EXHIBIT B

UNITED STATES DISTRICT COURT
WESTERN DISTRICT OF NEW YORK

UNITED STATES OF AMERICA,	*	Docket Number: 1:22-CR-00035-JLS-HKS-1
	*	
	*	Buffalo, New York
v.	*	April 10, 2025
	*	10:03 a.m.
	*	
LUKE MARSHALL WENKE,	*	EVIDENTIARY HEARING CONTINUATION
	*	
Defendant.	*	
	*	
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TRANSCRIPT OF PROCEEDINGS
BEFORE THE HONORABLE JOHN L. SINATRA, JR.
UNITED STATES DISTRICT JUDGE

APPEARANCES:

For the Government:
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Appearing for the United States.

For the Defendant:
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Proceedings recorded by mechanical stenography, transcript produced by computer.

(Proceedings commenced at 10:03 a.m.)

THE CLERK: All rise.

The United States District Court for the Western District of New York is now in session. The Honorable John Sinatra presiding.

THE COURT: Please be seated.

THE CLERK: We're on the record in United States versus Luke Marshal Wenke. Case Number 22-CR-35. This is the date set for an evidentiary hearing.

Appearing for probation is John Taberski.

Counsel, please state your appearances for the record.

MR. WRIGHT: Good morning, Your Honor. Franz Wright for the United States.

MR. PASSAFIUME: Frank Passafiume with Fonda Kubiak for Mr. Wenke.

THE COURT: Good morning to all of you.

MR. PASSAFIUME: Good morning, Your Honor.

MS. KUBIAK: Good morning, Judge.

THE COURT: And we're going to continue with two people that are with us, we think and hope, remotely, right?

MR. PASSAFIUME: Yes, Judge.

THE COURT: Are you ready to proceed, both of you?

MR. WRIGHT: Yes, Your Honor.

MR. PASSAFIUME: Yes, Judge.

THE COURT: Okay. So, Ms. Henry, what's next?

MR. PASSAFIUME: We're going to call Dr. Robin Watkins, so --

THE COURT: My understanding for the record, is that both people are on, though, for everything.

MR. PASSAFIUME: Correct.

THE COURT: So that's going to be -- Dr. Nelson will be the second witness?

MR. PASSAFIUME: Correct.

THE COURT: All right. And we're going to proceed with Dr. Watkins first?

MR. PASSAFIUME: Yes.

THE COURT: All right. Go ahead.

MR. PASSAFIUME: Good morning, Dr. Watkins.

THE CLERK: Hold on one second, Frank. I need to swear her in.

MR. PASSAFIUME: Sorry.

DR. ROBIN WATKINS,

witness on behalf of the **DEFENDANT**, having first been duly sworn, appearing by Zoom, testified as follows:

THE WITNESS: I do.

THE CLERK: Thank you. Can you please state your name and then spell it for the record?

THE WITNESS: Yes. Robin Watkins, R-O-B-I-N, W-A-T-K-I-N-S.

DIRECT EXAMINATION BY MR. PASSAFIUME:

BY MR. PASSAFIUME:

Q. All right. Good morning, again, Dr. Watkins. Could you --

A. Good morning.

Q. -- please tell us your title?

A. Yes. Yes. I'm a forensic psychologist.

Q. And who do you work for?

A. I work for the U.S. Department of Justice, Federal Bureau of Prisons.

Q. And how long have you worked for the Department of Justice?

A. For about 13 and a half years.

Q. And have you been at the BOP the entire time?

A. I have, yes.
Q. What's the process of becoming a doctor for the BOP?
A. Well, for me, I obtained my doctorate in 2004. And the process of becoming a doctor involves about ten years, after high school, four years of college and about six years of grad school, getting a Masters and a PhD in clinical psychology.
Including an internship -- predoctorate internship, which I did do with the Federal Bureau of Prisons in 2003 to 2004 at Lexington, Kentucky.
Prior to coming to the BOP, I did work in the community for about seven years, at a court clinic in the Chicago area, doing forensic evaluations, as well as private practice and teaching.
And then just applied to return to the BOP as a psychologist and began my career with the BOP at the Federal Medical Center in Devens, Massachusetts.
Q. And how long were you at Devens, Massachusetts?
A. I believe just shy of three years. I was there from 2011 to late 2013.
Q. And --
A. Before I transferred to the Federal Correctional Conference in Butner, North Carolina.
Q. And how long have you been at MCC Chicago?
A. I've been here at MCC Chicago for about eight and a half years. I was at Butner for about three years as well.
Q. Can you describe what the MCC means in that? How that

compares to other BOP facilities?
A. Sure. Well, both have medical centers which are more of inpatient settings. Butner has more of a complex, where there is a variety of different facilities within it.
MCC is more of a pretrial detention center. It's Downtown Chicago. It's a high rise building, as opposed to a sprawling compound, which more BOP facilities would look like.
But it houses mostly pretrial detainees and there is a fairly substantial forensic commission here, where we get a lot of inmates that are designated for the purposes of forensic evaluation.
We do have a newer program, which is a jail-based competency restoration unit, which is the BOP's actual -- actually, it's a pilot program.
The first in the BOP to use jail-based competency restoration model. We have that unit as well.
We do have a lot of psych services here. And we have some hold over or sentenced inmates as well, but I would say the majority of pretrial detainees.
Q. How many inmates can you estimate are housed there for psychiatric reasons?
A. Okay. Our overall capacity is in the six hundreds total. How many are here for psychiatric reasons in terms of being here for the purposes of forensic evaluation or competency restoration?

I don't have those numbers offhand. It's -- our forensic -- sorry -- our competency restitution unit houses a capacity, I believe, of 42.

And then we have probably about the same amount, at the max, in other forensic studies at any given time. Probably less. So maybe 60 to 80 at any given time.

Q. Okay. And you mentioned the competency restoration. Do you see inmates that are sent there for competency evaluations?

A. Yes. That is the majority of what I do here.

Q. And that's under the 4241 statute?

A. Correct.

Q. Okay. And could you tell me the -- the purpose and what the goal is for those competency evaluations, when somebody gets to you?

A. Sure. For a competency evaluation, the goal is really to determine do they have any sort of mental disease or defect that would impair their competency related abilities, meaning do they have an adequate factual and rational understanding of their charges and the proceedings before them and are they able to assist in their own defense.

It's very present focused. It's looking at their present functional impairment or lack thereof. And any psychological disorders, diagnoses, symptoms that could be leading to impairment that could interfere or is presently interfering with their competency-related abilities.

Q. So for every competency evaluation, you have to do a -- you have to diagnose a mental disease or defect before coming to the conclusion whether that person is competent or not?
A. I would say it all occurs sort of together if somebody -- if I'm opining somebody is competent, I might not diagnose any mental disease or defect.
If I am opining they are not competent, there would need to be some sort of mental disease or defect that would be linked to that.
Q. For every individual there, though, you do assess that person, whether that person has a mental disease or defect, right?
A. For a competency evaluation, yes.
Q. All right. Transitioning to the statute of why we're here, this 4244.
Are you familiar with that?
A. I am.
Q. And could you tell us what this statute is all about? What its purpose is?
A. Sure. I will say I've done some of these evaluations during my career in the BOP, so my understanding of 4244, it's a sentencing option.
And this type of evaluation, from our perspective, would be to assess whether an individual is suffering from a mental disease or defect.

For the treatment of which, they are in need of custody for care or treatment in a suitable facility, which in the BOP typically translates to a federal medical center, such as Devens or Butner, like I mentioned before -- but inpatient setting.

Q. Okay. Is that mental disease or defect the same we're talking about when we're talking about the competency part?

Are they overlapping when you are talking about mental disease or defect?

A. I'm not sure I fully understand the question. Can you maybe rephrase?

Q. Sure. Sure. Yeah. I'm not good at this.

A. That's okay.

Q. When in competency, you know, you assess on whether the inmate has a mental disease or defect.

For the 4244, you are -- he's there to -- or she's there to treat the mental disease or defect.

Are we generally talking about the same mental disease or defect for both?

A. I guess it depends. I've done 4244 evaluations where there was never a question of competency.

Q. Okay.

A. I would say they are separate questions. They don't necessarily have to be the same.

There could be someone who was competent, but does have a mental disease or defect that requires treatment in a suitable

facility, under 4244. So I don't think it necessarily has to be the same.

Q. That makes sense. Is the process for diagnosis of the mental disease or defect the same under both statutes?

A. I -- I can speak to my own methods, I guess.

Q. Sure.

A. For -- for a competency evaluation, I would say it tends to be much more focused. Much more present focused.

I do explore diagnoses. The statute requires a diagnosis, if there is one, under 4241.

So I would certainly offer that and provide that if one is present under 4241 for competency, but, I guess, my exploration of that would be limited to the extent that it impacts current competency-related abilities, if that makes sense.

Under 4244, I would say my inquiry would be much more broad based, because the question is different. The question is, you know, are they suffering from the mental disease or defect? Yes.

But what are the treatment recommendations? What are the treatment needs for that mental disease or defect, which is a much broader question than simply does it impact their current competency to stand trial.

Q. If an inmate gets to you with a diagnosis that was made by a private doctor, somebody outside the BOP, how does that factor into your assessment under the 4244?

A. I would say probably similarly to how it would factor in in any evaluation.

We value collateral sources of information. We seek them out in all evaluations, if available.

We review collateral records. We weigh them in our decision-making.

However, in each case, we're conducting our own independent assessment. So I think you want to avoid, as an evaluator, the sort of diagnostic kind of carrying forward diagnoses from previous evaluations without critically thinking about, you know, whether they are present at the current time, whether they were present at that time.

What -- you know how the well document lays out the symptoms that were observed at the time.

So they -- they are viewed critically and they are valued, but they are not relied upon to necessarily carry forward a diagnosis.

Q. Could -- could you -- this is probably a loaded question -- could you maybe generally explain the timeline once somebody gets to your facility under 4244, what you would do -- what you would next? Things like that?

A. Sure. Under 4244, they would -- as in any evaluation, the first thing I would do upon being assigned the case is conduct a -- what's called a forensic intake.

Where I would meet with them, go over -- provide a

notification and go over a form called a statement of understanding.

Where we provide information about how the information they are giving us will be used, just so they are clear on the fact that the information they are giving us is not confidential.

That it can go into a report and will be given to both the Court and both attorneys in the case, talking about safety and security issues within the institution.

Things they can expect within the institution and their time here. What the evaluation will look like; the fact that they are not -- you know, we're not going to force them to speak with us, but their participation is valuable in the evaluation and that kind of thing.

You know, the fact that we'll ask for records. That we'll meet with them periodically. Just sort of -- kind of expectations.

So that would be the first thing I would do. Collect some background information, seek any releases of information.

I always reach out to the prosecution and defense right away to request collateral records, if any are available.

As I said, collateral records are very valuable in, I believe, pretty much all forensic evaluations.

So that would be all of the initial steps. And then from there, any -- it gets more -- more individualized, I would say, depending on the referral question and the defendant in front of

me.

But I may choose to do some psych testing -- psychological testing. So we may meet a couple of times to do various psychological tests.

And there may be some specialized interviews that if it's a competency evaluation, for example, it would be legally focused on competency-related abilities.

If it's a 4244, which I believe the question was geared toward, it may be more about the history of symptoms.

It may be more symptom focused, but I would also be doing, sort of, a deeper dive into the -- the timeline, the evolution of symptoms; how they developed over time; how they have manifested from this person's perspective.

I probably would potentially also do some -- some measures that could look at their response style, to take a look at what -- you know, are they reporting genuinely or are they may be motivated to overreport or underreport symptoms, things like that.

Q. So while the purposes are different between 4241 and 4244, some of the things you are talking about now overlap between the two examination and evaluations, right?

A. Sure. Yes.

Q. You mentioned collateral records and how that is valuable. Why is that valuable?

A. It's valuable to corroborate or potentially refute a

individual's self report. As we know, defendants may have a variety of reasons for reporting certain things during evaluations.

And some people come to evaluations with very accurate self reports, but others may be skewed in one direction or another.

So collateral records can be very useful to -- to corroborate the self report. And also people may or may not have a very accurate view of their own symptom history, especially if they have a history of being mentally ill and perhaps their insight wasn't that great at the time.

And they have had a treatment history. They may not recall all the medications, dosages, dates, things like that, but if there are records that can get detail and document all of that, that's also very helpful.

Q. Would you give us some examples of what you mean by collateral records? Are they people? Actual documents or both?

A. It can be both. It can be useful to have previous psychological evaluations, hospital records, treatment records.

Also, just interviews with family members or other people who know the person well, who can maybe speak to their functioning.

We look for any identification of, like, a departure from their normal, like their baseline functioning.

And if there is a specific time when things seemed to change for that person, sometimes family can be really good at

pointing those things out.
Q. Okay. And that's all something you do basically in the beginning and after you get this background information, is that what you said?
A. Typically, yes. Typically, upon receiving the case, we'll reach out to the attorneys right away to request collateral information.
And a lot of times for competency and criminal responsibility evaluations, that also includes things like discovery, police reports, things like that, too.
Q. Okay.
A. But it's sort of a dynamic process that occurs over the course of the evaluation.
Q. Sure. Have you ever done an evaluation when you haven't used any collateral resources or haven't sought any collateral resources?
A. I don't know that there has ever been one where I haven't sought any, but there has certainly been some when there were none available.
Q. Okay.
A. So I had to go off of the person in front of me and what was available.
Q. But you've always sought them or tried to get some collateral records?
A. Yes. In every case, I attempt to.

Q. The 4244 has the mental disease or defect, but also treatment -- can you kind of explain the process of how treatment plans, kind of, get created for each inmate and what goes into that?

I'm sorry for the loaded questions here.

A. That's okay. So when you ask about treatment plans, are you asking within the context of a 4244?

Q. Sure. Yes.

A. Okay. I don't know that I -- I guess, I -- I would make treatment are recommendations. I don't know that I would go into the extent of making a full treatment plan within the context of that evaluation.

But -- my apologies -- the first part would be identifying the mental disease or defect that's causing impairment and then using my existing knowledge of the treatment resources we have available in the Bureau of Prisons.

And, also, consulting -- I've certainly consulted with colleagues in our central office staff about what may be available within the Bureau of Prisons that could best accommodate the needs of the defendant that I'm evaluating.

Whether that be inpatient facility or whether there is specific substance abuse treatment needs, whether there is a personality disorder that would require specialized treatment -- we have pretty much every impaired supported treatment that's -- that's -- I don't know about everyone, but we have the -- the

main empirically supported treatments in the Bureau of Prisons for each of those issues.

We do offer drug abuse programing, both residential and nonresidential drug abuse programming.

We have inpatient treatments for psychotic disorders and we have, like, residential programs for personality disorder, specifically borderline personality disorder.

So just using my knowledge of those things to dovetail the recommendations to what may be most appropriate to inform the treatment recommendations that I would then make and spell out in a 4244 evaluation.

Q. Okay. Do -- does the treatment involve the opinion of a psychiatrist, if -- if medication becomes, kind of, a part of the treatment plan?

A. Yes. If -- if I believe the person suffers from a disorder that is -- you know, for which psychiatric treatment is recommended, I would recommend a psychiatric consultation with the psychiatrist to assess what medication would be most appropriate for that defendant and go forward from there.

I would not recommend a specific medication or dose or anything like that, but I would recommend the consultation piece.

Q. How does an inmate get discharged under a 4244? What is the -- kind of, the end game there?

A. I feel like that's a perhaps a legal question that may be

better answered by an attorney.

But my -- I guess, my understanding is that it's a provisional sentence that can be modified during the course of that sentence.

I don't -- I don't know that I've been present to witness the end of a 4244. I do know -- you know, inmates when they reach the end of any sentence can be assessed, if there is concern about risk of violence.

For example, they can be assessed under 4246, at that point for a risk assessment, but I don't know if that's what you are asking specifically or not.

Q. How long can this treatment go on for at the BOP under 4244?

A. I believe it's for a specific amount of time, that would be the maximum amount of that person's sentence.

Q. Sure. And, I guess, during that time of the treatment, would you give, like, regular reports to the Court on how the person is doing?

Like, how does the Court know, you know, that kind of the progress?

A. That's a great question. I have not been involved in that end of it.

I've been involved in the initial end of doing the evaluations, but the treatment typically doesn't occur at the same place where I'm doing the evaluation --

Q. Okay.
A. -- so I don't know that I can speak to that piece in terms of how that communication occurs.
Q. Do you do those 4244s at MCC Chicago?
A. I have. I would say they are rare, but I have had them come from before and I've done them from here, yes.
Q. And the treatment happens there, too?
A. Typically, no. Those are similar to a competency evaluation or criminal responsibility evaluation.

I do those on the front end. The person then returns to their jurisdiction for the hearing and then they go wherever they are going to go in the BOP for that treatment.

Q. And the treatment is always in a BOP facility? It's never at, like, a local hospital or medical facility?
A. Under 4244?
Q. Correct.
A. Not that I've seen. I've only seen it where the suitable facility defined as a BOP FMC or a Federal Medical Center.
Q. Are people sent to the BOP under 4241 and 4244, are they housed in the same way?
A. No. Typically not.
Q. They are kept separate?
A. I don't know that that's the case always, in every case, but -- so if somebody, for example, is found not competent and in need of competency restoration -- inpatient competency

restoration, they would automatically be sent to a Federal Medical Center for competency restoration.

They may go to a restoration unit specifically where they participate in groups and treatment for that particular purpose.

Now, somebody who is found to be in need of a suitable facility under 4244 may also go to a medical center, but there could be different housing options and units, if that makes sense, within that medical center.

They wouldn't necessarily be participating -- they wouldn't be participating in the same programming --

Q. Okay.

A. -- as the competency restoration folks.

Q. To your knowledge, are the -- is the psychology staff, you know, the same for those that treat the 4241 and 4244?

There is not, like, specialists under 4244 that come in under that statute?

A. No. I mean, typically -- and I can't speak how to how each department works.

I -- for example, here we have a restoration program, for example. Now, we don't have anyone here who is sentenced under 4244, but -- but there are people -- there are several psychologists had who do those evaluations specifically.

And they only do the 41D evaluations, which are the restoration evaluations.

And are there are others who just do 41B, which are the

front end competency evaluations, the initial competency evaluations.

So it may be that -- that a department, sort of, assigns psychologists to do different tasks, but -- yes. A department would -- as a larger whole, address all of those needs.

Q. Has there -- again, to your knowledge -- ever been a scenario where somebody is sent to BOP under 4244 that is found not to have a mental disease or defect by you after, you know, he or she gets there?

THE COURT: Hang on a second, Mr. Passafiume. You've been meandering in and out, maybe not on purpose, between evaluations and treatment.

And we're talking about two different things, two different locations and perhaps even things that this doctor doesn't get involved in.

So can you just try to keep it to evaluations, when you are talking about evaluations?

And if you want her to tell you about what she thinks happens elsewhere, where people who are in the middle of their treatment, are getting their treatment, that's a whole different thing.

But right now, you are having her move in and out and I can see she is not comfortable doing that.

So be more clear about whether you are talking about evaluations under 4241 or 4244, versus what happens after

somebody is being treated, okay?

Thank you.

MR. PASSAFIUME: Okay.

BY MR. PASSAFIUME:

Q. So not the treatment part, under 4244, somebody gets to you, what happens or has there been a case where you found that there is no mental disease or defect?

A. And you mean when somebody comes to me for evaluation under 4244 --

Q. Yes.

A. -- have I concluded there was not a mental disease or defect?

Yes, I have.

Q. What happens then, if you know?

A. I don't always know the outcome, unless I go look it up afterwards or unless it's communicated to me by typically one of the attorneys involved.

But, to my knowledge, the person just moves forward with their -- with their case and with their sentencing.

Q. But what do you specifically? If you make that conclusion, what acts -- what do you do with that conclusion once you make that?

A. Well, I would just -- I would write the report, like I would in any case and address the statute. And I would explain the diagnostic formulation that I have, which -- you know,

sometimes results in a diagnosis of, you know, something that would qualify as a mental disease or defect and sometimes does not.

If it does not, I would explain that in the report. And, you know, there is a case that I did here recently where it -- that was the case.

There wasn't a severe mental illness. However, the person did have some pretty serious substance use issues and a personality disorder, so I listed those things.

Now, whether the Court would say that those qualify as a mental disease or defect under 4244 is a question for the Court.

But I did make some treatment recommendations as to what would be most appropriate to treat those disorders and which programs within the BOP are available to treat those disorders.

Q. Okay. And you know -- you were part of an evaluation of Luke Wenke; is that right?

A. Correct. Yes.

Q. What was your role in that evaluation?

A. So I am the forensic post-doctoral supervisor or training director and I supervise Dr. Nelson, who is also here today.

She was the primary evaluator on the case, but I oversaw her work on that case, start to finish.

And I was present for -- for three of the meetings with the defendant, so I was able to meet him, participate in some of the interviews and observe directly his responses and his behavior

as well as, you know, help her with the report.

She was able to write the report, but I worked with her on that report throughout that process as well.

Q. So you agree with everything in that report that she submitted?

A. Correct. Yes. We worked on that together. I provided edits and suggestions along the way.

Q. Gotcha. One question -- and if you can't answer, especially after what the Judge said, don't answer.

If that diagnosis is correct of this other specified personality disorder, with mixed personality traits, how would you treat an individual with that diagnosis?

A. Yes. It's kind of a complicated question because I think there are times when people come for the purpose of a competency evaluation.

And like I said earlier, our inquiry and the extent to which we delve deeply into the diagnostic picture is a little bit more limited for this purpose, because we're really just focused on does it or does it not impact current competency.

Q. Okay.

A. But, I think, with a longer period of observation or perhaps if he did have a 4244 evaluation or some other evaluation, where that was parsed out a little bit more, the treatment recommendations may be tailored based on the information that comes out.

But I can say based on what we had, the primary personality traits were narcissistic, which is a little tougher to treat, but also borderline, which there are empirically supported treatment programs designed to treat those traits.

And there actually is a residential-based program in the BOP for individuals with borderline personality disorder.

Whether he would qualify for that, specifically, I don't know at this time.

But what -- but there are treatment programs that are designed and based on what's called DBT or dialectal behavioral therapy, that -- that are designed to treat those types of traits.

MR. PASSAFIUME: Okay. I think -- I think that's it from -- from me.

Thank you so much, Doctor.

THE WITNESS: Thank you.

THE COURT: Okay. Just hang in there, Dr. Watkins, to see if the Government lawyer wants to ask you some questions.

MR. WRIGHT: Yes, Your Honor.

THE COURT: Mr. Wright?

MR. WRIGHT: May I proceed from my seat, Your Honor?

THE COURT: You may.

MR. WRIGHT: Thank you, Your Honor.

CROSS EXAMINATION BY MR. WRIGHT:

BY MR. WRIGHT:

Q. Good morning, Dr. Watkins.

A. Good morning.

Q. I would like to follow up on just a few questions. So relating to the evaluations, you mentioned that you were present for three of them?

A. Three of the meetings.

Q. Three of the meetings?

A. Yes.

Q. Do you recall when those meetings were that -- that you were present for?

A. I -- actually, let me -- I can look at the file real quick.

So that would have been the notification and intake, I was present, along with Dr. Nelson. That was on September 16th.

I was also present for the legally focused interview, which is a competency interview on October 17th. This is all 2024.

And we also did a follow-up interview on October 21st to that legally focused interview. That totalled about three hours, across those three interviews.

Q. Understood. Relating to the November 13, 2024, report that was submitted by BOP, you mentioned that Dr. Nelson and you worked on this together.

During this process of working on this final report, did you have any differing opinions with Ms. Nelson about the

diagnostic impression that you guys had?

A. I don't think I would say we had differing opinions. That's -- it's kind of a dynamic process, I would say though, across the evaluation period.

Because we talked -- we talked through this case and we met for supervision routinely, weekly, throughout the evaluation period.

As part of Dr. Nelson's post-doctoral experience, she also has a group supervision-type experience that I'm also involved in, as well as other supervisors and other post Docs across the BOP.

She does that once a week and I recall her bringing this case up in that. So it was discussed routinely throughout the evaluation period, where, I think, both of us sort of kept an open mind and were in, sort of, more of a data collecting phase, while reserving judgment about, you know, our conclusions until the end, but at the same time, we were processing the information together, so-to-speak.

So I don't think we differed in our opinion once -- and then once she did the report, she did that independently.

And I reviewed -- I reviewed each draft. We went through a couple of drafts and I gave her maybe some suggestions as to how to write up the diagnostic information.

But I don't recall disagreeing on the crux of the -- of what she was concluding. It was more how to present it and

formulate it in the report.
Q. Understood. You have already gotten through parts of this, but relating to -- this was a 4241 examination, focused on a very discreet issue of the defendant's competency, correct?
A. Yes. Yes.
Q. And you mentioned earlier, as well, that under 4244 analysis, there are different considerations that may be involved, different assessments, different measurements, that may be involved as well in, kind of, assessing that analysis, correct?
A. That's correct.
Q. And the 4244 process, I think you mentioned was a broader question that's involved?
A. Yes. Particularly when it comes to diagnoses, I would say the inquiry and the examination of diagnosis would be much more broad based in terms of looking at the history and -- you know, I would, kind of, describe it as a deeper dive into that area.
Whereas for a competency evaluation, it's more focused on symptoms, to the extent that they impact competency-related abilities.
Q. Okay. Relating to -- can someone be deemed competent, but still have or suffer from a medical diagnosis or mental disease or defect for which they would need treatment for?
Is that a possibility?
A. Absolutely.

Q. Okay. And to go back to your 4241 process and procedures that you employed in this case, you and Dr. Nelson, did you -- you, kind of, went through, kind of, collecting information from different sources.

And I know in your report, you mentioned letters. You received a report from Dr. Rutter as well.

Did you review that in your analysis?

A. Correct.

Q. Okay. Can you talk about -- did you agree with Dr. Rutter's diagnosis, for instance, about the defendant suffering from a bipolar disorder, specified hypermania, borderline personality traits?

A. Are you asking if we agreed with all of those different diagnoses?

Q. Yeah. Like, what was your opinion relating to Dr. Rutter's diagnosis, for instance?

A. Well, can you -- I'm sorry, could you direct me to what page of the report summarizes those diagnoses?

Q. Let me see here.

A. I think I may have found it. Page seven?

Q. Yep. That's right.

A. Yes. As I was describing earlier, I think the historical evaluations and treatment records and collateral records are very informative in what other professionals have seen and documented.

It does not necessarily mean that we would always carry forward those diagnoses, though. We always think critically about them.

And I would say, no. We did not -- we did not currently find evidence of bipolar disorder in Mr. Wenke's presentation.

Q. Thank you. Relating to the assessments that are employed, you mentioned there is obviously differences in the types of assessments that are employed, depending on the type of forensic examination or evaluation that's being done.

For instance, I think in your report you mention doing a PAI analysis for Mr. Wenke?

A. Yes.

Q. What do you -- hypothetically, if you were doing a 4244 analysis examination, would you employ that type of assessment in that situation?

A. Not automatically. But potentially, if that's something that could be used in that type of assessment, yes.

Q. Okay. And -- and you also did a RCAI as well?

A. Correct.

Q. Would you have done that in a 4244 analysis?

A. No. I would not see a reason to use an RCAI. That's more of competency --

Q. Competency?

A. -- focused, yes.

Q. Okay. Let's focus more specifically on your evaluation of

Mr. Wenke.

So there are several dates listed in your report or listed in the report where examinations were done first. Let's define some terms.

How do you define the term delusion?

A. A delusion is a fixed false belief that remains steadfast, even in the face of contrary evidence.

Q. What about paranoia?

A. Paranoia is a little bit more a colloquial term, I would say, but -- yeah. Persecutory -- it's -- it's more similar to persecutory ideation or beliefs, where someone believes others are trying to harm them --

Q. Okay.

A. -- in some way.

Q. You mentioned on direct or that as part of your evaluation, sometimes you'll employ certain measurements or measures to see if the person being examined is responding truthfully or trying to hide certain information.

Can you talk -- did you employ these measures in your analysis with Mr. Wenke?

A. I don't believe we did any of that formally with him. But there was one validity scale -- well, there are several validity scales embedded with -- within the PAI that informed our decision on that.

Q. The reason why I asked that is on page 16, there is a -- a

reference here about Mr. Wenke may not have been forthright in answering some of the questions.

Can you talk through that analysis of did you do anything to figure out more information relating to that or how was that determination used or employed in your overall assessment?

A. Yes. So that -- that's the validity scales that I was referring to within the PAI. So there are several embedded within the PAI.

There is one that looks at, sort of, positive impression management or, sort of, defensive responding.

There is one that looks at negative impression management, where people try to exaggerate symptoms and appear more impaired than they actually are.

And there are measures of, like, inconsistency or infrequency, where people may respond randomly within the test or respond unusually or idiosyncratically.

He didn't spike on any of those other scales, but he did spike on the positive impression management, which is actually unusual for criminal defendants.

You tend to see that more in custody evaluations or sometimes preemployment police and fire assessments, things like that.

Q. Okay. Can you explain that a little bit more? Why is that important?

A. Sure. It's important because essentially what it says is

the person is attempting to minimize any thoughts or symptoms or any problems and try to sort of appear, quote, unquote, normal, as though there are no problems or symptoms to report.

Again, you can imagine why you might see that more frequently in custody evaluations, for example, because people want to appear symptom and problem free.

And they are a good candidate to be a, you know, a parent and custodial parent and that kind of thing.

In this case, in criminal proceedings and when we are doing forensic evaluations, we tend to see the other side of it more frequently, where people are exaggerating symptoms.

Looking for some sort of secondary gain, potentially, to be found incompetent so they can potentially go to competency restoration or they have a belief, maybe, that they're charges will go away, things like that.

Because Mr. Wenke showed actually defensiveness and was maybe suppressing any symptoms or problems, that suggested to us -- and it was also very consistent with his presentation, too.

He wasn't trying to advertise any sort of symptoms or play off any sort of symptoms in his interviews with us, so that suggested to us that there wasn't feigning or malingering going on.

To define those terms, basically intentionally producing symptoms that aren't really there. And some of the measures I

was talking about that we might use to assess that would be looking for feigning or malingering, where people are reporting symptoms, but they are actually not genuine symptoms.

Because Mr. Wenke wasn't really reporting distress from symptoms in general in his interviews and then his PAI results were very consistent with that.

In fact, they showed he was suppressing or minimizing any problems. Those two things together suggested that we were very unlikely to find any significant results in any feigning measures that would be indicative of malingering or feigning.

Q. Okay. You mentioned this term idiosyncratic. There is a reference through the report that the defendant, Mr. Wenke, did not discuss overtly delusional beliefs.

So that statement is made throughout the report at various portions of it. What does that mean?

A. That he didn't discuss overtly delusional beliefs?

Q. Yeah.

A. Sometimes we'll get defendants that talk repeatedly about things that are easily identifiable as delusional.

They may believe, for example, as it pertains to competency, they may believe that everyone in the Courtroom is involved in a conspiracy against them and they are all working together.

And that it has to do with some other organization or religious sect or -- you know, something that's clearly not

accurate or based in reality.

Those would be overtly delusional beliefs. Things that someone can listen to and hear and clearly pinpoint as that's not based in reality.

Mr. Wenke -- yes, he talked about things that you could see how someone might question whether it was based in reality not.

You might wonder, for example, this relationship with RT, whether that was reciprocal or not; whether it was, as others have said, an erotomanic delusion.

But was it clear based on the evidence we had? No. It wasn't -- no. It wasn't overtly delusional. There was nothing that suggested clearly that that was not based in reality.

Q. Okay. What about -- let me ask you this example, for instance, on page 11 of the report, there is a discussion from the September 27, 2024, interaction with Mr. Wenke -- or examination with Mr. Wenke, where he explained discussing the idea that because of this case, there will be a future Supreme Court ruling that would create a Homeland Security Order of Protection program that will increase public safety preventing cases like his from happening again.

He suggested this program will implement public safety drones, public safety satellites or chips in driver's licenses to monitor people as they ever driving.

He identified this as an interstate order of protection program and noted there are District Court formalities to

complete.

In reading that -- or hearing that analysis or -- or what he stated, how do you classify that in, kind of -- is that something that's more delusional or where on the scale would that be?

A. Sure. That's a great example of what I think Dr. Nelson was spot on in identifying as a grandiose idea.

I mean, it is certainly a grand idea of having a lot of influence over or -- you know, having some impact in a very important future Supreme Court ruling, that he believes will happen in the future.

It -- whether that's likely to happen, I guess, remains to be seen. But -- but in order to classify something as a delusion, it would need to be clearly not based in reality.

And I think it gets really slippery to -- to start looking at someone's statements about what they think is going to happen in the future as a delusion.

Q. Okay.

A. And without any other evidence to suggest that their beliefs about anything present are not based in reality, it gets -- it would be kind of a stretch, I believe, to say that a future-based statement that they think something is going to happen in the future is a delusion.

Q. Okay. Let me ask you this: So relating to the interaction -- Mr. Wenke had several interactions with various

individuals: RT, RT's father, there is -- there is involvement of Mr. Wenke's, for lack of a better term, attention to -- relating to various individuals.

On that page 11, again, later on down, from the October 2, 2024, evaluation or interaction, there is a reference here about Mr. Wenke planning to make amends with RT's father, MT.

And it goes through a process or discussion about suing the Libertarian party for $3,500. And that he plans to offer the $3,500 in exchange, for payment, to make RT a national committee matter instead, thus fixing the relationship between Mr. Wenke and MT.

How would you classify this type of information?

Well, first, let me ask you this: Is this more of a present-based analysis that you would focus on or is this something that he's talking about in the future?

A. It also sounds like future plans.

Q. Okay.

A. It's something -- it's a plan of how he intends to make amends with somebody in the future.

I guess to answer your question of how I would a classify it, one way I conceptualized this -- and, again, I wasn't doing a risk assessment or in depth inquiry into the dynamics involved in any of these relationships, because our focus was primarily on competency and present focused competency.

However, having a -- you know, a background in, you know,

domestic violence and Order of Protection violation evaluation and things like that, it is not uncommon to see various cognitive distortions in offenders involved in those types of charges, where -- you know, people may have intentions to continue relationships or make amends, despite the desire of the other party not to be involved in that.

And I don't know -- I can't say one way or the other whether that was the case in this situation, but I did consider whether that could be just an example of one of those cognitive distortions that is involved in those types of cases.

Q. Okay. Let me ask you this question: When it comes to -- there is a reference in the report of Mr. Wenke's or the defendant's belief in psychics, for instance, and going to -- as part of his family, et cetera.

At what point does a belief that someone has from their experience in life -- you know, it could be -- there is -- in the report there is that reference or discussion about his grandmother's belief in, kind of, psychics and how that connected to his own personal beliefs.

At what point does generic beliefs like that that are formed by familial relationships transfer over to a delusional belief?

A. That's a tough question and it's -- it's hard to identify specific point, but I think it's very important to consider the cultural context in the DSM or the Diagnostic Statistical Manual

of, you know, mental disorders that informs all of our diagnoses emphasizes that we consider the cultural context of the individual, when assigning diagnoses to avoid pathologizing what may be a culture norm set beliefs or behaviors.

So that's where, I think, Dr. Nelson appropriately used the Cunningham article that she cited to, kind of, take a look at and analyze some -- some of these beliefs and behaviors to determine, are they unique to him or are they part of a larger subgroup?

Even if it may be not typical for the general population, it does seem like the beliefs in psychics -- specifically, that belief set, was very common within his family system.

And that was all corroborated through the collateral interview with his mother that she conducted.

Q. Okay. But if someone is confronted with independent information that confronts that belief that they may have had, but it continued to persist in that belief, is that an example -- does that then cross over to that delusional aspect?

A. I would say it depends on what the belief is. There are plenty of people that have strongly held religious beliefs that would be considered culturally normative, that would not be amenable to contradiction or challenging by others.

But that would not be the defining factor that would somehow classify that as delusional, just because the person didn't waiver in their belief in the face of a challenge.

Q. Okay. But it has to be idiosyncratic to that person for it to be determined as delusional?
A. It's one of the factors that we look at. I don't know that it's quite as formulaic as an if then rule.
The Cunningham model has 17 different factors. It's sort of a complicated system and it -- it still doesn't arrive at a formula that classifies somebody as delusional or not, but it's more of a complex system to review.
So I would just say it's one of the factors that we consider in terms of whether it's -- the person -- it's one of the 17 factors, specifically, does the person hold that belief in isolation or are they part of a subgroup that also holds that belief.
Q. Okay. I think this will be my final question. So the mental disease -- the mental disease or defect analysis under the 4244 analysis, even with your report of -- kind of, the -- the going through what you, kind of, just went through or discussed relating to the delusional aspects or considerations that you did, that that may still exist, where -- under the 4244 analysis versus the 4241 analysis that you conducted?
A. I'm sorry. Could you possibly rephrase the question?
Q. Yeah. It goes back to whether or not someone who may have been deemed competent before, may still under the 4244 analysis -- because they are different considerations, may still have a mental disease or defect, in need of treatment?

A. Yes.

MR. WRIGHT: Okay.

Nothing further, Your Honor.

THE COURT: Dr. Watkins, in the context of this 4244 hearing that we're in, my job is to decide whether Mr. Wenke is presently suffering from a mental disease or defect and whether he should, in lieu of being sentenced to imprisonment, instead be committed to a suitable facility for care or treatment.

That's the question I have to ask. Do you have an opinion on that issue?

THE WITNESS: I do not currently have an opinion on that issue, only because I didn't do that type of evaluation.

THE COURT: If you were asked to do the 4244 evaluation, in addition to or instead of or now, what would you do differently that perhaps you hadn't done already?

THE WITNESS: I would conduct a more thorough inquiry into, I guess, the history and course of symptoms.

We would do a lot more diagnostic differential diagnosis. I guess, between -- I believe we listed a number of diagnostic possibilities and some tentative diagnoses.

I think we would do more to try to pars out exactly what's going on with him diagnostically, to better determine what the most appropriate treatment recommendations would be at this time.

THE COURT: With everything that you know about

Mr. Wenke, and -- and acknowledging the limits of your 4241 evaluation, is it possible, knowing what you know now, that you could ultimately conclude under 4244, that he is suffering from a mental disease or defect.

As a result of which, he is in need of custody for care or treatment in a suitable facility?

THE WITNESS: Yes. Your Honor, that's possible.

THE COURT: All right.

Anybody else have more questions for Dr. Watkins?

MR. PASSAFIUME: No, Judge.

MR. WRIGHT: No, Your Honor.

THE COURT: Thank you, Dr. Watkins.

THE WITNESS: Thank you, Your Honor.

(Witness Excused)

THE COURT: And we have the next witness. Mr. Passafiume, go ahead.

MR. PASSAFIUME: Sure. Dr. Kaitlyn Nelson.

THE WITNESS: Hello. Yes.

THE COURT: You are going to be sworn now. Dr. Nelson stand by.

Dr. Nelson, can you do something to help us with the background noise that's coming in from you?

THE WITNESS: I can try. Sorry. Our offices are on a housing unit, so --

THE COURT: Okay. We're sometimes familiar with those

kinds of sounds. Let's do the best we can. We have to get you sworn still.

Ms. Henry, go ahead.

DR. KAITLYN NELSON,

witness on behalf of the **DEFENDANT**, having first been duly sworn, testified as follows:

THE WITNESS: I do.

THE CLERK: Can you please state your name and then spell it for the record.

THE WITNESS: Kaitlyn Nelson, K-A-I-T-L-Y-N, N-E-L-S-O-N.

THE COURT: Okay. Mr. Passafiume --

DIRECT EXAMINATION BY MR. PASSAFIUME:

BY MR. PASSAFIUME:

Q. Hi, Dr. Nelson. Could you please tell us your title?

A. My current title is a forensic post-doctoral fellow.

Q. And how long have you been that?

A. Since August of 2024.

Q. And how long have you been -- worked at MCC Chicago?

A. Since August of 2024.

Q. Have you always worked under the supervision of

Dr. Watkins?
A. Yes. At this facility.
Q. Did you -- was there a point in time where you evaluated a gentleman by the name of Luke Wenke?
A. Yes.
Q. Do you remember what that evaluation was about?
A. That was an evaluation related to competency to proceed.
Q. And you -- you issued this report with Dr. Watkins. I want to say, dated November 13th, that comes from that evaluation?
A. That's correct.
Q. And I want to go through, kind of, the process of that. So Mr. Wenke got there on September 4th and the evaluation ended on October 21st?
A. Correct.
Q. So is that a typical duration for these competency evaluations?
A. Yes. So, typically, they are by statute, a 30 day evaluation, within an allowance of a 15 day extension period, if it's requested or there needs to be a reasonable reason for the extension.
Q. And in that time, you state in the report that Mr. Wenke was routinely observed by correctional and psychology staff?
A. Uh-huh.
Q. You have to say yes or no.
A. Yes.

Q. Can you explain what do you mean by that? What is routinely observed?
A. So as I mentioned earlier, there are offices on housing units. And I believe in Mr. Wenke's case, all of the interviews with him took place on his housing unit.
So you go to his housing unit. I could see him there on the unit and then would call him up to an office.
But, also, when I say routinely observed by correctional staff, there is always an officer on the unit, who in most situations I elicit their opinion on how that individual has been functioning on the unit.
Similarly, if they had any interactions with other staff members, including psychology or other professions, I may elicit their observations as well.
Q. And those observations go into your ultimate determination of your ultimate diagnosis of Mr. Wenke?
A. I think they play a role in my formulation, yes.
Q. Over the course of those 45 days or so, how many times do you think you saw Mr. Wenke, personally?
A. I met with Mr. Wenke on six different occasions for interview purposes.
Q. And did you -- in addition to that, did you -- when you weren't there, did you speak the psychology staff and the corrections officers about what they observed?
A. I did speak with officers about what they observed and they

noted, you know, no concerns behaviorally from him. He mostly just kept to himself on the housing unit.

Q. And what kind of things would you be looking for in those observations?

Why is that important?

A. Yeah. Talking to the correctional officers is very valuable, because they are the ones who are on the housing units with the defendants at all times.

So a lot of times we're asking about -- you know, anything that stands out. Are they able to follow the unit rules?

Do they appear to be getting along with other people or are they having problems? Things of that nature that can speak to their functional impairment or lack thereof.

Q. So is it relevant if somebody is able to be housed in a general population setting, as opposed to a -- kind of, a private solitary setting?

A. Are you referring to -- like, the private setting, you are talking to, like, a secured setting?

Q. No. When somebody is in general population at the jail, like, Mr. Wenke did not have to be separated from anybody else, why is that important or is it?

A. Right. Yes. I would say it is important. A lot of times, we see, you know, if someone is having significant mental health problems, sometimes that might cause difficulties with them interacting with their peers.

Peers might also point out, you know, various oddities that they have noticed as well or not wanting to have interactions with them.

Sometimes it leads to, you know, fights or concerns for safety for both the individual and other people. So those could all be reasons why someone might end up in a more confined secure housing, outside of the general population units.

But as in Mr. Wenke's case, that did not happen. He was able to maintain appropriate behavior and -- within the general population setting.

Q. In those 45 days, you also gave him some assessments. And one is this personality assessment inventory.

Can you explain what that is?

A. That's correct. The personality assessment inventory or PAI is a self-report measure.

Meaning, it's 344 questions that the individual answers on their own. And that measure is looking at a broad range of both psychological symptoms and personality traits.

So they are asked to give, you know, their opinion of themselves and the various statements that are included in the measure.

Q. Is that a routine assessment that you give in these competency evaluations?

A. I would say I use it often, but it's not in every case.

Q. And does the result of that assessment go into the ultimate

diagnosis at the end?
A. Yes.
Q. You also did this revised competency assessment instrument. Could you explain what that is?
A. Yes. The revised competency assessment or RCAI is more of a semi-structured interview measure, specifically, looking at various areas related to competency-related abilities.
So there are various categories that have questions listed in each category related to things, such as their charges, who the people are in the Courtroom.
You know, various Courtroom procedures, such as -- you know, entering a plea or what is a plea bargain, things like that.
And the goal of that is to make sure that we're asking questions in all areas related to competency. But as I mentioned, it is a semi-structured interview, so we also ask follow-up questions and oftentimes ask a lot more questions than are listed in the interview.
Q. Does the result of that assessment give you any insight into the ultimate diagnosis, whether Mr. Wenke has a mental disease or defect?
A. Yes. I would say so. The -- the RCAI -- RCAI doesn't give, like, a score or results or anything like that.
But the way an individual approaches the questions, how they are able to attend to them, what information is included in

their responses -- all of that can speak to someone's mental state.

Q. You also reviewed a lot of materials. I want to go through some of them real quick now: Some legal documents, the indictment, presentence report motions, BOP records.

Why do you review those documents? Why was that important?

A. Yeah. So a lot of the documents that I reviewed are helpful to one get an understanding of, you know, what his current legal situation is, so that I can assess Mr. Wenke's understanding of what's happening.

But then also some of the other records that I've reviewed, such as, like, past evaluations and letters that he has written, medical center records, all of that can speak to whether or not this is his mental state.

How he is presenting currently, if that's a pattern across time. What, if any, mental health issues have been present in the past, things of that nature.

Q. And you mentioned -- so you reviewed letters that Mr. Wenke sent to the Court and other people?

A. That's correct.

Q. And you reviewed his social media posts?

A. Yes. Some that were provided in the discovery materials.

Q. And that material was provided by myself and the prosecutor and probation, right?

A. Yes.

Q. You didn't independently go and find your own letters and your own stuff? It was everything that we gave to you?
A. Yes. With the exception of -- I believe he sent a couple letters while he was housed at MCC Chicago, so I reviewed those as well.
Q. Perfect. You also reviewed some prior evaluations, for example, one from Dr. Leidenfrost.
Do you remember that?
A. Correct.
Q. And --
A. Yes.
Q. -- why is it important to review these prior evaluations from -- from past doctors?
What insight does that give you?
A. Yeah. Reviewing past evaluations is incredibly helpful to get an understanding of how the individual was presenting at different points in time.
That can speak to -- you know, how their presentation is consistent or changes across time.
Timeline of potential symptoms, what that clinician -- how they are conceptualizing an individual. And all of that, kind of, plays into my own conceptualization of an individual.
But, again, it's kind of just that. It's a piece of data that I take into consideration and then use that to aid in formulating my own opinion.

Q. Perfect. You also spoke to several individuals, right?
A. Correct.
Q. One of those people -- you spoke to myself, the prosecutor and probation.
Do you remember that?
A. Yes.
Q. We met by video conference and, kind of, discussed the case? Yes?
A. Correct. Yes.
Q. And --
A. Sorry.
Q. -- then you sought our opinions of the matter. Why would you do that? Why was -- why was that relevant?
A. Yeah. Specifically, in a competency evaluation, I routinely try to elicit observations from both the prosecution and the defense, because the question that we're answering related to competency is partially their ability to assist in their defense and whether they have the factual rational understanding.
So it's really important to understand why the question of competency was raised; what concerns related to competency either side has for that specific defendant.
And that can be useful to, kind of, guide what areas we need to clarify in the competency evaluation with that specific individual.

Q. Would any of that give insight into whether Mr. Wenke has a mental disease or defect?

A. It certainly could, depending on what the attorneys are reporting.

You know, if -- certainly, if the attorneys are seeing particularly odd or bizarre behaviors or having difficulty maintaining a conversation with an individual -- those are just some examples, but all of that can speak to how the person is presenting, which can inform, you know, a decision on whether or not that person may or may not be experiencing mental illness.

Q. And what about talking to somebody's family members? Is that important?

A. Yes. And it doesn't happen in every case, but when it -- when I am able to speak with someone who knows the defendant personally, maybe even over a significant amount of time, it's really helpful to determine, you know, patterns of behavior or patterns in their presentation.

Or if there had been a significant change in that person and what may have been going on in their life at that time, things of that nature.

It can also help corroborate some of what the defendant is self-reporting, particularly when we are gathering background information, speaking with family or people who were close with them can help, kind of, clarify some of that information as well.

Q. Were you able to do that for Mr. Wenke?
A. Yes. I was able to speak with his mother.
Q. And how did you get her information, if you remember?
A. I don't recall specifically in Mr. Wenke's case. Typically, I would either ask the defendant if there was someone close to them.

But also ask -- you know, both defense and prosecution, in my initial e-mail to you, asking if there is any collateral contacts that may be available to share contact information with.

Q. What did you do talk about, if you can share and if you remember, with Mr. Wenke's mother?
A. Typically I approach the collateral interviews as -- kind of like a general background information, similar to what I would ask the defendant.

So in Mr. Wenke's case, I, kind of, went through, you know, the whole timeline of his life. You know, tell me about how he was when he was a child?

And what about his schooling? And his work history? And things of that nature. So that's -- that's what I did with Mr. Wenke's mother as well.

Q. And would that information give insight as to whether Mr. Wenke has a mental disease or detect?
A. Yes.
Q. All right. You also cited some research -- this article

from Cunningham.

Are you familiar with that?

A. Yes.

Q. What -- what is that? Can you explain that and what this 17 factor model is?

A. Yeah. So the article that I reviewed specifically for this case was the differentiating delusional disorder from the radicalization of extreme beliefs a 17 factor model and what this article does is develop a 17 factor model that can be helpful for clinicians in doing the differentiating between delusions and these extreme beliefs, as they call them.

The intent is to just use that tool -- the 17 factor model as, kind of, a guide in considering different factors that play into -- you know, what makes something a delusion versus an extreme belief.

It's not like a checklist or doesn't give you an end result. More so, it's just a guide to make sure you are considering various aspects of those beliefs.

Q. And you apply that to, basically, each belief individually? Not as a whole? How does that work?

A. So in this situation, I tried to use it as a guide in my thinking for considering different components in Mr. Wenke's presentation.

So not necessarily every belief, individually, but, kind of, more clusters. So these beliefs related to his past

relationships or beliefs related to his political views or beliefs in his spiritual beliefs and mediums and psychics and things like that.

Q. We'll get back to that in a second. I want to walk you through your report and, kind of, explain it in a category section by section basis.

A. Sure.

Q. So the report starts with this background information and it lists all of these different histories.

Could you -- the first one is developmental history. What is -- what does that mean?

What is that section about?

A. Yeah. So, typically, in the developmental history, it's talking about, like, from birth, what they were like as a kid. Where they grew up, what that was like. What their family structure was like, things of that nature.

Q. Would that information give insight as to whether Mr. Wenke has a mental disease or defect?

A. It can be used to, kind of, develop those hypotheses. And potentially -- you know, provide insight into timelines of possible symptoms, things of that nature.

Q. We'll skip to the social and mental history section. The other ones are self explanatory.

What is that section about?

A. This section is about, like, friendships and romantic

relationship history.

Specifically -- you know, if that person was able to maintain relationships, what those, kind of, looked like in more broad terms.

Q. And would the information contained there give you any insight as to whether Mr. Wenke has a mental disease or defect?

A. Yes. It can certainly provide insight into that. For nearly all mental illnesses, part of a diagnosis is talking about their functional impairment in some of these various categories.

So with their functional impairment and social interaction or functional impairment in education or employment areas.

Q. And all the information contained in this -- well, let me get it right -- this background information, did that come from your collateral -- like, the collateral sources and -- and all the, kind of, evidence that we've discussed that you reviewed?

A. Yes. In addition to specifically or directly from Mr. Wenke.

Q. Okay. The starting from -- like, I guess day one, if you remember, what was the -- the interaction with Mr. Wenke like?

What would you say to him? What happens during that initial meeting?

A. Yeah. During the initial intake meeting that I typically have with someone, it is generally we're providing a forensic notification.

Which is providing them information about the current evaluation, what the evaluation -- or what information will be used for, the lack of confidentiality in what their -- the information they are providing and what they can expect over their time at this facility, things of that nature.

And then the other piece is getting -- more so general background information.

I believe with Mr. Wenke that first interview lasted around 30 minutes, which is not uncommon to have a more brief interaction during the first interview.

And when I say we gather general background information, we might ask where he's from or if he had a mental health history if he had a substance abuse history or what he did for work.

And then during later interviews, we, kind of, dive more deeply into those topics.

Q. In that initial interview, if you remember, did Mr. Wenke discuss any delusional beliefs or did anything stand out that you felt was not appropriate during that initial interview?

A. If I can have just a minute to review what I wrote about that?

Q. Yes.

A. So from what I remember, at no point did any of his beliefs appear overtly delusional.

I wasn't a hundred percent certain at this point that the beliefs he was talking about were just clearly delusional or not

based in reality.

And I think the same would be true during his initial contact with us. He seemed to be generally forthcoming.

And I mentioned in the report, he provided information about various parts of his background.

He was a little bit more defensive when talking about things such as substance use history. However, that's not uncommon for interviewing someone in this sort of setting.

A lot of times people tend to minimize things such as substance use or past legal history, things of that nature.

Q. And during that initial, kind of, meeting -- and what's reflected in the report, it says that he was placed in open population.

Does that sound right?

A. Yes.

Q. And what's -- again, we talked about this a little bit before -- what is open population?

And did Mr. Wenke remain in open population the entire time that he was with you?

A. Yes. Mr. Wenke was on an open population housing unit, which means within the unit, the individuals are free to roam pretty much within the designated areas.

And then they -- on the unit that Mr. Wenke was on in particular, he had a singular cellmate that during lockdown times, he would have been housed and locked in that cell with

that individual.
Q. Okay.
A. And he remained in open housing for the duration of his time here.
Q. Perfect. September 27th, it says that he was seen for a -- a psychosocial history interview?
A. Correct.
Q. What does that entail? What is that about?
A. That is what I had mentioned earlier about that deeper dive into background information.
So it is essentially going through those same categories of his background, but gathering more thorough information or asking more detailed follow-up questions.
Q. And every -- did every time you see him, was there a personal interaction?
Did you have, like -- like, a conversation with him, whether it was performing an assessment or just chatting?
Did you have this, kind of, one-on-one interaction with him?
A. So I met with him individually three of the six times that I met with him. It was just myself and Mr. Wenke in an office.
And then the other three times, Dr. Watkins was also present.
Q. Okay. The next part of the report is titled: Clinical formulation.

What is that part of the competency evaluation? What goes into that section?

A. The clinical formulation section of the report, is where now I have all of the background information and collateral records.

And this is, kind of, where I'm outlining how I am conceptualizing those in relation to mental-health-related concerns.

Q. And the information that goes in there, again, is from your personal interactions, the assessments and also that collaterally information?

A. Correct.

Q. Would you say that the more collateral information you have, the more accurate the formulation would be?

A. I would say so, yes.

Q. And -- and, ultimately, the next section is the diagnosis. And you diagnosed Mr. Wenke with an other specified personality disorder, with mixed personality features. Primarily borderline personality traits and narcissistic personality traits.

A. Correct.

Q. You -- you explain it very well in each one of these reports. I'm not going to go through that at all, but could you -- could you explain in general what a personality disorder is as opposed to a psychiatric disorder?

A. Sure. A personality disorder is a pattern of -- basically,

a pattern of personal characteristics of that person -- personality characteristics.

So these are often persistent traits that the individual continuously presents with over time, oftentimes starting in early adulthood and that kind of persists throughout.

On the other hand, a -- another mental health or mental illness would be something that would be, kind of, a deviation from what their typical presentation would be.

For example, if we're talking about a mood disorder, that would be, kind of, a deviation from their typical mood presentation.

Whereas in a personality disorder, those patterns are more consistent across longer periods of time.

Q. And I -- if you can, again, if you don't know, that's fine. What is treatment typically for a personality disorder?

A. The treatment for personality disorder varies depending on the type of personality disorder or personality traits that are present.

A lot of times it includes individual therapy or group therapies. Specifically, for borderline personality disorder, as Dr. Watkins had mentioned earlier, the dialectal behavioral therapy is, kind of, the gold standard for borderline personality disorder.

And, certainly, can be used to treat these traits and not full personality disorder as well.

Q. Was Mr. Wenke medicated at all in the 45 days that he was there?
A. No.
Q. Do you believe he needed to be medicated at all?
A. While Mr. Wenke was at this facility, it did not appear that medication was indicated, so he did not -- he was not referred to a psychiatrist for consultation during the competency evaluation.
Q. If you believe that was an issue, you would have referred him to a psychiatrist during that competency evaluation period?
A. Yes. That's an available option.
Q. And -- and the psychiatrist would be to -- kind of, because the psychiatrist prescribed medication, it would be to further your findings? Further for your diagnosis?
A. Well, a psychiatrist would do their own independent brief assessment to determine whether or not the symptoms are present that deem medication to be appropriate.
And then they would be the ones to determine which medication, if any, they would prescribe.
Q. The next section I want to talk about is the prognosis and recommendation section.
If you again just explain what that section is about and what goes into that?
A. Yes. In this section, specifically, in a competency evaluation report, the prognosis and recommendations are

typically geared specifically towards competency.

So in this situation, I am -- in Mr. Wenke's case, I'm describing, you know, he -- the personality traits that I observed, how they are typically a pervasive pattern across time.

Even with treatment, sometimes they -- there is a significant change, but there may be some improvement, but ultimately I provide the recommendation that he was expected to remain competent, because of the persistent nature of these traits and that they were unlikely to change significantly.

Q. Could you -- could you just explain that though more? I know you say: With either diagnosis, the features are pervasive and character illogical, such that they are unlikely to change in the future.

Can you explain that more -- if you can, just, kind of, elaborate?

A. Sure. What I mean by that is personality traits being just that. That they are traits and characteristics of the individual.

Sometimes they are difficult to change. So when I say there may not be or they are unlikely to have significant change in the near future, I mean that -- you know, even with treatment, it could -- it could definitely take time for any change to be seen.

And, again, depending on what the traits are and what

personality disorder is present, there are various treatment options and effectiveness of those treatments.

Q. And those treatments don't need to happen in a -- in a controlled facility or jail or hospital? They could -- they could happen on an outpatient basis?

A. Certainly. They are available in the community as well.

Q. I said the wrong word before. I said psychiatric. I meant psychotic disorder, because I want to get into that part now a little bit.

Part of your -- one of the documents you reviewed was this evaluation from a Dr. Leidenfrost.

Do you recall that?

A. Yes.

Q. And he -- he goes through -- he gives a psychotic diagnosis. And that -- that's different than your diagnosis.

And he -- and we've talked about this a little bit -- he goes through this persecutory, paranoid, erotomanic delusions.

Are you familiar with his diagnosis? That those symptoms of delusions -- I know you talked -- you know, I know your colleague talked about it a little bit.

What's your understanding of -- of the disorder that he diagnosed Mr. Wenke with?

Terrible question.

A. Are you asking if I'm familiar with that diagnosis?

Q. Yeah. So what -- in your opinion, can you describe was a

persecutory delusion would be?
A. Yes. A persecutory delusion would be fixed beliefs that people are out to get this individual or are coming after them, to harm them in some way.
Q. And similar -- that's similar to, like, a paranoid delusion?
What's the difference?
A. I would say they are similar. Paranoid may also include -- like, you know, bad things are going to happen.
More broadly, persecutory would be more -- could be directly related to that individual they are targeting.
That individual, specifically -- but, again, both have this overarching theme of -- you know, that others are out to get this person or bad things will happen to this person.
And when it rises to a delusional belief, it is now based not in reality. And it's fixed beliefs that persist, even in the presence of evidence suggesting otherwise.
Q. So there is -- there is a big difference in an extreme belief versus a delusion.
And that a delusion is a symptom of a psychotic disorder, but an extreme belief is not; is that accurate?
A. I would be hesitant to say there is a big difference, because differentiating between a delusional belief and a very firmly held extreme belief can be a very fine line. And they can be very difficult to pars those things out.

Q. And the Cunningham research tool is an aide for that?
A. It is an aide, yeah.
Q. Is it the go-to aide for that? Is there some other tool that you can use to determine whether there is an extreme belief versus a delusion?
A. I am not familiar if there is, like, a specific tool design that's the gold standard to use to differentiate.

But outside of the 17 factor tool, one of the biggest things that's useful in differentiating these beliefs is looking at it in the context of the whole picture, rather than looking at each belief as existing in a vacuum.

And just looking at, you know, a belief related to believing in mediums, for example.

At face value, that may seem to lean more towards a delusional belief. However, when we are taking in the whole picture and thinking about the context in which that person holds that belief, where they might have come to develop that belief, is it impacting their functional abilities in their every day life that they are holding this belief?

Do other people believe it? When we look at the whole picture and, also, through consultation with other colleagues, you can, kind of, then develop your -- your conceptualization in whether or not this belief is delusional or it is firmly held extreme belief.

Q. So the belief in psychics -- we'll start there. That's a

good example. You did not find that to be a delusion.

Can you expand on that? And what kind of -- what information did you use to come to that conclusion?

A. That's correct. I did not conceptualize Mr. Wenke's belief in mediums or psychics as being delusional in nature.

And I came to that conclusion based on my conversations with him, that he reported that was something that was consistent throughout his life and in his family.

In addition, to the collateral interview with his mother, who -- you know, without prompting and simply asking about spiritual beliefs, she provided the information that that was commonly held in his family or a practice within his family.

Q. Okay. So that information came from both Mr. Wenke and then confirmation from his mother?

A. Correct.

Q. All right.

MR. PASSAFIUME: When did you want to break?

THE COURT: How much more do you have?

MR. PASSAFIUME: Maybe ten minutes. 15 minutes. I can go fast.

Thank you, Judge.

BY MR. PASSAFIUME:

Q. I want to just go --

THE COURT: Do you need we need a facilities break? Is that what you were --

MR. PASSAFIUME: I don't.

THE COURT: Let's take a five minute break. If we can accommodate everyone in that short of a period of time and then recess five minutes and come back and keep going and try to wrap it up before lunch.

MR. PASSAFIUME: Yes.

THE COURT: We're going to take a five minute recess.

(Recess commenced at 11:49 a.m., until 11:56 a.m.)

THE COURT: Okay. Everybody is where they are supposed to be.

Mr. Passafiume, please proceed.

MR. PASSAFIUME: Thanks, Judge.

BY MR. PASSAFIUME:

Q. All right, Doctor. I want to go through a few examples of delusions that have come up in this case and I want to get your opinion on those things.

Some of the ones you discussed in your report already, but we'll start with one of them that you discussed in your report.

So this delusion that Mr. Wenke was the former chairman of the Libertarian party of Cattaraugus County, you found that not to be a delusion.

I think it's on page 20. Because you found out that he actually was the county chairman for the Libertarian party; is

that right?

Do you remember that?

A. Yes. I remember that.

Q. So this might be an obvious question, but why isn't it a delusion? Because it actually happened?

A. Yes. Because it seemed to be based in reality.

Q. And you say: Upon further review -- I don't know if you remember.

Do you remember what that review was? Did you do any, like, research?

A. I -- I don't remember specifically what I reviewed, but I do believe that I Googled Mr. Wenke's name for the purposes of, like, looking up that specific fact.

Q. And was it easy to Google Mr. Wenke?

A. I don't recall having difficulty.

Q. Okay. These other delusions involve one of the victims in this case, KV.

And the delusion is that Mr. Wenke believes that KV created a website to harass him.

This is not your report. That would fall under the -- like, a persecutory delusion, right?

A. I apologize. There is some background noise. If you can hear that.

But I -- it could possibly be a persecutory belief, if he's thinking that -- I'm sorry.

It could be a persecutory belief if the individual is thinking that someone is intentionally out to get them, if that's not based in reality.

I'm not with the familiar of the website that you are referring to, but if there was truly a website that is targeting this individual, that could also possibly be based in reality to hold a persecutory belief.

Q. Perfect. If I told you that the website existed was created by KV, where she blogs every day and summarizes every Court appearance, posts every single legal document, transcribes all of Mr. Wenke's letters and comments on them and posts altered pictures of Mr. Wenke -- if I told you that website exists, would that change your opinion?

Would that make this not a delusion?

A. Those are -- would all be things that I would definitely want to take into consideration before determining whether or not that was a delusional belief or not.

Now I will add that there are times when delusional beliefs are stemmed from reality.

There is some piece of a truth in a delusional belief, oftentimes.

However, I would need to look at the situation as a whole and really look at that website myself and how Mr. Wenke was interpreting that.

Q. I gotcha. You know that the website exists, but you would

need to look at it yourself to verify everything that I just said?

A. I think seeing at least a sample of some of what was being posted would be helpful in informing the type of content that was being said about Mr. Wenke.

And also then having a conversation with Mr. Wenke and his beliefs, specifically related to that website.

Q. Okay. Would examples of persecution in this context be altered pictures, commentary, posting of documents, things like that?

Would that be examples of the persecutory delusion?

A. It could be, yes.

Q. Okay. Another -- another delusion is that KV stole Mr. Wenke's car. And, again, that's not in your report.

If -- if I told you that there is a story to that, where our office gave the car keys to KV and Mr. Wenke is aware of that, would that impact whether the -- the belief that KV stole his car, whether that's a delusion or not?

A. I think that certainly provides context for how he may have come to this belief, that this individual stole his car.

But, again, I would want more information as to how he rose to now that person stole the car, as opposed to had permission to use it.

Q. And that more information would come from the collateral sources?

You can ask him. You can ask me. You can ask family members, right?

A. That's correct.

Q. And you would do that in all of these instances of potential delusions?

A. Attempts would be made, yes.

Q. Okay. Another one of these is the delusion that Mr. Wenke believes KV left a negative yelp review on Mr. Wenke's mother's restaurant cite.

If I were to tell you that there was a negative yelp review and that Mr. Wenke's mom told Mr. Wenke that she believes it was KV that posted it, would that impact whether that's a delusion or not?

A. That could also inform, again, how and why Mr. Wenke was holding these beliefs.

I think the -- the overarching delusion would be that this person was out to get Mr. Wenke. And each of these examples that you are providing, if they are based in reality, those or -- or if they are not based in reality, they are all examples of why this belief is being maintained.

Now, because all of the examples that you are providing are based in reality, that doesn't automatically exclude someone from having a delusional belief.

Rather, these are examples of that belief being perpetuated. However, again, I would need more -- like, to have

a conversation to -- before determining whether or not that delusion or that belief is delusional or not.

Q. Okay. But these -- you would need other examples that were not based in reality to ultimately form the conclusion that it is a persecutory delusion?

A. I would say so, yes.

Q. The -- the last delusion, real quick, I want to talk about is that -- and I think this is in your report, actually, that KV and I had a screaming match.

If I were to tell you that I actually did speak with KV and she became irate on the phone and hung up -- and I told Mr. Wenke about that.

Do you think that would impact the whether that delusion exists, that we had a screaming match?

A. I don't recall specifically referencing a screaming match, but I do recall Mr. Wenke talking about various interactions with various people involved in his case.

So I certainly think that's informative to know there are truly, in fact, various interactions with multiple people involved in this case.

I think that may also lend to providing more reality-based context for these beliefs.

Q. And I guess -- I don't know if I should ask this -- if these don't rise to the level of delusions and maybe they are just extreme beliefs, would those also be symptoms of traits or

traits of the personality disorder that you diagnosed Mr. Wenke with?

A. They could be. So, you know, when we're talking about persecutory beliefs, the -- the diagnoses -- diagnosis that I provided related to borderline personality traits and narcissistic traits with referencing, kind of, the instability in relationships that seems to be persistent in Mr. Wenke's life.

And I certainly think the relationship that you were referencing before, with this individual who may be posting negatively about Mr. Wenke, and involved in the case could be in relation to those borderline personality traits as well.

Q. And his boasting about his political connections and publics, would that be a trait of narcissistic personality disorder?

A. That's how I conceptualized it as being art of these grandiose -- grand ideas that he has, you know, in his own self importance in what his personal case is going to lead to future action and things of that nature.

So, yes. I conceptualized those as being part of the other specified personality disorder traits.

Q. What be the excessive letter writing? How does that fit in?

A. Yeah. I also conceptualized as part of those personality traits specifically related to impulsivity. And that can be a

trait related to borderline personality disorder as well.
Q. Would that also be a trait of autism spectrum disorder?
A. It could be.
Q. I know you considered that in your report.
Traits of that would also include -- you know, abnormal speech, providing excessive details. That would be a trait of autism spectrum disorder, right?
A. It possibly could be. And the way that I -- someone may interpret the letter writing could be, you know, poor understanding of some social norms or not fully understanding that the things that he's writing in the letters could be interpreted as, you know, threatening or causing fear in the other person.
And, yes. Autism spectrum disorder was something that Dr. Watkins and I considered and spoke about.
But, ultimately, we -- we determined that at this point, we were not offering that diagnosis and there wasn't enough information to support that diagnosis at this time.
Q. Okay.
MR. PASSAFIUME: That's all I've got. Thank you so much. That was awesome.
THE WITNESS: Thank you.
MR. WRIGHT: May I proceed, Your Honor?
THE COURT: Go ahead.

CROSS EXAMINATION BY MR. WRIGHT:

BY MR. WRIGHT:

Q. Good morning or afternoon, Dr. Nelson.

A. Thank you.

Q. Can someone have a mental disease or defect and still suffer from a personality disorder?

A. Yes. Both can occur at the same time.

Q. Okay. From the examinations that you did in your 4241 analysis, focusing on the competency aspect of the defendant, from the assessments that you employed in your evaluation, could you have detected, based on those assessments, if someone had a schizoaffective disorder?

A. Yes. It's possible to detect during a competency evaluation.

Q. Okay. And for schizoaffective disorders, what are you looking for in that?

A. For a -- a schizoaffective diagnosis, it's kind of a combination of both psychotic symptoms and mood symptoms.

So you're looking for a deviation from their normal presentation, but also these mood-related symptoms being -- persisting throughout the majority of time -- meaning, having -- it could be excessive energy, things of that nature.

Lack of need for sleep, disorganized behavior. But then the part that makes this more schizoaffective is that there are

psychotic symptoms.

Specifically, hallucinations or delusions that persist or continue to be present in the absence of mood-related symptoms.

And those psychotic symptoms have to be present for a period of at least two weeks, in the absence of mood-related symptoms.

Q. Okay. So for this psychotic symptoms, could they have been present during your evaluation of the defendant, but the -- the examinations that you employed would not have picked up on those?

A. Typically, for psychotic symptoms -- and I'm not sure if I'm -- I made this clear, but the psychotic symptoms would be present the entire duration of the schizoaffective disorder and then would continue to be present in the absence of those mood symptoms.

But during the competency evaluations, psychotic symptoms could be detected mostly in the individual interactions I have with the individual.

A lot of times in the phone calls or letters that I review. They can also be noted -- or the impairment that a lot of times people experience with delusions or hallucinations, could be observed while in the housing unit.

So most times -- many of the times, other people pick up on symptoms that could suggest or indicate that they may be, you know, hallucinating or something like that.

But the delusional piece would certainly be present during interviews.

Q. So depending on how the defendant or the person being examined is acting before the examiner, that could be a very important determination of whether or not a determination of a psychotic treatment is needed or psychoactive disorder is present?

A. You are saying their presentation with the evaluator?

Q. Correct. It would depend on who they -- how they are -- who is doing the interview, that could change the analysis?

A. Certainly. So part of why we meet with an individual on multiple occasions, across time, is if someone is experiencing genuine symptoms of mental illness -- specifically, they are hallucinating or hold delusional beliefs, it's a lot harder to conceal those if you are meeting with them across different time periods.

I also think that in different contexts, it's important to look at the different contexts, because the consistency of the person's presentation is also very informative.

So the other things that I mentioned, such as the functioning on the housing unit when I'm not present or how they are speaking to their family in the phone or how -- what they are writing in letters, all of that speaks to the consistency of their presentation and can inform us of whether or not a psychotic symptoms are present.

Q. Understood.

MR. WRIGHT: Nothing further, Your Honor.

THE COURT: Mr. Passafiume?

MR. PASSAFIUME: That's all. Nothing.

THE COURT: Okay. Thank you, Dr. Nelson.

THE WITNESS: Thank you, Your Honor.

(Witness Excused)

THE COURT: Okay.

Kirstie, you can shut off the video feed.

Okay. So any other witnesses for this hearing from either side?

MR. PASSAFIUME: Not from the defense.

MR. WRIGHT: Nothing from the Government, Your Honor.

THE COURT: All right. So the hearing -- the evidentiary portion of the hearing is closed.

And as far as I'm concerned, the only thing left for to do is for me to make a decision, which I intend to do.

Do we need to submit anything else from either side? Mr. Wright?

MR. WRIGHT: I -- I don't think so, Your Honor. I think we will rest on the presentation that we have.

THE COURT: Mr. Passafiume? Ms. Kubiak?

MS. KUBIAK: Judge, it may be necessary for us to do some very brief response or briefing.

What I would like to do is maybe have a quick

turnaround of the transcript from today's proceeding.

I just don't want to commit to the fact that we're not going to do anything further.

Can we have a quick turnaround on a transcript in a very short submission?

THE COURT: You will have to order one, an expedited transcript.

And then let me talk to the court reporter offline here for a minute.

MS. KUBIAK: Yes.

(Discussion off the record.)

THE COURT: When we're done here, Ms. Kubiak, why don't you speak with Ms. Weber about how to handle that request to make sure it's done in a way that facilitates success.

MS. KUBIAK: Absolutely.

THE COURT: And to the extent you need approvals for that expedited or daily, whatever terminology you two ultimately use, I am hereby approving that.

So, you know, I still may need to sign something nonetheless.

Mr. Wright?

MR. WRIGHT: Yes. If the defense is going to file something, we will submit something in writing as well.

THE COURT: So I think that Ms. Weber would have it done in that scenario by Monday.

Why don't we have some joint submission done by next Friday, because we've just got to put an end on this.

You know, because to the extent that we're headed in one direction or to the extent we're headed in another direction, we're just holding Mr. Wenke is limbo.

And I'm sensitive to the fact that he's been held in limbo for a long time, so we need to wrap it up.

So filing deadline for any post-hearing submissions would be Friday, April 18. And Ms. Weber will endeavor to the transcript docketed Monday, as long as everything moves smoothly in terms of requesting it the right way.

And, again, if you need to put something, Ms. Kubiak, in front of me for signature, I'm happy to sign it. If you need verbal approval, then you have it.

MS. KUBIAK: Thank you, Judge.

THE COURT: Anything else, folks?

MR. WRIGHT: No, Your Honor.

MS. KUBIAK: No, Your Honor.

THE COURT: Take care everybody. Be well.

MS. KUBIAK: Thank you.

(Proceedings concluded at 12:18 p.m.)

* * *

In accordance with 28, U.S.C., 753(b), I certify that these original notes are a true and correct record of proceedings in the United States District Court for the Western District of New York before the Honorable John L. Sinatra, Jr.

s/ Bonnie S. Weber — Signature

April 14, 2025 — Date

BONNIE S. WEBER, RPR

Official Court Reporter
United States District Court
Western District of New York

E X A M I N A T I O N S