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
	:	February 15, 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
55 North Court Street, P.O. Box 530
Westminster, Maryland 21157

APPEARANCES: (continued)

FOR THE DEFENDANTS:

BRIAN L. DeLEONARDO, Esq.
DeLeonardo Smith & Associates, LLC
215 Main Street, Suite 1
Reisterstown, Maryland 21136

ALEXANDER J. CRUICKSHANK, Esq.
Office of the Public Defender
101 North Court Street, Suite 140
Westminster, Maryland 21157

I N D E X

WITNESSES	DIRECT	CROSS	REDIRECT	RECROSS
For the State:				
William R. Morrison		5(BD) 66 (AC)	71(AW) 75(DD)	81(BD) 84(AC)
Tom Woodward	87(DD)	94(BD)		

EXHIBITS:	FOR IDENTIFICATION	IN EVIDENCE
For the Defendant:		
27	43	
28	110	

KEYNOTE: "---" indicates inaudible in the transcript.

P R O C E E D I N G S

THE CLERK: Silence in Court, all rise, the Honorable Michael M. Galloway presiding.

THE COURT: Good morning, be seated please.

MR. WELLS: Good morning, Your Honor, for the record, Adam Wells, spelled W-e-l-l-s, and David Daggett, spelled D-a-g-g-e-t-t, on behalf of the State.

Your Honor, would you like me to recall all the cases with the case numbers today or just Frye-Reed, et al.?

THE COURT: We will just designate this is the Frye-Reed cases and reference Charles Brightful, State versus Charles Brightful, et al.

MR. WELLS: Thank you, Your Honor.

THE COURT: That is sufficient.

MR. DeLEONARDO: And for the record, Brian DeLeonardo, D-e-L-e-o-n-a-r-d-o.

MR. CRUICKSHANK: For the record, Alex Cruickshank, C-r-u-i-c-k-s-h-a-n-k.

THE COURT: All right. Good morning, are we ready to proceed?

MR. DeLEONARDO: We are.

THE COURT: All right.

THE CLERK: Please remain standing and raise your right hand?

Whereupon,

OFFICER WILLIAM R. MORRISON

was recalled as a witness by the State, having been previously duly sworn, resumed the stand, was examined and testified further as follows:

THE CLERK: Thank you, you may be seated. For the record, please state your full name, spelling your first and last and give your us your current duty assignment.

THE WITNESS: Officer William R. Morrison, Montgomery County Police Department, last name is Morrison, M-o-r-r-i-s-o-n.

THE CLERK: Thank you.

CROSS-EXAMINATION (Resumed.)

BY MR. DeLEONARDO:

Q Good morning, Officer Morrison.

A Good morning.

Q Just to pick up essentially where we left off yesterday, I think when we left off we talked about the process that a DRE goes through, three step overview, which is determining if there is an impairment, determining if the impairment is from drugs and not a medical condition and then determining the category of drugs, correct?

A That’s correct.

Q And we talked about the second part where you are actually determining that there is not a medical condition accounting for what you are seeing, that that medical

diagnosis is in that second overview stage, correct?

A That's correct.

Q Now when we turn to the training, you indicated yesterday that you regularly instruct this program based on what is in the manual, correct?

A That's correct.

Q And in the manual the discussion about the body and the medical conditions that could mimic impairment are contained within session six of the manual, is that correct?

A The physiology section, I believe?

Q The physiology and drugs and overview?

A That's correct.

Q Right?

A Yes.

Q Now, the course, the instructors are advised essentially exactly how long to use to cover this information, is that correct?

A That's correct.

Q In fact, the entire teaching protocol is set out in pretty explicit detail as to how long you take for each section, what slide you use, and what material you use, correct?

A That's correct.

Q And in the 2010 version, in session six, the time that is used to cover the physiology and drugs and overview is

two hours and 10 minutes, is that right?

A Off the top of my head, I don't know. I would have to refer to the manual.

Q Okay. That will be the manual. There is also a schedule in there, is that correct?

A There should be, yes.

Q Okay. So, if you could take a look at the schedule?

A Actually, this is a student manual. Do you have the instructor's manual?

Q Sure. Just to refresh your memory.

A (Looking through manual.) The manual says here two hours.

Q So, it is two hours time block to cover -- and just to clarify this. The subject matter that is covered in that section is body systems, right?

A Physiology and Drugs and Overview.

Q Well, I understand that is the title of it. I am asking the subject matter that is covered in that section. It includes all the systems of the body, correct?

A That's correct.

Q And it includes the concept of homeostasis, right? The nervous system, parts, circulatory systems, correct?

A Yes, it does.

Q And there is -- in the manual, there is a section that deals with medical conditions that mimic impairment,

correct?

A That's correct it does.

Q So, that is simply one part of that two-hour block, correct?

A Yes it is.

Q And if I could show you then, you know how many pages are used to cover those medical conditions?

A I believe four if I recall right.

Q Four pages that cover that?

A Actually if you cut down the additional stuff, it's probably about three and a half.

Q I am going to show you what has been marked as defense Exhibit No. 5 and can you tell me in the 2010 student manual, if you could take a look at session six, tell me how much is devoted to medical condition that mimic impairment?

A About a page and a third.

Q So not four pages?

A That's correct.

Q All right. And on that page and a quarter, it essentially list a few medical conditions that it says can mimic the signs of impairment, correct?

A That's true.

Q All right. It says bipolar disorder, manic depression, right?

A Yes, it does.

Q And it simply describes it as a condition that is characterized by the alteration of the manic and depressant states?

A Yes, it does.

Q Does the manual indicate what signs or symptoms that mental disorders in general may cause to be exhibited by a person?

A No, it does not.

Q It talks about conjunctivitis, right?

A Yes, it does.

Q Does it indicate to -- it indicates as far as that, it says that first glance it may appear similar to bloodshot condition associated with impairment by alcohol or cannabis, correct?

A That’s correct.

Q But it is indicating that is also non-impairing reasons for it, correct?

A That’s correct.

Q Does the manual indicate or tell the students how to distinguish between a normal indication of that versus an indication that could be from impairing substances?

A No, it does not.

Q Diabetes. It talks about the concept of going to insulin shot, right?

A Yes, it does.

Q All right. And that was sort of a kind of emergency condition you were referring to yesterday that you are excluding when you are trying to make your decision, right?

A That could be one of them, yes.

Q Okay. Does the manual at all instruct the students what affect systemic diabetes may have on a person's physical sense?

A No, it does not.

Q So, it doesn't indicate what signs or symptoms could be affected by prolonged but maintenance diabetes, does it?

A No, it does not.

Q As to multiple sclerosis, it gives a short paragraph on that, is that right?

A Yes, it does.

Q It gives a short paragraph on shock, correct?

A Yes.

Q Which would also be another one of those emergency type conditions you discussed?

A That's correct.

Q And then it talked about stroke and the affect of someone having a stroke when you are evaluating them, correct?

A Yes, it does.

Q What about -- does the manual instruct the student at all what affect a person who has a history of strokes, what affect may be seen in the signs or symptoms they could

exhibit?

A No, it does not.

Q Now, there is a paragraph at the very end, you get that quarter page of the second page, that top quarter, it says that there is a lot of other medical conditions that could also, but it doesn't give an extensive list. It only says some of what could be included, correct?

A That's correct.

Q All right. It says carbon monoxide poisoning, right?

A Yes.

Q Seizures?

A Yes.

Q All right. And that would be seizures that could have occurred prior to this, prior to the evaluation, right?

A Could be, yes.

Q Endocrine disorders?

A Yes.

Q Neurological conditions?

A Yes.

Q Psychiatric conditions and infections, right?

A Yes.

Q Does it anywhere, does it describe the signs or symptoms that would be caused for many of these medical conditions?

A No, it does not.

Q So, it does not at all instruct the student how to distinguish between these medical conditions and what they may be seeing in the evaluation, does it?

A No, the manual does not.

Q All right. Do it also describe excitement, fear, anxiety and depression as also being examples that could affect, right?

A That's correct.

Q And exercise as well, correct?

A That's correct.

Q Does it, and again, the manual does not describe anywhere what weight to give that previous history, nor what signs and symptoms could be produced, correct?

A No, it does not.

Q When we talk about -- now there is also on the next page, there is topics for study at the end of this two-hour block, correct?

A Yes, it is.

Q And you would agree with me that the topics for study in each of these sections is intended to emphasize the major information that you want the student to get from this chapter, correct?

A Yes.

Q That is the reason for it, right?

A Yes, these are review questions.

Q Right. And essentially in all of these sections, the topics for study, the review questions are the points of emphasis that you really want to make sure the student takes away from this chapter, right?

A That's correct.

Q How many questions are dedicated to medical conditions that mimic impairment out of the eight?

A I do not see any.

Q As to -- however, you would agree that there are two sections in the manual that are dedicated to teaching the officer to be able to prepare themselves and do well in Court that is in the 2010 manual, is that correct?

A That's correct.

Q There is session 13, which is CV Preparation and Maintenance, correct?

A Yes, sir.

Q And 50 minutes is devoted to that?

A There is.

Q And there is session 18, which is Case Preparation and Testimony and a hour and a half is devoted to that, correct?

A That's correct.

Q So combined, you are talking essentially two hours and 20 minutes is devoted to how they testify in Court, is

that fair to say?

A That's correct.

Q In the session 18, if you could turn to that please. One of the purposes of this section is to teach the officer how to be able to go into Court and try to establish that the only logical explanation for these signs and symptoms is drug impairment, correct?

A Not sure I understand your question.

Q Well, my question is that the reason that there is an hour and 30 minutes devoted to teaching these experienced officers how to go in and testify is because this section is designed to teach them how to make sure they convey that the only reason for these signs and symptoms is drug impairment, correct?

A In session 18?

Q Correct. It is Courtroom Preparation and Testimony.

A I have Practice Test Interpretation.

Q You have -- then maybe I am speaking the wrong -- then it would be 19 then. Is that what you are referring to?

A 19, I have Inhalants.

(Long pause.)

BY MR. DeLEONARDO:

Q I apologize. It is a roman numeral error, it is 20. That is in Exhibit 5?

A Case Preparation and Testimony, yes.

Q Right. And so, again, back to my question that the thrust of that section is how to present testimony that will be persuasive to the Court that the only logical interpretation is that there is drug impairment?

A Yes.

Q Okay. And there is eight pages devoted to -- well six pages devoted to explaining to the officer how to do that and two pages as to potential cross examination questions, correct?

A That's correct.

Q And let me ask if you can recall this in the instructor's manual in session six of the instructor manual, the student is actually told by the instructor that if they get questions as to bodily functions that the best response is to say, I don't know that I conducted a series of evaluations and documented my observations and based on my training experience, the results of the observations are consistent with what I found. Correct?

A I am not familiar with that.

Q I am going to point out to you -- Well, I ask you to refresh your recollection.

(Long pause.)

THE WITNESS: I'm sorry, what was your question, again?

BY MR. DeLEONARDO:

Q My question is that the DRE instructor manual tells those that are instructed to tell the students during this section that if they get questions on bodily systems that they are simply to say they don't know. Correct?

A Bodily function, specific drug interaction is, I don't know, right.

Q Right.

A Okay.

Q So that is what it says.

A Okay.

Q Well, you weren't aware of that. Is that what you instruct your students?

A I wasn't aware of this line, no.

Q But the instructor manual tells you step by step exactly what they are to be informed, correct?

A That's correct.

Q All right. I am going to turn to -- let me just emphasize one point of that. But you indicated earlier that when you are doing this, you are making a medical diagnosis, correct?

A I'm looking for drug impairment.

Q Which is, you are determining that someone is not medically -- it is not a medical condition that causes what you see, correct?

A That's correct.

Q Preliminary examination. You talked yesterday about when you do this preliminary examination with the person, you would agree with me that the way it is taught in the manual is that it is a structured series of questions, correct?

A Yes, it is.

Q And the questions are intended to elicit certain response to see whether or not there is information that the person would have that could demonstrate that it is from a medical condition, correct?

A That's correct.

Q And this is after they have been advised of Miranda warnings, correct?

A In the State of Maryland, yes.

Q And you would agree with me that if someone doesn't give you information, someone decides to invoke their constitutional rights, do you stop the examination?

A It would depend on the situation, yes, there have been times I have.

Q But that is not what the manual says, correct?

A Well, it's going to be tough to complete the evaluation. It's going to have to look under the case by case basis.

Q But if someone is unwilling to tell you about their -- let's say that they cooperate but they are unwilling to tell about their medical history. Would you stop your

examination?

A Again, I would have to look at a case by case basis. Could I do a complete evaluation, no.

Q The questions that are -- there is essentially a series of six questions that the student is advised to ask, is that right?

A That's correct.

Q So, are you sick or injured? Do you have any physical defects? Are you diabetic or epileptic? Do you take insulin, are you under a doctor or dentist care and are you taking medication, right?

A That's correct.

Q And the student is advised that based on those answers, you should answer appropriate follow up questions, right?

A That's correct.

Q Now, is the student advised at all based on what those answers, what would be the appropriate questions?

A Some of the instructors do go into what would be the appropriate questions. Is there anything in the manual? No. But the officers would be instructed to expand and find out more details related to this person's medical history or medication that they have been taking.

Q Well, first of all, as you indicated, the manual doesn't tell them to do that, correct? There is no

standardized way to do that?

A No, there is none.

Q And a far as what questions to ask, it is pretty much left up to the DRE to decide what would be appropriate questions, right?

A That's correct.

Q But the DRE is not advised, for example, on medication to ask how long they have been taking it, correct?

A Well, it's not in the manual, no.

Q All right. Nor what dosage that they have been taking, correct?

A It's not in the manual but as an instructor, I would be instructing people to do that.

Q Well, you may say that that is something that you instruct them to do but, again, that is not something that is part of the standardized process, is it?

A No, it's not in the manual.

Q All right. And, in fact, it doesn't actually even say that you should ask for a history of treatment they have received over the past, does it?

A It does not.

Q Does not say to ask what their normal vital signs that they are, does it?

A It does not.

Q It doesn't ask about any family history or how often

they exercise or anything like that, true?

A It does not.

Q All right. Now, you would agree with me that the appropriate questions to ask would be influenced by your knowledge of what is relevant, right?

A Yes.

Q In other words, the more knowledgeable you are about what could affect vital signs, the more likely it is that you would know what the appropriate follow up questions would be, right?

A Yes, it can be.

Q All right. Now in this preliminary examination also, when someone tells you that they, let's say, taken a drug, do you assume that to be automatically true?

A To a certain extent, yes.

Q Okay. So, for example, if someone says I smoked marijuana earlier, you would assume that to be true?

A To a certain extent, yes.

Q Well, you are aware that some DREs that created this program have indicated that sometimes people will tell you one drug and it is really a different drug?

A And that's exactly why I say that. I would take them for what they say at that time, but that would not influence my evaluation. I would conduct my evaluation and determine is this person telling me the truth or was that part

of the truth, or was this person just flat out lying to me.

Q Okay. So when someone tells you something, as far as you are concerned, it doesn't affect your ability to reach a conclusion whatever they tell you?

A That's correct.

Q All right. So, it is a fair -- I think I got what I wanted. If someone in the manual -- we went over the conditions that are covered. Can you tell me in the manual does it say what the DRE officer is to do if someone reports a medical condition they aren't familiar with?

A In the manual, we talked about that a little bit under references. In that section we over the PDR, we go over poison control, we go over the Nurses Handbook, we go over the drug bible, medical dictionary.

Q Okay. So, again, are you telling me that the student is advised to go look it up somewhere what the medical condition is?

A Yes.

Q And the PDR deals with drugs and what affects may cause the symptom?

A That's correct.

Q Okay. That is what they would be relying on?

A That would just be one source. The main one for what you're specifically asking for would be the medical dictionary.

Q Okay. So, they are going to go to a medical dictionary and look up what the disease is and based on that, know how it would affect this particular patient?

A They would have an understanding on what his issue is.

Q All right. And they would be able to determine what affect it may have on this particular person with the history and with the other information they have obtained?

A It would depend on what the issue was.

Q Now as to the matrix, you said that the heart of reaching your opinion is this matrix, correct?

A We refer back to the matrix to determine the impairment or what category the drugs would be.

Q If I recall, Exhibit 5 was the symptomatology matrix that we used, is that correct?

A That is a copy of it, yes.

Q In fact, you provided that to the State is that correct?

A That's correct.

Q But you saw, did you not a matrix that I later submitted. Did you have an opportunity to review that matrix?

A I have not seen your matrix, no.

Q Okay, I am going to show you Defendant's Exhibit No. 11. Can you tell me officer, which is the correct matrix being used there?

A Without a date on both of them, I cannot.
Q You can't tell?
A Not off the top of my head, I'm looking for a date on them.
Q Okay. We don't need a date -- look at major indicators? Is muscle tone listed on yours?
A It is not.
Q Is it listed on mine?
A Yes, it is.
Q What is the more current matrix?
A Again, I would have to -- I don't believe yours is the most current.
Q You don't believe that?
A No.
Q So, is muscle tone a major indicator?
A It is, yes.
Q But it is on yours and not on mine -- or it is on mine and not on yours, correct?
A On the most recent one it would be on ours, yes.
Q Okay. Muscle tone, how long has it been a major indicator?
A I couldn't tell you, as long as I can remember.
Q So, are you indicating to me that mine may not be more current, that they took off a major indicator on the chart?

A Oh, no, I'm not saying that they took it off.

Q Okay. But you are still not sure which is more current?

A Out of these, no, I don't think either of these are the most current.

Q Okay.

THE COURT: Well, can I interject here. We are using the word more and most. Is your question which is the more current of these two?

MR. DeLEONARDO: And that is fair. Which is more current?

THE WITNESS: Which one has the most information? Yours does.

THE COURT: I think where we are breaking down here. I think the officer is interpreting your question to mean most current out of all of the matrix, which may have been generated.

I think the question you are asking is of these two, which is the more current and I would think the conclusion would have to be that Defendant's Exhibit 11 is more current in that it has muscle tone.

And the officer is indicating that that now is on whatever is the current version of the matrix is. Is that a fair statement, officer?

THE WITNESS: That is correct, sir.

THE COURT: Okay.

MR. DeLEONARDO: Thank you, Your Honor.

BY MR. DeLEONARDO:

Q Now, I want to step through these major indicators. First of all, can you tell me, what does it mean to be an indicator? What is it indicating? What does the DRE manual say that it indicates?

A What does it indicate?

Q Well, it is called a major indicator and I am asking you what is it intended to indicate?

A Well, it could be an indication of impairment.

Q Okay. So as far as it is used by the DRE protocol, when we talk about indicators, you are saying those are indicating of impairment, not just presence of that drug, correct?

A Well, it can be both. I mean it can be the presence and it can also show impairment.

Q And it could also indicate medical?

A It could also -- yes, there are situations where it could be medical.

Q Okay. So when you say major indicator, it only indicates that could be one of many, many things, is that they way the DRE uses that?

A Okay, yes.

Q All right. Now, why is there a difference between

major and general indicators, can you tell me why the DRE calls one major indicators and one called general?

A I don't know.

Q You have been in the program for what 20 years?

A Yes.

Q You have no idea why they call certain things major indicators and certain things general?

A I have no idea.

Q Okay. Let's talk about the major indicators. Major indicators are listed as first of all, HGN, correct?

A Right, horizontal gaze nystagmus.

Q All right. Now when we deal with that, first of all, I am going to ask you about the scoring. When this is scored, how many -- there is a possibility when we talk about field sobriety test, there is a possibility of six potential clues, correct?

A That's correct.

Q And when you deal with this major indicator, what is the number of clues that you have to have before the DRE can say this is an indicator in the matrix?

A Well, it's just a case of whether it's present or not?

Q Well, does all six of six have to be present, two of six, four of six, how many have to be present for it to be an indicator?

A I don't know of a specific number value.

Q So what you are telling me is that according to the manual, if you simply have lack of smooth pursuit, right, that would be enough for a DRE to say that is an indication?

A It can be yes.

Q With horizontal gaze nystagmus as well, you said that you do evaluations on people that would even be as high as a .06 BAC, right? We talked about that yesterday.

A That's correct.

Q And so if they exhibited lack of smooth pursuit even with that alcohol reading, you would still indicate -- you would still mark that could be an indicator for drugs, correct?

A Not necessarily, no.

Q Well, not necessarily means that you could. A DRE could and that would be permissible?

A That .06 could be just the alcohol present that could be causing the HGN -- I mean, yeah.

Q It is true but you have told me that it could also be from drugs, right?

A That's correct.

Q So, it would be perfectly acceptable for a DRE to say that is one of my indicators in my matrix, true?

A But that wouldn't be the result of the DRE would see.

Q Well, we don't know what DRE would see. You would agree with me that people are different in terms in even in alcohol levels what signs or symptoms they my exhibit in the eye, true?

A They can be yes.

Q Okay. So, we really don't know what they could see but my point was that would be okay for the DRE who saw two out of six clues on someone even at a .05. That would be an acceptable indicator to use in a matrix, true?

A That HGN was present.

Q Yes. All right. Vertical nystagmus. In the matrix there is two places, both CNS depressant and inhalants, where it says it would be present in high dosage, correct?

A That's correct.

Q So, if I understand you correctly in the way this is taught, if in fact it was found in those two categories, if it was found present, the DRE is instructed to take from that that there is a high dose of that drug present, is that true?

A Drug or combination of drugs.

Q Okay. But that is the conclusion that the DRE is instructed. That if they see this vertical gaze nystagmus, that they should draw from that that there is a high dose of drugs in the body?

A That's correct.

Q Now, are they taught at all to distinguish between

vertical gaze or vertical gaze nystagmus?

A I'm not sure I understand what you are saying.

Q Well are you aware that there is a different between vertical gaze versus vertical gaze nystagmus?

A We are looking for vertical gaze nystagmus. We are looking for a vertical balance.

Q So, are they taught at all how to distinguish what else they may see with someone, seeing vertical gaze and vertical gaze nystagmus?

A If they are seeing anything that would be unusual, then that would not be classified as vertical gaze nystagmus.

Q And in the manual does it describe what would be unusual findings versus what they need?

A The student is instructed to look for horizontal gaze nystagmus, vertical gaze nystagmus and resting nystagmus?

Q Right. I understand they are instructed. I was asking is there anything in the manual that tells him how to distinguish between vertical gaze and vertical gaze nystagmus?

A No, they do not.

Q Lack of convergence, this other major indicator. Now, is it not true, you have been involved with this for some time, that up until 2005 the students were instructed to go to the bridge of the nose?

A That' correct.

Q They were advised that when they do the test go all

the way to the nose and see whether there is a lack of convergence, right?

A That's correct.

Q It was only recently, the last several years, that they actually changed it to two inches, is that right?

A That's correct.

Q And on this indicator, again, there are certain categories that indicate present would be an indicator. That would be CNS depressant, that would be dissociative anesthetic and it would be inhalants and cannabis, correct?

A That's correct.

Q So, the student is instructed that if they find their opinion lack of convergence, that that should be an indication of drug impairment, correct?

A It can be.

Q Pupil size. Now on the matrix and you can certainly use mine, on the matrix there is pupil ranges at the bottom right, which are described as normal ranges, is that right?

A That's correct.

Q And when this is instructed to the student, they are told that these are the ranges that are to be used as they do evaluations, right?

A That's correct.

Q And they are further instructed that if it is even a half millimeter off on any one of these readings, either high

or low, that that would be enough to say that there is an indication of dilation or constriction on pupil size, is that right?

A It can be, yes.

Q Well, I am asking you, that would be perfectly acceptable, if for example, in room light, I had a reading of 5.5. You would say that is perfectly acceptable to say that that is an indicator for pupil size, is that right?

A For -- I'm not sure I understand.

Q Okay.

A You are saying you see a 5.5 in room light --

Q Yes.

A -- as a perfect good indicator of what?

Q Well, your matrix. Your matrix says that you look for a dilation in constriction, correct?

A Right.

Q So, that would be an indication that 5.5 according to the DRE program, that would be an indication of dilation, right?

A Yes, it can be.

Q Okay. So, that would be something that you would instruct the students would be an indicator of possible impairment by drugs?

A That's one thing, yes.

Q And that would be even true even if the reading in

near total darkness and direct light were even within your range, correct? In other words, you only need one of those to be off?

A Not necessarily, we're looking at the totality of everything.

Q Well, we are speaking of pupil sizes?

A Well, again, we are looking at the totality of all the different pupil sizes. We would say then in room light this person displayed a dilated pupil at this reading. However, in near total darkness and direct light, we obtained whatever.

Q Would it be acceptable according to the DRE's standards for that DRE to say there were signs of dilation as a sign of impairment as a major indicator?

A It would be one.

Q Thank you. Now, as far as the -- let's talk about room light. You indicated that this was a standardized process that you used yesterday. You said that room light is standardized. It is basically you turn on all the lights in the room, right?

A Whatever light we have in the room.

Q Okay. So, for example in this courtroom, we have all the lights on, is this brighter or darker than the police station?

A I have no idea.

Q So, when we say that room light is standardized, you really have no idea that room light is the same from place to another, correct?

A Oh, no, it would not be the same.

Q And you would agree with me that DRE officers are not instructed how to compensate for variants in room light?

A That's correct.

Q And you would agree with me that the intensity of the room light could affect the readings that you would obtain?

A It can.

Q Near total darkness. Now when you do the near total darkness examination, you said well, one of the things we look to do is perhaps take them into a closet, is that right?

A I gave the closet as an example, some place that can be made totally dark.

Q And when you go into the room, do you go in dressed as you are now?

A Yes.

Q Okay.

A If I'm in uniform.

Q All right. And you actually not only go in by yourself but you go in with someone else, right?

A If that -- you know, I prefer to that, yes.

Q And in some places, they actually will only let the

person go in with their hands cuffed, is that right?

A If that's their policy.

Q Well, but you know that there is many places that that's required, that they are going to take them in handcuffs, is that right?

A If that's their policy.

Q I didn't ask if their policy. I am saying you know that to be the case?

A I'm sure that there is some departments out here that says, yes, they have to be in handcuffs.

Q Is the instructors -- the DRE instructors advised what affect anxiety or fear could have on the readings they obtained in near total darkness?

A No, they are not.

Q Are they advised of any of when they are conducting this, any errors that they could induce during the process of obtaining these readings?

A No, they are not.

Q One of the things that you also have is direct light, is that right?

A That's correct.

Q And yesterday you demonstrated that -- I think you had a picture actually of the penlite that you use, right?

A That's correct.

Q But also indicated that is not something in the DRE

program that is standardized, is that right?

A That's correct.

Q Do you know the intensity of the bulb that you use?

A No, I do not.

Q So, you would agree with me, however, that the intensity of the bulb could, in fact, affect the amount of constriction or dilation that may occur in a person, is that right?

A It could, yes.

Q All right. Are the students taught at all that therapeutic levels of drugs can produce certain signs or symptoms in the eyes?

A If that drug could affect the eyes, then yes it can.

Q But my question is are they advised that it may not mean that they are impaired it just may mean that the drug is present?

A That's correct.

Q All right. But yet if you have a reading, it would be an indicator -- it could be used as an indicator, right?

A It would be -- could possibly be one indicator.

Q Now, pulse rate, one of the things is it not true that the students are advised, they are actually advised that the ranges that they use are actually wider than used by doctors, whether it is blood pressure, pulse rate or pupil size, right? Oh, I am sorry, pulse, body pressure -- blood

pressure and body temperatures?

A That they're wider than what doctors use?

Q Yes.

A Not that I'm aware of.

Q You teach the preschool, is that correct?

A That's correct.

Q And when you do that, and when you turn -- when you talk about pulse, -- I am going to ask you first of all about. When we are dealing with pulse, that is taken three times throughout the course, is that right?

A That's correct.

Q And the pulse range that is used is 60 to 90, is that right?

A That's correct.

Q And when we are dealing with pulse range, any one of those ranges -- any one of those readings that are outside of that 60 to 90 would justify the DRE saying it is indicated, right?

A It could be high or it could be low, yes.

Q All right. I am going to show you -- refresh your recollection of January 2007 edition of the preschool. Will you take a look at that and see if it refreshes your memory as to what you were told about doctors?

A It does say humans are very widely depending on the person, they can have a different pulse rate and blood

pressure depending on their body -- and their body temperatures depending their physical fitness or lack of.

Q Illness, anxiety, heredity, correct?

A I'm sorry.

Q It also says that things can affect it like heredity, right, illness, anxiety, true?

A Yes.

Q And at the bottom, what does it say about the ranges being used by the DRE?

A It says our ranges are usually a little bit wider than what those used by doctors?

Q Okay. So, you weren't aware of that prior to that?

A I was not aware of that one, no.

Q All right. The DRE is also not instructed to ask if they get what they consider to be an abnormal range, to even ask what the person believes the normal range is, are they?

A Instructors will ask or tell the students to ask that but is it in the manual, no.

Q Okay. That would be something that is important to be in the manual, wouldn't you think?

A Could be.

Q All right, blood pressure. When we deal with the taking of blood pressure, the ranges are listed on the matrix, correct?

A That's correct.

Q And that is the ranges that the DREs follow, right?

A That's correct.

Q And if either the systolic or the diastolic is outside -- the reading is outside by two beats, that would be enough to say an indicated sign on the major indicator, correct?

A It could be one indicator, yes.

Q And we heard yesterday -- well, let me ask you this. How long is dedicated to teaching the taking of blood pressure?

A The actual teaching part?

Q Yes.

A If I could refer to a instructor's manual?

Q Give me roughly. I am not trying to hold this ---. I mean generally. You have been doing this for 20 years.

A I think that -- in the preschool, I think it's probably about an hour.

Q Okay.

A Okay. I am guessing here, maybe an hour and a half.

Q All right.

A And the seven-day school --

Q Yes.

A -- we go over it again and then we actually -- throughout both the preschool and the seven-day school, they have practice time where they get to practice doing these.

Q Okay. Do you think it is something that can just be taught in a couple of minutes?

A Can I teach somebody do it in a couple of minutes?

Q Right?

A Sure.

Q Can you teach them to do it accurately in a couple of minutes?

A All depends on the ability of the student?

Q And of course these are students with no medical history or background coming in, right?

A Well, if you look at -- I mean we teach people all the time.

Q In a couple of minutes?

A In a couple of minutes. I mean a good example would be family relatives who need to take their spouse's blood pressure. And the doctor says this is how you do it.

Q Well, I think you would agree with me that the stakes are a bit higher when you are subject to being arrested, wouldn't you think at that point?

A I would have to disagree with you.

Q Okay.

A Because the person would be dying of a heart attack and if your spouse wants to keep that person alive, I would disagree.

Q Okay. Well, let me ask you about radar then. You

are a certified operator of radar, right?

A Yes, I am.

Q You sat here yesterday and watched as you did with all the witnesses, when we questioned Mr. Tower, right?

A Yes.

Q And Mr. Tower said that in order to --- radar, it has to be certified equipment, correct?

A That’s correct.

Q It has to be shown to have been working properly and maintained properly, correct?

A That’s correct.

Q And you actually calibrated both before and after you, in fact, take a reading, true?

A That’s correct.

Q And even the radars are -- there are scheduled regular maintenance on that, true?

A That’ correct.

Q In fact when we deal with intoximeter, you are an intoximeter operator, correct?

A I am.

Q And you know that there is regular calibration of that equipment, correct?

A There is.

Q How often?

A Monthly.

Q So, monthly someone verifies that that equipment is, in fact, working properly true?

A That's correct.

Q I mean even normally before each test it does a test standard, correct?

A It does a test before and after each test.

Q But even with that test, both before and after, there is still monthly check to make sure it is accurate, right?

A That's correct.

Q In the DRE protocol, is there absolutely anything that requires the calibration of any of the equipment?

A No, there is not.

Q So, as the blood pressure and the sphygmomanometer and the temperature, the penlite, there is actually no standards on what you should use, correct?

A There is not.

Q No standards on how to maintain it, correct?

A No, there is not.

Q No standards on how to calibrate it, correct?

A That's correct.

Q Now, you indicated yesterday that you have certain equipment that you particular use, right?

A That's correct.

Q Do you calibrate your equipment?

A No, I do not.

Q And you know of DREs that use their equipment for years, is that right?

A Mine.

Q All right. You used it for years?

A That's correct.

Q Now, are you familiar with the requirements in the field or even from the manufacture on calibration of that type of equipment?

A I have checked into that.

Q And when did you check into it?

A When I was purchasing the equipment.

Q And what did it tell you?

A I checked with the manufacturer and they said that -- first off, I checked with the doctors. I went to my doctors, I went to the hospital. I asked them when they are using manual blood pressure cuffs, how often are these instruments calibrated and they laughed at me and said these are never calibrated. If they were broken, we replace them.

I then checked with our EMS, SWAT Medics, and to the doctors who actually train in the use of manual blood pressure cuffs, our ambulance personnel, and, again, they said that that if it's on the zero and it's working properly, then it is used correctly.

I then checked with Steel, the distributor for our

medical equipment. And I got the same response from them. They said if we are using manual equipment, not the electronic kind that the doctors and hospitals are currently using, and the ones that your experts refer to, they have to be calibrated.

Q Oh, that my experts refer to?

A Yes.

Q You know what my experts refer to?

A When I was in here, I heard them talk about electronic equipment.

Q Don't believe that is true but okay. They were referring to the equipment here but I am not going to argue over that. You have an Aneroid Sphygomomanometer, is that correct?

A That's correct.

Q It is produced by Welch Allyn, is that correct?

A That's correct.

MR. DeLEONARDO: Your Honor, if I could have marked?

THE CLERK: Defendant's Exhibit 27 for identification.

(The document referred to was marked for identification as Defendant's Exhibit 27 for identification.)

BY MR. DeLEONARDO:

Q Service manual from Welch Allyn?

A Okay.

Q For the sphygmomanometer you have?

A Okay.

Q What does it say about periodic calibration requirements?

A During normal operation the location of the pointer within the oval square indicator that the instrument is most likely in calibration.

Q Most likely in calibration. Proceed?

A So, that's what we look at.

Q Okay.

A Should the pointer rest outside the oval box with zero pressure applied, the instrument should be recalibrated.

Q Okay.

A At that point if we don't have that -- it's outside that calibration, that piece of equipment is removed from service.

Q Okay. Proceed.

A Welch Allyn recommends that the calibration of mechanical sphygmomanometers may be checked -- or be checked using the following procedures on an annual basis if the pointer rests inside the oval box.

Q So, even if it is resting there, it is recommended its annual calibration, is that correct?

A That's correct.

Q And you turn to the next page. It tells you specifically how to calibrate, correct?

A Okay.

Q So the manufacturer, in fact, tells you that even if it is rested at the bottom at zero out, you should still annually calibrate that instrument, is that correct?

A It does say it here.

Q Well, that is very different than what you testified to, isn't it?

A That's correct. I was unaware of this.

Q Obviously. Now, as far as your blood pressure, the reason why the accuracy is important is because essentially as you go through and take a reading, you are essentially relying -- it is a judgment call when you take a reading, is it not?

A A judgment call?

Q Well, because you are trying to hear when the sound starts and where it ends, correct?

A That's correct.

Q So, what you are trying to do is you are making a judgment as to when the last time that you could actually hear sound, right?

A I guess if that is what you want to call it. I start it when I hear it and I --

Q Well, you would agree with me that two different people could come to two different readings, right?

A I would think that we would be very close.

Q But they could come to different readings, true?

A Actually, I don't see how we could. If we both can hear and we are using the same amount of equipment at the same time, then we should both be hearing the starting of the sound and the ending of the sound.

Q You have never had students that have had difficulty hearing the sounds?

A Once they start, yes. They are not sure what sounds they are actually listening for.

Q And you would also, would you not agree, that when you are taking the reading, you are taking the reading, you are listening and you are looking at the gauge?

A That's correct.

Q All right. When you are doing some of these -- well let me change. Let me change that. With the temperature, the temperature is the other thing that you take?

A That's correct.

Q And when you take temperature, it, again, when it is plus or minus one degree, that is an indication, is that true?

A That's correct.

Q And are the students advised what, if anything, could affect temperature other than drug impairment?

A We go through the fact that if a person has the flu and they are aware that they would have an elevated temperature.

Q Is that all? Is that the only explanation that they are given for an elevated temperature?

A There's other things out there but --

Q Well, I know that there's other things out. I am asking what they are advised?

A I don't think there is a whole lot in that section about that.

Q And similarly with blood pressure, they are not advised of other things that could affect the blood pressure other than drug impairment are they?

A That's correct.

Q Now, the other major indicator, the last one is muscle tone, right?

A That's correct.

Q How do you assess muscle tone -- well let me say this. How does the DRE program assess muscle tone?

A By feeling the person's arms, seeing if the person's arms are rigid or if they are near normal or if they are flaccid.

Q So, you just feel, you just feel --

A Starting at the top, coming down to the hands.

Q Okay. Now, is the student advised how to

distinguish between someone who simply has a lack of fitness versus someone that has -- that is flaccid as a result of drug impairment?

A We go through the fact that we are looking for -- if you think -- I don't want to say extremes but there should be no question in your mind that this is a flaccid arm rather than being a lack of muscle.

Q And of course, the DRE manual doesn't say look for extremes, does it?

A I don't believe so, no.

Q And, in fact, it simply says if you feel it and it seems rigid, then that is an indicator?

A Okay.

Q Well, okay, that's correct?

A Yes.

Q As far as -- so when we get to -- so that is the extent of what is described as the major indicators, whatever major means, right?

A Okay.

Q General indicators. Now, one of the things that you talked about was the field sobriety test. And first of all whether it is the performance on field sobriety, Romberg or finger to nose, none of those are classified as major indicators, are they?

A That's correct.

Q And, again, nowhere does it say how much weight the DRE is supposed to put on the fact on how someone performs on these tests, does it?

A It does not.

Q As far as the walk and turn, now you were trained as a field sobriety expert in administering the test, correct?

A That's correct.

Q And as part of that training, you were advised that the field sobriety test as we know then were -- as part of your training in that, you were told that it applied only to show an estimated presence of blood alcohol not impairment, is that right?

A For the SFST program, yes.

Q Correct. But in the DRE program, you teach the students that that is a sign of impairment, is that correct?

A That's a sign of psychophysical impairment, yes.

Q All right. As far as the walk and turn, when you are dealing with the walk and turn in this program, are the students advised how many -- I would say clues, I know that is not what you want to use, but clues that is necessary to say that that is a lack of coordination?

A No, they are not.

Q So, it is really a subjective decision up to the individual officer, right?

A That's correct.

Q And are they taught to account for age, medical conditions or anything in the performance of that?

A Oh, yeah, we have to look at the totality of everything.

Q Okay, but they are not told how much weight to put on that, right?

A They are not, not.

Q As far as -- so in the one leg stand, now, this is very different from field sobriety test, is that right?

A It's the same one leg stand that we use in the field sobriety test, we are just doing it twice, once on each foot.

Q Well, you were instructing in the field sobriety program that you only use one leg because the people may not be able to do both legs, is that right?

A No, we give them the option of using whichever one is easier for them.

Q And part of the training is that you give them the option that way some people may not be able to do both legs?

A Okay.

Q Well, okay, that was what --

A Very possible.

Q -- you were instructed, was it not?

A Yes, okay. I am agreeing with you.

Q All right. So, but in the DRE program you are now making them use both legs, right?

A That's correct.

Q And you are not only making them use both legs but you would agree with me that if they don't perform well, according to DRE, on either leg that is an acceptable indicator of impairment?

A It's one sign of impairment, yes.

Q Now, you are also aware that when it comes to the one leg stand and field sobriety test, there are certain people that are excluded from being able to take the test, right?

A Such as?

Q Such as the people that are over a certain weight?

A They are not excluded, they were just not validated for it.

Q And the instructors are told not to administer it to them, correct?

A No, you can --

Q Fifty years of age?

A -- go ahead and administer it, they are just not validated for them.

Q But in the DRE program there is no such restriction, is there?

A No, there is no real restriction in the SFST program.

Q It specifically says they should not be

administered, does it not?

A It does not. It says the tests were not validated for people who are --

Q Right.

A But it doesn't say you can't administer the test.

Q Okay. So, you are -- it is acceptable to use non-validated. Is that what you -- it is okay in the DRE program, right?

A I'm sure I understand.

Q In the DRE program, there is no restrictions on age, weight, anything in administering this, is there?

A We are still doing it the same way as we would in the SFST program.

Q But both legs?

A But both legs.

Q All right. Now, the finger to nose. When you do the finger to nose, you are asked to put your feet together and you tell them to tilt their head back, correct?

A Slightly, yes.

Q All right. Do you tell them how much slightly is?

A No, I do not.

Q So, that is really up to the judgment call of the DRE as to how much to have them tilt back?

A That's correct.

Q All right. When you have them tilt back, let me ask

you this. Is there anything in the manual that says how to score the finger to nose test?

A I don't believe there are scores, it's just observations that we record on our sheet.

Q Okay. So, the DRE is not instructed as to how many times if they missed, if that is significant or if they missed versus the pad, versus the very tip of the finger? There is nothing to tell them how much weight to put in that, is there?

A No, there is not.

Q All right. And you also agree that is not scientifically validated?

A That's correct.

Q The manual says that, right?

A That's correct.

Q The Romberg. This is also where you have them put their feet together and you ask them to tilt their head back, is that correct?

A Tilt their head back slightly.

Q All right. And, again, there is no determination as to how far that is, right?

A That's correct.

Q When this test is done, one of the things you are looking for is sway, right?

A That's correct.

Q Now in the field sobriety test that we talked about

in your training, one of the major emphasis is that you need to make sure that you tell the person exactly what is expected of them in order to -- so that when they can't do it, it has significance, correct?

A Okay, yes.

Q Yes. So, but in the Romberg test that is not what takes place, is it?

A That's correct.

Q I mean in fact when you tell the person to estimate 30 seconds, they are not told how to do that, are they?

A The passage I -- they are explained that they need to -- the passage of 30 seconds.

Q Right. They are not told how to count, right?

A We leave that up to them on how to best to estimate that 30 seconds.

Q And, in fact, they are also not told that they -- to not sway, are they?

A They're not.

Q And when you initially do that, there is nothing in the manual that talks about obtaining a baseline first, is there?

A No, it does not.

Q As to scoring it, is there anything in the manual that says how much sway is okay?

A No there's not.

Q So, the DRE, if there is any sway in their mind, any slight sway, that would be acceptable according to the program to say there is an indication of uncoordination, correct?

A It's an observation and they would take note of and it could be one part of the test.

Q Okay. As far as the estimation of time, is there anything that says what is an acceptable estimation of time?

A I don't believe so, no.

Q So, if you are telling them to do it in 30 seconds, they do it in 29, then it would be acceptable for the DRE to say, well their body time clock is accelerated, right?

A Not necessarily, no.

Q Not necessarily, but it could, right?

A No, if they are within a couple of seconds, I don't think that you are going to see a DRE say that they are accelerated or passed. If they are 15 seconds before or after, then yes.

Q What about five seconds?

A I think then you are in that little area that it will be up to the DRE to determine where we are at.

Q So, again, it is up to the DRE and their judgment to decide what weight to place on that?

A On that one part.

Q Well, on that part as well as sway, correct?

A Yes.

Q Now one of the things that the manual also instructs is that they should look and listen for muscle tone, right?

A I'm sorry?

Q The manual as to the Romberg test says that they should also look and listen for muscle tone, is that correct?

A Look and listen for muscle tone?

Q That is what it says. You aware of that, that you should look for muscle tone in that step?

A I was unaware of the listen part. I am aware that it says look for muscle tone, look for body tremors and eyelid tremors, yes.

Q Now as far as the other general indicators, you would agree, I mean there is a number of them. I am not going to run through all of them but as to the general indicators that these general indicators are essentially judgment calls by and large by the drug recognition expert as to whether or it is not there or not, correct?

A I guess, yes.

Q And is there anything in the manual or the instruction that tells the DRE how to evaluate this information?

A No, it does not.

Q So, when they are using these general indicators, again, it is just up to whenever their opinion or their judgment is on these indicators here, correct?

A What their observations are.

Q All right. There is no special training to say, well, medically this is what loss of appetite would require, right?

A Not sure I understand.

Q Well, for example, one of the indicators that you have --- stimulants one of the general indicators is loss of appetite, right?

A Okay.

Q And that was something that was pulled from some PDR, correct?

A Could be, yes.

Q All right. And the DRE is not instructed what is required to demonstrate a loss of appetite, correct?

A No, but it would be something that would be recorded if I asked the person what have you eaten last, and they say, oh, I haven't eaten in days, I'm just not hungry, then I would record that as a loss of appetite.

Q What if they said, I haven't eaten today, would that be a loss of appetite?

A I would ask what time are we talking about today, are we talking about this morning?

Q Haven't eaten today, would that be an acceptable indicator based on the DRE's judgment?

A That would -- I would say, no. We would need more

information on that.

Q But you would agree with me that there are other DREs that would say yes?

A Not necessarily.

Q Well, they could and it would not be wrong --

A A lot of people -- if we are going with the example you just gave at 11 o'clock this morning, a lot of people just don't eat breakfast.

Q All right.

A And that would be normal.

Q All right, so, it --

A If they say they haven't eaten in two days --

Q What about talkative? How do you evaluate -- how does that evaluate from person to person?

A Just depends on how fast they are talking, how much they're talking. Are they excited, are they nervous, or are they just rambling on and on?

Q You have been around a long time, you have arrested a lot or people that could be talkative after arrest and have nothing to do with drugs, would you agree?

A Oh, yes.

Q Okay. And there is really, as you indicated, no standard for determining when someone is talkative from a drug impaired standpoint versus a normal condition, right?

A That's correct.

Q And typically your only contact with someone, in some examples, but typically, your only contact with someone is this particular incident, right?

A That's correct.

Q So, you don't know what their "normal" state is in general, right?

A Most of the time, you're right.

Q So when we reach the opinion and we have this chart, you indicated that there is nothing in the manual that says what the difference is between major and general and importance, correct?

A That I'm familiar with, yes.

Q All right. And you would also agree that there is no set number of indicators that have to be there in order to determine someone is impaired, correct?

A That's correct.

Q So, it could be one, it could be eight, right?

A You have to look at the totality of everything.

Q Right. Because, every individual DRE it comes down to their medical judgment, correct?

A That's correct.

Q And when we talk about -- when we get to this stage of reaching your opinion, and again we talked about this before, that even apart from not having to have a certain number of indicators, you don't actually even have to complete

all the steps, is that right?

A To put a person under the influence?

Q To reach your opinion that someone is impaired and unable to drive?

A I have to do an evaluation, yes.

Q Well, I understand that but is it not true that the DRE manual says you don't actually even have to complete all the steps. If the DRE feels they could still reach an opinion, that is fine.

A A person can -- a DRE can say that those signs and symptoms are consistent with. I'm not sure they can actually say they are under the influence if they haven't completed the evaluation.

Q Okay, well what is required to complete an evaluation? Do you have to do all the steps?

A You would have to basically go through the entire process and request a blood test or a chemical test.

Q All right. So, you would agree with me that the request and the requirement of a blood test, that is required for reaching your opinion?

A Well, the request is.

Q Oh, but you don't have to worry about the result?

MR. DAGGETT: Objection, Your Honor. You couldn't possibly. I mean how could you give an opinion when the -- just on the drawing of the blood? It has to be sent to the

crime lab to be analyzed, et cetera. I mean it is one of the 12 steps but it is certainly, it is not dispositive of the opinion, it is not required for the opinion.

MR. DeLEONARDO: Your Honor, I don't think that is an objection. I think it is arguable.

MR. DAGGETT: Well, it was a ludicrous question. I mean it just doesn't make any sense. So, I do object.

THE COURT: All right. I will sustain.

BY MR. DeLEONARDO:

Q Let me ask you. So, you reach your opinion prior --- blood work, correct?

A That's correct.

Q And when you actually reach your opinion, if the blood work comes back and shows none of that drug is present, for example, you reach a determination that someone is impaired by a CNS stimulant, for example, and you request their blood and that blood comes back and there is nothing in the blood, do you still believe that you can testify in Court that a person is impaired by a CNS stimulant?

A In -- sometimes, yes.

Q Okay. So, even with no cooperation, you believe it is still acceptable?

A It can be.

Q Is there anything in the DRE manual that says when it is and isn't acceptable?

A Well, we what we would have to look at then is the lab.

Q Okay, so you would look to the lab having a problem?

A Well, what are the cutoffs of the lab? I mean what type of drug are we referring to? Good example, you picked cocaine, all right. Cocaine, when it continues to metabolize outside the body, so if I draw blood, that blood needs to be analyzed as quickly as possible.

For whatever reason if that blood is not analyzed quickly, that could drop down below the threshold and it could come back no drugs detected even when there is drugs in the body.

Q What about CNS depressants?

A Well CNS depressants, we would have to look at the fact that every lab cannot test for every possible depressant.

Q Okay. So when you did your DRE certification, when we talked about what was required, you told me if it wasn't confirmed, if you didn't have confirmatory lab results, that didn't count towards certification, correct?

A That's correct.

Q And you told me that because you want to make sure they got it right, correct?

A That's correct.

Q But yet you would come in and testify in a Court case without corroboration that is required for certification,

is that what you are telling me?

A Because of the fact that we are using two different tests now. We are using urine and blood. In urine, they can expand and test farther and, again, we are talking about the DRE process and we are talking about the lab.

Q Oh, I know what we are talking about. You told me that you wouldn't even allow a DRE to use that evaluation for recertification or certification if it wasn't confirmed by a laboratory, correct?

A That's correct.

Q But now you are telling me that you don't need a laboratory to confirm your opinion in Court, right?

A Well, we form an opinion prior to asking for blood because at that point we have determined that a person is impaired, that we've looked at everything, and now we are going to ask for blood. If we determined the person is not impaired, we wouldn't be asking for a toxicological sample.

Q So, when you look at -- if you had a DRE that regularly did not have confirmatory testing that showed that they even had it present in their system, would you recertify?

A I would have to look at is this person -- I would have to look at the evaluations, look at the face sheets, look at the reports, and see if I agree with what this DRE is calling is accurate.

Q Without having seeing the person, and this gets me

to the next thing. When you -- the DRE program, and I am going to give you a couple hypotheticals of what is appropriate. Let me ask you this.

The DRE, do you believe that a DRE could simply look at an arresting officer's report and a photo of the person and be able to testify and render an opinion on their impairment as to drugs?

A Can they say this person is under the influence? No.

Q So, you don't believe that it would be appropriate to just look at a police report and a photo and say, well, these are all signs and symptoms of drug impairment?

A They could say that that's signs and symptoms that are consistent with. That if the officer has written down good notes, good observations, but can that person then say this person is impaired? No.

Q So, it would -- that would be acceptable to the DRE program even without even seeing the person, right?

A Not sure I understand.

Q Oh, forget it, I will take that back. All right, one last question. When you talked about making your medical diagnosis as you go through and do this, you would agree with me that the DRE, when they are exercising this medical judgment, they are doing it based on their DRE training exclusively once they are certified, correct?

A No, I would put it towards --

Q Well, let me rephrase that, I didn't mean it that way. The DRE when they are certified, you would agree with me, as we talked about, they are just as able to make a determination as any other DRE at that point, correct, and they are certified?

A Still not sure I understand your question.

Q When a DRE is certified, that is the IACP saying that this DRE is fully capable of rendering an opinion that someone is impaired by a drug and not able to operate a vehicle safely, correct?

A That's correct.

Q And in doing that, as you agree with me, they are exercising their judgment, their medical judgment, as to what is going on with a person, correct?

A That's correct.

Q And so as a result of that, you would agree with me, that that medical judgment they are exercising at that point is as a result of their training from the program or whatever other outside activities they choose to do, correct?

A Well, that would be a totality of all their training. Are they first responders, are they trained as a paramedic? What training did they have in high school? Are they a boy scout? Did they have first aid? I mean looking at everything.

Q But, again, it is not a requirement to be a paramedic to be a DRE, is it?

A That's correct.

Q Not required to be a nurse to be a DRE, right?

A That's correct.

Q An EMT, correct?

A That's correct.

Q All right. And none of you when you get your certification are medically licensed to practice medicine in Maryland, are you?

A That's correct.

Q All right, that is all I have. I think Mr. Cruickshank has something.

MR. CRUICKSHANK: Just a couple of questions.

THE COURT: All right.

CROSS-EXAMINATION

BY MR. CRUICKSHANK:

Q Mr. DeLeonardo touched on -- good morning.

A Good morning.

Q Mr. DeLeonardo touched on some of the eye exams that the DREs do. One of the eye exams that is in the manual is the vertical gaze nystagmus test, is that correct?

A That's correct.

Q Okay. Can you describe to the Court how the vertical gaze nystagmus test is taught?

A It is taught so we ask the subject to follow our stimulus. We are taught to -- they are taught to turn their stimulus sideways. They will take it up and hold it there for four seconds or at least four seconds and then bring it back down and they will do that twice.

Q Okay. And what would be an indicator, a vertical gaze nystagmus when the test is done according to the manual?

A If you were to see vertical nystagmus, you would see distinct and sustained vertical bouncing of the eyes.

Q And do you have your matrix in front of you?

A Yes, I do.

Q Okay.

A I have both of them.

Q And looking at either one of those matrix, there is a category for vertical gaze nystagmus, is that correct?

A That’s correct.

Q And vertical gaze nystagmus is a major indictor on both your matrix and Mr. DeLeonardo’s matrix, is that correct?

A That’s correct.

Q And in what categories do you find vertical gaze nystagmus as a major indicator?

A Your would see that in alcohol -- oh, I’m sorry, CNS depressants, and eye concentrations or eye dosage is exactly the word they use, dissociative anesthetics, and inhalants in high dosages.

Q Now referring to the manual both the student manual and the teaching manual, either one of those manuals teach or explain how to identify vertical nystagmus?

A Not sure I understand what you are saying.

Q In the manual is there a section on vertical nystagmus?

A No. Vertical gaze nystagmus is what we teach.

Q When you teach it, it is vertical gaze nystagmus, is that correct?

A That’s correct.

Q So, in none of your teaching or in the manual, there is no differentiation between a vertical gaze nystagmus and a vertical nystagmus, correct?

A That’s correct.

Q And when you do a DRE evaluation, you need to write everything down on a face sheet, is that correct?

A That’s correct, and whatever other notes that you possibly need.

Q All right, and you call it a face sheet?

A Yes, it is.

Q And face sheets are all standardized?

A Not necessarily.

Q Okay. Is there a section on your face sheet for vertical gaze nystagmus, the ones that you use?

A Yes.

Q And do you use ones that you got from the manual? Where did you get your face sheets from?

A We actually got it from the IACP but we then converted it to include citation number -- add some little things to it such as citation number, report number and the logo for the department.

Q Now, the IACP face sheet -- let me just show you what I have here and see if --

A Okay. This is the student manual that you all have.

Q Now, somewhere in this manual, I am going to try to locate it as quickly as I can. There is a section where they have students complete face sheets, is that correct?

A Yes, there should be.

Q Okay. And those face sheets should be standardized face sheets, correct? Let me show you one. It looks like I am looking in Section 25, it looks like page 5, all right?

A Okay.

Q Would you just turn the back so you can see what the Exhibit No. is?

A Oh, I'm sorry.

Q It looks like Exhibit 5.

A That's correct.

Q Okay. And I just want to draw your attention to the box across from pupil size. That box says vertical nystagmus, is that correct?

A That's correct.

Q Okay, thank you. When Mr. DeLeonardo was questioning you, you made reference to the fact that you and your practices of DRE use the Physicians Desk Reference, is that correct?

A That's one resource that we use, yes.

Q When you use the Physicians Desk Reference, do you use the section on signs and symptoms for particular drugs?

A We can use the entire -- whatever we need to out of the book.

Q So, you would use the section on adverse incidents?

A If it is relevant to the situation, yes.

Q Are you familiar with the federal regulations governing the use of the Physicians Desk Reference?

A No, I'm not.

Q Did you know that the Physicians Desk Reference actually makes acausal connections not causal connections between the drug and the symptom?

A I did not.

Q Thank you. No further questions.

THE COURT: All right. We are going to take a recess. We will take 15 minutes.

THE CLERK: All rise.

(Whereupon, a brief recess was taken.)

THE CLERK: Silence in Court, all rise.

THE COURT: Be seated, please.

MR. WELLS: For the record, Adam Wells, spelled W-e-l-l-s, on behalf of the State. Dave Daggett, spelled D-a-g-g-e-t-t. And we are back on the record for Charles Brightful, et al., the Frye-Reed hearing.

MR. DeLEONARDO: Brian DeLeonardo, D-e-L-e-o-n-a-r-d-o.

MR. CRUICKSHANK: Alex Cruickshank, C-r-u-i-c-k-s-h-a-n-k.

THE COURT: All right, Mr. Wells.

MR. WELLS: Thank you, Your Honor.

REDIRECT EXAMINATION

BY MR. WELLS:

Q Good afternoon, Officer Morrison -- or --

A Good morning.

Q -- morning. You have been on the stand for awhile and I just want to give you the opportunity to respond to some of the very specific examples that Mr. DeLeonardo raised. One of those was with regards to essentially a hypothetical.

If you had the example of the Defendant had blown a .05 at the breath test prior to submitting to the DRE evaluation, and then during the DRE evaluation, he exhibited two out of six clues on the horizontal gaze nystagmus. Now, how does the DRE protocol take that into consideration?

A That's just one step, that is just one part of the

entire process. And that could be consistent with but we would have to look at the entire everything, each step, each component of each step to see if that would play a factor if this person -- if that .05 is playing a factor in their impairment.

Q Now is it fair to say that the DREs do and are required to use their judgment during the process?

A Most definitely. Everything that we do, we have the guidelines, we have the standardized and the systematic approach, but it doesn't take away from the DRE's judgment of what they see.

Just like a regular DWI, it doesn't take away from an officer's judgment to determine if a person should be arrested and if they are impaired.

Q Now there was another specific incident that he raised. He asked about therapeutic use of drugs and how some drugs as therapeutic use may cause -- say horizontal gaze nystagmus or some of the issues with the eyes. How does the DRE protocol take into consideration or help you to deal with the issue of the use of therapeutic use of drugs?

A If the person is taking their therapeutic portion of drugs, then we shouldn't see impairment to the point where that person would be under arrest, would be unable to operate the vehicle safely.

But, again, this is just one minute part of the

entire process. We are looking at everything and combining all that information together to form an opinion, is this person impaired.

Q Now with regards to, again, the therapeutic use of drugs, is there an opportunity to find out if that person is on a therapeutic type of drug. I mean are you asked -- is there a section where they do ask about that?

A Yes. During the preliminary exam, one of the questions we ask is are you taking any type of drugs or medication? And if we get that response, then we teach the students to go beyond what those questions are.

You have got those sets of questions but ask more about, you know, what are you taking, how are taking it? If they know the quantity, they may be even able to give you a sample -- show you the bottle. All of this information to expand on determining if this person should be arrested or be charged or whether they are impaired.

Q Now specifically with regards to the preliminary examination, the questions that are in there are -- there are only listed, is that right?

A That’s correct.

Q Now, are they limited to those six questions?

A No.

Q Are they encouraged or are they trained to do anything else with those six questions?

A They are encouraged to do more.

Q How so?

A Good example is when was the last time you were at the doctor's? Do you know what your normal blood pressure is? Do you know what your normal pulse rate is? These are questions that are routinely asked but we have a face sheet that only has so much space.

And we could actually write an entire book but that is not really, that would be the extreme. We are dealing with a simple face sheet that we try to keep it simple but, yes, we want the students -- or the DRE to continue and to find out more.

Q Now one more thing that he has brought up is he, Mr. DeLeonardo has routinely referred back to the manuals, either the teacher manuals or the student manuals. Is everything that is -- meaning is that the total sum and parcel of everything that is taught or trained or encouraged with the DRE protocol?

A That is the standardized systematic class. That is what, yes, we encourage -- we want them to teach from and, like I spoke yesterday, we can always add to it. You cannot subtract from it.

And that's why when we get into those questions, we want them to ask additional questions, find out about their medical history. Find out how does this affect them, what

type of medical history they have and to what extent and what type of medicine or drugs they are taking?

Q Now with regards to -- I will kind of lump these together just kind of in the interest of time, he had examples -- the examples to phrase towards you were pulse range, blood pressure, temperature and specifically I believe Romberg for pulse range, if was over just slightly or blood pressure, again, if it was over just slightly.

Temperature, plus or minus one degree and the Romberg's estimation of the time if it was off by one second. Again, these are the specific examples that he gave and they are small ones.

Does the DRE protocol have a way to deal with those very specific issues?

A Well, we are still not talking about judgment. What is the DRE, is that within what they consider to be the normal range, you know, one beat off? But we are also talking maybe that is the higher range or the lower range of that person. But, again, that's only one minute part of the entire process.

MR. WELLS: Court's indulgence.

(Pause.)

MR. WELLS: Your Honor, I have no further questions. I will defer to Mr. Daggett.

REDIRECT EXAMINATION

BY MR. DAGGETT:

Q Officer Morrison, Mr. DeLeonardo went through the, I guess the matrix of the drug category symptomatology chart. I have a series of questions for you.

HGN taken on its own, is that dispositive of drug impairment or being under the influence?

A By itself with nothing else?

Q Yes.

A No.

Q Vertical nystagmus, is that dispositive?

A You are talking about just by itself?

Q By itself?

A No.

Q Lack of convergence?

A No.

Q Pupil size?

A No.

Q Reaction to light?

A No.

Q Pulse rate?

A No.

Q Blood pressure?

A No.

Q Body temperature?

A No.

Q Or muscle tone?

A No.

Q Now do you look at those in their totality?

A We do, we combine all that together to see if those are a factor and if so, how much of a factor are they playing?

Q Now general indicators, lack of coordination taken on its own, do that indicate impairment by drugs?

A No, it does not.

Q Disorientation?

A No, it does not.

Q Slurred speech?

A No.

Q Drowsiness?

A No.

Q Droopy eyes?

A No.

Q And I believe that the drug category symptomatology chart is in evidence, is that correct, that you know of?

A That’s correct.

Q Okay. Shallow breathing?

A No.

Q Cold, clammy skin?

A No.

Q Increased body temperature?

A No.

Q Pulse rate that is beyond either above or below the

normal range?

A No.

Q Pupil size, large, small?

A No.

Q Blood pressure?

A No.

Q Body temperature?

A No.

Q What about a coma? I mean is that in and of itself dispositive of drug impairment?

A If they are in a coma, DRE is not going to be involved in it.

Q Bloodshot watery eyes?

A No.

Q Flushed face?

A No.

Q Poor balance?

A No.

Q All of the other -- you also do DUI/DWI arrests driving under the influence of alcohol?

A I do.

Q I assume you have made a number of DUI/DWI arrests in your day?

A I have.

Q And you filled out reports?

A Yes, I have.

Q Walk and turn test, in and of itself, dispositive of a DUI?

A No, it's not.

Q Are any of the factors that you look at for an arrest, for driving under the influence of alcohol or driving while impaired by alcohol, what is the only factor -- or is there any one factor taken by itself, that is dispositive of impairment or being under the influence of alcohol?

A That would be a chemical test.

Q So the breath test or the blood test for alcohol is the only one of all these factors that we have been hearing about for the last 14 days or over the last five months or so, the breath test for alcohol or the blood test for alcohol is the only one that is dispositive by itself?

A For alcohol, yes.

Q Is there any one at all, any one factor taken by itself, that is dispositive of impairment by drugs?

A No.

Q And what is the time -- there was a lot of, Mr. DeLeonardo and Mr. Cruickshank asked you a series of questions about the reports and the drug influence evaluation and all of the things that you -- I guess what they think you should do or should be required to do before you make your or come up with your opinion. What is the time limitation for

drawing blood to check for drugs or CDS from the time of arrest?

A In the State of Maryland, it's four hours.

Q Okay. And that is from time of arrest, is that correct?

A That's correct.

Q And you are not there at the time of arrest, are you? I am talking about the DRE is not there at the time of arrest?

A Most of the time, no.

Q Would it be possible to do everything that the defense would ask you about and still be able to come up with an opinion and ask for a blood test to be done within four hours?

A I'm not sure I understand.

Q From all the questions that you were asked about, all the things that supposedly that you do not ask, the questions that they wanted to know whether you asked the subjects certain questions?

A Okay.

Q Would it be possible to do everything that they asked of you and still have time to ask for a blood test within a four-hour time period?

A It would depend on the situation.

Q One final question, you used the term -- and I know

the that Court hears it a lot, we hear it in search warrants, we hear it on a lot of different things but as far as -- and I believe you used it a number of times, totality of the circumstances.

A That's correct.

Q Could you explain to the Court what you mean when you said that you need to look at the totality of the circumstances in order to make your opinion on drug impairment?

A Your Honor, I don't look at one particular thing. I don't hang my hat on one particular thing. We have talked -- taught all the examples that Mr. Daggett just gave. I want to see that first off, this person is impaired, they're psychophysical impairment, and that by looking at everything from every part of my evaluation that this is consistent with somebody who would be impaired by this drug.

And do we have to have every minute thing? No. But by using my judgment, I feel that this is what's causing the impairment.

MR. DAGGETT: No further questions.

THE COURT: Any recross?

MR. DeLEONARDO: Very briefly.

RECROSS-EXAMINATION

BY MR. DeLEONARDO:

Q Just touch on the -- you were asked about the .05

and the effect on HGN, Mr. Wells was just asking about that. When a person has .05, they could have HGN, correct?

A They could display HGN, yes.

Q Okay. Now, but in the categories here, the only categories where there is present for HGN as an indicator is CNS depressant -- I'm sorry, for dissociative anesthetic and an inhalant, correct?

A That's correct.

Q So, if someone had a .05, one of the reasons that you look for HGN or you start with the eyes first is because it helps you narrow down the categories, correct?

A That's one thing, yes.

Q Okay. But then -- that would, you would agree with me, would prevent you from being able to narrow the categories down based on the eyes, right?

A By that one thing?

Q Well, by HGN, correct?

A I'm not sure what you are asking.

Q Well, what I'm asking is you say a .05 can produce horizontal gaze nystagmus, correct?

A That's correct.

Q Have you been taught whether it can produce vertical nystagmus?

A It would not.

Q So, they are taught that vertical nystagmus will not

be caused by alcohol in the system?

A At a .05.

Q At what point can it cause, are they taught?

A A high concentration of alcohol for that person.

Q .05 can also cause lack of coordination, correct?

A Yes, it could.

Q It can cause a lot of the other indicators that Mr. Daggett pointed out to you, correct?

A It could, yes.

Q So, in the end, it is ultimately your medical judgment as to whether or not it is caused from alcohol, drugs, combination of two or medical condition, correct?

A Well, again, we are looking at everything. I mean if we are just have the few things, is this person impaired at all? At a .05, we wouldn't expect to see somebody who is impaired.

Q Oh, no, okay. I will remember that for my future cases. When you are dealing with the -- I guess the point that I was trying to get to is you were asked about therapeutic uses and you said, well, with therapeutic drugs, we shouldn't see impairment, correct?

A That's correct.

Q But what you are looking for to find impairment is these major indicators, correct?

A That's correct.

Q So, are you saying that you cannot have these major indicators if you have just taken a therapeutic dose of a drug, is that what you are saying?

A If you are taking your therapeutic dose of the drug you may not be causing those in general -- in those general indicators -- major indicators.

Q Okay. So the DRE officers are taught that if a person is just taking a therapeutic level, you would not have these major indicators, isn't that right?

A Yes.

MR. DeLEONARDO: That is all I have.

THE COURT: All right, Mr. Cruickshank?

MR. CRUICKSHANK: Just one.

RECROSS-EXAMINATION

BY MR. CRUICKSHANK:

Q When Mr. DeLeonardo referred to vertical nystagmus, was you understanding in your answer that he was talking about vertical gaze nystagmus as you are trained to understand it in your manual?

A I only know of one vertical gaze nystagmus.

Q Thank you.

THE COURT: All right. I am sorry you will be -- I am sure you will be sorry to hear this, officer, but you can stand down.

(Laughter.)

THE WITNESS: Thank you, Your Honor.

(Witness excused.)

MR. DAGGETT: Our final witness, Your Honor, will be Lieutenant Thomas Woodward.

THE COURT: How long do we need for Lieutenant Woodward?

MR. DAGGETT: I don't know. Hopefully, we can be done by 12:30/12:40. Not just me, but I mean in its entirety.

MR. DeLEONARDO: I am not really sure what all he is testifying to. And I guess maybe we could start with his proffer because it is a rebuttal witness.

MR. DAGGETT: Well, he is not a rebuttal witness. At this point, he is the current -- we had Bill Tower who was the former DRE supervisor. He is the current.

MR. DeLEONARDO: Well, I seem to recall that he was proffered previously that he was a rebuttal witness, and so I guess I was wondering why if he is not now a rebuttal witness, what changed between the last hearing and now.

Because, we were advised that he was merely being called as a rebuttal last time and if, Your Honor, may recall I said well I want to know what he is rebutting because at that point we had called three medical experts.

So, I don't know what he is adding that hasn't been covered by two DREs and certainly what he is rebutting in the medical community, I don't it would be -- I don't think he is

qualified to rebut.

THE COURT: Well, he is not a rebuttal witness.

MR. DeLEONARDO: What?

THE COURT: He is not a rebuttal witness, and I would agree with you, rebuttal of any medical testimony unless the witness is a doctor, would probably not be admissible.

MR. DAGGETT: Right, he wouldn't be doing that. He is the -- since he is the current and has been for the most part of the last decade, I just think it is important for the Court hear about what has been going -- you heard from Mr. Tower so now I just think it is important for Mr. -- Lieutenant Woodward.

THE COURT: All right. Well, let's --

MR. DeLEONARDO: Well, if I could just ask one thing, the other thing I would ask is, and I am not trying to be technical about this, but we have not received anything as to what the nature of his testimony is.

So as I sit here right now, I have no idea what he is here to talk about. So, I think in fairness and I want to hear it but at least to have some time to prepare a cross-examination since I have no idea what he is going to talk about.

THE COURT: All right.

MR. DeLEONARDO: I mean I don't know that I will need it but I am just raising the issue ahead of time so Your

Honor knows it.

MR. DAGGETT: I imagine the cross-examination will be the exact same thing it was of Mr. Tower.

MR. DeLEONARDO: Well, I have to go get that book out of my car.

THE COURT: Well, my guess is you will be able to do that during the lunch recess.

MR. DeLEONARDO: Okay.

THE COURT: All right, let's move on.

THE CLERK: Please remain standing and raise your right hand.

Whereupon,

LIEUTENANT TOM WOODWARD

was called as a witness by the State, having been first duly sworn, was examined and testified as follows.

THE CLERK: Thank you, you may be seated. For the record, please state your full name, spelling your first and last and give us your current duty assignment.

THE WITNESS: It's Lieutenant Tom Woodward of the Maryland State Police, I am currently serving as the Commander of the Hagerstown Barrack in Washington County.

I spent five years prior to that as the commander of our chemical test for alcohol unit.

DIRECT EXAMINATION

BY MR. DAGGETT:

Q Tell us briefly your police background?

A I've been a law enforcement officer for 33 years, 25 of that with the Maryland State Police. I served in the capacities of planning and research, criminal investigation, road patrol, I'm an instructor in the standardized field sobriety testing, drug recognition expert, a drug evaluation classification program. And I have served as a State Coordinator as you said for most of the last 10 years.

Q Now can you explain your current -- well, your current position I guess is at the Hagerstown Barrack, but when you were as far as the DRE program. Explain what your duties and responsibilities were are for the DRE program?

A For the DRE program, I am responsible for ensuring that our program is operated within the guidelines of the International Association of Chiefs of Police. That all of our drug recognition experts receive the appropriate training and that all of them meet the qualifications for certification and recertification.

Q And how do you go about doing that?

A I review the paperwork. We get -- in Maryland, we have agency coordinators for the particular departments who are responsible for their particular DREs. They report to regional coordinators who also help ensure that all of the paperwork for certification, recertification is within the guidelines.

They submit that to me, I, for the third time check and make sure it is appropriately -- that they have met all the guidelines before I submit it to the IACP.

As far as the training, I take part in at least some degree in all of our training courses for the DREs.

Q Now, I am going to ask you what -- as far as training goes for the applicants, because the law enforcement officers who are the applicants for the DRE program, could you indicate to the Court, what the State of Maryland and what you require or what is required of the applicants as far as training goes?

A Okay. Well, by International Association of Chiefs of Police standards anyone being considered for the drug evaluation classification program has to have previously been trained in the standardized field sobriety test.

The National Highway Safety Administration --

MR. DeLEONARDO: Your Honor, I am sorry. I am just going to object from the standpoint that, I mean we have covered this through two witnesses now.

We covered it through Officer Morrison and Mr. Tower. I mean if there is something additional that is new, if he wants to target that but to go through field sobriety, certification, preschool, DRE -- I mean I don't know what it is adding to the testimony.

I mean, again, if you have certain things that you

want to add that hasn't been -- I mean I note that is fine, I am just trying to --

MR. DAGGETT: He is the head of the program. I think it is important for him to explain to the Court exactly what has been going and what Maryland requires and what Maryland has done.

Now he is the one who is the current head of the program and I think he has more knowledge than anybody else and I think it is important to lay that out.

THE COURT: Well, I guess my question is I think Lieutenant Woodward was here during prior testimony. I mean I am sure he heard what Mr. Tower and Officer Morrison said.

I mean it might be a good idea to try and focus on anything that is different than what we have already heard. But I am not going to unduly limit some of maybe repetitious but -- all right?

MR. DeLEONARDO: Okay.

THE WITNESS: Okay, I can maybe narrow it down a little bit. Mr. Daggett, if you will, let me know if I am not covering something you think is appropriate but one of the issues that I heard brought up was what the International Associations of Chiefs of Police allows in the training.

And a recent revision in the manual does allow a combination of standardized field sobriety testing. The DRE preschool and the DRE seven-day school.

I can ensure you that we have never done that in Maryland and as long as I am the coordinator we never will do that.

We want any candidate for our DRE program to be experienced in the use of the standardized field sobriety tests. We want road experience. And we have a standard of a minimum of one year being a practitioner and we will evaluate their experience. One year may not be sufficient for somebody who has done a limited amount of impaired driving enforcement.

If we have somebody who has been aggressive, we may allow them in with just one year of experience. Usually it is more than that before they are admitted to the DRE school.

We do teach a combined DRE preschool, DRE seven-day school. We have taught them with a gap in between and we have taught them combined. We see no difference in the capabilities of the students in those two programs. Whether there is time in between the two schools or whether they are combined. The advantage to us in having them combined, it is easier for scheduling for their law enforcement agencies who send those students to the school.

BY MR. DAGGETT:

Q And what do you mean by -- explain what you mean by that?

A Well, there is a two-day preschool, DRE preschool, and the seven-day DRE school. And years back we would teach

the DRE preschool and then we would have maybe three or four weeks between that and the DRE seven-day school.

In recent years, we have eliminated that. We teach the preschool and we move right in to the seven-day school. We will do the two-day preschool and then the very next day for those who successfully complete the preschool, move right into the seven-day school. There is just no time in between them.

Q And we heard yesterday, I believe, that the national program is the combination of three schools together?

A It gives that option.

Q Gives that option, I am sorry.

A Correct.

Q And what was the third and what would be -- what was the third component that the National that --

A Well, they allow the combination of the standardized field sobriety testing preschool --

Q The SFST, okay.

A -- and seven-day school --

Q Okay, so it is the SFST.

A -- yeah, we do not do that in Maryland.

Q Why do you not do that in Maryland?

A Just a personal preference. I -- and I say I, we have meetings with the coordinators and I don’t want to dictate, we will get a sharing of the opinion and we all tend

to agree that it is important to make sure that the students for the DRE school have practical experience in enforcing our impaired driving laws.

That's why we want at least a minimum of one year's experience enforcing this.

(Long pause.)

MR. DAGGETT: Court's indulgence, please, Your Honor. I don't have a whole lot more in light of --

(Pause.)

BY MR. DAGGETT:

Q Did you work for Mr. Tower?

A I did. I was under his command for about two years before he was transferred.

Q And you took over the DRE program when?

A He was transferred and I have to look at my CV but -- 199--, late 1991, I believe it was. I served in that capacity through 1995 beginning of the year. Turned that over because my assignment at that time, I didn't feel it gave me the time that I wanted, I felt I needed to devote to the program.

So I asked that it be given to another individual and it was. That individual kept it for a couple of years until they retired. At which time, my assignment was back in the chemical test for alcohol unit.

So I reassumed that responsibility with the

authority of the Governor's Highway Safety Representatives who by the IACP makes that appointment.

Q Now under your stewardship, I guess, does the Maryland -- is the Maryland DRE program -- well, maybe you can't answer this. Maybe I am not phrasing it very articulately but are you more strict? Would you describe yourself as more strict or less strict in the national standards?

A Much of our program, we have more stringent requirements than what the IACP requires. An example is that one year of experience, another is the final knowledge exam that Dave had described to you.

We require 100 percent on that. That is not the IACP standard. We are very strict there. Urinalysis results during training we require at least 80 percent. That is more stringent than what the IACP standards are.

So, we do have our standards in many areas higher than what the IACP requires. We look at theirs as a minimum standard. They allow us to set more stringent standards if we choose to do so.

MR. DAGGETT: That is all I have, Your Honor.

THE COURT: Cross?

CROSS-EXAMINATION

BY MR. DeLEONARDO:

Q When you were talking about the revisions that were

made in the three-day course, the three-day combined, you were asked about that? The field sobriety test, the preschool and the DRE school?

A Not three-day, three parts combined, correct.

Q I am sorry, I apologize. The three parts combined is what I meant to say.

A Yes.

Q And you said you had never done that and you would never be in favor of that?

A That is correct.

Q But you would agree that someone else who could take over, that they could decide that that is the way that they are going to allow it now, correct?

A That is correct.

Q It is a personal call that you are making, you are disagreeing with what IACP is saying at this point, right?

A No, I am not disagreeing with them. They allow us to be more stringent. They set standards that would apply nationwide. And certainly different states have different circumstances. You know, you might have a state that exceeds the NHTSA IACP standards for standardized field sobriety testing.

Let’s say as an example they extend that for two or three weeks. Well, okay, if they are going to do that then they might tie preschool and seven-day school in with it. I

mean you know I can't address a lot of ifs there.

Q The reason why though is they set the standard of what is -- what makes a qualified DRE, correct?

A They set the minimum standards, correct.

Q They are the ones who are ultimately going to give you the certificate and the certification, correct?

A They give the certificates. The certification comes from the State Coordinator but they give, they credential, essentially.

Q Okay. So, they are saying that you could do this combined and be a certified DRE, correct?

A Well, really it's the State Coordinator that says that. They set the standards, the coordinator is the one makes the determination whether the person reaches the level that that coordinator wants for a drug recognition expert in the given state. So, --

Q I understand that you ultimately are the one who has to sign off on people in Maryland --

A Yes.

Q -- I understand that. What I am saying is, however, the fact that they allow that to happen means that they are saying for their purposes that is enough to be a certified DRE, correct?

A As long as they get the credentialing from the State Coordinator, then they will -- I mean the paperwork from the

State Coordinator, then they will issue the credentials. What they are setting are minimum standards.

Q I understand.

A Okay.

Q But that also means that if Maryland decided to change that that would be a permissible way to do it, correct?

A Correct.

Q Now I assume the reason that you don't want it done that way is you think that they may not be as qualified to be a certified DRE, is that correct?

A There are a couple of trains of thought along that line.

Q That certainly is one of the big trains coming down, right? Is that you don't think that having someone be able to do those all at once, all that information at once is an appropriate thing to do to have them be a certified DRE, right?

A I believe it's important to have the separation but if I may give you an example. When I went through the academy, I shot thousands of rounds of ammunition and firearms training, qualified 100 percent. Everything I shot at the end of it for qualification hit the bulls eye.

I have never qualified that good again because I don't shoot that frequently. So the argument could be made by going right through step by step, the person may be qualified.

So, I am not going to say that what they suggested is not a valid process. I am only saying that is not what I choose to use in Maryland.

Q Okay. You don't choose to use it but you don't find it to be inappropriate, and is that a summation?

A Correct.

Q And so if you don't find it inappropriate to do it that way, then it is certainly not unreasonable that one day that may be very well what we are doing in Maryland, correct?

A Could be.

Q When you are -- this qualification or what they have approved, you are actually involved in IACP, correct?

A I am currently a member of the DRE section of the IACP. I previously served in the capacity of general chair of the section, had one year I spent in that capacity on the technical advisory panel. I do not anymore.

Q And when you were on that panel, what years was that?

A Let's see, 2007 to 2008.

Q And was there a medical person on that panel with you?

A I'm sorry 2008 to 2009. But at the time I was on there, it was right after Dr. Phillips had passed away. And they had not yet appointed a new doctor. So, from the medical field, we just had Dr. Jack Richmond.

Q And he has been on there for a very long time?

A A number of years, yes.

Q Now, you said you didn't see any benefit to having the pre -- because initially, it used to be, did it not, that the preschool had to be completed. There had to be a break and then you were brought back for the actual seven-day, correct?

A I don't want to say that had to be done. We did it that way. The theory was they finished the preschool, you give them their DRE seven-day manual with the hopes that they would go back, start reviewing that manual.

Q And continue to do field sobriety testing, correct?

A And practice some of the skills.

Q And they were also taught to, while they are now getting the time doing that after preschool to look for some of the things they have been alerted to, correct?

A When they are doing their enforcement in the field.

Q Correct?

A Yes.

Q And so you talked earlier about the real benefit of having -- you talked about your shooting. Now when you are doing it regularly, you could shoot pretty well, right? The reason was it not for the preschool and the break to then DRE school, was that the person had a chance to go out, do some of these things, see it in action in real life, and then come

back and learn this seven-day program, correct?

A Correct.

Q But you see no benefit in keeping it separate now?

A Well, we found no benefit. We tried one year combining the schools and evaluated the outcome. Did we have better students when they were separated or were they equivalent, or were they better with the combined school?

And what we found was there was really no difference in the capabilities of the students whether there was a separation between the two schools or whether they were combined.

And, again, as I mentioned for the benefit of scheduling for the agencies that send them, we have chose to keep them combined.

And we continue to evaluate it, you know, each time we have a school to see. And we haven't seen any degradation in the quality of our students.

Q Well, let me ask you. You say that. How do you determine the quality of your students?

A Do they know the material? How well do they score on the exams? How well do they perform in the practical exercises? And how well do they perform when they get out? We do retraining every year.

So, when they come back, have they retained as much information with the combined school as they did with the

separate school.

Q So, you found no benefit to their ability to memorize material by taking the break, correct?

A I'm sorry?

Q Well, I mean a lot of the testing in the DRE program is you have to remember a lot of information?

A Correct.

Q You have to remember all the information that is contained in the manual, correct?

A We hope so.

Q Right. Well, that is what they are learning, that is what they need to know, right?

A Correct.

Q Okay. So, you didn't see any difference in taking a break in their ability to remember and score well on the test, correct?

A That is correct.

Q Now, what about the ability of them to execute this kind of material in the field?

A Well, again, we did not see any decline in the capability of the DREs once they were -- once they went into certification training really is where we would evaluate them and to see if they had a change under the new style or new scheduling. Were they able to perform as well during certification training as they did otherwise?

Q Now one of the ways that -- one of the duties that you have in your position is to report Maryland's -- I would say an annual report that you have to do where you report and say the status of how DREs are doing in Maryland, correct?

A Correct. To report that to the International Association of Chiefs of Police.

Q And one of the ways that you evaluate the performance of your DREs is by looking at their logs, correct? Their DRE rolling logs?

A I don't see too many of those. On a random basis, I see them. Most of that is done by the agency coordinators, regional coordinators will, again, will randomly look at some as well. I see some now and then. If there is a problem and it's brought to my attention, then, obviously, I will look at each individual.

We do report. I think maybe what you are getting at, we -- okay, go ahead.

Q I will get to where I want to get.

A Okay.

Q What I am asking you is though you said that you saw no difference in how they performed in the field, correct?

A That is correct.

Q But you have no involvement in how they perform in the field because you don't even see what their logs are and how they performed, correct?

A I see some but I also keep a database that reports on their -- how many evaluations, lab results and so forth.

Q Right, lab results. So, when we are talking about the issue of their performance and you said, I see no difference in their field performance, do you analyze how much you get. Like when they are coming in, do you look at what they determine categories to be and whether there was actual confirmatory testing to show that is what it was?

A I will compare an individual DRE's accuracy rate, if you will, to the state average. If it is way out of line, then, obviously, it brings to our attention something that may need to be addressed.

Q Like, again, so, I just want to clarify. So, when you say, when you basing your opinion that you saw no difference of them in the field, that is based on what you saw in terms of how accurate they were in the field based on confirmatory testing?

A When we are evaluating them initially it is during their certification training. Okay?

Q Right.

A That's not necessarily out in the field, although it's not in the field, I mean it is in a controlled environment. Typically, we use Baltimore Central Intake Booking Facility. That is where we are evaluating their outcome as part of their accuracy really in their evaluations.

Once they get certified and go out into the field, then for recertification purposes we look at their accuracy compared to the statewide average.

Q Okay. One of the things that took place though, at least in Maryland, for a period of time and you reported this and you have heard it come up that actually was no testing being done on any of these opinions, is that correct?

A That is correct.

Q And so when you say you didn't see any difference, well at least, how many years was that?

A Right about two and a half years where we did not -- well actually that is not true. Two years and two months, I think, where we did not have testing.

Q Okay. And you didn't stop anybody from rendering opinions during that time as the coordinator for Maryland, did you?

A No, I did not.

Q And you continued to recertify people during that time is that correct?

A That is correct.

Q Even though you would agree with me, you have no idea how "accurate" they were in the field because there was no confirmatory testing to look at?

A I don't mean for this to sound like a flippant answer but I compare their average to the State average. And

we could argue that each one of their averages was identical to the State average because we didn't have testing, so, the State average was what it was.

Q So, it was whatever they said it was, they were right?

A There is no requirement by IACP standards that we evaluate that, that we take that into consideration.

Q You went to great lengths to tell me how much stricter Maryland is than IACP --

A That is correct. And we are in some areas.

Q But not that area?

A That is true.

Q All right. In fact the strictness that you talk about you say, you gave a couple of examples, one of them was you were stricter in that you wouldn't allow this three SFST, preschool and DRE -- that is one that you said you were stricter in, right?

A Correct.

Q The one you said is that on your final knowledge, you require a 100 percent, right?

A That is correct.

Q And the normal test that is taken by IACP, it is 80 percent, is that right?

A Well, no. The accurate -- you have a 100-question test at the end of the DRE school. That is separate from the

final knowledge exam.

Q Okay.

A The final knowledge exam is usually done about half to three quarters of the way through the certification phase. The standards for the IACP is that the DRE student show a proficiency and knowledge of the DRE program.

That is it, there is no percentage there. We require them to get a 100 percent in that.

Q So, on the examinations that are done all the way through the program and completing -- before we get to field, sir, completing the program. You use the very same pass rates that they use in IACP, correct?

A You mean for the quizzes and for the 100 --

Q Correct, for the quizzes and the --

A -- yes 80 percent.

Q -- knowledge pass and all that, right?

A Correct.

Q The only thing you are saying is -- and you are describing it as more strict, is this final knowledge exam that occurs at the end where IACP doesn't tell you what percentage it has to be, correct?

A No, we use a higher standard for during the training, certification training, we require more accuracy in confirming their tests.

Q Well, that is a separate issue, and I will get to

that.

A Okay.

Q Talking about your final knowledge exam, okay. Final knowledge exam, IACP does not set a percentage that a person has to get, correct?

A On the final knowledge exam, correct.

Q Right. So, you are saying that you pick a 100 but they also, isn't it true, that IACP doesn't say you can give it to them multiple times, correct?

A They have the -- you mean multiple times?

Q Right. For example, they simply say you need to make sure the person is proficient. They don't tell you that you can give it more than once, do they?

A No.

Q But Maryland allows you to do it more than once if you don't score a hundred, correct?

A I don't believe we have ever had someone come back in and retake the final knowledge exam. We have had a permitted retake of the 100-question test at the end, but not the final five-part, final knowledge exam.

Q So, how many people have you had that failed the exam, didn't get a hundred?

A We have had -- oh, I don't know, over the years, probably six to eight who have failed the final knowledge exam. We have had more than that that were unable to complete

portions prior to that.

Q Okay. And as to the final knowledge were they allowed to retake it?

A No.

Q And as to the final knowledge, how many students have you had that have gone through in your time as the administrator of this approximately?

A 150 to 200 in Maryland roughly.

Q Okay, so out of that you had six that didn't get a 100, right?

A That is correct.

Q As to the testing, when you had the lack of blood testing that was going on, the IACP standards require you may not, that there is confirmatory testing that is collected and analyzed by the coordinators?

A For a state to be chosen to be a DRE state, they have to have laws in place that enable that and the ability to do so.

Q Okay. So for that over two-year period of time, Maryland didn't have the ability to do so, correct?

A That is correct. We were already a DRE state by then.

Q Well, I understand, but Maryland was operating below IACP standards during that time, isn't that right?

A I don't believe IACP specifies standards for yearly

ongoing service. For a state to become a DRE state, they are required to have laws in place and the ability to do the testing. I have never read anything in their standards that require them to reevaluate that on a year-to-year basis.

Q So they don't decertify someone who then doesn't follow their initial requirements, is that it?

A Now, you would have ask them about that. I have not seen that.

Q Well, you were part of the --

A They did not remove Maryland from the DRE program, that is correct.

Q And you reported to them, in fact, they were not -- that you were not getting blood results, is that right?

A That is correct.

Q And you also are familiar with Dr. Barry Levine, the State Toxicologist for Maryland, is that right?

A I am.

Q And you spoke to him during this time about the lack of blood testing, is that not right?

A That is true.

Q And he expressed his opinion, did he not, to you, that without blood testing that you cannot render an opinion as to impairment, is that right?

A I had several discussions with Dr. Levine and I expressed my opinion to him that he is trained in toxicology,

he is not trained in identifying psychophysical impairment and so any opinion that he would deliver based on a trained person's ability to identify psychophysical impairment could be questionable.

Q So, you are saying that Dr. Levine -- let me make sure I have got this right. Dr. Levine is less qualified than a certified DRE to render an opinion without blood?

A I'm saying that Dr. Levine is not trained in identifying psychophysical impairment. He is identified in toxicology. He cannot talk about quantities of blood in the system, he can talk about the effects that drugs would have on an individual.

He has never been, to the best of my knowledge, and he has never told me that he has been trained in identifying psychophysical impairment like law enforcement officer does.

THE CLERK: Defense Exhibit 28 for identification.

(The document referred to was marked for identification as Defendant's Exhibit 28 for identification.)

BY MR. DeLEONARDO:

Q Now I am going to show you defense Exhibit 28 marked for identification. And you can take a look just to satisfy yourself. It is a transcript of Dr. Barry Levine.

A Uh-huh.

Q Okay. I am going to ask and if you would, you could certainly peruse it on a discussion about a DRE opinion. And I will ask you some questions.

A (Reading.)

MR. DAGGETT: I am not -- we haven't seen it. I don't even know what that is. And I would like some sort of proffer at least before we can as to what it is.

THE COURT: Well, I think I am going to recess for lunch.

MR. DeLEONARDO: Okay. We will resume at 2:00 p.m. This room will be locked over the lunch recess.

THE WITNESS: May I have -- while we are on break, may I -- in this room may I have an opportunity to review this.

MR. DeLEONARDO: Yes, absolutely.

MR. CRUICKSHANK: We just gave you guys a copy.

MR. DeLEONARDO: We just gave copies so you can certainly take a look.

MR. DAGGETT: Oh.

MR. DeLEONARDO: Because Madam Clerk, I am sure would like her copy back.

THE CLERK: All rise.

(Luncheon recess was taken.)

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

THE CLERK: Silence in Court, all rise.

THE COURT: Be seated.

MR. WELLS: Your Honor, we are back on the record in the Charles Brightful, et al., DRE Frye-Reed hearing. And both parties for the State, Daggett and Wells, are present, Your Honor.

MR. DeLEONARDO: And for the record, Brian DeLeonardo, D-e-L-e-o-n-a-r-d-o.

MR. CRUICKSHANK: Alex Cruickshank, C-r-u-i-c-k-s-h-a-n-k.

THE COURT: All right, ready to proceed?

MR. DAGGETT: Yes, sir. Lieutenant Woodward is on the stand. Your Honor, we are going to -- when we left for lunch, I believe Mr. DeLeonardo was in the process -- I think he had marked it and was getting ready to ask Lieutenant Woodward some questions about things that Barry Levine might have said.

We are going to object to that entire line. I mean we don't think there is any way that that is admissible and I just don't think it is appropriate.

I mean it doesn't qualify under anyone of the hearsay exceptions. There is no showing that Dr. Levine is unavailable. And it is something that -- I mean as far as for the Court's information, evidently some time ago, a few months

ago, Mr. Wells, Mr. DeLeonardo, and Mr. Cruickshank had a DUI or a DUI/CDS trial in which Dr. Levine was called at that point. I think Judge Hughes was the Judge. It is a transcript of the testimony of Barry Levine at that particular hearing.

But I don't think it is -- it is certainly nothing and Barry Levine is not a witness here. And he has not been shown to be unavailable, so we don't think it is proper -- it is a proper area for cross-examination because we can't certainly ask any questions about it.

So we just don't think that line -- I mean everything else we have no problem with but I think that line is just inappropriate.

MR. DeLEONARDO: If I could respond, Your Honor?

THE COURT: Yes.

MR. DeLEONARDO: First of all, initially he was being called as a rebuttal witness now he was being called as a substantive witness, which was a surprise, obviously, to me and to the defense.

He has testified and the reason he was being proffered is that he is, in fact, in charge of the State DRE program. It also works in conjunction with the State Toxicologist.

I asked questions as to him as to the conversations they had and what Dr. Levine's position was. He indicated one

position, I'm exploring a line of questioning on that. So, to that extent I think it is certainly a fair line of questioning from an impeachment standpoint.

Second of all, there is no requirement to show unavailability. It is a certified transcript that certainly has the indicia of reliability that I would be able and permitted to use that at a Frye hearing.

We are not talking about this being a Court trial as to those kind of issues. This is a Frye hearing, which frankly you can introduce all kinds of items as we have all done, from letters from some association to certified transcripts that the parties that are before you were involved in.

So I don't see how at all that is objectionable.

THE COURT: Well how is this, Mr. DeLeonardo, how is this not outside the scope of direct?

MR. DeLEONARDO: Well, Your Honor, I would say that it is not outside the scope of direct because he was asked about the stringency and the protocol and how they determine the accuracy or the reliability of the DREs.

That was some of the substantive testimony that was --

THE COURT: Right.

MR. DeLEONARDO: -- in fact, elicited. And so I am inquiring as to whether or not that, in fact, is accurate.

What is his understanding of how --

THE COURT: How does Dr. Levine's testimony relate to that?

MR. DeLEONARDO: Because he is one of the people who oversees or helps oversee the programs and testing, I mean the blood testing and the urine test of whatever is taking place in the State of Maryland.

So, I think it goes to that. I mean it goes to what information is being provided to the people that run DRE as to what the proper way is to run it.

MR. DAGGETT: My response to that is number one, first and foremost, we did notify the defense that Lieutenant Woodward was going to be expert in the field of drug evaluation and the DRE program --- in the State of Maryland.

So we have gotten -- you know we keep hearing that we didn't notify them of that. We did.

Secondly, Maryland Rule 5-804 talks about testimony given in a deposition and it has to be -- there has to be shown that the declarant is unavailable.

But most importantly, Dr. Levine -- I know what the testimony is going to be, and Dr. Levine basically -- and I have no problem in proffering this because it is accurate.

Dr. Levine basically if he were to be called, he would say -- and if I say it, -- feel free to jump in. He would say that he cannot if by looking at drug results

determine if somebody is impaired.

And we acknowledge that. We have no -- because there is no per se, there are no per se levels for drugs, he cannot come to Court and look at somebody's drug results and say based upon this, this person is impaired by this drug or this drug.

We concede that. There is no doubt about it. That is why -- but to take a one line or something that he might have said at a hearing sometime ago and put that in as gospel and we can't clarify it. It is just not and we just don't think it is appropriate and we do think it is beyond the scope as well, I should have said that but I mean we are just getting real far afield.

Dr. Levine could have been -- Dr. Levine could have been called here if they wanted him -- if they feel he is that big a deal, that important a witness, I guarantee you they would have called him as a defense witness.

MR. DeLEONARDO: Well, first of all, I would say, Your Honor, at to the proffer, it is an incomplete proffer. Actually, and I would be happy to put the full transcript in --

MR. DAGGETT: Well, yes, I am sure you would because it is inadmissible.

MR. DeLEONARDO: -- and, again, what he says is that you cannot reach an opinion -- he cannot reach any degree of

an opinion based on just signs and symptoms. That he would need both the signs and symptoms as well as the confirmatory blood test before you could testify as to an opinion.

That is so completely on point with the issue that we are dealing with. And as a result of what was being raised as to the way the blood is and the way Maryland is operating as we had testimony on that there was years that their blood testing was being done.

I inquired about the conversations on whether that was permissible and he indicated, my recollection was it was not an issue and, obviously, there is extensive testimony from Dr. Levine right on that point that says it is.

MR. DAGGETT: It is not extensive it is --

MR. DeLEONARDO: And I think it goes to impeachment on the program.

MR. DAGGETT: -- it is probably about four questions, it is not extensive and it is so inadmissible hearsay, Your Honor. We cannot -- we have all sorts of question and again I repeat if they thought that Dr. Levine was the key witness here, they would have subpoenaed him.

They paid all this money for everybody else, they certainly would have brought Dr. Levine in but they know that is not what he going to say.

And so when we have this difference of opinion, certainly I think it is just -- it is not admissible based

upon the rule.

THE COURT: I going to sustain.

MR. DeLEONARDO: Is, Your Honor, going to give leave at least based on this witness being added that we could bring Dr. Levine in if we choose?

THE COURT: I am sorry? When are you going to bring him?

MR. DeLEONARDO: Will we be able to have leave to bring Dr. Levine in if we choose? I mean the State obviously didn't want to bring the State Toxicologist in yet they are sure that he has something terrible to say for them.

So, I am asking if we choose to do that, whether we still have leave --

THE COURT: When would you do this, Mr. DeLeonardo?

MR. DeLEONARDO: I guess we would do that now.

MR. DAGGETT: On what basis? They have had six months -- a year to subpoena Dr. Levine. We will never get this thing over.

MR. DeLEONARDO: This is purely for impeachment, Your Honor, as to the witness. I mean I don't understand why I would be limited for not introducing it as evidence.

I have had impeachment evidence that I used against Ms. Burks, that was an internal affairs memorandum. Impeachment, you are given latitude to do that. And I am simply asking him if he knows and if that, in fact, what Dr.

Levine has shared with him.

THE COURT: Well, ask him but I am not going to admit the transcript.

MR. DeLEONARDO: Well, okay, and that is fine. I was just simply wanted to pursue the line of questioning as an impeachment purpose and I think I have a right to do that.

THE COURT: Because my concern is, quite honestly, I think the State raises a valid point here, I mean we are talking now about a deposition coming in and we all know --

MR. DeLEONARDO: It is a Court transcript and a trial.

THE COURT: Well, but, you know, as a practical matter, I mean it may be that the witness would expound upon his answer in a way that might be -- I mean I would much prefer to have the witness here.

But I don't really -- I mean we have heard I think similar testimony from other witnesses and I understand this is for impeachment purposes but we have heard as I understand the proffer, I believe the record is replete with testimony from other witnesses during the course of these hearing, which probably says essentially the same thing.

Now if you want to ask the witness about that, any discussions he has had, anything, that is fine.

MR. DeLEONARDO: And that was my only point because he was being proffered as a witness as the reason why he was

so important to bring in was because he is in charged of the DRE program and he obviously has conversations with Dr. Levine and they had conversations about what is appropriate.

Again, I simply ask that line of questioning.

THE COURT: All right. Proceed.

MR. DeLEONARDO: Thank you.

BY MR. DeLEONARDO:

Q Now, you have had the opportunity to review what was marked for identification as defense Exhibit No. 28, is that correct? Did you read this over lunch?

A Yes, correct.

Q Okay. And you are aware in the transcript or what you read is it was basically a drugged driving situation, correct?

A Correct.

Q And you saw in there the fact that there was Dr. Levine, and Dr. Levine is who?

A He is the State's Toxicologist.

Q Okay. And he has been the State Toxicologist for some time, correct?

A Correct.

Q And as far as the blood testing that is done as part of the drug recognition expert program, he oversees that testing, does he not?

A He certifies the instrumentation that is used and he

certifies the people doing the testing.

Q Right.

A That's the extent of his oversight. The testing is actually done by the State Police Forensic Sciences Division and they have Dr. Ross --- there who oversees the actual testing of it.

Q But he is the certifying agency in Maryland for any type of blood testing and how it is performed, correct?

A Probably so. That I don't know. I know he certify people and equipment.

Q And you certainly over the years consult with Dr. Levine as the State Toxicologist when it comes to those issues, do you not?

A Correct.

Q And when we talked earlier, there was this period of time where there was no blood testing going on, on these DRE cases, right?

A Correct.

Q And so you would have consulted him and you did consult him as to how the blood testing and whether what you could do to get it started, correct?

A Correct.

Q And you also had discussions with him, did you not about the affect that it had on the DRE program by not having blood testing, correct?

A In a round about way, correct.

Q And you were aware that his position was and is that unless you or have the confirmatory blood results, you can't say within a reasonable degree of certainty that there is drug impairment simply on signs and symptoms, correct?

A That is incorrect. In my conversations with him and we had many of these, he, Dr. Levine, is unable to say conclusively because he is not trained in identifying psychophysical impairment.

So, he, as a toxicologist, needs a blood test or a urine test or some type of chemical test result to say whether certain indicators would be present or whether a person would be impaired.

But he's going to have trouble saying whether a person is impaired based on a chemical test result other than for drugs because there is no study anywhere in the country -- although there is a new one for marijuana, it hasn't been peer reviewed.

Q I am not suggesting that -- I am not using him for the fact that just because it is in the blood, it means you are impaired. I understand that.

A Okay.

Q We can all agree with that.

A Okay.

Q What I am focusing on is you reviewed that

transcript, did you not?

A I did.

Q And you saw that Dr. Levine was specifically asked whether or not given the signs and symptoms --

MR. DAGGETT: And this is where I am going to object because obviously we have a difference of opinion. You are talking about one simple, single line or -- in a transcript, asking a witness who wasn't there to interpret what that means.

THE COURT: I am going to sustain.

MR. DeLEONARDO: So, I can't impeach with what Dr. Levine said, Your Honor?

THE COURT: I think what we are doing -- what I said was go ahead and ask him about his conversations with Dr. Levine. But I am not -- I don't think it is appropriate to -- I agree with the State on this point as far as the use of the transcript and any testimony given.

But I just don't think -- unless everybody wants to come back here at some later date and I really am not anxious to do that.

MR. DeLEONARDO: Can I just clarify what he said the conversation was?

THE COURT: Yes.

MR. DeLEONARDO: All right.

BY MR. DeLEONARDO:

Q You said the conversation and I may agree with you on this, the conversation was that Dr. Levine said even with the signs and symptoms, he would have to have a confirmatory blood test before he could render an opinion, correct?

A The way I interpreted that is Dr. Levine said based on the chemical test results, he would also need to see the psychophysical signs of impairment.

That is a little different that what you said. He is saying that based on the chemical tests, he is not able to say whether the person is impaired. He would need the psychophysical test to do that.

What I'm saying is law enforcement officers have that psychophysical test. We are able to identify that psychophysical impairment.

Q Now let me stop you there. Because, you obviously read the transcript. He was explaining, was he not, that you have to have both. That he has to have both --

MR. DAGGETT: Objection. Again, Your Honor, that is exactly what you have ruled on twice. He asked --

THE COURT: Sustained.

MR. DeLEONARDO: No further questions.

THE COURT: Redirect.

MR. DAGGETT: No, sir.

THE COURT: All right, Lieutenant, thank you, you can step down.

THE WITNESS: Thank you, sir.

(Witness excused.)

MR. DAGGETT: We have nothing further, Your Honor, I believe all the -- I don't know if defense had anything further.

THE COURT: Anyone have any further witnesses to call?

MR. DeLEONARDO: As I said, Your Honor, the only outstanding issue is whether Dr. Levine was called. Your Honor is indicating you don't want to hear that. Again, I don't necessarily feel I got a chance to impeach witness from the standpoint that it is not just accurate as to what is in the transcript.

But I understand Your Honor is holding on to the transcript. So, I guess that would be appropriate --

THE COURT: Well, you know, again, I think Dr. Levine could have been subpoenaed. I don't see this as a major point after -- how many days have we been altogether? Anybody keep track?

THE CLERK: 10.

THE COURT: 10? 10 days.

MR. DAGGETT: I would have guessed 12 but --

MR. DeLEONARDO: And if Your Honor --

THE COURT: I wonder if any of those Frye-Reed hearings that were conducted -- I wonder if we now hold the

Guinness Record? No.

MR. DeLEONARDO: I would suspect so.

MR. WELLS: No, my understanding is that -- I think the one in Florida was 20 some days of testimony? It wasn't spread out over these six months.

THE COURT: Well how about we limit it to Maryland?

MR. DeLEONARDO: Oh, there is no --

MR. WELLS: Oh, yes.

MR. DAGGETT: No doubt.

MR. DeLEONARDO: Oh, yes. And actually at least what I will say is probably most of them I don't think we are anywhere close to that. Most of them are shorter in duration. Even around the country. Because a lot of them --- defense experts and all that.

Your Honor, if it is not a major point to you, then I will let it go.

THE COURT: All right, now. I am going to make everybody's day by telling you we are not going to have oral arguments. I am going to ruin it by telling you that I want it in writing -- what I like you to do is give me proposed findings of fact and conclusions of law. And I would like you to send it electronically to my law clerk.

Now, again, if you want to throw some conventional argument in there too, I don't really care but the format I would like is the findings of fact and conclusions of law.

I have in excess of 60 pages of notes. I think my notes are fairly complete. Obviously, I could have overlooked some things but I think this is important. Obviously I want to try and get any decision right. Of course, I never know until the people on Annapolis tell me one way or the other.

However, I think it is fair to say regardless of how the Court decides this, there is strong possibility that it will be appealed.

I think counsel are to be commended. I think everybody, obviously, was well prepared. I think that the subject matter here is something that does need to be decided.

I think there have been, obviously, judging by the number of hearings that have taken place on this subject, not only in Maryland but nationwide, a lot of people do have some interest.

This issue of whether something is generally accepted within the scientific community is one that is difficult because first of all you have to define what the scientific community is.

Heard a lot of testimony from various people on both sides. And of course everyone I think acknowledges on both sides that there is a strong public interest -- public safety interest with regard to the enforcement of laws pertaining to enforcement of our drunk driving laws, a very significant public interest, however, the question which has been raised

during the 10 days we have been in Court is the underlying scientific underpinnings of the drug recognition expert program, are those principles, are they generally accepted.

We all know, of course, that -- I don't know when the first polygraph test was performed and a lot of people believed that the polygraph is reliable but yet as of today and this goes back many, many years, polygraph results are still not admissible.

I don't think the opinion of a DRE rises to the level of a polygraph result in terms of the degree of prejudice to the rights of the Defendant and that may be one reason that the polygraph has kind of sat where it is in terms of admissibility.

But I do think that anytime you cloak someone with the title expert, even though, of course, juries and Courts are not bound to accept the opinion of any expert, but I think any time that you do that and you say someone is an expert, I think that that person's opinion is obviously going to be given some additional weight by particularly jurors.

So, I think something that needs to be decided. I guess I am surprised in a way that apparently it has not been decided previously by at least one of our Appellate Courts.

And I would think that if it hadn't been decided by the Court of Special Appeals, the Court of Appeals clearly, I believe would have granted ---. And we would have by now then

have a Court of Appeals decision. This may be the case.

So, at any rate, I am going to ask everyone to give us your argument in that format.

How much time, and I want to be reasonable here. I mean I would be fairly flexible depending on everyone's schedule and how much time you think you might need.

MR. DeLEONARDO: I was going to say, Your Honor, maybe this is outside the realm for other people, I would say 90 days. And it is not that I want to take a lot of time but I mean --

THE COURT: I am sorry, how much?

MR. DeLEONARDO: I would say 90 days.

MR. DAGGETT: I was going to say two weeks.

MR. DeLEONARDO: Well, if the State could submit theirs in two weeks, I would be happy to submit my -- and I say that obviously because while it may not look like it over these 10 days, I do have other things. And it is very time consuming. I am happy to try to do it but I know for example, I am out of town a fair amount.

THE COURT: Well, you have got your law clerk here besides you.

MR. DeLEONARDO: So, I just say I just, you know, I would ask --

MR. : I got a day job, too.

MR. DAGGETT: Not like we don't.

MR. DeLEONARDO: What is right now?

THE COURT: Everybody has got a busy schedule, believe me I --

MR. DeLEONARDO: My only concern is between the end of February and a lot of round the middle of March, I am out of town a fair amount. So, I was just concerned about limiting my time to that. So, I mean not that I am trying to take a lot of time but --

THE COURT: All right, well this is mid-February. How about if we say mid-April?

MR. DeLEONARDO: Yes, I was going to say maybe even if it is somewhere around between the mid and the end of April that would be find.

THE COURT: How about if we say April 15th -- well now wait a minute, you guys probably have lengthy tax returns to file.

(Laughter.)

THE COURT: So, we will say April 20th, how about that. Now, obviously, if we have them both in sooner than that, we will --

MR. DeLEONARDO: Yes, absolutely.

THE COURT: All right. We are finished, and again I appreciate -- I think everybody has done a good job of laying it out for the Court, and for the most part it has been spirited but civil and I always appreciate that.

MR. DeLEONARDO: Not bad for 10 days together, right? Thank you very much, Your Honor.

MR. DAGGETT: Thank you, Your Honor.

MR. WELLS: Thank you, Your Honor.

(Whereupon, the hearing was concluded.)

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 15, 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