

**In The Matter Of:**  
*The State of Florida v.*  
*Ashley Christina Benefield*

---

*Dr. Russell S. Vega*  
*February 15, 2023*

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IN THE CIRCUIT COURT OF THE TWELFTH  
JUDICIAL CIRCUIT OF THE STATE OF FLORIDA,  
IN AND FOR MANATEE COUNTY, FLORIDA

CASE NO.: 2020-CF-003014AX

THE STATE OF FLORIDA,

Plaintiff,

vs.

ASHLEY CHRISTINA BENEFIELD,

Defendant.

-----/

DEPOSITION OF

DR. RUSSELL S. VEGA

Taken on Behalf of the Defendant

DATE TAKEN: Wednesday, February 15, 2023  
TIME: Commencing at 9:00 a.m.  
PLACE: 2001 Siesta Drive  
Suite 302  
Sarasota, Florida 34239

Examination of the witness taken before:

Olivia Cristantiello, CSR  
Certified Shorthand Reporter

Imperial Court Reporting (941) 260-9000

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1 WHEREUPON,

2 DR. RUSSELL S. VEGA

3 acknowledged having been duly sworn to tell the truth and  
4 testified upon his oath as follows:

5 THE WITNESS: I do.

6 DIRECT EXAMINATION

7 BY MR. TAYLOR

8 Q. Good morning. Would you please tell us your  
9 full name.

10 A. Good morning. My name is Russell Scott Vega.  
11 The last name is spelled, V-E-G-A.

12 Q. And you are the district medical examiner?

13 A. That's correct.

14 Q. I have a few question on behalf of Ashley  
15 Benefield that I'd like to ask you, Dr. Vega.

16 A. All right.

17 Q. I'd first like to start out with some  
18 questions -- I'm not going to do the traditional take up  
19 your time with your qualifications. I'm quite familiar  
20 with them. I'd like to ask you in general some questions  
21 about the analysis and the interpretation of gunshot  
22 wounds in particular, and whether or not it's an  
23 essential and common practice among forensic  
24 pathologists.

25 A. Meaning, the examination and interpretation of

1 such wounds?

2 Q. Yes, sir.

3 A. Absolutely, it is.

4 Q. All right. Essential, no?

5 A. Yes.

6 Q. Would you agree it's an integral aspect of  
7 training for pathology residency?

8 A. It is in that forensic pathology training is  
9 part usually a one-month rotation of overall pathology  
10 training. And in most of those one-month rotations,  
11 pathology residents can expect to get at least a little  
12 bit of exposure to gunshot wounds.

13 Q. I want to ask you about some of the  
14 post-academic education factors that perfect the skills  
15 of a forensic pathologist as they relate to the study of  
16 gunshot wounds. I think we can probably agree that some  
17 forensic pathologists are better than others?

18 A. Sure.

19 Q. Like any category of professionals?

20 A. Sure.

21 Q. So share with me if you wouldn't mind,  
22 Dr. Vega, some of the criteria that contribute to making  
23 someone a top tier forensic pathologist.

24 A. I will share with you what I think are the  
25 necessary attributes to do the job well. I don't really

1 think of putting myself and my colleagues around the  
2 country into tiers necessarily.

3 Q. I understand.

4 A. But to do the job well requires -- and  
5 specifically with regard to the interpretation of gunshot  
6 injuries, it requires being trained by people who are  
7 knowledgeable in the -- knowledgeable and have experience  
8 in the interpretation of such things, and getting  
9 experience over years and looking at many such injuries  
10 in the context of both the examination and a thorough  
11 understanding of the background events leading to the  
12 injuries.

13 And then in correlating those findings with  
14 other analyses that are present in every autopsy, such  
15 that in those cases, you have the opportunity to build a  
16 repertoire of experience in correlating background,  
17 autopsy findings, other analyses and ultimate  
18 determinations of the cause and manner of death, which is  
19 the principal responsibility of the medical examiner.

20 Q. Sure. And would you agree that the actual  
21 experience that is to say with the number of autopsies  
22 that are conducted help perfect those skills?

23 A. Sure.

24 Q. All right. Are you familiar, Dr. Vega, with  
25 Dr. Emma Lew?

1 A. Yes.

2 Q. How so?

3 A. She was an associate medical examiner for an  
4 extended period of time for the Miami-Dade Medical  
5 Examiner Office. And I think at the passing of Dr. Bruce  
6 Hyma -- when was that -- actually, not the passing of,  
7 the resignation of Dr. Bruce Hyma, his ultimate passing,  
8 first part of the second decade of the 2000s.

9 I don't remember exactly what year. But she  
10 was his successor as chief medical examiner in Miami-Dade  
11 and she served in that capacity until a year -- last  
12 year. I think last year she resigned from that position.

13 Q. And are you familiar with her standing in the  
14 forensic pathology community?

15 A. She's a well respected member of the community.

16 Q. And I would assume that includes you, as well,  
17 as far as acknowledging her as a respective member of the  
18 forensic pathology community?

19 A. Yes.

20 Q. Did you conduct the autopsy of Douglas  
21 Benefield?

22 A. I did.

23 Q. So I want to ask you a few questions about that  
24 in particular and one of the three wounds in particular,  
25 Dr. Vega, specifically what you characterize as probably



1 a grazing gunshot wound to the right arm.

2 A. Yes.

3 Q. I believe that was on page five of your autopsy  
4 report; correct?

5 A. That's right.

6 Q. All right. So would -- can we agree that a  
7 grazing gunshot wound is one which strikes the skin at a  
8 relatively shallow angle and produces an elongated area  
9 of abrasion?

10 A. It depends on the surface of the skin, how  
11 tangential it is to that course and such as to whether or  
12 not it's going to be elongated. But I think if you were  
13 to talk about the classic or characteristic of a grazing  
14 wound, they typically are elongated.

15 Q. Okay. Can you describe for me the other  
16 features that are unique to a grazing gunshot wound?

17 A. I don't know that I would use the term unique.  
18 But grazing wounds have certain characteristics because  
19 of essentially the parameters we're setting to call  
20 something a graze.

21 Q. Yes, sir.

22 A. When you call -- when one would call an injury  
23 a grazing wound, that by definition is limiting it to not  
24 penetrating or tunneling or in some deeper fashion  
25 involving the underlying tissues besides the skin.

1           So, you know, I think in terms of unique or  
2   characteristic, whatever findings, that's the only one.  
3   And it very much then depends on the nature of the skin,  
4   the nature of the projectile at the time that it's  
5   causing the injury. Those are the two principal features  
6   that will determine how such an injury is going to  
7   manifest.

8           Q.    A lot of variables at play?

9           A.    Sure.

10          Q.    All right. Let's take a look, if we can, at  
11   what I'm going to mark as Defendant's Exhibit Number 1  
12   for the purposes of the deposition, and ask you if you  
13   would be kind enough to identify that for me. If you  
14   need to compare it with your file, take your time.  
15   That's fine.

16          A.    No. This is the wound of the arm that -- the  
17   right arm specifically that we are discussing and is  
18   described on page five of the autopsy report.

19                (Defendant's Exhibit No. 1 was marked for  
20   Identification.)

21   BY MR. TAYLOR

22          Q.    And if you would, you can keep that for  
23   purposes of the next few questions. Directing your  
24   attention specifically to -- well, let me first ask you  
25   this: Would you explain for me, for purposes of a

1 grazing gunshot wound, if there's something that is  
2 relatively common to where the projectile first meets the  
3 skin?

4 A. Again, it depends on the shape and the nature  
5 of the projectile. When you think of the way a -- say,  
6 maybe a non-tumbling, non-deformed projectile grazing  
7 against relatively flat skin, then the first part of the  
8 projectile that is in contact with the skin is the nose,  
9 and if it's firing, as most of these typically are  
10 without any other affect, a spinning nose of the  
11 projectile. That in a most characteristic fashion will  
12 lead to a -- an oval or scalloped initial -- what's the  
13 right word I'm looking for -- proximal aspect of the  
14 wound.

15 Q. Okay. So now, directing yourself to our  
16 Exhibit Number 1. Would you take a look and specifically  
17 focus on the proximal aspect of that wound and tell us  
18 whether or not it's a more rounded area of the anterior  
19 inferior and specifically at the 5 o'clock area?

20 A. It's not.

21 Q. You don't believe it to be?

22 A. No.

23 Q. All right. If it were, would that be  
24 indicative of where the projectile first struck the skin?

25 A. It could be.

1 Q. Are the projectiles for grazing gunshot wounds  
2 generally when they first make contact with the skin,  
3 Dr. Vega, or one of the other characteristic of such a  
4 wound, does it produce a deeper area of penetration where  
5 the projectile first strikes the skin generally?

6 A. Generally, that's the shallow area. Skin,  
7 typically, is at least somewhat rounded. So a tangential  
8 wound is going to be shallower at the ends, both the  
9 entrance and the exit, and is going to be deeper in the  
10 middle portion of that wound.

11 Q. Okay. And just so there's no confusion --

12 MR. TAYLOR: Jack, do you have pen that  
13 Dr. Vega can use to draw?

14 MR. O'KEEFE: I got one like a felt tip, and  
15 then an actual little marker tip.

16 THE WITNESS: Doesn't matter to me.

17 BY MR. TAYLOR

18 Q. Would you, Dr. Vega, for purposes of our  
19 exhibit, first, describe if you wouldn't mind where the 5  
20 o'clock area is?

21 A. Well, 5 o'clock depends on one's orientation.  
22 So if I'm going to orient this photograph with the number  
23 and ruler at the bottom where the number is written with  
24 numerals straight up, as one would normally read them --

25 Q. Mm-hmm.

1           A.    -- then the 5 o'clock margin of the injury is  
2 here, where I put the star.

3           Q.    Okay. And would that also be characterized as  
4 the anterior inferior area?

5           A.    No.

6           Q.    All right. Where would that be?

7           A.    Marked that with a triangle.

8           Q.    Okay. Would you agree, Dr. Vega, that the  
9 direction of travel in these type of wounds is often  
10 difficult to determine?

11          A.    Yes.

12          Q.    And, in fact, you acknowledge that in your  
13 earlier testimony, did you not before the court at the  
14 dependency hearing?

15          A.    I honestly don't recall my testimony in that  
16 hearing, but I have no reason to doubt that statement.

17          Q.    All right. So do these type of wounds,  
18 Dr. Vega, often have accompanying lacerations?

19          A.    The term laceration, in my opinion, would not  
20 be an appropriate term to use in describing the  
21 manifestations of a gunshot wound in general. So I would  
22 say no, but it may be because of the terminology you're  
23 using.

24          Q.    All right. Are they often accompanied by  
25 surrounding marginal splits in the skin?

1           A.     Sometimes.

2           Q.     Okay.  And when they are, do those generally  
3 point in the direction of travel?

4           A.     The skin tags, generally when they're well  
5 developed, point in the direction from when the bullet  
6 came.

7           Q.     And what about as opposed to skin tags, the  
8 splits in the skin, what I was referring to as  
9 lacerations?  Will those generally point in the direction  
10 of travel?

11          A.     I guess it depends on what you mean by point.

12          Q.     Will they be consistent with the direction of  
13 travel as opposed to the skin tags which point towards  
14 the gun, if you will?  Do they help the pathologist make  
15 that determination?

16          A.     They do.  And I think I want to answer your  
17 question yes.  I'm not -- I want to make sure I  
18 understand.  Maybe a diagram will help me confirm that  
19 we're using the terminology in a similar way.

20          Q.     Okay.  Well, I just happen to have something  
21 that I think will help.  What I would like to do is I  
22 want to read you some brief excerpts from a couple of  
23 articles first, then ask you whether or not you agree or  
24 disagree with the statement that I'm going to read.  The  
25 first is from Forensic Pathology Principals and

1 Practices, and it states as follows:

2 Graze gunshot wounds are usually superficial.  
3 Graze wounds have skin tags that point toward the  
4 firearm. In other words, the skin tags point opposite to  
5 the direction of travel of the projectile. Tiny skin  
6 tags can frequently be seen in entrance gunshot wounds  
7 and in exit wounds to indicate direction of travel of the  
8 projectile.

9 Agree or disagree?

10 A. I agree. Except the last part is talking about  
11 entrances and exits is typically reserved for perforating  
12 wounds, not (crosstalk) --

13 Q. Penetrating. Agreed. Okay. All right. The  
14 next one I'm going to read from is from the Academy of  
15 Forensic Pathology and Unusual Feature of Grazing Gunshot  
16 Wound by Michael Heninger, and he states as follow -- and  
17 this will be the diagram that I think you're looking for,  
18 which will help all of us.

19 The common appearance of a graze wound consists  
20 of an elliptical furrow in the skin of variable depth.  
21 The initial point of contact or the proximal corner of a  
22 graze wound may have a partially round or crescentic  
23 margin of abrasion resembling a portion of a typical  
24 entrance wound margin of abrasion.

25 This can be helpful in distinguishing a graze

1 wound from a laceration and determining direction. The  
2 edges of the graze wound may have small diagonal  
3 lacerations. Because the kinetic energy of the  
4 projectile is dissipated away in every direction, the  
5 lacerations tend to radiate away from the initial point  
6 of contact.

7           These small lacerations create corresponding  
8 diagonal skin tags that point back in the direction from  
9 which the projectile came. The distal corner is variable  
10 in appearance, often irregular, and lacerations may be  
11 present.

12           Agree?

13           A. Except that I would not use the term  
14 lacerations. I think the term laceration is best  
15 reserved for tearing of the skin that occurs as a result  
16 of blunt impact. So I would continue to call these  
17 tears. That's the only difference I would take in  
18 terminology there.

19           Q. Well, and I defer to you since this is your  
20 field and I'm merely a trespasser momentarily. Here is  
21 an exhibit that I'm going to present to you and I'm going  
22 to mark as Defendant's Number 2.

23           (Defendant's Exhibit No. 2 was marked for  
24 Identification.)

25           MS. FREEL: Dr. Vega, while he does that, would



1           you mind showing me that picture you were looking at  
2           before?

3           THE WITNESS:   The exhibit that Mr. Taylor  
4           showed me that I marked on it?

5           MS. FREEL:   Does it have your ME number on it,  
6           or it doesn't?

7           THE WITNESS:   It does.   It does.

8           MS. FREEL:   Would you mind telling me what it  
9           is.   Thank you, sir.   I was looking for the picture  
10          number.   It doesn't, but I'll find that one.

11          Thank you, sir.   Thank you.

12          THE WITNESS:   Yep.

13   BY MR. TAYLOR

14          Q.   All right.   Does defendant's Exhibit Number 2,  
15   Dr. Vega, adequately depict a grazing gunshot wound?

16          A.   I think it's a good diagram of a -- maybe a  
17   typical or characteristic example of a grazing gunshot  
18   wound.

19          Q.   All right.   And it shows both tears, if you  
20   will, which we're debating whether or not apparently some  
21   in the profession refer to them as lacerations, as well  
22   as skin tags?

23          A.   Yes.

24          Q.   And we're in agreement that the skin tags  
25   generally point in the direction of the gun?

1           A.     Yes.

2           Q.     And the tears or lacerations generally point in  
3     the direction of travel, the projectile?

4           A.     The only issue I ever had here was what the  
5     term point meant. And if we mean point being the  
6     direction of the broader base of the tear to the apex of  
7     the tear, then I would say yes.

8           Q.     Okay.

9           A.     I think there's maybe a presumption that's what  
10    point would mean. But if somebody was saying point is  
11    starting from the beginning and going toward the larger  
12    portion, which some people might mean pointing, it would  
13    be the opposite direction.

14                So just I want to make sure we were talking  
15    about the same direction. So when you're saying point,  
16    you are referring to the direction that I also was  
17    presuming you meant, and so I think I can answer your  
18    question -- initial question and say, yes, I agree with  
19    that.

20           Q.     All right. Let's take a look on the diagram,  
21    which has been marked Number 2 as defendant's exhibit.  
22    And I'm going to ask you if you would explain what they  
23    refer to as the proximal corner in an initial contact  
24    area of the projectile?

25           A.     I mean, they've labeled this on the diagram.

1 I'm not sure I know what you mean by explain.

2 Q. In this diagram, where the projectile first  
3 makes contact with the skin, would that be described as  
4 the proximal corner?

5 A. Yes.

6 Q. Okay. So going back to our exhibit that we  
7 have labeled number one. Would you using the pen that I  
8 gave you, would you mark what you believe to be the  
9 proximal corner of that wound?

10 A. I circled it with dotted lines.

11 Q. Mm-hmm. Okay. Now, I have just a couple of  
12 other excerpts I'd like to read to you. This is from the  
13 Archives of Pathology and Laboratory Medicine Practical  
14 Pathology of Gunshot Wounds, and it says as follows:

15 When a bullet penetrates the skin nose on, it  
16 produces a concentric margin of abrasion, that is ring of  
17 scraped skin of uniform thickness because it enters  
18 perpendicular to the skin. When the nose of a bullet  
19 penetrates the skin at an angle, it produces an eccentric  
20 margin of abrasion, that is, a ring that is thicker in  
21 one area. The thick area of an eccentric margin of  
22 abrasion indicates the direction from which the bullet  
23 came.

24 Agree?

25 A. Yes.

1 Q. Here's an article I'm sure by an author you're  
2 familiar with. Vincent J. M. Di Maio, former San Antonio  
3 medical examiner and professor of pathology. Gunshot  
4 Wounds: Practical Aspects of Firearm Ballistics and  
5 Forensic Technics. And Dr. Di Maio says:

6 A graze wound is one in which a bullet strikes  
7 the skin at a shallow angle producing elongated area of  
8 abrasion without actual perforation or tearing of the  
9 skin. In a tangential wound, the injury extends down  
10 through the subcutaneous tissue. The skin is torn or  
11 lacerated by the bullet. In both grazed and tangential  
12 wounds, it may be difficult to tell the direction in  
13 which the bullet was traveling when it produced the  
14 wound.

15 A. Yes, I agree with that.

16 Q. And lastly, from the Forensic Aspects of  
17 Ballistic Injury Division of Forensic Medicine, Forensic  
18 Aspects of Ballistic Injury by Velma and Schultz. They  
19 write:

20 A grazed wound resulting from tangential  
21 contact with passing bullet may reveal the direction of  
22 fire. Careful hand lens examinations of such a wound may  
23 reveal skin tags on the lateral wound margins of the  
24 grazed wound through trough pointing towards the weapon.  
25 The lacerations along the wound trough margins point in

1 the direction the bullet moved.

2 Agree?

3 A. Those are all very similar and reasonable  
4 characterizations of a typical grazing wound.

5 Q. I want to ask you a couple questions now,  
6 Dr. Vega, about the actual investigation that you  
7 conducted.

8 A. Sure.

9 Q. How did you determine the nature of this wound  
10 that we are focusing on?

11 A. Well, I didn't determine the nature of the  
12 wound. I gave you a probable -- in my report --

13 Q. Yes, sir.

14 A. -- an opinion of what I thought was the more  
15 likely underlying etiology of that wound.

16 Q. You used the qualifier?

17 A. Yes.

18 Q. Okay. And as opposed to, for example, the  
19 other two wounds which had no qualifiers, this one did?

20 A. Yes.

21 Q. All right. Did you use -- in examining the  
22 wound, Dr. Vega, did you use a hand lens and/or a  
23 microscope?

24 A. No.

25 Q. Were you able to determine if any tears or

1 lacerations were present?

2 A. There were no tears or lacerations present.

3 Q. Would you have been able to determine whether  
4 or not any skin tags were present?

5 A. No skin tags were present.

6 Q. Would you have been able to better make that  
7 decision had you examined it with a microscope or a hand  
8 lens?

9 A. No.

10 Q. Why?

11 A. Because it's not that kind of a wound. There  
12 is no penetration of this wound beyond the epidermis,  
13 maybe the very superficial -- or the superficial dermis.  
14 So I don't think there are -- I don't think there's skin  
15 tag here to be examined.

16 Q. Okay.

17 A. I shouldn't say super -- I think there's  
18 involvement of the epidermis and the dermis.

19 Q. Mm-hmm.

20 A. Superficial is probably not an appropriate term  
21 here, so I'm going to rephrase my description. But this  
22 injury does not go -- it does not involve the depth of  
23 the wounds that were typically being described, I think,  
24 in your very well formulated descriptions in those  
25 references to look for skin tears or tags.

1 Q. Okay. Can we characterize, if I can --

2 MR. TAYLOR: Do we have a different color  
3 marker?

4 MR. O'KEEFE: One here.

5 BY MR. TAYLOR

6 Q. Would you -- I'm going to draw a box around  
7 this right here. Are you able to see where I've drawn  
8 the red box?

9 A. I am.

10 Q. Okay. It's not very obvious. Little better.  
11 Could that be characterized as a skin tag?

12 A. I wouldn't characterize it as a skin tag.

13 Q. Does it have enough of a characteristic that  
14 you would understand if a colleague would characterize it  
15 as a skin tag?

16 A. People -- people characterize things in lots of  
17 ways. I can tell you in the parlance of deeper injuries  
18 with skin tags and furrows of grazing wounds, I would not  
19 characterize that in that way.

20 Q. And you would not consider that, a colleague  
21 might?

22 A. A colleague might characterize that in many  
23 number of ways. People have different opinions about  
24 things.

25 Q. Okay. With regard to opinion, in the autopsy

1 on page five, you described this wound as having a  
2 probable direction of travel from back to front?

3 A. Yes.

4 Q. Okay. Again, a qualifier?

5 A. Yes.

6 Q. Then at the dependency hearing, and I will  
7 happy to show you a transcript if you'd like, you said  
8 that it had features more suggestive of back to front.  
9 Do you recall that?

10 A. I don't recall it, but that sounds reasonable.

11 Q. Again, a qualifier?

12 A. Yes.

13 Q. And these are, again as we've read earlier,  
14 difficult wounds to determine?

15 A. Yes.

16 Q. All right. Would it help you to know if I told  
17 you that another forensic pathologist determined that it  
18 was a front to back trajectory rather than a back to  
19 front?

20 A. It wouldn't help me. It wouldn't surprise me.  
21 People have different opinions.

22 Q. Okay. And you would respect the opinion,  
23 assuming that the colleague was otherwise qualified?

24 A. I can respect an opinion and not necessarily  
25 agree with it.



1 Q. Absolutely. So let me show you another  
2 photograph, which hopefully I'll find here in a moment.

3 MR. O'KEEFE: Is it that one?

4 MR. TAYLOR: I'm going to mark this as Defense  
5 Exhibit 3.

6 (Defendant's Exhibit 3 was marked for  
7 Identification.)

8 BY MR. TAYLOR

9 Q. And I'm going to pass to you what is the same  
10 photograph, would you agree?

11 A. Yes.

12 Q. But marked by another, which indicates an  
13 abrasion and the direction of travel and skin tag?

14 A. Yes.

15 Q. Now, can we agree, Dr. Vega, that your use of  
16 the qualifiers both probable and suggestive, means that  
17 you have opinion, you did the best you could, but you're  
18 not certain?

19 A. Yes.

20 Q. Okay. And that is the nature of these type of  
21 wounds; is it not? Or I should say are they not?

22 A. I mean, it's the nature of many things at  
23 times. Some things are more characteristic and much more  
24 likely to have an overwhelming consensus of opinion about  
25 what the nature is and some things are less so.

1 Q. This would be less so?

2 A. I believe yes.

3 Q. All right. Toward that end, you're absolutely  
4 certain about the other two wounds and the opinion that  
5 you have?

6 A. Yes.

7 Q. As to this wound, you would not be prepared to  
8 live and die over your opinion?

9 A. I don't live and die over any opinion. But I  
10 certainly have a much lower degree of certainty with this  
11 injury and the opinions that I've rendered in my report  
12 and determinations, as opposed to the other injuries.

13 Q. Okay. Let me see if I can phrase the question  
14 this way: If I were to ask you, Dr. Vega, is it a fact  
15 that you have no reasonable doubt as to the opinion of  
16 the trajectory of this wound, what would you say?

17 A. I would say that is wrong. I do have a  
18 reasonable doubt.

19 Q. Okay. Fair enough. I have just a few  
20 miscellaneous questions I would like to ask you,  
21 Dr. Vega, and then we can wrap up.

22 A. Sure.

23 Q. Are you familiar with the term blading? This  
24 is not a medical term.

25 A. I don't believe I am.

1           Q.     Okay.  It's generally used with respect to  
2     gunshots and attempting to defend from being struck by a  
3     projectile.  Never heard it used before?

4           A.     No.

5           Q.     Twisting of the body, minimizing the area of  
6     potential impact?

7           A.     I have not heard that term before.

8           Q.     All right.  Sometimes with gunshot wounds, you  
9     have obvious defensive wounds; yes?

10          A.     I generally don't use that terminology.  But  
11     are there sometimes injuries which are consistent with  
12     one trying to fend off an attack by bullet or anything  
13     else?  Yes.

14          Q.     Yes.  Same thing with knives?

15          A.     Absolutely.

16          Q.     Okay.  Does the absence of defensive gunshot  
17     wounds exclude aggressive behavior?

18          A.     No.

19          Q.     Does the absence of defensive gunshot wounds  
20     exclude offensive behavior?

21          A.     No.

22          Q.     Are we able to reconstruct -- strike that.

23                 We cannot reconstruct with any real reliability  
24     the order of the shots; can we?

25          A.     There's nothing that I can recall about the

1 nature of the injuries or any other information, you  
2 know, based on my examination that would allow me to do  
3 that.

4 Q. Okay. So in this instance, and these are  
5 hypothetical, the chest wound could have been the first  
6 shot?

7 A. Yes. I might need to -- I might need to give a  
8 caveat to my first answer. When you asked that question,  
9 I was considering the gunshot wounds we were sort of  
10 dealing with after the graze I think because you had  
11 asked me about those separately, meaning the gunshot  
12 wound to the chest and the one to the extremity.

13 One of the -- one of the reasons that I came to  
14 the opinion that the arm wound could be grazed and/or is  
15 probably grazed and probably has a direction of travel,  
16 was that in my examination lined up well with the  
17 trajectory of the projectile extrapolated from the chest  
18 wound prior to it entering the chest.

19 And thus, if that is indeed the case, which I  
20 think is reasonable or -- or probable, but by no means  
21 certain, then the arm wound would proceed the chest  
22 wound. With regard to the chest wound and the leg wound,  
23 I don't have anything that allows me to determine which  
24 of those was first.

25 Q. Okay. And even with respect to your

1 description of the arm and the chest wound, it's again  
2 with a qualifier?

3 A. Yes.

4 Q. Okay. So here's the remaining questions that I  
5 have for you. Could the chest wound have been the first  
6 shot?

7 A. Yes.

8 Q. All right. And could the remaining two wounds  
9 then have been attributable to flight?

10 A. I mean, could they have occurred during a  
11 retreat from attack essentially --

12 Q. Yes.

13 A. Yes.

14 Q. General definition homicide. Can we agree it's  
15 the death of a human being at the hands of another?

16 A. I don't use that exact definition, but I use  
17 one that's close to that.

18 Q. Go ahead.

19 A. And I use that definition with a caveat that  
20 there has to be some intent to cause harm, injure or  
21 kill, otherwise, every traffic fatality is essentially a  
22 homicide and I don't agree with that interpretation,  
23 so --

24 Q. You're stealing my thunder.

25 A. I apologize.

1 Q. All right. So your definition of a homicide.

2 A. Yeah. The -- the death of a person at the  
3 hands of another, or by the direct actions of another  
4 with some intent to hurt, injure or kill.

5 Q. Okay. So you would agree not all homicides are  
6 crimes?

7 A. Yes.

8 Q. All right. We can have justified homicides?

9 A. I mean, that's a legal term, I think. But yes,  
10 my determination of homicide in manner of death from a  
11 medical legal perspective may result in anything from no  
12 charges at all to manslaughter to murder, and there are a  
13 lot of other factors at play in making that  
14 determination.

15 Q. Okay. You've seen through your extensive  
16 experience justified homicides, as well as excusable  
17 homicides; no?

18 A. Yes.

19 Q. Okay. Law enforcement officer having to shoot  
20 and kill a perpetrator of a violent crime as it's taking  
21 place; justified homicide?

22 A. Yes.

23 Q. Okay. A driver suffering a heart attack and  
24 having the car veer into a pedestrian and killing them;  
25 excusable?

1           A.     Yes.

2                   MR. TAYLOR:  I appreciate your time, especially  
3           given the short notice of this deposition.

4                   Give me just one moment.

5                   (A short recess was taken.)

6   BY MR. TAYLOR

7           Q.     One last question, if you would be kind enough.

8           A.     Yes.

9           Q.     With respect to Defendant's Exhibit Number 1,  
10   can you give us some explanation.  Within the circle that  
11   you drew indicating the proximal area of contact, there's  
12   the facing of the skin, a small portion.  Can you explain  
13   what that is?

14          A.     It looks to be a very focal area of abrasions  
15   separate from the main or more continuous other part of  
16   the injury.

17          Q.     So if that's the case and this is the proximal  
18   point of the injury, there would have been a topical  
19   contact initially and then a deeper contact following  
20   that?

21          A.     I think so.  I honestly don't have an excellent  
22   explanation for why the wound has that characteristic at  
23   that position.

24                   MR. TAYLOR:  Okay.  Thank you very much.  As  
25   you well know, you have the right to read or to

1 waive. Up to you. No difference to me. You get  
2 to --

3 THE WITNESS: So we're done?

4 MR. TAYLOR: We are. Unless the assistant --  
5 I'm sorry. Unless the assistant has any questions.  
6 I come from the school of if you haven't --

7 MS. FREEL: I do not have any questions. Thank  
8 you.

9 THE WITNESS: Okay. I just wanted to be sure.  
10 Usually, there's at least that I don't have any  
11 questions comment that comes up.

12 MS. FREEL: Appreciate it. I couldn't get  
13 unmuted.

14 THE WITNESS: I'll waive.

15 THE COURT REPORTER: Mr. Taylor, are you  
16 ordering this?

17 MR. TAYLOR: Yes, I am.

18 (Whereupon, the deposition was concluded at  
19 9:49 a.m.)

20

21

22

23

24

25



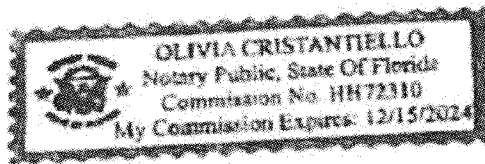
## CERTIFICATE OF OATH

STATE OF FLORIDA

COUNTY OF SARASOTA

I, Olivia Cristantiello, CSR, the undersigned authority, certify that DR. RUSSELL S. VEGA personally appeared before me on February 15th, 2023, at 9:00 a.m. and were duly sworn.

WITNESS my hand and official seal this 15th day of February, 2023.



A handwritten signature in cursive script that reads "Olivia Cristantiello".

---

Olivia Cristantiello, CSR

Imperial Court Reporting (941) 260-9000

## CERTIFICATE OF REPORTER

STATE OF FLORIDA

COUNTY OF SARASOTA

I, Olivia Cristantiello, Certified Shorthand Reporter, do hereby certify that I was authorized to and did stenographically report the deposition of DR. RUSSELL S. VEGA; that a review of the transcript was requested; and that the foregoing transcript, is a true record of my stenographic notes.

I FURTHER CERTIFY that I am not a relative, employee, or attorney, or counsel of any of the parties, nor am I a relative or employee of any of the parties' attorney or counsel connected with the action, nor am I financially interested in the action.

DATED this 28th day of February, 2023 at Sarasota County, Florida.



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Olivia Cristantiello, CSR

Imperial Court Reporting (941) 260-9000

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EXHIBIT

1

Vega 02/15/23 OC

5

4

3

2

1 mm

20-02495-M

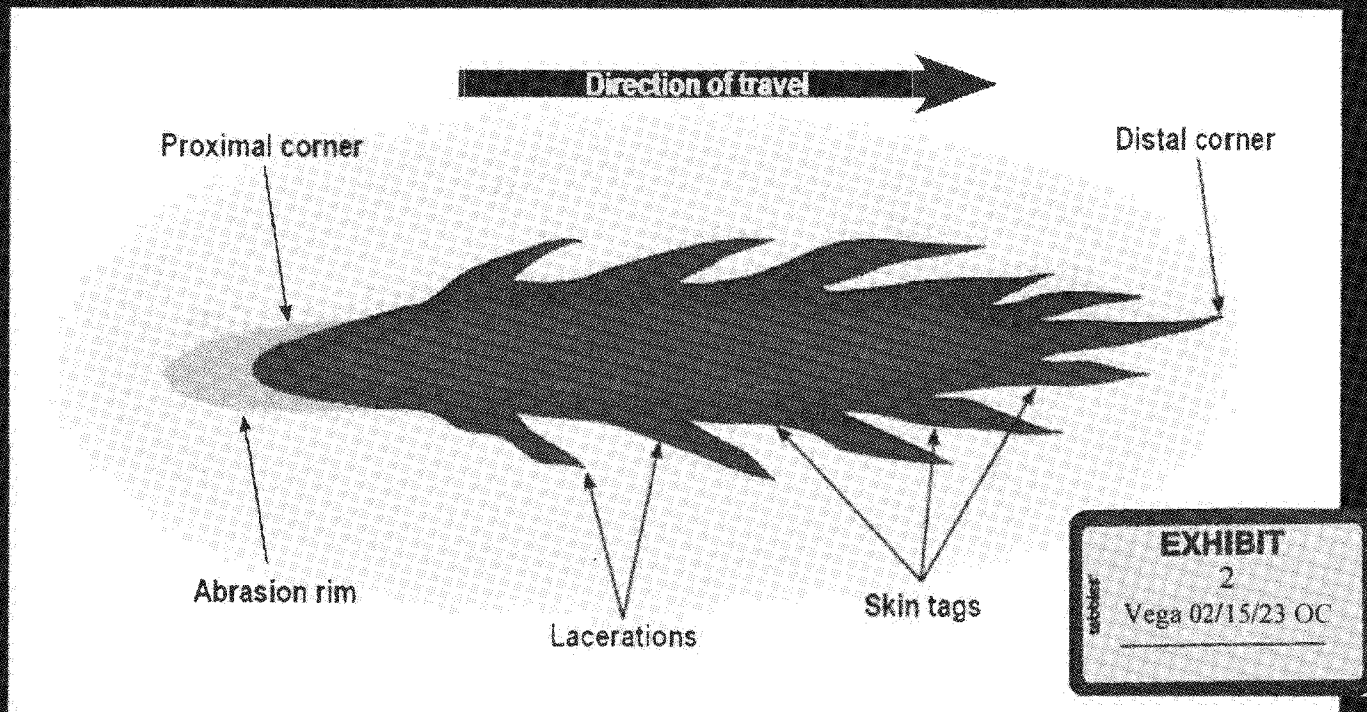
mm 1

2

3

4

5



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**Figure 1** Typical graze wound. Drawn under contract with professional medical illustrator Diana Kryski.



EXHIBIT

3

Vega 02/15/23 OC

LABORATORY

20-02495-M

5

4

3

2

1 mm

mm 1

2

3

4

5

Direction

Position

5 min