UNITED STATES DISTRICT COURT SOUTHERN DISTRICT OF FLORIDA

Case No. 21-cv-21940-BLOOM/Otazo-Reyes

NEIMA BENAVIDES, *as Personal Representative of the Estate of Naibel Benavides Leon, deceased*,

Plaintiff,

v.

TESLA, INC., *a/k/a. Tesla Florida, Inc.*,

Defendant.
_____/

Case No. 22-cv-22607-BLOOM

DILLON ANGULO,

Plaintiff,

v.

TESLA, INC., *a/k/a/ Tesla Florida, Inc.*,

Defendants.

_____/

DILLON ANGULO'S MOTION TO LIMIT AND EXCLUDE CERTAIN OPINIONS OF TESLA'S NEUROPSYCHOLOGIST, DR. BARRY CROWN

Dillon Angulo, by and through his undersigned attorney and in accordance with this Honorable Court's Order granting leave to file this Motion (DE 336), hereby files this Motion to limit and exclude certain opinions of Tesla's expert neuropsychologist, Dr. Barry Crown, and states as follows:

FACTUAL BACKGROUND

In the immediate aftermath of this crash, Dillon Angulo was in dire condition. When police officers arrived at the scene and attended to Angulo, they noted that Angulo was "agonal", referring to a pattern of labored, gasping breaths that indicates a life-threatening situation where the brain is not receiving enough oxygen. Body worn camera footage from the scene certainly leaves no doubt as to the life-threatening severity of the injuries suffered by Angulo. See:

Ultimately, Angulo was air-lifted to Jackson's Trauma Center, where during the air-transfer paramedics noted that Angulo was completely unresponsive, with a Glasgow Coma Score of 3 (the worst possible score). Thankfully, at Jackson, attending doctors were able to stabilize Angulo. The records from Jackson reflect that over his first several days in the trauma ICU, Angulo remained in varying degrees of a comatose state secondary to his brain injury[1]. Imaging ultimately revealed that he sustained an intraparenchymal hemorrhage, where the brain tissue itself is

[1] In addition to his traumatic brain injury, Angulo suffered substantial orthopedic polytrauma and other internal injuries.

bleeding; a life-threating injury known to cause significant neurological deficits.

Today, almost six years after the crash, and after a long and arduous path to recovery including numerous surgeries, rehab through Baptist Health's Intensive Brain Injury Program, and substantial continuing medical care, Angulo still suffers from neuropsychological disturbances secondary to his brain injury and PTSD. These disturbances include diminished executive functions, impaired memory and concentration, and emotional dysregulation, among others.

To contest the extent of the continuing brain damage and neurocognitive deficits suffered by Angulo as a result of this crash, Tesla has retained Dr. Barry Crown, a neuropsychologist. Dr. Crown acknowledged that Angulo's medical records reflect that he suffered a "severe" [2] traumatic brain injury. (Ex. A, Dr. Crown Depo at 32; 86). Dr. Crown also conducted an interview with Angulo and administered a neuropsychological testing battery. The end result of that testing is that Dr. Crown found, unsurprisingly, that Angulo does have continuing neuropsychological disturbances secondary to his brain injury. (Ex. A, Dr. Crown Depo at 35; 49). More specifically, Dr. Crown's testing demonstrated substantial neurocognitive disturbances in Angulo's (1) general reasoning ability, (2) immediate memory, (3) constructional ability, (4) language ability, (5) attention, and (6) delayed memory, among others. (Ex. A, Dr. Crown Depo at 44-45). Additionally, Dr. Crown acknowledged that Angulo continues to suffer from PTSD, secondary to his own injuries as well as the death of Naibel Benavides. (Ex. A, Dr. Crown Depo at 106; 146).

Notwithstanding these findings, at his deposition, Dr. Crown made it clear that it is his intent at trial to testify as to a host of irrelevant and prejudicial matters in an attempt to deflect from the real issues. Plaintiff challenges those opinions as follows:

[2] The Glasgow coma scale has three categorizations for traumatic brain injuries; mild, moderate and severe.

I. The extent and specifics of Angulo's former drug use.

Angulo developed an addiction to Xanax in high school. Thereafter, he gradually began using more substances including marijuana, and for a very short period, cocaine and crack cocaine. Very shortly after using crack cocaine for the first time, Angulo voluntarily checked himself in – on his own accord – to an inpatient drug rehabilitation program. The unrefuted facts establish that following his admission to this rehab facility, approximately one year prior to this incident, Angulo never used any illicit substances ever again. Indeed, it is unrefuted that even after his discharge from the hospital following this crash, when he was completely wheelchair bound, had an external fixator, and was in horrible physical pain, not only did Angulo remain clean and not relapse, but he even refused to take any medication (such as narcotic pain medication) which could have led to a relapse.

While Dr. Crown does agree that Angulo's traumatic brain injury, PTSD, and chronic pain resulting from this crash are all contributory towards Angulo's continuing neurocognitive deficits, Dr. Crown also opines that Angulo's pre-morbid issues of (1) drug use, (2) ADHD, and (3) depression are also contributing to his current deficits. (Ex. A, Dr. Crown Depo at 34-35). And, Dr. Crown has made it clear that he intends to lay out the sordid details of these pre-morbid issues for purposes of causing juror prejudice. For example, Dr. Crown's Report contains the following details of Angulo's medical history:

> On December 15, 2014, Mr. Angulo was seen in the emergency room of Baptist Hospital after having a seizure at a workplace. He was transported by ambulance. Medical records indicate that he had been taking one to two 2mg Xanax (alprazolam) tablets a day and had abruptly stopped two days prior to the seizure. Medical screening was positive for cannabis and benzodiazepines.
>
> In June of 2018, Mr. Angulo voluntarily entered a program for substance abuse and addiction at the Beachcomber Center in South Florida. He tested positive for cannabis, benzodiazepines, and cocaine. He was taking 2 to 4 milligrams of Xanax (alprazolam) per day and using cocaine in powder and crack form. He also

> complained of and was treated for depression. He was prescribed Wellbutrin for depression. Issues of sex addiction and love addiction emerged during treatment. When challenged in group counseling, he left the program against medical and clinical advice. His primary therapist noted that he was at high risk for relapse.
>
> (Exhibit B, Crown Report at 6)

While in § II below, Plaintiff challenges the scientific basis for Dr. Crown's opinion that these pre-morbid issues and drug use contributed to Angulo's neurocognitive disturbances, here Plaintiff challenges the need for Dr. Crown (or any other Tesla expert or lawyer) to go into the details of Angulo's prior drug use should this Court allow presentation of same. More specifically, to the extent that this Court finds that Angulo's pre-crash drug use relevant and admissible, Plaintiffs request that only the minimum possible information be introduced. Certainly, Dr. Crown and Tesla's other lawyers and experts can make any points they need by simply referring to "prior drug use" or other similar terminology. Details as to the specifics of that drug use, such as the fact that Angulo used cocaine or crack cocaine, or the fact that he had a seizure as a result from Xanax withdrawal, are completely irrelevant and highly prejudicial, and thus should be excluded under a Rule 403 analysis.

II. That Angulo's former drug use, ADHD, and depression are contributors to his current neurocognitive deficits.

In the preceding section, Plaintiff argues that Dr. Crown (and, more broadly, Tesla) should not be allowed to introduce the sordid details of Angulo's pre-morbid drug use. Before the Court even gets to that question, however, it must answer a first question – is that pre-morbid drug use even relevant and should it come in at all? Dr. Crown's testimony makes it clear that the answer to that question should be no.

As discussed in the factual background section above, Dr. Crown's opinion is that while this incident did cause Angulo to suffer a traumatic brain injury and resulting neurocognitive

disfunction, Angulo's pre-morbid drug use, ADHD, and depression were also contributing factors. However, Dr. Crown's opinions on this matter are not based on sufficient facts or data, and are not the product of reliable methodology, and thus should be excluded.

More specifically, from a factual standpoint, Dr. Crown acknowledges that there is no medical evidence of any kind to show that Angulo had any pre-existing neurocognitive disorders or brain damage as a result of his pre-morbid drug use, ADHD, or depression. (Ex. A, Dr. Crown Depo at 54-55).

Without any base-line evidence to establish that Angulo had such pre-existing brain damage or neurocognitive disfunction, Dr. Crown asserts baldly that Angulo must have had such pre-morbid deficits because "95 percent of former benzodiazepine users will suffer from continuing neuropsychological disturbances". (Id. at 39). Obviously, such a statistical opinion requires an empirical study, yet when pressed, Dr. Crown was unable to cite to any scientific literature or peer-reviewed studies to support same (Id.). Of course, Plaintiff did notice Dr. Crown's deposition duces tecum and specifically requested that he bring any and all studies and literature which supported his opinions. (Ex. C, Crown Deposition Notice at ¶ 4). Dr. Crown did not bring any such materials even though he acknowledged that "[he's] familiar with them by memory" and that it would take him approximately five to six hours to compile them. (Ex. A, Dr. Crown Depo at 8-11). Instead of producing such literature for Plaintiff's review, Dr. Crown asserts that Plaintiff should accept these statistics and opinions without verification. (Id. at 39).

Staying on the subject of pre-morbid drug use, Dr. Crown's own testimony causes substantial doubts as to the reliability of his opinions. First, he acknowledges that he can only say that such pre-morbid drug use would have caused "one or more" (but not necessarily all) of

Angulo's continuing neurocognitive impairments. (Id. at 39). Next, he even acknowledged that he could not be certain as to the contribution of same. See:

> Q: Okay. By your own logic are you sure that the drug use and the depression treatment contributed to his neuropsychological disturbance?
>
> A: It very well may have. Again, I can't tell you for certainty.
>
> (Id. at 34-35).

Accordingly, with regards to the former drug use issue, it is clear that Dr. Crown has not based his opinion on sufficient facts or reliable data. Without any medical evidence of pre-morbid brain injury or neurocognitive disfunction, he asserts that Angulo must have had same due to the fact that 95% of former benzodiazepine ("benzo") abusers have such brain damage, but can't and wouldn't cite to any research or studies to support that opinion, and couldn't state which of Angulo's neurocognitive deficits were caused by the pre-morbid drug use vs. the traumatic brain injury (or his PTSD for that matter).

Pursuant to Federal Rule of Civil Procedure 26(a)(2)(B), an expert's report must contain the facts or data considered by the witness in forming his or her opinions. If a party fails to comply with this rule, his opinions may be excluded unless the failure was substantially justified or harmless. Fed. R. Civ. P. 37(c)(1); see *Mitchell v. Ford Motor Co.*, 318 F. App'x 821, 825 (11th Cir. 2009) (affirming order striking expert because failure to disclose scientific basis for expert's opinions obstructed opposing party's right to discovery under Fed. R. Civ. P. 26). By failing to provide this information, Dr. Crown renders his opinion impermissibly conclusory and speculative. See e.g. *Haggerty*, 950 F. Supp. At 1167 ("an expert's testimony must be based on 'more than subjective belief or unsupported speculation.'"); see also *McDowell*, 392 F.3d at 1299

("an expert's self-serving assertion that his conclusions were 'derived by the scientific method' [cannot] be deemed conclusive").

As it relates to ADHD, Dr. Crown's opinion is equally speculative. First, Dr. Crown again didn't provide any studies or literature to support his opinions on ADHD despite specifically referencing one such study in his testimony (Ex. A, Dr. Crown Depo at 37). More importantly, Dr. Crown acknowledged that ADHD would only be a contributing factor towards Angulo's neuropsychological disfunction if Angulo suffered from ADHD "after the adolescent growth spurt." (Id. at 40-41). Yet, on questioning, Dr. Crown could not point to any medical evidence to show that Angulo did in fact suffer from ADHD after reaching adulthood. (Id. at 41). Instead, Dr. Crown opined that Angulo must have suffered from ADHD after reaching adulthood based solely on his interview with Angulo, where Angulo was never asked nor indicated that he had ADHD in adulthood. (Id. at 41-42). Instead, Dr. Crown assumes that Angulo must have had ADHD as an adult because he "called himself a knucklehead" and because "he didn't do well in school". (Id.). The speculative nature of Dr. Crown's basis here was best exemplified by his acknowledgement that "I don't *think* that his ADHD resolved in his childhood.". (Id at 42)(emphasis added). This type of speculation lacks reliability and should not be allowed.

III. That Angulo is Malingering.

In his testing of Angulo, Dr. Crown administered three (3) separate malingering tests. Those tests are "specifically designed to tell if he's giving his best effort without letting him know that he's being tested for his best effort". (Ex. A, Dr. Crown Depo at 112-113). Angulo passed two of the three tests. (Id. at 113). The one malingering test that Angulo did not pass flagged him as potentially malingering for answering affirmatively that he was suffering from symptoms of depression, PTSD, and substance abuse. (Id. at 113-115). Obviously, it would make sense that

Angulo endorsed these items, as he is or was previously suffering from them. Ultimately, Dr. Crown acknowledged that based on the testing results he could not testify within a reasonable degree of neuropsychological probability that Angulo was malingering or exaggerating. (Id. at 116). Accordingly, Dr. Crown should be completely prohibited from expressing or suggesting in any manner that Angulo is malingering or exaggerating his injuries and neuropsychological deficits.

IV. The use of the MCMI-III personality factors.

On page 10 and 11 of his report, Dr. Crown has a "Personality Factor" section that frankly makes Angulo sound like a sociopath. Excerpts from that section include:

> Notable may be tendencies to intimidate and exploit others and to expect special recognition and consideration without assuming reciprocal responsibility. Actions are likely to be present that raise questions about personal integrity, such as a *ruthless indifference to the rights of others*. These may indicate a pervasively deficient social conscience, a disdain of traditional ideals, and a contemptuousness of conventional values.
>
> . . .
>
> Antisocial behavior, alcoholism, or drug problems would not be inconsistent with this clinical picture. When his life is under control, he may be *skillful in exploiting the goodwill of others*. More characteristically, he will be envious of others and wary of their motives.
>
> . . .
>
> Deficient in deep feelings of loyalty and displaying an occasional *indifference to truth*, he may successfully *scheme beneath his veneer of civility*.
>
> . . .
>
> There are further indicators of borderline personality disorder with *antisocial and sadistic features*.
>
> (Ex. B, Dr. Crown Report at 10-11)(emphasis added).

In deposition, it was revealed however that these "personality factors" are not the opinions of Dr. Crown, but instead are a verbatim copy and paste of a printout from the MCMI-III test administered by Dr. Crown. More specifically, the MCMI-III test consisted of 175 true or false questions. (Ex. A, Dr. Crown Depo at 61-62). Dr. Crown fed Angulo's answers into a computer program and the program generated the description of the personality factors. (Id.) Dr. Crown copied and pasted that summary into his report, and did not contribute to or editorialize it in any way. (Id.). On questioning, Dr. Crown was unable to identify the type of questions that Angulo would have endorsed to produce the result generated by the software. (Id. at 63-64). Dr. Crown further acknowledged that (1) none of the opinions or conclusions reflected in the "personality factors" were reached independently by Dr. Crown, and (2) none of the personality factors were even complained of by Angulo or at issue in Angulo's claims (Id. at 64-70).

Federal case law is clear that Dr. Crown cannot simply copy and paste information generated by a software program before the jury and disguise it as his own opinion. *See Schoen v. State Farm Fire & Cas. Co.*, 638 F. Supp. 3d 1323, 1336–37 (S.D. Ala. 2022) (holding that expert was "free to rely on information and data from an expert in formulating *his* opinions. However, at the end of the day, it is imperative that [the expert] apply *his knowledge* to the facts and form *his own opinion.*" (Emphasis supplied). *See also United States v. Dukagjini*, 326 F.3d 45, 58 (2d Cir. 2003) (although an expert was permitted to "rely on hearsay evidence for the purposes of rendering an opinion based on his experience," in this case the government's expert was merely "repeating hearsay evidence without applying any expertise whatsoever, thereby enabling the government to circumvent the rules prohibiting hearsay"); *United States v. O'Keefe*, 825 F.2d 314, 319 (11th Cir. 1987) (affirming district court's restriction of testimony of plaintiff's second tax expert which was "nothing more than a personal vouching of one expert for another expert."); *American Key Corp.*,

762 F.2d at 1580 ("Expert opinions ordinarily cannot be based upon the opinions of others whether those opinions are in evidence or not."); *Grayson v. No Labels, Inc.*, No. 6:20-CV-1824-PGB-LHP, 599 F.Supp.3d 1184, 1193 (M.D. Fla. Apr. 25, 2022) ("An expert may not blindly rely on the conclusion of another expert and still meet the reliability requirements of Rule 702 and *Daubert*."); *Mchale v. Crown Equip. Corp.*, No. 8:19-CV-707-T-27SPF, 2021 WL 289346, at *3 (M.D. Fla. Jan. 28, 2021), *aff'd*, No. 21-14005, 2022 WL 4350702 (11th Cir. Sept. 20, 2022) ("Inappropriate parroting occurs when an expert adopts another expert's opinion wholesale, without reaching independent conclusions in reliance on that opinion.") (quoting *Fox v. Gen. Motors LLC*, No. 1:17-CV-209-MHC, 2019 WL 3483171, at *26 (N.D. Ga. Feb. 4, 2019)); *Hanson v. Colgate-Palmolive Co.*, 353 F. Supp. 3d 1273, 1292 (S.D. Ga. 2018) ("An expert 'may not simply repeat or adopt the findings of another expert without attempting to assess the validity of the opinions relied upon.'") (quoting *Hernandez v. Crown Equip. Corp.*, 92 F. Supp. 3d 1325, 1352 (M.D. Ga. 2015)).

Moreover, as acknowledged by Dr. Crown, the personality factors identified in this computer-generated profile (e.g. "ruthless indifference to the rights of others", "skillful in exploiting the goodwill others" and "antisocial and sadistic features") are not even complained of by Angulo in any manner nor are they at issue in this case. Accordingly, they lack any probative value and of course would be extremely prejudicial, and thus must be excluded under Rule 403.

V. That childhood corporal punishment received at the hands of his mother contributed to Angulo's PTSD.

There is debatable record evidence showing that, as a child, Angulo was the victim of corporal punishment wherein his mother would hit his hand with a spoon at times. (Ex. A, Dr. Crown Depo at 146-147). Dr. Crown did not offer any opinions related to same in his report. (Ex. B., Dr. Crown

Report). Notwithstanding, in deposition Dr. Crown opined that this corporal punishment was a contributing factor to Angulo's PTSD, along side the death of Naibel Benavides and Angulo's own injuries suffered in the crash. (Ex. A, Dr. Crown Depo at 146-147).

PTSD is diagnosed through DSM (Diagnostic and Statistical Manual of Mental Disorders) criteria. (Ex. A, Dr. Crown Depo at 147). Dr. Crown admits that he never went through a PTSD DSM analysis with Angulo. (Id.) The DSM criteria for PTSD requires "exposure to actual or threatened death, serious injury, or sexual violence."[3] Clearly, being the victim of a car crash that killed his girlfriend and sent Angulo to the trauma center in life threatening condition satisfies that DSM criteria. Conversely, being hit with a wooden spoon as corporal punishment obviously falls far short. Accordingly, because Dr. Crown did not go through a DSM analysis, and because the criteria for PTSD clearly does not allow for it, Dr. Crown's opinion that this childhood corporal punishment contributed to Angulo's PTSD is a product of both insufficient data and unreliable methodology, and must not be allowed. Moreover, it was surprise testimony in that it was not included in Dr. Crown's report.

In reality, Tesla and Dr. Crown's intent here is crystal clear; they intend to introduce prejudicial information about Angulo's mother to cause juror prejudice for if and when she is called to testify on her son's behalf regarding his physical, mental and emotional condition as a result of this crash. For this reason, any reference by any of Tesla's experts or lawyers to this corporal punishment should be excluded under a Rule 403 analysis.

[3] see, https://www.ncbi.nlm.nih.gov/books/NBK207191/box/part1_ch3.box16/

VI. Any testimony that Dr. Crown has provided testimony or guidance to the government or governmental agencies.

To bolster his statistical opinion that 95% of former benzo abusers will have continuing and permanent neuropsychological disturbances, instead of citing actual research to support his opinion, Dr. Crown pointed to the fact that he has previously provided similar unsworn opinions to the National Institute of Drug Abuse. (Ex. A, Dr. Crown Depo at 39-40; 47-49). More specifically, Dr. Crown served as a consultant on a committee that reviewed and granted federal contracts and grants. (Id. at 47). Of course, Dr. Crown couldn't confirm that the opinions he gave in that role mirrored the statistical opinions regarding former benzo abuse that he offers here. (Id. at 48-49). Either way, the law of the land is clear – it is impermissible to "place[] the government's prestige behind the witness to bolster the witnesses' credibility." *Sok v. Romanowski*, 619 F. Supp. 2d 334, 359 (W.D. Mich. 2008).

VII. That Angulo has a love or sex addition, that he left rehab against medical advice, that he suffered a seizure as a result of benzodiazepine withdrawal, or any other evidence or arguments related to character or prior bad acts of Angulo.

As has been made clear by Tesla, in light of the obvious nature of the severe and life altering damages suffered by Angulo, its strategy at trial will be to lob as many collateral attacks as possible in hopes that same causes juror prejudice against Angulo. This Honorable Court should not allow same by Dr. Crown or by any other member of Tesla's expert or legal team.

In his report, Dr. Crown notes that during his pre-crash self-imposed rehab admission, "[i]ssues of sex addiction and love addiction emerged during treatment". (Ex. B, Dr. Crown Report at 6). Likewise, Dr. Crown points out that Angulo "left the program against medical and clinical advice. His primary therapist noted that he was at a high risk for relapse." (Id.) Dr. Crown also notes that in 2014, five years before this crash, Angulo had a seizure as a result of benzo

withdrawal. (Id.). None of these facts are at issue in this case. Besides the fact that he continues to deeply mourn the loss of Naibel Benavides, Angulo has not made any claims that can be even remotely related to issues of love or sex addiction. Likewise, the unrefuted evidence in this case shows that Angulo never relapsed after leaving rehab, including after this crash when he had every excuse and reason in the world to relapse. Lastly, as discussed in detail above, there is no evidence whatsoever to show that the one seizure that Angulo had from benzo withdrawal caused any type of neurological injury. The only reason to introduce these items and others like it at trial is to cause juror confusion and prejudice. Nothing more.

Generally, character evidence and evidence of prior bad acts – i.e. "other crimes, wrongs or acts" – may be introduced only in limited circumstances and only then to prove a material fact in issue. Fla. Evid. Code § 90.404(2). Such material facts include proof of motive, opportunity, intent, preparation, plan, knowledge, identity or absence of mistake or accident. The rules curtail the use of unrelated prior bad act evidence because it "tends to distract the trier of fact from the primary issues of the case." Eleaszer and Weissenberger, FLORIDA EVIDENCE, 1999 ed., at 170.

Even otherwise admissible prior bad acts or character evidence is subject to the dictates of Rule 403, which precludes admission of even relevant evidence whose probative value is substantially outweighed by its unfairly prejudicial effect. *Perper v. Edell*, 44 So. 2d 78, 80 (Fla. 1949); Fla. Stat. § 90.401-403. Where evidence is unfairly prejudicial, tends to mislead jurors, or confuse the issues, the Court should exclude it notwithstanding relevance. Fla. Evid. Code § 90.403.

WHEREFORE, Plaintiff prays this Honorable Court grant this instant Motion, and enter an order prohibiting Dr. Crown and all other Tesla experts and lawyers from introducing

testimony, argument or evidence related to the matters set forth above.

CERTIFICATE OF CONFERRING WITH COUNSEL PURSUANT TO RULE 7.1(a)(3)

Pursuant to Local Rule 7.1 (a)(3), the undersigned counsel for Plaintiff conferred with Whitney Cruz, counsel for Tesla, who indicated that Tesla objects to the relief sought herein.

CERTIFICATE OF SERVICE

I HEREBY CERTIFY that on this 21st day of February, 2025, I electronically filed the foregoing document with the Clerk of Court using CM/ECF and will serve a copy via e-mail to all parties on the attached service list.

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Vol. 1

02/04/2025

UNITED STATES DISTRICT COURT FOR THE
SOUTHERN DISTRICT OF FLORIDA

CASE NO. 21-cv-21940-BLOOM/Otazo-Reyes

NEIMA BENAVIDES, as Personal Representatives of the Estate of Naibel Benavides Leon, deceased,

Plaintiff,

-vs-

TESLA, INC., a/k/a Tesla Florida, Inc.,

Defendant.

CASE NO. 22-cv-22607-BLOOM

DILLON ANGULO,

Plaintiff,

-vs-

TESLA, INC. a/k/a Tesla Florida, Inc.,

Defendants.

VIDEO-RECORDED ZOOM DEPOSITION OF: DR. BARRY CROWN

DATE TAKEN: February 4, 2025

TIME: 1:03 p.m. - 5:16 p.m.

PLACE: All Parties Appeared Remotely via Zoom Conference

Stenographically Reported Remotely By:

Sharon Ambersley, FPR
Notary Public, State of Florida
U.S. Legal & Support

- - -

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CHERYL LOPEZ, THE VIDEOGRAPHER

I N D E X

WITNESS:

Dr. Barry Crown

\- - -

E X H I B I T S M A R K E D

- - -

Exhibits retained by Mr. Boumel.

P R O C E E D I N G S

- - -

Deposition taken remotely before Sharon Ambersley, Florida Professional Reporter and Notary Public in and for the State of Florida at Large, in the above cause.

- - -

THE VIDEOGAPHER: Okay. All right. So we are now on the record. The time is 1:03 p.m., February 4, 2025. This begins the video-recorded deposition of Dr. Barry Crown taken in the matter of Neima Benavides, Estate of Naibel Benavides Leon versus Tesla Incorporated. I'm the court reporter, Cheryl Lopez -- I mean, the videographer, Cheryl Lopez. The court reporter is Sharon Ambersley. Counsel will state their appearances for the record after which the court reporter will swear in the witness. Counsel?

MR. BOUMEL: Good afternoon, everybody. Adam Boumel on behalf of the plaintiffs.

MS. CRUZ: Whitney Cruz on behalf of Tesla.

THE COURT REPORTER: Can you raise your right hand, please? Do you swear or affirm that the testimony you're about to give will be the truth, the whole truth, and nothing but the truth?

THE WITNESS: I do.

THE COURT REPORTER: Thank you.

Thereupon,

Dr. Barry Crown,

having been first duly sworn, was examined and testified under oath as follows:

DIRECT EXAMINATION

BY MR. BOUMEL:

Q All right. Doc, good afternoon. How are you today?

A Good. How are you?

Q I am fantastic. Thank you for asking. I know we're all jazzed up to be here today. Quick housekeeping before we go forward. I know you charged me for a two-hour minimum. Do we have a hard stop in two hours or can we keep going after that?

A You're welcome to go up to -- at the moment I'm on central time, 4:00 p.m. central which is 5:00 p.m.

Q Okay. I think at 5:00 p.m. eastern, I think that should give us more than enough time. In the very unlikely scenario that we need more, we'll deal with it, but I think four hours will be more than enough and Whitney will be yelling at me that I'm taking that long. She's very efficient, by the way. All right. Let us -- there's Todd Poses coming in. He's also representing

the plaintiffs, looking handsome as ever.

All right. So, Doc, you've done this once or twice before. Yes?

A What's that?

Q You've done this once or twice before. Yes?

A Yes.

Q All right. How many times have you testified in total would you approximate?

A I have no idea. It would be a guesstimate and it would be well over a hundred. I was part of the panel in the 11th Circuit so that required testimony once or twice a week in criminal proceedings so --

Q Understood.

A I have been around.

Q And how long has it been that you've been serving as an expert witness in court cases?

A Since the mid-1970s.

Q And you have been doing it on a consistent basis since then?

A Yes.

Q And we are going to mark as -- well, strike that. I'm assuming we don't need to go over any instructions. You've done this more times than I have, right? You're good? It's a question. Are you good? Do you need me to explain about the process?

A That's fine. If I have a question, I'll ask.

(Plaintiffs' Exhibit No. 1 was marked for identification.)

BY MR. BOUMEL:

Q Perfect. All right. We're going to mark as Plaintiffs' 1 your notice of taking deposition. I'll put it up on the screen. And have you seen this document before, Doc?

A I have it in front of me. Yes.

Q Okay. Perfect. And there's a Schedule A duces tecum request. Have you produced everything responsive to these nine items?

A Yes.

Q Okay. I have your -- I have your file. I'm going to go through it in a minute and I've seen documents responsive to --

MS. CRUZ: Adam? Adam?

MR. BOUMEL: Yep.

MS. CRUZ: I can't -- you guys are frozen for me. You were frozen for me. So if we can take a break. I'm sorry to interrupt you. Let me see if I can connect from my phone because for some reason --

MR. BOUMEL: Let's go off.

MS. CRUZ: You guys aren't having issues,

right? It's on my end.

MR. BOUMEL: Let's go off the record while Ms. Cruz handles her IT stuff.

MR. POSES: Yeah. I hear you loud and clear.

THE VIDEOGAPHER: We're off the record at 1:07.

(Thereupon, a brief recess was taken.)

THE VIDEOGAPHER: Okay. We are back on the record at 1:11 p.m.

BY MR. BOUMEL:

Q All right. Thank you, Doctor, for your patience as we got the IT stuff handled. I'm going to pull back up Plaintiffs' 1 which is the notice of taking deposition and I will tell you, I went through the file that was produced to us by Tesla's counsel and I believe I have everything. I think everything was produced other than items responsive to four and five, so let's start with four. Books, articles, literature, films, experiments or other materials which support your opinions, have you produced anything of that nature?

A I didn't look at anything. There are no books, articles or what have you. I did no research.

Q Okay. Certainly there are peer-reviewed articles that you rely on for your practice, correct?

A Yes. And I'm familiar with them by memory,

but I didn't do a search with regard to this matter.

Q Okay. And if you were to do that search, how long would it take you?

MS. CRUZ: Object to form.

THE WITNESS: If I would do a search? I don't believe I need to do a search.

BY MR. BOUMEL:

Q Well, we were --

A If I were to start from scratch it would probably take five or six hours, but I don't know why I would.

Q Okay. Other than the fact that we requested it. So five or six hours and you would be able to produce all the peer-reviewed articles and other literature relied on for your opinions today?

A Well, I didn't do --

MS. CRUZ: Object to the form. Dr. Crown. Dr. Crown, give me a second.

THE WITNESS: Certainly.

MS. CRUZ: Object to form. Mischaracterizes the testimony. Go ahead. Sorry, Dr. Crown.

THE WITNESS: Yes. I didn't do a particular search. The information that I utilized I'm aware of and know from memory.

BY MR. BOUMEL:

Q And that I understand that. And my question to you is because I obviously don't know what you know and I'm not, you know, I haven't been doing what you've been doing for the decades that you have been doing it, so it appears from what you told me that it would take you about five or six hours to put together all the different articles, peer-reviewed articles and literature used and relied upon in coming to your opinions in this case; is that accurate?

MS. CRUZ: Object to form. Object to form. Dr. Crown, give me a second. Object to form. Mischaracterizes the testimony. That's not what he said.

THE WITNESS: I haven't relied on them. It's part of my general fund of knowledge.

BY MR. BOUMEL:

Q And to accumulate the general fund of your knowledge utilized in reaching your opinions in this case, I believe you indicated that it would take you about five or six hours to compile those peer-reviewed articles and literature; is that accurate?

MS. CRUZ: Object to form.

THE WITNESS: That's a speculative pronouncement since I didn't do a search and I

don't know what that search would consist of.

BY MR. BOUMEL:

Q Okay. Do you have a better estimate than five -- the five or six hours came from you, so is there a better estimate as you sit here and think about it some more?

A No.

(Plaintiffs' Exhibit No. 2 was marked for identification.)

BY MR. BOUMEL:

Q Okay. All right. That's Plaintiffs' 1. We're going to mark your entire file as Plaintiffs' 2 and I just want to go through the file real quick. You've only issued one singular report, correct?

A That is correct.

Q Okay. And then we have docs sent by local -- I'm just going to read the different file names that were sent to me. It was docs sent by local counsel, crash report, depositions, education, employment and tax info, expert report files, invoices, medical and then there's your case list, your CV, your fee schedule and the notice of taking deposition and your report. Is that a full summation of everything that's in your file?

A It is.

Q And you've only issued one report, correct?

A That is correct.

Q Okay. Who hired you in this case?

A I was originally retained by the Cole Scott Kissane firm.

Q And I understand --

A Henry Salas, I believe.

Q That was going to be my next question. I understand it was Henry Salas. How many times other than this case have you been retained by Mr. Salas or the Cole Scott Kissane firm?

A Zero. Only time.

Q Okay. Have you ever been retained by Bowman and Brooke before?

A No.

Q Okay. And let's see. Just for clarity, in the docs sent by local counsel you have imaging studies, you have medical records, and you have the police report, correct?

A Correct.

Q Okay. I noticed in your file you have some deposition transcripts from Mary Cummings. Do you see that?

A Yes.

Q Did you review those in conjunction with your expert --

A I looked at that. She's a human factors engineering expert. It was interesting but unrelated to really what I do.

Q That was going to be my next question. Was there anything in there that you relied upon for your scope of work in this action?

A No.

Q All right. Looks like we have two invoices to date. We have one for 16,000 dated February 28, 2024, and one for 78 -- $7,800.75 dated July 5th, 2024. Is that the sum total of all your invoices other than for this deposition which I'm paying for?

A No. I haven't submitted an invoice since July. There are about 35 hours in addition to that.

Q Okay.

A Which accounts for rereview and review of documents that I received after July 5th as I recall.

Q And so 35 hours at what hourly rate?

A It would have been my 2024 rate and then for those things that were done in 2025, the rate was $100 more. So the bulk was 450 an hour and there would have been some that were 550.

Q Any way that we can apportion the 35 hours, how much of it was billed at 450 and how much at 550?

A Thirty-five and ten at 550 and 25 at 450.

Q All right. So let me just do some quick math here. So looks like you have probably about $16,750 in pending charges on top of the current charges?

A That sounds about right.

Q So total charges on the file to date, other than this deposition which I am paying for, over $40,000?

A Correct.

MS. CRUZ: Adam, could I just interrupt. There's one invoice that you didn't mention that was sent to you. I'm looking at the same folder that we sent to you. There's three invoices in there. I didn't hear you say -- the dates are February 2024, January 2025 and July, whatever the July --

BY MR. BOUMEL:

Q Yes. So the third deposition is the December 30th, which is the invoice for this deposition, correct?

A Correct.

MR. BOUMEL: Are you referencing something else, Whitney?

MS. CRUZ: You just said there were two invoices and there are three different invoice --

MR. BOUMEL: Right. And, Whitney, you're

breaking up pretty badly. You're breaking up pretty badly, Whitney.

MS. CRUZ: I see what you're saying. One is the depo invoice from you all?

MR. BOUMEL: Yes.

MS. CRUZ: Um-hmm. Okay. Then --

MR. BOUMEL: I don't know if you want to call -- do you want to call in on, like, a landline or your cellphone or something. Let's go back off the record while Ms. Cruz handles her IT stuff.

THE VIDEOGAPHER: We're off the record at 1:21 p.m.

(Thereupon, a brief recess was taken.)

THE VIDEOGAPHER: We are back on the record at 1:24 p.m.

BY MR. BOUMEL:

Q Okay, Doc. We just went through your file. I want to ask you a question, has your testimony ever been stricken or limited by any court for any reason?

A Yes.

Q On how many occasions?

A One significant one as I recall -- two, two.

Q Okay. Tell me about those.

A One was a criminal matter in federal court. Neither the neurologist or I were able to date stamp

when a particular impairment occurred and the second was the Florida Supreme Court determined that neuropsychologists or psychologists as a group could not testify as to medical causation.

Q The -- I know the Grenitz v. Tomlian Supreme Court case. What was the federal court case that you're referencing?

A I don't recall. It's been quite some time. It was a determination by the magistrate judge and the magistrate judge excluded the testimony -- my testimony and the testimony of the neurologist.

Q Have you had a court submit a court order stating that it did not find your opinions credible?

A Not that I'm aware of.

Q Have you ever had a court submit a court order stating that you presented as a go-to witness for defendants in capital cases in need of mental health mitigation?

A Not that I'm aware of.

Q Okay. Let's talk about your practice. So I understand you have -- let's do this. Let's pull up your resume. You have your resume in front of you, right?

A Yes.

Q Okay. First of all I see on your report you

have your practice name listed as Barry M. Crown, Ph.D and Associates, PA?

A Yes.

Q Do you have any associates that work for your office?

A Not at this time.

Q And how many people work for your practice?

A It's a solo practice. Only me.

Q Just you. Okay. And you are the sole owner of that practice?

A I am.

Q And you have, looks like, two offices, one in Miami, one in Pensacola, correct?

A Correct.

Q What do you do out of the Pensacola office that's different from your Miami office?

A No difference.

Q Okay. You have a Ph.D from Florida State University, correct?

A Correct.

Q What's your Ph.D. in?

A Counseling.

Q What it's specifically in?

A Counseling.

Q It's a counseling Ph.D.?

A Yes.

Q That's what it says on the certificate. And what about your --

A I think it says counselor education.

Q Counselor of education?

A Counselor education. The department then changed its name to school psychology.

Q Okay. And your undergraduate degree was in what?

A Psychology.

Q Okay. And your master's degree was in what?

A Human behavior.

Q Okay. And you did not get a degree from Harvard Medical School, correct?

A That's correct.

Q You also didn't list on your CV that you went to law school, correct?

A Correct.

Q Your practice is a forensic practice only, correct?

A No.

Q Okay. Clarify please.

A I also see people with various psychological and neuropsychological disorders. I served as a consultant to various professional organizations. I do

academic work.

Q Do you offer patients any type of treatment?

A I stopped doing psychotherapy one or two decades ago. I have a diagnostic assessment practice.

Q Basically --

A I occasionally will do crisis intervention types of work, three or four sessions.

Q Okay. So generally speaking in your practice you are a diagnostic assessment practice, meaning that you test people to see what's going on with them from a psychological standpoint, correct?

A From a psychological and neuropsychological standpoint, yes.

Q I understand. I see -- I saw somewhere, I think it's on your CV, that you are a diplomat of the American Academy of Pain Management?

A Yes.

Q Tell me about that work that you do in regards to the American Academy of Pain Management?

A I took a test and passed it, written test, three hours. I recall taking it. It was in Las Vegas, Nevada.

Q I'm just a little curious frankly because you don't normally think of, you know, pain management and a psychologist in the same sentence, so what's the

interplay between those two things?

A The organization credentialed physicians and psychologists and other healthcare professionals.

Q And what does that credential mean to you in terms of its practical or clinical use?

A I have seen and do see people who are experiencing or complaining of pain.

Q Okay. And what is the interplay between pain and either a psychological disorder or neuropsychological disorder?

A May have been an impact on psychological behavior and on neuropsychological behavior.

Q What type of impact may it have?

A It may decrease performance. It may conflict with adequate performance.

Q And when you say performance, what's the context of the performance that you're speaking of?

A How they do in a testing environment and how they do in life.

Q Okay. So if I understand you correctly, if a patient is a chronic pain patient, number one, when they are testing with you their tests might be skewed because of that chronic pain; is that accurate?

A It's possible.

MS. CRUZ: Object to form.

THE WITNESS: Yes.

MS. CRUZ: Did you get my objection? Did you get my objection? I just want to make sure --

MR. BOUMEL: We can hear you.

MS. CRUZ: Okay.

BY MR. BOUMEL:

Q And then number two, you're saying that when somebody is a chronic pain patient on top of any psychological or neuropsychological disorders, then it can create an increased likelihood that they will not perform well in life?

MS. CRUZ: Object to form. Mischaracterizes the testimony.

THE WITNESS: It's possible.

BY MR. BOUMEL:

Q We got to figure out a way that you guys aren't talking over each other. Doc, if you want to just give a pause in between your answers just to --

A Certainly.

Q -- let Ms. Cruz give an objection.

And is there any difference in the interplay between a chronic pain patient and a regular -- a non-neuropsychological disorder, you know, just a standard psychological disorder versus a neuropsychological disorder?

A I don't understand your question.

MS. CRUZ: Object to form.

BY MR. BOUMEL:

Q Sure. So --

MS. CRUZ: Object to form.

BY MR. BOUMEL:

Q So --

MS. CRUZ: Dr. Crown, if you can just try to get a little pause. Thank you.

BY MR. BOUMEL:

Q So the previous question I lumped in psychological and neuropsychological disorders into the same question and you gave your answer based on that. Now what I'm trying to say, is there any difference in the impact that chronic pain plays in a neuropsychological patient versus a general psychological impaired patient?

A Not necessarily, no.

MS. CRUZ: Object to form.

MR. BOUMEL: What's wrong with the form, Ms. Cruz?

MS. CRUZ: I don't even understand the question.

BY MR. BOUMEL:

Q Okay. Doc, you understood the question,

right?

A I believe I understood.

MS. CRUZ: It mischaracterizes what he said earlier when it seems like you're building on a foundation that doesn't exist. So it's lack of foundation. Mischaracterizes the testimony and I don't understand the question.

BY MR. BOUMEL:

Q Okay. Doc, you understand it, right?

A I believe I did.

Q Okay. How many people -- how many patients do you see a week for forensic purposes?

A On average, two.

Q And when you say two, are you including forensic -- so let's take a step back. In your forensic practice, you see patients both on behalf of plaintiffs and on behalf of defendants, correct?

A Correct.

Q Okay. When you say two patients per week, does that include both patients that you're seeing for plaintiffs and defendants?

A Yes.

Q Okay. Are your charges generally the same for each case?

A Yes.

Q Okay. How do you advertise or market your forensic practice?

A I don't.

Q Have you ever given any presentations to defense firms?

A Criminal defense, yes.

Q When was that?

A The 1980s and 1990s.

Q Do you still have any materials from your presentations?

A No.

Q What was the presentation on? What was the subject matter of the presentation?

A Use of expert witnesses.

Q It's a very broad category. Anything more specific?

A No.

Q Have you ever given any presentations to any insurance companies?

A No.

Q Okay. Have you authored any articles or studies?

A I authored a chapter on conflicts of interest in the Handbook of Forensic Neuropsychology, first and second editions.

Q And give me a two-sentence synopsis of what that was about?

A It was about conflicts of interest.

Q Well, that's the title of it, but what was the subject matter?

A The subject matter was ethical responsibilities, not to engage in situations that foster dual relationships and other forms of relationships outside of what you were being asked to do. I authored it with two attorneys.

Q Understood. All right. Moving forward to then instant matter before us. You were hired by the defense in this case obviously to perform a compulsory medical evaluation from a neuropsychological standpoint on Dillon Angulo, correct?

A Yes.

Q Can you talk me through the process of your neuro-psychic -- neuropsychological evaluation from start to finish?

A I reviewed records. I saw him. I conducted a clinical interview and administered some neuropsychological and psychological tests.

Q Okay.

A Prepared a report.

Q So if I understand three main components,

review of medical records, number one; number two, a interview with Mr. Angulo; and then, number three, a neuropsychological testing, correct?

A Correct.

Q Medical records, why are they important to your opinions that you derived in the case?

A They provide the background information, particularly in the sense of litigation about why Mr. Angulo was presenting himself. It tells me the background history of what happened.

Q And part of your opinions are based on the medical records to the extent that when medical records show injuries to the brain, those are important for your opinions from a neuropsychological standpoint, correct?

MS. CRUZ: Object to form.

THE WITNESS: -- things, yes.

BY MR. BOUMEL:

Q Okay. And you would agree with me that it's important to be accurate in incorporating the medical records into your opinion, correct?

A Generally, yes.

MS. CRUZ: Objection to form.

BY MR. BOUMEL:

Q And why is that?

A It provides the backdrop for the person I'm

seeing.

Q Okay. And if the backdrop is wrong, then your ultimate opinion could be wrong, correct?

A Possibly.

Q What about the interview? Why is that important?

A Gives the individual an opportunity to explain his life and complaints.

Q And you would agree that the explanation that the person explaining their complaints is an important part of the interview process, right?

A Generally, yes.

Q Because you as the neuropsychologist need to understand what the person is complaining of in order to then evaluate those complaints, correct?

A Generally, yes.

Q Okay. And then testing, why is that important?

A That's an objective way and an objective measure to look at the performance of the individual.

Q Okay. And you said the word objective twice in there. Is there any subjectivity when it comes to testing?

A No.

Q Okay. Is there any subjectivity when it comes

to the battery or tests that are selected?

A There are 4,000 neuropsychological tests roughly. Selecting the tests will always be subjective.

Q And you would agree with me that the results that are ultimately -- the results of any battery can be impacted by the tests that were selected to be in the battery?

A There's always that possibility.

Q Okay. And what about in scoring and in interpreting the tests? Is there any subjectivity in that?

A It's according to the scoring provisions of the test manuals.

Q Is there any type of interpretation or subjectivity in interpreting and scoring the tests?

A I don't believe so.

Q Well, for instance, as a scorer, you can decide to disregard certain tests as outliers, right?

A Possible.

Q Okay. So you as the test administrator and scorer do have some subjective influence on the test results, correct?

A Possibly, yes.

MS. CRUZ: Object to form.

BY MR. BOUMEL:

Q And in fact that does happen sometimes, correct?

A It's possible.

MS. CRUZ: Object to form.

BY MR. BOUMEL:

Q Okay. Let us go to your ultimate opinions in this case and I just want to make sure I understand them before we dig in. So when we go to page 11 of your report under impressions, you state that -- the first sentence: There is mild brain function, neuropsychological disturbance which appears to be exaggerated in this evaluation with no baseline pre-accident comparative basis. First of all, did I read that accurately?

A Yes.

Q Okay. Second of all, do I understand what you're saying there is that Mr. Angulo does have some sort of continuing brain impairment as a result of this accident?

A He has some continuing brain --

MS. CRUZ: Object to form.

THE WITNESS: He has some continuing brain impairment. I didn't say that it was as a result of that -- the incident in question, the 2019

incident.

BY MR. BOUMEL:

Q Okay. Well, let's take a step back then. Let's just talk about the 2019 incident broadly. You agree that Mr. Angulo did suffer a traumatic brain injury, correct?

A Yes.

Q Okay. And how would you categorize or describe the traumatic brain injury that he suffered?

A Mild.

Q Okay. And what do you base that off of?

A Glasgow Coma Scale, 13.

Q And where did you get Glasgow Coma Scale of 13?

A It's in the hospital records. Jackson South.

Q When we're looking at Glasgow Coma Scales, is it important to consider all Glasgow Coma Scales even in the initial presentation?

A It was eight and improving and maintained itself at 13. There was eight at onset.

Q Okay. And my question was when you're considering -- so you yourself have classified the traumatic brain injury that Mr. Angulo suffered as mild and you told me that it's because of his Glasgow Coma Scale. So my follow-up question to that, and I'm trying

to be very specific here, is do we have to consider all Glasgow Coma Scales from the presentation or do we just pick it up as to when it improves and stabilizes?

A No. You need to look at the sequence.

Q Okay. So if somebody starts with a very low Glasgow Coma Scale, that needs to be accounted for in how we categorize a traumatic brain injury, correct?

A No. The actual diagnosis is an end diagnosis, not a entry diagnosis.

Q Okay. So you're saying let's say, for instance, that if somebody was struck as a pedestrian by a car and got airlifted to the hospital with a Glasgow Coma Scale of three and presented at the hospital with a similar Glasgow Coma Scale and then ultimately over several days stabilized to a 12, then we're going to -- we're going to only consider the stabilized 12 Glasgow Coma Scale and we're not going to consider the initial presentation of a three?

A We're going to consider the earlier Glasgow Coma Scales hypothetically, but the diagnosis is based on the end result. There's a gentleman in your building, an attorney, who had a Glasgow Coma Scale of seven and is practicing law in your building.

MR. BOUMEL: Okay. I'm going to move to strike that.

BY MR. BOUMEL:

Q And I want to focus on the hypothetical that I asked you. So if I understand you correctly, we do have to consider the initial presentation of what the Glasgow Coma Scale is in rendering an opinion as to the severity of a brain injury; is that accurate?

MS. CRUZ: Objection. Asked and answered a few times now.

BY MR. BOUMEL:

Q I'm sorry, Doctor. Can you answer?

A No. It's a matter of history.

Q Okay. And it's your testimony that Mr. Angulo's lowest Glasgow Coma Scale was an eight, correct?

A As I recall, yes.

Q And eight is a severe traumatic brain injury, correct?

A An eight is an indicator of a brain injury, yes.

Q An eight is categorized as a severe traumatic brain injury under the Glasgow Coma Scale rating, correct?

A Yes.

Q So going back to your impressions. You opine that he does have mild brain function,

neuropsychological disturbance, but you did not attribute a cause to it. Is that how I understand your opinion to be?

A Well, I went on and indicated some other aspects of Mr. Angulo that were contributory.

Q Okay. And I understand that. But you didn't in your impressions anywhere list this incident where he was struck by a car as a pedestrian and airlifted to the hospital, correct?

A Correct.

Q Okay. Is there any reason that you left that out of your opinions in this case?

MS. CRUZ: Object to form.

THE WITNESS: Under impressions I was reporting my findings. I don't know for certainty when I saw him in 2024 that what I was seeing was the direct result of that incident and not compounded by other factors.

BY MR. BOUMEL:

Q So if I understand you correctly, when you wrote this impression, you just weren't sure that this incident where he was airlifted to the hospital with, as you say, a Glasgow Coma Scale of eight, you weren't sure if that was contributing to his neuropsychological dysfunction so you didn't include that in your

impressions. Do I understand that correctly?

MS. CRUZ: Objection to form.

Mischaracterizes his testimony.

BY MR. BOUMEL:

Q That's why I --

A No. I was simply reporting my findings and I just don't know and I don't know now. He had a brain injury. People recover from brain injuries.

Q Do people recover from former drug use?

A Do people recover from drug use? Some do and some don't.

Q Okay. Do people recover from having ADHD?

A Some do and some don't. There was an interesting article that just came out in the last two weeks that suggested that was not the case and referred to it as a neurodevelopmental disorder.

Q Now going back to your impressions, though. So you gave this impression that he's suffering from neuropsychological disturbances, but you did not -- you did not list this collision where he was airlifted to the hospital with a brain bleed, but you did list that he had substance abuse problems and depression treatment, correct?

A Yes.

Q Okay. By your own logic are you sure that the

drug use and the depression treatment contributed to his neuropsychological disturbance?

A It very well may have. Again, I can't tell you for certainty.

Q So just --

A Certainly is contributory.

Q So just so we're crystal clear on what your opinions are here. This is a gentleman who was struck by a car as a pedestrian, airlifted to the hospital with a Glasgow Coma Score of a severe eight with a brain bleed, and it's your testimony as we sit here today that while he does have neuropsychological disturbances, you can't be sure that that incident contributed to his neuropsychological disturbance, but you're pretty sure that his former drug use and his depression treatment did contribute to it. Do I understand you correctly?

A That's incorrect.

Q Okay. Please --

A They are all contributory. I can't apportion them.

Q So the brain -- so this incident is contributory to -- this incident and the injuries he suffered is contributory to his neuropsychological disturbance?

A Yes.

Q Okay. You didn't say that before.

A I can't apportion it.

MS. CRUZ: What's the question? I mean, there is no question there. You didn't ask him that. That's not what you asked. So he's answering the question that you asked. So, Dr. Crown, I would ask you to just respond when there's a question pending, not just a statement.

BY MR. BOUMEL:

Q He's doing great.

What science or records or other materials are you relying on to opine that the drug use and the depression treatment were contributory to his neuropsychological disturbances?

A Well, we know the neurocognitive effects of benzodiazepines which, in a habitual user, create permanent brain dysfunctions. ADHD also contributes to problems. Brain science in the last ten years has gone further in indicating that in fact this is the case. There is the multiple demand network. There is the central executive network that are both impaired by both ADHD and by other circumstances, particularly substance use. Use of benzodiazepines create situations in which there are problems with attention, concentration, memory, focus. ADHD creates problems with focus and

attention. I can't apportion it. They contribute to the same set of problems and he never had the type of imaging that might have further clarified this.

Q And I thank you for that last point. So what I'm trying to understand is it sounds like you just gave me a host of reasons as to why those conditions could potentially cause neurocognitive disorders, correct, or neurocognitive disturbances?

A Well, they do. They very simply do.

Q Okay. They do, but we're looking -- that's in a general population, right?

A That most recent study that came out two weeks ago involved 30,000 people so --

Q Okay. And are you saying --

A -- a significant number with the same findings, yes.

Q Are you saying that all 30,000 people in those studies who took Xanax, they all had neurocognitive disturbances?

A No. This is ADHD, not Xanax.

Q So are you saying --

A The vast majority of people who abuse benzodiazepines experience some new cognitive problems which are lifelong.

Q According to -- name the studies that you're

relying on for all of these issues?

MS. CRUZ: Object to form.

BY MR. BOUMEL:

Q I would like to know the studies that you're relying on to say that the use of benzo -- what's the name of the classification of the drug? I'm sorry.

A Benzodiazepines.

Q Benzodiazepines. What's the name of the articles of the materials that you're relying on to -- excuse me -- Doctor, I'm speaking --

A I'm not.

Q -- to testify that benzodiazepines result in neuropsychological disturbances?

A I'm not. It's based on my experience. I have seen thousands of benzodiazepine abusers.

Q Do all former benzodiazepine abusers suffer from neurocognitive disturbances?

A Some form.

MS. CRUZ: Objection. Asked and answered.

BY MR. BOUMEL:

Q Okay. What form? So if I understand you correctly, 100 out of 100 former benzodiazepine users will suffer from some form of neuropsychological disturbances?

MS. CRUZ: Object to form.

THE WITNESS: There are obviously some outliers who don't. Our best estimate as psychologists, we strive for a 95 percent rate.

BY MR. BOUMEL:

Q So you're saying that 95 percent of former benzodiazepine users will suffer from neuro -- continuing neuropsychological disturbances?

A That's my opinion, yes.

Q And you have no articles, literature that you can point us to to support that opinion, correct?

A No. That's the information I have given to the National Institute of Drug Abuse as a consultant.

Q Okay. And you said they will have some form of neuropsychological disturbance, what does that mean when you say some form, what do you mean?

A Possible problems with concentration, or attention, or memory, or focus or information processing.

Q And is your testimony today that 95 percent of former benzodiazepine users suffer from all of those deficits?

A No.

Q Okay.

A One or more, and I'm referring to abusers, not users.

Q And I'm referring to former users, former abusers, however you want to call it. Is everything that you just said still applicable when somebody has quit their addiction and no longer takes the drug?

A Yes.

MS. CRUZ: Object to form.

BY MR. BOUMEL:

Q And you said that you gave some sort of testimony to some organization; can you repeat that, please?

A United States Government National Institute of Health.

Q Okay. And how did you present your testimony to them or your opinions?

A In committee meetings or direct meetings.

Q Are there --

A If you look at my CV, my qualifications in addiction is stated there.

Q Are there any writings or any type of written form of those opinions?

A No.

Q So we just have to rely on your testimony here?

A As they did. Yes.

Q Okay. We also -- switching now to ADHD

because we talked about that. Is it your testimony that everybody with childhood ADHD will suffer from some form of neuropsychological disturbance?

A Neurocognitive disturbance, yes.

Q And that's 100 out of 100. Everybody with childhood ADHD is going to show testing as an adult with neurocognitive disturbances?

A No. Referring to those who have ADHD after the adolescent growth spurt.

Q Okay. Did Mr. Angulo have his ADHD before or after his adolescent growth spurt?

A He has it before and it continued after.

Q What are you relying on to say that it continued after?

A What he said. Of course he called himself a knucklehead, but not unusual for ADHD.

Q So based -- you're basing your opinion that Mr. Angulo suffered from post-adolescent ADHD based solely on what he told you in an interview?

A If he was being honest.

Q Okay. I just -- I'm going to look into your interview session. Please tell me why he said he has continuing ADHD after reaching the age of adolescence?

A He didn't specifically say it, but he certainly exhibits the pattern in terms of his

schooling, in terms of his education, in terms of his work history. I don't know that anyone has a better explanation.

Q Okay.

A I don't think that his ADHD resolved in his childhood.

Q But I asked you to state where you got that information from and you told me you were told that by Mr. Angulo and it was from your interview with him so --

A Well, he called -- he called himself a knucklehead, but the records reflect that he didn't do well in school. He had difficulty with focus. He continued to have difficulty with focus even through his program at the community college.

Q Does everybody with bad grades have ADHD?

A No.

Q Okay. Did Mr. Angulo tell you that he suffered from ADHD as an adult or after the age of adolescence?

A I don't know that he was sophisticated enough to be able to diagnose himself.

Q So the answer is no, he never said that?

A He didn't use the term ADHD. No.

Q Okay. He used the term -- he said he was a knucklehead and you interpreted that as having ADHD?

MS. CRUZ: Objection. Form.

THE WITNESS: Along with --

MS. CRUZ: Mischaracterizes his testimony.

BY MR. BOUMEL:

Q Let's talk about the neuro -- the neurocognitive disorders which you did find. What neurocognitive disturbances does Mr. Angulo have?

A Reflected in my report.

Q So I'm asking you, sir.

A But I would start with looking at the first neuropsychological evaluation that he had with Dr. Hamilton. Dr. Hamilton found some problems.

Q Dr. Crown, let me interrupt you please. I'm not asking you what doctor -- for Dr. Hamilton's findings. I have Dr. Hamilton's report in front of me. In your own --

MS. CRUZ: Adam, Adam. Let him finish his answer. He hasn't answered.

MR. BOUMEL: He's answering the question --

MS. CRUZ: You can't cut him off in the middle --

MR. BOUMEL: He's answering the question.

MS. CRUZ: That's his answer. So let him -- I would ask that you not cut him off. Let him finish.

MR. BOUMEL: Let me respectfully -- respectfully, I'm going to take the deposition as I see fit. Doctor --

MS. CRUZ: We're going to go to the court if you don't let him finish his answer.

MR. BOUMEL: Because he's asking a question -- he's asking a question -- he's answering a question that I haven't asked.

BY MR. BOUMEL:

Q I did not ask about Dr. Crown's findings. I'm asking about your own findings -- I'm sorry.

I did not ask about Dr. Hamilton's findings. I'm asking about your own findings, Dr. Crown. In your own impression you wrote there's mild brain function neuropsychological disturbance. We've already said that based on -- that's based on your testing, correct?

A Correct.

Q Okay. So based on your testing, what neurocognitive disorders does Mr. Angulo have?

A The test of general reasoning ability has a standard score of 70 which placed him at the second percentile that would mean that 98 out of 100 people in his age group could perform better in terms of reasoning and judgment. Immediate memory, he was at the 13th percentile. What does that mean? It means that 87 out

of 100 people have better memory function. His constructional ability was at the 30th percentile. That would mean that 70 out of 100 people would have better visual spatial knowledge. His language ability was at the eighth percentile so his ability to use language, 92 out of 100 people would do it better. His attention was at the fifth percentile which would mean that 95 out of 100 people would be better at paying attention. His delayed memory was 21st percentile, which would mean that 79 out of 100 people would be able to recall things better than Mr. Angulo. That left a composite index score at the eighth percentile, which would mean that in his age group 92 out of 100 people standing in a line would be ahead of him.

Q So --

A Going -- let me go further.

Q Sure.

A In terms of initiation and maintenance of set trails one, he was high average, then he dropped to average then to mild and moderate impairment. And leading to inhibitory constructs, average. Set shifting, mild to moderate impairment and total at the 19th percentile which would indicate that 71 out of 100 people would be able to perform better at his age level.

Q Okay. And I'm not asking you to recite all the scores from your test. What I'm simply asking you, which I believe you answered, is in your impression you stated he has neuropsychological or neurocognitive disturbance and I wanted to understand what the neurocognitive disturbances that you found and you told me it's his general reasoning ability, his immediate memory, his constructional ability, his language ability, his attention, his delay and his delayed memory, correct?

A Yes. Except let me go further. When we talk about language in terms of verbal and conceptualization and fluency he was at the 50th percentile and whether naming was at the 50th percentile, 46 percentile.

Q Okay.

MS. CRUZ: Adam, can we take a break? We've been going for an hour. If we take a break whenever. Doesn't have to be this moment, but --

MR. BOUMEL: Yeah. How long do you need? Five?

MS. CRUZ: Five minutes is fine.

MR. BOUMEL: Cool. Off for five. Back at 2:13. Thank you.

THE VIDEOGAPHER: We're off the record at 2:08.

(Thereupon, a brief recess was taken.)

THE VIDEOGAPHER: We are back on the record at 2:15 p.m.

BY MR. BOUMEL:

Q Doc, going back a couple -- and I hate to ask this of you again. You said you gave testimony to some sort of governmental entity. I didn't write it down so I'm going to write down this time.

A National Institute of Drug Abuse.

Q When you say you -- did you give testimony or you just spoke at a committee meeting?

A No. These were committees to review and grant contracts and grants.

Q And did you give sworn testimony or was it just you gave a speaking opinion?

A It was considered confidential advisatory to the government, meaning that we were security cleared and there was security guards at the door and the rooms were swept for detection instruments.

Q Were you sworn in before you spoke?

A No.

Q Were there any audio recordings made of you speaking?

A No.

Q Do you know if the government acted on your

opinions that you offered?

A Yes.

Q Okay. What actions did the government take in response --

A They engaged in contracts or they didn't.

Q Contracts with what type of entities?

A Academic entities, research entities.

Q And your opinions that you offered specifically related to the continuing neurocognitive disturbances that can be expected after somebody has abused benzos?

A Well, it related to benzodiazepines. It related to other drugs, cocaine and the cocaine kindling phenomena.

Q Okay. Do you need me to repeat my question?

A What's that?

Q Did you need me to repeat my question?

A Go ahead.

Q Okay. The opinions that you offered to the National Institute of Drug Abuse, did that specifically include an opinion that you offered that 95 percent of former benzo users suffered from continuing neurocognitive deficits?

A I don't know that I used a percentage.

Q Okay. So then what did you use?

A You know, that was some time ago. I don't recall.

Q Okay. So going back to the impression section, are you -- is it your position or your opinion that the trauma from this incident where Mr. Angulo was struck by a car as a pedestrian is not a significant contributor to his current neurocognitive disturbances?

A I didn't say that. I don't know. There are multiple factors involved and certainly that accident is one of those factors.

Q Okay. And you just can't say that it was whether it was a substantial contributing factor or not. It was a contributing factor, you're just not willing to say it was a substantial contributing factor. Is that what we're saying?

A That's correct.

Q Okay. So how do you differentiate between the cognitive psychological effects caused by this incident versus those caused by premorbid conditions such as drug abuse or ADHD?

A There is no way to apportion it. They overlap.

Q Okay. Do you agree that traumatic brain injury related cognitive and emotional issues differ significantly from those associated with addiction

history?

A To the extent that they create brain impairments and functional impairments, no.

Q Okay. So we expect a former user of benzos to have the same type of impairments as somebody who gets hit by a car as a pedestrian and is airlifted to the hospital with a brain bleed?

A Neurocognitively or neuropsychologically, those people in those categories can have the same kinds of problems under neuropsychological testing or assessment, problems with attention, problems with concentration, problems with the ability to form memories, to retain information, to problem solve. There's no way to apportion it.

Q And as a practitioner doing this for -- what, about 50 years now?

A Close.

Q You're saying that there is no differences in the presentation of expected symptoms or expected deficits between somebody who is a former drug user and somebody who is airlifted to the hospital with a brain bleed?

MS. CRUZ: Objection to form.

THE WITNESS: It's a compound set of circumstances and there's no way to apportion the

difference.

BY MR. BOUMEL:

Q I'm not -- and this question isn't asking you to apportion the difference. This is you've been a clinical neuropsychologist for 50 years and you have seen trauma patients and you've seen drug addicts, right?

A Yes.

Q Do they generally present with the same issues?

A Not during their rehabilitation. The course of their rehabilitation obviously might be different because of the physical injuries that are associated with a motor vehicle accident, for example, as opposed to just popping a bunch of pills.

Q So -- but I'm asking you from a neurocognitive standpoint. My question is neurocognitively you have a patient who comes into your office with severe head trauma with a diagnosed brain bleed and you have another patient come into your office that is a recovered benzo user and no longer uses it. You expect, based on your clinical experience, for those patients to have the same type and severity of deficits?

A It would depend on where I was seeing them and the time between the incident and the time that I was

seeing them and they very well would all present with problems with attention, concentration, ability to form memory, problem solve, judgment.

Q So you expect them --

A They would be similar. The only difference would be in the history of why or how they got there.

Q Okay. So they would be the same. They would present the same, same severity of issues, same type of issues?

A They certainly --

MS. CRUZ: Objection to form.

THE WITNESS: -- could have those they attention problems, focusing problems and so on and I've seen any number of drug abusers who insist they are not using when they really are continuing.

BY MR. BOUMEL:

Q Since you mentioned that, let's talk about that for a second. Any indication that you can tell that Mr. Angulo ever used any type of benzos or other elicit narcotics following the time that he left rehab?

A I have no idea.

Q Okay. Well, you sat with the gentleman for an interview. You sat at a table and you spoke with him. Any reason to think that he was on any type of narcotics then?

A That's not an accurate way of making the assessment. Had I had the opportunity, I would have sent him for a urine test and a blood -- and hair analysis.

Q Okay. Is there anything in all of the records that you've reviewed or in any of the tests that you administered or any of the work that you have done in this case that you can sit here and say I think Mr. Angulo has used any type of narcotic, a single -- even a single time following his leaving rehab?

A No, but he was never tested.

Q Okay. Do you agree that modern studies on neuroplasty (as spoken) show that the brain has the capacity to recover from substance abuse?

A Plasticity suggest that other parts of the brain will takeover and the individual will be able to function adequately or normally. But again, he didn't have the contemporary imaging studies that might have demonstrated that.

Q And I'm -- thank you for bringing that up. So you're not aware of any medical studies demonstrating that Mr. Angulo had any type of neurocognitive disorders as a result of his former drug use, correct?

A The last scan I'm aware of was in 2023 and it was read as normal or no acute problems.

Q Mr. Crown -- Dr. Crown, we're going to be here for a long time if we don't get answers to the questions I'm asking you. I'm asking you very specific questions and you're answering with something else. My question to you is very specific. I'm going to repeat it.

Are you aware of any studies, including imaging studies, that show that Mr. Angulo was suffering from neurocognitive disorders or brain damage as a result of his former use of benzos or other drugs?

A Former use, no.

Q Okay. Are you aware of any type of studies or medical records showing that -- other than your testing showing that Mr. Angulo -- well, strike that.

Are you aware of any medical testing showing that Mr. Angulo had any type of brain injury or brain dysfunction as a result of his drug use?

A No. That type of assessment was never done.

Q Okay. Are you aware of any study -- medical studies showing that Mr. Angulo had any type of brain damage or drain dysfunction as a result of his earlier history of ADHD?

A No. Those studies were never done.

Q Are you aware of any medical studies showing that Mr. Angulo had any type of brain damage or cognitive dysfunction as a result of his premorbid

depression?

A No, not aware of that.

Q Okay. Now staying on your opinion page, you list several premorbid conditions which you have already opined you believe were contributors to his current neurocognitive disturbance and those are the early history of ADHD, the history of substance abuse, and depression, correct?

A Yes.

Q Do those conditions make him more or less resilient to trauma?

A Likely less resilient.

Q Okay. So basically what we're saying is if we're taking the same person, all bio and genetic markers the same, and we take one of them and we clone that person and one of them has early history of ADHD, a history of substance abuse and a history of depression and the other doesn't have any of those issues, we subject them to the same trauma, we expect the one who has those premorbid conditions to do much worse as a result of the trauma, correct?

A They would be less resilient.

Q And that means they are going to do worse, right? Their outcome is going to be worse?

A Or take longer.

Q Okay. You agree that somebody with -- I'm going to have to go back there. You would agree that a right-hand dominant person will recover more slowly from traumatic brain injury, correct?

A Not necessarily.

Q Have you ever --

A That would be dependent. Left-handed people have more cross connections through the corpus callosum, for example, than right-handed people. But 90 percent of the population, which is where most of our understanding comes from, is right handed.

Q Have you ever testified that you believe a left-handed person will recover more quickly than a right-handed person from traumatic brain injury?

A They tend to because of the cross connection. But again, our findings are based on 90 percent of the population so that may be skewed.

Q Okay. But you've testified before that a left-hand person is going to recover more quickly, so it stands to hold that a right-handed person is going to recover slower, correct?

A Yes.

Q Okay.

A If something happens to you, you're better off if you're left handed.

Q Would you agree with the statement that trauma tends to make a person's -- strike that.

Would you agree with the statement that brain trauma tends to make a person's worse characteristics worse?

A I have said that before. Yes.

Q I know you have. Would you agree me that having an initial brain injury increases the potential damage that can occur in subsequent concussions?

A Possible, yes.

Q So we went through the different disfunctions that you believe Mr. Angulo suffered from as a result of both the trauma and his premorbid conditions, correct?

A Yes.

Q Okay. What type of real life issues do we expect from each of these dysfunctions? So let's start one by one. You said general reasoning ability. What type of real world dysfunction do we expect to see in somebody who's got in the second percentile of general reasoning ability?

A They would be intellectually disabled and be in a sheltered home.

Q And you say intellectually disabled; specifically I want to know what type of dysfunction we expect to see in that person?

A They would have difficulty reasoning, exercising in judgment, focusing on things, paying attention. They would be unable to drive a vehicle. They would be unable to shop in a grocery store. They would be unable to manage their money.

Q Why would a person with general reasoning ability be unable to drive a vehicle?

A That requires orientation. It requires judgment in adjusting speed. It requires sensory motor feedback in terms of hands on steering wheel, foot on accelerator or brake. It depends on looking at the periphery, all of those things would be extremely difficult if not impossible for a person who had significant problems.

Q What type of real word deficits would we expect to see in somebody who is in the seventh percentile of immediate memory?

A They would obviously be extremely forgetful, not be able to find themselves and orient themselves from one place to another and not recognize faces, not recognize streets, not being able to make decisions based on information that they might have had stored.

Q What type of real world deficits would we expect from somebody who has deficits in their constructional ability?

A Well, it's visual constructional so that would make them a hazard in terms of driving because that does require visual input obviously. They would also have difficulty in distinguishing people's facial expression being able to match their -- or understand someone's facial behavior and be able to match it, be able to assess whether someone was angry or sad or liked them or not. That's visual memory.

Q And what type of real world deficits would we expect in somebody who has deficits in their language ability?

A They would be confused in communication. They would have difficulty putting a sentence together. They would have difficulty reading. They would have difficulty comprehending what they might hear on the radio or see on TV.

Q What type of real world deficits would we expect in somebody with -- who tests as having a deficit in their attention?

A I didn't hear the last part.

Q Attention.

A Attention. If you can't pay attention, you can't put anything into memory. Memory requires attention first in order to insert something into memory. They would be involved in situations where they

might be asked to do A, B, and C. They would remember A and remember C and not remember and guess at B.

Q And what type of real world deficits would we expect to see in somebody who has delayed memory deficits?

A The delayed memory is recall. So they would have difficulty recalling information that was given to them.

Q Lastly, in your impressions you said that pain perception may also cloud the presentation. What did you mean by that?

A I mean, that someone could be preoccupied with pain and discomfort and not be able to respond appropriately. It might hamper their concentration, might hamper their attention, might hamper their focus ability.

Q I think that's kind of what we spoke about at the start of this deposition, that if somebody has chronic pain their testing scores may be impacted as a result, correct?

A May. May.

Q Okay. And in fact you said that that may be a possibility here?

A Possible.

Q Okay. Let's turn to your personality

profile -- personality factor starting on page ten. Now first of all, is this like -- so I understand that this -- this personality factor section was derived from the MCMI-3, correct?

A Correct.

Q Okay. In terms of nuts and bolts of how these words get on the paper, is this all your writing or is it a printout from the MCMI-3 or how does that work?

A Significant portions are from the data analysis that was put together by Dr. Millon and his group.

Q Okay. And who is Dr. Millon?

A He was the originator of the MCMI. It's the Millon Clinical Multiaxial Inventory.

Q So just take me through, like, the X's and O's of how Mr. Angulo took the MCMI-3 and how these words got on this paper in this personality factor section.

A He answered a series of 175 true/false questions and that was fed into a computer and the computer developed a profile from that.

Q Okay. And did you contribute at all to that profile or did you just take it and put in your report and that's what we're looking at?

A I believe it's essentially the printout.

Q Okay. So this is a printed -- so all the

personality factors are just a printout from the computer after you logged in 175 true or false questions that Mr. Angulo answered, fair?

A Yes.

Q Okay. Now there's some pretty kind of strong words in here, to say the least, in terms of the personality factors. One of the things says he may be skillful in exploiting the goodwill of others. That's the second paragraph. Do you see that?

A Yes.

MS. CRUZ: Objection to form.

BY MR. BOUMEL:

Q Is it your opinion that Mr. Angulo is skillful in exploiting the goodwill of others?

A I haven't seen him in varying circumstances so I can't make that assessment. It's essentially what he said about himself.

Q Okay. He said that he was skillful in exploiting the goodwill of others?

A That's what his pattern of responses indicates.

Q Tell me specifically what questions he answered that would -- that translated to this notion that he is skillful at exploiting the goodwill of others?

A I can't tell you that. That's based on Dr. Millon's algorithms.

Q Do you have the testing questions in front of you?

A No.

Q Do you have the raw test data in front of you?

A No. I have a printout.

Q Why not?

A I have his answer sheet, but that's meaningless. It's just T's and F's.

Q Well, I specifically -- if you're going to come in and say that Mr. Angulo's -- that there is an opinion that Mr. Angulo is skillful in exploiting the goodwill of others, I want to know exactly what that's based off of?

A It's based on the Millon Group's analysis of the MCMI using a commercially available program.

Q Do you know what questions -- what type of questions were asked of him? Were there any questions in that 175 questions that asked about how he likes to exploit people?

A Not specifically, no. It's a pattern.

Q Okay. Enlighten me. What type of pattern leads to the ultimate conclusion that Mr. Angulo is skillful in exploiting the goodwill of others?

A I can't tell you specifically. I don't have the test questions.

Q Okay. And certainly that's not an opinion that you intend to offer at trial, is it?

MS. CRUZ: Object to form.

THE WITNESS: I don't know that I'm specifically going to relate to that. I don't think it's really central to this neuropsychological assessment.

BY MR. BOUMEL:

Q Well, Doc, today is my day and --

MS. CRUZ: I'm just going to -- let me just clarify so it's crystal clear. Adam, he may or may not, but he may offer opinions about anything that's in his report. So whatever it is that you want to ask about in the report, now would be the time to do that.

BY MR. BOUMEL:

Q Okay. So, Doctor, with that soliloquy, I'm going to ask you are you going to come in to trial and offer the opinion that Mr. Angulo is skillful in exploiting the goodwill of others?

MS. CRUZ: Objection.

THE WITNESS: That's a sentence and not a diagnosis.

BY MR. BOUMEL:

Q And my question remains the same. Are you going to offer that opinion?

A I will -- if asked, I will read it. Yes.

Q Okay. You intend to read that opinion that you didn't actually -- that's -- you would agree with me that's not your opinion, correct?

MS. CRUZ: Objection. Form.

THE WITNESS: I have no way of making that assessment. That was an assessment he made of himself.

BY MR. BOUMEL:

Q So you would agree with me that you personally have no opinion based on anything that Mr. Angulo told you or anything that you've seen of him that he may be skillful in exploiting the goodwill of others?

MS. CRUZ: Objection to form. Mischaracterizes --

THE WITNESS: I didn't follow him around so I don't know.

MS. CRUZ: Objection. Form. Mischaracterizes the testimony and mischaracterizes the evidence and it's a confusing question.

BY MR. BOUMEL:

Q Okay. I'm going to ask it to you again

because we're having trouble getting a clear answer, Dr. Crown. Are you going to -- is it your opinion based on your own work in this case that Mr. Angulo is skillful in exploiting the goodwill of others?

MS. CRUZ: Same objection as to the last question and adding asked and answered about, I think, three times now.

THE WITNESS: I would only comment on that to the extent that I would say that this is what he said about himself. It is not my opinion.

BY MR. BOUMEL:

Q So now your testimony is that Mr. Angulo said that he may be these skillful in exploiting the goodwill of others. Those words came out of his mouth?

A No.

MS. CRUZ: Objection to form. Mischaracterizes the testimony. Asked and answered. Borderline badgering the witness. Not really sure how many times he can answer the same question.

MR. BOUMEL: Whitney. Your objection to form --

MS. CRUZ: This is what the tests showed, this is what his answers were.

MR. BOUMEL: Whitney, you --

MS. CRUZ: I'm not going to let you badger him.

MR. BOUMEL: Your objection to form is noted.

THE COURT REPORTER: Okay. And it has to be one at time.

MR. BOUMEL: When we're making objections, we say object to form and we move on.

BY MR. BOUMEL:

Q Dr. Crown, you can answer the question.

MS. CRUZ: Adam, you don't tell me what to do. Leave that for your kids, but thanks. I appreciate it. When I feel the need to object, I will object.

MR. BOUMEL: You can object as much as you want, but you know the rules are very clear that the proper objection is an objection to form without a speaking objection and I'm asking you to stop the speaking objections.

BY MR. BOUMEL:

Q Dr. Crown, you can answer.

MS. CRUZ: What's the question? Or ask the court reporter to read it back because I don't know what it was.

MR. BOUMEL: Ms. Court Reporter, can you read it back?

(The record was read as requested.)

"Q So now your testimony is that Mr. Angulo said that he may be these skillful in exploiting the goodwill of others. Those words came out of his mouth?

"A No."

BY MR. BOUMEL:

Q Okay. So he answered that question. Thank you. Doc, let's go to -- so let's say the third paragraph. He may successfully scheme beneath his veneer of civility. See where we are?

A Yes.

Q That's copied and pasted from the MCMI-3 results, correct?

A Correct.

Q That's not an opinion that you reached independently, correct?

A That is correct.

Q And do you have any independent basis other than what the MCMI printout told you that Mr. Angelo may successfully scheme beneath the veneer of civility?

A No.

Q Okay. And those questions would be true for everything in this personality factor, right? Everything that's listed in this personality factor section, including the second to last paragraph stating

that he has antisocial and sadistic features, all of this is based solely on an MCMI printout, correct?

A Correct.

Q None of it was reached independently by you, correct?

A Correct.

Q None of it was stated by Mr. Angulo, correct?

A Correct.

Q And in fact Mr. Angulo does not complain of any of these issues, correct?

A Complain?

Q Let me ask you a more specific question. Does Mr. Angulo state that because -- is there any complaint or statement by Mr. Angulo suggesting that because of this incident he is skillful and he seems to find himself exploiting the goodwill of others?

A No.

Q Is there any claim or statement by Mr. Angulo to suggest that because of this incident and his injuries suffered that he finds himself scheming beneath the veneer of civility?

A No.

Q Is there any statement or claim Mr. Angulo that because of the injuries suffered in this incident that he is suffering from antisocial and sadistic

features?

A No.

Q And those same questions would be true to the rest of the statements in this personality factors, correct?

A Yes.

MR. BOUMEL: All right. With that, let's take a five, everybody.

THE VIDEOGAPHER: We're off the record at 2:51.

(Thereupon, a brief recess was taken.)

THE VIDEOGAPHER: Okay. We are back on the record at 2:56 p.m.

BY MR. BOUMEL:

Q All right. Doc, how are you doing?

A Good.

Q All right. Perfect. Let's keep it rocking. We got a couple of easier, more gentle subjects coming up so me and Whitney can friends again. Okay.

MS. CRUZ: We are not not friends.

MR. BOUMEL: You know, we had a 30-second period where we weren't and now we are again. That's what I'm saying.

BY MR. BOUMEL:

Q All right. Let's talk about brain injuries

generally speaking. So you would agree with me that brain damage is a problem in the brain where it is not operating at full capacity, correct?

A Generally speaking, yes.

Q And you've testified to that before. I don't think I'm splitting hairs here. That's a true statement, correct?

A Yes. That's a general statement. Yes.

Q Okay. And brain damage is an organic problem, correct?

A Yes.

Q What does that mean? Can you explain that a little bit?

A As an organic problem it means that there is some kind of physical impact. Now that's been expanded in the last ten years because of the new findings in functional neuroanatomy, but it still holds for the most part.

Q Meaning brain damage is actually damage to the tissue of the brain?

A Well, tissue or tracts or fibers. How specific do you want to be?

Q You're -- you got the Ph.D., not me, so give us an education.

A Well, it's a matter of the chemical

composition as well as the anatomic composition. For example, there's some chemicals that can in effect pickle the brain without ripping out parts of it.

Q Got it. So you can -- because it's a living tissue, you can poison it with chemicals or you can destroy it through physical trauma, correct?

A Yes.

Q Okay. You would agree with me that -- and again, I'm using your own words here -- you would agree that brain injury gives people little reserve, meaning that they have very little to fall back on, correct?

MS. CRUZ: It sounds like you're reading -- give me a second, Doctor. It sounds like you're reading from something, a direct quote. Can you show him what you're reading from if you're asking him something based on a direct quote --

MR. BOUMEL: I don't have it in front of me.

MS. CRUZ: -- that he allegedly made.

MR. BOUMEL: I can't. I mean, I'm asking him if he agrees with it and if he doesn't then we'll move on.

BY MR. BOUMEL:

Q So you would agree with me that brain injury and cognitive dysfunction gives people little reserve meaning that they have very little to fall back on,

correct?

A It may certainly --

MS. CRUZ: I'm just going to object -- Dr. Crown, give one second. I'm just going to object to this line of questions. As you've already indicated you're reading this from somewhere and that he allegedly said, I don't know if it's a deposition transcript or an article, and you're not giving him the entire context of his statement. I'm just going to object on that basis.

BY MR. BOUMEL:

Q Dr. Crown, you can answer.

A It can reserve -- it can deplete cognitive reserve. It doesn't have to necessarily. It may or may not.

Q And what is cognitive reserve?

A Cognitive reserve is the abilities and capacities that you have to rely on in problem solving and decision making.

Q Okay. And you would agree that somebody with cognitive dysfunction has very little to fall back on because of their depleted reserves, right?

A That may be the situation.

Q What we talk about somebody having very little to fall back on, what does that mean?

A It means that they don't have a substantial amount of information and history that they can draw back on to make decisions and to interact with others.

Q And you would agree that people with neurocognitive dysfunction following traumatic brain injury tend to misconstrue things?

A I can't hear you.

Q You would agree with me that people with neurocognitive deficits following traumatic brain injury tend to misconstrue things?

A They may.

Q You would agree with me that people with traumatic brain injuries and subsequent neurocognitive disability or deficits that can impact emotional responsiveness?

A It may.

Q Let's -- you know what, let's -- instead of asking these questions generally, let's focus on Mr. Angulo. Okay. It is your opinion that he has neurocognitive deficits, correct?

A Yes.

Q Okay. The neurocognitive deficits that Mr. Angulo has, could that lead to him having little reserve?

A It could be.

Q Okay. And why could it or why could it not?

A He has damage to parts of his brain. Those parts are generally unknown.

Q It's unknown what parts of his brain he has damage to?

A Yes.

Q Give me one second. Isn't it true, Dr. Crown, that as a neuropsychologist the testing that you provide is designed to detect what parts of the brain might be damaged in any given individual?

A No. That's the old wives' tale. That's the old school neuropsychology that was developed and used before the advent of CT scans, MRI scans, PET scans. That's no longer the direction and focus of neuropsychology.

Q Well, you would agree with me that the brain has different areas like the temporal lobe, the frontal lobe, the cortex, right. They are different areas of the brain, correct?

A Yes, of course. That's the old school way of looking at the brain. It doesn't take into account the central executive network, the multiple demand network, and the networks and fiber tracts that we know exist.

Q So it's your testimony and then -- I'm just trying to understand you here. My understanding, and

you're going to correct me, is that neurocognitive testing is designed to find impairments like executive function impairment and if we find an executive function impairment we can deduce that there's trauma to a specific type of the brain. You're saying that's no longer true?

A No.

MS. CRUZ: Object to form.

THE WITNESS: That's not necessarily true. That was based on our understanding of the brain that included broken networks. But now we know, using more moderate and contemporary imaging, that there are fiber tract networks that are far different from those. For example, we now know that executive function which used to be known as frontal lobe behavior actually has a component in the parietal lobes at the very opposite end of the brain. The fiber tracts tell us that. The neuropsych testing has never told us that.

Neuropsych testing used to be used before imaging was available because it was the next best thing to opening up the brain and picking around, but we now have noninvasive techniques that tell us much more. So neuropsych testing tells us now about function and the old school methods just

don't work.

BY MR. BOUMEL:

Q Okay. So if I understand you correctly, neuropsych testing is completely unusable for detecting what parts of the brain are damaged?

A It's not our best way of doing it.

Q Okay. Well, my question was different. Is it used at all or can it be used at all to determine what parts of the brain are damaged?

A It could be, but it may be inaccurate.

Q Okay. And I understand you saying that scans are more accurate, correct?

A Yes.

Q And in this case --

A Particular types of scans.

Q Okay. Well, elaborate.

A There are various forms of brain scans that have been developed in the last ten years that are far more accurate in making assessments of which areas of the brain are impaired than others. They are a methodology that was first used by neurosurgeons and is now being used elsewhere that looks at single individual behavior rather than aggregate behavior.

Q Okay. What are the names of the different scans you're referring to, sir?

A I think you can go to your own expert to get that information. I don't think I have to educate your expert.

Q We're in a deposition. This is discovery. You do have to answer my questions. You're the one --

A Well, I will because probably I haven't seen it mentioned so your people may not know. Resting state MRI would be one example.

Q What are the other examples?

A Complex functional MRI.

Q Okay.

A Various forms of PET scan using neuro-radioactive tracers.

Q And these are all scans that can show, per what you're saying, continuing cognitive or neuropsychological cognitive deficits?

A Yes.

Q Okay.

A I use them.

Q Okay. You prescribe them?

A Yes.

Q Okay. And what's their -- what's their effective rate or what's their accuracy rate?

A Going back to my use of single positive emission, computerized technology in order to assess

malingering, the rate has been close to 100 percent in terms of accuracy.

Q Where does one go to get one of these scans done?

A They are done at Baptist Hospital in Miami would be one place.

Q Any other locations in Miami that you're aware of?

A University of Miami Medical School.

Q Any outpatient facilities?

A As long as they have an agreement with the -- with one of the companies that does the data analysis, yes.

Q What about DTI MRI? What's your take on that?

A DTI MRI's reliant aggregate behavior, plaintiffs' lawyers have been sold a bill of goods. Resting state is much more accurate. DTI relies on aggregate behavior where you take a person and try to fit them into a set of normative standards whereas resting state relies on that person alone.

Q All right. So thank you for that. I appreciate the free education. Now we're going to go back to the pertinent questioning. You did say that you did not know where the damage to Mr. Angulo's brain was, but you do have the imaging studies from the CT scans

performed in the hospital, correct?

A Yes.

Q Okay. And have you independently reviewed those?

A I looked at it, yes. I'm not a neuroradiologist.

Q No. But you have testified in the past that you do -- that you are able to read and interpret brain imaging results, correct?

A Correct.

Q And so what did you see when you read and interpreted Mr. Angulo's CT scan taken from Jackson Memorial Hospital?

A He had minor or small mild impingements, as I recall, in the posterior portion of his brain.

Q Okay. And your report, page five, second paragraph, you would agree with me that the CAT scan of his brain identified -- intra -- and I'm going to -- help me out with the pronunciation of this, intraparenchymal?

A That's pretty close. That's good enough for a lawyer.

Q Okay. How do we say it for a non-lawyer?

A Intraparenchymal.

Q All right. Intraparenchymal --

intraparenchymal. I'm just going to call it an IP hemorrhage --

A That's fine.

Q -- in the left parietal lobe, correct?

A Correct.

Q Okay. And you don't disagree with that, correct?

A No. That was a finding on imaging at that time.

Q Okay. Going back to Mr. Angulo, is it -- and we've already established that you do believe that he has cognitive -- neurocognitive deficits. Is it possible that his neurocognitive deficits impact his emotional responsiveness?

A It's possible, but again, there are other factors that could be involved. Pain, for example.

Q Okay. Focusing -- laser focused on Mr. Angulo and what he has, is it possible that his neurocognitive impairment could impair his impulse control?

A It's possible, but there are other factors that could equally create that problem.

Q Such as?

A PTSD.

Q Okay. We're going to talk about that in a second. I'm going to try and keep us on track here.

Possible that Mr. Angulo's neurocognitive deficits could have a significant impact on his reasoning and judgment?

A Yes, possible.

Q Same questioning for his mental flexibility?

A Yes, possible.

Q Same question for his ability to measure future consequences?

A Yes, possible.

Q Same question for the ability to control his behavior and to understand the consequences of his behavior? Let's end it there.

A Well, understanding the long-term consequences of immediate behavior is something that's associated with the left frontal lobe. I don't know that there are any indications that that was damaged, but it would certainly be possible just because of frustration and personality problems. But again, once again, we don't know because he didn't have the imaging to show it.

Q You would agree with me that polytrauma increases the likelihood of long-term cognitive dysfunction with TBI?

A Polytrauma is a broad, broad term. I don't know how to respond to that. I don't know.

Q A patient with a TBI and polytrauma increases the likelihood of long-term cognitive dysfunction versus

a patient with just TBI, correct?

A It's possible. Yes.

Q And Mr. Angulo did have polytrauma, correct?

A Yes. He had orthopedic injuries, yes.

Q Let's go to the Glasgow Coma Scale. What is the Glasgow Coma Scale?

A It was a scale developed in Glasgow, Scotland -- that's where it got it's name, Glasgow General Hospital -- to assess and categorize people who arrived in coma or difficulties with awareness.

Q Okay. And what's the use and purpose of the Glasgow Coma Scale?

A It's to make an assessment and categorize people as to problems and possible prognosis.

Q Okay. And you would agree with me that a Glasgow Coma Scale does impact the prognosis for a specific patient?

A It may, yes.

Q Okay. For instance, if they come in with a Glasgow Coma Scale or if they present -- strike that.

If a patient presents with a Glasgow Coma Scale of 15, which is the highest, then you would expect virtually no cognitive impairment, no neurocognitive impairment versus if somebody presents with a Glasgow Coma Scale of three, which is the lowest, you would

expect that person's prognosis to be much worse, correct?

A I would expect them to be dead.

Q Okay. You would expect somebody with a Glasgow Coma Scale of three to be dead?

A Yes.

Q Why is that?

A Going below six, the survival rate is extremely poor. Poor to none.

Q Okay. And what's the prognosis of somebody with a initial Glasgow Coma Scale of three?

A Of three?

Q Yep.

A They are likely going to die.

Q And if they don't die, if they survive, what would be --

A They are going to be -- a vegetable case is also likely.

Q Okay. People can recover from Glasgow Coma Scales of three, right? They can come back?

A Very rarely.

Q How rare?

A I can't tell you.

(Plaintiffs' Exhibit No. 3 was marked for identification.)

BY MR. BOUMEL:

Q Okay. Let's mark Exhibit 3. All right. Is this chart a fair and accurate chart for what the Glasgow Coma Scale is?

A Yes.

Q Okay. And basically we have three different responses, eye opening, verbal response and motor response, scored from one to four, correct?

A Correct.

Q Or actually that's not true. It's one to four on eye opening, one to five on verbal and one to six on motor, correct?

A Right, for a total of 15.

Q And anything eight or below -- well, strike that. Three is the lowest, correct?

A Correct.

Q And anything from three to eight indicates a severe brain injury, correct?

A Yes.

Q Okay. And then anything from nine to 12 is a moderate brain injury, correct?

A Yes.

Q And per your own testimony when Mr. Angulo presented, he initially had a Glasgow Coma Scale of eight, correct?

A Correct.

Q And that puts him into the severe brain injury category, correct?

A Correct.

Q Would you agree with me that a Glasgow Coma Scale of three to eight is associated with poor functional outcome such as long-term cognitive deficits, personality changes, and social reintegration difficulties?

A It may.

Q Okay. And are you aware that Mr. Angulo had a Glasgow Coma Scale of three when he was airlifted from the scene to Jackson Hospital?

A I don't recall that.

Q Okay. Do you think that that would be important to include in your notes and reports that he had initial scale of three and not eight?

A If I was aware of that, but I don't believe I was.

Q Okay. Well, going to your records, you did have the -- I'm looking at page four of your record review and you have Miami-Dade Fire Rescue listed as some of the records that you reviewed in this case, correct?

A Yes.

(Plaintiffs' Exhibit No. 4 was marked for identification.)

BY MR. BOUMEL:

Q Okay. Let's look at Miami-Dade Fire Rescue report. This will be Exhibit 4. Have you seen this before, Dr. Crown?

A Yes.

Q Okay. And you're telling me that you didn't -- you didn't realize that they listed for Mr. Angulo as he was being airlifted from the scene to Jackson that he had no eye movement, no verbal response, no motor response for a Glasgow Coma Scale of three?

A Thanks for refreshing me. It's been some time since I saw that.

Q Okay.

A And obviously if someone is unconscious because of any type of injury, they are going to get a score of three because they are unresponsive.

Q Because he was unresponsive?

A Whether it's a football player on the field who gets the wind knocked out or a child who fell out of a tree, if you're unconscious you're going to wind up with a three, but where the unconsciousness came from may be another question.

Q Where did the unconsciousness come from?

A Being battered, orthopedic injuries, overwhelming pain, being knocked unconscious. You could be knocked unconscious without --

MS. CRUZ: I'm going to object to the extent -- I'm just going to object. This is way outside of -- he is not here as a medical doctor to talk about the medical injuries and what resulted in a Glasgow Coma Score. He's not an MD. That's not what he's here to talk about. So we're going way far afield. You can ask him, you know, what Glasgow Coma score did you see, but now you're asking him for what he told you that the Supreme Court has said he's not allowed to give. He cannot give medical causation opinions. So he can't about this was the score and this is why. That's not what he's here to do. This is just completely irrelevant.

BY MR. BOUMEL:

Q So, Dr. Crown --

MS. CRUZ: Ask an MD about this, not him.

BY MR. BOUMEL:

Q So, Dr. Crown, as a neuropsychologist who has been retained to give expert opinions at trial in this matter, it's your opinion that Mr. Angulo's Glasgow Coma Scale of three is irrelevant and it's the same as if we

were on a football field and somebody had the wind knocked out of them?

A I have no comment on that.

MS. CRUZ: Objection to form and mischaracterizes the testimony.

BY MR. BOUMEL:

Q What do you mean you have no comment?

A I'm not a physician. That's a medical issue.

Q Does the fact that Mr. Angulo had a Glasgow Coma Scale of three change any of the opinions that you've offered?

A No.

Q Why not?

A Because a short time later he had a Glasgow Coma Scale of 13.

Q When did he have a Glasgow Coma Scale of 13?

A At Jackson South.

Q Okay. And did his -- did his Glasgow Coma Scale at Jackson South go back down at all or did it remain 13?

A It vacillated and that may be dependent on other circumstances that he was involved in, but I'm not a treating doctor. I can't help you.

Q Okay. But Glasgow Coma Scales are relied upon by you in reaching your opinions in this case, correct?

A It's historical information, but it doesn't affect my opinion. A neuropsychological evaluation is always a static status evaluation.

Q Well, all of the history that you obtained from the medical records impacts your opinions. You told us that at the very beginning of this deposition, correct?

A Yes. It places things in context.

Q Okay. And it's important to place in context the severity of Mr. Angulo's symptoms when he first presented in the air ambulance and at Jackson Hospital, correct?

A Yes.

Q Okay. And you've already testified that you did not -- you did not include or incorporate Mr. Angulo's presentation in the air ambulance into your opinions, correct?

MS. CRUZ: Object to form. Mischaracterizes the testimony.

THE WITNESS: No. It's not mentioned.

BY MR. BOUMEL:

Q Okay. And did you also mention or incorporate the fact that Mr. Angulo had vacillating Glasgow Coma Scales at the time that he presented to Jackson?

A No.

MS. CRUZ: Objection to form. He said that earlier in the deposition.

BY MR. BOUMEL:

Q And why not? Why didn't you incorporate it, Doc, if it's important?

A There was no reason to. As I said, a neuropsychological is always a status evaluation and I knew that in 2023 he had a clear CT scan.

Q Okay. But you didn't consider the severity of his initial condition, accurate?

MS. CRUZ: Object to form.

THE WITNESS: Not in terms of the Glasgow Coma Scale.

BY MR. BOUMEL:

Q What about in -- what about in -- forget about the number, what about the notations of the nurses as to his mental cognition in the day or two following his admission to Jackson; did you incorporate any of that into your opinion?

A No. I incorporated it into my knowledge of Mr. Angulo.

Q Okay. Would it be important for a neuropsychologist giving opinions as to whether or not somebody has continuing neurocognitive deficits to understand exactly how severe those neurocognitive

deficits were after that person is admitted to a hospital?

A As I said, a neuropsychological examination is a status examination at the time that the person is seen. So the history is interesting, but the focus of a neuropsychological evaluation is how well is the person functioning at the time that you see him, not how he was four years earlier.

Q But as you so eloquently put it at the beginning of this deposition, you have to have the backdrop. Without the backdrop you can't form accurate opinions, right?

A Yes. So Mr. Angulo has made a wonderful recovery. He's gone from brain damage identified on the CT scan in 2019 to a clear CT scan in 2023.

Q And just because he has a clear CT scan doesn't mean that he has no neurocognitive dysfunction; you would agree with that?

A I found neurocognitive dysfunction when I saw him.

Q Okay. And I'm going to repeat my question. Just because he has no brain damage appreciable on a continuing brain damage seen on a CT scan, doesn't mean that there is not neurocognitive dysfunction, correct?

A That's correct.

MS. CRUZ: Objection. Form. Asked and answered.

BY MR. BOUMEL:

Q Okay. How low did his Glasgow Coma Scale vacillate to when he was in Jackson?

A I'm not sure; 11 or 12.

(Plaintiffs' Exhibit No. 5 was marked for identification.)

BY MR. BOUMEL:

Q Show you what we'll mark as Plaintiffs' 5, 4,987 pages, Jackson admission, April 25, 2019. I probably will only admit -- I'll admit the first 100 pages. So we're starting at the beginning from his initial presentation. Fair to say he was not oriented to the situation?

MS. CRUZ: I'm just going to object to the form. The record says what it says. You want him to read what the record says?

MR. BOUMEL: I'm asking if he disagrees.

THE WITNESS: No. Those are medical decisions.

BY MR. BOUMEL:

Q Okay. I think we're going to get out of this. What is a diffuse axonal injury?

A I can't hear you.

Q What is a diffuse axonal injury?

A Diffuse abdominal injuries?

Q Axonal.

A Oh, diffuse injury axons. Axons are large connecting segments of the brain.

Q Did Mr. Angulo have that?

A Yes.

Q Okay. How do we know that?

A Imaging.

Q Okay. And you would agree with me, wouldn't you, that diffuse axonal injuries with a Glasgow Coma Scale of eight or below is a brain injury that can produce the equivalent of Swiss cheese in the brain?

A Possible.

Q Okay. And you would agree with me that someone with diffuse axonal injury Glasgow Coma Scale of eight and under are very likely to have very severe problems and not be able to function?

A Some people, yes. If you want to be specific to Mr. Angulo, apparently no.

Q Okay. Well, just because he's functioning pretty well doesn't mean that he doesn't have issues, correct?

A Correct.

MS. CRUZ: Object to form.

BY MR. BOUMEL:

Q And you've testified to both of those things in the past. That somebody with a diffuse axonal injury and a Glasgow Coma Scale of eight or below is somebody who you would believe would have Swiss cheese, the equivalent of Swiss cheese in the brain?

A They could, yes.

Q Okay. Let's talk some more. An intraparenchymal -- how am I doing on that?

A Not bad.

Q An intraparenchymal hemorrhage is a hemorrhagic cerebral contusion, correct?

A Correct. A bleed.

Q A hemorrhagic cerebral contusion is one of the most severe forms of traumatic brain injury, correct?

A A brain bleed is a problem. Yes.

Q And it's one of the most severe forms of traumatic brain injury that there is, correct?

A A bleed is, yes.

Q And you would agree that they are closely related to death and disability if they result in a coma?

A Yes.

Q And you would agree with me that Mr. Angulo was comatose for a period?

A He was unconscious. Yes.

Q And he had -- he fell on the severe side of the Glasgow Coma Scale, correct?

A Yes.

Q Okay. You would agree with me that nearly half of hospitalized survivors of traumatic brain injury experience long-term disabilities?

A I'm not aware of the percentage.

Q Okay. Have you ever testified in the past that nearly half of hospitalized survivors of TBI experience long-term disabilities?

A I don't know. I would agree that a significant number of people who sustained traumatic injuries have continuing problems.

Q You would agree with me that traumatic brain injury increases the likelihood of early onset dementia?

A Yes.

Q This is going to be wordy. I'm apologizing to everybody in advance, especially Ms. Sharon. Would you agree with me that in patients with traumatic brain injury involving intraparenchymal hemorrhage long-term issues such as executive dysfunction, impulsivity and emotional dysregulation are common?

A It would depend on the extent of the bleed and whether it required neurosurgical intervention.

Q Okay. Would you agree with me that in patients involving traumatic brain injury with intraparenchymal hemorrhage that they can suffer impairments including affecting relationships, career opportunities, and overall life satisfaction?

A It would depend on where the bleed was.

Q Okay. How about --

A Yes.

Q How about for Mr. Angulo? Let's keep it to Mr. Angulo.

A That was in the parietal lobe. The parietal lobes have nothing to do with establishing relationships.

Q Okay. Let's -- we're going to start the whole process over and we're going to make it Mr. Angulo focused. With regards to Mr. Angulo's traumatic brain injury involving an intraparenchymal hemorrhage -- Whitney, can you say that three times fast?

A Intraparen --

MS. CRUZ: No.

THE WITNESS: Now you got me doing it. Let's just call it IP.

BY MR. BOUMEL:

Q All right. IP. IP. In patients -- sorry, not in patients. In regards to Mr. Angulo's traumatic

brain injury involving an IP hemorrhage, is it true that he would be expected to suffer from long-term issues such as executive dysfunction, impulsivity and emotional dysregulation?

A It would be possible but improbable because it didn't require neurosurgical intervention.

Q Okay. So your testimony is that as long as you don't require neurosurgical intervention then you're not going to suffer from any of these consequences?

A In all likelihood, but now you're asking me medical questions.

Q No. You're a neuropsych. These are on board for you. Fair to say that --

MS. CRUZ: They are not. They are not. Adam, he's told you that this is outside of his expertise, so he testified within his expertise and he is not offering opinions about that in this case.

BY MR. BOUMEL:

Q Okay. Dr. Crown --

MS. CRUZ: So I'm not really sure -- this is taking a lot longer not because he's not answering your questions because you're asking him all these medical questions. He's not an MD. He is not an MD. He is not holding him out -- holding himself

to be an MD. Tesla has a neurologist. You could have asked all these questions of the neurologist.

MR. BOUMEL: Okay.

MS. CRUZ: His opinions are based on his testing, his testing. So I don't know how much longer we're going to be here with all of these medical questions that don't relate to his opinion.

BY MR. BOUMEL:

Q Dr. Crown, would you agree that a traumatic brain injury with -- involving an IP hemorrhage can significantly affect relationships, career opportunities, and overall life satisfaction?

A May. Depending on the location of the IP.

Q Okay. Would you agree that for Mr. Angulo with his TBI and his IP hemorrhage that the recovery trajectory for him is going to be protracted and even after initial improvement, he may report enduring deficits affecting his overall quality of life?

MS. CRUZ: Object to form.

THE WITNESS: Possible, but I would defer to a neurologist.

BY MR. BOUMEL:

Q Would you agree with me that studies show that patients with IP hemorrhages have higher rates of unemployment, social withdrawal, and dependency on

family or caregivers, indicating that their life satisfaction is profoundly impacted?

A I would defer to a medical doctor. That's a determination that would be based on the size of the IP and possible interventions.

Q I'm not asking for a medical opinion. I'm asking for a psych -- for a neuropsychological opinion as to the person's expected -- expected psychological impact.

MS. CRUZ: He gave you his answer, Adam. His answer is his answer.

BY MR. BOUMEL:

Q Okay. And what's your answer, Doc?

A My answer --

MS. CRUZ: He just stated --

THE WITNESS: -- is ask a neurologist.

MS. CRUZ: Court Reporter, can you read it? Hold on, Dr. Crown. Court Reporter, can you read the answer --

MR. BOUMEL: Whitney, Whitney.

MS. CRUZ: -- to the last question?

MR. BOUMEL: Whitney, can you please just keep your objections to form. I'm not trying to be rude here. You can't tell him how to answer and what to answer. I'm the one asking the questions.

BY MR. BOUMEL:

Q Dr. Crown, please answer the question.

MS. CRUZ: I'm not going to let you go outside of his opinions. He literally just told you, I can't answer that. That's out of my expertise. You would have to ask a neurologist. He can't answer that. So if you want to tell the jury that he wouldn't answer it because it's outside of his expertise, you can. You can't make him -- he told you, I can't answer it. Have the court reporter read the last question. I can't answer means I don't have an opinion. I'm not going to let you sit here and keep ask him and ask him and ask him. He said, I don't have an opinion on that. I can't answer it.

BY MR. BOUMEL:

Q Okay. Is it a medical opinion that people with IP hemorrhages and TBI have higher rates of unemployment, social withdrawal, and dependence on family or caregivers? It's your testimony, Dr. Crown, that that's a medical opinion?

MS. CRUZ: Objection to form.

THE WITNESS: That's a physiatrist opinion. That's a medical doctor.

BY MR. BOUMEL:

Q Okay. And you, as a neuropsychologist, are not qualified to give an answer as to that question?

A I don't answer questions about employment. I'm not an employment specialist. I'm not a rehabilitation specialist.

Q Okay. You are a psychologist and the question also incorporated social withdrawal. Is social withdrawal within the course of your area of expertise?

A Social withdrawal, yes.

Q Okay. So let's talk about social withdrawal. Would you expect that a person suffering from an IP hemorrhage with TBI would have social withdrawal?

A They may. But being specific to Mr. Angulo, he made several trips to Colombia. He was at the Indy 500. He made trips to New York that's with a girlfriend. That doesn't sound like social withdrawal to me. That sounds like having a good time.

Q So Mr. Angulo is having a good time?

A Based on the making several trips to Colombia, having a girlfriend, going to the Indy 500, taking trips to New York, he wasn't going for treatment.

Q Okay. And in the brain -- in your own clinical practice where you treated patients with severe trauma, that's -- you treated plenty of patients with

severe trauma in your practice, correct?

A Yes.

Q Okay. Is it uncommon for those patients to take trips and activities to try to get themselves back to a place of feeling better about themselves?

A No.

Q It's not uncommon or it is uncommon?

A It's uncommon.

Q It's uncommon. Okay.

MS. CRUZ: Adam, we've been going for, like, an hour. I don't know if it's time to stop, but sometime soon can we get a break?

MR. BOUMEL: Yeah. Let's take it now.

THE VIDEOGAPHER: We're off the record at 3:42 p.m.

(Thereupon, a brief recess was taken.)

THE VIDEOGAPHER: We are back on the record at 3:50 p.m.

BY MR. BOUMEL:

Q All right. Doc, we are going to switch gears. Let's talk about PTSD. You would agree with me that PTSD is a cognitive disorder, correct?

A Yes.

Q Okay. And can you explain for us what means?

A I didn't hear you.

Q Can you explain what that means, that PTSD is a cognitive disorder?

A It means that it affects thinking, feeling, and action.

Q What is the interplay between PTSD and neurocognitive dysfunction?

A They mimic one another. It's extremely difficult to tell the difference between one or the other in terms of the effect it may have.

Q Do they exacerbate each other?

A They may exacerbate one another or they may mimic in behavior or in cognition, so it's unknown. It's very difficult to differentiate.

Q And just so we're talking the same language here, you're agreeing that they do exacerbate each other. And so for our jury what that means is if one -- if a person has PTSD with neurocognitive dysfunction, the PTSD can make the neurocognitive function worse and the neurocognitive dysfunction can also make the PTSD worse; is that accurate?

A That's possible or they could display the very same symptoms, making it almost impossible to discern what's neurocognitive and what's PTSD.

Q Would you agree with me that individuals with PTSD often experience significant decline in their

quality of life?

A Yes.

Q Would you agree with me that individuals suffering from PTSD suffer symptoms such as intrusive thoughts, hyperarousal and emotional numbness which not only affects their daily functioning, but also impairs their social relationships and overall life satisfaction?

A Yes.

Q Would you agree with me that long-term PTSD can have a devastating effect on an individual's functioning and quality of life?

A Yes.

Q Would you agree with me that even with treatment many individuals with PTSD report persistent deficits and emotional regulation, interpersonal relationships and work performance?

A Some do, with inadequate treatment, yes.

Q And sometimes people with PTSD have suicidal ideations, correct?

A Yes.

Q What's the interplay between chronic pain and PTSD?

A The interplay, one may exacerbate the other.

Q Okay. And same thing with chronic pain and

neurocognitive disorder, one may exacerbate the other?

A Yes.

Q Okay. What about in somebody with all three, chronic pain, PTSD, and neurocognitive disorders? Does that -- do they all exacerbate each other?

A They may, yes.

Q Have you -- I know in your file you have the deposition transcripts and report of Dr. Korman, correct?

A Yes.

Q Do you disagree with his opinions at all?

A No.

Q Okay. Dr. Korman diagnosed -- opined that he believes that Mr. Angulo does have PTSD. Are you aware of that?

A Yes.

Q Okay. Do you believe that Mr. Angulo has PTSD?

A Yes.

Q Okay. How come in your report you stated otherwise?

A No. I stated or meant to say that psychometrically on the Mollin Clinical Multiaxial Inventory, which has a special category for PTSD, he did not indicate PTSD, but I believe that he has it.

Q Okay. So you do believe he has it?
A Yes.
Q Okay. Continuing, correct?
A Yes.
Q Okay. Let's go to your interview with Mr. Angulo. Did you -- do you believe he lied or exaggerated to you in any way in your interview setting?
A That he lied to me, not that I'm aware of.
Q Was he exaggerating to you in your interview?
A I don't believe so, but I don't know. I didn't have independent ways of tracking his daily activities.
Q I guess what I'm trying to get at is based on your interview with Mr. Angulo, did you have any reason or concern to believe or concern that he was not being honest and forthright with you?
A No.
Q Okay. Let's go to your testing selection. It seems as though you administered three tests for malingering and then -- which would be the Rey 15 and the B test and then the Structured Inventory of Malingered Symptomology [sic] test, correct?
A Yes.
Q Those three tests were all specifically for malingering, correct?

A Performance validity, malingering, exaggeration, they are compounded.

Q And then other than the three performance validity tests and malingering test, you did four other tests, correct?

A Yes.

Q Okay. How did you chose the tests that you ultimately gave?

A I felt that those were the tests that would tap his behaviors and answer the question that I was asked to address, whether he had brain damage or not.

Q And do you choose the same battery for each patient that you're testing?

A I may add or subtract.

Q Do you choose the same battery regardless if you're being called by the defense or testifying on behalf of a plaintiff?

A Generally.

Q Okay. Always?

A Well, it's hard to say always. Sometimes I may add something. Sometimes I may subtract something. Sometimes there's a new test that I might want to see how it works.

Q Well, talk me through your decision-making process. How do we determine in any given scenario what

test we're administering?

A That's based on an individual basis. There's individual behavior. I knew that I was dealing with or going to see Mr. Angulo. I knew that he had a history of attentional problems. I knew that he had a history of pain problems. I knew that I probably couldn't keep him seated for long periods of time. I wanted to be relatively quick in what I did. Modern neuropsychological testing runs somewhere between two and four hours. I wanted to be on the lower end rather than the higher end in order to ensure that I was getting his best behavior rather than worn out behavior or complaining behavior.

Q Did you get any worn out or complaining behavior?

A Yes.

Q You did?

A No.

Q Just -- okay. We're clear you did not get any worn out or complaining behavior, correct?

A That's correct. I did not.

Q Okay. What's the difference between a fixed battery versus a flexible battery?

A A fixed battery is the same tests given at the same time and a flexible battery involves choosing tests

to meet situational demands.

Q You would agree with me that fixed batteries have been scientifically validated through peer-reviewed studies whereas flexible batteries have not been, correct?

A That's an old wives' tale. There is a study by -- an important study by Rohling that says there's no difference. There's an article by Larrabee and there's a New Hampshire Supreme Court opinion that put everything to rest in Baxter v. Temple so by 2009 it was a myth.

Q And I'm assuming it would be just taking a moment of seconds or minutes to pull those studies?

A I could.

Q Please do so.

A But you can probably obtain them from your own expert.

Q Please pull them and provide them to Tesla's counsel. We're requesting copies of them. Flexible batteries are not co-normed, correct?

A That's correct.

Q What does that mean?

A That means that they weren't taken as a group and norm together. That's another myth that relates to your concatenated versus hierarchal theories when you

want to get down to the basis of them. The two articles that I mentioned and the New Hampshire Supreme Court opinion all say that it's unnecessary and makes no difference. In addition, there's a formula if you want to co-norm, there's a simple statistical formula that can be used to do that, but there's no reason. I think you're dealing with old neuropsychological tales.

Q If you use --

A And I understand where you got them.

Q I'll let her know you said hi. If you're dealing with a validated fixed battery you would be able to provide a global impairment index, correct?

A If that were one of the figures. It doesn't mean that you can apply. It just so happens that there are -- there is a battery that allows for that, but it's not available with every fixed battery.

Q Okay. But it is available in fixed batteries and it's not available in flexible batteries, correct?

A An impairment index?

Q A global --

A I gave you a composite index from the repeatable battery.

Q What I'm asking for is a global impairment index?

A That's correct. It's available in only one

old instrument.

Q Okay. And it's not available in the battery that you choose, correct?

A Correct.

Q And if you choose a validated fixed battery, you can provide a probability of brain damage index, correct?

A You could.

Q Okay. And that's not available in the battery that you chose, correct?

A The probability -- the probability is that Mr. Angulo is brain damaged.

Q Let's talk about malingering. You gave three test scores, correct?

A Yes.

Q He passed two, correct?

A He passed two and one was suspect.

Q Okay. And when we say that one was suspect, let's deal with that one. First of all, the two that he passed, do we know what his scores were?

A They were within normal limits. I don't know that there would be a particular reference. Your expert would have a raw data and would know.

Q And just so we're on the same page, these malingering tests, Mr. Angulo didn't know what tests

were testing for what, correct?

A Correct.

Q So he's just taking all of these tests and the malingering tests are specifically designed to tell if he's giving his best effort without letting him know that he's being tested for his best effort, correct?

A Correct.

Q And two of three he passed, correct?

A And one was suspect, yes.

Q And one was suspect. Now the one that was suspect, first of all it has five different sections, correct?

A Correct.

Q And he passed two of the five, correct?

A I believe so.

Q And you didn't put that in your report, correct?

A I didn't put in what he passed and -- what he passed, no. That's not the function of the test. A person who is not exaggerating or -- should pass everything. The test should be clear and clean.

Q So let's talk about -- so we're talking about the SIMS test, right, S-I-M-S?

A Yes.

Q Okay. And that is comprised of 75 questions,

true or false questions with no room for explanation, correct?

A Correct.

Q Okay. And basically it ask a question true or false and if he answers true it adds a point, correct?

A Yes.

Q And if he gets enough points then it flags his responses as being potentially malingering, correct?

A Questionable, yes.

Q Okay. And some of those -- so he flagged as questionable on three things including neurological impairment, effective disorders, and low intelligence, correct?

A Yes.

Q So if he answered a question in the positive stating it was true that he's suffering from some sort of effects of neurological impairment, then he gets a point added towards potentially malingering, correct?

A Yes.

Q But what if he is suffering from neurological impairment?

A Well, the test is designed to deal with people who have these problems. It only triggers a problematic area when they over-endorse, not that they endorse; we expect people to endorse. It's a question of

over-endorsing.

Q Okay. And is it true that most of his endorsements on the SIMS were for complaints of depression, PTSD, and substance abuse?

A No. It was neurologic impairment, effective disorder, and low intelligence.

Q Those are the categories, but within those categories there are subsets of questions dealing with depression, PTSD, and substance abuse, correct?

A Yes. That's correct.

Q And those are the questions that he answered in the affirmative, correct?

A Yes. He over-endorsed.

Q So he over-endorsed substance abuse, is that what you're --

A Yes.

Q Okay. And that flagged him for potentially malingering?

A Or exaggeration, yes.

Q Okay. Give me one second. And if he endorsed issues related to PTSD, that also under the SIMS flagged him for potential exaggeration, correct?

A Correct.

Q Even though he has PTSD, correct?

A Correct.

Q Okay. Now you said potential exaggeration, what did you mean?

A It may or may not be.

Q Okay. Within a reasonable --

A That was my conclusion that it was possible, but again if something is possible it's also might be not possible.

Q So fair to say you cannot testify that within a reasonable degree of medical probability or neuropsychological probability that Mr. Angulo was malingering or exaggerating?

A Yes. That's what I intended to express.

Q Okay. That's not an opinion that you're going to offer at trial?

A Correct.

Q Just to be clear, you do not intend to come to trial and tell our jury that you believe that it's possible that Mr. Angulo may be malingering or exaggerating his symptoms?

A Well, he may be exaggerating, you know. One of the ways to look at that is look at his language score which is at the eighth percentile, but then in another language test he was at the 50th percentile. How could that be?

Q Okay.

A And then on a test that was administered after I saw him, he scored well above the 50th percentile on the test given by another neuropsychologist.

Q Same test or different test?

A Different test, but language is language.

Q But different test is a different test, correct?

A Yes.

Q You stated in under behavioral observations, his level of disclosure was variable and possibly incomplete. What did you mean?

A I meant that he was hesitant to answer at times.

Q What question was he hesitant to answer?

A About his life, about his substance use, about how he spends his days.

Q Okay. What information did he not give you about he spends his days?

A I don't know. I don't know what information he didn't give me because I have no way to check on that. It's merely an observation. It's not a measurement.

Q What question were you asking him where you believe he did not give you a full response as to how -- as to how he spends his days?

A I don't know whether he gave me a full response or whether he was just absent. I asked him how do you spend your day.

Q What did he say?

A He said I just hang out.

Q That's the question and answer?

A And then I go to doctor's.

Q Okay. And that's your testimony as to how that conversation went?

A Yes.

Q You know we have it on video, right?

A Yes.

Q Okay. Let's go to the TOGRA test, T-O-G-R-A. What is that testing measuring?

A General reasoning ability.

Q How is the test constructed?

A Person has examples of -- well, an example is a bird and a nest and then the spider and a question mark and then there are five things to choose from to complete the pattern; bird, nest, spider, and one of the choices is web. That would be an example.

Q Is that an example of, like, the easiest question on that test or --

A That's the example.

Q Okay. And how long does that test take?

A Sixteen minutes.
Q Okay. And for -- on the TOGRA test, Mr. Angulo presented at the second percentile, correct?
A Correct.
Q And in your report you said this is below expectancy levels given his education, history, and self-sufficiency, correct?
A Correct.
Q First of all, you did no type of testing to determine what his premorbid functioning was, correct?
A Correct.
Q And there are tests that approximate that, correct?
A Not in the contemporary tests.
Q Okay. And what does that mean?
A That means that there are old tests that may still be used by some people, but they are old.
Q Given his education, history, and self-sufficiency, what did you mean by his history?
A His history of completing an AA degree at a community college, his having a high school diploma.
Q Well, that would be his education. You said his score is below expectancy levels given his education, history and self-sufficiency. I understand what you're saying about education. I'm asking about

history.

A He lives alone in the Keys. He manages a household. He drives.

Q Did you consider in the history section that he suffered traumatic brain injury and was airlifted to a trauma center with a Glasgow Coma Scale of three?

A I took that into account, but the second percentile -- and by the way the -- that correlates with IQ, the TOGRA does correlate with IQ. That would place him one point above intellectually disabled. That didn't make sense to me. Perhaps it makes sense to you.

Q When you say self-sufficiency, what do you mean? How is Mr. Angulo self-sufficient?

A He's able to rely on himself. He's able to get about. He is able to shop for things. He maintains a household.

Q Okay. Let's go to the RBANS, which I believe is your next test.

A Yes. I believe we already spoke about that and I gave you the percentile.

Q I don't think we did.

A Well, I know we did.

Q Okay. Remind me. You gave --

MS. CRUZ: What's the question?

BY MR. BOUMEL:

Q Yes. So you gave me the percentile, but now we need to speak a little bit more detail. You went over what the testing results were, correct?

A Yes.

Q Okay. Now let's talk about what is the RBANS test -- I'm sorry, what is the RBANS test measuring?

A Measuring immediate memory, delayed memory, visual, spacial and constructional abilities, language and attention and then produces a composite score in addition to those single domain scores.

Q How is that test constructed?

A How is it constructed? The immediate memory begins with reading a list of -- reading him a list of ten words and asking him to repeat back as many as he can remember, doing that four times and asking him to repeat back as many as he can remember each time.

Q What about the remainder of the sections?

A I beg your pardon?

Q What about the remainder of the sections of that test? How are they -- there are different sections of --

A Visual, spacial involves copying a complex figure, and pattern recognition, language involves -- mentioning -- listing all the fruits and vegetables that

you can think of and also coding representing symbols, numbers and symbols and correlating numbers and symbols. Attention relates to recalling numbers in sequence. Delayed memory is a follow-up to the list of ten words about how many are remembered and then there is a series of words that the person has to acknowledge whether they have seen them or not, whether they have heard them or not, and then also they are asked to recall a story about a fire that was read to them earlier.

Q Did we go through everything on the RBANS?

A Yes.

Q How long does that test take?

A About 45 minutes.

Q Okay.

A Forty minutes.

Q And Mr. Angulo's testing results were consistent with him having neurocognitive dysfunction, correct?

A Yes.

Q And same thing for the TOGRA; his test findings were consistent with him having neurocognitive dysfunction, correct?

A Or some kind of problem. Yes.

Q Potentially compounded by PTSD and chronic pain, correct?

A Possibly.

Q Okay. The Comprehensive Trail Making Test -- hold on. Let's stay on -- let's stay on the RBANS. Say the RBANS profile reflects performance that is inconsistent with trauma-related neuropsychological disturbance. What did you mean by that?

A I mean, it doesn't seem to represent a trauma profile. For example, if his immediate memory is a 13 percent but then 20 minutes later he's able to remember 21 percent, that's suspect.

Q Okay.

A And in addition his language was at the eighth percentile, but certainly he was conversant, able to use language, and on another test of language he was at the 50th percentile and then reinforced by his better performance with Dr. Hamilton and then if I compare it to another test that was done after I saw him, it doesn't make sense.

Q Okay. Is it possible that his scores are impacted by his PTSD and chronic pain?

A It's possible. But you're also telling me that somehow he got worse after he saw Dr. Hamilton and then he got better after he saw me.

Q Well, let's talk about that. Did Dr. Hamilton give the RBANS test?

A No.

Q So again, you're comparing completely different tests to each other?

A The brain remains the same. I'm testing brain function behavior. It doesn't make any difference --

Q Compare --

A -- what kind of test I use. If someone has a Littmann stethoscope versus a DGI stethoscope, it's still a stethoscope.

Q Well, the results from one test can be different from the results from another test, right?

A Possibly within a standard error of measurement, but not dramatically. Not between the 55th percentile and the second.

Q Dr. Crown, you've been doing this for 50 years, you're telling me that you never had a patient where you gave them one test and on the same area of the brain it showed a much different result than from another test?

A Yes --

MS. CRUZ: Object to form.

THE WITNESS: -- and that's why it was suspect. But I'm talking now about results betweens three different people testing the same person's brain function.

BY MR. BOUMEL:

Q But all with different tests, correct?

A But all with different tests.

Q And in your own practice you see that variability when you're using different tests, correct?

A It can happen.

Q Comprehensive Trail Making Testing, Second Edition, talk to us about that. What is that test measuring? How is it conducted? How long does it take?

A It's a connect-the-dot test. It stems from the inadequacies of the original Halstead-Reitan test, which only has two forms. This has five. It's more comprehensive. It has age-based norms. He scored a high average on the first, then average, average, mild to moderate impairment for a total below average.

Q And the tests get consecutively harder; one is the easiest, five is the hardest, correct?

A Correct.

Q So we would expect somebody to start doing better and then get worse, correct?

A Yes.

Q Okay. And his results are consistent with somebody who has neurocognitive trauma, correct?

A Possibly. But going from the 79th percentile to the second is unusual.

Q Okay. Seventy-nine being -- he scored a 79 percentile on the easiest test and second percentile on the hardest test, correct?

A Correct.

Q Okay. And overall total profile, this is consistent with somebody who suffered neurocognitive dysfunction, correct?

A Possibly, yes.

Q It's also consistent with somebody who suffered neurocognitive dysfunction compounded with PTSD and chronic pain, correct?

A Possibly. Or it could simply be a function of pain or it simply could be a function of PTSD or it could be a function of not doing your best.

Q Okay. But you don't have any evidence that he didn't do his best, correct?

A No.

Q Am I incorrect or do you have evidence -- do you have evidence or do you not have evidence?

A I do not.

Q You do not?

A No.

Q So you don't intend to offer that opinion at trial, correct?

A I don't have evidence.

Q Okay. So you're not going to tell the jury that he may not have been doing his best because you don't have evidence to support it, correct?

A No. What I can --

MS. CRUZ: Objection to the form.

THE WITNESS: -- is that there is a discrepancy between 79 and two.

BY MR. BOUMEL:

Q Okay. The Test of Verbal Conceptualization and Fluency. Talk to us about that. What's it measuring? How is it constructed? How long does it take?

A Categorical fluency involves things such as tell me all the things that go in a house, tell me all the things that you wear, tell me all of the foods that you eat, tell me all the different animals that you can think of, goes along those lines.

Q Okay. And --

A And letter naming is I'm going to say a letter of the alphabet, I'd like you to tell me all the words that you can think of that begin with that particular letter of the alphabet.

Q And what's that test measuring?

A Verbal conceptualization and fluency, languaged based, essentially frontal lobe behaviors.

Q And how long does it take to administer?
A You're allowed 60 seconds per category.
Q And how many categories are there?
A Ten, I believe.
Q Okay. And Mr. Angulo's results are consistent with somebody with neurocognitive dysfunction, correct?
A No, they are average.
MR. BOUMEL: Okay. Let's take five and then hopefully we can wrap up before 5:00.
THE VIDEOGAPHER: We're off the record at 4:26.
(Thereupon, a brief recess was taken.)
THE VIDEOGAPHER: All right. We're back on the record at 4:34 p.m.
BY MR. BOUMEL:
Q All right. Doc, you have read the neuropsychological examination and report of Dr. Sally Russell Kolitz, [sic] correct?
A Yes.
Q And I know you made some comments directed towards Ms. -- Dr. Kolitz throughout this deposition. I would ask you about -- do you have comments on her methodology?
A She uses an antique methodology, an old -- probably the old school. She's a Russellian.

Q A Russellian? And what is that?
A That's how we refer to people that follow Bert's methodology.
Q And Bert being?
A Bert Russell, her husband.
Q Okay. And aside from the fact that her testing battery is old, is it -- are there any other comments that you have on the testing battery that she uses?
A No. She's very familiar with it. She uses it. She uses old tests. For example, she used the WAIS-3, there's a WAIS-5. There's also a WAIS for a neuropsychological impairment. She uses the old tests because those were the last test that, Dr. Russell, her husband used, so they go back to the early '90s.
Q Okay. Give me a second. You said something that I need to track down.
A But she's certainly entitled to use whatever tests she wants to use.
Q Are the tests that she gave in any way invalid or inferior?
A Well, when you're using a WAIS-3 and there's a WAIS-5 that actually has neuropsychological components to it, you know, maybe that would have been a better choice. Dr. Russell doesn't use something called the

Flynn effect in his calculations. The Flynn effect adds 3.3 points to an IQ score for every decade.

Q Okay. Anything else that -- other than the fact that there were more -- here we go. So you would agree with me that you administered the MCMI-3, correct?

A Correct.

Q There is an MCMI-4, correct?

A Yes. However, there's a difference. The MCMI-3 is based on the DSM. Whereas the DSM4 is based on Dr. Millon's own theory of the personality. As a result, it's not accepted by some of the major organizations that require testing. For example, the Federal Aviation Administration finds it unacceptable.

Q Okay. Do you disagree with Dr. Russell's ultimate findings and opinions?

A I agree with her findings. I don't agree with her opinions. She doesn't consider the multi-factorial apportionment issues between all of his -- Mr. Angulo's problems so she focuses everything on neurocognitive issues and doesn't seem to consider pain and PTSD as contributors.

Q Okay. So basically you -- what about -- okay. Well, on her summary and I'm looking specifically, not in her rebuttal report, but at her neuropsychological evaluation dated 11/8/24. On the summary page she says:

Evaluation of Mr. Angulo is consistent with mild to moderate cognitive impairment as well as significant emotional distress consistent with posttraumatic stress disorder. You agree with that, right?

MS. CRUZ: Adam, where are you reading from? You were going so fast. I'm trying to follow.

MR. BOUMEL: Yeah. Page 15 of Dr. Russell's second report.

MS. CRUZ: Fifteen of the second. So that's the November report?

MR. BOUMEL: Yes.

MS. CRUZ: Okay. If you can just give Dr. Crown a chance to get to it.

BY MR. BOUMEL:

Q Sure. I think he was there, but --

A I am there.

Q Okay. Dr. Crown, did you see where I read that and you agree with that, right?

A Yes.

Q Okay. Last paragraph on the same page, page 15. Multiple tests throughout the course of examination demonstrate consistent evidence of mild to moderate impairment, particularly in the areas of frontal lobe, processing speed and executive function. First of all, do you see where I'm reading from?

A Yes.

Q You agree with that, correct?

A I think that our modern understanding of the brain doesn't talk about the frontal lobe. It talks about the multiple demand network which is much more inclusive since we now their frontal lobe behavior maybe moderated by fibers and tracts in the parietal lobe, so I'm not sure about that. Processing speed, yes. But processing speed is also something that's found in ADHD, and executive functions, I'm not sure. And I'm also not sure that he ever was identified as having frontal lobe organic brain damage. The IP bleed was in the back of the brain.

Q Okay. In general though, take the frontal lobe out of it. We understand your opinions with the frontal lobe and take processing speed out of it because I understand the ADHD comment. You would agree that the test results are consistent with mild to moderate impairment of executive functioning, correct?

A Again, that's now known and moderated through the central executive network which includes some areas beyond the -- what we used to call the executive function area, so we're talking about old school language here.

Q And how would you phrase it?

A How would I phrase it?

Q Yep.

A I don't know that --

MS. CRUZ: Object to form.

THE WITNESS: -- that his executive function problems come from neurocognitive issues or whether they come from personality issues. I can't apportion it.

BY MR. BOUMEL:

Q Well, you know that they come partially from neurocognitive issues, correct?

A Likely or possibly.

Q Likely or possibly. So if I understand your ultimate opinions, we can imagine that there are four different buckets going on that are contributing to Mr. Angulo's issues. Number one, he's got a traumatic brain injury with an IP hemorrhage resulting in a Glasgow Coma Scale of three as he's being airlifted to the trauma center. Number two, he's got PTSD as a result of both going through that experience himself as well as seeing his girlfriend killed before his eyes. Number -- I think that was -- I said number three, I meant number two. Number three, he's got chronic pain as a result of his injuries. And then number four, he had some premorbid issues with substance abuse which he

recovered from before this incident. Do I have that pretty much accurate as far as all the contributing factors?

A He had preexisting --

MS. CRUZ: Objection to form. Hold on, Dr. Crown. Objection to form. Mischaracterizes the testimony and the facts.

BY MR. BOUMEL:

Q Is that an accurate summarization of the different contributing that may be at play in terms of the neurocognitive deficits that Mr. Angulo is suffering from?

A No. You would have to add his ADHD, depression, and his history of substance abuse which also included the seizure.

Q Okay. So for completeness, let's do it again. Maybe I'll even bust out a Word doc.

MS. CRUZ: Adam, this is improper. I don't know what you're doing here. We're not going to start writing down things and ask him to agree. This is a question and answer. Verbal question and an answer.

MR. BOUMEL: I appreciate --

MS. CRUZ: So if you have a verbal question, ask him a verbal question.

MR. BOUMEL: I appreciate you telling me how to ask my questions and how to be a lawyer. I will definitely take that under consideration.

MS. CRUZ: I just won't let him answer if you're going to do it improperly. It's real simple. So I'm letting you know what my objection is so when I tell him not to answer you'll know. I'm just trying to do you a favor and speed this up here. In fact, let's go on a break before you start this whole writing down of the Word document. Let's take a five-minute break.

THE VIDEOGAPHER: Okay. We are off the record at 4:45 p.m.

(Thereupon, a brief recess was taken.)s

THE VIDEOGAPHER: We are back on the record at 4:54 p.m.

BY MR. BOUMEL:

Q Dr. Crown, over the break you had a chance to speak with Tesla's counsel, correct?

A Yes.

MS. CRUZ: Objection to form. That's not -- you're not entitled to know that, but if you want to know, yes, we talked on the break and I explained to him and we discussed the same things that I objected -- that I just objected to which is

this line of questioning. How you're going about it is improper.

BY MR. BOUMEL:

Q Did she give you any instructions on how to testify?

A No.

Q What did you guys talk about?

A What?

Q What did you guys talk about?

MS. CRUZ: I'm objecting to this whole line of questioning.

BY MR. BOUMEL:

Q Dr. Crown, you can answer.

A We talked about how we were coming to a conclusion, that I should be careful in what my responses are, and did I have any time to go beyond 5:00 eastern because she may have a lot of things to discuss or question me about.

Q Okay. I'm going to show you what I'm going to pull up my screen. We may mark it as an exhibit, we may not. I need ask you some questions about it. All right. Little homemade chart. We're going to go word by word and discuss it. First of all, contributing factors for Dillon Angulo's neurocognitive dysfunction. You agree that he has neurocognitive dysfunction and the

dispute as to what is contributing to it, correct?

MS. CRUZ: I'm objecting to all of the questions as I said before in this document that you created, Adam, in which you've tried to form his opinions into using the words that you want to use and crafting the words that you want to use. You've been talking to him for over four hours, over four hours about his opinions. There is not one word on this piece of paper that he has not already given his opinion about.

MR. BOUMEL: Okay.

MS. CRUZ: His opinions are his opinions.

MR. BOUMEL: Thanks, Whitney.

MS. CRUZ: They are his opinions. So take his opinions and compare them to this document that you you've created.

MR. BOUMEL: Thanks, Whitney.

BY MR. BOUMEL:

Q Dr. Crown, do you remember the question or do you need me to read it back?

A No. Give me the question.

Q The question is at the end of this day you agree that Mr. Angulo suffers from neurocognitive dysfunction, you just question what the contributing factors for that are, correct?

MS. CRUZ: Objection to form. Mischaracterizes the testimony and same objection as to the last question.

THE WITNESS: I have testified for almost four hours. I don't think you can reduce it to this document nor can you ask me now what I said three and a half hours ago.

BY MR. BOUMEL:

Q Okay. You agree that Mr. Angulo has neurocognitive dysfunction, correct?

A He has neuropsychological impairments. Yes.

Q And your testimony is that you just can't be sure where it's coming from, whether it's the brain injury he suffered, the PTSD, the chronic pain or his premorbid conditions, correct?

A And in addition --

MS. CRUZ: Objection to form. Mischaracterizes the testimony.

THE WITNESS: And in addition, I can't apportion it and I must take into account his history of ADHD, depression, and substance use which included a seizure.

BY MR. BOUMEL:

Q So as you will note, I have all those premorbid conditions down in this bucket number four

here. Is there anything else, other premorbid conditions which you believe may have contributed to his neurocognitive dysfunction other than his former drug use, which included a seizure, his ADHD, and his depression?

A Those items including the ADHD and depression, and substance abuse, including a seizure disorder.

Q That's right here.

A Yes.

Q Got it.

A I disagree with number one.

Q Okay.

A The initial Glasgow Coma Scale was three to eight, but in assessing a Glasgow Coma Scale, you have to take into account whether that Glasgow Coma Scale number is sustained or whether it changes and in Mr. Angulo's case it changed and rose up to a 13.

Q Well --

A And you're being imprecise in making the suggestion that that was a static number when in fact it wasn't.

Q Okay. And if the record showed that he had a sustained Glasgow Coma Scale of nine for over a day, would you disagree with that?

A The most important element is that he rose to

13.

Q Okay. Well, so the fact that he had an initial Glasgow Coma Scale of three, then it rose to nine, you're going to -- that's irrelevant? We're not going to --

A And then it rose to 13. I need to know the progression and I need to advocate for the progression. The progression is very important. In recovery and rehabilitation and treatment, what we're looking for is a static number versus a changing number.

Q Okay. Would this be more accurate that it started as a three, then it went to an eight and then it was at a nine and then a 13?

A That would be more accurate.

MS. CRUZ: Objection to form.

BY MR. BOUMEL:

Q Okay. And he had a brain bleed in the hospital, correct?

A That did not require neurosurgical intervention.

Q Okay.

A In which case I would characterize that as mild.

Q Okay. So even with a sustained Glasgow Coma Scale of nine, you're going to say it's a mild traumatic

brain injury?

A It's a mild --

MS. CRUZ: Objection. Adam, at some point we have to stop. You have asked this same question honestly at least ten times. You've asked the same question ten times. He said the word mild, let's have the court reporter go look and see how many times he said the word mild to describe the traumatic brain injury. We're going back to hour one. Like, what are we doing?

BY MR. BOUMEL:

Q Go ahead, Doc.

MS. CRUZ: What was the question?

MR. BOUMEL: I don't know because you're --

THE WITNESS: My answer was that it's a mild bleed that did not require neurosurgical intervention.

BY MR. BOUMEL:

Q Okay. And you would agree that the classification of the initial traumatic brain injury was moderate to severe, correct?

A Based on the initial Glasgow Coma Scale.

Q Okay. So now --

A But that can occur at any situation where a person is unconscious and being unconscious is not being

in a coma.

Q So I have your -- I corrected your Glasgow Coma Scale notation here. I corrected the fact that there's no surgery here. Any other corrections to make point number one accurate?

MS. CRUZ: Objection. These are Adam Boumel's opinions. These are not Dr. Crown's opinions. He has given opinions regarding neurocognitive dysfunction, traumatic brain injury, Glasgow Coma, brain bleed, chronic pain, the ortho injuries, PTSD, premorbid conditions, drug use, ADHD, depression for the past over four hours.

BY MR. BOUMEL:

Q Doc?

A You can defer to a neurologist or neurosurgeon.

Q Okay.

A You're asking me essentially to offer a medical opinion about the medical records.

Q No. What we're trying to do here is we're trying to understand the different contributing factors that have all played a role potentially in Mr. Angulo's neurocognitive dysfunction and we need to look at them all together because you're saying you can't apportion them, so what I'm trying to do is put them all on the

table so we can look at everything at the same time and figure out if there is any way for you to apportion them. So trying to put the buckets in front of you, bucket number one is his brain injury. You've already given me several corrections. Do you have any other corrections that you need to make on this?

MS. CRUZ: Objection to form to the way that you're doing this questioning. The fact that these are your opinions and this has been asked and answered ad nauseam and it's getting abusive and you're mischaracterizing the testimony. He literally just told you, for example, that it's mild. He's been telling you that for four hours yet you leave moderate to severe in this document.

MR. BOUMEL: That's not true. You're mischaracterizing the evidence or the testimony, but that's okay.

BY MR. BOUMEL:

Q Doc, any other corrections that you need for this? And, Whitney, I understand that you don't want me to do this. I get it.

MS. CRUZ: It's not that I don't want you to --

MR. BOUMEL: I wouldn't me to do it if I were you --

(Indiscernible crosstalk.)

THE COURT REPORTER: Okay. I cannot.

MR. BOUMEL: I wouldn't want you to do it -- me to do it if I were you either, but here's the deal, it's going to take five minutes. Either it comes in or it doesn't. That will be a ruling for the court. I'm going to do it. So please stop giving speaking objections which you know are improper, otherwise just terminate the deposition if you feel like the need to. It's your choice.

BY MR. BOUMEL:

Q So, Doctor, I'm asking you, any other corrections that you need to make to point number one here?

A Yes. It's moderate to severe --

MS. CRUZ: Objection to form --

THE WITNESS: -- traumatic --

MS. CRUZ: -- mischaracterizes. Let me -- Dr. Crown, please. I'm sorry. I know this is frustrating, trust me. I know. But you got to let me object here so that the record is clear. Again I will refer -- Adam, do you want to give me a standing objection to every single question that relates to this?

MR. BOUMEL: Yes. Absolutely. You want a

standing objection to this, absolutely. Happy to give it. Maybe you're right, Whitney, maybe this doesn't come in. We'll see.

THE WITNESS: Do you have a question?

BY MR. BOUMEL:

Q Any other corrections? I corrected --

A Oh, yes. It should be moderate to severe traumatic brain injury leading to a mild brain injury.

Q Okay. Anything else for point number one?

A Yes. You have no surgery, no neurosurgical intervention.

Q No --

A And it must be that language.

Q Okay. And then -- all right. Bucket number one is done, correct?

A Yes. Although it relies and requires a medical opinion which I'm not qualified to render.

Q Bucket number two is chronic pain subsequent to, you know, I listed several of his injuries. If there's anything you would like me to change on this, I'm happy to.

A Those are medical opinions based on his treatment. I'm not qualified to respond to any of that.

Q Well, we're not talking -- okay. But you agree that he is dealing with chronic pain subsequent to

his polytrauma, correct?

A He has chronic pain now managed by, I last read, one or two Advil.

Q Okay. And it's your understanding as a diplomat of the American Board of Pain -- what's that? I got to go back. You are a diplomat of the American Academy of Pain Management, correct?

A Correct.

Q And it's your understanding that this gentleman does suffer from chronic pain subsequent to his polytrauma, correct?

A Chronic pain now managed with over-the-counter Advil.

Q And did he tell you why he only takes Advil?

A He's afraid of becoming addicted.

Q Okay. Let's just -- let's take all that -- the other words out there. Let's leave chronic pain. And then he has PTSD as a result of both his own injuries and the death of Naibel, correct?

A Correct. Although there were other factors involved. For example, abuse as a child and adolescence.

Q What type of abuse did he suffer?

A Both physical and emotional.

Q What type of physical abuse did he suffer?

A He was beaten with a spoon and other household objects.

Q How often and how severe?

A Daily.

Q How severe?

A Sufficient enough that he finally had the strength and was big enough to grab his mother's hand in order to prevent him from being beaten.

Q Okay. And you think his PTSD is from that?

A It's contributory.

Q Okay. What's causing his PTSD?

A The death of his girlfriend of two weeks. It's unclear whether he witnessed it, however, but you don't have to witness it to have PTSD. In addition, his own injuries and recovery and his earlier history of physical and emotional abuse.

Q Okay. Was he -- there's a DSM diagnostic criteria for PTSD, correct?

A Yes.

Q And you never went through that criteria with him, correct?

A No, but he would need it. Under the new criteria, particularly for complex PTSD, someone could just tell you what happened and you could have PTSD. You no longer have to directly witness it.

Q Okay.

A So I don't see that you've added that, so that category is incomplete and I can't endorse it. So number three I can't endorse.

Q Yeah. You know what, I'm going to abandon it. We're not marking it. It was a fun idea.

A By the way, we're over the 5:00 limit.

Q Yeah. Just one last -- one last question.

A The meter is running and you'll be getting another bill.

Q One last question. Did you even ask Mr. Angulo what his complaints were?

A As I recall, I did. Yes.

Q Where is that in your report?

A He shied away from it.

Q He shied away from it?

A Well, he didn't respond and I didn't press it because, again, my job was not to do a psychological historical evaluation. It was to do a status evaluation.

Q Okay. But at the beginning of this deposition some four hours ago now, we stated that getting the person's complaints is an integral part of your examination because you need to understand what you're measuring and what everything is about, right? Do you

remember that testimony?

A Yes. And I also said that he wasn't sophisticated enough to diagnose himself. He's not sophisticated enough to know what components of history he needs to recite unless he has been coached by someone.

Q Are you suggesting that he was coached by someone?

A I don't know.

Q Do you have any evidence or any evidence to suggest that he was coached by someone?

A No.

Q Okay. You keep throwing things out there without having evidence, Doc.

A It's a matter what evidence --

(Indiscernible crosstalk.)

MS. CRUZ: Wait, wait, wait. Dr. Crown, there's no -- Dr. Crown.

THE WITNESS: So if you want to look at a bit more on evidence or the federal rules of evidence --

MS. CRUZ: There's no question pending. So, Adam, I don't know, these gratuitous statements are like -- I'm not sure where we're going with this.

BY MR. BOUMEL:

Q So again one last question. Did you ever ask him what his complaints were, what he's suffering from as a result of everything that he's gone through?

A Yes.

Q What he's complaining of?

A Yes.

Q You did. What did he say?

A That he has pain, that he has emotional responses, that he doesn't think he's getting enough treatment.

Q Where in your interview do you have any of that -- take away pain because you did ask him about pain. Where did you ask him about any neurocognitive dysfunction, any of it?

A I didn't. I didn't want to prime him.

Q So in a neuropsychological evaluation you did not ask him about any neuropsychological dysfunction?

A No. I tested him and found it.

MR. BOUMEL: Okay. Thanks, Doc. No more questions.

MS. CRUZ: Nothing from me. We'll read.

MR. BOUMEL: We'll order.

THE WITNESS: Read.

THE VIDEOGAPHER: Is it possible that before

we go off the record I can get e-mail addresses in the chat?

MR. BOUMEL: Of course.

MS. CRUZ: Yes. I can put mine now.

THE WITNESS: Let me just give you mine now. I'm in a hurry. Bmcrown, B as in boy, M as in Michael, bmcrown@yahoo.com.

THE VIDEOGAPHER: Thank you. So everybody wants a copy of the video?

MR. BOUMEL: Yes. Oh, no. I'm fine on the video for how. I'm just going to take the transcript for now.

THE VIDEOGAPHER: Okay.

MS. CRUZ: Also, Madam Court Reporter, I gave you two e-mail addresses. I'm going to give you a third one too just to make sure -- because these people can better help with you with the transcript than I can.

MR. BOUMEL: Whitney, I'm going to retain the exhibits just because, you know, I don't know how, frankly, to get an entire file over to the court reporter, so I will just send you a Dropbox of the exhibits if that's okay with you.

MS. CRUZ: Yes, that's fine.

MR. BOUMEL: I will do that tomorrow. Madam

Court Reporter, do you need spellings? I know there's some difficult ones.

THE COURT REPORTER: I'll e-mail you if I run into it. Ms. Cruz, do you want a copy of the transcript?

MS. CRUZ: Yes, please.

THE VIDEOGAPHER: I'm sorry. Ms. Cruz, did you want a copy of the video also?

MS. CRUZ: Yes, please.

THE VIDEOGAPHER: Okay.

MR. BOUMEL: I'm not ordering the video right now.

THE VIDEOGAPHER: Okay.

MR. BOUMEL: Just to be clear. All right. Thanks, everybody.

THE VIDEOGAPHER: Okay.

MS. CRUZ: Thank you. Bye-bye. Have a good day.

- - -

(Thereupon, the deposition was concluded and reading and signing was not waived.)

CERTIFICATE OF REPORTER

THE STATE OF FLORIDA)
COUNTY OF ST. LUCIE)

I, Sharon Ambersley, FPR, do hereby certify that I was authorized to and did stenographically report the foregoing video-recorded deposition of Dr. Barry Crown; that a review of the transcript, was requested; and that the foregoing transcript, pages 1 through 156, is a true record of my stenographic notes.

I FURTHER CERTIFY that I am not a relative, employee, attorney or counsel of any of the parties' attorneys or counsel connected with the action, nor am I financially interested in the action.

Dated this 13th day of February 2025, at St. Lucie County, Florida.

_____
Sharon Ambersley, FPR
Notary Public - State of Florida
My Commission: HH511304
My Commission Expires: 07/06/28

CERTIFICATE OF OATH

STATE OF FLORIDA)

COUNTY OF ST. LUCIE)

I, Sharon Ambersley, Florida Professional Reporter, Notary Public, State of Florida, certify that the witness, DR. BARRY CROWN, personally appeared before me on the 4th day of February 2025 and was duly sworn.

WITNESS my hand and official seal this 13th day of February 2025.

_____

Sharon Ambersley, FPR
Notary Public - State of Florida
My Commission: HH511304
My Commission Expires: 07/06/28

E R R A T A S H E E T

IN RE: NEIMA BENA VIDES, AS PERSONAL REPRESENTATIVE OF THE ESTATE OF NAIBEL BENAVIDES LEON, DECEASED, VS. TESLA, INC.,

DEPOSITION OF: DR. BARRY CROWN

TAKEN: February 4, 2025

DO NOT WRITE ON TRANSCRIPT - ENTER CHANGES HERE

PAGE #	LINE #	CHANGE	REASON

Please forward the original signed errata sheet to this office so that copies may be distributed to all parties.

Under penalty of perjury, I declare that I have read my deposition and that it is true and correct subject to any changes in form or substance entered here.

DATE: _____

SIGNATURE OF DEPONENT:_____

DATE: February 13, 2025

TO: WHITNEY CRUZ, ESQUIRE
c/o Dr. Barry Crown
41000 Woodward Avenue
Suite 200 E
Bloomfield Hills, MI 48304
U.S. Legal Job#: 6790496-001

IN RE: NEIMA BENA VIDES, AS PERSONAL REPRESENTATIVE OF THE ESTATE OF NAIBEL BENAVIDES LEON, DECEASED, VS. TESLA, INC.,

IN RE: Dear : Ms. Cruz

This letter is to advise you that the transcript of your client, DR. BARRY CROWN, taken in the above-styled case on February 4, 2025, has been completed and is awaiting his/her reading and signing.

Please have him/her contact our office at (754) 201-2346 to make arrangements to read and sign the deposition transcript. Our office hours are 9:00 a.m. to 5:00 p.m., Monday through Friday.

If the transcript is not signed by the witness within 30 days after this letter has been furnished, we will then process the transcript without a signed errata page. If your client wishes to waive their signature, please have him/her sign his name at the bottom of this letter and return it to our office @ U.S. Legal Support, 16825 Northchase Drive, Suite 900, Houston, TX 77060-6004.

Your prompt attention to this matter is appreciated.
Sincerely,

_____
Sharon Ambersley

I do hereby waive my signature:

_____
DR. BARRY CROWN

cc via transcript: Adam Boumel, Esq.
Whitney Cruz, Esq.
Todd Poses, Esq.

Barry M. Crown, Ph.D. and Associates, P.A.

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NEUROPSYCHOLOGICAL EVALUATION

ANGULO, Dillon Date Seen: 02-16-24
DOB: 04-14-92
CA: 31
D/L: 04-25-19

Mr. Dillon Angulo, a 31-year-old male, is seen for compulsory neuropsychological evaluation at a court reporter's office in downtown Miami, Florida. He was driving an SUV with his girlfriend as a front seat passenger and had pulled to the side of the road. After Mr. Angulo and his girlfriend had exited the SUV, but while they were standing near it, his vehicle was struck by a Tesla sedan. He sustained multiple injuries and his girlfriend died in this accident. He has continued with surgeries and treatments since this accident. There is pending litigation.

IDENTIFYING DATA

This information was obtained from Mr. Angulo.

He was born and raised in Miami. Mother and father are living and well. There is one younger brother.

He now lives in the Florida Keys but stays with his parents in Miami when he has appointments in Miami-Dade County.

He attended public elementary and middle schools and then attended Christopher Columbus High School but dropped out. He obtained a high school diploma from "Roger Whitten something". Per his representation to me, he did attend Miami-Dade College where he received an A.A. degree in accounting in 2018.

He has worked helping in his grandmother's landscaping business and has done varying air conditioning, restaurant work, and pressure cleaning.

He has been taking classes to obtain a general contractor's license. He has been doing this off and on as he has "focused on health".

He has been receiving psychological counseling once per week and seeks "ways to manage pain". He receives physical therapy once per week.

He takes Advil, two to four per day. He is taking tadalafil for erectile dysfunction, and was taking Wellbutrin (an antidepressant), but discontinued use.

He recalls the accident taking place on April 25, 2019.

He states that he will drink alcohol socially and will have a couple of drinks. He denies tobacco and recreational drug use.

Since the 2019 accident, he has been in another accident in which his vehicle was rear-ended resulting in him being seen in a hospital emergency room two days later.

RECORDS REVIEW

Records reviewed include, but are not limited to…

Initially Received
Florida Traffic Crash Report
Jackson Health System- Univ of Miami Hospital and Clinics
- Post-op Evaluation (6/13/19)
- X-Ray of pelvis (6/13/19)
- Post-op Evaluation (7/18/19)
- X-ray of pelvis (7/18/19)
- Post-op Evaluation (8/29/19)
- X-Ray of pelvis (8/29/19)
- X-Ray of right elbow (9/27/19)
- X-ray of right knee (9/27/19)
- Post-op Evaluation (10/3/19)
- X-Ray of pelvis (10/3/1 Evaluation (1/2/20)
- Post-op Evaluation (11/21/19)
- X-Ray of pelvis (11/21/19)
- 2nd Opinion (11/26/19)
- Post-op Evaluation (1/2/20)
- X-Ray of pelvis (4/13/22)

Neuropsychological Evaluation - Richard A. Hamilton, Ph.D. (7/1/19)

Mind & Soul Therapy
- Initial intake (7/25/19)
- Therapy notes (9/5/19 to 3/20/23)

Elite Physical Therapy
- Initial Examination (9/20/19)
- PT progress note (7/8/20)
- PT Recertification (1/17/22)
- Daily notes (9/30/19 to 3/20/23)

DVD of Imaging
Jackson Memorial Hospital
Baptist Hospital of Miami

Second Records Submission
Jackson Health System (complete medical chart)
Baptist Health (hospital and out-patient/urgent care)
Ocean Reef Public Safety EMS
Monroe County Sherrif's Office

Miami-Dade College
Florida International University
Miami Dade Fire Rescue
Key Largo EMS
Ledya Estino Nursery
Pincho/Westchester
Viking Landscaping
United States Treasury/IRS

Design Neuroscience Center (Kester Need, D.O.)

Third Records Submission
The Beachcomber Family Center for Addiction Recovery
U Health Lennar Foundation Medical Center
Evolv Wellness (massage)
IRS tax returns – Steven H. Dohan, CPA
IRS account transcripts
Christopher Columbus High School transcript
College of the Florida Keys
Paul Canali, D.C.
Plasencia & Associates, P.A.

Mr. Angulo sustained significant, multiple injuries (altered mental status and injury of abdomen) in the April 25, 2019 accident as reported by Ocean Reef EMS who were first at the scene. Glasgow Coma Scale rating by Ocean Reef EMS was an 8 (scale of 0 to 15) and rising. He was transferred to

Jackson South and then to Jackson Memorial Hospital/University of Miami Hospital and Clinics. He had multiple pelvic surgeries. After leaving Jackson Memorial Hospital, he received treatment in the out-patient rehabilitation program at Baptist Hospital in Miami. He continued to receive psychotherapy and physical therapy.

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A CT brain scan identified tiny foci of hyperdensity in the superior left parietal lobe likely reflecting tiny areas of intraparenchymal hemorrhage. There was no neurosurgical intervention.

Richard Hamilton, Ph.D. saw Mr. Angulo at the Baptist Hospital Out-Patient Rehabilitation facility. He prepared a neuropsychological evaluation report based upon assessment in four visits from October to December of 2019. This evaluation was conducted at Dr. Hamilton's private practice office. Dr. Hamilton concluded that Mr. Angulo suffered a moderate traumatic brain injury. He also found a moderate to severe level of depression and PTSD. He concluded that there was mildly impaired cognitive processing speed, moderately impaired executive functioning, mildly impaired attention and concentration and mildly impaired memory. Mr. Angulo's baseline functioning remains unknown and is not stated in Dr. Hamilton's report or reported elsewhere.

Mr. Angulo was in psychotherapy with Maridelie Diaz, Psy.D. for an extended period of time. He ultimately elected to discontinue treatment. It appears that the therapy consisted of revisiting the April 25, 2019 accident and did not appear to utilize the framework of Cognitive Behavior Therapy (CBT) with a focus on reframing and refocusing nor was there utilization of EMDR, another active therapeutic intervention for possible traumatic experiences.

Mr. Angulo returned to psychotherapy in 2023 with Carlos Plasencia, Ph.D., a licensed mental health counselor. Records indicate a treatment plan to utilize CBT and EMDR, but this is not apparent in the treatment records.

Mr. Angulo appeared to have utilized Baptist Health Urgent Care rather than a primary care physician. He has been seen at these urgent care facilities for upper respiratory infections, GERD, and various forms of dermatitis.

Following his treatment at Jackson Memorial Hospital, he was an out-patient at the Baptist Hospital Intensive Out-Patient Brain Injury Program. He initially saw Dr. Richard Hamilton, neuropsychologist, at that location. Dr. Hamilton noted problems with recent memory. Mr. Angulo was successfully discharged from the program on December 31, 2019.

On December 15, 2014, Mr. Angulo was seen in the emergency room of Baptist Hospital after having a seizure at a workplace. He was transported by ambulance. Medical records indicate that he had been taking one to two 2mg Xanax (alprazolam) tablets a day and had abruptly stopped two days prior to the seizure. Medical screening was positive for cannabis and benzodiazepines.

In June of 2018, Mr. Angulo voluntarily entered a program for substance abuse and addiction at the Beachcomber Center in South Florida. He tested positive for cannabis, benzodiazepines, and cocaine. He was taking 2 to 4 milligrams of Xanax (alprazolam) per day and using cocaine in powder and crack form. He also complained of and was treated for depression. He was prescribed Wellbutrin for depression. Issues of sex addiction and love addiction emerged during treatment. When challenged in group counseling, he left the program against medical and clinical advice. His primary therapist noted that he was at high risk for relapse.

On April 24, 2023, He was seen at Baptist Urgent Care after being rear-ended in a motor vehicle accident. He was directed to the Baptist Hospital emergency room. The diagnosis was concussion and headache. A CT without contrast showed no acute abnormalities.

There was an early history of hyperactivity and treatment for ADHD.

Many of Mr. Angulo's problems are orthopedic and pain related and are beyond the scope of this neuropsychological evaluation.

Dr. Kester Nedd saw Mr. Angulo on June 29, 2023 and focused on orthopedic rehabilitation and pain management. A neuropsychological evaluation was recommended.

EXAMINATION PROCEDURES

Test of General Reasoning Ability (TOGRA); Comprehensive Trail-Making Test- 2nd Edition (CTMT2); Test of Verbal Conceptualization and Fluency F); The b Test; Rey 15 Figure Test; Structured Inventory of Malingered Symptomatology (SIMS); Repeatable Battery for the Assessment of Neuropsychological Status (RBANS- Update Form A); Millon Clinical Multiaxial Inventory-III (MCMI-III); 4 Item Pocket Smell Test (Sensonics); signature sample; clinical interview and behavioral observation in structured and unstructured situations.

BEHAVIORAL OBSERVATIONS

Mr. Angulo was appropriately dressed and groomed. Speech was appropriate and goal directed. He was oriented 3X the environment.

He stated that he had driven himself from his parent's South Miami-Dade home to downtown Miami for this evaluation.

Three tests of performance symptom validity were administered. The Rey 15 Figure Test was within normal limits and The b Test was passed appropriately.

The Structured Inventory of Malingered Symptomatology (SIMS) in the areas of neurological Impairment (NI), Affective Disorders (AF), and Low intelligence (LI) were elevated and suggestive of malingering or exaggeration related to neurologic complaints, affect, and intelligence.

The 4 Item Pocket Smell Test was within normal limits.

His level of disclosure was variable and possibly incomplete.

Mr. Angulo is right-hand dominant.

RESULTS OF EXAMINATION

A neuropsychological assessment is a status examination on the date seen.

NEUROPSYCHOLOGICAL FINDINGS

The Test of General Reasoning Ability (TOGRA) produced an average profile with a standard score of 70 placing Mr. Angulo at the 2nd percentile rank (95% Confidence Interval: 64 - 80). This is below expectancy levels given his education, history, and self-sufficiency. A standard score of 70 would reflect borderline intellectual functioning in the areas of reasoning and judgment.

The Repeatable Battery for the Assessment of Neuropsychological Status (Update Form A) produced the following profile:

Factor	Percentile
Immediate Memory	13.0
Visuospatial/Constructional	30.0
Language	8.0
Attention	5.0
Delayed Memory	21.0
TOTAL (composite)	8.0

This RBANS profile reflects performance that is inconsistent with any trauma related neuropsychological disturbance. It is inconsistent with the

accident history and prior assessments. Findings are well below Dr. Hamilton's 2019 findings for this static form of possible brain injury.

The Comprehensive Trail-Making Test – 2nd Edition (CTMT2) involves visual scanning, initiation and maintenance of set, and conceptual flexibility. Mr. Angulo's obtained profile is as follows:

Trail	T-Score	Percentile	Descriptive Rating
1	58	79	High Average
2	45	31	Average
3	47	38	Average
4	4	6	Mild to Moderate Imp
5	30	2	Mild to Moderate Imp
Inhibitory Con		50	Average
Set-Shifting		2	Mild to Moderate Imp
TOTAL		19	Below Average

This profile represents erratic responding that is inconsistent with trauma. This problem type of response is typically only seen in individuals whose primary language is other than English.

The Test of Verbal Conceptualization and Fluency, a language-based primarily frontal lobe assessment produced Categorical Fluency at the 50th percentile (Average) and Letter Naming at the 46th percentile (Average).

PERSONALITY FACTORS

Mr. Angulo's response profile on the MCMI-III is psychometrically valid. His profile suggests that he is driven by his desire to display an image of hard-boiled strength. Notable may be tendencies to intimidate and exploit others and to expect special recognition and consideration without assuming reciprocal responsibility. Actions are likely to be present that raise questions about personal integrity, such as a ruthless indifference to the rights of others. These may indicate a pervasively deficient social conscience, a disdain of traditional ideals, and a contemptuousness of conventional values.

Antisocial behavior, alcoholism, or drug problems would not be inconsistent with this clinical picture. When his life is under control, he may be skillful in exploiting the goodwill of others. More characteristically, he will be envious of others and wary of their motives. He feels unfairly treated and easily provoked to anger. A marked suspicion of those in authority causes him to feel secure only when he has power.

Deficient in deep feelings of loyalty and displaying an occasional indifference to truth, he may successfully scheme beneath his veneer of civility.

It is likely that Mr. Angulo is now undergoing a significant major depression that is probably characterized by agitation and erratic qualities. He may also feel trapped and powerless to control raging inner tensions. Fearing that he may jeopardize his problematic situation further, he may act contrite and self-accusatory following explosive acts. The conflicted qualities in his personality makeup tend to result in jumpiness and hyperdistractibility.

His overall profile is consistent with individuals who are likely to abuse drugs, legal or street substances, or both. Irritable, negative, and hostile, he may employ drugs not only to help him unwind his tensions and undo his conflicts but also to serve as a statement of resentful independence from constraints of social convention.

Post-Traumatic Stress Disorder indicators are within normal limits. There are indicators for a major depressive disorder, anxiety disorder, and psychoactive substance abuse (either "dry" or active).

There are further indicators of borderline personality disorder with antisocial and sadistic features.

These personality and behavioral findings are self-reported and pre-exist the accident and treatments in questions.

IMPRESSIONS

There is a mild brain function (neuropsychological) disturbance which appears to be exaggerated in this evaluation with no baseline (pre-accident) comparative basis. This is significant because of the early history of ADHD and the history of a substance abuse induced seizure episode as well as substance abuse treatment and depression treatment. Pain perception may also cloud the presentation

Exaggeration and possible malingering are noted in the evaluation.

There are confirmed indications of pre-existing depression and no present indications of a Post-Traumatic Stress Disorder.

Barry M. Crown, Ph.D.
FL PY002131

Barry M. Crown, Ph.D.
Diplomate, American Board of
Professional Neuropsychology

Added Qualifications in
Rehabilitation Neuropsychology

Certified Addictions Specialist

Associate Professor of Translational Medicine
and Neuroscience
Wertheim College of Medicine
Florida International University

Electronically signed by Barry M. Crown, Ph.D. on June 20, 2024 at 2:05PM CDT

UNITED STATES DISTRICT COURT FOR THE SOUTHERN DISTRICT OF FLORIDA

Case No. 21-cv-21940-BLOOM/Otazo-Reyes

NEIMA BENAVIDES, *as Personal Representative of the Estate of Naibel Benavides Leon, deceased,*

Plaintiff,

v.

TESLA, INC. *a/k/a Tesla Florida, Inc*.

Defendant,

_____/

Case No. 22-cv-22607-BLOOM

DILLON ANGULO,

Plaintiff,

v.

TESLA, INC., a/k/a *Tesla Florida, Inc.,*

Defendants.

_____/

NOTICE OF TAKING VIDEO DEPOSITION DUCES TECUM

PLEASE TAKE NOTICE that the undersigned attorney will take the deposition, duces tecum, of the following individual:

NAME	DATE AND TIME	LOCATION
Dr. Barry Crown	**January 6, 2025 1:00 PM (EST)**	**U.S. Legal Remote Via Zoom *(link to be provided)***

DOCUMENTS AND ITEMS TO BE PRODUCED: Please see attached "Schedule A".

Upon oral examination before an officer authorized by law to take depositions in the State of

Florida, the court reporting service of **US Legal Support** will be present to record the above detailed depositions. The oral examinations will continue from day to day until completed. **These depositions are being taken Duces Tecum and Defendant's above specified retained experts are each required to bring with them all documents and materials specified in the attached "Schedule A".** This deposition is being taken for the purpose of discovery, for use at trial, or for such other purposes as are permitted under the Florida Rules of Civil Procedure.

SCHEDULE A

1. The entire file of documents reviewed by Dr. Barry Crown, including, but not limited to, correspondence, memoranda, notes, depositions, photographs, medical records, reports, and any other reference materials used or being relied upon.

2. Any and all reports prepared or furnished by Dr. Barry Crown in relation to this matter.

3. Any and all written correspondence by and between Dr. Barry Crown and Defendant's counsel in relation to this matter. Please include all formal letters as well as all email and text communications.

4. Any books, articles, literature, films, experiments, or any other materials which support the opinions of Dr. Barry Crown.

5. Any books, articles, literature, films, experiments, or any other materials which contradict the opinions of Dr. Barry Crown.

6. Dr. Barry Crown's current curriculum vitae.

7. Dr. Barry Crown's current testimony list.

8. Dr. Barry Crown's current fee schedule.

9. All billing documents, invoices, or other documents showing the total amount of money charged by Dr. Barry Crown., as of the current date in relation to this matter.

CERTIFICATE OF SERVICE

I hereby certify that on October 31, 2024, a true and correct copy of the foregoing was served via email to all counsel identified in the below service list.

/s/ Adam T. Boumel
Adam T. Boumel, Esq.

SERVICE LIST

Bowman and Brooke LLP 41000 Woodward Ave., Suite 200E Bloomfield Hills, Michigan 48304 **Whitney, Cruz, Esq.** **Thomas P. Branigan, Esq.** **Drew P. Branigan, Esq.** whitney.cruz@bowmanandbrooke.com thomas.branigan@bowmanandbrooke.com drew.branigan@bowmanandbrooke.com *Counsel for Defendant, Tesla, Inc.*	**Eaton & Wolk PL** 2665 South Bayshore Dr., Suite 609 Miami, FL 33133 **Attn: Doug Eaton, Esq.** deaton@eatonwolk.com *Co-Counsel for both Plaintiffs.*
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