

IN THE CIRCUIT COURT OF THE SIXTH JUDICIAL CIRCUIT OF
THE STATE FLORIDA, IN AND FOR PASCO COUNTY
CASE NO. CRC14-0216CFAES

STATE OF FLORIDA,

Plaintiff,

vs.

VOLUME II

CURTIS J. REEVES,

Defendant.

_____ /

PROCEEDINGS: Stand Your Ground Motion

DATE: February 20, 2017

BEFORE: The Honorable Susan Barthle
Circuit Court Judge

PLACE: Robert D. Sumner Judicial Center
38053 Live Oak Avenue
Dade City, Florida 33523

REPORTED BY: Charlene M. Eannel, RPR
Court Reporter
PAGES 130 - 251

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

2 THE COURT: Were there any other matters we
3 need to address before we get started?

4 MR. MICHAELS: None from Defense, Your Honor.

5 MR. MARTIN: None from the State.

6 THE COURT: Mr. Michaels.

7 MR. MICHAELS: Defense calls Dr. Michael Foley.

8 THE COURT: All right.

9 THE BAILIFF: Step this way, stand right here.
10 Face the clerk, raise your right hand to be sworn.
11 (Thereupon, the witness was duly sworn on oath.)

12 THE BAILIFF: Come have a seat up here. Adjust
13 the mic. Speak in a loud and clear voice for the
14 Court.

15 THE WITNESS: Good afternoon, Judge.

16 THE COURT: Good afternoon, Dr. Foley.

17 THE WITNESS: Good afternoon.

18 DIRECT EXAMINATION

19 BY MR. MICHAELS:

20 Q. Dr. Foley, what is your present occupation,
21 please?

22 A. I'm a diagnostic radiologist and a forensic
23 radiologist.

24 Q. What's a diagnostic radiologist?

25 A. So a diagnostic radiologist is an -- a medical

1 doctor whose job it is to read films of the human body.
2 So whether they're x-rays or CT scans, MRI scans, we read
3 those films and we make a diagnosis of what is going on
4 inside of the patient based on the images.

5 Q. And what is a diagnostic radiologist?

6 A. That one was just diagnostic radiologist.

7 Q. Forensic.

8 A. Forensic radiologist is looking at the images
9 with an eye towards whether the findings are new or old.
10 So in other words, if they're chronic and degenerative or
11 old or whether they're new and acute.

12 Q. And have you always been exclusively a forensic
13 radiologist?

14 A. No, sir. I've been in practice for 34 years.
15 I've worked at hospitals for 20 years, one of them right
16 in Dade City Hospital where I was chairman at that
17 hospital for several years. And then I worked at imaging
18 centers for multiple years, and then after those imaging
19 centers were sold, I now am doing forensic radiology.

20 Q. Okay. Let's talk a little bit about your
21 medical educational background.

22 What qualifies you to be both a diagnostic and
23 a clinical radiologist?

24 A. Right. So I guess I would start out with
25 internship and so forth. Following college, I went to

1 medical school at Northwestern University in Chicago from
2 '74 to '78 and graduated with an M.D. degree in 1978.

3 From there, I did a medical internship. And a
4 medical internship, as the Court is probably familiar
5 with, is where a physician rotates through the 12
6 different specialty areas in medicine.

7 Q. Where did you do your internship at?

8 A. I did my internship at the University of
9 California, San Diego, and so it's a one-year rotation
10 going through the 12 different areas, and it helps most
11 physicians figure out what area of specialty they want to
12 go into.

13 So after doing that I decided I wanted to go
14 into diagnostic radiology, and I returned to my alma
15 mater, Northwestern University, to do what's called a
16 diagnostic radiology residency. So the residency is one
17 specialty training in diagnostic radiology.

18 Q. Is there some kind of hierarchy among
19 residents?

20 A. Well, of course, the first year, second year,
21 third year and so forth. But in your last year, the
22 professors in the program pick a chief resident, so one
23 resident to be in charge of all of the other residents,
24 and that person would also have teaching responsibilities
25 to all of the other residents in the program.

1 Q. And were you ever so honored?

2 A. I was honored with that. I was elected by the
3 professor of the program to be chief resident at
4 Northwestern in my senior year.

5 Q. And --

6 MR. MARTIN: Excuse me, Mr. Michaels.

7 In the interest of time, Dr. Foley has a CV.
8 I've read it and it's extensive.

9 I have no objection whatsoever to the CV being
10 put into evidence. The Court can rely on it, and
11 Dr. Foley could render whatever opinions he wants
12 today.

13 MR. MICHAELS: Judge, I appreciate that. I
14 still would like Dr. Foley to be able to talk about
15 his qualifications, and I'd be more than happy to
16 put the CV into evidence when I'm ready.

17 THE COURT: Okay.

18 BY MR. MICHAELS:

19 Q. And are you Board certified?

20 A. Yes, sir.

21 So following completing the residency at this
22 point, one is considered Board eligible. It means you've
23 completed a qualified program. But to become Board
24 certified, you have to take the Board certification
25 tests, and they consist, basically, of an 8-hour oral

1 exam where you're tested in the 12 different areas of
2 radiology shown.

3 If you pass that test, then you're invited back
4 in about three months to take an oral Board exam, again
5 tested by approximately 12 different experts from
6 throughout the country who show you unknown exams. And
7 if you pass that test, then you are at that point Board
8 certified in diagnostic radiology.

9 So I took that test in 1982 following
10 completing my residency, passed both of those on my first
11 attempt and became Board certified in diagnostic
12 radiology in '82.

13 Q. After becoming Board certified, did you do any
14 additional training in radiology?

15 A. I did. I stayed on at Northwestern University
16 for an additional year to do what's called a fellowship,
17 and a fellowship is an additional year of focused
18 training.

19 Following completing that fellowship, it
20 qualified me to be able to take an additional Board exam,
21 this time in nuclear medicine or nuclear radiology, which
22 has to do with using radio isotopes to image the human
23 body such as a bone scan, looking for metastatic disease
24 or a kidney scan, liver scan, brain scan. And I took
25 both of those tests, written and oral, passed both of

1 those on my first attempt, and became Board certified in
2 nuclear radiology in 1983.

3 Q. Now, that's two boards. After that did you
4 continue your education and training?

5 A. Well, at that point, I did go out into
6 practice, but while I was out in practice in 1996, the
7 American Board of Radiology offered for the first time a
8 separate Board in interventional radiology. And
9 interventional radiology is the minimally-invasive aspect
10 of radiology.

11 So, in other words, doing things with needles,
12 guide wire, catheter and bringing those things into the
13 body and being able to carry out a therapy.

14 So, as an example, in angiogram and
15 angioplasty, putting a stent in an artery, whether it's a
16 carotid artery or kidney artery, running a micro-catheter
17 up into the brain to dissolve a clot before that person
18 gets a full-blown stroke, or to coil an aneurysm in the
19 brain so that the person doesn't need to get their skull
20 cut open and the aneurysm clipped.

21 So I had been trained in interventional
22 techniques at Northwestern University, but there was
23 never a separate Board for that. So once that became
24 available, I decided to go ahead and take that test, and
25 I passed that on my first attempt as well.

1 So at that point, I had achieved three separate
2 boards in radiology, diagnostic radiology, the nuclear
3 radiology and the interventional radiology.

4 Q. Is that rare in your field?

5 A. It is. Most people seek to get Board
6 certified, but usually you don't see very many people
7 with three separate boards.

8 Q. Let's talk a little bit about your work history
9 and the positions you've held.

10 I know you spoke about being here in Dade City.
11 Talk to me a little bit about your work history and the
12 different positions you've held.

13 A. Okay. So when I left Northwestern after my
14 fellowship in '83, I moved down to Tampa, Florida. I
15 joined a relatively large radiology group in the Tampa
16 area. I think I was the number 15th member in the group.
17 That ultimately, over 20 years, grew to be one of the
18 largest radiology groups in the State of Florida, with 55
19 men and women radiologists.

20 I was on staff at seven different hospitals
21 throughout the Tampa Bay area, on staff as a radiologist
22 at Manatee Memorial Hospital in Bradenton, at the Brandon
23 Regional Medical Center, at University Community
24 Hospital, which is now called Florida Hospital university
25 Community Hospital Carrollwood, St. Joseph Women's

1 Hospital, Dade City Hospital, and New Port Richey
2 Hospital.

3 Early in my career, I became assistant chairman
4 of radiology at the Manatee Memorial Hospital in
5 Bradenton. Then later, I was elected chairman of
6 radiology at Dade City Hospital right up here in the Dade
7 City area, served as chairman of that hospital for
8 multiple years.

9 Then following that, I was elected Chairman of
10 Radiology at Brandon Regional Medical Center, where I
11 served for about 10 years as chairman, and also sat on
12 the executive committee at that hospital for about 10
13 years.

14 Q. Now, have you served on any committees or had
15 any leadership roles in various medical organizations?

16 A. I have. I've sat on some national committees.
17 One of them is called the Society of Interventional
18 Radiology, and I was on that committee for several years.

19 I have worked as -- locally, I'm on the
20 Editorial Board of Hillsborough County Medical
21 Association Journal.

22 I've also served as president of the Florida
23 West Coast Radiologic Society, which is a membership of
24 radiologists up and down the West Coast of Florida,
25 wrapping around from the Panhandle all the way to Miami.

1 And this is an organization where we use the
2 dues that we collect from radiologists to fly in experts
3 from around the country to give us a lecture, and then we
4 can sit with them after the lecture and compare how
5 they're doing things at the Mayo Clinic or Mass General
6 or UC San Francisco compared to what we're doing at our
7 hospitals in the Tampa Bay area.

8 Q. What's the American College of Radiology?

9 A. So the American College of Radiology is an
10 organization that oversees all radiologists throughout
11 the United States, and most radiologists do belong to the
12 American College of Radiology.

13 Q. Now, I understand that you are a fellow of the
14 American College of Radiology. Is that true?

15 A. That is true.

16 Q. What is that?

17 A. So a fellow is one of the highest levels that
18 you can achieve in the American College of Radiology.
19 Basically, one would need to be nominated and elected as
20 a fellow, and it's based on your contributions to
21 radiology, leadership roles in radiology, or publications
22 and teaching in radiology.

23 So I was very honored to be elected to that
24 position. It allows one -- besides writing your name,
25 Michael J. Foley, M.D., you get to put FACR at the end of

1 your name as well, which stands for Fellow of the
2 American College of Radiology. And even though most
3 people don't know what that means, people in medicine do
4 know what that means.

5 Q. Now, have you published any articles or
6 participated in presenting any scientific courses or
7 seminars in your specialty?

8 A. I have. I think I've got 34 publications right
9 now, and many of the publications have to do with trauma
10 radiology, and some of the first articles that I wrote,
11 in fact, were due to spine trauma and brain trauma.

12 Another area of interest of mine has been MI or
13 breast cancer, and I've written a few articles on that as
14 well.

15 Q. Now, you've talked about being a member of a
16 big imaging center. Whatever happened to that particular
17 imaging center?

18 A. Well, I think I took you through the hospital
19 years, so I worked at those seven hospitals that I
20 mentioned for about 20 years and so that would take me
21 from '83 to 2003.

22 So in 2003, I left hospital radiology and
23 helped open a couple of imaging centers in the Tampa Bay
24 area. One of them is right up here on I-75 and Highway
25 54, so those are full-service imaging centers that do

1 everything from x-ray, CT, MRI, nuclear medicine studies
2 and so forth.

3 And ultimately after working at those centers
4 for multiple years, Tampa General Hospital came to me and
5 basically they wanted to buy both of those imaging
6 centers, and so I, along with one of the other
7 radiologists there, decided to go ahead and sell those
8 centers.

9 So at that point I could have retired from
10 radiology, but all along during my career, ever since
11 1987, I've also served as a forensic radiology expert,
12 and I still continue to have a string of expert cases
13 coming into me.

14 So rather than fully retiring, I decided to
15 continue with the expert radiology until such time that I
16 do decide to retire.

17 So with that in mind, that's why I'm here
18 today. I looked at some imaging studies that you sent to
19 me. And then part of that is if you're needed to come to
20 court and explain those findings to the Judge or the
21 jury, that you would be willing to do so.

22 Q. Okay.

23 MR. MICHAELS: At this time, I would move into
24 evidence Defense Exhibit 4, the CV of Dr. Foley, as
25 well as 5 and 6. 5 being the MRI of Mr. Reeves

1 taken June 2015. Exhibit 6 would be x-ray taken of
2 Curtis Reeves 2000 -- in June 2015, both stipulated
3 to by the State.

4 (Whereupon, State's Exhibits 4 through 6 for
5 identification were received in evidence by the
6 Court.)

7 MR. MICHAELS: May I approach the clerk?

8 THE COURT: You may.

9 BY MR. MICHAELS:

10 Q. Now, Dr. Foley, you've had an opportunity to
11 actually download the information that we've provided you
12 into your own computer; is that correct?

13 A. Yes, sir.

14 Q. Is that what we have here on this table to my
15 left?

16 A. Yes, sir. It is.

17 Q. If you would, please, with the Court's
18 permission, Dr. Foley, would you come down and let's take
19 a look at what we have here?

20 THE COURT: Okay. Very good.

21 MR. MARTIN: If Mr. Foley is going to testify
22 from the chair, his back is, of course, to the
23 State. Is there any way that we could hook up a
24 microphone or something so that we can hear him?
25 Because he will be talking down into his computer

1 away from us.

2 THE COURT: Just move that mic, I guess, down a
3 little bit.

4 BY MR. MICHAELS:

5 Q. Now, Dr. Foley, you've had an opportunity to
6 look at both x-ray images and MRIs; is that correct?

7 A. Yes, sir.

8 Q. And what is the difference between an x-ray and
9 an MRI?

10 A. So, an x-ray, basically, is one of the oldest
11 imaging studies around. X-rays have been known for over
12 a hundred years.

13 An x-ray, basically, is a form of invisible
14 light, and it was discovered that if one focuses an x-ray
15 and shoots it through a body part, say with a film
16 underneath, it can record images of the human body. So
17 basically, an x-ray shows us bones very well, allows us
18 to see if there is a fracture or a dislocation, allows us
19 to see if there are arthritic changes of the bones, and
20 it's a common imaging study even today.

21 An x-ray does not show certain things, though,
22 like you cannot see the spinal cord on a spine study.
23 You do not see the disc. You do not see the spinal cord
24 or the nerve roots.

25 So if we want to see those types of findings,

1 we need to go to a higher imaging study, which would be
2 an MRI, which stands for magnetic resonance imaging,
3 sometimes referred to as MR, magnetic resonance.

4 It basically is not an x-ray study. It doesn't
5 use ionizing radiation. It takes advantage of the fact
6 that our body is composed of about 75 percent water, H2O.
7 And it was discovered that the hydrogen atom in water,
8 when put into a magnetic field, gives off a magnetic
9 resonance, a signal that can be picked up by the MRI
10 scanner. And it can locate each and every one of those
11 signals of hydrogen atoms in the three-dimensional space
12 and locate them in an X, Y and Z plane.

13 And so from all of this information, very
14 accurate images can be constructed of the human body. So
15 for the first time, we can accurately see the disk, the
16 spinal cord, the nerve roots, brain tissue, all sorts of
17 things that we couldn't see before on regular x-rays. So
18 as you've said, in this particular series of studies we
19 have x-rays and MRIs to look at.

20 Q. Okay. And you've arranged them in kind of a
21 logical order; is that fair to say?

22 A. Yes, sir.

23 Q. Where are we going to start?

24 A. Well, we can could start right up at the top.
25 I've got them labeled 1 through 11, so we can look at,

1 first of all, the hands.

2 Q. Now, let me ask you something before you get
3 there.

4 If you can pull back a little bit, please, what
5 is this writing we see on the image up on the left and on
6 the right-hand side?

7 A. Yes. So let me focus in on this.

8 So this is just all the verification that the
9 pictures we're looking at are of the particular patient
10 we're talking about. So in this case, it says the
11 imaging center, Rose Radiology, where the study was
12 carried out. It says the patient's name, Curtis Reeves.
13 It gives the date of birth, 8/31/42. It states the
14 patient is 72 years old.

15 Then over here, this is telling us the date of
16 the study, so this study was performed on 6/8/15, so
17 June 8th, 2015.

18 So most of the images that we're going to look
19 at were done on either June 8th, 2015, or the MRI studies
20 that we're going to look at were done on June 9th, 2015.

21 Q. So what are we looking at here, Doctor?

22 A. So these are views of the hands, the right hand
23 and the left hand, and what we can see is arthritic
24 changes of both hands. But I'll focus in on some of the
25 findings so the jury and the Judge can appreciate this.

1 This is the thumb right here we're looking at,
2 and all of these are bones of the wrist called the carpal
3 bones. If we focus into this area right here, we're
4 looking at what's called the radiocarpal joint space, and
5 this is the first metacarpal bone.

6 One of the things to notice is how close each
7 bone is to one another. So, in other words, if we use
8 this as an example here, notice that we see a space
9 between this bone and this bone. That's because
10 cartilage, which cannot be seen on an x-ray, separates
11 the two pieces of bone. When the cartilage is worn down
12 or worn out, we get this bone-on-bone appearance that we
13 see here, so this would be an example of degenerative
14 change of the first carpal -- metacarpal joint where we
15 literally have bone on bone.

16 Also realize that bone reacts to when it
17 developed degenerative change by trying to thicken up the
18 bone, and the thickening of the bone causes the bone to
19 appear denser on x-ray, and dense bone will look white.

20 So if we look down here at the radius, so we're
21 right at the wrist -- this is the radius, this is the
22 ulna -- notice that the bone is very white here. That is
23 sclerotic bone or thickening of bone. Notice the bone
24 right here and right here is very white, so that is more
25 sclerotic bone.

1 Even note where we have the wearing out of
2 cartilage right here, we also have this white line of
3 sclerosis which is a sign of degenerative change.

4 As we look at the other bones throughout the
5 body or throughout the hand here -- and this is the right
6 hand -- we can see narrowing of the interphalangeal
7 joint.

8 So the interphalangeal joints are the various
9 joints of the fingers, and that narrowing is degenerative
10 change there as well.

11 The white sclerosis is degenerative change, so
12 this patient had degenerative change, particularly at the
13 so-called DIP, distal interphalangeal joint, which are
14 the distal-most aspect of the joint spaces of the hand.

15 So -- and the left hand has similar findings.
16 If we go over here to the left hand, notice we have
17 narrowing of the various joints of the wrist, narrowing
18 and degenerative change of the first carpal, metacarpal
19 joints, and then as we go to the interphalangeal joints,
20 we see arthritic changes with sclerosis and narrowing of
21 those joints.

22 So basically, both hand films show degenerative
23 changes, both left-sided and right-sided, involving the
24 carpal bones and also involving the interphalangeal
25 joints.

1 Q. And so when you say degenerative changes, what
2 are you talking about?

3 A. So degenerative change is sort of a broad
4 umbrella term to refer to wearing-out of the joint space.
5 So we know as we age, we have been moving our body parts
6 for years and years, and that can lead to those joint
7 spaces and those various body parts to wear out. And
8 that wearing-out process is called degenerative change.

9 So, you know, an analogy, compared to like a
10 tire of a car, if you just put a new set of tires on your
11 car and drove the car for 10 miles and then checked the
12 tread on the tire, it would be fine. Nothing much would
13 be happening after 10 miles, but if you check those tires
14 after 40,000 miles, the tread would be worn down to some
15 degree.

16 So that would be degenerative change in a way
17 or wearing out of the tire. The same kind of process is
18 going on inside the human body, where we're slowly
19 wearing out our various body parts over time.

20 Q. Would you agree or disagree with me that those
21 changes happen over a period of time and not overnight or
22 maybe within a year or so?

23 A. Well, that's true. I mean, degenerative
24 change, in general, takes years and years, so it's not
25 something that pops up in six months or a year or

1 something like that. It takes many, many years to get
2 the kind of findings that we're seeing here.

3 Q. Now, an individual with a similar x-ray, would
4 it be consistent with somebody who, let's say, had
5 trouble opening a jar?

6 A. Yes. Well, particularly since we notice that
7 the degenerative change in the joints of the thumb are
8 prominent in this patient. As we can see here, we see
9 another nice demonstration of sclerosis of the bone.

10 So typically, a patient with this kind of
11 degenerative change in this location will have a weakness
12 of hand grip, for instance. And one of the things that
13 people tend to notice when they have that is that the
14 jar -- they can't open a jar. You know, you have the jar
15 of pickles or mustard; you can't get it open because the
16 whole grip of the hand is not as strong as what it used
17 to be.

18 Q. When you talked about distal phalanges, you're
19 talking about fingertips?

20 A. So basically, right -- that joint right before
21 you get to the nail of the finger. This is where we're
22 seeing degenerative change as well.

23 Q. So --

24 A. So we're even seeing -- this is little
25 osteophytes that show up right here.

1 Q. What's an osteophyte?

2 A. An osteophyte is basically a bony growth.

3 Osteo means bone, and phyte means growth. So the bone,
4 by constant rubbing of bone on bone, develops thickening
5 of the bone that eventually turns into these bony
6 osteophytes that we see.

7 Q. Now, the x-rays we're looking at concerning the
8 fingertips -- I know it's not your term, the
9 fingertips -- would that be consistent with somebody who
10 now has trouble maybe doing detail work with their hands,
11 such as stitching, for instance?

12 A. Yes. When you get degenerative change in the
13 fingers, we often notice we don't -- we're not able to
14 move our fingers as well. So sometimes that is reflected
15 in their handwriting and, as you said, in any kind of
16 detail work that one might do.

17 Q. Okay. Can we look at -- I apologize, Doctor.
18 Could we just look at the image number just so we can put
19 it on the record, please?

20 A. So that image number that I had was number 1,
21 which was of the bilateral hands that was done on 6/8/15.

22 And so now we can move to the wrists, taking a
23 quick look at that. So, again, the wrists are this area
24 of the hand, so all of these carpal bones down here are
25 part of the wrist.

1 This is the radius right here and this is the
2 ulna. And again, basically, it's showing us the same
3 thing that we already saw in the hands, just a more
4 focused-down view. And it particularly nicely
5 demonstrates the bone-on-bone appearance of the
6 degenerative change of the first carpal-metacarpal joint.

7 So it's literally seeing bone on bone here with
8 the dense white sclerosis of the bone, particularly
9 involving the regions of the thumb of both hands.

10 And the next one we will go to is the left
11 shoulder. And the left shoulder is where, obviously, the
12 humerus, the long bone in our upper arm, connects to or
13 articulates with the scapula, which commonly in layman's
14 terms might be considered, like, the wing bone.

15 But in medical terms, this complex-appearing
16 bone as outlined here is part of the scapula.

17 The scapula has a curved, cup-like -- cup-like
18 shape called the glenoid, and the humeral head
19 articulates and connects into this glenoid area.

20 This part that we are seeing here is the
21 collarbone, and over here is the acromion in this area
22 right here. And if we look over here, this is called the
23 AC joint, or acromioclavicular joint.

24 What we are noticing is that the patient has
25 osteophytic changes in this region as well, so this

1 pointed piece of bone here and the pointed piece of bone
2 here is arthritic change of the AC joint. If we move
3 over here, we can again see some more osteophytes here
4 and here.

5 So the important point of seeing the
6 degenerative change at the AC joint is to realize that
7 the rotator cuff, the muscles and then the tendons come
8 through this region right here and connect to this area
9 of bone called the greater tuberosity.

10 So in this region, it is sometimes referred to
11 as the critical zone, and so as someone attempts to lift
12 their arm up, this muscle and tendon system works as a
13 pulley to lift the humerus up from this edge.

14 But the tendon tends to get scraped across
15 these osteophytic changes that are right here which can
16 cause pain in any individual patient and can scrape the
17 tendon to the point that the patient can eventually
18 develop what's called a rotator cuff tear, or the tendon
19 is actually frayed and kind of sawed through that area,
20 so that the tendon eventually becomes completely torn.

21 Q. Now, what we're looking at, again, the same
22 sort of question in terms of time period, is this
23 something that's degenerative in nature that happened
24 over a period of time and not something that is the
25 result of an acute injury, for instance?

1 A. That's true. Again, all these degenerative
2 changes that we're pointing out typically take years to
3 form. This is not something that you get in a relatively
4 short period of time.

5 So this is the left shoulder. If we move over
6 here, that was number 3 on this list. So number 4 would
7 be the right shoulder.

8 If we look at this, not surprisingly, we see
9 the same kind of findings. So here is the
10 acromioclavicular joint, this is the clavicle right here,
11 and this is the acromion process of the scapula. The
12 space in between is the so-called AC joint or
13 acromioclavicular joint.

14 Perhaps the Judge has heard of an AC joint
15 separation. Sometimes football players get this kind of
16 thing where the AC joint is separated. But notice again
17 here, just like on the left shoulder, we're now looking
18 at the right shoulder, we see this bony osteophyte right
19 here, and the critical nature of something like that is,
20 again, the tendon of the rotator cuff passes through here
21 and attaches over here.

22 So with this piece of bone now in the way, it
23 serves as a mechanism where it can scrape away and saw
24 away, if you will, at the tendons of the rotator cuff and
25 can cause pain, can cause rotator cuff tear, for

1 instance, in any individual patient.

2 Q. Is an individual who has an x-ray like this --
3 is it consistent with somebody who has difficulty raising
4 their arm?

5 A. Well, it is, because realize again the rotator
6 cuff muscles and then the tendon come through this area
7 and attach over here. I think we see it better on this
8 where it's the greater tuberosity.

9 So if the muscle has to pull the tendon through
10 this area, this tends to be painful. This often causes
11 limitation in movement of the shoulders, often causes the
12 person not to use their shoulders so much because of the
13 fact that it hurts when you do it.

14 So consequently, the muscles of the rotator
15 cuff begin to lose mass and become what's called
16 atrophied or they shrink, so the muscles become smaller
17 in size and become weaker.

18 So it's not unusual when we see patients like
19 this that they have limitation in range of motion. They
20 have shoulder pain. The muscles in this region are often
21 atrophied and have gotten weaker over time.

22 Q. And in older patients, would you expect some
23 atrophy whether or not we had such an acute -- is that
24 also called a bone spur?

25 A. Yes, sir. Bone spur is a typical layman's

1 term. For instance, for an osteophyte, which is a
2 medical term, which means osteo means bone, phyte means
3 growth.

4 Q. So my question was then, even, if we didn't
5 have that bone spur, would we expect in an elderly
6 patient to see diminished muscle mass?

7 A. Well, I think that's true in almost everybody.
8 As we get older, we do lose muscle mass over time, even
9 despite the fact that we try to go to the gym and work
10 out and everything so that it might help maintain some of
11 the muscle mass, but we invariably do get weaker over
12 time. We invariably lose muscle mass over time, despite
13 our best attempts for most of us.

14 Q. And might an individual who was -- whose x-ray
15 looked like this have difficulty in picking up heavy
16 items?

17 A. Well, that's true. I mean, any time you have
18 to use the shoulder, you're going to be affecting this
19 area. And it could be difficult in any particular
20 patient to lift heavy items up, to move the shoulder in
21 general because of the limitations by the AC joint and
22 arthritis.

23 Q. Is there anything else there you see that is of
24 interest, Doctor?

25 A. I think those are the main findings on that.

1 So we can move on to -- that was number 4, the
2 right shoulder. So we'll move onto number 5, which is
3 the left hip, and this study again is performed on June
4 8th, 2015.

5 What we're taking a look at here with the left
6 hip is we're seeing a piece of bony pelvis, and then this
7 white object that we're seeing is a left hip prosthesis.
8 So this is the ball of the femoral head, so the femoral
9 head has been replaced, and then this stem is going down
10 into the medullary cavity of the femur. And so at some
11 point, the patient ended up getting a left hip prosthesis
12 put in.

13 Q. And can you tell anything about the hip in
14 terms of any sort of degenerative properties?

15 A. Well, we could tell that the patient did have
16 degenerative changes, because if you look at this cup
17 shape here, which in the hip area is called the
18 acetabulum, one can see there's a thick rim of sclerotic
19 bone at this level, also sclerosis over here along the
20 superior margin.

21 But particularly along this medial or inside
22 margin, and this sclerosis that we see going all the way
23 around is consistent with degenerative changes.

24 Q. Now, is it typical for older individuals to
25 lose bone mass?

1 A. It is. So in medical terms, that's called
2 either osteopenia or osteoporosis.

3 Q. Did you see evidence of that in Mr. Reeves?

4 A. Well, you can see that in several areas. For
5 instance, if you're losing bone mass, the bone is going
6 to become less dense on an x-ray.

7 So if we just compare, in the pelvic bone area,
8 the density of this bone to the density of this more
9 translucent appearance right here, this is loss of bone
10 density.

11 If we go to the femur, notice how translucent
12 the bone is right here. So all of this kind of grayish
13 black lucency is bone loss, and in medical terms that
14 would be consistent with osteoporosis and osteopenia.

15 We commonly think of osteoporosis in older
16 females, but men get this as well, and we have a
17 demonstration of that right here.

18 Q. Does that explain why a 20-year-old and a
19 70-year-old could both fall from three feet off the
20 ground, hip level, and the 70-year-old breaks his hip and
21 the 20-year-old doesn't?

22 A. Well, exactly. I mean, that's actually not an
23 uncommon scenario where you might see two people slip on
24 some water in a store or something, and the 20-year-old
25 falls from a standing level and lands on their hip, and

1 they get up and they have a bruise on the side of their
2 hip; the older person doesn't get up because they broke
3 their hip.

4 And the reason that occurs is a combination of
5 factors including degenerative changes and including
6 osteoporosis that can make that area more easy and more
7 fragile and can break on an easier basis.

8 Q. Okay.

9 A. So that was the left hip. Now we will go to
10 number 6, which is the right hip.

11 Now, in the right hip we can see the patient
12 has not had a hip replacement yet, so we get to see in
13 the native hip the type of degenerative changes that can
14 occur.

15 And so here, just to go through the anatomy a
16 little bit, this is called the femoral head right here.
17 This is called the greater trochanter. This is where
18 tendons attach from the muscles in our thigh. Right here
19 is the hip joint, and notice that we again have this
20 finding of this dense sclerosis along the 11:00, 12:00,
21 1:00 region of the acetabulum. Again, the acetabulum is
22 the cup-like shape of the -- where the femoral head fits
23 into the pelvis.

24 So -- and it makes sense that we would see
25 something like that in this region because as a person is

1 standing, they're putting pressure -- a lot of pressure
2 on the upper aspect of the acetabulum. And so the bone
3 tries to add additional bone density, which creates a
4 sclerosis, but it's also a form of degenerative change.

5 Also, notice if one evaluates the vertical
6 height between the femoral head here to there versus the
7 vertical height of the femoral head from here to here,
8 notice that it's narrower here. And that, again, is a
9 sign of degenerative change of the hip.

10 Same kind as the other finding, though. Do you
11 remember we talked about the osteoporosis, how we have
12 some dense bone here but lucent bone over here? Lucent
13 bone over here, lucent bone over here. This is all
14 evidence of osteopenia, osteoporosis of the bone.

15 Q. Now, we got a chance to look at the right hip
16 without a hip replacement. Would it be fair to say that
17 before the hip replacement, the left hip had similar
18 signs of degenerative disease?

19 MR. MARTIN: Your Honor, I will object to that.
20 That calls for speculation. There is nothing so far
21 that we've had for any type of comparison. If we
22 had an x-ray two years ago, maybe that would be
23 appropriate.

24 But just to speculate that because we have a
25 hip replacement, one is like the other just calls

1 for pure speculation, even from Dr. Foley.

2 MR. MICHAELS: I'll ask the question a
3 different way, Judge.

4 THE COURT: Okay.

5 BY MR. MICHAELS:

6 Q. Assuming that an individual has an even gait,
7 can we expect that one hip would look like the other in
8 an x-ray?

9 A. Yes. In general, I mean, when one develops
10 degenerative change of the hips, it's often fairly
11 symmetric. The pressure point for most people walking is
12 going to be on the superior acetabulum. But like we saw
13 in the prosthetic hip, we saw sclerosis along the medial
14 side and we saw sclerosis along the superior side of the
15 acetabulum.

16 We saw that in the prosthetic hip because when
17 they put the prothesis in, they take out the bony femoral
18 head, but the sclerosis of the acetabulum remains. And
19 we can see just like the prosthetic left hip, the right
20 hip has that same pattern of sclerosis superiorly and in
21 the same pattern of sclerosis along the medial side.

22 Q. Anything else remarkable about the hip we're
23 looking at, Doctor?

24 A. I think that's about it for the time being.

25 We can go now to the left knee, and this --

1 again, we are still on 6/8/15?

2 Q. I forgot to ask. I apologize, Doctor.

3 The x-ray of the hip and the degenerative
4 properties that you've described, is that something that
5 we would expect to happen over time, as in the other
6 x-rays?

7 A. Yes. Again, typically a degenerative change
8 that takes years and years to develop, so this is not
9 something that just pops up in a year or two. It
10 generally takes many, many years.

11 I kind of -- having gray hair, I kind of relate
12 it to a person: How long does it take to get gray hair?
13 You know, many times you're not going to be able to say,
14 "My hair went totally gray in a year or two." It
15 generally occurs over a long period of time.

16 So maybe in your late 20s or 30s you have a few
17 speckles of gray hair, and then your 30s and 40s, you've
18 got more gray hair, and now it's going from gray to white
19 such that by the time you get into your 60s, you have all
20 white hair.

21 So you can look at somebody like that and feel
22 fairly assured that they didn't go from brown or black
23 hair to gray hair in a matter of a year or two. It
24 typically would take many, many years, whether it's five
25 years or 10 years or 20 years; who knows for sure in that

1 individual? But it would take more than just a year or
2 two.

3 So the same kind of thing with degenerative
4 changes inside the body. It doesn't happen in one or two
5 years. It take many, many years to get that.

6 Q. On to the knee.

7 A. So we will go to the left knee now, and this is
8 6/8/15, so I'll show the Judge this one first.

9 This is so-called standing views of the knees.
10 The person is standing up and the x-ray plate is behind
11 their knee, and the x-ray is shot straight through. So
12 this is the left knee over here. This is the right knee
13 over here.

14 Just to go over some anatomy, this is the
15 femur, which is the long bone of our thigh coming down to
16 form part of the knee joint. This rounded piece of bone
17 is the kneecap or, medically, is called the patella right
18 here. And right over here, the two bones that are seen
19 that go from the knee joint downward, the larger bone is
20 called the tibia.

21 Commonly, people call this the shinbone.
22 Sometimes we accidentally run our tibia into the coffee
23 table or something like that, and this is that major,
24 larger bone.

25 The smaller bone out to the side of our calf,

1 both left side and right side, on the outer side is the
2 fibula, and so these are the two bones of the lower knee
3 joint. So the knee joint is actually this part right
4 here where the femur bone comes together with a joint
5 space, and then the tibia here and the fibula here.

6 Now, what we are seeing, basically, in this is
7 that we're seeing the medial knee joint, medial meaning
8 the inside of the knee joint is narrowed. It should be
9 wider than this, and if we compare it to the lateral knee
10 joint, it should have a nice vertical height like this.
11 But right here, it's narrowed, both on the right side and
12 on the left side.

13 In addition, we see sclerosis, this white
14 thickening of bone along the tibial plateau. This whole
15 area is called the tibia plateau here, and we've already
16 learned that the buildup or thickening of bone is called
17 sclerosis, a sign of degenerative change. And losing the
18 vertical height of the joint is also a sign of
19 degenerative change.

20 So the patient has a pattern that's typical for
21 developing degenerative change in the knee, and that is
22 it's affecting the medial side of the knee joint.

23 And the Court may not know that in most people,
24 it is the medial side of the knee joint that wears out
25 first in almost all people. And that's because just the

1 angle of the way the femur comes down when we stand, we
2 put most of our weight on the medial aspect of the knees
3 and, thus, we tend to wear out the medial aspect of our
4 knees faster than the outer or lateral aspect.

5 So it's quite common not only to get the
6 degenerative bony changes like we see here, but also to
7 get tears of the meniscus, the cartilage that fits in
8 between these two bones.

9 So the Court may have heard of medial meniscal
10 tears being discussed in other patients, other cases, and
11 this is the reason why this is the area that gets the
12 biggest workout.

13 If we look at the side view or lateral view --
14 and again, we are looking at left knee here -- notice
15 that we see this patella from the side, the kneecap, and
16 notice that we see the patella lying very close to the
17 femur, to the femoral condyle, almost bone on bone.

18 Now, realize the bone of the femur is capped by
19 cartilage and the back of the patella is capped by
20 cartilage. So when one has degenerative change, the
21 cartilage wears out and this bone-on-bone appearance
22 begins to occur.

23 And notice, if you want to see an osteophyte
24 here, this pointed piece of bone right here is an
25 osteophyte, a bony overgrowth. So when this person is

1 moving or walking, this patella would be rubbing bone on
2 bone in this region, and this osteophyte would be
3 scraping on the cartilage and on bone, a kind of finding
4 that we all can get when we get to be in our 70s just
5 from the use of our legs and our knees over time. So
6 that was the left knee.

7 If we go to number 8, which is the right knee,
8 again, we already went over this front picture, the
9 standing view where we see the medial right knee joint
10 narrowed. But let's look at the side view for a second
11 and, again, in this view notice that the patella is
12 riding high. That means we would like to see this
13 patella down more along this region.

14 In other words, the top of this patella should
15 be sitting down here more, and it's not. So one might
16 question whether the person has had some previous injury
17 to the tendons attaching to the patella. That would be
18 the quadricep tendon up here attaching to the patella and
19 the patella tendon down here. Nevertheless, we can see
20 this bone-on-bone in appearance, just like we saw on the
21 left knee on the right side, a sign of degenerative
22 change of the meniscus.

23 So basically, we have degenerative change in
24 both knees involving the medial knee joint and involving
25 both -- what are called the patellofemoral joint,

1 meaning, the patella and the femur are narrowed in that
2 area, thus, called the patellofemoral joint.

3 Q. Now, would you agree with me that we can't see
4 pain on an x-ray?

5 A. That is correct. We can see the anatomy on
6 x-rays and MRIs. We cannot tell what severity of pain
7 the patient may be in at the time just based on the x-ray
8 or the MRI.

9 Q. But based on what we are looking at, would it
10 be inconsistent with an individual that complains of knee
11 pain, for instance?

12 A. No, not at all. I mean, it's quite common when
13 people have degenerative change in their knees like this
14 that they would have pain.

15 Q. Again, you're calling them degenerative
16 changes. We are talking about these changes happen over
17 a period of time?

18 A. Yes, sir. Typically many years.

19 Q. Okay.

20 A. We then go -- so at this point, we're going to
21 go from the 6/8/15 studies. We've covered all the
22 regular x-ray studies.

23 And now number 9, 10 and 11, we would be
24 covering the MRI cervical, MRI thoracic, MRI lumbar done
25 the next day on 6/9/15.

1 Should we keep going and go to the cervical,
2 then?

3 Q. Let's do that.

4 A. Okay.

5 Q. Before we go to the cervical, I notice there
6 are -- it looks like six images. How does a radiologist
7 actually look at MRIs? Do they just view it just as
8 still images?

9 A. Okay. Well, I'll show you.

10 Just as an example, I'm popping up this still
11 image, and we'll go through it more thorough to explain
12 what this side view or sagittal view is, and what this
13 axial view is.

14 But if you'd like, I can just bring up the
15 whole study so that the Court can see how one would
16 analyze a study.

17 Q. If you would, Doctor.

18 A. Okay. So if we open up this study, basically
19 we can see all of the different images that were
20 performed on this exam. We can see that nine survey
21 images were done, then 15 sagittal images, so-called
22 T2-weighted, which makes the spinal fluid white, 13
23 sagittal or side-view, S-T-I-R or stir images, which
24 allows us to see fluid signal particularly well.
25 Thirteen TI-weighted images where the spinal fluid is

1 black, and then 28 axial images.

2 So to show the Court how one might evaluate
3 this, if we press on the sagittal images and make this
4 larger so we can see it -- notice when we first start
5 looking at the side view -- and just for orientation,
6 this would be the person's chin here and this would be
7 the back of the neck over here -- we're not really seeing
8 any cervical spine yet, and that's because this initial
9 image is taken off to the side. And then as we move
10 forward, we're beginning to now cut into the cervical
11 spine.

12 Now we're into the mid cervical spine, where we
13 can see spinal cord, and as we cut through, we're cutting
14 out of the cervical spine getting to the opposite side of
15 the neck.

16 So just toggling through this, there's certain
17 things that we can see. What we're noticing here -- and
18 if I zoom this up a little bit, this tall vertebral body
19 in the cervical spine is called C2 or cervical 2. And
20 then from there, once we identify that, we can count down
21 to C3, cervical 4, cervical 5, C6, C7.

22 One of the first things that we can notice is
23 if we look at the back of the disk, we can see some discs
24 are flat. Like this disc is C2, 3, and some disks are
25 sticking out like we see at the C5, 6, C6, 7 levels.

1 So let's go now and look at an axial view. An
2 axial is a cross-sectional view. So if we look at that,
3 we are now seeing -- and I will bring this down a little
4 bit. We are now seeing both the axial view and the
5 sagittal view. The sagittal is the side view, the axial
6 is the cross-sectional view.

7 And if the Court notices, there's a line coming
8 through the spine right here. And as I rotate this, this
9 line moves, so this line is telling us what level we're
10 cutting through, which disc.

11 So if we bring this line down to where the disk
12 is the biggest, right here -- and let's bring that over
13 here and let's adjust it a little bit like that. So what
14 we can see here is that the disk is sticking out, coming
15 very close to the cord, and the disk is sticking out
16 here.

17 Now, I have a magnified picture of that so we
18 can see it even better, which would be this view that the
19 Court can take a look at. And in this view, we can see
20 that the disk is extending out and herniating out into
21 the spinal canal.

22 Now, just for orientation, this is the cervical
23 spinal cord, this structure running up and down. The
24 white is spinal fluid wrapping around the cervical spinal
25 cord, and the disc sticking out shouldn't be like that.

1 It should be flat like the disc above.

2 If we want to talk about this disk, we'd call
3 out the vertebral body above and below. So if I want to
4 talk about this disc, I would say at the C5, 6 level,
5 meaning the disc between C5 and C6, there is a disc
6 sticking out and it's approaching the front surface of
7 the spinal cord there.

8 If we want to look at that in the axial view,
9 we come over here and in this cross-sectional view, all
10 of this is herniated disc material sticking out into the
11 spinal canal and lying adjacent to the cord.

12 Realize this entire area here should be white.
13 It should be white spinal fluid. Here is the spinal cord
14 right here, so this disc is sticking out and coming very
15 close to the cervical spinal cord.

16 If we go to the next level down and analyze
17 this from the side view, the sagittal view, notice the
18 disc is sticking out here. It's extending upward and
19 extending downward, so this means that the disc has
20 literally herniated out of the wall of the disc with
21 jelly material extending upward and downward, so that is
22 called a disc extrusion.

23 If one looks at the front margin of the cord,
24 notice how the cord has, like, an indent here? That
25 means that -- and tells us that as this person flexes

1 their neck forward, the cord bends over these regions and
2 the herniated disc has literally caused an indent into
3 the cord in this region.

4 If we look at it from the axial view
5 perspective, notice how close the herniated disc is to
6 the front of the cervical spinal cord. There's virtually
7 no white spinal fluid here separating the back of the
8 disc to the front of the spinal cord.

9 So those are the two most important features on
10 this study; however, there's a lot of degenerative
11 findings. For instance, the Court may not know that the
12 disc should have a white-looking center like we see here,
13 but notice all of these disks are black, black, black,
14 black.

15 All of the discs that are black like this mean
16 that they've lost the water content in the disks, so all
17 of these discs should have a grayish-white center to
18 them. That loss of water content is a sign of
19 degenerative change of the disc or fluid has leaked out
20 of the disc over time, and --

21 Q. Why is that important, Doctor?

22 A. Well, it's just a sign that this person has
23 multi-level degenerative disc disease, changes up and
24 down the cervical spine, only sparing the C4, 5 disc.
25 But all the rest of the discs are all degenerated.

1 If we want to see a nice example of an
2 osteophyte, here is a bone spur sticking out here, bone
3 spur sticking out at this level, bone spur over here at
4 C6, 7 sticking out, and in the back we have these
5 herniated disks sticking into the spinal canal.

6 So these findings are very significant because,
7 in general, it's thought that the cord does not like
8 being touched by anything except spinal fluid. So when
9 you have these findings sticking out into the spinal
10 canal, touching this spinal cord and lying near the
11 spinal cord, this can cause symptomatology for a patient.
12 This can cause weakness of the upper extremities for a
13 patient.

14 Q. When you say symptomatology, what do you mean?

15 A. Well, symptomatology meaning pain, tingling,
16 numbness, things of that nature would be the kind of
17 symptoms one can get.

18 Q. What do we have next?

19 A. Okay. So we're going from the cervical spine,
20 which was number 9, MRI cervical spine. We'll go to the
21 thoracic spine.

22 So the thoracic spine, as the Court probably
23 knows, the neck is called the cervical spine. We've got
24 seven cervical vertebral bodies.

25 The mid back is the thoracic spine. There are

1 12 thoracic vertebral bodies. These are where our ribs
2 are attached to our thoracic vertebral body, so we know
3 we have 12 ribs on each side, and we also have 12
4 thoracic vertebral bodies where the ribs can attach.

5 The key finding here -- so there's a lot of
6 disc levels in the thoracic spine because there's one
7 disc between each of the 12 thoracic vertebral bodies,
8 but notice at first glance, all of the disks in the
9 thoracic spine are black. They're darkened. That's
10 called disc desiccation, so every one of these disks are
11 degenerated up and down the thoracic spine.

12 Notice that we have prominent osteophytes at
13 some levels in the thoracic spine, but here is probably
14 the -- one of the more important findings is we have a
15 disc sticking out in the mid thoracic spine right here at
16 T7, 8, and it's immediately abutting the thoracic spinal
17 cord. We can see it right here, and if we go over to
18 this view, we can see it right here, so this disc is
19 sticking out and immediately abutting the thoracic spinal
20 cord.

21 Again, the importance of that is just like in
22 the cervical spine, this can cause symptomatology such as
23 pain, weakness, tingling, numbness. It can also be a
24 source of overall weakness to the person's back because
25 of pressing on the spinal cord at that level.

1 Q. We are looking at a still picture, a static
2 image. Is that how it works in the body, the spinal cord
3 just stays in one place?

4 A. Right. Well, that's an interesting question.
5 Just like in the cervical spine or thoracic spine --
6 obviously we need still images to get clearer pictures of
7 the spine and vertebral body and the cord, spinal cord.

8 But in real life, obviously, the neck flexes
9 back and forth. The thoracic spine flexes and extends
10 back and forth, so what happens is that this spinal cord
11 actually moves and slides up and down within the spinal
12 canal, and so the spinal cord itself can get scraped and
13 roughed up by these disks that stick out.

14 We saw those two significant disks in the
15 cervical spine, and this one disc in the thoracic spine,
16 so the point I think you're raising is that the spine
17 actually moves, and so the spinal cord itself inside is
18 going to be moving and scraping up and down against
19 this -- these disks and spur formation that sticks out.

20 That in and of itself can cause problems to the
21 thoracic spinal cord and cervical spinal cord leading to
22 effects on the nerves that are contained in the spinal
23 cord.

24 So that's the thoracic spine. And then lastly,
25 we have the lumbar spine, number 11, and this was fairly

1 remarkable because of this finding. So here's the lumbar
2 spine. So we've covered cervical where we have seven
3 cervical vertebral bodies. We've covered the thoracic
4 spine, the mid back, where we have 12 thoracic vertebral
5 bodies.

6 Now we're into the lower back. For orientation
7 purposes, these are the vertebral bodies. This is the
8 lowest one in the lumbar area. This is called L5. Then
9 L4, L3, L2, L1. And then this is thoracic 12 here.

10 So what I put an arrow on is this finding right
11 here. There is a cystic-appearing fluid collection in
12 the lowermost tip of the spinal cord.

13 So if we back up, section -- probably most
14 folks that aren't medical people do not know that the
15 spinal cord itself ends typically at about the T12 or L1
16 level. It doesn't run all the way down to the lower part
17 of the spinal canal.

18 So if we look in this patient, here is L5, L4,
19 L3, L2, L1, it's ending in the typical location of many
20 patients where it's ending at around the L1 level. Some
21 can end as low as T12, others go down to L1.

22 But what we have is we have a fluid collection
23 in the spinal cord. This is not normal. It's not
24 typical. This is called a syrinx, and a syrinx is an
25 abnormal fluid collection within the spinal cord itself.

1 This can cause weakness because it affects the nerves
2 running down the spinal cord, and we see this nicely
3 demonstrated on the lumbar view at the T12, L1 level.

4 And this is the corresponding axial view, and
5 if you look at this for a second, here is the spinal
6 cord, and this round hole essentially that we see in the
7 spinal cord is the syrinx.

8 So there literally is a cystic cavity in the
9 spinal cord itself which, in general, can cause weakness
10 for a patient, sometimes in coordination of the legs, may
11 even cause imbalance for a patient.

12 Also look at the disc. We've learned to look
13 for disc desiccation now. Look at the disc here. It's
14 black, black, black, black. These lower two have a small
15 amount of remaining fluid collection in the disc, so this
16 is some residual hydration in the disc.

17 But we have multi-level degenerative discs.
18 These discs, even these down here, are not as white as
19 what they should be. They should be comparable to the
20 white spinal fluid and they're not, so all of the discs
21 have become dessicated to some degree.

22 If we look at one last finding here, we're
23 seeing what's called an annular tear. And the Court has
24 probably heard about annular tears before where the outer
25 wall of the disc, called an annulus, is torn, and this

1 could be a source of degenerative change and may cause
2 symptoms for some patients.

3 So really, we took sort of a whirlwind tour up
4 and down the cervical, thoracic and lumbar spine and saw
5 two large herniated discs in the cervical spine. We saw
6 a disc sticking out and touching the cord in the thoracic
7 spine, in the lumbar spine. We saw a cystic cavity in
8 the lower spinal cord called a syrinx.

9 We see multi-level degenerative changes up and
10 down the lumbar spine, and finally we see this annular
11 tear in the lower lumbar spine.

12 Q. This syrinx, is this a common occurrence?

13 A. It's actually rather rare. They can be
14 produced by trauma and they can be congenital but, you
15 know, if you lined up a hundred people, you wouldn't
16 hardly see it in one or two people of that entire
17 hundred-person population. So it's not a very common
18 finding.

19 Q. From the appearance of the syrinx, is that
20 something that would take time to develop?

21 A. Well, it would -- even if it's trauma-related,
22 it takes time to develop, but something like this would
23 likely be around for many, many years.

24 MR. MICHAELS: Thank you. I don't have any
25 other questions.

1 THE COURT: Okay. Thank you.

2 MR. MICHAELS: Do you want to take your seat,
3 please? Just one last question.

4 THE WITNESS: Okay.

5 BY MR. MICHAELS:

6 Q. Now, the opinions that you've expressed today,
7 are they all within a reasonable degree of medical
8 certainty?

9 A. Yes, sir. They are.

10 MR. MICHAELS: I don't have any further
11 questions.

12 THE COURT: Okay. Thank you.

13 CROSS-EXAMINATION

14 BY MR. MARTIN:

15 Q. I want to go back a few minutes to the
16 beginning of your testimony.

17 You've been hired by Defense in this case?

18 A. Yes.

19 Q. Did you sign an employee contract with them?

20 A. No.

21 Q. All right. And your hourly rate to be paid in
22 return for your services?

23 A. It's \$750 an hour.

24 Q. And up until today, how many hours have you put
25 into this case at \$750 an hour?

1 A. Well, the total bills, I think we talked about
2 before. It adds up to \$5,000. 2,900 of that was review
3 of the films which are just flat fee charges, and then I
4 had two one-hour conferences and spent about 30 minutes
5 loading the films on the computer and selecting out the
6 images.

7 Q. All right. Then you have your time here today?

8 A. Yes, sir.

9 Q. Okay. Which you haven't billed for yet?

10 A. I have not.

11 Q. All right.

12 Before we get into the individual x-rays and
13 MRIs, you would agree that not everyone has the same pain
14 threshold. That's a fair statement, isn't it?

15 A. True.

16 Q. Prior to coming into the courtroom today, did
17 you have an occasion to sit down with Mr. Reeves and
18 conduct a medical history?

19 A. No. I want to make that very clear to the
20 Court and the Judge, that as a radiologist, I read the
21 films of people, so normally I'm not sitting down meeting
22 the patient, talking to the patient, examining the
23 patient.

24 Basically, my examination of the patient, as
25 with most radiologists, is looking at the films, so we're

1 not sitting their tapping on knees or taking a history.
2 We're reading the films of the patient.

3 Q. In this particular case, what was the years of
4 the last film that you looked at prior to June of 2015 as
5 far as x-rays of Mr. Reeves' hips, knees, shoulders and
6 fingers?

7 A. Those were all June 8th and June 9th, 2015.

8 Q. Prior to that, what was the date and the year
9 of the x-rays that you used to compare with the x-rays of
10 June 2015?

11 A. These were the only films that I had, so I read
12 what I was given.

13 Q. All right. You have no way to go back, say, on
14 January 13th, 2014, and tell this Court whether or not
15 what we saw displayed in here today was the same,
16 substantially the same, or even different than what was
17 taken on June 15th -- I mean, June 8th, 2015?

18 A. Well, I think that's true to a degree. We know
19 the findings are longstanding, that it takes many, many
20 years to get those findings. But if no one takes an
21 x-ray on a certain day, you can't, with 100 percent
22 certainty, say what the film looks like on that
23 particular day.

24 Q. So what we were presented here today is simply
25 a snapshot in the life of the medical history of Mr.

1 Reeves on June 8th and June 9th, 2015?

2 A. That's true.

3 Q. You cannot, to any reasonable degree of medical
4 certainty, go back and tell this Court that after the
5 time of this particular incident on January 13th, 2014,
6 that Mr. Reeves' condition was exactly the same as it was
7 presented by the x-rays today? You can't do that to any
8 degree of medical certainty?

9 A. No, I would not try to do that because I'd want
10 to have a film done exactly that day. But I'm not trying
11 to say that the films looked exactly the same, either.
12 I'm saying those films showed degenerative changes that
13 likely took a long time, many, many years.

14 So more likely than not, I could say that these
15 kind of findings preexisted the date of the incident.

16 Q. But you cannot say to what extent they existed?

17 A. I agree with that.

18 Q. All right. And along those same lines, if we
19 go back to January 13th, 2014, it is just as consistent
20 that the degree of the degenerative are -- what was the
21 word after that?

22 A. Degenerative changes?

23 Q. Yeah, the degenerative changes that you said
24 had taken place over the years, you don't know to what
25 extent on January 13th, 2014, Mr. Reeves was aware of

1 those, do you, to any type of outward manifestations of
2 pain?

3 A. Right. As I mentioned to the Judge, I'm not
4 trying to testify about what symptoms this patient
5 specifically would have, because in order to find out the
6 symptoms, one would have to talk to the patient,
7 interview the patient and so forth.

8 What my testimony was based on was the degree
9 of degenerative changes. It's common for patients to
10 have pain, but as you said, you could have two people
11 that have the same degree of degenerative change and one
12 might say they have pain 3 out of 10, and the other
13 person might say they have pain 8 out of 10, so there
14 could be some variability among patients. I'm just
15 saying that more likely than not, these findings
16 preexisted the date of the incident.

17 Q. Along those same lines on January 13th, 2014,
18 you cannot tell the Judge as an expert to any reasonable
19 degree of medical certainty exactly what Mr. Reeves knew
20 about his physical condition, correct?

21 A. Right. I would have no idea. You would have
22 to interview the patient to know that.

23 Q. And you did not do that?

24 A. No. My job is to read what I see on the films.

25 Q. Which were taken in June of 2015?

1 A. Yes, sir. That is true.

2 Q. Okay. What I would like to do is just very
3 generally go through the different areas, all right?
4 Maybe. I'm going to think about that a second.

5 A. Okay.

6 MR. MARTIN: May I have a moment with counsel,
7 Judge?

8 THE COURT: You may.

9 MR. MARTIN: Thank you, Judge. No further
10 questions.

11 THE COURT: Any redirect?

12 MR. MICHAELS: Judge, if I may.

13 REDIRECT EXAMINATION

14 BY MR. MICHAELS:

15 Q. I apologize, Doctor. I forgot to ask you, was
16 there any other area of concern regarding the coaxial
17 nerve in Mr. Reeves' MRI that you're aware of?

18 A. Not quite sure what you mean by coaxial nerve.

19 Q. Well, there's an opening where some nerves
20 passed through?

21 A. Yes.

22 Q. And there was --

23 A. The area you're referring to may be the spinal
24 canal stenosis. Is that what you're talking about?

25 Q. Yes.

1 A. Okay. Yes, sir.

2 Q. And did you identify any spinal canal stenosis
3 in Mr. Reeves' images?

4 A. Yes, sir. Several areas -- and the Court might
5 remember this -- where we see the large herniated disc at
6 C5, 6 and C6, 7. When the disc is sticking out into the
7 spinal canal, the cord is actually being pushed back in
8 the spinal canal, and so that tightness that is wrapping
9 around the spinal canal because the disc is pushing
10 into -- it's narrowing the space that the spinal cord can
11 come down. And that tightness is called cervical spinal
12 canal stenosis.

13 So stenosis means a focal narrowing, and there
14 is focal narrowing of the spinal canal at C5, 6 at C6, 7
15 and then again at the mid thoracic spine, level T7, 8.

16 Q. That would cause weakness, tingling, those
17 sorts of things?

18 A. Yes, sir. That is true.

19 MR. MARTIN: Judge, since he brought up a new
20 subject, may I just cross on that very limited area?

21 THE COURT: Yes, you may.

22 RE CROSS-EXAMINATION

23 BY MR. MARTIN:

24 Q. Dr. Foley, as I mentioned before, because you
25 did not have any x-rays to compare, you cannot say as an

1 expert to any reasonable degree of medical certainty that
2 on January 13th, 2014, that Mr. Reeves suffered from that
3 condition to the extent that you saw on the x-ray that
4 was taken in June of 2015? You have no idea of what his
5 condition was in 2014?

6 A. I understand what you're saying, and I will
7 agree with you to the degree that if -- without having a
8 film done on that exact day you can't say what it looked
9 like that exact day. But I can say within a reasonable
10 degree of medical probability that more likely than not,
11 those findings preexisted the date of the incident.

12 So I can say the person did, more likely than
13 not, have cervical spinal canal stenosis from the disc
14 abnormalities that were present, but again, in -- partly
15 agreeing with you. Because you don't have an exact film
16 on the exact day, I can't say exactly what it looked like
17 on that day.

18 Q. So to any reasonable degree of medical
19 certainty, you can't quantify to what extent that
20 condition existed?

21 A. Well, yes and no on that, because I testified
22 that it takes many, many years to get the kind of finding
23 that we're seeing here. So if the time separation was
24 about a year-and-a-half, something like that, between the
25 date of the incident and the date of the films -- and my

1 testimony is that it takes many, many years to get these
2 kind of findings.

3 So I would say more likely than not, the
4 patient had similar findings to what we're seeing a
5 year-and-a-half later after the incident, and those
6 findings existed prior to the date of incident.

7 Q. And as we discussed before, every individual's
8 pain threshold is different?

9 A. I agree with that.

10 Q. So an individual who -- and I'm just going to
11 use A and B because without -- let's not make it too
12 complicated. If you have a condition A and it gets worse
13 to B, one person could have pain at A, but really another
14 person can have no pain until they get to condition B,
15 correct?

16 A. That's a possibility.

17 Q. All right. And because you conducted no
18 medical history on Mr. Reeves and you have no comparison
19 x-rays of Mr. Reeves on January 13th, 2014, you cannot
20 tell us to any reasonable degree of medical certainty as
21 to exactly how that impacted Mr. Reeves' daily activity
22 and living on January 13th, 2014, correct?

23 A. As I said before, I've agreed with you on that
24 point, because my job as radiologist is to say what I see
25 on the films. I did not do any discussion for the Court

1 on what kind of symptoms this particular patient had at a
2 specific date in time.

3 MR. MARTIN: Thank you for your time.

4 THE WITNESS: Thank you, sir.

5 THE COURT: Redirect?

6 MR. MICHAELS: May I, Judge? Very, very
7 shortly.

8 REDIRECT EXAMINATION

9 BY MR. MICHAELS:

10 Q. But one thing you can be certain of is we're
11 looking at an individual that's aging?

12 A. Yes, sir. That's true.

13 MR. MICHAELS: Nothing further. Thank you,
14 Your Honor.

15 THE COURT: Are you okay with that?

16 MR. MARTIN: You just told me I was.

17 THE COURT: I know. Typically we are. May
18 this witness be released?

19 MR. ESCOBAR: Yes, he can be completely
20 released, Your Honor.

21 THE COURT: You're free to go.

22 THE WITNESS: Thank you. It might just take a
23 minute to take down my computer.

24 THE COURT: Oh, yes. Okay.

25 (Witness excused.)

1 MR. ESCOBAR: Could we take a break, Your
2 Honor?

3 THE COURT: Now would be a good time for a
4 ten-minute recess. Let's do that at 3:12.

5 (Recess taken.)

6 MR. ESCOBAR: While Mr. Garcia is out, I just
7 want you to know we have two more witnesses that are
8 here. We've got Dr. Cohen, and then we're going to
9 have Mr. Sassani, who's going to be authenticating
10 the previews that played on the day of the incident.
11 So we'll play the previews here, and then we'll be
12 done with our witness list for today.

13 THE COURT: Okay. Who is the next one going to
14 be so we can --

15 MR. MICHAELS: Dr. Cohen.

16 THE COURT: Before we -- well, we've got to
17 address something.

18 State, are you reviewing your previous
19 objections and we are going to address them as we've
20 indicated?

21 MR. MARTIN: Yes. I'm not going to belabor the
22 point. The Court is well aware of my objections to
23 the testimony.

24 THE COURT: Correct.

25 MR. MARTIN: You are the trier of fact. You

1 know, as the trier of fact, you will accept or
2 reject just like any other person sitting over there
3 in the jury box.

4 THE COURT: Exactly.

5 MR. MARTIN: So I think that's the way we'll do
6 it.

7 THE COURT: Okay. Is that okay?

8 MR. MARTIN: That's good with me.

9 THE COURT: All right, Judge. Thank you. Mr.
10 Michaels?

11 MR. MICHAELS: Defense calls Dr. Donna Cohen.

12 THE BAILIFF: Step this way, stand right here.
13 Face the clerk, raise your right hand to be sworn.
14 (Thereupon, the witness was duly sworn on oath.)

15 THE BAILIFF: Come have a seat up here. Adjust
16 the mic. Speak in a loud and clear voice for the
17 Court.

18 THE COURT: You may proceed, Counselor.

19 DIRECT EXAMINATION

20 BY MR. MICHAELS:

21 Q. Please state your name.

22 A. Donna Cohen.

23 Q. And what is your occupation, please?

24 A. I'm a professor of tenure at the University of
25 South Florida.

1 Q. And how long have you been at the university of
2 South Florida?

3 A. Since June 17, 1992.

4 Q. What is your current title there?

5 A. Professor and Head of Violence and Injury
6 Prevention Unit.

7 Q. And what school is that part of?

8 A. That's part of a college called College of
9 Behavioral and Community Sciences, and I'm in the
10 Department of Child and Family Studies, which is one of
11 several departments.

12 Q. And what does that have to do with the issue of
13 aging?

14 A. What, my appointment?

15 Q. Yes.

16 A. I was specifically hired by the University of
17 South Florida in 1992 to come in as professor and
18 chairman of the then Department of Aging and Mental
19 Health, which was subsequently combined in about 2011
20 with some other aging groups, so I was actually brought
21 in to run the department.

22 I also, the year I was hired, was made head of
23 the Aging Studies Ph.D. Program, and I was also the
24 founder of the USF Institute on Aging. So that my role
25 was to actually develop aging research, training, and

1 service.

2 Q. Let's talk about your educational background.
3 Undergrad?

4 A. Duke University, Bachelor of Science in
5 Biology.

6 Q. What's the next degree?

7 A. The next degree was a master's in 1973 in
8 psychology with a specialization in human development and
9 aging, and that was followed by a Ph.D. They normally
10 have a master's in a Ph.D. sequence.

11 Q. What school was that?

12 A. That was at the University of Southern
13 California.

14 Q. And so how would you describe what your
15 specialty was?

16 A. I came into the field of aging because I was
17 excited about the opportunities. It was a growing field
18 at that time, and I would describe my activities as
19 focused in on the biopsychosocial aspects of aging.

20 I have my specializations in elder abuse, in
21 the dementias, and several other areas, including
22 violence.

23 Q. And so how long have you worked in the field of
24 aging?

25 A. Actually worked in the field of aging, since

1 1975, because I was -- at that time I got my Ph.D., but I
2 was also working full time at the Brentwood Veterans
3 Administration Center in LA on aging issues.

4 Q. Could you walk me through what your various
5 positions were before you got to USF?

6 A. The work I did at the Veterans Administration
7 was a prelude to going off to the University of
8 California, Los Angeles to do some work with one of the
9 professors there.

10 Then I went on to the University of Washington
11 in Seattle where I went from an assistant to an associate
12 professor in the Department of Psychiatry in that aging
13 program.

14 After that, I was recruited to the Albert
15 Einstein College of Medicine in Montefiore Medical Center
16 where I was awarded a professorship and continued to
17 develop aging programs, get grants, and left Einstein --

18 Q. Now, before we get there --

19 A. Sure.

20 Q. -- you talked about developing the aging
21 program and getting grants?

22 A. Right.

23 Q. What do you mean by that?

24 A. Fundamental to developing a program is to go to
25 various funding sources, federal, state, and otherwise.

1 The prestigious guess being the National Institute of
2 Health, the National Institute of Mental Health, so it
3 means writing grants.

4 I was successful in getting them to set up a
5 geriatric psychiatry program in aging. I was successful
6 in setting up the University of Washington -- the very
7 first training program for post-ops in psychology and in
8 psychiatry, so the job you have when you come into a
9 position is to actually develop the programs through
10 grants and other sources.

11 You also are responsible for developing
12 educational programs for the various individuals and
13 doing training on the outside with a wide range of
14 professionals from dentistry to pharmacy to medicine to
15 almost any field, because aging is a multidisciplinary
16 program.

17 Q. And what do you mean by "a multidisciplinary
18 program." What are the various disciplines within the
19 umbrella of aging?

20 A. What makes aging an exciting and unique field
21 is that it relies upon a -- multiple perspectives. It's
22 not like you're doing research on cancer or heart
23 disease.

24 Aging is accompanied by a series of biological
25 and psychological and social and cultural changes. It's

1 a field where you have to have a specialty, mine being
2 psychology, but the field and the institutes that are
3 around the country and the ones that I developed require
4 bringing together a variety of medical professionals,
5 bringing together everybody from public administrators to
6 nursing to social work to pharmacy so that the field
7 requires multidisciplinary, a multiple-discipline
8 approach so that you can actually work with individuals
9 who are changing in various ways.

10 Q. Now, you said Albert Einstein. Where is the
11 next place?

12 A. After Einstein, I was recruited to the
13 University of Illinois, Chicago. I believe that was
14 1985, and there I was a professor in the College of
15 Public Health. I was also Deputy Director of the
16 University's Institute on Aging. And again, had similar
17 responsibilities to develop programming and do education.

18 After UFC, I was recruited to come to USF to
19 head up their Department of Aging and Mental Health.

20 Q. What year was that again?

21 A. I believe that was 1992.

22 Q. And tell me, are you a member of any sort of
23 professional associations that deal with aging?

24 A. Yes, many.

25 Q. Okay. Tell us about them.

1 A. The American Psychological Association, which
2 is a huge association of psychologists, has sections on
3 aging and sections on law, neuropsychology, and I
4 actually held some offices in that division which dealt
5 with aging on human development.

6 Q. What sort of offices did you hold?

7 A. I was in charge of -- I was a member of their
8 executive committee. I was in charge of setting up
9 policy and programming for the division.

10 Q. Okay. And what other professional
11 associations?

12 A. The Gerontological Society of America.

13 Q. What's that?

14 A. It's, again, the premier gerontology, aging
15 society in this country. And it's composed, again, of
16 multiple disciplines from the biology of aging to the
17 psychology of aging, sociology of community and public
18 health issues.

19 The other organizations include the other range
20 of the American Association of Suicidology. Older people
21 have very, very high rates of suicide, and recently were
22 higher than even children and teenagers. There, I was
23 not only a board member, but I was a clinical director,
24 again developing the association's mission to approve
25 research, education and training.

1 I'm trying to remember all of the other
2 associations. There are many of them.

3 Q. Okay.

4 THE WITNESS: May I just request a glass of
5 water, please?

6 MR. MICHAELS: Can we get her some water or
7 should I get my bottle?

8 May I approach the witness, Your Honor?

9 THE COURT: You may.

10 BY MR. MICHAELS:

11 Q. What about this: The American College of
12 Forensic Examiners Institute, American Board of
13 Psychological Specialties, diplomate in medical
14 psychology?

15 A. Right. That's an organization that, again, has
16 a wide range of professionals from the microforensics to
17 the macroforensics. And there I have presented at their
18 meetings, have peer-reviewed papers for them for their
19 journal.

20 And again, it's -- with all of these
21 organizations, the challenge is to be a professional
22 leader in the field and develop programming.

23 Q. Let's go over some honors and awards.

24 Regional awards, Future Scientists of America,
25 National Science Teachers of America, 1965.

1 What is that one for?

2 A. That's for my very early years when I was first
3 developing my scientific interest. And at that time for
4 that age group it was a nice feather in the cap.

5 Q. Bausch and Lomb Science Award Medal?

6 A. That was a prestigious award for some work I
7 was doing on psychology with aging.

8 Q. NINCHD Traineeship?

9 A. That's a precious commodity that people can get
10 in the field that really pays your expenses for your
11 graduate education. And at that time, like I said, aging
12 was a growing field, and the government was investing a
13 fair amount of money. One way to get through graduate
14 school was to be awarded one of these fellowships.

15 Q. And do they just give them out to anybody that
16 asks? How do you get that fellowship?

17 A. You have to go through an credentialed school
18 like the University of Southern California and have
19 letters of support from various individuals.

20 Q. Honorable Mention from the American Medical
21 Writers Association for "The Loss of Self; A Family Guide
22 for Alzheimer's Disease" in the category of Best Trade
23 Book.

24 What's that about?

25 A. One of the critical issues as a leader in the

1 field was not only to educate students -- undergraduate,
2 graduate students and fellows -- but also to play a role
3 in public education, and our editor at the time suggested
4 that we compete for that award. And it was an honorable
5 mention, but it was an indication that the book was
6 making a difference.

7 Q. Founder's Award, Alzheimer's Association?

8 A. That's a favorite of mine. Back in the '80s,
9 eight different groups of professionals and families came
10 together and established what was then the Alzheimer's
11 Disease and Related Disorder Society under Gerald Stone.

12 It later was changed to Alzheimer's Disease
13 Association, and the founder award was given in honor of
14 being one of many professionals who worked with -- put
15 that together.

16 I also went on to help develop the
17 International Alzheimer's Society.

18 Q. Metropolitan Chicago's Health Care Council
19 Award for Health Care Management, 1988.

20 What is that?

21 A. That was an award where I was nominated for the
22 community service that I was doing in Chicago on behalf
23 of the university and the service to the community -- the
24 greater community of Chicago, Illinois.

25 Q. 1988 Listed "100 Women Shaping Chicago's

1 Future"?

2 A. That was another award that the dean of my
3 college had nominated me for, again, in recognition of
4 going above and beyond the typical academic duties and
5 being responsive to the needs of older people in the
6 community.

7 Q. Special Citation, 39th Annual Progressive
8 Architectural Award, Design of Architectural
9 Interventions and Day Care Settings for Older Persons?

10 A. That, again, is another special award. One of
11 the disciplines that I didn't mention in the field of
12 aging is, in fact, environmental and architectural
13 issues.

14 Working with Stanley Tigerman, (phonetic) who
15 was Dean of the College of Architecture at the University
16 of Illinois, Chicago, and four of his faculty and two of
17 my faculty, we developed a project to enhance the ability
18 of older people in day care settings.

19 This is for people who have physical as well as
20 cognitive kinds of issues. And the project really led to
21 the esthetic transformation of the day care center from
22 just a place with bars and seats and desks to a place
23 where there were rails with photographs with supportive
24 devices, for everything from where you hung your hat to
25 where you ate, and it just created this kind of

1 environment.

2 And the Progressive Architecture Award is
3 probably one of the premier awards that you could get for
4 that.

5 I was not the lead on that. I was the mentor,
6 sponsor, and Mark Rankatowski (phonetic), who was one of
7 Stanley Tigerman's students at the time.

8 Q. Annual Author's Award at the University of
9 South Florida in 1995?

10 A. I'm sorry?

11 Q. Annual Author's Award, University of South
12 Florida?

13 A. Again, it's -- the University recognizes
14 individuals who publish. And the provosts takes very
15 special pride in maintaining of a library of books each
16 year of the productions of faculty members.

17 Q. Who's Who in Medicine and Health Care, 1997.
18 What's that one about?

19 A. That's a listing, again, based upon meeting
20 certain credentials and certain levels of productivity in
21 your field.

22 Q. When you say "certain credentials and certain
23 levels of productivity," what exactly are you talking
24 about?

25 A. The reference is really to the number and

1 quality of one's publications, and it also rests upon
2 your reputation from giving talks and other kinds of
3 things. But it's really primarily representative of your
4 national and international presence on the basis of the
5 awards of your work.

6 Q. Honors Undergraduate Medallion, University of
7 South Florida?

8 A. That's another special one that really
9 recognizes that I have taught in the honors college for a
10 number of years and developed the first aging courses
11 ever given in the honors college, and the fact of getting
12 another medallion. But I just completed 22 years of
13 teaching in the honors college and the courses have been
14 extremely well received and well rated.

15 Q. Founders Commemorative Award, National
16 Alzheimer's Association, Chicago, 1998?

17 A. That was another celebration of the
18 (inaudible.)

19 THE COURT REPORTER: I'm sorry. Could you
20 repeat the last part of your answer?

21 THE WITNESS: That was another commemorative
22 event celebrating the establishment of the
23 Alzheimer's Association.

24 BY MR. MICHAELS:

25 Q. 2010, USF Ambassador's Apple Polishing Award?

1 A. That's exactly what it is, an Apple Polishing
2 Award. Students vote for the faculty who made the
3 biggest difference in their careers at USF. It's a
4 special kind of commemoration, and the numbers of faculty
5 who get those are relatively few.

6 Q. And let's talk about articles, monographs, and
7 books that have been published that you have authored or
8 co-authored.

9 How many do you think there are out there?

10 A. Probably in the neighborhood of 10 books, and
11 probably -- with things that are now in press, maybe 180
12 to 185 articles.

13 Q. And are any of those articles peer reviewed?

14 A. Most of them are. Some of them are book
15 chapters, but most of the article are peer reviewed.

16 Q. What do you mean by peer reviewed?

17 A. Peer reviewed refers to the process, whether
18 it's in a grant or a publication, where you submit
19 something and your product, in this case a journal
20 article, is reviewed anonymously by usually two to three
21 to four individuals. And those individuals will make a
22 decision about whether it's worthy of publications being
23 revised and then published.

24 The -- there are different kinds of journals,
25 but the only ones that I published that are not peer

1 reviewed are ones that I specifically tailored for the
2 public and the community. So we could advance the
3 knowledge of the public about aging issues and not just
4 the professionals in the university.

5 MR. MICHAELS: Judge, at this time, without
6 objection by the State, I would move into evidence
7 what's been marked as Defense Exhibit Number 7,
8 which is the CV of Dr. Cohen.

9 THE COURT: Okay. What exhibit number is that?

10 MR. MICHAELS: It was our Exhibit Number 7.
11 We've premarked them. There may be some gaps, but
12 we would will be filling them up as we go along.

13 THE COURT: Well, they have to come in
14 numerically, whatever way they come in.

15 MR. MICHAELS: Is this 4 or 5?

16 THE CLERK: 5.

17 MR. MICHAELS: Madam Clerk informed me it's
18 actually Number 4.

19 BY MR. MICHAELS:

20 Q. Now, you said a couple of times that you do
21 what you do because it's necessary to educate students
22 regarding aging.

23 What do you mean by that? Why does a
24 student -- doesn't a student know that people get older
25 and they can see it on their own? Why do you have to

1 educate them regarding that issue?

2 A. Students coming into the university as
3 undergraduates have very little experience with aging.
4 They've barely learned what it's like to grow up and be
5 friends with the opposite gender. They know aging
6 through their grandparents, perhaps, or having cared for
7 a sick parent or whatever, but their knowledge of aging
8 is really nonexistent.

9 In fact, the deans were very surprised that
10 students were flocking to the courses to take it. And
11 the challenge here is to show them that there's a science
12 to aging, that there's a clinical component to aging,
13 that there's a societal mandate to further our knowledge
14 of aging, and that there are a series of ethical issues
15 and cultural issues with the growth of the population.

16 It astounds them to know that -- give data, you
17 know, at different times, but roughly now there are 15
18 percent of the population 65 and over. That's about 44
19 million Americans by 2050.

20 That number is going to almost double to be 25
21 percent of the population, 88 million people. So, to
22 them, it's a way of showing them that this is a major
23 portion of the population, and someday they're going to
24 join it.

25 Because the children of today are the aged of

1 tomorrow, and the aged of today were the children of
2 yesterday, and getting them to understand the
3 developmental issues that they will be facing and our
4 country will be facing because the growth is going to
5 continue to explode.

6 Q. When you say "developmental issues," what is it
7 that you're talking about?

8 A. We're talking about the biological process,
9 undergrad.

10 Q. Let's talk about that for a moment.

11 The biological process, what do you mean by
12 that?

13 A. Again, to tie that into your previous question,
14 the students get excited about biomedical issues or
15 psychological issues, but they have no understanding of
16 what actually happens to people post adolescence and the
17 issues that confront people as they go into adulthood to,
18 you know, 18 to 24; then adulthood which goes to about
19 55, 60; then looking at late life and understanding how
20 genes can determine what happens to you as you grow
21 older.

22 That the education you get makes a difference
23 in how you grow older, to describe to them the kinds of
24 things they need to do today to keep from getting sick
25 tomorrow.

1 The health issues that will affect them in the
2 middle and later stages of life could be directly tied to
3 things that happened to them now. Roughly one-quarter of
4 adolescents have high blood pressure and high
5 cholesterol, and these are issues that are critical to
6 them growing older.

7 So it's really taking them through the various
8 biologic systems and helping them understand that people
9 change at different rates. You don't necessarily grow
10 old and grow sick, but as you grow old, the risk for
11 disease increases.

12 Impairments and disabilities which keep you
13 from functioning become a higher-risk issue, and even if
14 you live life relatively healthy, the average American is
15 going to spend 11 years frail before they die.

16 Q. Is that part of what you do to study the
17 vulnerability of the elder population people over 60?

18 A. Yes, study the vulnerability, because that's a
19 handle to understand how to build resilience to help
20 support people who have excess disabilities who probably
21 will not get too much better and to help them understand
22 that process.

23 Q. When you say vulnerability, describe what it is
24 that you mean by that term.

25 A. Vulnerability has many, many meanings.

1 Vulnerability refers on one level to your ability to
2 function safely without getting hurt.

3 Q. So let's talk about that particular aspect.
4 Are you talking about physiological changes in the
5 elderly population?

6 A. I'm talking about physiologic changes, yes.

7 Q. When you say to function without getting hurt,
8 what do you mean by that?

9 A. The older population, as I said, is at higher
10 risk for a variety of physical and mental changes.
11 They're at higher risk for chronic illness. They're at
12 higher risk for excess disabilities, which means the
13 vulnerability can't be compensated for easily, and it
14 affects their frame of mind.

15 So here we're talking about the ways that we
16 can understand how to keep people from doing things that
17 will hurt themselves. There's many older people who have
18 chronic illnesses because of skeletal issues, muscular
19 issues, changes in their organ systems including
20 cardiovascular, endocrine systems that really don't know
21 what they can do to take care of themselves.

22 There's a whole science which has grown up
23 around this issue of geriatric medicine, and the number
24 of well-known textbooks in geriatric medicine really take
25 this issue to heart.

1 Q. And can you name any of them today?

2 A. Yes, there's a Brocklehurst Handbook of --
3 Textbook of Geriatric Medicine and Gerontology.

4 Q. How does that deal with the issue of
5 vulnerability of the aging population?

6 A. That and many other textbooks really are
7 providing the -- and I think the Brocklehurst is in its
8 eighth edition, at this point. They lay out the changes
9 that occur in the aging process at the bio and
10 psychosocial level, and they provide the basis for
11 clinical care; what is it that clinician has to do,
12 whether that person is a social worker, nurse and/or
13 rehabilitation therapist, so it's really laying out the
14 science of the field.

15 There are other textbooks, and probably one of
16 the most prominent is the Handbook of Physiology,
17 Exercise, Health and Aging by Michael Taylor which really
18 lays out very specifically the issues around exercise and
19 maintenance of health in older people from young ages --
20 young, old being those who are under 65 to the older
21 population, you know, 80s and 90s, so it's a
22 comprehensive text.

23 Q. Certainly he doesn't suggest that if one
24 exercises, they aren't aging?

25 A. Pardon?

1 Q. Certainly he doesn't suggest that if one is
2 exercising, one is not aging?

3 A. Of course not.

4 Q. What other studies in regard to the subject of
5 vulnerability of the elderly and kind of realization of
6 that vulnerability?

7 A. One of the most common changes with aging is
8 the loss of muscular functioning, and that actually
9 starts, you know, in the 40s, but progresses at a rapid
10 rate as you get into your 60s and 70s and beyond.

11 There are some very specific changes that make
12 people vulnerable. Genes do have some role in how your
13 muscles change, but with advancing age there is
14 significant loss of muscle mass.

15 Muscles don't replicate themselves. Red blood
16 cells do, skin cells do, so when you lose muscle mass,
17 that's not going to be replaced.

18 There are different kinds of muscle fibers.
19 There are high twitch and low twitch. The high twitch
20 ones send messages to the brain very, very quickly.
21 In -- with advancing age, the conduction velocity of
22 nerves from muscles to the brain and back to the muscles
23 slows down significantly.

24 When people lose muscle mass, they lose
25 different kinds of muscles, and muscle quality changes.

1 Muscle quality refers to specific fibers, and that's
2 actually a better indication of muscular strength than
3 just mass.

4 Other things that happen are different kinds of
5 pain. Back pain, spine pain, actually can change the way
6 your brain responds to pain which affects your ability to
7 keep your balance and walk, so...

8 MR. MARTIN: Excuse me, Judge. I'm going to
9 object to that testimony that is far from afield.
10 This is more along the lines of medical testimony.

11 In fact, you might even remember that we heard
12 very similar testimony from Dr. Foley who is, in
13 fact, a medical doctor. She does not qualify to
14 render that type of an opinion or to make that type
15 of testimony.

16 MR. MICHAELS: Judge, certainly as a Ph.D. in
17 the field of aging, she can rely on treatises and
18 textbooks that she read to form an opinion or to
19 give testimony. That's, frankly, what she's doing
20 here.

21 MR. MARTIN: She rendered a medical diagnosis,
22 Judge.

23 MR. MICHAELS: I don't think she diagnosed
24 anyone.

25 THE COURT: Okay. I will overrule that.

1 THE WITNESS: (Indiscernible) research paper.

2 BY MR. MICHAELS:

3 Q. So explain what you were saying that -- how do
4 the -- this physical degenerative process or physical
5 inability to do what you did before as a younger person,
6 how does that affect one's psychological makeup in terms
7 of feelings of vulnerability?

8 A. It has a very dramatic effect, because when you
9 think about having lost strength, having problems with
10 balance, having more fat which has replaced the muscle
11 mass, weight gain, instability coupled with, you know,
12 other kinds of diseases, whether they're vascular or
13 endocrine, like diabetes, makes life very, very
14 difficult.

15 The simple act of walking and the simple act of
16 going up steps are affected. And if you have circulation
17 problems and you've got decreased musculature
18 coordination and muscle mass, it's very difficult to
19 negotiate the environment and you're at high risk for
20 lots of things, the most common of which is falls.

21 30 to 50 percent of people over the age of 65
22 fall every year, and people who break a hip when they
23 fall have a high likelihood of falling again and doing
24 more serious damage.

25 So these kinds of aging changes coupled with

1 other pathologic changes impair the individual's ability
2 to do everything from navigate their environment with
3 steps to getting in and out of bed, to pursue their
4 hobbies and to even walk up on the curb of the sidewalk
5 because there's constant concern and fears of not just
6 falling, but getting hurt.

7 Q. What about fears of the outside world,
8 interacting with strangers and that sort of thing?

9 A. There's a -- a literature that specifically
10 looks at the vulnerabilities that people perceive who are
11 older, and there are some gender differences. Women
12 perceive being much less safe living in their communities
13 because they're less able to protect themselves, to run
14 away.

15 So that the issues of vulnerability, our
16 perceptions of: How safe am I in my home? How safe am I
17 when I walk out on the street? How safe am I if someone
18 comes and grabs my purse, and how safe am I if someone
19 comes after me with a knife?

20 Q. Are the aging population, the elderly -- are
21 they more susceptible to be the victim of crimes from the
22 literature that you've studied?

23 A. The data depends upon age and sex and the type
24 of crime. Older men are more likely to -- well, first of
25 all, older people aren't out running around the way

1 younger people are. They're generally in their community
2 and more subdued environments, so the fear really is
3 around: How safe am I in my home and in my community?

4 When it comes to burglaries, men are more
5 likely to be attacked than woman, so that the -- and it
6 depends where you live. When you're in communities where
7 there's a high crime rate, the fears of older people are
8 significantly high, much higher than the young.

9 Q. Now, let's talk about some of the publications
10 that you've listed in your CV.

11 Number 25, Eisdorfer & Cohen. 1980. Issue of
12 Biological and Psychological Deficits in the Aging.

13 A. That was a -- early in my career, was a review
14 of the major kind of changes which occur in the biologic
15 systems as well as the psychology of systems, so we're
16 talking about everything from the organ changes that I
17 spoke about to changes in one's mood, one's affect, one's
18 anxiety, one's fears and one's ability to cope with the
19 environment. So it was a review of what we knew at that
20 time in 1985.

21 Q. Were you able to correlate an increase in fear
22 with a perspective that that person is no longer as
23 physically able as they once were?

24 A. The -- that's a theme that runs through the
25 field. I mean, it's with degenerative changes. There

1 are psychological effects which increase anxiety and
2 concern, and the 1985 article was not so much dealing
3 with the perceptions of older people as much as the later
4 work that we did.

5 Q. Eisdorfer & Cohen. 1983. Health and
6 Retirement, Retirement and Health: Background and future
7 directions. Policy issues in Work and Retirement.

8 A. That was, again, an early article which was
9 examining the literature of how health impacts people's
10 decisions to retire, and that's really one of the most
11 prominent reasons that people leave the work force when
12 they're older.

13 Q. Here's one from 2006. Older Adults and
14 Terrorism. Brown, Cohen & Kohlmaier.

15 A. That was a chapter -- responder's first texts
16 on terrorism dealing with older people. I was
17 Dr. Brown's mentor at that time, and we were examining
18 the responses -- the perceptions of fear and the
19 responses to fear and interventions to deal with those
20 fears of older people living in the community.

21 This was post-9/11, and older people are
22 extremely vulnerable when it comes to whether it's
23 man-made or natural disasters, and the consequences can
24 be everything from traumatic brain injury to death.

25 Q. And are they more vulnerable because they're

1 older?

2 A. Because they're older and they're impaired and
3 unable to control their environment.

4 Q. So an individual doesn't have to be in a
5 wheelchair to feel that he or she is more vulnerable as
6 an elder adult?

7 A. Not at all. The issue really has to do with
8 whether the older person perceives something threatening
9 such as a terrorist attack, whether that occurs, and
10 their inability to defend themselves or to take safe
11 actions if a threat is occurring.

12 Q. Okay. Now, what did you do in this particular
13 case? What sort of materials did you review for our
14 office and Mr. Reeves' case?

15 A. A variety of materials. I went through the
16 latest versions of the various premier textbooks, not
17 just the Brocklehurst, but the Oxford Handbook of
18 Geriatric Medicine which is, again, in its Fifth or Sixth
19 edition.

20 I went through Chris Castle's classic textbook
21 on geriatric medicine.

22 William Hazard and Jeff Holter, and some other
23 co-editors have, again, a classic textbook in multiple
24 editions, and each of these are really considered tomes
25 in their field.

1 I also reviewed a series of articles on the
2 different kinds of physiologic vulnerabilities that older
3 people have, and Michael Taylor's book on Exercise of
4 Physiology was one.

5 Tim Doherty did a very nice analysis of
6 Sarcopenia and aging. Sarcopenia refers to the loss of
7 muscle mass and its profound effect on one's abilities to
8 walk and move around and be safe.

9 I also reviewed two very important documents
10 that had to do with the importance of older people, even
11 those with chronic illness and impaired, to do some
12 exercise.

13 And the American Association of Sports Medicine
14 and the American Heart Association came out with a report
15 in 2003, which is a summary of a panel's recommendations
16 for what kinds of exercises should be done to promote the
17 ability to locomote, navigate, the ability to stay
18 healthy with cardiovascular disease or other kinds of
19 things.

20 There was another panel that came out, work by
21 Nelson at the University of South Carolina, who did a
22 public health panel report looking at exercise and
23 healthy aging and public health. And there were a series
24 of other articles that -- journal articles that I looked
25 at at that point.

1 I also re-reviewed the very important document
2 that came out of the -- not the Institute of Medicine,
3 but came out of the National Research Council, which is
4 part of the national academies. The Academy of
5 Engineering, there's the Institute of Medicine, as well
6 as the National Academy of Sciences Program, and that was
7 specifically elder abuse risks and the impact and what
8 could be done about it.

9 The two editors of a huge panel of respected
10 scientists and community leaders was led by a very
11 prominent Bob Wallace, who is the chairman of -- at the
12 University of Iowa, and Richard Beasley, who was at the
13 University of Virginia.

14 And again, this was a panel of at least 50 to
15 60 people. This was a 2003 document that really covers
16 the field pretty extensively.

17 Q. Have you been qualified to testify as an expert
18 in any court in the field of aging?

19 A. Yes.

20 Q. Okay. And where would that be?

21 A. I've been qualified to testify in terms of
22 older people who have been financially exploited, abused,
23 older people whose family members are contesting their
24 wills, cases where competency is -- or capacity which the
25 scientists attest to, and a series of cases that deal

1 with nursing home abuse and neglect, and a number of
2 cases dealing with suicide and the use of medications,
3 and other cases dealing with situations where caregivers
4 had killed care recipients and did not kill themselves
5 and go through the legal system.

6 Q. None of that has anything to do, it seems, with
7 the issue of vulnerability and an elder citizen
8 perceiving his or her vulnerability. Would you agree
9 with me on that?

10 A. Not -- I don't think -- I don't think I would
11 agree with you when it comes to financial exploitation.

12 Q. Okay. And tell me how that's related, then.

13 A. Individuals who are at risk for abuse -- and
14 I'll give you the numbers, one in 10 Americans over the
15 age of 65 suffer some kind of abuse, from psychological
16 to financial to physical to sexual abuse, and the numbers
17 are not exactly known because not everybody reports it.

18 But people who are being abused are quite
19 frequently afraid of what's happening to them, so that
20 issue of vulnerability and recognition -- they're
21 vulnerable in recognizing they have no control to get out
22 of the situation.

23 Q. Does that have -- is that elder person's
24 ability to perceive a situation and make a decision on
25 what to do based on his or her perception?

1 A. Hopefully they can do something about it, but
2 if I understand your question -- would you repeat it just
3 to make sure?

4 Q. I don't think I could repeat it.

5 A. If I -- okay. If I understood it, it's that
6 the older person who's in a potentially threatening
7 situation where they're being hit, they're being
8 neglected, family members are taking money from them,
9 recognize that they're vulnerable and threatened, but
10 they also recognize that they're embarrassed because it
11 may be a family member.

12 They also know there's very little they can do
13 about it, particularly, if they're constrained by
14 multiple impairments and disabilities.

15 Q. In this case, you interviewed Mr. Reeves,
16 correct?

17 A. Yes.

18 Q. Tell us about that interview. Where did that
19 take place?

20 MR. MARTIN: Your Honor, at this time, I'm
21 going to object to her describing or going into the
22 interview of Mr. Reeves.

23 THE COURT: All right.

24 MR. MARTIN: There's some additional argument
25 if you want it, but, I mean, that's my base --

1 MR. MICHAELS: She's not going to say what
2 Mr. Reeves said. She's just going to say she
3 interviewed him.

4 THE COURT: What is your --

5 MR. MARTIN: Well, what Mr. Reeves said,
6 there's certainly nuances that may come into play,
7 but we need to ferret those out.

8 THE COURT: All right. For purposes of the
9 moment, we will -- I will overrule it.

10 BY MR. MICHAELS:

11 Q. Did you interview Mr. Reeves?

12 A. Yes, I did.

13 Q. And where did that take place?

14 A. That took place in your law office.

15 Q. And how long did that interview last?

16 A. An hour and a half plus.

17 Q. Okay. Now, let me ask you a hypothetical:

18 If an individual was healthy and robust when he
19 was younger, and over the years suffered degenerative
20 changes to his body, and that person had some kind of
21 cognitive recognition of those degenerative changes,
22 would that person perceive his own vulnerability in a
23 one-on-one stressful situation?

24 A. Yes.

25 MR. MARTIN: Your Honor, I'm going to object to

1 the hypothetical, assuming facts not in evidence,
2 the specific part that is not in evidence is that he
3 had cognitive ability -- awareness of those medical
4 issues.

5 I know we've had the testimony from Dr. Foley,
6 but he embellished upon that in this hypothetical
7 because we have no testimony whatsoever as to
8 exactly what and to what extent Mr. Reeves had any
9 knowledge of any of this.

10 So I object to the form of the question for
11 that very limited purpose when he added cognitive
12 recognition, because we've had no testimony as of
13 yet of that.

14 MR. MICHAELS: Judge, that's the very nature of
15 a hypothetical. He doesn't want me to ask if she
16 formed an opinion based on Mr. Reeves' interview. I
17 know he doesn't want me to ask that, so I'm asking a
18 hypothetical.

19 I'll change the hypothetical a little bit if it
20 will make the prosecutor more comfortable.

21 BY MR. MICHAELS:

22 Q. Let me ask it to you this way, Dr. Cohen:

23 If -- and this is a hypothetical -- if I'm a
24 person who was very active through my 40s and through my
25 50s, and then as I got to be 50, 60 and 70 all of a

1 sudden I wake up in the morning and my knees hurt a
2 little bit. I wake up in the morning and I can't ride my
3 bike like I used to. I wake up in the morning and I
4 can't run like I use to.

5 I wake up in the morning and I'm having trouble
6 with my hands, my joints. My shoulder hurts, my feet
7 hurt, my back hurts, and I realize this because I'm going
8 through this, and now I'm 70, and I've been through that.

9 I've been healthy, I've been okay, and now I'm
10 getting a little weaker as I go, and I realize these
11 things are happening to me because I feel them every day.

12 Am I a person -- as a 70-something-year-old, as
13 an elder citizen, am I somebody who's going to be --
14 first, let's say -- let me ask you this way: Is that a
15 person that's going to be more vulnerable than like a
16 40-year-old?

17 A. Yes.

18 Q. Well --

19 MR. MARTIN: Excuse me, Judge. I object to --
20 we're talking about more vulnerable than what?

21 I mean, we have to have a hypothetical that is
22 based on the facts that are in evidence. So when we
23 talk about more vulnerable, we haven't talked about
24 vulnerable as to what?

25 Vulnerable stepping out of the shower and

1 slipping and falling? Twisting my knee when I get
2 out of my car? I mean, more vulnerable is so broad.
3 How are we supposed to know what the answer is?

4 MR. MICHAELS: Did he want me to ask if I'm
5 sitting in a movie theater and a six-foot guy
6 attacked me? I'll be happy to ask that.

7 MR. MARTIN: Okay. Hopefully that was tongue
8 in cheek.

9 BY MR. MICHAELS:

10 Q. I'm a 70-something-year-old, and I'm in a quiet
11 place or maybe a noisy place or a dark place, but I'm
12 seated, and somebody who doesn't appear to me to have any
13 sort of malady, perfectly healthy, is larger than me --
14 if they're coming after me and attacking me, is it
15 reasonable for me as a 70-year-old -- describing what I
16 did to you?

17 Is it reasonable for me to perceive my own
18 vulnerability?

19 A. Yes.

20 MR. MARTIN: Your Honor, again, I'm going to
21 object because we don't have any of those facts in
22 evidence.

23 What you've heard from Dr. Cohen is her ability
24 and her research deals with vulnerability, and if
25 you listen carefully to what she said her research

1 was, it was vulnerability -- so that society would
2 recognize vulnerability so industries and cottage
3 industries could be set up in order to take care of
4 those individuals so they wouldn't hurt themselves.

5 That's what her research is about. That's what
6 she has testified to, and now we're adding -- all of
7 a sudden, we've got people coming at them and people
8 are going to attack them. She's never, ever, ever
9 indicated there's any research in which she has done
10 that.

11 It's only recognizing the elderly are
12 vulnerable and society has to recognize that,
13 because we are becoming an older society and we need
14 to develop the industry in order to take care of
15 them. That's her research. And how it applies to
16 this particular case I fail to understand.

17 MR. MICHAELS: It's like somebody inventing a
18 seat belt and then say they can't talk about the
19 nylon they used to invent it. She's talking about
20 her research. She's talking about -- certainly, the
21 great breadth of literature. She's mentioned
22 several authors she's depending on. She's been
23 doing this for 40 years.

24 What the prosecutor says is true, that's part
25 of what she does, but she's doing something else

1 here and she's trying to educate the public for
2 other reasons, too. Not just so somebody doesn't
3 slip and fall in a nursing home because she's
4 designed a shower rug a non-slip floor. But it's so
5 that society becomes aware that older people are
6 more vulnerable and they should not be picked on by
7 other people that are bigger, stronger and younger,
8 because that part of society also has a
9 responsibility.

10 And I think she -- that's what Dr. Cohen is
11 also trying to educate the public and these students
12 on. So that's my argument, Judge.

13 THE COURT: All right. Mr. Martin's objection
14 really rings to me to be a Daubert-type objection.
15 At least that's kind of what I'm hearing.

16 I'm going to overrule at this point for reasons
17 we've already discussed. And any ruling I make as
18 to that issue, I'm not -- is for this -- the
19 purposes of this hearing.

20 As far as hearing further testimony and the
21 proffers, I'm not going to make any. I'm not going
22 to be held to the same exact procedure. Should we
23 have further proceedings such as a jury trial in
24 this case, we will have to readdress issues such as
25 that.

1 Again, obviously I'm the trier of fact here for
2 Daubert, Frey, determinations, so I'm going to --
3 we're going to proceed in the manner that we
4 indicated previously, so I'm going to overrule.

5 MR. MARTIN: Thank you, Judge.

6 BY MR. MICHAELS:

7 Q. So your answer was would an individual in that
8 situation be vulnerable, number one?

9 A. Yes. And it goes right to the heart of Michael
10 Taylor's analysis of physiologic changes with aging.

11 There are four different kinds. There's the
12 ones that are total, like high hearing, vision at some
13 point. Then there are those that are structural like
14 muscle mass.

15 Then there are changes in efficiency, like the
16 conducting velocity that I referred to with the
17 nerve/brain connection. And the fourth is the incapacity
18 to respond to highly stressful situations.

19 Q. What do you mean by that?

20 A. Referring to the fact that the -- it's not just
21 the muscles that are changing, that there's systemic
22 changes. And the various parts of the body work together
23 so that you can be healthy or function.

24 What happens is that the fourth kind of change
25 really refers to the fact that the system -- the body's

1 system can't mobilize itself as efficiently or as quickly
2 to respond to stress.

3 MR. MICHAELS: Thank you.

4 May I have a moment, Your Honor?

5 THE COURT: You may.

6 MR. MICHAELS: I don't have any further
7 questions of Dr. Cohen.

8 Thank you.

9 THE COURT: Cross?

10 MR. MARTIN: I would ask a favor of the Court:
11 Could we take five minutes and let Mr. Garcia and I
12 have a discussion somewhere in private? I think
13 then I'll know how I want to proceed based on the
14 Court's ruling.

15 And based on the testimony that we've heard, I
16 may have a certain direction that I want it go, and
17 I think a five-minute break would help me with that
18 and I would greatly appreciate it.

19 THE COURT: Okay. I will allow that.

20 MR. MARTIN: Thank you, Judge, very much.

21 THE WITNESS: We'll take five minutes.

22 MR. MARTIN: Thank you.

23 (Recess taken.)

24 THE BAILIFF: All rise.

25 Court is back in session.

1 You may be seated. Thank you.

2 MR. MARTIN: Judge, thank you for the five
3 minutes.

4 After speaking with my colleagues -- and I know
5 that you indicated that my last objection sounded
6 like a Daubert and Frey. Who knows where we're at
7 now in the State of Florida as of Friday.

8 But the bottom line is, Judge, I think, at this
9 point, in order to preserve the appellate record,
10 I'm going to ask that you consider my Motion in
11 Limine to exclude the testimony of Defense expert,
12 Dr. Donna Cohen -- to consider that, along with my
13 reply to the Defense response to my motion, and I
14 will -- and I'm sure you're going to say, "Same
15 ruling," or whatever, and then once you do that, I
16 will have no cross of Dr. Cohen.

17 THE COURT: Okay. Any input as to that?

18 MR. ESCOBAR: No, Your Honor.

19 THE COURT: All right. I'm going to reserve,
20 as I indicated, on that issue, and so I am going to
21 overrule and deny the State's Motion in Limine at
22 this time.

23 MR. MARTIN: I'm a little confused, because you
24 said you were going to reserve and then deny it.

25 THE COURT: No, I'm going to -- we're not going

1 to go forward -- I mean, I'm not going to address
2 it.

3 MR. MICHAELS: Correct.

4 THE COURT: So I'm going to --

5 MR. MARTIN: I think what we decided in this
6 process is that you'll take it under advisement.

7 THE COURT: Uh-huh.

8 MR. MARTIN: You'll make a determination as to
9 whether or not your initial role as a Judge and how
10 you're going to fulfill that as to whether or not it
11 would be admissible. And then once you make that
12 determination, then, as the trier of fact, you will
13 apply the rules as the trier of fact, and you, at
14 your own discretion, can either accept or reject her
15 testimony just like any other trier of fact would.

16 THE COURT: Correct.

17 MR. MARTIN: Okay. That's acceptable to the
18 State.

19 THE COURT: And as far as further, my only
20 concern with reserving on that is that I don't want
21 that to be an open invitation for more submissions
22 by either side on that issue at this point.

23 MR. MARTIN: No.

24 THE COURT: You know, I'm good with that, and
25 we'll-- we'll have a little bit more discussion as

1 to what's the appropriate analysis in light of the
2 fact that Supreme just ruled Friday, but in my brief
3 overview of it, it appears that we fall back to
4 Frey. So...

5 MR. ESCOBAR: Which is an easier standard.

6 THE COURT: Correct.

7 MR. MARTIN: Colleagues differ on that, so I
8 don't know, but hopefully in a week we'll have some
9 guidance.

10 THE COURT: Let's hope.

11 MR. MARTIN: Let's hope.

12 THE COURT: Either way, I'm going to reserve --

13 MR. MARTIN: Thank you, Judge.

14 THE COURT: -- as to that.

15 MR. MARTIN: All right.

16 THE COURT: So no further cross?

17 MR. MARTIN: No, ma'am. I'm going to rely on
18 my motion, and then let you decide as we discussed.

19 THE COURT: Okay. May this witness be
20 released?

21 MR. ESCOBAR: Yes, Your Honor.

22 THE COURT: Thank you.

23 Dr. Cohen, you're free to go.

24 THE WITNESS: Thank you.

25 (Witness excused.)

1 THE COURT: Your next witness?

2 MR. MICHAELS: The next witness is Gino
3 Sassani.

4 THE COURT: And, Mr. Garcia, you had requested
5 the ability to talk to him?

6 MR. GARCIA: Judge, just for the record, during
7 the lunch break Mr. Shah gave me his phone number so
8 I was able to talk to him --

9 THE COURT: Okay.

10 MR. GARCIA: -- so I know what he's going to
11 testify to.

12 THE COURT: All right. Very good.

13 Please make sure you spell the spelling of the
14 witnesses' names for the record.

15 MR. MICHAELS: I'll make sure that happens,
16 Your Honor.

17 MR. MARTIN: Judge, I apologize. I'm a little
18 confused. We've stipulated to the disk. We've
19 stipulated to the trailers. It was my understanding
20 that we were going to play this at the theater, so
21 why are we doing it now? That's where my confusion
22 is.

23 THE COURT: Okay.

24 MR. MARTIN: We're going to have a viewing and
25 it's going to be played, I thought that's where we

1 were going to play it because we did the stip, so
2 that this guy doesn't have to be there. I mean,
3 really that's -- that's what I thought we were
4 doing.

5 MR. ESCOBAR: Judge, I think what we stippled to
6 was the Prologic list of the actual trailers that
7 we're playing.

8 If the Court recalls, we found this particular
9 expert to authenticate the actual previews maybe two
10 weeks ago. When I presented that to the Court, his
11 response was, "Well, I've got to look at it. I have
12 to see it and see if, in fact, it's the original
13 ones."

14 At no point in time -- at no point in time has
15 he stipulated to these -- this particular disk being
16 authenticated.

17 MR. MARTIN: I thought I did.

18 THE COURT: Okay.

19 MR. ESCOBAR: Now, if he wants to say he'll do
20 it today, that's fine. We'll play it and off we go.
21 But I think it's important, at this point in time,
22 for the Court to see the previews to hear the
23 previews.

24 Yes, the Court will see and hear the preview
25 again when we go to the theater because it has other

1 components. It has the actual lighting, it has the
2 actual seat, but in our presentation for you to be
3 able to judge the witnesses that are going to be
4 coming in to testify before you, I think it is very
5 important, those particular previews, Your Honor,
6 are saying that, Robocop, Three Days to Kill, when I
7 tell you that they are impactful is an
8 understatement.

9 So this was our process that we had told them a
10 long time ago we were going to do it. At no point
11 in time have we signed a stipulation concerning the
12 authenticity of the actual disk.

13 I remember vividly him saying, "No, I've got to
14 look at that particular disk."

15 MR. MARTIN: Let me go back to my desk. I
16 swear I signed a stip regarding --

17 MR. ESCOBAR: Prologic only.

18 MR. MARTIN: Let me go and look, and then I
19 will owe you an apology.

20 MR. ESCOBAR: You spoke to him, right?

21 MR. GARCIA: Yes, I spoke to him.

22 MR. MARTIN: I told him I would owe him an
23 apology. I don't think we've even signed it. Is
24 this the one that's been signed? Has it been
25 signed?

1 MR. ESCOBAR: We never stipulated that the
2 trailers are on the CD.

3 MR. MARTIN: We just have Prologic.

4 MR. SHAH: That's one thing that he wanted
5 to --

6 MR. ESCOBAR: Judge, if he wants to agree that
7 Mr. Sassani, a movie critic for a gazillion years,
8 authenticated it properly, I gave him a copy of it.

9 MR. MARTIN: I reviewed it.

10 MR. ESCOBAR: -- we don't need to have him over
11 there just to go up there and authenticate it. We
12 stipulate it's authentic, and we play it and off we
13 go.

14 MR. GARCIA: Judge, I have an objection to it
15 being played here. And the reason being, when I
16 spoke to Mr. Sassani, he said that you cannot set
17 the lights at the level that it would be in the
18 theater. You don't get the same effect as far as
19 surround sound.

20 So if we're going to the theater, I suggest we
21 do it there. We will not do it here, then do it
22 there as well. Because in here, it's misleading,
23 and I'm going to object to that.

24 MR. ESCOBAR: Judge, it's not misleading.
25 You're mixing apples and oranges. We're not doing

1 it for the effect of the lighting. We're not doing
2 it for the effect of seating. We're doing it just
3 for the effect of the viewing and the actual
4 hearing.

5 We have to make this presentation now to the
6 Court because there are going to be witnesses that
7 are going to be talking to this Court and testifying
8 that they were seated in particular locations during
9 this particular incident.

10 And I think it's important for you to be able
11 to evaluate those particular witnesses, especially
12 with the issue of the rampant contamination in this
13 case.

14 When I tell you rampant. When you see the
15 number of people that we are going to bring before
16 this Court concerning contamination, including the
17 vast majority of the law enforcement officers that
18 are going to come in and say: "You're right. That
19 should have never been done."

20 It's important for this Court to see and hear
21 those particular previews, and then the Court can
22 sit in Mr. Reeves' shoes, which are going to bring
23 forth a lot of more issues, including the proximity
24 of Chad Oulsen at 6'4", 200 pounds to Mr. Reeves'
25 body seated in that chair.

1 The lighting conditions, the noise, the glare
2 from the actual previews on Reeves' face, there's a
3 whole lot of factors that we're going to be
4 presenting at some point in time.

5 MR. GARCIA: But I'm going to object, Judge.
6 Mr. Sassani said when I spoke to him, "If you do it
7 in the courtroom, it is not representative of the
8 trailer, of the lighting, of the way it was back on
9 January 13th, 2014. You cannot recreate it in the
10 courtroom," is what he told me.

11 MR. ESCOBAR: We are going to try to. We're
12 not showing it for that purpose.

13 MR. GARCIA: If we're going to see it at the
14 theater, why are we going to do it again here?

15 THE COURT: When are the witnesses in relation
16 to the theater --

17 MR. ESCOBAR: This is the problem. We can't
18 get the theater to agree. We wanted to do it on
19 Tuesday. That was going to be, obviously, one of
20 our means of doing this. The theater can't do it
21 until Friday.

22 These witnesses are going to be starting to
23 come on Wednesday morning, and so we lose that
24 effect in the presentation.

25 THE COURT: All right. I absolutely

1 understand. How long are we talking?

2 MR. ESCOBAR: I think it's 17 minutes.

3 THE COURT: All right. So it's not like we're
4 going to be hours.

5 I understand Mr. Garcia's objection, and so it
6 only -- if we had a jury, I think it would be more
7 impactful. I think it would not be -- well, I
8 understand Mr. Escobar's argument as well, so I'm
9 going to overrule it. I don't think it would be
10 prejudicial to either side.

11 Certainly, I will have an idea of what we're
12 looking at, and then we will play it in the theater
13 as well.

14 MR. GARCIA: We are going request
15 Mr. Sassani -- I think we're going to need
16 Mr. Sassani because there is some cross-examination
17 that I wanted to -- for the Court to hear.

18 THE COURT: Okay. Get him back.

19 MR. MARTIN: Judge, do you mind if I walk out
20 here with my papers?

21 THE COURT: Sure. Go ahead.

22 MR. MARTIN: Thank you.

23 MR. ESCOBAR: Mr. Sassani, we will not have any
24 questions for you right now, but the prosecution may
25 have some questions for you when it's done playing.

1 THE BAILIFF: Step this way, stand right here.
2 Face the clerk, raise your right hand to be sworn.
3 (Thereupon, the witness was duly sworn on oath.)

4 THE BAILIFF: Come have a seat up here. Adjust
5 the mic. Speak in a loud and clear voice for the
6 Court.

7 THE COURT: This is not excessively loud where
8 we're getting blasted out of it.

9 MR. ESCOBAR: We did a preview playing it. It
10 should be loud. I know they had the volume
11 somewhere that they turned.

12 MR. SHAH: The volume is off right now. I'll
13 put it to a low level, so we don't get blasted.

14 THE COURT: Thank you.

15 MR. ESCOBAR: Your Honor, could I turn the
16 lights off a little bit?

17 THE COURT: Yes.

18 (Thereupon, the previews were played for the Court.)

19 MR. SHAH: Your Honor, I will move that into
20 evidence. I believe Dr. Cohen's CV was Number 4, so
21 we will mark this as Number 5.

22 THE COURT: Actually, 6. The CV was 5.

23 (Whereupon, State's Exhibit 6 for
24 identification was received in evidence by the
25 Court.)

1 MR. ESCOBAR: I believe the State has no
2 questions at this point.

3 THE COURT: Okay.

4 MR. ESCOBAR: Judge, normally I would object
5 because it's outside the scope of direct, but I'm
6 going to let it go since it's late in the hour.

7 THE COURT: Thank you, Mr. Escobar. You're
8 right. It really wasn't much direct, was there?
9 Do we still have the lights off?

10 MR. ESCOBAR: Oh, I'm sorry, Your Honor.

11 THE COURT: Counsel, approach.

12 (Sidebar conference was held.)

13 THE COURT: I have something to address right
14 away. It was -- ABC News is requesting a copy of
15 the MRIs.

16 MR. ESCOBAR: No, that's --

17 MR. MARTIN: They've been admitted into
18 evidence.

19 MR. ESCOBAR: I don't think they can. They
20 can't pull anything from the evidence, just like a
21 gun or anything else.

22 MR. MARTIN: I don't know. I will let this be
23 your fight.

24 MR. ESCOBAR: That's an easy fight. It is
25 admitted into evidence. You can't get it.

1 THE COURT: Well --

2 MR. ESCOBAR: Judge, listen. It would benefit
3 me, but that's not the right thing to do.

4 THE COURT: No, it's not. They would put those
5 x-rays over every station. It would be chaos. I'm
6 afraid this is not the first time we'll have this
7 issue, but for right now I'm just going to say no.

8 MR. ESCOBAR: I can tell you what the problem
9 is, is that the camerawoman right there is --
10 instead of taking pictures that she should have been
11 taking, okay, she was -- she had the phone. She had
12 her camera on Dr. Foley. It's her fault.

13 THE COURT: Okay. And as a practical matter,
14 there are no copies available at this time, so that
15 would be a no, and I'm sure we are going to have to
16 talk more about this and other issues.

17 MR. GARCIA: They can file their motion in the
18 morning.

19 THE COURT: Yes. I'm going to -- my response
20 is going to be that there are no copies available at
21 this time and --

22 MR. ESCOBAR: The only thing that I would ask
23 you to do, if they're going to file motions and we
24 will have hearings, that we have those hearings
25 after my expert testimony tomorrow. They've come

1 from Virginia and they're expensive.

2 THE COURT: Absolutely. It's not my priority.

3 MR. GARCIA: May it please this Court, Counsel.

4 CROSS-EXAMINATION

5 BY MR. GARCIA:

6 Q. Mr. Sassani, good afternoon, sir.

7 A. Good afternoon.

8 Q. Mr. Sassani, it is my understanding that you
9 obtained a copy of the printout from Mr. Escobar in
10 reference to the trailers that were being shown at the
11 Cobb Theater back on January 13th of 2014?

12 A. That is correct.

13 Q. And then you were -- from that list you were
14 able to obtain the trailers, correct?

15 A. That's correct.

16 Q. And you are able to authenticate that you were
17 able to download them onto the disk that we saw?

18 A. Correct.

19 MR. ESCOBAR: I don't want him to lead. It's
20 improper. I mean, I know it's cross but, you know,
21 it's his witness. At this point in time, we're just
22 going out of turn, so I will object to any leading.

23 If he wants to ask him questions, he can ask
24 him questions. I'm sure Mr. Sassani will oblige.

25 THE COURT: Let's make this correct

1 procedurally.

2 MR. GARCIA: That's fine, Judge.

3 THE COURT: So I'll sustain.

4 Before you go too much further, have him spell
5 his name for the record, please.

6 MR. GARCIA: Okay.

7 BY MR. GARCIA:

8 Q. Mr. Sassani, if you could, please, could you
9 state your full legal name?

10 A. Sure. My name is George Eugenio Sassani, and
11 did you want me to spell my last name?

12 Q. Yes.

13 A. S-A-S-S-A-N-I.

14 Q. Thank you.

15 A. You're welcome.

16 Q. The printout that you received from Cobb
17 Theater, what does it tell you?

18 A. Well, it gives a list of the trailers
19 themselves. It lists the production codes of those
20 particular trailers that help identify a specific
21 trailer. It gives the running times of the trailer and
22 the studio that produced the trailer.

23 Q. So it essentially tells you when the trailer
24 ran, the time that it ran?

25 A. And the order. That is correct.

1 Q. Does it tell you the lighting condition at the
2 time the trailer ran?

3 A. Well, the remainder of the page, that data is
4 there included on the paper, but it wasn't necessary for
5 what I did. I didn't use that information in any way.

6 Q. Okay. So let me ask you, though, are you
7 familiar with the different levels at the different
8 theaters?

9 A. Sure.

10 Q. Do you know what Mid Level 1 is?

11 A. No, I don't know.

12 Q. You don't know?

13 A. No.

14 Q. My next question -- and I don't know if you
15 know this or not -- would Mid Level 1 be the same at Cobb
16 Theater as it would at another theater?

17 A. No.

18 Q. They're different?

19 A. Yes.

20 Q. So all the theater lighting is different?

21 A. Yes.

22 Q. All right. Now, as to the trailers that we saw
23 here in court today, are they a true and accurate
24 representation of what a patron would have seen back on
25 January 13th, 2014?

1 A. Yes, they are.

2 Q. The content?

3 A. The content.

4 Q. But as far as the surround sound and the
5 lighting, you would agree with me it's not a true
6 representation, what we are seeing here and what we would
7 see in the theater is once it was played again?

8 A. Yeah. What you see on a television isn't going
9 to match what you see on a movie screen, obviously.

10 Q. Okay. In fact, the only way to reproduce these
11 trailers --

12 MR. ESCOBAR: Objection. Leading.

13 MR. GARCIA: I'm sorry, Judge.

14 BY MR. GARCIA:

15 Q. Is it fair to say that the only way to
16 reproduce this exact trailer --

17 MR. ESCOBAR: I'm going to object. It's still
18 leading. Is it fair to say: Bang, bang, bang?
19 Yes, it's leading.

20 MR. GARCIA: Judge, as long as it calls for a
21 yes-or-no answer, that's not a leading question,
22 so...

23 MR. ESCOBAR: Judge, to save time, I will
24 withdraw the objection.

25 THE COURT: Thanks.

1 BY MR. GARCIA:

2 Q. The only way to reproduced these accurately,
3 you would agree, would be in the movie theater, correct?

4 A. If you want to reproduce the way they looked at
5 that time, yes.

6 MR. GARCIA: Okay. Thank you, sir.

7 I don't have any other questions, Judge.

8 THE COURT: Okay. Any cross?

9 MR. SHAH: No, Your Honor.

10 THE COURT: May this witness be released?

11 MR. SHAH: Yes, Your Honor.

12 THE COURT: Thank you, Mr. Sassani. You're
13 free to go.

14 THE WITNESS: Thank you.

15 (Witness excused.)

16 THE COURT: Counsel, I believe that's the end
17 for today; is that correct?

18 MR. ESCOBAR: That's correct.

19 THE COURT: Very well done. We are good
20 planning on everyone's part.

21 MR. GARCIA: Judge, we're going to need a list
22 of witnesses for tomorrow.

23 MR. ESCOBAR: They will be e-mailed tonight.
24 We don't have them right now. We've got to meet
25 with one of our experts. Assuming everything is in

1 line, like I said, every night we'll do that, e-mail
2 it to you.

3 MR. GARCIA: Judge, I'm going to object. I
4 mean, at night? What is "at night"? It could be
5 10:00.

6 MR. ESCOBAR: I'm not doing an 11:00 showing
7 like Mr. Martin did. I will do it within an hour or
8 two.

9 I promise as soon as I get all my witness lined
10 up, and I know that they're all going to be there, I
11 will immediately send an e-mail.

12 THE COURT: All right. There is no question
13 that you have all been tied up today, so I
14 understand the request and the response. Certainly
15 it will be within a reasonable time.

16 MR. ESCOBAR: I promise, Your Honor.

17 THE COURT: I'm not seeing a tremendous
18 prejudice to that. You guys know who the witnesses
19 are. It's just the order. We're all planning on
20 being here every day --

21 MR. ESCOBAR: Judge, I will give it to him by
22 7:00.

23 MR. GARCIA: I thought it would be the close of
24 business every day so we could start preparing for
25 the next morning? I mean, that was my understanding

1 the last time we met.

2 We don't need to know the order. I mean, they
3 have to know kind of who they intend on calling. I
4 mean, that's all we are asking for is --

5 THE COURT: Ballpark?

6 MR. ESCOBAR: Ballpark, I could give that to
7 him right now.

8 MR. GARCIA: Yeah. That's all we're asking,
9 Judge.

10 MR. ESCOBAR: Bruce Koenig. As can you see,
11 Bruce Koenig will be really long.

12 Thomas Peck, Joanna Turner and Vivian Reeves is
13 what our list was supposed to be. I just need to
14 make sure Mr. Peck is going to be available. That's
15 the one that -- I think the one that's giving me
16 some concern.

17 THE COURT: Okay. We won't hold you to an
18 exact --

19 MR. GARCIA: That gives us an idea. Thank you,
20 Mr. Escobar.

21 MR. ESCOBAR: You're welcome.

22 THE COURT: Any other matters we need to
23 address tonight?

24 MR. ESCOBAR: No.

25 THE COURT: The matter that was just brought to

1 my attention, we need to --

2 MR. ESCOBAR: There is one matter, Your Honor.

3 As the Court knows, Mr. Reeves is on pretrial
4 release. We have changed my office now to Lake
5 Jovida, so I need Mr. Reeves, obviously, in
6 preparation to be able to come to my townhome there
7 for preparation. So I would ask the Court to allow
8 us to do that.

9 THE COURT: Absolutely.

10 Okay. All right. Any other matters, issues
11 that just arose? I anticipate more of that, so
12 please be pondering that and how we're going to
13 respond and in what fashion and when.

14 Other than that, we will be in recess until
15 9:00 tomorrow morning, and well done, everybody.

16 Thank you.

17 (Proceedings concluded for 02/20/17.)

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