IN THE CIRCUIT COURT FOR CARROLL COUNTY, MARYLAND

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STATE OF MARYLAND,            :
                              :
          Plaintiff,          :
                              :
     v.                       :
                              :
CHARLES DAVID BRIGHTFUL,      :    Criminal No. K-10-040259
HARVEY ALEXANDER CARR,        :    Criminal No. K-10-040331
JENNIFER ADELINE FLANAGAN,    :    Criminal No. K-10-040167
RYAN THOMAS MAHON,            :    Criminal No. K-09-039370
CHRISTOPHER JAMES MOORE,      :    Criminal No. K-09-039569
VALERIE ANN MULLIKIN,         :    Criminal No. K-09-039636
RONALD DALE TEETER,           :    Criminal No. K-10-040300
                              :
          Defendants.         :    Westminster, Maryland
                              :
- - - - - - - - - - - - - - - - - - x    September 27, 2010
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HEARING

WHEREUPON, proceedings in the above-entitled matter commenced.

BEFORE: THE HONORABLE MICHAEL M. GALLOWAY, Judge

APPEARANCES:

FOR THE STATE:

DAVID DAGGETT, Esq.
ADAM WELLS, Esq.
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FOR THE DEFENDANTS:

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APPEARANCES: (continued)

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I N D E X

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WITNESS For the Defendants:	DIRECT	CROSS	REDIRECT	RECROSS
Dr. Jeffrey Janofsky	7	72(DD) 132(AW) 157(Ct)	145(AC) 147(BD)	156(DD) --

EXHIBITS: For the Defendants:	FOR IDENTIFICATION	IN EVIDENCE
10	33	34
8	--	44
11	58	--
12	62	--
13	148	160

KEYNOTE: “---” indicates inaudible in the transcript.

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

2 THE CLERK: Silence in Court, all rise.

3 THE COURT: Be seated, please.

4 MR. WELLS: Your Honor, for the record, Adam Wells

5 spelled, W-e-l-l-s, on behalf of the State, calling State of

6 Maryland versus Charles Brightful, Case No. K-10-40259; Harvey

7 Carr, Case No. K-10-40331; Jennifer Flanagan, K-10-40167;

8 Matthew Kennedy, 40250; Ryan Mahon, K-09-39370 and Christopher

9 Moore, K-09-39569. For the record, Adam Wells spelled, W-e-l-

10 l-s, on behalf of the State and David Daggett spelled,

11 D-a-g-g-e-t-t.

12 MR. DeLEONARDO: Good afternoon, Your Honor, Brian

13 DeLeonardo, D-e-L-e-o-n-a-r-d-o.

14 MR. CRUICKSHANK: And Alex Cruickshank,

15 C-r-u-i-c-k-s-h-a-n-k, Office of the Public Defender on behalf

16 of the Public Defender clients.

17 THE CLERK: Judge Galloway, they called a case that

18 is not on here. Kennedy? Kennedy should not be on here.

19 MR. WELLS: Kennedy is not on there.

20 THE COURT: Kennedy is not --

21 MR. WELLS: Case No. K-10-40250 that was the docket

22 case --

23 THE COURT: All right. So, I don't forget we are

24 going to start tomorrow at 10:30 with this -- I have got a few

25 odds and ends on the criminal docket. I am trying to hand off

26 some stuff to Judge Hughes so we will figure on starting at

27 10:30 tomorrow morning. Anything preliminary?

1 MR. DeLEONARDO: Your Honor, I think the only thing
2 is just, obviously, Dr. Janofsky we need to be able to at
3 least resolve him, finish him out today, so, he was graciously
4 enough back again.
5 THE COURT: Well, that is the goal.
6 MR. DeLEONARDO: Absolutely.
7 THE COURT: All right.
8 MR. WELLS: And, Your Honor, just for scheduling, I
9 think what we were tentatively talking about was doing
10 Dr. Janofsky, finishing up with him today and then tomorrow is
11 Dr. Gengo and we will go from Dr. Jingle into their other
12 experts, which I believe is Dr. --
13 MR. DeLEONARDO: Dr. Adams.
14 MR. WELLS: -- Adams. That is probably going to
15 take through probably at least Wednesday afternoon, I would
16 assume.
17 MR. DeLEONARDO: At least through Wednesday morning,
18 I would say.
19 THE COURT: Well, Wednesday morning, we are not
20 here. We are here in the afternoon all Wednesday unless
21 something changes regarding other cases I am supposed to hear.
22 MR. DeLEONARDO: Okay.
23 MR. WELLS: At which time, we have our two DRE
24 experts and we anticipate calling one rebuttal expert as well.
25 THE COURT: All right.
26 MR. WELLS: Just so, I guess, we are all on the same
27 page.

1 MR. DeLEONARDO: And we could potentially have one
2 rebuttal expert as well.
3 THE COURT: Well, I am guessing we are not going
4 finish this week.
5 MR. DeLEONARDO: It does not appear that way.
6 MR. WELLS: Does not appear so, Your Honor, no.
7 THE COURT: Okay. All right.
8 MR. DeLEONARDO: Thank you. If I could call recall
9 Dr. Janofsky, Your Honor.
10 THE CLERK: Please remain standing and raise your
11 right hand.
12 Whereupon,
13 DR. JEFFREY JANOFSKY
14 was recalled as a witness by the Defendants, having been
15 previously duly sworn, resumed the stand, was examined and
16 testified further as follows:
17 THE CLERK: Please have a seat. For the record,
18 please state your full name, spelling your first and last and
19 give your business address, please?
20 THE WITNESS: Sure, it's Jeffrey Janofsky,
21 J-e-f-f-r-e-y, last name is J-a-n-o-f-s-k-y, 30 East Padonia
22 Road, Suite 206, Timonium, Maryland.
23 THE CLERK: Thank you.
24 DIRECT EXAMINATION (Resumed)
25 BY MR. DeLEONARDO:
26 Q Doctor, just to kind of summarize where we were, I
27 think last time, last Thursday, we had been working through

1 the studies and had gone through what was termed the Bigelow
2 Study?
3 A Right.
4 Q And the LA Field Study as well as the Minnesota
5 Reporter Study, correct?
6 A Correct.
7 Q So, if I can, I am going to direct your attention to
8 a study that His Honor has heard about so far which is
9 referred to as the Arizona Study --
10 A Yes.
11 Q -- a study that was done by Adler and Burns. Are
12 you familiar with that?
13 A Yes.
14 Q And you have had a chance to review that in detail?
15 A Yes.
16 Q And can you tell us, initially, what your findings
17 were after having reviewed that particular study?
18 A Well, first of all, Your Honor, it's a non-published
19 study. It hasn't even been published in a technical manual.
20 So, obviously, it's not been peer reviewed and basically it's
21 a compilation of data from January of 1989 through May of
22 1993, collecting data on only when the DRE thought the
23 subjects were impaired and also when they submitted urine
24 toxicological samples to a State laboratory.
25 So, there was no data collected from subjects
26 evaluated by the DREs thought not to be impaired and also no
27 studies collected where no toxicological samples were set --

1 or sent.

2 And no data was presented from those who refused the
3 urine or blood test or those subjects where the DRE evaluation
4 was terminated by police.

5 So, Your Honor, these were classic errors in
6 validation research because it only reports a non-random
7 subsample of citizens administered the DRE, which makes it
8 impossible to calculate validity.

9 So, there is no way to calculate the number
10 sensitivity, specificity, positive, predicted value,
11 et cetera, that you need in order to calculate accurate
12 validity statistics essentially.

13 Although it’s -- I know the areas that the studies
14 have been cited as showing a high precision or high validity.
15 It means nothing of the sort. The numbers are worthless for
16 assessing validity.

17 Q Okay. And if I could ask you a couple of specific
18 questions on that, you said that it didn’t capture unimpaired
19 numbers, so in the field of research and your experience --

20 A Yes.

21 Q -- was there anything in this study that really
22 demonstrated the ability of a DRE officer to distinguish
23 between someone who is impaired and unimpaired?

24 A That’s the point, Your Honor, you can’t use the
25 study to do that. There is nothing in the study that allows
26 you to determine or calculate numbers necessary to decide
27 whether the test is valid or not.

1 Q Was there anything in the study that demonstrated
2 the DRE's ability to show that someone was behaviorally
3 impaired by drugs?
4 A No.
5 Q And did the study acknowledge that fact?
6 A Yes.
7 Q And as far as the urine test --
8 A Yes.
9 Q -- you indicated that they used urine test to
10 determine whether or not the DRE's opinion was confirmed or
11 not.
12 A Right.
13 Q In your experience what is the validity of using
14 that as a confirmation?
15 A So, Your Honor, when you are using urine alone as
16 the confirmatory test, you are not getting at whether the
17 drug -- even if the drug is positive in the urine, you are not
18 getting at whether the drug is present in the blood and
19 therefore in the brain.
20 So, depending on the pharmacology of the various
21 drugs and they vary, you can have a positive urine test and
22 all that means is that the drug was in the blood hours before
23 the day of arrest.
24 And it tells you nothing about whether the drug was
25 present around the time of the stop or the arrest in the blood
26 or the brain.
27 That's why, Your Honor, for alcohol the valid

1 measures for current intoxication are either blood or breath,
2 which is a surrogate for blood. And that means the
3 drug/alcohol is in the blood affecting the brain right then at
4 that point in time. You can't use urine to get at that.
5 Q And to be specific on this point -- you talked about
6 alcohol. But as to drugs, the fact that the drugs even are in
7 the blood mean that a person is impaired so as to not be able
8 to drive?
9 A Correct. So there is -- again, there is no data
10 anywhere in the literature that the mere presence of a
11 particular drug in the blood means that the person is driving
12 impaired. There's just -- again, I keep coming back to that
13 when I think about this.
14 If as a matter of law, impairment means driving
15 impairment. There is nothing anywhere in the literature to
16 equate blood levels, urine levels, DRE -- anything with
17 driving impairment, nothing.
18 Q Now one of the other issues that we have discussed,
19 the previous study, is the ability of the DRE to distinguish
20 between someone who has a medical or a psychiatric condition
21 that mimic impairment an actual impairment from a drug. Was
22 this study able to determine whether they could distinguish
23 that?
24 A No, no data whatsoever.
25 Q Now one of the other issues that you have raised
26 before is the need for a study to be double-blind?
27 A Yes.

1 Q And in this particular case where you in analyzing
2 the study, if I could -- I am going to approach and show you
3 the Arizona study which was marked as State's Exhibit No. 12.
4 A Yes.
5 Q Okay, and is that the Arizona study that you have
6 been discussing?
7 A Yes.
8 Q And if you would please turn to page 51, now in this
9 particular study are there anything of note as to the
10 importance of a double-blind?
11 A Yeah, because this study allowed the officers to ask
12 the arrestees or the people that were stopped whether they
13 admitted to using the drug. So, if the purpose of the DRE
14 evaluation is to find out whether someone has a particular
15 drug on board and the subject admits to it, you don't need the
16 DRE evaluation.
17 The officer would be not smart if he didn't
18 correlate the admission with the drug he puts down on the
19 form.
20 So, if you are going to test whether the DRE
21 procedure is accurate, the test that the officer uses at the
22 roadside or back at the Barracks, it's vital that they not be
23 allowed to interrogate the subject or have search incident to
24 arrest data. You know, they found the marijuana roach in the
25 car, they found the bag of powdered cocaine because that will
26 tamper or change their opinion.
27 So you end up not testing the actual parameters of

1 the DRE but testing the officer's interrogation techniques.
2 Now, that's what police officers are supposed to do. They are
3 supposed to get admissions, they are supposed to do searches
4 and that's all fine.
5 The problem is you cannot use a study that allows
6 them to do that to test the validity of the DRE.
7 Q As you discussed previously the idea of inter-rater
8 reliability and the need to replicate, did this study do that?
9 A No.
10 Q And what about the signs or symptoms that were being
11 used by the DREs to reach these opinions, was there any
12 categorization as far as validation of those?
13 A No. And, in fact, this study like all of the
14 earlier studies was done before the DRE protocol was
15 standardized or right around the time it was standardized.
16 So, it's unclear if the officers are actually
17 following the DRE protocol as in the books or are following
18 earlier I guess you would call pilot versions or earlier
19 versions of the test.
20 Q And since that time, there has been multiple changes
21 or --
22 A Yes.
23 Q -- new manuals, correct?
24 A Yes, because I've gotten them. I have -- Your
25 Honor, I was searching through my files to find a specific
26 piece of paper about the DRE and I found I had eight full file
27 drawers full of material on this from stuff over the years

1 including multiple manuals. So, yes, it's changed.
2 Q Okay. If I can direct you then to the next study
3 that I would like to discuss as to the what's called Heishman
4 studies?
5 A Yes.
6 Q Can you describe what those studies are?
7 A So, Your Honor, the Heishman study or the first
8 Heishman study, which was '99 -- 1996, is the first study that
9 was put together under controlled conditions that actually
10 gave us data where it were able to look at the validity of the
11 DRE. It was very careful -- it was done at Hopkins -- it was
12 done on the Hopkins campus at the site, the National Institute
13 Drug Abuse site.
14 It was thoughtful, it was well-planned, it went
15 through the institution review board for subject safety and it
16 collected the data that one needs to collect in a double-blind
17 fashion, meaning neither the participants were police officers
18 from various jurisdictions who were certified as drug
19 recognition experts.
20 The subjects who were recruited from the community
21 and the researchers did not know what drug was being given nor
22 were the police officers allowed to interrogate the
23 defendants, to ask them things like, well, you know, you are a
24 defendant -- you are an experimental subject, what does this
25 feel like to you.
26 Because all of the experimental subjects, Your
27 Honor, were of necessity experience drug users. You don't

1 want to give a drug to a person who has never -- in an
2 experiment, to a person who has never had the drug before.
3 The only way you can ethically do these studies is
4 to recruit subjects who've had experience with these drugs.
5 You put them into the residential unit, you watch them for a
6 time, you make sure there is none of the drugs on board and
7 then you give them the protocol, which is what they did.
8 So, this is the first study that actually generated
9 statistic that were useful, to actually calculate the
10 sensitivities and specificities data and to generate the
11 numbers that allow one to generate predicted numbers and
12 likelihood ratios that you need.
13 Q Okay. If I could approach, I am going to show you
14 what has previously been marked as State's Exhibit Nos. 13 and
15 14 and ask if these are the two Heishman studies that you are
16 referring to?
17 A Yes.
18 Q Okay. And --
19 A Slightly different types.
20 Q Okay. And they are two different studies but two
21 different titles, correct?
22 A Right and done at two different times but using the
23 same general method of administering the drugs or creating the
24 subject, et cetera. But analyzing the data a little
25 differently.
26 Q Okay. So they actually separately -- you say
27 separately tested certain drugs at different stops?

1 A Yes, right. With different officers and different
2 subjects over two -- I think it’s two different years.
3 Q Okay. As far as this one, you said that this was
4 published and peer reviewed?
5 A Yes. So, this was the first study, Your Honor, that
6 was published in a peer reviewed journal and that journal
7 title is they’re both published in the Journal of Analytical
8 Toxicology, which is a well-known peer review journal.
9 Q Now before we get into what the study actually
10 found, let me ask you a couple of questions. Did this study
11 demonstrate whether or not the drug recognition expert could
12 actually determine someone was behaviorally impaired so as not
13 to give them drugs?
14 A No. And like I say, this is very important, Your
15 Honor, although this is the best study and the best
16 methodology, this study -- neither of the two Heishman studies
17 nor a subsequent study will talk about actually used as a gold
18 standard behavioral impairment or driving impairment.
19 They all used as the gold standard presence or
20 absence of the drug in blood or urine, or witnessing them,
21 taking the drugs so they know they took it.
22 Q All right. So, just to make sure that distinction
23 is, you are saying that even though the study followed the
24 protocol, it didn’t answer their question of behavioral
25 impairment?
26 A Again, none of the studies answered the questions of
27 behavioral impairment.

1 Q What about the ability of them to distinguish
2 between someone with a medical or psychiatric condition versus
3 someone who has drug impairment?
4 A No, in fact, they all screen -- people with medical
5 or psychiatric conditions were screened out. Again, as would
6 be necessary to ethically do a study like this. You don't
7 want to have someone with a medical or psychiatric condition
8 and give them street drugs, it wouldn't be a good idea. Well,
9 it's not a good idea to give them even if they didn't but it's
10 even a worse idea to give them that in a research study.
11 Q We heard previously that it would be impossible to
12 test whether or not they could determine those with medical
13 impairment and mimic versus drug impairment. Is it impossible
14 to test that?
15 A No. In fact, you know, if I was going to be -- if
16 we go to the next stage of studies although I don't think we
17 need to because I think it's pretty well decided.
18 The next stage of studies you mix in people with
19 medical or psychiatric conditions don't give them drugs but
20 have the DREs examine them and not tell the DREs or anybody
21 else who was -- you know, give them placebo in other words,
22 sugar pills.
23 And then let the DREs test them and see how that
24 works out. But no one has done that, although it's an obvious
25 thing to do, I think.
26 Q Now a far as -- as far as this particular study, if
27 I can get specifically -- I guess first start on the study

1 that was entitled Ethanol, Cocaine and Marijuana in '96?
2 A Right, the first one, yes.
3 Q Can you tell us about what the findings were as to
4 how accurate or precise they were as to making determinations
5 on whether or not a drug was actually on board at the present
6 time?
7 A So, Your Honor, you can -- although the authors
8 didn't directly calculate validity statistics, they presented
9 the data that's available so one can calculate them. And you
10 can go through an analysis to calculate the numbers for
11 sensitivity and specificity both for all drugs combined or
12 dosed with any drug versus not dosed with any drug, versus the
13 actual condition dosed with any administered drug or no drug.
14 In other words, you calculate numbers, the DRE
15 predictions of whether they were dosed with any drug or no
16 drug, versus the actual state, whether they got the actual
17 drug or not.
18 You can create a two by two table, which is then
19 used to calculate sensitivity and specificity and from that
20 number you can calculate the key number in all this, which is
21 called the likelihood ratio.
22 And for this study the likelihood ratio for all
23 drugs combined is 1.39. And, Your Honor, in order for a test
24 to be useful, I remind you, that likelihood ratio in order to
25 be useful needs to be 10 or more.
26 So what this means is that the subjects who the DRE
27 predicted were dosed with any drug were only 1.3 times more

1 likely to be actually dosed with any drug class than subjects
2 who were not actually dosed with any drugs.
3 So, as an example, if you set a population
4 probability and let me know if this is getting too detailed
5 for you.
6 Q I was going to say if you could step back just to
7 make sure we understand. You have talked about sensitivity
8 and specificity. I know we covered a little bit on Thursday,
9 but could you explain what those terms mean again?
10 A Your Honor, those are numbers or ratios that allow
11 you to decide validity. And you combine them together, you
12 generate a number called the likelihood ratio. That's the key
13 number and from that number you can decide, you know, whether
14 it's one, meaning the test is absolutely random. It doesn't
15 distinguish at all. Ten, meaning the drug -- the test is
16 really good or something significantly less than one meaning
17 the test is worse than useless.
18 So the DRE, for example, predicts that if drug X is
19 present, it's really likely that drug Y is present or nothing
20 is present.
21 So, that's why those numbers are important. So, if
22 you combine all the drugs together, DRE prediction for any
23 drug versus drug present or absent, that likelihood ratio is
24 1.39 and meaning that the test is not useful at all.
25 And Heishman says that. What he concludes in his
26 paper that -- and I will just quote it, "for these data,
27 sensitivity and specificity were relatively low," which is

1 correct, "and false positive and false negative rates were
2 high." And then he goes on to say,
3 "These data clearly indicate that the variables of
4 the DRE evaluation alone, did not permit DREs to
5 predict impairment and drug intake with a consistency
6 that the IACP."
7 And that's the International Association of Chiefs
8 of Police, which is the DRE so-called certifying body requires
9 for certification. So, they weren't able to do it.
10 And then you can also take -- pull out the actual
11 numbers and calculate likelihood ratios for particular
12 individual drugs. And I did that for stimulants and cocaine.
13 And for stimulants, the likelihood ratio that comes
14 out is 0.31. And that's a number, Your Honor, that's
15 significantly less than one.
16 And it means when DREs predict a subject to be dosed
17 by cocaine they are less likely to be impaired by cocaine.
18 So when the DRE makes a -- made a cocaine called in
19 the study, it was actually predicted that the subject was not
20 impaired by cocaine, which is absolutely not what you want.
21 You don't want it to be worse than useless.
22 And for marijuana, the likelihood ratio was 1.3,
23 which means it's not worse than useless but it's not high
24 enough to be useful in making an accurate prediction about
25 cocaine's use -- I'm sorry about marijuana's use.
26 So, Heishman speculates in his paper in the
27 conclusion of the paper that the DRE's poor showing in its

1 study occurred because of several factors.
2 One, in the field -- I think that's probably the
3 most important one of all, there may be preliminary evidence,
4 drugs or drug paraphernalia that makes it more likely that the
5 individual has used drugs and the DRE are aware of this.
6 So, essentially, Your Honor, this is being used as
7 an interrogation tool that the police officers will do a
8 search incident to arrest. To maybe get an admission and then
9 use the DRE protocol as another method to perhaps get the
10 Defendant to admit to the drug use after all is done.
11 He says that in the field the DREs may smell
12 marijuana on the subject's breath, or observed cocaine
13 crystals in the nose and in the studies these clues were
14 meaningless and in the field DRE's attempts to supplement the
15 examination by interviewing subjects and often received
16 incriminating statements or confessions and no such
17 interviewing techniques were committed in study.
18 Q So just to make sure I understand what you are
19 talking this concept of likelihood ratio one. Is that like
20 where it gives you 50/50 point -- I am just trying to
21 understand your concept?
22 A Your Honor, if the likelihood ratio is one, it means
23 the test gives you no -- it's random. A likelihood ratio of
24 one means the test is random. It's no good at all.
25 A likelihood ratio of significantly greater than
26 one, usually around 10 means that it's a good test. And a
27 likelihood ratio significantly less than one means the test is

1 worse than useless because it means that when the predictor is
2 saying the drug is present it's really not present or
3 something else is present.
4 Q So, in the medical community and research scientific
5 community, can you at least give us an analogy as far as how
6 this would apply for example if you were using this kind of
7 test in the medical community?
8 A So, basically if you had a test with these numbers,
9 you wouldn't use them because it would be worthless. It would
10 not be used.
11 Q But what if it was the likelihood ratio was less
12 than one what could that mean?
13 A Well, then you would have to turn your whole
14 hypothesis around that if it was significantly less than one
15 what you thought was positive was negative. So, you could use
16 it paradoxically to say, well, you know, it's one-tenth.
17 And that means the prediction was really wrong but
18 if you could flip it around and say well that means the other
19 prediction is right.
20 But that's generally is not what happens. Usually,
21 what the likelihood ratio are significantly low less than one,
22 it means that the whole methodology behind the test is wrong
23 and you have to rethink it.
24 Q Now as to this particular study, was there any
25 attempt to determine inter-rater reliability?
26 A None.
27 Q And was there also anything determined as far as how

1 they were reaching these decisions?
2 A How they were reaching it?
3 Q Right. In other words how they were coming up with
4 the ---
5 A No, because, again, the authors note that the DRE
6 manual says that the officers are supposed to reach the --
7 whatever it means the totality of the circumstances.
8 And this particular study did not try to break out
9 those particular factors. They basically, you know, used the
10 DRE's final opinion as the outcome variable.
11 Q And as to their final opinion they were just testing
12 even presence?
13 A Right. It's presence, again, back again, none of
14 this has to do with impairment to drive, driving impairment.
15 Q And that was -- you covered those -- I just want to
16 make sure. Did you cover those in your -- I know you talked
17 about just a few of them. What about the other drug
18 categories?
19 A Well, the other drug categories weren't tested for.
20 So, I believe in this study like all the other studies, the
21 DREs are informed that only five possible drug categories are
22 present. They are also told that more than one drug would be
23 given. In fact, in this study, there were only three possible
24 drug categories; alcohol, marijuana and -- let me get it
25 right, and stimulants.
26 So, those were the only ones that were tested in
27 this particular study. And no combinations of drugs were

1 studied. In fact, Your Honor, none of the literature test any
2 drug combinations.
3 Q And why is that significant to you?
4 A Because, again, the DRE purports to be able to --
5 the manual says you can test if the DREs are accurate in
6 testing drug combinations and there's no data whatsoever
7 anywhere in any of these studies to support that?
8 Q All right. So as to each particular drug category
9 that was tested, you were able to reach the likelihood ratios
10 for each individual one as well?
11 A Yes, both together and -- right, I've already talked
12 about that.
13 Q Okay. I was just making sure. So --
14 A For the '96 study, we haven't talked about the '98
15 study.
16 Q Okay Well, let's move to the '98 study.
17 A Right.
18 Q And what can you tell us about that study, that was
19 also the Heishman study?
20 A Right. This is another -- this is the same group,
21 at the same place, with some modifications. This time they
22 were detecting DRE's ability to detect whether a depressant,
23 which they used alprazolam; a stimulant, they used
24 destroamphetamine; a narcotic analgesic, they used cocaine;
25 and marijuana, they used cannabis or marijuana.
26 Those were the test drugs. And the key general
27 question was whether the drug recognition experts could be

1 accurate based on the IACP consistency standards and the
2 manual at least at the time this study was present had IACP
3 consistency standards and I won't go through it.
4 But if you follow essentially how the certifying
5 body requires the DREs to test their accuracy in the fields.
6 And, again, I was able to generate the same two by two table
7 with DRE prediction on the left and actual condition on the
8 right.
9 This case is a little different because the actual
10 condition is consistent by IACP standards where drug
11 administered or not consistent by IACP standards where no drug
12 administered and the DRE predictions were even dosed with the
13 drug or not dosed with the drug.
14 And, again, you can calculate sensitivity and
15 specificity numbers, calculate from that likelihood ratios and
16 in this case the likelihood ratio is 0.49, which is less than
17 one, meaning that it's significantly less than one, meaning
18 that it's worse than doing nothing at all.
19 Q Let me stop you. Is that collectively for all of
20 the drugs?
21 A This is for all of the drugs present or absent. So,
22 again, it's not capable. This shows that the drug recognition
23 experts were -- and this is a quote from Heishman, "Using IACP
24 standards, DRE's predictions were consistent with administered
25 drugs in only 32 percent of the cases."
26 Another way of saying that is through these validity
27 calculations, which I've just done -- in other words, the test

1 is not useful.
2 And then you can do similar calculations breaking
3 out specific drugs for depressants. The likelihood ratio is
4 0.98, that's almost one, meaning it's almost literally random,
5 it has got no useful information at all.
6 For stimulants, it is 0.12. This is a really low --
7 this is really significantly below one meaning that test is
8 really, really worse than useless.
9 So, when DRE say the drug is present, there is a
10 high probability that it's not present. For narcotic
11 analgesics, the likelihood ratio is 0.43, not as lower than
12 one, but lower than one. Again, worse than doing nothing at
13 all.
14 And then for marijuana, the likelihood ratio is
15 0.75, again, less than one, meaning that the ability for the
16 officers to predict marijuana again is -- when the same
17 marijuana is present, it's more likely that it's not present.
18 Q As to these -- both of these studies, we already
19 talked about behavioral, peer review, inter-relater
20 reliability, the same, correct?
21 A The same, yes.
22 Q If I could just ask you a couple of questions
23 regarding this?
24 A Sure.
25 Q The State's expert Ms. Michelle Spirk, indicated
26 there were -- in her opinion some flaws with the Heishman
27 study. And if I could step through and ask you some of those?

1 A Sure.
2 Q She indicated that they didn't actually follow the
3 protocol because they didn't allow them to interview people.
4 What is your opinion as to that?
5 A Well, it's true. They didn't follow the protocol
6 because they didn't allow one to interview people. But that's
7 because the only way to test a drug's validity in this double-
8 blind fashion and if they have done that, what they would have
9 been testing were the test subject's ability to communicate
10 data to the researchers, which you never want to do. It would
11 make the study invalid.
12 So, there is no way to a validation study that would
13 allow such communication. It can't be done.
14 Q So, do you think that is a flaw of the study?
15 A No. I think it makes -- it's what makes the study
16 valid and useful.
17 Q Okay. It was also indicated by two of their experts
18 that they used alcohol. They gave alcohol to these test
19 subjects in addition to drugs and that that would call into
20 question the success?
21 A This is in the first study I presume she means?
22 Q Yes.
23 A And, no, in fact, one of the steps in the protocol
24 is that the DRE or maybe the original officer, you can just
25 administer a roadside breath test, is supposed to do that to
26 rule out the presence of alcohol.
27 In fact, in the first Heishman study, they

1 calculated their validity statistics using the presence or
2 absence of alcohol. And, of course, the DRE evaluators knew
3 with absolute certainty that alcohol was present because they
4 were allowed to measure it with a breath test.
5 So, it doesn't call into question, it was part of
6 the protocol, they administered alcohol and they saw what
7 happened. It made it analysis -- it made it a little more
8 difficult to pull out the actual validity data but it was able
9 to do it and it's not a problem in the study.
10 Q And is that part of what the DRE purports to be able
11 to do is --
12 A Yes.
13 Q -- distinguish between the --
14 A Yes.
15 Q -- low level of alcohol and drug impairment?
16 A Yes, which I don't believe they can based on what
17 I've reviewed.
18 Q All right. So that is certainly what they purport
19 to do?
20 A Yes.
21 Q As far as an addition, she described that these were
22 given -- these were low dosage that you wouldn't typically see
23 in a street dose.
24 A Right.
25 Q And could you explain your position on that?
26 A Your Honor, no one knows that usual street dosages
27 are, that's number one. Two is that for the drugs that were

1 used at half legitimate street usages, stimulants, opiates and
2 benzos, they used three to six times the normal drug dose.
3 So, it’s significantly higher than the normal drug
4 dose and dosage that would almost certainly result in some
5 physiologic affect.
6 Q Okay. So, in your experience in working with -- I
7 think you indicated earlier that you had worked with patients
8 in the city with high drug population areas?
9 A Yes.
10 Q In your experiences, are there any generally
11 accepted street dose?
12 A No.
13 Q In your opinion, did the dosing that they did hear
14 was it sufficient to validly test what they purport to claim
15 it was --
16 A Yes, it’s reasonably, Your Honor, you can’t give
17 people so high a dose you might kill them if you are doing
18 research. So, you have to pass all research through an IRB
19 and that’s what they did.
20 Q And an IRB is what?
21 A Institutional Review Board, which for human
22 subjects, which passes on test like this. So, three to six
23 times a recommended dose is a reasonable dosage to give, I
24 think. Obviously, the Institutional Review Board thought so
25 too.
26 Q As far as in addition, she indicated that the DREs
27 evaluated some of the subjects after only 10 minutes from

1 ingestion --
2 A Right.
3 Q -- could not be seen by the DRE.
4 A Right.
5 Q And can you tell us your opinion on that?
6 A Yes. I think that's actually wrong. I think that
7 the number is longer and I think that it depended on the drug.
8 But that number was based on the known pharmacology of the
9 drugs that were given and it was done specifically to maximize
10 the peep drug affect.
11 So, it was actually done as an argument against the
12 first or second or third problem. That is they were
13 calculating the peep of the drug and they wanted the DRE to do
14 it around the maximum drug effect to give them every chance to
15 be able to pick up the drug.
16 Q So, is it your opinion that the way they actually
17 dosed and have them see them maximize the ability of the --
18 A Yes, that was the idea.
19 Q Now, the fifth one that was also raised was that the
20 researchers falsely told the DREs that they could expect more
21 than one drug to be present and that they never actually did
22 that?
23 A Right.
24 Q And that was indicated as a flaw. Would you
25 consider that a flaw?
26 A No.
27 Q And why not?

1 A Because in any experimental subject, you set the
2 experimental conditions. One of the things the DREs purport
3 they are able to do is decide whether more than one drug is
4 present. Giving them that instruction puts them in a real
5 world situation and even then they didn't do more than one
6 drug because it would have made the analysis of sensitivity
7 and specificity impossible.
8 It was a reasonable thing to do to see what the
9 outcomes would be.
10 Q And as far as one of the other issues as to inter-
11 rater reliability, it was indicated that that would be
12 impossible to determine or test. What is your opinion as to
13 that?
14 A No. I think it's quite possible to test. There
15 would be various ways to do it either using the two raters
16 with similar subjects with similar dosages or doing them
17 through -- during them independently. So, it's possible to
18 do. No one has done it though.
19 Q Okay. But you don't see that as a flaw or --
20 A No. I mean it is what it is. The data we have is
21 the data we have. It would be -- we really only have three
22 decent studies, the two Heishman studies, we have talked
23 about, and, I guess, the Shinar and Schechtman study, that we
24 are about to talk. That's what available. You have what you
25 have.
26 Q All right. Does that cover your everything you
27 need?

1 A Yes.
2 Q All right, if I could approach. I am going to -- if
3 I could have marked.
4 (Pause.)
5 BY MR. DeLEONARDO:
6 Q If I could approach, I am going to show you what has
7 been marked as Defense Exhibit No. 10 and ask if you can
8 identify that document?
9 A Yes. This is the Shinar and Schechtman study, which
10 an accident analysis and prevention in 2005 and that's another
11 peer review journal.
12 (The document referred to was
13 marked for identification as
14 Defendant's Exhibit No. 10.)
15 BY MR. DeLEONARDO:
16 Q And that was a published and peer reviewed study
17 that you used in reaching your opinion?
18 A Yes. And it was, again, done using the same
19 methodology that was used in the Heishman study at the same
20 place. It was all done in beautiful downtown East Baltimore.
21 Where a lot of the -- or a great deal of the national or
22 international actually human subject drug research is done.
23 Q Okay. And is that a fair and accurate copy of that?
24 A Yes.
25 Q Okay.
26 MR. DeLEONARDO: Your Honor, I am going to move to
27 admit Defendant's Exhibit No. 10.

1 THE COURT: All right. Defendant's Exhibit 10 is
2 admitted.
3 (The document marked for
4 identification as Defendant's
5 Exhibit No. 10 was received
6 in evidence.)
7 BY MR. DeLEONARDO:
8 Q Your Honor -- I mean I am sorry, doctor, if we
9 could, first of all, could you tell us in this particular
10 study what drugs were actually included in this analysis?
11 A Yes. They tested for marijuana, depressants,
12 opiates and stimulants and the particular drugs they chose
13 were cannabis for marijuana, alprazolam as to depressants,
14 codeine as a narcotic, and amphetamine as a stimulant.
15 Q And as far as this particular study, it was double-
16 blind?
17 A Yes, same methodology.
18 Q Okay. And, again, did it test actual the ability of
19 the DRE to determine behavioral impairment?
20 A No. Again, the gold standard is presence or absence
21 of the drug. And they know this by dosing the subject and
22 then testing.
23 Q And I am going to ask again, did they attempt to
24 test them on their ability to distinguish between someone with
25 a medical condition that could mimic impairment versus drug
26 presence?
27 A No.

1 Q Did the study acknowledge that?
2 A Yes.
3 Q As far as the, and again, I assume there was no
4 inter-rater reliability?
5 A No.
6 Q What were the results that you were able to analyze
7 as a result of this study?
8 A Well, they directly presented their data -- they
9 actually directly calculated sensitivity and specificity,
10 however, they collected their outcome data slightly different
11 way based on -- in a little different way based than the other
12 folks had done it. And I will just read it to you.
13 Q Okay.
14 A They said that Heishman's analysis relied on a
15 different interpretations of the officers' written report. In
16 their report, the officers were required to note all
17 observable signs and symptoms and then state their conclusion
18 regarding presence of impairment.
19 If impairment was noted, then they were required to
20 name the source of impairment in terms of one or more of the
21 seven drug categories.
22 Unfortunately, in approximately half the cases, the
23 officers checked the unimpaired category and at the same time
24 cited one or more sources of drug impairment and the Shinar
25 and Schechtman state this is not the practice recommended by
26 the Deck's procedures. And it could only be surmised here
27 that it reflects a lower level of confidence concerning

1 impairment for driving.

2 I've got to say that's, again, there is no

3 impairment for driving in none of these test impairment for

4 driving but that's what they say.

5 Q Okay.

6 A Heishman dealt with this discrepancy by ignoring the

7 drug cited by the officers when the unimpaired category was

8 checked. This created a large subject of unimpaired decisions

9 and in response to that Shinar and Schechtman modified how

10 they were going to collect the data.

11 They relied on all of the officers' report of drug

12 impairment even when the officers check the unimpaired

13 category.

14 So, this approach fielded a much smaller set of

15 unimpaired cases and they say was arguably a better indicator

16 of the officers' sensitivity to drug impairment.

17 Essentially, what they are doing is giving the

18 officers even more of a chance to be accurate. Even if they

19 check unimpaired, they are counting that as impaired under the

20 DRE if they named the drug category.

21 But they are giving them the benefit of the doubt.

22 And from the study they generated sensitivity and specificity

23 numbers -- again, they used the same methodology in doing the

24 studies as the Heishman studies.

25 Q Okay. And what were your conclusions as to the

26 report ---, category and their conclusions?

27 A That they calculated the likelihood ratios for the

1 particular drugs and for marijuana it was 1.6, which again is
2 well under the 10 that's required to be used for test.
3 For depressants, you were able to calculate a
4 likelihood ratio of 2.35, again well under the 10 number.
5 For opiates, it's 1.6 and for stimulants it's 1.1.
6 So, again, the DRE's predictions under these circumstances are
7 at least slightly better than chance. Again, the test is not
8 useful.
9 Now, again, we have three studies, and the peer
10 reviewed literature that I think showed conclusively that the
11 DRE is not valid for predicting whether or not the drug is
12 present in the blood or urine and we still have no studies
13 anywhere that talked about driving impairment.
14 Q And also, I guess, the medical issues?
15 A No difference with the medical issues, that's
16 correct.
17 Q Okay. In this particular study as well, they noted
18 some specific reasons that the officers gave for findings as
19 well, is that correct?
20 A They did that in this study and a subsequent study,
21 yes.
22 Q Well, as far as this particular study -- you have a
23 copy in front of you?
24 A No, I don't actually have a study.
25 Q I am sorry. I have another copy. I will show you
26 on page 849.
27 A Yep.

1 Q You are familiar with that section?
2 A Yep.
3 Q And this particular tests, they actually tried to,
4 is it true, take a look to see how they reached their
5 decision?
6 A Yes. So, Your Honor, one of the problems with the
7 DRE protocol is that it doesn't instruct the officers how to
8 weigh the factors. So, there's multiple factors that they are
9 looking at that doesn't tell them the effect of A, plus B,
10 plus C, is present that it's a stimulant.
11 It doesn't really help to do them at all. And
12 officers are instructed to use the "totality of the
13 circumstances," whatever that means.
14 So, what these researchers did is actually attempt
15 to pull out the specific factors of the test that officers
16 might rely on.
17 And they found that officers -- I'll just read one
18 piece of it. "That officers relied on all four
19 psychophysiologic tests and horizontal gaze nystagmus to
20 conclude that a person is impaired.
21 And this is the important piece regardless of the
22 selected impairment drug category. This was deduce from the
23 fact that the average performance scores on the nystagmus test
24 and on all of the psychophysical tests were significantly poor
25 whenever any impairment was identified.
26 And say that this reliance is not always appropriate
27 because those psychophysiologic tests are really only relevant

1 for one major category of drugs, depressants, including
2 alcohol and benzodiazepines, but not of the other three drug
3 categories tested, narcotics, stimulants and cannabis.
4 Yet the officers occasionally noted the nystagmus
5 and still concluded the impairment was due to one of the
6 latter categories.
7 So, they -- what the authors point out is that the
8 officers often reached conclusions that were not consistent
9 with the matrix.
10 Now, of course, they are allowed to do that because
11 they are supposed to rely on the totality of the circumstances
12 but it just shows that it has no understandable bearing. It
13 does not make sense.
14 Q Okay. If I could just stop there for a moment?
15 A Sure.
16 Q I am going to show you what has been previously
17 marked and admitted as State's Exhibit No. 5. And you
18 recognize that, correct?
19 A Yes, it's one of the -- I guess it's the newer
20 version of the matrix. This one is in color.
21 Q And can you tell us according to the matrix what
22 category show that HGN is an indicator and which one say that
23 it is not an indicator?
24 A So HGN is an indicator for what they term CNS
25 depressants, what they term dissociative anesthetics and what
26 they term inhalants. But is negative for stimulants,
27 Hallucinogens, narcotic analgesics, and cannabis.

1 Q And so as to this particular study, they indicated
2 HGN as to which categories were being used by the officers?
3 A That the officers noted an impairment based on HGN
4 but then noted the specific drug might be a stimulant or might
5 be a cannabis or might be a narcotic. And that's just not
6 consistent with the matrix or general medical knowledge.
7 Q So, they indicated then they were doing it actually
8 against what the protocol says?
9 A Right. Well, not really against what the protocol
10 says because, again, this is the problem, they are allowed to
11 use judgment. But it's not consistent with the actual data
12 that they are taught.
13 And they are not required to specify how they are
14 using their judgment. They are not -- Your Honor, the problem
15 is there is no method that the manuals used or anyone else
16 uses or the study show to weigh these factors.
17 So, there is really no way to actually
18 operationalize this stuff.
19 Q Did the study also talk about certain signs that
20 were relied on by the officers?
21 A Yes, they found that the officers tended to use what
22 they called pivotal systems. So, they note that in addition
23 to the psychophysical test in nystagmus the officers typically
24 noted only one measure that was significantly different from
25 their unimpaired judgment and they go into details about that.
26 Q All right. Well, if I could just -- we could
27 explain that point, that there is -- they indicate that the

1 officers used, you said, primarily one sign or symptom --
2 A Right.
3 Q -- to distinguish between someone impaired and
4 unimpaired?
5 A Right, yes.
6 Q And could step through what some of those are?
7 A Yes. So, first, they say, for example, for their
8 identification of cannabis as the impairing drug, the officers
9 noted a raised pulse. For identification of depressant, they
10 relied on a raised temperature and possibly reduced pupil
11 diameter under direct light.
12 When they believed the impairment was due to
13 narcotic analgesic, it was based on a lower temperature and a
14 slightly constricted pupil under direct light.
15 When they believed the impairment was due to a
16 stimulant, they relied on a large pupil and the dark increased
17 and horizontal gaze nystagmus.
18 And they state, although this approach simplifies
19 the officer's task, it is not sensitive enough to the true
20 complexities of drug affects and consequently it is also
21 likely to lead to erroneous conclusions.
22 And, in fact, that's exactly what the data showed.
23 It leads to erroneous conclusions.
24 Q Now, you are aware in the manual that it actually
25 cites various studies in support of the program?
26 A Yes.
27 Q Are any of the Heishman or the Shinar studies noted?

1 A No. Your Honor, it's remarkable. I've been reading
2 these manuals for years. I've been following it. And the
3 manuals continue to cite the non-peer reviewed studies that
4 are worthless. And do not cite the three peer reviewed
5 studies that are useful for validation. I don't know why.
6 Q So, ultimately, and getting back to the basis of
7 your opinion, can you summarize your opinion within -- and I
8 am going to ask you a couple of questions?
9 A Sure.
10 Q If I could ask you first all to summarize your
11 opinion as to the research, medical research and can you tell
12 us what your opinion within a reasonable degree of scientific
13 medical certainty is as far as the ability to the validity and
14 reliability of the research what it shows?
15 A The validity and --
16 Q What the program -- the clinical research, what is
17 your overall opinion from all these studies, can you summarize
18 that for us?
19 A In summary, Your Honor, the DREs neither are
20 reliable nor a valid measure for determining whether a person
21 has alcohol or illicit drugs in his blood or urine and that
22 there is no scientific data whatsoever which shows the DRE can
23 predict whether an individual is impaired in driving ability
24 from the use of alcohol or illicit drugs.
25 There is no data whatsoever the literature testing
26 the DRE's reliability and that's whether two or more officers
27 administering the DRE to the same subject would reach the same

1 conclusion.

2 And that all of the prior studies that we've talked
3 about with the exception of the Heishman studies and the
4 Shinar and Schechtman study are seriously flawed and falsely
5 portray high accuracy numbers when, in fact, careful analysis
6 shows validity is close to chance or worse than chance.

7 That the Heishman studies and the Shinar and
8 Schechtman study conclusively show that the DRE when tested
9 appropriately is not an accurate predictor of the presence of
10 drugs.

11 In fact, the Heishman study and the Shinar and
12 Schechtman study conclusively show that the police officers'
13 predictions are either no better than chance or are worse than
14 chance.

15 And, again, none of the studies attempted to test
16 multiple drug classes in the same subjects and there is
17 therefore no reliable data whatsoever about DRE's accuracy in
18 predicting whether more than one drug class is present.

19 Q And you prepared -- I show you again defense Exhibit
20 No. 8 that I identified previously?

21 A Yes.

22 Q That is that sets out your complete opinion and your
23 analysis, is that correct?

24 A Yes.

25 MR. DeLEONARDO: I would move to admit State's
26 Exhibit No. 8.

27 THE CLERK: You mean defense?

1 THE COURT: I am sorry 8 is --
2 MR. DeLEONARDO: I am sorry, defense Exhibit No. 8,
3 I apologize. Move in to admit State's Exhibit No. 8,
4 Dr. Janofsky's report.
5 THE COURT: Which is --
6 MR. DeLEONARDO: Dr. Janofsky's report on his
7 studies.
8 THE COURT: All right, it will be received.
9 MR. CRUICKSHANK: I think you said State's Exhibit?
10 MR. DeLEONARDO: Yes, I did.
11 MR. CRUICKSHANK: You did it again.
12 MR. DeLEONARDO: I know I -- defense Exhibit No. 8.
13 I don't know why I have a brain block.
14 (The document marked for
15 identification as Defendant's
16 Exhibit No. 8 was received
17 in evidence.)
18 BY MR. DeLEONARDO:
19 Q Okay, just a couple of additional questions, doctor,
20 if I could. First of all let me -- relying on some of your
21 medical background?
22 A Yes.
23 Q Do you believe that the DRE is attempting to make a
24 medical diagnosis in this protocol?
25 A I think that's what they are attempting. They are
26 not doing a very good job.
27 MR. WELLS: Objection.

1 BY MR. DeLEONARDO:
2 Q All right, well, can you explain what is the
3 medical --
4 MR. WELLS: Objection.
5 MR. DeLEONARDO: -- diagnosis --
6 THE COURT: Did I hear an objection?
7 MR. DeLEONARDO: Oh, I am sorry.
8 MR. WELLS: Yes, Your Honor, that's the -- the
9 ultimate issue, it is really not this doctor's opinion. What
10 his opinion is really doesn't matter. This is -- that is the
11 ultimate issue or one of the issues that the Court has to
12 decide. It really doesn't make any difference what this
13 particular doctor thinks.
14 THE COURT: I will sustain.
15 BY MR. DeLEONARDO:
16 Q Can you tell us what it is a medical diagnosis,
17 doctor?
18 A Yes, Your Honor, a medical diagnosis is done based
19 on training and experience by taking history, during various
20 physical tests, obtaining laboratory data, talking to
21 collateral informants, putting that data altogether to reach
22 what calls a differential diagnosis, which is a list of
23 possible diagnostic categories then narrowing that list down
24 again by taking more history, doing other tests, et cetera.
25 Q I want to step through some of that with you.
26 A Sure.
27 Q But let me ask you, what is the difference between

1 you as a doctor and a technician?
2 A Sure. So, Your Honor, professionals like physicians
3 and advanced practice nurses and other folks like that go
4 through thousands of hours of training, see hundreds or
5 thousands of patients and based on -- and continually update
6 their knowledge and based on that training and experience put
7 data together in various ways to reach a differential
8 diagnosis.
9 Technicians who don't have such an extensive kind of
10 training, if they are going to collect data and make a
11 "decision," need to follow a protocol so that they do the same
12 thing, in the same way every time. Check boxes, et cetera.
13 And then at the end they can either come up with a
14 score or add things together. And then that data is usually
15 reviewed by a professional who then makes the opinion.
16 So, for example, a medical technician and a LPN
17 would never make a -- they are not allowed to make a
18 diagnosis. They are allowed to collect data, they are allowed
19 to follow protocols but they are not allowed to reach the
20 ultimate conclusion of diagnosis or treatment because it's
21 beyond the scope of their training and experience.
22 Q And you got a chance to review the medical and
23 pharmacological information provided to the students in the
24 manual, the DRE?
25 A Oh, yes.
26 Q Would that be sufficient in your opinion?
27 A To make an accurate diagnosis?

1 Q Correct.
2 A Absolutely not.
3 Q And you talked about taking the history, physical
4 examination, et cetera. It's been said by prior experts, I
5 think you might have been in here that getting the history
6 from the patient and talking to family members it is really no
7 difference than what a drug recognition expert is doing. Can
8 you explain what your opinion is as to that issue?
9 A Well, I hope it's different, Your Honor, because I
10 haven't pulled the person over with my lights and sirens and
11 I'm not the person who's going to put them under arrest if the
12 data suggest it.
13 It's really a matter of agency, Your Honor. When I
14 am a doctor, my job is to act as the patient's fiduciary or
15 agent.
16 And I am bound ethically, morally and professionally
17 to do what's in the patient's interest and to put the
18 patient's interest above mine.
19 That's the crux in our system of the doctor/patient
20 relationship. So because of that, patients will tell
21 physicians things they wouldn't tell anyone.
22 It amazed me, Your Honor, as a medical student first
23 time I walked into a room and introduced myself. Someone who
24 you have never met before at 3:00 in the morning they are in
25 pain, they will give you detailed family history, things they
26 wouldn't tell their wives and I was thinking about that for a
27 long time.

1 And the reason they do it is because they know you
2 are working for them and your goal is to help them.
3 Well, police officers' major goal is to represent
4 society and protect society from bad people. So, they are not
5 the patient or the arrestee's agent. It's just the opposite.
6 They're job is to accurately and ethically using their
7 professional system make a decision about to arrest and
8 collect the data necessary for a prosecution.
9 So, they're are almost always, although not always,
10 but almost always working against the Defendant's interests.
11 So, it's an extraordinarily different situation and you would
12 not assume that they are going to get a similar kind of -- in
13 fact, you can assume they are not.
14 Q And in your experience when you don't have that
15 trust, is it difficult for patients to disclose?
16 A Sure.
17 Q Even when you have that trust in a relationship, do
18 patients always know what they have wrong with them?
19 A No, no. In fact, that's -- a lot of the time,
20 that's why they come because they are not feeling well,
21 something is wrong and they don't know why.
22 Q And as far as a specific situation, let me ask this.
23 As far as the examination, you talked Thursday about the fact
24 that impairment is when you have -- medically you have a
25 bodily function and somewhere that is impaired from the --
26 A Not working correctly.
27 Q Correct. Not working correctly. Is that the same

1 as impaired to drive?

2 A No. They are totally separate issues. And this,

3 again, this is what the DRE manual confuses over and over

4 again, impairment in a particular body function verses driving

5 impairment. They are not the same things. They might be

6 totally -- in fact, they are totally unrelated.

7 Q And if some of the points if we can just touch, for

8 example, we heard extensively and I am not going to step

9 through them horizontal gaze nystagmus. Is there any research

10 that you know of that would show that that impaired the

11 ability to drive?

12 A None.

13 Q And in your experience in your practice when you

14 have seen that, is there anything that --

15 A Yes.

16 Q -- would conclude that?

17 A No. Your Honor, some patients have various kinds of

18 nystagmus. Some have eye movement difficulties, sometimes

19 associated with an ability to drive especially if it's related

20 to blindness or impaired vision, but nothing else.

21 Q Okay. And is it something that you use in the

22 medical field to show drug impairment?

23 A No.

24 Q As far as lack of convergence, what about that?

25 A Same answer, lack of convergence, again, is part of

26 an irregular neurological examination, screening examination.

27 It's just one -- you are testing various midbrain circuits and

1 eye muscles and you put that into the pot if it's abnormal or
2 normal in your differential diagnoses. But it's certainly not
3 used as a method to decide whether someone is intoxicated or
4 can't drive.
5 Q And as to the taking of vital signs is that
6 something that you use to show drug impairment?
7 A No.
8 Q Do you know of anyone in the medical field that uses
9 that to show drug impairment?
10 A No.
11 Q As far as the -- we have heard about the walk and
12 turn, one leg stand, first of all, does age of the person and
13 weight affect that as well?
14 A Oh sure or if you are not -- you know, if you are an
15 athlete or not an athlete, if you have bad joints, I mean
16 these are not tests that would be used in any way to look at
17 driving impairment or intoxication.
18 Q And that was my next question. In the medical
19 field, do they use these tests to show drug impairment?
20 A No.
21 Q As far as the Romberg, again, is that -- the same
22 question, is that used in the medical field to show drug
23 impairment?
24 A Well, the Romberg, essentially, Your Honor, is a
25 method to decide whether someone is off balance, whether it's
26 because of an impairment and cerebellar function, which is the
27 back part of the brain or impairment in sensory input either

1 through the feet or through the spinal column or through the
2 brain.
3 So, it has been used -- not the Romberg itself but
4 people swaying around is a common sign of drunkenness. So, it
5 is used for alcohol impairment. But it is not used for any
6 other drug.
7 Q And why is that?
8 A Because there is no data to support its use.
9 Q As to finger to nose, that as well?
10 A Yes. Again, finger to nose is a -- you are testing
11 several things. You are testing vision, you are testing body
12 awareness, but it is not used to test for drug impairment.
13 Q Now as to these tests in --- Romberg, we have heard
14 that in some situations the DRE has been used with your head
15 tilting back. Can you tell us what effect that would have?
16 A Yes, it would -- it's not how it's done usually.
17 So, I don't know what effect it would have. It is not how it
18 is routinely done in medicine so it would make it much more
19 difficult to do correct for the person to do correct -- I
20 don't think I could do it, frankly, because I have balance
21 problems.
22 Q So, --
23 A And I am not impaired with any drug.
24 Q -- tilting of the head back is not something the
25 medical community would ---?
26 A No.
27 Q What about muscle tone? I think you were in Court

1 and you heard the description of how muscle tone is used in
2 the medical profession?
3 A Yes, I heard the Pillsbury Dough Boy analogy.
4 Q Right. Could you explain, is that the way that you
5 were taught it in medical school?
6 A No, that's not how you measure muscle tone. The way
7 you measure muscle tones is with a muscle in motion and the
8 way to examine it is to grab the patient's arm, move the arm
9 or the joint or the extremity back and forth like this and you
10 are feeling for various things.
11 You are feeling for whether the tone is loose or
12 normal, whether there is what is called lead-pipe rigidity,
13 whether there is clicks like this. So, these are all signs of
14 symptoms of various different medical problems including
15 Parkinson Disease.
16 But you don't measure it by poking at people. You
17 don't --
18 Q That was not what your understanding was?
19 A No, that's not how you measure muscle tones.
20 Q If I could move to confirmatory testing?
21 A Yes.
22 Q We heard from Dr. Zuk who indicated that he would
23 reach the conclusion without needing blood or alcohol -- blood
24 or urine results. Would you reach a determinant of impairment
25 from a drug that in fact there was no medical or psychiatric
26 condition causing those symptoms without any confirmatory
27 testing?

1 A No.

2 Q Do you know of any doctor in the field that would do
3 that?

4 A Not any licensed doctor who is competent in
5 Maryland.

6 Q Okay. And if you're actually -- when you are
7 testing someone's blood in the medical community, what are you
8 testing for?

9 A Well, I mean you can have multiple tubes of blood
10 drawn. There are thousands of tests based on analysis of the
11 blood both its chemistry, the presence of various antigens,
12 the presence of various blood cells. And these blood tests
13 results all go into the mix to help come up with a
14 differential diagnosis.

15 Q So the fact that something is present in someone's
16 blood would that allow you to reach a conclusion just based on
17 only that?

18 A Well, the fact that it's in -- if a drug is in a --
19 if the drug test you are getting is a toxicology screen and
20 the drug is in the person's blood, that tells you that the
21 drug is affecting their brain. But it doesn't tell you
22 whether that drug is causing behavioral impairment or driving
23 impairment.

24 Q So you would still look for other things then?

25 A Sure.

26 Q As far as -- another quick issue. The calibration.

27 A Yes.

1 Q If your medical instruments were used, for example
2 the sphygmomanometer and the blood pressure cuff, are those
3 things regularly calibrated in the medical world?
4 A Yes, I have it in patient/hospital practice and the
5 hospital has various specific regulations on how frequently
6 they need to be calibrated, the sphygmo -- I could never
7 pronounce it -- the blood pressure machine, needs to be
8 calibrated every couple of months and there is a whole
9 department to do it.
10 Q So, it's generally accepted that they have to be
11 calibrated on a regular basis?
12 A Sure.
13 Q As far as the -- you seen in looking through the
14 manual, have you not, the classification, the way that drugs
15 are classified?
16 A Yes.
17 Q And if I could, I am going to move to the student
18 manual, which would be State's Exhibit, -- I mean, I am sorry,
19 Defense Exhibit No. 5. And I am going to turn this to section
20 9 as an example, this would be CNS depressants.
21 A Right. So, this is a 2010 manual, Central Nervous
22 System Depressants, Section 9.
23 Q Okay. And I am going to direct you to pages 4 and 5
24 and can you tell us what is listed on pages 4 and 5?
25 A Yes. So, Your Honor, I think this listing of drugs
26 highlights the non-sophisticated and really non-medical nature
27 of this DRE program because what the book does and what the

1 officers are trained to do is to identify drug classes. And
2 this is the CNS -- what they call the CNS depressant class.
3 And, Your Honor, it includes barbiturates, it
4 includes Benadryl, which is used for colds, it includes
5 various benzodiazepines, which are like Valium, it includes
6 antidepressant medicines. It includes antipsychotic
7 medicines, it includes medicines like Lithium and other drugs.
8 So, no physician or nurse or anyone would ever put
9 these drugs in the same class because they have
10 extraordinarily different neurophysiologic actions.
11 And just as an example, Your Honor, if you would
12 look at the matrix under CNS depressants they say that -- I
13 believe it says CNS depressants -- do you have the matrix?
14 Q Yes.
15 A Oh, here it is. It says CNS depressants are
16 supposed to cause -- let's see if I can find -- this one
17 doesn't have the muscle tone on it, unless I'm missing it. So
18 let me find my own.
19 Q Let me --
20 A Let me get me a new one where I can find it in my
21 notes. (Looking through notes.)
22 (Long pause.)
23 MR. DeLEONARDO: Your Honor, I am going to mark
24 defense Exhibit No. 7.
25 THE CLERK: 11.
26 BY MR. DeLEONARDO: 11.
27 (The document referred to was

1 marked for identification as
2 Defendant’s Exhibit No. 11.)
3 BY MR. DeLEONARDO:
4 Q Okay, I am going to show you what has been marked as
5 Defendant’s Exhibit No. 11 and the updated drug symptomatology
6 chart.
7 A Yes, thank you.
8 Q Okay?
9 A Yes.
10 Q If you can take a look at and is that what you were
11 trying to tell us?
12 A Right. So, it says CNS depressants muscle tone
13 flaccid meaning floppy. And there -- in particular, there is
14 a whole class of drugs on here which they are listing as CNS
15 depressants and those are the antipsychotic medications.
16 Where their most common side affect is increased
17 muscle tone or what we would call extra ---, so there are a
18 whole bunch of drugs in here that have no affect on muscle
19 tone at all.
20 One could argue I suppose that certain
21 benzodiazepines might cause decrease in tone but they mixed
22 all the drugs up together. It’s medically meaningless. And
23 doesn’t -- makes no sense.
24 Q Okay. So this particular -- the way that this is
25 set out in the manual in terms of -- is that consistent with
26 all the different types of drugs?
27 A Yeah.

1 Q ---

2 A But in particular with depressant, it really stands

3 out.

4 Q And as far as in the medical community, you are

5 saying you would not use the categorization?

6 A No, absolutely not.

7 Q Doctor, we heard from Dr. Zuk, it was an

8 introduction of some letters from different medical

9 associations and I want to ask you if you would mind a couple

10 of questions about these?

11 A Sure.

12 Q This is what was marked as State's Exhibit No. 17

13 and I am going to ask you if you have ever seen this document

14 before?

15 A Yes.

16 Q And when did you see it?

17 A Your Honor, I was involved in a case in Florida

18 called Florida v. Williams, in 1994 and as part of that case I

19 was actually given these. And I actually phoned these doctors

20 to find out how they came to sign them.

21 Q Okay. And that was back in -- you said mid '90s?

22 A 1994.

23 Q 1994?

24 A Yes.

25 Q And you said you actually talked with Dr. Franco

26 whose signature is on that?

27 A Yeah, I spoke -- see if I have an exact date on

1 here. I don't have it exact date -- oh, I'm sorry, I spoke
2 with Dr. Franco on July 14, 1994.
3 Q And what did he tell you about the letter?
4 MR. DAGGETT: Objection.
5 THE COURT: Mr. DeLeonardo?
6 MR. DeLEONARDO: Your Honor, they introduced a
7 letter which contains hearsay information from the doctor as
8 support. I think they opened the door to be questioned about
9 what the doctor said about it.
10 THE COURT: This doctor or --
11 MR. DeLEONARDO: This particular doctor that signed
12 it, yes.
13 MR. DAGGETT: Not to introduce hearsay evidence, I
14 mean how are we supposed to cross -- how are we supposed to
15 possibly find out if it is accurate what this doctor
16 supposedly said to Dr. Janofsky.
17 I mean that is exactly what hearsay is about. We
18 didn't open the door by putting in pieces of evidence. I mean
19 we put in documents from different medical associations and
20 for this doctor to now come in and say, oh yeah, by the way, I
21 then called this medical association and they told me this. I
22 mean that is not -- that is the ultimate issue of hearsay.
23 MR. DeLEONARDO: Your Honor, --
24 THE COURT: Okay, let me hear Mr. DeLeonardo.
25 MR. DeLEONARDO: If I could be heard, Your Honor.
26 They put in a letter signed by a particular doctor claiming to
27 have endorsed the program. And I would say that they admitted

1 that, which is, in and of itself, hearsay information.
2 What I would say is, at a minimum, I have a right to
3 combat that. Just like he says he has no way to cross, well,
4 I have no way to cross a letter.
5 So, if they want to withdraw the exhibits then I
6 will move on. But if they don't, I think it is a fair basis
7 for me to be able to challenge if Dr. Janofsky knows what they
8 meant by this and why they did it.
9 MR. DAGGETT: The fact that the defense allowed a
10 particular piece of evidence to come in is not then -- give
11 them the ability to violate the rules of evidence and say,
12 well, they put it in so therefore I now get to put in hearsay.
13 That is not what -- he is not allowed to do that.
14 MR. DeLEONARDO: And I am also, Your Honor, I would
15 say, I am not -- I think, Your Honor, --- on non-hearsay as an
16 impeachment.
17 THE COURT: I am sorry?
18 MR. DeLEONARDO: I think it also can be offered as
19 non-hearsay at least in terms of impeachment as an exception
20 to hearsay in the sense that we are challenging the --
21 THE COURT: Who are you impeaching?
22 MR. DeLEONARDO: Well, it would be the writers of
23 the letters.
24 THE COURT: I am going to sustain.
25 BY MR. DeLEONARDO:
26 Q Doctor, let me ask you this as well.
27 A Sure.

1 Q You did, in fact, however, speak to Dr. Franco, is
2 that correct?
3 A I did. And I testified under oath in a deposition
4 in this case in Florida about my conversation with him and was
5 cross-examined on it by the State's Attorney and the defense
6 attorney in Florida case at trial. And I just happened to
7 have the deposition here.
8 MR. DeLEONARDO: Can mark defense Exhibit --
9 THE CLERK: No. 12.
10 (The document referred to was
11 marked for identification as
12 Defendant's Exhibit No. 12.)
13 THE WITNESS: And I will either need a copy of that
14 back or the original.
15 MR. DeLEONARDO: I understand. I will get you a
16 copy.
17 BY MR. DeLEONARDO:
18 Q I am going to show you what has been marked as
19 defense Exhibit No. 12, do you recognize that?
20 A Yes. This is a copy of my telephoned deposition
21 taken in this case in Florida, Your Honor, a criminal case as
22 they allow depositions.
23 Q And, Your Honor, -- and that sets out your
24 conversations with these particular doctors, is that correct?
25 A I essentially read my notes and was cross-examined
26 about them by the State's Attorney -- with the District
27 Attorney.

1 Q --- on this issue?
2 A Yes.
3 Q And you said it was previously under oath?
4 A This was under oath and the deposition was under
5 oath and my trial testimony was under oath.
6 MR. DeLEONARDO: I want to move State's Exhibit -- I
7 mean defense Exhibit No. 12.
8 MR. DAGGETT: And I am going to object again. That
9 is not what this rule is meant to -- the fact that 18 years
10 ago he gave a telephone deposition to somebody in Florida does
11 not allow them to get around the rules against hearsay
12 evidence.
13 That is not what the rules are for. And we have no
14 way -- the State has no way of cross-examining or doing
15 anything regarding this witness if he is going to try to say
16 that he spoke with him. I mean that is just not what the
17 rules are for.
18 THE COURT: Well, apparently, there are different
19 rules in Florida regarding the use of depositions in criminal
20 cases, which is very, very rarely permitted in Maryland.
21 I wouldn't even be wrestling with this but for the
22 fact that the State introduced a letter. Now, I do agree with
23 Mr. Daggett if the State introduces something and the defense
24 chooses not to object, I don't think that automatically opens
25 the door as Mr. DeLeonardo is suggesting.
26 However, I do think that probably the deposition has
27 some of the -- has more indicia of reliability perhaps but I

1 am sure Mr. Daggett would argue and say well just because some
2 prosecutor in Florida had the opportunity to cross-examine
3 Mr. -- or Dr. Janofsky at the hearing, that still does not
4 give us the opportunity to cross-examine the doctor with whom
5 he spoke. Interesting issue.
6 I am going to -- I will allow it.
7 MR. DeLEONARDO: Thank you, Your Honor.
8 BY MR. DeLEONARDO:
9 Q And so what you are testifying today, you testified
10 in the deposition, is that correct?
11 A Yes, in fact, I can just make it easier, I would
12 like to just read from the deposition.
13 Q Okay. Well, --
14 A Or from my notes --
15 Q -- the same questions, I am going to ask you the
16 same questions. You spoke with Dr. Franco, is that correct?
17 A Yes.
18 Q And why did you call him?
19 A Well, because I wanted to know if I was missing
20 something. Remember, Your Honor, this is before any of the
21 validation studies. So, this case in Florida occurred before
22 the two Heishman studies and before the other validation
23 studies. So, there was very little in the literature.
24 So, I was calling Dr. Franco to find out what does
25 he know that I don't know, am I missing something, you know,
26 should I be changing my testimony, et cetera, and I asked him
27 about that. I asked him what the process was that they used

1 to sign this?
2 Q Okay. And based on your conversation, what did
3 Dr. Franco tell you about his letter? Was it an endorsement?
4 A He said I didn't write it, I just signed it. The
5 police came down and brought documentation someone had worked
6 up for them regarding these physical findings, fluttering
7 eyes, other symptoms.
8 It had been field tested, it had been tried out on
9 people and comparisons made. There was a high correlation to
10 do it and his statement, "It looked like it deserved
11 endorsement."
12 He said if there is any one problem, it's the
13 ability to differentiate between various drugs.
14 But then I said, well, I mean, do you use this down
15 in Florida in your emergency room? And he said, I'm a
16 pulmonologist, meaning he is a lung doctor. He does no ER
17 work, he has never done it.
18 I don't think ER doctors were told about this. I
19 don't remember and he doesn't think this is used in the
20 emergency room to diagnose intoxication. So, that's what he
21 told me.
22 Q Now, additionally, one of the letters that was
23 introduced was from the Broward County Medical Association.
24 And I am going to show you State's Exhibit No. 20.
25 A Right.
26 Q Have you seen that letter before as well?
27 A Yes I have. This is by --- and Weiss.

1 Q Did you have the opportunity to speak to Dr. Weiss?
2 A Let me find my -- yes. This is my phone call with
3 Dr. Weiss on July 13th, 1994 and he told me that --
4 MR. DAGGETT: Same objection.
5 THE COURT: Now is this the subject of a deposition?
6 MR. DeLEONARDO: Yes, this is all in the deposition.
7 It was all subject to the deposition that he is testifying to
8 now.
9 THE COURT: All right. We are just moving onto
10 another doctor?
11 MR. DeLEONARDO: Yes, a different doctor.
12 THE COURT: All right.
13 MR. DeLEONARDO: But it was all part of the same
14 deposition.
15 THE COURT: Objection noted, I will overrule.
16 THE WITNESS: He said that Steve Talpins was the
17 Assistant State's Attorney in Dade County and he requested our
18 Board to take a look at the DRE concept and endorse it. The
19 Board sent it to his committee. He said that Mr. Talpins, the
20 State's Attorney, came to one of our meetings along with an
21 officer who spearheaded the DRE for Dade County and he showed
22 us a videotape and answered our questions.
23 Dr. Weiss was informed by Mr. Talpins that this
24 procedure was the subject of a Frye Hearing in Florida, which
25 is what this case I was involved in, and it was our consensus,
26 he said, that there was a body of scientific evidence to
27 support it.

1 But he also said he understood that there is some
2 controversy in supporting it. The major critical thing that
3 he thought didn't support things was that there was no peer
4 reviewed literature.
5 He said it's not there practice to use the DRE
6 clinically. And the way that it was presented to them was
7 that it would be used only for probative value and would never
8 be used as a standalone test without a blood or urine
9 confirmation.
10 And it was presented to them as the "missing link"
11 for driving under the influence evaluations when they don't
12 have a drug level at the time of operations. So, this was his
13 understanding.
14 Q The understanding was only supposed to be for
15 probable cause to get blood.
16 A Probable cause, that's correct.
17 Q Now, I know the results, I am going to show you,
18 subject to your deposition State's Exhibit No. 18 Broward
19 County Psychiatric Society?
20 A Yes.
21 Q Did you attempt to contact him as well?
22 A Yes, I never received a phone call back Dr. ---.
23 Q Okay. But these letters were all around that same
24 time, is that correct?
25 A They are all in the same case. They are all from
26 the Florida v. Fredrick Williams case in 1994.
27 Q Are you aware of any organization that has seriously

1 looked at the program and evaluated its merits that actually
2 has endorsed it?
3 A No, I am not aware of any particular professional
4 organization that has actually looked at the actual validity
5 data and endorsed it.
6 Q Now we have heard the argument previously that a lot
7 of these concepts, pupil size, convergence, pulse rate,
8 et cetera, are all things that have been around for hundreds
9 of years and that none of this is new or novel, right?
10 A Well, I am not sure hundreds of years, but probably
11 a hundred years.
12 Q Okay. Well, let me ask you this. In your opinion,
13 is the DRE program applying -- first of all, are they applying
14 medical and scientific techniques in order to reach the
15 opinions?
16 A Yes, they are.
17 Q And in the manner that they compile and utilize
18 these medical and scientific principles is it a valid way in
19 your opinion?
20 A It's not valid.
21 Q Is it a reliable way in your opinion?
22 A No data on that so there is no data to prove
23 reliability.
24 Q Is the manner that they are using this -- compiling
25 and utilizing these principles, is it new and novel in the
26 field of medicine in your opinion?
27 A Yes, their attempt to do it is a new and novel

1 approach.
2 Q What about in the scientific arena as well?
3 A Yes.
4 Q Do you know of anyone in the medical communities who
5 actually uses this 12-step protocol matrix to diagnose if a
6 person is impaired?
7 A No, no one.
8 Q What about impaired by a drug and not a medical
9 condition?
10 A No.
11 Q By a drug and not able to drive?
12 A No.
13 Q So, this entire totality of the circumstances is it
14 your opinion that this is all new and novel application?
15 A Absolutely.
16 Q And I assume all of these opinions that I have asked
17 you, are they all within a reasonable degree of medical and
18 scientific certainty?
19 A Yes, they are.
20 MR. DeLEONARDO: Your Honor, that is all I have.
21 THE COURT: Doctor, do you want to take a brief
22 recess?
23 THE WITNESS: That would be wonderful, I could use
24 some water.
25 THE COURT: All right. We will take a 15-minute
26 recess. Can I see Mr. DeLeonardo and anybody else who wants
27 to come along.

1 MR. DeLEONARDO: Okay.
2 THE COURT: Mr. Daggett, Mr. Wells, Mr. Cruickshank,
3 whoever. One from each side is all right.
4 (Whereupon a Bench Conference followed.)
5 THE COURT: Although I let this deposition in, I
6 think in fairness to the State, if you want to get something
7 sworn either an affidavit or deposition from these doctors or
8 anybody else --
9 MR. DAGGETT: Assuming, they are still alive.
10 THE COURT: What?
11 MR. DAGGETT: Assuming, they are still alive.
12 THE COURT: Or anybody else from, you know, --
13 MR. DAGGETT: Understood, that is fine. I
14 appreciate that.
15 THE COURT: I can give you the opportunity to do it.
16 I don't know whether the reason Brian let those letter come in
17 was because he knew what was going to be the -- what he had in
18 rebuttal or whether it just occurred to him. But I can see
19 the argument quite honestly.
20 And the State is right, I mean, if the defense
21 doesn't object, and I don't know that that automatically means
22 that some rebuttal evidence which is also hearsay then becomes
23 admissible but I think the deposition does give it some
24 indicia reliability and at least someone had the opportunity
25 to cross-examine this doctor on that particular issue.
26 All right. Now, are we going -- I mean, I am -- if
27 we need to, I am willing to stay late tonight. I don't know

1 how much more cross Dave has.
2 MR. DeLEONARDO: I mean I am done.
3 MR. DAGGETT: If we start at 3:15 we will be done by
4 4:30. I mean I am not going to --
5 MR. DeLEONARDO: And I am not going to have a lot of
6 redirect ---
7 THE COURT: Okay, very good.
8 MR. DeLEONARDO: Thank you.
9 (Whereupon, the Bench Conference was concluded.)
10 THE CLERK: All rise.
11 (Whereupon, a brief recess was taken.)
12 THE CLERK: Silence in Court, all rise.
13 THE COURT: Be seated, please. Mr. Daggett.
14 MR. DAGGETT: Thank you, Your Honor.
15 CROSS-EXAMINATION
16 BY MR. DAGGETT:
17 Q Dr. Janofsky, why are you here?
18 A Because the Public Defender asked me to come here to
19 testify.
20 Q And the Public Defender first asked you to come here
21 and testify -- not come here but come to Court in 1992, is
22 that what I think you said your testimony was?
23 A Right.
24 Q And did you get paid for doing that?
25 A Sure.
26 Q By the Office of the Public Defender?
27 A Yep.

1 Q And you went to Minnesota --
2 A Right.
3 Q -- and testified in the State of Minnesota v.
4 Klawitter case, is that correct?
5 A Right.
6 Q And the Minnesota Office of Public Defender, they
7 paid you to come to Minnesota?
8 A Right.
9 Q And you also went to Florida in the Florida v.
10 Williams. Was that a Public Defender case as well?
11 A Yes.
12 Q And you testified in that case for the defense
13 against DRE?
14 A Right.
15 Q And you were paid for that?
16 A Sure.
17 Q And you are being paid here to do your time here?
18 A I'm paid for my time, that's exactly right.
19 Q And how much are you paid?
20 A My hourly rate is $225 an hour. And I think I have
21 put in about 20 hours worth of time.
22 Q Does that including sitting around in Court the last
23 week during the time that Dr. Zuk, I believe was testifying?
24 A Yes.
25 Q So, that is about close to $5,000 then I assume,
26 somewhere around there?
27 A It's a little less than half of my hour -- my usual

1 hourly rate. I discounted the rate for the Public Defender's
2 Office, that's right.
3 Q So, if I am correct, in Minnesota the Supreme Court
4 of Minnesota didn't take your side, basically, they ruled in
5 favor of the DRE's admissible, --
6 MR. DeLEONARDO: Objection. It is asking for legal
7 conclusions. I don't think that that is an issue for the
8 doctor.
9 THE COURT: Was there any dispute as to that?
10 MR. DeLEONARDO: Well, I mean I think that certainly
11 could be as to reasons as to why they accepted it, absolutely.
12 THE COURT: Well, the reasons but I mean we can
13 agree that the Minnesota Supreme Court -- I mean I am not
14 asking you to stipulate to something that -- I mean, I am sure
15 we can introduce a copy of the -- of whatever opinion was --
16 MR. DAGGETT: Well, I will say, Your Honor, that
17 during -- I suspect during closing arguments we all are going
18 to be talking about case law as well and so I certainly --
19 MR. DeLEONARDO: Right. And I think that is fair.
20 THE COURT: Yes, I don't know that most doctors are
21 intimately familiar with the case --
22 MR. DAGGETT: Well, I think he is. I think he is
23 very familiar with the case, Your Honor.
24 BY MR. DAGGETT:
25 Q Do you know what the -- that the --
26 A Well, Minnesota was kind of a weird case because as
27 I recall it, my memory may be wrong. When I testified, I

1 think this is what happened. I testified at a time --
2 Q Excuse me, sir, I don't mean to cut -- I guess I do
3 mean to cut you off, but I really just --
4 A I think you do too.
5 Q -- want to know if you know what the -- if you knew
6 ultimately that Minnesota ruled that DRE evidence was
7 admissible?
8 A Well, that's not my understanding of what happened.
9 It's complicated, Your Honor, because at the time of
10 testimony, as I recall, Minnesota was under Frye and at the
11 time of the opinion, it had switched to a Daubert standard.
12 This was right at the time the Supreme Court had decided
13 Daubert. So, that's all I can say.
14 And my memory is that the Supreme Court, I think in
15 part, part of the finding of the Supreme Court was that they
16 made a finding that the DRE was not novel and scientific.
17 That's my memory but I could be wrong.
18 Q So, they made --
19 A But the DRE was adopted in Minnesota.
20 Q And in Florida, in the Williams case?
21 A Right.
22 Q The DRE that was accepted by the Florida --
23 A Right.
24 Q -- Appellate Court as being admissible?
25 A Correct.
26 Q And in Nevada, I believe you said you testified in
27 Nevada but the US -- United States District Court representing

1 Nevada --

2 A Yes.

3 Q -- also ruled DRE is admissible?

4 A No, that's not correct.

5 Q That's not correct?

6 A No.

7 Q I am not talking about your case, sir, I am talking

8 about -- you testified in a civil case.

9 A Right. That's the case I testified in.

10 Q In a civil case?

11 A Yes.

12 Q You did not testify in United States of American v.

13 Larry Lee Everett in a criminal matter?

14 A No, I testified in the US District Court in a civil

15 rights case.

16 Q Right, in a civil rights case. But you didn't

17 testify --

18 A And the Court found that the DRE was not appropriate

19 scientifically.

20 Q So, you are no aware of what they ruled in the

21 United States of America v. Larry Lee Everett?

22 A I was not involved in that case at all.

23 Q Okay. Then we will reserve that for closing

24 argument. Now, have you ever done the DRE training?

25 A No.

26 Q Have you ever been along on a ride-along in which

27 the DRE training was conducted?

1 A No.
2 Q Have you been with a DRE when he conducted an
3 examination?
4 A No.
5 Q You have not. So, you reviewed the 19 -- I believe
6 you reviewed some of the manuals?
7 A I reviewed all of the manuals I believe. I have a
8 large collection of them in my office. I cited in my report,
9 I believe, the 2004 manual. The reason I did that is that's
10 the manual closest to around the time of the studies that I
11 cited. But I've reviewed the 2010 manual, some intermediate
12 manuals, I have I think two large file drawers filled with
13 manuals.
14 Q Okay. Let's -- I know the Court has heard and we
15 have all heard a lot about I mean gold studies and -- or gold
16 standards, I guess and --
17 A Right.
18 Q -- Platinum standards and that type of thing --
19 A No, never testified about a platinum standard, just
20 a gold standard.
21 Q No, I know you didn't but I mean I think we all have
22 heard -- but as far as your concern what is the gold standard?
23 A The gold standard is whatever the finder of law
24 finds it to be.
25 Q Okay.
26 A So, in the studies, the validity studies, the gold
27 standard was presence or absence of the drug. But the real

1 question I think for the Court is what the gold standard
2 should be and that relies in my understanding of what
3 interpretation of what the law means.
4 Q So, would you agree or disagree with me if I said
5 that the important issue, the crux of the issue here is
6 whether or not the driver is impaired as opposed to whether or
7 not the driver has some sort of substance in his blood stream?
8 A Again, it's not my call. It's up to the Judge.
9 Q No, I am asking you. Okay, I am asking you?
10 A I don't know. I think it depends on what the finder
11 of law finds the law says.
12 Q Okay.
13 A It's not my call. It's the Judge's call.
14 Q All right, if we assume that the standard is the
15 impairments of the driver?
16 A Meaning unable to drive, driving impairment?
17 Q Driving impairment?
18 A Yes, if you want me to assume that, I will be glad
19 to.
20 Q Okay, then let's assume then. So, if we assume that
21 the standard is that the Court needs to look at is whether or
22 not the driver is impaired --
23 A Yes.
24 Q -- as opposed to whether or not he has drugs in his
25 system --
26 A Yes.
27 Q -- okay, there is essential. Now, how would you as

1 a physician if somebody was brought to you and you had
2 suspected that they were on drugs, what would you do? I mean
3 how would you try to determine whether or not they had drugs
4 in their system and whether or not they were impaired?
5 A Well, now you are asking for presumably another kind
6 of impairment, whether there was impairment in particularly
7 body system because I don't assess driving impairment. That's
8 not what I do.
9 Q Sure.
10 A It's not what physicians usually do. But what
11 happens if someone usually gets brought in the emergency room,
12 sometimes by police, sometimes by an ambulance, sometimes they
13 walk or stagger in and I have to try to decide -- and they
14 look not normal.
15 And I have to decide as a physician why they are not
16 normal. So one takes a history on --
17 Q Okay, and by history --
18 A Yes.
19 Q -- you ask them questions?
20 A Correct.
21 Q You ask them questions about their past drug use?
22 A Right.
23 Q And you ask them questions about their current or
24 recent past drug history?
25 A Sure, absolutely.
26 Q Okay. All right, go ahead.
27 A Then one does a physical examination. But let me

1 take a step back. You are asking them about their recent and
2 current drug use but you are also asking them hundreds of
3 other questions, which goes into the differential diagnosis
4 because the worse mistake you could make is to attribute a
5 change in something that you have observed as "only do the
6 drugs" when, in fact, the patient might be having a stroke or
7 might be in a diabetic coma, or may have been hit on the side
8 of the head and may be bleeding into their brain.
9 So, my job as a physician is to determine how best
10 to explain this by taking the history and drugs may or may not
11 be on board but may have nothing whatsoever to do with their
12 abnormal behavior.
13 Q Okay, that is fine.
14 A And then you do a physical exam and that's a
15 systematic looksy at various body systems that's been done in
16 a particular -- we are trained to do that in a particular way
17 about the same way each time.
18 Then one may try to collect collateral information.
19 If they are brought in by a police officer, you may talk to
20 the police officer, you may talk to the ambulance attendant,
21 you may call family members, one gets labs and if substance
22 abuse isn't a differential diagnosis, you get a tox screen, a
23 toxicology screen.
24 Then one thinks about the case and scratches her
25 head and then makes a differential diagnosis and in the
26 emergency room, the decision is, the key decision is, is there
27 something I need to do right now to save the person's life?

1 Are they having a situation where if I don't do something in
2 an hour they are going to die or be seriously impaired?
3 In which case, I will do what I need to do to get
4 going on treatment for that? Is it something that we need to
5 observe over time to see if it changes, but isn't an acute or
6 fatal so they can stay in the emergency room for awhile until
7 we decide what service to admit them to?
8 Is it primarily psychiatric, is it neurologic, is it
9 medical, is it surgical so we can call in the appropriate
10 consult? And you are continually collecting information based
11 on your observation, the observations of the nurses, the more
12 data that you are collecting.
13 And then make the decision to think -- can they --
14 you send them as an out-patient for out-patient treatment, do
15 they need to be admitted, if so, what service should they be
16 admitted to?
17 Do they need acute treatment in the emergency room
18 right now, et cetera. That's what goes through your mind.
19 Q How much time would typically that take?
20 A Gosh, depending on the patient, you might be able to
21 reach a conclusion in 30 seconds. It might take several days
22 in the ER.
23 Q How could you reach -- based upon what you just
24 said, how could that possibly be reached in 30 seconds?
25 A Because they come with a hole in their head. You
26 know, or something like that. It may be very obvious while
27 they are acutely ill or it might not be, or you get a lab, a

1 single lab and you find out that their blood glucose is 20.
2 So, you know that they have to be treated immediately for that
3 blood glucose of 20.
4 Q Now that assumes that you have blood to analyze?
5 A Say that again?
6 Q That assumes that you have blood -- some sort of
7 blood that can be analyzed?
8 A Right. And if you do that for blood by doing a
9 pinprick, putting it on a piece of plastic tab and putting it
10 in a machine that tells you what that blood is in about 30
11 seconds.
12 Q I believe your testimony in the defense Exhibit No.
13 11 or 12 whatever that was just submitted by Mr. DeLeonardo,
14 your deposition in Florida.
15 A Yes.
16 Q I just got a copy of that and for the first time I
17 was just reading it. And one of the question I believe the
18 prosecutor asked you was do you believe that the DRE -- and I
19 will ask you this now. Do you believe that the DRE should be
20 allowed to give its opinion based upon -- if it is also done
21 in conjunction with some sort of toxicological analysis?
22 A I don't remember being asked that question. Maybe
23 if you show it to me?
24 Q All right, it was on page 20, do you have your
25 deposition?
26 A Hold on let me find --
27 Q It should be on page 20.

1 A Thank you.
2 Q And it says starting with line 12?
3 A Okay.
4 Q Back to where I asked you if you agreed with the
5 proposition that DRE testimony in evidence should be admitted
6 with positive urine results or could be admissible with
7 positive urine results?
8 And your answer was, my answer was no. But I wish
9 to expand to say that I have no problem with police officers
10 using components of the DRE examination as well as their own
11 experience in judgment as police officers to get the probable
12 cause or to make a requirement that the subject either has to
13 produce a blood or -- a urine or blood specimen.
14 A Right.
15 Q Okay. Now, are you aware, sir, that in -- are you
16 aware that in very, very, and I will say probably in less than
17 one percent and I am not -- of the cases that we have, that
18 the police can require someone to give a blood sample?
19 MR. DeLEONARDO: I am going to object, Your Honor,
20 only because of one, I think it calls for a legal conclusion
21 as to what legally an officer can do. But also I think it is
22 factually incorrect because a DRE can request blood. So, if
23 we are talking about --
24 MR. DAGGETT: If that is --
25 MR. DeLEONARDO: -- DRE cases, then I would say that
26 a DRE in every case can ask for blood.
27 MR. DAGGETT: That is not my -- that was not my

1 question and that is not what he said. He said make it a
2 requirement that the person produce urine or blood. And that
3 is not the law. Yes, the DRE can request it, but he can't
4 require, he can't demand it.
5 THE COURT: Well, I mean --
6 THE WITNESS: I guess I don't -- I'm sorry.
7 THE COURT: -- you can ask the -- The question is,
8 is Dr. Janofsky aware and the answer is either yes or no.
9 THE WITNESS: So, I don't know what the current
10 status is for force blood drawing in Maryland.
11 BY MR. DAGGETT:
12 Q Okay, if I told you it is only in deaths or life
13 threatening injury cases.
14 A Okay.
15 Q Which and I think you would agree then in the
16 percentage of DUIs and DUIs arrest that are made is a very
17 small percentage.
18 A I would just assume that to be true. I don't have
19 no knowledge of that.
20 Q Okay. So, based upon that so are you aware that it
21 is a very, very small percentage of cases in which the DRE or
22 police officer can demand the suspect to produce blood?
23 A I am not aware but you have just informed me that it
24 is and I will assume it to be true.
25 Q All right, now, with that assumption knowing that to
26 be true --
27 A Yes.

1 Q -- I am going to ask you for your opinion as to how
2 would you suggest that the DRE evidence and DRE testimony is
3 not admissible and the Defendant refuses to produce blood --
4 A Right.
5 Q -- what is the State expected to do?
6 A Go to legislature and change the law because in my
7 opinion if the DRE is allowed to testify to a reasonable
8 degree of police officer's certainty or whatever it is, that
9 based on this matrix that the person is intoxicated, the Court
10 will be receiving inaccurate and false evidence and will be
11 convicting the wrong people. So, you need to change the law.
12 Q Okay, well --
13 A And I think there's various ways to do it for
14 talking public policy.
15 Q Let's talk about alcohol?
16 A Yes.
17 Q The same thing?
18 A Yes.
19 Q Somebody is pulled over for a DUI and they refuse to
20 take the intoximeter, which is certainly their -- unless it is
21 a fatality or a life threatening injury, it is their right to
22 refuse to either give blood or take the intoximeter.
23 A Right.
24 Q Are you aware of that?
25 A I'm not aware -- I'm aware that they can refuse. I
26 didn't know that there was an exception for fatal accidents.
27 Q Fatal accidents or life threatening injuries.

1 A No, didn't know that.

2 Q So long as there is reasonable belief that they are
3 impaired. So, in those cases, you would agree that police
4 officers can use all of their observations?

5 A I think that they can always use their observations.
6 That is what they are supposed to do. They are police
7 officers they have done a lot more traffic stops than I will
8 ever do, --

9 Q And they can --

10 A -- since I have done none.

11 Q And it is your belief that they should be allowed to
12 testify to those observations?

13 A I think police officers should be allowed to testify
14 about their opinions based on their judgment and -- for
15 whatever this is worth, Your Honor, because I am certainly no
16 expert in police officer procedure but of course police
17 officers should be able to testify using their experience.
18 What they shouldn't do --

19 Q Well, isn't that what we are here?

20 A No. It's absolutely not what we are here for.

21 Q It is not?

22 A No, because we are here about a particular test that
23 has been purported to be able to allow police officers to
24 testify with some validity that a person is impaired on a
25 particular drug and not only that which class it is and that
26 absolutely is not true.

27 Q Okay. Now, are you aware that it is not a

1 requirement that the particular type of drug -- when somebody
2 is charged with driving under the influence or driving when
3 impaired --
4 A Yes.
5 Q -- of a drug or a controlled dangerous substance, it
6 is not an element the State has to prove what that particular
7 drug is?
8 A No, idea. I simply don't know the answer to that
9 question.
10 Q Okay. Now, blood shot eyes.
11 A Yes.
12 Q Would you agree that there are a large number of
13 physical conditions that can cause blood shot eyes?
14 A Sure.
15 Q Large number of physical conditions -- medical
16 conditions that can cause watery eyes?
17 A Yes, sure.
18 Q Red eyes?
19 A Sure.
20 Q Flushed face, rosacea, somebody just went running --
21 a lot of things cause flushed face?
22 A Yes.
23 Q Staggering. A lot of things can cause staggering.
24 A Right.
25 Q A lot of physical and mental conditions can cause
26 agitation, move swings, sudden move swings?
27 A We are down now to a smaller number of conditions,

1 but, yes.
2 Q But there are a number?
3 A Sure.
4 Q And those are all -- would you agree that those are
5 all indicia of alcohol abuse?
6 A They might be.
7 Q They might be?
8 A Yes.
9 Q Okay. Now, there was -- I guess the Court -- a lot
10 of testimony I am not sure exactly -- I don't think you were
11 here for the first doctor, Dr. Citek, but --
12 A No, I was not.
13 Q -- there was -- you do know a little something about
14 nystagmus, obviously?
15 A Yes.
16 Q And it is your testimony and I believe it was your
17 testimony if not certainly you heard it when doctor -- when
18 some of the other doctors might have spoken that there are a
19 number of things that can cause nystagmus?
20 A That is certainly true.
21 Q And they can be medical, they can be alcohol related
22 and they can be drug related. Is that not true?
23 A Some drugs can cause nystagmus, some do.
24 Q Okay, which kind -- which drugs -- which classes of
25 drugs that can cause nystagmus.
26 A Usually benzodiazepines, and some inhalants. Those
27 are the two major ones.

1 Q What was the last one?
2 A Inhalants.
3 Q Okay. So, we are talking about glue and paint and
4 gasoline and those kinds of --
5 A Yeah, gasoline, that's a big one.
6 Q And what about PCP?
7 A That can certainly cause weird kind of nystagmus.
8 Q So, the fact that the DRE protocols indicate that
9 those three categories of drugs can cause and I am not saying
10 are the only -- the sole cause --
11 A Right.
12 Q -- but they can cause nystagmus --
13 A Right.
14 Q -- is accurate?
15 A Well, the problem is and now we are back to the CNS
16 depressant category, because many of the drugs that the DRE
17 manual list as a CNS depressant do not cause nystagmus. So,
18 there are multiple drugs that they list in there, like
19 antidepressants, anti-psychotics, Benadryl, do not cause
20 nystagmus. There are only particular drugs that they list as
21 CNS depressants that do and that's mostly benzodiazepines.
22 Q Okay.
23 A So, that's a -- I think that's a major problem.
24 Q But you would agree with me that nystagmus is just
25 one of a large number or a large list of possible indicators
26 of impairment? Nystagmus alone is not the sole indicator for
27 impairment?

1 A See, but this is -- see, you are doing it now. You
2 are using the term impairment. And if you mean driving
3 impairment, we are totally off the page. If you mean --
4 Q Okay, I will go one further, I will take that back.
5 And I didn't mean to say -- I guess I meant to say presence.
6 A Presence, yes.
7 Q I mean I will say presence.
8 A That's fine.
9 Q So, we will -- because you are correct. I mean I
10 think we all agree that police can't say that because somebody
11 had nystagmus therefore their BAC, their blood alcohol level
12 is a certain level. We all agree with that.
13 THE COURT: In Maryland, but --
14 MR. DAGGETT: In Maryland.
15 THE COURT: -- aren't there some states that do
16 allow for that purpose?
17 MR. DAGGETT: Yes, sir, that is correct, yes, sir.
18 BY MR. DAGGETT:
19 Q So, you would agree that when the -- there are
20 certain categories --
21 A Yes.
22 Q -- that can show the presence of nystagmus?
23 A Sure, there are certain drugs that might cause
24 nystagmus in a particular person.
25 Q And that is only one category or only one of the
26 areas that the DRE list?
27 A Yes, sure.

1 Q On the factors, I guess, that they are looking at?
2 A Yes.
3 Q Can a medical -- now if a medical association gives
4 a particular endorsement of a program, they can certainly --
5 they have every right to retract that endorsement if they so
6 choose can they not?
7 A Let me tell you something. I've chaired the
8 American Psychiatric Association Committee on Advocacy and
9 Public Policy and I was the chair until May but --
10 Q Is this going to be a yes or no answer to my
11 question?
12 MR. DeLEONARDO: Your Honor, I think he is trying to
13 answer.
14 THE WITNESS: I'm trying to answer. Certainly, one
15 can endorse things and one can retract things but one needs to
16 be careful on endorsing and careful on retracting.
17 BY MR. DAGGETT:
18 Q But they do have the ability to retract?
19 A Sure.
20 Q And when you spoke to these two particular doctors
21 in Florida --
22 A Yes.
23 Q -- as far as you know they never retracted that
24 endorsement?
25 A Well, I didn't ask -- I didn't want to be accused by
26 the prosecutor of trying to talk them into retracting so I was
27 just listening. I can tell you though that those endorsements

1 were done before any of the three validity studies were done.
2 Essentially, before any decent study was done.
3 So, it was essentially based on nothing. I suppose
4 if we could find those doctors and put this before the
5 associations and they were able to take a look at it, I hope
6 they would retract. But, one never knows.
7 Q Now, if you were going to -- this DRE program you
8 said you never participated in the training, --
9 A Right.
10 Q -- you never went on a ride-along, --
11 A Nope.
12 Q -- you never observed the DRE evaluation but if you
13 were going to, you have seen the protocol, you have seen the
14 12 steps --
15 A Yep.
16 Q -- if you were going to evaluate the DRE program,
17 wouldn't you say that it is only fair to evaluate on all 12
18 steps and not just certain parts? You have to look at the
19 totality of all 12 of them?
20 A I would say that if you are evaluating the validity
21 of the program, it is important to set up a study where can
22 one can accurately do validity in a double-blind fashion using
23 standard scientific procedures.
24 Q Okay, and if you were to skip or rule out or
25 disallow DREs to do certain aspects of that program, that is
26 not going to give you a true evaluation of the effectiveness
27 of the program, wouldn't you agree with that?

1 A I would -- you are obviously talking about the
2 Heishman studies and the subsequent studies not allowing the
3 DRE officers to talk to the subjects. And I think that is --
4 the only way to test validity of the steps in the protocol
5 rather than testing the validity of the police officers'
6 interrogation ability, which is a separate issue, and police
7 officers need to be good interrogators and need to be good
8 investigators.
9 But the only way to test whether the so-called
10 physiologic factors or physical exam factors are the piece of
11 the study that are contributing to accuracy is to not allow
12 the police officer to talk to the subject, not allow the
13 subject to talk with the police officer and not allow the
14 experimenters to even know who got what drug.
15 So, there is no other way to accurately validate the
16 study except to keep that piece out. This wouldn't work.
17 Now, I suppose you could, if you are interested in finding out
18 how much the police officer's interrogation skills are useful,
19 one could try to design a on-the-road study taking that piece
20 out, et cetera.
21 But there is really no way to that in the lab
22 because it is an artificial situation where research subjects
23 have no reason not to cooperate with the DRE evaluator. There
24 is no motivation against it.
25 So, really, this is a design component of the
26 validation studies and there is no other way to do it. It
27 can't be done otherwise.

1 Q That really wasn't my question. My question was in
2 evaluating the program in general --
3 A Yes.
4 Q -- wouldn't you think that the best way to evaluate
5 any program is to look at the entire program and all the
6 steps, all the components as opposed to picking and choosing
7 which ones --
8 A The best way to validate this program, which
9 purports to say that police officers can decide whether
10 someone is impaired on drugs and not only that which class, is
11 to do the Heishman studies and using that methodology.
12 And those are the only three studies in the
13 literature that have done that.
14 Q But the ultimate -- you would agree also that the
15 ultimate decider or the ultimate arbiter of that would be the
16 trier of fact, would be the --
17 A Oh, sure.
18 Q -- Judge or the jury?
19 A That's why we are here, sure. I'm just giving you
20 my opinions.
21 Q And since you read the -- I know you haven't done
22 the training but you have read a number of the training
23 manuals.
24 A Yes.
25 Q Officers are not -- you would agree that officers
26 are not taught that each symptom individually is indicative of
27 impaired driving or presence of drugs?

1 A The problem is the manual talks about impairment and
2 it doesn't even talk about presence. It talks about
3 impairment when there are no studies that actually look at
4 driving impairment.
5 Q Okay, I am not really -- you know you keep talking
6 about the studies and I don't really care about that. I mean
7 if you --
8 A Okay, but that's why I'm here so that's why --
9 Q Okay, that's fine. And I don't -- that's not really
10 why I am here.
11 A Okay.
12 Q That is not the question I am asking you.
13 A Fair enough.
14 Q But since you read the studies, you would agree that
15 officers are not taught, they are not taught that if somebody
16 has this symptom --
17 A Yes.
18 Q -- or somebody has that symptom, that is
19 indicative --
20 A Yes.
21 Q -- to either the presence or certainly not
22 impairment?
23 A Yes, they are taught to collect the data and then
24 look at the totality of the circumstances. I think that is
25 the direct quote.
26 Q And that is as a doctor and as a -- I guess as a --
27 you said as a citizen --

1 A Yes.
2 Q -- that sounds reasonable to you, does it not?
3 A No. That's not reasonable.
4 Q It is not reasonable to look at all the steps of the
5 program instead of just looking at --
6 A No, now you are asking a different question.
7 Officers are taught to make their decision about so-called
8 impairment and drug class based on the totality of the
9 circumstances.
10 Q Correct.
11 A They do not have the capacity based on their
12 training to do that. I view DRE officers based on what I have
13 read about their training to be technicians.
14 They are also police officers, that's over here, but
15 they are technicians. They are taught a series of watered
16 down neurologic examination and from the data that they get,
17 they are supposed to reach a conclusion.
18 They do not have the capacity, in my opinion, as a
19 technician, the capacity to use judgment in order to reach
20 that decision to a reasonable degree of medical -- or police
21 officers' certainty or however police officers testify.
22 Q And I have got to tell you, I mean I know that this,
23 I mean I can't speak for Mr. Wells or anybody else here. But
24 I have to tell you, I had a hard time reading these studies.
25 I mean it is -- they may be fascinating for some people but --
26 A I don't find -- no, I think you are right. They are
27 very dense and hard to read for anyone, even a scientist.

1 Q Good.
2 A Yes.
3 Q I don't feel so bad now. But the -- tell me if I
4 am -- but didn't the, didn't the Heishman authors and maybe I
5 read that -- maybe I just read that incorrectly, but didn't
6 they conclude that DRE -- I want to make sure I get the
7 wording right, the DRE testing variables are highly accurate,
8 noting that 17 to 28 of the variables of the evaluation
9 predicted the presence or absence of each of the three drugs
10 with a high degree of sensitivity and specificity?
11 A Are you reading from the second study?
12 Q I was reading from page 475 I believe which I think
13 was on the -- was the 1996, which would have been the first
14 one.
15 A So, you will have to show me where you are reading?
16 Q Under discussion --
17 A I don't have the thing in front of me.
18 Q Oh, okay.
19 (Handing witness a copy, witness is reading.)
20 (Pause.)
21 THE WITNESS: Yes, see, -- so, this is one of the
22 problems. This is using a discriminant function analysis.
23 So, this is using an analysis. What they did is, they
24 collected the data, they used something called a discriminant
25 function analysis --
26 BY MR. DAGGETT:
27 Q But by they are you talking about the --

1 A The researchers.
2 Q -- evaluators or the researchers?
3 A The researchers.
4 Q The researchers.
5 A And what they did is they pulled out 17 of the -- 17
6 to 28 variables in order to use a model of factors that would
7 have the highest predicted values.
8 Q And by variables, what are we talking about?
9 A The factors that they collect. The data that the
10 DRE --
11 Q Okay, so, the variables apply to the DREs?
12 A Right. But this is not how -- the point is the
13 discriminant function analysis is not how the DREs apply the
14 factors. This is their attempt to improve the model. And
15 it's only when they improve the model that they get an
16 improved accuracy.
17 So, this actually, I think, proves my point, that
18 the DRE as administered by the officers is not accurate in
19 allowing the folks to figure out whether someone is impaired
20 and which drug. It's only when you are doing a discriminant
21 function analysis, pull out particular variables that you can
22 increase the positive hit rate.
23 Q So they are looking at the variables that the DREs
24 are trained to look at?
25 A But they are pulling out the variables -- they are
26 pulling out the variables that maximize the correct decision.
27 This does not talk about at all, this discussion section here,

1 how the DREs actually administered and what the officers
2 actually conclude.
3 Q During the Heishman study?
4 A Yes, during the study.
5 Q Not, during the DRE -- the typical DRE exam. That
6 particular --
7 A Right.
8 Q -- part of that study says that when the DREs were
9 able to use what they are taught to use they are highly
10 accurate.
11 A No, that's not -- it says exactly the opposite. It
12 is saying exactly the opposite. It says that the way to
13 improve accuracy is to use a discriminant function analysis
14 pulling out particular variables.
15 Q That is not where I am -- I didn't read that.
16 A Well, that's what I'm interpreting that to mean.
17 Q Okay, but your interpretation may be different from
18 the Court's but if I could just read --
19 A Yes, sure.
20 Q -- into the record from Heishman 1996, which we will
21 call Heishman 1, page 475. It was found that 17 to 28
22 variables of the DEC evaluation predicted the presence or
23 absence of each of the three drugs with a high degree of
24 sensitivity and specificity and low rates of false positive
25 and false negative errors.
26 The five best predicted variables were nearly as
27 accurate as the entire subsets of 17 to 28 variables.

1 A Right.
2 Q Okay.
3 A I think that's what I said. That they had to pull
4 out variables in order to improve the accuracy and it's not as
5 administered.
6 Q In that study?
7 A Yes. That's all we have. The only validation
8 studies we have are these three studies in my opinion.
9 Q Right. So, I just want to make sure. So, in the
10 three studies they had to pull certain out but in reality and
11 according to the protocols and according to the training
12 manuals they have a large number of variables?
13 A No, no, no. You are absolutely misstating what that
14 study says. Absolutely, misstating it.
15 Q Well, I would say that you are misstating it. We
16 will leave it at that. We will let the Court --
17 A Can I answer, Your Honor?
18 Q -- we will let the Court --
19 THE COURT: If two bright guys like you can't agree
20 on what it says, what am I to do?
21 THE WITNESS: ASTAR, Your Honor, ASTAR.
22 BY MR. DAGGETT:
23 Q I believe you testified in Minnesota.
24 A Yes.
25 Q I think it was Minnesota. You said --
26 A And, again, as I recall, I could be misremembering
27 it. I believe my testimony in Minnesota was before the --

1 right before the first Heishman data was published.
2 Q I think -- no, I think you are right. I think your
3 Minnesota testimony was -- well, the Court ruled in 1994,
4 so --
5 A So, it was before the first Heishman study.
6 Q It would have been before the first Heishman study.
7 A Yes.
8 Q So, yes, your memory is correct in that. You talked
9 about field sobriety -- in Minnesota, you talked about field
10 sobriety tests and some sort of -- there had to be some sort
11 of -- we are talking about the standardized field sobriety
12 test. And I think you used the walk and turn test as an
13 example. And if you do not remember --
14 A I don't remember that at all.
15 Q You don't?
16 A No.
17 Q Okay. Well, do you recall and if you need be I can
18 show it to you. But do you recall saying that for a study to
19 be reliable --
20 A Yes.
21 Q -- you should have three separate evaluators conduct
22 the exact same test --
23 A Right.
24 Q -- with the exact same person -- with the same
25 person, obviously, --
26 A Right.
27 Q -- in close proximity and time. Very close --

1 obviously, so as --
2 A I don't recall saying that.
3 Q Well you said right the first two times but --
4 A No, I don't recall that testimony at all.
5 Q Okay. Well --
6 A You have to show me. It was a long time ago.
7 Q Sure and I understand. Then I will ask you the
8 question so I don't have to spend time -- spend our time
9 looking it up. But do you think the only way to test the
10 reliability of a particular test is to have multiple
11 evaluators doing the same test, obviously with the same
12 person, --
13 A Yep.
14 Q -- in close proximity --
15 A Yes.
16 Q -- obviously, you are not just drugs --
17 A Right. I mean it's just the definition of what
18 reliability is, Your Honor. Reliability is a term of art in
19 test analysis. It's different than validity -- excuse me,
20 what reliability means is whether two people doing the test
21 under the same conditions, on the same subject, would get the
22 same or similar or very similar results.
23 That's reliability versus validity, which is whether
24 the test accurately reflects the gold standard or not. They
25 are separate concepts. And none of the studies ever, no study
26 has every tested reliability of the DRE. So, we don't know --
27 there is no data anywhere about whether two DREs looking at

1 the same subject will likely come to the same result. That,
2 it doesn’t exist.
3 Q Okay, I will show -- I did find it.
4 A Okay.
5 Q This was in Klawitter, Minnesota v. Klawitter,
6 and -- first I will read it to you and then I will let you
7 take a look at it.
8 A Sure.
9 Q So, it says,
10 “Question: “So, let’s say they missed their nose on
11 number one and six one time. And the second time,
12 they missed their nose on two and four. The third
13 time, they missed on number three?”
14 That was the question and your response was,
15 “Yep.
16 So that means that the test is totally invalid
17 because they did it differently?”
18 And you said,
19 “We don’t know what that means.”
20 The prosecutor,
21 “It’s unreliable?”
22 And your answer was,
23 “That’s right, it tells us nothing.”
24 A Right.
25 Q Okay. So, in other words, if a person suspected of
26 driving while impaired by drugs is asked to do the finger to
27 nose test and the first time they do it they touch their ear

1 and the second time they touch their forehead, that means it
2 is unreliable because they didn't touch the same thing twice?
3 A You have to -- I'll have to read the context here.
4 I thought what we were talking about is reproduce ability of
5 the symptom, maybe? I have to look at the transcript because
6 I don't remember this at all.
7 Q --- and unfortunately this is not -- here --
8 A Okay. (Reading.) This is actually talking about a
9 term called precision whether when either one person does the
10 test, they get the same result or not on multiple
11 administrations of the same test.
12 So, it's not about the validity of finger to nose.
13 This is -- my reading of this is about using finger to nose as
14 he was using -- the prosecutor was using finger nose as an
15 example and what does it mean if you don't get the same result
16 on multiple administrations of the same test?
17 So, it has nothing to do with validity, you know,
18 whether it's an accurate test for alcohol. It has everything
19 to do with reliability whether the same results reproduce it
20 over and over again.
21 Q Well why would it make it unreliable if -- why would
22 it make it unreliable if the person -- if they keep fouling up
23 the test but fouling it up in different ways? Why does that
24 make the test unreliable?
25 A Again, it's about precision whether the person makes
26 the same error over and over again and what that means.
27 Q Okay, well, another example would be is in every --

1 believe me Mr. Cruickshank and Mr. DeLeonardo have seen
2 hundred of these cases and pretty much every DUI arrest is one
3 of the field sobriety tests that is given is the walk and
4 turn?
5 A Right.
6 Q You know, the one that --
7 A Right, right.
8 Q So, if and I believe in that same case --
9 A Right.
10 Q -- you testified that if they stepped off the line
11 for officer number one --
12 A Yes.
13 Q -- they stepped off the line say on steps two and
14 six --
15 A Right.
16 Q -- and then a different officer had them do it a
17 short time later --
18 A Yes.
19 Q -- and they stepped off the line on steps one and
20 seven --
21 A Right.
22 Q -- that that test is not valid or reliable either?
23 A Again, I don't think we are talking about validity.
24 I think we are talking about reliability to try to get the
25 same result each time.
26 Q But as far as reliability --
27 A And precision.

1 Q -- as far as producing indicators of impairments --
2 A Yep.
3 Q -- you would say that it is a --
4 A No, again, you have just used the word impairment
5 again. So what --
6 Q No, obviously, it wouldn't prove the fact that
7 somebody is stepping off the line --
8 A Yep.
9 Q -- and I am sorry it doesn't mean that they have --
10 it certainly doesn't prove that they have alcohol or drugs in
11 their system.
12 A Right.
13 Q But it may show and it may be one of the indicators
14 of impairment if they can't do the test.
15 A Again, it's not driving impairment but impairment of
16 certain neurological systems. So, it could mean that they
17 have arthritis. It could mean that they have cerebellar
18 problems, it could mean they have proprioceptive problems.
19 Those problems, proprioception or cerebellar could be from
20 alcohol, could be from benzodiazepine --
21 Q Absolutely. I agree with you a hundred percent.
22 But the fact that the first -- they do the test for me --
23 A Yep.
24 Q -- and they step off on two and six and then they do
25 the test for Mr. DeLeonardo --
26 A Yep.
27 Q -- and they step off on three and seven --

1 A Right.
2 Q -- that doesn’t mean -- the fact that they happen to
3 have -- it may still be the same, they still may have the same
4 ultimate issue that is causing them to do that.
5 A Right.
6 Q But the fact of the matter is it is still something
7 that you believe can be looked at --
8 A Sure.
9 Q -- and doesn’t make it unreliable or invalid.
10 A Sure it does. It makes it unreliable but it is
11 another factor you might look at.
12 Q Unreliable for what?
13 A Unreliable for looking at tests, retest reliability,
14 which is another precision factor. Again, no one has tested
15 the DRE on these factors.
16 Q So, it is -- and I want to make sure I get -- it is
17 certainly, or maybe it is but it is certainly not your
18 testimony is it, that if somebody -- and hypothetical,
19 somebody is stone on heroin --
20 A Yep.
21 Q -- and they happen to do that test --
22 A Yes.
23 Q -- and they -- say they make the same mistakes but
24 on different numbers --
25 A Right.
26 Q -- that certainly doesn’t make that test unreliable,
27 is that what you are saying?

1 A I think we are confusing reliability as a term of
2 art in scientific test design and the general terms for the
3 reliability.
4 Q And I am not talking about a test of a term of art.
5 A Right.
6 Q I'm talking about an indicator as an indicator of
7 possible impairments --
8 A Right.
9 Q -- whatever it may be --
10 A Yes.
11 Q -- be it alcohol --
12 A Yes.
13 Q -- or drugs or some neurological issue --
14 A Right, yes.
15 Q -- the fact that they make -- that they step off the
16 line on different numbers doesn't make that an invalid test?
17 A No, we are not talking about validity at all. We
18 are talking about Intertest, retest for reliability. These
19 are just technical terms that has nothing to do with validity
20 at all.
21 Q But I believe your words were unreliable?
22 A Yeah, it's technically unreliable. It's true.
23 Q So, it should be discounted?
24 A No. It's just a fact. It's technically unreliable.
25 It's a factor.
26 Q I believe you also testified in Minnesota and it
27 should be on page 133 there.

1 A Okay.
2 Q And I think the question was you would agree that --
3 A 1033?
4 Q 1033, yes, sorry. You would agree that a person
5 under the influence of PCP, marijuana, heroin, et cetera,
6 cannot drive a vehicle or car safely? Again, the question is
7 under the influence of not -- that is the ultimate issue.
8 That means that certainly -- well in Maryland it is impaired
9 by not under the influence of --
10 A Right.
11 Q -- but you would agree that -- and I believe that
12 you did say that, did you not say that?
13 A Well, I said, -- the question was,
14 "So if you thought someone was high or under the
15 influence of marijuana, would you give them the keys to
16 your car and let them drive?
17 Answer: Absolutely, not.
18 And why is that? Isn't it because they are under the
19 influence that they can't operate a car safely?
20 Answer: That's not why. I wouldn't want them on the
21 street. I think these folks need to be away from other
22 folks until they have sobered up. They shouldn't be
23 anywhere."
24 That's my testimony.
25 (Pause.)
26 MR. DAGGETT: Do you have a copy of that ---.
27 MR. DeLEONARDO: No, not at all.

1 (Long pause.)
2 BY MR. DAGGETT:
3 Q Doctor, do you believe that when a drug is in a
4 person's blood stream --
5 A Yes.
6 Q -- affecting that person's brain --
7 A Yes.
8 Q -- that that person will exhibit outward signs in
9 indicators?
10 A Outward signs in indicators? I don't know what you
11 mean.
12 Q Well, if a person who is high on heroin --
13 A Yes.
14 Q -- or high on cocaine or down on barbiturates or
15 whatever it might be, at a certain level, they reach a certain
16 level that they are going to be outward indicators, outward
17 signs of this?
18 A There may or may not be depending on what we are
19 talking about.
20 Q How experienced a drug abuser they are?
21 A That's one factor, whether they have underlying
22 medical or psychiatric factors. They may look very different.
23 But the key issue is and in order for the drug to affect the
24 brain, it must be found present in the blood.
25 That's why for alcohol testing the key is blood
26 levels or breath levels. Breath levels are just a proxy for
27 blood levels. You wouldn't never use a urine level for

1 alcohol. That's why you shouldn't use urine levels for blood
2 test.
3 Q Right. And we don't, we all agree in Maryland we
4 don't. We are not talking urine here, we are talking blood.
5 A Right, blood, absolutely.
6 Q And there is -- basically it has been scientifically
7 proven, I guess, or maybe that is not the correct term but at
8 .08 just about everybody isn't affected at one point or
9 another by alcohol?
10 A Those levels are public policy decisions and we have
11 gone from .12 to .08 in my life time. So, those are public
12 policy decisions chosen by our legislature.
13 There is good data on blood when alcohol levels and
14 driving impairment.
15 Q Right.
16 A Okay, but there is no such data for illicit drugs.
17 That's the point I've been making. So, there is a great deal
18 of data so that legislators can make reasonable public policy
19 decisions about what the levels should be.
20 So, I think if you are a pilot, the level is
21 supposed to be I think below .02 or .04, very different public
22 policy decision.
23 Q I hope it is .02.
24 A Yes, something like that.
25 Q I would hope.
26 A But, you know, the legislature has the ability to
27 make those public policy decisions based on good data and in

1 my life time it has gone down from .12 to .08. I think that's
2 a good thing.
3 Q But they can't do it on presence of drugs because
4 every drug is different. And every person is different. So,
5 it is impossible, you would agree that it is impossible to --
6 A No. Every person is different with alcohol too, but
7 we have made a public policy decision that there is a cut
8 point. We could make, if we chose to, public policy decisions
9 based on drug levels.
10 The problem is that there is no data to -- like
11 there is on alcohol, to make those important public policy
12 decisions.
13 Q So --
14 A And, in fact, some drugs may improve driving, like
15 amphetamines, for particular people. In fact, --
16 Q In certain situations?
17 A Yes. Like, for example, our long term bomber pilots
18 who fly from bases here to the battlefield and back are
19 frequently given amphetamine, and it improves their flying
20 ability. The army gives it to them.
21 So, if you are going to make these decisions, you
22 have got to have, you know, if you are a policy maker, you
23 have got to make it based on data. We don't have it.
24 Q Well, that is exactly -- I guess that is exactly my
25 point. There can't -- it can't be. I mean if different types
26 of drugs affect different people differently.
27 A Different levels of alcohol affect different people

1 differently. But we have made a public policy decision to
2 have a cut point.
3 Q So, and again, in your opinion, the only way and if
4 I am misstating this, please correct me. I am sure you will.
5 The only way to prove this is for the legislature to say,
6 number one, if you are pulled over for suspected driving
7 impairment, you have, you don't have any choice, you are
8 required, it is mandatory that blood be taken --
9 A Yep.
10 Q -- and then step two, the presence of any type of
11 drug in your system is, per se, driving while impaired?
12 A No. The legislature can make any kind of decision
13 they want. They usually do. They are down there in
14 Annapolis, Lord knows what they do down there. They can make
15 any kind of decision.
16 I would say, I think there is a better way -- if you
17 are asking me of my fantasy what we should do in Maryland, I
18 think we should have a system where police officers have
19 cameras and microphones in their vehicles.
20 That the cameras and microphones get automatically
21 turned on whenever the siren or light gets on, that folks who
22 are pulled over are videotaped, and let a jury decide about
23 impairment after hearing all the data, you know, plus minus,
24 presence or absence of drug.
25 Let a fact finder -- rather than having a police
26 officer come in with this pseudo science, and I think it is
27 pseudo science. Let the police officer explain the situation.

1 If he found marijuana there, let him explain it.
2 And let the fact finder decide how impaired the
3 person looks based on their driving because we could have the
4 camera --
5 Q Well, isn't that the whole purpose of the DRE
6 program?
7 A No.
8 Q It is not? The whole purpose of the DRE program is
9 not to present to the finder of fact observations?
10 A It's presenting observation but then the DRE
11 concludes to a reasonable degree of police officer's certainty
12 what that observation means and they can't do it because the
13 data shows they can't.
14 Q But as far as alcohol goes, they can?
15 A No. Alcohol, we have, per se, we have a law per se
16 laws.
17 Q What about if they refuse the intoxicator --
18 A Then we -- I don't -- I honestly don't know how that
19 goes in a criminal case. I know they lose their license but I
20 don't know what happens in a criminal case, that's a good
21 question.
22 Q On that same, and I am going to read you from
23 Klawitter, again, --
24 A Yep.
25 Q This is you --
26 A Yep.
27 Q Professionals, law enforcement officers,

1 psychologists, psychiatrists, nurses should, of course, be
2 able to give their expert opinion.
3 A Right.
4 Q Do you recall saying that?
5 A Yes.
6 Q But not in relation to the DRE?
7 A No, not in relation to a medical test that you are
8 not -- that number one has no validity. Police officers
9 should of course be able to give their opinions as police
10 officers. But not as technicians using a test that has no
11 validity.
12 Q Or how about if they were call drug recognition
13 examiners as opposed to drug recognition experts, you have any
14 problem with that?
15 A I don't care what they are called. They have been
16 called a lot of things. This test has been called the Deck,
17 the DRE, various other things and in various other states.
18 Q Let's look at the so-called test that we are talking
19 about here.
20 A Yep.
21 Q And I would say that certainly you are the doctor,
22 we are not, but I would ask the Court to take judicial notice
23 to the fact that four of us here are fairly intelligent
24 people, the four of us I am talking about.
25 THE COURT: Well, that is a leap.
26 (Laughter.)
27 MR. DeLEONARDO: That is not what I heard last week.

1 (Laughter.)
2 THE COURT: I am willing to go out on a limb.
3 MR. DAGGETT: Okay, thank you, sir.
4 BY MR. DAGGETT:
5 Q Now, blood pressure?
6 A Yes.
7 Q And I am talking about if you had to teach the four
8 of us how to take blood pressure, heart rate, pulse, things
9 like that, it's really not that difficult is it? It has been
10 around forever.
11 A It has been around but it is -- blood pressure,
12 unless you use a machine is actually subjective and difficult
13 to teach the various sounds, especially difficult if you are
14 not doing it in a quiet controlled room, but if you are doing
15 it at the side of the highway. Pulse is something that you
16 can teach most people to take assuming the pulse is regular,
17 if it's not regular, it's actually a bit difficult, but you
18 can teach people to do it.
19 Q Okay, but as long as we talking -- but if we are
20 talking about recognizing in the medical community and I think
21 we all agree that blood pressure tests, pulse rate tests,
22 dilation and contraction of pupils, both as to the size and
23 speed of their reaction, they are all well accepted tests?
24 A Those tests are well accepted, no question about
25 that.
26 Q And the HGN is at this point in time, I mean even
27 back in 1992 and 1993, the time of Klawitter and Williams,

1 that even -- and I think --- came out somewhere around that
2 time. So, it is --
3 A Now you have me.
4 Q Okay. But HGN has been around for awhile and it is
5 used as an indicator or for different sorts of -- we have
6 already said, it is --
7 A It's used medically to help diagnose various brain
8 stem problems.
9 Q So, there is nothing new about that?
10 A No.
11 Q It is has been around for at least 20 years, I mean
12 if not more than that.
13 A The new thing is how this is being applied.
14 Q Okay. And you would agree that field sobriety tests
15 be they be the finger to nose, the one leg stand, the walk and
16 turn test, you know, -- counting the alphabet backwards or
17 even dropping something, you know a bunch of change down on
18 the floor and asking somebody to pick it up, those are really
19 just tests of physical dexterity. There is nothing scientific
20 about those --
21 A No, that's not correct.
22 Q That's not correct?
23 A No. Those are scientific tests that are presumably
24 used to get at cerebellar or brain dysfunction.
25 Q What is scientific about taking a pocket full of
26 change, dropping it in front of a person and having that
27 person bend over and pick it up?

1 A Well, I've never actually heard of that being used.
2 That particular thing used in a field sobriety test. But I
3 imagine what you are testing is vision. The ability to follow
4 directions, coordination, et cetera.
5 Q Sure, okay, absolutely. But that doesn't make those
6 tests scientific?
7 A Well then why are you doing it?
8 Q Because you are looking for balance issues?
9 A Yes.
10 Q You are looking for, like you said the coordination,
11 the inability, the fumbling fingers, that type of stuff. It
12 doesn't make it scientific --
13 A So as a clinician, I may choose to do various
14 procedures or interventions when I am evaluating a person and
15 that makes it part of my physical examination.
16 I have never thrown change on the floor before but I
17 have certainly tested people's balance and coordination in
18 various ways.
19 And the key -- the scientific piece is you put this
20 data together to reach a conclusion based on clinical
21 experience or judgment.
22 Q Klawitter, page 1052, the question posed to you was,
23 "Sir, do you believe that a properly trained individual
24 can go into Court and give an opinion whether they
25 think if a person is impaired by a drug other than
26 alcohol?"
27 And your answer was,

1 “Sure, a police officer, an experience traffic officer,
2 for instance, who has had years of experience,
3 absolutely.”
4 A Yes, if the Court allows it. Sure they can, based
5 on their experience. What they shouldn’t be doing is coming
6 in and saying there is a test that I’ve run that proves based
7 on these factors that the person is intoxicated.
8 Q Well, I think -- I don’t think the Court, you would
9 have to worry about the Court allowing them to say that
10 proves, I mean that is a question of law -- I mean that is a
11 question of fact for the trier of fact.
12 A Right. It is what it is.
13 Q Have you ever -- you have talked about all these
14 studies Heishman and --
15 A Yes.
16 Q Shinar and Schechtman and all the others, have you
17 ever planned or attempted to put one of these studies
18 together?
19 A No.
20 Q I mean you have been involved in these and I don’t
21 mean any disrespect when I say -- will say anti-DRE but I mean
22 obviously you testified against --
23 A Right. It’s actually, I think it’s pro-public
24 safety because I think we need to develop protocols and tests
25 where we can accurately decide whether people are impaired.
26 And if the law requires a particular drug, that’s fine, and
27 the DRE is not it.

1 But we need to find something else because of course
2 we all want impaired drivers off the road. So, it's not anti-
3 DRE, it's pro figuring out how to do this right.
4 Q Well, I mean I didn't mean that in an insulting way,
5 I just meant you testified -- you have testified a number of
6 cases and a number of jurisdictions against the DRE.
7 A Of course, how else could I testify if I believed
8 the validity is not there. I am not going to be getting any
9 calls from State's Attorney's Offices about this I don't
10 think.
11 Q I understand, but, sir, against and anti pretty much
12 means the same thing, wouldn't you agree with that?
13 A Well, I stand by my testimony about that. I think
14 we are all on the same side here. We just want to do this
15 right.
16 Q Well, quite frankly, I am still waiting for you to
17 give us a shorter -- never mind, strike that.
18 (Long pause.)
19 BY MR. DAGGETT:
20 Q You were here when Mr. Wells put in a number of
21 the -- where you had the Broward County -- the Florida
22 endorsements, I guess, which you saw --
23 A Right.
24 Q Okay. Are you aware that the -- in 1999, the -- and
25 I believe it was also one of the State's Exhibits here, that
26 the Hawaii Medical Association basically adopted -- I will
27 read it since it is in evidence.

1 It says,
2 "We have reviewed the 12 steps DRE evaluation process
3 and believe that the procedures can be properly
4 informed by laypersons who are specially trained.
5 We are impressed by the amount of training given the
6 police officers who were trained as DRE experts and
7 believe this training will enable them to reach
8 reliable conclusions and render accurate opinions
9 regarding drug impairment."
10 That is the Hawaii Medical Association from 1999.
11 Now, you haven't spoken to anybody in Hawaii about this?
12 A No.
13 Q Okay. And I believe -- and I am going to -- we will
14 not be here much longer, for Your Honor's information.
15 THE COURT: I am not hurrying you at all,
16 Mr. Daggett, take as much time as you need.
17 (Long pause.)
18 BY MR. DAGGETT:
19 Q Now, you are not an ophthalmologist, is that
20 correct?
21 A No, certainly not. God, forbid.
22 Q I guess I want to make sure and I -- we touched on
23 this and I am not sure if you -- maybe, I am not sure what
24 your answer was but from your reading and if it is asked and
25 answered then I withdraw it, but from your reading of the
26 multi training manuals --
27 A Yes.

1 Q -- the DREs are taught to look at the entire
2 situation?
3 A I think the term that's used is the totality of the
4 circumstances.
5 Q And look at -- and I mean there are a number of
6 factors --
7 A Yep.
8 Q -- that they are taught to look at?
9 A Right.
10 Q And DREs are not taught that if somebody's pupil
11 sizes, or pupil sizes are either too small or too large or
12 whatever it might be, that means, taken on its own, that they
13 are impaired -- not impaired, that they have a particular
14 substance in their system?
15 A No, they are not taught that.
16 Q So, you would agree that the -- I guess my wording
17 and the wording from the manual is it is a totality of the
18 circumstances?
19 A Right, that's what they are taught.
20 Q And it is also that they indicate the possible
21 consumption of a drug?
22 A Now that wording I don't remember but it wouldn't
23 surprise me.
24 Q So they are not -- would you agree with me, they are
25 not saying categorically that they have ingested these
26 particular substances, they have testified to indicators of
27 what they observed?

1 A No, my experiences as I've been in cases and usually
2 they have not gone to trial where a Defendant was stopped by a
3 police officer. Was evaluated by a DRE, that there was no
4 blood or urine taken and the DRE had been willing to testify
5 that the person was impaired and was impaired on a particular
6 drug. That's my understanding, which I thought was wrong.
7 Q I think you made that -- I think that has been
8 clear. But wouldn't you also -- you talked about public
9 policy. Wouldn't you also agree that the best method since
10 the trier of fact, be it the Judge or the jury, that the best
11 method if for the police officer to give their opinion and
12 then if there is a medical issue, certainly cross-examination,
13 the defense could put in cross-examination or other contrary
14 medical evidence?
15 A Sure, I have no --
16 MR. DeLEONARDO: Your Honor, I am going to object.
17 I think we have gotten to the point where he is asking him to
18 write legislation as to what should be allowed.
19 I think he is here to testify as to what is
20 generally accepted. I mean, I haven't objected earlier but we
21 are asking questions about what should the Court allow in
22 Court. And that really goes to legal issues, I think, Your
23 Honor, has to decide.
24 THE COURT: Well, I will sustain as long as you are
25 not going to ask any more questions when Mr. Daggett is
26 finished, Mr. DeLeonardo.
27 (Laughter.)

1 MR. DeLEONARDO: Well, I will withdraw the
2 objection, Your Honor.
3 (Laughter.)
4 THE COURT: Overruled.
5 THE WITNESS: Okay, I am sorry, I was laughing and I
6 lost the question, sorry.
7 THE COURT: Repeat the question, Mr. Daggett.
8 BY MR. DAGGETT:
9 Q Quite frankly, Your Honor, I forgot what the
10 question was?
11 THE COURT: All I know is Mr. DeLeonardo said you
12 were trying to get the witness to talk about legislation.
13 (Long pause.)
14 BY MR. DAGGETT:
15 Q I am going to -- I think I found that one particular
16 section I was asking you about the walk and turn test. I knew
17 I had it marked in here somewhere. Again, this was in
18 Minnesota --
19 A Right.
20 Q -- and the question was posed to you,
21 "But based on what you do know, a person probably will
22 not do that test the same way if they do it three
23 different times?"
24 And your answer was,
25 "That's correct, you can't use it. It shouldn't be
26 used. If it cannot be done in a reproducible fashion,
27 it shouldn't be used."

1 A Right.
2 Q So, the question followed up with:
3 "So, are you saying that if a person that you are
4 testing cannot do that test exactly the same way, for
5 instance, they step off the line on step six and step
6 eight, they raise their arms four times, if they don't
7 each and every time step off on lines six and eight and
8 raise their arms four times that you can't use that
9 test?"
10 And your response was -- and this is what I have.
11 "Absolutely. Think about it, every time you run the
12 patient through these tests and you come up with a
13 different number what use is the test? What use is a
14 test that you can't but every time a person does it
15 you get a test value from zero to 10."
16 And maybe I am reading this wrong but it sounds to
17 me like you are saying if somebody does these field sobriety
18 tests, and they do it on more than one occasion --
19 A Right.
20 Q -- like you think they should, and they do it
21 differently, --
22 A Right.
23 Q -- that test is not valid?
24 A No, it's about -- again, the question was about
25 reliability not validity. So, it shouldn't be used because
26 you don't know what the answer means.
27 Q Well, it can't --

1 A Remember this is all in the context of the DRE. I
2 believe -- I'm assuming that's what these questions are about
3 because I'm certainly no expert in field sobriety testing.
4 Q Well why would they ask --
5 A I don't remember why they asked these questions, and
6 all I can say is that it sounds to me like we are talking
7 about reliability and not validity here.
8 Q Well, they asked you if you were familiar with the
9 walk and turn tests, and you said I'm familiar with the test
10 it's been described in these documents.
11 A Right.
12 Q "Have you ever seen it?" "No."
13 A Right, exactly.
14 Q What about if a person gives you three different --
15 if a police officers are asking a person at the side of the
16 road during whether it is a police officer himself or a DRE --
17 A Yep.
18 Q -- if they ask the question and the suspect gives
19 three different answers?
20 A Yes.
21 Q Does that not make -- is that not indicative -- what
22 would -- let me put it this way. Would that make their
23 answers not reliable because they gave three separate answers?
24 A If part of the test required the answer be asked
25 three ways and you are measuring whether or not there's three
26 different answers.
27 Q Asked three ways or answered three ways?

1 A Answered three ways.

2 Q Answered three ways, okay, I thought you said asked.

3 A But you are asking hypothetical outside of this

4 testing. I mean we would have to think about what the purpose

5 of the questions were. So, it's a non-answerable question.

6 Q You would agree, I guess, I mean would you not, I

7 read that report -- the report that you -- and I also read

8 your transcript in Klawitter and certainly you know about the

9 studies. But you would agree that certainly basically any

10 study out there criticisms could be found?

11 A Any study out there? Well, you have generally three

12 studies out there that have any way of calculating the

13 variables you need to look at validity.

14 And they are what they are. There is nothing else

15 out there. All the other studies, you know, it's in my

16 report, have -- that there is no way to accurately look at

17 validity. They are seriously flawed. There are three peer

18 reviewed studies that have passed peer review and in my

19 opinion they show conclusively that the test is invalid.

20 Q Well, again, that -- I guess that is up for the

21 Court to decide and when I --

22 A Sure, I am just giving my opinion, that's what I'm

23 here to do.

24 Q All right. And I believe your testimony and I

25 believe in your report you basically called the LAPD, the

26 Arizona, the Minnesota and the Bigelow, I guess your wording

27 was worthless or worse than worthless?

1 A Correct.

2 Q All right.

3 MR. DAGGETT: Your Honor, I don't have any more

4 questions but I think Mr. Wells just has a couple.

5 MR. WELLS: I do have a few.

6 CROSS-EXAMINATION

7 BY MR. WELLS:

8 Q Good afternoon, doctor.

9 A Hello.

10 Q You indicated that it is your practice that you

11 forego the use the blood pressure cuff, is that correct?

12 A Sure.

13 Q Okay, what kind of blood pressure cuff, is it

14 automatic or manual?

15 A Right now, we are using automatic. I've used

16 manuals for a large part of my career.

17 Q Thank you. Number two, with regards to the DRE

18 protocol, there is the matrix, which you -- would you agree

19 with some parts of it but not all of it, is that a general

20 characterization?

21 A I'm sorry some what?

22 Q With regards to the matrix, is it a characterization

23 that you agree with some but not necessarily all of it?

24 A No, no.

25 Q You don't agree with anything in the matrix?

26 A It's not that I agree with anything with the matrix,

27 the problem that you cannot use the data presented in the

1 matrix to reach a decision about impairment or drug --
2 Q That was not my question.
3 MR. DeLEONARDO: I think he is answering the
4 question. He agreed --
5 MR. WELLS: No, he is not. I asked him --
6 MR. DeLEONARDO: -- with it and he is explaining
7 what he --
8 MR. WELLS: -- if he generally agrees with some of
9 the matrix.
10 THE COURT: Is the question whether certain parts of
11 the matrix are more --
12 MR. WELLS: He agrees with --
13 THE COURT: -- reliable than others?
14 MR. WELLS: I will rephrase the question.
15 THE COURT: Okay.
16 MR. WELLS: If we want to go the long route. I was
17 trying to speed that up but I guess I can't.
18 BY MR. WELLS:
19 Q Okay. With regards to, obviously, every drug that
20 is out there it has an affect on the body, correct?
21 A No.
22 Q Generally speaking, the drug is something which
23 affects the human body, is that correct?
24 A Yes.
25 Q Okay. So, drugs affect the human body in varying
26 degrees as opposed to various different types of drugs,
27 correct?

1 A They are there to not necessarily affect the human
2 body, they are there usually to treat illnesses. Some affect
3 the body, some don't, some affect the brain some don't.
4 Q Okay. You would agree that say controlled dangerous
5 substances can affect a person's ability to drive?
6 A Yes, sure.
7 Q Heroin can affect somebody's ability to drive?
8 A Yes.
9 Q Crack cocaine can affect somebody's ability to
10 drive?
11 A Well, --
12 Q You don't think crack cocaine can affect somebody's
13 ability to drive?
14 A All I can tell you is that there are no studies in
15 the literature --
16 Q Okay.
17 A -- you are asking my viewpoint of what's in the
18 literature and what I know. There are no studies in the
19 literature linking particular drugs with particular levels
20 with particular kinds of driving impairment.
21 Q So, you have no problem with somebody who is high on
22 crack cocaine driving?
23 A That's not what I said. I don't want somebody --
24 Q Do you believe and I asked you this --
25 MR. DeLEONARDO: Objection, and I am going to ask
26 that he be allowed to answer.
27 THE COURT: Let him answer.

1 MR. DeLEONARDO: He explained that is not what he
2 said.
3 THE WITNESS: I'm here as an expert, I think, on the
4 literature and what's available. However, I'm a citizen, too.
5 And I don't want people that are high on cocaine or heroin
6 driving.
7 MR. WELLS: Sure. Okay.
8 THE WITNESS: That's just my opinion as a citizen.
9 BY MR. WELLS:
10 Q Okay, my question is do you believe that crack
11 cocaine can impair somebody so that they cannot drive? It is
12 a simple question.
13 A There is no data to support that.
14 Q Okay.
15 A But I don't want them to drive either.
16 Q Okay. Well, thank you for answering my question.
17 With regards to the DRE matrix -- all right, we will take them
18 down. The narcotic analgesics --
19 A Yep.
20 Q -- heroin, they are derivatives, essentially,
21 correct?
22 A Heroin is a kind of narcotic analgesic, yes.
23 Q Okay. And its derivatives, morphine, methadone,
24 that kind of stuff, correct?
25 A Yeah, sure.
26 Q All right, just walking down that one. You indicate
27 that generally speaking horizontal gaze nystagmus would not be

1 present solely due to narcotic analgesics?
2 A Correct.
3 Q Okay. Vertical gaze nystagmus?
4 A No.
5 Q Lack of convergence?
6 A No.
7 Q Pupil size, how would --
8 A Well, I would take it -- no, I wouldn't. Pupil
9 size, opiate intoxication causes small pupil.
10 Q Constriction?
11 A Yeah.
12 Q Reaction to light, would there be a definitive
13 reaction to light?
14 A Depending on the dose, there is, it's just hard to
15 see.
16 Q Okay. And when I am talking about dosages, I am
17 definitely not talking about clinically?
18 A What are you talking about?
19 Q I am talking about street level usages and street
20 level dosages?
21 A People, again, different people --
22 Q Above clinical?
23 A Say it again?
24 Q Above clinical usages?
25 A There is no clinical use for heroin. It doesn't
26 exist and there's no standardized --
27 Q Okay, above a therapeutic -- oh, you agree with

1 that?

2 A No, no, heroin is not a legal drug. There is no

3 clinical use for it in the United States.

4 Q Methadone, then I will switch to methadone.

5 MR. DeLEONARDO: Your Honor, I am going to ask that

6 he be allowed to answer the question. I mean --

7 MR. WELLS: I will slow down.

8 BY MR. WELLS:

9 Q Methadone?

10 A Yes, what about methadone?

11 Q Above therapeutic dosage?

12 A Now, you have stepped into a difficult question

13 because therapeutic dosage can go all the way up to 200

14 milligrams of methadone a day and I don't know of any addict

15 that takes that much. So, there really is no such thing as

16 above therapeutic dosage.

17 Q I am sorry, can you repeat that, you don't know any

18 addict that uses above 200 methadone -- grams of methadone a

19 day?

20 A I have never seen an addict who has told me that

21 they have used more than 200 milligrams of --

22 Q Has told you?

23 A -- methadone.

24 Q Okay.

25 A That's a lot of methadone. If you or I took that,

26 we would be dead in about five minutes.

27 Q I believe it. Now, pulse rate. You would agree

1 that a narcotic analgesic lower pulse rates?
2 A It may or may not.
3 Q Generally speaking it would lower the blood
4 pressure?
5 A It may or may not.
6 Q And it may also lower the body temperature?
7 A It may or may not.
8 Q Okay. It would cause constricted pupils?
9 A It would, yes it would do that.
10 Q It can cause depressed reflexes at high dosages?
11 A It may or may not.
12 Q Drowsiness?
13 A Depending on the dose and the person experiencing it
14 may or may not.
15 Q Again, at a high dose? I am not talking about
16 therapeutic dose.
17 A Depends on the person and their experience.
18 Q Okay.
19 A Could or couldn't.
20 Q Droopy eyelids?
21 A Very unlikely. I don't know where that comes from.
22 Q And it would definitely not cause somebody's muscles
23 to be rigid in and of itself, would it?
24 A But it wouldn't cause them to be flaccid either
25 unless they were unconscious.
26 Q With regards to the DRE protocol, obviously, what we
27 are here to do is to try to determine whether or not somebody

1 is impaired?
2 A No, that's not -- what I'm here to do is to testify
3 about --
4 Q May I ask -- I am talking with regards to the DRE
5 protocol. I can rephrase the question so you can understand
6 it.
7 A Please do.
8 Q Okay. With regards to the DRE protocol, the idea is
9 to determine, A, whether or not a person is impaired?
10 A Again, the problem --
11 Q And if it is by drugs -- okay, so, you don't agree
12 that that is one of the things that we are trying to do?
13 A What I disagree with is the manual and some officers
14 who testify, misuse and confuse the term impairment. Because,
15 again, there is no data to show driving impairment. There is
16 data that some drugs impair particular body systems.
17 Q Okay. So, hypothetically, can you agree that some
18 drugs, although it took a while, you agree that some drugs can
19 affect somebody's ability to drive a vehicle safely?
20 A No, I haven't testified about that at all.
21 Q You don't think that -- I thought that we just went
22 through that.
23 THE COURT: I think what he said was that some drugs
24 can impair different systems of the body. Not necessarily
25 driving ability, that there aren't any studies on that, I
26 believe.
27 BY MR. WELLS:

1 Q You are familiar with the 12-step protocol -- the
2 DRE protocol, correct?
3 A Yes.
4 Q One of those steps is the psychophysical test, is
5 that correct?
6 A Yes.
7 Q Including the walk and turn test?
8 A Yes.
9 Q And the one leg stand test?
10 A Yep.
11 Q Okay. Now you indicated that the best way for a
12 person or for -- strike that. Let me ask you, I will give you
13 a hypothetical. If somebody went through the walk and turn
14 test, validly done, correctly done, and they started too
15 early, they staggered beforehand, they stepped off the line by
16 more than an inch, six out of nine steps on the way up, --
17 A Right.
18 Q -- couldn't do the turn correctly, --
19 A Right.
20 Q -- and they were off by six out of nine steps on the
21 way back, --
22 A Right.
23 Q they missed heel to toe on all the steps, --
24 A Yes.
25 Q -- they did the turn the wrong way, and they took
26 too many steps --
27 A Yep.

1 Q Okay. Now, the one leg stand.
2 A Right.
3 Q They put the foot down repeatedly, they couldn't
4 count correctly while doing the test, they started too early,
5 they couldn't follow the directions, they had slurred speech,
6 they had trouble keeping their eyes opened, they had trouble
7 keeping their head up, they had trouble speaking.
8 A Okay.
9 Q Okay. Would those things indicate an impaired
10 ability to drive taken together?
11 A If you know that it is going in that it's directly
12 related to alcohol, they might or they might have no relation
13 whatsoever to ability to drive.
14 Q So, you are telling me that if somebody had all of
15 these signs symptoms --
16 A Yes.
17 Q -- they could drive a motor vehicle safely?
18 A I'm saying that what I know is what I know from the
19 data. These are not tests I usually use. What I do know is
20 that there is no validation data other than for alcohol use.
21 That means that relate those signs and symptoms to impairment
22 because of a substance.
23 Q Okay. You said --
24 A There is good data for alcohol.
25 Q Okay. So, if somebody had those signs and symptoms,
26 with no blood test, no breath test for alcohol --
27 A Right.

1 Q -- you would agree that they would not be able to
2 drive safely?
3 A No.
4 Q Really?
5 A That's related --
6 Q You would say that -- I am sorry, I didn't mean to
7 cut you off.
8 A -- the data about those factors are related to blood
9 alcohol levels. If you had a --
10 Q I am not asking about blood alcohol levels, sir.
11 A But there is no way to interpret it without the
12 level, which is the point of my testimony. Because, they
13 might be due to many other factors, medical factors.
14 Q I wasn't asking about alcohol, I wasn't asking about
15 medical factors, --
16 A Okay.
17 Q -- I was talking about simply an impaired ability to
18 drive a motor vehicle, that is all I am asking.
19 A All of those studies are related --
20 Q Sir, I am not asking about the studies.
21 A I am trying to answer as best I can.
22 Q All I am asking is based on these signs and
23 symptoms, --
24 A Yeah.
25 Q -- would you agree that a person who exhibited all
26 of those signs --
27 A Yes.

1 Q -- taken in conjunction would be impaired and not
2 able to drive safely?
3 A And we didn't know if it was from alcohol? Can't
4 answer the question, impossible to answer.
5 Q Never would be able to tell that?
6 A Say it again?
7 Q You could never tell?
8 A No.
9 Q Okay. So, there would never, ever possibly based on
10 all this, you would never say that a person was unable to
11 drive a motor vehicle safely?
12 A No. But that's not a decision I'm making as a
13 clinician. I'm just telling you --
14 Q I am not asking you --
15 A Look I'm just telling you as best I can based on
16 what I know how these tests have been interpreted and
17 validated. I am not a police officer, I don't make traffic
18 stops. I am a clinician who takes care of patients.
19 MR. WELLS: Your Honor, I have no further questions.
20 MR. CRUICKSHANK: Just a couple of questions.
21 REDIRECT EXAMINATION
22 BY MR. CRUICKSHANK:
23 Q Dr. Janofsky, you work in a hospital?
24 A Yes.
25 Q And in the hospital there are personnel who follow
26 protocols?
27 A Yes.

1 Q What is important to know about the way they in
2 which they must follow protocols?
3 A Your Honor, if you have a nonprofessional, a
4 technical person, who has been trained to do things in a
5 particular way, they must be trained to administer the
6 protocol in the same way.
7 And they're usually -- maybe to add up some numbers.
8 Technicians are never or almost never asked to reach a
9 conclusion based on the data that's collected.
10 In order to reach a conclusion, a clinician will use
11 the data collected from the protocol as well as other data to
12 reach a conclusion.
13 Q So, is it generally set within the medical community
14 to have a protocol that can be subjectively interpreted?
15 A No. Your Honor, protocols are never -- they cannot
16 be subjectively interpreted because the technician who's
17 utilizing the protocol doesn't have the capacity or judgment
18 or experience in order to subjectively interpret the data.
19 Q You are a psychiatrist?
20 A Yes.
21 Q And in order to study psychiatry, do you need to be
22 mentally ill?
23 A (No audible response.)
24 Q Well, let me --
25 (Laughter.)
26 A I have never been asked quite like that before.
27 (Laughter.)

1 MR. WELLS: No objection to that question.
2 BY MR. CRUICKSHANK:
3 Q Let me rephrase here. In order to study mental
4 illness --
5 A Yes.
6 Q You don't have to have mental illness?
7 A No and just like -- in order to study cancer, you
8 don't have to cancer. If that's the point you are trying to
9 make.
10 Q In other words, to study why bears hibernate, you
11 don't have to be a bear? Let me ask you this. Let me see
12 what else I have got out there. In order to understand the
13 study, the DRE --
14 A Yes.
15 Q -- validation studies --
16 A Yep.
17 Q -- you didn't have to go along on a ride-along with
18 the DRE?
19 A No. The way to -- again, to look at validity and
20 reliability, the way to look at them is to look at the
21 literature, see what experiments have been done and interpret
22 them, which is what I have done.
23 Q Okay. That is it.
24 MR. DeLEONARDO: Real quickly.
25 REDIRECT EXAMINATION
26 BY MR. DeLEONARDO:
27 Q First of all, on the issue that Mr. Wells was asking

1 you about, about whether or not you would conclude that walk
2 and turn and one leg stand and horizontal gaze would
3 necessarily mean driving impairment?
4 A Right.
5 Q Do you recall that?
6 A Yes.
7 Q Have you previously looked at any of the validation
8 studies from --- and Burns?
9 A Yeah.
10 Q Okay. And could -- I am going to have this marked.
11 THE CLERK: Defendant's No. 13.
12 (The document referred to was
13 marked for identification as
14 Defendant's Exhibit No. 13.)
15 BY MR. DeLEONARDO:
16 Q I am going to ask you to take at this study and I
17 actually direct you to the bottom of this page --
18 A Okay. First let me see if this is -- yes, okay. I
19 got you.
20 Q You have reviewed that before --
21 A Yes.
22 Q -- am I correct. That is one of the studies in the
23 field that deals with validating field sobriety tests under a
24 certain blood alcohol content?
25 A Yes, right.
26 Q Okay. And based on the study that was actually put
27 out to come up with clues, when it comes to walk and turn and

1 one leg stand, do they attempt to standardize what number of
2 clues had to be there first of all to determine blood alcohol?
3 A Yeah, you know, I will have to read it to -- I
4 haven't look at --
5 Q Okay. If you can just read that portion and then I
6 will --
7 A Yes, it says, "Many individuals including some
8 Judges believe that the purpose of the field sobriety test is
9 to measure driving impairment.
10 For this reason, they tend to expect test that
11 possess face validity that is test that appear to be related
12 to actual driving tests.
13 Tests of physical and cognitive ability such as
14 balance, reaction time, information processing have face
15 validity to varying degrees based on the involvement of these
16 ability in driving tests. That is the test seem to be
17 relevant on the face of it.
18 Horizontal gaze nystagmus lacks face validity
19 because it does not appear to be linked to the requirements of
20 driving a motor vehicle.
21 The reasoning is correct, but it is based on the
22 incorrect assumption that field sobriety test are designed to
23 measure driving impairment."
24 Q And is that exactly what you were trying to say?
25 A Yes. They are not designed to measure driving
26 impairment.
27 Q And so, now with the drug recognition expert's

1 program, what are they using, these field sobriety tests that
2 have not been validated to do that, what are they using them
3 for in the program?
4 A They're using them to check the impairment blocks or
5 not, which is wrong.
6 Q Which has not even been supported National Highway
7 Transportation, correct?
8 A Correct, yes.
9 Q Now, you also brought up this totality of
10 circumstances.
11 A Yes.
12 Q We kept asking why can't they do this? When we
13 talked about Shinar -- when it has actually been independently
14 tested to see whether they could follow totality of
15 circumstances, again, what does that research say?
16 A It says they can't because they are incorrectly
17 overusing particular factors in order to come up with their
18 conclusions.
19 So, you can't -- this totality of the circumstances
20 approach, Your Honor, is interesting but there is no data to
21 show that that's what they are doing and that it works.
22 You know, essentially, they are reaching a
23 conclusion and based on the totality of the circumstances but
24 it's really not, I don't think, based on the DRE protocol as
25 written. And, again, when it's tested, it's not valid.
26 Q Now, you were asked about first of all on the field
27 sobriety test --

1 A Yes.

2 Q -- in this particular situation, they were obviously
3 validated a certain way in the field, correct?

4 A Yes.

5 Q In this situation they actually changed them for
6 their drug recognition expert program, is that correct?

7 A They changed the field sobriety test that they would
8 use for the DRE, yes.

9 Q By using both legs, for example, on one leg stand?

10 A No, I don't want to go -- I'm not an expert on the
11 particular details.

12 Q Okay, you don't really recall what they have?

13 A No.

14 Q Well, let me ask you this. When you talk about --
15 you were asking I don't know what missing the nose means?

16 A Yes.

17 Q Can you explain the concept of clues, validated
18 clues?

19 A No, not really.

20 Q I mean in terms of general. Like when we were
21 talking about the drug recognition expert program?

22 A Yes. I mean, what their literature talks about is
23 they call them clues or factors that they say are validated
24 for impairment or for deciding on a particular drug.

25 Q Okay. And that is what you were talking about that
26 you wouldn't know what it means if you didn't have those?

27 A Right.

1 Q Now you were also asked by Mr. Daggett regarding the
2 Heishman study --
3 A Yes.
4 Q -- and I know there was some discussion about
5 discriminate analysis.
6 A Right.
7 Q And he read the portion of -- I want to show you
8 again State's Exhibit 13, page 474.
9 A Yep.
10 Q Do you recall him questioning you about this part
11 right here?
12 A Yes, yes.
13 Q Okay. But the section actually, you were
14 explaining, if I understand correctly, that this wasn't the
15 way the DRE used it but that they tried to take what
16 information they used to see if you could it a better way?
17 A Correct.
18 Q And even doing it the better way, depending on the
19 way that they used it --
20 A Right.
21 Q -- do you see where it says, when DRE is concluded
22 subjects?
23 A Yes, I know where you are reading.
24 Q It is about half way down. It was right after where
25 Mr. Daggett stopped.
26 A Yes, let me see if I can find it. Actually, this
27 is -- yes, "When DRE concluded, subjects were impaired by

1 Ethanol or drugs or both. Their predictions were consistent
2 with toxicological analysis in 51 percent of cases.”
3 When ethanol -- and, Your Honor, this is the study
4 where they used alcohol and the DREs could be absolutely sure
5 whether there was alcohol or based on a breath analyzer.
6 So, they said, “When ethanol only decisions, which
7 were guaranteed to be consistent with toxicology were
8 excluded, DRE’s prediction were consistent in only 44 percent
9 of cases.”
10 Q And that was even taking the best out of the program
11 in trying to satisfy -- is that correct?
12 A Yes, that’s my read of this.
13 Q You were asked about the changes in the manual and
14 what had changed?
15 A Yep.
16 Q In clinical research when you change the way a
17 protocol is done, what is required in the medical scientific
18 community to be done with that protocol?
19 A You have to revalidate it based on the new protocol.
20 So, if there are significant changes in the manual across
21 time, it would need to be reevaluated validity wise based on
22 those changes.
23 Q And has that been done?
24 A No.
25 Q You also were asked about some of your testimony. I
26 think you indicated in Minnesota and Florida, that was done
27 before the validation -- any validation.

1 A Right. So, you know, the problem with testifying in
2 those cases and I think I made it very clear especially in the
3 Minnesota cases as I recall because I believe I had talked I
4 talked to Steve Heishman and he told me that they were working
5 on those. I said, great, you know, when is it coming out?
6 And it wasn't out in time for the testimony, so
7 there was nothing out there about validity. There were these
8 other very poor studies which had not been published in the
9 peer review literature.
10 Q But you also had indicated when asked about --
11 A That's my memory anyway.
12 Q -- you were asked about what happened in those
13 cases, but I guess you were also not asked about what happened
14 in your --- Maryland v. --- case?
15 A Yes.
16 Q And what took place in that case?
17 A My memory, Your Honor, is that the DRE was excluded
18 based on a Frye-Reed hearing.
19 THE COURT: Which case?
20 MR. DeLEONARDO: Maryland v. ---.
21 MR. WELLS: Your Honor, that was a -- I believe it
22 was a District Court Judge in Baltimore City in 1992. That
23 certainly has --
24 THE WITNESS: I think it was in Circuit Court at the
25 time. I'm pretty sure. I could be wrong but I was -- it
26 definitely was taking place in Circuit Court.
27 THE COURT: But it is a nice surprise decision.

1 BY MR. DeLEONARDO:
2 Q Okay. Let me ask you this as well. You talked
3 about the issue of the judgment call and I think you were
4 asked at some point without the set number of clues for
5 each -- in other words, you were asked about could this be
6 possible?
7 A Yep.
8 Q You went through the matrix and said sometimes it is
9 and sometimes it isn't.
10 A Right.
11 Q Would you also agree that if your ranges that you
12 use are not even correct that sort of compounds the problem?
13 A Yes. I mean if it's what's on the matrix is wrong,
14 that's the problem.
15 Q Okay. So, if the blood pressure ranges are wrong or
16 the pulse range is wrong, that would also lead to wrong
17 results, is that fair?
18 A Sure, yes.
19 Q And, finally, I know you were asked about your pay
20 and that you were being compensated here for your time?
21 A Right.
22 Q Is it costing you to be here?
23 A It's not costing me to be here but I'm certainly --
24 Q I mean in terms of could you -- you said that you
25 basically are here in a lesser hourly rate than --
26 A Yes, it's less than half of my usual hourly rate but
27 it's, you know, I discount my rate for the Public Defender.

1 Q Understood and I certainly appreciate it then. And
2 let me ask you this. I assume you have also and you testified
3 earlier, you have testified in other situations for the
4 State --
5 A Yep.
6 Q -- where you found that they were correct?
7 A You mean in non-DRE cases?
8 Q Correct.
9 A Oh, of course, yes. But, again, it would -- I
10 couldn't do that in this case because that's not what I
11 believe unless the State wanted to call me to show DRE was not
12 valid, which I doubt they would.
13 Q Very Good.
14 MR. DeLEONARDO: All right, that is all I have, Your
15 Honor.
16 THE COURT: Recross?
17 MR. DAGGETT: Very briefly, Your Honor.
18 RECROSS-EXAMINATION
19 BY MR. DAGGETT:
20 Q Are you aware that since Heishman has come out in
21 1996, there has been a large number of states that have heard
22 this issue and admitted that --
23 A No, I'm not ware of that at all.
24 Q Okay.
25 A Just, don't know.
26 Q Okay. Very good. That is it.
27 A I don't follow this. I get called by someone and I

1 decide or not to testify. This is not my thing.
2 Q Understood.
3 MR. DAGGETT: Nothing else.
4 MR. DeLEONARDO: That is all. Just move in the
5 study that I --
6 THE COURT: I have a couple of questions. What is
7 the likelihood ratio for Shinar and Schechtman, overall?
8 THE WITNESS: Yes, Your Honor, if you turn to
9 page -- I don't think I calculated it overall.
10 THE COURT: Okay.
11 THE WITNESS: So, it's --
12 THE COURT: That answers my question. That is all
13 right. I didn't know whether you had -- I saw it for the
14 individual drug.
15 THE WITNESS: Specific drugs, I don't think I
16 calculated it overall though.
17 THE COURT: Lot of talk about various field sobriety
18 tests.
19 THE WITNESS: Yep.
20 THE COURT: Things like finger to nose, or throwing
21 coins on the ground, and I recall a time when we would hear in
22 alcohol cases about other field sobriety tests other than the
23 three which are now considered standard, that would be the
24 horizontal gaze nystagmus, walk and turn and one leg stand,
25 which I believe are promulgated by the National Highway
26 Traffic Safety Administration.
27 THE WITNESS: That's my understanding, Your Honor,

1 but I'm certainly not an expert at field sobriety tests.
2 THE COURT: Do you know, though, doctor, whether
3 first of all, whether those particular -- do you know whether
4 field sobriety tests which are used for alcohol, are the
5 product of studies which were peer reviewed and published?
6 THE WITNESS: I just don't know.
7 THE COURT: Okay. And have you ever testified
8 before the legislature in Maryland?
9 THE WITNESS: Yes, sure. Not about this issue but
10 on many others.
11 THE COURT: Right. It is my understanding and I
12 don't know whether you know this or not, but my understanding
13 is when we went from two alcohol related traffic offenses,
14 driving while intoxicated was the more serious offense.
15 Driving while impaired by alcohol was the less serious offense
16 and we now call it driving under the influence being the less
17 serious offense -- I am sorry, the most serious offense and
18 driving while impaired is the less serious offense.
19 And you said public policy decisions, for instance,
20 the per se level for driving under the influence, which is the
21 .08, blood alcohol content --
22 THE WITNESS: Yes.
23 THE COURT: -- is a public policy decision. It is
24 my understanding that actually there is some disagreement and
25 the reason we now have dropped the term driving while
26 intoxicated is that there was disagreement in the scientific
27 community as to whether many people would be intoxicated at a

1 .08 blood alcohol content.

2 THE WITNESS: I'm not directly familiar with that

3 literature, Your Honor, I know that there have been arguments

4 back and forth about where to set the cut point and it's just

5 a matter of at what alcohol level, you know, in the blood or

6 the breath, you know, causes significant enough problems with

7 driving that you don't people to be doing.

8 THE COURT: The definition in Maryland now driving

9 under the influence is substantial impairment. So arguably,

10 when we use a per se level, we are saying that in most people

11 a .08 would cause substantial impairment?

12 THE WITNESS: No, I don't know what was in the

13 legislators' mind when they did that. I just don't know the

14 answer to that. It's a good question.

15 THE COURT: But there is some -- there are studies

16 which you believe would support that?

17 THE WITNESS: I think there are studies that show

18 that as the alcohol level goes up, driving ability goes down.

19 THE COURT: Okay.

20 THE WITNESS: And there is clear data on that. It's

21 the drug we have clear data on.

22 (Long pause.)

23 THE COURT: I don't have anything else. Does

24 anybody have any questions in light of what I asked?

25 MR. DeLEONARDO: I think I just have -- I would just

26 move the one exhibit that I had the study that he read from.

27 I would move that into evidence.

1 THE COURT: Defense Exhibit --
2 MR. DeLEONARDO: That would be Defendant's Exhibit
3 No. 13.
4 (The document marked for
5 identification as Defendant's
6 Exhibit No. 13 was received
7 in evidence.)
8 THE COURT: All right. Well, we have concluded
9 Dr. Janofsky's testimony, is that correct?
10 MR. DeLEONARDO: That is correct, Your Honor.
11 THE COURT: All right, well, doctor, thank you very
12 much.
13 THE WITNESS: Thank you very much, Your Honor.
14 (Witness excused.)
15 THE COURT: And we will be back here tomorrow. We
16 will begin at 10:30 on this and then hopefully we will have
17 the rest of the day to just devote to the Frye-Reed.
18 I would say leave your stuff here but we are going
19 to have some things that are going to be called criminal
20 matters, so you probably want to take your materials with you.
21 MR. DeLEONARDO: Okay. Thank you, Your Honor.
22 MR. WELLS: And, Your Honor, just for clarification,
23 we are hoping that most of tomorrow from about 10:00 a.m.
24 beyond for the Frye-Reed case and then Wednesday afternoon
25 around 1:30, is that correct?
26 THE COURT: 1:30, Wednesday afternoon. And then the
27 question will be whether we have to schedule some additional

1 dates in order to finish.

2 THE CLERK: All rise.

3 (Whereupon, the hearing was recessed to reconvene on

4 09/28/10.)

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C E R T I F I C A T E

CompuScribe hereby certifies that the attached pages represent an accurate transcript of the electronic sound recording of the proceedings heard on September 27, 2010, in the Circuit Court for Carroll County in the matter of:

Criminal No. K-10-040259
STATE OF MARYLAND
v.
CHARLES DAVID BRIGHTFUL

Criminal No. K-10-040331
STATE OF MARYLAND
v.
HARVEY ALEXANDER CARR

Criminal No. K-10-040167
STATE OF MARYLAND
v.
JENNIFER ADELINE FLANAGAN

Criminal No. K-09-039370
STATE OF MARYLAND
v.
RYAN THOMAS MAHON

Criminal No. K-09-039569
STATE OF MARYLAND
v.
CHRISTOPHER JAMES MOORE

Criminal No. K-09-039636
STATE OF MARYLAND
v.
VALERIE ANN MULLIKIN

Criminal No. K-10-040300
STATE OF MARYLAND
v.
RONALD DALE TEETER

By:

_____________________________ _____________________________
Cora C. Holliday, Transcriber Date