UNITED STATES COURT OF APPEALS FOR THE SECOND CIRCUIT

Thurgood Marshall U.S. Courthouse 40 Foley Square, New York, NY 10007 Telephone: 212-857-8500

MOTION INFORMATION STATEMENT

Docket Number(s): 25-1165 Caption [use short title]

Motion for: An order staying the district court's April 23, 2025 Decision and Order

Set forth below precise, complete statement of relief sought:

an Order staying the district court's April 23, 2025 decision and order of commitment pursuant to 18 U.S.C. Sec. 4244.

United States v. Wenke

MOVING PARTY: Luke Wenke **OPPOSING PARTY:** United States of America

☐ Plaintiff ☑ Defendant

☑ Appellant/Petitioner ☐ Appellee/Respondent

MOVING ATTORNEY: Timothy P. Murphy, AFPD **OPPOSING ATTORNEY:** Tiffany H. Lee, AUSA

[name of attorney, with firm, address, phone number and e-mail]

Federal Public Defender's Office (WDNY)
300 Pearl Street, Suite 200, Buffalo, NY 14202
(716) 551-3341; martin_vogelbaum@fd.org

United States Attorney's Office (WDNY)
138 Delaware Avenue, Buffalo, New York, 14202
(716) 843-5827; tiffany.lee@usdoj.gov

Court- Judge/ Agency appealed from: Hon. John L. Sinatra, Jr.

Please check appropriate boxes:

Has movant notified opposing counsel (required by Local Rule 27.1):
☑ Yes ☐ No (explain):

Opposing counsel's position on motion:
☐ Unopposed ☑ Opposed ☐ Don't Know

Does opposing counsel intend to file a response:
☐ Yes ☐ No ☑ Don't Know

FOR EMERGENCY MOTIONS, MOTIONS FOR STAYS AND INJUCTIONS PENDING APPEAL:

Has this request for relief been made below? ☑ Yes ☐ No

Has this relief been previously sought in this court? ☐ Yes ☑ No

Requested return date and explanation of emergency:

Is oral argument on motion requested? ☐ Yes ☑ No (requests for oral argument will not necessarily be granted)

Has argument date of appeal been set? ☐ Yes ☑ No If yes, enter date:

Signature of Moving Attorney:

/s/ Timothy P. Murphy **Date:** 05/28/2025 Service by: ☑ CM/ECF ☑ Other [Attach proof of service]

UNITED STATES OF COURT OF APPEALS
FOR THE SECOND CIRCUIT

UNITED STATES OF AMERICA,

Appellee,

v. No. 25-1165

LUKE M. WENKE,

Defendant-Appellant.

MEMORANDUM IN SUPPORT OF MOTION TO STAY DISTRICT COURT'S ORDER OF COMMITMENT

The defendant-appellant Luke Wenke respectfully submits through Timothy P. Murphy, Esq., Assistant Federal Public Defender for the Western District of New York, the instant memorandum in support of the appellant's motion for a stay of the enforcement of the District Court's Decision and Order of Commitment, entered April 23, 2025, pending the appeal of this matter. [1]

I. Introduction

The District Court's April 23, 2025 order concluded Mr. Wenke is in need of custody for care and treatment in a suitable facility

[1] *See U.S. v. Wenke*, WDNY file no. 1:22-CR-00035, Dkt. 194, **Exhibit A** herein.

pursuant to 18 U.S.C. § 4244. As set out below, without a stay, the Bureau of Prison ("BOP") may issue a treatment determination prior to Mr. Wenke's sentence being completed.

While the decision to grant a stay pending appeal is a matter of discretion for this Court, the Supreme Court has observed,

> [t]he authority to hold an order in abeyance pending review allows an appellate court to act responsibly. A reviewing court must bring considered judgment to bear on the matter before it, but that cannot always be done quickly enough to afford relief to the party aggrieved by the order under review. The choice for a reviewing court should not be between justice on the fly or participation in what may be an "idle ceremony." The ability to grant interim relief is accordingly not simply "[a]n historic procedure for preserving rights during the pendency of an appeal," but also a means of ensuring that appellate courts can responsibly fulfill their role in the judicial process.

Nken v. Holder, 556 U.S. 418, 427 (2009) (internal citations omitted); but see *id.* at 427-428 (also discussing the importance of finality in court orders).

This Circuit looks at four factors in determining whether to stay district court orders or proceedings pending appeal: (1) whether the stay applicant has made a strong showing that he is likely to

succeed on the merits; (2) whether the applicant will be irreparably injured absent a stay; (3) whether issuance of the stay will substantially injure the other parties interested in the proceedings; and (4) where the public interest lies. *United States v. Grote*, 961 F.3d 105, 122-123 (2d Cir. 2020), citing *In re World Trade Center Disaster Site Litig.*, 503 F.3d 167, 170 (2d Cir. 2007); *see also generally United States v. Gelb*, 826 F.2d 1175, 1177 (2d Cir. 1987).

This Circuit has "also noted that the degree to which a factor must be present varies with the strength of the other factors, meaning that "more of one [factor] excuses less of the other."" *In re World Trade Ctr., et al.*, 503 F.3d at 170 (2d Cir. 2007) (internal citations omitted). Finally, as argued below, the public interest is best served, *Grote*, 961 F.3d at 122-123, by exercising caution here: granting the stay while this Court reviews the matter, as appellant remains imprisoned in the interim. *See again*, *Nken*, 556 U.S. at 435 (recognizing the third and fourth stay-related factors merge where the government is the opposing party).

In sum, this Court should have the opportunity to review this appeal before it becomes moot.

II. Pertinent procedural history

Mr. Wenke admitted in 2023 to violating a condition of his supervised release and is awaiting sentence. Doctor Corey M. Leidenfrost examined Mr. Wenke and issued reports on 4/1/24 and 1/13/25, opining that Mr. Wenke suffers from a "schizoaffective disorder, bipolar type," and, among other things, possesses symptoms significantly influencing a high risk for "future and imminent violence." Dkt. 122 (filed on 4/2/24); 2/18/25 hearing, pp. 102-103; Dkt. 175 (filed 1/14/25). [2] On 11/12/24, BOP Doctors Kaitlin Nelson and Robin Watkins issued a report finding Mr. Wenke to be competent, while suffering from an "other specified personality disorder, with mixed personality features." Dkt. 164 (filed on 11/14/24); 4/10/25 hearing, pp. 24-26, 61-62. [3]

On April 23, 2025, the District Court, following a two-day evidentiary hearing, conducted on 2/18/25 and 4/10/25 (**Exhibits B**

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[2] Dr. Liedenfrost's initial opinion, following an examination of the defendant in March of 2024, was that Mr. Wenke suffered from an unspecified bipolar I disorder, with psychotic features. 2/18/25 hearing, pp. 35; *see also*, *id.* at 22, 24.

[3] All three of these reports were previously filed under seal in the District Court, are incorporated by reference for purposes of this motion and are submitted herein under seal.

and **C** herein), issued a Decision and Order of Commitment, finding by a preponderance of the evidence that Mr. Wenke suffers from "a mental disease or defect for which he is in need of custody for care or treatment in a suitable facility." WDNY Dkt. 194, p. 10. This order was deemed, pursuant to 18 U.S.C. § 4244, a "provisional sentence of imprisonment to the maximum term authorized by law for the violation of supervised release to which [Mr.] Wenke admitted." *Id.* at p. 10.

On May 1, 2025, the appellant timely filed a notice of appeal. WDNY Dkt. 196. Our office has sought an expedited transcript schedule and once in receipt of the final transcript, will seek an expedited appeal schedule with this Court.

Federal Rule of Appellate Procedure ("Fed. R. App. P.") 8(a)(1) indicates that "[a] party must ordinarily move first in the district court for… a stay of the judgment or order of a district court pending appeal." On May 16, 2025, the District Court denied appellant's motion for a stay of the instant judgment. WDNY Dkt. 205 (**Exhibit D**); *see also id.* at Dkt. 202 (appellant's previous motion for a stay); Dkt. 204 (government response).

III. Reasons for granting the stay

A. Likelihood of success

As to the likeliness of success on appeal, as Mr. Wenke argued previously, the opinion of Dr. Leidenfrost that Mr. Wenke suffered from a "[s]chizoaffective disorder, bipolar type," and, among other things, possessed symptoms significantly influencing a high risk for "future and imminent violence," WDNY Dkt. 175, pp. 4, 6-7, was based was based on erroneous and insufficient information, as the doctor conducted only one in-person meeting with the defendant and failed to consult at all with defendant's counsel and family. 2/18/25 hearing, pp. 55-56, 63, 74-75; WDNY Dkt. 192, pp. 2-9. This is despite such commonsense outreach efforts potentially providing helpful insight in arriving at a proper diagnosis. 2/18/25 hearing, p. 55.

Dr. Leidenfrost's opinion was also based on the erroneous conclusion that Mr. Wenke suffered from delusions. *See*, WDNY Dkt. 192, pp. 6-8 (counsel addressing eight examples of wrongly found delusions); *see also*, 4/10/25 hearing, p. 32 (Dr. Watkins defining a delusion as "a fixed belief that remains steadfast even in the face of contrary evidence"); 4/10/25 hearing, p. 41 (Dr. Watkins discussing 17-

factor Cunningham Model for classifying individuals as delusional). All three doctors agreed that a "schizoaffective disorder, bipolar type" diagnosis is dependent upon there being psychotic symptoms, such as delusions. 2/18/25 hearing, pp. 20, 37-40; 4/10/25 hearing, pp. 77-79. Indeed, the purported existence of delusions was "critical" to Dr. Liedenfrost's diagnosis. 2/18/25 hearing, p. 73; *see also*, *id.* at 20-21.

But Doctors Nelson and Watkins, whose conclusions were based on observing Mr. Wenke on a number of occasions over a 45-day period, directly contradicted Dr. Liedenfrost on this issue. *Contrast* 2/18/25 hearing, pp. 26-32, 35-36, 40, 42-45, 52-53, 57-60, 64-66, 69-71, with 4/10/25 hearing, pp. 46-47, 59-60, 66-67, 77-79. During the latter observation period, Mr. Wenke remained in general population, raising no concerns to Dr. Nelson regarding the safety of others in custody. 4/10/25 hearing, pp. 46-47, 59-60. Indeed, Mr. Wenke demonstrated the ability to follow rules, 11/12/24 report, p. 13 (WDNY Dkt. 164), despite not being on medication during this time-period. 4/10/25 hearing, pp. 63. [4] Moreover, a schizoaffective disorder is

[4] Dr. Liedenfrost acknowledged that mental health treatment had not been necessary for Mr. Wenke during his time in the BOP system. 2/18/25 hearing, p. 92.

something that could be detected during individual interactions with the patient -- but wasn't discovered here by either Doctors Nelson or Watkins. 4/10/25 hearing, pp. 77-79. In sum, Doctors Nelson and Watkins believed that Mr. Wenke's expressed beliefs were not "overtly" delusional. 4/10/25 hearing, pp. 35-37, 58; 11/12/24 report, p. 20.

While part of Dr. Liedenfrost's ultimate conclusions included his opinion that Mr. Wenke would likely refuse to voluntarily take medication, 2/18/25 hearing, p. 102-103, he also testified to not actually knowing if the defendant could be medicated voluntarily. *See, id.* at 100. Moreover, neither Doctors Nelson nor Watkins could opine on a specific treatment plan, as Mr. Wenke suffers only from Other Specified Personality Disorder, with Mixed Personality Features -- containing features unlikely to significantly change in the near future. *See e.g.*, 4/10/25 hearing, pp. 62, 64-65 (Dr. Nelson opining that therapy, including group therapy, was important and that treatment could take time; not necessarily requiring hospitalization); *see also*, 11/12/24 report, p. 18; WDNY Dkt. 192, p. 10. Even Dr. Liedenfrost acknowledged that Mr. Wenke could be released to his father's

custody, who could then bring him to the Erie County Medical Center for treatment. 4/10/25 hearing, pp. 107-108.

Along these lines, Dr. Liedenfrost recognized that having Mr. Wenke in custody hundreds of miles away, with less access to his family, could worsen his condition. 2/18/25 hearing, pp. 93-94, 101. It's also telling that -- unlike BOP Doctors Nelson and Watkins -- Dr. Liedenfrost: (1) was not familiar at all with the BOP system, (2) had never been to any of its facilities and (3) naturally had no knowledge of BOP's treatment plans. 2/18/25 hearing, pp. 92-93. As Mr. Wenke previously argued, even if his personality disorder qualified as a mental disease or defect, there was insufficient evidence before the District Court to warrant an order of hospitalization to provide appropriate treatment. WDNY Dkt. 192, pp. 9-10.

Finally, Dr. Liedenfrost's opinion about Mr. Lemke's potential for committing future violence is suspect. For instance, the doctor references an incident flagged in social media of the appellant possessing a firearm in 2020. 2/18/25 hearing, pp. 32-33. In addition to this purported event occurring two years before the 2022 offense at bar, there was no police report filed regarding this incident, nor was

there any report of a gun being recovered. 2/18/25 hearing, pp. 77-78. Indeed, the 33-year-old Mr. Lemke had no prior arrest record before the present matter. 11/12/24 report, p. 9 (WDNY Dkt. 164).

B. Irreparable harm and potential injury to the government

Without this Court staying the enforcement of the April 23rd order, Mr. Wenke will be irreparably harmed by being deprived of the opportunity to receive appellate review. Mr. Wenke has been in custody on the instant violation of supervision since October 4, 2023. WDNY Dkt. 78. He admitted to committing charge #5 of the second amended petition on November 7, 2023. WDNY Dkt. 95. His maximum statutory penalty for this violation offense is two (2) years. 18 U.S.C. § 3583(e)(3). Upon information and belief, Mr. Wenke will have completed serving "the maximum term authorized by law" for his violation in early October of this year.

Should the director of the facility in which Mr. Wenke is held determine (pursuant to the District Court's April 23rd order) that the appellant has "recovered from his mental disease or defect to such an extent that he is no longer in need of custody or care in such a facility" (*see again*, WDNY Dkt. 194, p. 10) prior to the appellant's maximum

term being completed in October 2025, his pending appeal will be moot.

As Mr. Wenke would remain in custody under the District Court's October 4, 2025 detainment order, WDNY Dkt. 78, even if he successfully obtained a stay herein, there is no potential injury, substantial or not, to the government or the public in this Court granting the relief sought herein.

WHEREFORE, Mr. Wenke respectfully requests that this Court stay the enforcement of the District Court's April 23, 2025 Decision and Order of Commitment (WDNY Dkt. 194) and grant such other and further relief as this Court deems just and proper.

Dated: Buffalo, New York
May 28, 2025

Respectfully submitted,

/s/ Timothy P. Murphy
Timothy P. Murphy

Assistant Federal Public Defender
(Appellate Unit)
Federal Public Defender's Office
300 Pearl Street, Suite 200
Buffalo, New York 14202
(716) 551-3341
timothy_murphy@fd.org

On behalf of appellant

EXHIBIT A

UNITED STATES DISTRICT COURT
FILED
APR 23 2025
CLERK, U.S. DISTRICT COURT
WESTERN DISTRICT OF NY

UNITED STATES DISTRICT COURT
WESTERN DISTRICT OF NEW YORK

UNITED STATES OF AMERICA,

v.

LUKE MARSHALL WENKE,

Defendant.

22-CR-35 (JLS)

DECISION AND ORDER OF COMMITMENT

As detailed below, the Court finds by a preponderance of the evidence that Defendant Luke Marshall Wenke is presently suffering from a mental disease or defect for the treatment of which he is in need of custody for care or treatment in a suitable facility.

BACKGROUND

I. PROCEDURAL HISTORY

Wenke was indicted on March 15, 2022, for cyberstalking and making interstate threats. Dkt. 8. He pled guilty to cyberstalking on April 18, 2022 (Dkt. 24), and this Court sentenced him on August 18, 2022, to eighteen months of imprisonment and three years of supervised release. Dkt. 41. Upon release, Wenke violated his supervised release. His initial appearance was held on October 4, 2023. Dkt. 78. On November 7, 2023, he pled guilty to Charge 5, and is now awaiting sentencing. Dkt. 95.

At a status conference on January 30, 2024, the Court ordered Wenke to undergo a psychiatric evaluation with Dr. Corey M. Leidenfrost.[1] *See* Dkt. 113–15. The Probation department facilitated the evaluation and filed Dr. Leidenfrost's report under seal on April 2, 2024. Dkt. 113, 122.

The Court then ordered a hearing pursuant to 18 U.S.C. §§ 4244 and 4247, and provided defense counsel with an opportunity to arrange for an alternative expert to conduct a separate evaluation. Dkt. 125. The hearing was initially set for October 17, 2024. Dkt. 128.

On July 25, 2024, defense counsel filed a motion, pursuant to 18 U.S.C. §§ 4241 and 4247, to determine Wenke's competency and for a psychiatric evaluation. Dkt. 140. The Court held a status conference on July 30, 2024, where it granted the motion and entered an order—directing, *inter alia*, that Wenke undergo a psychiatric examination and that he be committed to the Bureau of Prisons ("BOP") for the evaluation.[2] *See* Dkt. 143–44. The Court subsequently converted the hearing, which had been set pursuant to section 4244, to a status conference. Dkt. 151.

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[1] The parties agreed that Dr. Leidenfrost would evaluate Wenke. *See* Dkt. 113.

[2] At the parties' request, the Court issued an amended order on September 18, 2024. Dkt. 152–53. On September 30, 2024, BOP requested a fifteen-day extension to complete the evaluation, which the Court granted. Dkt. 154, 156. Wenke's evaluation period started on September 4, 2024. Dkt. 154.

BOP's competency report was filed under seal on November 14, 2024. Dkt. 164. Dr. Kaitlyn Nelson drafted the report, under the supervision of Dr. Robin Watkins. *Id.* Dr. Nelson and Dr. Watkins concluded that Wenke is competent. *Id.* at 25–26.[3]

Based on this, the Court also found Wenke competent, under 18 U.S.C. § 4241, but determined that there remained reasonable cause to believe that Wenke may be suffering from a mental disease or defect, under 18 U.S.C. § 4244. Dkt. 166. At the direction of this Court, the parties contacted Dr. Leidenfrost to ask whether he could supplement his prior report to opine as to the statutory standard under 18 U.S.C. §§ 4244(b) and 4247(c). *Id.* Dr. Leidenfrost agreed and met again with Wenke, this time remotely. *See* Dkt. 169; Dkt. 175, at 1. His supplemental report was filed under seal on January 14, 2025. Dkt. 175.

The parties appeared for a section 4244 evidentiary hearing on February 18, 2025. Dkt. 182. Dr. Leidenfrost testified. *Id.* The hearing continued April 10, 2025, where Dr. Watkins and Dr. Nelson both testified. Dkt. 190. The parties submitted post hearing briefs on April 18, 2025. *See* Dkt. 192–93.

II. THE HEARING

Dr. Leidenfrost testified based on his two separate reports and two evaluations of Wenke. *See* Dkt. 122, 175. In his first report, he concluded that Wenke is suffering from a bipolar or schizoaffective disorder. Dkt. 122, at 21–22. Dr. Leidenfrost further opined that Wenke is at a high risk for future violence,

[3] The page numbers referenced refer to the CM/ECF pagination.

serious physical harm, and imminent violence, due to an underlying mental disease or defect—here, bipolar or schizoaffective disorder. *See id.* Dr. Leidenfrost based his findings on his evaluation of Wenke, documents from the record, Wenke's social media, and the letters Wenke has written to this Court. *Id.* at 2–3.

The factors underlying Dr. Leidenfrost's opinions from the first report remain unchanged in his second report, but he updated Wenke's diagnosis to "[s]chizoaffective disorder, bipolar type" after evaluating Wenke again. *See* Dkt. 175, at 4, 6–7; Dkt. 186, at 39. He further determined—and so testified—that Wenke is in need of custody for care or treatment, in a suitable facility, for his mental disease or defect, because: (1) Wenke is presently suffering from a mental disease or defect; (2) he has no insight regarding his symptoms of serious mental illness; (3) he will likely refuse to take psychiatric medication; and (4) his symptoms significantly influence his high risk for future and imminent violence. *See id.* at 7.

Dr. Nelson and Dr. Watkins testified based on their report prepared pursuant to 18 U.S.C. § 4241. *See* Dkt. 164. They opined that Wenke presented symptoms consistent with a personality disorder or autism spectrum disorder because he becomes fixated on his interests and devotes significant efforts in making his opinions and thoughts known. *Id.* at 25. As noted above, they found Wenke competent to proceed in his case because he demonstrated the ability to assist effectively in his defense. *Id.*

DISCUSSION

I. LEGAL STANDARD

Prior to sentencing, the court may order a hearing "on its own motion, if it is of the opinion that there is reasonable cause to believe that the defendant may presently be suffering from a mental disease or defect for the treatment of which he is in need of custody for care or treatment in a suitable facility." 18 U.S.C. § 4244(a).

Before such a hearing, the court has discretion to order a psychiatric or psychological examination and report. *See id.* 4244(b) ("Prior to the date of the hearing, the court *may* order that a psychiatric or psychological examination of the defendant be conducted, and that a psychiatric or psychological report be filed with the court . . . .") (emphasis added). If the court orders an examination and report under this section, the report and examination must conform to the requirements set forth in sections 4247(b) and 4247(c). *See id.*

After the hearing, if the court finds by a preponderance of the evidence that "the defendant is presently suffering from a mental disease or defect and that he should, in lieu of being sentenced to imprisonment, be committed to a suitable facility for care or treatment," the court shall then "commit the defendant to the custody of the Attorney General." *Id.* § 4244(d).

II. ANALYSIS

Here, after finding Wenke competent, the Court determined that there was reasonable cause to initiate proceedings, *sua sponte*, under section 4244. *See* Dkt. 166. The Court did not order a new report from BOP, like it did under section 4241,[4] but Dr. Leidenfrost supplemented his previous report—opining as to the standard in section 4244. Dkt. 169, 175. The evidentiary hearing has now concluded, and the parties have submitted post-hearing briefs. *See* Dkt. 190, 192–93.

For the below reasons, the Court finds by a preponderance of the evidence that Wenke is presently suffering from a mental disease or defect for the treatment of which he is in need of custody for care or treatment in a suitable facility. *See* 18 U.S.C. § 4244(d).

Dr. Leidenfrost testified credibly at the hearing. And his reports are supported by a fulsome factual basis. He evaluated Wenke himself, on two occasions, and he relied on his own research, observations, evaluation, and the docket, including the numerous letters Wenke has sent to this Court. Dr. Leidenfrost concluded that Wenke "is in need of custody for care or treatment, in a suitable facility, for his mental disease or defect," which is "[s]chizoaffective

[4] In making this determination, the Court considered Wenke's time in custody. At that time, he had approximately eleven months left before reaching his statutory maximum. The Court had concerns about the time it would take to obtain another report through BOP, including round trip travel out of the district.

disorder, bipolar type." Dkt. 175, at 4, 7; Dkt. 186, at 39. The Court gives appropriate weight to his testimony and report to support its finding.

Although there are some differences, as discussed below, the 4241 BOP report and Dr. Leidenfrost's 4244 report—and corresponding testimony—do not contradict each other because they are based on two separate standards. *See United States v. Chaudhry*, 646 F. Supp. 2d 1140, 1149 (N.D. Cal. 2009) ("In sum, the [c]ourt holds that 18 U.S.C. § 4241 and § 4244 apply to independent inquiries."). Dr. Watkins confirmed this during her testimony:

> **THE COURT:** Dr. Watkins, in the context of this 4244 hearing that we're in, my job is to decide whether Mr. Wenke is presently suffering from a mental disease or defect and whether he should, in lieu of being sentenced to imprisonment, instead be committed to a suitable facility for care or treatment. That's the question I have to ask. Do you have an opinion on that issue?
>
> **DR. WATKINS:** I do not currently have an opinion on that issue, only because I didn't do that type of evaluation.
>
> **THE COURT:** If you were asked to do the 4244 evaluation, in addition to or instead of or now, what would you do differently that perhaps you hadn't done already?
>
> **DR. WATKINS:** I would conduct a more thorough inquiry into, I guess, the history and course of symptoms. We would do a lot more diagnostic differential diagnosis. I guess, between—I believe we listed a number of diagnostic possibilities and some tentative diagnoses. I think we would do more to try to pars[e] out exactly what's going on with him diagnostically, to better determine what the most appropriate treatment recommendations would be at this time.
>
> **THE COURT:** With everything that you know about Mr. Wenke, and—and acknowledging the limits of your 4241 evaluation, is it possible, knowing what you know now, that you could ultimately conclude under 4244, that he is suffering from a mental disease or defect[,] [a]s a result

> of which, he is in need of custody for care or treatment in a suitable facility?
>
> **DR. WATKINS:** Yes. Your Honor, that's possible.

Dkt. 191, at 42–43.

Thus, the finding of competency does not negate a determination that Wenke is nevertheless suffering from a mental illness that requires treatment.

Wenke argues that, because a schizoaffective disorder diagnosis requires delusions, and the BOP doctors found that Wenke did not exhibit overt delusions, Dr. Leidenfrost's diagnosis is skewed. *See* Dkt. 192, at 6–8. Although the experts disagree about whether Wenke suffers particular delusional beliefs (Dkt. 186, at 44), Dr. Leidenfrost's conclusions remain well supported.

Moreover, when diagnosing Wenke, Dr. Leidenfrost considered delusional beliefs that Dr. Nelson and Dr. Watkins did not fully evaluate—such as Wenke's fixation on particular individuals, or erotomanic delusions—because the scope of BOP's evaluation was limited to present-based competency. *See* Dkt. 186, at 29–30; *see also* Dkt. 193, at 6–10. Dr. Watkins testified that it was not clear whether Wenke's relationship with R.T. was an erotomanic delusion and, as a result, found that it was not an overt delusion (Dkt. 191, at 36), but she also stated: "I wasn't doing a risk assessment or in depth inquiry into the dynamics involved in any of these relationships, because our focus was primarily on competency and present focused competency." *Id.* at 38. Dr. Watkins testified that she would need to evaluate Wenke's symptoms further to make a diagnosis under section 4244. *Id.* at

29. Beyond that, the evaluators disagree about delusions but, given the different standards and overall credibility assessment, the Court remains convinced by Dr. Leidenfrost's conclusions.

Based on all of the hearing evidence, the Court finds that Wenke is presently suffering from a mental disease or defect for the treatment of which he is in need of custody for care or treatment in a suitable facility, in lieu of sentencing. This conclusion *is corroborated by* the Court's lengthy involvement in the case, the facts of the case, Wenke's violation history, his letters to the Court,[5] and the Court's courtroom observations of, and interactions with, Wenke.

CONCLUSION

This Court spent months reflecting on this issue, and has considered the testimony, reports, post-hearing briefs, and the record in rendering this decision. For the reasons set forth above, the Court finds by a preponderance of the evidence that Luke Wenke is presently suffering from a mental disease or defect for the treatment of which he is in need of custody for care of treatment in a suitable facility pursuant to 18 U.S.C. § 4244.

[5] *See* Dkt. 69, 71, 86, 87, 92, 97, 116, 117, 118, 119, 120, 121, 124, 126, 127, 129, 132, 133, 134, 135, 136, 137, 138, 139, 142, 145, 146, 147, 148, 149, 150, 155, 157, 160, 162, 165, 167, 168, 170, 174, 189.

ORDER OF COMMITMENT

For the reasons set forth above, the Court finds by a preponderance of the evidence that Defendant is presently suffering from a mental disease or defect for the treatment of which he is in need of custody for care or treatment in a suitable facility pursuant to 18 U.S.C. § 4244. Accordingly, it is hereby

ORDERED that, in lieu of being sentenced to imprisonment, Wenke shall be committed to the custody of the Attorney General; and it is further

ORDERED that the Attorney General shall hospitalize Wenke for care or treatment in a suitable facility; and it is further

ORDERED that such commitment constitutes a provisional sentence of imprisonment to the maximum term authorized by law for the violation of supervised release to which Wenke admitted; and it is further

ORDERED that if the director of the facility in which Wenke is hospitalized determines that Wenke has recovered from his mental disease or defect to such an extent that he is no longer in need of custody for care or treatment in such a facility, the director of the facility shall promptly file a certificate to that effect with the Clerk of Court. And if, at the time of filing the certificate, the provisional sentence imposed has not expired, the Court will proceed to sentencing and may modify this provisional sentence; and it is further

ORDERED that if Wenke's sentence is about to expire and the director of the facility in which Wenke is hospitalized certifies that Wenke is presently suffering from a mental disease or defect as a result of which his release would create a

substantial risk of bodily injury to another person or serious damage to property of another, and that suitable arrangements for State custody and care of the person are not available, the director of the facility shall transmit such certificate to the Clerk of Court.

SO ORDERED.

Dated: April 23, 2025
Buffalo, New York

JOHN L. SINATRA, JR.
UNITED STATES DISTRICT JUDGE

EXHIBIT B

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.	*	
	*	

* * * * * * * * * * * * * * * * *

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

APPEARANCES:

For the Government:

MICHAEL DiGIACOMO,
UNITED STATES ATTORNEY,
By FRANZ M. WRIGHT, ESQ.,
Assistant United States Attorney,
Federal Centre,
138 Delaware Avenue,
Buffalo, New York 14202,
Appearing for the United States.

For the Defendant:

FEDERAL PUBLIC DEFENDER'S OFFICE
By ALEXANDER J. ANZALONE, ESQ.,
FONDA D. KUBIAK, ESQ.,
Assistant Federal Public Defender,
300 Pearl Street,
Suite 200,
Buffalo, New York 14202.

The Courtroom Deputy:

KIRSTIE L. HENRY

The Court Reporter: BONNIE S. WEBER, RPR,
Notary Public,
Robert H. Jackson Courthouse,
2 Niagara Square,
Buffalo, New York 14202,
Bonnie_Weber@nywd.uscourts.gov.

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(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
Signature

March 6, 2025
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

INDEX TO EXHIBITS

EXHIBIT C

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.	*	April 10, 2025
	*	10:03 a.m.
	*	
LUKE MARSHALL WENKE,	*	EVIDENTIARY HEARING CONTINUATION
	*	
Defendant.	*	
	*	
* * * * * * * * * * * * * * * * *		

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

APPEARANCES:

For the Government:

MICHAEL DiGIACOMO,
UNITED STATES ATTORNEY,
By FRANZ WRIGHT, ESQ.,
Assistant United States Attorney,
Federal Centre,
138 Delaware Avenue,
Buffalo, New York 14202,
Appearing for the United States.

For the Defendant:

FEDERAL PUBLIC DEFENDER'S OFFICE
By FRANK R. PASSAFIUME, ESQ.,
FONDA KUBIAK, ESQ.,
Assistant Federal Public Defender,
300 Pearl Street,
Suite 200,
Buffalo, New York 14202.

The Courtroom Deputy:

KIRSTIE L. HENRY

The Court Reporter: BONNIE S. WEBER, RPR,
Notary Public,
Robert H. Jackson Courthouse,
2 Niagara Square,
Buffalo, New York 14202,
Bonnie_Weber@nywd.uscourts.gov.

Proceedings recorded by mechanical stenography, transcript produced by computer.

(Proceedings commenced at 10:03 a.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're 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 John Taberski.

Counsel, please state your appearances for the record.

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

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

THE COURT: Good morning to all of you.

MR. PASSAFIUME: Good morning, Your Honor.

MS. KUBIAK: Good morning, Judge.

THE COURT: And we're going to continue with two people that are with us, we think and hope, remotely, right?

MR. PASSAFIUME: Yes, Judge.

THE COURT: Are you ready to proceed, both of you?

MR. WRIGHT: Yes, Your Honor.

MR. PASSAFIUME: Yes, Judge.

THE COURT: Okay. So, Ms. Henry, what's next?

MR. PASSAFIUME: We're going to call Dr. Robin Watkins, so --

THE COURT: My understanding for the record, is that both people are on, though, for everything.

MR. PASSAFIUME: Correct.

THE COURT: So that's going to be -- Dr. Nelson will be the second witness?

MR. PASSAFIUME: Correct.

THE COURT: All right. And we're going to proceed with Dr. Watkins first?

MR. PASSAFIUME: Yes.

THE COURT: All right. Go ahead.

MR. PASSAFIUME: Good morning, Dr. Watkins.

THE CLERK: Hold on one second, Frank. I need to swear her in.

MR. PASSAFIUME: Sorry.

DR. ROBIN WATKINS,

witness on behalf of the **DEFENDANT**, having first been duly sworn, appearing by Zoom, testified as follows:

THE WITNESS: I do.

THE CLERK: Thank you. Can you please state your name and then spell it for the record?

THE WITNESS: Yes. Robin Watkins, R-O-B-I-N, W-A-T-K-I-N-S.

DIRECT EXAMINATION BY MR. PASSAFIUME:

BY MR. PASSAFIUME:

Q. All right. Good morning, again, Dr. Watkins. Could you --

A. Good morning.

Q. -- please tell us your title?

A. Yes. Yes. I'm a forensic psychologist.

Q. And who do you work for?

A. I work for the U.S. Department of Justice, Federal Bureau of Prisons.

Q. And how long have you worked for the Department of Justice?

A. For about 13 and a half years.

Q. And have you been at the BOP the entire time?

A. I have, yes.
Q. What's the process of becoming a doctor for the BOP?
A. Well, for me, I obtained my doctorate in 2004. And the process of becoming a doctor involves about ten years, after high school, four years of college and about six years of grad school, getting a Masters and a PhD in clinical psychology.
Including an internship -- predoctorate internship, which I did do with the Federal Bureau of Prisons in 2003 to 2004 at Lexington, Kentucky.
Prior to coming to the BOP, I did work in the community for about seven years, at a court clinic in the Chicago area, doing forensic evaluations, as well as private practice and teaching.
And then just applied to return to the BOP as a psychologist and began my career with the BOP at the Federal Medical Center in Devens, Massachusetts.
Q. And how long were you at Devens, Massachusetts?
A. I believe just shy of three years. I was there from 2011 to late 2013.
Q. And --
A. Before I transferred to the Federal Correctional Conference in Butner, North Carolina.
Q. And how long have you been at MCC Chicago?
A. I've been here at MCC Chicago for about eight and a half years. I was at Butner for about three years as well.
Q. Can you describe what the MCC means in that? How that

compares to other BOP facilities?

A. Sure. Well, both have medical centers which are more of inpatient settings. Butner has more of a complex, where there is a variety of different facilities within it.

MCC is more of a pretrial detention center. It's Downtown Chicago. It's a high rise building, as opposed to a sprawling compound, which more BOP facilities would look like.

But it houses mostly pretrial detainees and there is a fairly substantial forensic commission here, where we get a lot of inmates that are designated for the purposes of forensic evaluation.

We do have a newer program, which is a jail-based competency restoration unit, which is the BOP's actual -- actually, it's a pilot program.

The first in the BOP to use jail-based competency restoration model. We have that unit as well.

We do have a lot of psych services here. And we have some hold over or sentenced inmates as well, but I would say the majority of pretrial detainees.

Q. How many inmates can you estimate are housed there for psychiatric reasons?

A. Okay. Our overall capacity is in the six hundreds total. How many are here for psychiatric reasons in terms of being here for the purposes of forensic evaluation or competency restoration?

I don't have those numbers offhand. It's -- our forensic -- sorry -- our competency restitution unit houses a capacity, I believe, of 42.

And then we have probably about the same amount, at the max, in other forensic studies at any given time. Probably less. So maybe 60 to 80 at any given time.

Q. Okay. And you mentioned the competency restoration. Do you see inmates that are sent there for competency evaluations?

A. Yes. That is the majority of what I do here.

Q. And that's under the 4241 statute?

A. Correct.

Q. Okay. And could you tell me the -- the purpose and what the goal is for those competency evaluations, when somebody gets to you?

A. Sure. For a competency evaluation, the goal is really to determine do they have any sort of mental disease or defect that would impair their competency related abilities, meaning do they have an adequate factual and rational understanding of their charges and the proceedings before them and are they able to assist in their own defense.

It's very present focused. It's looking at their present functional impairment or lack thereof. And any psychological disorders, diagnoses, symptoms that could be leading to impairment that could interfere or is presently interfering with their competency-related abilities.

Q. So for every competency evaluation, you have to do a -- you have to diagnose a mental disease or defect before coming to the conclusion whether that person is competent or not?

A. I would say it all occurs sort of together if somebody -- if I'm opining somebody is competent, I might not diagnose any mental disease or defect.

If I am opining they are not competent, there would need to be some sort of mental disease or defect that would be linked to that.

Q. For every individual there, though, you do assess that person, whether that person has a mental disease or defect, right?

A. For a competency evaluation, yes.

Q. All right. Transitioning to the statute of why we're here, this 4244.

Are you familiar with that?

A. I am.

Q. And could you tell us what this statute is all about? What its purpose is?

A. Sure. I will say I've done some of these evaluations during my career in the BOP, so my understanding of 4244, it's a sentencing option.

And this type of evaluation, from our perspective, would be to assess whether an individual is suffering from a mental disease or defect.

For the treatment of which, they are in need of custody for care or treatment in a suitable facility, which in the BOP typically translates to a federal medical center, such as Devens or Butner, like I mentioned before -- but inpatient setting.

Q. Okay. Is that mental disease or defect the same we're talking about when we're talking about the competency part?

Are they overlapping when you are talking about mental disease or defect?

A. I'm not sure I fully understand the question. Can you maybe rephrase?

Q. Sure. Sure. Yeah. I'm not good at this.

A. That's okay.

Q. When in competency, you know, you assess on whether the inmate has a mental disease or defect.

For the 4244, you are -- he's there to -- or she's there to treat the mental disease or defect.

Are we generally talking about the same mental disease or defect for both?

A. I guess it depends. I've done 4244 evaluations where there was never a question of competency.

Q. Okay.

A. I would say they are separate questions. They don't necessarily have to be the same.

There could be someone who was competent, but does have a mental disease or defect that requires treatment in a suitable

facility, under 4244. So I don't think it necessarily has to be the same.

Q. That makes sense. Is the process for diagnosis of the mental disease or defect the same under both statutes?

A. I -- I can speak to my own methods, I guess.

Q. Sure.

A. For -- for a competency evaluation, I would say it tends to be much more focused. Much more present focused.

I do explore diagnoses. The statute requires a diagnosis, if there is one, under 4241.

So I would certainly offer that and provide that if one is present under 4241 for competency, but, I guess, my exploration of that would be limited to the extent that it impacts current competency-related abilities, if that makes sense.

Under 4244, I would say my inquiry would be much more broad based, because the question is different. The question is, you know, are they suffering from the mental disease or defect? Yes.

But what are the treatment recommendations? What are the treatment needs for that mental disease or defect, which is a much broader question than simply does it impact their current competency to stand trial.

Q. If an inmate gets to you with a diagnosis that was made by a private doctor, somebody outside the BOP, how does that factor into your assessment under the 4244?

A. I would say probably similarly to how it would factor in in any evaluation.

We value collateral sources of information. We seek them out in all evaluations, if available.

We review collateral records. We weigh them in our decision-making.

However, in each case, we're conducting our own independent assessment. So I think you want to avoid, as an evaluator, the sort of diagnostic kind of carrying forward diagnoses from previous evaluations without critically thinking about, you know, whether they are present at the current time, whether they were present at that time.

What -- you know how the well document lays out the symptoms that were observed at the time.

So they -- they are viewed critically and they are valued, but they are not relied upon to necessarily carry forward a diagnosis.

Q. Could -- could you -- this is probably a loaded question -- could you maybe generally explain the timeline once somebody gets to your facility under 4244, what you would do -- what you would next? Things like that?

A. Sure. Under 4244, they would -- as in any evaluation, the first thing I would do upon being assigned the case is conduct a -- what's called a forensic intake.

Where I would meet with them, go over -- provide a

notification and go over a form called a statement of understanding.

Where we provide information about how the information they are giving us will be used, just so they are clear on the fact that the information they are giving us is not confidential.

That it can go into a report and will be given to both the Court and both attorneys in the case, talking about safety and security issues within the institution.

Things they can expect within the institution and their time here. What the evaluation will look like; the fact that they are not -- you know, we're not going to force them to speak with us, but their participation is valuable in the evaluation and that kind of thing.

You know, the fact that we'll ask for records. That we'll meet with them periodically. Just sort of -- kind of expectations.

So that would be the first thing I would do. Collect some background information, seek any releases of information.

I always reach out to the prosecution and defense right away to request collateral records, if any are available.

As I said, collateral records are very valuable in, I believe, pretty much all forensic evaluations.

So that would be all of the initial steps. And then from there, any -- it gets more -- more individualized, I would say, depending on the referral question and the defendant in front of

me.

But I may choose to do some psych testing -- psychological testing. So we may meet a couple of times to do various psychological tests.

And there may be some specialized interviews that if it's a competency evaluation, for example, it would be legally focused on competency-related abilities.

If it's a 4244, which I believe the question was geared toward, it may be more about the history of symptoms.

It may be more symptom focused, but I would also be doing, sort of, a deeper dive into the -- the timeline, the evolution of symptoms; how they developed over time; how they have manifested from this person's perspective.

I probably would potentially also do some -- some measures that could look at their response style, to take a look at what -- you know, are they reporting genuinely or are they may be motivated to overreport or underreport symptoms, things like that.

Q. So while the purposes are different between 4241 and 4244, some of the things you are talking about now overlap between the two examination and evaluations, right?

A. Sure. Yes.

Q. You mentioned collateral records and how that is valuable. Why is that valuable?

A. It's valuable to corroborate or potentially refute a

individual's self report. As we know, defendants may have a variety of reasons for reporting certain things during evaluations.

And some people come to evaluations with very accurate self reports, but others may be skewed in one direction or another.

So collateral records can be very useful to -- to corroborate the self report. And also people may or may not have a very accurate view of their own symptom history, especially if they have a history of being mentally ill and perhaps their insight wasn't that great at the time.

And they have had a treatment history. They may not recall all the medications, dosages, dates, things like that, but if there are records that can get detail and document all of that, that's also very helpful.

Q. Would you give us some examples of what you mean by collateral records? Are they people? Actual documents or both?

A. It can be both. It can be useful to have previous psychological evaluations, hospital records, treatment records.

Also, just interviews with family members or other people who know the person well, who can maybe speak to their functioning.

We look for any identification of, like, a departure from their normal, like their baseline functioning.

And if there is a specific time when things seemed to change for that person, sometimes family can be really good at

pointing those things out.
Q. Okay. And that's all something you do basically in the beginning and after you get this background information, is that what you said?
A. Typically, yes. Typically, upon receiving the case, we'll reach out to the attorneys right away to request collateral information.
And a lot of times for competency and criminal responsibility evaluations, that also includes things like discovery, police reports, things like that, too.
Q. Okay.
A. But it's sort of a dynamic process that occurs over the course of the evaluation.
Q. Sure. Have you ever done an evaluation when you haven't used any collateral resources or haven't sought any collateral resources?
A. I don't know that there has ever been one where I haven't sought any, but there has certainly been some when there were none available.
Q. Okay.
A. So I had to go off of the person in front of me and what was available.
Q. But you've always sought them or tried to get some collateral records?
A. Yes. In every case, I attempt to.

Q. The 4244 has the mental disease or defect, but also treatment -- can you kind of explain the process of how treatment plans, kind of, get created for each inmate and what goes into that?

I'm sorry for the loaded questions here.

A. That's okay. So when you ask about treatment plans, are you asking within the context of a 4244?

Q. Sure. Yes.

A. Okay. I don't know that I -- I guess, I -- I would make treatment are recommendations. I don't know that I would go into the extent of making a full treatment plan within the context of that evaluation.

But -- my apologies -- the first part would be identifying the mental disease or defect that's causing impairment and then using my existing knowledge of the treatment resources we have available in the Bureau of Prisons.

And, also, consulting -- I've certainly consulted with colleagues in our central office staff about what may be available within the Bureau of Prisons that could best accommodate the needs of the defendant that I'm evaluating.

Whether that be inpatient facility or whether there is specific substance abuse treatment needs, whether there is a personality disorder that would require specialized treatment -- we have pretty much every impaired supported treatment that's -- that's -- I don't know about everyone, but we have the -- the

main empirically supported treatments in the Bureau of Prisons for each of those issues.

We do offer drug abuse programing, both residential and nonresidential drug abuse programming.

We have inpatient treatments for psychotic disorders and we have, like, residential programs for personality disorder, specifically borderline personality disorder.

So just using my knowledge of those things to dovetail the recommendations to what may be most appropriate to inform the treatment recommendations that I would then make and spell out in a 4244 evaluation.

Q. Okay. Do -- does the treatment involve the opinion of a psychiatrist, if -- if medication becomes, kind of, a part of the treatment plan?

A. Yes. If -- if I believe the person suffers from a disorder that is -- you know, for which psychiatric treatment is recommended, I would recommend a psychiatric consultation with the psychiatrist to assess what medication would be most appropriate for that defendant and go forward from there.

I would not recommend a specific medication or dose or anything like that, but I would recommend the consultation piece.

Q. How does an inmate get discharged under a 4244? What is the -- kind of, the end game there?

A. I feel like that's a perhaps a legal question that may be

better answered by an attorney.

But my -- I guess, my understanding is that it's a provisional sentence that can be modified during the course of that sentence.

I don't -- I don't know that I've been present to witness the end of a 4244. I do know -- you know, inmates when they reach the end of any sentence can be assessed, if there is concern about risk of violence.

For example, they can be assessed under 4246, at that point for a risk assessment, but I don't know if that's what you are asking specifically or not.

Q. How long can this treatment go on for at the BOP under 4244?

A. I believe it's for a specific amount of time, that would be the maximum amount of that person's sentence.

Q. Sure. And, I guess, during that time of the treatment, would you give, like, regular reports to the Court on how the person is doing?

Like, how does the Court know, you know, that kind of the progress?

A. That's a great question. I have not been involved in that end of it.

I've been involved in the initial end of doing the evaluations, but the treatment typically doesn't occur at the same place where I'm doing the evaluation --

Q. Okay.
A. -- so I don't know that I can speak to that piece in terms of how that communication occurs.
Q. Do you do those 4244s at MCC Chicago?
A. I have. I would say they are rare, but I have had them come from before and I've done them from here, yes.
Q. And the treatment happens there, too?
A. Typically, no. Those are similar to a competency evaluation or criminal responsibility evaluation.
I do those on the front end. The person then returns to their jurisdiction for the hearing and then they go wherever they are going to go in the BOP for that treatment.
Q. And the treatment is always in a BOP facility? It's never at, like, a local hospital or medical facility?
A. Under 4244?
Q. Correct.
A. Not that I've seen. I've only seen it where the suitable facility defined as a BOP FMC or a Federal Medical Center.
Q. Are people sent to the BOP under 4241 and 4244, are they housed in the same way?
A. No. Typically not.
Q. They are kept separate?
A. I don't know that that's the case always, in every case, but -- so if somebody, for example, is found not competent and in need of competency restoration -- inpatient competency

restoration, they would automatically be sent to a Federal Medical Center for competency restoration.

They may go to a restoration unit specifically where they participate in groups and treatment for that particular purpose.

Now, somebody who is found to be in need of a suitable facility under 4244 may also go to a medical center, but there could be different housing options and units, if that makes sense, within that medical center.

They wouldn't necessarily be participating -- they wouldn't be participating in the same programming --

Q. Okay.

A. -- as the competency restoration folks.

Q. To your knowledge, are the -- is the psychology staff, you know, the same for those that treat the 4241 and 4244?

There is not, like, specialists under 4244 that come in under that statute?

A. No. I mean, typically -- and I can't speak how to how each department works.

I -- for example, here we have a restoration program, for example. Now, we don't have anyone here who is sentenced under 4244, but -- but there are people -- there are several psychologists had who do those evaluations specifically.

And they only do the 41D evaluations, which are the restoration evaluations.

And are there are others who just do 41B, which are the

front end competency evaluations, the initial competency evaluations.

So it may be that -- that a department, sort of, assigns psychologists to do different tasks, but -- yes. A department would -- as a larger whole, address all of those needs.

Q. Has there -- again, to your knowledge -- ever been a scenario where somebody is sent to BOP under 4244 that is found not to have a mental disease or defect by you after, you know, he or she gets there?

THE COURT: Hang on a second, Mr. Passafiume. You've been meandering in and out, maybe not on purpose, between evaluations and treatment.

And we're talking about two different things, two different locations and perhaps even things that this doctor doesn't get involved in.

So can you just try to keep it to evaluations, when you are talking about evaluations?

And if you want her to tell you about what she thinks happens elsewhere, where people who are in the middle of their treatment, are getting their treatment, that's a whole different thing.

But right now, you are having her move in and out and I can see she is not comfortable doing that.

So be more clear about whether you are talking about evaluations under 4241 or 4244, versus what happens after

somebody is being treated, okay?

Thank you.

MR. PASSAFIUME: Okay.

BY MR. PASSAFIUME:

Q. So not the treatment part, under 4244, somebody gets to you, what happens or has there been a case where you found that there is no mental disease or defect?

A. And you mean when somebody comes to me for evaluation under 4244 --

Q. Yes.

A. -- have I concluded there was not a mental disease or defect?

Yes, I have.

Q. What happens then, if you know?

A. I don't always know the outcome, unless I go look it up afterwards or unless it's communicated to me by typically one of the attorneys involved.

But, to my knowledge, the person just moves forward with their -- with their case and with their sentencing.

Q. But what do you specifically? If you make that conclusion, what acts -- what do you do with that conclusion once you make that?

A. Well, I would just -- I would write the report, like I would in any case and address the statute. And I would explain the diagnostic formulation that I have, which -- you know,

sometimes results in a diagnosis of, you know, something that would qualify as a mental disease or defect and sometimes does not.

If it does not, I would explain that in the report. And, you know, there is a case that I did here recently where it -- that was the case.

There wasn't a severe mental illness. However, the person did have some pretty serious substance use issues and a personality disorder, so I listed those things.

Now, whether the Court would say that those qualify as a mental disease or defect under 4244 is a question for the Court.

But I did make some treatment recommendations as to what would be most appropriate to treat those disorders and which programs within the BOP are available to treat those disorders.

Q. Okay. And you know -- you were part of an evaluation of Luke Wenke; is that right?

A. Correct. Yes.

Q. What was your role in that evaluation?

A. So I am the forensic post-doctoral supervisor or training director and I supervise Dr. Nelson, who is also here today.

She was the primary evaluator on the case, but I oversaw her work on that case, start to finish.

And I was present for -- for three of the meetings with the defendant, so I was able to meet him, participate in some of the interviews and observe directly his responses and his behavior

as well as, you know, help her with the report.

She was able to write the report, but I worked with her on that report throughout that process as well.

Q. So you agree with everything in that report that she submitted?

A. Correct. Yes. We worked on that together. I provided edits and suggestions along the way.

Q. Gotcha. One question -- and if you can't answer, especially after what the Judge said, don't answer.

If that diagnosis is correct of this other specified personality disorder, with mixed personality traits, how would you treat an individual with that diagnosis?

A. Yes. It's kind of a complicated question because I think there are times when people come for the purpose of a competency evaluation.

And like I said earlier, our inquiry and the extent to which we delve deeply into the diagnostic picture is a little bit more limited for this purpose, because we're really just focused on does it or does it not impact current competency.

Q. Okay.

A. But, I think, with a longer period of observation or perhaps if he did have a 4244 evaluation or some other evaluation, where that was parsed out a little bit more, the treatment recommendations may be tailored based on the information that comes out.

But I can say based on what we had, the primary personality traits were narcissistic, which is a little tougher to treat, but also borderline, which there are empirically supported treatment programs designed to treat those traits.

And there actually is a residential-based program in the BOP for individuals with borderline personality disorder.

Whether he would qualify for that, specifically, I don't know at this time.

But what -- but there are treatment programs that are designed and based on what's called DBT or dialectal behavioral therapy, that -- that are designed to treat those types of traits.

MR. PASSAFIUME: Okay. I think -- I think that's it from -- from me.

Thank you so much, Doctor.

THE WITNESS: Thank you.

THE COURT: Okay. Just hang in there, Dr. Watkins, to see if the Government lawyer wants to ask you some questions.

MR. WRIGHT: Yes, Your Honor.

THE COURT: Mr. Wright?

MR. WRIGHT: May I proceed from my seat, Your Honor?

THE COURT: You may.

MR. WRIGHT: Thank you, Your Honor.

CROSS EXAMINATION BY MR. WRIGHT:

BY MR. WRIGHT:

Q. Good morning, Dr. Watkins.

A. Good morning.

Q. I would like to follow up on just a few questions. So relating to the evaluations, you mentioned that you were present for three of them?

A. Three of the meetings.

Q. Three of the meetings?

A. Yes.

Q. Do you recall when those meetings were that -- that you were present for?

A. I -- actually, let me -- I can look at the file real quick.

So that would have been the notification and intake, I was present, along with Dr. Nelson. That was on September 16th.

I was also present for the legally focused interview, which is a competency interview on October 17th. This is all 2024.

And we also did a follow-up interview on October 21st to that legally focused interview. That totalled about three hours, across those three interviews.

Q. Understood. Relating to the November 13, 2024, report that was submitted by BOP, you mentioned that Dr. Nelson and you worked on this together.

During this process of working on this final report, did you have any differing opinions with Ms. Nelson about the

diagnostic impression that you guys had?

A. I don't think I would say we had differing opinions. That's -- it's kind of a dynamic process, I would say though, across the evaluation period.

Because we talked -- we talked through this case and we met for supervision routinely, weekly, throughout the evaluation period.

As part of Dr. Nelson's post-doctoral experience, she also has a group supervision-type experience that I'm also involved in, as well as other supervisors and other post Docs across the BOP.

She does that once a week and I recall her bringing this case up in that. So it was discussed routinely throughout the evaluation period, where, I think, both of us sort of kept an open mind and were in, sort of, more of a data collecting phase, while reserving judgment about, you know, our conclusions until the end, but at the same time, we were processing the information together, so-to-speak.

So I don't think we differed in our opinion once -- and then once she did the report, she did that independently.

And I reviewed -- I reviewed each draft. We went through a couple of drafts and I gave her maybe some suggestions as to how to write up the diagnostic information.

But I don't recall disagreeing on the crux of the -- of what she was concluding. It was more how to present it and

formulate it in the report.

Q. Understood. You have already gotten through parts of this, but relating to -- this was a 4241 examination, focused on a very discreet issue of the defendant's competency, correct?

A. Yes. Yes.

Q. And you mentioned earlier, as well, that under 4244 analysis, there are different considerations that may be involved, different assessments, different measurements, that may be involved as well in, kind of, assessing that analysis, correct?

A. That's correct.

Q. And the 4244 process, I think you mentioned was a broader question that's involved?

A. Yes. Particularly when it comes to diagnoses, I would say the inquiry and the examination of diagnosis would be much more broad based in terms of looking at the history and -- you know, I would, kind of, describe it as a deeper dive into that area.

Whereas for a competency evaluation, it's more focused on symptoms, to the extent that they impact competency-related abilities.

Q. Okay. Relating to -- can someone be deemed competent, but still have or suffer from a medical diagnosis or mental disease or defect for which they would need treatment for?

Is that a possibility?

A. Absolutely.

Q. Okay. And to go back to your 4241 process and procedures that you employed in this case, you and Dr. Nelson, did you -- you, kind of, went through, kind of, collecting information from different sources.

And I know in your report, you mentioned letters. You received a report from Dr. Rutter as well.

Did you review that in your analysis?

A. Correct.

Q. Okay. Can you talk about -- did you agree with Dr. Rutter's diagnosis, for instance, about the defendant suffering from a bipolar disorder, specified hypermania, borderline personality traits?

A. Are you asking if we agreed with all of those different diagnoses?

Q. Yeah. Like, what was your opinion relating to Dr. Rutter's diagnosis, for instance?

A. Well, can you -- I'm sorry, could you direct me to what page of the report summarizes those diagnoses?

Q. Let me see here.

A. I think I may have found it. Page seven?

Q. Yep. That's right.

A. Yes. As I was describing earlier, I think the historical evaluations and treatment records and collateral records are very informative in what other professionals have seen and documented.

It does not necessarily mean that we would always carry forward those diagnoses, though. We always think critically about them.

And I would say, no. We did not -- we did not currently find evidence of bipolar disorder in Mr. Wenke's presentation.

Q. Thank you. Relating to the assessments that are employed, you mentioned there is obviously differences in the types of assessments that are employed, depending on the type of forensic examination or evaluation that's being done.

For instance, I think in your report you mention doing a PAI analysis for Mr. Wenke?

A. Yes.

Q. What do you -- hypothetically, if you were doing a 4244 analysis examination, would you employ that type of assessment in that situation?

A. Not automatically. But potentially, if that's something that could be used in that type of assessment, yes.

Q. Okay. And -- and you also did a RCAI as well?

A. Correct.

Q. Would you have done that in a 4244 analysis?

A. No. I would not see a reason to use an RCAI. That's more of competency --

Q. Competency?

A. -- focused, yes.

Q. Okay. Let's focus more specifically on your evaluation of

Mr. Wenke.

So there are several dates listed in your report or listed in the report where examinations were done first. Let's define some terms.

How do you define the term delusion?

A. A delusion is a fixed false belief that remains steadfast, even in the face of contrary evidence.

Q. What about paranoia?

A. Paranoia is a little bit more a colloquial term, I would say, but -- yeah. Persecutory -- it's -- it's more similar to persecutory ideation or beliefs, where someone believes others are trying to harm them --

Q. Okay.

A. -- in some way.

Q. You mentioned on direct or that as part of your evaluation, sometimes you'll employ certain measurements or measures to see if the person being examined is responding truthfully or trying to hide certain information.

Can you talk -- did you employ these measures in your analysis with Mr. Wenke?

A. I don't believe we did any of that formally with him. But there was one validity scale -- well, there are several validity scales embedded with -- within the PAI that informed our decision on that.

Q. The reason why I asked that is on page 16, there is a -- a

reference here about Mr. Wenke may not have been forthright in answering some of the questions.

Can you talk through that analysis of did you do anything to figure out more information relating to that or how was that determination used or employed in your overall assessment?

A. Yes. So that -- that's the validity scales that I was referring to within the PAI. So there are several embedded within the PAI.

There is one that looks at, sort of, positive impression management or, sort of, defensive responding.

There is one that looks at negative impression management, where people try to exaggerate symptoms and appear more impaired than they actually are.

And there are measures of, like, inconsistency or infrequency, where people may respond randomly within the test or respond unusually or idiosyncratically.

He didn't spike on any of those other scales, but he did spike on the positive impression management, which is actually unusual for criminal defendants.

You tend to see that more in custody evaluations or sometimes preemployment police and fire assessments, things like that.

Q. Okay. Can you explain that a little bit more? Why is that important?

A. Sure. It's important because essentially what it says is

the person is attempting to minimize any thoughts or symptoms or any problems and try to sort of appear, quote, unquote, normal, as though there are no problems or symptoms to report.

Again, you can imagine why you might see that more frequently in custody evaluations, for example, because people want to appear symptom and problem free.

And they are a good candidate to be a, you know, a parent and custodial parent and that kind of thing.

In this case, in criminal proceedings and when we are doing forensic evaluations, we tend to see the other side of it more frequently, where people are exaggerating symptoms.

Looking for some sort of secondary gain, potentially, to be found incompetent so they can potentially go to competency restoration or they have a belief, maybe, that they're charges will go away, things like that.

Because Mr. Wenke showed actually defensiveness and was maybe suppressing any symptoms or problems, that suggested to us -- and it was also very consistent with his presentation, too.

He wasn't trying to advertise any sort of symptoms or play off any sort of symptoms in his interviews with us, so that suggested to us that there wasn't feigning or malingering going on.

To define those terms, basically intentionally producing symptoms that aren't really there. And some of the measures I

was talking about that we might use to assess that would be looking for feigning or malingering, where people are reporting symptoms, but they are actually not genuine symptoms.

Because Mr. Wenke wasn't really reporting distress from symptoms in general in his interviews and then his PAI results were very consistent with that.

In fact, they showed he was suppressing or minimizing any problems. Those two things together suggested that we were very unlikely to find any significant results in any feigning measures that would be indicative of malingering or feigning.

Q. Okay. You mentioned this term idiosyncratic. There is a reference through the report that the defendant, Mr. Wenke, did not discuss overtly delusional beliefs.

So that statement is made throughout the report at various portions of it. What does that mean?

A. That he didn't discuss overtly delusional beliefs?

Q. Yeah.

A. Sometimes we'll get defendants that talk repeatedly about things that are easily identifiable as delusional.

They may believe, for example, as it pertains to competency, they may believe that everyone in the Courtroom is involved in a conspiracy against them and they are all working together.

And that it has to do with some other organization or religious sect or -- you know, something that's clearly not

accurate or based in reality.

Those would be overtly delusional beliefs. Things that someone can listen to and hear and clearly pinpoint as that's not based in reality.

Mr. Wenke -- yes, he talked about things that you could see how someone might question whether it was based in reality not.

You might wonder, for example, this relationship with RT, whether that was reciprocal or not; whether it was, as others have said, an erotomanic delusion.

But was it clear based on the evidence we had? No. It wasn't -- no. It wasn't overtly delusional. There was nothing that suggested clearly that that was not based in reality.

Q. Okay. What about -- let me ask you this example, for instance, on page 11 of the report, there is a discussion from the September 27, 2024, interaction with Mr. Wenke -- or examination with Mr. Wenke, where he explained discussing the idea that because of this case, there will be a future Supreme Court ruling that would create a Homeland Security Order of Protection program that will increase public safety preventing cases like his from happening again.

He suggested this program will implement public safety drones, public safety satellites or chips in driver's licenses to monitor people as they ever driving.

He identified this as an interstate order of protection program and noted there are District Court formalities to

complete.

In reading that -- or hearing that analysis or -- or what he stated, how do you classify that in, kind of -- is that something that's more delusional or where on the scale would that be?

A. Sure. That's a great example of what I think Dr. Nelson was spot on in identifying as a grandiose idea.

I mean, it is certainly a grand idea of having a lot of influence over or -- you know, having some impact in a very important future Supreme Court ruling, that he believes will happen in the future.

It -- whether that's likely to happen, I guess, remains to be seen. But -- but in order to classify something as a delusion, it would need to be clearly not based in reality.

And I think it gets really slippery to -- to start looking at someone's statements about what they think is going to happen in the future as a delusion.

Q. Okay.

A. And without any other evidence to suggest that their beliefs about anything present are not based in reality, it gets -- it would be kind of a stretch, I believe, to say that a future-based statement that they think something is going to happen in the future is a delusion.

Q. Okay. Let me ask you this: So relating to the interaction -- Mr. Wenke had several interactions with various

individuals: RT, RT's father, there is -- there is involvement of Mr. Wenke's, for lack of a better term, attention to -- relating to various individuals.

On that page 11, again, later on down, from the October 2, 2024, evaluation or interaction, there is a reference here about Mr. Wenke planning to make amends with RT's father, MT.

And it goes through a process or discussion about suing the Libertarian party for $3,500. And that he plans to offer the $3,500 in exchange, for payment, to make RT a national committee matter instead, thus fixing the relationship between Mr. Wenke and MT.

How would you classify this type of information?

Well, first, let me ask you this: Is this more of a present-based analysis that you would focus on or is this something that he's talking about in the future?

A. It also sounds like future plans.

Q. Okay.

A. It's something -- it's a plan of how he intends to make amends with somebody in the future.

I guess to answer your question of how I would a classify it, one way I conceptualized this -- and, again, I wasn't doing a risk assessment or in depth inquiry into the dynamics involved in any of these relationships, because our focus was primarily on competency and present focused competency.

However, having a -- you know, a background in, you know,

domestic violence and Order of Protection violation evaluation and things like that, it is not uncommon to see various cognitive distortions in offenders involved in those types of charges, where -- you know, people may have intentions to continue relationships or make amends, despite the desire of the other party not to be involved in that.

And I don't know -- I can't say one way or the other whether that was the case in this situation, but I did consider whether that could be just an example of one of those cognitive distortions that is involved in those types of cases.

Q. Okay. Let me ask you this question: When it comes to -- there is a reference in the report of Mr. Wenke's or the defendant's belief in psychics, for instance, and going to -- as part of his family, et cetera.

At what point does a belief that someone has from their experience in life -- you know, it could be -- there is -- in the report there is that reference or discussion about his grandmother's belief in, kind of, psychics and how that connected to his own personal beliefs.

At what point does generic beliefs like that that are formed by familial relationships transfer over to a delusional belief?

A. That's a tough question and it's -- it's hard to identify specific point, but I think it's very important to consider the cultural context in the DSM or the Diagnostic Statistical Manual

of, you know, mental disorders that informs all of our diagnoses emphasizes that we consider the cultural context of the individual, when assigning diagnoses to avoid pathologizing what may be a culture norm set beliefs or behaviors.

So that's where, I think, Dr. Nelson appropriately used the Cunningham article that she cited to, kind of, take a look at and analyze some -- some of these beliefs and behaviors to determine, are they unique to him or are they part of a larger subgroup?

Even if it may be not typical for the general population, it does seem like the beliefs in psychics -- specifically, that belief set, was very common within his family system.

And that was all corroborated through the collateral interview with his mother that she conducted.

Q. Okay. But if someone is confronted with independent information that confronts that belief that they may have had, but it continued to persist in that belief, is that an example -- does that then cross over to that delusional aspect?

A. I would say it depends on what the belief is. There are plenty of people that have strongly held religious beliefs that would be considered culturally normative, that would not be amenable to contradiction or challenging by others.

But that would not be the defining factor that would somehow classify that as delusional, just because the person didn't waiver in their belief in the face of a challenge.

Q. Okay. But it has to be idiosyncratic to that person for it to be determined as delusional?

A. It's one of the factors that we look at. I don't know that it's quite as formulaic as an if then rule.

The Cunningham model has 17 different factors. It's sort of a complicated system and it -- it still doesn't arrive at a formula that classifies somebody as delusional or not, but it's more of a complex system to review.

So I would just say it's one of the factors that we consider in terms of whether it's -- the person -- it's one of the 17 factors, specifically, does the person hold that belief in isolation or are they part of a subgroup that also holds that belief.

Q. Okay. I think this will be my final question. So the mental disease -- the mental disease or defect analysis under the 4244 analysis, even with your report of -- kind of, the -- the going through what you, kind of, just went through or discussed relating to the delusional aspects or considerations that you did, that that may still exist, where -- under the 4244 analysis versus the 4241 analysis that you conducted?

A. I'm sorry. Could you possibly rephrase the question?

Q. Yeah. It goes back to whether or not someone who may have been deemed competent before, may still under the 4244 analysis -- because they are different considerations, may still have a mental disease or defect, in need of treatment?

A. Yes.

MR. WRIGHT: Okay.

Nothing further, Your Honor.

THE COURT: Dr. Watkins, in the context of this 4244 hearing that we're in, my job is to decide whether Mr. Wenke is presently suffering from a mental disease or defect and whether he should, in lieu of being sentenced to imprisonment, instead be committed to a suitable facility for care or treatment.

That's the question I have to ask. Do you have an opinion on that issue?

THE WITNESS: I do not currently have an opinion on that issue, only because I didn't do that type of evaluation.

THE COURT: If you were asked to do the 4244 evaluation, in addition to or instead of or now, what would you do differently that perhaps you hadn't done already?

THE WITNESS: I would conduct a more thorough inquiry into, I guess, the history and course of symptoms.

We would do a lot more diagnostic differential diagnosis. I guess, between -- I believe we listed a number of diagnostic possibilities and some tentative diagnoses.

I think we would do more to try to pars out exactly what's going on with him diagnostically, to better determine what the most appropriate treatment recommendations would be at this time.

THE COURT: With everything that you know about

Mr. Wenke, and -- and acknowledging the limits of your 4241 evaluation, is it possible, knowing what you know now, that you could ultimately conclude under 4244, that he is suffering from a mental disease or defect.

As a result of which, he is in need of custody for care or treatment in a suitable facility?

THE WITNESS: Yes. Your Honor, that's possible.

THE COURT: All right.

Anybody else have more questions for Dr. Watkins?

MR. PASSAFIUME: No, Judge.

MR. WRIGHT: No, Your Honor.

THE COURT: Thank you, Dr. Watkins.

THE WITNESS: Thank you, Your Honor.

(Witness Excused)

THE COURT: And we have the next witness. Mr. Passafiume, go ahead.

MR. PASSAFIUME: Sure. Dr. Kaitlyn Nelson.

THE WITNESS: Hello. Yes.

THE COURT: You are going to be sworn now. Dr. Nelson stand by.

Dr. Nelson, can you do something to help us with the background noise that's coming in from you?

THE WITNESS: I can try. Sorry. Our offices are on a housing unit, so --

THE COURT: Okay. We're sometimes familiar with those

kinds of sounds. Let's do the best we can. We have to get you sworn still.

Ms. Henry, go ahead.

DR. KAITLYN NELSON,

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

THE WITNESS: I do.

THE CLERK: Can you please state your name and then spell it for the record.

THE WITNESS: Kaitlyn Nelson, K-A-I-T-L-Y-N, N-E-L-S-O-N.

THE COURT: Okay. Mr. Passafiume --

DIRECT EXAMINATION BY MR. PASSAFIUME:

BY MR. PASSAFIUME:

Q. Hi, Dr. Nelson. Could you please tell us your title?

A. My current title is a forensic post-doctoral fellow.

Q. And how long have you been that?

A. Since August of 2024.

Q. And how long have you been -- worked at MCC Chicago?

A. Since August of 2024.

Q. Have you always worked under the supervision of

Dr. Watkins?

A. Yes. At this facility.

Q. Did you -- was there a point in time where you evaluated a gentleman by the name of Luke Wenke?

A. Yes.

Q. Do you remember what that evaluation was about?

A. That was an evaluation related to competency to proceed.

Q. And you -- you issued this report with Dr. Watkins. I want to say, dated November 13th, that comes from that evaluation?

A. That's correct.

Q. And I want to go through, kind of, the process of that. So Mr. Wenke got there on September 4th and the evaluation ended on October 21st?

A. Correct.

Q. So is that a typical duration for these competency evaluations?

A. Yes. So, typically, they are by statute, a 30 day evaluation, within an allowance of a 15 day extension period, if it's requested or there needs to be a reasonable reason for the extension.

Q. And in that time, you state in the report that Mr. Wenke was routinely observed by correctional and psychology staff?

A. Uh-huh.

Q. You have to say yes or no.

A. Yes.

Q. Can you explain what do you mean by that? What is routinely observed?

A. So as I mentioned earlier, there are offices on housing units. And I believe in Mr. Wenke's case, all of the interviews with him took place on his housing unit.

So you go to his housing unit. I could see him there on the unit and then would call him up to an office.

But, also, when I say routinely observed by correctional staff, there is always an officer on the unit, who in most situations I elicit their opinion on how that individual has been functioning on the unit.

Similarly, if they had any interactions with other staff members, including psychology or other professions, I may elicit their observations as well.

Q. And those observations go into your ultimate determination of your ultimate diagnosis of Mr. Wenke?

A. I think they play a role in my formulation, yes.

Q. Over the course of those 45 days or so, how many times do you think you saw Mr. Wenke, personally?

A. I met with Mr. Wenke on six different occasions for interview purposes.

Q. And did you -- in addition to that, did you -- when you weren't there, did you speak the psychology staff and the corrections officers about what they observed?

A. I did speak with officers about what they observed and they

noted, you know, no concerns behaviorally from him. He mostly just kept to himself on the housing unit.

Q. And what kind of things would you be looking for in those observations?

Why is that important?

A. Yeah. Talking to the correctional officers is very valuable, because they are the ones who are on the housing units with the defendants at all times.

So a lot of times we're asking about -- you know, anything that stands out. Are they able to follow the unit rules?

Do they appear to be getting along with other people or are they having problems? Things of that nature that can speak to their functional impairment or lack thereof.

Q. So is it relevant if somebody is able to be housed in a general population setting, as opposed to a -- kind of, a private solitary setting?

A. Are you referring to -- like, the private setting, you are talking to, like, a secured setting?

Q. No. When somebody is in general population at the jail, like, Mr. Wenke did not have to be separated from anybody else, why is that important or is it?

A. Right. Yes. I would say it is important. A lot of times, we see, you know, if someone is having significant mental health problems, sometimes that might cause difficulties with them interacting with their peers.

Peers might also point out, you know, various oddities that they have noticed as well or not wanting to have interactions with them.

Sometimes it leads to, you know, fights or concerns for safety for both the individual and other people. So those could all be reasons why someone might end up in a more confined secure housing, outside of the general population units.

But as in Mr. Wenke's case, that did not happen. He was able to maintain appropriate behavior and -- within the general population setting.

Q. In those 45 days, you also gave him some assessments. And one is this personality assessment inventory.

Can you explain what that is?

A. That's correct. The personality assessment inventory or PAI is a self-report measure.

Meaning, it's 344 questions that the individual answers on their own. And that measure is looking at a broad range of both psychological symptoms and personality traits.

So they are asked to give, you know, their opinion of themselves and the various statements that are included in the measure.

Q. Is that a routine assessment that you give in these competency evaluations?

A. I would say I use it often, but it's not in every case.

Q. And does the result of that assessment go into the ultimate

diagnosis at the end?

A. Yes.

Q. You also did this revised competency assessment instrument. Could you explain what that is?

A. Yes. The revised competency assessment or RCAI is more of a semi-structured interview measure, specifically, looking at various areas related to competency-related abilities.

So there are various categories that have questions listed in each category related to things, such as their charges, who the people are in the Courtroom.

You know, various Courtroom procedures, such as -- you know, entering a plea or what is a plea bargain, things like that.

And the goal of that is to make sure that we're asking questions in all areas related to competency. But as I mentioned, it is a semi-structured interview, so we also ask follow-up questions and oftentimes ask a lot more questions than are listed in the interview.

Q. Does the result of that assessment give you any insight into the ultimate diagnosis, whether Mr. Wenke has a mental disease or defect?

A. Yes. I would say so. The -- the RCAI -- RCAI doesn't give, like, a score or results or anything like that.

But the way an individual approaches the questions, how they are able to attend to them, what information is included in

their responses -- all of that can speak to someone's mental state.

Q. You also reviewed a lot of materials. I want to go through some of them real quick now: Some legal documents, the indictment, presentence report motions, BOP records.

Why do you review those documents? Why was that important?

A. Yeah. So a lot of the documents that I reviewed are helpful to one get an understanding of, you know, what his current legal situation is, so that I can assess Mr. Wenke's understanding of what's happening.

But then also some of the other records that I've reviewed, such as, like, past evaluations and letters that he has written, medical center records, all of that can speak to whether or not this is his mental state.

How he is presenting currently, if that's a pattern across time. What, if any, mental health issues have been present in the past, things of that nature.

Q. And you mentioned -- so you reviewed letters that Mr. Wenke sent to the Court and other people?

A. That's correct.

Q. And you reviewed his social media posts?

A. Yes. Some that were provided in the discovery materials.

Q. And that material was provided by myself and the prosecutor and probation, right?

A. Yes.

Q. You didn't independently go and find your own letters and your own stuff? It was everything that we gave to you?
A. Yes. With the exception of -- I believe he sent a couple letters while he was housed at MCC Chicago, so I reviewed those as well.
Q. Perfect. You also reviewed some prior evaluations, for example, one from Dr. Leidenfrost.

Do you remember that?

A. Correct.
Q. And --
A. Yes.
Q. -- why is it important to review these prior evaluations from -- from past doctors?

What insight does that give you?

A. Yeah. Reviewing past evaluations is incredibly helpful to get an understanding of how the individual was presenting at different points in time.

That can speak to -- you know, how their presentation is consistent or changes across time.

Timeline of potential symptoms, what that clinician -- how they are conceptualizing an individual. And all of that, kind of, plays into my own conceptualization of an individual.

But, again, it's kind of just that. It's a piece of data that I take into consideration and then use that to aid in formulating my own opinion.

Q. Perfect. You also spoke to several individuals, right?
A. Correct.
Q. One of those people -- you spoke to myself, the prosecutor and probation.
Do you remember that?
A. Yes.
Q. We met by video conference and, kind of, discussed the case? Yes?
A. Correct. Yes.
Q. And --
A. Sorry.
Q. -- then you sought our opinions of the matter. Why would you do that? Why was -- why was that relevant?
A. Yeah. Specifically, in a competency evaluation, I routinely try to elicit observations from both the prosecution and the defense, because the question that we're answering related to competency is partially their ability to assist in their defense and whether they have the factual rational understanding.
So it's really important to understand why the question of competency was raised; what concerns related to competency either side has for that specific defendant.
And that can be useful to, kind of, guide what areas we need to clarify in the competency evaluation with that specific individual.

Q. Would any of that give insight into whether Mr. Wenke has a mental disease or defect?

A. It certainly could, depending on what the attorneys are reporting.

You know, if -- certainly, if the attorneys are seeing particularly odd or bizarre behaviors or having difficulty maintaining a conversation with an individual -- those are just some examples, but all of that can speak to how the person is presenting, which can inform, you know, a decision on whether or not that person may or may not be experiencing mental illness.

Q. And what about talking to somebody's family members? Is that important?

A. Yes. And it doesn't happen in every case, but when it -- when I am able to speak with someone who knows the defendant personally, maybe even over a significant amount of time, it's really helpful to determine, you know, patterns of behavior or patterns in their presentation.

Or if there had been a significant change in that person and what may have been going on in their life at that time, things of that nature.

It can also help corroborate some of what the defendant is self-reporting, particularly when we are gathering background information, speaking with family or people who were close with them can help, kind of, clarify some of that information as well.

Q. Were you able to do that for Mr. Wenke?
A. Yes. I was able to speak with his mother.
Q. And how did you get her information, if you remember?
A. I don't recall specifically in Mr. Wenke's case. Typically, I would either ask the defendant if there was someone close to them.

But also ask -- you know, both defense and prosecution, in my initial e-mail to you, asking if there is any collateral contacts that may be available to share contact information with.

Q. What did you do talk about, if you can share and if you remember, with Mr. Wenke's mother?
A. Typically I approach the collateral interviews as -- kind of like a general background information, similar to what I would ask the defendant.

So in Mr. Wenke's case, I, kind of, went through, you know, the whole timeline of his life. You know, tell me about how he was when he was a child?

And what about his schooling? And his work history? And things of that nature. So that's -- that's what I did with Mr. Wenke's mother as well.

Q. And would that information give insight as to whether Mr. Wenke has a mental disease or detect?
A. Yes.
Q. All right. You also cited some research -- this article

from Cunningham.

Are you familiar with that?

A. Yes.

Q. What -- what is that? Can you explain that and what this 17 factor model is?

A. Yeah. So the article that I reviewed specifically for this case was the differentiating delusional disorder from the radicalization of extreme beliefs a 17 factor model and what this article does is develop a 17 factor model that can be helpful for clinicians in doing the differentiating between delusions and these extreme beliefs, as they call them.

The intent is to just use that tool -- the 17 factor model as, kind of, a guide in considering different factors that play into -- you know, what makes something a delusion versus an extreme belief.

It's not like a checklist or doesn't give you an end result. More so, it's just a guide to make sure you are considering various aspects of those beliefs.

Q. And you apply that to, basically, each belief individually? Not as a whole? How does that work?

A. So in this situation, I tried to use it as a guide in my thinking for considering different components in Mr. Wenke's presentation.

So not necessarily every belief, individually, but, kind of, more clusters. So these beliefs related to his past

relationships or beliefs related to his political views or beliefs in his spiritual beliefs and mediums and psychics and things like that.

Q. We'll get back to that in a second. I want to walk you through your report and, kind of, explain it in a category section by section basis.

A. Sure.

Q. So the report starts with this background information and it lists all of these different histories.

Could you -- the first one is developmental history. What is -- what does that mean?

What is that section about?

A. Yeah. So, typically, in the developmental history, it's talking about, like, from birth, what they were like as a kid. Where they grew up, what that was like. What their family structure was like, things of that nature.

Q. Would that information give insight as to whether Mr. Wenke has a mental disease or defect?

A. It can be used to, kind of, develop those hypotheses. And potentially -- you know, provide insight into timelines of possible symptoms, things of that nature.

Q. We'll skip to the social and mental history section. The other ones are self explanatory.

What is that section about?

A. This section is about, like, friendships and romantic

relationship history.

Specifically -- you know, if that person was able to maintain relationships, what those, kind of, looked like in more broad terms.

Q. And would the information contained there give you any insight as to whether Mr. Wenke has a mental disease or defect?

A. Yes. It can certainly provide insight into that. For nearly all mental illnesses, part of a diagnosis is talking about their functional impairment in some of these various categories.

So with their functional impairment and social interaction or functional impairment in education or employment areas.

Q. And all the information contained in this -- well, let me get it right -- this background information, did that come from your collateral -- like, the collateral sources and -- and all the, kind of, evidence that we've discussed that you reviewed?

A. Yes. In addition to specifically or directly from Mr. Wenke.

Q. Okay. The starting from -- like, I guess day one, if you remember, what was the -- the interaction with Mr. Wenke like?

What would you say to him? What happens during that initial meeting?

A. Yeah. During the initial intake meeting that I typically have with someone, it is generally we're providing a forensic notification.

Which is providing them information about the current evaluation, what the evaluation -- or what information will be used for, the lack of confidentiality in what their -- the information they are providing and what they can expect over their time at this facility, things of that nature.

And then the other piece is getting -- more so general background information.

I believe with Mr. Wenke that first interview lasted around 30 minutes, which is not uncommon to have a more brief interaction during the first interview.

And when I say we gather general background information, we might ask where he's from or if he had a mental health history if he had a substance abuse history or what he did for work.

And then during later interviews, we, kind of, dive more deeply into those topics.

Q. In that initial interview, if you remember, did Mr. Wenke discuss any delusional beliefs or did anything stand out that you felt was not appropriate during that initial interview?

A. If I can have just a minute to review what I wrote about that?

Q. Yes.

A. So from what I remember, at no point did any of his beliefs appear overtly delusional.

I wasn't a hundred percent certain at this point that the beliefs he was talking about were just clearly delusional or not

based in reality.

And I think the same would be true during his initial contact with us. He seemed to be generally forthcoming.

And I mentioned in the report, he provided information about various parts of his background.

He was a little bit more defensive when talking about things such as substance use history. However, that's not uncommon for interviewing someone in this sort of setting.

A lot of times people tend to minimize things such as substance use or past legal history, things of that nature.

Q. And during that initial, kind of, meeting -- and what's reflected in the report, it says that he was placed in open population.

Does that sound right?

A. Yes.

Q. And what's -- again, we talked about this a little bit before -- what is open population?

And did Mr. Wenke remain in open population the entire time that he was with you?

A. Yes. Mr. Wenke was on an open population housing unit, which means within the unit, the individuals are free to roam pretty much within the designated areas.

And then they -- on the unit that Mr. Wenke was on in particular, he had a singular cellmate that during lockdown times, he would have been housed and locked in that cell with

that individual.

Q. Okay.

A. And he remained in open housing for the duration of his time here.

Q. Perfect. September 27th, it says that he was seen for a -- a psychosocial history interview?

A. Correct.

Q. What does that entail? What is that about?

A. That is what I had mentioned earlier about that deeper dive into background information.

So it is essentially going through those same categories of his background, but gathering more thorough information or asking more detailed follow-up questions.

Q. And every -- did every time you see him, was there a personal interaction?

Did you have, like -- like, a conversation with him, whether it was performing an assessment or just chatting?

Did you have this, kind of, one-on-one interaction with him?

A. So I met with him individually three of the six times that I met with him. It was just myself and Mr. Wenke in an office.

And then the other three times, Dr. Watkins was also present.

Q. Okay. The next part of the report is titled: Clinical formulation.

What is that part of the competency evaluation? What goes into that section?

A. The clinical formulation section of the report, is where now I have all of the background information and collateral records.

And this is, kind of, where I'm outlining how I am conceptualizing those in relation to mental-health-related concerns.

Q. And the information that goes in there, again, is from your personal interactions, the assessments and also that collaterally information?

A. Correct.

Q. Would you say that the more collateral information you have, the more accurate the formulation would be?

A. I would say so, yes.

Q. And -- and, ultimately, the next section is the diagnosis. And you diagnosed Mr. Wenke with an other specified personality disorder, with mixed personality features. Primarily borderline personality traits and narcissistic personality traits.

A. Correct.

Q. You -- you explain it very well in each one of these reports. I'm not going to go through that at all, but could you -- could you explain in general what a personality disorder is as opposed to a psychiatric disorder?

A. Sure. A personality disorder is a pattern of -- basically,

a pattern of personal characteristics of that person -- personality characteristics.

So these are often persistent traits that the individual continuously presents with over time, oftentimes starting in early adulthood and that kind of persists throughout.

On the other hand, a -- another mental health or mental illness would be something that would be, kind of, a deviation from what their typical presentation would be.

For example, if we're talking about a mood disorder, that would be, kind of, a deviation from their typical mood presentation.

Whereas in a personality disorder, those patterns are more consistent across longer periods of time.

Q. And I -- if you can, again, if you don't know, that's fine. What is treatment typically for a personality disorder?

A. The treatment for personality disorder varies depending on the type of personality disorder or personality traits that are present.

A lot of times it includes individual therapy or group therapies. Specifically, for borderline personality disorder, as Dr. Watkins had mentioned earlier, the dialectal behavioral therapy is, kind of, the gold standard for borderline personality disorder.

And, certainly, can be used to treat these traits and not full personality disorder as well.

Q. Was Mr. Wenke medicated at all in the 45 days that he was there?
A. No.
Q. Do you believe he needed to be medicated at all?
A. While Mr. Wenke was at this facility, it did not appear that medication was indicated, so he did not -- he was not referred to a psychiatrist for consultation during the competency evaluation.
Q. If you believe that was an issue, you would have referred him to a psychiatrist during that competency evaluation period?
A. Yes. That's an available option.
Q. And -- and the psychiatrist would be to -- kind of, because the psychiatrist prescribed medication, it would be to further your findings? Further for your diagnosis?
A. Well, a psychiatrist would do their own independent brief assessment to determine whether or not the symptoms are present that deem medication to be appropriate.

And then they would be the ones to determine which medication, if any, they would prescribe.

Q. The next section I want to talk about is the prognosis and recommendation section.

If you again just explain what that section is about and what goes into that?
A. Yes. In this section, specifically, in a competency evaluation report, the prognosis and recommendations are

typically geared specifically towards competency.

So in this situation, I am -- in Mr. Wenke's case, I'm describing, you know, he -- the personality traits that I observed, how they are typically a pervasive pattern across time.

Even with treatment, sometimes they -- there is a significant change, but there may be some improvement, but ultimately I provide the recommendation that he was expected to remain competent, because of the persistent nature of these traits and that they were unlikely to change significantly.

Q. Could you -- could you just explain that though more? I know you say: With either diagnosis, the features are pervasive and character illogical, such that they are unlikely to change in the future.

Can you explain that more -- if you can, just, kind of, elaborate?

A. Sure. What I mean by that is personality traits being just that. That they are traits and characteristics of the individual.

Sometimes they are difficult to change. So when I say there may not be or they are unlikely to have significant change in the near future, I mean that -- you know, even with treatment, it could -- it could definitely take time for any change to be seen.

And, again, depending on what the traits are and what

personality disorder is present, there are various treatment options and effectiveness of those treatments.

Q. And those treatments don't need to happen in a -- in a controlled facility or jail or hospital? They could -- they could happen on an outpatient basis?

A. Certainly. They are available in the community as well.

Q. I said the wrong word before. I said psychiatric. I meant psychotic disorder, because I want to get into that part now a little bit.

Part of your -- one of the documents you reviewed was this evaluation from a Dr. Leidenfrost.

Do you recall that?

A. Yes.

Q. And he -- he goes through -- he gives a psychotic diagnosis. And that -- that's different than your diagnosis.

And he -- and we've talked about this a little bit -- he goes through this persecutory, paranoid, erotomanic delusions.

Are you familiar with his diagnosis? That those symptoms of delusions -- I know you talked -- you know, I know your colleague talked about it a little bit.

What's your understanding of -- of the disorder that he diagnosed Mr. Wenke with?

Terrible question.

A. Are you asking if I'm familiar with that diagnosis?

Q. Yeah. So what -- in your opinion, can you describe was a

persecutory delusion would be?

A. Yes. A persecutory delusion would be fixed beliefs that people are out to get this individual or are coming after them, to harm them in some way.

Q. And similar -- that's similar to, like, a paranoid delusion?

What's the difference?

A. I would say they are similar. Paranoid may also include -- like, you know, bad things are going to happen.

More broadly, persecutory would be more -- could be directly related to that individual they are targeting.

That individual, specifically -- but, again, both have this overarching theme of -- you know, that others are out to get this person or bad things will happen to this person.

And when it rises to a delusional belief, it is now based not in reality. And it's fixed beliefs that persist, even in the presence of evidence suggesting otherwise.

Q. So there is -- there is a big difference in an extreme belief versus a delusion.

And that a delusion is a symptom of a psychotic disorder, but an extreme belief is not; is that accurate?

A. I would be hesitant to say there is a big difference, because differentiating between a delusional belief and a very firmly held extreme belief can be a very fine line. And they can be very difficult to pars those things out.

Q. And the Cunningham research tool is an aide for that?
A. It is an aide, yeah.
Q. Is it the go-to aide for that? Is there some other tool that you can use to determine whether there is an extreme belief versus a delusion?
A. I am not familiar if there is, like, a specific tool design that's the gold standard to use to differentiate.

But outside of the 17 factor tool, one of the biggest things that's useful in differentiating these beliefs is looking at it in the context of the whole picture, rather than looking at each belief as existing in a vacuum.

And just looking at, you know, a belief related to believing in mediums, for example.

At face value, that may seem to lean more towards a delusional belief. However, when we are taking in the whole picture and thinking about the context in which that person holds that belief, where they might have come to develop that belief, is it impacting their functional abilities in their every day life that they are holding this belief?

Do other people believe it? When we look at the whole picture and, also, through consultation with other colleagues, you can, kind of, then develop your -- your conceptualization in whether or not this belief is delusional or it is firmly held extreme belief.

Q. So the belief in psychics -- we'll start there. That's a

good example. You did not find that to be a delusion.

Can you expand on that? And what kind of -- what information did you use to come to that conclusion?

A. That's correct. I did not conceptualize Mr. Wenke's belief in mediums or psychics as being delusional in nature.

And I came to that conclusion based on my conversations with him, that he reported that was something that was consistent throughout his life and in his family.

In addition, to the collateral interview with his mother, who -- you know, without prompting and simply asking about spiritual beliefs, she provided the information that that was commonly held in his family or a practice within his family.

Q. Okay. So that information came from both Mr. Wenke and then confirmation from his mother?

A. Correct.

Q. All right.

MR. PASSAFIUME: When did you want to break?

THE COURT: How much more do you have?

MR. PASSAFIUME: Maybe ten minutes. 15 minutes. I can go fast.

Thank you, Judge.

BY MR. PASSAFIUME:

Q. I want to just go --

THE COURT: Do you need we need a facilities break? Is that what you were --

MR. PASSAFIUME: I don't.

THE COURT: Let's take a five minute break. If we can accommodate everyone in that short of a period of time and then recess five minutes and come back and keep going and try to wrap it up before lunch.

MR. PASSAFIUME: Yes.

THE COURT: We're going to take a five minute recess.

(Recess commenced at 11:49 a.m., until 11:56 a.m.)

THE COURT: Okay. Everybody is where they are supposed to be.

Mr. Passafiume, please proceed.

MR. PASSAFIUME: Thanks, Judge.

BY MR. PASSAFIUME:

Q. All right, Doctor. I want to go through a few examples of delusions that have come up in this case and I want to get your opinion on those things.

Some of the ones you discussed in your report already, but we'll start with one of them that you discussed in your report.

So this delusion that Mr. Wenke was the former chairman of the Libertarian party of Cattaraugus County, you found that not to be a delusion.

I think it's on page 20. Because you found out that he actually was the county chairman for the Libertarian party; is

that right?

Do you remember that?

A. Yes. I remember that.

Q. So this might be an obvious question, but why isn't it a delusion? Because it actually happened?

A. Yes. Because it seemed to be based in reality.

Q. And you say: Upon further review -- I don't know if you remember.

Do you remember what that review was? Did you do any, like, research?

A. I -- I don't remember specifically what I reviewed, but I do believe that I Googled Mr. Wenke's name for the purposes of, like, looking up that specific fact.

Q. And was it easy to Google Mr. Wenke?

A. I don't recall having difficulty.

Q. Okay. These other delusions involve one of the victims in this case, KV.

And the delusion is that Mr. Wenke believes that KV created a website to harass him.

This is not your report. That would fall under the -- like, a persecutory delusion, right?

A. I apologize. There is some background noise. If you can hear that.

But I -- it could possibly be a persecutory belief, if he's thinking that -- I'm sorry.

It could be a persecutory belief if the individual is thinking that someone is intentionally out to get them, if that's not based in reality.

I'm not with the familiar of the website that you are referring to, but if there was truly a website that is targeting this individual, that could also possibly be based in reality to hold a persecutory belief.

Q. Perfect. If I told you that the website existed was created by KV, where she blogs every day and summarizes every Court appearance, posts every single legal document, transcribes all of Mr. Wenke's letters and comments on them and posts altered pictures of Mr. Wenke -- if I told you that website exists, would that change your opinion?

Would that make this not a delusion?

A. Those are -- would all be things that I would definitely want to take into consideration before determining whether or not that was a delusional belief or not.

Now I will add that there are times when delusional beliefs are stemmed from reality.

There is some piece of a truth in a delusional belief, oftentimes.

However, I would need to look at the situation as a whole and really look at that website myself and how Mr. Wenke was interpreting that.

Q. I gotcha. You know that the website exists, but you would

need to look at it yourself to verify everything that I just said?

A. I think seeing at least a sample of some of what was being posted would be helpful in informing the type of content that was being said about Mr. Wenke.

And also then having a conversation with Mr. Wenke and his beliefs, specifically related to that website.

Q. Okay. Would examples of persecution in this context be altered pictures, commentary, posting of documents, things like that?

Would that be examples of the persecutory delusion?

A. It could be, yes.

Q. Okay. Another -- another delusion is that KV stole Mr. Wenke's car. And, again, that's not in your report.

If -- if I told you that there is a story to that, where our office gave the car keys to KV and Mr. Wenke is aware of that, would that impact whether the -- the belief that KV stole his car, whether that's a delusion or not?

A. I think that certainly provides context for how he may have come to this belief, that this individual stole his car.

But, again, I would want more information as to how he rose to now that person stole the car, as opposed to had permission to use it.

Q. And that more information would come from the collateral sources?

You can ask him. You can ask me. You can ask family members, right?

A. That's correct.

Q. And you would do that in all of these instances of potential delusions?

A. Attempts would be made, yes.

Q. Okay. Another one of these is the delusion that Mr. Wenke believes KV left a negative yelp review on Mr. Wenke's mother's restaurant cite.

If I were to tell you that there was a negative yelp review and that Mr. Wenke's mom told Mr. Wenke that she believes it was KV that posted it, would that impact whether that's a delusion or not?

A. That could also inform, again, how and why Mr. Wenke was holding these beliefs.

I think the -- the overarching delusion would be that this person was out to get Mr. Wenke. And each of these examples that you are providing, if they are based in reality, those or -- or if they are not based in reality, they are all examples of why this belief is being maintained.

Now, because all of the examples that you are providing are based in reality, that doesn't automatically exclude someone from having a delusional belief.

Rather, these are examples of that belief being perpetuated. However, again, I would need more -- like, to have

a conversation to -- before determining whether or not that delusion or that belief is delusional or not.

Q. Okay. But these -- you would need other examples that were not based in reality to ultimately form the conclusion that it is a persecutory delusion?

A. I would say so, yes.

Q. The -- the last delusion, real quick, I want to talk about is that -- and I think this is in your report, actually, that KV and I had a screaming match.

If I were to tell you that I actually did speak with KV and she became irate on the phone and hung up -- and I told Mr. Wenke about that.

Do you think that would impact the whether that delusion exists, that we had a screaming match?

A. I don't recall specifically referencing a screaming match, but I do recall Mr. Wenke talking about various interactions with various people involved in his case.

So I certainly think that's informative to know there are truly, in fact, various interactions with multiple people involved in this case.

I think that may also lend to providing more reality-based context for these beliefs.

Q. And I guess -- I don't know if I should ask this -- if these don't rise to the level of delusions and maybe they are just extreme beliefs, would those also be symptoms of traits or

traits of the personality disorder that you diagnosed Mr. Wenke with?

A. They could be. So, you know, when we're talking about persecutory beliefs, the -- the diagnoses -- diagnosis that I provided related to borderline personality traits and narcissistic traits with referencing, kind of, the instability in relationships that seems to be persistent in Mr. Wenke's life.

And I certainly think the relationship that you were referencing before, with this individual who may be posting negatively about Mr. Wenke, and involved in the case could be in relation to those borderline personality traits as well.

Q. And his boasting about his political connections and publics, would that be a trait of narcissistic personality disorder?

A. That's how I conceptualized it as being art of these grandiose -- grand ideas that he has, you know, in his own self importance in what his personal case is going to lead to future action and things of that nature.

So, yes. I conceptualized those as being part of the other specified personality disorder traits.

Q. What be the excessive letter writing? How does that fit in?

A. Yeah. I also conceptualized as part of those personality traits specifically related to impulsivity. And that can be a

trait related to borderline personality disorder as well.

Q. Would that also be a trait of autism spectrum disorder?

A. It could be.

Q. I know you considered that in your report.

Traits of that would also include -- you know, abnormal speech, providing excessive details. That would be a trait of autism spectrum disorder, right?

A. It possibly could be. And the way that I -- someone may interpret the letter writing could be, you know, poor understanding of some social norms or not fully understanding that the things that he's writing in the letters could be interpreted as, you know, threatening or causing fear in the other person.

And, yes. Autism spectrum disorder was something that Dr. Watkins and I considered and spoke about.

But, ultimately, we -- we determined that at this point, we were not offering that diagnosis and there wasn't enough information to support that diagnosis at this time.

Q. Okay.

MR. PASSAFIUME: That's all I've got. Thank you so much. That was awesome.

THE WITNESS: Thank you.

MR. WRIGHT: May I proceed, Your Honor?

THE COURT: Go ahead.

CROSS EXAMINATION BY MR. WRIGHT:

BY MR. WRIGHT:

Q. Good morning or afternoon, Dr. Nelson.

A. Thank you.

Q. Can someone have a mental disease or defect and still suffer from a personality disorder?

A. Yes. Both can occur at the same time.

Q. Okay. From the examinations that you did in your 4241 analysis, focusing on the competency aspect of the defendant, from the assessments that you employed in your evaluation, could you have detected, based on those assessments, if someone had a schizoaffective disorder?

A. Yes. It's possible to detect during a competency evaluation.

Q. Okay. And for schizoaffective disorders, what are you looking for in that?

A. For a -- a schizoaffective diagnosis, it's kind of a combination of both psychotic symptoms and mood symptoms.

So you're looking for a deviation from their normal presentation, but also these mood-related symptoms being -- persisting throughout the majority of time -- meaning, having -- it could be excessive energy, things of that nature.

Lack of need for sleep, disorganized behavior. But then the part that makes this more schizoaffective is that there are

psychotic symptoms.

Specifically, hallucinations or delusions that persist or continue to be present in the absence of mood-related symptoms.

And those psychotic symptoms have to be present for a period of at least two weeks, in the absence of mood-related symptoms.

Q. Okay. So for this psychotic symptoms, could they have been present during your evaluation of the defendant, but the -- the examinations that you employed would not have picked up on those?

A. Typically, for psychotic symptoms -- and I'm not sure if I'm -- I made this clear, but the psychotic symptoms would be present the entire duration of the schizoaffective disorder and then would continue to be present in the absence of those mood symptoms.

But during the competency evaluations, psychotic symptoms could be detected mostly in the individual interactions I have with the individual.

A lot of times in the phone calls or letters that I review. They can also be noted -- or the impairment that a lot of times people experience with delusions or hallucinations, could be observed while in the housing unit.

So most times -- many of the times, other people pick up on symptoms that could suggest or indicate that they may be, you know, hallucinating or something like that.

But the delusional piece would certainly be present during interviews.

Q. So depending on how the defendant or the person being examined is acting before the examiner, that could be a very important determination of whether or not a determination of a psychotic treatment is needed or psychoactive disorder is present?

A. You are saying their presentation with the evaluator?

Q. Correct. It would depend on who they -- how they are -- who is doing the interview, that could change the analysis?

A. Certainly. So part of why we meet with an individual on multiple occasions, across time, is if someone is experiencing genuine symptoms of mental illness -- specifically, they are hallucinating or hold delusional beliefs, it's a lot harder to conceal those if you are meeting with them across different time periods.

I also think that in different contexts, it's important to look at the different contexts, because the consistency of the person's presentation is also very informative.

So the other things that I mentioned, such as the functioning on the housing unit when I'm not present or how they are speaking to their family in the phone or how -- what they are writing in letters, all of that speaks to the consistency of their presentation and can inform us of whether or not a psychotic symptoms are present.

Q. Understood.

MR. WRIGHT: Nothing further, Your Honor.

THE COURT: Mr. Passafiume?

MR. PASSAFIUME: That's all. Nothing.

THE COURT: Okay. Thank you, Dr. Nelson.

THE WITNESS: Thank you, Your Honor.

(Witness Excused)

THE COURT: Okay.

Kirstie, you can shut off the video feed.

Okay. So any other witnesses for this hearing from either side?

MR. PASSAFIUME: Not from the defense.

MR. WRIGHT: Nothing from the Government, Your Honor.

THE COURT: All right. So the hearing -- the evidentiary portion of the hearing is closed.

And as far as I'm concerned, the only thing left for to do is for me to make a decision, which I intend to do.

Do we need to submit anything else from either side? Mr. Wright?

MR. WRIGHT: I -- I don't think so, Your Honor. I think we will rest on the presentation that we have.

THE COURT: Mr. Passafiume? Ms. Kubiak?

MS. KUBIAK: Judge, it may be necessary for us to do some very brief response or briefing.

What I would like to do is maybe have a quick

turnaround of the transcript from today's proceeding.

I just don't want to commit to the fact that we're not going to do anything further.

Can we have a quick turnaround on a transcript in a very short submission?

THE COURT: You will have to order one, an expedited transcript.

And then let me talk to the court reporter offline here for a minute.

MS. KUBIAK: Yes.

(Discussion off the record.)

THE COURT: When we're done here, Ms. Kubiak, why don't you speak with Ms. Weber about how to handle that request to make sure it's done in a way that facilitates success.

MS. KUBIAK: Absolutely.

THE COURT: And to the extent you need approvals for that expedited or daily, whatever terminology you two ultimately use, I am hereby approving that.

So, you know, I still may need to sign something nonetheless.

Mr. Wright?

MR. WRIGHT: Yes. If the defense is going to file something, we will submit something in writing as well.

THE COURT: So I think that Ms. Weber would have it done in that scenario by Monday.

Why don't we have some joint submission done by next Friday, because we've just got to put an end on this.

You know, because to the extent that we're headed in one direction or to the extent we're headed in another direction, we're just holding Mr. Wenke is limbo.

And I'm sensitive to the fact that he's been held in limbo for a long time, so we need to wrap it up.

So filing deadline for any post-hearing submissions would be Friday, April 18. And Ms. Weber will endeavor to the transcript docketed Monday, as long as everything moves smoothly in terms of requesting it the right way.

And, again, if you need to put something, Ms. Kubiak, in front of me for signature, I'm happy to sign it. If you need verbal approval, then you have it.

MS. KUBIAK: Thank you, Judge.

THE COURT: Anything else, folks?

MR. WRIGHT: No, Your Honor.

MS. KUBIAK: No, Your Honor.

THE COURT: Take care everybody. Be well.

MS. KUBIAK: Thank you.

(Proceedings concluded at 12:18 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
Signature

April 14, 2025
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

EXHIBIT D

UNITED STATES DISTRICT COURT
FILED
MAY 16 2025
MARY C. LOEWENGUTH, CLERK
WESTERN DISTRICT OF NY

UNITED STATES DISTRICT COURT
WESTERN DISTRICT OF NEW YORK

UNITED STATES OF AMERICA,

v.

LUKE MARSHALL WENKE,

Defendant.

22-CR-35 (JLS)

DECISION AND ORDER

Before the Court is Wenke's motion to stay enforcement of this Court's [194] Decision and Order of Commitment pending appeal. *See* Dkt. 202. For the reasons that follow, the motion is DENIED.

BACKGROUND

On April 23, 2025, following an evidentiary hearing pursuant to 18 U.S.C. § 4244, this Court issued a Decision and Order of Commitment. Dkt. 194. Based on the hearing evidence, the Court found, by a preponderance of the evidence, that Wenke "is presently suffering from a mental disease or defect for the treatment of which he is in need of custody for care or treatment in a suitable facility." *Id.* at 10. And as a result, the Court ordered Wenke committed to the custody of the Attorney General to hospitalize him for care or treatment in a suitable facility. *Id.*

On May 1, 2025, counsel for Wenke filed a notice of appeal. Dkt. 196. He then moved to stay enforcement of this Court's order of commitment pending appeal. Dkt. 202. The Government opposed the motion. Dkt. 204.

DISCUSSION

The "factors relevant to granting a stay pending appeal are the applicant's 'strong showing that he is likely to succeed on the merits,' irreparable injury to the applicant in the absence of a stay, substantial injury to the nonmoving party if a stay is issued, and the public interest." *Uniformed Fire Officers Ass'n v. de Blasio*, 973 F.3d 41, 48 (2d Cir. 2020) (citing *Nken v. Holder*, 556 U.S. 418, 434 (2009)). The "first two factors are the most critical, but a stay 'is not a matter of right, even if irreparable injury might otherwise result,' it is 'an exercise of judicial discretion,' and '[t]he party requesting a stay bears the burden of showing that the circumstances justify an exercise of that discretion.'" *Id.* (quoting *Nken*, 556 U.S. at 433-34).

Here, all of the relevant factors counsel against granting a stay pending appeal. First, Wenke fails to demonstrate a "strong showing that he is likely to succeed on the merits." *See Uniformed Fire Officers Ass'n*, 973 F.3d at 48. On this record, there is "reasonable cause to believe that [Wenke] may presently be suffering from a mental disease or defect for the treatment of which he is in need of custody for care or treatment in a suitable facility." *See* 18 U.S.C. § 4244(a).

At the hearing, Dr. Corey M. Leidenfrost credibly testified that, based his two separate reports and two evaluations, Wenke is at a high risk for future violence, serious physical harm, and imminent violence due to an underlying mental disease or defect—namely, bipolar or schizoaffective disorder. *See* Dkt. 175 at 4; Dkt. 186 at 39. Dr. Leidenfrost further determined—and so testified—that Wenke is in need of

custody for care or treatment, in a suitable facility, for his mental disease or defect, because: (1) Wenke is presently suffering from a mental disease or defect; (2) he has no insight regarding his symptoms of serious mental illness; (3) he will likely refuse to take psychiatric medication; and (4) his symptoms significantly influence his high risk for future and imminent violence. *See* Dkt. 175 at 7. In addition, Dr. Robin Watkins and Dr. Kaitlyn Nelson opined that Wenke presented symptoms consistent with a personality disorder or autism spectrum disorder. *See* Dkt. 164 at 25. This record does not portend success on the merits.

Second, Wenke fails to demonstrate "irreparable injury" absent a stay. *See Uniformed Fire Officers Ass'n*, 973 F.3d at 48. To the contrary, enforcement of this Court's order ought to—and is intended to—benefit Wenke by affording him access to appropriate care and treatment for his conditions. And a stay would harm the Government by obstructing its interest in preventing future crimes and protecting public safety.

Lastly, a stay is not in the public interest. The evidence demonstrates that Wenke is at high risk for future violence, serious physical harm, and imminent violence due to an underlying mental disease or defect. And he is set for release from custody no later than October 2025. It is in the public's best interest that Wenke receives care or treatment in a suitable facility prior to his release—as opposed to remaining in a local jail, where such treatment is not as readily accessible.

CONCLUSION

For the reasons above, Wenke's motion to stay enforcement of this Court's [194] Decision and Order of Commitment pending appeal is DENIED.

SO ORDERED.

Dated: May 16, 2025
Buffalo, New York

JOHN L. SINATRA, JR.
UNITED STATES DISTRICT JUDGE