

UNITED STATES DISTRICT COURT  
WESTERN DISTRICT OF NEW YORK

UNITED STATES OF AMERICA, \*

Docket Number:  
1:22-CR-00035-JLS-HKS-1

v. \*

Buffalo, New York  
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,  
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Appearing for the United States.

For the Defendant:

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

The Courtroom Deputy:

KIRSTIE L. HENRY

1 The Court Reporter: BONNIE S. WEBER, RPR,  
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3 Robert H. Jackson Courthouse,  
4 2 Niagara Square,  
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7 Proceedings recorded by mechanical stenography,  
8 transcript produced by computer.

9  
10 (Proceedings commenced at 1:33 p.m.)

11  
12 **THE CLERK:** All rise.

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

16 **THE COURT:** Please be seated.

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

20 Appearing for probation is Matthew Zenger.

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

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

25 **THE COURT:** Good afternoon, Counsel and good

1 afternoon, Mr. Wenke.

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

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

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

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

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

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

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

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

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

4 **THE COURT:** They are asking different questions.

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

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

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

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

14 That's the whole point of the hearing.

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

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

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

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

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

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

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

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

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

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

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

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

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

1           Why didn't that accomplish that goal then?

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

21 **MR. PASSAFIUME:** No, you don't.

22 **THE COURT:** Right.

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

25 **MR. PASSAFIUME:** I guess that's right.

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

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

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

9           **THE COURT:** Right.

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

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

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

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

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



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

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

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

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

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

13           Okay, Ms. Kubiak.

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

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

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

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

1 medical facility, but to be hospitalized somewhere else.

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

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

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

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

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

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

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

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

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

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

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

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

12           We could --

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

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

17           **MR. PASSAFIUME:** That's right. Sure.

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

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

22           **MR. PASSAFIUME:** Sure.

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

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

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

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

6           **THE COURT:** Yeah.

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

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

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

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

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

17          **THE COURT:** You want to try again?

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

19          **THE COURT:** Okay.

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

24          **THE COURT:** Right.

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

1 already found him competent, et cetera.

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

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

6 **MR. PASSAFIUME:** Okay.

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

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

15 **MR. WRIGHT:** Yes, Your Honor.

16 The Government calls Dr. Corey Leidenfrost.

17 **THE COURT:** Please remain standing for a moment.

18 **THE CLERK:** Can you raise your right hand?

19

20 **COREY LEIDENFROST,**

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

23

24 **THE WITNESS:** I do.

25 **THE CLERK:** Thank you. Have a seat.

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

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

5 **THE COURT:** Mr. Wright.

6 **MR. WRIGHT:** May I proceed, Your Honor?

7 **THE COURT:** Yes.

8

9 **DIRECT EXAMINATION BY MR. WRIGHT:**

10

11 **BY MR. WRIGHT:**

12 Q. Good afternoon, Dr. Leidenfrost.

13 A. Good afternoon.

14 Q. Where do you work?

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

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

18 A. City of Brockport.

19 Q. What did you receive your degree in?

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

22 Q. Did you receive any further education after that?

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

1 Q. Do you have any licenses in the psychology as well?

2 A. Yes. I'm a licensed psychologist in New York State.

3 Q. Are you a member of any boards and organizations as well?

4 A. Yes.

5 Q. Can you explain some of them?

6 A. American Psychological Association, the American  
7 Psychological Law Society, and the Society for Personality  
8 Assessment.

9 Q. Okay. Do you have experience handling forensic  
10 examinations?

11 A. Yes.

12 Q. Okay. These are psychological forensic examinations?

13 A. Yes.

14 Q. Can you provide some examples of the types of forensic  
15 examinations you have provided in the past?

16 A. Yes. Mostly many, many competency evaluations in New York  
17 State. I've conducted sex offender and violence risk  
18 assessments.

19 I've done cases regarding mental health mitigation for  
20 sentencing. I've done Domestic Violence Survivor Act cases.

21 Q. You mentioned competency examinations. Is that referred to  
22 as a 4241 examination as well?

23 A. Yes. 730 in New York State, but, yes.

24 Q. Okay. But Federally it's a 4241 examination?

25 A. Yes.

1 Q. Okay. What about -- have you ever heard the expression a  
2 4244 examination?

3 A. Yes. I've heard of it.

4 Q. I'm sorry, 4244 examination.

5 A. Yes.

6 Q. And what is that?

7 A. I believe that is potentially need for treatment, due to  
8 mental illness.

9 Q. Okay. And you mentioned conducting violence risk  
10 assessments?

11 A. Yes.

12 Q. And what are those?

13 A. So that is making a determination, usually using some sort  
14 of structured tool to provide an opinion about somebody's risk  
15 for future violence and imminent violence.

16 Q. Okay. And based on the type of forensic examination that  
17 you are doing, are there types of different psychological  
18 assessments that you use, depending on which one you examine?

19 A. Yes.

20 Q. Okay. So based on your experience, is it fair to say that  
21 you have experience diagnosing various types of mental illness?

22 A. Yes.

23 Q. I'd like to just define some terms for the Court, so we can  
24 have some context.

25 Can you provide a definition of delusions?



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

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

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

9 A. Yes.

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

12 A. Yes.

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

15 A. Yes.

16 Q. Can you explain some examples?

17 A. Yes. Some of the most common are paranoid, persecutory,  
18 grandiose, erotomaniac.

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

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

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

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

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

7       Q.     Sure.

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

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

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

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

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

21       Q.     Mania, how would you define mania?

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

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

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

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

9 Q. Okay.

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

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

16 Q. Okay. A couple more. Psychosis?

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

21 Q. Okay. Bipolar I disorder?

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

25 They may have experienced a depressive episode as well, but

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

3 Q. What are some examples of those symptoms?

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

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

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

10 A. Yes.

11 Q. What is that?

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

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

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

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

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

1 A. Yes.

2 Q. Okay. And when did you first meet him?

3 A. January of 2024.

4 Q. And why was that?

5 A. I was approached and asked to conduct an evaluation to  
6 determine whether he was dangerous, due to a mental disease or  
7 defect.

8 Q. Did you end up meeting him in person at some point?

9 A. Yes.

10 Q. And when was that?

11 A. Late January, 2024.

12 Q. Okay.

13 A. Or was that -- I'm sorry. It was in March. It was March.  
14 I'm sorry.

15 Q. If I say it was around, like, March, 2024 --

16 A. Yes.

17 Q. And we'll take a step back. Where did this examination  
18 occur?

19 A. I believe it was Orleans County Jail.

20 Q. Okay. And what was the reason for you meeting with him at  
21 that time?

22 A. It was part of the process to conduct a violence risk  
23 assessment, but also to determine whether he had a mental  
24 disease or defect.

25 Q. And what is a violence risk assessment?

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

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

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

10 A. Yes.

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

13 A. Yes.

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

15 **THE COURT:** Yeah.

16 **BY MR. WRIGHT:**

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

18 A. Thank you.

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

21 A. I am.

22 Q. And what is that?

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

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

1 report that you filed -- or submitted?

2 A. Yes.

3 **MR. WRIGHT:** Your Honor, I would like to move it into  
4 evidence. I know the Court has reviewed this, but just for the  
5 record's sake.

6 **THE COURT:** Any objection?

7 **MR. PASSAFIUME:** No, Judge. We can stipulate to all  
8 the reports. That's fine.

9 **THE COURT:** All right. Exhibit 1 is admitted.

10 **The following was received in Evidence:**

11 **GOVT. EXH. 1 UNDER SEAL**

12

13 **MR. WRIGHT:** And the report will remain under seal,  
14 Your Honor? I know there's some --

15 **THE COURT:** All right. So just work through that  
16 issue with Ms. Henry.

17 So Exhibit 1 under seal.

18 **MR. WRIGHT:** Will do, Your Honor. Thank you.

19 **THE COURT:** All right.

20 **BY MR. WRIGHT:**

21 Q. Dr. Leidenfrost, can you provide some examples of the  
22 sources of information that you used as part of your evaluation  
23 of the defendant from this April -- March, 2024 time period?

24 A. Yes. I was provided with over a dozen letters to the Court  
25 from Mr. Wenke. I was provided segments of information from

1 social media, including X, Twitter, Facebook.

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

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

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

9 A. Yes.

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

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

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

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

18 Q. Okay. You mentioned reviewing letters as well?

19 A. Yes.

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

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

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

24 A. Yes. There was a letter from KB.

25 Q. Okay. Are you familiar with the psychological evaluation



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

3 A. Yes.

4 Q. What is it?

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

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

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

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

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

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

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

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

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

25 **THE COURT:** Mr. Wright?

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

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

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

10           Overruled.

11           **BY MR. WRIGHT:**

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

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

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

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

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

1 portion, the static portion, is that like the historical items  
2 portion?

3 A. Yes.

4 Q. And can you just provide a brief description of what items  
5 you are looking for? That aspect of it?

6 A. So these include history of evidence of mental health  
7 problems, history of personality issues, adherence to mental  
8 health treatment or adherence to other efforts of supervision in  
9 the past.

10 Q. Okay. And for that static portion, is that the clinical  
11 scale? Is that another term for that portion?

12 I mean -- I'm sorry, dynamic portion, I should say. The  
13 dynamic aspect of it --

14 A. Is the clinical.

15 Q. -- for the clinical portion?

16 A. Yes. The five items in the clinical are the dynamic. And  
17 there are -- many of them are similar to the history items, but  
18 the time frame is different. It is right now and recently  
19 versus history.

20 Q. Okay. And this HCR Version 3 -- 20 Version 3, this is a  
21 common accepted -- I'm sorry -- commonly accepted assessment  
22 tool in forensic examinations?

23 A. Yes.

24 Q. Okay. So I would like to turn your attention to that  
25 examination that you did with Mr. -- with the defendant.

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

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

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

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

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

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

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

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

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

1 illness.

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

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

9 A. Yes.

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

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

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

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

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

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

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

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

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

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

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

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

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

1 was considering changing her name and changing her appearance.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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



1 be an assault rifle.

2 Q. Okay.

3 A. And I think, to add context to that, there is corroboration  
4 in other documentation that the Boogaloo Boys supplied him with  
5 a weapon in Minnesota, in 2020.

6 Q. What -- one thing I would like to discuss with you as well  
7 is, in your report you mention this issue of problems with  
8 insight?

9 A. Yes.

10 Q. So let me ask you this: As part of your HCR-20 Version 3  
11 psychological evaluation, what did you mean by this reference of  
12 problems with insight?

13 A. So with that item, there is a history item and a clinical  
14 item that has to do with insight that's relevant here. There  
15 are three areas you are looking at insight about.

16 Does the person have insight about their mental health  
17 problems?

18 Does the person have insight about the violence they have  
19 committed?

20 And do they have insight about their need for treatment?

21 So I evaluated those three areas and I had concerns about  
22 all three areas.

23 Q. Okay. And from your interaction with the defendant, can  
24 you provide some specific examples of what problems of insight  
25 you found, based on your interaction with him?

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

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

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

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

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

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

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

24 A. Yes.

25 Q. Can you explain that to the Court?

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

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

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

9 A. Yes.

10 Q. And what was that diagnosis?

11 A. Bipolar I disorder with psychotic features.

12 Q. And explain.

13 A. Versus schizoaffective disorder bipolar type.

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

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

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

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

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

4 Because he's clearly delusion. Clearly has some mood  
5 symptoms. He's experienced those symptoms at least since 2020,  
6 2019. And they have been untreated.

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

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

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

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

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

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

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

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

1 factors. That is the risk factors I'm most concerned about.

2 Q. Okay. So I would like to turn your attention to the  
3 January, 2025 forensic examination. And this one I will just  
4 show you.

5 **MR. WRIGHT:** Your Honor, I'm just to approach with  
6 Government's Exhibit 2.

7 **THE COURT:** Okay.

8 **BY MR. WRIGHT:**

9 Q. Dr. Leidenfrost, did you have a chance to review Government  
10 Exhibit 2?

11 A. Yes.

12 Q. And what is that?

13 A. It is the report I generated on January 13, 2025.

14 Q. And this is a report of your examination with the  
15 defendant?

16 A. Correct.

17 Q. And is that report a fair and accurate representation of  
18 the report that you submitted?

19 A. Yes.

20 Q. Okay.

21 **MR. WRIGHT:** Similar, Your Honor. I would just like  
22 to move that into evidence under seal.

23 **THE COURT:** No objection?

24 **MR. PASSAFIUME:** No objection.

25 **THE COURT:** All right. Under seal, it's admitted,

1 Government's Exhibit 2.

2 **The following was received in Evidence:**

3 **GOVT. EXH. 2 UNDER SEAL**

4

5 **BY MR. WRIGHT:**

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

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

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

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

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

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

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

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

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

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

11 A. I did.

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

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

16 A. Schizoaffective disorder, bipolar type.

17 Q. Can you say again?

18 A. Yes. Schizoaffective disorder, bipolar type.

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

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

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

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

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

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

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

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

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

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

18 A. Schizoaffective disorder, bipolar type.

19 Q. And what does that mean?

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

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



1 mood symptoms at the same time.

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

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

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

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

14 A. Yes.

15 Q. Similar to the August -- I'm sorry. Similar to the April,  
16 2024 evaluation as well?

17 A. Yes.

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

20 A. Yes.

21 Q. And what was your opinion?

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

1 appropriate facility.

2 Q. Okay. What about this issue of insight? Can you provide  
3 some further information relating to the defendant's insight?  
4 Were there any changes to his insight?

5 A. None that I observed.

6 Q. Okay. You mentioned in your report that the defendant is  
7 in need of treatment that includes the use of a psychiatric  
8 medication -- or use of psychiatric medication such as one with  
9 antipsychotic action.

10 What do you mean by that?

11 A. So I need to qualify, I'm a psychologist. I cannot  
12 prescribe medication. I think that's important to point out.

13 I have done inpatient psychiatric work for over ten years  
14 and I am familiar with the American Psychiatric Association's  
15 guidelines for treatment of bipolar and schizoaffective.

16 And they make it clear, first line treatment for those  
17 disorders is antipsychotic medications.

18 Q. Okay. And just a couple more things.

19 I'm going to show you Government's Exhibit 3.

20 **MR. WRIGHT:** Your Honor, if I may?

21 **THE COURT:** Yes.

22 **BY MR. WRIGHT:**

23 Q. Dr. Leidenfrost -- I'll give you a second to review.

24 Dr. Leidenfrost, what's in front of you?

25 A. This is the competency evaluation report from the BOP dated

1 in November of 2024.

2 Q. Okay. And this was something that you reviewed as part of  
3 your January, 2025 evaluation?

4 A. Yes.

5 Q. Okay. And you said that's a competency evaluation.

6 That's -- to be clear, that's different from what you were asked  
7 to examine or look at in January of 2025?

8 A. Correct.

9 Q. And similarly in April of 2024 as well?

10 A. Correct.

11 Q. Okay. You mention in your report having some disagreements  
12 on a couple of points in the competency evaluation.

13 Can you just explain those differences and their importance  
14 in your overall diagnosis relating to the defendant's need to  
15 be -- need for -- need to be in custody or for treatment in a  
16 suitable facility?

17 A. Yeah. My disagreement is how they derived a diagnosis.  
18 They laid out -- the individuals that wrote this laid out their  
19 thought process pretty well and how they reached their  
20 diagnosis. I disagree with the arguments that they put forth.

21 One, they argued that the defendant could not have a manic  
22 episode, because they argued there wasn't evidence of a clear  
23 change in personality or behavior. I disagree.

24 I think there is evidence to suggest a marked change of  
25 personality behavior sometime around 2019, 2020, based upon one

1 of the things I have discussed before.

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

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

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

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

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

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

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

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

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

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

6 Is that a fair assessment?

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

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

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

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

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

16 **THE COURT:** Is Exhibit 3 getting moved into evidence?

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

19 **MR. PASSAFIUME:** No objection.

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

22 **The following was received in Evidence:**

23 **GOVT. EXH. 3 UNDER SEAL**

24

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

1 **BY MR. WRIGHT:**

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

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

7 A. Yeah. That is part of my concern.

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

9 **THE COURT:** Okay.

10 Mr. Passafiume --

11 **MR. PASSAFIUME:** Thank you, Judge.

12

13 **CROSS EXAMINATION BY MR. PASSAFIUME:**

14

15 **BY MR. PASSAFIUME:**

16 Q. Hi, Dr. Leidenfrost.

17 A. Hello.

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

20 A. Sure.

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

23 A. Yes.

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

1 A. Yes.

2 Q. And the BOP identifies three of these personality disorders  
3 in their report?

4 A. I'll take your word for it. It sounds reasonable.

5 Q. Narcicisstic personality disorder, that would be one of  
6 them, right?

7 A. I remember that, yeah.

8 Q. And some of the traits for that would be patterns of  
9 grandiosity or grandiose -- however you pronounce it?

10 A. Yes.

11 Q. It would be the need for admiration?

12 A. Yes.

13 Q. Being self-centered?

14 A. Yes.

15 Q. Having an exaggerated self image?

16 A. Yes.

17 Q. Lack of empathy?

18 A. Yes.

19 Q. The other personality disorder, the next one, is borderline  
20 personality disorder, right?

21 A. Yes.

22 Q. And traits for that disorder is -- could be instability  
23 with relationships?

24 A. Yes.

25 Q. Instability with emotions?

1 A. Yes.

2 Q. And impulsivity?

3 A. Yes.

4 Q. The third disorder they mention is autism spectrum  
5 disorder.

6 Are you familiar with that?

7 A. Yes.

8 Q. Some of the traits for that disorder would be difficulty  
9 in -- with social communications and interactions?

10 A. Yes.

11 Q. And it would be difficulty understanding social norms?

12 A. Yes.

13 Q. It would be, you have an abnormal approach to the social  
14 norms?

15 A. Potentially, yes.

16 Q. Okay. Unable to have back and forth conversations like  
17 this?

18 A. That's not true.

19 Q. No?

20 What about the ability to understand the perspective of  
21 others?

22 A. Potentially, yes.

23 Q. Okay. And fixation on interests?

24 A. Yes.

25 Q. And that's a -- there is -- it's a repetitive pattern of



1 behavior with that personality disorder?

2 A. Autism is not a personality disorder.

3 Q. Autism spectrum disorder.

4 A. Yes. It's not a personality disorder. It's a separate  
5 diagnosis.

6 Q. Sorry.

7 A. Yeah.

8 Q. Sounds good.

9 The treatment for these is generally psychotherapy,  
10 correct?

11 A. Yes.

12 Q. And there is different types of that therapy?

13 A. Yes.

14 Q. Psychoanalytical? Is that one?

15 Dialectical. I don't know if I'm pronouncing that -- is  
16 that one?

17 A. Yeah. Dialectical behavior therapy.

18 Q. And cognitive behavioral therapy.

19 A. Yes.

20 Q. I've heard of that. Medications are not generally used to  
21 treat these disorders and autism?

22 A. They are often used, yes.

23 Q. They are?

24 A. Uh-huh.

25 Q. It's not to treat specifically the disorder. It's to treat

1 the symptoms of other -- like anxiety or depression; isn't that  
2 right?

3 A. Yeah. That's fair.

4 Q. And the BOP says -- and I wonder if you agree, that these  
5 are -- I'm not saying that Mr. Wenke -- I'm not saying you agree  
6 with the BOP diagnosis -- but these traits are unlikely to  
7 change in the future if somebody has these disorders?

8 A. Unless the person gets treatment.

9 Q. Okay. Gets treatment.

10 A. Autism is not going to go away.

11 Q. Okay.

12 A. But with personality pathology, there is really good  
13 treatment, you can expect the person to improve.

14 Q. With, like, therapy, for example?

15 A. Yes.

16 Q. Okay. You have an affiliation with ECMC, right?

17 A. Through contract.

18 Q. Can you explain that a little bit?

19 A. So I work for University Psychiatric Practice. Because it  
20 is part of UB Department of Psychiatry. We have a contract with  
21 ECMC to provide psychiatric and psychological services in the  
22 hospital.

23 Q. Does the term "chief of transitions" mean anything?

24 A. Yes. It's one of my titles.

25 Q. One of your titles?

1           Could you explain what a chief of transition is?

2       A.    So transitions is the inpatient psychiatric unit I work on.  
3       We're a psychiatric intensive care unit.

4           We work with patients who are at high risk for violence or  
5       aggression due to symptoms of serious mental illness. I've been  
6       the unit chief on that unit for ten years.

7       Q.    And ECMC, it's a hospital-based emergency psychiatric  
8       service, correct?

9       A.    Part of what they have -- right. The comprehensive  
10      psychiatric emergency program or CPEP.

11      Q.    CPEP. And it's actually one of the biggest ones in New  
12      York State, isn't it?

13      A.    Yes.

14      Q.    They provide emergency mental health services?

15      A.    They provide emergency evaluation.

16      Q.    And those emergency evaluations could lead to extended  
17      observations?

18      A.    Yes.

19      Q.    Future assessments?

20      A.    It can lead to -- right, being extended observation or  
21      admission psychiatrically to an acute inpatient unit.

22      Q.    And they make their own evaluation and treatment  
23      recommendations?

24      A.    Correct.

25      Q.    And those recommendations obviously are dependent on the

1 symptoms, right?

2 A. Yes.

3 Q. And examples of those would be residential treatment --  
4 residential inpatient treatment?

5 A. Are we talking about CPEP and the determinations?

6 Q. After the fact.

7 A. After the fact?

8 Q. Yeah. After they had been evaluated.

9 A. Yes. Part of the discharge plan could be a residential  
10 facility.

11 Q. Would be outpatient treatment?

12 A. Yes.

13 Q. And, again, those all depend on the severity of the  
14 symptoms?

15 A. Yes.

16 Q. Okay. Let's go into your diagnosis a little bit here.

17 A. Sure.

18 Q. Yours was very different than the BOP diagnosis?

19 A. Yes.

20 Q. And you diagnosed Mr. Wenke with the schizoaffective  
21 disorder?

22 A. Yes.

23 Q. And you need certain traits or characteristics to make that  
24 diagnosis, right?

25 A. Yes.

1 Q. And one would be the delusions?

2 A. It can be, yes.

3 Q. Right. You need to have at least two of the following, but  
4 one of the first three, is that what you're meaning?

5 A. Yeah. There is different ways of getting to the diagnosis.

6 Q. But here, applying it here would be the delusions?

7 A. Yes, you're right. That's what's relevant here.

8 Q. And organized speech, I think, is one of them?

9 A. It can be, yes.

10 Q. And treatment for this is usually medication, right?

11 A. Yes.

12 Q. And people come into ECMC and are treated with this  
13 disorder?

14 A. Yes.

15 Q. Is that frequently?

16 A. Yes.

17 Q. And you guys have -- I don't want to say, you guys.

18 In your work with ECMC, they have the -- an adequate  
19 support structure to receive these individuals, evaluate and  
20 treat them?

21 A. Yes.

22 Q. Do they make recommendations of future treatments?

23 A. Yes.

24 Q. Did they arrange the transition from being at ECMC into  
25 future treatment?

1 A. Yes.

2 Q. There is never really a period where somebody would miss  
3 out on treatment in between the transition?

4 **MR. WRIGHT:** Objection. Your Honor, relevance.

5 **THE COURT:** Overruled.

6 You can answer.

7 **THE WITNESS:** Are you meaning while they are in the  
8 hospital?

9 **BY MR. PASSAFIUME:**

10 Q. Sure. So if somebody leaves the hospital --

11 A. Yeah.

12 Q. -- and they are supposed to be to outpatient, they are  
13 going to leave the hospital with enough medication until the  
14 outpatient starts?

15 A. Right. Yes. I got you, yes.

16 Q. And before we get to more specifics of the delusions and  
17 disorganized speech, I want to talk about how you got to that  
18 diagnosis.

19 You talked about your sources of your assessment on direct  
20 examination, right?

21 A. Yes.

22 Q. And, right? All the various reports? Letters? All of  
23 that stuff, right?

24 A. Yes.

25 Q. It is different than what the BOP used, right?

1 A. Can I look at the report?

2 Q. Yes. Well, actually, I'll withdraw that and make it  
3 easier.

4 A. Yeah.

5 Q. You didn't speak to any individuals regarding Mr. Wenke,  
6 aside from the e-mails that we all exchanged?

7 A. No.

8 Q. You didn't speak to his mom?

9 A. No.

10 Q. His dad?

11 A. No.

12 Q. Any prior counselors?

13 A. No.

14 Q. Any of the victims in this case?

15 A. No.

16 Q. Would you classify those as collateral information?

17 A. Yes.

18 Q. And you talked a little bit about collateral information  
19 before. And that information is helpful when making a  
20 diagnosis, right?

21 A. Yeah.

22 Q. It could shed more light on the timeline of the symptoms?

23 A. Yeah.

24 Q. It could have insight into additional symptoms?

25 A. Yeah.

1 Q. And when you gave -- you gave Mr. Wenke that HCR  
2 assessment, right?

3 A. Yes.

4 Q. And there is -- there is a manual to that that kind of  
5 tells you how to do it, right?

6 A. Yes.

7 Q. And the first step is to gather information?

8 A. Yes.

9 Q. And that -- again, that information, not only is it used to  
10 give you a better understanding, it makes sure that the  
11 information you do have is accurate?

12 A. Yes.

13 Q. An inaccurate information would lead to skewed results as  
14 far as a diagnosis?

15 A. Yes.

16 Q. And another difference -- well, you did not review this  
17 research paper titled: Differentiating Delusional Disorder from  
18 the Radicalization of Extreme Beliefs?

19 A. I'm quite familiar with it, yes.

20 Q. You didn't use that in this report specifically?

21 A. I didn't cite it, but I'm well aware of it. I've received  
22 training in it and I train others about it.

23 Q. Okay. And you saw Mr. Wenke on two occasions, right?

24 A. Correct.

25 Q. And in an ideal world you would want to observe a patient



1 more than those two times, right?

2 A. I mean, that's not usually reasonable for these types of  
3 evaluations.

4 Q. But the BOP evaluated him from September of 2024 to  
5 November of '24.

6 If you had the same, would you -- if you could switch  
7 places and evaluate him from September to November, would you?

8 **MR. WRIGHT:** Objection. Speculation.

9 **THE COURT:** I'll let him answer it. Overruled.

10 **THE WITNESS:** Sure.

11 **MR. PASSAFIUME:** All right.

12 **BY MR. PASSAFIUME:**

13 Q. And during that time, those months, the BOP routinely  
14 visited Mr. Wenke?

15 A. I don't know if they did.

16 Q. From the report?

17 Okay. All right. Let's get into some of the delusions  
18 here. The first one is this grandiose, paranoid and persecutory  
19 delusion.

20 And you specifically reference that Mr. Wenke thought he  
21 was a public figure and a former chairman of the Libertarian  
22 Party of Cattaraugus County?

23 A. Yeah.

24 Q. Are you aware that Mr. Wenke was a former chairman of the  
25 Libertarian Party of Cattaraugus County?

1 A. Yeah.

2 Q. And you also referenced two articles about Mr. Wenke in  
3 your report. And, specifically, it's the Tap Into article?

4 A. Yes.

5 Q. And one from the wellness -- or Wellsville Sun?

6 A. Yeah. It sounds familiar.

7 Q. And both of those articles discuss Mr. Wenke's history in  
8 public office.

9 A. Yes.

10 Q. And are you aware that he actually ran for county coroner  
11 in 2019?

12 A. I don't remember if I knew that or not. Maybe.

13 Q. And you believe that the BOP is wrong when they don't  
14 consider this a delusion?

15 A. Well, they frame it differently. They're putting it  
16 under -- I don't think they disagree that it's an inflated sense  
17 of self.

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

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

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

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

5 A. I wouldn't be surprised.

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

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

9 A. What do you mean?

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

11 A. No.

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

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

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

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

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

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

22 Q. Let's talk about KV.

23 A. Okay.

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

1 A. One of the delusions, yes.

2 Q. Right. You talk about her extensively when you are  
3 discussing Mr. Wenke's delusions?

4 A. Yes.

5 Q. And the updated report, the second one that you have, I  
6 think you referenced her almost the entirety of the report,  
7 right?

8 A. Yes.

9 Q. And it is this fixation -- delusional fixation that  
10 Mr. Wenke has on KV, right?

11 A. Yes.

12 Q. And she indicated that she suffered a psychological harm in  
13 one of the letters.

14 Do you remember?

15 A. Yes.

16 Q. And I think you testified that in one of the letters she  
17 also said that she considered changing her name and appearance  
18 to escape Mr. Wenke?

19 A. Yes.

20 Q. And you give some of these -- some examples of these  
21 delusions. And the first one is that Mr. Wenke insisted that KV  
22 made a website and posted all of his paperwork?

23 A. Yes.

24 Q. Are you aware that there is a website?

25 A. I don't know.

1 Q. Luke Wenke Online is not familiar to you?

2 A. No.

3 Q. So you are not aware that KV has created a blog that  
4 documents every single one of Mr. Wenke's court appearances?

5 A. Okay.

6 Q. You are not aware of that?

7 A. No.

8 Q. You are not aware that she has posted every single court  
9 document that's been listed on the public docket?

10 A. Okay.

11 Q. All right. You are not aware that she summarizes each --  
12 each court proceeding and kind of gives her opinion of what's  
13 going on?

14 A. Okay.

15 Q. You are not aware that this website has -- you know,  
16 altered pictures that poke fun or ridicule Mr. Wenke?

17 A. Yeah. I don't know.

18 Q. You don't know that she also posts Mr. Wenke's letters and  
19 actually transcribes them in those pages?

20 A. Okay.

21 Q. All right. You are not aware that she identifies herself  
22 and actually gives reasons why she is doing it --

23 A. No.

24 Q. -- or created this?

25 And on one of the pages -- so you are not aware -- she says

1 she knows and does not care that this would make Mr. Wenke,  
2 quote, mad?

3 A. Okay.

4 Q. All right. Did how come you didn't know this -- the  
5 website existed?

6 A. I didn't know it existed.

7 Q. Did you look for it?

8 A. I did look for things he told me about, yes. And I  
9 couldn't find it.

10 Q. Did you Google Luke Wenke?

11 A. Most recently, I don't remember if I specifically Googled  
12 that.

13 I think I did, because I was looking for other things that  
14 he had referenced when I talked to him.

15 Q. Did you Google Luke Wenke and KV?

16 A. I don't think so.

17 Q. Is there a reason why you didn't do that?

18 A. I don't know.

19 Q. You verified -- or tried to verify, other information in  
20 your report, right?

21 A. Yes.

22 Q. You did -- you did other Google searches, right?

23 A. Yes.

24 Q. You saw other materials?

25 A. Yes.

1 Q. Yes?

2 A. I'm sorry, yes.

3 Q. But you didn't do this Google search?

4 A. No.

5 Q. Are you aware that she updates it regularly, with the last  
6 one being February 17th?

7 A. I don't know.

8 Q. Okay. It's a very extensive website.

9 Let's go to the second example of a delusion involving KV.  
10 And it's about how Mr. Wenke believes she stole his car and  
11 wants her charged with stealing her car, right?

12 A. Yeah.

13 Q. Did you do any investigation about that?

14 A. No.

15 Q. Did you call me at all when you -- in preparing this  
16 evaluation?

17 A. No.

18 Q. You didn't want -- you didn't want my opinion or my history  
19 with Mr. Wenke?

20 A. You were welcome to reach out. You approached me.

21 Q. That's right. That's true. That's true.

22 And to be fair, you didn't call the Government either,  
23 right?

24 A. I spoke to them.

25 Q. Before you did the evaluation?

1 A. Again, you all reached out to me. I asked for all the  
2 information that you had available.

3 Q. Okay. So you weren't aware that an investigator from our  
4 office actually delivered Mr. Wenke's keys to Miss [REDACTED]  
5 back in 2022?

6 A. You didn't tell me.

7 Q. I did not tell you.

8 Would that impact whether you believe that she stole his  
9 car is a delusion?

10 A. Maybe.

11 Q. All right. The next example is this -- that KV left a  
12 negative Yelp review at Mr. Wenke's mother's restaurant?

13 A. Yes.

14 Q. Again, you didn't call me, but I didn't reach out to you.  
15 So you are not aware that Mr. Wenke's mother believes that it  
16 was KV?

17 A. Okay.

18 Q. And that she sent messages to Mr. Wenke's father regarding  
19 this Yelp review alleging that it was KV, right?

20 A. No.

21 Q. You are had not aware of that?

22 And if -- if his mom -- if Mr. Wenke's mom told Mr. Wenke  
23 this, that she believes KV left a negative Yelp review, and then  
24 he tells you that, is that still a delusion?

25 A. Not necessarily.



1 Q. And that's because it's -- it comes from his mother, a  
2 trusted source, that he believes?

3 A. If there is some accuracy.

4 Q. Okay. How much accuracy do you need or does it vary?

5 A. I mean, it varies because with delusion, a lot of it can be  
6 grounded in reality and other parts are not.

7 People become paranoid for a reason. Oftentimes real  
8 things happen that contribute to the paranoia. Or they get into  
9 legal trouble and then things comes out about them that further  
10 fuels the paranoia. It becomes this reciprocal thing that  
11 happens sometimes.

12 Q. That makes sense. The next delusion is that, I had a  
13 screaming match with KV.

14 A. That may or may not have happened. That's obviously not a  
15 delusion. He's brought that up a lot.

16 Q. Well, you brought it that up in your delusion analysis.

17 A. That's more about his fixation with KV.

18 Q. All right. Did -- again, you didn't e-mail me saying, did  
19 this actually happen?

20 A. Again, I asked for all the information available from  
21 everybody involved when you approached me.

22 Q. That was before you prepared the evaluation though,  
23 obviously, right?

24 A. What do you mean?

25 Q. The information that we provided to you was before you

1 prepared the initial evaluation?

2 A. Right. Right.

3 Q. So you are not aware that something like that actually did  
4 happen?

5 A. I don't deny that it did.

6 Q. You are not aware that we, meaning an investigator from my  
7 office and myself, attempted to contact KV?

8 A. I don't know.

9 Q. You are not aware that she became irate on the phone?

10 A. No.

11 Q. You are not aware that then she hung up the phone on us  
12 before we could respond?

13 A. I don't know. You didn't tell me.

14 Q. I didn't tell you. That's right.

15 Let's talk a little bit about treatment. And this is going  
16 to be a loaded question, but what would your treatment plan be  
17 for Mr. Wenke if you were his doctor?

18 A. I'm a psychologist. I would have to approach it like a  
19 psychologist. I cannot prescribe medication.

20 Q. Perfect. So as a psychologist, in your vast experience,  
21 right, you have worked with psychiatrists a lot, what would your  
22 plan be?

23 A. I mean, if I had someone who was presenting with  
24 schizoaffective disorder and the symptoms are acute, meaning  
25 that they are active and going on right now, they're actively

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

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

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

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

9 Q. Medical doctors.

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

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

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

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

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

19 A. It may be.

20 Q. Do you work with social workers at ECMC?

21 A. Yeah.

22 Q. And what about family -- family support?

23 A. It's crucial, family support.

24 Q. It's crucial?

25 A. Uh-huh.

1 Q. And what about the environment of the initial evaluation?  
2 What is -- how is it like in CPEP?

3 A. I'm sorry to laugh. It can get very full and very busy and  
4 chaotic, but there is, like, a large open room with chairs and  
5 beds where people are kept until they can be evaluated by a  
6 psychiatrist to make the determination whether they are --  
7 should be admitted psychiatrically or not.

8 Q. That's not ideal, right?

9 A. No.

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

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

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

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

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

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

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

25 **MR. PASSAFIUME:** Sure.

1           **THE COURT:** Unless it substantially alters your  
2 presentation.

3           **MR. PASSAFIUME:** I have no flow, Judge.

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

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

7           **MR. PASSAFIUME:** Thank you.

8           **THE COURT:** Okay.

9 (Discussion off the record.)

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

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

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

16           **THE WITNESS:** It depends, yeah.

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

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

22 Why is it delusional sometimes and not in others?

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

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

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

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

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

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

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

22 **THE COURT:** Mr. Passafiume --

23 **MR. PASSAFIUME:** Thank you.

24 I'll start there.

25 **BY MR. PASSAFIUME:**

1 Q. Mr. Wenke knew RT, right?

2 A. Yeah.

3 Q. They met online?

4 A. Yes.

5 Q. They met in person as well?

6 A. Yes.

7 Q. Did you ever hear of the expression love at first sight?

8 A. Yes.

9 Q. All right. The relationship with RT itself is not a  
10 delusion, it's the extent of it -- or what the extent that  
11 Mr. Wenke believes?

12 A. Yes.

13 Q. Okay. What if -- and we're talking about context. And you  
14 just mentioned RG. And one of the examples with RG is this  
15 e-mail that -- that Mr. Wenke sent to him.

16 Do you remember that?

17 A. I think there was 76 e-mails.

18 Q. Sure. You cite -- you cite parts of one e-mail or two  
19 e-mails, right?

20 A. I believe so.

21 Q. Like, for example, the one he sent in January of 2002 where  
22 Mr. Wenke says, men respect each other after a fight, right?

23 A. Yeah.

24 Q. That he would take a steel chair to Mr. -- to RG's face?

25 A. Yes.

1 Q. And that the fight will happen?

2 A. Yes.

3 Q. The -- there is context to that e-mail. You are aware that  
4 RG was emailing Mr. Wenke?

5 A. I don't know.

6 Q. Are you aware that during that same conversation RG  
7 e-mailed Mr. Wenke and called and said, quote, you are a weak  
8 human being?

9 A. I wasn't provided that information.

10 Q. And -- and then challenged Mr. Wenke to a fight. And if he  
11 wanted to fight, he should come to Minneapolis?

12 A. I wasn't aware. I wasn't provided that information.

13 Q. This information came from the original PSR. You were  
14 provided that, right?

15 A. Yes.

16 Q. More kind of in this context -- so if the website is real,  
17 the website is geared to harass Mr. Wenke.

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

21 Does that alter -- or could that alter your diagnosis?

22 A. It could.

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



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

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

6           **BY MR. PASSAFIUME:**

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

9           A. Yes.

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

12          A. Yes.

13          Q. They were the examples that you relied on?

14          A. Yes.

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

16               This is a structured professional judgment assessment,  
17 right?

18          A. Yes.

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

22          A. Yes.

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

25          A. They shouldn't.

1 Q. They shouldn't, but judgments -- reasonable people can  
2 disagree on something?

3 A. I mean, the way that the test is constructed is to make it  
4 as objective as possible. If you follow the rating criteria,  
5 you should have interrelated reliability.

6 Q. The criteria is evaluated by the doctor conducting that  
7 assessment?

8 A. It's based upon the definitions provided in the manual.

9 Q. But it's -- I'm belaboring here -- but it's the evaluator  
10 that makes a determination of whether a symptom is present.  
11 How relevant it is, right?

12 A. Right. Ultimately, the professional is making that  
13 determination.

14 Q. Okay. For this assessment, again, the first step is to  
15 gather information, right?

16 A. Yes.

17 Q. And, you know, that collateral information could be from a  
18 number of sources, right?

19 A. Yes.

20 Q. Especially for this kind of assessment.

21 You didn't speak to any of Mr. Wenke's family, right?

22 A. No.

23 Q. You didn't speak to his dad?

24 A. No.

25 Q. Didn't speak to his mom?

1 A. No.

2 Q. You didn't call me. I didn't call you either.

3 A. No.

4 Q. All right. You didn't reach out to any of his prior  
5 counselors?

6 A. No. I had treatment records.

7 Q. Did you reach out to any authors of any assessments or  
8 reports that you relied on?

9 A. No.

10 Q. For example, the threat assessment, are you familiar with  
11 that?

12 A. Yeah.

13 Q. You indicate that it was completed by Endeavor Health  
14 Services staff, right?

15 A. Yeah.

16 Q. Why do you think it was completed by Endeavor Health  
17 Services staff?

18 A. Whatever was indicated on the paperwork.

19 Q. That paperwork doesn't have an author. But are you -- so  
20 you are not aware that was actually completed by a police  
21 officer?

22 A. Okay.

23 Q. You weren't aware of that?

24 A. No.

25 Q. It was not done by a mental health professional.

1 A. Okay.

2 Q. And that -- there is no formal name for that threat  
3 assessment, like HCR or anything like that?

4 A. I don't know.

5 Q. It's not a standard, widely-accepted assessment, the one  
6 that you saw?

7 A. I don't know.

8 Q. You have never seen it before?

9 A. No. It doesn't mean it's -- doesn't -- it's not based upon  
10 something.

11 Q. But in your experience, you have never seen that threat  
12 assessment that you reviewed for this case?

13 A. In that format? No.

14 Q. Okay. Let's go through -- and, again, just like the  
15 Government, I'm not going to go through all of the -- all the  
16 factors.

17 I'm going to just talk about the ones that you deemed  
18 relevant -- high relevance. Is that okay?

19 A. Okay.

20 Q. For the violence -- and we already discussed it, you -- you  
21 cite and you back it up with those e-mails with RG, right?

22 A. Yes.

23 Q. That went into your determination that this factor is  
24 present?

25 A. Yes.

1 Q. You also rely on KV's self reporting?

2 A. Yes.

3 Q. That she was having so much psychological harm that she  
4 considered changing her name and moving?

5 A. Yes.

6 Q. Same person that has this website?

7 A. Apparently.

8 Q. The next factor, the other antisocial behavior.

9 A. Okay.

10 Q. For this you cite this 2018 incident, where Mr. Wenke is  
11 carrying a street sign down the road?

12 A. Yes.

13 Q. That he was charged with marijuana possession in 2020?

14 A. Yes.

15 Q. And that he sent unwanted text messages?

16 A. Yes.

17 Q. None of these contacts with law enforcement resulted in any  
18 arrest or charges, to your knowledge?

19 A. I thought the possession of marijuana did.

20 Q. Okay. Correct. I'm sorry.

21 The text messages and the street sign?

22 A. I don't know.

23 Q. Okay. The next is Mr. Wenke's alleged involvement with the  
24 Boogaloo Boys.

25 A. Okay.

1 Q. You admit in your report that the extent of that  
2 involvement is not clear?

3 A. Right.

4 Q. And you make a claim that they supplied him with a -- with  
5 a gun in 2020?

6 A. Yes.

7 Q. That was five years ago, two years before the original  
8 offense in 2022.

9 A. Okay.

10 Q. And there is no known allegation that that weapon was ever  
11 recovered or found?

12 A. I don't know.

13 Q. No probation officer has told you he has seen it or she has  
14 seen it?

15 A. Correct.

16 Q. There is no other report regarding that weapon?

17 A. No. Not that I know of.

18 Q. Okay. The next factor is this mental -- major mental  
19 disorder factor.

20 You make it relevant -- or you say it's relevant that you  
21 know the onset of the symptoms?

22 A. I'm not sure. That's speculation.

23 Q. Well, you testified that it was important that you knew  
24 that these symptoms started around 2019 or 2018.

25 A. That's what I think based on the available information.

1 Q. Well, why -- why wouldn't you call his family to find that  
2 information out?

3 A. I could have.

4 Q. You took everything that KV said at face value as if it was  
5 true.

6 A. In the letter? I considered it as part of the data.

7 Q. If someone creates a blog that's updated every day, that's  
8 worked on every day, that is geared towards harassing another  
9 person, would you say the creator of that blog is fixated on the  
10 other person?

11 A. I don't know.

12 Q. Would that be a symptom of fixation?

13 A. It could be a fixation, I'll give you that. Sure.

14 Q. Okay. The violent attitudes factor. You use examples from  
15 the two articles we mentioned before?

16 A. Yes.

17 Q. The Wellsville Sun and the Tap Into Greater Olean?

18 A. Yes.

19 Q. Did you speak to the authors of any of those articles?

20 A. No.

21 Q. Do you know where any of that information came from that  
22 was contained in those articles?

23 A. I believe one of them was an interview with the defendant.

24 Q. Right.

25 The -- a picture where Mr. Wenke was labeled armed and

1 dangerous was first referenced in that Tap Into article, right?

2 A. Maybe. I don't remember.

3 Q. And you don't know if that was a -- like an official  
4 designation by law enforcement or that it was even created by  
5 law enforcement, right?

6 Have you ever seen that picture?

7 A. I have seen a picture, yeah.

8 Q. Was that -- is there anything in that picture that  
9 indicates that it was made by New York State?

10 A. No. It was posted on, I think, the Olean War Zone website.

11 Q. Right. Do you know where that picture came from?

12 A. No.

13 Q. So you're not aware that that picture was included in a  
14 reply tweet to Mr. Wenke by an anonymous unknown user?

15 A. Okay.

16 Q. The -- part of this violent attitudes and these factors  
17 obviously overlap. Again, you use the Boogaloo Boys  
18 involvement?

19 A. It's part of it.

20 Q. It's part of it. And, again, the degree of Mr. Wenke's  
21 involvement with that group is unknown?

22 A. Correct.

23 Q. The -- you talk about how he -- he wanted to subvert gun  
24 laws of New York State in making guns with 3D printing?

25 A. Yes.



1 Q. And those quotes that you use were taken from the article?

2 A. Yes.

3 Q. And you didn't put the whole context of those quotes, you  
4 selected these lines specifically, right?

5 A. Yeah.

6 Q. So I think -- and I -- I don't want to put words in your  
7 mouth. But the last, kind of, sentence in one of those quotes:  
8 "I honestly encourage everybody to do that", what do you think  
9 that that was referring to?

10 A. I mean, in the context of, like, 3D printing guns being  
11 prepared?

12 Q. In that -- in that quote, because you use that specific  
13 quote in your report?

14 A. Uh-huh.

15 Q. Why did you use that specific quote?

16 A. Because I thought it contributed to evidence of violent  
17 ideation.

18 Q. The sentence before that quote states that: "I want people  
19 to know that I have no illegal guns myself, but I want people to  
20 be aware that instead of throwing money at the NRA and expecting  
21 that to be the only answer, just remember 3D printing is going  
22 to make that obsolete. I honestly encourage everybody to do  
23 that."

24 A. Okay.

25 Q. He could be referring to the throwing money, not -- stop

1 throwing money at the NRA, right?

2 A. Fair enough.

3 Q. Okay. The -- you mentioned some Internet searches with  
4 some, I guess, some trigger words that you considered part of  
5 these factors?

6 A. There was a Google search history, I think, that was  
7 provided to me. That's what you are referring to?

8 Q. I'm sorry?

9 A. Is that what you are referring to as the Google search  
10 history?

11 Q. Yeah.

12 A. Okay.

13 Q. You cite certain words that Mr. Wenke Googled that you were  
14 concerned about.

15 A. Yes.

16 Q. None of those -- none of those words -- or none of those  
17 Google searches pertain to a specific person or thing, right?

18 A. I mean, I think there was references to the Government.

19 Q. There was nothing like how to poison somebody and get away  
20 with it?

21 A. I think there was about how to murder somebody and get away  
22 with it.

23 Q. You don't say that in the report. You just mention the  
24 word murder.

25 A. Okay.

1 Q. Okay. Is that different if somebody says: "This is how  
2 you murder somebody", versus just Googling "murder"?

3 A. Sure.

4 Q. One of the factors is problems with supervision. You are  
5 aware that Mr. Wenke successfully completed substance abuse  
6 treatment in 2021?

7 A. I believe so, yeah. I think he told me that.

8 Q. In your report you said it didn't appear -- from March of  
9 2023 to May of 2023 -- that Mr. Wenke attempted to complete  
10 mental illness or substance abuse treatment.

11 A. Yes.

12 Q. Where did that information come from?

13 A. Maybe the PSI -- the presentence investigation. I believe  
14 I had -- I asked the defendant about that, too.

15 Q. Could it impact your opinion if that was not true and  
16 Mr. Wenke actually did attempt to complete mental health  
17 treatment?

18 A. Sure.

19 Q. So you are not aware that he -- he was released with a  
20 condition to attend mental health treatment and actually  
21 attended that treatment?

22 A. When -- when was that?

23 Q. He -- actually, every single time he was released.

24 So are you aware that the first time he was released -- I  
25 think it was before the first violation --

1 A. Okay.

2 Q. -- he was traveling from Olean to Buffalo three times a  
3 week for treatment?

4 A. Is that the first or the second time? Because I know he  
5 went to, like, an anger management program in 2023. He told me  
6 he was traveling back and forth from Buffalo to Olean. I know  
7 that.

8 Q. And that was for mental health treatment?

9 A. Mental health or anger management, yeah. I think he told  
10 me it was an anger management program.

11 Q. And the Horizon reports that I believe you had --

12 A. Yeah.

13 Q. -- said that when Mr. Wenke reported that when he was  
14 stressed, overwhelmed, irritable or anxious, he could see the  
15 benefit of mental health counseling.

16 Did you read that?

17 A. Yeah. I read those records.

18 Q. The next one was that he wants to learn ways to mediate his  
19 emotions when times are tough.

20 A. Yeah.

21 Q. The next one is, Mr. Wenke was motivated to engage in  
22 therapy, to learn about himself and effectively manage his  
23 moods.

24 A. Okay.

25 Q. The -- the final opinion from that counselor said that --

1 well, I'll withdraw that.

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

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

9 A. Yeah. Definitely an obstacle.

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

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

14 A. Yes.

15 Q. And that was reported by KV?

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

18 Q. Like what?

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

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

23 A. Yes.

24 Q. -- as one of them?

25 A. Yes.

1 Q. As one of the factors?

2 A. Yeah.

3 Q. And, again, the involvement was unclear to you, right?

4 A. The extent.

5 Q. The extent of it.

6 A. Uh-huh.

7 Q. You then bring up a local example of Payton Gendron.

8 A. Yes.

9 Q. Are there any similarities between that case and this case?

10 A. I only brought that up to illustrate an example of, like,  
11 an overvalued idea. In talking about -- somebody can have --  
12 you know, people exhibit violence for different reasons.

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

15 Somebody that has mental health issues, just because they  
16 are delusional, doesn't mean they also have overvalued ideas.

17 Q. It's Buffalo. You mention that case. You know that that's  
18 going to be, for lack of a better word, fixated on by the  
19 reader?

20 **MR. WRIGHT:** Objection. Your Honor, relevance.

21 **THE COURT:** Overruled.

22 You can answer.

23 **THE WITNESS:** I don't know that.

24 **BY MR. PASSAFIUME:**

25 Q. It's going to read more to somebody in Buffalo as opposed

1 to in Texas?

2 A. Yes.

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

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

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

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

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

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

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

21 **MR. PASSAFIUME:** Thank you, Judge.

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

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

25 **MR. WRIGHT:** Thank you, Your Honor.

1

2

**REDIRECT EXAMINATION BY MR. WRIGHT:**

3

4

**BY MR. WRIGHT:**

5

Q. Thank you, Dr. Leidenfrost.

6

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

8

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?

12

A. No.

13

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

15

A. Yes.

16

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

18

A. Yes.

19

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

22

A. Correct.

23

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

25

You mentioned this word idiosyncratic to the defendant,



1 correct?

2 A. Yes.

3 Q. And so the issue of the psychics is not just, hey, going to  
4 a psychic. It's what he's interpreting for himself, correct?

5 A. Yes.

6 Q. And the extent of he's tying that to other things that he's  
7 believing that he expressed to you during your evaluation?

8 A. Yes.

9 Q. Is it a fair statement that part of what you relied on was  
10 the totality of what the defendant stated relating to  
11 interactions between various people?

12 A. Yes.

13 Q. And this was a significant -- or one of the elements that  
14 you reviewed or used in your overall determination of why this  
15 defendant has a mental disease or defect?

16 A. Yes.

17 **MR. WRIGHT:** Nothing further, Your Honor.

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

20 **MR. PASSAFIUME:** Me?

21 **THE COURT:** Do you need a recross?

22 **MR. PASSAFIUME:** No. Not on that stuff.

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

24 **MR. PASSAFIUME:** Can I, Judge?

25 **THE COURT:** Give me just a moment.

1           **MR. PASSAFIUME:** Sure.

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

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

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

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

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

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

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

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

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

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

6           Mr. Passafiume --

7           **MR. PASSAFIUME:** Thank you.

8

9           **RECROSS EXAMINATION BY MR. PASSAFIUME:**

10

11          **BY MR. PASSAFIUME:**

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

14          A.     Okay.

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

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

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

22          A.     Sure.

23          Q.     You can be arrested on that?

24          A.     Yeah. 941, I think it is.

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

1 A. Not that I know of.

2 Q. And you know that Mr. Wenke did time at the BOP?

3 A. Yes.

4 Q. You know that he -- mental health treatment was not deemed  
5 necessary there, right?

6 A. Yeah. I believe I read that in the report.

7 Q. And that he was a care level one?

8 A. Yes.

9 Q. And that he was not diagnosed with anything.

10 Do you remember that?

11 A. It was the personality -- he had a diagnosis, the  
12 personality.

13 Or are you talking just in the facility overall?

14 Q. Well, let me backtrack. When he served his sentence before  
15 the competency evaluation --

16 A. Oh, okay. I got you. I don't know.

17 Q. Okay. So do you -- are you aware of any Federal  
18 psychiatric hospitals?

19 A. I'm not familiar with that system.

20 Q. Do you -- are you familiar with the BOP at all?

21 A. Not well.

22 Q. You don't know if there are different prisons for different  
23 things?

24 A. Right. I assume there are specializations of different  
25 facilities that do different things, sure.

1 Q. But you don't know what the facilities are like?

2 A. I've never been to them.

3 Q. And you don't know what their treatment plan would be?

4 A. I don't know.

5 Q. No? And so you wouldn't know if their treatment plan would  
6 be the same as yours?

7 A. Right.

8 Q. Right. And you couldn't tell us at all what happened at  
9 the BOP, right?

10 A. No. I think I requested any mental health treatment  
11 records from any time in prison. I wasn't provided anything.

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

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

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

19 **THE COURT:** Okay.

20 **BY MR. PASSAFIUME:**

21 Q. So if somebody were to have to be transported in custody to  
22 a facility that's over 500 miles away, would that be detrimental  
23 to his mental health condition?

24 A. Sure.

25 Q. It could worsen his condition?

1 A. Maybe.

2 Q. Before you said, you know, having family around and  
3 support, that's crucial, right?

4 A. Yes.

5 Q. So, ideally, you would want family to be close to the  
6 psychiatric facility where the person is staying?

7 A. Yeah, ideally. Having a family involvement is important to  
8 people's care and recovery.

9 Q. And you -- you know, your diagnosis is very different than  
10 the BOP's diagnosis.

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

14 Would you follow -- and that individual comes back to you,  
15 would you follow your original diagnosis and treatment plan or  
16 this other doctor's original diagnosis and treatment plan?

17 A. I mean, hopefully, I would take them both into  
18 consideration. Maybe that doctor saw something I didn't.

19 Q. Okay.

20 A. Because also -- if I can just broadly expand it. People  
21 look different at different times, too. I can see somebody at  
22 point A, two months later, they can be very different, so --

23 Q. Okay. When you evaluated Mr. Wenke after the BOP  
24 examination, nothing much changed, right?

25 A. Compared to when I saw him last year, no. He presented in

1 a similar way.

2 Q. Okay. So you don't know if they'd turn Mr. Wenke away, if  
3 he went back to the BOP for treatment?

4 A. I don't know.

5 Q. How would you treat somebody -- well, we already talked  
6 about that.

7 Main treatment for those personality disorders would be  
8 psychotherapy, right?

9 A. Yes.

10 Q. Which is different than the treatment you said about  
11 schizoaffective disorder?

12 A. Correct.

13 Q. And you need to be medicated with schizoaffective disorder?

14 A. Yeah, usually.

15 Q. And if the person does not want to take that medication, he  
16 would have to be forcibly medicated?

17 A. If there is a dangerousness there, yes.

18 Q. And in your opinion, in your report, you allude to -- I'm  
19 going to basically say -- that Mr. Wenke will need to be  
20 forcibly medicated?

21 A. Maybe.

22 Q. Maybe?

23 A. I don't know that for certain. I've seen people where we  
24 thought there would have to be a medication over objection, and  
25 the person, knowing that's going to happen, they give in and

1 took medication.

2 Q. And New York State has a mechanism to forcibly medicate  
3 somebody?

4 A. Yes.

5 Q. You've seen that in action before?

6 A. Yes.

7 Q. All right. So let's -- what is CPEP and how does  
8 everything play out here?

9 So tell us a little bit about the conversation you and I  
10 had before Court, where we talked a little about the steps. You  
11 can start with what CPEP is.

12 A. It's Comprehensive Psychiatric Emergency Program. It is  
13 like a psychiatric ER, right.

14 Instead of people in a mental health crisis going to the  
15 ER, they are going to CPEP, where they are getting an evaluation  
16 by a psychiatric provider to determine whether they meet legal  
17 criteria for admission to the hospital, whether it is voluntary  
18 or involuntary.

19 And there has to be certain criteria met, and certain  
20 thresholds, such as, you know, imminent risk because of mental  
21 health or this person can't take care of themselves because of  
22 mental health.

23 Q. And those folks there would obviously get your report as --  
24 to review in making that determination?

25 A. Yeah. They could be supplied with it.



1 Q. Okay. And say somebody goes there and they deem somebody  
2 worthy of involuntary admission, how long is the period of --  
3 how long does that person stay at that CPEP unit?

4 A. CPEP stays should be short as possible. Ideally turning  
5 around in 24 hours.

6 Sometimes people are down there for two or three days --  
7 I'm sorry -- sometimes they are in CPEP for two or three days.

8 Q. So if somebody is in need of medication, that medication  
9 wouldn't kick in for the two or three days, what happens in the  
10 interim?

11 A. Sometimes in CPEP, medication -- if we know somebody is  
12 going to admit them, they will initiate medication in CPEP.

13 Other times the medication is not started until the person  
14 is on a inpatient psychiatric floor.

15 Q. And that's at ECMC?

16 A. Correct.

17 Q. There is also the Buffalo Psychiatric Center, right?

18 A. Yeah. That's a state facility.

19 Q. And they are both equipped, to your knowledge, to handle  
20 schizoaffective disorder?

21 A. Yes.

22 Q. And so the transition is seamless, I guess. If somebody is  
23 diagnosed with a condition that requires involuntary or  
24 voluntary for that matter, care, they just go to another part of  
25 ECMC and receive that care?

1 A. Correct.

2 Q. And how long does somebody stay in that part?

3 A. Average length of stay is about ten to 14 days.

4 Q. What happens after that?

5 A. The person is discharged, if they are improved. If the  
6 person improves and they are deemed to no longer meet legal  
7 criteria to remain in the hospital, they are going to be  
8 discharged. And there are -- some sort safe discharge will be  
9 done.

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

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

15 Q. So before somebody is released, there is going to be an  
16 evaluation to determine if he's made enough progress to be  
17 released?

18 A. Correct.

19 Q. And that determination would essentially have to say he is  
20 no longer a danger to somebody else, right?

21 A. Due to symptoms of serious mental illness.

22 Q. Right.

23 A. That's the key part there. And so the -- specifically, for  
24 stay in the hospital, the dangerousness has to be tied to  
25 psychiatric symptoms.

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

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

6       A.    Yes.

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

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

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

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

15       A.    At BPC, do you mean?

16       Q.    Yeah.

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

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

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

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

24       Q.    You haven't done them?

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

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

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

5 **MR. PASSAFIUME:** That's a terrible question.

6 **BY MR. PASSAFIUME:**

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

10 A. Yes.

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

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

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

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

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

21 A. Nothing that I know of, no.

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

24 A. Yes.

25 Q. I did?

1 A. Well, you phrased it for personality pathology versus  
2 schizoaffective. Depending on what the diagnosis is, it will be  
3 different treatment.

4 Q. Let's go for your diagnosis.

5 A. Schizoaffective -- like I said, I'm not a medical doctor or  
6 psychiatrist.

7 I am aware of the American Psychiatric Association's  
8 guidelines for treatment of bipolar and schizoaffective. When  
9 somebody is acutely symptomatic, the first line of treatment is  
10 an antipsychotic medication.

11 Q. At ECMC, can family come and visit?

12 A. Yes.

13 Q. Again, that's a big part of somebody's recovery?

14 A. Yes.

15 Q. Can that person leave voluntarily, if he's involuntarily  
16 committed? Can he just --

17 A. No.

18 Q. No?

19 A. No.

20 Q. There is no way he could tie sheets together and jump out a  
21 window?

22 A. No. No.

23 Q. That's securely monitored?

24 A. Yes. It is monitored. Locked doors.

25 Q. Okay. And that person won't leave until there is some

1 psychiatrist that deems Mr. Wenke not a danger to the community?

2 A. Due to symptoms of serious mental illness, yes.

3 Q. And you can't give us an exact treatment plan because you  
4 don't know medication you would prescribe -- you can't prescribe  
5 medication?

6 A. Correct.

7 Q. You don't know what medication would be appropriate for  
8 Mr. Wenke?

9 A. I am not competent to offer that opinion.

10 Q. The psychiatrist at ECMC would make that determination?

11 A. Correct.

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

14 **THE COURT:** Let me see. Stay there.

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

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

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

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

1 defect.

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

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

7 Number two, has no insight regarding his symptoms.

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

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

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

15 **THE WITNESS:** Yeah.

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

18 **THE WITNESS:** Yeah, spot on.

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

21 **THE WITNESS:** Yes.

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

24 **THE WITNESS:** Uh-huh -- yes.

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

1 your professional concerns?

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

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

6 **MR. PASSAFIUME:** No, Judge. Thank you.

7 **THE COURT:** Mr. Wright, your turn.

8

9 **FURTHER REDIRECT EXAMINATION BY MR. WRIGHT:**

10

11 **BY MR. WRIGHT:**

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

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

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

19 A. Yes.

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

23 A. I don't know.

24 Q. Okay.

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



1 give an example of what happens locally.

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

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

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

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

14 A. No.

15 Q. -- to conduct the treatment there?

16 A. No. The evaluation occurs in CPEP.

17 Q. Okay.

18 **MR. WRIGHT:** Nothing further, Your Honor.

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

24 **THE WITNESS:** Correct.

25 **THE COURT:** Assuming everyone agrees with you, right?

1           **THE WITNESS:** Yes.

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

7           **MR. WRIGHT:** Correct.

8           **THE WITNESS:** Yes.

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

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

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

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

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

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

2           **MR. WRIGHT:** No, Your Honor.

3           **THE COURT:** Mr. Passafiume?

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

6

7           **FURTHER RECROSS EXAMINATION BY MR. PASSAFIUME:**

8

9           **BY MR. PASSAFIUME:**

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

15          A. Sure.

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

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

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

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

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

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

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

10 **MR. PASSAFIUME:** Okay. Thank you.

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

13 (Witness Excused)

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

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

18 **MR. PASSAFIUME:** No, Judge.

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

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

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

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

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

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

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

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

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

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

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

3 Dr. Leidenfrost's evaluation is the evaluation under  
4 4247 that brought us to the hearing. So he's not going to get  
5 evaluated again at the BOP. He would go there for treatment.

6 **THE COURT:** Right.

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

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

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

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

16 Nobody knows exactly what's inside the black box.

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

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

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

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

1 are proposing it.

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

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

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

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

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

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

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

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

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

21 **MR. PASSAFIUME:** Sure.

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

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

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

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

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

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

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

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

13 **MR. PASSAFIUME:** Right.

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

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

20 **MR. PASSAFIUME:** Understood, Judge.

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

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

25 **MR. WRIGHT:** What is today, Tuesday?



1           **THE COURT:** Tuesday.

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

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

6           **THE COURT:** Starting today or tomorrow?

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

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

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

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

15           **MR. PASSAFIUME:** Yes.

16           **THE COURT:** Thursday? Yes? Okay.

17           **MR. WRIGHT:** Yes, Your Honor.

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

19           **THE CLERK:** Thursday, 9:30.

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

22           **MS. KUBIAK:** That's fine.

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

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

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

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

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

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

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

13 Anything else?

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

15 **MR. PASSAFIUME:** Thank you.

16 **THE COURT:** Take care, everybody. Thank you.

17

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

19 \* \* \*

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23

24

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1  
2 In accordance with 28, U.S.C., 753(b), I certify that these  
3 original notes are a true and correct record of proceedings in  
4 the United States District Court for the Western District of  
5 New York before the Honorable John L. Sinatra, Jr.

6  
7  
8  
9  
10 s/ Bonnie S. Weber  
Signature

March 6, 2025  
Date

11  
12 **BONNIE S. WEBER, RPR**

13 Official Court Reporter  
14 United States District Court  
15 Western District of New York  
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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

1 The Court Reporter: BONNIE S. WEBER, RPR,  
2 Notary Public,  
3 Robert H. Jackson Courthouse,  
4 2 Niagara Square,  
5 Buffalo, New York 14202,  
6 Bonnie\_Weber@nywd.uscourts.gov.

7  
8  
9  
10 Proceedings recorded by mechanical stenography,  
11 transcript produced by computer.

12  
13  
14 (Proceedings commenced at 10:03 a.m.)

15  
16  
17 **THE CLERK:** All rise.

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

21 **THE COURT:** Please be seated.

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

25 Appearing for probation is John Taberski.

Counsel, please state your appearances for the record.

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

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

1           **THE COURT:** Good morning to all of you.

2           **MR. PASSAFIUME:** Good morning, Your Honor.

3           **MS. KUBIAK:** Good morning, Judge.

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

6           **MR. PASSAFIUME:** Yes, Judge.

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

8           **MR. WRIGHT:** Yes, Your Honor.

9           **MR. PASSAFIUME:** Yes, Judge.

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

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

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

15          **MR. PASSAFIUME:** Correct.

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

18          **MR. PASSAFIUME:** Correct.

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

21          **MR. PASSAFIUME:** Yes.

22          **THE COURT:** All right. Go ahead.

23          **MR. PASSAFIUME:** Good morning, Dr. Watkins.

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



1                   **MR. PASSAFIUME:** Sorry.

2

3

**DR. ROBIN WATKINS,**

4 witness on behalf of the **DEFENDANT**, having first been duly

5 sworn, appearing by Zoom, testified as follows:

6

7

**THE WITNESS:** I do.

8

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

10

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

12

13

**DIRECT EXAMINATION BY MR. PASSAFIUME:**

14

15 **BY MR. PASSAFIUME:**

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

17

A. Good morning.

18

Q. -- please tell us your title?

19

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

20

Q. And who do you work for?

21

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

23

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

24

A. For about 13 and a half years.

25

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

1 A. I have, yes.

2 Q. What's the process of becoming a doctor for the BOP?

3 A. Well, for me, I obtained my doctorate in 2004. And the  
4 process of becoming a doctor involves about ten years, after  
5 high school, four years of college and about six years of grad  
6 school, getting a Masters and a PhD in clinical psychology.

7 Including an internship -- predoctorate internship, which I  
8 did do with the Federal Bureau of Prisons in 2003 to 2004 at  
9 Lexington, Kentucky.

10 Prior to coming to the BOP, I did work in the community for  
11 about seven years, at a court clinic in the Chicago area, doing  
12 forensic evaluations, as well as private practice and teaching.

13 And then just applied to return to the BOP as a  
14 psychologist and began my career with the BOP at the Federal  
15 Medical Center in Devens, Massachusetts.

16 Q. And how long were you at Devens, Massachusetts?

17 A. I believe just shy of three years. I was there from 2011  
18 to late 2013.

19 Q. And --

20 A. Before I transferred to the Federal Correctional Conference  
21 in Butner, North Carolina.

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

23 A. I've been here at MCC Chicago for about eight and a half  
24 years. I was at Butner for about three years as well.

25 Q. Can you describe what the MCC means in that? How that

1 compares to other BOP facilities?

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

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

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

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

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

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

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

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

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

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

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

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

10 Q. And that's under the 4241 statute?

11 A. Correct.

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

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

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

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

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

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

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

13 A. For a competency evaluation, yes.

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

16 Are you familiar with that?

17 A. I am.

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

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

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

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

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

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

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

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

12 A. That's okay.

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

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

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

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

21 Q. Okay.

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

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

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

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

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

6 Q. Sure.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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



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

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

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

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

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

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

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

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

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

1 me.

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

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

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

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

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

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

22 A. Sure. Yes.

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

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

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

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

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

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

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

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

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

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

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

1 pointing those things out.

2 Q. Okay. And that's all something you do basically in the  
3 beginning and after you get this background information, is that  
4 what you said?

5 A. Typically, yes. Typically, upon receiving the case, we'll  
6 reach out to the attorneys right away to request collateral  
7 information.

8 And a lot of times for competency and criminal  
9 responsibility evaluations, that also includes things like  
10 discovery, police reports, things like that, too.

11 Q. Okay.

12 A. But it's sort of a dynamic process that occurs over the  
13 course of the evaluation.

14 Q. Sure. Have you ever done an evaluation when you haven't  
15 used any collateral resources or haven't sought any collateral  
16 resources?

17 A. I don't know that there has ever been one where I haven't  
18 sought any, but there has certainly been some when there were  
19 none available.

20 Q. Okay.

21 A. So I had to go off of the person in front of me and what  
22 was available.

23 Q. But you've always sought them or tried to get some  
24 collateral records?

25 A. Yes. In every case, I attempt to.

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

5 I'm sorry for the loaded questions here.

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

8 Q. Sure. Yes.

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

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

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

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

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

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

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

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

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

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

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

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

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

1 better answered by an attorney.

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

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

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

12 Q. How long can this treatment go on for at the BOP under  
13 4244?

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

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

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

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

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

1 Q. Okay.

2 A. -- so I don't know that I can speak to that piece in terms  
3 of how that communication occurs.

4 Q. Do you do those 4244s at MCC Chicago?

5 A. I have. I would say they are rare, but I have had them  
6 come from before and I've done them from here, yes.

7 Q. And the treatment happens there, too?

8 A. Typically, no. Those are similar to a competency  
9 evaluation or criminal responsibility evaluation.

10 I do those on the front end. The person then returns to  
11 their jurisdiction for the hearing and then they go wherever  
12 they are going to go in the BOP for that treatment.

13 Q. And the treatment is always in a BOP facility? It's never  
14 at, like, a local hospital or medical facility?

15 A. Under 4244?

16 Q. Correct.

17 A. Not that I've seen. I've only seen it where the suitable  
18 facility defined as a BOP FMC or a Federal Medical Center.

19 Q. Are people sent to the BOP under 4241 and 4244, are they  
20 housed in the same way?

21 A. No. Typically not.

22 Q. They are kept separate?

23 A. I don't know that that's the case always, in every case,  
24 but -- so if somebody, for example, is found not competent and  
25 in need of competency restoration -- inpatient competency



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

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

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

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

11 Q. Okay.

12 A. -- as the competency restoration folks.

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

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

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

19 I -- for example, here we have a restoration program, for  
20 example. Now, we don't have anyone here who is sentenced under  
21 4244, but -- but there are people -- there are several  
22 psychologists had who do those evaluations specifically.

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

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

1 front end competency evaluations, the initial competency  
2 evaluations.

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

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

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

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

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

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

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

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

1 somebody is being treated, okay?

2 Thank you.

3 **MR. PASSAFIUME:** Okay.

4 **BY MR. PASSAFIUME:**

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

8 A. And you mean when somebody comes to me for evaluation under  
9 4244 --

10 Q. Yes.

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

13 Yes, I have.

14 Q. What happens then, if you know?

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

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

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

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

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

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

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

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

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

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

17 A. Correct. Yes.

18 Q. What was your role in that evaluation?

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

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

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

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

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

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

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

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

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

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

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

20 Q. Okay.

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

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

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

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

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

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

15 Thank you so much, Doctor.

16 **THE WITNESS:** Thank you.

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

19 **MR. WRIGHT:** Yes, Your Honor.

20 **THE COURT:** Mr. Wright?

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

22 **THE COURT:** You may.

23 **MR. WRIGHT:** Thank you, Your Honor.

24

25

**CROSS EXAMINATION BY MR. WRIGHT:**

1

2 **BY MR. WRIGHT:**

3 Q. Good morning, Dr. Watkins.

4 A. Good morning.

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

8 A. Three of the meetings.

9 Q. Three of the meetings?

10 A. Yes.

11 Q. Do you recall when those meetings were that -- that you  
12 were present for?13 A. I -- actually, let me -- I can look at the file real quick.  
14 So that would have been the notification and intake, I was  
15 present, along with Dr. Nelson. That was on September 16th.16 I was also present for the legally focused interview, which  
17 is a competency interview on October 17th. This is all 2024.18 And we also did a follow-up interview on October 21st to  
19 that legally focused interview. That totalled about three  
20 hours, across those three interviews.21 Q. Understood. Relating to the November 13, 2024, report that  
22 was submitted by BOP, you mentioned that Dr. Nelson and you  
23 worked on this together.24 During this process of working on this final report, did  
25 you have any differing opinions with Ms. Nelson about the

1 diagnostic impression that you guys had?

2 A. I don't think I would say we had differing opinions.

3 That's -- it's kind of a dynamic process, I would say though,  
4 across the evaluation period.

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

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

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

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

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

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



1 formulate it in the report.

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

5 A. Yes. Yes.

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

11 A. That's correct.

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

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

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

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

24 Is that a possibility?

25 A. Absolutely.

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

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

7 Did you review that in your analysis?

8 A. Correct.

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

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

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

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

19 Q. Let me see here.

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

21 Q. Yep. That's right.

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

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

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

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

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

12 A.   Yes.

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

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

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

19 A.   Correct.

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

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

23 Q.   Competency?

24 A.   -- focused, yes.

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

1 Mr. Wenke.

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

5 How do you define the term delusion?

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

8 Q. What about paranoia?

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

13 Q. Okay.

14 A. -- in some way.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

17 Q. Yeah.

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

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

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

1 accurate or based in reality.

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

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

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

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

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

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

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



1 complete.

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

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

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

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

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

18 Q. Okay.

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

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

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

4 On that page 11, again, later on down, from the October 2,  
5 2024, evaluation or interaction, there is a reference here about  
6 Mr. Wenke planning to make amends with RT's father, MT.

7 And it goes through a process or discussion about suing the  
8 Libertarian party for \$3,500. And that he plans to offer the  
9 \$3,500 in exchange, for payment, to make RT a national committee  
10 matter instead, thus fixing the relationship between Mr. Wenke  
11 and MT.

12 How would you classify this type of information?

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

16 A. It also sounds like future plans.

17 Q. Okay.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

1 A. Yes.

2 **MR. WRIGHT:** Okay.

3 Nothing further, Your Honor.

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

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

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

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

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

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

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

25 **THE COURT:** With everything that you know about

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

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

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

8 **THE COURT:** All right.

9 Anybody else have more questions for Dr. Watkins?

10 **MR. PASSAFIUME:** No, Judge.

11 **MR. WRIGHT:** No, Your Honor.

12 **THE COURT:** Thank you, Dr. Watkins.

13 **THE WITNESS:** Thank you, Your Honor.

14 (Witness Excused)

15 **THE COURT:** And we have the next witness.

16 Mr. Passafiume, go ahead.

17 **MR. PASSAFIUME:** Sure. Dr. Kaitlyn Nelson.

18 **THE WITNESS:** Hello. Yes.

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

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

23 **THE WITNESS:** I can try. Sorry. Our offices are on a  
24 housing unit, so --

25 **THE COURT:** Okay. We're sometimes familiar with those

1 kinds of sounds. Let's do the best we can. We have to get you  
2 sworn still.

3 Ms. Henry, go ahead.

4

5

**DR. KAITLYN NELSON,**

6 witness on behalf of the **DEFENDANT**, having first been duly  
7 sworn, testified as follows:

8

9

**THE WITNESS:** I do.

10

**THE CLERK:** Can you please state your name and then

11

spell it for the record.

12

**THE WITNESS:** Kaitlyn Nelson, K-A-I-T-L-Y-N,

13

N-E-L-S-O-N.

14

**THE COURT:** Okay. Mr. Passafiume --

15

16

**DIRECT EXAMINATION BY MR. PASSAFIUME:**

17

18

**BY MR. PASSAFIUME:**

19

Q. Hi, Dr. Nelson. Could you please tell us your title?

20

A. My current title is a forensic post-doctoral fellow.

21

Q. And how long have you been that?

22

A. Since August of 2024.

23

Q. And how long have you been -- worked at MCC Chicago?

24

A. Since August of 2024.

25

Q. Have you always worked under the supervision of



1 Dr. Watkins?

2 A. Yes. At this facility.

3 Q. Did you -- was there a point in time where you evaluated a  
4 gentleman by the name of Luke Wenke?

5 A. Yes.

6 Q. Do you remember what that evaluation was about?

7 A. That was an evaluation related to competency to proceed.

8 Q. And you -- you issued this report with Dr. Watkins. I want  
9 to say, dated November 13th, that comes from that evaluation?

10 A. That's correct.

11 Q. And I want to go through, kind of, the process of that. So  
12 Mr. Wenke got there on September 4th and the evaluation ended on  
13 October 21st?

14 A. Correct.

15 Q. So is that a typical duration for these competency  
16 evaluations?

17 A. Yes. So, typically, they are by statute, a 30 day  
18 evaluation, within an allowance of a 15 day extension period, if  
19 it's requested or there needs to be a reasonable reason for the  
20 extension.

21 Q. And in that time, you state in the report that Mr. Wenke  
22 was routinely observed by correctional and psychology staff?

23 A. Uh-huh.

24 Q. You have to say yes or no.

25 A. Yes.

1 Q. Can you explain what do you mean by that? What is  
2 routinely observed?

3 A. So as I mentioned earlier, there are offices on housing  
4 units. And I believe in Mr. Wenke's case, all of the interviews  
5 with him took place on his housing unit.

6 So you go to his housing unit. I could see him there on  
7 the unit and then would call him up to an office.

8 But, also, when I say routinely observed by correctional  
9 staff, there is always an officer on the unit, who in most  
10 situations I elicit their opinion on how that individual has  
11 been functioning on the unit.

12 Similarly, if they had any interactions with other staff  
13 members, including psychology or other professions, I may elicit  
14 their observations as well.

15 Q. And those observations go into your ultimate determination  
16 of your ultimate diagnosis of Mr. Wenke?

17 A. I think they play a role in my formulation, yes.

18 Q. Over the course of those 45 days or so, how many times do  
19 you think you saw Mr. Wenke, personally?

20 A. I met with Mr. Wenke on six different occasions for  
21 interview purposes.

22 Q. And did you -- in addition to that, did you -- when you  
23 weren't there, did you speak the psychology staff and the  
24 corrections officers about what they observed?

25 A. I did speak with officers about what they observed and they

1 noted, you know, no concerns behaviorally from him. He mostly  
2 just kept to himself on the housing unit.

3 Q. And what kind of things would you be looking for in those  
4 observations?

5 Why is that important?

6 A. Yeah. Talking to the correctional officers is very  
7 valuable, because they are the ones who are on the housing units  
8 with the defendants at all times.

9 So a lot of times we're asking about -- you know, anything  
10 that stands out. Are they able to follow the unit rules?

11 Do they appear to be getting along with other people or are  
12 they having problems? Things of that nature that can speak to  
13 their functional impairment or lack thereof.

14 Q. So is it relevant if somebody is able to be housed in a  
15 general population setting, as opposed to a -- kind of, a  
16 private solitary setting?

17 A. Are you referring to -- like, the private setting, you are  
18 talking to, like, a secured setting?

19 Q. No. When somebody is in general population at the jail,  
20 like, Mr. Wenke did not have to be separated from anybody else,  
21 why is that important or is it?

22 A. Right. Yes. I would say it is important. A lot of times,  
23 we see, you know, if someone is having significant mental health  
24 problems, sometimes that might cause difficulties with them  
25 interacting with their peers.

1 Peers might also point out, you know, various oddities that  
2 they have noticed as well or not wanting to have interactions  
3 with them.

4 Sometimes it leads to, you know, fights or concerns for  
5 safety for both the individual and other people. So those could  
6 all be reasons why someone might end up in a more confined  
7 secure housing, outside of the general population units.

8 But as in Mr. Wenke's case, that did not happen. He was  
9 able to maintain appropriate behavior and -- within the general  
10 population setting.

11 Q. In those 45 days, you also gave him some assessments. And  
12 one is this personality assessment inventory.

13 Can you explain what that is?

14 A. That's correct. The personality assessment inventory or  
15 PAI is a self-report measure.

16 Meaning, it's 344 questions that the individual answers on  
17 their own. And that measure is looking at a broad range of both  
18 psychological symptoms and personality traits.

19 So they are asked to give, you know, their opinion of  
20 themselves and the various statements that are included in the  
21 measure.

22 Q. Is that a routine assessment that you give in these  
23 competency evaluations?

24 A. I would say I use it often, but it's not in every case.

25 Q. And does the result of that assessment go into the ultimate

1 diagnosis at the end?

2 A. Yes.

3 Q. You also did this revised competency assessment instrument.

4 Could you explain what that is?

5 A. Yes. The revised competency assessment or RCAI is more of  
6 a semi-structured interview measure, specifically, looking at  
7 various areas related to competency-related abilities.

8 So there are various categories that have questions listed  
9 in each category related to things, such as their charges, who  
10 the people are in the Courtroom.

11 You know, various Courtroom procedures, such as -- you  
12 know, entering a plea or what is a plea bargain, things like  
13 that.

14 And the goal of that is to make sure that we're asking  
15 questions in all areas related to competency. But as I  
16 mentioned, it is a semi-structured interview, so we also ask  
17 follow-up questions and oftentimes ask a lot more questions than  
18 are listed in the interview.

19 Q. Does the result of that assessment give you any insight  
20 into the ultimate diagnosis, whether Mr. Wenke has a mental  
21 disease or defect?

22 A. Yes. I would say so. The -- the RCAI -- RCAI doesn't  
23 give, like, a score or results or anything like that.

24 But the way an individual approaches the questions, how  
25 they are able to attend to them, what information is included in

1 their responses -- all of that can speak to someone's mental  
2 state.

3 Q. You also reviewed a lot of materials. I want to go through  
4 some of them real quick now: Some legal documents, the  
5 indictment, presentence report motions, BOP records.

6 Why do you review those documents? Why was that important?

7 A. Yeah. So a lot of the documents that I reviewed are  
8 helpful to one get an understanding of, you know, what his  
9 current legal situation is, so that I can assess Mr. Wenke's  
10 understanding of what's happening.

11 But then also some of the other records that I've reviewed,  
12 such as, like, past evaluations and letters that he has written,  
13 medical center records, all of that can speak to whether or not  
14 this is his mental state.

15 How he is presenting currently, if that's a pattern across  
16 time. What, if any, mental health issues have been present in  
17 the past, things of that nature.

18 Q. And you mentioned -- so you reviewed letters that Mr. Wenke  
19 sent to the Court and other people?

20 A. That's correct.

21 Q. And you reviewed his social media posts?

22 A. Yes. Some that were provided in the discovery materials.

23 Q. And that material was provided by myself and the prosecutor  
24 and probation, right?

25 A. Yes.

1 Q. You didn't independently go and find your own letters and  
2 your own stuff? It was everything that we gave to you?

3 A. Yes. With the exception of -- I believe he sent a couple  
4 letters while he was housed at MCC Chicago, so I reviewed those  
5 as well.

6 Q. Perfect. You also reviewed some prior evaluations, for  
7 example, one from Dr. Leidenfrost.

8 Do you remember that?

9 A. Correct.

10 Q. And --

11 A. Yes.

12 Q. -- why is it important to review these prior evaluations  
13 from -- from past doctors?

14 What insight does that give you?

15 A. Yeah. Reviewing past evaluations is incredibly helpful to  
16 get an understanding of how the individual was presenting at  
17 different points in time.

18 That can speak to -- you know, how their presentation is  
19 consistent or changes across time.

20 Timeline of potential symptoms, what that clinician -- how  
21 they are conceptualizing an individual. And all of that, kind  
22 of, plays into my own conceptualization of an individual.

23 But, again, it's kind of just that. It's a piece of data  
24 that I take into consideration and then use that to aid in  
25 formulating my own opinion.

1 Q. Perfect. You also spoke to several individuals, right?

2 A. Correct.

3 Q. One of those people -- you spoke to myself, the prosecutor  
4 and probation.

5 Do you remember that?

6 A. Yes.

7 Q. We met by video conference and, kind of, discussed the  
8 case? Yes?

9 A. Correct. Yes.

10 Q. And --

11 A. Sorry.

12 Q. -- then you sought our opinions of the matter. Why would  
13 you do that? Why was -- why was that relevant?

14 A. Yeah. Specifically, in a competency evaluation, I  
15 routinely try to elicit observations from both the prosecution  
16 and the defense, because the question that we're answering  
17 related to competency is partially their ability to assist in  
18 their defense and whether they have the factual rational  
19 understanding.

20 So it's really important to understand why the question of  
21 competency was raised; what concerns related to competency  
22 either side has for that specific defendant.

23 And that can be useful to, kind of, guide what areas we  
24 need to clarify in the competency evaluation with that specific  
25 individual.



1 Q. Would any of that give insight into whether Mr. Wenke has a  
2 mental disease or defect?

3 A. It certainly could, depending on what the attorneys are  
4 reporting.

5 You know, if -- certainly, if the attorneys are seeing  
6 particularly odd or bizarre behaviors or having difficulty  
7 maintaining a conversation with an individual -- those are just  
8 some examples, but all of that can speak to how the person is  
9 presenting, which can inform, you know, a decision on whether or  
10 not that person may or may not be experiencing mental illness.

11 Q. And what about talking to somebody's family members? Is  
12 that important?

13 A. Yes. And it doesn't happen in every case, but when it --  
14 when I am able to speak with someone who knows the defendant  
15 personally, maybe even over a significant amount of time, it's  
16 really helpful to determine, you know, patterns of behavior or  
17 patterns in their presentation.

18 Or if there had been a significant change in that person  
19 and what may have been going on in their life at that time,  
20 things of that nature.

21 It can also help corroborate some of what the defendant is  
22 self-reporting, particularly when we are gathering background  
23 information, speaking with family or people who were close with  
24 them can help, kind of, clarify some of that information as  
25 well.

1 Q. Were you able to do that for Mr. Wenke?

2 A. Yes. I was able to speak with his mother.

3 Q. And how did you get her information, if you remember?

4 A. I don't recall specifically in Mr. Wenke's case.

5 Typically, I would either ask the defendant if there was someone  
6 close to them.

7 But also ask -- you know, both defense and prosecution, in  
8 my initial e-mail to you, asking if there is any collateral  
9 contacts that may be available to share contact information  
10 with.

11 Q. What did you do talk about, if you can share and if you  
12 remember, with Mr. Wenke's mother?

13 A. Typically I approach the collateral interviews as -- kind  
14 of like a general background information, similar to what I  
15 would ask the defendant.

16 So in Mr. Wenke's case, I, kind of, went through, you know,  
17 the whole timeline of his life. You know, tell me about how he  
18 was when he was a child?

19 And what about his schooling? And his work history? And  
20 things of that nature. So that's -- that's what I did with  
21 Mr. Wenke's mother as well.

22 Q. And would that information give insight as to whether  
23 Mr. Wenke has a mental disease or defect?

24 A. Yes.

25 Q. All right. You also cited some research -- this article

1 from Cunningham.

2 Are you familiar with that?

3 A. Yes.

4 Q. What -- what is that? Can you explain that and what this  
5 17 factor model is?

6 A. Yeah. So the article that I reviewed specifically for this  
7 case was the differentiating delusional disorder from the  
8 radicalization of extreme beliefs a 17 factor model and what  
9 this article does is develop a 17 factor model that can be  
10 helpful for clinicians in doing the differentiating between  
11 delusions and these extreme beliefs, as they call them.

12 The intent is to just use that tool -- the 17 factor model  
13 as, kind of, a guide in considering different factors that play  
14 into -- you know, what makes something a delusion versus an  
15 extreme belief.

16 It's not like a checklist or doesn't give you an end  
17 result. More so, it's just a guide to make sure you are  
18 considering various aspects of those beliefs.

19 Q. And you apply that to, basically, each belief individually?  
20 Not as a whole? How does that work?

21 A. So in this situation, I tried to use it as a guide in my  
22 thinking for considering different components in Mr. Wenke's  
23 presentation.

24 So not necessarily every belief, individually, but, kind  
25 of, more clusters. So these beliefs related to his past

1 relationships or beliefs related to his political views or  
2 beliefs in his spiritual beliefs and mediums and psychics and  
3 things like that.

4 Q. We'll get back to that in a second. I want to walk you  
5 through your report and, kind of, explain it in a category  
6 section by section basis.

7 A. Sure.

8 Q. So the report starts with this background information and  
9 it lists all of these different histories.

10 Could you -- the first one is developmental history. What  
11 is -- what does that mean?

12 What is that section about?

13 A. Yeah. So, typically, in the developmental history, it's  
14 talking about, like, from birth, what they were like as a kid.  
15 Where they grew up, what that was like. What their family  
16 structure was like, things of that nature.

17 Q. Would that information give insight as to whether Mr. Wenke  
18 has a mental disease or defect?

19 A. It can be used to, kind of, develop those hypotheses. And  
20 potentially -- you know, provide insight into timelines of  
21 possible symptoms, things of that nature.

22 Q. We'll skip to the social and mental history section. The  
23 other ones are self explanatory.

24 What is that section about?

25 A. This section is about, like, friendships and romantic

1 relationship history.

2 Specifically -- you know, if that person was able to  
3 maintain relationships, what those, kind of, looked like in more  
4 broad terms.

5 Q. And would the information contained there give you any  
6 insight as to whether Mr. Wenke has a mental disease or defect?

7 A. Yes. It can certainly provide insight into that. For  
8 nearly all mental illnesses, part of a diagnosis is talking  
9 about their functional impairment in some of these various  
10 categories.

11 So with their functional impairment and social interaction  
12 or functional impairment in education or employment areas.

13 Q. And all the information contained in this -- well, let me  
14 get it right -- this background information, did that come from  
15 your collateral -- like, the collateral sources and -- and all  
16 the, kind of, evidence that we've discussed that you reviewed?

17 A. Yes. In addition to specifically or directly from  
18 Mr. Wenke.

19 Q. Okay. The starting from -- like, I guess day one, if you  
20 remember, what was the -- the interaction with Mr. Wenke like?

21 What would you say to him? What happens during that  
22 initial meeting?

23 A. Yeah. During the initial intake meeting that I typically  
24 have with someone, it is generally we're providing a forensic  
25 notification.

1 Which is providing them information about the current  
2 evaluation, what the evaluation -- or what information will be  
3 used for, the lack of confidentiality in what their -- the  
4 information they are providing and what they can expect over  
5 their time at this facility, things of that nature.

6 And then the other piece is getting -- more so general  
7 background information.

8 I believe with Mr. Wenke that first interview lasted around  
9 30 minutes, which is not uncommon to have a more brief  
10 interaction during the first interview.

11 And when I say we gather general background information, we  
12 might ask where he's from or if he had a mental health history  
13 if he had a substance abuse history or what he did for work.

14 And then during later interviews, we, kind of, dive more  
15 deeply into those topics.

16 Q. In that initial interview, if you remember, did Mr. Wenke  
17 discuss any delusional beliefs or did anything stand out that  
18 you felt was not appropriate during that initial interview?

19 A. If I can have just a minute to review what I wrote about  
20 that?

21 Q. Yes.

22 A. So from what I remember, at no point did any of his beliefs  
23 appear overtly delusional.

24 I wasn't a hundred percent certain at this point that the  
25 beliefs he was talking about were just clearly delusional or not

1 based in reality.

2 And I think the same would be true during his initial  
3 contact with us. He seemed to be generally forthcoming.

4 And I mentioned in the report, he provided information  
5 about various parts of his background.

6 He was a little bit more defensive when talking about  
7 things such as substance use history. However, that's not  
8 uncommon for interviewing someone in this sort of setting.

9 A lot of times people tend to minimize things such as  
10 substance use or past legal history, things of that nature.

11 Q. And during that initial, kind of, meeting -- and what's  
12 reflected in the report, it says that he was placed in open  
13 population.

14 Does that sound right?

15 A. Yes.

16 Q. And what's -- again, we talked about this a little bit  
17 before -- what is open population?

18 And did Mr. Wenke remain in open population the entire time  
19 that he was with you?

20 A. Yes. Mr. Wenke was on an open population housing unit,  
21 which means within the unit, the individuals are free to roam  
22 pretty much within the designated areas.

23 And then they -- on the unit that Mr. Wenke was on in  
24 particular, he had a singular cellmate that during lockdown  
25 times, he would have been housed and locked in that cell with

1 that individual.

2 Q. Okay.

3 A. And he remained in open housing for the duration of his  
4 time here.

5 Q. Perfect. September 27th, it says that he was seen for a --  
6 a psychosocial history interview?

7 A. Correct.

8 Q. What does that entail? What is that about?

9 A. That is what I had mentioned earlier about that deeper dive  
10 into background information.

11 So it is essentially going through those same categories of  
12 his background, but gathering more thorough information or  
13 asking more detailed follow-up questions.

14 Q. And every -- did every time you see him, was there a  
15 personal interaction?

16 Did you have, like -- like, a conversation with him,  
17 whether it was performing an assessment or just chatting?

18 Did you have this, kind of, one-on-one interaction with  
19 him?

20 A. So I met with him individually three of the six times that  
21 I met with him. It was just myself and Mr. Wenke in an office.

22 And then the other three times, Dr. Watkins was also  
23 present.

24 Q. Okay. The next part of the report is titled: Clinical  
25 formulation.



1           What is that part of the competency evaluation? What goes  
2 into that section?

3       A.    The clinical formulation section of the report, is where  
4 now I have all of the background information and collateral  
5 records.

6           And this is, kind of, where I'm outlining how I am  
7 conceptualizing those in relation to mental-health-related  
8 concerns.

9       Q.    And the information that goes in there, again, is from your  
10 personal interactions, the assessments and also that  
11 collaterally information?

12      A.    Correct.

13      Q.    Would you say that the more collateral information you  
14 have, the more accurate the formulation would be?

15      A.    I would say so, yes.

16      Q.    And -- and, ultimately, the next section is the diagnosis.  
17 And you diagnosed Mr. Wenke with an other specified personality  
18 disorder, with mixed personality features. Primarily borderline  
19 personality traits and narcissistic personality traits.

20      A.    Correct.

21      Q.    You -- you explain it very well in each one of these  
22 reports. I'm not going to go through that at all, but could  
23 you -- could you explain in general what a personality disorder  
24 is as opposed to a psychiatric disorder?

25      A.    Sure. A personality disorder is a pattern of -- basically,

1 a pattern of personal characteristics of that person --  
2 personality characteristics.

3 So these are often persistent traits that the individual  
4 continuously presents with over time, oftentimes starting in  
5 early adulthood and that kind of persists throughout.

6 On the other hand, a -- another mental health or mental  
7 illness would be something that would be, kind of, a deviation  
8 from what their typical presentation would be.

9 For example, if we're talking about a mood disorder, that  
10 would be, kind of, a deviation from their typical mood  
11 presentation.

12 Whereas in a personality disorder, those patterns are more  
13 consistent across longer periods of time.

14 Q. And I -- if you can, again, if you don't know, that's fine.  
15 What is treatment typically for a personality disorder?

16 A. The treatment for personality disorder varies depending on  
17 the type of personality disorder or personality traits that are  
18 present.

19 A lot of times it includes individual therapy or group  
20 therapies. Specifically, for borderline personality disorder,  
21 as Dr. Watkins had mentioned earlier, the dialectal behavioral  
22 therapy is, kind of, the gold standard for borderline  
23 personality disorder.

24 And, certainly, can be used to treat these traits and not  
25 full personality disorder as well.

1 Q. Was Mr. Wenke medicated at all in the 45 days that he was  
2 there?

3 A. No.

4 Q. Do you believe he needed to be medicated at all?

5 A. While Mr. Wenke was at this facility, it did not appear  
6 that medication was indicated, so he did not -- he was not  
7 referred to a psychiatrist for consultation during the  
8 competency evaluation.

9 Q. If you believe that was an issue, you would have referred  
10 him to a psychiatrist during that competency evaluation period?

11 A. Yes. That's an available option.

12 Q. And -- and the psychiatrist would be to -- kind of, because  
13 the psychiatrist prescribed medication, it would be to further  
14 your findings? Further for your diagnosis?

15 A. Well, a psychiatrist would do their own independent brief  
16 assessment to determine whether or not the symptoms are present  
17 that deem medication to be appropriate.

18 And then they would be the ones to determine which  
19 medication, if any, they would prescribe.

20 Q. The next section I want to talk about is the prognosis and  
21 recommendation section.

22 If you again just explain what that section is about and  
23 what goes into that?

24 A. Yes. In this section, specifically, in a competency  
25 evaluation report, the prognosis and recommendations are

1 typically geared specifically towards competency.

2       So in this situation, I am -- in Mr. Wenke's case, I'm  
3 describing, you know, he -- the personality traits that I  
4 observed, how they are typically a pervasive pattern across  
5 time.

6       Even with treatment, sometimes they -- there is a  
7 significant change, but there may be some improvement, but  
8 ultimately I provide the recommendation that he was expected to  
9 remain competent, because of the persistent nature of these  
10 traits and that they were unlikely to change significantly.

11 Q.    Could you -- could you just explain that though more? I  
12 know you say: With either diagnosis, the features are pervasive  
13 and character illogical, such that they are unlikely to change  
14 in the future.

15       Can you explain that more -- if you can, just, kind of,  
16 elaborate?

17 A.    Sure. What I mean by that is personality traits being just  
18 that. That they are traits and characteristics of the  
19 individual.

20       Sometimes they are difficult to change. So when I say  
21 there may not be or they are unlikely to have significant change  
22 in the near future, I mean that -- you know, even with  
23 treatment, it could -- it could definitely take time for any  
24 change to be seen.

25       And, again, depending on what the traits are and what

1 personality disorder is present, there are various treatment  
2 options and effectiveness of those treatments.

3 Q. And those treatments don't need to happen in a -- in a  
4 controlled facility or jail or hospital? They could -- they  
5 could happen on an outpatient basis?

6 A. Certainly. They are available in the community as well.

7 Q. I said the wrong word before. I said psychiatric. I meant  
8 psychotic disorder, because I want to get into that part now a  
9 little bit.

10 Part of your -- one of the documents you reviewed was this  
11 evaluation from a Dr. Leidenfrost.

12 Do you recall that?

13 A. Yes.

14 Q. And he -- he goes through -- he gives a psychotic  
15 diagnosis. And that -- that's different than your diagnosis.

16 And he -- and we've talked about this a little bit -- he  
17 goes through this persecutory, paranoid, erotomaniac delusions.

18 Are you familiar with his diagnosis? That those symptoms  
19 of delusions -- I know you talked -- you know, I know your  
20 colleague talked about it a little bit.

21 What's your understanding of -- of the disorder that he  
22 diagnosed Mr. Wenke with?

23 Terrible question.

24 A. Are you asking if I'm familiar with that diagnosis?

25 Q. Yeah. So what -- in your opinion, can you describe was a

1 persecutory delusion would be?

2 A. Yes. A persecutory delusion would be fixed beliefs that  
3 people are out to get this individual or are coming after them,  
4 to harm them in some way.

5 Q. And similar -- that's similar to, like, a paranoid  
6 delusion?

7 What's the difference?

8 A. I would say they are similar. Paranoid may also include --  
9 like, you know, bad things are going to happen.

10 More broadly, persecutory would be more -- could be  
11 directly related to that individual they are targeting.

12 That individual, specifically -- but, again, both have this  
13 overarching theme of -- you know, that others are out to get  
14 this person or bad things will happen to this person.

15 And when it rises to a delusional belief, it is now based  
16 not in reality. And it's fixed beliefs that persist, even in  
17 the presence of evidence suggesting otherwise.

18 Q. So there is -- there is a big difference in an extreme  
19 belief versus a delusion.

20 And that a delusion is a symptom of a psychotic disorder,  
21 but an extreme belief is not; is that accurate?

22 A. I would be hesitant to say there is a big difference,  
23 because differentiating between a delusional belief and a very  
24 firmly held extreme belief can be a very fine line. And they  
25 can be very difficult to pars those things out.

1 Q. And the Cunningham research tool is an aide for that?

2 A. It is an aide, yeah.

3 Q. Is it the go-to aide for that? Is there some other tool  
4 that you can use to determine whether there is an extreme belief  
5 versus a delusion?

6 A. I am not familiar if there is, like, a specific tool design  
7 that's the gold standard to use to differentiate.

8 But outside of the 17 factor tool, one of the biggest  
9 things that's useful in differentiating these beliefs is looking  
10 at it in the context of the whole picture, rather than looking  
11 at each belief as existing in a vacuum.

12 And just looking at, you know, a belief related to  
13 believing in mediums, for example.

14 At face value, that may seem to lean more towards a  
15 delusional belief. However, when we are taking in the whole  
16 picture and thinking about the context in which that person  
17 holds that belief, where they might have come to develop that  
18 belief, is it impacting their functional abilities in their  
19 every day life that they are holding this belief?

20 Do other people believe it? When we look at the whole  
21 picture and, also, through consultation with other colleagues,  
22 you can, kind of, then develop your -- your conceptualization in  
23 whether or not this belief is delusional or it is firmly held  
24 extreme belief.

25 Q. So the belief in psychics -- we'll start there. That's a

1 good example. You did not find that to be a delusion.

2 Can you expand on that? And what kind of -- what  
3 information did you use to come to that conclusion?

4 A. That's correct. I did not conceptualize Mr. Wenke's belief  
5 in mediums or psychics as being delusional in nature.

6 And I came to that conclusion based on my conversations  
7 with him, that he reported that was something that was  
8 consistent throughout his life and in his family.

9 In addition, to the collateral interview with his mother,  
10 who -- you know, without prompting and simply asking about  
11 spiritual beliefs, she provided the information that that was  
12 commonly held in his family or a practice within his family.

13 Q. Okay. So that information came from both Mr. Wenke and  
14 then confirmation from his mother?

15 A. Correct.

16 Q. All right.

17 **MR. PASSAFIUME:** When did you want to break?

18 **THE COURT:** How much more do you have?

19 **MR. PASSAFIUME:** Maybe ten minutes. 15 minutes. I  
20 can go fast.

21 Thank you, Judge.

22 **BY MR. PASSAFIUME:**

23 Q. I want to just go --

24 **THE COURT:** Do you need we need a facilities break?

25 Is that what you were --



1           **MR. PASSAFIUME:** I don't.

2           **THE COURT:** Let's take a five minute break. If we can  
3 accommodate everyone in that short of a period of time and then  
4 recess five minutes and come back and keep going and try to wrap  
5 it up before lunch.

6           **MR. PASSAFIUME:** Yes.

7           **THE COURT:** We're going to take a five minute recess.

8

9           **(Recess commenced at 11:49 a.m., until 11:56 a.m.)**

10

11           **THE COURT:** Okay. Everybody is where they are  
12 supposed to be.

13           Mr. Passafiume, please proceed.

14           **MR. PASSAFIUME:** Thanks, Judge.

15           **BY MR. PASSAFIUME:**

16           Q. All right, Doctor. I want to go through a few examples of  
17 delusions that have come up in this case and I want to get your  
18 opinion on those things.

19           Some of the ones you discussed in your report already, but  
20 we'll start with one of them that you discussed in your report.

21           So this delusion that Mr. Wenke was the former chairman of  
22 the Libertarian party of Cattaraugus County, you found that not  
23 to be a delusion.

24           I think it's on page 20. Because you found out that he  
25 actually was the county chairman for the Libertarian party; is

1 that right?

2 Do you remember that?

3 A. Yes. I remember that.

4 Q. So this might be an obvious question, but why isn't it a  
5 delusion? Because it actually happened?

6 A. Yes. Because it seemed to be based in reality.

7 Q. And you say: Upon further review -- I don't know if you  
8 remember.

9 Do you remember what that review was? Did you do any,  
10 like, research?

11 A. I -- I don't remember specifically what I reviewed, but I  
12 do believe that I Googled Mr. Wenke's name for the purposes of,  
13 like, looking up that specific fact.

14 Q. And was it easy to Google Mr. Wenke?

15 A. I don't recall having difficulty.

16 Q. Okay. These other delusions involve one of the victims in  
17 this case, KV.

18 And the delusion is that Mr. Wenke believes that KV created  
19 a website to harass him.

20 This is not your report. That would fall under the --  
21 like, a persecutory delusion, right?

22 A. I apologize. There is some background noise. If you can  
23 hear that.

24 But I -- it could possibly be a persecutory belief, if he's  
25 thinking that -- I'm sorry.

1           It could be a persecutory belief if the individual is  
2           thinking that someone is intentionally out to get them, if  
3           that's not based in reality.

4           I'm not with the familiar of the website that you are  
5           referring to, but if there was truly a website that is targeting  
6           this individual, that could also possibly be based in reality to  
7           hold a persecutory belief.

8       Q.    Perfect. If I told you that the website existed was  
9           created by KV, where she blogs every day and summarizes every  
10          Court appearance, posts every single legal document, transcribes  
11          all of Mr. Wenke's letters and comments on them and posts  
12          altered pictures of Mr. Wenke -- if I told you that website  
13          exists, would that change your opinion?

14          Would that make this not a delusion?

15       A.    Those are -- would all be things that I would definitely  
16          want to take into consideration before determining whether or  
17          not that was a delusional belief or not.

18          Now I will add that there are times when delusional beliefs  
19          are stemmed from reality.

20          There is some piece of a truth in a delusional belief,  
21          oftentimes.

22          However, I would need to look at the situation as a whole  
23          and really look at that website myself and how Mr. Wenke was  
24          interpreting that.

25       Q.    I gotcha. You know that the website exists, but you would

1 need to look at it yourself to verify everything that I just  
2 said?

3 A. I think seeing at least a sample of some of what was being  
4 posted would be helpful in informing the type of content that  
5 was being said about Mr. Wenke.

6 And also then having a conversation with Mr. Wenke and his  
7 beliefs, specifically related to that website.

8 Q. Okay. Would examples of persecution in this context be  
9 altered pictures, commentary, posting of documents, things like  
10 that?

11 Would that be examples of the persecutory delusion?

12 A. It could be, yes.

13 Q. Okay. Another -- another delusion is that KV stole  
14 Mr. Wenke's car. And, again, that's not in your report.

15 If -- if I told you that there is a story to that, where  
16 our office gave the car keys to KV and Mr. Wenke is aware of  
17 that, would that impact whether the -- the belief that KV stole  
18 his car, whether that's a delusion or not?

19 A. I think that certainly provides context for how he may have  
20 come to this belief, that this individual stole his car.

21 But, again, I would want more information as to how he rose  
22 to now that person stole the car, as opposed to had permission  
23 to use it.

24 Q. And that more information would come from the collateral  
25 sources?

1           You can ask him. You can ask me. You can ask family  
2 members, right?

3       A.     That's correct.

4       Q.     And you would do that in all of these instances of  
5 potential delusions?

6       A.     Attempts would be made, yes.

7       Q.     Okay. Another one of these is the delusion that Mr. Wenke  
8 believes KV left a negative yelp review on Mr. Wenke's mother's  
9 restaurant cite.

10           If I were to tell you that there was a negative yelp review  
11 and that Mr. Wenke's mom told Mr. Wenke that she believes it was  
12 KV that posted it, would that impact whether that's a delusion  
13 or not?

14       A.     That could also inform, again, how and why Mr. Wenke was  
15 holding these beliefs.

16           I think the -- the overarching delusion would be that this  
17 person was out to get Mr. Wenke. And each of these examples  
18 that you are providing, if they are based in reality, those  
19 or -- or if they are not based in reality, they are all examples  
20 of why this belief is being maintained.

21           Now, because all of the examples that you are providing are  
22 based in reality, that doesn't automatically exclude someone  
23 from having a delusional belief.

24           Rather, these are examples of that belief being  
25 perpetuated. However, again, I would need more -- like, to have

1 a conversation to -- before determining whether or not that  
2 delusion or that belief is delusional or not.

3 Q. Okay. But these -- you would need other examples that were  
4 not based in reality to ultimately form the conclusion that it  
5 is a persecutory delusion?

6 A. I would say so, yes.

7 Q. The -- the last delusion, real quick, I want to talk about  
8 is that -- and I think this is in your report, actually, that KV  
9 and I had a screaming match.

10 If I were to tell you that I actually did speak with KV and  
11 she became irate on the phone and hung up -- and I told  
12 Mr. Wenke about that.

13 Do you think that would impact the whether that delusion  
14 exists, that we had a screaming match?

15 A. I don't recall specifically referencing a screaming match,  
16 but I do recall Mr. Wenke talking about various interactions  
17 with various people involved in his case.

18 So I certainly think that's informative to know there are  
19 truly, in fact, various interactions with multiple people  
20 involved in this case.

21 I think that may also lend to providing more reality-based  
22 context for these beliefs.

23 Q. And I guess -- I don't know if I should ask this -- if  
24 these don't rise to the level of delusions and maybe they are  
25 just extreme beliefs, would those also be symptoms of traits or

1 traits of the personality disorder that you diagnosed Mr. Wenke  
2 with?

3 A. They could be. So, you know, when we're talking about  
4 persecutory beliefs, the -- the diagnoses -- diagnosis that I  
5 provided related to borderline personality traits and  
6 narcissistic traits with referencing, kind of, the instability  
7 in relationships that seems to be persistent in Mr. Wenke's  
8 life.

9 And I certainly think the relationship that you were  
10 referencing before, with this individual who may be posting  
11 negatively about Mr. Wenke, and involved in the case could be in  
12 relation to those borderline personality traits as well.

13 Q. And his boasting about his political connections and  
14 publics, would that be a trait of narcissistic personality  
15 disorder?

16 A. That's how I conceptualized it as being art of these  
17 grandiose -- grand ideas that he has, you know, in his own self  
18 importance in what his personal case is going to lead to future  
19 action and things of that nature.

20 So, yes. I conceptualized those as being part of the other  
21 specified personality disorder traits.

22 Q. What be the excessive letter writing? How does that fit  
23 in?

24 A. Yeah. I also conceptualized as part of those personality  
25 traits specifically related to impulsivity. And that can be a

1 trait related to borderline personality disorder as well.

2 Q. Would that also be a trait of autism spectrum disorder?

3 A. It could be.

4 Q. I know you considered that in your report.

5 Traits of that would also include -- you know, abnormal  
6 speech, providing excessive details. That would be a trait of  
7 autism spectrum disorder, right?

8 A. It possibly could be. And the way that I -- someone may  
9 interpret the letter writing could be, you know, poor  
10 understanding of some social norms or not fully understanding  
11 that the things that he's writing in the letters could be  
12 interpreted as, you know, threatening or causing fear in the  
13 other person.

14 And, yes. Autism spectrum disorder was something that  
15 Dr. Watkins and I considered and spoke about.

16 But, ultimately, we -- we determined that at this point, we  
17 were not offering that diagnosis and there wasn't enough  
18 information to support that diagnosis at this time.

19 Q. Okay.

20 **MR. PASSAFIUME:** That's all I've got. Thank you so  
21 much. That was awesome.

22 **THE WITNESS:** Thank you.

23 **MR. WRIGHT:** May I proceed, Your Honor?

24 **THE COURT:** Go ahead.  
25



1 **CROSS EXAMINATION BY MR. WRIGHT:**

2  
3 **BY MR. WRIGHT:**

4 Q. Good morning or afternoon, Dr. Nelson.

5 A. Thank you.

6 Q. Can someone have a mental disease or defect and still  
7 suffer from a personality disorder?

8 A. Yes. Both can occur at the same time.

9 Q. Okay. From the examinations that you did in your 4241  
10 analysis, focusing on the competency aspect of the defendant,  
11 from the assessments that you employed in your evaluation, could  
12 you have detected, based on those assessments, if someone had a  
13 schizoaffective disorder?

14 A. Yes. It's possible to detect during a competency  
15 evaluation.

16 Q. Okay. And for schizoaffective disorders, what are you  
17 looking for in that?

18 A. For a -- a schizoaffective diagnosis, it's kind of a  
19 combination of both psychotic symptoms and mood symptoms.

20 So you're looking for a deviation from their normal  
21 presentation, but also these mood-related symptoms being --  
22 persisting throughout the majority of time -- meaning, having --  
23 it could be excessive energy, things of that nature.

24 Lack of need for sleep, disorganized behavior. But then  
25 the part that makes this more schizoaffective is that there are

1 psychotic symptoms.

2 Specifically, hallucinations or delusions that persist or  
3 continue to be present in the absence of mood-related symptoms.

4 And those psychotic symptoms have to be present for a  
5 period of at least two weeks, in the absence of mood-related  
6 symptoms.

7 Q. Okay. So for this psychotic symptoms, could they have been  
8 present during your evaluation of the defendant, but the -- the  
9 examinations that you employed would not have picked up on  
10 those?

11 A. Typically, for psychotic symptoms -- and I'm not sure if  
12 I'm -- I made this clear, but the psychotic symptoms would be  
13 present the entire duration of the schizoaffective disorder and  
14 then would continue to be present in the absence of those mood  
15 symptoms.

16 But during the competency evaluations, psychotic symptoms  
17 could be detected mostly in the individual interactions I have  
18 with the individual.

19 A lot of times in the phone calls or letters that I review.  
20 They can also be noted -- or the impairment that a lot of times  
21 people experience with delusions or hallucinations, could be  
22 observed while in the housing unit.

23 So most times -- many of the times, other people pick up on  
24 symptoms that could suggest or indicate that they may be, you  
25 know, hallucinating or something like that.

1 But the delusional piece would certainly be present during  
2 interviews.

3 Q. So depending on how the defendant or the person being  
4 examined is acting before the examiner, that could be a very  
5 important determination of whether or not a determination of a  
6 psychotic treatment is needed or psychoactive disorder is  
7 present?

8 A. You are saying their presentation with the evaluator?

9 Q. Correct. It would depend on who they -- how they are --  
10 who is doing the interview, that could change the analysis?

11 A. Certainly. So part of why we meet with an individual on  
12 multiple occasions, across time, is if someone is experiencing  
13 genuine symptoms of mental illness -- specifically, they are  
14 hallucinating or hold delusional beliefs, it's a lot harder to  
15 conceal those if you are meeting with them across different time  
16 periods.

17 I also think that in different contexts, it's important to  
18 look at the different contexts, because the consistency of the  
19 person's presentation is also very informative.

20 So the other things that I mentioned, such as the  
21 functioning on the housing unit when I'm not present or how they  
22 are speaking to their family in the phone or how -- what they  
23 are writing in letters, all of that speaks to the consistency of  
24 their presentation and can inform us of whether or not a  
25 psychotic symptoms are present.

1 Q. Understood.

2 MR. WRIGHT: Nothing further, Your Honor.

3 THE COURT: Mr. Passafiume?

4 MR. PASSAFIUME: That's all. Nothing.

5 THE COURT: Okay. Thank you, Dr. Nelson.

6 THE WITNESS: Thank you, Your Honor.

7 (Witness Excused)

8 THE COURT: Okay.

9 Kirstie, you can shut off the video feed.

10 Okay. So any other witnesses for this hearing from  
11 either side?

12 MR. PASSAFIUME: Not from the defense.

13 MR. WRIGHT: Nothing from the Government, Your Honor.

14 THE COURT: All right. So the hearing -- the  
15 evidentiary portion of the hearing is closed.

16 And as far as I'm concerned, the only thing left for  
17 to do is for me to make a decision, which I intend to do.

18 Do we need to submit anything else from either side?  
19 Mr. Wright?

20 MR. WRIGHT: I -- I don't think so, Your Honor. I  
21 think we will rest on the presentation that we have.

22 THE COURT: Mr. Passafiume? Ms. Kubiak?

23 MS. KUBIAK: Judge, it may be necessary for us to do  
24 some very brief response or briefing.

25 What I would like to do is maybe have a quick

1 turnaround of the transcript from today's proceeding.

2 I just don't want to commit to the fact that we're not  
3 going to do anything further.

4 Can we have a quick turnaround on a transcript in a  
5 very short submission?

6 **THE COURT:** You will have to order one, an expedited  
7 transcript.

8 And then let me talk to the court reporter offline  
9 here for a minute.

10 **MS. KUBIAK:** Yes.

11 (Discussion off the record.)

12 **THE COURT:** When we're done here, Ms. Kubiak, why  
13 don't you speak with Ms. Weber about how to handle that request  
14 to make sure it's done in a way that facilitates success.

15 **MS. KUBIAK:** Absolutely.

16 **THE COURT:** And to the extent you need approvals for  
17 that expedited or daily, whatever terminology you two ultimately  
18 use, I am hereby approving that.

19 So, you know, I still may need to sign something  
20 nonetheless.

21 Mr. Wright?

22 **MR. WRIGHT:** Yes. If the defense is going to file  
23 something, we will submit something in writing as well.

24 **THE COURT:** So I think that Ms. Weber would have it  
25 done in that scenario by Monday.

1           Why don't we have some joint submission done by next  
2 Friday, because we've just got to put an end on this.

3           You know, because to the extent that we're headed in  
4 one direction or to the extent we're headed in another  
5 direction, we're just holding Mr. Wenke is limbo.

6           And I'm sensitive to the fact that he's been held in  
7 limbo for a long time, so we need to wrap it up.

8           So filing deadline for any post-hearing submissions  
9 would be Friday, April 18. And Ms. Weber will endeavor to the  
10 transcript docketed Monday, as long as everything moves smoothly  
11 in terms of requesting it the right way.

12           And, again, if you need to put something, Ms. Kubiak,  
13 in front of me for signature, I'm happy to sign it. If you need  
14 verbal approval, then you have it.

15           **MS. KUBIAK:** Thank you, Judge.

16           **THE COURT:** Anything else, folks?

17           **MR. WRIGHT:** No, Your Honor.

18           **MS. KUBIAK:** No, Your Honor.

19           **THE COURT:** Take care everybody. Be well.

20           **MS. KUBIAK:** Thank you.

21

22                   (Proceedings concluded at 12:18 p.m.)

23                               \*    \*    \*

24

25

1  
2 In accordance with 28, U.S.C., 753(b), I certify that these  
3 original notes are a true and correct record of proceedings in  
4 the United States District Court for the Western District of  
5 New York before the Honorable John L. Sinatra, Jr.

6  
7  
8  
9  
10 s/ Bonnie S. Weber  
Signature

April 14, 2025  
Date

11  
12 **BONNIE S. WEBER, RPR**

13 Official Court Reporter  
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15 Western District of New York  
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