

1 IN THE CIRCUIT COURT OF THE SIXTH JUDICIAL CIRCUIT OF
2 THE STATE FLORIDA, IN AND FOR PINELLAS COUNTY
3 CASE NO.: CRC23-03157CFANO

4 STATE OF FLORIDA,
5 Plaintiff,

6 vs.

7 THOMAS ISAIAH MOSLEY,
8 Defendant.

9 _____/

10 PROCEEDINGS: TESTIMONY OF
11 JOHN MATTHEW FABIAN, PSY.D., J.D., ABPP

12 BEFORE: THE HONORABLE SUSAN ST. JOHN
13 Circuit Court Judge

14

15 DATE: June 26, 2025

16

17 PLACE: Courtroom 2
18 Pinellas County Justice Center
19 14250 49th Street North
20 Clearwater, Florida 33762

21 REPORTED BY: Charlene M. Eannel, RPR
22 Court Reporter, Notary Public

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A-P-P-E-A-R-A-N-C-E-S

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1 P-R-O-C-E-E-D-I-N-G-S

2 THE COURT: Good afternoon, everybody. You can
3 have a seat. I see Mr. Mosley is present already.
4 We have a court reporter here. Okay.

5 We're here on Case Number 23-03157CF. State of
6 Florida versus Thomas Mosley, and today is the first
7 day of our competency evidentiary hearing, and the
8 notes I have from our conversations previously is
9 Dr. Fabian is going to be testifying today; is that
10 accurate?

11 MS. RUSSELL: Yes, Your Honor.

12 THE COURT: All right. Is there anything we
13 need to discuss before we get started with testimony?

14 MS. RUSSELL: Two matters, Your Honor. First of
15 all, it's Margaret Russell and Julia Seifer-Smith on
16 behalf of Mr. Mosley. Dr. Fabian is present and
17 waiting in the gallery.

18 If I might approach?

19 THE COURT: Sure.

20 MS. RUSSELL: This is our motion filed this
21 morning for the disclosure of Dr. Railey's score
22 sheets for the WHODAS 2.0. We don't necessarily have
23 to argue that much in today but eventually we are
24 going to be wanting that in order to prepare for
25 Dr. Railey's testimony two weeks from now.

1 THE COURT: Okay. I don't -- I don't want to do
2 that today for a couple of reasons, and it's probably
3 a good time to bring it up. We're a hard stop at
4 5:00 today.

5 MS. RUSSELL: Absolutely.

6 THE COURT: I don't know how much time you
7 expect Dr. Fabian to take. I just want to make sure
8 I give you enough time to get him done before 5:00,
9 and then if we have time afterwards, I'm happy to
10 discuss it, or we can discuss it on one of the other
11 days.

12 MS. RUSSELL: Understood, and I appreciate the
13 accommodation of starting early, Your Honor.

14 THE COURT: Okay.

15 MS. RUSSELL: The only other preliminary matter
16 is may we have permission to conduct the direct exam
17 from the table --

18 THE COURT: Of course.

19 MS. RUSSELL: We're using his PowerPoint, which
20 because of technology problems, we're --

21 THE COURT: You all have a lot of paper and
22 stuff. Wherever you are more comfortable is fine
23 with me.

24 MS. RUSSELL: Excellent. Well, I think we are
25 ready to go, and we are ready to call to the stand

1 Dr. John Matthew Fabian.

2 THE COURT: All right. Do you have any
3 preliminary matters before we get started with
4 Dr. Fabian?

5 MS. SULLIVAN: No, Your Honor.

6 THE COURT: All right. Let's have Dr. Fabian up
7 here, please.

8 THE BAILIFF: Right up here for me, sir. Once
9 you get over here, if you can face the clerk, raise
10 your hand and accept the oath.

11 (Witness was duly sworn on oath.)

12 THE BAILIFF: Come over here. Have a seat.
13 Make sure you answer in a loud and clear voice for
14 the Court.

15 THE WITNESS: Sure.

16 MS. RUSSELL: For the record, thank you to Eric
17 Ferguson from the IT Department of the Public
18 Defender's Office who worked very hard to make this
19 technology work.

20 DIRECT EXAMINATION

21 BY MS. RUSSELL:

22 Q. Hello, sir.

23 A. Hello.

24 Q. Would you introduce yourself to the Court,
25 please?

1 A. Sure. My name is John Matthew Fabian.

2 Q. Dr. Fabian.

3 A. Yes.

4 Q. What is your career of choice?

5 A. I practice as a forensic psychologist and
6 neuropsychologist.

7 Q. I would like to talk to you a little bit about
8 both your educational and vocational background, but first
9 I'm going to --

10 MS. RUSSELL: If I may approach, Your Honor?

11 THE COURT: Yes.

12 BY MS. RUSSELL:

13 Q. -- show you what's been premarked as Exhibit 1,
14 which is your CV.

15 Dr. Fabian, is this your curriculum vitae?

16 A. Yes, it is.

17 MS. RUSSELL: May we ask that Dr. Fabian's CV be
18 admitted into evidence as Exhibit 1?

19 THE COURT: Any objection to Exhibit 1?

20 MS. SULLIVAN: No objection.

21 THE COURT: It will be admitted as such.

22 (Defense Exhibit 1 was received into evidence.)

23 BY MS. RUSSELL:

24 Q. Dr. Fabian, tell me about your background.

25 A. So I'm from Ohio originally, and I've been a

1 psychologist in the forensic field for about 26 years, and
2 I can go through that in a bit with, you know?

3 Q. Do you want me to change the slide, or can you
4 change the slide?

5 A. I will do it. Okay.

6 So, basically, I have a bachelor's degree in
7 political science and psychology from the University of
8 Cincinnati. I have a master's degree in general
9 psychology there. I have a master's degree in clinical
10 psychology. And I have a doctorate in clinical psychology
11 with an emphasis in forensic psychology from Chicago
12 School of Professional Psychology.

13 I went to law school -- I've been a masochistic
14 nature. I don't practice law, but I attended Cleveland
15 Marshall and also Case Western's University of Psychiatry
16 and Law programming there.

17 I then became -- I started studying
18 neuropsychology, clinical neuropsychology, and earned a
19 postdoctorate certification in clinical neuropsychology
20 from the Fielding Graduate Institute, which then allowed
21 me to get into fellowship training at the University of
22 New Mexico School of Medicine in the Albuquerque, VA
23 polytrauma unit in New Mexico working with veterans as
24 well.

25 So that was a postdoctorate fellowship in

1 clinical neuropsychology.

2 Q. What did you do when you finished your
3 postdoctorate?

4 A. Well, I continued my forensic practice in Ohio.
5 Actually, I had returned there for a period before then
6 moving to Austin, Texas, which is where I live primarily.
7 I spend a lot of time in Florida as well, but I -- my
8 whole career has been really working as a court
9 psychologist and neuropsychologist, and I can kind of go
10 through that career trajectory.

11 Q. Excellent. Tell us more about your career
12 trajectory.

13 A. Yeah. So, I guess it started in Chicago. So I
14 was at the Cook County Jail for a year. That's where
15 really, I learned mental illness and was assessing, you
16 know, folks. Back in Ohio, I also was exposed mostly to,
17 you know, graduate training and education with my, you
18 know, undergraduate and graduate degrees. I did an
19 externship at the state hospital system, where it was a
20 Not Guilty By Reason Of Insanity Ward.

21 Then I also was an aquatics instructor at a
22 Fairfield Center, it was a residential treatment facility
23 for intellectually disabled. I was a lifeguard. We had a
24 lot of swimming aquatics programs at this facility.

25 But in Chicago, I was in graduate school and

1 that's where I learned more of mental illness, and then
2 really how to conduct psychological testing, including
3 intelligence. Then I did a year at the Federal Bureau of
4 Prisons in downtown Chicago.

5 Then for internship, I went to the Medical
6 College of Ohio. That was a residency program where I was
7 the Court psychologist trainee, and that's where the
8 rubber hit the road, where I was starting to do
9 competency, insanity, sexual predator evaluations,
10 mitigation, risk assessment, where I was assessing
11 defendants for legal purposes, legal questions that the
12 Courts or lawyers had.

13 Then I really started my career -- in Ohio, they
14 have probably about 10 court psychiatric clinics around
15 the state. They're either in regions or in large cities.
16 So I was a director of one, and I had worked at four of
17 them, three adult and one juvenile, and these were in
18 pretrial, presentence capacities. Again, like competency,
19 insanity, aid in sentencing for the Courts, risk
20 assessments, and working closely with probation
21 departments, assisting the Courts in sentencing folks.

22 I did that for several years and started working
23 in capital litigation and mitigation probably in 2000,
24 2001. Then after several years, I moved to Minnesota and
25 worked -- I would just say parallel like Florida State

1 Hospital of Minnesota. So it was a maximum-security state
2 forensic hospital, and I was one of several forensic
3 psychologists at that time, where it was pretrial
4 evaluations, competency, sanity, mitigating circumstances,
5 risk assessment, but also, they had a Jimmy Ryce law
6 there. So sexual violent predator civil commitment, and
7 mentally ill dangerous civil commitments. So I evaluated
8 folks there.

9 That was the end of the road in that state. I
10 mean, that was a maximum-security state hospital. So when
11 I was in Ohio, I was doing, like, a court psychiatric
12 clinic in a city, county, or region. In Minnesota, it was
13 the whole state of Minnesota.

14 So I did that and realized that with the death
15 penalty work I was doing, I was missing half the boat
16 because a lot of these defendants had neuropsychological,
17 neurological conditions, and I needed further training in
18 order to do and understand those types of, you know,
19 neuropathology, how the brain works, versus just
20 psychopathology of mental illness.

21 So that's when I did a few years extra training
22 in neuropsychology, and, you know, did fellowship training
23 as well. And so I practice, essentially, as a forensic
24 psychologist and neuropsychologist doing these
25 evaluations.

1 Right now, I handle a lot of -- most of what I
2 would do is still pretty much court-appointed. A lot of
3 my triangle is Austin, San Antonio, and Houston and
4 everywhere in between.

5 Then I do a fair amount of work here. I'm
6 licensed in Florida. We have a -- we have a -- we -- I
7 have a place we stay at in Hollywood as well, Hollywood
8 Beach.

9 So that's pretty much kind of the trajectory of
10 what I do, and most of what I do is pretrial, presentence
11 evaluations for criminal courts with adults and juveniles.

12 Q. Do you have any Board certifications,
13 Dr. Fabian?

14 A. Yes, I do. So I'm Board-certified --

15 Q. Dr. Fabian, maybe if you point it at the
16 computer over here.

17 A. Oh, that's what I need to do. Okay. That
18 computer.

19 Q. I got it up. Slide 3, right?

20 A. Yes. Forensic psychology, clinical psychology,
21 fellowship training, clinical neuropsychology, those are
22 Board certifications.

23 Q. Have you had any academic appointments?

24 A. Yes. So I don't have them on the slide. I
25 was -- I taught two courses at Cleveland State University

1 in the Department of Psychology. One was Psychology of
2 Violence. The other one was Forensic Psychology in the
3 Law, and I did teach intellectual assessment at Case
4 Western Reserve University Department of Psychology.

5 More recently, I've been doing forensic
6 psychiatry and psychology, training the fellows at these
7 institutions. Stanford University, I -- they have a
8 forensic psychiatry fellowship, and yesterday -- so
9 ironically, yesterday they said, Are we doing it again
10 this year? Yes.

11 So I present on the death penalty and sexual
12 violent predator civil commitment legislation and
13 evaluations of sex offenders.

14 Then the University of Texas Health Sciences
15 Center, they have a psychiatry residency fellowship I do
16 didactics training with, which I also do at Walter Reed.
17 They have a forensic psychology and psychiatry program
18 which they focus only on forensic evaluations within the
19 military criminal justice system. So I do -- well, I do
20 presentations with them with their fellows to train them.

21 And then I -- I think the next one is -- let's
22 see if I can do it. I think yours is working. Do you
23 want to just do it?

24 Q. Sure.

25 A. Because I was pressing over there and --

1 Q. I think if you press and if you direct it toward
2 me, it will work better. There we go. Yes.

3 A. Okay. This is basically what I said before just
4 about the kind of career. I do quite a bit of pilot air
5 traffic control evaluations as well, which -- for FAA. So
6 just fitness for flight duty, psychological, psychiatric
7 conditions, and neurological conditions.

8 They may -- a lot of it is ADHD, traumatic brain
9 injury, other type of neurological conditions as well.
10 Sometimes I will see strokes. Just other conditions where
11 the FAA has been flagged to have further evaluations.

12 Q. Are you a member of any professional
13 organizations?

14 A. Past and present, yeah. I mean, I think like
15 American Psychology Law Society in the past. More
16 recently, I've been a member of, like, National Academy of
17 Neuropsychology, and I've been a member, I know, of ATSA
18 for sex abuse, sex offender-type evaluations and
19 assessment.

20 Q. Have you published any articles?

21 A. I have, yes.

22 Q. How many?

23 A. I don't know. I forgot. This is updated
24 except -- I'm not boasting here, but I do -- I do have a
25 book in press that's coming out August 1st, so that should

1 be on the top here, publications, which is from Wiley &
2 Sons. It's not on there.

3 But as far as, you know, publication in my field
4 based on kind of the evaluations that I do do, I am
5 published in quite a few book chapters, journals. I don't
6 know if you want to put any of them on the record or.

7 Q. Well, I think we have your CV.

8 A. Sure.

9 Q. But it looks like maybe 30 or so articles and
10 peer-reviewed research?

11 A. That's fair. Yeah.

12 Q. Okay. How many cases have you been qualified as
13 an expert?

14 A. Do you mean to testify, or just where I've
15 gotten Court orders.

16 Q. To testify?

17 A. 600, maybe.

18 Q. And that's over the course of the past 20 years?

19 A. 26 years, yeah. And I -- the other thing I'll
20 say is that, you know, some of them are civil and family
21 law cases, but most of them would be criminal.

22 Q. And what jurisdictions have you been qualified
23 in?

24 A. Probably 22 state and federal courts.

25 Q. All right.

1 Dr. Fabian, is it time to switch gears and talk
2 about your testimony today?

3 A. Sure. I'm done talking about myself. Yeah.

4 So intellectual disability, I think that's kind
5 of what we're here for, right? Okay.

6 Q. And is there anything else that you're going to
7 cover today in your testimony?

8 A. Well, I think related to the topics intellectual
9 disability, maybe in the lighter context of competency to
10 stand trial, and also other psychiatric, neuropsychiatric
11 conditions or diagnoses related to schizophrenia and
12 Autism Spectrum Disorder, ASD.

13 Q. So tell me in all of your experience working
14 with people with intellectual disability and understanding
15 that condition, can you tell me why people with ID
16 struggle in court cases?

17 A. Well, I look at it, when you look at cognitive
18 ability and intelligence and you look at adaptive
19 functioning, that covers much of human nature and how
20 someone navigates their life. So they both are very
21 important to the assessment of intellectual disability,
22 but also just to how people function and get along and
23 live and survive.

24 So when you're intellectually disabled, you have
25 cognitive deficits, again, we'll talk about ability

1 intelligence, but there's typically significant
2 impairments in not only cognitive ability and skills, but
3 emotional functioning, behavioral functioning,
4 interpersonal functioning, and -- yeah, I mean, social
5 functioning.

6 You know, unfortunately, they're less resilient
7 than the typical person, and they're more prone to
8 experience other neurological conditions, other
9 psychiatric conditions and diagnoses and, you know,
10 they're just more susceptible to a lot of other
11 impairments and conditions.

12 Q. Okay. Has the Supreme Court in the United
13 States written about some of these problems?

14 A. They have.

15 Q. Okay.

16 A. And the case I have evaluated just got granted
17 cert June 6th, and they are hearing a case on cumulative
18 IQ scores. And that's Hamm, H-A-M-M, v. Smith. So they
19 have heard on Atkins -- was it Texas v. Moore, Florida v.
20 Hall, so a litany of cases that are addressing similar but
21 distinct issues.

22 Q. Should I switch the slide, and you could tell us
23 about Atkins?

24 A. Yes.

25 Q. Okay.

1 A. So the -- yeah, the U.S. Supreme Court, I have a
2 law degree, I don't practice, but I can briefly comment on
3 this. You know, the U.S. Supreme Court found it was in
4 violation of the Eighth Amendment, it was cruel and
5 unusual to execute and put to death someone who qualified
6 as intellectually disabled.

7 And, in part, because I think the frailties of
8 that population and issues related to retribution,
9 deterrence, you know, do they appreciate, you know, their
10 punishment, issues of that nature.

11 Q. Okay.

12 THE COURT: Am I going to get a copy of the
13 PowerPoint at some point?

14 MS. RUSSELL: Yes, Your Honor. Do you want a
15 copy now?

16 THE COURT: I would love that.

17 MS. RUSSELL: Oh, okay.

18 May I approach?

19 THE COURT: Yes. I'm not always at the best
20 angle for seeing the screen.

21 MS. RUSSELL: I apologize. This is Number 2.

22 THE COURT: Do you want us to put this in now?

23 MS. RUSSELL: Sure, if there's no objection.

24 THE COURT: Is there any objection to it?

25 MS. SULLIVAN: No.

1 THE COURT: It will be admitted.

2 (Defense Exhibit No. 2 was admitted.)

3 BY MS. RUSSELL:

4 Q. So moving on to Moore v. Texas?

5 A. So Moore vs. Texas, I can get a little specific,
6 but the State of Texas identified by case law the Briseno
7 factors, and much of that adaptive functioning was based
8 on the defendant's role in the crime, their homicidal
9 behaviors.

10 And the U.S. Supreme Court was looking at the
11 nonclinical judicially developed means of diagnosing
12 intellectual disability, ID, including the defendant's
13 role in the crime, and those Briseno factors that were
14 basically adaptive functioning related to the offending
15 behaviors.

16 And they emphasized -- the Court emphasized the
17 clinical assessment of intellectual disability and the
18 professional assessment of it, focusing and referencing on
19 the American Association of Intellectual and Developmental
20 Disabilities, and the American Psychiatric Association
21 Diagnostic and Statistical Manual of Mental Disorders.

22 So for short for this hearing, AAIDD and APA or
23 DSM. And the Court focused that, you know, modern
24 scientific clinical standards, really referenced by those
25 two organizations, is how intellectual disability should

1 be evaluated, and we'll cover that today, but that was the
2 main thrust of that holding.

3 But also, you know, that an individual with ID
4 can also have other disorders such as, you know,
5 antisocial personality disorder, personality disorders or
6 other, you know, mental illness. They can have, as we
7 say, co-morbidity, other psychiatric conditions, along
8 with the ID condition.

9 Q. So Moore tells all of us that intellectual
10 disability, in a legal context, should be governed by a
11 scientific consensus; is that fair?

12 A. That is very fair, yes.

13 Q. So what are some of the features of individuals
14 with intellectual disability that cause problems in the
15 criminal legal system?

16 A. Sure. In that -- I didn't fully answer your
17 question before about, you know, why they struggle in the
18 criminal justice system, and this, I think, slide can help
19 answer that question.

20 So the characteristic feature on the left is
21 very helpful because that gets at some features of ID, but
22 also overlaps with adaptive functioning and
23 neuro-cognitive deficits that we often see part and parcel
24 to cognitive ability or what we call intelligence.

25 So characteristics such as gullibility, naivete,

1 acquiescence, desire to please. Now, those, when I do
2 competency, you know, to waive Miranda rights or
3 confession type of evaluations, certainly are relevant in
4 those types of cases. When a defendant may be given their
5 rights or a choice to make a statement or leave, and more
6 of an interpersonal part -- a social part of adaptive
7 function that we'll go over.

8 Now, the other ones get into concrete thinking,
9 memory, attention, language. So receptive and expressive
10 language skills. Those are, you know, key in
11 communication, which folks with ID often struggle with.

12 They may not be neuropsychological tests that
13 are exactly listed in an IQ test, but they're relevant to
14 the proper neuropsychological assessment of intellectual
15 disability where we really will always do an IQ test, but
16 there's other cognitive neuropsychological tests that are
17 relevant in -- with assessing this population.

18 So these language deficits are relevant to how
19 they understand language at different levels of the
20 criminal justice system, such as during, you know,
21 interrogation where their ability to communicate their
22 thoughts, feelings even to lawyers in competency to stand
23 trial related legal matters.

24 The memory, obviously, is critical in a number
25 of forensic assessments where we're looking at their

1 ability to attend to information, present it either on
2 paper or verbally, as well as their ability to manipulate
3 that information in mind, which is really working memory,
4 which goes from attention to memory. Working memory is
5 kind of somewhere in between. Processing that
6 information, and then learning -- remembering it,
7 recalling it.

8 So that neuro-cognitive skill set is quite
9 important to competency proceedings whether it's Miranda
10 or competency to stand trial. We'll probably get into
11 that in a bit.

12 Then also, you know, their ability to, I guess,
13 display appropriate emotions pursuant to the nature and
14 context of what's going on. You know, are they
15 emotionally appropriate given the matter at hand? And
16 sometimes they may have what we call maladaptive
17 behaviors, where they can show aggression, anger,
18 impulsivity where a typical person will not.

19 Finally, the last one is cloak of competence
20 which is really an important concept in these types of
21 cases and evaluations in forensic criminal justice
22 matters. And that's really a lot of individuals that have
23 ID don't want to have that label.

24 In that case, I'm referencing Hamm v. Smith.
25 That gentleman -- you know, a lot of these folks have been

1 abused, ridiculed, picked on their whole life about being
2 slow, being quote, retard, end quote, and it's always had
3 a negative connotation, that label.

4 So they often will present as they understand
5 what people are saying when they don't because they don't
6 want to look, you know, ignorant, unintelligent. They
7 don't want to be picked on, rejected. So they will cloak
8 and cover competence and yeasay and answer yes, and say
9 they understand when they really don't because they want
10 to fit in and, you know, look the part like they're
11 intelligent.

12 Q. How do those factors influence the Florida
13 standards for competency?

14 A. Sure. So there are, I would say, no matter what
15 jurisdiction, including Florida, there's going to be
16 cognitive comprehension versus appreciation and rational
17 reasoning and logical thinking. Essentially, the types of
18 prongs or elements that are going to be relevant to a
19 defendant's, what I refer to as, psycho-legal abilities.

20 So do they understand the charges or
21 allegations? That's, you know, a comprehension,
22 cognitive, knowing understanding. And I look at that as,
23 in part, like, Do they -- do they understand the charge,
24 the elements, the severity, the consequences if convicted?
25 But then do they appreciate issues related to their case?

1 So it's not just understanding and cognitive kind of
2 knowing, it's an appreciation as well.

3 So there's an abstract reasoning component of
4 this. Certainly, understanding there's two sides. That
5 they're adversarial. I know this is basically narrative
6 testimony. I don't know if it's appropriate, I can
7 present examples.

8 Q. Sure.

9 A. Okay. The other night we had, basically, a
10 rape -- a life rape case where the defendant had both
11 autism and intellectual disability where they reported a
12 58 -- a 58 IQ score, and it was hard for him to appreciate
13 that the prosecutor was not there to help him. And over
14 the course of the evaluation, it was difficult for him to
15 appreciate -- actually, understand, appreciate, and retain
16 terms and information.

17 And over time, over a couple of hours, he could
18 not demonstrate that fully. He understands some
19 information, but he was able to parrot some of that
20 information back, but not fully appreciated pursuant to
21 his fact pattern.

22 So you could understand words, but can you apply
23 it to your case? And he failed doing that with my
24 evaluation. Whether he's restorable, I'm not clear, but
25 that would be an example. They have to understand,

1 comprehend, but apply it to their case. And that is
2 information, but then they have to make legal decisions,
3 which is even more of a higher-order, I think, cognitive
4 skill set.

5 So when we're looking, some of these, you know,
6 these several six factors understanding, disclosing. D
7 would be related to communicating, and facts of their
8 case.

9 E is more, can they control themselves
10 emotionally, behaviorally? Do they understand,
11 comprehend, and appreciate courtroom conduct? Testify
12 relevantly, it's going to be, again, communication skills
13 fluency, but also understanding, which we get into more,
14 like, oral language, auditory, comprehension skills. Your
15 questions, and to be able to answer them rationally on
16 point.

17 Going back to A and B, you know, this is more
18 about understanding, comprehending legal terms. I think
19 that the next slide gets more complicated, as far as
20 cognitive demands.

21 Q. So how should an expert begin to think about the
22 problem of competency with ID?

23 A. Competency to stand trial evaluations, they take
24 work for the examiner when -- it's often -- even with some
25 intellectually disabled folks, they may be able to

1 understand and comprehend words, okay? Defense lawyer.
2 The other night the gentleman said they're there to help
3 me. He's right.

4 They may understand what a jury does. Where the
5 meat and the complexity is, is how are you going to handle
6 your case, and you need to make legal decisions. That
7 becomes more difficult for them, and it takes a lot more
8 work for the expert to examine. And that's where experts,
9 they -- some of them don't put enough time into that part
10 of the evaluation.

11 So when we're looking at, like, this slide, the
12 sufficient present ability to consult with counsel, and
13 the reasonable degree of rational understanding. And so
14 applying the facts to the legal decisions and options that
15 the defendant has, and to communicate that with trial
16 counsel, that's -- there's a lot of meat there to
17 evaluate.

18 So "rational" means a reason. Is it logical
19 pursuant to your own fact pattern? And we'll get to trial
20 demands in a minute because that's more pressing cognitive
21 demands on a lower-functioning individual.

22 Q. All right. So what are the psycho-legal skill
23 sets that are required for a defendant to engage in a
24 death penalty trial?

25 A. Well, we start, you know, again, with the easy

1 prong, so to speak, of understanding -- you know, do they
2 understand their charges? Legal concepts is going to be,
3 you know, broad. That can be charges and pleas. You
4 know, do they understand the elements of the offense?

5 They do not, as you know, need to be a lawyer,
6 okay, but they need to have sufficient ability to
7 understand really the nature of the charge, the elements
8 or offending behaviors that are relevant to that charge.
9 They ideally will have recollection. We call more of that
10 declarative autobiographical memory of what happened.

11 Ideally, one -- you know, a lack of memory or
12 amnesia is typically not a bar to competency, but it does
13 compromise the communication that you, as a lawyer, would
14 have with your client.

15 So comprehension of police version of events,
16 but also -- you know that could include where you've given
17 Miranda rights, did they ask you if you're free to leave?
18 A lot of defendants don't remember or don't know, or they
19 can fabricate, which is a true lie, meaning, they don't
20 know, and they may say they do know, and they say, Yeah, I
21 was read my rights when we know they weren't.

22 So now the -- when -- you know, when I do these
23 evaluations of competency, and I do them multiple times a
24 week, you know, I do ask them what happened and I don't
25 document that, unless they are competent and there's an

1 insanity referral with it, but I want to know if they can
2 testify to what the facts are in their case.

3 Also, you know, how they respond to my questions
4 and to get an understanding as to maybe even a brief
5 testimony style or ability or capacity. So those are --
6 and, again, when we're dealing with someone that we
7 suspect or know is ID, we're going to want to look at this
8 cloak of competency because they may say they understand
9 legal terms, but that does not mean you assume they do.
10 You then need to take a step further and say, What does
11 that mean?

12 The last bold I find, you know, to be a
13 significant factor here in these types of cases. The
14 trial demands of cases are relevant. You know, is it
15 possible that an individual, let's say, who is ID is
16 competent, you know, cocaine possession case and not in a
17 death penalty case? Yes, that's possible.

18 Q. Why would that be?

19 A. The cocaine case may take a day of trial. The
20 facts may be a four-page police report. It may not be
21 weeks of jury selection, weeks of a jury trial, a death
22 penalty mitigation phase. The cognitive demands are much
23 less significant, let's say, in misdemeanors or other
24 types of felony cases.

25 Q. Okay.

1 A. You're asking a defendant to attend,
2 concentrate, assimilate, process, recall, retain
3 information and assist you in hours or a day versus weeks
4 or months.

5 Q. Is it just about the time, or is it also about
6 the complexity?

7 A. Both.

8 Q. What else, Dr. Fabian?

9 A. Well, some of this seems simplistic, but it's
10 not where individuals may understand the severity of the
11 charges, but they may not really appreciate the
12 consequences, the here and now.

13 Often similar to dealing with, let's say, a
14 juvenile or a child or adolescence, where it's difficult
15 for them to have a future orientation perspective.

16 And the understanding and recollection of pleas
17 and alternative pleas. Now, the no contest and not guilty
18 by reason of insanity pleas or, in some cases, diminished
19 capacity or even self-defense, these are very complicated.
20 More of those versus just I'm guilty or not guilty.

21 So with folks with ID, I often see that we have
22 a problem after not guilty. So when we go to no contest
23 or NGRI, it is difficult for them to understand and
24 appreciate, but when I say "understand," that means, let's
25 say, I'm mentally ill or mentally defective and did not

1 know what I was doing.

2 So that does require -- they may understand that
3 on its face, but then you appreciate -- understand and
4 appreciate that you are defected -- defective or you have
5 a mental illness or intellectual disability. How that may
6 apply to your offending behaviors and how that can be
7 appreciated as a legal safeguard in your case. So that --
8 there's a lot of depth to that.

9 And the other area that's complicated which, you
10 know, requires abstract thought is: Do you understand
11 what a plea bargain is? Often the answer is no, and we go
12 into my typical example of a flea market. Trade. What
13 would you like? Air Jordans. I like video games. I have
14 a booth. You have a booth. We're at a parking lot. I
15 trade this. You want that. You've got to give something
16 up to get something. And what are the rights that you
17 give up if you take a deal? That is complicated.

18 Do all experts ask that? No. Should they?
19 Certainly. So the level of abstract reasoning gets deeper
20 as you peel the onion. Like, you know what a deal is? A
21 trade. Then we want to kind of keep -- what about your
22 case? What rights do you give up? Can you testify if you
23 take a deal?

24 Or simple questions, if you take a plea
25 bargain -- or if you plead guilty, can you go to trial?

1 Okay. So you're not putting that not guilty in there.
2 You're mixing it up. If you plead guilty, can you go to
3 trial? And that simplicity is very much a concern in
4 these types of cases, which is kind of (indiscernible) in
5 a plea bargain process.

6 Now, the parroting -- and there's case law on
7 this, but capacity to understand legal advice. We're
8 limited when we do these evaluations, and I will highlight
9 that. It depends on who refers us, how we're resourced.
10 We're hired by JAC versus the Public Defender's Offices,
11 whatever.

12 It's difficult to assess how long that defendant
13 can retain this information. So can they parrot it for,
14 you know, sometimes the 40 minutes the evaluator is there?
15 And then 40 minutes later say, What did I -- what was a
16 plea bargain?

17 I did that the other night, but it was a couple
18 hours, and he could not retain that information. And so
19 the parroting will say later on, Do you remember I asked
20 you what a plea bargain is? Maybe they say "deal," but I
21 want to ask them again, How would you apply that to your
22 case? What are you going to do with your case?

23 So it's not just deal and parroting that
24 information back. It's, like, you need to apply it to
25 your own case. That's where -- that's another area of

1 abstract reasoning. So then that's when how are you going
2 to rationally assist your attorney in planning legal
3 strategy?

4 Now, we can have debates as to who makes what
5 decisions in court. Obviously, the defendant has a right
6 to testify, but the legal strategy, you know, the
7 defendant should have some input. Whether that lawyer
8 takes it their own direction, you know, but they need to
9 be able to assist their counsel in planning legal strategy
10 or appreciating the rational decisions of taking a case to
11 trial versus taking a plea, for example.

12 Q. And that requires abstract reasoning?

13 A. Yes. And the last one -- yeah, the last one is:
14 Do they have realistic and plausible appreciation as to
15 really the outcome of their court case? And that is --
16 that gets a bit deep as well. Appreciation and now
17 there's other factors of denial, you know, but folks that
18 have cognitive limitations may not have a realistic
19 appraisal as to the consequences.

20 In some cases that I've had, you know, let's say
21 the parents are heavily involved and whenever you're in
22 court, they look at mom and dad to answer the question for
23 the lawyer, even as an adult, low functioning, and the
24 parents have always taken care of them, and so they may
25 not have a realistic appreciation as to the consequences.

1 Q. Anything else, Dr. Fabian?

2 A. No.

3 Q. All right. Let's switch gears and talk about
4 intellectual disability and diagnosis.

5 What is "intellectual disability"?

6 A. Oh. Can you go back to 15?

7 Q. Sure.

8 A. Just two I want to mention. The capacity to
9 track events and follow, process, and recall information.
10 That is often markedly impaired with low-functioning or ID
11 folks. I -- I don't see that as the only issue where a
12 person is found not competent. Whether that could be,
13 sure. I often don't see that as being the decision
14 because usually there's the Dusky standard involved as to
15 rational reason, which is different than cognitive
16 attending, processing, and recollecting.

17 So if we really looked at that bullet point, in
18 my experience, most ID folks will fail on that. There's
19 no way they can comprehend and attend to recall
20 information for months.

21 The other one is challenge witness testimony.
22 And that's you, at the trial table, have the -- your
23 client, the defendant, assisting that trial counsel in the
24 here and now that day and time at that trial table when
25 someone is testifying.

1 And their ability to, you know, understand,
2 comprehend day and time, that information and assist trial
3 counsel is another area that is often impaired, and that's
4 difficult to assess in an evaluation. What you do is you
5 read them police reports and get into the facts of their
6 case, and that could be certainly time consuming.

7 Q. Especially in a courtroom scenario where things
8 aren't repeated and things happen quickly --

9 A. Right.

10 Q. -- it would be difficult for someone who is
11 disabled to necessarily engage and respond appropriately;
12 is that fair?

13 A. Fair. In very complicated cases, I will meet
14 with the defendant and lawyer or lawyers together and do
15 that evaluation.

16 Q. Anything else on that slide?

17 A. No.

18 Q. Okay. So now we'll switch gears and talk about
19 intellectual disability and diagnosis.

20 So what is "intellectual disability"?

21 A. So, basically, it's a neuro-developmental
22 disorder and it's a mental condition where the person has
23 accommodation of cognitive ability, intellectual
24 functioning deficits and co-occurring adaptive functioning
25 deficits. You know, adaptive functioning is really how we

1 adapt, survive, and get along in our society, and we'll go
2 through that.

3 So the AAIDD I would say is the leading
4 organization that defines and conducts research both with
5 the assessment and even the determining needs and supports
6 and providing information to society and the community as
7 to intellectual disability.

8 The three prongs are: Significant or
9 substantial limitations in intellectual functioning,
10 substantial limitations in adaptive functioning, and then
11 onset before -- or during the developmental period. In
12 the last 5 years it's been extended from age 18 to age 22.

13 Meaning two things: One, it's a
14 neuro-developmental mental disorder. Developmental -- a
15 compromise in brain development during the developmental
16 years, and the reason, in part, that they extended it was
17 just what we know about neuroscience and brain
18 development.

19 Q. In young adults, correct?

20 A. Yes.

21 Q. So that's sort of the Miller and Graham aspect
22 of pushing forward --

23 A. Yes.

24 Q. -- brain development in juvenile law?

25 A. Correct.

1 Q. Okay. And the two organizations that do
2 diagnostic --

3 A. Yeah, the other --

4 Q. -- information is what?

5 A. Yes. The AAIDD, that's the American Association
6 on Intellectual and Developmental Disabilities. Then the
7 APA, American Psychiatric Association.

8 Q. Let's start with the AAIDD.

9 What is it?

10 A. Yes. The American Association on Intellectual
11 and Developmental Disabilities. And that, per your slide,
12 has been around for 100 years, 150 years. They, again,
13 produce guidelines and really the definition and
14 assessment and diagnosis of that condition.

15 It certainly has developed over the years. They
16 do publish a book. It's in its 12th Edition. You may
17 have it. I have it on my laptop here. Thank you.

18 MS. RUSSELL: Yeah. We have a copy, if Your
19 Honor is interested.

20 THE WITNESS: Yeah. And I appreciate the way
21 it's written. It's not this big. It probably could
22 be, and it's very easy and elementary to follow.

23 BY MS. RUSSELL:

24 Q. So what does the AAIDD say about intellectual
25 disability and how it's defined?

1 A. Yes. So, again, significant limitations in
2 both, and that's current in both intellectual functioning,
3 adaptive behavior, adaptive functioning originating during
4 the developmental period, essentially, prior to age 22.

5 Q. Is there anything else to it?

6 A. Yes. So they have assumptions, you know. There
7 would be a lot else to it. We want to look at cultural
8 issues, you know, where the person may be living.
9 Community, contextual, I would say, elements. Language
10 issues.

11 I had a case recently in Volusia County in
12 Daytona where the defendant was born in Haiti, so there's
13 language issues that you're evaluating.

14 So number two would be, you know, consideration
15 of different other factors. Communication, sensory,
16 perceptual motor, behavioral factors.

17 And three is quite important. You know,
18 basically, the limitations, deficits that -- you know,
19 these two organizations focus on limitations, significant
20 limitations, substantial limitations, and acknowledging
21 that everyone has strengths, but the more impaired,
22 obviously, the less strengths a person has.

23 So when I was, you know, a lifeguard aquatics
24 instructor for a residential treatment facility, that's
25 where, you know, my hair was blown back with what ID was.

1 Q. What happened?

2 A. Well, what happened is you got to watch the
3 people that you're instructing in the pool, okay? So we
4 would have a few of us lifeguard instructors and if you
5 have someone that's profoundly intellectually disabled in
6 an inner tube and you're not watching them, you look over
7 and they're underwater drowning and they do not have the
8 capacity to do one thing, lift their head up and breathe
9 and survive.

10 So I had never been around a profound ID person.
11 85 percent of ID folks are mild, thank heaven, you know.
12 We go moderate, and I would say that's 85 down to 10
13 percent. Severe, probably 3 percent. Profound, 1
14 percent. So most of them are mild and we may not know
15 that they're even mild, you know. So they're high
16 functioning, of course.

17 Or we went to -- was it Ponderosa? And I did
18 not realize that they -- certain more profound, severe
19 folks, let's say, profounds really could not go on trips,
20 but they would drink enough Pepsi to fill this room and
21 not stop. So they have difficulties even with kind of
22 bodily functions, and I was not aware of that.

23 Then I started when there were, you know,
24 lightning, we couldn't do the swimming pool. We couldn't
25 move folks across the facility because it was a whole

1 campus. So if we couldn't do training in the pool, we
2 would go to residential. We would go to the units and
3 help them, help the staff. That's where we were helping
4 bathe, you know, and that type of thing.

5 So you would see the milds versus the profounds
6 and kind of the levels of adaptive functioning even on
7 their structured unit.

8 Q. And you began to realize that there are
9 stereotypes in ID that maybe many people might think that
10 the people drowning in the pool is what ID looks like?
11 Like 85 percent of people have mild ID?

12 A. Yes. Yeah. I mean, eventually, when I was
13 doing more evaluations for the courts, I would be -- you
14 know, I may have somebody that I would be talking to
15 interviewing, spent hours, even a day or so, and then go
16 and do an IQ test and it would be a 72. And I would be
17 like, no way his -- he -- I would be shocked, maybe, that
18 their -- I thought their IQ would be higher, you know?

19 So just saying, Oh, I think based on
20 interview -- their verbal skills during my interview, what
21 their IQ would be, I don't do that because I don't know
22 unless I do the testing.

23 Number four is -- yeah, four. So the AAIDD and
24 the APA, I want to emphasize for the Court that this is
25 really based clinical, you know, psychiatric, designed to

1 assess intellectual disability and really focusing on
2 needs, supports, resources.

3 So you want to see how they function, IQ,
4 intelligence, just as important to the adaptive
5 functioning, to then get at, okay, how do we help this
6 person, you know, adapt better in their context and
7 society?

8 The death penalty is, like, separate. That's
9 gotten important over the years, but I think that we
10 sometimes lose the definition of really what this is.
11 It's clinical and, you know, supports in the community to
12 assist these folks.

13 Q. And what about the context of community
14 environments in assessing ID? I'm not sure if we covered
15 number one.

16 A. Oh. Yeah. Where are they going to live in the
17 community? So, like, one of the instruments I may use in
18 some of these cases, they'll have norms on folks that are
19 ID, independent living, versus, you know, they need
20 assisted living versus residential based on their
21 impairments.

22 So, you know, there's a lot of different types
23 of community services, resources, but also placements
24 based on their deficits that we, you know, that they need
25 to assess because, you know, everyone is going to have

1 different resources and live in different places in the
2 community.

3 Q. What is "intellectual functioning"?

4 A. Well, traditionally we were focusing a lot on
5 IQ, which we still do, intelligence and intelligence
6 testing. In the last several years, both organizations, I
7 think, broadened their definitions a bit qualitatively to,
8 as we see, reasoning, planning, solving problems, abstract
9 thinking, higher order cognitive functioning, learning
10 quickly, efficiently, learning from experience, that
11 bullet point is really executive functioning as a
12 neuropsychologist.

13 So when I see that bullet point, that means that
14 I should be evaluating their neuropsychological
15 functioning with executive functioning, in addition to an
16 IQ test.

17 The last -- go back, if you can.

18 Q. Go back.

19 A. Yeah. The last one, traditionally, we have in a
20 slide here in a minute, you know, when we're looking at a
21 bell curve. You know, the average Joe is 100. A standard
22 score is 70 will be two standard deviations from that
23 second percentile, give or take. So, you know, that
24 basically 70 to 75, and depending on the state,
25 jurisdiction, court, you know, it's around the score of

1 70.

2 The AAIDD in the DSM have written that, well, 75
3 because we're considering, you know, it's a standard
4 measurement.

5 Q. So that feels like it's the next slide.

6 A. Yeah. So that --

7 Q. Significant limitations. What are significant
8 limitations in intellectual functioning?

9 A. Technically, they do have an objective finding
10 that they still adhere to both organizations, where it
11 will be two standard deviations below the average score of
12 100, and that would be a 70. That just means 98 out of
13 100 people that are the same age will score higher on that
14 IQ test.

15 Q. So what are some examples of these limitations
16 in intellectual functioning?

17 A. So -- and this is from the AAIDD Manual, 12th
18 Edition, where the functioning area there's some examples,
19 and we had seen that in the previous slide. Thinking and
20 learning will be understanding complex ideas, abstract
21 thinking, learning, processing information.

22 Reasoning and decision making. And that's --
23 will get into planning, initiating, putting forth your
24 decision-making. And then flexibility and thinking. So
25 cognitive flexibility.

1 Then finally, learning from experience. You
2 know, kind of understanding consequences as well.
3 Appreciating high-risk situations. Then how that may be
4 affected by more of these emotional cognitive constructs
5 of like gullibility, suggestibility.

6 Q. Let's talk about adaptive behavior, Dr. Fabian.

7 A. Sure.

8 Q. What is "adaptive behavior"?

9 A. Well, it's really how we adapt to our
10 environment. Survive. Get along. Navigate the world.

11 The AAIDD and DSM break it down into three
12 prongs of conceptual, practical, and social skills. So
13 conceptual skills are concepts. So they understand
14 concepts, like money. Can they read and write. Can they
15 tell time. You know, mathematics. You know, can they
16 kind of make decisions based on that type of knowledge.

17 The social skills gets really into kind of
18 emotional, social, interpersonal. But social
19 responsibilities, self-esteem, communication. It gets
20 back to this naivete, suggestibility. Follower or leader.
21 Are they able to follow rules, laws. The victimization.
22 Are they taken advantage of?

23 And then practical skills focus, you know,
24 really on getting around working, using, you know, public
25 transportation. Following rules at work, use of money,

1 getting to the doctor. Those types of practical living
2 skills.

3 And there's different ways that we'll see that
4 we can assess adaptive behavior and in both -- especially
5 AAIDD will offer, like, best practices.

6 Q. So tell us more about the AAIDD and how adaptive
7 behavior is assessed.

8 A. So the best way to assess this, I think, what
9 the AAIDD and APA empathizes to ultimately gather
10 information about this person's adaptive functioning and
11 that's records, collateral information, but also, at some
12 point, have a credible knowledgeable, adaptive informant.

13 Be interviewed with a specific adaptive
14 functioning test that is normed on different, like,
15 populations ID and normal folks, so to speak. And to have
16 that person or people rate that person's functioning here
17 and now or in the past retrospectively. And there's some
18 instruments that we may brush on that basically have,
19 like, a 0, 1, 2, 3 scale.

20 A zero, the person can never do it.

21 1, they have difficulties. They may need
22 assistance.

23 2, they're able to do it, but not always.

24 3, they can do it without a problem, like
25 independently.

1 Q. So adaptive behavior is based on typical
2 performance, not maximum or one-time performance; is that
3 fair?

4 A. That is fair, but again, you can assess the
5 examinee, patient, defendant, whoever, adaptively, which I
6 do, but also interview one or more people that know that
7 person very well that can answer those questions.

8 So when I have that form and I'm, you know,
9 talking to the parent, if they cannot answer those
10 questions, then I don't do a form.

11 Q. That's fair.

12 What about assessment in community settings?

13 A. Well, the community settings, you know, you
14 also -- the context of where they're going to be placed is
15 important. So I can, I guess, answer that question in a
16 couple different ways. I mean, we want to know where --
17 the options they may be placed, where they may live, but,
18 at the end of the day, we have to get someone that has
19 knowledge and sometimes it may be at a facility that
20 they've lived at that we may want to interview them about
21 adaptive functioning of that individual.

22 Q. All right. Let's talk about the conceptual
23 adaptive skill domain. I think that we've been through it
24 a little bit.

25 Is there anything that we missed?

1 A. Okay. Well, if you go back to 24. Sorry. I'll
2 keep on the same slide you are, so I don't break my neck.

3 If you go back to 24 and you're on -- you're
4 looking at like, D, is your -- your assessment is based on
5 the individual's typical performance at home, school,
6 work, and leisure, not their maximum performance you had
7 mentioned, but these instruments get into ratings as to
8 different context. Let's say using the microwave versus
9 using a bus versus going to a movie, let's say.

10 The community setting is going to be typical for
11 that age peer. So we're assessing and rating an
12 individual who the age ranges go probably from 18 to,
13 let's say, 80 on these scales, and we're using their
14 normative group that's the same age of that person you're
15 evaluating.

16 And, again, ultimately, this information will
17 provide data as to what supports they may need in the
18 community.

19 So conceptual --

20 Q. Tell us about conceptual adaptive skills.
21 What's in that domain?

22 A. Sure. So, again, it's about assessing concepts
23 of their ability to understand concepts. This also gets
24 into problem solving, planning, thinking abstractly,
25 academics.

1 The second to last one is when we do these
2 evaluations, we want to do reading, writing, math, these
3 are achievement tests, okay? So typically, when someone
4 is ID, they're going to have an IQ assessing cognitive
5 ability around that 70 mark, but they usually have their
6 academic achievement scores somewhere around that as well.
7 They may -- they may be deficient. They may be higher
8 than 70, but they're often around that mark.

9 So it's important to assess those academic
10 achievement skills, which is one area of conceptual
11 adaptive functioning. And a psychologist, a
12 neuropsychologist will do that.

13 And then, you know, get information as to, you
14 know, money cards, banking, how their money was
15 transitioned from their employer to, you know, their --
16 either their bank account, but getting information as to
17 that.

18 Now, I also have, I would say,
19 neuropsychological adaptive functioning tests that can get
20 into writing checks and writing letters, using maps.
21 Those are hands-on adaptive functioning assessments that
22 we can do. The field needs to progress with some of that,
23 though, you know, as far as writing checks and whatnot as
24 society changes.

25 But here, you're looking at concepts, money

1 concepts, using calculators, for example, things, you
2 know, of that nature. Planning activities, which gets
3 into a bit of the social prong.

4 Q. All right. Tell us about the social adaptive
5 skills domain?

6 A. So that gets into the, you know, interpersonal
7 peer relationships, who do they associate with, what do
8 they do for leisure. Do they just do things by
9 themselves. Social judgment. Appreciating, let's say,
10 situations. Hazards of people they're associating with.

11 Then more of this cloak of competence, pleasing
12 other people, gullibility, suggestibility. Then looking
13 at vulnerability, victimization, and that can be relevant
14 in different domains of their life.

15 Q. How about the practical adaptive skills domain.

16 A. That is more of, like, working, and kind of
17 overlaps a bit with concepts with, you know, paying bills,
18 writing checks, signing leases, purchases, credit cards.
19 Then also, you know, hygiene, grooming, washing clothes,
20 cooking, practical life skills.

21 Q. Does the AAIDD say that you need deficits in all
22 three domains for a diagnosis of intellectual disability?

23 A. No.

24 Q. What does it say?

25 A. It says you need at least domain -- or deficits

1 in one or more domains.

2 Q. Tell us about the age of onset according to the
3 AAIDD?

4 A. So that would be before the age of 22. And,
5 again, that highlights that intellectual disability is a
6 neuro-developmental disorder that should be, you know,
7 that manifests during the developmental years. Whether
8 it's formally diagnosed, that often is not the case.

9 Q. What are neuro-developmental disorders?

10 A. So, yeah. They are basically conditions listed
11 in the DSM. The DSM, the APA will focus on several ID,
12 intellectual disability; ASD, Autism Spectrum Disorder;
13 ADHD, Attention Deficit Hyperactivity Disorder; LD,
14 Learning Disorder, and then there's other ones that get
15 into communication and language disorders, for example.

16 And it's really based on compromise in brain
17 development, I would say, structure and function, but also
18 that focus on processing of information. That is a
19 hallmark of neuro-developmental disorders of any type.

20 With ASD, it's mostly emotional disability.
21 With ID, it's cognitive and adaptive disability.

22 Q. So are some deficits that you might see in
23 autism very similar to deficits that you might see with
24 ID?

25 A. Yes. And I -- there's -- there's -- well, ASD

1 is -- has been more in the mainstream. You know,
2 mainstream, I think in society, just a lot of talk about
3 Autism Spectrum Disorder. And the prevalence is higher
4 right now, and that's part of the reason why there's more
5 discussion as to it.

6 When someone is intellectually disabled, they
7 typically are so compromised that they have emotional,
8 cognitive behavior, behavioral and social deficits. Folks
9 with autism really have often that emotional, social
10 impairment.

11 When we look at someone who was ID, we typically
12 focus on the ID assessment, forgetting that a substantial
13 amount of folks with ID qualify for ASD.

14 Q. We'll get to ASD in a little bit more detail
15 down the road, but for now, tell me what the DSM-TR says
16 about neuro-developmental disorders.

17 A. Sure. There's conditions that occurred during
18 the developmental years, often prior to school, and they
19 impact one's brain processing, functioning, and, again,
20 produce problems, deficits, impairments a number of areas
21 of life functioning: Academic, occupational, emotional,
22 personal, social, behavioral, you know, domains.

23 They also can limit learning and compromise
24 executive functioning as well as social skills. So that's
25 when I do these types of assessments, as a

1 neuropsychologist, I do want to typically hit and assess
2 all of those areas that are listed here.

3 Q. Why is it important to have a clear
4 understanding of ID?

5 A. Well, I mean, diagnostic clarity is good. So
6 sometimes because we just, like, the State statutes or
7 requirements for disability, and to also figure out what
8 supports and resources the individual needs.

9 Q. What are some of the limitations of people with
10 intellectual disability?

11 A. Well, yeah. This may be redundant, Your Honor,
12 but, you know, basically, impairments, intellectual
13 functioning, adaptive functioning, and again, this really
14 gets even into the neuropsychological functioning domain
15 of executive functioning, problem solving, reasoning,
16 decision making, and emotional and social functioning.

17 Q. So do people with intellectual disability have
18 strengths?

19 A. Yes. I mean, obviously, the mild type will have
20 the most strengths. So when we get to the profound, we
21 really don't see many at all. But the folks that have the
22 mild, moderate levels certainly have strengths depending
23 on the individual.

24 Q. So could someone with mild ID send a simple
25 e-mail?

1 A. Yes.

2 Q. Could someone with mild ID converse with their
3 family?

4 A. Yes.

5 Q. Could someone with mild ID read a simple Bible
6 passage like the 23rd Psalm?

7 A. Yeah.

8 Q. Could someone with mild ID learn to drive,
9 albeit poorly?

10 A. Absolutely.

11 Q. Can someone with mild ID use a cell phone?

12 A. Yes.

13 Q. Why do we consider intellectual functioning
14 beyond IQ?

15 A. Well, IQ is, you know, like, when I do an IQ
16 test, it assesses a number of domains, but it does not
17 assess every type of domain. And it's also limited as to,
18 perhaps, the applicability to real-life situations. I
19 think it's important to have an objective marker, as both
20 organizations do, but we also want to look at just human
21 functioning beyond an IQ test itself.

22 And then some of these other areas of
23 functioning, again, problem solving, planning, initiation,
24 decision making, interpersonal relationships, they are
25 very applicable to everyday life, where the IQ may have

1 correlations with those, but they don't -- it doesn't
2 measure exactly those factors.

3 So when we're doing these assessments, we're
4 looking at data, you know, let's say from school records
5 30 years ago, about how they got along with kids. It's
6 maybe not just about a score, or how they're doing now,
7 whether they can, you know, do particular tasks. That may
8 not just be related to a score.

9 So the organizations that really emphasize the
10 last 10-plus years to equal the import for both adaptive
11 functioning and intelligence. You know, an attorney the
12 other day called me and say, Hey, what's her IQ score?
13 And I'm like, It's not just that, you know. And it was in
14 light of an Atkins question, but I'm, like, that's half
15 the story; do you know what I mean? So we focus on the IQ
16 score a lot.

17 Q. And the focus is also on adaptive behavior
18 during the developmental period; is that fair?

19 A. Correct, and that is more difficult, at times,
20 to assess. It's retrospective. You've got different
21 informants. You know, it's based in part on the memory of
22 those folks.

23 Q. And why is adaptive behavior an important
24 concept?

25 A. Well, again, it's really that's how we navigate

1 the world, and how we get along with folks. So that IQ
2 score is critical. And there's a correlation between IQ
3 and adaptive functioning, intelligence and adaptive
4 functioning, but this gets more into how you live your
5 life.

6 Q. Is there anything else you wanted to say about
7 the relationship between intellectual functioning and
8 adaptive behavior?

9 A. Well, on 2 on this slide, it says a low to
10 moderate statistical correlation between intelligence and
11 adaptive behavior scores. And there's no empirical
12 evidence to support a causal interpretation between the
13 two.

14 So but it is correlational. You need both --
15 you need deficits, substantial deficits, of both domains
16 intelligence and adaptive functioning to qualify for ID,
17 but that does not mean you're going to -- typically, you
18 don't have a 70 IQ, and then mom's adaptive behavior
19 rating is a 70, you know, but they're often -- usually,
20 there's, you know, limitations in both.

21 Q. Have you ever examined someone with a 55 IQ who
22 had no deficits in adaptive functioning?

23 A. No.

24 Q. Why is that?

25 A. They're, like, at that point 1.55 percentile of

1 intelligence. So out of 1,000 people, 995 people will
2 have a higher IQ score, and they don't have significant
3 limitations in navigating their world. I've never seen
4 it.

5 Q. Okay. One more time. I think we've covered the
6 diagnosis of intellectual disability.

7 A. Yes. Do you want me to define it again?

8 Q. No.

9 A. Okay.

10 Q. So let's talk about best practices for assessing
11 intellectual disability.

12 A. Okay.

13 Q. What are the best practices for assessing
14 intellectual disability?

15 A. Well, we want -- we want, basically, to have as
16 many records as we can about this individual. There are
17 data points, obviously, school records, mental health
18 records, work records, just for example. And then we also
19 will want to utilize updated, appropriate, accepted
20 assessment measures for intelligence IQ and for adaptive
21 functioning.

22 So ultimately, you know, we're going to want to
23 evaluate with ideally an informed collateral informant.
24 So someone who knows this individual quite well and how
25 they function and get along in society, in order to be

1 able to answer these questions on a required test.

2 So, you know, when I do competency evaluations
3 on a robbery and the person may be low functioning, we may
4 not have the resources to do all of this, but on an Atkins
5 claim, we do. So, ultimately, you're going to need to
6 have an IQ test and really academic achievement testing,
7 as well as an adaptive test ideally, the latter with a
8 collateral informant knowledgeable about this individual.

9 That may be easier to do with a pretrial case
10 like this versus if that individual had been on death row
11 for 30 years, and then we have to go back in time and then
12 try to find people, for example, but also, too, I think
13 it's -- I try to evaluate -- I'm seeing someone in Dallas
14 this Saturday on an ID case, and I need to do some
15 neuropsychological assessment with that person separate
16 from IQ.

17 Some of that assessment is going to be as to
18 practical adaptive functioning one on one. I'll interview
19 them about, Hey, you ever have a bank account? Tell me
20 about that. That is important, but I want objective data.
21 Can they utilize this map? So self-report is tricky in
22 these cases.

23 Q. Why is self-report tricky?

24 A. Some people will -- it's a response style. So
25 some people will -- again, cloak of competency, say they

1 can do things they cannot do. Some will lack insight into
2 what their strengths and weaknesses are. Some people may
3 want to be found ID and exaggerate their deficits.

4 I think it's more of a lack of insight in part,
5 and whether they actually know -- and you have to ask them
6 if they know what you're talking about, you know. Do you
7 know what that is? I guess we would call, is it reliable
8 self-report?

9 And the AAIDD in the DSM -- or the AAIDD in
10 particular will -- they do not recommend self-report
11 assessments of adaptive functioning and instruments for
12 self-report with ID or suspected ID folks.

13 Q. And is that because self-report is not
14 necessarily accurate?

15 A. Yes. I mean, for whatever -- yes, for the
16 reasons I mentioned, yes. So you want -- I try to -- I
17 try to -- when I do these, I'll interview people just to
18 get the information from them qualitatively and then try
19 to look to see if they even know what Johnny could do.
20 Some people you can just tell they just don't know.
21 They're not going to be able to answer these questions.

22 So you want to look at, Who was he living with
23 before his arrest, let's say, in a case like this, right?
24 Even a girlfriend, mom, or whoever. And then you ask
25 enough questions to where you believe that they can answer

1 this type of form.

2 Then you go over the form because the form is
3 basically 0, 1, 2, 3, with specific criteria as to each
4 score. And they often will just get in the habit of --
5 it's easier, it's human nature to say yes, no. Can you
6 use a microwave? Yes. Well, no. It's 0, 1, 2, 3, you
7 know? With assistance? You know, so it's detailed.

8 So, you know, ideally, you have quality
9 informants, plural, you have more than one, but I had only
10 one. I've had cases where we have none.

11 Q. But it sounds like you're saying it's important
12 to triangulate between many sources and as many sources as
13 you can, right? Records, collateral informants, people
14 who knew the defendant and the diagnosis, and then the
15 assessments you do yourself of the defendant?

16 A. Correct, and that really gives us what we call
17 "convergent validity." So is the data we're getting, is
18 it convergent? Does it make sense? Is it consistent?
19 And it won't always be, but we try to get as much
20 information as we can. I mean, we're never going to be
21 able to interview everybody.

22 Q. So we were talking about gathering that
23 information for the developmental period, and I think
24 you've explained why the developmental period changed from
25 18 to 22?

1 A. Correct. And if I may, sometimes we have to do
2 them retrospectively or -- and currently. So, you know,
3 mom may be able to fill them out when he was age 10 or
4 when he was age 20.

5 Q. So what are the causes of ID?

6 A. Well, you know, there are many. I mean, we
7 usually don't know. So if Johnny has ID, 90 percent of
8 the time we don't know why. 85 percent of the time. But
9 it can be certainly prenatal, perinatal at birth, birth
10 complications, you know, anoxic brain injuries, nuchal
11 cord issues, premature births, exposure to neurotoxins,
12 lead.

13 I've had domestic violence assaults on mom
14 during pregnancy, which is a big part of what we think
15 would be ID. You know, FAS, Fetal Alcohol Syndrome.
16 We've had head injuries during childhood that was, I
17 think, part of the ID finding.

18 Q. Let's switch gears and move to the American
19 Psychiatric Association and the DSM. What is the DSM?

20 A. Diagnostic and Statistical Manual of Mental
21 Disorders.

22 Q. When was the most recent volume published?

23 A. The fifth edition text revision was in 2022.

24 Q. And how does the DSM-5-TR define intellectual
25 disability?

1 A. Initially, they refer to it as intellectual
2 developmental disorder and it's characterized by deficits
3 in mental abilities, reasoning, problem solving, planning,
4 abstract thinking, judgment, again, academics, learning,
5 and learning from experience. Very similar to the AAIDD.

6 They require impairments in adaptive functioning
7 and -- we didn't really talk about this, but there's,
8 like, a threshold of, Can this person live independently?
9 Again, that gets to more of the needs and supports.
10 Social responsibility. Then communication, relationships,
11 work, academic functioning, and then, you know,
12 independence in community or home settings.

13 Q. The diagnostic criteria?

14 A. So there's going to be deficits in intellectual
15 functions. They, again, define them like we just did.
16 Reasoning, problem solving, planning, abstract thinking,
17 judgment, academics, learning, intellectual assessments,
18 standardized assessment.

19 And then, again, the deficits in adaptive
20 functioning. And deficits to the point where, you know,
21 they struggle living independently without some type of
22 support. And then having deficits in different domains,
23 do you remember, like, again, the social community
24 practical domains, and then it's got a developmental prong
25 as well where, you know, the onset needs to have occurred

1 developmentally before, I would say again, age 22.

2 Q. So basically --

3 A. So the social, practical, and conceptual domains
4 they cite, just like the AAIDD.

5 Q. And are there any differences between -- in
6 substance, between what the DSM-5-TR is saying and what
7 that AAIDD is saying?

8 A. Offhand on surface, no. I would say not really.

9 Q. Okay. And for the IQ, it's approximately two
10 standard deviations below the mean?

11 A. Yes. Are you looking at the criteria?

12 Q. Yes. I think we've pretty much covered
13 conceptual, social, and practical domains. Are there any
14 differences between what's in the DSM-5-TR in terms of
15 deficits and those domains and the AAIDD?

16 A. If we line them up, I'm sure the wording is a
17 little bit different. I think the concepts of the
18 adaptive domains are the same.

19 Q. How does DSM-5-TR assess the differences in the
20 severity of the level of disability?

21 A. So they will look at, you know, mild, moderate,
22 severe, and profound, like I discussed before, and they're
23 related to, in much part, the adaptive functioning.
24 They -- the APA and the AAIDD for years had focused much
25 on the IQ score with the severity of levels and they --

1 they've gone away from that, more looking at the adaptive
2 functioning levels.

3 Q. So how does DSM-5-TR now assess the severity --

4 A. So --

5 Q. -- of ID?

6 A. Yes. I mean, based on the three domains of
7 adaptive functioning, you know, conceptual, social,
8 practical, as well as their ability -- an individual's
9 ability to live independently.

10 So when we -- I'm looking at, what, 55; is that
11 where you're at? Yeah.

12 So they mention, like, a severe would result in
13 a child having little understanding of written language or
14 concepts involving numbers, quantity, and money, speech
15 and communication being focused on here and now with
16 everyday events. That would be social. The first one
17 would be conceptual.

18 And then the practical severe, not being able to
19 make a responsible decision regarding the well-being of
20 self and others, necessitating supervision at all times.

21 So, you know, that's a lot of -- that's
22 complicated assessment. In the DSM, there is like a chart
23 where it will say, mild, moderate, severe, profound, and
24 then give examples like this.

25 So the examiner, technically, has to look

1 through their records and interview folks and kind of see
2 where they fit based on the severity level.

3 Q. Could you give us some specific examples of
4 behavior, you know, mild, moderate, severe?

5 A. Yes. I'm going to -- maybe it will make it
6 easier if I can -- I don't want to misquote the DSM,
7 but -- so if I said mild -- I don't know if you have the
8 DSM with you?

9 Q. I do.

10 A. I believe it's on your page -- it may be -- I
11 don't know if it's 39 or 40. It's a chart. Table 1.
12 Severity levels for intellectual developmental disorder.
13 So what they have is a chart and some columns where it
14 will say severity level. It will say mild. Then it will
15 say a conceptual column, social column, practical column.

16 So mild -- there's a lot of information here,
17 but I -- so I don't want to read it, just for brevity's
18 sake, but I can -- what I'll do is, like, for example,
19 mild, conceptual in adults, abstract thinking, executive
20 functioning, priority setting, strategizing, short-term
21 memory, functional use of academic skills like reading,
22 money management, concrete approach to problems, solutions
23 compared with age peers.

24 Under the social, under mild severity for
25 adults, there's going to be some deficits, let's say, with

1 immaturity in their social interactions. Deficits in
2 perceiving social cues. Concrete knowledge, information
3 with limited abstract reasoning. You'll have some
4 difficulties with impulsivity or emotional regulation,
5 understanding some risks in social situations,
6 gullibility.

7 And then practical domain would be -- like,
8 under mild could be competitive employment is often seen
9 in jobs that do not empathize conceptual skills. May need
10 some support with healthcare decisions, legal decisions,
11 and they may need support to learn -- vocational support
12 for jobs. And they would need support often to
13 appropriately raise a family.

14 Q. Dr. Fabian, do you have Table 1 in the DSM-5 on
15 page 39 in front of you?

16 A. Yes.

17 Q. So in the practical domain for mild intellectual
18 developmental disorder or intellectual disability, the
19 DSM-5 says: That the individual may function age
20 appropriately in personal care, right?

21 A. Yes.

22 Q. However, individuals generally need support to
23 make healthcare decisions and legal decisions?

24 A. Correct.

25 Q. And that's consistent with your understanding of

1 mild ID?

2 A. Yes.

3 Q. Okay. Now, in the conceptual domain, it also
4 says: For preschool children, there may be no obvious
5 conceptual differences?

6 A. That is correct. Yeah, it just may not be
7 observable at that time.

8 Q. But as children age and as the tasks become more
9 difficult, that's when mild ID becomes more apparent; is
10 that fair?

11 A. Very fair. That's usually often that I see in
12 the middle part of elementary school, fourth to sixth
13 grade, that's really where abstract thought gets more
14 intense with school.

15 Q. And they can't keep up?

16 A. They often start struggling. Then it becomes
17 more observant in some cases, often in the mild folks.

18 Q. And in the social domain with mild ID, social
19 judgment is immature for the age?

20 A. Right.

21 Q. And a person is at risk of being manipulated and
22 gullible?

23 A. Correct.

24 Q. And that's just mild ID?

25 A. Right. But you don't need impairments with all

1 of the domains you just said. You just have deficits in
2 one.

3 THE COURT: Ms. Russell, now is probably a good
4 time to take a break. It's almost 2:30.

5 MS. RUSSELL: Sure.

6 THE COURT: So we've been going for about two
7 hours, I'm sure the doctor would like a break. So I
8 will see you all back here in 10 minutes.

9 (Break taken.)

10 THE COURT: Whenever you're ready.

11 BY MS. RUSSELL:

12 Q. Dr. Fabian, is intellectual disability ever
13 confused with other diagnoses?

14 A. Yes. Learning disabilities, learning disorders,
15 and they can be looked at different ways, but typically,
16 learning disability, learning disorder is when there's a
17 significant disparity between IQ and ability and academic
18 achievement. With ID, typically both are deficient.

19 Mental illness. At times, individuals with
20 chronic schizophrenia that is severe, they can be confused
21 with based on other factors, especially what we call
22 negative symptoms of schizophrenia, which are described
23 by, you know, poor communication skills, thought blocking,
24 thought delays, difficulties in some of their life
25 functioning.

1 Other, you know, on some cases, a person may
2 have low intelligence, but higher adaptive functioning
3 skills.

4 And then Autism Spectrum Disorder where some of
5 their communication -- they will have communication or a
6 language delay, but they may also have, you know, again,
7 emotional, social deficits that one may, you know, have
8 difficulties just on their face differentiating,
9 especially if they're not, like, an expert of evaluating
10 those folks.

11 Q. Let's talk about best practices in assessing ID.

12 A. Okay. So, yeah. Briefly, we're going to use
13 accepted intelligence tests, such as, you know, the WAIS,
14 Wechsler Adult Intelligence Scale, now in its fifth
15 edition. We're going to also assess academic achievement
16 skills, and other neuropsychological functioning tests
17 that are going to get at some of these executive
18 functioning skills, motor skills, sensory motor,
19 perceptual reasoning skills.

20 And then also ideally using adaptive functioning
21 skill -- or scale with an informant that is informed, so
22 that they know this individual pretty well in order to be
23 able to be deemed a collateral informant, a reliable one
24 for this type of case.

25 Q. Anything else about best practices in

1 interpreting scores?

2 A. Well, you want to -- obviously, when you're
3 interpreting this data, you're also looking at records and
4 other collateral information that you may have. I do like
5 to assess one on one some adaptive functioning skill sets
6 with, you know, tests that are appropriately normed.

7 So there are some practical adaptive functioning
8 neuropsychological type tests out there that I may use, or
9 I may also use certain parts of other tests that look into
10 their ability to understand, let's say, what a will is,
11 and then practical reasoning about healthcare, okay. What
12 to do in different scenarios, for example, which gets more
13 into the practical domain of functioning. And you're
14 considering, you know, these test results based on
15 practice effects, personal or environmental community
16 factors.

17 Q. Let's talk about best practices in diagnosis.

18 A. Well, you know, there's going to be a
19 psychologist, a neuropsychologist, typically. A
20 psychiatrist can, but they're going to need some of this
21 testing data as well.

22 Then we're looking at, again, standardized
23 tests, collateral interviews, and review of appropriate
24 collateral records.

25 And then again, there may be linguistic cultural

1 issues, especially folks that are born in other countries,
2 you know, English as a second language issues.

3 Q. So let's talk about a standardized IQ test.

4 A. Okay. There are several. I have four of them,
5 I think, I own. And they are normed throughout the
6 country with different populations, children, adolescents,
7 and adults, depending on the IQ test. When we're
8 looking -- I made mention before, the average here in a
9 bell curve of the population is 100, and each standard
10 deviation is 15 points above or below that mean.

11 The really, really intelligent folks, let's say,
12 at the second percentile are going to be around a 130 IQ,
13 and the folks at the other spectrum ID are going to be a
14 70.

15 Q. So that two standard deviations we were talking
16 about, what percentage of the population is that?

17 A. The second percentile.

18 Q. And that's just for mild ID?

19 A. Yes.

20 Q. Someone with a 55 IQ, would be where on the bell
21 curve?

22 A. They're still in the mild. Mild, based on
23 former DSM data is, like, 50 to 55 is 70, 75.

24 Moderate is more of that 50 level and below to
25 40. That's kind of traditionally how we look at that by

1 IQ.

2 Q. And in terms of the percentage of the population
3 in that 55 range?

4 A. About 1 percent, I would say.

5 Q. That's low?

6 A. Very low.

7 Q. These are the IQ tests, the four IQ tests you
8 use?

9 A. Yes. These are four IQ tests I have. Actually,
10 I have the Woodcock Johnson IV. I don't have the V yet,
11 but those are four that I would say are most widely used
12 with the WAIS-5 being the most prominent on the list.

13 Q. And the WAIS-5 recently came out, right?

14 A. Yes.

15 Q. When did it recently come out?

16 A. In the fall of '24.

17 Q. And before that, people were using?

18 A. The WAIS-4.

19 Q. WAIS-4.

20 How long had the WAIS-4 been around?

21 A. Since 2008, I believe.

22 Q. Well, let's talk about the WAIS-4.

23 A. Sure. So we typically use about 10 subtests.
24 The WAIS-5 has more, and I like that, but you didn't ask
25 me about that.

1 Q. Do you feel like the WAIS-5 is a better test?

2 A. Yeah. I mean, it should be more
3 psychometrically sound. I haven't compared it exactly,
4 but there is more executive functioning, and it's more
5 neuropsychological friendly and comprehensive than the
6 WAIS-4. There's probably 18 subtests. You only need 7
7 instead of 10 for a full scale, and I'm still tinkering
8 with it, but I like it.

9 But traditional WAIS-4 would be four domains of
10 intelligence. The first two are really the traditional
11 domains. Back in the day, it was really focused more on
12 that. It was really verbal comprehension. We call that,
13 like, crystallized intelligence, and that is, in most
14 part, learned. Vocabulary. Fund of knowledge.
15 Jeopardy-type information. Verbal Comprehension Index.
16 Then Perceptual Reasoning is more of that fluid
17 intelligence. Basically, kind of more innate
18 intelligence.

19 But the two last ones, working memory and
20 processing speed, are really attentional, but they are
21 tests. So, again, working memory. That line between
22 attention, memory, executive functioning, manipulating
23 information in mind, and processing speed, of really how
24 fast and efficient you can solve problems. It also has to
25 do with psychomotor coordination. The four of them have

1 multiple subtests within each of them. And that gets
2 into, actually, Slide 67. These are --

3 Q. How many subtests are there on the WAIS-4?

4 A. Well, including supplemental subtests, 15. And
5 really, we look at the 7, 6, 8, 9, 10. When I administer
6 these, I usually do the core subtest and the comprehension
7 of -- verbal comprehension.

8 Q. And those subtests are basically correlated to
9 certain skills? For example, Processing Speed Index,
10 Working Memory Index, Comprehension Index, and Perceptual
11 Reasoning Index, right?

12 A. Yes.

13 Q. And some of them correlate to more than one?

14 A. Yes.

15 Q. Okay.

16 A. Uh-huh.

17 Q. Okay. And that's all because the WAIS people
18 who developed the test at the American Psychological
19 Association?

20 A. Yeah. I mean, they're psychologists and
21 researchers as well, yeah. And the WISC-V is out as well.
22 That's the Wechsler Intelligence Scale for Children.

23 Q. And what does that use?

24 A. That would be typically up to age 16, yeah. And
25 there is the, I think, WISC-V. That's for preschool

1 before the WISC.

2 Q. So when assessing adaptive functioning, you've
3 talked about having a broad base of records and
4 information from different sources, much of it
5 retrospective. Where can we look to find that kind of
6 information?

7 A. Well, you could find work records, you know,
8 mental health records, school records. There could be
9 different, I guess, clubs, activities, different
10 certifications, vocational certifications. Those types of
11 records. CPS records or DCF records, you know. Then we
12 have on there, like, banking records, driver's license,
13 legal records, probation records, social services records,
14 birth records.

15 Q. And all of this information might inform whether
16 or not there are deficits in the social, conceptual, or
17 practical domains, right?

18 A. Correct.

19 Q. Tell us more about assessing adaptive
20 functioning.

21 A. Well, gathering those records. And then I would
22 say ideally, if you find a reliable collateral informant
23 or informants, you can either interview them separately or
24 together. I've done both. You know, with mom, dad,
25 aunts, uncles, siblings. I would say probably

1 individually is better to do, and then maybe collectively.

2 Then also, if you find those individuals, then
3 to have them, you know, answer, fill out adaptive
4 functioning assessment instruments. And, again, there's
5 going to be several of those that we can brush on that are
6 going to be appropriate, like the IQ test I just reviewed.

7 You know, the goal -- the last bullet is kind of
8 like, Measure how well a person functions on an
9 independent level and provide direction for optimal
10 support. So this type of context is a bit different,
11 obviously, but, you know, that's what it really is
12 designed for traditionally is needs and supports and
13 figuring out strengths, weaknesses, limitations. Then
14 what could we do with this person based on those scores
15 and abilities or deficits.

16 Q. So tell me about the Practice Guidelines
17 Regarding the Assessment of Adaptive Behavior?

18 A. Okay. So we're looking at adaptive functioning
19 instruments that are normed on the general population, but
20 then with and without disabilities. And you're looking at
21 a -- typically, these instruments will have a global
22 score, like a GAD, Global Adaptive -- or Global Adaptive
23 Composite, like a GAC, which is kind of like a full-scale
24 IQ that, instead of four domains of IQ, we just went over
25 it, it will have, like, the conceptual, social, practical

1 domains, for example, that coincide with the -- you know
2 the AAIDD and the DSM, you know, domains.

3 And then we want to appreciate that this
4 adaptive behavior is typical and not at their best. So
5 they're kind of average skills in those areas, and we're
6 hoping that whatever collateral informant we use, they
7 know that person well enough to provide that information.

8 And then also did we observe -- you know, did
9 they observe that person on a daily, weekly basis, and
10 across multiple community contexts. Now, that is
11 sometimes difficult, but we do the best we can with these
12 types of cases in trying to find folks that knew the
13 person.

14 Q. Okay. And how important is it that that person
15 who is a collateral interviewer has directly observed the
16 behavior that they're speaking about?

17 A. Yeah, I mean, that's -- that's really a
18 necessity. So some scales allow you to say when
19 they're -- let's say that the mother has never seen their
20 child do a particular question, you know. What -- if
21 given the opportunity, how do you think they would do. So
22 they can answer it that way as well, if they've not
23 observed it, but we want that person to be able to answer
24 a lot of those questions on the test.

25 Q. What is the ABAS?

1 A. So the Adaptive Behavior Assessment System, it's
2 in its third edition. That is one of those types of
3 tests. So it does go from childhood into adulthood. It
4 does allow for us to score that person's score based on,
5 well, if given the opportunity, you have not seen them do
6 particular tasks, how would they do it if they were
7 exposed, let's say?

8 That, again, is rated by a caregiver, someone
9 that -- or a family member, someone that knows them in
10 different, let's say, context.

11 Q. And does it identify individual strengths and
12 weaknesses?

13 A. Yes. So strengths, limitations, and, again, it
14 will -- the assessment is, again, designed to then line up
15 appropriate resources and supports for those needs or
16 limitations.

17 Q. And, in general, those assessments are done
18 thinking about the individual in the community-based
19 setting?

20 A. Yes. That's where -- that's exactly where they
21 would be in the community. So it's not based in jail,
22 prison, or, you know.

23 Q. So this is an example of the way the scoring is
24 done on --

25 A. That is --

1 Q. -- ABAS-3?

2 A. That is exactly correct.

3 Q. And has basically scores for each domain;
4 conceptual, social, and practical?

5 A. Yes. And you can see each domain, like
6 communication, functional academics, self-direction, are
7 under the conceptual domain. So they have a few subtests
8 per domain.

9 Q. Then there's that General Adaptive Composite,
10 and that's the scale score?

11 A. Yeah. That's like your full-scale adaptive
12 score, yes.

13 Q. And that would have to be two standard
14 deviations below the norm?

15 A. Yes. And that would -- that would, again,
16 include your standard of measurement, yes.

17 Q. What about the Vineland Adaptive Behavior Scale?

18 A. Yes. Very similar measuring adaptive
19 functioning presenting, like, an overall adaptive
20 functioning score. This one is not -- not delivered to
21 the subject being evaluated, but it's, I think, to, you
22 know, family, collateral caregivers.

23 That one also has -- looking at communication,
24 daily living skills, that's more practical.
25 Socialization, social skills, problem solving, motor

1 functioning, and it can also be used to assess behavioral
2 disorders that may impact some of the physical
3 disabilities.

4 Q. So the ABAS and the Vineland are both created
5 specifically for the assessment of adaptive functioning in
6 the intellectual disability context; is that correct?

7 A. Correct.

8 Q. And what makes them good measures of that in
9 this context?

10 A. Well, the construct, validity, the psychometrics
11 is designed to assess the definitions of what the AAIDD
12 will refer to, as far as these adaptive functioning skills
13 or deficits relevant to the diagnosis. Plus, they're
14 normed in different populations, including folks with ID.

15 Q. Are you familiar with the WHODAS 2.0?

16 A. Yes. That is World Health Organization
17 Disability or -- DAS, Developmental Adaptive Schedule or
18 Second Edition. Well, what it is is it covers adaptive
19 functioning in these types of different domains, and it
20 is, I think, based in self-report of the subject.

21 Q. It's an open source that's available on the
22 internet?

23 A. Yes.

24 Q. Is it scientifically valid for assessing
25 adaptive functioning in the context of intellectual

1 disability, or is it more of a general disability type --

2 A. Well --

3 Q. -- assessment?

4 A. -- I would say it's more of the latter. I look
5 at it as more of a guide, as kind of maybe -- if you're to
6 use it, it would be more of like a structured interview.
7 When I evaluate, it can be an ID case. It doesn't have to
8 be an Atkins case. It can be some other type of forensic
9 matter.

10 I will ask this individual I'm evaluating a lot
11 of these questions, okay, and I'm relying on their
12 self-report. Have you ever had a bank account? How did
13 you get money? Do you have a -- do you have a, you know,
14 caregiver? Have you ever lived independently? Do you
15 drive a car? Do you have medical insurance? How many
16 times did you take the driver's license? GED? What grade
17 did you finish?

18 All of that type of information we would do, but
19 then I -- and the WHODAS, I think, is fine to do as a
20 structured interview, but the AAIDD does not support that
21 as being adaptive functioning assessment in an
22 intellectual disability evaluation.

23 Q. Why is that?

24 A. Well, it's self-report. So they adhere to,
25 again, a collateral informant providing information.

1 Q. And would the fact that it is only 30 days
2 retrospective also be an issue since adaptive functioning
3 should be assessed during the developmental period?

4 A. Well, yes. I will say that would be current,
5 but, like, let's say if they're in jail or a psych
6 hospital, you know, we're also going to want to know how
7 you are doing currently in the community.

8 So I think it acts as a structured kind of
9 clinical interview of -- you know, you can ask them how
10 they're doing currently, even if they're in a facility,
11 but that is not going to be really relevant to an ID
12 assessment in a case like this.

13 Q. Okay. We're going to talk about that a little
14 bit more, but let's make sure we've covered self-report.

15 Why is self-report not the best method?

16 A. Well, again, it can be -- you know, a person can
17 be susceptible to biased reporting either way, okay. They
18 can exaggerate, minimize their skills, or have lack of
19 insight into that, and that would be the most concern that
20 I have in this type of case.

21 So I like to do, like, the comprehension testing
22 on the IQ or in a neuropsychological assessment battery
23 because that's function here and now. Do you know the
24 answer? What do you do in this circumstance, and that
25 requires knowledge.

1 So, you know, a lot of people can say a lot of
2 things and they exaggerate or minimize their skills and
3 there's really no way for me to assess the validity other
4 than they may say they drive a car, and I know they never
5 have because I talked to 12 family members. So there's
6 not a way to validity check it within the instrument
7 itself.

8 Q. Are inaccuracies in self-report always a result
9 of intentional misrepresentation?

10 A. No.

11 Q. Why is that?

12 A. They may lack insight, and they may confabulate.
13 They may not understand the question they're being asked.
14 Like, an interview, no different. Do you know what a plea
15 bargain is? Do you know what X, Y, or Z is in an adaptive
16 functioning setting? They may not know what you're
17 talking about.

18 Q. All right. Let's switch gears and talk about
19 adaptive functioning in structured environments like
20 institutions, prisons, hospitals.

21 A. Okay.

22 Q. Why is assessing adaptive functioning in the
23 institutional setting disfavored?

24 A. Well, you know, obviously, a lot of things are
25 being done for that person. So, you know, they don't have

1 to get health insurance, buy a car, get car insurance, go
2 to the grocery store, find a way to get food, things of
3 that nature. So it's more of a structured setting, and a
4 lot of things are taken care of for them.

5 There are really no normed adaptive functioning
6 tests with folks that are in correctional facilities, and
7 it's not always advisable to interview correctional
8 officers that may or may not know this defendant. It's
9 just like a structured kind of artificial setting, and it
10 is not a community where AAIDD is really based in its
11 development of assessing someone who is intellectually
12 disabled. It's a developmental disorder, and the kid
13 wasn't born in a prison.

14 Q. Okay. Have you ever heard institutions like
15 prisons and hospitals been referred to as the "ultimate
16 group home"?

17 A. Yes, I have.

18 Q. What does that refer to?

19 A. Well, two things: Some of the folks, you know,
20 we evaluate and represent have always been either in a
21 group home, a juvenile detention facility, and now in
22 prison, but a group home is, you know, the things are
23 there. They're provided, in part, for you. So you don't
24 have to show and exhibit as much to receive.

25 Like, you don't want to have to go and sometimes

1 buy your food or find a way for transportation, money to
2 do this, that, or the other. Live independently. You're
3 not living independently. That's the AAIDD's goal, is to
4 what supports do you need to live independently? In a
5 prison setting, the person is not.

6 Q. There are many cognitive tests that you can use
7 to assess adaptive behavior, right?

8 A. Yes.

9 Q. And those are listed inside 79?

10 A. Yeah, and just real quick on that. When you're
11 doing this type of assessment, the clinician/examiner must
12 do an IQ test, academic achievement test, and an adaptive
13 functioning test, assuming you have a reliable informant.
14 The last two are for -- the first, let's say, the AAB,
15 KTEA through the -- those are all academic achievement
16 tests, reading, writing, spelling, math that really need
17 to be done with this type of assessment, and that's in the
18 area of conceptual adaptive functioning.

19 The last few should also be done as well because
20 they do hit on language.

21 Q. Do you think it's important as a
22 neuropsychologist to know what the reading level is of
23 someone before you give them a test?

24 A. Well, that's how you find out. So, yeah, the
25 first few, you find out their reading level.

1 Q. Before you give further testing?

2 A. I think it's a good idea, especially when we
3 have more complicated cases that may require. Like,
4 forensic assessment instruments, some require reading, and
5 also, some require oral comprehension. I'm asking you,
6 let's say: Are you malingering psychiatric symptoms?

7 Let's say the guy may have schizophrenia. So I
8 may ask them -- do a test orally that assesses psychiatric
9 symptoms, and I want to know if they can understand the
10 questions. Or maybe it's a true-false that looks at
11 credibility of psychiatric symptoms.

12 You typically want to know their reading level
13 before I give them a psychological test. The Personality
14 Assessment Inventory, the PAI, that's a fourth grade level
15 of reading. I'm not going to give it to the person if
16 they don't have a fourth grade level of reading.

17 THE COURT: How are you going to determine their
18 reading level if you already think they have a
19 credibility problem as it relates to malingering?

20 THE WITNESS: Malingering of mental illness?

21 THE COURT: Yeah. You just mentioned a lot
22 about self-reporting, and how it's not necessarily
23 the best way to go, and people can exaggerate
24 symptoms or try and cover up symptoms.

25 But in this case, we're talking about not

1 someone who is applying for benefits or trying to get
2 an IEP done a certain way for particular educational
3 purposes, but someone who is facing criminal charges.

4 So how would you even know their reading level
5 is accurate?

6 THE WITNESS: Well, that's a good question. A
7 couple of things -- well, we want to know -- well, do
8 we have reading school records just to see by history
9 their reading skills. So that's one way. It's their
10 history -- historically.

11 I would give them, let's say, the test and see
12 if they can read it in front of me, which I would
13 want to do now, and you could then say, Well, what if
14 they're faking? Do you know if they are or not?

15 Two things with this: One, in psychology, we
16 can assess someone whether they're exaggerating,
17 feigning, malingering mental illness. Often
18 schizophrenia. In neuropsychology, we're looking if
19 they're exaggerating, feigning, malingering cognitive
20 deficits, okay.

21 So I do both of those depending on the case, and
22 those -- the latter is more related to, like, effort
23 testing.

24 THE COURT: That's the point I'm trying to make
25 is that --

1 THE WITNESS: Yes. So I want to assess that --

2 THE COURT: In the last round of hearings, we
3 had really as to Mr. Mosley, there was a lot of
4 conversation related to effort. So how am I supposed
5 to make that determination, whether or not he's
6 putting forth his full efforts in any testing that
7 anybody is giving? How do I know?

8 THE WITNESS: Sure. So I, first of all,
9 appreciate your conundrum. This is deep weeds in the
10 field.

11 THE COURT: It sure is.

12 THE WITNESS: It sure is, okay. And you know
13 what? I mean, there are -- in 2025, we do the best
14 we can. Recently, we had an Atkins hearing in
15 Florida having these issues. And I'm putting the
16 cart before the horse, but the judge asked so --

17 THE COURT: I'm sorry. I sort of skipped ahead.

18 THE WITNESS: No, you're fine. And one of the
19 problems here is that, in some cases -- and I end up
20 getting referred smorgasbords and buffets, as I call
21 them, where they had every problem potentially in the
22 world, but two big ones are schizophrenia and
23 intellectual disability, okay?

24 And the person -- those are the two most
25 profound disorders in that DSM you have over there,

1 okay. You want to look at effort testing, but
2 there's a caveat because there's probably only a few
3 that are pretty well normed with folks with ID.
4 They're often normed with folks with traumatic brain
5 injury, dementia, but not cleanly ID.

6 And so -- but we have a number of different
7 types of effort tests that we use, and you may have
8 heard about them. So there's a few that I use that
9 are, I think, better than other ones with this
10 population.

11 You're also kind of looking at convergent
12 validity as to see, well, how many has he passed or
13 how many has he failed and how much has he failed by?
14 The other thing you need to know is that these two
15 populations -- let's say, ID. There are often more
16 false positive results saying the instrument says --
17 kind of falsely stating they're malingering when
18 they're not.

19 And it's even more of a chance of that when the
20 person has a co-occurring schizophrenia condition.
21 They're ID and schizophrenia because they're more
22 likely to be disengaged, and that is not malingering.

23 So when we look at these assessments --

24 THE COURT: Well, explain the difference between
25 the two.

1 THE WITNESS: Sure. I look at -- you know,
2 there's different -- there's different semantics
3 here, but, like, you could have -- you could pass a
4 test cleanly, and I'll say it's valid. You could
5 have more confidence than the testing I do after that
6 are valid.

7 So when I go into this jail Saturday in Dallas
8 with this woman, I'm going to start with an effort
9 test, and I'm not going to tell her this, and I want
10 to see where she's at. And -- so you could have if
11 you pass -- typically, we give more than one effort
12 test. I know this -- and you may -- yeah, I think
13 you've heard of this.

14 THE COURT: I may have heard of a few of the
15 tests.

16 THE WITNESS: Sure, you have. But you also have
17 three standing effort tests, and the test is
18 designed, and this is what it is. It's an effort
19 test, okay?

20 Then there's embedded. You may have heard that.
21 That means, in an IQ test, there may be one or two
22 scales in that IQ that we can say are embedded to
23 look at effort, and I typically do both.

24 So -- and I don't know if I should, I guess,
25 reference. So, I mean, so reliable digits in the

1 digits span of the IQ is an embedded effort test, but
2 then I have -- you may have heard the test of memory
3 malingering, the TOMM, which is, by itself, an effort
4 test. These are very simple tests that folks with
5 moderate to severe TBI, dementia pass.

6 Now, if you pass most all, we could have more
7 confidence that you're trying, put forth pretty good
8 effort, and that whatever we do beyond that, like an
9 IQ test, is valid. It's kind of representative of
10 your true intellectual cognitive, ability whatever
11 that test measures, okay?

12 So we have pass valid, valid, responding. The
13 other thing I said it's kind of variable suboptimal
14 effort. Somebody may say it's poor. That's kind of
15 the disengagement variable. So when we look at these
16 tests, often it's kind of, like, they have two
17 choices.

18 And below chance, you know that they're
19 basically saying, you know -- they're basically
20 feigning and manipulating.

21 The pass is often like at a 95 percent clip
22 because they're easy tests. When you're somewhere in
23 that above the 50 chance, you're kind of looking at
24 the variable effort. The variable effort can be
25 different based on different things. They're in a

1 jail/prison, they're looking at the death penalty.

2 They have ADHD, PTSD, the trauma of killing
3 someone, okay. Like, psychiatric pain, medical
4 issues, a combination, right? The more tests you
5 fail even above chance, the more likely we may say
6 there's manipulation.

7 However, when you get someone with suspected
8 intellectual disability and schizophrenia, you're
9 going to have failures. You should expect them. It
10 shouldn't be below chance, but you're going to fail
11 the effort tests. There's going to be disengagement.

12 And where that comes in in the research is the
13 negative symptoms of schizophrenia. The positive
14 ones are the ones we hear about, hearing voices,
15 delusions, seeing things, hearing things. That's not
16 as significant. It can be if they're actively
17 psychotic at that moment.

18 The negative symptoms: Avolition, lack of
19 motivation, initiative, disengagement, spontaneity in
20 speech, blunted affect, flatness, not caring, maybe
21 lacking insight as well. Not caring, not in
22 pejorative way, but disengaged.

23 So when you have that, and that these tests are
24 not normed on folks with ID often, the double whammy
25 is schizophrenia and intellectual disability. You're

1 going to probably find more -- one or more effort
2 tests that are failed.

3 You want to make sure you look at -- you know,
4 they're 85 percent, 75 percent. That may not be that
5 they're, like, manipulating. So it's not just all
6 catchall, you're valid or you're malingering. If you
7 fail an effort test, again, you're going to expect
8 that in -- when someone is that impaired
9 psychiatrically and cognitively.

10 But then the issue is, okay. Well, if they
11 failed and you have other testing, what's that other
12 testing worth, right? So if you fail and the person
13 has a particular IQ score, is it really that low?

14 Then you kind of have to make a judgment as a
15 clinician -- and it depends on the case. I don't
16 have all the numbers nor am I going to be answering
17 about this case.

18 THE COURT: I understand.

19 THE WITNESS: Okay. So that's kind of how I
20 look at it. There may not be a perfect true score
21 because of human nature, you know. Like, in a case
22 with schizophrenia and intellectual disability, that
23 person -- these are the most profound conditions that
24 are known to man.

25 Is there anything else?

1 THE COURT: I think that answers my question.

2 Sorry to interrupt.

3 THE WITNESS: You're fine.

4 BY MS. RUSSELL:

5 Q. So we were just going to head into our
6 discussion about malingering and symptom validity and test
7 validity. So we're trying to move quickly through it
8 since some of it was covered.

9 A. Okay.

10 Q. Dr. Fabian, how important is it that effort
11 testing is chosen for the particular situation and is
12 appropriate for the situation? In other words, how
13 important is it that effort testing is normed on people
14 who have cognitive impairment?

15 A. Well, I mean, it's really important because you
16 want to ideally assess -- the assessments and tests you
17 use, you want to have been tested and normed on the
18 population you're assessing, okay.

19 So, you know, you want to -- really, you can't
20 use those tests, you know, unless it's really normed and
21 tested on the person you're examining, and whether -- it's
22 hard to have exactly -- some people have a lot of
23 deficits, right, but they need to be -- or conditions, but
24 they should be normed. You need to use an assessment test
25 that is really normed to the population you're assessing.

1 Q. So how do we figure out if someone is
2 malingered intellectual disability? I'm on Slide 82.

3 A. I'm processing your question. Well, if Johnny
4 had special education when he was aged 8, was he
5 malingered in the second grade? Probably not. That's
6 one way.

7 Q. There is --

8 A. The records --

9 Q. Sorry.

10 A. Go ahead.

11 Q. There would be no secondary gain in elementary
12 school?

13 A. Well, I mean, consciously, typically not. I
14 think that sometimes you'll see notes that will say, this
15 may not be a valid or reliable, you know, assessment of
16 their intellectual function when they're age eight or
17 twelve, but that may be because of the domestic violence
18 going on in the home that the teacher knows about. There
19 could be other variables.

20 But, typically, I mean, kids are relatively
21 motivated. They may be ADHD running around, and usually,
22 there's clinical signs and the mental status and then the
23 IQ results that will be discussed by this
24 psycho-educational school psychiatrist, you know? So you
25 want to look at those records. We start with that, okay.

1 Then you want to look -- you know, is there a
2 correlation between malingering and, let's say,
3 criminality? Yeah. Antisocial personality disorder?
4 Yeah. Length of criminal offending? Yes. Chronicity,
5 yes. But you also want to look at the history of, you
6 know, their deficits or disability, their mental health
7 records, et cetera.

8 Also, just some other factors as to collateral
9 information as to, Did they understand? Did they get
10 fired from work because they didn't understand what they
11 were doing? Couldn't catch on, et cetera.

12 So there are other markers that are separate
13 from just scores. So, again, that mental synthesizing
14 information from multiple sources. The self-report,
15 again, is we get into, you know, that can be a problem
16 both for and against. They may exaggerate or minimize
17 deficits.

18 You know, some of these cases I have they --
19 like the one, this gentleman did not want to be found ID
20 because he got beat up, and he was always saying yes to
21 everything, and he did not know really the questions I was
22 asking him. He would just say, yeah, I understand when
23 they don't. That's the cloak of confidence.

24 Again, most of those instruments have not been
25 cleanly normed on the folks with ID. Some of them have.

1 A couple of my users are more normed on, like, fetal
2 alcohol children that are found to be ID. And I may say,
3 Well, they may have been low -- lower functioning than an
4 adult with ID, you know?

5 But, you know, we're mixing a little bit of
6 apples and oranges. We do the best we can. We look at
7 trends, and we want to look at kind of the number of, you
8 know, validity markers that are given and their results.

9 THE COURT: Can I ask a question? I'm sorry.

10 Environmental factors are certainly a
11 consideration because that was something we just -- I
12 think you just -- I'm using a different word than
13 you, I think, but this is something that's come up
14 before, and I think you just touched on it, that, for
15 example, a child could be on an IEP in school because
16 mom and dad fight, and they don't sleep at night.
17 Therefore, they don't perform well at school or mom
18 and dad aren't checking their homework or mom goes
19 out all night. There's no dad in the home.

20 I mean, I can think of the various scenarios
21 when I was in family court of reasons why during a
22 divorce, for example, children might not do so well
23 in school at a very early age and it's not -- it
24 doesn't appear as if it's related to a mental illness
25 or an intellectual disability, but they --

1 environmentally, there's something going on outside
2 of school do not perform well in school.

3 Does that make sense? Did I explain that?

4 THE WITNESS: Yes. Absolutely.

5 THE COURT: Okay. You touched on it a little
6 bit, but I think you would agree with me that
7 environmental factors, when I'm looking through
8 historical data, could be relevant.

9 THE WITNESS: Yes.

10 Can I respond?

11 THE COURT: Yes, please.

12 THE WITNESS: Okay. When someone is really low
13 functioning, you can't put all the eggs in that
14 basket.

15 THE COURT: Correct.

16 THE WITNESS: Often when they are low
17 functioning, they're going to be tested, hopefully
18 ideally, depending on the school system, at multiple
19 junctures. They may often be in the same home, but,
20 you know, there may be days when they're tested, when
21 it's a good day or a healthier day.

22 THE COURT: Right.

23 THE WITNESS: The other thing is, often there
24 will be a note in that, you know, where the -- they
25 don't test effort in elementary school, okay.

1 THE COURT: Right.

2 THE WITNESS: Now, they often don't. I worked
3 at juvenile court in Cleveland, Ohio, for 10 years,
4 and we weren't really testing effort either where it
5 really should have been, okay? Now they are doing
6 that more with juvies.

7 I always -- whenever I do juvenile exams, I do
8 effort testing, and now there's more test assessing
9 them as well. So with that said, when there's
10 multiple testing points, usually, there's some valid
11 scores there somewhere, okay?

12 Now, ADHD can also get in the way. Are we
13 looking at learning problems or emotional behavioral,
14 or is it PTSD trauma and ADHD? Kids are complicated,
15 so are their lives and environments, as you say. So
16 with that said, usually -- I -- I rarely see a kid
17 that's been tested multiple times where every time
18 it's said, Oh, this is a valid marker.

19 THE COURT: Well, yes. Just to Ms. Russell's
20 point that, at a certain age, there's really no
21 secondary gain to not put forth the effort, say, in
22 elementary or middle school. There's something else
23 going on. There's either a true intellectual
24 disability, a learning disability, environmental
25 factors. It could be a whole host of different

1 things that could make, for example, a child needs an
2 IEP.

3 THE WITNESS: Correct. And in that, when they
4 have the ARD Committee, you're doing interviews with
5 different teachers that are observing the classroom,
6 ideally, and then also doing interviews. They're
7 doing their own BASC, behavioral assessment of
8 systems checklist, or their A-BASC where in those
9 notes or in those tasks it will say, Johnny doesn't
10 understand directions and that's just not an IQ score
11 based on -- you know, these are observations that are
12 just not about what's going on at home.

13 THE COURT: Right.

14 THE WITNESS: The true low functioning comes
15 out.

16 THE COURT: Sorry to interrupt again.

17 MS. RUSSELL: No worries, Your Honor.

18 BY MS. RUSSELL:

19 Q. The TOMM and the Rey 15 are effort tests normed
20 for people who are cognitively impaired?

21 A. Yes, but really not ID. The TOMM -- the TOMM
22 even has an article by Christopher Ray, R-A-Y, and he did
23 some studies on this, where he suggests a lower cutoff
24 score for those with ID because of the false positives of
25 that test found with folks with ID.

1 So falsely saying, this test, the person failed,
2 and you're falsely saying they're malingering or having
3 poor effort when they're not, okay. A failed effort test
4 does not equate with malingering, okay? It equates with
5 suboptimal effort, disengagement. Maybe malingering. It
6 just depends kind of on how bad they failed, how many of
7 them they failed, et cetera.

8 Q. Are you aware of whether the VIP and the M-FAST
9 are normed for people with cognitive problems?

10 A. They're not. I mean, so the VIP, Validity
11 Indicator Profile, is not recommended to be used with
12 folks with ID. That gets into some cognitive effort, but
13 the M-FAST, Miller Forensic Assessment of Symptoms Test,
14 is me reading questions saying: Do you hear voices only
15 on Tuesdays when you're hungry? I'm making that up, but
16 it's kind of the gist. That person needs to understand
17 what you're saying, and that is tricky when you're
18 evaluating someone with ID.

19 It's oral comprehension, auditory comprehension.
20 They're not reading, so you want to know -- well, ideally,
21 you want to test their auditory oral comprehension to
22 really see where they're at.

23 They're also -- so, really, it's about
24 psychiatric symptoms and really about schizophrenia
25 symptoms, and 23 of the 25 items are about schizophrenia,

1 I would say. So this was not a cognitive effort. It's
2 not about cognition. It's about psychiatric symptoms.

3 It is really at norm with folks with ID, so
4 you've got to be careful when you give that because you're
5 going to be more likely to have false positives with that
6 because folks could be naysayers they can also malingering,
7 but it's -- you have to be careful with that with folks
8 that are low functioning.

9 Q. That dovetails perfectly with a discussion of
10 the differences between performance validity and symptom
11 validity.

12 Tell us what is Performance Validity Testing?

13 A. That's more of, like, the TOMM. So we're
14 looking at performance, its function. So it's really
15 looking at visual, learning, memory, and effort. The
16 cognitive skills set is visual, learning, and memory, but
17 it really is designed to assess effort.

18 And then the symptom validity can be like a
19 Personality Assessment Inventory, the MMPI. Also, like
20 the M-FAST where you're looking at psychiatric symptoms.

21 Q. So do symptom validity tests tell us anything
22 about effort?

23 A. No. And I had cases where the individual is
24 malingering on the M-FAST and not on the TOMM.

25 Q. And what does that tell you?

1 A. Well, they could be ID and not schizophrenic or
2 exaggerating schizophrenia. Let's say they tested it in
3 the ID range. I've had cases like that. It's
4 complicated, but I can say, Hey, they passed the TOMM, and
5 they have a 70 IQ. It looks pretty valid, but they're
6 exaggerating psychotic symptoms or vice versa.

7 Q. I know you touched on this super briefly, but
8 just to cover all our bases, could you tell us how
9 performance validity tests are categorized?

10 A. Yes. Stand-alone or embedded. So embedded
11 within the measure, the cognitive or neuropsychological or
12 intelligence test kind of hidden in there. It's not
13 really designed to do it, but there's been research on it
14 subsequent to the manufacturing of the test, versus
15 stand-alone, where it's really kind of designed to measure
16 that effort.

17 Q. Dr. Fabian, are there embedded measures of
18 effort on the WAIS?

19 A. Yes.

20 Q. What are they?

21 A. The one I use is reliable digits span, RDS. I
22 believe there's a vocabulary one as well of a particular,
23 I think, threshold of -- I think the raw score -- I forget
24 the cutoff. I use reliable digits span forwards and
25 backwards. I can share it with you. I don't know if you

1 want to know more about it.

2 Q. Okay. Is there anything else we need to know
3 about performance and symptom testing in populations with
4 intellectual disability?

5 A. No. I mean, not at this point.

6 Q. All right. How do medications affect testing?

7 A. Well, I mean, depending on the -- I know studies
8 cited, the medication, how long the person has been on the
9 meds, dosages, other comorbid symptoms, et cetera, it can
10 have an effect.

11 Now, once stabilized, it can improve the
12 person's functioning, but it also can lead to impairments.
13 So I want to say, you know, for the Court, there are
14 neuro-cognitive effects or sequelae to mental illness. So
15 our field has changed from, you know, PTSD, you have
16 flashbacks, you have nightmares of a traumatic event or
17 events, or you're schizophrenic and you hear or see things
18 or have delusions, to more being brain-based disorders
19 where they -- we know now where schizophrenia is housed,
20 and that area is where kind of memory is as well and some
21 executive functioning.

22 So there's going to be some neuro-cognitive
23 effects of the mental illness, but also from the
24 medication being used. So the antipsychotic medication
25 depending, again, on dosages, et cetera, can impact one's

1 cognitive performance, also their effort, their
2 engagement, et cetera.

3 Q. What's "co-morbidity"?

4 A. Just when someone has, you know, more than one
5 psychiatric disorder at the same time.

6 Q. Are people with ID more likely to have other
7 syndromes?

8 A. Absolutely.

9 Q. Okay.

10 A. Yes.

11 Q. Okay. How so? Is it a high risk of
12 co-occurring mental health conditions?

13 A. And medical and neurological. They're
14 simplistically just less resilient than the typical
15 person. So they're going to be more at risk for physical
16 anomalies, conditions, and mental. So often when you have
17 a neuro-developmental disorder, you're at high risk for
18 another one.

19 Q. And, in fact, that would be three to four times
20 higher than in the general population; is that what the
21 DSM says?

22 A. Yes. So, typically, if you have ID, you're
23 going to have a co-occurring ADHD and/or autism, and
24 autism will place you at risk to develop schizophrenia.

25 Q. So what are the most common neuro-developmental

1 disorders that come with ID?

2 A. Usually, I will see LD and ADHD. So, like, a
3 learning disorder and ADHD, comorbid. Probably in a 30 or
4 more rate.

5 Q. And what about other neuro-cognitive disorders?

6 A. Well, yeah. I mean, with ID and ASD -- and
7 again, that -- if I may. When you look at ID, they're so
8 impaired in so many areas cognitive, emotional,
9 behavioral, social you forget that they can be autistic,
10 you know? Because they're just ID, you know? And I think
11 that's becoming more relevant in our field. We should
12 really be assessing both.

13 So the rates are pretty high that when someone
14 is ID, they're going to have other, like,
15 neuro-developmental conditions. Also psychiatric, like,
16 conditions. Especially, like, anxiety, sometimes
17 depression.

18 Q. Let's talk about ID and autism and the
19 relationship between the two.

20 A. Sure. Right. Well, I have seen studies when it
21 is, like, 30 percent, even 50 percent. So folks with ID
22 are going to have language delays, which is necessary for
23 autism, and they're going to have difficulties in some of
24 the areas -- like, a number of the diagnostic criteria for
25 ASD that we'll see just in a minute.

1 Q. So, Dr. Fabian, just because we're running a
2 little bit short on time --

3 A. Sure.

4 Q. -- we do have all the ASD criteria.

5 A. Yeah.

6 Q. Could you just point out, as we scroll through
7 them, what symptoms are similar or, in fact, identical
8 between intellectual disability and ASD?

9 A. All right.

10 Q. Being Autism Spectrum Disorder.

11 A. So a difficulty with back-and-forth
12 conversation, emotional reciprocity, sharing of
13 information, emotions, empathy, kind of really
14 appreciating how other people may feel or think,
15 initiative, and appreciating, let's say, nonverbal
16 communication, language deficits, problems appreciating,
17 identifying nonverbal cues.

18 And then perhaps deficits in developing, keeping
19 relationships. Problems, you know, with imagination.
20 Interest in peer groups. Now, a lot of folks with ID do
21 have those skills, so I think it's more of just
22 appreciating other's emotions, understanding, you know,
23 jokes, let's say.

24 Now, some of that is going to be mixed with
25 cognitive versus emotional or social deficits, but when we

1 look, social domain is one of the domains of adaptive
2 functioning deficits. So they do overlap.

3 Q. What about symptoms of autism as they might
4 affect competency?

5 A. I've seen difficulties appreciating charges or
6 really the consequences of their offending behaviors,
7 leading to the severity of the charge and consequence.
8 I've seen that in different cases. They may be able, on
9 the face, understand that rape was a sex -- you know,
10 committing a sex crime against someone, but the shared
11 experience of a sexual encounter is often different
12 between, let's say, a woman normal and a man that has
13 autism. Does no mean no? Appreciating that, especially
14 if they have had sex before, let's say, and appreciating
15 that context, and then looking at life, rape, as a
16 consequence. I've seen that before, for example.

17 Q. What about inappropriate facial gestures,
18 inappropriate laughter, that kind of thing? How does that
19 play in front of a jury?

20 A. Well, yeah. I mean, just as far as the -- they
21 may -- well, if someone is, like, testifying, let's say,
22 just some of the emotional cuing they may not really
23 appreciate facial gestures, and especially if they have
24 suspected ID and ASD together, and even schizophrenia.

25 Q. All right. Let's talk about schizophrenia.

1 A. As noted, you know, the positive symptoms we
2 often see hallucinations, hearing things, seeing things.
3 Delusions, having false beliefs. Then disorganized
4 behavior, speech, incoherence, derailments, all of these
5 types of, you know, psycho lingo that shows that they are
6 nonsensical, disorganized in thoughts and speech, and hard
7 to follow in their own world, really, with just a lack of
8 contact with reality, which is the hallmark of
9 schizophrenia.

10 And that can also lead, you know, to negative
11 symptoms. That would, you know, the blunted lack of
12 emotional expression; Avolition, again, leading to a lack
13 of initiative drive; anhedonia, lack of pleasure in life.
14 Some of these then will start overlapping with a
15 depressive disorder.

16 But also, then, adaptive functioning deficits
17 are in practical domain, such as grooming, self-care.
18 Then difficulties in life functioning, occupational
19 relationships, for example.

20 Q. So these negative symptoms, for example, blunted
21 affect, alogia -- did I pronounce that right?

22 A. Well, I think it's alogia.

23 Q. Alogia?

24 A. Yeah.

25 Q. How are those -- how is that even possible that

1 those things could be confused with, for example, poor
2 effort in testing?

3 A. Well, alogia is going to be a lack of
4 spontaneous speech conversation. The avolition is just,
5 again, a lack of initiative, motivation, response. Again,
6 disengagement, spontaneity, but motivation, you know. And
7 the effort tests are motivation. Like, we're looking at
8 the motivation effort.

9 So, you know, when you have these negative
10 symptoms, that is part of the problem when we're doing
11 this type of effort testing. There's often thought
12 blocking consistent with schizophrenia, which is a delay
13 in responses because of difficulties with processing.
14 Things going on in one's mind that we may not know about
15 where they're trying to process information, they may be
16 hearing things or hearing delusions or strange thought
17 processes that are cognitive, I would say, deficiencies
18 with schizophrenia.

19 Q. So do antipsychotic medications necessarily
20 treat all the negative symptoms of schizophrenia?

21 A. Well, some -- so the person may have a
22 medication to really assist with the voices or delusions,
23 and then another medication may assist with the negative
24 symptoms as well.

25 Q. But sometimes those aren't the same medication?

1 A. Correct.

2 Q. So sometimes the negative symptoms of
3 schizophrenia can persist even if the positive symptoms,
4 the hallucinations, have been dealt with?

5 A. Yes.

6 Q. But those negative symptoms could also cause
7 problems with --

8 A. Correct.

9 Q. -- competency?

10 A. And --

11 Q. Is that fair?

12 A. Fair. And the medications may cause a person to
13 be sedated which can affect cognition and motivation.

14 Q. So what's the relationship between effort,
15 motivation, intellectual disability, and schizophrenia?

16 A. Wow. It's complicated. So -- well, there's a
17 lot of relationships. I can give you a zillion ways that
18 could affect -- I guess they're separate disorders. When
19 they're together, they're most profound.

20 As I said in your manual over there, together
21 they're going to place an individual at highest risk to
22 fail effort tests than just one condition alone. So all
23 of those conditions can affect effort, which ultimately
24 can affect your testing and your results even, let's say,
25 an IQ test.

1 I would -- well, that leads to: What's your
2 best practice? When do you administer these tests? Okay.
3 So do you want to administer them when they're on certain
4 medications? Do you want to wait? There's different ways
5 to look at that synopsis there.

6 Q. Okay. Should I go back to Slide 104?

7 A. Well, the lower a person's cognitive functioning
8 and the more significant the symptoms of schizophrenia,
9 the more likely they'll fail effort.

10 Q. What about schizophrenia and competency to stand
11 trial?

12 A. That's the number one disorder that is found to
13 be amongst folks that were found to be incompetent by far.
14 So, really, it lends itself to the Dusky standard, because
15 many folks with schizophrenia are not rational. So they
16 will have difficulties in making rational legal decisions,
17 as far as pleas, and also as to how they communicate and
18 think and assist with you.

19 So those are kind of the two -- they often
20 understand their charges and penalties, that's the easy
21 stuff. The meat is: How are they going to assist their
22 defense in their defense? And when are their legal
23 decisions going to be made? You know, are they making
24 logical, rational legal pleas in their decisions when you
25 talk about the evidence? You know, how they want to

1 handle their case?

2 As well as whether they appreciate that they
3 have mental illness and appreciate an important legal
4 safeguard as to insanity. So that defense, if they lack
5 insight, which is very common with folks with
6 schizophrenia, as you know, they don't think they're
7 mentally ill. They don't think there's any connection
8 with mental illness to the crime, and they will not plead
9 insane because they don't think they're mentally ill.

10 If he has a viable insanity defense, then they
11 may not be competent to stand trial because they're not
12 appreciating that legal defense.

13 Q. Dr. Fabian, if you have a case that involves
14 potentially three of these syndromes; intellectual
15 disability, autism, and schizophrenia, how are people
16 supposed to figure out what causes the incompetence?

17 A. There are a lot of cooks in the kitchen, I'll
18 start with that. So you've got different examiners in
19 different facilities doing different things.

20 So if I may, I -- you know, a judge from
21 Indianapolis called me the other day and said, We need you
22 to do an Atkins evaluation, and he needs it lickety-split.
23 I'm like, Well, you need to talk to the other experts.
24 There's a prosecutor expert, a defense expert, and I'm
25 your expert.

1 So there's different ways to do this IQ. And
2 I've done it with a prosecutor expert or a defense expert.
3 I've done it on my own. We don't want to do the same test
4 quick, like, with a practice effect. So that's rule one.
5 You would need to communicate on what people are doing, if
6 you can. He told me, he said, the Defense expert already
7 did the WAIS-5. I'm not doing it. I may not do an IQ
8 test. It was valid then. So we don't need me to reinvent
9 that wheel.

10 So there's communication about what's going on.
11 Your question -- and I get it, and I don't want to do a
12 narrative. There's so many things I can answer.

13 So what do we do with someone who has suspected
14 schizophrenia, ID, ASD who's on medications, is related to
15 evaluating him for competency to stand trial?

16 Q. Yes. My question to you is: If somebody has
17 those three co-occurring problems, right, what are the
18 best practices for trying to sort it out?

19 A. Well, as an examiner, no matter who is retaining
20 you, we want to look to see if -- we want to look at their
21 records first, okay. We want to see what their diagnoses
22 are, what their history is, okay? Is this the first time
23 they've had schizophrenia, psychotic symptoms following
24 the offense? Was it present before? Things of that
25 nature.

1 We're also looking at what medications maybe
2 they're on historically now. Do they help the condition?
3 We want to look at school records to see, you know, how
4 they functioned historically, if we have school records.

5 If I'm on an inpatient unit, I want to see how
6 they're getting along with their presentation is are
7 they -- just observations of that person in that facility
8 because it's hard to fake long term in a facility being
9 watched and, you know.

10 So we want to look at their criminal record. A
11 lot of things we want to look at kind of before we --
12 that's what we start with. Then we start with the
13 assessments. Knowing that this -- well, you know, I can
14 understand that if you're thinking the person is low
15 functioning, you want to start, really, with an effort
16 test and then -- I typically start with that, and then
17 give an intelligence test, okay or whatever reading test,
18 let's say, you know, but I want to see how their effort
19 is, you know.

20 I've seen it different ways, Your Honor, where
21 when I was in my fellowship if we -- we had a
22 neuropsychological battery and it could be brain cancer,
23 it could be a tumor, it could be epilepsy, a seizure, a
24 stroke, a TBI, ID, and if they failed effort, we still did
25 the battery, okay?

1 And any strength -- any average or above
2 average, we knew that was their ability. Anything below,
3 we didn't know if that was an impairment or not, but some
4 other people look at it as if you fail, then you don't
5 continue with testing. We're not sure if it's valid.

6 The problem is, you can do that if it's a clear
7 kind of malingerer, right? But in this type of case,
8 sure, if you suspect that they're cognitively delayed or
9 impaired, you can do the testing. I would suggest you do
10 the effort testing before you do IQ, okay.

11 You have to be careful about whether they are --
12 where their functioning is to really do the M-FAST, for
13 example, and really maybe not do it if it's really not
14 normed on that population, okay? Or if you come to court,
15 you have to testify to the limitations of that instrument
16 with that particular population.

17 So I would look to see what their prior
18 diagnoses are to be able to figure out what test you may
19 or may not want to do with that person. So when you
20 evaluate him, you may not know, Hey, this guy is ID. I
21 should not use this test, because you may have to figure
22 out if they're ID.

23 Q. So for all three in sorting it out, it's records
24 from history, collateral interview, testing; is there
25 anything else?

1 A. Well, I also -- I mean, I typically will -- now
2 often I will get a call, and they say, Do everything;
3 competency, sanity, mitigation, Atkins, the whole thing,
4 but there's different experts at different times as well.

5 So -- (indiscernible) doing competency -- the
6 other night, I didn't do an IQ test, and it was a rape
7 case that I referenced. I didn't do an IQ test. Now, I
8 do have a 5-8 -- 58 before. I didn't have it with me. It
9 was in the gentleman's health records. I don't know if
10 that was true or not.

11 So I didn't do an IQ test, and I'm recommending
12 he's not competent to stand trial. I didn't need to do an
13 IQ test to know that he was not -- that I believed he was
14 not competent, okay.

15 Q. That's fair.

16 One financial question: Is it scientifically
17 valid to give the WAIS twice in a three-month period?

18 A. No.

19 Q. Why not?

20 A. Practice effects of -- the AAIDD will say a year
21 depending on the research study and the subtest, there's
22 more practice effects in tests that you do -- you get
23 practice on. So let's say block design. Oh, I remember
24 those blocks, that's right.

25 So the other day my psychometrist who does a lot

1 of my testing, she said -- he was at the office, the
2 defendant. I had met him before. He said, I recognize
3 the blocks. We don't do it. I've got another IQ test
4 I'll do or I'll just get him to sign a release and I'll
5 get that IQ score. So you have to kind of ask questions
6 before you do, especially in these types of cases, but
7 three months, that's a problem.

8 MS. RUSSELL: Okay. I think we're done now,
9 Dr. Fabian. Thank you.

10 THE WITNESS: Thank you.

11 THE COURT: Thank you.

12 Any cross-examination?

13 MS. SULLIVAN: Yes.

14 CROSS-EXAMINATION

15 BY MS. SULLIVAN:

16 Q. Hi, Dr. Fabian.

17 A. Hi.

18 Q. You were hired by the Public Defender's Office?

19 A. Yes.

20 Q. Is that right?

21 A. Yes.

22 Q. Do you charge by the hour? What was your fee
23 schedule with them?

24 A. Yeah, by the hour is 350.

25 Q. Okay. How many hours would you say you've put

1 into this?

2 A. Like probably before today, a dozen.

3 Q. Okay. Did that consist of generating this
4 PowerPoint we've been watching?

5 A. Yeah.

6 Q. And you live in Austin, Texas; is that right?
7 Did I catch that? Or where do you live?

8 A. I live in Austin. Yeah, I live there primarily.
9 I'm here as well sometimes. I am joining this trip with a
10 case that I'm driving to today.

11 Q. Okay. I'll be a little clearer.

12 Where did you fly from to get here?

13 A. Austin.

14 Q. Okay. And that will be paid for as well by
15 Defense counsel?

16 A. Yeah.

17 Q. Okay. I just want to be clear. We've talked a
18 lot about different mental illnesses and intellectual
19 disability and IQ testing. You've never evaluated Thomas
20 Mosley, right?

21 A. That is correct.

22 Q. You've never met him other than he's in the
23 courtroom here today, correct?

24 A. Yes. I don't know him.

25 Q. You haven't diagnosed him with any, if any,

1 mental illness?

2 A. Nothing.

3 Q. You haven't conducted any testing on Mr. Mosley.

4 A. I have not.

5 Q. You do not have an opinion as a doctor regarding
6 his competency to stand trial?

7 A. I do not.

8 MS. SULLIVAN: May I have a moment?

9 THE COURT: Yes.

10 MS. SULLIVAN: Nothing further. Thank you.

11 THE COURT: Any redirect?

12 MS. RUSSELL: No, Your Honor.

13 THE COURT: Thank you for your time. Would you
14 all mind e-mailing me a copy of this? That way, I'm
15 not taking something out of evidence and copying it.
16 I'm just going to hand it off to the clerk for
17 filing, and that way, I will have a copy for my
18 notes. If that's okay, that would be great.

19 MS. RUSSELL: Sure.

20 THE COURT: Did you have a chance to look at
21 this motion?

22 MS. SULLIVAN: I was given it when I walked in
23 here this afternoon. I want to talk to Dr. Railey.
24 My understanding is that Dr. Railey has turned over
25 everything that he had that wasn't proprietary. I

1 need to talk to him. I need a moment because I just
2 got handed this --

3 THE COURT: That's fine. I'm not -- that's why
4 I'm asking if you had a chance to look at it. If
5 you're not prepared to discuss it today, we won't do
6 it today. We have other hearings coming up, not next
7 week, but the week after.

8 So who do you want them provided to, you or
9 another doctor?

10 MS. RUSSELL: Us.

11 THE COURT: Okay.

12 MS. RUSSELL: The story is, Your Honor, the
13 WHODAS, as it turns out, is open source. The
14 manual --

15 THE COURT: Right.

16 MS. RUSSELL: -- is in my hand right here. I
17 got it off the Internet. We don't really believe the
18 materials are proprietary.

19 THE COURT: Okay.

20 MS. RUSSELL: And we would like to see those
21 score sheets because there are some real
22 discrepancies in both the time and the method of his
23 having given it to Mr. Mosley.

24 THE COURT: So let's --

25 MS. RUSSELL: The broad -- he did provide it to

1 our experts, but our expert is saying that, you know,
2 even though we've had a long discussion with her, in
3 deference to Dr. Railey's deeming those materials
4 proprietary, she said, I will need a Court order in
5 order to show you those tests.

6 THE COURT: Okay. So let's do this. Next week,
7 let's come in preferably on the 2nd, if that works
8 for everybody.

9 MS. SULLIVAN: I'm not here next week. I'm at a
10 conference. I'm also -- can we -- I just want to
11 clarify.

12 Your doctors have whatever it is you're asking
13 for, right?

14 MS. RUSSELL: I'm just asking the Court to let
15 me look at it because normally that would be -- if it
16 were proprietary -- for example, if it were the WAIS
17 or the WAIS score sheet --

18 THE COURT: Right.

19 MS. RUSSELL: -- it would be proprietary.

20 THE COURT: No, I understand.

21 MS. RUSSELL: We would have to do it under seal
22 and all of that kind of stuff.

23 THE COURT: Got it.

24 MS. RUSSELL: But because this is open source,
25 Dr. Railey did provide the bubble sheet right to our

1 expert who has it. It is not really an
2 interpretative test where someone would be scoring.
3 It's basically, like, yes, maybe, no. So it's not
4 something that's really subject to sort of
5 psychological interpretation. It's pretty easy for
6 somebody like us to interpret.

7 Because of some of the discrepancies about what
8 Dr. Railey said in his report and what is on that
9 score sheet, and because of the difficulty with us
10 talking to our experts. Basically, we've talked to
11 our expert about it and she's telling me on the
12 phone, Well, then they circle here.

13 I mean, it's practically impossible to do it
14 without actually seeing the sheet. And if it's
15 impossible for me to do it without seeing the sheet,
16 it's also going to be impossible for the Court to
17 understand it without a sheet and to be in the
18 appellate record.

19 THE COURT: Okay.

20 MS. RUSSELL: So our position is, we would just
21 like our neuropsychologist to be able to produce that
22 to us, so we can actually look at the thing.

23 THE COURT: Okay.

24 MS. RUSSELL: Be a little bit more specific in
25 our cross-examination of Dr. Railey.

1 THE COURT: Okay. So when can you have an
2 answer, and when can you come to Court and tell me
3 what that answer is?

4 MS. SULLIVAN: But you're -- I just have a
5 question.

6 THE COURT: I'm not going to rule on the motion
7 today.

8 MS. SULLIVAN: Okay.

9 THE COURT: I want to give you an opportunity to
10 look into whatever you want to look in. I'm just
11 asking when you can give me an answer on whether or
12 not you're agreeing or when we could have a motion.

13 MS. SULLIVAN: Can I ask a few questions of
14 Defense, though?

15 THE COURT: Of course you can.

16 MS. SULLIVAN: So Dr. McClain doesn't want to
17 turn that over without a Court order to you?

18 MS. RUSSELL: Correct.

19 MS. SULLIVAN: Because is she having concerns
20 that it's --

21 MS. RUSSELL: No, because, again --

22 THE COURT: Her concern is because Dr. Railey
23 said it was proprietary.

24 MS. SULLIVAN: Okay. So I just want to know
25 what -- I can talk to Dr. Railey about it, but if

1 you're just wanting the Court to do an order, it's
2 not really me, then, going back because he's turned
3 over whatever it is.

4 MS. RUSSELL: Right. He's already given it to
5 her. And she, I think, would say that it's probably
6 not proprietary because we all picked -- it's not
7 really that test security --

8 THE COURT: You need clarification from
9 Dr. Railey --

10 MS. SULLIVAN: Yes.

11 THE COURT: -- about whether it's proprietary?

12 MS. SULLIVAN: Well, also from Mr. McClain. It
13 sounds like she has concerns, too.

14 MS. RUSSELL: No. I'm saying I don't think she
15 has concerns.

16 MS. SULLIVAN: You don't think she does?

17 MS. RUSSELL: Right, because her basic thing is
18 that she's trying to be respectful of Dr. Railey
19 because he's considering it to be proprietary.

20 For the record, he said that he gave the
21 questions orally to Mr. Mosley while I was sitting
22 there, and then he asked me to leave when he gave the
23 WAIS. So he also said many things during the exam,
24 but he didn't think it was proprietary, and he didn't
25 care, he was going to ask the questions while I sat

1 there. So again --

2 MS. ELLIS: (Indiscernible.)

3 THE COURT: What day do you want to come in and
4 have a motion, then? In the meantime, if you agree
5 to it, fine, but if you want to have a motion, you
6 should do it, obviously, before Dr. Railey testifies.

7 Dr. Railey is scheduled to testify on Thursday
8 the 10th. So I can even do July 7th, which is
9 Monday.

10 MS. SULLIVAN: Ms. Ellis says she can come in
11 next week, so you're not waiting on me. I mean, I'm
12 the -- it's fine. We can argue about it later. I
13 don't want to go back and forth, but it sounds to me
14 like Dr. Railey is going to say it is proprietary, so
15 I don't really know how we're going to get anywhere
16 other than you just deciding if you're going to order
17 them to turn it over.

18 THE COURT: I would like to know the answer.
19 Dr. Fabian just told us it's open source and not
20 proprietary, so I would like to hear what Dr. Railey
21 has to say about that. I'm not --

22 MS. ELLIS: I'll give him a call to clarify.

23 THE COURT: July 2nd, please.

24 MS. ELLIS: Okay.

25 MS. RUSSELL: Sure. Can I --

1 THE COURT: That way, they have enough time, if
2 it's going to get looked at to --

3 MS. RUSSELL: Can I just add one thing?

4 THE COURT: Of course.

5 MS. RUSSELL: In the past, we also have actually
6 gotten into the raw data in the WAIS -- and I'm not
7 saying we're going to do this in this case, but we
8 basically close the courtroom, put the thing up, then
9 file it under seal. Because sometimes the actual
10 proprietary data is important, and it's important for
11 it to be an exhibit, and for it to be entered into
12 the record. I think that, actually, this data is
13 going to end up being important in this analysis.

14 THE COURT: Okay.

15 MS. RUSSELL: And I think that this Court and
16 the appellate court and, you know, for time and
17 memorial in that 3.851, they're going to need to see
18 it even under seal.

19 THE COURT: We'll have that motion July 2nd and
20 talk about it. So set it for July 2nd, and also set
21 it, Madam Clerk, for pretrial so Mr. Mosely is
22 brought up, and we'll need a court reporter for that
23 day as well. Okay?

24 MS. ELLIS: Are they going to file a motion, or
25 this was your oral motion to do that?

1 MS. RUSSELL: We filed the motion today.

2 MS. ELLIS: For the WAIS data, too?

3 MS. RUSSELL: No. No. We're not asking for the
4 WAIS. We --

5 THE COURT: I'm only hearing the Motion to
6 Compel on Tuesday.

7 MS. ELLIS: Okay. All right. I will see you
8 all next week, then.

9 (Hearing was concluded.)

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1 CERTIFICATE OF REPORTER

2
3 STATE OF FLORIDA)4 COUNTY OF PINELLAS)
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6 I, CHARLENE M. EANNEL, RPR, Stenographic Court
7 Reporter, certify that I was authorized to and did
8 stenographically report the foregoing proceedings and that
9 the transcript is a true record of my stenographic notes.

10 I further certify that I am not a relative,
11 employee, attorney, or counsel of any of the parties, nor
12 am I a relative or employee of any of the parties'
13 attorney or counsel connected with the action, nor am I
14 financially interested in the action.

15
16 DATED this 1st day of July, 2025.
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CHARLENE M. EANNEL, RPR
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