


◆ **FREE DWI training** ◆  
**Rolling Stoned:**  
**Investigating and Prosecuting the Drugged Driver**

Texas District and County Attorneys Association (TDCAA) Statewide DWI Training  
in cooperation with the Texas Department of Transportation

**W**e are proud to offer 6 hours of TCOLE and CLE credit free of charge for this important training. Over the last 30 years, police and prosecutors have gotten pretty good at detecting and prosecuting the alcohol-impaired driver, thanks to SFSTs, lots of training, lots of resources, and then—with “no refusal” programs—we obtained blood evidence of a driver’s intoxication. But these days, we’ve noticed many more drivers who’ve used drugs with their alcohol, or drugs without alcohol. How do these “combination” cases change how officers and prosecutors do their jobs? This course will help answer that question. Its focus is the special issues of drugged driving. The scope of the problem will be addressed first, followed by best practices on the road and in the courtroom. We will cover combination cases, move to marijuana, discuss illegal drugs, and then address prescription drugs. Forensic toxicologists, lab procedures, DREs, and the ARIDE program will also be included.

**Today’s schedule**

8:15 a.m.	Registration
8:40 a.m.	A Shot and a Beer: New Habits Resulting in Mixed Toxicology
9:40 a.m.	Break
9:50 a.m.	The Three-Legged Stool of Drugged Driving Cases
10:50 a.m.	Break
11:00 a.m.	Blood Toxicology
Noon	Lunch
1:15 p.m.	Marijuana (and Other Illegal Drugs)
2:45 p.m.	Break
3:00 p.m.	Prescription and No-Toxicology Cases
4:30 p.m.	Adjourn

 In addition to this excellent free training, every attendee will receive two TDCAA publications: DWI Investigation & Prosecution and Traffic Stops. These books give attendees resources in many areas not covered by this seminar. Please be sure you’ve signed in and double-checked your Bar number or TCOLE number. The TCOLE Course number is **3402**. If lunch is not provided, all afternoon times are delayed by 15 minutes.



## **Rolling Stoned: Investigating and Prosecuting the Drugged Driver**

Over the last 30 years, police and prosecutors have gotten pretty good at detecting and prosecuting the alcohol-impaired driver, thanks to SFSTs, lots of training, lots of resources, and then—with “no refusal” programs—we obtained blood evidence of a driver’s intoxication. But these days, we’ve noticed many more drivers who’ve used drugs with their alcohol, or drugs without alcohol. How do these “combination” cases change how officers and prosecutors do their jobs? This course will help answer that question. Its focus is the special issues of drugged driving. The scope of the problem will be addressed first, followed by best practices on the road and in the courtroom. We will cover combination cases, move to marijuana, discuss illegal drugs, and then address prescription drugs. Forensic toxicologists, lab procedures, the DRE, and ARIDE programs will also be included.

### **A Shot and a Beer: New Habits Resulting in Mixed Toxicology**

#### ***Learning Objectives***

*By the end of this session students will be able to:*

1. *Describe the scope of alcohol, drugged and combination cases in crashes on Texas highways.*
2. *Discuss cognitive bias in investigating and prosecuting cases where the impairment may be caused by multiple substances.*
3. *Identify best practices in investigating and prosecuting a driver with more than one impairing substance.*

### **The Three-Legged Stool of Drugged Driving Cases**

#### ***Learning Objectives***

*By the end of this session students will be able to:*

1. *Describe the need for complete observation, documenting and reporting in court all the clues the officer can and should make in the field in a drugged driving case*
2. *Compare and contrast the role of the DRE and Forensic Toxicologist.*
3. *Identify advantages and use of ARIDE and DRE curriculums.*

### **Blood Toxicology**

#### ***Learning Objectives***

*By the end of this session students will be able to:*

1. *Describe the need for blood samples in drugged driving cases.*
2. *Describe the key components of blood testing.*

## **Marijuana (and Other Illegal Drugs)**

### ***Learning Objectives***

*By the end of this session students will be able to:*

- 1. Identify common symptoms of marijuana intoxication.*
- 2. Describe how marijuana affects the user's brain and body.*
- 3. Testify appropriately when relating to marijuana impairment.*

## **Prescription and No-Toxicology Cases**

### ***Learning Objectives***

*By the end of this session students will be able to:*

- 1. Describe the law on driving impaired on prescription medications.*
- 2. Define, in terms of impairment, therapeutic levels.*
- 3. Explain to themselves and juries the meaning of "no substances detected" in a lab report.*

**Rolling Stoned:  
Investigating and Prosecuting the Drugged  
Driver**

I A Shot and a Beer: New Habits Resulting  
in Mixed Toxicology

II Drugged Driving is Tremendously Under Reported

III Intoxication is:...by reason of the introduction of alcohol, a controlled substance,  
a drug, a dangerous drug, a combination of two or more of those substances, or any  
other substance into the body

IV Pet Peeve

- A. Officer stops a driver
- B. Smells burned Marihuana
- C. PC search of person or vehicle results in seizure of marihuana
- D. NO DWI INVESTIGATION!

V DWI V. POM

- A. Range of Punishment
  - 1. POM Up to six Months
  - 2. DWI Can be 25-99 TDC
- B. Bond Conditions?
  - 1. POM No chance
  - 2. DWI Yes, including inter lock
- C. Cut off for enhancement?
  - 1. POM Can't Enhance
  - 2. DWI Lifetime

VI DWI V. PCS (< 1g)

- A. Range of Punishment
  - 1. PCS Up to 2years, Mandatory Probation
  - 2. DWI Can be 25-99 TDC
- B. Bond Conditions?
  - 1. PCS No chance
  - 2. DWI Yes, including inter lock
- C. Cut off for enhancement?
  - 1. PCS Up to 2-10 on third
  - 2. DWI Lifetime, Up to 25-99, 2-10 on third

VII What is Best Charge for:

- A. Less likely to Divert
- B. More Likely to go to trial
- C. Heavier Probation Conditions

- D. Highest Defense Lawyer Cost
  - E. Subsequent Violation of the Law will Result in Defendant's Death
  - F. Subsequent Violation will Result in Your Death
- VIII Cognitive Bias
- A. Once you smell alcohol, what clues are you expecting?
  - B. What happens to clues we are not expecting.
  - C. Lets take a Test.
  - D. Awareness Test
- IX Best Investigative and Prosecution Tools for Alcohol?
- A. HGN
  - B. Conversation During Personal Contact
  - C. Breath or Blood
- X HGN For Drugs
- A. Yes for: CNS, Dissociative Anesthetics, Inhalants
  - B. No for : Stimulants, Hallucinogens, Narcotic Analgesics, Cannabis
  - C. Stay Tuned: High Doses of THC
  - D. God and a Chinese Chemist Only Know: Synthetic Marihuana
  - E. Oh and Did I Mention People Use More Than One Drug?
- XI Conversation During Personal Contact
- A. More questions produce more evidence. Period
  - B. More than "Are you using drugs?"
  - C. Lets take two cases
    1. Right side of room: Smell of marihuana, driver 20 miles under speed limit, unexplained frequent braking.
    2. Left side of the room: Weaving, looks like alcohol, no smell of alcohol, Prescription bottle in console.
    3. Discuss in small groups report back at least five questions.
  - D. Remember how your suspects think.
  - E. Marihuana does not equal drugs.
  - F. Prescriptions do not equal drugs.
  - G. Ask your questions like a civilian, not a cop.
- XII Prosecutors you must expose these conceptions on Voir Dire.
- XIII Breath or Blood
- A. Please Remember AND
  - B. Consent After Arrest, Search Warrant, Exigent Circumstances

# **The Three-Legged Stool of Drugged Driving Cases**

- I Exercise: Take the Drug, what can an officer observe during contact, be ready to report back
- II All Three Legs Working Together (video)
- III DRE: Drug Recognition Experts
  - A. Find one
  - B. What they need
  - C. Get blood as back up
  - D. When do you need one?
- IV The drugged driving training continuum.
  - A. Trained police officers with observational skills
  - B. SFST refresher now has additional material on drugged driving.
  - C. ARIDE
    - 1. Advanced Roadside Impaired Driving Enforcement
    - 2. 16 hour course
    - 3. By DRE's
    - 4. Must be proficient in SFSTs to start
    - 5. For primarily roadside use
  - D. DRE
    - 1. Drug Recognition Experts
    - 2. Drug Evaluation and Classification Program
    - 3. 152 hours training in 3 parts
    - 4. Requires full field certification
    - 5. For roadside, officer assistance and courtroom expert use.
    - 6. Continued use required to keep certification
  - E. Case Law
    - 1. Everitt v. State, 2014 Tex. App. LEXIS 1667 (Tex. App. Houston 1stDist. Feb. 13, 2014)
    - 2. Layton v. State, 280 S.W.3d 235 (Tex. Crim. App. 2009)
    - 3. DeLarue v. State, 102 S.W.3d 388 (Tex. App. Houston 14<sup>th</sup> Dist. 2003)
- V For Prosecutors
  - A. DRE's are experts.
  - B. They can explain even if they can't give ultimate opinion. DRE Reconstruction.
  - C. May fill gap left by Toxicologist
  - D. If you need the experts pressure the departments.



- E. You must know your DREs
- F. They can give you your theory
- G. They can destroy defense theory
- H. Often, they strengthen problem officer's testimony
- I. Often stronger when NOT associated with case
- J. Let them testify

K.

# Blood Toxicology

- I. General Toxicology
- II. Why is there No *Per Se* Number for Drugs?
  - A. No Studies
  - B. More Choices for Absorption
  - C. Many Drugs not Water (i.e.: Blood) Soluble
  - D. Every Drug and Combination Varies
  - E. Elimination is by Half Life not Simple Metabolizing
- III. What Happens To Blood in the Lab? (Video)
- IV. Forensic Toxicology: a hybrid of Analytical Chemistry and Basic Toxicology;
- V. Submission to the Lab
  - A. Alcohol and/or Inhalants if needed
  - B. Important to know the reported BAC before Tox testing is completed
- VI. Drug Toxicology Criteria at DPS Toxicology
  - A. No intoxilyzer or blood alcohol testing, OR
  - B. BAC <0.100 g/100 mL, OR
  - C. BAC >0.100 g/100 mL and living driver with deceased victims, OR
  - D. BAC >0.100 g/100 mL and written request from prosecutor with considerations screened by Toxicology Section Supervisor
- VII. The Two Step
  - A. The Initial Screen
  - B. Utilizes immunoassay technique (EMIT) to determine the category or categories of drugs that might be present
    - 1. Amphetamines
    - 2. Barbiturates
    - 3. Benzodiazepines
    - 4. Carisoprodol/Meprobamate
    - 5. Cocaine/metabolites
    - 6. Opiates
    - 7. PCP
    - 8. THC/metabolite
  - C. The Confirmation
  - D. If the Immunoassay indicates the presence of a drug, Confirmation is sought
  - E. This utilizes GC/MS or LC/MS/MS to determine exact drug and concentration if possible
- VIII. Cut Offs
  - A. Two Reasons for Cut Offs
    - 1. Are we sure what is there,
    - 2. Is there enough to impair
  - B. Cut Offs are in Both Steps

- C. So What Does "None Detected" Really Mean?
- IX. Why Screening Can Differ From Confirmation
- X. Lab Accreditation and Quality Control (video)
  - A. Quality Control
  - B. Lab Accreditation
  - C. Chemist Accreditation
  - D. Instruments
    - 1. Manufacturer Certifies
    - 2. Lab Validates
    - 3. Lab Monitors
- XI. SOP
- XII. Words Prosecutors Need to Learn
  - A. Controls
  - B. Calibrators
  - C. Validators
  - D. Blanks
  - E. Curve
- XIII. Sound like Breath Testing?
- XIV. Cut Offs, Absorption and Elimination (video)
  - A. Ok so .....No *Per Se*, Get it?
- XV. Learn More

# Marijuana

## (and Other Illegal Drugs)

- I. Drugs Other than Alcohol
- II. Drugged Driving Jury Selection
  - a. Feeling Questions are More Important
  - b. Identify those that don't care early.
  - c. Who doesn't think it's the same thing as Drunk Driving?
  - d. Being high isn't the same as drunk
  - e. It takes a lot of....
- III. We have lost credibility with much of the public.
  - a. A Brief History of Cannabis
    - i. Used as Fiber Source in earliest cultivation.
    - ii. Used as medicine by 500 B.C.
    - iii. Smoking for fun spread with Islam beginning about 800 A.D.
    - iv. Law required its cultivation for fiber in colonial US
    - v. Use as drug spread from Mexico in 1920's and 1930's
    - vi. Marihuana Tax Act 1937
    - vii. Controlled Substance Act 1970
    - viii. California Medical Legalization 1996
- IV. Marihuana The Vocabulary
  - a. Cannabis is not addictive but,
    - i. According to National Institute on Drug Abuse:
    - ii. In 2015, about 4.0 million people in the United States met the diagnostic criteria for a marijuana use disorder;<sup>3</sup> 138,000 voluntarily sought treatment for their marijuana use.
    - iii. Marijuana use can lead to the development of problem use, known as a marijuana use disorder, which takes the form of addiction in severe cases. Recent data suggest that 30 percent of those who use marijuana may have some degree of marijuana use disorder. People who begin using marijuana before the age of 18 are four to seven times more likely to develop a marijuana use disorder than adults.
  - b. Can you overdose on Cannabis?
    - i. From CDC
    - ii. *A fatal overdose is unlikely, but that doesn't mean marijuana is harmless. The signs of using too much marijuana are similar to the typical effects of using marijuana but more severe. These signs may include extreme confusion, anxiety, paranoia, panic, fast heart rate, delusions or hallucinations, increased blood pressure, and severe nausea or vomiting. In some cases, these reactions can lead to unintentional injury such as a motor vehicle crash, fall, or poisoning.*
    - iii. The Why has to do with Cannabis receptors which are not in Brain Stem.

- V. What is Cannabis Sativa L
  - a. THC
  - b. Tetrahydrocannabinol (THC) is one of at least 113 [cannabinoids](#) identified in [cannabis](#). THC is the principal [psychoactive](#) constituent of cannabis. With chemical name (-)-*trans*- $\Delta^9$ -tetrahydrocannabinol, the term *THC* also refers to cannabinoid [isomers](#).
  - c. Delta 8, 9 and 10
  - d. CBD, CBN, THCA, CBG
  - e. Terpenes
  - f. Strains include: Indica, Sativa, Hybrid, Ruderalis
- VI. Impairment
  - a. Delta 9 tetrahydrocannabinol
  - b. 11 Hydroxy THC
  - c. CARBOXY THC
  - d. Marijuana is LIPOPHILIC (FAT Soluable)
    - i. Garden Hoses
    - ii. Delta 9 THC
    - iii. In blood it is not making you high but it will
    - iv. Carboxy THC
    - v. In your blood, THC has passed through fat and been metabolized
- VII. Cannabinoid Pharmacokinetics
  - a. Observations
    - i. Are You Seeing Physical Effects?
    - ii. Pupils
    - iii. Conjunctiva
  - b. Are You Seeing Mental Effects?
    - i. Divided Attention
    - ii. Conversation
    - iii. Executive Functions
- VIII. Can We Use SFST for Drugs?
  - a. SFSTs are Designed to detect IMPAIRMENT.
  - b. Alcohol is a drug.
  - c. The SFSTs have been validated in subsequent field and lab studies for alcohol and the other recognized drug categories.
  - d. SFST Clues for THC
  - e. No HGN (If THC is alone).
  - f. 9 Step and One Leg Stand.
  - g. No physical impairment or balance Issues.
  - h. Executive functions and following instructions.
  - i. Non-standardized Instruction Issues
- IX. What is better than SFSTs?

- a. Conversation
  - b. Interaction
  - c. Booking
  - d. Admissions about their “Cannabis Medication”
- X. NOT YOUR GRANDMA’S WEED
- XI. High Times 5/7/14
- a. “With dabs your local action news team gets to do a marijuana story that shows crack pipe torches used on sticky heroin-looking goo made from a process that [blows up like meth labs.](#)”
- XII. Marihuana: Where are we now?
- a. Oh Pops! Nobody smokes cannabis anymore.
  - b. M-Cigarettes  
(marijuana vaporizers) – Brought to you by *Groupon!*
  - c. Marijuana Edibles
  - d. If you want to make your own...
- XIII. Cannabis and Alcohol

# Prescription and No-Toxicology Cases

- I. Prescription Cases
  - a. Why Does a Doctor Prescribe the Drug?
  - b. Does the Drug Impair?
  - c. What does a prescription (or lack thereof) mean to your case?
  - d. How much is prescribed (dose)?
  - e. Warnings
  - f. Therapeutic Value
    - i. Doing what it is supposed to.
    - ii. That means patient is not “Normal”.
    - iii. Actually a Range
    - iv. Side Effects
    - v. Combinations
- II. Requesting Prescription History from Texas State Board of Pharmacy
  - a. Apply for Access through the Texas State Board of Pharmacy
  - b. <https://www.pharmacy.texas.gov/PMP/aware.asp>
  - c. Law Enforcement Access Portal
  - d. Allows for approved LE and Prosecutors to submit subpoenas, warrants, or court orders to obtain information contained in the Texas Prescription Monitoring Program (PMP)
  - e. PMP information may only be released to LE or Prosecuting Attorney that is engaged in the administration, investigation, or enforcement of a law governing illicit drugs.
  - f. Controlled by the Texas Controlled Substances Act
- III. The Dreaded “None Detected” Case
  - a. Remember Half-Lives
  - b. Remember Cut Offs
  - c. Not Every Drug has a Test
  - d. Video V. Toxicology
- IV. What Does “Detected” Mean?
  - a. The Report
  - b. Even if both the immunoassay is conducted and every single additional test is performed, you may still not get a positive result. The lab cannot test for everything, including:
    - i. Psilocybin
    - ii. Mescaline
    - iii. GHB
    - iv. LSD
    - v. Synthetic Cannabinoids (K2, Spice, etc)
    - vi. Antibiotics
    - vii. Most Designer Amphetamines
- V. The Report

- a. Sometimes you will have a defendant who is obviously impaired on video and there is simply no way to identify what they are on using the crime lab
- b. There are a near inexhaustible number of substances that can cause impairment
- c. A fully completed lab report which indicates nothing is detected does not equate to no intoxicant
- d. It may equate to diminished evidence

VI. Do I File the Case?

- a. Call A DRE
- b. Review Report and Video with DRE
- c. Then Call the Lab
- d. Can you Eliminate Mental Health?
- e. More Research May be Necessary

VII. Do I Try the Case?

- a. Probable Cause v BRD
- b. Not Every Crime Can be Prosecuted
- c. Win or Lose in Jury Selection
- d. What Can I Find?
- e. What Can Defense Show?
- f. DRE Post Incident Review

VIII. Call the Toxicologist

IX. See That Justice is Done

X. A matter of life and death.

XI. Please drop evaluations off at registration table.

Be careful on the roads

Thanks for all you do.



# Cannabis Impairment Quick Assessment

## EYES

Conjunctiva Tissue (looks like pink eye in both eyes), **Lack of Convergence, Dilated Pupils, & No HGN** (when cannabis alone).

## MUSCLES

**Tremors** Observed in extremities, up- per torso, & eyelid (closed eye).

## ODOR

**Smell** Burnt marijuana, additive flavor for vaping, & maybe for edibles.

## OBSERVATIONS

**Indica:** Produces a 'stoned' feeling. Physically & mentally relaxing. Centered on the body. Enhances sensations of taste, touch, & sound. Euphoria & relaxed inhibitions.

**Sativa:** Produces the 'high' feeling (energetic). Less overpowering than the Indica 'stone'. Less likely to produce drowsiness. High described as: cerebral, energetic, creative, giggly & or psychedellic.

**Psycho-Physical Tests:** Generally slow performance; muscle tremors, especially in legs & arms.

**Information processing:** Likely diminished. Impaired memory & comprehension. Jumbled thought formation & lack of concentration.

Likened to attention deficit disorder, cognitive impairment. Altered distance perception.

**Modified Romberg:** Distorted internal clock. Eyelid Tremors.

**Mood Changes:** Including panic & paranoia.

**Mouth:** Flacks of Green Vegetable Matter (GVM - marijuana) in teeth. Possible green or

## IMPORTANT STUDIES TO KNOW

- National Highway Traffic Safety Administration, **Drug and Alcohol Crash Risk**, (Report No. DOT HS 812 117) Washington DC: U.S. Government Printing Office (2015). **Often cited by defense- Virginia Beach Study.**
- Hartman, R.L., Huestis, M.A., et al., **Cannabis Effects on Driving Lateral Control With and Without Alcohol**, \***MUST KNOW\*** Drug and Alcohol Dependence, <http://dx.doi.org/10.1016/j.drugaldep.2015.06.015> (2015).
- Huestis, M.A., et al., **Estimating the Time of Last Cannabis Use from Plasma  $\Delta^9$ -Tetrahydrocannabinol and 11-nor-Carboxy- $\Delta^9$ -Tetrahydrocannabinol Concentrations**. Clinical Chemistry, 51(12), 2289-2295, doi:10.1373/clinchem.2005.056838 (2005).
- Hironen, J., Huestis, M.A., et al., **Reversible and Regionally Selective Downregulation of Brain Cannabinoid CB 1 Receptors in Chronic Daily Cannabis Smokers**. Molecular Psychiatry, 59(3), 642-649, doi:10.1038/mp.2011.82 (2012).
- \* Bosker, W., Hironen, J., Huestis, M.A., Ramaekers, J.S., et al., **Psychomotor Function in Chronic Daily Cannabis Smokers During Sustained Abstinence**. PLoS ONE, 8(1), e53127, doi:10.1371/journal.pone.0053127(2013).
- Hartman, R.L., Huestis, M.A., et al., **Effect of Blood Collection Time on Measured  $\Delta^9$ -Tetrahydrocannabinol Concentrations: Implications for Driving Interpretation and Drug Policy**. Clinical Chemistry, 62:2, 367-377, doi:10.1373/clinchem.2015.248492 (2016).

## GET. BLOOD. FAST.

**Smoked: Impairment Peak:** 0-30 mins

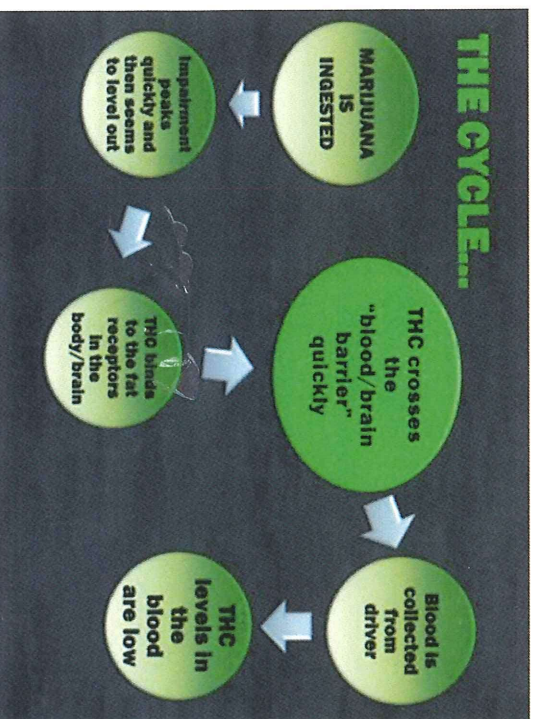
**High Experience:** 1-3 hours

Impairment may last up to 24 hours, without awareness effects.

**Oral/ Edible: Impairment Peak:** 1-3 hours

**High Experience:** 4-8 hours

Residual effects depend on dosage



"The Cycle" created by Courtney Popp, WA TSRP

- Hartman, R.L., Huestis, M.A., et al., **Controlled Cannabis Vaporizer Administration: Blood and Plasma Cannabinoids With and Without Alcohol**, Clinical Chemistry, 61(6), 850-869, doi:10.1373/clinchem.2015.238287(2015).
- Bergamaschi, M., Hironen, J., Huestis, M.A., et al., **Impact of Prolonged Cannabinoid Excretion in Chronic Daily Cannabis Smokers' Blood on Per Se Drugged Driving Laws**. Clinical Chemistry, 59(3), 519-526, doi:10.1373/clinchem.2012.195503 (2013).
- Desrosiers, N., Huestis, M.A., et al., **Phase I and II Cannabinoid Disposition in Blood and Plasma of Occasional and Frequent Smokers Following Controlled Smoked Cannabis**. Clinical Chemistry, 60(4), doi:10.1373/clinchem.2013.216507 (2014).
- DRUID. **Analytical Evaluation of Oral Fluid Screening Devices and Preceding Selection Procedures**. (Project No. TREN-05-FP6TR-S07.61320-518404) Finland (2010).
- Grotenhermen, F., Drummer, O.H., Ramaekers, J.G., et al., **Developing Limits for Driving Under Cannabis**. Addiction, 102, 1910-1917, doi:10.1111/j.1360-0443.2007.02009.x (2007).
- Grotenhermen, F., Ramaekers, J.G., et al., **Developing Science-Based Per Se Limits for Driving Under the Influence of Cannabis (DUI/C): Findings and Recommendations by an Expert Panel/ DUI/C Report** (2005).
- Papatofou, K., et al., **An Evaluation of the Sensitivity of the Standardized Field Sobriety Tests (SFFSTs) to Detect Impairment Due to Marijuana Intoxication**. Psychopharmacology, 180, 107-114, doi:10.1007/s00213-004-2119-9 (2005).
- Hartman, R.L., & Huestis, M.A., **Cannabis Effects on Driving Skills**. Clinical Chemistry, 59(3), 478-492, <http://dx.doi.org/10.1373/clinchem.2012.194381> (2013).
- Hartman, R.L., Huestis, M.A., et al., **Drug Recognition Expert (DRE) Examination Characteristics of Cannabis Impairment**. Accident Analysis & Prevention, 92, 219-229, <http://dx.doi.org/10.1016/j.aap.2016.04.012> (2016).

**Delta-9-THC** - The main psychoactive substance found in marijuana.

AKA: delta-9-tetrahydrocannabinol ( $\Delta^9$ -THC), dronabinol

**11-Hydroxy-THC** - The main psychoactive metabolite of THC formed in the body after marijuana consumption. AKA: Hydroxy THC, 11-Hydroxy- $\Delta^9$ -tetrahydrocannabinol (11-Hydroxy- $\Delta^9$ -THC), 11-OH-THC

Delta-9 + Hydroxy = Impairment

**11-nor-9-Carboxy-THC** - The main secondary metabolite of THC formed after marijuana is consumed. It is NOT active, but indicates historical use.

AKA: THC-COOH (most often seen this way), Carboxy THC, 11-nor-9-carboxy-delta-9-tetrahydrocannabinol (11-nor-9-carboxy- $\Delta^9$ -THC), 11-COOH-THC

**Cannabinoids** - Group of active compounds found in marijuana.

**Cannabinoid (CBD)** - Non-psychoactive ( $\alpha/\beta$  not impairing) cannabinoid. Found in medical strains.

**Cannabidiol (CBN)** - THC metabolite (10% as psychoactive as THC), which may show recent or heavy use.

**Chronic vs. Occasional** - Terms denoting frequency of use.

**Chronic** - Continuing for a long time or recurring frequently.

**Occasional** - Happening infrequently and irregularly.

**Psychoactive or Active** - Causes euphoric and impairing effects (THC and 11-OH-THC).

**Not active or inactive** - Does NOT cause euphoric or impairing effects (THC-COOH).

**Compensation** - Behavior that develops either consciously or unconsciously to offset a deficiency.

**Critical Tracking** - A set of tasks used to determine impairment in a clinical setting.

**Epidemiological** - Is the study and analysis of the patterns, causes, and effects of health and disease conditions in defined populations.

**First-order Elimination Kinetics** - Elimination of a constant fraction per time unit of the drug quantity present and is proportional to the drug concentration.

**Lateral Control** - Control of side-to-side or sideways movement.

**Limit of Detection (LOD)** - Lowest quantity of a drug that can be distinguished from the absence of that drug.



**Limit of Quantitation (LOQ)** - Lowest amount of a drug in a sample that can be quantitatively determined.

**Measurement of Uncertainty (MOU)** - Best estimate of how far a quantity might be from "true value." If two people measure one cup of flour, the amount will always be different even if it's not noticeable to the naked eye.

**Metabolite** - A chemical created in the body as part of the process of breaking down the parent compound (11-OH-THC and THC-COOH).

**Parent compound or parent drug** - The drug in the original form that it is ingested (e.g. THC).

**Per Se Law** - Statutory assignment of a blood concentration above which is an offense to drive.

**Permissible Inference** - A legally specified fact that the jury may infer.

**Pharmacokinetics** - The movement of a drug into, through & out of the body - the time course of its absorption.

**Plasma vs. Whole Blood**

**Plasma** - The colorless fluid part of blood, lymph, or milk, in which corpuscles or fat globules are suspended.

**Whole Blood** - Blood drawn directly from the body from which none of the components (such as plasma or platelets) has been removed.

**Titrate** - Continuously measure & adjust the balance of [a substance].

**Tolerance** - The capacity of the body to endure or become less responsive to a substance.

### INTERNET RESOURCES

[www.wsp.wa.gov/breathtest/dredocs.php](http://www.wsp.wa.gov/breathtest/dredocs.php) (NHTSA/JACP Manuals)

[www.ndaajustice.org/nrlc\\_home.html](http://www.ndaajustice.org/nrlc_home.html) (Nat'l Traffic Law Center)

[www.nih.gov/research-training](http://www.nih.gov/research-training) (Research)

[www.decp.org](http://www.decp.org) (Int'l Drug Eval. & Classification Program)

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## Cannabis Impairment Quick Assessment

Document Observations of MENTAL & PHYSICAL Impairment

### EYES

**Conjunctiva Tissue** (looks like pink eye in both eyes), **Lack of Convergence**, Dilated Pupils, No HGN (when cannabis alone).

### MUSCLES

**Tremors** Observed in extremities, upper torso, & eyelids (closed eyes).

### ODOR

**Smell** Burnt marijuana, additive flavor for vaping, & maybe for edibles.

**Indica:** Produces a 'stoned' feeling. Physically and mentally relaxing. Centered on the body. Enhances sensations of taste, touch, & sound.

**Sativa:** Produces the 'high' feeling (energetic). Less overpowering than the Indica 'stone.' Less likely to produce drowsiness. High described as: cerebral, energetic, creative, giggly & or psychedelic.

**Psycho-Physical Tests:** Generally slow performance; muscle tremors, especially in legs & arms.

**Information processing:** Likely diminished. May forget certain parts of instructions. Likened to attention deficit disorder, cognitive impairment.

**Modified Romberg:** Distorted internal clock. Eyelid Tremors.

**Impairment Peak:** 0-30 mins

Impairment may last up to 24 hours,

**High Experience:** 2-3 hours

without awareness effects.

ONSET OF EFFECTS DIFFERS DEPENDING ON MANNER OF INGESTION

**Delta-9-THC** - The main psychoactive substance found in marijuana.

**11-Hydroxy-THC** - The main psychoactive metabolite of THC formed in the body after consumption. Delta-9 + Hydroxy = Impairment

**11-nor-9- Carboxy- HC** - The main secondary metabolite of THC formed after consumption. Not active, but indicates historical use.

**Cannabinoids** - Group of active compounds found in marijuana.

**Cannabidiol (CBD)** - Non-psychoactive (a/k/a not impairing) cannabinoid.

**Cannabinol (CBN)** - THC metabolite (10% as psychoactive as THC).

**Measurement of Uncertainty** - Best estimate of how far a quantity might be from "true value."

**CO Permissible Inference 5 ng/mL** - If at time of driving, driver had 5 ng/mL delta-9 in whole blood, jury may infer defendant was DUI. CO does not have a per se law (statutory assignment of a blood concentration above which is an offense to drive)!

**Titrate** - Continuously measure & adjust the balance of [a substance].

#### INTERNET RESOURCES

[www.wsp.wa.gov/breathtest/dredocs.php](http://www.wsp.wa.gov/breathtest/dredocs.php) (NHTSA/IACP Manuals)

[www.ndaajustice.org/ntlc\\_home.html](http://www.ndaajustice.org/ntlc_home.html) (Nat'l Traffic Law Center)

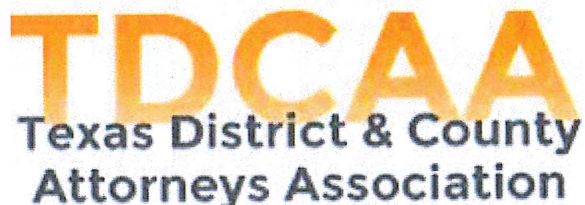
[www.nih.gov/research-training](http://www.nih.gov/research-training) (Research)

[www.decp.org](http://www.decp.org) (Int'l Drug Eval. & Classification Program)

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[Home](#) > The devastation of driving while drugged

## **The devastation of driving while drugged** <sup>[1]</sup>

By Andrew James and Tyler Dunman

Assistant District Attorneys in Montgomery County

Even with a doctor's prescription and legitimate medical need, often people should not be driving with drugs in their systems. How to investigate and prosecute a case of driving while intoxicated (on prescription drugs).

On Sunday, September 20, 2015, at about 12:45 p.m., Roland Sedlmeier, his wife Mendy, and their two kids, Harley, age 6, and Sofie, 4, were driving home from church on State Highway 105 in Conroe.

A few minutes later, a 911 call came in to Montgomery County dispatch. The caller described a gray sedan that was almost hitting other vehicles and driving off the road. The sedan's driver was Ronald Cooper, who was also heading home from church on Highway 105. A Conroe Police Department (CPD) officer, hearing the call, raced down Highway 105 in an attempt to stop Cooper, but the officer could not get there in time. Cooper's sedan careened into the Sedlmeiers' small car—a crash witnessed by several other drivers, including the 911 caller—and Roland, Mendy, Harley, and Sofie were killed instantly.

Tyler Dunman, a co-author of this article, had just gotten home from church himself when the phone rang. The Conroe Police sergeant in charge of investigating fatal crashes told him about a bad crash on Highway 105 where several were dead. In Montgomery County, we have a Vehicular Crimes Callout Team where prosecutors are on-call on a rotating basis to respond to scenes of crashes when there is potential for criminal charges to be filed. We believe this team is very important because we are able to actively assist law enforcement in real time with evidence collection; prosecutors can also see the crime scene with their own eyes. Overall, it gives us better connection to the case and a perspective that you can't get from photos or videos of the scene. Because it was a Sunday afternoon, Tyler, then the supervisor of the team, decided to give the on-call prosecutors a rest and handle this one himself.

He arrived about 35 minutes after the crash to a fairly chaotic scene. He was briefed by CPD officers and began to think about all that needed to be done. He learned that the entire Sedlmeier family had been killed and that the "at fault" driver was being treated by Emergency Medical Services (EMS) for what appeared to be impairment from prescription medication. He knew immediately this was not going to be an ordinary crash investigation. He called Andrew James, an experienced vehicular crimes prosecutor and co-author of this article, to the scene to help out. Andrew and Tyler had been on many crash scenes, but nothing could prepare them for this one. An entire family smashed together in such a way that none of them were easily identifiable, including two little kids. It was horrific and shocking to even the most experienced first responders on scene that day.

In looking at the crash evidence and talking with witnesses, we learned that Cooper was driving in the same direction as the Sedlmeier family when he left his lane and clipped the back end of the

family's compact sedan. This caused the Sedlmeiers' car to skid into the oncoming lanes, where they were hit head-on by a young man driving a Jeep Wrangler. This young man and his passenger had also just left church and were headed to a local restaurant to have lunch with his family. His Jeep struck the Sedlmeiers' car broadside and caused significant damage, while the two men in the Jeep walked away with only minor injuries.

Although the crash was fairly involved, the two of us began to focus our attention on Ronald Cooper. At the time, he was a 67-year-old man driving alone in his car, the same vehicle that had been reported for reckless driving by 911 callers and other witnesses. The initial witnesses and law enforcement officials noticed fairly quickly that something seemed "off" with him. Some of the witnesses characterized it as a "likely medical condition," such as diabetes or low blood pressure, while others said he just seemed to be "dazed" from the crash. Some on-site witnesses told law enforcement that they did not smell any alcohol so they knew that he "wasn't drunk," but other witnesses and officers described Cooper as having slurred speech, slowed reactions, and unsteady balance, as well as being confused. One of the more experienced CPD officers believed that Cooper's signs of impairment were probably from prescription medication. Another CPD officer on scene discovered several prescription pill bottles in the center console of Cooper's car. The prescriptions were recently filled, and the bottles for Valium and oxycodone still had pills inside.<sup>1</sup> A crime scene investigator collected the pills as evidence.

At this point, we decided to call a Drug Recognition Expert (DRE) to the scene to do the initial follow-up and intoxication investigation with Cooper. Cooper was still being evaluated by EMS, and one of the paramedics stepped out of the ambulance to talk with us. She believed that Cooper was impaired, and he had admitted to taking Valium and oxycodone that morning. She also said that he appeared to have substantial medical history, although all his vitals and other signs were checking out just fine. We learned that he had not suffered any injuries in the crash and that his blood pressure and blood sugar were both within normal range.

Soon thereafter, DRE Michael Dean arrived. We decided that it would be best for this investigator to interview Cooper and determine the extent and likely cause of his impairment. Cooper had previously been read his Miranda warnings by one of the patrol officers before getting into the ambulance. He had also been read the DIC-24 and had consented to a blood sample. This initial blood sample was taken in the back of the ambulance by one of the paramedics, who was also a registered nurse.

Following the DRE's initial interview and collection of the blood sample, paramedics consulted with law enforcement and decided that Cooper should be transported to the emergency room to be checked out, a decision we highly encouraged. Because of Cooper's age, the fact that he had admitted to taking multiple prescription medications, and the numerous "medical conditions" and "prior injuries" he had mentioned to the paramedics, we just knew that in any future prosecution, his defense would attempt to raise those issues as causes of the crash. It was important that Cooper be seen by a medical doctor to rule out any of those factors from playing a role in this case. And frankly, as seekers of the truth, we wanted to make sure there was in fact no medical event that could have contributed to this crash.

Cooper was transported to the ER and seen by a medical doctor and nursing staff. Other than noting impairment from the prescription drug use, they found nothing wrong with him. At the ER, the DRE also conducted his full evaluation, including taking a second blood sample. The DRE determined that Cooper was intoxicated on a narcotic analgesic. Following the medical screening at the emergency room and the DRE evaluation, Cooper was arrested and charged with four counts of intoxication manslaughter for the Sedlmeier family and two counts of aggravated assault with a deadly weapon for the injuries to the two young men in the Jeep. Our investigation into this crash was well underway.

### **Cooper's medical history**

Understandably, the crash garnered a lot of attention from local news outlets, and Ronald Cooper's wife and daughter-in-law both spoke to various news organizations the evening after the crash and in the days following. They claimed that Mr. Cooper's conduct had to be the result of his health issues, which include diabetes and a blood clot on his brain.<sup>2</sup> We knew that we needed to talk with

both women to investigate the details of Mr. Cooper's ailments and injuries and obtain whatever information we could from them.

In our crash investigations, it is normal practice for our Vehicular Crimes Team to rely heavily on the grand jury to obtain records and interview witnesses to lock down testimony and gain insightful information for the investigation. Several of Cooper's family members were interviewed at grand jury. From their testimony, we learned generally about Cooper's numerous prior crashes, his hospitalizations, his medical history, his previous doctors, his family's concern about letting him drive and letting people ride in the car with him, and all of the prescription medications he was taking (in addition to the ones that he admitted to and which were found in his car after the crash). One of the drugs is called Gabapentin, which is an anti-epileptic medication that affects the body's chemicals and nerves that are involved in the cause of seizures and some types of pain. His family expressed concerns that Gabapentin was the primary cause of any impairment they had seen in him before the crash. Having never heard of Gabapentin, we did some research into it and found that it also causes central nervous system (CNS) depression. We reached out to our usual lab3 to find out if it could test for Gabapentin and were told that it couldn't but that the National Medical Service Labs in Pennsylvania could conduct the testing we needed. Our office uses NMS occasionally for blood testing, as it is often the only lab in the country that will test for certain substances. There can be significant costs associated with independent testing at private labs like NMS, but given the serious nature of this case, we felt it was necessary and well worth it to spend the additional funds. A few weeks later, we received a report showing that Gabapentin was in Cooper's blood in a low, therapeutic amount.

Next, we zeroed in on Cooper's medical history and other prescription drug use. We subpoenaed his medical records from those hospitals that Cooper admitted to visiting in the last couple of years, as well as the hospital he visited on the day of the crash. To expedite things, we had an investigator serve those subpoenas at the hospital and pick them up once they were ready. Based on the information obtained in these records, we discovered additional hospital stays and identified Cooper's primary care and pain management doctors. We then subpoenaed records from these doctors and the records about Cooper's prescriptions.

We also ran Cooper through the statewide prescription drug database and found all the other (numerous) doctors that he had visited, along with the prescription history from each visit. That finding led to additional grand jury subpoenas and follow-ups with other pharmacies in the area. As these records came in, we put together a fairly extensive timeline and spreadsheet that included a number of other crashes that Cooper had been involved in, as well as several hospital visits going back as far as 2001. Again, anticipating that his attorney would surely use Cooper's medical history and health issues as defenses in the trial, we studied all of these records in great detail and became very well-versed in Cooper's medical conditions, their causes, their treatments, and the drugs he was taking. This process took lots of time and organization, as the records accumulated into thousands of pages.

Generally, these records obtained through the grand jury were a goldmine of information. To better understand them, Tyler reached out to the director of our county-wide EMS service, a medical doctor who had some involvement in the case. We arranged for several meetings to review the medical records together so that Tyler could better understand what the medical conditions were and the best practices for treating them, including what prescription drugs we would expect to see. Tyler found these meetings to be very informative. With this doctor's help, he understood what we needed to prepare for and what would likely be an issue at trial.

Also during this time, Tyler pulled Cooper's medical records from his time in jail. (He spent about a year in jail before trial, where he was treated by a doctor for his basic medical needs.) These records were incredibly valuable. We discovered that Cooper was able to function perfectly for an entire year in jail without taking any type of controlled substance for alleged pain from prior injuries. He went an entire year in the jail never once requesting pain medication and often describing his overall condition as "very good." We felt his medical progress and abilities to function without pain medication would be an important point during the trial (and it was). We were confident that if the defense decided to open Pandora's Box of prior medical conditions as either causes of the crash or as mitigation, we were prepared to defend such claims. We subpoenaed many of Cooper's doctors

for trial and were ready to truthfully explain his medical history and the fact that none of it was the cause of (or even relevant to) this particular crash. We probably knew Cooper's medical history and prescription drug use better than he did!

### **Jury selection**

During voir dire, in addition to the typical intoxication manslaughter topics, our biggest hurdles to overcome involved:

- 1) misperceptions surrounding "legally prescribed" prescription drug use, intoxication, and driving;
- 2) how drugs affect the body,
- 3) lack of per se limits; and
- 4) signs of impairment being attributed to prior injury and age.

In all honesty, this was the first case we had seen in some time that involved a defendant who was taking prescription medication based on a valid prescription for what appeared to be legitimate medical conditions. Of course, we have had our share of drug-related DWI cases, and a number of those involved prescription drugs as the intoxicant. But most of the time, DWI offenders are taking prescription drugs without a valid prescription and for the "high" effect rather than for any legitimate medical purpose. In Cooper's case, we had to overcome the public's perception that a person cannot commit DWI (or any other crime) if he has a legitimate medical condition, goes to a legitimate doctor, is prescribed a drug, takes the drug as prescribed, and then drives. If you ask around, many laypeople assume that if someone has a valid prescription from a doctor and he takes the drug as prescribed, that person can safely operate a motor vehicle. Although laypeople might not perceive the consequences up-front, usually once we remind them about the warnings on the pill bottles against operating machinery and driving and then discuss the effects of certain drugs on the body and mind, they come around to understanding that such practice could be criminal. We addressed these issues head-on in voir dire.

We began with the definition of intoxication manslaughter and what it means to be intoxicated generally. We turned the conversation to drugs and of course, no one was surprised to learn that drugs (of any caliber) can cause intoxication. Before we jumped too far into the details of prescription drug use, Tyler wanted to test the waters with a general question so to start off, he asked something like, "Do you believe that a person could be legally intoxicated on prescription medication even if taking it as prescribed by their doctor?" He went person by person gauging gut reactions to this question. This helped with identifying those who might need more persuasion (or evidence) as to this element in the case. We then carefully transitioned the conversation to prescription medication and asked whether certain prescription medications might cause someone to be intoxicated. This question led to follow-up questions about types of prescription medications that might be an issue and experiences some people on the panel had had with taking certain medications. This conversation led to responses running the gamut from those who had never taken these types of drugs to those who were taking them right then for medical issues. Panelists also talked about the effects of these drugs and why medications have warnings on their labels.

Most of the conversation led to the group educating itself and coming to grips with the ramifications of taking these types of drugs while driving. To address this issue, we asked a series of basic questions so the panel would consider a number of scenarios, such as "whether it is legal to take prescription medication and drive," as compared to "driving while intoxicated on prescription medication." We ended the discussion with explaining Texas Penal Code §49.10, which states that "the fact that the defendant is or has been entitled to use the alcohol, controlled substance, drug, dangerous drug, or other substance is not a defense." It was a good ending point, as it reaffirmed the discussion and the logical conclusion in prescription drug cases.

The voir dire process on per se limits on drugs and potential medical conditions that could affect an intoxication investigation were no different from in any other DWI case. It is important for the jury panel to know and understand why we do not have per se limits for drugs like we do for alcohol. In our voir dire, we found a nurse on the panel who spoke about the basics on prescription drug use and how these drugs affect the body and most importantly, how they vary with half-lives, etc. This could lead to a complicated discussion if prosecutors are not careful, but it is important that the



panel understand the differences in our procedures and abilities between alcohol and drugs. The panel must also understand that medical conditions and other injuries might affect an officer's ability to test for intoxication. In this voir dire, we discussed field sobriety tests, how they are used, and what would happen if someone was unable to complete them because of a medical condition (i.e., what other ways an officer might check for intoxication). Included in this discussion were questions about how police officers could exclude certain medical conditions, such as diabetes or high blood pressure, from indicating impairment (for example, consulting with medical professionals during a DWI investigation). Of course, getting the panel to understand the totality of the circumstances is an important part of jury selection in a case like Cooper's, and overall, this voir dire was more educational than most we might do in an intoxication manslaughter case. But educating the jury and dispelling related myths are very important.

### **Proving intoxication**

We knew that to prove Cooper was intoxicated and that his intoxication caused a crash that killed four people, we needed to explain to the jury the medical reasons a doctor would prescribe oxycodone, Valium, and Gabapentin to a patient, how these drugs affect the human body, and that those effects impaired Cooper's ability to safely operate a car.

It was paramount to proving our case to connect the side effects of the drugs in Cooper's system with his driving, appearance, and actions at the time of the crash and during the investigation. About a month before trial, we sat down with our DRE and our toxicology expert, Dr. Sarah Kerrigan.<sup>4</sup> When we first retained Dr. Kerrigan, we provided her with several important items from the case file: the police report, EMS records, DRE evaluation report and video, videos of the EMS and officers interviewing Cooper at the scene, toxicology reports, and Cooper's prescription records. We prepared for this first meeting by reviewing the DRE evaluation and police report to familiarize ourselves what officers, first responders, and civilians witnessed at the crash scene.

We discussed our concerns and what we thought would be potential issues at trial. A person intoxicated on prescription drugs can often look nothing like the stereotypical drunk, and Cooper was no exception. On the various videos of his interactions with EMS and officers, the evidence of Cooper's intoxication often appeared subtly. When Cooper was engaged in conversation, he would generally respond appropriately and maintain his focus; however, when he was not being engaged, he had trouble keeping his eyes open and displayed one of the classic indicators of narcotic analgesic impairment, being "on the nod" (that is, the semi-sleep state that narcotics users experience while on the drug).

We also discussed some of the evidence that our toxicology expert believed to be inconsistent between the DRE evaluation and toxicology reports. The amount of oxycodone in Cooper's blood was above the therapeutic range, the amount of Valium and its active metabolite was around the middle of the therapeutic range, and the amount of Gabapentin was in the low end of the therapeutic range. Our toxicology expert would have expected Cooper to display horizontal gaze nystagmus (HGN) because of the Valium, a CNS depressant, but neither our current DRE nor the DRE officer who interviewed and administered tests to Cooper at the scene saw HGN in his eyes. Our toxicology expert explained that although Cooper did not have HGN, that did not mean that the Valium and its metabolite were not contributing to his intoxication.

The fact that our DRE did not see HGN would also allow us to respond to the confirmation bias argument that defense attorneys often make against DREs. Defense attorneys often argue that DREs claim to observe clinical indicators of impairment consistent with the type of substance the arresting officer tells them the suspect admitted to taking. But though our DRE was told that Cooper admitted to taking Valium and oxycodone and he would have expected to see HGN, he didn't actually observe nystagmus, and he documented only what he observed.

We ended our first meeting with a plan to meet again in another week; Andrew would prepare direct examination questions for both the DRE and our toxicology expert, our DRE would review his materials, and the toxicology expert would delve into the scientific studies and literature on oxycodone and Valium, peak concentrations and dosages, and how they affect driving. The three of us met once more, and after that Andrew met with the DRE and tox expert separately (to review the videos of the DRE's evaluation of Cooper and to finalize the questions that we would ask her and

what her answers would be, respectively). Our tox expert also provided me with several studies to use during cross-examination of the defense expert.

### **The trial**

Everyone who interacted with Cooper immediately after the crash, from civilian witnesses to first responding officers and paramedics, noted that his speech was slurred, his reactions were slow, his balance was unsteady, his pupils were constricted, his thought disorganized, and that he was “on the nod.” We knew that narcotic analgesics and CNS depressants typically cause all of these signs, and we decided to highlight this intoxication evidence throughout the trial by calling all of the witnesses who made these observations.

The civilians and most of the officers couldn’t say whether Cooper’s behavior and appearance was due to intoxication on prescription drugs or whether it was caused by a medical condition. The paramedics, the ER staff, and the DRE, however, could make that distinction. We felt that it would help the jury understand that Cooper’s impairment was due to drug intoxication by walking them through the same analysis that we did on the day of the crash and eliminating medical impairment as a possibility.

We started by calling a close friend of the Sedlmeiers who saw them leaving church that morning and who could tell us what the typical Sunday was like for the family. We then went straight into the good Samaritans who called 911 and followed Cooper for more than 5 miles trying to get him off the road, the first two responding officers, paramedics, the DRE who interviewed Cooper and administered SFSTs right after the crash, and emergency-room personnel. At this point the jury had heard from numerous people who believed Cooper was intoxicated and that his impairment was not caused by any sort of injury, ailment, or illness.

We then called analysts from SWIFS and NMS who tested Cooper’s blood. We asked only about the testing process and the results of the testing and did not ask the analysts to interpret their findings or get into detail about how those drugs affect the human body. We wanted all the interpretation testimony to come from our toxicology expert, Dr. Kerrigan, so there would be only one consistent line of testimony for the jury to consider.

Next up was our DRE, who went through the details of his evaluation. His testimony combined what jurors had already heard regarding the physical manifestations of the drugs in Cooper’s system (from civilians, other officers, and medical personnel) with the known drugs in his system. Jurors had already heard, “I observed slurred speech, unsteady balance, constricted pupils, and the nod,” as well as that Cooper had oxycodone, Valium and its active metabolite, and Gabapentin in his system. The DRE could then say that oxycodone is a narcotic analgesic and that such drugs cause constricted pupils and being “on the nod.” The DRE could do the same thing for the other drugs, explaining their effects on the body.

We followed the DRE with our toxicology expert, who built on and reinforced the DRE’s testimony. Dr. Kerrigan gave meaning to the amounts of each drug in the defendant’s system and explained that although Cooper had likely developed some tolerance to these drugs after taking them for years, he wouldn’t have been showing impairment if he had a tolerance to the drug amounts in his system. She also explained the additive effect that narcotic analgesics and CNS depressants often have when taken together and that even though two of the three drugs in his system were in the therapeutic range, their combined effect was impairing.

At this point in the trial we transitioned from putting on evidence to prove intoxication to proving that Cooper’s intoxication caused the crash. We did so by explaining how these three drugs can and do impair someone’s ability to safely operate a car. The jury heard about common driving mistakes made by people intoxicated on Valium and oxycodone, such as an inability to maintain a single lane or overcorrecting, the same things Cooper was doing that caused the crash. We also wanted to show the jury the aftermath of how these drugs impair driving by calling the medical examiner to testify as to the horrific injuries sustained by each member of the Sedlmeier family. We followed the medical examiner by calling crash reconstruction officers to explain how the crash happened, and we ended our case by putting one of the Sedlmeiers’ family members on the stand to identify their bodies from the autopsy photos.

## Countering the defense

Starting at the crash scene on that Sunday afternoon, we anticipated that the defense would try to attribute Cooper's behavior to a medical or age-related explanation. It was the only plausible defense available to them. They could attempt to minimize and provide innocent explanations for the observations that the witnesses made of Cooper's person, but they would have a difficult time explaining away his driving.

The defense initially provided us with notice of eight potential defense experts, including some of the more well-known names in the industry, and we provided it to our toxicology expert. We learned which one of these experts the defense actually had lined up to testify, and with that information our toxicology expert determined the avenue of attack that defense expert would pursue: that Cooper had developed a tolerance to the oxycodone and Valium because he had been taking them both for years and, therefore, those drugs did not cause impairment—the crash had to be caused by either medical or age-related issues. We also expected that the defense would talk about the various drugs in isolation and avoid discussing any additive effects. We were confident that several factors—our work early on in the investigation, Cooper having been evaluated by EMS and ER staff the day of the crash, and our obtaining so many of Cooper's medical records—would pay dividends at trial by allowing us to disprove the defense claims. We were right.

## Conclusion

Ronald Cooper was convicted of intoxication manslaughter for each of the four deaths in this case and was also found guilty of two counts of aggravated assault. The defense elected to have the judge assess punishment, and Cooper was sentenced to 20 years in prison on each count (the maximum). The judge stacked the sentences for a total of 80 years.

This case highlights the dangers with drug impaired drivers, especially those who take legally prescribed medication and drive, thinking they are all good. Like it or not, prosecutors cannot approach one of these cases like we would an alcohol intoxication case or even an illegal drug intoxication case. They are different, and juries will see them as different until we spend time educating them through voir dire, researching the defendant's medical history and reasons for taking the drugs, shoring up State's experts, and addressing anticipated defenses head-on and up-front. But all of that work is worth it. The Sedlmeiers' deaths were not the result of an accident. Ronald Cooper drove while intoxicated, and his intoxication killed them. Justice requires that we take up these challenges for the victims, and it is well worth the fight in any prescription drug intoxication man-slaughter case.

## Endnotes

1 The discovery of these pills led to an entirely separate criminal investigation into the doctor who prescribed them. By happenstance, a police officer on scene recognized the doctor's name on the pill bottles and knew that the Drug Enforcement Administration (DEA) had been investigating him for operating a "pill mill" in our county. I reached out to the DEA and discovered that authorities there had been waiting for two years for the U.S. Attorney's Office to move forward on the case. Our office decided that the safety of the public required immediate action, so the next day (two days after this crash), we ran a search warrant on the doctor's office and shut it down. The doctor and others were subsequently charged with various counts of insurance fraud and prescription fraud. Those cases are still pending.

2 [www.houstonchronicle.com/neighborhood/woodlands/news/article/Wife-of-retiree-charged-in-deadly-crash-says-he-6520435.php](http://www.houstonchronicle.com/neighborhood/woodlands/news/article/Wife-of-retiree-charged-in-deadly-crash-says-he-6520435.php) [2] and [www.desertsun.com/story/news/2015/09/20/four-dead-in-major-accident-on-highway-105-in-conroe/72523854/](http://www.desertsun.com/story/news/2015/09/20/four-dead-in-major-accident-on-highway-105-in-conroe/72523854/) [3].

3 We sent Cooper's blood samples to the Southwestern Institute of Forensic Sciences (SWIFS) in Dallas for testing. Our office often uses SWIFS to test blood on fatality crashes where substances other than alcohol are suspected because the turnaround time is much faster than the DPS lab.

4 Although we were able to hire an independent forensic toxicologist for this case, the forensic toxicologist who performed the analysis would have been otherwise capable of assisting in pretrial planning and in testifying in the trial.



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[3] <http://www.desertsun.com/story/news/2015/09/20/four-dead-in-major-accident-on-highway-105-in-conroe/72523854/>