IN THE UNITED STATES DISTRICT COURT
FOR THE EASTERN DISTRICT OF VIRGINIA
Newport News Division

UNITED STATES OF AMERICA	
	CRIMINAL ACTION
V.	
	NO. 4:11cr112
KEITH BRENT DUNCAN,	
Defendant.	

TRANSCRIPT OF PROCEEDINGS

Norfolk, Virginia

May 21, 2013

(Sell Hearing)

Before: THE HONORABLE RAYMOND A. JACKSON
United States District Judge

Appearances:

UNITED STATES ATTORNEY'S OFFICE
By: DEE M. STERLING, ESQUIRE
Assistant United States Attorney
Counsel for the United States

FEDERAL PUBLIC DEFENDER'S OFFICE
By: PHOENIX A. HARRIS, ESQUIRE
and
KAUFMAN & CANOLES
By: LAUREN B. TALLENT, ESQUIRE
Counsel for the Defendant

The defendant appearing in person.

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(Court convened at 10:06 a.m.)

THE DEPUTY CLERK: United States of America versus Keith Brent Duncan, in criminal case 4:11cr112.

Ms. Sterling, is the government ready to proceed?

MS. STERLING: The government is ready, Your Honor.

THE COURT: Ms. Harris, Ms. Tallent, is the defendant ready to proceed?

MS. TALLENT: He is. We are ready, Your Honor. Good morning.

THE COURT: All right. Good morning.

Ladies and gentlemen, we are here this morning for the purposes of conducting a hearing pursuant to *Sell*. I have had an opportunity to read the submissions of the United States and of the defendant, as well as the stipulation that the parties have filed in the case.

Ms. Sterling, how many witnesses do you intend to call in this hearing?

MS. STERLING: We intend to call two this morning, Your Honor.

THE COURT: Two witnesses.

And is the defense potentially calling any witnesses in this case, Ms. Harris, just to get an idea of where we are going?

MS. HARRIS: Your Honor, at this time we do not plan to call any witnesses. Mr. Duncan has expressed his wish to testify, but we have advised him he doesn't have that right in this capacity and we don't intend to call him as a witness, Your Honor.

THE COURT: Okay. That's fine.

Ladies and gentlemen, the Court is prepared to go forward.

Ms. Sterling, are there any preliminaries you want to address, or do you want to call your first witness?

MS. STERLING: Your Honor, if I might address the Court briefly.

As the Court has indicated, there was a stipulation filed yesterday. It was the desire of the government and defense counsel to try to pare this down to get to the issue at hand, and that is the reason for the stipulation.

The stipulation contains stipulations of fact and stipulations as to documents that would be used as exhibits in this case. I would advise the Court first as to the stipulation of facts. These are facts that were gleaned from the various reports that the physicians, these psychiatrists, prepared. So rather than making reference back and forth to materials contained in the

report, we have just set those forth as a stipulation.

The stipulation does state the charge, which, as the Court knows, the defendant was indicted for possession of a firearm in violation of a protective order. It states, very briefly, that the evidence of the government would be that this occurred on September 25th, 2011 at Langley Air Force Base. The defendant approached the gate about a matter of national security is what he was claiming. Due to his erratic behavior, officers requested permission to search his vehicle. That search produced a shotgun, a box of ammunition, along with several other articles.

Also contained in the stipulation is the fact that there was a protective order in the case of *Dushan versus Keith Duncan* at the Superior Court for the County of Cobb, State of Georgia, issued on February 22nd, 2011 to remain effective for a period of one year to February 22nd, 2012, and a finding in that order specifically that Ms. Dushan was a protected authority pursuant to 18 U.S.C. 922(g). So those are the basic facts underlying the reason Mr. Duncan is here today.

There's also, beyond that in the stipulation, really just a setting forth of the procedural history in the case, which I'm sure the Court is aware of.

THE COURT: Right.

MS. STERLING: But, again, we are just trying to not have to go over the various matters in this case that are not really related to the testimony today about the involuntary medications or the government's motion to involuntary medicate.

Your Honor, as to the exhibits, the government would like at this time to offer these exhibits and move them into evidence. As listed in that stipulation to exhibits, the first four are the reports that the Court has received, both from Dr. Brauman at MCC and-- two reports from Dr. Brauman and two reports from the Butner Medical Center involving the two psychiatrists who are testifying today.

In addition to that, under Stipulation No. 5, there's an involuntary medication report. I'm not sure if that was in the Court's file. This was a hearing that was conducted subsequent to our last appearance before the Court. It is essentially what's commonly known as a *Harper* hearing to determine the defendant's dangerousness in an institutional setting. Defense counsel had asked that be admitted in evidence, so the government has included that for that reason.

THE COURT: All right.

MS. STERLING: And, finally, there is an exhibit which is a copy of a letter from Mr. Duncan sent to the

Court. I assume that is also in the Court's file. That's why it's included, but just for the sake of--

THE COURT: Yes, let's do that because right now the Court has read so much the Court doesn't exactly recall this Exhibit 6.

Do you have it there?

MS. STERLING: I do, Your Honor, and it is addressed to the Court.

MS. TALLENT: May we be heard, Your Honor?

THE COURT: All right. I was going to ask you whether you had any objection to any of these exhibits?

MS. TALLENT: We do stipulate, Your Honor, as to their authenticity and agree that they are admitted. We don't need a custodian for certification. For items 1 through 5 we have no objection.

We do have an objection on relevance grounds to the letter from Mr. Duncan to the Court. We understand that it has been sent to the Court previously so it may be in the Court's possession already, but as for it to be considered as an exhibit or evidence in the context of the *Sell* hearing, our position is that it does not go to the factors under *Sell*. That's my stance on that particular exhibit. The other exhibits, no problem. We have no problem with them being admitted and considered by the Court.

But I did want to make one more note, Your Honor just so we are very clear, which is the protective order that Ms. Sterling mentioned in paragraph 3 of the stipulation of facts. This was carefully worded between us that this protective order was issued and was to remain in effect until February 22nd, 2012, but we are not conceding that it was in effect on February 22nd, 2012. That would be an issue that could be litigated still at trial. So we are not conceding that point. We agree that it was issued and that it was to remain in effect if it was not canceled in the future.

THE COURT: All right. That's a very fine distinction.

MS. HARRIS: I'm sorry, sir?

THE COURT: It's a very fine distinction.

MS. HARRIS: Yes, sir.

THE DEFENDANT: Sir, may I add that it was canceled July 15th, 2011?

THE COURT: Mr. Duncan, in here don't talk today. Counsel will represent you.

THE DEFENDANT: If she can do that for me.

THE COURT: All right. Well, let her handle it. Don't talk out loud like that in here, okay?

All right. The Court has it.

MS. HARRIS: That was all I had to say, Your

Honor.

THE COURT: All right. The Court has it.

Ms. Sterling, with respect to the letter, the Court understands what the *Sell* factors are. The Court doesn't even understand what is in that letter, but the Court has serious doubt that what's in that letter, unless the Court can be shown otherwise, has any bearing on the findings the Court has to make under *Sell*.

MS. STERLING: Your Honor, it is the position -- the reason it was offered into evidence is because there's a lot of reference made about the voluminous writings of Mr. Duncan. It is illustrative of that. The government did not want to offer into evidence all these various writings that had been received by the government and all sorts of other parties.

If there is an objection to that, we can certainly take it out of the stipulation, but that was the reason for it. It was the government's understanding that that was agreeable, but we are not offering it specifically for the purposes of the Court's determination under *Sell*.

THE COURT: Upon the stipulation of counsel, Government's Exhibit 1, 2, 3, 4 and 5 are admitted. Exhibit 6 is not admitted.

(Government's Exhibits 1, 2, 3, 4 and 5 were

marked and admitted.)

MS. TALLENT: Your Honor, we did want to address just a couple of other preliminary matters before the hearing.

THE COURT: You may.

MS. TALLENT: Thank you, Your Honor.

We want to make clear, Your Honor, that we don't object and we will agree that Drs. Volin and Patole are experts and are qualified as experts in their fields, and we have no objection to them being qualified as experts before the Court today.

We would ask that the witnesses be sequestered. And additionally, Your Honor, because this is a complex matter-- I mean, there will be a complex argument given at the end sort of trying to pull the factors together with the testimony, then we would offer to Your Honor and, if you would like, we will submit post-hearing briefings.

THE COURT: Okay. The Court certainly can have the parties submit post-hearing briefings within 30 days of the date and the time of this hearing to save you the trouble of arguing. If you believe that that would in any way assist you, the Court believes it has an understanding here-- maybe I better wait until the end of the hearing to determine whether I'm going to request

that briefing or not. We are going to do that. We are simply going to wait.

Now, the Court would direct that the witnesses be sequestered, be separated.

Where are they located anyway? Wherever they are, they need to be sequestered.

MS. STERLING: They are testifying via video conference phone, but, Your Honor, the government's first witness would be Dr. Patole.

THE COURT: Okay. Dr. Patole is your first witness, then your next witnesses certainly needs to be sequestered during the testimony of Dr. Patole, and if you could direct them to do that.

I don't know which one is Dr. Patole, so you will have to--

MS. STERLING: Dr. Patole is in the purple shirt.

THE COURT: Okay. Well, then we are going to have Dr. Volin to step out.

MS. STERLING: And Dr. Marra as well, Your Honor.

THE COURT: Okay. Will all witnesses step out except Dr. Patole.

(The witnesses were excused from the courtroom.)

THE COURT: All right. Patrice, you may swear

her in.

(The witness was sworn by the deputy clerk.)

THE COURT: You may be seated.

SONAL PATOLE, M.D., called as a witness, having been first duly sworn, was examined and testified as follows:

DIRECT EXAMINATION

BY MS. STERLING:

Q. If you would, ma'am, please state your full name for the Court.

A. Yes. My name is Sonal Patole. It's spelled S-o-n-a-l, last name P-a-t-o-l-e.

Q. Dr. Patole, how are you employed?

A. I am currently a forensic psychiatrist Fellow at UNC Chapel Hill. As far as my training, I have rotated through the Butner Medical Center here in Butner.

Q. And you are training for what?

A. I am a forensic psychiatrist Fellow. I'm currently under training for a forensic psychiatrist.

Q. Okay. And what is your educational background in the field of forensic psychiatry?

A. So after graduating college, I attended medical school. I graduated from medical school in 2008. After that I finished a general psychiatry residency in 2012, and then I joined the forensic psychiatry training

program here at UNC Chapel Hill as well.

Part of my training involves me rotating through the state hospitals. That's the Central Regional Hospital, the North Carolina State Hospital, the Federal Medical Center, and also the Dorothea Dix Hospital in Raleigh.

Q. Are you still involved in training to be a forensic psychiatrist?

A. Yes, ma'am.

Q. Okay. And are you at Butner at this time in your training?

A. I finished my rotation at Butner in December of last year.

MS. STERLING: Okay. I do have for the Court, Your Honor, and I would move to admit Government's Exhibit 7, the CV for Dr. Patole. I realize there's been a stipulation, but I would ask she be qualified as an expert in forensic psychiatry. I submit that for the Court's information.

THE COURT: Any objection?

MS. TALLENT: No objection, Your Honor.

THE COURT: Okay. Exhibit 7 will be admitted.

(Government's Exhibit 7 was marked and admitted.)

BY MS. STERLING:

Q. In your course of rotation at Butner, did you have occasion to evaluate Keith Duncan?
A. Yes, I did.
Q. Are you having trouble hearing me?
A. A little bit, but I think we can manage.
Q. All right. I will try to speak a little more slowly.

Are you able to see the courtroom to see that Mr. Duncan is here today?

A. I am not able to see Mr. Duncan. He's not on the screen for me.

THE COURT: What can she see?

THE WITNESS: I can see yourself and also Ms. Sterling, and the court reporter.

Yes, I see Mr. Duncan. He's the gentleman waving at me.

MS. STERLING: All right. If the record could reflect that the witness has identified the defendant, Your Honor.

THE COURT: The record will so reflect.

MS. STERLING: Thank you.

BY MS. STERLING:

Q. And what was the purpose of your evaluation?
A. Mr. Duncan was admitted to FMC on the 19th of July of last year. On admission he received both a medical

evaluation and a psychiatric evaluation, just on the intake.

As far as the medical evaluation, he received basic labs and also he received a full medical and physical exam. The intake was done by Dr. Volin. And subsequent to that when I joined the facility as part of my training, I interacted with Mr. Duncan at least on a weekly basis while I was here, and it involved extensive interviews ranging anywhere from between 15 and 45 minutes on a weekly basis.

It also involved a gathering of collaterals on both the AUSA and also from medical records, also information from his family. We also had consulted with Dr. Dillon Grant, who is a psychologist at FMC.

Q. Okay. And do you know why Mr. Duncan was admitted to Butner in July of 2012?

A. Yes. Under Section 4241 he was admitted to Butner for competency restoration and evaluation of competency to stand trial.

Q. Okay. And was that pursuant to a court order?

A. Yes, ma'am. It was a court order.

Q. All right. Now, you indicated that you met many times with Mr. Duncan. Can you tell us approximately how many times you met with him in the course of your evaluation?

A. I met with him at least on a weekly basis. So at least 12, 13 times that I was here I have had occasion to meet with him, if not more.

Q. All right. And how would you describe his demeanor and his conduct during those meetings?

A. Mr. Duncan is a very nice fellow. He's an intelligent person. He was cooperative with the examination, but when we would attempt to try to talk about his legal issues and his current evaluation he would become easily agitated and, therefore, at times I had to terminate interviews due to that agitation.

Q. And what do you mean about the agitation, what specifically?

A. When he would discuss his legal issues, he would repeatedly try to assert that the reason for him being here was part of a conspiracy. For example, if we were to talk about, you know, as far as the competency evaluation, what the role of the lawyer was, he knew what his defense attorney was supposed to do, but then the conversation would derail into how his attorney is involved in the conspiracy and then it would further derail into encompassing other folks in the institution and outside of the institution, and kind of just sort of postulating about why these folks are after him and are involved in a conspiracy.

He would have to be redirected to talk about the issue at hand. His volume would increase, the rate of his speech would increase, and he would become-- he would physically become agitated. So that's why we would have to terminate the interview.

Q. Did you terminate the interview after trying to redirect him?

A. I'm sorry. Can you repeat the question, please?

Q. Did you try to redirect his focus before terminating?

A. Yes. I would try several times. I think we would try-- you know, I tried several approaches with him to redirect him to the issue at hand, but I was often unsuccessful.

Q. Okay. And I believe you indicated that because you were a Fellow, you were supervised by a staff in your evaluation; is that correct?

A. Yes. I was supervised by Dr. Volin.

Q. That's Dr. Jill Volin?

A. Yes, ma'am.

Q. Okay. And I believe you touched on this also, but in addition to your interviews with Mr. Duncan, what, if any, other sources of information did you use in performing your evaluation?

A. The other sources we used were medical records that

we obtained from Peachford Hospital in Atlanta. We also contacted his family members for information. We also reviewed material from his previous evaluation in New York, and we also reviewed any other Bureau of Prisons records that were available. We also reviewed incident and witness reports that were forwarded to us regarding the alleged offense.

Q. Okay. You indicated you reviewed medical records from Peachtree (sic.). What did those entail?

A. I believe it's Peachford Hospital. It was a involuntary psychiatric admission that was done for Mr. Duncan in the past, and we obtained those records.

Q. Okay. Based on your evaluation, including a review of the documents you have indicated and your interviews with Mr. Duncan, did you form a medical opinion with a reasonable degree of certainty as to whether he suffers from a mental disease or defect?

A. Yes.

Q. Okay. And what is your opinion?

A. He has schizoaffective disorder.

Q. Okay. And could you tell us briefly what you mean by that? What is schizoaffective disorder?

A. Sure. So schizoaffective disorder is the type of disorder that has symptoms both of a mood disorder, which is bipolar disorder, and also symptoms of a

psychotic disorder, which is schizophrenia.

So with schizophrenia a person usually experiences delusions or hallucinations. Delusions are fake, false beliefs, and hallucinations meaning hearing things that no one else can hear or seeing things that no one else can see.

Bipolar disorder is more of a cyclical disorder. You see symptoms of mania, which is when folks have deeper sleep, they talk really fast, they are disorganized, and that's a manic episode. They can also experience a depressive episode.

But schizoaffective disorder is a combination of both schizophrenia and bipolar disorder. So schizoaffective disorder you have the cyclical nature of the illness, whereas on occasion the patient experiences manic episodes and also can experience depressive episodes later on. But in between episodes they still have the psychotic symptoms.

In bipolar disorder you have the episodes of mania and depression, but in between those episodes the patient is symptom free. In schizoaffective disorder that's not the case. You have the episodes, but in between those episodes the patient doesn't have psychotic symptoms present but the delusions present.

Q. So in schizoaffective disorder, as I understand what

you are saying, there was never a time when the person diagnosed is asymptomatic; is that correct?
A. That is correct.
Q. Are there different types of schizoaffective disorder?
A. Yes. Schizoaffective disorder bipolar type, and there is schizoaffective disorder disorganized.
Q. Did you diagnose Mr. Duncan, the defendant, as having a particular type of schizoaffective?
A. We diagnosed him with schizoaffective disorder bipolar type.
Q. Now, you have described for us what that diagnosis entails as far as symptoms, but can you tell us specifically why you diagnosed Mr. Duncan with schizoaffective disorder bipolar type?
A. Sure. Mr. Duncan, he was initially hospitalized in Arizona, I believe, in '98 and during that time we were not able to get the records, but his wife described him as having a manic attack.

After that he was again hospitalized where he was seen to have manic symptoms, and that's when he was admitted at Peachford Hospital.

During that hospitalization the description, basically, on his admission note stated that he had this paranoid belief that his wife was trying to kill him.

He was described as floridly manic, very paranoid, delusional and grandiose. He was treated and discharged.

Again, he was seen by Dr. Hege, and he also noted episodes of Mr. Duncan being hypomanic or manic. That's how he was described.

More importantly, even within these periods where it appears that he was having these psychotic episodes, there was instances where he was just having psychotic symptoms.

His son-- his family provided to us that even when he was less manic, he would have thoughts such as he had the ability to control things with his mind, which they were delusions.

Also, when he was arrested after-- when he was under observation with Dr. Brauman, he was noted to require very little sleep, he was always irritable, grandiose, demanding, symptoms you see in mania.

While he has been here, we have not seen him as manic, but what we have seen is that he continues to have the delusional beliefs regarding Mr. Rose and Ms. Bashama, which he's had these symptoms throughout his illness. He has not really shown us that he has the manic symptoms, but that's why we diagnosed him as having the schizoaffective disorder because he has the

cyclical episodes of mania, but also being psychotic.
Q. Just for those of us who are not psychiatrists, when you say someone is manic or hypomanic, what do you mean by those terms?
A. So when I describe somebody as manic, it's somebody who has a lot of energy but they really don't require any sleep. They have decreased need of sleep and they will not feel tired. They will be able to do multiple things and they start multiple things, but don't finish them. Their thoughts can be disorganized. Their speech, we call it, can be uninterpretable. He's talking. It's hard to interrupt and put any suggestions in there.

They also have impulsive behaviors such as, you know, driving fast or using substances. They can also have psychotic symptoms such as paranoid delusions or delusions of grandeur. So that's what a manic episode looks like.
Q. What about hypomania? You used that term. How is that different from manic or mania?
A. So mania means-- usually the symptoms I mentioned earlier, they last for either a week or less than a week if the person needed hospitalization. But in hypomania, they have the same degree of-- in hypomania, we have somebody who does require less sleep, but their thoughts

might not be quite as disorganized. They might have a lot more energy, but they will at times feel tired. The symptoms only last for about four days. The person does not experience any psychotic symptoms. Their life is not impaired by these symptoms to the point that they need hospitalization. So hypomania is kind of a baby mania, basically. There are symptoms, but to a much lesser degree and no psychotic.

Q. Okay. Thank you for that explanation.

Dr. Patole, based on your evaluation, did you prepare a report containing your diagnosis?

A. Yes, we did.

Q. In fact, weren't there two reports prepared in Mr. Duncan's case?

A. Yes, there were two reports. Yes.

Q. Just for the record, those reports were prepared in September of 2012 and December 2012; is that correct?

A. Correct.

Q. And in your report --

Your Honor, those are moved into admission as Government's No. 3 and 4.

THE COURT: They have been admitted.

MS. STERLING: Thank you, Your Honor.

BY MS. STERLING:

Q. In your report, in addition to your diagnosis, did

you address the issue of Mr. Duncan's competence to stand trial?
A. Yes, we did.
Q. And did you form an opinion as to whether he was competent to stand trial?
A. Yes. I believe that Mr. Duncan is currently not competent, based on the information I have, to stand trial.
Q. Okay. When you say currently, you mean as of the dates of those two reports; is that correct?
A. Yes. As of the date of those reports he was not competent to stand trial, correct?
Q. And you would state that with a reasonable degree of medical certainty; is that correct?
A. That is correct.
Q. Okay. Does your report indicate a medical opinion as to whether there's a substantial likelihood that Mr. Duncan's competence could be restored with appropriate treatment?
A. Yes.
Q. And, again, can you state an opinion with a reasonable degree of medical certainty as to whether he could be restored?
A. I believe Mr. Duncan can be restored within a reasonable medical certainty.

Q. Okay. And what do you base that opinion on?
A. So Mr. Duncan has in the past, he has a history of being noncompliant. But we do know that when he was at Peachford Hospital he was treated, and compared to when he was admitted to the hospital where he was described as floridly manic and delusional and so forth, with treatment his mental status improved. And based on that window, we know that medications are effective in treating his symptoms.

There's also a lot of data that support that people with similar symptoms as Mr. Duncan have been restored to competency with treatment.

Q. Okay. And you say you reviewed the records of Peachford. What was he treated with at Peachford?
A. He was treated with Abilify at Peachford.
Q. What is Abilify?
A. Abilify is an antipsychotic medication.
Q. And how is that medication administered?
A. Can you repeat the question?
Q. How is that administered?
A. That was administered orally.
Q. Okay. So you based your opinion on his personal record, studies of similarly situated people, and your just basic understanding of his situation; is that correct?

A. I'm sorry, I didn't hear that last part.
Q. So in your opinion he could be restored based on his history and studies or things that you know about similarly situated persons; is that correct?
A. That is correct.
Q. All right. And in the report or in both of the reports did you outline a treatment plan that was designed to restore Mr. Duncan's competence?
A. Yes, we did.
Q. Okay. And did that plan entail the use of psychotropic medications?
A. Yes, it does.
Q. And what type of medications did you recommend in the report as far as would be needed to treat or best treat Mr. Duncan?
A. So the proposed treatment plan would be-- well, first of all, we would like for Mr. Duncan to participate in the treatment, so that would be to give us the permission to treat him voluntarily because it would allow us to sit down with Mr. Duncan and, you know, show him the order and discuss the various options he has in terms of taking medications orally versus injectable medications. We would prefer to use oral medications if he is amenable to be treated. You know, we have several medications available to us.

There are older medications which we call typical medications or typical antipsychotics and newer ones which we call atypical antipsychotics. Some of the older medications are alda corphenadene, and the newer medications are Risperdal, Abilify, Zyprexa, and so forth. So we would sit down with him, talk to him about the risks and benefit of each medication and, you know, we would work with him to make a choice. Abilify is also one of the newer medications, and that's also available to us to administer.

Were Mr. Duncan not wanting to participate in his treatment plan, we do have available injectable antipsychotics. Haldol, Perphenazine are available. And also Zyprexa, which is a newer antipsychotic medication, that's available as well. And we would have administered them intramuscularly, and you would take appropriate institution measures to ensure safety in administering those medications?

Q. These medications would be injected only if Mr. Duncan would not agree to take medications orally; is that correct?

A. That is correct.

Q. Has Mr. Duncan taken medications or been offered medications orally, psychotropic medications, while at Butner?

A. Yes, he was. When he initially came here, he was offered an oral trial of Risperdal. He took maybe one or two doses but then complained about side effects, and later on said he had actually not taken the medications. A search of his cell was done, and I believe two Risperdal pills were found that he had not taken.

Q. And does your review of the medical history of Mr. Duncan, including his prior treatment at Peachford and with other psychiatrists or healthcare professionals, indicate his compliance with oral medication?

A. He has-- as I mentioned earlier, he has been mostly noncompliant in the past. The only time that he would let me know he was truly treated was when he was at Peachford, and that was in a hospitalized setting.

Q. As far as medications that might be used for involuntarily medicating the defendant, does the treatment plan suggest a number of different medications and what, if any, is the order of preference?

A. The treatment plan does talk about different medications. We would be able to offer him the newer medications that I mentioned: Risperdal, Zyprexa and Abilify. We would monitor him for any side effects, and again, we would be able to discuss the risks and

benefits and monitor, you know, what type of side effects, if any, he's having.
Q. Okay. And what about the plan for Haldol and other medications to be injected, if necessary?
A. If Mr. Duncan declines medication, declines treatment, we would start with Haldol, which is an injectable medication and one of the older medications. We would start with like 5 milligrams intramuscularly every day and then monitor how he's doing.
Q. And does the plan also indicate the dosage amount, the frequency, and the amount of time you believe would be necessary before it became effective in making him competent or rendering him competent again?
A. The plan does suggest some dosages of the medications. I believe you have outlined those on page 33 of the report. They include Haldol, 5 milligrams intramuscularly.
Q. The plan, in fact, is a suggested dosage frequency and amount necessary for restoration of the three suggested injectable medications; is that correct?
A. That is correct.
Q. All right. Does the plan also set forth for the Court the potential side effects of the medications suggested?
A. Yes. The report does contain information about the

side effects.
Q. If you would, could you tell us briefly what those potential side effects are and what, if any, measures are set forth in the plan to deal with those?
A. Okay. The three main side effects that would be of concern would be, first, primarily vision, especially Mr. Duncan, you know, wanting to be able to participate in his legal defense.

But, again, the patient will be monitored, and you are going to start at a very low dose and then increase the medication as needed, but at the same time you are going to balance it with the need for him to be alert. Usually the side effect of sedation lessens the more the patient is on the medication.

Also, the other side effects are movement disorders. Sometimes initially they will experience stiffness and that can be treated, what we call Parkinsonism, and that could be treated with medications like Cogentin, and also the other movement disorder that we worry about is a long-term movement disorder called Tardive Dyskinesia, which is abnormal movements that occur after a person has been on an antipsychotic medication for a long time. So that side effect is something that has to be monitored for long term and it's unlikely that we will see it within the time frame

that we will be monitoring Mr. Duncan.

And lastly, the last side effect of concern is what we call metabolic syndrome. Metabolic syndrome is a tendency for, especially the newer medications, to cause folks to gain weight, develop diabetes, have increased cholesterol, and so forth. That is something that would need to be monitored on a periodic basis. Mr. Duncan would have to agree for us to do lab work in order to monitor for those things.

We would measure his pituitary, his lipids on a regular basis to make sure-- see how he was doing. His weight would also be monitored on a regular basis.

Q. And are there also, or is there not, as indicated in the report, a possibility of very severe, in rare cases, very severe side effects?

A. Yes. The very severe side effect is what we call a neuroleptic malignant syndrome. That is when a person becomes confused, develops a fever, and so forth. But again, this is something that we monitor for, and the way we avoid it is we start low and increase the medication slowly.

Q. And does the report indicate or do you have an opinion as to what the likelihood is of any severe side effects of the medications outlined?

A. Let me refer to my report for a second.

Q. Yes, ma'am.
A. So the estimated rate of neuroleptic malignant syndrome is somewhere from .07 percent to 2 percent for an individual treated with antipsychotic medication. So that would be, at the most, two out of a hundred patients would experience it, or at least seven out of a thousand.
Q. Are there any others there that you-- any other severe effects?
A. I'm sorry?
Q. I'm sorry. Does the report list any other severe side effects and the potential of their occurrence?
A. There's also because recently there has been what we call a black box warning with antipsychotic medication, it has been known to cause cardiac arrhythmia or causing the heart to beat in an abnormal way, and this is a very rare side effect. This cardiac arrhythmia can lead to sudden death. The incidents for that in a general adult population is somewhere between 7 events per 10,000 persons to 10 to 12 events per 10,000 persons.
Q. Okay. In the medications, does the treatment plan suggest that the Haldol, the Perphenazine and Risperdal, is there a difference amongst them the likelihood of any of these side effects?
A. So the side effects that I mentioned earlier, the

Parkinsonism side effects or the stiffness that I mentioned earlier, it's more likely to occur with the older medications, and the older medications are also more likely to cause the Tardive Dyskinesia or the abnormal movements that I talked about earlier. So Haldol or Perphenazine are the older medications and there's a higher incidence of those causing the movement side effects.

Risperdal is a newer medication. It's more likely to cause the metabolic syndrome that I mentioned earlier, causing folks to gain weight and so forth. The older medications and newer medications have a different side effect profile.

As far as the neuroleptic malignant syndrome and cardiac arrhythmia, the literature, I believe, says that all the older and the newer medications have pretty much the same incidence of those occurring.

Q. All right. So by way of summary, the report outlines all of the potential side effects and a plan for dealing with them through monitoring and treatment; is that correct?

A. That is correct.

Q. All right. Now, you have indicated that you believe the treatment plan outlined in the report is substantially likely to return Mr. Duncan to competence;

is that correct?
A. That is correct.
Q. And if you could, just tell the Court briefly why do you believe that to be the case, that this treatment plan will restore him to competence for the purposes of proceeding in this matter?
A. We are basing that on some of the competency maturation data that is already out there. There have been two studies published in 1993 where there were 61 incompetent folks and they were involuntarily treated in the state of New York and 89 percent of them were able to be restored to competency.

More recently in 2012, actually here at FMC Butner, Drs. Herbel, Cochrane, Reardon and Lloyd published a paper which basically looked at 132 folks who were incompetent and were involuntarily treated under *Sell* and were able to restore 70 plus percent of them to competency.

Q. Okay. What was the name of that study, I'm sorry, just to make that clear for the record?
A. It's on page 22. It's the study by Drs. Cochrane, Herbel, Reardon, and Lloyd. It was done in 2012. It's mentioned in the last paragraph.

MS. STERLING: Your Honor, I do have a copy of that study. Counsel has it also. I would mark it and

provide it for the Court as an exhibit, if that's agreeable.

THE COURT: Any objection?

MS. TALLENT: No objection, Your Honor.

THE COURT: All right.

MS. STERLING: I am marking a document entitled "The Sell Effect: Involuntary medication treatment is a clear and convincing success." Offered by Cochrane, Herbel, Reardon and Lloyd, as described by the witness. It is marked as Government's Exhibit 8, and we would move for its admission, Your Honor.

THE COURT: All right. It will be admitted.

(Government's Exhibit No. 8 was marked and admitted.)

BY MS. STERLING:

Q. So in addition to research which would indicate to you that the treatment plan would restore Mr. Duncan to-- or would be substantially likely to restore Mr. Duncan to competence, is there any other factor that you want to share with the Court as far as what leads you to that opinion?

A. Again, when Mr. Duncan was treated at the Peachford Hospital, he responded positively to antipsychotic medication treatment, and that tells me that he will more than likely be able to be treated with

antipsychotic medication again and get benefit from it.
Q. Okay. And Dr. Patole, do you have an expert opinion or opinion with a reasonable degree of medical certainty as to whether Mr. Duncan's competence could be restored without medication?
A. In my opinion his competency will not be restored without medication. Mr. Duncan has been without-- the evidence for that is Mr. Duncan has been without medication for the last year or more than a year as he's been in observation and his symptoms have not retracted. He continues to have the psychotic beliefs that are interfering with his ability to work with his attorney in a meaningful way.
Q. When was the last time you evaluated or saw Mr. Duncan in a professional capacity?
A. I met with Mr. Duncan, I think it was, mid-December of 2012.
Q. All right. And is there anything in the two reports, the September report and the December report that's been filed with the Court, or any of your observations, or any of those facts or any of your opinions different today than what was expressed in those reports when you wrote them?
A. No.
MS. STERLING: Thank you very much, Dr. Patole.

THE COURT: Cross-examination?

MS. TALLENT: Yes, Your Honor.

Before we start, Your Honor, we just wanted to clarify that the exhibits that have already been admitted, those will be under seal; is that correct?

THE COURT: Yes.

MS. TALLENT: Okay.

CROSS-EXAMINATION

BY MS. TALLENT:

Q. Good morning, Dr. Patole. My name is Lauren Tallent Rogers. I represent the defense.

A. Good morning.

Q. I would like to start with your certification. I would just like to clarify at the time you wrote the report, originally in September and then the addendum in December, you were not Board certified by the American Board of Psychiatry and Neurology as a forensic psychiatrist?

A. I had taken my board examination in mid-September. So by the time we issued our first report I had not heard back from the board, but the second time when we submitted the second report I had received my board report and at that point I was Board certified.

Q. So at the time you wrote the report, you explained you were participating in this fellowship in training?

A. I'm sorry. Can you repeat the question again?
Q. So at the time you wrote the report, you were participating in training for a forensic psychiatry program; is that right?
A. That is correct.
Q. Okay. And did your fellowship start roughly around July of 2012?
A. Yes, it did.
Q. Okay. So that's approximately two months before you submitted the original report in September?
A. Yes.
Q. Okay. And so was this the first time that you had dealt with forced medication in the Bureau of Prisons context?
A. Yes.
Q. And Dr. Volin supervised your evaluation?
A. Yes.
Q. But she wasn't present during all of your interaction with Mr. Duncan?
A. No.
Q. And there were times Dr. Volin met with Mr. Duncan without you?
A. Yes.
Q. But you wrote the report and the addendum that are before the Court today?

A. I'm sorry. Can you repeat that last part again?
Q. Yes. You, yourself, drafted the report and the addendum that are before the Court today?
A. The addendum-- I wrote the initial report, but the addendum was primarily written by Dr. Volin.
Q. Okay. Would you agree that the ultimate diagnosis of schizoaffective disorder was yours?
A. Yes.
Q. And, again, just to clarify, your fellowship with Butner ended in December of 2012, so you are no longer with FMC Butner?
A. I am not. I am rotating to other sites.
Q. Okay. I would like to talk a little bit about your diagnosis now.
So you diagnosed Mr. Duncan with schizoaffective disorder?
A. Um-hum, correct.
Q. I assume you are aware that all of Mr. Duncan's past doctors have diagnosed him with some form of bipolar disorder and not with schizoaffective disorder?
A. That is correct. As I mentioned earlier, there's a lot of overlap between bipolar disorder and schizoaffective disorder. We, fortunately, have the benefit of time. We have had a longer time to observe his symptoms.

Q. Okay. Just to kind of walk through them specifically, Dr. Hege who treated Mr. Duncan off and on from 2008 to 2011, he diagnosed Mr. Duncan with "Rule out bipolar disorder"; is that correct?
A. Correct. That is one of the diagnoses, yes.
Q. And at Charter Peachford Hospital where he was involuntarily committed for a short period of time, they diagnosed him with bipolar disorder, most recent episode manic with psychotic symptoms; is that correct?
A. That is correct.
Q. And then Dr. Brauman, who was the BOP appointed psychologist that gave the competency evaluation submitted to the Court, she diagnosed Mr. Duncan with bipolar type I, severe with psychotic features; is that correct?
A. That's correct.
Q. And the report itself seems to imply that Dr. Volin initially diagnosed Duncan with bipolar disorder. On page 15 of your report it says that she informed him she was treating him for bipolar disorder; is that correct?
A. On page 15 of my report?
Q. It mentions that Dr. Volin informed Mr. Duncan she was treating him for bipolar disorder.
A. Yes, that is what Dr. Robbins' recommendations are.
Q. And so you would agree that you are the only doctor

to have ever diagnosed Mr. Duncan with schizoaffective disorder?

A. As I mentioned earlier, I have had the advantage of looking at Mr. Duncan over a period of time rather than as a set period of time. Dr. Hege when he was seeing Mr. Duncan-- first of all, Mr. Duncan was noncompliant with his medication and there were large periods when there were relapses in between visits. So Dr. Hege would not know how Mr. Duncan was doing.

The second thing is, you know, again, when he was seen at Peachford Hospital, it was like one snapshot. It was kind of like seeing an entire movie versus seeing one scene of a movie. You can't really judge as to what was going on in the entire movie based on one scene.

Again, as far as Dr. Robbins' diagnosis, when she saw him, he was having symptoms that were consistent with mania, but his symptoms have evolved over time and we have seen him not manic but still psychotic.

Q. I understand. But just to clarify, you are the only doctor to have ever diagnosed Mr. Duncan with schizoaffective disorder?

A. That is correct.

Q. And you are obviously familiar with DSM-IV, so that's what you based your diagnosis on?

A. Um-hum, correct.
Q. And you are familiar with DSM-IV's criteria as it relates to schizoaffective disorder?
A. Um-hum.
Q. And as you begin to describe here, one of those criteria for schizoaffective disorder is observation of delusions for at least two weeks and absent of prominent mania symptoms?
A. That's correct.
Q. And the report states that you base this observation on conversations with family members; is that correct?
A. Yes, but I could clarify further. It was not only based on the information we got from the family, but also our observations here. He was not manic when he was here, but he was still psychotic for more than two weeks while at FMC Butner. So it was more than just the family report.
Q. Your report never mentioned observation of Mr. Duncan without having mania, does it?
A. It does. I think if you look through the exam again, you will see that there are times where he was able to-- he was not manic but still psychotic.
Q. If you could point to the page in the report, that would be great, because it does not appear the report ever mentioned a description of Mr. Duncan not being

manic. In fact, on page 16 of your report you note that he often had both manic and psychotic symptoms.

A. Let me look at my report, and I will let you know. One second.

THE COURT: What page of the report are you asking her to look to?

MS. TALLENT: This report is the addendum dated December 17, 2012.

THE COURT: Exhibit 4?

MS. TALLENT: Exhibit 4, yes, Your Honor.

BY MS. TALLENT:

Q. Dr. Patole, I will go ahead and move on.

A. Okay.

Q. In terms of your conversations with Mr. Duncan's family, did you personally talk to his family?

A. No, Dr. Volin did.

Q. Okay. So a second requirement for schizoaffective disorder-- in addition to observing him have delusions without mania, a second requirement is that you must show a manic episode concurrent with symptoms that meet criterion A for schizophrenia; is that correct?

A. Um-hum.

Q. So--

A. That is correct.

Q. So DSM-IV, when you are diagnosing schizoaffective

disorder, takes you over to look at schizophrenia in criterion A?

A. Uh-huh.

Q. Particularly, this is on page 12 of DSM-IV, it lists under criterion A that you have to have some combination of the following: Disorganized speech, grossly disorganized or catatonic behavior, negative symptoms such as affective flattening or bazaar delusions.

A. Um-hum.

Q. And he has to have at least one of those things concurrent with his manic episodes and concurrent with his delusions; is that right?

A. I'm sorry. Say the last part again, please.

Q. He has to experience at least one of those list of things concurrent with his manic episode and concurrent with his delusions?

A. Are you saying that he needs to have one of these criterion A symptoms, the delusions, hallucinations, and so forth, during a manic episode?

Q. Yes.

A. Yes. He can have psychotic symptoms during a manic episode, yes. I'm not sure I'm understanding your question, frankly.

Q. I will rephrase it.

Nowhere in your report do you describe Mr. Duncan as

having bazaar delusions, disorganized speech, disorganized or catatonic behavior, or negative symptoms such as affective flattening?
A. Part of the reports we received from his family, Mr. Duncan did believe he could control things with his mind, which I would classify as a bazaar delusion.
Q. Okay. But you personally have not experienced or observed Mr. Duncan having bazaar delusions. His delusions are, at least the majority, based in real life, based in fact.
A. I mean, they are probable; but, no, they are not--
Q. They involve real characters.
A. I'm sorry?
Q. You would agree they involve real actors, real people that exist in real life?
A. He had beliefs about real people, yes.
Q. Okay.
A. But they are delusions.
Q. So just to clarify, your basis for criterion A is that he has bazaar delusions?
A. I would classify being able to control things with your mind as a bazaar delusion, yes.
Q. Okay. But you didn't personally observe that?
A. No, I did not.
Q. Okay. So working with your diagnosis of

schizoaffective disorder, delusions or hallucinations are one of the main characteristics; is that correct?
A. That's correct.
Q. But as we have seen from the past diagnoses of other doctors, delusions can also be a feature of bipolar disorder?
A. That's correct.
Q. And those are not the only mental illnesses that can feature delusions; is that correct?
A. That's correct.
Q. In fact, there's delusional disorder?
A. You can have delusional disorder, yes.
Q. And just because one has a particular mental diagnosis doesn't mean that they cannot have a second mental diagnosis at the same time. That's why we have Axis I, Axis II; is that correct?
A. No, actually Axis I is where you would list all of the mental health issues. Axis II is for different personality disorders. The system does not differentiate that as Axis I diagnosis and Axis II is another diagnosis, no.
Q. Great. You can have more than one diagnosis at the same time?
A. Yes, you can.
Q. So it's possible to have both a mood disorder and a

delusional disorder?
A. You are right, it's possible. But in Mr. Duncan's case, that's not the case.
Q. So it's possible, just like you said, that Mr. Duncan's delusions could be a result of his bipolar or his schizoaffective, but it's also possible they could be a result of delusional disorder?
A. As I said, you could be right, but that's not the case in Mr. Duncan's situation.
Q. Schizoaffective disorder typically occurs or begins early in life; is that right?
A. There's a range and there's always people who fall on either side of the range, yes, but it typically starts from young adulthood.
Q. I'm sorry. So you agree the typical onset is early in life?
A. Yes.
Q. Mr. Duncan is currently 54 years old. It appears his symptoms began to appear in his late 40s. Does that sound correct?
A. That is correct.
Q. And delusional disorder typically has an onset later in life, would you agree?
A. Yes.
Q. But delusional disorder is never discussed in your

report, is it?
A. As I mentioned earlier, Mr. Duncan's situation does not warrant a delusional disorder diagnosis, but rather schizoaffective. And, again, schizoaffective disorder is a range. You can say on average a person starts experiencing these things at 30, or some can start at 20 and some can start at 40. You know, it's a range of when a person starts to experience those symptoms. In Mr. Duncan's case, his symptoms don't fit delusional disorder.
Q. So with any of the disorders we have discussed, including schizoaffective disorder, it's possible, even with medication, that the delusions could persist?
A. You are right, it's possible, but we have to make sure that we treat Mr. Duncan and see if it's true or not.
Q. Now, you have mentioned that you reviewed the Charter Peachford medical records?
A. I'm sorry, the Peachford medical records?
Q. Yes. You reviewed those; is that correct?
A. Yes, that's correct.
Q. And those records indicate that even after being treated with an antipsychotic and experiencing some improvement, Mr. Duncan's delusions still persisted somewhat?

A. That is correct. He improved with intervention to hypomania, but not improve full blown mania.
Q. And you also reviewed the records by Dr. Hege?
A. Correct.
Q. And so you are aware that Dr. Hege noted that even while Mr. Duncan was on antipsychotics and experienced some improvement, his delusions still persisted somewhat?
A. When Mr. Duncan was seeing Dr. Hege, there was a question of his compliance with medication and based on that, I cannot comment on as to if he was taking the medication or not and if he was, you know, completely compliant and still having symptoms.
Q. Did you ever personally talk to Dr. Hege about his treatment of Mr. Duncan?
A. No. I reviewed his records.
Q. And Dr. Hege treated Mr. Duncan off and on from 2008 until 2011; is that correct?
A. That's correct.
Q. But you didn't personally talk to him?
A. No.
Q. Now, you mentioned a couple studies in your report that you relied on for the effectiveness of the proposed treatment plan.
A. Um-hum.

Q. Particularly on page 22 of your report you mentioned the Herbel and the Cochran study?
A. Correct.
Q. Focusing first on the Herbel study which dealt with the treatment of delusion disorder, Herbel did not make a comparison to an untreated control group, did it?
A. Actually, I'm not sure of the specifics of the study, but if you-- I think Dr. Volin would be better able to answer this question.
Q. Okay. Do you know if the Cochrane 2012 study made a comparison to an untreated control group?
A. I believe the patients were in a control group. They did not have an untreated control group, no.
Q. But you would agree that it's a basic tenant of the scientific method that failure to compare the results to an untreated control group can lead to an erroneous leap in the efficacy of whatever is done?
A. The gold standard is a double-blind control study, but it's not feasible in every case. This study was done in the Bureau of Prisons, well, that it would be unethical to not offer medication to one set of prisoners and not offer it to others. So that study could not be done. So this study would not be done.
Q. But you agree that it is the gold standard in relying on reports and their efficacy?

A. Correct.
Q. I would like to move now and talk about some of the side effects of antipsychotics. Your report discusses a number of different antipsychotics you believe would effectively treat Mr. Duncan; is that right?
A. That's correct.
Q. On a very basic level, and correct me if I am wrong, antipsychotics tend to block dopamine receptors in the brain and this can help manage psychosis, including hallucinations and delusions; is that right?
A. Yes.
Q. And psychosis is different from mania; is that right? Mania is a mood symptom.
A. Actually, the dopamine hypothesis also applies to mania because if you think about it, drugs that increase dopamine in your brain such as cocaine or whatever, they have symptoms that are similar to mania. They show symptoms that are similar to psychosis. So I guess we believe both mania and psychotic symptoms are similar; they are related. That's why we are able to use antipsychotics to treat manic patients.
Q. Okay. So you believe that antipsychotics can be used as a broad brush drug that will treat both mood symptoms and mania or, I'm sorry, mood symptoms and psychosis?

A. I don't believe it. It's just been proven by studies that you can treat both mania and psychotic symptoms with antipsychotics.
Q. Okay. But it's possible Mr. Duncan's mood symptoms could persist with antipsychotics and he may need a mood stabilizer; is that correct?
A. You are right, it's possible.
Q. And mood stabilizers do not come in injectable forms, so they cannot be forced; is that right?
A. That's right, but antipsychotics have also been used as mood stabilizers by themselves and if Mr. Duncan improves to a point that we can discuss further medications with him with the help of antipsychotic medications, we could improve his symptoms further by adding a mood stabilizer at that point.
Q. So Mr. Duncan could later on voluntarily decide to take mood stabilizers, but you cannot forcibly medicate with mood stabilizers?
A. Not at this time. We cannot use lithium or Depakote in a form that could be administered forcibly. Again, antipsychotics such as Risperdal and Haldol, both newer and older ones have been used as mood stabilizers for people who have bipolar disorder without adding--
Q. And you mentioned-- I'm sorry?
A. I'm sorry, without the need for adding a mood

stabilizer.
Q. You mentioned that you believe Mr. Duncan experienced some improvement at Peachford Hospital while he was on an antipsychotic; is that right?
A. That is correct.
Q. And you are aware that at Peachford Hospital while he was being given an antipsychotic, he was at the same time being given a mood stabilizer?
A. He was, yes.
Q. Okay. So to now move on and discuss some specific side effects of different medications, I would like to start with some medications that Mr. Duncan has been prescribed before and that we have records of in the past.
A. All right.
Q. Now, are you aware that Mr. Duncan was prescribed Seroquel, which is an antipsychotic, for a short period of time by Dr. Westerman?
A. I am not.
Q. But you did review the competency evaluation conducted by Dr. Brauman dated May 8, 2012, did you not?
A. I did.
Q. Dr. Brauman's report on page 7 indicates that a Dr. Westerman prescribed Mr. Duncan with Seroquel in 2008.

A. I'm looking on page 7, and it says that-- I'm trying to find where he mentioned Seroquel on here. I'm sorry, I'm not seeing that.

THE COURT: Where are you located, Counsel?

MS. TALLENT: This is page 7 of Dr. Brauman's competency evaluation, the middle of the second paragraph.

THE WITNESS: Okay. I have located it. Yes, that's correct. He was treated temporarily with Seroquel, but continued with untoward side effects.

BY MS. TALLENT:

Q. Do you know how Dr. Brauman was able to access these medical records and you were not?

A. I do not know.

Q. Okay. But you do know that Seroquel is an antipsychotic?

A. Yes.

Q. And like many antipsychotics, it can have numerous side effects?

A. That's correct.

Q. It could include side effects such as drowsiness?

MS. STERLING: Your Honor, I'm sorry. I'm going to object at this point. I don't know why we are discussing Seroquel. It was not part of her report. It's not something that's she's reviewed. It's contained

in a separate report and, quite frankly, it's not a medication that's recommended in the treatment plan. I don't see how this is relevant. I don't want to have to discuss every potential medication on the books.

MS. TALLENT: Your Honor, the doctors heavily rely on Mr. Duncan's past treatment with antipsychotics. He had side effects on Seroquel, and it's mentioned in the report.

THE COURT: The question becomes though they relied on it as a part of the projected treatment plan, did they indicate they were going to use Seroquel? Though they relied on it in the past, it's irrelevant if they are not going to use it again, they are not going to determine if it had those side effects.

MS. TALLENT: Your Honor, it's very relevant because antipsychotics tend to have similar side effects, and there's a reported note that he experienced side effects while on Seroquel. They rely on the Peachford Hospital records with Abilify, and Abilify is not an injectable.

THE COURT: The question for the Court-- it's not a question. My observation is simply this: They may have similar side effects, but unless you can establish that the side effects of Seroquel are the same as the side effects as the one that they are going to rely on,

then we are wasting time.

Now, are you going to put in something that says that the antipsychotic they plan to use in the treatment plan has the same side effects as Seroquel?

MS. TALLENT: Your Honor, I could ask the doctor right now.

THE COURT: Okay. Well, now, let's do this, then. Let's find out whether the antipsychotic they intend to use in their treatment plan-- I'm trying to remember what the name is?

MS. TALLENT: Haldol.

THE COURT: Whether that has the same side effects as Seroquel.

MS. TALLENT: Yes, sir.

THE COURT: Then the discussion of Seroquel will become relevant.

MS. STERLING: May I make one additional objection, Your Honor?

Looking at this report counsel is making reference to, all it says is he was given Seroquel and it was discontinued because of side effects and that Dr. Brauman reviewed that. There was no--

THE COURT: Okay. Well, that's something you can ask on redirect. Let's just get this point straight, and then you can ask that on redirect.

MS. STERLING: Yes, Your Honor.

THE COURT: Let's get this straight. Otherwise, let's leave Seroquel alone.

BY MS. TALLENT:

Q. Dr. Patole, Seroquel is an antipsychotic. Would you agree that it has similar side effects to Haldol, which is also an antipsychotic?

A. So Seroquel is a newer antipsychotic versus Haldol. Haldol is one of the older antipsychotics. As I mentioned earlier, the older antipsychotics have different side effects that we worry about over the newer ones. The older antipsychotics we worry about the mood disorders that I mentioned earlier where the newer antipsychotics we worry more about the metabolic side effects.

Q. Okay. I will move on to the next drug. Your report mentions that Dr. Hege prescribed Mr. Duncan Abilify; is that correct?

A. That's correct.

Q. And Abilify is an antipsychotic?

A. Yes.

Q. It's an antipsychotic that you highly recommend if Mr. Duncan will take voluntarily; is that right?

A. That's correct.

Q. And similar to many antipsychotics, Abilify can have

side effects?
A. Yes, it can.
Q. Specifically, Abilify can cause dizziness, drowsiness, fatigue, sedation?
A. Yes. That is one of the slew of side effects included in the packaging list.
Q. As you discussed earlier, it can also cause neuroleptic malignant syndrome, which you describe as a life-threatening neurologic disorder?
A. That's correct.
Q. And another side effect is Tardive Dyskinesia, which is involuntary muscle movements?
A. Actually, Abilify is one of the newer antipsychotics. It's less likely to cause the Tardive Dyskinesia than the older antipsychotics like Haldol and Perphenazine.
Q. I understand that it may be less likely than Haldol, but it's still a potential side effect. Do you agree?
A. That's correct.
Q. Seizures are another potential side effect that have been noted with Abilify. Would you agree?
A. I'm sorry. Can you repeat the first part of the question?
Q. Another side effect that has been reported for Abilify are seizures. Would you agree?

A. Yes, it's a potential side effect.
Q. And in your report you note that Mr. Duncan complained of side effects when he was on Abilify; is that correct?
A. Yes, that's correct.
Q. Specifically, he complained of feeling nonfunctional and lethargic and complained of sedation; is that correct?
A. So that's correct. It's kind of like a normal speed limit is 45. But if you are driving 100 miles per hour and, you know, somebody stops you and says, hey, you have got to go 45, of course you are going to say I'm going slower, I am functioning less; I am lethargic. So compared to his 100 miles per hour, yes, he was slower. Again, that's the best way I can understand what he was trying to explain to me.
Q. And Mr. Duncan was again prescribed Abilify by Dr. Volin recently in February of 2013. Are you aware of that?
A. I am not since I was not here.
Q. Okay. So you are not aware that he also complained of feeling sedated and lethargic?
A. As I mentioned, I was not here. I left in December of 2012.
Q. And although it's your opinion that these symptoms

may just be a result of Mr. Duncan's brain appropriately reacting to the antipsychotic, you would agree that feeling sedated and lethargic and nonfunctional, those are all reported side effects of these antipsychotics?
A. Again, sedation is a potential side effect, but again, we will monitor him for it and also you will dose it appropriately. Also, the longer he's on the medication, the less the sedation will be something that will interfere with his functioning.
Q. Okay. So Mr. Duncan was also prescribed Risperdal at FMC Butner in June of 2012; is that right?
A. That's correct. Starting in July.
Q. I'm sorry, July. And Risperdal is also an antipsychotic; is that correct?
A. Yes.
Q. And side effects of Risperdal can also include sedation, fatigue, dizziness?
A. That's correct.
Q. And it can include neuroleptic malignant syndrome, that life-threatening neurological disorder?
A. Yes, that's possible.
Q. And Tardive Dyskinesia is also possible?
A. Again, Risperdal is one of the newer medications, so it's less likely, but, yes, it's possible.
Q. Seizures are also possible?

A. Yeah, that is slightly.
Q. Now, you mentioned earlier you were aware that Mr. Duncan was prescribed Risperdal in July of 2012. Are you also aware that he stops taking those medications shortly thereafter and complained of side effects?
A. Again, I'm not sure exactly-- we can't be sure the medication caused the side effects-- that Risperdal caused side effects because, again, we found medications in his cell that he had not taken. So I don't know, I cannot put 2 and 2 together.
Q. Your report notes that he was prescribed the medication on July 27, and then it was on August 2nd, 2012 that he stopped taking it and you found two pills in his room; is that right?
A. That's correct. That's what the report says.
Q. So from July 27th to August 2nd, even taking away two pills he potentially took at least five doses of Abilify-- or Risperdal, I'm sorry?
A. Again, this is based on a pattern Mr. Duncan has of noncompliance. So it is possible that he took the five doses and was experiencing side effects, but I can't say for sure.
Q. And do you know what the specific side effects he complained of consisted of?

A. Mr. Duncan basically complained about feeling slowed down, I believe.
Q. I do not believe the report ever mentions any specific complaints of side effects. Was a record made of those complaints?
A. Yes, I think so. It should be in the Bureau of Prisons records in the medical records.
Q. But you didn't describe his experience or complaints in your report?
A. I did not, no.
Q. Now, in addition to Mr. Duncan's own complaints of side effects, your report notes that his side effects have also been observed by others. Specifically on page 6 of your report, you note that his wife mentions he was often zombie-like on antipsychotics?
A. Yes. I recall that being documented, yes.
Q. I would like to now move to some of the antipsychotics you recommend. First I would like to talk about Haldol. That's your No. 1 recommended antipsychotic; is that right?
A. If Mr. Duncan does not take medications voluntary, that would be the No. 1 recommended injectable medication, yes.
Q. And in your report on page 29 you note that it will likely be ineffective for the Court to threaten a

contempt order in order to get Mr. Duncan to take the medication voluntarily. So in your opinion it's unlikely he's going to take his medication voluntarily?
A. It is unlikely, but again, if we have the support of the Court, that could give Mr. Duncan a different perspective on things and he might be more cooperative to his treatment.
Q. But on page 29 of your report you say that a contempt order from the Court is not effective in persuading defendants to take medication; is that correct?
A. Again, how Mr. Duncan is going to react to the Court order I cannot say, but I'm putting a positive spin on things that I'm hoping that we can work with Mr. Duncan on a voluntary basis.
Q. Okay. Well, given that Haldol is your No. 1 injectable medication, it's an antipsychotic that would have side effects; is that correct?
A. Yes, it does.
Q. Specifically on Haldol, one can experience lethargy, heart arrythmia, drowsiness or sedation; is that correct?
A. Again, these are all known side effects of Haldol, and we are going to be monitoring Mr. Duncan closely in the hospital setting for these side effects.

Q. And you can also experience neuroleptic malignant syndrome, a life-threatening neurologic disorder?
A. Yes. And again, it's possible. But again, we are going to be monitoring him closely in a hospitalized setting.
Q. And the risk of Tardive Dyskinesia is higher with Haldol than with many other antipsychotics; is that right?
A. That is correct. But again, the risk increases after more than six months of therapy with Haldol. If Mr. Duncan is able to maintain well, we can even talk about switching him to another less antipsychotic medication that is less likely to do so long term, but immediately we need to stabilize him where we can have that discussion with him.
Q. Another side effect that has been reported with Haldol is sudden death; is that correct?
A. That is correct, in folks who have dementia. There's a black box warning regarding this that folks who have-- elderly folks who have dementia have a higher risk of sudden death with antipsychotic medications.
Q. You just mentioned earlier that this risk with Haldol, especially for Tardive Dyskinesia, only increases in the long term; is that correct?
A. Yes. The longer you are on the medication, the

higher the risk.
Q. And your report also mentions Cogentin may be also given in conjunction with Haldol to combat some of these muscular side effects; is that correct?
A. Yes. Cogentin can be given to combat any symptom that the patient may be experiencing with Haldol.
Q. And Cogentin is a medication that could have side effects; is that correct?
A. That is correct.
Q. But your report does not discuss any side effects associated with Cogentin; is that correct?
A. It does not.
Q. Specifically, studies have shown that Cogentin can increase the risk of Tardive Dyskinesia. Are you aware of that?
A. I am not.
Q. I would like to move to the next antipsychotic you recommend, and that's Prolixin.
Q. Okay. Prolixin, I guess, is a common name for Fluphenazine; is that correct?
A. That's correct.
Q. And Prolixin is an antipsychotic that can have side effects?
A. Yes.
Q. It can cause neuroleptic malignant syndrome and

Tardive Dyskinesia?
A. Yes.
Q. And it can also cause mental and physical disabilities and cause liver damage potentially?
A. It's possible.
Q. And the third antipsychotic you list is Risperdal; is that correct?
A. That's correct.
Q. And we've already discussed the side effects of Risperdal and Duncan's past complaints of side effects on that medication; is that correct?
A. That's correct.
Q. And with all of these side effects, in addition to the serious ones I have pointed out, it can also cause metabolic side effects such as weight gain, diabetes, elevated serum lipids; is that correct?
A. That's correct. Again, these are all of the side effects that we would be watching Mr. Duncan closely for.
Q. And we have discussed Tardive Dyskinesia, which is a painful involuntary muscle spasm.
A. That's correct.
Q. Tardive Dyskinesia can be irreversible even after discontinuing the medication; is that correct?
A. It is possible, yes.

Q. And, again, this risk of Tardive Dyskinesia, this irreversible risk only increases with time; is that correct?
A. That is correct.
Q. Ultimately we have discussed multiple medications at this point and numerous side effects, and part of the reason we have discussed so many is that you cannot say definitively which specific medications will actually be administered to Mr. Duncan; is that correct?
A. That's correct. Again, this is all based on what options we will have available when we are allowed to treat Mr. Duncan. Every medication has a side effect, but again, you always weigh the risk against the benefit. The benefit is that he will be able to go on with his legal issues and be able to resolve them, whereas just kind of languish here in this limbo state.
Q. So it's possible Mr. Duncan could be given a medication that's not listed in the report; is that correct?
A. We have proposed this plan and, yes, we are going to be trying to adhere to this plan. That's the reason we proposed it.
Q. But again, as you mentioned earlier, you can't guarantee that any of these medications will be the actual medications that are administered?

A. I mean, as a physician I cannot guarantee anything. It would be wrong of me to say so.
Q. And this is especially true given you will not be involved in the treatment of Mr. Duncan?
A. That's correct, I will not be involved in Mr. Duncan's treatment as I will have graduated.
Q. I would like to just briefly go back and discuss the long term versus short term side effects we mentioned earlier. Your report mentions, and you have said today, that Tardive Dyskinesia is much less likely to emerge over the short term; is that correct?
A. That's correct, only after about six months of therapy.
Q. Okay. So by short term, you think six months or less or likely the four-month period he will be treated?
A. That's correct.
Q. So in evaluating his side effects, you took into consideration this short-term period you thought he would be forcibly medicated for?
A. I think that's correct, I think. Again, clarify your question, please? I had a hard time hearing the last part.
Q. Yes. When you evaluated the side effects of the antipsychotics that you recommend, you took into account the short term four-month period that you believe he

will be medicated for?
A. That's correct.
Q. But ultimately, no matter what the time frame, it's possible that any of these side effects could appear in the short term?
A. It's always possible.
THE COURT: Let's put it this way: I have listened to the questions about what is possible. The Court always understands it really calls for speculation. Anything is possible when you start talking about medication. So I hear the questions and I hear the answers, but I understand it's pure speculation about what might happen with all of these drugs.
You can continue.
BY MS. TALLENT:
Q. To move on from some of the side effects-- before we completely move on, I would like to discuss monitoring these side effects. You have mentioned that you will closely monitor for the emergence of any of these side effects; is that right?
A. That's correct.
Q. Because it's very important, especially with things like Tardive Dyskinesia that can be permanent and debilitating, that you catch these signs early; is that right?

A. That's correct.
Q. But on page 25 of your report you note that the treating psychiatrist will only check for delayed onset mood disorders on a monthly basis.
A. That's correct.
Q. And even assuming that you can effectively monitor him at FMC Butner, there's going to be a period of time where if he's rendered competent, he will leave FMC Butner for his trial; is that correct?
A. I think you are asking me to speculate about the future, which I have no power to do, about where he will go and what type of treatment he will receive.
Q. So you cannot guarantee that his side effects will be monitored once he leaves FMC Butner?
A. Like I said, I can't guarantee anything.
Q. And do you know if any of these local prisons will even administer these antipsychotics?
MS. STERLING: Objection, Your Honor. Clearly she has no basis of knowledge for that.
THE COURT: Sustained. She has indicated she is leaving training and she can't speculate about what they are going to do after she leaves.
MS. TALLENT: Yes, sir, Your Honor.
BY MS. TALLENT:
Q. Now, moving on, not only have you opined that your

treatment plan will be substantially likely to render Mr. Duncan competent, but you have also opined that none of these side effects will interfere with his ability to assist counsel; is that correct?

A. That is correct. We are going to be monitoring him periodically and closely to make sure that he is receiving the best possible side-effect profile, basically, that they are minimizing all these side effects.

Q. Presumably you have never sat at counsel table in a criminal trial, have you?

MS. STERLING: Objection, Your Honor.

THE COURT: I will see where we are going with this question. I think-- let's see where we are going with this question.

BY MS. TALLENT:

Q. I'm sorry, I didn't hear your answer.

A. Can you please repeat your question?

Q. You have never sat at counsel table in a criminal trial, have you?

A. No, as a doctor, I have not.

Q. So you have not experienced what it really is for a defendant to assist in his defense?

A. I have not.

Q. So you would agree that a defendant may have to sit

relatively still for long periods of time?

MS. STERLING: Objection again, Your Honor. This witness has no basis of knowledge for answering these questions.

THE COURT: Well, the Court will permit her to rephrase the question as a hypothetical in terms of whether-- as a hypothetical, since she has never sat at counsel table, to get at what potential side effects may come into play.

MS. TALLENT: Yes, Your Honor.

BY MS. TALLENT:

Q. So you would agree that, hypothetically, in a criminal trial a defendant may have to sit for long periods of time?

A. That's correct.

THE COURT: Well, that's the wrong form, but she said correct.

BY MS. TALLENT:

Q. And, hypothetically, he will have to respond quickly to questions from his counsel?

MS. STERLING: Your Honor, again, the government objects.

THE COURT: Well, I sustain the objection because of the form of the question. I told you that you could put it in the form of a hypothetical, the

hypothetical being if A, B, C, D, E and F, then what is the potential impact of certain antipsychotic drugs? If you are sitting long, if you have to confer with counsel, if then what impact potentially would the antipsychotic drugs have?

BY MS. TALLENT:

Q. I will just reiterate, and then I will move on, that you opined that these side effects are not likely to interfere with his ability to assist counsel, but you have never experienced or sat at counsel table at a criminal trial; is that correct?

A. I have no experience with criminal proceedings, no.

Q. Okay. I will move on to discuss alternative less intrusive treatments. You didn't consider less intrusive treatments to forced medication, did you?

A. There are no alternative medications-- alternative treatment to medications at this point for Mr. Duncan.

Q. Your report states that cognitive behavioral therapy could be considered in conjunction with antipsychotics; is that correct?

A. Again, the key word is in conjunction, not by itself.

Q. Right. Have you ever attempted cognitive behavioral therapy without also treating with antipsychotics?

A. No.

Q. And you are not willing to consider less common alternatives such as dark therapy?
A. I am not-- there is no such thing as dark therapy. I know it's a theoretical treatment model, but it's not something I would treat my patients with.
Q. Although you may not agree with it, you would agree that there are studies showing that dark therapy can be a treatment for mania?
A. Actually, I am just aware of one paper that I glanced at, so I am not familiar with the literature, no.
Q. But dark therapy simply consists of induced darkness; is that correct?
A. I think basically dark therapy is putting somebody in isolation, which Mr. Duncan was in isolation when he was in New York, but it was not effective.
Q. Have you ever attempted any alternative treatments besides medication?
A. No, I have not, not for somebody who is largely psychotic.
Q. Mr. Duncan is very willing to participate in alternative treatments, isn't he?
A. I would commend Mr. Duncan for that, but at this time in my medical judgment he requires medication and not any alternative therapy.

Q. But you would agree he's willing to a participate in alternative treatments?
A. I am not willing.
Q. To touch briefly on Mr. Duncan's fundamental rights, you would agree that it's a tenant of your medical license which was issued by the North Carolina medical board that there be a respect for patient autonomy?
A. I'm sorry, can you repeat the last part?
Q. Sure. One of the tenants of your medical license which was issued by the North Carolina medical board is a respect for patient autonomy?
A. And in order for me-- I think-- I respect my patients, but at this time Mr. Duncan lacks the insight and the judgment in his illness that does not allow him to make medical decisions for himself. He does not have the insight or judgment. As a physician, it's part of my job in treating my patients to recommend the best therapy possible.
Q. Have you witnessed the forced medication procedure when a defendant is uncooperative?
A. I have not since I have been here, no.
Q. Do you know what the procedure is?
MS. STERLING: Objection to the relevance again, Your Honor. She says she has never witnessed it. There is no suggestion there's any forced medication treatment

protocol in the treatment plan.

THE COURT: Well, the Court sustains the objection. She says she has not witnessed it. You asked does she know what it is? I don't know that these questions and answers are going to help the Court decide the four *Sell* factors.

BY MS. TALLENT:

Q. On page 34 of your report you mentioned that standard procedures will be used to forcibly medicate the defendant if he becomes uncooperative?

A. That is correct.

Q. So my question is, are you aware of what those procedures are?

A. I don't know the specifics of them, no.

Q. Okay. Just to end, you are no longer at FMC Butner; is that correct?

A. That's correct.

Q. And so you will not be administering or treating Mr. Duncan?

A. I will not.

Q. And so because you are gone and you have no control over his treatment, you can't say with certainty that the medications discussed in the report will be the medications actually administered?

A. You are correct, I cannot speculate about what's

going to happen.

MS. TALLENT: Okay. Thank you, Dr. Patole. Those are all the questions I have.

THE COURT: Any redirect?

MS. STERLING: I will be brief, Your Honor.

REDIRECT EXAMINATION

BY MS. STERLING:

Q. Dr. Patole, defense counsel asked you about the number of diagnoses Mr. Duncan has had in the past. With regard to Dr. Hege's diagnosis, you indicated, and this is in the report, it was rule out bipolar. What does "rule out" mean?

A. So "rule out" diagnosis is a working diagnosis. It's a diagnosis in progress. It's not the ultimate diagnosis, but it's an assumed diagnosis. You don't have a complete picture, and that's why we used the word "rule out".

Q. Okay. So he's thinking it could be. It's possibly bipolar. That wasn't an actual diagnosis?

A. That's correct, it's a possible diagnosis.

Q. Okay. And the Peachford diagnosis was bipolar manic; is that correct?

A. That's correct.

Q. Okay. Dr. Brauman's diagnosis was bipolar, severe with psychotic features, correct?

A. That's correct.
Q. Just briefly, if you could, tell us what is different between your diagnosis and the diagnosis of the Peachford doctors and Dr. Brauman?
A. I'm going to go back to the analogy of a movie. Both at Peachford and Dr. Brauman saw Mr. Duncan at certain points of time, but we have the advantage of reviewing their record and collecting information from everybody else. Rather than just seeing him on these instances, we have seen the entire-- we have kind of reviewed the history to know what type of symptoms he was having.

So based on that, you know, he was having psychotic symptoms when he was less manic. He was having-- you know, when he was manic, he had periods of true mania, that he was not sleeping, he was very hyperverbal, and so forth. So based on that, we diagnosed him as schizoaffective disorder.
Q. Okay. Correct me if I am wrong. Bipolar disorder is characterized by mania; is that correct?
A. Yes, that's correct. In order for him to meet criteria for bipolar disorder, he must have had experienced a manic episode.
Q. Do you necessarily have psychotic features with bipolar?

A. It's not necessary for-- that's correct, it's not required for the episode to have psychotic features.
Q. And the term "psychotic features", what does that mean?
A. Sure. Psychotic features or psychotic symptoms are what we call delusions, hallucinations. You know, deluded like a fake belief, and hallucinations are auditory, visual hallucinations, meaning you hear things no one else can hear and you see things no one else can see. So those can be psychotic features.
Q. And psychotic features are characteristic or symptomatic of schizophrenia; is that correct?
A. I'm sorry. Could you repeat the question, please?
Q. Psychotic features are characteristic or symptomatic of schizophrenia; is that correct?
A. Yes. Delusions and hallucinations can be symptoms of schizophrenia.
Q. So Dr. Brauman's evaluation of bipolar severe with psychotic features, that diagnosis acknowledges an observation of mania and delusion or psychotic features in the patient, Mr. Duncan; is that correct?
A. That's correct.
Q. And these were the same features that you observed that led you to your diagnosis; is that correct?
A. That is correct. Again, it was an episodic period

where he was manic and psychotic at the same time, but when we saw him here at FMC, he was mainly psychotic.
Q. All right. Now, counsel asked you quite a bit about delusional disorder. Is delusional disorder a recognized diagnosis?
A. It is a recognized diagnosis. It's a nonbazaar fixed belief that-- or nonbazaar delusion that is interfering with somebody's life.
Q. What do you mean by nonbazaar delusion?
A. Nonbazaar is something that's possible to occur. An example would be a student who thinks that their teachers may be grading them unfairly, and that's the only belief that they subscribe to and you can't talk them out of it.
Q. And so how is delusional disorder different from schizoaffective disorder bipolar type II that you have diagnosed?
A. So again, delusional disorder, that's the only symptom you have. You just have this held belief. You don't have any root symptoms.
Q. No mania?
A. No mania, no depression. You just have the delusional belief.
Q. Okay. And based on your evaluation that would include your observations and discussions with

Mr. Duncan, as well as your review of his records, can you see any basis for diagnosing him with delusional disorder as opposed to schizoaffective or bipolar severe with psychotic features?
A. No. Based on our evaluation, he meets criteria for schizoaffective disorder and bipolar type II.
Q. Would it be fair to say that you ruled out delusional disorder?
A. Yes, it was ruled out.
Q. Thank you. When we are talking about whether delusion is bazaar or nonbazaar, what exactly is the nature of Mr. Duncan's delusion?
A. Mr. Duncan had both bazaar and nonbazaar delusions. He believed that Mr. Rose swindled him out of some money, which we know is correct, but again he carried it to the next degree, believing that Mr. Rose is after him for monitoring him; he was monitoring his router activity and so forth. He also had bazaar delusions such as I'm able to control things with my mind.
Q. Right.
A. But he has a combination of both.
Q. Okay. And as far as his delusion involving Mr. Rose, he had also involved a Ms. Bashama; is that correct.
A. That's correct.

Q. Who does his delusion extend to beyond those two persons?
A. I'm sorry. Say again?
Q. Who is included in that delusion beyond those two persons? Does his delusion apply to persons outside of those two individuals?
A. Yeah. So initially Mr. Duncan's delusions were only encompassing Mr. Rose and Ms. Bashama. When he came here, the more resistant he got to the staff in terms of his delusions, he included more and more folks into that delusion, including Dr. Volin as being involved in a conspiracy with Mr. Rose against him.
Q. All right. And did it also include government agencies and other persons involved in these proceedings?
A. Yes. It involves the FBI, the IRS and the military. The scope of these delusions has continued to expand.
Q. Okay. You made reference to interviews with family members, including his ex-wife and son. Are there indications that he had a delusion that he had mind control? Doesn't your report also indicate on page 7 that he has a delusion that he is the grandson of Albert Einstein?
A. That is correct. That's one of his delusions that

while his grandmother-- Albert Einstein was at the place where his mother was staying, and he's related to Albert Einstein.
Q. Would you characterize that as bazaar or nonbazaar delusion?
A. I would definitely characterize that as a bazaar delusion.
Q. All right. Moving on to the medications, you were asked about the different medications and, specifically, about mood stabilizers. Just to be clear, these medications, the antipsychotics, they have mood stabilizing attributes; is that correct?
A. That is correct. Antipsychotic medications are used as mood stabilizers in folks with bipolar disorder or schizoaffective disorder.
Q. Okay. It is, of course, the case and you would agree that all medications have side effects; is that correct?
A. I'm sorry?
Q. That all medications have side effects?
A. That is correct.
Q. And the reported treatment plan, they outlined every instance where side effects are discussed, the likelihood, the possibility, as well as a plan to monitor and treat side effects; is that correct?

A. That's correct.
Q. And as far as these severe side effects, the neuroleptic malignant syndrome and sudden death syndrome, the report does outline that these are very, very unlikely to occur; is that correct?
A. These are extremely rare side effects.
Q. But, as in all medications, you as a physician are setting forth all of the possible side effects for the purposes of disclosure and letting the Court know that you are aware of these and plan to deal with them; is that correct?
A. That's correct.
Q. Also, the--
THE COURT: You are doing a fine job of leading there, Counsel.
MS. STERLING: I'm sorry, Your Honor. I've got to wind this up.
THE COURT: Yes, ma'am.
BY MS. STERLING:
Q. As far as alternative treatments, you indicated in response to the question that cognitive behavior theory would not be effective alone with Mr. Duncan. Why is that?
A. Cognitive behavior therapy is for a patient who has psychotic delusions and would involve somebody willing

to work with a therapist in acknowledging that their beliefs might be true. That's pretty hard to do with Mr. Duncan. It's unlikely that any therapist would be able to work with him on that delusional belief. That's why cognitive behavior therapy is always used in conjunction with medication, because it gives us that little wiggle room to have the patient work on their delusional beliefs and work through them.

MS. STERLING: Okay. Thank you, Dr. Patole.

THE COURT: Ladies and gentlemen, I think this is the time to take a break. We are going to take about a 15-minute break and when we come back, we are going to the next witness.

(A recess was taken at 12:04 p.m., after which court reconvened at 12:25 p.m.)

THE COURT: Counsel, may Dr. Patole be excused permanently?

MS. STERLING: No objection from the government, Your Honor. Thank you.

MS. TALLENT: No objection.

THE COURT: All right. Doctor, you may be excused permanently. Thank you very much.

THE WITNESS: Thank you.

(Witness excused.)

THE COURT: We still have two witnesses here.

MS. STERLING: The government would like to call next Dr. Jill Volin. I'm not sure that we are going to need the third witness. I would ask him to remain.

THE COURT: Well, what I prefer to do during the course of the testimony is just have one there at the table, whoever is testifying. They can remain, but I just want one there at the table.

MS. STERLING: Perhaps we don't need Mr. Marra. Quite frankly, Your Honor, Mr. Marra was here today in case there was some question that arose. He is currently treating Mr. Duncan at the facility. The government had no questions, but thought the Court might have questions and wanted him to be available for that purpose.

THE COURT: Okay. If he would just step out of the frame of the camera, he can just wait in case we need him.

Okay. That way we are looking at one person.

MS. STERLING: Yes, sir.

(The witness was sworn by the deputy clerk.)

THE COURT: Before we get started, approximately how long do you think this direct examination will probably take?

MS. STERLING: Perhaps 45 minutes. No more than that. I'm going to try to shorten it up so we don't have too much repetition.

THE COURT: The Court has a jury that's waiting, and I'm trying to make sure I don't conflict with that schedule. So I think what we may have to do to avoid conflicting with that schedule, I will have you get to the end of your-- well, let's move on. We may be here until 2:00, but we are still going to take a break. We will try to get through this witness without a break.

MS. STERLING: All right. Thank you very much, Your Honor.

THE COURT: All right. You can proceed.

JILL C. VOLIN, M.D., called as a witness, having been first duly sworn, was examined and testified as follows:

DIRECT EXAMINATION

BY MS. STERLING:

Q. If you would, please state your full name for the Court.

A. Dr. Jill C. Volin, V-o-l-i-n.

Q. And how are you employed, Dr. Volin?

A. I'm a staff forensic psychiatrist at FMC Butner, North Carolina.

Q. And how long have you been a staff psychiatrist at Butner?

A. Since March of 2012.

Q. And you are licensed to practice medicine; is that

correct?
A. Yes. I have had a full unrestricted license to practice medicine since 2006.
Q. And are you board certified in forensic psychiatry?
A. Yes. I am double boarded both in psychiatry and forensic psychiatry.
Q. Okay. And have you ever testified in court before as an expert in forensic psychiatry?
A. Yes. I have been qualified as an expert 12 times in forensic psychiatry and three times in psychiatry.
Q. Thank you, Dr. Volin.
MS. STERLING: Your Honor, we would offer Government's Exhibit No. 9, which is Dr. Volin's CV, which has been stipulated to. I would ask she be found to be an expert in forensic psychiatry.
MS. HARRIS: No objection, Your Honor.
THE COURT: All right. Thank you. The document will be admitted.
(Government's Exhibit No. 9 was admitted.)
BY MS. STERLING:
Q. In the course of your employment as a forensic psychiatrist at Butner, have you come in contact with Keith Duncan?
A. Yes. Mr. Duncan was admitted to our facility July 19th, 2012 for an evaluation of his competency to stand

trial and restoration. He was discharged January 8th, 2013, re-admitted February 28th and discharged April 30th.

Q. Are you able to see Mr. Duncan here today? Is that within your range of view?

A. Yes, I can see Mr. Duncan now.

Q. And if the record could reflect that the witness identified the defendant, Your Honor.

THE COURT: The record will so reflect.

BY MS. STERLING:

Q. And what did your evaluation of Mr. Duncan consist of, if you would just describe it briefly?

A. Well, over the course of the last ten months the evaluation consisted of clinical interviews with Mr. Duncan, with myself, with Dr. Patole and with Dr. Marra. It also consisted of routine physical examination and laboratory studies, an MRI of his brain. We also reviewed collateral information provided by the defense and the government and his family, and the observation of our staff members, our nurses and our correctional officers were also incorporated into the report.

Q. Okay. And did you personally meet with Mr. Duncan during this period of evaluation?

A. Yes, I did.

Q. And about how many times?
A. I met with him multiple times a week during August of 2012 and July of 2012.
After the report was submitted in August, I met with him less often, probably once or twice a week. And then when he returned to us again in February, I met with him multiple times a week at the beginning and then weekly as we were waiting for the Court to reschedule this hearing.
Q. And about how long were your meetings?
A. In the beginning the meetings would last a long time, an hour or more. As the course of the evaluation continued and we were waiting for the Court to answer the question of involuntary medication, the meetings were much shorter. Mr. Duncan was unwilling to take medication and his presentation had not changed. Multiple meetings resulted in him becoming more agitated, which is the reason why those meetings were cut short and held less often.
Q. Has he changed significantly in all of these meetings from the time that you first met him until the time of your last meeting?
A. I would say the content of his psychotic delusions has remained the same. However, there has been some variation in levels of mania. There have been times

when he has had a very pressured speech, has had insomnia and very difficult to redirect as a result of his mania, and especially his last admission when that was not as prominent. So that's how I would briefly describe the change in his mental status.

Q. And in addition to your own meetings and evaluations with Mr. Duncan, did you supervise the work of Dr. Patole in her examinations and evaluations?

A. Yes, I did. I sat in on a small number of her interviews with him and the interviews I did not sit in on, I discussed them with her. I also edited the portions of the report that she wrote.

Q. And you, in fact, prepared two reports with Dr. Patole; is that correct?

A. That is correct.

Q. And there was one in September and one in December; is that correct?

A. Yes. I believe the date of the first report was August 7, 2012, and the second December 12th.

Q. And based on your evaluation with Dr. Patole, based on what you received and did with her as well as your own observations and assessments of Mr. Duncan, did you formulate an opinion as to whether Mr. Duncan was suffering from a mental disease or defect?

A. Yes. It is my opinion that he suffers from a severe

psychotic illness called schizoaffective disorder.
Q. Is that the same diagnosis that Dr. Patole arrived at?
A. I was not present for her testimony, but yes, that's the diagnosis we arrived at together, and we put it in our report.
Q. That is the diagnosis that was in the report; is that correct?
A. Yes.
Q. Okay. What caused you to reach this diagnosis?
A. Schizoaffective disorder is diagnosed when someone meets criteria for criterion A schizophrenia while also having evidence of previous manic mix or depressive episodes.

We diagnosed Mr. Duncan with schizoaffective disorder bipolar type because over the course of his illness he has had manic and hypomanic episodes, and the reason why we diagnosed him schizoaffective disorder over bipolar disorder is there have been periods in his history and I have also personally witnessed times in which the psychosis, the delusions, continued while the mania is much less prominent.
Q. Okay. And are you aware of diagnoses made by other treating psychiatrists or health professionals with regard to Mr. Duncan?

A. Yes. Most of his previous treating professionals, either on an outpatient basis or an inpatient basis, diagnosed bipolar disorder. Some people diagnosed bipolar disorder with psychotic features. In addition, Dr. Brauman IMPT North also diagnosed bipolar disorder with psychotic features.

Q. How did you come up with the diagnosis that you made of Mr. Duncan?

A. Well, there are significant overlaps between these two diagnoses, schizoaffective disorder bipolar type and bipolar disorder with psychotic features.

You diagnose bipolar disorder with psychotic features when the psychosis occurs only when the patient is experiencing a severe episode, only when they are in an event with symptoms of depression or in the midst of manic depression; a schizoaffective disorder of bipolar type when the psychotic symptoms or, in Mr. Duncan's case, the delusions continue when he is not in a prominent mood episode.

Q. Okay. And you did review the findings of other psychiatrists and treating physicians in reaching your evaluation and diagnosis; is that correct?

A. Yes. The mental health diagnoses is important to look at person's history and how that person and their illness progresses over time. At the time he was

diagnosed with bipolar disorder with psychotic features in Atlanta he was in the midst of a manic episode.

Also when he was in New York with Dr. Brauman, he was in the midst of a manic episode. One of the advantages of having a four-month or, in this case, an almost nine-month evaluation is that I get the opportunity to review an extensive amount of collateral, interview family and to make these observations myself.

If I had the same information that was presented to me as Dr. Brauman did or the treating psychiatrist, I may have arrived at the same conclusion, bipolar disorder with psychotic features; but because I assessed more information and more observational data, I think that a diagnosis of schizoaffective disorder is more accurate.

Q. Okay. But it is not entirely contrary or inconsistent with bipolar disorder with psychotic features; is that correct?

A. No. Given the information they were privy to, I saw how they came to that conclusion. I am privy to more information.

Q. Okay. So what was the basis for your diagnosis, then, of schizoaffective disorder bipolar type?

A. Mr. Duncan has experienced symptoms of mental illness in 2008. At that time he was described as

manic. He was in treatment with an outpatient psychiatrist from, I believe, 2008 to 2011. At that time he presented with symptoms of mania and psychosis. He was admitted to Peachford Hospital in Atlanta in 2009 with symptoms of mania and psychosis. Then, of course, he was evaluated by Dr. Brauman at the time he presented with symptoms of mania and psychosis.

I was also able to get collateral information from his family, particularly regarding his instances of mania and his particular delusions, and was able to get information from his son, Kyle, that there are times when he is not manic, but he still continued having very persistent fixed delusions that do not vary over time.

Q. Would you describe his delusions as bazaar or nonbazaar?

A. Most of his delusions are nonbazaar. He believes that he is being monitored via technology. He believes that people are following him, that people may want to murder him or his children.

In the past he has exhibited some arguably bazaar delusions in that he believes that he was the fourth component of the universe and part of the Holy Trinity, but most of his delusions and the delusions that I have observed have been what we would classify as nonbazaar.

Q. And did you get information from his family regarding delusions that they believed he had suffered from or he indicated to them or exhibited in their presence?
A. Yes. In particular, the one that I mentioned before, he told his wife that he believes he was part of the Holy Trinity, God the Father, Son and Holy Ghost. He believed he was the fourth component of the universe. He believed that a judge in Cobb County was murdered in relation to his knowledge of Robert Rose. He believes he is the grandson of Einstein. There are other examples if you would like.
Q. No, that's fine. So he has both bazaar and nonbazaar delusions. That's essentially what your testimony is; is that correct?
A. You just cut out, I'm sorry.
Q. I'm sorry. Let me speak more clearly. He has both bazaar and nonbazaar delusions; is that correct?
A. Yes, nonbazaar for the most part.
Q. When you say nonbazaar, what's the nature of the nonbazaar delusions?
A. It's something that could possibly happen. However unlikely, it is possible.
Q. And are you familiar with the diagnosis of delusional disorder?

A. I am.
Q. Okay. And you did not diagnose Mr. Duncan with delusional disorder; is that correct?
A. That is correct.
Q. And he has never been diagnosed with that disorder based on your review of his records; is that correct?
A. That is correct.
Q. And how is delusional disorder different from schizoaffective disorder or bipolar or other such diagnoses that have been made in Mr. Duncan's case?
A. Delusional disorder is very rare. It's present in .03 percent of the population. People who exhibit delusional disorder are very functional. They often do not come to care because they do not believe that there's anything wrong with them. They often do not meet criteria for involuntary commitment because they are so functional.

The diagnostic criteria, according to the DSM, require that they have nonbazaar delusions, and it also requires that criterion A for schizophrenia has never been met. It also requires that mood episodes have occurred concurrent with delusions and has been brief in duration to the delusional period.

No mental health professional has diagnosed Mr. Duncan with delusional disorder because a diagnosis

of delusional disorder would be inaccurate. You cannot diagnose delusional disorder when criterion A for schizophrenia has been met. You cannot diagnose delusional disorder when there is a strong reason for a person's course of illness.

Q. All right. What exactly are the symptoms of schizophrenia that Mr. Duncan exhibits?

A. Mr. Duncan, his most prominent symptoms are delusions, and also he exhibits thought disorganization. His thoughts become tangential, circumstantial, disorganized. So those are the criterion A symptoms that Mr. Duncan exhibits.

Q. And what about the symptoms of mania that he exhibits?

A. So symptoms of mania would not be criteria for schizophrenia, and the reason why we have him diagnosed with schizoaffective disorder bipolar type is because that reflects the combination of both the psychosis and the mood component.

The symptoms of mania that he exhibits, both with myself and various times in his history, include irritability, grandiosity, pressured speech, flight of ideas, increased polarized activity, distractibility, insomnia. He also has exhibited risky behavior in the past, including skiing at great speeds. He's also done

unusual things according to his family as trying to leave a waitress a $1 million tip.

Q. All right. Thank you, Dr. Volin. In the report you submitted, or the two reports, did you express an opinion as to whether Mr. Duncan is competent to stand trial?

A. Yes, I did.

Q. And what is your opinion?

A. My opinion is that he is not competent to stand trial.

Q. And why is that?

A. Mr. Duncan, because of his delusions, does not have a rational understanding of the consequences of the case against him. He doesn't have a rational understanding of his situation in relation to the proceedings. He believes that various court officials, including his attorney, are involved in a conspiracy with Robert Rose. He believes that the federal court does not have jurisdiction over him, that only a military court could have jurisdiction over him. He also believes that various court officials have an influence, even both the Atlanta judge who was murdered because of Mr. Duncan's knowledge of Robert Rose.

He also believed that at any point in time the FBI is going to come get him and put him in witness

protection. He also believes that his arrest was not valid.

Q. All right. And in your report did you express an opinion as to whether Mr. Duncan's competence can be restored?

A. I did. Mr. Duncan suffers from a psychotic disorder, schizoaffective disorder bipolar type. That illness is very treatable with antipsychotic medication, so it's my opinion he can be restored.

Q. Okay. And is that based on your experience?

A. It is based on countless double-blind placebo studies; it is based on his results on medication in the past; it is based on studies that have demonstrated the restorability of pretrial witnesses with psychotic illness.

Q. Has Mr. Duncan taken the psychotropic medications well at Butner?

A. Briefly he took the medication Risperdal during the previous evaluation period. I believe that was probably either in mid-July or early August 2012. In addition, he took one dose of the antipsychotic medication Aripiprazole or Abilify when he was most recently admitted to our facility.

Q. But did treatment with those drugs have any noticeable effect?

A. He took those medications so briefly that it would be difficult to say what effects he had. I can tell you what he complained of.
Q. That's fine if you want to tell us that, but he did not take the medication long enough to have any beneficial effect; would that be correct?
A. That is correct.
Q. Do you have an opinion as to whether Mr. Duncan can be restored to competence without psychotropic medications?
A. Yes. I do not believe he can be restored to competence without psychotropic medications.
Q. Why is that, Dr. Volin?
A. Psychotic illness requires treatment with antipsychotic medications. Talk therapy and other modalities do not work to attenuate a psychotic symptoms.

Therapy such as Harmon behavioral therapy has been shown to be beneficial as adjunctive treatment to antipsychotic medication in that they help the patient work through problems, they help the patient understand the importance of medication and treatment compliance, but they do not on their own attenuate psychotic symptoms.

Q. And do you have an opinion as to whether Mr. Duncan

can be administered psychotropic medications orally in order to restore him to competence?
A. Any method of administration of antipsychotic medication would be likely to restore him to competence, whether that be oral or injectable.
Q. Okay. But in your experience has he been willing to take the medication orally?
A. He has not been willing to take medication orally after he tried the Aripiprazole for one dose. So that is not something he's been willing to do.
I'm sorry. I'm getting a message that says, "Scheduled meeting ends in ten minutes. Please call video support."
MS. STERLING: Thank you very much, Dr. Volin. We will take care of that.
Are we okay?
THE COURT: Yes.
MS. STERLING: Okay. Thank you.
BY MS. STERLING:
Q. Now, the report that you prepared with Dr. Patole, that outlined a treatment plan for Mr. Duncan as far as medication; is that correct?
A. That's correct.
Q. And without going into all of the details of the treatment plan, did you prepare that with Dr. Patole, or

is it something you prepared together, or did she prepare it and you reviewed it? How was that accomplished?
A. The medical analysis *Sell* section of the report was written by me. She has read it and reviewed it and may have added some to it, but the *Sell* section which begins on page 20.
Q. And so that would include the treatment plan, correct?
A. Yes.
Q. Okay. And you said the treatment plan that you outlined gives a step-by-step procedure for medicating Mr. Duncan; is that correct?
A. That's correct.
Q. And there's a procedure to be followed if he refuses to take oral medication or initially agrees and then decides not to cooperate; is that correct?
A. That's correct.
Q. And should he be involuntarily medicated, the Court indicates a plan for that process including various medications that would be used or could be used in order of preference; is that correct?
A. That's correct.
Q. And that treatment plan for each of these medications, specifically for Haldol, Fluphenazine-- I

may be mispronouncing it --and Risperdal, gives detailed information about dosage, about the frequency of dosage and the likelihood that medication will be required before he was restored to competence; is that correct?
A. That's correct.
Q. And does the plan also take into account the possible side effects of each of these medications?
A. Yes, it does.
Q. And it also provides a plan or a method of dealing with those side effects; is that correct?
A. Yes, it does.
Q. Just very briefly on the side effects, there are two types of medications that you mentioned there, Haldol and-- help me with the pronunciation --Fluphenazine. Those are first generation psychotropic medications, are they not?
A. I'm having trouble understanding you. Did you ask me if Haldol and Fluphenazine are first generation medications?
Q. Yes.
A. They are.
Q. Okay. And the Risperidone, the Risperdal, is second generation; is that correct?
A. That is correct.
Q. There are slightly different side effects for the

first generation and second generation of drugs; is that correct?

A. When looked at as a higher class, then the side effects do differ. However, Risperidone in particular does have a similar side effect profile to Haloperidol. I can go into more detail about it if you like.

MS. STERLING: Your Honor, at this point I can ask her more questions. I believe we have gone through this a lot with the last witness. I also don't know when the Court wants to take a break.

THE COURT: What the Court is going to try to do is try to let you finish your direct exam or we are going to try to see if we can finish the witness. I don't know whether we can make it, but we are going to try.

MS. STERLING: Okay. We are going to try.

BY MS. STERLING:

Q. If you could, Dr. Volin, tell us very briefly about the side effects of the various medications and the methods outlined in the treatment plan for dealing with those side effects.

A. Okay. Firstly, if the Court were to grant involuntary medication, the first thing that would happen-- and let me clarify. It is very likely that I will not be the person administering his medications, so I am going to advocate to the Court on what I would do

if I was the person prescribing it and also what the standard of care both in the community and our institution would be.

So if the Court were to grant prescribing involuntary medication, the first thing that would happen is that order would be discussed with him. It would be explained to Mr. Duncan that if he did not choose the medication orally, that an injectable medication would be chosen for him.

It is very often in that situation, even with patients who have refused oral medications in the past, that when they know an injectable medication will be administered on refusal that they do take the time to choose an oral medication. So the first thing that would happen is he would be offered the choice of the various formulary antipsychotic oral medications, and their risk and benefits and various side effect profiles would be discussed with him.

That being said, we can look at the psychotic medication as first generation or second generation or the individual antipsychotic medications themselves. For example, the medication he's been on in the past, Abilify or Aripiprazole has a very favorable side effect profile and is often chosen for that reason.

If you look at sedation, sedation with Abilify

has been reported at about 6 percent, whereas sedation on Risperdal has been recorded at 5 to 11 percent. So those are comparables depending on which studies you look at.

If you look at extrapyramidal symptoms, and these are the movement side effects of antipsychotic medications, Parkinsonism, I have heard, is about 18 to 25 percent and Risperidone where it occurs about 5 to 16 percent in Abilify. We know that those rates of extrapyramidal symptoms are higher in the first generation, particularly the high potency first generation of which Haldol and Fluphenazine are a member.

So the rates of extrapyramidal symptoms in Haloperidol and Fluphenazine would be higher, 21 to 31 percent as opposed to the slightly lower rates of Risperidone and even lower of Abilify.

Another important point to bring up, and I'm only going to go through them briefly, so please tell me if you want more details. The metabolic side effects as a whole are more of a concern with the second generation than with the first, the metabolic side effects being weight gain, blood sugar abnormalities and cholesterol abnormalities. So these would be more of concern particularly with Risperidone than they would be in the first generation or in Aripiprazole. Abilify or

Aripiprazole has very low rates of metabolic syndrome.

Are there any other side effects you would like me to go into in more detail?

Q. Could you just briefly address the severe side effects that were listed in the report, the sudden death and the-- I'm sorry, there was another one.

A. So all medication has potential side effects, and what I'm about to discuss is the potentially dangerous side affects of antipsychotic medications. Please note that these have been approved as safe by the Federal Drug Administration and are prescribed everyday as an outpatient to patients all over the world.

We have the luxury of being a joint commission certified hospital with 24-hour nursing and 24-hour doctor care. The reason why I say that is because we are a hospital where we can monitor for these very rare but possible dangerous side effects.

The ones I would like to discuss are neuroleptic malignant syndrome. The rate of neuroleptic malignant syndrome, depending on how it's assigned, are .722 percent of those who take antipsychotic medications. This also occurs in patients who are coming off of Parkinsonism medication and patients who take medication for vomiting.

The reason why we are so hypervigilant about

looking for neuroleptic malignant syndrome is because it can have dangerous and possibly lethal effects. The symptoms we look for are muscular rigidity, Metonia, high fever, increased blood pressure and heart rate, and lack of movement.

Antipsychotics also can cause abnormal heart rhythms. It is much more prominent in certain antipsychotic medications than others such as Mellaril and Gson.

As the antipsychotic medication causes an arrhythmia of the heart, that can in theory lead to what is called sudden death. Now, sudden death occurs both in the general healthy population and in patients who are on antipsychotic medication. It is a very, very rare event.

The reason why we think it's important is because you take something extremely rare and with antipsychotic medication it is still extremely rare, but there is a specifically significant increase in the risk.

The reason why we think that patients, particularly with schizophrenia, have still particularly small but a higher rate than the general population of sudden death is because this is a population-- not only are they taking antipsychotic medication, but they also

have much higher rates of smoking and much less medical care and also higher rates of obesity.

So the potentially dangerous side effects we look at, once again, are neuroleptic malignant syndrome and also abnormalities of cardiac conjunction or sudden death. Either of those are both incredibly rare events and something that here we have the luxury to monitor 24 hours a day.

Q. Thank you, Dr. Volin.

The treatment outlines for nonvoluntary medication, injectable medication, it outlines three medications in order of preference; is that correct?

A. Yes. Let me explain that these are all equally efficacious medications. That order that you are calling an order of preference is based on very small factors such that Haloperidol, the reason why it was listed first is not because it's a better medication or its ratification, it's because it only needs to be administered once a month and the onset is fairly quick.

Fluphenazine is listed as second because the onset is very quick, but it's administered every two weeks.

And then Risperidone listed third not because it's the worse medication or less efficacious, but

because the onset, particularly for Risperidone, is much longer because of the formulation of the medication and it also has to be administered every two weeks.

Q. If the Court were to grant the government's motion to involuntary medicate, would the staff at Butner, which you indicated would probably not be you, would the doctors and psychiatrists use them in that order or would they use those three medications or could they change their recommendation and use different medications?

A. There are only three currently available long-acting injectable medications on formulary. There are various factors that could lead a professional to rank something higher than another. For example, the injectable immediate release Fluphenazine has been difficult to obtain. Therefore, Fluphenazine could be in the third box, whereas Risperdal possibly would be in the second because of the availability of medication.

I can't predict certain things like that right now, which is why when we submit very detailed treatment plans it doesn't necessarily take into account real world variables that we have to take into account as doctors.

In addition, even if Mr. Duncan were not to choose an oral medication, if he were to choose one of

the three injectables, the doctor would most likely go with his choice. I know I would go with his choice, even if it did not meet my order. If he chose that one, that would be the one I would go with.

Q. So you listed the three injectable psychotropic medications because those are the only three that are injectable; is that correct?

A. I didn't hear you, I'm sorry.

Q. I'm sorry. The three medications you have listed are the three that are injectable. There would not be a choice for another medication because there is no other psychotropic medication that's injectable; is that correct?

A. The three long-acting injectables are the ones that I listed. There are other antipsychotic medications available as injectables. They are currently not on the Bureau formulary. That can change.

Q. Okay. So as far as the treatment plan that you have outlined with the various side effects, that would apply to another psychiatrist treating Mr. Duncan because those are the only three medications that could be used at Butner?

A. Yes.

Q. All right. Thank you.

Dr. Volin, you indicated that you in the latest

report, the December 2012, performed the *Sell* analysis; is that correct?

A. I didn't hear you. If you are asking if I wrote that, that is correct.

Q. Okay. The *Sell* analysis, I want to direct your attention to that portion of the report.

The report indicates that-- the first question under *Sell* is whether there was an important government interest at stake. That's obviously a legal question we are not going to address with you, but I want to go to the analysis on the other four *Sell* factors and if you need to, you can make reference to your report.

A. Okay.

Q. Okay. As to the second *Sell* factor, the question being whether involuntary medication will significantly further those interests, the question for you as the treating psychiatrist is whether the medications will substantially likely render the defendant competent to stand trial and be unlikely to have side effects that will interfere with his ability to assist counsel?

So as to the first of that two-part criteria, in your opinion does the treatment plan for involuntarily medicating the defendant, is it substantially likely to restore the defendant's competence to stand trial?

A. Yes.

Q. Okay. And can you tell us what the basis of your opinion is?

A. Mr. Duncan suffers from a psychotic disorder, schizoaffective disorder. The appropriate first-line treatment for that illness is antipsychotic medication. Countless peer review sublime placebo trials have indicated the effectiveness of antipsychotic medication.

Studies have also shown the restorability of patients to trial when administered involuntary medication. Particularly in his population, federal pretrial defendants have been restored to competency after an order for involuntary medication has been rendered by the Court, and also Mr. Duncan has a history responding well to antipsychotic medication according to the Peachford hospitalization records where he was admitted to inpatient service from March 28th to April 4th 2009.

On admission he was, quote, floridly manic, very paranoid, delusional and grandiose, and just eight days later he was discharged from the inpatient hospitalization to a partial hospitalization program.

At the time of his discharge the doctor noted he exhibited greater insight into his illness and his sleep improved. He remained hypomanic, so without full-blown

mania. His paranoid delusions regarding his wife also improved. He no longer thought she was trying to kill him but did believe she wanted to financially harm him. So that is a very good example of how his senses attenuated after just eight days of medication.

Q. Do you have an opinion whether he could be restored to competency without the use of these psychotropic medications?

A. There was a radio call while you were speaking, so I missed what you were saying.

Q. Oh, I'm sorry. Do you have an opinion as to whether he could be restored to competence without the psychotropic medications?

A. Yes. Without psychotropic medication I do not believe he can be restored to competence.

Q. And do the psychotropic medications outlined in the report, and specifically the treatment plan, have side effects that are likely to interfere with the defendant's ability to assist counsel at trial? Do you have an opinion as to that?

A. I do. Antipsychotic medications actually improve cognition. They particularly improve attention and thought organization, so those should be expected to assist him at trial. There is a possibility of sedation with antipsychotic medication.

As I stated before, 6 percent of patients reported fatigue on Aripiprazole or Abilify while 11 percent of patients reported sedation on Risperidone. Sedation as a side effect is very easily managed. It is managed by moving the medication to nighttime. It is also managed by decreasing the dosage of the medication. And if sedation does not improve with those very simple fixes, a new medication can be chosen. But like I said, with a particular medication we are talking about, it does occur in less than 20 percent of people and it's easily managed.

Q. Are you aware of any side effects from psychotropic medications that Mr. Duncan has specifically complained of that would interfere with his ability to assist counsel at trial?

A. No.

Q. In your opinion, Dr. Volin, are there any alternative less intrusive involuntary medications that would have a substantial likelihood of restoring the defendant's competence?

A. I do not believe there are any less intrusive alternatives that would restore him to competence without psychotropic medications.

Q. Have you considered any other alternatives?

A. Of course we consider with all of our patients

whether or not other modalities might be accepted. However, it is widely accepted that psychotic symptoms require antipsychotic medication. That does not say there's no use for talk therapy. It's just that we do not expect him to engage in therapy when he does not believe that there is anything wrong with him.

Also, just as he cannot engage with attorneys, just as he has derailed on additional topics, he would do the same in therapy. So it's something that he would definitely have from the beginning and require medication.

Q. So would it be your opinion, then, under the third criteria of *Sell* that a voluntary medication, should Mr. Duncan agree to take the medication, would be necessary to further the Government's interest in proceeding to trial in this matter?

A. Yes, that's correct.

Q. Finally, do you have an opinion as to whether the voluntary medication, the medications recommended in the treatment plan, are in the defendant's best interest in light of his medical condition?

A. I do. Regardless of his legal proceedings, I recommend that he take antipsychotic medication for proper treatment of his illness.

Q. Okay. And have you considered other medical issues

that he has and how the medication might interact with his conditions or the medication for those conditions?
A. Yes. Mr. Duncan has reported preexisting restless leg syndrome. Because of the nature of the antipsychotic medication, it can worsen restless leg syndrome. So if that were the case, that he were experiencing those symptoms, I would prescribe, or whoever was assigned as his psychiatrist would prescribe, medication to treat that condition.
Q. Again, your report details the potential side effects, long term and short term, their likelihood and how they would be dealt with; is that correct?
A. That's correct.
Q. And what, if anything, can you say about the likelihood for his future medication, whether medication in this point would increase, decrease, or have any effect on his future ability or desire to take medication for his condition?
Do you understand my question?
A. Are you asking if taking medication would increase his desire to take medication?
Q. Future likelihood of voluntarily seeking medication?
MS. HARRIS: We object, Your Honor. Speculation.
THE COURT: Sustained.

BY MS. STERLING:
Q. Now, you indicated if the government's motion is granted today, the treatment plan you have outlined is what will be used for the framework for medicating Mr. Duncan; is that correct?
A. That's correct.
Q. Do you know whether Mr. Duncan has been evaluated for involuntary medication under the criteria set forth in *Harper*? Has he attended any *Harper* hearings?
A. Yes, he has.
Q. And when did that occur?
A. March 7th, 2013.
Q. All right. So a report was prepared; is that correct? A report was prepared?
A. A memo was.
Q. Okay.
A. A memo was written by myself to the chief psychiatrist, and she prepared a report.
Q. Thank you. And what exactly is a *Harper* hearing?
A. *Washington v. Harper* allows an institution such as prisons to involuntarily medicate inmates in case of dangerousness to self or others or grave disabilities, and that requires that the inmate or the patient be dangerous within confinement. So that could be within a locked single cell.

So to rise to the level of dangerousness in that situation some examples that would rise to that level would include a diabetic who refuses to take insulin because he is paranoid and believes insulin could be poison and his blood sugar rises to a dangerous level that could impact his life.

Another example would be an inmate or patient who refuses food, who loses a significant amount of weight that creates electrolyte imbalance or inner organ damage.

Another example would be a patient actively trying to kill himself because of psychotic delusions.

Another example would be physically attacking a staff member, even within that confined cell.

So those are the type of situations that we look at that would satisfy grave disability or danger to self or others within confinement to involuntarily medicate under *Harper*.

Q. And the finding in Mr. Duncan's case was what?

A. The finding was that he did not meet *Harper* criteria.

Q. And in fact, when you prepared the report for this Court, you indicated to the Court that you did not think that he met the *Harper* criteria for involuntary medication; is that correct?

A. That's correct.
Q. Now, in the event the Court did not grant the Government's motion today and the defendant was not to be involuntarily medicated, are you familiar with the procedures under 18 U.S.C. 4246, the evaluation that would be conducted subsequent to the proceedings today?
A. Yes, I am.
Q. Tell us what that hearing is and how that is different from what we are doing here today and what occurred in *Harper*?
A. The factors that we look at in *Harper* and the 4246 are different than what you look at in *Washington v. Harper*. *Washington v. Harper,* like I said, is dangerousness to self or others or break in senility within confinement.

In 4246 we look at whether or not someone would be dangerous to persons or property if released because of a mental illness.

So that evaluation is very different. You take a very detailed history, especially in the area of history of violence, mental illness and treatment compliance, substance abuse, history of weapon use, social support and institutional adjustment. You also review what is called an HCR-20. That is a measurement, an assessment tool to try to judge someone's risk of

dangerousness in the community.

All of this information is presented to a risk panel that consists of the evaluator who presents the information, the patient, and also the chief psychiatrist and the deputy chief psychologist. That risk panel then makes recommendations to the evaluator to determine whether or not that person meets the criteria for 4246.

Q. Okay. And what is 4246? You said meets the criteria. What exactly is 4246?

A. Okay. That is, does the individual because of mental illness pose a risk of danger to others or the property of others if released?

Q. And if he does pose such a risk, it would require hospitalization; is that correct?

A. Please repeat?

Q. I'm sorry. Does it not provide that the person, the individual in question, if they do pose a risk pursuant to those factors under 4246, would be hospitalized rather than released? Is that correct?

A. Committed within the federal system. But also there's one step after the evaluator and the risk panel render their opinion. You do have to appear before a judge, and the judge makes the final determination.

Q. Okay. And that type of hearing would occur after

the proceeding we are involved in today, after a *Sell* hearing, is that correct, or could occur?
A. Yes. It would have to be requested.
Q. Okay. So we haven't had that hearing and you don't have any opinion as to what would likely happen under 4246, is that correct, that hearing?
A. That's correct, I do not have an opinion on that.
Q. All right. One final question, Dr. Volin. Do any of the findings, opinions or recommendations contained in the reports filed with the Court that you prepared with Dr. Patole, the September and December reports, has anything changed since the time you filed those reports?
A. Well, like I said before, his last time he was here he was less manic than on other interviews. The only other change is in the *Sell* section I had mentioned that because I had personally witnessed him taking a dose of Risperdal, that him having to take a dose of Risperdal as a test dose would not be necessary. But so much time has passed that I think his next treating psychiatrist would consider whether or not another test dose needed to happen. That would be their clinical judgment and their clinical opinion.
One thing they would likely look at is has our formulation of Risperidone changed? Are we using a different manufacturer since he last took it? So that

would be the only thing that I would mention as a possible difference were he to come back.

MS. STERLING: Okay. Thank you, Dr. Volin.

THE COURT: Cross?

CROSS-EXAMINATION

BY MS. HARRIS:

Q. Good afternoon, Dr. Volin?

A. Good afternoon.

Q. Mr. Duncan is not dangerous, according to the *Harper* hearing, correct?

A. He does not meet *Harper* criterion, that is correct.

Q. And he's never had any type of physical confrontation or altercation at Butner, correct?

A. That is correct.

Q. Except for the prescription medication and his noncompliance with prescribed medication, he complies with everyone else's orders and requests; isn't that true?

A. That's correct.

Q. And I want to ask you about this diagnosis. You and Dr. Patole arrived at the diagnosis together?

A. That's correct.

Q. And you said it was based on several different things, including clinical interviews by you and Dr. Patole?

A. That's correct.
Q. And that there were variations in his level of mania?
A. Yes. So, I can explain that further if you like.
Q. Well, that's what you testified to on direct, right, you said that sometimes he exhibited pressured speech, insomnia and he was difficult to redirect?
A. Yes. For most of the summer and fall of 2012 he was manic or hypomanic.
Q. Okay. Now, one of the things that you mentioned on direct was that you had extensive collateral information that allowed you to make this diagnosis of schizoaffective disorder?
A. That's correct.
Q. You actually reached-- you and Dr. Patole actually reached that diagnosis after only two months of observing Mr. Duncan, right?
A. Yes. We had that observational data; we had information from his family, particularly from his ex-wife and his son Kyle; we had the information from Dr. Hege. We also had Dr. Brauman's evaluation. We had discovery information.
Q. All of that except for your observations at Butner, those had been available to Dr. Brauman at the Bureau of Prisons facility in New York; isn't that true?

A. If you look at Dr. Brauman's report, she did not have access to-- give me one second and I will find it.
Q. Okay.
A. So she had records from a Dr. Westerman, who is a police doctor, and a Dr. Schwartz, an endocrinologist. If I am correct, she did not have the records from Dr. Hege and did not have the records from Peachford, she did not interview his family.
Q. Excuse me for just one moment.
A. I'm sorry, Ms. Harris. I didn't hear you.
Q. Didn't Dr. Brauman have the Dr. Hege-- I'm sorry, I'm looking for the page in the report --Dr. Hege's records?
A. I do not see it listed on page 2 of her report.
Q. Thank you, Dr. Volin. I may have to come back to that in a minute. I don't want to take up our time now on that point.

With respect to this diagnosis, to have schizoaffective disorder Mr. Duncan would have had to have had previous manic depressive mood disorder symptoms as well as concurrent schizophrenia criterion A symptoms, right?
A. Yes. It requires, I believe-- let me get the DSM out.

Okay. Schizoaffective disorder requires either

a major depressive episode, a manic episode, or a mixed episode concurrent within the criterion A for schizophrenia and does not require multiple episodes.

Q. It's possible, Dr. Volin, for an individual to have two different mental health diagnoses; isn't that true?

A. Yes, of course.

Q. Okay. And so I understand that you don't agree that Mr. Duncan would correctly be diagnosed with delusional disorder based on your interviews and your analysis, right?

A. I am unaware of anyone ever diagnosing Mr. Duncan with delusional disorder.

Q. Okay. My next question is, isn't it possible for someone to have delusional disorder as well as bipolar disorder at the same time?

A. So, delusional disorder requires, according to the DSM, that if mood episodes have occurred concurrently with delusions, their total duration has been brief relative to the duration of his delusional period. Therefore, someone who has had criteria for a major mood disorder such as bipolar disorder, it would be improper to diagnose simultaneous delusional disorder because of the DSM criteria.

Q. So if I understand you correctly, if you have delusions and mood components, then this diagnosis takes

into account both of them?
A. Okay. What I'm saying is if you follow the DSM, which is what we try to do in my profession, criterion D, a delusional mood disorder, mood episodes have a part and partly with delusions. Their total delusions have been brief compared to the total duration of the delusional period.

So if you look at Mr. Duncan in particular, his mood symptoms have been prominent since 2008.

Q. Dr. Volin, the antipsychotics that you think will treat the schizoaffective disorder in Mr. Duncan, they will mostly address his mood symptoms, correct, the disorganized speech-- I'm sorry, the manic symptoms?
A. So, antipsychotic medication are effective both in the treatment of psychosis and the mania. Antipsychotic medications are the first-line treatment for psychotic illness. Some of the antipsychotic medications have also been approved as modern therapy for treatment of mania. So the antipsychotic medications treat both.
Q. These delusions that Mr. Duncan has, you have classified them as mostly nonbazaar?
A. Yes. The delusions that he has exhibited in clinical interviews with me have been nonbazaar.
Q. And you have been working with him since July of last year, correct?

A. That is correct.
Q. We are saying that they are nonbazaar because they are grounded in reality in things that actually happened to him and real people who exist, right?
A. By definition, a delusion is a break with reality. We classify bazaar versus nonbazaar when it is possible that this thing could happen. Someone may believe he is being conspired against and followed by the FBI that is not necessarily grounded in reality. So a delusion is a break with reality. However, if it could possibly happen in real life, we classify it as nonbazaar.
Q. Okay. So Mr. Duncan's beliefs, you are saying, are not grounded in reality, but they are possible?
A. Yes. They are both not grounded in reality and possible.
Q. This is the main thing that you are saying is interfering with his ability to be competent; isn't that correct?
A. His focus on these delusions to the exclusion of everything else is directly related to his incompetence.
Q. Isn't it true, Dr. Volin, that these thoughts and beliefs are never going to stop bothering or haunting Mr. Duncan?
A. That is not true. Delusions are a treatable component of a psychotic illness.

Q. Even if they are not bazaar?
A. Yes, absolutely. Delusions are a treatable component of a psychotic illness.
Q. When he was treated at Charter Peachford and Dr. Hege on antipsychotics he continued to have delusions, these particular delusions; isn't that true?
A. That's a mischaracterization of the record from the 2009 hospitalization.

If I can quote you directly from it, his delusions in particular improved. Let me just find it real quick.

Okay. "At the time of discharge he exhibited greater insight into his illness and seemed to improve. He remained hypomanic but without full-fledged mania. His paranoid delusions concerning his wife also improved. He no longer thought she was trying to kill him but did believe she wanted to financially harm him." The delusions improved.
Q. And he continued to be hypomanic, which means that he was exhibiting symptoms of mania, correct?
A. Hypomanic is not full-fledged mania. Hypomania is an attenuated version of mania, in effect.
Q. It could be referred to as a baby mania or not as bad as maybe full-blown mania, correct?
A. Yes.

Q. Okay. But it's still characterized by some disorganized thoughts, impulsive behaviors and uninterruptable speech?
A. I can tell you exactly what he was at that time if that's helpful.
Okay. "On April 4th, 2009, the day he was discharged--" I'm reading directly from Peachford Behavioral Health in Atlanta discharge summary. "April 4th, patient not in denial of his illness, sleeping better, but still with hypomanic symptoms but no full-blown mania. He was denying hallucinations. Denying suicidal or homicidal ideations. Family--"
Q. Could you slow down a little bit, please?
A. I'm reading from the Peachford Health System discharge summary, the date he was discharged from inpatient April 4th. "Patient not in denial of his illness. Sleeping better, but still with hypomanic symptoms but no full-blown mania. He was denying hallucinations, denying suicidal or homicidal ideations.
"Family section: With son, Kyle, and sister, Katie. His brother died. Katie is in Maine. His brother is in North Carolina. Family told Katie that he has been in denial of his illness for over a year now and they want him to accept his illness, also take his

medications. Patient is still hypomanic. No longer "believes that his wife wants to physically harm him. Now says she wants to financially harm him. Patient is willing to start PHT on April 5th." So they did not specifically discuss his particular hypomanic symptoms at that time."

Q. But that discharge summary does note twice that he was still hypomanic, right?

A. I don't know if it-- certainly in the section I read he was hypomanic.

Q. His delusions were better, but they still persisted to some degree?

A. So the particular delusion that necessitated his admission that he believed his wife wanted to kill him, that had resolved. He believed she wanted to financially harm him. That was in the context of a divorce.

Q. He has both types of beliefs about Mr. Rose and Ms. Bashama. Number one, that they are going to physically harm him; and number two, they are going to financially harm him. Isn't that true?

A. Yes.

Q. Additionally, when he was under the care of Dr. Hege from 2008 to 2011, he still had persistent symptoms, even though he was medicated and showed some

improvement?
A. Mr. Duncan, according to his son, Kyle, and also according to Dr. Hege's records, was largely noncompliant. The doctors at Peachford were able to interview Dr. Hege regarding the treatment of his patient, and I can read exactly what they said in their discharge summary. They said, "In speaking to Dr. Hege, he reported that he has tried starting the patient on Abilify, but the patient refused to take the prescribed dose and kept taking smaller and smaller amounts which has resulted in manic decompensation." So he was largely noncompliant when he was under the care of Dr. Hege outpatient.
Q. So he began decreasing his dose on his own of Abilify when under the care of Dr. Hege?
A. According to the Peachford records, that's correct.
Q. But he was taking some amount of the Abilify, and my original point was he still had persistent delusions at that period of time?
A. It would be erroneous to conclude that a medication was ineffective when it's not being taken properly.
Q. Well, let's talk about that. One of the reasons that he did not take the medication as prescribed is because he experienced side effects and complained of side effects; isn't that true?

A. It is very common for patients who are manic or hypomanic to complain of side effects of sedation when in actuality the speed of their thoughts and speech and actions has returned to a more normal level.

If you look at his family, the lateral report from that time, his son reported that he was sleeping very little, that he was engaged in a lot of bold directed behavior that was not actually productive behavior, and you see that simultaneously with his complaining of side effects of sedation we have a family report that he's not sleeping. So that would be inconsistent information.

Q. Do I understand you correctly that you are saying even though he was complaining of sedation side effects, his family's reports tend to show that he maybe wasn't experiencing that? Is that what you are saying?

A. That's correct.

Q. When he was given both Abilify and Risperdal at Butner under your care, he also complained of side effects, isn't that true?

A. That is correct.

Q. And in the report, the report from Butner that you and Dr. Patole submitted, it's opined that he should also be given a mood stabilizer in conjunction with the antipsychotic in order to render him competent; isn't

that true?
A. We say that mood stabilizers can also be helpful. I do not think he has to have a mood stabilizer to be rendered competent.

In our study and the studies I have reviewed most patients were restored to competence on one antipsychotic medication. Very few of the patients also had a concomitant mood stabilizer on board that resulted in their competence. So I do think they can be restored on antipsychotic therapy. As I stated before, antipsychotics are approved for treatment both for psychosis and for mania.

Q. Dr. Volin, isn't it correct, however, that in the past when he has improved and his symptoms have improved under Dr. Hege's care and under Charter Peachford's care, that he was also being given mood stabilizers?
A. Yes. So in the Charter Peachford he improved in eight days, and he was given not only the Abilify and Depakote that he was taking there at the end of the eight days, he was also additionally prescribed other medications.

It is not uncommon for inpatient hospitals who are very expensive to try to treat people very quickly. I would not have the burden of trying to render Mr. Duncan competent in eight days. Therefore, I would

give the antipsychotic medication time to work to make sure that those other medications were actually needed.

Q. But regardless, you or the staff at Butner FMC cannot give mood stabilizers involuntarily; isn't that correct?

A. Yes. There is no injectable mood stabilizer, that is correct.

Q. Dr. Volin, when we spoke about alternative therapies and you said that talk therapy does not work for his particular diagnosis and that cognitive behavioral therapy needs the addition of medication, would you agree that, therefore, you are not considering these as alternatives to medication?

A. So the various therapies that would be used in conjunction when they have antipsychotic medication, some have shown to be effective, some have not. However, it is widely accepted in my profession that you cannot treat psychotic symptoms with therapy or other less alternative measures alone. It simply does not work. So I cannot divorce myself from that knowledge, even though as a mental health professional I understand and respect the value of talk therapy. I think that's something that you try to engage with every time you sit down with a patient. You try to create a therapy that aligns, you try to assist the patient; you try to help

the patient see things that he cannot or will not see.
Q. And so in your expert opinion, you are saying that these alternative therapies are not an option for Mr. Duncan?
A. They are not going to restore him to competence. They are not going to treat his psychotic illness the way in which medication would.
Q. Doctor, when we are talking about the effectiveness of the suggested or recommended medications, you relied on a couple of studies; isn't that correct?
A. The studies listed in the report is all restoration of competence. There are countless double-blind placebo trials that have shown the effects of antipsychotic medications in patients with psychotic illness that I do not reference.
Q. Did you reference in the report the Herbel study and the Cochrane study?
A. Yes. There is a 2008 Herbel and Stelmach and 2012 Cochrane and Herbel. They are specifically referencing pretrial inmate restoration to competence.
Q. Those particular studies that are cited in the report as a basis for the effectiveness, those were not double-blind placebo studies like you just mentioned, were they?
A. They were not. Those were retrospective analysis.

Because this particular population is not a very large population, it would be almost impossible to get a double-blind placebo controlled trial. And because where you may have two percent of the entire population with schizophrenia, how many of those are federal pretrial inmates? So when you have such a small sample size, that necessitates this type of study.

If you look at the restoration literature, most of them were retrospective reviews.

Q. I am going to ask you another question about the medications. Some of the side effects that you went through on direct of the recommended medications are the Parkinsonism effects?

A. Yes.

Q. Okay. With respect to Haldol, which is the No. 1 recommended involuntary medication, isn't it the practice for Cogentin to be given to counteract the Parkinsonism symptoms?

A. If those symptoms are present, it would be a practice to administer Cogentin.

Q. Okay. And Cogentin itself, some studies indicated that that can then cause Tardive Dyskinesia; isn't that correct?

A. You would have to direct me to the study because if someone-- it would be difficult to separate out people

who had never been on antipsychotic medication and people who had been given Cogentin alone. So if you are noting a correlation, we would have to make sure that there was not a compounding factor in the psychotic medications.

Q. Okay. With respect to side effects, though, can we agree that Mr. Duncan's main complaints thus far have been lethargy, sedation, being zombie-like, etc.?

A. Yes. He often had some very unusual complaints after the dosage of Abilify that were not sedation.

Q. But the ones you would be most concerned about or expect him to have would be these lethargy, feeling like a zombie or feeling sedated?

A. I am most concerned about the symptoms that the patient presents. I am, of course, very concerned about the possible symptoms that might indicate a serious condition. So I can't say that I'm more concerned with sedation than I am with another symptom. My focus is going to be on what I observe within the physical exam and other observations and what the patient is telling me.

Q. But sedation has been specifically complained about by Mr. Duncan in the past with antipsychotics; isn't that true?

A. Yes.

Q. And for an individual experiencing this side effect, that person could hypothetically have a difficulty in sitting at counsel table and listening to witnesses and comprehending and observing testimony; isn't that correct?

A. That is correct. I would also like to note that antipsychotic medications actually improve cognition. So if Mr. Duncan were experiencing a side effect of sedation here after treatment, we would monitor that very different ways. We would get a sleep log. We have the advantage of 24-hour nursing. We would get a sleep log that would monitor all of the times that he was sleeping throughout the 24-hour day.

I would also-- we could administer neuropsychological testing to see if there was a lack of concentration in a particular area that counsel would be interested in. We would also do interviews various different times of day and determine when these symptoms were most prominent, and we would address that by changing the dosage or the timing of his medication or changing the medication altogether if that were going to be a barrier to the competence.

Q. But were he to continue to experience side effects that render him zombie-like, wouldn't that interfere with his ability to relate to his attorney if he's

hearing contradictory or untrue information, relating that in a coherent and organized manner and being able to respond to questions from his counsel?

A. So, I have never observed Mr. Duncan behaving in a zombie-like fashion. The records that I reviewed from previous evaluators and the treatment at Charter Peachford did not reflect that he was zombie-like after treatment with medication.

Of course, if someone were oversedated, we would address that immediately.

Q. Isn't it true that his wife relayed to either you or Dr. Patole that when he was medicated in the past, he was zombie-like?

A. When he was initially treated-- hold on. Let me get her interview.

Q. It's on pages 6 and 7 of the report, Doctor.

A. Okay. So when he was initially treated prior to treatment with Dr. Hege in 2008, Mrs. Duncan indicated that the medication made him a zombie. I did not have those records from that particular outpatient provider to review.

Q. Dr. Volin, you mentioned that if the Court grants the government's motion, you as Mr. Duncan's treating doctor, if you were his treating doctor, would give him the opportunity to choose his medication, whether it was

injected or taken orally?
A. That's correct.
Q. Is that Butner's protocol?
A. If it were one of the approved formulary and available antipsychotic medications.
Q. What I'm asking, if that is the protocol of the hospital you are leaving, would the next doctor have to follow that protocol of allowing him the choice?
A. Yes. That is our standard here. We do not-- as psychiatrists, as doctors, we do not like forcing patients to take medication. If he were to choose an oral medication, we would all be delighted.
Q. But were he to be involuntarily medicated and not comply with the Court's order, the standard procedures at Butner require that he be strapped down and held down while he's injected; isn't that correct?
A. So, the forced medication procedures, if they are required, eventually a nurse would offer it to him and then he might say no. People may offer it again and explain to him what would happen if he chose not to comply. If what was called a forced *Sell* move was required, then the officers would be on camera, the nurse and the doctor would be interviewed on camera. All of the procedures would take place on camera.
Depending on whether or not this was within his

cell or in a nurse's station, it would be very unlikely he would be strapped down, but the officers might physically restrain him while he was being injected with the medication by the nurse. And, like I said, all this would occur on camera.

Q. And you have no knowledge of whether the local jail that he would be transported to after Butner would continue to administer the medications that had been successful for him at Butner; isn't that true?

A. I cannot force any other doctor to prescribe the same medication that I would prescribe. However, if there's concern that he is not going to take his medication or not going be administering them properly after restoration of competence, the Court can request that he remain at our site for the competency hearing and that occur via video conference if noncompliance or not being administered medication at a local jail is a concern.

Q. Finally, Dr. Volin, you opine that Mr. Duncan is not competent to assist in his defense and, therefore, not competent to stand trial; isn't that correct?

A. That is correct.

Q. Because of these persistent delusions that interfere with his ability to focus?

A. Yes, so the delusion and the thought disorganization.

Q. Would your opinion change if Mr. Duncan had been able to sit in court today, pay attention, assimilate all the information of witness testimony and interact with his attorneys in an organized and coherent fashion?

A. I would have to evaluate Mr. Duncan. I would be particularly interested in whether or not he continued to believe that his counsel, that the judge in this case, that other court professionals were involved in the conspiracy with Robert Rose, that Robert Rose was directly involved in his incarceration. So it would be very important to me to make sure that those delusions were either present or not present.

One's decorum in court does not necessarily mean that delusions are no longer present.

MS. HARRIS: Your Honor, may I confer with cocounsel?

THE COURT: You may.

MS. HARRIS: Thank you very much, Dr. Volin. I have no further questions. Have a good afternoon.

MS. STERLING: I have just one question, Your Honor.

THE COURT: Okay. One brief redirect question.

MS. STERLING: One brief redirect question.

REDIRECT EXAMINATION

BY MS. STERLING:

Q. Dr. Volin, can you state with a reasonable degree of medical certainty that Mr. Duncan does not meet the criteria for delusional disorder?

A. Yes.

MS. STERLING: Thank you.

THE COURT: May this witness be permanently excused, ladies?

MS. HARRIS: No, sir, Your Honor.

THE COURT: You do not wish to permanently excuse her?

MS. HARRIS: We have no objection to her being excused, Your Honor.

THE COURT: That's what I was asking.

You may be permanently excused, Dr. Volin.

THE WITNESS: Thank you, Your Honor.

(The witness was excused.)

THE COURT: Do you have another witness?

MS. STERLING: Your Honor, the Government would not call our remaining witness. As I indicated before, it was only if a question was raised as to something that came up. We would rest at this time.

THE COURT: If you intend to call any witnesses,

the Court is going to have to take a break.

Do you intend to call any witnesses?

MS. TALLENT: No, sir, Your Honor.

THE COURT: All right. If you are not calling any witnesses and the defendant is not calling any witnesses, here's what the Court is going to do.

THE DEFENDANT: May I save the taxpayer dollars? There's a robbery report that Bashama--

THE COURT: No, we are not going to do it this way.

THE DEFENDANT: Bashama robbed my business of four contracts.

THE COURT: Mr. Duncan, you will not address the Court. You will go through your counsel. If your counsel doesn't raise it--

THE DEFENDANT: She needs to admit it into evidence.

THE COURT: That's because she is trained, and she knows what needs to be--

THE DEFENDANT: She is refusing to admit evidence. The area police department report proves--it's her job, and she is not doing it.

THE COURT: No. It is her job and not yours, so be quiet.

THE DEFENDANT: That's correct.

You do it.

THE COURT: She is not going to do it.

THE DEFENDANT: Why?

THE COURT: Because she is in charge of the case, not you, and the Court relies on counsel, not an untrained person.

THE DEFENDANT: I have fired her so many times, and she refuses to pass my information to the FBI.

THE COURT: Here's where we stand. I want you to deliver any post-argument memoranda you wish to present to the Court within 20 days of today. Today is-- within 20 days of today-- you can calculate 20 days from today's date --in writing, and the Court will promptly get back to you probably within 20 days with its ruling on the issue raised here on the question of involuntary medication.

THE DEFENDANT: I will continue giving my information to the FBI.

THE COURT: The Court will be in recess.

THE DEFENDANT: Put that on the record, please.

(This hearing concluded at 2:03 p.m.)

* * *

CERTIFICATION

I certify that the foregoing is a correct transcript of the record of proceedings in the above-entitled matter.

X_____/s/_____X

Sharon B. Borden, RMR, FCRR

X August 27, 2019 X

Date