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1 IN THE CIRCUIT COURT FOR PINELLAS COUNTY, FLORIDA
23-03157-CF
2 SECTION K
3
4 STATE OF FLORIDA,
5
vs.
6
7 THOMAS ISAIAH MOSLEY, Person
ID: 3322179
8
9 ________________________________/
10
11
Via Videoconference
12 Florida City, Florida
Tuesday, June 11, 2024
13 1:00 p.m. to 3:47 p.m.
14
15
DEPOSITION OF DR. THERESA ASCHEMAN-JONES
16
17 Taken before Marlene Gutierrez, Notary
18 Public, State of Florida at Large, pursuant to Notice of
19 Taking Deposition filed in the above cause.
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ELECTRONICALLY FILED 06/13/2024 10:35:44 AM: KEN BURKE, CLERK OF THE CIRCUIT COURT, PINELLAS COUNTY

1 APPEARANCES:

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On behalf of the the State of Florida.
5
6
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1 I N D E X
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Witness
3
DR. THERESA ASCHEMAN-JONES
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Direct Examination By Ms. Russell 4
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Cross-Examination By Ms. Manuele: 85
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EXHIBITS
9 (No exhibits marked.)
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1 Thereupon --
2 DR. THERESA ASCHEMAN-JONES
3 was called as a witness by the Defendant and, having
4 been first duly sworn, and responding, "Yes, I do," was
5 examined and testified as follows:
6 DIRECT EXAMINATION
7 BY MS. RUSSELL:
8 Q Dr. Jones, my name is Margaret Russell, I am one
9 of the lawyers for Thomas Isaiah Mosley. I am going to
10 be here with our team Jessica Manuele and Nichole
11 Blaquiere to ask you some questions today for your
12 deposition in the case.
13 Would you start by introducing yourself and
14 spelling your name for the court reporter, please?
15 A Yes. It is Theresa, T-H-E-R-E-S-A, Lynn,
16 L-Y-N-N, Ascheman-Jones, A-S-C-H-E-M-A-N, Jones,
17 J-O-N-E-S.
18 Q I'm sorry, but I think I lost sound on you.
19 A Oh. Can you hear me?
20 Q Sorry. Can you hear me now?
21 A Yes.
22 Q And I can hear you. That's good news. So
23 should I refer to you by Dr. Ascheman Jones or Dr.
24 Jones?
25 A Either way is fine.

1 Q I'll use Dr. Jones since it's short and easier.
2 Dr. Jones, tell me if you've given a deposition before.
3 A At least once before.
4 Q Do you think it's been less than ten times?
5 A Yes.
6 Q Okay. And is this in the context of your work
7 with the South Florida Evaluation and Treatment Center?
8 A Yes.
9 Q Okay. Just to go over some of the basic rules
10 of the deposition and especially because we're
11 operating with Zoom, it would be great if you could
12 give a complete verbal answer so the court reporter can
13 take a complete record of what we're doing here today.
14 A Yes.
15 Q As opposed to a nod of the head or a shake of
16 the head, if that makes sense. All right? If there's
17 anything about any one of my questions that's confusing
18 or difficult to answer, you're welcome to ask me to
19 rephrase the question. Does that make sense?
20 A Yes.
21 Q All right. And we'll hope that if you endeavor
22 to answer a question, that you'll do your best to
23 answer it fully and truthfully throughout the course of
24 the deposition.
25 A I will.

1 Q Excellent. Tell me what you did to prepare for
2 this deposition.
3 A I reviewed my report and looked at the medical
4 records on-line of the defendant.
5 Q Okay. Do you have anything in front of you that
6 you're using to refresh your recollection about your
7 testimony as you're testifying?
8 A Yes. I have a copy of my report. I also have
9 our medical records open to refer to if needed.
10 Q Is there anything else that you have? And you
11 are in your office, so do you have access to your
12 DSM-5, for example, any other books and things that you
13 might keep on hand?
14 A Yes, I am in my office. I have access to the
15 DSM-5-TR.
16 Q Was there anything else that you did to prepare
17 for your deposition that we haven't discussed?
18 A No, aside from correspondence and receiving the
19 logistics for this meeting, no.
20 Q Do you have a current résumé or a CV?
21 A I do.
22 Q Would it be possible for you to either forward
23 that to the state attorney or forward directly to us so
24 we can take a look at that in preparation for Friday's
25 hearing?

1 A Yes, I can do that. Do you want me to do that
2 now or just prior to Friday?
3 Q Let's just make a note of it and make sure we
4 can get it middle of the week, if that's all right.
5 A Sure.
6 Q Excellent. I am going to start since I don't
7 have your CV with asking you some basic questions about
8 your educational background. We'll start with
9 undergraduate and graduate school. Where did you go?
10 A I attended the University of Minnesota for my
11 undergraduate. I have a bachelor's degree in
12 psychology. I then attended Minnesota Professional
13 School of Psychology Argosy University Twin Cities for
14 my doctorate in clinical psychology.
15 I've done and completed the necessary trainings,
16 including practicum in therapy and assessment, as well
17 as advanced practicum and internship at the VA Medical
18 Center, as well as a two-year postdoctoral residence
19 here in Florida for a company that is typically
20 retained for personal injury and nurse psychological
21 injury cases.
22 Q So where was that?
23 A International Assessment Systems, IAS in Miami.
24 Q Is that a hospital or?
25 A No, it's a business. A private practice.

1 Q So when did you get your degree in psychology?
2 You're telling me basically that what you have is a
3 PsyD?
4 (Overlapping speakers.)
5 A Yes. That degree was conferred in 2014.
6 Q So after you got the PsyD, do you have to do
7 additional clinical work in order to become certified?
8 A Yes. In Florida in order to earn licensure, you
9 have to have supervised hours, I believe it's 4,000
10 which would require at least a year postdoctoral
11 residency training. I did that in two years.
12 Q And where did you do your postdoctoral residency
13 training?
14 A That was IAS.
15 Q What did you do after IAS?
16 A I started working here at South Florida
17 Evaluation and Treatment Center.
18 Q And when did you start there?
19 A 2017.
20 Q And what was your initial job title when you
21 came in?
22 A Forensic psychologist.
23 Q Is that your job title now?
24 A It is.
25 Q Tell me about what you need to do in order to be

1 licensed in the state of Florida?
2 A So you need to earn a doctoral degree in
3 psychology. It is typically a five-year program,
4 including a fifth year of internship, a one-year
5 predoctoral internship. As I mentioned, I completed
6 that at the VA Medical Center. And then you need to
7 complete supervised clinical hours, which most people
8 accomplish with a postdoctoral residency. You need
9 then to sit for the exams. There's the national exam,
10 the EPPP, and then each state -- well, Florida has its
11 state rules evaluation.
12 Q And for Florida, is that a test basically that
13 you have to take and pass?
14 A Yes, it is. I should note that in order to
15 maintain licensure, we do have to complete 40 hours of
16 continuing education biannually.
17 Q And you have completed that for every year that
18 you've been licensed in Florida?
19 A Yes.
20 Q When did you get certified in Florida?
21 A My license is Florida, so that would've been
22 2016, November of 2016 that I've been continuously
23 licensed in Florida since then.
24 Q Do you have any specific forensic certification?
25 A No. Aside from in my current position, we are

1 required to complete a biannual, although many of us
2 complete it annually, Florida examiner training, which
3 is conducted by Dr. Randy Otto and it's a multiday
4 course that we complete.
5 Q What kinds of things are covered in that
6 multiday course?
7 A Competency evaluations primarily. In some
8 years, he's also included a kind of advanced topics,
9 such as the sanity evaluations, other special issues
10 within the examination of legal matters.
11 Q And when was the last time you took that course?
12 A I think I have my certificate posted. It looks
13 like -- I think I have a more recent one. This one
14 says November and December of 2022, but I may have
15 taken it as recently as last year. It's typically in
16 the fall.
17 Q Where would those records be available?
18 A I can access them. My supervisor keeps records
19 of that. I could also look at my continuing education
20 transcript records that would show when I last
21 completed that.
22 Q Great. I want to take the time now, because
23 we're all here on Zoom, but if it would be possible to
24 produce your continuing education transcript to the
25 state attorney or to us, that would be outstanding.

1 A Yes.
2 Q So that's basically a certification, that class
3 that you take for forensic?
4 A It's not a formal certification. It's for my
5 position currently, it's a requirement. For other
6 evaluators, psychologists, psychiatrists who do this
7 type of work, it may or may not be required depending
8 on their role and where they work. It's not a formal
9 certification process.
10 Q Okay. So when you sign your report or when
11 you're referred to in your report from South Florida
12 Evaluation and Treatment Center and you say "forensic
13 psychologist," what exactly does that mean?
14 Does that mean that you've just taken this class
15 or is there some special certification or special
16 licensure that comes out of that?
17 A No, that is the title of the position at this
18 hospital. In terms of my education, my degree is as a
19 clinical psychologist. I do have background in
20 forensic work. No, I wouldn't say that it's a formal
21 title.
22 Q It's just the title of your job that you're
23 performing right now?
24 A Yes.
25 Q Tell me what governing body supervises

1 psychologists in terms of licensure and ethical rules,
2 things like that?
3 A In terms of ethical rules, that would be the
4 American Psychological Association. That's our
5 governing ethics board.
6 And in terms of license that would be the
7 Florida Board of Health Psychology.
8 Q Are you a member of the American Psychological
9 Association?
10 A Yes.
11 Q And is that something basically where you pay
12 money and you are a member?
13 A Yes, you pay dues.
14 Q Are you a member of any other professional
15 associations?
16 A Within American Psychological Association there
17 are various divisions. I am a member of South Florida
18 News, the division of rehab psychology, division 22,
19 the division of neuropsychology, which is division 40.
20 There's another one and I am blanking on the name of
21 that division, but it has to do with legal issues
22 within psychology. I believe I am still an active
23 member in that one as well.
24 Q When you say you're a member of the division of
25 neuropsychology, are you a neuropsychologist?

1 A No, I wouldn't say I am a neuropsychologist, but
2 I have background and training in neuropsychology. I
3 am not a board-certified neuropsychologist, no, I
4 wouldn't say that.
5 Q Can you tell me what your training in
6 neuropsychology is?
7 A Yes. In my doctoral program one of the
8 concentrations was health in neuropsychology, so I
9 pursued and completed that requirement.
10 My internship at the VA Medical Center was a
11 neuropsychology-specific track. My postdoctoral
12 residency at IAS included specific training in
13 neuropsychological evaluation under a
14 neuropsychologist.
15 And also early in my program I completed the
16 specialized neuropsychology practicum for my assessment
17 practicum, so I was on a neuropsychology track.
18 Q Is there a reason why you didn't complete the
19 neuropsychology track?
20 A It's not that I completed it, I began working
21 here and it's broader. So my postdoctoral residency
22 was part forensic working with the courts, being
23 retained in legal cases and I went more towards the
24 legal route versus neuropsychology.
25 Q Have you worked at any other facilities within

1 the state of Florida, other than the South Florida
2 Evaluation and Treatment Center and the VA, which was
3 in Florida, correct?
4 A No, that was in Ohio. No, I haven't. Outside
5 of my training along the way that I've mentioned while
6 I've -- you know, in some of those positions was
7 considered a formal employee, it was part of my
8 training. Type of facilities, if we go way back, I was
9 working in group homes as a graduate student, but I
10 suspect you don't need to hear about that.
11 Q I don't, but that's okay.
12 So basically this was your first job as a
13 licensed professional, was in Florida at the South
14 Florida Evaluation and Treatment Center, correct?
15 A Yes.
16 Q Why did you come to Florida?
17 A To complete the postdoctoral residency. I moved
18 specifically to Florida for that.
19 Q Okay. Do you mind telling me how much you're
20 paid at South Florida Evaluation and Treatment Center
21 annually?
22 A We most recently had a change in pay. I would
23 estimate it's 120,000 annually.
24 Q And are you paid bonuses or anything like that?
25 A No bonuses, no.

1 Q It's straight salary?
2 A Yes.
3 Q Do you know anything about the reimbursement
4 models of South Florida Evaluation and Treatment Center
5 for the patients that come for competency or NGRI?
6 A No, I do not.
7 Q In terms of how the state reimburses expenses?
8 A No, I do not.
9 Q Tell me what you know about the policies of
10 discharge of patients at South Florida Evaluation and
11 Treatment Center?
12 A I mean, how much detail do you want me to
13 provide? Are you talking about when they're
14 discharged? Why they're discharged.
15 Q Let's start with, in general, what is your
16 understanding of the policy of the hospital in terms of
17 discharging people who have been sent for competency
18 restoration?
19 A Okay. I don't know that it's so much the
20 hospital's policy than it is the courts, the rules
21 regarding competency and discharge. So when we opine
22 that an examinee or a defendant is competent, we submit
23 a report to the court and the court advises the
24 hospital whether the person is to be discharged. So
25 the judge would write a transport order to have the

1 patient discharged back to jail. And there are laws
2 governing that. The hospital, though, does not have
3 the authority to choose when someone is discharged
4 aside from coordinating with the jail, with the
5 sheriff's office the transport under the judge's
6 jurisdiction.
7 Q Okay. So just talking about a general process,
8 as soon as someone is found competent, they are sent
9 back. And you're saying that basically there aren't
10 any other policies or procedures or target dates or
11 anything else that is involved in that determination?
12 A From my end, when I find -- when I opine
13 somebody competent, I am expected to write that report
14 within four days to submit to our legal department so
15 that it can be processed and submitted to the court,
16 which is to be done within seven days by, you know,
17 rules that govern that. And then following newer
18 procedures, it is my understanding the defendant is
19 generally supposed to be transported back to their
20 county of origin to the jail within seven days of the
21 court receiving that report. It used to be 30, now
22 it's seven.
23 Q Understood. It's a lot more work now.
24 You're not a psychologist, right? I mean you're
25 not a psychiatrist?

1 A Correct.
2 Q So you can't prescribe medicine?
3 A Correct.
4 Q Although you do have a general understanding of
5 the way that psychotropic medication works?
6 A Yes.
7 Q And you are not actually certified as a
8 neuropsychologist?
9 A No.
10 Q And so diagnosing organic brain damage is also
11 not necessarily your strength or your job on the team?
12 A Not -- I wouldn't say that. Psychologists do
13 have the ability to diagnose organic brain conditions.
14 In fact, I would tend to have more experience doing
15 that than a typical psychologist via my background in
16 neuropsychology training. However, I would not call
17 myself a neuropsychologist because I am not board
18 certified. Not all psychologists would agree with
19 that. Some of them would still call themselves
20 neuropsychologists despite not having that board
21 certification.
22 Q I'd like to talk to you a little bit and switch
23 gears and talk generally about Thomas Mosley at this
24 point. You basically completed one report?
25 A Yes.

1 Q And the date of that report was January 11th of
2 '24?
3 A Correct.
4 Q And that was the only report that you completed
5 for this matter?
6 A Correct.
7 Q When was he admitted?
8 A He was admitted on December 14th of 2023.
9 Q And when did you find him competent?
10 A January 9th was the date of the evaluation.
11 Q And when was the report completed?
12 A January 11th.
13 Q So about three and a half weeks?
14 A Correct.
15 Q Does that seem like a short time in the history
16 of patients who go to South Florida Evaluation and
17 Treatment Center?
18 A Not particularly, no. I mean, some patients are
19 here for multiple months, some patients unfortunately
20 are here for multiple years and some are released or
21 found competent within a month. There's a range.
22 Q When he was first admitted on December 14th,
23 there are records in the file that say that his target
24 discharge was supposed to be April 12th. Did you see
25 those?

1 A No, I did not.
2 Q Do you have the file in front of you?
3 A I have -- I can pull up the electronic medical
4 records. My guess is that you may be referring to a
5 treatment plan, which would be just a standard
6 document.
7 Q Yeah. And in the treatment plan it does say
8 that his target date was April 12th. And I guess what
9 I am asking is, is there often a target date assigned
10 that's months in advance?
11 A That's the first time my attention has been
12 drawn to that target date and I could not tell you how
13 it is determined or what it's based on. I don't know
14 of any scientific basis for that date.
15 Q And you had no role in setting that date?
16 A I did not.
17 Q And you have no idea how it was set?
18 A I do not.
19 Q There are a few documents in the file that are
20 called the CAT, C-A-T, competency assessment tool?
21 A Yes.
22 Q Were there any additional that were done or just
23 the two: One dated December 15th and one dated
24 January 9th?
25 A Yes. So that's the competency assessment tool

1 that we use at least monthly with each patient. The
2 requirement is that one is submitted or completed
3 within the first five days of their admission and then
4 monthly thereafter, calendar month, not necessarily
5 30 days. So the initial one would be for his initial
6 treatment team meeting in which we met him, we
7 observed. Just a brief general mental status.
8 And then the second one would be attached to the
9 report I have in front of me.
10 Q Are there any additional CATS? I am just trying
11 to make sure we have all the records.
12 A That is it.
13 Q So how many times did you meet with Mr. Mosley
14 personally?
15 A I am looking at my electronic records. I
16 reviewed the signature history. My recollection is
17 that it would have been the encounter attached to the
18 those CATS, so most likely twice: his initial
19 treatment team meeting and then the competency
20 evaluation and report. It looks like -- yes, I would
21 say that that's correct. It was twice.
22 Q Are you saying you met with him twice? When did
23 you meet with him?
24 A December 15th during the initial team meeting
25 and January 9th for the current evaluation documented

1 in the report. When the patients are first admitted,
2 the first eight weeks they are met with weekly by the
3 psychology department as well as other departments.
4 For those encounters I have practicum students,
5 postdoctoral residents who assist me, so they saw him
6 for the counters, the weekly encounters.
7 Q Who are the folks who actually saw him for the
8 weekly encounters?
9 A Two practicum students and one postdoctoral
10 resident.
11 Q Would you provide their names?
12 A Yes. One is Skylar Slawiak.
13 Q Do you mind spelling that name for me, please?
14 A Yes. S-L-A-W-I-A-K, Skylar is S-K-Y-L-A-R.
15 Q And Mr. Slawiak or Ms. Slawiak -- is it Ms.
16 Slawiak?
17 A Yes.
18 Q That was a practicum student, she is not a
19 licensed psychologist?
20 A Right, she is supervised by me.
21 Q Who were the other folks who had meetings with
22 Mr. Mosley?
23 A Hannah Browning. I want to make sure that
24 she -- actually, yes, she did meet with him as well.
25 Q And Ms. Browning was again a student?

1 A Yes.
2 Q Not a licensed psychologist?
3 A No. Under my supervision.
4 Q Who was the third person?
5 A Anabel Bobes, A-N-A-B-E-L, Bobes is B-O-B-E-S.
6 She's a postdoctoral resident, so again not licensed,
7 but under my supervision.
8 Q When you say under your supervision, were you
9 present with them or in the hallway or down the hall?
10 A No. On-siite, but not physically present for
11 the encounter. They report to me. We consult. They
12 inform me what occurred during any encounter with
13 patients and I form opinions.
14 Q How else did you form opinions aside from your
15 personal observations? So you talk to the students and
16 did you have anything else to form your impression or
17 diagnostic impression about Mr. Mosley?
18 A Yes. I reviewed his records, including, I
19 believe, it was four prior competency evaluations. I
20 reviewed records of other disciplines within the
21 hospital, including his psychiatrist or intake
22 psychiatry department, as well as the attending
23 psychiatrist who designs the treatment team along with
24 me. And for the current report, in addition to the
25 standard competency assessment, which is primarily a

1 clinical interview and mental status examination, I
2 included objective psychological assessment measures
3 given concerns about his effort and difficulties with
4 forthcoming.
5 Q Did you become aware of concerns about his
6 effort prior to January 9th when you interviewed him?
7 A Yes. I reviewed the evaluation reports that
8 were conducted and my recollection is that at least one
9 of the evaluators provided the opinion that there was
10 potential concerns about his motivation, specifically
11 with malingering.
12 Q So when you say one of the evaluators, are you
13 talking about the students Slawiak, Browning and Bobes?
14 A No. I am talking about the court -- the
15 evaluations that were conducted prior to his admission
16 to this hospital. Dr. Ram, it appears, noted that
17 there was a possibility of malingering.
18 Q And that was the basis?
19 A No. That is something I considered in forming
20 an opinion. I don't base my opinion on someone else's
21 evaluation. I do consider prior evaluations that have
22 occurred.
23 Q But Dr. Ram's report was the only thing that you
24 considered in terms of malingering before your meet on
25 January 9th. Is that fair?

1 A That is not fair, no. That's inaccurate. My
2 role as the psychologist, as an evaluator, is to
3 continually be evaluating somebody's presentation. And
4 my impression on initial intake, the initial meeting,
5 was that some of his claims related to -- his symptoms
6 were atypical and questionable in terms of validity.
7 Q I want to drill down on that a little bit down
8 the road, but I want to finish this line of questioning
9 and we'll talk about that when we get to a little
10 closer examination of the documents in the case. Tell
11 me about your procedure for taking notes. Is it all
12 electronic or do you ever take handwritten notes?
13 A I take handwritten notes.
14 Q What happened to the notes related to this case?
15 Are they in a file somewhere?
16 A They are summarized in reports.
17 Q Do you still have your notes that you took by
18 hand?
19 A No. Those would be work product.
20 Unfortunately, mostly eligible. I don't keep any
21 handwritten documents, notes that are work product that
22 go into my report and when I finish using them, I
23 discard them.
24 Q So are you telling me that all of your notes
25 have been discarded from this case that were

1 handwritten?
2 A Yes, I would suspect so.
3 Q I think that would be something we would be
4 interested in having you check. So if you do have a
5 file of notes and if there are notes relating to this
6 case that haven't been produced by the state or haven't
7 been incorporated specifically in the electronic
8 medical records that we were provided, we'd ask that
9 those be produced.
10 A Okay.
11 Q I'd like to also ask you about the two measures
12 that you gave to Mr. Mosley. First, let me just ask:
13 Was the ILK and the SIMS the only two measures you gave
14 Mr. Mosley?
15 A Yes.
16 Q And when you gave him those tests, did you do an
17 electronic version or did you do a handwritten version?
18 A Handwritten. So they are verbally administered
19 and the evaluator completes the protocol.
20 Q Were you the evaluator who gave him the ILK?
21 A Yes.
22 Q And you basically took that -- you're saying
23 that you took handwritten notes on the ILK itself or
24 no?
25 A No, I don't take handwritten notes on protocols,

1 it's just the responses are recorded.
2 Q How are the responses recorded?
3 A Handwritten. They're force-choice measures, so
4 they're just -- items are circled. The responses are
5 circled.
6 Q Do you have that response?
7 A Yes.
8 Q And is it contained in your file?
9 A No. That would be in my file. Yes, we keep
10 protocols. There are ethics requirements in terms of
11 test security, so it's not something that is provided
12 in a standard medical record.
13 Q Okay. Let's talk about -- if you believe that
14 the ILK is proprietary and you aren't willing to
15 produce it to the state or to the lawyers, we can ask
16 that you produce it directly to our neuropsychological
17 expert. Is that --
18 A Yes, I do believe so, that that would be
19 appropriate.
20 Q Just so you know, we're going to ask we get, in
21 fact, your entire file, all your raw data and all of
22 your test results produced to our expert if you're
23 going to take the position that these tests are
24 proprietary and, you know, you're not going to produce
25 them to the lawyers. Fair?

1 A Yeah.
2 Q I want to move on to the SIMS. Again, did you
3 take notes and was there raw data involved when you
4 gave him the SIMS test?
5 A Similarly to the ILK, that is a protocol that is
6 just completed. The items are circled. The responses
7 are circled, not checked. But in any case, their
8 responses is recorded on the protocol. I don't take
9 notes on that. It's a force-choice measure.
10 Q So are you saying that there's no remaining
11 evidence of the responses on the SIMS? There's no raw
12 data?
13 A There is. It's just a protocol that has, you
14 know, either true or false marks.
15 Q Okay.
16 A With the items, the statement or the question
17 listed which makes it proprietary information.
18 Q Right. But you can produce that to our
19 neuropsychological experts?
20 A Yes.
21 Q I'm interested in what other things may be in
22 your personal file that never made it into the medical
23 records or made it into our request for Mr. Mosley's
24 medical records from the state hospital. Can you tell
25 me what else is in the file?

1 A It would only be protocols, which we don't -- we
2 don't upload to the electronic records because again,
3 it's not something we can just hand over with the
4 entire records. If there are any handwritten notes,
5 they would've all been summarized in the report, but as
6 I said, I often would discard them once I finish
7 because they're work product. And that's really about
8 it. I wouldn't necessarily even keep copies of the
9 report because it's available in the electronic
10 records. I wouldn't keep copies of the commitment
11 orders because that's all in the electronic records, so
12 it would be minimal. Generally, just the protocols.
13 Q So we'd like to ask again that you produce any
14 of the contents of that file that are not proprietary
15 to us or to the state attorney and that the raw data
16 from both the ILK and SIMS be produced to our
17 neuropsychological expert so we can get you that
18 information. We'd like to hopefully do that before the
19 hearing on Friday, if possible. Is it possible?
20 A It should be.
21 Q So Mr. Mosley was admitted to South Florida
22 Evaluation and Treatment Center on December 14th, just
23 to wrap up. You found him competent three and a half
24 weeks later.
25 Can you tell me what all the treatments he had

1 while he was there that took him from incompetent,
2 right, to competent in three and a half weeks?
3 A From my report, I note that he initially was not
4 attending the conference restoration programs that are
5 provided here. At some point, he did begin attending
6 those.
7 I have his medications that he was taking at the
8 time of this assessment. If I were to know whether
9 those are the same medications he was admitted to
10 hospital, I would need to check his medical record.
11 Sometimes patients come in on medication and if the
12 psychiatrists don't see any reason to change the
13 medication, they may not. Other times, they come in
14 with no medication in which case the psychiatrist
15 will prescribe what they think is clinically indicated.
16 So I can tell you what he was taking in terms of
17 medications when I assessed him.
18 Q Let's start with the medications since that's an
19 easy way to start. When he came in, what medications
20 was he on?
21 A I got the initial records for that. It looks
22 like when he was admitted was he was prescribed
23 hydroxyzine, 50 milligrams at night. I will skip over
24 the medications like naproxen and medication for
25 constipation, which I don't think are particularly

1 relevant to competency. He appears to have been
2 admitted on olanzapine or Zyprexa, 10 milligrams at
3 night. And mirtazapine 45 milligrams at night. And
4 that appears to be all of his intake psychotropic
5 medication.
6 Q When you say "psychotropic," that means they are
7 antipsychotics, right?
8 A No, not necessarily. They could also be mood
9 stabilizer, anything that is related to mental health
10 symptoms.
11 Q Can you walk me through those again and tell me
12 what they are?
13 A Sure. Hydroxyzine is typically used as an
14 antipsychotic -- I'm sorry -- an antianxiety. And the
15 olanzapine is an antipsychotic and mirtazapine, that
16 one I can't say with certain. I am not a prescriber,
17 but my understanding is -- well, at least in my report
18 I noted that the indication for it from this provider
19 was for depression. So it appears he was taking the
20 same medications when I saw him that he was admitted
21 with. So his medications were not changed.
22 So to answer your question about what was done
23 in that time to take him from incompetent to competent,
24 without having done a formal evaluation myself at
25 intake or prior to intake, I can't say for certainly

1 that he wasn't competent when he arrived. I may -- had
2 I seen him the first day of admission, I may have found
3 him incompetent, but we do our process. We do our
4 intake. We observe and we have a time by which we
5 complete a more formal evaluation and that was this
6 evaluation.
7 Q I'm sorry. So the December 15th, 2023,
8 competency assessment tool --
9 A Yes.
10 Q -- that has your name on it, was not your
11 assessment when he came in?
12 A It's a brief assessment. It's an intake
13 assessment. We're doing observations, looking at
14 potential symptoms that are attributing to why they've
15 been sent to the hospital, why they're incompetent to
16 proceed.
17 Q And that was not an actual evaluation of him?
18 A I didn't sit with him formally and ask him every
19 single item on the competency tool. No, that's not --
20 it's a briefer examination.
21 Q But you did meet with him in person on the 15th,
22 correct?
23 A Yes, yes, as a treatment team. It was not an
24 individual assessment.
25 Q And even though that report says that he is

1 incompetent and finds him unacceptable on all six
2 criteria, you're telling me now that you think he might
3 have been competent when he came in and when you wrote
4 that report?
5 A There's no report attached to it. It's a
6 progress note. It's a mental status examination. He's
7 considered incompetent because the court has sent him
8 to us. And that was my initial evaluation, which was
9 not as formal as the one in January. It's not -- it
10 was not an individual assessment.
11 Q So getting back to the question of how his
12 competency was restored in three and a half weeks, his
13 medications didn't change, correct?
14 A Correct.
15 Q Did he get competency training?
16 A He attended some of the sessions, as far as I am
17 aware.
18 Q Can you tell me what dates he attended
19 competency training? Unfortunately we've been unable
20 to find it in our record.
21 A Yes. I am referring to the notes from the
22 program department. My understanding is that they
23 complete a document. I don't know what the period on
24 it is, if it's for an entire month or what, but I am
25 looking. So initially there's a document that says the

1 date is from December 14th to December 20th. It has
2 multiple different classes. So there's competency,
3 there's illness management and recovery, there's anger
4 management and recovery, adult basic education, social
5 skills, vocational life skills. And from that time
6 period that this captures, it says he did not attend
7 any scheduled programs.
8 Then the next document is from December 21st to
9 December 27th. Same classes listed. It appears he did
10 not attend any of the scheduled programs.
11 From January 4th to January 10th, for this next
12 document, it looks like he attended one of the one
13 scheduled for life skills. Two out of two scheduled
14 social skills. One out of one vocational prep, two out
15 of two anger management, five out of five competency,
16 three out of three management, two out of two adult
17 basic education. So it appears the week of
18 January 4th, he began attending all scheduled programs
19 and I am looking at the following weeks after that and
20 the same, it looks like he continued to attend
21 consistently January 11th through the 19th, as well as
22 January 15th through the 24th. So he did begin
23 attending in January.
24 Q But you found him competent on January 9th?
25 A Yes.

1 Q So all of his progress occurred in that last
2 week between January 4th and January 9th?
3 A He attended --
4 Q In terms of attending classes. He didn't really
5 attend any classes ever before that?
6 A Correct.
7 Q Was there anything else that you can point to in
8 the medical records or in your experience that was part
9 of his treatment for competency?
10 A No.
11 Q I have a lot of questions about your report from
12 January 11th, but I am going to start with some simple
13 ones just about the way that you create the report and
14 the process of writing it and then we can move into
15 more of the details a little bit later.
16 Can you tell me generally how you go about
17 drafting a report, such as the one that you did in this
18 case?
19 A Yes. So I review their demographic information,
20 their name, their medical records. I put all of that
21 into the report, as well as their committing
22 information, the court from which they were committed,
23 the judge. I review the evaluation reports that were
24 previously completed. I write summaries of those
25 reports. I review their instant case. I write a

1 summary of that and include that in the report.
2 I review the psychiatric intake evaluation here
3 at the hospital and summarize that. And I review their
4 current medications. I include that in the report. If
5 there are any relevant significant notes from
6 psychology department or psychiatry department or
7 nursing department or programs department, I summarize
8 those and put them in the report. That typically
9 occurs before I see the patient, not always, but
10 typically.
11 I then meet with the patient. I conduct the
12 competency evaluation. I gather the clinical history,
13 if it is the first time I am meeting with them. So I
14 ask about their social history, their educational
15 history, their medical history, their psychological
16 mental health history, their legal history. And I
17 would later after seeing them, input all of that into
18 the report as well as their observed mental status
19 during the evaluation, their responses to competency
20 related questions which are summarized in the
21 competency assessment tool.
22 During the evaluation I consider whether or not
23 I think that effort measures, symptom validity measures
24 need to be administered and I administer those as
25 needed. So following the evaluation, I score and

1 interpret those results and I integrate them into the
2 report.
3 I review their symptom presentation as
4 documented in the history and from what I observed and
5 from what others here in the hospital have observed and
6 documented and I use that to come to an impression in
7 terms of their clinical diagnosis and that's included
8 in the report.
9 And then I consider whether I think that they're
10 competent or not competent and why. And what the --
11 you know, if they're not competent, what the barriers
12 are, what the symptoms are that are interfering and
13 why. And if there aren't any symptoms that appear to
14 be interfering with their competency, then they would
15 be considered competent.
16 Q How long did you spend with Mr. Mosley on the
17 9th?
18 A I don't recall the specific amount of time, but
19 given the inclusion of his background history as well
20 as the competency standard questions, in addition to
21 the two measures, I would suspect I would've had to
22 spend at least 90 minutes with this evaluation.
23 Q And how much time did you spend with him on the
24 15th of December?
25 A That would've been much briefer; 10, 15 minutes

1 probably for that initial meeting.
2 Q When was the last time you saw Mr. Mosley?
3 A I think it was most likely during this
4 evaluation, aside from possibly seeing him in passing
5 through the window at the unit. But from my
6 recollection, this mostly would've been the last.
7 Q And if you had actually evaluated him after
8 January 9th, you certainly would've included a report
9 or a note in the records?
10 A Yes, absolutely.
11 Q And I haven't seen a note like that. I don't
12 know if you have one or you have a recollection, right?
13 A No, I'm not seeing one in the charts and I would
14 think so.
15 Q So that was six months ago?
16 A Yes.
17 Q You have a bunch of forensic training having to
18 do with competency in the courts, correct?
19 A Correct.
20 Q And in any of that training, have they talked to
21 you about how competency can wax and wane?
22 A Yes.
23 Q And, you know, for example, Mr. Mosley came in
24 December 15th and he was incompetent according to the
25 CAT tool that is in the file. And three and a half

1 weeks later he's competent and sent back to court,
2 right?
3 A Correct.
4 Q So in that three and a half weeks, there was a
5 marked change according to your diagnosis, correct?
6 A Not diagnosis, but competency status, yes.
7 Q Competency status. I'm sorry. So given that
8 things can change so quickly in three and a half weeks,
9 do you think that things can change quickly in six
10 months?
11 A Of course.
12 Q So you talked a lot about things that can change
13 somebody's mental status from competent to incompetent
14 and I assume those things can also change from
15 incompetent to competent, right? It really goes both
16 ways; medication, therapy, circumstances, for example,
17 jail versus therapeutic in hospital. What other things
18 do you think can change someone's competency status
19 over time; weeks, months?
20 A In addition to medication compliance, which you
21 mentioned and environment, which you mentioned, illicit
22 drugs, organic brain conditions, traumatic brain
23 injuries, those are some of the main ones.
24 Q In addition to a therapeutic environment and
25 circumstances of confinement, right?

1 A It can. I would think in terms of competency,
2 that would be less likely to change somebody's
3 competency. Medications is really one of the main
4 factors in terms of somebody's competency status, if
5 they have a significant mental illness that needs
6 treatment.
7 Q So today, on June 11th, 2024, six months after
8 you've seen Thomas Mosley, do you have any information
9 about any of those factors and how they might have
10 affected his competency status?
11 A I understand that he was returned to the jail.
12 So I with some certainty can say he's in a different
13 environment. In terms of medication compliance and any
14 of the other factors no, I can't. I don't have any
15 information about that.
16 Q So do you have any opinion as to whether Mr.
17 Mosley is competent right now?
18 A No.
19 Q And you would agree that in general in
20 competency determinations, you really can't extrapolate
21 from observations that are six months old?
22 A I agree.
23 Q And in your forensic training, have you come
24 across many of the legal definitions of staleness? In
25 other words, have you ever been involved in a case

1 where courts talk about stale competency report? Have
2 you ever come across that in your own forensic
3 training? Are you aware of the concept?
4 A I am aware of the concept. I don't know that I
5 could state with accuracy what is generally considered
6 stale and/or whether people within the legal arena
7 agree on that term. So that's the limit of my
8 knowledge on that.
9 Q But a lot can happen in six months?
10 A Of course.
11 Q I'd like to ask you some more specific questions
12 about your report and I'd like to start with page 1 of
13 the report. You were telling me that -- well, it says
14 in your report that you reviewed records from the
15 Florida Department of Corrections.
16 A Yes.
17 Q What records were those?
18 A I review the inmate database to look at any
19 previous legal history. To me, it's significant
20 whether somebody has a legal history and is reporting
21 to me that they have no knowledge of the courts. I
22 find that significant, so I do like to be aware of
23 somebody's legal history.
24 It's also relevant in terms of the potential an
25 examinee down the road might be recommended for a

1 lesser restrictive setting. There are DCF requirements
2 in terms of what is considered high-profile cases.
3 Patients with high-profile legal histories that are
4 less likely to be acceptable for a step-down. So I
5 routinely review that information.
6 Q Did you find any Florida Department of
7 Corrections records for Mr. Mosley?
8 A My recollection is that I did not. I think
9 that's noted in my report. No.
10 Q So you did independent research to find out his
11 criminal history?
12 A Yes.
13 Q Did you do any independent research on any other
14 aspect of Mr. Mosley's past history, diagnosis, past
15 mental health history, anything?
16 A No.
17 Q You read the report of four forensic doctors on
18 intake, right?
19 A Yes.
20 Q Those were two MDs, medical doctors who have the
21 power of prescription, correct?
22 A Correct.
23 Q One neuropsychologist who is actually a
24 certified neuropsychologist, correct?
25 A I don't have access to whether he is -- he or

1 she is board certified, so I don't know that.
2 Q Well, it's Dr. McClain and she is a
3 neuropsychologist and there was one psychologist and
4 that was Dr. Ram.
5 A Okay.
6 Q And you read all those reports and you took them
7 into consideration in writing your report?
8 A Yes.
9 Q Okay. On page 5 of the report, you made a
10 comment about a diagnostic impression. I want to ask
11 you what a diagnostic impression is.
12 A It's a clinical impression of the examinee's
13 diagnosis, the symptom presentations that they are
14 demonstrating or that their history also suggests. And
15 also in using in this case, the DSM-5-TR, which
16 diagnosis is most consistent with that type of
17 presentation.
18 Q So what's the difference between a diagnostic
19 impression and an actual diagnosis?
20 A There really isn't one.
21 Q Because in the actual diagnosis, you have in the
22 report, the diagnoses, I should say, unspecified mood
23 disorder, and malingering. They also have diagnostic
24 codes next to them.
25 A Yes.

1 Q It's confusing because I don't really
2 understand; I went to law school, I'm not a
3 psychologist, what a diagnostic impression means.
4 A I mean, I would say because there's additional
5 information provided, so it explains what the symptom
6 presentation is and why the diagnoses are being put
7 forward. So I don't have all of the criteria of every
8 single diagnosis listed here. That's not a good use of
9 report space. That information is, you know,
10 documented elsewhere in the DSM-5-TR. But I provide in
11 that diagnostic impression, some of the examples of
12 symptoms that are consistent with those diagnoses. I
13 don't know if that explains it well, if that's helpful.
14 Q I'd like to ask, for example, when you say in
15 the diagnostic impression that there were atypical
16 hallucinations. What were the atypical hallucinations
17 that you observed?
18 A So the reported frequency and duration is what I
19 found atypical. To explain that, one is experiencing,
20 you know, screaming and that it's fairly continuous and
21 not having any observable behaviors that you would
22 expect to be consistent with that level of symptoms, I
23 find that atypical even in a patient who is
24 experiencing distressing hallucinations, having them be
25 constant is not typical.

1 Q And you didn't observe them in the 15 minutes
2 you saw him on December 15th and the 90 minutes you saw
3 him on January 9th?
4 A No, I didn't observe any behaviors that would
5 suggest symptoms really at all, but particularly to the
6 level that they were being reported, to the degree and
7 severity and frequency.
8 Q What about poor cooperation and effort? If you
9 could list all of the evidence of poor cooperation and
10 effort.
11 A I can list all of them, but I will say I need to
12 leave here at 4 o'clock. So I just want you to be
13 aware I cannot continue past 4 o'clock.
14 Q That's fine. Thank you. I appreciate it.
15 A Thank you. So in asking the examinee about what
16 his pending charges are, he reported that he forgot,
17 but then he said that, I know I see one. So he was
18 indicating I know I had one charge. I don't remember
19 what it was, but I know I have one. I find that
20 implausible and at the time of this evaluation I found
21 that implausible. Recollection for information that is
22 emotionally salient that one has a very significant
23 serious charge is not a typical presentation. It's not
24 consistent with somebody who's putting forth adequate
25 effort. It would be very, very unlikely. There would

1 have to be extremely unusual circumstances for somebody
2 to have that level of memory deficits. I found that to
3 be an example of poor cooperation.
4 Q Is there any other examples?
5 A Yes. So when I asked if you could recall what
6 the one pending charge was, he acknowledged that there
7 was at least one. There was one. I asked: What is
8 it. Well, I have to call my public defender. So no
9 attempt to tell me what the charge was, but I have to
10 call my public defender. And when I asked him why, he
11 said, to see what my charges are. And I reminded him
12 that during our initial meeting, the treatment team on
13 December 15th, I had offered him a copy, if he needed a
14 copy of his case, his charges, the arrest report. He
15 said he didn't need that. He indicated that he knew
16 what the case was about and I asked him about this on
17 January 11th or January 9th when you told me earlier
18 you knew, you didn't need this. Why? And he said,
19 well, he didn't explain it, I guess. All right. I'm
20 sorry. I pointed out to him that he had told me
21 earlier in the eval he didn't trust his public
22 defender, so he's now telling me, I would need to call
23 them to ask what my case is about, but I also don't
24 trust them. I found those things discrepant, so I
25 tried to point that out to him and he didn't reconcile

1 that discrepancy. I reminded him that I had offered
2 him the case documents and he said he didn't need them.
3 Q So that was under the poor cooperation and
4 effort. Was there anything else that you noted in
5 terms of poor cooperation and effort?
6 A Yes.
7 Q I am just really looking for a list. Is it
8 because he said this, because he said this, you know.
9 I am going to move to the other ones just again, to
10 just to have a list of what, in your mind, you know,
11 comprised the poor cooperation and effort.
12 A Okay. So his explanation for why he, you know,
13 was telling me he said he knew what the case was about,
14 but actually he didn't know what the case was about and
15 didn't accept the offer earlier to receive a copy, he
16 said he didn't want to know about the case.
17 He told me that he didn't know the difference
18 between a misdemeanor and a felony, which is again
19 unusual for individuals who have some experience with
20 the legal process. Also, in his case, he appears to
21 have had some legal history. That is something that
22 commonly individuals know or can at least make an
23 attempt at choosing one or the other and he declined to
24 do so.
25 Initially he did tell me what probation was and

1 I do recall that I reminded him that he had noted
2 previously being on probation, but I think probably to
3 elicit some effort from him given my concerns about his
4 effort at that point. I should also note I most likely
5 did not go through the competency, the CAT tool in the
6 order I am going through it in the report and the
7 manner that I report it. I typically don't start with
8 their case. That can be a bit difficult for an
9 examinee, so most likely, and I do think in his case, I
10 probably started with discussing the roles of people in
11 the courtroom. So likely my first question related to
12 the court would have been: What is the judge's role,
13 to which he responded, To be honest with you, I don't
14 really know. Which again, is unusual for an examinee
15 who's giving an adequate effort and most examinees know
16 at least some aspect of what the judge does. In his
17 case, he was claiming not to know that information.
18 Q I was trying to get you -- I was trying to ask
19 if you could give me all of the -- basically all of the
20 evidence that you relied on about his poor cooperation
21 and effort. Is that still where we are? You're still
22 listing?
23 A Yes.
24 Q Because the next question is going to be, I am
25 going to ask you about inconsistencies and all the

1 evidence of inconsistencies that you saw. So I am just
2 sort of asking you to list them off.
3 A There's some overlap I would say within
4 consistency and effort.
5 Q I understand.
6 A Okay.
7 Q But we're still on poor cooperation and effort.
8 You're telling me about all the instances of poor
9 cooperation and effort?
10 A Yes.
11 Q And lack of effort. Is there anything else?
12 A Yes. So he reported that the judge's role was
13 to make sure that he's -- well, to help him, I guess,
14 to be doing good and that the judge sent him to the
15 hospital. And he described the jury as to make sure I
16 am in court. And when I pointed out to him that this
17 was not correct, he didn't attempt to correct his
18 response. He said he didn't know what a public
19 defender's role was or indicated he didn't know, but
20 when I challenged that, again, it's unlikely to be a
21 accurate statement. He said, well, my lawyer, right.
22 So he kind of backpedaled on his initial response was
23 that he didn't know. And for state attorney he said,
24 see me in court was their role. And when I asked him
25 further about that, he said to make sure I am doing

1 okay, to help me. At that point, I did tell him. I
2 don't -- you know, I advised him that I was not under
3 the impression that he was wanting to be competent,
4 that he was suggesting to me that he was unwilling to
5 demonstrate competency. He asked what I meant by that.
6 I explained to him that I reviewed his records and that
7 he previously with some evaluators reportedly was able
8 to demonstrate some knowledge of this information, yet
9 with me he was not doing so. To me, that was
10 discrepant. He didn't reconcile that.
11 Q Dr. Jones, you have years of experience in the
12 mental health field and I am sure you've met with
13 people with all kinds of mental health diagnosis from
14 quite severe to less severe. However, in your mind and
15 with your patients, do you often see that at times they
16 are more competent or able to give more complete, more
17 thorough answers and other times not?
18 In other words, isn't inconsistency one of the
19 symptoms of mental illness?
20 A I'm not sure how you mean.
21 Q Well, for example, when you said, you know, with
22 an evaluator three months ago he was able to answer
23 this question, but with me he wasn't. So it must show
24 that he's not cooperating with me. And I guess my
25 question is: Is that really not cooperating with you

1 or is it possible that inconsistency is a symptom of
2 mental illness?
3 A I don't think inconsistency is a symptom of
4 mental illness. I've never seen it listed as a
5 criteria for any mental illness in any diagnostic or
6 statistical manual that I've seen. I do think that
7 somebody's demonstration of factual knowledge related
8 to the court can fluctuate with their mental status and
9 with their competency. However, when that occurs, as
10 an evaluator my role is to consider what symptom is
11 causing this person to not be able to demonstrate what
12 they know or that they currently know that information.
13 In his case, I was not seeing symptoms that would
14 explain this lack of knowledge compared to what he
15 apparently was able to demonstrate previously.
16 So some individuals experience disorganized
17 thought process and so discerning what they usually
18 know can be difficult or nearly impossible because they
19 can't communicate clearly. They cannot focus on the
20 topic at hand. I did not observe that with him. Some
21 individuals have cognitive deficits so their abstract
22 ability interfere with clearly understanding the
23 information. So they may be able to tell you something
24 about the court that's accurate, but when you delve
25 into it further, they don't understand it and their

1 understanding is very superficial. I didn't observe
2 anything with him that would make me suspect that that
3 was the case.
4 Q Can I interrupt you and follow up because I am
5 interested. Did you give him any cognitive testing?
6 A No, I did not.
7 Q No IQ test?
8 A No.
9 Q Didn't do any research or records into his past
10 educational background?
11 A No, I don't have access to that information.
12 Q You did read the reports of the four doctors,
13 correct?
14 A Yes.
15 Q Submitted along with the other state hospital
16 record.
17 Give me one second.
18 Right, you read all four reports of the doctors
19 that were submitted to you before he was admitted?
20 A Yes. The reports were completed before he was
21 admitted and I would have read them once he was --
22 sometime after he was placed on my unit.
23 Q Right. And you referred to those four doctors'
24 reports in your report, correct?
25 A Yes.

1 Q Okay. So you saw in those reports that Mr.
2 Mosley had a history of learning disability?
3 A Yes.
4 Q That he had both cognitive deficits and
5 cognitive impairment as Dr. McClain and Dr. Maher both
6 found that, correct?
7 A I'm looking at my summaries of those reports. I
8 see that Dr. McClain's diagnostic impressions included
9 major depressive disorder severe with psychotic
10 features, unspecified schizophrenia and other psychotic
11 disorder, generalized anxiety and cannabis use
12 disorder. I don't see any diagnosis related to, but I
13 do see that she noted a history of learning disability
14 and apparent cognitive deficits for which testing is
15 appropriate to address.
16 Q She is a neuropsychologist so her whole gig is
17 organic brain damage. She thought he was not competent
18 to be tested with a neuropsych battery. But she did
19 note cognitive deficits and you noted that in your
20 report, right?
21 A My report that -- she noted it in the report,
22 yes.
23 Q And the cognitive impairment noted by Dr. Maher?
24 A Yes.
25 Q He couldn't maintain employment, right? Mr.

1 Mosley couldn't maintain his employment?
2 A Right.
3 Q He failed classes? That's also in your report
4 that he failed classes in high school?
5 A That there was report of it by him, yes.
6 Q He was a tenth grade dropout?
7 A Yes. I can't verify that, but, yes, I noted
8 that he reported that.
9 Q But you didn't do any testing to determine
10 whether he had IQ or adaptive functioning deficits?
11 A No, I do not routinely do testing unless I see
12 that there is a barrier to competency that I think
13 needs to be measured and to be assessed. And I did not
14 do so in this case.
15 Q I'd like to go back to that series of questions
16 about the diagnostic impression and just ask what other
17 signs or information you had that showed that Mr.
18 Mosley had a failure to plan ahead?
19 A I do think that some of his responses to me in
20 terms of saying that he didn't know information was
21 suggestive of a failure to plan ahead. Suggestive of
22 the lack of recognition or acknowledgment that other
23 records are available, that I can review information
24 showing that he reportedly demonstrated knowledge of
25 these legal concepts prior.

1 Q So he failed to plan ahead in that what he
2 should have studied with his meetings with you on the
3 9th? I don't understand how that is a failure to plan
4 ahead. Do you mind explaining?
5 A So my impression was that he was not
6 forthcoming. He was not responding to questions in
7 terms of what he actually knew, but instead was saying
8 that he did not know information that he mostly likely
9 did know. The reason being that I have access to
10 records where evaluators showed he did know this
11 factual information better than he presented with me.
12 And I do think that it shows a lack of planning ahead
13 to say I don't know information, when previously
14 there's record documentation that I show that I knew
15 that information.
16 Q I want to ask you about page 8 of your report
17 where you talk about the fact that Mr. Mosley endorsed
18 bizarre psychotic symptoms. And I know that we touched
19 on it before, but I wanted to make sure I more
20 thoroughly covered which symptoms you're talking about
21 when you describe them as "bizarre."
22 A And that is an interpretation from the measure
23 from the SIMS. So there are items that include bizarre
24 symptoms and it includes then a total or a score in
25 terms of what they endorse, so the specific ones that

1 he endorsed, I couldn't tell you on that measure.
2 Q So you're aware of Mr. Mosley's medication
3 regimen at South Florida Evaluation and Treatment
4 Center, correct?
5 A Yes. What it was while he was here, yes.
6 Q And he was prescribed antipsychotic medication,
7 correct?
8 A Yes.
9 Q And he was taking antipsychotic medication?
10 A As far as I can be certain, yes, the
11 documentation suggests he was taking it.
12 Q Now, I know you're not a medical doctor with the
13 power of prescription, but I do know that you know a
14 little something about psychotropic medications,
15 correct?
16 A Yes.
17 Q Is it the practice and procedure for a hospital
18 to be treating people with antipsychotic medication if
19 they are not psychotic at some point?
20 A That, I don't know. But as I noted earlier, he
21 was admitted on those medications and it's not uncommon
22 for the psychiatrist to leave the medications as are if
23 the patient is doing well. If they're not
24 demonstrating acute symptoms, there's no concern in
25 terms of their presentation. So, yes, they may come in

1 on antipsychotic medication, but my understanding is
2 that it's not common to discontinue that medication
3 just to see what happens. The clinical indication for
4 doing that is not something that psychiatrists
5 generally want to deal with. Like you said, I am not a
6 prescriber, so I can't speak to that exact certainty.
7 Q I was looking at the report. I'm looking at
8 page 9 of the report. Dr. Jones, just so you can
9 follow along, towards the middle of the page under
10 "Capacity to appreciate the adversarial nature of the
11 legal process," having to do with Mr. Mosley's
12 description of the state attorney's role in this case
13 where you asked him about the state attorney's role and
14 he replied, See me in court, make sure I am doing okay
15 and help me. And I guess I am wondering in what world
16 someone who understands the judicial process might
17 think that the state attorney's office is actually
18 trying to help him and what you made of that disclosure
19 on his part.
20 A I did not think that he was forthcoming in terms
21 of what he knows about the state attorney. By that
22 point, his effort appeared to me so poor that I
23 confronted him about it. So I don't think -- it's my
24 opinion, that that was not a genuine response on his
25 part.

1 Q Right. I'd like to switch gears for a minute
2 and talk about the DSM-5-TR. What is it?
3 A It is the diagnosis manual that the field of
4 psychology and psychiatry really use in terms of
5 diagnosing mental illnesses.
6 Q And is there anything else that you use from day
7 to day in order to diagnose mental illness?
8 A No, aside from clinical observation and review
9 of records and looking at consistency of symptoms with
10 the diagnoses contained therein, no.
11 Q And does the DSM-5-TR allow a practitioner to
12 sort of add or subtract criteria according to the way
13 they feel things should go?
14 A No.
15 Q So explain to me how the diagnosis criteria
16 works in your mind.
17 A So diagnosis criteria for each disorder include
18 symptoms that are -- may be present or have to be
19 present. So there's specific criteria. So in some
20 diagnoses, a certain number of symptoms have to be
21 present in order to meet full criteria for that
22 diagnosis. In some, there are specific criteria that
23 have to be present in order to meet criteria. And in
24 addition to a certain number of other symptoms that
25 need to be, it varies by diagnosis.

1 Q Do you have any qualms with the diagnostic
2 criteria of the DSM-5-TR or do you follow it like it's
3 the Bible?
4 A It has a significant amount of research behind
5 it, so I follow it because it is currently our best
6 system in terms of diagnosis; however, I will say it
7 is -- you know, there's obviously been multiple
8 editions over the years. I fully expect there will be
9 future publications of it, so it is a working document,
10 but yes, I follow it.
11 Q And do you think it's possible to make an
12 accurate diagnosis if you don't meet the criteria for
13 the diagnosis in the DSM-5-TR?
14 A I will say that some diagnoses within the DSM
15 are toward settings where limited information is
16 available. So, for example, in his case, I went with
17 unspecified mood disorder and that's one of those
18 diagnoses where the criteria is a bit less specific in
19 terms of things like duration of symptoms or number of
20 symptoms that are present. Often it's used when either
21 there's not enough information or maybe because of the
22 acute setting or the subacute setting or because of the
23 individual not being particularly forthcoming or
24 reliable historian, that it's a more -- it's a more
25 tentative diagnosis, I would say. So in this setting,

1 because we're don't have the opportunity often to
2 observe individuals over, you know, many months, the
3 diagnosis may be more unspecified. So, you know, it's
4 not uncommon for somebody to be diagnosed with an
5 unspecified psychotic -- sorry -- an unspecified mood
6 spectrum or any other psychiatric disorder because we
7 haven't had the opportunity to observe them over the
8 course of the months that you would need to look at how
9 long do they meet the criteria for these symptoms. And
10 also, we don't wait for a month for somebody to
11 demonstrate psychotic symptoms. We treat those
12 symptoms. So some diagnoses, the duration by which
13 they have to demonstrate symptoms is much longer than
14 we tend to see them here without treatment.
15 Q So to summarize, it sounds like you're saying
16 that you diagnosed Mr. Mosley with unspecified mood
17 disorder because you didn't have enough time to
18 diagnose him with something that might be a more
19 complete, more thorough diagnosis?
20 A Not necessarily time, though, that is a factor,
21 but it's exceedingly difficult to accurately diagnose
22 someone who's demonstrating unreliable self-report. So
23 if somebody is -- self-report is unlikely given, you
24 know, the frequency, the duration, the severity of what
25 they're reporting compared to their observed

1 presentation, it's difficult to come to an accurate
2 diagnosis.
3 What I did see, which seemed most likely genuine
4 was some depressive symptoms, some depressive reports
5 of depression. And that's the basis for that
6 diagnosis.
7 Also, he was prescribed medications that are
8 typically, at least one medication that's typically
9 prescribed, was depressive symptoms. And so of all of
10 his reports, depressive symptoms seemed the most likely
11 genuine.
12 Q Do you have your DSM-5-TR handy?
13 A I do.
14 Q I wanted to ask you about major depressive
15 disorder. It's on page 183. Can you tell me which of
16 the diagnostic criteria for major depressive disorder
17 that disqualified Mr. Mosley from that diagnosis?
18 A I mean, this is one of the diagnoses where you
19 would need some time to observe. And given concerns
20 about the validity of his symptom report, which was
21 also supported by his performance on a symptom validity
22 measure, it's unreliable. Could he meet criteria for
23 major depressive? He could. He may, but I didn't have
24 enough information to make that formal diagnosis which
25 is one of reasons we would start with something like an

1 unspecified mood disorder.
2 Q And you're saying basically the only reason is
3 because he bombed the SIMS; is that correct?
4 A No, I wouldn't say that's the only reason. He
5 would need to report depressive most of the day, nearly
6 every day. He's reporting some depression, but not
7 some of the other symptoms in terms of, you know,
8 weight loss, interest in activities. That's difficult
9 to discern here there aren't a lot of activities. I
10 don't recall that there were any indications of
11 insomnia or hypersomnia. I think he was taking
12 medication for sleep so it's possible he experienced
13 that at some point, but not to my recollection while he
14 was here. Psychomotor agitation or retardation every
15 day, he may have demonstrated some of that in terms of
16 slowed movements, but not to the point it was
17 interfering with daily activities. It's not something
18 he's reporting. Fatigue, loss of energy, not something
19 that I recall him reporting. Feelings of worthlessness
20 or excessive or inappropriate guilt is not something
21 that I recall him reporting.
22 Q There is evidence of all that stuff in the
23 medical records from the nurses, right? And you
24 reviewed the medical records?
25 A From the nurses?

1 Q Yeah. The psychiatric nurses and some of the
2 other medical personnel. I mean, the records are
3 replete with information about his being tired, lying
4 in bed, depressed moody, depressed affect, right?
5 I mean, you reviewed the rest of the medical
6 records and the notes from the nurses during his three
7 and a half week stay, correct?
8 A Yes.
9 Q And there were many symptoms consistent with
10 major depressive disorder noted by the nurses; isn't
11 that right?
12 A My report notes that on December 1st and 28, the
13 unit nurse documented that he had restless sleep, his
14 behavior was calm, logical thinking and process, memory
15 was oriented. And I noted that there appeared to be no
16 document observation by nursing staff to indicate the
17 presence of acute psychotic disorder, psychotic
18 symptoms or suicidal ideation.
19 Q Are you reading from your report?
20 A I am.
21 Q Okay. I'll get to some of those things a little
22 bit later. I want to talk about malingering now.
23 THE COURT REPORTER: Is this a good time for a
24 two-minute restroom break?
25 MS. RUSSELL: Sure.

1 (A recess was taken at 2:32 to 2:34 p.m.)
2 BY MS. RUSSELL:
3 Q So we're back on the record in Mr. Mosley's
4 case.
5 And, Dr. Jones, I wanted to talk to you a little
6 bit about your diagnosis of malingering. Tell me why
7 you think that Mr. Mosley meets the diagnostic criteria
8 for malingering?
9 A Well, malingering is actually not a diagnosis,
10 it is a clinical issue for consideration. It has a Z
11 code, but it's in the diagnostic and statistical manual
12 and the criteria for that are summarized in the report
13 because it's something that a lot of individuals are
14 not familiar with what that means. So we do tend to
15 include that in our reports.
16 In the four main criteria that clinicians are
17 directed to consider in terms of looking at potential
18 criteria for malingering would be that one is in a
19 medical-legal context. So that, you know, they may be
20 referred by an attorney or they are involved in
21 litigation or they have criminal charges pending, so he
22 obviously does meet that criteria.
23 Q I'd like to just look at the language of number
24 14 a little bit more carefully. It says "Medicolegal
25 context of presentation, e.g., the individual is

1 referred by an attorney to the clinician for an
2 examination or the individual self-refers," the
3 individual itself refers "while litigation or criminal
4 charges are pending." So it seems those two things go
5 together.
6 Now, Mr. Mosley was actually ordered by the
7 court to do treatments at your facility. He neither
8 self-reported nor did he get referred by an attorney.
9 So how is it that you think that Mr. Mosley meets
10 criteria number one right there?
11 A This examination, like all of the examinations
12 here, take place within a medical-legal context. So
13 these are examples that the DSM-5-TR provides in the
14 criteria, e.g., they are examples. I don't think this
15 is an exhaustive list. I don't see how he could not be
16 considered within the medical-legal context despite,
17 yes, you're right, not meeting criteria for those two
18 examples provided.
19 Q Because he didn't really have any choice in
20 showing up at the state hospital, he was ordered there
21 by the court?
22 A Correct.
23 Q Let's talk about criteria number 2. Marked
24 discrepancy between the individual's claimed stress or
25 disability and the objective findings." What evidence

1 did you see there to support that criteria?
2 A So many of the examples that I provided in that
3 list that I don't think we actually completed in terms
4 of what I perceived to be ingenuine responses to
5 questions related to legal knowledge about the court.
6 In addition, to results of the measures that
7 were administered. So the ILK is designed to detect
8 one's effort towards demonstrating factual knowledge of
9 the legal process. And the SIMS is a symptom validity
10 measure that indicates whether somebody's reported
11 symptoms, distress, disability, what have you, are not
12 consistent with their actual presentation. So again,
13 his observations of his behavior did not suggest that
14 he was experiencing the symptoms to the degree which he
15 reported or to the degree which he endorsed on that
16 item.
17 Q And do you think that might have anything to do
18 with the discrepancy between your finding that he is
19 cognitively normal and the other doctor's finding and
20 the evidence that he was cognitively impaired?
21 A His results on the symptom validity measure, you
22 mean?
23 Q No. I mean, his marked discrepancy between his
24 claimed stress and disability and the objective
25 findings and observation?

1 A No. I think an individual who has cognitive
2 deficits, those can be observed, those can be measured
3 and typically the observations will be consistent with
4 what the objective measures find. If the person is
5 being genuine, and somebody who does not have cognitive
6 deficits or who is within the range of intellectual
7 finding, their clinical presentation or demonstration
8 of symptoms or lack thereof should also be consistent
9 with what the measures designed to measure those
10 factors measure, if they're being genuine. However, if
11 an individual is not being genuine, then there will be
12 discrepancy between what they are reporting and what
13 they're demonstrating and what the tests designed to
14 measure are measuring and that was the case in this
15 case.
16 Q Do you happen to know if the SIMS is normed on
17 people's cognitive impairment?
18 A Off the top of my head, I don't know the sample
19 for it, but no, I couldn't say specifically what the
20 normative sample or samples were.
21 Q But you gave an instrument to Mr. Mosley without
22 knowing how the test was normed?
23 A It's a standard measure that we use and it can
24 be used with individuals who are -- have lower
25 intellectual functioning, so long as they understand

1 the items and he didn't give me an indication that he
2 was not understanding the items.
3 Q Diagnostic criteria number 3 for malingering
4 "Lack of cooperation during diagnostic evaluation and
5 complying with the prescribed treatment regimen." Is
6 it possible that poor effort could be a symptom of
7 depression?
8 A It can be. My experience has been that it tends
9 not to interfere with somebody responding to direct
10 questions. It more likely be somebody who is not
11 participating at all, not leaving their room. That was
12 not the case for him. So yes, it could be, but that
13 was not my impression in this case.
14 Q Could that same symptom be a symptom of
15 cognitive impairment?
16 A Lack of cooperation?
17 Q And complying with the prescribed treatment
18 regimen?
19 A It can be, yes.
20 Q And finally, in the presence of antisocial
21 personality disorder. What evidence of antisocial
22 personality disorder did you see?
23 A I didn't diagnose him with antisocial
24 personality disorder. One of the diagnostic criteria
25 of antisocial personality disorders, which we've looked

1 for in terms of malingering as well, would be
2 deceitfulness and I didn't think he was presenting with
3 that. That would be the main one. I didn't diagnose
4 him with antisocial disorder nor does one have to meet
5 criteria in order to be considered malingering, it's
6 just one of the criteria.
7 Q So we're clear that he didn't meet -- he doesn't
8 meet the diagnosis for antisocial personality disorder
9 and that he didn't meet criteria for?
10 A I mean, I can't say that I am clear that he
11 doesn't meet the criteria. It's just I didn't think
12 that it was currently an issue concerning competency.
13 He didn't clearly meet the criteria in my assessment.
14 Somebody would have to have access to history that's
15 more suggestive in terms of behaviors within childhood
16 and adolescent and I didn't have access to enough
17 information to support that he has that diagnosis.
18 Q And as a result, he doesn't meet criteria 4
19 under malingering, correct?
20 A Not that I am aware. Could he? If I had more
21 information, he could, but he doesn't have to meet that
22 criteria in order to be considered malingering. So no,
23 currently I wouldn't say I have information to suggest
24 that he meets that fourth criteria, no.
25 Q So the hallmark of malingering is a loss of

1 function. This is in the notes beneath the definition
2 of the DSM-5-TR is a loss of function present during an
3 exam, but not at home. And I am wondering what
4 specific loss of function you saw during the exam that
5 was not present when Mr. Mosley was at home or in --
6 A I'm sorry. What are you referring to loss of
7 function?
8 Q It's, like, down on page 835 where it talks
9 about the loss of function.
10 A Oh.
11 Q "Such as clear evidence that loss of function is
12 present during the examination, but not at home would
13 suggest a diagnosis of factitious disorder if the
14 individual's apparent (inaudible) sick role."
15 A So they're providing an example.
16 Q What kind of loss of function did you notice?
17 A I didn't. I didn't observe a loss of function
18 per se. I think this is just an example that the
19 diagnostic manual is giving to illustrate a diagnosis
20 of fictitious disorder, which I clearly did not
21 entertain as a diagnosis in this case. But what
22 they're getting at in bringing this up within the
23 section on malingering is that one might present who's
24 malingering by saying they cannot do a task, a typical
25 normal task that most people would be able to do during

1 an examination, whereas there's collateral information
2 to show that they have that ability and they
3 demonstrate it at home, but that's not what I am saying
4 in this report.
5 Q Okay. I'd like to switch gears now and talk
6 about Mr. Mosley's compliance with his treatment
7 regimen while he was at hospital for three and a half
8 weeks. Are you aware of any disciplinary issues that
9 he had while he was there?
10 A No.
11 Q And he took his medications regularly?
12 A Yes. At the time of this report, I noted that
13 he was compliant. I didn't have any indication that he
14 was not.
15 Q And he was generally cooperative?
16 A Outside of the evaluation as far as I
17 understand, yes. I was not hearing reports of issues
18 with rule compliance on the units or behavioral
19 disturbances or altercations with other patients or
20 anything of that nature, no.
21 Q So there are weekly psychology progress notes
22 and sort of the pages -- I think in the set of records
23 that we were given, it was sort of basically between
24 pages like 90 or 100 or 88 or 100. Basically I would
25 share the screen with you. They are basically things

1 that look like this. They're one-page reports.
2 There's one from December 18th, December 27th,
3 January 4th, January 9th, and then again on the 19th of
4 January and the 26th of January before he was sent back
5 to the Pinellas County Jail. Are you generally aware
6 of what I am talking about?
7 A Yes.
8 Q So these reports, and let's start with the one
9 that's from December 18th, these were prepared after
10 meetings with the student?
11 A Yes. Well, actually one of them looks like...
12 Oh. I see one of them is -- I submitted it on
13 December 18th, but it was in relation to his initial
14 treatment team meeting, so it's a later note. But,
15 yes, that was completed by me, but others were by
16 students or postdoctoral resident.
17 Q So just so I am clear, this psychology weekly
18 progress note, the progress note from December 18,
19 2023, so we're all talking about the same thing, was
20 completed by you?
21 A Yes.
22 Q How are you able to tell?
23 A So we have a signature history in the electronic
24 records and my name is the one listed.
25 Q Unfortunately, we don't have that information

1 and it would be helpful to have. I am kind of
2 wondering what other information we don't have by
3 unfortunately the way the electronic records were
4 printed out.
5 A I know the competency assessment tool in the
6 progress note section, it would have the name of the
7 person who wrote it. These notes unfortunately are not
8 set up that way and so you have to look in the
9 signature history.
10 Q So how long did you meet with him then on the
11 18th, if this is the note that you did?
12 A I'm uncertain because I am looking at this and
13 it says "Treatment team," but he was also seen per his
14 initial team. My impression is most likely that he was
15 seen on the 15th, but that there was a covering
16 psychiatrist and then his regular attending
17 psychiatrist chose to have his team meeting on the
18 18th, it seems to be the case. Yeah, it does look like
19 that was when he was seen by his attending
20 psychiatrist. So again, it was probably fairly brief,
21 I would guess 10 to 15 minutes.
22 Q So in general, the psychology weekly progress
23 note is a meeting with Mr. Mosley and there's some sort
24 of follow-up with the team and discussion of the note
25 with the team?

1 A It's kind of a nuance. So if the patient is
2 scheduled for a treatment team meeting that month, that
3 week, so either their initial meeting, the first time
4 they're meeting with the team or they're due for their
5 monthly meeting and they also are within the first
6 eight weeks of them being at the hospital, then I would
7 most likely be the one writing a weekly progress note,
8 rather than meeting with him individually. I've just
9 seen him in treatment teams, so you know, we're
10 required to write those weekly notes every week for the
11 first eight weeks.
12 If they don't have a treatment team that week,
13 then they'll be seen individually either by me or more
14 likely one of my staff who will do a brief individual
15 check-in with them, a mental status and just ask if
16 they have any concerns, symptoms, make observations of
17 their presentation, something of that nature, so those
18 are quite brief interactions.
19 Q So on the 18th --
20 A Yes.
21 Q -- of December --
22 A Yes.
23 Q -- did you meet with Mr. Mosley?
24 A I would have because I was the only person
25 attached to this note, so yes, it appears I did. I did

1 not recall that, but it looks like somehow he ended up
2 having monthly treatment team meetings, two in a short
3 duration, which is not typical. But again, in this
4 case, I think it was because the day after he was
5 admitted there was a covering psychiatrist and then his
6 regular psychiatrist on his treatment team chose to
7 meet with him with the team.
8 When a patient's first admitted, they have their
9 meeting usually the following day. So it's like a
10 special meeting, it's not a regularly scheduled
11 meeting. We have patient meetings scheduled twice a
12 week, so patients who are here longer are put on that
13 schedule and we'll see, you know, upwards of -- this
14 morning I saw a dozen patients, I think, for just
15 regularly scheduled. But if they come in on a
16 different day we are going to see him soon. And I
17 think that's happened with him, that he was seen twice
18 in a short amount of time by the team which usually
19 doesn't happen.
20 Q Do you have an independent recollection of
21 meeting with Mr. Mosley on December 18th or are you
22 just referring --
23 A No, not aside from this note.
24 Q Looking at that note, can you tell me what the
25 evidence of malingering is that you noticed?

1 A In this note I don't see any indication unless
2 he didn't report any concerns. He answered questions.
3 He didn't provide much detail. That's all he -- you
4 know, he didn't endorse any thoughts of self-harm. The
5 attending psychiatrist advised him that he would be
6 allowed to wear regular clothes rather than a gown and
7 he would be taken off one-to-one precaution tomorrow.
8 Q I can read the note as well, but what I am
9 asking is, in your professional opinion, do you see any
10 evidence of malingering in your note?
11 A No, no.
12 Q On this visit?
13 A On that visit, no.
14 Q What about any indication that depression might
15 be present?
16 A Blunted affect is often a symptom of depression.
17 Q Any other symptoms of depression apparent to
18 you?
19 A Sometimes poverty of speech can be, not always,
20 but I noted he didn't provide much detail in responding
21 to questions.
22 Q Now, when these weekly reports were done, even
23 if they were done by one of the students, you naturally
24 read them and signed off on them and supervised them,
25 correct?

1 A Correct.
2 Q Let's turn to the note from December 27th of
3 2023 and correct me if that's not the next one but --
4 A That's correct.
5 Q -- it looks like the next weekly report was
6 December 27th, correct?
7 A Yes.
8 Q And if you want to take a minute to look at it.
9 I'd like to ask what signs and symptoms of
10 malingering -- and first of all, do you know which of
11 the students completed this?
12 A Yes. Oh. This one was actually the
13 postdoctoral resident, Dr. Bobes, and it was signed off
14 on by my supervisor Dr. Gio. And judging by the date,
15 I was probably away for Christmas vacation.
16 Q Completely fair. What evidence in this report
17 from December 27th do you see of Mr. Mosley's
18 malingering?
19 A In this case, he did report auditory and visual
20 hallucinations all the time and as I noted earlier,
21 that isn't a typical presentation for somebody to be
22 continuously experiencing both auditory and visual
23 hallucinations of that intensity, particularly for an
24 individual who apparently is able to respond relevantly
25 and in a full direct manner to questions.

1 He also reported to the postdoctoral resident he
2 was currently experiencing auditory hallucinations, so
3 seeing blood in his eyes. That would be unlikely given
4 his ability to apparently engage in the encounter.
5 Q Did he deny auditory hallucinations?
6 A He did. And he noted that it was because the
7 postdoctoral resident was talking. And it's possible
8 some individuals note that auditory hallucinations can
9 improve or at least be muted by themselves talking or
10 other people talking or other background noise. So
11 different individuals experience different things that
12 ameliorate the symptoms, so it's possible.
13 Q And he reported he was found incompetent?
14 A Yes.
15 Q Which was true?
16 A Yes. It's not uncommon for evaluators to ask
17 their understanding of why they're here, the purpose
18 of, you know, why we're seeing them, what they're doing
19 here. So it looks like that's what happened. And his
20 response was, I guess they found me incompetent. So
21 I'm assuming he's referring to previous evaluators
22 and/or the court.
23 Q And he was offered a study guide for competency
24 and he took it?
25 A In this encounter, yes. Yes.

1 Q There was a potential to plan ahead maybe?
2 A Yes, potentially.
3 Q Potentially. What evidence of symptoms of
4 depression do you see in this report from
5 December 27th?
6 A She noted that he appeared lethargic and he
7 reported that he feels tired all day. He reported that
8 his mood is okay. His sleep is okay, his appetite is
9 okay. Those are things we look at in terms of
10 depression. So it doesn't sound that he was endorsing
11 a lot in terms of depression for those areas, but the
12 energy level he was endorsing depressive symptoms.
13 Q And the fact that he was obviously having
14 trouble with his sleep because the medication wasn't
15 helping, correct? Is insomnia a symptom of depression?
16 A I mean, I can't verify that he was having
17 trouble with his sleep. I know that he was on
18 medication, that he continued to be on that was
19 prescribed apparently for insomnia for sleeping, but
20 the status of his sleep at this time, I don't know. I
21 recall noting some of the nursing notes reported being
22 well-rested or sleeping well, but at some point he may
23 have had some sleep difficulty, yes.
24 Q Moving on to the report from January 24th of
25 2024. Do you know whichever the students did this

1 evaluation?
2 A That would be Hannah Browning.
3 Q What signs of malingering do you see in this
4 report?
5 A Not much. He reported that he -- well, he
6 didn't go to programs that day, but he reported it was
7 due to being tired. You can argue that it's not
8 compliant with treatment and that he's not attending.
9 We can also argue that he's too tired to go and. And
10 he didn't get up from his bed. I don't know whether
11 she asked him to do so or not. It's not necessarily
12 noncompliant not to do that.
13 Q What symptoms of depression do you see in that
14 report?
15 A His report that he was too tired could be
16 considered a possible symptom of depression and blunted
17 affect.
18 Q Anything else?
19 A Possibly his minimal response to questions;
20 however, that could also be -- that could also be an
21 effort issue with possible malingering, either way.
22 Q Moving on to the report from January 9th, 2024,
23 which of the students did that report?
24 A That was me. Actually, that week we had
25 treatment team with him. It appears we had treatment

1 team with him that day. So if that's the case, I most
2 likely would have seen him in treatment team in the
3 morning, conducted the evaluation in the afternoon and
4 then probably wrote this note as a follow-up to both of
5 those encounters that seem to have been on the same
6 day.
7 Q So did you have two visits with Mr. Mosley on
8 the 9th or just one visit?
9 A It appears so. Yeah, it appears so because I
10 dated this also the 9th and it notes that he was seen
11 for monthly treatment team, so I believe I must have
12 seen him twice in the same day.
13 Q Do you have any independent recollection of this
14 first visit with him?
15 A No.
16 Q And how long do you think you spent with him, if
17 you know?
18 A I would say probably quite brief. Maybe ten
19 minutes given this note. Had there been more content
20 to that meeting, I would've likely included that so it
21 was probably a fairly brief treatment team meeting.
22 Q Symptoms of malingering in this report?
23 A No.
24 Q What about symptoms of depression?
25 A He reported feeling depressed. And he reported

1 sleep could be better. I mean, I don't know if that's
2 a symptom of depression. I think a lot of people would
3 say that who are not depressed.
4 Q So the psychology weekly progress, even after
5 you completed a report and decided that he is
6 competent, the psychology weekly progress notes
7 continue?
8 A Yes. They're required for the first eight weeks
9 of their admission.
10 Q So the report on January 19th of 2024, which of
11 the students wrote that report?
12 A Hannah Browning.
13 Q Ms. Browning wrote this one and can you tell me
14 what evidence of malingering you see in this report?
15 A Similar to the other weekly encounters. So he
16 provides minimal detail which could be considered poor
17 cooperation or effort, but it could also be a symptom
18 of depression. And I should note it could be a sign of
19 a host of other things. It could be one's just
20 personal style, they prefer not to provide information.
21 It could be volitional, they are guarded and they don't
22 want to provide information. There's not a lot that
23 could be interpreted from that in this type of
24 encounter. He provided minimal detail.
25 Q What symptoms of depression do you see in this

1 report?
2 A She noted that his affect appeared depressed
3 and he also reported decreased appetite which he
4 attributed to his current state of depression.
5 Q Anything else?
6 A I don't think so.
7 Q Do you update your report from January 11th to
8 include the findings of these later reports on
9 January 19th --
10 A No.
11 Q -- and January 22nd?
12 A No.
13 Q Why not?
14 A They're brief observations. I did my formal
15 evaluation. It doesn't change my opinion that a
16 student observed him to appear depressed. He may be
17 depressed. I diagnosed him with an unspecified
18 depressive disorder. It doesn't affect my opinion
19 regarding competency.
20 Q Can we move forward to the report from
21 January 26th of 2024, another report that was done post
22 competency?
23 A Yes.
24 Q Can you tell me which of the students did this
25 report?

1 A Skylar Slawiak.
2 Q What symptoms of malingering do you see in this
3 report?
4 A He reported that he has stopped medications,
5 though he hadn't stopped medication, to my knowledge.
6 And treatment compliance or lack of treatment
7 compliance can be one criteria of malingering; however,
8 I don't think that was the case for him. He just
9 mentioned that he had stopped. And, yeah, in fact, he
10 continues to say that he's compliant with medication,
11 but he believes it's not helping him. Sometimes that
12 is a claim of individuals who are malingering, that
13 they are compliant with the medication and they're
14 saying, well, it's not helping my symptoms. Because of
15 their overreporting symptoms, they're faking or
16 exaggerating symptoms, then their reporting of those
17 symptoms won't necessarily be genuine, so it's not
18 uncommon for somebody to say, yes, I am taking
19 medications, but it's not helping, I still have these
20 symptoms.
21 Q But I mean, just to be clear, he reported that
22 he used to take medication for it in the past, but it
23 didn't help, so he stopped. It seems to me that that's
24 a reference to when he was 16 years old, right? It has
25 nothing to do with, like, the current malingering

1 diagnosis, correct?
2 A Yes.
3 Q I just wanted to be clear on that. So there
4 really isn't any evidence of malingering on this report
5 from January 26th. Is that fair?
6 A That's fair. I would say it's possible that he
7 could be inaccurately reporting that he hears voices
8 that tell him to kill himself, but there's not any
9 clear way of knowing that. It does not indicate
10 whether he was reporting currently during that
11 encounter that he was experiencing that symptom. But
12 there's nothing in this note that suggests to me that
13 he was demonstrating that he was actively responding to
14 hallucinations or that he wasn't. And he was reporting
15 them currently, so I can't say that that's a clear
16 indication of malingering from this encounter.
17 Q What about symptoms of depression in this
18 encounter?
19 A He reported feeling down.
20 Q Loss of appetite?
21 A Yes. That could be a symptom of depression.
22 Q Any other symptoms that you see?
23 A Not that I am seeing here, no.
24 Q And was that the last psychology weekly progress
25 note that there is in the file?

1 A Yes.
2 Q Have you been provided any of Mr. Mosley's
3 telephone calls at any point to listen to?
4 A No.
5 Q And you don't record phone calls up there at the
6 South Florida Evaluation and Treatment Center, correct?
7 A Not to my knowledge and I have never listened to
8 one unless it was a voice message sent directly to my
9 phone and so, no.
10 MS. RUSSELL: I'd like to turn the questioning
11 over to my co-counsel, Jessica Manuele, and also
12 Ms. Blaquiere, if anyone has any additional
13 questions.
14 CROSS-EXAMINATION
15 BY MS. MANUELE:
16 Q Good afternoon, Doctor.
17 A Good afternoon.
18 Q I was taking notes on different things, so let
19 me try to organize myself.
20 Going back to kind of the beginning, Ms. Russell
21 had asked you about any correspondence and you had
22 mentioned some correspondence about setting the
23 deposition.
24 A Yes.
25 Q Other than the report that you sent to the

1 court, have you had any discussions with the state
2 attorney's office about your opinions in this case or
3 opinions about Mr. Mosley?
4 A No.
5 Q The international assessment systems that you
6 did two years with, explain to me what that was.
7 A It's a private practice led by two
8 psychologists; one neuro -- one of them being a
9 neuropsychologist and they were typically retained in a
10 lot of personal injury cases. For example, they're
11 retained by either plaintiff or defense and they
12 conducted psychological and neuropsychological
13 assessments.
14 Q That company specifically, were they more often
15 retained by the plaintiff versus the defense?
16 A No, it was fairly equal.
17 Q Okay. And what did you do there?
18 A So I conducted many of the evaluations. I wrote
19 reports, scored and interpreted test measures. There
20 was always test measures, it was not always clinical
21 interviewing. So a lot of testing. I at times would
22 observe testimony, but I never myself testified in that
23 position.
24 Q When you said there was always test measures
25 done in those evaluations, why was that?

1 A That was just the nature of their practice,
2 their procedures. The cases were related typically to
3 psychological and neuropsychological damages related to
4 the legal situation, so different than competency
5 restoration, for example.
6 Q And then when you switched over to doing
7 criminal forensic work. Did you work under anybody in
8 that arena as far as when you first went to the
9 hospital, was there any, like, in-house training where
10 you were working under a different psychologist? Tell
11 me how that was.
12 A Sorry, you're kind of cutting out a little bit,
13 but I think you asked whether I was working under
14 anyone. I mean, I was a licensed psychologist prior to
15 starting this position. So I have always had a
16 supervisor, the director of psychology. But no, I
17 mean, I was working under my license and my opinions
18 were mine. And the only thing was prior to completing
19 the Florida examiner training that I mentioned, the
20 DCF's requirement is that somebody who has completed
21 that training, reviews our reports administratively to
22 make sure we're following, you know, including the
23 required items for those types of evaluations. So I
24 guess in that way you can say somebody was signing off
25 on my report administratively initially, but otherwise,

1 no.
2 Q Is that during the training that somebody does
3 that or you're saying that once you did the training
4 back in actual real life practice, somebody signed off
5 on your evaluations?
6 A So until you first completed that training,
7 somebody would review your reports administratively to
8 make sure that it's following the requirements of the C
9 file, for example. These are the things you need to
10 address in the reports and that's all.
11 Q So how many competency evaluation reports did
12 you do while under the direct supervision of somebody
13 credentialed to perform those evaluations?
14 A I don't recall. It was -- that would've been in
15 2017.
16 Q You don't know how many you did?
17 A I really couldn't recall. It wasn't a specific
18 number that you had to do this many reports. It was
19 just until you've completed that training, somebody has
20 to sign off on your reports.
21 Q What --
22 A It's not about the clinical opinions. It wasn't
23 that somebody could say, well, I don't agree with your
24 clinical opinion, as I would do as a supervisor of
25 somebody who is unlicensed. It was more is the report

1 following what is expected in terms of competency
2 report for the court.
3 Q Okay. And you did that Florida forensic
4 training, you said, back in 2017 the first time?
5 A No. I started this position in 2017. I want to
6 say I didn't complete the training until the following
7 year, because I started the training and then there was
8 a hurricane. The training got interrupted. I am
9 trying to recall which hurricane, but we couldn't
10 complete the training because people evacuated.
11 Q Okay. So you think you did it first in 2018?
12 A I think so, yes.
13 Q How many trained evaluators are at South Florida
14 Evaluation and Treatment Center currently?
15 A Let's see. Licensed psychologists who are
16 evaluators or trained evaluators? Because we have at
17 least five licensed psychologists who conduct
18 evaluations in addition to postdoctoral residents who
19 are not licensed, interns who are not licensed and
20 practicum students who are not licensed.
21 Q But that have been trained appropriately
22 pursuant to DCF guidelines, how many trained
23 evaluators?
24 A I don't know. There are students that I have
25 not worked with and I don't know whether they've taken

1 that training or not, so I couldn't say.
2 Q And as far as when your last refresher training
3 with the Florida forensic examiner was, do you know
4 when that was?
5 A I was saying I don't recall. I want to say it
6 would be within the last year, but it could have been
7 December of 2022, if this certificate on my bulletin
8 board is accurate. I know we're required to do it
9 every other year, but we often do it yearly just
10 because we have the opportunity. So it's possible it
11 was December 2022, but it's not that long ago. I feel
12 I may have done one last year. I will provide that
13 information.
14 Q All the years mesh together. And I know you
15 said -- we talked about specifically the actual data
16 being sent over to the other doctors in the case, what
17 was the score that you reached on ILK?
18 A I don't have access to that right now. I will
19 have to include that. I will have to have that sent
20 to -- well, I guess we'll have to coordinate who that
21 is to be sent to. I don't include that information in
22 my report because it's a number that doesn't
23 necessarily mean anything to somebody who's not
24 familiar with the test. But I do provide the
25 interpretation so that the results can be understood to

1 anyone. So I don't know what the number is off the top
2 of my head.
3 Q All right. What about the SIMS, do you have
4 what he scored that out?
5 A No, I don't have that information currently. I
6 will have to access the protocols.
7 Q And are you familiar with the research that the
8 SIMS may overestimate faking in patients with
9 intellectual disabilities?
10 A Yes.
11 Q I wanted to look at -- we received a report from
12 Dr. Abraham that was dated a whole month after Mr.
13 Mosley made it back from the hospital and I thought
14 that was a little weird. Do you have a copy of a
15 report signed by Dr. Abraham? It was dictated and
16 typed on March 7th. It was signed on March 8th of
17 2024.
18 A I don't think so. I am wondering if it could be
19 a discharge report, not a report necessarily. I
20 understand psychiatrists complete documentation related
21 to a discharge, but it's not something I typically
22 review because it occurs following somebody being
23 opined competent. That does sound unusual for it to be
24 dated after his discharge. I can't say that I have
25 access to it, but if you could tell me the name of it,

1 I may be able to find it in the record.
2 Q It says "South Florida Evaluation and Treatment
3 Center." It doesn't have any other title on that at
4 the top. This is the first page. I don't know if you
5 can see it.
6 A I think that's what the discharges look like,
7 but I'm not seeing anything in the psychiatry section
8 of the record. Oh. Okay. Well, I do see the
9 discharge summary, but it's -- the date for the
10 document in the medical records says February 1st,
11 which is his discharge date from the hospital. So I'm
12 not sure about the date attached to that. I am looking
13 to see if it's -- okay. So the signature date, I see
14 is March 8th. I don't know why that is dated that way.
15 Q And the report was dictated March 7th, right?
16 A Okay. Is that at the end, it says that?
17 Q Yes, ma'am.
18 A Yeah.
19 Q So you're not familiar with why this would've
20 been done five weeks after he was already returned to
21 the jail?
22 A No, I am not.
23 Q Okay. Does this have anything -- is there any
24 kind of requirement that if somebody is returned within
25 a very short period of time, there's supposed to be

1 some kind of sign-off by a psychiatrist? Are you
2 familiar with anything like that?
3 A I am not. I understand that occasionally, not
4 often, but sometimes patients are returned within
5 30 days of their discharge and in that case, the
6 requirement for the typical intake documentation, like
7 intake psychiatric evaluation and intake psychology
8 evaluation, those aren't conducted again. It's almost
9 as if it's a continuation of the previous admission.
10 But, otherwise, no, I am not familiar with what the
11 expectation is from a psychiatrist.
12 Q Okay. Did Dr. Abraham consult with you in
13 writing this report?
14 A Writing this report, no. We would have talked
15 about our observations of him throughout his
16 hospitalization, but for the discharge report, no.
17 Q Okay.
18 A My understanding is that it tends to be just a
19 summary of their course of hospitalization and that's
20 all.
21 Q I am looking at the bottom of page 2 and going
22 on to page 3 of that report where it indicates or the
23 question is was the patient cognitively impaired during
24 the entire hospitalization. And then there's an option
25 for yes, no or unknown. Do you see where I'm looking

1 at?
2 A Page 2. Oh. Yes, I do. Yes, I see that.
3 Q And in looking at this, it looks like Dr.
4 Abraham checked "no," but correct me if I'm wrong, you
5 indicated that there were two different reports in the
6 packet received by your hospital that both -- I believe
7 it was Dr. Maher and Dr. McClain that both referenced
8 having an impairment or cognitive deficit; is that
9 correct?
10 A Yes. So I noted those opinions by evaluators
11 that saw him prior to this hospitalization in my
12 report, but I think her response in following this item
13 is during the entire hospitalization. I have to think
14 their opinion was no, but I can't speak for how or why
15 she rated it.
16 Q And there would be documentation in the medical
17 record because you referenced it during this depo,
18 right, those two reports; am I mistaken?
19 A Right. But those evaluation reports didn't
20 occur during this hospitalization, they were prior.
21 Q Okay. Explain to me how, like, would those
22 cognitive impairments just go away?
23 A I wouldn't expect they would. It's more, I
24 think, clinical opinion in terms of their presence.
25 Q Okay. And there was no cognitive testing done

1 while Mr. Mosley was at the facility; is that right?
2 A Right.
3 Q Okay.
4 A Well, I will say mental status examinations do
5 look at somebody's cognitive functioning in terms of
6 their language abilities, their memory, their
7 attention, those are all cognitive abilities, but in
8 terms of like in formal assessment measure, a test, an
9 IQ test, no, none of that was done.
10 Q And would you agree that a symptom of
11 intellectual disability could be difficulty in
12 reasoning and logic?
13 A Yes.
14 Q Would you agree that a symptom of intellectual
15 disability could be deficits in memory?
16 A Yes.
17 Q Deficits in language?
18 A Yes.
19 Q And the ability to express one's self in using
20 language?
21 A Yes.
22 Q And would it affect any of your opinions
23 regarding how you viewed those "I don't knows," and not
24 being able to provide additional information, if you
25 had records from 2011 showing that Mr. Mosley was on an

1 individual education plan to specifically address those
2 issues of language and reading, verbal comprehension
3 and the like?
4 A It could, depending on what those records show.
5 It could.
6 Q And you had indicated that -- you kind of said
7 he left or he stopped going to school in the tenth
8 grade. Were you aware that he was already 20 years old
9 at that time?
10 A No.
11 Q Were there any measures done to test his memory?
12 A No, no. The SIMS does include a scale that
13 assesses the likelihood that somebody is faking or
14 exaggerating memory impairment, but testing his memory
15 formally, no.
16 Q Does South Florida Evaluation and Treatment
17 Center, if somebody were committed and was found
18 incompetent to proceed due to intellectual disability,
19 does your facility treat those individuals or would
20 they go to one of the hospitals?
21 A So the legal criteria on that has changed within
22 the last few years that my understanding is that
23 somebody with an intellectual disability, if that's
24 their only diagnosis and/or a neurocognitive disorder
25 like formerly called dementia and no psychiatric

1 illness, and no psychotic disorder, no mood disorder,
2 no anxiety disorder, something of that nature,
3 typically they are not supposed to meet criteria for
4 commitment to the forensic hospital with only an
5 intellectual or neurocognitive disorder. Does it still
6 happen, yes.
7 Q Does your facility have any right now, any of
8 those patients?
9 A Yes.
10 Q I didn't know because, like the DDP I thought
11 that was at the actual Florida State hospital.
12 A Oh. Okay. No. So -- and then also there's the
13 patients who have both a psychiatric diagnosis as well
14 as a neurocognitive or an intellectual disorder. And
15 so, you know, sometimes the assessment includes that as
16 well. However, yeah, legally if they don't have a
17 psychiatric qualifying condition, they're really not
18 supposed to be comitted here, but sometimes evaluators
19 disagree on what the diagnosis is. There's overlapping
20 symptoms, so somebody might be incorrectly diagnosed
21 with, you know, a mood or a psychotic disorder and then
22 be committed and further evaluation indicates that they
23 probably never really met criteria in the first place.
24 Unfortunately, we know that individuals with
25 intellectual and neurocognitive issues can, in fact, be

1 incompetent from those disorders, so it's a difficult
2 legal situation.
3 Q Are there within, like, the state hospital
4 system is there, you know, one facility over another
5 that is supposed to -- that focuses more on
6 intellectual disability and cognitive, like
7 neurocognitive issues?
8 A Not that I am aware of, no.
9 Q Okay. Regarding Mr. Mosley's legal history, as
10 far as the juvenile stuff that he had, are you familiar
11 at all with the differences in, like, the adult
12 criminal system versus, like, the juvenile criminal
13 system in Florida?
14 A No. I've not worked with juveniles. I know
15 that those records are not as available as the adult
16 records. So all I have is what he told me.
17 Q And so are you personally familiar with, like,
18 the plea negotiation system, like a plea doesn't
19 necessarily mean your case is done and over with in
20 juvenile, whereas it would in adult system?
21 A Okay. No, I was not aware of that.
22 Q Are you aware in the juvenile system that jury
23 trials are heard by a judge not a jury?
24 A No.
25 Q Okay. And you had also made reference to a

1 careless driving and a violation of a learner's permit.
2 Are you aware that those are civil citations, not
3 criminal charges?
4 A Depending on the way the docket presented them,
5 I may or may not be aware, but I listed whatever
6 information I had.
7 Q So you had mentioned that regarding the classes
8 he attended and on one of the dates -- all right. So
9 the class notes or the class participation notes, I'm
10 sorry, program weekly note, that's how they're
11 identified, right?
12 A Yes.
13 Q Okay. And going to the program weekly note,
14 now, you had mentioned that he wasn't attending all of
15 the classes in your report?
16 A Correct.
17 Q Looking at the week of 12-14 to 12-20 of 2023,
18 he had no classes scheduled to attend; isn't that
19 correct?
20 A Yes, that would be correct.
21 Q And then looking at December 21st to
22 December 27th of 2023 again, he had no classes
23 scheduled in order for him to attend, correct?
24 A Yes, I see that.
25 Q Okay. He was not scheduled for any of these

1 classes until January 4th, was the first one, right?
2 January 4th to January 5?
3 A I'm not sure why that would be. My
4 understanding is they conduct their initial evaluation
5 and then they're scheduled for program. So I don't
6 know if there was some delay in that or if he didn't do
7 that. There's really no indication of why he wouldn't
8 have been scheduled. I didn't notice that he wasn't
9 scheduled. I don't know why, if it's a holiday
10 schedule or what was happening with that.
11 Q I don't know. But maybe based on his close
12 observation status and then going into the holidays?
13 A That's also possible, yes.
14 Q So he was not scheduled for any classes until
15 January 4th through January 10. And then they have a
16 progress note dated January 11th to talk about the
17 progress of those classes, correct?
18 A Yes.
19 Q And on January 11th he had attended all five
20 hours of the five hours scheduled for competency
21 training, correct?
22 A Yes.
23 Q And the indication on that progress note was
24 that the objective was unmet, correct?
25 A Yes.

1 Q And then also on that day, and I think every
2 other day or the other notes, he had adult basic
3 education in which his goal was to demonstrate basic
4 reading skills, correct?
5 A Yes.
6 Q And his objective was unmet, correct?
7 A That's what they documented, yes.
8 Q Okay. Now, who is doing these competency
9 classes? This isn't done by you, I am guessing, right?
10 A No, it is not.
11 Q Are there notes on there that indicate who was
12 doing the classes?
13 A That particular note, the signature is listed as
14 Crystal Monroe and it's noted mental health technician
15 next to her name.
16 Q And so January 9th is the day that you found him
17 competent; is that right?
18 A Yes.
19 Q And then he continued to do the classes until
20 they transported him out, right? We have another --
21 A Yes.
22 Q -- program weekly note dated January 22nd,
23 right, of '24?
24 A Yes.
25 Q And that is for the period of January 11th to

1 January 19th of '24, correct?
2 A Correct.
3 Q And at that time, his competency training
4 objective was still unmet; is that correct?
5 A That's what they documented, yes.
6 Q And that he had also not met the objective of
7 demonstrating basic reading skills, correct?
8 A That's what they documented, unmet, yes.
9 Q And then they do one final note on January 25 of
10 2024, documenting January 15th to January 24th
11 programs, correct?
12 A Yes.
13 Q And again, he indicated he attended all five
14 hours of competency training offered and his objective
15 was unmet?
16 A Yes.
17 Q And also the basic reading skills, his ability
18 to demonstrate basic reading skill objective is still
19 unmet?
20 A Yes.
21 Q Did you consult with any of the teachers or
22 anything?
23 A No.
24 Q Are you able -- I'm sorry. On the psychology
25 weekly progress notes that you went through, and I know

1 Ms. Russell had you indicate who had noted those. On
2 12-27, what was that name you said?
3 A Oh. Bobes, B-O-B-E-S.
4 Q Thank you. Are you able to tell in your
5 system -- it doesn't show on our printed one, but I am
6 not sure if you're able to tell, how long Dr. Bobes met
7 with Mr. Mosley on that 12-27 date?
8 A No, I don't have that information.
9 Q On January 9th, you did your big evaluation,
10 right, with the team. There was also a psychiatrist or
11 psychiatry risk assessment done on that same day?
12 A Yes.
13 Q And there was also that psychology weekly
14 progress note.
15 A Okay. Risk assessment. Okay.
16 Q Is that all done at the same time? Like, is the
17 team meeting and all members of the team, you're each
18 kind of writing different notes, but that's all based
19 on the same interaction?
20 A Yes.
21 Q So everything that happened on January 9th,
22 whether from you, from the psychiatrist, that would've
23 all been in one meeting?
24 A Yes, as far as I can tell.
25 Q Okay.

1 MS. MANUELE: Meg and Nicole, do you have
2 anything else while I check my last notes?
3 MS. RUSSELL: I don't have any additional
4 questions.
5 MS. MANUELE: Nicole, do you have anything?
6 Oh, I do have something else.
7 BY MANUELE:
8 Q The competency assessment tool, is that what
9 your hospital uses in place of the competency
10 evaluation administration record? Do you know?
11 A I'm sorry, the what? Competency administration?
12 Q Right. So all forensic facilities are required
13 to use the competency evaluation administrative record
14 or an approved alternative form.
15 A Yes, this is ours.
16 Q I'm sorry?
17 A Yes, this is our standard management tool that
18 we use for competency assessments.
19 Q Do you know if that form was approved by -- I
20 guess who was supposed to approve the form if it's not
21 the right one?
22 A No, I don't know.
23 Q And you're going to send us your CV, so I don't
24 have to talk about your background stuff?
25 A Right, I will submit my CV.

1 Q Thank you. Are all of the interns or your
2 interns that you had mentioned, are those included on
3 the approved evaluators list?
4 A My understanding is yes. I mean, they conduct
5 evaluations under supervision and they generally have
6 an opportunity every year that they're here to complete
7 that examiner training.
8 Q Do you know if -- I don't know how to say it --
9 S-L-A-W-I-A-K, if that individual has done the
10 training?
11 A Skylar Slawiak, I believe she did, but I'm not
12 certain.
13 Q Okay. What about Hannah Browning, do you know
14 for sure if she's done the training?
15 A I believe she has, but I don't recall. My
16 recollection is that I may have gone to one that they
17 attended. I don't know. I'd have to confirm that with
18 my supervisor who keeps those records.
19 Q And what about Dr. Bobes?
20 A I don't recall. She started in January, so I am
21 trying to think that she would have the opportunity to
22 have done it or not, I don't recall.
23 MS. MANUELE: Okay. I don't think I have any
24 other questions. Let me see if my co-counsel do.
25 Thank you very much for your time, Dr. Jones.

1 THE WITNESS: You're welcome.
2 MS. RUSSELL: I don't have anything further,
3 but the State may have some questions for you.
4 MS. SULLIVAN: Hi. I don't have any questions.
5 Thank you, Doctor.
6 THE WITNESS: Thank you.
7 MS. RUSSELL: I think you have the choice. At
8 this point we're probably going to ask for an
9 expedited transcript. You have a choice now whether
10 you'd like to read or waive.
11 THE WITNESS: Read.
12 MS. RUSSELL: Thank you.
13 (The taking of the deposition was concluded at 3:47
14 p.m.)
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1 EXCEPT FOR ANY CORRECTIONS
2 MADE ON THE ERRATA SHEET BY ME,
3 I CERTIFY THIS IS A TRUE AND
4 ACCURATE TRANSCRIPT. FURTHER
5 DEPONENT SAYETH NOT.
6
7 _____________________________
8 WITNESS' NAME
9
10 STATE OF FLORIDA)
11) SS:
12 COUNTY OF MIAMI-DADE)
13
14 Sworn and subscribed to before me this ____ day
15 of ________ 2024.
16 PERSONALLY KNOW_______ OR I.D.
17 ______________________________________
18 ______________________________________
19 Notary Public in and for the State of Florida at
20 Large.
21 My commission expires: July 20, 2025
22
23
24
25

1
*Federal Civial Procedure Rule 30(e)/Florida Civil
2 Procedure Rule 1.310(e)
3 CASE : State of Florida v. THomas Mosley
DATE/DEPO OF: Dr. Theresa Ascheman-Jones, June 11, 2024
4 JOB# 6742220
ERRATA SHEET
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11 _________
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Page Line Change
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22 Reason
23 Under penalties of perjury, I declare that I have read
the foregoing document, and that the facts stated in it
24 are true.
25 ____________ ________________________
Witness name Date

1 CERTIFICATE OF OATH
2
STATE OF FLORIDA:
3 : SS
COUNTY OF DADE:
4
5 I, Marlene Gutierrez, Shorthand Reporter and
6 Notary Public, State of Florida, certify that DR.
7 THERESA ASCHEMAN-JONES appeared before me via
8 videoconference on the 11th day of June, 2024, and was
9 duly sworn.
10
11 WITNESS my hand and official seal this 13th day
12 of June, 2024.
13
14
15 ____________________________
16 Marlene Gutierrez
17 Notary Public-State of Florida
18 My Commission #GG126375
19 Expires: July 20, 2025
20
21
22 Personally known_______
23 Or Produced Identification____x
24 Type of Identification Produced____ID
25

1 REPORTER'S DEPOSITION CERTIFICATE
2
3
4 STATE OF FLORIDA:
5 : SS
6 COUNTY OF DADE:
7
8 I, Marlene Gutierrez, Notary Public, certify
9 that I was authorized to and did stenographically
10 report the deposition of DR. THERESA ASCHEMAN-JONES
11 that a review of the transcript was requested; and that
12 the transcript is a true and complete record of my
13 stenographic notes.
14
15 I further certify that I am not a relative,
16 employee, attorney, or counsel of any of the parties,
17 nor am I financially interested in the action.
18
19 Dated this 13th day of June, 2024.
20
21

22

____

23 MARLENE GUTIERREZ
24
25

1 June 13, 2024
2 Dr. Theresa Ascheman-Jones
EMAIL: Taschemanjones@recoverysolutions.us
3
RE : State of Florida Vs. Thomas Isaiah Mosley
4 DEPO OF: Dr. Theresa Ascheman-Jones
TAKEN : June 11, 2024
5 JOB NUMBER: 6742220
6
The above-referenced transcript is available for
7 review.
8 DR. THERESA ASCHEMAN-JONES should read the
testimony to verify its accuracy. If there are any
9 changes, DR. THERESA ASCHEMAN-JONES should note those
with the reason on the attached Errata Sheet.
10
DR. THERESA ASCHEMAN-JONES should, please, date
11 and sign the Errata Sheet and email to the deposing
attorney as well as to Veritext at
12 Transcripts-fl@veritext.com and copies will be email to
all ordering parties.
13
It is suggested that the completed errata be
14 returned 30 days from receipt of testimony, as
considered reasonable under Federal rules*, however,
15 there is no Florida statute to this regard.
16 If the witness fails to do so, the transcript may be
used as if signed.
17
18 Yours,
19 Veritext Legal Solutions
20
21
22
23
24
25

1 VERITEXT FLORIDA REPORTING CO.
2 South Biscayne Boulevard, #2030
2 Miami, Florida 33131
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3
June 13, 2024
4
JESSICA MANUELE, ESQ.
5 MARGARET RUSSELL, ESQ.
NICHOLE BLAQUIERE
6 Public Defender's Office
County Justice Center
7 14250 49th Street North
Clearwater, Florida 33762
8 Jessicalmanuele@flpd6.gov
Pubdef-efiling@co.pinellas.fl.us
9
RE: State of Florida vs. Thomas I. Mosley
10 DEPO OF: Dr. Theresa Ascheman-Jones
TAKEN: June 11, 2024
11
Dear Counsel:
12 The original transcript of the deposition listed above
is enclosed for your file. The witness did not waive
13 reading and signing and has been sent a letter
notifying them to read and sign their deposition
14 transcript.
The witness will be provided a copy of their deposition
15 transcript for reading, and we will forward to you any
corrections made by the witness at that time, along
16 with an original signature page which should be
attached to the original transcript which is in your
17 possession.
18 Sincerely,
19
20 Marlene Gutierrez
21
22
23
24
25

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the deposition wholly or partly, on motion under rule 1.330(d)(4).

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