar and they're
10 separate. They're independent. That doesn't make sense.
11 People are not carved up in that way.

12 Q If a child has Prader-Willi how likely is it that
13 they're going to display certain behavioral issues?

14 A The statistics that Dr. Lipman cited were pretty
15 accurate based on my research as well.

16 There's a very high incidence of psychiatric disorder
17 in Prader-Willi syndrome. It tends to focus on mood and
18 anxiety disorders with symptoms of transient psychosis also
19 occurring.

20 There's one paper that refers -- out of Europe -- where
21 they use this language. They talk about what's called the
22 psychoid psychosis, which is a psychotic experience that
23 occurs with a rapid onset, some pretty intense symptoms and
24 then a rather abrupt ending. So the transients is
25 significant. And that paper described the occurrence of

Dr. Thomas Edward Schacht
Direct examination by Mr. Schoen

1 psychoid psychoses in nine Prader-Willi individuals.

2 There were also other features that are part of a
3 condition where I talk up here about resistance to change
4 and obsessions.

5 Individuals with Prader-Willi syndrome seem to -- many
6 of them -- and, again, everything I'm saying here has to
7 conditioned on the idea that none of these things are
8 universally true for every individual with the diagnosis.
9 But as a group individuals with Prader-Willi syndrome have
10 difficulty with change. They're resistant to change. They
11 want things to be the same. They may become obsessed with
12 things, get on something and stay with it and have
13 difficulty being redirected as a result of that.

14 And Tony's developmental history also contains evidence
15 of that either by descriptions of people who were treating
16 him or in the reports of his mother when she was giving
17 developmental history to her explanations.

18 Q Is it -- would it be accurate to compare Prader-Willi
19 to some forms of autism?

20 A There are -- well, there's been some research that has
21 specifically made those comparisons, and it has found some
22 similarities, particularly in terms of the difficulty in
23 forming accurate perceptions of other people and the
24 difficulty in generating an accurate theory of mind, what's
25 going on in other people's minds.

Dr. Thomas Edward Schacht
Direct examination by Mr. Schoen

1 Q You also mentioned psychia -- or psychosis mood and
2 interpersonal aggression. What -- how does Prader-Willi
3 affect aggression?

4 A It -- it's -- they repeatedly observed in the
5 Prader-Willi literature that temper outbursts, aggressive
6 outbursts, often explosive, are part of the Prader-Willi
7 presentation in many cases.

8 And Mr. Torres' developmental history certainly shows
9 those features to an extreme degree. When -- you know, when
10 you're admitted to a psychiatric hospital at the age of
11 three and a half with the chief complaint of
12 I-am-going-to-kill-myself-or-you, that's exceptional.

13 Q What else in -- in Mr. Torres' clinical records
14 suggests that he has this type of aggression that is
15 correlated with Prader-Willi?

16 A The -- well, we'll get -- we'll get into that more when
17 we talk about the Medical University of South Carolina
18 hospitalization in some more detail, but the aggression is
19 also not necessarily only against others. It's not always
20 outwardly directed. It can be inwardly direct.

21 So there's reports of headbanging in his records going
22 back to infancy, as well as later on there's a description I
23 think in Dr. Warren's testimony about an episode that she
24 learned of of him banging his head to the point where he was
25 bloody.

Dr. Thomas Edward Schacht
Direct examination by Mr. Schoen

1 Now, that's partly an expression of emotional -- of
2 being emotionally overwhelmed. For some children
3 headbanging can also be a desperate, if doomed, attempt at
4 self-regulation. When something is happening and you can't
5 control it any other way, you bang yourself into
6 insensibility just by banging your head.

7 Q Just being clear, Doctor, is it possible to have all of
8 these cognitive impairments or these behaviors without
9 having impaired I.Q.?

10 A Yes.

11 Q How is that possible?

12 A Well, the clearest examples of how that can be are seen
13 in adults who have damage, say, to the orbital frontal lobes
14 and acquire many of these same behaviors even after a period
15 of time when that's not been the case.

16 For example, I once treated a physician who had a
17 stroke that wiped out his orbital frontal lobe. He was a
18 surgeon. His I.Q. was unaffected by the stroke, but his
19 ability to manage impulses and to accurately read social
20 situations and to behave appropriately was dramatically
21 effected so that ultimately his partners threw him out of
22 their practice and forced him into retirement because he
23 couldn't behave appropriately with patients.

24 Q Was he still capable of performing surgery at the point
25 they kicked him out?

Dr. Thomas Edward Schacht
Direct examination by Mr. Schoen

1 A He was capable of doing all of the technical aspects of
2 surgery.

3 what he was not capable of was sustaining the effort.
4 So he might get part way through an operation and then just
5 decide he was done and quit and leave the patient open on
6 the table, and somebody else would have to step in and
7 finish for him.

8 Q But his I.Q. remained unaffected.

9 A I.Q. remained unaffected.

10 Q Let's talk about vegetative dysfunction. What do you
11 mean when you -- when you refer to vegetative dysfunction?

12 A Vegetative functions are the functions like sleep,
13 eating, the things that are more a part of the body as
14 opposed to mental phenomena. And these are also part of the
15 characteristic behavioral picture in Prader-Willi.

16 Sleep disorder is a very common problem. In Antonio's
17 case there were references in the clinical records to his
18 mother reporting that beginning as early as age seven months
19 he would simply be up all night and unable to sleep.

20 Q Is that consistent with Prader-Willi?

21 A That -- that particular problem I did not see as a
22 specialty consistent with Prader-Willi.

23 The more common problem -- well, there would be
24 insomnia. But the more problem would be in connection with
25 the obesity, some form of sleep apnea, and that's also

Dr. Thomas Edward Schacht
Direct examination by Mr. Schoen

1 potentially relevant ultimately to brain function because
2 sleep apnea undetected and untreated will produce a
3 condition where the brain is chronically deprived of oxygen.
4 And then you can get a whole host of additional problems
5 with that.

6 It's very common in general psychiatry for treatment of
7 a mood disorder or any disorder to fail until something like
8 sleep apnea is properly treated because the person will be
9 treatment resistant until that issue is addressed.

10 Q Let's talk about the eating. How do you -- what do you
11 typically see in patients who have got Prader-Willi with
12 regard to the way they eat?

13 A Well, Prader-Willi produces a condition called
14 hyperphagia, hyper meaning excessive, phagia referring to
15 eating.

16 And it's not just behavior. It's subjective. What you
17 read when you read descriptions quoting Prader-Willi
18 patients is they will -- they will say it's like I have
19 knives in my stomach all of the time and it doesn't matter
20 how much I eat, the knives don't go away.

21 In the extreme individuals with Prader-Willi
22 syndrome -- may eat things that are not nutritive. They may
23 eat garbage; they may eat dog food.

24 One of the common and typical environmental
25 interventions that is sometimes necessary with Prader-Willi

Dr. Thomas Edward Schacht
Direct examination by Mr. Schoen

1 individuals is for the family to literally padlock all of
2 the food in the house, because, as Dr. Rary said, these
3 individuals, some of them, can eat themselves to death.

4 In a developmental history given by Tony's mother to
5 Dr. Caston when he was around seven she endorsed the idea
6 that she -- she has terrible difficulty keeping him from
7 eating everything.

8 Q Doctor, if -- if a child has Prader-Willi, in addition
9 to eating everything are there any -- do they have any
10 preferences when it comes to particular types of foods?

11 A There can -- there can. Prader-Willi syndrome because
12 of the connections with obsessiveness and so forth can also
13 be associated with very idiosyncratic food preferences.

14 One research study that I read about this,
15 interestingly, indicated that the likelihood of having very
16 strong food preferences was actually more likely to be the
17 case in the individuals with Prader-Willi who also had I.Q.s
18 in the higher range of Prader-Willi. So that would fit
19 Mr. Torres quite well.

20 And what his history shows, for example, when he was
21 admitted to the Medical University of South Carolina, he had
22 an extremely strong preference for carbohydrates.

23 He would not eat meat or vegetables or other things,
24 and that were battles between Mr. Torres and the hospital
25 staff over his food preferences.

Dr. Thomas Edward Schacht
Direct examination by Mr. Schoen

1 Q Doctor, what would you say if someone suggested that
2 the reason that Mr. Torres was obese was because he was
3 rejected by his mother and was trying to fill an emotional
4 void?

5 A Well, he was rejected by his mother, and he may have
6 been trying to fill an emotional void, but that's not why he
7 was obese.

8 Q How do you know that?

9 A The kind of obesity that he has doesn't come from that
10 sort of emotional problem. It's just -- it's just a silly
11 question.

12 Q When did -- when did his obesity --

13 A Well, his obesity began by three months of age, and the
14 behavior problems that led to the maternal rejection didn't
15 begin until after that.

16 I mean, at three months of age all a baby does is lie
17 there and maybe make eye contact and interact in some very
18 simple ways with a parent, but a three-month-old is not
19 going to be creating the sort of extreme behavioral problem
20 that's going to make a parent say I'm sending you to an
21 institution, which would eventually happen.

22 Q Doctor, you talked a bit about the impact of
23 Prader-Willi on the -- on an individual's self-regulation.

24 A Yes.

25 Q Why is self-regulation in children important?

Dr. Thomas Edward Schacht
Direct examination by Mr. Schoen

1 A Before we go there should I talk about the 22q11
2 portion of this?

3 Q I have not -- I have not asked you about that.

4 A Okay.

5 Q Let's cover that. Thank you.

6 A Let me do that. And I also wanted to talk about the
7 pain issue here too.

8 Another feature of Prader-Willi is the occurrence in
9 some individuals of a relative insensitivity to pain. This
10 is not one of those syndromes where a person can't feel pain
11 at all, but their sensitivity to pain is reduced as compared
12 to an ordinary person.

13 This creates medical problems in the medical management
14 of individuals with Prader-Willi syndrome because they can
15 have infections or injuries, and they may not complain about
16 them, and so there has to be external monitoring of their
17 medical condition more with a higher degree of vigilance
18 than you might have with someone else who you can count on
19 to make complaints.

20 In Mr. Torres' case there is a reference in the
21 clinical record to him having suffered second degree burns
22 at the age of two on the soles of both feet.

23 Now, before Prader-Willi was introduced as an issue
24 into this case by Dr. Rary's analysis my reading of that was
25 this is not something a kid did on his own by standing on a

Dr. Thomas Edward Schacht
Direct examination by Mr. Schoen

1 hot floor grate as was reported to the medical staff,
2 because any normal child would have simply jumped off. He
3 wouldn't have stood there long enough to get burns to a
4 second degree on both feet.

5 And so I was even thinking about the possibility that
6 this was a case where that story actually reflected
7 undetected child abuse, because that would be another reason
8 a child might get such burns. But Prader-Willi syndrome is
9 also a sufficient explanation for that.

10 Someone with the relative pain insensitivity of
11 Prader-Willi might stand on the grate and might get burned
12 just that way.

13 Q How does that type of pain insensitivity affect
14 someone's behavior, if at all?

15 A Well, it's an interesting relationship between physical
16 pain and psychological development in this sense.

17 Our ability to understand the pain of another person
18 depends on our having an intact experience of pain ourselves
19 so that when we see another person in pain or when we see
20 something happening to another person that would cause pain,
21 part of how we know that is because we have been in similar
22 situations and we felt the same way.

23 An individual who has relative pain insensitivity is at
24 a disadvantage in terms of developing that kind of empathic
25 capacity, and they may well be impaired as a result of that.

Dr. Thomas Edward Schacht
Direct examination by Mr. Schoen

1 And there's some research showing that the ability to
2 perceive pain in others, in fact, is related to the capacity
3 to feel pain in one's self. So developmentally it would
4 potentially affect his capacity for developing empathy
5 towards the pain in others.

6 And you see behavioral indications of that in the
7 record. Well, it's talked about in terms of Tony lacks
8 insight and that sort of thing, but what they're talking
9 about is Tony doesn't appreciate the impact of his behavior
10 on others and doesn't understand why other people would be
11 upset or hurt by what he did.

12 Q Doctor, is there anything else in Tony's records that
13 you want to talk about with regard to Prader-Willi syndrome
14 before we move on?

15 A Well, the synergy here that I want to talk with --
16 that's why the word synergy is in the slide. It has to do
17 with the 22q11 syndrome simply because the psychiatric
18 features of that syndrome as they were articulated by Dr.
19 Lipman overlap to a substantial degree with the features
20 that are also known to be seen in Prader-Willi syndrome.

21 So now you've got two genetic conditions, either of
22 which is capable of producing this picture. And the most
23 reasonable assumption would be that there would be a synergy
24 here that one's not going to cancel out the other, that
25 they're going to aggravate each other.

Dr. Thomas Edward Schacht
Direct examination by Mr. Schoen

1 Q And what type of -- what type of symptoms do you expect
2 to see from someone suffering with 22q11 deletion?

3 A Mood spectrum symptoms, transient psychotic symptoms,
4 disruptive social behavior, emotional lability meaning
5 emotions will change very suddenly and often can be very
6 intense, and frequent angry outbursts are what's described
7 in literature.

8 I think it's also important to note that as with
9 Prader-Willi syndrome the behavioral problems in 22q11 do
10 not appear to improve with age, nor are they specifically
11 correlated with I.Q. They're -- they're separate.

12 In other words, something that improves with age is
13 something that people grow out of when you have a condition
14 or that you can have some hope to influence through a
15 developmental process.

16 When you have a condition where the normal -- where the
17 natural developmental trajectory is for things not to get
18 better with age that inspires a certain amount of clinical
19 pessimism that we may be dealing with a condition that's
20 relatively immutable.

21 Q So if Tony is having inappropriate emotional outbursts
22 at 19 months or at three-and-a-half years there's not a lot
23 of hope that that's going to get better as his life
24 progresses.

25 A To the extent that those things were the product of

Dr. Thomas Edward Schacht
Direct examination by Mr. Schoen

1 Prader-Willi and 22q11 those -- those portions of the causal
2 picture do not appear to improve over time.

3 Q why is that?

4 A I don't know the answer to that.

5 Q So why is it important that -- or I guess what -- let
6 me phrase it this way. What can you -- what do we know
7 about impulsivity and an impaired capacity for
8 self-regulation in children?

9 A well, the capacity for self-regulation is one of the
10 most critically important developmental lines. Without it
11 people end up adaptively impaired in a variety of contexts.
12 Self-regulation exists in multiple developmental lines.
13 So we can talk about regulating one's thought processes; we
14 can talk about regulating emotional experience. So, for
15 example, if you become very upset, you have the ability to
16 calm yourself down.

17 We can talk about regulating behavior, if you find
18 yourself driven to perform a particular behavior do you have
19 the capacity to refrain and to redirect yourself or to
20 respond to efforts of others to help you do that.

21 Okay. Because self-regulation is so fundamental to
22 other aspects of development it's been the focus of a great
23 deal of developmental research. And we now have follow-ups
24 as long as 40 years on what has happened to children who
25 were shown to have some deficits in self-regulation when

Dr. Thomas Edward Schacht
Direct examination by Mr. Schoen

1 they were three, four, five years old.

2 Q I'm going to advance to the next slide.

3 A Sure.

4 Q what -- what do those studies show?

5 A well, in general the capacity to delay grat -- let me
6 describe how it's -- how it's measured for research
7 purposes.

8 when -- when you want a study concept like
9 self-regulation or anything else you need to create a
10 research model for doing so. And so one research model for
11 studying capacity for self-regulation has looked at delay of
12 gratification as a measure of that.

13 If you offer someone something that should be
14 attractive to them under terms where if they delay there's a
15 bigger reward, the question is can they do that and how do
16 they do that, how do they go about doing that if they can.

17 And there's something called the marshmallow experiment
18 which was formulated by Dr. Walter Mechell at Stanford back
19 in the late 1960s that has classically been used to measure
20 this in young children. And that's -- that's the line of
21 research that we now have many, many studies on including
22 the 40-year followup.

23 And essentially what it involves is sitting a child
24 down at a table or some place and putting something they
25 would like to eat in front of them like a marshmallow or a

Dr. Thomas Edward Schacht
Direct examination by Mr. Schoen

1 cookie or candy. In Mechell's case he used marshmallows, so
2 that's why it's called the marshmallow experiment.

3 And what you say to the child is this is yours, you can
4 have it and you can eat it right now if you want to but I'm
5 going to leave the room and if you wait till I come back you
6 can have two.

7 Okay. And then the researcher leaves the room, so the
8 child is alone with the challenge of do I eat it now and get
9 immediate gratification or do I delay.

10 The purpose of leaving the child alone is so that the
11 entire burden of regulating this situation is on the child.
12 It's self-regulation. There isn't any help coming from an
13 adult or from the environment to do that.

14 And what that research has shown is that children who
15 are poor at this, who succumb to temptation, who cannot
16 control the desire to eat that marshmallow, who gobble it
17 right down, when you follow them up down the road have a
18 variety of health and mental health outcomes and behavioral
19 outcomes and psychosocial outcomes, all of which share in
20 common the vulnerability to impulses or to impulsivity.

21 So, for example, individuals who do poorly at this at
22 the age of four or five when you measure them later on are
23 much likelier to have a high body mass index. In other
24 words, they don't regulate their food intake very well. And
25 this is normal individuals, not people with Prader-willi.

Dr. Thomas Edward Schacht
Direct examination by Mr. Schoen

1 They're more likely to abuse stimulants like cocaine.
2 Okay. They are more likely to demonstrate borderline
3 personality features. And this is not necessarily a cause
4 and effect thing.

5 It may well be that the reason they couldn't do it at
6 the age of three or four was because they carried some of
7 the genetic loading for borderline personality which has
8 impulsivity. Self-damaging impulsivity is one of the
9 diagnostic features, and you're simply seeing that genetic
10 vulnerability in the preschool period expressed in a
11 different way.

12 And then there's also an impaired capacity for any
13 personal relationships, because if there's anything that's
14 true about relating to other people in an effective way it's
15 that you have to take other people into account if there's a
16 constant give and take between what I want and what you want
17 and how we're going to find some common ground, how we're
18 going to balance this and so forth. And an individual who
19 is impulsive has great difficulty with that.

20 Q So tie this study back to someone like Tony or to
21 somebody who's suffering from Prader-Willi syndrome or 22q11
22 deletion. How did you predict that a child with
23 Prader-Willi syndrome is going to do on this particular
24 experiment?

25 A I would predict that a kid with Prader-Willi syndrome

Dr. Thomas Edward Schacht
Direct examination by Mr. Schoen

1 at the age of five would probably grab the marshmallow out
2 of the researcher's hands before he got to put it on the
3 desk.

4 Q And is -- is the fact that the kid's going to eat the
5 marshmallow quickly because he's hungry, is that -- is that
6 the full extent of why this is significant or --

7 A Well, I think your question goes to why the marshmallow
8 experiment wouldn't be a fair test of impulsivity in
9 somebody like Tony, because an ordinary kid isn't also
10 dealing with the extra burden of ravenous hunger all of the
11 time. But there would be other ways to measure this, other
12 forms of delay of gratification.

13 And if you look in Tony's clinical record, you know,
14 there are things like, you know, asking him to, you know,
15 delay doing something with a toy, asking him to change -- a
16 variety of situations in which there are clinical
17 observations that he was terribly impulsive.

18 Q So I guess part of what I'm asking, Doctor, is how is
19 somebody with Prader-Willi or 22q11 just different from a
20 kid who's got poor self control.

21 A Worse. It's just worse. I mean, when you say just
22 poor self control, that makes it sound as if poor self
23 control is benign. It's not. It's a serious problem.

24 Q And --

25 A And for somebody with Prader-Willi or the kind of

Dr. Thomas Edward Schacht
Direct examination by Mr. Schoen

1 problems that are seen in any syndrome that is known to
2 affect the orbital frontal cortex you have a problem that is
3 not only manifest behaviorally but exists in a context where
4 the neuro machinery to develop out of the problem, to grow
5 out of it, is also damaged.

6 Q So these conditions would be related to, would you say,
7 very poor self control that you don't grow out of?

8 A That's -- that's what in general you would expect from
9 these conditions, yes, and that's what Tony's early history
10 shows. It shows a persistent problem with lack of self
11 control throughout the record.

12 Q Doctor, let's -- let's talk about the next factor on
13 that initial overview chart which is the fetal environment.
14 What can you tell us about the fetal environment that's
15 relevant to this case?

16 A The year that Tony's mother became pregnant with him
17 was 1979. The portion of the prenatal records that I could
18 read indicated that she had had an abortion the previous
19 year.

20 I understood from some of the testimony in the prior
21 proceeding that things were different now. What was
22 striking to me about this was that there obviously had been
23 some kind of a major turnaround in mother's attitude about
24 having children.

25 She was in an abusive relationship. I don't know what

Dr. Thomas Edward Schacht
Direct examination by Mr. Schoen

1 role that may have played in it. The attitude that was
2 described in the testimony from the original trial was that
3 Tony's mother had harbored an idea that Tony was going to be
4 her companion for life.

5 So you've gone within the span of a year from being a
6 woman who is prepared to abort a child to being a woman who
7 now is going to have a companion for life.

8 Those two things could be related. Having a companion
9 for life could be a way of compensating for her regret over
10 an abortion. It could also be connected with mother's
11 underlying mental illness for which that kind of
12 flip-flopping would be consistent. I don't know. It's just
13 developmentally striking that you would have this happen
14 that quickly.

15 It raised for me concern about what exactly was going
16 on in mother's life and mother's attitude towards even
17 having a child.

18 Whatever that was, the joy about the idea of having a
19 child was apparently not shared by Tony's father. It's
20 according to the available records. He beat her while she
21 was pregnant.

22 It's hard to overestimate the importance of that in
23 terms of being a marker for dysfunction in the family. If
24 you look at it from a domestic violence perspective, for
25 example, one of the key indicators that a domestic violence

Dr. Thomas Edward Schacht
Direct examination by Mr. Schoen

1 situation is exceptionally severe is when there has been
2 physical harm to a woman while she is pregnant.

3 Okay. So that's important in terms of what it says
4 about the family. It's also potentially important in terms
5 of the possibility for fetal harm either through direct
6 physical trauma or through indirect physiological effects
7 such as the effects of stress hormones evoked in the mother
8 by being beaten on the developing nervous system.

9 And then, finally, there was an issue of toxicity that
10 was raised by the early medical record having to do with
11 mother's substance exposure including tobacco at the rate of
12 greater than a pack a day, some exposure to marijuana and
13 some exposure to alcohol.

14 Q Doctor, why -- why are those exposures significant?

15 A Well, if there was enough alcohol you would be
16 concerned about fetal alcohol syndrome. We don't have a
17 history to support that.

18 If there was enough marijuana you might have been
19 concerned about some other things as well.

20 There was enough tobacco to be concerned about toxicity
21 to the developing nervous system.

22 And there's quite a robust literature showing effects,
23 adverse effects, of prenatal exposure to tobacco, as little
24 as ten cigarettes a day. And the effects persist over time
25 so that children have now been followed for as long as 20

Dr. Thomas Edward Schacht
Direct examination by Mr. Schoen

1 years or more, and adverse effects continue to be
2 detectable.

3 At the time that Tony's mother was pregnant there was
4 no surgeon general's warning on cigarettes telling women not
5 to smoke. That warning there was not required until 1985.
6 Tony was already five years old.

7 We have good research showing that tobacco exposure in
8 utero has adverse effects on brain development as compared
9 to normal controls.

10 If you measure the brain volume in children who are
11 exposed to tobacco in utero, as long as 10 to 14 years after
12 the exposure they have got reduced brain volume, reduced
13 cortical thickness and differences, importantly, for what
14 we're talking about here in the frontal lobe. Those kinds
15 of differences are also reflected in the behavior. There's
16 a concept known as behavioral teratogenicity.

17 Q Define that for us.

18 A I will. A teratogen is something that causes a birth
19 defect. Birth defects can have physical form, meaning you
20 have physical malformation of your ears or your face or your
21 eyes or something. Birth defects can also affect function
22 including behavior.

23 Now, for a very long time behavioral teratogens were
24 not appreciated the way they should be because they're not
25 immediately evident at birth.

Dr. Thomas Edward Schacht
Direct examination by Mr. Schoen

1 Every baby when they're born in the delivery room gets
2 a quick physical examination to look for, you know, major
3 malformations. There's no way to examine a baby in the
4 delivery room to see whether its nervous system has been
5 altered in a way that's going to affect its behavior down
6 the road. The only way we know those things is to actually
7 see what happens to the behavior.

8 And so in the case of tobacco -- this has been studied
9 extensively at all levels of development so that in infants
10 what you see is as compared to children who are not exposed
11 increased irritability, less focused attention, more
12 distractibility, decreased capacity for self-regulation,
13 which in an infant is something very simple such as can I
14 put this baby down and can it calm itself in order to go to
15 sleep, okay, can this baby learn to do that.

16 Okay. Based on what I read in the record at the age of
17 seven months Tony's up all night. He's not able to calm
18 himself. He's not able to put himself to sleep.

19 Even when he was much older and in psychiatric
20 hospitals there were descriptions of home life that included
21 Tony could only sleep if he was with his mother. He
22 required outside assistance to calm and sooth himself down
23 enough to simply drift off into slumber.

24 There's also some indication and some research that
25 there can be impairments in auditory processing which can

Dr. Thomas Edward Schacht
Direct examination by Mr. Schoen

1 affect language development.

2 I didn't see anything in this record that suggested
3 that Tony had a language impairment.

4 Q what about when kids get a little farther along in
5 their development?

6 A Okay. Early childhood. At these various ages, again,
7 we see affects on physical aggression, problem behaviors,
8 sleep problems, excessive crying, attention problems.

9 Moving further on, middle childhood. The term
10 inhibitory deficits in hot but not cool executive
11 functioning is important to understand.

12 when I talked earlier about executive functioning and I
13 was talking about how it involved judgment, planning,
14 sequencing and so forth, there's another distinction that
15 gets made in a discussion with executive functioning having
16 to do with the presence or absence of intense emotionality
17 when that is occurring.

18 when you are trying to carry out tasks that require
19 executive functioning in the presence of intense emotion
20 that's referred to as hot executive functioning. when
21 you're simply making an unemotional cool, rational,
22 deliberate choice, then you're talking about cool executive
23 functioning.

24 what was seen in the seven-to-nine-year-olds in the
25 particular study I'm referencing there was that the deficits

Dr. Thomas Edward Schacht
Direct examination by Mr. Schoen

1 in self-regulation were most evident when the children were
2 asked to do something in a condition that was also
3 emotionally evocative.

4 Age ten, again, activity impulsivity, the length with
5 any aggressive behaviors, early latency and early
6 adolescence, more conduct disorder; and then finally
7 followed for 22 years, more symptoms of emotional
8 disturbance, more aggression, more physical complaints and
9 more likely to have a history of arrest.

10 Q Doctor, you told us that -- I think you said that ten
11 cigarettes a day was sufficient to cause some of these
12 problems.

13 Can you -- can you tell us how many cigarettes Tony's
14 mother was reported to have been smoking?

15 A Well, it was at least a pack a day, which would be 20.

16 Q Forgive this question, but, so what, Tony's mother
17 smoked. I mean, a lot of people's moms smoked. why -- why
18 is that particularly significant?

19 A Only in the sense that what we're looking at in this
20 case is a compounding of developmental adversities, one on
21 top of another, on top of another. And this is simply
22 another piece of the picture.

23 Q So you're saying that since he's got genetic problems,
24 he's got a history of mental illness, he's got his mother
25 being beaten when he was a child, he's got smoking, he got

Dr. Thomas Edward Schacht
Direct examination by Mr. Schoen

1 all of these things together, that's what's significant?

2 A Correct. Developmental adversities have additive
3 effects. They don't subtract from each other. They don't
4 compensate one making the other one better.

5 Q Now, you've told us a lot about these, these causes
6 that take from us the point of conception or before
7 conception all the way up to Tony's birth.

8 Let's talk about some effects. Do you see any effects
9 of these things in Tony's early childhood?

10 A well, the most significant thing was the very early --
11 very, very early -- onset of severely disordered behavior
12 in -- in Tony.

13 The fact that he was put on antipsychotic medication as
14 a toddler is something I have never seen in my entire
15 career.

16 And apart from the pharmacological issues that Dr.
17 Lipman talked about, if I look at that choice clinically I
18 can either conclude this was cowboy medicine by a doctor who
19 didn't know what he was doing or this was a situation where
20 the child's behavior was so severe that desperate measures
21 were called for, okay, and they were reaching as far as they
22 could reach in order to try to find something to manage
23 those.

24 I would also point out that at the age of 19 months
25 when Tony was put on antipsychotic medication -- most

Dr. Thomas Edward Schacht
Direct examination by Mr. Schoen

1 children are only minimally verbal. And you're going to
2 have some -- some short phrases. You know, you may not
3 complete all of your sentences, that sort of thing.

4 So how are you going to assess the effects of the
5 medication on the child? It's not going to be from anything
6 the child tells you. It's going to be just from gross
7 observations of behavioral change, which as Dr. Lipman
8 noted, are going to be very difficult to separate from
9 simple sedation and chemical restraint.

10 Q When you say chemical restraint, can you explain that
11 concept?

12 A Chemical restraint exists as a concept in just a
13 position to physical restraint. Many individuals lack the
14 capacity to control themselves. It can be necessary to
15 impose external controls on them.

16 Every psychiatric hospital, for example, is equipped
17 with an apparatus to physically restrain patients who cannot
18 be controlled. And there are serious legal and professional
19 concerns about doing that, so it's done under very strict
20 circumstances.

21 Another way to restrain somebody without an external
22 apparatus is to do it from within the person by giving them
23 a drug that essentially incapacitates them.

24 And the term chemical restraint is used when a person
25 is given a drug not for primarily therapeutic purposes, not

Dr. Thomas Edward Schacht
Direct examination by Mr. Schoen

1 to treat a condition, but simply to contain them in the same
2 way that a physical restraint would.

3 Q And in your -- you said 34 years of practice -- have
4 you ever seen chemical restraint used on a
5 three-and-a-half-year-old?

6 A I've seen chemical restrained used. I've never -- I've
7 seen it as the subject of abuse allegations by department of
8 children's services. I've seen it as something that is
9 avoided as much as possible.

10 Parents sometimes do it on their own by buying
11 over-the-counter medicines like Benadryl and sedating their
12 children, for example. But it's -- it's not -- no one is
13 ever going to write in medical note I prescribed him
14 chemical restraint. It's not legitimate.

15 Q What does the fact that Tony was on medicine like
16 Mellaril at the age of 19 months suggest to you?

17 A Well, again, it suggests either a doctor didn't know
18 what he was doing or a doctor was desperate because of --
19 because of the severity of the child's problems. It's --
20 it's just something I've never seen in my career.

21 And I independently did a literature search -- and Mr.
22 Lipman referred to being unable to find anything that would
23 support that. I likewise could not find anything in any
24 professional literature to support the use of antipsychotic
25 medication in a child at that age. There's no treatment

Dr. Thomas Edward Schacht
Direct examination by Mr. Schoen

1 protocol; there's no guidelines. There's nothing.

2 Q Let's talk about this psychiatric hospitalization.

3 When was -- when was the first time that Tony was
4 psychiatrically hospitalized?

5 A Tony was three-and-a-half years old. It was April of
6 1984.

7 He was hospitalized at the Medical University of South
8 Carolina. The location is significant because it was quite
9 a distance from his home, a several-hour drive. And that
10 meant that by being hospitalized there his mother either had
11 to quit her job and stay at the hospital or she had to
12 commute and see him. And what the hospitalization record
13 shows is that he was there alone during the week and she was
14 able to come on the weekends for contact with him and
15 contact with the staff.

16 That in itself creates a very unfortunate situation
17 because -- because with a very young child or even with an
18 older child a critical treatment parameter involves
19 understanding the interactions and relationship between the
20 child and the parent.

21 And, for example, at the facility where I did my
22 postdoctoral fellowship in developmental disabilities what
23 we would do would be to actually hospitalize the parent and
24 the child together. We had an apartment that was part of
25 the facility where we would put them up and they would live.

Dr. Thomas Edward Schacht
Direct examination by Mr. Schoen

1 We had the ability to video monitor what was going on
2 in there. Staff would also spend time in there
3 unobtrusively observing so that we could see what's
4 happening between this parent and child.

5 There was no opportunity to do that in Tony's
6 hospitalization at the Medical University of South Carolina.

7 What the record talks about is instead of the staff
8 observing Tony with his mother on an ongoing basis where
9 they could really get some deep observations, it was more
10 the staff figuring out their own ways to respond to Tony,
11 and then mother got to watch them. And she was instructed
12 to imitate what they were doing.

13 The presenting complaint when Tony was hospitalized was
14 related to anger outbursts that had gotten to the point
15 where he was threatening to kill himself and/or other
16 people. The chief complaint is actually recorded in the
17 record as I'm going to kill myself or you.

18 He also reported in the initial evaluation workup that
19 his mother was mean to him and hit him. And what was
20 striking to me was that there was no followup on that,
21 particularly in light of the fact that he had some physical
22 injuries on his body that were noted on physical exam. He
23 had bruising and was also missing a fingernail. And I
24 thought that it would have been important to follow up on
25 the etiology of those things.

Dr. Thomas Edward Schacht
Direct examination by Mr. Schoen

1 Now, in hindsight with a Prader-Willi diagnosis at
2 least the fingernail has a potential explanation that
3 doesn't involve abuse, and that would be that some
4 individuals with Prader-Willi will bite their fingernails
5 and literally chew them off. So it's possible that he could
6 have done that.

7 The bruise may also have been related to his
8 headbanging, and so I'm not saying that there was abuse.
9 I'm simply saying it wasn't investigated despite his
10 complaint of being hit.

11 There was a history given of -- a history given of
12 emotional discontrol, prolonged crying spells that went on
13 for hours at a time.

14 And what was also notable was that they were for no
15 apparent reason. No one could understand why he was crying.
16 This similar business of for-no-reason also appears in
17 relation to descriptions of anger outbursts where they're
18 described as unprovoked on many occasions. Not always, but
19 on many occasions.

20 The headbanging was reported; ongoing sleep disturbance
21 was reported; and stress intolerance was reported. He would
22 have explosive reactions to trivial stressors, which is the
23 kind of thing that you can see in Prader-Willi as well
24 described in the literature.

25 Q Now, Doctor, one of the things -- were you here when

Dr. Thomas Edward Schacht
Direct examination by Mr. Schoen

1 Dr. Lipman testified --

2 A Yes.

3 Q -- early this morning? But one of the things he had
4 said was that the major effort to treat a patient with a
5 22q11 deletion or Prader-Willi syndrome has to be through
6 psychological treatment and that the appropriate expert is
7 someone who is trained in psychology. Would you agree with
8 that?

9 A I don't think it goes far enough. With a child with a
10 complex developmental disability the treatment -- well, the
11 diagnostic effort and the treatment planning really requires
12 a team effort.

13 I mean, in a sense what we have here in this courtroom
14 has been a team -- myself, Dr. Rary and Dr. Lipman -- that
15 in some sense approximates a part of what you would have had
16 in a multidisciplinary treatment team.

17 In the facility where I did my postdoctoral training in
18 developmental disabilities we would have a developmental
19 pediatrician; we would have a child psychiatrist; we would
20 have a geneticist; we would have speech and language
21 therapy, occupational therapy, physical therapy, psychology,
22 and on and on and on.

23 We've had 10 or 12 disciplines around the table all
24 contributing to the understanding of the child and the
25 treatment plan. So I would agree to the extent that, yes, I

Dr. Thomas Edward Schacht
Direct examination by Mr. Schoen

1 think psychology is important. It's not going to be the
2 whole story.

3 Q With regard to the psychological treatment and
4 treatment in general that Tony received at M.U.S.C., is the
5 treatment that he received consistent with the way that you
6 would want to treat a child if you realize the child had
7 these particular genetic problems -- Prader-Willi and 22q11?

8 A In my opinion what happened at M.U.S.C. was well
9 intended but unfortunate.

10 Very, very challenging patients, whether they're
11 children or adults, produce reactions in clinicians that are
12 not always the best in us.

13 Okay. There are papers written in the literature
14 about -- well, the classic paper called "Hate in the
15 Countertransference".

16 What it refers to is patients who behave in ways that
17 make you hate them. And part of a professional's training
18 and duty in dealing with very challenging patients is to
19 learn to manage all of that, because one of the things that
20 can happen is your whole formulation of a case, your whole
21 way of thinking about a case, can be shaped by hypotheses
22 that in turn are biased because you're angry or frustrated
23 or forming some other kind of judgmental attitude about
24 this.

25 What I saw in the M.U.S.C. record was that from a very

Dr. Thomas Edward Schacht
Direct examination by Mr. Schoen

1 early time in the hospitalization there appeared to be a
2 conclusion, premature conclusion, that Tony's problems at
3 the age of three and a half were simply because he didn't
4 have adequate respect for authority and he had been spoiled.
5 And so the solution was let's crack down on this kid.

6 And there is a place for providing structure and doing
7 that, but there was a whole other side to the situation that
8 was not appreciated. It was evident throughout the
9 record -- only one or two people ever made even passing
10 notes about it -- and that was that Tony was suffering from
11 damaged attachment.

12 Another thing that is as important as self-regulation
13 to development is development of the capacity for secure
14 attachment.

15 A securely attached child is able because of that
16 secure attachment to use a parent as a safe base, go out in
17 the world, explore something, take a risk, but you can come
18 back and be safe and mom's going to be there and take care
19 of you and so forth.

20 In a child who has some kind of damage to attachment --
21 and in Tony's case he had the worst kind of attachment
22 damage, what's called disorganized attachment. The
23 attachment figure is not safe. The attitudes toward the
24 attachment figure are profoundly ambivalent and the child's
25 behavior can seem incomprehensible to outsiders who are

Dr. Thomas Edward Schacht
Direct examination by Mr. Schoen

1 observing it.

2 So, for example, what's documented in the record are
3 occasions when Tony is crying for his mother to come and
4 hold him. And then when she gets near, he hits her.

5 well, this is what a child with disorganized attachment
6 does. He can't balance the need to be connected with the
7 anger feelings he has for mother not having been there in
8 the past. And it all comes out at once. It messes up the
9 parent-child relationship.

10 In terms of treatment what is essential in a situation
11 like that is that the treatment first focus on improving the
12 positive side of the parent-child relationship.

13 So, for example, they did some things with Tony that
14 are kind of standard behavior modification -- put him in a
15 chair and make him sit there, put him in a corner and so
16 forth. But what was missing from all of that intervention
17 was any effort to work on improving the positive side of the
18 parent-child relationship.

19 When I used to do this kind of work and when I learned
20 to do this kind of work what we were taught -- and I think
21 it was absolutely correct and it reflects a profound wisdom
22 about parent-child relationships -- is you don't even teach
23 parents the coercive techniques until they have first
24 demonstrated that they can have positive interactions with
25 their children.

Dr. Thomas Edward Schacht
Direct examination by Mr. Schoen

1 So we would spend weeks and sometimes months teaching
2 parents how to play with their children and how to talk with
3 their children before we ever taught them how to be coercive
4 and controlling with their children, because in the absence
5 of that positive foundation the coercive interventions were
6 simply cruel.

7 Q Doctor, if you could, summarize for us. How -- how did
8 Tony behave during that almost month-long hospitalization at
9 M.U.S.C. when he was three and a half?

10 A Well, here are some descriptions from the record. On
11 the day of his arrival there was a meeting at which it was
12 an initial interview of some kind.

13 The history given by mother at that time was of Tony
14 engaging in a variety of behaviors that suggested impairment
15 and self-regulation -- banging his head, unable to calm
16 himself, reacting explosively to minor stressors, requiring
17 extended physical restraint for up to half an hour at a time
18 at home.

19 He gets to the hospital. He's sitting in a room with
20 his mother and somebody's trying to talk to her. And the
21 description is, quote, "Almost immediately after being in
22 the room Tony threw two chairs to the floor, hit his mother
23 and demanded that she hold him." This is the kind of
24 disorganized attachment. "Mother refused to hold him."

25 Okay. He continued to escalate the behavior, and so

Dr. Thomas Edward Schacht
Direct examination by Mr. Schoen

1 the staff took him from the room and physically restrained
2 him. And that's just upon his arrival at the hospital.

3 Later on in the same day when Tony apparently realized
4 that his mother and grandmother were going to leave him
5 there he escalated again, and there was another episode.

6 Now, I want to point out that the term escalate is one
7 I've taken from the record. And I think the choice of that
8 word is an example of how the staff were already feeling
9 like they're at the end of their rope with this kid, because
10 escalation as a word implies a calculated strategic
11 behavior. And that's not what you're seeing from a
12 three-and-a-half-year-old child.

13 Okay. When this kid's mother was about to leave him,
14 he's desperate. For a three-and-a-half-year-old this is
15 abandonment. This is emotionally catastrophic.

16 Unfortunately, instead of helping him feel safe,
17 assisting him with calming himself, perhaps a staff member
18 taking him, holding him, rocking him, comforting him, what
19 they did was they made him stand in a corner by himself for
20 20 minutes.

21 Now, what happened after that that I thought was
22 particularly striking in light of the Prader-willi component
23 of this was that he lost his appetite. He couldn't eat
24 lunch. Okay. And the level of stress that he must have
25 been under to be in that state strikes me as quite

Dr. Thomas Edward Schacht
Direct examination by Mr. Schoen

1 remarkable.

2 Later on in some other interactions where mother and
3 staff were together mother did some of the things that she
4 had reported doing at home.

5 Some of the things she reported doing at home she never
6 did in the hospital. So, for example, there was a
7 description of at one time locking Tony in a closet as a way
8 of just trying to contain him.

9 There was also a description of -- or a statement that
10 spanking seems to have no effect on him. That may be partly
11 related to the pain and sensitivity. It may be partly
12 related to other things. But it speaks to the
13 out-of-control nature of the behavior and inability to deter
14 it easily.

15 Tony continued to cry for his mother at various times,
16 and the staff's response was to instruct him to suppress
17 that, tell him to stop crying rather than appreciating it
18 as -- as pain on his part.

19 At some point during the hospitalization when Tony and
20 his mother were together and he was misbehaving, refusing to
21 pick up a toy, she threatened him with leaving but then
22 didn't leave.

23 So the staff -- I think they were focused on the idea
24 that it's important to follow through without thinking about
25 what it was they were following through on and trying to

Dr. Thomas Edward Schacht
Direct examination by Mr. Schoen

1 teach mother that if you threaten to leave, you should do
2 that -- you should do that. But you've got a child who has
3 got disorganized detachment here. The last thing you want
4 to do is abandon him and leave him.

5 Q What about eating, Doctor? Was there anything
6 significant about Tony's?

7 A There was a constant battle in the hospital with trying
8 to get him to eat a balanced meal. He simply refused. He
9 focused on the carbohydrates throughout.

10 Q Is that consistent with Prader-Willi?

11 A It's consistent with the food selectivity that can be
12 seen with Prader-Willi, yes.

13 Q What about changes in his behavior or oscillation?

14 A Well, the things that I am describing were not
15 continuous. I mean, no child throws a tantrum that simply
16 continues constantly.

17 So, yes, there -- I mean, Tony would go back and forth
18 between crying for his mother, wanting to be with her,
19 saying I've been bad, I need to be good, this sort of stuff,
20 and then hitting her.

21 Okay. And the fact of the oscillation shouldn't be
22 taken as a sign that Tony has no problem because he can
23 behave differently at some times. What the oscillation
24 actually shows is that there's not reliability because he's
25 not able to rely and to control himself.

Dr. Thomas Edward Schacht
Direct examination by Mr. Schoen

1 Q So the fact that a child with Prader-Willi syndrome can
2 control their behavior for a period of time, that doesn't --
3 that should not be taken then as an indicator that the child
4 has control of their behavior?

5 A Not in the absolute sense. I mean, every -- every --
6 every episode of discontrolled behavior was preceded by
7 something that wasn't discontrolled.

8 Okay. To have -- to have a person who was out of
9 control all of the time, constantly, whose behavior was
10 constantly at the extreme here would be extremely rare,
11 first of all, and would require that an individual be
12 permanently institutionalized.

13 The only place I've ever seen that, for example, is the
14 kind of state institution where children get sent and they
15 never come out.

16 Q If there were a suggestion at trial that because Tony's
17 outbursts were punctuated by periods of calm when he was a
18 nice kid, and therefore he didn't have a -- an organic
19 problem, how would you respond to that?

20 A I'd simply say it's not evidence of the proposition
21 that's being advanced.

22 If you have an individual who's brain damaged and who
23 develops discontrol as a result of the brain damage, that
24 can also be episodic, because behavior's multifactorial.
25 There are going to be multiple things that are going to

Dr. Thomas Edward Schacht
Direct examination by Mr. Schoen

1 converge at any one moment in time to produce a behavioral
2 outcome, and it's just an oversimplification to say, well,
3 because he can behave differently at one time than another
4 he should be able to behave that differently all of the
5 time. It's just not how people work.

6 Q Is there anything else from the records that you want
7 to talk about before we move on to the next point?

8 A This is not working now.

9 (Pause.)

10 A Okay. So just as a summary of, you know, what happened
11 during that hospitalization, it was not an experience that
12 appeared to my reading of the record to bring out the best
13 in the hospital staff.

14 There was a focus on enhancing the coercive aspects of
15 the parenting relationship. No focus on enhancing the
16 positive aspects of it.

17 He was discharged without anything that looked to me
18 like a comprehensive multidisciplinary followup plan and so
19 forth.

20 It did not appear to me that there was appreciation in
21 the record of particular roots of Tony's difficulty in
22 genetic disorders, in trauma, in failures in the
23 parent-child relationship other than the idea that mother
24 lacked a few skills. It wasn't seen as a fundamental
25 problem with attachment. It was just mom needs some

Dr. Thomas Edward Schacht
Direct examination by Mr. Schoen

1 parenting skills and how to sit on this kid better.

2 Q In assessing the effects of the hospitalization can you
3 tell us whether you reviewed any subsequent medical records
4 of treatment for Tony that he received after he came out of
5 that particular institutionalization?

6 A Well, I did. You know, my original charge for Mr.
7 Ehlied was to review up through this point because this was
8 an issue that apparently had not been known about in the
9 prior proceedings.

10 But I was concerned after reading this that the
11 trajectory of his future care may have been important and
12 shaped by what happened here.

13 This hospitalization creates a medical record that then
14 is relied upon by the next people in line. It creates a
15 history that mother learns to tell in conjunction with the
16 caregivers that she repeats in the future. And so it can
17 have a very important shaping effect on what happens next.

18 So at the age of seven when he's back in the hospital
19 again, my understanding from other information is that in
20 the intervening period mother had not been successful with
21 him, that he had to live outside the home in some group
22 settings and some other places.

23 I don't have any records from that. I just understand
24 that from other information. But I do have records from the
25 second hospitalization at the Medical University of South

Dr. Thomas Edward Schacht
Direct examination by Mr. Schoen

1 Carolina. And he's just a little bit after his seventh
2 birthday, and he's hospitalized for 37 days.

3 The chief complaint was of rage episodes, threatening
4 his mother with a knife, being oppositional. And for me a
5 key here was intolerance of separation. This is a child who
6 is still dealing with the attachment problems.

7 Now, by the time we get to Dr. Schwartz-Watz when he's
8 an adult what she describes is Tony telling her that he'd
9 given up on people, that he couldn't connect with anybody,
10 couldn't trust them, they come and they go. Well, he's had
11 a lifetime of people coming and going that started way back
12 here.

13 There was some psychological evaluation that was done
14 that showed an average I.Q. in academic achievements, but
15 emotional intelligence was severely impaired so that he was
16 described as frequently acting upon raw affect and is
17 lacking control over his emotions. And now they give him a
18 diagnosis that reflects this lack of capacity for
19 self-regulation. They called the diagnosis intermittent
20 explosive disorder.

21 Q What is intermittent explosive disorder?

22 A It's simply a way of describing a pattern of rage
23 episodes that can occur with trivial or inadequate
24 provocation and that are out of proportion to provocation
25 that occur intermittently. It's not -- it's not continuous;

Dr. Thomas Edward Schacht
Direct examination by Mr. Schoen

1 it's not the product of ongoing irritability; it's not part
2 of a manic episode and so forth.

3 There can be serious harm to other people or to
4 property in the course of them. And in adults you would
5 also expect to see in order to get this diagnosis that there
6 was significant remorse afterwards. And there are
7 indications of that in Tony's record so that there are
8 places where he's talking about why he's in the hospitals,
9 he was bad, you know, I tried to hit my mama, I have to not
10 do that any more, that sort of thing.

11 Q What about O.D.D.? What's O.D.D.?

12 A O.D.D. is oppositional defiant disorder. That reflects
13 the judgment of the people who are treating him that there
14 was a problem in his relationship with his mother and it
15 revolved around her role as a parental authority figure.

16 Q Are these conditions that we're talking about here --
17 intermittent explosive disorder and oppositional defiance
18 disorder -- are they -- are they causes of behavior? Are
19 they -- are they a disease?

20 A No. They're simply descriptive categories for which
21 causes should be sought.

22 Q So if a kid has Prader-Willi syndrome and is acting out
23 you might call it intermittent explosive disorder.

24 A Well, you're getting into deep philosophical territory
25 here because the question is how far back do you go in the

Dr. Thomas Edward Schacht
Direct examination by Mr. Schoen

1 chain of causes before you say you've reached the final
2 cause.

3 You know, ultimately, what you're looking for when
4 you're searching for causes is something you can change, you
5 know, or something that will make a difference in how you
6 approach a problem.

7 Okay. So in this case what would have been relevant is
8 that if you understood the Prader-Willi syndrome was
9 present. And you understood that temper outbursts and
10 explosive anger and so forth were part of Prader-Willi
11 syndrome, you wouldn't have treated this as a behavioral
12 problem stemming from the parent-child relationship. You
13 might have really zeroed in on what else can we do to
14 contain this.

15 Some of it might have been some of the pharmacological
16 interventions that Dr. Lipman was talking about; some of it
17 might have been environmental interventions that don't
18 require Tony to internalize or change something on his
19 own -- the -- the behavioral equivalent of padlocking the
20 refrigerator.

21 Q Explain that.

22 A Well, in other words, with the eating disorder with
23 Prader-Willi syndrome you can't -- it doesn't matter what
24 you do. You can't get that individual to self-control that.
25 That's why you just padlock the refrigerator. That is an

Dr. Thomas Edward Schacht
Direct examination by Mr. Schoen

1 environmental intervention.

2 Okay. So in a sense what happened in Tony's life is
3 they sort of backed into that environmental intervention at
4 the point where his mother gave up and turned him over to
5 institutions, and he spent his time in controlled
6 environments for, you know, most of his developmental
7 period.

8 Q So just to make sure I understand it. Intermittent
9 explosive disorder is not -- it's not a genetic condition.
10 It's not -- it's not like a virus or bacteria or anything.
11 It's just a description of symptoms or it's a --

12 A It's a description. It's a description of behaviors,
13 yes.

14 Q Okay. All right. Is there anything else regarding
15 Tony's second M.U.S.C. hospitalization that you think is
16 significant?

17 A Well, in the period that follows this -- and there were
18 hospitalizations at Patrick Harris and so forth -- there's
19 some additional descriptions that I think are important
20 because they point to a much longer developmental history
21 for certain things that might be otherwise appreciated.

22 For example, in connection with the anger outbursts
23 that Tony experienced there are multiple references in the
24 clinical record to him being amnesiac for those afterwards,
25 not remembering what happened.

Dr. Thomas Edward Schacht
Direct examination by Mr. Schoen

1 Now, the way you would understand that from a
2 psychological point of view is that the level of emotional
3 arousal or emotional intensity was so great that it produced
4 a disorganizing effect on him.

5 In order to recall or retrieve a memory the memory has
6 to have some anchor. It has to have some hooks. It has to
7 be organized in some way. Otherwise, you can only recall
8 bits and pieces of it.

9 And so it would be indirectly a reasonable hypothesis
10 to consider that the reason he was amnesiac for those things
11 is because he was so aroused and so out of control that he
12 couldn't consolidate the memories of what he had done.

13 There was some discussion during Dr. Lipman's testimony
14 about, you know, whether drugs or alcohol may have played a
15 role in things that happened later on. That's possible.
16 But when he -- during the developmental period that was not
17 an issue and he was still having the amnestic episodes in
18 connection with rage.

19 Q Now, along similar lines there was a -- there was a
20 question that was asked during the cross-examination of Dr.
21 Lipman about the effect of taking Lithium on -- on Tony.

22 Did -- it was suggested that taking Lithium
23 significantly improved his behavior. Did he continue to
24 have outbursts during that period in the early 1990s?

25 A I don't have all of the records, but I don't have any

Dr. Thomas Edward Schacht
Direct examination by Mr. Schoen

1 indication from anything in the record that he ever went
2 into remission.

3 Okay. There were periods that were better; there were
4 periods that were worse. But it was always punctuated by
5 explosive outbursts. They may have changed in frequency or
6 intensity, but they didn't disappear.

7 Q Did taking Lithium enable Tony to avoid being
8 institutionalized --

9 A No.

10 Q -- during that entire period?

11 A No. In fact, the treating clinicians when they were
12 giving their diagnostic summary -- at that time there was a
13 multiaxial diagnostic system. And Axis IV referred to
14 something about those issues. And one psychiatrist wrote
15 that Tony was unable to regulate himself well enough to
16 avoid being institutionalized.

17 Q Let me take you back to that -- that second M.U.S.C.
18 hospitalization. Can you talk a little bit about the
19 methods that were used to control Tony and whether or not
20 those are methods that would be recommended for someone who
21 has Prader-Willi syndrome or 22q11 deletion?

22 A Well, again, it was very similar to the first
23 hospitalization in the sense that the guiding theory of what
24 was wrong with Tony was that he simply couldn't tolerate
25 threats to his autonomy. And the therapeutic approach was

Dr. Thomas Edward Schacht
Direct examination by Mr. Schoen

1 like breaking a wild horse. They were just going to sit on
2 him until he submits. It's just not going to work. It
3 didn't work.

4 Q How did Tony respond to attempts to evaluate him or to
5 treat him?

6 A Well, there -- there was an episode of explosive
7 behavior that occurred during the second hospitalization
8 that I think both illustrates the nature of his
9 explosiveness and also points to the importance of food in
10 the Prader-Willi situation.

11 He was being asked to undergo some psychological
12 testing. Now, for most -- for a normal child psychological
13 testing is not unpleasant. It's a time when you get
14 one-to-one individualized attention from an adult who's
15 totally focused on you who's going to be praising you and
16 doing everything they can to get your best performance out
17 of you and to make you feel good about what's going on.
18 Okay. Most kids enjoy that. They like it.

19 Tony's response the first three times it was attempted
20 was to throw a fit on each occasion that lasted as long as
21 40 minutes and that required as many as three adults to
22 physically hold him on his bed while he, quote, cried,
23 kicked, screamed and cursed at all present.

24 Now, we're talking about three adults holding down a
25 seven-year-old child. To me that says something very

Dr. Thomas Edward Schacht
Direct examination by Mr. Schoen

1 impressive about how out of control this child was.

2 They finally succeeded in getting him to cooperate with
3 the testing. And when he did cooperate it was with flying
4 colors. Not only did he do everything that was asked of
5 him. He persisted past the time limits and really focused
6 and gave them an excellent performance. And the thing that
7 made the difference was ice cream.

8 Q Ice cream.

9 A Ice cream, which for somebody with Prader-Willi is --
10 this is we'll move Heaven and earth for food.

11 Q Is there anything else from that hospitalization you
12 think is of significance before we move?

13 A No, I mean, other -- other than the treatment notes
14 also reflect the continuing problem that I think the staff
15 was having with being frustrated with Tony and succumbing to
16 ways of understanding his behavior that were pejorative.

17 Q Doctor, we've talked. We've talked about Tony's
18 genetics; we've talked about the fetal environment; we've
19 talked some of the effects of those things; we've talked
20 about some of his early childhood.

21 I think the next thing on your -- your developmental
22 factors -- and perhaps I should ask Your Honor.

23 MR. SCHOEN: Do you want me to move to the next
24 session or do you want me to stop at this point?

25 THE COURT: Well, let me see y'all just a minute.

Dr. Thomas Edward Schacht
Direct examination by Mr. Schoen

1 (Bench conference held off the record.)

2 THE COURT: All right. We're going to have to recess
3 for the afternoon.

4 I'll ask the witness to step down from the stand.

5 You can't discuss your testimony with anybody during
6 the overnight recess because you're still on the witness
7 stand.

8 THE WITNESS: Understood.

9 THE COURT: We'll resume in the morning at 9:30.
10 Court is in recess until 9:30 in the morning.

11 END OF PROCEEDINGS April 22, 2014
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Dr. Thomas Edward Schacht
Direct examination by Mr. Schoen

1 (Proceedings April 23, 2014)

2 MR. EHLIES: Good morning.

3 THE COURT: Good morning.

4 MR. EHLIES: We'll resume with direct examination.

5 THE COURT: Okay. Let me ask the witness to come back
6 around, please, sir.

7 Take your seat on the witness stand. You're still
8 under oath, of course.

9 THE WITNESS: Yes, sir.

10 MR. SCHOEN: May it please the Court.

11 THE COURT: Mr. Schoen.

12 BY MR. SCHOEN

13 Q Good morning, Dr. Schacht.

14 A Good morning.

15 Q I have to resume with your direct examination.

16 A Yes.

17 Q When we concluded yesterday you were telling us about
18 the second M.U.S.C. hospitalization. And I think we were
19 almost done with -- with that material.

20 Is there anything else about the second M.U.S.C.
21 hospitalization that you think is relevant that you didn't
22 have a chance to share with us yesterday?

23 A Nothing that wouldn't be redundant.

24 Q Let me real quickly ask you about the significance of
25 these M.U.S.C. records in general.

Dr. Thomas Edward Schacht
Direct examination by Mr. Schoen

1 A Yes.

2 Q Specifically, the -- the records that we talked about
3 yesterday, the three-and-a-half-year-old records.

4 Can you tell us whether those records from a
5 developmental standpoint are critical to understanding the
6 development of Tony Torres?

7 A Yes. Well, I guess it depends on what you mean by
8 critical.

9 In terms of the scope of all of the available
10 information they are a very useful source of information
11 because they represent a 25-day period of a 24-hour-a-day
12 interaction and observation with him in a controlled
13 clinical setting. It's a kind of observation and a level of
14 information that would be very difficult to obtain
15 retrospectively in any way.

16 Q What is the most significant period, if any, for
17 development in terms of age?

18 A Well, it starts at conception. You know, you have to
19 win the -- what's been called the ovarian lottery in terms
20 of getting a good outcome in terms of genetics.

21 And then there are certain functions that only occur
22 during what are called critical periods. So, for example,
23 if the eyes are masked so there's no visual input during
24 certain critical periods in infancy the parts of the brain
25 that are responsible for developing visual capacity will not

Dr. Thomas Edward Schacht
Direct examination by Mr. Schoen

1 properly develop.

2 There's lots of controversy in the developmental
3 literature about when and where critical periods begin and
4 end and whether certain functions are subject to critical
5 periods and so forth. But they're scattered at different
6 points in development.

7 So the question that you asked about are there critical
8 periods or periods that are most important, it depends on
9 which functions you're talking about and so forth.

10 In the case of very early development such as we've
11 been talking about with Tony for the kinds of outcomes that
12 I think this Court would be interested in there are social
13 and emotional components to development that have their
14 origins in early attachment dynamics that are very
15 important. Okay. And those are manifest in caretaker-child
16 relationships and the extent to which those relationships
17 are secure, anxious, avoidant, disorganized and so forth.

18 Then there's also cognitive development which can be
19 blunted by the private environments. I don't see any
20 evidence of that in this case, but there are important
21 developmental periods for that.

22 Many years ago we had a concept on this cultural
23 familial retardation in which the origin of mental
24 retardation was basically environmental deprivation. So
25 there can be -- am I answering your question?

Dr. Thomas Edward Schacht
Direct examination by Mr. Schoen

1 Q Yeah. I think -- I think maybe I should be a little
2 bit more specific.

3 I guess what I'm wondering is if a -- if a doctor or a
4 psychologist was trying to evaluate the ability of Tony
5 Torres the -- the impact of his development on his
6 self-regulation and they didn't have the records from that
7 three-and-a-half-age hospitalization, they didn't have any
8 of the information about his very early childhood, would
9 that compromise their ability to successfully analyze and
10 accurately analyze his development?

11 A It would. Well, as I said earlier, when I saw that he
12 was put on antipsychotic medication at the age of 19 months
13 my first thought was for a problem to be this severe this
14 early really screams the need for genetic evaluation.

15 Okay. So when you -- when you have problems at a very,
16 very early onset when there's not been opportunity for the
17 vastitudes of life to have enough of an impact to create
18 those kinds of things or when the problems are simply
19 disproportionately severe and you start to think about
20 genetics -- so having that early information would have
21 pointed somebody reasonably in that direction.

22 Q Now, I'd like to move on. We've talked about genetics;
23 we've talked about the fetal environment; we're talked about
24 some of the effects of these factors. I want to talk a
25 little bit about the next category that you had on -- on

Dr. Thomas Edward Schacht
Direct examination by Mr. Schoen

1 this -- this PowerPoint --

2 A Sure.

3 Q -- which was physical and psychological trauma.

4 Doctor, what are we looking at here?

5 A What we're looking at here is a graphic that I took
6 from the website of the federal centers for disease control
7 that is part of their description of a very long term
8 ongoing study called the ACE study. ACE is an acronym for
9 Adverse Childhood Experiences.

10 This study's been going on for quite some time. And
11 the purpose of it was to look in a systematic
12 epidemiological way at the impact of a range of adverse
13 childhood experiences on a range of physical and mental
14 health outcomes.

15 The study was organized in the context of a very large
16 health maintenance organization. The research advantage of
17 that is a health maintenance organization takes care of all
18 of the healthcare for a population so they can track
19 everything that happens to the patients in that program
20 through a centralized record.

21 So in this case in collaboration with the C.D.C. a very
22 large number of patients -- I think close to seventeen or
23 eighteen thousand -- were evaluated with respect to the
24 occurrence of adverse childhood experiences. And I'll
25 describe what those -- what those were in a moment. And

Dr. Thomas Edward Schacht
Direct examination by Mr. Schoen

1 then they were simply followed to see what outcomes occurred
2 in their health and mental health records.

3 And over time what has been learned is that there is no
4 safe level of adverse childhood experiences and that the
5 more of them you have the more likely you are to have health
6 or mental health adverse outcomes in your own life.

7 So in this case there's some evidence in Tony's record
8 of things that bear on this category. And it's just another
9 element in the piling on of factors that would have -- be
10 expected to have an adverse developmental effect on him.

11 Some of the kinds of things that have been shown to
12 have an adverse effect are -- I mean, some of the kinds of
13 effects that have been shown to occur are things like
14 ability to relate to other people's quality of interpersonal
15 relationships, the capacity for response to stress, a
16 variety of mental illnesses, depression, vulnerability to
17 drug use, risk for intimate partner violence, liver disease,
18 heart disease, suicide attempts. It's quite a long list.

19 The factors that are looked at in terms of identifying
20 adverse childhood experiences include various forms of
21 abuse -- verbal abuse, physical abuse, sexual abuse,
22 psychological abuse in the form of abandonment, or the
23 difference, neglect, adverse experiences related to the
24 structure of the family such as parental separation or
25 divorce or imprisonment of someone in the family and the

Dr. Thomas Edward Schacht
Direct examination by Mr. Schoen

1 occurrence of domestic violence or mental disorder in a
2 family member.

3 In Mr. Torres' case with respect to those kinds of
4 factors from the records I reviewed there's a history of
5 early paternal terrorizing. Starting with the prenatal
6 beatings of the mother, there's a reference in the record to
7 Antonio being dangled out of an open window.

8 Q By whom?

9 A By his father.

10 There was a reference to Tony having had the breath
11 squeezed out of him. I couldn't tell from the record
12 whether that was the same episode as dangled out the window
13 or whether it was juxtaposed or different.

14 There was a description of a form of psychological
15 terrorizing in which Tony would be on the floor and there
16 would be stomping around his head as if his head was going
17 to be stomped.

18 There's a reference in the record to him having been
19 hit with sufficient force to have a tooth knocked out.

20 Q And, again, make it clear. Who did this? Who squeezed
21 the breath out of him, he was stomped on his head and
22 knocked -- knocked his tooth out?

23 A My understanding is that that was the father.

24 There's a reference in the medical history to him
25 having been head injured at seven months from having fallen

Dr. Thomas Edward Schacht
Direct examination by Mr. Schoen

1 down stairs at age seven months.

2 Even a normally developing child has just begun perhaps
3 to crawl. Some seven-month-olds don't crawl. And I would
4 not understand how a seven-month-old could fall downstairs.
5 He's not walking.

6 So if I were to see a record saying in the court clinic
7 in which I work in which there was a claim that a
8 seven-month-old had fallen down stairs and become head
9 injured, that would immediately trigger for me a referral to
10 the department of children's services for an abuse
11 investigation because of the suspicious nature of the
12 injury.

13 There was a reference in the record to misdirected
14 forms of discipline -- locking Tony in a closet, locking him
15 in the whole house, corporal punishment, hitting him despite
16 acknowledging that it didn't have any effect on him.

17 And then there was also reference in the record to very
18 early substance abuse exposure, him having been given
19 alcohol and having marijuana smoke blown into his face as a
20 child.

21 Q What else of significance do you note in Tony's
22 history?

23 A Well, another thing that also has a bearing on the ACE
24 categories is the mental-illness history in his mother.

25 The records available to me indicated that -- and these

Dr. Thomas Edward Schacht
Direct examination by Mr. Schoen

1 were her own mental health records -- that she came from a
2 family that was itself very dysfunctional.

3 The relevance of that is that somebody growing up in
4 that kind of family does not acquire by model and by example
5 good parenting skills.

6 According to the history that I saw starting at the age
7 of seven, which is exceptionally young, she actually
8 functioned as a -- what's called a parental child where she
9 was a child in the family but functioning as the parent for
10 her siblings because her own mother was incapacitated by her
11 own mental illness.

12 At the age of 15 mother -- who's name is Lisa -- was
13 psychiatrically hospitalized. The admitting diagnosis was
14 borderline schizophrenic reaction complicated by severe
15 depression. And there were also noted to be what were
16 called at the time prominent characterological features
17 including passive aggression and manipulateness.

18 Q What's -- what is borderline schizophrenia or
19 borderline schizophrenic reaction?

20 A Well, it's -- it's an obsolete diagnostic term. It was
21 replaced in the DSM-III in 1980 with the term borderline
22 personality disorder, and because one of the features that
23 can occur in borderline personality are transient psychotic
24 symptoms.

25 It was in the past thought to be something that was

Dr. Thomas Edward Schacht
Direct examination by Mr. Schoen

1 related to schizophrenia but didn't meet all the criteria,
2 so it became called borderline schizophrenia.

3 We now know that the category borderline personality is
4 itself too broad and that there are subgroups so that
5 there's some of those folks who look more schizophrenic,
6 some who look more bipolar and so forth.

7 In the case of mother, some of the symptoms that were
8 described fit both of those subgroups. So, for example,
9 there were schizophrenic type spectrum systems in the form
10 of auditory hallucinations that she reported in the
11 hospitalization, and then there were also mood disorders
12 spectrum symptoms that were reported.

13 There was a description of explosive rage episodes.
14 I'll quote from the record. "The patient stated that she
15 gets in a state of mind where she wants to scream, pull her
16 hair, bash her head against a wall and kill herself. She
17 gets angry toward anyone around her and feels that she blows
18 off towards her mother, her father and her sisters. If she
19 does anything wrong she gets mad at herself. She even gets
20 mad because she was born, she says."

21 Q What is the significance of having a parent who has
22 borderline personality disorder?

23 A Well, as I mentioned in the beginning in my
24 presentation, there's the potential for some genetic
25 transmission of these traits. And then individuals with

Dr. Thomas Edward Schacht
Direct examination by Mr. Schoen

1 this condition as a group show significant deficits in
2 parenting.

3 The classic presentation would be to oscillate in a
4 very unstable way between harsh or hostile forms of
5 parenting and aloofness or indifference, both of which are
6 characterized by an absence of warmth and would play
7 directly into a child's anxiety and ability to form a secure
8 attachment with such parent.

9 Q Let's -- let's go back now that you've talked about
10 these particular factors. And first I should ask you. Is
11 there anything else that -- that you think is of
12 significance with regard to his mother's mental-health
13 history and his own history of abuse?

14 A Well, only that, you know, yesterday I talked about the
15 treatment that was instituted at the Medical University of
16 South Carolina during that first hospitalization that was
17 notable for the absence of any effort to work on the
18 positive side of a parent-child relationship that focused on
19 teaching mother how to be more coercive.

20 It doesn't state this in the record, but another
21 possible way to understand that would be they didn't think
22 mother was capable of learning the other skills.

23 Q Let's back up to the ACE study, and I'd like for you to
24 discuss with us a little bit the potential significance of
25 these factors that you described.

Dr. Thomas Edward Schacht
Direct examination by Mr. Schoen

1 A Sure. Well, in -- in looking at what's available in
2 the record in relation to the issues that were surveyed in
3 the ACE study there were ten areas as I mentioned -- verbal
4 abuse, physical abuse, sexual abuse, abandonment,
5 indifference, neglect and so forth.

6 out of the ten I could find evidence to support eight
7 being applicable to Tony. The two that I didn't find any
8 evidence for were sexual abuse, and I didn't find any
9 evidence that a household member had gone to prison. But
10 the other eight had some evidence in the record to suggest
11 that they were applicable to Tony.

12 so that's a -- that's a pretty heavy burden of what is
13 collectively called early childhood adversity. And it just
14 adds to the adverse developmental factors that are operating
15 in this case.

16 Q Just to be clear the -- was there any effort in that
17 ACE study? They picked people who've already got genetic
18 disorders --

19 A No.

20 Q -- and then seeing those effects, or are these just
21 normal --

22 A This is -- this is a random sample of patients. Based
23 on the number that was selected it wouldn't be surprising if
24 there was not a single person in it with the kind of genetic
25 problems that Tony has, because the rarity of Prader-Willi

Dr. Thomas Edward Schacht
Direct examination by Mr. Schoen

1 syndrome is such that you could pick 17,000 people and not
2 get one.

3 Q So all of this is simply more on top of the genetics
4 and the fetal environment.

5 A Correct.

6 Q I want to talk a little bit about -- now that we've
7 discussed these various factors that may have affected
8 Tony's development, I want to talk a little bit about what
9 you might see in the way of a prognosis.

10 You know, you've got someone with Tony's particular
11 situation. You've looked at the records, or it appears.
12 We've talked about him through age seven.

13 What do you expect? What would be your providences for
14 someone given the developmental history you've got of Tony
15 up until age seven at this point?

16 A Prognosis made at what point in time?

17 Q If you were looking if someone --

18 A If you were looking him -- looking at him at three and
19 a half or looking at him at 15 or at 10?

20 Q If you're looking him at the age of seven --

21 A Age seven.

22 Q -- and you've got all of the information that you've
23 got about his fetal environment --

24 A Right.

25 Q -- about his history of trauma, about the genetics,

Dr. Thomas Edward Schacht
Direct examination by Mr. Schoen

1 what would you -- what would you be able to -- what would
2 your prognosis be for the future of his development?

3 A well, by that point he had a chronic history of very
4 poorly controlled behavior.

5 He was sufficiently dangerous to himself and to others
6 to warrant inpatient psychiatric hospitalization. There had
7 not been any effective treatments identified up to that
8 point. And all of this was occurring during an early
9 developmental period which is very important for organizing
10 a person, for shaping their future.

11 So I would see this as having a grave prognosis and as
12 warranting very intensive evaluation to try to get to the
13 bottom of what's going on and also all of the intervention
14 that could be thrown at him.

15 Q Can you tell us whether you saw anything in Tony's
16 subsequent records to the extent you reviewed subsequent
17 records that suggested that that is exactly what happened
18 with him?

19 A I can't tell. The records that I have were from acute
20 care. You're not going to -- this is not a problem you're
21 going to fix in acute care. Acute care was used as crisis
22 management.

23 The ongoing treatment would have been in residential
24 settings and so forth. I only know what happened there by
25 reference to other things. I don't have enough of a basis

Dr. Thomas Edward Schacht
Direct examination by Mr. Schoen

1 to have an opinion about it.

2 I can tell you that in general a residential setting,
3 you know, operates in multiple ways. It can provide a
4 milieu which can provide some structure. Depending on the
5 need of the setting that can be good or bad. And then it
6 can provide a variety of therapeutic interventions. I don't
7 know anything about what happened there.

8 Q Let me -- let me put you up a few scenarios.

9 A Okay.

10 Q Let you comment on them. And discuss for us whether --
11 whether the behavior is consistent with what you would --
12 what you'd expect given the developmental history.

13 I want you to imagine that Tony is with his aunt and is
14 told that he is not able to go to the mall and that he
15 proceeds to destroy her mailbox and break all of the windows
16 in the front of her house.

17 Is that consistent with a type of impaired
18 self-regulation that you would expect given his
19 developmental history?

20 A I did read a description of something like that in the
21 record, yes. It was just more of the same.

22 I mean, there were other descriptions like that. There
23 was a -- an occasion when at the mental health center for
24 minimal provocation or no provocation he destroyed a
25 therapist's office and the police had to be called.

Dr. Thomas Edward Schacht
Direct examination by Mr. Schoen

1 So, yeah, those kinds of things punctuate the record.
2 That's not about his treatment. That's about his behavior.

3 Q Would it be consistent with his -- with what you
4 described in his development if he early beat his mother and
5 broke all of the windows out of the back of her car with a
6 brick?

7 A Yes.

8 Q Would it be consistent if he continued to need to be
9 hospitalized and institutionalized throughout his later
10 childhood?

11 A Yes.

12 Q What -- I'd like to talk a little bit about the next
13 slide.

14 MR. SCHOEN: Move to the next slide.

15 Q You've talked about the developmental antecedents of a
16 number of different factors. Can you explain to us how
17 Tony's development services antecedents for these various
18 factors?

19 A Well, I understood that this proceeding was related to
20 the issue of mitigation, and so part of my thinking about
21 what I was learning is how would it bear if I were
22 presenting a mitigation testimony.

23 And the first four issues up there are from the South
24 Carolina statutory mitigators. Three of them -- mental or
25 emotional disturbance, impaired capacity to conform conduct

Dr. Thomas Edward Schacht
Direct examination by Mr. Schoen

1 to the requirements of the law, and impaired mentality -- I
2 understand from documents I've seen were offered at Tony's
3 trial.

4 I think this record would set a developmental stage for
5 considering two others up there. One is impaired capacity
6 to appreciate the criminality of his conduct and the other
7 is there are significant functional equivalencies between
8 Prader-Willi syndrome and mental retardation that can be
9 demonstrated by empirical research.

10 Q Let's talk a little bit about those functional
11 equivalencies.

12 Now, can you describe for us what a phenotype is?

13 A Phenotype is distinguished from a genotype.

14 Genotype is what a geneticist measures when they do a
15 biochemical analysis of the actual genetic material. It's
16 what the chromosomes say. It's what the genes say.

17 The phenotype is what you see expressed in the
18 organism.

19 Okay. There can be a difference between the two, okay,
20 because genes may be expressed incompletely or they may be
21 expressed on and off in various ways and so forth so that
22 there's a distinction between those two concepts.

23 Q Does it make sense to refer to the phenotype of a
24 particular condition if we talk about the phenotype of
25 Prader-Willi syndrome?

Dr. Thomas Edward Schacht
Direct examination by Mr. Schoen

1 A Sure. What -- what I was talking about earlier in my
2 testimony with respect to the typical behavioral
3 manifestations, all of those things together comprise what's
4 called the behavioral phenotype of Prader-Willi.

5 Q I'd like to ask you some questions about that
6 behavioral phenotype.

7 Is it -- well, first of all, can you tell us whether
8 you are familiar with I guess -- would -- would you agree
9 that Tony Torres fits the behavior, phenotype, for
10 Prader-Willi?

11 A Yes.

12 Q Is it consistent with the behavioral phenotype for
13 Prader-Willi to act on impulse?

14 A Impulsivity is characteristic of a significantly large
15 number of individuals with Prader-Willi, yes.

16 Q Is it consistent with the behavioral phenotype for
17 Prader-Willi to have a diminished ability to understand and
18 process information?

19 A As I described yesterday, particularly social
20 information.

21 Q How does Prader-Willi syndrome affect one's ability or
22 the typical person's ability to learn from experience?

23 A Well, it's going to vary depending on what the nature
24 of the experience is.

25 In -- in Tony's case one of the things that was

Dr. Thomas Edward Schacht
Direct examination by Mr. Schoen

1 striking to me were the repeated descriptions of amnesia for
2 rage episodes. I find it difficult to imagine how a person
3 can learn from an experience they can't remember.

4 Q By the same --

5 A Now -- now, to -- to illustrate in a slightly different
6 way, if -- if the issue were remembering where food is
7 located, I think he would do fine.

8 Q By the same token, does that diminished ability to
9 remember -- is that likely to have -- to affect his ability
10 to meaningfully assist counsel?

11 A I don't have an opinion about that.

12 Q What about his ability to describe his own condition or
13 to serve as a historian for his own life and accurately
14 assess his condition?

15 A The clinical record as far as I was able to review it
16 repeatedly indicated that Tony had very poor insight,
17 that -- and that's another way of saying he's not likely to
18 be an accurate describer of his own state of mind and
19 perhaps his own history.

20 Q How does the phenotype of Prader-Willi, the typical
21 Prader-Willi -- does that impair an individual's ability to
22 empathize with other people?

23 A Interpersonal and social deficits are clearly present.
24 There are deficits in social competence. Again, looking at
25 Prader-Willi individuals as a group, yes. So the answer is

Dr. Thomas Edward Schacht
Direct examination by Mr. Schoen

1 yes.

2 Q And would that -- would those social difficulties -- is
3 it consistent or likely that they would have the ability to
4 create the unwarranted impression that a person was not
5 remorseful for what they had done?

6 A I don't have an answer to that. It is possible. I
7 don't know.

8 Q Would Prader-Willi -- is that the phenotype -- does
9 that result in a diminished capacity in logical reason?

10 A The emotional explosiveness interferes with logical
11 reasoning so that, you know, as was described in the
12 psychological evaluations, Tony acts on raw affect. It
13 doesn't get processed through the rational capacities,
14 through a reflective process the way it would in a normal
15 individual.

16 So it's not so much that he can't reason. It's that
17 his capacity for reasoning gets short circuited by overly
18 intensive emotion on an episodic basis.

19 Q Was the presence of the 22q11 -- does that have any
20 impact on any of the factors that I've just talked about?

21 A If it has an impact it would be additive. Simply as I
22 mentioned earlier, that the areas in which there are
23 psychiatric difficulties overlap substantially with
24 what's -- what the literature describes for Prader-Willi as
25 well.

Dr. Thomas Edward Schacht
Direct examination by Mr. Schoen

1 Q Doctor, because you've testified that Prader-Willi is
2 a -- a -- is a rare condition, I'd like to ask you to
3 compare the behavioral symptoms associated with Prader-Willi
4 to other conditions that might be more familiar to the Court
5 or to a jury, namely Down syndrome and forms of -- I think
6 what you said the DSM is now calling intellectual disability
7 or mental retardation --

8 A Right. Okay. So the figures you see here are from a
9 1997 study done by Dickens and Caesary. They collected a
10 sample of individuals in each of these categories. They
11 found the Prader-Willi individuals through self-help
12 associations. Families who have individuals with rare
13 conditions sometimes form associations for purposes of
14 mutual assistance and support, knowledge-sharing and so
15 forth.

16 So you can go to a large state that has good services
17 and find a Prader-Willi association. So they did this in
18 Connecticut and in California, and they compared individuals
19 with Prader-Willi syndrome, Down syndrome, which is another
20 genetic condition that is often associated with mental
21 retardation, and then individuals with mental retardation
22 that was nonspecific, meaning it hadn't been genetically
23 characterized.

24 Half of the Prader-Willi group had an I.Q. that was
25 above the mentally retarded range. This is the incidence of

Dr. Thomas Edward Schacht
Direct examination by Mr. Schoen

1 clinically significant childhood behavior problems
2 identified in the research. And what was found was that the
3 Prader-Willi group was far and way more problematic in terms
4 of behavior than either the Down syndrome group or the
5 nonspecific mental retardation group.

6 You can use behavior problems in a child as a proxy
7 for -- for the inference that the problems are due to some
8 impairment of self-regulation, so that they could have
9 easily said significantly -- clinically significant
10 impairments and self-regulation and the numbers would have
11 been the same because behavior is the way you would measure
12 that impairment in self-regulation.

13 Q When you say behavior, can you give us some specific --

14 A Sure.

15 Q -- behaviors of the kind of things that we're talking
16 about?

17 A Sure. These are -- the next slide shows some details
18 from that study in specific kinds of behaviors -- skin
19 picking, arguing, stubbornness, tantrums, disobeying, mood
20 changes, excessive talking, excessive sleeping, impulsivity,
21 being teased by peers.

22 Now, you might think that's not a problem behavior, but
23 it's actually a marker of problem behavior because it --
24 in -- in children this is a sign that the young person has
25 been behaving in a way that has resulted in their being a

Dr. Thomas Edward Schacht
Direct examination by Mr. Schoen

1 social outcast.

2 Not being liked by kids is kind of similar to that.
3 Engaging in compulsions, lying, cheating and stealing. You
4 know, if you look at the last one -- stealing --
5 Prader-Willi is way ahead of the other groups, for example.

6 Q Doctor, is that the only study that's documented in
7 these particular --

8 A No. There's another study by independent
9 investigators, Einfeld, et al, in 1999.

10 And if you would go to the next graph I'll show what
11 their results were.

12 They compared Prader-Willi syndrome, Down syndrome,
13 Williams syndrome and Fragile X. These are all different
14 kinds of genetic syndromes.

15 Q Can you briefly just tell us a little bit about those
16 other syndromes so we will have a --

17 A Well, they're all associated with some form of mental
18 retardation.

19 Q Let's go to the next slide.

20 A I hope you can see this clearly enough. It's the best
21 scan that I could get.

22 The -- the higher up you go in the graphic the more
23 behavior problems and emotional problems were present.

24 This was a longitudinal study that followed children
25 over a 4-year period. And what you see is that the

Dr. Thomas Edward Schacht
Direct examination by Mr. Schoen

1 Prader-Willi group is certainly not less than the other
2 mentally retarded groups. And in the beginning they're
3 second to the highest, and at the end they're the highest.

4 The -- being the highest at the end there is consistent
5 with other research which has shown that behavior problems
6 in Prader-Willi syndrome do not get better with age.

7 In fact, there's a burst of increase in behavior
8 problems that begins in adolescence and continues into young
9 adulthood. And so this is just another demonstration
10 comparing Prader-Willi syndrome to other mental retardation
11 syndromes in terms of behavior problems.

12 Q So if a child has Prader-Willi and they're acting out,
13 unlike normal children or unlike children would be in other
14 disabilities, would it fair to say that if you're not going
15 to -- you can't expect that they're going to -- that the
16 behavior is going to improve with time?

17 A Based on this kind of research the most reasonable
18 clinical assumption would be to plan for organizing a kid's
19 environment to mitigate the damage that's going to occur.

20 You would also want to do anything you can to help
21 prevent behavior problems from occurring. But this could be
22 a treatment plan that's focused on damage control as opposed
23 to we're going to turn this kid into a model citizen who's
24 going to be self-controlled.

25 Q What else can you tell us about people who suffer from

Dr. Thomas Edward Schacht
Direct examination by Mr. Schoen

1 Prader-Willi syndrome?

2 A Well, another area that -- where we have research
3 showing comparisons to other syndromes is in the area of
4 social competence.

5 There's research showing in Prader-Willi syndrome
6 deficits in the ability to accurately recognize emotional
7 expression in human faces.

8 As I mentioned earlier in my testimony while I was
9 talking about the concept of theory in mind that's also
10 relevant to autism, there have been similarities shown in
11 that capacity to autism.

12 And then research in Rosner in 2004 did a specific
13 comparison of social competencies between Prader-Willi
14 syndrome, Down syndrome and Williams syndrome using the
15 Achenbach Child Behavior checklist which is a
16 well-validated, widely-used, standardized instrument for
17 measuring this sort of thing.

18 And the Down syndrome group was superior to the
19 Prader-Willi group and to the Williams group on overall
20 social competence. There were no differences in overall
21 activity competence. Activity refers to ability to engage
22 successfully in activities in the community that would be
23 age appropriate.

24 And then competence was positively correlated with
25 increasing age in the Down and Williams groups but not in

Dr. Thomas Edward Schacht
Direct examination by Mr. Schoen

1 Prader-Willi. In other words, Prader-Willi group did not
2 get better with age.

3 Q I think you may have mentioned this yesterday, but if
4 not I want to make sure that I ask you about it.

5 There -- you indicated that there's a range of I.Q.s
6 for Prader-Willi syndrome, that there's a range between
7 normal and -- and significant -- significantly impaired.

8 A Right.

9 Q Does having a normal I.Q. if you are -- if you have
10 Prader-Willi syndrome, does that protect you from your
11 behavioral or social challenges that come with having that
12 particular condition?

13 A According to the research, it does not.

14 So, for example, in Rosner's study here with the social
15 competence there was a finding that there were no effects
16 for gender or I.Q.

17 And the finding of no effects for gender is also
18 interesting because in general boys have more behavior
19 problems than girls do. And so the -- the effects of the
20 genetic syndrome appeared to wipe out the gender
21 differences. Of course there are also -- it's hard to find
22 females with Prader-Willi, which is another -- another
23 issue.

24 There was a similar finding to Rosner's in another
25 study that I don't have a slide for by Dimitropoulos, again,

Dr. Thomas Edward Schacht
Direct examination by Mr. Schoen

1 looking at social competence and finding no relationship to
2 age or I.Q.

3 Q Doctor, you -- you finished school 34 years ago and
4 have been working as a clinical and forensic psychologist
5 since that time.

6 Have you ever seen a case with as many factors
7 contributing to the impairment of self-regulation as with
8 Mr. Torres?

9 A No, not in a -- in a forensic context. The -- the only
10 place I've ever seen people like that would be individuals
11 who are totally institutionalized.

12 MR. SCHOEN: Beg the Court's indulgence for just one
13 moment.

14 (Pause.)

15 Q Thank you, Doctor. I have no further questions for
16 you. Please answer any questions the state may have.

17 CROSS-EXAMINATION

18 BY MR. ZELENKA

19 Q Dr. Schacht, let me go right to the last question.

20 How many other cases have you dealt with Prader-Willi?

21 A I've seen a hand full, all of them actually during my
22 fellowship. I've not seen a single one since then. It's an
23 extremely rare condition.

24 Q Okay. Prader-Willi basically one in 25,000 of the
25 population?

Dr. Thomas Edward Schacht
Cross-examination by Mr. Zelenka

1 A I've seen epidemiological estimates going as high as
2 one in 52,000. When -- when you have a very rare condition
3 the numbers can swing because of a chance, you know, one
4 person in a single sample can change. But, yeah, basically
5 very rare. Hundreds to maybe as much as a thousand times as
6 rare as garden-variety mental retardation.

7 Q Okay. And these days Prader-Willi is usually
8 determined through the use of a methylation specific test,
9 right?

10 A I would defer questions about the genetics to the
11 genetics experts.

12 Q I understand that. But that's usually the way it's
13 determined. You're an expert in developmental disabilities.
14 You would look at those studies, wouldn't you?

15 A When you say usually, it's usually the way it's
16 determined. Are you talking about for research purposes or
17 for clinical purposes?

18 Q Either.

19 A I can't answer that question. Again, I would defer to
20 genetics experts.

21 Q When you have a test that suggests the individual
22 doesn't meet like Applicant's Exhibit 16, the testing
23 criteria for Prader-Willi when the LabCorp test was done and
24 it shows it's negative -- I want to show you Applicant's
25 Exhibit 16 so you know what we're talking about.

Dr. Thomas Edward Schacht
Cross-examination by Mr. Zelenka

1 A Okay.

2 Q Okay. That test showed that that run -- that
3 methylation specific test that's generally used to determine
4 Prader-Willi has been found to be 97 to 99 percent accurate
5 on whether it exists or doesn't -- that study showed it was
6 negative, didn't it?

7 A My understanding -- and now what I'm basically doing is
8 reciting from my recollection of Dr. Rary's testimony,
9 because, again, I said I'm deferring to the genetics expert
10 here -- is that there are multiple pathways to Prader-Willi
11 and that genetic testing can help sort out what kind of
12 Prader-Willi an individual has, but the diagnosis is
13 fundamentally clinically.

14 Q But that test is a gold standard that is used in
15 developmental disabilities to determine the existence of
16 Prader-Willi, isn't that correct?

17 A I would say it's a gold standard that's used to
18 determine whether or not that particular pathway to
19 Prader-Willi is there.

20 Q Okay.

21 A That test, for example, doesn't do a physical
22 examination and doesn't do the other things that were part
23 of Dr. Rary's examination.

24 Q Which was done before that testing was developed to
25 determine the existence of Prader-Willi, correct?

Dr. Thomas Edward Schacht
Cross-examination by Mr. Zelenka

1 A I'm sorry? Say that again.

2 Q The use of the physical examinations was done before
3 that type of test was utilized to determine the existence of
4 Prader-Willi, correct?

5 A Yes, right.

6 Q Okay.

7 A Prader-Willi was originally characterized on the basis
8 of physical examination.

9 Q And let me ask this question. Have you reviewed any
10 literature that discusses the combination, specific
11 combination, of Prader-Willi and 22q11 deletion syndrome?

12 A If I have, I don't recall it.

13 Q Okay. So when you talk about the relation between
14 22q11 and Prader-Willi syndrome, is that just speculation on
15 your part?

16 A No. It's based on a general principle that impairments
17 would tend to be additive in their effects. In other words,
18 there's -- I'm -- I'm unaware of anything that would suggest
19 that the 22q11 deletion would somehow compensate for a
20 problem with Prader-Willi and make the Prader-Willi better,
21 or vice versa.

22 Q Okay. Are you aware of anyone else that has in your
23 study, in your experience, 22-q11 and Prader-Willi syndrome?

24 A No.

25 Q Okay. So this would be the first one.

Dr. Thomas Edward Schacht
Cross-examination by Mr. Zelenka

1 A May well be. I can tell you that when I was a -- doing
2 the developmental disabilities fellowship the geneticists
3 who we worked with there had more publications than anybody
4 unless in the facility because they were constantly finding
5 things that were unique and had never been reported before.

6 Q Okay. Let me go to the -- to the DiGeorge study. If I
7 recall Dr. Rary's testimony correctly the deletions that he
8 found in the 22q11 with the test he had done was not a very
9 severe amount of deletions, correct?

10 A I would defer to whatever -- whatever the record says
11 that he said.

12 Q Okay. When he said that they were roughly around
13 90,000 deletions noted --

14 A Uh-huh.

15 Q -- in the chromosome 22 -- 22q11, the report that he
16 was relying on, correct?

17 A Yes.

18 Q So but the average with 22q11 for the deletions is
19 about 3 million, isn't that also correct?

20 A I don't know that.

21 Q So that's a fairly significant difference for what --
22 the average person who has 22q11 deletion and this
23 defendant, is that not also correct?

24 A I can't answer that because the issue here is not
25 counting. It's function.

Dr. Thomas Edward Schacht
Cross-examination by Mr. Zelenka

1 Q Okay. Well, let me ask this then.

2 How does the severity of the 22q11 deletion play in
3 your assessment of the symptoms, the effect that that has on
4 an individual if at all?

5 A I'm not sure I understand the question.

6 Q Okay. If an individual has 3 million deletions --

7 A Okay. I --

8 Q -- in 22 chromosome, does that impact that individual
9 different than one who has one deletion in that chromosome,
10 or 90,000?

11 A I'm not aware of any literature that is able to parse
12 that question the way you've asked it.

13 Q Okay. So the literature that you're reviewing then
14 would take the average -- would be 3 million deletions,
15 correct?

16 MR. SCHOEN: Objection, Your Honor, to the extent that
17 that's being offered into evidence. There's a lack of
18 foundation for it as to how Mr. Zelenka knows that or as to
19 how this witness would have known it.

20 THE COURT: All right. Lay some foundation for it.

21 Q Have you reviewed the literature about the amount of
22 deletions in a 22q11 --

23 A I -- I looked -- I looked at literature related to
24 22q11. I wasn't specifically focused on the details of the
25 deletion because I'm not a geneticists.

Dr. Thomas Edward Schacht
Cross-examination by Mr. Zelenka

1 Q Okay.

2 A I was focused on the behavior correlates.

3 Q So, I mean --

4 A I would have to have the paper in front me to see
5 whether that --

6 Q Okay. So when Dr. Rary said it's up to you to make the
7 determinations of the behavior --

8 A Correct.

9 Q -- your assumptions on the behavior is based upon the
10 average person with 22q11, is that correct?

11 A That's -- that's the best that anyone can do.

12 Q Okay.

13 A Well, if -- if you're talking about assumptions, if
14 you're talking about generalizing from literature, the best
15 you can do is whatever the literature says.

16 If you're talking about looking at the actual facts of
17 Mr. Torres' life, there are other records for those.

18 Q Okay. But, again, this is the first person that you're
19 aware of who's ever had that combination in your practice of
20 Prader-Willi and 22q11.

21 A I've never seen -- I've never seen it before.

22 Q Now, you asserted that M.U.S.C. when they're evaluating
23 him for treatment did not use a multidisciplinary team
24 approach, is that correct?

25 A They -- they did not use a multidisciplinary

Dr. Thomas Edward Schacht
Cross-examination by Mr. Zelenka

1 developmental team approach, that's right.

2 Q Okay. And/but they had a series of doctors,
3 psychologists view him and review him while he was in -- I
4 don't want to say in their custody -- but within their care,
5 correct?

6 A Yes.

7 Q So how was that different than a multidisciplinary
8 approach?

9 A First of all, in -- in a developmental center there
10 would be more disciplines.

11 Secondly, the work of the group would have been
12 coordinated and integrated in an ongoing way.

13 what you see in acute care hospitalization like
14 M.U.S.C. is kid comes in, doctor says, hum, he's fat, let's
15 get pediatrician or endocrinologist or somebody to come in
16 and look at him.

17 That person comes in and does their thing and writes a
18 note and is gone. They're not part of an integrated team
19 which continually generates and tests hypotheses about
20 what's going on with the child.

21 Q Okay. When you reviewed the records from the M.U.S.C.
22 hospitalization in 1994 did you see any references, any
23 concerns, about this -- this defendant's genetic background?

24 A You're talking about the Klinefelter's reference?

25 Q No, I'm not. I'm talking about any reference that you

Dr. Thomas Edward Schacht
Cross-examination by Mr. Zelenka

1 saw in the 1984 records to concern, or issues related to,
2 any genetic matter concerning this defendant's background.

3 A Yes. There was -- there was an evaluation by a
4 pediatric endocrinologist.

5 Q In 1984.

6 A '84.

7 Q And what was the result of that evaluation in 1984?

8 A Well, first of all, I believe the evaluation was done
9 by a resident, a trainee, because of the note for a counter
10 signature.

11 The result of that evaluation was a determination
12 that -- an opinion that Tony had exogenous obesity and that
13 they didn't think that he had a genetic problem.

14 Q Okay. And -- and what genetic problem did they
15 specifically think he did not have, do you recall?

16 A There were -- there were a couple. There was one
17 that's got three names, something evil, something or other,
18 and there was also Prader-Willi.

19 Q Okay. And so they did look at and rule out
20 Prader-Willi on April the 11th of 1984, is that correct?

21 A It was considered in the context of a -- an evaluation
22 for obesity. It was not done by a medical geneticist. It
23 was done by what I believe was a trainee in endocrinology
24 and that's what -- that's what was concluded at that time.

25 Q Okay.

Dr. Thomas Edward Schacht
Cross-examination by Mr. Zelenka

1 A What I take from that was that the presentation was
2 sufficiently suspicious for this. But somebody actually
3 asked the question. I'm not convinced that -- that that
4 answer without a geneticist's involvement is one that I
5 would have trusted.

6 Q Okay. So they looked at the possibility in 1984 of
7 Prader-Willi, correct?

8 A It's referenced in a note. It's something that the
9 person thought was not likely at that time.

10 Q Okay. And then more recently there was a methylation
11 specific test that determined that he did not have the
12 Prader-Willi issue, correct?

13 A No. Again, relying on Dr. Rary's testimony, what I
14 understood him to say was that that particular pathway to
15 Prader-Willi was not demonstrated.

16 Q Okay. And, you know, the records of the hospital
17 reflect that they did physical examinations of this
18 defendant also, correct?

19 A Yes.

20 Q Throughout, correct, each of those hospitalizations?

21 A To varying degrees.

22 Q To varying degrees. What does that mean?

23 A Well, for example, the specific dysmorphology
24 examination that Dr. Rary did was not duplicated anywhere in
25 any record that I saw.

Dr. Thomas Edward Schacht
Cross-examination by Mr. Zelenka

1 There were elements of things that were noted but not a
2 full dysmorphology exam. It's very common in psychiatric
3 facilities not to do a genital examination at all. So that
4 was deferred. There were also problems with Tony
5 cooperating, didn't want people to touch him so that --

6 Q But that -- please finish.

7 A Excuse me?

8 Q I didn't want to interrupt you.

9 A Oh, I'm sorry. So -- so there were -- there were some
10 examinations; there were some efforts at examination. There
11 was nothing that I saw that was of the scope and focus of
12 what Dr. Rary did.

13 Q Okay. But there were references in the record, some
14 that he had normal genitalia, correct?

15 A Yes.

16 Q Consistent with his age, correct?

17 A That's -- that's what was said in 1984.

18 Q Okay. And there were later -- '87 -- and at Patrick
19 Harris there was a review of his physical characteristics
20 there too, is that not also correct?

21 A Yes.

22 Q And did they suggest that there was a problem with his
23 genitalia --

24 A There was --

25 Q -- during their review?

Dr. Thomas Edward Schacht
Cross-examination by Mr. Zelenka

1 A There was -- there was a reference to concern about
2 whether a testicle was descended, I believe. There was a
3 question about Klinefelter syndrome. There was a
4 recommendation for a referral for chromosome studies. And
5 then the issue was lost to follow up as far as the record
6 that was available to me.

7 Q Okay. And that was in -- the Klinefelter issue was in
8 1994, correct?

9 A He was a young teenager. That sounds about right.

10 Q And did you discern from those records the reason that
11 Klinefelters was considered and then rejected?

12 A I don't remember.

13 Q Okay. Now, the evidence in this record is pretty clear
14 that the defendant throughout his adolescence and while a
15 toddler had tantrums, correct?

16 A Yes.

17 Q Violence against others, correct?

18 A Yes.

19 Q And general aggression when he chose to do so, correct?

20 A I'm not going to endorse the way-he-chose-to-do-so part
21 of what you're saying because the record can be easily read
22 to understand that he was out of control. That's the
23 description that was used.

24 Q Okay.

25 A There -- there were people who in relation to certain

Dr. Thomas Edward Schacht
Cross-examination by Mr. Zelenka

1 individual episodes offered opinions that they believed Tony
2 was in control, but the overall patten of this was being out
3 of control, particularly notable through the amnestic
4 episodes.

5 Q Okay. But there's also evidence that he could control
6 himself, correct?

7 A Define what you mean by control.

8 Q He's controlling himself now, correct?

9 A Well, I see him shackled and handcuffed.

10 Q He's not speaking out; he's understanding what's
11 expected of him in the courtroom, correct?

12 A I don't know what's in his mind.

13 Q Okay. And when you reviewed his social history he
14 wasn't constantly acting out in this nature that he had to
15 be permanently institutionalized, correct?

16 A He was, in fact, institutionalized for most of his
17 development.

18 It's not necessary that a person be, quote, constantly
19 acting out. In fact, you would not expect constant to be a
20 characteristic of human behavior in that regard. These --
21 these were episodic things.

22 Q Episodic.

23 A Episodic.

24 Q Okay. Which means it's not constantly happening.

25 A By definition, yes.

Dr. Thomas Edward Schacht
Cross-examination by Mr. Zelenka

1 Q Okay. Now, there was questions about the defendant's
2 I.Q. and the affect that has or whether it has any affect on
3 his ability to self-regulate. This defendant's I.Q. was
4 tested out as being a normal I.Q. Is that not true?

5 A Yes.

6 Q In fact, the I.Q. was 101 at one point, correct?

7 A In that range.

8 Q And 90 in another test that I believe was done,
9 correct?

10 A Yes.

11 Q Full scale I.Q.

12 A Yes.

13 Q And standard error of measurement, plus or minus five,
14 the way that's generally tested, correct?

15 A Depends on which test is used. Standard error of
16 measurement will vary from test to test but could be that
17 much.

18 Q Okay. And among the individuals with Prader-Willi
19 syndrome -- you've read the literature that five percent of
20 those with Prader-Willi have I.Q.s above 85, haven't you, or
21 similar statistics?

22 A Yes.

23 Q Okay. But the norm of those with Prader-Willi are in
24 the borderline mental retarded range though, is that not
25 also correct?

Dr. Thomas Edward Schacht
Cross-examination by Mr. Zelenka

1 A well, which are you saying, borderline or mentally
2 retarded? Those are two different ranges.

3 Q You define it.

4 A There's a spectrum of I.Q. in Prader-Willi, and it can
5 range from severe mental retardation up to low-average or
6 even average I.Q.

7 Most of them are going to be in a range that is
8 hovering right around the border between mental retardation
9 and nonmental retardation as that term is conventionally
10 defined.

11 So, for example, in the Dickens and Caesary study that
12 I've put up there half of their sample had an I.Q. above 69.
13 In other words, it was outside of the mentally retarded
14 range. The other half were below. So that was a median.

15 Q Okay. So the median is mentally retarded.

16 A No. Median is --

17 Q I thought you just said that.

18 A The median is right at -- median is right at the border
19 in that sample. Okay.

20 Q Okay. Just so I understand the Dickenson [sic] chart,
21 when it says Prader-Willi it's including the full range of
22 individuals within that group of Prader-Willi, is that
23 correct?

24 A I'm sorry. Say again.

25 Q Let me. On this particular document --

Dr. Thomas Edward Schacht
Cross-examination by Mr. Zelenka

1 A Correct, correct.

2 Q -- which is on the PowerPoint, Prader-Willi versus
3 mental retardation --

4 A Correct.

5 Q -- that includes in the segment of Prader-Willi those
6 individuals who are also mentally retarded --

7 A Correct.

8 Q -- and have Prader-Willi.

9 A Correct.

10 Q Okay. And you stated that 50 percent of those
11 individuals are mentally retarded with low --

12 A They have -- they have I.Q.s in the retarded range,
13 yes.

14 Q Correct. Okay. So nonscientifically if 95 percent of
15 those with Prader-Willi are included in one of the ranges,
16 for example, skin picking, 50 percent of those are likely
17 mentally retarded, correct?

18 A I don't know that. What I -- what I do know is that
19 the researchers ran a specific correlational analysis
20 looking to see whether the differences in behavior problems
21 between the groups could be explained by differences in
22 I.Q., and they found that they could not so that even though
23 the Prader-Willi group on the whole had higher I.Q.s than
24 the others, the behavior problems were worse.

25 Q Okay.

Dr. Thomas Edward Schacht
Cross-examination by Mr. Zelenka

1 A That's -- that's where the conclusion led.

2 Q So we don't know, for example, impulsivity, 72 percent,
3 nonspecific M.R., 72 percent, we don't know if that range is
4 heightened on those that were mentally retarded or those
5 that were not mentally retarded.

6 A Well, we -- we do know that there would not be any
7 systematic heightening because there was no correlation.
8 There would be no systematic relationship.

9 Q So they didn't try to correlate it?

10 A No. What I'm saying is they did, and because they
11 found no correlation that means there was no systematic
12 relationship between I.Q. and the behavior problems.

13 Q Okay. Now, there was testimony here from some of the
14 defendant's family members that they had never seen the
15 defendant violent or aggressive. Do you recall hearing that
16 testimony? Were you present in court at that time?

17 A I was not.

18 Q Okay. But if that testimony is true you would agree if
19 they had significant exposure to Mr. Torres' life that it
20 would reflect that he was able in their mind to control his
21 aggression, correct?

22 A You're -- you're asking me to say something about the
23 state of mind of people whose testimony I haven't heard. I
24 don't know how to respond to that.

25 Q Okay. Well, you pointed out evidence, episodes in the

Dr. Thomas Edward Schacht
Cross-examination by Mr. Zelenka

1 materials, when the defendant was not controlling himself.
2 He was having outbursts. They've emphasized he was kicking
3 out windows. He was aggressive towards his mother.

4 A Those -- those are the -- those are some of the extreme
5 examples. Those are the ones that triggered
6 hospitalizations. But the clinical history given during
7 those hospitalizations is that there were ongoing problems.

8 Q Okay. But if there is evidence in the record that
9 Mr. Torres at least contemporaneous to the time of the
10 events or earlier in the minds of some of his family members
11 was not an aggressive person, was controlling himself, would
12 that impact on your understanding of whatever effects the
13 possibility of Prader-Willi or 22q11 would have on his
14 ability to self-regulate when they saw him as
15 self-regulating?

16 A If -- if I understand what you're saying, what you're
17 asking me, you're asking me if some lay witnesses testified
18 on the basis of an unknown foundation that in their opinion
19 Tony didn't show the characteristics that the clinical
20 record shows what would I -- how would I resolve that
21 conflict?

22 Q Yes, because it's all being self-reported to some
23 extent.

24 A Well, first, I would take issue with your statement
25 that it's all being self-reported.

Dr. Thomas Edward Schacht
Cross-examination by Mr. Zelenka

1 The clinical record contains descriptions and
2 observations of this behavior. As for what family members
3 said, I would have to interview them and see what the basis
4 for their statement was and see whether, in fact, there was
5 something that might modify the clinical picture.

6 Q Okay. And you didn't do that, did you?

7 A No.

8 Q Okay. Concerning the use of Mellaril you -- it strikes
9 me that you took issue with M.U.S.C.'s use of Mellaril on
10 this defendant at that young age, is that correct?

11 A What do you mean by said-take-issue?

12 Q You questioned whether it should have been used on
13 Mr. Torres based upon what was occurring in the
14 hospitalization.

15 A What I said was there are no clinical guidelines.
16 There's no literature to support this. I have never seen
17 it. I've talked to colleagues who've never heard of it.
18 It's not strongly of chemical restraint.

19 And I raised two hypotheses as a result of those. One
20 is that it was for treatment. The other is that it was
21 desperate treatment warranted by the extreme presentation
22 that Mr. Torres made. I can't choose between those two.

23 Q Okay. And when it was first prescribed to -- to
24 Mr. Torres that was one group of doctors that did it,
25 correct?

Dr. Thomas Edward Schacht
Cross-examination by Mr. Zelenka

1 A We actually -- I don't think we actually have the
2 original prescription records. That was done on an
3 outpatient basis. When he was first taken to M.U.S.C. he
4 was actually taken off it and then put back on at some other
5 point.

6 Q Okay. But it wasn't one singular doctor that has
7 prescribed Mellaril to this defendant, is it?

8 A No.

9 Q So there are a series of doctors who prescribed that
10 treatment for this defendant, correct?

11 A I believe so, yes.

12 Q A series of doctors who were of an opinion that that
13 was the best treatment for this individual based upon the
14 information that they had received, correct?

15 A I don't know what their opinions were about that. I
16 can tell you that there is a difference between initiating
17 medication and continuing one. It's much easier for a
18 physician to simply continue something that a patient's
19 already on because there's a risk and a liability associated
20 with discontinuing.

21 Q Okay. What effect did the Mellaril have on -- I guess
22 you'd call -- the phenotype of his syndromes? What effect,
23 if any?

24 A I don't know.

25 Q And --

Dr. Thomas Edward Schacht
Cross-examination by Mr. Zelenka

1 A I mean, Dr. Lipman had some opinions about likely
2 developmental effects. In terms of therapeutic effects, I
3 couldn't tell from the record.

4 There were some indications much later on in the record
5 that the accuracy of the record with respect to medication
6 may have been distorted because of noncompliance.

7 Q Okay. It appeared that you're making a connection
8 between the mother's smoking and the presence of genetic
9 problems with this defendant, is that --

10 A No.

11 Q Okay. Please, please explain.

12 A No. The -- the research on prenatal exposure to
13 tobacco that I cited is not about genetic problems. It's
14 about teratogen issues in which there are defects in the
15 developing organism that are caused by a toxic effect which
16 is not a genetic effect.

17 Q Okay. So you're not saying that the mother's smoking
18 enhanced the possibility to have the chromosome deletions
19 and 22q11 or present --

20 A That's a fascinating -- that's a fascinating question
21 as to whether or not that could occur, but I've not
22 researched the issue of genetic modification about tobacco,
23 and I don't know the answer.

24 Q Okay. So, again, what particular about this
25 defendant's actions, ability to self-regulate, did the

Dr. Thomas Edward Schacht
Cross-examination by Mr. Zelenka

1 mother's prenatal use of tobacco have in your opinion, if
2 any?

3 A Well, as I testified, what the literature shows is that
4 there is a long-term effect measurable in the offspring of
5 women who have used tobacco during their prenatal period.
6 And mother's use is well above the threshold in which those
7 phenomena have been detected.

8 The kinds of problems that occur include conduct
9 problems, problems with impulsivity measurable at age 22 and
10 increased likelihood of arrest. So my point was this is
11 simply another developmental burden on this young man in
12 addition to the other factors.

13 Q Okay. In the studies that you've read what was the
14 percentage of the individuals that would suffer those
15 deficiencies when the mother smoked a pack a day?

16 A I don't recall specifically off the top of my head.
17 I'd have to go back and look at the exact numbers. There
18 are statistically significant findings in all cases though.

19 Q What does that mean, statistically significant?

20 A Not -- not due to random. They're observable
21 differences and they're not due to random chance.

22 Q Above 50 percent?

23 A I'm sorry. I can't answer that question.

24 Q Below 50 percent?

25 A I can't answer that question.

Dr. Thomas Edward Schacht
Cross-examination by Mr. Zelenka

1 Q Just existed in a number?

2 A It's -- it's a statistically significant risk. I don't
3 think you can predict for an individual person what that
4 risk is going to be. It would be similar to saying we know
5 that tobacco causes lung cancer, but we can't say with
6 certainty whether tobacco is going to cause lung cancer in
7 any individual who happens to start smoking.

8 Q Okay. Now, during your presentation your prognosis
9 reflecting the questions that counsel asked as to what would
10 be the better prognosis for the defendant when he was a
11 child, you suggested that there should have been a plan to
12 mitigate and act as damage control. Did I hear that
13 correctly?

14 A I'm saying that -- that sometimes that has to be part
15 of the treatment plan. It's a situation where you're not
16 simply going to change a person. You have to change the
17 environment that they're in and take other measures to
18 prevent damage from occurring.

19 Q Okay. And by damage control, what do you mean?

20 A The whole range of -- well, for example, it was pretty
21 clear that Tony's home life was not one that could be
22 sustained. He couldn't be maintained in a home environment,
23 couldn't live in a normal family or community where he
24 didn't have -- couldn't live in a family setting in a
25 community where a normal child could. And so some form of

Dr. Thomas Edward Schacht
Cross-examination by Mr. Zelenka

1 institutionalization was essential. That's damage control.
2 That's essentially incapacitation.

3 Living is contact with the community. It's not
4 necessarily -- in itself it's not necessarily something
5 that's going to have longterm effects, but it all depends on
6 how it's done and how it's part of this planning.

7 My understanding is that when his period of residential
8 treatment ended he was simply put out and that there was no
9 more structure or environmental support for him after that
10 point.

11 Q Okay. And with the damage control are you suggesting
12 it was inevitable that he would be aggressive and violent
13 based upon his history and his actions?

14 A No, not inevitable but elevated risk.

15 Q How elevated?

16 A Substantially. More than an average mentally retarded
17 person.

18 Q More than an average mentally retarded person.

19 A Correct.

20 Q More than an average person?

21 A Yes.

22 Q Because he's not mentally retarded.

23 A I know. I was using that as a comparison simply
24 because of the -- of the research that I cited.

25 Q Okay. Now, a presentation was made during the trial by

Dr. Thomas Edward Schacht
Cross-examination by Mr. Zelenka

1 the defense experts where the -- they had an opinion that
2 the defendant would be nonviolent and adaptable to prison,
3 correct?

4 A Yes, that was Dr. Schwartz-Watz's opinion.

5 Q And Mr. James Aiken's opinion also, wasn't it?

6 A He was the counselor from the residential facility?

7 Q No, sir. He was the former warden of -- in the South
8 Carolina prison system.

9 A I don't believe I read his testimony.

10 Q Okay. Your testimony today is essentially his
11 aggressive actions will not evolve favorably over time,
12 isn't that correct?

13 A You talking about from the present?

14 Q Yes.

15 A No. I didn't testify to that issue.

16 Q Oh, I -- I thought you testified his lack of
17 self-regulation does not wane with adulthood.

18 A To the -- to the extent that we have research on this.
19 What it says is that behavior problems in Prader-Willi
20 syndrome as compared to other conditions do not get better
21 with time and that there's a burst in adolescence and young
22 adulthood.

23 We don't have followup data into older age groups --
24 30, 40, 50, whatever. So I can't speak to what might happen
25 in the future there.

Dr. Thomas Edward Schacht
Cross-examination by Mr. Zelenka

1 Another piece of all of that literature is that it's
2 for the most part ambiguous as to the treatment status of
3 the individuals. So as Dr. Lipman described, he's now on a
4 treatment regimen that is Dr. Lipman's opinion biochemically
5 appropriate for him and I don't -- I'm not sure that you can
6 generalize from this point on on that developmental
7 literature.

8 Q Okay. How old was he when he committed the crime?

9 A He was about 27 or 28, I think.

10 Q Okay. What was your literature at the time of 27 as
11 to, if any, he would wane out of aggressive activity
12 impulsivity?

13 A No indication that it would have waned by that age in
14 what I have reviewed.

15 Q Okay. Now, you're a forensic psychologist, correct?

16 A Yes, sir.

17 Q And you give opinions in court settings about the
18 existence or nonexistence of mental illnesses, correct?

19 A Sometimes, yes.

20 Q And Dr. Schwartz-Watz opined that at the time of the
21 trial she had an opinion that he suffered from bipolar
22 disorder, correct?

23 A Yes.

24 Q And you don't disagree with that opinion, do you, or do
25 you have any opinion about it?

Dr. Thomas Edward Schacht
Cross-examination by Mr. Zelenka

1 A About the issue of diagnosis?

2 Q Yes.

3 A One of the hazards of psychiatric diagnosis is that
4 because the criteria are descriptive it is very easy to pile
5 one diagnosis on top of another and end up with multiple
6 diagnoses in a single case. This is widely recognized as a
7 problem. The DSM has been criticized for that.

8 Good clinical reasoning focuses on the principle of
9 parsimony. What you want to do is pick a diagnosis that
10 best accounts for all the features of the case.

11 So in this case Dr. Schwartz-Watz picked bipolar
12 disorder. She picked anxiety disorder, not otherwise
13 specified by history. She picked intermittent explosive
14 disorder by history and so forth.

15 The features are all of those things that are there.
16 She chose to treat them as separate categories. All of
17 those features are also characteristic of Prader-Willi
18 syndrome.

19 So by the principle of parsimony you could just as
20 reasonably, and perhaps more reasonably, diagnosed Mr.
21 Torres as Prader-Willi syndrome with features of, and then
22 list all of the features she described.

23 Q Okay. So she hit the features. You disagree with the
24 manner that she did it.

25 A No. It's not about disagreeing. She didn't have any

Dr. Thomas Edward Schacht
Cross-examination by Mr. Zelenka

1 information about Prader-Willi syndrome.

2 Q Okay. But she looked into the existence of genetic
3 issues, didn't she, by --

4 A She -- she reviewed records.

5 Q And you've reviewed records also.

6 A Yes.

7 Q What caused you upon your initial assessment to be
8 concerned about the existence of genetic issues?

9 A As I said earlier, the -- the -- well, two -- two
10 things tripped me off.

11 The first one was the extremely early onset of this and
12 the severity of it at such a young age.

13 The second that was striking to me was the food
14 selectivity. That to me -- initially I wasn't thinking
15 anything like Prader-Willi. In fact, Prader-Willi didn't
16 cross my radar until Dr. Rary brought it up. Excuse me.

17 But there were other things in Dr. Caston's early
18 workup suggesting some metabolic abnormalities --
19 abnormalities in tyrosine, metabolism, abnormal dexton [sic]
20 as not results of presson tests. He was treating some of
21 that with some metabolic therapies which, unfortunately,
22 became unavailable for reasons beyond his control.

23 The point is that those kinds of things, you know,
24 metabolic abnormalities and so forth, they point to a
25 genetic cause. They raise your index of suspicion about

Dr. Thomas Edward Schacht
Cross-examination by Mr. Zelenka

1 those kinds of things.

2 Q Okay.

3 A Dr. Schwartz-Watz recited those facts in her report
4 about those abnormalities but didn't take the next step of
5 considering that maybe a geneticist ought to get involved.

6 Q Okay. She had him sent for an M.R.I., correct?

7 A Yes, yes.

8 Q Essentially, to determine if there was a defect in
9 brain volume in those matters, correct?

10 A I haven't seen the M.R.I. report, so I don't know what
11 the scope of the M.R.I. study was.

12 Q Okay.

13 A I -- I -- by her description in her report there was a
14 venus abnormality that's not likely to be pertinent to this.

15 with the exception that it was located in the
16 cerebellar area and mostly that -- she said that mostly has
17 to do with ataxia which is ability to -- to move in a
18 coordinated way, that's true. But there's some more recent
19 neuropsychological literature suggesting that the cerebellum
20 is also involved in attention and concentration. That's
21 potentially concerned there with it.

22 other than that I didn't see a detailed description of
23 the M.R.I.

24 Q Okay. But she referenced the Klinefelter's issue.

25 A I believe that's correct, yes.

Dr. Thomas Edward Schacht
Cross-examination by Mr. Zelenka

1 Q And in your initial impression were you concerned about
2 the possibility of Klinefelter's, or was there another --

3 A I'm -- I'm not a geneticist. I'm not going to get to
4 the level of saying it's this particular syndrome or not.
5 I'm at the level of saying this kid needs to see a
6 geneticist.

7 Q Okay. Let me slide back a step.

8 During the trial Dr. Alexander Morton testified a
9 psychopharmacologist -- about the defendant's use of illicit
10 drugs at the period -- at that period of time suggested that
11 there was a genetic quality towards the affect that those
12 drugs have on -- on an individual and the impact that he
13 thought those drugs would have on the defendant during his
14 life and at the time of the crime. Did you review
15 Dr. Morton's testimony?

16 A I did.

17 Q You've made no mention about the use of meth, the use
18 of L.S.D., any longterm effects it would have on the ability
19 of the defendant to function based upon that use of those
20 particular drugs.

21 Does that affect at all any longterm effects on the
22 defendant's ability to self-regulate?

23 A Well, I was asked to focus on the developmental period.
24 I wasn't asked to give an opinion about his current state or
25 his condition after the onset of substance abuse.

Dr. Thomas Edward Schacht
Cross-examination by Mr. Zelenka

1 Generally, that said, generally speaking, substance
2 abuse would not help. It would be another factor that would
3 contribute to impairment. That's what you would expect.

4 Q And in the information that Dr. Morton testified about
5 consistent with the information that Dr. Lipman was asked
6 yesterday was a significant amount of drug use self-reported
7 by the defendant around the time of the crime, correct?

8 A I shared Dr. Lipman's concern about the accuracy of
9 that information. The quantities of drugs that were
10 described as being used to my understanding would be
11 incapacitating.

12 Q Okay. Which would suggest consistent with what you
13 said is not a good self-reporter?

14 MR. SCHOEN: Objection. Lie the foundation as to who
15 reported the amount of drug use.

16 A Well, when you're talking about street drugs there can
17 be multiple sources of inaccuracy in the information. He
18 might have swallowed 15 pills, but what were they? They
19 didn't come from the pharmacy. So who knows?

20 Q Okay. Now, we know in the diagnosis that he had an
21 antisocial personality disorder. Persistent lying is one of
22 those symptoms for antisocial personality disorder, correct?

23 A Yes.

24 Q Is persistent lying a symptom or an effect of
25 Prader-Willi syndrome?

Dr. Thomas Edward Schacht
Cross-examination by Mr. Zelenka

1 A It's a commonly reported behavioral problem in
2 Prader-Willi. It was specifically reported by his mother as
3 an issue when he was a child.

4 Q Okay. Would an individual saying they didn't have a
5 memory of an event, could that be seen or advanced -- could
6 that be seen as persistent lying?

7 A If, in fact, they were lying and they had a memory,
8 sure.

9 Q Okay. Which would be consistent with antisocial
10 personality disorder, correct?

11 A Well, lying is an everyday occurrence. People lie all
12 of the time. So it wouldn't be proof of antisocial
13 personality disorder in itself if they --

14 Q Consistent with --

15 A If there were a pervasive pattern of it over time in
16 multiple context, then yes.

17 Q Okay.

18 MR. ZELENKA: Court's indulgence.

19 (Pause.)

20 Q I've just got a couple of more questions, Doctor.

21 Is it your testimony that the defendant was better
22 served during his youth by being placed in a residential
23 setting?

24 A I think there was virtually no choice in this matter.
25 His mother did not want him.

Dr. Thomas Edward Schacht
Cross-examination by Mr. Zelenka

1 At one point the record indicates she said terminate my
2 parental rights. Under those circumstances when there's no
3 other parent, no other family wanted to take the child, he
4 becomes a ward of the state.

5 Q Okay. And relating to that your criticism or what
6 sounded like criticism of M.U.S.C. related to not involving
7 the mother in that treatment in a different way, how was
8 that different from your suggestion that he be placed in a
9 residential setting beyond the control of his mother?

10 A At the age of three and a half that was not as
11 inevitable as it was when he was ten. So the issue was at
12 the period in time in his development when there was at
13 least a chance that you could have made a difference in this
14 the treatment that I saw was not directed at doing that or
15 not properly directed at doing that.

16 Q Okay. Did he speak with the mother about her desires,
17 her requests for involvement at that stage?

18 A At which stage?

19 Q At the stage when he was three years old and seven
20 years old, ten years old, and whether she --

21 A whether she wanted to be involved?

22 Q Uh-huh.

23 A Yes. Well, there was behavioral evidence of her desire
24 to be involved in the sense that she was traveling hundreds
25 of miles to participate in what was going on at M.U.S.C.

Dr. Thomas Edward Schacht
Cross-examination by Mr. Zelenka

1 She was exerting substantial effort to be involved.

2 Q Okay. What is your understanding of why he was sent
3 down to M.U.S.C. in Charleston rather than a more local
4 facility at that time in his life?

5 A I'm not aware of what the referral arrangements were.

6 Q Okay. Did you talk to Dr. Watz concerning --

7 A No.

8 Q -- her evaluation?

9 A No.

10 Q Her diagnosis?

11 A No.

12 Q Her decisions on coming up with the particular opinions
13 that she expressed about his social background, his violence
14 and the reason for it?

15 A You've said several things there. I did not talk to
16 Dr. Schwartz-Watz about anything. So I guess that covers
17 the answer.

18 Q Okay. Why didn't you do that?

19 A It wasn't pertinent.

20 Q Why wouldn't it be pertinent what another
21 psychiatrist -- or a psychiatrist -- I guess I shouldn't say
22 another psychiatrist -- who expressed an opinion related to
23 this defendant and her reasons for it?

24 A I had access to her report; I had access to her
25 testimony.

Dr. Thomas Edward Schacht
Redirect examination by Mr. Schoen

1 My focus was specifically on a very early period of
2 childhood including some issues that she was not able to
3 consider because of the records that were obtained after the
4 trial.

5 She did not approach the case from the perspective of
6 child development. She was focused on mental state at the
7 time of offense and explaining that. And that's simply not
8 my focus in this case.

9 Q She was also focused on mitigation by her own report.

10 A She -- she -- she recited history in her report that
11 when I reviewed many of the same records that she reviewed I
12 thought she had recited accurately. There was nothing to
13 discuss.

14 Q Okay. And by that she recited accurately that he had
15 the capacity to conform his conduct to the requirements of
16 the law, correct?

17 A That's not -- that's not a medical-record issue.

18 Q But that was her opinion.

19 A That was her opinion.

20 Q No further questions. Thank you, Dr. Schacht.

21 MR. SCHOEN: A few on redirect.

22 REDIRECT EXAMINATION

23 BY MR. SCHOEN

24 Q Doctor, you were asked about the fact that Mr. Torres
25 had some -- been making a lot of verbal outbursts and acting

Dr. Thomas Edward Schacht
Redirect examination by Mr. Schoen

1 out in court. You wanted to note that he's currently
2 shackled.

3 Are there medications that can be used to help treat
4 the symptoms of Prader-Willi or help treat some of the
5 issues associated with it?

6 A Yes, as Dr. Lipman described.

7 Q And because you were here for the testimony of Dr.
8 Lipman, to your understanding is Mr. Torres currently taking
9 those medications?

10 A I've not seen the jail medical records, but by his
11 report he is taking Paxil and Neurontin.

12 Q And you have seen his records as a child. Was he
13 taking Paxil and Neurontin as a child?

14 A No.

15 Q Are there from what -- from what you've -- the records
16 you reviewed, is there anything to suggest he was taking
17 Paxil and Neurontin at the time of the offense?

18 A I have not seen a comprehensive set of records
19 surrounding that time.

20 My understanding from what I have read in the trial
21 transcript is it is not a treatment of any kind. Any
22 substances he was using were obtained on the street.

23 Q Doctor, you also talked about behavioral modifications
24 in the environment that a Prader-Willi person is in.

25 Would it be accurate to say that a controlled

Dr. Thomas Edward Schacht
Redirect examination by Mr. Schoen

1 environment is easier for a person with Prader-Willi to
2 handle?

3 A Yes, particularly because if you remember when I talked
4 about the obsessiveness, the resistance to change, the need
5 for sameness, that's one of the features of controlled
6 environments. They're rigid; they're structured; they're
7 organized; they're less challenging than the world out at
8 large in terms of imposing the requirements to adapt to
9 ongoing change on an individual.

10 Q An environment where the same schedule is kept every
11 single day.

12 A Sure.

13 Q Environment where the same limitations are imposed
14 regularly.

15 A Yes.

16 Q An environment potentially like a prison setting that
17 Mr. Torres can currently be in.

18 A Yes.

19 Q I want to talk a little bit about this diagnosis of
20 antisocial personality disorder.

21 Can you tell -- tell us whether antisocial personality
22 disorder, is it -- is it a genetic condition?

23 A There are -- there is research suggesting that people
24 who end up with that diagnosis may have a heritable
25 component to the underlying traits that lead them to that

Dr. Thomas Edward Schacht
Redirect examination by Mr. Schoen

1 place.

2 Q Is -- is it a -- is it a description or is it -- is it
3 like a pathogen or a particular gene? I mean, do we know
4 what causes it?

5 A It's -- it's -- well, there are multiple pathways, but
6 it's simply a description or collection of behaviors.

7 Q Kind of --

8 A It's a -- it's a patten of behavior.

9 Q So it's kind of like --

10 A Carried out -- carried out over time with certain
11 requirements for, you know, conduct disorder and as a
12 precursor and then features after the age of 18.

13 There are some exclusions for antisocial personality
14 disorder in the diagnostic criteria. One of them is the
15 behaviors in question do not occur solely during
16 schizophrenic episodes. Another is that they don't occur
17 solely during manic episodes.

18 There is no exclusion for developmental disabilities,
19 but it wouldn't logically make sense to do that because by
20 definition antisocial personality does not occur before the
21 age of 18 and developmental disabilities do occur before age
22 18. So they wouldn't have put that in there.

23 Q You talked a little bit about this yesterday. You
24 talked about intermittent explosive disorder and
25 oppositional defiance disorder. Is this -- is this an

Dr. Thomas Edward Schacht
Redirect examination by Mr. Schoen

1 analogist type of descriptive label that's put on behavior?

2 A Yes.

3 Q Now, there were some questions about Mr. Torres' drug
4 use at the time of the offense. In the records that you
5 reviewed was there any indication that Mr. Torres was taking
6 methamphetamine when he was 19 months old and acting out,
7 rocking his crib, doing all of the things that you
8 described?

9 A There -- there was description of early exposure to
10 substances, but it was alcohol and marijuana.

11 Q No methamphetamine.

12 A Not unless the marijuana was laced with it.

13 Q No L.S.D.

14 A No L.S.D.

15 Q Klonopin?

16 A No.

17 Q And when he went to M.U.C. and was acting out, is there
18 any reason to believe that they were giving him
19 methamphetamine at that time?

20 A No.

21 Q Klonopin?

22 A No.

23 Q L.S.D.?

24 A No.

25 Q what about when he was seven and he was breaking things

1 and had to be institutionalized again? Any evidence of
2 methamphetamine?

3 A No.

4 Q Klonopin?

5 A No.

6 Q L.S.D.?

7 A No.

8 Q But when he broke his mother's windows out with a brick
9 and beat her up, any evidence in the record that he came in
10 and tested positive for methamphetamine, L.S.D., Klonopin?

11 A There was -- there was -- I did not see any evidence of
12 juvenile substance abuse anywhere in the record.

13 Q Finally, I want to talk to you a little bit about this
14 medical record that was referenced to rule out Prader-Willi
15 syndrome when he was a child. And to do that I want to
16 present you with the record. Have you reviewed it?

17 A I've seen it.

18 Q Okay. Doctor, I'm going to show you documents that
19 have been produced to state as Torres 00174 and Torres
20 00175. Do you recognize the document I just handed you?

21 A Yes. In my file it's numbered differently, but I
22 recognize the document.

23 Q And is this the document that counsel was asking you
24 about on cross-examination?

25 A I believe so.

Dr. Thomas Edward Schacht
Redirect examination by Mr. Schoen

1 Q would you read the last sentence on the first page?

2 A The one that begins "Normal growth and height?"

3 Q Yes, sir.

4 A "Normal growth and height eliminates Cushing's disease
5 and hypothyroidism, lack of mental retardation or
6 hypogonadism, Prader-Willi syndrome or Laurence-Moon-Biedl
7 syndrome unlikely."

8 Q Doctor, do all Prader-Willi syndrome patients have
9 mental retardation?

10 A No.

11 Q Is it diagnostically appropriate to rule out
12 Prader-Willi syndrome because a person is not mentally
13 retarded?

14 A No.

15 MR. SCHOEN: Permission to approach and retrieve
16 evidence.

17 Q Doctor, I'm going to show you Applicant's 15.

18 A Yes.

19 Q Do you recognize those pictures?

20 A The first one was the picture that I think was supplied
21 to Dr. Rary taken by others. The second two pictures were
22 taken during Dr. Rary's examination of Mr. Torres that I
23 attended.

24 Q Those are pictures of Mr. Torres' genitalia.

25 A Yes, they are.

Dr. Thomas Edward Schacht
Redirect examination by Mr. Schoen

1 Q And the note says that a lack of mental retardation and
2 hypogonadism make Prader-Willi syndrome unlikely.

3 would you look up in the paragraph right above that and
4 read out loud the portion of the description of Mr. Torres'
5 genitalia?

6 A "Tanner 1, genitalia." That simply refers to the
7 developmental stage with respect to progress towards
8 puberty. "Five centimeter phallus." In other words,
9 they're saying his penis is 2 inches long.

10 Q Were you here when Dr. Rary testified that Mr. Torres'
11 phallus is currently 2.75 inches long?

12 A Yes.

13 Q would that mean that between the ages of three and a
14 half and his current age his phallus grew less than an inch?

15 A That's simple arithmetic, yes.

16 Q Doctor, you testified that often when these exams are
17 done in a psychiatric setting the genital exam is deferred.

18 A Yes.

19 Q why is that done?

20 A Having a stranger poke around your genitals is
21 potentially stressful. And because there is a very low
22 yield of those examinations for factors that are
23 psychiatrically relevant it's deemed a -- an unnecessary
24 stress on the patient.

25 Q Doctor, the record states that the Prader-Willi

Dr. Thomas Edward Schacht
Redirect examination by Mr. Schoen

1 syndrome is unlikely. Does it rule it out?

2 A No. It says unlikely.

3 Q And that's based on hypogonadism and a lack of mental
4 retardation.

5 A That's what the -- that's what the note says, yes.

6 MR. SCHOEN: Court's indulgence one moment.

7 (Pause.)

8 Q Doctor, did you see anything in the records that
9 indicated they had done an I.Q. test when he was three and a
10 half?

11 A My recollection from the M.U.S.C. records is that he
12 was resistant to being tested. It's very difficult to test
13 a three-and-half-year-old anyhow and get a reliable result.

14 Q And is it true -- can you tell us whether mental
15 retardation is -- is diagnosed exclusively through the use
16 of an I.Q. test?

17 A Well, to reach a formal diagnosis, yes. What -- what
18 is -- what is being done here is simply a clinical
19 impression --

20 Q Doesn't --

21 A -- that he was not markedly developmentally delayed in
22 a global manner.

23 Q Doesn't an evaluation of mental retardation typically
24 involve evaluation of various competencies in addition to
25 I.Q.?

Dr. Thomas Edward Schacht
Redirect examination by Mr. Schoen

1 A well, again, to properly reach the diagnosis there
2 would need to be some kind of systematic assessment of
3 intelligence with an individually administered standardized
4 intelligence test, and then there would also need to be a
5 systematic assessment of what -- what you're referring to,
6 which is adaptive behavior.

7 Q If that wasn't done it would be difficult for them to
8 rule out mental retardation.

9 A I don't know that it's -- it makes it difficult to rule
10 it out, but it makes it -- it makes the conclusion that they
11 reached based on clinical impression rather than the kind of
12 data that you would need to properly assess that issue.

13 Q No further questions. Take the record back.

14 MR. ZELENKA: Just one followup, probably just one
15 followup.

16 RECROSS-EXAMINATION

17 BY MR. ZELENKA

18 Q Dr. Schacht, did you review the -- the video of the
19 defendant that was introduced at the trial concerning an
20 outburst while he was in detention?

21 A It was offered to me. The video files were mailed
22 but -- e-mailed to me, but I couldn't open them. So I have
23 not seen it. I've read a description of what happened.

24 Q And while he -- are you aware of what his mental state
25 was as far as being under the influence of any drugs at that

Kathleen J. Hodges
Direct examination by Mr. Ehliès

1 particular time --

2 A No.

3 Q -- prescribed to him?

4 A No.

5 MR. ZELENKA: No further questions.

6 MR. SCHOEN: Nothing further from this witness, Your
7 Honor.

8 THE COURT: You may step down.

9 We'll be in recess for 15 minutes.

10 (Whereupon, a recess was taken.)

11 THE COURT: All right. Next witness.

12 MR. EHLIES: Yes, sir. We would call Kathleen Hodges.

13 KATHLEEN J. HODGES, having
14 been first duly sworn, testified as follows:

15 DIRECT EXAMINATION BY MR. EHLIES

16 Q Are you in?

17 A I'm in.

18 MR. EHLIES: Judge, I owe this lady an apology for
19 moving her over here I think twice already and had her
20 standing in the hall. And I wanted to state on behalf of
21 the applicant that sometimes we don't really know how
22 things are going. She's been very good about being here
23 when I've asked her to be, and it just didn't work.

24 Q So I apologize to you for moving you over from
25 Anderson. Is that correct -- Anderson?

Kathleen J. Hodges
Direct examination by Mr. Ehliès

1 A I do work in Anderson now. And no apology is
2 necessary.

3 THE COURT: She has always been very accommodating.

4 MR. EHLIES: She's been here when asked to be.

5 Q Tell us what your role is in Anderson.

6 A I am one of the staff attorneys for the Anderson County
7 Department of Social Services.

8 Q And are you an attorney?

9 A I am.

10 Q When were you licensed?

11 A I was licensed in the State of Georgia in 1994 and in
12 South Carolina in 2000.

13 Q And you're currently serving in that capacity as an
14 attorney with DSS?

15 A That's correct.

16 Q Is that a full-time position for you?

17 A Yes, it is.

18 Q Okay. Prior to that can you give us a little summary
19 of your work history?

20 A Sure.

21 Q I'm sorry. Your legal-as-an-attorney work history.

22 A I prosecuted in the State of George for six years from
23 1994 until 2000. I married in 2000 and moved to South
24 Carolina from Georgia.

25 I worked in the attorney general's office for about 11

Kathleen J. Hodges
Direct examination by Mr. Ehliès

1 months in the post conviction relief division doing
2 noncapital P.C.R. cases.

3 I then prosecuted in Anderson from approximately 2001
4 until 2005 with the Anderson solicitor, Druanna White.

5 Then I joined the public defender's office in 2005 here
6 in Spartanburg. Was there from 2005 until approximately
7 April of 2011, and at that point I went to DSS in Anderson.

8 Q Was there ever a time in your attorney work history
9 that you were working with the solicitor's office in
10 Spartanburg?

11 A No. I never worked for the solicitor's office in
12 Spartanburg.

13 Q All right. So on occasions that you were working as a
14 deputy solicitor, that would have been in the Tenth Circuit
15 over in Anderson?

16 A That's correct.

17 Q And under that employment and working with Druanna
18 White did you handle any capital cases?

19 A Yes. I was the second chair with Ms. White in the
20 retrial of the State vs. Troy Burkhart. It had been --
21 first trial was overturned on appeal based on a
22 jury-instruction issue. And then I was working with her on
23 the trial of that, the second trial of that case.

24 I had also -- the only other -- well, I did one other
25 previous involvement with a capital case in Georgia. It was

Kathleen J. Hodges
Direct examination by Mr. Ehliès

1 noticed for the death penalty, and/but that case was
2 resolved by a guilty plea prior to trial.

3 Q All right. Let's talk a little bit about that case.

4 Georgia has a significant history in -- and from time
5 to time I'll say SCOTUS. And what I mean by that is the
6 Supreme Court of the United States. Okay?

7 A Yes.

8 Q Okay. And as regards the capital jurisprudence issue
9 by the Supreme Court of the United States, Georgia has a
10 very significant role starting with a case called Furman vs.
11 Georgia in 1972. And are you familiar generally with what
12 that was all about?

13 A I am familiar generally with Furman.

14 Q There was a follow-up case to that out of Georgia also.
15 It's was almost a companion case. It was a few years later
16 in '76. And it was for a fellow named Gregg -- G-R-E-G-G,
17 vs. the State of Georgia. Do you remember that case?

18 A Not as well as Furman. I remember -- the name Gregg is
19 familiar, but I don't remember it as well as Furman.

20 Q Okay. Well, for purposes of our work here today I need
21 to see if you and I can agree on a couple of things.

22 A Okay.

23 Q First is that in Gregg there was a phrase coined that
24 had been used and has been used ever since, and that was
25 that an imposition of a sentence of death is quantitatively

Kathleen J. Hodges
Direct examination by Mr. Ehliès

1 different from any other sentence that could be given. In
2 other words, death is different.

3 Does that ring a bell to you in the course of
4 reviewing?

5 A It does.

6 Q SCOTUS.

7 A It does.

8 Q Jurisprudence. Okay. And can you tell me why death is
9 different for you? Or excuse me. That assumes that death
10 is different. I had a lawyer tell me once it's no different
11 from a D.U.I.

12 When you served in a capital case before this one did
13 you consider that to be a different type of case than your
14 other criminal cases?

15 A Yes, I did.

16 Q And do you ascribe to the -- the general opinions
17 expressed in Gregg vs. Georgia that death is quantitatively
18 different from any other sentence that might be imposed on
19 an offender?

20 A Yes. I would agree with that.

21 Q And as a consequence of that when you were involved in
22 a death penalty case are you aware that there are also
23 certain ethical requirements both from the prosecution side
24 about seeking death and prosecuting cases and from the
25 defense representation side?

Kathleen J. Hodges
Direct examination by Mr. Ehliès

1 A Yes.

2 Q Okay. And are you sensitive to that, that those things
3 would need to be adhered to?

4 A Yes.

5 Q And in my case reviewed constantly. I never remember
6 exactly what all of the rules are. Are you like that
7 somewhat?

8 A I would hope so, yes.

9 Q And you would have to review those rules.

10 A Yes.

11 Q There was another case that involves what we're doing
12 here today. And since you've actually spent time
13 prosecuting -- or defending, actually. You would be the
14 respondent in the state's office -- I'm sorry -- with this
15 group here in P.C.R. cases. There was a case issued by
16 SCOTUS, and it was referred to as Darrell Strickland who was
17 the claimant-applicant, the petitioner in that case, and
18 against Washington.

19 A Yes.

20 Q We referred to as the Strickland case.

21 A Yes.

22 Q So when I say Strickland in the course of our talk,
23 that's what I'm referring to as the Darrell Strickland case.

24 A Okay.

25 Q And do you have any kind of familiarity with Darrell

Kathleen J. Hodges
Direct examination by Mr. Ehliès

1 Strickland's case and the ruling in Strickland?

2 A I certainly have familiarity with the ruling in
3 Strickland. I certainly couldn't give what the facts of
4 Strickland's case was.

5 Q All right. Well, let me show you very briefly some of
6 the holding, the fundamental holding that has caused the
7 case history of Strickland to be one of the most cited. If
8 you did a Shephard's on Strickland -- you know what that is.

9 A I do.

10 Q It goes on more than -- I think there are only a couple
11 of other cases that involve more citation. And we're going
12 to take a look at this.

13 At the first part of Strickland we have this
14 representation of a criminal defendant entails certain basic
15 duties. I think that's part of it. So you -- can you see
16 from where you are --

17 A I can. Thank you.

18 Q -- what I'm talking about?

19 A Yes.

20 Q And those duties are significantly different.

21 MR. EHLIES: Judge, and I'm sorry. This witness we're
22 offering under 611(c). As nice as she is, she is adverse
23 to our position. So I will be using leading questions and
24 then cites of 611 rule -- evidence of 611(c) which allows
25 leading questions on parties and witnesses that are adverse

Kathleen J. Hodges
Direct examination by Mr. Ehliès

1 to each other.

2 THE COURT: Okay. I've not heard any objections to
3 it.

4 MR. EHLIES: Yes, sir.

5 Q Do you agree then that in representing the individual
6 that is either charged with or where you're prosecuting that
7 the process and procedures of a capital litigation case then
8 are significantly different than any other case?

9 A I would agree with that.

10 Q And fundamentally it's because, isn't it, the only case
11 in the criminal arena where in South Carolina statutory
12 authority the sole sentencing discretion is with the jury?

13 A That's true.

14 Q In South Carolina we don't sentence in any D.U.I. or
15 whatever as some states do with the jury. And you would
16 agree with that.

17 A I would agree with that.

18 Q So when you handle a South Carolina case that is death
19 noticed -- and can we agree that means that someone in the
20 solicitor's office has made a decision to issue and serve a
21 notification that the state intends to seek the death
22 penalty?

23 A Yes.

24 Q Okay. And having been involved in that process as a
25 prosecutor you know there are certain things that go into

Kathleen J. Hodges
Direct examination by Mr. Ehliès

1 making decision -- considerations.

2 A Yes.

3 Q And in doing that based on your experience as a
4 prosecutor involved in the case twice was there any role and
5 is there any role for the family of the deceased victim who
6 was the subject of the murder?

7 A Any role in terms of the decision-making process?

8 Q Any role in making the decision whether or not to seek
9 death.

10 A Ultimately, no. I think that solicitors are certainly
11 sensitive to what a family's desires and wishes are, but,
12 ultimately, the decision as to whether to serve notice to
13 seek death penalty lies solely with the solicitor.

14 Q Based on your experience is it fair to say and would
15 you agree with me that the solicitor at least in the Tenth
16 Circuit had some interest in knowing what the surviving
17 family members of the victim think about that decision?

18 MS. BROWN: Objection, Your Honor, to relevance
19 because it goes to the Tenth Circuit decision-making. Not
20 applicable here.

21 THE COURT: Sustained.

22 MR. EHLIES: Judge, we'd have a --

23 THE COURT: Do you want to make a proffer?

24 MR. EHLIES: Absolutely.

25 Q Are you aware of a duty imposed on trial litigants for

Kathleen J. Hodges
Direct examination by Mr. Ehli

1 the person charged to seek a negotiated resolution to every
2 capital case continuously?

3 A Yes.

4 Q Okay. So in the making of the decision, whether it be
5 in the Tenth Circuit or this circuit, trial counsel on the
6 defense side has a duty to seek a negotiated resolution, is
7 that not correct?

8 A That is correct.

9 Q Okay. And as I understood your answer to my question
10 before the objection, is that the ultimate decision lies
11 with the prosecutor, is your opinion.

12 A That's correct.

13 Q What my question was, whether there was room within
14 that decision-making process for input by the victim's
15 family.

16 A Absolutely.

17 Q And when you came to this circuit in Spartanburg did
18 you find anything that suggested to you that -- and was
19 solicitor Gowdy when you came to work in the public
20 defender's office -- was it Solicitor Gowdy?

21 A Yes, sir.

22 Q Okay. Was there anything that suggested to you that he
23 was different in that regard?

24 A Not in my experience.

25 Q Okay. I want to -- I want to read this next thing on

Kathleen J. Hodges
Direct examination by Mr. Ehli

1 "Counsel has a duty to bring to bear such skill and
2 knowledge as will render the trial a reliable adversarial
3 testing process." Would you agree with that?

4 A I would.

5 Q Right below that in the Strickland holding -- I'm
6 sorry -- is the statement if I can read it. I'm going to
7 have to blow mine up.

8 "Prevailing norms of practice as reflected in the A.B.
9 A. -- American Bar Association Standards -- the like A.B.A.
10 standards for criminal justice."

11 Now, these standards of criminal justice should not be
12 confused with the guidelines that are a version of that.
13 These were out in 1980 and were actually initially in 1952.
14 So those guidelines that are referenced in this decision, in
15 the Strickland decision that we had at the time, predate
16 even the capital specific guidelines. Okay?

17 A Okay.

18 Q But this statement is that the prevailing norms of
19 practice -- okay. And what I want to ask you is where would
20 you as a practitioner, capital litigator, find norms for
21 practice.

22 A I guess you would find it either in case law, in
23 statutes. You would find it in other ethical rules and
24 guidelines and conduct.

25 Q Very good. And would the norms of practice be

Kathleen J. Hodges
Direct examination by Mr. Ehliès

1 educational to you as regards your duties and
2 responsibilities?

3 A I would believe so, yes.

4 Q And is it, in fact, in this statement, the SCOTUS, is
5 referencing the norms as expressed in the American Bar
6 Association Standards?

7 A Yes, it is.

8 Q Okay. Otherwise norm means nothing. Would you agree
9 with me? There has to be some basis to establish a norm.
10 Otherwise, everybody's opinion would be a norm.

11 A I would agree with that.

12 Q So we have to have a benchmark in deciding whether
13 conduct is above or below the norm. There has to be some
14 sort of a definition benchmark.

15 A Yes.

16 Q Okay. They go on a little lower and say that no
17 particular set of detailed rules for counsel's conduct can
18 satisfy -- satisfactorily take account in the variety of
19 circumstances. So can we agree that what they're saying is
20 that is a norm-based level but the facts and details of
21 every case and circumstance will be different and require
22 different considerations?

23 A I would agree with that.

24 Q Okay. Now, I'm going to jump forward a little bit.

25 In South Carolina we started talking about this. And

Kathleen J. Hodges
Direct examination by Mr. Ehliès

1 for the longest time in our courts we had this resistance.
2 But there was a case that's going to come up on the board
3 for you, and that case is Mr. Ard's case out of Lexington,
4 and his case was decided more than once in the U.S. -- in
5 the South Carolina Supreme Court. And on 2007 -- and I
6 believe this case was in 2008.

7 A Yes.

8 Q Tried in 2008. South Carolina Supreme Court issued a
9 decision in Joseph Ard, and down in that decision we find
10 this statement, page seven.

11 "When evaluating the reasonableness of counsel's
12 conduct," which is -- you understand that's why we're here.

13 A Absolutely.

14 Q "It doesn't make any difference how much testimony we
15 put in, there are only two issues: Was counsel's
16 performance deficient or not, and was there a prejudice as a
17 consequence," basically stated. Is that correct?

18 A That would be correct.

19 Q This statement from our state Supreme Court when
20 evaluating the reasonableness of counsel's conduct -- of
21 course you keep in mind that counsel's function as
22 elaborated in prevailing professional norms," again, "is to
23 make the adversarial testing process work in the particular
24 case." We're citing Strickland. "At a minimum, counsel has
25 the duty to interview potential witnesses and to make

Kathleen J. Hodges
Direct examination by Mr. Ehli

1 independent investigation of the facts and circumstances of
2 the case."

3 And we had a number of witness issues that are going to
4 coming up later and whether or not they were interviewed and
5 what could have been learned. But do you agree with that
6 statement?

7 A Yes.

8 Q Little bit below that, on the next page actually, I
9 think -- now we have a specific reference to a different set
10 of documents that came out establishing norms for handling
11 capital litigation. Originally in '83 major undertaking by
12 the American Bar Association, and then in '89, and then in
13 2003, and then again in 2005, and then another one.

14 But in this case prior to trial of your case the Court
15 in in Ard is citing to the A.B.A. guidelines for the
16 appointment and performance of defense counsel in death
17 penalty cases and issued a citation for doing that.

18 So would you agree with me that the State of South
19 Carolina at least at the Supreme Court level was thinking of
20 and referencing the guidelines that are identified as the
21 A.B.A. guidelines?

22 A I think that's a fair statement.

23 Q And can I just say the guidelines from now on?

24 A Absolutely.

25 Q Okay. There's a significant footnote, and it is the

Kathleen J. Hodges
Direct examination by Mr. Ehliès

1 next thing that in the Ard decision about what were
2 performance and duties Strickland -- citing back now, way
3 back, to the really fundamental case of Strickland in the
4 United States Supreme Court -- explained that prevailing --
5 there's that word again -- the prevailing norms -- and this
6 is the South Carolina Supreme Court talk -- "of practices as
7 reflected in the American Bar Association standards are
8 guides to determining whether counsel's performance is
9 reasonable."

10 And then he goes on to cite cases we're going to see in
11 this case -- Wiggins -- and referencing whether the conduct
12 in that case -- Wiggins particularly, and it relates to the
13 conduct you'll see later in this case -- can be judged from
14 the norm of the A.B.A. guidelines.

15 Okay. Now, let me jump over one more, and I'm going to
16 change things. There was another case that came out of the
17 South Carolina Supreme Court just as you were trying this
18 case, December of 2008. And that was Donney Council's case.
19 It was decided in 2008. I'm looking at it. So it's not
20 that my memory is so wonderful, I want you to know.

21 Okay. And this case again endorses and references as
22 the benchmark for any decision-maker and lawyer handling
23 capital cases of norms -- that is standard expectations of
24 performance, generally standards.

25 Okay. And I'm going to take you to page nine -- page

Kathleen J. Hodges
Direct examination by Mr. Ehli

1 eight -- I'm sorry -- of the Donney Council. And this is a
2 couple of years after Ard. As in Wiggins, counsel's conduct
3 fell below the standard set by the American Bar Association
4 Guidelines.

5 In this case we're talking about granting relief
6 because counsel did not meet the standards and the norms set
7 by these set of guidelines. That quote goes over to the
8 next page and is somewhat significant.

9 Okay. This is sort of a basic entry into handling a
10 capital murder case. "She should begin, among other things,
11 collecting information relevant to the sentencing phase,
12 including but not limited to, medical history."

13 Now, we're going to have a big yah-yah in this case
14 about what medical history was available to defense counsel
15 and the people they chose to help work on the case,
16 particularly as it pertains to M.U.S.C. records from 1984.

17 A Okay.

18 Q Okay. So we collect these medical records and history,
19 educational history. We note that these guidelines were
20 revised in 2003. That was one of their recommendations.
21 However, we cite to the '89 guidelines. And I don't know
22 exactly why they decided to do that, because it was -- but
23 there you have it. Okay. You with me?

24 A I am.

25 Q Okay. Now, before I go to that specific set of

Kathleen J. Hodges
Direct examination by Mr. Ehli

1 documents to set the framework for asking you a lot of
2 questions I want to ask you a few more questions about your
3 background.

4 A Okay.

5 Q You've told us about the two cases that you were
6 actually involved in, one of which negotiated out --

7 A Correct.

8 Q -- to a plea. Was that a case you were handling as a
9 prosecutor, assisting as a prosecutor, or handling as a
10 defense --

11 A I was assisting as a prosecutor. The district attorney
12 for the Northern Circuit in Georgia was the primary
13 prosecutor on that case. And since it happened in the
14 county that I was assigned to I was assisting.

15 Q Have you ever had the opportunity to attend specific
16 capital litigation training offered by any sanctioned
17 organization, like the administrative branch of the United
18 States Court Systems offer it several times a year, four
19 days long. And they have different levels of competent --
20 somebody new to the process or up. Have you ever attended
21 any of those?

22 A I've not attended any of those trainings.

23 Q Have you ever attended any capital litigation, specific
24 training sessions for the function of a trial lawyer
25 handling the defense of a capital case?

Kathleen J. Hodges
Direct examination by Mr. Ehli

1 A The only capital litigation training that I have
2 attended specifically was a seminar. I believe it was a
3 day-long seminar dealing with voir dire and qualifying
4 jurors to be picked to actually sit on -- on cases.

5 Q Very good. So you did a single seminar.

6 A Yes.

7 Q Day long?

8 A Yes.

9 Q Focused entirely, or just a segment on voir dire to
10 qualify, what we call death qualify, a jury panel.

11 A It was focused entirely on -- on questioning jurors to
12 determine their qualifications to sit on a death-qualified
13 jury.

14 Q And SCOTUS has issued a couple of decisions in that
15 regard -- Morgan vs. Illinois and Turner vs. Murphy. Do you
16 remember any of those?

17 A No, sir.

18 Q Okay. If I gave you the outgrowth of that was that
19 trial counsel in a death penalty case while qualifying the
20 jurors to serve must voir dire for a race neutral juror --

21 A Yes.

22 Q You've heard that term. It's a big focus.

23 A Yes.

24 Q Especially if it's a minority group on a majority group
25 in a murder and it would involve a sexual problem and the

Kathleen J. Hodges
Direct examination by Mr. Ehliès

1 offender is a man and the -- and the victim is a woman. Was
2 that present in this case -- the victim? There was a -- do
3 you remember there were two?

4 A Yes. There were two victims.

5 Q And Ann and Ray Emery?

6 A Yes.

7 Q And Ann Emery, in fact, I think -- I'm jumping way
8 ahead -- but there was some indication in a charge of
9 criminal sexual conduct.

10 A That's correct.

11 Q And it involved some evidence, what we call evidence,
12 sample that was drawn from the body of Ann Emery that sort
13 of associated with Mr. Torres.

14 A Yes.

15 Q Do you remember that?

16 A I do.

17 Q So and you noticed also in the testimony of Ms. Hughey
18 in the proffer that there was a reference specifically by
19 the law enforcement officers to where is the Mexican.

20 A Yes.

21 Q And if you see that page -- do you recall that? You've
22 got a great memory. And he is Hispanic extract, and
23 although he's not Mexican, he is Puerto Rican. And there is
24 a record that reflects that. So I'm not offering it.

25 Did you do a racially neutral voir dire of the

Kathleen J. Hodges
Direct examination by Mr. Ehli

1 potential jurors and advise them that there was going to be
2 and was, in fact, an allegation, a criminal sexual conduct
3 on a white female by a minority group member?

4 A No.

5 Q Page 1463 if you haven't remembered.

6 Okay. Now, I want to take -- I want to take you
7 through a couple of these guidelines. And in fairness to
8 you, which is very important from my perspective -- okay.
9 And this isn't a pleasant thing for me. Fairness to you,
10 your role in this case was what? Tell us.

11 A Sure. Mr. Allen, Clay Allen, was the primary counsel.
12 As chief public defender he was appointed to represent
13 Mr. Torres.

14 John Reckenbeil was appointed as the second chair.

15 I worked in the public defender's office at the time.
16 I had been considered by the South Carolina Supreme Court to
17 be qualified to handle death penalty cases. However, I had
18 never done one from the defense perspective. So I asked
19 Mr. Allen to be able to assist him at trial for whatever
20 purpose he wanted me.

21 So, you know, technically I was third chair, if you
22 will. I did do -- I did the opening statement. I did do
23 some cross-examination of some witnesses. And I presented
24 one mitigation expert.

25 Q Okay. And I think that was Alex Morton.

Kathleen J. Hodges
Direct examination by Mr. Ehli

1 A Yes.

2 Q Pharmacologist in the case.

3 A Yes.

4 Q What were the dynamics of the team assignments? How
5 did -- how did the team -- did y'all have regular meetings
6 every week?

7 A I don't necessarily know if we met every week all
8 throughout our -- the time that we were, you know, working
9 on the case. But, I mean, towards the end we were obviously
10 meeting quite regularly. But I would say we had regular
11 meetings in terms of assessing the status of case
12 development, research those sorts of things.

13 Q And in that context did you receive any specific
14 assignments from Mr. Clay Allen?

15 A Essentially, you know, the assignments were to develop
16 Mr. Morton's testimony. And, you know, I don't recollect
17 what other assignments I had. I'm sure that I did. I just
18 -- you know, I can't recollect.

19 Q Okay. Well, as we go through these you may see and it
20 may refresh your recollection that, bang, you hit right
21 there.

22 A Okay.

23 Q Okay. And feel free to volunteer that if I miss asking
24 you.

25 A Okay.

Kathleen J. Hodges
Direct examination by Mr. Ehliès

1 Q One of the guideline principles in the education
2 process in handling capital litigation cases for lead
3 counsel, chief counsel -- you've never been there, right?

4 A That is correct.

5 Q Okay. I'll offer to you that in the guidelines that
6 chief counsel is responsible not only for supervising the
7 case and development of the work -- would you agree with
8 that --

9 A I would agree with that.

10 Q -- but in offering peer assessment, mentoring and, most
11 important, educational opportunities to those who are coming
12 up in handling it second and third chair, for attending
13 seminars necessary to get up to speed to handle one of these
14 cases. Did that ever happen?

15 A No, it did not in terms of we all -- and I say that
16 Mr. Reckenbeil went to that conference with us in terms of
17 the jury qualifications, but I don't think he did. I think
18 it was just Clay and I went to that particular conference in
19 Columbia.

20 I know Mr. Allen had an opportunity to go to one of
21 the -- I don't remember if it was National College of
22 Defense Lawyers or who put it on. There was -- I know that
23 he went to a seminar called Building the Case or something
24 like that -- Building a Case for Life.

25 There was a nationally known seminar. He went to that

Kathleen J. Hodges
Direct examination by Mr. Ehli

1 seminar at some point. I don't know if it was in the fall
2 of 2008 or the fall of 2007. The only reason why I know he
3 went to that is because he then went from that seminar to
4 the public defender's conference at Myrtle Beach. And I
5 picked him up from the airport.

6 Q Okay.

7 A And I got lost. And so I vividly remember picking him
8 up from the airport and not being able to find the Myrtle
9 Beach Airport.

10 Q Okay. Okay. Well, the point is now that as far as
11 specific education and training and opportunities presented
12 to you to achieve that and to have the benefit of that in
13 handling this case, it did not happen.

14 A That's true.

15 Q I'm going to show you then some basic principles that
16 drive those seminars if you had attended. Some of them you
17 may know in your personal practice.

18 For instance, they always have a segment on SCOTUS.
19 Review and status. But it is not based on the decisions
20 that they had issued. The entire focus for a day is on the
21 cert petitions, whether they're granted and whether they're
22 denied.

23 Okay. Would you know why that is based in your
24 experience and training?

25 A Do I know why that is and based on my training? Not

Kathleen J. Hodges
Direct examination by Mr. Ehli

1 necessarily. I mean, I could hazard a guess but --

2 Q Very good. You're an expert. You're a licensed lawyer
3 with experience.

4 why would you think they would focus on certain
5 petitions filed, granted and/or denied?

6 A My presumption is that it's so that you know what sort
7 of things you need to do at the trial level in order to
8 build the record in order for review to be effective.

9 Q Precisely. And we call that forward-looking
10 representation. And we had a very famous -- did you ever no
11 Harry Lightsey, dean of the law school?

12 A No, I did not. I did not attend law school in South
13 Carolina.

14 Q He said the law -- he said the law is never what the
15 Court said it is, it's always what they're going to say it
16 is the next time they see it. And in capital litigation one
17 of the other phrases, SCOTUS issued, is evolving standards
18 of decency. Have you ever heard that?

19 A Not -- not that term, phrase, no.

20 Q There's a phrase about evolving standards. And what
21 does that mean to you -- evolving?

22 A well, it's changing that --

23 Q Ever changing. So the thrust of representation -- and
24 it appears in this case over this circumstantial-evidence
25 rule -- the thrust -- and I'm giving you the heads up -- of

Kathleen J. Hodges
Direct examination by Mr. Ehli

1 that point is to be prepared to advance a theory that is
2 arguable and potentially winning based on what is broadcast
3 from the certs granted and denied, whatever, is that
4 correct?

5 A I assume so, yes.

6 Q Okay. And is that a principle that you would endorse
7 as an ideal?

8 A Absolutely.

9 Q And is it a principle that you would like to have as a
10 regular in the course of representing your clients?

11 A Absolutely.

12 Q Be in a position to take advantage of change.

13 A Sure.

14 Q I think we've done that in this case as far as the
15 categorical ineligibility for a death sentence based on
16 Atkins like phenomena -- pheno types, etc. That's where
17 we're going. You've seen our second amended application.

18 A I actually have not, but I have heard of it and talked
19 about it.

20 Q Okay. Well, I sent it all to Clay Allen. I'm sorry
21 that it didn't get shared with you.

22 I also sent the applicant's memoranda, trial merits
23 memorandum, hearing that outlined almost everything we're
24 going to talk about. Have you seen that?

25 A I have not.

Kathleen J. Hodges
Direct examination by Mr. Ehliès

1 Q Have you heard about that?

2 A I have heard about that.

3 Q Okay. Did you meet with Clay Allen prior to coming
4 here at all?

5 A Briefly, yes.

6 Q Okay. Were you present when he was in conference with
7 the attorney general's office?

8 A I was not.

9 Q And have you ever been informed by the attorney
10 general's office of what was going to be expected from you?

11 A No, I have not.

12 Q Has anybody from their office told you what the issues
13 are?

14 A No, they have not.

15 Q 1.1, guideline 1.1. I'm going to go through these real
16 quick.

17 By the way, the guidelines are available on line, and
18 they're annotated, and they have a lot of dialogue and
19 things in them about what the theories are for the rules.

20 I'm just citing what we call black-letter law.

21 A Okay.

22 Q Do you remember from law school?

23 A That I do remember.

24 Q Okay. And the objectives from the guidelines set
25 forth, "National standard practice for the defense of

Kathleen J. Hodges
Direct examination by Mr. Ehliès

1 capital cases in order to ensure high quality legal
2 representation for all persons facing the possibility of the
3 imposition of death." That is different.

4 Okay. Would you agree that that is more than an ideal,
5 it is the objective that should be sought?

6 A Sure.

7 Q Okay. Okay. Let me slip down then to 5.1 skipping
8 over a bunch. And this would be F.

9 Okay. This is lifted from the guidelines and has to do
10 with the mitigation side of the case. It is not present in
11 any other type of criminal case.

12 And it says the skill is part of training and
13 development and focus in the investigation and preparation
14 and presentation of evidence bearing upon -- and you see
15 what it says next -- mental status.

16 A Yes.

17 Q In this case was there significant evidence of a mental
18 issue in the life of Tony Torres?

19 A Yes.

20 Q And jumping ahead, again, y'all offered the testimony
21 of Dr. Schwartz-Watz. Do you remember that?

22 A I do.

23 Q And do you remember that she said that she had never
24 seen a patient who started off having significant drug --
25 psychotropic drug interventions at age 19 months, admitted

Kathleen J. Hodges
Direct examination by Mr. Ehli

1 at three and a half years -- actually 3.7 years -- into a
2 residential placement hospital -- M.U.S.C. Do you remember
3 her saying that?

4 A I do.

5 Q Okay. So there was significant
6 medical-mental-psychiatric type issues in this case, is that
7 correct?

8 A That is correct.

9 Q And for that reason this particular guideline about
10 developing and handling that -- 8.1 is how you learn to do
11 that without having to learn on the tennis court and
12 dropping the ball or the golf course and hitting it
13 backwards.

14 On B-3, "Pretrial investigation, preparation and theory
15 development regarding guilt/innocence and penalty is
16 required. Trial preparation and presentation including the
17 use of experts." And I saw your mitigation case. And I say
18 yours. I stand to be corrected. It wasn't yours. Who set
19 the theory of the mitigation case in Tony Torres?

20 A I mean, it ultimately I guess was a team decision. I
21 mean, we talked about it. And -- and, you know, but
22 ultimately, you know, I followed whatever lead that
23 Mr. Allen had.

24 Q Okay. So he had an open forum on the theory --

25 A Sure.

Kathleen J. Hodges
Direct examination by Mr. Ehliès

1 Q -- that y'all would talk about?

2 A Yes.

3 Q Is that sort of like the solicitor's office in making
4 the decision involving the victim's family of whether to
5 seek death?

6 A Well, I -- phases of -- of a trial and in making those
7 determinations, so in a sense, no, but...

8 Q Okay. We'll look. We'll go down to No. 10. Says,
9 "The presentation and rebuttal of scientific evidence, and
10 developments in mental health fields and other relevant
11 areas of forensic and biological science."

12 Do you remember in this case whether or not you got a
13 consultant for purposes of voir dire of a race neutral
14 juror?

15 A We did not --

16 Q Okay.

17 A -- that I remember.

18 Q Okay. Did you contract with Jeff Blume, for instance,
19 to provide focus group of any type?

20 A That name is not familiar to me, so I assume not.

21 Q How about phrase focus group?

22 A The phrase focus group is familiar to me, yes. But I
23 don't remember doing any -- consulting with any jury
24 qualification experts.

25 Q Do you know -- at that time did you know that they were

Kathleen J. Hodges
Direct examination by Mr. Ehli

1 available?

2 A Yes, I believe I did.

3 Q And did you know that specific focus group sessions
4 were available for capital murder defense work at no cost?

5 A That I did not know.

6 Q And that would be because you were new to the process.

7 A Right.

8 Q Okay. So who would you have been looking to in your
9 team for that kind of information?

10 A I would have been looking of course to Mr. Allen for
11 that information.

12 Q And did he give that to you, that kind of information?

13 A Not that I recall.

14 Q Okay. And as regards then the consulting role --
15 skipping from the jurors to what we've been hearing here --
16 and you're not privy to it, but it's right complicated
17 medical case in genetics.

18 Did you know whether -- or did you consult with any
19 medical experts? And by that I mean not people who are
20 witnesses but had a team-directed, medically based expert
21 who would help you understand what the records were showing.

22 A I don't recall consulting with any medical. I know, in
23 fact, did not, and I don't recall the team consulting with
24 medical experts to review the records and give us an
25 interpretation, if you will, of what those records said.

Kathleen J. Hodges
Direct examination by Mr. Ehli

1 I can tell you that I recall I think reading some
2 correspondence that the records were sent to various people
3 that we did consult with in terms of potential experts. But
4 how far those experts actually read records and either gave
5 feedback or not, I couldn't tell you because that wasn't
6 what I was working on.

7 Q And would -- that wasn't -- because that was mitigation
8 as opposed to guilt?

9 A Well, A, it was mitigation because of guilt, but, B,
10 that that simply wasn't the area of mitigation that I was
11 focused on.

12 Q Okay.

13 A You know, we took sort of a divide-and-concur, I guess,
14 mentality, if you will, in terms of trying to build the
15 different aspects of mitigation as well as different aspects
16 of attack on the guilt-innocence phase, so.

17 Q Are we in agreement that some books shouldn't be judged
18 from their cover?

19 A Sure.

20 Q And isn't that the same as assuming that the appearance
21 of a medical record may be different than what is actually
22 the case with the client?

23 A I would agree with that.

24 Q And so it's not enough to look at a medical record. It
25 isn't even enough to understand a medical record. It has to

Kathleen J. Hodges
Direct examination by Mr. Ehli

1 be explored, developed -- and it's language we're going to
2 see here -- exploring, developing and presenting what there
3 is to find from those records. Do you agree with that?

4 A I could agree with that.

5 Q And that is the fundamental role of an informed
6 consultant, is it not?

7 A It is.

8 Q Because you may not know what it suggests if you're not
9 a geneticist, for instance, isn't that true?

10 A Very true.

11 Q Okay. But that seat was empty on your team as far as
12 you know.

13 A As far as I know that seat was empty, yes.

14 Q I'm at 10.4, paragraph B. We've been talking about
15 Mr. Allen and how your team worked, because it is a team
16 function. And I have great team members, and/but I rely on
17 them heavily. Is that how Mr. Clay Allen functioned with
18 your --

19 A I would say so, yes.

20 Q -- input? He was not arbitrary and distant, is that
21 correct?

22 A No.

23 Q He was available to you and y'all made -- had
24 opportunities to enter your opinions and suggestions.

25 A Absolutely.

Kathleen J. Hodges
Direct examination by Mr. Ehli

1 Q Paragraph B. "Lead counsel bears overall
2 responsibility for the performance of the defense team, and
3 should allocate, direct and supervise its work in accordance
4 with these guidelines and professional standards, including
5 developing and presenting the mitigation evidence." 10.7 is
6 where I'm getting that.

7 And I'm looking at 10.7 guideline, paragraph A.
8 "Counsel at every stage have an obligation to conduct
9 thorough independent investigation relating to the issues of
10 both guilt and penalty."

11 Paragraph two: "The investigation regarding guilt
12 should be conducted regardless of any statement by the
13 client that evidence bearing upon penalty -- that evidence
14 bearing upon penalty is not to be collected or presented."

15 The essence is whether the client cooperates. And that
16 would be later in this case.

17 Do you have any recollection of whether or not the
18 client cooperated with your team in developing his case?

19 A At times.

20 Q And did you --

21 A Yes, and at times, and at times no.

22 Q And did you find his cooperation particularly helpful?

23 A I am probably at a disadvantage in terms of commenting
24 on that, primarily because Mr. Allen and John met with
25 Mr. Torres more than I did.

Kathleen J. Hodges
Direct examination by Mr. Ehliès

1 So, but I do know of instances. There was a -- some
2 medical exam that we had asked an expert to conduct and that
3 Mr. Torres did not cooperate with that exam. And I think
4 there were some issues in terms of calling some -- some
5 witnesses at -- that we were pretty much instructed to, you
6 know, kind of leave those issues alone.

7 Q Okay. And that's what this guideline is talking about.

8 A Right.

9 Q We have that after sentencing frequently on what we
10 call clients who are volunteers to death. Like I said, and
11 we've got a whole host of problems in dealing with that.

12 This guidelines is directed, and I'm looking at two,
13 paragraph two, of the one that just went away that says the
14 investigation regarding penalty should be conducted,
15 regardless of the cooperation or whatever you're getting out
16 of your client.

17 Okay. And so that was a factor in your case from what
18 I hear you saying.

19 A In two particular instances, yes, it was a factor.
20 Whether there are more than that, I don't recall.

21 Q All right. There's a mechanism and a practice within
22 the training -- capital litigation practitioners -- for how
23 to handle that with third parties.

24 Okay. Did you and Clay Allen or any other team member
25 discuss how to handle a reluctant client in doing medical

Kathleen J. Hodges
Direct examination by Mr. Ehliès

1 examinations?

2 A I don't remember a conversation regarding that.

3 Q Okay. And they're very similar to what we're going to
4 see also in the case of Crystal Williamson. Do you know
5 that name?

6 A Yes.

7 Q Crystal Williamson was the sole child of the deceased
8 Ann Emery.

9 A Yes.

10 Q Okay. The standard of practice involves getting third
11 parties to deal with a hostile witness. You don't recall
12 ever discussing any of that.

13 A I don't recall asking a third party to step in to deal
14 with either hostile witnesses or a hostile client.

15 Q or hostile client.

16 Do you know whether or not the victim outreach program
17 for capital litigators based in Atlanta was ever consulted
18 to reach out to the surviving family of the victims?

19 A I don't believe that we contacted them to do that. I
20 am familiar with the program, and I learned about the
21 program during the voir dire seminar that I went to, but I
22 don't remember if we -- if we contacted them or not.

23 Q Okay. And was the voir dire seminar you went to before
24 or after the trial of Andrew Torres?

25 A It was before.

Kathleen J. Hodges
Direct examination by Mr. Ehli

1 Q Okay. And do you remember why -- did you have someone
2 else, not the Atlanta group, to all other groups --

3 A Right.

4 Q Did you have anyone else performing the function of
5 victim outreach?

6 A I don't remember. I don't know.

7 Q If, as a consequence of victim outreach, you found very
8 significant and important victim family members who are not
9 in favor of death and actually had more to offer, would that
10 be a good thing or a bad thing in representing your client?

11 A That would have been a good thing.

12 Q Would that have been something you would have marched
13 right down front and center and say this is the door of the
14 deceased victim?

15 A Yes.

16 Q Would you hear what she has to say, what she has to say
17 if she's uncomfortable with death and a reason why she would
18 be uncomfortable with death?

19 A Yes.

20 Q Would that be something that would be helpful?

21 A Yes, it would.

22 Q Okay. In that regard 10.9.1 paragraph A of the norms,
23 minimum thresholds endorsed by two cases in South Carolina,
24 says that, "Counsel at every stage of the case have an
25 obligation to take all steps that may be appropriate in the

Kathleen J. Hodges
Direct examination by Mr. Ehliès

1 exercise of professional judgment in accordance with
2 guidelines to achieve." And what does that say?

3 A An agreed-upon disposition.

4 Q And what does that mean to you -- agree-upon
5 disposition, that phrase?

6 A I guess a result that everyone is bought into.

7 Q Would it -- would it surprise you to say the guilty
8 plea?

9 A Sure.

10 Q A negotiated resolution in terms of this statement,
11 what we're talking about, is securing a plea to avoid a
12 sentence of death?

13 A I would agree with that.

14 Q Okay. And we're about to wind this up.
15 What number was that?

16 A 10.9.1.

17 Q Thank you.

18 In that same section we have paragraph E way down
19 towards the bottom, and it deals with developing mitigation
20 evidence favorable to your client outside the litigation.
21 Ever heard the phrase from capital defense litigators that
22 if you're looking at the jury you've lost them? Does that
23 ring a bell?

24 A Sure.

25 Q There's a lot of effort to avoid that, is there not?

Kathleen J. Hodges
Direct examination by Mr. Ehli

1 A Sure.

2 Q Okay. On E it says, "If a negotiate disposition would
3 be in the best interest of the client." Can we agree that
4 in this case in light of the evidence against him it would
5 have been in the best interests of the client?

6 A Yes.

7 Q "Initial refusals by a prosecutor to negotiate should,"
8 what?

9 A "Not prevent counsel from making further efforts to
10 negotiate."

11 Q Okay. Do you know whether or not you and your team
12 ever visited Trey Gowdy to attempt to negotiate any kind of
13 a settlement in this case?

14 A I don't remember going to meet with Mr. Gowdy. I'm
15 sure that Mr. Allen and Mr. Reckenbeil did.

16 Q Okay. Do you know how many times they did?

17 A I do not.

18 Q Do you know what the result was? In the end,
19 obviously, we had a trial.

20 A That's true.

21 Q Do you know what the dialogue was as regards potential
22 conditions to achieve a negotiated resolution?

23 A I do not.

24 Q And is that because -- well, was that just an
25 administrative matter, or why did that happen? Why were you

Kathleen J. Hodges
Direct examination by Mr. Ehli

1 not involved?

2 A Well, you know, I guess I don't necessarily know why I
3 wasn't involved. I just know that, you know, that I wasn't.

4 Q Okay. Again, we've gone past that. But every team
5 member has full responsibility even though there is ultimate
6 responsibility with the lead counsel.

7 A Yes.

8 Q Okay. I'm going to go to 10.10.1. And this also --
9 the reason I've selected all of these guidelines is they
10 have specific application in this case.

11 This guideline says, "As the investigations mandated by
12 10.7" -- which we are looking at -- "produce information,
13 trial counsel should formulate the defense theory. Counsel
14 should seek a theory that will be effective in connection
15 with both guilt and penalty and should seek to minimize any
16 inconsistencies."

17 Did y'all meet about the strength of the guilt-phase
18 evidence?

19 A Yes.

20 Q And did you develop a theory to incorporate the
21 strength of the guilt-phase evidence that would support the
22 application and request to the jury for a life sentence?

23 A I don't remember any conversations that well
24 articulated, no.

25 Q And, in fact, did you ever have any team meeting about

Kathleen J. Hodges
Direct examination by Mr. Ehli

1 how to, what we call, front load? Do you know that
2 expression?

3 A I do know that expression.

4 Q Okay. How you would front load for the jury's purpose
5 information about a life sentence, supporting a life
6 sentence, when the case is overwhelming on the guilt phase?
7 Did you just talk about how to do that in this case?

8 A Yeah. I don't remember strategizing on that issue.

9 Q Okay. 10.11. Now, I know that you were sort of
10 involved as third chair and all, and maybe not involved in
11 the negotiations for a settling the case and that sort of
12 thing. But do you remember talking about this guideline,
13 that at every stage of the case continuing a duty to
14 investigate and continuing the pressure on the investigation
15 concerning the penalty?

16 A Yes.

17 Q For instance, whether missing records could be
18 recovered prior to putting a witness on the stand? Records
19 that were not available at the time maybe the initial
20 opinions were issued by your expert witnesses that could
21 possibly be obtained and presented to them before they
22 testified.

23 A Yeah. That would be something that I think we would
24 want to have pursued.

25 Q Okay. And paragraph two, F2, and I'm at 10.11, talks

Kathleen J. Hodges
Direct examination by Mr. Ehliès

1 about that in a little more detail.

2 It talks about favorable opinions, the client's
3 capacity to rehabilitation, adaptation and other medical
4 records.

5 In this case we're going to have testimony from
6 probably Mr. Allen that certain records were not available,
7 certainly in other suggestions by the expert witnesses that
8 were called.

9 We've heard from our experts how important those
10 records initially were in formulating the inquiry to
11 understand what those records were about, why the symptoms
12 were reported, needed to be investigated. Okay.

13 A Yes.

14 Q All right.

15 THE COURT: Mr. Ehliès, getting to a convenient
16 stopping point?

17 MR. EHLIES: And this is about there, Judge. I'm
18 going to review just one more, and it is on what we have
19 called the recommendation charge. It's 10.11. It's F.J.K.
20 No. It's K.

21 I don't know how big you can get that.

22 Q "Trial counsel should request jury instructions and
23 verdict forms that ensure that jurors will be able to
24 consider and give effect to all relevant mitigation
25 evidence. Trial counsel should object to instructions or

Kathleen J. Hodges
Direct examination by Mr. Ehliès

1 verdict forms that are constitutionally flawed or are
2 inaccurate or confusing and should offer alternative
3 instructions. Post conviction counsel should pursue those
4 issues through factual investigation and legal arguments."

5 Do you know whether you filed any motion with Judge
6 Couch to see and obtain a hard copy of every written
7 instruction from voir dire through the end of the case that
8 he was going to give to the jury?

9 A I do not -- I know I did not file any such motions. I
10 do not remember any other such motions being filed.

11 Q If you had available to you those records while you
12 were qualifying the jury would it be helpful for you in
13 formulating the questions you would ask them concerning the
14 law you knew the judge was going to charge?

15 A Yes.

16 Q And to be certain of what he was going to say.

17 A Yes.

18 Q And when is the time to make an objection? Is it
19 better to make it before something bad happens or is it
20 better to sit and wait until it happens and then make the
21 objection?

22 A Obviously, if you can avoid any objectionable material
23 being brought forth, we'd want to do that ahead of time.

24 Q And that standard also talked about verdict forms
25 and --

Kathleen J. Hodges
Direct examination by Mr. Ehliès

1 A Yes.

2 Q There is no reason that Judge Couch wouldn't have given
3 you the verdict forms in advance, is there?

4 A I don't -- I don't know that there are any particular
5 reason other than he just didn't, and that's not his
6 practice but...

7 Q But nobody asked him for them.

8 A No, not to my recollection.

9 Q If he had given them to you in advance and you saw
10 something misleading as far as the jury's role was concerned
11 would you have brought it up to him?

12 A Yes.

13 Q And made a suggestion or recommendation that he change
14 that?

15 A Yes.

16 Q And if you felt that it was serious enough would you
17 have put an objection in the record prior to it happening?

18 A Yes.

19 MR. EHLIES: Judge, this is a good point.

20 THE COURT: Okay. We're going recess for lunch.

21 We'll resume this afternoon at 2:30.

22 MR. EHLIES: Thank you, sir.

23 THE COURT: The witness is excused until then.

24 (Whereupon, a recess was taken.)

25 THE COURT: Ms. Hodges, if you will, come back around,

Kathleen J. Hodges
Direct examination by Mr. Ehliès

1 please.

2 All right. Mr. Ehliès.

3 MR. EHLIES: Thank you, sir.

4 BY MR. EHLIES

5 Q Ms. Hodges, I forgot to ask you if you have children.

6 A I do not.

7 Q Okay. You wound up actually handling the opening
8 statement, guilt phase, did you not?

9 A I did.

10 Q And I think that appears at 1605 in the trial
11 transcript. What did you do with your team members in
12 preparing that opening statement?

13 A We discussed essentially the opening statement -- what
14 we based on conversations I think with Mr. Allen and
15 Mr. Reckenbeil had had with the client as to, you know, how
16 we wanted to construct the opening statement.

17 And basically, you know, it was pretty important to the
18 client to put up a fight even though in our professional
19 opinion we felt that the evidence was going to be, you know,
20 clearly -- the fight in this case was going to be in the
21 penalty phase as opposed to the guilt or innocence phase.
22 But we -- you know, we discussed as to whether -- how to --
23 how to craft the opening statement. But it was essentially
24 kind of left up to me to actually develop it.

25 Q Okay. And did you do that? First off, when you

Kathleen J. Hodges
Direct examination by Mr. Ehli

1 mentioned client wanting to put up a fight and all, we
2 looked at the time A.B.A. guidelines about hostile clients.

3 A Yes.

4 Q And not overriding professional judgments.

5 A Yes.

6 Q And in your professional judgment you just alluded to,
7 what was your concern about the guilt-phase opening
8 statement in relation to the sentencing-phase function of
9 presenting the case in mitigation to the jury?

10 A In retrospect the opening statement, I guess, was kind
11 of diametrically opposed to -- well, I mean, in the opening
12 statement essentially, you know, we denied that -- we as a
13 team, you know, we're denying any culpability and asking the
14 jury to acquit the client.

15 Q Okay. And you're saying that that was a team decision
16 to present that way.

17 A That's my recollection, yes.

18 Q Okay. Did -- but the responsibility fell to you.

19 A Yes.

20 Q And would you agree to me, with me -- I am sorry --
21 that the opening statement may be the most important thing
22 that happens in the course of a trial with the jury in
23 developing relationships and credibility?

24 A I guess I would -- in most trials, yes. I don't
25 necessarily know that in terms of a death penalty trial -- I

Kathleen J. Hodges
Direct examination by Mr. Ehliès

1 mean, your first instance that you're building a
2 relationship and credibility with the jury is during the
3 voir dire process.

4 Q Correct. But as far as the single function with the
5 petit jury once they're in the box and you are presenting
6 yourself to that jury, isn't it very important to have their
7 good will and credibility, maintain your credibility with
8 the jury?

9 A I would say that's true, yes.

10 Q So even if the case is difficult and even if the client
11 is difficult, those are factors that you should consider in
12 formulating your opening statement to the jury.

13 A Yes.

14 Q Okay. And did you consult with anybody in doing that
15 work formulating the opening statement?

16 A I remember consulting with Mr. Allen about it and
17 discussing with him the conflict, but I don't know that I
18 consulted with anybody outside of kind of the defense team
19 about the issues.

20 Q You didn't do a video preparation, again, on your
21 opening statement --

22 A No.

23 Q -- with an expert to give you pointers about how to
24 change this, how to change that.

25 A No.

Kathleen J. Hodges
Direct examination by Mr. Ehliès

1 Q Okay. When you -- when you made your preparations and
2 developed a theory of not guilty -- would that be fair?

3 A Sure.

4 Q Did you do that in full awareness of what the evidence
5 was going to be from the state?

6 A Yes.

7 Q And were you involved in that aspect of the
8 investigation and developing the presentation being the
9 Brady materials and all of the physical evidence? And I
10 think in this case there was scientific evidence in the
11 number of features, is that correct?

12 A Yes.

13 Q D.N.A. included.

14 A Yes.

15 Q However, on the D.N.A., as opposed to the mitigation
16 side, is it your understanding and your recollection that it
17 was limited solely to purposes of comparing a known sample
18 from the defendant with an evidentiary sample taken from the
19 victim, Ann Emery, for purposes of an identification?

20 A Yes.

21 Q It was not used for medical purposes or for any other
22 aspect that you know of besides identification from the
23 evidence sample to the known sample.

24 A That is correct.

25 Q Okay. And when you prepared your statement did you do

Kathleen J. Hodges
Direct examination by Mr. Ehliès

1 so not only with all of the evidence in mind that the state
2 was going to have, but did you have a pretty good
3 understanding and grasp of what the defense evidence was
4 going to be?

5 A Yes.

6 Q And I want to now restrict that to your role at that
7 particular time, which was the opening statement at the
8 guilt phase. So you had a good awareness of the evidence
9 that the defense was going to present in its case to the
10 jury --

11 A Yes.

12 Q -- on guilt.

13 A Yes.

14 Q Did you prepare an opening statement in writing?

15 A In terms of crafting out like word for word?

16 Q well, or ideas and themes and functions and that sort
17 of thing.

18 A Yeah. I would have outlined it. That's usually my
19 practice, is I do some sort of an outline.

20 Q Okay. And did you share that in a presentation mode
21 with Clay Allen or anyone else? Did you ask --

22 A Not that I -- not in terms of actually doing the actual
23 presentation of the opening statement prior to coming into
24 the jury room, no.

25 Q when you did the outline and prepared that were you

Kathleen J. Hodges
Direct examination by Mr. Ehliès

1 aware that there was an initiative in the defense to argue
2 that maybe someone else was involved in the murder of Ann
3 and Ray Emery?

4 A Yes. I knew that there was an initiative involved,
5 that there was someone else involved. There certainly --
6 early on in our investigations and talking about the case we
7 thought that there's a good possibility that somebody else
8 was involved.

9 I do not remember at this point at what point we had
10 already had some initial rulings from the Court as to
11 admissibility of some of that evidence, so I don't know if
12 I -- you know, if any of that had been presented to the
13 Court or not.

14 Q All right. Now, you just mentioned that the evidence
15 was -- and I missed it -- was strong. How did you
16 characterize the evidence of someone else involved in the
17 murder?

18 A We had a good -- well, I mean, I can only speak for
19 myself. My suspicions in terms of developing the case, I
20 mean, I always suspected there was somebody else involved.

21 Q Okay. And did you suspect that based on interviews
22 with witnesses and other physical evidence?

23 A Yes.

24 Q For instance, do you recall whether Chuck Emery -- do
25 you know who Chuck Emery was?

Kathleen J. Hodges
Direct examination by Mr. Ehliès

1 A I do.

2 Q Do you recall whether he was living in the house where
3 the murders occurred in and about the time that they did
4 occur on May the 11th of 2007?

5 A Yes.

6 Q So had the law enforcement done a detailed forensic
7 investigation of the crime scene it is not likely that they
8 wouldn't have been picking up D.N.A. from the residence of
9 the household, including Ann Emery, including Ray Emery and
10 other people living in that household, isn't that true?

11 A If I understand your question correctly, the question
12 is that it's likely had Mr. Chuck Emery been living in the
13 home that a complete forensic analysis would have included
14 everyone else living in that home.

15 Q They would have discovered evidence -- physical
16 forensic evidence, D.N.A. and otherwise -- of other people
17 occupying that home.

18 A That's correct.

19 Q And were you ever presented by Brady motion or
20 otherwise to your recollection any forensic evidence of
21 anyone other than Ann Emery, Ray Emery or Tony Torres?

22 A No. Nobody else was identified.

23 There was some D.N.A. evidence that showed some other
24 unknown person, and, you know, but that was it.

25 Q Okay.

Kathleen J. Hodges
Direct examination by Mr. Ehliès

1 A We -- the known person -- Ann Emery, Ray Emery and Tony
2 Torres.

3 Q And did you -- in fact, your group team filed a Brady
4 motion?

5 A Yes.

6 Q Do you recall ever getting a response on the Brady
7 motion identifying witnesses who may support or be favorable
8 to that particular theory in your defense case that someone
9 else may have been involved?

10 A Not specifically.

11 Q Okay. And I know you only have a tiny file compared to
12 what's in the file.

13 A Yes.

14 Q Did you happen to look? Because I think you have our
15 application.

16 A I did.

17 Q And did you happen to look through the materials you
18 have to determine whether or not there was an indication
19 that the state ever put you on notice that there was
20 potential evidence in support of the idea that someone else
21 may have been involved, whether by witness or forensics?

22 A A part -- I mean, nothing specific in terms of the
23 state saying in response to defense's Brady motion the state
24 is now saying, you know, is providing us evidence that, you
25 know, a particular individual may have been involved.

Kathleen J. Hodges
Direct examination by Mr. Ehli

1 However, part of the reason why we thought somebody
2 else was involved is based on our conversations and
3 investigation and reading the discovery material provided by
4 the state.

5 Q All right. Well, did that discovery material lead you
6 to Phyllis White as a potential witness in favor of the
7 defense position?

8 A I do not remember the name Phyllis White.

9 Q Crystal Williamson?

10 A Crystal Williamson I know of as a person from her
11 testimony at the trial as the daughter.

12 Q And my question in that connection is do you remember
13 whether the state ever sent a Brady response to you that you
14 may want to talk to Crystal Williamson.

15 A No. They never did.

16 Q Or did they -- to your recollection did they do that
17 with any particular individual?

18 A No. We never got a response to the Brady motion as
19 a -- as a direct response to our request for Brady material.

20 Q And did they ever send you a notice that they
21 selectively approached the forensic evidence instead of
22 globally?

23 A No.

24 Q To isolate out just three people instead of everybody
25 that may have been in that house?

Kathleen J. Hodges
Direct examination by Mr. Ehliès

1 A No.

2 Q When you crafted your opening statement did you do that
3 assuming any third-party guilt may be presented in the
4 chief -- case in chief on guilt base?

5 A I honestly don't remember.

6 Q You do remember -- and are you testifying from
7 independent, current recollection about the case?

8 A Yes.

9 Q Is it a case that sort of lives with you, I suspect?

10 A It is a case that lives with me, yes, but it has been,
11 unfortunately, six years, and a lot has happened.

12 Q Yes. Okay. So when you prepared your opening
13 statement -- and you can't say that you have a current
14 independent recollection as to whether you were
15 incorporating in your initial ideas and theories about your
16 opening statement -- third-party-guilt witnesses?

17 A That is true. And I'll tell you that it is my practice
18 to try not to broach things in opening statement that I
19 don't know for sure that I'm going to be able to get in. So
20 if there's an issue that may be controversial or if there's
21 an issue that -- that I'm not sure what the Court's ruling
22 is going to be, you know, I might not -- you know, I usually
23 don't incorporate that into an opening statement.

24 Q All right. And the reverse would be the truth also,
25 would it not, that you wouldn't volunteer to the jury

Kathleen J. Hodges
Direct examination by Mr. Ehliès

1 something you were uncertain about and may not play?

2 A That's true.

3 Q But you would address what is definitely coming in and
4 you know is going to happen.

5 A More than likely unless the client's told me that he
6 wants me to fight it. And then, you know, I -- I cede to
7 the client's wishes in this case.

8 Q To the exclusion of your independent, professional
9 judgment and obligations under the A.B.A. standards?

10 A I don't know that I would -- I think that is a fair
11 characterization. I don't know that I feel comfortable in
12 admitting that. But I think that's a fair characterization.

13 Q There's a lot that may be uncomfortable, and I respect
14 that, and I'm sorry for it. But you understand my point.

15 A I absolutely do.

16 Q Okay. In this case you knew about what was going to
17 happen, and you had uncertainty about the possibility of
18 third-party guilt. But wasn't that issue resolved in a
19 proffer prior to the jury being in for opening statement
20 before Judge Couch? And I think the record indicates that
21 you were present.

22 A Yeah, and it is -- it very well -- I mean, that very
23 well could be. I don't, you know, recall that, but, you
24 know, I would have to definitely rely on what the record
25 shows.

Kathleen J. Hodges
Direct examination by Mr. Ehli

1 Q Okay. And Mr. Reckenbeil, in fairness to you, was in
2 charge apparently of conducting the examination of the
3 witnesses --

4 A Yes.

5 Q -- that are in the transcript. And you did not. And
6 as far as the transcript is concerned you did not actually
7 participate in the questioning of any of the witnesses as
8 regards third-party guilt.

9 A That is true.

10 Q My question to you is though that issue was presented
11 in response to the state's motion, if you might recall, to
12 exclude it.

13 A Yes.

14 Q And do you recall that?

15 A I do recall the state making that motion.

16 Q And so that came before the judge prior to your opening
17 statement to resolve the issue.

18 A Yes.

19 Q And do you remember what the judge's ruling was?

20 A My recollection is the judge ruled that third-party
21 guilt was not going to be allowed.

22 Q Okay. And based on the showing that had been made, and
23 the proffer.

24 A Yes.

25 Q And it was not your responsibility, was it, to

Kathleen J. Hodges
Direct examination by Mr. Ehli

1 determine what the law was on third-party guilt or what else
2 is involved in admitting it or using it? Is that something
3 that would have fallen to Mr. Reckenbeil?

4 A That is correct.

5 Q Did you ever get an assignment to participate in a
6 research project to determine what the law is to govern
7 that?

8 A I don't remember getting that -- that assignment.

9 Q All right. Now, so the third-party guilt is resolved
10 and you take the fee -- you take to your feet. And you're
11 going to go up and make your opening statement, right?

12 A Right.

13 Q And I think -- well, I don't know how we're going to
14 get it big enough. Can I have a copy? Let me give you a
15 copy.

16 (Pause.)

17 Q Okay. I'm getting a lot of help, and I hope you did
18 when you went through this. But the purpose of the team was
19 for everybody to pull together, correct?

20 A True.

21 Q One of the things that happens frequently is resistance
22 from clients if you're talking to them. Did you have a lot
23 of dialogue with Tony frequently?

24 A Yes.

25 Q Okay. And you would go to jail and visit with him.

Kathleen J. Hodges
Direct examination by Mr. Ehliès

1 A Yes.

2 Q And the jail log would reflect that. How many --

3 A Not necessarily.

4 Q Well, the public defender goes in outside in this --

5 A Yeah. And at times our case -- you know, our contact
6 would be logged. At times it wasn't, you know, so.

7 Q Did you ever talk to Tony about his resistance in
8 wanting to fight if you felt it was the wrong thing to do?

9 A I did not. That was not a role that I took on. I
10 mean, Tony had a better relationship with Mr. Reckenbeil in
11 terms of talking at the jail from my recollection, as well
12 as -- you know, and Clay and John did most of the talking
13 with him at the jail.

14 Q In fact, they were the ones that went to negotiate with
15 the solicitor.

16 A That's correct.

17 Q To your exclusion, unfortunately.

18 A Well, true. And, you know, at that point I was also
19 handling other cases. I mean, you know, I was only
20 protected as to this case for a -- you know, just a brief
21 period of time prior to the actual trial.

22 Q Okay. Did you have two statements prepared, one in the
23 event that third-party guilt was admitted and one in the
24 event that third-party guilt was excluded?

25 A I don't remember. You know, my file doesn't -- doesn't

Kathleen J. Hodges
Direct examination by Mr. Ehli

1 indicate. I -- actually, I can't find any of my notes from
2 my opening statement in my file, so.

3 Q All right. In light of what we've been through as far
4 as the importance of the opening statement and not to
5 volunteer what we don't know is going to happen and to make
6 sure you maintained your credibility with the jury, let's
7 take a look at this.

8 We're talking here about your introduction to the jury.
9 Ms. Hodges, Monday morning. It's been a long time since
10 Monday morning. And then in this first part -- we'll skim
11 through. You reviewed with the jury everything that's been
12 presented to them by indictments.

13 A Right.

14 Q Seven indictments. And you go through those. The
15 state went through them. They've been through them on voir
16 dire. They know what the charges are. But you repeated
17 that here.

18 Was there a particular reason for reiterating all of
19 the six charges?

20 A Not that -- no.

21 Q Okay. Let's just scroll through.

22 Then in this portion of the charge I'm really happy
23 with, because you pointed out in the middle, "The state in
24 this case has -- will choose which witnesses to present to
25 you. The state in this case is going to choose -- choose

Kathleen J. Hodges
Direct examination by Mr. Ehliès

1 whether to make this a capital crime or not. The state in
2 this case goes first, and you go through these matters. And
3 when I say elements, I'm talking about the factors in the
4 law of the case."

5 Okay. And I understand why that may be strategically
6 significant for you.

7 Then we're taking a turn. Most important thing -- do
8 you see where I am on 19? "Most important thing for you to
9 realize in this particular case is that it's the state's
10 burden to prove each of these elements. And if you do not
11 prove any particular element, then you have the duty to
12 consider as to whether the state has proven the case to you
13 beyond a reasonable doubt."

14 Okay. Now, that's the first time we've alerted the
15 jury that you're counting on a verdict based upon
16 constitutional principle of the state having the burden of
17 proof, and not based upon anything factual at that point, is
18 that correct? You're claiming the constitutional law.

19 A Sure.

20 Q And nothing particular to this case.

21 A Sure.

22 Q And they've heard that before.

23 A Presumably, yes.

24 MR. EHLIES: Okay. Next.

25 Q All right. "Mr. Tony Torres is pleading not guilty to

Kathleen J. Hodges
Direct examination by Mr. Ehliès

1 each and every one of these indictments. He's put the state
2 on notice that they have to prove their case to you. He
3 asks for the right to a jury trial. As the judge told you,
4 the criminal justice and the heart of our foundation
5 cornerstone" -- jury trial and defendant's presumption of
6 innocence. "Telling you he's not guilty."

7 And then you start talking to them about circumstantial
8 evidence. Do you see that? "I can go outside."

9 A Sure.

10 Q You say on lines 13, 14 and 15, "The first thing about
11 presumption of innocence that that is -- that this is a case
12 of circumstantial evidence." And you give them an example
13 of circumstantial evidence.

14 And on line 23 -- 24, 21 and 23 -- "They're not going
15 to provide it to any direct proof from the elements involved
16 in these indictments. No live witness testimony."

17 I presume what you meant from that is no eye witness.

18 A Yes.

19 Q Because there were a lots of live people, correct?

20 A Everybody that came to the witness stand was alive,
21 yes.

22 Q Right.

23 A It would have been no eye witness testimony.

24 Q Okay. And they would have had something to offer.

25 A Yes.

Kathleen J. Hodges
Direct examination by Mr. Ehliès

1 MR. EHLIES: Okay. Let's scroll over.

2 Q You're not going to see any evidence proving to you
3 that Tony Torres poured gasoline throughout that house.
4 You're not going to have any evidence proving to you that he
5 was the one that turned on the stove. You'll have evidence
6 that the stove was turned on, but there's no fingerprint
7 evidence from the stove. You're not hearing any evidence
8 about fingerprints from the stove."

9 MR. EHLIES: Next.

10 Q "There's no signs of forced entry. You're not going to
11 see any quantity of blood, any evidence or testimony of a
12 quantity of blood that was on Tony Torres to corroborate the
13 amount of blood that you're going to see. You're going to
14 see pictures, I'm sure, and you're going to hear
15 descriptions of the scene, I'm sure, and you're going to
16 hear that it is a bloody scene." Correct?

17 A Correct.

18 Q "It's blood spatter basically throughout this bedroom.
19 You're going to see it on evidence. You're going to see it
20 on pictures. You're going to hear testimony about it. But
21 what you're not going to hear, you're not going to hear any
22 evidence that corroborates blood on him. You're going to
23 hear an incomplete analysis of the evidence. Evidence was
24 collected. Evidence was sent to the state laboratory for
25 investigation, for analysis. And much of the evidence they

Kathleen J. Hodges
Direct examination by Mr. Ehliès

1 didn't even analyze. Some of that evidence they claimed to
2 have been submitted wasn't even submitted. You're not going
3 to hear any definitive evidence that alleged murder weapon,
4 the hammer was in his hand. You're going to ask -- they're
5 going to ask you to try and draw the inference that the
6 murder weapon was in his hand, but you're not going to hear
7 any definitive evidence that the weapon was in his hand.
8 And all that brings me to the second point about presumption
9 of innocence, because the bottom line, presumption of
10 innocence, means that Tony Torres is not guilty. He is not
11 guilty on May 11th; he was not guilty when they served
12 notice; he was not guilty on Monday morning; he's not guilty
13 on the days that you were here being questioned; he's not
14 guilty today; he is not guilty tomorrow."

15 I counted nine of them in reference to not guilty. And
16 you can count them, but would I be basically correct in
17 that?

18 A Yes.

19 Q So the opening statement -- the opening statement then
20 focused on two things, circumstantial evidence, which draws
21 me to the question of whether you asked for that definition
22 from the judge in advance in making that statement, what
23 charge he is going to use.

24 A I do not remember asking the judge for any definition
25 prior to the opening, making any opening statement.

Kathleen J. Hodges
Direct examination by Mr. Ehliès

1 Q And excuse me just a second.

2 (Pause.)

3 Q The opening statement then focused on the
4 circumstantial evidence as you understand the rule to be in
5 South Carolina.

6 A Yes.

7 Q And you did not ask for a copy of the judge's charge
8 before you did that.

9 A That's correct. I did not.

10 Q The second aspect of it was the burden of proof being
11 that Tony was not guilty.

12 A Right.

13 Q And you stressed that to the extreme, is that correct?

14 A Sure.

15 Q So I want to ask you what you were planning to do with
16 the fingerprint evidence of Tony that was lifted from the
17 items in the van and the van itself in which he was found to
18 be in control of a few minutes, 27 minutes, later. And the
19 van was wrecked. You remember he was driving.

20 A Sure.

21 Q The -- okay.

22 MR. EHLIES: Could I have just a break a second?
23 Could I speak to you a second?

24 THE COURT: Sure.

25 Q Excuse me.

Kathleen J. Hodges
Direct examination by Mr. Ehliès

1 A Sure.

2 (Bench conference held off the record.)

3 THE COURT: We're going to take a short break. Then
4 we'll resume.

5 You can step down.

6 THE WITNESS: Yes, sir. Thank you.

7 (Whereupon, a recess was taken.)

8 MR. EHLIES: Thank you, Judge, for your patience.

9 THE COURT: Sure.

10 MR. EHLIES: I appreciate it.

11 BY MR. EHLIES

12 Q We were talking about your opening statement and
13 whether it complied with the general rules to make things
14 work in both a guilt phase and a sentencing phase in a
15 capital case.

16 A Yes.

17 Q And in that context we were talking about building
18 credibility and that sort of thing and focused on two
19 components to your opening statement, one of which was the
20 circumstantial-evidence rule and how we define that in South
21 Carolina. The other was the overwhelming expression.

22 would it be fair to say nine references in the
23 paragraph to not guilty is a pretty strong reference to the
24 jury that something's coming, he's not guilty?

25 A Yes.

Kathleen J. Hodges
Direct examination by Mr. Ehliès

1 Q Okay. In that regard I would ask -- I think this is
2 where I actually left off.

3 "You remember that Tony was caught in the Ray Emery
4 van, or registered to Ray Emery van, just a few minutes --
5 27 miles down the road towards Union. Got in a wreck,
6 single-car wreck. And law enforcement at a little bit
7 before 7:00, right at 7:00 a.m. on Friday morning in Union,
8 called for a welfare check to the Spartanburg sheriff's
9 department based on the registration of the tag to get
10 Spartanburg to come and check on the Emerys." Do you
11 remember that?

12 A I do.

13 Q And so that's how it all unfolded in this whole thing,
14 because once they got there -- we'll talk later about what
15 happened.

16 Okay. But what did come out in the case were a lot of
17 things that I just wanted to mention to you. I was going to
18 go stretch that out a little bit, but under the
19 circumstances I think I'm just going to mention it to you.

20 They got eye witnesses -- four of them -- at the Union
21 County crash site scene that identified Mr. Torres. They
22 testified -- three of them or more.

23 They had a video from the store, the convenience store,
24 that he went into there at the scene of the wreck and got a
25 ride, paid a fellow to take him to the hospital in

Kathleen J. Hodges
Direct examination by Mr. Ehliès

1 Spartanburg. And they had that fellow as an eye witness who
2 rode with him. Do you remember that?

3 A I do.

4 Q And when he got to the Spartanburg hospital on the ruse
5 that his wife was there admitted or something. He was on
6 the video cameras there in Spartanburg. And so they had
7 like four or five eye witnesses, fingerprints.

8 They had the videos; they had some forensic analysis,
9 because you remember very shortly, within an hour of the
10 police doing the investigation at the murder site, they were
11 at Tony's grandmother's house where Tony was. They'd
12 already picked up on who they thought was a suspect. And
13 they went there, and they retrieved clothing and tennis
14 shoes from Tony's house where he was at his grandmother.
15 And do you remember they were in there?

16 A Yes. They were in the washing machine.

17 Q And they extracted those shoes. And then on page 2076
18 -- you don't need to go there -- 20 -- I'm just going to
19 summarize this. We had all of these points laid out --

20 A Sure.

21 Q -- on 2076 and 77. They dealt -- dealt in the trial
22 record with Exhibit 42.5, which was Ann Emery's blood on
23 Tony's shoe. It was his right shoe that was positive
24 identification.

25 They did lift blood on his left shoe, but they didn't

Kathleen J. Hodges
Direct examination by Mr. Ehliès

1 attribute that to anybody for -- there wasn't enough, I
2 think, to profile it.

3 They also had -- and I think you may have questioned
4 Easler who is a dog handler.

5 A Roger Means was a dog handler, was the arson dog
6 handler.

7 Q Okay. Easler --

8 A Easler. But Easler I think worked in -- in -- also as
9 one of the crime scene analysts or investigators or whatever
10 that came in and took some -- some evidence.

11 Q And that included some swabs from the shoes.

12 A Yes.

13 Q And that came back -- not only was it an alert -- do
14 you remember that the dog alerted on the shoes? On page
15 1848 of the trial transcript, it was an item -- was in
16 evidence Item 80. But you remember that.

17 A I do.

18 Q Okay. And of course they did lift an evidence sample
19 of semen from the body of Ann Emery. And it was very
20 unclear as to whether there was sperm involved. But the
21 references are generally to semen. And that was
22 Exhibit 34 -- and it's on 2074 of the record. And you
23 remember that that came back with words that not supposed to
24 be used but were used -- match.

25 A Yes.

Kathleen J. Hodges
Direct examination by Mr. Ehli

1 Q And so the testimony was as I recall that the evidence
2 sample was identified as being contributed by the known
3 sample. And the person who provided pursuant to the
4 Schmerber request the known sample was Tony Torres.

5 A Right.

6 Q So that evidence was going to the jury. And although
7 the murder weapon was not placed in his hand when there was
8 no third party allowed then -- and Tony's got the blood on
9 his shoes, gasoline on his shoes and the other evidence --
10 how were you anticipating -- and right now the page number
11 escapes me for the end of the state's case. We need to see
12 that page number.

13 I can tell you though that -- that it's not quite as
14 dramatic for the decision-maker in this case. But at the
15 end of the state's case they made a very good clear
16 statement to the jury that they rest. Do you remember what
17 the next thing was that happened?

18 A I do not.

19 Q Court turned to Mr. Allen and said, "Mr. Allen, do you
20 have any evidence to present if you choose?" And Mr. Allen
21 said -- do you remember what he said?

22 A I presume he said no but...

23 Q Correct. So the state presented the entire case and
24 the defendants presented nothing.

25 A True.

Kathleen J. Hodges
Direct examination by Mr. Ehliès

1 Q And when I read it I was a little concerned for where
2 we were going with the opening statement when the known
3 physical evidence in advance was very strongly incriminating
4 of the client in that case.

5 A Yeah. The known physical evidence in advance was very
6 strong indicating the client's presence at the scene.

7 Q I agree.

8 A The known physical evidence in the case did not prove
9 entry into the home without permission, did not prove
10 actual -- well, the known physical evidence presented proves
11 that the Emerys are killed.

12 You know, I still think that there was an argument that
13 the Emerys -- there's no evidence that the Emerys were
14 killed by Mr. Torres.

15 You know, the known physical evidence still did not
16 answer each of those elements that I articulated in the
17 opening statement that the state was going to have to prove
18 concretely enough to the exclusion of any sort of other --
19 you know, I guess other conclusions the jury could have
20 drawn had they chosen to draw that conclusion.

21 Q Okay. And so what I hear you saying is that although
22 there was a lot of evidence to support the conclusion that
23 Tony Torres was present at the murder scene with the two
24 bodies, that his D.N.A. was in Mrs. Ann Emery's body, that
25 there was no reason to conclude that Tony himself was the

Kathleen J. Hodges
Direct examination by Mr. Ehli

1 one that broke into the house if there was a break-in,
2 because there is no evidence of it.

3 A Right.

4 Q Do you remember there was no evidence --

5 A That's right.

6 Q -- of forcible entry? Who had the key to that house,
7 by the way? Do you remember?

8 A Chuck Emery would have had a key to the house.

9 Q Chuck Emery had a key to that house.

10 Okay. That was your position since there was no real
11 physical evidence that it was Tony that did those things,
12 they couldn't conclude that it was Tony that did those
13 things.

14 A That was -- that was -- that was the -- the premise
15 behind my opening statement.

16 Q Okay. Now, I'm troubled with that because if it walks
17 like a duck and it quacks like a duck, then it must be a
18 duck. Something about that troubled me greatly.

19 So did you -- did you switch away from third-party
20 liability? Because that was the perfect explanation for
21 your position underpinning your opening statement.

22 A Right.

23 Q But it wasn't there.

24 A Right.

25 Q So did you make a shift in recognition that the judge

Kathleen J. Hodges
Direct examination by Mr. Ehli

1 said it isn't going to be there and calculate and
2 recalculate what you needed to do with the jury to protect
3 in the mitigation case, or did you present what you were
4 planning to present, and you present it?

5 A You know, I honestly don't remember recalculating or
6 replanning or rethinking, you know, redefining the argument.
7 I can't tell you one way or the other.

8 Q And it was page 2124 if you need to confirm whether I
9 remember this correctly that the state rests.

10 Okay. In the opening statement -- we do need to pull
11 up the opening statement of Mrs. Crick. Do you remember
12 Lance -- Lance Crick?

13 A Cindy.

14 Q Her husband is U.S. assistant --

15 A Yes.

16 Q -- from Greenville.

17 A Yes.

18 Q You remember she made the opening statement.

19 A She did.

20 Q Y'all had just finished making the proffer. It was
21 very close. You had actually, I think, gone through jury
22 selection, and it was in that window of time before you
23 actually started the trial a proffer was made on third-party
24 guilt.

25 A That's correct.

Kathleen J. Hodges
Direct examination by Mr. Ehliès

1 Q And you were going straight into the trial of the case.
2 was that your recollection?

3 A That's my recollection.

4 Q So then after the ruling came down denying the right to
5 third-party guilt -- and I need to be able to quote this
6 exactly how it happened in the opening statement from
7 Mrs. Crick.

8 MR. EHLIES: If you could, give us just a second,
9 Judge.

10 (Pause.)

11 Q Okay. This is what it says on Mrs. Crick.

12 "Sometimes in life we have a tendency to make things
13 very complicated and overlook the obvious. I think what
14 you're going to find out in this case, that it's not that
15 complicated. All of the forensic evidence that you will
16 hear about points to one person, and only one person.

17 Now, you heard her say that. In fact, that was the
18 last thing she said before you got up, that this is entirely
19 Tony Torres, no one else.

20 Did you and your team think that that theory of the
21 case from the government was wrong and that you had evidence
22 that they had opened the door to a representation to this
23 jury that it is entirely Tony, which you knew and suspect
24 was not true --

25 A Right.

Kathleen J. Hodges
Direct examination by Mr. Ehliès

1 Q -- to then get a sidebar with the judge and say they
2 have just opened the door to allow what you said is not
3 third-party guilt because it explains the theory of the
4 government's case is wrong, or at least suggests that?

5 A That certainly would have been an ideal time to bring
6 that to the Court's attention if obviously -- either I
7 missed it or didn't think of it because -- well, obviously,
8 that didn't happen. The record doesn't show that that
9 happened.

10 Q That's correct. But you were not alone there.

11 A That is correct. I was not.

12 Q And worse than that, it was you that was going to get
13 up, and why do I have these people here with me while I'm
14 standing here talking, what are they doing.

15 A They are thinking.

16 Q They are thinking, and they're writing and throwing in
17 more notes than I can stand.

18 A That's right.

19 Q That's what they're supposed to do. And did that
20 happen on your team?

21 A No. I do not recollect that happening.

22 Q So that's a potential, at least a potential,
23 opportunity to change what happened in the jury's attitude
24 about this case. One person, and one person only, is not
25 true based on what your witnesses were saying.

Kathleen J. Hodges
Direct examination by Mr. Ehliès

1 A That's -- that is correct.

2 Q And that would introduce the whole question as to
3 whether or not the other people -- what testimony would be
4 admissible for another reason.

5 A Yes.

6 Q Which is to dispel and disprove the government's case.

7 A Yes.

8 Q The theory of their case.

9 Okay. The second thing then about the opening
10 statement was -- and I want to go to the State vs. Wayne
11 Edwards.

12 MR. EHLIES: Can you get there?

13 Q Now, we've talked about the importance of front-end
14 loading, and we've talked about the importance of training
15 in capital litigation to condition your case and posture
16 your client to where if something happens to change the law
17 it will be to his advantage. You'll be in a position to
18 take it, and the record's protected, is that true?

19 A That is true.

20 Q And one of the big things for you was circumstantial
21 evidence and how that's defined in South Carolina.

22 A Yes.

23 Q And that at the time of this trial was a very fluid
24 situation, because the State vs. Wayne Edwards in 1989 set a
25 definition, a charge, that was very favorable to your client

Kathleen J. Hodges
Direct examination by Mr. Ehliès

1 and the circumstances of your case.

2 And I am going to read it to you if you can get there
3 and lift that out.

4 "Every circumstance relied upon" -- this was the
5 state's approved charge. "Every circumstance relied upon by
6 the state to be proven beyond a reasonable doubt; and all of
7 the circumstances so proven be consistent with each other
8 and taken together point conclusively to the guilt of the
9 accused to the exclusion of every other reasonable
10 hypothesis." You see how that goes on?

11 A Yes.

12 Q Well, what happened next -- and I'll drop off and get
13 Grippon -- was just before your trial. In 1997 the state
14 revisited that, and this was the third time they had
15 revisited circumstantial evidence. And they issued another
16 statement.

17 "However, we never rejected reasonable hypothesis
18 phraseology or found this phrase shifted the burden of
19 proof. In fact, use of a similar phrase was recently
20 approved."

21 And then they gave this charge on the right as the
22 preferred charge in South Carolina on circumstantial
23 evidence. And this I will represent to you -- Grippon
24 charge -- was the charge that was in place at the time that
25 you tried this case.

Kathleen J. Hodges
Direct examination by Mr. Ehliès

1 And you will see that this is a very different charge.
2 First, they talk about direct evidence, and then
3 circumstantial evidence, proof of chain of facts,
4 circumstances indicating the existence of a fact. The law
5 makes absolutely no distinction about the weight or value,
6 either direct or circumstantial evidence. Nor is a greater
7 degree of certainty required of circumstantial evidence than
8 of direct.

9 Do you see how that's fundamentally different for your
10 purposes?

11 A Yes.

12 Q Okay. Well, what happened next was the Supreme Court
13 of South Carolina revisited Grippon. Right. You knew that
14 was coming, didn't you, because you read your advance sheets
15 and you know Lippon -- Logan. Sorry. And what they did in
16 Logan -- now, this is new, relatively new.

17 Okay. But the point is that while this case was on
18 appeal and in the process, for yet a fourth time the Supreme
19 Court revisited. "While direct and circumstantial evidence
20 carry the same value, the jury cannot accurately analyze
21 these two types of evidence using identical approaches."

22 Okay. And then the next statement that they made
23 recognizing their error in the Grippon change, "While direct
24 and circumstantial evidence carry the same value, unlike
25 direct evidence, evaluating circumstantial evidence requires

Kathleen J. Hodges
Direct examination by Mr. Ehliès

1 jurors to find that the proponent of the evidence has
2 connected collateral facts."

3 Okay. So they start talking now about where they were
4 in the Edwards charge.

5 And so then on page nine they make the statement,
6 "Without this instruction, the jury does not know that this
7 critical step in the reasoning process exists," between how
8 do you handle circumstantial evidence. And then they offer
9 then yet another definition starting at the bottom of page
10 nine and going over to page ten.

11 They give the Court and you and I another definition.
12 "Direct evidence directly proves," and it's a hybrid that
13 draws the jury into the function of doing what you wanted
14 them to do, exactly what you wanted them to do, which is
15 it's not enough to find circumstantial evidence points, but
16 you've got to know how to analyze that in the context of the
17 burden of proof.

18 So they met again in 2013, changed Grippon and actually
19 jeopardize it as flat reversed by this case.

20 Okay. So when that all was unfolding had you asked for
21 his charge, compared it to the charge just prior to that in
22 Edwards and positioned yourself with it, you may have had an
23 advantage taken, or even asked the judge to soften the
24 landing on his circumstantial evidence. Did you do that?

25 A We did not.

Kathleen J. Hodges
Direct examination by Mr. Ehliès

1 Q And did anybody suggest to you to question this fluid
2 definition of circumstantial evidence since it was so
3 important to your case?

4 A No.

5 Q Okay. Now, the State vs. Miller pretty well -- you
6 understand that murder can be proven circumstantially.

7 A Oh, absolutely.

8 Q State vs. Miller was it. And the three basic things to
9 establish murder -- motive meaning -- we know what the
10 definition is, taken in the light of being the malice
11 aforethought.

12 A Right.

13 Q But basically in the investigative effort, when the
14 police are investigating it, they're looking for motive,
15 means and an opportunity. That's State vs. Miller.

16 A Yes.

17 Q When they affirm the conviction in an alibi.

18 Okay. Now, we have talked. I'm skipping right down to
19 get to the core of this and let you go.

20 Okay. We talked about Brady.

21 A Yes.

22 Q And we also talked about the resistance of the client.
23 But you said -- and I want to underscore and make sure I
24 understand correctly -- that really the dialogue between the
25 client and the team was through Mr. Reckenbeil and Clay

Kathleen J. Hodges
Direct examination by Mr. Ehliès

1 Allen much more so than with you.

2 A That is true.

3 Q So you never really had any arguments with Mr. Torres,
4 the client, about strategy and theories.

5 A Oh, no.

6 Q And you didn't have any direct involvement in trying to
7 let -- or get him to go along with what you thought or would
8 have thought a better approach to handling the case in the
9 guilt phase would have been.

10 A The only -- the only issue that we had that I remember
11 having any direct contact with him in that respect was
12 dealing with some issues regarding challenging the evidence
13 that came from his grandmother's home and the entry into the
14 home, and then the issues of getting the clothes from the
15 washing machine and those sorts of things and the motion to
16 suppress on those issues.

17 Q And --

18 A And I remember kind of walking through in terms of why
19 we were approaching it the way we were approaching it in
20 order to -- to explain that.

21 Q And those motions were made and heard and ruled on.

22 A That's correct.

23 Q So they were protected for appeal and all of the rest
24 of that.

25 A That's correct.

Kathleen J. Hodges
Direct examination by Mr. Ehliès

1 Q And I have absolutely no fault with that. That's
2 exactly what should have been done.

3 Okay. So he didn't resist to the point that he asked
4 you not to do that.

5 A That is correct.

6 Q Now, you know, and you and I have talked, about one of
7 the big issues that we have in this case is how we feel the
8 recommendation issue came. Now, and by recommendation I
9 mean that when the judge charges the jury about what their
10 role is.

11 A Right.

12 Q Okay. Now, I want to go to that if we can very
13 briefly. And that would be the judge's charge on
14 recommendation. You can draw that up. It's an exhibit to
15 the summary judgment motion -- D.

16 while she is doing that let me -- let me suggest to you
17 that the statute, 16-3-20(c), has a phrase in there that the
18 jury shall make a recommendation as to whether the defendant
19 should be sentenced to life or sentenced to death. Are you
20 familiar with that?

21 A I am.

22 Q Immediately after that there's a sentence that says,
23 "If the jury recommends death, the judge must impose --
24 shall impose."

25 MR. EHLIES: Can you get that sentence? It's in the

Kathleen J. Hodges
Direct examination by Mr. Ehli

1 recommendations under the statutes.

2 (Pause.)

3 Q I'm going to read it, believe it or not, and I'll read
4 it to you to make sure I get it absolutely correct. I know
5 that it's in there.

6 "The jury, if its verdict is a recommendation of death,
7 shall designate in writing and signed by all members of the
8 jury the statutory aggravating circumstances. Where
9 statutory aggravating circumstance of" -- okay. Here it is.
10 It's the paragraph below the process defined by the
11 legislature. And do you know the difference between a
12 procedural statute and a substantive statute -- substantive
13 statutes being the definition of murder, the definition of
14 criminal sexual conduct? Those are intended to be read to
15 the jury.

16 A Yes.

17 Q Procedural statutes aren't --

18 A That's correct.

19 Q It sets forth this is how we want you to do a death
20 penalty case. And this statute sets forth the procedure for
21 doing that.

22 In the next paragraph it says, "where a statutory
23 aggravating circumstance is found and a recommendation of
24 death if made the trial judge shall sentence the defendant
25 to death." There's no discretion about it.

Kathleen J. Hodges
Direct examination by Mr. Ehli

1 Okay. But what is happening is that the judge is only
2 select-out recommending, and in this case it appeared
3 throughout the charge, initially, 61 times. In the other
4 group charge, remember he gave a charge at the beginning of
5 the sentencing there that their sole role is to make a
6 recommendation. He never stated in that that he would
7 follow the recommendation.

8 So my point there is that under State vs. Davis if he
9 does not make it plain to the jury that they are the
10 sentencing authority and that he must impose the sentence
11 they return, then the charge is defective and it violates
12 Caldwell vs. Mississippi, as well as our state law, Davis,
13 and Clemmons and everything before Caldwell, which held that
14 the judge has to convey clearly to the jury that they are
15 the sentencing authority and he will impose the sentence
16 they return.

17 So did you make any objections at all or talk about it
18 in your team group, about that recommendation reference?

19 A I did not make any objections and I do not recall any
20 discussion amongst our team about it.

21 Q Okay. And was there any particular person assigned to
22 watch that sort of thing in the statute?

23 A You mean assigned to watch that thing in the charge?

24 Q Yes. What we'll do is we'll say you pay attention to
25 the witness while you're talking to the witness and all, I'm

Kathleen J. Hodges
Direct examination by Mr. Ehli

1 going to watch the judge?

2 A Right.

3 Q Or --

4 A Yeah. I don't remember. If we had anybody assigned to
5 do that, I don't remember what those assignments were.

6 Q Okay. So you can't say definitively that someone was
7 not assigned to be paying attention to exactly what the
8 judge was saying and nothing else.

9 A That's correct.

10 Q Not to be distracted with anything else.

11 A That's correct.

12 Q So far as you know there was no attention paid to that
13 charge.

14 A Yeah. No specific attention paid to that charge in
15 reference to those issues, no.

16 Q Okay. Now, the charge was given in two parts. At the
17 beginning your sole role is to make a recommendation. No
18 reference to him following it.

19 So was there any way since you didn't have his full
20 charge at the end of the case that you would have known at
21 that point that he would ever say, by the way, I'll follow
22 your sentence, I'll follow your recommendation and impose
23 the sentence? As far as you knew when he finished the first
24 charge he would never make that statement, isn't that true?

25 A Yeah. We -- we did not have his written charge in

Kathleen J. Hodges
Direct examination by Mr. Ehliès

1 advance, so we did not know what to anticipate or to expect.

2 Q And Mr. Reckenbeil on interview, I will relate to you,
3 had a good relationship with Judge Couch. And you did too,
4 I believe.

5 A Yes.

6 Q And he was very forthcoming, is that correct?

7 A Yes.

8 Q And helpful?

9 A He being?

10 Q The Judge Couch was accommodating and helpful?

11 A Sure, to the extent that he could be.

12 Q Yes.

13 A without, you know, kind of violating judicial and --
14 you know, neutrality.

15 Q There was no reason you would expect that he wouldn't
16 give you his written charges if you had asked.

17 A No.

18 Q And you could have had those simply by asking.

19 A Sure.

20 Q Okay. Now, this is the actual initial charge. "So our
21 purpose in conducting the proceeding in which we are now
22 engaged is to determine whether the defendant, Mr. Torres,
23 should be sentenced by the Court," by the way. But the
24 Court isn't -- with discretion. We read that. The
25 sentencing authority in the courtroom in a capital murder

Kathleen J. Hodges
Direct examination by Mr. Ehliès

1 case is the jury, not the Court. Would you agree with that?

2 A I would agree that the determination as to whether the
3 sentence ought to be death or life is the -- is made by the
4 jury. In terms of the actual imposition of the sentence, my
5 argument would be that that is done by the Court.

6 Q And we call that a magisterial administrative
7 process -- of imposing the sentence they issue.

8 A That's correct.

9 Q And it was mandatory. Shall impose the sentence of
10 death.

11 A That is correct.

12 Q Okay. And so then the next thing it says, "Respect to
13 your particular role in this proceeding, you will be asked
14 to recommend to the Court whether it should sentence the
15 defendant to death or life. Should you recommend a sentence
16 of imprisonment or should you recommend a sentence of death,
17 that's the only issue that's involved in this phase of the
18 trial."

19 The rest of all of the evidence came in after that, and
20 the jury is like, oh, well, that's it. And you didn't know
21 at that point what he was going to do in the end of the
22 case, did you?

23 A No.

24 Q Thank you.

25 MR. EHLIES: Judge, I'm getting real close. I'm

Kathleen J. Hodges
Direct examination by Mr. Ehliès

1 sorry.

2 Q Now, I know that you weren't primarily involved -- I'm
3 going to third-party guilt. I'm going to show you a case
4 that I think is suited where you were. And it's Charping.
5 This case is 19 -- I can't see it quite. It's a 1998 case.
6 It's out of South Carolina.

7 And you were struggling with this third-party guilt.
8 And I want to show you on page five. It starts off, because
9 I think this is where the defense team came off the track.

10 "Third-party guilt is limited to having evidence that
11 excludes the defendant's guilt. Misidentification can
12 possibly be meaning misidentified it was him."

13 Okay. But that's not really what you were out to show,
14 is it?

15 A No.

16 Q what you were out to show was not third-party guilt.
17 when you do a guilty plea what's the first thing the judge
18 wants to do once he's informed that the guy's making an
19 informed decision and he's not under the influence? Is he
20 asks for what? what did he do?

21 A Right.

22 Q Give me a factual. what is his role in the office?
23 Isn't that what he does?

24 A Most times, yes.

25 Q You do not suggest the evidence of codefendant's

Kathleen J. Hodges
Direct examination by Mr. Ehliès

1 participation may not be mitigating.

2 Now, the codefendant, Chuck Emery, is not indicted.

3 But have you ever heard of unindicted codefendants?

4 A I have.

5 Q And aren't there times where cases aren't fully
6 investigated but they've started at least with some of the
7 defendants hoping to tweak some information maybe?

8 A That is true.

9 Q And isn't that sort of how law enforcement will work
10 even from the prosecution side?

11 A That is true.

12 Q So we've got Chuck Emery. Suggest the evidence of
13 codefendant's participation may not be mitigated. However,
14 although a codefendant's participation might be relevant to
15 circumstances of the offense and therefore mitigating the
16 fact that the codefendants receive a lesser sentence.

17 So the only distinction there is you can get all of the
18 evidence you want about what the roles are, but the sentence
19 to be imposed is not relevant in mitigation.

20 So have you had that case? Did you have that case and
21 strategy available to you when you were talking to Judge
22 Couch about what you were calling third-party guilt?

23 A Yes.

24 Q And did you couch it in terms of role in the office?

25 A No.

Kathleen J. Hodges
Direct examination by Mr. Ehliès

1 Q Especially when the prosecutor said it's all Tony.

2 A No. We did not.

3 Q Okay. Okay. After Charping -- okay. You know the
4 U.S. Supreme Court weighed in on this in South Carolina --
5 Skipper vs. South Carolina. I'm going to move over to that.

6 MR. EHLIES: By the way, can you go to 16 -- can you
7 get back to 16-3-20(c)?

8 Q Just show this to you, because I -- I didn't see it
9 mentioned at all in the trial transcripts. And I need
10 section 16-3-20(c). It's the mitigators. And I need No. 4.

11 Here is No. 4. It is what we call role in the offense.
12 The defendant -- there's a statutory mitigating
13 circumstance. The defendant was an accomplice involved in
14 the crime. Actually it says in the murder. I'm sorry.
15 There so many crimes -- six of them.

16 A Yes.

17 Q Involving another person. And his participation was
18 relatively minor or not the killer. Okay. So, in essence,
19 the legislature has captured role-in-the-offense as a
20 statutory mitigator. And didn't that fit what you were
21 really wanting to say, not that Tony wasn't there but he may
22 not have been the killer?

23 A Yes.

24 Q And had you been able to persuade the jury you know
25 you're entitled to a charge from the judge in South Carolina

Kathleen J. Hodges
Direct examination by Mr. Ehli

1 that if they found he was not the killer and did not intend
2 death he would not be eligible for death penalty? And
3 that's also Inman vs. Story.

4 A That's true.

5 Q Tison vs. Arizona. So if you had the jury thinking,
6 well, what would his role be, and would that be actually
7 improved in circumstances if the state didn't go forward to
8 indict Chuck and bring him before the jury and you had
9 evidence about why he should have been?

10 A I'm sorry. I just --

11 Q would that not have strengthened your argument that
12 maybe Tony wasn't?

13 A It would have.

14 Q And death might not have been suited with that big
15 question?

16 A It could have.

17 Q And do you know who else thought exactly that and
18 testified from where you're sitting that it gave her so much
19 trouble that she did not think death appropriate because she
20 didn't believe Tony did it by herself? Do you know who that
21 was?

22 A Having not heard her testimony, I don't know, but I can
23 guess.

24 Q Crystal Williamson was exactly on this mitigator for
25 the same reason you were. You were on the same sheet of

Kathleen J. Hodges
Direct examination by Mr. Ehli

1 music. But to your knowledge no one ever talked to Crystal
2 Williamson.

3 A To my knowledge, we did not.

4 Q I'm going down to the last subject here, and it has to
5 do with mitigation case. There were records missing. But
6 was that your responsibility to get the medical records
7 specifically?

8 A No, it was not.

9 Q And I know globally everybody's responsible. But,
10 specifically, that wasn't you. So you can't answer the
11 questions about why the trial lawyers' file does contain
12 M.U.S.C. records for an admission at age 3.7 months --

13 A I do not know.

14 Q -- in 1984.

15 A I have -- I have no answer for that.

16 Q And you don't know why the genetic history of medical
17 records of Mr. Torres' mother were not available.

18 A No.

19 Q Okay. Would you be surprised to know that a lot of the
20 expert testimony regarding the genetics centered on family
21 histories and genetically communicated conditions?

22 A No, I'd not be surprised.

23 Q In fact, we've heard that this case -- screening
24 genetics is the word I wrote down. And in honesty -- and
25 the reason I asked you about children, we worry about it in

Kathleen J. Hodges
Direct examination by Mr. Ehli

1 our own kids.

2 Did you not think something like that when you saw what
3 is previously marked in the trial these two documents which
4 were prepared by your expert, Marti Loring, your trial
5 exhibits, No. 3 and No. 4, which starts the total history?

6 And your witness, Dr. Schwartz-Watz, said -- and this
7 is a quote -- "I have never seen a case starting at 19
8 months of age." And didn't it kind of -- when you first saw
9 it didn't you think there's something wrong here?

10 A Yes.

11 Q But nobody hired a consult to walk you through that, an
12 informed consultant.

13 A Not to my knowledge.

14 Q A lot of reference going up about the ovarian lottery.
15 And that supports that concept of what you get in the
16 genetic structure. Being kind of aware of that, you can see
17 that happening from what you are gathering, is that not
18 correct?

19 A Sure.

20 Q There was a medical record in your file from an expert
21 medical provider, Dr. H. Wayne Tobin. And he saw Tony when
22 he was 14. And Dr. Tobin thought immediately funny looking
23 kid. And he testified by deposition.

24 And his medical records reflected his thinking. His
25 thinking was in terms of genetics. And on the discharge

Kathleen J. Hodges
Direct examination by Mr. Ehli

1 summary however -- and he asked rule out, and he named a few
2 genetic chromosomal defects -- Klinefelters -- and he asked
3 if they do the genetic studies rule it out. And the
4 discharge summary says, well, he didn't have anything that
5 suggested Klinefelters by clinical expression. And they did
6 not do the evaluation. Were you aware of that record in
7 your file?

8 A I was not.

9 Q Was there anyone in your team, your mitigation
10 specialists or anyone else, charged with responsibility to
11 sift through every word of those medical records?

12 A Not that I know of. Yeah. I mean, but I -- but I -- I
13 didn't make those team assignments, so I don't know if Clay
14 had asked someone else to do it.

15 Q It's a ton of work, isn't it?

16 A It would be.

17 Q And you have to do it though, go through those records
18 and press out to answer the questions that are apparent in
19 these records but not answered.

20 A Yes.

21 Q Now, I want to ask you one thing. I'm getting just
22 about to the end of this thing.

23 Is it fair to say that the mitigation case that was
24 presented through your experts was a summary of the existing
25 records they had available and they are conclusions from

Kathleen J. Hodges
Direct examination by Mr. Ehli

1 those records about what his condition would be or it was,
2 what the diagnosis from Dr. Schwartz-Watz by looking at his
3 medical records from beginning to the end?

4 A Yes to the -- but I do believe that Dr. Schwartz-Watz
5 may have actually had -- and my recollection is that she
6 actually had an interview and did her own interview and
7 evaluation.

8 So, you know, to say that her testimony was only the
9 review of the records, then the answer would be no. But I
10 think that -- and Marti Loring also had independent
11 conversations with the client.

12 Q She was a social worker.

13 A She was a social worker, right, right, well, yeah.

14 Q But the point I'm driving at is no one hired a
15 geneticist, did they?

16 A No. We did not.

17 Q No one hired -- and doesn't this scream developmental
18 psychology? Do you know that's a specialty?

19 A Yes. It is.

20 Q And you know the A.B.A. guidelines say get into these.

21 A Yes.

22 Q Get this down to the appropriate people to look at.

23 A Yes.

24 Q And no one did blood screens to your knowledge for
25 genetic issues.

Kathleen J. Hodges
Direct examination by Mr. Ehli

1 A That's correct.

2 Q No one did the urinalysis and the lab work on assays or
3 hogenome or any other assays as far as you know.

4 A No. That's correct.

5 Q No one got a syndrome specialist out of genetics to
6 take an assessment and make -- and make a determination.

7 A That's true.

8 Q Okay. So what you presented really was a summary of
9 the medical records and not an investigative effort to get
10 to the bottom of it.

11 A That's true.

12 Q Did you ever consider challenging the statute as
13 applied to your count -- your client -- on recommendation as
14 an unconstitutional application?

15 A No.

16 Q Okay. You know there's a difference between being
17 unconstitutional on its face and unconstitutional as they
18 actually apply it.

19 A Absolutely.

20 Q So the conflict between a recommendation yet is binding
21 and mandatory, is a suggestion that is sort of intentioned
22 at each other. Would you agree?

23 A Sure.

24 Q Okay. So to apply it by selecting out only
25 recommendation to the exclusion of I-have-to-do-it would be

Kathleen J. Hodges
Direct examination by Mr. Ehliès

1 unfair.

2 A Could be.

3 Q And on the -- we have proposed a categorical
4 ineligibility for people like Tony Torres based on
5 phenotypes which are consistent with mental retardation.
6 You're familiar with Atkins vs. --

7 A Yes.

8 Q Gerald Atkins vs. State of Virginia?

9 A Yes.

10 Q And the thrust of the whole case was that in certain
11 behavioral circumstances and organic physiology it would be
12 against evolving standards of social justice to execute
13 these people --

14 A Yes.

15 Q -- because moral culpability is reduced, is that
16 correct?

17 A That's true.

18 Q Did you ever think or talk about opposing and advancing
19 a forward looking theory consistent in using the Atkins
20 analysis that this Prader-Willi group is, in fact, a good
21 subset with mental retardation to be ineligible for the
22 death penalty?

23 A I don't remember any conversations about that issue.

24 MR. EHLIES: Thank you so much for your patience,
25 Judge.

Kathleen J. Hodges
Cross-examination by Ms. Brown

1 THE COURT: Who's examining this witness?

2 MS. BROWN: I can. Would you like for me to go on
3 today?

4 THE COURT: Yes, ma'am.

5 MS. BROWN: Okay.

6 CROSS-EXAMINATION

7 BY MS. BROWN

8 Q Good afternoon.

9 A Good afternoon.

10 Q You were asked a little bit about the concept of death
11 being different --

12 A Yes.

13 Q -- in your direct testimony. And you were keenly aware
14 that this was a capital case, correct?

15 A Absolutely.

16 Q And you knew that going into the case.

17 A Yes.

18 Q And you requested to be on the case to learn a little
19 bit more about capital litigation in and of itself.

20 A That's correct.

21 Q But you knew. You were very aware that your client
22 could be sentenced to death at the end of the proceeding.

23 A Yes.

24 Q And I believe you said that you're very familiar with
25 Strickland?

Kathleen J. Hodges
Cross-examination by Ms. Brown

1 A I am.

2 Q And the Strickland test that is controlling in
3 ineffective assistance of counsel claims. Do you agree?

4 A Absolutely.

5 Q And Strickland itself advises that much of the
6 representation may be guided by the client and what he says
7 and what he's done, correct?

8 A True.

9 Q Especially what he says.

10 A True.

11 Q Okay. And even though this is a capital case, the
12 client still has the right to a jury trial, right?

13 A Absolutely.

14 Q You can't make the decision whether to go to trial or
15 plead guilty, can you?

16 A No.

17 Q You can't coerce him to do that.

18 A That is true.

19 Q But you can advise him.

20 A Yes.

21 Q And did you advise him about the dangers of contesting
22 guilt in light of the evidence that the state had?

23 A Yes. I mean, the team certainly did.

24 Q And you were aware that there could be a perceived
25 inconsistency in going to trial and contesting guilt and

Kathleen J. Hodges
Cross-examination by Ms. Brown

1 then going to the mitigation phase, right?

2 A Yes.

3 Q And I believe in your direct testimony you had actually
4 said it was important to the client to go to trial and
5 unless the client tells me otherwise we're going to trial.
6 Do you remember those phrases?

7 A Yeah, yes.

8 Q Mr. Torres wanted you to contest and challenge that
9 guilt, didn't he?

10 A That's my recollection, yes, ma'am.

11 Q And he was firm with that?

12 A Yes, ma'am.

13 Q Okay. And you reviewed some of the evidence in your
14 direct examination, once again. And I believe you said at
15 one point that you thought this was going to be a mitigation
16 case, not so much a guilt case.

17 A That's true.

18 Q So you were aware of the evidence going in. And when
19 you were advising or the people on the team advising
20 Mr. Torres of the danger of saying not guilty and then going
21 to mitigation, did you review all of that evidence?

22 A Yes, ma'am.

23 Q And you reviewed the opinion that this was strong
24 evidence.

25 A Yes, ma'am.

Kathleen J. Hodges
Cross-examination by Ms. Brown

1 Q Okay. And you said that Mr. Torres was quite firm that
2 he wanted a trial --

3 A Yes.

4 Q -- on guilt. Do you have any indication that he ever
5 wanted to plead guilty?

6 A Not to my recollection.

7 Q And some of the evidence that you went over I won't go
8 over again -- the fingerprints and D.N.A. and that sort of
9 thing. There was some evidence that was not allowed or the
10 state chose not to present. Do you recall that?

11 A Yes, vaguely.

12 Q In particular statements?

13 A Yes.

14 Q Do you remember that some of those statements did not
15 come in?

16 A Yes.

17 Q Now, the statement about the clothes came in, correct?

18 A Yes.

19 Q But there was another statement saying essentially I
20 recognize why you're here, I know to go with you to answer
21 some questions, you have had questions of me. There's
22 another statement that said something along the lines of I
23 understand that that was a beating death before the -- the
24 method of the killing was publicly announced.

25 A Yes.

Kathleen J. Hodges
Cross-examination by Ms. Brown

1 Q And then there was the statement prove it after
2 Mr. Torres was presented with some of the evidence,
3 correct --

4 A Yes.

5 Q -- and the accusation? That wasn't allowed. And the
6 state didn't use all of the photographs that it could have.
7 Do you recall that?

8 A That is true. The state did not use all of the
9 photographs it could have.

10 Q Okay. Now, you've already told us a little bit about
11 the evidence. And you would have reviewed all of the
12 evidence, the evidence that the state could have put in, not
13 necessarily what they did but all of it.

14 A No. That's true. We -- we did review all of the
15 evidence prior to trial.

16 Q Okay. Now, we talked about Strickland just a few
17 minutes ago and that sometimes what your client tells you
18 will direct where you're going in this case.

19 Now, you didn't rely completely on Mr. Torres or the
20 discovery from the state concerning the facts of the case.

21 A That's correct.

22 Q You actually had an investigator, didn't you?

23 A We did.

24 Q Do you recall the investigator's name?

25 A It was Mr. Skidmore, Pete Skidmore.

Kathleen J. Hodges
Cross-examination by Ms. Brown

1 Q Okay. Do you recall how long the investigator was on
2 the case?

3 A That I do not.

4 Q Okay. Would you -- or do you remember whether it was
5 six months, a year, or even longer?

6 A That I don't -- that I don't know.

7 Q Okay. Do you recall being in meetings with
8 Mr. Skidmore?

9 A Yes.

10 Q Talking about the investigation?

11 A Yes.

12 Q And him going into the neighborhood and talking to
13 neighbors and trying to get additional information --

14 A Yes.

15 Q -- and some of the friends that Mr. Torres and
16 Mr. Chuck Emery would have shared. You approached those
17 through Mr. Skidmore.

18 A That's correct.

19 Q Let me ask you something. When you're doing your
20 investigation are you ever going back to Mr. Torres and
21 asking him whether this line of inquiry is correct or that
22 line of inquiry is correct?

23 A I would assume that -- would presume that that
24 happened. I did not do that, but I presume that that
25 happened, yes, ma'am.

Kathleen J. Hodges
Cross-examination by Ms. Brown

1 Q Okay. And who suggested --

2 MR. EHLIES: Judge, I am sorry. I do have to object.
3 The presumption is she doesn't know. The question is did
4 it happen, and her answer I think was I presume that it did
5 but I don't know.

6 THE COURT: Okay. Well, just be sure you testify to
7 things you have personal knowledge of.

8 THE WITNESS: Yes, sir.

9 Q So did you -- let me ask this. Who suggested that the
10 defense look into any kind of connection Chuck Emery would
11 have had with the killing?

12 A I honestly don't remember if there was one person that
13 suggested it or if it was kind of a communal thought.

14 Q And by communal thought, what do you mean by that?

15 A Well, in terms of discussions amongst the defense
16 team -- the attorneys, Mr. Skidmore, you know, I guess
17 mitigation specialist. Those would have been the people
18 that would have been involved in those discussions.

19 Q Did Mr. Torres ever tell you that he had talked to
20 Chuck Emery about killing Chuck Emery's parents?

21 A To me directly, no, ma'am.

22 Q Do you know whether he ever said anything like that to
23 either of the other two attorneys on the case?

24 A I don't know.

25 Q Now, at one point the defense and Mr. Torres entered a

Kathleen J. Hodges
Cross-examination by Ms. Brown

1 stipulation with the state. Do you recall that?

2 A I do recall entering a stipulation, yes, ma'am.

3 Q And do you recall that you all signed off on a paper, a
4 written stipulation, that Mr. Torres had Ann Emery's phone
5 and was making a call at 5:14 a.m.?

6 A Yes.

7 Q why did you make that stipulation?

8 A My recollection of the reason for making that
9 stipulation was because there was an issue with a records
10 custodian involved that would be required and in getting
11 those records in.

12 Q Did you explain what a stipulation meant to Mr. Torres?

13 A I -- I do not remember having that conversation with
14 him.

15 Q Do you remember going over the stipulation with
16 Mr. Torres before he signed it?

17 A I don't have an independent recollection of that.

18 Q Do you recall why he would want to agree that, yes, he
19 had the victim's phone at 5:14 a.m.?

20 A No, ma'am.

21 Q Do you remember any hesitation in the stipulation?

22 A I -- I don't recall one way or the other.

23 Q And you were asked a little bit about forensic
24 analysis, the evidence in the home and what D.N.A. would
25 have been in the home and that sort of thing. And you said

Kathleen J. Hodges
Cross-examination by Ms. Brown

1 that you thought that it was your opinion or the evidence --
2 I forgot exactly how you might have referred to it -- but
3 somehow or another you connected Chuck Emery as a resident
4 in the home at the time that the murders occurred.

5 A Yes.

6 Q Okay. Do you remember how that came up? Was that
7 something that Mr. Torres told you? Was that something that
8 your investigation turned up?

9 A The -- it is the impression and information I believe
10 that I gleaned from the discovery in the case.

11 Q Okay. He certainly was somewhere around the home,
12 right?

13 A Yes.

14 Q And Mr. Torres was somewhere around the home too.

15 A Yes.

16 Q In fact, Mr. Torres lived next to the Emerys, correct?

17 A I honestly don't recall what the close proximity was of
18 the actual homes.

19 Q Okay. Do you remember discussing a little bit about
20 the cross-examination going to the D.N.A. material?

21 A Yes.

22 Q Okay. And do you recall Mr. Allen's cross-examination
23 on the matches at certain points in the spectrum? Do you
24 remember that?

25 A Yes.

Kathleen J. Hodges
Cross-examination by Ms. Brown

1 Q Okay. And do you remember the questions that there's a
2 presumption that the samples come from different genetic
3 backgrounds?

4 A Okay.

5 Q And if -- if you recall.

6 A I mean, I don't recall. I don't recall the
7 cross-examination specifically.

8 Q Okay. Okay. Well, in your view in asking about the
9 different tests and forensics that you could get out of some
10 of the information from the house, did you discuss that
11 Mr. Chuck Emery was an adopted son?

12 A I knew that Mr. Chuck Emery was an adopted son.
13 Whether there was a discussion with the genetics or in the
14 cross-examination about that nonbiological relationship, I
15 don't remember.

16 Q Okay. Well, from your knowledge of D.N.A. in general,
17 and specifically in this case, the adopted son, they're not
18 going to have a shared genetic background.

19 A That is true.

20 Q So that would be a difference.

21 A That is true.

22 Q It wouldn't be massed within Mr. Emery's D.N.A.

23 A I find myself in a difficulty in terms of being able to
24 answer that question, because my -- my scientific background
25 is not that of an expert. But, you know, in terms of there

Kathleen J. Hodges
Cross-examination by Ms. Brown

1 are certain D.N.A. markers that can be similar even though
2 you're biologically related -- and I do remember that --
3 there being some controversy and some dispute in terms of
4 the genetics how -- the SLED analyst was -- was testifying
5 in terms of items being massed within or, you know,
6 partially mixed or whatever versus Dr. Ostroski's
7 explanation of the D.N.A. material.

8 Q Okay. And how familiar were you with Dr. Ostroski's
9 opinion on the D.N.A. material?

10 A I was familiar but, you know, was not -- he was not a
11 mitigation witness that I was putting up. So I know that I
12 talked with Clay Allen about it. I know that I was involved
13 in some of the discussions about it amongst the team.

14 Q And were you aware his opinion was that the SLED report
15 was fine, SLED statistics were fine, the SLED matches on the
16 certain particular points within the spectrum were correct
17 according to the raw materials that he had, the raw data?

18 A I honestly don't remember.

19 Q Okay. Let's talk a little bit about the
20 circumstantial-evidence charge. You were asked about the
21 language to the exclusion of all reasonable hypotheses. Do
22 you remember that?

23 A Yes, ma'am.

24 Q And you were asked a little bit about State vs. Logan.

25 A I was.

Kathleen J. Hodges
Cross-examination by Ms. Brown

1 Q A 2013 case.

2 A I was.

3 Q And are you familiar with State vs. Cherry?

4 A Somewhat.

5 Q Somewhat. Well, after having reviewed Logan -- Logan
6 of course references Cherry.

7 A Right.

8 Q And isn't it fair to say that even today, even in the
9 Logan case to the exclusion of all reasonable hypothesis, is
10 not language that the Court has adopted and offered in these
11 situations?

12 A Having not practiced criminal law for the last three
13 years, you know, I'm probably not going to be the best
14 person to answer that question.

15 Q That's fair enough -- that's fair enough. But you
16 didn't have any cases at the time back in October of 2008, I
17 believe it was, that would allow you to get to that language
18 to the exclusion of all reasonable hypothesis that you know
19 of.

20 A That I remember, no, ma'am.

21 Q Okay. And, again, you said that in your opinion this
22 was a mitigation case, right?

23 A Yes, ma'am.

24 Q And that wasn't that you didn't have a basis to
25 challenge as I understand your testimony -- not that you

Kathleen J. Hodges
Cross-examination by Ms. Brown

1 didn't have a basis to challenge. You could represent
2 Mr. Torres at trial, and you did when he was exercising his
3 right to trial.

4 A Yes, ma'am.

5 Q Right? And you would not have intentionally sabotaged
6 that trial, would you, after your client asked you to
7 provide a trial for him?

8 A Absolutely not.

9 Q Okay. You were also asked a little bit about the
10 recommendation and the use of a recommendation in the
11 statute when you're talking about sentencing.

12 I want to just quickly read a portion of what Judge
13 Couch said at trial and ask you a question about it. And
14 this is on page 2754 of the record, and it starts at line
15 11.

16 Your sentence: "Sentencing recommendation will be
17 followed by this Court."

18 Is there anything wrong or unclear with that
19 instruction in your opinion?

20 A With that one sentence, no, ma'am.

21 Q So in your opinion this would be fine language to say
22 your recommendation is the sentence, it will be followed.

23 A I think that the sentence speaks for itself.

24 Q Okay. And Mr. Ehlied asked you to direct your
25 attention to State vs. Charping, I think, or Charping vs.

Kathleen J. Hodges
Cross-examination by Ms. Brown

1 State. I can't remember exactly which one he put up there.
2 And he commented that you were struggling with the concept
3 of a third-party guilt. Were you struggling with the
4 concept of third-party guilt?

5 A To be honest, I always struggle with the concept of
6 third-party guilt.

7 Q And in what respect do you struggle?

8 A I just think that -- I think the law as it was
9 developed in South Carolina on the issue of third-party
10 guilt has been torturous at times. But, you know, until
11 Mr. Ehlied talked about using a potential unindicted
12 codefendant as mitigating factor or as mitigating evidence
13 that, quite frankly, was a concept that had not -- that I do
14 not remember thinking of.

15 Q Okay. And that's a good segue right into my next
16 question, and that is you have to have evidence in the
17 record to be entitled to a statutory mitigating
18 circumstance, correct?

19 A You do.

20 Q All right. So you can have an unindicted codefendant,
21 but you have to have the presence of a codefendant, correct?

22 A Well, I don't necessarily -- necessarily have to have
23 the -- I guess the question becomes what you do you mean by
24 presence.

25 You know -- you know, there has to be, obviously, a

Kathleen J. Hodges
Cross-examination by Ms. Brown

1 good factual basis and a good faith basis for putting up
2 evidence as to a particular person, or essentially enough
3 evidence in order to be able to point to there is somebody
4 else out there even if you cannot necessarily identify that
5 person by name.

6 Q So you have to have some evidence to suggest another
7 perpetrator.

8 A Yes.

9 Q As far as guilt, you would have to have a sufficient
10 amount of evidence to reach the statutory -- excuse me --
11 the evidentiary standard to allow it in the guilt phase.

12 A That's correct.

13 Q But even if you can't identify that person you have to
14 have some evidentiary basis to say another person was
15 involved.

16 A Yes.

17 Q Otherwise you're at residual doubt, right? And you
18 stay away from residual doubt in the penalty phase in a
19 capital trial, correct?

20 A Right.

21 Q Okay. You were also asked a little bit about Crystal
22 Williamson's testimony, which I don't believe you heard, is
23 that correct?

24 A The testimony of this trial with Crystal Williamson, I
25 have not heard.

Kathleen J. Hodges
Cross-examination by Ms. Brown

1 Q Right.

2 A That is correct.

3 Q Okay. And Mr. Ehlied gave you a portion of the -- the
4 testimony, as I believe as he recalled it, that she may have
5 suspected Chuck Emery had some involvement if you remember
6 his --

7 A That's -- that's essentially what I remember him
8 telling me.

9 Q And I believe he also suggested that she may have been
10 amenable to suggesting a life sentence at some point for
11 Mr. Torres. But if you knew that she would also say, as she
12 did in this proceeding, that if the evidence did, in fact,
13 show that it was only Mr. Torres involved, that the case
14 supported the death sentence, that's not something you could
15 use to take to the solicitor and argue for a plea, is it?

16 A Not with Trey Gowdy.

17 Q And let's talk about that a little bit.

18 You said you weren't involved with the plea process.

19 A I don't remember being involved in any real extent in
20 the plea process.

21 Q Okay. But you were aware that there was some
22 discussion about the possibility of a plea offer in certain
23 cases.

24 A Sure.

25 Q And that they would attempt that here.

Kathleen J. Hodges
Cross-examination by Ms. Brown

1 A Sure.

2 Q But you can't make the state offer something or a
3 particular deal, a particular favorable deal.

4 A No.

5 Q You just can't do that.

6 A No. That's true.

7 Q Okay. And Mr. Ehliès presented you with his view of
8 the evidence and his theory in this case and how things
9 could have been different. But I want to ask you something.

10 The evidence as you recall reviewing and discovery and
11 presenting at trial and the totality of that evidence that
12 was before the jury, that can support the jury verdict on
13 guilt, can't it?

14 A It can.

15 Q It can support that Mr. Torres was the only actor in
16 the death of Mrs. Ann Emery and Mr. Ray Emery.

17 A It can.

18 Q And everything that was presented can very well support
19 the jury's sentencing recommendation which was followed of
20 death.

21 A It can.

22 MS. BROWN: Court's indulgence, please.

23 (Pause.)

24 MS. BROWN: Thank you, Your Honor. Just a few more
25 questions.

Kathleen J. Hodges
Cross-examination by Ms. Brown

1 Q You said you had reviewed the evidence, both the
2 evidence that came in and the evidence that you had gathered
3 in your investigation, and all of the discovery provided to
4 you.

5 Was there anything in that evidence that suggested that
6 Mr. Torres was only a minor participant in the crime?

7 A You know, probably not. But, you know, I still
8 struggle with some of the evidence and -- in this case in
9 terms of finding that he's the only participant and
10 definitively the most culpable.

11 Q And tell me why.

12 A You know, I don't know if it's a matter of just -- it's
13 not that I think that I could actually pinpoint. It is more
14 of a -- a suspicion and a -- the amount of rage that is
15 depicted in some of the photographs of the injuries to
16 Mr. and Mrs. Emerys' faces, simply does not in terms of what
17 I have been able to see -- and I've not been through this
18 proceeding here and listened to all the evidence that has
19 now come out since the trial -- but in terms of what I've
20 seen I just -- I still have doubts.

21 Q Okay. And that's because of the rage, the level of
22 violence that you saw in this case?

23 A Yes.

24 Q And you were aware that Mr. Torres had a history of
25 extreme rage and injury to others, injury to property, that

Kathleen J. Hodges
Cross-examination by Ms. Brown

1 he was a small child and had to be restrained by three
2 adults. You're aware of that?

3 A I'm aware of that.

4 Q And that sounds like the type of rage -- rage that
5 could translate into this kind of crime, doesn't it?

6 A It could.

7 Q Okay. And that D.N.A. evidence that we were talking
8 about, that is very reflective of a violent rape, isn't it?

9 A I don't know that any rape's not violent, so I would
10 say it is indicative of criminal sexual assault.

11 Q And the way that the body was left, what do you think
12 about that? Does that not show a disregard?

13 A It does.

14 Q And that would flow into a violent rape as well. As
15 you said, all rapes are violent, right?

16 A Yes.

17 Q And that D.N.A. matches Mr. Torres on these particular
18 sites as they were shown at trial, correct?

19 A He was identified as the contributor of that D.N.A.,
20 yes, ma'am.

21 Q And matches on those particular sites that your experts
22 said were correct according to his review.

23 A Yeah. It indicates -- identifies him as a contributor,
24 yes, ma'am.

25 Q Okay. Do you have any solid information that Chuck

Kathleen J. Hodges
Cross-examination by Ms. Brown

1 Emery was involved in the beating death of his step-mother
2 Ann Emery?

3 A I do not, no, ma'am.

4 Q And you would have brought it forward if you did.

5 A Yes, ma'am.

6 Q And do you have any evidence that Chuck Emery was
7 involved in the death of his father who supported him
8 financially and took care of him?

9 A I do not.

10 Q One moment, please.

11 (Pause.)

12 Q One more line of questioning.

13 In voir dire you said that you had gone to, I believe,
14 a seminar shortly before that.

15 A Yes, ma'am.

16 Q And that was part of the training that Mr. Allen was
17 providing you about capital cases.

18 A That's correct.

19 Q And in that seminar you were aware or became aware that
20 you may ask some questions sometimes about race.

21 A Yes.

22 Q And was there --

23 A Well, actually I don't know that I necessarily knew
24 about it. In that seminar I knew that there were in terms
25 of the case law, that there was, you know -- so, I mean,

Kathleen J. Hodges
Cross-examination by Ms. Brown

1 that seminar was basically designed to inform kind of how to
2 ask the questions in terms of kind of stripping away, you
3 know, jurors' perceptions about the death penalty.

4 Q Okay. Well, was there a racial component to this crime
5 that you were aware of that you could identify?

6 A Other than -- other than -- other than some issues or
7 statements in discovery of looking for a Hispanic person or
8 Mexican person or -- or something like that. I mean, that
9 was essentially the only component that injected any sort of
10 other race ethnicity.

11 Q Okay. And that was something you read.

12 A It was in the discovery, yes, ma'am.

13 Q Okay. What was your impression? Did Mr. Torres
14 present to you as looking particularly Hispanic?

15 A Yes. I mean, he definitely has Hispanic/Latino
16 features, yes, ma'am.

17 Q Okay. And that was something that you initially
18 thought?

19 A Yes, ma'am.

20 Q And isn't it true that the discovery also showed that
21 some people thought that Mr. Torres and Mr. Chuck Emery
22 looked alike?

23 A Yes, ma'am.

24 Q And Mr. Emery to your knowledge did not have Hispanic
25 background.

Kathleen J. Hodges
Redirect examination by Mr. Ehliès

1 A That is correct.

2 Q Thank you very much.

3 MS. BROWN: No further questions, Your Honor.

4 REDIRECT EXAMINATION

5 BY MR. EHLIES

6 Q The last set of questions on race neutrality and a --
7 the racial issue on voir dire. Those don't have anything to
8 do with the discovery, do they? Don't they address the
9 community dynamics on minority relations from the jurors'
10 perspective? So what you want is a race neutral juror, not
11 a race neutral police officer, isn't that true?

12 A That is true. I mean, you want somebody who is both --
13 any sort of protected-class neutral juror.

14 Q And we have a lot of those in our communities --

15 A We do.

16 Q -- of different ethnic backgrounds. And then we have a
17 white female victim.

18 A We do.

19 Q She's white.

20 A She is white.

21 Q A female victim.

22 A Yes.

23 Q So the whole issue is juror race neutral and not police
24 officer or anything else.

25 A That's true.

Kathleen J. Hodges
Redirect examination by Mr. Ehli

1 Q And all they have to do is see the white victim and a
2 minority-based-charged individual, and the issue is now
3 presented as far as your investigation for race neutrality.

4 A I would think that's fair.

5 Q Okay. And you said something very important. You said
6 that although you could not particularize an evidentiary
7 basis for why you had doubts about Tony being the sole
8 perpetrator of the crime, you had suspicions.

9 A That's true.

10 Q And isn't that all it takes for a jury to sentence to
11 life?

12 A If a juror has a reasonable doubt, that's all it takes
13 to sentence to life.

14 Q And no doubt. A juror can sentence to life for no
15 reason at all.

16 A That is true.

17 Q But if they harbored the same sort of gnawing question
18 about the role, then they'd have a reason to come back with
19 life even though they have to have no reason at all, right?

20 A They could.

21 Q Okay. So what you were sensing is the same thing
22 you're trying to generate in the juror in the sentencing
23 phase.

24 A True.

25 Q And Tony Torres never really gave you trouble when he

Kathleen J. Hodges
Redirect examination by Mr. Ehliès

1 was saying he wanted a trial. He was actually supporting
2 your conclusion, wasn't he? He wasn't saying I'm not there.

3 If he wasn't the murderer because his role was to set
4 the gasoline out and try and start a fire and get all the
5 stuff loaded in the car and get of here, then he would say
6 fight for me because I'm not the murderer, right? And
7 that's not inconsistent with your theory.

8 MS. BROWN: Your Honor, I'm going to object because it
9 seems that there's no factual basis for that. I mean, it's
10 a hypothetical perhaps, but there's no factual basis for
11 the question as it's presented.

12 MR. EHLIES: Her testimony is that she had --

13 THE COURT: Overruled.

14 Go ahead.

15 Q Okay. So Tony's request that you fight for him may not
16 have been argumentative. It could have been because he
17 believes he was entitled to a trial because he wasn't the
18 killer.

19 A That is true.

20 Q And if somehow you established through the context with
21 Biggerstaff, Ms. White, Crystal Williamson, Tammy Hughey --
22 and the list goes on and on -- about Chuck maybe you could
23 have raised that doubt in the jury's mind, right?

24 A That is true.

25 Q His cooperation was also evidenced by the fact that he

Kathleen J. Hodges
Redirect examination by Mr. Ehliès

1 signed. Did he sign the stipulation, or did counsel?

2 A Yes. I'm pretty sure he signed it as well.

3 Q So he went right along with y'all's suggestions.

4 A Yes.

5 Q And I had another confusion. I was remembering that
6 you said really the -- the contact was between Reckenbeil
7 and Clay Allen with the client and that you never really sat
8 down with him and reviewed all the evidence.

9 A I mean, I did not go through the entire discovery in
10 the file and review all of the evidence with him in detail
11 like I did with any of the other clients that I was lead
12 counsel for.

13 Q Okay. And counsel here is suggesting all kinds of
14 things that were incorrect because it involved ethics. And
15 Judge Traxler issued an opinion in 2010 in United States vs.
16 Chapman to clarify this bright line between what is a
17 tactical decision for lawyers to make and where the client
18 stands on the other decisions. And if we go to the caption
19 of that case -- and the judge can see if he wants to write
20 this down -- I'm pretty sure it's a 2010 case.

21 MR. EHLIES: Okay. This is at 593 F.3d 265, United
22 States Court of Appeals, Fourth Circuit, decided
23 January the 29th of 2010, and I can tell you that that's
24 Judge Traxler's decision.

25 Q And let's take a look at the highlighted portions about

Kathleen J. Hodges
Redirect examination by Mr. Ehliès

1 whose responsible. "Well known established that in a
2 criminal trial the defense counsel has authority to manage
3 most aspects of the defense without first obtaining the
4 consent of the defendant. Decisions that may be made
5 without the defendant's consent primarily involve trial
6 strategy and tactics such as what evidence should be
7 introduced, what stipulation should be made or objection
8 should be raised, what pretrial motions should be filed.
9 The only decisions that have been identified by the Supreme
10 Court as belonging exclusively to the defendant is whether
11 to plead guilty."

12 Short of that, you're the boss. Did you know that in
13 2008?

14 A I knew that in 2008. I guess the other thing that -- I
15 don't know if Judge Traxler -- I guess it just says
16 whether -- the client decides whether to testify. That
17 would be the only thing I would add.

18 Q And you're right. Only the client can make that
19 decision. But the core decisions belong to the client, as
20 pointed, but all of this stuff about what to do and how to
21 do it and that sort of thing belong to the trial lawyer, is
22 that correct?

23 A That is true.

24 Q Thank you so much.

25 MR. EHLIES: Thank you, Judge.

Kathleen J. Hodges
Recross-examination by Ms. Brown

1 MS. BROWN: Your Honor, if I could have just one line
2 of inquiry.

3 THE COURT: Okay.

4 RECROSS-EXAMINATION

5 BY MS. BROWN

6 Q If Mr. Torres was only a minor participant -- in his
7 belief he was a minor participant -- he could have told you
8 he was a minor participant, couldn't he?

9 A He could have.

10 Q He didn't tell you that, did he?

11 A He did not tell that to me.

12 Q And he didn't tell you that Chuck Emery was involved,
13 did he?

14 A He did not tell that to me.

15 Q Do you have any --

16 A I don't know whether he had those conversations with
17 any of the other trial team members.

18 Q Thank you.

19 And he could have taken the stand and he could have
20 said I had a partner, and that might have been some evidence
21 that might have gotten him that mitigating circumstance,
22 correct?

23 A He could have.

24 Q But he didn't do it.

25 A That is true. He did not. He chose not to testify, as

Kathleen J. Hodges
Redirect examination by Mr. Ehliès

1 was his right.

2 Q Thank you.

3 MS. BROWN: No further questions, Your Honor.

4 REDIRECT EXAMINATION

5 BY MR. EHLIES

6 Q Had he done that he would have been exposed to
7 cross-examination on his records, right?

8 A He absolutely would have been exposed to
9 cross-examination on his record.

10 Q And other issues in the case.

11 A Yes.

12 Q And who was it that had the motive for the deaths? Who
13 inherited the estate?

14 MS. BROWN: Objection, Your Honor.

15 THE COURT: Sustained.

16 MR. EHLIES: It's in evidence in the --

17 THE COURT: I know. We're rehashing what we've
18 already heard.

19 MR. EHLIES: Okay. Thank you. That's all.

20 THE COURT: All right. You may step down.

21 THE WITNESS: Thank you, Your Honor. Your Honor, may
22 I be excused?

23 THE COURT: You may be without objection.

24 MS. BROWN: No objection, Your Honor.

25 (Whereupon, the witness was excused.)

1 THE COURT: Court is in recess until 9:30 in the
2 morning.

3 END OF PROCEEDINGS APRIL 23, 2014
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Dr. Stacey Wood
Direct examination by Mr. Tessier

1 (Proceedings April 24, 2014)

2 MR. TESSIER: Good morning, Judge. Are you ready?

3 THE COURT: Okay. Sure.

4 MR. TESSIER: Call Stacey Wood, Ph.D.

5 DR. STACEY WOOD, having been
6 first duly sworn, testified as follows:

7 DIRECT EXAMINATION BY MR. TESSIER

8 MR. TESSIER: May it please the Court.

9 THE COURT: Yes, sir.

10 Q Good morning, Dr. Wood.

11 Would you please state your full name for the record
12 for us? And spell your last name.

13 A Sure. My name is Stacey Wood, W-O-O-D.

14 Q And if you need to get some more things assembled, feel
15 free.

16 MR. TESSIER: If I may approach, Your Honor, I'm going
17 to hand.

18 Q I believe it's the first exhibit I'd like for you to
19 look at when you're ready.

20 Dr. Wood, I've handed you what's marked as Applicant's
21 Exhibit No. 22 just to see if you can identify that for us.

22 A I can. It looks like a recent version of my C.V.

23 Q And when you prepared that C.V. was the information you
24 provided in the C.V. accurate at the time?

25 A It was.

Dr. Stacey Wood
Direct examination by Mr. Tessier

1 Q There may be some updates to it, but other than updates
2 since the time you prepared this, this was a comprehensive
3 or attempt to be a comprehensive outline of your educational
4 background, professional experience and publication?

5 A Yes.

6 Q Tell us if you would.

7 MR. TESSIER: Your Honor, we would offer Exhibit No.
8 22 into evidence.

9 MR. ZELENKA: No objection.

10 THE COURT: It's admitted.

11 (Curriculum vitae of Stacey Wood, Ph.D. marked
12 Applicant's Exhibit No. 22.)

13 Q Tell us if you would, Dr. Wood, your educational
14 background first.

15 A Absolutely. So, I received my B.A. in biology and
16 psychology. It was a dual major at Middlebury College in
17 Vermont in 1989.

18 I studied clinical neuropsychology at the University of
19 Houston in Houston, Texas, receiving both my M.A. and Ph.D.
20 in clinical neuropsychology. And I completed a postdoctoral
21 fellowship in neuropsychology at U.C.L.A.

22 Q And about when was it that you completed your
23 postdoctoral fellowship?

24 A Around 1997.

25 Q After you completed the postdoctoral fellowship, what

Dr. Stacey Wood
Direct examination by Mr. Tessier

1 did you do for professional experience?

2 A I worked as an assistant research professor at U.C.L.A.
3 for a couple of years, and then I obtained my current
4 position at Scripps College as a professor of psychology.

5 Q And are you a tenured member of the faculty at Scripps
6 college?

7 A I am.

8 Q And how long have you been a professor at Scripps
9 college?

10 A Roughly 12 years. I was also a professor at the
11 University of Colorado, Colorado Springs, for three years.

12 Q And what kind of a teaching load do you currently carry
13 at Scripps College?

14 A It's a 5-course equivalent.

15 Q Do you do anything else with your time other than serve
16 as a professor at Scripps College?

17 A Well, I run a lab. So I have federal funding right now
18 from the Department of Justice for my work on
19 decision-making.

20 I supervise undergraduates and graduate students. I
21 have a lot of administrative responsibilities on campus. I
22 was recently chair -- I'm not chair of my department any
23 more -- but I serve on a campus-wide committee related to
24 promotion and tenure.

25 And I have a private practice. So I work one -- about

Dr. Stacey Wood
Direct examination by Mr. Tessier

1 one day a week doing neuropsychological consultations.

2 Q And doing the neuropsychological consultations, is that
3 a clinical practice?

4 A Yes.

5 Q So you're a clinical neuropsychologist, not just a
6 neuropsychologist.

7 A That's correct.

8 Q What would be -- how would you describe the difference
9 between the two if there -- if there is one?

10 A So, a clinical neuropsychologist has a license to
11 practice psychology, works with different patient
12 populations. A experimental neuropsychologist is also
13 interested in brain behavior disorders but doesn't see
14 patients and works more in experimental settings, lab-based
15 settings.

16 Q And how long have you worked in a clinical setting in
17 addition to serving as a -- as a professor roughly?

18 A So I -- you know, in my training, in my clinical
19 training, in graduate school that started around 1990 we
20 were expected to carry a 20-hour-a-week case load. So, you
21 know, for -- I don't want to add it up -- 24 years.

22 Q Okay. So, would it be fair to say that your -- pretty
23 much your entire professional career you have also served as
24 a clinical neuropsychologist?

25 A Yes. There -- there was a couple of years pretenure

Dr. Stacey Wood
Direct examination by Mr. Tessier

1 where I wasn't seeing patients, but besides that time period
2 I have always seen cases as well.

3 Q And on a day-to-day basis -- tell me if I understate
4 it -- but on a day-to-day basis would it be fair to say that
5 clinical neuropsychologists among other things evaluate
6 intellectual and cognitive function?

7 A That's right.

8 Q And is there a basic sort of general methodology that
9 you employ as a clinical neuropsychologist to test for
10 intellectual and cognitive function?

11 A Yeah. Clinical neuropsychologists use standardized
12 tools that have been developed over time to be sensitive to
13 different brain dysfunction. So what most clinical
14 neuropsychologists do is use standardized tests in
15 combination to form some kind of test battery.

16 Q Explain if you would for those who don't know, what is
17 the significance of a standardized test?

18 A So standardization simply means that the instructions
19 are scripted so that if two neuropsychologists were
20 administering the same tests they would use the same
21 instructions and it would be administered under the same
22 condition.

23 It would be scored the same way, so there's very strict
24 guidelines for scoring. And that normative data is used to
25 interpret them so that two neuropsychologists, again,

Dr. Stacey Wood
Direct examination by Mr. Tessier

1 working in different parts of the country can compare their
2 patient to the general population and then be able to
3 interpret their findings in a similar fashion.

4 Q So, part of what the purpose of a standardized test
5 would be would be to allow you if I'm hearing you correctly
6 to generalize the results you receive over a broader
7 population?

8 A That -- there's two issues. One is reliability so that
9 the test is administered in the same way and scored in the
10 same way. And the second is generalized ability that
11 it's -- that you're able to interpret the information in the
12 same way.

13 Q Okay. So you want -- you want to be in a position that
14 other neuropsychologists throughout the country could
15 conduct the same testing and come up with the same or
16 similar results for the same patient.

17 A That's right.

18 Q Is that the primary basis of what you use as a
19 methodology to evaluate intellectual and cognitive
20 intervention as a clinical neuropsychologist -- standardized
21 testing, in other words?

22 A It's certainly one of the most important tools, but you
23 would never interpret scores without a context. So you're
24 also taking a good history, reviewing medical records,
25 interviewing the patient. Those are all important parts of

Dr. Stacey Wood
Direct examination by Mr. Tessier

1 coming up with some type of interpretation and potentially a
2 diagnosis.

3 Q So it's -- the standardized testing component is one of
4 the tools in your toolbox.

5 A That's right.

6 Q How -- would you tell us a little bit about how are
7 those standardized tests used? Like in what context are
8 they used? Is it just in this type of setting or do you
9 have a forensic application?

10 A No. They're -- they're widely used in different
11 clinical settings.

12 So, for example, a neuropsychologist working with
13 children may use these types of tests to look at learning
14 disabilities or attention deficit disorder. Individuals
15 working in the military may use these tests to look at
16 traumatic brain injury in combat veterans.

17 Neuropsychologists working with older adults can use
18 these tests to differentiate normal aging from dementia
19 syndromes. They're very broadly used in clinical
20 populations, not just in a forensic setting.

21 Q Okay. And have you actually used them in some of these
22 different contexts yourself?

23 A I have.

24 Q How do you go about as a neuro -- a clinical
25 neuropsychologist -- how do you go about selecting from --

Dr. Stacey Wood
Direct examination by Mr. Tessier

1 or, first of all, is there a variety of different
2 standardized tests available to you as a neuropsychologist
3 to use on a given patient, if I may call them a patient?

4 A Yes. There's dozens of neuropsychological tests.

5 Q And do you as a part of your work, do you make a
6 decision as to which of the various tests that are available
7 to you that you're actually going to use for that particular
8 context?

9 A I do. So, I review the records that I have available
10 to me. I look at the demographics of the patient. You're
11 going to use a different test battery with someone that's an
12 adult versus someone that's a child or an adolescent.

13 And I think about the referral question. So, I look at
14 their history, the referral question, the demographics and
15 put together a test battery that will allow me to answer the
16 question but still provide a comprehensive assessment.

17 Q Is it important in your view as a clinical
18 neuropsychologist to come up with a comprehensive
19 assessment?

20 A Yeah, if it's standard practice.

21 Q You are obviously here serving as an expert in a
22 forensic setting. Is that fair? Is that all of the
23 clinical neuropsychological work that you do, or do you work
24 in other contexts as well?

25 A At this point most of my practice is forensic, but I do

Dr. Stacey Wood
Direct examination by Mr. Tessier

1 see clinical cases as well.

2 Q And for your forensic work, is it all for defense
3 counsel?

4 A It's not.

5 Q How would you -- give us some examples of the work you
6 do in the forensic context.

7 A So, some of the types of cases that I see include --
8 there's a group that includes more civil work --
9 conservatorships and guardianships -- so, working with
10 probate court as an expert in trying to determine if
11 dependent adults, an adult with a cognitive impairment or an
12 older adult, would benefit from formal supports.

13 I also do competency evaluations. I'm an appointed
14 expert in two counties -- L.A. County and Riverside
15 County -- for the courts.

16 And I also have an interest in working on cases of
17 elder mistreatment. So, I've worked with L.A. County's
18 D.A.'s office. I worked with them for three years helping
19 them investigate those types of cases.

20 Q Is that an ongoing engagement?

21 A No. I left. I left that group in 2010.

22 Q So, for some period of time you were working with the
23 L.A. County Sheriff's Department.

24 A Well, it was more for the county. It was a -- it was
25 like a partnership between U.S.C. and the D.A.'s office to

Dr. Stacey Wood
Direct examination by Mr. Tessier

1 form a medical unit to investigate cases against older
2 adults and adults with cognitive impairment.

3 Q And so were you working with law enforcement officers
4 and/or prosecutors?

5 A Yes.

6 Q And you've also been appointed as an expert for the
7 courts?

8 A I have.

9 Q Now, you realize we are here to ask you some questions
10 about intellectual and cognitive functions specifically
11 related to Tony Torres, right?

12 A I understand that.

13 Q And is your expertise as a clinical neuropharmacologist
14 particularly suited to answering that type of questioning?

15 A You know, it's not because I'm not a clinical
16 neuropharmacologist.

17 Q All right. I've got two experts in my brain. I
18 apologize.

19 A No problem.

20 Q You can probably explain it better than I can why that
21 would be. But let me ask the question again.

22 Is your expertise then as a clinical neuropsychologist
23 particularly helpful in answering questions about Mr. Torres
24 and his intellectual cognitive function?

25 A Yes. It's a good background for that.

Dr. Stacey Wood
Direct examination by Mr. Tessier

1 MR. TESSIER: Your Honor, at this time we'd offer Dr.
2 Wood as an expert in the field of clinical neuropsychology.

3 MR. ZELENKA: No objection.

4 THE COURT: She is so qualified.

5 Q Dr. Wood, I'm going to try to do what I did with some
6 other experts, and that is to try to open up this series of
7 questions with getting your opinions up front a little bit
8 and then move back into how did you come to those opinions
9 in this case.

10 Do you have an opinion to a reasonable degree of
11 certainty as a clinical neuropsychologist based on all that
12 you have done in this particular case as to whether
13 Mr. Torres suffers from any particular intellectual or
14 cognitive function impairments?

15 A I do.

16 Q And what is your opinion just as a general statement?

17 A It's my opinion that Mr. Torres does suffer from some
18 cognitive impairment, specifically in the areas of executive
19 functioning and verbal memory in the context of relatively
20 intact general intellectual functioning.

21 Q And I'm going to try to clarify for the Court as well
22 what you were not doing in this case. Would it be fair to
23 say you are not a geneticist?

24 A Very fair.

25 Q And you are not a psychiatrist.

Dr. Stacey Wood
Direct examination by Mr. Tessier

1 A I'm not.

2 Q You're not a developmental psychologist.

3 A I'm not.

4 Q And you're not a -- as you just corrected me -- you're
5 not a neuropharmacologist.

6 A I'm not.

7 Q So you were not asked to -- and I suspect you did
8 not -- make any attempt to diagnose underlying genetic or
9 psychiatric conditions that Mr. Torres may suffer from.

10 A That's correct.

11 Q Your focus was entirely on conducting -- and you'll
12 talk about this in a minute -- neuropsychological testing
13 for cognitive intellectual functioning.

14 A That's right.

15 Q How did you come to be involved in this particular case
16 with -- for Mr. Torres?

17 A I was contacted by Mr. Ehliès.

18 Q Do you remember approximately when that was, in the
19 ballpark?

20 A It was in the fall of 2012.

21 Q And were you provided at some point as you became
22 involved in this case with some material for your review?

23 A I was.

24 Q What type of material do you recall having available to
25 you for review concerning Mr. Torres that was particularly

Dr. Stacey Wood
Direct examination by Mr. Tessier

1 relevant to your work?

2 A So, I was able to review trial testimony from
3 Dr. Schwartz-Watz, Dr. Wren. I think it was Marty Morin.

4 I was also able to review a letter from the
5 neuropsychologist, Dr. Brawley, and I was able to review and
6 rescore her test data.

7 I was given medical records from Mr. Torres' childhood
8 including some psychiatric inpatient admits.

9 I was given school records.

10 I was given prison medical records. Actually that was
11 after the assessment I saw those.

12 So, it was a combination of legal records, medical
13 records and the prior test data and school records. I think
14 that's everything.

15 Q And just to help us out in the process, were you able
16 to ask for documentation that you thought might be helpful,
17 or was everything just provided to you and you were limited
18 to certain types of information, or how did that work?

19 A You know, I don't remember the particulars in this
20 matter. Typically, I ask for school records, medical
21 records, any previous testing.

22 Q Cognitive testing?

23 A Yeah, cognitive testing especially to get started.

24 Q And are these -- is this the type of information that
25 you as a neuropsychologist and other neuropsychologists

Dr. Stacey Wood
Direct examination by Mr. Tessier

1 reasonably rely on in doing your work?

2 A Yes.

3 Q What was your specific role in this case as you
4 understood it?

5 A I was asked to assess general intellectual functioning
6 and also to assess neurocognitive functioning.

7 Q And how did you go about conducting your work?

8 A So, after reviewing records and talking to counsel we
9 set up an in-person interview and assessment at Lieber.

10 Q So you went to see Mr. Torres.

11 A I did.

12 Q Is that something you would pretty much have to do in
13 order to conduct your work as a neuropsychologist?

14 A It's -- yes. I mean, it's -- there's times where you
15 can't necessarily do that, but most of the time absolutely
16 you want to see the client and administer the test yourself.

17 Q So, would it be fair to say that your first effort in
18 this engagement was to review existing information that
19 related to cognitive function with respect to Mr. Torres and
20 then talk to counsel? And at some point you made a decision
21 or it was made available to you that you could actually go
22 see Mr. Torres. Is that a fair summary of how you started
23 your work?

24 A Yes.

25 Q And when you went to see Mr. Torres had you come up

Dr. Stacey Wood
Direct examination by Mr. Tessier

1 with your own decision, I guess, as to sort of the basic
2 array of tests that you thought might be helpful to you for
3 Mr. Torres in particular?

4 A Yes, I did.

5 Q I understand that we have a PowerPoint presentation
6 that will assist you in presenting some of your testimony
7 here today, is that right?

8 A I do, yeah.

9 Q I'm going to go ahead and put it to the -- well,
10 actually you have control of it with that clicker there.

11 A Okay.

12 Q So whenever you find it helpful to refer to the slide,
13 feel free to do so, and we can talk about, you know, what
14 work you did and what conclusions you drew from that work.

15 The first slide talks -- seems like it talks more
16 generally about some neuropsychological domains that I just
17 asked you to explain. What does that mean?

18 A So, a comprehensive neuropsychological evaluation will
19 cover different areas of cognition. Neuropsychology is
20 different from other types of psychology, and really the
21 emphasis is on thinking, memory, how people solve problems,
22 decision making.

23 So, this slide goes over the conceptual domains that a
24 comprehensive neuropsychological evaluation should include.
25 So, it should include an assessment of attention, language.

Dr. Stacey Wood
Direct examination by Mr. Tessier

1 Memory is a -- is a complex construct. There's not one type
2 of memory. So, a good battery should have an opportunity to
3 test different types of memory -- memory for verbal
4 material, memory for visual material, the ability to learn
5 information and retain it over time.

6 The domain of executive functioning is also complex.
7 Executive functioning is an umbrella term for a number of
8 subtasks that are important for reasoning, goal-related
9 behavior, decision-making. So, it's because it's not a
10 unitary construct you can't just have one test that assesses
11 executive functioning.

12 Intellectual functioning is -- can use I.Q. for
13 shorthand. It's -- this is a capital case, and so it's
14 always important to assess I.Q. and think about that in
15 these cases.

16 Academic achievement is our tests that look at
17 school-related behavior -- reading ability, mathematics,
18 that type of thing.

19 Q So, academic achievement -- just to pick on that one
20 for a second -- is that -- is that an assessment of past
21 academic achievement or is that an assessment of the
22 individual to look at the potential for a future academic
23 too?

24 A So, what my tests do is they give me a sense of their
25 current functioning, what's their current reading level, you

Dr. Stacey Wood
Direct examination by Mr. Tessier

1 know, what are their current skills.

2 Q Okay.

3 A And motivation. Again, in these cases it's always
4 important to consider the possibility of malingering and
5 effort sometimes. So, there are formal measures that
6 neuropsychologists use to think about to determine if a
7 person's giving forth their best effort.

8 It can even be true that a person is trying to give
9 forth their best efforts, you're not making an effort to
10 malingering, but they just aren't that motivated. There's
11 other reasons they may perform poorly. So, these
12 motivational measures are important to provide some context
13 for interpreting the other findings.

14 Q So, it's important to you as a neuropsychologist to --
15 and I don't know if I'm using this word correctly -- but to
16 sort of control for the possibility of malingering or poor
17 motivation, for example?

18 A That's right.

19 Q And that's part of what's included or incorporated into
20 some of the tests that you actually run?

21 A Yes, and it's also -- and there are also
22 sub-stand-alone tests that -- whose primary purpose is to
23 look at effort.

24 Q Okay. And in these -- you have these all as sort of
25 separate blocks -- attention versus language, versus

Dr. Stacey Wood
Direct examination by Mr. Tessier

1 executive functioning. Is it -- is it possible that a
2 person can be strong in one area and poor in another or weak
3 in another?

4 A Oh, absolutely.

5 Q And what about the context of your testing itself? I
6 mean, is there anything important about the setting or the
7 scenario within which you are trying to have your patient
8 undergo the testing that you're asking of them?

9 A Yes. And it relates back to the point I made earlier
10 on standardization. So, ideally neuropsychologists are
11 administering these tests under standard conditions so that
12 there is -- the client is cooperative. They're calm;
13 they're sober; they're -- they've had food; they're --
14 we're -- we're in conditions that'll provide a good setting
15 for giving standardized administration of these tests.

16 Q And with these different areas of -- or domains, I
17 guess -- neuropsychological domains -- are there different
18 areas of the brain that are more important concerning
19 individual domains that you've got listed here?

20 A Yes. I'm going to go ahead to the next slide just to
21 help answer that question more completely.

22 Q Okay. What do you have here?

23 A It's a neuropsychology --

24 Q If it helps you there's a laser pointer on that device.

25 A Oh, cool. So, neuropsychologists -- the tests that we

Dr. Stacey Wood
Direct examination by Mr. Tessier

1 use haven't only been developed to assess different types of
2 thinking. They've also been developed over time to be
3 related to different -- to different functions and different
4 brain regions.

5 So, let me give you some examples. So, we know based
6 on studies of different patients that some aspects of the
7 temporal lobe are critical for learning -- for learning and
8 retaining information from memory.

9 So, studies -- again, combat veterans and people with
10 Alzheimer's disease often have atrophy in the temporal lobe.
11 So, over time, you know, neuropsychologists have been able
12 to correlate poor performance on some of these memory
13 measures with lesions, with injury, to this part of the
14 brain.

15 Q And this part being the temporal lobe, which is orange
16 on your picture.

17 A I would say it's more gold, but yes.

18 Q Not great with colors. So, the gold portion, which is
19 the temporal lobe, seems or you've proven -- it's been
20 demonstrated -- that that's more likely to affect memory.

21 A Yes. Very much so.

22 Q What about others areas of the brain?

23 A The occipital lobe, primary role is vision. So,
24 injuries to the occipital lobe have been linked like in
25 stroke patients to loss of vision in the contralateral

Dr. Stacey Wood
Direct examination by Mr. Tessier

1 field, visual field. If the entire occipital lobe is
2 damaged you'll have complete blindness. So, occipital lobe
3 is important for vision. Less so for higher cognitive
4 functioning.

5 Q And to orient this picture of the brain for us, which
6 way is this oriented? Which way would your nose and eyes be
7 on this picture?

8 A So -- so, this is the front.

9 Q Okay.

10 A Eyes are about here.

11 Q Okay.

12 A Say about there.

13 Q Even though the vision portion is in the back, that
14 still has been demonstrated to effect how you see.

15 A Yes. The optic radiations course through -- actually
16 kinda go behind the brain and then through the -- under the
17 frontal lobes and through the parietotemporal lobes back to
18 the occipital lobe.

19 Q What about the other areas of the brain that you have
20 depicted?

21 A So, the frontal lobes you can see are -- are quite
22 large in humans. There's different subregions that are
23 important. This sulcus here that this bump, the part on the
24 brain here, is critical for movement. So moving the
25 opposite side of the body, a stroke here would result in an

Dr. Stacey Wood
Direct examination by Mr. Tessier

1 inability to -- say this is the left frontal lobe, the right
2 side of the body.

3 This part here, the most anterior aspect of the frontal
4 lobe, is prefrontal cortex, and so we know that executive
5 functioning and decision-making, social judgment is related
6 to these regions here.

7 The parietal lobe has an important role on the left
8 hemisphere in language, in understanding language, in
9 reading, and also more on the right hemisphere related to
10 spatial relationships.

11 So, these tests not only help us understand
12 behaviorally how a person is functioning and what their
13 strengths and weaknesses are, but they also help us to think
14 about brain integrity in the regions that are -- are maybe
15 impacted by a pathology.

16 Q Do these various different parts of the brain that you
17 have depicted on this slide, do they operate independent of
18 one another?

19 A Yeah. For the most part the brain is working together.
20 But we talk about this construct called modularity in
21 neuropsychology. And what modularity is is it's this idea
22 that there are different parts of the brain that have a very
23 focused role.

24 So, I was using the temporal lobe as an example. If I
25 were to remove both of your hippocampi bilaterally you would

Dr. Stacey Wood
Direct examination by Mr. Tessier

1 no longer be able to form any new memories. You're --
2 there's been patient studies where that's happened. I.Q.
3 functioning actually went up.

4 The reason they were doing the surgery was because of
5 epilepsy. Their seizures went down, but they were unable to
6 form new memories.

7 So, similarly, there have been many case studies
8 involving the frontal lobe where injuries to the frontal
9 lobe impact behavior, executive functioning, but our key
10 functioning is not changed or may even increase.

11 So, it's very important to think about which part of
12 the brain is involved in an injury or when you're trying to
13 make sense of a case.

14 Q And is that part of how the field of neuropsychology
15 has evolved, is that you see real-life situations where you
16 happen to know a person has been damaged in a particular
17 area of the brain and then you can see how they have
18 responded to that and it helps confirm some of what you all
19 study about how the brain works? Is that fair?

20 A Yeah, that's fair. We go from brain to behavior.

21 Q Now, with respect to Mr. Torres, I think you had an
22 opportunity among the information available to you to
23 evaluate various cognitive testing that had already been
24 done on Mr. Torres from his past.

25 A There was intellectual testing. I didn't see much

Dr. Stacey Wood
Direct examination by Mr. Tessier

1 cognitive testing.

2 Q So, intellectual testing. Would that be an I.Q. test?

3 A Yes.

4 Q Did you draw any conclusions or any significance from
5 the I.Q. test scores that you saw for Mr. Torres?

6 A Yes, I did.

7 Q What -- what does this tell us? This slide, I assume,
8 has -- does this have all of the I.Q. testing that you had
9 available with respect to Mr. Torres? I mean, everything
10 you knew about, in other words.

11 A Yes. These are the tests that I had. And I'd be happy
12 to walk you through it a little bit.

13 Q Yes. Tell us what we're seeing on this -- on this
14 chart.

15 A Sure. So I.Q., again, is -- I.Q. itself is not an
16 unitary construct. An I.Q. test is made up of ten or twelve
17 subtests that assess different parts of intellect -- of
18 intelligence.

19 For example, oftentimes they'll have a vocabulary test
20 or they may have puzzles to solve, so that this number kind
21 of represents the average score across all of these very
22 different subtests. That's what the full scale is.

23 I have verbal and performance because at least from the
24 WAIS-IV and before there were two factors that were pulled
25 out of the full scale that were scored separately. So, you

Dr. Stacey Wood
Direct examination by Mr. Tessier

1 can see some difference in verbal and nonverbal testing.

2 In the last column what I've done is what's called a
3 Flynn correction. So, the basic idea is that I.Q. tests
4 become stale over time. And the reason for that is that an
5 average I.Q. -- a hundred -- is relative to the current
6 population.

7 So, if you have an average I.Q. it means -- a hundred
8 I.Q., it means that you're at the 50th percentile for your
9 population.

10 So, our population has changed -- and although this may
11 seem hard to believe -- we've been getting smarter at least
12 in terms of I.Q. testing.

13 So, if you use an old I.Q. test what you're -- they're
14 easier in a way. You're going to overestimate I.Q.

15 So the Flynn correction just allows -- is a -- is a
16 formula. It's .3 points per year. Allows you to compare
17 the person to the date the test was normed to eliminate that
18 effect. So, it's a little bit cleaner and especially -- so
19 that WAIS-R's norm in 1974 and it was -- this clinician was
20 still using it in 1991. Those -- those norms are really out
21 of date. Those are really stale.

22 So, this column here, I think you can make more of an
23 apples-to-apples comparison in terms of the full scale I.Q.

24 Q So is the -- is it known as the Flynn effect?

25 A Yes, the effect that over time populations around the

Dr. Stacey Wood
Direct examination by Mr. Tessier

1 world have been performing better on basic I.Q. tests.

2 Q Is the Flynn effect recognized by neuropsychologists as
3 an appropriate corrective measure to normalize I.Q. scores
4 across different tests?

5 A It is.

6 Q So that's what you've done here with respect to
7 Mr. Torres and the I.Q. tests. And the information you had
8 available was you have a column that corrects for the Flynn
9 effect.

10 A Yes.

11 Q Did you -- and do these scores that are on the board
12 reflect any I.Q. testing that you conducted yourself?

13 A Yes. I saw Mr. Torres in early January in 2013.

14 Q And those are the results on the bottom, the last
15 entry?

16 A They are.

17 Q And so what kind of conclusions, if any, did you draw
18 overall about Mr. Torres' intellectual functioning based on
19 the I.Q. test results you had access to?

20 A I would say they've been roughly stable. I mean, the
21 I.Q. has a mean of a hundred and a standard deviation of 15.

22 So, these -- these scores are 11 apart. So, that's
23 more than a half standard deviation, but 86, 91, 86, 87, 83,
24 these are all within a half standard deviation of each
25 other. So they're, you know, quite similar given that they

Dr. Stacey Wood
Direct examination by Mr. Tessier

1 were different tests administered across different decades
2 by different clinicians. And overall I would place his I.Q.
3 in the low average to average range.

4 Q Okay. And you talked on the earlier slide about one of
5 the areas of the brain dealing a lot with or dealing
6 primarily with executive functioning. You gave us some idea
7 of what executive functioning looks like. And I guess my
8 question is do we -- are we exhibiting executive function,
9 you know, most of the time that we are living our lives and
10 making decisions on a daily basis?

11 A So, let me answer that.

12 On the one hand I want to say I hope so, but on the
13 other hand I know that, you know, although we would like to
14 engage our most analytic aspects of our thinking at all
15 times so we make the best decisions across our entire day,
16 the truth is the brain gets tired. And for a lot of the
17 time we're in default mode.

18 So, I imagine there's people in this courtroom right
19 now that are kind of checked out. Now they -- maybe it's
20 not that interesting, just sort of not necessarily thinking
21 analytically about everything I'm saying. And other people
22 are very, very engaged in terms of their executive
23 functioning in their deliberative reasoning.

24 So, much of the time during our days we are in this
25 default mode that does not actively engage executive

Dr. Stacey Wood
Direct examination by Mr. Tessier

1 functioning.

2 Q And can that be described -- I don't know if it's fair
3 to say -- that would be almost like a defense mechanism
4 where it's almost like a conservation mechanism? You're --
5 you're conserving your brain output for when you need it?

6 A You know, I'm not -- I'm not entirely sure of the
7 mechanism, but there is a line of research related to this
8 idea called ego depletion, and it's that -- it's the idea
9 that these resources are limited.

10 You know, there are differences within individuals in
11 terms of how much executive functioning ability that you
12 have. But they can be depleted and -- and people aren't as
13 able to engage them when that happens.

14 Q Okay. And then back to the I.Q. testing that you
15 actually did. I think you have a separate slide that just
16 focuses on your test results for Mr. Torres' I.Q. test. Is
17 that what this is that we see before us?

18 A Yes.

19 Q And is there anything in particular that you would like
20 to highlight about Mr. Torres' particular I.Q. test scores
21 from 2003? And you may have to help us just by explaining,
22 you know. You have full scale, which we can all appreciate
23 I'm sure, but the rest --

24 A Sure. No. I'd be happy to do that.

25 So, one pattern I wanted to just point out -- and I'm

Dr. Stacey Wood
Direct examination by Mr. Tessier

1 just going to go back a slide because I think it'll be
2 helpful -- is that in general you'll see that the nonverbal
3 abilities are stronger, that this pattern is consistent,
4 almost ten points -- here are 14 points -- across all of the
5 testing.

6 So, that's a consistent pattern of nonverbal abilities
7 being better than verbal abilities. Again, multiple tests
8 across decades -- different tests. And I see that as well.

9 What's nice about the WAIS-IV is I think
10 psychometrically it's a better test than its predecessors.
11 It doesn't just have two subscales. It doesn't just have
12 verbal-nonverbal. But it's called out a couple of other
13 factors.

14 One is working memory, so that's the WMI. That's the
15 working memory index. And the other is processing speed,
16 because in the past it wasn't always possible to know if the
17 reason a person performed poorly was because there's never a
18 time test. Were they just slow? You know, what -- is that
19 the reason motorically.

20 So, looking kind of more closely at this profile I see
21 someone that has a weakness, relative weakness, in verbal
22 domain and relative strength in nonverbal abilities with
23 low-average working memory and average processing speed.

24 Q And of the categories you have listed there the only
25 one that Mr. Torres tested average on in your particular

Dr. Stacey Wood
Direct examination by Mr. Tessier

1 I.Q. test was the processing speed?

2 A Yes, although 90 is right at the cutoff of low average
3 to average.

4 Q Okay.

5 A So 25th percentile -- 23rd's pretty close.

6 Q And your next slide talks a little bit about the
7 significance of this. And I think you just said what's on
8 the slide effectively.

9 Essentially, you concluded that Mr. Torres has stronger
10 visual abilities than verbal abilities?

11 A Yeah. That seems to be a consistent finding across
12 different clinicians.

13 Q And the "Y" question on here, what's the significance
14 of that?

15 A So, I -- I can't say for -- for sure why it's true in
16 his case, but often verbal abilities benefit vocabulary
17 knowledge about the world, the ability to perform like
18 abstract reasoning, benefits from school learning. And I
19 know in this case Mr. Torres had something of a disrupted
20 education due to institutionalizations, so that that might
21 be one reason that we're seeing this pattern. But it's a
22 hypothesis.

23 Q And did you as part of the work you did with respect to
24 Mr. Torres also look into academic achievement?

25 A I did some testing in that domain as well.

Dr. Stacey Wood
Direct examination by Mr. Tessier

1 Q And what did you observe in that domain? What does
2 this tell us that you did?

3 A So assessing academic achievement is pretty -- what we
4 would call face valid in neuropsychology. So you want to
5 assess word reading. You have the person read a card that
6 has words on it and see if they're able to pronounce it.

7 Reading fluency is a test where you have them read
8 different very simple sentences like the sky is blue and say
9 true or false and see how many they can do.

10 Picture vocabulary is looking at a picture and being
11 able to come up with the right name for it. And arithmetic
12 is simple calculations. And vocabulary is defining words.

13 So, again, these are all pretty, I think, obvious
14 tests. And when I look at them I see someone that has a
15 range of middle school to high school abilities. And that
16 was consistent with the records that I reviewed as well.

17 Q So what you're doing with this test if I understand is
18 effectively trying to get a gauge for what sort of academic
19 level this person is on.

20 A Yeah. So where are they functioning right now? So, my
21 understanding is that Mr. Torres completed some high school.
22 And, you know, again, we were just talking about how he has
23 a low average to average I.Q. And these scores are quite
24 consistent with that.

25 Q And his reading fluency on here looks like one of the

Dr. Stacey Wood
Direct examination by Mr. Tessier

1 higher categories for him.

2 A Yeah.

3 Q Is that -- how does that jive with his verbal
4 abilities?

5 A So reading fluency, again, was reading these statements
6 that are, you know, the sky is blue, milk is green. And you
7 just quickly make a judgment whether they're true or false.

8 The vocabulary level is very low. It's a test that you
9 can use with much younger kids as well. So, that might be
10 one difference. It doesn't require an extensive vocabulary.
11 It's more just the ability to read words and comprehend
12 them.

13 Q So you indicate the significance on the bottom of these
14 findings.

15 A I do.

16 Q And so far on the testing that you have done did you
17 have any reason to think the test scores were not reliable
18 based in any way on Mr. Torres' efforts?

19 A I didn't. And I have a slide that might be helpful to
20 talk to you a little bit about that. Let me skip ahead to
21 it if that's all right.

22 Q Sure.

23 A So, as I said earlier, it's always important to think
24 about motivation when you're doing these kind of
25 assessments.

Dr. Stacey Wood
Direct examination by Mr. Tessier

1 One way that I assess effort is to administer formal
2 measures of effort. And this is how they work. They're
3 tests that look complicated but are actually quite simple.
4 And even individuals with substantiated brain injury perform
5 well on them.

6 So, again, a person trying to malingering wouldn't know
7 that. And they often perform quite badly. So that's the
8 one measure I used.

9 A formal measure of malingering is called the TOMM, and
10 in the TOMM the person is shown a series of pictures. Then
11 they're asked -- then they're shown a series of -- of cards
12 that have two pictures on them and asked to identify the one
13 that they saw before.

14 So, again, even a person that hadn't ever seen those
15 pictures would get that right 50 percent of the time.

16 You can see Mr. Torres on the first trial got 43 out of
17 50, and on the second trial got 50 out of 50. So that's
18 well within the valid range in interpreting that.

19 And I also administered a forced choice effort measure
20 that's part of a memory test I'll talk about in a little
21 while. That was valid.

22 But I don't want to ever just use effort tests.
23 There's other ways a clinician can look at effort. I mean,
24 one -- another way is to look at the range of scores. So,
25 Tony had some very low scores during my testing but also

Dr. Stacey Wood
Direct examination by Mr. Tessier

1 some quite -- quite high scores.

2 And, as I said, I was showing you the I.Q. across
3 decades, across clinicians using different tests. We're
4 having scores within four points of each other, so that
5 pattern's been consistent over time.

6 So, taken together I'm confident that the effort was
7 adequate for the interpretation of these tests.

8 Q And the testing you do for what you call motivation --
9 what other people might call malingering -- that test is
10 done in the same session as the other testing you did?

11 A Yes.

12 Q And that's important for you as a neuropsychologist to
13 do that testing at or about the same time you're doing the
14 underlying testing which you're trying to see if it's valid?

15 A Of course, yeah.

16 Q So, tell us if you would just to get this on the
17 record, I guess, how -- how long of a period of time did it
18 take you with Mr. Torres to run through the testing that you
19 did with him in 2013?

20 A You know, I don't remember exactly, but I think it was
21 between five and six hours, which is the average amount of
22 time it takes me to do this test battery.

23 Q And was there anything about the session you had with
24 Mr. Torres that was remarkable from your perspective as a
25 neuropsychologist in terms of his cooperation level, lack of

Dr. Stacey Wood
Direct examination by Mr. Tessier

1 cooperation, the conditions or setting you were in, that
2 sort of thing? Anything that jumped out at you that would
3 cause you concern about the test result?

4 A No. We were -- we were given a good space with a table
5 and two chairs with adequate lighting and plenty of room for
6 my equipment.

7 It was quiet. It was -- Mr. Torres was calm and
8 cooperative. He was able to understand and comprehend
9 instructions that I gave him.

10 Q He was obviously in a controlled setting.

11 A Yes.

12 Q At Lieber?

13 A That's right.

14 Q And did you check to see whether or not he was -- had
15 been on medication at that time?

16 A I did.

17 Q How did you do that?

18 A Well, at first I asked him what he was taking, and he
19 reported that he was taking medication for diabetes. He was
20 taking Paxil for depression. He was taking Neurontin for
21 pain. I think that's right. But then I went back later and
22 checked the jail records to see if he -- if that was
23 accurate. And I checked both the log, and they have a
24 narrative part of the notes, so that he was compliant. And
25 that was accurate, that he taking those at the time of the

Dr. Stacey Wood
Direct examination by Mr. Tessier

1 assessment.

2 Q I think you mentioned this earlier, but as a
3 neuropsychologist it's important for your testing to ensure
4 that it's done in a controlled setting like the one
5 Mr. Torres was in?

6 A Yes.

7 Q And --

8 A Well, not always that controlled.

9 Q Right. But you want a control for various factors that
10 could impact the results of the tests, is that fair?

11 A Yes.

12 Q What are you testing for? I think you have a word for
13 it like cold cognition or something like that.

14 A So, right. So, what I think about what a
15 neuropsychologist does is that we're looking kind of at the
16 hardware of the brain. This is a person. They're not
17 aroused; they're not stressed out; they're not delirious;
18 they're not -- you know, they're -- they're, you know, at
19 their best so that we can get a sense of this is their brain
20 functioning kind of under optimal conditions. That's what
21 we hope to do.

22 Q And that's -- so that's the context in which you're
23 looking to see are there deficits.

24 A Yes, in this context are there deficits.

25 Q After we talked about academic achievement, I suspect

Dr. Stacey Wood
Direct examination by Mr. Tessier

1 that's not the last of the testing that you did on
2 Mr. Torres. And I'd like to go back to figure out what
3 other testing did you do beyond academic achievement.

4 A Sure. And so let me start with attention.

5 Q Okay.

6 A So attention is assessed in a couple of different ways.
7 One common test is the Digit Span Test where I read a
8 string of numbers and ask the client to say them back, so
9 that it starts simple like one, two. But it becomes much
10 more complex. Even you increase the number of digits each
11 time after two trials and measure when the person starts
12 failing. So, his digit span was -- was okay -- 16th
13 percentile. So that's low average. And -- and other tests
14 like it, again, were in the sort of low average range.

15 He also did relatively well on visual-spatial tests.
16 So, I've talked already about how that's a relative strength
17 for him.

18 And these tests are things like asking a person to copy
19 a figure, solve nonverbal puzzles, put together blocks to
20 match a pattern. And we know, again, from our work as
21 neuropsychologists that they're sensitive to visual-spatial
22 and instructional abilities. So, these -- I would describe
23 these as intact domains for him.

24 Q What about memory for Mr. Torres? Did you try to
25 assess memory?

Dr. Stacey Wood
Direct examination by Mr. Tessier

1 A I did.

2 Q And how did you go about -- how do you assess memory
3 generally, and then specifically with Mr. Torres?

4 A So, that, you know, there's different types of memory,
5 and I was just talking about the Digit Span Tests where we
6 say a string of numbers and then ask a person to say them
7 back. So that's a very short term type of memory. That
8 looked pretty good.

9 But another assessment we might do is to read a short
10 story and ask a person to say it back. Now, we don't expect
11 them to say it back perfectly. You know, we are -- we are
12 comparing their performance to others with the same age and
13 education. But on a simple task of reading a story and
14 asking him to say it back his performance was low. It was
15 at the fifth percentile. So it's mildly impaired.

16 Q And that's called -- is that called story memory?

17 A The test I used was Logical Memory.

18 Q Okay.

19 A But it's consistent -- Dr. Brawley also used a story
20 memory task, and she reported that a performance was up to
21 second percentile when she administered as well.

22 So, it's, again, it's reading a story, asking the
23 person to say it back but then asking them in 15 or 20
24 minutes what they recall as well. So both the immediate
25 presentation and also the delay was impaired in this client.

Dr. Stacey Wood
Direct examination by Mr. Tessier

1 Q And the significance of all of this, you conclude, was
2 that he has poor verbal memory?

3 A Well, it's a little more nuance than that.

4 Q Okay.

5 A So, another way that we look at memory is to repeat
6 information multiple times. So, it's -- there's another
7 test that we use. It's like a -- I call it the grocery-list
8 test. So, I read a relatively long list of items -- 16
9 items -- and ask the person to tell me as many as they can
10 recall.

11 Okay. Nobody can do this. Very few people can do this
12 perfectly after one -- hearing it one time. So we repeat
13 the list five times.

14 We give the client an opportunity to learn these words.
15 And he was able to learn the words when given that
16 opportunity with repetition.

17 Q But did anything strike you as unusual with respect to
18 how Mr. Torres performed on that test?

19 A Yes. So, what was very unusual was the number of
20 repetitions during the trial. So, let me just give you a
21 little flavor for the test.

22 So, a person may be trying to remember the words, and
23 they kind of are saying them out loud. They're saying,
24 okay, said truck, spinach, zebra, cow, onion. Did I already
25 say zebra? Subway, tomato. And they go on and on.

Dr. Stacey Wood
Direct examination by Mr. Tessier

1 So, it's not uncommon for a person to repeat an item
2 once like that. Mr. Torres repeated items 52 times.

3 So, over the course of the five trials, again, later on
4 there's also a delay. So, asking the person after a delay
5 can you remember those words that I read to you five times,
6 he still had these intrusions of repetitions.

7 So, as a neuropsychologist I think about that primarily
8 as a problem with encoding and organizing information unless
9 it's kind of memory per se.

10 Also, most people would notice they were doing that.
11 You know, they would have -- yeah. So they would -- if you
12 repeated or perseverated by saying the word subway five
13 times during one trial you would probably catch that.

14 So, it's so unusual. It was five standard deviations
15 below the norm, which is less than a first percentile. So,
16 that's a very unusual finding. And to me looking at -- and
17 I also want to note that visual memory was quite good. So,
18 verbal memory, there was evidence of impairment. But visual
19 memory, the ability to copy a figure and then draw it from
20 memory and then draw it from memory again about 15 to 20
21 minutes later was fine. It was good. It was high average.

22 So, we know, again, based on brain organization, the
23 left hemisphere is important for language, the right
24 hemisphere is important for nonverbal type learning that
25 this is a theme or seem with him. He has a relative

Dr. Stacey Wood
Direct examination by Mr. Tessier

1 strength in nonverbal abilities. But there was this high
2 number of repetitions on his verbal memory tests consistent
3 with problems with frontal lobe impairment or deficits in
4 executive functioning.

5 Q Okay. So, that's the next subject area there, will be
6 executive functioning, which is a different part of the
7 brain, the frontal lobe, is that right?

8 A We're moving to the frontal lobe.

9 Q So, what did you -- what do you do or like what is the
10 importance of executive function from the perspective of a
11 neuropsychologist?

12 A So, you know, executive functioning is this umbrella
13 term that neuropsychologists use when we talk about the
14 executive of the brain.

15 So, you can imagine this little guy ordering around the
16 rest of the brain so that -- but there are many different
17 subcomponents to executive functioning. So, all of the ones
18 I have listed on this slide like being able to think
19 flexibly, being able to plan, being able to problem-solve,
20 control impulsive behavior, stay on tasks, simulate
21 consequences and ability to regulate emotion -- a patient
22 may have problems with some but not all of these. Again,
23 they're -- all of them are aspects of executive functioning
24 but it's -- they're related to slightly different areas of
25 the prefrontal cortex.

Dr. Stacey Wood
Direct examination by Mr. Tessier

1 Q So, these are important for people in making and then
2 carrying out decisions, is that fair, among other things?

3 A Yeah. Maybe it would be helpful for me to give you an
4 example.

5 Q Yeah. I'm sure.

6 A So, earlier on I was talking a little bit about default
7 mood. You know, when we're driving to work we're just all
8 in default mode often, you know, we don't necessarily think
9 about where we're going. We just get there. Our minds are
10 kind of free to wander unless something happens, right?

11 If there's an accident -- in Los Angeles it's a normal
12 part of life to have an entire freeway closed. And you have
13 to -- at that point you're on your way to court. You have
14 to start to think what should I do. Generate solutions.
15 Maybe I should get off the freeway and take side streets,
16 maybe I need to call my office and let the Court know I'm
17 going to be running late. Maybe I shouldn't do anything.
18 Maybe it's just a small, you know, detour and we'll be past
19 it pretty quickly.

20 So, and sometimes when we start getting stressed out,
21 you know, we might feel -- feel a little agitated. We have
22 to keep that under control too. You know, we have to be
23 able to control that impulsive behavior and regulate our
24 emotions.

25 So, even something -- with that example you can see

Dr. Stacey Wood
Direct examination by Mr. Tessier

1 that shifting from default every -- automatic pilot into
2 engaging executive functioning in order to make a decision
3 that'll allow you to -- to meet your goal, which, let's say,
4 is going to court.

5 Q So more of a reason function compared to emotional
6 response is what executive function helps you control?

7 A Well, so, yeah. I think about executive functioning as
8 the cognitive breaks on emotion. They're the cognitive
9 tools that help us manage emotion. That's one thing they
10 do.

11 Q And is there any -- have there been any situations
12 where neuropsychologists have been able to study and confirm
13 that that executive functioning resides primarily in the
14 frontal lobe of the brain? Or why are we convinced that's
15 where it resides?

16 A Yeah. There have been, you know, hundreds of case
17 studies linking frontal -- linking the prefrontal cortex to
18 executive functioning decision-making.

19 And I have a slide here with the -- the infamous case
20 of Phineas Gage. So, Phineas Gage was a railway worker in
21 Vermont in the 1800's. And he is -- he was like a manager.
22 He had a position of authority. He was considered a very
23 conscientious and good worker.

24 He's famous because he survived a horrible accident
25 where the tamping rod he's holding in this photograph

Dr. Stacey Wood
Direct examination by Mr. Tessier

1 flew -- was an explosion, flew through his cheek and through
2 the top of his head injuring the prefrontal cortex. Yet he
3 lived. He was walking around and even speaking the same
4 day. And his physician, John Harlow, wrote about this case.

5 others that knew Gage before and after the accident,
6 you know, famously describe him as Gage was no longer Gage.
7 And what they mean is that his personality changed. He was
8 socially inappropriate, often cursing, getting into fights.

9 He was able to have jobs, but he often lost them
10 quickly. He had this sort of chaotic life after the
11 accident wandering around the country. Even there's some
12 discussion of him being in the circus.

13 And so from this case and others like it we realize the
14 importance of the frontal lobe to decision-making, emotional
15 regulation and social judgment.

16 So this is, again -- this was the first case where only
17 prefrontal cortex was injured, patient survived, and you see
18 this dramatic shift in their ability to make good decisions
19 and regulate emotion.

20 Q Obviously, zero psychologists are not basing all of
21 their findings on the frontal lobe, but it's important to
22 executive function on the case of Phineas Gage. I'm
23 assuming there's much more in the literature about studies,
24 MRI type studies and other case studies that confirm this as
25 well?

Dr. Stacey Wood
Direct examination by Mr. Tessier

1 A Yeah. I mean, it's a common entry as part of car
2 accidents just because of the nature of the accident. So,
3 individuals that survive traumatic brain injury often have
4 deficits in executive functioning.

5 There are certain types of dementia that target the
6 frontal lobes first so that the first changes are deficits
7 in executive functioning in what looks like psychiatric
8 symptoms, frankly, changes in disinhibition and personality
9 and placidity.

10 So, yes, there is a good research literature that
11 relates executive functioning to the frontal cortex.

12 Q And would it be fair to say it's generally accepted in
13 the field of neuropsychology that that is where executive
14 function primarily resides within the brain, is the
15 prefrontal lobe?

16 A Yeah, again, primarily. The frontal lobes, you know,
17 because they are the executive they're -- there are multiple
18 circuits between front only lobes and other brain regions,
19 both cortical and subcortical areas, so, but --

20 Q Part of the brain has to tell the rest of the brain
21 what to do?

22 A That's --

23 Q May be oversimplifying it but --

24 A No. That's -- that's about right.

25 Q Okay. And you have another slide that has some very

Dr. Stacey Wood
Direct examination by Mr. Tessier

1 new depictions on it.

2 A I do.

3 Q What -- what does this tell us about executive
4 functioning as compared to emotional decision-making?

5 A So, as I said earlier, you know, the frontal lobes are
6 quite large in humans. There's different regions. These
7 regions here are important for motor functioning. The blue
8 is for premotor -- motor sequency, motor planning.

9 Some aspects of executive functioning are -- have been
10 localized in more lateral areas, the lateral prefrontal
11 cortex or dorsal lateral prefrontal cortex. You may see
12 D.L.P.F.C. used to describe these.

13 So, this is a region that's important for analytic
14 delivery of decision-making. So, if you are thinking about
15 where to go to college or law school, you're thinking.
16 You're weighing the pros and cons or, you know, maybe
17 whether to -- you're buying a car and you're looking at
18 financing and models and mileage. You're trying to really
19 analyze the decision. We think this is the region that's
20 important for that kind of analysis.

21 It's also important for -- for thinking flexibly and
22 being able to initiate.

23 So, back to my car example, being able to think like,
24 okay, the road is shut, I have to come up with some other
25 solution.

Dr. Stacey Wood
Direct examination by Mr. Tessier

1 Q That's where it happens.

2 A Yeah.

3 Q That part of the brain.

4 A That's for the most part.

5 So, the other slide is a picture if I -- there's two
6 hemispheres to the brain. If I took the brain and pulled it
7 apart and we're just looking at the medial or the middle
8 aspect here, we can see some other regions that aren't as
9 apparent looking at the external view of the brain.

10 Q Is this also oriented the same way as that prior brain
11 slide -- your face?

12 A Yes. The eyes here. And this region here, this gold
13 part, the ventromedial prefrontal cortex, is here. It's
14 related to orbital frontal cortex. That's another name
15 that's sometimes used for this region.

16 We know that this is a region that has -- it's critical
17 for good decision-making, but it seems to have a role in
18 integrating emotion and cognition, regulating emotion. And
19 it's important for more social judgment types of decisions.

20 So, when you're -- when you're getting that feeling
21 that this is going really well and you integrate that into
22 your decision-making, that's this region. Or that feeling
23 this is not going well, we need to do something different,
24 that cuts sense. We talk about this region being important
25 for that.

Dr. Stacey Wood
Direct examination by Mr. Tessier

1 Q And this -- in Dr. Schacht -- he's a developmental
2 psychologist who testified, talked, about what he called a
3 theory of mind or an ability to sort of figure out what
4 someone else is thinking. Is that what you're talking about
5 in part with this area of the brain, the ability to sort of
6 assess what other people are thinking?

7 A Partly. But even more so the ability to integrate your
8 own emotional experience into your own decision-making.

9 Q Taking the cues from the environment and then factoring
10 them in.

11 A Yes.

12 Q Okay.

13 A And then this region here, the anterior cingulate, is
14 another important region for executive functioning.

15 We talked about this being critical for the ability to
16 monitor one's self. So, during our typical day we often
17 make small mistakes. So, we might call someone by their
18 wrong name. And immediately you catch yourself. You go,
19 oh, I'm sorry, Susan. I don't know why I called you Stacey.

20 So we're all often monitoring our own behavior here.
21 And this is an important structure for motivation and
22 attention as well. And so this is a structure we talk about
23 as potentially being important for social judgment too in
24 terms of monitoring others, as well as ourselves.

25 So, these are -- these are different brain regions. We

Dr. Stacey Wood
Direct examination by Mr. Tessier

1 have our motor region; we have our cognitive lateral region;
2 we have our motivation region; we have an emotion region.
3 These are all different circuits that are part of the
4 frontal lobe.

5 Q That's what I was going to ask. Just to make sure
6 we're clear these -- these colored areas are all part of the
7 frontal lobe.

8 A They are. So, it's possible to have an injury, let's
9 just say, right here. The person's kind of apathetic. They
10 don't have a lot of initiative; they don't have good
11 cognitive flexibility, but their social judgment may still
12 be okay.

13 Q Okay.

14 A You know, in the Phineas Gage case what they talk most
15 about is damaged -- sounds like to me more here. He had --
16 he had difficulty regulating his emotion; he had difficulty
17 inhibiting inappropriate responses; and he had difficulty
18 with social judgment.

19 So, it's possible to have dissociations. I mean,
20 usually you see patients that cut across all of these
21 circuits. Right. The lesions aren't necessarily that
22 localized, but it is possible to have smaller lesions too.

23 Q And we know in history we had a time period in this
24 country where people were doing prefrontal lobotomies, which
25 they thought would medically help them for some reason.

Dr. Stacey Wood
Direct examination by Mr. Tessier

1 What part of the brain were confronted by prefrontal
2 lobotomies?

3 A So, you know, again, I evidence studied -- you know;
4 lesion studies of those cases.

5 My understanding is they were going in right behind the
6 orbits of the eyes, so they were severing these regions here
7 just by moving a scalpel or a knife right behind the orbits
8 in the eyes and be targeting more of these emotional social
9 aspects of decision-making.

10 Q In the neuropsychological field what would you expect
11 damage in that part of the brain to result in in a patient?

12 A Well, if it included the cingulate I would expect to
13 see a lot of apathy, you know, low levels of initiative and
14 poor self-monitoring, decreased social judgment, could have
15 impaired ability to regulate emotion. I don't see why it
16 would be helpful.

17 Q So now that we go back to Mr. Torres and the testing
18 that you did with him, did you do some of your testing to
19 focus on impairments in executive functioning in Mr. Torres
20 particularly?

21 A Well, I did a comprehensive assessment of executive
22 functioning.

23 Q And how did you go about doing that? What tests did
24 use?

25 A So -- so, I included a few tests to look at executive

Dr. Stacey Wood
Direct examination by Mr. Tessier

1 functioning. And one test that I like to use a lot is the
2 Trail Making Test. It's a -- it's a popular test in
3 neuropsychology. And there's two trials. There's two parts
4 to Trail Making.

5 Trail Making part A is simply a connect-the-dots test.
6 So, the client is simply connecting, drawing a line,
7 connecting the dots one, two, three, four just like you
8 might have done as a kid.

9 So that Trail Making part A, Mr. Torres scored around
10 the 50th percentile. He was able to understand the task,
11 completed it within an average amount of time, didn't make
12 any errors.

13 Trail Making Two is a little more complicated. In this
14 case -- in this task individuals have to alternate between
15 numbers and letters. So, they start with one and then go to
16 A, 2-B, 3-C, etc.

17 So, you can see that it kind of builds in nicely this
18 cognitive flexibility aspect on top of the motor aspects
19 that you've already assessed.

20 And so Trail Making, Mr. Torres is scoring in the
21 impaired range at the first percentile in Trail Making part
22 B.

23 Q A very low score.

24 A Yes.

25 Q Does this go to the ability to change course of a

Dr. Stacey Wood
Direct examination by Mr. Tessier

1 decision once you started down a path?

2 A You know, I'm hesitant to answer that without knowing
3 more about the decision. But we know it is related to that
4 ability to think flexibly and to sequence information.

5 Q Thinking outside the box, that phrase, this is directed
6 towards that a little bit, I mean.

7 A I would say more connecting the dots.

8 Q Okay. What about any other test for executive function
9 with Mr. Torres?

10 A I also administered the Wisconsin Card-Sorting Test.
11 This is another commonly used test to assess executive
12 functioning.

13 And the basic idea of this test -- it's administered on
14 a computer -- can be hand-administered too. I used a
15 computer -- is that on the computer screen there's four
16 cards. And then you're given another card.

17 And what I say is this test is a little different from
18 some of the other tests we've done. I'd like you to tell me
19 where you should place this card.

20 So, if you're looking at this now you can see that the
21 answer is kind of ambiguous, right? There's a number of
22 different options you might choose. So you could match on a
23 number; you could match on shape; or you could match on
24 color.

25 So, what the client has to do is kind of generate an

Dr. Stacey Wood
Direct examination by Mr. Tessier

1 answer. And when they -- when they give it -- let's say
2 they pick No. 1. The computer says whether or not their
3 response is correct or incorrect.

4 So, doing this test in terms of being able to figure
5 out the rules Mr. Torres did -- did well. He was -- he was
6 in the average range. He was within normal limits on this
7 test.

8 The only thing that was -- I just wanted to note is
9 that he made this unusual error in that once he figured out
10 the rule -- most people, they go in default mode, right.
11 They're like, all right, the answer is color. I'm just
12 going to match each card on color.

13 He would forget the rule and sort of have to start
14 over. So that's failure to maintain set. And his score on
15 that indocy [sic] was in this borderline range.

16 Q Six to ten percent?

17 A Yes. So, overall his performance on this executive
18 functioning test, which is more related to dorsal lateral
19 prefrontal cortex, was -- was -- was average, again, with
20 this one weakness in retaining the rule.

21 Q And were there other tests you did for executive
22 functioning with Mr. Torres?

23 A I did.

24 Another test I like to use to look at executive
25 functioning is the Stroop. So, the Stroop -- you may have

Dr. Stacey Wood
Direct examination by Mr. Tessier

1 seen versions of this, but let me just walk you through it a
2 little bit.

3 The Stroop is a relatively simple test. You ask your
4 client to read a card that -- or to look at a card that has
5 different patches of color and to tell you the name of the
6 color. That's the first part.

7 On that -- oops. On that his ability to read a card,
8 to name colors, was at the 63 percentile, so average.

9 The next part of the test is you ask the person to read
10 color words like words red, blue. They're printed in black
11 and white. And his ability to just read those words was at
12 the 37th percentile. So, that's speed with very few errors.

13 But the Stroop effect was -- when it gets interesting
14 is when these color words are printed in an incongruent ink.

15 So, here you see the word is blue, but it's printed in
16 green ink. And your brain wants to say that word. People
17 that are good readers, good strong readers, in English, they
18 want to say that word.

19 Q They want to say blue.

20 A Yes. So they inhibit it. You have to inhibit that
21 response in order to successfully complete this task.

22 And Mr. Torres performed on that task where -- where he
23 had to say the color green while inhibiting the word at
24 less -- at around the first percentile. So, that's in the
25 severely impaired range.

Dr. Stacey Wood
Direct examination by Mr. Tessier

1 And there's another -- there's another condition where
2 there's little boxes around some of the words. And if
3 there's a box around it, you read the word. And if there's
4 not you say the name of the color. So, that brings in that
5 cognitive flexibility.

6 Q Are these timed tests?

7 A They are. They're timed.

8 Q And so the conclusion you can draw from this is what
9 about Mr. Torres' ability in this area of executive
10 functioning?

11 A So, he had a lot of difficulty inhibiting a dominant
12 response and monitoring errors.

13 What I like about the Stroop is based on findings from
14 more imaging as we know that it -- when -- when people are
15 doing this task it activates the anterior cingulate. So, it
16 really gets out that other kind of -- as well as other parts
17 in the frontal lobe.

18 So, this was a test that was really difficult for him.

19 Q And I think you have one other test that you conducted
20 on Mr. Torres with respect to executive functioning. Is
21 that this Iowa gambling test?

22 A Yes.

23 Q What's the significance of this? What are you testing
24 for here?

25 A The Iowa Gambling Test is -- is a computerized test

Dr. Stacey Wood
Direct examination by Mr. Tessier

1 that looks at decision-making, and it's -- it's administered
2 on a computer, and the client is given four decks of cards
3 again. But this time when you turn over a card it tells you
4 whether or not you've won some money. But you might also
5 have lost money. So, that's why it's called the gambling
6 test.

7 And it's -- it's rigged. You know, the bank always
8 wins in the Iowa Gambling Test basically, because we know
9 that two of the decks have -- have bad contingency.

10 So, if you draw from decks A and B, then you have high
11 wins but higher losses. And clients that like those decks
12 tend to be more risk-seeking and tend to kind of -- they're
13 making poor financial decisions.

14 Clients that choose the good deck, C, indeed they have
15 lower payouts but lower losses -- do better on this test
16 over time, so that the healthy neurologically intact pattern
17 is to choose to -- everyone starts with the bad decks. They
18 love those high payouts, but they learn it's not worth it,
19 and they kind of migrate over around 25 to 50 cards -- 25 to
20 50 cards over in the good decks.

21 Tony's profile was -- you know, I'm sorry. It looks to
22 me like maybe this was an old version of the slide, but I'll
23 correct it now.

24 So, Tony's preference was -- there's a typo. He didn't
25 have a preference for deck A. It was for deck B. But his --

Dr. Stacey Wood
Direct examination by Mr. Tessier

1 his strategy suggested to me that he didn't really
2 understand this task. So, it was what's called a sawtooth
3 pattern, so, like he didn't consistently draw from the good
4 decks or the bad decks. He drew kind of randomly from all
5 of the decks scoring overall in kind of the averagey range
6 but not demonstrating ability to identify the optimal
7 strategy.

8 Q You -- you would expect to see a pattern over time of
9 trying out the various decks and then eventually migrating
10 to the less risky decks.

11 A Yes.

12 Q And with Tony he never migrated to any particular set
13 of decks.

14 A That's right.

15 Q It was more random. And that tells you something about
16 his executive functioning capabilities.

17 A Well, I would say it's more descriptive. It's not that
18 it's impaired. It just means he didn't identify the best
19 strategy.

20 Q Let me.

21 MR. TESSIER: If I may approach, Your Honor.

22 Q I'm going to hand you, Dr. Woods, what's marked as
23 Applicant's Exhibit 23. I just want to make sure I get this
24 in the record and have you tell us. What is Exhibit 23 now
25 that you've talked about all of the testing that you did?

Dr. Stacey Wood
Direct examination by Mr. Tessier

1 A You know, I didn't talk about all of the testing that I
2 did.

3 Q Oh, I'm sorry if I missed any.

4 What other testing should we cover before you talk
5 about Exhibit 23? And maybe 23 helps you identify any other
6 tests we missed.

7 A Well, I noticed that I didn't have verbal fluency on my
8 slides, and so verbal fluency is the ability to generate
9 words to a cue. And his performance was low average, so,
10 consistent with other findings that we had.

11 Let me see if there were any other omissions.

12 (Pause.)

13 A Yeah. I also didn't talk about his motor functioning.
14 So, I looked at fine motor ability as well using what I call
15 a grooved peg board. So, the person literally has to put
16 pegs in a hole, and on that he was -- he was slow for his
17 right hand but not his left hand.

18 Q And is that test a test of executive function in some
19 way?

20 A No. Those were just tests I didn't include in a
21 PowerPoint. So, to go back to executive functioning, there
22 weren't any other tests of executive functioning, I don't
23 think, that I administered.

24 Q Okay. Now, is Exhibit 23 a summary of all of the test
25 results that you either performed for Mr. Torres or that you

Dr. Stacey Wood
Direct examination by Mr. Tessier

1 were aware of that concerned his cognitive ability?

2 A Not completely. It includes all the tests that I
3 administered.

4 Q Okay. Is that starting on the first page when you say
5 test results?

6 A Yes.

7 Q Below that line would be tests you administered?

8 A I also -- when they were available I compared it to Dr.
9 Brawley's findings from 2008. So, she gave some of the same
10 tests that I gave. And I say it's not complete because
11 there was some academic testing done of Mr. Torres when he
12 was a child that I didn't table but I did review. So, the
13 first table includes all of the I.Q. tests that I reviewed.

14 Q And just to walk you through it, then that's on the
15 first page at the top, correct?

16 A It is.

17 Q And that shows all the various results he got on the
18 I.Q. testing you were aware of or that you performed.

19 A That's right.

20 Q And then the second part of the first page would be
21 your I.Q. test that you performed on Mr. Torres.

22 A Yes.

23 Q Now, on the second page, these are test results. If
24 you'd just walk us through quickly so we know, for the
25 record, what are you reflecting in terms of which tests you

Dr. Stacey Wood
Direct examination by Mr. Tessier

1 did on this page?

2 A On page two?

3 Q Yes.

4 A So, on the left side of the left column I list the
5 tests.

6 Q Okay. So there's a name of a test listed?

7 A And then I have the raw score.

8 Q Okay. That's the next column over.

9 A Then I have a standard score.

10 Q Is that a percentile score?

11 A It is not. The next column is percentile.

12 Q Okay. So, the second column of numbers is the --

13 A It's like some kind of standard score. It could be a Z
14 score or it could be a standard score depending on the test.

15 Q And then the third column numbers would be his
16 percentile score?

17 A Correct.

18 Q And then you indicate in the fourth or the fifth column
19 actually on this chart, is what you would list him in terms
20 of average, impaired, high average, etc.

21 A Right. Those are my interpretations. And the last two
22 columns are comparisons to Dr. Brawley's testing done in
23 2008 where available.

24 Q So where you had testing results from Dr. Brawley who's
25 another neuropsychologist --

Dr. Stacey Wood
Direct examination by Mr. Tessier

1 A Yes.

2 Q -- you added a comparison to her test results.

3 A I did.

4 Q Is the same true then for pages -- well, page three, I
5 guess. You have the same data presented on page three for
6 different tests?

7 A I do.

8 Q And in the same format?

9 A Yes.

10 Q And the last page, is that the same as well?

11 A It is.

12 MR. TESSIER: Your Honor, we offer Exhibit No. 23 into
13 evidence.

14 MR. ZELENKA: No objection.

15 THE COURT: It's admitted.

16 (Neuropsychological evaluation summary of Stacey Wood,
17 Ph.D., dated 1/18/2013 marked Applicant's Exhibit No. 23.)

18 Q You talked about Dr. Brawley. You had the opportunity,
19 I take it, then to review test results done by Dr. Brawley
20 on Mr. Torres?

21 A Yes, I did.

22 Q And those tests were done sometime prior to his murder
23 trial in 2008. Is that your understanding?

24 A That's my understanding.

25 Q Tell us if you would what differences, if any, were

Dr. Stacey Wood
Direct examination by Mr. Tessier

1 there in the testing you performed on Mr. Torres to the
2 testing you were aware of that Dr. Brawley performed on
3 Mr. Torres.

4 A Well, to start with, test selection was very different.
5 So, I noted that Dr. Brawley administered part of an I.Q.
6 test. She prorated it, which means didn't include all of
7 the subtests.

8 I'm just going to note that that's kind of unusual in a
9 capital case to prorate an I.Q. test versus just
10 administering the whole test.

11 She also administered a neuropsych screen tool called
12 the RBANS, the repeatable battery for neuropsychological
13 status. So, that the RBANS takes about 30 to 40 minutes to
14 administer and is kind of a quick and dirty screen for
15 cognitive impairment, and it's relatively easy both to
16 administer and to pass.

17 And she administered a couple of other measures --
18 attentional contracking [sic] measure; she administered the
19 Trail Making Test; and she administered Grooved Pegboard.
20 So, it was not a comprehensive assessment over all.

21 Also, I want to note she didn't even administer all of
22 the RBANS. She did not administer two of the subtests. So,
23 you can't calculate overall indices from the RBANS from that
24 testing. It only included one measure of executive
25 functioning.

Dr. Stacey Wood
Direct examination by Mr. Tessier

1 So -- so, one important difference is that I used a
2 much more comprehensive battery that didn't include
3 screening measures, and it did include multiple measures of
4 executive functioning.

5 Q Were all of the tests that you conducted on Mr. Torres
6 available to neuropsychologists back in 2007 and 2008?

7 A Well, the WAIS-IV had just come out, so, a lot of
8 neuropsychologists weren't using it.

9 Q That's one of the I.Q. tests?

10 A Yeah, but it's -- but it was available. I mean, again,
11 the WAIS-II -- I'm not faulting her for using that in 2008,
12 but he should -- correct, because at that point the norms
13 were -- were stale. But otherwise all of the tests that I
14 use would have been available in 2008.

15 Q And those various different tests of executive
16 function -- tell me if I'm wrong -- but the various
17 different tests for executive function that you were
18 utilizing with Mr. Torres were designed at least in part to
19 test for deficiencies in different parts of the frontal
20 lobe, is that fair?

21 A Yeah. That's right.

22 Q That's why it's comprehensive?

23 A Yes.

24 Q You're trying to get a comprehensive view of how his
25 particular frontal lobe regions work.

Dr. Stacey Wood
Direct examination by Mr. Tessier

1 A Yes.

2 Q Because, as you showed on the slide, the different
3 parts of that frontal lobe have a different impact on your
4 executive function, decision-making, those types of things.

5 A That's right.

6 Q And, so, did you come up with a conclusion to a
7 reasonable degree of certainty as a neuropsychologist as to
8 whether or not Mr. Torres suffers from impairments in
9 executive functioning as a result of the testing you did?

10 A I did.

11 Q And what was your conclusion?

12 A That Mr. Torres did suffer from impairment in some
13 aspects of executive functioning.

14 Q And did you see from the results you had -- I know you
15 said they weren't complete -- but from the results you had
16 with respect to Dr. Brawley, were her results concerning
17 Mr. Torres and impairment of executive function at odds with
18 yours?

19 A No, they weren't. She -- she wrote a brief letter, and
20 she says that the client had severe impairments in verbal
21 memory, borderline impairments in verbal fluency. I don't
22 remember exactly the term she used, but impairments in the
23 ability to track complex information.

24 So, she doesn't use the term executive functioning, but
25 she does note that difficulty in tracking complex

Dr. Stacey Wood
Direct examination by Mr. Tessier

1 information.

2 Q And the significant impairments in executive function
3 that Mr. Torres exhibits as demonstrated by the testimony
4 you did, is that something that you saw presented at the
5 trial level below for Mr. Torres' first, or his trial for
6 murder?

7 A I didn't see them presented.

8 Q Did you see any testimony from Dr. Brawley that
9 presented that information to the sentencing jury?

10 A My understanding is she did not testify.

11 Q And did you see any reference to Dr. Brawley's
12 testimony in anyone else's?

13 A I saw a brief -- brief reference in Dr. Schwartz-Watz's
14 testimony related to it.

15 Q And did the brief reference you saw in Dr.
16 Schwartz-Watz's testimony appear to be an accurate
17 reflection of the results you saw from Dr. Brawley?

18 A No. Dr. Schwartz-Watz implied there was no indication
19 of brain injury or brain damage from the neuropsych testing
20 but did not bring in the significant impairments that Dr.
21 Brawley herself noted even after giving kind of a
22 short-screen battery.

23 Q And so if the more complete battery of tests that you
24 had done -- you did on Mr. Torres -- if that had been done
25 back in 2007 and 2008 you would expect as a

Dr. Stacey Wood
Direct examination by Mr. Tessier

1 neuropsychologist to come up with the results that you
2 testified about here today?

3 A Yes.

4 Q And that could have been presented at the trial of
5 Mr. Torres back in 2008?

6 A Yes.

7 Q When you see that Mr. Torres has impairments in his
8 cognitive intellectual functioning based on your testing
9 does that typically indicate to you that there must have
10 been some sort of risk factor that could lead to such an
11 impairment in Mr. Torres' past?

12 A So, again, when we see a -- a kind of focal pattern of
13 impairment like this -- impaired executive functioning
14 within intact intellectual functioning -- you want to think,
15 start thinking, about etiology, so what could be causing
16 these -- is that what you mean?

17 Q Yes.

18 A And in his case there's so much core morbidity it's
19 really not possible for me to point to one cause.

20 Q And just to make it clear, you're not here to try to
21 tell the Court that you have solved the riddle and figured
22 out what has caused the executive function impairment in
23 Mr. Torres, is that correct?

24 A That's right.

25 Q But if you're looking as a neuropsychologist at the

Dr. Stacey Wood
Direct examination by Mr. Tessier

1 various risk factors you know are present with Mr. Torres,
2 what are some of those risk factors that strike you as
3 possible explanations for his executive functioning
4 deficits?

5 A Well, Mr. Torres has sort of a host of risk factors
6 that I would consider.

7 You know, when he was seven months old he was described
8 as falling down stairs and being hospitalized as potential
9 traumatic brain injury.

10 His -- you know, his early childhood, he's described as
11 having these emotional outbursts and difficulty regulating
12 behaviors. One would wonder if it's of a longstanding
13 nature.

14 I know that he was exposed to various medications as a
15 child. I know later as an adult and adolescent he was a
16 polysubstance user himself.

17 He also has various mental health diagnoses, some of
18 which also increase the risk of cognitive disability and
19 more recently has a history of diabetes. So, there's a lot
20 of different risk factors.

21 Q What about genetic disorders? Can they be risk factors
22 for executive function impairment?

23 A You know, genetic disorders often have neurocognitive
24 associated features.

25 Q And in this case we've heard testimony. I'm not asking

Dr. Stacey Wood
Direct examination by Mr. Tessier

1 you to agree or disagree with the testimony we heard, but
2 we've heard testimony that Mr. Torres has Prader-Willi
3 syndrome and 22q11 deletion syndrome.

4 Are you aware of either one of those being a risk
5 factor for later executive function impairment in the
6 frontal lobe?

7 A You know, I'm just going to start by saying that, you
8 know, clinical genetics is outside of my area of expertise.
9 I know and can speak a little to Prader-Willi, because,
10 again, I think of it as a genetic disorder that -- that
11 usually has neuro -- associated neurocognitive features.

12 Two -- well, I guess sort of the two most common that
13 you see are decreased I.Q. and the psychomotor deficits in
14 executive functioning.

15 So, Mr. Torres does have deficits in executive
16 functioning that would be not inconsistent with that
17 diagnosis.

18 The second one -- honestly, until this trial I'd never
19 heard of it. And I'm not going to express an opinion.

20 Q Between 22q11 deletion?

21 A 22q11 deletion.

22 Q What about anything organically wrong with Mr. Torres
23 in his brain like a tumor or any other organic problem with
24 his brain? Are you aware of anything like that that could
25 lead to executive function impairment?

Dr. Stacey Wood
Direct examination by Mr. Tessier

1 A Well, I -- I saw in the trial transcript that he had a
2 cerebellar angioma that looked congenital, so that from
3 birth he has this mass of -- of means that are abnormal in
4 this -- in the cerebellar region. You know, potentially
5 it's possible that that could also influence brain
6 development.

7 Q From the neuropsychological perspective is it fair to
8 say that there are a host of risk factors that Mr. Torres
9 was exposed to or subjected to -- if you want to look at in
10 a genetic sense -- that he didn't acquire that later in
11 life, each of which could be an explanation for executive
12 function impairment at this age?

13 A Yes. It's really not possible for me to point to one
14 over the other.

15 Q Did you -- was there any information that you wanted to
16 have available to you as you did your work with respect to
17 Mr. Torres that you were not able to review before you
18 formed your opinions about him in this case? Anything that
19 jumps out at you that you wanted and didn't have available?

20 A Just give me a minute to think about that.

21 (Pause.)

22 A Not to form my opinion on -- on his neuropsychological
23 functioning.

24 Q Okay. And the last question I'll ask you just to save
25 myself maybe.

Dr. Stacey Wood
Cross-examination by Mr. Zelenka

1 Is there anything else that you think would be
2 important to share with the Court about Mr. Torres'
3 cognitive abilities that did not come up in the questions
4 that I asked you here?

5 A I don't think so.

6 Q If you would, please, just answer any questions the
7 government has. I thank you for your time.

8 A Of course.

9 CROSS-EXAMINATION

10 BY MR. ZELENKA

11 Q Dr. Wood, when you were contacted by Mr. Ehliès what
12 was the referral question that was posed to you?

13 A I was asked to assess the client's general intellectual
14 and neuropsychological functioning.

15 Q Okay. And was -- were you to emphasize the executive
16 functioning?

17 A No.

18 Q Okay. Were you asked to emphasize either verbal memory
19 or I.Q.?

20 A I wasn't.

21 Q Okay. The battery of tests that you gave him on
22 January 18th of 2013, is that generally the battery you
23 would give in most of your clients' situations?

24 A In clients similar to Mr. Torres. So, it's a
25 comprehensive battery. Yes. I would say so.

Dr. Stacey Wood
Cross-examination by Mr. Zelenka

1 Q Okay. In clients similar to Mr. Torres, what does that
2 mean?

3 A So, in capital cases.

4 Q In capital cases.

5 okay. And why would what to give in capital cases be
6 different than what you would give in noncapital cases?

7 A So, you know, I do a lot of work in terms of
8 conservatorships. So, then you really need to assess the
9 person's functional ability and their financial
10 decision-making, can they still manage their money, their
11 day-to-day functioning, activities of daily living.

12 In competency cases I would include measures that
13 formally assess the competency to proceed. So, you know, I
14 may add different tools depending on the referral question.

15 Q Okay. So, is what you did in Mr. Torres' case more
16 than you would usually give in these other cases, or less?

17 A It's pretty typical. My average test battery is four
18 to six hours.

19 Q Okay. You appeared to have criticized Dr. Brawley on
20 failure to give certain testing based upon the information
21 that she was presented in her referral question. Is that a
22 fair statement?

23 A Yes.

24 Q Okay. Yet with the results that you gave and your
25 conclusions, they're not dissimilar from Dr. Brawley's

Dr. Stacey Wood
Cross-examination by Mr. Zelenka

1 assessment as reflected in her letter, is that correct?

2 A The -- were -- they were mixed. So, our I.Q. testing,
3 I would say, was roughly equivalent. But because there was
4 cognitive domains that weren't assessed as thoroughly, for
5 example, executive functioning, that was -- that was
6 different.

7 Q Okay. But Dr. Brawley did give the Trail Making --

8 A Yes, she did.

9 Q -- Test that assessed the executive functioning,
10 correct?

11 A Yes.

12 Q And her results were not all that different than what
13 you had done, is that correct?

14 A Yeah. I mean, they're two seconds different, and, so,
15 you know, I looked at -- up the normative data, and I was
16 surprised she didn't catch that. She didn't interpret it.

17 Q What do you mean, did not interpret it?

18 A So, usually -- let's say you're taking a screening
19 battery approach. So, you're going and you do a screen
20 battery. You end up finding things, as she did, then
21 usually go back and finish the battery. So, I'm surprised
22 she didn't take that next step.

23 Q Okay. Was there a reference in her letter that at any
24 time Mr. Torres refused to complete testing during that time
25 period?

Dr. Stacey Wood
Cross-examination by Mr. Zelenka

1 A I didn't see one.

2 Q Okay. So, she -- you're saying she could have given
3 the test then in a complete form?

4 A I -- you know, I -- she only wrote a letter, so, it
5 doesn't delineate all of the constraints that she had, but
6 it would have been optimal for her to do more testing.

7 Q Okay. Have you seen situations where similar
8 neuropsychologists having given the same number of tests
9 that you gave --

10 A Yeah, yes, I have.

11 Q Is -- is when you're in this setting, is it normal that
12 you have given more tests than neuropsychologists who had
13 represented -- been involved in representing capital
14 defendants, that you're giving more tests than they normally
15 give?

16 A Typically, I give fewer.

17 Q Really?

18 A Yeah. So, a lot of people doing this work do eight or
19 nine hours of testing. I think it's excessive, but that's
20 true.

21 Q Okay. Do you know what the norm is for the
22 neuropsychological testing in South Carolina?

23 A I don't.

24 Q Okay. But what you acknowledge you're assessing is
25 Mr. Torres' current functioning on January 13th of 2013,

Dr. Stacey Wood
Cross-examination by Mr. Zelenka

1 correct?

2 A I'd have to doublecheck the date, but yes.

3 Q Okay.

4 A Yeah.

5 Q That's the date on --

6 A I have the 18th on my notes but --

7 Q What did I say -- 13?

8 A Yes.

9 Q I probably need one of the tests.

10 In -- describe again the setting that you gave the
11 test.

12 A It was a room with a table and two chairs at the table
13 and other chairs in the room. It was glass-paneled, so
14 there's a guard that could observe.

15 Q Okay.

16 A It was quiet. It was a little cool.

17 Q Okay. So, and this was at Lieber and you were in a
18 quiet setting? You didn't hear any other inmate commotion
19 going on in that particular room at all -- loud noises from
20 other inmates at all during that testing?

21 A Not that I recall.

22 Q Okay. Let me talk a little bit about the I.Q. test you
23 gave --

24 A Okay.

25 Q -- and your assessment.

Dr. Stacey Wood
Cross-examination by Mr. Zelenka

1 You relied upon the Flynn correction in the I.Q. test
2 that you gave in 2013. You applied that correction to the
3 I.Q. standards which were given previously in his life,
4 correct?

5 A Say relied. I made the Flynn correction. I present
6 both uncorrected and corrected versions for comparison.

7 Q Okay. And what year did you start utilizing the Flynn
8 corrections --

9 A You mean --

10 Q In I.Q. testing?

11 A You mean --

12 Q You either gave or that you reviewed in similar
13 situations.

14 A So you mean in my professional career when did I start
15 thinking about the Flynn correction?

16 Q When did you start doing the Flynn corrections?

17 A Probably like 2010.

18 Q Okay. So, in a test that was done in 2008 your
19 criticism of Dr. Brawley in not doing a Flynn correction was
20 not inconsistent with your practice at the time, is that
21 correct?

22 A Yeah. That's -- I would say that's fair.

23 Q Okay. And even with the Flynn correction that you gave
24 the results are somewhat similar. He was around an average
25 I.Q. throughout most of his life given the standard error of

Dr. Stacey Wood
Cross-examination by Mr. Zelenka

1 measurement.

2 A I -- I would take it a closer to 89 to 91. So that's
3 the cutoff between low average and average. But I would
4 agree that it's been stable.

5 Q Okay. With respect to the academic achievement slide,
6 you asserted in your testimony that your testing revealed
7 that what he was testing at was consistent with what you
8 understood his educational level to be, is that correct?

9 A Yes.

10 Q So, that is basically a score that you would have
11 expected in advance of the testing that Mr. Torres would do,
12 is that correct?

13 A And I also had the opportunity to review standardized
14 testing that's been done throughout his -- his childhood.
15 So, yeah. I'd say it was broadly consistent with that.

16 Q Okay. And the memory testing that you gave, was that
17 consistent or inconsistent with what Dr. Brawley had had?

18 A The findings were consistent. He was formed actually
19 around the fifth percentile for me on a story memory test;
20 second percentile for Dr. Brawley on a story memory test.
21 But then we both note that with repetition he performs
22 better.

23 Q Okay. And explain what that means, with repetition
24 performs better, because I was trying to figure out the
25 difference between that and what you found to be the

Dr. Stacey Wood
Cross-examination by Mr. Zelenka

1 repetition problem he had with --

2 A Oh.

3 Q -- one of the known test.

4 A Sure. Let me explain that.

5 So, the test is this grocery list like test where we
6 did 16 words. And, so, I repeat that list five times.

7 Again, very few people can remember 16 items, you know,
8 just hearing it one time.

9 He remembered about six. But by the fifth trial he was
10 remembering, you know, many more like ten to twelve.

11 So, Brawley, Dr. Brawley, found the same thing, that,
12 you know, when you just read a story one time or give a list
13 of words one time, Mr. Torres' performance was quite low.
14 But when he has the benefit to hear something many times
15 he's able to learn and retain it.

16 The error that I mentioned was that when he was saying
17 the words back to me he would repeat words over and over
18 again or perseverate. And that's just a common symptom we
19 see in frontal lobe patients.

20 So, it was more not necessarily an error of memory, per
21 se, but more an error of organizing information and
22 perseverating.

23 Q Okay. Let me just be sure I understand.

24 For example, if you gave me a list of numbers one, two,
25 three, four, five was what Mr. Torres -- and asked him to

Dr. Stacey Wood
Cross-examination by Mr. Zelenka

1 repeat that -- that is what you asked him to do -- and he
2 would say one, two, one, two, one, two, one, two, three, is
3 that what we're talking about that he is repeating the
4 sequence as he's trying to recall what the next one is in
5 the sequence?

6 A No. That's an interesting point. I went back and
7 looked at that myself.

8 No. It's more -- the -- I'm going to use words. It's
9 a little easier for me to think about it that way. Like,
10 say fruits and vegetables. So carrots, peaches, bananas,
11 oranges, carrots, zucchini, carrots, cucumbers, carrots.
12 It's more like that.

13 Q Okay. So, he might be trying to remember what exactly
14 that is describing in addition to the word, correct?

15 A I'm not sure I understood that question.

16 Q I'm not sure I understood what I asked, so let me
17 withdraw that.

18 With respect to the executive function that you found
19 some problems with, you noted at the outset that executive
20 functioning is sequencing mental flexibility, initiation,
21 impulsivity and decision-making.

22 A Well, it --

23 Q Is that correct?

24 A Regulating impulsivity.

25 Q Regulating impulsivity.

1 And with respect to the particular executive
2 function -- I guess -- what the particular behavior allows
3 you to regulate is the ability to think flexibly, the
4 ability to plan, ability to problem-solve, ability to
5 control impulsive behavior, the ability to stay on tasks,
6 the ability to simulate consequences and the ability to
7 regulate emotion, is that correct?

8 A So, I don't remember precisely that first part of your
9 question, but those are all components of executive
10 functioning.

11 Q Okay. You included in your testimony and your
12 PowerPoint.

13 A Yes.

14 Q Okay. Yet your -- you stated you found or your
15 conclusions with executive functioning did not find deficits
16 in all of those areas, is that correct?

17 A I didn't find deficits on all of the tests that I did.

18 Q Okay. I just wanted to be sure I understood that.

19 But what you found as being significant in executive
20 function deficits were the inability to shift set. What
21 does that mean?

22 A Yeah. I'm sorry. That's pretty targety [sic]. So,
23 that -- I'm referring to the Trail Making part B test. So,
24 with the added cognitive component of having to switch
25 between numbers and letters his performance was impaired.

Dr. Stacey Wood
Cross-examination by Mr. Zelenka

1 Q Okay. And you had a finding on your PowerPoint,
2 borderline ability to maintain and follow rules once
3 established.

4 A I --

5 Q And where did you get that conclusion from?

6 A So, that's a description of the type of errors that
7 Mr. Torres made on the Wisconsin Card Sorting Test with
8 performance at the sixth to tenth percentile, which I
9 characterize as borderline, and other psychologists do as
10 well.

11 Q Okay. So that was just on that phase, correct?

12 A Yes.

13 Q Severely impairability to inhibit the dominant
14 response. And where did you draw that conclusion from?

15 A So, that -- that is related to the finding that
16 Mr. Torres scored at the first percentile on the
17 interference trial of the Stroop test.

18 Q Okay. And some parts of the Stroop test you found to
19 be average, correct?

20 A Well, those were the parts that didn't have executive
21 functioning components. So, those were the other basic
22 cognitive mechanisms that are part of the test that don't
23 include executive functioning.

24 Q Okay. Inability to identify optimal decision strategy
25 when provided with a feedback is one of your conclusions on

Dr. Stacey Wood
Cross-examination by Mr. Zelenka

1 your PowerPoint. Where did that come from in your testing?

2 A So, that conclusion result was related to my
3 observation of his performance on the Iowa Gambling Test
4 where he demonstrated this random -- not random
5 responding -- but the sawtooth pattern that indicated he
6 didn't identify the best strategy.

7 Q Okay. And you found significance, evidence of weak
8 performance across all of the measures of executive
9 functioning, correct?

10 A There were components of them.

11 Q And did you find that to be average, low average,
12 grossly impaired, highly impaired? On a spectrum, where did
13 that fit based upon your test scores that you have?

14 A You know, again, because there's these different
15 subcomponents, it depends, right.

16 So, just to walk back, the Trail Making Test was at the
17 first percentile. The Wisconsin Card Sorting Tests was
18 roughly average with one error. The ability to maintain
19 sets, sixth to tenth percentile. The Stroop measure was at
20 the first percentile.

21 In the Iowa Gambling Test, again, I'm not saying he's
22 impaired. I'm describing his performance as someone that
23 didn't -- he didn't identify the best strategy. He didn't
24 pick the worst strategy either.

25 Q Okay.

Dr. Stacey Wood
Redirect examination by Mr. Tessier

1 A So, it varied.

2 Q Okay. And if I understand your testimony correctly,
3 you can't address specifically what caused any of the
4 impairment you saw in his executive function based upon your
5 understanding of Mr. Torres' record, is that correct?

6 A Can you repeat that question?

7 Q You can't specifically point to what has caused
8 Mr. Torres' problems with executive functioning. Is that a
9 fair statement?

10 A Yes. That's right.

11 Q Okay.

12 MR. ZELENKA: Court's indulgence.

13 (Pause.)

14 MR. ZELENKA: I don't think I have any further
15 questions. Thank you, Your Honor.

16 MR. TESSIER: Very brief, Your Honor.

17 REDIRECT EXAMINATION

18 BY MR. TESSIER

19 Q As a neuropsychologist, Dr. Wood, are you confident
20 that based on your work and testing in this case that
21 Mr. Torres does indeed suffer from executive function
22 impairment?

23 A Yes, I am.

24 Q Are you confident that Mr. Torres based on your review
25 of his records has in his past a number of risk factors that

Dr. Stacey Wood
Redirect examination by Mr. Tessier

1 could have caused this executive function impairment?

2 A Yes. That's my understanding.

3 Q And is it fair to say that the difficulty for you would
4 be to try to sort out and give an opinion as to which one or
5 more in combination of those risk factors might have caused
6 this executive function impairment?

7 A Yes.

8 MR. TESSIER: That's all I have. Thank you, Your
9 Honor.

10 THE COURT: You may step down.

11 MR. TESSIER: Your Honor, we're okay to release the
12 witness.

13 THE COURT: Any objection?

14 MR. ZELENKA: No objection.

15 THE COURT: She may be excused. Thank you.

16 (Whereupon, the witness was excused.)

17 THE COURT: We will take lunch. Court will be in
18 recess until 1:45.

19 (Whereupon, a recess was taken.)

20 MR. EHLIES: Are we ready to proceed, sir?

21 THE COURT: We are.

22 MR. EHLIES: The applicant calls Dr. George Woods.

23 DR. GEORGE WOODS, having been
24 first duly sworn, testified as follows:

25 DIRECT EXAMINATION BY MR. EHLIES

Dr. George Woods
Direct examination by Mr. Ehli

- 1 Q Dr. Woods, I need you to introduce yourself to the
2 Court since we've had one Dr. Wood already. And we'll
3 stress the fact that you are slightly different. And spell
4 me your name.
- 5 A Sure. George Woods, W-O-O-D-S.
- 6 Q And --
- 7 A Shall I spell my first name as well?
- 8 Q No.
- 9 A Okay.
- 10 Q And are you a medical doctor?
- 11 A Yes, I'm a doctor. I specialize in neuropsychiatry.
- 12 Q All right, sir. I'm going to hand you what is marked
13 as Applicant's Exhibit 24.
- 14 A Thank you.
- 15 Q You need to take a look at that. This document is
16 entitled I believe curriculum vitae.
- 17 A That's correct.
- 18 Q And is this document --
- 19 A Yeah.
- 20 Q -- of 15 -- 15 pages prepared by you?
- 21 A Yes. It was.
- 22 Q Or under your supervision and direction.
- 23 A Yes.
- 24 Q Okay. And does it accurately reflect your educational
25 background?

Dr. George Woods
Direct examination by Mr. Ehliès

1 A Yes, it does.

2 Q Does it reflect your academic accomplishments?

3 A Yes.

4 Q And does it reflect the various certifications by peer
5 group or governing agencies?

6 A Yes.

7 Q And does it reflect your independent research work?

8 A Yes, it does.

9 Q And your joint publication work I think with cohorts
10 and peers.

11 A That's correct.

12 Q Is there any significant difference in your current
13 status from what is represented in Applicant's Exhibit 24?

14 A Other than a change of address for my office, it's
15 absolutely accurate.

16 Q All right, sir. And you better give us that change.

17 A Sure. 582 Market Street, Suite 1102, San Francisco,
18 California 94104.

19 Q And I noticed also that you have an office listed on
20 that document for Atlanta, Georgia.

21 A That's correct.

22 Q And can you tell us why that is there?

23 A Yes, because I teach at Morehouse School of Medicine in
24 the department of psychiatry in Atlanta, Georgia. And I run
25 a group called Johnson Wood's Education, which we do

Dr. George Woods
Direct examination by Mr. Ehliès

1 webinars for continuing medical education and continuing
2 legal education. And that's based in Atlanta, Georgia.

3 Q All right, sir. And do you actually spend time in
4 Atlanta as opposed to internet connecting to Atlanta?

5 A A week a month.

6 Q Okay. And I think you even have connections closer to
7 us than Atlanta. I think you have some familial connection
8 by marriage to Mauldin?

9 A My mother-in-law and her family's from Mauldin, South
10 Carolina, yeah.

11 Q All right, sir. I believe also is it true that you --
12 that you travel to lecture and do presentations?

13 A Yes.

14 Q And can you describe sort of what work you do in that
15 connection?

16 A Most of my presentations are in neurodevelopmental
17 disorders.

18 I'm -- my subspecialty in psychiatry that I specialize
19 in is neuropsychiatry, and, so, many of my lectures or my
20 presentations are around issues in neurodevelopmental
21 disorders -- field of alcohol spectrum disorder,
22 intellectual disability, Fragile X, other types of problems
23 where they relate to development -- child development, fetal
24 development, adolescent development and the manifestation of
25 psychiatric illnesses or psychiatric symptoms.

Dr. George Woods
Direct examination by Mr. Ehli

1 Q What is the significance, if I might ask, of the neuro
2 aspect of the brain and central nervous system?

3 A Sure.

4 Q Is that what we're referencing?

5 A Yes, sir.

6 Q In neuropsychiatry.

7 A Neuropsychiatry is really the subspecialty of
8 psychiatry that looks at the relationship between the brain
9 and other parts of the nervous system -- the autonomic
10 nervous system and behavior. And so it's a bit different
11 than psychiatry.

12 We certainly look at the issues of medication and
13 psychotherapy. I have a clinical practice. But we also
14 focus on those areas that we are now beginning to see impact
15 behavior that are really neurologically related.

16 And that was something that 25 or 30 years ago we
17 weren't as familiar with. We have new tools now like
18 neuropsychology in the last 50 years -- to some degree
19 neuroimaging. And so these are the tools that we try to use
20 to look at behavior in much more specific ways.

21 Q And would another tool on those lines and in that order
22 be neuropharmacology?

23 A Sure. I -- I have a fellowship in geriatric
24 psychopharmacology that I did with the National Institute of
25 Mental Health and the American Psychiatric Association.

Dr. George Woods
Direct examination by Mr. Ehliès

1 Q The National Institute of Mental Health is a federally
2 governed and funded organization?

3 A That's correct.

4 Q And are you on staff with them or are you an outreach
5 researcher? What is the connection?

6 A No. After I finished my residency I did a 2-year
7 fellowship. And fellowships really are designed to give you
8 an enhanced knowledge of that particular area. And so I did
9 a 2-year fellowship with the American Psychiatric
10 Association and the National Institute of Mental Health
11 researching geriatric psychopharmacology.

12 I purposely picked geriatric psychopharmacology because
13 of the changes in the body and the changes in the brain that
14 occurred in the elderly which impacts the way drugs and
15 medications are utilized in the body.

16 Q Okay. To make that study and draw conclusions is it
17 required that you have a specialized expertise in the actual
18 structure and function of the brain?

19 A You do need to have an understanding of the
20 relationship between the various -- as Dr. Wood described,
21 the various domains in the brain, as well as other parts
22 of -- as well as other parts of the body.

23 When we talk about neuro we always think of brain, but
24 there are many other issues that come into play. For
25 example, the endocrine system, you know, how does -- how do

Dr. George Woods
Direct examination by Mr. Ehli

1 the hormones impact, how do environmental factors; for
2 example, alcohol, or in this case medications, how do those
3 impact the neuro working.

4 Q All right, sir. And we've had testimony earlier in
5 this case from a Dr. Rary who is a geneticist in the field
6 of neuropsychiatry. Do you embrace educational efforts in
7 the field of genetics?

8 A Sure. I'm not -- I'm not trained as a geneticist, but
9 I do follow genetics, particularly as it relates to
10 syndromes that are specific to brain function.

11 Q Okay. And would it be sort of like an orthopedist who
12 reads x-rays pretty frequently but is not a radiologist?

13 A Yes. It's sort like, and particularly in my clinical
14 practice because of the people that I see.

15 Q You were talking about your clinical practice.

16 A You -- you have to have an understanding of these
17 different tools. It doesn't mean that you're an expert in
18 the administration of those tools.

19 Q All right, sir. So you would then in the context of
20 Tony Torres, you would be looking for the genetic
21 information, is that fair?

22 A That's correct.

23 Q And you would be applying the genetic information
24 within the context of your particularized expertise, is that
25 correct?

Dr. George Woods
Direct examination by Mr. Ehli

1 A That's correct.

2 Q But you would defer to the genetic call diagnosis and
3 descriptions to, for example, Dr. Rary who is a geneticist.

4 A That's correct.

5 Q Okay. And I believe in that context before I forget it
6 you have consulted and participated in global discussions
7 concerning this case with a number of resources including
8 Dr. Rary and Dr. Schacht and Dr. Lipman, is that correct?

9 A And Dr. Wood.

10 Q And Dr. Wood.

11 A Yes. That's correct.

12 Q All right, sir. Now, I interrupted you when I was
13 asking about your lecturing and presentation and the nature
14 of that. And you were describing pretty academic functions
15 to the medical community. Do you do that internationally?

16 A Yes.

17 Q Okay. Can you tell us about that?

18 A Sure. I'm the vice-president and president elect of
19 the International Academy of Law and Mental Health. Our
20 organization has been around for 35 years. I'm not going to
21 give a shout out, but we do really excellent work looking at
22 interdisciplinary -- interdisciplinary relationships between
23 what can -- new developments in the law and new developments
24 in mental health like neuropsychiatry, for example.

25 I'm also on the executive committee and newsletter

Dr. George Woods
Direct examination by Mr. Ehliès

1 editor for the International Association for the Specialized
2 Study of Developmental Disorders. And that particular
3 organization is an organization that looks at problems that
4 arise either during the prenatal period or directly after,
5 shortly thereafter, that impact brain function, impact
6 behavior.

7 The particular special interest research group that I'm
8 a newsletter editor of is called the "Challenging Behavior".
9 Special interest research group.

10 Q And the developmental aspects of your training,
11 lecturing and research, does that have -- do they have any
12 application as you saw the case and investigated and
13 participated in the development of the case of Tony Torres?

14 A I think they're directly relevant.

15 Q Okay. And, so, what you -- characterize the
16 presentation, investigation, development of the information
17 relevant to Tony Torres as comprehensive and
18 multidisciplinary.

19 A It was definitely multidisciplinary. We certainly see
20 a psychopharmacologist; we see someone that specializes in
21 early childhood development; we see someone that specializes
22 not only in neuropsychology but the neuropsychology of
23 decision-making, which I think is obviously directly
24 relevant here; we see a geneticist. And so there are
25 multiple ways in which this information was examined, and I

Dr. George Woods
Direct examination by Mr. Ehliès

1 think that's very important.

2 Q And also in the course of your association with other
3 disciplinary people in the team of Tony Torres was it, in
4 fact, more than reviewing the records but also included
5 investigative efforts along the lines of physical exams,
6 blood work and that sort of thing?

7 A Yes, as well as -- which I thought it was very good --
8 literature, right, literature to --

9 Q Exchanging literature among team members?

10 A Exactly right.

11 Q All right, sir. Now, you -- back to your lecturing,
12 you've identified the research, federally funded research,
13 and involvement for various elements of the government and
14 the medical community both nationally and internationally.
15 Do you also lecture and present in the legal forum on that
16 discipline of the law?

17 A Yes.

18 Q Okay. And how do you do that? And can you describe
19 that for us?

20 A Sure. I teach at the University of California Berkeley
21 in the Boalt Law School, Boalt Hall, the law school there.

22 I teach a course to second-year lawyers called Law and
23 the Introduction to Law and Mental Health. And I teach that
24 course with another, with an attorney. And we attempt to
25 present the standard of care within the mental health

Dr. George Woods
Direct examination by Mr. Ehliès

1 community that is relevant to lawyers.

2 I also -- I also have a webinar series for Thompson
3 warders [sic] on Westlaw called Introduction to the Law and
4 Mental Health. And we've been conducting the webinar for
5 about three years now, and it's a 28-webinar series where we
6 attempt to present, along with experts, different aspects of
7 that relationship between law and mental health.

8 Q And have you spent a significant amount of time
9 interfacing between the physical biology and psychiatry of
10 individuals and the law?

11 A Yes, I have. It's part of my practice. I have a
12 clinical practice where I see people, and then I have a
13 forensic practice as well.

14 Q All right, sir. Now, in the context of your interface
15 from your medical background with the law are you familiar
16 with the case of Daryl Atkins vs. the State of Virginia?

17 A Yes.

18 Q And in that context I think it's fair to represent that
19 it dealt with the mental biological condition affecting a
20 person's abilities to reason and that sort of thing. In
21 fact, it's a mental retardation case which is now, I
22 understand, an intellectual disability.

23 A That's correct.

24 Q Is that the nature of that case?

25 A That's correct.

Dr. George Woods
Direct examination by Mr. Ehli

1 Q And in that -- are you somewhat familiar with that
2 case?

3 A I am familiar with that case.

4 Q All right. And did the Court in that case express
5 certain behavioral criteria that they were looking at in
6 defining mental retardation?

7 A Yes.

8 Q All right, sir. Do you lecture to the capital group of
9 lawyers who are representing capital-charged individuals?

10 A I have. I've -- I don't lecture often, but I have.

11 Q Are you a professor of any particular field or
12 discipline?

13 A Well, as I mentioned, I teach at the University of
14 California Berkeley School of Law. I also teach at the
15 Morehouse School of Medicine in the department of psychiatry
16 in Atlanta, Georgia.

17 Q Do you hold any professorships in those?

18 A I'm lecturer. I'm adjunct professor in both, yes.

19 Q All right, sir. Now, I want to ask you as far as your
20 curriculum and background and training whether you can
21 distinguish for us the difference between a
22 neuropsychiatrist and a forensic psychiatrist.

23 A Yes.

24 Q Okay. Would you do that?

25 A Both are subspecialties of psychiatry.

Dr. George Woods
Direct examination by Mr. Ehli

1 Forensic psychiatry relates to that relationship
2 between the law and mental health. There are specific
3 statutory requirements such as insanity or competence that
4 require a mental-state understanding, that you understand
5 the person's mental state.

6 This is also true -- of course most of my practice is
7 civil. This is also true when you're doing other types of
8 law -- employment law, elder law -- that you understand what
9 a person's mental state is and therefore apply that to a
10 statutory requirement.

11 Q Do you --

12 A And I'm sorry.

13 Q Go ahead.

14 A And that's probably -- and that's really what forensic
15 psychiatrists do.

16 Now, within that body you can be, as I am, a
17 neuropsychiatrist in that you take an approach that is
18 really gained more toward understanding the brain. And
19 that's what I do.

20 Q All right, sir. So, is it fair to say then that
21 real -- your real focus is more than on the behaviors
22 demonstrated by an individual who is subject to
23 investigation but includes the particular causes and
24 functions of the brains that -- the brain that might be
25 contributing?

Dr. George Woods
Direct examination by Mr. Ehliès

1 A Certainly, Mr. Ehliès, certainly the functions. You
2 know, often it's very difficult to establish the causative
3 factor.

4 You mentioned the Daryl Atkins case. In intellectual
5 disability it's very difficult to capture the cause. So,
6 what you most look at is how is that brain function. And
7 then the next step that you look at is what we call
8 ecological validity.

9 Q Okay.

10 A And --

11 Q would you explain that to us?

12 A Sure. Ecological validity is how do the tests that you
13 are looking at translate to the street, how do the tests
14 that -- the neuropsychological tests where the neuroimaging
15 that you look at -- how does that translate into real-world
16 behavior. And so that's what ecological validity is.

17 The tests are great, but if they can't cross that
18 bridge, then they can't -- they can't give you the type of
19 information that you want.

20 Q Did you within your role in this case bring those
21 questions to bear and focus on the facts pertaining to Tony
22 Torres?

23 A I tried to, yes.

24 Q Okay. So we'll hear about that in the course of your
25 presentation.

Dr. George Woods
Direct examination by Mr. Ehli

1 A Yes.

2 Q Okay. Having performed the function -- and I think I
3 gave you a referral question to more particularize your
4 involvement in the case -- was that task embraced by your
5 qualifications as a neuropsychiatrist?

6 A I believe that my training as a neuropsychiatrist and
7 my practice as a neuropsychiatry -- psychiatrist -- would
8 speak directly to the questions that were presented.

9 Q And how about forensic psychiatry?

10 A Forensic psychiatry -- I teach a course at Morehouse in
11 forensic psychiatry, as well as in neurodevelopment through
12 neurodevelopmental psychiatry.

13 And I've taught at the University of California Davis
14 in the forensic fellowship, the forensic psychiatric
15 fellowship. So, I -- I bring that experience as well.

16 Q All right, sir. And then if I qualify you as an
17 expert -- excuse me. If the Court accepts you as an expert
18 in neuropsychiatry, is that broad enough to embrace the
19 various issues that we've talked about in forensic
20 psychiatry and developmental psychiatry?

21 A I think so. I have been qualified as an expert in
22 neuropsychiatry before.

23 Q All right, sir. And have you qualified as an expert in
24 any other particular field?

25 A I qualified as an expert in forensic psychiatry; I've

Dr. George Woods
Direct examination by Mr. Ehli

1 qualified as an expert in addiction psychiatry; I've
2 qualified as an expert in developmental psychiatry as it
3 relates to the intellectual disabilities. I think those are
4 the ones that have been most relevant.

5 Q All right, sir. Do you have any idea how many times
6 you've testified?

7 A Probably over my 30-year career I've testified -- I'd
8 say it's getting close to -- testifying?

9 Q Yes, sir.

10 A I would say it's getting close to a hundred times. I
11 only testify in approximately eight percent of the cases
12 that I'm consulted on, so I don't testify a lot.

13 Q And can you give us enlightenment at all about why only
14 eight out of a hundred actually resolve along the way, or
15 are they not litigation cases, you're serving in some other
16 capacity?

17 A Well, they're cases that my findings -- in most cases
18 they're situations where my findings don't necessarily jive
19 with the needs of the consultants. I do more civil cases
20 than I do criminal cases.

21 And on the criminal side I -- on the capital side I've
22 never been asked by the government to evaluate a case. So
23 my cases, the ones that I have evaluated, about eight
24 percent of them have I felt I could come to conclusions that
25 would be supported in a court of law.

Dr. George Woods
Direct examination by Mr. Ehliès

1 Q All right, sir. And if then in summary, if I have you
2 qualified in neuropsychiatry is that going to be adequate
3 for the purposes of the opinions and conclusions that you
4 rendered globally in this case?

5 A I think so. And if you'd like me to talk about the
6 other jurisdictions that I've been qualified in
7 neuropsychiatry, I could. I will do that.

8 Q I don't think that'll be necessary.

9 MR. EHLIES: But we will, No. 1, move into evidence --
10 I think it is No. 27. Was that the number?

11 THE COURT: Twenty-four.

12 Q Twenty-four.

13 A Yes, yes.

14 MR. ZELENKA: No objection.

15 THE COURT: It's admitted.

16 (Curriculum vitae of George W. Woods, Jr., M.D. marked
17 Applicant's Exhibit No. 24.)

18 MR. EHLIES: And we would also offer Dr. Woods as a
19 specialist in neuropsychiatry.

20 MR. ZELENKA: No objection.

21 THE COURT: He's so qualified.

22 THE WITNESS: Thank you.

23 Q Let's go to your presentation I think that you prepared
24 for us in reviewing the summary of your cases. And before
25 we get too deep into it, we've passed through much of the

Dr. George Woods
Direct examination by Mr. Ehli

1 qualifying data in your educational background.

2 A Sure.

3 Q And I wanted just to get to the core elements on the
4 referral question, and after that. And I think you control
5 how we turn through the pages here.

6 A Yes.

7 Q But first let me ask you this. Did you receive
8 information about this case regarding Mr. Torres' early
9 developmental history from birth -- prebirth?

10 A Yes.

11 Q His mom and his parents and some of the psychiatric
12 history from his mother's side and that sort of thing?

13 A Yes, I did.

14 Q And maybe it will be better if I just asked you if you
15 would summarize for us the specific categories of
16 information that you received that formed the basis for your
17 opinions.

18 A Sure. I received medical records of Mr. Torres pretty
19 much from about 18 months until much later in his life
20 around 17. Specific medical records up until about the age
21 of seven.

22 I received school records.

23 There were other records that looked at the previous
24 trial, and those included the records of psychiatrists and a
25 neuropsychologist that Dr. Wood recommended.

Dr. George Woods
Direct examination by Mr. Ehli

1 There was also within the psychiatric records or
2 psychiatric report references to neuroimaging that had been
3 completed.

4 I interviewed Mr. Torres on two different occasions.

5 And I reviewed the court transcripts of that case.

6 I also got a good substance abuse history from
7 Mr. Torres; a very, very good history through medical
8 records of both his developmental years, psychiatric
9 diagnoses and the multiple hospitalizations that he had had,
10 as well as placements that he had had during the course of
11 his developmental years.

12 Q And did you, in fact, receive the trial transcripts or
13 portions thereof relating to the case?

14 A Yes, I did.

15 Q I think you only received those in the mitigation case
16 involving his background and medical history.

17 A That's correct.

18 Q But you did also receive, I believe, the testimony of
19 Dr. Schwartz-Watz.

20 A Yes.

21 Q And you received the testimony of Dr. Alex Morton.

22 A Correct.

23 Q And you received the testimony of a lady by the name of
24 Marti Loring.

25 A Right.

Dr. George Woods
Direct examination by Mr. Ehli

1 Q I believe who was a social historian, is that correct?

2 A That's correct.

3 Q Okay. You identified the medical records, and I'm
4 going to ask you if you have a particular recollection,
5 current recollection, of having received and reviewed
6 medical records from the Medical University of South
7 Carolina regarding an admission of Tony Torres at age 3.7
8 years, which would have been for him in 1994.

9 A Yes, I did.

10 Q And did you find those particular records significant
11 and helpful in drawing your conclusions about his case?

12 A Yes.

13 Q We'll talk about it later, but I wanted to specifically
14 mention that group of medical records.

15 A Sure.

16 Q Okay. And based -- when you did your interview -- I
17 think we missed that -- you went to see Tony Torres, did you
18 not, at Lieber Correctional Institution?

19 A Yes, I did.

20 Q In your earlier involvement in this case.

21 A That's correct.

22 Q And did you do any testing or evaluation of Tony Torres
23 in that setting?

24 A I did a limited neuro -- I did a neuropsychiatric
25 examination, but I also did a limited neurological

Dr. George Woods
Direct examination by Mr. Ehliès

1 examination.

2 Q Okay. Based on your information that's been provided
3 to you and your physical contact with Tony do you have
4 sufficient information in your professional opinion to
5 render opinions about Mr. Torres' case?

6 A In my professional opinion, I believe that I do.

7 Q All right, sir. Is there anything that would -- that
8 is missing that would prevent you from expressing opinions
9 concerning Tony Torres' conditions?

10 A More information is always better.

11 Q Yes.

12 A But I do believe that I have enough information to
13 support the conclusions that I have drawn.

14 Q All right, sir. Now, would you -- very briefly,
15 have you -- have you formed specific opinions concerning his
16 condition to a reasonable degree of medical certainty?

17 A Yes.

18 Q And will you tell us what those conclusions are?

19 A There are two sets of conclusions, Mr. Ehliès.

20 The first conclusions are clinical, and the clinical
21 conclusions is that Mr. Torres suffers from a number of
22 neurocognitive impairments. And at the time of the -- of
23 his trial these would have been called cognitive -- the
24 diagnosis would have been cognitive disorder not otherwise
25 specified severe.

Dr. George Woods
Direct examination by Mr. Ehliès

1 And this diagnosis speaks to cognitive impairments --
2 impairments in thinking, behaving, responding, effectively
3 weighing and deliberating, perhaps sequencing one's
4 behavior, perhaps being able to block some things out while
5 letting other things in, being able to understand social
6 context and respond appropriately in social situations, or
7 being able to just -- to inhibit one's behavior. So, that
8 would -- that would be the first diagnosis that I would
9 make.

10 The second one is -- and this is based upon the genetic
11 studies of Dr. Rary -- would be Prader-Willi syndrome. I
12 would agree that Mr. Torres meets the clinical criteria for
13 that diagnosis based upon Dr. Rary's evaluation.

14 The third would be a cerebellar affective syndrome.
15 And what we see in Dr. Schwartz-Watz's report is findings of
16 an angioma in the left cerebellum. And we'll talk more
17 about that.

18 But we -- we really have known since about 1997 looking
19 at the work of Dr. Shamamine [sic] at Harvard that blood
20 problems, blood vessel problems, in that part of the brain
21 are unique. And they can create behavioral problems, as
22 well as motor problems, that can impact behavior.

23 So that angioma -- and I'll talk about later what an
24 angioma is -- it's also -- is also relevant.

25 So those are my three clinical diagnoses.

Dr. George Woods
Direct examination by Mr. Ehli

1 Q And do you hold those as opinions to a reasonable
2 degree of medical certainty?

3 A Yes.

4 Q Okay, sir. Let's go then, having expressed your
5 opinions, to the referral question that I think you
6 received. And this referral question was developed in
7 connection with the investigation that we undertook
8 utilizing multiple disciplines to define the various roles.

9 So, would you please tell the Court what question you
10 received to help and assist with the development of an
11 explanation after investigation of Tony Torres' condition?

12 A Yes. I have to say that in listening to Dr. Wood's
13 testimony I -- I had to review the referral questions,
14 because obviously the first one is relatively
15 straightforward -- does Mr. Torres suffer from a
16 neuropsychiatric or neurocognitive disorder.

17 However, as I looked at the second question -- "If so,
18 does the condition affect his ability to control impulses,
19 effectively weigh and deliberate decisions, learn from
20 experience, understand and process information and
21 understand context?" -- it was interesting to me to see how
22 Dr. Wood's testing really crossed the bridge between the
23 neuropsychological testing and these actual behaviors. And
24 in many ways many of these actual behaviors are reflected in
25 impairments on her testing.

Dr. George Woods
Direct examination by Mr. Ehliès

1 Q And that if I understand correctly -- although you may
2 not be a neuropsychologist administering the test -- am I
3 correct and are you able to answer that the testing is
4 really targeted towards a better understanding of the
5 functioning of the brain as an anatomical organ?

6 A Yes. If I could give you a quick example.

7 Q Yes, sir.

8 A When we -- when we talk about learning from experience,
9 one of the things that Dr. Wood noted on the Wisconsin Card
10 Sorting Test was that even though -- which is a test of
11 executive functioning -- really, specifically, a test of the
12 ability to learn and apply your learning to changing
13 circumstances.

14 Even though he did relatively well on that particular
15 executive functioning test, he fell down in what she called
16 being able to hold set.

17 Once he learned the instructions, being able to hold
18 onto those instructions, hold onto those directions and
19 apply -- apply them -- and that's really -- when we talk
20 about learning from experience, that directly applies to
21 about learning from experience as well as understanding and
22 processing information.

23 The same is true when we discuss affect and ability to
24 control his impulses. She described his finding -- her
25 findings on the Wisconsin Card Sorting Test. And the

Dr. George Woods
Direct examination by Mr. Ehli

1 Wisconsin -- I mean, I'm sorry -- on the Iowa Gambling Test.
2 And on the Iowa Gambling Test -- again, a test in which he
3 did reasonably well -- yet within the context of doing
4 reasonably well he -- he was impulsive.

5 She -- you know, he -- the vulnerability we saw there
6 was this in -- inability to control the dominant impulse.
7 What that implies is that there may be other things that
8 come up, but it's -- you get stuck. Your ability to move
9 away from your initial thought or your overwhelming action
10 is very difficult.

11 So, we really see in her testing -- and I'll talk more
12 about this as we go on -- we really see in her testing that
13 crossing the bridge, that ecological validity, the kind of
14 behaviors that are certainly described in his medical
15 records and psychiatric records even as early as 18 months
16 old.

17 Q And you're familiar also with his behavior after the
18 age-seven window, are you not?

19 A Yes.

20 Q Okay. So you can address how these behaviors continued
21 and/or progressed or became worse --

22 A Sure.

23 Q -- as he matured into adult, early young adulthood, is
24 that correct?

25 A Sure.

Dr. George Woods
Direct examination by Mr. Ehliès

1 Q Before we leave the referral question, you were
2 referencing Dr. Wood's testing. And we've identified that
3 that's a really targeting biology in the brain.

4 Did you hear her express that those tests are
5 administered in reasonably good clinical conditions?

6 A Yes.

7 Q And those test results then are ideal performance?

8 A They are ideal. They are. They are -- they are ideal,
9 and so they're aimed to get the best possible performance.

10 Q Okay. And so in a real-life setting on the street
11 without support or proper medication and treatment would you
12 expect -- what would you expect of the behavioral
13 consequences that were tested in the ideal circumstances?

14 A When someone has a vulnerability, a neurological
15 vulnerability, they may do completely well from day to day.
16 Things might go okay. You might not even be aware of it.

17 where you see neurological vulnerabilities show
18 themselves in becoming real problems are in new, novel and
19 stressful situations. When you see a person stress -- and
20 that's true for anyone. When you see a person in stress
21 that's often where their thinking starts to break down.

22 If their ability to marshal their cognitive voices is
23 not good that thinking breaks down even more so. And so
24 that's what we're really talking about, is that inability to
25 marshal your cognitive forces either because you don't have

Dr. George Woods
Direct examination by Mr. Ehli

1 them or because they don't function real well in stressful
2 situations.

3 Now, stressful situations aren't always environmental.
4 You know, taking certain drugs and alcohol can be stressful
5 on brain function.

6 As Dr. Lipman, I'm sure, described, having the wrong
7 medication, even though it's prescribed medication, can have
8 an impact on one's ability to function effectively. So
9 these -- there can be numbers of reasons why that
10 vulnerability comes out.

11 Q All right, sir. And I think we had heard from Dr.
12 Schacht in reference to certain behaviors bursting forward
13 under conditions in aging.

14 A Yes.

15 Q Would that fairly describe what you're referencing
16 now --

17 A Yes.

18 Q -- in your testimony?

19 A Yes. We know that the brain develops over time,
20 certainly into your early 20s. And, so, when you look at
21 certain periods -- for example, we talked a lot about brain
22 executive functioning.

23 Executive functioning has these spurt periods -- zero
24 to two, approximately seven to nine, and then after about 16
25 to 22 or 23 -- are the times that the frontal lobes are

Dr. George Woods
Direct examination by Mr. Ehliès

1 really trying to cure.

2 And you get what we call myelination. The part of the
3 brain is getting covered, the part of the brain that kind of
4 helps us control ourselves better.

5 So, you're absolutely right that there is this
6 bursting. But if your brain doesn't work properly, it's
7 like having a gate that's broken. And, you know, that gate
8 may be okay if there's not much wind, but if there is more
9 wind that gate may pop open at times that it absolutely
10 should not.

11 Q All right. Having reviewed the referral question, I
12 want to move to the next slide and let you tell us what you
13 have found or how you went about finding it.

14 A Sure. We -- I talked about the records review. We
15 talked about the interviews conducted.

16 And not only do I do a neuropsychiatric interview and
17 neuropsychiatric mental status, which is a little bit
18 different -- actually, I shouldn't say that. It's quite a
19 bit different than a psychiatric or forensic mental status,
20 because it includes testing of some brain function.

21 And that is particularly relevant with Mr. Torres,
22 because if we go back and look at his medical records we see
23 that there was some testing of brain function, very limited.
24 But the testing of brain function, particularly at the age
25 that we talked about, correlates with my findings. It also

Dr. George Woods
Direct examination by Mr. Ehli

1 correlates with other bits of information that have been
2 brought forth like the M.R.I. that Dr. Schwartz-watz talked
3 about finding an angioma in Mr. Torres' brain.

4 Q Can I interrupt you right there and make you promise us
5 to describe somewhere in the course of this presentation an
6 angioma?

7 A Sure. Absolutely.

8 Q And where -- are you intending to do that?

9 A I will do that.

10 Q Great.

11 A Okay. So these all seem to be like just little bits of
12 a puzzle that are setting out there. He's got this, you
13 know, problems when he's very young in terms of kinda being
14 able to walk properly.

15 You know, he's got some other little things that don't
16 seem to be tied into it. And, luckily, I was in a position,
17 in some ways in hindsight, of being able to gather this
18 information and reproduce some of the neurological testing
19 that -- to see if these behaviors, these neurological
20 skills, continued.

21 That's really what my interview was about. It was
22 really about getting history from Mr. Torres, looking at how
23 he provided that information, how he looked at his own
24 experiences, but also doing some neurological screening to
25 see if some of these cognitive problems continued.

Dr. George Woods
Direct examination by Mr. Ehliès

1 Q All right, sir. Moving. Now, we have talked a little
2 bit about Dr. Rary's testimony you did not hear. But you
3 have consulted with Dr. Rary, have you not?

4 A Yes, I have.

5 Q And you have reviewed his findings with him and
6 listened to a presentation that he made.

7 A Yes.

8 Q And you're familiar basically with what his opinions
9 were.

10 A Yes.

11 Q And, in fact, I think you even went into the literature
12 and got up to speed, if you will, on Prader-Willi, which is
13 not a particularly common --

14 A That's correct.

15 Q -- syndrome phenomenon in the population.

16 A Yes, correct.

17 Q Okay, sir. Can you tell us the other areas of interest
18 for you in the genetic familial context of as far as the
19 opinions that you finally drew and have expressed?

20 A Well, yes. If I could perhaps just give a quick
21 overview, I really like to look at three areas.

22 I like to look at the genetic familial; I like to look
23 at the environmental; and I like to look to see if there's
24 any psychological and/or medical documentation that is
25 supportive. And I try to look at those three areas because

Dr. George Woods
Direct examination by Mr. Ehli

1 it helps me organize my -- my thinking and my understanding.
2 It also allows me to start to create what we call
3 differential diagnoses.

4 Q And what is that?

5 A A differential -- I'm sorry.

6 Q A differential diagnoses. What is -- could you define
7 that for us?

8 A Yes. A differential diagnosis is someone comes in and
9 they've got a cough. Well, that cough could be the flu;
10 that cough could be cancer; that cough could be a smoker's
11 cough. It's a -- it's a symptom that could be related to a
12 number of different causative factors, a number of different
13 disorders.

14 So, you really don't want to start a diagnosis. You
15 really want to start it as a symptom and create as wide of
16 base of understanding of where that symptom could possibly
17 come from and then over time let the -- let the information,
18 let the medical records, let your own examination, let the
19 neuropsychological testing, let the neuroimaging, if there
20 is neuroimaging available, de -- refine your differential so
21 that you eventually get to a more accurate and complete
22 understanding and so --

23 Q All right, sir. And that function was applicable in
24 this case?

25 A Absolutely.

Dr. George Woods
Direct examination by Mr. Ehliès

1 Q All right. Proceed if you would.

2 A And in this case we -- we see a number of things that
3 in and of themselves singularly are less important.

4 For example, we know that -- it's my understanding that
5 his mother drank at some time. The word that was used was
6 occasionally. You know, there's no indication that she was
7 a heavy drinker during her pregnancy, that perhaps she
8 occasionally drank during her pregnancy.

9 However, what we also know is that when you look at the
10 way that the body develops and the fact that the brain and
11 the facial structure develop first, that if a parent, if a
12 mother, is not drinking or is drinking less between the
13 14th and 17th day of pregnancy there may be no facial
14 features.

15 In other words, when we think of things like fetal
16 alcohol disorder or fetal alcohol spectrum disorder we
17 always think of a certain facial representation. That's not
18 accurate.

19 If a mother's drinking less during that 14th to
20 17th day or is not drinking during that 14th to 17th day,
21 that's the time that the facial features are being
22 developed.

23 And so when you look at fetal alcohol or other types of
24 neurodevelopmental disorders you not only look at that early
25 period, but you say, okay, face first couple of -- maybe

Dr. George Woods
Direct examination by Mr. Ehli

1 first six weeks, eight weeks; chest, maybe three months;
2 abdomen, maybe five months; abdomen and genitalia, maybe
3 five months.

4 So, you really walk down the midline trying to
5 determine if there is an impact at any time during that
6 pregnancy.

7 So, we know that the history is that she drank
8 occasionally. We keep that in mind. We know that she
9 smoked more. And certainly there is evidence now that
10 smoking during pregnancy can cause problems like lower birth
11 rate. It can cause issues in terms of language development.

12 We know that his mother was physically abused during
13 pregnancy. And what does -- what impact does that have? A
14 number.

15 First of all, it changes the interchronological makeup
16 of the mother. It changes the hormonal relationship of the
17 mother so that she is actually secreting more of the
18 hormones that are involved in fight or flight. You know,
19 she's worried. And this can change the structural
20 functioning of the child itself. We also --

21 Q Do I understand from that that we may be in error to
22 assume that a fetus within the womb is insulated from the
23 circumstances and biology of the mother and, in fact, is
24 integrated into the total biology of the mother?

25 A The -- the fetal -- you know, the -- the -- the birth

Dr. George Woods
Direct examination by Mr. Ehliès

1 space is an amazing space, because it is a space that keeps
2 this child suspended but interconnected --

3 Q Okay.

4 A -- in every way.

5 Q So, the things happening to the mother are happening
6 with the child.

7 A That's exactly right.

8 She was treated for premature labor at -- at three
9 months. And the -- again, a clue, because what that tells
10 us when -- often when a child has genetic impairments or
11 there's been some problem with the development, particularly
12 in the first trimester, we often see that as a time that a
13 child may be miscarried. Or that's really the time
14 neurological development is going on. And for her to
15 develop labor pains, labor, at three months is, again, a
16 clue, not a definitive determination but a clue, that there
17 may have been something unusual occurring.

18 Q All right. And meconium. I think we've heard that
19 recorded in other people's opinions. Was it significant in
20 yours?

21 A Yes. Meconium stains during birth can be just a part
22 of, you know, the child coming into the world. But what
23 meconium stains really reflect are placental insufficiency
24 as opposed to cord insufficiency.

25 when you have a child that is developing there are --

Dr. George Woods
Direct examination by Mr. Ehli

1 there are multiple ways in which that child is connected --
2 connected through the placenta. It's connected through the
3 cords as well.

4 And when you get meconium stains that most commonly
5 reflects a placental insufficiency rather than a cord
6 insufficiency. And the -- the importance of that is that
7 the placenta is really the feeding trough, so to speak, of
8 the child. And, consequently, it, again, gives you a clue
9 that something may not be functioning in this pregnancy the
10 way that it should be.

11 Q All right, sir. And when he is born, he gets an Apgar
12 score?

13 A Apgar scores are scores -- they've been replaced now.
14 Occasionally, you see Apgar scores. They're really scores
15 that are aimed to look at various functions of development
16 in the child.

17 A seven Apgar score is a relatively low Apgar score.
18 We see that coming up to a nine, which is, you know, is
19 pretty normal.

20 So, again, we see the child being born with some what
21 we call fetal distress. And then after they get out -- and
22 what -- what happens with children that are not premature is
23 that they have within their lungs, they have a chemical
24 called Surfactant -- S-U-R-F-A-C-T-A-N-T. And Surfactant
25 usually only develops within the last two weeks or three

Dr. George Woods
Direct examination by Mr. Ehliès

1 weeks of birth.

2 And you have to have that cry. The cry is not just the
3 cry of help. That cry is the lungs expanding. Right. So
4 you know that's a factor and it's working and the lungs are
5 expanding. And when their lungs expand and the child can
6 take in that first breath, you know, that's a very important
7 sign.

8 And that's usually what changes an Apgar. When you
9 hear that child cry you know that the lungs are expanding.
10 You know they're surfacting. It's acting appropriately.

11 Q All right, sir. I think you had a continuation of
12 genetic familial screen.

13 A Yes. We have a multigenerational history of both
14 mental illness and substance abuse. And what we -- what we
15 really know now is that mental illness and substance abuse
16 are, as Dr. Wood used the word earlier, comorbid. Comorbid
17 means that there are several things happening at the same
18 time.

19 And, in fact, this is really one of the limitations I
20 think in the long run when we look at psychiatric disorders.
21 We so often want one diagnosis. We want schizophrenia or we
22 want bipolar disorder or we want Prader-Willi syndrome.
23 That's not the way diseases work.

24 When you go to your doctor, you know, you may have low
25 diabetes which causes a little hypertension which causes a

Dr. George Woods
Direct examination by Mr. Ehli

1 little liver problem.

2 So psychiatric disorders occur together, and one of the
3 things that we know occurred together are mental illness and
4 substance abuse.

5 Bipolar disorder about -- people that are diagnosed
6 with bipolar disorder, about 45 percent of them in some time
7 in their life will meet the criteria for a substance abuse
8 problem as well. That's also true with P.T.S.D.

9 So, these things occur together. It's not surprising
10 that we would see a family history of mental illness on the
11 mother's side. We don't have as good of a history on the
12 father's side. But we know that his mother at a young
13 age around 15 had psychiatric -- actually had psychiatric
14 problems and some treatment, and perhaps her grandmother,
15 which would have been Mr. Torres' great-grandmother.

16 Again, of course, you know, we -- we see the clinical
17 diagnosis of Prader-Willi Syndrome and the clinical
18 diagnosis of 22q11 deletions -- deletions. All of these,
19 each of these and all of these, create a vulnerability to
20 brain dysfunction.

21 Q All right, sir. And so as I understand it from your
22 expression of significant features of the genetic familial
23 background in this particular case, you are not expressing
24 or pinpointing any one particular circumstance or
25 conditions. But do I understand then your testimony is and

Dr. George Woods
Direct examination by Mr. Ehliès

1 your opinion is that as a group in the cumulative effects of
2 this group they are significant in your opinion regarding
3 his condition?

4 A Yes, sir. If I could -- yes. Let me say they -- the
5 tragedy of course when you see these multiple disorders is
6 that they are not only cumulative but they are synergistic.
7 And so what you really see are symptoms that -- that build
8 upon each other and create atypical symptoms and more severe
9 symptoms. And I think that's the history of Mr. Torres in
10 his early mental health treatment.

11 Q And by synergistic you mean providing energy and
12 emphasis one to the other?

13 A Yes.

14 Q A momentum for want of a more common word?

15 A Unfortunately, that's correct.

16 Q A momentum of features that move this thing forward --

17 A That's correct.

18 Q -- in its direction, which in this case not
19 particularly healthy.

20 A That's correct.

21 Q All right. Let's look at the next category. You have
22 defined it as environmental, I believe.

23 A Yes.

24 Q And can you tell us what -- tell the Court what you
25 mean to describe by using the phrase or the word

Dr. George Woods
Direct examination by Mr. Ehli

1 environmental.

2 A When children -- when a child is born about 40 percent
3 of their brain is developed as opposed to other creatures.
4 An ant, about 90 percent of their brain is developed; a cat,
5 about 65 percent of their brain is developed.

6 And yet you see in children, it's really only about
7 40 percent. And the reason why only about 40 percent of
8 their brain is developed is because environment has such an
9 impact on the rest of that development. Environment is so
10 important on the rest of that development. And, so, you
11 have to watch what happens in the environment because it
12 impacts that child developmentally. And we see that
13 certainly in the first --

14 Q Can I interrupt you there just a second?

15 A Sure.

16 Q For clarification, you're -- you are talking about
17 development. But when you say development, you don't mean
18 particularized. Behavioral development is separate and
19 distinct from biological development. Are you using that
20 term globally, the total development of an infant into an
21 older person?

22 A Yes.

23 Q In adulthood.

24 A Yes. And you have to because you can't separate those
25 out.

Dr. George Woods
Direct examination by Mr. Ehliès

1 If I can -- if I can give you a quick example, children
2 before six or seven can acquire language skills very, very
3 quickly.

4 You can -- you know, you can see children in bilingual
5 families go between one language and another just like that.
6 They didn't learn the grammar; they didn't learn the -- you
7 know, the structure of the language. They just picked it
8 up.

9 And certainly from zero to two what you really see is
10 that children just absorb. They absorb everything that's in
11 their environment. And that is really making that brain
12 grow. It's really making that brain grow. It's also
13 modeling certain types of behavior.

14 Usually by about three or four years old you have a
15 neurological phenomenon that the gardeners in this room
16 would be familiar with called pruning. And as that brain is
17 kind of just blossoming and, you know, from zero to two,
18 zero to three, by about three or four that brain starts to
19 organize itself.

20 And in the same way that you might prune your roses in
21 order to make them grow a certain way, that's what happens
22 to the brain. And the brain starts to organize itself in
23 these very specific domains that Dr. Wood talked about --
24 domains of memory, domains of language, domains of motor
25 functioning, domains of executive functioning.