EXHIBIT A

UNITED STATES DISTRICT COURT
WESTERN DISTRICT OF NEW YORK

UNITED STATES OF AMERICA,	*	Docket Number: 1:22-CR-00035-JLS-HKS-1
	*	
	*	Buffalo, New York
v.	*	February 18, 2025
	*	1:33 p.m.
	*	
LUKE MARSHALL WENKE,	*	EVIDENTIARY HEARING
	*	
Defendant.	*	
	*	

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TRANSCRIPT OF PROCEEDINGS
BEFORE THE HONORABLE JOHN L. SINATRA, JR.
UNITED STATES DISTRICT JUDGE

APPEARANCES:

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Proceedings recorded by mechanical stenography, transcript produced by computer.

(Proceedings commenced at 1:33 p.m.)

THE CLERK: All rise.

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

THE COURT: Please be seated.

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

Appearing for probation is Matthew Zenger.

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

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

THE COURT: Good afternoon, Counsel and good

afternoon, Mr. Wenke.

I understand, Mr. Passafiume, that you wanted to be heard at the outset today. So, please --

MR. PASSAFIUME: Thank you. And I hope it's okay with the Court if Fonda jumps in. Of course, she's got more experience than I do.

But the bottom line is, if the goal of the Court is to medicate and possibly force medicate Mr. Wenke, we don't believe a sending him back to the BOP under this statute accomplishes that.

And there is a way -- fortunately, if that's the Court's goal, there is a way to do that, and there is a way to follow Dr. Leidenfrost's recommendations locally.

And we -- I guess, would like to explore that route, which is a route that none of us knew existed. But after talking with Dr. Leidenfrost, there is a possibility that that could happen.

And it would, I think, make everybody happy. It would get the evaluation that Your Honor wants. It would get the medication that Your Honor wants.

It would keep Mr. Wenke local with the family support, which I think would be crucial to any type of treatment.

And, frankly, sending him back to the BOP, they would have to completely reject their findings and their competency evaluation, and I don't think that's going to happen.

I don't think that has ever happened, where you are going to have two different BOP reports saying completely different things.

THE COURT: They are asking different questions.

MR. PASSAFIUME: But the questions -- I don't know if they are necessarily different questions, because there is a different goal.

But the diagnoses and the observations -- and it is going to be the same. They are going to overlap.

THE COURT: And I don't, Mr. Passafiume, have any kind of, like, thought process on where things ought to be.

I don't have a thought process on whether he ought to be medicated or not. You know what I mean?

That's the whole point of the hearing.

MR. PASSAFIUME: I'm sorry, Judge. Sure.

THE COURT: And the idea of what has to happen is, I guess, if -- if the case has been made that he's in need of hospitalization, then, I guess, it's their decision to decide what's next. Not mine.

MR. PASSAFIUME: Sure. And speaking to that point -- because he was already found competent -- even if Your Honor, again, adopts Dr. Leidenfrost's report in whole, that -- that says -- you know, there is a chance that Mr. Wenke might need to be force medicated, that's not going to happen at the BOP.

They can't -- he's already been found competent.

There no *Sell* hearing. There's none of that stuff.

So, again, if Dr. Leidenfrost's opinion is Mr. Wenke needs medication, and maybe to be forcibly medicated, that's just not going to happen at the BOP.

THE COURT: Well, what is this path forward that you think might exist?

MR. PASSAFIUME: So -- and I would -- if Your Honor wants to hear directly from Dr. Leidenfrost -- I'm sorry to put him on the spot, but, you know, he explained a way where Mr. Wenke could go from jail to the ECMC CPEP unit, where then he could be involuntarily admitted.

They would -- they could then, you know, ask -- an attending psychiatrist would be there. Would make a further finding, if there needs medication.

Again, what Your Honor is talking about, the attending psychiatrist there would take the next steps.

And if, by chance, whatever attending psychiatrist says, you know, Mr. Wenke does not need to be here, he does not need to be medicated, we would know that finding ahead of time, and Mr. Wenke would return to custody.

It would be a condition of release that -- that he go directly to the ECMC CPEP and follow all the recommendations.

THE COURT: So when I sent him to ECMC the last time, was that -- did I use the wrong address or I didn't pick the right doctor's office or what happened?

Why didn't that accomplish that goal then?

MR. PASSAFIUME: That's right, Judge. And I don't know, because Dr. Leindenfrost -- I didn't know that Dr. Leidenfrost had this affiliation with ECMC.

You know, that's me. I guess I should have known that and this should have come up earlier.

But that's where Dr. Leidenfrost comes in, where he could help facility that.

Mr. Wenke just appeared voluntarily there. He wasn't brought there by any law enforcement or ambulance or by anything like that.

And he didn't get the evaluation that he would have gotten in that CPEP unit -- that comprehensive psychiatrist program that ECMC has.

And there is a way to ensure that he does get that and that he would only be released for that.

We would coordinate -- the day of the evaluation would be the day of his release, where they would wait for him to take him in.

They would do that evaluation. They make a determination if he needs to be in voluntarily committed.

We don't know what's going to happen then, but according to Dr. Leidenfrost, there is a good chance that he would be. And if he's not, he would just come right back.

And, again, this happened before, to the custody of

his dad and there was no issue. He just didn't get that evaluation that we all wanted.

But now that we have Dr. Leidenfrost and we're at this stage of having the proceeding, there is a way to get all that.

THE COURT: Whose custody is he in while this all happens?

MR. PASSAFIUME: He would be released to -- with the condition saying that he needs to abide by all the recommendations of ECMC.

THE COURT: All right. So maybe. But is there any reason why we shouldn't proceed with the hearing anyway, so I can at least get the facts from Dr. Leidenfrost on his opinion, cross-examine it, as you see fit.

And then I can perhaps examine the options at that point?

MR. PASSAFIUME: I don't necessarily think so, Judge. The statute says, shall commit to the custody of the Attorney General.

THE COURT: If I make the finding, right? I don't have to make the finding just yet.

MR. PASSAFIUME: No, you don't.

THE COURT: Right.

I don't have to do it on the spot sitting up here. I can do it in writing and think about it for a period of time.

MR. PASSAFIUME: I guess that's right.

THE COURT: Otherwise, we are wasting his time having come here ready to testify.

MR. PASSAFIUME: No. I don't think we would be wasting his time. He could give testimony and I think the questions would be the same as the Government's about the treatment and suitable facility.

You know, that's what we have always wanted. That's been the issue the entire time.

THE COURT: Right.

MR. PASSAFIUME: It doesn't necessarily need to be a hearing. You know, he can just come in. He can talk to you right now and tell you what that is.

You know, as far as -- I'll leave it at that, Judge. If guess you want to call it a hearing, do a hearing that a way, but it would just be everything that I said to you with more specifics coming directly from the doctor.

MR. WRIGHT: A couple of things, Your Honor. So, first, obviously, the Government has some concerns relating to this proposed release, if the Court would consider that.

I think, first, you have a defendant who was examined by Dr. Leidenfrost under this violence risk assessment where a determination was made of the violence that he does present as a result of a mental disease and defect.

Relating as well, Your Honor -- so catching up to speed relating to a couple of things. But, for instance, what I

expect Dr. Leidenfrost to talk about is, number one, he didn't examine the defendant for competency.

There was this determination by BOP where they found him competent. But I expect Dr. Leidenfrost to talk about some differences in opinions relating to that issue specifically as well, Your Honor.

So, obviously, the Government has some concerns about the proposed solution, Your Honor. And we'll leave it to the discretion of the Court of how it wants to proceed.

MS. KUBIAK: Judge, if I could interject --

THE COURT: Sure, Ms. Kubiak. Give me one second to catch up to both of you. Hold on.

Okay, Ms. Kubiak.

MS. KUBIAK: I just want to clarify a couple of things based upon what the Government just said.

As I am aware, the Court has already made a finding reflective to competency. So for the Government to put on Dr. Leidenfrost to refute or dispute that finding is not what I understood the hearing to be. That the hearing was under 4244 and a provisional sentence.

If we are now relitigating competency, that's a different situation.

And as I think Mr. Passafiume is trying to indicate, that 4244 is basically a mechanism in the statute for individuals to not be incarcerated at a Bureau of Prisons

medical facility, but to be hospitalized somewhere else.

And because he's competent, there wouldn't be that mental -- or there would not be that treatment, because the Bureau of Prisons has found, one, that he is competent.

And, two, that he is not suffering from mental disease or defect.

So Mr. Passafiume's recommendation is, if the goal is to get treatment, there is a different mechanism.

MR. WRIGHT: And, Your Honor, just to clarify, this isn't going to be a 4241 hearing or proceeding.

The reason I raised that was when the defense argued that because the defendant was previously found competent by BOP, the 4244 proceeding or process wouldn't work, because they wouldn't treat him for a mental disease or defects because they already found him competent.

The reason why I raised is that, based on information that possibly Dr. Leidenfrost would talk about, would seek that he be reexamined for competency.

THE COURT: Okay. Well, look, we're in 4244. We're beyond competency.

And I don't think there is anything that happened on the competency evaluation that binds me going forward. I really don't.

I read everything that came from BOP the first time around and it is speaking to a different question.

So 4244, however, requires the hearing. And it says, if, after that hearing, I find by a preponderance of the evidence. Okay?

So I don't have to make any findings if your off ramp is suitable and appropriate. But there is no reason, I don't think, to get this testimony on the record, so that the record exists. And then we can decide whether it's one path or the other at that point.

MR. PASSAFIUME: Yeah. You have three reports in front of you, Judge. You have both Dr. Leidenfrost and the BOP report.

We could --

THE COURT: I know, but we're here and ready and this is the hearing and he's here.

And why would -- why would we stop short of that on an if come that this plan might work?

MR. PASSAFIUME: That's right. Sure.

THE COURT: Why not put him on the stand and adjust the statutory requirement of him being here to testify?

And then if you want to, while he's here, tell me about this other plan. I'm happy to hear it.

MR. PASSAFIUME: Sure.

THE COURT: I've got my thinking cap working. I didn't have it working this morning when you were with me, but it's working now.

MR. PASSAFIUME: Sure. Your Honor. That's right.

The Government just said, though, they are -- you know, Dr. Leidenfrost is going to opine that 4244 wouldn't work.

That he would need -- Mr. Wenke being "he" -- a reevaluation of competency and all that stuff, so --

THE COURT: Yeah.

MR. PASSAFIUME: -- we're all -- I think we're all on the same page.

THE COURT: I don't know what any of that means. I really don't.

MR. PASSAFIUME: Okay. I guess we'll see.

THE COURT: I really don't. All I know is we're teed up under 4244 here, so I don't know what Mr. Wright is talking about.

MR. PASSAFIUME: I don't know if I misunderstood what the Government said, though.

THE COURT: You want to try again?

MR. WRIGHT: No. This is a 4244 hearing, Your Honor.

THE COURT: Okay.

MR. WRIGHT: I was just trying to address the concern relating to, if we proceed with a 4244 proceeding, and the Court renders its decision, that he is in need of a -- of a -- to be hospitalized for treatment --

THE COURT: Right.

MR. WRIGHT: -- this whole issue of -- well, BOP has

already found him competent, et cetera.

That's what I was trying to provide some more insight on, but this is a 4244 hearing, Your Honor.

THE COURT: Okay. I don't think we're, right now, at cross purposes, so I think we ought to proceed.

MR. PASSAFIUME: Okay.

THE COURT: And when we are done listening to the evidence, if you have got any additional evidence, we'll put it on, and we can talk about what our next steps are.

I can certainly proceed and write up findings or you can convince me maybe that isn't what I should do. I should sit on the evidence for a moment and I should consider an alternatively off ramp, if you will. I'm certainly happy to do that.

MR. WRIGHT: Yes, Your Honor.

The Government calls Dr. Corey Leidenfrost.

THE COURT: Please remain standing for a moment.

THE CLERK: Can you raise your right hand?

COREY LEIDENFROST,

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

THE WITNESS: I do.

THE CLERK: Thank you. Have a seat.

Can you please state your full name and spell it for the record?

THE WITNESS: Sure. Corey Leidenfrost. C-O-R-E-Y L-E-I-D-E-N-F-R-O-S-T.

THE COURT: Mr. Wright.

MR. WRIGHT: May I proceed, Your Honor?

THE COURT: Yes.

DIRECT EXAMINATION BY MR. WRIGHT:

BY MR. WRIGHT:

Q. Good afternoon, Dr. Leidenfrost.

A. Good afternoon.

Q. Where do you work?

A. I work for a university psychiatric practice, which is part of the UB department of psychiatry.

Q. Where did you go to undergrad -- undergraduate school?

A. City of Brockport.

Q. What did you receive your degree in?

A. I have a Bachelor's Degree in Psychology and a Master's Degree in Psychology.

Q. Did you receive any further education after that?

A. Yes. After my undergrad, I went to SUNY Brockport and got a Master's Degree in Psychology. And then I went to Walden University and got a PhD in Psychology.

Q. Do you have any licenses in the psychology as well?
A. Yes. I'm a licensed psychologist in New York State.
Q. Are you a member of any boards and organizations as well?
A. Yes.
Q. Can you explain some of them?
A. American Psychological Association, the American Psychological Law Society, and the Society for Personality Assessment.
Q. Okay. Do you have experience handling forensic examinations?
A. Yes.
Q. Okay. These are psychological forensic examinations?
A. Yes.
Q. Can you provide some examples of the types of forensic examinations you have provided in the past?
A. Yes. Mostly many, many competency evaluations in New York State. I've conducted sex offender and violence risk assessments.

I've done cases regarding mental health mitigation for sentencing. I've done Domestic Violence Survivor Act cases.
Q. You mentioned competency examinations. Is that referred to as a 4241 examination as well?
A. Yes. 730 in New York State, but, yes.
Q. Okay. But Federally it's a 4241 examination?
A. Yes.

Q. Okay. What about -- have you ever heard the expression a 4244 examination?
A. Yes. I've heard of it.
Q. I'm sorry, 4244 examination.
A. Yes.
Q. And what is that?
A. I believe that is potentially need for treatment, due to mental illness.
Q. Okay. And you mentioned conducting violence risk assessments?
A. Yes.
Q. And what are those?
A. So that is making a determination, usually using some sort of structured tool to provide an opinion about somebody's risk for future violence and imminent violence.
Q. Okay. And based on the type of forensic examination that you are doing, are there types of different psychological assessments that you use, depending on which one you examine?
A. Yes.
Q. Okay. So based on your experience, is it fair to say that you have experience diagnosing various types of mental illness?
A. Yes.
Q. I'd like to just define some terms for the Court, so we can have some context.
Can you provide a definition of delusions?

A. Yes. A delusion is a strongly held belief that an individual has that is not true and it is not congruent with an individual's culture, religion, political affiliation.

Oftentimes, delusions can occur by themselves, as part of a delusional disorder or they often occur as part of a different psychiatric illness.

Q. And the definitions that you are using, are these psychiatric definitions?

A. Yes.

Q. These are definitions that are generally accepted in your field?

A. Yes.

Q. Okay. Related to delusions, are there different types of delusions?

A. Yes.

Q. Can you explain some examples?

A. Yes. Some of the most common are paranoid, persecutory, grandiose, erotomanic.

Q. What are some symptoms that you look for when you are considering diagnosing someone for delusions, for instance?

A. For a delusion, I'm curious about what the belief is and how the person came to believe what they believe.

As I mentioned, the need to evaluate whether this belief system is congruent with something in the culture or religion or political affiliation.

A key differentiation between delusion and overvalued ideas or extreme beliefs is oftentimes the idiosyncratic nature of the belief.

Meaning that, this person's belief deviates from what is common in the culture. I can give an example, if that's helpful.

Q. Sure.

A. Say I believe that there are vampires after me. They're in my house. They're in my walls and I'm scared and I maybe start chopping the walls apart to find the vampires. That would be delusion.

That is something only I hold. It is idiosyncratic to me. It's causing functional problems.

Versus an overvalued idea. An example would be people who believe that the earth is flat. That is not a delusion, because it's a strongly held culture belief.

It's strongly held, even though there is facts to suggest that is not true. People continue to believe it.

But because there is large groups of believe that believe it, it is not delusion. It's an overvalued idea.

Q. Mania, how would you define mania?

A. So mania is a mood episode. And what is really significant about this is, when people have a manic episode, they have a marked change of their personality and behavior. So they are acting in ways that are not typical to them.

People that have manic episodes, it's not usual for them to suffer from depression or hypermania beforehand, which is a less severe type of mania.

Mania is characterized by abnormal and persistent alterations of a person's mood. They are elevated, expansive or irritable.

But there's also a significant change to the person's activity and energy levels.

Q. Okay.

A. There is seven symptoms. You need three symptoms to diagnose.

Symptoms include, like, reduced need for sleep, distractibility, pressured speaking, engaging in behavior that has a high potential to be dangerous or ruinous to the person, they keep engaging in it even with negative consequences.

Q. Okay. A couple more. Psychosis?

A. So psychosis is a broad term for different symptoms, which would include hallucinations, delusions, disorganization of one's thoughts, disorganized behavior or catatonic behavior or a series of negative symptoms.

Q. Okay. Bipolar I disorder?

A. So bipolar I means, an individual has experienced at least one episode of mania in their life time. That's all you need, is evidence the person experienced a manic episode.

They may have experienced a depressive episode as well, but

the key component is experience of the manic episode symptoms lasting for at least a week.

Q. What are some examples of those symptoms?

A. Yeah. Like I mentioned, the decreased need to sleep, destructibility, more talkative than usual or pressured speech.

Increased in goal-oriented activity or psychomotor agitation, engaging in behavior that's dangerous or reckless.

Q. Are you familiar with a term, a psychoactive schizoaffective?

A. Yes.

Q. What is that?

A. So, we'll get in the weeds a little bit, I apologize, but I'll break it down.

With psychiatric illnesses, neurobiologically what's happening in the brain is very similar. So illnesses can look very similar to each other.

Schizoaffective disorder is very similar to bipolar disorder. And what happens is, somebody experiences symptoms of a major mood disorder, like bipolar and at the same time they are experiencing psychotic symptoms.

It would often seem like schizophrenia, so they co-occur. And on top of that, there is periods of time where the person does not have major mood symptoms, but they continue to be psychotic for at least two weeks.

Q. Okay. Are you familiar with the defendant, Luke Wenke?

A. Yes.
Q. Okay. And when did you first meet him?
A. January of 2024.
Q. And why was that?
A. I was approached and asked to conduct an evaluation to determine whether he was dangerous, due to a mental disease or defect.
Q. Did you end up meeting him in person at some point?
A. Yes.
Q. And when was that?
A. Late January, 2024.
Q. Okay.
A. Or was that -- I'm sorry. It was in March. It was March. I'm sorry.
Q. If I say it was around, like, March, 2024 --
A. Yes.
Q. And we'll take a step back. Where did this examination occur?
A. I believe it was Orleans County Jail.
Q. Okay. And what was the reason for you meeting with him at that time?
A. It was part of the process to conduct a violence risk assessment, but also to determine whether he had a mental disease or defect.
Q. And what is a violence risk assessment?

A. So that has a number of steps, which involve use of some sort of standard decision-making tool to guide.

Doing a violence risk assessment, it often includes conducting an interview and then reviewing whatever evidence I can get my hands on; treatment records, medical records, letters, social media, whatever -- as much information as one can gather.

Q. Okay. And here you conducted that initial evaluation in person, with the defendant?

A. Yes.

Q. Okay. And at some point did you issue a report relating to your findings?

A. Yes.

MR. WRIGHT: Okay. May I approach, Your Honor?

THE COURT: Yeah.

BY MR. WRIGHT:

Q. I'm showing you what's been marked as Government Exhibit 1.

A. Thank you.

Q. I'll have you take a look at that. Are you familiar with that document?

A. I am.

Q. And what is that?

A. That is my report that I generated on April 1st, 2024, based upon my meeting with him on March 5th, 2024 -- Mr. Wenke.

Q. Is that document a fair and accurate representation of the

report that you filed -- or submitted?
A. Yes.
MR. WRIGHT: Your Honor, I would like to move it into evidence. I know the Court has reviewed this, but just for the record's sake.
THE COURT: Any objection?
MR. PASSAFIUME: No, Judge. We can stipulate to all the reports. That's fine.
THE COURT: All right. Exhibit 1 is admitted.
The following was received in Evidence:
GOVT. EXH. 1 UNDER SEAL

MR. WRIGHT: And the report will remain under seal, Your Honor? I know there's some --
THE COURT: All right. So just work through that issue with Ms. Henry.
So Exhibit 1 under seal.
MR. WRIGHT: Will do, Your Honor. Thank you.
THE COURT: All right.
BY MR. WRIGHT:
Q. Dr. Leidenfrost, can you provide some examples of the sources of information that you used as part of your evaluation of the defendant from this April -- March, 2024 time period?
A. Yes. I was provided with over a dozen letters to the Court from Mr. Wenke. I was provided segments of information from

social media, including X, Twitter, Facebook.

I located articles completed by local news sources. I was provided with the piece -- presentence investigation.

I reviewed a report from Dr. Rutter. I believe it was completed around July 2023. And then used a risk assessment tool.

Q. Okay. You mentioned a report from Dr. Rutter. Was that a psychological report assessment?

A. Yes.

Q. And was that focused on the violence risk assessment or was it something different?

A. If I remember correctly, it was evaluating a presence of mental health concerns.

Q. Okay. And do you recall what the diagnosis was from that report?

A. Unspecified bipolar disorder, hypomania and borderline personality traits, I believe.

Q. Okay. You mentioned reviewing letters as well?

A. Yes.

Q. What are some examples of the letter that you reviewed?

A. These are letters that Mr. Wenke wrote addressed to the Court, specifically. I think most of them were to Your Honor.

Q. Okay. Were there letters from other individuals as well?

A. Yes. There was a letter from KB.

Q. Okay. Are you familiar with the psychological evaluation

assessment tool, History, Clinical and Risk Management 20, Version 3?

A. Yes.

Q. What is it?

A. So that is a well regarded and probably, if not the most popular violence risk assessment tool in the world.

It is a standard decision-making tool to help one guide in making an opinion about somebody's risk for violence.

Q. Okay. And when is this tool usually used?

A. This tool is used, A, somebody is in a correctional facility or a psychiatric hospital, considering the person for release and making plans about this person's risk for violence.

It is also used prior to sentencing to make determinations about somebody's risk for violence that may guide what happens in court.

Some are also used as a treatment tool to help come up with treatment tool to manage somebody's violence risk.

MR. PASSAFIUME: Judge, a quick objection to the testimony regarding the violence part of this.

I don't believe that -- we're here for the determination of whether Mr. Wenke has a mental disease or defect, not whether he's violent.

That is a separate proceeding. We would object to the testimony regarding the violence assessment.

THE COURT: Mr. Wright?

MR. WRIGHT: Your Honor, the violence assessment ties into the mental disease and defect conclusion that Dr. Leidenfrost is going to discuss of how he reached that conclusion, which is tied to later on his second evaluation that he did in January, 2025. So it's all tied together, Your Honor.

THE COURT: I don't disagree, Mr. Passafiume, with you in terms of what the statute requires.

But there is -- in my view, it's part of his thought process, so I'm going to allow it.

Overruled.

BY MR. WRIGHT:

Q. So I'm just going to briefly have you discuss, what are you examining when you do this history, clinical and risk management evaluation?

A. So it includes static and dynamic risk factors. So there is ten potential risk factors in the history item. Those are the static items, so risk factors that do not change.

There is five items in the clinical section and those are dynamic. So these are risk factors that should change.

And the remaining five are the risk management factors. These are things to consider if this person's being released in the community, what are the things that you should be concerned about in managing their violence risk and that may contribute to the violence risk.

Q. We don't have to go through all ten, but for the first

portion, the static portion, is that like the historical items portion?
A. Yes.
Q. And can you just provide a brief description of what items you are looking for? That aspect of it?
A. So these include history of evidence of mental health problems, history of personality issues, adherence to mental health treatment or adherence to other efforts of supervision in the past.
Q. Okay. And for that static portion, is that the clinical scale? Is that another term for that portion?
I mean -- I'm sorry, dynamic portion, I should say. The dynamic aspect of it --
A. Is the clinical.
Q. -- for the clinical portion?
A. Yes. The five items in the clinical are the dynamic. And there are -- many of them are similar to the history items, but the time frame is different. It is right now and recently versus history.
Q. Okay. And this HCR Version 3 -- 20 Version 3, this is a common accepted -- I'm sorry -- commonly accepted assessment tool in forensic examinations?
A. Yes.
Q. Okay. So I would like to turn your attention to that examination that you did with Mr. -- with the defendant.

Can you talk about, kind of, the process that you went through and what you recall of that examination?

A. So the risk assessment involves extensive data collection, including an interview.

And there -- for each risk factor, there is a manual that lays out how you are supposed to score each item.

You make a determination whether the risk factor is present for the individual and then a determination of whether that risk factor is relevant for the person you are evaluating.

So the interview, collateral information, the letters -- again, all the data that I have, using the definition for each item, I'm seeing whether there is enough data to support that item as present, or probably present, or not present.

And then whether that data supports whether that risk factor is a relevant one to this person's violence risk, from low, moderate or high.

Q. Okay. Relating to your examination of the defendant, what were some items that you discussed and what do you recall relating to the defendant's interaction with you during that evaluation?

A. So particularly was the evaluation for a mental disease or defect, and that was an item in the history, and also an item in the clinical.

So does the person show evidence of having mental illness in the past and do they currently show evidence of mental

illness.

So that was guided by my interview with the defendant, observations during that interview, along with review of all the other information, the letters to the Court, social media, to establish that history. And then the interview is establishing the present mental health issues.

Q. Okay. Were there certain discussions that you had or that the defendant had with you about certain specific individuals?

A. Yes.

Q. And can you provide some context to the Court of those discussions and why those discussions were important in your overall examination?

A. So to go to my concerns, how I reached that there is paranoid, persecutory and grandiose delusions, namely the paranoid and persecutory, was the defendant's fixation on particular individuals.

I'm know we're going to avoid full names. I'm just going to use initials.

Particularly this belief regarding RT, and how he spoke about RT, and the behaviors that were associated with that, including traveling 14 hours straight to a different state to rescue the individual, after not really knowing the individual, spending about two weeks with the person.

Based upon the available data, I came to believe there is erotomanic delusion for RT.

That is based upon -- the definition of erotomanic delusion is believing that another individual is infatuated and in love with you, and there are outside forces at play trying to prevent you from realizing that relationship.

So that infatuation is there. The defendant told me his belief that RT is infatuated with him. And I believe that is imported in collateral information as well.

He also believes that there are forces, including the courts, BT, KV, RG, they are all working to prevent that relationship from being realized.

The paranoid persecutory is -- what I found peculiar in that preoccupation, particularly with KV. He used to be a friend of the defendant.

And in her letters to the Court, she talked about that the defendant had a personality behavior change at some point, I think around 2019, 2020.

And he's fixated on her, which is clear -- clear based upon social media, the letters and his statements.

It was difficult to get him to talk about much of anything else other than these individuals. Believing that KV is breaking into his home, is posting his personal information on the Internet.

Something to do with a car that I never quite figured out what was occurring. And to the degree that she sought an Order of Protection and expressed to the Court she was so afraid she

was considering changing her name and changing her appearance.

What I found peculiar then was -- there is a term called loose associations, where you take information and you connect them together, but they don't really connect.

So the defendant's belief that somehow RG is involved with KV; that KV was working for RG, even those these are individuals that, to my knowledge, have no prior knowledge of each other.

And his reasoning for why that was true was, well, she was looking for work.

Then this association with BT, which is, I believe, the father of RT, to the degree he sought an Order of Protection because he was harassing him.

And then his, I think, admitted harassment of RG leading to an Order of Protection, through over sentimental e-mails, voicemails, showing up at the office, just clear fixation.

But also believing that RG was setting up false profiles on apps to communicate with the defendant, which he insisted he knew was true because he felt like the writing was consistent.

So these are just some of the examples that I thought contributed to delusional thinking.

Q. Okay. You mentioned this initial -- or person, RT, related to this discussion of delusion and the fixation aspect of it that you discussed earlier.

Were there any -- can you discuss the interaction with psychic mediums and how that played in?

A. So, when I evaluate whether somebody has a delusion, I want to look at how they know this is true, like what's supporting it.

And one thing that the defendant indicated was, a second medium told them they are destined to be together.

And that in itself is not problematic. You know, there are people that believe in psychics. People that believe in spiritualism, so that can be a culturally congruent brief.

But that belief in context, with all the other things that I mentioned that he believes ties him to RT makes it a delusion.

So even though part of is culturally congruent, taking that belief that a psychic told you you're going to be together with somebody -- like, even people that go to psychics have some discernment.

Just don't take it blindly. Particularly, this is a person that he didn't know for more than two weeks.

Q. Relating to this issue of your review, you also reviewed items from Facebook pictures.

What did you find there, like from Facebook, relating to weapons or anything like that?

A. So in particular, I looked at a Facebook page called Olean War Zone, which I believe Mr. Wenke started in July of 2020. That group is still active. A couple thousand members.

I found a picture that showed Mr. Wenke apparently with members of the Boogaloo Boys and he was holding what appeared to

be an assault rifle.
Q. Okay.
A. And I think, to add context to that, there is corroboration in other documentation that the Boogaloo Boys supplied him with a weapon in Minnesota, in 2020.
Q. What -- one thing I would like to discuss with you as well is, in your report you mention this issue of problems with insight?
A. Yes.
Q. So let me ask you this: As part of your HCR-20 Version 3 psychological evaluation, what did you mean by this reference of problems with insight?
A. So with that item, there is a history item and a clinical item that has to do with insight that's relevant here. There are three areas you are looking at insight about.
Does the person have insight about their mental health problems?
Does the person have insight about the violence they have committed?
And do they have insight about their need for treatment?
So I evaluated those three areas and I had concerns about all three areas.
Q. Okay. And from your interaction with the defendant, can you provide some specific examples of what problems of insight you found, based on your interaction with him?

A. So with the problems of mental health, I brought up Dr. Rutter's report and that diagnosis of bipolar disorder.

And during the interview, I give him feedback about some symptoms that I thought I saw. And he denied that bipolar was an accurate diagnosis for him and insisted he didn't have a history of mental health concerns.

With the violent insight, I brought up that it was clear he was scaring the hell out of people. And I thought there was a -- not an acknowledgement of the degree of fear he was causing for particular individuals that we've been talking about.

And then as far as need for treatment, we talked about -- you know, he had been ordered to receive mental health treatment as a condition of release.

And I think at one period, he didn't receive it -- didn't seek it. And then in 2023, I think he did seek anger management with Horizons, but he was clearly resentful about it and didn't think that he needed treatment.

So I had concern about his belief that he could benefit from treatment as well. Believing -- insisting that there is nothing wrong with him.

Q. Okay. And based on all of this information and your evaluation, you created what's called a violence risk formulation?

A. Yes.

Q. Can you explain that to the Court?

A. That's one of the last steps, when you complete the HCR-20 Version 3, is this formulation.

That's when you are telling the story of this person's violence risk. You are explaining how you made your determination, what are your sources of data and why you are going to make the conclusions that you are making.

Q. And for that conclusion that you made, you rendered a diagnosis, correct?

A. Yes.

Q. And what was that diagnosis?

A. Bipolar I disorder with psychotic features.

Q. And explain.

A. Versus schizoaffective disorder bipolar type.

Q. Okay. Explain to the Court the interaction between your diagnosis and this violence risk assessment as well.

A. Yes. I believe that all of this seemed to start -- as far as the legal troubles, is this belief about RT and the erotomanic delusion.

Because it seems a lot of this behavior we're talking about expanded from there. Going after RG, because he felt he didn't do a good enough job defending RT. And then somehow it expanded to KV and then it expanded to BT.

And so those delusions and the symptoms of mania, which I think was clouding his judgment, making him disinhibited, impulsive, engaging in behavior that had a high risk of being

harmful, which he did over and over again, I thought those symptoms were one of the main factor that's driving his violence risk.

Because he's clearly delusion. Clearly has some mood symptoms. He's experienced those symptoms at least since 2020, 2019. And they have been untreated.

The main treatment for bipolar schizoaffective is some sort of psychiatric medication. That hasn't happened.

So that is my concern, is the symptoms are present. They haven't been treated. They really seem to be fueling his violence risk.

Q. Okay. And in summary, related to your opinion on his violence risk, what did you find?

A. So there is three determinations for the HCR. For determination of whether a person poses a risk for future violence, I thought he was a high risk.

There is a determination for risk for causing future serious physical injury. I thought he was a high risk.

And then a determination for imminent risk of violence. I thought he was a high risk.

Q. And these risks of violence in the future, the risk of serious physical harm, the risk of imminent violence, this is all based on the mental disease or defect determination that you made?

A. That is one of the main drivers. There are other risk

factors. That is the risk factors I'm most concerned about.
Q. Okay. So I would like to turn your attention to the January, 2025 forensic examination. And this one I will just show you.
MR. WRIGHT: Your Honor, I'm just to approach with Government's Exhibit 2.
THE COURT: Okay.
BY MR. WRIGHT:
Q. Dr. Leidenfrost, did you have a chance to review Government Exhibit 2?
A. Yes.
Q. And what is that?
A. It is the report I generated on January 13, 2025.
Q. And this is a report of your examination with the defendant?
A. Correct.
Q. And is that report a fair and accurate representation of the report that you submitted?
A. Yes.
Q. Okay.
MR. WRIGHT: Similar, Your Honor. I would just like to move that into evidence under seal.
THE COURT: No objection?
MR. PASSAFIUME: No objection.
THE COURT: All right. Under seal, it's admitted,

Government's Exhibit 2.

The following was received in Evidence:

GOVT. EXH. 2 UNDER SEAL

BY MR. WRIGHT:

Q. So relating to the January, 2025 examination, provide some context to the Court about what you are asked to do in that examination.

A. So I was approached about whether I could provide an opinion whether the defendant required treatment in an appropriate facility and whether I can make that determination or if I needed to see him again.

And since it had been almost a year since my last evaluation, I needed to see him again.

So given that question, whether I could offer that opinion, I agreed to do that with the agreement that I needed to see him again, to see if -- how he was doing now, to update essentially that report from last year and his current mental condition.

Q. And tell us more about that interaction relating to you meeting with the defendant.

A. Yep. So I met with him remotely in January for about an hour. But, also, I was provided letters to the Court, including this Court and other judges, along with the BOP report.

Q. Okay. And did you review similar items to what you did in the April, 2024 examination?

A. Yes. Along with a -- so the sources of the data from that first report were relevant, but then updated, based upon the current interview, and then the dozens of letters that I was provided to update my report.

So, really, it gave me a nice timeline of how he was doing in January when I met him, but also an idea of his mental state, as demonstrated through those letters, going all the way back to the last time I saw him in early 2024.

Q. Okay. And as part of your report, did you review a Bureau of Prisons examination?

A. I did.

Q. Okay. And we'll come back to that as well, but let's focus on your report and examination first.

What was your updated diagnosis after your second evaluation with the defendant?

A. Schizoaffective disorder, bipolar type.

Q. Can you say again?

A. Yes. Schizoaffective disorder, bipolar type.

Q. Okay. I'll have you define that later on, but take us back to that interaction you had with him.

How was it different from the previous interaction? How was it similar? Can you explain a little bit more?

A. It was very similar. In fact, before I could explain consent, like why I was meeting with him, what my goal was, what I was going to do with the information, he immediately started

talking about some of these individuals we spoke about before, right off the bat.

I had to stop him to be able to finish consent, informing him what the purpose was.

And similar to the first interview, very often he seemed fixated on KV. And particularly KV and RG, talking about KV over and over again.

I would repeatedly have to redirect him back on topic. I would ask a question, he would diverge to talk about something else. I would have to bring him back and then he would diverge.

But, really, there was evidence of the delusional beliefs, which is oftentimes marked that the person has a difficult time talking about anything else, because they are so consumed by this belief, it's hard for them to shift to other topics.

And that was apparent, again, in this meeting in January.

Q. And you mentioned you found a diagnosis. What was your diagnosis from this January, 2025 interview or evaluation?

A. Schizoaffective disorder, bipolar type.

Q. And what does that mean?

A. So it is very similar to bipolar disorder, where somebody experiences symptoms of a major mood disorder, such as bipolar disorder, and at the same time they have psychotic symptoms such as delusions.

But, for a period of at least two weeks, the person just experiences psychotic symptoms and does not have significant

mood symptoms at the same time.

And so that was based upon this idea of his presentation and the review of the letters, where I wasn't convinced that symptoms of mania are always present.

They seem to ebb and flow based upon the tone of those letters. But the psychotic symptoms seem to be present all the time.

The psychotic symptoms, the delusions seem to be present all the time. I'm not convinced the mood symptoms are always present. That's why I landed on schizoaffective disorder.

Q. In your January, 2025 evaluation, did you have the same concerns relating to delusions and mania and paranoia at that same time as well?

A. Yes.

Q. Similar to the August -- I'm sorry. Similar to the April, 2024 evaluation as well?

A. Yes.

Q. Okay. And you've rendered an opinion as a result of your examination in January of 2025?

A. Yes.

Q. And what was your opinion?

A. That given the current symptoms of a serious mental illness or mental disease or defect, and that the symptoms of a mental disease or defect still significantly contribute to a violence risk, the defendant would benefit from receiving treatment in an

appropriate facility.
Q. Okay. What about this issue of insight? Can you provide some further information relating to the defendant's insight? Were there any changes to his insight?
A. None that I observed.
Q. Okay. You mentioned in your report that the defendant is in need of treatment that includes the use of a psychiatric medication -- or use of psychiatric medication such as one with antipsychotic action.
What do you mean by that?
A. So I need to qualify, I'm a psychologist. I cannot prescribe medication. I think that's important to point out.
I have done inpatient psychiatric work for over ten years and I am familiar with the American Psychiatric Association's guidelines for treatment of bipolar and schizoaffective.
And they make it clear, first line treatment for those disorders is antipsychotic medications.
Q. Okay. And just a couple more things.
I'm going to show you Government's Exhibit 3.
MR. WRIGHT: Your Honor, if I may?
THE COURT: Yes.
BY MR. WRIGHT:
Q. Dr. Leidenfrost -- I'll give you a second to review.
Dr. Leidenfrost, what's in front of you?
A. This is the competency evaluation report from the BOP dated

in November of 2024.
Q. Okay. And this was something that you reviewed as part of your January, 2025 evaluation?
A. Yes.
Q. Okay. And you said that's a competency evaluation. That's -- to be clear, that's different from what you were asked to examine or look at in January of 2025?
A. Correct.
Q. And similarly in April of 2024 as well?
A. Correct.
Q. Okay. You mention in your report having some disagreements on a couple of points in the competency evaluation.
Can you just explain those differences and their importance in your overall diagnosis relating to the defendant's need to be -- need for -- need to be in custody or for treatment in a suitable facility?
A. Yeah. My disagreement is how they derived a diagnosis. They laid out -- the individuals that wrote this laid out their thought process pretty well and how they reached their diagnosis. I disagree with the arguments that they put forth.
One, they argued that the defendant could not have a manic episode, because they argued there wasn't evidence of a clear change in personality or behavior. I disagree.
I think there is evidence to suggest a marked change of personality behavior sometime around 2019, 2020, based upon one

of the things I have discussed before.

They also seem to argue that it couldn't be a manic episode because of the time frame of how long these symptoms lasted.

There is no time frame. The minimum is one week. There is no outer limit. I've worked with individuals who have experienced these symptoms for years without treatment, so there is no outer limit how long they can last.

The second prong is their argument that his beliefs are not delusional. And, curiously, they only focused on the erotomanic delusion for RT, arguing it can't be a delusion because the defendant has beliefs consistent with spiritualism, including going to Lily Dale, which is a spiritualist community south of here.

Therefore, since that is a culturally congruent belief, it can't be a delusion.

I agree, spiritualism is a culture congruent belief. People going to go psychics, people follow that advice.

However, it ignores the other evidence that support the presence of an erotomanic delusion that I talked about a little while ago in my testimony.

Namely, insisting that RT is infatuated with him, insisting that if you do a Google search, the results prove they are destined to be together.

Insistent that individuals under Orders of Protection oftentimes end up to together and believing that outside forces,

including the Court, is preventing him from being together with RT. The BOP report didn't address those other facts.

Q. And you mentioned the psychic portion of it as well. And that ties back to the discussion relating to the psychic from April of 2024 examination that you did.

Is that a fair assessment?

A. Yeah. He indicated that he had talked to a psychic medium who told him they were meant to be together.

And that was part of this evidence that he was meant to be with RT, despite family members having an Order of Protection, despite him sitting in prison. It is incongruent.

So to me, it raised beyond a culturally congruent belief to something that was idiosyncratic for the defendant.

Q. And that's an example of a delusion?

MR. WRIGHT: Give me a second, Your Honor.

THE COURT: Is Exhibit 3 getting moved into evidence?

MR. WRIGHT: Yes, Your Honor. I would like to move Exhibit 3 into evidence.

MR. PASSAFIUME: No objection.

THE COURT: All right. Under seal, Exhibit 3 is admitted.

The following was received in Evidence:

GOVT. EXH. 3 UNDER SEAL

MR. WRIGHT: Just one more question, Your Honor.

BY MR. WRIGHT:

Q. As part of your opinion, you rendered an opinion that the defendant would likely refuse to voluntarily take psychiatric medication.

Is that part of your analysis in why he should be -- is in need of custody, care, treatment at the suitable facility?

A. Yeah. That is part of my concern.

MR. WRIGHT: Okay. Nothing further, Your Honor.

THE COURT: Okay.

Mr. Passafiume --

MR. PASSAFIUME: Thank you, Judge.

CROSS EXAMINATION BY MR. PASSAFIUME:

BY MR. PASSAFIUME:

Q. Hi, Dr. Leidenfrost.

A. Hello.

Q. We kind of ended on the BOP diagnosis, so I'm going to start there.

A. Sure.

Q. Their diagnosis was other specified personality disorder, right?

A. Yes.

Q. And that disorder is diagnosed when there are multiple, like, traits of multiple disorders?

A. Yes.
Q. And the BOP identifies three of these personality disorders in their report?
A. I'll take your word for it. It sounds reasonable.
Q. Narcicisstic personality disorder, that would be one of them, right?
A. I remember that, yeah.
Q. And some of the traits for that would be patterns of grandiosity or grandiose -- however you pronounce it?
A. Yes.
Q. It would be the need for admiration?
A. Yes.
Q. Being self-centered?
A. Yes.
Q. Having an exaggerated self image?
A. Yes.
Q. Lack of empathy?
A. Yes.
Q. The other personality disorder, the next one, is borderline personality disorder, right?
A. Yes.
Q. And traits for that disorder is -- could be instability with relationships?
A. Yes.
Q. Instability with emotions?

A. Yes.
Q. And impulsivity?
A. Yes.
Q. The third disorder they mention is autism spectrum disorder.
Are you familiar with that?
A. Yes.
Q. Some of the traits for that disorder would be difficulty in -- with social communications and interactions?
A. Yes.
Q. And it would be difficulty understanding social norms?
A. Yes.
Q. It would be, you have an abnormal approach to the social norms?
A. Potentially, yes.
Q. Okay. Unable to have back and forth conversations like this?
A. That's not true.
Q. No?
What about the ability to understand the perspective of others?
A. Potentially, yes.
Q. Okay. And fixation on interests?
A. Yes.
Q. And that's a -- there is -- it's a repetitive pattern of

behavior with that personality disorder?
A. Autism is not a personality disorder.
Q. Autism spectrum disorder.
A. Yes. It's not a personality disorder. It's a separate diagnosis.
Q. Sorry.
A. Yeah.
Q. Sounds good.
The treatment for these is generally psychotherapy, correct?
A. Yes.
Q. And there is different types of that therapy?
A. Yes.
Q. Psychoanalytical? Is that one?
Dialectical. I don't know if I'm pronouncing that -- is that one?
A. Yeah. Dialectical behavior therapy.
Q. And cognitive behavioral therapy.
A. Yes.
Q. I've heard of that. Medications are not generally used to treat these disorders and autism?
A. They are often used, yes.
Q. They are?
A. Uh-huh.
Q. It's not to treat specifically the disorder. It's to treat

the symptoms of other -- like anxiety or depression; isn't that right?
A. Yeah. That's fair.
Q. And the BOP says -- and I wonder if you agree, that these are -- I'm not saying that Mr. Wenke -- I'm not saying you agree with the BOP diagnosis -- but these traits are unlikely to change in the future if somebody has these disorders?
A. Unless the person gets treatment.
Q. Okay. Gets treatment.
A. Autism is not going to go away.
Q. Okay.
A. But with personality pathology, there is really good treatment, you can expect the person to improve.
Q. With, like, therapy, for example?
A. Yes.
Q. Okay. You have an affiliation with ECMC, right?
A. Through contract.
Q. Can you explain that a little bit?
A. So I work for University Psychiatric Practice. Because it is part of UB Department of Psychiatry. We have a contract with ECMC to provide psychiatric and psychological services in the hospital.
Q. Does the term "chief of transitions" mean anything?
A. Yes. It's one of my titles.
Q. One of your titles?

Could you explain what a chief of transition is?
A. So transitions is the inpatient psychiatric unit I work on. We're a psychiatric intensive care unit.
We work with patients who are at high risk for violence or aggression due to symptoms of serious mental illness. I've been the unit chief on that unit for ten years.
Q. And ECMC, it's a hospital-based emergency psychiatric service, correct?
A. Part of what they have -- right. The comprehensive psychiatric emergency program or CPEP.
Q. CPEP. And it's actually one of the biggest ones in New York State, isn't it?
A. Yes.
Q. They provide emergency mental health services?
A. They provide emergency evaluation.
Q. And those emergency evaluations could lead to extended observations?
A. Yes.
Q. Future assessments?
A. It can lead to -- right, being extended observation or admission psychiatrically to an acute inpatient unit.
Q. And they make their own evaluation and treatment recommendations?
A. Correct.
Q. And those recommendations obviously are dependent on the

symptoms, right?
A. Yes.
Q. And examples of those would be residential treatment -- residential inpatient treatment?
A. Are we talking about CPEP and the determinations?
Q. After the fact.
A. After the fact?
Q. Yeah. After they had been evaluated.
A. Yes. Part of the discharge plan could be a residential facility.
Q. Would be outpatient treatment?
A. Yes.
Q. And, again, those all depend on the severity of the symptoms?
A. Yes.
Q. Okay. Let's go into your diagnosis a little bit here.
A. Sure.
Q. Yours was very different than the BOP diagnosis?
A. Yes.
Q. And you diagnosed Mr. Wenke with the schizoaffective disorder?
A. Yes.
Q. And you need certain traits or characteristics to make that diagnosis, right?
A. Yes.

Q. And one would be the delusions?
A. It can be, yes.
Q. Right. You need to have at least two of the following, but one of the first three, is that what you're meaning?
A. Yeah. There is different ways of getting to the diagnosis.
Q. But here, applying it here would be the delusions?
A. Yes, you're right. That's what's relevant here.
Q. And organized speech, I think, is one of them?
A. It can be, yes.
Q. And treatment for this is usually medication, right?
A. Yes.
Q. And people come into ECMC and are treated with this disorder?
A. Yes.
Q. Is that frequently?
A. Yes.
Q. And you guys have -- I don't want to say, you guys.
In your work with ECMC, they have the -- an adequate support structure to receive these individuals, evaluate and treat them?
A. Yes.
Q. Do they make recommendations of future treatments?
A. Yes.
Q. Did they arrange the transition from being at ECMC into future treatment?

A. Yes.
Q. There is never really a period where somebody would miss out on treatment in between the transition?
MR. WRIGHT: Objection. Your Honor, relevance.
THE COURT: Overruled.
You can answer.
THE WITNESS: Are you meaning while they are in the hospital?
BY MR. PASSAFIUME:
Q. Sure. So if somebody leaves the hospital --
A. Yeah.
Q. -- and they are supposed to be to outpatient, they are going to leave the hospital with enough medication until the outpatient starts?
A. Right. Yes. I got you, yes.
Q. And before we get to more specifics of the delusions and disorganized speech, I want to talk about how you got to that diagnosis.
You talked about your sources of your assessment on direct examination, right?
A. Yes.
Q. And, right? All the various reports? Letters? All of that stuff, right?
A. Yes.
Q. It is different than what the BOP used, right?

A. Can I look at the report?
Q. Yes. Well, actually, I'll withdraw that and make it easier.
A. Yeah.
Q. You didn't speak to any individuals regarding Mr. Wenke, aside from the e-mails that we all exchanged?
A. No.
Q. You didn't speak to his mom?
A. No.
Q. His dad?
A. No.
Q. Any prior counselors?
A. No.
Q. Any of the victims in this case?
A. No.
Q. Would you classify those as collateral information?
A. Yes.
Q. And you talked a little bit about collateral information before. And that information is helpful when making a diagnosis, right?
A. Yeah.
Q. It could shed more light on the timeline of the symptoms?
A. Yeah.
Q. It could have insight into additional symptoms?
A. Yeah.

Q. And when you gave -- you gave Mr. Wenke that HCR assessment, right?
A. Yes.
Q. And there is -- there is a manual to that that kind of tells you how to do it, right?
A. Yes.
Q. And the first step is to gather information?
A. Yes.
Q. And that -- again, that information, not only is it used to give you a better understanding, it makes sure that the information you do have is accurate?
A. Yes.
Q. An inaccurate information would lead to skewed results as far as a diagnosis?
A. Yes.
Q. And another difference -- well, you did not review this research paper titled: Differentiating Delusional Disorder from the Radicalization of Extreme Beliefs?
A. I'm quite familiar with it, yes.
Q. You didn't use that in this report specifically?
A. I didn't cite it, but I'm well aware of it. I've received training in it and I train others about it.
Q. Okay. And you saw Mr. Wenke on two occasions, right?
A. Correct.
Q. And in an ideal world you would want to observe a patient

more than those two times, right?
A. I mean, that's not usually reasonable for these types of evaluations.
Q. But the BOP evaluated him from September of 2024 to November of '24.
If you had the same, would you -- if you could switch places and evaluate him from September to November, would you?
MR. WRIGHT: Objection. Speculation.
THE COURT: I'll let him answer it. Overruled.
THE WITNESS: Sure.
MR. PASSAFIUME: All right.
BY MR. PASSAFIUME:
Q. And during that time, those months, the BOP routinely visited Mr. Wenke?
A. I don't know if they did.
Q. From the report?
Okay. All right. Let's get into some of the delusions here. The first one is this grandiose, paranoid and persecutory delusion.
And you specifically reference that Mr. Wenke thought he was a public figure and a former chairman of the Libertarian Party of Cattaraugus County?
A. Yeah.
Q. Are you aware that Mr. Wenke was a former chairman of the Libertarian Party of Cattaraugus County?

A. Yeah.
Q. And you also referenced two articles about Mr. Wenke in your report. And, specifically, it's the Tap Into article?
A. Yes.
Q. And one from the wellness -- or Wellsville Sun?
A. Yeah. It sounds familiar.
Q. And both of those articles discuss Mr. Wenke's history in public office.
A. Yes.
Q. And are you aware that he actually ran for county coroner in 2019?
A. I don't remember if I knew that or not. Maybe.
Q. And you believe that the BOP is wrong when they don't consider this a delusion?
A. Well, they frame it differently. They're putting it under -- I don't think they disagree that it's an inflated sense of self.

I'm putting that under a symptom of mania versus their conceptualization that it's narcissist personality, because there is other information that went into that sense of grandiose.

I mean, those things are true. I know he also told BOP that his case was the foundation for grandparents' rights in New York State. I don't know if it's true or not. If it's not true, it's clearly grandiose.

But also this fixation that his case is going to go all the way to the Supreme Court.

Q. You are aware that Mr. Wenke actually appealed his original conviction?

A. I wouldn't be surprised.

Q. Let's get into these psychic medium and psychic beliefs.

Did you ask him to elaborate on what he meant when he was referring to psychic mediums and to spiritual things like that?

A. What do you mean?

Q. Did you ask him, why do you believe that stuff?

A. No.

Q. So you weren't aware that these spiritual psychics have been common in his life? This belief?

A. I'm not sure when I became aware of that.

Q. You are not aware that his family went to Lily Dale, which is a community for psychics and mediums often, right?

A. Yeah. I don't think I knew that when I first saw him.

Q. So you weren't aware that this belief system was normal -- normative in his life?

A. I mean, he believed that psychics were a thing. So, yes, I understood this was a norm for him.

Q. Let's talk about KV.

A. Okay.

Q. We've -- we've singled her out as a big part of the diagnosis, right?

A. One of the delusions, yes.
Q. Right. You talk about her extensively when you are discussing Mr. Wenke's delusions?
A. Yes.
Q. And the updated report, the second one that you have, I think you referenced her almost the entirety of the report, right?
A. Yes.
Q. And it is this fixation -- delusional fixation that Mr. Wenke has on KV, right?
A. Yes.
Q. And she indicated that she suffered a psychological harm in one of the letters.
Do you remember?
A. Yes.
Q. And I think you testified that in one of the letters she also said that she considered changing her name and appearance to escape Mr. Wenke?
A. Yes.
Q. And you give some of these -- some examples of these delusions. And the first one is that Mr. Wenke insisted that KV made a website and posted all of his paperwork?
A. Yes.
Q. Are you aware that there is a website?
A. I don't know.

Q. Luke Wenke Online is not familiar to you?
A. No.
Q. So you are not aware that KV has created a blog that documents every single one of Mr. Wenke's court appearances?
A. Okay.
Q. You are not aware of that?
A. No.
Q. You are not aware that she has posted every single court document that's been listed on the public docket?
A. Okay.
Q. All right. You are not aware that she summarizes each -- each court proceeding and kind of gives her opinion of what's going on?
A. Okay.
Q. You are not aware that this website has -- you know, altered pictures that poke fun or ridicule Mr. Wenke?
A. Yeah. I don't know.
Q. You don't know that she also posts Mr. Wenke's letters and actually transcribes them in those pages?
A. Okay.
Q. All right. You are not aware that she identifies herself and actually gives reasons why she is doing it --
A. No.
Q. -- or created this?
And on one of the pages -- so you are not aware -- she says

she knows and does not care that this would make Mr. Wenke, quote, mad?
A. Okay.
Q. All right. Did how come you didn't know this -- the website existed?
A. I didn't know it existed.
Q. Did you look for it?
A. I did look for things he told me about, yes. And I couldn't find it.
Q. Did you Google Luke Wenke?
A. Most recently, I don't remember if I specifically Googled that.
I think I did, because I was looking for other things that he had referenced when I talked to him.
Q. Did you Google Luke Wenke and KV?
A. I don't think so.
Q. Is there a reason why you didn't do that?
A. I don't know.
Q. You verified -- or tried to verify, other information in your report, right?
A. Yes.
Q. You did -- you did other Google searches, right?
A. Yes.
Q. You saw other materials?
A. Yes.

Q. Yes?
A. I'm sorry, yes.
Q. But you didn't do this Google search?
A. No.
Q. Are you aware that she updates it regularly, with the last one being February 17th?
A. I don't know.
Q. Okay. It's a very extensive website.
Let's go to the second example of a delusion involving KV. And it's about how Mr. Wenke believes she stole his car and wants her charged with stealing her car, right?
A. Yeah.
Q. Did you do any investigation about that?
A. No.
Q. Did you call me at all when you -- in preparing this evaluation?
A. No.
Q. You didn't want -- you didn't want my opinion or my history with Mr. Wenke?
A. You were welcome to reach out. You approached me.
Q. That's right. That's true. That's true.
And to be fair, you didn't call the Government either, right?
A. I spoke to them.
Q. Before you did the evaluation?

A. Again, you all reached out to me. I asked for all the information that you had available.
Q. Okay. So you weren't aware that an investigator from our office actually delivered Mr. Wenke's keys to Miss Valentine back in 2022?
A. You didn't tell me.
Q. I did not tell you.
Would that impact whether you believe that she stole his car is a delusion?
A. Maybe.
Q. All right. The next example is this -- that KV left a negative Yelp review at Mr. Wenke's mother's restaurant?
A. Yes.
Q. Again, you didn't call me, but I didn't reach out to you. So you are not aware that Mr. Wenke's mother believes that it was KV?
A. Okay.
Q. And that she sent messages to Mr. Wenke's father regarding this Yelp review alleging that it was KV, right?
A. No.
Q. You are had not aware of that?
And if -- if his mom -- if Mr. Wenke's mom told Mr. Wenke this, that she believes KV left a negative Yelp review, and then he tells you that, is that still a delusion?
A. Not necessarily.

Q. And that's because it's -- it comes from his mother, a trusted source, that he believes?
A. If there is some accuracy.
Q. Okay. How much accuracy do you need or does it vary?
A. I mean, it varies because with delusion, a lot of it can be grounded in reality and other parts are not.
People become paranoid for a reason. Oftentimes real things happen that contribute to the paranoia. Or they get into legal trouble and then things comes out about them that further fuels the paranoia. It becomes this reciprocal thing that happens sometimes.
Q. That makes sense. The next delusion is that, I had a screaming match with KV.
A. That may or may not have happened. That's obviously not a delusion. He's brought that up a lot.
Q. Well, you brought it that up in your delusion analysis.
A. That's more about his fixation with KV.
Q. All right. Did -- again, you didn't e-mail me saying, did this actually happen?
A. Again, I asked for all the information available from everybody involved when you approached me.
Q. That was before you prepared the evaluation though, obviously, right?
A. What do you mean?
Q. The information that we provided to you was before you

prepared the initial evaluation?
A. Right. Right.
Q. So you are not aware that something like that actually did happen?
A. I don't deny that it did.
Q. You are not aware that we, meaning an investigator from my office and myself, attempted to contact KV?
A. I don't know.
Q. You are not aware that she became irate on the phone?
A. No.
Q. You are not aware that then she hung up the phone on us before we could respond?
A. I don't know. You didn't tell me.
Q. I didn't tell you. That's right.
Let's talk a little bit about treatment. And this is going to be a loaded question, but what would your treatment plan be for Mr. Wenke if you were his doctor?
A. I'm a psychologist. I would have to approach it like a psychologist. I cannot prescribe medication.
Q. Perfect. So as a psychologist, in your vast experience, right, you have worked with psychiatrists a lot, what would your plan be?
A. I mean, if I had someone who was presenting with schizoaffective disorder and the symptoms are acute, meaning that they are active and going on right now, they're actively

manic, they're actively psychotic, I cannot do psychotherapy with them until they are stabilized.

And then at that point, when the symptoms have decreased, then I can come in and do treatment.

Q. And in order to do that, Mr. Wenke would have to be observed by you and the psychiatrist?

A. I mean, to make a determination whether medication is prescribed would be up to medical doctors.

Q. Medical doctors.

And, again, you would need to assess him to see what kind of psychotherapy would be appropriate as well?

A. Which I would do after the symptoms have stabilized more.

Q. And this is something that the ECMC, the CPEP unit, could do -- the initial assessment?

A. Well, they are going to make a determination whether somebody is eligible for admission to a psychiatric service.

Q. And with somebody that has disorder -- this disorder, being given a social worker would be a benefit to that person, right?

A. It may be.

Q. Do you work with social workers at ECMC?

A. Yeah.

Q. And what about family -- family support?

A. It's crucial, family support.

Q. It's crucial?

A. Uh-huh.

Q. And what about the environment of the initial evaluation? What is -- how is it like in CPEP?
A. I'm sorry to laugh. It can get very full and very busy and chaotic, but there is, like, a large open room with chairs and beds where people are kept until they can be evaluated by a psychiatrist to make the determination whether they are -- should be admitted psychiatrically or not.
Q. That's not ideal, right?
A. No.

MR. WRIGHT: Your Honor, I'm just going to object here, relevance. I know we're focused on the 4244 proceeding, now we're going into future treatment.

THE COURT: Right. Let me -- we're going to take a quick bathroom break in any event.

Mr. Passafiume, are you done with cross-examination specifically as to 4244 topics?

Are we now going to move into evaluating the ECMC option, if you will?

I think it's okay to do that. I just want to know if we're demarking --

MR. PASSAFIUME: I have some more stuff I want to address, like the danger as well.

THE COURT: Okay. Can we hold on the ECMC stuff until the very end of your examination?

MR. PASSAFIUME: Sure.

THE COURT: Unless it substantially alters your presentation.

MR. PASSAFIUME: I have no flow, Judge.

THE COURT: Let's hold and do that at the end.

Right now let's take five minutes, something like that, to refresh, okay?

MR. PASSAFIUME: Thank you.

THE COURT: Okay.

(Discussion off the record.)

(Recess commenced at 3:07 p.m., until 3:15 p.m.)

THE COURT: Okay. In case you are not getting back to the delusions concept, I have a question on my own, let's put it in here.

Reliance, Dr. Leidenfrost, or belief in psychic medium is not a delusional thing you said at the beginning, correct?

THE WITNESS: It depends, yeah.

THE COURT: Okay. So that's my question. Maybe you anticipated where I'm going.

You mentioned in this case it was evidence of a delusion when the psychic says that he and RT are destined to be together. In your view, in this instance, it is delusional.

Why is it delusional sometimes and not in others?

THE WITNESS: It's in context with other information. So if it was just that all by itself, the person sees psychics, concurrent to the belief that spiritualization is a thing and

you can talk to dead people, and they were told, I'm destined to be with this person, okay. That's all right.

But in context with his other behavior and other beliefs, it goes into looking for evidence to support this belief that they are destined to be together. That's one part of it.

But along with this idea of a Google search proves that they are going to be together; this idea that even though there is an Order of Protection, that's not going to prevent it; insisting that RT is infatuated with him, after they knew each from what I can gather only two weeks; believing that people are conspiring to be against him.

But then going after RG that led to all these legal troubles, clearly believing that he failed to justify this campaign of stalking, harassment, in context with of all of that, does the psychic stuff by itself, not a problem.

In context with those other behaviors and beliefs, it goes to that context of a delusion. That it's idiosyncratic to him.

He took it way beyond what an ordinary person would if they talked to a psychic medium.

THE COURT: Mr. Passafiume --

MR. PASSAFIUME: Thank you.

I'll start there.

BY MR. PASSAFIUME:

Q. Mr. Wenke knew RT, right?
A. Yeah.
Q. They met online?
A. Yes.
Q. They met in person as well?
A. Yes.
Q. Did you ever hear of the expression love at first sight?
A. Yes.
Q. All right. The relationship with RT itself is not a delusion, it's the extent of it -- or what the extent that Mr. Wenke believes?
A. Yes.
Q. Okay. What if -- and we're talking about context. And you just mentioned RG. And one of the examples with RG is this e-mail that -- that Mr. Wenke sent to him.
Do you remember that?
A. I think there was 76 e-mails.
Q. Sure. You cite -- you cite parts of one e-mail or two e-mails, right?
A. I believe so.
Q. Like, for example, the one he sent in January of 2002 where Mr. Wenke says, men respect each other after a fight, right?
A. Yeah.
Q. That he would take a steel chair to Mr. -- to RG's face?
A. Yes.

Q. And that the fight will happen?
A. Yes.
Q. The -- there is context to that e-mail. You are aware that RG was emailing Mr. Wenke?
A. I don't know.
Q. Are you aware that during that same conversation RG e-mailed Mr. Wenke and called and said, quote, you are a weak human being?
A. I wasn't provided that information.
Q. And -- and then challenged Mr. Wenke to a fight. And if he wanted to fight, he should come to Minneapolis?
A. I wasn't aware. I wasn't provided that information.
Q. This information came from the original PSR. You were provided that, right?
A. Yes.
Q. More kind of in this context -- so if the website is real, the website is geared to harass Mr. Wenke.

There was some incidents regarding the car. There was a negative Yelp review. And psychics were part of Mr. Wenke's life. That is all true.

Does that alter -- or could that alter your diagnosis?
A. It could.

THE COURT: Could it alter your conclusion about whether he needs to be in care for treatment and hospitalized for treatment? Separate question.

THE WITNESS: No. There are many other symptoms that support.

Again, I have worked with many people with mental illness that have lots of things grounded in realty. It doesn't mean that they are not having symptoms of a mental illness.

BY MR. PASSAFIUME:

Q. The delusions, though, is crucial for your diagnosis for the schizoaffective disorder?

A. Yes.

Q. And you put these examples of delusions in your report for a reason, right?

A. Yes.

Q. They were the examples that you relied on?

A. Yes.

Q. Let's -- before the ECMC stuff, let's go through that HCR.

This is a structured professional judgment assessment, right?

A. Yes.

Q. I did my homework. And it's an evidence-based approach that combines empirically validated tools with professional judgment?

A. Yes.

Q. And the version for me is, the results can vary depending on who the evaluator is?

A. They shouldn't.

Q. They shouldn't, but judgments -- reasonable people can disagree on something?
A. I mean, the way that the test is constructed is to make it as objective as possible. If you follow the rating criteria, you should have interrelated reliability.
Q. The criteria is evaluated by the doctor conducting that assessment?
A. It's based upon the definitions provided in the manual.
Q. But it's -- I'm belaboring here -- but it's the evaluator that makes a determination of whether a symptom is present.
How relevant it is, right?
A. Right. Ultimately, the professional is making that determination.
Q. Okay. For this assessment, again, the first step is to gather information, right?
A. Yes.
Q. And, you know, that collateral information could be from a number of sources, right?
A. Yes.
Q. Especially for this kind of assessment.
You didn't speak to any of Mr. Wenke's family, right?
A. No.
Q. You didn't speak to his dad?
A. No.
Q. Didn't speak to his mom?

A. No.
Q. You didn't call me. I didn't call you either.
A. No.
Q. All right. You didn't reach out to any of his prior counselors?
A. No. I had treatment records.
Q. Did you reach out to any authors of any assessments or reports that you relied on?
A. No.
Q. For example, the threat assessment, are you familiar with that?
A. Yeah.
Q. You indicate that it was completed by Endeavor Health Services staff, right?
A. Yeah.
Q. Why do you think it was completed by Endeavor Health Services staff?
A. Whatever was indicated on the paperwork.
Q. That paperwork doesn't have an author. But are you -- so you are not aware that was actually completed by a police officer?
A. Okay.
Q. You weren't aware of that?
A. No.
Q. It was not done by a mental health professional.

A. Okay.
Q. And that -- there is no formal name for that threat assessment, like HCR or anything like that?
A. I don't know.
Q. It's not a standard, widely-accepted assessment, the one that you saw?
A. I don't know.
Q. You have never seen it before?
A. No. It doesn't mean it's -- doesn't -- it's not based upon something.
Q. But in your experience, you have never seen that threat assessment that you reviewed for this case?
A. In that format? No.
Q. Okay. Let's go through -- and, again, just like the Government, I'm not going to go through all of the -- all the factors.
I'm going to just talk about the ones that you deemed relevant -- high relevance. Is that okay?
A. Okay.
Q. For the violence -- and we already discussed it, you -- you cite and you back it up with those e-mails with RG, right?
A. Yes.
Q. That went into your determination that this factor is present?
A. Yes.

Q. You also rely on KV's self reporting?
A. Yes.
Q. That she was having so much psychological harm that she considered changing her name and moving?
A. Yes.
Q. Same person that has this website?
A. Apparently.
Q. The next factor, the other antisocial behavior.
A. Okay.
Q. For this you cite this 2018 incident, where Mr. Wenke is carrying a street sign down the road?
A. Yes.
Q. That he was charged with marijuana possession in 2020?
A. Yes.
Q. And that he sent unwanted text messages?
A. Yes.
Q. None of these contacts with law enforcement resulted in any arrest or charges, to your knowledge?
A. I thought the possession of marijuana did.
Q. Okay. Correct. I'm sorry.
The text messages and the street sign?
A. I don't know.
Q. Okay. The next is Mr. Wenke's alleged involvement with the Boogaloo Boys.
A. Okay.

Q. You admit in your report that the extent of that involvement is not clear?
A. Right.
Q. And you make a claim that they supplied him with a -- with a gun in 2020?
A. Yes.
Q. That was five years ago, two years before the original offense in 2022.
A. Okay.
Q. And there is no known allegation that that weapon was ever recovered or found?
A. I don't know.
Q. No probation officer has told you he has seen it or she has seen it?
A. Correct.
Q. There is no other report regarding that weapon?
A. No. Not that I know of.
Q. Okay. The next factor is this mental -- major mental disorder factor.
You make it relevant -- or you say it's relevant that you know the onset of the symptoms?
A. I'm not sure. That's speculation.
Q. Well, you testified that it was important that you knew that these symptoms started around 2019 or 2018.
A. That's what I think based on the available information.

Q. Well, why -- why wouldn't you call his family to find that information out?
A. I could have.
Q. You took everything that KV said at face value as if it was true.
A. In the letter? I considered it as part of the data.
Q. If someone creates a blog that's updated every day, that's worked on every day, that is geared towards harassing another person, would you say the creator of that blog is fixated on the other person?
A. I don't know.
Q. Would that be a symptom of fixation?
A. It could be a fixation, I'll give you that. Sure.
Q. Okay. The violent attitudes factor. You use examples from the two articles we mentioned before?
A. Yes.
Q. The Wellsville Sun and the Tap Into Greater Olean?
A. Yes.
Q. Did you speak to the authors of any of those articles?
A. No.
Q. Do you know where any of that information came from that was contained in those articles?
A. I believe one of them was an interview with the defendant.
Q. Right.
The -- a picture where Mr. Wenke was labeled armed and

dangerous was first referenced in that Tap Into article, right?
A. Maybe. I don't remember.
Q. And you don't know if that was a -- like an official designation by law enforcement or that it was even created by law enforcement, right?
Have you ever seen that picture?
A. I have seen a picture, yeah.
Q. Was that -- is there anything in that picture that indicates that it was made by New York State?
A. No. It was posted on, I think, the Olean War Zone website.
Q. Right. Do you know where that picture came from?
A. No.
Q. So you're not aware that that picture was included in a reply tweet to Mr. Wenke by an anonymous unknown user?
A. Okay.
Q. The -- part of this violent attitudes and these factors obviously overlap. Again, you use the Boogaloo Boys involvement?
A. It's part of it.
Q. It's part of it. And, again, the degree of Mr. Wenke's involvement with that group is unknown?
A. Correct.
Q. The -- you talk about how he -- he wanted to subvert gun laws of New York State in making guns with 3D printing?
A. Yes.

Q. And those quotes that you use were taken from the article?
A. Yes.
Q. And you didn't put the whole context of those quotes, you selected these lines specifically, right?
A. Yeah.
Q. So I think -- and I -- I don't want to put words in your mouth. But the last, kind of, sentence in one of those quotes: "I honestly encourage everybody to do that", what do you think that that was referring to?
A. I mean, in the context of, like, 3D printing guns being prepared?
Q. In that -- in that quote, because you use that specific quote in your report?
A. Uh-huh.
Q. Why did you use that specific quote?
A. Because I thought it contributed to evidence of violent ideation.
Q. The sentence before that quote states that: "I want people to know that I have no illegal guns myself, but I want people to be aware that instead of throwing money at the NRA and expecting that to be the only answer, just remember 3D printing is going to make that obsolete. I honestly encourage everybody to do that."
A. Okay.
Q. He could be referring to the throwing money, not -- stop

throwing money at the NRA, right?
A. Fair enough.
Q. Okay. The -- you mentioned some Internet searches with some, I guess, some trigger words that you considered part of these factors?
A. There was a Google search history, I think, that was provided to me. That's what you are referring to?
Q. I'm sorry?
A. Is that what you are referring to as the Google search history?
Q. Yeah.
A. Okay.
Q. You cite certain words that Mr. Wenke Googled that you were concerned about.
A. Yes.
Q. None of those -- none of those words -- or none of those Google searches pertain to a specific person or thing, right?
A. I mean, I think there was references to the Government.
Q. There was nothing like how to poison somebody and get away with it?
A. I think there was about how to murder somebody and get away with it.
Q. You don't say that in the report. You just mention the word murder.
A. Okay.

Q. Okay. Is that different if somebody says: "This is how you murder somebody", versus just Googling "murder"?
A. Sure.
Q. One of the factors is problems with supervision. You are aware that Mr. Wenke successfully completed substance abuse treatment in 2021?
A. I believe so, yeah. I think he told me that.
Q. In your report you said it didn't appear -- from March of 2023 to May of 2023 -- that Mr. Wenke attempted to complete mental illness or substance abuse treatment.
A. Yes.
Q. Where did that information come from?
A. Maybe the PSI -- the presentence investigation. I believe I had -- I asked the defendant about that, too.
Q. Could it impact your opinion if that was not true and Mr. Wenke actually did attempt to complete mental health treatment?
A. Sure.
Q. So you are not aware that he -- he was released with a condition to attend mental health treatment and actually attended that treatment?
A. When -- when was that?
Q. He -- actually, every single time he was released.
So are you aware that the first time he was released -- I think it was before the first violation --

A. Okay.
Q. -- he was traveling from Olean to Buffalo three times a week for treatment?
A. Is that the first or the second time? Because I know he went to, like, an anger management program in 2023. He told me he was traveling back and forth from Buffalo to Olean. I know that.
Q. And that was for mental health treatment?
A. Mental health or anger management, yeah. I think he told me it was an anger management program.
Q. And the Horizon reports that I believe you had --
A. Yeah.
Q. -- said that when Mr. Wenke reported that when he was stressed, overwhelmed, irritable or anxious, he could see the benefit of mental health counseling.
Did you read that?
A. Yeah. I read those records.
Q. The next one was that he wants to learn ways to mediate his emotions when times are tough.
A. Yeah.
Q. The next one is, Mr. Wenke was motivated to engage in therapy, to learn about himself and effectively manage his moods.
A. Okay.
Q. The -- the final opinion from that counselor said that --

well, I'll withdraw that.

He was he was compliant with that and he was attending. And those reasons, the quotes I just read, was a reason why the counselor deemed him compliant -- that's a terrible question.

The counselor acknowledged all of those things; that Mr. Wenke was motivated to attend treatment, but cited the distance between his house and the treatment provider as one of the biggest obstacles?

A. Yeah. Definitely an obstacle.

Q. The final violent risk formulation -- I want to make clear what you relied on for that.

It was first the -- Mr. Wenke's change in personality and behavior in 2019 or 2020? Yeah?

A. Yes.

Q. And that was reported by KV?

A. Part of it, yes. That was part of it. There was other evidence that went into that.

Q. Like what?

A. Well, the change of behavior. Namely the articles of getting into trouble I found documented and then the legal trouble that ended up with him here.

Q. You cite this involvement with the Boogaloo Boys --

A. Yes.

Q. -- as one of them?

A. Yes.

Q. As one of the factors?
A. Yeah.
Q. And, again, the involvement was unclear to you, right?
A. The extent.
Q. The extent of it.
A. Uh-huh.
Q. You then bring up a local example of Payton Gendron.
A. Yes.
Q. Are there any similarities between that case and this case?
A. I only brought that up to illustrate an example of, like, an overvalued idea. In talking about -- somebody can have -- you know, people exhibit violence for different reasons.

People can exhibit violence based upon overvalued ideas. It is not mental illness.

Somebody that has mental health issues, just because they are delusional, doesn't mean they also have overvalued ideas.
Q. It's Buffalo. You mention that case. You know that that's going to be, for lack of a better word, fixated on by the reader?

MR. WRIGHT: Objection. Your Honor, relevance.

THE COURT: Overruled.

You can answer.

THE WITNESS: I don't know that.

BY MR. PASSAFIUME:
Q. It's going to read more to somebody in Buffalo as opposed

to in Texas?

A. Yes.

MR. PASSAFIUME: I'm sorry, Your Honor, can I have a minute?

Judge, we're back on the treatment portion of ECMC. I don't know if you wanted me to just cross-examine him on that or if you want to pose your own questions. I remember you told me to save it to the end.

THE COURT: Mr. Wright, do you want a redirect at this point on the 4244 factors before we talk about this kind of topic?

MR. WRIGHT: Yes, Your Honor. I think that that may be better, actually.

THE COURT: What do you think about that? And then kind of just keep it discrete.

MR. PASSAFIUME: I would still want to ask questions about the witness about that.

THE COURT: Yeah. I can bring you back up after Mr. Wright does a redirect and then we can have a -- kind of, a different topic conversation.

MR. PASSAFIUME: Thank you, Judge.

THE COURT: Why don't we do it that way.

Mr. Wright, why don't you do a redirect on 4244 topics?

MR. WRIGHT: Thank you, Your Honor.

REDIRECT EXAMINATION BY MR. WRIGHT:

BY MR. WRIGHT:

Q. Thank you, Dr. Leidenfrost.

So the defense just went through a whole bunch of matters relating to KV and different -- different things.

Given your evaluation, the totality of everything you reviewed, would that have changed your opinion relating to the defendant's need for -- of custody for care or treatment in a suitable facility because of his mental disease or defect?

A. No.

Q. Okay. And you are relying on information being provided to both the defense and the Government, correct?

A. Yes.

Q. And then here, you issued a report in April of 2024 and another one in January of 2025, correct?

A. Yes.

Q. And there was no additional documents or, for instance, this website, for instance, by KV, that was never provided to you?

A. Correct.

Q. And just one more thing relating to this issue of delusions.

You mentioned this word idiosyncratic to the defendant,

correct?
A. Yes.
Q. And so the issue of the psychics is not just, hey, going to a psychic. It's what he's interpreting for himself, correct?
A. Yes.
Q. And the extent of he's tying that to other things that he's believing that he expressed to you during your evaluation?
A. Yes.
Q. Is it a fair statement that part of what you relied on was the totality of what the defendant stated relating to interactions between various people?
A. Yes.
Q. And this was a significant -- or one of the elements that you reviewed or used in your overall determination of why this defendant has a mental disease or defect?
A. Yes.

MR. WRIGHT: Nothing further, Your Honor.

THE COURT: All right. Do you need a recross as well on that redirect or are we moving on to the next topic?

MR. PASSAFIUME: Me?

THE COURT: Do you need a recross?

MR. PASSAFIUME: No. Not on that stuff.

THE COURT: Okay. Okay. So we're --

MR. PASSAFIUME: Can I, Judge?

THE COURT: Give me just a moment.

MR. PASSAFIUME: Sure.

THE COURT: Dr. Leidenfrost, I've got -- we're going to do, kind of, sounds like a little bit of a conversation with you about things that are a little bit atypical.

Under this hearing, we're probably finished with you, I think, for purposes of what I need for the statute, at least from this witness.

But we're going to talk about this other proposal that Mr. Passafiume has been discussing with me.

And so in your conversation with Mr. Passafiume now -- and if there are questions from Mr. Wright as well, the things I'm interested in is -- look, I've got three -- I think three options in front of me now.

One, within the statute, is I can agree with you and that requires him to be sent to Bureau of Prisons for them to treat him in their suitable facility.

I can disagree with you and then we're done with this conversation.

And then the third option is, sounds like this ECMC CPEP option.

So if I'm going to consider that third option, I'm going to need to know things like, what is this? What is it? How does it play out?

How might it play out? What are the different permutations that could happen?

Ultimately, I've got to decide which is the right path. And perhaps it's relevant, I think, too -- maybe you can give me your opinion on the ultimate issue, too, I suppose, which is which of these paths do you think is the right path? And why wouldn't I listen to that as well?

Mr. Passafiume --

MR. PASSAFIUME: Thank you.

RECROSS EXAMINATION BY MR. PASSAFIUME:

BY MR. PASSAFIUME:

Q. So Mr. Wenke was seen by two agencies, Horizon and Endeavor, right?

A. Okay.

Q. Neither of them believed that he -- that there was an imminent danger, right?

A. I don't know. The threat assessment, I think, suggested there was a risk.

Q. Well, under New York State Mental Health Law, if a counselor or somebody believes that someone else is a threat for imminent danger, you can be admitted to a psychiatric facility?

A. Sure.

Q. You can be arrested on that?

A. Yeah. 941, I think it is.

Q. And there is no evidence that that happened here, right?

A. Not that I know of.
Q. And you know that Mr. Wenke did time at the BOP?
A. Yes.
Q. You know that he -- mental health treatment was not deemed necessary there, right?
A. Yeah. I believe I read that in the report.
Q. And that he was a care level one?
A. Yes.
Q. And that he was not diagnosed with anything.
Do you remember that?
A. It was the personality -- he had a diagnosis, the personality.
Or are you talking just in the facility overall?
Q. Well, let me backtrack. When he served his sentence before the competency evaluation --
A. Oh, okay. I got you. I don't know.
Q. Okay. So do you -- are you aware of any Federal psychiatric hospitals?
A. I'm not familiar with that system.
Q. Do you -- are you familiar with the BOP at all?
A. Not well.
Q. You don't know if there are different prisons for different things?
A. Right. I assume there are specializations of different facilities that do different things, sure.

Q. But you don't know what the facilities are like?
A. I've never been to them.
Q. And you don't know what their treatment plan would be?
A. I don't know.
Q. No? And so you wouldn't know if their treatment plan would be the same as yours?
A. Right.
Q. Right. And you couldn't tell us at all what happened at the BOP, right?
A. No. I think I requested any mental health treatment records from any time in prison. I wasn't provided anything.

MR. WRIGHT: Your Honor, just -- are we going back to the 4244? Or I thought this was going to be more of a conversation about what the --

THE COURT: I'm viewing it as a segue, so I hope that's where we're going, Mr. Passafiume. Yes?

MR. PASSAFIUME: I'm just comparing the BOP versus ECMC.

THE COURT: Okay.

BY MR. PASSAFIUME:

Q. So if somebody were to have to be transported in custody to a facility that's over 500 miles away, would that be detrimental to his mental health condition?
A. Sure.
Q. It could worsen his condition?

A. Maybe.
Q. Before you said, you know, having family around and support, that's crucial, right?
A. Yes.
Q. So, ideally, you would want family to be close to the psychiatric facility where the person is staying?
A. Yeah, ideally. Having a family involvement is important to people's care and recovery.
Q. And you -- you know, your diagnosis is very different than the BOP's diagnosis.

If you diagnose somebody with condition A. That person goes to another doctor. That person diagnoses him with condition B.

Would you follow -- and that individual comes back to you, would you follow your original diagnosis and treatment plan or this other doctor's original diagnosis and treatment plan?
A. I mean, hopefully, I would take them both into consideration. Maybe that doctor saw something I didn't.
Q. Okay.
A. Because also -- if I can just broadly expand it. People look different at different times, too. I can see somebody at point A, two months later, they can be very different, so --
Q. Okay. When you evaluated Mr. Wenke after the BOP examination, nothing much changed, right?
A. Compared to when I saw him last year, no. He presented in

a similar way.
Q. Okay. So you don't know if they'd turn Mr. Wenke away, if he went back to the BOP for treatment?
A. I don't know.
Q. How would you treat somebody -- well, we already talked about that.
Main treatment for those personality disorders would be psychotherapy, right?
A. Yes.
Q. Which is different than the treatment you said about schizoaffective disorder?
A. Correct.
Q. And you need to be medicated with schizoaffective disorder?
A. Yeah, usually.
Q. And if the person does not want to take that medication, he would have to be forcibly medicated?
A. If there is a dangerousness there, yes.
Q. And in your opinion, in your report, you allude to -- I'm going to basically say -- that Mr. Wenke will need to be forcibly medicated?
A. Maybe.
Q. Maybe?
A. I don't know that for certain. I've seen people where we thought there would have to be a medication over objection, and the person, knowing that's going to happen, they give in and

took medication.
Q. And New York State has a mechanism to forcibly medicate somebody?
A. Yes.
Q. You've seen that in action before?
A. Yes.
Q. All right. So let's -- what is CPEP and how does everything play out here?
So tell us a little bit about the conversation you and I had before Court, where we talked a little about the steps. You can start with what CPEP is.
A. It's Comprehensive Psychiatric Emergency Program. It is like a psychiatric ER, right.
Instead of people in a mental health crisis going to the ER, they are going to CPEP, where they are getting an evaluation by a psychiatric provider to determine whether they meet legal criteria for admission to the hospital, whether it is voluntary or involuntary.
And there has to be certain criteria met, and certain thresholds, such as, you know, imminent risk because of mental health or this person can't take care of themselves because of mental health.
Q. And those folks there would obviously get your report as -- to review in making that determination?
A. Yeah. They could be supplied with it.

Q. Okay. And say somebody goes there and they deem somebody worthy of involuntary admission, how long is the period of -- how long does that person stay at that CPEP unit?
A. CPEP stays should be short as possible. Ideally turning around in 24 hours.
Sometimes people are down there for two or three days -- I'm sorry -- sometimes they are in CPEP for two or three days.
Q. So if somebody is in need of medication, that medication wouldn't kick in for the two or three days, what happens in the interim?
A. Sometimes in CPEP, medication -- if we know somebody is going to admit them, they will initiate medication in CPEP.
Other times the medication is not started until the person is on a inpatient psychiatric floor.
Q. And that's at ECMC?
A. Correct.
Q. There is also the Buffalo Psychiatric Center, right?
A. Yeah. That's a state facility.
Q. And they are both equipped, to your knowledge, to handle schizoaffective disorder?
A. Yes.
Q. And so the transition is seamless, I guess. If somebody is diagnosed with a condition that requires involuntary or voluntary for that matter, care, they just go to another part of ECMC and receive that care?

A. Correct.
Q. And how long does somebody stay in that part?
A. Average length of stay is about ten to 14 days.
Q. What happens after that?
A. The person is discharged, if they are improved. If the person improves and they are deemed to no longer meet legal criteria to remain in the hospital, they are going to be discharged. And there are -- some sort safe discharge will be done.

If the person does not improve, usually after a period of two to four weeks, very often a referal will to be made to the state hospital, Buffalo Psychiatric Center.

They will review the case and may or may not take the person. That process takes months.

Q. So before somebody is released, there is going to be an evaluation to determine if he's made enough progress to be released?
A. Correct.
Q. And that determination would essentially have to say he is no longer a danger to somebody else, right?
A. Due to symptoms of serious mental illness.
Q. Right.
A. That's the key part there. And so the -- specifically, for stay in the hospital, the dangerousness has to be tied to psychiatric symptoms.

Meaning this person can still be dangerous, but the psychiatric symptoms are stabilized, they are going to let them go.

Q. Is it -- have you seen people transition from ECMC to the Buffalo Psychiatric Center?

A. Yes.

Q. And do you know anything about the Buffalo Psych Center? How long does somebody stay there?

A. They consider themselves an intermediate level of care, so months. Not years, usually months.

Q. And does -- is there a review process? I know New York State has that 60-day review process.

Is there, like, an internal review process to see somebody's prognosis?

A. At BPC, do you mean?

Q. Yeah.

A. I mean, I'm not familiar with their procedures.

Q. So pretend we're in State court and we're doing that 60-day assessment. You come into court, what information do you use for that 60-day assessment?

Like, what do you come to Court with to give your recommendation?

A. I haven't -- I haven't done those.

Q. You haven't done them?

A. I can't speak to them. Sorry.

Q. If -- if Buffalo Psych Center did not have a mechanism to forcibly medicate somebody, would you recommend that Mr. Wenke go there?

THE COURT: I don't think I understand the question.

MR. PASSAFIUME: That's a terrible question.

BY MR. PASSAFIUME:

Q. You -- your preference, based on your evaluation, is that Mr. Wenke go to a facility that has the ability to forcibly medicate him?

A. Yes.

Q. And in your opinion, he won't be medicated voluntarily?

A. Maybe. I don't know. Like I said, I've seen people, knowing they are going to be taken to Court, take medication. That's probably the best case outcome, I think.

Q. To your knowledge, you don't know if Mr. Wenke was ever offered medication?

A. I don't know. I believe I've had those conversations with him. I don't think anybody has offered a medication, but I can't be certain.

Q. Nothing was ever prescribed to him, to your knowledge?

A. Nothing that I know of, no.

Q. I don't know if I asked you. So -- did I ask you already what your treatment plan would be for Mr. Wenke?

A. Yes.

Q. I did?

A. Well, you phrased it for personality pathology versus schizoaffective. Depending on what the diagnosis is, it will be different treatment.
Q. Let's go for your diagnosis.
A. Schizoaffective -- like I said, I'm not a medical doctor or psychiatrist.
I am aware of the American Psychiatric Association's guidelines for treatment of bipolar and schizoaffective. When somebody is acutely symptomatic, the first line of treatment is an antipsychotic medication.
Q. At ECMC, can family come and visit?
A. Yes.
Q. Again, that's a big part of somebody's recovery?
A. Yes.
Q. Can that person leave voluntarily, if he's involuntarily committed? Can he just --
A. No.
Q. No?
A. No.
Q. There is no way he could tie sheets together and jump out a window?
A. No. No.
Q. That's securely monitored?
A. Yes. It is monitored. Locked doors.
Q. Okay. And that person won't leave until there is some

psychiatrist that deems Mr. Wenke not a danger to the community?
A. Due to symptoms of serious mental illness, yes.
Q. And you can't give us an exact treatment plan because you don't know medication you would prescribe -- you can't prescribe medication?
A. Correct.
Q. You don't know what medication would be appropriate for Mr. Wenke?
A. I am not competent to offer that opinion.
Q. The psychiatrist at ECMC would make that determination?
A. Correct.

MR. PASSAFIUME: Judge, I don't know if you have -- if I answered the questions that you wanted answered.

THE COURT: Let me see. Stay there.

Dr. Leidenfrost, in your second report under conclusory opinions, the first one is that he is at high risk for future violence.

And that -- I'm paraphrasing just a little. And that is primarily due at this time to an underlying mental disease or defect, being bipolar or schizoaffective disorder. That's number one.

On page seven, number two says that he's at high risk for serious physical harm.

Number three says that he's at high risk for imminent violence, primarily due to the underlying mental disease or

defect.

And if released to the community at this time, he would create a substantial risk of bodily injury to another person due to that mental disease or defect.

And then at the very end, your opinion is that he has a mental disease or defect, number one.

Number two, has no insight regarding his symptoms.

Number three -- again paraphrasing -- likely to refuse to initially voluntarily take the medication.

And his symptoms, number four, significantly influence his risk for future and immediate violence.

Based on all of that, then ultimately your opinion is that he's in need of custody for care or treatment in a suitable facility for his mental disease or defect at this time?

THE WITNESS: Yeah.

THE COURT: Is that a fair assessment of the ultimate conclusion?

THE WITNESS: Yeah, spot on.

THE COURT: Is it your view that this ECMC CPEP program satisfies that opinion on your part?

THE WITNESS: Yes.

THE COURT: There is two ways to do it, right? Bureau of Prisons can take him and do what they do?

THE WITNESS: Uh-huh -- yes.

THE COURT: Or ECMC CPEP plan, in your view, satisfies

your professional concerns?

THE WITNESS: Yeah. I just want him to get some sort of treatment. So, yes.

THE COURT: All right. Anything to follow up, Mr. Passafiume?

MR. PASSAFIUME: No, Judge. Thank you.

THE COURT: Mr. Wright, your turn.

FURTHER REDIRECT EXAMINATION BY MR. WRIGHT:

BY MR. WRIGHT:

Q. So, Dr. Leidenfrost, you can't -- you cannot offer an opinion on the type of treatment BOP would use if he got sent back to BOP?

A. Right. I don't know what they are going to do.

Q. And, again, not to rehash this, but BOP, in their report, was looking at something completely different than what you were looking at in your report in January, 2025?

A. Yes.

Q. For this CPEP program, at ECMC would -- as a hypothetical, would the U.S. Marshals bring him there? And how would he be taken into custody at ECMC?

A. I don't know.

Q. Okay.

A. Like I was talking before -- before this hearing, I can

give an example of what happens locally.

Say if the Erie County Sheriffs Department brings somebody in who is in custody, who is under arrest, they bring them to CPEP, that person cannot be admitted to a civil floor.

They are going to be evaluated and either go to the forensic unit that's at ECMC, which is a different -- different unit on the ninth floor or they are going to go to the holding center and we will do psychiatric treatment there.

In this circumstance -- like, if the U.S. Marshals brought him to CPEP, I'm not frankly sure how they would handle that.

Q. If someone is being held locally, can someone from CPEP go to a local jail, like in Niagara County or somewhere, to meet with that person --

A. No.

Q. -- to conduct the treatment there?

A. No. The evaluation occurs in CPEP.

Q. Okay.

MR. WRIGHT: Nothing further, Your Honor.

THE COURT: If -- Dr. Leidenfrost, if BOP reaches the same conclusions that you do about the mental disease or defect part of it and -- on the one hand -- and the ECMC CPEP program reaches the same conclusions, then presumably the treatment path would be the same in BOP as it would be at ECMC?

THE WITNESS: Correct.

THE COURT: Assuming everyone agrees with you, right?

THE WITNESS: Yes.

THE COURT: And then in that case, the difference would be, he would be somewhere else at BOP for the duration of time that BOP decides is appropriate, up to the eight months or something approximately that he has got left under his supervised release maximum, correct?

MR. WRIGHT: Correct.

THE WITNESS: Yes.

THE COURT: Who pays for this ECMC CPEP program? Is there going to be a problem if we go down that road, that somebody is going to say, who is paying and we're not doing it?

THE WITNESS: Yeah. That's a good concern. It would depend whether his insurance is in network -- whether he has insurance, the insurance is in network.

And if there isn't insurance, it could be potentially a private pay circumstance. Somebody would be on the hook paying for it and I don't know what kind of insurance he has, whether he has insurance, what that would be.

THE COURT: What do they do if someone comes in off the street and clearly needs to be admitted right away, in that scenario, with no insurance or anything like that, it's a Medicaid pay kind of situation?

THE WITNESS: Yeah. They would be admitted no matter what, despite their ability to pay. And the social workers would probably try to get that person on Medicaid or Medicare.

THE COURT: Okay. Any further questions, Mr. Wright?

MR. WRIGHT: No, Your Honor.

THE COURT: Mr. Passafiume?

We can still talk, but the question is whether we need the witness on the stand any longer.

FURTHER RECROSS EXAMINATION BY MR. PASSAFIUME:

BY MR. PASSAFIUME:

Q. Would it work if somebody -- if Mr. Wenke were to get released to, like, his father's custody and his father brings him directly to ECMC, we can have it set up where they would be waiting for him or they knew that he would be coming that day, right?

A. Sure.

Q. And if for some reason -- I guess -- so there does not need to be a period where Mr. Wenke is not in the custody of someone, whether it's his dad or law enforcement?

A. Yes. Because I think if he came to CPEP in custody, like he's still in custody of some criminal justice entity, they can't admit him to a civil floor. They wouldn't do that.

Q. But a way of doing it would be if he was out of custody and his dad is bringing him in directly there.

And, again, we could set it up and coordinate where everything is done the same day, same time?

A. Yeah. And he would be like any other individual coming into CPEP.

And I need to say, there is no guarantee he would get admitted either. I can coordinate with them, but I don't work in CPEP.

I'm not a medical doctor. I'm not able to admit people in New York State. I can convey information. They are my colleagues, but I can't make any guarantees about what they would do -- you know, working under their own license.

MR. PASSAFIUME: Okay. Thank you.

THE COURT: Okay. Thank you, Dr. Leidenfrost. You may step down.

(Witness Excused)

THE COURT: All right. While we're all together, let's keep talking a little bit.

Do you have any other witnesses for the purposes of this hearing?

MR. PASSAFIUME: No, Judge.

THE COURT: I think, nevertheless, that what I ought to do procedurally is hold the hearing open and think about what we're going to do next, while the hearing is still technically held open.

That way there is no, you know, statutory pressure on me, I guess, to conclude one way or the other on whether the standard has been met.

So I need to hear from the Government, ultimately -- and probation, if they've got a view as well, on this proposal from -- the ECMC proposal.

MR. WRIGHT: Your Honor, number one, obviously the Government has some concerns relating to release and all that stuff, to the parents.

But I think part of it, too, was -- and the question to Dr. Leidenfrost relating to if BOP was asked to do a similar examination under 4244, that type of examination related to mental disease and defect, if they came to the same conclusion, would they be in -- kind of like in the same position of kind of following up with the defendant and doing the treatment there. The answer was yes.

If -- and this is an uncertainty is how quickly potentially that could be done versus going through the CPEP route and all of that.

So it's something I know we would like to look into a little bit more, Your Honor.

THE COURT: Right. I think we need to reconvene at some point soon.

Probably a lot of questions for everybody at this point in time, to see whether this is something that's workable, and then take everyone's temperature on whether they're for it or against it.

MR. PASSAFIUME: The one thing I want to point -- I

want to make sure that we're clear, because I did have a conversation with Mr. DiGiacomo.

Dr. Leidenfrost's evaluation is the evaluation under 4247 that brought us to the hearing. So he's not going to get evaluated again at the BOP. He would go there for treatment.

THE COURT: Right.

MR. PASSAFIUME: So I guess what the Government is saying now is that's not right.

I want to make sure that's clear. That we have already done that evaluation. This is for whether he is going to go for treatment.

THE COURT: Well, in that scenario, he would go down to BOP with this report in hand, I suppose, right?

And BOP would pick it up and treat him accordingly, but I don't know, right?

Nobody knows exactly what's inside the black box.

MR. PASSAFIUME: Well, the BOP had the first report when they saw him on the competency.

THE COURT: Yeah. But we don't know if he's going back to the same people either, right?

Will he go back to the same people at BOP or different people? I don't know that. Nobody knows.

So that's why you are proposing something where there is more certainty and more things that can be managed, et cetera, and family proximity. I get it. I understand why you

are proposing it.

So let's reconvene after Mr. Wright can work on things.

If probation has views, they can give them to me now or think about it and give it to me.

But, Mr. Passafiume, if there is a payment problem, do we need to worry about that now?

So things that you need to work on, I guess, are that one, payment and logistics. How do we effectuate it?

Number three, then, is how do we make sure that Dr. Leidenfrost's report goes along as well?

You'd think that we want the psychiatric provider that does the intake to have that report in hand, perhaps even before they meet with Mr. Wenke.

MR. PASSAFIUME: I asked him that in the hall and he said they would -- they would have that evaluation.

THE COURT: They would have it. So that's got to be in hand, I would say. No point in sending Mr. Wenke first.

I think the report needs to go first, because it would take a little time to read it, wouldn't it?

MR. PASSAFIUME: Sure.

THE COURT: So those logistics, keep working on how those would work out and ultimately what the plan would be and I can decide whether we want to try it.

Clearly, given the amount of time we spent on it, I'm

open to it, otherwise I wouldn't have wasted everybody's time.

But if I hear impediments that are structurally unavoidable, then I need to hear that, too.

So, Mr. Wright, a little bit of homework on your side to see what your office's position is.

Same thing -- Mr. Zenger, same thing from you, if you have got views.

And I think, Mr. Passafiume, you have got to work on the logistics part of it, right?

Because the last thing I want to do is hear that he gets there and they won't talk to him because he doesn't have insurance, right?

MR. PASSAFIUME: Right.

THE COURT: I can't have that be an impediment, otherwise we are back here and resume the hearing and I make my findings and we wasted everybody's time.

And then ultimately, in that scenario, taking time away from Mr. Wenke's treatment, which would be an unintended consequence, I guess.

MR. PASSAFIUME: Understood, Judge.

THE COURT: Because all this time passing that we've used up is time that's not available to us for his treatment.

Okay. Well, let's -- when should we come back? A couple of days?

MR. WRIGHT: What is today, Tuesday?

THE COURT: Tuesday.

MR. WRIGHT: That's fine, Your Honor. I'll be out for a portion of next week, so this week would probably be better.

MR. PASSAFIUME: Judge, as you know, I'm out until February 25th.

THE COURT: Starting today or tomorrow?

MR. PASSAFIUME: Starting tomorrow. In my mind, I'm already gone. Thursday.

THE COURT: All right. So can Ms. Kubiak finish for you on Thursday then?

MS. KUBIAK: Yes, Judge. I can handle the report back.

THE COURT: But the legwork in the meantime can be done before you go, Mr. Passafiume, right?

MR. PASSAFIUME: Yes.

THE COURT: Thursday? Yes? Okay.

MR. WRIGHT: Yes, Your Honor.

THE COURT: How does Thursday look, Ms. Henry?

THE CLERK: Thursday, 9:30.

MR. WRIGHT: That works for the Government, Your Honor.

MS. KUBIAK: That's fine.

THE COURT: And if -- Mr. Wright, if there is a problem with the logistics in terms of getting him there physically via his father -- it did work the last time, I think

it was his father who drove him there the last time.

If that's a problem and there needs to be some other way, like through the U.S. Marshals Service, then check to see if that's even available.

Sometimes the Marshal's Service tells me things like, we can't do that. Maybe they can, maybe they can't. I don't know the answer to that.

I think that would be on you, Mr. Wright, to see if that's a possibility in terms of driving him there.

MR. WRIGHT: Okay. Thank you, Your Honor.

THE COURT: So the hearing is held open and we'll talk about things again Thursday morning at 9:30.

Anything else?

MR. WRIGHT: No, Your Honor. Thank you.

MR. PASSAFIUME: Thank you.

THE COURT: Take care, everybody. Thank you.

(Proceedings concluded at 4:13 p.m.)

* * *

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

s/ Bonnie S. Weber — March 6, 2025
Signature — Date

BONNIE S. WEBER, RPR

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

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

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