

1 move 2026, as long as we're --

2 THE COURT: 2026?

3 MR. NEVIN: -- dealing with Ms. Goody.

4 MR. ROSENTHAL: That's the resume. And I have
5 no objection, Your Honor.

6 THE COURT: 2026 is admitted.

7 (Whereupon, Exhibit 2026 was admitted.)

8 THE COURT: You may call your next witness.

9 MR. NEVIN: Thank you. Call Craig W. Beaver.

10 THE COURT: Dr. Beaver, please step before the
11 clerk and be sworn.

12 CRAIG W. BEAVER,

13 called on behalf of the Petitioner, having been first
14 duly sworn upon oath, was examined and testified as
15 follows:

16 THE CLERK: Please have a seat in the witness
17 stand, and please state your name and spell your last
18 name for the record.

19 THE WITNESS: Craig W. Beaver. B-, as in boy,
20 e-a-v-e-r.

21 THE CLERK: Thank you.

22 THE COURT: You may inquire.

23 MR. NEVIN: Thank you.

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1 DIRECT EXAMINATION

2 QUESTIONS BY MR. NEVIN:

3 Q. Dr. Beaver, would you tell Judge Winmill where
4 you live and what your occupation is?5 A. I am a licensed psychologist here in the state
6 of Idaho. I reside here in Boise, Idaho.7 Q. And, Dr. Beaver, would you describe what your
8 educational background is that you have pursued to
9 become a psychologist?10 A. I have a bachelor's degree in psychology from
11 the University of Oregon, with honors. I have a
12 master's and a Ph.D. in clinical psychology from Miami
13 University of Ohio. I also completed a clinical
14 internship at the VA Medical Center in San Francisco,
15 California.16 I also completed four years of additional
17 training under Dr. Lloyd Kriep, a licensed
18 neuropsychologist out of Fort Madigan Army hospital in
19 Washington.20 Q. How long have you had your Ph.D. in
21 psychology?22 A. I have had my Ph.D. since 1983, and I have
23 been licensed to practice as a psychologist since 1984.24 Q. So, in other words, 24 years you have been a
25 psychologist?

1 A. Yes.

2 Q. Would you describe the work that you have done
3 as a psychologist since you obtained your Ph.D.?

4 A. Well, when I first returned to the Boise area
5 I had been recruited by Saint Alphonsus Regional
6 Medical Center to help them establish a
7 psychology/neuropsychology consultation service, in
8 anticipation, in part, with them reestablishing a
9 rehabilitation unit. I did that for approximately
10 four years.

11 I then was recruited by Idaho Outreach
12 Rehabilitation Hospital to start an inpatient and
13 outpatient brain injury spinal cord rehab program. I
14 started that program in '87, and it was operational in
15 1988. And I continue to be the director of
16 neuropsychological services at Elk's rehab hospital.

17 Along the way, I also established a private
18 practice that involves primarily neuropsychology,
19 working with neurosurgery, neurology, rehabilitation
20 medicine, primarily evaluating and treating patients
21 with various medical conditions that affect their
22 behavior or their function.

23 And I also have a forensic practice that is
24 pretty evenly divided between criminal and civil, doing
25 a wide range of activities.

1 In addition to that I am also, in terms of
2 employment, I've been employed by the State of Idaho in
3 various capacities, also, along the way, with Health
4 and Welfare, child and family services, doing
5 evaluations of parents and families. Also, the
6 Department of Vocational Rehabilitation, looking at
7 rehabilitation, return to work issues for primarily
8 neurologically impaired individuals.

9 I've also been the consulting psychologist to
10 several drug alcohol treatment programs along the way.

11 Q. Doctor, you've referred a number of times to
12 neuropsychology. Would you explain for the record
13 briefly just what neuropsychology is, how it differs
14 from psychology?

15 A. Well, it's a specialty area and it's really
16 the study of brain behavior relationships. It's trying
17 to understand, evaluate, treat the behavioral
18 manifestations of neurological problems or changes with
19 an individual, be it emotional, behavioral, academic,
20 whatever.

21 But it's really looking at that interface
22 between how changes in neurological systems and other
23 medical systems within the body affect a person's
24 functioning and helping to deal with that.

25 Q. Are you board certified in that field?

1 A. Yes. I hold a diplomat in clinical
2 neuropsychology from the American Board of Professional
3 Psychology. I obtained that in 1992.

4 Q. I'll represent to you that Dr. Bigler of
5 Provo, Utah, has testified in the case.

6 Are you familiar with Dr. Bigler, familiar
7 with his work?

8 A. Yes, I know Dr. Bigler quite well.

9 Q. And also, that Dr. Robert Engle has testified
10 on behalf of the state. Are you familiar with
11 Dr. Engle?

12 A. Yes.

13 Q. And, finally, that we expect the testimony of
14 Dr. Daniel Martell of Newport Beach, California on
15 behalf of the state, you know, later in our hearing.

16 Are you familiar with his work, as well?

17 A. Yes.

18 Q. Is it correct that -- is it your understanding
19 that Dr. Bigler and Dr. Martell are also both
20 neuropsychologists?

21 A. Yes. Dr. Bigler also holds diplomatic status
22 in clinical neuropsychology. I think that Dr. Martell
23 is a diplomat, but I think it's in forensic psychology.

24 Q. As opposed to neuropsychology?

25 A. Yes.

1 Q. Okay. What about Dr. Engle?

2 A. I am not aware of him having any board
3 certifications, other than being a licensed
4 psychologist.

5 Q. All right. But not having a specialty in
6 neuropsychology?

7 A. No.

8 Q. All right. Now, you mentioned that you had a,
9 in part, a forensic practice. You mentioned that you
10 had done a number of things in terms of employment, and
11 I take it you've done some of these things
12 simultaneously, you know, at the same time during the
13 course of your professional practice?

14 A. Yes.

15 Q. One of the things you mentioned was forensic
16 practice. And just so we're clear, what do you mean by
17 a forensic practice?

18 A. Essentially doing clinical work that has some
19 relationship to the courts. You know, in the civil
20 arena, it's typically involved evaluating individuals
21 to look at damages, causation, things of that nature,
22 both in workers' compensation and personal injury
23 litigation. And then that deals -- I dealt with both
24 emotional and neurological issues.

25 In the criminal arena, I've done quite a

1 variety of different things that has included things
2 from psychological or neuropsychological evaluations as
3 it relates to sentencing issues, risk assessments,
4 future treatment of need, that type of thing, to
5 evaluating people for competency to proceed, things of
6 that nature. Consulting on reliability and veracity of
7 statements, things of that nature, as well as doing
8 work in capital cases, doing mitigation work.

9 Q. Let's talk about the criminal cases just for a
10 minute. Who hires you or appoints you to do your
11 forensic work in criminal cases?

12 A. Well, it varies from case to case. I'm
13 retained broadly by defense, prosecutors, judges. It
14 depends upon the case and what's being asked.

15 Q. Have you had to statistically -- or maybe you
16 have, statistically determine how many times you have
17 been hired by the defense, by -- as a court appointment
18 and also by the prosecution? Can you tell us anything
19 about the numbers in that?

20 A. Sure. In terms of broadly doing criminal
21 work, probably two-thirds of the time it's been at the
22 request of the defense counsel. And the other third,
23 probably most of it by the prosecutor, occasionally by
24 the judge.

25 In capital cases, it's almost always by the

1 defense.

2 Q. Okay. Have you published and done research?

3 A. Yes, I have published and done some research,
4 although that's probably not my long suit.

5 Q. I asked you before if you were familiar with
6 Dr. Bigler's work. Is your research and publication
7 similar in extent to his?

8 A. No. Dr. Bigler has published hundreds if not
9 thousands of articles, book chapters, books, things of
10 that nature. He's very well published.

11 Q. Now, you mentioned also that in addition to
12 your forensic practice, you actually deal with
13 patients. And would you just say that -- the settings,
14 again, in which that occurs?

15 A. Certainly. About two-thirds of my time spent
16 in any given week is actually treating patients. Now,
17 two days a week I'm at Elk's Rehabilitation Hospital.
18 And there I take care of patients, both inpatient and
19 outpatients, that have had some type of neurological
20 event that affects them. Probably head injury is the
21 most common, but I also see strokes, tumors, people who
22 have metabolic disorders, spinal cord injuries.

23 Basically, a lot of what I do is evaluate
24 them. I also supervise a multidisciplinary treatment
25 team that provides services to them. I decide -- I'm

1 responsible for deciding how long they are going to be
2 in the hospital, whether they can go back to work or
3 school, things of that nature, and so also I frequently
4 test them.

5 In my private practice, in terms of
6 neuropsychology, I'm frequently asked to evaluate
7 patients, let's say for neurology, neurosurgery where
8 they're trying to better understand why a particular
9 patient has certain complaints. Is it neurologically
10 based? Is it psychologically based? What can be done
11 about it? Things of that nature.

12 I also am the consulting neuropsychologist for
13 the St. Luke's Epilepsy Surgery Center. And in that
14 capacity we evaluate patients to see if they are a
15 candidate for neurosurgical intervention for their
16 seizure disorder.

17 And that often involves neuropsych symmetric
18 testing, in coordination with reviewing PET and MRI
19 scans, consulting with the neurosurgeons, things of
20 that nature.

21 Q. So you regularly treat patients who have brain
22 injuries?

23 A. Yes.

24 Q. Just in passing, does part of your treatment
25 of patients with brain injuries address itself to the

1 environment in which your patients live?

2 A. Very much so. For example, the rehabilitation
3 unit, historically, brain injury patients have created
4 a lot of difficulties in traditional medical units
5 because they get overstimulated very easily.

6 We very aggressively do environmental
7 management to reduce their agitation and to manage
8 their behavior without use of medications or restraint,
9 for example. In my outpatient practice, many times
10 when patients are found to have some neurological
11 dysfunction that affects them, part of the solution or
12 part of it may be direct treatment with them. Almost
13 always, part of the overall solution or management of
14 the issue is environmental management and change, as
15 well.

16 Q. Doctor, are you familiar with brain injury,
17 structural injury, organic injury, those kinds of
18 terms?

19 A. Yes. They're all terms that apply to patients
20 that have some neurological pathology that affects
21 their function. You know, we use those terms a little
22 bit interchangeably. We used to use them a lot more in
23 different ways when we had less sophisticated
24 technology. We're getting better and better at being
25 able to look at structure and structural change in the

1 brain, and so we're starting to see a little bit more
2 merging of those terms and words, but they're somewhat
3 interchangeable.

4 Q. So when we say structural injury or structural
5 change, what exactly is it that that term means to you?

6 A. Well, in the architecture of the central
7 nervous system, and primarily we're talking about the
8 brain itself, that there is some abnormality in that
9 structure. That's what we're really looking at. It
10 may be in the neuronal tracts that connect different
11 parts of the brain. It may be in the actual layering
12 of the neuro cell bodies. It just varies. But there
13 is some abnormality within the structures of the
14 system.

15 Q. We're talking now the physical tissue of the
16 brain has something wrong with it?

17 A. Yes.

18 Q. And is the same thing meant by the term
19 organic condition or organic injury, that kind of
20 thing?

21 A. Yes. The only reason I have a little bit of a
22 qualifier on there is that historically in the past we
23 have not always had as detailed of imaging and, for
24 example, radiologic studies that we have today. So in
25 the distant past, we sometimes suspected that there was

1 structural abnormalities. We could measure or evaluate
2 some of their outer manifestations in terms of the
3 patient's behavior, conduct, cognition, affect, things
4 of that nature, but we didn't have fine enough
5 instruments to actually tell us where the structural
6 changes were occurring.

7 As the technology has gotten more
8 sophisticated, we have gotten much better at
9 recognizing smaller but significant structural changes
10 in the system.

11 Q. And, Dr. Beaver, I will represent to you that
12 the timing of these things is something that Dr. Bigler
13 commented on during his testimony.

14 Are you -- let me ask whether you -- it is
15 within your area of expertise to comment on the
16 contents of the MRI scans which are present in this
17 particular case?

18 A. Well, two parts to that. I mean, certainly in
19 the course of my clinical practice and my training, I
20 certainly have training and experience of when
21 abnormalities are noted on, say, an MRI scan,
22 considering how that may affect the person's behavior
23 or function in either assessing that or treating that.
24 And so in that regard, I frequently utilize MRI scans
25 and reports. I often, for example, with more severe

1 injured patients, will review the MRI scans of the
2 patient with the family to help them understand what's
3 going on.

4 On the other side of the coin, I don't
5 consider myself having expertise to interpret an MRI
6 scan. While I have certainly looked at many of them,
7 I'd be hesitant to call myself an expert in that field.

8 Q. Well, Doctor, I asked you to become involved
9 in Mr. Leavitt's case, and when was that and what did I
10 ask you to do?

11 A. Well, most recently my involvement with
12 Mr. Leavitt was in '06. I first saw him in January
13 of '06 and then saw him again in March of '06. I
14 previously had also seen Mr. Leavitt back in '95 and
15 '96.

16 Q. And what was your understanding of the reason
17 for your involvement in the case?

18 A. There were concerns about several issues. One
19 was whether or not there was some organic basis to
20 better understand his behavior and conduct. Also, to
21 look at psychological or psychiatric issues that may be
22 relevant in his case.

23 Q. And, Dr. Beaver, we've put your report into
24 evidence already. Well, very possibly I misremembered.
25 I don't think your report actually refers specifically

1 to the items that you've reviewed, so -- prior to
2 giving your testimony today, so let's just talk about
3 that briefly.

4 First, have you had occasion to meet with,
5 examine Mr. Leavitt himself?

6 A. Yes, on a number of occasions.

7 Q. Just describe that, if you would.

8 A. In '95 and '96, I met with him on three
9 different occasions, interviewing him at the maximum
10 security facility outside of Boise.

11 Then again in '06. I also met with him again
12 in January and March of '06.

13 Q. And what did those meetings consist of?

14 A. Primarily going through history and
15 information gathering from him. Also, he underwent
16 testing both in '95, '96 and in '06.

17 Q. Could you describe that testing in general?

18 A. Certainly. Did testing to look at general
19 intellectual skills and abilities, did testing to look
20 at his ability to pay attention to things, his language
21 skills, memory abilities, problem solving skills,
22 things of that nature.

23 Q. Did you also review the reports, police
24 reports, psychological reports, papers -- papers of any
25 kind related to the case?

1 A. I have quite a box of paper on Mr. Leavitt
2 that ranges anywhere from some educational records to
3 various treatment records where he has been seen at
4 local hospitals or care providers. I've seen
5 psychological records on him where he's been evaluated
6 by a number of different individuals in the past, as
7 well as the present. I've reviewed CT and MRI scans
8 and EEGs relating to Mr. Leavitt. I've reviewed
9 multiple transcripts from various hearings related to
10 Mr. Leavitt. I reviewed a limited amount of police
11 investigative records related to him and this specific
12 instance that he's here in court for today, as well as
13 prior legal history. I've reviewed the work of Mary
14 Goody in her information gathering and interviews with
15 various individuals and families. Quite a bit of
16 material.

17 Q. Have you reviewed the reports of
18 Drs. Hildebrandt, Laible, Ackley, Gordon, Groberg, and
19 Jaynes?

20 A. Yes.

21 Q. And you've written a report yourself?

22 A. Yes.

23 Q. And have you reviewed the reports, the more
24 recent reports written by other psychologists and
25 physicians, namely, those of Drs. Missett, Anderson,

1 Engle, Martell, and Bigler?

2 A. Yes.

3 Q. And have you reviewed the reports of MRI scans
4 performed in 2006 and in 1996?

5 A. Yes.

6 Q. And have you reviewed the report of a CT scan
7 done on December 13th of 1985?

8 A. Yes.

9 Q. Beyond the materials that I referred to
10 specifically and that you've referred to generally, are
11 there other categories or specific materials that
12 you've reviewed that we haven't talked about?

13 A. No. I think that's pretty inclusive.

14 Q. Okay. Now, Doctor, based on your training and
15 experience and on reviewing the materials you've
16 described, have you arrived at some conclusions about
17 Mr. Leavitt's psychological condition over time?

18 A. Yes.

19 Q. Okay. Well, I want to ask you to express
20 those opinions, but I think we'll just proceed in a
21 certain order here. And let me begin by asking you
22 about the testing that you did. And I'll point you
23 to -- and I think I might well -- give me a minute and
24 I'll actually see if I can produce this on the screen
25 for you.

1 I'll just ask you if you have -- do you, by
2 any chance, have your report, Exhibit 1056, in front of
3 you?

4 A. Yes, I do.

5 Q. All right. And I'd just ask you to turn to
6 page 2 of that report. And down at the bottom of
7 page 2, there is a paragraph that begins clinical
8 summary, or heading that begins clinical summary. And
9 I'm going to direct you to paragraph one of that and
10 ask you if you would just read that first sentence,
11 please.

12 A. "Neuro psychometric testing conducted on
13 Richard Leavitt on 3/20/06 and 3/21/06 found no
14 significant cognitive deficits. The tests were
15 completed in a cooperative straightforward manner
16 without evidence of exaggeration or defensiveness."

17 Q. Doctor, I just wanted to ask you about the
18 statement that you had found no significant cognitive
19 deficits. Could you explain what that means?

20 A. Well, in looking at the areas that you had
21 asked me about earlier, like attention and
22 concentration, language communication, visual
23 perception, visual/spatial skills, memory, problem
24 solving, sustained attention, those areas, his
25 performance on a number of tests that measured those

1 skills and abilities were well within normal limits.

2 Q. Is there a difference between cognitive and
3 emotional or behavioral deficits?

4 A. Yes.

5 Q. What was the difference?

6 A. Well, cognitive means one's thinking skills
7 and abilities as we traditionally think of, things like
8 being able to concentrate, being able to speak clearly,
9 being able to learn and remember new information, being
10 able to problem solve. Those are things we refer to as
11 cognition. Behavior is the actual actions of the
12 individual in their environment.

13 Affect would be another dimension. Sometimes
14 it's shown behaviorally or it may be communicated
15 verbally as an internal process. But affect is another
16 domain or dimension that one looks at.

17 Q. Does the kind of testing that you did and that
18 neuropsychologists do in general measure
19 behavioral/emotional deficits by comparison to
20 cognitive deficits?

21 A. Well, the testing is designed to look at
22 cognitive issues or cognitive deficits. And while
23 there can be a correlation between cognitive deficits
24 that you find on the exam and behavioral or emotional
25 deficits that you observe with the individual, they are

1 not the same things.

2 So you're evaluating cognition. You may make
3 statements about behavior and affect, but you're making
4 them as an extension of looking at the test results,
5 rather than the tests actually measuring behavior or
6 emotion.

7 Q. So you're saying your tests don't get directly
8 at behavioral/emotional issues. They get directly at
9 cognitive issues, and then you make inferences maybe
10 about behavior and emotion from what you know about the
11 cognitive issues?

12 A. Yes.

13 Q. Why is it that your testing doesn't get at
14 behavioral/emotional issues directly?

15 A. We don't really have a good way of testing
16 that. I think you would have to -- and some of this
17 may be possible. You would have to be able to
18 construct various scenarios, place the person within
19 that context and observe their behavior and actions,
20 for example, as a way to do that.

21 There actually is some interest in trying to
22 develop those kinds of protocols. Actually, we are
23 starting to do it with driving, for example, different
24 kinds of three-dimensional simulated driving to
25 evaluate those kinds of issues with patients that have

1 difficulties. But as of yet, we are still not very
2 good at doing that.

3 Q. Well, let me ask you this. Emotional
4 regulation or dysregulation can arise -- is it possible
5 for emotional regulation or dysregulation to arise out
6 of brain injury?

7 A. Very much so.

8 Q. And what areas of the brain would you expect
9 to give rise to emotional -- problems with emotional or
10 behavioral dysregulation?

11 A. Well, there are many areas of the brain that
12 can produce that kind of problem. The area that we
13 most associate with that is the frontal cortex or the
14 more interior parts of the brain and the neuro pathways
15 that connect the frontal part of the brain with other
16 parts of the brain. That's probably your primary area.

17 Probably the secondary areas and the more deep
18 limbic or more primitive structures of the brain that
19 gives the drive behind some of those or the drive
20 behind the energy, if you will, in some of those affect
21 responses, that would be the secondary area.

22 Q. Is that more -- is that isolated, or is it
23 focused more in one hemisphere as opposed to the other?

24 A. Well, we know that the right and the left
25 hemispheres play different roles in this process. We

1 know that, for example, the left hemisphere is
2 sometimes much more associated with some of our more
3 logical analysis, you know, labeling of our emotions,
4 things of that nature.

5 We think of the right frontal area as more
6 involved with regulation of affect, more involved with
7 what I would call non-verbal or pragmatics of behavior
8 and emotion, you know, reading the queues in one's
9 environment, verbal or non-verbal, that kind of gut
10 response kinds of phenomena that people will sometimes
11 talk about, that we think is more regulated in that
12 right hemisphere in the front.

13 Q. And just to interrupt you, having reviewed the
14 results of the 2006 MRI, the 1996 MRI and Dr. Bigler's
15 report, do you have an understanding about where the
16 brain abnormalities with respect to Mr. Leavitt reside?

17 A. Well, in the '96 and the '06 MRIs, it was
18 predominantly in that right frontal region, somewhat
19 inferior orbital area.

20 Q. So that's the area that you're referring to as
21 being connected with emotional dysregulation?

22 A. It's an area that's, yes, that we think is
23 very much involved with emotional regulation.

24 Q. And then you said that the left brain would be
25 more connected with things like language or logic,

1 those sorts of things?

2 A. Yes.

3 Q. Now, the testing that you do, does it use
4 language?

5 A. Yes.

6 Q. So, in other words, you have a person, you ask
7 a person questions using words and you communicate with
8 the person to ask for responses; is that right?

9 A. Predominantly. We certainly have some
10 non-language based tasks, but predominantly language is
11 a mediating factor in the testing.

12 Historically, if you look at the neuro
13 psychometric literature that looks at testing and the
14 research, particularly in the last few years, that
15 looked at our ability to tap or evaluate certain areas
16 of the brain and their function, the right frontal area
17 is probably the area that we're least able to access
18 because it is predominantly a non-verbal kind of a
19 gestalt processing we think that goes on more in that
20 area, which is much more difficult for us to assess.

21 We have had a number of tests in the past.
22 But we thought maybe tapping into that area, but some
23 of the more PET scan research has shown that actually
24 we are not very good at tapping that area.

25 Q. And so the portion of your report that you

1 read previously that said that you didn't find
2 cognitive deficits, I'll just ask you directly, does
3 that mean that Mr. Leavitt did not have deficits in
4 emotional or behavioral control?

5 A. No.

6 Q. Now, we've been using for the last few minutes
7 the term behavioral/emotional control or dyscontrol.
8 Would you describe for Judge Winmill what those terms
9 mean to you?

10 A. Well, you know, when a person has an
11 experience and they react to something emotionally,
12 there's a certain pattern of different areas of the
13 brain that you will light up and are connected via
14 pathways, and how that experience occurs and how that
15 experience manifests itself.

16 And in talking about this particular process
17 in the right frontal area, this is that a person may
18 have some initial response to an event, an emotional
19 event, but both the intensity of the response, the
20 amount of affective energy, if you will, that gets
21 generated, oftentimes the type of emotion that gets
22 generated, and then how the person responds
23 behaviorally in their environment to that emotion is
24 regulated.

25 And as we move through life, and especially by

1 late adolescence, early adulthood, the frontal lobes
2 are the structures that are essentially wired into
3 place to mediate, monitor this whole process.

4 So, in a sense, you know, the initial spark,
5 if you will, travels up the wire to the frontal cortex
6 that then helps interpret it, helps decide what affect
7 should be presented and how it's going to manifest
8 itself behaviorally.

9 And so in that way it acts as a governor or a
10 mediator on those emotions and that emotional response.

11 Q. What does -- when you use the term
12 dysregulation, what does that refer to?

13 A. Just simply that that mechanism for governing
14 that affective response in all the ways I just talked
15 about doesn't work very well. It doesn't, in fact,
16 modulate. There is less processing of it. There is
17 less moderating what the intensity should be. There is
18 less discriminating about what the appropriate affect
19 might be. And there is certainly less control of what
20 the behavioral action might be that would be produced
21 by that emotional feeling or response.

22 Q. Well, then, let's turn to the -- back to the
23 two MRIs, 2006 and '96, and the CT scan of 1985. And
24 I'll just represent to you that Dr. Bigler testified
25 that these indicated damage to the white matter tracts

1 of Mr. Leavitt's brain.

2 Let me ask, to begin with, do you agree with
3 that?

4 A. Yes, from everything I've seen, although I
5 refer to Dr. Bigler.

6 Q. Given that, and accepting that these represent
7 injuries, do you consider that the location of the
8 injuries is important?

9 A. Well, it's important particularly in trying to
10 understand how it could affect a person.

11 Q. And you know the locations of these injuries
12 in Mr. Leavitt's case. Do you think that the location
13 of those injuries is -- does it say anything about his
14 behavior and his diagnoses?

15 A. Well, just like we've talked before, they are
16 in an area of that right frontal cortex, particularly
17 the more inferior section that we know is very much
18 involved with mood, emotional behavior regulation. And
19 so those are the kinds of difficulties that you would
20 hypothesize would be affected by that type of
21 structural pathology.

22 Q. Okay. Now, we've had some discussion, lots of
23 discussion in the reports and a fair amount of it
24 during the testimony so far about intermittent
25 explosive disorder.

1 First, you're familiar with this discussion?
2 Or are you, from reading reports and so on?

3 A. Yes. That's been a possible diagnosis for
4 Mr. Leavitt way back in '77, I believe.

5 Q. Okay. First, the area of the injury to
6 Mr. Leavitt's brain, does that say anything about the
7 likelihood or non-likelihood that he suffers from
8 intermittent explosive disorder?

9 A. Yes, it does have value in trying to make that
10 distinction.

11 Q. And how is that?

12 A. Well, interestingly, two different things. On
13 the one hand, if we think about that structural
14 abnormality being an area that's involved with mood or
15 emotional regulation, you would expect that person to
16 show a lot more emotional behavioral outbursts or
17 sometimes some of the explosiveness or angry acting out
18 behavior that is associated with the diagnosis of
19 intermittent explosive disorder or the earlier
20 diagnosis of explosive personality.

21 On the other side of the coin, the DSM
22 manuals, and IV-TR, which is the one that is in place
23 right now, for example, are very clear in talking about
24 that it's important, when you're considering a
25 psychiatric diagnosis, that you rule in or rule out

1 whether, in fact, this behavior that you're observing
2 to make the diagnosis is caused by some underlying
3 neurological or medical phenomenon, because if that is,
4 in fact, the case, it argues that then that diagnosis
5 or labels of those behaviors should not be applied.

6 And so, yes, you may have many of the
7 behaviors that would result when you're considering
8 that diagnosis. But because there is an underlying
9 organic cause, that takes it out of the realm of making
10 a mental health diagnosis.

11 Q. And when you say out of the realm of being a
12 mental health diagnosis, what does it put it into the
13 realm of?

14 A. Well, it's a neurological phenomena. They do
15 allow for that in the DSM-IV under personality change
16 due to medical condition in the DSM-IV, where in the
17 old DSM-III it used to be organic personality disorder.
18 But those terms then clearly denote that there is an
19 organic cause to the behavior that you are observing.

20 Q. Does Mr. Leavitt, in your opinion, have a
21 disorder that relates to explosion -- to behavioral
22 explosions?

23 A. Yes, I believe he does.

24 Q. And what is that?

25 A. Well, I think that the personality chain

1 signaled medical condition is quite appropriate for
2 Mr. Leavitt, which says, on the one hand, yes, we're
3 seeing behavior abnormalities with him, but there's
4 evidence of an organic cause for those difficulties.

5 Q. Now, if you see the explosions, but you don't
6 see an organic cause for it, then where do you go?

7 A. Then you would look back more at intermittent
8 explosive disorder or a possible impulse control
9 disorder and otherwise specify.

10 Q. Is this, is what you see in Mr. Leavitt's
11 history -- I guess I would ask it this way.

12 Do you see in Mr. Leavitt's history incidences
13 of emotional dysregulation?

14 A. Yes.

15 Q. And what are you referring to?

16 A. Well, I mean, there is quite a bit of history
17 here ranging anywhere from earlier in his early school
18 years in some of the interviews with family. For
19 example, they talked about him being excessively
20 active. You know, they considered him possibly having
21 attention deficit hyperactive disorder, for example.
22 That's a good example of that kind of behavioral
23 dysregulation.

24 You know, as he moves into adolescence, we see
25 acting out behaviors that are not well controlled. You

1 know, we see him engaging in what I would call angry
2 acts on a frequent basis that are inappropriate,
3 whether it's, you know, treatment of animals or whether
4 it's getting into fights or things of that nature.

5 Q. Dr. Beaver, you've read Dr. Martell's report,
6 I think?

7 A. Yes.

8 Q. And Dr. Martell has not testified yet, but
9 you're aware that Dr. Martell does not agree that
10 Mr. Leavitt was appropriately diagnosed with
11 intermittent explosive disorder; is that correct?

12 A. Yes.

13 Q. And are you aware that Dr. Martell refers to
14 an incident occurring when Mr. Leavitt was about
15 18 years old in which he confronted, assaulted a couple
16 of kids there in Blackfoot?

17 A. Yes.

18 Q. And Dr. Martell points to certain features of
19 that incident as indicating that Mr. Leavitt did not
20 suffer -- that that was not a traditional explosion in
21 the way that we normally -- that we normally think of
22 this in this context. Is that correct, generally?

23 A. Yes.

24 Q. Have you looked at that incident, as well?

25 A. Yes.

1 Q. Do you agree with Dr. Martell about that?

2 A. Well, in several ways, yes, in that in terms
3 of just -- well, first of all, it's important to
4 understand that when we talk about intermittent
5 explosive disorder, it doesn't mean that people also
6 don't have other times when they're just being angry
7 and inappropriate and have some control about their
8 actions.

9 What intermittent explosive disorder means is
10 that they do have a number of incidences in which their
11 affective reaction, typically anger, is out of context
12 and out of proportion to the circumstances. It doesn't
13 mean that you can't have other instances where you're a
14 little bit more controlled. So that's the first thing.

15 Secondly, in this case, that I think that
16 Dr. Martell is right in the sense that if you look at
17 the police record and talk with Mr. Leavitt about what
18 happened, you know, he wasn't, you know, a wild man
19 completely out of control in terms of some of the
20 things that happened.

21 And so that does cut that way in terms of
22 Dr. Martell's conclusions. But what is interesting,
23 when you talk with Leavitt about it and as it's talked
24 about by others, is that clearly, though, talks about
25 what I would link to as an emotional dysregulation. He

1 talks about -- and he talks about this in some other
2 places, as well, where things just click and he -- he
3 describes himself as, "I start feeling mean. I feel
4 angry. I don't" -- you know, he talks about it in a
5 almost depersonalized way where he's outside of himself
6 when he has these experiences. He talks about it that
7 way with these two boys, for example.

8 So, behaviorally, there is some control. But
9 affectively, when you are talking to him, there is very
10 much the sense of an immediate affective reaction that
11 then leads to inappropriate behavior and actions.

12 Q. I am going to show you what has been marked as
13 Exhibit 1050. And just -- it should be on your -- it
14 should be on the screen now. And we will just
15 represent to you that this is Dr. Hildebrandt's
16 evaluation from December of 1976.

17 And, Dr. Beaver, I'll -- do you see the date
18 there?

19 A. Yes.

20 Q. And it's somewhat cut off down here at the
21 bottom, but does that appear to be Dr. Hildebrandt's
22 report?

23 A. Yes.

24 Q. And I'm going to direct your attention to a
25 portion of this first paragraph, and is it your

1 understanding that this is describing this incident we
2 were just referring to?

3 A. Yes.

4 Q. And this is a report that was prepared, I
5 guess, in response to perhaps around the sentencing
6 associated with that incident?

7 A. Yes.

8 Q. Now, I wanted to direct your attention to this
9 sentence that begins "he chased," and I want you to
10 read down through where it talks about him being nine
11 or ten years old. Would you read that, please?

12 A. "He chased and caught them. He had both of
13 them undress from the waist down so that one of them
14 would not run away while he was beating the other one.
15 Rick explained this incident by stating that, 'I just
16 all of a sudden get this urge to be mean to someone or
17 something.' He remembers first having these feelings
18 when he was nine or ten years old."

19 Q. Okay. Now, just to return to the testimony
20 you were giving a minute ago, this part about him
21 chasing them and catching them, undressing them from
22 the waist down so that one of them would not run away,
23 and Dr. Martell refers to that as kind of goal directed
24 behavior that suggests planning and it doesn't suggest
25 being out of control, that's what you were referring to

1 previously; correct?

2 A. Yes.

3 Q. Okay. But then if I understand, you're
4 saying, you go on to that next sentence, and what do
5 you get from that next sentence -- those next two
6 sentences, actually?

7 A. I think that that's what we're talking about
8 when we talk about that emotional dysregulation.

9 Q. But then directing your attention to the next
10 sentence where it says "...he started having these
11 feelings when he was nine or ten years old."

12 Doctor, we have his birth certificate in
13 evidence and I'll represent to you he was born in 1958.
14 This is an evaluation that's occurring in 1976. So
15 that would make him 18 years old; right?

16 A. Yes.

17 Q. Do you know of any events that occurred at
18 about the time that he's nine or ten years old that
19 might be important in this case?

20 A. Well, as best as we can place it, this whole
21 sledding accident where he had the head injury occurred
22 shortly before that period of time.

23 Q. Of course, this is now 1976. We are talking
24 30 years ago. This was 30 years ago that he was making
25 this reporting; correct?

1 A. Yes.

2 Q. Well, Dr. Beaver, you were asked to comment on
3 the question of whether Mr. Leavitt's -- Mr. Leavitt
4 suffers from intermittent explosive disorder, as well,
5 and I think you -- would it be correct that you agree
6 with Dr. Engle and Dr. Martell that he does not, that
7 that's not the correct diagnosis?

8 A. Yes.

9 Q. But you arrive at that conclusion in a
10 different way; right?

11 A. Yes, best as I can tell by looking at the
12 reports.

13 Q. And would you explain that for Judge Winmill,
14 please?

15 A. Well, primarily I think that Mr. Leavitt does
16 have many of the behavioral manifestations that you'd
17 see with people that get the label of intermittent
18 explosive disorder; not that there can't be some
19 controlled anger outbursts, as we just talked about,
20 but there are many other aspects of his history that
21 are suggestive of that.

22 However, if you review the diagnostic
23 criteria, as we talked about earlier, the key is
24 whether or not that problem behavior, if you will,
25 arises because of some psychological problem or

1 inadequacy versus arises from an organic problem.

2 And in this case I think that we have evidence
3 that, in fact, Mr. Leavitt does have an organic
4 problem, and in particular it's in an area of the
5 system that causes emotional dysregulation. That would
6 fit with what we know about his history. And,
7 therefore, that would exclude those diagnostic
8 considerations.

9 Q. Well, let's turn to that question of brain
10 injury for just a few moments then.

11 First, I will remind you or I'll represent to
12 you that Dr. Engle, in his report, stated that he
13 thought it was exceedingly unlikely that Mr. Leavitt
14 had any kind of structural brain injury, and he
15 conceded on cross-examination that we now know, based
16 on the MRIs, that that was incorrect.

17 Do you agree with that?

18 A. Yes.

19 Q. And, second, he thought it was very unlikely
20 that the injury, if there was one, which he thought
21 there wasn't, but that if there was one he thought it
22 was very unlikely that any injury would have been
23 caused by trauma. Do you recall that from his report?

24 A. Yes.

25 Q. Now, I will represent to you, as well, that

1 Dr. Bigler testified that white matter hyperintensities
2 such as are found in Mr. Leavitt's brain can be caused
3 by a number of factors.

4 First, do you agree with that?

5 A. Oh, yes. Many things can cause it.

6 Q. And Dr. Bigler mentioned premature birth,
7 childhood hyperactivity, traumatic head injury,
8 inhalation of paint fumes, among many others.

9 Do you agree with that?

10 A. Yes.

11 Q. Now, I will represent to you, as well, that
12 Dr. Bigler testified that from looking at these white
13 matter hyperintensities that are present in
14 Mr. Leavitt's brain, that you can't say with certainty
15 what caused them. Do you agree with that?

16 A. Yes.

17 Q. He also testified, I will represent to you,
18 that irrespective of what causes the white matter
19 hyperintensities, that they have a particular impact on
20 the functioning of the brain. Do you agree with that?

21 A. Yes.

22 Q. And there has been some testimony about the
23 presence or absence of hemiacidrin staining in these
24 white matter hyperintensities.

25 I'll represent to you that Dr. Bigler

1 testified that if hemiacidrin staining is present, you
2 can say conclusively it was caused by trauma, head
3 injury. But in its absence, it just makes it
4 impossible to say. It's still possible that it's
5 caused by trauma, but you just can't say that
6 conclusively.

7 Is this within the area of your expertise, and
8 if so, do you agree with Dr. Bigler?

9 A. Well, first of all, I would say that in terms
10 of the neurobiological issues that Dr. Bigler is
11 talking about, I have some familiarity with that area.
12 But it is clearly a very technical area, and I would
13 defer to Dr. Bigler.

14 Q. Okay. Now, I just want to ask you whether you
15 looked at or gave consideration to records describing
16 Mr. Leavitt's behavior in prison over the last
17 22 years?

18 A. Yes, I have reviewed those records.

19 Q. And generally speaking, what do they show?

20 A. Well, certainly for the last 17 years in
21 particular, he's done quite well. You know, as you may
22 be aware, he is one of the few prisoners on this
23 particular unit that has now been able to have
24 employment, be out of his cell to do those work
25 activities, things of that nature. He has done very

1 well in the system.

2 Q. Do you consider that to be diagnostically an
3 important factor?

4 A. Yes, I think it does have diagnostic value.

5 Q. Why?

6 A. Well, from what we know, first of all, with an
7 emotional dysregulation disorder that is organic in
8 nature, people are very dependent in the sense on
9 what's occurring in their environment because they are
10 essentially responding in a dysregulated, inappropriate
11 way to stimuli in their environment, okay?

12 So if that's what's driving the behavior,
13 reaction to stimulus in their environment that has been
14 not well regulated, if he'd modified that environment
15 so there aren't those stimuluses to trigger that
16 dysregulated behavior, then you should see a
17 significant decline in those behavioral outbursts or
18 problems.

19 If, on the other hand, the angry, acting out
20 behavior is driven because of some psychological need,
21 you know, the need to intimidate others and to
22 experience some positive rewards from that experience,
23 this type of thing, then being in a controlled
24 environment isn't going to do anything to satisfy that
25 basic psychological need that drives the behavior. And

1 there's, unfortunately, I think we're all aware, there
2 are certainly some inmates on that confined unit that
3 have found many ways to be very intimidating to other
4 inmates. We don't have that history or trying to be
5 intimidating with the correctional officers. We don't
6 see that history with Mr. Leavitt.

7 Q. And to be clear, the absence of that history,
8 does it make it more likely or less likely that
9 Mr. Leavitt's behavior is organically based as opposed
10 to personality driven?

11 A. Well, I think it's most consistent with the
12 organic-based driven emotional dysregulation.

13 Q. Let's turn to the diagnosis of antisocial
14 personality disorder. And I will represent to you that
15 Dr. Engle testified that if organic features are
16 causing or in play in the behaviors, that the diagnosis
17 of antisocial personality disorder is not appropriate.

18 Do you agree with that?

19 A. Yes.

20 Q. Why is that?

21 A. Again, you're looking at what is driving the
22 behavior, the behavioral difficulties that you're using
23 to make that diagnosis. Antisocial personality
24 disorder is a diagnosis in the DSM-III or the DSM-IV.
25 It's predominantly based on behavior, what things you

1 see in their behavior.

2 And so if you're assuming that it's a
3 personality disorder, there are certain assumptions
4 that that behavior is being driven by some
5 psychological inadequacies or aberrant need --
6 psychological needs.

7 When we think that behavior comes about
8 because of an organic factor that is outside of the, in
9 a sense, volitional control or regulation of the
10 patient, then that puts it in a different realm all
11 together.

12 And so that's why, if you look at the DSM-III
13 or the DSM-IV, you don't make that diagnosis if you
14 think that behavior that you're seeing is a product of
15 or sufficiently caused by an organic factor such as an
16 organic brain syndrome we're talking about here.

17 Q. Doctor, I'll represent to you that Dr. Engle
18 concluded that Mr. Leavitt is not a psychopath and he
19 does not meet the definition of psychopath using the
20 Hare diagnostic checklist. Do you agree with that?

21 A. Yes.

22 Q. Is that important for making predictions about
23 Mr. Leavitt's future?

24 A. Yes.

25 Q. And why is that and how?

1 A. Because much of the research, in fact most of
2 the research that has been done looking at the issue of
3 psychopathy, and psychopathy is a mediating variable in
4 terms of understanding bad acts, and also, in
5 particular, understanding risk assessment in different
6 situations and adjustment.

7 Psychopathy is a very powerful factor. You
8 know, people that are psychopaths, for example, are one
9 of the categories that are -- that substantially
10 increases their risk of, for example, within a
11 correctional setting causing difficulties, either
12 posing a risk to the correctional officers or other
13 inmates, things of that nature.

14 And so it has a lot of value in that
15 predictive sense, and it is distinct from antisocial
16 personality disorder.

17 Q. Thank you.

18 Doctor, you have reviewed the 1985 CT scan
19 report?

20 A. Yes.

21 Q. And also the '96 and 2006 MRIs?

22 A. Yes.

23 Q. And looking at the 1985 CT scan, do you recall
24 what that scan showed, what the symptoms -- I mean, I'm
25 sorry, what features it referred to?

1 A. Well, there were two sets of things. There
2 was one particular area that's more associated with the
3 left hemisphere where they noted some volume loss. And
4 then there also was noted volume loss in the frontal
5 cortex as a whole, suggesting atrophy.

6 Q. And what's your understanding of Mr. Leavitt's
7 age at the time of the 1985 CT scan?

8 A. He was, I think, in his mid 20s, I think,
9 about then.

10 Q. Born in '58. '85.

11 A. Right. So he would have been -- I am not very
12 good at my math today, but about 27.

13 Q. Yeah, about 27.

14 Do you have an opinion, based on the findings
15 that appeared in 1985 at age 27, also in 1996 at age
16 38, and here more recently in 2006, age 48, as to
17 whether these brain abnormalities have existed over
18 time?

19 A. Certainly it would appear to be the case.

20 Q. Finally, Doctor, I'll represent to you that
21 Dr. Engle, in his report, refers to cautions that
22 appear in the DSMs, stating that a diagnosis of persons
23 coming within particular disorders in the DSM does not
24 equal, is not the same as particular legal kinds of
25 areas or considerations, and he has a portion in his

1 report that speaks to that.

2 Are you familiar with that part of his report?

3 A. Yes.

4 Q. And I wanted to direct you to page 3 of your
5 report, in paragraph 4. And I won't put it up on the
6 presenter, but I just wanted to direct your attention
7 to the last sentence of that which says:

8 "Clearly, individuals suffering from this
9 condition, referring to explosive disorders, have
10 diminished capacity to control their actions and
11 behaviors at times."

12 Does any of the aspects of the DSM, the
13 cautions contained in the DSMs that Dr. Engle refers
14 to, does any of that change your statement contained
15 there in that report?

16 A. No. I mean, I think that Dr. Engle is
17 correct. Just because you have a psychiatric label
18 doesn't necessarily mean that that has relevance in
19 looking at your criminal proceedings, in whether it's
20 the guilt phase or the sentencing phase. What's
21 important is to understand the person's behavior, where
22 it came from, how it occurs. And in this particular
23 case, it's important to understand what the level of
24 control is for that individual, or the willfulness,
25 which is something that's, you know, a dimension that's

1 considered in our laws.

2 MR. NEVIN: Dr. Beaver, thank you. I don't
3 have any further questions.

4 THE COURT: Let's go for a few minutes before
5 we take the morning break.

6 CROSS-EXAMINATION

7 QUESTIONS BY MR. ROSENTHAL:

8 Q. Dr. Beaver, good morning, first of all.

9 A. Good morning.

10 Q. You examined Mr. Leavitt in November and
11 December of 1995, as well as in January of 1996; is
12 that correct?

13 A. Yes.

14 Q. What tests did you give him during those
15 evaluations?

16 A. In 19 -- in the testing that was done in '95
17 and '96 --

18 Q. And I'm not speaking to your 2006 March 20th
19 and 21st testing.

20 A. Right. I'm just pulling it up. Did the Wide
21 Range Achievement Tests, Third Edition; Trial Making
22 Test; Wechsler Limit Skills Tests, revised; Wechsler
23 Adult Intelligence Scale, Revised; Boston Naming Test;
24 Controlled Oral Word Fluency Test, Stroop Test, Rey
25 Auditory Verbal Learning Test; Pen Test; Rey 59 and

1 Memory Test; Wisconsin Card Arranging Test; effect
2 depression inventory, the Millon clinical multi-axle
3 inventory, I believe it was the second edition at that
4 time. The Minnesota Multi-phasic Personality
5 Inventory, Second Edition.

6 I'm looking to see if there are any others
7 that I haven't mentioned. Also, he was given the
8 Rorschach Inkblot Test at that time. I believe that's
9 it.

10 Q. And what reports did you generate, sir, as a
11 result of those exams and those tests?

12 A. As best as I can remember, I didn't generate a
13 report.

14 Q. Did you have verbal communication with --
15 well, first of all, who asked you to do those tests and
16 do that evaluation?

17 A. Well, I think originally, to be honest, I
18 can't remember. And part of my file was purged, so I'm
19 not completely certain if it was Mr. Nevin and
20 Mr. Parnes then or if it was somebody else who was
21 representing him.

22 Q. And have you kept the details of those tests,
23 the scorings, the actual results and such?

24 A. Yes, I have all the test protocols.

25 Q. And did you come to some diagnosis as a result

1 of those 1995 and January '96 tests?

2 A. Yes.

3 Q. And what diagnosis did you give to either
4 Mr. Parnes or Mr. Nevin, if they're the ones you gave
5 them to?

6 MR. NEVIN: Well, Your Honor, I object to the
7 form of the question to the extent that it addresses
8 the communication. No objection to him stating what he
9 arrived at.

10 THE COURT: Well, Counsel, are you saying it's
11 work product? Is that --

12 MR. NEVIN: I guess I would say relevance,
13 Your Honor. The relevance that it was communicated to
14 me or Mr. Parnes.

15 THE COURT: Well, if he has an opinion or a
16 diagnosis, regardless of how it was communicated or to
17 whom, it seems to me it's relevant.

18 MR. NEVIN: I agree with that. I focused only
19 on the part about communication to me or Mr. Parnes.

20 THE COURT: Let's rephrase the question,
21 Mr. Rosenthal.

22 MR. ROSENTHAL: Thank you, sir.

23 BY MR. ROSENTHAL:

24 Q. What diagnosis did you come to at that time,
25 Dr. Beaver?

1 A. Well, in the cognitive testing I didn't see
2 evidence of significant cognitive deficits, although I
3 had, at the time that I did the testing I was looking
4 to see if there was some issues of organicity given his
5 history and his behavior. But I didn't find cognitive
6 difficulties on exam.

7 I did -- I was at that time involved, I think,
8 with recommending that they do some further
9 neurological study of Mr. Leavitt to explore that
10 hypothesis further.

11 Q. And, in fact, on the basis of that, was
12 another MRI conducted?

13 A. Yes.

14 Q. And that MRI was apparently evaluated and came
15 back with nothing identified at that time; was it not?

16 A. The neuroradiologist that reviewed those scans
17 concluded that there was not significant abnormalities,
18 although since that time it has been re-reviewed and
19 abnormalities were found to be present.

20 Q. I realize that. But at that time, neither you
21 nor the radiologist found any abnormalities?

22 A. Correct.

23 Q. In your report, Doctor, I believe it's on page
24 3, paragraph 3 -- and go ahead, get your drink of
25 water.

1 In your report on page 3, paragraph 3, I
2 believe you indicate that the EEG findings in 1985
3 reported by Dr. Jaynes indicated abnormal EEG findings.

4 My reading of Dr. Jaynes' report indicates
5 that's not correct.

6 A. Yes, I think that's an error. The CT findings
7 were abnormal, but the EEG was not.

8 Q. Thank you.

9 Now let's go to the issue of cognitive defects
10 or the lack of cognitive defects. And I appreciate the
11 fact that you deal with a lot of brain injured patients
12 at the Elk's rehabilitation center.

13 Isn't it significant overall with brain
14 injured people that many have memory problems?

15 A. Yes, many do.

16 Q. And many have problems with all sorts of
17 physical activity?

18 A. Yes, they can.

19 Q. Balance, depth perception, things like that?

20 A. Yes.

21 Q. Many have speech problems, difficulty in
22 following directions?

23 A. Yes.

24 Q. But here you have Mr. Leavitt, as I understand
25 the testing of all those issues, comes out with between

1 average, high average, and superior on all of those
2 frontal lobe cognitive issues?

3 A. Yes, he did well across the cognitive
4 measures.

5 Q. Wouldn't you expect, if someone had serious
6 injury, organic injury in the frontal lobe area, either
7 on the right or left hemisphere, to have some
8 difficulties in those areas that we mentioned?

9 A. Well, first of all, I think that you're
10 certainly correct. And if he had primarily left
11 frontal damage, I would be surprised that we didn't
12 pick it up on the testing.

13 With right frontal, it's more of an unknown.
14 We're not very good at picking up right frontal
15 injuries.

16 Other areas of the brain that were injured,
17 like significant injury in the temporal cortex, for
18 example, or the parietal or simple cortex, I wouldn't,
19 again, be surprised that we wouldn't find it on the
20 cognitive test.

21 Q. And even when we speak of the right frontal
22 area, did you find it unusual that his thoughts were
23 logical, coherent, goal directed, and found no sign of
24 disorder?

25 A. Well, in cognitive tasks, I thought that he

1 was able to be goal directed and logical under those
2 circumstances. But that's not measuring emotional
3 regulation.

4 Q. And we'll get to that. Though his stable
5 affect is one of those emotional regulators; is it not?

6 A. Well, him displaying stable affect during the
7 interview and testing is what it is. I mean, he wasn't
8 overly emotional during the testing or the
9 interviewing.

10 Q. And certainly you found no evidence of
11 psychosis, delusions, hallucinations?

12 A. No, we found no evidence of that.

13 Q. And he had good insight of what was going on
14 both in your '95 evaluation of him, as well as your
15 2006 evaluation?

16 A. I don't know if I -- I guess I'm not sure how
17 you're applying the word good insight. He was aware he
18 could do well on the tests. He had that awareness.
19 You know, he could talk appropriately about his current
20 job and what he was doing within the correctional
21 setting. I don't think that he has good insight about
22 some of his affect.

23 Q. And how do you test that, sir, or how do you
24 determine that?

25 A. Well, first of all, there isn't a good test of

1 that. And secondly, you form your clinical opinions
2 about that by both interviewing and reviewing other
3 information.

4 Q. All right. And when we get to the question of
5 intermittent explosive disorder, organic personality
6 syndrome, antisocial personality disorder, as you deal
7 with those areas in the DSM -- and in 1985 we'd be
8 talking about DSM-III R; would we not?

9 A. Yes.

10 Q. Aren't those determinations that you make,
11 sir, very subjective?

12 A. Well, I think that this is a pretty
13 well-defined criteria that you apply, and based upon
14 what information you gather from the person, as well as
15 history.

16 Q. All right. And to do that you look at DSM-III
17 to make those judgments; do you not?

18 A. Yes, in '85, that's what you would have used.

19 MR. ROSENTHAL: Your Honor, I am going to
20 start going into the DSM-III. It might be easy to --

21 THE COURT: All right. It would be a good
22 time to take a break.

23 Could I just ask a couple of questions of the
24 witness?

25 MR. ROSENTHAL: Certainly.

1 THE COURT: And then you will be allowed to
2 follow up, obviously, in your further examination after
3 the break and, likewise, Mr. Nevin, on redirect.

4 EXAMINATION

5 QUESTIONS BY THE COURT:

6 Q. Doctor, if I'm -- I just want to make a couple
7 of points. I wanted to confirm that this, in fact, is
8 in your opinion. I want to make sure I'm right,
9 basically.

10 The first is that although Mr. Leavitt
11 demonstrates the characteristics of intermittent
12 explosive disorder, your conclusion is that that's an
13 organic -- at this point your conclusion is that that's
14 an organic personality disorder and not a mental or a
15 psychological problem; is that fair?

16 A. Yes. As the way they used the DSM to make
17 those kinds of determinations, the manual is pretty
18 clear. If you think that the behavioral manifestations
19 that result in that diagnosis are predominantly from an
20 organic cause rather than more of a purely
21 psychological cause, then that diagnosis is not
22 applicable.

23 Q. Then the other two, I think, opinions were
24 that you concluded that Mr. Leavitt does not have --
25 does not suffer from antisocial personality disorder,

1 nor is he a psychopath?

2 A. One is that he isn't a psychopath or a
3 sociopath, in terms of how we define it using Hare,
4 which is the primary person that we use for that
5 definition these days.

6 Secondly, he does have some of the behavioral
7 manifestations, again, of an antisocial personality
8 disorder as defined in the DSM-III or the DSM-IV. But
9 yet again, if those behaviors are primarily a product
10 or a result from an organic impairment, then that label
11 is not applicable.

12 Q. I had a sense that your conclusion, Doctor, of
13 the organic origin of these problems really were the
14 result of things that have occurred since between 1995
15 and '96 when you first examined Mr. Leavitt in 2006
16 when you saw him again based upon information obtained
17 through more detailed MRI studies.

18 A. Yes.

19 Q. Okay. The second -- I guess the last question
20 I would ask is what difference does it make in terms of
21 a prognosis, danger to the community, et cetera, that
22 Mr. Leavitt's behavior has an organic base rather than
23 a psychological base? I mean, is it more or less
24 treatable? Is it more or less controllable because
25 it's organic in nature, or does it make any difference

1 at all? Or do we know?

2 A. Well, several parts to that. First of all,
3 the treatment is different if it's predominantly
4 organic versus psychological in nature, particularly as
5 we talk about explosive behavior. If it's organic, you
6 are looking at much more environmental controls. If
7 it's more psychological, you're looking at more
8 traditional counseling, psychotherapeutic
9 interventions. I would say that, in general, if you
10 were just out in the community, both are difficult to
11 treat and both of them don't have a great prognosis.

12 Having said that, within a correctional
13 setting, however, that's not entirely true. Within a
14 correctional setting what you actually find is that
15 very controlled environment is very advantageous for
16 treating an organic-based problem. It isn't as much of
17 an advantage in treating the more psychological-based
18 problem.

19 THE COURT: Okay. Counsel, I think that's
20 enough. I just thought I would strike while the iron's
21 hot, or lukewarm, perhaps. That's the depth of my
22 thought processes.

23 In any event, let's take a 15-minute recess.

24 (Whereupon, the Court recessed.)

25 BY THE COURT:

1 Q. Dr. Beaver, you're not opining, and I assume
2 you feel you are probably not qualified to opine as to
3 whether in 1990 the, I guess, technological -- whether
4 it was technologically possible or technically possible
5 to determine the organic basis for Mr. Leavitt's
6 exhibited behavior.

7 The question is whether you're offering an
8 opinion or -- on that subject.

9 A. Well, I'm not an expert on what caliber of MRI
10 technology, for example, was available in 1990. That
11 would be outside my area of expertise. The only thing
12 I know, as of 1990, is we did have an '85 CT scan,
13 which is different technology than an MRI, that raised
14 the -- you know, raised some concern about
15 abnormalities. I am not the one to offer expertise on
16 the MRI.

17 THE COURT: All right. Mr. Rosenthal.

18 MR. ROSENTHAL: Thank you, Your Honor.

19 BY MR. ROSENTHAL:

20 Q. Dr. Beaver, the last question I asked you was
21 whether your determination of diagnoses under DSM --
22 the DSM, and in particular with DSM-III, was
23 subjective, and I think you answered you make your
24 interpretation based on what is contained in the DSM.

25 Is that reasonably accurate?

1 A. Yes. You use their criteria that they set
2 forth.

3 Q. And you would agree that psychologists such as
4 yourself are disagreed with by other psychologists on a
5 regular basis concerning this subject; are you not?

6 A. Yes. There is debate.

7 Q. I would like you -- I have placed, and I'll
8 represent to you and the Court that I have taken and
9 made a copy of organic personality syndrome from
10 DSM-III-R, which I think you have already testified was
11 the applicable DSM in 1985. Can you see that on your
12 screen?

13 A. Yes.

14 Q. I would like you to read into the record
15 organic personality syndrome, that whole -- one, two,
16 three, four -- well, five paragraphs. The last is a
17 simple --

18 A. Okay.

19 Q. -- sentence. Would you please read it into
20 the record, please.

21 A. Certainly.

22 "The essential feature of this syndrome is a
23 persistent personality disturbance, either a lifelong
24 or representing a change or accentuation of a
25 previously characteristic trait, what is due to a

1 specific organic factor. Affective instability,
2 recurrent outbursts of aggression or rage, markedly
3 impaired social judgment, marked apathy and
4 indifference or suspiciousness or paranoid ideation are
5 common. Organic personality syndrome in a young child
6 may occur before the development of an enduring style
7 of relating to the environment," parenthesis,
8 "personality," parenthesis. "In such cases the
9 syndrome is recognized by significant changes in the
10 child's usual behavior patterns.

11 "The clinical syndrome in a particular person
12 depends principally on the nature and localization of
13 the pathologic process. A common pattern is
14 characterized by affective instability and impairment
15 in social judgment. The person may be belligerent or
16 have temper outbursts that are grossly out of
17 proportion to any precipitating psychosocial stressors.
18 Socially inappropriate actions, such as sexual
19 indiscretions, may be engaged in with little concern
20 for the consequences.

21 "Another pattern is characterized by marked
22 apathy and indifference. The person may have no
23 interest in his or her usual hobbies and may appear
24 unconcerned with the events occurring in the immediate
25 environment. Both of these patterns may be associated

1 with damage in the frontal lobes and, for this reason,
2 are sometimes referred to as frontal lobe syndromes.

3 "Another recognized pattern, seen in some
4 people with temporal lobe epilepsy, is a marked
5 tendency towards humorless verbosity in both writing
6 and speech, religiosity, and, occasionally, exaggerated
7 aggressiveness. The personality change may be the
8 development of suspiciousness or paranoid ideation.

9 "If outbursts of aggression or rage are the
10 predominant feature, this should be noted as explosive
11 type."

12 Q. And the associated features, if you could,
13 sir, please,

14 A. "Associated features. Mild cognitive
15 impairment and irritability may be present."

16 Q. And I'm going to the next page.

17 A. Okay.

18 Q. Would you read the paragraphs entitled
19 "Impairment, Complication and Etiological Factors,"
20 please.

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

1 "Complications. Socially unacceptable
2 behavior may lead to social ostracation" -- "ostracisms
3 or legal difficulties. Impulsive or explosive behavior
4 may be dangerous to the person and to others.

5 "Etiologic factors. Organic personality
6 syndrome is usually due to structural damage to the
7 brain. Common causes are neoplasms," parentheses, "for
8 example, meningiomas pressing on the frontal lobes,"
9 parenthesis, "head trauma, and cerebral vascular
10 disease.

11 "A characteristic organic personality syndrome
12 has been described as an entorhinal phenomena in some
13 people with temporal lobe epilepsy. Multiple sclerosis
14 and Huntington's Correa are sometimes associated with
15 this syndrome.

16 "Rather uncommon causes are endocrine
17 disorders," parentheses, "thyroid and anadrenal
18 cortical disease," parenthesis, "and ingestion of
19 certain psychoactive substances."

20 Q. Thank you, Doctor. And I'm going to go -- if
21 you bear with me, please. And I'm placing from
22 DSM-III-R, intermittent explosive disorder on the
23 prompter. Can you read that?

24 I'd like you to read from 312.34, intermittent
25 explosive disorder, to the end of that page, if you

1 would, sir.

2 A. "The essential features of this disorder are
3 discrete episodes of loss of control of aggressive
4 impulses resulting in serious assaultive acts or
5 destruction of property. The degree of aggressiveness
6 expressed during the episodes is grossly out of
7 proportion to any precipitating psychosocial stressors.
8 There are no signs of generalized impulsivity or
9 aggressiveness between the episodes.

10 "Other disorders that are sometimes associated
11 with loss of control of aggressive impulses must be
12 ruled out before the diagnosis can be made. These
13 include psychotic disorders, organic personality
14 syndrome, antisocial or borderline personality
15 disorder, conduct disorder, or intoxication with a
16 psychoactive substance.

17 "The person may describe the episodes as
18 spells or attacks. The symptoms are said to appear
19 within minutes or hours and, regardless of the
20 duration, remit almost as quickly. Genuine regret or
21 self-reproach about the consequences of the action and
22 the inability to control the aggressive impulse may
23 follow each episode.

24 "This category has been retained in the
25 DSM-III-R, despite the fact that many doubt the

1 existence of a clinical syndrome characterized by
2 episodic loss of control that is not symptomatic of one
3 of the disorders that must be ruled out before the
4 diagnosis of intermittent explosive disorder can be
5 made."

6 Q. And I'm going to the next page, and would you
7 read the paragraph beginning with "Differential
8 Diagnosis," please, sir.

9 A. "Differential Diagnosis. The diagnosis of
10 intermittent explosive disorder can be made only after
11 other disorders that are sometimes associated with loss
12 of control of aggressive impulses has been ruled out,
13 such as a psychotic disorder, organic personality
14 syndrome, antisocial or borderline personality
15 disorder, conduct disorder, or intoxication with a
16 psychoactive substance."

17 Q. And again, if you would continue to bear with
18 me. I'm placing from DSM-III-R, antisocial personality
19 disorder.

20 Could you read the three paragraphs beginning
21 with 301.70, Antisocial Personality Disorder, please,
22 sir?

23 A. "The essential feature of this disorder is a
24 pattern of irresponsible and antisocial behavior
25 beginning in childhood or early adolescence and

1 continuing into adulthood. For this diagnosis to be
2 given, the person must be at least 18 years of age and
3 have a history of conduct disorder before the age of
4 15.

5 "Lying, stealing, truancy, vandalism,
6 initiating fights, running away from home, and physical
7 cruelty are typical childhood signs. In adulthood, the
8 antisocial pattern continues and may include failure to
9 honor financial obligations, to function as a
10 responsible parent or to plan ahead, and an inability
11 to sustain consistent work behavior. These people fail
12 to conform to social norms and repeatedly perform
13 antisocial acts that are grounds for arrest, such as
14 destroying property, harassing others, stealing, and
15 having an illegal occupation.

16 "People with antisocial personality disorder
17 tend to be irritable and aggressive and to get
18 repeatedly into physical fights and assaults, including
19 spouse or child beating. Reckless behavior without
20 regard to personal safety is common, as indicated by
21 frequently driving while intoxicated or getting
22 speeding tickets. Typically, these people are
23 promiscuous, defined as never having sustained a
24 monogamous relationship for more than a year.

25 "Finally, they generally have no remorse about

1 the effects of their behavior on others. They may even
2 feel justified in having hurt or mistreated others.

3 "After age 30, more fragrantly antisocial
4 behavior may diminish, particularly sexual promiscuity,
5 fighting and criminality."

6 Q. And, Doctor, I'm going to the next page.

7 Would you read the paragraphs, Associated
8 Features, Age at Onset, and then Predisposing Factors,
9 if you would, please, sir?

10 A. "In early adolescence, these people
11 characteristically use tobacco, alcohol, and other
12 drugs and engage in voluntary sexual intercourse
13 unusually early for their peer group. Psychoactive
14 substance use disorders are commonly associated
15 diagnoses. Less commonly, somatization disorder may be
16 present.

17 "Despite the stereotype of a normal mental
18 status in this disorder, frequently there are signs of
19 personal distress, including complaints of tension,
20 inability to tolerate boredom, depression, and the
21 conviction, often correct, that others are hostile
22 toward them. The interpersonal difficulties and
23 dysphoria tend to persist into late adult life, even
24 when the more flagrant antisocial behavior has
25 diminished. Almost invariably, there is a markedly

1 impaired capacity to sustain lasting, close, warm and
2 responsible relationships with family, friends, or
3 sexual partners.

4 "Age at Onset. By definition, the conduct
5 disorder symptoms began before the age of 15. The
6 first symptoms of conduct disorder in females who
7 develop antisocial personality disorder usually appear
8 in puberty, whereas in males the conduct disorder is
9 generally obvious in early childhood.

10 "Impairment. The disorder is often extremely
11 incapacitating, resulting in failure to become an
12 independent, self-supporting adult, and giving rise to
13 many years of institutionalization, more commonly penal
14 than medical. Some people who have several features of
15 this disorder achieve political and economic success,
16 but these people virtually never present the full
17 picture of the disorder, lacking, in particular, the
18 early onset in childhood that usually interferes with
19 educational achievement and precludes most public
20 careers."

21 Q. Compositions and predispositioning factors,
22 please, sir.

23 A. Oh, okay.

24 "Predispositioning factors. Predispositioning
25 factors are attention deficit hyperactive disorder and

1 conduct disorder during pre-puberty. The absence of
2 consistent parental discipline apparently increases the
3 likelihood that conduct disorder will develop into
4 antisocial personality disorder. Other predisposing
5 factors include abuse as a child, removal from the
6 home, and growing up without parental figures of both
7 sexes."

8 Q. Thank you, Doctor. I appreciate that.

9 Now, you have testified, in response to
10 Mr. Nevin's questions, that you are familiar with, and
11 as did Dr. Missett, rely on Ms. Goody's declaration and
12 testimony that has now been introduced as part of this
13 record?

14 A. Yes.

15 Q. You note that Mr. Leavitt played sports,
16 baseball, primarily, as a young child, as well as an
17 adolescent?

18 A. I believe so.

19 Q. In fact, he played on a men's team in his late
20 teens; did he not?

21 A. That sounds familiar.

22 Q. And you're aware that he worked on the
23 family's cabin, I believe it was in Island Park,
24 building the family's cabin?

25 A. I don't remember that detail, but I don't have

1 any reason to disagree with that.

2 Q. All right. And you have discussed the sled
3 accident when he was apparently nine or ten years of
4 age, even though there is some question as to his exact
5 age. And you understand that that was not a
6 two-by-four that he hit, but a quarter-inch piece of
7 plywood that flew up and hit him in the forehead as he
8 went over it in his toboggan?

9 A. Something like that, yes.

10 Q. And you're aware, are you not, that
11 Mr. Leavitt has a history of heart disease and diabetes
12 that was onset during his term in the penitentiary?

13 A. Yes.

14 Q. He did not have that before he was sent to the
15 penitentiary. You're aware of that; are you not?

16 A. Not that he was diagnosed.

17 Q. All right. And from reading Ms. Goody's
18 declaration and affidavit, you're aware that
19 Mrs. Leavitt, his mother, was fairly aggressive and
20 physically violent toward the children when they were
21 growing up?

22 A. Yes, that's my understanding.

23 Q. And, in fact, she testified or told Ms. Goody
24 that she actually hit the kids with broom sticks, be
25 they wood or plastic, as well as threw things, in

1 particular, at Mr. Leavitt, Rick Leavitt?

2 A. Yes, that's my understanding.

3 Q. Is there some significance to that type of
4 environment when a young man is raised in that, in
5 terms of his future conduct?

6 A. Yes. It can have a negative impact on his
7 future conduct.

8 Q. And you are aware that at age 15, Mr. Leavitt
9 received a major injury to his arm in a potato
10 warehouse accident; are you not?

11 A. Yes.

12 Q. And you're also aware that many family members
13 have stated, not only in this proceeding, but to
14 Ms. Goody, that they felt that this was a major turning
15 point in Mr. Leavitt's life?

16 A. Yes.

17 Q. And that does not surprise you, does it, that
18 a child of 15 or an adolescent of 15 who was active in
19 sports, playing the guitar, to some significant extent
20 loses the use of one of his limbs?

21 A. No, it's not surprising that it did affect
22 him.

23 Q. And you're aware that family members thought
24 Mr. Leavitt was immature for his age during his
25 adolescent years?

1 A. I don't remember that specific term, but I
2 think that that's consistent with my review of him.

3 Q. And I think you've commented that you're aware
4 he had a large number of traffic tickets during his
5 teen years?

6 A. That's my understanding.

7 Q. And you're aware from the comments of his
8 mother, as well as brothers, Bret and Reed, that
9 Mr. Leavitt, during his adolescence, started using
10 drugs, alcohol, marijuana, and otherwise smoking during
11 those years?

12 A. Yes.

13 Q. Now, also you're aware, are you not, that on
14 May 21st or 22nd of 1985, while Mr. Leavitt was
15 incarcerated prior to his trial, but incarcerated based
16 on the legal proceedings that ultimately brought us
17 here, that while in jail he overdosed on medications,
18 lost consciousness, fell, struck his right forehead,
19 and was knocked unconscious?

20 A. Yes.

21 Q. And you're aware he was taken to the hospital
22 for observation and stitches?

23 A. Yes.

24 Q. Could that injury account for whatever
25 findings occurred in the scan interpreted by Dr. Jaynes

1 and the radiologist who examined that?

2 A. Yes, it's possible.

3 Q. And do you know that while Mr. Leavitt worked
4 for the short period of time that he did in the auto
5 body shop, he was said to have a great way with
6 customers, has an easygoing way with people?

7 A. I don't remember that comment, but I don't
8 have any reason to dispute your representation.

9 Q. And in terms of Mr. Leavitt's conduct, do you
10 know that Mrs. Leavitt, during Mr. Leavitt's youth,
11 Mrs. Leavitt ran a daycare with 30 to 50 kids in that
12 daycare up to six days a week?

13 A. I understood that she ran a daycare. I don't
14 recall the particulars of how many children, but yes --

15 Q. I will represent to you that Ms. Goody
16 indicates, based on her declaration, that it was
17 between 30 and 50 kids during the week.

18 And are you aware that family members felt
19 that Mr. Leavitt did things, acted out to get attention
20 from his mother because she had all these other kids in
21 the house?

22 A. Yes, I remember comments about that.

23 Q. And would you find that unusual based on that
24 circumstance?

25 A. No.

1 Q. Also, some of the violence or aggressive acts
2 that have been alluded to in these proceedings involve
3 conduct between Mr. Leavitt and his three brothers.

4 Does it strike you as unusual that a family
5 with three boys, albeit one girl, but with three boys,
6 that there would be a great deal of aggressiveness back
7 and forth amongst them?

8 A. Not surprising, no.

9 Q. In fact, it's fairly typical for those of us
10 who have grown up with a bunch of brothers; is it not?

11 A. Yes.

12 Q. And is it reasonable to assume that a great
13 deal of Mr. Leavitt's conduct was a result of how he
14 was raised, the family dynamic?

15 A. I certainly think his family dynamics and how
16 he was raised impacts his behavior.

17 Q. In fact, who do we learn parenting skills
18 from?

19 A. Typically, our parents.

20 Q. And who teaches you about proper conduct?

21 A. Well, you model it from your family, peers, a
22 lot of different places.

23 Q. Now, you did not learn of the white matter
24 hyperintensities until after the respondent had
25 those -- had that MRI done in 2006; were you?

1 A. Correct.

2 Q. Now, you have indicated that you believe that
3 Mr. Leavitt has organic brain deficiencies. Is that
4 accurate?

5 A. Yes.

6 Q. Thank you. Go ahead and get your drink.
7 Has he gotten rid of those organic
8 deficiencies?

9 A. Not as far as I'm aware.

10 Q. And how could you become aware? How can you
11 tell whether he has or has not?

12 A. Well, I guess you could rescan him, except
13 that in Dr. Bigler's review of the '96 and then the
14 2006 scans, and as well was said on the CT scans, that
15 it appears these deficits have been persistent.

16 Q. But what you find on those scans are signal
17 abnormalities, not necessarily defects?

18 A. Well, the way that you read an MRI scan is to
19 look at signal abnormalities, irregardless of what kind
20 of structural defect you're looking at.

21 Q. But you do not know whether those are, in
22 fact, causing any neurological defect to Mr. Leavitt;
23 do you?

24 A. Well, I think that they are a structural
25 defect, and I do see a pattern of dysregulation in his

1 behavior in a less controlled environment that I think
2 on a more probable than not basis is consistent with
3 that area that is involved.

4 Q. Well, but in terms of the environment, the
5 less controlled environment, if -- excuse me. Let me
6 find my note. I think you addressed that in page 3,
7 paragraph 4, when you're speaking of intermittent
8 explosive disorder. Do you see that?

9 A. Yes.

10 Q. And don't you say: "By the very nature of
11 this behavior, organically or physio -- excuse me,
12 "psychiatrically caused, an individual is unable to
13 resist their aggressive impulses despite potentially
14 being able to recognize the wrongfulness or
15 inappropriateness of their actions."

16 Isn't that inconsistent with what you're
17 saying, Dr. Beaver?

18 A. No, because you're reducing the number of
19 stimuli in the environment that would trigger those
20 aggressive impulses.

21 Q. And those stimuli in the environment, tell us
22 what you mean by that in terms of Mr. Leavitt out of
23 the institution versus Mr. Leavitt in the institution.
24 If you can just opine on that in general.

25 A. Well, it's a stress issue or a stimulus stress

1 issue. For example, out in the world there are lots of
2 unpredictable events. People can be confrontational.
3 People can have interactions with you that are poorly
4 controlled or regulated that can trigger those
5 affective responses, particularly when they occur
6 within a less structured situation.

7 Within a correctional setting, his actions and
8 behaviors are pretty well regulated. He has a pretty
9 set schedule, you know. Things occur at very timed --
10 are timed, structured. There is a lot of familiarity,
11 a lot of routine that reduces those types of stimuli
12 that may occur.

13 Q. Doctor, you have been to the Idaho state
14 maximum security facility; have you not?

15 A. Many times.

16 Q. And you're aware that in everyday activities
17 out there between inmates there are great deals of
18 confrontations, both physical and verbal; are you not?

19 A. It can be. It's much more restricted on the
20 unit that he's housed.

21 Q. And interactions with people also become very
22 aggressive verbally and sometimes physically?

23 A. They can.

24 Q. And you're aware that for approximately the
25 last, I think at least two or more years, Mr. Leavitt

1 has had general access to the tier in his duties in a
2 janitorial capacity or the likes of that?

3 A. Yes, that's my understanding.

4 Q. And you're also aware that his conduct has
5 been very appropriate, according to reports testified
6 to here and otherwise within these proceedings?

7 A. Yes.

8 Q. In your interviews in '95 and -- November and
9 December of '95, January of '96, as well as in your
10 testing and interviews in March of 2006, did you see
11 any behavior in Mr. Leavitt that indicated traumatic
12 brain injury or -- traumatic brain injury?

13 A. My interactions with him within that
14 controlled setting, he was appropriate. And so, no, I
15 did not see any obvious manifestations of neurological
16 deficits.

17 Q. And you saw no dysregulation, as you described
18 it?

19 A. Not within that context.

20 Q. And, again, you have no idea if there is some
21 organic or traumatic brain injury, when it occurred?

22 A. No, I can't say for certain when it occurred.

23 Q. In your comments in response to Mr. Nevin's
24 questions, you commented on Dr. Hildebrandt's 1976
25 report, something to the effect of he -- Mr. Leavitt

1 reported that he just wanted to be mean to someone or
2 something. Something to that effect; did you not?

3 A. Yes.

4 Q. Does that strike you as in any way unusual for
5 a teenager when they get angry, that feeling of I want
6 to do something about it?

7 A. Well, as an adolescent feeling that they
8 wanted to do something, if they were made angry about
9 something, that's not an unusual. But the way that he
10 describes that experience I think is atypical for an
11 adolescent.

12 Q. So that's just how you interpreted what
13 Dr. Hildebrandt has said about how he viewed what
14 Mr. Leavitt said to him?

15 A. Yes, it's just my interpretation.

16 MR. ROSENTHAL: Excuse me, Your Honor. I need
17 to check my notes.

18 (Pause in the proceedings.)

19 MR. ROSENTHAL: Thank you, Dr. Beaver.

20 THE COURT: Mr. Nevin.

21 REDIRECT EXAMINATION

22 QUESTIONS BY MR. NEVIN:

23 Q. Dr. Beaver, returning to Dr. Hildebrandt's
24 report, the one that had the reference to an urge to be
25 mean, Dr. Hildebrandt also interpreted that statement

1 as being important for his diagnosis; didn't he?

2 A. Yes.

3 Q. And how did he consider it to be important?

4 A. Well, he felt that, you know, if you look at
5 what he ultimately said and recommended, that he needed
6 treatment, that, you know, he concluded that, in fact,
7 there was some abnormalities about Mr. Leavitt at that
8 time when he examined him.

9 Q. Do you see yourself as interpreting that in
10 some different way than Dr. Hildebrandt did?

11 A. No. I thought he was abnormal, also.

12 Q. All right. Counsel asked you whether you
13 could say -- whether, and I think his question was you
14 had no idea when the brain injury occurred, and you
15 responded slightly differently. You said, no, I can't
16 say for certain.

17 Do you remember those questions just a few
18 minutes ago?

19 A. Yes.

20 Q. Okay. And, Doctor, I asked you, I pointed you
21 to Dr. Bigler's testimony that occurrences such as
22 Mr. Leavitt's premature birth, the reported
23 hyperactivity that he had as a child, the sledding
24 injury, the inhalation of paint fumes, that Dr. Bigler
25 had said all of these things could have contributed to

1 or caused the occurrence of the white matter
2 hyperintensities, and you said you agreed with that,
3 with those statements; is that correct?

4 A. Yes. I can't tell you exactly which event was
5 the distinct cause in an absolute way. But Mr. Leavitt
6 had a number of events in his life at a young age that
7 could account for these difficulties and would be
8 consistent with the structural difficulties that we
9 see.

10 Q. So your opinion has not changed any since when
11 I was questioning you before on that question?

12 A. No.

13 Q. Okay. You were asked whether you saw any
14 indications of Mr. Leavitt having emotional
15 dysregulation at the time you interviewed him.

16 And just to return to that, would you have
17 expected to see emotional dysregulation at the time
18 that you interviewed him?

19 A. No, not in that type of controlled setting.

20 Q. Is the absence of that kind of dysregulation
21 being manifest right at that moment, does that say
22 anything about Mr. Leavitt's diagnosis or prognosis?

23 A. Well, I can't say that it doesn't say
24 anything. But I would just tell you that in my
25 experience as a clinician, evaluating and treating

1 neurological patients for many years, most neurological
2 patients that I see and evaluate within the confines of
3 an interview setting and/or testing are relatively
4 composed. That, typically, is not the area that you,
5 whatever the situation, that you see manifestations of
6 their behavioral dysregulation.

7 Q. Some question as to whether the environment
8 within the penitentiary is really closely controlled or
9 not, reducing stimulus and so on. Does it continue to
10 be your view that the prison setting is more controlled
11 than the setting in normal life?

12 A. Yes.

13 Q. That there are fewer options available to
14 persons from minute to minute and from day to day?

15 A. Yes.

16 Q. That it's a less rich and varied and
17 unpredictable environment?

18 A. Yes.

19 Q. Now, there was a question about -- some
20 questions were asked of you on this question of signal
21 abnormality and of what Dr. Bigler's -- reference to
22 Dr. Bigler's testimony. And I will tell you that there
23 was discussion -- I'll represent to you that there was
24 discussion with Dr. Bigler about the fact that a white
25 matter hyperintensity can sometimes be accounted for by

1 a space in the brain that's filled with cerebral spinal
2 fluid. These are called Virchow-Robin spaces. I don't
3 know if that's what counsel was getting at when he
4 asked you the question that he asked.

5 But first, is the differentiation between a
6 structural defect, on the one hand, and a Virchow-Robin
7 space on the other, differentiating those two things,
8 is that something that's within your area of expertise?

9 A. Well, it's not within my area of expertise.
10 But you've got to remember that, you know, having that
11 space of cerebral spinal fluid does represent some
12 structural differences in the brain. So it's not
13 completely apples and oranges. But no, that's out --
14 that's probably outside of my technical area.

15 Q. Is that an area that you would defer to -- I'm
16 sorry.

17 MR. ROSENTHAL: I am going to move that his
18 answer be struck as to any interpretation of that,
19 since I think he just stated that it's outside his area
20 of expertise.

21 THE COURT: All right.

22 MR. ROSENTHAL: That's how I understood it, at
23 least.

24 THE COURT: Well, I understand him saying
25 that, but I don't recall him -- to the extent that he

1 may have offered some opinion as to the correlation
2 between the two based upon some testimony, then it
3 probably should be struck. But I don't recall any
4 definitive opinions offered.

5 So at this point I'll grant the request, but I
6 don't know that that will have any practical effect
7 upon the record.

8 Mr. Nevin.

9 MR. NEVIN: Thank you, Your Honor.

10 BY MR. NEVIN:

11 Q. There were some questions about his history of
12 heart disease and diabetes and that their onset had
13 been after Mr. Leavitt had arrived at the penitentiary.
14 And that's your understanding, as well, that those
15 arose after he got to the penitentiary?

16 A. Yes.

17 Q. And so, therefore, abnormalities which existed
18 in 1990 at the time of the resentencing hearing in this
19 case, 1989-90, those could not have been caused by
20 heart disease or diabetes. Would you agree with that?

21 A. Probably not.

22 Q. Counsel asked you whether the diagnoses of
23 intermittent explosive disorder, organic personality
24 and antisocial personality disorder, that in dealing
25 with those areas, that that was subjective.

1 First, that's correct, isn't it? I mean,
2 those are subjective impressions that an examiner gets;
3 right?

4 A. Well, you have a specific criteria that you
5 utilize and the nomenclature and rules that you follow
6 to offer those opinions. But those are, in fact,
7 opinions that you're offering.

8 Q. Right. With respect to the findings on MRI,
9 however, and on CT, those are not subjective. Those
10 are objective findings; aren't they?

11 A. Well, the findings on those scans are a
12 reflection of physical measures of particular
13 phenomenon.

14 MR. NEVIN: That's my questions. Thank you,
15 Your Honor.

16 THE COURT: Counsel, I'm going to try to ask
17 just a couple questions again. You will each get a
18 chance to follow up in case I muddy the water, which
19 probably is likely, but... This may take me a moment
20 to kind of set the stage.

21 EXAMINATION

22 BY THE COURT:

23 Q. Doctor, you went through all of the reports
24 that have been prepared with regard to Mr. Leavitt's
25 psychiatric -- or psychological condition, and I assume

1 that you were probably able to identify, perhaps in
2 your own mind, those that were available to, I guess,
3 Mr. Parmenter, I assume Mr. Moss was the prosecutor at
4 the time, and Judge George in 1989-1990, so you know
5 roughly what the, I guess, psychological landscape was
6 based upon those reports at that time.

7 Using that as kind of a baseline and putting
8 yourself now in a position where you're writing a
9 report for, say, defense counsel, how different and
10 what different things would you have said in a report
11 that you prepared back then if you knew what we
12 apparently now know about the dysfunctions, the
13 organic -- the potential organic source of
14 Mr. Leavitt's behavior?

15 Do you understand the question?

16 A. I think that I do, Your Honor.

17 And in putting a report together back
18 in '85-ish or so, around this time, and looking --
19 first of all, the psychologists that had seen him all
20 talked about, you know, poorly controlled behavior. I
21 mean, they may have used different terms, but they
22 talked about it that way. There is, in fact, even
23 though there is a -- Dr. Groberg, for example, said
24 that he didn't find abnormalities on his testing. He
25 still recommended a neurological workup.

1 I think that there was -- if I was writing a
2 report, I guess that my emphasis would have been on
3 trying to better understand this dysregulated behavior
4 and recommending that, as thorough as possible,
5 evaluation of an organic dysregulation needed to be
6 done because there was a lot of warning signs, if you
7 will, that that should be an issue or a concern.

8 Q. Do you know -- the problem is you have
9 referred to warning signs, and I guess it goes back to
10 a question I asked earlier about it being beyond your
11 level of expertise to be able to testify as to what was
12 or was not available in 1989, 1990.

13 So you probably can't offer an opinion as to
14 whether a more thorough workup would have revealed the
15 kind of detail that's now being made available through
16 the more recent 2006 MRI?

17 A. One of the difficulties is that, on the one
18 hand, actually, given the CT scan report, we have never
19 been able to get the actual films. But the report,
20 there was enough findings on that one that. As a
21 neuropsychologist, it would have been appropriate to
22 talk about possible organic-based disinhibition of
23 behavior based upon that CT scan finding that found
24 atrophy in the frontal lobes.

25 Q. So your feeling is there was enough

1 information available even just from the CAT scan made
2 in -- was it 1985?

3 A. Yes.

4 Q. -- to essentially modify the opinions along
5 the lines that you described here today, to take into
6 account the organic base for this lack of inhibition?

7 A. Yes.

8 THE COURT: All right. Mr. Nevin, I'm sorry.
9 I thought you were done. Did I misunderstand?

10 MR. NEVIN: No, sir, I was done. Do I get to
11 go again now?

12 THE COURT: You will, after Mr. Rosenthal
13 does.

14 MR. NEVIN: Okay.

15 THE COURT: I still have to go in order here,
16 so...

17 MR. NEVIN: I forgot.

18 THE COURT: Mr. Rosenthal.

19 RECROSS-EXAMINATION

20 BY MR. ROSENTHAL:

21 Q. Doctor, to make a determination about
22 Mr. Leavitt's deregulation at the time of the crime
23 that he has been convicted of, wouldn't you have to
24 examine him at that time to come to any conclusion
25 about it?

1 A. Well, obviously, if I was being asked to
2 provide testimony back in 1985 regarding those issues,
3 I would have wanted to have examine Mr. Leavitt then.

4 Q. But even then you could really tell very
5 little about his, quote, deregulation, unless you were
6 there at the time, that's the only way you can really
7 be sure as to what took place. Isn't that accurate?

8 MR. NEVIN: Excuse me. I object to the form
9 of the question because it doesn't specify at what time
10 we're referring to.

11 THE COURT: Do you wish to restate the
12 question, or do you want me to rule?

13 MR. ROSENTHAL: Let me restate.

14 THE COURT: All right.

15 BY MR. ROSENTHAL:

16 Q. You've talked about deregulation. Tell us
17 what you mean by deregulation.

18 A. An inability to control and appropriately
19 monitor one's emotions.

20 Q. And to tell whether Mr. Leavitt had that
21 inability, that deregulation at the time that he
22 committed the crime that he was convicted of, wouldn't
23 you have to actually be present to make a definitive
24 judgment on that?

25 A. Well, two parts. I think you're certainly

1 correct. If you had, in fact, a trained observer there
2 when the crime took place, that would be the ideal or
3 the ultimate way to develop that evidence for or
4 against this hypothesis.

5 As to whether or not you can offer a clinical
6 opinion about that issue, I think that you can,
7 understanding the limits and the value of expert
8 testimony and how the Court decides to weigh that.

9 It's, similarly, if a person was acutely
10 psychotic, for example, you examine them six months
11 later, many times, even though you weren't there when
12 the crime actually took place, I certainly have had
13 many occasions where I felt quite confident in arguing
14 that the patient was indeed psychotic when the crime
15 took place.

16 So, yes, I realize that it's an inference, but
17 I believe that that's taken into account when expert
18 testimony is given.

19 Q. And I appreciate that, Dr. Beaver. But here
20 we certainly are not talking about a psychotic
21 individual. We've already determined that he is not
22 psychotic.

23 A. Right. I was just using that as an example.

24 Q. And making determinations as to one who has
25 been involved in a crime or a psychotic episode is much

1 simpler than what we're dealing with here; is it not?

2 A. Yes.

3 Q. And Judge Winmill asked you about what you --
4 how would you write up what you knew in 1985 -- or
5 1990, based on the reports that were available up to
6 that point of sentencing. In fact, in 1996, an MRI was
7 performed at the request of the petitioner; was it not?

8 A. That's my understanding, yes.

9 Q. And nothing was found at that time?

10 A. Well, the person that interpreted did not
11 interpret it as positive findings. But, subsequently,
12 it was found to have --

13 Q. I appreciate that. But at that time, it was
14 not found. And, in fact, in '95 and '96, when you
15 evaluated Mr. Leavitt, you did not find anything that
16 was truly indicative of organic or traumatic brain
17 injury; did you?

18 A. He did fine on the cognitive testing.

19 MR. ROSENTHAL: Thank you, Doctor.

20 THE COURT: Mr. Nevin.

21 MR. NEVIN: Thank you, Your Honor.

22 FURTHER REDIRECT EXAMINATION

23 BY MR. NEVIN:

24 Q. Well, Dr. Beaver, your findings, however -- or
25 you testified previously that the findings that you

1 have made are consistent with an organic cause for
2 Mr. Leavitt's condition and have been all along. Has
3 that changed?

4 A. No, that hasn't changed.

5 Q. Okay.

6 A. You know that the complexity, as we talked
7 about earlier, and this is particularly the case in
8 that more right frontal or right anterior area of the
9 brain, is our tests are not very good at picking up
10 those changes?

11 Q. Right.

12 A. But we do have the pattern of behavior and we
13 do have evidence on neuroradiological studies that show
14 that structural abnormality.

15 Q. And your testimony before about these being
16 cognitive tests, whereas this is primarily a
17 behavioral/emotional problem, none of that has changed?

18 A. No.

19 Q. Okay. Now, it is correct that the person who
20 read the MRI in 1996 didn't see these defects? And
21 counsel asked you about that just a moment ago.

22 A. Correct.

23 Q. Okay. When people read MRIs and X-rays and
24 CTs and blood tests and all the other testing that is
25 done in the medical, psychological, psychiatric field,

1 has it been your experience that they are perfect, that
2 they are always 100 percent accurate in these efforts?

3 A. No.

4 Q. So the field is now and has always been
5 populated by human beings; correct?

6 A. Yes.

7 Q. And they do sometimes make mistakes?

8 A. Yes.

9 Q. And it appears that the doctor here made a
10 mistake, as well?

11 A. I think it's one of perspective. I think that
12 Dr. Vic -- or -- anyway, is the one that did the scans.
13 And if you look at it, he was particularly looking for
14 structural changes as related to the temporal area
15 associated with possible temporal lobe seizure.

16 Then you go into those scans -- if you have
17 ever looked at the very technical MRI scans, there is a
18 ton of data there. And just like any clinician, you go
19 in there with a particular perspective and a series of
20 hypotheses that you are ruling in or ruling out things,
21 and that influences what you find.

22 Q. But now, Doctor, just to return to the
23 question that I heard the Court ask you before, and I
24 just would like to ask you to address this, I think
25 Judge Winmill asked you how different your report would

1 be if you knew what we know now based on these organic
2 factors, how different a report that you would have
3 prepared in 1990 would have been by comparison to what
4 was available, what was actually provided in 1990.

5 And so now the question becomes, if you
6 include the existence of organic features back in 1990,
7 how different would the picture have been? And if I
8 understand the testimony you have given previously, you
9 would have ruled out antisocial personality disorder?

10 A. Yes.

11 Q. And antisocial personality disorder was very
12 significant -- would you say that antisocial
13 personality disorder was a very significant finding in
14 the reports that were made in 1990?

15 A. Well, certainly a central focus of the report.

16 Q. Second, you've testified that a finding of
17 organicity or structural injury would have ruled out a
18 diagnosis of intermittent explosive disorder?

19 A. Yes.

20 Q. And intermittent explosive disorder was a
21 significant feature of the judge's -- of the reports
22 that were provided to the judge in 1989 and '90;
23 correct?

24 A. Yes.

25 Q. And the central idea of organic structural

1 defect is that -- you referred to this previously, that
2 it causes behavior that comes out of a physical injury
3 as opposed to coming out of personality; correct?

4 A. Well, it really goes more to -- it's a little
5 bit different than that. When you have a structural
6 problem where you have poor regulation of the system
7 emotionally, okay, what you see then is the person
8 reacting to a stimuli. But that reaction, both
9 internally and externally, is significantly skewed.
10 That creates difficulty.

11 That is different than a person who has some
12 aberrant psychological needs that motivates the
13 behavior in a particular way or direction to meet those
14 aberrant psychological needs.

15 So that's why historically within the
16 profession we've viewed it as apples and oranges.

17 Q. Well, you have testified in criminal cases
18 before, both before 1990 and continuing up until the
19 present; is that correct?

20 A. Yes.

21 Q. And is it a feature of psychiatric testimony
22 in criminal cases, of the inquiry, to look at whether a
23 person has organic injuries as opposed to just behavior
24 that flows out of personality?

25 A. Yes, very common.

1 Q. I will represent to you that Mr. Timothy Ford
2 testified during the case previously, and that he
3 testified that this is a distinction that's extremely
4 significant.

5 . Has it been, in your experience, also
6 extremely significant?

7 A. Yes.

8 Q. Okay. And all of those things would have been
9 different if you had been able to include the existence
10 of organic defects in a report given to Judge George
11 and to Mr. Moss and to Mr. Parmenter back in 1990?

12 A. Yes.

13 MR. NEVIN: That's all I have. Thank you.

14 THE COURT: I can't resist the temptation. I
15 just want to be clear on just one or two...

16 Well, first of all, Counsel, I may be leading
17 with my chin on this one and acknowledging something
18 that I may have misunderstood from the record. I had
19 thought that the psychological testing that had been
20 done pre-1989-90 concluded no sociopath, no psychopath
21 ambiguity on antisocial personality disorder, but a
22 finding of intermittent explosive disorder. Am I
23 incorrect on that? I mean, I certainly can dig that
24 out and find it out. But just for purposes of my
25 understanding as I sit here today, how far off am I?

1 Mr. Rosenthal?

2 MR. ROSENTHAL: I believe you're accurate,
3 Your Honor.

4 THE COURT: Well, Mr. Nevin, I'm not too far
5 off. I mean, I -- Mr. Rosenthal said I'm dead on. And
6 I think you're going to probably quibble a little bit
7 with that, but I'm not too far off.

8 MR. NEVIN: Not too far off.

9 MR. ROSENTHAL: But I've been dealing with
10 judges longer than he has.

11 MR. NEVIN: Not much. But, no, I think that's
12 right. It was intermittent explosive disorder, and it
13 had been diagnosed for some period of time.

14 THE COURT: Right.

15 MR. NEVIN: Coming up to '89-90. And when you
16 throw in the overlay of the antisocial personality
17 disorder there in '85 at the first sentencing. And at
18 the second sentencing --

19 THE COURT: So there was a diagnosis of
20 antisocial personality disorder at the time of the
21 second sentencing?

22 MR. NEVIN: Yes. And at the time of the first
23 sentencing.

24 THE COURT: Okay. That's helpful. I, for
25 some reason, thought that there was some ambiguity.

1 Okay. Mr. Durham is sending me a message that
2 Dr. Groberg may have diagnosed him --

3 MR. NEVIN: Yes, exactly.

4 THE COURT: -- with that, so...

5 All right. Let me gather my thoughts here,
6 Counsel, and see if I have any further questions.

7 EXAMINATION

8 BY THE COURT:

9 Q. Dr. Beaver, I think this may be almost
10 rhetorical. I am going to assume that no one can
11 conclusively say that the signal -- I use the word
12 signal abnormalities, revealed in that 2006 MRI and
13 hinted at in the 1985 CAT scan, no one can conclusively
14 say that those signal abnormalities indicate a defect,
15 an organic defect which explain Mr. Leavitt's conduct.
16 I mean, you can't conclusively -- I mean, can one
17 conclusively say that? Well, let me explain.

18 A. Okay.

19 Q. My sense is that what you're saying is that
20 when one couples those signal abnormalities with the
21 fact that they exist in an area which regulate response
22 and propriety of a response, and couple that with the
23 intermittent explosive-type behavior exhibited by
24 Mr. Leavitt leads you to infer that there is a
25 correlation between the two, and that to a degree of

1 scientific probability, you're willing to offer that
2 opinion?

3 A. Yes. It's an inference, Your Honor.

4 Q. Right. Because I suspect there is probably
5 not a science around that could, because of the
6 complexity of the brain, no one could conclusively say
7 that that injury is exactly in the area which would
8 control this type of behavior and we can say with
9 100 percent certainty.

10 But given, again, the way we function in
11 courts and the way you have to function in your
12 profession, we make -- and I won't use the word
13 educated guesses, but we draw inferences and then offer
14 opinions based upon what we perceive to be reasonable
15 inferences based upon your training and experience?

16 A. Yes.

17 Q. Fair?

18 A. Yes.

19 Q. All right. I believe that's all.

20 Back to the '95 MRI.

21 MR. NEVIN: Your Honor, '96.

22 THE COURT: '96 MRI. I'm sorry. My notes
23 were a little confused on that. I appreciate your
24 clarifying.

25 BY THE COURT:

1 Q. The fact that the doctor did not pick up on
2 the abnormalities, the signal abnormalities, does that
3 indicate that they are fairly subtle, or only that he
4 was misdirected because he was looking at the temporal
5 area of the brain rather than the frontal lobe?

6 A. I think both.

7 Q. Okay.

8 A. If I might add one other?

9 Q. Yes.

10 A. With an MRI is -- you know, there is a huge
11 amount of numerical data that gets generated in the
12 process, and then the computer program interprets that
13 data and generates both the images and other technical
14 readouts in terms of numbers. And so both things are
15 the case in what you were saying, is that, one, we're
16 talking about more subtle findings, which still can
17 have profound impacts on emotional regulation, but they
18 are still more subtle findings.

19 And, secondly, it is the case that within that
20 backdrop, looking at it from a clinical treatment
21 perspective, okay, we're looking for, in this
22 particular case you will see in the report they are
23 looking for a temporal seizure disorder. And they did
24 a particular set of slides as looking at the temporal
25 medial area, which is where you look for those kinds of

1 problems. That really wasn't a focus.

2 So you wouldn't expect a lot of attention on
3 those more frontal wide tract areas. So they are more
4 subtle. They are not going to jump out at the
5 clinician. And my point was that his perspective and
6 focus was more on those medial temporal regions.

7 THE COURT: All right. Anything else?

8 MR. ROSENTHAL: Nothing else, Your Honor.

9 MR. ANDERSON: Oh, just a moment.

10 THE COURT: All right. While you're
11 discussing it, I'll ask Mr. Nevin. Do you have
12 anything else?

13 MR. NEVIN: Not unless they do, Your Honor.

14 THE COURT: Okay. Fair enough. Fair enough.

15 MR. ROSENTHAL: I do have a question.

16 THE COURT: All right.

17 FURTHER RECROSS-EXAMINATION

18 BY MR. ROSENTHAL:

19 Q. Dr. Beaver, did you direct the 1996 MRI scans?
20 Was that at your recommendation?

21 A. Yes.

22 Q. And didn't you emphasize to the radiologist
23 what you were looking for?

24 A. No.

25 Q. And in 1989 you talk about the subtleties of

1 these hyperintensities or signal abnormalities. The
2 technology and the knowledge in 1989 was even less than
3 it was in 1996; was it not?

4 A. Well, again, I don't think I am the expert on
5 technology about this, but technology has changed,
6 obviously, over the years.

7 MR. ROSENTHAL: Fine. Thank you, Dr. Beaver.

8 THE COURT: Yes. Apparently, you have
9 reconsidered? Go ahead, Mr. Nevin.

10 MR. NEVIN: Yes, sir, I did.

11 FURTHER REDIRECT EXAMINATION

12 BY MR. NEVIN:

13 Q. You know, Dr. Bigler, I will represent to you
14 that Dr. Bigler testified that these white matter
15 hyperintensities would have been discernible in 1990
16 and would have been interpretable. And I take it you
17 are not in a position to disagree with that -- agree or
18 disagree with that finding or that testimony?

19 A. You know, Dr. Bigler is internationally known
20 for his skills in this particular area and I wouldn't
21 want to second-guess him.

22 MR. NEVIN: All right. That's what I had.
23 Thank you.

24 THE COURT: All right. Nothing else?

25 MR. ROSENTHAL: No.