IN THE CIRCUIT COURT FOR CARROLL COUNTY, MARYLAND

STATE OF MARYLAND,	:	
v.	:	
CHARLES DAVID BRIGHTFUL,	:	Criminal No. K-10-040259
BONNIE DENISE BRISCOE	:	Criminal No. K-10-040783
HARVEY ALEXANDER CARR,	:	Criminal No. K-10-040331
MATTHEW BRIDGER FARLEY	:	Criminal No. K-11-041045
JENNIFER ADELINE FLANAGAN,	:	Criminal No. K-10-040167
RYAN THOMAS MAHON,	:	Criminal No. K-09-039370
PERRY GILBERT MAY	:	Criminal No. K-10-040717
CHRISTOPHER JAMES MOORE,	:	Criminal No. K-09-039569
VALERIE ANN MULLIKIN,	:	Criminal No. K-09-039636
RYAN LUCAS MULLINIX	:	Criminal No. K-10-040575
DARRELL PATRICK PEYOK	:	Criminal No. K-10-040686
RONALD DALE TEETER,	:	Criminal No. K-10-040300
Defendants.	:	Westminster, Maryland
	x	February 14, 2011

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.
Carroll County State's Attorney's Office
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APPEARANCES: (continued)

FOR THE DEFENDANTS:

BRIAN L. DeLEONARDO, Esq.
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I N D E X

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Defendants Advised and Waived Hicks on Record By Alex Cruickshank, Esq.	7

WITNESSES For the State:	DIRECT	CROSS	REDIRECT	RECROSS	VOIR DIRE
Thurl William Tower, II	11(DD) 50(AW) 50(DD)	52	102	103	--
William R. Morrison	109(AW) 132(AW)	175	--	--	129

EXHIBITS:	FOR IDENTIFICATION	IN EVIDENCE
For the State:		
22	13	20
23	109	109
25	162	165
26	163	165
27	164	165
28	164	165
For the Defendants:		
20	54	108
21	59	108
22	60	108
23	65	108

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EXHIBITS: For the Defendant:	FOR IDENTIFICATION	IN EVIDENCE
24	67	108
25	68	108
26	85	108

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, the

3 Honorable Michael M. Galloway presiding.

4 THE COURT: Good morning, be seated please.

5 MR. DAGGETT: Good morning, Your Honor, David

6 Daggett and Adam Wells are present for the State. It is

7 D-a-g-g-e-t-t and W-e-l-l-s.

8 After Mr. DeLeonardo and Mr. Cruickshank introduce

9 themselves, I will go ahead and read the cases and the case

10 numbers. I think there are 12 of them. We are going to call

11 them and have a couple of Hicks waivers and then excuse, I

12 guess, -- excuse a lot of people that are here, is that

13 correct, is that your understanding?

14 MR. DeLEONARDO: That is correct.

15 MR. DAGGETT: Okay.

16 MR. DeLEONARDO: Well, for the record, Brian

17 DeLeonardo, D-e-L-e-o-n-a-r-d-o, on behalf of Mr. Carr and

18 Mr. Mahon.

19 MR. CRUICKSHANK: Alex Cruickshank, Office of the

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

21 Public Defender's clients.

22 MR. DAGGETT: Your Honor, there are 12 cases I

23 believe that are set before you. Ryan Mullinix, 10-40575;

24 Darrell Peyok, 10-40686; Perry May, 10-40717; Bonnie Briscoe,

25 10-40783; Matthew Farley, 11-41045; Ryan Mahon, 9-39370;

1 Christopher Moore, 9-39569; Valerie Mullikin, 9-39636;
2 Jennifer Flanagan, 10-40167; Charles Brightful, 10-40259;
3 Ronald Teeter, 10-40300; and Harvey Carr 10-40331.
4 MR. CRUICKSHANK: And, Your Honor, we waived Hicks
5 on a number of clients when we started. If I could just go
6 around and have everybody state their names for the record?
7 THE COURT: All right.
8 MR. CRUICKSHANK: State your name.
9 THE DEFENDANT: Matthew Bridger Farley.
10 MR. CRUICKSHANK: Spell your last name.
11 THE DEFENDANT: F-a-r-l-e-y.
12 THE DEFENDANT: Charles Brightful.
13 MR. CRUICKSHANK: Spell your last name
14 Mr. Brightful.
15 THE DEFENDANT: B-r-i-g-h-t-f-u-l.
16 MR. CRUICKSHANK: Sir, in the green shirt?
17 THE DEFENDANT: Darrell Peyok, P-e-y-o-k.
18 MR. CRUICKSHANK: Right here, sir.
19 THE DEFENDANT: Ryan Mullinix.
20 MR. CRUICKSHANK: Spell your last name.
21 THE DEFENDANT: M-u-l-l-i-n-i-x.
22 MR. CRUICKSHANK: Ma’am?
23 THE DEFENDANT: Bonnie Briscoe, B-r-i-s-c-o-e.
24 MR. CRUICKSHANK: Mr. Teeter?
25 THE DEFENDANT: Teeter, T-e-e-t-e-r.

1 MR. CRUICKSHANK: Ms. Flanagan?
2 THE DEFENDANT: Jennifer, last name Flanagan,
3 F-l-a-n-a-g-a-n.
4 MR. CRUICKSHANK: Mr. May?
5 THE DEFENDANT: Perry May, M-a-y.
6 MR. CRUICKSHANK: In the back, sir?
7 THE DEFENDANT: Harvey --
8 MR. DeLEONARDO: Harvey Carr, C-a-r-r
9 THE DEFENDANT: H-a-r-v-e-y C-a-r-r.
10 MR. CRUICKSHANK: Okay. And I am prepared to waive
11 speedy trial rights in the Public Defender's clients who are
12 present today Your Honor. May I do that?
13 THE COURT: Yes.
14 MR. CRUICKSHANK: Everybody, what we are going to do
15 here today and if you have any questions let me know. We are
16 going to waive your right to a speedy trial in this case.
17 You have the right to have your cases tried within
18 180 days of my first appearance in Court, your first
19 appearance in Court or my appearance slip in Court. It is
20 called a Hicks right under Maryland law.
21 Mr. Mullinix, are you waiving your right to a speedy
22 trial?
23 THE DEFENDANT: Mr. Farley.
24 MR. CRUICKSHANK: Mr. Farley -- excuse me?
25 THE DEFENDANT: Yes, sir, I am.

1 MR. CRUICKSHANK: Mr. Brightful?
2 THE DEFENDANT: Yes, sir.
3 THE DEFENDANT: Yes, sir.
4 MR. CRUICKSHANK: What is your name, sir?
5 THE DEFENDANT: Peyok, P-e-y-o-k.
6 MR. CRUICKSHANK: Waiving your right to a speedy
7 trial?
8 THE DEFENDANT: Yes, sir.
9 MR. CRUICKSHANK: Mr.?
10 THE DEFENDANT: Mullinix.
11 MR. CRUICKSHANK: Waiving your right to a speedy
12 trial?
13 THE DEFENDANT: Yes, sir.
14 MR. CRUICKSHANK: Ma'am what is your name?
15 THE DEFENDANT: Ms. Briscoe.
16 MR. CRUICKSHANK: Waiving your right to a speedy
17 trial.
18 THE DEFENDANT: Yes, sir.
19 THE DEFENDANT: Mr. Teeter.
20 MR. CRUICKSHANK: Mr. Teeter, waiving your right to
21 a speedy trial?
22 THE DEFENDANT: Yes, sir.
23 MR. CRUICKSHANK: Ms. Flanagan?
24 THE DEFENDANT: Yes.
25 THE DEFENDANT: Yes.

1 MR. CRUICKSHANK: Mr. May said yes, as well.
2 MR. DeLEONARDO: In the back, Your Honor, from my
3 clients, Mr. Carr, I think we previously addressed this as
4 well as Mr. Mahon and they have already previously done that.
5 THE COURT: All right, very well.
6 MR. CRUICKSHANK: Thank you, Your Honor.
7 MR. DAGGETT: Your Honor, there are three people
8 that aren't here. I am not too concern about it because I
9 think they were here before, that was Ryan Mahon --
10 MR. DeLEONARDO: That is correct.
11 MR. DAGGETT: -- Christopher Moore and Valerie
12 Mullikin. Now, I think they waived Hicks before and we --
13 MR. CRUICKSHANK: Yes.
14 MR. DAGGETT: -- excused them before --
15 MR. DeLEONARDO: Right.
16 MR. DAGGETT: -- so they are not present but we have
17 no issue as far as I can tell.
18 MR. DeLEONARDO: At least that goes to Mr. Mahon, my
19 client, as well as Mr. Carr, we have waived their presence
20 previously, although Mr. Carr came anyway.
21 MR. CRUICKSHANK: And the only thing I would add is
22 that if you want to stay you can stay. If you would like to
23 leave, you can leave and you do not have to come back tomorrow
24 if you don't want to come back tomorrow.
25 THE COURT: All right, very well.

1 (Long pause.)
2 MR. DAGGETT: If I can -- I guess briefly summarize.
3 I think the last time we were here back in early December,
4 defense put on their three witnesses. We kind of had to go
5 out of order because we had scheduling -- there were
6 scheduling difficulties with a lot of people.
7 So, I think the defense called three -- we had
8 called three doctors, the defense called three doctors and
9 then today we are planning -- we have two former police
10 officers or police officers and I think there might be one
11 more. So, is that -- I guess we are back on that.
12 MR. DeLEONARDO: Although, I think it was actually
13 September --
14 MR. DAGGETT: Was it?
15 MR. DeLEONARDO: -- last time we were here.
16 MR. DAGGETT: Was it September?
17 MR. DeLEONARDO: I know it. Time flies when we are
18 having fun.
19 MR. DAGGETT: Okay.
20 MR. DeLEONARDO: So, yes, and I do, I think we kind
21 of took it out of order because of the witnesses. So, I think
22 the defense has two witnesses that are in their direct. And
23 then there is an issue of rebuttal witness. I guess we will
24 cross that bridge when we get to it.
25 THE COURT: Okay.

1 MR. DAGGETT: Are you ready to proceed, Your Honor?
2 THE COURT: I am ready to proceed.
3 MR. DAGGETT: Okay. William Tower.
4 THE CLERK: Good morning.
5 THE WITNESS: Good morning.
6 THE COURT: Good morning.
7 THE CLERK: Please remain standing and raise your
8 right hand.
9 Whereupon,
10 THURL WILLIAM TOWER, II
11 was called as a witness by the State, having been first duly
12 sworn, was examined and testified as follows:
13 THE CLERK: Please have a seat.
14 THE WITNESS: Thank you.
15 THE CLERK: For the record, could you please state
16 your full name, spelling your first and last and give your
17 business address please.
18 THE WITNESS: Thurl, T-h-u-r-l, William Tower, II.
19 My business address is 10 South Howard Street, Suite 6700,
20 Baltimore, Maryland 21201.
21 MR. DAGGETT: And Tower is T-o-w-e-r?
22 THE WITNESS: Yes, sir.
23 THE CLERK: Thank you.
24 DIRECT EXAMINATION
25 BY MR. DAGGETT:

1 Q Can you tell us your current position?
2 A I am the law enforcement liaison for the National
3 Highway Traffic Safety Administration. That's an agency of
4 the US Department of Transportation for Region 3, that's
5 located in Baltimore.
6 Q And what are your duties and responsibilities in
7 that position?
8 A I work with law enforcement agencies in our seven
9 states in Region 3 to promote enforcement programs relating to
10 highway safety.
11 I do some training of law enforcement officers. I
12 also provide technical assistance in setting up sobriety
13 checkpoints and other enforcement operations.
14 Q What is your background, your training and your
15 experience?
16 A Well, in relation to DUI and highway safety, my
17 training began many years ago when, in fact, in 1975 and '76
18 in the Maryland State Police Academy.
19 As part of a six-month training academy, I had
20 several weeks of specific DUI training relating to field
21 sobriety testing and DUI detection.
22 I also received significant amount of training
23 relating to dealing with drug impaired individuals and drugs
24 themselves.
25 Following that, I attended a number of seminars

1 relating to DUI. And in 1982 and if I may follow along with
2 my CV --
3 Q Actually I have a copy, I have -- actually you can.
4 I have a copy State's Exhibit No. 22 for identification. Just
5 take a look at that. Is that the same thing that you have?
6 A It is. It's exactly the same.
7 (The document referred to was
8 marked for identification as
9 State's Exhibit No. 22.)
10 BY MR. DAGGETT:
11 Q All right, then I will go ahead and refer to this
12 and you can use that one and I will enter this one into
13 evidence --
14 A Very well.
15 Q -- at the appropriate time.
16 A In 1982, I attended a seminar, a training class,
17 that was actually put on by NHTSA. It was called Improved
18 Sobriety Testing.
19 And it was the first class of its kind where the
20 Federal Government had worked with a number of law enforcement
21 agencies, especially the LAPD, to develop the most current and
22 accurate field sobriety tests that were used.
23 And they were pilot testing this class and they, in
24 fact, came to Maryland and they brought instructors from the
25 LAPD.

1 As part of this course, we learned the horizontal
2 gaze nystagmus test, the walk and turn, and one leg stand.
3 And they dosed volunteers to various levels of alcohol and we
4 evaluated them based on the testing protocols that we had
5 learned.
6 Q So you -- back then you were with the Maryland State
7 Police?
8 A I was.
9 Q So why don't you -- before we get into that specific
10 part, why don't you just talk about when you became, when you
11 started working with the State Police and how long you worked
12 for them and when you retired?
13 A All right. I began the academy in October of 1975,
14 completed in March of 1976. I worked as a patrol trooper at
15 the Frederick Barrack. Proceeded on, I was promoted to
16 corporal, sent to the Forestville Barrack as a supervisor, was
17 then transferred to the Alcohol Speed Enforcement Unit, which
18 works specifically in enforcement of DUI and speed-type
19 violations around the state.
20 Was then promoted to sergeant, stayed with the unit,
21 promoted to first sergeant, went on staff at the State Police
22 Headquarters.
23 Also during that time, I spent about a year as the
24 public information officer for the Maryland State Police.
25 In 1986, I was given a one year special assignment

1 to the National Highway Traffic Safety Administration in
2 Washington.
3 And my job during that period of time is to work
4 with NHTSA, the National Highway Traffic Safety
5 Administration, to evaluate the current field sobriety testing
6 course and update it and standardize it as well as go through
7 training in Los Angeles and Sacramento to take a look at a new
8 technique that was being developed called DRE, Drug
9 Recognition Expert.
10 I attended and successfully completed both the Los
11 Angeles Police Department training as well as the California
12 Highway Patrol version.
13 Came back to the Transportation Safety Institute in
14 Oklahoma City where along with two other specialists from the
15 National Highway Traffic Safety Administration and IACP, the
16 International Association of Chiefs of Police, developed a
17 curriculum that is DRE today.
18 And in addition to helping write the curriculum
19 itself, I also produced and edited and narrated a series of
20 videos to go along with those programs.
21 To do that I took a film crew to Los Angeles where
22 we actually videotaped actual drug evaluations taking place
23 and used that footage along with the instructors to develop
24 the narration and complete the training.
25 After all of that, we pilot tested this new course,

1 this DRE, at that time, NHTSA developed a name called the Drug
2 Evaluation a Classification Program. That was to be the
3 official name of the course.
4 Student who successfully completed it would become
5 drug recognition experts or drug recognition technicians
6 depending on the state that they were from.
7 And, of course ultimately, it's the Court's decision
8 whether to determine if one of these officers is, in fact, an
9 expert or not.
10 Q Have you received any certifications in regard to
11 the DRE program?
12 A Yes, yes.
13 Q And what were they.
14 A Well, originally, I was certified by the Los Angeles
15 Police Department when I went through the original training in
16 the summer of 1986 as a Drug Recognition Expert.
17 I also received a certification from the California
18 Highway Patrol in September of 1986 after successfully
19 completing their program.
20 Following that, NHTSA and IACP worked together to
21 develop a national certification because in 1986 really there
22 was only one state where this program was working and only
23 just a few agencies.
24 Q And that was California?
25 A That was California. And as we developed it, the

1 curriculum, and began training nationwide, NHTSA and IACP
2 knew, in fact, that there needed to be some kind of
3 standardization and a certification process that would apply
4 to everyone equally.
5 In the early 1990s, NHTSA provided funding to the
6 International Association of Chiefs of Police to do just that.
7 To develop a certification process where a minimum number of
8 hours of training, evaluations completed, a certain accuracy
9 in evaluation opinions and toxicology results would be done.
10 The development of a personal resume for the officer
11 to use and finally an actual evaluation sheet where the state
12 coordinator would check that an individual officer would meet
13 all those requirements and then sign off.
14 That would be sent to the IACP and they would issue
15 a certificate and a card showing that particular officer was
16 certified.
17 Q That is the program that -- and we are going to get
18 to that. We are going to the program itself but as far as
19 certifications go, you have been certified you said by Los
20 Angeles Police Department and any other --
21 A The California Highway Patrol and eventually the
22 IACP.
23 Q And what about Maryland State Police?
24 A And the Maryland State Police.
25 Q Have you ever had any -- published any or authored

1 any articles regarding the DRE program and its protocols?
2 A I have. And, again, if I may refer to my CV so I
3 can be precise.
4 In 1994, I authored a program for the Department of
5 Transportation for Alcohol and Drug Supervisory Training.
6 This involved federal regulations that required supervisors in
7 certain fields of transportation, aviation, commercial
8 vehicles, vehicles such as that, those modes of transportation
9 where a supervisor must be able to have a level of knowledge
10 to determine if someone, in fact, may be using some sort of
11 illegal drugs, in fact, the particular drugs are listed in the
12 federal regs.
13 And just have enough reasonable suspicion to request
14 a urine test. And these are administrative civil proceedings.
15 And I developed that curriculum, in fact, taught it for the
16 Department of Transportation for a number of years.
17 I wrote a sobriety checkpoint operation's manual for
18 the Maryland State Police as well as edited and developed a
19 videotape that is used around the country to conduct sobriety
20 checkpoints.
21 Q So how many -- approximately how many articles have
22 you -- would you either be the author or contributing author
23 to regarding DUIs and DREs?
24 A I would imagine just looking over the list here 25
25 or 30.

1 Q Have you ever testified in Court as an expert in
2 the -- as a DRE or in the DRE program?
3 A I have.
4 Q And how often and where have you testified in Court
5 as an expert?
6 A I have testified throughout the State of Maryland as
7 well as in the District of Columbia. Over the years as recent
8 as 2008 and as far back as the '80s, I've testified and been
9 qualified as an expert in the effects of alcohol and drugs.
10 Most recently, was the Superior Court of the
11 District of Columbia. This was a DRE case. It was a Frye
12 Hearing.
13 I was qualified as an expert in the DRE procedure as
14 well as recognizing the effects of drugs.
15 In Maryland most recently in Hartford County, in the
16 Circuit Court, in State v. Novak, I was qualified as an expert
17 in the DRE program in the effects of drugs. That also was a
18 Frye Hearing.
19 And in 2003, I was qualified as an expert in a
20 deposition in the US District Court hearing that involved a
21 civil case between a Defendant's family and Howard County.
22 And then there were a number on back through the
23 years.
24 MR. DAGGETT: Your Honor, subject to any questions
25 from defense counsel, I am going to, at this point, make a

1 motion to enter State's Exhibit No. 22, which is Mr. Tower's
2 curriculum vitae and also put him before the Court as an
3 expert in the field of DRE and DRE program.
4 MR. DeLEONARDO: Your Honor, again, just in an
5 abundance of caution to make sure as long as he is not
6 testifying as to the reliability, the validity of the program
7 or the effects of alcohol and drugs.
8 MR. DAGGETT: No, that is certainly up to -- that is
9 the Court's decision ultimately to make that ruling,
10 obviously, but we are going to talk about the program itself,
11 and the training he has received and what he has done.
12 MR. DeLEONARDO: Well, again, so as long as he is
13 not talking about its acceptance in the community then I think
14 that is fair. And I don't have an objection to that.
15 THE COURT: All right. First of all, we will admit
16 State's Exhibit 22 and we will accept Mr. Tower as an expert
17 regarding the DRE program and the DRE protocol.
18 (The document marked for
19 identification as State's
20 Exhibit No. 22 was received
21 in evidence.)
22 BY MR. DAGGETT:
23 Q Okay, Mr. Tower, now we are going to focus
24 specifically on your background and your involvement with the
25 DRE program and its history.

1 And we have heard a lot of -- you are probably the,
2 I guess the seventh witness maybe that has come forth.
3 A lot of people have had information about the DRE
4 program. We have all heard about Los Angeles and that type of
5 thing.
6 But I am going to ask you since you were in
7 basically kind of in on one of the ground level. I would like
8 you to explain to the Court how you became involved and what
9 your duties and responsibilities were and what you had to do
10 as a result of that.
11 A Very well. My first exposure to the DRE program was
12 in 1984 I was conducting standardized field sobriety testing
13 and instructor training in Pikesville and NHTSA had funded the
14 Maryland State Police to bring instructors from across the
15 country to teach the three-step process.
16 During that time, the research study was going on at
17 Johns Hopkins and DREs from the LAPD, Sergeant Studdard, one
18 of those, who was one of the founding officers of the DRE
19 program and a team who were being utilized as the evaluators,
20 came to our class and gave a briefing on what was going on at
21 this research project and what the DRE program was.
22 I became very interested, I felt that at some point
23 that might be appropriate for Maryland, but this was very
24 early in the process, we certainly weren't ready for it as
25 yet.

1 Following that in 1986 as I continued with the
2 sobriety testing courses, I had an opportunity to go to NHTSA
3 for one year on a special detail, and my responsibilities
4 during that time were several.
5 First of all to develop the most latest curriculum
6 standardized field sobriety testing and bring the student
7 instructor manuals in line, develop videotapes, but more
8 importantly to take a look at this fledgling DRE program,
9 which had started in Los Angeles back in the 1970s where
10 officers began noticing folks who were arrested for DUI
11 clearly impaired but yet were showing no results on -- at that
12 time, the old breathalyzer test.
13 So, there was something other than just alcohol
14 causing this impairment. And they worked with a number of
15 researchers, physicians, nurses, toxicologists, to take a look
16 at what were they seeing in the way of signs and symptoms.
17 And they developed a series of simple examinations
18 that through years of testing found to them to be very
19 accurate.
20 What we wanted to do was from NHTSA take a look at
21 this course and they had been training occasionally officers
22 in Los Angeles in these techniques.
23 To take a look and see if they really were valid and
24 if so could we develop a curriculum that was standardized that
25 could be used outside of Los Angeles?

1 One that would be standardized across the country.
2 So if we do take this training out of California, would it be
3 the same everywhere? That was our ultimate goal.
4 Well, during the 70s and early 80s, the California
5 Highway Patrol had sent officers to this training and they, in
6 term, had developed their own DRE course, both were about a
7 week in length.
8 I successfully completed the LAPD course, which was
9 five days of classroom and several nights of field training at
10 the Central District Detention Facility called Parker Center
11 in downtown Los Angeles where all arrestees were brought to
12 the central location.
13 Where I examined under the supervision of Sergeant
14 Studdard these people who were suspected of being under the
15 influence of different drugs.
16 And based on the steps of the evaluation that I had
17 learned, I formed an opinion that they were first under the
18 influence and that it was one or more categories of the then
19 seven possible categories of drugs of which all impairing
20 drugs can fit into.
21 And then we got urine samples --
22 MR. DeLEONARDO: Objection to the last statement.
23 Objection as to that all drugs fit into the seven categories.
24 I think that is going outside of his expertise. Especially in
25 light of our testimony of a pharmacologist.

1 THE COURT: I am sorry?
2 MR. DeLEONARDO: Especially in light of the
3 testimony of our pharmacologist.
4 THE COURT: All right, I will reserve on that.
5 THE WITNESS: I completed that training
6 successfully, received my certification and certificate and
7 then went to in September of that year to Sacramento the --
8 BY MR. DAGGETT:
9 Q And what year are you talking about -- you are up to
10 '86 now?
11 A This is 1986, yes.
12 Q '86.
13 A My year started in July of '86 and completed in June
14 of '87. I Went to the California Highway Patrol Academy in
15 September, successfully completed their version of the DRE
16 training and it was very similar, seven categories of drugs,
17 the 12 steps in the process, like the LAPD, we had a physician
18 who provided much of the training as well as experienced
19 officers.
20 I went to downtown Sacramento and some surrounding
21 cities on the following two nights, observed 13 or 14 impaired
22 subjects, evaluated them under the supervision of the senior
23 instructor and Officer John Rydell. Formed my opinions, and
24 obtained urine samples and eventually, as I said, was, in
25 fact, certified.

1 Following that, I returned to the Transportation
2 Safety Institute in Oklahoma City. This is the USDOT's main
3 training facility where all of their training programs are
4 developed.
5 I worked in conjunction with two other experts from
6 NHTSA who were curriculum development specialists. We brought
7 several of the DRE instructors from Los Angeles out and we
8 developed a standardized curriculum.
9 We took the best of both programs, put them in a
10 format that we felt based on the current techniques of law
11 enforcement training would be the best to convey this
12 information and ultimately train officers in these techniques.
13 In addition, I had mentioned earlier --
14 Q So, you talk -- before you were talking about the
15 LAPD and the California Highway Patrol those two programs and
16 took the best of --
17 A Yes, I took those two, the documentation, the
18 curriculums, everything they had. We brought it all back to
19 Oklahoma City and we sat down and we worked for months to
20 develop a standardized curriculum.
21 One that we felt could be used in any state across
22 the country to train officers effectively to use these
23 techniques.
24 During that time, I took a film crew to Los Angeles,
25 we videotaped actual drug evaluations of impaired persons. We

1 showed the signs and symptoms that appear when someone is
2 under the influence of different types of drugs and we
3 packaged that to go along with the written curriculum.
4 We pilot tested this new technique in early 1987 in
5 Los Angeles from officers from the LAPD as well as CHP. We
6 then developed an instructor version.
7 And that really started the National DRE Program.
8 Many of those instructors traveled to a number of pilot states
9 where we used the curriculum and we started training officers
10 in those states and eventually to this day has now spread to
11 some 47 states across the country.
12 Q Now the training that you said you began the
13 national DRE course, so the training that you would demand of
14 your students, I guess, what did that consist of?
15 A Well, first of all, an officer to be selected for
16 DRE must have successfully completed standardized field
17 sobriety testing.
18 It is a three-day course where it includes
19 horizontal gaze nystagmus, walk and turn and one leg stand.
20 Not only must they successfully complete that, they
21 must be very proficient in administering those tests.
22 Once they are selected to attend DRE school, there
23 is a two-day preschool and this is really the officer's first
24 exposure to the seven drug categories, the effects of those
25 drugs or the signs and symptoms that impairment by those

1 produces and the 12-step process.

2 They even have an alcohol workshop where folks are
3 dosed to different BAC levels and they get to practice the
4 different steps on impaired people.

5 Granted alcohol because we legally and ethically
6 can't dose people on drugs other than alcohol, but at least it
7 gives them an opportunity to practice these steps.

8 They learn a little bit about human physiology and
9 drugs effect the human body. But it's just an initial general
10 overview and practice of the techniques.

11 Q And that is a two-day pre --

12 A That's a two-day school. It's called the preschool.
13 And at the end of that course, there is an examination they
14 have to pass with 80 percent.

15 Now following that is the seven-day DRE school and
16 this is where the students are taught in depth about the
17 seven-drug categories. What drugs are involved in those
18 categories? What are the signs and symptoms that are
19 produced? Human physiology is discussed.

20 The 12-step process is practiced over and over and
21 over again. And another alcohol workshop for them to practice
22 on impaired people.

23 They truly learn every aspect about drugs that they
24 will see out on the street and how to determine if someone is
25 under the influence.

1 But this is all classroom and they have quizzes each
2 day during the course. At the end of the course, there is a
3 100-question test, they have to pass with at least 80 percent.
4 Now, they are still not certified yet. Now, they go
5 to perhaps the most important part, field certification.
6 And this is where the DRE student under the
7 supervision of certified instructors must examine people who
8 are under the influence.
9 They must do a full evaluation and, in fact, they
10 must do at least 12 of these evaluations and they need to see
11 at least three of the seven categories of drugs.
12 They complete the evaluations, they write reports.
13 These reports are reviewed by the instructors and approved by
14 the instructors. They form their opinions.
15 They must at least 75 percent of the time be correct
16 in the toxicology results that are obtained from either a
17 urine or a blood test at the end of the evaluation.
18 And this is where they really learn what someone
19 under the influence of perhaps a central nervous system
20 depressant or stimulant, or hallucinogens, a dissociative
21 anesthetic, narcotic analgesics, inhalants and all the seven
22 drug categories. What someone actually looks like right in
23 front of them and the signs and symptoms that impairment
24 produces.
25 They also learned that not everybody they see is

1 going to be under the influence. Not everybody is going to be
2 impaired for various reasons.
3 Some people are impaired just by alcohol, some
4 people are not impaired at all. And then in some cases there
5 may be a medical condition, the possibility of one. And, if
6 so, they are trained to get that person to medical attention
7 immediately.
8 Because I've had personal experience where we've had
9 people with heart conditions that had very high pulse rates,
10 high blood pressure.
11 I've seen people who were later diagnosed, not by
12 me, I saw that there was a problem in the disparity of the
13 pupils of their eyes and eye nystagmus because true impairment
14 by a drug will affect the eyes equally --
15 MR. CRUICKSHANK: Objection. I think we are
16 starting to go into the category of what the experts on both
17 sides have talked about.
18 THE COURT: I will sustain.
19 THE WITNESS: Very well. They are taught that if
20 there is any possibility of a medical issue then get the
21 person to medical attention and I've seen that in a number of
22 cases.
23 In fact, over the years, the DRE program many lives
24 have been saved because these issues were noticed, a question
25 brought up, the evaluation was discontinued and the person

1 taken to a medical attention and dealt with that way.
2 But in the majority of cases the evaluation is
3 completed and the officer forms an opinion. Whether the
4 person was under the influence, unable to operate a vehicle
5 safely and to what category or categories the impairment is
6 caused by.
7 BY MR. DAGGETT:
8 Q So at the conclusion of the -- so the field
9 certification follows the classroom?
10 A Yes, sir, that is correct.
11 Q And they have to do at least 12 examinations?
12 A That is correct, under the supervision of a DRE
13 instructor -- certified instructor. And they must see at
14 least three of the seven categories of drugs during that
15 evaluation period and following that they must complete a
16 resume.
17 All of these items are on a checklist that the IACP
18 provides to the state coordinator. All of these are
19 completed. The DRE state coordinator reviews everything, two
20 instructors have to verify that all of these items have been
21 completed and the DRE coordinator for that state signs the
22 bottom of that form and certifies that officer as a DRE.
23 Q And how does one go from being a certified DRE to
24 taking the next step in being an instructor?
25 A A DRE must be certified for at least a year, must be

1 recommended by the state coordinator or agency coordinator as
2 a candidate to be an instructor and then go through a four-day
3 instructor's course and successfully complete that. You have
4 to be a certified DRE before you can become a DRE instructor.
5 During the process, once a DRE becomes certified,
6 they must be recertified every two years. So, there is a
7 continuing education.
8 They also have to do a minimum number of evaluations
9 during that two-year period to maintain certification.
10 Now, the state coordinator is the key person that
11 keeps the records of all the requirements that each DRE both
12 initially has to obtain for certification as well as
13 recertification.
14 That documentation is forwarded to the IACP in
15 Alexandria, Virginia. The IACP then reviews the documents.
16 If it meets their standards, they then issue a certificate and
17 a card credentialing those DREs and DRE instructors.
18 Q Now, you have -- once you got the program underway
19 or once you got the -- completed the pilot test and developed
20 the course and what else did you then do? What was your next
21 step?
22 A Well, I wanted the program to come to Maryland. I
23 had seen it work. I had been trained as a DRE --
24 MR. DeLEONARDO: Objection on seeing it work.
25 THE COURT: Well --

1 MR. DeLEONARDO: As long as the Court is not taking
2 it as to the Frye issue. Only his personal --
3 THE COURT: I --
4 MR. DAGGETT: We are not asking -- I mean
5 regardless, we are not asking the Court -- we understand.
6 MR. DeLEONARDO: As long as the Court --
7 THE COURT: I think I am clear.
8 MR. DAGGETT: Okay, so go ahead.
9 THE WITNESS: Thank you. I wanted to bring the
10 program to Maryland but at the time Maryland did not have the
11 legislation that would allow a DRE program to work.
12 And in that the implied consent back in the 1980s
13 only applied to --
14 MR. CRUICKSHANK: Objection.
15 MR. DeLEONARDO: Your Honor, I am going to object as
16 to his discussion about the law. Again, I don't know what
17 relevance it would have to our Frye hearing, what he -- what
18 legislation has been enacted. The Court heard that issue and
19 ruled.
20 MR. DAGGETT: He certainly has the ability to
21 explain how the program came about and how it came about in
22 Maryland and how it ended up in our statute to be perfectly
23 honest, which is what -- why we are having him testify.
24 THE COURT: I am going to overrule.
25 THE WITNESS: In order to make a DRE program work,

1 you have to have an alcohol test first to eliminate alcohol as
2 the impairing substance.
3 Then the DRE, if the alcohol result is inconsistent
4 with a person's apparent intoxication or zero then a DRE can
5 be called in.
6 At the end of the DRE evaluation, the last step is
7 to request some sort of chemical test. In some states it's
8 urine and some states it's blood.
9 And the purpose of that test is to show that a
10 substance was, in fact, in the person's body. A substance
11 that the DRE believed is causing the impairment. It's a
12 corroboration if you will.
13 We didn't have that in Maryland. We had one test
14 and it was breath for alcohol. I was made a member of the
15 Governor's Executive Committee under Governor Schaffer to
16 develop legislation that would bring this ability to Maryland.
17 I was also an advisor to the Joint Legislative Task
18 Force in 1988 and '89 created by the legislature to provide
19 information to them to determine what legislation would be
20 best to bring the DRE ability to Maryland.
21 Well based on the Joint Legislative Task Force's
22 recommendations, the recommendations by the Governor's
23 Executive Committee on drunken drug driving, I assisted one of
24 the attorneys from the Governor's office in drafting
25 legislation that eventually became a Senate Bill that

1 eventually was passed and became law.
2 Which enabled police officers when they made a DUI
3 arrest to first, of course, continue getting a breath test for
4 alcohol, but then a DRE, after doing an evaluation, or at some
5 point specifically listed in the Maryland law, which is
6 unusual, is very -- its only occurred in one other state that
7 I know of, a DRE would then request a blood test for drugs.
8 And if the person arrested refused that blood test,
9 then the administrative suspension or sanctions would apply
10 just as if they would have refused the breath test for
11 alcohol.
12 BY MR. DAGGETT:
13 Q And just so we are all clear, and we have heard -- I
14 believe we have heard, certainly had it kicked around, we are
15 talking about Transportation Article 16-205.1(i)?
16 A I believe that is correct, yes.
17 Q Okay. You can carry on.
18 A Once that legislation was obtained, that passed, we
19 set up the first DRE training course in Maryland. It was
20 consisted of State Troopers and representatives of the largest
21 police agencies in Maryland, the Baltimore City Police, the
22 Baltimore County, Prince George's County, Montgomery County,
23 Anne Arundel County and Howard County.
24 The training was actually conducted in DC,
25 Washington, D.C., at the US Capitol Police Headquarters.

1 Q And, Mr. Tower, what year are we talking about now?
2 A This would have been 1990, early 1990. Now, based
3 on that training, we ultimately certified those initial nine
4 officers. Shortly after that, we -- legislation also been
5 introduced in the Governor's budget to fund the development of
6 a laboratory specializing in the analysis of blood samples for
7 drug impaired driving.
8 That was on track but a budget crises hit and that
9 was one of the items, unfortunately, that was taken out of the
10 budget.
11 To make sure we had some way of testing blood, I was
12 able to obtain some funding through the National Highway
13 Traffic Safety Administration to use a private lab.
14 And the laboratory was American Medical Labs in
15 Chantilly, Virginia. And we set up a protocol, we used the
16 exact same blood kits that we used for alcohol but we
17 collected them and sent them to this new lab for analysis.
18 And that began late '90/early '91.
19 Q So that was the training -- so that was the initial
20 program encompassed nine officers from some of the larger
21 jurisdictions in the State of Maryland --
22 A Yes, sir.
23 Q -- and did you also say in the District or just the
24 State of Maryland?
25 A We did the training in DC but these nine officers

1 were all from Maryland.

2 Q All from Maryland?

3 A Yes.

4 Q And, at that point, can you carry on with the

5 history of the DRE program I guess in Maryland?

6 A Yes. After those initial nine officers began

7 working as DREs and doing evaluations, we started collecting

8 the blood samples, started getting results back, we made the

9 determination that it was working well and we decided to

10 expand.

11 And we started doing yearly training classes

12 anywhere from 15 to 20 officers. And, ultimately at one

13 point, we had well over a hundred officers from many different

14 jurisdictions and I believe that has expanded somewhat since

15 then, at least to different agencies.

16 I was the coordinator for the first 15 years of the

17 program. I was assigned as the supervisor or commander for

18 the chemical test for alcohol unit during that time, which

19 enabled me to work very well with the lab and every aspect of

20 DUI that the State Police was involved in.

21 I then was promoted to lieutenant, became Commander

22 of Traffic Operations for the State Police. I still have kept

23 the chemical test unit and those -- and the DRE program under

24 my control.

25 But then, ultimately, I was transferred to be the

1 Commander of the Rockville Barrack, which handles the
2 Montgomery County side of the Capitol Beltway, the interstates
3 there.
4 And at that time in 2000, I had to give up my
5 certification as a DRE and DRE instructor because I had to
6 focus on command duties.
7 I did continue, though, my knowledge. I attended
8 every national DRE conference, every seminar that I could go
9 to on drugs. I continued to do that. They are listed in my
10 CV.
11 And at one point, I was awarded the DRE Emeritus.
12 The IACP DRE section, has an award for DREs and DRE
13 instructors that are no longer certified yet over the course
14 of their career and after, they continued to provide
15 information, support, and continued education in the DRE
16 field.
17 And they contributed substantially to the progress
18 and the success, expansion of the DRE program.
19 Q Now as the coordinator for the first 15 years of the
20 program, did you, as far as the training that was required of
21 both the DRE officers and also the instructors, did you comply
22 with the original NHTSA guidelines that you guys came up with
23 back in 19-- I guess you said it was in the mid '80s, '86 or
24 so?
25 A Not only did we comply, we exceeded the IACP

1 recommendations. Instead of 12 evaluations to be conducted
2 under the supervision and instructor during that initial
3 certification process in three drug categories, I felt that
4 because we were a new state, we were setting precedent that we
5 needed to go a little bit further.
6 So that all of our students had to do at least 15
7 evaluations and had to successfully identify four of the
8 categories of drugs.
9 And, in fact, many times it took 20 evaluations to
10 find that fourth category.
11 Some drug categories are widely used and very easy
12 to find. People on heroin, for instance, in Baltimore City,
13 or cocaine and narcotic analgesics and the central nervous
14 system stimulant are everywhere.
15 So it's easy to find those folks. They are arrested
16 on a variety charges. And when we did the training in the
17 City of Baltimore at the various districts, we saw many of
18 those folks.
19 Marijuana was fairly frequent. PCP, at that time,
20 was a separate category. Now it's called dissociative
21 anesthetics because other drugs have been added, also
22 occasionally was seen.
23 But getting that fourth category took quite a few
24 evaluations to complete.
25 So, at that time, those officers were probably the

1 best trained in the country and had actually done more to get
2 to their certification than officers anywhere.
3 Q Lieutenant Tom Woodward are you familiar with him?
4 A I am.
5 Q And how did you know him and was he one of your
6 students?
7 A He was. I originally trained -- at that time, it
8 might have been Trooper or Corporal Woodward in standardized
9 field sobriety testing.
10 After he became proficient, we trained him as an
11 instructor. We then trained him as a DRE. And then
12 ultimately a DRE instructor.
13 And upon my promotion to lieutenant in the State
14 Police, my superintendent told me that my time in traffic
15 operations was limited and I should be looking for someone to
16 take the reins and in come in and take over the DRE program.
17 Lieutenant Woodward as well as a number of other
18 officers from other agencies certainly were very capable
19 outstanding instructors but Lieutenant Woodward was in my
20 agency and I chose him, highly qualified, highly motivated,
21 outstanding instructor.
22 Certainly one of the most experienced and
23 knowledgeable DREs in the State of Police.
24 Q So, he was -- I guess he was your successor?
25 A He was indeed. And he took over around 2000 when I

1 had to resign as DRE coordinator.
2 Q Now other than Maryland, where else have you gone --
3 what other states have you -- or other jurisdictions have you
4 gone and provided I guess either assisted in developing the
5 program or got DREs up and running?
6 A Well during the years from 1987 throughout my time,
7 the National Highway Traffic Safety Administration and IACP
8 would look to new states to develop their own programs.
9 And there were certain requirements that a state had
10 to have to be considered to be a DRE state.
11 One of those was they had the legislation permitting
12 to test. One is that they have the sufficient number of
13 officers trained in standardized field sobriety testing to
14 both pull candidates to DRE from as well as officers who on
15 patrol could at least have an initial recognition that someone
16 is under the influence of something other than alcohol.
17 There has to be support among the State's attorneys
18 as well as the health department or some other agency to do
19 these chemical testing. So, I was on a team that went to a
20 number of states to do that.
21 I also was tasked with going to states to actually
22 do classroom and field certification training. Indiana,
23 Illinois, Arizona, Virginia, I even went to Los Angeles to
24 keep my skills proficient in teaching to teach with the LAPD
25 and the California Highway Patrol.

1 I also provided over the years seminars to recertify
2 DREs in Arkansas, Missouri, Kansas and a number of other
3 states.
4 I also was asked to present Grand Rounds at Shock
5 Trauma at the University of Maryland.
6 Dr. Carl --- was the Chief of Physician Education
7 who I collaborated with in the DRE program in Maryland and he
8 gave me a lot of advice.
9 In fact, he was part of that joint legislative task
10 force in the Governor's Executive Committee.
11 He asked me to come to Grand Rounds, which is all
12 the physicians at shock trauma, the nursing staff and make a
13 presentation on how to recognize the effects of impairment
14 that we use in the DRE program that was unprecedented at that
15 point.
16 Q And as far as Maryland goes, Maryland specifically,
17 you say you followed all the NHTSA guidelines and all the
18 guidelines that were originally created, plus you added some
19 more --
20 A We did.
21 Q -- were those guidelines and regulations also
22 followed as far as -- the best you can tell when you went to
23 these other states to make a presentation in an attempt to get
24 their programs up and running?
25 A To the best of knowledge they were. At least while

1 I was there, I didn't see any discrepancies. And that
2 continued in Maryland even after I left my state coordinator's
3 post because the Sergeant and Lieutenant Woodward certainly
4 continued the IACP standards.
5 I understand at some point that they did start using
6 12 evaluations and three categories of drugs, which meets the
7 IACP guidelines.
8 But consistently all through the history of DRE in
9 Maryland the standard set by NHTSA and IACP have been met or
10 exceeded.
11 MR. DAGGETT: Court's indulgence, please?
12 (Pause.)
13 BY MR. DAGGETT:
14 Q Mr. Tower, is there any -- as far as the protocols
15 themselves, you are familiar with the protocols?
16 A Yes, sir.
17 Q We have all heard and I think even you mentioned the
18 12 steps. We have heard ad nauseam I guess talk about the 12
19 steps as far as -- I guess there are different types of 12
20 steps. We are talking about the 12-step DRE evaluation,
21 obviously.
22 Is the 12 steps that you taught the same -- are they
23 the nationally accepted, the same 12 steps that are taught in
24 these other states?
25 A Yes. Essentially, they have remained the same

1 throughout the history of the DRE program since NHTSA and IACP
2 began their certification.
3 There have been some minor adjustments in pupil size
4 measurement. I understand there have been some minor changes
5 in the range of pupil size for a normal person under different
6 lighting conditions. But essentially the 12 steps have
7 remained the same.
8 Q When you were creating or helping, assisting in
9 creating the standardized program, the 12 different steps, I
10 guess, the -- you went through all those -- you received all
11 the training, is that correct?
12 A Yes.
13 Q Is there anything that -- strike that. The 12 steps
14 that are a part of the evaluation, the BAC, the interview of
15 the arresting officer, the preliminary examination of the
16 suspect, the eye examination, the psychophysical test, the
17 vital sign examinations regarding blood pressure, temperature,
18 let's talk about that if we could. The vital sign
19 examination, to what degree was that taught at the classes
20 that you gave?
21 A That was taught pretty much as it is today. And we
22 had either doctors or nurses conduct that portion of the
23 training.
24 And we had practical exercises in taking pulse and
25 blood pressure under their supervision.

1 Q The darkroom examinations, can you explain what that
2 is?
3 A Yes. We take a suspect, an arrestee, into a room
4 that can be completely darkened. And the reason for that is
5 we are looking primarily at the pupils of the eyes because we
6 learned in our training that the pupils of the eyes can be
7 affected in different ways by different drugs.
8 We know that the pupil of the eyes in a normal
9 person will constrict in bright light, such as if I was
10 looking up into the light above me, or in darkness will dilate
11 or expand.
12 And that helps a person see in either light or
13 darkness. It protects the eyes as well. But when certain
14 drugs are involved and causing impairment, some --
15 MR. DeLEONARDO: Objection. We are getting into --
16 he is reaching a conclusion as to what will happen in certain
17 drugs and, again, I believe that has been covered.
18 MR. WELLS: Your Honor, with regards to that, he has
19 been admitted as a DRE and it is exactly what the DREs do.
20 So, per his training, knowledge and experience, it is exactly
21 what he is being called to be able to testify to.
22 That is exactly why we are here because their
23 experts have --
24 THE COURT: Let's approach.
25 (Whereupon, a Bench Conference followed.)

1 THE COURT: I think the defense concern is that what
2 this is going to -- what is going to happen is that this
3 witness is testifying he is going to lead into areas that he
4 is not really qualified to talk about.
5 We had all this testimony about eye exams from
6 doctors from Hopkins. I mean I don't think he is qualified
7 to -- I mean he may be qualified to say this is the reason we
8 do this training.
9 But if he starts and I am not just talking about
10 this darkroom exam, but if he starts rendering opinions
11 regarding the effects of substances from a physiological
12 standpoint, I am going to sustain objection.
13 He can say, you know, what the curriculum is and how
14 they train but once he starts saying well, you know, I think
15 you can -- based upon a certain substance that it is going to
16 create a certain reaction, I think that is out of his areas of
17 expertise --
18 MR. DAGGETT: I don't think that is really -- I mean
19 that is not where I was planning on going with it. I mean I
20 asked the question -- I think we are all in agreement that
21 there is debate about that.
22 So, I mean, I wasn't asking him to testify as an
23 expert that this particular drug causes this and I think that
24 we all are in agreement that certain drugs, whatever they
25 might be, have certain effects.

1 I mean that is pretty much the extent of what I
2 was -- where we were going. I wasn't going to say that --
3 have him say that this particular -- you know, one particular
4 drug causes this, this and this.
5 I mean I would agree that is probably -- that is
6 something for the Court to ultimately determine as to whether
7 they --
8 THE COURT: Well, the things is, I mean, I don't
9 want to unduly restrict the witness. But when he is talking
10 about things like training and the protocol and if he says,
11 well, you know this particular part of the protocol is
12 designed because we believe that there are certain things that
13 can be ascertained.
14 But once he starts -- I mean, want you to remember
15 that when we were here before and we had these medical people
16 and other people testifying, I mean he wouldn't have been able
17 to testify with regard to pharmacology --
18 MR. DAGGETT: Sure.
19 THE COURT: -- or --
20 MR. DAGGETT: And I agree a hundred percent with
21 what everything has been said. That is not really where I was
22 going with him. It is really more just talk about the
23 individual components.
24 THE COURT: Well, I think, obviously, we are trying
25 to preserve a record and I know the defense is sensitive to

1 him saying something that goes beyond what he is really
2 qualified to say.
3 MR. DAGGETT: Okay. And I will make sure that --
4 MR. DeLEONARDO: The other point is I don't know if
5 you plan to go into protocol but I know you had Morrison I
6 wasn't going to go through all the 12 steps but I think the
7 more we get into it I am going to have to with both witnesses.
8 So, I wasn't really going to go through all the 12 steps with
9 him, you know, but since you are going to call Morrison.
10 MR. DAGGETT: But I am not talking about -- I am not
11 going through the 12 steps in ---. I am just trying to
12 explain what they are. I am just getting them out and we are
13 almost done to be perfectly honest. I don't have a whole lot
14 more questions.
15 MR. DeLEONARDO: And I will just add I didn't want
16 to necessarily have to go through it twice because I knew had
17 Morrison as your --
18 MR. DAGGETT: Yes, that is right. Sure. We are
19 almost done.
20 (Whereupon, the Bench Conference was concluded.)
21 BY MR. DAGGETT:
22 Q Mr. Tower, I think the defense objection was geared
23 on the fact that they didn't want you testifying to what a
24 specific result of ingestion of certain drugs cause. And I
25 agree. That is not why -- obviously, that is not why you are

1 here.

2 I am just talking about as far as the darkroom

3 examination you were talking about the effect that certain

4 drugs have on pupil size but not specific -- you are not

5 getting into specifics.

6 A Very well.

7 Q But that is the basic idea of it?

8 A In the darkroom we check the pupil size under

9 different lighting conditions and check to see if there is a

10 difference in what we would consider normal.

11 Q And who is assisting you or who assist the students

12 in that particular component of the 12 steps?

13 A Well in the training, the student in every step is

14 supervised by a DRE instructor. And in the darkroom, we also

15 check for signs of ingestion in the mouth and the nose.

16 Q And we do have, I guess Officer Morrison will also

17 go through those further. Now, as far as the statements, the

18 part about suspect statements and observations, what does that

19 consist of?

20 A Well, that's near the end of the steps of the

21 evaluation. In fact, I think it might be step number 10. At

22 this point, the DRE has started to form an opinion based on

23 the observations that he or she has made in the previous

24 steps.

25 Whether it be in the darkroom, the psychophysical

1 test, the vital signs of the pulse and the blood pressure,
2 body temperature, evidence from the arresting officer, the
3 results of the breath alcohol test, statements made by the
4 arrestee initially in the preliminary examination, at this
5 point, the DRE knows what that person is under the influence
6 of.
7 And, of course, Miranda has already been given prior
8 to the evaluation at the beginning. But they ask the arrestee
9 at what time did you use certain drugs because they are
10 confident at that point based on everything that they have
11 seen --
12 Q So, they would mention the particular -- if they
13 believed that the person was under the influence of cocaine,
14 they would say when was the last time you used cocaine? Is
15 that --
16 A Well, a stimulant drug if --
17 Q Okay, all right.
18 A -- a person has said early on that they may have
19 used cocaine. And asked them when did you use the cocaine?
20 Q Okay.
21 A And frequently, arrestees make statements at this
22 point. And all of that is used to corroborate the opinion
23 that the officer is making or bolster that opinion. And
24 following that, then the opinion is, in fact, concluded and if
25 possible, a toxicological test is requested.

1 Q Mr. Wells I believe has a couple of questions he
2 might have for you.
3 A Yes, sir.
4 MR. WELLS: ---.
5 BY MR. WELLS:
6 Q Mr. Tower, you spoke -- and in all of your
7 experience you are aware of the number of states that utilizes
8 the DRE protocol, are you?
9 A Yes, I believe it is up to 47 now.
10 Q Okay, 47. Now, do you know if the protocol is just
11 used nationally or if it is used internationally as well?
12 A It actually is used internationally. Training has
13 been conducted in I believe Germany and France and a number of
14 European countries.
15 BY MR. DAGGETT:
16 Q And for the last 10 years, I think you said that you
17 stepped down, I believe in 2000 when Lieutenant Woodward
18 succeeded you. For the last 10 years, you have been working
19 for the -- is it law enforcement liaison?
20 A I actually, retired from the State Police. I had
21 been commander at the Rockville Barrack from 2000 to 2003. I
22 then retired in late 2003. During that time, I was also
23 working as a reporter for WBAL Television as an expert in
24 traffic and law enforcement issues.
25 I was then hired by the National Highway Traffic

1 Safety Administration in October of 2003 to be their law
2 enforcement liaison.
3 Q And you said you have kept involved in the DRE
4 program. To what extent since ’03 to -- we are now up to --
5 in the last seven/eight years?
6 A Well, I have monitored curriculum changes. I attend
7 the national DRE conference every year. I also drop in on DRE
8 classes and usually speak about the history of DRE to the
9 students.
10 I’ve been involved in developing a DRE program in
11 Delaware, Pennsylvania and Kentucky. And I’ve tried to keep
12 up on any developments in DRE.
13 I am an active member of the IACP DRE section. In
14 fact, I was general chair of that section back in around
15 2000/2001. But I’ve maintained my membership and continued to
16 be involved as possible.
17 Q So it has been in last eight years that you
18 developed the program in Delaware, Pennsylvania and Kentucky?
19 A Yes.
20 Q Any other states in that period of time I guess in
21 the last eight years?
22 A No. Those states were all within our regent and
23 that’s primarily who I work with.
24 Q So, in the last eight years since you have been
25 working as a law enforcement liaison attending all these

1 conferences and the trainings and that type of thing, from
2 what you have been able to determine, is the DRE program or
3 protocol still -- does it still consist of the same components
4 that you created or helped create back in the mid '80s?
5 A It does. In fact, working in those three of our
6 states that I mentioned, one of the important things for me to
7 do is to ensure that that state could, in fact, support a DRE
8 program and that their coordinator can continued to follow the
9 same protocols, the same standardization as set by IACP.
10 And I monitored the DRE program in all the states
11 that have them.
12 Q And they are all consistent with your original goals
13 and --
14 A Yes.
15 Q -- objectives and ---?
16 A Yes. They followed the IACP rules and objectives as
17 required.
18 Q Thank you, sir, I have no further questions. They
19 probably have some questions for you over here.
20 MR. DeLEONARDO: We do.
21 THE COURT: Cross?
22 CROSS-EXAMINATION
23 BY MR. DeLEONARDO:
24 Q Good morning, sir. All right, we will start with
25 you said you were still a very active member of IACP, correct?

1 A Yes.
2 Q And that is the International Association of Chiefs
3 of Police, right?
4 A Yes.
5 Q And they are the ones that are essentially charged
6 with any changes, administering the program, certifying -- I
7 mean that would exclusively be their domain now, correct?
8 A That is correct.
9 Q I mean NHTSA's only role is basically to fund. I
10 mean they provide funds to help IACP to do what it wants to do
11 but IACP decides what to do, correct?
12 A That's correct.
13 Q And the International Association of Chiefs of
14 Police is to be a member is exclusively limited to law
15 enforcement, is that correct?
16 A No, you an be an associate member and still be a
17 member of IACP. You don't have to be in law enforcement. If
18 you are in some related field and there are thousands of
19 members who work for companies that support law enforcement
20 programs, produce products used by law enforcement, so you can
21 be an associate member.
22 Q Right. So, to be an active voting member, you have
23 to be a law enforcement agent, correct?
24 A That's correct or retired.
25 Q Right. To be an associate, essentially, it is

1 police officers employed by agencies below the rank of
2 lieutenant, correct?
3 A That's correct.
4 Q And basically if you are superintendent of prisons
5 or involved in prison type of atmosphere, you can be an
6 associate member?
7 A I believe you could be an active member if, in fact,
8 you are a uniform correctional officer that's permitted to
9 carry a firearm.
10 MR. DeLEONARDO: I guess this would be defense
11 Exhibit 20, Your Honor?
12 THE CLERK: Yes.
13 THE COURT: Defendant's Exhibit --
14 THE CLERK: 20.
15 THE COURT: -- 20?
16 THE CLERK: Yes, sir.
17 (The document referred to was
18 marked for identification as
19 Defendant's Exhibit 20.)
20 BY MR. DeLEONARDO:
21 Q I am going to show you what has been marked as
22 defense Exhibit No. 20 for identification and have you seen
23 this before?
24 A This appears to be an IACP membership application.
25 I don't see a date on it.

1 Q But it is familiar --
2 A But generally --
3 Q Have you been to the Website?
4 A I believe so. It looks like one.
5 Q Okay, all right. And on the right-hand side it
6 indicates who can be members and who cannot, correct?
7 A Yes, it designates between active and associate
8 membership.
9 Q Okay. And without going through active, active
10 membership is going to be primarily your active or retired law
11 enforcement, is that correct?
12 A I believe so.
13 Q You can certainly take time to look at it.
14 A Okay. Yes, active membership, commissioners,
15 superintendents, sheriffs, chiefs, directors, commanders,
16 generally the rank of lieutenant and above is classified as an
17 active membership.
18 Private colleges, officers, commanding divisions,
19 district bureaus and the department. Command must be
20 specified on the application.
21 Chief executive officers, railroad police, railroad
22 systems, company police systems.
23 Q So, it involves those acting in a governmental law
24 enforcement capacity in different ways?
25 A Generally, yes, sir.

1 Q Okay. Now for associate membership, it involves
2 officers below certain ranks, is that right?
3 A It says, police officers employed by police agencies
4 below the rank of lieutenant.
5 Q And who else?
6 A Superintendents, other executive officers or
7 prisons. Chief executives, departmental officers, technical
8 assistants, city, county, state, provincial, national
9 agencies, technically responsible for police related
10 activities.
11 Prosecuting attorneys, deputies, professors,
12 technical staffs of colleges, universities involved in
13 teaching research of criminal law.
14 Staffs of crime institutes, chief executives of
15 industrial ---, securities, police agencies.
16 Employees of companies providing services to law
17 enforcement.
18 Q Okay. So, all of the areas, save the prosecuting
19 attorneys, are all individuals who in some capacity support
20 law enforcement or are involved in law enforcement related
21 activities?
22 A Yes. To my knowledge that is true.
23 Q Right. So to be whether it is active membership or
24 associate membership, you actually cannot be, for example,
25 defense attorneys, right?

1 A Unless you are involved in law enforcement in some
2 way.
3 Q Right.
4 A I don’t see that on here.
5 Q Okay, fair enough. And I assume it doesn’t involve
6 medical personnel unless they are serving the needs of law
7 enforcement, correct?
8 A If they are serving the needs of law enforcement, I
9 believe they can be.
10 Q All right, okay. So, when we look at as far as
11 this, as far as if I can step back a little bit, when you look
12 at whoever sees this, IACP, as I think as you indicated has
13 been overseeing the DRE protocol since 1992, is that correct?
14 A I believe they actually started in 1990. They first
15 started issuing certificates in ’90 and ’91. In fact, when I
16 got mine, it was 1991.
17 Q I am not going to split hairs with you, ‘91/’92 that
18 is fine. If, in fact, it is not under IACP, IACP is run by
19 certain executive officers, correct? In other words, there is
20 a president?
21 A Yes, there is an administrative staff as well as a
22 president, first, second, third, fourth, vice presidents who
23 are all active law enforcement.
24 Q Right.
25 A But there is also a CEO or a director and a civilian

1 staff that runs the company as it is.

2 Q But all of it is under the auspices of the president

3 and executive officers who are all law enforcement, right?

4 A Yes, they are all chiefs or sheriffs or high ranking

5 officials.

6 Q Now, in moving towards the DRE committee, you have

7 another level which is called IACP Highway Safety Committee,

8 correct?

9 A Correct.

10 Q And that committee is charged with developing

11 proactive strategies to promote and enhance traffic safety

12 management and et cetera, correct?

13 A Generally, that's true.

14 Q And the members of that, who are the members of that

15 committee?

16 A many of those are chiefs, superintendents of state

17 police and other law enforcement officials. And under them,

18 is what's called the Technical Advisory Panel, the TAP

19 Committee if you will.

20 Q Okay. And I will get to that next. But let me ask

21 you first, the Highway Safety Committee is comprised

22 exclusively of law enforcement, active law enforcement, right?

23 A I believe so, although there are several NHTSA

24 personnel, high ranking NHTSA folks from our headquarters in

25 DC that are also members as I recall.

1 Q Okay.

2 A So they would be associate IACP members, possibly.

3 Q There is no medical personnel involved with that, is
4 that correct?

5 A On the Highway Safety Committee, I am not sure
6 recently. On the TAP Committee there are.

7 THE CLERK: Defense No. 21.

8 MR. DeLEONARDO: Thank you.

9 (The document referred to was
10 marked for identification as
11 Defendant's Exhibit 21.)

12 BY MR. DeLEONARDO:

13 Q I am going to show you Exhibit, for identification,
14 No. 21. Can you identify -- you have seen the roster before
15 this put out by IACP, have you not?

16 A Yes. This is the -- appears to be the roster of the
17 Highway Safety Committee from IACP.

18 Q Okay. You can take a minute if you would to look
19 through it.

20 A Okay. (Looking through the roster.)

21 (Pause.)

22 BY MR. DeLEONARDO:

23 Q So, just to confirm there is no medical personnel
24 involved with that, is that correct?

25 A I don't see any listed here.

1 Q Okay. And all of those individuals are appointed
2 exclusively by the president, is that correct?
3 A I am not sure how they are appointed to this
4 committee. I know in some IACP committees, someone with a
5 particular interest in highway safety may ask to be on a
6 committee but the chairman, I think, essentially makes that
7 decision and that's Mr. -- that's Commissioner Sweeney from
8 New Hampshire.
9 Q You sure about that?
10 A Not exactly sure.
11 Q Okay.
12 THE CLERK: Defendant's Exhibit No. 22.
13 (The document referred to was
14 marked for identification as
15 Defendant's Exhibit 22.)
16 BY MR. DeLEONARDO:
17 Q I am going to show you what is Exhibit No. 22. You
18 are familiar with the IACP Website, is that correct?
19 A Generally.
20 Q Okay.
21 A I haven't looked at the entire Website.
22 Q And there is a paragraph that speaks about the
23 Highway Safety Committee and how it is comprised and who
24 appoints it. Can you take a look at that and see if that
25 refreshes your memory.

1 A Generally, yes.
2 Q Okay. So, it is comprised of 30 members of whether
3 it is federal, state, municipal, county law enforcement, is
4 that correct?
5 A As well as criminal justice institutes.
6 Q Right.
7 A Yes.
8 Q Okay. And those are all appointed by the president
9 for a three-year term?
10 A Yes. That's what it says.
11 Q Now under the National Highway Safety Commission,
12 you had briefly mentioned TAP. Can you tell us what TAP
13 stands for?
14 A The National Highway Safety Commission I am not sure
15 what that is.
16 Q I am sorry?
17 A You said National Highway Safety Commission.
18 Q Oh, I am sorry. I meant IACP.
19 A Okay.
20 Q The Technical Advisory Panel can you tell us what
21 that does? First of all, what does it stand for, TAP?
22 A Technical Advisory Panel.
23 Q And they make recommendations or changes to the
24 Highway Safety Committee that we just discussed, correct?
25 A That is correct.

1 Q And the Highway Safety Committee decides whether or
2 not to accept those changes?
3 A I believe that is correct.
4 Q All right. So, when it comes to the Technical
5 Advisory Panel, you were involved with that previously, is
6 that correct?
7 A I have been. I have attended many meetings over the
8 years. I've made comments on a number of issues over the
9 years. Especially, most recently, when Pennsylvania and
10 Delaware and Kentucky were up for DRE status, I made
11 presentations on their behalf.
12 Q Okay. So, the Chair of the Technical Advisory
13 Committee is also the Chair of the Highway Safety Committee,
14 is that correct?
15 A Currently, that's true. It's Commissioner Sweeney.
16 Q Right. And Commissioner Sweeney is the one who
17 makes all the appointments to the Technical Advisory Panel?
18 A I believe that's true. It doesn't say specifically
19 and in anything that I've seen and you may have it there, but
20 I believe that to be true.
21 Q Would you like to review it?
22 A Sure.
23 Q To refresh your memory?
24 (Pause.)
25 A (Reading.) The Chair makes all the appointments.

1 Q And save a few members at large, there are generally
2 three-year appointments as well, is that correct?
3 A (Reading.) I don't believe that TAP is exclusively
4 three years because it indicates here --
5 Q There are two positions on a one year, correct?
6 A Yes. The Chair of the DRE section and the State
7 Highway Safety Office Representative is one year. I don't see
8 a three-year appointment listed here. It does say three years
9 on the Highway Safety Committee document that you gave me.
10 But I don't see three years here. And that may very well be
11 the case. I just don't see it.
12 Q Now as far as the composition of this panel and this
13 is the panel that oversees the DRE program, correct?
14 A Yes, sir.
15 Q The composition of this panel, you have that
16 document that I gave you in front as well but let me step
17 through.
18 It is comprised through -- as we already established
19 the Chair of the Highway Safety Committee, correct?
20 A Correct.
21 Q The IACP program manager, correct?
22 A Yes, it says three IACP staff members who oversee
23 the DRE programs implementation, expansion and credentialing
24 process.
25 Q There is four drug recognition expert regional

1 representatives, correct?
2 A Correct.
3 Q There is a representative of police officers
4 standards and trainings?
5 A Correct.
6 Q There is one member of the medical field, correct?
7 A Here it says two.
8 Q I agree. Currently, it is one, however, is that
9 right?
10 A Actually, currently, it’s two. They just at the
11 last meeting, I believe, appointed a new physician to fill
12 Dr. Phillips medical doctor position who passed away suddenly.
13 Q Okay.
14 A And I believe it’s the new medical director for the
15 Maryland State Police.
16 Q Okay. Let me finish what I am doing and I will come
17 to that. There is a NHTSA staff person, right?
18 A Yes, sir.
19 Q A representative of police training academy?
20 A Yes, sir.
21 Q Prosecutor?
22 A Yes, sir.
23 Q A state DRE coordinator?
24 A Yes, sir.
25 Q Toxicologist?

1 A Yes, sir.

2 Q Police administrator?

3 A Yes, sir.

4 Q Governor Highway Safety Representative?

5 A Yes.

6 Q And there is two at-large, one of whom is the Chair
7 of the DRE section, right?

8 A That's what it says here.

9 Q And then there is one international at-large member,
10 is that in your list?

11 A I don't see that.

12 Q That second medical position replacement is
13 international wasn't it?

14 A No, there's still two medicals.

15 Q Okay.

16 A There's an optometrist and an MD.

17 Q Okay.

18 A And I attended the last TAP meeting, that's how I
19 know that.

20 THE CLERK: Defense Exhibit No. 23.

21 (The document referred to was
22 marked for identification as
23 Defendant's Exhibit 23.)

24 BY MR. DeLEONARDO:

25 Q On the last Technical Advisory Panel that we do have

1 is comprised -- can you take a look at that?
2 A Yes, sir.
3 Q And how many individuals on that are -- that is
4 updated as of '09, correct?
5 A May 1st, 2009.
6 Q Okay. And can you take a look at that and see many
7 medical personnel are involved?
8 A On this list Dr. Jack Richmond, an optometrist, I
9 believe is the only one listed. And I think that's because
10 Dr. Phillips had passed away shortly before that meeting.
11 Q So, that is how Dr. Richmond got on the Board?
12 A No, Dr. Richmond, I believe, has been there for some
13 time.
14 Q How long has he been in that position?
15 A I don't recall.
16 Q As long as you can remember?
17 A He's been there for quite sometime and I don't
18 remember exactly how long.
19 MR. WELLS: Your Honor, at this time, I am going to
20 object to the line of questioning. Where is this going?
21 THE COURT: I don't know.
22 MR. DeLEONARDO: I would like to have a chance to
23 get there.
24 THE COURT: What?
25 MR. DeLEONARDO: I would like to have a chance to

1 get there.
2 THE COURT: All right. We will see where it goes.
3 BY MR. DeLEONARDO:
4 Q So on that indicates -- can you see also the terms
5 as well?
6 A I see a date beside their name and I am not sure if
7 that's the expiration of their term or when it begins. I
8 don't know what that means.
9 Q Okay. Well, let me show you defense Exhibit No. 24.
10 And this is the Tap Panel as of October of '05, correct.
11 A Okay.
12 (The document referred to was
13 marked for identification as
14 Defendant's Exhibit 24.)
15 BY MR. DeLEONARDO:
16 Q How many medical personnel are on there?
17 A It appears that Dr. Richmond is the only one on this
18 particular list.
19 Q The optometrist?
20 A Yes.
21 Q Okay.
22 A I believe shortly after that, Dr. Phillip was added
23 in between 2005 and 2009.
24 Q But he wasn't on the 2009 list?
25 A He's not on the list, no.

1 Q Okay. Well, he certainly would be on the 2010 list,
2 correct?
3 A No, he's deceased.
4 Q Well technically, he got replaced. You said he was
5 on their previously.
6 A He was replaced, yes.
7 Q I show you defense Exhibit No. 25?
8 A Okay.
9 (The document referred to was
10 marked for identification as
11 Defendant's Exhibit No. 25.)
12 BY MR. DeLEONARDO:
13 Q That the roster for Technical Advisory Panel?
14 A He wouldn't be on this list because the meeting
15 didn't occur --
16 Q I am not asking --
17 A -- until October or November.
18 Q Is he on that -- take a look at that? How many
19 medical --
20 MR. DAGGETT: Your Honor, I am going to object. If
21 he wants to -- if Mr. DeLeonardo wants to proffer to the
22 Court, maybe we can speed this up. If he wants to proffer to
23 the Court where he is going with this, perhaps Mr. Tower might
24 agree with him a hundred percent.
25 I mean we are dancing around here on things that are

1 just so far afield. We will be here all day.
2 MR. DeLEONARDO: Well, he has so far told me that
3 there are two medical people involved and for the last seven
4 years there is not. So, I'm just trying to figure out -- I am
5 trying to establish what his understanding of the TAP
6 Committee is. How many medical personnel are on there.
7 THE COURT: All right. I will overrule.
8 THE WITNESS: Currently, there are two. And, at
9 times, there have been two. There has always been a place but
10 we initially found Dr. Phillips who I knew personally being
11 involved in the DRE program with the Maryland State Police.
12 In fact, he taught some of the courses and session
13 in the course. Unfortunately, after he passed away, there was
14 a time period where we were looking for another physician and
15 it turned out we found a new doctor to take his place.
16 And he was at the meeting, at the most recent IACP
17 conference where TAP meets. So, currently, there are two.
18 BY MR. DeLEONARDO:
19 Q But of course this list is generally updated in
20 March to May of each year, is that correct?
21 A Well, March, May, October I guess it's updated --
22 Q Comes out periodically?
23 A -- whenever changes are made.
24 Q Okay. Now, as far as when you look at the -- you
25 say you were involved at Technical Advisory Panel prior to

1 that, correct?

2 A Yes. I've attended meetings over the years.

3 Q And you have been involved in making any requested

4 revisions, right?

5 A I've commented on revisions from time to time. And

6 as I testified earlier, I've -- when a new state is being

7 considered for DRE status, I've made presentations on their

8 behalf.

9 Q But as far as changes to the protocol or the

10 information contained within the manual, I think you indicated

11 it has changed very little since you originally created it, is

12 that right?

13 A The basic steps, the seven categories of drugs

14 generally are the same. Drugs have been added or taken away,

15 I understand, from the seven categories. There have been some

16 minor adjustments, I understand, in pupil size of normal and

17 ranges.

18 Q When was that done?

19 A I don't recall exactly.

20 Q Is there is anything else that have been changed

21 regarding the vital signs?

22 A There may be, I am just not aware of it.

23 Q As far as you then said, -- okay, we have the

24 Technical Advisory Panel, below that is the drug recognition

25 committee, right?

1 A It's called the Drug Recognition Expert Section.
2 Q Section. All right. And there's generally four
3 officers that are all active law enforcement, correct?
4 A There are four overseeing officers, yes.
5 Q Okay. Now, as far as the Technical Advisory Panel,
6 and the DRE committee, one of their main goals is to promote
7 their program being used in as many places as possible,
8 correct?
9 A That's one of the goals, yes.
10 Q And the IACP will even provide technical assistance,
11 I think it's called, which in the way of testimony and experts
12 to come in and testify, correct?
13 A That's correct. And NHTSA does have a funding
14 source provided to IACP to pay travel and expenses for
15 witnesses to come to trials.
16 Q Like for these hearings. IACP will pay to bring the
17 witnesses to come in and testify in support of the program,
18 correct?
19 A Yes, sir, that is correct.
20 Q All right. Now, you were contacted at some point to
21 be a witness in this case, correct?
22 A Yes.
23 Q Were you contacted by the prosecution or IACP?
24 A I was contacted by the prosecution.
25 Q All right. And when that occurred, when you get

1 involved or I guess you are involved with something like this,
2 did you -- were you ever provided any assistance on any other
3 physicians that could be used. You indicated that you did
4 Ground Rounds at Shock Trauma, right?
5 A Uh-huh.
6 Q And you say there is a physician that is involved in
7 TAP now that is not listed, right?
8 A Yes. I just met him for the first time.
9 Q Did you offer any of that as someone who could come
10 in and corroborate the program?
11 A I don't recall that I did because this process, this
12 Frye Hearing, started before he was made a member of the TAP
13 Committee.
14 Q Well, I mean there are physicians that you dealt
15 with you said for years on this, correct?
16 A That's true.
17 Q Now, Dr. Zuk, you know Dr. Zuk, correct?
18 A I do.
19 Q And you know him essentially from testifying?
20 A I know him through DRE training in Los Angeles.
21 Q So, he was involved back then. That was the
22 physician you refer to was teaching you?
23 A No, no. The primary physicians that taught me were
24 Dr. Forest Tennant who was a leading expert in treating drug
25 rehabilitation and he had a series of clinics around the

1 southern California area.
2 He was a consulting physician for the California
3 Highway Patrol. Also a consulting physician for a number of
4 national sports. I believe it was the NBA or the NFL one of
5 the two.
6 Also the primary physician for the LAPD at Parker
7 Center a Dr. Moody was involved in the initial training.
8 In LAPD, they have a process where at Central
9 Booking where all of the arrestees are brought in, if there is
10 a suspicion of an overdose of some drug or a medical
11 condition, they have a medical staff right there, all the
12 time, 24 hours a day.
13 Q And as we heard from Dr. Zuk that is what he did.
14 Right?
15 A That may very well be.
16 Q Okay. Well, let's move to how the program was
17 created. You -- and I am not asking you to comment, I just
18 want to make it clear this is not a question about commenting
19 on the validity of the studies, but I am asking is timeline,
20 okay? When you initially got involved in taking the training,
21 it was in 1986, correct?
22 A That is correct.
23 Q And the actual program that all of you got together
24 to create, it wasn't even a standardized program until 1987,
25 correct?

1 A It wasn't a NHTSA IACP standardized program. There
2 were two programs functioning at the LAPD and the CHP prior to
3 that.
4 Q But the program in its current form was only created
5 in 1987, correct?
6 A It was very similar to that which was being utilized
7 in the late '70s and early '80s.
8 Q Well I think you told me earlier that you took the
9 best parts of different programs and tried to put them
10 together, right?
11 A That's correct. And primarily --
12 Q And you tried to create it to be standardized?
13 A What we tried to do was put it in a format that
14 students could easily learn from. And to give you an example,
15 in the LAPD, they had certain officers and experts, where
16 there were nurses or physician, would come in and teach
17 certain blocks of instructions because they personally had a
18 field of expertise.
19 Q Right.
20 A They were the best ones to teach that. What we
21 wanted to do was develop a program that a qualified DRE
22 instructor, regardless if they were a subject matter expert or
23 not, could present that particular session and do it
24 effectively.
25 Q Right. So, again, back to my question. So, in 1987

1 is when the program that you created that is in its
2 substantial form today, that is when it was put together,
3 right?
4 A That’s correct.
5 Q And that was after -- you know the Bigelow study, by
6 referring to the Bigelow study, the Hopkins study from 1985?
7 A Generally, yes.
8 Q Okay. And you know there was a LA Field study that
9 was in 1986, correct?
10 A I believe one was in ’84 and one was ’85 but in the
11 mid ‘80s.
12 Q In that range, okay. So, your work in creating the
13 standardized process was after that, correct?
14 A That’s correct.
15 Q So those studies didn’t have -- those studies were
16 not testing what you put together, they were testing whatever
17 existed prior, is that fair to say?
18 A Yes, sir.
19 Q All right. Now, one of the reasons and you sort of
20 alluded to it -- one of the reasons initially that these LA
21 officers you talked about Studdard and Leeds, right, were the
22 two main ones?
23 A Yes.
24 Q Studdard was a traffic officer, correct?
25 A He was.

1 Q And Leeds was a narcotic officer, correct?
2 A That's correct.
3 Q And the two of them found that they couldn't get
4 physicians to render opinions on someone being drug impaired.
5 Either they were unwilling or unable to do it, is what they
6 say, correct?
7 A I'm not certain of that.
8 Q Well, you are familiar with the statements on the
9 history in the manual, are you not?
10 A That's correct. I know that Sergeant Studdard and
11 Sergeant Leeds worked with physicians and other medical
12 community personnel, some scientific research personnel, a
13 Dr. Marcy Burns from Southern California Research Institute
14 and other health professionals to take what they were seeing
15 on the street, simple observations and simple techniques and
16 put together a series of these techniques that ultimately at
17 the end of that they could form an opinion that someone, in
18 fact, was under the influence of a certain category or
19 categories of drugs.
20 Q Okay, so back to my question. The reason they did
21 that is because doctors were not willing to do it the way that
22 they wanted it done, is that correct?
23 A I'm not sure I understand or agree with what you are
24 trying to say here.
25 Q You are familiar with the current 2010 student

1 manual, is that correct?

2 A I don't believe I've seen it, not in its most recent

3 form.

4 Q Well, I am going to show you what was previously

5 admitted as Defendant's Exhibit No. 5. And there is a

6 section, which is session 3 on page 3 that discusses the

7 origin and the evolution of the program, correct?

8 A Yes, it does.

9 Q Did you write that section?

10 A I don't believe I did.

11 Q I assume it is substantially the same as when it was

12 written?

13 A (Reading.) It appears to be substantially from the

14 first version that I saw.

15 Q And so let me ask if you agree with this that

16 occasionally officers succeeded in having physicians examine a

17 low BAC subject sometimes resulting in medical diagnosis of

18 drug influence.

19 The medical personnel typically received little or

20 no training and their recognition of specific signs of drug

21 impairment particularly street level dosage.

22 Therefore, they often were unable or reluctant to

23 offer a judgment about subject's condition. Is that correct?

24 A It does say that, yes.

25 Q And then in the next paragraph, it talks about Dick

1 Studdard and Len Leeds, correct?
2 A Yes.
3 Q And how they then set out to do their own
4 independent research, is that right, to create a program?
5 A By consulting with physicians.
6 Q Right, okay.
7 A So they apparently did.
8 Q So they consulted these physicians to come up with
9 this protocol, right?
10 A I believe that to be true, yes, sir.
11 Q And you went to LA in 1986 and you actually as you
12 indicated were one of the officers that were being trained in
13 this from NHTSA, right?
14 A That's correct.
15 Q It was you and two others, Jack Oates and there is a
16 William Nash?
17 A That is correct.
18 Q And when you went to this training that was held in
19 Los Angeles, at the time it was an 11-day long training?
20 A I don't recall exactly how long it was. I believe
21 the classroom portion was shorter than that.
22 Q Okay. You are familiar with Thomas Page?
23 A I am.
24 Q And, in fact, he was one of your instructors at the
25 time, correct?

1 A As I recall, he actually may have been a student at
2 the time and became one of the first instructors but that was
3 25 years ago, so, I'm not exactly sure. He certainly was one
4 of the first instructors in the pilot in 1987.
5 Q But at the time when you came out there, one of the
6 things that you did from that training, did you not, is that
7 you took the information that these officers had collected,
8 you took their lesson plans, their overheads, their handouts,
9 essentially took that material back to put into a standardized
10 form, correct?
11 A Yes, sir.
12 Q So, the information that you originally obtained was
13 from what the officers had compiled?
14 A That's right. What was presented to me both there
15 and at the California Highway Patrol, I took back to Oklahoma
16 City with Mr. Nash and Mr. Oates and we developed the
17 curriculum.
18 Q And neither one of those, whether it is Mr. Oates or
19 Mr. Nash had any experience in medical training, is that
20 correct?
21 A I don't know that they had. I know Mr. Oates has a
22 degree, a Ph.D. in some scientific area, but I don't know that
23 for certain.
24 Q Well, Mr. Oates implements grants for NHTSA?
25 A Oh, he does much more than that.

1 Q Well, sure. He is also the director for -- he does
2 aggressive driving symposiums, he takes grants for car seat
3 safety, right?
4 A No. Mr. Oates, throughout his career, he began with
5 IACP, that's when I first met him back in the early '80s. He
6 is a law enforcement trainer. He provides training in a
7 variety of fields. He is a specialist in training.
8 At NHTSA, he works at our headquarters currently and
9 he works in our regional operations --
10 Q Okay, I understand he is a specialist in training.
11 That wasn't my question. My question was he didn't have any
12 medical background? He wasn't a doctor?
13 A He wasn't a doctor.
14 Q He wasn't a pharmacologist?
15 A No.
16 Q He wasn't a toxicologist?
17 A No, sir.
18 Q And neither was Mr. Nash?
19 A That's correct.
20 Q And neither are you?
21 A No, sir.
22 Q And the three of you took the information you were
23 given from LAPD and you put that into this form, correct?
24 A Yes.
25 Q And there was no medical personnel involved with the

1 formation of this protocol, is that correct?
2 A No, there was.
3 Q Whatever was done by LA is what you are saying,
4 correct?
5 A There were physicians involved in LA prior to us
6 getting involved but afterwards, during the development of the
7 curriculum, we did call in some subject matter experts and
8 Dr. --- , from the Connecticut State Police, came into help us
9 look at some of the eye signs and some of the other technical
10 parts of the curriculum.
11 Q Anybody other than an optometrist?
12 A Not that I am aware of.
13 Q All right. Now you take this information and you
14 said -- I think you said it is currently composed, the
15 information is the same, right?
16 A The basic tenants. The basic procedures, the basic
17 categories are the same.
18 Q So, if it was -- I presume if it was wrong back
19 then, it would be wrong now, right?
20 A And that's considering if it was wrong.
21 Q Okay.
22 A I'm not saying that it was.
23 Q Well, let's just that for a hypothetical that a
24 Board Certified Physician says that your ranges on pupil size
25 are grossly wrong. Those are the same ones that have been

1 used, other than a minor change, you said, since you created
2 the program, correct?
3 A That’s correct.
4 Q Let’s say that Board Certified Physician say that
5 the ranges for blood pressure are incorrect for normal. You
6 simply took what you were given from the LA Police Department,
7 correct?
8 A And what they obtained from physicians.
9 Q You are assuming -- that is relying on what they
10 said, correct?
11 A Physicians were there in the class.
12 Q Okay. So, those physicians and you said they
13 indicated they were part of the ones that worked at the jail?
14 A No, Dr. Forest Tennant had nothing to do with the
15 jail facility at all. He was a well known physician and drug
16 expert in southern California.
17 Q Okay. So, he is the one who gave you the
18 information that was used for medical information?
19 A They both did.
20 Q All right.
21 A Personally. What came before that, I don’t know any
22 of their names but those two personally were involved in my
23 training.
24 Q But suffice it to say that whether there are doctors
25 in LA that were involved or whoever was involved, the

1 information -- you didn't go gather new information, you just
2 took what you had been given?
3 A That's correct, along with some supplemental
4 information from Dr. ---, who was at one time a member of the
5 TAP early on.
6 Q The optometrist you are referring to?
7 A Yes.
8 Q Okay. Now, let's talk about the training. You were
9 discussing the training regiment and I think you first said
10 that you have to go through standardized field sobriety test
11 and that you want to make sure someone -- I think your words
12 were, very proficient at doing that, correct?
13 A That's correct.
14 Q And you would agree with me, would you not that when
15 you go through the class, it takes a while to become
16 proficient at field sobriety tests even after the class,
17 correct?
18 A It takes continued practice, yes.
19 Q Right. I mean it is a lot of information to get in
20 three days when you haven't had exposure to this?
21 A Well, it's not a lot of information, it's more of
22 practicing the three tests.
23 Q Remembering all of the proper ways to give the
24 instructions and the way to ask people to stand, et cetera?
25 A Well, before they leave the class to successfully

1 complete it, they must have a proficiency test and a written
2 test.
3 So, when they leave, they've got the basic knowledge
4 in proficiency. It is just that after the class we strongly
5 urge them to continue practicing the tests.
6 Q But when you say very proficient, that certainly
7 would imply that they go out and practice for a while,
8 correct?
9 A Yes. In fact, to be considered for DRE, they are
10 going to take a proficiency test. We need to know that they
11 can administer the test properly.
12 Q How long do you think between taking the field
13 sobriety training and taking the preschool, how long should it
14 be?
15 A I would think six months to a year. It all depends
16 if the officer is one who is working DUI patrol frequently and
17 comes in contact and actually uses the SFSTs frequently, then,
18 obviously, they are going to develop and maintain their
19 proficiency much faster.
20 Q Now, are you aware of whether or not they are still
21 following -- IACP is still following your creation and
22 recommendation that you have to take field sobriety tests, go
23 out and be proficient, take the preschool, go out and be
24 proficient and then come back and take the seven-day?
25 A Well, I understand that there have been some changes

1 that in some cases and I don't know if this is the case in
2 Maryland, that the preschool and the seven-day school are
3 actually combined into nine consecutive days.
4 Q As a matter of fact they have even combined field
5 sobriety tests, preschool and seven-day school all in one now.
6 A I've heard that that may have happened. I don't
7 know where that is.
8 Q Now in each of the manuals -- the instructor
9 manuals, they put forth a schedule, correct, of how it is
10 supposed to be administered.
11 A I believe so.
12 Q Okay. I am going to show you what has been marked
13 as defense Exhibit No. 26. And that is the, is it not, the
14 schedule for how to conduct one that includes all three in one
15 shot, correct?
16 A It appears that it is.
17 (The document referred to was
18 marked for identification as
19 Defendant's Exhibit No. 26.)
20 BY MR. DeLEONARDO:
21 Q And it is a 10-day course that essentially covers
22 all of those areas all at once, right?
23 A It appears that it is.
24 Q But it is not consistent with what you recommended
25 as the best practice, however, is it?

1 A It's not what I utilized when I was the DRE
2 coordinator.
3 Q Now, as far as -- you went to great lengths to talk
4 about when you were in Los Angeles that you had medical
5 personnel teaching the course for you, correct?
6 A That's right.
7 Q But that is not a requirement, is it?
8 A No, it's not.
9 Q And, in fact, the program is set up so that it
10 actually is typically taught by police officers, correct?
11 A Generally, that's true.
12 Q Right. And as far as the seven-day school, first of
13 all the preschool, we talked about that that was a two-day
14 training, right, 16 hours?
15 A That's correct.
16 Q Is that fair to say it is sort of a quick overview
17 of the program?
18 A It's not really a quick overview. It's a general
19 overview and it gives the students a chance to learn several
20 of the new techniques and actually practice some of them in
21 the alcohol workshop.
22 Q And then go home with that knowledge. And study --
23 A That's correct.
24 Q -- and then come back for the DRE?
25 A And really the period of time between the preschool

1 and the seven-day school doesn't need to be of any significant
2 duration because after they leave the preschool, perhaps they
3 will have additional time to practice and study but that
4 doesn't prohibit it from being a very short period of time.
5 Q So, you are okay with IACP now allowing students to
6 come in and do all three at once?
7 A I'm not sure I agree with during SFST and
8 immediately followed by the preschool and the DRE school but
9 that's my opinion. I'm not representing NHTSA or IACP, that's
10 my personal opinion.
11 Q Because you wrote the book so to speak, literally?
12 A Originally, I did.
13 Q Now, as to the certification process -- well, first
14 of all, as to the seven-day school, they have to take a
15 proficiency exam, essentially score 80 percent to pass, right?
16 A Yes, sir.
17 Q And then as you discussed, there is a field
18 certification component to that, right?
19 A Yes, sir.
20 Q I think you said that -- and actually the
21 requirement is there has to be 12 evaluations but actually
22 only six of them have to be done by the actual student, right?
23 A That's correct.
24 Q So, we are only talking about the student having to
25 do six on their own, right?

1 A The basic requirements I understand now do say that,
2 yes.
3 Q Okay. And out of those, they only have to be
4 corroborated by 75 percent, right?
5 A I believe that's correct.
6 Q And corroborated means either by blood or urine,
7 right?
8 A Yes.
9 Q So, if they determine that someone was currently
10 under the influence of marijuana, they would rely on a urine
11 test to confirm that that was a valid assessment?
12 A That's correct.
13 Q All right. As far as -- and during that process,
14 they can interview the suspects, correct?
15 A During the DRE evaluation, yes.
16 Q Right, the field certification. They interview the
17 arresting officer, right?
18 A Yes.
19 Q So even with that --
20 A If it's a DUI arrest, during certification, the
21 officers may not always be available but every attempt is made
22 to get information from the arresting officer.
23 Typically, evaluation -- the field evaluations, the
24 certifications are done at a jail facility, a detention
25 facility.

1 These suspects or arrestees are brought in on any
2 type of charge. The fact that they are under arrest and they
3 are suspected of being under the influence is what's
4 important.
5 The DRE students have to examine them under the
6 supervision of a DRE instructor and the instructors have gone
7 through and checked these individuals first to determine if
8 there is a possibility of impairment.
9 Q So, the DRE and this field certification, this
10 student, knows that the instructor has already found someone
11 that they believe is suitable for a drug evaluation?
12 A Suitable but not necessarily under the influence
13 because the instructors will often times bring someone who is
14 not under the influence to see if the students can, in fact,
15 differentiate between impairment or being sober.
16 Q Well you indicated early on that one of the critical
17 components is to get a breath test first, correct?
18 A That's very important.
19 Q Because if you don't have a breath test, then you
20 can't tell whether whatever you are seeing is a result of
21 drugs or alcohol or some other condition?
22 A Well, it could be alcohol or some other depressant
23 drug because all the drugs in the depressant category have the
24 same --
25 Q So these individuals that are pulled out for other

1 reasons have they been given a breath test?

2 A They are at some point during the evaluation.

3 They're given a PBT or something like that.

4 Q Okay.

5 A Yes.

6 Q So, they are given a breath test and that

7 information is then known to the person, right?

8 A It's known to the instructor and the evaluator, the

9 student evaluator.

10 Q And the standard for whether they get it correct is

11 whether or not they pick -- if they pick two categories,

12 whether or not they are right on one of them, right?

13 A They have to get at least one of the categories

14 present.

15 Q So, if for example, they evaluate a person who had a

16 .02 and they said alcohol and marijuana was present and it

17 only turned out there wasn't marijuana, that would still be a

18 correct finding, correct?

19 A I don't believe so. I think they actually have to

20 find one of the drugs. Now, keep in mind that with urine

21 testing the capability of the laboratory is quite limited, as

22 it is with blood, they don't test for every single drug.

23 And depending on when the marijuana was smoked and

24 when the sample was collected, that level may fall below the

25 detectable range. And we have to keep that in mind.

1 Q So even if the results of the test comes back
2 negative, you would still score that as a correct?
3 A I'm not sure what the current classification for
4 correct and not correct it is but during my time as the
5 coordinator, alcohols are known because you have the PBT, they
6 know that up front.
7 If they are going to call it alcohol and cannabis or
8 marijuana, and to be a correct finding, I would say that they
9 would have to say that cannabis was there and, in fact, it
10 comes back to be validated.
11 Q So, you would -- so, your understanding is the
12 requirement is that it actually have to be present in the
13 system to be a correct?
14 A Yes, at least one of the drug categories. Alcohol
15 is not a drug category. It's separate. It's a depressant but
16 it's several because we test for it independently prior to the
17 evaluation even being done.
18 Q Okay. Now, you are aware -- well, first of all you
19 indicated that during your time, you actually required more
20 evaluations to be certified?
21 A I did.
22 Q But that has actually been reduced again to what
23 IACP wants, correct?
24 A I believe that is correct, yes.
25 Q And in addition when you do these confirmatory or

1 these field certifications, you don’t use blood, right?
2 A It’s my understanding they do not use blood.
3 Q They use a urine strip, correct?
4 A I believe so, yes.
5 Q And as you indicated urine -- drug and urine you
6 said can be there for some time, so that is still what you
7 use, however?
8 A I don’t know that I said that but that is true
9 result. A metabolite after a drug breaks down in the body is
10 excreted to --
11 Q I am not asking you to get into details.
12 A -- the urine.
13 Q I was just repeating, you were saying that a urine
14 sample is what is used, right?
15 A In the field certification, yes.
16 Q Okay. Now, there is also a requirement for
17 recertification, which is that you are required to have a DRE
18 log book, right?
19 A That’s correct.
20 Q And a DRE log book is when a drug recognition expert
21 is required to keep every evaluation they do, what they
22 determine the categories to be and the result of confirmatory
23 testing, right?
24 A Yes, sir.
25 Q And that is how you can take a look at a DRE to see

1 whether or not they are correct in what they go out and they
2 do, right?
3 A Generally, that's one part of evaluating a DRE. The
4 other is you always have to keep in mind the capability of the
5 laboratory because some drugs just aren't tested for.
6 The lab doesn't have the ability to test for them.
7 Or it's an additional test that -- I mean we all face budgets.
8 We have to keep our testing within a budget or we don't have
9 any money to do any testing, so we test for the majority of
10 the most frequently used drugs.
11 Q IACP requires that in order to be recertified you
12 have a DRE log book and demonstrate confirmatory testing
13 results, correct?
14 A I believe that is correct, now.
15 Q And, in fact, the drug recognition experts in
16 Maryland are required for to forward their face sheets and
17 their opinions to the Maryland coordinator, correct?
18 A During my time, that was correct. I believe it's
19 still the same but I don't know for sure.
20 Q And then it is after that that the confirmatory
21 testing comes through, correct?
22 A Well, typically, there is quite a bit of time
23 between when you send the sample in and you get the results,
24 so that may very well be.
25 Q But you are aware, are you not, that for several

1 years there was actually no blood testing at all going on in
2 these cases, isn't that right?
3 A I was aware there was a period of time that the lab
4 refused to any testing.
5 Q But so for years, you had DREs that were going out
6 doing evaluations with absolutely no confirmatory testing
7 being done on their opinions, correct?
8 A I believe that to be true.
9 Q But they were still recertified, right?
10 A That's correct, as far as I know.
11 Q In the protocol you indicated that the reason you
12 did your legislation as to the testing for blood was because
13 you got to have the 12 steps for the program to run, right?
14 A It's a very important step and we knew from the
15 beginning that you are not going to have it in every case
16 because under the law people can refuse. They don't have to
17 take the test. And unless it's a fatal crash or a serious
18 injury crash, in Maryland you can't hold somebody down and
19 take their blood.
20 Q I ask you, you agree that it was -- I think in your
21 words were to make it work you had to have blood testing.
22 A To make it work we needed a sample. The legislative
23 task force and the Governor's Executive Committee debated this
24 back and forth.
25 In fact when the bill was in front of the House

1 Judiciary --
2 Q I wasn't asking for the history, I am just --
3 MR. DAGGETT: I thought you were -- I mean the
4 question -- first of all the question at least he should be
5 able to respond to the question.
6 THE COURT: Let him answer.
7 THE WITNESS: And if you would repeat the question,
8 sir?
9 BY MR. DeLEONARDO:
10 Q My question was you previously indicated that blood
11 was required in order for this program to work, isn't that
12 right?
13 A It was an essential part.
14 Q And in the original versions, the 12-step was a
15 required confirmatory testing for the opinion, right?
16 A It was one of the 12 steps that we knew was not
17 present in every single case. It was preferred, it was
18 important but it's just not there every time. So, you have to
19 rely on other cooperative facts.
20 Q But you would agree that if an officer doesn't even
21 request blood, that that should not be a valid opinion?
22 A If they have the capability to get blood, they
23 should request it. If they don't have the capability, I'm not
24 sure that there is a reason to request it if you are not going
25 to be able to ever get it.

1 Q Well if that were the case, then why didn't you
2 simply have 11 steps? Why didn't you just create program and
3 say 11 steps and testing if you can get it?
4 A 12 preferred steps.
5 Q Because that was what the medical personnel in LA
6 told you, you had to have to render an opinion, correct?
7 A No, they didn't say that. That was just part of the
8 original training, the part of the original curriculum, part
9 of the original procedure that it's an important step but, I
10 mean, let's face the facts, you just don't get it every time.
11 Q You touched on vital signs and I think you were
12 asked about how it was taught. Let me ask you this, in your
13 original program when you went to LA, what equipment did you
14 use?
15 A Used a blood pressure cuff and a stethoscope.
16 Q And what training did you receive on calibration and
17 certification of the equipment?
18 A The only training we had was that the gauge on the
19 blood pressure cuff needed to zero out in between tests.
20 Q Okay. That was it?
21 A That was it.
22 Q And when you -- as your time as a police officer,
23 you were certified to operate radar, is that correct?
24 A Yes.
25 Q And a requirement for you to operate radar is that

1 you be certified in operating the equipment, correct?
2 A Correct.
3 Q And that you be able to calibrate the radar both
4 before and after you use it, correct?
5 A Correct.
6 Q Now when it comes to the equipment, when you created
7 this program for the DRE equipment, you are taking blood
8 pressure, you are taking pulse, you are taking temperature,
9 was there any requirement that a person calibrate or ensure
10 that their equipment is calibrated both before and after it
11 use?
12 A We use the same equipment they do in hospitals and
13 doctors' offices. They don't calibrate theirs. I mean --
14 Q They don't?
15 A A blood pressure cuff is not as complicated as a
16 radar unit. It's a simple --
17 Q A sphygmomanometer is.
18 A -- piece of equipment.
19 Q Is it not?
20 A A sphygmomanometer we were trained as long as it
21 zeros out then it should be good to use.
22 Q So DREs use the same equipment as long as they wish,
23 correct?
24 A No, sir. During recertification, it was our policy
25 for the DRE instructors to examine the equipment to see if it

1 was operating correctly. If the gauge zeroed out, it appeared
2 to be working properly, they would do tests, they would take
3 people's blood pressure during the recertification process and
4 then as long as it is in working condition then they continued
5 to use the equipment.
6 Q So, what happened if the equipment stopped working
7 before those two years, would they just replace it themselves?
8 A They would, at least in the State Police, contact me
9 and I would give them a new one. Thank you, very much.
10 Q And was that, did you use the same equipment every
11 time?
12 A Generally so, yes. We used the same manufacture,
13 the same provider, the same vendor.
14 Q And did you ever look at what their recommendations
15 are for calibration and how long you could use it?
16 A Well, I showed the equipment to the MD from the
17 State Police, the medical director, and he took a look at it
18 and said these are the exact same things we use, they will
19 work fine. Just make sure that they are in operating --
20 Q Just come back in and see me in two years.
21 A Well, we were told what to do look for in case there
22 were problems.
23 Q Okay. Now is that anywhere in the training manual
24 what to look for to make sure your equipment is working
25 properly?

1 A I don't know that it is.

2 Q And is there -- and you said it is a lot easier to

3 use than radar?

4 A Yes, sir, it is.

5 Q Okay.

6 A You can learn blood pressure and taking body

7 temperature in a matter of a couple of minutes.

8 Q You can do it correctly in a couple of minutes?

9 A Yes, sir.

10 Q Taking blood pressure?

11 A Yes, sir.

12 Q As far as when we talk about -- you said suspect

13 statements, you indicated that those are statements that are

14 only made near the end. That is not correct, they also make

15 an interview prior to the examination, is that correct?

16 A There is a preliminary examination where the DRE ask

17 general questions as is the person on any kind of medication,

18 are they suffering from any illness or injury, what have they

19 eaten, how much sleep have they had? Questions like that.

20 They are very general overview kind of questions

21 just to help the DRE make a determination initially, should we

22 proceed with this evaluation or is there something else going

23 on here?

24 Is there a medical problem or is just alcohol or

25 something like that.

1 Q All right. And you said when the DRE gets to the
2 end, the DRE knows what they are under the influence of,
3 right?
4 A Essentially, that's correct.
5 Q All right. And based on that, what is the level of
6 certainty that in the manual or how you are taught, what is
7 the level certainty that a DRE must have to call a drug -- a
8 person impaired by a drug?
9 A I don't recall if there is a specific percentage.
10 Q Just up to the individual --- of the individual DRE?
11 A It's based on their training and their experience up
12 to that point, they know or they need to proceed further.
13 Q So, they also, but you would agree, to make that
14 determination they have to rule out all medical causes?
15 A They do at least anything that's obvious or that the
16 person relates to them, or inconsistencies in the
17 observations, the signs and symptoms.
18 Q All right. And the last thing is -- well, you do
19 agree that they have to rule out medical causes, right?
20 A They make every attempt to do so based on the
21 evidence in front of them.
22 Q Now, I want to ask you one thing. The section, do
23 you recall the section in the manual when you created this
24 manual the physiology section?
25 A I recall there is a physiology section. I didn't

1 write that particular section.
2 Q Okay. But you were involved in the overall
3 implementation, right?
4 A Yes.
5 Q And do you know how many pages were devoted in that
6 original version to medical causes that mimic impairment?
7 A I don’t. I don’t recall.
8 Q Let me ask you if this is the same. If I could show
9 you Defendant’s Exhibit No. 5, I am going to go to session 5
10 and I will take you to medical conditions which sometimes
11 mimic drug impairment. Does that look familiar to you?
12 A (Reading.) Yes, it’s generally familiar.
13 Q Okay. Is that the same, the extent, that you put in
14 your original version or has it changed?
15 A Again, I didn’t write that section. I don’t recall
16 just how much was in the original one. It may have been
17 similar to this but I don’t recall exactly.
18 Q As long as you can remember back and obviously you
19 have been involved with this program for sometime, has it ever
20 in your memory been more than that?
21 A I don’t recall. It’s always been something that
22 generally talked about medical conditions but to the extent, I
23 honestly don’t know.
24 Q Okay. So beyond that page and a quarter, that is
25 the most that you can remember?

1 A That's all I can remember at this point. Without
2 actually looking at the previous additions of the manual, I
3 honestly can't tell you.
4 Q All right.
5 MR. DeLEONARDO: Your Honor, that is all I have.
6 Mr. Cruickshank? If you want to break or --
7 MR. CRUICKSHANK: No questions.
8 THE COURT: All right, we will recess --
9 MR. DAGGETT: I just have one question, Your Honor,
10 then I think we can -- I think he will done if that is okay.
11 THE COURT: Oh, okay. That is fine.
12 REDIRECT EXAMINATION
13 BY MR. DAGGETT:
14 Q Sir, I just want -- Mr. Tower, if you -- just make
15 sure I understand, if you go through the 11 -- the first 11
16 steps of the protocol from the original BAC down to number 11,
17 the opinion of the evaluator. You have gone through all of
18 those with the trained DRE and then you get to step number 12,
19 which is asking for a blood sample in which DRE -- so is it my
20 understanding that unless it is a fatality or a life --
21 serious life threatening injury that the suspect can basically
22 tell you to ---, I am not going to give a blood test?
23 A That's correct and in many cases that is exactly
24 what they do.
25 Q So you are forced then to come up with the opinion

1 based upon the first, I guess the first 10 as opposed to the
2 end 12?
3 A Well, your opinion is already made.
4 Q Right, of course.
5 A That's done before we get the sample. At that point
6 without a toxicological sample, one needs to rely on training,
7 statements made by the person, admissions as to what drugs
8 they have been using, what drugs may have been found on them
9 when they were first arrested, what they may have said when
10 they were first arrested. So, there are many opportunities.
11 Or, in fact, in some cases evidence on their person
12 during the evaluation, such as the odor of a particular type
13 of drug. Or, the residue found on their hands and their
14 clothing and their nose and their mouth.
15 So, there are many ways to corroborate an opinion
16 with physical evidence in addition to a blood sample but blood
17 is preferred.
18 Q But with exceptions to those very limited
19 circumstances, you cannot force them to give you blood?
20 A No, you can't.
21 Q Okay. All right, thank you, sir, that's all I have.
22 MR. DeLEONARDO: Just very brief follow up.
23 RECROSS EXAMINATION
24 BY MR. DeLEONARDO:
25 Q You said that the opinion is already made prior to

1 the blood, correct?

2 A Yes.

3 Q All right.

4 A You are not going to change it after you get the

5 blood.

6 Q Right. So, even if the blood comes back with

7 nothing in it, you will still say that opinion is a valid

8 opinion?

9 A Absolutely, because you are limited on what the lab

10 can test for.

11 Q So, there really is nothing that could come out of

12 that blood result that in your opinion would ever undermine

13 the opinion of this DRE?

14 A I don’t believe so.

15 MR. DeLEONARDO: That is all I have.

16 THE COURT: All right.

17 MR. DAGGETT: I believe Mr. Tower can be -- we are

18 going to break for lunch I assume, Your Honor?

19 THE COURT: Right.

20 MR. DAGGETT: I think Mr. Tower can be excused then

21 is that fair.

22 THE COURT: Thank you, sir.

23 THE WITNESS: Thank you, Your Honor.

24 (Witness excused.)

25 THE COURT: All right, we will resume at 2:00 p.m.

1 (Luncheon recess was taken.)

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1 A F T E R N O O N S E S S I O N

2 THE CLERK: Silence in Court, all rise.

3 THE COURT: Be seated, please.

4 MR. WELLS: Good afternoon, Your Honor. For the
5 record, Adam Wells spelled, W-e-l-l-s and David Daggett
6 spelled, D-a-g-g-e-t-t, on behalf of the State. And we are
7 back on the record with the Frye-Reed hearings.

8 Your Honor, would you like us to recall the cases
9 and the case numbers or not?

10 THE COURT: Well, we will just designate these as
11 the Frye-Reed hearings and State versus Charles Brightful,
12 et al. Madam Clerk?

13 THE CLERK: Yes, sir.

14 THE COURT: Exhibits 21 --

15 THE CLERK: 20, 21, 22, 23, 24, 25 and 26.

16 THE COURT: Are they in?

17 THE CLERK: No.

18 THE COURT: None of them are in. Okay.

19 MR. DeLEONARDO: I can move to go ahead and move
20 those exhibits in that I identified. The only thing that I
21 think I wasn't moving in was the internal memorandum but other
22 than that everything else I would move in. Is that correct,
23 Madam Clerk?

24 MR. WELLS: The State has no objections, Your Honor.

25 THE CLERK: Which one are we not admitting?

1 MR. DeLEONARDO: It was one that was a while ago.
2 It was the internal memorandum regarding the ---.
3 THE CLERK: Oh, from previous hearing.
4 MR. DeLEONARDO: Correct.
5 THE CLERK: Oh, okay.
6 MR. DeLEONARDO: That was an impeachment. I didn't
7 move that in.
8 THE COURT: That is the only you want in?
9 MR. DeLEONARDO: No, that is the only I am not
10 moving into evidence.
11 THE COURT: You are not moving in. Which one is
12 that?
13 MR. DeLEONARDO: That is the internal -- 2, Exhibit
14 2.
15 THE COURT: Exhibit 2.
16 MR. DeLEONARDO: Correct.
17 THE CLERK: It is from September 22nd.
18 THE COURT: All right, but --
19 MR. DeLEONARDO: All the ones from today I am moving
20 in.
21 THE COURT: Do you have those? All right,
22 Defendant's Exhibits 21 through 26 are admitted. And I think
23 I previously admitted State's Exhibit 22, Mr. Towers CV.
24 THE CLERK: And No. 20 as well?
25 THE COURT: What?

1 THE CLERK: It is 20 through 26. I think you said
2 21. You want 21 as well?
3 THE COURT: 20 is not in?
4 THE CLERK: No.
5 THE COURT: All right, 20 through 26 then.
6 THE CLERK: Okay, thank you.
7 (The documents marked for
8 identification as Defendant's
9 Exhibit Nos. 20 through 26 were
10 received in evidence.)
11 THE COURT: All right, ready to proceed?
12 MR. DeLEONARDO: Well, I guess for the record just
13 to identify, Brian DeLeonardo, D-e-L-e-o-n-a-r-d-o.
14 MR. CRUICKSHANK: Alex Cruickshank,
15 C-r-u-i-c-k-s-h-a-n-k.
16 THE COURT: Mr. Wells?
17 MR. WELLS: Your Honor, the State would call Officer
18 William Morrison to the stand.
19 Whereupon,
20 OFFICER WILLIAM R. MORRISON
21 was called as a witness by the State, having been first duly
22 sworn, was examined and testified as follows:
23 THE CLERK: Please have a seat. For the record,
24 could you please state your full name, spelling your first and
25 last and give your business address please -- I am sorry, give

1 me your current duty assignment please.
2 THE WITNESS: I am Officer William R. Morrison,
3 Montgomery County Police Department, last name,
4 M-o-r-r-i-s-o-n. I am with Montgomery County Police and I am
5 currently the department's coordinator for our chemical test
6 for alcohol unit.
7 THE CLERK: Thank you.
8 DIRECT EXAMINATION
9 BY MR. WELLS:
10 Q Good afternoon, Officer Morrison. Officer Morrison,
11 did you prepare a curriculum vitae for today?
12 A Yes, I did.
13 MR. WELLS: Your Honor, if I may approach and have
14 this marked as State's Exhibit 23? And actually, I will move
15 it at this time and ask to have it admitted into evidence if
16 there is no objection.
17 MR. CRUICKSHANK: No objection.
18 THE COURT: All right. State's Exhibit 23 will be
19 admitted.
20 (The document referred to was
21 marked for identification as
22 State's Exhibit 23 and was
23 received in evidence.)
24 BY MR. WELLS:
25 Q Officer, you indicated that you are currently the

1 head of the chemical test for alcohol unit for Montgomery
2 County, is that correct?
3 A That's correct, Your Honor.
4 Q Will you please tell the Court what current duties
5 you have as of now?
6 A Your Honor, at this time, my job is to maintain all
7 the instruments, the intoximeters for our department, as well
8 as all blood testing, and oversee are DRE program.
9 I am also responsible for the training related to
10 underage drinking, DWI, preliminary breath test and DRE within
11 our department.
12 Q Now with regards to some of your personal training
13 leading up to this point, just go through some of your CV. Go
14 through generally speaking your law enforcement experience?
15 A Your Honor, I went through the police academy in
16 Montgomery County in 1985. After graduating in 1986, I was
17 assigned to the Patrol District, to the Wheaton Patrol
18 District in Wheaton, Maryland.
19 I was assigned just regular patrol work until I was
20 taken out of that by the commander and placed in what was
21 known as the power shift.
22 The power shift was to address the issue of the
23 open-air drug markets that were currently in the Wheaton
24 district.
25 From there, I was -- went on to DRE school and then

1 I basically became a officer in my own unit. They actually
2 developed a DRE unit, a unit of one.
3 And from there I then in 2000 went on to become in
4 charge of our chemical test for alcohol unit.
5 Q Now, you indicated you became a DRE, when did you
6 first become a DRE?
7 A Your Honor, I first started going to school for DRE
8 in 1990. I attended the preschool in the beginning. I then
9 went on to the DRE school shortly after that and that was in
10 1991 and I actually became certified as a DRE.
11 Q Prior to becoming a DRE, did you become and have
12 experience with field sobriety tests in general?
13 A Your Honor, I did. When I went through the academy
14 in 1985, I was trained in the standardized field sobriety
15 testing program. I was certified in administering those three
16 validated -- or those three tests.
17 And from there, I then became a preliminary breath
18 test instrument operator along with a SFST or a DUI instructor
19 and also teaching the standardized field sobriety test.
20 Q When did you first become a standardized field
21 sobriety test instructor?
22 A If I could refer here to my notes for a second. It
23 was in 1990, Your Honor.
24 Q What was required to become an instructor?
25 A It was a 40-hour class on how to teach adults in

1 learning. And went over the SFST curriculum along with
2 becoming proficient at doing presentations for the classroom.
3 Q Now with regards to the drug recognition expert and
4 field sobrieties, are you simply a DRE or did you go beyond
5 being a simple DRE?
6 A At the end of 1991, I went on to attend DRE
7 instructor school, I passed that class. It was a 40-hour
8 class on how to administer and how to become a DRE instructor.
9 Since that time, I have been teaching in the State of Maryland
10 and also across the United States as a DRE instructor.
11 Q Now, obviously, you have been in law enforcement for
12 some period of time, drawing obviously specifically to the
13 areas of alcohol and drug impairment, have you had any other
14 on top of these trainings, which you have indicated to the
15 Judge, anymore training?
16 A Yes, I have.
17 Q Please indicate to the Court generally speaking the
18 ones that you find are most important and from what dates onto
19 the present?
20 A Okay. Your Honor, over the last 16 years, I have
21 attended all 16 of the DRE conferences throughout the United
22 States.
23 These are conferences that are geared towards
24 impaired driving and identifying the drug impaired driver.
25 And they address what changes to the curriculum, updates, what

1 new drug trends and a review of the drug evaluation and
2 classification program.
3 I have also attended some additional classes. I
4 attended the pharmacology for pediatric drugs, the misuse,
5 which was done for Children's National Medical Center.
6 I have -- and these have gone through over the last
7 years. Every year I have had DRE in-service in the State of
8 Maryland, which has been going over what updates and what new
9 drug trends have taken place.
10 I have had classes on club drugs and rave parties,
11 designer drugs. I went to a NIDA class that was conducted at
12 NIH on ecstasy.
13 Additional training by doctors on medical conditions
14 such as diabetes and also working with the blood lab.
15 I attended a class by Dr. Phillips on human
16 physiology. I had a class on over-the-counter medicine and
17 prescription medicine. And an overview of drugs and different
18 symptoms that are classified with some of these drugs.
19 Q Now with regards to some of this training,
20 specifically after you became a DRE, the trainings that you
21 indicated were these trainings ever taught or were these --
22 strike that, let me rephrase that. Were these trainings today
23 involved being trained by medical professionals?
24 A Yes, they did.
25 Q Okay. Was it the majority of them or just a -- let

1 the Judge know a little bit more about much the medical
2 professional field was involved in your training?
3 A Your Honor, the medical classes I just spoke about,
4 most of those were done by the medical field. I've gone
5 outside and wanted additional training by the medical field in
6 these areas.
7 Q Okay. Now, with regards to being a DRE, you have
8 been a DRE exactly how long?
9 A Your Honor, I became certified as a DRE in 1991.
10 Q And since that time, approximately how many DRE
11 evaluations have you performed?
12 A Your Honor, I have been involved in over a thousand
13 evaluations at this time.
14 Q Okay. Now, my understanding as a DRE you are
15 required to keep a rolling log, is that correct?
16 A That's correct.
17 Q Now do you a rolling log?
18 A I do.
19 Q Okay. Can you please explain to the Court what that
20 is?
21 A Your Honor, a rolling log is a log of all the
22 evaluations that I've been involved in, whether it being the
23 actual DRE who did the evaluation, whether I was a witness to
24 it or a scribe, I assisted in the evaluation, and as an
25 instructor, the ones that I've also supervised, and overseeing

1 the actual evaluation conducted.

2 MR. WELLS: I am going to approach and have this

3 marked as State's Exhibit No. 24.

4 MR. DeLEONARDO: I will object to that. I am going

5 to object to this. There is an attempt to introduce a DRE log

6 for Officer Morrison that was never provided to us.

7 And I think that is actually a significant issue.

8 Especially since I have outstanding orders from this Court

9 with other DREs that were supposed to provide their logs,

10 which I still have not received.

11 So, I have not had a chance to go through that log

12 to see the accuracy of the log, to digest the information in

13 it. I think it is inappropriate. He can testify he keeps a

14 log, I don't have any problem with that.

15 But I think it is being introduced to show how good

16 or good he is, if that is the intent, I object.

17 THE COURT: Mr. Wells?

18 MR. WELLS: Your Honor, with regards to that, if

19 they subpoenaed Officer Morrison's log, I would like to see

20 the subpoena.

21 MR. DeLEONARDO: I would not suggest that I did.

22 But we did request any documents that they were intending to

23 rely on in testimony and nothing was provided.

24 MR. WELLS: Your Honor, with regards to this, this

25 is simply a summation of his prior DRE experience. That is

1 all it is.

2 MR. DeLEONARDO: And he said there is a thousand and

3 I have no reason to disagree.

4 THE COURT: Well, what is it that if it is just to

5 show his experience that is not being -- I mean what probative

6 value does it really have other than if it is -- he says he

7 has done over a thousand and there is no dispute or no one is

8 questioning that?

9 MR. WELLS: Well, Your Honor, to go more into it, I

10 want to know exactly how many of those he had that were -- he

11 had corroborated by blood test and those were --

12 THE COURT: Well that is the objection. That is the

13 objection. It is not just being offered to show his -- let me

14 see counsel at the bench.

15 (Whereupon, a Bench Conference followed.)

16 THE COURT: What would you do with this had you been

17 provided ahead of time?

18 MR. DeLEONARDO: Well, I would have taken it, I

19 would have gone through and determined how often he was right

20 or not right, whether it was confirmed or not confirmed. Then

21 I would contrast it with all the other DREs in these cases.

22 And one of the things --

23 THE COURT: Contrast it with?

24 MR. DeLEONARDO: Well, again, he is being brought in

25 I guess as sort of for lack of a better term their super DRE,

1 which is not, I would contend, which is not consistent with
2 what most DREs do.
3 THE COURT: Well, I mean I have to say, I am sitting
4 here thinking how many people have -- that do this kind of
5 thing have the background that he has. I mean that is the
6 first thing that occurs to me.
7 But with regards to this specific issue, I mean if I
8 let it in, I will certainly, you know, we could come back
9 another day and you can go through it all and --
10 MR. DeLEONARDO: We also get into the issue of our
11 experts --
12 THE COURT: I am sorry?
13 MR. DeLEONARDO: We can also get into the issue of
14 our experts because I think part of it is, is the categories
15 that are being claimed I have -- one of the things, that is
16 simply the log, there is also face sheets. In every log there
17 is a face sheet that has to be completed. So for me to look
18 at -- and that is where it indicates all the signs and
19 symptoms that led to conclusions. So, that is not present
20 either.
21 So, that information is simply, this is what I said
22 it was and this is what the lab said. But, again, then there
23 is that analytical gap between why he said it. So, did they
24 give a statement, did they not give a statement, did he find
25 drugs in the car, and that is why they said it? So, there is

1 a relative weight that has to be provided.

2 MR. WELLS: Your Honor, with regards to that and the

3 other DRE -- well, we had no request by him specifically for

4 either the rolling log or for any of the face sheets. In the

5 other cases, -- strike that. In the other hearings, which I

6 have come up and have since gone through, he has requested

7 that from those DREs.

8 He did not request that here. We had no knowledge

9 that he wanted it. If he wanted it, we could have. We have

10 offered everything. We have had an open policy with them

11 since the get-go.

12 They never requested this. We could have done that

13 at any time had they asked. But they never did.

14 MR. DeLEONARDO: We requested pursuant to the rule

15 every document that their experts were to rely on in Court.

16 And, again, --

17 MR. WELLS: And in fairness with regards to that, I

18 don't mean to cut you off but --

19 MR. DeLEONARDO: That is okay.

20 MR. WELLS: When we had the issue with Dr. Gengo and

21 they presented a power point presentation that was something

22 that they had a direct obligation to provide.

23 THE COURT: No power point.

24 MR. WELLS: But more specifically, and I can go

25 that, the front presentation on that said -- showed that it

1 was directly prepared for this Court hearing and that was
2 allowed in.
3 This is not directly prepared for this Court
4 hearing. The front of that face sheet specifically said that.
5 MR. CRUICKSHANK: Dr. Gengo's presentation didn't
6 come into evidence.
7 MR. DeLEONARDO: It didn't come into evidence and
8 remember it was demonstrative of evidence. What is being
9 proposed here is not demonstrative. It is being introduced to
10 show that him as a DRE is reliable --
11 THE COURT: I think it is substantive evidence.
12 MR. DeLEONARDO: It is and he is trying to show that
13 he is reliable and that was the exact issue that we have. Is
14 that we are crossing that line again. He can say he did all
15 of these evaluations but now he is trying to bolster --
16 MR. DAGGETT: What is it that you are trying to --
17 maybe you should address the Court what you are trying to --
18 what is the purpose of this.
19 MR. WELLS: Specifically, he is trying -- he has
20 his accuracy as it was correlated by the blood test. I mean
21 because it shows in there that he had a number of the DRE
22 evaluations were done. A number of them had the --
23 THE COURT: Which your prior witness said it didn't
24 make any difference whether it was correlated by a blood test
25 or not. You know, it wouldn't affect the --

1 MR. WELLS: No, Your Honor. With regards to -- no,
2 but it also goes to back up what his opinion was. I mean that
3 is not what the prior witness said. The prior witness said
4 they could go through the evaluation, the 12-step is important
5 and here it is and the 12-step is present and it correlates
6 what his statement was, number one, number two --
7 THE COURT: What I understood the prior witness to
8 say is because you can't test for everything. Even if the
9 test comes up negative and nothing is shown that that would
10 not affect their opinion.
11 MR. WELLS: Because the opinion had already been
12 made.
13 THE COURT: Right. Let me ask a question. This is
14 a log of tests that he actually performed?
15 MR. WELLS: This is the log of evaluation that he
16 has done, yes.
17 THE COURT: In what setting?
18 MR. WELLS: As a DRE -- oh, I can go into more
19 detail with regards to that. I believe it was as a DRE where
20 he has done the evaluation.
21 MR. DeLEONARDO: And that is my point. They are
22 trying to show that he did these evaluations and that he is
23 right. And I think that goes to the reliability issue and I
24 don't think that is appropriate. I don't think --
25 THE COURT: Well, let me ask a question. Is he

1 going to be qualifying in someway his percentage of accuracy
2 based on this?
3 MR. WELLS: I am sorry, repeat --
4 THE COURT: Is he going saying, you know, based on
5 this I was accurate 90 percent of the time?
6 MR. WELLS: I would ask it for a percentage how
7 accurate it was he correlated it by in the blood test?
8 THE COURT: And these are all blood tests?
9 MR. WELLS: Yes. And I can ask those questions if
10 there is concerns about that. I can do that as well.
11 Additionally, one of the --
12 THE COURT: Let me ask this question.
13 MR. WELLS: Sure.
14 THE COURT: Did these represent all of the tests
15 that he did?
16 MR. WELLS: Unfortunately, no. This goes back 10
17 years.
18 MR. DAGGETT: Can I ask a question. If we are just
19 here on Frye-Reed, I mean there is really a question as to
20 whether it is new or novel as generally accepted in the
21 scientific community? I mean if he just -- I am just saying
22 if he testifies as to how many he has done and that he -- I
23 mean obviously he is still doing it, he has testified in Court
24 as an expert on it before, I mean, I just don't think there is
25 specific percentage --

1 MR. WELLS: Of his accuracy? True.
2 MR. DAGGETT: I don't that is really -- I mean if
3 its --
4 MR. WELLS: The reason, and I am just saying that
5 the reason I wanted to bring this up is because the accuracy
6 has been attached by them throughout their case in chief. And
7 I want to show that and the practice of it, it is accurate.
8 And there is no other way we do it except for showing that
9 the practice was.
10 MR. CRUICKSHANK: But the missing picture here is we
11 don't know who tested the blood and how they tested the blood.
12 And we heard testimony today about the way in which blood may
13 be tested in Maryland and that they don't test for all the
14 drugs. They may test for some drugs. And when you look at
15 the DRE face sheet, remember that the face sheet, he can say
16 it was five categories he found three or four things.
17 And then we just get the blood result back and he
18 says, oh, you were right on the CNS depressant. But if we had
19 the face sheets, it was show he was wrong on two other
20 categories of drugs.
21 MR. WELLS: Which they never requested.
22 MR. CRUICKSHANK: Yes, we did.
23 MR. WELLS: They never requested that. They have
24 requested that specifically beforehand, and they have never
25 requested any of those.

1 THE COURT: Well --

2 MR. CRUICKSHANK: And it was a thousand of them.

3 MR. DeLEONARDO: I would only add to that further is

4 that this is a document exclusively prepared by him. So there

5 is really no basis to do any investigative work or to look at

6 the face sheets, which I have looked at conviction rate and I

7 haven't even seen it.

8 So, I am only saying that when you start talking

9 about we are moving into an area that he is going to vouch

10 how reliable he is, I don't see how -- I mean we have had

11 studies that have been discussed. They have had experts to

12 come in that have talked about how reliable they think DREs

13 are.

14 I mean, again, I think it is opening up a door that

15 is not appropriate for the DRE to testify. He is vouching

16 that the protocol is reliable and that is not something that

17 is a proper subject for DRE testing.

18 MR. WELLS: What I would do with this is say he did

19 this many evaluations, this many of them came back as what it

20 was that he called. And I would say, did you do any medical

21 rule outs? Yes. How many? Did you ever find people not

22 under the influence? Yes. That is the limit that I would go

23 with that.

24 MR. CRUICKSHANK: But it doesn't allow us to cross-

25 examine him upon what is the heart of that law, which is the

1 face sheets.
2 MR. WELLS: And, again, they didn't request that.
3 MR. CRUICKSHANK: There is a thousand face sheets we
4 did not --
5 MR. WELLS: And they did hot request that. They did
6 not.
7 THE COURT: Well, I don't know whether that is
8 something that should have been anticipated. Should have been
9 provided by the State or whether the defense should have
10 anticipated that it might have some relevance.
11 My inclination always is when these discovery issues
12 come up is to give the party who is objecting the opportunity
13 if they are saying, oh, I am surprised by this, the
14 opportunity and come back on another day.
15 Now, the other way of dealing with it, the worse is
16 to say well yes it all comes in or the third way is to say,
17 you know, I am not going to allow any of it. I really don't
18 want to -- I don't want to hamstring anybody.
19 MR. DeLEONARDO: And that is why I say, Your Honor,
20 my objection while it is on the discovery issue too, and that
21 could be cured by a postponement, what I would say is I don't
22 think it comes in even on the merits.
23 THE COURT: Because?
24 MR. DeLEONARDO: Because it is intended to vouch
25 that he is a reliable -- that this protocol is a reliable

1 indicator and I don't think that is a proper --
2 THE COURT: Only based on his experience. I mean
3 this is one person. I mean we heard a lot of testimony before
4 about various studies and double-blind studies and that kind
5 of thing. I mean we went on and on and on. Why some studies
6 were flawed and the methodology was not good.
7 I mean, ultimately, this particular individual used
8 the word super DRE, well maybe that is what he is and maybe
9 his percentages are very, very good. I don't think that
10 that --
11 MR. DeLEONARDO: I think it needs to be proffered
12 as, but yes --
13 THE COURT: What?
14 MR. DeLEONARDO: I think that is what he intended to
15 be proffered as. But I guess that is my concern because then
16 I guess the question is does that open up when I examine -- I
17 have some -- previously obtained some DRE logs for some
18 officers that I think the results were quite poor. So I mean
19 I am happy to open that door --- and do that.
20 I just think that when we are dealing with DREs I
21 think what we are dealing with is that he was proffered, that
22 he was come in and testify as to the DRE program and the
23 protocol, never that it was reliable. And that is essentially
24 what they are proffering him as.
25 And even in their expert notification DRE expert and

1 the protocol administration and how it is taught. And nothing
2 about that it is reliable or that --
3 MR. WELLS: That is the whole purpose behind the
4 hearing.
5 THE COURT: Well that is.
6 MR. WELLS: It is the entire purpose behind the
7 hearing.
8 MR. DeLEONARDO: From outside experts, not in front
9 of that witness.
10 THE COURT: Well, I think the way I -- the bottom
11 line is I don't see this really is that big of a deal. But I
12 will certainly give you the opportunity after today to defer
13 any cross-examination of this witness.
14 You know get the documents from the State. And we
15 will come back here on another day.
16 MR. DeLEONARDO: Okay.
17 THE COURT: I don't think we are talking about a --
18 probably a big chunk of time. Now, let me ask you this. Is
19 he your last witness?
20 MR. WELLS: He is our last witness in our case in
21 chief and we should potentially have a very short rebuttal
22 witness with Officer --
23 MR. DAGGETT: Basically we would have called him --
24 yes, we have two more witnesses. He is going to be called
25 so -- they are not putting anybody else on.

1 MR. DeLEONARDO: We may have a rebuttal witness as
2 well at least one --
3 THE COURT: Well, then we will probably come back
4 here another day.
5 MR. DeLEONARDO: Well, I had hoped we were because I
6 was --
7 MR. CRUICKSHANK: I had too.
8 MR. DeLEONARDO: -- inclined to call our rebuttal --
9 MR. DAGGETT: Can I speak to Mr. Wells for a second?
10 THE COURT: Sure.
11 (Long pause.)
12 MR. DAGGETT: Your Honor, we want to speed things
13 up. I think -- go ahead.
14 MR. WELLS: Okay, well then I will not be admitting
15 this evidence.
16 THE COURT: All right.
17 MR. WELLS: My questions will be simply so that it
18 is clear that he has done the thousand DREs, the fact that he
19 has had medical rule outs, I won't ask numbers, the fact that
20 he has --
21 MR. DAGGETT: We can ask those when we get going but
22 I think --
23 MR. DeLEONARDO: Yes, I don't any problem with that.
24 I just don't --
25 MR. WELLS: While we are up here --

1 THE COURT: All right.
2 (Pause.)
3 (Whereupon, the Bench Conference was concluded.)
4 BY MR. WELLS:
5 Q Officer Morrison, back to where we were. You
6 conducted -- I am sorry, over a thousand DRE evaluations?
7 A Over a thousand DRE evaluations, yes?
8 Q Okay. Now with regards to those evaluations, have
9 their come times when you have found people to be not under
10 the influence?
11 A Yes, I have.
12 Q And have you been able to determine that there were
13 medical rule outs at certain times as well?
14 A Yes, I have.
15 MR. WELLS: Court’s indulgence?
16 (Pause.)
17 BY MR. WELLS:
18 Q Officer Morrison, have you been qualified as an
19 expert in the field of drug recognition previously?
20 A Yes, I have.
21 Q How many times?
22 A Your Honor, at this point, 67 times throughout the
23 State of Maryland and DC.
24 Q Likewise, the field sobriety tests approximately how
25 many?

1 A I couldn’t even begin to tell you how many times
2 related to the standardized field sobriety tests.
3 (Pause.)
4 MR. WELLS: Court’s brief indulgence?
5 (Pause.)
6 MR. WELLS: Your Honor, at this time, the State
7 would move to admit Officer Morrison as an expert in DRE field
8 sobriety tests and horizontal gaze nystagmus and the
9 underlying components in DRE evaluation.
10 MR. DeLEONARDO: I just have very limited questions
11 I want to ask.
12 THE COURT: Okay.
13 VOIR DIRE
14 BY MR. DeLEONARDO:
15 Q Just to clarify -- you were I guess -- you saw the
16 CV that Mr. Wells had, that is the CV that you prepared for
17 Court today?
18 A That’s correct.
19 Q And when you provided that, I assume it was the most
20 up-to-date that you had at the time, is that correct?
21 A The one that I provided today?
22 Q Yes, the one that the Court has?
23 A Yes.
24 Q Okay. And you made sure it included all the
25 information that you were testifying to regarding your

1 credentials?
2 A Yes.
3 Q Now, you were asked how many times you have
4 testified as a DRE expert and you indicated 67 times?
5 A That’s correct. I think that is what it is now.
6 Q Okay. Now, you have Court qualifications and
7 under -- it is several pages in but it is not numbered, you
8 have a session that says Court Qualifications, Drug Affect,
9 Drug Recognition Expert Program, is that correct?
10 A That’s correct.
11 Q And that is where you listed all the time that you
12 have testified?
13 A That’s through each of the Judges that have
14 qualified me as an expert.
15 Q Okay. So, when you say 67 times, it is in front of
16 these same Judges multiple times?
17 A Some of these, yes.
18 Q Okay. And it looks like they are all in Montgomery
19 County other than one in Frederick and one in District of
20 Columbia, is that right?
21 A That’s correct, both the District and Circuit Court
22 of Montgomery County.
23 Q Okay, now in Frederick County, how many times were
24 you an expert there?
25 A One time.

1 Q And how many times in the District of Columbia?
2 A Just once.
3 Q And was your qualifications contested?
4 A Yes, they were.
5 Q Okay. So in both of those were contested whether
6 you were a DRE in the courtroom, they accepted you?
7 A Yes.
8 Q Okay. So, those are the jurisdictions, Montgomery
9 County, Frederick and District -- okay. Now, did you indicate
10 and I see didn't on here, when?
11 A I am not sure I understand your question.
12 Q Well how often, like when? How long ago were you
13 qualified as an expert? I am not asking for all of them but
14 generally.
15 A Oh, since --
16 Q Was it regular?
17 A On a regular basis except for probably last six
18 years, I really haven't testified. I haven't had any trials.
19 So other than the one in DC has been the most recent one,
20 probably.
21 Q So, all of these times that you were accepted were
22 all about six years ago at least?
23 A Majority of them, yes.
24 Q Okay.
25 MR. DeLEONARDO: That is all I have. No objection

1 to him being accepted.

2 THE COURT: All right. We will accept Officer

3 Morrison as an expert in the drug recognition protocol.

4 MR. WELLS: Thank you, Your Honor.

5 DIRECT EXAMINATION (Resumed)

6 BY MR. WELLS:

7 Q All right, moving on. Officer Morrison, I am going

8 to ask you --

9 THE COURT: Oh, and I think generally field sobriety

10 testing.

11 MR. WELLS: Thank you, Your Honor.

12 BY MR. WELLS:

13 Q Going to move on to the area of training of DREs.

14 It is my understanding that you are a DRE trainer, is that

15 correct?

16 A That's correct, Your Honor.

17 Q Now, with regards to that, can you explain to the

18 Court any preliminary requirements that would be needed for an

19 applicant to enter into -- to become a DRE?

20 A Your Honor, in the State of Maryland, we have an

21 application process that the student must fill out. It must

22 be signed by their supervisor and then two DREs have to review

23 this applicant and test them to see if they are proficient in

24 the standardized field sobriety test.

25 The two DREs will then sign off on them and then

1 they are allowed to -- then their name goes to whoever is
2 teaching the class to allow them in the class.
3 Q Now, with regards to that requirement, is that just
4 in Montgomery County for you or is that for the State of
5 Maryland?
6 A That's for the State of Maryland, Your Honor.
7 Q Okay. Now, is there any issue with SFST
8 proficiency?
9 A In that, like I said, two DREs must agree that this
10 person is proficient in the standardized field sobriety test.
11 Q Okay. Now, once again it starts -- it is found to
12 be proficient is accepted, what is the first step in training
13 for DRE?
14 A The very first step is making sure they are
15 proficient. They have to know the standardized field sobriety
16 test, the horizontal gaze nystagmus, the walk and turn and the
17 one leg stand.
18 They must be proficient in doing it along with being
19 able to satisfy the requirements of the written test.
20 Once they are selected for the class, then the very
21 first step is the preschool. This is a two-day preschool,
22 which begins with just an overview of the entire program.
23 What they are getting themselves into, what this
24 class will have to deal with and then goes into the next step
25 would be the 12 steps, going over what those steps are. So,

1 they begin learning what those 12 steps actually are going to
2 be and what they are going to be learning.
3 We also at that time go over a brief little bit
4 about the seven categories of drugs. And then we have -- we
5 get into eye exams, expanding on horizontal gaze nystagmus,
6 vertical gaze nystagmus. But now we are including lack of
7 convergence and estimating the pupil sizes on the subjects.
8 Then we get into the additional psychophysical test
9 that they will be administering. Not only will they be doing
10 the walk and turn and one leg stand, as you know in the
11 standardized field sobriety test, but now they are going to be
12 doing the Romberg Balance and the finger to nose test.
13 At the conclusion of that, we also have an alcohol
14 workshop. The students will participate in alcohol workshop
15 and take some of this information that we have just given them
16 and apply that to the alcohol-induced subjects.
17 Now, the alcohol workshop, the drinkers don't know
18 how much they're drinking, the students don't know how much
19 they're drinking, so it's the student's job to actually figure
20 out if they are impaired, if so, what's causing -- you know,
21 how much alcohol is causing the impairment.
22 So, like I said, it's sort of like a double-blind
23 study where nobody knows how much they have actually had to
24 drink.
25 We may be dosing them with placebos or small

1 quantities of alcohol when they think they have had a lot.
2 At the completion of this class, we prepare them for
3 moving on to the DRE school, what they are going to need to
4 know.
5 We also get into the vital signs. Learning how to
6 take vital signs, being the blood pressure or the pulse and
7 the body temperature.
8 And at the completion of the two-day school, we have
9 a test that they must obtain a score of 80 to go on.
10 Q Now, you were talking about the preschool, correct?
11 A That's simply the preschool.
12 Q Okay. About how many hours of training and studies
13 is involved in the preschool?
14 A That's 16 hours, Your Honor.
15 Q Okay. Now, with regards to the training that is
16 presented is the training, and I will ask that generally for
17 both the preschool and for the DRE school, is that all
18 standardized?
19 A It is. It is all standardized. We teach from the
20 IACP or the National Highway Traffic Safety Administration's
21 DRE preschool instructor manual.
22 Q Okay. Now, moving on from the -- well let me ask
23 you this. Why is it separated into a preschool and a DRE
24 school itself?
25 A We're preparing the students for the seven-day

1 school. This is -- we are throwing a lot of new information
2 to them. We want them to start practicing and learning how to
3 do things that most law enforcement officers are unfamiliar
4 with, taking vital signs and expanding on their knowledge of
5 impaired drivers.
6 Q Now, how long are the classes each day? I mean is
7 this like a two-hour class each day or is it more than that?
8 A No, each day is eight hours long, a minimum of eight
9 hours. Some of these days will take longer than eight hours.
10 Q Is there any hands on training at that point of time
11 as well or is it all lectured?
12 A Your Honor, during this classroom part and it’s not
13 only hands on, there will be an instructor standing there
14 helping them, assisting them with learning it, making sure
15 they are doing it correctly and then we also evaluate it when
16 we are doing the alcohol workshop and at the conclusion of the
17 two-day school.
18 Q Now upon completion of the preschool, well let me
19 ask you this. Does everyone who enter into the preschool, do
20 they make it through onto DRE school?
21 A No. We have washed out subjects right out of the
22 preschool. Some of them find how overwhelming this program
23 can be, the commitment to it, and they decide that they don’t
24 want to do it. And some just aren’t able to grasp it and need
25 to move on.

1 Q Okay. Moving onto the DRE school itself. Let the
2 Court know a little bit about the DRE school?
3 A Your Honor, in the DRE school, that's a seven-day
4 school. And I say seven to eight hours day. But the majority
5 of that time is -- those days will go over eight hours. And
6 that's classroom part, that's not including the part that the
7 students are going to have to go home and study and prepare
8 for the next day and practice.
9 There is an introduction going over what they are
10 going to learn over the next seven days.
11 There is a session on the effectiveness and the
12 development of the DRE program, how everything came about.
13 We go in depth into the seven categories of drugs.
14 We breakdown each category of drugs, showing them how each of
15 these drugs came about, why they are in the seven categories
16 and what the signs and symptoms and observable trademarks
17 would be for each one of those seven categories.
18 We go into drug combinations. We found -- we go
19 into drug combinations showing that what's a person is going
20 to look like when they are using more than one drug, polydrug
21 using.
22 We then go into physiology, how the drugs affect the
23 body. Medical conditions that may mimic or mask the signs of
24 drug impairment.
25 We go into report writing, preparing your case for

1 Court. We have a lot of hands on during this session.
2 We review the eyes, the vital signs, but we have
3 lots of hands on where they are actually going to be
4 practicing not only certain segments just the vital signs,
5 working with the eyes, but also the entire 12-step process.
6 This is then, again, we have an instructor right
7 there who is working with the group of students making sure
8 that they are getting the information and being able to adapt
9 and being able to use it.
10 We also have outside resources, Physician Desk
11 References, Poison Control, how these outside resources can be
12 of assistance to officers in determining what the affects of
13 the drugs are and what type of medical conditions may be -- we
14 may be working with.
15 We have an alcohol workshop. And during this
16 alcohol workshop since we can't use drug impaired subjects, we
17 actually use alcohol impaired subjects and again they are
18 dosed to different levels. The drinker doesn't know and
19 neither the subject or the tester.
20 They are brought in and they do a drug evaluation on
21 an alcohol impaired subject. And their job is, of course, to
22 determine if they are impaired and if so what level of
23 impairment they are.
24 We also have role playing where we have instructors
25 pretend to be drug impaired subjects. And when I say that, we

1 use real drug evaluations.
2 We want them to actually, give you an example, take
3 our pulse, making sure they are doing it properly but then we
4 would tell them what the pulse would be. So, if I was to be
5 working with a group of students, my drug category or what I'm
6 supposed to be under the influence of may be cannabis.
7 So, even though I'm watching and I'm monitoring and
8 evaluating, making sure they are doing the evaluation
9 properly, I am going to be giving them results of somebody who
10 possibly would be under the influence of cannabis or a
11 different type of drug, or, if there is no drug at all.
12 We also want to see -- identify the person who is
13 not impaired at all.
14 So, we give them the results -- going through this
15 very quickly. Let's see, -- there is testing. Everyday there
16 will be a quiz. We monitor how the students are doing.
17 We give a midcourse review along with a end of the
18 class review prior to the final where we go over all the
19 material making sure the students are grasping it.
20 And then we give a final exam. And the final exam
21 is a 100 hundred questions that they must score 80 or above.
22 At the conclusion of that, then we go into the DRE
23 certification where we explain to them how certification is
24 going to work, what they are going to need, what they are
25 going to need to be able to do and then go through the

1 process. Also not only the certification process, but the
2 final knowledge exam and then preparing to become a DRE.
3 Q Let me ask you a few more questions before you move
4 onto certification. With regards to the test, you said you
5 have to pass at least an 80 percent on the test before the DRE
6 school, is that correct?
7 A That’s correct.
8 Q Okay. What happens if the person fails that test do
9 they have to -- can they take another test?
10 A Your Honor, on the seven-day school, the student can
11 come back and we can give another test. It is not the same
12 test. It is a makeup test. Again, they must score 80 to move
13 on. If they don’t pass that, then they are removed from the
14 program and can reapply for the next class.
15 Q Okay. Now, moving on. You said there was also the
16 next phase was the certification phase. What is the purpose
17 of the certification phase?
18 A Your Honor, during the certification phase, we are
19 actually looking for drug impaired subjects. And when I say
20 drug impaired, they can be -- we are also looking for people
21 who may not be impaired at all. We want them to start
22 practicing the actual 12 steps in determining if the person is
23 impaired, what is causing the impairment, learning first hand
24 from these drug impaired subjects, how they are going to
25 affect the human body, what they feel.

1 So, what we do is we go out into the field. In
2 Maryland we use two locations. We use the Baltimore City Jail
3 and we also use Montgomery County.
4 And when we use Montgomery County, we started our
5 central processing but yet if we don't have anybody that
6 night, we also can roam around.
7 We will look at PG County, Howard County, Frederick,
8 we are looking for people, anybody who may be under the
9 influence of drugs. So, we can also move.
10 But what the student does, we come in with our
11 students. There will be a group of students assigned to a
12 particular instructor.
13 The instructor will go out, look for drug impaired
14 subjects and we don't want people who are actually driving.
15 We would much rather have people who are just high, who have
16 been locked up. And when I say high, it could be any type of
17 drug that we could possibly be using.
18 We will ask them to cooperate and participate with
19 us. We will tell them what they are going to be -- what the
20 drug impaired subject will be going through.
21 And we ask them that they not tell the student what
22 they have been using until we tell them it's okay. And that's
23 done at the end because at the end when everything is
24 complete, we want the drug impaired subject to talk about what
25 it's like to be under the influence of this drug.

1 How it feels, you know, do you have to have more of
2 it? What it feels like to go into withdrawals, all this? So,
3 they get the actual drug perspective of it.
4 The students will -- excuse me. The instructor will
5 get the students and the drug impaired subjects together. We
6 will monitor and watch them and evaluate the actual
7 evaluation. They will obtain a sample -- or I will obtain a
8 urine sample from them.
9 They will then tell us what this person is under the
10 influence of and they will justify why they feel this person
11 is under the influence of this rather than something else to
12 the instructor.
13 At which time, we will then take that sample and now
14 we actually have the capability of testing the urine right
15 there afterwards, after we obtain it. And then we will
16 determine if they are correct.
17 We will also be using alcohol impaired subjects.
18 And we will be using people who aren't impaired at all. We
19 want them to see many different things and see if they are
20 able to identify somebody who is not impaired, have an alcohol
21 rule out and, if so, if they are impaired by drugs, what's
22 causing the impairment and what categories are causing that.
23 Q Now with regards to the certification phase, I mean,
24 obviously, it was the two-day preschool and the seven-day
25 school itself, how long is the certification phase?

1 A We've become a lot more efficient than what we were
2 in my day it took me six months. And that was every night --
3 four nights a week going to Baltimore.
4 Now, if we can get the students and we get the drug
5 impaired subjects, we can normally get people done in about
6 four weeks.
7 We are looking to get them as many evaluations as we
8 possibly can. You've heard that they must do a minimum of 12
9 but we like to get them as many as possible. The more the
10 better.
11 Q Now with regards to the evaluations, they have to do
12 12, can you give a little bit more description of do 12
13 evaluations? Are they the ones doing the entire evaluations
14 are is there something else going on?
15 A Your Honor, the student will do a minimum of six
16 personal evaluations. Meaning that I will actually be the
17 evaluator doing the person the complete evaluation.
18 I can also get credit for six additional ones. We
19 want them to have a minimum of 12 evaluations. A minimum of
20 six they must do themselves but they can also get credit for
21 being a -- what we call a scribe.
22 Somebody there, standing over the shoulder of the
23 evaluator who's actively participating in the evaluation. So,
24 they can actually get credit for watching an evaluation.
25 Out of that, we would like them to --

1 Q Let me cut you off real quick. Why is that the same
2 as doing the evaluation? I mean it seems like if you want to
3 get the credit for the evaluation, why is it okay for them
4 just to observe?
5 A Well, if they are participating in it and they are
6 actually watching the evaluation. Hopefully, they are getting
7 the exact same out of it as they are as being the person hands
8 on.
9 Q Okay. Keep going.
10 A They are required to have a minimum of three
11 categories and we require them to be 80 percent correct. We
12 are above the national standard. We want them to be 80
13 percent correct in determining what this person is under the
14 influence of.
15 The only ones that we will count are if they are
16 actually impaired by a drug. So meaning that if they -- if we
17 get the person who is a .10 alcohol, yeah, we may practice
18 with that person, but that would not count as a category of
19 drug -- or that would not count as an evaluation because of
20 the fact it's just alcohol -- or if the person is not impaired
21 at all.
22 So in any words, I want somebody who is going to be
23 impaired by narcotic analgesic, give you an example, and then
24 it comes back positive that's what they call it, that's the
25 one they will get credit for.

1 Q Now with regards to you indicated that they said
2 that the requirement is that there be at least three
3 categories of drugs for which the potential DRE is getting
4 certification for. Can you give a little bit more of a
5 description to the Court as to what is required for that?
6 Specifically, say the person comes back with a
7 positive or has marijuana and say a narcotic analgesic in
8 their system and they only called them for the marijuana,
9 would that be enough to count as two of the different
10 categories?
11 A It would not, Your Honor. What they see and what
12 they tell us and what they justify to us, and if that would
13 come back, that's what get credit for.
14 So in that situation right there, the person --
15 let's say I get the tox screen back. I've called the person
16 to be under the influence of marijuana, it comes back positive
17 for marijuana and for some type of narcotic analgesic, then I
18 would not get credit for that narcotic analgesic because I did
19 not call that. I would get credit for the marijuana.
20 And what happens a lot of times is what is the most
21 active drug in the body? They have got to justify to us that
22 I see this drug category is causing this impairment.
23 Q Now is that all the requirements for the
24 certification?
25 A No, it's not.

1 Q Okay, what else?
2 A From there we -- about three quarters of the way
3 through certification phase, we will then try to give this
4 final knowledge exam. We want them to have some hands on with
5 these drug impaired subjects, actually during the evaluations
6 and then we get into the final knowledge exam, which is an
7 extensive exam.
8 There are many parts to this exam. Each one of
9 those parts is done separately. Meaning that you come into
10 the classroom, you sit down at your desk and we give you part
11 one. Part one is 25 fill in the blank questions.
12 You bring that up, an instructor immediately
13 corrects it, if you have something wrong with it, the
14 instructor can only say that you have x amount of things
15 wrong.
16 So if the student comes up and has one thing wrong,
17 I turn it back to the student and say you have one thing
18 wrong.
19 It's your job then as a student to go back to your
20 desk and figure out what is possibly wrong. If you come back
21 up the second time and you have not made that correction, at
22 that time we require in each one of these parts that you get a
23 100 percent in each one of them.
24 And you are allowed, like I said, one chance to make
25 a correction but we can't tell you where that correction needs

1 to be.

2 So that's phase one. Phase two of this test is the

3 symptomatology matrix. That that's extensive piece of paper

4 with all that information on the seven categories. What's

5 going to happen to the eyes, what's going to happen to the

6 pulse rate, what's going to happen to the pupils, what's going

7 to happen to nystagmus? All the general indicators, duration

8 of effects, the muscle tone. At this point, they must

9 duplicate that word for word, letter for letter.

10 And all we do is just give them a blank sheet of

11 paper and they must be able to recreate that. And, again,

12 they must get a 100 percent.

13 From there, we then move on to four different

14 effects, whether it be an additive effect, antagonistic

15 effect, overlapping, we want them to explain to us what each

16 of these effects are and how they would effect the human body

17 and give us examples of each one of those.

18 We then have some exemplars. Exemplars are

19 evaluations that have been done. It is the face sheet of the

20 evaluation that they must look at and they must determine what

21 this person is under the influence of by looking at this face

22 sheet.

23 After that, they have to write essays on justifying

24 why they called what they did on each one of those exemplars

25 and if -- not only why they called it but why did they rule

1 out the other different categories.

2 So, I called it this because of this and I was able

3 to rule out the categories because I did not observe these

4 general indicators and these signs and symptoms.

5 They must write a report. They must take one of

6 these exemplars and then write a narrative report for the

7 instructor, spelling out just like they would in a true

8 evaluation everything that they would need for a good

9 narrative report.

10 Like I said, each one of these phases, they must

11 obtain a 100 percent. If they are not able to obtain that,

12 they are removed and they come back to the next class and

13 start over again.

14 At the completion of that, they are still not done.

15 They must then produce their curriculum vitae, showing an

16 instructor that they have done that, it has to be signed off

17 by an instructor.

18 Two DREs who have actually watched the student do an

19 evaluation have to agree that, yes, this person is ready to be

20 signed off. This person knows what he is talking about, we

21 are ready to go and sign this person off.

22 At that time, if they have completed all of their

23 testing, they have got all their numbers, they have gone

24 through the certification, they have got all their

25 evaluations, they have got their CV, they take everything then

1 to the state coordinator.

2 The state coordinator reviews everything, make sure

3 everything is accurate and then signs off on the student.

4 Q And are at that point in time they are considered to

5 be a certified DRE?

6 A At that point in time they are. The state

7 coordinator would then sign off on that student and then

8 submit the paperwork to the IACP saying that this student has

9 fulfilled all of the requirements and is qualified to be a

10 DRE.

11 Q Okay. Now, once a person is determined to be a

12 certified DRE, are their requirements in order to remain a

13 DRE?

14 A Yes there are.

15 Q What are they?

16 A Every two years, Your Honor, they must have

17 completed eight hours of training. In the State of Maryland,

18 we like to try to do DRE in-service every year. There have

19 been a few years where we just have not been able to do that

20 but the majority of the time we do training every year for all

21 of our DREs here in the state.

22 They must complete four evaluations and two of these

23 evaluations had to be in front of another instructor.

24 So, not only do they do four evaluations, but an

25 instructor has to then watch them do an evaluation to make

1 sure that during that two-year period they are maintaining
2 their knowledge and can do a correct evaluation.
3 Q Now is there any other requirement that is needed or
4 that is -- well needed to become a DRE or to maintain a DRE?
5 A The DRE must maintain an updated curriculum vitae.
6 And they also must maintain their rolling log.
7 Q What is the purpose of that, the rolling log?
8 A I'm sorry?
9 Q What is the purpose of maintaining the rolling log?
10 A The purpose of the rolling log is to maintain a list
11 of all your evaluations, to see how well you are doing and to
12 see if there is any problem that needs to, as an instructor,
13 need to work on if you are not able to identify correctly an
14 evaluation or a subject who may be impaired.
15 Q All right, at this point and time, I would like to
16 move on as to how a DRE evaluation is done.
17 A Okay.
18 Q Now, it is my understanding there are 12 steps of
19 the evaluation. Prior to the evaluation getting started, what
20 leads up to the DRE being called?
21 A Well, Your Honor, the DRE is called from an
22 arresting officer. The DRE can be the arresting officer but
23 the majority of the time we are called to assist other
24 officers who have already made an arrest.
25 We are not normally called to the scene to determine

1 if somebody should be arrested. We want that to be done by
2 the arresting officer. If there is enough impairment there to
3 justify that they are under arrest, place them under arrest.
4 They are then taken to the station. They are given
5 an opportunity to take a breath test. And the breath alcohol
6 concentration if their level of impairment is inconsistent
7 with their BAC, then a DRE is called to determine if a person
8 is impaired by something other than alcohol.
9 Q Generally speaking from the time that a person is
10 pulled over, how long does it take for a DRE to actually even
11 show up for an evaluation?
12 A Your Honor, it's really just going to depend on
13 where you are at and if you have a DRE working. In Montgomery
14 County, they were very fortunate mot of the time. We have one
15 normally trying to work around the clock.
16 Some parts of the state, you know, it may be an hour
17 before you get the DRE actually to the station to conduct that
18 evaluation.
19 Q Once the evaluation is to start, what are the 12
20 steps, let's go through the 12 steps?
21 A Well, we are going to start with the breath alcohol
22 test.
23 Q What is the purpose of this?
24 A We want to rule out alcohol as being the factor but
25 we also want to know is alcohol a factor in this evaluation.

1 If so, at what level?
2 If the person has a BAC of .07 or higher though,
3 then the DRE will normally not be utilized because you have a
4 good B case, will go forward with just that.
5 Q Okay. What happens next?
6 A The next thing we are going to do is we are going to
7 have an interview with the arresting officer. We are going to
8 speak with that arresting officer, there are things we need to
9 know. Was this person involved in a crash? Was there some
10 type of injury? Did the person hit their head? Did the
11 person complain?
12 Were there any medical tags in the car, were there
13 any pill bottles in the car, were there any odors on the
14 subject's breath? How did the person do in the field sobriety
15 test? What drew your attention? How did you come into
16 contact with this person?
17 We wanted to know was there any paraphernalia found
18 in the car, just everything that we can possibly -- would be a
19 factor related to having come in contact with this person.
20 Q What happens after the -- well, Court's indulgence.
21 How long generally is the interview of the arresting officer?
22 A Your Honor, that could take three to five minutes.
23 That could take 15 to 20 minutes. It just depends on the
24 extent of what the officer has seen and what's happened at the
25 scene related to the arrest.

1 Q What happens after the interview of the arresting
2 officer?
3 A The next phase there, Your Honor, is a preliminary
4 exam.
5 Q What is the purpose of the preliminary exam?
6 A Your Honor, at this point during the preliminary
7 exam, we are trying to, one, verify -- we are at what they
8 call a fork in the road. And that is, is this person
9 impaired, is this person a medical rule out or is there
10 something else causing the impairment and this person needs to
11 go get medical assistance.
12 So at this point, we are there to see where does our
13 role play. Does this evaluation then need to stop? Do we
14 need to call 911, get EMS involved and have an evaluation and
15 get this person to the hospital or is this truly drug
16 impairment, should we go on?
17 During this phase, I'm going to take the first
18 pulse. I'm going to look at the eyes and the pupils. I'm
19 going to check for equal tracking and equal pupil size to see
20 if there is any signs of head injury.
21 And also at this phase, I am going to then begin my
22 preliminary questions that I am going to ask the subject who
23 is under arrest.
24 These questions are all recorded on a drug
25 evaluation and classification report. I'm going to ask this

1 person what was the last thing he had to eat today? What was
2 the last thing they had to drink and when? What time did they
3 eat? Get an idea of if they know what's going on, what time
4 is it? If so, what day is it?
5 From there, I'm going to get into a little bit about
6 the person's medical history. Does the person have diabetes
7 or epilepsy? Is the person on any type of medication? Has
8 the person been to a doctor in the last couple of days? Does
9 the person have any type of blindness in either eye?
10 Going through those questions to determine if,
11 again, is this some type of medical rule out or is this a
12 situation where this person truly is impaired?
13 Q Now with regards to this, you said this is a fork in
14 the road indicating that this is where you initially start
15 asking or observing things that may be a medical rule out, is
16 that correct?
17 A That's correct.
18 Q Okay, does the concern about a medical rule out
19 continue pass just this phase?
20 A I'm sorry, I am not sure I understand your question?
21 Q Meaning after this preliminary examination, do you
22 at any time, were you ever concerned with the possibility of a
23 medical rule out further on in the evaluation?
24 A At this point, if I know that this doesn't look like
25 this drug impairment, no, we are going to cut it off and we

1 are going to activate EMS and take him to the hospital.
2 Q In your personal experience, have you ever done
3 that?
4 A Yes, I have.
5 Q Okay. Now, further on -- well, strike that. Well,
6 keep going. What else happens in the preliminary examination?
7 A Like I said, we will get the first pulse, we will
8 check the eyes and then we will move -- after the questions,
9 then we will move into our next step, which will be the
10 initial test of the eyes.
11 We are looking for horizontal gaze nystagmus,
12 vertical gaze nystagmus, and a lack of convergence. Now when
13 we look for horizontal gaze nystagmus, we are also going to be
14 checking for an angle of onset.
15 And when I say an angle, we are actually going to be
16 estimating what that degree is of onset. And the reason for
17 that is, is alcohol the only factor here and, if so, yes we
18 know that the person has been drinking, we know what the BAC
19 is, but is that consistent with that angle of onset?
20 Q Okay, continue.
21 A From their, we will then move on past the eye exam.
22 We have done a lack of convergence, horizontal gaze nystagmus,
23 vertical gaze and resting nystagmus, we are going to record
24 all that information and then we are going to get into the
25 psychophysical test.

1 Q Actually, let me back you up for a second, I
2 apologize. With regards to the eye examination and the
3 horizontal gaze nystagmus, are there anything -- when you are
4 performing the horizontal gaze nystagmus test and the
5 indicators, which would be concerning to you and maybe raise
6 the flag that the person may have a medical issue?
7 A Well, prior to this, --
8 Q As you been trained, yes.
9 A Prior to this, we have already check in the
10 preliminary exam. Does this person have equal tracking and
11 are the pupils equal in size and is there any indication of
12 resting nystagmus.
13 Q Now let me give you a hypothetical. For instance,
14 the person comes in and they exhibit nystagmus, they exhibit
15 lack of smooth pursuit, however, they do not exhibit distinct
16 and sustain nystagmus at maximum deviation.
17 They do then, however, exhibit nystagmus prior to 45
18 degrees. Would that concern you and why?
19 A Yes because if there is anything outside the normal
20 of what we have been taught, I have never seen that scenario
21 but I have seen scenarios where completely bizarre effects on
22 the eyes. And, at that point, we know that that’s not
23 something that we have been trained in and that we need to go
24 EMS, get the hospital involved, stop the evaluation and have
25 this person go right to the hospital.

1 Q Okay. Now what is the next step after the
2 preliminary examination?
3 A Your Honor, the next step that we are going to do is
4 we are going to do the divide attention test. The first thing
5 we are going to do is the Romberg Balance where we are going
6 to test the internal clock, seeing if the person can estimate
7 for us the passage of 30 seconds.
8 We will ask the person to tilt their head back,
9 close their eyes and simply estimate for us the passage of 30
10 seconds. Tilt their head forward and tell us that they are
11 done when they have completed the test.
12 We are looking to test that internal clock, is it
13 sped up, is it very slow, and as they are doing this, are they
14 able to stand with their head slightly tilted back and
15 standing in a straight position?
16 Are they rotating back and forth, are they moving in
17 some ways, are there any type of body tremors.
18 The next thing we are going to do is the walk and
19 turn test. The walk and turn is the same test that we do on
20 the standardized field sobriety test that you are very
21 familiar with. I can go into that if you need to.
22 Q Well, some of the things you talked about body
23 tremors. I mean give me a little bit more example of that.
24 That sounds like not very much, explain that a little bit.
25 A Okay. Certain -- when we talk about body tremors,

1 we are looking at how the actual -- I mean you can actually
2 see tremors within the body.
3 You can also see eyelid tremors. How is the person
4 standing. Are they able to stand erect or are they twitching,
5 are they moving back and forth? Is something happening that's
6 out of the ordinary?
7 Q Now with regards to this, is this minutia we are
8 looking at or this is something which is grossly obvious?
9 A No, these are things that are obvious to the person.
10 Q Okay. Now, with regards to the divided attention
11 test, there have been in -- previous witnesses have discussed,
12 there have been some discussion with regards to indicators of
13 impairment versus indicators of which category of drug may be
14 causing the impairment. What is the importance of the divided
15 attention test?
16 A What we are looking for here is, is there impairment
17 and how is that effecting them physically? I mean, are they
18 able to do those psychophysical tests.
19 Q Now, with regards to some of the other ones, say
20 horizontal gaze nystagmus and lack of convergence are those
21 indicators of impairment or something else? Just so that we
22 can differentiate.
23 A Well, they can be impairment but they can be
24 something else. I mean we are looking for signs and symptoms
25 that are associated with these drug categories.

1 Q Okay. So, that would be more of an indicator of a
2 category versus an indicator of impairment, is that correct?
3 A That's correct.
4 MR. DeLEONARDO: Your Honor, I wasn't objecting, I
5 assume that this is what is meant, but I assume this line of
6 question is in the DRE protocol what emphasis do they place
7 on. Is that --
8 MR. WELLS: Rephrase that?
9 MR. DeLEONARDO: Well, when you are indicating that
10 it can be a sign of impairment, in DRE protocol they would use
11 it for that, is that -- I just want to clarify that where,
12 again, we are only talking about he is explaining what the DRE
13 protocol considers it.
14 MR. WELLS: Oh, exactly.
15 MR. DeLEONARDO: Okay.
16 MR. WELLS: Exactly.
17 MR. DeLEONARDO: Then, I am good.
18 MR. WELLS: And if it comes out incorrectly --
19 MR. DeLEONARDO: Just wanted to clarify because it
20 was going down that road.
21 THE WITNESS: In the psychophysical test, Your
22 Honor, just to clarify. This is done -- these are done not
23 out on the street, these are now done in a processing area,
24 away from everybody else. It is normally a quiet and a
25 controlled atmosphere. It is very well lit --

1 MR. DeLEONARDO: Objection, he is speculating as to
2 what they are all done. He can talk about himself but not
3 anybody else.
4 THE COURT: Overruled.
5 BY MR. WELLS:
6 Q Well, let me clarify with regards to that. How is
7 it trained where the evaluation is supposed to be done?
8 A They are trained to not do it -- this would not be
9 done out on the street. This would be done away from
10 everybody else in a more control setting that is well lit,
11 flat level, free of debris, knowing there is going to be a
12 lying on the ground. In an area that we can -- that's a
13 little bit more conducive to doing the field sobriety test.
14 Q Okay. Now continue, okay.
15 A The next one is the walk and turn. This is the same
16 one, like I said, this is the same one that we have been doing
17 for the standardized field sobriety test.
18 After that we will do the one leg stand with the
19 exception here is we are going to do both feet. We are going
20 to ask them to stand on the left foot, raise their right foot
21 for the first one, and then we are going to ask them to switch
22 before we move on to the finger and nose test.
23 During the finger and nose test, we are going --
24 excuse me, to ask the subject to stand, tilt their head back
25 slightly, close their eyes.

1 Prior to that, we will give them instructions on
2 taking their hand, making a fist with each hand and extending
3 their index finger and explaining to them we want them to come
4 up with the very tip of their finger and touch the very tip of
5 their nose and automatically bring it back down. Not pad, tip
6 to tip, automatically bring it back down.
7 And we ask the subject do you know which hand is
8 your right hand is your right hand and which hand is your left
9 hand?
10 We again give them the instructions and then we go
11 through the series of finger to nose test, going left, right,
12 left, right, right, left.
13 Q Okay.
14 A Okay. After the psychophysical tests are done, we
15 then move onto the examination of the vital signs. At this
16 point, we are going to take a second pulse, we are going to
17 take a body temperature and we are going to take the person's
18 blood pressure.
19 Q Are there any tools which are used to take either
20 the blood pressure or the body temperature?
21 A Yes. We will be utilizing a stethoscope, a manual
22 blood pressure cuff and a thermometer.
23 Q Do you have any copies of the pictures of those by
24 any chance?
25 A I do. I have also included in those pictures, there

1 is a picture of my penlite when we get to the eye exam.

2 (Long pause.)

3 BY MR. WELLS:

4 Q I show you what has been marked as State's Exhibit

5 No. --

6 THE CLERK: 25.

7 MR. WELLS: 25.

8 (Pause.)

9 MR. WELLS: And No. 26.

10 THE CLERK: 26.

11 MR. WELLS: 27.

12 (Pause.)

13 BY MR. WELLS:

14 Q State's 25, do you recognize this?

15 A Your Honor, this is a picture of my stethoscope out

16 of my DRE kit.

17 (The picture referred to was

18 marked for identification as

19 State's Exhibit 25.)

20 BY MR. WELLS:

21 Q Now is there any standardization as to what kind of

22 stethoscope is used by DREs throughout the State of Maryland?

23 A There is none.

24 Q States 26?

25 A Your Honor, this is a picture of one of my blood

1 pressure cuffs that I utilize in my DRE kit.

2 (The picture referred to was
3 marked for identification as
4 State's Exhibit 26.)

5 BY MR. WELLS:

6 Q Okay. Now can you give little more description as
7 to just blood pressure cuff? Is there anything about this?

8 A Your Honor, this blood pressure cuff is equipped
9 with three different cuffs. The average person, a pediatric
10 one for infants, and a very large one for extremely large
11 subjects who would have unusually large biceps or arms.

12 Q Now, were you present during the prior Frye-Reed
13 testimony, it was done in September?

14 A Yes, I was.

15 Q Were you present when there were some questions
16 about whether or not the cuffs would fit or the right sizes
17 were adjustable for specific people?

18 A Yes, I was.

19 Q Okay. Can you please address the Court as to how
20 that takes care of that issue?

21 A Your Honor, by utilizing the three cuffs, it does
22 give you the option to switch. However, in my evaluations, I
23 have never needed the pediatric one. And I have only used the
24 extra large one on one of my own particular officers.

25 I have never found one that would not work using the

1 normal adult size.

2 Q State's No. 27?

3 A Your Honor, this is the new blood pressure cuff that

4 is now being put out by Welch Allyn that I am issuing my

5 officers. And it actually has a fourth cuff that comes with

6 it.

7 (The picture referred to was

8 marked for identification as

9 State's Exhibit 27.)

10 BY MR. WELLS:

11 Q And State's No. 28?

12 A Your Honor, this is a Welch Allyn penlite that the

13 DREs can utilize to determine if in the darkroom when doing

14 the pupil exam that we will get to in a minute.

15 (The picture referred to was

16 marked for identification as

17 State's Exhibit No. 28.)

18 MR. WELLS: State would move to have these admitted

19 into evidence.

20 MR. DeLEONARDO: No objection.

21 THE COURT: This is State's 25, 26, 27 and 28?

22 THE CLERK: Yes, sir.

23 MR. WELLS: That is correct, Your Honor.

24 THE COURT: They will be admitted.

25 (The pictures marked for

1 identification as State's
2 Exhibits 25, 26, 27 and 28 were
3 received in evidence.)
4 BY MR. WELLS:
5 Q Okay. Now with the vital sign measurements, what is
6 the first vital sign that you take?
7 A First vital sign measurement will be the second
8 pulse. Then we will take the blood pressure and the body
9 temperature.
10 Q Okay. Now what is the importance of these?
11 A To test what the person is happening on the inside
12 with the body. Drugs will cause elevation or decreasing of
13 pulse rate, --
14 MR. DeLEONARDO: Objection.
15 THE WITNESS: -- blood pressure --
16 MR. CRUICKSHANK: Objection.
17 MR. DeLEONARDO: I think we are getting into that
18 area again, will, may or have no effects. So, if you could
19 say he is looking for that effect but I don't think he can
20 testify that it has that effect.
21 MR. WELLS: Your Honor, with regards to that, I will
22 just ask him what are you looking for?
23 THE WITNESS: I am looking to see what the person's
24 vital signs are.
25 MR. WELLS: Okay.

1 BY MR. WELLS:
2 Q And moving on at this point.
3 A The next test we will do will be a darkroom exam.
4 Prior to going into the darkroom, we will be utilizing a
5 pupilometer and a penlite.
6 The pupilometer being a card with dots on the side
7 measuring the size of the pupils that we will estimate pupil
8 sizes.
9 Our very first one will be in room light under this
10 type of lighting condition whatever the room light with all
11 its lights on would be.
12 Q Briefly, I am showing you what has been admitted as
13 State's Exhibit No. 4.
14 A This is one of the pupilometers that is issued or
15 can be used by DREs.
16 Q Okay.
17 A From there, we will then go into a darkroom where a
18 room can be a closet -- something that can be made totally
19 dark. Where we shut the lights off, there are no -- there is
20 no ambient light in the room.
21 Q From there, we will wait 90 seconds for their eyes
22 and our eyes to adjust to the light. Utilizing a penlite and
23 covering the penlite with just our fingers so we have a little
24 orange glow, that's the only light then that is in the room.
25 We ask the subject to focus on a spot on the wall.

1 And then we will use the glow of the finger to estimate that
2 person's pupil size in the darkroom conditions.
3 From there, we will then utilizing the penlite again
4 will bring it around -- will shine the light into the
5 subject's eye and see how that light affects the pupils.
6 Does it constrict them, does it cause them to stay
7 the same? And is the reaction time normal, or is it slow?
8 And when you constrict it, does it stay constricted or does it
9 actually pulsate back out?
10 During the darkroom exam, we will also check the
11 oral cavity to see if there is any indications of -- if they
12 have been taking anything orally that could be leaving some
13 type of residue or smoking something.
14 We will check the nasal area. Have they been
15 snoring or sniffing something. Then we will also check the
16 front of their clothing to see if they have any residue or
17 anything of that nature on the front of their clothing.
18 Q And the next step in the evaluation?
19 A At this time, Your Honor, we have moved back out to
20 our room. We have out our room light on again and at this
21 time we are going to check for muscle tone.
22 Q What is the purpose of this?
23 A I'm looking for is the person very rigid, are they
24 normal, are they rigid -- could be -- are they flaccid? There
25 are times when subjects are very rigid to the point where they

1 are like a piece of steel. They can't move their arms.
2 And there are times where they are just very
3 flaccid. Where it's like there's nothing there.
4 At this time, we will check for muscle tone in the
5 arms and then we will check for injection sites in those arms.
6 Has the person been injecting some type of drug. We
7 will look not only in the arms where you normally would see it
8 but also between the fingers and the hands and ask them if
9 there's any indication of that type of drug use? Have they
10 been shooting anywhere else on their body?
11 We don't get into looking and checking those
12 particular areas out but we will record that information.
13 Q Now with regards to determining whether a muscle
14 tone is normal or not, are you looking at minutia or again is
15 this something which is grossly apparent?
16 A This is grossly apparent. I mean you are definitely
17 going to know that this is muscle -- I mean this is muscle
18 rigidity or this is muscle -- you know being very flaccid.
19 Q As a matter of fact with regards to the DRE
20 evaluation, is there a saying that is taught that if you think
21 you see it, you don't? And explain that to the Court.
22 A When we are going back to horizontal gaze nystagmus,
23 if you think you are seeing it, then you are not.
24 Q Explain that.
25 A I'm sorry?

1 Q Explain that.

2 A A good example is that's why we had to change the
3 clues to nystagmus. We have that lack of smooth pursuit but
4 we also have distinct and sustain the nystagmus at maximum
5 deviation. So, in other words, if you take the eye all the
6 way out and maybe it bounces once or twice, you are like, did
7 I see it? Then, no, you didn't see it.

8 If you take it all the way out though and it's
9 distinct and it's sustained, then that's what we are looking
10 for.

11 Q Okay. And does that hold true with regards to the
12 examination of the muscle tone as well?

13 A It can, yes.

14 Q Okay. I am sorry, you were on the examination of
15 injections sites. Were you finished with that?

16 A Yes, I was.

17 Q What is the 10th step?

18 A The 10th step at this time, we are going to over our
19 evaluation with the subject. We have already advised them of
20 their rights and I'm going to go over the evaluation going
21 through what their body is telling me and then coming back and
22 saying, I think that you are under the influence of this.

23 And then having a conversation with that subject and
24 getting a statement from the Defendant.

25 Q How long does that take, generally speaking?

1 A Your Honor, again, that can take a couple of minutes
2 and, at this point, this may take 20 minutes. Getting into a
3 person's -- at this point, they may want to talk about their
4 prior injuries, how long they have been taking different
5 drugs, how they worked, how they didn't work, how they have
6 been self-medicating themselves? It can go from one extreme
7 to the other.
8 Q And what specifically, I mean what are the general
9 questions that you are asking at this point? What are you
10 looking for with regards to this point?
11 A I want to corroborate what I'm observing. And I am
12 confronting them with, yeah, I think you are under the
13 influence of cannabis and this the reason why. And then they,
14 you know, are they going to admit to taking it and, if so, how
15 much do they admit and when did they admit to taking it?
16 Q Okay. And at this point, what happens after the
17 suspect's statements?
18 A At this point, Your Honor, I've gone through, I look
19 at everything that I've done, the notes that I've recorded.
20 How the arresting officer came in contact with this person
21 that night.
22 My complete evaluation and I form my opinion and,
23 again, is this person under the influence. If so, what's
24 causing the impairment? Is this person not under the
25 influence? Is there some type of alcohol rule out or is there

1 some type of medical condition that could be causing this.
2 And, at that point, I form my opinion.
3 Q Is there any tool that you use to form that opinion?
4 A I use the matrix.
5 Q Okay. What happens after you have formed your
6 opinion?
7 A At that point, I then go over the advice of rights
8 again with them explaining to them that I have found them to
9 be under the influence of drugs, if that's what my outcome
10 was. And that I am requesting them to take a blood test.
11 Explain to them the process for having a blood draw.
12 Q Now with regards to developing your opinion, is
13 there one thing over another in which gives more -- well
14 strike that. How do you develop your opinion, is it just one
15 specific thing? Is it one thing has more weight than an
16 other, just how do you develop your opinion out of all the
17 information that's presented?
18 A Your Honor, I just look at the totality of the
19 circumstances. What am I seeing that is causing the
20 impairment and what am I ruling out? And do I have enough to
21 say that this person is truly impaired?
22 Are the psychophysical tests so bad that this person
23 is unable to operate a vehicle safely tonight or today,
24 whenever ---?
25 Q I guess the question to ask is the trickier part to

1 determine whether or not the person is impaired or what
2 category of drug that they are impaired under? Does that make
3 sense?
4 A I'm not sure I understand?
5 Q Well, my understanding is with regards to the DRE
6 protocol, there is signs which indicate a category of drug and
7 signs which indicate impairment. Now, what exactly is the DRE
8 doing with regards to all of this?
9 A Well if I'm going to find that the person is
10 impaired, then I most likely am going to be able to figure out
11 what's causing that impairment. If it's not in my
12 symptomatology matrix, then there has to be something else
13 going on.
14 At that time, it would then be referred to the
15 hospital that this must not be a drug impairment but must be
16 something else that would be causing that impairment.
17 Q So, the concerns of a medical rule out continue
18 throughout the entire evaluation, is that correct?
19 A Yeah, just because we are at the crossroads, you
20 know, that's just the initial phase of whether this person is
21 a drug impairment. I'm sorry, is medical impairment.
22 But at anytime during this evaluation, it could be
23 to the point where we are going to get the, you know, I form
24 my opinion, I can stop and say, hey, wait a second, this just
25 doesn't look right. We need to have this person taken to the

1 hospital.

2 (Pause.)

3 MR. WELLS: Your Honor, at this point, I have no

4 further questions.

5 THE COURT: All right, I am going to take a 10-

6 minute recess.

7 THE CLERK: All rise.

8 (Whereupon, a brief recess was taken.)

9 THE CLERK: Silence in Court, all rise.

10 THE COURT: Be seated, please.

11 MR. DeLEONARDO: Your Honor, if I could

12 preliminarily just to get some idea as to how far the Court is

13 looking to go this evening just so I know what subject

14 matters, because some may take a lot more time. I would

15 rather not interrupt. So, I didn't know how long the Court

16 had anticipated going this evening?

17 THE COURT: Well, how long does everyone want to go?

18 MR. DeLEONARDO: I am sorry, I couldn't hear you.

19 THE COURT: How long does everyone want to go?

20 MR. DeLEONARDO: Well, I mean that is up to

21 everybody, I mean, I am fine with however Your Honor wants to

22 do it. I think either way we can finish up all that testimony

23 tomorrow but I just want to at least know --

24 THE COURT: I mean we are scheduled for tomorrow.

25 MR. WELLS: With regards to the additional

1 testimony, we have the cross-examination, which Mr. DeLeonardo
2 knows how long best that is going to take and then we have, I
3 think very short period of time for a rebuttal witness. So
4 that, I don't expect to take what a half an hour, if?
5 MR. DAGGETT: Well, totally an hour, maybe an hour
6 and a half.
7 MR. WELLS: Okay. Maybe an hour total for Officer
8 Woodward -- Lieutenant Woodward.
9 THE COURT: How long Defendant show up with for this
10 witness?
11 MR. DeLEONARDO: I assume it is going to be a couple
12 of hours.
13 THE COURT: Couple of hours?
14 MR. DeLEONARDO: Maybe two hours.
15 THE COURT: Well then I would say we are probably
16 going to knock off by quarter of five.
17 MR. DeLEONARDO: Okay.
18 THE COURT: Because we are not going to finish.
19 MR. DeLEONARDO: Well, no, that is what I was
20 anticipating --
21 THE COURT: If we are going to finish with --
22 MR. DeLEONARDO: -- I mean depending on legality,
23 it could take awhile and I didn't know whether the Court
24 wanted to go ahead and start --
25 THE COURT: Yes, if we were going to finish with

1 Officer Morrison today. I don't think it makes a whole lot of
2 sense to -- because everybody agrees, we can finish with
3 Officer Morrison and then finish with the State's next witness
4 tomorrow.
5 MR. DeLEONARDO: Yes, absolutely. We have tomorrow
6 and there is no -- I don't think that is going to be a problem
7 at all.
8 THE COURT: Very well.
9 MR. DeLEONARDO: Okay.
10 CROSS-EXAMINATION
11 BY MR. DeLEONARDO:
12 Q Good afternoon, Officer Morrison.
13 A Good afternoon.
14 Q I want to touch on a couple of areas. We will start
15 back with some of your background? You had indicated in your
16 initial direct examination that you initially did the
17 preschool in '90, correct?
18 A That's correct.
19 Q And that was after you had spent about five years in
20 field sobriety testing, is that right?
21 A That's correct.
22 Q And then it was '91 I think you said you actually
23 became the DRE, right?
24 A That's correct. I started in the end of 1990.
25 Q Okay. Now, the manual that you were trained with

1 back in 1991, you have seen the 2010 manual obviously,
2 correct?
3 A Yes, I have.
4 Q And is it substantially the same as the manual you
5 were trained in, in 1991?
6 A In regards to what?
7 Q Well, I guess I will turn that around and say are
8 there any substantial differences that you can point out
9 between the manual in 1991 and the 2010 version?
10 A There are updates, yes.
11 Q Okay. Well, could you give us an idea of what
12 updates have occurred?
13 A I don't have them all in front of me. I can go over
14 some that I know off the top of my head.
15 Q That is fine.
16 A Your Honor, when I originally went through the DRE
17 process, it was a category of PCP or phencyclidine. We have
18 now found that there are additional drugs that cause similar
19 effects --
20 MR. DeLEONARDO: Objection as to what he found
21 caused. I asked about what changes he could explain. And now
22 PCP instead just being labeled that, it is now dissociative
23 anesthetic is what you are saying?
24 THE WITNESS: That's correct.
25 MR. DeLEONARDO: Okay.

1 BY MR. DeLEONARDO:
2 Q So, they changed the name of the category, is that
3 correct?
4 A And they've added drugs to that category.
5 Q Fair enough. Okay, what other changes?
6 A Pupil sizes. When I went through, originally, they
7 had a 3.0 to 6.5 was the normal pupil range and now it has
8 been broken down into each different types of lighting
9 conditions.
10 Q Do you know approximately when that was?
11 A The exact year, no. I would say probably within the
12 last five years.
13 Q Anything else notable?
14 A Your Honor, I'm sure there is more notable stuff in
15 there but off the top of my head, I'm teaching from the new
16 manual and I haven't kept track of what else has been changed.
17 Q Well, you have been involved with the program for
18 about 11 years. I mean it is fair to say it is pretty much
19 substantially similar since you got involved, correct?
20 A A lot of things, yes.
21 Q Okay. And as far as the conferences, I mean you go
22 to these conferences yearly, you said there were 16
23 conferences you have attended?
24 A That's correct.
25 Q And those are all over the country, right?

1 A They have been.

2 Q Okay. Now you are also part of -- you hold
3 positions in IACP, is that correct?

4 A I am a section member, yes.

5 Q And how long have you been a section member? You
6 are talking about a DRE expert section, correct?

7 A Yes. I'm a DRE section member and I've probably
8 been that for probably going on 10 years now.

9 Q So, almost as soon as you got involved?

10 A No, it probably wasn't that soon. It was probably I
11 would say maybe eight or nine years after I got involved.

12 Q Well, you said you became a DRE -- okay, so you were
13 talking about as about midway about 2001 approximately you got
14 involved?

15 A That's probably -- well, actually, I guess just
16 before that?

17 Q So, have you ever been part of TAP?

18 A Have I ever been a part of TAP?

19 Q Yes. Have you ever been a member of TAP?

20 A Never a member of TAP. I have sat in on numerous
21 TAP meetings.

22 Q Now when you go to all these conferences, you know
23 you belong to Montgomery County Police, do they pay for you to
24 do these or is it IACP?

25 A I have been paid -- I have gone as an instructor so

1 IACP wouldn't be paying my way but NHTSA has paid my way to do
2 a presentation at the conference. And State Highway has paid
3 my way to attend these conferences and trainings.
4 Q Okay. So, it is not you but it is some other agency
5 other than Montgomery County?
6 A Yes because Montgomery County has never paid my way
7 to go there.
8 Q Now, you talked about in your curriculum vitae you
9 pointed out that you had done a lot of additional medical
10 classes after you became certified over the years, is that
11 right?
12 A That's correct.
13 Q And I assume that you went to those classes because
14 you thought you would learn something new, is that right?
15 A That's correct.
16 Q And so it is fair to say that it wasn't information
17 that you felt that you had already learned as a DRE certified
18 instructor or examiner?
19 A Well, it's information that I had already learned.
20 But it is stuff that I had wanted to continue my education on?
21 Q So, all of the classes that you went to was taught
22 as part of your DRE class?
23 A I can't say a part of but it would be related to.
24 Q Well, related to is different. You went to great
25 lengths to point out that you had gone and had all of these

1 additional medical classes or informational seminars that you
2 went to, right?
3 A That's correct.
4 Q And the detail and the content of that information
5 was something you didn't already know, right?
6 A No because if I'm learning about stimulants, I
7 already know about stimulants but if ecstasy comes out or a
8 new stimulant should come out and I want to learn more about
9 that and learn more from the medical field about it, then that
10 was my goal to expand what I already knew about stimulants.
11 Q Okay.
12 A I give that just as an example.
13 Q But again, so, it is a way for you to learn new
14 information that you didn't already know, right?
15 A Okay.
16 Q And it is not a requirement for DRE certification to
17 go to those classes, is it?
18 A Is it a requirement, no?
19 Q And when a person becomes a certified DRE, you would
20 agree with me that at that point IACP is saying this person is
21 fully qualified to give an exam without any additional
22 training?
23 A Yes.
24 Q And reach an opinion, correct?
25 A That's correct.

1 Q And rule out medical causes, correct?

2 A That's correct.

3 Q And so while you had all this extra training, you
4 would agree with me that there is a substantial number of DREs
5 that have never had that training?

6 A Yes and no.

7 Q Yes they have or they haven't? Go ahead and answer
8 I am intrigued.

9 A Your Honor, one of the reasons I go to the training
10 is so that I can bring it back to Maryland to teach in in-
11 service. To educate the other DREs what is new, what changes
12 are taking place and what we are seeing, what is happening?

13 Q Okay, but, again, that is part of their in-service
14 as they go along but upon graduation, they are fully able to
15 make these determinations without any additional training,
16 correct?

17 A That's correct but they are also required to attend
18 a yearly in-service to get updates.

19 Q An eight-hour in-service, correct?

20 A That's correct.

21 Q All right. And now when you have these classes,
22 were they taught by -- you said you have actually taught the
23 in-service, is that correct?

24 A Our in-service here in the State of Maryland, yes.

25 Q Okay. And those are generally taught by you or

1 other DRE instructors, right?
2 A Or doctors.
3 Q Okay. Doctors that you have come in they are
4 teaching subject areas, for example, they talk about a topic
5 regarding physiology, correct?
6 A They can, yes.
7 Q Okay. But the DREs in order to get into the
8 program, they have no requirements for any prior medical
9 training, true?
10 A No, there is no requirement.
11 Q Okay, so they can go through the field sobriety
12 test, the DRE preschool and the DRE school and, without any
13 prior medical training, they are considered to be sufficient
14 to rule out any medical causes of impairment?
15 A Yes with what you are saying.
16 Q Okay. Now when you talked about the preschool, you
17 mentioned that in order to -- as part of the preschool, you go
18 over the different parts of the DRE protocol but you also said
19 you do an alcohol workshop, is that right?
20 A That's correct.
21 Q And in that alcohol workshop, you said that you
22 obviously only dose with people with alcohol, right?
23 A That's correct.
24 Q And I assume as part of your requirements having
25 been involved in these alcohol workshops, essentially, you

1 have to ensure that people are healthy, right? The
2 volunteers?
3 A Rephrase that question?
4 Q Well, when you are part of the --
5 A I'm not sure I understand it, I apologize.
6 Q Okay. Part of the protocol in running these
7 alcohol -- there is a protocol required to run alcohol
8 workshops, is there not?
9 A That's correct.
10 Q And one of the things you have to ensure is the
11 safety of the participants, correct?
12 A That's correct.
13 Q And so one of the things you are doing is not
14 putting people in there that may have medical conditions,
15 correct?
16 A That's correct. We want to rule out -- we want to
17 make sure they are healthy?
18 Q Right. So, when they are doing these alcohol
19 workshops, you are dosing people with alcohol and then they
20 are healthy volunteers, right?
21 A Yes.
22 Q Okay. So, they are trying to distinguish someone
23 who has alcohol and is healthy versus someone who has alcohol
24 or no alcohol and is healthy, correct?
25 A Well, to a certain extent because we have had people

1 who have had eye issues that we have used as placebos or keep
2 that very low doses that -- so the students can see if the
3 student identifies some type of eye issue or some type of
4 injury that would prevent them from doing the evaluation.
5 Q So, that is part of the protocol in running an
6 alcohol workshop in the preschool manual?
7 A That's actually just a part of the protocol for
8 working an alcohol workshop in every manual.
9 Q In every manual is to use people with medical
10 conditions?
11 A If they are available, if we have them available,
12 yeah, we can use them.
13 Q Okay. That is in -- you have the protocols for that
14 in the preschool manual?
15 A Do I?
16 Q That tells you how to run an alcohol workshop?
17 A I do not have the alcohol workshop material here,
18 no. That would be actually in the train the trainer manual
19 for SFST, I believe.
20 Q So, there is not one for DRE preschool?
21 A Not that I am aware of.
22 Q Okay. So the alcohol workshops for DRE, they don't
23 actually have a module explaining you how to run the workshop?
24 A Well, you are using people who are already trained
25 as instructors, who have already gone through the train the

1 trainer program.

2 Q Who have been train how to run it for alcohol,

3 right?

4 A That's correct, yes.

5 Q Okay. Again, when you run this, do you use people

6 that are taking prescribing medication?

7 A Only if we know if that prescribed medicine is not

8 going to have an adverse affect. In other words if a person

9 comes in and they say, I've been prescribed Zyntas and I'm

10 taking a very low dose of Zyntas, this is my dose. Then, yes,

11 then, yeah, we can use that person. But we would keep them at

12 a very low dose of alcohol to not have an additive effect.

13 Q So, let me ask you this. How do you get your

14 volunteers?

15 A How do we get volunteers?

16 Q Yes.

17 A For what class?

18 Q For your alcohol workshop preschool?

19 A Okay. Well, it would depend.

20 Q Well, give me an idea?

21 A Okay.

22 Q I mean you have a lot of people in the police

23 academy -- police force, right, do you use them?

24 A I can, yes.

25 Q Do you run an ad in the college paper?

1 A No, we do not.
2 Q So who -- is it basically --
3 THE COURT: Too many volunteers.
4 (Laughter.)
5 MR. DeLEONARDO: Yes, exactly. That is where you
6 get them.
7 BY MR. DeLEONARDO:
8 Q So primarily, you would agree with me you are using
9 other officers?
10 A No.
11 Q Who else do you use?
12 A Well, first off, Your Honor, if I'm the course
13 manager, then I am responsible for getting the drinkers. If
14 somebody else is the course manager, they are responsible for
15 getting the drinkers and that's where the gray area -- I don't
16 know where the drinkers are coming from.
17 Where do people come from? Their friends, their
18 family, of the classmates, of the instructors, of other
19 academy -- or other people who may be working in the academy
20 or wherever we are teaching.
21 We've gotten hotel staff before. It depends on just
22 where we are teaching the class and where we can get people to
23 volunteer for us.
24 Q But there is no concerted effort to get people with
25 systemic medical conditions to participate, is there?

1 A No.
2 Q And there is no concerted effort to get people who
3 are taking therapeutic dosage of medication that could induce
4 certain signs or symptoms, is there?
5 A No.
6 Q When we talk about you also said that you teach
7 right from the book was your term, right?
8 A I don't recall that but okay.
9 Q Well, you -- well, I will ask you then. There are
10 manuals that are put out both preschool manual, there is the
11 actual seven-day manual -- or excuse me, the preschool manual
12 and a seven-day manual, correct?
13 A That's correct.
14 Q And there is an instructor manual that goes with
15 both, correct?
16 A That's correct.
17 Q And in all of that, it sets out the exact
18 standardized process that you are to use to teach or to
19 administer the program, correct?
20 A It sets the guidelines, yes.
21 Q Well, but it sets, as you said the standard for how
22 it is supposed to be done, right, the evaluation?
23 A That's correct.
24 Q All right. So, you certainly agree that when it is
25 taught, the DREs are taught to follow the manual, right?

1 A They cannot subtract from the manual. If there is
2 something that they can use to assist in training, then, yes,
3 they can do that. That would be recorded with the course
4 manager and depending on what the situation was, whether it be
5 some type of handout, some type of drawing, then that would be
6 recorded and placed in the course manager's report to show
7 what was used to help illustrate the teaching.
8 Q All right. The 2010 DRE Student Manual that was in
9 Exhibit 5 --
10 A Okay.
11 Q -- when students are taught, they are taught
12 following that manual and what it says, correct?
13 A That's correct.
14 Q They are not to deviate or come up with their own
15 way to assess someone. They are supposed to follow the
16 matrix, correct?
17 A That's correct.
18 Q All right. So, even though there may be additional
19 training, ultimately, they follow what is in the manual,
20 correct?
21 A Yes. The manual is the guide and there can also be
22 training aids that will assist in the training of the
23 students.
24 Q Well, the guide would suggest that you could not
25 follow it. You are saying that you do have to follow it

1 though, right?

2 A Oh, yeah, you are going to follow the manual. You

3 are going to follow the material that's in the manual, but

4 there can always be additional material that was handed out.

5 Q All right. Now, again, when you talked about the

6 DRE seven-day school, you said, again, with the same kind of

7 alcohol class, there is no concerted effort to bring people

8 with medical conditions and therapeutic levels, right?

9 A No.

10 Q Okay. Now, you also said that one of the things

11 that occurs is that you have this -- how to say it, you have

12 people that pretend to play that they are impaired, correct?

13 A Yes, Your Honor, one of these sessions that we have

14 is called role playing where we have instructors utilizing a

15 known evaluation assist in trying to get the student to look

16 at doing an evaluation, coming up with results and then

17 determining what the results mean.

18 Q So, for example, you have someone who goes in and

19 pretends, for example, to be under the effects of marijuana,

20 right?

21 A That's correct.

22 Q And so how do they fake blood pressure?

23 A They don't.

24 Q They just assume that that's what it is?

25 A No, no. When they do this, Your Honor, they would

1 administer the blood pressure on me, they would tell me what
2 my results were. I would be looking to make sure they are
3 doing it properly, I may be even using a dual headed
4 stethoscope to listen to make sure that the results are the
5 same. And, at that point, yes, I can -- they have done it
6 correctly.
7 But what I am going to tell them then is off my
8 sheet. That here is somebody who is under the influence, a
9 cannabis, off this evaluation, but these are what the results
10 are.
11 So, yes, I am going to confirm that they are doing
12 it properly but in the role playing I'm then going to give
13 them the results.
14 And that at the end, they are going to have to look
15 at the face sheet that I have given them to determine is this
16 person impaired and what's causing the impairment.
17 Q So what they are practicing on essentially is
18 knowing what signs you tell them that are on the matrix,
19 correct?
20 A No, they are practicing on results that I give them.
21 Q Well, in terms of reaching their conclusions?
22 A I give them results and then they apply that to the
23 matrix, yes.
24 Q Okay. So, it really is not about observing you,
25 it's about the information you give and then being able to

1 apply it to the matrix?
2 A To interpret it.
3 Q Okay. So, when you say there is lots of hand on, I
4 think is the phrase I actually I had, when you said there is
5 lots of hands on. That hands on really is involving this
6 pretend -- these are my symptoms now tell me what it is,
7 right?
8 A No, that's just one part of our hands on. When we
9 go through vital signs, we are going to have a classroom
10 session and then part of that class room session will be them
11 breaking up into groups, working with partners with an
12 instructor and then actually doing blood pressure, doing pulse
13 rate, doing body temperature, doing the pupil sizes,
14 estimating the pupil sizes in all the different lighting
15 conditions.
16 So, we are going to have repeatedly practicing those
17 different things and then we are also going to repeat or have
18 them practice the 12-step process.
19 Q Now, you say they have to have -- let me step to the
20 certification. Again, with the certification, you said that
21 essentially you pulled subjects from I guess the jails,
22 essentially, that are not arrested for driving impaired but it
23 maybe arrested for some other reason, correct?
24 A That's correct.
25 Q And that essentially who tells you whether someone

1 should be someone you should look at? Like, who tells you
2 this is a good person, a good candidate for --
3 A Me as an instructor?
4 Q Yes.
5 A Well, I mean I'll go in and ask the jail, hey, do
6 you have anybody that you think that could be under the
7 influence? Just sort of push me into the right, you know, to
8 maybe speed up the process.
9 After that, I then go through and look to see if
10 there is somebody who may be impaired and it would be a good
11 candidate for us to use.
12 Q So, when you go in at that point, and you said you
13 evaluate them first to make sure they are impaired?
14 A That's correct.
15 Q Okay. And so now when you evaluate them, you do the
16 full protocol for them?
17 A I do not, no.
18 Q Well, how much of a protocol do you do to ensure
19 they are impaired?
20 A I'm looking for certain things that will determine
21 if the person is under the influence, ask them questions and
22 see if they would be a good candidate to utilize.
23 Q Well, what you said is what you don't do is you
24 don't allow students to actually interview the person or the
25 subject about their history of drug abuse, correct?

1 A Not until the very end.

2 Q I guess you don't interview them at all about their
3 history, is that right?

4 A No, I do. At the end, I --

5 Q At the end, but I am talking about prior to them
6 reaching their own opinion?

7 A We are going to ask -- they are going to ask them
8 the questions at the front -- at the very front of the exam,
9 what did you eat today, what was the last thing that you drank
10 today and when was the last time you went to the doctor? Do
11 you have diabetes or epilepsy, are you under the care of a
12 doctor or dentist? What time is it now, do you wear glasses
13 or contacts?

14 But the question of are you taking any type of drugs
15 or medicine? No, I don't allow that question. I immediately
16 step in and say I don't want you to answer that question.

17 Q Nor, do you have them say what drug they typically
18 use, correct?

19 A That's correct.

20 Q All right. So, I think you said that you try to do
21 it at the double-blind situation?

22 A No, I did not.

23 Q Not on this? Because obviously the person does,
24 correct?

25 A No. Because what you are referring to as a double-

1 blind study would be sort of like with our alcohol workshops.
2 Q Okay, so that is fine tune. But on this, you would
3 at least make sure that they are not able to find out that
4 information so that you can test whether they are really using
5 the matrix?
6 A I want to make sure that they are doing a correct
7 evaluation, interpreting what they see correctly, applying
8 that to the matrix and justify what they are calling.
9 Q But I guess the question I have is you won't let
10 them ask the person what they are on and that is typically
11 what happens in the protocol, right, up front?
12 A That one question, yes, they're not -- we're not
13 allowing them to ask it up front.
14 Q And the reason that you are doing that is because
15 you really want to test whether they can do what they purport
16 they can do, correct?
17 A I want to know if they can do it, yeah.
18 Q Okay. Because you don't want them just relying on
19 what the person said?
20 A That's correct.
21 Q All right. So, now, when you do this and you have
22 the situation when you are testing, you a person -- the person
23 that -- the subject, do you advise them of Miranda?
24 A Which subject are you referring to?
25 Q The one who is in jail that you are now interviewing

1 about --

2 A Oh, no, no.

3 Q Okay. They are told that noting is going to be used

4 against them, right?

5 A That's correct.

6 Q And then they are asked questions about their

7 history and all of that, correct?

8 A That's correct. We also have a -- we actually have

9 a waiver form for them to sign, voluntarily agreeing to

10 participate in it. And this spells out the fact that what

11 we're doing cannot be used against them.

12 Q Okay. Which is very different than in the normal

13 course, where you advise them that what they say can be used

14 against them, right?

15 A Oh, that's correct.

16 Q So, you would agree with me their odds are much more

17 free with the information when they know it can't be used

18 against them as opposed to it can, right?

19 A I'm sure they are.

20 Q Right. And as far as when you talked about the

21 testing, now there are at least 12 that have to be done. The

22 student only has to do six by themselves, correct, the

23 evaluations?

24 A That's correct, six of them they have to do

25 themselves.

1 Q Okay. Now when you do this, when this occurs, is
2 there ever any disagreements between DREs as to whether there
3 is impairment or not?
4 A I can't think of any that they've ever disagreed on
5 impairment. I know that there's been -- they may be looking
6 at different matrix -- looking at the matrix and maybe one
7 thinks it's more of some type of drug whether then the other
8 one, or trying to figure out why this one is playing a factor,
9 or if this one is playing a factor, that type of thing.
10 Q And how long have you been doing these field
11 certifications?
12 A How long have I been?
13 Q I mean how many students have you ever seen during
14 your --
15 A I couldn't even begin to tell you.
16 Q Hundreds?
17 A I would say -- I don't know, 500.
18 Q And you have never had somebody say that person is
19 impaired, no that person has a medical condition, you have
20 never had that kind of disagreement?
21 A No, I've never encountered that.
22 Q All right. So, you talked about -- I am going to
23 move to the recertification. When you have the
24 recertification process, you said in every two years and there
25 are eight hours of required training, correct?

1 A That's correct.
2 Q And part of it is that there is the DRE log is to
3 ensure accuracy in the opinion, that is the reason for it,
4 correct?
5 A Making sure they are keeping their DRE log and it's
6 up-to-date.
7 Q Right. And part of that includes testing to confirm
8 in the DRE's opinion to confirm the result or the opinion,
9 right?
10 A I'm not sure I understand.
11 Q Well, when you have a DRE log, one of the categories
12 is confirmatory testing, did it confirm or not confirm to your
13 opinion, correct?
14 A That's correct.
15 Q And that is part of what is required to be kept in
16 the DRE log, right?
17 A Yes, so if we get a toxicological sample, we want
18 them to write that down.
19 Q And it's part of the requirements for
20 certification -- recertification, correct?
21 A That's correct.
22 Q And you are aware of for several years that there
23 was no blood testing being done on any of these samples, is
24 that right?
25 A That's correct.

1 Q Well, were the people still recertified?
2 A Yes, they were.
3 Q So even though that they would do however many
4 evaluations and there was no confirmatory testing, they would
5 just be recertified anyway?
6 A What they would do, Your Honor, is because of that
7 situation, we would routinely bring them down to Baltimore and
8 actually do certification down there and do that with a urine
9 test. So, it would not be a true -- I mean it would be under
10 the classroom setting not a actual evaluation.
11 Q It is not an actual true as you were getting ready
12 to say, it is a true recertification?
13 A No, it would not be a true evaluation as on
14 enforcement efforts as what I would say.
15 Q All right. Well, let's talk when we get into -- I
16 want to talk about the first step, which is the breath. You
17 talked about getting a breath test result, is that correct?
18 A That's correct.
19 Q And if I understood you, that it is perfectly
20 acceptable to do a DRE examination as long as it is not .07 or
21 higher, is that right?
22 A It's our standard here in Maryland that we will not
23 administer a test on subjects with a high BAC because we
24 already have a B case or an A case. There is no reason to go
25 forward with trying to get a C or D because if you already

1 have a .07, you have a good B case.
2 Q So you would do it on a .06?
3 A I'm sorry?
4 Q You would do it on a .06 BAC?
5 A It could be, yes.
6 Q Okay and is the standard in the manual for when you
7 should or shouldn't do it?
8 A I'm not sure there is a standard.
9 Q Okay. The way the protocol is written you can do it
10 if it is a .15, correct?
11 A I'm not sure, I would have to look that up and it
12 would probably. I have no idea even where to begin to look
13 for that one.
14 Q The standard for you is .06, so what you are saying
15 is that at a .06 that a DRE should be able to distinguish
16 between someone who is a .06 and signs and symptoms versus
17 there must be drugs as well?
18 A Well, Your Honor, the first thing here is with the
19 BAC, we are looking for signs of impairment. So, if me as the
20 arresting officer make an arrest and this person is falling
21 down drunk but yet I give him a breath test and their BAC is
22 inconsistent with their level of impairment, then, yeah, I'm
23 going to call the DRE.
24 Q I guess it would be hard if they are falling down
25 drunk to do the protocol, wouldn't it?

1 A Depending on what type of drug or --
2 Q Well, let's take it back, they are .04?
3 A Okay.
4 Q Okay. You still, in your opinion, can still do a
5 DRE examination, correct?
6 A Is there BAC inconsistent -- consistent --
7 Q It is a .04?
8 A Is there BAC consistent with their level of
9 impairment?
10 Q Okay. Well, right there, you are trying to
11 determine whether it is consistent with their impairment,
12 right?
13 A With the arresting officer's arrest.
14 MR. WELLS: Your Honor, objection, asked and
15 answered. I think we have been through this, I think the
16 point is made, asked and answered.
17 THE COURT: I heard the asked and answer. I am just
18 not sure I agree. Overruled.
19 MR. DeLEONARDO: Thank you, Your Honor.
20 BY MR. DeLEONARDO:
21 Q .04, you are saying that you can actually do a DRE
22 evaluation with someone who has a .04 blood alcohol content
23 already, correct?
24 A Yes, I can.
25 Q And one of the ways you try to determine whether the

1 impairment that you are seeing is consistent is by looking at
2 the exact angle of onset, is that correct?
3 A That's just one of many steps.
4 Q Well, that is a major step that you pointed out on
5 direct examination, is it not?
6 A It is one of the ways of --
7 Q It is the concept as referred to in the manual we
8 heard is the Tharp's Equation, correct?
9 A That's correct.
10 Q And that is something that DREs are taught that if
11 you determine an exact angle of onset and it doesn't line up
12 with the blood alcohol content then that means that there is
13 more impairment than should be there from alcohol, is that
14 correct?
15 A That's correct.
16 Q And so at that point, the belief is that there is
17 drugs ---?
18 A Can be, yes.
19 Q Okay. So it is your -- it is the DRE manual and the
20 training that says that despite that, you can still
21 differentiate between the impairment caused by alcohol and
22 impairment caused by some drug, right?
23 A I guess in your words, yes.
24 Q Well, it isn't my words, you agree with that, right?
25 A To a certain extent.

1 Q So, let's -- we talk about distinction. Let's talk
2 about step two in your interview of the arresting officer.
3 Now, one of the things you described is that you are trying to
4 get, in this case, certain information from the arresting
5 officer, right, the person that arrested them?
6 A That's correct.
7 Q And you said that could take five to 20 minutes or
8 so?
9 A It just depends on how much information the
10 arresting officer has to give us.
11 Q And you said depending on upon where you are for a
12 DRE to respond it could be an hour, I mean it is hard to say.
13 It could be any length of time, correct?
14 A That's correct.
15 Q And the full examination takes about an hour to
16 perform, does it not?
17 A About 45 minutes to an hour depending on the
18 cooperation and the level of impairment.
19 Q Okay. So, conceivably it is not unreasonable that
20 from the time that the person was caught driving to the time
21 that you reached your opinion as to whatever drug they are
22 impaired in, it could be two to two and a half hours after the
23 fact, right?
24 A That's correct.
25 Q All right. And when you make your determination,

1 you are making your determination only as to what the
2 impairment is at the time, correct, of your evaluation?
3 A I'm looking at the totality of the circumstances but
4 my interpretation -- or my determination is this person
5 impaired at the time that I see the person?
6 Q Right. You are actually -- the manual actually
7 tells you, you are not to speculate as to what someone may
8 have been back at the time that they were operating the
9 vehicle, correct?
10 A That's correct.
11 Q Okay. So, when you do this evaluation, it is two
12 and a half hours after the fact, the only thing that the DRE
13 could say is at this time a person is impaired or not
14 impaired, correct? But not -- could not guess what they were
15 two and a half hours prior?
16 A Yes and no.
17 Q Well, you told me you can't speculate as to what a
18 person's condition was previous to that. Your manual is
19 pretty clear on that, is it not?
20 A If the arresting officer is seeing the exact same
21 signs and symptoms that I'm seeing, that the drug is a
22 category that would last that long, then it could be the same.
23 Q Okay. So, this arresting officer that has not been
24 through preschool, correct; not been through the seven-day,
25 correct --

1 A Well, we don't know that.
2 Q Well, so now it is okay if it is a DRE as well on
3 the scene? They wouldn't have to call one at that point,
4 would they?
5 A DRE?
6 Q Are we going to play semantics -- I mean --
7 A DRE --
8 Q -- the original police officer on the traffic side,
9 right?
10 A If we are dealing with a regular patrol officer --
11 Q Right.
12 A -- on the side of the road, he is not a DRE --
13 Q Right.
14 A -- then they may not have seen those things but they
15 may -- the officers in Maryland have received the drugs
16 that -- impaired driving blocks or --
17 Q Oh, everybody have?
18 A The majority of the police officers.
19 Q Talking about A-Ride?
20 A No, I'm talking about the four eight-hour block and,
21 yes, there are officers now in Maryland who are trained in
22 A-Ride.
23 Q So, let me ask you this. When that arresting
24 officer on the scene, they don't have the training that a DRE
25 has, correct?

1 A That's correct.
2 Q Which is the very reason why you are getting called
3 in to make this assessment, correct?
4 A That's correct.
5 Q And as we even heard from the State legislatively,
6 police officers can't ask for blood, correct?
7 A That's correct.
8 Q Because they don't have the training to figure out
9 whether or not someone would be warranted giving blood,
10 correct?
11 A That's correct.
12 Q So, when you are making this assessment, you are not
13 taking what the officer says as completely accurate and true
14 as to impairment, are you?
15 A I hope the officer is not lying to me.
16 Q Well, I am not saying they are lying. They may
17 believe what they believe. But you would agree with me that
18 you have had this trained distinguished between medical and
19 drugs or alcohol, correct?
20 A That's correct.
21 Q That officer hasn't had that, have they?
22 A I don't know what that officer has had.
23 Q Well, precisely, so when I asked you whether or not
24 you can estimate or predict back in time, the reason the
25 manual says you can't do that is because you are the one who

1 is offering the opinion, correct?

2 A To a certain extent, yes.

3 Q You need to be able to substantiate your findings,

4 correct?

5 A Yes, I do.

6 Q The roadside officer is not doing blood pressure and

7 temperature and pulse, are they?

8 A No, they are not.

9 Q Now, so when we talk about the next step, which was

10 you talked about this preliminary examination. And you said

11 this is where we make this fork in the road to determine

12 whether it is medical or not medical, right?

13 A That's correct.

14 Q And I think you said it several times, if it is

15 medical, I am call an ambulance and if it is not, we are going

16 to proceed, correct?

17 A That's correct.

18 Q So, in your interpretation of a medical rule out, it

19 is only a medical rule out if you have got to call an

20 ambulance?

21 A No.

22 Q I mean you would agree with me that there is a large

23 number of people who could have had medical problems that

24 don't necessarily need to be carted off in an ambulance?

25 A Oh, that's correct.

1 Q All right. So, when you make this preliminary
2 decision as to medical rule out, at that point, you are trying
3 to rule out all medical conditions that the person could have,
4 correct?
5 A That's correct.
6 Q You are what is commonly referred as a differential
7 diagnosis. You are trying to determine what could be causing
8 this medical condition, correct?
9 A That's correct.
10 Q And so this diagnosis that you are making at the
11 time is, one, that there is impairment, right?
12 A That's correct.
13 Q That is a diagnosis, correct? You agree with me?
14 A If they are impaired.
15 Q Okay. And, secondly, you are making a diagnosis
16 that it is not medical but drugs, it is step two, right? You
17 are ruling medical out, right?
18 A I'm ruling out medical and I'm ruling out -- I'm
19 ruling is this just drug impairment?
20 Q Right. Well, let's step through. You have three
21 phases. The first phase is, is there impairment? That is the
22 first phase?
23 A That's correct.
24 Q The second diagnosis is, is this impairment from the
25 medical condition or it impairment from drugs, correct?

1 A That’s correct.
2 Q And the third one is, if it is from drugs, what
3 category of drugs?
4 A That’s correct.
5 Q All right. So, in this second -- so when you talk
6 about this fork in the road, you are talking about the second
7 step, correct, is it medical or is it drugs, right?
8 A I’m not sure I understand what you say by second
9 step.
10 Q Well, we just established that there was three steps
11 to your evaluation in using global steps, which is you have to
12 determine if there is impairment, determine if it is from
13 medical or from drugs and then determine which category,
14 correct?
15 A Okay.
16 Q That is the objective. When we use objective, I
17 think it would be clear.
18 A Yes.
19 Q Those are the three objectives that --
20 A Yes.
21 Q -- you are accomplishing?
22 THE COURT: All right, good place to break.
23 MR. DeLEONARDO: Thank you.
24 THE COURT: I think we will be in this -- Rachel?
25 THE CLERK: Yes, sir.

1 THE COURT: Check with Carol and ask her will I have
2 anything else tomorrow morning.
3 (Pause.)
4 THE CLERK: We will be in here. There is nothing --
5 we will be in here, there is nothing scheduled in the morning.
6 There may protective orders in the afternoon depending on the
7 ---?
8 THE COURT: All right. This mean will be secure.
9 If you want to leave your materials on the table, you are free
10 to do so. We will try, I think I have got one pretrial. We
11 will try to get started at 9:30 tomorrow morning and move
12 right along.
13 I think I could have some protective orders in the
14 afternoon but this will get priority. I mean I am not going
15 to do this --
16 MR. DeLEONARDO: I definitely think we should be
17 able to wrap -- and we will talk I guess to whether or not we
18 are going to do the rebuttal or not.
19 MR. DAGGETT: Very good, see you tomorrow.
20 THE COURT: All right, thank you very much everyone.
21 MR. WELLS: Thank you, Judge.
22 THE COURT: Mr. Cruickshank?
23 MR. CRUICKSHANK: Yes, sir.
24 THE COURT: The reason I am recessing so early is I
25 understand you need to speed up to Walmart and get your wife a

1 big box of chocolates.
2 (Laughter.)
3 MR. CRUICKSHANK: Oh, see I did it right this year.
4 THE COURT: Did you?
5 MR. CRUICKSHANK: I did it yesterday. I did get
6 schooled on that in years past though. I am like a good dog,
7 I learn.
8 (Laughter.)
9 THE COURT: Well, you are probably much more --
10 MR. CRUICKSHANK: I learned, Judge.
11 THE COURT: You are probably a lot smarter. It took
12 me a lot longer to learn.
13 MR. CRUICKSHANK: Just once is enough with my wife.
14 (Laughter.)
15 THE CLERK: All rise.
16 (Whereupon, the hearing was recessed until tomorrow
17 morning, February 15, 2011, at 9:30 a.m.)
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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 February 14, 2011, 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-10-040783
STATE OF MARYLAND
v.
BONNIE DENISE BRISCOE

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

Criminal No. K-11-041045
STATE OF MARYLAND
v.
MATTHEW BRIDGER FARLEY

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-10-040717
STATE OF MARYLAND
v.
PERRY GILBERT MAY

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-10-040575
STATE OF MARYLAND
v.
RYAN LUCAS MULLINIX

Criminal No. K-10-040686
STATE OF MARYLAND
v.
DARRELL PATRICK PEYOK

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

By:

______________________________ ________________________
Cora C. Holliday, Transcriber Date