DISTRICT COURT
COUNTY OF JEFFERSON
STATE OF COLORADO
100 Jefferson County Parkway
Golden, Colorado 80401

PEOPLE OF THE STATE
OF COLORADO

v.

WILLIAM ANTHONY MILNE

FOR COURT USE ONLY
Case No. 06 CR 3327
Division 3

REPORTER'S TRANSCRIPT

The hearing in the above-entitled matter commenced on May 23, 2007, before the HONORABLE JANE TIDBALL, Judge of the District Court.

This is a complete transcript of the proceedings had on this date in the aforementioned matter.

A P P E A R A N C E S

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I N D E X

FOR THE PEOPLE:

P R O C E E D I N G S

THE COURT: People v. William Milne, 06 CR 3327.

MS. EASTER: Dana Easter for the People.

MR. LOEWER: Ryan Loewer for Mr. Milne who's present with me at counsel table.

THE COURT: Good morning. This matter

comes before the Court for hearing as to the testimony of Jean McAllister.

Are you ready to proceed on behalf of the People?

MS. EASTER: Yes, Judge.

THE COURT: And how would you like to proceed? Did you intend to call Ms. McAllister?

MS. EASTER: Judge, I had hoped to call Ms. McAllister, but she is not here today. I'm going to have to rely on both her curriculum vitae, as well as the report. And I believe a copy of the report of her anticipated testimony was supplied to the Court.

THE COURT: I don't think so. Let me just check. I know what I have, but I thought it was more in the nature of a CV.

MS. EASTER: Judge, I did supply the Court with a CV.

THE COURT: Right.

MS. EASTER: The Court gave us a deadline to do that. And because Ms. McAllister is not here this morning, I think it might be better if I just summarized, very briefly, what her report indicates.

And I double-checked with Mr. Loewer this morning. He indicated that he does have a copy of that summary of anticipated testimony.

THE COURT: Okay. That's fine. Just one moment. I know I was just looking at those yesterday afternoon and this morning, what I have in the way of the CV. And I just want to have that in front of me,

because I apparently don't have it with the other items in the file. So if you could just give me one minute to get that.

MS. EASTER: Certainly.

THE COURT: Oh, I did have, on the front of the file, the second motion to request additional time to file specification of charges.

What's your position on that, Mr. Loewer?

MR. LOEWER: Your Honor, when we addressed that motion the last time we were present on this case, I expressed that it was imperative that I receive it as soon as possible.

We're nearing trial. And I'm at a position where I still don't know exactly what Mr. Milne --

the specifics underpinning the charges are at this point. And we are less than two months away from trial. And I'm still guessing and trying to formulate a defense and interview people.

And so I'm at a disadvantage right now, each day that goes by beyond that. I'm going to object to any further extension of time.

It's my understanding that it was due on the 18th. And for the record, today is May 23rd.

THE COURT: And there have been two motions for additional time, one through today, and then another one through June 5th.

MS. EASTER: If I could address the reasons, Judge.

THE COURT: You may.

MS. EASTER: One of the victims is involved

in graduation. I don't remember the exact particulars. But I will not be able to talk with her until May 31st. And the other victim is in route from Pennsylvania, driving, and I have not been able to contact her at all.

So it would be -- whatever specification of charges I provided at this time would really be meaningless. It would just be based a hundred percent on the discovery, which, of course,

Mr. Loewer already has.

In order for it to be a meaningful specification of charges, I really have to talk with the victims again. And I will not be able to do that until the end of next week. And that's the reason --

We still -- that still leaves five weeks until trial. And, frankly, the case law would support us going to trial on all of the events that the girls talk about. And we could even select our specified incidents at the end of evidence.

I think it's reasonable to do it ahead of time. And I think five weeks is plenty of time.

THE COURT: I'm going to order that you provide any specification of charges no later than June 4th.

And, Mr. Loewer, you can reserve any right to object based upon the specification of charges if it's something -- you know, if you believe the defendant will be prejudiced. So I will grant the second motion, but only through June 4th.

I do now have in front of me the CV of Ms. McAllister, which I have previously reviewed. And I guess, if you wish to just proceed with your offer of proof of the testimony of Ms. McAllister at this time, Ms. Easter.

MS. EASTER: I will, Judge.

MR. LOEWER: And if I might interject before Ms. Easter does that?

THE COURT: You may.

MR. LOEWER: Your Honor, it's my position that the district attorney has the burden here. I'm a bit surprised, and perhaps Ms. Easter is as well, that Ms. McAllister isn't here to subject herself to direct and cross-examination, not for my benefit, but for the Court's benefit, to be able to make an accurate and detailed ruling, which is required in Rule 702 that we're dealing with here.

I don't want a situation where if the Court finds that the district attorney hasn't met their burden and the Court is wavering, that they open up this to later testimony, or later offer of proof.

And so my position now, is that Ms. Easter proceeds at her own peril, and that that is a final order by the Court if they don't meet their burden.

THE COURT: Okay. Well, I will consider that position.

Ms. Easter, why isn't Ms. McAllister here?

MS. EASTER: Well, Judge, I spoke with her the last time I was in court on this case. I spoke with her afterwards. And she was -- had already

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accepted a commitment in Lake County.

And I was not -- and frankly, I was not clear with her, and did not get back with her. And it's really my responsibility about whether or not she was going to be able to come here on her way up to Lake County.

And -- however, I will tell the Court that I think that we have more than enough evidence in her -- in the summary, as well as -- which I'll make an offer of proof about -- as well as in her curriculum vitae.

And she -- I can tell the Court that she has testified as an expert in most of the district court rooms in this county, and many others, and has a very impressive resume of experience.

And I have personally known her since 1989 and have heard her testify as an expert ever since then.

THE COURT: Okay. But I think -- well, in any event, I think, under the circumstances, that we just need to proceed and we'll see how it goes.

MS. EASTER: All right. And so, Judge, if I could just have a moment -- can I have just a moment, please?

THE COURT: Yes.

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MS. EASTER: Actually, she is here, Judge.

THE COURT: Okay.

MS. EASTER: And I'll go ahead and call her to the stand and have her testify about both of these things.

(The witness was duly sworn.)

THE COURT: Please be seated and state your name for the record.

THE WITNESS: My name is Jean McAllister, M-c-A-l-l-i-s-t-e-r.

THE COURT: Go ahead, Ms. Easter.

DIRECT EXAMINATION

BY MS. EASTER:

Q Ms. McAllister, what is your current occupation?

A I am currently primarily a consultant and trainer in the area of interpersonal violence.

Q All right. Including sexual assault?

A That's accurate.

Q All right. And in this particular case did you provide me with your curriculum vitae, as well as a summary of anticipated testimony?

A I did.

Q All right. And just so you know, your curriculum vitae has been provided to the Court, but

I do want to ask you a couple of questions about that.

First of all, what is your educational background?

A Educationally I have a Bachelor's degree in Sociology from the University of Northern Colorado. And a Master's degree in Social Work from the

University of Denver.

Q And have you treated victims of trauma, including victims of sexual assault, over the course of your profession?

A Yes, I have. I've provided child protection investigations. Initially, I worked in residential treatment with adolescents. I worked as a program supervisor and caseworker at Gateway Battered Women's Shelter, where we dealt with the entire family. So adults and children who -- many of whom had experienced some sort of sexual assault, about 40 percent of those clients had.

I spent eight years as a psychotherapist at the Assault Survivor's Assistance Program at West Pines Lutheran Medical Center. And we were primarily a trauma treatment program.

Q And what were those eight years? What year did you start and end that?

A I left in '97. So it would have been '89 to '97. I actually have my CV, if I need to refer to it.

Q Okay. I won't ask you any more questions about years.

Did you -- have you -- since you left the Assault Survivor's Program at West Pines, have you done any other counseling over -- since 1997?

A Yes. I -- periodically I'm called in, sometimes by the Colorado Organization for Victim Assistance, to do some of those things.

I responded fairly extensively to the shootings at Columbine High School. And then I was asked to provide supervision and training for the victim advocates who responded to the families for the first year following those shootings.

I was called and asked to coordinate victim services for the incoming evacuees to Colorado from Hurricanes Rita and Katrina.

And have done intervention, periodically, with people who experience secondary trauma from being exposed to working with sex assault victims or other kinds of trauma. So periodically I do some.

Q All right. But you were involved with Columbine -- it's primary and secondary victims --

for over a year?

A Yes.

Q Have you -- in terms of training that you have provided, could you give us the highlights of the training that you've conducted, say, in the past ten years?

A I have -- it's one of the primary parts of my work history. I have done extensive training in the arena of sexual assault, sexual assault victim response, extensive training in sex offender dynamics and management.

And some of that -- initially I was doing training through the -- if we're looking at about ten years ago -- through many of my relationships with the Assault Survivor's Assistance Program.

So I was training medical practitioners,

other psychotherapists, people who do victim advocacy -- primarily those kinds of people -- about appropriate interventions for sex assault victims and appropriate treatments.

When I worked at the Sex Offender Management Board we -- a substantial portion of what we did was to do training with professionals who might interact with sexual assault cases anywhere along the continuum, from victim services and initial

reporting -- like child advocacy centers -- through convicted offender management. So I did substantial amounts of training in that arena as well.

And we always included victim information in those trainings. We approved sex offender treatment providers for those who were intervening with offenders as required by law, postconviction.

And part of the requirement was that they have training in, and understand victim impact, what happens to primary and secondary victims as a result of what they do and what victims need to recover. I've done that extensively.

I have worked with the American Prosecutor's Research Institute in the National Judicial Education Program to do training in sex assault and domestic violence intervention.

I work with the Ending Violence Against Women training team, which is an interdisciplinary team that addresses sex assault and domestic violence.

I have recently done training for the Air Force in sex assault intervention and developing their sex assault response. A substantial amount of work with the advocates on Buckley Air Force Base. I did some of the initial leadership training at the

Air Force Academy after the scandal broke there.

So just a range of different kinds of training and populations that I train over time.

Q All right. But is it fair to say that you -- a lot of your training has involved training other professionals, including physicians, psychiatrists, psychotherapists, and other professionals?

A That would be accurate.

Q All right. I want to turn now to the summary of anticipated testimony that you provided to me for this case. Do you have that in front of you?

A I can have that in front of me right now.

THE COURT: I do not have it, Ms. Easter. Do you have an extra copy?

MS. EASTER: I will give you my copy, Judge.

THE COURT: Well, I can get a copy made real quick.

I knew I'd seen it. And the reason -- so it's attached to the objection filed by Mr. Loewer. I just don't have it separately. So I do have it now. But in any event, my clerk is making a copy.

MS. EASTER: Thank you.

THE COURT: You can proceed if you can

without it, and otherwise I'll have a copy and you can wait until you have a copy.

Q (By Ms. Easter) Ms. McAllister, in your summary of anticipated testimony, do you break that down into several topic areas?

A Yes, I do.

Q And is one of the topic areas, what you talk about, the people's responses to trauma, just generalized trauma?

A Yes, it is.

Q And let me just ask you, what do you base -- where do you draw the information from for that part of your summary?

A Well, the initial information that I got about trauma was observing clients and people that I intervened with in over more than 25 years of working with people who are victims of differing kinds of trauma.

I also have received training from a number of different professionals and researchers who study trauma.

And there is a relatively large body of research information that was initially developed by Judith Herman, who's a medical doctor, who is on the faculty at Harvard Medical School and Cambridge

Psychiatric Hospital, who did some initial research on common reactions to trauma, and particularly women

and children who have been abused in the home.

I also -- the trauma research was then greatly expanded by Bessel Vandercolk (phonetic) who is a medical doctor who does medical research at Harvard Medical School, who looked at the actual biophysiology of trauma.

And I have attended trainings that he has given, and have read a substantial amount of information in this arena; Rothschilds, Foa, (phonetic), other people have followed that information.

But basically there is a large body of information that's been replicated since the mid-nineties that addresses common human reactions to trauma, both psychologically and physiologically, how it changes brain chemistry, how information is stored.

And there are just a range of pieces of information across the research literature that support what many people who were doing treatment for years observed. But now we understand how that actually works.

Q And just as a general question, did your

study of Judith Herman and Vandercolk and the work of others in this area, did it validate the observations that you personally made in your clinical practice?

A Absolutely, it did.

Q All right. Just briefly, how would you summarize what are victim's responses to traumatic events?

A Okay. I will try to do this briefly. And tell me if I speak too fast. I sometimes do.

Essentially, trauma is identified in the psychological literature as an event or series of events that are so powerful, harmful, threatening or severe, that they overwhelm the existing coping mechanisms of human beings and require extraordinary coping skills.

What that means, essentially, is that there is perceived, sometimes threat, and sometimes just intense overwhelm of someone's capacity to cope.

And we initially thought it had to be a physical threat against a human being. We now understand that a physical threat to bodily integrity is not necessarily a component of the trauma response; that this response can be engaged whenever someone experiences an event such as I just described.

There are actually two kinds of generalized reactions that all human beings are found to experience. One is the set of extraordinary coping mechanisms, which I just described. And those are basically three things. There's the set of anxiety responses, or the responses that tell the human being that something wrong.

You see those accompanied by hyperarousal. There's usually some physiological distress indicating that people feel at risk, or are in danger, or need to do something because something bad

is happening.

It's very akin to what pain does when there's a physiological injury. It warns the human mechanism that something is wrong.

The other set of responses that is concomitant with that is what's called the dissociative responses during trauma. These are normal and adaptive. And the dissociative responses means that people compartmentalize or distance themselves from all or a part of their reaction to an event.

And the purpose of compartmentalizing is to give people some distance so that they don't absorb the full impact of the overwhelming negative event.

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It's very similar to what physiological shock does when there is a physiological injury. Physiological shock drops blood pressure, heart rate, body temperature. And it allows the body to be injured without absorbing the full impact quickly, and protects the body from being harmed as much. People don't bleed to death as quickly, those sorts of things.

Disassociation serves the same function psychologically. It protects us from going crazy because we're so overwhelmed by the negative event.

Those are accompanied by what are called affective responses, or very strong emotions, typically negative, that often are experienced by victim survivors of trauma.

During traumatic events those things are

normal and adaptive, because they inform the brain, literally, that there's a risk, and that the body needs to behave differently.

In our typical vernacular we have called that the fight or flight response. However, what -- one of the things that the research on trauma has contributed, really beautifully, I think, is that there really are three primary reactions to trauma in human behavior.

There are four across all the animal kingdom; fight, flight, freeze or faint. We don't typically see human beings fainting. And so we don't incorporate that as often.

But, essentially, what happens, is that our brain decides that we are in that position where we're experiencing trauma. It basically stops our access to the cortex, or the part of our brain that does cognitive processing, language, thinking, those kinds of things.

And often, most of the information is processed through the more primitive part of the brain or the amygdala. And what happens is the brain wants someone to react very quickly in a very limited repertoire when there's a perceived trauma.

And one of the options is to try to flee. One is to try to fight and get away. The third is to freeze. And some of that is because our biology is really based on literally hundreds and thousands of years of being attacked by large predators.

And one of the most protective things you can do when a big animal is after you is to not move, because large predators won't eat dead things. And some large predators will actually not be able to see someone if there's not movement.

We use those to cope. Whether or not the threat is a large predator, our biology behaves the same way.

So what you get is people who, if they perceive they might be able to get away, may attempt to do so. But that needs to be a very quick judgment.

Typically, in cases of sexual assault, in my experience, people are not often aware that something bad is going to happen, because most people know their offenders.

Most offenders are not a scary person who jumps out of somewhere with a gun, which is, unfortunately, what most of our culture believes. But that's not the most common scenario.

So most people are not really aware that they may be needing to get away or to fight, until after they're already at fairly serious risk. So we see a lot less of that in non-stranger sex assault.

And the third function is to freeze or to in some way stop reacting and just try to survive through the event.

And what we know is that when people are exposed to trauma over longer periods of time, it's much more likely that that is the primary coping

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response they will use over time.

Q Did you experience that? Did you hear about that in your practice, the freeze response?

A Over and over and over again you hear people say things like, I felt so stupid because I thought I should be doing something. I thought I should be saying no. I felt like I wanted to fight, but I just couldn't. I just sat there. I don't understand why I just sat there. I went with him again. I don't understand why I did that.

And even children, or people who are under the control of someone else, will make those kinds of statements about their own response.

Some people describe things like, I felt like I was watching myself, which is freezing accompanied by the dissociative coping skill.

Some people will be able to describe, very vividly, some minor details of something around them, and not very vividly what happened during the assault. That's also typically a dissociative response. So that's a very common response with people who survive trauma.

The other thing that we know about --

Q Can I stop you real quick?

A Yes.

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Q Would you spell amygdala, because I think it was the only word that was difficult.

A A-m-y-g-d-a-l-a.

Q I'm sorry. Where did I stop you? You were --

A I was going to talk about -- the other set of information that we have learned about trauma is how the brain functions. And it -- as I said, it functions differently.

It provides chemistry. It dumps chemicals into our system when we experience trauma that allow that different brain function, that allow the amygdala to be the primary place that functions.

People call that the fear center of the brain, and that cut off some of our access to the more traditional cognitive abilities in our brains.

So what has been identified is that information that we experience, normally is what is stored after people develop whole language.

So after they're past being young toddlers and able to speak in complete sentences and understand language and have meaning connected to their language, it's what we call narrative semantic and symbolic. That means it is composed of words, language. It has a time line, a story. And people

understand how that story and that time line connect together.

It's what you call social and adaptive, which means we understand how much of it is appropriate or inappropriate for other people to want to hear about.

It's -- it can be shortened or lengthened.

Our response -- it's called -- it can be condensed in time. Our response or discussion or thinking about it -- we can think about it for one minute or for 20 minutes, depending on what we want.

And it's under our voluntary control for recall. Which means that we can typically pull it up. We might have to think about it for a minute, but we can go through the files in our brain and pull it up and say, I want to think about this. And if something else happens, we can put it away and not think about it.

What we know about how traumatic memory is stored, it's stored in the amygdala. It's stored not as language and typical narrative memory, but as images, physical sensations, affective states or feelings, and behaviors or behavioral states.

And kind of a classic example of that is, for instance, a vet coming back from the Iraq war.

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On the 4th of July might be having a picnic in the backyard with his family. He knows he's home from the war and he's not in danger.

But if the kid next door sets off a firecracker, the sound, the physical sensation of that firecracker and the smell of gunpowder are very likely to cause that vet to experience immediate terror and to dive under the table.

Because he has a behavior that's attached to how he coped with being bombed or shelled in the war, that was protective. So people literally don't

think about things like that.

You also see things not stored -- connected to a typical timeline. People may describe something that is very vivid to them, and it may not be in the order that we think it would be in, or they may not be able to put it in an order.

I've literally worked with people who told me that their car was struck by a bus and a truck. And they couldn't tell me which one hit their car first. The content, the vivid memory of what happens, is very valid.

The reason why it's not connected to knowledge about how it happened is because of how it's stored. They don't have that cognitive capacity

to evaluate it until, over time, people can sometimes integrate that trauma and make sense out of it, but...

Q How does that relate to, say, an adolescent who was subjected to repeated inappropriate touchings, which her body perceived as traumatic events? How would that relate to somebody's ability to recall those, particularly in a given sequence or in a time setting?

A Well, what we know is that information that is stored traumatically is not subject to voluntary recall and dismissal. It can be triggered by reminders in the environment rather than pulled up voluntarily.

And sometimes it's dissociated or compartmentalized. And somebody can even be asked

something and not have access to that information.

And it's typically experienced by the person who's experiencing it, until it's integrated into the cortex as emotionally valid, or as intensely distressing as it was at the time that it happened.

What that means is that people typically report sexual assault, or any other sort of trauma, in fits and starts. They will tell you a little bit.

Most adolescents actually do what's called

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accidental disclosure. It's rare when adolescents actually call up the authorities, or go to a rape crisis center, or go to a school counselor and say, I was sexually assaulted.

Often it will come up when they've heard or seen something that reminds them of what happened to them. They often will tell a trusted person that they know that something happened to them, and they'll say a little bit about it, but they won't tell the whole story.

And part of that is related to how trauma is experienced. Part of it is also related to shame and humiliation and distress that they feel while they're talking about it.

The research literature that looks at adolescents actually says that we should look at disclosure as a process rather than as an event; that we should not expect kids of any age -- and we don't expect this with adults either -- to have a specific time line with great detail.

But that what's more consistent is that we're looking for the content of what's called the central theme, or what actually happened to them, and whether, over time, that makes sense for them.

Typically people report those things that

are more distressing, later with sexual assault. And I saw that very consistently; that people will tell a little bit about what happened. Often they tell someone who they trust, whether it's a friend or a family member, a little bit, and that person says, oh, this was bad. You need to tell somebody. And that will precipitate a report. That is actually the most common report that you get from anyone about sexual assault.

People typically believe that sexual assault or other traumas will be immediately reported post-trauma. And we have research, clearly, that indicates that only about 16 percent of sex assault survivors ever report to anyone.

Now, there's a range in the national research that runs from about 20 percent -- 18 to 20 percent, to less than 5, depending on the age of the victim, how close the perpetrator is in relationship to the victim, and how much power that perpetrator has over the victim.

The younger the victim, the less likely they are to report immediately post-assault. The most common reporting scenario is substantially delayed after assaults have happened.

And actually we have -- when I was working

with the Colorado Coalition Against Sexual Assault on public policy, we actually recommended extending statutes of limitations laws on child abuse reporting, because there's very clear research that the most common age for reporting child sexual abuse is 26 to 27 years old. Kids don't report when they're home very often, unless it's done accidentally.

Q In your experience -- well, is it fair to say that most lay people do not have an understanding of delay in reporting, of why people -- children or adults -- delay reporting sexual trauma?

A That's accurate.

And, in fact, there is research, initially starting with some of the early work that Burgess (phonetic) and Holstrom (phonetic) did; Mary Cox (phonetic) identified this in her research; Dean Kilpatrick in Rape in America, which was a massive national random sample study; and the studies that have been done on interpersonal violence, intimate -- violence by intimate partners, nationally funded by the Centers for Disease Control; and our own Colorado Behavioral Health survey, all indicate that there is misinformation in the general public about sexual assault in many ways.

We typically believe that sex assaults are committed by strangers; that there is serious

physical injury; that victims immediately report; that we can observe serious physical injury when they happen; and that if you don't have serious physical injury, people are not traumatized.

And all of those things are what we call myths about sexual assault. And, actually, people in the sexual assault field teach information that is accurate about sexual assault, both to the general community, but to other professionals as well.

Because there is strong indication that people have less clear information about sexual assault, sexual assault victims, and sex offenders, than they do about any other set of crimes and criminals.

Q Would you -- let me just ask you this: Is there a myth about the effect of sexual assault on children and adolescents, just that there should be a very dramatic effect?

A Absolutely.

Many children, after initial trauma, appear to be what we call asymptomatic; i.e., they don't look really disturbed or distressed to people who are seeing them outside of themselves. And people

typically think that means they weren't harmed or hurt in some way.

What we know about children is that because the dissociative response is often very strong, because children are often abused or assaulted by people that they know, they will not deal with the issue. They will try to not think about it, not feel

it. They will try to ignore it. And many times they are successful in that for periods of time.

When you look at the research literature about long-term negative effects, what you see with kids is that the negative impact emerges developmentally.

We see kids developing difficulty over time, and developing problems over a long period of time. And what seems to happen is that they -- as they approach each new developmental stage and they have a better understanding of what happened to them, their reaction can become more harmful over time, actually.

So you can see a kid who's been sexually assaulted who people around them would say, this kid looks fine, who may develop serious trouble with anxiety, or intrusive thoughts about the assaults, or school trouble, or behavioral problems later on. And

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that's actually a fairly common presentation in sex assault.

It accompanies the kind of information that I talked about earlier, which is identified, that we should -- we should view children and adolescent disclosures as a process that goes through no disclosure and no response; passive disclosure, which is that accidental kind of thing that I told you where something may come up, they may share something with somebody that they didn't really mean to tell; and then active disclosure, which is where they can

actually think about, talk about, and deal with what happened to them, and that kids go back and forth among those stages.

And so you may see, actually, worse problems emerging, after a report, than you saw immediately after the assault. Partially because they are, maybe, having more impact, because they're ability to compartmentalize or not deal with the information is having more difficulty -- is having more impact, because they're being forced to deal with the information.

Q Ms. McAllister, I'm going to call that -- fair to say that's a very rough summary of what you provided us as a summary that's even further

condensed?

A Yes, that's accurate.

Q Okay.

MS. EASTER: Thank you. I don't have any other questions for you now.

THE COURT: Okay. Mr. Loewer --

MR. LOEWER: Yes.

THE COURT: -- cross-examination?

CROSS-EXAMINATION

BY MR. LOEWER:

Q Good morning.

A Good morning.

Q Ms. McAllister, do you know what case you're currently testifying in regard to? Do you know the --

A The name of the case is Milne, I believe,

yes.

Q All right. And do you know where Mr. Milne is?

A I do not.

Q Can you tell me specifically why you are being -- what's your understanding of why you're being called to testify in this particular case?

A My understanding is that this was a case of sexual contact with a child or adolescent; and that

there are some issues that are typical of sexual assault in those cases, but which may not be generally understood by people who would be involved with the case or by the jury.

Q Okay. Can you be any more specific than that?

A Not much. I know that -- I'm trying to think what I know. I don't think I have really much more information than that. I have very little information about the actual facts of the case.

Q All right. You've been -- you've previously testified before as an expert, correct?

A Yes, I have.

Q You've testified in areas of sexual assault?

A Yes.

Q Specifically sexual assault on victims and the symptomology they present?

A That's one of the areas, yes.

Q You've testified, then, as an expert in

other areas, such as impact of domestic violence, right?

A That's accurate.

Q And specifically symptomology presented by the alleged victims of domestic violence, yes?

A That's correct.

Q All right. You've also testified in other areas, right?

A Yes.

Q What other areas have you testified in?

A Several times I've been qualified in either sex offender dynamics, or sex offender management, trauma, victim trauma, domestic violence offender behavior.

They're generally in the area of sexual assault, domestic violence, and trauma. And the language around that is -- it varies, depending on sometimes who's trying the case, I think, as much as anything.

Q Fair enough.

You've also testified as an expert with regard to memory loss as it relates to trauma?

A That could be the way someone has framed my testimony. I -- and it's possible that a judge found me as an expert in that arena, but I am not -- I'm not saying that hasn't happened. That's not typically how I would ask to be qualified if I were asked. But I do testify about how memory is impacted by sexual assault.

Q All right. Ms. McAllister, you have your

MSW from DU; is that correct?

A That's correct.

Q You got that in 1993?

A That's correct.

Q And in 1993, DU stopped having a concentration as part of their MSW program; is that right?

A I think after our class they stopped the incoming class in '93. We still had concentrations when I was in school.

Q You concentrated, then, in child and family; is that right?

A I concentrated in clinical, which means direct practice, therapeutic interventions. And I addressed both -- I took courses in the clinical concentration in child and family, child intervention, adolescent, and adult intervention.

Q Is it fair to say that not all people with a concentration or focus in clinical social work become clinical social workers?

A That's accurate.

Q Some do become clinical social workers?

A That's accurate.

Q Those that are clinical social workers don't necessarily have to be licensed to engage in

some sort of clinical practice?

A That's accurate.

Q Do you have a license as a clinical social worker?

A I do not.

Q Okay. And so since your graduation in 1993, you've been practicing as a clinical social worker, not licensed as a clinical social worker, right?

A Yes.

And, actually, the State identifies that practice, while I was practicing primarily as a psychotherapist, as an unlicensed psychotherapist.

Q All right. How many classes in psychology did you take as part of your education at DU?

A I would have to go back and check that. There are -- the concentration in social work required that about half of our course work was required -- standard requirements across the board, and some of that was in clinical practice.

About half of it was in our area of concentration. So somewhere, I believe -- we had quarter hours, so probably somewhere around 90 hours.

And then my internships we had 20-hour-a-week internships. And both years in

graduate school were in direct practice, as well. And I was able to do those through the Assault Survivor's Assistance Program.

Q And in your studies at DU -- it was a two-year program, correct?

A Yes.

Q None of your professors were psychologists,

right?

A I believe not. I think I had clinical social workers who were both doctoral candidates, Ph.D.s and Master's level clinical social workers.

Q How does one become a licensed clinical social worker?

A You have to practice for a certain number of hours under supervision. It used to be around three thousand and some. You take an exam. And that's basically -- and if you pass the exam and have hours that have been supervised, you become a clinical social worker.

Q You didn't take any specific classes with regard to the dynamics and grooming of sex assault victimization between older men and teenagers, did you?

A I did not. There were actually very few classes about sexual trauma at all at that time.

I have done a lot of work, and attended a lot of training in that arena when I ran the Sex Offender Management Board, and also when I was at the Assault Survivor's Assistance Program.

And we developed a family reunification assessment program, did extensive training with Jan Hineman (phonetic) and some other people who looked specifically at child sex offender behavior and how they groomed families, and the kinds of things you need to look at if you're thinking about allowing contact in the long run.

So I've done a lot of study in that arena, but did not do that study in my graduate program, because it wasn't available.

Q Then post-graduation -- so we're talking post 1993 after your graduation from DU, I take it you haven't received any other formal certifications?

A I actually believe that my EMDR, which is eye movement desensitization and reprocessing certification was -- I think that was post '93. That's a trauma-specific treatment. And I have a Level II certification in that.

Q Ms. McAllister, nothing in your curriculum vitae references anything with regard to grooming, does it?

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A No. It wouldn't say "grooming" as the primary behavior. That is a subset of sex offender behavior.

My years managing the sex offender program, we looked at that behavior extensively. The sex offender research and literature looks at that behavior. But that's not how I would list my experience. I would list it as sex offender management.

Q Do you agree that your primary experience, then, specifically regarding grooming, deals with your experience as a clinician?

A I would say it -- it is both my experience as a clinician, and my experience with the Sex Offender Management Board, where I worked setting standards for how offenders are managed

post-conviction.

I was responsible for being the staff person who ensured that those standards were well grounded in the research on sex offender behavior, both -- both undetected sex offenders and post-conviction; and worked extensively with people who worked with offenders, and participated in research done by our division of criminal justice looking at offender behavior.

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So I would have to say part of it is clinical direct practice, experience. And part of it is really ongoing policy development based on research in sex offender management.

Q When you --

A So it's both.

Q Sorry to interrupt.

When you referred to this research, you didn't have any direct participation in this research that you're referring to?

A Actually, I did. I was not the lead investigator, but I served on committees that developed research in Colorado. We had several grants through our division of criminal justice that did research on convicted offenders.

I worked with the division of criminal justice very closely, because our sexually violent predator risk assessment format was developed in collaboration with the Sex Offender Management Board when I was the program administrator.

So I participated in gathering information. I read files in the prisons. I interviewed sex offenders. And I went around the state and interviewed people who were working with sex offenders to develop some of the information that

went into that research.

So I participated in a number of studies, sometimes by sitting on advisory committees, sometimes by actually participating in helping to gather information. And then by using that information to develop policy of the sex offender management board level.

Q Now, you mentioned grants. How are you currently funded, Ms. McAllister?

A Typically I am paid for whatever I'm asked to do. So right now I'm paid to come in to court the standard hourly rate that --

Q By whom?

A By the prosecution, the State.

Q All right. Have you ever been funded by anyone other than the district attorney, victim's assistance associated organizations?

A When -- do you mean ever? Because the Sex Offender Management Board was entirely funded by the National Institute for Justice; initially a federal grant, and then was funded by state dollars. Almost all of the programs that I've ever worked with have been funded by state dollars.

The Assault Survivor's Assistance Program was funded by Lutheran Medical Center. We had a

small victim assistance grant, but it was relatively tiny compared to our costs. So I've been funded by a number of different -- and there were a number of different situations by a number of different places.

Q Ms. McAllister, each time you've testified as an expert, you have testified on behalf of the prosecution, correct?

A Yes, that's true.

THE COURT: Mr. Loewer, I think this is really on the periphery of a Rule 703 analysis. And I need you to focus on what I need for that determination.

MR. LOEWER: Understood, Your Honor, but I was going into the credibility of the witness for purposes of her testimony.

Q (By Mr. Loewer) Ms. McAllister, to the extent that you participated in research or have observed things clinically, have you always had contact with the individuals that you are forming some sort of opinion on?

A If I formed a specific opinion about an individual, I would have had direct contact with them.

When I did child sex abuse investigations and child protection investigations, I met with

offenders and with victims and with many other people involved with families.

When we did family reunification assessments or family treatment, when I was at the Assault Survivor's Assistance Program, we always met with people who were identified as offenders.

So, yes, I have always -- if I form a specific opinion about a person, I would always have had contact with that person.

Q And that extensive face-to-face contact was necessary so that you might be able to rule out certain things that might skew your observations, right?

A That's accurate.

Q Because you might need to address certain things, such as whether or not someone is presenting certain symptomology because of other organic mental disorders?

A That's one of the things you might look at.

Q Because something such as schizophrenia might present such similar symptomology?

A Similar symptomology to --

Q Well, let's talk about the symptomology that you've discussed so far; such as, you discussed avoidant or numbing symptoms?

A Yes.

Q Okay. You've discussed hyperarousal?

A Yes.

Q And then you've discussed freezing. Okay?

A Yes.

Q And those are the larger sets. And then within those there are subsets, wouldn't you agree,

of certain experiences or presentations of symptomology, such as lack of emotion, acting out, nightmares. Would you agree?

A You missed the intrusive symptoms, that are the anxiety-based symptoms, in your overview. But, yes, if you include that, the fluctuation between those two sets of symptoms post-trauma is an indicator of trauma.

Any individual symptom on its own, absent any other symptoms, is not -- would not be an indicator.

Q Try and -- thank you for answering my questions, but try and focus specifically on my questions.

I asked you if now that we've established, sort of, what this symptomology is we're talking about, would you agree that such organic mental disorders, such as schizophrenia, would present some

of the symptomology consistent with someone who, in your opinion, has been a victim of sexual assault?

A Depending on the type of schizophrenia, some of those individual symptoms, in different combinations with other symptoms, might be present. Not in the same exact formulation that you would see in sexual trauma, unless you have somebody who's been traumatized, and is also schizophrenic, in which case you might have a comorbid condition.

But you might see some individual symptoms in someone who's schizophrenic. But the combination

of symptoms would not be the same and would not look the same in presentation.

Q All right. Would your answer be similar, then, with regard to an organic situation for having bipolar illness as opposed to schizophrenia?

A Yes. You might see some similar behaviors or symptoms. The combination, how they operated over time, the -- what we would call total presentation, would be different, which is why you need to look at the whole pattern and not just individual symptoms.

Q Is your answer "yes" then?

A Yes.

Q And it would be, then, a similar answer for substance abuse, something not necessarily organic.

But substance abuse might lead someone -- might lead to similar symptomology that we're discussing, right?

A In some cases. Substance abuse is probably a little -- in some cases that's possible.

Q All right. Now, your testimony -- or as you have testified as an expert before, normally you have not had face-to-face contact with the person you understand to be the victim?

A That's correct. That's rare.

Q You've not had face-to-face contact or any sort of interview or examination of the person you understand to be the alleged perpetrator?

A That's accurate.

Q And so what you are doing, then, is presenting -- given hypothetical behaviors, you're essentially saying whether or not it's consistent

with what your experience is?

A Primarily what I do -- I can do that. I am sometimes doing that. Primarily what I do is provide general education about whatever topic I'm being asked to testify in regard to.

Q But you would agree that normally your testimony is that you are presented with hypothetical symptomology, and then you're asked to determine whether or not that's consistent with your experience

of individuals you understand to be victims of some sort of trauma, or specifically sexual assault?

A That is a piece of the testimony sometimes, yes.

Q Now, are you licensed to dispense medications?

A I am not.

Q Okay. But you do, sort of, set up a treatment plan for the people that you see, correct?

A Yes, I have.

Q And you don't -- you make sure that if you set up a treatment plan, that you meet this person face-to-face and you have a detailed conversation with with them, right?

A Yes. And, actually, you would have more than one conversation with someone that you were setting up an extensive treatment plan for.

Q Because if you were, then, just provided a piece of paper with certain symptoms and just set out a treatment plan, it might lead to error or vast

assumptions on your part, right?

A That's accurate. It's unethical to diagnose someone you haven't met.

Q Have you ever treated someone -- well, let me ask you this: Is the normal situation, in your

clinical practice, that you're presented with a patient or a client who you understand to be a victim of some sort of trauma?

A In some settings that was accurate. In some settings people were referred who had presented with relationship problems, or eating disorders, or substance abuse problems, and another professional made a referral, even though the person wasn't presenting saying they were traumatized, and asked us to evaluate.

It was very common for psychiatrists, in the hospital at West Pines, to ask us to see their patients to assess whether trauma might be one of the factors that was contributing to the need for hospitalization, even when patients weren't initially presenting saying they had experienced trauma.

So I've done both. I've treated people who present saying I've experienced a trauma, and I have worked with people who do not present saying that.

Q Your clinical focus, once you understand someone is -- in your understanding, a victim of trauma is to, then, treat that trauma or help them cope with that? Yes?

A Yes.

Q Okay. Your job has nothing to do with

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determining whether or not they were actually a victim of some sort of trauma?

A Only to the extent that if -- I was responsible, at times, for identifying that somebody who presented saying they had trauma, who was not traumatized -- because your responsibility is to treat what the actual issue is, as a clinical social worker or any other person who provides psychotherapy.

So there were times when I identified people who had presented saying they'd been traumatized in some way, and was able to identify that they hadn't.

Those people needed to be treated for other issues. And that's rare, not very common, but it does happen. And to the extent that I -- I don't investigate or do the kinds of things that somebody in a criminal justice setting might do. But I do have some responsibility to assess whether reports that clients give me are accurate and based on reality and those sorts of things.

Q Okay. Do you ever deal with any sort of control group; a group that you might not know whether or not they are actually a victim of trauma, and then you're presented with this individual, and

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they're telling you that they are, and then you are then to set up a treatment plan?

A I don't know what you mean by "a control group."

Typically in -- you're talking about research and then clinical practice. And they're typically two different settings. Yes, I have seen people who are not saying they present with trauma.

Q Let's focus this, then, between the two.

A Okay.

Q You said you've participated in particular types of research?

A Yes.

Q Have you ever dealt with a control group with regard to your research participation?

A We have had control groups that -- much of the work that we've done either had control groups involved, or previous research had determined information about what control groups look like.

The strongest research will look at what --

Q I'm going to interrupt you. I'm sorry.

Would you focus on whether or not you participated with a control group, or was there a control group presented to you where you didn't know whether or not they were actually victim of trauma?

A I have not -- you're setting up a situation that I've not experienced. I've not had someone present me with a control group and say, did these people have trauma in that in way, no.

Q So your answer is "no" then?

A To that question, which is not typically how control groups work, so it's only an incomplete

answer.

Q I would ask you to focus on my question.

A I will, as long as I can be honest. I gave a pledge here to testify to the whole truth. It would not be an accurate answer if I just said no without explaining that's not how control groups work.

Q Ms. McAllister, I'm going to interrupt you --

MS. EASTER: Judge, I'm going to object to this.

THE COURT: Wait. Wait. You can't both talk at the same time.

Finish, Mr. Loewer.

MR. LOEWER: I'm not trying to be mean here. She may respond in further detail on redirect examination. I asked Ms. McAllister -- I mean, we're getting narratives here. And I'm trying to focus

this in here.

THE COURT: The objection is sustained. Ms. Easter, you can address it on redirect.

For purposes of this hearing, Ms. McAllister, please answer the questions posed by Mr. Loewer to the best of your ability.

THE WITNESS: Thank you, Your Honor.

Q (By Mr. Loewer) Again, I'm not trying to be difficult here, Ms. McAllister.

Now, we focused on your participation with scientific research. Now, your participation or your

experience in the clinical field, are you ever presented with any sort of control group?

By that I mean specifically, you being presented with a group of individuals who may tell you they are victims of trauma, but, in fact, there is someone behind the scenes who understands that, in fact, they are not victims of trauma?

A In my clinical practice, no.

Q All right. Ms. McAllister, are you aware of some sort of -- just in the general population -- are you aware of the base rate of abuse? Meaning, the percentage of people out there who it's been determined are victims of some sort of trauma? Let's discuss that.

A I'm aware of research that's been done on that, yes.

Q Okay. And are you aware of what that rate is?

A The -- and are you talking about any trauma, is that -- or are you talking about sexual abuse?

Q Very good question.

Let's talk about trauma from sexual abuse.

A Base rates for exposure to any kind of -- even a single incident, one-time, very minor incident -- exposure to sexual trauma, the research indicates that one in probably five females, and one in -- in Colorado -- one in 17 males have some exposure to some -- at least one incident of sexual trauma at some point in their life, no matter how

minor.

And that's based on large random sample research that is -- like the behavior health surveys that the health department do, and large studies with random samples that look at large samples of people who don't report initially.

Q Ms. McAllister, of that one in five females -- let's focus on -- are you aware of the percentage of that one in five that present

symptomology of experiencing sexual trauma? And by "symptomology," I'm again referring to the three categories that you referred to?

A I am aware of some research that looks at those issues.

Q Do you know the result of that, what percentage that is?

A Some of the studies that I've looked at indicates that upwards of 80 percent of people who experience sexual trauma experience what's called negative sequela, or post-trauma symptomology.

That is unusually high compared to other trauma. About a third of people who experience any general trauma experience one determinative negative sequela.

Q So to be specific, what you're aware of is the general population -- again, we're not just focusing just on females, right?

A Right.

Q Then let's focus on that -- you said one in

five females are victimized, even in some minor way, sexually?

A Yes.

Q Let's focus, then, on those five females who aren't. Are you aware of any studies that deal

with the percentage, if any, of those five females that present symptomology consistent with being a victim of some sort of sexual trauma?

A There are -- there are studies that I know of that compare normal populations to people who are experiencing different kinds of trauma. They're not -- I guess I don't know how -- ask me the question again, because I'm not certain how to answer it.

A I'll set it up again.

We talked about one in five females are victims of even some small type of sexual trauma. We focused already on the one in five. Now we're focusing on the five who, we're assuming, have not been sexually assaulted or experienced sexual trauma.

Of those five, are you aware of any percentage of those five that, nevertheless, still present symptomology consistent with being victimized, even to a minor degree, of sexual assault?

A There are a number of different situations where studies address that. I can't give you a yes or no answer.

Q Okay. And by symptomology we had three categories. But we're talking about such things as

disassociation, distress, crying, shaking, fear, anger, nightmares, lack of grooming. Are we on the same page?

A If you're asking about the full range of symptomology that would indicate that I could assume or address or make the diagnosis that someone was experiencing post-traumatic symptoms, I would need the full range of behaviors, yes.

Q All right. Ms. McAllister, I'm wrapping up here.

Are you aware of the phrase, "falsification principle?"

A I'm aware of it, but I'm not extremely familiar with it.

Q What's your understanding of what it is?

A It's -- and this is a very minimal understanding -- it's the idea that there are certain things people can assess to understand when something is not accurate. It would be a test when somebody would understand -- or somebody would do something that would indicate something is not accurate, or their understanding of something is not accurate. That's not very articulate, but...

Q I think I understand where you're going.

We had a conversation already about control

groups.

A Yes.

Q All right. Based on your understanding of falsification principle, have you specifically -- or have you personally engaged in any falsification principle studies or tests?

A I think what you're referring to, if you're looking at that in the context of research, is that you're required to try to control for, or identify any things that might skew the outcome of your findings in a research study.

And every study I've ever participated in, and those that I rely on, have done extensive intervention. And there are a number of different ways you do that to try to protect against false findings.

The strongest way to do that is to have a primary control group. Almost no social science research has a primary control group, because we find it unethical not to intervene when people have been harmed, which is what you would need to do.

We have a lot of large random sample studies. We have a number of studies that are prospective which control against falsification very strongly.

Q Okay. Is it, then, your answer, "no," that you haven't personally participated in any falsification principle test?

A I need you to define that for me in the way you're talking about it.

Q Specifically you are presenting your theory to a test.

A Every study I've participated in and every study I rely on would be held to a test that would address falsification.

Q But a test without a control group? Do you agree with that, yes or no?

A I haven't actually -- I do have some things that I rely on that have had control groups, but that's rare.

Q Specifically with regard to symptomology of victims of sexual assault, as you understand them to be victims, have you ever participated in a falsification principle test or a control group?

A I've not participated in a control group. I have participated in things that would address falsification. And I believe that would meet the standard for what you're calling a falsification test.

Q How, then, is it tested without a control

group? What's your understanding of how this research is, then, being tested?

A There are a number of ways that you can protect against finding false information. One is that you -- one standard is that you have a very large group of people so that you're not just making findings about a select group of people that you somehow may have skewed; that those people are identified randomly, rather than that they self-select, or they come from a program that you run, or they've asked for treatment.

Large random sample studies are much stronger for getting accurate information, because you're not likely to have any ways that you accidentally pick a group of people that are alike in some way.

When you have large random sample studies, asking questions that are behaviorally specific rather than emotionally charged are more likely to get accurate responses from participants.

The larger the study and the more consistent, or the stronger the responses that you get across the group, the greater likelihood that the study is accurate; the more different kinds of approaches that are used to the same question.

For instance, if you just ask people who come to a program saying, I was sexually assaulted, if they were sexually assaulted, you're very likely to have very skewed, not accurate information.

If you ask those people and you get the same consistent information that you would get from thousands of people in a large national random sample study who have been victimized, the same information from convicted offenders who disclose with they have done to how many people, and the same information from a large group of prospective studies of offenders who have never been caught or identified in the system who describe what they've done, if all of those different bodies of literature give you the same information, then you have a very strong protection against it being false or unfounded in

some way.

So there are a number of different kinds of protections. You need to have people look at the validity of your research questions, the kind of language that you use. All of those things should be incorporated into any reasonable study. The right kind of mathematical analysis needs to be used.

All of those things, used appropriately, help protect against findings that are not accurate

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or that might be misconstrued or find something false accidentally.

Q All right. You would agree with me that a large part of your understanding from your training, and the research that substantiates this training, and your clinical practice, has a huge reliance on the truthfulness of what either alleged victims or alleged perpetrators are telling you, yes?

A Some of it does, some of it does not.

Q All right. Ms. McAllister, last couple of questions.

We've talked about symptomology here, and we sort of parsed that down. Some of those symptoms are also -- would also be presented by someone who is malingering, yes?

A They could be.

MR. LOEWER: One moment, Your Honor.

THE COURT: All right.

Q (By Mr. Loewer) Last question, Ms. McAllister. Have you ever --

MR. LOEWER: Well, that's all I have, Your Honor. Those are all my questions, Ms. McAllister. And pardon the slight bit of contention there.

THE COURT: Redirect, Ms. Easter, briefly, please.

MS. EASTER: Very briefly.

REDIRECT EXAMINATION

BY MS. EASTER:

Q Ms. McAllister, you indicated that you had not -- you are not licensed?

A That's correct.

Q And can you explain why that is?

A I had a couple of reasons for choosing not to be licensed. I had my supervision hours and took the study class for the practice exam. And on that exam there were four questions, at the time, that would have caused great harm to people who experienced serious trauma.

And I wrote to the licensing board in Colorado. I met with the director of the Colorado Association of Social Workers and tried to get them to change the licensing exam and to address trauma in a way that would not be harmful, because my ethical requirement, as a social worker, is that I do no harm, that I put the client's needs first.

And I had a fight with them for two years. And they did not change those things. And I decided not to be licensed. It was choice that a number of my professors also made. About half of the teachers I had chose not to be licensed, because they felt

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like being licensed, while it has some ability to predict consistency in education, is also often more to promote the well-being of the provider than the client.

And so there is a -- there's a history of discussion about that in the field. And I chose not to at that time.

I'm very happy that now, in social work school, they teach classes on trauma. They actually have a certificate program at DU. And were I doing primarily direct service practice right now, I may consider becoming licensed.

MS. EASTER: Thank you.

Thank you, Judge. I don't have any other questions and would ask that Ms. McAllister be excused. She does have to head up to Lake County, I believe.

THE COURT: You don't have any objection to that, do you?

MR. LOEWER: No objection, Your Honor.

And for the record, there was a previous sequestration order. And no party to this case has been in the courtroom since we started this proceeding.

THE COURT: Okay. Thank you.

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Thank you, Ms. McAllister. You're excused.

THE WITNESS: Thank you.

THE COURT: Ms. Easter.

MS. EASTER: Your Honor, I will be very brief in my initial statements. I think that two cases, People v. Lafferty at 9 P.3d 1132, and People v. Master, which is 33 P.3d 1191, both of those cases -- well, one postdates Shreck -- but certainly the reasoning and analysis of those cases is aside from Shreck.

I would just state that even in Shreck, the Court -- the Supreme Court says that the Daubert factors are neither mandatory nor exclusive.

And I really believe that the Shreck analysis applies to novel scientific processes. I think we could hear in the discussion that Mr. Loewer had with Ms. McAllister that the social sciences are very different, of necessity, from the hard sciences.

So I think the two-tiered analysis that the Court performs is: Will the substance of the testimony be helpful to the trier of the fact and the fact finder? And is the witness competent to render such an expert opinion?

Judge, I think based on Ms. McAllister's knowledge of the literature, the training she's

received and provided, and her clinical practice -- just her vast experience renders her very competent to assist a jury in understanding some things.

I want to make clear to Mr. Loewer and the Court that I am not going to ask Ms. McAllister to render an opinion about whether or not Emily or Olivia have been traumatized, or whether or not they

have the symptoms of someone who's been sexually assaulted.

What I intend to ask Ms. McAllister to do is assist the jury to understand why reporting occurs the way it does, and why memory is as spotty as it is, and that there are actual reasons that memory cannot be called up like a video and reported, either from the stand or to a police officer, as something that occurs like a video.

So I'm not asking Ms. McAllister to compare symptoms. And I think that education of the jury as to things that are really different from their expectations is helpful to a jury.

THE COURT: Okay. Thank you, Ms. Easter.

Mr. Loewer.

MR. LOEWER: Yes, Your Honor.

Your Honor, we discussed at the previous hearing, sort of, the difference between soft science

and hard science. And it was agreed by all that this is dealing with a soft science. And I think Ms. Easter conceded that today, that that's what we were dealing with.

Shreck deals with science, and sometimes it deals with novel science. It doesn't mean that novel science is just new science. Novel science is such science that has had difficulty with proving.

And when we're dealing with a soft science, I believe that Shreck would be appropriate. And I think to the extent we apply Daubert or Shreck, I

think there's quite a bit of overlap.

But the three prongs of Shreck deal, first of all, with the reliability of scientific principles. And, Your Honor, to the extent Ms. McAllister is relying on studies, other people's work, what we're doing -- she is basing her opinion on other people's opinions.

And I believe it was the Lafferty case that Ms. Easter referred to, addresses that an expert opinion can't be based primarily or solely on other people's opinions. And that's what we're dealing with there.

Now, to the extent that we are dealing with her clinical experience, she is engaging in what is

contrary to science by engaging in inductive rather than deductive reasoning or logic.

And by inductive, I mean, specifically that she is -- she's starting with her understanding that -- specifically that the people she treats are victims of trauma or specifically victims of sexual assault.

And so what she is doing is going from the very particular and then going to the general to determine that these people act in certain ways.

Now, I focused on symptomology, Your Honor, because that's what Ms. McAllister has normally testified to. And I focused on dynamics and grooming because the notice I received focused on that. And so I think we're changing gears slightly here though.

She is engaging in, to a large part,

conjecture, in having assumptions that the individuals she sees in her clinical practice are actually victims of trauma, or specifically in our situation, victims of sexual trauma. She is making those assumptions.

And when we deal with actual percentages, or when she testified that one in five females experience some sort of minimal type of sexual trauma, then what we have are not all of these -- the

one out of the five are experiencing or presenting the reporting in such a way that is common with the rest of that one representative group.

Nor are they all in that one representative group having the same experiences with regard to memory.

And then we go on the other hand and then we have the other five -- or we said one in five, so essentially, then, the four remaining, we have their memories at issue, their issues of reporting.

Ms. McAllister conceded that malingering might be a way that particular people might present certain symptomology. And I would present by argument that they might also present certain memory characteristics, or specific types of reporting of sexual trauma when none existed.

And so we spent a lot of time on control groups, on a falsification principle. And that is all for the basis to make sure that Ms. McAllister's testimony, and that the basis of it is not based on

conjecture.

And that's exactly what she's doing. And, you know, Your Honor, in the practice of clinical social work, induction is appropriate. Conjecture is appropriate. It's a soft science. She has no other

alternative. And her ultimate goal is to help the person.

To the extent she is wrong, that they are actually victims of sexual trauma, she may nevertheless help the individual cope with some sort of presentation of memory or reporting or some symptomology.

But when we're dealing with a criminal case where an individual, for the allegations of kissing on the lips and patting the rear-end, is facing an indeterminant lifetime sentence, Your Honor, we cannot allow conjecture and induction, as opposed to deduction, to control an opinion by someone who is being presented to a jury by the judge as an expert.

The second prong of Shreck -- and I promise I won't address that as long as the first one -- is the qualifications of the witness.

She is not a licensed clinical social worker. She addressed why. It was because of a decision. I would suggest that the law allows her, in her practice, to continue her practice not as a licensed social worker.

But when we deal with law and people -- when their freedom is at stake in a criminal case, we have different standards, once again. I could not

choose that I disagree with taking an oath before becoming a licensed attorney, and then nevertheless go on and practice as an attorney.

And that is because I would not be able to dabble with someone's freedom.

Then we deal with the usefulness of the testimony to the jury. And essentially we're dealing with a Rule 403 analysis. And, Your Honor, we are dealing with a very highly charged case.

We are dealing with a presentation by Ms. McAllister that is based on inductive reasoning and conjecture. And the possibility that she may be testifying in a case in which we are dealing with individuals who are malingering, as the alleged victims, and that she presents as though the Court has endorsed her as an expert witness, and it is essentially that the Court has endorsed her testimony, the jury is going to understand that they can accept this as whole cloth, and then apply that to the specific circumstances in this case.

And that is exactly what the prosecution is attempting to do, is have the people of the jury apply this to the circumstances.

It is as though there is a new criminal case in the newspaper, and then we put someone in an

orange suit next to them, and then later ask the jury, or the person who is reading the newspaper, not

to make the assumption that this person committed that crime.

Lastly, Your Honor, I'll present you with case Salcedo v. People -- if I may approach.

THE COURT: You may.

MR. LOEWER: This is primarily a 702 analysis. It doesn't refer to Shreck. It is pre-Shreck. And it's dealing with whether or not the police -- pardon me -- citation is 999 P.2d 833. It's a 2000 Colorado Supreme Court case -- where a police officer or investigator is wanting to testify as an expert, whether or not the behavior or characteristics of the defendant conform to that of a drug courier.

Now, I understand Ms. Easter presented that she is not going to ask Ms. McAllister whether or not symptomology is consistent. But she is going to ask whether or not -- or tell the jury about memory, about reporting, or delayed reporting.

And essentially that's what she's doing, is inviting the jury to believe that it is consistent. All of the other people who have experienced those reporting or memory issues are consistent with what's

going to happen in this case.

And, Your Honor, in this case the Supreme Court held that it was harmful error to allow this detective to present, as an expert, that his behavior and characteristics, the way he looked, the way he acted, was consistent with a drug courier.

And so, Your Honor, based on People v.

Shreck, the underpinnings of Daubert and Fry, Salcedo v. People, and the United States and Colorado Constitutions, Your Honor, I'd ask that you exclude Ms. McAllister as an expert.

And that is my argument, Your Honor.

THE COURT: Thank you, Mr. Loewer.

MS. EASTER: Judge, if I could just say very briefly, I do not believe that I can, nor would I prevent -- present any offender profiling behavior.

THE COURT: Okay. Thank you, Ms. Easter.

The Court is prepared to rule at this time.

I have considered the testimony of Ms. McAllister, her curriculum vitae, which has been submitted, as well as the summary of -- or rather the report regarding expert testimony; and on behalf of the Defendant, the objection to admit the ability of the prosecution expert testimony and summary of Defendant's Shreck argument.

I believe here that the analysis is not a Shreck analysis. I don't believe that it is an issue of scientific principles or a novel of scientific process.

I think, rather, the analysis is whether or not the testimony would be helpful to the jury, and whether or not this particular witness is competent to testify in the areas disclosed in her report.

I believe that the categories set forth in this summary by Ms. McAllister, which she testified about, that she has provided testimony, and in the

report, issues that will be helpful to the jury.

And I don't agree with Mr. Loewer that it's based on inductive versus deductive reasoning, and that the lack of the control group or a falsification principle would in any -- would detract substantially from the helpfulness and reliability of the information that she relies on.

The testimony of Ms. McAllister is that she has relied on both her own personal practice and information provided from other people practicing in her field, and also on large random studies. I believe that in those areas her testimony would be helpful to the jury.

In terms of her qualifications, I think

that they're set forth in detail, both in the CV or resume provided on her behalf, as well as were provided during her testimony. And I believe that she is competent to testify in those areas, to include the nature and dynamics of trauma, the victim responses to traumatic events, nature and dynamics of sexual assault, victim responses to sexual assault.

I believe that under the circumstances her testimony will be helpful, that she's competent, and that the concerns framed by the Defendant can adequately be addressed on cross-examination.

And that will be the order of the Court.

Anything further on behalf of the People, Ms. Easter?

MS. EASTER: No, Your Honor.

THE COURT: On behalf of the Defendant,

Mr. Loewer?

MR. LOEWER: I just want to make sure there's something clear. Ms. Easter has suggested that she is not going beyond the realm of -- it's my understanding -- the alleged victims of sexual trauma as it specifically regards their reporting and memory.

And I don't know if the Court sort of addressed that in its ruling, but that's my

understanding, and that's what I would prepare for.

THE COURT: Ms. Easter?

MS. EASTER: Judge, I intend to present evidence -- or testimony based on the summary here provided. And I think that I further condensed that to memory and reporting. But I think that's a condensation of those areas that the Court just listed.

THE COURT: I believe that Ms. McAllister may testify consistent with the substance of the areas that are in her report, and as identified by Ms. Easter.

Does that address your concern, Mr. Loewer?

MR. LOEWER: Yes, it does.

THE COURT: Okay. Thank you.

Then, Court is in recess in this matter.

Mr. Milne's bond is continued until the next motions hearing, which is on June 5th at 8:00.

MS. EASTER: Right, Judge. And I do not recall who's covering this. I will not be here for

that. But I think it's just on suppression.

MR. LOEWER: Yeah.

THE COURT: Only suppression? Okay. I'll make a note of that.

MR. LOEWER: And to the extent I'm able to

digest the Bill of Particulars presented the day prior on the 4th, since we have a hearing already, should we address that? I'm not saying I will necessarily, but...

THE COURT: Please. If you could, to the extent there's any issue, I would really like to address it on that day. I would prefer not to have more than three motions hearings. So if possible.

MS. EASTER: Judge, we can't, because I'm the one that's going to be doing the specification of charges. And I will not be able to be here to address it. And whoever is covering for me -- I think it's Mr. Randall -- and he's been told -- I mean, he cannot absorb this whole case for that point.

THE COURT: Okay. Well, we'll see if there's an issue or not. And, then, I guess if we have to -- if I determine it's appropriate, we can set it for further hearing.

Mr. Milne, your bond will be continued until June 5th at 8:00.

Thank you.

MR. LOEWER: Thank you, Your Honor.

REPORTER'S CERTIFICATE

I, Ronda K. Dominguez, Registered Professional Reporter and Notary Public in and for the State of Colorado, duly appointed to take the within hearing, certify that the hearing was reported by me at the time and place hereinabove set forth and was thereafter reduced to typewritten form by the use of computer-aided transcription under my direct supervision; that the same is a true and correct transcription of my shorthand notes then and there taken.

DATED this 25th day of June, 2007.

Ronda K. Dominguez, RPR
Court Reporter