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 V

THOMAS ISIAH MOSLEY,

Defendant.
_____/

PROCEEDINGS: COMPETENCY EVIDENTIARY HEARING

BEFORE: THE HONORABLE SUSAN ST. JOHN
Circuit Court Judge

DATE: June 28, 2024

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

REPORTER: Carla Jessal
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(Pages 456 to 639)

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(VOLUME IV)

THE COURT: We're here on case number 23-03157. This is part four, I think, of our competency evidentiary hearing. And I believe the only doctor we have left to hear from is Dr. McClain, who is present in the courtroom.

Anything we need to discuss before we start with Dr. McClain's testimony?

MS. RUSSELL: Not from our side, your~Honor.

MS. ELLIS: No, your Honor.

THE COURT: Okay. Dr. McClain, I'm ready when you are.

THE BAILIFF: Stand right here. Face the clerk. Raise your right hand to receive the oath.

THEREUPON,

VALERIE R. MCCLAIN, PH.D.,

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

THE BAILIFF: This way, ma'am. Have a seat. Make yourself comfortable. Speak loud and clear into the microphone.

THE WITNESS: Good afternoon, your~Honor.

THE COURT: Dr. McClain, how are you today?

THE WITNESS: Very good, your~Honor.

THE COURT: All right. Ms. Russell, whenever you're ready.

DIRECT EXAMINATION

BY MS. RUSSELL:

Q Good afternoon, Dr. McClain.

A The chair is kind of low. I'm not used to that. Good afternoon.

Q Do you need us to fix it for you?

A I -- I don't know. Does it rise up a little bit or no?

THE COURT: There should be a handle there.

THE WITNESS: There we go. Perfect. Now I can see better. Thanks.

BY MS. RUSSELL:

Q Dr. McClain, would you mind introducing yourself to the court reporter.

A Dr. Valerie R. McClain, M-C-C-L-A-I-N.

Q Dr. McClain, I'd like to talk to you a little bit about your background and your expertise. Do you have a curriculum vitae?

A I do.

MS. RUSSELL: Your Honor, may I approach the witness?

THE COURT: Yes.

BY MS. RUSSELL:

Q Dr. McClain, is Defense Exhibit 10 your curriculum vitae?

A It is.

Q All right. Thank you.

MS. RUSSELL: We'd ask to admit Defense 10 into evidence.

THE COURT: Any objection to what's been premarked as Defense Exhibit 10?

MS. SULLIVAN: No, your Honor.

THE COURT: All right. It will be admitted as such.

(DEFENSE'S EXHIBIT NUMBER 10 WAS RECEIVED IN EVIDENCE)

BY MS. RUSSELL:

Q Tell me about your educational background?

A I received my bachelor's, master's and doctoral degree from Florida Tech in Melbourne, Florida, specializing in clinical psychology.

I then went on to complete an internship at Portland VA Medical Center in Portland, Oregon, and I specialized initially with posttraumatic stress disorder and debriefing Desert Storm veterans. I also studied neuropsychology and forensic psychology with Larry Binder

and Diane Howieson and Loren Pancratz, all of which were diplomates in neuropsychology and forensics.

After I completed my training at Portland VA Medical Center, I went on to study at the rehab hospital, the Pacific, in Honolulu, Hawaii, which is called a postdoctoral fellowship, specializing in multicultural issues, forensic psychology, neuropsychology and rehabilitation.

Q What did you do after that?

A After that, I took on a job as a psychologist or neuropsychologist in rehabilitation at Charlotte Institute of Rehabilitation where I did rotations with individuals who had had head trauma, strokes, orthopedic injuries, or other types of trauma that resulted in both cognitive and physical problems.

So I went ahead and studied there for a year and took a job, and then I transitioned into being supervised in Florida for private practice with Flora and Michael Greenberg, who also practice locally.

I completed supervision with them in private practice and then branched out to do some of my own private practice initially in 1998, as well as working various positions, one being Sunshine Psychosocial Group, which was really direct treatment and therapy to day-program patients, so it was more therapy in nature,

and also outreach to geriatric population with nursing homes.

I worked with Dr. Gambone locally in Clearwater doing cognitive assessments with older adults and triaging with his psychiatric nurse, as well as Dr. Gambone.

I then got a job as director of neuropsychology at Walton Rehab Institute. That's in Augusta, Georgia. So I worked there four days a week and then fly back to Florida on the weekends to maintain my private practice because I wanted more experience specifically in neuropsychology, both with pediatric and adult. So within that job, what I did was I sat with treatment team, both pediatric and adult, that had a neurologist, as well as physical therapist, occupational therapist, speech therapist and, basically, would staff each patient. I would do immediate triage, for example, with acute and traumatized head injured or if they'd been, like, affected by cerebral palsy or some other disease process, participate in the assessment and then assisting the treatment team in doing a treatment plan that would be appropriate for facilitating their cognitive functioning and also their social and occupational functioning.

After that -- so I stayed in private practice that entire time to some extent, and then I went on to work with a neurologist for ten years. I had been a

supervising psychologist for her psychologists, and then she left and they asked if I would take the job. So I worked with Dr. Rosanna Garner. She's currently a neurologist. I worked for ten years with her practice, and they have a physical therapist, occupational therapist, cognitive therapist, being myself, where I did neuropsychological assessments for individuals who had had head trauma, as well as posttraumatic stress or depression. So I would do the workups and then generate a report to help the neurologist know if, in fact, these were legitimate cognitive deficits or if there was any intentional faking or malingering. This, of course, was in a civil setting, civil law setting, so there's a lot of focus, as well as in criminal settings, of knowing if these are legitimate or if there's some exaggeration, if you will. So I did the assessments and I also did therapy, cognitive therapy, with patients there from 2002 until 2012.

In 2012, I resigned to just do my private practice. I had given birth to my twins, so it was like trying to juggle too much to have two jobs plus take care of the twins. And since that time I've been in private practice exclusively. And within the context of that practice, doing court-ordered evaluations in 20 counties in Florida. Up until recently, I cut back to like five

because Pinellas referrals increased, Hillsborough referrals increased, but I had been on court-appointed cases for competency, for mental health concerns, as well as neuropsychological concerns and/or developmental disabilities like intellectual disability, autism.

Q Excellent. Dr. McClain, I'd like to talk specifically about your work for the courts in a little bit, but, first, there were a lot of words there, and I'd like you to explain the difference between a neuropsychologist and someone with training in neuropsychology versus a garden variety psychologist.

A So, in general, when an individual has a degree in psychology, they are studying, of course, mental health issues and diagnoses that are defined in the *DSM-5-TR*, and specifically looking at treatment modalities, the causality of mental health disorders, and then trying to essentially create, you know, treatment plans and whatnot.

If they're clinical psychologists, there is a certain category of disorders, neurological disorders, for example, that require specialization in understanding neurobiology, neuroanatomy. In other words, understanding how the brain, being damaged or having some trauma, can impact basic functions like cognitive functions, such as thinking and memory, processing information and even motor functioning reaction time issues.

So neuropsychology, within the umbrella of psychology, is a subcategory that is focused more on how behavior is affected by brain diseases, brain trauma. And then there's a whole series of tests that are used specifically to tease out functional problems. What I mean by "functional" is like -- an example of a function is memory function, short-term memory function, long-term memory function, speech and language function, expressive receptive speech function. So there's just a large amount of tests within the neuropsychological battery that can be used to help to answer questions, whether it's a legal question, such as is this person competent and what is the underlying reason why. For example, if they had severe head trauma, their memory right be so impaired that they're not gonna benefit from giving them some type of training.

Within forensic psychology, it goes more towards the issue of how mental issues impact decision making, legal decision making. For example, competency is an example of that. If a person has a mental disorder such schizophrenia and it's untreated treated, how might that to impact their ability to consult with their attorney in a rational manner, or be able to respond if they're on the stand to questions, direct or cross-examination. Because if their thought processes are impaired by intrusive

auditory hallucinations, or seeing things that aren't there, it could be distracting and impair their concentration so that what might be perceived as reluctance to cooperate could actually be active mental illness.

And the -- this is sometimes seen also with individuals who have limitations with regard to intellect, so lower intelligence, that there could be long pauses, there could be, you know, just sort of a presentation that suggests there's a lack of cooperation. So it's -- in forensics, it's very complex from the standpoint of there are many layers of it, but the bottom line is the forensic psychologist tries to be useful to the courts and to attorneys to provide answers about questions such as competency, sanity, whether or not they suffer from some sort of mental disorder or substance use disorder that requires treatment.

And, of course, there's another level of capital cases where it becomes compelling for the forensic psychologist to aid in looking at life history information that could be considered with regard to, you know, obviously, death penalty or other issues.

Q How many years of practice in the field of neuropsychology total?

A So I started practicing neuropsychology and

learning as an undergraduate and graduate student. I did a neuroscience fellowship before my doctorate to specifically look at visual-motor movement, experimental neuroscience, and then I went on to continue my studies under the tutelage of my professor at college who -- Tom Peek, who was a diplomate in neuropsychology. So, basically, from the time of undergraduate, after I graduated, since that very day. In other words, since 1992 I've continued to practice in the area of neuropsychology after I was licensed.

Q Okay. So eight and 24, 32 years? Is my math right?

A About -- about 32 years. And, again, I was still working in neuropsychology even when I wasn't licensed, but I was supervised in it because I had an interest in it. So it's just a field where I've been active in doing assessments, but also in offering articles and staying abreast of the latest developments just out of an interest, my own interest in it.

Q Excellent. And how many people do you feel that you've evaluated over the course of your 32-year career?

A I have to estimate, but I know I've evaluated thousands of people at this point. I had a very active caseload when I worked with a neurologist on top of my private practice, so it's like double volume during those

years. Just for the -- for the learning purposes, because with neuropsychology, the more experience you have academically with seeing patients and clinical experience, the more you're going to recognize things, basically.

Q Right. I want to talk to you now about your experience with courts. When did you first start joining court-appointed lists to evaluate defendants?

A So I got my training with Randy Otto, Dr. Randy Otto, in the Florida Mental Health Institute where you take the competency training. It's just basic training on what the standards are for doing competency assessments. I've since had other courses in it, but that's whenever I started was about 1998.

Q And are you on -- are you court-appointed neutral in a number of counties?

A So, yes. I started in Hillsborough County on the court-appointed list back in 1998. By 2000, I had applied to the Pinellas County list and became active in the Pinellas County list. Then I was asked to do Polk County, so I got on the list in Polk County. Then I was asked to be on the list in the Fifth Judicial Circuit, so I was Citrus, Hernando, Sumpter County. And then I was asked to do Orlando and Osceola and some other counties that were underserved. So, basically, I ended up in 20 difference counties until I recently cut back on it to be

able to focus more on the local counties. But I was on, I think -- I was in 20 counties, and I think it represents like 10 or 12 different judicial circuits. I still do work if the judge asks me to, even though I'm not on the court appointed list, because there might be a specific question about neuropsychology or intellectual disability and autism. There's not a lot of providers in that area, so they might ask would you take this case and see this person.

Q So what percentage of your work is court-appointed neutral versus work where you're hired by the defense versus work where you're hired by the State?

A So the State -- being retained by the State occurs sometimes in the court-appointed cases. So the State may request me to do, like, a second, third opinion. Okay? But as far as confidential retention by the State, it's -- I've done a sanity case for the State specifically in Pinellas County. I've done some work that I would call more Office of the Attorney General, like child dependency cases or victim advocacy type cases. But other than the court-appointed, it's been limited with regard to the State. It's mainly court-appointed, with the exception of a sanity case I did recently. On the court-appointed, it varies, basically, who requests me. And I don't really look at it as anything other than it's court-appointed,

you know, that I'm gonna be doing that.

But I would say right now my practice has really changed to be court-appointed than confidentially retained. It used to be more confidentially retained, but as I got into more counties, it's more court-appointed.

Q How many cases have you been on whether court-appointed or retained by the defense?

A So I've been in at least 40 death penalty cases at this point.

Q And is death different in your mind?

A Well, death penalty cases are quite different. Death penalty cases, even like sentencing, it is something that has to be very reversely addressed at the front end. And when I say that, I mean to try to uncover underlying variables or factors, such as academic functioning, social functioning, mental health issues. Being very thorough and exhaustive in terms of looking at that particular defendant, looking at details of the crime itself, and then casting in the perspective of how best to assist, whether it be competency, sanity, mitigation.

Q How much do you charge an hour?

A So I charge $200 per hour uniformly for whatever service I offer at this point.

Q And that's no matter what kind of case?

A Correct.

Q Dr. McClain, I'd like to ask you a few questions about competency very generally. What is competency?

A Competency, as it pertains to competency to proceed to trial, is a specific, I would say, abilities that the individual has to possess in order to proceed with the case. Meaning that when competency is considered within the court of law, it would be addressed by criteria that's specifically designated in the Florida Statutes that preserves the rights of the defendant and allows the lawyers involved and the judge to be aware that that person possesses that ability or be sure that that person possesses that ability, such as the individual's ability to identify their charges, the individual's ability to understand the seriousness of the charges and what could potentially be an outcome legally as far as consequences, to understand options that they have as far as possible pleas, to understand that it's adversarial, that there is opposing parties, meaning the defense attorney, the state attorney, even though they might work together, by definition they're on opposite sides.

Other things that are important in terms of addressing competency are making sure the defendant understands the judge's role, making sure that they understand, if they were to enter a certain plea, what could happen. For example, going to trial, what that

would entail as far as witnesses, as far as potentially testifying.

Another important thing is an individual's capacity to behave appropriately in court, being able to show appropriate respect and composure, even if something's said that they're not in agreement with, knowing how to handle that. And I think a factor that's very important is the person's ability to testify relevantly and to participate in the proceedings as it's ongoing, which is a very important part of resolution.

Q So as a neuropsychologist, how do you determine if someone is competent?

A So, in general, as a neuropsychologist and forensic psychologist, basically what I would do is first obtain information about the defendant in terms of their charges itself, try to obtain any medical, mental health, or academic records that would be relevant, and this is especially true with regard to cases of intellectual disability or autism. But, in general, having academic records or knowing their level of comprehension and overall intelligence level become important factors as far as interviewing them and determining what level of understanding they have.

The mental health records become important because the psychologist is able to look and see if

they've been identified as having a mental health disorder, and if so, is it treated or untreated.

Jail records can be very important as far as knowing if the person has been compliant or noncompliant with medication, which would go to the issue of perhaps their lack of competency could have to do with just not being medicated properly. So it's important to look at have they recently been placed on medication, have they recently discontinued their medication, has their medication changed. For example, transitions from the hospital to the jail, sometimes that will happen and they'll be very careful in the report to say they need to maintain on this regimen in order to, you know, preserve the gains that they've made.

Q And as dovetailing to that response, what factors can actually change a person's competency status over time?

A So, simply put, in my experience in the cases that I've done, medication changes, a person being noncompliant with medication, acute traumatic events that could occur, such as them having an illness, a head injury, some sort of urinary tract infection could cause delirium. If they, for example, have something happen within the context of being incarcerated, or even if they're in the community, it causes them to be impacted,

such as a head trauma, you know, or a death in the family. So there is multiple variables that could be situational variables, environmental variables, such as homelessness, which does impact people to participate in training and the consistency of their training. So there can be multiple variables, environmental, medical, psychosocial, medication. Just the basics, though, the basics, medication is a big one that can impact competency.

Q Dr. McClain, have you formed an expert opinion as to whether Mr. Mosley is currently competent under the six criteria in Florida 916.12 and Florida Rule of Criminal Procedure 3.112?

A So, I have.

Q And I'm just asking now --

A I have.

Q -- if you formed an opinion, but I'm gonna ask you more about the opinion down the road.

A Sure.

Q So have you formed an opinion?

A I have.

Q Excellent. We'll get to that opinion in a minute, but before we get there, I'd like to talk to you about some of the things that you did in order to form your opinion. Did you review any documents and records --

A I did.

Q -- before you performed your opinion?

Tell me what you reviewed.

A So I reviewed the charging documents, the indictment, the notice to seek the death penalty, All Children's Hospital records, BayCare records, and academic records from Boca Ciega, Wellpath records from South Florida Evaluation and Treatment Center, and that would be specific to 12/14/23 through 1/9/24, St. Anthony's records and Pinellas County Jail records.

THE WITNESS: Excuse me, your~Honor. Is it okay to get some water?

THE COURT: Absolutely.

MS. MANUELE: Your Honor, while we're on -- more on a quick break, Ms. Blaquiere, I think, was on and then got kicked out. Did she get back -- she changed devices and so she's --

THE COURT: She is there.

MS. MANUELE: Oh, perfect. Thank you.

THE COURT: Yep.

THE WITNESS: Better.

BY MS. RUSSELL:

Q Are you okay?

A Yeah. I've been talking a lot this morning in court.

MS. RUSSELL: Your Honor, may I approach the

witness?

THE COURT: Yes.

MS. RUSSELL: I'll be showing the witness what's been premarked as Defense Exhibit 11 and Defense Exhibit 12.

MS. SULLIVAN: Ms. Russell, could I just see them?

MS. RUSSELL: Do you need copies? I do have copies with me.

BY MS. RUSSELL:

Q Dr. McClain, I'm showing you what's been premarked as Defense Exhibit 11 and Defense Exhibit 12.

A Okay.

Q Do you recognize Defense Exhibit 11?

A I do.

Q What is it?

A It's a psychological report dated 3/25/2011.

Q How old was Mr. Mosley at the time that report was offered?

A He would have been eight years old.

Q Do you recognize Defense Exhibit 12?

A I do.

Q What is that?

A That would be a transcript giving his grades from Boca Ciega.

Q And that was high school?
A Correct.
Q Did you review Defense Exhibit 11 and Defense Exhibit Number 12 in conjunction with your evaluation of Mr. Mosley?
A I did.
Q Thank you. I'll probably leave them with you.
A Sure.
MS. RUSSELL: We'd ask that Defense 12 -- Defense 11 and Defense 12 be admitted into evidence.
THE COURT: Eleven and 12-B?
MS. RUSSELL: Eleven and 12. We'd ask that that 11 and 12 be admitted.
THE COURT: "Be." Okay. Any objection to 11 and 12?
MS. SULLIVAN: No.
THE COURT: Okay. They will be admitted as such.
(DEFENSE'S EXHIBIT NUMBERS 11 AND 12 WERE RECEIVED IN EVIDENCE)
BY MS. RUSSELL:
Q Dr. McClain, referring first to Defense 11, the psychological report from March 2011 when Mosley -- Mr. Mosley was eight years old.

THE COURT: Do you happen to have a copy for me?

MS. RUSSELL: Oh, I do, your~Honor. In fact, do you want both?

THE COURT: That would be great. Thank you.

MS. RUSSELL: Uh-huh.

BY MS. RUSSELL:

Q At that tender age when he was eight, he was only absent from school five times that year?

A Correct.

Q But yet he was behind in reading?

A Correct.

Q Even though his mom took him for tutoring at Sylvan Learning Center?

A That is correct.

Q And at eight years old he had trouble learning, and at the end of that report he was recommended for exceptional student education?

A Correct.

MS. SULLIVAN: Objection to leading.

THE COURT: Okay. Do you want to rephrase your questions, please.

BY MS. RUSSELL:

Q Dr. McClain, at eight years old was Mr. Mosley referred to a program for exceptional student education

due to his learning disabilities?

A Yes.

Q Does that report suggest anything else to you?

A I think that, basically, in looking at this, one thing that is noteworthy to me is that he's basically put in a dropout prevention program early on. Typically, that's seen later in development, but he's being identified as, basically, having some difficulties with reading and letters, spelling. So more verbal skills.

Q Did you notice in the report whether or not he was engaged in school?

A With regard to him being engaged, can you clarify that for me?

Q Sure. Dr. McClain, if you'd look at page 2 of the psychological report.

A Okay.

Q And in the second paragraph.

A Okay. In this particular paragraph, it's talking about his level of cooperation, basically, and it's talking about him being receptive and cooperative.

Q At the age of eight?

A Correct.

Q Now, he got in a fight that year it looks like?

A Correct.

Q Is that unusual for an eight-year-old?

A So in terms of fighting with the student, I'm not sure the details of that fight, but as far as verbal/physical back and forth between young peers, that's pretty common, in general.

Q Doesn't make him a bad kid?

A So I think what they're -- in the context of what it is, is they're just saying one discipline referral. So I think they're trying to say the frequency of, you know, basically, his level of cooperation, what might be going on as far as attendance, but I don't think there's any reference to him being a problem child, if, you know, that's the question. It's not saying an emotional behavior disability, which oftentimes will be a differential, to be quite frank, in these types of assessments. So these are designed more to troubleshoot.

Q What does that report tell you about the state of Mr. Mosley's young brain at the age of eight?

A So just as a piece of data on his functioning in regards to his academic functioning, they are basically pinpointing and identifying what we would call a potential learning disability specific to the area of verbal skills, such as reading, spelling, comprehension.

Q Anything else that you note in that report?

A No, ma'am.

Q All right. I'd like to turn your attention to

Defense 12, and that's Mr. Mosley's transcript from Boca Ciega High School.

A Correct.

Q What does that transcript tell you about Mr. Mosley's functioning in high school?

A Basically, this transcript is referencing his functioning, ninth grade, tenth grade, up until 11th grade, but specifically ninth and tenth grade are referenced in the notations as far as grades. And, basically, just the summary of it is he's functioning primarily in the below average -- that would be C and below range -- with much of his functioning being F, or failing.

Q So we have poor grades, fair?

A Pardon?

Q He had poor grades; is that fair?

A Well, they're below average to poor, yes.

Q And he never made it through algebra?

A Correct.

Q He did get an A in basketball?

A Correct.

Q And he dropped out after the tenth grade when he was 19 years old?

A Correct.

Q Is there anything about that transcript that

tells you about Mr. Mosley's cognitive problems?

A So cognitive with regard to achievement functioning and school functioning, he is showing deficits in general. Failing and not able to perform for what reason is not clear, but he is definitely functioning at a level that's not gonna graduate him or get him through high school.

Q Dr. McClain, I'd like to turn now to your evaluations of the Thomas Mosley. How many times did you evaluate Mr. Mosley over the course of more than a year?

A So, in total, I saw him four times.

Q When was the first time that you saw Mr. Mosley?

A I initially saw him May 12th of 2023.

Q And how long were you with him that day?

A I would say approximately an hour.

Q What did you do on your first evaluation?

A So during the first evaluation, essentially, I just did what we would call an intake of just introducing myself, talking about my role, distinguishing between it being confidential as opposed to court-appointed, and then talking about the purpose that I was there for.

Q What else did you do?

A Just inquire as to his history, whether or not he was, basically, you know, aware of things, such as his medications, any type of mental health symptoms he was

having.

Q Did you give him any tests at that time on your first meeting?

A I did not.

Q Why not?

A So I did not test him because he did not appear to be stable from the standpoint of stabilized on medication for his mental health issues. He did appear to be exhibiting what I call psychotic symptoms, which was concerning because any testing that I might do would be impacted by the lack of stabilization.

Q Does someone have to be stable for the tests to be accurate?

A So just in general in doing testing, whether it's neuropsychology, IQ testing or personality testing, the reason it's important is because the symptoms which I mentioned earlier of psychosis or the symptoms of, for example, mood swings, bipolar episodes, depressive episodes can significantly suppress or impact functioning so that basically what we see is a bottoming out as opposed to an accurate representation of what they're capable of.

Q And testing should be accurate?

A Well, it's very important to get an accurate measure to be able to inform the courts, but also to make

an opinion as to what is actually going on in terms of diagnostically and as far as mental health diagnoses, but also answering questions like competency or sanity.

Q Did you see Mr. Mosley a second time in 2023?

A I did.

Q And when was that?

A I saw him again 6/23/23.

Q How long were you with him, if you recall?

A I would say somewhat less time. I would say about a half hour that day.

Q And what did you see?

A So they had started a new medication with him, Zyprexa. And, basically, he was saying his appetite was good, but he was still experiencing hearing voices telling him to harm himself, seeing blood in people's eyes, and experiencing a image of blood when he would be in the shower or see water.

Q Did you do any testing at that time?

A I did not.

Q Why not?

A Again, I did not think that he was stable.

Q Dr. McClain, did you write a report back in 2023 to summarize your conclusions after your two meetings with Mr. Mosley?

A I did.

MS. RUSSELL: Your~Honor, may I approach?
THE COURT: Yes.
MS. RUSSELL: I'm showing Dr. McClain what is marked as Defense 13.
BY MS. RUSSELL:
Q Dr. McClain, is this the report that you wrote after seeing Mr. Mosley on two occasions back in 2023?
A That's correct.
MS. RUSSELL: Did you want a copy, your~Honor?
THE COURT: I have mine in front of me. Thank you.
MS. RUSSELL: We'd ask that Defense 13 be moved into evidence.
THE COURT: Any objection to Defense 13?
MS. SULLIVAN: No objection.
THE COURT: It will be received as such.
(DEFENSE'S EXHIBIT NUMBER 13 WAS RECEIVED IN EVIDENCE)
THE COURT: That's the -- just so we're clear and I'm looking at the right thing, that is the report that was authored when? Does it have a date on it? I just have at the top, Date of Evaluation: 5/12 and 6/23/23, cell side, right, on the verry top heading?
MS. RUSSELL: Yes.

THE COURT: Okay.

MS. RUSSELL: Unfortunately, it is not dated, but perhaps Dr. McClain knows the date that this report was authored.

THE WITNESS: So in this particular case, I believe it was authored within 24 hours of doing the evaluation.

MS. RUSSELL: Okay. And I know also, your Honor, that it was filed in the record in the case within days after its being provided to me.

THE COURT: I'm not so much worried about that. I just want to make sure that I'm looking at the same report you have.

MS. RUSSELL: Okay. It says, Date of evaluation: 5/12 and 6/23.

THE COURT: Yep.

MS. RUSSELL: Okay. Perfect.

BY MS. RUSSELL:

Q Dr. McClain, what was your diagnosis of Mr. Mosley?

A So my diagnosis at that point in time was major depressive disorder, severe, with psychotic features; unspecified schizophrenia, other psychotic disorder; generalized anxiety; and cannabis use disorder.

Q How come there are so many?

A Because it wasn't clear to me what the -- these are all provisional. In other words, he's not stabilized, and what I saw was very, very severe depression, but also the psychotic features, which typically with major depression with psychotic features, the psychosis may resolve and a person won't see that anymore, or it will only come up when they're under extreme stress. But if it's a psychotic disorder, such as schizophrenia, those symptoms are not going to go away. So it was more of a rule out for me in terms of is this more a psychotic disorder or a mood disorder, and over time it became clear, you know, based upon my review of other information, more interviews with the defendant, that it was more of a -- what I would call a psychotic disorder and the mood disorder.

Q What's the normal age of onset for the psychotic disorders, such as schizophrenia?

A So with schizophrenia, it would be late teens in which the symptoms of psychosis might first be seen. As far as, you know, what we call a "prodromal period" where there is lack of attention to hygiene, lack of attention in social situations, them not really being responsive, so a flat affect, and then gradually they'll -- I don't want to say blossom, but they develop a psychotic episode in which you have blatant symptoms of psychosis, such as

delusions and/or hallucinations where they're actively responding to internal stimuli or they're talking about thinking the radio's got a special message for them, people are micro-chipping them. So, basically, they'll have their first episode like late teens.

Q Did you notice any symptoms of a cognitive problem when you first visited with him?

A So what I focused on when I was interacting with him was really looking at what was the underlying reason for, for example, what I would describe as slowed processing, both receptive and expressive processing. Meaning that it was like it was on the conveyor belt, but the answer wasn't coming up fast. It took a lot of time for him to produce a response, and that's been consistent throughout my interactions with him and it hasn't really changed even with medication.

So it raised an issue of whether or not there might be something aside from the mental health symptoms, such as an underlying learning disability or lower functioning as far as overall intellect, and specifically because, also, I noted that in the academic records there was a suggestion that he had had these receptive and expressive issues early on. So it wasn't one or the other. It was just trying to figure out what part was most impacting his competency aside from the mental health

issues.

Q Did you find that Mr. Mosley was competent back in 2023?

A I did not.

Q Why not?

A So I did not think he was competent from the standpoint of -- and I want to clarify the word -- actually, consistently in three areas where I thought he demonstrated, you know, an adequate understanding of the prongs of competency. For example, understanding his charges; understanding, basically, what could happen as far as his legal charges; understanding possible pleas; and demonstrating an accurate understanding of the adversarial nature of the legal process.

I also thought that his behavior was within acceptable limits pretty consistently. Even though I noted it could be passive and maybe inattentive due to internal stimuli, behaviorally, I didn't think he would pose any threat to court personnel or to his attorney in the courtroom. But I did find him consistently to be within acceptable limits on those four area.

The areas where I had concern, moving along to those areas, were really on two particular areas. One being that he was not able on any of the occasions to provide a description of, basically, describing what had

happened or what he's being alleged to have done. There was no ability on his part to accurately say, for example, what his discovery might be saying or facts about his case.

And I also found him to, basically, have difficulty in the area of capacity to testify relevantly for the reasons described that over the occasions that I saw him, even post hospital and post medication, he still did not demonstrate, like, speed of response. His processing speed was just consistently so slow, he actually appeared more depressed during the last times that I saw him. And was taking his medication, but still was having difficulty, I think, with the mental health symptoms. And I mean, specifically, the depression, slow motor functioning, slow verbal responses, being distractable, if you will, like when I would stop him and say, you know, What are you thinking about? There was still a component of a psychosis, meaning seeing things or hearing voices.

Q So when you say that, are you talking about when you saw him more recently in 2024 or are those comments limited to your visits in 2023? I'm trying to focus just on 2023.

A Oh, 2023?

Q Correct.

A No, it was -- you asked for me to address the competency component.

Q Right.

A So that was 2023.

Q Okay. Was there anything else that you found remarkable at the time you saw him back in 2023?

A No.

Q Do you have an idea what happened after your report was filed with the Court and what happened to Mr. Mosley?

A Well, I know that he was sent to the hospital.

Q Did you know what kind of treatment he was getting at the hospital?

A So in reviewing the hospital notes, he was basically there, I believe, three weeks, and there was some medication administered for him at the hospital. And then I believe he was given one additional medication just prior to being released back to Pinellas County.

Q So when did you next see Mr. Mosley?

A So my next visit with him was March 1st of 2024.

Q And where did you meet with him?

A I met with him at the jail.

Q And how long did you meet with him?

A Approximately an hour.

Q What did you do?

A Basically, went over his mental status, how he was doing, talked with him about him being at the hospital, and then explaining that I was, again, going to endeavor to do a competency assessment.

Q And did you?

A I did.

Q Did you give any testing?

A I did not test him.

Q Why not?

A I didn't test him because, in talking with him -- and I want to clarify for the courts and the attorneys, when we talk about testing, in communication with the attorney, I did think that it was important to have testing done specific to determine his IQ, his reading level, and also to determine, of course, malingering, those type of questions, you know, but I did not feel that he was stable yet. I felt that he was still exhibiting psychotic symptoms.

Q So you saw him about five weeks after he came back from the South Florida Evaluation and Treatment Center?

A That's correct.

Q What was his condition compared to when you saw him back in the summary of 2023?

A So in terms of his condition, he still appeared

to be responding to internal stimuli, meaning, I'm talking about hearing voices, seeing blood, specifically voices telling him to harm himself. He still experienced slowness in processing. He was still exhibiting what we call passive suicidal ideation, thoughts of self-harm. So in other words, in simple language, it didn't seem to be fixed.

Q And your experience when patients moved from the therapeutic hospital setting to the setting of the jail, is that usually a circumstance that improves their competency?

A So when a person is, basically, sent to the hospital and returns, typically, the hope and usual expectation is that the person will be more stable and able to go forward on their case. And largely that is the case, in my experience, that there is improvement. There are like a -- I would say outliers where they're not restorable for various reasons, or there is a persistent delusional system that causes problems, and when they come back it's still there. But, in general, there is the expectation that the individual will be stabilized on medication and he will be able to go forward.

Q Was that true in this case?

A To date, I haven't seen that. It's not that I have the opinion it can't occur. I just haven't seen it

yet. Maybe, perhaps, not a long enough treatment period or the right medication combo, but I haven't been able to do testing that I think is important, nor have I been able to communicate on a level that assures me on at least two areas of competency that he's able to go forward.

Q Dr. McClain, you evaluated Mr. Mosley just a few weeks ago on May 31st of 2024?

A That's correct.

Q How long were you with him then?

A Approximately a half hour.

Q And what were your impressions?

A My impressions, basically, were the same. Same type of symptoms. There had not been any significant change as far as him being more stable, and less responsive to what I call the visual and auditory hallucinations. I actually saw him right after he had been showered, and so the immediate discussion was about the blood images. And so I still felt that that was impacting his ability to communicate.

Q Dr. McClain, did you write a report after your last visit with Mr. Mosley?

A I did.

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

THE COURT: Yes.

BY MS. RUSSELL:

Q Dr. McClain, I'm showing you what has been premarked as Defense Exhibit 14.

A Yes, ma'am.

Q Is that the report that you wrote after your last visit on May 31st?

A Correct.

MS. RUSSELL: We'd ask that Defense 14 be entered into evidence.

THE COURT: Any objections to what's been premarked as Defense Exhibit 14?

MS. SULLIVAN: No objection.

THE COURT: No? Okay. It will be admitted as such.

(DEFENSE'S EXHIBIT NUMBER 14 WAS RECEIVED IN EVIDENCE)

BY MS. RUSSELL:

Q Dr. McClain, did your diagnosis change from the summer of 2023?

A My diagnosis has remained the same.

Q So did you think that Mr. Mosley was competent when you saw him on May 31st?

A I did not.

Q And after evaluating Mr. Mosley both in March and May in 2024, what did you learn about his capacity to

appreciate the charges against him?

A So consistent with my initial evaluation, he was within acceptable limits in that area.

Q Why was that?

A He was able to identify his charges. He was able to identify the seriousness of his charges.

Q And what about his appreciation of the range and the nature of the penalties?

A Consistent with my first report, he was able to express an awareness of the likely legal outcomes associated with his charges.

Q And what did he say about that?

A That he knew that he could get the death penalty or he could get life.

Q And what about the adversarial process; what was his understanding of that?

A That he understood the role of his attorney. He understood the role of the state attorney and that it was opposing and not on his side. He understood the role of the judge is fair and did not demonstrate, for example, any paranoid ideation about that or persecutory ideation. He was also able to identify what a potential plea bargain was and what a jury trial was.

Q Was his understanding pretty simple?

A Very simple, but to the point. Enough to say

that he met, you know, an acceptable limit.

Q And nothing inconsistent with someone with cognitive impairment?

A So, no. It would be consistent with someone that is simple, that has the ability to understand on a simple level and respond with -- and when I say that, I mean like one to two-word responses to something. So it's not like an elaborate thing where they're elaborating, but he was able to provide correct, simple responses.

Q What about the capacity to disclose pertinent facts to his defense team?

A Within that category, it still was in unacceptable limits. He was not able to provide an understanding or details concerning the charges itself.

Q Was that because he was unable or was he merely unwilling?

A So I think that that's really the issue. Consistently, he has not been able to provide that, and the underlying reason for that is still to be decided. And what I mean by that is simple. With regard to mental health disorders, if there is any type of psychotic disorder or dissociative disorder where they actually have what we call "compartmentalization," they actually may not have that recollection. They could be told about what happened, but may not actually remember it. But the

important thing is that he's not really saying that. He has that working knowledge of what occurred, and so it's problematic from the standpoint of him going forward, if he, for example, goes to trial or were to go, for example, for not guilty by reason of insanity or another defense. So I did not find him to be able to relate those facts on any of the occasions I saw him. And as to the causality for that, I think it's multilevel. Obviously, I think there's potential issues of unwillingness, lack of cooperation, as well as possible dissociative factors more related to the mental illness.

Q What about manifesting appropriate courtroom behavior?

A Consistent with my interviews with him and my reports, he, I think, can comply with appropriate courtroom behavior. There's not been any behavioral outbursts when I've been interviewing with him, and I know of no particular disciplinary reports that he's had with regard to outbursts, so I would say that his behavior is predictable at this point in time.

Q And what about his capacity to testify?

A So, again, consistent with the first report, there are difficulties, and I think it's multilayered. Just to start with the basic level of comprehension, expressive and receptive issues that were obvious on the

different occasions and -- and I'm separating that out from what might be called willingness or lack of cooperation to just say that consistent with what the academic records suggest, there are some underlying learning disability issues or comprehension issues and verbal expression issues, but there was no real change in that in terms of his ability to process information, and it was interrupted by what I would call the psychotic symptoms that were being expressed consistently.

So it's several factors I think there, but I think it would be important to get to the bottom of that from the standpoint of wanting to find out the reason that that's occurring, like through testing, potentially, neuropsychological or intelligence testing, in order to ensure that if he, for example, was in trial taking the stand, that his capacity is maximized or optimized so that, as much as he can get out of his brain power, gets out of his brain power to participate in the proceedings.

Q Is Thomas Mosley's case complicated?

A So relative to cases that I have, and a lot of them are complicated, but in his particular case it is complicated. And I say that, and I'm just going to clarify --

THE COURT: Are we talking about the facts of his case or the evaluation portion being

complicated?

MS. RUSSELL: Okay. I can rephrase the question.

BY MS. RUSSELL:

Q Is Thomas Mosley's mental health status and diagnosis complicated?

THE COURT: Thank you.

THE WITNESS: Yes.

BY MS. RUSSELL:

Q Why is that?

A So this hasn't been brought up yet, but I have reviewed the hospital raw data, I've reviewed the hospital records, and so it makes it even more complicated, just to throw in a little wrench there. So --

Q We'll get to the state hospital testing.

A So I -- I just want to say, so it is complicated, and to keep it simple, there is, I think, underlying overall intelligence level that is a factor. Achievement level, such as reading comprehension, expressive and that receptive language deficits that makes it complicated, and also, then, the mental health issues are complex. So it makes it something where there's -- you know, all of those things need to be sort of defined in a way as to understand how it impacts his competency.

Q Dr. McClain, did you personally observe any

genuine psychotic symptoms while you visited with Mr. Mosley on the four occasions that you saw him?

A So in terms of observing psychotic symptoms, yes. In terms of distractibility, reporting auditory hallucinations, visual hallucinations, yes.

THE COURT: While actively talking to him?

THE WITNESS: He was reporting them, your~Honor.

THE COURT: As you're talking to him?

THE WITNESS: Absolutely.

THE COURT: You would be the first doctor to observe that.

THE WITNESS: Yes.

THE COURT: Okay.

BY MS. RUSSELL:

Q Was he exaggerating any symptoms during your evaluation?

A It -- so that would be something that would be basically -- his presentation was consistent. It's very passively delivered. And what I mean by that is he was reporting seeing blood, like after he came out of the shower, and was talking about that. He was talking about hearing voices telling him to harm himself. So that -- when I say I observed it, yes, he did report that to me. And so the --

THE COURT: Well, I -- I'm sorry to interrupt. I want to just -- I'm trying to understand.

THE WITNESS: Okay.

THE COURT: Is he reporting to you an hour ago when I was in the shower I saw blood, or you're talking to him and he's telling you I actually see blood right now, or he's so distracted he can't answer your question because he's hearing voices in his head, or is he reporting something that's happened before you started talking to him?

THE WITNESS: Both of the above.

THE COURT: Okay.

THE WITNESS: Both of the above, Your Honor. And, specifically, I saw him right after he had showered the last occasion, so I think that's where it was more prominent that he talked about actually seeing the blood because of the timing of it because I -- he had just showered. So I'm certain that that had some correlation with why he was reporting it right in that moment as opposed to I've had that happen.

BY MS. RUSSELL:

Q I'll go back to the last question just to make sure we got your response on the record. Was Mr. Mosley exaggerating any symptoms during any of your examinations?

A So he did not appear to be exaggerating from the standpoint of it was very consistent. It wasn't, like, embellished, dramatic, I can't talk standing up, I'm hearing voices. It was just very passive, like, I hear voices telling me to harm myself. I see blood. Very matter of fact, not embellished. In other words, I see demons and they were all bloody and black and satanic, it wasn't like that. It was just consistently, I see blood, I hear voices telling me to harm myself, but not anything that it was -- oh, for example, just a good example, when I went through the basic facts of competency, very consistently he said what he knew, and I felt like, again, he was very much on point. Even simple, concrete, but for -- for factors of competency, good to go. So there wasn't any suggestion, I don't know what my attorney does; I don't know what the state attorney does. I didn't see that or observe that with him. It was just more an issue of how the mental health issues were impacting two areas, basically.

Q Did he try hard to do what you asked?

A He was responsive. He didn't refuse to answer questions. He didn't make any gesture to get up and leave from the situation or the interview.

Q He cooperated?

A He was cooperative.

Q Dr. McClain, based on all the records you reviewed, your four forensic evaluations over the course of more than a year, all of your training and experience, do you have a professional opinion as to whether Mr. Mosley is currently incompetent under the six criteria of Florida Statute 916.12 and Florida Rule of Criminal Procedure 3.112?

A I do.

Q What is it?

A I do not think that he is competent to proceed at this time.

Q And why is that?

A Because, basically, the mental health issues or the apparent mental health symptoms do not appear to be stabilized.

Q Dr. McClain, I'd like to turn your attention to a discussion of malingering, also known as feigning.

A Sure.

Q Can you tell me what that is?

A Intentional exaggeration of symptoms, or deficits, too, for secondary gain.

Q So, as a neuropsychologist, how do you determine if someone is malingering?

A Well, fortunately, there is many tests that can be done to determine malingering. Some of them focus on

malingering psychiatric symptoms. Others focus on malingering cognitive deficits. For example, the Miller --

THE COURT: Say that one more time.

THE WITNESS: Sure. So there's different types of tests. Some of them focus on exaggerating mental health symptoms, or psychiatric symptoms. Others focus on whether or not they are exaggerating cognitive deficits. So they're more towards what I would call memory, such as the Test of Memory and Malingering, the TOMM. That's frequently given in neuropsychological testing to see if they are attempting to feign cognitive deficits, such as memory problems.

BY MS. RUSSELL:

Q So, Dr. McClain, when you're trying to assess if someone is malingering, you might choose a screening test, or a test, correct?

A Correct.

Q Is there anything else that you might use in order to determine if someone is malingering or not?

A Sure.

Q What else?

A So --

Q Other than tests.

A So there's a list, and I'm gonna reference the literature just for a minute. Spreen & Strauss authored a book on neuropsychological testing, a compendium, if you will, of neuropsychological testing and assessment. And in it they detail a list of 14 factors to look at as far as malingering. Amongst those things, just as an example, are tests that are used that we've talked about. The Inventory of Legal Knowledge would be an example, the Structured Interview of Malingering. There can be tests, such as the Test of Memory and Malingering that I talked about, the TOMM.

There's also what we call "comparisons of behavioral differences." For example, observations, if the person is talking with other inmates, reading a book, interacting on the phone, demonstrating the ability to interact appropriately with good verbal skills and ability, then all of a sudden during testing they can't remember anything on the Word List or they -- they are talking about not comprehending or knowing their birthday. So there can be some pretty extreme examples and some subtle examples. But that would be -- basically, that category falls within collateral information comparison.

And then, if, for example, they say they're experiencing psychotic symptoms, like hearing voices and seeing things, but there's actually no record of him

having any mental health history before they, you know, for example, got a crime or something occurred, then, you know, it's questionable whether or not it's in fact genuine or valid. Or if they say they had a head injury and they never had one. There's no record of it. So there's those kinds of comparisons.

And then there's also looking at somebody else's interview that knows the individual, a loved one, or, you know, a partner, and they give a commentary that says, you know, they go to work every day; there's no problem. And then they're complaining that, for example, on workers' comp cases, they can't move, you know, and they're not able to, like, mow the lawn, but then they're caught mowing the lawn.

So there's just a lot of different ways, basically, to assess malingering. And no one is going to be definitive, but the combination thereof can be suggestive of malingering and consistent with it. But it doesn't -- one thing that's important, though, in talking about the malingering, is that it doesn't mean that the person wouldn't have, like, genuine problems or anything, like mental health issues or even some cognitive problems. It's just that they can have the problems, but may be exaggerating the problems.

Q So would it be inconsistent for someone to

exaggerate a symptom and also be incompetent? Can those two things exist in the same world?

A So they can, yes.

Q And do you feel it's important to use a lot of care in diagnosing someone as a malingerer?

A Malingering, unfortunately and fortunately, has a negative connotation, and once it's put in the record, it's pretty much an anchor that's used to wrap around every time it comes up.

Now, the truth is, a person can be malingering and exaggerating on one occasion and then not on the other occasion. For example, in cases where I come to the attorney and say that person is really faking and they're not on board. Talk to them because, you know, this is something that's going to be definitive. And then their level of cooperation might change. It might actually change, and then they become more credible in terms of the information they're actually providing. So, definitely, a malingering diagnosis can change. It will remain in the records, but a person can be cooperative on one occasion but not cooperative on the other. So it's variable.

Q And if, for example, a person were found incompetent by a number of experts but was also found to be, for example, exaggerating symptoms, would that automatically make him competent?

A It -- no, and it's an issue that comes up frequently within my experiences as a forensic psychologist where -- and I'll just give an example to explain. If, for example, a person is not competent or deemed to be not competent from the psychologist's perspective or the forensic psych's perspective, but then they get jail calls and they listen to the jail calls, and to some extent they demonstrate some knowledge of the case, certainly, it is definitely important to consider whether or not that would suggest complete competency, but it wouldn't definitively say they're competent because they had a meaningful conversation with their family member. So it's something that requires a lot of care from the standpoint of there can be some -- what is perceived as exaggeration on testing or observations, but the person could still be not competent.

Q Because it wouldn't really be consistent with professional diagnosis that a finding of exaggerating symptoms in the past would mean that a person is competent in perpetuity, forever, right?

A I want to make sure I understand that.

THE COURT: I didn't understand it either.

Sorry.

BY MS. RUSSELL:

Q So just as a hypothetical, if there was a past

finding of malingering or exaggerating symptoms --

A Correct.

Q -- and that led to a finding of competence, that doesn't necessarily mean that because there was a past event or past accusation of malingering that that would make them sort of competent in perpetuity, or always malingering?

A I think I understand the question, and I think I'll say it back to make sure I answer it properly. So if at one point the person was found to be malingering on testing or by virtue of phone calls, and then the courts say, okay, deem them competent, they could still at some point be not malingering and incompetent at a different window of time.

Q Because competency waxes and wanes, right?

A Correct.

Q Can symptoms of depression ever be mistaken for malingering?

A Yes.

Q How is that?

A So mental health disorders, such as depression, impacts memory. And it's a differential that has to be considered because a person can be slowed -- and when I say "slowed," slowed verbal processing, receptive expressive processing, and also physically slowed by

depression. It's one of the symptoms. So there may be some short-term memory problems observed and some inability to communicate because depression does impact memory and concentration and can affect the person's ability to sustain concentration.

Q Mr. Mosley always presented to you as slow?

A Slow in responses and slowed in motor responses. In other words, just generally in responding to questions and interacting, he was very slowed.

Q Can symptoms of psychosis ever be mistaken for malingering?

A So on a continuum, in looking at malingering with psychotic symptoms, there are tests that utilize what we call "base rates" for symptoms and unusual symptoms, atypical symptoms, such as the Miller Forensic Assessment of Symptoms Test, and if they score beyond a cutoff, it could be indicative of malingering. At times it can be also be gross psychosis, but it can be indicative of malingering.

And just as an example, you know, I -- I only hear voices when I've lost weight. I only hear -- you know, there's -- there's kind of bizarre questions they'll ask, and sometimes they'll be endorsed -- or I hear voices continually for two weeks in a row nonstop, or I only see visual hallucinations that are black and white. So

there's just these atypical type of symptoms on this test that will help to determine if, in fact, the person's endorsing something that's odd and atypical of the diagnosis of psychosis, which would raise the issue of them exaggerating deficits.

Q But are the actual symptoms of psychosis ever mistaken for malingering, or not so much?

A Sometimes. Sometimes they are. The persistence of the symptoms and the response to medication is a big part of that, too, because if, for example, a person is medicated and they -- you know, they're appropriate medications, and they still are acting like they can't understand, talking about atypical symptoms, then that would go more to the issue of, you know, it being more of an exaggeration of the psychotic symptoms.

Q So exaggerating a symptom really is not inconsistent with a diagnosis of depression?

A No. I mean, a person can have a genuine -- I'm gonna try to make sure I understand this. A person can have depression. A person can have schizophrenia. They can still exaggerate deficits and still be genuinely mentally ill, but they use the term "playing the system" or, you know, that type of thing. But you can have genuine mental disorders and -- and a lot of that is borne out in history. Have they ever been treated for mental

disorders prior to encountering the legal system? So that would be something to look at if, in fact, there is a documented history of psychotic symptoms or depression. And when they entered into the legal system, it negate the fact they have a mental disorder, but because of various reasons there may be some exaggeration.

Q When you say a prior mental health history, that would be things like prior Baker Acts or suicide attempts?

A Correct.

Q All right. Dr. McClain, I'd like to talk to you a little bit about neuropsychological testing.

A Sure.

Q In general, what is neuropsychological testing?

A So neuropsych testing, basically, is testing utilizing specific tests that will assess a person's cognitive functioning. Those tests are objective. They're standardized on a demographic group that's consistent with the population that the evaluator is gonna be conducting the evaluation on. Meaning they take the same age levels, education levels, race into consideration, gender, and then, basically, the neuropsychologist selects tests that will specifically assess a certain function, such as memory functioning, immediate, short-term and delayed memory functioning, orientation.

An example would be the Wechsler Memory Scale that's used. It's a very complicated test, but it helps to tease out verbal learning and maybe even delayed visual and verbal memory. Basically, you know, processing type of deficits. That sort of thing.

There's also what we call the Delis-Kaplan, which is a battery of frontal lobe tests, if you will. It's thrown into one. You can pick and choose whichever one you think is more important. Like trail making is an example. It's highly sensitive to organic damage.

But, basically, those types of tests will look at, for example, processing speed, motor speed, looking at shifting sets, which is more of a frontal lobe function. It means being able to shift categories. For example, if I said, Okay, I want you to go -- I'm gonna time you. I'm gonna have you go from number to letter, number to letter, number to letter. Like, A to 1, 1 to B, B to 2. So kind of a sequencing test, and it'll look -- you know, extrapolate from that and look at, okay, are they having deficits in processing like executive -- we call that executive deficits because it's associated with the frontal lobe functioning.

Q Hundreds -- fair to say there are hundreds of neuropsychological tests?

A There are.

Q And you are an expert in selecting the right test for the right situation?

A So that's -- part of my job is to try to be appropriate in what test I select so that answers the referral question, especially in forensics, be it in a civil case as opposed to, like, a criminal case, to be able to say, okay, why does that the affect, for example, their ability to get a job; why would that affect their ability to be competent. And the biggest area that I see within the neuropsych as applied to competency is if there's general organic impairment due to, like, head trauma or due to some type of underlying organic issue.

Q An organic issue can also be intellectual disability?

A Correct.

Q So does a person have to be competent for accurate testing?

A So, no, but the person needs to be stabilized. If --

Q Could you explain the difference?

A Sure. So I could have a person who is intellectually disabled but not psychiatrically impaired and I can do testing with them. Even though they're incompetent, they want to get a baseline of their intellectual functioning. So if they are stabilized for

mental health issues or have no mental health issues, I can still do testing that might yield an IQ of 40 or 50, and then I can answer a question for the courts of I think the reason they're incompetent is they're intellectually disabled. But them being incompetent would not preclude me doing testing with them. What is more factors that would affect testing are like psychotic type of symptoms, severe depression, behavioral issues associated with conditions like autism, where the person can't sit still or complete the testing due to, like, rocking back and forth, head banging, you know, some extreme disorders like that, or just profoundly nonverbal and can't really be tested because they have no verbal ability.

Q So when you choose a test, you take into consideration many of the attributes of the person you're testing?

A Yes.

Q Whether it be concern about a certain lack of function or, for example, a learning disability or cognitive problem?

A Correct.

Q So why is neuropsych testing different than just talking to someone?

A Neuropsychological testing has the advantage of being objective testing. And couched within that there is

what we call "malingering testing" that's done through embedded measures within the test itself where it's not a specific malingering test, but there's measures used within a test that helps you to look at whether or not there might be some exaggeration.

For example, in the Wechsler Adult Intelligence Scale there's Reliable Digit Span. So you look at the Index of Reliable Digit Span to see if it's actually valid because it could impact the entire interpretation of the test.

So, basically, in neuropsychological testing, it allows you to get a pretty darn good baseline of their overall functioning cognitively. Even on a screen like the Repeatable Battery for the Assessment of Neuropsychological Status, it allows, basically, for you to see immediate and delayed memory, attention concentration, visual-spatial constructional skills. So it's comprehensive.

Q Are you familiar with a test called the Inventory of Legal Knowledge, or the ILK?

A Yes.

Q What is it?

A Basically, it's a test that looks at a person's response to being involved in the legal system and their general knowledge of legal concepts. And so it's a brief

measure, but it does give an indicator of whether or not the evaluator thinks that they may be underreporting knowledge of the legal system. And it's not specifically defining competency, whether they're competent or not competent, but it does yield a suggestion of whether or not the person might be underreporting their knowledge of general legal concepts. So it could impact their perception of their cooperation with the evaluation and/or contribute to an interpretation that they're feigning legal incompetence.

Q Do you routinely use the Inventory of Legal Knowledge, or the ILK?

A I do not.

Q Why not?

A So what I do, I basically approach the evaluations for competency from the standpoint of just addressing the psychosocial history, doing a forensic interview. As to are there suggestions of faking or malingering, sometimes I'll use what we call the "M-FAST," Miller Forensic Assessment of Symptoms Test. The cutoff is six, and it will give me an idea if they are malingering psychiatric symptoms.

Or if it's, for instance, cognitive, I might do the Test of Memory and Malingering. That would give me a measure of whether or not they fall within the

below-chance level. And just to explain, it's essentially a test that would look at their ability to identify common objects and retain them over time, two trials, with a recognition trial.

So those are the two that I routinely use. I do occasionally use a very brief measure if there is someone who's intellectually disabled and it's just possible cognitive impairment called the Rey 15 Item Test, but it's only a brief measure.

Q So in terms of the ILK, you are saying that you prefer to use the M-FAST and the TOMM because you think they're better tests?

A So -- so there's limitations on some of the tests. Because of the areas I work in with brain-injured, intellectual disability, autism, some of the tests that are developed have limitations for the population that I typically am working with. Meaning that they're not normed on intellectual disability individuals, so they may give a false positive. Meaning that they're identifying them as malingering when they aren't really malingering because maybe they didn't comprehend the questions or don't have the vocabulary to, you know, really get the concepts. So they might be just guessing or they might just randomly -- "Christmas tree" we call it. They're trying to look like they know something, but it's really

doing the reverse.

So I try to look at and always take into consideration -- and, again, I have deep respect for the authors of the Inventory of Legal Knowledge, including Dr. Otto, but I'm careful because there are some limitations within the population of organically impaired or intellectually disabled.

Q So you've never used the ILK on someone with a cognitive impairment?

A No.

Q Because?

A Well, there's fifth grade reading level. This is poorly administered to them. There's a fifth grade reading level required, and unless one knows and has done testing to look at their comprehension level or knows from academic records what their comprehension level is, there can be some difficulty with their understanding of some of the -- the words, the context of the words. So it just can be problematic unless you have a lot of history on the person. Just in terms of, you know, like comprehension level.

Q So you're aware that Mr. Mosley was given the ILK at the state hospital by Dr. Jones?

A Correct.

Q And you had the chance to review the data?

A I do have the data, yes.

Q Do you notice anything about his test responses?

A Well, just that -- just for clarification, because this is an objective test that's done, the -- the Independent Legal Knowledge Test, it does show up as a low score of 26 -- the ILK total score is 26, whereas, you know, the expected norm is gonna be approximately 47. So it's below the level that would be expected. But as far as the -- there's no, like, verbal commentary on it or anything like that.

Q What does that tell you about whether or not Thomas Mosley was malingering or feigning, if anything?

A So it does fall within the category of the hypothesis of possible malingering. So, definitely, it is below the level that would be expected given the age norms and the reference sample.

Q And is there reason that might be true?

A Well, there's multiple reasons that it could be true, but just from the face value, you know, it falls within the range of exaggeration based on that test alone. And this is specific to -- of the general legal concepts that I'm referring to. Okay? So it's not psychiatric in nature. It's more knowledge of the legal system.

Q Does that test tell you that Thomas Mosley was malingering or feigning?

A No, but what it does tell me is that it's potentially a possibility there is malingering. It also brings up the issue that was brought up before of comprehension level because in the records it does suggest there is verbal and reading deficits, so his oral comprehension, but also whether or not there was any psychiatric symptoms that might have impacted him as well. So there's some concerns about that.

Q But Dr. Jones didn't take any notes to indicate whether any of those things were happening at the time that she gave the test, correct?

A Well, I can't infer what Dr. Jones did to determine comprehension level or expressive level. I just have the data itself.

Q Dr. McClain, I'd like to talk to you a little bit now about the SIMS test.

A Sure.

Q What is the SIMS?

A The SIMS is another malingering measure that, basically, is 75 items that have different scales that are designed to look at the person's answers to questions concerning, for example, affective disorders, such as depression, neurological impairment, psychosis or psychotic symptoms, amnestic symptoms, and then limited intellect.

Q And do you know anything about how the SIMS was normed?

A So the SIMS was normed, basically, on a limited population. Predominantly, there were a lot of female representation on it, but it also was normed on individuals who were asked to fake those particular disorders.

THE COURT: Counsel, we've been going for like an hour and a half. I'd like to give the court reporter a break, if you don't mind.

MS. RUSSELL: Sure. I, honestly, have probably ten more minutes.

THE COURT: How are you doing?

MS. RUSSELL: But we can take a break at any time.

THE COURT: Can you do ten?

THE COURT REPORTER: I can do ten.

THE COURT: Okay. Let's do ten.

BY MS. RUSSELL:

Q Are there reasons not to use the SIMS for people with cognitive deficits?

A Really, it's very similar to the independent -- the Inventory of Legal Knowledge, the same thing as fifth grade comprehension level. There's also issues about true genuine organic deficits, if a person is organically

impaired. As an example is if they've had any head trauma or they're limited intellect, there can be a problem in terms of comprehending questions and responding to them. So it's the same factors that are really present for the Inventory of Level Knowledge as well.

Q And you're familiar with the literature -- the academic literature that says that the SIMS can often overstate feigning in populations of people with fifth grade or lower reading level or people with cognitive impairment?

A So, actually, there is also a whole 'nother category if they're severe pathology, and what they mean by "pathology" is their psychopathy, such as psychosis, that it can definitely impact the outcome and the interpretation of it. That's why in the manual they'll talk about, you know, take into consideration those factors within the context of the person and their history because the test itself, you -- like if you get one of these and you say, oh, they're malingering, without knowing the individual's background and whether there's been legitimately academic problems, limited intellect, mental health diagnosis, it wouldn't be accurate. So it has to be interpreted within the context of that particular person's history.

Q Knowing what you know from Thomas Mosley's

school records, is there a reason you wouldn't have given him the SIMS?

A So I personally, just as my preference, would not have given him that for several reasons, one being academic, suspected limited intellect. But, also, even related to, like, comprehension issues, whether or not he would really accurately understand what I was reading to him, especially in light of the fact that there may be active psychotic symptoms at the same time.

Q Did you get a chance to look at Dr. Jones' data --

A I did.

Q -- of the SIMS?

Was there anything that stands out to you?

A So, basically, it's scored properly. And I don't have any notations. There's no notes on it or anything. It's just that I can tell you that the cutoff is what was considered to be 14 -- just one second -- and his is 39.

Q And what does that tell you?

A Well, one, that it's -- it would be suspected that there's some exaggeration of the symptoms for whatever reason because the cutoff is, of course, 14, and all the scales that I mentioned earlier, he's above the cutoff across the board. So it's not like one scale he's

lower than the cutoff, but just in general, across the board, he falls above the cutoff. That would suggest malingering.

Q When you take these two tests and that raw data, along with your four behavioral evaluations and all the information that you've reviewed, do you think that Mr. Mosley is feigning or malingering?

A So I -- I think it's an excellent question, and it's complicated from the standpoint of the testing that was done on the malingering, I don't have evidence that his comprehension level was ascertained or his ability to understand it was determined before they gave it. And I don't want to speculate about what Dr. Jones did to make sure that he was comprehending it because I don't have notation on that, but I would just question the reliability of the results only because I don't have the baseline of his overall intellect. I do have a baseline of his academic functioning that suggests there were comprehension deficits. But I wouldn't conclude based on those two tests that he's malingering.

Q Dr. MacClain, is IQ testing required for an I.D. diagnosis --

A Yes.

Q -- intellectual disability?

A Yes, ma'am.

Q And why is that?

A So the criteria for diagnosing intellectual disability has several things that are important to consider. One is that the person had the testing done or demonstrated intellectual deficits prior to the age of 18 and that they were defined by an objective test, such as the Wechsler Adult Intelligence Scale or the Wechsler Intelligence Scale for Children or another similar test like the CTONI-2 or 4. Preferably, the Wechsler or the Stanford-Binet Test, and that it shows that they are based -- based upon the average, which is 100, that they are two standard deviations below the average, plus or minus the standard error of measurement, which is considered to be 3 to 5 either way. Meaning that, essentially, 70, which is two standard deviations below, plus or minus 5 points, so 65 to 75.

But that said, they also have to demonstrate adaptive deficits on a standardized measure, such as the Adaptive Behavior Assessment System. That would show that an area, such as communication, health and safety, life skills, various areas like that, social skills, that they demonstrate the same thing, extremely low performance under adaptive skills as well.

Q Is Thomas Mosley stabilized enough in your opinion that he could give accurate IQ testing?

A So, currently, I don't think the IQ testing would be accurate only because I think that still there's the evidence that he's not fully stabilized for the mental health symptoms. I do think adaptive measures can be done simply because a collateral could answer those questions. But I don't think that the IQ testing at this point in time would be accurate only because I think he still requires further stabilization.

Q Thank you, Dr. McClain.

MS. RUSSELL: Give me one second.

THE COURT: Sure.

BY MS. RUSSELL:

Q You said that Mr. Mosley was above the cutoff on scales on the SIMS and the ILK?

A That's correct.

Q And you said that's consistent with potential malingering?

A Correct.

Q But it's also consistent with comprehension deficits?

A It's con -- it, basically, raises a question of why the result is what it is. And so it -- it -- on the decision path, it has to be determined, okay, could he comprehend what was being asked because it was orally administered, and was it for some other reason, such as

limited intellect, low functioning and/or a neurological impairment that the results were that elevated.

Q When did you receive that data about Mr. Mosley's testing from the state hospital?

A I believe I received it -- I think it was Tuesday.

MS. RUSSELL: Okay. I don't have any further questions at this time.

THE COURT: Okay. We're going to take a ten-minute break. We'll come back at 2:55.

Dr. McClain, you're still on the stand. Okay?

THE WITNESS: Thank you, your~Honor.

THE COURT: Mr. Mosley, if you need to use the restroom, now would be a good time to do that. Okay?

All right. We'll be back in ten.

THE BAILIFF: All rise. Circuit court is in recess.

(RECESS)

THE BAILIFF: All rise. Circuit court is back in session.

THE COURT: You can have a seat. Thank you. I'm ready if you are.

CROSS-EXAMINATION

BY MS. SULLIVAN:

Q Good afternoon, Dr. McClain.

A Good afternoon.

Q I'm gonna try not to jump around too much, but if at any point you're not sure what evaluation or what I'm -- what timeframe I'm referencing, please let me clarify. Okay?

A No worries.

Q Starting with some basic stuff, you were hired initially confidentially by defense in this case, right?

A That's correct.

Q And I think you talked extensively about your court-appointed employment, but you were not court-appointed on this case?

A Not on this case, no.

Q And, in fact, if we needed a court-appointed doctor, you would not be able to be appointed because you were hired by defense, right?

A Not without the Court's approval of that.

Q Okay. In terms of your education, are you -- are you still currently board certified in neuropsychology or not?

A No.

Q Okay. Is that something that you have to every

few years redo or how does that work?

A No, no. It's something that -- board certification changed. So at one point, according to the standards of board certification for the American College of Forensic Examiners, I was board certified, and then they changed the standards from just having your doctorate, experience, and expertise to a whole 'nother level. And at that point because of the time involved in reapproaching it, I let it go because, my thinking was, it just would take too much time to do that.

Q So it's not board certification that drives you being able to say you're a neuropsychologist. It's your educational background to your post-fellowship, all of that training and experience that you have, right?

A Correct.

Q Let's see. You met with Mr. Mosley in May and June of last year and then again in March and May of this year?

A That's correct.

Q Am I getting those times right?

A Yes, ma'am.

Q Back when you evaluated him a year ago, he provided you some background information about himself, which you did include in that first report, right?

A Yes, ma'am.

Q He told you about his family?
A Correct.
Q He told you about his prior employment?
A Correct.
Q He denied any family history of mental health issues?
A Correct.
Q Same thing with any substance abuse issues?
A Correct.
Q He denied any prior head injuries, right?
A That's correct.
Q And that was all information that he self-reported to you?
A Yes, ma'am.
Q Okay. We've talked about his high school transcript a bit. So you're aware he did not complete high school?
A That's correct.
Q Are you aware of any truancy cases that Mr. Mosley had for not going to school?
A I'm aware that he did have a history of truancy in high school.
Q Okay. And so the time period that you saw in the transcript, that was high school, right?
A Correct.

Q So you would agree with me that not going to school, that could also influence getting bad grades?

A Absolutely.

Q Okay. So the discussion you had with Ms. Russell about whether it's a cognitive reason that he has bad grades, it also could be because he wasn't going and he wasn't participating in high school?

A That's definitely a hypothesis, yes.

Q Okay. And you only had, essentially, about two years of transcript for any grades he received, right, in his education?

A That is correct.

Q The history and the background information in your newest report from the two recent evaluations, it's the same as the first one. Did you ask him anything differently? Did you talk to him about his history again?

A No.

Q All right. In the section for -- in both reports for mental status and behavioral observations --

A Correct.

Q -- those two reports, they're a year apart, right?

A Correct.

Q And they have the same information, again, listed in it for those sections, right?

A Correct.

Q It appears, I think, the only differences are that you added that -- the third and fourth visit in the second report, you said you went to see him?

A Correct.

Q And then there's no new observations or self-reports noted in that newest report, right?

A The only thing that I clarified was that I was going to be specific that under Speech and Language it remains slowed, and he did continue to be -- appeared distracted by internal stimuli.

THE COURT: Where are you reading from?

THE WITNESS: Your~Honor, it would be third, fourth, fifth, sixth line down. Five and sixth line down, his speech and language were slowed.

THE COURT: I see it. Thank you.

THE WITNESS: Yeah. That -- there was, I think, some exacerbation that was noted during the second evaluation. During all four, he did consistently express he experienced auditory hallucinations and visual hallucinations.

And then I also talked about, in the second one, where he's got -- you know, he talked about he sees blood in the eyes, specifically talked about that.

In the first one, it was blood inside the showers that triggers images, talked about that. Also paranoid ideation.

So very similar. And it wasn't really any definite difference in, you know, the symptoms being lessened in any way. It still appeared to be very prominent.

BY MS. SULLIVAN:

Q Okay. But you would agree with me that other than the sentence -- so I'm looking at your fourth sentence under Mental Status and Behavioral Observations in the second report.

A Okay.

Q "During the third and fourth visit, he was seen in an evaluation room in the mental health unit."

A That's correct.

Q That sentence, and then the sentence -- probably three sentences below that, "During all four evaluations, he reported experiencing auditory hallucinations and visual hallucinations."

A That's correct.

Q Those two sentences are the only differences in those two paragraphs between the two reports, right?

A Yes, ma'am. That's correct.

Q Okay. So everything that is stated in the

second report is something that you have indicated occurred on those first and second evaluations, right?

A Absolutely correct.

Q Okay. So how do we know the difference between what you're saying on the first, the second, the third and the fourth evaluation?

A Basically, his symptoms were consistent.

Q Okay. Did he say the exact same things to you when he was talking about seeing blood and -- obviously, the shower incident was one incident, right?

A Correct.

Q He came out of the shower. What visit was that?

A That was the very last visit.

Q Okay. So that was -- that didn't occur every time you talked to him?

A I'm sorry?

Q That he didn't -- he hadn't just come out of the shower every time you had an evaluation with him?

A No. That's correct.

Q Okay. So that recorded hallucination about seeing blood after being in the shower, that's different than the first, the second, and the third time that --

A It's different from the standpoint that he still had to express that he experienced that, but it was more proximally related to talking with him right after he had

showered. So it was something that he was still experiencing. So that was important because it actually was, in the moment, him experiencing that particular symptom, which I found was significant. But as to the consistency, yes, he was consistently, mental status, very similar every time I saw him. There really wasn't a remarkable change or something that suggested the symptoms were lessened in any way or that they worsened to an extreme degree.

Q Okay. And because what you've written is the same, is that -- in terms of distracted by internal stimuli, are you seeing that every -- all four times you meet with him?

A Absolutely.

Q Okay. Did you review Dr. Hall's report at all? He was the other confidential hired doctor by defense.

A I have not seen Dr. Hall's report.

Q Okay. He also testified a couple weeks ago, I think now, or last week. I'm not sure. In his opinion, Mr. Mosley's psychosis appears better this year. Are you disagreeing with that? Are you saying it's the same, nothing changed?

A So I didn't see a change.

Q Okay. You were the only doctor that has noticed that Mr. Mosley appeared distracted by internal stimuli.

Three of the doctors who have evaluated him, some of them also --

MS. MANUELE: Objection to counsel testifying.

THE COURT: What's your question?

BY MS. SULLIVAN:

Q Some of them didn't see that. Is that surprising to you?

A Not at all.

Q And why is that?

A I think the examiner is different how they ask questions and their observations. When I met with him, he did appear to be distracted by internal stimuli. There would be long pauses before he responded, and I would ask him what is -- you know, What is happening or what's going on? And he would say that he does hear voices. He wouldn't be necessarily specific to volunteer that. Like, unless I asked him, he wasn't gonna say he's hearing voices, but he would look away or he would be very distracted and, you know, it was clear that he was experiencing psychotic symptoms.

Q Okay. He doesn't have a history of psychosis, right?

A He has a history of being hospitalized with major depressive episodes.

Q But not with psychosis?

A I didn't see a diagnosis of psychosis in records, no.

Q Okay. So from what information are you drawing your conclusion that he's psychotic?

A From the observed symptoms that I saw during the interviews with him, and his symptoms consistent with the *DSM-5-TR* which would define that as a psychotic symptom if you're having an auditory hallucination or visual hallucination.

Q And it seems that -- and correct me if I'm wrong -- that that's coming from his own self-reporting, him telling you I'm seeing blood, right? I'm hearing voices telling me to kill myself. It's himself self-reporting that to you?

A Well, that would be correct.

Q Okay.

A Absolutely.

Q You noted during your visits with him that he reported a good appetite?

A He did.

Q And a good sleep pattern?

A Correct.

Q Talking about the major depressive disorder diagnosis, what criteria in the *DSM-5* are you finding that he meets for that?

A So, historically, he has been identified as having major depression from the hospitalizations and suicidal ideation. So that would represent historical periods in which he's been diagnosed and hospitalized for depression and for symptoms of suicidality. So, historically, that's important, but his flat affect, psychomotor slowing, persistent depressed mood were very consistent --

THE COURT: All right. Let's hold on for a moment. I'm not sure what's going on here, but I need the courtroom to be quiet.

Thank you, Deputy.

Can you repeat your answer, please.

THE WITNESS: Absolutely, absolutely. So throughout the interviews that I had with him and behavioral observations and also documented in the mental health records from the hospitalizations or Baker Acts, he's diagnosed with depressive episodes that lead to hospitalization. He also very consistently demonstrated psychomotor slowing, verbal slowing, depressed mood, flat affect, suicidal ideation, passive or active, when he was hospitalized. So in looking at those records, coupled with my observations, very consistently I found him to exhibit depression, major depression.

BY MS. SULLIVAN:

Q You also mentioned cannabis use disorder, right?

A Correct.

Q And from his reporting to you, he told you he used marijuana daily from the age of 13 up until arrest?

A That's correct.

Q Okay. At least for the -- during the time period when his historical records show past depression, so prior to him being in Pinellas County Jail --

A Correct.

Q -- when, by his own report, he would be using marijuana every day, couldn't that be attributed to the physiological effects of a -- the past depression be attributed to the use of marijuana every day?

A So your question is excellent, and the way that that is decided is looking at the differential diagnosis in the *DSM-5-TR* where one of the things that you have to rule out is is not better explained by substance-induced disorder.

Q Right.

A But the difference is this, that he is still exhibiting those symptoms absent being on cannabis, and they're also medicating him with medication, but he's still exhibiting the symptoms. Whereas, if it was just substance induced, you would expect the symptoms to remit

and not be there anymore.

Q And, again, I know you said from the historical records and him reporting the suicidal ideations. What about other areas of his everyday life? Are you saying that he's showing the signs of major depressive disorder?

A So in terms of other areas of his life, right now all I have as a benchmark is him in jail and in custody. So I'm not seeing him out there trying to get a job or how he might be affected by it socially and occupationally, which is really what the key issue is, is if it's major depression recurrent, it's gonna significantly impact social and occupational functioning.

So I do see that in his school records it's clear that he's got truancy, but for what reason? I don't know if it, perhaps, was from severe depression that he wasn't going to school, but that would definitely be an area that would have affected his functioning that's obvious in the records for whatever reason.

Q And for the -- I think Ms. Russell asked you that when you're looking at the competency status over time and the factors that you look at for that, you talked about whether you're on medicine, whether you're compliant with the medicine and whether that medication has changed, right?

A Correct.

Q And have you -- are you aware that his medication has remained the same since he came back from the hospital up until today?

A So, yes, I am.

Q Okay. So he's consistently been on the same medication since he's been returned from the hospital?

A So, yes, and I believe that's olanzapine, mirtazapine, hydroxyzine, and I believe ibuprofen. I believe he was also given Vistaril.

THE COURT: Given what?

THE WITNESS: Vistaril.

THE COURT: Okay.

THE WITNESS: It's for anxiety. And I think, just to clarify, this was my records from the hospital, from South Florida Evaluation and Treatment Center, lists that he was diagnosed with affective disorder unspecified and that those were the medications given to him there at the time that he was at the hospital.

BY MS. SULLIVAN:

Q Okay. In terms of testing, so you have not up until today done any cognitive testing on Mr. Mosley?

A Well, I haven't done any today either, but I haven't done any testing with him, no.

Q And no malingering testing?

A No.

Q No neurological, no IQ testing?

A That's correct.

Q And I think you said the reason for that is he isn't stable enough to do that?

A That's correct.

Q Okay. So if the hallucinations and the auditory and visual, what he's reporting -- he's self-reporting that he's seeing this. As long as he's telling you he's seeing things, are you just not gonna do any testing because, in your mind, he's not stable enough?

A So, no. It's actually the opposite. Just to kind of explain, the hospital diagnosed him with a legitimate mental health disorder, but also raised the issue of malingering. So I think there are several things going on. But he is on medication which would suggest they saw some legitimate reason to medicate, otherwise it wouldn't make any sense to medicate if it's just malingering.

So I'm trying to really comprehensively look at that and say what could be potentially the problem. And the thing that I think is important is that his stay at the hospital fell far short of what is normally seen. Like three weeks -- it's usually three months is the limit, the cutoff, right, and they try to get them in and

out in three months. This is like three weeks. So my concern is that, given the gravity of the situation, making sure that this optimal psychotropic cocktail is optimal so that he's able to mobilize and utilize what brain powers he has to go forward on his case. So, to me, I would love to do testing with him. And I have a lot of academic questions about what's going on that, you know, just to solve the problem and figure out, you know, what the causality is in this.

Q Uh-huh.

A But I think he could be stabilized. I think he could become competent. I just don't think enough time was spent getting him to a stabilization place and exposing him to competency training.

Q But again, and I know you're not -- I know you're not a psychiatrist and I know you're not in charge of his medications, but --

A Absolutely correct.

THE COURT: Well, hold on. If he's -- if he's gonna be exposed to competency training, he's already answered the questions for you about the role of everybody --

THE WITNESS: Correct.

THE COURT: -- which is a huge portion of competency training --

THE WITNESS: Absolutely correct.

THE COURT: -- right? I mean, really, competency training isn't gonna help him discuss anything with his lawyer or testify relevantly, which are the two factors, really, that you're concerned about.

THE WITNESS: Yes and no, your Honor. I think that it is relevant because there are other defenses potentially.

THE COURT: I understand that, but when we're talking about competency training, generally speaking, you get updated reports about whether or not they're able to pass the test about --

THE WITNESS: That's correct.

THE COURT: -- who the judge -- what I do, what these folks do, and so on and so forth. So is it really competency training that he needs?

THE WITNESS: Your~Honor, I think that given the fact that he has been able to answer the basic questions in a basic way, I would agree with you completely. I think that what I'm focusing more on is the hospitalization and stabilization education.

THE COURT: I understand the perspective on that. I'm not arguing with you on that. I'm not arguing with you, period, but I just want to make

sure I understand. I don't -- I mean, from everything I've heard from you and everyone else, I don't know that it's -- what we'd consider traditional competency training of understanding everybody's role in the courtroom and what the sentence is and how a trial works and all that is necessarily what he needs. He's passing the test by all of the folks that have testified so far. I'm gathering that your concern is he's not stable on his meds.

THE WITNESS: I would agree.

THE COURT: And he needs to, essentially, get his depression under control before he can talk to his lawyer about the facts of his case, right?

THE WITNESS: I would agree, your~Honor.

THE COURT: Okay. Sorry to interrupt.

THE WITNESS: No worries.

BY MS. SULLIVAN:

Q But in terms of the medication, he's -- he's been seen by multiple doctors even since he's been back. He -- one was a psychiatrist, but his meds have remained the same.

A That's correct.

Q Okay. My next thing I was gonna talk about is the criteria itself, so I'll move into that.

A Sure.

Q So, basically, in your opinion what we're talking about is criteria four and six?

A That's correct.

Q If it is truly the mental health issues affecting criteria four and six, then how is the mental health -- how is it only -- how when he -- I want to make sure I'm clear on this. He's acceptable on the other criteria in your opinion, right?

A Yes, ma'am.

Q Okay. So the mental health diagnosis is not playing an issue into those criteria, right?

A I don't think it is, no.

Q Okay. But when we get to four and six, specifically four and six, all of sudden it -- the mental health issues are what is impeding his ability to be acceptable in those categories, right?

A Correct.

Q Okay. But four and six are basically when we get to the point where Mr. Mosley would have to talk about his case and disclose information, kind of get into the nuts and bolts of why we're all here, right?

A That's correct.

Q So I think what it kind of comes down to, and we've had this conversation with the other doctors, is

whether he is truly unable to talk about criteria four and six, whether he's truly unable to disclose pertinent facts to his lawyers and he's truly unable to get up on the witness stand and testify relevantly about his case, or if he is simply unwilling to do that, right?

A Right.

Q Okay. And if he's unwilling to do that, that doesn't equal incompetency. That's just an unwillingness to talk about it?

A That's correct.

Q Okay. Versus, if he's unable, then you kind of have to dive a little more into what's causing him to be unable, and that could lead to incompetency, right?

A That's absolutely correct.

Q Okay. So that's kind of where -- all of this other stuff aside, that's kind of where we are in this on criteria four and six and why he won't talk about his case?

A Correct.

Q All right. So I want to ask you, when you -- lets start with criteria four.

A Okay.

Q When you're -- you know, can he -- this person discuss and disclose the pertinent fact to his attorney, what specifically did he say to you when you asked him to

talk about that?

A Absolutely nothing.

Q Okay. So did that mean he just stared at you?

A He didn't provide any responses. He just at one point said something like snapped, and that's it.

THE COURT: He said what?

THE WITNESS: My quote of what he said was, "Went black. Snapped, went black." That was the only response I got.

BY MS. SULLIVAN:

Q Okay. And that was in response to you asking about the facts of this case?

A Correct.

Q Okay. He didn't say to you I don't know?

A He didn't say I don't know.

Q Okay. So I think what you're telling me is either he was nonresponsive to you or he said that phrase that you just told us?

A He was responsive to me.

Q Okay. Well, how was he responsive to you?

A That he provided an answer.

Q Okay.

A He didn't say I don't know, but it wasn't clear to me that he had a recollection of what actually went down.

Q Okay. Would it matter -- would it -- would you -- would it have any bearing on your decision if he's told not to talk about the facts of this case to anybody, if you knew that information?

A Well, I think that's always the case that they're told not to talk about the case, but the -- he didn't say I'm not supposed to talk about my case, so I'm not going to talk about my case. I need my lawyer present. Typically, people will commonly tell me that, I'm not gonna talk about my case.

But I'll even ask a question just like, What did they say happened that led to you getting arrested or what did they say happened, and there was not a response to that.

Q When he told you that he just snapped or blacked out, or whatever it is he said, did you ask follow-up questions about that?

A He didn't have any other response other than that. He said he blacked out.

So I said, Do you remember anything else?

And he said, I blacked out, snapped.

Q Okay.

A There wasn't any elaboration of that.

Q And then the same for criteria six about testifying relevantly. Do you remember specifically what

you asked him and what his response to you was?

A So in terms of testifying relevantly, that really has more to do with the interactions that I had with him and then anticipating how he's gonna respond in court to questions or taking the stand. And based upon my observations and interactions with him, he did not demonstrate the capacity to do that on all occasions.

Q Okay. Because of his depression or he didn't want to?

A I don't think it's about that. He didn't say, I'm not gonna take the stand. I'm just saying that based upon his mental condition when I interacted with him, it posed a problem potentially for him being able to participate in the proceedings relevant to his case.

Q Okay. The malingering, you didn't do any malingering testing. I think we covered that, right?

A I didn't, no.

Q But you -- you've had the opportunity to review the raw data, and have you reviewed Dr. Jones' report from the facility --

A Yes, ma'am.

Q -- about her finding?

A Yes, ma'am.

Q Okay. You didn't see anything wrong with the way she did her testing, right?

A So I don't -- I know that she mentions that she orally administered it. The only thing I don't know is if there was any type of psychometric testing done to determine comprehension level.

Q Okay.

A So I don't -- I can't infer that, but I know that it appears that she orally administered it.

Q And so with these tests -- and correct me if I'm wrong, but it's a series -- it's multiple-choice questions, right?

A So true-false question. The ILK is true-false questions to 61 items that have bearing on their knowledge of the legal system.

Q Okay. And so if per Dr. Jones' report she orally administered, meaning she orally asked the question out loud, right?

A Correct.

Q Okay. And he would give an answer?

A Correct.

Q And then she would document the answer?

A Correct.

Q Okay. And then a score gets tallied up?

A Correct.

Q And you don't see any issue with the math on the scoring or anything like that?

A No, ma'am.

Q Okay. When you're talk -- you talked to him four times. So you're having a back-and-forth conversation, right?

A Correct.

Q Did he ever indicate to you that he didn't understand what you were asking him?

A No.

Q Okay. And you're asking him about legal concepts?

A Correct.

Q Who the state attorney is, who the public defender is, who the judge is, all that. You're asking him that out loud verbally?

A That's correct.

Q And he was able to answer those to an acceptable level in your opinion, right?

A Yes, ma'am.

Q Okay. So same thing. So for both of these tests, if she's orally asking questions and he's responding -- I know you weren't there. So I know you weren't there to say how -- you know, but you yourself never got an indication that he was not understanding or comprehending what you were asking him during all four of your visits?

A I would agree.

Q Okay. And these tests are designed specifically when somebody is suspected of malingering. These are -- they're not the only tests, but they're some of the tests that you can give out if you suspect malingering, right?

A That's absolutely correct.

Q And so they're specifically designed, based upon the score system, that if you were at a cutoff or above, then that is indications that possibly someone is malingering, right?

A That is correct.

Q All right. So by the design of both the ILK and the SIMS, and based on Mr. Mosley's scores, he is suspected of malingering because of his scores?

A That is correct.

Q And you said that his subscale scores, which are those different disorders, the affective, the neuro, the psychotic --

A Correct.

Q -- he was elevated in all of those as well?

A Yes.

Q Which would indicate possible malingering?

A Correct.

Q And you would agree with me that you take into account -- something gets you to the testing, right? So

if a doctor -- you, as a doctor, you're evaluating someone, something gets you to the point where you are doing the malingering testing, right?

A Correct.

Q And that could be either through historical records that someone else has suspected it in the past, right?

A Could be, yes.

Q Or just by your own conversations with somebody, that could lead you to think, based on his -- the person's own self-report, I've got to do some malingering testing, right?

A That's correct.

Q All right. So in the case of Ms. -- Dr. Jones, she ended up -- however she got there, she got to this testing, right?

A Correct.

Q And then you then, by the time you do your third and fourth evaluation, you now have this historical record?

A Correct.

Q That malingering testing has been performed because it has been suspected?

A Yes.

Q And, in fact, a finding of malingering has

occurred while he's at the state hospital?

MS. RUSSELL: Objection, your~Honor. I think that question assumes facts not in evidence. I'm not sure if Dr. MacClain had anything from Dr. Jones prior to last Tuesday.

MS. MANUELE: No, this Tuesday.

MS. RUSSELL: This Tuesday, correct. So at the last time she had her evaluation and wrote her report back in May, she didn't have any information from Dr. Jones. No one did.

THE COURT: The written report said malingering, though, right?

MS. RUSSELL: Yes.

THE COURT: She sends a written report --

MS. RUSSELL: But there was no test data. There was no test information. We had no idea what the scores were. It is -- her question assumes facts not in evidence.

THE COURT: All right. Overruled.

BY MS. SULLIVAN:

Q Do you remember where I was? I can get us back there. So you have information in the form of what we would call historical records, which would be Dr. Jones' report where she suspected malingering and did the testing, because it's in her report that she did the two

tests, right?

A That's correct.

Q Raw data and scores aside, it's very much in her report that she did the two tests?

A Correct.

Q All right. And then, ultimately, that she made the finding of malingering, you had that information before you went and saw him the third and fourth time that she --

A That's correct.

Q Okay. But you opted not to do any malingering testing?

A That's correct.

Q All right. And one of the reasons that somebody may be malingering in the *DSM-5* is if they have criminal charges pending against them, right?

A Correct.

Q Okay. And Mr. Mosley, in your opinion, the two criteria that he is not wanting to talk to you about has to do with the facts of his case and his criminal charges that are pending against him, right?

A The prong of disclosure to attorney pertinent facts does.

Q Okay.

A The other one is not as related to that as is

his ability to process information, respond, comprehend information relevant to his case and, for example, to take the stand, and what could occur if, in fact, he still has active mental health symptoms that are impeding his ability to concentrate, or if he has underlying intellectual disability or receptive deficits.

Q Okay. But we don't have any testing to say that we're at that stage. We don't have an IQ test, right?

A That's exactly correct.

Q And in terms of any possible learning disabilities, all you've looked at are a psychological evaluation from 2011, which is about him getting special classes on reading and everything in like the third grade, right?

A Correct, I don't have any other academic records or don't know if there even are more academic records that could shed light on that.

Q And then you have the high school transcript which is for the ninth and tenth grade, which we know he also wasn't going to school during that time period, right?

A That's correct.

Q And you stated on direct that a person can have depression but still be exaggerating, right?

A That is correct.

Q Isn't it possible that a person could have depression and still be competent?

A Absolutely.

MS. SULLIVAN: May I have a moment?

THE COURT: Yes.

MS. SULLIVAN: I have nothing further.

THE COURT: Do you mind if I ask a few questions before you do redirect, or do you want to finish up with yours first?

MS. RUSSELL: Not at all, your Honor.

THE COURT: And then that way you can ask based on whatever I ask.

MS. RUSSELL: Sure.

THE COURT: I'm going to try to summarize what I've heard from you.

THE WITNESS: Yes, ma'am.

THE COURT: And if I'm wrong about this, please correct me, but your impression of the state hospital report and the time Mr. Mosley spent there, coupled with your evaluation and everything that you've reviewed, is that there are indications of malingering, but not enough information or time has gone by to ascertain if that is actually correct?

THE WITNESS: Exactly correct.

THE COURT: Okay. Someone can have delusions and be competent, correct?

THE WITNESS: Correct.

THE COURT: As long as they don't interfere with his ability to communicate with his lawyer?

THE WITNESS: Correct.

THE COURT: And it sounds like from listening to you testify today, he is self-reporting delusions, but we don't know if those interfere with his attorney conversations because he won't really talk about it.

THE WITNESS: The only thing I would say differently is he's not reporting delusions or false beliefs. He's reporting what I would call more auditory and visual hallucinations.

THE COURT: So did you read Dr. Hall's reports, any of them?

THE WITNESS: I don't have his reports, no.

THE COURT: You never read them?

THE WITNESS: No.

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

THE WITNESS: I don't have them.

THE COURT: Okay. He made reference to -- and I'm paraphrasing what the reports say and what his

testimony was, but there's a difference between delusions and what he called intrusive thoughts. And I had a -- some of my questions I asked him related to that topic that it's entirely possible that Mr. Mosley knows what the allegations are against him, and thinking about those things or talking about them brings up memories, what may or may not have occurred.

THE WITNESS: I would agree with that.

THE COURT: And those would be intrusive thoughts, not necessarily delusions.

THE WITNESS: Correct.

THE COURT: And I would suspect, based on the allegations -- we don't need to repeat them here in court today -- would have been very bloody.

THE WITNESS: Absolutely.

THE COURT: And so Mr. Mosley having flashbacks, intrusive thoughts related to blood, wouldn't surprise anybody, I don't think.

THE WITNESS: No, I would agree with that.

THE COURT: Hence, it would be common, I would think, for him to be depressed under that scenario, right? I mean, he's accused of something -- you know, the allegations are what they are. He's sitting in jail. The State is seeking the death

penalty. Not an unusual circumstance to be depressed, correct?

THE WITNESS: Correct.

THE COURT: So I'm basically in a position to try and determine whether or not his inability to communicate about those issues is volitional or really he can't because of his depression. Would you agree? I mean, that almost seems like the singular issue. I understand you want him to be tested about cognition, but so far he's been able to understand everything you've said, answered your questions, although slowly. He is medicated. The singular issue -- and if I am wrong, correct me. The singular issue here that's the barrier between competency and incompetency that I need to decide is whether his major depression that everyone has diagnosed him with, except for the state hospital, is causing him to not be able to communicate or whether or not he's willfully choosing not to communicate.

THE WITNESS: Well, I think that is the crux of the issue.

THE COURT: Do you agree with that?

THE WITNESS: I would agree.

THE COURT: I'm just trying to narrow my

issues here.

THE WITNESS: I would agree.

THE COURT: And you may have answered this question, but I'm not 100 percent certain I wrote the answer down. You reviewed his prior -- he had been -- he had two prior hospitalizations for mental health, potential suicide attempts, correct?

THE WITNESS: Yes, ma'am.

THE COURT: Prior to having any legal issues.

THE WITNESS: Correct.

THE COURT: Related to this case, anyway. Anything in those reports, self-reported or recognized by a doctor, suggesting delusions?

THE WITNESS: No.

THE COURT: Depression?

THE WITNESS: Depression.

THE COURT: Anything else?

THE WITNESS: No.

THE COURT: Okay. All right. Those are all of my questions for Dr. McClain. And then if you-all have any follow-up that you want to ask based on what I've asked, you can, if you want to.

REDIRECT EXAMINATION

BY MS. RUSSELL:

Q Dr. McClain, just a few additional questions?

A Sure.

Q In your numerous interviews with Thomas Mosley, did you notice that he was guarded?

A That he was guarded?

Q Yes.

A I did not.

Q Did you have to ask him questions multiple times?

A No.

Q Did you feel like you had to simplify your questions?

A I didn't feel compelled to simplify, no.

Q And have you heard of the cloak of competence?

A To some extent.

Q What is the cloak of competence, Dr. McClain?

A Well, just from my work being with people who are intellectually disabled or neurologically impaired, there can be, like, a surface level of competency. Meaning, they know the basic facts. They know that, you know, what could potentially happen. But then a higher level type of processing, like interacting in the moment, becomes more problematic because it's a more complex situation as opposed to just the basic facts, like concrete simplistic knowledge.

And because, like, I work with individuals who

are neurologically impaired at times or limited intellect, I'll do a double-take sometimes and, like, redo something to make sure on serious cases they actually demonstrate sufficient understanding. For example, of a jury trial, taking the stand, to make sure that it's not just, okay, they're competent, baseline's met.

Q Did you do that in this case?

A I did.

Q Is it unusual that people with cognitive issues or intellectual disability not repeatedly explain that they don't understand? I don't understand; I don't understand. Is that something that you notice with cognitive --

A So --

Q -- issues?

A -- it's a great question. I kind of hate to laugh at it, but -- so sometimes folks don't even know to say I don't understand because they think they understand, and they're not understanding or they want to be able to say that they do understand and show that they're capable. So it's something that's very delicate, but -- I don't commonly get I don't understand, but when I do get that question, I'll repeat it or try to simplify.

Q Did Mr. Mosley ever say, I don't understand, please explain?

A No.

Q Does that definitely mean that he understood everything you asked him?

A No, not necessarily, but I didn't -- just to clarify, I think I stated earlier that he had basic responses that were on point for basic competency criteria. So that wasn't really my issue. There was not a lot of elaboration, but there was some basic appropriate responses.

Q I think you talked to the State a little bit about your noticing mental health symptoms. Did you personally observe anything that worried you that Mr. Mosley may also have cognitive problems?

A Well, when I went through the records and the intake records -- and this was separate and apart from my observations, which were that he's slowed, very concrete and simplistic -- and the school records, that aside, when I saw him and I looked through the records, he had not reported to me any history of head injury or trauma, but then when I went through the records and the intake from the hospital, it said that he hit his head on a metal pole and lost consciousness. So it just raised the issue again of did something happen because he just does seem very thick or slow in terms of his responses. So I had concerns just from my own observations across four

different sessions that there's something impeding his ability to respond, whether it's depression, limited intellect, comprehension deficits, combination of all.

Q But as a neuropsychologist with vast familiarity with psychometric testing, you don't feel it's appropriate to give him those tests until he's stabilized?

A So stabilization, meaning that there may be periods where that person is having some symptoms, but they're not as blatant as to interrupt the process of testing so that the accuracy of the testing can be better determined.

You know, in other words, if he were to say, yeah, there is only limited times when that occurs and it's only at night or it's only in the shower, but, otherwise, you know, I don't think about it, that'd be different. But if it's more what it is -- the symptom presentation is what it is right now, I wouldn't be comfortable myself doing testing, cognitive or IQ testing, until such time as, you know, I would see a reduction of the depression and reduction of the psychotic features.

Q You can have psychotic symptoms with depression, right?

A Yes. It's one of the levels of categorization. It goes major depression, you know, mild, moderate, severe, and then severe with psychotic symptoms.

Q And you can have hallucinations with depression?
A In the psychotic stage, yes.
Q You've testified in a number of death penalty cases?
A Correct.
Q What do you know about the way a trial is conducted in a death penalty case?
A Just that the way that it's conducted, for example, like in a jury trial, that, you know, it basically would be, you know, very interactive as far as, you know, the evidence and the intensity of the evidence presented, the graphic nature of the evidence.
Q There are two phases?
A Correct.
Q First phase, guilt?
A Correct.
Q Second phase, mitigation?
A And sentencing.
Q And in mitigation and sentencing phase, it's not just about the facts of the crime, right?
A Correct.
Q Mitigation?
A That's correct.
Q Past history?
A Correct.

Q Many aspects to a mitigation presentation?
A Correct.
Q And those would be facts relevant for a defendant to be able to understand?
A That is correct.
Q And also work with their attorneys?
A Yes, ma'am.
Q Dr. McClain, when Mr. Mosley returned from the state hospital after three and a half weeks of treatment and we asked you to go evaluate him in March and then later in May of 2024, what did we ask you to do?
A Basically, to assess his competency and also to basically see, you know, what information, you know, I could find that would be important in terms of his ability to go forward on his case.
Q And we asked you to write a brief addendum; isn't that right?
A Correct.
Q And that's what you did?
A Correct.
MS. RUSSELL: Give me one minute, your~Honor, please.
THE COURT: Sure.
BY MS. RUSSELL:
Q Dr. MacClain, if a defendant is not competent on

two of six criteria, they're still incompetent according to Florida law, right?

A Yes.

MS. RUSSELL: No further questions.

THE COURT: All right. Thank you, Ms. Russell.

Any follow-up from the State based on what I've asked?

MS. SULLIVAN: No, your Honor.

THE COURT: All right. Dr. McClain, thank you so much for your time today.

THE WITNESS: You bet, your~Honor. Thank you.

THE COURT: Okay. We have -- we're done with witnesses, I assume, right?

MS. RUSSELL: Yes, as far as I know.

THE COURT: Okay. How much time do you-all want for argument?

MS. MANUELE: Five, ten minutes.

THE COURT: Okay.

MS. SULLIVAN: Yes, I'll do my best.

THE COURT: Okay. Madam court reporter, do you need a break or do you want to just roll into it?

THE COURT REPORTER: Keep on going.

THE COURT: All right. Let's go. Keep on

going.

I don't care who goes first.

MS. SULLIVAN: One thing I think we should probably address before legal argument is the remaining evidence.

THE COURT: Let's make sure everything is in.

Madam clerk, can you tell us what's in and what's out?

THE CLERK: Everything for defense is in. As far as --

THE COURT: Which is 1 through 13, I think?

THE CLERK: Fourteen.

MS. RUSSELL: Fourteen.

THE CLERK: One through 14 for the defense, and theirs is all in.

THE COURT: Okay.

THE CLERK: And then for the State, they have 1 through 9.

THE COURT: Nine.

THE CLERK: And Exhibits 7, 8 and 9 are not in.

MS. SULLIVAN: And we're not gonna be moving those in. Just keep them marked.

THE COURT: Keep them marked.

MS. SULLIVAN: Yes.

THE COURT: Okay. All right.

So, Madam Clerk, we're gonna ask you to hang on to them, but it will not be part of my consideration.

THE CLERK: Okay.

THE COURT: Okay? What was 7, 8 and 9?

MS. SULLIVAN: The court-appointed order for Dr. Ogu.

THE COURT: Okay.

MS. SULLIVAN: We talked about that in her -- the truancy petitions, I think we talked about that.

THE COURT: Okay.

MS. SULLIVAN: And then it was the rest of the records --

THE COURT: The big --

MS. SULLIVAN: -- that we talked about last week, and we're not going to argue about that.

THE COURT: Okay. All right. Sounds good.

Who's gonna do the argument for defense?

MS. MANUELE: I am.

THE COURT: I'm ready if you are.

MS. MANUELE: Well, I suggest the State goes first since he's presumed incompetent, but I don't mind going.

THE COURT: I was gonna give you first and last --

MS. MANUELE: All right. Sure. Okay. I'll take it.

THE COURT: Do you want to go first and last?

MS. MANUELE: I'll take it.

Your~Honor, at this time we would ask that the Court consider the order of incompetency. There is no competent substantial evidence that Mr. Mosley is competent to proceed at this point. The standard order for Mr. Mosley to be deemed competent to proceed, he would have to have sufficient present ability to consult with his lawyer with a reasonable degree of rational understanding and have a rational, as well as factual understanding of the proceedings against him. This principle is grounded in his due process rights pursuant to *Dusky v. United States*.

The testimony and the evidence before the Court is expert testimony of three expert witnesses who testified and their -- provided oral and written testimony, Brian Hall, board certified psychologist; Precious Ogu, neuropsychologist; and Valerie McClain, neuropsychologist.

Between all three of them, they -- Dr. Ogu met

with Mr. Mosley once over about a two-hour period. Dr. Hall and Dr. McClain both met with him three to four times each.

Specifically in addressing the criteria, and I think the evidence that -- the experts have offered opinions as to each prong. I think all of the experts indicated that Mr. Mosley was sufficient on whether he could appreciate the charges or allegations against him, and I disagree. There is absolutely no evidence of that. What the evidence is is that he's able to say that he's charged with murder. Every single expert, even the hired defense experts, even when those hired defense experts were confidential, he has never been able to tell them what the factual allegations are. And so there -- I don't believe there is any way to make an assumption that he knows what the factual allegations are when he has never once disclosed them to any -- any of the confidential evaluators -- or, I'm sorry, any of the evaluators.

I think Dr. Mc -- one of the last questions that came about was that it's entirely possible that he knows about the allegations. However, there is literally nothing in the record to suggest that.

In fact, the hospital, we have their handwritten notes from their competency assessment tool on January 9th of 2024, and these are -- this is the only item we have that actually documents a question and an answer. Even from the expert -- the defense experts, nobody was able to testify this is the question I asked and this is the answer he gave. But we did, luckily, finally get these handwritten notes, and I think it's important for the Court to consider this against what was actually written in the report --

THE COURT: Is it Dr. Hall's handwritten notes?

MS. MANUELE: No, no. Dr. Ascheman Jones' handwritten notes.

THE COURT: Sorry. That's what I meant.

MS. MANUELE: Yes.

THE COURT: The state hospital doctor, yeah.

MS. MANUELE: Her handwritten notes. And so she testified, I do handwritten notes and I take that information and put it in my written report. Except for there are wild inconsistencies from her report and the information that this suggests.

And so as far as whether -- I mean, this document, Can the defendant state his or her

charges? And there's not even an indication whether it was unacceptable or acceptable.

There's specific answers when she asked about his charges. Forgot; I haven't seen one; I have to call my PD to see what my charges are.

The appreciation under the possible penalties, she specifically says, Can the defendant state the possible penalties if found guilty or not guilty? There's a note that says, Don't know what NG is.

There's -- they ask -- probation is the only thing that is marked that he's able to explain. And I think everybody in this courtroom agrees probation is not a possible penalty in this case.

We've heard testimony from Dr. Hall -- everybody said he understands the death penalty is an option, that death is an option. However, Dr. Hall also indicated, when he inquired further, he didn't even realize that that was DOC, that that is the same thing, that you are on death row at the Department of Corrections until execution time.

So even his bare answers of saying I understand I can get death, when they said, Do you understand the possible penalty, and he says death, when asked to explain or whether he actually understands that, the evidence is that he --

there's not even a basic understanding in that regard.

So I -- I encourage the Court to review this because I -- I think that gives an understanding of the actual questions that were asked. And I think if --

THE COURT: Was that admitted into evidence?

MS. MANUELE: It was.

THE COURT: Okay. Do you have a copy for me?

MS. MANUELE: Yes.

THE COURT: An extra, because I don't want to take evidence in the back with me.

MS. MANUELE: Can I give it to you --

THE COURT: I'll take it now.

MS. MANUELE: Oh, okay. Just --

THE COURT: Or if you need it to argue, hold on to it.

MS. MANUELE: Okay. But I will give it to you before we're done.

MS. RUSSELL: Is that Defense 9? I don't remember what exhibit it is.

THE COURT: Who was it introduced through; do you remember?

MS. MANUELE: It was during -- it was during the last hearing. It was introduced through --

MS. SULLIVAN: You just put it in.

MS. MANUELE: Right, not through a witness.

MS. RUSSELL: It's Defense 7.

THE COURT: Okay. Yes. So if I can have a fresh copy before we end today.

MS. MANUELE: And she made reference in her report and testified about whether he had indicated that he did have children or not. Well, that question is actually on this form, and that's the only one that yes or no wasn't answered, which would suggest -- and there's an option -- that he did -- it wasn't even posed to him because all of the other ones are answered. So I think, going back even to the very basics, I -- we are in no way conceding that he even meets the criteria on that prong, but, certainly, there's no evidence to suggest that he does.

Whether he is able to disclose pertinent facts to his attorney, there's been some indication or questioning by the State about whether -- about the facts of the case. Certainly, we all understand that in a death penalty case everything is mitigating. There are statutory mitigators, but then the jury is instructed that they can find anything as mitigating, which requires some level

of a defendant being able to offer information to his attorneys. And, consistently, I think the evidence before the Court has been -- I think Dr. Hall explained this as trying to pull teeth. Dr. Ogu said it was incredibly difficult because she had to ask a question and -- and Dr. McClain, she said he -- described him as being more forthcoming, but as she said, his answers were simplistic, one or two-word responses, which is certainly not the level of comprehension and cooperation and participation that an individual that the government is seeking to kill should be able to provide to his attorney.

The only competent substantial evidence that was presented was -- is that Mr. Mosley is not competent to proceed. I do have for the Court -- may I approach?

THE COURT: Yes.

MS. MANUELE: A few cases on the comp -- on this issue specifically. I know I emailed all the other stuff.

THE COURT: Yes. Thank you. Are you going to put the citations on the record?

MS. MANUELE: I will. Yes, your Honor.

Specifically, I've provided *Bittle v. State* at

245 So.3d 792, Fourth DCA from 2018. That indicated that -- in *Bittle*, the issue was not preserved because the defense had not objected at the time, but that the court went on to say an evaluation four months old was stale.

They said, We agree with the defendant insofar as he argues that the nine-month-old competency evaluations conducted by the court-appointed experts were stale, but for that matter, so were the four and the seven-month-old evaluations presented to the court by the defense.

Certainly, Dr. Jones' evaluation, that was over five months old. That does not offer competent substantial evidence as to his competency. The -- her testimony herself was that she does not have an opinion on his current competency, that she -- she also testified that she would be unable to render an opinion looking back to her evaluation in January. So, certainly, I think all of her testimony and her report is not relevant and should not be considered competent substantial evidence based on the case law.

Specifically, also while I'm on *Bittle*, looking also to that, the Court also discussed there -- and this is regarding the issue that

wasn't preserved. The defense didn't object to the relevancy of the evaluations and so they hadn't preserved that issue.

And they said, The First District recently held that the fact that the right to a competency hearing is unwaivable does not relieve a defendant of the responsibility to make evidentiary objections relating to the competency determination.

The fact that the courts say defense still needs to make evidentiary objections means that the rules of evidence still apply to the hearing. In which case, Dr. Jones should have never been allowed to offer any opinion in this case. She was called as has an expert witness. Pursuant to 90.702, an expert is allowed to offer an opinion if, and the proponent of the evidence is able to establish that the testimony is based upon sufficient facts or data, the testimony is the product of reliable principles and methods, and the witness has applied the principles and methods reliably to the facts of this case.

She offered an opinion without laying any foundation despite defense request for a Daubert hearing. The Court should completely not consider

any of her testimony. The -- there's no evidence that it was based on sufficient facts or data, and for a fact, her testimony was I don't know what the data is it's based on. That was reliable principles and methods, and that was applied reliably to this case.

Everybody told you -- your Honor, Dr. Ogu, who was court-appointed, said that you would never administer the SIMS in this manner and you certainly wouldn't report on the SIMS in that manner without being able to offer a score to compare it. Also, she indicated that it would be questionable using that on somebody with cognitive deficits.

Dr. Jones ultimately conceded she was aware that she shouldn't -- that it shouldn't be used on somebody with cognitive deficits and that she had evidence in her records that there were potentially cognitive deficits that would make him an individual not supposed to be -- that that instrument should not be used on.

And then, also, Dr. Hall had testified similarly that he, based on the circumstances -- Dr. McClain, I think, elaborated the most that it's -- under the circumstances, it would be

especial -- one, it's normed against mostly females and against individuals who were told to fake bad. So we're not -- it's not normed on the subset of actual -- actual mentally impaired individuals. It's normed on people being told you go out there and pretend that you're mentally ill.

So -- and it requires a fifth grade reading level. Both instruments require a fifth grade reading level. The information that Dr. Jones had, had she actually reviewed the progress notes from the classes, was that Mr. Mosley had failed to meet his stated objective of reading -- of meeting the basic adult reading goal. That right there should suggest to her I need to do some screening instrument, some comprehension screening before I start administering any of this.

The evidence is that this is an instrument that was not reliably used under the facts of this case. The methodology was flawed. She was not able to establish otherwise. And so for those reasons, her opinion should be discard -- or disregarded by the Court altogether.

Additionally, under 90.702, the -- an expert opinion is admissible only when it will assist the trier of fact in understanding or in determining a

fact in issue. Whether Mr. Mosley is competent today, she offered nothing in regards to that. So that is the fact that's in issue for your Honor, and she wasn't able to add any -- add any insight in that regard.

Additionally, I -- I would suggest -- I provided the Court also *Collier v. State*, 857 So.2d 943. That's Fourth DCA from 2003. This is a Frye case, but it is analogous to the issue that in -- in *Collier*, Dr. Bursten, Dr. DeClue, both as experts in a -- I believe it was a Jimmy Ryce proceeding -- administered an SVR-20 in order to talk about future dangerousness, essentially. They were not able to establish that that instrument is reliable in making that determination under the Frye standard and, therefore, it should not have been admissible.

The Court went further to say that Bursten and DeClue's opinion testimony regarding Collier's mental state is also not admissible. This is because both psychologists admitted employing the SVR-20 to reach a diagnosis, and the SVR-20 is not Frye admissible. Thus, the trial court erred by admitting SVR-20 evaluation, as well as the experts' testimony because the experts relied on

those results.

And I would argue that is equivalent here. Once Dr. Jones' opinion relied on an instrument that she was unable to establish the reliability of and the methodology of and that was appropriate in this case, she shouldn't have administered it. And the fact that her opinion relies on an instrument that wasn't approved for this purpose means her opinion should be disregarded additional -- or as an additional reason her opinion should be disregarded by the Court.

Then I also provided *Brockman v. State*, and that's at 852 So.2d 330. That is Second DCA from 2003 also. And in *Brockman* they indicated that was the five-month-old report was too old. It was stale and did not offer competent substantial evidence.

And then, additionally, *In Re: Reilly*, 970 So.2d 453, Second DCA from 2007. And in this one the Court even goes on to say that, While we recognize that 916.12 permits a trial court to adjudicate the defendant incompetent based on stipulation of the parties, we do not believe that that permits the court to rely on a stipulation to an expert's report that is so stale that it no

longer speaks to the defendant's present competence.

So it kind of goes in even further than a -- than regular evidence. Normally, if both sides are agreeing and stipulating the evidence should come in, the court is never going -- I can't think of a scenario where the court would say, no, I'm not going to allow that evidence in. However, in competency proceedings, the court here says even if there's a stipulation, the court still has the duty to rely on competent substantial evidence. And we don't have any that Mr. Mosley is competent to proceed in this case.

There's been testimony from all three of the doctors named. All -- I believe it -- multiple of them referenced at least two other experts. So we have five expert opinions that have all diagnosed Mr. Mosley with a mood disorder and/or a psychotic disorder.

There has been a lot of talk about malingering, and I think Dr. Hall and Dr. McClain both touch on the danger of this. And, essentially, we -- because she threw in the word "malingering" -- because her testimony, as the Court recalls, I can't offer an opinion on his

competency to proceed. But because she was able to throw out malingering and -- and without having any data to rely on, but because she was able to throw out malingering, every single time this case comes before your~Honor, that is going to be a seed planted in your head. I think it was described as an anchor, that it will always keep coming back. And the reality is, is that is so dangerous. And they all said that is incredibly dangerous because you can absolutely be not competent to proceed and be malingering.

But even more important than that, it was way too early to make any assessment on malingering because everybody agreed that he has a serious -- a severe mood disorder and that the symptoms of his severe depression look a lot like he's not trying. Lack of attention, lack of concentration, faulty memories, inability to fully express himself or provide elaborate responses or answers, simplistic, concrete. Everybody said that those are all symptoms of his either severe depression or psychosis. And those are the same symptoms, the exact same things that Dr. Jones used, and only those things when she administered this instrument.

She -- she testified that -- in fact, every --

all of the other experts explained why it's important to look at many sources before you make an assessment or offer an opinion that somebody is malingering. And in this case, that opinion wouldn't have even passed the Daubert standard.

However, when she indicated that she did this, she conceded on the stand that this was based on -- well, she didn't really tell us what because she conceded that there was not a single note in the training records that indicated he was not putting forth adequate effort or that he was malingering. There was not a single note in the nursing records and all of the hospital records that would indicate that he was malingering, that she -- in fact, she -- she at one point started to say that she based it on her comparison for multiple observations, but then she actually backpedaled and said, well, technically, on that whole competency evaluation I did on 12/15 of '23, maybe I didn't even really evaluate, and then maybe it was just like not a full evaluation, even though we submitted this whole form. And so, essentially, we don't even have any accurate comparison for her to say this was different and this --

THE COURT REPORTER: I'm sorry.

MS. MANUELE: I'm sorry. Slow down?

THE COURT REPORTER: Yes.

MS. MANUELE: Sorry, sorry.

-- for her to say his presentation on this date was different because she backpedaled and essentially said, Oh, well, I don't even know if he was incompetent. I know I said that in that report, but maybe I didn't really spend enough time with him. She agreed that in all of the reports that she reviewed, there was only one reference outside of her own, and that came from Dr. Ramm's report.

And specifically what Dr. Ramm said was that Thomas Mosley was unable to talk the event -- was unable to talk about the events leading to his arrest. On further questioning, he indicated he could not remember. While his claims to be amnestic for the event could be an effort at malingering or a symptom of PTSD precipitated by his witnessing this homicide, it is reasonable to conclude that this deficiency in memory constitutes current lack of capacity to disclose facts to his counsel.

So even in that where she said, Oh, I read about it in report and that's what triggered, she

conceded on the stand that the only time that word popped up was in that context in that report in which it was offered as an alternative to PTSD. She did no assessment of any PTSD symptoms. We certainly didn't hear anything about that. Everybody testified for her to be using this instrument, she should have scanned his reading comprehension if there was any issues.

She conceded that in his initial psychiatric intake, the cognitive assessment, there were multiple indications that he was cognitively impaired, and yet she still gave him -- administered an instrument that requires a fifth grade reading comprehension. So not just reading the word -- I -- you know, what she said was, Well, if it's just a reading issue, then I can read it to him. If it's a comprehension issue, that doesn't necessarily fit.

And everybody said that, yeah, those scores could suggest malingering. They could also equally suggest true lack of understanding and comprehension of the questions. The symptoms of depression, apathy, lack of interest, poor concentration, being guarded about information all equally explain any lack of effort.

So I suggest that her testimony actually added nothing. It was not -- it did not add to a material issue before the Court. It does not pass Daubert screening. Defense did object contemporaneously and repeatedly, and the Court should disregard her testimony. All that is left is that Mr. Mosley is not competent to proceed.

The State introduced some jail calls, and the -- what we learned from the jail calls is telling. That this his mom repeatedly tells him "I know you don't understand." Well, they're not talking about the facts of the case. So the fact that mom knows he doesn't understand suggests that she knows that from prior occasions and interactions with her son. She knows his ability to comprehend. That was evidence introduced by the State, not us.

Additionally, they said -- you know, Dr. Hall testified -- you know, he said that he reports that he reads the bible, and he tells his mom that, right? And what did his mom say in response? Well, I know you don't understand. You just keep reading until you get it.

When Dr. Hall said, Oh, you know, you read the bible. Tell me about something that you read, and

he was unable to describe that.

I suggest to the Court that's consistent with him not offering when he doesn't understand something, which is completely inconsistent with any suggestion that he's malingering or exaggerating his symptoms. If anything, he's actually downplaying. And I think Dr. Hall indicated that, that his behavior, how he was guarded with him, how he -- it was hard to get information out about his family is actually evidence to the contrary to suggest there is no malingering here because most people would -- that would be a sign if he was freely willing to talk about some things, not the other, but he was like, it's just difficult to get information from him.

The calls showed there's an indication -- I think Dr. Hall testified about it, the concept of leap year that occurs in one of the jail calls between Mr. Mosley and his mother, that he doesn't know the concept of a leap year. There's some back and forth. He asked her to repeat what exactly it was again. What'd you call that? A leap? What was a leap?

Which is also consistent -- I think Dr. Hall also testified that he had talked to him about

symptoms of depression, only he had worded it as he had asked about self-esteem, and he was like that was a concept I then had to educate him on because he didn't know what self-esteem meant. Well, I think we all were taking for granted that you don't know what you don't know. And self-esteem is a concept that would certainly come up, you know, how are -- and depending on how you ask the question, do you have low self-esteem, might yield a completely different answer than, How do you like yourself? How do you feel about yourself?

And so I think it's important to acknowledge, and I think Dr. McClain said it well also, excuse me, that as far as why do different experts have different opinions, why does it seem that he may give more or less information to some examiners, and she said, I think it really depends on how you ask the question. Because had -- had there been no follow-up as to whether he understood what self-esteem meant, that might have yielded a very different answer.

So the fact that he, in speaking to McClain, denied head injuries despite their being documentation of head injuries and loss of consciousness, that, additionally, goes to the

opposite of exaggerating, him leaving out pertinent information. Obviously, head injuries, lack of consciousness, that's something that is incredibly relevant to a mitigation phase, potentially guilt phase as well, but absolutely a sentencing phase, and that information isn't freely and voluntarily offered or remembered.

So I -- and especially -- going back to Dr. Jones, we have no idea how she was asking the questions. She herself testified she got very confused about a couple questions and had to change answers herself a number of times. So I think it's reasonable to expect that she was not, perhaps, asking -- especially when she realized she didn't -- or testified she didn't realize Mr. Mosley had not started competency training classes until the week of January 4th, she also indicated she didn't realize they were giving him basic adult reading as one of his skills. So it seems unreasonable that she actually did a thorough assessment and then asked the questions appropriate to his level of understanding.

Mr. Mosley has been found incompetent by the Court. Certainly, all of the testimony at this point is that everybody believes he is restorable.

Certainly, at least, as to any mental illness, to have that treated sufficiently, to do additional testing and look into whether there is any additional deficits.

But at this point there is just no evidence that Mr. Mosley has a rational understanding of the proceedings, that he is able to provide his attorneys relevant and pertinent information, that he is able to testify relevantly, even less likely that he could sustain any sort of cross-examination, and we would ask the Court to continue the order of incompetency and have him sent to a hospital that will actually provide some treatment.

I don't think I've ever seen a turnaround as short as three weeks in my 17, 18 years. I -- it's -- I don't know. I don't know what was going on there, but I would suggest that Mr. Mosley receive adequate treatment and training at a different hospital.

THE COURT: So not the same treatment center?

MS. MANUELE: No.

THE COURT: All right. State?

MS. SULLIVAN: I'm gonna stand at the podium, if you don't mind, so I don't have to look down.

THE COURT: Wherever you'd like.

MS. SULLIVAN: May I approach with case law?

THE COURT: Yes.

MS. SULLIVAN: These were provided to the --

THE COURT: Make sure to put your citations on the record.

MS. SULLIVAN: I will. I'm gonna get -- talk about those cases in a minute, but I want to address first, as I move through this, the defense staleness argument.

I think it's no secret that when Mr. Mosley was brought back from the state hospital back in January that the State wanted to have a hearing quickly for obvious reasons because we've read the case law.

And I'm not surprised at all by what the defense is arguing, however, because we ended up not having our hearing until now, I extensively looked at the case law. And, in distinguishing it from what we actually have here -- and I kind of gotten to the opinion that what has happened between when he's been -- what happened at the state hospital and from when he got back until today and all the people have evaluated him, actually, I think has turned out to be a beneficial

thing because it's actually given us a wider span and a bigger context to really look at Mr. Mosley and his actions and who he is talking to and the evidence that we can take from all of that when your~Honor is making a decision.

For the staleness argument, the case law that the defense has presented that are -- those usually are situations where solely relying on an old report is not enough. I think everyone can agree on that. The case law is clear. You just look at one old report and everyone agrees to it, that's not gonna be enough.

But what the courts do point out is that the trial court can rely on the older report, as well as other additional evidence, and that's what the State has provided to the Court in this case. We have jail calls that we'll talk about in a little bit. We have the Court's own personal observations of Mr. Mosley, the cross-examination of defense and court-appointed experts, which the Court can weigh that testimony.

So the State is not by any means, and I want that to be clear for the record, asking the Court to only look at one report from January or only what Dr. Jones said, but use that report and

Dr. Jones' testimony and weigh that information against the other evidence being provided, which the courts do allow to occur. In addition, we've had a multi-day evidentiary hearing where all of this evidence has been put before you to make a determination and resolve the factual and opinion disputes.

So that brings me to the case law I provided to the Court and defense. *Hunter v. State*. It's the Supreme Court of Florida from 1995. The case cite is 660 So.2d 244. In that case the trial court found the defendant competent, and the Supreme Court found that was not error.

Specifically, on page 5 of the case, the court stated that the reports of experts are merely advisory to the trial court, who itself retains the responsibility of the decision.

And although there were conflicting opinions from the experts on the issue of competency, it's within the sound discretion of the court to resolve that dispute, and --

THE COURT REPORTER: Slow down, please.

MS. SULLIVAN: -- the Supreme Court found that there is evidence to support that decision.

In *McCray v. State*, which is 71 So.3d 848, and

that's, again, Supreme Court of Florida from 2011. Again, the trial court found the defendant competent. Supreme Court find that was not error.

That was a case where two experts opined the defendant was incompetent, and then the third testified that the defendant was competent and malingering. The court reiterated what was said in *Hunter v. State* regarding the conflicting testimony and noted that the trial court personally observed the defendant's behavior in the courtroom and expressly relied on that observation as one basis for its determination.

Then *Peede v. State*, which is 955 So.2d 480 from 2007. Again, the Supreme Court of Florida. Again, the trial court found the defendant competent. The court found that was not error.

The court states that the trial court subsequently found the defendant competent to proceed, concluding, simply put, the defendant could assist his attorneys if he wanted to, but is, instead, choosing not to discuss the facts of his case. The court said it was that clear that the defendant was not incompetent, simply uncooperative. The court stated that any difficulties in communicating with counsel were of

the defendant's own choosing rather than due to any mental defects. The court further pointed out that a trial court's decision does not constitute an abuse of discretion unless no reasonable person would take that view adopted by the trial court.

So with that as kind of the context that the Supreme Court has set up for the trial courts to evaluate these types of issues, I think what we end up having is four days of four different doctors all giving their opinions based on their time spent with the defendant in this case. And I don't want to rehash all the testimony. We've all heard it. We were all here. But I do think that what your~Honor said towards the end of Dr. McClain's testimony is basically the crux of the point.

We know that he has the ability to self-report to all these different doctors various things about his life. Consistently, each doctor reported that he's able to talk about his personal life, his social history, family history, his educational history, his work history. No issues. When he's asked about that, he's able to report that. No memory issues about that. Able to talk about that. Easily self-reporting that information. Same for his mental health history, for his physical health

history, his substance abuse history. All the doctors said he's able to disclose all of that information, no issue. Even different times when they go back and talk to him, he's always able to do that.

Then we get to the legal information, and every time we get to legal information, sometimes information he's previously divulged to other people, all of a sudden he doesn't know or showing poor effort.

Dr. Jones pointed that out that she knew from that initial psychiatric assessment when he first comes in that he was able -- he said, I know about my case. I don't need information about my case. Then she is meeting with him for her full eval, and he all of a sudden is saying he doesn't know certain information she knows personally he previously disclosed. Essentially, the self-reporting in the legal area is inconsistent amongst all the doctors that he talks to.

And that kind of goes the same for the hallucinations. Dr. Jones specifically reported that he was experiencing atypical hallucinations while being treated. And when I asked her what she meant by that, essentially, he's reporting

frequency and duration of these hallucinations, but in her opinion and in her experience, if someone is continuously experiencing that severe of hallucinations and for that duration, you would observe that. She would observe that behavior. And she said in no time that she spent with the defendant, or in any of the records she reviewed from other people being around him, suggested that those symptoms were really occurring or the hallucinations were occurring, particularly to the level that he is reporting them, to the degree and the frequency and the severity. That was not observed by anyone at the treatment center, which is why she found that to be atypical.

And all of this, as I am talking about Dr. Jones, is what is building her impressions of Mr. Mosley which leads her to doing her malingering testing. She did not do cognitive testing because she said unless she sees a barrier to competency that needs to be measured, and she just didn't see that in this case.

Again, with Dr. Hall -- because I'll go back to Dr. Jones and the tests again --

THE COURT: I don't know if Dr. McClain found that either.

MS. SULLIVAN: I'm sorry? That there was a barrier to competency that needed to be measured?

THE COURT: Due to cognitive issues.

MS. SULLIVAN: I agree.

THE COURT: She wanted testing, but I don't know that she ever came out and said that.

MS. SULLIVAN: Right.

THE COURT: Okay.

MS. SULLIVAN: I agree with that.

And -- where was I? I'm just gonna stick with Dr. Jones and finish that so I don't jump around.

THE COURT: Sorry.

MS. SULLIVAN: It's okay.

So, ultimately, where we get with Dr. Jones is after her own observations, her review of the records while he's been at the treatment facility, and in her talking to him, she suspects the malingering. So she does the two tests, and the two tests she does are tests that you would do for suspected malingering. They are options to use. We found out the total scores for each of those tests. And I'm not gonna hash out what that -- I think we all understand. The scores are elevated. The scores are high. That does raise the significant concerns about a feigned or irrelevant

response style and suggests that he has little investment in demonstrating true knowledge or abilities. That's specific to the ILK, which is the legal knowledge.

She put in her report that he scores within the range of those expected for examinees who are simply guessing or responding randomly and lower than scores typically obtained by people with bona fide mental disorders. And these tests are -- and I was asking Dr. McClain about this today, and she agreed. They're designed to be able to gauge, you know, if you're feigning it versus you actually have the disorder. And that's why they have the cutoffs and the scaled scores and all of that. And he grouped into that group that he's higher and raising concerns that it's beyond a mental health disorder.

And then because of that result, she does the SIMS. And, again, we have the tests that are consistent with her suspicions, which is it's a high score. It's 39. It's way above the cutoff score of 14. And then the subscale scores, which are different psychiatric cognitive disorders, he was selecting a high frequency of symptoms that are highly atypical of patients with genuine

psychiatric or cognitive disorders. In all five of those subscales, his scores are elevated above the cutoff. That's how high he's scoring on those tests.

And then Dr. Jones, just finishing her testimony out, she ultimately diagnosed the defendant with unspecified mood disorder. And when asked why -- she is the doc -- the only doctor that says unspecified mood. Everyone else is in the major depressive disorder diagnosis. But she said it's difficult to diagnose someone who's not giving self-reports accurately compared to the observed presentation. What she did see which was most likely genuine was some depressive symptoms and reports of depression, and that's why she bases her diagnosis on unspecified mood disorder, and he was prescribed meds that have to do with depressive symptoms.

But for the finding of major depressive disorder, she said that's a diagnosis you need time to observe, and given the question of his validity of self-reporting, it's unreliable. He would have to report depressed mood every day, reporting other symptoms like weight loss, interfering with daily activities every day, loss of energy every day.

None of that was reported. And she, in her opinion, to formally diagnose that, he would have to participate and self-report those symptoms more.

And we have and she relied on nursing notes who were checking on him daily. He's reporting restful sleep. He's reporting he ate. He's reporting that he's not having suicidal ideations. So in her opinion, which I think is credible, she can't get to major depressive disorder because when you read the *DSM-5* criteria for that, you have to have at least five over a two-week period where someone is reporting every day that they are doing at least five of these things, and she's just not seeing it from what the records show, the people that are constantly monitoring him at the hospital. She is not seeing it in her own observations of him. And then, even on top of that, she's seeing -- you know, he seems to be feigning his knowledge of things when it comes to the legal -- the legal standards that he's being asked about.

Dr. Hall said that the meds that he's on could affect -- we've heard a lot about his flat affect. He talks slow. Dr. Hall is a psychiatrist that said these mood stabilizers, the medications he's on, could be causing that type of behavior for why

he kind of responds a little slower. He is on different mood stabilizers.

What I found the most interesting about Dr. Hall's opinion is when he said that competency was a sliding scale. And I asked him about that and he -- he consistently said that -- he would admit that the criteria is the same regardless of the charge, but his belief is that this defendant should know more because this is a murder. He admitted that the defendant knows the State is seeking the death penalty, but he thinks he should know about the aggravators and the mitigators, and that's just, frankly, not the standard. That's not what is asked and that's not what the criteria is.

So the State's position is that should call into credibility the entire evaluation because if somebody who's conducting the evaluation truly believes that it's this sliding scale and that the defendant has to know more because it's a murder case versus any other case, I think that calls into question how he's evaluating it and when he ultimately concludes that someone is unacceptable or acceptable in a certain criteria. But he -- he consistently said that he believes that it's that sliding scale, and it's just that's not the

standard that we're asked to look at.

He stated that Mr. Mosley was a little more open on June 22nd of '23 than on May 16th of 2023, which the State believes it shows he's capable of disclosing more if he chooses to. He's on the same meds today as when he got back from the state hospital. It's been consistent.

The State argues that weighs in favor of Dr. Jones' opinion that he's competent. You know, they put him on certain meds, he stayed on that consistently, and that's why I think it actually may be a good thing that we've had this range of time where he's on the same meds, and we start with what Dr. Jones says, and then we come to today with McClain and Hall being the last people to see him, and we can kind of see what -- what is -- what is he resisting talking about? What is he refusing to talk about? Same meds for the depression. And where are the -- where are the issues popping up?

He states for major depressive disorder that he does list -- exhibits symptoms consistent with the diagnosis, but what is being self-reported during the evals with the doctors versus what he's saying on jail calls and what the nurses are observing at the hospital? There's conflict in

that. So he may report -- be reporting issues with sleep, but we have evidence to suggest he's sleeping fine. He may be reporting loss of interests, but we have evidence to suggest that that's not accurate as well for that every day that is required for the criteria of major depressive disorder.

We have to take into consideration the evidence that he's being told maybe not to discuss things with certain people, either by family members and -- and that could be influencing whether or not these symptoms are consistent.

Dr. Hall stated that other places to find symptoms or evidence of malingering would be saying things to doctors that you are not saying anywhere else, and I think that was an important statement that Dr. Hall made. And we have that here. We have someone that at certain times and then other times not, he's reporting that he's seeing blood. He's seeing blood coming out of his eyes, out of the shower. Those are severe hallucinations for somebody to be having. They sound disturbing. But we only have it at certain times with certain doctors. We have jail calls where he's never saying I'm hallucinating. I'm seeing blood. I was

in the shower again today, Mom, and blood was coming out of it. It's -- you know, it's driving me crazy. You never hear that from this person, but you hear it when he's talking to certain doctors.

We have him telling the doctors that, you know, I just want to kill myself, but then he's asked by nurses, How are you feeling today, and there's no suicidal ideations. I can't sleep, but then he's reporting, I slept restful.

I think that's important that you find symptoms of malingering where you're saying things to doctors you're not saying anywhere else, and I think we have that here. And I think it's all over these written reports and from the testimony that things are coming out during these evaluations that we're just not seeing any other evidence in, his behavior or in his own words and conversations in various areas, whether just with other doctors or with his family.

And with Dr. Jones, but she's not solely relying on that testing. We have to get that -- to that testing somehow, and she saw other evidence that lead her to doing that.

And then the last thing for Dr. Hall is that

he said that Mr. Mosley said just seemed to want to move things along and have the shortest evaluation possible. I found that to be important because when we get to this unwilling versus unable conversation, if he just wants to get in and get out of there, is that exhibiting someone not being able to do these things and meet this criteria or just not wanting to deal with it and not wanting to talk to the doctors and get on with this day?

Dr. Ogu, she discussed the importance of historical records, but she didn't report any malingering testing because she said she didn't have a reason to suspect it. She agreed with Ms. Ellis that it was in the history, but she just didn't take that into account. Although, she used history for every other part of her diagnosis.

For example, she said, I didn't see an anxious person, but she accounted for that because of the history. And then she was basing her psychotic features diagnosis on other history. So malingering at this point that Dr. Ogu is doing an April evaluation is in the historical record, but she's ignoring that. She chose to look at history for anything else that she was diagnosing, the depression, anxiety, any psychosis, but ignored the

idea that malingering had been found by another doctor very recently and didn't do any testing on that. She said she would do it if he was sent back and then kicked back again, but this time she wasn't gonna do it. Although, she said that it was not unreasonable or unfounded that Dr. Jones found malingering based on the severity of the charges and the deficits he was claiming.

She didn't know the scores at the time, but she said, you know, maybe that would make a difference if I knew what his scores were in relation to that cutoff. And we know that those scores are very high in relation to the cutoff.

She never observed him responding or interacting with any type of disturbance. It was only his history that supported that.

He denied having hallucinations with her during her evaluations.

She said the psychosis associated with the depressive disorder was 100 percent based on the history of the records and his prior self-reporting, nothing that she observed behaviorally on her own.

Ms. Ellis asked her what in the PCJ records was consistent with his self-report of psychosis.

She looked through them and said nothing in the record said he was exhibiting hallucinations or psychosis. So, again, he's not reporting to anyone interacting with him at the jail that he's seeing blood out of the shower. It's only to certain doctors at certain periods of time during these few months.

The jail medical records per Dr. Ogu diagnosed Mr. Mosley with just adjustment disorder with mixed anxiety, which I would argue is very similar to what the treatment facility was diagnosing him with.

And then for what Mr. Mosley is actually this unwilling versus unable conversation, she said he refused to talk or explain the circumstances surrounding the incident. But, specifically, she said he told her, I don't like speaking on it because it is emotionally too much.

And then he did interact with her, but he didn't want to discuss specific things. But most specifically, he didn't want to talk about the facts of the case. But she said he was not staring into space. He was alert. He was oriented. He stayed on task without redirection. He was verbal. He was -- and Dr. Ogu, in contrast to what

Dr. McClain just said today, said his receptive and expressive language was intact. He was coherent, goal directed with meaningful ideas, cooperative, and engaged with her. So we have, basically coming down to when he chooses not to talk about something, it's too much emotionally. I don't want to talk about it.

And then I won't harp on Dr. McClain too much because we all heard that just recently, but, again, all of a sudden, all of these other doctors don't see any evidence of internal stimuli, and we have her saying not only she sees it, but he's reporting it actively as he gets out of the shower and comes to see her. It's completely inconsistent with any other doctors' assessment of him or observations of him.

She comes to the same conclusion of the major depressive disorder with the psychotic symptoms. This conflicts with the self-report of good appetite, good sleep. She didn't have to simplify anything with him. She didn't have to repeat questions. She also did not do any malingering testing, even though she agreed with me that it was in the history and could be something to consider. And she understood why Dr. Jones did the testing

based on what Dr. Jones herself was observing.

So basically in terms of all these doctors, we're coming down to the two -- the only two criteria are they agree he's unacceptable on are four and six. And the State's argument is that these two criteria are highly dependent on the defendant's willingness to talk to his attorney about the case or disclose information or testify relevantly to it. He's choosing not to. And just because the defendant doesn't want to talk about these homicides does not mean he cannot do so and should not mean he is incompetent. And I'm not just deciding on my own that he doesn't want to, he is be -- he is telling doctors actively, Don't want to talk about. It's too emotional for me.

Dr. Hall, I said, You know, you -- you chose the specific language when you wrote your reports. You didn't write he's unable to. You wrote he did not want to. And I think it's important that that doctor is choosing his language, and he agreed, yes, he did not want to.

This idea of your -- when your~Honor talks about the intrusive thoughts versus the delusions, I think the fact that -- if you listen to what Mr. Mosley himself is actually saying, he's saying

I don't want to talk about it. It's too emotional. If I -- I'm afraid if I talk about it, I'll have flashbacks. I -- you know, if -- if he's truly seeing blood in the showers sometimes, I think those types of intrusive thoughts show a reasonable response to the situation Mr. Mosley finds himself in at this point in time. It is serious charges. It is very sad allegations. It is a serious penalty that he is looking at.

And it seems reasonable that somebody would be somewhat depressed over the situation, not only who was killed in this situation, but where his life is right now in jail. And I think when you're taking that, you can be depressed and still be competent. You can be sad and have flashbacks and not want to talk about something because it's too emotional. It doesn't mean you are unable, if necessary, to do so.

And I think that when you said is it volitional or he can't because of himself depression, I would argue that it is a voluntary choice that he does not want to talk about it. But I think to say that he is depressed to the level that he cannot talk to his attorneys and disclose the information that he knows -- I mean, we found

out today with Dr. McClain that when asked about it, he said, I snapped, and he didn't want to talk about it anymore. But he knew enough to say, I snapped, and it's his own choice not to go any further than that.

And I end with talking about the jail calls because I think they're an important way to kind of piece together is this volitional or can he truly, because he's so depressed, not meet the criteria of four and six.

I provided the Court with only 13 calls, I think the total number is. And it's not all the calls he's ever made, but I picked them out for a certain reason. A lot of it is obvious because -- I'm not gonna read through all of these. The Court has them to listen to.

He, obviously -- he knows when he has court and he knows what happened at court.

He knows that he has a public defender. I think we can all agree that he knows that.

He knew the day that someone was court-appointed.

He knew that he had been found competent and was now back here. So he is understanding, I think, and what Dr. McClain agreed on, those

criteria of he knows why he's here, he knows who the State is, he knows who his lawyers are, he knows who the judge is and the situation he's in.

But I think -- the reason why I wanted the jail calls to come in as evidence is the overall theme. This is someone who doctors are diagnosing with major depressive disorder. This is not somebody who is catatonic, not able to get out of the bed, having symptoms every day of severe, severe depression to the point that that mental health diagnosis is impeding his ability to be competent.

This is a person who talks to his mom every other day. Every other day since he's been in Pinellas County Jail, he communicates with her. And she will ask him what he had to eat, and he tells her what he's eating. And they'll talk about their day. And it's Mr. Mosley who continuously, when he talks to his mom, wants -- has an interest. Wants to know what'd the family do today. What are you doing? What'd you eat for dinner? He's talking about -- he's actively engaged back and north with his mother. This is not somebody who's just sitting idly on the phone not responding to her and she's just talking to him. He's back and

forth asking questions. He's showing an interest.

Again, I'm not gonna go through everything he says on all of these calls, but highlights of what I think is important is there's one call where he calls someone's grandmother for a buddy for -- of his in jail, passing him information back and forth. I mean, he's obviously got someone he's friendly enough with in the jail that he's calling on their behalf to pass information. It shows both competency of knowing lawyer talks to you and passing that information through, his ability to comprehend and have a back-and-forth conversation like that, and having an interest in helping someone out and finding that information out for somebody.

In terms of when Ms. Manuele referenced his mom always says "you don't understand," I agree. I agree his mother continuously says in jail calls, You don't understand that, you don't understand that. That's not Mr. Mosley saying I don't understand what's going on. I have no idea what happened in court today. I think she likes to tell him he doesn't understand things.

And there's specific times where he says -- she's like, Be mindful of who you call, what you

say on the phone.

He says, I know that. Why are you saying that? He says he knows what to say and not to say on the phone.

His mom is the one that says, They will tell you what's going on. That was on March 20th of 2024.

There's other examples of that. They talk about the kiosk system a lot, and she at one point was like, Oh, did someone explain how to do the kiosk? I think that was a call Dr. Hall heard in court, actually, about the discussion of the kiosk.

And it's his mother says, Did someone show you how to work that?

And he says, No. I know how to work that.

She -- the remote video visitation, I guess just recently you can actually do remote video visits from your own home, and that's a new thing that's been set up within the jail.

And he many times is telling his brother and his mom, Hey, you guys can do these remote video visits now. You gotta set it up.

His brother at one point was like talking about having to do a background check for it.

And Mr. Mosley says, You have to do a

background check. See if you have a felony.

I mean, so this is somebody who is able to explain to his brother and his mom, hey, there's a new thing, a new concept at the jail. It's called remote video visits. You gotta -- you gotta go on, you gotta sign up and you gotta get a background check to see if you have a felony. He's understanding concepts and he's able to comprehend.

He constantly is talking about the kiosk and commissary, what days things are being ordered, when packages are coming. All of this, you know, the underlying thing is this does not sound like someone who is so depressed. He is wanting to get packages from his mom. He knows when they're gonna arrive. He's wanting to have these video visits.

He says on one call, I just want to get home, be with friends, be with family.

I completely agree that to some extent Mr. Mosley is and should be depressed given his situation, but this -- his own actions, which is the best way to make a determination about someone's competency, how they actually behave when the spotlight's not on him, when the doctor's not in his face, when he is just on the phone talking to his family, being himself with people he trusts,

he is fully aware what's going on. He's never saying, I'm unable to sleep. I'm not able to eat. I just can't get out of bed. He's asked how he's doing. He usually says good.

And with his brother, they share a passion for rap music and he talks to his brother. And I argue as these months go on since he's got back from the state hospital, he sounds better, even like he -- he sounds even more willing to talk and alive with talking to his brother.

And most telling is he tells his brother, I wanna be home, and they talk about the video visits again, but then they go on and on about their interest in rap music, and they talk about rappers who are fighting with one another and have you heard this song. And Mosley -- Mr. Mosley says, I'm listening to the music on my radio.

He is having an interest in things. He's not just laying in a bed not just dog anything day in and day out not. He's not showing any sides of suicidal ideations by anyone. It's nowhere in the PCJ medical records. It's nowhere in the mental health records. It was all self-reported in the past.

And then what he told them the reasons for the

cuts on his hands, which we know were not self-inflicted that day, they were the results of why he was arrested. So because he said that, he has this tack on him that he's a suicide precaution and he's been monitored throughout because of those statements he made the day he was arrested.

If I could have one moment.

THE COURT: Yes.

MS. SULLIVAN: So just to close, I think -- I think the Court is correct of what was said to Dr. McClain. I think it is a determination of is this criteria not being met on testifying relevantly and disclosing pertinent facts, if it is a true inability to do that because he is so depressed and this mental health diagnosis is gonna prohibit him from doing that, or is it he's choosing not to do it because, yes, it is a sad situation, he doesn't want to talk about it, but he is making that choice voluntarily.

And I argue that the State has provided enough evidence, not just from what the state hospital saw, but what the state hospital saw is consistent with what we see as we move through all the different testimony and the evidence that the State has provided.

He is picking and choosing when he wants to provide information to doctors, and that on its own should not be the reason why he's found incompetent. He has a choice to do that. He is choosing not to do it. He is also, then, with the malingering tests, it showed that he is malingering. We have tests to prove that. We have observations to back that up. We have doctors who are not doing the follow-up testing. So what they opine is limited because they didn't do the testing themselves.

So with all of the evidence, the State is asking that you do find that he is competent to proceed. He meets the criteria that the statute lays out to be competent to proceed. He knows that information. He has demonstrated that information in other ways through the evidence that we've provided. Thank you.

THE COURT: Thank you.

Final thoughts from defense.

MS. MANUELE: Yes. I think there was a number of inaccuracies as to how the testimony came out, but I'm going to focus on I think there's a real -- well, one, we just learned for the first time in argument that the State picked and chose which jail

calls they were going to actually collect and provide. We didn't know that until argument. We didn't know that those weren't all of his jail calls. Certainly, we would have pulled them and looked at them. I think that is an additional reason that those calls should not be considered.

Further, I think it is a real issue that the State argue -- is arguing to you what those calls show -- offering an expert opinion and arguing. Saying that these calls show that he's not depressed. I would submit that this is akin to *Moore v. Texas*. There's *Moore 1* and a *Moore 2*.

I acknowledge and agree this is regarding intellectual disability in death penalty cases. And it's specifically Texas, how they had their statutes set up was to look at a number of, for lack of a better word, like -- kind of like lay witness things and, like, oh, well, this person can talk on the phone. This person can order commissary. So he must not be of intellectually disabled. He's not adaptive functioning.

And all of the expert testimony was that, in making a diagnosis of intellectual disability in the field, those aren't the things we look at. These are the things we look at.

And so the U.S. Supreme Court said once, and then again twice when Texas got -- took a minute to get it right, that there's a reason that we employ experts. It doesn't make sense to have lay opinions and have statutes and regulations based on these lay nonexpert opinion views of things when the scientific community recognizes and uses different information.

And so the fact that the State has introduced the jail calls, there were four -- three expert witnesses -- I -- I accept that the Court allowed an expert opinion from Dr. Jones. I don't believe the proper predicate was laid. We maintain that position.

But counting her, four expert witnesses for which the State had an opportunity to play these jail calls to them and say, Does this suggest a symptom of depression or not? And, in fact, when they were played for an expert for the first time in this courtroom, Dr. Ryan -- Dr. Ryan Hall said, actually, those calls are consistent with my opinions. You're able to pick up on the tone, his apathy, his short answers, his -- so I think for -- for them to get up and argue that there is -- you -- the Court should make expert opinions based

on those calls when there were four experts to testify before the Court, they had ample opportunity to have those experts offer expert opinions on those calls if they wanted and chose not to, I think is improper.

Nobody suggested that major depressive disorder requires that you be comatose, that you be unable to ask what somebody ate for dinner. In fact, the State's argument, essentially, was that he's able to parrot back the questions that his mom asked him. Mom asked how he's doing, what he ate. He's able to answer, and then he also asked them, What are you guys doing? What did you guys eat?

So I think that the Court should be wary and hesitant to make any additional leaps that the State has suggested when that is inconsistent with the expert opinion offered in the case. The --

MS. RUSSELL: Excuse me. Could we ask just have one minute? We think that the Zoom link got logged off.

THE COURT: It's on.

MS. RUSSELL: Okay. She's having trouble. I think she got --

THE COURT: I think she just probably fell off again.

MS. RUSSELL: All right. I apologize for the delay.

THE COURT: That's okay. She's been in and out throughout the hearing. I think she's having connection problems.

MS. MANUELE: The Court should be informed by the medical consensus in the relevant community, and -- and I -- I think it was interesting that, you know, their -- Dr. Hall was asked a number of hypotheticals about the calls. On redirect, we suggested, well, let's just play it for him. If we're going to ask him an opinion, let's give him the actual data that we're asking him to render an opinion on. And then once he rendered an opinion that those calls were consistent with his opinion, we just didn't ask any additional experts any hypothetical questions about that. I think that's telling also.

So I -- I understand the calls were admitted, but I certainly don't believe that those calls provide competent substantial evidence that Mr. Mosley is competent to proceed.

Additionally, the State the indicated that, yeah, we understand he's sad because of his current situation, except there is a documented history of

depression from 13 to 14 years old he was diagnosed. Seven to eight years prior to this offense, he already had that diagnosis. He had already been prescribed medication. So, certainly, I think that it's more than just the circumstances suggest that you're sad.

The issue -- the issue is that if -- before we talk about of all evidence, the first bar we talk about is is this relevant to the issue? Is this relevant? And so when the State says that this malingering opinion is relevant because it leads her to her competency opinion, everybody agreed that her competency opinion isn't relevant at this point. So to say that malingering is relevant because it led to Dr. Jones' competency opinion, even though Dr. Jones' competency opinion is not relevant and she doesn't have a current one seems backwards and --

THE COURT: How do you distinguish that from documented history of depression going back 13 years? Why would that be relevant, then? I'm not arguing. I'm asking you to distinguish the two.

MS. MANUELE: So the two, that would be if the documented history --

THE COURT: Documented history would be important.

MS. MANUELE: To show that these are not symptoms that are just oncoming now.

THE COURT: Okay.

MS. MANUELE: There's actual evidence to say what, you know -- yeah, that it's not just -- he's not just sad about the current circumstances. It shows that he had that history well before the current circumstances.

The -- also, the State had mentioned the atypical hallucinations and that Dr. Jones opined he had atypical hallucinations. How did she ask that question? How did she ask it? Because every single other person said nothing -- said nothing about his hallucinations being atypical. And so what question did she ask? What words did she use? And were they words that he could have comprehended? Because the records show and she admitted that he's not reporting that to the staff all the time, that there's nursing progress notes where they ask him, Are you having hallucinations, and he says no.

So the fact that she is describing them as atypical because she said they were reported to her

all the time leaves serious doubt on how did she ask that question. But all of the other evidence suggested he's not reporting them all the time, and so there is nothing to suggest that those are atypical hallucinations.

Regarding evidence of his sleeping, the State said a couple times he's sleeping fine. He's sleeping fine. Well, we know he's not sleeping fine because the state on -- the state hospital on January 10th, one day after that evaluation, added a second medication to assist in his sleep. And so there's certainly no evidence to suggest he's really sleeping fine unless they're just adding medication for no reason.

There's certainly no evidence -- no reason to think that -- another thing with the jail calls regarding the State said you don't hear him talking about hallucinations in jail calls. There's not a single witness who testified that you would expect to hear somebody talking about their hallucinations. In fact, what the expert actually said about Mr. Mosley is he tends to underreport and not talk about his symptoms, not offer additional information. So you wouldn't expect to hear that.

And I think, finally, the position -- the State made mention in their argument that Mr. Mosley does not have to understand aggravators and mitigators in a death penalty sentence -- in a death penalty case, which is absurd. Death is different. To suggest that the death penalty doesn't make a difference is just untrue, and it's inconsistent with what our courts have held for decades. Your~Honor is taught that death is different. Defense counsel is taught that death is different. I thought the State Attorney's Office were taught that death is different. Perhaps not.

Defense attorneys have to have special qualifications in order to handle these cases. Whereas, any single other case, any other first degree murder where the death penalty isn't on the table, you can literally practice tax law, walk in off the street. It would be your first criminal case, and that's totally okay. There are -- death is different.

THE COURT: Unadvisable, however.

MS. MANUELE: Definitely, unadvisable.

There was a whole additional trial, a whole procedure. To say that Mr. Mosley doesn't have to understand aggravating factors and mitigating

factors, those factors that will ultimately determine his sentence, suggests that he would not have a rational understanding of the proceedings. There is no way that somebody can have a rational understanding of death penalty proceedings without understanding aggravating and mitigating factors. It -- death is different. Death is different. It should be different.

Due process always requires that a defendant not be brought -- not be proceeded against when he's incompetent to proceed, but especially when the government is seeking to kill somebody. When they are seeking to take a life, due process is especially important.

And so we have a three-week stint in the state hospital for a man who is new to the criminal justice system. He has no adult priors. He has a juvenile -- a couple juvenile charges, which we all understand that is a different process. He has no experience in the criminal justice system as an adult. He has a lengthy history of mental illness. He was 20, had just turned 21 when this happened.

You heard from Dr. McClain that the symptoms of -- psychotic symptoms will start to manifest in teenage years and then progress ultimately to those

hallucinations, delusions, some of those -- those -- the psychosis we're more accustomed to, the more serious psychosis, which is consistent with the timeline we have here. We have a mood disorder diagnosis from forever and then there's now findings of psychosis.

And everybody agreed -- I think Dr. Jones agreed that you can't rule out schizophrenia without at least six months of observation, and she had three weeks.

There are five experts that have opined Mr. Mosley is not competent to proceed.

There is a red herring who indicates that he has possibly -- that he was possibly malingering. However, again, her testimony was not introduced pursuant to the evidentiary standard, and nobody else is indicating that they have nearly enough information to be making that kind of assertion in addition to how dangerous it is.

May I have one moment?

THE COURT: Yes.

MS. MANUELE: I think that's it, your~Honor.

THE COURT: Okay. All right. Thank you, everybody. I'm going to order the transcripts, review the cases and everything else you've given

me. Do you have anything else --

MS. MANUELE: Do you want *Moore*, the *Moore* cases?

THE COURT: Whatever you want to give me.

THE CLERK: You want to reserve, right?

THE COURT: I'm going to reserve. I'm going to prepare a written order. My hope is to have it out to you by July 26th. I'll set a status check on August 2nd, if everyone's here, just to make sure -- or any other day that week just to make sure I've got the order in. I don't care. July 29th, 30th, 31st, August 1st?

MS. SULLIVAN: I can do any of those dates. Whatever works for defense.

THE COURT: Why don't we do August 1st, a Thursday, if that's okay? Again, I'm going to try to have the order out the Friday before.

MS. MANUELE: What time?

THE COURT: 8:30.

MS. MANUELE: I'm sorry. You said August 1?

THE COURT: August 1, Thursday.

MS. MANUELE: That's good, Your Honor.

THE COURT: All right. Sounds good. I'll see you-all, then. Thank you.

(THE HEARING 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 18th day of July, 2024.

/S *Carla Jessal*
Carla Jessal
Registered Professional Reporter