

1 JAMES MISSETT,  
2 called on behalf of the Respondent, having been first  
3 duly sworn upon oath, was examined and testified as  
4 follows:

5 THE CLERK: Please take a seat in the witness  
6 stand, and please state your name and spell your last  
7 name for the record.

8 THE WITNESS: It's James Missett,  
9 M-i-s-s-e-t-t.

10 THE CLERK: Thank you.

11 DIRECT EXAMINATION

12 QUESTIONS BY MR. PARNES:

13 Q. Good morning, Dr. Missett.

14 What is your occupation?

15 A. I am a psychiatrist.

16 Q. Briefly, what education have you had that was  
17 to prepare you for that occupation?

18 A. I got a bachelor's degree in philosophy and a  
19 master's degree in political philosophy from the  
20 University of America in Washington, DC in 1963 and  
21 1964. And I was in a teaching fellow in the philosophy  
22 of science at St. John's University for two years. And  
23 eventually, in the early 1970s, got a doctorate in the  
24 philosophy of science from there.

25 In the meantime, I had gone to medical school

1 at Yale University. And when I graduated from there in  
2 1970, I went to the Department of Medicine at Stanford  
3 University Hospital for an internship. I had already  
4 had a commission since the mid 1960s in the United  
5 States public health service, so I had an active duty  
6 obligation. And for the last of those three years, I  
7 was assigned to Johns Hopkins University to run a  
8 research project and got a master's degree in public  
9 health while I was there. Then I came back to Stanford  
10 as a resident and then the chief resident in psychiatry  
11 until 1978.

12 Q. And since 1978 have you been practicing as a  
13 psychiatrist?

14 A. I have.

15 Q. And generally, what does your work experience  
16 since your end of your residency?

17 A. Well, I have had a private practice of  
18 psychiatry in Nima Park for close to 30 years now, same  
19 address. And initially I would have about 40 to 60  
20 patients a week that I would see. At the present time,  
21 it's about 20 patients a week I see of patients. So  
22 about half a day, every day.

23 And I've done a lot of consulting to courts  
24 and government agencies, industry, taught a lot. And  
25 for these last four or five years I've been the

1 director and co-director of the center for psychiatry  
2 and law at Stanford University.

3 Q. And what does the center for psychiatry and  
4 the law do?

5 A. Well, its primary role is to teach,  
6 principally, the faculty, the full-time faculty at the  
7 university, especially in the medical school, how to do  
8 a forensic evaluation and how to take whatever skills  
9 they have in whatever particular area of medicine  
10 they're in. So it's not just psychiatrists, but it's  
11 principally psychiatrists. And then apply that  
12 expertise in a way that answers questions that more  
13 commonly come up before courts and in treating or doing  
14 consultations about or evaluations of patients for  
15 treatment purposes.

16 Q. Are you board certified?

17 A. Yes.

18 Q. And what board certifications do you hold?

19 A. Well, I was board certified in psychiatry by  
20 the American Board of Psychiatry and Neurology in 1979,  
21 and then in forensic psychiatry by the American Board  
22 of Forensic Psychiatry in 1993, and then again in  
23 forensic psychiatry in 1995 and 2005, and addiction  
24 psychiatry in 1998.

25 Q. And in order to become board certified,

1 generally what steps do you have to take?

2 A. Well, it depends on the board. But the  
3 general certification in psychiatry, at the time I did  
4 it, was a two-day examination, one day paper, one day  
5 practical examinations, personal interview kinds of  
6 questions. That was the same in the 1993 forensic  
7 psychiatry exam, with the exception that they added  
8 requirements that you submit copies of reports that you  
9 have written and then defend them in front of their  
10 group. The other ones since then have been, by and  
11 large, examinations that take anywhere between a half  
12 day and a full day.

13 Q. Now, in your work, you treat patients and you  
14 also -- do you also do forensic reports?

15 A. Yes.

16 Q. And approximately what percentage of your work  
17 is in forensic reports for the courts?

18 A. Well, I work about 80 hours a week. So  
19 20 hours with patients. At Stanford, a requirement at  
20 Stanford or the agreement with them is for up to  
21 20 hours a week. A lot of that is teaching. A lot of  
22 it is going over reports written by faculty members who  
23 write, do evaluations. And I think the breakdown would  
24 be about 25 percent treatment over the course of the  
25 week and about 75 percent forensic psychiatry, but

1 that's administration, teaching, doing evaluations  
2 myself.

3 Q. And are you a consultant to any state or  
4 governmental agencies?

5 A. Yes.

6 Q. And what agencies are those?

7 A. Well, if we start with the federal level, the  
8 most longstanding of those is I've been the west coast  
9 consultant for the United States Secret Service since  
10 1986. So, 20 years for that. And depending on the  
11 situation, the federal prosecutor's office, either in  
12 San Francisco or San Jose, most of the time.

13 On the state level, the California Attorney  
14 General's Office, with respect to cases that they  
15 prosecute, particularly against physicians or other  
16 people who hold licenses in the state of California,  
17 but also on death penalty appeals in the state of  
18 California.

19 And then I will average one or two cases a  
20 week in criminal cases. And they break down -- they  
21 have broken down almost for 20 years now pretty  
22 regularly into about a third appointments by the Court,  
23 a third retention by the defense, and a third retention  
24 by the prosecution.

25 Q. And do you also provide psychiatric services

1 in the forensic field for civil, in civil cases?

2 A. Yes. That's about half of the total number of  
3 evaluations.

4 Q. And I take it, have you testified and been  
5 certified as an expert in psychiatry in courts in  
6 California and other places?

7 A. Yes. I'll testify about three times a month.  
8 So, at least once a week.

9 Q. So have you testified in capital cases before?

10 A. Yes.

11 Q. And have you testified, been called as a  
12 witness by the defense in some of those cases?

13 A. About half were called by the defense and  
14 about half called by the prosecution. A little bit  
15 more by the defense than by the prosecution.

16 Q. Are you familiar with the DSM?

17 A. Yes, very much so.

18 Q. And when did you first become familiar with  
19 DSM?

20 A. I served as a resident member of the committee  
21 that wrote DSM-III for the American Psychiatric  
22 Association for two years in 1977 and 1978.

23 Q. And do you use DSM in your practice, both  
24 privately and for the courts?

25 A. Yes.

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1 Q. Do you recall when you were contacted  
2 regarding this case?

3 A. It was about a year and a half ago.

4 Q. And did you interview Mr. Leavitt as a result  
5 of that?

6 A. I did.

7 Q. And did you prepare a report?

8 A. I did.

9 Q. And do you recall when you met with  
10 Mr. Leavitt, approximately?

11 A. Not without refreshing my recollection.

12 Q. You can refresh your recollection.

13 A. March the 13th of 2006.

14 Q. And you're being paid for your services in  
15 this matter?

16 A. Hopefully, at some point in time.

17 Q. And what is your hourly rate?

18 A. I will bill your office \$275 an hour.

19 Q. And when you were contacted, did you have a  
20 focus of your investigation in preparation of the  
21 report?

22 A. Yes.

23 Q. And what was -- briefly, what was the focus of  
24 that investigation and evaluation?

25 A. It first had to do with a general assessment

1 of his personality, any indications that Mr. Leavitt,  
2 at the time that I was seeing him or any time over the  
3 previous 20 years, appeared to give indications of  
4 having suffered from any diagnosable mental or  
5 emotional condition; any indications as to whether, and  
6 if so, in what ways and to what extent Mr. Leavitt's  
7 mental or emotional condition appeared to be the same  
8 at the time I was seeing him in 2006 as it had at other  
9 points in time earlier; any indications as to what a  
10 mental health evaluation in 1989 might have indicated,  
11 and the question of his prognosis for the future.

12 Q. And were you asked to review a number of  
13 materials in preparation of this evaluation?

14 A. Yes. At various points in time, a lot.

15 MR. PARNES: Your Honor, I believe  
16 Exhibit 1057 has already been admitted, which is  
17 Dr. Missett's report.

18 THE COURT: That's correct.

19 MR. PARNES: And just for the Court's ease.

20 BY MR. PARNES:

21 Q. Dr. Missett, I believe you're looking at your  
22 desk at a copy of your report?

23 A. Yes.

24 Q. And are those -- are the items that you  
25 reviewed contained in pages 1 through 3 of your report?

1           A. The article -- the material I had reviewed  
2 through April 14th is indicated in the report, and then  
3 they have sent me quite a bit of material since then.

4           Q. And since you've prepared the report, have you  
5 been provided the reports of Dr. Martell and Dr. Engle?

6           A. Yes, with accompanying DVDs or CDs. Yes.

7           Q. And have you also seen the reports of  
8 Dr. Andersen and Dr. Bigler?

9           A. Yes.

10          Q. And Dr. Mark?

11          A. Yes.

12          Q. In your report, did you come to certain  
13 conclusions regarding Mr. Leavitt's mental condition?

14          A. Yes.

15          Q. And what generally were those conclusions?

16          A. That the indications from the records, and  
17 also from what Mr. Leavitt said, appeared to be most  
18 consistent with his suffering at the time I saw him,  
19 and for a substantial number of years before that, from  
20 what would be called an organic personality disorder,  
21 if we were using a DSM-III-R rather than DSM-IV. If it  
22 was DSM-IV, it would have been personality changes  
23 secondary to what in this case appeared to be brain  
24 trauma in a general way, although it may not be exactly  
25 clear what the trauma was. There is some that is

1 clearer than others.

2 Q. Just may I ask, DSM-III-R, that was the DSM  
3 that was in effect in 1989?

4 A. Yes.

5 Q. And 1990?

6 A. Yes. All it meant was a revised edition of  
7 DSM-III that had come out in 1980.

8 Q. And DSM-IV?

9 A. Came in about 1995. And the general reason  
10 for all of these changes was an attempt to get a series  
11 of psychiatric diagnoses that are more scientifically  
12 based on presentations or findings for which you can  
13 conduct research projects in order to demonstrate that  
14 they're actually there or not.

15 Q. And in preparation of your evaluation, did you  
16 review the prior reports of other doctors,  
17 Dr. Hildebrandt, Dr. Ackley, Dr. Groberg, Dr. Gordon?

18 A. Yes.

19 Q. And they had seen Dr. Leavitt at prior points  
20 in times?

21 A. Various points in time, yes.

22 Q. And I think the earliest was in 1977?

23 A. Yes.

24 Q. Up through 1985?

25 A. Yes.

1           Q. And did you use those reports to assist you in  
2           formulating your opinion in this matter?

3           A. Yes, because without exception, those doctors  
4           were seeing Mr. Leavitt at a point that was closer in  
5           time to various events that were going on in his life  
6           or between himself and other people, both at a younger  
7           age for him and at a closer point in time to the events  
8           which he was charged and convicted.

9           Q. And does an organic personality disorder, how  
10          is that described in the DSM?

11          A. Basically, it is a diagnosis that is given to  
12          an individual who has suffered some kind of brain  
13          trauma. It can be -- that can be by being hit with  
14          something, usually on the head. It can come from  
15          anoxia, lack of oxygen for a period of time. It can  
16          come from various types of poisons. Carbon monoxide  
17          might be one, although that's less common. Other kinds  
18          of neurotoxins that might affect the brain. Certain  
19          kinds of conditions that are, some of which are called  
20          neoplastic in origin. It means they are cancers.  
21          Others of which are autoimmune diseases. Other which  
22          are endocrine diseases, such as hyperthyroid,  
23          hypothyroid, too little thyroid hormone.

24                        Certain other endocrine conditions,  
25          corticosteroidisms, basically referring to

1 corticosteroids that are put out in either too high a  
2 level or too low a level by the adrenal glands.  
3 Certain other conditions of which the etiology is less  
4 certain, multiple sclerosis.

5 So there are a lot of different causes for  
6 trauma to the brain. And in a significant proportion  
7 of those, it's a minority proportion, but it's still a  
8 significant proportion. One of the manifestations of  
9 damage from the disorder is a change in the person's  
10 personality, the way he or she characteristically  
11 thinks, feels, and to some extent sometimes thinks,  
12 with the most common and prominent elements being in  
13 the person's personality and behavior, the way they  
14 present themselves to other people, and in particular  
15 the intensity with which they report feeling emotions  
16 or described by others as exhibiting emotions, what's  
17 called an emotional dyscontrol. That's probably the  
18 most common one.

19 Q. Must there be a cognitive impairment or  
20 cognitive deficit in order to be diagnosed with organic  
21 personality disorder?

22 A. No. As a matter of fact, with most of the  
23 organic personality disorders you would not see that  
24 much in the way of a cognitive disorder. You could  
25 measure it on the standard testing. You might see what

1 others would regard as a cognitive aspect to the  
2 disorder in that -- for instance, if I had an organic  
3 personality disorder and I got terribly upset at  
4 something or somebody, it would not be unusual for me  
5 to attribute the cause of my upset to what it was that  
6 the other person or the situation had caused in me.  
7 That's a common element of getting angry or upset.

8 Q. In DSM-III-R, when it talks about impairment,  
9 does it indicate that a person's cognitive function may  
10 be relatively intact?

11 A. Yes.

12 Q. When you have organic personality syndrome?

13 A. Yes.

14 MR. PARNES: May I use the Elmo?

15 THE COURT: Yes.

16 MR. PARNES: I have my technician here.

17 THE COURT: Mr. Nevin beat me to the punch.

18 BY MR. PARNES:

19 Q. Now, I represent to you this is from  
20 DSM-III-R. It's on there. Could you read the  
21 paragraph beginning "Impairment"?

22 A. "The degree of impairment is variable.  
23 Although the person's cognitive function may be  
24 relatively intact, his or her poor judgment may cause  
25 such difficulties that he or she may require constant

1 supervision or even custodial care."

2 Q. And is that what you were referring to in  
3 terms of not having an affect on cognitive functioning?

4 A. Yes.

5 Q. And did you review the reports of Dr. Beaver  
6 regarding Mr. Leavitt's cognitive functioning?

7 A. Yes.

8 Q. And what do those reports state?

9 A. That there did not appear to be much in the  
10 way of cognitive abnormalities that were demonstrative  
11 in his functioning.

12 Q. And when you concluded that Mr. Leavitt was  
13 suffering from organic personality disorder syndrome,  
14 did you take into account the fact that he had  
15 performed fairly well on the cognitive testing?

16 A. Yes.

17 Q. And did that in any way impact your conclusion  
18 that this was organic personality disorder?

19 A. It didn't change it. If there had been  
20 indications of abnormalities, I might have started  
21 thinking about other things, depending on what the  
22 abnormalities might have been. But since there weren't  
23 any, there was no reason to change whatever it was that  
24 I was looking at in terms of arriving at the decision  
25 about what diagnosis appeared most clearly to apply to

1 him.

2 Q. Now, you, in reviewing the prior reports of  
3 the other doctors and psychologists and psychiatrists  
4 that had seen Mr. Leavitt, they had provided a  
5 diagnosis of explosive disorder, intermittent explosive  
6 disorder; is that correct?

7 A. Yes.

8 Q. And do you know what they -- could you see  
9 what they were basing their analysis on?

10 A. Well, depending on who it was who was writing  
11 the report, they appeared to focus on the fact that  
12 Mr. Leavitt, either himself or was described by others,  
13 as repeatedly either losing his temper or becoming  
14 involved in a violent outburst on a somewhat repeated  
15 basis, frequently enough to have him stand out from  
16 others, and that the doctors who were seeing him felt  
17 that on the basis of that, if that's what they were  
18 focusing on, he would qualify for that particular  
19 diagnosis.

20 Q. And is intermittent explosive disorder a  
21 disorder that is a residual diagnosis, a diagnosis of  
22 exclusion? In essence, that you exclude other  
23 disorders, and if they don't fit the description, you  
24 result in intermittent explosive disorder diagnosis?

25 A. Yes. If you're giving that diagnosis you're

1 presuming that the principle thing with which you're  
2 dealing is just the fact this person loses his or her  
3 temper and shows it and behaves accordingly on a  
4 somewhat repetitive basis. But you are also implying  
5 that the loss of temper, the explosive outbursts is not  
6 due principally to substance abuse, because that's  
7 probably the most common etiological agent in causing  
8 people to have explosive outbursts.

9 And you're also implying that, at least in  
10 your opinion, it's not due to some kind of organic  
11 problem, whether it's trauma, which is, again, the most  
12 common. But secondly, some other kind of physical  
13 disorder that you can nail down.

14 Q. Now, you've read Dr. Engle's report?

15 A. Yes.

16 Q. And he also discounts intermittent explosive  
17 disorder. Is that correct?

18 A. Yes.

19 Q. And Dr. Martell also dismisses or discounts  
20 intermittent explosive disorder?

21 A. Yes.

22 Q. So, in essence, you -- and Dr. Beaver does, as  
23 well?

24 A. Yes.

25 Q. So that all of you agree, albeit for maybe

1 different reasons, but that Mr. Leavitt is not properly  
2 diagnosed with intermittent explosive disorder?

3 A. That is a parallel conclusion that each of us  
4 appears to have arrived at.

5 Q. And regard to antisocial personality disorder,  
6 what is your conclusion regarding antisocial  
7 personality disorder as a diagnosis for Mr. Leavitt?

8 A. That it's less likely, and to me, far less  
9 likely than the organic personality disorder.

10 Mr. Leavitt did, by report, evidence some behavior, you  
11 know, prior to, say, age 15, which would be the  
12 controlling element for a conduct disorder of childhood  
13 or adolescence, but the behavior he's described as  
14 exhibiting followed the head injury that he appears to  
15 have suffered at age nine or ten.

16 And generally, if you have a head injury that  
17 appears causally to be related to behavioral or  
18 emotional dyscontrol, the head injury becomes the  
19 trump, just as if, say, that he had a cancer or he had  
20 some kind of other central nervous system problem.  
21 Whatever the central nervous system problem was, that  
22 becomes the controlling element in the diagnosis. And  
23 at that point in time you would switch from conduct  
24 disorder of childhood or adolescence, this is prior now  
25 to age 15 we're talking about, to a diagnosis of a

1 personality -- at the present time it would be  
2 personality change secondary to whatever the condition  
3 was, and earlier on it would have been an organic  
4 personality disorder.

5 And that would then be true of the same kind  
6 of assessment of emotional dyscontrol behavior after  
7 age 18, though to the extent that there does appear to  
8 be tangible, objective evidence of something wrong with  
9 Mr. Leavitt's frontal lobe. And to the extent that  
10 it's known that the frontal lobe is the source of most  
11 of the control mechanisms for our emotional  
12 experiences, to that extent I would rely on the  
13 technical evidence of the existence of that abnormality  
14 in coming to the decision that I did about the  
15 diagnosis with respect to Mr. Leavitt.

16 Q. And in regard to that, at the time you wrote  
17 this report you had access to the report of the CT  
18 scans in 1985?

19 A. Yes.

20 Q. And now you have access to the reports of  
21 others regarding the 2006 MRI and the 1996 MRI?

22 A. Yes.

23 Q. And is that -- are those -- those reports  
24 formulate your decision regarding the organic  
25 personality syndrome/diagnosis?



1 saying is that there is some indications, when you look  
2 at this man's history, that he did behave in a way that  
3 reasonable people who were experienced as physicians  
4 saw him as behaving, when he was losing his temper, in  
5 an antisocial way and doing that over a consistent  
6 period of time.

7 I think they should have been paying probably  
8 more attention, if they had known about it, to the  
9 underlying evidence of organic problems. But they were  
10 trying to do an adequate job and they were focusing on  
11 things that they and others agreed were there.

12 And I would say the same thing with respect to  
13 the intermittent explosive disorder. I don't think  
14 that Mr. Leavitt meets the criteria for either of  
15 those, but other doctors did. But they are also pretty  
16 clear they were not paying attention to evidence from  
17 CT or MRI scans with regards to any damage that  
18 Mr. Leavitt I think we know now quite clearly has,  
19 whatever the etiology of that damage was.

20 Q. Now, in your report you also discuss the  
21 possible effects of a premature birth. Is that  
22 something that you took account of in your diagnosis?

23 A. Yes.

24 Q. How did you do that?

25 A. Well, the indications from Mr. Leavitt's

1 history are that he had in a number of times in his  
2 life exposure to situations that, at least  
3 theoretically, have resulted in damage to the structure  
4 or function of his brain. Prematurity is known to  
5 increase the infant's vulnerability to any number of  
6 noxious situations. The first would be whatever the  
7 cause was of the prematurity. Was there some kind of  
8 toxic relationship between the fetus and the mother?  
9 Was there some kind of problem that the child had  
10 immediately after birth in terms of oxygenation? The  
11 kinds of things that might, theoretically, have  
12 resulted in some kind of damage to the structure or  
13 function of the brain.

14 Then although there was no real answer to  
15 that, there were also no pictures or exploration of  
16 Mr. Leavitt's neurological functioning that really  
17 stood out as an infant or a child, except that when he  
18 got to school there were descriptions of his  
19 behavior/interactions, at least consistent with what we  
20 might call a hyperactivity attention deficit disorder.

21 By itself, in the vast majority of cases,  
22 people who have attention deficit hyperactivity  
23 disorder, you don't find evidence of damage to the  
24 structure or function of the brain. But again, if you  
25 had a child who was premature, suffered some damage

1 there, whether it's going to be visible or not, and you  
2 have that same child four or five years later showing  
3 problems in terms of adjustment to or focusing in  
4 school, you can't rule out that there's a relationship  
5 between the two.

6 But again, there were no pictures. There's no  
7 evidence from scans or whatever kind of electronic  
8 measuring devices that one might want to use that  
9 Mr. Leavitt at that time, early on in life, had those  
10 kinds of problems.

11 And you could say the same thing with respect  
12 to his having been hit in the head by, I guess what  
13 appears now to be a piece of plywood, a two-by-four,  
14 but hit, nonetheless, at about age nine and ten. The  
15 reason I focused more on the issue of being hit with  
16 the wood was that it is more localized in nature,  
17 whereas you would expect offhand that any brain  
18 problems arising from prematurity or any brain problems  
19 associated with attention deficit hyperactivity  
20 disorder would be more diffuse, sort of all over the  
21 place.

22 Mr. Leavitt's description of the incident and  
23 other people's description of the incident wherein he  
24 was hit was that he was hit in the forehead. That  
25 appears to be consistent with, in general, being hit in

1 the general area where there appears to be evidence of  
2 some kind of brain hyperintensity on the various scans.

3 Q. Now, Doctor, you talked about the difference  
4 between a two-by-four and a piece of plywood. Does  
5 that difference or those different versions of things,  
6 did that affect your analysis of the impact of the  
7 sledding accident on Mr. Leavitt?

8 A. No. I think that he was pretty clearly hit by  
9 something that was -- with enough force to leave a scar  
10 and with it being followed, I believe causally, others  
11 might believe otherwise, with evidence of dyscontrol  
12 over at least the next four or five years while he is  
13 still a teenager and for at least the next ten to  
14 15 years after that.

15 Q. Now, in reviewing the reports of Dr. Engle and  
16 Dr. Beaver, they conclude that Mr. Leavitt is not  
17 diagnosed as a psychopath; is that correct?

18 A. That's what they said, yes.

19 Q. And do you agree with that?

20 A. On the basis of the reasoning I just gave you,  
21 yes. That would be an appropriate -- to the extent  
22 there is a basis for my reasoning and to the extent  
23 that that applies to Mr. Leavitt.

24 Q. And you're familiar with the Hare checklist  
25 and the Hare standard?

1           A. Yes. It's probably one of the most commonly  
2 used measures of sociopathy, particularly in a prison  
3 population.

4           Q. And Dr. Engle and Dr. Beaver applied those  
5 tests to Mr. Leavitt?

6           A. Yes.

7           Q. And they found that he did not meet the  
8 criteria for suffering from psychopathy?

9           A. Yes.

10          Q. And based on that and your interview with  
11 Mr. Leavitt, you would agree with that?

12          A. I would.

13          Q. Now, in 1989, is it accurate that you were  
14 practicing forensic psychiatry at that time?

15          A. Yes.

16          Q. And if you had been called to examine  
17 Mr. Leavitt at that time, would your examination have  
18 been pretty close to what you did in 2006?

19          A. I had more information already available to me  
20 in 2006 about things that had been done earlier. I  
21 think if it was -- if I were doing the same exam in the  
22 same situation, say, now with the amount of information  
23 that was available about Mr. Leavitt in 1989, I would  
24 have had an MRI or a CT scan at that time. I think  
25 that's probably number one.

1 I would, in addition to what I have done, I  
2 would have, in fact commonly do, arrange for the person  
3 to see a board certified neuropsychologist. I think  
4 certainly those two, on the basis of the information  
5 that -- I'm going back to now in 1989, to what appears  
6 to have been available then.

7 Q. And based on what you know now and what has  
8 been provided to you, if you had been asked to write  
9 your report for the sentencing in 1989-1990, would your  
10 report have been essentially what you have testified to  
11 today?

12 A. Yes, presuming that the findings and anything  
13 that were done in 1989 were similar to what is implied  
14 by the tests, the CT scan in 1985 and what appears to  
15 have been the results of the MRI this past year.

16 Q. And if I represent to you that Dr. Bigler,  
17 when he testified, testified that it would be likely  
18 that what showed up in the 1996 and 2006 MRIs, if one  
19 had been taken in 1990 would likely have been there as  
20 well, is that part of what you base your opinion on?

21 A. Very much so, had those been the findings  
22 then.

23 Q. And you're not an MRI expert; are you?

24 A. I'm not.

25 MR. PARNES: If I might just have a moment.

1 I have no further questions.

2 THE COURT: Cross-examination, Mr. Rosenthal.

3 MR. ROSENTHAL: Thank you.

4 MR. NEVIN: Excuse me, Your Honor. May I step  
5 out of the courtroom for a moment?

6 THE COURT: You may.

7 MR. NEVIN: Thank you.

8 MR. ROSENTHAL: Should I wait until Mr. Nevin  
9 returns?

10 MR. NEVIN: That's fine.

11 THE COURT: No, go ahead.

12 CROSS-EXAMINATION

13 QUESTIONS BY MR. ROSENTHAL:

14 Q. Good morning, Dr. Missett.

15 A. Mr. Rosenthal.

16 Q. You spent about four and a half hours with  
17 Mr. Leavitt on or about March 13, 2006; did you not,  
18 sir?

19 A. Yes.

20 Q. And did you tape or video record that  
21 interview or session with him?

22 A. I don't remember. If I did, I know I did not  
23 video record it. If I did, it would have been audio  
24 recorded.

25 Q. And was anyone else present with you, sir,

1 when that was done?

2 A. No.

3 Q. Did you administer any tests to Mr. Leavitt?

4 A. No.

5 Q. How would you describe your interview with  
6 him? Was it just a conversation? Can you put that  
7 into some terms for us, sir?

8 A. It's give and take. It would have been almost  
9 exactly the same in terms of my behavior and what I  
10 asked him and in what order to all of the other  
11 forensic exams that I do, whether it's a civil or a  
12 criminal case. I would have given him maybe  
13 five minutes or ten minutes of admonitions and  
14 instructions about what we were going to cover and what  
15 I was aware would probably happen with the material  
16 afterwards and how it was not confidential and things  
17 like that.

18 I would then start by asking him about his  
19 family of origin, who's in it, their identities, their  
20 ages, their relationships one to another, if someone  
21 has died, when that was, under what circumstances, what  
22 the impact was on him. Where it was that he was born,  
23 where he grew up, when the family moved, what he  
24 understood as being the reasons for the move. The  
25 schools that he attended, how things were for them in

1 those schools, why he went to one school rather than  
2 another, why he changed schools. Any problems that he  
3 might have had in school, his physical health as he was  
4 going through.

5 Then with respect to his teenage years,  
6 physical problems, physical health, jobs that he had,  
7 activities at school, again, extracurricular  
8 activities, if any, how he spent his free time. Drugs  
9 and alcohol in the teenage years. Problems so far as  
10 with his parents or teachers or others. That would be  
11 both elementary school and high school. And then what  
12 he did after that in terms of jobs, relationships,  
13 problems with the law.

14 And then what it was that he had been charged  
15 with, what involvement, if any, he had in that.  
16 Mr. Leavitt did not admit to having committed the  
17 murder which he stood convicted, but I would have gone  
18 through in detail with him if he had acknowledged that,  
19 what the circumstances were of the offense before,  
20 during and after.

21 I would have asked him about other, the  
22 contact with other doctors at various points in time  
23 during the course of his life, whether they are  
24 physical or psychological or psychiatric doctors.

25 Hospitalizations, medications, other kinds of

1 legal involvement aside from the offense with which he  
2 was charged. What happened after that in terms of his  
3 life, his experiences in incarceration, that sort of  
4 thing.

5 Q. Thank you.

6 I take it you had previously examined the  
7 reports of Drs. Jaynes, Groberg, Ackley, Gordon and  
8 Hildebrandt?

9 A. Yes.

10 Q. And I take it you also had examined the  
11 chronology and other data provided by mitigation  
12 specialist, Ms. Goody?

13 A. Some before, more after seeing Mr. Leavitt.

14 Q. And in terms of your discussions with  
15 Mr. Leavitt, you have no idea, sir, whether he was  
16 telling you the truth or not?

17 A. I have no idea.

18 Q. Now, just going through, and I'll be bouncing  
19 back and forth between things that Mr. Parnes asked you  
20 and otherwise, you are not acquainted with any of those  
21 other psychologists or psychiatrists who examined  
22 Mr. Leavitt in prior years; are you?

23 A. Not the previous ones. The only person who  
24 was familiar was Dr. Beaver.

25 Q. All right. You have worked with Dr. Beaver

1 previously; have you not?

2 A. Well, it wasn't so much working with him. He  
3 was involved in another case, I think similar in terms  
4 of it being a federal appeals case at the time that I  
5 met him. But I think I only met him once in the course  
6 of my life, even though I think he was probably  
7 involved in maybe two or three other cases.

8 Q. And you would agree, would you not, Doctor,  
9 that the interpretation of various things that go into  
10 a diagnosis are, to a great extent, very subjective?

11 A. Well, it depends. There can be subjective  
12 elements to any diagnosis, I think particularly where  
13 it is that the professional giving the diagnosis  
14 decides or feels that he or she should put their  
15 emphasis. But the general thrust in medicine and  
16 psychology as a whole is to try to decrease as much as  
17 possible the subjective elements in a diagnosis,  
18 especially in a situation where you're not principally  
19 in a treatment stance.

20 Q. Well, you seem to base, sir, a great deal of  
21 your diagnosis on what you describe as a traumatic  
22 injury that occurred, the sledding accident when  
23 Mr. Leavitt was nine or ten years of age; is that  
24 correct?

25 A. I thought that that was the most likely cause

1 for the abnormalities that were evidenced in --  
2 principally starting with the CT scan in '85. At the  
3 time that I wrote this, I didn't know what the -- what  
4 a CT scan or MRI would show in 2006.

5 But the general rule is, if you have evidence  
6 of organic brain damage, you have to rule out a causal  
7 relationship between that damage and other things that  
8 might reasonably be associated with it. Thinking  
9 problems, if you can demonstrate those, behavior  
10 problems, if you can demonstrate those, emotional  
11 dyscontrol, if you can demonstrate those.

12 So, in doing this, I was being unbelievably  
13 conservative. I was sticking to those things that are  
14 objectively demonstrable.

15 Now, the fact that it's objectively  
16 demonstrable that there is damage of some sort, on the  
17 one hand, and that there is behavioral dyscontrol or  
18 emotional problems on the other does not, by itself,  
19 establish without question that there is a causal  
20 connection between those two. The most you can say is  
21 most often, not uncommonly, it's not surprising to see  
22 that. But that doesn't mean it is 100 percent certain.  
23 It just has a high degree of probability.

24 Q. Well, Doctor, going on your statement that  
25 this, to the best of your knowledge, occurred between

1 Mr. Leavitt's ninth and tenth year, based on his date  
2 of birth, that would have been between 1966 and 1967;  
3 would it not?

4 A. Yes.

5 Q. And you have talked about, in your prior  
6 testimony, personality changes that occurred after  
7 that, and you've also indicated that you have read  
8 Ms. Goody's chronology, as well as her other data.

9 Would you agree that after his ninth or tenth  
10 year, he had only normal sibling rivalries with his  
11 four brothers? You don't find that unusual; do you?

12 A. I didn't find that unusual.

13 Q. And his basic skills and his test from that  
14 time through his junior high, the finish of his junior  
15 high year, went up every year; did they not?

16 A. I don't remember their not going up, but I  
17 don't remember offhand what they were. I don't  
18 remember a problem with them.

19 Q. I will represent to you Ms. Goody's very  
20 detailed chronology, which has been stipulated in by  
21 counsel, indicates that -- does it indicate that he did  
22 rather well in grade school, making S's, which I  
23 believe indicates satisfactory in Idaho schools, and  
24 had no discipline problems in school throughout grade  
25 school.

1           A. Again, I didn't remember seeing any problems  
2 with discipline while he was in school.

3           Q. And would you expect that, to have discipline  
4 problems if, in fact, he was having behavioral  
5 dyscontrol, sir?

6           A. If it was in the school system, you would  
7 expect that. But ordinarily it's going to be due to  
8 provocation of some sort or what's perceived as  
9 provocation on the person's part. That might or might  
10 not be evident in the classroom. But, I mean, if you  
11 had seen it, I would have regarded it as indicating  
12 more in the way of indication that the brain damage was  
13 contributing to it. But in the absence of it, I  
14 wouldn't know.

15          Q. Well, and you are aware that he had no  
16 juvenile problems prior to, basically, his 18th year?

17          A. Well, my memory is he had gotten involved in  
18 some fights. It might be that those were regarded as  
19 the normal kinds of fights that a youngster might get  
20 involved in. Again, I couldn't disagree with that  
21 because it is certainly possible that that is what  
22 happened and it was not principally related to brain  
23 damage. That's certainly possible.

24          Q. Well, and what I'm getting to, Doctor, if, in  
25 fact, he only had normal grade school, junior high

1 fighting and fighting with his siblings, you would not  
2 find that unusual; would you?

3 A. No. Certainly, as long as you're using the  
4 word normal, you're basically saying it's somewhere  
5 within an expected range.

6 Q. And I'm only using the words that have been  
7 testified to by Mr. Leavitt's family members in this  
8 courtroom, as well as that has been stipulated in, sir,  
9 by Ms. Goody.

10 A. I understand.

11 Q. Now, a great deal has been attributed to an  
12 incident that took place after his 18th birthday  
13 involving the two young men who threw a rock and he  
14 accosted them, using my words.

15 A. I understand.

16 Q. Are you aware that that took place after he  
17 had been -- the day after he had been expelled from  
18 school for having worn his hat and, when confronted,  
19 uttered an obscenity to the principal?

20 A. Yes.

21 Q. Doctor, did the fact that Mr. Leavitt, in  
22 1985, after he was incarcerated on this charge,  
23 attempted to overdose, fell down, hit his head on a  
24 steel -- the corner of a steel plate in the jail and  
25 was knocked unconscious and apparently was unconscious

1 for some time and taken to the hospital, is it possible  
2 that a traumatic brain injury could have occurred then?

3 A. If you have evidence of an injury to the head,  
4 particularly if it's going to be anywhere near the  
5 frontal area, that's possible.

6 Q. And I believe he's identified a scar on his  
7 head that came from that to Ms. Goody and other  
8 therapists in this case.

9 THE COURT: Counsel, just for the record, when  
10 you made that comment, you made a gesture by pointing  
11 towards the area in the front of the forehead. And I  
12 just want the record to reflect that. If that's, in  
13 fact, what the record reflects, then that needs to be  
14 made clear. If it doesn't, then I think the doctor  
15 needs to know where that injury or that scar actually  
16 was so that he is not misled in any way.

17 So could you clarify that?

18 MR. ROSENTHAL: I am just going from the  
19 description that I recollect --

20 THE COURT: Well, the problem is what does not  
21 show in the record is that you pointed to an area --

22 MR. ROSENTHAL: I did point, and that is from  
23 my recollection --

24 THE COURT: Okay.

25 MR. ROSENTHAL: -- only, Doctor.

1 BY MR. ROSENTHAL:

2 Q. If Mr. Leavitt was knocked unconscious in that  
3 incident, would that be more indicative of the  
4 potential for some traumatic brain injury?

5 A. The general rule is that if someone later on  
6 is going to conclude a head injury having been severe  
7 enough to cause damage to the structure and function of  
8 the brain, you'd expect that it would have been -- the  
9 injury, if it's a traumatic impact injury, would have  
10 been such as to most likely result in unconsciousness.  
11 But the period of time can vary from, you know, a few  
12 seconds, usually, you know, 10 to 20, 30 seconds, but  
13 where they're coming around afterwards to much longer  
14 periods of time.

15 There is a general rule that the longer period  
16 of time, the more severe the -- and widespread the  
17 damage.

18 Q. And, Doctor, you were aware, were you not,  
19 that in 1988, within the penal institution, that he was  
20 involved in an incident with guards where he described  
21 a beating which knocked him unconscious. In fact, he  
22 said he was in and out for several days after. Were  
23 you aware of that?

24 A. Yes.

25 Q. And could that be the cause of some traumatic

1 brain injury?

2 A. Theoretically?

3 Q. Certainly, sir.

4 A. Certainly. But if you were to focus on the  
5 1985 CT scan findings, you'd have a problem relating to  
6 that, of course. What appears to have been an  
7 abnormality, was reported to have been an abnormality  
8 on that particular report to something that's going to  
9 happen three years later.

10 Q. But the '85 CT was after the incident in the  
11 jail where he hit his head.

12 A. That's true.

13 Q. And you're aware now of the radiologists and  
14 physicians indicating that the MRI images do not show  
15 any hemiacidrin staining that would be indicative of  
16 traumatic brain injury?

17 A. Well, bleeding associated with traumatic brain  
18 injury, that's true.

19 Q. And isn't bleeding basically the indication  
20 between major and minor head injury?

21 A. Well, not necessarily. I think all of those  
22 conditions that I mentioned earlier, we're talking here  
23 about the non-impact injuries to the brain,  
24 disease-related, endocrine-related, auto  
25 immune-related. None of those would have, you would

1 expect, bleeding associated with them. But if you had,  
2 for instance, an injury that resulted from his being  
3 hit, it would be more likely that you would have had  
4 bleeding. Again, you don't have to have it, but it  
5 would be more likely, and that would be whether it was  
6 the earlier one at age nine and ten or later on when he  
7 was in jail.

8 Q. And, Doctor, you saw no problems with any  
9 history of his autoimmune system in any of the  
10 histories that are given?

11 A. No, I did not.

12 Q. You are aware, are you not, that after his  
13 incarceration in the state penal facility he began  
14 suffering in the past few years of cardiovascular  
15 problems and diabetic problems; are you not?

16 A. Yes, relatively late. Yes.

17 Q. And those are maladies that are seen  
18 frequently on scans where white matter hyperintensities  
19 appear; are they not?

20 A. I think the problem is with the word  
21 frequently. If you have arteriosclerosis, you can have  
22 the intensity of that or the severity of it increased  
23 if you also have diabetes. And if you have  
24 atherosclerosis in your heart, the vessels of your  
25 heart, you would be more likely to have it in other

1 vessels in your body, and that would include the neck  
2 and the brain, so that you can have a -- if you see a  
3 higher incidence of hyperintensity in brain scans or  
4 MRIs, you're not surprised. It doesn't mean it has to  
5 be from the atherosclerosis, but you're not surprised  
6 if you see it.

7 Q. And in your four-and-a-half-hour interview,  
8 was there any objective evidence of any frontal lobe  
9 irregularity?

10 A. No, not during the time I was with him.

11 Q. So his speech, his memory, his mood were all  
12 appropriate?

13 A. Yes.

14 Q. Nothing bizarre in his thought patterns, no  
15 anger shown towards you or the system, I take it?

16 A. Not during the time I was with him.

17 Q. Did he talk about or show you any of his  
18 poetry or artwork?

19 A. He talked about the poetry and did not show me  
20 any, and did not show me any artwork.

21 Q. And you didn't find anything bizarre in that  
22 type of activity, did you, or in the content that he  
23 spoke about?

24 A. No.

25 Q. And, Doctor, did he tell you about the injury

1 to his arm when he was 15?

2 A. I know he did, yes.

3 Q. And are you aware that family members and  
4 others have testified that after that injury, basically  
5 everything went downward for Mr. Leavitt in terms of  
6 his conduct, school, and his behavior?

7 A. That appeared to have been seen by others as  
8 one of the things that marked -- that they remembered  
9 as marking changes.

10 Q. And that's some five or six years after the  
11 traumatic, alleged traumatic injury from the sledding  
12 incident; is it not?

13 A. Yes.

14 Q. You're aware that during his adolescence he  
15 used alcohol, marijuana, and drugs?

16 A. Yes.

17 Q. And were you aware that his mother maintained  
18 a daycare with between 30 and 50 children, five or  
19 six days a week?

20 A. Yes.

21 Q. And I take it you have read that Mr. Leavitt  
22 did things to get her attention and, many family  
23 members thought, because of her preoccupation with her  
24 occupation?

25 A. Yes.

1 Q. And that doesn't surprise you; does it?

2 A. No. In other words, if there is an  
3 explanation for it, that doesn't necessarily have to be  
4 related to any kind of injury he suffered earlier.

5 Q. And when Mr. Parnes was asking you to read  
6 that portion of organic personality syndrome, paragraph  
7 starting "Impairment," indicating the cognitive  
8 function might be relatively intact, it goes on to say,  
9 and I'm reading from DSM-III-R: "His or her poor  
10 judgment may cause such difficulties that he or she may  
11 require constant supervision or even custodial care."

12 You know of no supervision or custodial care  
13 prior to his incarceration that he was -- that was  
14 imposed upon him; are you?

15 A. No, although I think the incarceration  
16 certainly fits that kind of criteria because he is in  
17 custodial care and has been now for over 20 years.

18 Q. But that incarceration did not occur until  
19 1984?

20 A. That's true. But at least, in my opinion, it  
21 is related to the injury that he sustained earlier.  
22 Whether it was the one at nine or ten, which I think is  
23 the most obvious, but -- or to some other case, he does  
24 give indications of having had a personality change  
25 that was severe enough that eventually he's had

1 20 years of custodial and institutional care.

2 THE COURT: Counsel, would this be a good  
3 breaking point?

4 MR. ROSENTHAL: Certainly, Your Honor.

5 THE COURT: Let's take a 15-minute recess. We  
6 will reconvene at 25 to.

7 (Whereupon, the Court recessed.)

8 THE COURT: Dr. Missett, I will remind you,  
9 you are still under oath.

10 Mr. Rosenthal, you may resume your  
11 examination.

12 MR. ROSENTHAL: Thank you, Your Honor.

13 BY MR. ROSENTHAL:

14 Q. Dr. Missett, you indicated you're aware that  
15 Mr. Leavitt was delivered approximately 30 days early;  
16 were you not?

17 A. Yes.

18 Q. And you indicated that might be a causative  
19 factor of any potential mental or emotional problem?

20 A. Yes.

21 Q. You're aware, are you not, that the records  
22 indicate that it was a normal birth?

23 A. Yes.

24 Q. And that he stayed in the hospital, as I  
25 understand the records that have been introduced in

1 this proceeding, for three or four days?

2 A. Yes.

3 Q. And that he made all of his milestones in  
4 growing up, both from his description, I believe to  
5 either you or other therapists, but also his mother's  
6 statement to Ms. Goody?

7 A. That there were no indications of delay,  
8 that's true.

9 Q. All right. And his grade school and junior  
10 high grades and conduct were appropriate?

11 A. Yes, that's true.

12 Q. And, again, would you not expect, if there was  
13 injury to his brain, that it would have manifested  
14 itself in some type of conduct during those years?

15 A. I think the most accurate way to say it is if,  
16 indeed, there had been aberrations of conduct and you  
17 were looking for an explanation, I think you would have  
18 looked at the prematurity as being one of the possible  
19 explanations. In the absence of that, I think what  
20 you'd say is that there was nothing at that point in  
21 time that was obvious that you might relate to  
22 something earlier on.

23 It doesn't mean that the vulnerability wasn't  
24 there and that the vulnerability wasn't something that  
25 was heightened later on by any number of things in his

1 life. It could have been the substance abuse. It  
2 could have been a blow to the head. It could have been  
3 any number of things.

4 But I think the only thing you would say is  
5 there was no reason to go look for something.

6 Q. All right. And in your report, on page 9,  
7 when you are talking about intermittent explosive  
8 disorder, and you find it in the middle of that  
9 sentence under "Intermittent explosive disorder  
10 diagnosis trumped by organic personality disorder," you  
11 state:

12 "The essential feature of an impulse control  
13 disorder is the failure," underlining the failure, "not  
14 an inability or an organically impaired ability,"  
15 closing the paren, "to resist an impulse or drive or  
16 its temptation to perform an act that is harmful,  
17 either to the person performing the act or to other  
18 people."

19 And that is your belief; is it not?

20 A. How does that paragraph start? I just didn't  
21 see where you were. That was all.

22 Q. It starts in your stylized print:  
23 "Intermittent explosive disorder diagnosis trumped by  
24 organic personality disorder," and that sentence begins  
25 five lines down.

1           A. I'm sorry. Yes, that's true. Yes.

2           Q. And you're aware that the reports talking  
3 about Mr. Leavitt's having thrown the family cat around  
4 or kicking the dog was done when others were not  
5 around, that he did those in private, not when other  
6 people were watching him?

7           A. No. That's my understanding.

8           Q. Now, going back to the sledding incident,  
9 Mr. Leavitt could recall details of that incident;  
10 could he not?

11          A. Yes.

12          Q. Both --

13          A. A few. But, I mean, he did remember the  
14 incident, yes.

15          Q. Both before and after?

16          A. Yes.

17          Q. And he indicated that, basically, he had no  
18 loss of consciousness that he recollected. Maybe  
19 30 seconds, but --

20          A. I think that's a little bit closer to what he  
21 said, that he didn't remember as such. And if it did  
22 occur, he said it would have been relatively brief,  
23 yes.

24          Q. But you are aware that in the two incidents in  
25 '85 -- or the two incidents, one in '85 and one in '88,

1 that Mr. Leavitt could not remember for several days  
2 details of what took place?

3 A. Yes.

4 Q. And isn't post-traumatic amnesia indicative of  
5 the seriousness of a head injury?

6 A. In a general way.

7 Q. Well, in a very specific way, as well, isn't  
8 it, Doctor?

9 A. No. It's in a general way because the --  
10 basically, all the amnesia tells you is that the blow  
11 that was suffered, if we're talking here about an  
12 impact injury, was such as to disrupt the function of  
13 the brain for a long enough period of time that a  
14 person is not able to either experience, encode, keep,  
15 or retrieve what his or her awareness is of what is  
16 going on; namely, what we call memories.

17 That can happen from damage to any part of the  
18 brain. It can be reflective, too, of just a general  
19 swelling of the brain afterwards or an increased amount  
20 of cerebral spinal fluid. You can have lots of causes  
21 for it.

22 But, in general, if you were to say a person  
23 is unconscious for two days, that implies that the blow  
24 was more substantial or the injury, that much more than  
25 a period of time when -- they were unconscious for a

1 much shorter period of time. In general, that would be  
2 true.

3 Q. And you've just stated, if I understand you  
4 correctly, that that could be caused by the  
5 accumulation of cerebral spinal fluid within your brain  
6 causing some pressures or whatever?

7 A. Absolutely. Or it can also be due to  
8 treatment in that it's not uncommon when you're  
9 treating people for a brain injury, sort of sedate them  
10 and sort of keep under control medication, that you  
11 don't let them get back to consciousness in other than  
12 in a controlled way.

13 Q. And that accumulation of cerebral spinal fluid  
14 could have been that which showed up on the 1985 CT  
15 just months after the incident in the jail; couldn't  
16 it?

17 A. You can have fluid show up as a  
18 hyperintensity. So as long as you're asking it in  
19 terms of possibility rather than probability, but  
20 certainly it's possible.

21 Q. And in terms of intermittent explosive  
22 disorder, you have no idea whether these outbursts that  
23 were attributed to Mr. Leavitt emanated from  
24 Mr. Leavitt's apparent use of either alcohol or  
25 controlled substances during his adolescence; do you?



1           A. Medical school, sir.

2           Q. Medical school?

3           A. Yes.

4           Q. That as I try to reflect upon what difference  
5 it would make, whether or not this has an organic --  
6 whether the problems that Mr. Leavitt manifests is  
7 organic or not organic is that it might come in two  
8 possible areas. One would be kind of a broad category  
9 of culpability, that perhaps a person's culpability is  
10 different if their conduct is a result of an organic  
11 brain injury as opposed to a psychiatric -- you know,  
12 again I'm not even going to suggest that I understand  
13 what causes people who have psychiatric problems and  
14 mental health problems to be the way they are.

15           The second possible area would be in terms of  
16 future danger. And I guess I would ask you to kind of  
17 address both.

18           With regard to culpability, that if, in fact,  
19 the crime with which Mr. Leavitt was charged would at  
20 least have some aspects of being a planned criminal  
21 activity, what role, in terms of culpability, would  
22 your diagnosis have, given the fact that we're talking  
23 about an intermittent explosive disorder, which would  
24 appear to be more of an impulse control, and I'm not  
25 sure there are aspects of impulse control at issue in

1 the crime with which Mr. Leavitt was charged and  
2 ultimately convicted. Perhaps the kind of aspects  
3 which would suggest antisocial conduct might be more in  
4 keeping with that. And then, secondly, what effect, if  
5 any, would your diagnosis have in terms of a prognosis  
6 and the ability to prevent future recurrences in or out  
7 of prison? I know that's a lot.

8 A. I understand.

9 Q. But could you comment upon that before I have  
10 counsel ask their follow-up questions?

11 A. I don't think I've ever had, Your Honor, in  
12 any court or any evaluation where -- particularly in  
13 homicides or where there was a lot of violence on the  
14 part of a given individual, ever seen cases where the  
15 attorneys for both sides did not pay a lot of attention  
16 to whether there were indications of the person having  
17 suffered brain damage at some point in time in life.

18 I know that I have had death penalty juries  
19 that indicated at the end of a hearing or a trial where  
20 they did not find for death, that the fact that when a  
21 particular individual had three instances of  
22 traumatically-induced unconsciousness in motorcycle  
23 accidents, even though the killings that he was  
24 convicted of at the same time were all motorcycle  
25 gang-related, that they said that made a tremendous

1 difference on them.

2 I had --

3 Q. Well, it's not a concern, but it's an issue.  
4 I'm assuming that people don't choose to be mentally  
5 ill any more than they choose to have an injury to the  
6 brain that results in an organic problem that manifests  
7 itself in ways very similar to, perhaps, mental  
8 illness.

9 And that's what I'm just wrestling with.  
10 Maybe it's the kind of generic question I don't even  
11 need to ask you. It's more wrestling with my own  
12 conscience and, I guess, wrestling with Judge George's  
13 conscience, who would have been the sentencing judge in  
14 1989-90, as to what impact, if any -- or what impact  
15 this information might have had upon his  
16 decision-making process, which I think is pretty  
17 critical, maybe the critical issue in this case.

18 Maybe just your comments in a very generic  
19 fashion. I guess I don't need anecdotal. I'm more  
20 curious whether, from an expert point of view -- well,  
21 let's leave it at that. Maybe if counsel wants to  
22 follow up with my concerns, you may. It's more my idle  
23 musings here than anything of real substance, but it's  
24 something that, you know, that just struck me.

25 I guess the one, maybe, specific thing is that

1 certainly if a person has an organic brain injury which  
2 is manifesting itself with an inability to control  
3 impulses, that would not be some kind of an explanation  
4 as to why a person might engage in a criminal act that  
5 was well planned and conceived as a thoughtful planning  
6 process. Is that fair to say?

7 A. I've seen cases where people did, Your Honor,  
8 in terms of careful planning. But at the same time,  
9 this was in the case where a person had lost a half a  
10 brain. The careful planning was accompanied by such  
11 defects in judgment that the person was held generally  
12 less responsible by everybody in the end for what he  
13 had done. But there was --

14 Q. That might go more towards the kind of  
15 antisocial-type behaviors in terms of not only having  
16 bad judgment, but having judgment that is kind of  
17 deprived of perhaps moral parameters that one might  
18 normally associate.

19 A. Deprived of many parameters, and that is  
20 including the ability to provide himself with reasons  
21 for proceeding in the way that he did in the face of  
22 intense -- intensity, the feelings he was having.

23 Q. What I sense you're saying is we are kind of  
24 compartmenting the categories, whether we talk about an  
25 organic brain injury resulting in manifesting itself

1 and types of behavior that might fall within a DSM-IV  
2 category. It's a very complex issue. And you can't  
3 just say it's an intermittent explosive problem. It's  
4 a problem that we probably can't define with sufficient  
5 specificity to say that these will be the only effects  
6 of this injury. There are effects we probably don't  
7 understand and will probably never understand.

8 A. Not for a long period of time, Your Honor.

9 THE COURT: Okay. Counsel, do you want to  
10 follow up? Mr. Parnes.

11 MR. PARNES: Just a moment, Your Honor.

12 THE COURT: Yes.

13 (Pause in the proceedings.)

14 REDIRECT EXAMINATION

15 BY MR. PARNES:

16 Q. Dr. Missett, just to follow up briefly on that  
17 regarding -- I think Judge Winmill asked you, regarding  
18 future dangerousness issues, is there a distinction for  
19 you between somebody who has -- would suffer from  
20 psychopathy or antisocial personality disorder  
21 vis-a-vis someone who has an organically-created,  
22 organically-based disorder? Is there any difference in  
23 terms of future dangerousness within a prison setting?

24 A. Yes.

25 Q. And what is that difference?

1           A. That a person with an antisocial personality  
2 disorder, whether there is a history of recurrent  
3 conduct that ignores the rights of others, is likely to  
4 continue as much in a custodial setting as outside a  
5 custodial setting, depending on how many opportunities  
6 present themselves.

7           To the extent that you have an  
8 organically-based condition, in general the treatment,  
9 whether it's in a jail or a prison or a mental hospital  
10 or some other kind of facility, is to decrease the  
11 amount of external stimuli to which the individual is  
12 exposed.

13           So there is a heightened emphasis on  
14 regularity and, basically, decreased exposure,  
15 especially noxious stimuli. Everything is quiet and  
16 it's regulated and regular, in part as a way of keeping  
17 people less susceptible to whatever kinds of internal  
18 problems they've got. And that would be as true of  
19 mental hospitals as a well as prisons, and one of the  
20 reasons for that it works.

21           People who have organic problems or severe  
22 mental illnesses, by and large, do kind of okay in  
23 those settings. Not that they're pleasant and not that  
24 they don't complain about it. Not that the settings  
25 are pleasant or that the people don't complain about

1 it. But in general, the absence of a lot of  
2 stimulating experiences helps them to keep their  
3 emotions in better control.

4 Q. Now switching, if you could look at  
5 Exhibit 1050, which will come up on the screen in front  
6 of you. And I would just identify this as a report of  
7 Dr. Hildebrandt that was prepared on December 31, 1976.

8 Do you see that?

9 A. Yes.

10 Q. And have you reviewed that report before?

11 A. I did.

12 Q. And what is your understanding about when this  
13 report was written and in what context?

14 A. It was written for the Court following the  
15 assault on the two boys who had tossed the rocks at  
16 him.

17 Q. And if we could just highlight the sentence  
18 beginning, "Rick explained."

19 And could you read that for the Court?

20 A. "Rick explained this incident by stating that,  
21 quote, 'I just all of a sudden get this urge to be mean  
22 to someone or something,' closed quotes. He remembers  
23 first having these feelings when he was nine or  
24 ten years old."

25 Q. Now, Mr. Rosenthal asked you about any unusual

1 behavior that was discussed. Is this the kind of  
2 unusual behavior that you would be looking for and  
3 looking to to rely on organic personality disorder and  
4 personality changes?

5 A. Yes.

6 Q. And is it unusual for an 18-year old,  
7 basically, to be making comments about himself  
8 regarding, "I just all of a sudden get this urge to be  
9 mean to someone or something"?

10 A. That's a little bit unusual. It's much more  
11 unusual for the person to fix on a given point in time  
12 in his or her life which they state this experience or  
13 these behaviors go back to.

14 Q. And at the time, I take it, Mr. Leavitt wasn't  
15 charged with any murders or anything, was he, at this  
16 time?

17 A. No.

18 Q. And if you look further down in the sentence  
19 beginning, "Rick's mother reports", could you read that  
20 for the Court?

21 A. "Rick's mother reports that he has been in his  
22 share of fights and that he has had conflicts with the  
23 school authorities. She feels that he is very immature  
24 and tries to get attention, but in the wrong ways.  
25 Also, he has poor judgment in social situations, for

1 instance, yelling out an obscenity at a school  
2 assembly."

3 Q. And is this the type of behavior that would  
4 indicate potential personality changes in an  
5 adolescent?

6 A. It's suggestive of poor impulse control. Just  
7 the statement from the mother, you wouldn't know why,  
8 and it could be almost anything. It could be  
9 substance. It could be relational. It could be brain  
10 related. You would not know if you were going just  
11 from that, except there is something here that's not  
12 quite right. But you couldn't say any more than that.

13 The other, the earlier comment that  
14 Dr. Hildebrandt attributed to Mr. Leavitt is a bit  
15 different because there you have somebody talking about  
16 internal feelings and relating it to a specific, at  
17 least, time in his life.

18 Q. And if you could look at Exhibit 1052. It  
19 will be brought up on your screen.

20 And could you identify this exhibit? Do you  
21 want to look at the second page as well?

22 A. My monitor is not as good as yours. I can see  
23 that it's from Dr. Dean R. Ackley, yes.

24 Q. Okay. And does it, on the first page, does it  
25 show a date in the upper right-hand corner?

1           A. It was written on May the 11th of 1977.

2           Q. And it's entitled "A Psychiatric Evaluation"?

3           A. Yes.

4           Q. Dr. Ackley is an MD?

5           A. Yes.

6           Q. If you could look at the first sentence under  
7 "history of the present illness," could you read that  
8 for the Court?

9           A. "The patient indicates that he has had  
10 episodes of rage for many years. He states that in  
11 these episodes he is aware of the action that he is  
12 taking, but cannot stop himself."

13          Q. Is that description the kind of description  
14 that you would expect in a diagnosis of organic  
15 personality syndrome or disorder?

16          A. It's consistent with either an organic  
17 personality disorder or intermittent explosive  
18 disorder, if you're going from just this alone. It  
19 would be consistent with either one. And depending on  
20 the circumstances, it might be consistent with an  
21 anti-personality disorder, depending on how old the  
22 person is who is making the statement and how far back  
23 this goes. It's all in the same ball park. What's  
24 missing here, is the specific relationship to an age,  
25 and then an age where you know something neurologically

1 significant happened.

2 Q. In forming your opinion, did you put this --  
3 these two reports, 1050 and 1052 from Dr. Hildebrandt  
4 and Dr. Ackley, together to make conclusions about your  
5 opinion in this matter?

6 A. Very much so. I thought that they were both  
7 presenting essentially the same information in slightly  
8 different ways. And neither one was specifying that  
9 there was a traumatic incident of neurological  
10 significance at the time that Mr. Leavitt was nine or  
11 ten years old, but they were very clear about how it  
12 was Mr. Leavitt said things had been for him going back  
13 a number of years. And with Dr. Hildebrandt it was to  
14 about nine or ten years old, and that was about the  
15 time from other sources, the indications that he  
16 suffered this head injury on the CT and the MRI scans  
17 is going to be shown to have resulted in a structural  
18 abnormality, and that's where it becomes significant.

19 Q. Now, looking further down in that report in  
20 the sentence that he describes intense conflict, we'll  
21 highlight that for you.

22 Now, Mr. Rosenthal asked you questions about  
23 whether it was normal sibling rivalry between the kids.  
24 Could you read that sentence beginning, "He describes  
25 intense conflict"?

1           A. "He describes intense conflict between himself  
2 and his brother, Read, who is five years younger. This  
3 intense conflict apparently dates back to the early  
4 childhood of his brother, perhaps from the time when  
5 he, himself, was about eight years of age."

6           Q. And then let's go on. Beginning, "History  
7 that he gives."

8           A. "History that he gives suggests there is a  
9 good deal of anger between a number of the siblings,  
10 but that it flares up into overt aggression or  
11 hostility characteristically with Read."

12          Q. And did you take that into account when you  
13 were forming your opinion that you wrote in your  
14 report?

15          A. Yes.

16          MR. PARNES: May I have just a moment.

17          (Pause in the proceedings.)

18 BY MR. PARNES:

19          Q. Now, Dr. Missett, you have read some materials  
20 regarding the murder in this case?

21          A. Yes.

22          Q. And that there were a number of stab wounds on  
23 the victim?

24          A. Yes.

25          Q. Would the scene and the number of stab wounds,

1 would that be consistent with the outburst, emotional  
2 outburst or rage, is that possible in this case?

3 A. Yes.

4 Q. And there is no way to know that for sure; is  
5 there?

6 A. No, I don't think there is, because it's  
7 subject to other explanations also. But certainly rage  
8 or frenzy or loss or lack of emotional control is one  
9 of those.

10 MR. PARNES: I have no further questions.

11 THE COURT: Mr. Rosenthal.

12 RE-CROSS-EXAMINATION

13 BY MR. ROSENTHAL:

14 Q. Dr. Missett, you indicated, in response to one  
15 of Mr. Parnes' questions, concerning if Mr. Leavitt  
16 suffers from some organic malady, that his prognosis  
17 within the institution might well be better because of  
18 a decrease on external stimuli, and you mentioned some  
19 things, that it's quiet and regular in the  
20 penitentiary.

21 Is that your belief, that being housed in a  
22 maximum security unit is quiet and regular?

23 A. I don't know about the particular place that  
24 he is. I have had exposure to both ranges, both where  
25 it's terribly noisy and also where it's unbelievably

1 quiet. And I don't know what the Idaho state prison is  
2 like. I have been there. I have been there a number  
3 of times, but I couldn't tell you what it's like all  
4 day long.

5 Q. And you're aware that during his years he has  
6 not been treated with any psychopharmacological drugs  
7 or medication to calm him in any way?

8 A. I saw no indications of that.

9 Q. And also concerning Dr. Hildebrandt's comment  
10 about he was angry and wanted to be mean or got mean,  
11 in his history he only got mean, at least to animals,  
12 when no one else was around. That's indicative, is it  
13 not, of having self-control?

14 A. You don't know. You just don't know what it  
15 means in that -- Dr. Hildebrandt didn't go into it in  
16 great detail. It's just a fact of his reporting what  
17 Mr. Leavitt had told him.

18 Q. And in terms of the aggressiveness, you're  
19 aware, are you not, that Mrs. Leavitt, his mother,  
20 indicated that she let the four boys just, quote, and  
21 I'm quoting her, just fight it out? That was her  
22 parenting style?

23 A. That's consistent with what I understood was  
24 going on in the family.

25 Q. And is that indicative of someone who would

1 normally have these aggressive situations with his  
2 various siblings? This was a lifestyle; was it not?

3 A. You don't know. You just don't know from that  
4 comment.

5 Q. So, again, is it accurate, all of these  
6 diagnoses just go back to a subjective determination of  
7 what you want to emphasize to come to the conclusion  
8 that one or another might come to?

9 A. Well, I don't think that's true. I think that  
10 it's very clear you've got abnormal CT and MRI scans.  
11 You may or may not know with certainty where they came  
12 from. You do know that there was an incident at age  
13 nine or ten wherein he had a head injury in the general  
14 area of where the abnormalities appear on the CT and  
15 MRI. And you also know that other doctors had him  
16 nearly ten years later relating problems that he was  
17 having with his temper and his getting into fights and  
18 starting to exercise bad judgment to a period in time  
19 that would be close to that where this other incident  
20 or accident occurred.

21 That's a lot of information, particularly when  
22 you know something's -- something's not right with his  
23 brain, even though you may not be able to specify  
24 exactly what, and I think that's of real importance.

25 Q. But what you call an abnormality is an

1 abnormal signal that occurs as a white matter  
2 hyperintensity; is it not?

3 A. Yes. I think that we're all talking about an  
4 abnormality that is evident on a picture of the  
5 function of the structure and function of the brain.  
6 Essentially, it's more structure than it is function.  
7 But you're basically talking about an abnormality in  
8 structure and in the way in which changes evidence  
9 themselves.

10 But that's also one of the reasons why one has  
11 to be very careful to relate it to history and to  
12 location, namely, in the brain without being able to  
13 say with absolute certainty that it has to have been  
14 this incident at age ten and nothing else. The  
15 likelihood it was that incident, but a likelihood is  
16 not a certainty.

17 Q. Do I understand you correctly that you are  
18 indicating that the white matter hyperintensity is  
19 indicative of a structural defect in the brain?

20 A. No. It has to do with the way the signal is  
21 returned. That's all.

22 I mean, the word structure, though, is what  
23 you're measuring. It does have to do with the way the  
24 signals are returned, but you're taking a picture. And  
25 so it's much as if you use a camera and you point it a

1 little bit too close to the sun. You are going to get  
2 an aberration. You are going to get in your film  
3 something that's a little bit different from what  
4 you're going to see in the view finder. That's a  
5 little bit -- that's probably closer to our general  
6 experience, so it's not too much different.

7 Q. And you're aware that Dr. Beaver ordered an  
8 MRI on Mr. Leavitt in 1996; are you not?

9 A. I was told that.

10 Q. And you're aware that a radiologist who read  
11 that did not identify any deficiencies in Mr. Leavitt's  
12 brain?

13 A. In 1996?

14 Q. That's correct.

15 A. That's my understanding.

16 MR. ROSENTHAL: Nothing further.

17 THE COURT: Anything else, Mr. Parnes?

18 MR. PARNES: No, I have no further questions.

19 THE COURT: All right. Dr. Missett, you may  
20 step down. Thank you for being here.

21 THE WITNESS: Thank you.

22 THE COURT: I'm not sure I know. We were kind  
23 of jumbled up as far as the order of presentation. Is  
24 there another respondent?

25 MR. NEVIN: No. I think it's --