IN THE CIRCUIT COURT OF THE SIXTH JUDICIAL CIRCUIT
OF THE STATE OF FLORIDA, IN AND FOR PINELLAS COUNTY
CASE NUMBER CRC23-03157CFANO

STATE OF FLORIDA,

Plaintiff,

vs. VOLUME III

THOMAS ISIAH MOSLEY,

Defendant.
_____/

PROCEEDINGS: COMPETENCY EVIDENTIARY HEARING

BEFORE: THE HONORABLE SUSAN ST. JOHN
Circuit Court Judge

DATE: June 20, 2024

PLACE: Courtroom 4
Pinellas County Justice Center
14250 - 49th Street North
Clearwater, Florida 33762

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(Pages 212 to 356)

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(P R O C E E D I N G S)

(VOLUME III)

THE COURT: Can we have Mr. Mosley out, please.

(DEFENDANT ENTERED THE COURTROOM)

THE COURT: We're here on case number 23-03157, continuation of a competency evidentiary hearing we started last Friday. Mr. Mosley is present with his lawyers. The State is present.

And I believe we were gonna hear from Dr. Hall today; is that right?

MS. RUSSELL: Yes, your Honor.

THE COURT: Okay.

MS. RUSSELL: Mr. Hall -- or, sorry, Dr. Hall is present and ready to testify. We have just a few preliminary matters, if we could handle them on the record?

THE COURT: Sure.

MS. RUSSELL: First of all, last Friday, your~Honor, defense admitted Exhibits Number 1 and Number 2, and at the time they were on two-sided copies. And I think the clerk had mentioned that that wasn't good for the system for whatever reason.

THE COURT: Okay.

MS. RUSSELL: I provided the State copies. They've reviewed them, and it's my understanding that they have no objection to our substituting them.

THE COURT: Any objection?

MS. SULLIVAN: No.

THE COURT: Okay. Good. They will be substituted.

MS. RUSSELL: Thank you.

THE COURT: Anything else?

MS. RUSSELL: Not to my knowledge. I'm not sure if there is anything from the State.

THE COURT: Anything?

MS. SULLIVAN: No.

THE COURT: All right. So if you're ready, I'm ready to hear from Dr. Hall.

MS. RUSSELL: That's fine.

Dr. Hall?

THE COURT: Dr. Hall, thank you for coming back today.

THE BAILIFF: Stand right here. Face the clerk and raise your right hand.

THEREUPON,

RYAN HALL, M.D.,

the witness herein, having been first duly sworn, was examined and testified as follows:

THE BAILIFF: Have a seat here. Make yourself comfortable. Speak in a loud and clear voice.

THE WITNESS: Thank you, sir.

DIRECT EXAMINATION

BY MS. RUSSELL:

Q Good afternoon, Dr. Hall.

A Afternoon.

Q Would you please introduce yourself to the Court.

A My name is Ryan Chaloner Winton Hall, M.D.

Q Dr. Hall, do you have a curriculum vitae with your qualifications?

A I do. I did not bring a copy with me, but I think we'd sent one to your office. I'm happy to go over it as best I can.

Q No worries.

MS. RUSSELL: May I approach the witness, your~Honor?

THE COURT: Yes.

BY MS. RUSSELL:

Q I'd like to show the witness what's been premarked as Defense Exhibit 4.

A Yes. I may have one that's a little more up to date, but this is within about the last year.

Q Dr. Hall, is Defense Exhibit 4 a current or reasonably current version of your curriculum vitae?

A Yes.

Q And it summarizes your qualifications and background?

A Yes.

MS. RUSSELL: At this point, your Honor, we'd like to ask that Defense 4 be moved into evidence.

THE COURT: Any objection?

MS. SULLIVAN: No objection.

THE COURT: Defense 4 will be admitted.

(DEFENSE'S EXHIBIT NUMBER 4 WAS RECEIVED IN EVIDENCE)

THE COURT: Can I see it?

MS. RUSSELL: Oh, yes, your~Honor.

THE COURT: Thanks. Appreciate it.

BY MS. RUSSELL:

Q Dr. Hall, tell me about your educational background.

A I went to school in Orlando, Florida, for high school. When I graduated, I went up to Maryland to

Johns Hopkins for undergraduate. Got a double degree in biology and psychology. I graduated magnum cum laude. Then went to Georgetown Medical School. Did four years of medical school there. Did an internship in internal medicine just to have a stronger medical background before starting my psychiatric training. Did three years of psychiatry at the Johns Hopkins psychiatry program, and then after I finished that, I did a fellowship up at Case Western Reserve in forensic psychology.

Q What is a -- is a -- what did you say it was in, forensic psychology at Case Western Reserve in --

A A fellowship. It's an additional year in addition to the normal psych residency where you focus on aspects of the evaluation, treatment and court procedures for individuals with mental health issues interacting with the court, whether criminally or civilly.

Q So how many combined hours after medical school, including your internship, your residency and your specific fellowship in forensics psychiatry?

A You know, I've never broken it down, but we were maxed out at 80 hours a week, and that's what most of us probably spent. By graduation, fellowship requirements, we weren't allowed to do more than 80 hours.

Q So it would have been 80 hours a week over the course of --

A For five years.

Q What happened after your forensic internship?

A Again, originally being from Florida, I came back down. My father was a psychiatrist, so I joined his practice and I've been practicing in the Central Florida area since 2008. I do regular patients, depression, anxiety, PTSD. I also am involved with the UCF medical school, the USF medical school, and adjunct faculty at Barry law school. So I teach about 15, 20 percent of my time, and then I do forensics work the remaining 30, 35 percent.

Q And of your forensics work, what portion is criminal and what portion is civil?

A I haven't broken it out, but it's probably roughly 50/50. Some years may be a little heavier in one than the other, but I try and do both types of cases.

Q So as somebody with a degree -- an MD degree, medical doctor, right, do you have any specific understanding of the way medications work in the human body?

A Yes. And I've also published a lot on psychopharmacology, looking at various groups of medicines, antidepressants, antipsychotics, anticholinergic medicines and the effects on the human body.

Q Is your list of publications contained in your CV?

A Yes. I believe it's relatively up to date, and there should be about a hundred publications. Some of them are book chapters, some of them are peer-reviewed articles, and then the newsletters are a little lighter level of article, but there's several of those as well.

Q Are you board certified in any particular specialty, Dr. Hall?

A I'm certified in general psychology, and the fellowship allowed me to do a certification -- or a sub-certification in forensics. And nowadays you have to do the fellowship in order to sit for the forensic exam.

Q Are you a member of any professional associations?

A Yes. Probably too many. So the big ones are the American Medical Association, the American Psychiatric Association, the American Academy of Psychiatry and the Law, and I also serve as a newsletter editor there. I'm also on the editorial board for their journal and I'm the chairman for their psychopharmacology committee. I'm on several other committees there as well. And then I'm active in the state with Florida Psych and Florida Medical Association.

Q What's psychopharmacology?

A It's looking at how medications can affect the mind. So some of it may be, you know, like Singulair is an asthma medication, but there's a high rate of people having depressive thoughts on it. So some of it is just understanding how medicines, whether meant for a mental health condition or not can impact it. Other side of it is how medicines specifically meant to treat conditions like depression, anxiety, PTSD affect and interact with the body.

Q Dr. Hall, you graduated from college with a degree in psychology, correct?

A Yes.

Q How does your current education and training differ from someone who has a mere degree in psychology?

A Psychology are also doctorates, but they're PhDs or PsyDs versus MDs. So they don't have the pharmacology background, they don't have the pathology background, the physiology background. They don't do rotations involving full aspects of the life, such as pediatrics, OB/GYN, surgery. So, again, I have a much stronger medical-medical background. Psychologists usually do more of the psychologic testing, so they do some additional training in terms of statistics and how to put together those tests. So on a very simplified level, you know, the medical aspects, the hormone elements, the medicine is

more MD-psychiatry side, whereas the testing is a little more the PhD-psychologic side. There is overlap, though. We both use kind of what's known as the *Diagnostics Statistics Manual* for how to diagnose or categorize a disorder.

Q Otherwise known as the *DSM-5-TR*?

A *DSM-5-TR* is the most recent version, which I think came out in 2022.

Q How much do you charge an hour, Dr. Hall?

A Standard clinical rates is $250. For court cases, if I'm working with a public defender or state attorney, I believe was $300. Although, we did raise our rates at the beginning of this year, and my office manager keeps track of that, so I don't know what we currently charge.

Q And your rates in the civil cases that you work on are higher, I assume?

A Usually, $400 to $500 an hour.

Q Dr. Hall, I'd like to ask you some questions about competency. First of all, can you tell me what competency is?

A In a very simple sense, and I believe this was said when I sat in last week, competency is what judges determine, capacity is often what physicians determine, but it's a similar concept of somebody intelligently,

knowingly, and voluntarily being able to make a decision or work with information.

Q And as a psychiatrist, how do you determine if someone is competent --

A Short answer is based --

Q -- or has capacity?

A -- is based off my training, expertise. That's partly why we do the fellowship is, you know, we do a lot of competency evals under supervision there. Also, we obtain ongoing education, CME credits. Some of the organizations I belong to, like American Academy of Psychiatry and the Law often will have additional CMEs, continuing medical education, on the topic of competency. And --

THE COURT REPORTER: I'm sorry. Could you slow down a little bit.

THE WITNESS: I apologize.

And also because I teach a law school class, competency is one of the issues we cover in that class.

BY MS. RUSSELL:

Q And how do you determine if someone has capacity?

A So, in an ideal world, I'd like to look at as many records as possible. If there's any preexisting

health records, that's often helpful to understand a patient's course, their history. I like to do an in-person interview. Usually, my interviews are about 90 minutes to 2 hours. Now, if somebody is floridly psychotic and can't sit in a room with me, it may be less. Then you kind of go through and get a history on them, and then you ask specific questions related to the court, and you're often looking at their factual understanding, but as well as is their mental health causing delusions or hallucinations that could impact their rational understand -- excuse me, understanding as well for their situation.

Q Does competency, or capacity as you call it, wax and wane over time?

A Yes, and that's one of the -- the key issues I discuss when I do my law school class is, you know, not guilty by reason of insanity is the person's state at the time of the crime; whereas, competency can change throughout their time in court, and it does wax and wane, and it depends on their current mental state, not their historic state or where they were at the time of the crime.

Q What factors can change capacity over time?

A Well, there's a lot about mental health we don't know. So there's not a full list that you can mention,

but stress can do it, medicine and compliance can do it, substance use can do it, changes in the natural course of someone's history, sleep deprivation can often affect or bring on symptoms such as bipolar disorder or manic episodes. So a lot of different factors can occur over someone's life. Also, organic. I've had cases where somebody's been in jail and got a head injury and they've had changes related to the head injury. So there could be multiple causes and multiple reasons why somebody can change over time.

Q And what about changes in circumstances of confinement, for example, moving from a jail to home or from home to a jail?

A Yes. Sometimes it has to do with their scheduling, how good they are with their meds, how comfortable they are in their environment, and just other factors that may be hard to tangibly assess, but there's definitely different stresses in jail, different structures, different routines in jail.

Q Dr. Hall, in reviewing records and doing interviews with Mr. Mosley, have you formed an expert opinion on whether Mr. Mosley is currently competent under the criteria in Florida Statute 916.12 and Florida Rule of Criminal Procedure 3.112?

A Yes.

Q Okay. I'm gonna get to your opinion in a minute, but first we're gonna talk about what you did during the course of your multiple examinations and reviews of documents.

Why don't you start by telling me what documents you reviewed in preparation and during your exams of Mr. Mosley.

A So if I could refer to, I think, the two reports I put in here. I've got some listed and then I received some after. So I reviewed the original St. Petersburg Police Department file or records, the indictment document, the medical records from Windermere (sic) Healthcare where he had been treated prior to his arrest. And I think that was very significant because he's had a past history of depression, suicidal ideation, multiple hospitalizations based on actual attempts, not just ideation. And then since he was at state hospital, I reviewed the state hospital records at Wellpath and Dr. Ogu's evaluation, the school board records of Pinellas County, and I also reviewed Dr. Jones' report to make sure I identified that separately, as well as the hospital records.

Q That's Dr. Jones from the South Florida Treatment and Evaluation Center?

A Yes. I'm not always good with names, but I

believe I've got the right name and person on that one.

Q You saw her testimony?

A I saw her testimony last week.

Q All right. You also did numerous evaluations of Mr. Mosley over the course of more than a year now, correct?

A Yes.

Q When did you first see Mr. Mosley?

A So I believe my first evaluation on him was May 16th, 2023. That was more, if I remember correctly, in a general section of the jail. I later came back on the 22nd and he had been moved to a more medical, single cell subspecialized because there had been changes in his behavior and concerns over suicidal ideation.

THE COURT: You said May 22nd?

THE WITNESS: May 22nd -- I'm sorry, May 16th for the first eval. June 22nd for the second evaluation.

THE COURT: June 22nd. All right. Thank you.

BY MS. RUSSELL:

Q How long did you meet with Mr. Mosley on May 16th of 2023?

A I believe it was roughly three hours.

Q And did you give him any tests on the 16th?

A I did. I gave him some standard screens. And,

again, tests sometimes may get into, again, the psychologic field, but I did standard bedside screens that most doctors would do, something called a Mini-Mental Status Exam; a clock drawing, which looks at kind of cognitive function and isolate brain damage areas; and I think I did the Rey 15 Item with him at that time.

Q And did you give him those tests on the 16th or the 22nd of June?

A I believe it was the 22nd. On the 16th, because he was in an isolation cell, we were talking through the door and I wasn't able to pass pen and paper back and forth.

Q Okay. So I'd like to limit your comments right now just to the visit and the observations that you had on May 16th, and then we'll talk about June 22nd at a later time.

So on May 16th, did you give any tests?

A Yes. Well, screens, yes.

Q Screens. Okay. What screenings did you give him only on May 16th?

A Let me refer to my report to make sure I got it right. So we did the Mini-Mental Status Exam, which is usually a five-minute bedside type evaluation where you ask questions looking at cognition. One of the things you ask would be a Serial Sevens, which I know was discussed

last week, which tries to look at concentration, focusing, being able to manipulate information in your head on following a thread through. You also look at spatial construction. So it's a test to look to see broadly how someone's cognition is. It's not an IQ test, but if people do poorly on it, it may suggest the need for more in-depth testing.

Q So what was the result of your finding?

A So I put down two different scores because there's two ways to do the concentration element. One is a Serial Seven, which is what you use with somebody who's got a, theoretically, a sixth grade education or higher where you ask him to count backwards from 100 by sevens. Using that as a measure, he scored 22 out of 30. And then an alternative task would be spelling the word "world," W-O-R-L-D, forward and then backwards. And it's the backwards part that you score, again, being able to keep information in your head, work with it and use it. He did better doing world backwards. So giving a range would have been 22 to 27.

Q And what did that mean to you?

A Twenty-seven is usually seen as a norm. Now, there is a standard of error, plus or minus two. So once you get below 25, you start getting more concerned that there could be some cognitive limitations or issues.

Q What's a cognitive limitation?

A It could be a lot of different things. It could be poor concentration related to depression. It could be due to intellectual deficiency. It could be due to another medical condition, such as delirium. So --

Q How come you don't know for sure?

A Usually, you need to follow people over time. Usually, you also look at someone's labwork. And, again, this is an initial screen. You often need to do more in-depth testing to further narrow it down.

Q Did you see Mr. Mosley a second time on June 22nd of 2023?

A Yes.

Q And how long did you see him then?

A My rough remembrance is that was a little shorter. Probably about an hour, an hour and 30 minutes, just because, again, we were talking through the door of the cell and, again, we had guards next to us. So they were trying to give appropriate privacy, but they needed to be at arm's length. So it was a very different evaluation than the first time.

Q What tests did you give him on June 22nd?

A I didn't give him any formal paper and pencil on those. Again, he was in an isolated cell; we were talking through the hole. But we did try and talk about, you

know, could he repeat five digits forwards and backwards. That is often a way to look at someone's concentration, focus. Ask him if he was aware of any current events, just aware of his date and time. So just simple kind of, again, screening questions, but not a formal written assessment.

Q Did you do anything else on June 22nd when you saw him?

A Tried to confirm some of the original history. Mr. Mosley, I always thought, was a little guarded. Meaning that if you asked a question, you got very minimal responses back. Sometimes that could be because somebody doesn't want to talk to you or sometimes that could be that somebody's depressed or paranoid or concerned. So there could be different reasons for that response. He was still somewhat guarded when I saw him the second time, but he was a little more open and discussed some aspects of his psychosis in greater depth.

Q Dr. Hall, did you complete a report after your visits in May and June of 2023?

A Yes.

MS. RUSSELL: My I approach, your~Honor?

THE COURT: Yes.

MS. RUSSELL: I'm showing the witness what's been premarked as Defense Exhibit 5.

BY MS. RUSSELL:

Q Dr. Hall, is that your report of your 2023 evaluations of Mr. Mosley?

A Yes.

MS. RUSSELL: Did you want to see it?

THE COURT: I have it in front of me. Did you want to move it in at this time?

MS. RUSSELL: Yes, your Honor.

THE COURT: All right. Any objection to Defense 5?

MS. SULLIVAN: No, your Honor.

THE COURT: All right. Great. Defense 5 will be admitted as such.

(DEFENSE'S EXHIBIT NUMBER 5 WAS RECEIVED IN EVIDENCE)

BY MS. RUSSELL:

Q What were your final conclusions after evaluating Dr. Mosley twice in 2023?

A Let me review my reports to refresh my memory to make sure. I have it right here. I at that time diagnosed him with psychosis not otherwise specified, or unspecified. Rule out schizophrenia versus major depression with psychotic features.

Q Dr. Hall, what does "rule out" mean in the medical context?

A Meaning that I needed more information to make a

more firm diagnosis. With schizophrenia, you need symptoms for up to a six-month period of time. And given that he seemed to be a bit in crisis, I wasn't sure how long the symptoms had been going on. And when I reviewed past records, it was more the depressive symptoms I was seeing in the earlier records, the suicide attempts and things of that nature. So I wasn't sure. Sometimes we'll see what we call a prodromal where people a year or two before the psychotic symptoms present will have changes. So I figured I needed more time and wanted to see how he did after he'd been on medications.

Q Dr. Hall, in what ways did Mr. Mosley fall short of capacity in 2023?

A So at that time, just referring back to my report, I thought he was acceptable for appreciating the charges on a very basic level. He knew that there were two murder charges when I spoke with him.

I thought he was acceptable at that time on appreciating the range of the penalties and that he understood that these were significant charges, that there were significant possible outcomes that could come from them.

In terms of understanding the adversarial nature, I thought that was very questionable. And, again, very limited responses. Didn't give a lot of information,

either negative against his case or pro for his case, which was concerning.

For disclose to counsel, I thought that was unacceptable. And, again, when I talked with him, he was very guarded. There were just certain things he wouldn't talk about, even if you were just asking for factual information, such as the name of the victims. So I assume he does know who he's accused of or alleged murdering, but he would not discuss it with me, and I think a lot of that was due to his psychosis at this time, paranoia, and worries that that would somehow negatively impact him in a very physical sense, not in a legal sense.

Manifest appropriate courtroom behavior at that time I thought was unacceptable. And, again, he had just been moved from a higher level -- or a more general housing to a more specific housing because there was concerns about suicidality.

And then testify relevantly, I did not think he would do well with answering questions due to his mental illness and, again, the guardedness, the psychotic aspects that I think were limiting his abilities to testify or speak.

Q Dr. Hall, does Mr. Mosley's mental state back in May and June of 2023 inform anything about your current opinion about his capacity and competency?

A Yes. It was nice in the sense that I could see him over time. I also saw him on the first time he was on one antipsychotic medication called Seroquel. I don't think it was very effective for him. When I saw him the second time, he had been switched to Zyprexa, which is a different antipsychotic mood stabilizer.

THE COURT: You're talking about your two times you saw him before he went to the state hospital?

THE WITNESS: Yes, ma'am.

THE COURT: So between the May and June dates, his medication had changed?

THE WITNESS: His medication had changed, and usually these medications, textbook, take four to eight weeks to fully kick in. So when I saw him on the Zyprexa, rough remembrance, he had only been on it for three or four days. So he hadn't been on it long enough to see if it was gonna work for him yet or not. He was still very psychotic, and he was actually able to describe some of his psychotic symptoms better the second time I saw him than the first time. Whether that was the medicine maybe starting to kick in or him maybe being a little more comfortable with me since he'd seen me once before, you know, would be speculation, but there

was a little glimmer of improvement on the second visit.

BY MS. RUSSELL:

Q And, Dr. Hall, you noted that Mr. Mosley seemed guarded with you even though at that time you were a confidential defense expert, correct?

A Yes.

Q Do you know what happened as a result of your diagnosis back in 2023?

A I believe he went to the state hospital.

Q Do you know how long he was there?

A I -- my remembrance of the records is he arrived around December 14th, and then I think he left around January 19th. So, roughly, three weeks, four weeks.

Q Do you know what treatment he was given at the South Florida Evaluation and Treatment Center?

A From review of records, the medications, he was continued on the Zyprexa, 10 milligrams, which had been started in the jail. I believe they continued mirtazapine, that's the generic name -- the brand name is Remeron -- at a max dose, 45 milligrams, which is an antidepressant. It also tends to help with sleep and also tends to help with appetite. And I think he had hydroxyzine, also known as Vistaril, as an as-needed or as an additional med to try and help with sleep.

They also mention EPS symptoms in the records, which is extrapyramidal symptoms, which can be a side effect you get from the Zyprexa. So I -- I don't know how much he needed the Vistaril versus it was just put on to reduce risk of side effects.

Over his course at the treatment center, on the 10th, I believe, he was prescribed trazodone, which is an additional sleep aid, also an antidepressant. To get the full antidepressant effects with trazodone, you need about 300, 400 milligrams, but very few people are awake and functional at 400 milligrams. So we usually will use 50 to 150 to help with sleep or as an adjunct. I thought that was particularly interesting in Mr. Mosley's case since he was also on Remeron at a max dose, which is frequently used to help with sleep, already had the Vistaril, which is also somewhat sedating. So it seemed like he was having a lot of problems or difficulties with his sleep cycle based off of just the medicines they had been prescribing him.

Records reviewed also indicated that he did attend some groups, but because he got there around the holiday time -- it looked like the first two weeks -- he, for whatever reason, didn't participate in any group activities, and it was only after January that he started going to competency restoration, life skills group, or

something equivalent to that, and a few of the other group sessions that was there.

THE COURT: Were they available or he just didn't go?

THE WITNESS: The best I could tell is that they didn't sign him up. So I don't know if there was an error. I didn't see anything that indicated he was actively refusing, but he just didn't seem to be getting it. So I'm -- I'm assuming there was a -- lack of a better word, a glitch.

THE COURT: Okay.

THE WITNESS: Or they may just not have been offering him due to scheduling and staffing.

BY MS. RUSSELL:

Q Dr. Hall, we'll talk a little bit more specifically about the medications that Mr. Mosley was prescribed at the treatment center a little bit later, but for now I'd like to ask you a question about your second set of evaluations with him after he returned from the South Florida Evaluation and Treatment Center. Did you see him when he came back to the Pinellas County Jail?

A Yes. I don't remember exactly what day he was transferred back, but I saw him in March. So it would have been within about six to eight weeks, I believe, rough estimate, of when he had been approved or had left

the treatment center.

Q How long did you visit with him on March 5th of 2024?

A At that time I visited with him for two hours.

Q And what did you do?

A Basically, repeated the evaluation from the first time since I thought he was still somewhat symptomatic the first time I saw him. So I tried to go back and confirm the history, you know, ask about family history, what his parents did, what it was like growing up, what his work history was like.

I did discover some new information, like schooling was very difficult for him, that he was in special education classes from about third grade on, that he had trouble taking tests. Again, I can't independently confirm this, but he said he had to take the learner's permit driving test like 10 or 11 times before he could pass it. So he seemed to be a little better on getting some of the aspects of his day-to-day life and seemed that he had a lot of functional limitations even prior to high school.

Some answers were still kind of basic. So you ask why did you leave school, and it was, Well, just school wasn't more me. I think there was probably more to it than that. One of the hard things when you're doing a

forensic evaluation is how hard do you push. You don't want to ruin rapport. You want to build. So somebody may have gone into greater depth there. I just took that answer at face value, but I think there was probably more to it than just "it wasn't for me."

Reviewed his past psych history, reviewed his medications. Tried to review his time at state hospital. He didn't have a great remembrance of a lot of the things he did there. And I'll often ask specifically, Anything you learned; anything that surprised you; anything you weren't expecting? I don't think he was lying, but, again, he's not the best historian. So I asked, you know, What medications were you on? I think he could mention two or three of the four. Had a little trouble remembering the exact doses.

And then we talked about how he was doing currently on the floor and kind of, again, looked at his understanding of the situation.

Q So you saw him five weeks after he returned from the South Florida Treatment and Evaluation Center. What was his condition compared to when you saw him back in June of 2023?

A In some regards, I thought it was much better. He was less overtly psychotic. The paranoia was much better. When I'd seen saw him originally, he was worried

that people were going to physically attack him in jail and harm him while he was in jail. And at some level when I saw him in June, he was actually happy to be in the isolation cells because he felt safer there than if he was in the general population area.

So I thought the paranoia and aspects of the active hallucinations were better. Now, he still reported having some simple hallucinations of hearing a voice saying kill yourself, and that is a little more consistent with maybe a mood disorder with psychotic features. Sometimes hallucinations with schizophrenia can be a little more pronounced or varied.

I thought he was still very depressed, though. He had trouble making eye contact. Responses were still very minimal, slow. Still was having some issues with sleep. Appetite was okay. So he wasn't endorsing every symptom. Reported there were no interests or activities. And I understand when you're incarcerated there may not be the usual things you like to do, but, you know, some inmates I see will play cards or read a book or listen to music. And I think at times he gives answers that are socially expected even though they may not be fully accurate.

So, for example, Are you reading anything?

I'm reading the bible. I'm reading passages my

mother picked out for me.

Well, that's wonderful. What are those passages? What are the meanings of them? What do they -- he couldn't give answers on that. So I -- I think he's someone that may give very superficial answers that you have to go back and go a little deeper to see if there's true understanding or if he's just saying something socially acceptable to move things along.

He still seemed to have trouble with the speed of his thoughts, his statements. He still was a little difficult for me to hear. I know I'm getting older and my hearing is not quite as good as in my twenties, but I found him to be difficult at times to understand and appreciate. And for the most part, his affect was very flat. Meaning, he didn't seem to respond. He didn't smile. He didn't furrow. There was no aspect of tears, but he just didn't seem emotionally to have the depth you'd normally see with someone.

Q Is that flat affect indicative of any kind of mental health diagnosis?

A Yeah. You can see flat affect with schizophrenia. You can see flat affect with depression. Some medications may also contribute to it as well, but his affect seemed the same whether he was on Seroquel or Zyprexa, and he's not on a max dose of Zyprexa. So

although it's possible a little of it could be related to the medicines, I thought it was more likely his mental health condition.

Q Was there anything else that you noted or documented with regard to his condition on March 5th of 2024?

A I apologize. My report will probably highlight it better, but, again, still simple answers. Was a little more willing to talk. Was less paranoid about people harming him in the jail. I did not pick up on any delusions that would interfere with his ability to participate in the courtroom, but I thought there was a lot of apathy, which I thought was more depression based.

The other thing I should probably mention is when he was at the state hospital, he had an abnormal thyroid hormone value that was supposed to be followed up on, and I never saw a followup lab. So thyroid is kind of the thermostat for the body. So if his thyroid is not well regulated, we can put him on medications till the cows come home, he's not gonna respond.

Q And is thyroid, this regulation, associated with mental health disorders as a symptom?

A Depression. A lot people who are low thyroid, hypothyroid, look very depressed, and that's one of the reasons psychiatrists always check the thyroid. So I --

it may be fine. Maybe the jail did it, maybe records that I missed, but I do want to acknowledge that there was an abnormal lab value that I'm not sure if it was ever followed up on.

Q By the South Florida Treatment and Evaluation Center?

A Not that I remember seeing, or, if it was in there and I missed it, I apologize, but I -- it was supposed to be redone around the time he was discharged, and I don't know if it was.

Q Would that have been something important --

A Yes.

Q -- for the hospital to follow up on?

A Yes.

Q In order to make sure their diagnosis was accurate?

A Yes.

Q I want to switch gears for a minute, Dr. Hall, and talk to you a little bit about the malingering and feigning. As a psychiatrist, how do you determine if someone is malingering?

A It's always hard to make the diagnosis of malingering, and because of the significance of it, you want to be cautious and not accuse somebody who isn't. So what I often do, will look at past records, see if

symptoms are consistent throughout time. Especially if there's a legal issue, I try and look at records prior to the arrest to make sure that the pattern hasn't all of a sudden sprung up. You get a history from him. You try and look at collaterals. You look at how they present to other people. You ask questions, and then, you know, if you are in a position to, you may sometimes do tests of effort.

So one of the exams I gave him originally, the Rey, is a screen of effort, and if people are trying to fake memory difficulties, they often do poor on it. So the first time I saw him, he did not fail the test of effort or the malingering scale, or screen. And then there may be, as part of a full cognitive evaluation, certain validity scales or certain tests specifically designed to look at malingering.

Q Did you ever give Mr. Mosley a full cognitive evaluation?

A No. And, again, MD. So psychiatrist, not psychologist. Usually, it will be a psychologist that would do the deeper level of testing in that area. And, also, sometimes it's hard to do in a correction facility. You know, they try not to -- they usually don't like psychiatrists to bring in a lot of electronics. Psychologists, since they're doing the testing, can bring

in laptops and do more, but -- so I did more standard interview, looked at if the symptoms seemed consistent, looked at if his responses were consistent, was he thrusting for symptoms.

So one of the reasons I didn't think he was malingering is he was reporting improvement over time. So it wasn't that everything was bad or nothing had changed. Also, when he would be guarded, he would be guarded about information that also could be helpful for his case. For example, I asked him about past head injury, and he mentioned one event, but from having read the records, I knew there was a second event and I had to kind of bring that up. So I thought if he was trying to look sicker than he was, that he would have definitely mentioned both periods of loss of unconsciousness or played up, oh, I've never been the same since. So I thought his pattern of being sparse in responses cut both ways, which is not usually what you see with somebody who's malingering.

Q Just more generally about malingering, not necessarily in your evaluation of Mr. Mosley, but just in your evaluation of malingering generally, is it easy to conclusively establish malingering?

A It can be a challenge.

Q Why?

A Because there's a lot of variety in mental

health. And although I love my field, and it's a great field, we don't have a blood test for schizophrenia. We don't have an objective measure. You know, somebody is complaining of chest pain, I can order labs and say, yes, you had a heart attack. These labs are elevated. Psychiatry/psychology is a field of observations, and people may change, and there is not necessarily one set pattern for every condition.

So, yes, there are some rare symptoms. Yes, there may be reports that should raise flags for issues of malingering. You know, so when we talked about I'm seeing blood all the time, that does raise a little concern for me. But when you put it in context of the rest of the pattern, it seemed to be a consistent pattern that you would find with somebody with an illness as severe as his. So short of somebody admitting that they were lying or having video evidence, you know, somebody saying I can't walk and then you get video of them dancing, it's often very hard to prove malingering.

If I can give an example, there was a case where somebody claimed they had social phobia disorder, and this was a civil case, and that they couldn't go out and they couldn't be in crowds. And when they came up to Orlando to interview with me, the day beforehand they went to Walt Disney World, and they had a private investigator,

and they got on all the rides. When I asked them about it, they're like, Oh, I was just trying to do exposure therapy the way my counselor encouraged me. You know, so even when you sometimes have video evidence, it's hard to know what somebody is really experiencing.

Q Is it possible to properly diagnose malingering with the use of a mere screening test like the ILK, the Inventory of Legal Knowledge, ILK?

A This -- and, again, I've written papers on malingering. I have a broad general sense. I'm not going to get into the nuts and bolts because that's the psychologist's realm, but those exams are often helpful, but if you read the books, they say they should not be used in a vacuum, and they're not the begin all end all. So they should be part of a comprehensive evaluation. And, again, there is no blood test. There is no one value that says, yes, malingering.

THE COURT: Well, what other things should bees considered, then?

THE WITNESS: History. Look at the history. You look at changes over time. You look at how somebody is performing when they don't think they are being watched. So one of the things I will often look at is if somebody is saying, you know, I can't be around people, but then you read the

nurse's notes and it says they're playing cards or playing chess, but then when you're with them, they can't spell their name. You know, the difference in functioning seems so profound.

So I went to see someone in the Orange County Jail, and they refused to come out of the jail cell because they were yelling they were Jesus, literally. When I went back and looked at the jail records, there was no history of him claiming to be Jesus Christ and no history of him refusing to come out of their cell except when there was an evaluator there.

So sometimes there are better markers for it than others. And, again, in general, yes, there may be a few things here that I can understand how another evaluator could reasonably see it as a yellow flag. My look at the records, my interviews, I don't think there is clear indication of the malingering, and I think the symptoms of a major depression are just as easily to explain poor performances on at least the ILK and some of the other reasons raised.

BY MS. RUSSELL:

Q Well, you raised an important point, Dr. Hall. Can symptoms of depression ever be mistaken for

malingering?

A Yes.

Q How is that?

A One of the big symptoms of depression could be apathy. So somebody who doesn't want to answer questions or doesn't care or has poor concentration or has more of an irritable anxiety may be mistaken as intentionally trying to cut something short or not wanting to answer because they're avoiding the question. So there are times when there can't be overlap and you have to acknowledge that both can occur. And, again, in forensics, I always consider malingering as a possibility because forensics, by definition, there is always a medicolegal context. So forensic evaluators are usually a little more objective in their approach. A clinician, you assume that if somebody is coming to you, they're being honest because they're taking time out of their day to show up. So clinicians may not consider it as often, but most forensic people, malingering is always on their radar and always something they're considering.

Q Dr. Hall, your were here in the courtroom last Friday. You heard the in-court testimony of Dr. Jones.

A Yes. I did step out briefly to get a drink of water due to allergies and coughing, but I heard most of the testimony.

Q What were your impressions of her testimony that Mr. Mosley was not suffering from depression, but, rather, an unspecified mood disorder six months ago when she last saw him on January 9th of 2024?

A I can understand how she may want to go with an unspecified mood disorder, just as the first few times I saw him, I went with psychosis not otherwise specified. And, I apologize, when they changed the DSMs, I think unspecified is more current terminology, not NOS anymore.

So I'm not going to quibble over the mood disorder, but when I reviewed the records, based off of what I saw before and after, I thought there were symptoms of depression there. I thought that the symptoms had occurred for a long enough period of time. You need to have them for two weeks. And there's a relatively simple mnemonic for depression, SIGECAPS. You need five of the nine to meet their criteria, and the more you have above that, the higher the severity of depression.

But he complained of sleepless issues, which seemed consistent with the trazodone. He reported loss of interest, which is consistent with what I saw before and after. You know, there were reports of self-esteem or pathologic guilt, and I think that's more then just being accused of murder, that there was energy changes. And, again, my understanding of the record -- and if I'm wrong,

I'm sure someone will show me -- is that it wasn't that he refused to go to groups, but that they weren't available. But even with that, he was staying in his room a lot, especially when he first arrived at the treatment center.

Concentration was poor. Appetite, I think there was some fluctuation. So some reports, yes; some reports, no. Some of the records indicated that he looked puffy. So it looked like he may have put on some weight.

Speed of his thoughts. And, again, when I talked with him, he just talks kind of slow, minimal answers, low tones. So I thought there was, in my opinion, objective of psychomotor retardation. You often ask people how are you thinking or how is the speed of your internal thoughts.

And then suicidality. And, again, he's got a history of that even prior to his charges. And he was reporting not active suicidal thoughts, but passive death wish and just not caring and, you know, life had no meaning. And some of that was even in Dr. Jones' report. And I think when he was going to leave, he made some statement of I just doesn't care or it doesn't matter.

So I thought there were definitely indications of a major depression while he was at the hospital, that he met enough symptoms at the same time, and that that probably did impact his evaluation with her.

Q But then, again, you saw him over more than a course of a year, four visits?
A Yes.
Q Hours of evaluations, hours of records review?
A Yes.
Q Versus three and a half weeks?
A Yes.
Q So you had a much longer time to diagnose Mr. Mosley?
A Yes. And I had the benefit of being able to review those records as well, as well as records from his outpatient treatment centers -- or, sorry, his inpatient treatment.
Q Dr. Hall, what was your opinion about Dr. Jones' testimony that Mr. Mosley was malingering when she last saw him more than six months ago in January of 2024?
A Again, want to be careful because psychiatrist, not psychologist, but understanding the nature of a Forced Choice Test, and even if you look up Harr, which is the testing company that does it, they say if you're looking at somebody who scores average -- or scores, you know, 50 percent, that that is not necessarily an indication of malingering, that that could be an indication of poor concentration, random guessing, not putting forth a full effort. Somebody who scores significantly below

50 percent is when you start thinking malingering because that shows that they actually know the right answer and are intentionally choosing the wrong answer versus just randomly guessing. So she could have said I think he had poor effort. I could have said I didn't think he was taking it seriously. That, I think, would be reasonable conclusions from his ILK. I think it's a little bit of a stretch to say it's malingering and it's only malingering.

Q And those are also consistent with depression?

A Could be, yes. The SIMS I haven't seen, haven't reviewed. I mean, the score was high, you know, but I will let the psychologist talk about that more.

I had concerns over his cognitive functioning when I saw him. I think other people had concerns. So one of the key questions is is he an appropriate person to use on these tests and what standard population did you put him in?

So, yes, he got to tenth grade. From the records I reviewed, it looked like there was a lot of social promotion, so I don't think he's a true standard tenth grade level. I worry about his ability to read. I don't think anybody gave him a reading test. And there is an academic test called the Woodcock-Johnson that could have been used. I don't think anybody evaluated him with that. So from looking at the school records, I have

concerns if these items were appropriate for him or not.

Q Dr. Hall, I'd like to ask you some questions about your most recent evaluation of Mr. Mosley just a few weeks ago.

A Yes, ma'am.

Q You were able to meet with him on May 29th of 2024?

A Yes.

Q What were your general impressions of his psychiatric condition at that time?

A The psychosis, as I noted earlier, was better. He reports that he's been taking his medications. Still has trouble remembering all of his medicines, but still seemed very depressed, and the depression symptoms seem consistent since I saw him the first time. Not getting the best sleep, not really having interest or wanting to do anything, poor concentration.

And, again, normally when I see somebody, I assess concentration. Can you watch a two-hour movie and keep track? Can you tell me what was on a recent sporting event? Now, when people are incarcerated, they may not have access to the common area TV. He at the time said, I'm reading the bible, but, again, he couldn't discuss the content of what was in it. So if you just take the superficial statement and move on, you may miss that he's

not functioning as well as he says he is.

And then his appetite, I think, is doing better, but he's also on medicines that tend to stimulate appetite and cause weight gain. So if he stopped those medicines, I don't know where he would be.

Speed of his thoughts were still very slowed.

And he still didn't have active suicidal ideation, but there was definitely a strong interest in death and kind of a passive death wish. And, you know, I think he said either in March or May to me, If they put me to death, that'd be good because I'd no longer have to be dealing with these mental health issues. Paraphrasing a little bit.

THE COURT: I assumed he didn't use that exact verbiage.

THE WITNESS: It was relatively close.

BY MS. RUSSELL:

Q Dr. Hall, did you write a report after your 2024 evaluations, March 5th and May 29th?

A Yes.

MS. RUSSELL: May I approach, your Honor?

THE COURT: Yes.

BY MS. RUSSELL:

Q Dr. Hall, I'm showing you what's been premarked as Defense Exhibit 6.

A Yes.
Q Is that your report?
A Yes, ma'am?
Q From March 5th and May 29th of 2024?
A Yes.
MS. RUSSELL: Your Honor?
THE COURT: Any objection to Defense 6?
MS. SULLIVAN: No, your Honor.
THE COURT: It will be admitted as such. I have a copy already. Thank you.
(DEFENSE'S EXHIBIT NUMBER 6 WAS RECEIVED IN EVIDENCE)
BY MS. RUSSELL:
Q Dr. Hall, in your report you mentioned rule out schizophrenia, schizoaffective disorder. Was that a change from your findings of 2023?
A I don't think so is my rough remembrance. Again, I gave him a psychosis not otherwise specified the first time I saw him. There's been an improvement in the symptoms. Part of the reason I have rule out is I don't know what he would look like if he was off of the Zyprexa. So would those symptoms worsen or come back or is he looking less schizophrenic because he's partially treated. So that's why I left the "rule out" in there. But the depressive symptoms were what was most profound to me on -- when I saw him after the state hospital.

Q And you diagnosed him with major depressive disorder?

A Yes.

Q What are the symptoms of that mental health disorder?

A And, I apologize, I may have discussed this some earlier, but sleep changes, anhedonia, or a lack of interest, motivation, apathy, self-esteem or pathologic guilt concerns. Again, as a side note, that's one of the things I had to define for him on the two or three times I saw him is he wasn't even familiar with the concept of self-esteem.

Energy. So he said, I'm not going out to rec. I'm staying very isolated. And, again, some people in an incarcerative situation may do that because they're worried about, you know, of activity or being abused in the yard, but the general sense I got is he wasn't going out or engaging in recreation because he just didn't want to, didn't have the energy, didn't see any pleasure from it. Concentration, appetite changes, psychomotor retardation, physically -- you know, I've had some people describe it to me as I feel like I'm wearing a lead suit or walking through molasses. You know, he seemed relatively slow in his movements, and then also his speech, which is also a marker for how his internal

thoughts are doing.

And then thoughts about death, again, wasn't telling me he was actively suicidal, but, you know, passive death wish I thought was there.

Q Anything else, Dr. Hall?

A That would hit the main highlights for what you need for diagnosis of depression.

Q So after evaluating Mr. Mosley for three and a half hours on two days in March and May of 2024, the last time just a few weeks ago, what did you learn about his capacity to appreciate the charges against him at the present time?

A I was concerned about his ability to appreciate the current charges. He -- he -- and, again, I hope I'm answering the right question. He knew he had two charges of murder. When I tried to ask a little further about who were the alleged victims, again, I don't want to talk about it. And he was very straightforward about that, that no point -- I don't want to bring up the names. It's too painful for me to discuss. So, again, I'm assuming he does factually know who the alleged victims are. But when it came to understanding the possible penalties, I was more concerned this time than the last time I saw him.

Q You still found him acceptable, though?

A For the first aspect of appreciating the

charges, yes. For the understanding possible penalties, I was more concerned.

Q Okay. We're going to get to that in a minute. So I was gonna ask you, after evaluating Mr. Mosley for three and a half hours on two days in March and May, what did you learn about his ability to appreciate the range and nature of penalties at the present time?

A Given that he's facing a potential capital, I tried to ask a little more about did he know certain terms like mitigating, exacerbating. He had trouble understanding or grasping those concepts. He also only saw one outcome, which was the death penalty. So I don't think he appreciates that there may be varying sentence options that are there. And, again, he seemed very nihilistic of there's no point and death would be a good thing. So I didn't get the sense that he was aware of other options.

Q Dr. Hall, what did you find about his understanding of the adversarial process at the present time?

A Very poor, and I'm worried about his factual understanding in the courtroom. And I know he's had some understanding in juvenile court. And I'll be honest, I'm an adult psychiatrist, so I haven't worked in the Florida juvenile system, but part of my fellowship training was

working in the Ohio juvenile system. And my basic understanding is that's a different process, that it's more rehabilitative, it has a little more of a team approach, and it's not necessarily as much as an adversarial. So I think he was really having trouble factually understanding the concept of who are the different attorneys; what do they do; even though they're both paid by the government, why are they different or how are they different. And, again, due to the glitch at the hospital, he had very minimal competency restoration classes.

Q Was there anything else?

A I apologize. I lost the thread on the original question.

Q What -- if Mr. Mosley was having trouble understanding the adversarial process.

A No, that was my main concern. I mean, and I'm not sure he fully understands the role of a judge versus a jury and the finer aspects. So I do worry about his factual understanding, which would be important if he takes the stand or is asked questions.

Q Right. And after evaluating Mr. Mosley for three and a half hours on two days, both in March and May, only a few weeks ago, what did you learn about his present ability to disclose to counsel pertinent facts?

A I'm concerned that that's impaired. When I saw him the last time, his counsel was with me, and, again, he wouldn't answer certain questions even though he may factually know it. And back in March when I saw him, there was some question if there may have still been a little delusional element of, if I say it out loud, it'll lead to something bad happening. And this may be getting way too much into the weeds, so I apologize, but there is clear delusions, which is a false fixed idiosyncratic idea. You also sometimes run into what we call magical thinking. So even though I think a lot of the deeper delusions are doing better, he shows elements of magical thinking. So for example --

THE COURT: Spell it for me. Matrical? Is that what you said?

THE WITNESS: Magical, as in --

THE COURT: Like magic?

THE WITNESS: As in magic.

THE COURT: Oh.

THE WITNESS: So an example I'll give is if he's like, well, if I'm having a headache, I'll put the bible on my forehead and that will help the headache. You know, you sometimes see it with people with obsessive thoughts. If I say it out loud, it will somehow lead to it coming true. So,

you know, the -- the notion of if you step on a crack, you break your mother's back, there are some people who are very concrete, who, even though, you know, sort of know scientifically that's not how it works, is still worried of that outcome.

THE COURT: How is that different from what you put in your report of intrusive thoughts? Because it seems like the way I understood your report was that sometimes when people start talking about something, they can't stop thinking about it, and he doesn't want to think about it.

THE WITNESS: There is --

THE COURT: And it's hard for you to discern the difference between a delusion and an intrusive thought, right?

THE WITNESS: Correct. So there's the intrusive thought that once I start, it's just gonna bring up bad memories and it's gonna ruin the rest of my day. That's why I say obsessive thoughts and --

THE COURT: Is that the same thing that you're talking about with intrusive thoughts and obsessive thoughts?

THE WITNESS: There's a bit of a grey overlap. So the intrusive thoughts are much more classic for

depression. The magical thinking, I'm worried, is more related to possible cognitive functioning. So folks with lower IQs tend to be more prone to it.

THE COURT: Okay.

THE WITNESS: And also, again, folks with OCD, obsessive compulsive disorder, I don't think he has obsessive thoughts to that level, but, again, that's why I -- I know I'm dancing on a knife's edge here, and I apologize, but I --

THE COURT: I understand. Well, it is what it is, you know.

THE WITNESS: I do think there may be different symptoms due to different conditions and that they all somewhat overlap and affect the final product.

THE COURT: And so what was the final thought on Mr. Mosley, magical thinking, obsessive, intrusive thoughts, delusional?

THE WITNESS: I think that there's significant depression, so he doesn't feel it makes a difference. Because it doesn't make a difference, why put forth the effort and why get into great conversations if it's only going to cause me pain and maybe lead to a bad outcome when I know the outcome is already gonna occur.

THE COURT: Sorry to interrupt. I ask a lot of questions.

MS. RUSSELL: No worries, your~Honor.

BY MS. RUSSELL:

Q Dr. Hall, I'd like to get back to the six competency factors. Can you tell me what you found in terms of Mr. Mosley's present ability to manifest appropriate courtroom behavior?

A I thought -- I know I put questionable down, but I thought he'd probably do okay. I wasn't expecting him to have outbursts or be problematic. My only concern is, again, would he be able to participate and be aware of what was going on around him. So I didn't think he'd be disruptive, and it's sometimes hard to know if somebody may perk up in a different situation or not, so I was a little more neutral to concerned, but not clearly unacceptable.

Q And what about Mr. Mosley's present ability to testify relevantly?

A I'd be worried about that one, again, due to him not always answering fully a question, worried that answers may cause him harm or lead to a bad event or outcome.

Q Was -- or did you have any other observations about his inability or about his capacity?

A Those are the major ones. And, again, I'm not sure -- I would love to see more cognitive testing on him because I worry that he is very concrete in his thought process. He doesn't do well with abstractions, and I don't know how many terms he really understands versus not understands.

Q If a person is not competent, does that also mean they're not competent for psychological testing?

A Yes and no. In the sense that if somebody is very depressed, I worry that that can negatively impact the scores. And, again, somebody could look at the data and then say, ah, lower scores than we expected. That's malingering. So, again, you want to be careful when you do this testing that you're getting a true baseline and not something that's gonna fluctuate based off of whether he gets a different antidepressant or gets a different thyroid dose if he needs it.

Q Did you notice that Mr. Mosley was malingering at any point during your evaluations on March 5th of 2024 or May 29th of 2024?

A I didn't think he was. I thought his performance over both encounters was relatively consistent. It was similar symptoms. Again, you never get an exact word-for-word accounting, but I didn't pick up on great fluctuations or changes, except what I would

expect to see of, again, the psychosis doing better after being on Zyprexa for a longer period of time, and the fact that there was an improvement and he was even acknowledging to the improvement. Usually, somebody who is malingering is trying to thrust forth symptoms, call attention to them and highlight the deficits from him. He tended, again, to give very simple answers that I thought he was hoping would move things along and lead to the shortest evaluation possible.

Q Dr. Hall, based on all the records you've reviewed, the four forensic evaluations you've done over the course of more than a year, including the evaluation about three weeks ago, all of your training and experience, do you have a professional opinion as to whether Mr. Mosley is currently incompetent?

A I believe, based off of the last time I saw him, he lacks capacity.

Q Why is that?

A For the reasons we discussed above, particularly I'm worried about his ability to work for the best outcome of his case and that it's his depression that would limit his ability to engage in that work. And his ability to, you know, appreciate consequences, to weigh factors, to be able to make decisions on things he would need to, such as how to assess a plea bargain and what are reasonable

outcomes or expectations.

Q Dr. Hall, do you feel like competency changes depending on what charges are? For example, would it be different in a trespassing case versus a serious death penalty case?

A In a general sense, I will say yes. I'll give a clinical example. So if you go in to a doctor and you are going to be examined, it may be a lower level of capacity to consent to a stethoscope on your chest. If you're going in for surgery to remove a limb, you want a higher level and degree of understanding.

So Paul Appelbaum out of Columbia, who's written a lot on capacity for medical decisions, does talk about there are times being a sliding scale. Considering that this is a death penalty case, again, I think certain factors, such as mitigation and things like that, were a little more important to discuss with him than if it was a simple trespassing.

MS. RUSSELL: May I have a moment, your Honor?

THE COURT: Yes.

BY MS. RUSSELL:

Q Dr. Hall, I just have a couple more questions for you.

A Yes, ma'am.

Q Do you recall your last evaluation, just

focusing in on the May 29th?

A Yes.

Q And you were there with Ms. Blaquiere?

A Yes.

Q And Mr. Mosley?

A Yes.

Q Do you remember discussing on penalties with Mr. Mosley?

A Yes, and that he seemed to be very limited and focused just on the capital punishment element. Didn't appreciate that there were other options that could be looked at or worked towards.

Q Did you recall him being confused --

A Yes.

Q -- about the difference between death row and prison?

A Yes.

Q What do you recall about that?

A That he didn't understand that death row was in prison, that I think he thought it was, literally, a separate location. And, again, I don't think he understands the process and what it all entails and how quickly it may or may not occur even if he is found guilty and given the death penalty.

MS. RUSSELL: Your~Honor, may I approach the

witness?

THE COURT: Yes.

MS. RUSSELL: Defense 2, the medical records.

BY MS. RUSSELL:

Q Dr. Hall, I'm showing you what's been premarked as Defense Exhibit 2, which are the prescription records from the South Florida Evaluation and Treatment Center.

A Yes.

Q And I'd like you to take a look. Do you recognize Defense Exhibit 2?

A To be honest, no, but I know I looked at these records. I just -- I don't remember every page, but it looks consistent with the other records I saw.

Q Would you like to take a minute to familiarize yourself with the content of-the prescription records from South Florida Evaluation and Treatment Center?

A It fits my rough memory. The one thing is they have Desyrel listed, which is the brand name. Trazodone is the generic name. We have two names for every medicine, otherwise, it would be too simple.

Q All right. So you're familiar, with your medical degree and your training, with drugs used in mental health treatment?

A Yes.

Q And you've reviewed those records of

Mr. Mosley's pharmacological treatment while he was at South Florida Evaluation and Treatment Center?

A Yes.

Q Are you able to tell what the dates of his treatment were from those records?

A Roughly. It looks like three of the medicines were just started on December 14th. My rough remembrance is that's when he came to the facility. So those were probably the initial starting orders. It looks like they started the Desyrel, or the trazodone, on the 10th, which is my rough remembrance. I think when I looked at the MAR, he may not have received his first until the 11th, but it was in that general ballpark. MAR is the medical administration record. So there may have been a little lag between when it was prescribed and when it was given. Also looks like he was on Augmentin, which is an antibiotic, and I'm trying to remember if he had cellulitis or a skin infection or something, but that appeared -- they appeared to have stopped it early since the original stop date was February, and I think he left shortly before then, but this -- this looks consistent.

Q So, Dr. Hall, when you say he started something on the 10th, was that January 10th of 2024?

A January 10th, and my rough remembrance is that the capacity assessment was done on the 9th. So, again,

I'm assuming he was symptomatic if they're adding a new medicine.

Q So, Dr. Hall, just because we're lawyers, not doctors, I was going to ask you did his medication actually change when he was at the South Florida Evaluation and Treatment Center?

A Yes.

Q And how did it change?

A They added in a long-term sleep aid adjunct, and it looked like they were planning to keep it on him for months because they have the stop date down as May 9th. And often in state hospitals you don't know how long someone is gonna be there, so when you put it in, you put in kind of a renewal window, usually about three months, four months out, depending on the medicine. So it looks like they started a new med that they were planning to keep him on it, that they started at a dose that would be consistent as an adjunct for sleep and for depression. And it is --

Q So they added a sleep aid a day after he was found competent by the state hospital psychologist?

A Yes. And he was already on a max dose of the Remeron, or the mirtazapine is the generic name, so they couldn't go higher with that one, or usually you wouldn't go higher with that one. Vistaril, 50 milligrams, is a

good dose of that at night, and it does look like they were giving it to him consistently. And higher doses of that also could lead to drowsiness or sleepiness. And then his Zyprexa, he's at a moderate dose, so usually 5 to 20 milligrams is the range for most people on Zyprexa. I have seen some doctors or physicians go as high as 30 or 40, but 20 -- 5 to 20 is the usual range. So he's on a moderate dose of Zyprexa.

Q So insomnia medication was added January 10th?

A Insomnia/depression adjunct, yes.

Q And insomnia is a symptom of depression?

A Yes.

Q And antidepressants are used to treat depression?

A Yes. And Desyrel was originally an antidepressant. To get the best depression effect, you need to be at higher doses, but, again, most people complain of being overly sedated at a dose level that's usually best for just trazodone as a single agent. So it looks like they added it on for the Remeron.

Q So, Dr. Hall, in your experience, are medical doctors generally in the business of prescribing medication for nonexistent symptoms?

A No. You try to limit the amount of medicines. All medicines have side effects. Anybody tells you

otherwise is selling you something. So you try not to over medicate. Also, when you're dealing with a correctional facility, you don't want to have misuse or abuse. And although Desyrel is not a classic drug of abuse, sometimes in the prison system people may crush it up, snort it, get an anticholinergic hallucination or high from it. We don't see it a lot in the outside population because they can get better drugs, but when in Rome, you find ways to misuse things. So when you are working in state hospitals, you try to prescribe what is needed to reduce risks of cheeking, hoarding for either sell or for overdose.

Q Very well. Thank you, Dr. Hall.

THE COURT: Is that it for direct?

MS. RUSSELL: Yes.

THE COURT: All right. Thank you.

Cross-exam?

Doctor, do you need a break before cross-exam?

THE WITNESS: I think I'm good, but I'm at the will of the Court.

THE COURT: Let us know. Okay?

THE WITNESS: Thank you, ma'am.

THE COURT: Ms. Sullivan?

MS. SULLIVAN: Thank you.

CROSS-EXAMINATION

BY MS. SULLIVAN:

Q Good afternoon, Doctor.

A Afternoon.

Q I want to start by asking about something that you talked about towards the end.

A Yes, ma'am.

Q The competency criteria is the same regardless of what someone's charged with, right?

A In a general sense, yes. As I said, as a doctor, there are sometimes a notion that there's a bit of a sliding scale.

Q Okay. But the criteria for how someone is deemed competent or incompetent, it is the exact same regardless of what you're charged with?

A Yes, but certain factors you may need to address in greater depth.

Q Okay. So it's your opinion that if it's a murder charge versus a trespass charge, the defendant has to know more -- fit more criteria than if a trespass charge; is that what you're saying?

A No. The same criteria, but depth of understanding may need to be assessed and looked at if it's appropriate or if it changes.

Q So, for example, you think -- you stated that in

criteria of knowing the possible penalties, so in this case the death penalty, the fact that he didn't know about mitigators -- I think you said exacerbators, but aggravators --

A Yes.

Q -- that was -- you took that into consideration when deciding if he met that criteria or not?

A Yes.

Q But the criteria itself is if the defendant can appreciate the possible penalties, the death penalty, right?

A Yes.

Q It does not say in that criteria that he has to appreciate what aggravators, what mitigators, and what -- how all of that works?

A Sure.

Q Okay.

A And, again, it depends on what category you want to put that under, if that's working with his attorney or counsel or whether it's fits that check box. But, again, given the nature of the penalties looking at, I think it's important for him to be able to understand or be familiar with certain terms, and he seemed to lack factual understanding of multiple areas. That is just one of the examples.

Q Okay. So, again, that's your opinion that you think it's important, but it's not listed as part of the criteria, right?

A In the broad sense, it says, Do you appreciate the penalties? I would say with death penalty, understanding mitigation and aggravation would be part of understanding possible penalties.

Q Okay. I want to go back to your original evaluations of him in May and June of last year, 2023.

A Yes, ma'am.

Q Which eval was the one that you talked to Mr. Mosley through the food slot in the door?

A It would have been the second one.

Q Okay. And you stated that in your opinion he was a little more open with talking with you on June 22nd of '23 than on May 16th of '23, right?

A Yes.

Q Okay. So that showed he was capable of disclosing more if he chose to do so, right?

A Well, and, again, it depends on why he was being guarded or holding back. The first time, I think he was very fearful of the situation he was in. There was a lot of paranoia. When I saw him the second time, he said he felt safer because he was in a cell by himself and much limited access. So, again, I didn't see him discussing

more as, necessarily, willingness, but maybe more of a factor of his environment and the symptoms he was experiencing.

Q And the most -- the most recent evaluations, I think you said on direct that you did do another background history with him. You didn't note that in your report -- in your written report, did you?

A No.

Q Okay. And when you talked to him a year ago, he had given you background information about himself then, right?

A Yes.

Q Okay. And he told you about his mother and father?

A Yes.

Q And that neither parent had any mental health issues?

A As best he knew.

Q And he didn't report any psychiatric history in his immediate or extended family?

A As best I remember.

Q He told you that he only completed up to, roughly, 10th grade?

A I believe that's correct, and I think I had seen education records by that point.

Q Okay. Are you aware of any truancy reports about him not going to school in high school?

A Yes.

Q All right.

A Now, where or how I'm aware, I don't remember if he specifically told me or if I saw it in the report of someone else, but I was aware that there had been issues with truancy.

Q You would agree if someone's not going to school, they're probably not gonna get the best grades, right?

A Potentially.

Q It could factor in?

A It could factor in.

Q As for employment --

A I'll put this way --

Q I'm sorry.

A I had a friend that was very bright and would read the newspaper in math class. So he was there, but the teacher said, As long as you get good grades, we'll let you read the paper. He got straight As and went to West Point. Now, somebody else would do that, they may fail. So, again, there still could be variation. There still could be limitations. I have seen people who have been truant that still do well because they're just good

test-takers.

Q That would be the exception, not the norm, though, right?

A I haven't studied it, but I would think you'd be right.

Q As for employment, back when you first evaluated him, so back in 2023, he reported he worked at Waste Management for about four months?

A I think that's right. Somewhere I want to say it may have been eight months.

Q I think that would be when he was an assistant to his father for eight months as a carpenter. His dad is a carpenter?

A His dad is a carpenter. I thought he had done that for a longer period of time. And, again, my rough memory may not be perfect, and, again, I may be thinking of the third eval, but I though he had had two jobs, one was eight months, one was four months, then I thought there was time he worked as a carpenter's assistant.

Q And that's not -- I'm not gonna hold you to the months, but the point being he was able to tell you that he had held a steady job, even two jobs, for a period of time prior to his incarceration?

A Yes.

Q And he was able to tell you that his pending

charges were his first adult charges?

A Yes.

Q And we'll talk about his juvenile history in a minute, but during that eval back in 2023, you specifically noted that Mr. Mosley did not appear to be responding to any internal stimuli at all?

A Yes.

Q And you observed no active delusions?

A And, again, this gets a little complicated. So not everybody hallucinates 24/7. So when I say "no active hallucinations observed," he wasn't looking over his shoulder. He wasn't looking behind the window or the glass because he saw something go by. He did report at times that he would hear voices. I don't think he told me 24/7. And some people will say I hear them all the time, and whether or not they literally mean that every minute of the day or more is just a common experience.

So my understanding is that he was having these experiences, that there was no time of the day that it was more prevalent or less prevalent. Sometimes people at night people will hear them more because there's less stimulation and, therefore, the mind kind of fills in the gaps. But I didn't get the sense that he was saying it was always occurring. So when I was evaluating him, he didn't look like he was looking around.

Now, the delusions, again, he didn't engage in any active behaviors while I was there to suggest delusions, but he reported concerns that people were out to harm him, poison him. And, again, later he was in isolation cells and said, Hey, I feel much happier and safer here.

Q We're gonna talk about what he told you in a minute, but my question was -- I think you answered it at the end -- you did not see any active delusions?

A I didn't see any behavior consistent with the delusions in the sense that when I was talking with him, he just kind of sat in the chair. He didn't try and barricade himself in the room.

Q Okay. And that's consistent for -- Ms. Russell pointed out you saw him four different occasions for hours. You never saw any active delusions?

A I was a little concerned on the second time I saw him when he was in the isolation cells. He had put a lot of writing on his shoes, and I thought that was a little strange. And when I asked him about it, he said, No, I was just bored. So I don't know if that's the truth or if there was something more to it.

Q Okay. But as a psychiatrist, when you're -- is that through -- the time you're talking to him through the food slot?

A Yes.

Q Okay. As a psychiatrist, when you're talking to him, writing on his shoes is okay. Did you see him do any behavioral -- anything behaviorally that would indicate to you he was having an active delusion?

A No.

Q Okay. And what he's saying, that he's hearing voices, he's saying he's seeing blood. You would agree that those are pretty severe, serious hallucinations, auditory, visually that he would be having, that he's telling you he's having?

A Yeah, the hearing voices is sometimes more common, and it depends how many voices; do you recognize them; are they male or are they female. Usually, with major depressive disorder, they're simpler hallucinations. So it's a simple phrase. It's usually a voice similar to the sex of the individual. Schizophrenia -- and, again, it's not -- have a mnemonic meaning because with this diagnosis you usually have more complex, multiple voices having discussions amongst themselves. So what he was describing could be with either schizophrenia or depression. My take was it was probably a little more consistent with a depression with psychotic features. But, again, there's no one half a mnemonic. The seeing blood, yes, was a little bit of a yellow flag for me.

That's not a common one. But I also worry, if he does have intellectual deficiencies, folks with intellectual deficiencies sometimes misreport and it's sometimes hard to tell what is a hallucination versus what is their internal thoughts or monologues.

Q But he's report -- and you've read the other doctors' reports, right?

A Yes.

Q He's reporting both to you and other doctors that he's seeing blood out of his eyes. He's seeing blood coming out of the shower. I mean, that's pretty --

A He --

Q He's reporting that that's what he's seeing, not thinking about, but seeing that?

A Yeah. And that's why I say sometimes when you're dealing with intellectual deficiency, and I -- I don't know what his IQ is, so I'm putting down a flag possibility maybe to be circled back to. One of the other reasons I said he was a little more forthcoming is when I saw him the first time, he did not mention the blood or did not discuss it in as great of depth as the second time I saw him.

Q You had noted that his memory appeared grossly intact based on the history he was able to report to you about his family life, his educational life, that kind of

background?

A Generally, but, again, there were times where there were aspects of his life that he forgot to bring up or mention, such as he had two major head injuries or loss of consciousness. And when I say "major," just in the sense that he had loss of consciousness. I don't know if they caused brain damage or not. He mentioned one. He forgot the second one. But having looked at records, I new about the second one, so I had to specifically bring it up and ask him about.

Q And while you mention that again, what records did you look at that talked about head injury?

A I believe his hospital records mentioned that he had had a head injury.

Q What hospital records?

A Again, it's been a year and a half since I read them and I didn't reread them just for this, but -- not the Wellpath. Sorry. The Windmoor Healthcare.

Q Okay.

A I believe there was some reference to it in there. If not, I may be mistaken and may be mixing up somebody else's report.

Q All right. So the self-reporting about personal life, educational, his family life both in 2023 and then this year, although it's not noted in your report the

background self-reporting, he is able and willing to tell you all about that, that he had a job, that he has, you know, a support system from his family, no mental health history in his family. All of that he's reported to you with no problems?

A When asking specific questions and doing follow up. Again, a lot of his answers were very brief, minimal one, two-word answers.

Q Okay. So it's when we get to more about why he's in jail and what his charges are, that's when you start seeing he's not participating and talking about things as much, right?

A No. I thought he was very limited even about family history. For example, I think his mother was a phlebotomist. He didn't even mention that. I think he -- rough memory, he said something like she worked in food service or something. And, again, I had to say, Hey, I thought I saw somewhere else that she had a different job. I don't remember exactly when that came up, but that's what I mean. He would leave out information pretty much in all parts of the evaluation.

Q Well, okay. Well, let me ask you about that, though.

A Yeah.

Q He told you about his mom and his dad, right?

A When I specifically asked questions and had to circle back and get more information. If you went off just the initial responses, there was times where he'd only give partial information.

Q He never said to you I don't want to talk about my mom and dad?

A No.

Q He never said I don't want to talk about my education history?

A No.

Q He never said I don't want to talk about what jobs I had in my past?

A Not that I remember. But, again, it was like pulling teeth to get him to answer questions. I think I understand what you're saying about names he specifically said he didn't want to talk about them. That's true.

Q No. My point is, when you start asking him about the case, he told you he doesn't like to talk about his case, right?

A He said he didn't specifically like to mention the victims.

Q And you also said it'll give him flashbacks which would worsen his mood?

A Yes.

Q He told you he didn't want to talk to his

attorneys?

A Yes.

Q He was able to tell you that his medications had been changed and what he was taking now per your report?

A Roughly. He couldn't remember the exact dosages, but I think he said something of I'm on the same meds as I was at the state hospital, and then I had to say do you mean this, this, and this, because I had read the report from the hospital.

Q But he didn't say I don't want to talk about my meds?

A No, but he wasn't able to really talk about his meds either. Again, certain information he just didn't provide.

Q I agree. Defendant was able to tell you his two attorneys were Jessica and Margaret?

A Yes.

Q He was able to say that he was charged with two counts of murder?

A Yes.

Q He was able to do that the month prior, too. So I'm talking about the first time you talked to him.

A Yes.

Q He understands that he's potentially facing the death penalty?

A Yes.
Q I think we're all clear on that, right?
A Yes.
Q He was able to answer hypotheticals about what he would do if somebody was telling lies about him in court, right?
A Rough remembrances, yes.
Q He said he would tell his attorney?
A Correct.
Q And, again, in June last year he was reporting worsening -- I think what you had said before. First time you meet him, he's not really talking about seeing the blood. We get to June and he's reporting worsening of these auditory and visual hallucinations, right?
A Yes.
Q Okay. We just talked about that, how you said it got worse.
A Yes.
Q But, again, you're noting in your report that he did not appear to be responding to internal stimuli during that visit.
A Correct.
Q Okay.
A And not everyone does. Again, when he was directly in front of me and I'm directly talking to him,

he wasn't looking over his shoulder or looking in other areas, but he still seemed psychomotor slowed, still was giving simple answers, still had problems defining questions, doing follow up, and what he reported seemed consistent with what they were treating him with based on the medications they were giving him.

Q Okay. Now, moving on to your most recent evaluations, on direct when you were talking about -- well, I guess, first you said that you're still concerned he's suffering from major depressive disorder, and we'll talk about that in a minute, but, in your opinion, elements of any psychosis are appearing much better to you?

A Yes.

Q Okay. And, again, the most recent evals, you're not observing any active delusions or internal stimuli?

A No, and he even seemed to be reporting less delusions. So, again, when I originally saw him, it was, I'm afraid somebody's gonna jump me in jail. Later he says, Well, I'm worried somebody may attack me in the courtroom. Again, I'm not sure that's necessarily delusional since there may be people actually in the courtroom, but saying that I thought I saw family members or other people in the jail with me seemed much more delusional.

Q Okay. And you said on direct that it seems to you that he just wanted to move things along while you're talking to him and have the shortest evaluation as possible.

A Yes, which seemed consistent with the hospital records, too.

Q Okay. And it seems like you agree with Dr. Jones, who was testifying last week, regarding his poor effort, right?

A Yes, I agree there was poor effort, but I think it's due to a different cause. She puts that down as malingering. I see that as a depressive symptom and his apathy. He just doesn't see a point, doesn't care, thinks that there's one outcome and actually sees it as a good outcome because he'll no longer be suffering from his depression.

Q Okay. So going through the different criteria where you found him either acceptable or unacceptable --

A And, again, going back to poor effort, that's kind of what I was talking about minimal responses. You have to kind of pull teeth to get answers from him, that when he will say something, you sometimes need to go back and do follow up to make sure he really understood.

So I'd, for example, asked him, How's your self-esteem doing?

And he'd be like, Fine.

And I'd be like, Okay. Can you define self-esteem for me?

Well, I really don't know what that means.

Well, why did you say "fine"?

Well, I just thought that was -- I don't know.

Yeah, so it was -- it was kind of one of those situations.

So when she was talking about I asked him if he needed the paperwork, and he said no, well, did you ask him what the paperwork said? Did you ask him what his understanding was at that time? You know, so I -- I think there were other explanations for some of his events. And, again, reasonable people can agree to disagree. Her takeaway from some of those is different than my interpretation of the takeaway of those.

Q You would agree that there's being unable to do something versus being unwilling to do something, right?

A Sure.

Q Okay.

A But a lot of people with major depression are able to get out of bed, but a lot of them don't. And, again, it's a symptom of their illness.

Q And so, in terms of the criteria, I'm just gonna talk about the things -- we're gonna skip one because

you're saying he's acceptable for criteria one, right, the knowing what his charge is and appreciating --

A In a very general sense, yes.

Q Okay. For the second, you put unacceptable. He -- he did understand that death is a possible penalty. I think we've been through that. I don't -- we don't need to go through that again. You just think he doesn't see that as a punishment?

A Correct. Because when you talk to him, he's like, You know, that'd be a good thing. I'd no long have depression. I'd no longer have to deal with this. So he sees death as a positive and not because he sees it as penance or, you know, appropriate outcome, but as it will stop my suffering.

Q For the third criteria --

A And he's thought that previously even prior to the charges, hence, two suicide events. So when he's very depressed, death looks like a good option to him.

Q Okay. Since you brought up suicide attempts, I want to talk about that for a minute. You have looked at prior -- I'm guessing Baker Act reports where he had cut himself, right?

A Yes.

Q All right.

A And I was trying to remember what the second one

was. I thought the first one was cutting and the second one I thought was either an overdose attempt or --

Q Taking pills?

A Yeah.

Q All right. And then you -- I don't know if you specifically do, but other doctors have talked about a third incident, a third suicide attempt?

A I understand there may have been one around the time of his arrest, but there may also be debate on what actually happened there, so --

Q Right. Whether that was actually a suicide attempt or --

A Yeah, he --

Q -- stems from --

A He said that --

Q -- the homicide allegations?

A He had told me that he had cut his wrists that day.

Q Right. He is self-reporting that those cuts on his hands are from doing that to himself?

A Yes.

Q And it's that self-report that leads him to be on this suicide watch in the Pinellas County Jail and then even at the beginning of his stay at the treatment center, right?

A Yes. And they were very noticeable. He had to have surgery. He had wrist boards on. The first few times I saw him, they were still healing.

Q Oh, I agree, they are severe lacerations to his hands.

A Yes -- well, hands, wrists, forearm.

Q Yes. Required surgery?

A Yes, my understanding.

Q But my point is, is he's the one saying that's because he tried to cut himself, his suicide attempt, his self-report?

A Yes.

Q Okay.

A And since that is actually potentially in debate -- and, again, I was just doing competency, not sanity -- I did not go down that road more to find out more on that. So when I'm talking past suicide, I'm talking about when he was an adolescent, 16, 17. That event occurred. I'm not putting a lot of weight on that one one way or the other since I did not go into great detail on it with him.

Q Okay. But you'd agree that, you know, when he's in Pinellas County Jail right after he's been arrested, he's put on that suicide watch, and then at the treatment center when he first comes in, even those records -- you

read those records, right?

A Yes.

Q Those records reflect that it's based on him indicating he had cut his hands and that's why they kept an eye on him throughout the stay, his stay at the treatment center?

A Yes. And I want to be careful. I've never directly worked at that treatment center. I've worked at others similar to it when I was a fellow. So initial suicide precaution on someone coming out of jail is not uncommon.

Q Okay. And I'm not gonna hold you, too, because I know you don't work there.

A Yes.

Q But the records themselves, they indicate that that's why he was put on that precaution?

A Sure. And a lot of people are usually put on that precaution for various reasons.

Q And while Mr. Mosley has been incarcerated or at the treatment center, there -- to your knowledge, there's been no actual suicide attempts by him? To your knowledge.

A To my knowledge, I'm trying to remember if he did anything to potentially open the wound or reinjure his wound, and I -- I don't remember a specific document, but

it's one of those little things in the back of my mind, was that part of the reason why he was moved to the isolation cell or not?

Q Okay.

A So I don't want to miss-testify, but there may have been something.

Q And that's fine. And then -- but you did say you reviewed the state hospital records, and did you observe in there the nursing notes that when they -- they checkup on him every day, those daily checks, the weekly progress reports, when asked, it always stated he reported no suicidal ideations?

A Sure. And, again, there is a difference between passive death wish of I want to die and maybe they'll put me to death and that'll be a good thing versus I'm actively gonna take my life.

Q Is it interesting to you, though, when he's being evaluated for competency by a doctor -- and that's just because you weren't at the other ones, but you specifically, when he -- when he's talking to you, he is telling you, I just want to die?

A Yes.

Q But at the treatment center, when it's just a daily interaction, they're just walking up and checking on him in the dayroom, wherever he's watching TV, no one's

noting any suicidal ideations. He's not saying any of that to people?

A I'd actually disagree with that. I think in his actual evaluation with Dr. Jones, he says, I don't care. I don't wanna be here. It doesn't matter. So I think he was saying things similar while he was at the treatment center and it's documented in her note. Also, that's why I say, if they came up and say, Are you suicidal? He may say no because he's not suicidal. Are you thinking about death? I don't know if they asked that question or how they asked him that question. So I will acknowledge that there's nothing in there that says active suicidality. I don't know how deeply they assessed thoughts of death or wishing to die.

Q Okay. But I don't know, I don't care, I don't wanna be here, that could mean a lot of things. He's not saying to Dr. Jones "I want to die" like he was saying to you?

A Yeah, in her reports -- her report, my rough remembrance is he say it doesn't matter or it has no meaning, words to that effect.

Q Is the -- are the words "I wanna die" in her report?

A I don't remember that specifically. I just remember seeing something that was very similar to what he

told me.

Q Okay. For criteria -- oh, also I wanna -- on criteria three, again, you noted that you are aware that he may -- these may be his first adult charges, but he has history in the juvenile system, right?

A Yes.

Q And he was -- he was able to tell you how the juvenile system works?

A Roughly.

Q You said that in your report. You said he was able to tell me how the juvenile system works.

A Yes.

Q And then -- but you then said but that's different than adult court?

A Right, from my understanding.

Q I think -- I think we can agree there are variations with the juvenile court system, right?

A Yes.

Q But since he's been through that process, he was able to recall that, relay that to you, and tell you how that went, right?

A In very broad strokes.

Q And then on criteria four, you stated, I believe, on direct that you have concerns that he may not want to discuss topics and disclose to his attorneys even

though he may factually know it?

A Yes.

Q So, again, that's an example of being unwilling to do something versus unable to do something?

A Sure. And then you have to look at what's the motivation behind it. So as I said, I'm worried about magical thinking with him, and I give exceptions, some related to the court case, some of it not. Such as, if I have a headache, I put the bible on my head and that's gonna treat my headache.

THE COURT: Well, what's this magical thinking as it relates to him? I mean --

THE WITNESS: That if he --

THE COURT: -- give me an example that he's not saying that.

THE WITNESS: That if he gives the name that that's somehow gonna lead to physical problems for him.

THE COURT: Did he tell you that?

THE WITNESS: Yes, back in March. He did not --

THE COURT: What kind of physical problems? Because I would suggest the death penalty is a physical problem.

THE WITNESS: I understand. More --

initially, I was worried if there was an aspect of voodoo or bad juju or if there was a cultural element since this family is of Haitian descent. So if something along the lines that if I say their name out loud that almost spiritually something bad was gonna happen that would have a physical ramification. May, he still didn't want to say the name out loud, but he did not discuss that aspect as much or hardly at all. So, again, it was something that was raised at one of the two evaluations, and, again, he is guarded and I think there is more going on than he sometimes verbalizes. Also, I try and be careful when I get into cultural issues because one person's cultural competency is somebody else's stereotype.

THE COURT: Absolutely.

THE WITNESS: And so he --

THE COURT: Right. We've had this conversation in court before. Some people believe that Jesus rose from the dead. Some people don't. There's all sorts of religious overtones --

THE WITNESS: Yeah.

THE COURT: -- and things that we don't need to get into here. People are allowed to their own belief systems, correct?

THE WITNESS: Correct. And he wasn't endorsing a Caribbean belief system as his justification.

THE COURT: All right.

BY MS. SULLIVAN:

Q Criteria five, you had Mr. Mosley as questionable. You do not believe the defendant would be disruptive in court, right?

A Correct.

Q Okay. You believe he would follow the direction of his attorneys?

A Yes.

Q What you say you don't believe he would be able to do is follow or understand the court proceedings?

A That would be my concern.

Q Okay. Would you agree that if the defendant is on jail calls after each court date telling his mother what happened -- let me give you an example.

A Sure.

Q That the judge appointed -- saying that the judge appointed court-appointed doctors and then tells his mom when his next court date is, that shows an ability to follow court proceedings?

MS. RUSSELL: Objection.

THE WITNESS: It --

THE COURT: What's the legal objection?

MS. RUSSELL: Well, it's to foundation. I'm not sure we established that -- first of all, we haven't talked about the jail calls on direct. We haven't established that Dr. Hall has heard any jail calls. And if she'd like to play the jail calls for him to get his reaction, I think that would be fair, but I think just cross-examining him out of thin air without his hearing calls is really inappropriate.

THE COURT: Overruled.

BY MS. SULLIVAN:

Q Do you need me to say it again?

A No. I heard it. So my answer to that is I don't know if he knows that information just from court or if other people went over it with him. I don't know if he's a visual learner or a writing -- written learner. So did somebody put it on a piece of paper for him and that's why it stuck more? I think when I talked with him one time, he understood that he had an upcoming court date. So, again, I don't think that he lacks total rational understanding, but I do think there were certain areas where he has a rational issue and certain areas he has a factual issue.

Q Okay. In criteria six, again, you said

unacceptable, and I think to me and --

THE COURT: Are you looking at the old report or the newer one?

MS. SULLIVAN: I am on the new report.

THE COURT: Thank you.

MS. SULLIVAN: Thank you. I'm sorry. I should have specified that.

THE COURT: That's okay. I'm making sure I'm following.

MS. SULLIVAN: Yes.

BY MS. SULLIVAN:

Q So I'm going -- and just for the record, all this criteria, I'm talking about your most recent eval. So your most recent opinion on each one of the criteria is what we've been going through.

A Yes, ma'am, and that was my understanding.

Q So now we're on six. You put "unacceptable." Your opinion is that he cannot testify relevantly, again, because he doesn't want to?

A I don't think he is able to fully discuss things. I don't think it's as intentional as you make it sound. I'm worried that his depression will affect his judgment and his reasoning and that will lead to poor ability to testify.

Q And you said that he doesn't want to talk about

the victims in this case, just like he doesn't want to talk about the case in general because it may give him flashbacks?

A Yes. So, again, I was retained by his defense attorney. He'd seen me multiple times. Even with the understanding that if they don't like my opinion they may not use me, he still would not discuss certain just basic factual elements of the case.

Q Okay. But just to be clear, it's your words in your report. You're using the word doesn't -- the words "doesn't want to." You're not saying isn't able to --

A Because --

Q -- in your report.

A -- I think he has the information, but due to his depression, due to his concerns, he doesn't want to because he is -- his judgment is impaired by his major depression.

Q Okay. I want to -- a good time to switch to that. Let's talk about the major depressive disorder diagnosis.

A Sure.

Q You went through -- obviously, there's a list of criteria that someone can have, and then I think the number is five -- at least five of those things, and you said over a two-week period?

A Is the minimal, yes.

Q Okay. You said that things -- some of the examples of what you saw in Mr. Mosley was complaining of sleep issues?

A Yes.

Q So let's start with that one because I don't want to throw too much out. Let's just start with the sleep issues. Again, you've reviewed all the treatment center medical records, right?

A I reviewed them. I may not have them memorized, but --

Q Okay. As -- overall, those weekly progress reports, nurses checking up on him or whenever they ask him, they reported that he was sleeping well or he would say I slept well?

A Sure. And, again, there were times where he would give a somewhat neutral to affirmative response to me when I'd cycle back, but if he was sleeping well, why add in the trazodone or Dezyrel?

There were also notes where he said he wasn't sleeping well. When I talked with him, he said he was getting about four to five hours of sleep at night, and in my rough remembrance, again, I had to follow up on that. You know, you'd ask, How are you doing? Okay. How's your sleep? Okay. Well, how much hours are you actually

getting?

The other issue, sometimes with nursing notes and sleeping is they often base it off of the Q-15-minute suicide checks where they walk in and see if somebody's in bed. It's sometimes hard to tell if somebody's eyes are closed or not because, you know, you don't always want to shine the flashlight right in their eyes and wake them up every 15 minutes. So there have been times where I've asked patients and it looks like, hey, you're -- according to the records, it looks like you're sleeping well. And they'll say, no, I'm in bed, but I'm just, you know, not asleep. My eyes are open or I'm laying on my side and they can't see my eyes are awake.

So, again, I think there was smoke in the records when you look at sleeplessness. And when I talked with him in March and May, he said that he was only getting, I think, four or five hours, whatever I have in my report.

Q Okay. But at any point did he tell you he just for days on end was not sleeping at all?

A No. And you don't always get a days on end in the sense of -- unless somebody's manic where they've got too much energy, but a lot of times with depression what you'll hear is I'm having trouble falling asleep or I'm waking up intermittently during the night or I wake up

early and can't get back to sleep. And it's usually relatively frequently, but it may not be every night. And, you know, it affects their energy or their ability to function the next day.

Q And, again, I'm not gonna hold you to everything that's said in those medical records --

A Thank you.

Q -- at a place where you don't work, but if those records repeatedly indicate that he is sleeping well or getting a good night's rest or restful sleep, that would go against the specific criteria for major depressive disorder of having sleep issues, right? We can at least agree on that?

A No, because, as I said, they started a sleep medication for him. So if he was not having any sleep issues, why put him on trazodone? That doesn't make sense. So somewhere -- and I believe there were actually notes that said did have difficulty sleep. So there may be conflicting notes. Sure, I -- I will agree to that, but that's why I say I do think there's enough smoke in that record of -- and where there's smoke there may be fire -- that he was having sleep issues while he was there.

Q Okay. Next I want to talk about -- we've addressed the suicidal thoughts and we've agreed that he

did not -- there have not been any suicide attempts that you have any knowledge of and he has not expressed suicidal ideations to any of the doctors or at the treatment center. We've agreed on that, right?

A Direct suicidal ideations. I think there were some indications in the records, again, of apathy or not caring or feeling that life had no meaning or wasn't worth living.

Q Okay. Concentration being poor, poor concentration, that also could be in line with poor effort, not wanting to participate, trying to feign participation, all of that, that could also crossover into that area, right?

A Sure. Differential diagnosis, also thyroid abnormalities could be causing concentrations issues. So there could be a lot of issues for that, but, again, off of my interview, off of the history I looked at, it seems that depression is the most likely cause.

Q And speaking of the thyroid issue, having a thyroid issue is not a mental health issue, right? It's a medical issue.

A It can be. About 5 perfect of people who show up to a psychiatrist actually have a thyroid issue, not a classic mental health issue. So if your thyroid is too high, you tend to show with more anxiety symptoms because

the body is burning a little too hot. So you're anxious, you're jittery, you're not sleeping, you're restless. If your thyroid is too low, you tend to present more with depressive symptoms. So you're gaining weight, you're sluggish, you're not thinking clearly. So a lot of times people may initially misdiagnose a thyroid issue as a depression. And, also, thyroid helps regulate the body. So if your thyroid is out of whack, we can put you on medicines. You're not gonna be metabolizing them or using them efficiently.

So rough analogy is thyroid is kind of like the oil in the engine. It won't make the car go, but it makes it work more efficiently. So if I've got antidepressants, which is the gasoline, but there's no oil in the engine, the engine is not gonna run right. So I -- I'm hoping somebody checked. I don't know if the jail checked. I don't know if someone checked. And TSH is thyroid stimulating hormones. So the higher that value, the lower the actual circulating thyroid. So his TSH was five point something, not grossly outrageous, but it is high and it could be something that's impacting his mental state.

Q All right. You disagreed with me, but I think we're -- that was my point. Thyroid is a medical issue. It can give symptoms of mental health symptoms. It can make you feel sad and all those things, but it's not a

mental health diagnosis. It's not schizophrenia, right?

A No.

Q That was my point. I think we got there the same way. You just disagreed at the beginning. That's all I was saying.

A And you could argue that there -- the *DSM* has 725 sub-diagnoses, you know. So would it be mood disorder due to a medical condition, would it be -- you know, some other way to thread the needle. So in the grand sense, I'm saying major depressive disorder. I would love to know what his TSH and what his thyroid is right now just to make sure we're not also dealing with an endocrine issue or adjunct or, you know --

THE COURT: I assume all his other labs were normal other than that one finding?

THE WITNESS: As best I can remember.

THE COURT: Okay.

THE WITNESS: And that usually when somebody gets admitted to a psychiatric unit, thyroid is always one of the ones we check. B-12, depending. RPR to make sure there isn't syphilis, because syphilis often presents with depressive or psychotic symptoms. So there are usual screening labs that we look at. And then we usually check a comprehensive metabolic panel just to make sure

kidneys, livers, electrolytes are good, no delirium, and we check his CBC to make sure no signs of active infection, which can also affect mental health.

So one of the more classic medical screening labs was off. Now, was that a lab error? If they'd repeated it, is it normal? I just don't remember ever seeing a repeat. I don't know if the jail ever did a repeat. It may be a wasted worry or it may be a really significant issue. I just don't know on that.

BY MS. SULLIVAN:

Q One of the other criteria for major depressive disorder is that -- you said that the slow speed tone in the voice, but you also said that the medications can cause -- the medications he's on can kind of slow him down?

A Some of it. Some people can look a little flat with Zyprexa, but, again, his flatness has been very consistent throughout, whether he was on Zyprexa, whether he was on Seroquel, whatever his other medicines were.

Q Well, because he's consistently been on some type of medication, right?

A That I've seen him, yes.

Q The -- I want to talk about loss -- the reported

loss of interest, and it -- I'm gonna ask you about some of the jail calls, and let's just clarify, you didn't listen to any of the jail calls that Mr. Mosley has made, right?

A I have no not.

Q Okay. You said on -- at the beginning of direct that you'd like to look at as many records as possible, right?

A In an ideal world, yes.

Q Okay. You recall last year when you first evaluated Mr. Mosley that our office reached out to you about possibly listening to jail calls that we had; do you recall that?

A I remember being contacted by your office. I don't remember the specifics of that phone conversation. And considering that I had been retained by the defense, I wasn't sure what the proper etiquette was there.

Q Right. And so I think you referred us to defense counsel or you at least let them know that we had contacted you?

A Yes.

Q Okay. So you would agree that possibly listening to those jail calls could have at least helped you one way or another regardless of competent/incompetent?

A I don't know what's in those conversations until I listen to them.

Q You would have been willing to listen to them, though?

A If they were provided.

Q Okay. And I wanna -- again, talking about the loss of interest aspect, a major depressive disorder, your opinion -- and I don't want to just abbreviate to just this, but you are saying that he appears suicidal and is severely depressed, right?

A Yes.

Q Okay. If in your -- in your opinion --

A And, I apologize, it may be arguing. Again, strong passive death wish, strong -- you know, again, he didn't tell me I'm going to cut my wrists tomorrow, but what he said is my life has no meaning, death would be a relief, it would be something that I would welcome.

Q Yes. So severely depressed?

A Yes.

Q If he's on jail calls telling his family he just wants to be home with his family and his friends, does that seem a little inconsistent with what you're hearing from him?

A I don't know. I'd have to know the context. Sometimes when people are doing calls with family, they

try and put a positive spin on things. I don't know what he's doing. I'd have to look at the context. I'd have to look at what prompted him to say that, if there was people kind of led him down that, hey, we really miss you and wish you were here, you know, that may just be kind of a rote response back.

Q Okay.

MS. RUSSELL: Objection, your Honor. If we're gonna continue into the jail calls, I think at a minimum we need to know the date of the call, the time of the call, and we'd actually prefer that the call be provided and played for Dr. Hall.

THE COURT: Okay. Overruled.

BY MS. SULLIVAN:

Q How about if he's on jail calls talking to his brother about the rap music he's been listening to in jail and showing an interest in new music from his brother? I think you talked specifically, when talking about loss of interest, how he didn't seem to be wanting to do any activities in jail and all of that. If -- if he's on jail calls talking to his brother about listening on the radio to rap music and showing a strong interest to new music that's out with his brothers, that's something you'd take into consideration about this depressive disorder?

MS. RUSSELL: Objection. Can we have a

timeframe or a date of the phone call at the minimum?

THE COURT: What were the ranges of the calls that you provided to me?

MS. RUSSELL: Well, your~Honor, she's specifically asking about a certain quotation, which I would imagine comes from a certain date of a certain phone call, and I think, at a minimum, playing a guessing game with an expert is --

THE COURT: How does that help him answer the question, though, if there's a date and time?

MS. RUSSELL: Because it would -- it would -- he'd be able to relate it to when his report or interviews were. I mean, I just --

THE COURT: I'm not arguing. I'm just asking.

MS. RUSSELL: It seems clear that if she's asking him questions about his current opinion about present competency, perhaps a jail call from six or eight months ago wouldn't be relevant, and the doctor is entitled to know that before he plays a guessing game --

MS. SULLIVAN: To answer your question, everything I'm referencing right now is what I've given to the defense and the Court to listen to. That period of time from February, when he gets

back, to his recent is June 8th. It's in that time frame.

THE COURT: So it's all from this year.

MS. SULLIVAN: Yes.

THE COURT: Okay.

BY MS. SULLIVAN:

Q So if he's on jail calls talking to his brother about listening on the radio in the jail to rap music and then him and his brother are going back and forth talking about their interest in new rap music, rap people who are beefing with each other, and that kind of thing, to you, is that consistent or inconsistent with a -- what you said about loss of interest with major depressive disorder?

A The short answer is I don't know. I'd have to hear the context of it, tone of the voice, aspects like that. Again, his brother -- that may have been a conversation they often had, and if he's doing most of the talking, it may not be inconsistent. If of -- if it's more of an active and he seems excited, it could be.

Q And, again, with loss of interest, if -- and I understand you haven't had the opportunity to listen to these calls --

A No.

Q -- so it's fair what you're -- of context. But if he's on there showing an interest in what his family

did that day, what they ate that day, asking about how other family members and friends are, showing an interest in his family's life, is that something you would consider in weighing that criteria for major depressive disorder?

A Yeah. And, again, I'd have to hear the context of it, the tone, the temper, the pitch, what's said.

I know this is Hollywood and it's not a real example, but if you've ever watched *The Big Bang Theory* where Sheldon says, Mom told if you're sad, I should give a hot beverage, you know. So him saying, You're sad, do you want a cup of tea, I don't know if that necessarily shows he's got empathy and understanding or is it more of a rote response?

So I'd kind of have to hear it, listen to it, and understand the context to be able to weigh in.

Q And would it factor in if his mom is telling him that he doesn't have to talk to anyone about anything, if she's continually saying that to him? Would that weigh in on, you know, your interpretation of why he's not wanting to talk about his case, if he's being told not to, if he's being told not to talk to the doctors?

A Yeah. And, again, I need to know the context. Is she saying don't talk to the expert or is she saying, Hey, if you're worried about people in the jail bothering you, you don't have to tell them anything. So, again, I

don't know the context in which that was given or what his fear or anxiety was about.

Q Okay. Now, with malingering, specifically something you said that something that you look at in determining if someone's malingering or not is when they say things to the doctors that they're not saying anywhere else, right?

A Can be, yes.

Q Okay. So we know per the reports to the doctors that Mr. Mosley has reported that he's seeing blood either at his -- out of his eyes or out of the shower, right?

A Yeah. And --

Q Okay.

A -- that was more of an issue the first time I saw him. I think that's decreased.

Q Okay. If -- you would agree if on the jail calls he never reports any type of hearing voices, seeing blood, anything like that to his family, that that would be an example of saying things to the doctors that he's not saying anywhere -- anywhere else, right?

A Could be. And, again, you'd have to look at the context. And a lot of times people may be embarrassed or worried or not wanting to express to family what's really going, especially if they're paranoid and worried the family's involved or engaged, or if they're worried that

other people will hear or use the information against them. Whether we're talking a recorded phone call or whether where we're talking, hey, this is gonna get back to somebody in the neighborhood and they're gonna hurt me with this.

Q Okay. Same thing with paranoia, now that you've brought it up. He's exhibiting to you sometimes paranoia. If he's -- does not exhibit -- say I'm paranoid or I'm worried about this on the jail calls, that would be a difference between what he's telling his doctors and what he's saying on the calls. Is that something you would at least consider when determining malingering or not?

A Sure. You'd have to look at it. And, again, a lot of times when people are paranoid, they don't give that information because they don't want to call attention to something. So I'd -- I'd have to listen to it and look at the context. It could be or it could not be.

Q And you did -- you did agree that his SIMS score was quite a bit higher above that cutoff threshold, right?

A Based off of what she reported in court, but I haven't evaluated it and I don't even know if it was an appropriate exam to give to him given his reading and language difficulties that I'm concerned about.

Q Okay. But from what Dr. Jones reported, I think she reported a 39 and the cutoff is 14. That's

considerably higher.

A I thought she said 35, but either/or, it's a high score.

Q Right.

A But there's also issues of using that with folks with intellectual deficiency.

And, also, again, I'm not an expert on the SIMS, but as I said, I think sometimes he would answer questions in a way that would get him through the fastest. So I don't know if his thought process at the time is, hey, I'm gonna malinger for secondary gain or if it's, hey, I don't want to be in this room and I just wanna get out, and endorsing more symptoms will get me back to my bed faster.

Q Okay. I'm gonna show you what's been moved into evidence as Defense 3. That was moved into evidence by the defense at the end of court last Friday, and it was purported to be Mr. Mosley's notes from that day.

A Yes.

Q You were here last Friday, right?

A Yes.

Q You, I think, were here the whole time. We were here for a few hours, right?

A Yes. I was here for most of it. As I said, once or twice I may have stepped out --

Q Okay.

A -- due to allergies and coughing a little bit.

Q And you were sitting, I think, just a few rows behind Mr. Mosley?

A Yes, ma'am.

Q Did you -- were you observing Mr. Mosley during the hearing at all?

A At times, yes.

Q Okay. Did you observe that Mr. Mosley was actually playing Tic-Tac-Toe with his -- a member of his defense counsel?

A No, I didn't. Again, if he was writing gently underneath the bar, I may not have seen the hand movements. Mostly what I noticed was he had his head in his lap at times, that he wasn't turning around, that he wasn't looking at others, that he seemed to be looking straightforward, that there wasn't a lot of movement or change. No, I didn't see him writing or do this, but, also, I was trying to pay attention to the testimony. But I thought he was very still, reserved, and not really engaging much outside of his direct area.

Q Okay. So maybe you didn't see it, but just for argument's sake, if Mr. Mosley was in fact playing Tic-Tac-Toe with a member of his defense counsel during that hearing, passing the marker back and forth and engaging in that, would that context affect how you

evaluate something that is just purported to be Mr. Mosley's notes from a hearing?

A I -- again, my opinion. Others might view this differently. This is kind of why I put down "questionable" for his ability to be in court, as I don't think he's gonna be a behavioral outburst, but I think he's gonna have trouble maintaining focus, concentration, and being able to assist in a positive manner with his legal team.

Q But don't you think that the -- one of the defense attorneys is playing the game back with him, that that matters whether or not he thinks that that's appropriate or not? I mean, she's engaging with it with him in that game, not telling him to stop, not saying don't doodle on the pieces of paper, but actively playing the game back and forth, don't you think that matters in that consideration?

A You know, I don't know what her motivation was there. Again, if he's putting his head on his lap and is not engaging and it's an attempt to try to get him a little more attuned to his environment, I will leave that up to her judgment.

Q But overall, that piece of paper without that context of what was going on or what was said to him, you can't really get much from this, can ya?

A What I can say is I don't see any notes on there related to his situation, what he thought of the testimony, any thoughts on what was said about him. So, again, sometimes hard to prove a negative, but I don't see an indication that he was engaged in a positive manner based off of that.

Q Right, but would -- we don't know if he was told to take notes of what was happening, right?

A If --

Q We don't -- we don't know if he was told to take notes of what was happening, right?

A Again, and as you mentioned earlier, I don't know how many times he was told the court date either. So there may be a lot of factors at play.

MS. SULLIVAN: May I have a moment?

THE COURT: Yes.

MS. SULLIVAN: I don't have anything further. Thank you, Doctor.

THE WITNESS: Thank you.

THE COURT: Ms. Russell, do you want me to ask a couple questions first and that way you can follow up to whatever I ask, or do you want me to wait until you're done?

MS. RUSSELL: Why don't you go ahead, your~Honor.

THE COURT: Do you want me to go first? I'd like to ask some questions and then give you-all a chance to follow up on what I ask. If I do it now, then you can kind of do it all at the same time.

MS. RUSSELL: That makes sense.

THE COURT: Does that work?

MS. RUSSELL: That would be more time efficient.

THE COURT: All right.

So forgive me if some of this is duplicative. Okay? When assessing for malingering, you indicated it's important to look outside of just the testing, correct?

THE WITNESS: Yes.

THE COURT: Like what?

THE WITNESS: When you look at the booklets on a lot of the testing -- and, again, psychiatrist, not psychologist, but general --

THE COURT: I understand.

THE WITNESS: General studies.

THE COURT: I understand all that.

THE WITNESS: I'm just making sure I don't overstep my bounds.

THE COURT: Got it.

THE WITNESS: They often say that this is part

of a complete evaluation, that no one test is a definitive answer. So testing may be important, but you've also gotta make sure that it's given to somebody who's got the right reading level, age group, based on the right norms, and some tests are better than others. And at times there may be controversy in the psychologic world regarding tests. The Hare Psychopathy Checklist is one of the classic ones where people argue over what is it really measuring and what does it mean and how to apply it. So testing is a data point, but it's not the begin all end all. So, often, you look at the responses over time, how are they being discussed, are the symptoms somewhat consistent or are they really odd and unusual?

So, for example, if I think somebody is faking a memory issue, I may ask them who is the first president of the United States. Most people who've gone to elementary school here know George Washington because it's an overlearned piece of information. But somebody who's trying to fake a memory deficit may over-report that.

The issue with some of the testing is a lot of times when people are malingering, they fake stupid. So folks who have legitimate intellectual

deficiencies may also come across as a higher likelihood of malingering even though their intellectual deficiencies are legitimate. So that's why you've gotta be careful of the population.

THE COURT: Outside of the testing, what am I supposed to be looking for?

THE WITNESS: I apologize. So consistency of the history. So, for example, if I get somebody who says I heard a voice and they told me to kill someone. A better example, I had a case where somebody said I have this delusion that women are being sexually trafficked. Okay. That may be interesting for this case. I got previous records. Last three hospitalizations, there's discussion of he's worried about people being sexually trafficked. So the consistency of the symptoms even prior to the crime or the legal issue holds consistent. Now, again, delusions sometimes morph, there are sometimes changes, but if the overall pattern seems appropriate.

So when he talks about I've had major depressions, I've had suicide attempts, him now telling me after being arrested that he's got thoughts that death is appropriate doesn't come out

of the blue. It seems to be more than just his legal issues. And, again, is he thrusting forth symptoms? Is he only talking about symptoms that will do well for his court hearing? And, again, I thought he was difficult to get information on for things related to court, but also things not related to court. So if he was malingering, he was doing it at a very sophisticated level, and a lot of people tend to overplay one area but not the other.

So I thought his overall patterns, especially over multiple days separated by weeks -- you know, there's an old joke about the truth is the easiest thing to remember. So times people forget what symptoms they told an evaluator. So when you start getting a lot of different symptoms, you know, you start to get concerned. Now, again, the story is never always gonna be a hundred percent every time, so a little variation is reasonable, but wide variation is odd.

I saw someone recently -- going back to what's their behaviors -- you know, and I walk in. He didn't realize he was being evaluated. He thought he was talking to his lawyers, so he brought a big stack of legal documents and his reading glasses.

And I'm like, Well, what's your name?

I don't know.

Well, it's on your name badge. Read it off to me.

I can't read.

Well, why did you read your documents and your reading glasses then? So in that case his responses didn't match his other behavior.

So with Mr. Mosley, I did not get a classic "this is the moment where I thought it was malingering." Now, again, other people may have different evaluations. There may be areas where people can agree to disagree. The report of the seeing blood is a little unusual, so, yes, that is a yellow flag to me, but the other hallucinated symptoms --

THE COURT: That's kinded of gone now, though, right?

THE WITNESS: That improved. And that's the other thing is there was improvement that would be consistent with the medical treatments given. Also, he's not refusing to engage in treatments. He's not refusing his meds. That would make me more concerned about malingering or trying to look worse than it could be.

THE COURT: I think you told me that you were able to review records related to the suicide attempts. Those weren't all strictly self-reports, correct?

THE WITNESS: Correct.

THE COURT: Okay. What about the prior head injuries, was that a self-report to Windmoor or was there actual documentation that you reviewed about a head injury?

THE WITNESS: I apologize. I don't remember the specifics.

THE COURT: Okay.

THE WITNESS: My rough recollection is it may have been in the history as a self-report.

THE COURT: Okay.

THE WITNESS: I'm trying to remember if his mother may have also confirmed it.

THE COURT: That was the way I understood your testimony. That's why I'm asking for clarification.

So my understanding of your testimony -- this is a gross simplification. Okay? As he sits here now, his depression is such that the he cannot answer questions. Even though he has the information and you believe is capable of doing it,

he just won't because he's so depressed about where he is in life right now?

THE WITNESS: Yes, I think the depression is affecting his judgment and his ability to respond appropriately.

THE COURT: How do I tell the difference? Okay? Because, I mean, none of this is easy. Okay? Serious consequences all around here. Mr. Mosley is charged with murdering two people. Those are the allegations. The State has filed a notice to seek the death penalty on him. I would expect he would be depressed. Okay?

THE WITNESS: And I try --

THE COURT: And a very easy way to avoid that consequence, potentially, is to say I won't talk about it. How do I tell the difference between his depression interfering in his mental faculties so much that he just cannot answer the question because he's going to have intrusive thoughts and it's going to ruin his day versus if I just keep saying this, I can prolong this thing, right?

THE WITNESS: So I try to address this a little bit in my report that there is little D depression. And, again, everybody can have a bad day --

THE COURT: Right.

THE WITNESS: -- everybody can have a bad mood. Not every negative thought is a major mental illness. So I've been in other cases where they're like, well, gee, Dr. Hall, if you were facing life in prison or the death penalty, wouldn't you be down? And the answer to that is yes.

THE COURT: Right.

THE WITNESS: That's why I say there's a difference between little "d" depression and syndromic major depressive disorder. Unfortunately, my field does not have a blood test for it, so we have to diagnose it off of the symptoms we see.

A hundred years ago, cardiology denied congestive heart failure over if you had swelling in your ankles and how many pills you use to sleep at night because the blood wasn't pumping right and would backup into the lungs. Diagnosis made off the symptoms. Nowadays, they do a 2-D echo and they can give you exact percentages of how the heart is working.

We're still going off the symptoms. So part of it is is the symptom constellation meets criteria for major depression, it appears to be

longstanding over multiple evaluations documented by multiple different evaluators. And, again, the symptoms he's putting forth don't seem so out of the realm of normal that it's what you would see with somebody who was trying to malinger because they want to call attention to the symptoms. He sits here quietly. He doesn't make noise. He's -- because there's no point. He doesn't have the energy or the motivation to engage in his defense, and the outcome seems good to him because it will end the pain of depression, which is similar to when he tried to commit suicide two times prior. So the fact that we have history of not just thoughts, but actual attempts, I think is significant for his case.

THE COURT: Is he on -- I'm sorry. Are you finished?

THE WITNESS: Yes, ma'am.

THE COURT: Okay. If you're not, I'll let you --

THE WITNESS: No, I'm good.

THE COURT: All right. You paused, so I thought you were done. Okay. Is he on the same medication today that he was when he got back from the state hospital?

THE WITNESS: As best I know, yes.

THE COURT: And as a psychiatrist who deals with medication, is there anything you would change in his medication?

THE WITNESS: Yes.

THE COURT: What's that?

THE WITNESS: Again, hypothetical world, first I want to make sure his thyroid is good.

THE COURT: Right.

THE WITNESS: Because if his thyroid is off, I can have him on all the medicines in the world and we're not gonna necessarily see any further improvement.

Assuming his thyroid is good, I would probably look at a different trial of the major antidepressant. I'm not sure a hundred percent or I don't remember if it was in the notes why they picked Remeron. Nothing wrong with Remeron, but it's an atypical antidepressant. It's usually not people's first choice. Usually, we go more with an SSRI. He had been on Prozac in the past. I thought records indicated some improvement. He says, you know, looking back, I don't think it did much. Not uncommon when people have depression, and, again, it affects their judgment, it affects

their perception.

THE COURT: Right.

THE WITNESS: So I think it would be worth trying him on a different antidepressant, at the very minimal, and making sure his thyroid is good. And then, again, potentially, if he's improving some, some group therapy or some sort of psychotherapy because medicines are a good place to start, but they're not the begin all end all.

THE COURT: I think that is the extent of my questions. Ms. Russell.

MS. RUSSELL: Yes, your Honor. May I have just one minute?

THE COURT: You sure can.

THE WITNESS: And if I may also add, there's a thousand different approaches different docs could do, so I don't want to say my statements there are the only ways. Another doc may want to add lithium as an adjunct. Another doc may say I want to add Wellbutrin. There were some studies on what to do with people with depression that haven't responded to the first medication, and, usually, if you either change to a different antidepressant, add Wellbutrin on, add thyroid on, or add in a different mood stabilizer, about a third of them

will get better depending on whatever intervention you do. And that's the STAR*D trial.

THE COURT: So there's more than one way to skin a cat.

THE WITNESS: More than one way to skin a cat, but I do think there are multiple options that could be further explored. The problem is, is, again, it takes, textbook, six to eight weeks to see if you've got a -- a good response. So it may take two or three trials to see how well the improvement is.

THE COURT: Your opinion, though, is he is showing improvement, at least not to the point of being capable of disclosing information.

THE WITNESS: He's had a significant improvement in the psychotic symptoms. I'm still worried that there's still significant depressive symptoms.

THE COURT: Okay. I'll stop talking to the doctor.

THE COURT REPORTER: Could I have a short break?

THE COURT: Yes, ma'am.

We're gonna take five minutes for a comfort break for all.

Mr. Mosley, do you need to use the restroom? Are you sure? Do you need to use the restroom?

MS. RUSSELL: Are you sure?

THE COURT: Do you need to use the restroom?

THE WITNESS: I'm good.

THE COURT: Okay. All right. We'll be back in five minutes.

(RECESS)

THE COURT: Are you ready?

MS. RUSSELL: For redirect, we'd like to actually play two phone calls with Dr. Hall so he can actually opine on the actual phone calls themselves.

THE COURT: They're in evidence and you're welcome to do whatever you'd like with it.

MS. RUSSELL: Excellent. We're gonna start with call number 484, which was on February 16th of 2024. It's about 19 minutes and 18 seconds long. We're gonna try and play the phone call in its entirety. It would be off of the CD which is State's Exhibit Number 1.

THE COURT: Okay.

(Call Numbers 484 and 112 on State's Exhibit 1 were published to the Court)

REDIRECT EXAMINATION

BY MS. RUSSELL:

Q Dr. Hall, you just heard call number 112 between Thomas Mosley and his mother from March 1st of 2024. What did you notice about that call?

A So I had a pen and paper, took some notes this time. He at some level is able to voice factual information, such as, "I was in court. They said they found me competent." But I believe there was a follow-up question where she asked, "Do you understand?" And I think he said something about no.

Aspects of just general information where I thought, you know, most people know about leap year. It sounded like she was trying to explain that to him multiple times. So, again, I think he has trouble processing information, not just about court, but about everyday life.

Another example where I worry about his understanding and his environment is, if I understood correctly, he was having trouble using the kiosk system in the jail even though she had put money in. So, again, it doesn't seem he's functioning as good.

At one point she asked, "How you doing," and he said, "I'm good." And, again, maybe that's an accurate statement, but the tone and voice and everything else

doesn't sound like it was an upbeat statement. So when we talked earlier about did he tell the nurses he was suicidal, again, I -- that may be -- and, again, I don't want to overstate off of just hearing one time, but that may be kind of an example of where he'll say what gets the conversation through, even though I'm not sure it fully matched the rest of the tone of what he was talking about.

Most of the talking seemed to be done by her, just like previously. You know, there was, again, her talking about reading the bible. He did report to me that she encourages that, but there was also the statement of, well, just keep rereading until you understand, which also fits with what he told me, that he reads it, but he really doesn't process it or comprehend it.

Again, was aware that he had an upcoming court date on March 27th, so understood some factual aspect. If I heard correct, you know, they said, Do you know what you were going back for, and I thought he said something about he wasn't sure or didn't understand what the purpose of that March 22nd date was, but that he knew it was coming up.

Did sound like he was taking his medicines. Identified being on three pills. At one point they mentioned something about five, but MiraLax is for constipation, so that's usually a food additive. And I

believe that's kind of like Metamucil or something where you add it to a glass of water. So I don't think that's pill form, but I don't prescribe that one. It's usually a powder, if I remember right. And there was an issue with Augmentin, which was noted in the records from the treatment center. And, again, I think, rough remembrance, he had a skin infection or something, and that's why he was on the Augmentin. It's not a lifetime med. It -- best I can tell, he was taking the trazodone. I think they may have dropped off the Vistaril, but, again, not a lot of information there. The Vistaril, I don't think, would negatively impact his psychosis or his depression. It may help if there was some anxiety, and it may help reduce some of the side effects that you would see with Zyprexa.

He -- I don't remember if this was this call or the previous call, but he was talking about night sweats. That is a side effect you can sometimes get with medicines, especially SSRIs. My best guess is either the trazodone or the mirtazapine was probably causing that. So that would seem consistent with the side effects you could get with these medications.

Both calls he could, again, remember some basic factual information, such as what he had for dinner, but also there still seemed to be the parcity of

communication. There was no follow up. There was no addition. There was no I like meatballs or it reminded me of childhood or, you know. So, normally, I would expect more give or take in a conversation as a blanket statement.

There seemed to, again, be some notion of wanting to get home, but I had trouble grasping the concept. And there was some talk about an Uncle Frank, but I was having difficulty following the significance of what all that meant.

So those would be kind of my quick interpretations on this. Speech pattern, tone, not a lot that he seemed to get excited or seemed happy about. Again, not a lot of discussion of engaging in other activities. Mentioned the bible to me, but, again, I'm not sure he's comprehending or processing, and I'm worried about how he's functioning in the environment.

Q Dr. Hall, was there anything inconsistent that you heard with your diagnosis of depression?

A I don't think so. Again, it's a one-time listen through and, again, other people may agree to disagree on what they make out of his tone and the amount he speaks, but I think it would be consistent with the depression. And, you know, I didn't get a sense in talking to his mother that there wasn't more upbeat or change or

something more there.

Q And is there anything in either of the phone calls that you heard that's inconsistent with your finding of the incompetent?

A Not with my finding of incompetent. The one thing is, you know, he seemed more wanting to go home than when I talked with him, but I think, in general, most people don't want to be in jail.

Q Dr. Hall, the malingering is something that appears frequently in the forensic, and I think in the *DSM-5-TR* calls it the medicolegal context?

A Yes. And part of the problem with malingering is we don't have a good base rate, so we don't know how often it occurs in different contexts.

So there was a study done by neuropsychologist Binton Berg (phonetic) out of USF, and if I've got my numbers right, he estimated about 30 percent of the evaluations involving criminal population dealt with malingering, about 20 percent of the civil, and then about 8 percent of a general population going to see a doctor for treatment. So depending the context where you are, but even there, that's one study and there's still disagreement on how common it is or isn't.

Q In general, forensics experts are very attuned to finding malingering?

A Yes, it's one of the things -- at least when I did my fellowship, they always said you have to keep that in mind.

Q And it would be important for that to be evaluated by any expert who is in the business of finding competency or incompetency for purposes of the court?

A Yes.

Q You're aware that there were five expert witnesses who interviewed Mr. Mosley?

A If we're including the state hospital, yes.

Q Actually, not including the state hospital. I'm not sure -- just so we're all on the page, at the initial competency proceedings in 2023, Dr. Ramm evaluated Mr. Mosley?

A Yes.

Q Found him incompetent?

A Yes.

Q Dr. McClain --

A Yes.

Q -- interviewed Mr. Mosley, not once, but twice, also found him incompetent?

A Yes.

Q Dr. Maher, a court-appointed expert?

A I don't remember Maher one way or the other, so I will take your word for it.

Q You did review the reports of the state hospital?

A Yes.

MS. RUSSELL: Can I reach back?

THE WITNESS: And I'm not always the best with names, so I may have just forgotten that.

BY MS. RUSSELL:

Q I'm sorry.

A I thought there were four and then my -- or three others and then myself, and then there was --

THE COURT: Dr. Maher is a court-appointed doctor.

THE CLERK: I think the State --

THE COURT: Dr. Jones was the state hospital.

MS. RUSSELL: Correct.

BY MS. RUSSELL:

Q You reviewed Dr. Jones' report?

A Yes.

Q Dr. Hall, I'm just going to refresh your recollection.

A Thank you.

Q Exhibit Number 3.

MS. RUSSELL: Your~Honor, may I approach?

THE COURT: Yes.

BY MS. RUSSELL:

Q Dr. Hall, I'm just showing you Dr. Jones' report, which has been marked as State's Exhibit 3. She talks in detail about the prior evaluations that were given before the first competency hearing. Would you refresh your recollection with what she found.

A There was a Dr. Maher. I just didn't remember that one.

Q Thank you.

A I believe all the other experts had said incompetent.

Q Okay. So Dr. Maher evaluated -- a court-appointed expert named Dr. Maher evaluated Mr. Mosley back in 2023?

A Yes.

Q Found him incompetent?

A Yes.

Q Dr. Ogu more recently evaluated Mr. Mosley?

A Yes.

Q Just in the past six weeks?

A Yes.

Q Found him incompetent?

A I think I read that report as well. Yes.

Q And you've seen Mr. Mosley now over the course of more than a year?

A Yes.

Q Four evaluations, more than nine hours of personal time with Mr. Mosley, and you have also found him incompetent?

A Yes.

Q And there's nothing about any of the information that you've heard today in court that changes your opinion?

A No.

Q Very well.

MS. RUSSELL: I don't have anything further, your~Honor.

THE COURT: Did you want to ask any questions specifically about the questions that I asked him?

MS. SULLIVAN: No.

THE COURT: Okay. So we're done with Dr. Hall?

MS. SULLIVAN: Yes.

THE COURT: Sir, you are free to go. Thank you.

THE WITNESS: Thank you.

THE COURT: Thank you for coming back.

THE WITNESS: Should I take the pad with me or leave it here?

THE COURT: You should probably take your

notes, yes.

THE WITNESS: Thank you, your~Honor.

THE COURT: All right. Anything else we need to talk about for today's purposes? Are we gonna have enough time Friday to do two doctors?

MS. MANUELE: Hopefully. I was going to ask, though, do you anticipate we would go into argument Friday, or just based on time -- I'm just trying to figure out for preparation purposes.

MS. SULLIVAN: Is Dr. McClain available for tomorrow I guess is my first question.

MS. RUSSELL: Dr. McClain is available, but, unfortunately, we have learned that these -- this raw data and the test booklets have still not been produced.

THE COURT: Okay.

MS. MANUELE: So we will be renewing our motion to exclude her testimony if that does not -- we -- that is something that we would be asking to address tomorrow --

THE COURT: Not Dr. McClain, though.

MS. MANUELE: No, I'm sorry. If Dr. McClain comes in tomorrow and indicates she still has not received it, at that time we would be moving to strike her testimony based on the lack of the

foundation established by the State.

THE COURT: All of my trials next week have been moved.

MS. MANUELE: So maybe we can come back for argument?

THE COURT: Tuesday, Wednesday, or Thursday.

MS. BLAQUIERE: Not Thursday.

MS. SULLIVAN: Okay. So is Dr. McClain available tomorrow? I think that's what I asked.

MS. RUSSELL: Yes.

MS. SULLIVAN: Okay. I heard the issue -- I'm just -- I'm trying -- we're trying to do scheduling and then we can argue about that. Dr. McClain's available, Dr. Ogu, and we'll do argument another day if that will work.

THE COURT: That being as a pattern, yeah, I think --

MS. SULLIVAN: Okay.

THE COURT: I think trying to do two doctors tomorrow afternoon is not a good idea.

MS. SULLIVAN: Okay.

THE COURT: Unless you think we can get done by five or six o'clock. Either way, I certainly don't want to do argument at the end.

MS. MANUELE: I mean, perhaps, if the State

wants to inquire of the witnesses about either of the phone calls, they could provide them tonight so that they aren't answering -- we might not have to play the whole phone call if they're not asking questions without the evidence being presented to the witness. So I don't know if that would perhaps expedite things.

I just don't -- I -- when we had reached out to Dr. Ogu on Friday night about testifying perhaps another day this week, she was like, The only day I'm available was Friday. So that just makes me think she, perhaps, might have limited availability next week.

THE COURT: Okay.

MS. MANUELE: But I did not ask.

THE COURT: Okay. Well, you-all -- here's the thing. I'm here tomorrow afternoon and I'm yours. I don't really want to stay past 6:00 because, again, Friday -- you know how Fridays are. It's just gonna be a full day and I want to be able to pay attention and ask questions. So six o'clock is kind of my cap on time, but if we're close to rapping up, obviously, I'll finish.

And I don't care which doctor we do tomorrow. If Dr. McClain winds up getting the documents, she

needs tomorrow morning and says, you know what, I want to read them and don't really want to give an opinion on them Friday afternoon, I'd be happy to do her next week. I'm gonna be flexible so she can testify to what she needs to testify to. And I can do any argument or any testimony Tuesday, Wednesday, Thursday. And you-all have the overnight to talk about how you want to do that tomorrow.

MS. MANUELE: Okay.

THE COURT: Okay? Does that work?

MS. SULLIVAN: Yes. So we don't really know if we're doing both doctors or one tomorrow?

THE COURT: Well, here's the thing --

MS. MANUELE: We're for sure calling Dr. Ogu at 1:00. I can tell you that just because she -- that's her availability.

THE COURT: I think Dr. Ogu is going to go first, right? And then if there's gonna be a concern about Dr. McClain not having the data that she wants to review, then it might even be better to do her next week in case she gets it tomorrow. Maybe you can help expedite that.

MS. SULLIVAN: That's the thing. I wish I had known that she hadn't gotten the information before

this moment because I absolutely Monday, Tuesday, Wednesday, Thursday, I would have made phone calls, but I had just found that out.

THE COURT: I know.

MS. SULLIVAN: I would have been happy to do that.

THE COURT: I understand.

MS. SULLIVAN: But I didn't hear anything, so I assumed all was good.

THE COURT: All right.

MS. RUSSELL: We assumed all was good, too, your~Honor, because Dr. Jones testified in her deposition that there would be no problem getting this data to our experts by the 14th of June.

THE COURT: Who knows how it was sent. I don't know. We didn't ask if it was getting FedEx'd or snail-mailed or emailed or what. So -- but that falls in the category of things we all can't fix.

MS. SULLIVAN: Right.

THE COURT: Going forward, we just need to try and make sure Dr. McClain has the stuff she needs before she testifies.

MS. SULLIVAN: Is Dr. McClain -- do you know if she has availability next week? Can we work on

that? Because what I don't really want to happen is -- we know she's available tomorrow. I understand she needs the data that she needs, but I then don't want her not to be available for, like, three more weeks or something.

THE COURT: No, I know. I know. That's why I'm hoping you-all can figure that out in the overnight and let me know what best ideas you come up with tomorrow. I would like for Dr. McClain to be here tomorrow and that way we can just confirm her schedule. Even if it's just confirming that she's received the data, that would be helpful, unless you-all can agree she's got what she needs and can work on it over the weekend and be ready to testify next week. I just don't want there to be an assumption that she's not testifying and doesn't show up tomorrow.

MS. RUSSELL: No.

THE COURT: Okay.

MS. RUSSELL: But I did want to be clear and candid with the Court that she did have another obligation at 1:00 p.m. and she said that she was planning on being here at 1:30 or 2:00 on the theory that Dr. Ogu was gonna testify --

THE COURT: Yeah, that's fine. Ogu is gonna

go first, but --

MS. RUSSELL: -- she won't be here precisely at 1:00.

THE COURT: That's fine. Got it. That's not an issue. It's just at some point she needs to get here so we can talk about how this is all going to play out. Okay? All right. I will see you-all tomorrow. Start at 1:00 again tomorrow? 1:00 works for everybody?

MS. MANUELE: Yes, your Honor.

MS. RUSSELL: We had planned on it.

THE COURT: Okay. One o'clock tomorrow. See you then.

MS. RUSSELL: Thank you.

(COURT IN RECESS)

(VOLUME III CONCLUDED)

* * *

CERTIFICATE OF REPORTER

STATE OF FLORIDA)

COUNTY OF PINELLAS)

I, Carla Jessal, Registered Professional Reporter, certify that I was authorized to and did stenographically report the foregoing proceedings and that the transcript is a true record.

DATED this 16th day of July, 2024.

/S *Carla Jessal*
Carla Jessal
Registered Professional Reporter