IN THE CRIMINAL COURT FOR KNOX COUNTY, D~~IVISION I~~

AT KNOXVILLE, TENNESSEE

STATE OF TENNESSEE)
)
VS.) CASE NO. 24527
)
BILLY RAY IRICK)

FILED
AUG 27 2010
By Joy R. McCroskey, Clerk

TRANSCRIPT OF THE EVIDENCE

Volume 3 of 3 Volumes

(Proceedings on 8/16/10 and 8/17/10)

EXHIBITS

THE HONORABLE RICHARD R. BAUMGARTNER, PRESIDING JUDGE

APPEARANCES

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Assistant District Attorneys
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Knoxville, Tennessee 37902

FOR THE DEFENDANT:

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Chattanooga, Tennessee 37401-17499

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CURRICULUM VITAE

STATE OF TENNESSEE VS. Billy Ray Irick
CASE NO. 24527 EXHIBIT NO. 1
DATE 8/16/10 ID ___ EVD ___

PERSONAL

Name:	Peter I. Brown, M.D., F.R.C.P. (C)
Address:	UnumProvident 1 Fountain Square Chattanooga, TN 37402 Telephone: (423) 755-1263 FAX: (423) 755-1117 e-mail: peterbrown@UnumProvident.com
Date of Birth:	February 10, 1951
Place of Birth:	Cornwall, Ontario, Canada
Citizenship:	Canadian
Immigration Status:	Resident Alien, 1996 ("Alien of extraordinary ability": #AO45276508)
Medical Licenses:	Province of Ontario and State of Tennessee

ACADEMIC RECORD

1975 Degree: Doctor of Medicine, University of Western Ontario

1975 - 1979 University of Toronto, Faculty of Medicine
Postgraduate Program in Psychiatry

1979 Passed Royal College Examinations in Psychiatry; Fellow of the Royal College

Physicians and Surgeons of Canada

PREVIOUS POSITIONS

1979 - 1980 Lecturer in Psychiatry, McMaster University

1980 - 1986 Assistant Professor, Psychiatry, McMaster University
Received tenure in 1985

1981 - 1986 Brain and Behaviour Programme, McMaster University

1979 - 1986 Staff Psychiatrist, Chedoke-McMaster Hospital
Visiting Staff, St. Joseph's Hospital

1983 - 1986 Consultant Psychiatrist, Ontario Cancer Clinic, Hamilton Civic Hospitals

1986 - 1994 Head of Consultation-Liaison Service, Head of Research, and Staff Psychiatrist, Department of Psychiatry, Mount Sinai Hospital

1986- 1993 Assistant Professor, University of Toronto

1993 - 1994 promoted Associate Professor, University of Toronto

1994 - 1996 Private Practice, Toronto

1996 - 1998 Moccasin Bend Mental Health Institute, Chattanooga, TN, Acute Care, Forensic Service, Certified Forensic Evaluator for the State of TN, Continuing Education Coordinator

1997 – 2000	Private Practice - Psychiatric Group of Chattanooga, Chattanooga, TN. December, 1997 – June,2000 Consultant Psychiatrist, Memorial Hospital and April,1999-June,2000 Erlanger Medical Center Chattanooga, TN
1999 - 2000	Private Practice – Psychology Center, Chattanooga, TN Consultant, UnumProvident, Chattanooga, TN
7/2000-2/ 2002	Medical Director, UnumProvident, Chattanooga, TN
2/2002-present	Lead Medical Director, UnumProvident, Chattanooga, TN

PROFESSIONAL ORGANIZATIONS

1. American Academy of Psychiatry and Law, Member, Peer Review and Psychopharmacology Committees 1998-2003; Councilor for Tennessee, Southern Membership Group, 1998-2000
2. American Psychiatric Association
3. College of Physicians and Surgeons of Ontario
4. Royal College of Physicians and Surgeons of Canada
5. Ontario Medical Association
6. Canadian Medical Association
7. Association for the Advancement of Philosophy and Psychiatry
8. Past President, Ontario Society of Clinical Hypnosis, 1992-1993

REVIEWER

The Journal of the Canadian Medical Association
The Journal of the Canadian Psychiatric Association
The Canadian Psychiatric Research Foundation
Clarke Foundation, Clarke Institute of Psychiatry
Ontario Mental Health Foundation
Psychological Perspectives
OSCH Newsletter
Pacifica Graduate Institute
New England Journal of Medicine
Journal of Clinical Psychiatry
Journal American Academy Psychiatry and Law
American Journal of Forensic Psychiatry

ACADEMIC AWARDS AND PRIZES

Research Day Prize - awarded at the Annual Research Day, University of Toronto, Department of Psychiatry, September, 1978 for a paper entitled: "Neuroendocrine and Pharmacologic Predictors of Antidepressant Response."

Runner-up - Annual Essay Contest Canadian Doctor, 1980: "On Being of Two Minds: The Structure of Scientific Evolution."

Tenth International Congress Commemorative Prize awarded by the Stanley Kushnir Memorial Foundation and the Ontario Society of Clinical Hypnosis for a paper entitled: "Oral Poetry" - December, 1989.

ACADEMIC PRESENTATIONS

1. The Interrater Reliability of the Nurses' Observation Scale, Presented at the Annual Research Day, Department of Psychiatry, University of Toronto, Clarke Institute of Psychiatry, Toronto, Ontario, September, 1977, P. Brown, P. Brawley, W. Lancee and R. Allon.

2. Neuroendocrine and Pharmacologic Predictors of Antidepressant Response, Presented at the Annual Research Day, University of Toronto, Department of Psychiatry, Clarke Institute of Psychiatry, Toronto General hospital, Toronto, Ontario, September, 1978, P. Brown and P. Brawley.

3. Methylphenidate Mood Response and the Dexamethasone Suppression Test, Presented at the Annual Meeting of the American Psychiatric Association, Chicago, May, 1979, Abstract No. 161, P. Brown and P. Brawley.

4. Neuroendocrine Response to Apomorphine in Unmedicated Schizophrenic Patients, Third Annual Meeting of the Canadian College of Neuropsychopharmacology, Edmonton, May, 1980, D. MacCrimmon, J. Cleghorn, G. Brown, M.H. Blackall and P. Brown.

5. GH Dose Response to Apomorphine in Schizophrenic and Control Subjects, Psychoneuroendocrinology Symposium, Hamilton, May 1981, Poster Session, J. Cleghorn, G. Brown, P. Brown, and R. Kaplan.

6. Relapse in Schizophrenia: Growth Hormone Responses (abstract), Presented at the American Psychiatric Association, 135th Annual Meeting, New Research Abstracts NR4, 1982, J.M. Cleghorn, G.M. Brown, P.J. Brown, R.D. Kaplan, S.W. Dermer, D.J. MacCrimmon and J. Mitton.

7. Growth Hormone Responses to Apomorphine in Schizophrenia: Dose Response Curves (abstract), Society for Biological Psychiatry Annual Meeting, Toronto, 1982, J.M. Cleghorn, G.M. Brown, P.J. Brown, R.D. Kaplan and J. Mitton.

8. Clinical Assessment of Depression, In Symposium: Affective Disorders: Current Research Methodologies, Presented at the Canadian Psychiatric Association Annual Meeting, Montreal, Quebec, 1982, P. Brown, Chairman, with R. Prudo, M. Steiner and G.M. Brown.

9. Growth Hormone Responses to Apomorphine in Schizophrenia, Presented at the Ontario Psychiatric Association Annual Meeting, Toronto, 1982, J.M. Cleghorn, G.M. Brown, P. Brown, R.D. Kaplan and J. Mitton.

10. The McGuffin in Psychotherapy: A Discussion of Presented Papers, The Hincks Memorial Lectures, McMaster University, Hamilton, Ontario, May 1983, P. Brown.

11. Circadian Rhythms in Chronic Insomnia, Poster Session, Annual Meeting of the Society for Sleep Research, Toronto, Ontario, May 1984. J. McFarlane, G. Brown, J. Cleghorn, S. Garnett, G. Brown, R. Kaplan, P. Brown and J. Mitton.

12. Positron Emission Tomography: Schizophrenia and Order Effect, Abstract No. 60, Annual Meeting, Canadian Psychiatric Association, October, 1984, Banff, Alberta, J. Cleghorn, S. Garnett, G. Brown, R. Kaplan, P. Brown and J. Mitton.

13. Longitudinal Patterns of Schizophrenia Patients, World Congress of Biological Psychiatry, September, 1985, Philadelphia PA., Abstract No. 231.5, J.M. Cleghorn, P.J. Brown, G.M. Brown, R. Kaplan, H. Szechtman and J. Mitton.

14. Oral Poetry: The Work of Milton Erikson from the Neurobiologic Perspective, Presented at the Annual Joint Meeting of the International Society of Hypnosis and Family Therapy and the Italian Society of Clinical Hypnosis, Abstract 129, October 17, 1995, Rome, Italy, P. Brown.

15. Neuropsychological Characteristics Associated with Absent Hypofrontality and Regional Shifts of Glucose Metabolism in Acute, Untreated Schizophrenics, R. Kaplan, J.M. Cleghorn, S. Garnett, G.M. Brown, H. Szechtman, P.J. Brown, and J. Mitton, Annual Meeting, International Neuropsychological Society, Denver, 1986.

16. Psychosocial Issues for Oncology Patients, Panel Discussion, Annual Meting of Canadian Society of Oncology Nurses, Hamilton, Ontario, October 1987.

17. Ethical Considerations in HIV Infection, Panel Discussion, AIDS and Psychiatry, An Interdisciplinary Conference, Mount Sinai Hospital Toronto, Ont. March 1988.

18. The Everyday Trance, P. Brown, Poster Presentation 2949, Viii World Congress of Psychiatry, Athens, Greece, October 5-12, 1989

19. Behavioural Management of Anticipatory Nausea and Vomiting, P. Brown, Poster Presentation, Controversies in the Etiology, Detection and Treatment of Early Breast Cancer, Meeting of the Breast Cancer Site Group, Oncology Coordinating Council, University of Toronto, April 5-6, 1990.

20. Research Frontiers in the Evolution of Psychotherapy, E. Rossi and P. Brown, Symposium, The Evolution of Psychotherapy, Anaheim, CA, December 11-16, 1990.

21. A Review of Ultradian Rhythms of Cerebral Function and Hypnosis, P. Brown, Annual Scientific Meeting, American Society of Clinical Hypnosis, St. Louis, MO, April 14-18, 1991.

22. Weight Control in Early Breast Cancer: Pilot Testing of Psychological Questionnaires, P. Goodwin, L. DelGuidice, K. Pritchard, P. Brown, Controversies in the Etiology, Detection and Treatment of Early Breast Cancer: 1992, Toronto, Ontario, April 2-3, 1992.

23. Towards a New Research Paradigm: Applications of the Ultradian Model, P. Brown, American Society of Clinical Hypnosis, Las Vegas, NV, April 509, 1992.

24. Symposium: Weight Control in Early Stage Breast Cancer, Chairman: Peter Brown, M.D. with P. Goodwin and M. Elliott. World Congress of Cognitive Therapy, Toronto, June 17-21, 1992.

25. A Multi-Centre Randomized Trial of Group Psychosocial Support in Metastatic Breast Cancer: Pilot Results, P. Brown, P. Goodwin, K. Pritchard, International Congress of Psychosocial Oncology, Beaune, France, October 12-14, 1992.

26. Initial Weight and Weight Gain in Early Stage Breast Cancer: Relationship to Psychological Factors and Eating Behaviour, P. Goodwin, L. DelGuidice, K. Pritchard, M. Elliott, P. Brown, International Contress of Psychosocial Oncology, Beaune, France, October 12-14, 1992.

27. Psychobiological Research and the Ultradian Model, P. Brown, The Fifth International Congress on Eriksonian Approaches to Hypnosis and Psychotherapy, Phoenix, AZ, December 1-6, 1992.

28. The BEST Randomized Trial of Group Psychosocial Support in Metastatic Breast Cancer: Pilot Results, P. Brown, K.I. Pritchard, J. Koopmans, H.M. Chochinov, M. Navarro, G. Linn, S. Steggles, A Bellissimo, P.J. Goodwin, The International Association for Breast Cancer Research, Banff, Alberta, April 25-28, 1993.

29. Development of a Weight Management Program in Early Stage Breast Cancer, P. Brown, K.I. Pritchard, P.J. Goodwin, The International Association for Breast Cancer Research , Banff, Alberta, April 25-28, 1993.

30. Meta-analysis of the Prognostic Effect of Initial Body Size in Primary Breast Cancer, P. J. Goodwin, C. Quigley, S. Goel, P. Brown. The International Association for Breast Cancer Research, Banff, Alberta, April 25028, 1993.

31. Body Size is a Significant Predictor of Outcome in Axillary Node Negative Breast Cancer in an Ontario Clinical Oncology Group (OCOG) Study, P.J. Goodwin, P. Skingley, R.M. Clark, R. Wilkinson, M. Lipa, M.N. Levine, P. Brown. The International Association for Breast Cancer Research, Banff, Alberta, April 25-28, 1993.

32. Peer Review of Expert Psychiatric Testimony: Developing Ethical and Scientific Standards, P. Brown, 16th Annual Symposium, American College of Forensic Psychiatry, San Francisco, CA, April 23-26, 1998

33. Ethical & Scientific Standards for Psychiatric Expert Testimony in Sexual Harassment Cases, P. Brown, 17th Annual Symposium, American College of Forensic Psychiatry, Santa Fe, NM, April 22-25, 1999.

34. Mock Trial, participant expert witness, 17th Annual Symposium, American College of Forensic Psychiatry, Santa Fe, NM, April 22-25, 1999

35. Scientific and Ethical Standards for Independent Psychiatric Examinations, P. Brown, Panel presentation: "IME's and Disability Insurance" Private , Annual Meeting, American Academy of Psychiatry and Law, Baltimore, MD, Oct13-17,1999

36. Violence Risk Assessment of the Psychotic Patient, P. Brown, 18th Annual Symposium, American College of Forensic Psychiatry, Newport Beach, CA, March 30-April 2,2000

37. Evaluating Current Impairment and Risk of Relapse in the Chemically Dependent Anaesthesiologist, P. Brown, Workshop: "IME's and Private Disability Insurance", Annual Meeting, AAPL, Vancouver, B.C.,Oct 19-22, 2000

38. Evaluating Study Design for Antiandrogen Treatment P. Brown, Workshop: "Antiandrogen Treatment of Sexual Offenders, presentation of the Psychopharmacology Committee, Annual Meeting, AAPL, Vancouver, B.C., Oct 19-22, 2000
39. Evaluating Guideline Utility for Treatment Decisions for Patients with Long-term Violence Risk, P. Brown, Workshop: The Psychopharmacology of Violence, presentation of the Psychopharmacology Committee, Annual Meeting, AAPL, Boston, MA, Oct.25-28, 2001
40. The Fungible Center: Cognitive Science and the Potential and Limits of Moderation, Association for the Advancement of Philosophy & Psychiatry, 20th Annual Meeting, Washington, DC, May 3 & 4, 2008
41. The Experience of Freedom: Cognitive Science Models, International Network of Philosophy and Psychiatry, 11th International Meeting for Philosophy and Mental Health, Dallas, Texas, October 6-8, 2008
42. I am So the Boss of You: Narrative, Attention and the Development of Self-Regulation Association for the Advancement of Philosophy & Psychiatry, 21th Annual Meeting, San Francisco,CA, May 16&17,2009

INVITED LECTURES

1. The Neurobiology of Emotion, American Institute for Medication Education, Emotional Development in Adult Life, Honolulu, HA, December, 1983.

2. Current Concepts in Depression: Sleep Deprivation, Teleconference Ontario, Continuing Medical Education, Hamilton, Ontario, October, 1983.

3. The Neurobiology of Anxiety and Attachment, Guest Speaker Series, Neuroscience Postgraduate Students Programme, McMaster University, Hamilton, Ontario, November, 1983.

4. Anxiolytic Drugs, Woodstock Medical Society, Woodstock General Hospital, February, 1984, Woodstock, Ontario.

5. Conceptual Changes in the Neurosciences, Department of Psychiatry, University of Texas Medical Branch, Galveston, Texas, June, 1984.

6. The Biology of Hypnosis, Department of Psychiatry, University of Western Ontario, London, Ontario, November, 1985.

7. The Use of Hypnosis in Treating Medical Disorders, North York General Hospital, Toronto, Ontario, January 25, 1991.

8. Psychosocial Issues in the Treatment of Breast Cancer, A Symposium on Breast Diseases, OCTRF, Ottawa, Ontario, October 28-29, 1993.

9. Using Metaphor in Psychotherapy and Hypnotherapy, a Workshop at The Annual Meeting of the Society of Clinical and Experimental Hypnosis, San Antonio, TX, October, 1995.

10. Antipsychotic Medication, Chattanooga Psychological Association, Chattanooga, TN, September, 1997.

11. Coronary Artery Disease and Depression, Combined Meeting of Chattanooga Psychological and Chattanooga Psychiatric Associations, Chattanooga, TN, January, 1998.

12. Legal Liability Issues in Psychopharmacology, Decatur Mental Health Center, Decatur, AL, March, 1998.

13. Depression as a Risk Factor in Coronary Artery Disease, Grand Rounds, Chattanooga Unit University of Tennessee Memphis School of Medicine, Chattanooga, TN, September 17, 1998.

14. Violence in the Workplace and EAP, 7th Annual THRC Conference, Chattanooga, TN, September 15-17, 1999.

15. Integrated Treatment of Smoking Cessation, Meeting, Chattanooga Psychological Association, Chattanooga, TN, October 28, 1999.

16. Ethical Issues in Utilization Review, Disability Assessment and Case Management, P. Brown and J Connor JD, Seminar "Ethics and Risk Management", The Mental Health Association, Chattanooga TN, Oct. 4, 2001

17. Potential Legal Consequences of Psychiatric Disability Evaluations, Panel Discussion, Southern California Chapter of the AAPL, Pasadena, CA, Jan. 19, 2002

18. Psychiatric Disability Evaluations, The New York Academy of Medicine and the Tri-State Chapter of the AAPL, in: 'New Applications Of Forensic Psychiatry: The Workplace', New York Academy of Medicine, New York, NY, Jan. 26, 2002

PEER REVIEWED PUBLICATIONS

1. A simple method of monitoring behaviour change in the ward. Research Communications in Psychology, Psychiatry and Behaviour, 1978. P. Brawley, W. Lancee, R. Allon and P. Brown.

2. The neuroendocrinology of schizophrenia. International Journal of Mental Health 9: 108-138, 1981. P.J. Brown, J.M. Cleghorn, G.M. Brown and M.H. Blackall.

3. On Being of Two Minds: The structure of Scientific Evolution. McGill Journal of Education, pp. 13-18, Winter, Vol. 17, 1982, P. Brown.

4. Methylphenidate mood response and dexamethasone suppression in primary depression. American Journal of Psychiatry, 140: 990-993, August, 1983, P. Brown and P. Brawley.

5. Growth hormone responses to appomorphine HCI in schizophrenic patients on drug holidays and at relapse. British Journal of Psychiatry, 142: 482-488, 1983. J.M. Cleghorn, G.M. Brown, R.D. Kaplan, P. Brown, S.W. Dermer, D.J. MacCrimmon and J. Mitton.

6. Longitudinal instability of hormone responses in schizophrenia. Progress in Neuropsychopharmacology and Biological Psychiatry, Vol. 7, pp. 545-5491983. J.M. Cleghorn, G.M. Brown, P. Brown, R.D. Kaplan and J. Mitton.

7. Growth Hormone Responses to graded doses of apomorphine HCI in schizophrenia. Biological Psychiatry 18, 8:875-885, 1983. J.M. Cleghorn, G.M. Brown, P. Brown, R. Kaplan and J. Mitton.

8. Clinical and biological correlates of sleep deprivation in depression. Canadian Psychiatric Association Journal 19,3: 347-352, 1984. R.T. Joffe and P. Brown.

9. Neuroendocrine predictors of the antidepressant effect of sleep deprivation. Biological Psychiatry, 1984. R. Joffe, P. Brown, A. Bienenstock and J. Mitton.

10. Longitudinal growth hormone studies in schizophrenia. Psychiatry Research 24: 123-136, 1988. G.M. Brown, J.M. Cleghorn, R.D. Kaplan, H. Szechtman, P. Brown, B. Szechtman and J. Mitton.

11. Seasonal variations in prolactin levels in schizophrenia. Psychiatry Research 25: 157-162, 1988. P. Brown, J.M. Cleghorn, G.M. Brown, R.D. Kaplan, J. Mitton, H. Szechtman and B. Szechtman.

12. Review: Drug induced akathisia in medical and surgical patients. International Journal of Psychiatry in Medicine 18, 1: 1-15, 1988. P. Brown.

13. Utradian rhythms of cerebral function and hypnosis. Contemporary Hypnosis, Vol. 8, No. 1: 17-24, 1991. P. Brown.

14. Oral Poetry: Towards an integrative framework for Erikson's clinical approaches. Eriksonian Monographs, No. 8: 66-94, 1991. P. Brown.

BOOKS AND CHAPTERS

1. Hormonal markers in schizophrenia and depression. In: P. Hrdina and L. Singhal (Eds), Neuroendocrine Regulation and Altered Behaviour, pp. 339-362. Elsevier Biomedical Press, North Holland, 1981. G.M. Brown, J.M. Cleghorn, P. Ettigi and P. Brown.

2. A critical appraisal of neuroendocrine approaches to psychiatric disorder. In: E. Mueller and R.M. MacLeod (Eds), Neuroendocrine Perspectives, Elsevier North Holland, 1983. G.M. Brown, P.E. Garfinkel, E. Gorf, P. Grof, J.M. Cleghorn and P. Brown.

3. Growth hormone response in schizophrenia. In: Integrative Neurohumoral Mechanisms, Edited by E. Endroczi. Akadenial Kiado, Budapest, 1983. G.M. Brown, J.M. Cleghorn, H.B. Keward, P. Brown and R. Eastwood.

4. Adjunct Therapies, P. Brown , Chap 8, pp141-159, in Seeman, M.V., and Greben, S.E. (Eds.), Office Treatment of Schizophrenia, Washington, D.C.: American Psychiatric Press, 1990.

5. The Hypnotic Brain: Hypnotherapy and Social Communication. New Haven, CT: Yale University Press, 1991. P. Brown ISBN: 0-300-05001-1.

6. Metaphor and Hypnosis, P. Brown, Chapter 14,pp 291-308, in: Handbook of Clinical Hypnosis, Edited by S. Lynn, J. Rhue and I. Kirsh. American Psychological Association Press, 1993.

7. Towards a Psychobiological Model for Dissociation and Post-Traumatic Stress Disorder. Chapter 5 in: Dissociation: Clinical and Theoretical Perspectives. Edited by S. Lynn and J. Rhue. Guilford Press, 1994. Pp. 94-122.

8. DSM IV-TR, P. Brown, Chapter 4, in: Mental and Emotional Injuries in Employment Litigation, ed: J. McDonald, Jr. and F. Kulick, BNA Books, 2002

NON-PEER REVIEWED PUBLICATIONS

1. On Being of Two Minds: The Structure of Scientific Evolution. Canadian Doctor 47 (1): 31-40, January, 1981. P. Brown.

BOOK REVIEWS

1. Behaviour Modification: Principles and Clinical Applications. W.S. Agras. For The Journal of the Canadian Psychiatric Association, June, 1981.

2. Emotions in Health and Illness. Edited by L. Temoshok, Journal of the Canadian Psychiatric Association, June, 1986.

3. Biological Rhythms and Behaviour. Edited by J. Medlewicz. Journal of the Canadian Psychiatric Association, March, 1987.

4. Exploring the World of Lucid Dreaming. Edited by S. Laberge. Psychological Perspectives, pp. 179-181, Spring/Summer, 1991.

5. Hypnosis. Edited by N. Spanos. OSCH News, December, 1991.

6. Handbook of Psycho-Oncology. Edited by J. Holland, Journal of the Canadian Psychiatric Association, May, 1992.

7. The Psychological Treatment of Patients with Cancer. By S. Greer and S. Moorey. Journal of the Canadian Psychiatric Association, March, 1992.

8. Theories of Hypnosis: Current Models and Perspectives. Edited by S. Lynn and S. Rhue. OSCH News, , 1992.

9. Changing Expectations: A Key to Effective Psychotherapy. Edited by I. Kirsch. OSCH News, June, 1992.

10. Ultradian Rhythms and Life Processes. Edited by D. Lloyd and E. Rossi, Psychological Perspectives, FallWinter, 1993.

11. Critical Issues in the Treatment of Schizophrenia. Edited by N. Brumello, G. Racagni, S. Langer and J. Mendliwicz, Journal of Clinical Psychiatry, 58:3, March 1997.

12. The New Pharmacotherapy of Schizophrenia. Edited by S. Breier, Journal of Clinical Psychiatry, 58:5, May, 1997.

13.Principles and Practice of Military Forensic Psychiatry. Journal of Clinical Psychiatry, 58:11, pg. 500, November, 1997.

Updated 01/27/09

(CV - Dr. Brown)

Exhibit No. 1

Identified and made a part of the record this 27th day of August, 2010.

Judge Richard R. Baumgartner

D. MALCOLM SPICA, PH. D.
Licensed Clinical Psychologist
Neuropsychologist

NEUROPSYCHOLOGICAL CONSULTATION

STATE OF TENNESSEE VS. Billy Ray Irick
CASE NO. 24527 EXHIBIT NO. 2
DATE 8/16/10 ID ____ EVD ✓

-REPORT DRAFT-

Examinee:	**Billy IRICK**
Laboratory Number:	295218
Age:	51
Date of Birth:	8/26/1958
Handedness:	Right
Education:	8^c
Date of Examination:	11/12/09; 11/14/09; 12/04/09
Examiner:	D. Malcolm Spica, Ph.D.

REFERRAL QUESTION:

Mr. Billy Ray Irick is a 51-year-old, right-handed male referred for neuropsychological examination by attorney Howell Clements to assess Mr. Irick's neurobehavioral status. This assessment is intended to serve as a contributing component to the broader evaluation of Mr. Irick's psychological, developmental, and adaptive functioning being conducted by forensic psychiatrist Peter Brown, M.D. Mr. Irick was arrested in connection with events that occurred 4/16/85 in Knoxville, Tennessee.

Mr. Irick is completing the evaluation at the request of attorney Clements. No doctor/examinee relationship was established, nor were there any expectations or guarantees of future contact or relationship. The limits of confidentiality were explained to Mr. Irick. He stated that he understood some tasks are designed to determine if he is providing his best effort, and that what ever is stated during the evaluation may later be subject to inquiry. These factors of assessment were explained to Mr. Irick, and he stated that he understood the factors and consented to complete the testing. All testing and interviewing was conducted with the examinee at the Riverbend Maximum Security Institution in Nashville, Tennessee.

HISTORICAL INFORMATION:

Mr. Irick's history has been summarized by other examiners, and will not be repeated here. On the three days of the examination, Mr. Irick reported that he was in good health. He stated that his medical history was significant for a surgery in 8/77 to remove bone spurs from his spine. He stated that he was institutionalized in her approximately age 6, but cannot recall for what condition. He stated that he had a period of heavy drinking from age 18 to 26, and was arrested twice for public intoxication. He has been incarcerated since 1985. He reported no other serious illnesses, losses of consciousness, head injuries, or toxin exposures. He described his sleep as sporadic, as "I wake up after a couple hours." He described his appetite as "hungry all a time," and his mood as variable: "I'm usually alright, but when I get pissed off I get angry and hateful. But that's normal for anybody in here." He stated that he takes no medications.

The examinee believes he is the product of a normal pregnancy and birth. However, Mr. Irick was told by his mother that he had been adopted, but he is unsure if this was accurate. He knows of no difficulties in

his attainment of developmental milestones (e.g., learning to walk and speak). Mr. Irick reported that his family history is significant for myocardial infarction and cancer in his father, and diabetes and heart disease in his maternal grandmother. His maternal aunt suffered leukemia.

Mr. Irick reported being expelled from school for fighting during the ninth grade. He stated, "they said I threw him out the window, but it wasn't my fault." He reported being a poorly performing student throughout his education. He obtained his graduate equivalency diploma in 1988 while incarcerated. He stated that he was retained in no grades and received no special education assistance.

Mr. Irick last worked as a dishwasher in preparatory cook in 1985; he held that job for approximately 9 months. Previously he worked as a dishwasher for 1 month, did landscaping for approximately 1 year, and worked on a shrimp boat for approximately 1.5 years. He stated that he typically walked away from jobs when angered by the employer. He has never been married and has no children.

BEHAVIORAL OBSERVATIONS:

Mr. Irick presented as an adequately groomed man in his Riverbend Maximum Security Institution uniform, appearing his age. Hygiene appeared adequate. Mood appeared generally euthymic with a mildly restricted range of appropriate affect. Spontaneous speech was normal and receptive language abilities appeared intact. The examinee's eye contact was good throughout, and he appeared to engage easily with me. Mr. Irick's interpersonal behavior is best described as polite and cooperative with eager to please manner. He did not decline to answer any questions and he worked without complaint during the testing sessions. He appeared to give his best effort on all tasks.

EXAMINATION FINDINGS:

During the course of the examination, the following tests and procedures were administered:

- 21-Item Word Memory Test
- Beck Anxiety Inventory
- Beck Depression Inventory-II
- Benton Facial Recognition Test
- California Verbal Learning Test-II
- Delis Kaplan Executive Functions System:
  - Trail making test
  - Verbal Fluency Test
  - Design Fluency Test
  - Color-Word Interference Test
  - Twenty Questions Test
  - Tower Test
- Digit Span
- Finger Tapping Test
- Grooved Pegboard Test
- Hopkins Verbal Learning Test - Revised
- Judgment of Line Orientation Test
- Rey-Osterrieth Complex Figure Test
- Symptom Checklist-90-Revised
- Test of Memory Malingering
- Wechsler Adult Intelligence Scale - IV
- Wechsler Test of Adult Reading
- Wide Range Achievement Test-3
- Wisconsin Card Sorting Test

Validity/Motivation: Mr. Irick did not appear to withhold effort during his evaluation. He was administered both verbal and visual dedicated measures of effort/motivation. His performance of 15/21 on the verbal quantified symptom validity instrument (21-Item Word Test) ranked well within normal limits. Likewise, Mr. Irick provided a strong performance on the visual Test of Memory Malingering:

Trial 1	= 48/50
Trial 2	= 50/50
Retention Trial	= 50/50

The validity scales with the standardized self-report inventory, the Personality Assessment Inventory (PAI), revealed high levels of symptoms and some degree of inconsistent defensiveness. The PAI test publisher's computer analysis reported that the multiple scale elevations used to compute the Cashel Discriminate Function (CDF) suggested that he was reluctant to admit to common problems, although the Defensiveness Index (DEF) was not significantly elevated. Also:

"The Rogers Discriminate Function (RDF), an empirically -derived malingering index based on multiple PAI scale elevation s, is elevated... The Malingering Index (MAL) is not significantly elevated. The current PAI profile does not possess many of the characteristics commonly observed in profiles produced by research participants instructed to simulate psychiatric disturbance. In short, there was inconsistency in the evidence that pointed to the possibility of negative distortion and symptom exaggeration. This is not entirely unexpected because the NIM, MAL, and RDF scales appear to Different aspects of the negative distortio n construct... In short, there is inconsistency with respect to the PAI evidence indicating defensive responding. This is not unusual because the PIM, DEF, and CDF tap different aspects of defensiveness, or may reflect other factors such as comprehension difficulties. Additional information should be collected to determine the source of this inconsistency."

Taken together, the symptom validity and effort assessment findings suggest the examinee made no attempt to simulate difficulties on the tests of cognitive functioning, but was mildly inconsistent in his approach to self-report measures pertaining to psychiatric status.

Intellectual Functioning: General level of intellectual functioning was assessed with the Wechsler Adult Intelligence Scale-IV (WAIS-IV). Mr. Irick' performances ranged from the Low-Average to Average levels:

Verbal Comprehension Index	= 98	45th percentile
Perceptual Reasoning Index	= 107	68th percentile
Working Memory Index	= 92	30th percentile
Processing Speed Index	= 86	18th percentile
Full Scale IQ	= 96	39th percentile

Mr. Irick demonstrated a relative strength on tasks requiring visual pattern recognition/reasoning. Conversely, he had his greatest difficulty on tasks requiring mental speed or attention to detail.

Subtest	Percentile	Subtest	Percentile
Information	63rd	Picture Completion	25th
Digit Span	37th	Figure Weights	63rd
Vocabulary	25th	Block Design	25th
Arithmetic	25th	Coding	9th
Comprehension	25th	Matrix Reasoning	84th
Similarities	50th	Symbol Search	37th
Letter-Number Sequencing	50th	Visual Puzzles	84th
		Cancellation	16th

These scores are comparable to statistical premorbid estimates, which also placed Mr. Irick in the lower half of the Average range: for example, his score on the Wechsler Test of Adult Reading provided a

Predicted Full Scale IQ = 95 (37th percentile). Considering these findings, Mr. Irick' current intellectual scores likely reflect his long-standing abilities.

Academic skills were assessed with the Wide Range Achievement Test-3. Mr. Irick's word reading skills ranked in the Average range (27th percentile; high school equivalent). Written arithmetic was Borderline-Impaired: 7th percentile, sixth grade equivalent. Spelling was also Borderline-Impaired: 5th percentile, fifth grade equivalent.

<u>Attentional Control:</u> Mr. Irick appeared fully alert throughout the examination on the days of testing. As noted above, simple attentional spans ranked in the Average range for stimuli presented aurally (Digit Span, 37th percentile). Overall mental speed appeared Low Average: Processing Speed Index = 86, 18th percentile. Mr. Irick demonstrated Average ability (commensurate with his intellectual level) for holding information in his mind briefly: Working Memory Index = 92, 30th percentile.

<u>Executive Functioning:</u> More complex attentional controls were assessed with subtests of the Delis-Kaplan Executive Function System. Mr. Irick provided adequate performances on a task of simultaneous visual tracking (Trail Making Test Composite Score, 25th percentile), and a task of simple reasoning through process of elimination (Twenty Questions Test, 25th percentile).

However, Mr. Irick demonstrated severe impairment in his ability to organize information or utilize method or strategy to deal with material. For example, he was highly disorganized in his approach to generating novel designs under time pressure (Design Fluency Test, 5th percentile) or generating words beginning with specified letters (Letter Fluency Test, 2nd percentile).

Mr. Irick performed in the average range (63rd percentile) during the Tower Test. However, additional signs of executive control dysfunction were seen on more complex tasks requiring hypothesis testing and general mental organization: e.g., Wisconsin Card Sorting Test - Trials, 2nd percentile. During this task, Mr. Irick was highly distractibility, as he tended to lose track of his own approach to solving the problem: Failure to Maintain Set, 8th percentile. Use of such strategy is known to rely on the frontal lobes of the cerebral cortex.

<u>Language Functioning:</u> The examinee exhibited variable abilities in the area of language, as verbal fluency abilities ranked as Impaired (Letter Fluency, 2nd), but he performed adequately on a task of word knowledge (Vocabulary, 25th percentile). His semantic access abilities for generating words within a semantic category (e.g., exemplars of animals) ranked in the Impaired range: Category Fluency, 2nd percentile.

In general, Mr. Irick demonstrated adequate verbal skills, but when placed under time pressure he was unable to think quickly or express himself in an organized way.

<u>Sensory-Motor Functioning</u>: Mr. Irick reported being right-handed. Simple repetitive motor speed was within normal limits, bilaterally: Finger Tapping-right hand, >99th percentile; left hand, >99th percentile. Mr. Irick was less efficient on a task requiring fine motor dexterity for placing pegs into a board: Grooved Pegboard Test-right hand, 38th percentile; left hand, 24th percentile.

<u>Visuoanalytic Functioning:</u> The examinee demonstrated a relative strength in his abilities to work with visual spatial material. On a task of complex visuoanalysis, he performed in the Average range: Rey Complex Figure Test - Copy, 37th percentile. His ability to perceive simple angular relationships between two lines was strong: Judgment of Line Orientation Test, >86th percentile.

Mr. Irick's ability to solve nonverbal problems appeared variable, depending on the necessity to utilize executive functions: e.g., Visual Puzzles, 84th percentile vs. Wisconsin Card Sorting Test - Trials, 2nd percentile. Mr. Irick's performance on the Visual Puzzles test was one of his highest in the protocol, whereas

the executive control requirements of the Wisconsin Card Sorting Test proved to be challenging for him; the more the examinee was required to recall information and learn from experience, the poorer his performance.

Memory and Learning Functioning: Mr. Irick's memory skills ranked in the Low Average range for recall of either verbal or visual stimuli. For example, he performed in the Low Average range for his recall of a complicated visual design: Rey Complex Figure Test-Delayed Recall, 20th percentile. Similarly, his recall of a word list across three repeated trials was poor: Hopkins Verbal Learning Test - revised Total 1-3, 9th percentile. The examinee provided a better performance during a yes/no recognition trial (68th percentile).

These findings suggest Mr. Irick has difficulty learning new information and retaining it over time. These problems were especially prominent when he relied on information presented aurally. The memory patterns are again suggestive of mental disorganization.

Psychological/Mood Status: Mr. Irick was administered three standardized tests of mood and personality assessment: Beck Depression Inventory-II; Beck Anxiety Inventory; Personality Assessment Inventory.

Mr. Irick endorsed a number of symptoms of depression on the quantified Beck Depression Inventory-II (raw score = 18/63; Mild). He reported very few anxiety features on the Beck Anxiety Inventory (raw score = 4/63; Moderate). The items Mr. Irick endorsed on these measures generally pertained to feeling he is being punished, anhedonia, irritability, and nervousness.

On the quantified Symptom Checklist-90-Revised, Mr. Irick ranked within normal limits across domains measured. However, his highest scores were obtained the following scales:

Paranoid Ideation	83rd percentile
Hostility	89th percentile
Psychotic Symptoms	83rd percentile

The PAI yielded extreme elevations on scales pertaining to paranoia, schizophrenia-spectrum disorders, and depression. Mr. Irick's highest elevations on the PAI were on the following scales:

Paranoia	>99th percentile
Schizophrenia	>99th percentile
Depression	>99th percentile
Non-support	>99th percentile

Persons in correctional settings producing profiles similar to Mr. Irick's typically exhibit very high suspiciousness, disorganized thinking, and alienation. Significant depression was also evident. The examinee reported suicidal features on the PAI; upon further interview, he denied current suicidal ideation, plan, or intent.

According to the PAI publisher's computerized analysis, the examinee produced a profile of low dominance and warmth. He is likely to avoid social interactions and may have problem being assertive and standing up for himself. Consequently, he may be a target of predatory individuals who perceive his submissive tendencies as a sign of weakness. Others may view him as cold and socially inept. His low level of warmth is complicated by a high degree of suspiciousness, sensitivity, and social disinterest. Furthermore, he also reported a high level of interpersonal problems, suggesting that his interpersonal tendencies have not allowed him to effectively negotiate relationships.

He is likely to have notable psychotic symptoms, including thought disturbance, disorganization, and perceptual experiences (such as hallucinations and/or delusions) typically associated with schizophrenia-spectrum disorders. Based on the PAI responses, I recommend diagnostic considerations of paranoid personality disorder, depression, and psychotic disorder.

The PAI also provided information regarding conditions that may be reasonably ruled out. For example, the findings (including supplementary and subscales) were inconsistent with diagnosis of Antisocial Personality Disorder, as each of the following scales ranked within normal limits:

Antisocial scale
Antisocial Behaviors
Egocentricity
Stimulus-Seeking

Considering the specific scope of this neuropsychological examination, I defer to Dr. Brown to make a more precise classification of Mr. Irick's personality traits and psychological/psychiatric status through his ongoing psychiatric evaluation. I will provide provisional diagnoses for Mr. Irick's features of paranoia and psychosis.

SUMMARY & CONCLUSIONS:

This 51-year-old man participated in a neuropsychological examination to evaluate his neurobehavioral status. This assessment is intended to serve as a contributing component to the broader evaluation of Mr. Irick's psychological, developmental, and adaptive functioning being conducted by psychiatrist Peter Brown, M.D. Formal validity/motivation measures indicated that Mr. Irick provided his full effort on the neurocognitive procedures. The neuropsychological test results revealed the following deficits:

1. Executive Functioning
2. Verbal fluency
3. (Mental processing speed - mild)

These deficits are in the context of an individual with intact visual spatial skills: e.g., Perceptual Reasoning Index, 68th percentile. Taken together, the above features suggest cerebral dysfunction, and specifically implicate frontal territories as being maximally involved in the examinee's cerebral dysfunction. While the etiology of the examinee's deficits is not clear from his history, it is likely that they are long-standing in nature, as Mr. Irick reported a history of poor performance in school and no clear head injuries or other cerebral insults. Psychological testing indicated prominent features of paranoia, depression, and disorganized thinking.

During the current examination, Mr. Irick demonstrated intact visuoanalytic abilities. In fact, he performed in the normal range on select tasks of spatial analysis, nonverbal problem solving, and figural memory. While these skills indicate normal cerebral functioning for posterior/right hemisphere territories, it is likely rare that they benefit Mr. Irick's in his daily functioning. From the current data, the examinee's cognitive deficits in rapid verbal skills and executive functioning likely combine during times of stress to cause the examinee to feel overwhelmed by information from multiple sources and revert to known --but highly ineffective-- behavioral responses to solve problems at hand.

DIAGNOSTIC IMPRESSION:

1. Cognitive Disorder - Not Otherwise Specified: executive functioning, verbal fluency (294.9)
2. Psychotic Disorder - Not Otherwise Specified (298.9)
3. Depressive Disorder - Not Otherwise Specified (311)
4. Paranoid Personality Disorder (301.0)

The above diagnoses are provided as provisional. As noted above, these findings are to be used as part of an evaluation conducted by psychiatrist Dr. Peter Brown who will revise the specific diagnoses if additional information comes to light in his evaluation.

It was a pleasure working with this examinee. If I can be of any further assistance to Mr. Irick, please do not hesitate to contact me.

D. Malcolm Spica, Ph.D.
Licensed Clinical Psychologist

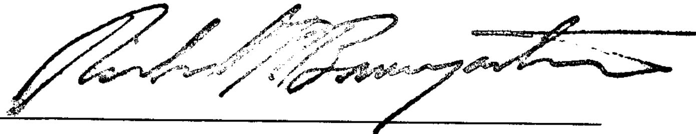
[Transcribed by speech recognition software]

(Report from Dr. Spica)

Exhibit No. 2

Identified and made a part of the

record this 27th day of August, 2010.



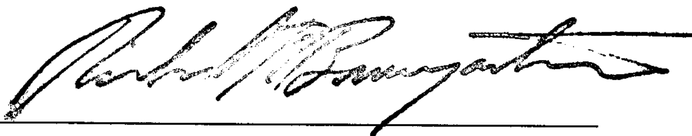
Judge Richard R. Baumgartner

(Report from Dr. Spica)

Exhibit No. 2

Identified and made a part of the

record this 27th day of August, 2010.



Judge Richard R. Baumgartner

Psychiatric Evaluation of Billy Ray Irick

Examiner: Peter I. Brown MD, FRCPC

STATE OF TENNESSEE VS. Billy Ray Irick
CASE NO. 24527 EXHIBIT NO. 3
DATE 8/16/10 ID ____ EVD ✓

I. IDENTIFYING DATA:

The examinee is a 51 yr. old single male.(dob:08/26/58).

II. PURPOSE OF EVALUATION:

The examinee was evaluated at the request of his attorney, to identify clinical factors related to issues of aggravation or mitigation concerning his offense.

III. CONCLUSIONS:

I conclude, to a reasonable degree of medical certainty, that:

1.There is insufficient information to conclude that Mr. Irick was capable of forming specific intent in the commission of his offense, as defined by Tennessee statute. There is evidence of severe mental illness at the time of the offense and his sanity at the time cannot be established beyond a reasonable doubt .

2.Specifically, the weight of the available information indicates that Mr. Irick, more likely than not, lacked substantial capacity either to appreciate the wrongfulness of his conduct or to conform that conduct to the requirements of the law due to a severe mental illness. It is more likely than not that he lacked substantial capacity to appreciate the wrongfulness of his acts.

3. Neuropsychological testing and developmental history indicates that the claimant has severe deficits in his capacity to premeditate, appreciate, make judgments or conform his behavior. It is more likely than not that these deficits have been present since childhood and have continued unchanged throughout his adult life. Test results are approximately consistent with those of a 7-9-year-old child. His severe impairments would have existed continuously from childhood and have been present both at the time of the offense and at the time of his trial and are present now.

IV.RECORD REVIEW:

In addition to an extended direct interview I reviewed a series of documents provided by Mr. Irick's attorney (see addendum).

V.INTERVIEW:

I conducted an extended face to face psychiatric examination of Mr. Irick, on December 7, 2009, lasting 3.25 hours and on January 21, 2010, for an additional 2.5 hours, at the RMSI facility, in Nashville TN.

IRICK : 00007

VI.CONFIDENTIALITY:

I explained to Mr. Irick that I was examining him for a psychiatric assessment on the request of his attorneys, I was not examining him as his physician or to provide treatment of any kind and that the results of the interview would not be limited by ordinary doctor-patient confidentiality. He was able to summarize my statements in his own words and agreed to participate in the interview under those terms.

VII.PERSONAL HISTORY:

Mr. Irick was born on August the 28th 1958 in Knoxville, Tennessee. His parents were Nancy and Clifford Irick. He was the second of 4 children and the eldest of two brothers. His mother (see 03/31/65,Braswell ACSW) reported that she had multiple urinary tract infections during the pregnancy and was diagnosed with cervical incompetency. He was described at birth as "almost blue" after a complicated delivery.

Braswell ACSW(03/31/ 65) Intake Evaluation:

Mr Irick was first referred for psychiatric evaluation at age 7. His mother reported that she had been "in a state of shock" for 6 months postpartum. Her sister provided most of the daily care for the newborn child. Nonetheless, she was also extremely resentful of her sister in law for "taking over" as his mother. She complained to the social worker that her sister-in-law tried to "undermine" her relationship with her son.

His mother reported that Mr Irick had been unusually quiet, negative and developmentally slow compared to other children. From an early age he was consistently difficult to manage, hyperactive and easily distracted, had problems with other children and had limited play capacity.

He had been referred by his school principal for unmanageable behavior, hyperactivity and poor performance. Both of his parents were noted to be extremely anxious. They reported long-standing problems with impulsivity, mistreating animals, hyperactivity, reversed sleep pattern and poor response to discipline. His parents described him as living "in a world of his own". He, in turn, repeatedly claimed that, on multiple occasions since the birth of his younger brother Jeffrey, he was tied up and beaten by his mother.

Multiple attempts to provide discipline and help him socialize at school had been ineffective. His mother was noted to be "an emotionally unstable person" and uncooperative with the school's efforts despite repeated requests ("3 to 4 calls per week "). His 3 siblings were described as functioning well despite the disorganization within the home.

Carpenter M D (04/28/65) Psychiatric Evaluation:

He was noted to be extremely anxious and eager to placate the examiner. His drawings were of poor quality for his age ("remarkably regressive"). A cousin on his mother's side had been

IRICK 00008

admitted to the psychiatric unit in Nashville. On examination he appeared to be extremely disturbed and disorganized. Marked cognitive and affective problems made a clear diagnosis difficult. The differential diagnosis included adjustment reaction, organic brain damage and childhood schizophrenia. Intensive treatment was recommended

Edwards MA (05/19/65) Psychological Test Report:

The psychologist noted marked and pervasive cognitive, affective and behavioral impairment with immaturity, dependency, low frustration tolerance, tearfulness in response to minimal stressors, and easy discouragement.

A full scale IQ of 84 (89/82) was recorded. This was contrasted with the prior report by a school psychologist of a full scale IQ of 107. Projective testing was consistent with marked persecutory themes and hostility with withdrawal from reality. There was no evidence of current hallucinations or delusions.

Carpenter M.D (06/17/65) progress note:

Home for Children psychiatric records noted the marked cognitive decline found in the testing (the 23 point drop in IQ in 6 months noted in testing). They also observed moderate to severe emotional disturbance (impulsivity and fear of being attacked). He was observed to be intensely anxious and unable to control his behavior. He saw himself as passive, vulnerable and unable to cope with ordinary challenges.

Florid hallucinations and delusions were believed to be absent but there was evidence of marked "primitive fantasy" and "atypical thought processes". The provisional diagnosis was severe psycho neurotic anxiety reaction with possible mild organic brain damage. Medication and psychotherapy were recommended. The critical importance of the parents being involved in treatment was emphasized.

Eastern State Psychiatric Hospital Admission (10/24/66-08/30/67)

In October 1966 he began a hospitalization that lasted 10 months (ie to 08/30/67). Repeated evaluations and case conferences (see variously Gruenberg MD, Bozgoz MD, and Price MD). He was started on an antipsychotic medication (Thorazine 200 mg daily) with evidence of overall improvement.

Lunn ACSW to Duncan ACSW(11/14/66 with update 03/07/67)

The hospital began planning post discharge placement at the Home for Children. The social worker notes: "... by no means is the diagnostic picture of Billy clear." He had not adjusted to the first grade and initial difficulties had progressively worsened. Problems included obvious anxiety, difficulties in dealing with other people and distractibility. This coincided with a worsening of his mother's mental state requiring "heavy medication and the possibility of hospitalization". Concurrent stressors included his father's "very unstable work situation". He

IRICK : 00909

was noted to respond well to a structured and supportive environment.

However, in March 1967 a recent marked deterioration in his behavior was noted. This consisted of negativism, self blame and easy frustration. The symptoms were still best managed in a structured setting. Consequently, transferred to the Home for Children was considered to be a better option than return home.

Webster PhD, Lietzke PE (06/16/67) psychotherapy update:

The patient had been admitted after the failure of outpatient psychotherapy for himself and his mother. She was characterized as "quite disturbed" and he had become unmanageable at home and school. He had been hyperactive, negative and "occasionally out of contact". However, during admission he had stabilized quickly and was adjusting well with no evidence of psychosis while being treated with antipsychotics. Discharge to an appropriate setting with ongoing treatment was recommended.

Tollerson PSW/Wilson ACSW (08/29/67) Discharge Summary:

He had been admitted for "turmoil in home and problems in discipline" with marked delays in cognitive, affective and behavioral function. He had responded well to a predictable and structured setting. However, his behavior worsened dramatically on home visits. His father was characterized as so busy working to support the family financially that he had little time to go to the family. His mother was characterized as emotionally poorly equipped to handle caring for 4 children. He remained on the antipsychotic chlorpromazine 200 mg daily. No significant side effects were noted.

A Social History (Duncan ACSW, 08/30/68) prepared for his upcoming third-grade teacher, because of "special problems" reports:

This 10-year-old student, about to enter third grade, had been living for the past year at the Home for Children after discharge from Eastern State Psychiatric Hospital after a 10 month admission (10/24/66-08/30/67). Severe chronic behavioral problems were noted including poor discipline, social withdrawal and temper tantrums. He became agitated by minimal stresses such as ordinary interaction with other children. School performance was limited by difficulties with persistence, lack of confidence and easy discouragement. These patterns were thought to have been caused by the extreme family turmoil.

He was noted to have adjusted and functioned well ("remarkable progress in his adjustment", pg1) in a structured setting with a consistent and stable caregiver. (NB: While remaining on antipsychotic medication.). He accepted corporal punishment ("one or two good whippings") without evident difficulty. "Mild" medication side effects, specifically early morning drowsiness was noted. However, the connection between the medication and morbid obesity was not addressed. He reports that by age 13 he was approximately 300 pounds.

In 1971 at age 13 he was admitted to what is now Lakeshore Psychiatric Hospital. The

IRICK : 00019

presenting problems listed include: Setting fires, repeated verbal and physical conflict, preoccupation with knives, destruction of school property and "claimed amnesia". He had been found in the girl's room with a knife, set fires in a waste can and cut up his sisters clothes. On discharge The Home for Children would not accept him back. He was returned to his parents who had not seen him for 5 years.

At the time he was approximately 300 pounds, irritable, anxious and inarticulate. He was a social out cast. "It was like I wore a bull's-eye... If there were 12 kids it would always be 11 against me. Then, I would be the one to get punished. "

He lost weight after stopping the medications. His father started him on a regimen of chores and diet. (He remains appreciative for his father's "tough love" in helping him lose weight."

The only subsequent medical contact noted prior to his arrest was in 1977 when he injured his back . The injury was treated by laminectomy (L2) and a subsequent postoperative abscess was treated successfully.

He was "thrown out of school" at age 16. His father, a Korean War veteran, pressured him to join the Army but "that didn't last ." He describes himself as being "rebellious" and unable to fit in. "I didn't like the following orders." He was discharged after few weeks. He says that he was beaten repeatedly because of his attitude. "The pattern of my life is 'punishment is always the max."

After returning home briefly he began to hitchhike around the country. This included Alaska and Hawaii. His travel appears to have been completely random. He did not stay in any part of the country for a long time. He reports doing a number of odd jobs (including short order cook, maintenance and custodial work, and briefly, working on a fishing boat in the Gulf). Generally, he had has little contact as possible with others and lived by himself. His favorite jobs (e.g. fishing) were those where he was most left on his own. He describes this as "... total freedom. The best years of my life... When I'm by myself it's always easier."

He says that this life proved to him that he is "adaptable". The idea of staying in one place made him nervous and restless: "I don't want to settle down."

Consistent with the records he describes his relationship with his mother as one off constant conflict and misunderstanding. He believes that his parents ":favored" the other children. He believes that he "may have been" adopted (i.e. that he is not his mother's biological child). He repeated several times "All I'm saying is that I have never seen my birth certificate."

His father died in 2002. He describes his father as "decent" but a strict and harsh disciplinarian. He reports that he was beaten frequently. However, compared with his mother their relationship was comparatively uneventful. "He and I could talk without fighting all the time and we could work together."

However, an affidavit from a neighbor (Inez Prigmore 05/20/99) describes a violent and unstable

home. At the time Mr Irick was 14-15 years old. She reports that even from her home, two doors down and 1000 feet away, his father's verbal abuse and violence were frequently audible. She observed his father striking Billy Ray across the head with a 2 x 4, knocking him to the ground. She saw her father knocking his pregnant daughter to the ground. On several occasions family members including Billy Ray had visible bruises.

He says that his mother has disowned him after his father's death, "She told me now I can focus on my real children." He says: " She hates me because she can't control me and because I'm not perfect.... She always had to be in control. We never got along. Ever."

He currently has no contact with his family. He blames this on his mother. He says that his mother is able to control his siblings because they are "afraid that she will do them like she did me".

He reports that his mother is a practicing witch who regularly used spells and witchcraft directed against others. He denies that she has special powers but also said "things do happen that you cannot explain."

NB: His mother has consistently refused to provide even the most minimal assistance for his defense. In 1990 she refused to be interviewed by the evaluating neuropsychologist, saying: "I don't care if my son's helped or not." (Auble PhD, 02/16/90, page 14) She has repeatedly declined to be interviewed. She accused the defense team of trying to control her by sending threatening messages via her television set. The message is disrupted her favorite programs. She reported placing a curse on one of the attorneys to get him to leave her alone.

After his fishing job ended abruptly he returned to the Knoxville area approximately 18 months before his arrest. He worked as a dishwasher in a bar and then at two truck stops. He met a childhood acquaintance, Kenneth Jeffers, while working in the kitchen of a truck stop. Over time they struck up a friendship. At the time he was working approximately 80 hours per week doing the third shift 6 to 7 days a week by himself and regularly doing over time.

He lost his job when a truck stop was closed. "I was walking with my backpack towards the highway when Kenny drove up and offered me a place to stay." At the time of the offense he had been living with the Jeffers family for several months. After the couple separated he moved with Mr. Jeffers to the home of Ramsey and Linda Jeffers.

Affidavits

His behavior with the Jeffers' family has been described by them in a series of affidavits:

1.Cathy Jeffers (11/03/99):

The sister of Mr. Jeffers reported that the couple had 5 children including 7-year-old Paula. The parents had been separated for approximately 2 weeks by 04/15/85. During that time Mr. Jeffers and Mr. Irick were living with her parents.

IRICK: 00912

Mr Irick had "atrocious" personal hygiene. She observed him "continuously" mumbling to himself. When she asked him what he was doing he said he was talking to "a voice" who would tell him what to do.

She described an episode when he woke her in the middle of the night "to warn me that the police were in the apartment and that they were there to kill us with chain saws."

Her parents threw him out of the house on or about 04/15/85 after he had had a verbal confrontation with her mother.

2.Linda Jeffers (11/03/99):

The mother of Kenneth and Cathy reported Mr. Jeffers and Mr. Irick were living with her in late March early April 1985. She reported grossly impaired personal hygiene and "horrible body odor".

Mr. Irick "repeatedly" told her that he spoke frequently with the Devil and that "voices told him what to do." The voices told him to kill people. She frequently observed him mumbling to himself, "listening and talking to his voices". On several occasions she heard him mumbling about killing people including people walking by the house.

A few days before 04/15/85 she observed him chasing a young girl down the street screaming that he would kill her while "holding a machete". He explained this by saying that he wanted to kill her because "I don't like her looks".

On 04/18/85 she threw him out of her home after an argument.

3.Ramsey Jeffers (11/03/99):

The husband of Linda says that he observed the same features (grossly impaired self-care, mumbling, reports of talking to voices who told him what to do and chasing a young girl with a machete. He also reported finding Mr. Irick in the hallway one night while he was mumbling to himself and walking with a machete towards Kenneth's bedroom. He said "I'm gonna kill Kenny". However, he surrendered the machete to Mr. Jeffers.

<u>Previous Forensic Evaluations</u>
After his arrest he had a series of forensic behavioral health evaluations for competency to stand trial and criminal responsibility. In summary:

1.<u>04/24/85 illegible</u>
Competency evaluation for charges of two counts of aggravated rate and one count of first degree murder:
"He gives the impression of not caring about the consequences of being found or pleading guilty to murder first degree." (sic) He was aware of the charges but did not give any information

IRICK 00913

concerning his actions at the time of the offense.

He had been living with the family for approximately 2 1/2 years. At the time of the offence he was unemployed. He reported babysitting the children "7 days a week". He reported that problems began when the husband accused him of having an affair with his wife.

His affect was initially angry and he reported depressed mood and thoughts of suicide. He was noted to be "somewhat tangential and circumstantial". He described himself as "a loner".

2.Dye PhD 04/29/85

Competency and criminal responsibility evaluation:
"... no impairment of his capacity to organize or communicate basic information about himself or circumstances."
Concerning the charges, he denied memory of events and said that he had been drinking. He conceded that he had been angry with the family. Thinking was characterized as "reasonably organized, relevant and coherent although... at times disrupted by tangentiality secondary to areas associated with highly charged affect." He denied delusions or hallucinations.
He was characterized as "predominantly antisocial, impulsive adaptation in a very emotionally disturbed young man". There was no evidence of current florid psychosis.

3.Tennison MD, 04/30/85

Evaluated in city jail he was unkempt, disorganized and "predominantly hostile, pejorative and sarcastic". His answers were terse and uninformative. He was alert and oriented to place and person. He occasionally laughed without any evident cause. His narrative was "rambling". His thought processes demonstrated occasional tangentiality when he became more upset. There were no explicit delusions or hallucinations reported. He did make reference to what appeared to be auditory hallucinations or misperceptions. His affect was predominantly irritable. He consistently demonstrated a nonspecific sense of being persecuted or unfairly treated. While intelligence was in the broad the normal range his responses were unusually concrete. He frequently misused unusual words. His judgment was rated as impaired.

"He fluctuated between blaming others for his problems and presenting a defensive posture in which he described himself as potentially very violent."

He described himself as a loner who frequently got into trouble with others. He had previously coped by withdrawing from contact and hitchhiking randomly. He denied ordinary levels of sexual interest.

With regard to his charges he reported being enraged with the father and daughter when he was asked to baby sit on an evening when he wanted to go out. He felt degraded and humiliated by the request. He admitted to having been drinking. He denied memory for events between the time when the child's father left the house and he awoke the next morning under a bridge.

"In a spontaneous attempt to show his affection for the deceased girl, he paradoxically ended up mocking and mimicking her with highly charged affect." (ie talking in a singsong tone while

IRICK:00914

gesticulating and grimacing.)

The examiner concluded that there was no evidence of gross neurologic damage to account for the reported memory loss. He noted marked "antisocial, schizoid, narcissistic and histrionic traits". He did not identify the specific evidence or criteria used to reach the diagnoses.

4.McCoy PhD, 02/16/90
History and mental status examination findings obtained by the psychological examiner noted that the claimant showed multiple paranoid or suspicious characteristics over the course of the examination. He made references to fears of being assaulted, executed, feeling that he was being unfairly persecuted and referencing poorly systematized conspiracies against him involving authorities and fellow prisoners. He described experiences of believing that there was someone behind him commenting ("you're dead") or observing him.

On mental status examination she observed pressured speech and periodically marked anxiety ("to the point of fear and panic", pg 2) against these perceived threats that led to hostile, overbearing and somewhat paranoid thinking and behavior. He was preoccupied with fantasies of retaliating and punishing anyone who might harm or attack him. These descriptions of what he was capable of doing to assailants who were bigger and stronger than him or who attacked him unexpectedly appeared to reassure him and reduce his anxiety. Appeared to exaggerate or embellish his prowess as a fighter. These episodes of fear or bravado alternated with periods of withdrawal and apathy throughout the course of the interview.

On testing he often perceived problems as being overwhelming and gave up easily. When frustrated he blamed the examiner or denied that any solution was possible when he could not answer the question. to

FAMILY NEUROPSYCHIATRIC HISTORY:

While the full history is unavailable there is evidence of severe psychiatric disorder in the family. An aunt or cousin was hospitalized for a psychotic illness. Further, his mother has a history of "heavy" psychiatric medication and evidence strongly suggesting paranoid delusions and auditory hallucinations of her own.

PERSONAL MEDICAL AND PSYCHIATRIC HISTORY:

He denies any significant general medical symptoms or impairment at present. However, he has refused regular medical care or checkups over many years. He is myopic and wears glasses.

CURRENT FUNCTION:

He is currently incarcerated at the facility in Nashville. There have been no serious incidents involving others or significant discipline problems. He obtained his GED in 1988. However his adaptation appears to be superficial, at best.

He says that he spends a great deal of time by himself and that he has no friends. He uses

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isolation and withdrawal as primary coping mechanisms. He is easily overwhelmed when conversations are complicated, unstructured or emotionally challenging. This results in him becoming unsure of how to proceed, agitated and angry. This appears to happen frequently, even when the other individual has no idea of how he is reacting.

He withdraws and isolates himself frequently ("to keep things cool").He spends most of his time alone whether working or engaged in solitary recreational activities such as painting and drawing. He listens to music and watches television. He reads very little. His interactions with others are limited to structured fantasy games or activities such as watching television. Conversations are brief and confined to a narrow range of issues.

He finds the restriction of his freedom and regular proximity to others to be extremely difficult. His best jobs have been noticed that he performed alone, preferably while looking after animals.

He says he has maintained one friendship, with a man who made a film about "the hoax of Apollo 11". He believes that an unspecified conspiracy 'may' have played a role in the moon landing, the Challenger disaster and the deaths of John Kennedy, Robert Kennedy and Martin Luther King.

He describes his current treatment as "de-humanization". He was recently placed in "lockdown", with marked restriction in physical movement, activities outside of the cell and visits for one year. He was accused of possession of a cigarette.(A guard founded on the floor in an area that he was cleaning.) He denies that the cigarette was his. "They just have to check the video to know that I never touched it."

As a result of the recent disciplinary actions he is no longer able to work. "This is the first time in my adult life that I am not working. You could call it a vacation, I guess."

Without the structure of work his wake /sleep cycle appears to be completely reversed. He says that he is sleeping only a few hours at night. He has regular night terrors in which he wakes up with feelings of intense anxiety. He cannot remember any causes. He rates his current mood as "so-so". His appetite is unchanged.

NEUROPSYCHOLOGICAL TESTING:

1. Auble PhD, January-February 1990 notes that he easily became belligerent and testing was frequently interrupted by "loud angry speeches" about the guards or his attorneys. These diatribes appear to have been generally tangential to the subject matter at hand.

Testing results were valid. He had a verbal IQ of 89 and a performance IQ of 82. He performed particularly poorly on "commonsense reasoning" and judgments of social behavior (pg 2). The ability to learn new information fell within the borderline retarded range and was particularly weak for verbal material. His attention span was impaired and he was easily distractible. Problem-solving involving new information (Wisconsin Card Sort Test) was significantly

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impaired.

Personality testing revealed "a very disturbed individual" (pg 2). In particular he had difficulties controlling his emotions, understanding the feelings or concerns of others or forming ordinary social bonds. He was easily frustrated and generally responded to ambiguous situations with anxiety or hostility. The test results indicated high levels of either antisocial behavior or paranoia.

The examiner noted that concerns about brain damage had been present since the first evaluation at age 6. There is evidence of childhood physical and emotional abuse and neglect by his mother (and, subsequently, by his father as well). Evidence for a likely neuropsychiatric disorder included a history of possible cerebral hypoxia at birth (blue baby), subsequent developmental delay, and the early onset of profound hyperactivity, oppositional behavior, persistent poor school intellectual and behavioral performance. A pervasive pattern of cognitive, affective and behavioral problems persisted through childhood and adolescence. These symptoms were of a severity that required several psychiatric hospitalizations, treatment with antipsychotic medication and residential placement (with no contact with family members for 5 years). At no point in the course of treatment as he ever considered to be in remission or no longer requiring ongoing care.

Current problems included impairment in empathy, impairment in ability to modulate anger, pervasive difficulties in modulating behavior and regulating his actions, impulsivity, major difficulties in relating to people and a failure to adequately consider consequences.

She noted a history of two suicide attempts (once attempting to slash his wrists with a steel shank and once trying to beat his head on the concrete floor). He had refused subsequent psychiatric treatment.

Updated Testing

Mr Irick was most recently examined in November-December 2009 (Spica PhD). The neuropsychologist reported three principal findings:

1. There was evidence of symptoms of paranoia and psychosis. The Personality Assessment Inventory showed the highest elevations on the subscales for paranoia, schizophrenia, emotional vulnerability and depression. There was evidence of subtle inconsistencies that suggested defensiveness and, possibly, a minimizing of difficulties. On the symptom checklist-90-revised the highest scores were found for paranoid thinking, hostility and psychotic symptoms.

The pattern describes an individual who feels unusually vulnerable, has great difficulty relating to other people and consequently feels suspicious and isolated most of the time. This is compounded by a tendency to withdraw (and therefore never developing relationships or learning that other people can sometimes be supportive and trustworthy).

Taken together there was evidence of paranoia and at least intermittent psychotic symptoms of

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perception, thought form and content (i.e. sporadic delusions, hallucinations and grossly disorganized thinking.

2.Overall cognitive function was in the low average to average range with a full scale IQ of 96. He was alert, cooperative and appeared to be making his best effort. He passed specific tests of malingering without any evidence whatsoever of symptom exaggeration. Verbal learning, attention and working memory were all in the low average range. Motor skill and visual analysis results were unimpaired.

3. There was evidence of gross impairment of executive function, the capacity to plan, premeditate, weigh consequences and carry out plans. The evidence of impairment in executive function was particularly evident with more complex tasks (i.e. decisions that are complicated, made under time pressure or emotionally charged).

While he performed in the average range in the easiest testing (Tower Test 63rd percentile) there was a dramatic and severe decline in function with more complex tasks (Failure to Maintain Set 8th percentile and WCST 2nd percentile).

A similar pattern was seen in language function: while word knowledge was only moderately impaired there were gross deficits in his ability to express himself when under pressure or under time constraints. Performance on these tests was in the impaired range (verbal and category fluency each in the 2nd percentile).

Problem solving showed a similar pattern: He performed well with simple problems but extremely poorly with more complex tasks that involved maintaining performance while recalling information and learning from experience (2nd percentile).

Based on the testing results the neuropsychologist (Spica PhD) provided diagnoses of:
1. Cognitive disorder not otherwise specified: executive function, verbal fluency
2. Psychotic disorder not otherwise specified
3. Depressive disorder not otherwise specified
4. Paranoid personality disorder

The results should be considered valid for the following reasons:
he passed specific tests of malingering without any evidence whatsoever of symptom exaggeration;
there was no evidence of motor or other mechanical problems to account for the results;
he was observed to be alert and oriented and providing good effort suggesting that the results could not be explained by a transient or reversible problem;
he performed best on the easiest tests and showed the expected increased impairment as the tests became more difficult;
the results are consistent with his level of education, results of prior IQ testing, occupational history and general social function;
there is evidence of external validation by contemporaneous psychiatric examination;

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and the results of the test are consistent with known neuroanatomic relationships.

The testing revealed particular profound deficits in verbal fluency and executive function. The deficits in verbal fluency means that his ability to communicate, particularly in the back and forth of conversation is severely impaired. This level of impairment means that it is difficult for him to:
a) establish the common frame necessary for face-to-face conversation; and
b) discuss events that are not immediately in front of him (e.g. giving descriptions of any extended past events).

The deficits in executive function mean that he will have severe impairment in the capacity to assess situations or decide on an appropriate course of action. He will have severe difficulties with planning or the capacity to organize, prioritize and utilize information and regulate behavior. He was especially poor at considering options and developing alternative courses of action.

The deficits in verbal fluency and executive function are likely to interact in a vicious cycle during times of stress. His anxiety will mount as he is unable to formulate a plan or to organize his thinking in words. Coupled with his difficulties in restraining his behavior this will likely lead to worsening anxiety, bizarre thinking and impulsive behavior.

His deficits are further complicated by marked paranoia and, possibly, intermittently florid psychotic symptoms. He is able to maintain himself, as is typical for many paranoid individuals through by avoiding all but the most perfunctory social contacts.

This pattern appears to been present since early childhood with documentation of a gross failure of normal social development both at home and at school, prolonged psychiatric hospitalizations, repeated school failure, premature discharge from the military, a prolonged period of time when he was a vagrant and his tenuous adaptation to present life through extreme isolation.

In fact, contrary to what would be expected with a normal individual the period of most severe deterioration came when he was taken in and given a home by the Jeffers family. Consistent with his repeated pattern during psychiatric hospitalization, after what appeared to be an initial period of rapid adaptation he deteriorated. In the final stages several adults who lived with him reported evidence of the most severe, and dangerous, psychotic symptoms: command hallucinations of violence accompanied by persecutory delusions. He reported steady consumption of marijuana and alcohol. These agents are commonly used by anxious people to "take the edge off". However chronic use will steadily worsened emotional and cognitive problems. In particular, the combination may have combined to heighten paranoid thinking patterns.

Finally, the deficits in executive function and working memory lead to the conclusion that in practical terms the individual test results are in fact overestimates of his cognitive abilities (i.e. his function in real life situations will be significantly worse than his performance on paper and pencil tests) because deficits in integrating knowledge into actual thinking and behavior will be disproportionately compromised in complicated and emotionally stressful real-life situations.

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VIII. MENTAL STATUS EXAMINATION:

1.General Appearance:
He was dressed in prison garb and glasses. His hair and beard were neatly groomed. He was of average height and is slightly over weight. There were no visible tattoos or jewelry. He was polite, wary and alert. His personal grooming was good. Eye contact was good. He used superficial humor to cover underlying anxiety or deflect uncomfortable questions. He was able to sit through to extended interviews without a break. He appeared to understand and make an effort to answer all questions. Topics that made him anxious over and notably followed by manifestations of suspicion (i.e. trying to identify some external threat) and provide (i.e. statements about how he was capable of defending himself and/or his defiance of a poorly systematized conspiracy against him.

2.Cognitive Function:
He was alert, oriented and responsive to simple requests. His attention, concentration and memory were grossly normal. He was able to perform simple addition and multiplication slowly but correctly continuously over 30 seconds or more. Long-term, intermediate and short-term memory are all grossly intact.

He denied memory for events in the days before and after his arrest. The deficits do not appear malingered in that his memory appears patchy and involve things and events that would help him as well as some that would harm him.

There were no significant pauses and he appeared to follow most of my questions. His answers were extremely concrete. He showed no significant ability to abstract. His interpretation of proverbs were also extremely concrete (e.g. "don't cry over spilt milk" was interpreted as "crying doesn't help when you spilt the milk"). Attempts to abstract information resulted in simple paraphrases.

3.Thought Processes:

There was no evidence of formal thought disorder. His speech was coherent and goal directed. He was able to answer my questions without florid evidence of disorganization.

Thought content is focused on constant fear of being attacked by others or resentment at previous wrongs.

For example, when talking of his mother he would frequently refer to their last phone call and say that his parents never told him that he was their child (He says that she refused any further contact with him, saying that she was going to devote herself "to her real kids".) He would add "I've never seen any birth certificate".

When I told him that I had seen his birth certificate and that his attorney had a copy of it, he was

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not mollified in the least. Rather, this became an example of his mother's lying to him: "She said I didn't have one. She told me I was adopted. She never told me the truth. Why would she say that I am not her real child?"

He reports that his mother has put curses on him with her coven. However "I told her that (i.e. curses) only work against you if you believe. I told her to stop wasting her time."

Any disagreement or confrontation is seen as part of a larger conspiracy against him. For example, he believes that the government has systematically portrayed him as "sub-human", in part to legitimatize his execution but, primarily, to assert its power and his vulnerability. He is not capable of seen his own role in events. He is not able to seriously consider alternative explanations or motives. His beliefs are of near delusional intensity.

There was no other immediate evidence of delusions, hallucinations or other psychotic features. He resolutely denies any auditory hallucinations or other psychotic content. People who have reported that he was seen talking to voices or reported hallucinations in the past are dismissed as "crazy" or "lying".

There was no evidence of current typical obsessional, post traumatic dissociative features or evidence of specific phobias.

4.Emotional State:
His predominant affect is a combination of anxiety, irritability and wariness. His mood is worried and unhappy. The current level of depression is of moderate severity ('five out of ten').

He describes himself as 'a loser'. He reports recurrent thoughts of suicide but no plan.

5.Insight and Judgment:
He has chronic low self esteem and a poor self image. He describes himself as "the lowest of the low." He believes that he is isolated and constantly endangered in prison: "Nobody here trusts anybody else. If there are 3, 2 will always gang up against the other. You have to watch your back or somebody will stab you." He was unable to give any specific examples despite saying it was the general rule.

He believes that he is despised by the general public because of a campaign by the government: "they turn the public against you." The purpose of the campaign is to make and helpless and defenseless. He will be vulnerable to being manipulated by unscrupulous and ambitious politicians to further their careers.

He believes that others may promise support but will always eventually abandon him because they are bribed or intimidated. He used his first attorney as an example: "He sold me out because of death threats. You could tell by his questions in court the way he always left him (i.e. the witness) a way out." He is fearful of being seen as vulnerable.

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His thinking is easily disorganized by anxiety and he quickly becomes irritable and defensive under minimal stress. When he does not understand the situation he tries to control his anxiety by blaming others. As a result he becomes more likely to misunderstand or misinterpret what he is being told.

His major coping mechanisms are isolation/withdrawal and a combination of suspicion and cynicism. "I always pay for feeling good so I tried to stay "pissed" (ie at others).... that way you don't get disappointed... Feel good and something (bad) is going to happen.... I don't have a black cloud hanging over me, my black cloud is a tornado... I'm always one step forward and four steps back If you feel good they will put you down." Similarly, "my father always said you are God's joke on this earth".

Concerning his conviction, he denies his guilt. Nonetheless he cannot provide any account of what did happen. "I can't say yea or nay about who did it. His denial of culpability is based on "It is just not in me to do this. If I thought I had done this I would kill myself."

He consistently denies mental illness of any kind. He does frequently say "I can't remember." about a variety of events. However, this appears to be a mechanism to avoid thinking about painful situations and to forestall further questions or discussion rather than true amnesia. These responses are not part of any evident comprehensive attempt to feign or malinger memory loss. Rather, the responses occurred at times when they would both hinder and help his case.

He does not meet criteria for anti-social personality disorder. There is no cognitive, affective or behavioral evidence from any source for pedophilia. There was no evidence of malingering at any point. Rather, he has persistently denied symptoms of severe mental illness that were reported by others.

IX. RELATIONSHIP WITH THE DECEASED

Mr Irick knew the deceased having lived with her and baby sat the children on multiple occasions. She was credited with saving the lives of all the children when an electrical short circuit set the house on fire.

There is no information to suggest any unusual circumstances in their relationship, sexual advances or infatuation. There is no information to suggest that he had a predilection or unusual interest in young girls. There is no report of any adult expressing concern about his relationship with any of the children, despite an ongoing scrutiny of the home by the department of human services.

He does describe an intense and loving connection with her infant stepbrother, Jason. He was able to describe, with marked animation, multiple examples of his close bond with Jason.

While he had frequently cared for the children when the parents were out of the house he reports that he "never" liked the role because "looking after children is not a male job". In describing how he looked after the children it was clear that he was conscientious and took his

responsibilities seriously. However, as his relationship with the parents gradually deteriorated it appears that he became progressively more resentful "I could see there were enjoying the benefits of free baby sitting".

He reports using alcohol and marijuana heavily at this time. On the night in question Mrs. Jeffers believed that he was significantly intoxicated. She had never complained to anyone previously about his mental state. However, on this night, she was concerned enough to phone her husband, express her concerns and arrange a plan whereby Mr. Jeffers would "check-in" to monitor the situation at home.

X Legal Summary

As summarized in the Southwestern reporter second series pages 121-135 and 643-661:

Mr Irick was convicted of first degree murder during perpetration of a felony and two counts of aggravated rape. Aggravating circumstances include: (1) The victim was less than 12 years of age and the defendant was 18 years of age or older; (2) The murder was especially heinous, atrocious or cruel in that it involved torture or depravity of mind; (3) the murder was committed for the purpose of preventing arrest or prosecution; and (4) the murder was committed while the defendant was engaged in committing the felony of rape.

Mitigating factors included: (1) the absence of prior conviction or misdemeanor; (2) a psychiatric history that included hospital admission in childhood; and (3) the likelihood that he was under the influence of alcohol or marijuana at the time.

The deceased was Paula Jeffers (age 7). Mr Irick was left to babysit the children while both parents were at work. He had many other occasions. This time he resisted, saying that he planned to leave the state of evening. Mrs. Jeffers was concerned that he had been drinking. She phoned Mr. Jeffers at work and he agreed to "check on the children".

Mr. Jeffers reported that about midnight he received a call from Mr Irick who said "I can't wake her up". Mr. Jeffers believed that he could feel a pulse and took her to the nearby Children's Hospital. After attempted resuscitation she was pronounced dead. Examination was consistent with death by asphyxiation and vaginal and anal rape.

Mr. Irick was found and arrested the following day under a highway underpass. He said that he had been hiding there over the course of the day.

DELIBERATION, PREMEDITATION AND SPECIFIC INTENT:

The testing and history demonstrate marked impairment with the cognitive abilities required to effectively deliberate, premeditate a course of action or to form specific intent as defined by Tennessee statute.

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There is evidence of gross impairment of brain function. Cumulatively, the history and testing are consistent with the emotional and social functioning of, at most, a child in primary school. The testing clearly indicates significant impairments in his capacities to plan, consider or evaluate behavior. Collectively, such deficits in executive function are commonly referred to as frontal lobe dysfunction (or "functional lobotomy") and the five most common behavioral patterns include problems with:
i) starting tasks with diminished initiative and spontaneity (i.e. his behavior will be strongly reactive to situations and show little evidence of self-direction);
ii) making behavioral or cognitive shifts with perseveration, mental rigidity and stereotyped behavior (i.e. once started on a particular pattern he will have enormous difficulties in shifting to new patterns, considering alternatives or stopping current behavior no matter how counterproductive);
iii) stopping ongoing tasks with impulsivity and over reactivity (i.e. once started on a particular pattern, behavior will be governed by circumstances rather than by the original plan. This is sometimes)
iv) deficits in self-awareness with inability to see one's mistakes and their impact on others and to properly evaluate social situations(i.e. he is very poor at recognizing when a social interaction is going badly and when there is a problem he is likely to repeat his behavior no matter how counterproductive and may be or what is sometimes known as "being unable to leave bad enough alone");
v) Concrete thinking (i.e. things and situations are taken only at their face value with inability to separate thinking from the immediate surroundings).

There is no evidence of premeditation or a previous pattern of pedophilia, either with the victim or with others. Rather, the events of the night, consistent with the presence of a psychotic illness, appeared to be entirely arbitrary and inconsistent with his behavior at other times.

Mr Irick, had lived with and babysat Paula Jeffers on multiple occasions over several years time without any report of difficulty. There was no evidence of a particular preoccupation or infatuation with her. Significantly, unlike previous occasions, he objected to being asked to babysit, saying that he had plans to leave the state (after being ejected earlier in the day from the place where he had been living). His behavior was such that, although she did not believe he was intoxicated, Mrs. Jeffers called her husband about her concerns.

Mr Irick's behavior after the crime is most consistent with a disorganized reaction to a reaction to unforseen events. Calling Mr. Jeffers saying that he could not wake Paula up is not consistent with a premeditated plan nor is it consistent with the hypothesis that he killed the victim to conceal a rape. Further, there is no suggestion that evidence was, in any way, systematically altered before Mr. Jeffers returned home. Most significantly, according to her stepfather, Paula Jeffers was still alive when arrived .

Finally, Mr. Irick was found under a highway overpass later that day. His being there is most consistent with a random, panicked wandering rather than with a premeditated plan to escape arrest. This is particularly so in an individual who was an experienced hitchhiker who would have known the best ways to go about leaving the area. Mr Irick was an experienced hitchhiker

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who had spent several years traveling throughout North American. He could easily have left the jurisdiction by ways that he was well familiar with. In fact, he spent the day hiding under an overpass. His behavior appears to be more consistent with a disorganized reaction than it is with a carefully thought out escape plan.

On reading his confession with his attorneys he denied that he had raped or killed the victim. He said that he had only complied to what the police said because "either I tell them what I (sic) wanted or I was coming out feet first" (page 647). On cross examination he said that that no one had specifically threatened him at any point. He reported that he had spent the evening in question watching television after drinking beer and smoking marijuana. He had no explanation for running away.

He refused to consider an insanity defense and told his attorneys that he wanted a "DNA analysis". He fought with his lawyers and his defense team was switched several times.

I conclude that the evidence best supports the position that at the time he was, more likely than not, grossly impaired by acute severe psychiatric illness and, it is probable that his condition would have severely impaired his ability to consider alternatives, consequences or perform any other aspects of what we understand to be deliberation.

There was no evidence of preparations before the fact that would be consistent with premeditation. His behavior after the fact is not consistent with a deliberate escape plan and is more consistent with the actions of someone simply reacting to events. He made no substantial attempt to evade detection or capture in the aftermath or to provide even the most rudimentary alibi.

The following mitigating factors are present: History and neuropsychological testing evidence of a chronic severe psychiatric illness and reports of heavy steady consumption of alcohol and marijuana at the time of the offense

PREVIOUS EXPERT TESTIMONY

There are two principal areas of weakness in previous evaluation:
a)critical, third-party information was not obtained; and
b) the limitations of previous testing.

A.Critical Third Party Information:

This was not a situation in which the examiners "failed to connect the dots". Rather, they were faced with a puzzle in which several critical pieces were missing.

Three people who lived with Mr Irick in the time immediately before the events and who had ample opportunity to observe him over several weeks give consistent, disinterested report of a constellation of severe and extremely dangerous psychiatric symptoms: Paranoid delusions that

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he was at imminent risk; command hallucinations to harm others; loss of contact with reality and the capacity to self monitor; loss of the capacity to control his behavior and a gross deterioration of ordinary function.

Had the evaluation team known, this information would have dramatically altered their conclusions and recommendations. By the standards of the time, report of this combination of psychotic symptoms would have met the criteria for a diagnosis of paranoid psychosis at the time of the offense. Moreover, the combination of paranoid delusions, lack of insight and command hallucinations are associated with an extremely high risk of violence. They would have certainly recommended, at a minimum, psychiatric hospitalization for close assessment and evaluation.

It is important to remember that rather than claiming a psychiatric illness Mr. Irick consistently denied psychiatric disturbance. In the absence of the information from the Jeffers family, they were left with a hostile and unsympathetic individual who denied any significant psychiatric symptoms and evidently claimed to be unable to remember the events in question.

B.Limitations of Previous Psychometric Testing

Advances in neuropsychological testing allow for improved evaluation of executive function (i.e. a closer correlation between test results and actual performance in real world situations). There is a dramatic difference in evaluating real world function between the tools existing at the time and the battery used in the recent neuropsychological examination. The difference is comparable to that between a resting EKG and a cardiac treadmill stress test. The latter gives much more information about function and actual situations.

DIAGNOSIS:

AXIS I: a. Cognitive disorder NOS
b. Psychotic Disorder NOS, by history, rule out Schizophrenia, Paranoid Type

AXIS II: Paranoid Personality Disorder
Schizoid Personality Disorder

AXIS III: No diagnosis

AXIS IV: Stressors (severe/prolonged): Post conviction 1st degree murder, Incarceration

AXIS V: GAF= 48/48 (severe symptoms or impairment)

DIFFERENTIAL DIAGNOSIS AND FORMULATION:

On axis I the primary diagnoses are Psychotic Disorder NOS by history (Rule out Schizophrenia,

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Paranoid-type) and Cognitive Disorder NOS.

1.Psychotic Disorder, not otherwise specified consists of "psychotic symptoms... for which there is inadequate information to make a specific diagnosis". (DSM-IV TR page 343). In this case the psychotic symptoms as observed by several individuals include reported auditory hallucinations, persecutory delusions and grossly disorganized behavior.

The information obtained from the Jeffers' family members (i.e. consistent, multiple third-party observation of psychotic symptoms) constitutes the strongest evidence of possible of a severe psychiatric illness (i.e. paranoid psychosis). Florid psychotic symptoms such as auditory hallucinations, paranoid delusions and gross impairment in activities of daily living can be reliably identified by non professional observers as being outside of the range of normal function. Such reports are typically used in making diagnoses of severe psychiatric conditions, particularly when confirmed by multiple observers on multiple occasions.

Even outside of a forensic setting the history and mental status examination of a paranoid patient is limited by the illness itself (i.e. paranoid individuals are particularly reluctant to confide in others, may be particularly afraid of disclosure of psychotic experiences and, by definition, have a lack of insight with regard to their symptoms). Thus, reports of direct observation of psychotic symptoms is the most reliable way of making the diagnosis.

A more specific diagnosis cannot be made on the available information. The major obstacles include:

a)(as in common in paranoid conditions) a lack of insight, organization and rapport. Far from malingering psychiatric illness, he is, more likely than not, to deny or minimize his psychotic symptoms. He does not claim or believe that he has a mental disorder. This has been consistent throughout his history. He refused to allow his attorneys to consider a "NGRI" defense.

b) The lack of adequate evaluation at the time for what is a severe and complex condition. Had the examiners been informed of his reported behavior as summarized in the affidavits they would have concluded that a further prolonged evaluation (in the form of a psychiatric hospitalization for round-the-clock observation) would have been indicated.

The combination of paranoid delusions with feelings of victimization or passivity and related auditory hallucinations constitutes a particularly high a risk of violence. Epidemiologic surveys showed that, on the whole, psychiatric patients are no more violent or dangerous than the rest of the population. Even the most severely ill psychiatric patients are no more likely to be violent than others in comparable situations.

A subset of psychiatric patients have a particularly high risk of violence because of the nature of their particular symptoms. The combination of a fixed belief (i.e. delusion) that others are planning active immediate harm combined with persuasive voices warning of danger or advising emergency action (ie hallucinations) with an impairment in the capacity to control behavior (evidenced in this case when he was observed to chase a young girl down a public street while

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screaming and brandishing a machete) have been shown to carry a high risk of imminent violence.

Additional risk factors include current substance abuse, particularly agents including, as in this case, the combination of alcohol and marijuana. These agents are often overused by vulnerable individuals to combat anxiety and depression but can exacerbate the situation by causing disorientation and impaired function while increasing feelings of isolation and paranoia.

Auditory hallucinations can take a variety of forms. The most potentially dangerous are "command" serious or voices that the patient believes cannot be resisted. This is particularly the case when there are related paranoid delusions (i.e. the patient believes that he is in some sort of danger and the voices threaten or warn of what will happen).

Most auditory hallucinations for most patients can be resisted or ignored most of the time. Most patients will not follow through on delusional beliefs or auditory hallucinations if the content is inconsistent with what they believe or if they believe that the hallucination can be safely ignored.

However, in a small number of psychotic patients the risk of danger is very high. Three specific symptom factors significantly increase the risk of imminent violence. There are number of both general and specific factors that increase the risk of acting on delusions or hallucinations and several of them are present in his case. The specific symptoms are referred to as "threat/control override" phenomena in the research literature. The individual believes that he has evidence of an immediate risk to his life or safety.

The situation is analogous to that nonpsychotic person who believes he must back in self-defense. All people whether they are psychotic or not are prone to believe an act on information that is consistent with what they believe to be true. Similarly, all people, whether they are psychotic or not, are likely to believe what they are told to by sources they respect or trust. Finally, all people whether they are psychotic or not will do things if they believe there is no alternative or that they are in grave danger.

More specifically, there are credible reports of delusions that are consistent with the contents of the hallucinations (e.g. as in this case hallucinations warning the individual of a coming attack and the delusion that others are planning to harm him). If the individual believes that the hallucination comes from an authoritative or credible source (e.g. as in this case supernatural powers) the risk is further increased.

In other words, if the voice is of an authority figure such as God or (as in this case) the Devil and the patient believes, because of his paranoid delusions that there is an imminent danger then the risk of violent behavior to self or others is extremely high. In paranoid delusions low self-esteem and the belief that danger is imminent are both additional strong risk factors for violence in the near future.
Under the circumstances, and individual like Mr. Irick with grossly impairment in the capacity to refrain or control his behavior would be extremely vulnerable.

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The combination of impaired ability to control behavior, command hallucinations and related paranoid delusions constitutes one of the most severe psychiatric emergencies. In this case there is evidence that he reported on multiple occasions in the weeks prior to his arrest that his behavior was being controlled by the Devil, that the police were coming to kill him and that he had to take action to save himself. This coincided with a dramatic impairment in hygiene and self-care. He was observed planning to attack or chasing other individuals with a knife. Chasing a total stranger down the street while screaming and brandishing a machete is not only consistent with the other reported symptoms but clearly demonstrates a severe, acute incapacity to control behavior.

General factors that increase the risk that have been identified in this case include a childhood history of parental rejection and physical abuse, a documented lack of coping skills, a lack of overall support system, current substance abuse and recent psychological stress (being thrown out of the home where he had been living and returning to a highly contentious setting).

There are a number of predisposing factors associated with increased risk of psychosis and related violence in vulnerable individuals. Genetic and psychological factors combined to increase the risk of violence. Mr Irick appears to have a genetic vulnerability for severe psychiatric illness with treatment histories in at least two blood relatives, including his mother. Paranoid individuals like Mr. Irick are hypervigilant and preoccupied with detecting threats.

The document gross impairment of premorbid adjustment at both home and school is also an independent risk factor for violence. Early life events such as trauma and negative experience with parents significantly increases the risk of violence in paranoid individuals. The long-term risk of psychosis is increased by being unwanted at birth or by early separation from parents. Maternal rejection and an adversarial relationship with his mother has been documented. She reported that she was being treated herself for a severe psychiatric illness, had been totally incapacitated for several months postpartum, and had long-term, consistent severe difficulties in caring for this child.

Treatment records dating back to childhood clearly show that he was identified as a severe problem, was rejected and abandoned by both parents for extended periods of time, reported being tied up with electrical cords at an early age and by report was subjected to severe physical abuse.

Physical abuse is associated with subsequent violence and victimization. The evidence shows that paranoid and psychotic individuals are particularly vulnerable to this factor.

Precipitating factors include the ongoing marital breakup in the family that he was living with and most immediately being thrown out of the home where he had been living immediately before the events. Such stressors are associated with acute paranoid psychosis in vulnerable individuals. The absence of a lack of stable support systems or current treatment increases the risk.

IRICK 00030

2.Cognitive Disorder, not otherwise specified is " characterized by cognitive dysfunction presumed to be due to the direct physiologic effects of a general medical condition that do not meet criteria for any of the specific... disorders" (DSM-IVTR page 179) and is diagnosed by "impairment in cognitive functioning as evidenced by neuropsychological testing or quantified clinical assessment" (DSM-IVTR page 180).

His neuropsychological test results fall within the floridly impaired range and unequivocally meets the criteria for the disorder. There are reports of a complicated delivery when he was born. The subsequent reported course of development and his school records indicate that impairment began early in life. Taken together, in the absence of any history of subsequent significant cerebral trauma or illness, this suggests points to the most probable mechanism of cerebral anoxia (i.e. prolonged lack of oxygen) at birth.

On Axis II, there are diagnoses of Paranoid Personality Disorder and Schizoid Personality Disorder.

There is clear evidence from historical review, several clinical evaluations and personality testing of a personality disorder. Based on the available information and using the accepted DSM IV TR diagnostic methods:

Paranoid Personality Disorder (DSM IV TR pages 690-694) can be made on the following criteria of durable, pervasive and grossly maladaptive traits:
a) recurrent suspicions without sufficient basis that he is being exploited, harmed or deceived;
b) unjustified doubts and preoccupations about the loyalty and trustworthiness of others;
c) reluctance to confide in others because of fear of the consequences;
d) reads hidden demeaning or threatening meanings into benign events or remarks;
e) bears grudges and is unforgiving of insults, injuries, or slights; and
f) perceives attacks on his character that are not apparent others and is quick to react angrily or to counter attack.

Schizoid Personality Disorder (DSM IV TR pages 694-697) can be made on the following criteria of durable, pervasive and grossly maladaptive traits:

a) neither desires nor enjoys close relationships; including being part of a family;
b) almost always chooses solitary activities;
c) little if any interest in having sexual experiences with another person;
d) takes pleasure in few activities personality disorder;
e) lax close friends or confidence including first degree relatives; and

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f) shows emotional coldness and detachment.

These diagnoses were made in the absence of a confirmed diagnosis of paranoid schizophrenia (exclusion criterion).

The intensity of these reactions is further amplified by his social or interpersonal deficits. He demonstrates a pervasive, significant and enduring pattern of: misinterpretation or misreading people and relationships with a hypersensitivity to possible attacks. Emotional stress will strongly exacerbate his maladaptive thinking patterns.

His propensity to perceive others as threatening or attempting to take advantage of him as well beyond the normal range, even in his exceptional circumstances. He is convinced that other people are only waiting for the opportunity when he lets down his guard. He holds this belief regardless of years of evidence to the contrary. His lack of insight into his situation is compounded by the severe deficits in his capacity to analyze and understand his situation.

Paranoid and Schizoid Personality Disorders, like other conditions in the "schizophrenia spectrum", have a strong genetic component. Certainly, he has features of disorder that, based on the available information he shares with his mother. She repeatedly declined to be interviewed or to offer any assistance (significantly, she "placed a curse" on one of the attorneys and complained that messages to her television set from the attorneys were spoiling her favorite programs). Her home psychiatric records have not been made available.

However, review of the child psychiatry records notes that she was being treated with "heavy medication" for a severe condition that might require hospitalization. Her rationale for refusing to assist her son, apart from the conspicuous lack of empathy, is consistent with persecutory thinking and auditory hallucinations.

A complicated delivery with possible cerebral anoxia is consistent with neuropsychological findings of severe impairment in executive function.

Mr. Irick also has a severe psychiatric condition that began in early childhood. There is no evidence of successful family or school function at any age. He was admitted to the hospital after both his family and the school system were unable to manage him. He was repeatedly hospitalized and treated with substantial doses of antipsychotic medication for prolonged periods of time. Unlike children with a reactive condition (i.e. psychiatric symptoms that are predominately the results of unfavorable environmental circumstances) he was unable to take advantage of custodial treatment. Hospitalizations and placements followed a recurrent pattern: after briefly and showing improvement after his acute distress abated he would gradually and progressively destabilize. He was unable to benefit from the opportunity for treatment. Rather, review of the full the actual treatment records consistently show that he did not make friends, establish meaningful relationships or progress in school.

Similarly, return to his family did not result in significant improvement. He was unable to

complete school. He enlisted but was quickly found to be unsuitable for military life. He did not form any significant friendships or heterosexual relationships at any point.

It is significant that he describes the time when he wandered aimlessly around the country living on handouts and part-time jobs as the most enjoyable part of his life.

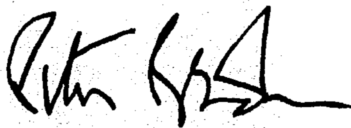
Most significantly, after he was taken in by family and allowed some measure of supportive family life he appears to have deteriorated catastrophically. He began to show evidence of the most severe and dangerous forms of psychiatric illness: persecutory delusions, command auditory hallucinations and total break with reality including his capacity to control his behavior.

There is no evidence of attempts to malinger psychiatric illness at any point.

He does not meet the criteria for antisocial personality disorder.

If personality or emotional and social development is compared to intellectual impairment, then he can reasonably be considered to be 'socially and emotionally retarded' with a functional level corresponding generally to those of a seven to nine year old.

Taken together the preponderance of the clinical evidence clearly demonstrates that Mr Irick has a lifelong, pervasive psychiatric condition of fluctuating severity dating back to childhood and that it is more likely than not that he was severely mentally ill at the time of the events.



Peter Brown MD FRCPC
Chattanooga, Tennessee
April 30 2010

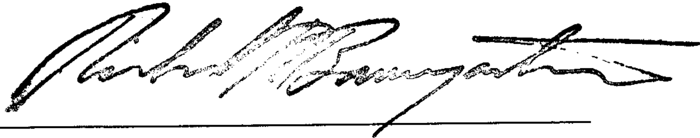
IRICK : 00932

(Psychiatric Evaluation by Dr. Brown)

Exhibit No. 3

Identified and made a part of the

record this 27th day of August, 2010.



Judge Richard R. Baumgartner

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Assessment of Competency for Execution: Professional Guidelines and an Evaluation Checklist

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The issue of whether mental health professionals should be involved in conducting evaluations of competency for execution is a topic that has elicited controversy and heated debate. This article picks up at a point beyond the controversy and addresses issues of professionalism and the objective assessment of competency for execution. Specifically, this article identifies professional standards for conducting competence for execution (CFE) evaluations, describes current practices in this area, and provides an interview checklist that can be used as an evaluation guide by involved professionals. Copyright # 2002 John Wiley & Sons, Ltd.

There has been much debate about whether mental health professionals should be involved in the assessment (and treatment) of competency for execution (CFE) (see Appelbaum, 1986; Bonnie, 1990; Brodsky, 1990 for early discussions of these issues; see Brodsky, Zapf, & Boccaccini, 2001 for an overview of the legal, ethical, and professional issues). Although some mental health practitioners refuse to participate in CFE cases, other mental health professionals choose to become involved. It is important, therefore, to look beyond the debate about whether mental health professionals should be involved in CFE cases and to develop professional guidelines for those who choose to become involved.

Brodsky (1990), in discussing ethical considerations in the evaluation of CFE, noted that 'the vaguer the goals and criteria are for any given task, the more likely the clinician is to utilize his or her own values: similarly, the more unstructured and vague the assessment methods are, the more likely it is that values will impose' (p. 92). An accepted protocol for performing CFE evaluations is needed to help prevent evaluators' personal values from having an undue inùuence on the results of their CFE assessments. As a úrst step toward meeting this need, we interviewed seven mental health experts who had conducted at least one CFE evaluation and

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CASE NO. 24527 EXHIBIT NO. 4
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used their reports and opinions about conducting CFE assessments as a foundation for proposing a CFE evaluation checklist. This article outlines professional issues relevant to CFE evaluations, describes current practices in this area via a summary of our interviews, and provides a checklist of items that can be used by evaluators to guide their CFE assessments.

DEFINITION AND CONCEPTUALIZATION OF COMPETENCY FOR EXECUTION

In Ford v. Wainwright (1986), the United States Supreme Court ruled that the Constitution's Eighth Amendment 'cruel and unusual punishment' clause prohibited the execution of an 'insane' person. Justice Marshall, delivering the opinion of the Court, concluded that the Eight Amendment 'prohibits the State from inùicting the death penalty upon a prisoner who is insane' (p. 419). The Court offered the following rationales for their decision: (i) execution of the insane would offend humanity,(ii)executingtheinsanewouldnotsetanexampleandwouldnotreafúrm the deterrence value believed to exist with capital punishment, (iii) any individual who is believed to be insane is also believed unable to prepare 'spiritually' for death, (iv) madness itself is punishment and, therefore, negates the punishment value of execution, and (v) no retributive value is believed to be served by executing the mentally incompetent.

The Court in Ford did not specify a proper legal test of incompetence in the execution context. Melton, Petrila, Poythress, and Slobogin (1997) noted that the Supreme Court failed to provide a single legal standard and speciúc guidelines for evaluating this type of competency because the very issue was never raised. Only Justice Powell, in his concurring opinion, addressed the issue of the legal test for competency for execution. Justice Powell stated that the Eighth Amendment 'forbids the execution only of those who are unaware of the punishment they are about to suffer and why they are to suffer it' (Ford v. Wainwright, 1986, p. 2608). Further, he concluded that the proper test of competency should be whether the individual can comprehend the nature, pendency, and purpose of his or her execution. Justice Powell argued that only when defendants are aware of the connection between their crime and the punishment is the retributive goal of the criminal law satisúed, and that defendants can only prepare for death if they are aware that it is pending shortly. Justice Powell also asserted that the states were free to adopt 'a more expansive view of sanity' that included the 'requirement that the defendant be able to assist in his own defense' (Ford v. Wainwright, 1986, p. 2608). Subsequent federal decisions have kept the Ford criteria intact and have not expanded upon the deúnition or criteria to be used in considering competency for execution (Brodsky et al., 2001).

Every state prohibits the execution of 'insane' or 'incompetent' offenders since Ford. The deúnition of insanity or incompetence for execution, however, varies among jurisdictions. Acker and Lanier (1997) reviewed statutes and case law in every state that allows capital punishment and concluded that legal tests in all US jurisdictions incorporate the examination of two basic cognitive criteria (with the essential precursor of these cognitive criteria being that the individual being evaluated has a severe mental disease or defect): (i) the ability to understand the nature of the punishment being imposed and (ii) the ability to understand the reasons why the punishment is being imposed (see also Harding, 1994). In addition, these authors noted that a third criterion is included in some jurisdictions, either as an alternative basis for a únding of incompetence or as an additional criterion to be satisúed. This third criterion takes into consideration the offender's capacity to comprehend the reasons that might make the capital sentence unjust and to communicate these reasons effectively.

It is important to note that some authors have commented on the relatively low standard of competence for execution as set out by the Ford decision and the necessity for evaluators to perform comprehensive assessments of all relevant aspects of competency—including those that go above and beyond the standard

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set out in Ford (see e.g., Zapf, 2002). The argument is that competence-related abilities such as rational understanding and appreciation (in addition to factual understanding) need to be addressed in the evaluation and discussed in the report to the court so as not to interpret the Ford criteria for the court, but rather to describe all relevant aspects of competency so the court can make an informed decision in each case.

ASSESSMENT OF COMPETENCY FOR EXECUTION

Although almost every state has a legal test for competency for execution, it is not clearexactlyhowtheFord or other CFE criteria should be assessed. That is, because CFE evaluations are such a low base rate phenomenon, there has been little case law that elaborates on how the criteria are to be applied and assessed. In addition to the lackoflegalguidelinesandprecedent,therearenoassessmenttoolstoaidevaluators called upon to perform this type of evaluation. Therefore, professionals who conduct these evaluations are left to their own devices in terms of how to perform the evaluation and how to interpret the legal criteria.

Brodsky, Zapf, and Boccaccini (1999) proposed a series of steps for the development of responsible, professional, and objective evaluations of CFE. These steps include (i) the development of minimum standards for adequate competence for execution evaluations, (ii) the collection of baseline data on current practices (e.g. interviewing a sample of psychologists and psychiatrists who conduct CFE assess-mentstoidentifythestateofpractice,problems,andconcerns),(iii)thecollectionof data on issues that are of importance to other professionals involved in CFE cases (e.g. attorneys who represent death sentenced offenders and attorneys who represent the state in CFEhearings shouldbe systematically sought out andinterviewed), (iv) an analysis of how CFE assessments relate to the emerging psychometric understanding of competency assessments in general (e.g. areas of overlap and non-overlap of scholarly and professional frames of reference need to be studied and identiüed), and (v) the development of a checklist that can be used to standardize assessments and criteria.

This article seeks to address three of these steps. First, we have proposed a series of minimum standards for the adequate evaluation of competence for execution. Second, we have interviewed a number of mental health experts who have experience conducting competency for execution evaluations. The professionals surveyed were not randomly selected, but rather were a sample of professionals who had agreed to be interviewed after being identiüed by the authors or others as having conducted an evaluation of this type. We believe the results of this survey can be used to help further develop standards and procedures for CFE evaluations. Finally, in the last section of this article, we propose a checklist of interview topic areas to be addressed by evaluators conducting assessments of competence for execution.

MINIMUM STANDARDS FOR ADEQUATE COMPETENCY FOR EXECUTION EVALUATIONS

Minimum standards for CFE evaluations should parallel standards that apply to other types of forensic assessment. That is, standardized procedures that are used during the evaluation should be described to the subject of the evaluation as well as in the examiner's report, assessment measures should be speciüc to the referral issue(s),andtheexaminershouldhaveasoundandsophisticatedconceptualization of the criteria for being not competent for execution. In addition, the knowledge base ofexaminers should cover three domains: general legal competencies,forensic assessment methodologies, and execution-related substantive content. Finally, collateral information should be gathered. This might include (but would not be limited to) information regarding life history, psychological history and disorders, deterioration-relateddata,previousandcurrentwrittenreports,andinterviewswith persons who have had extensive opportunities to observe the subject.

Although minimum standards for competency for execution evaluations can be identiüed, these should not be equated with professional standards or guidelines for these evaluations. Professional standards or guidelines, as we see them, are more encompassing than minimum standards and form the basis for sound forensic practice. Whereas an evaluation that meets only the minimum standards might address the relevant issue in a perfunctory manner, an evaluation that also meets professional standards or guidelines would go above and beyond simply addressing the issue in an obligatory manner. An evaluation that meets minimum standards

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might be a brief, narrowly focused, concrete, and surface inquiry into the psycholegal issue;[1] however, evaluations that meet professional standards should include informative and useful statements about the individual being evaluated and supply a detailed analysis of the issue to be addressed in the form of observations and statements that provide justiúcation for the úndings and opinions. An evaluation that meets professional standards should not only be useful to the court, it should ultimately be defensible in court. What follows is a discussion of assessment issues and professional guidelines for evaluations of competency to be executed.

ASSESSMENT ISSUES RELATED TO COMPETENCY FOR EXECUTION

[1] For instance, an examiner could conceivably conduct the interview portion of a CFE evaluation by askingonlytwoquestions:(i)Areyougoingtodie?and(ii)Doyouknowwhyyouaregoingtodie?

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There has been a dearth of empirical research conducted on competency to be executed. Part of the explanation may be the fact that only a handful of individuals have made successful claims of incompetency to be executed.[2]In addition, this particular type of competency tends to evoke strong emotion in individuals, which, in turn, may impact upon the motivation of involved professionals to conduct research in this area. The limited amount of research that has been conducted has been conúned to surveys, usually of legal professionals (see e.g., Miller, 1988). No studies have examined CFE-related criteria in death row inmates or forensic patients.

There has been more commentary on the assessment of competency to be executed than there has been research. Heilbrun (1987) discussed the implications of the Ford decision for the assessment of competency to be executed and made úve practical suggestions. First, with regard to the mental health professionals who are selected to evaluate an inmate's competency to be executed, Heilbrun argues that these evaluators need to have demonstrated skill in general clinical as well as clinical–legal areas. In addition, he makes the case that these professionals need to be chosen in a manner that eliminates the possibility of any systematic bias operating in the evaluation. For example, systematically eliminating (or including) only those evaluators that favor the death penalty from the potential pool of professionals who will conduct these evaluations may serve to introduce bias into the process that may not have otherwise existed. Second, Heilbrun contends that evaluators must (and, in fact, are ethically obliged to) inform any individual of the nature and purpose of a forensic evaluation before beginning. This is especially true in the case of competency to be executed. Evaluators should attempt to ensure that the inmate understands this notiúcation of purpose (e.g. present the information using easily understood language; ask questions to attempt to determine the inmate's understanding of the information). Third, Heilbrun emphasizes the importance of a comprehensive evaluation, that is, including an assessment of intellectual functioning, personality characteristics, and motivation in addition to symptoms ofpsychopathology;havingmorethanonecontact withtheinmatewhose competence is being evaluated; an assessment of the possibility of malingering; and the use of collateral or third-party information. Fourth, the circumstances of the evaluation,whichincludethepeoplewhoarepresentinthedailylifeoftheinmateas well as the physical environment, need to be taken into consideration by the evaluator. Finally, Heilbrun underscores the importance of comprehensive documentation, usually in theform of a written report, toassist the decision maker and to allow others access to the procedures and reasoning processes used by the evaluator.

Heilbrun and McClaren (1988) discuss the assessment of competency for execution in terms of both preadjudication (before a formal legal judgment about an inmate's competency for execution has been made) as well as postadjudication (after an inmate has been legally deemed incompetent for execution). Given that only a handful of individuals have ever been found to be incompetent for execution (and would therefore require postadjudicative assessment of this type of competency), preadjudicative assessment of competency for execution is certainly the more prevalent type of assessment. Of course, the reader must keep in mind that assessments of competency for execution are much less common than assessments of almost any other type of competency.

With regard to the preadjudicative assessment of competency for execution, Heilbrun and McClaren (1988) outline a number of 'minimum requirements for performing an excellent evaluation' and suggested that evaluators make their participation contingent upon having these minimum requirements met (p. 208). In addition, Heilbrun and McClaren argue strongly for the formal assessment of intellectual functioning, motivation,

[2]Atthetimeofwriting,wehavebeenabletoúndonlysixpost-Fordcasesofindividualsfoundincompetent.

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and psychopathology using well validated and standardized assessment instruments.

With respect to the legal criteria that need to be assessed, evaluators should be aware of the particular legal criteria that deúne the standard for competency within the relevant jurisdiction. If the criteria for competency for execution within a particular jurisdiction are not speciúed, Heilbrun and his colleagues (Heilbrun, 1987; Heilbrun & McClaren, 1988) advise that evaluators should consider the standard in its broadest form and then leave it up to the court to determine what is applicable and what is not. As previously mentioned, Zapf (2002) argues that, regardless of the speciúc criteria set out in a particular jurisdiction, a comprehensive evaluation of all relevant aspects of competency for execution be conducted and delineated in the report to court.

With regard to the postadjudicative assessment of competency to be executed, Heilbrun and MacClaren (1988) maintain that evaluators who are involved in the assessment of competency for execution at this stage should be independent of those who are responsible for treating the inmate for the purposes of restoring competence.

Mathias (1988) also observed the importance of taking the physical and social environment of the inmate into account when evaluating an individual's mental state on death row. He indicated that there are many variables that operate in the environment of death row that may affect an inmate's psychological functioning and presentation and may impact upon a mental health evaluation in a variety of different ways. The nature of a maximum-security setting can have a great impact upon an inmate's mental health and may affect competency status. Mathias argued that evaluators of an individual's competency need to consider these variables when conducting evaluations of competency to be executed.

Small and Otto (1991) explored the legal context and the clinical aspects of evaluations of competency to be executed. These authors encouraged the use of evaluation techniques that focus on the functional capacity of the inmate. Differing slightly from Heilbrun and his colleagues (Heilbrun, 1987; Heilbrun & McClaren,
1988) with respect to the use of traditional psychological testing, Small and Otto stated 'evaluations that emphasize traditional psychological testing and assessment are unlikely to assist the decision maker in assessing functional abilities' (p. 152; see also Melton et al., 1997). Consistent with this argument is the fact that the education level and/or mental state of many offenders on death row may render many traditional psychological tests invalid. Small and Otto do, however, concede that psychological testing may assist in identifying the core mental disorder, making treatment recommendations, or detecting malingering.

PROFESSIONAL STANDARDS FOR COMPETENCY FOR EXECUTION EVALUATIONS

In the introduction of this article, we argued that the more unstructured and vague thecriteriaandgoalsareforanygiventask,themorelikelyitisthataclinician'sown values and biases will impose on the task. We believe that the existence of accepted professional standards for CFE evaluations will reduce the likelihood that clinicians' biases and values will undermine the integrity of their CFE evaluations. As we consider appropriate professional standards for the assessment of competence for execution (see also Brodsky et al., 2001; Heilbrun, 1987; Heilbrun & McClaren, 1988; Melton et al., 1997; Miller, 1988; Small & Otto, 1991) it is prudent to extrapolate from the work on the assessment of other types of competency (such as competence to stand trial and competence to consent to treatment) and to apply these professional principles to the assessment of competence to be executed. In this section, we propose professional guidelines for CFE evaluations.

Knowledge Base

BeforeconductingaCFEevaluation,evaluatorsshouldbefamiliarwiththerelevant statutes, deúnitions, and criteria for competency for execution in their jurisdiction. In addition, CFE evaluators should be familiar with the procedural aspects of competence for execution cases within their jurisdiction (i.e. how, when, and by whom the

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issue of competence for execution may be raised; who determines that an evaluationistooccur;andwhatproceduresarespeciúctotheevaluationprocess).A competent evaluator should be knowledgeable about these legal requirements and procedures before beginning an evaluation of CFE. The evaluator should consult withwhoeverhasorderedtheevaluationtoclarifythereferralquestionandtoensure that all parties involved understand what is to be evaluated.

General Evaluation Procedures and Considerations

We now discuss whatit means to have a clear understanding of the referral question and

how to decide when to consult with the individual requesting the evaluation. For example, an evaluator may be the only expert retained or may be one of several and assigned to evaluate one aspect of functioning (e.g. mental retardation). In this instance, it would be necessary for the evaluator to be clear about the boundaries of the speciúc case. CFE evaluations should be conducted in a place with adequate space and privacy that is free from distraction. In addition, CFE evaluators should seektomeetwiththeoffenderonmorethanoneoccasionaspartofanassessmentof consistency, deterioration, improvement, and other changes. Finally, CFE evaluations should include a clinical–forensic interview in which the offender's psychiatric history, symptom validity, and understanding of the relevant legal criteria for CFE in the particular jurisdiction are assessed. The relevant psycholegal criteria should beassessed ina structured and replicable manner.The information gained fromthe interview should be considered in light of collateral information that has been collected.

Clinical–Forensic Interview

At the beginning of the forensic interview, CFE evaluators should inform the offender of the nature and purpose of the evaluation, the possible outcomes of the evaluation, for whom the evaluation is being performed, who will have access to the results of the evaluation, and the consequences of not participating in the evaluation. Any indication of a lack of understanding on the part of the offender should be noted and appropriate measures taken to determine whether or not to continue with the evaluation. During the interview, evaluators should assess the offender's understanding of the relevant information in this the jurisdiction, the offender's appreciation of his or her situation, and his or her reasoning about these issues. In addition, the evaluator should inquire about the offender's previous and current psychological functioning and psychiatric history as well as any medication that the offender may be prescribed and its effect on the offender.

Assessment Measures

CFEevaluatorsshouldbeaware ofthepsycholegal abilitiesrequiredofacompetent offender. In the absence of a standardized assessment instrument speciúcally developed to assess the psycholegal criteria for a given jurisdiction, the evaluator shouldoperationalizetheapplicablepsycholegalcriteria.Evaluatorsshouldfocuson thefunctionalabilitiesoftheoffender,inadditiontothementalstateoftheoffender and the appropriate diagnosis of a mental disorder, and should document how any functional deúcits may be causally related to mental, emotional, or intellectual deúcits. Ifit isa requirement ofthe jurisdiction that the offenderbe able to assist his or her attorney, then a true functional assessment would include observing the interaction of the offender with his or her attorney and attempting to determine whether or not the offender is able to assist the attorney (e.g. disclose relevant information to the attorney, understand what it is that the attorney is attempting to accomplish).

Finally, CFE evaluators should examine the possibility of response sets such as

defensiveness, uncooperativeness, or malingering. Every effort should be made to useinstrumentsthathaveestablishedreliabilityandvalidity;afterall,themotivation to malinger in this situation may be high. It

may be necessary to use an instrument speciúcally designed to evaluate the potential for malingering or the authenticity of reported symptoms. The evaluator should use other psychological tests in the evaluation of CFE as indicated in a particular case (e.g. neuropsychological tests if there is some question of cognitive or neuropsychological impairment).

Collateral Information

CFE evaluators should collect collateral information about the offender's previous and current functioning, as well as his or her functioning while on death row (including any speciúc behaviors that the offender has engaged in that might be relevanttopsycholegalunderstanding[3]).Friendsandfamilyoftheoffenderwhocan comment on previous and current functioning and characteristics should be interviewed. Correctional ofúcers, prison physicians and psychologists, and other prisoners should be asked to comment on the behavior of the offender while in the institution. Medical records and psychiatric history both within and outside the correctional institution should be gathered and evaluated.

Presentation of the Results of the Evaluation

3 Thesemightinclude,butnotbelimitedto,discussionsofexecutioncontentwithcorrectionalpersonnel or chaplains, writing letters of goodbye or issue resolution, writing a will, giving away possessions, selectingwitnesses, ormaking preferences fora lastmeal.

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CFE evaluators should carefully document the evaluation procedures as well as all other relevant information. Record keeping, note taking, and recording[4] the interview are important considerations and should be meticulous as these assessments arelikelytoundergoseriousscrutiny.ItisgoodpracticeforCFEevaluatorstospeak to the individual who retained their services before preparing a report. Although it remains arguable whether CFE evaluators should speak to the ultimate legal issue, they should certainly present the evidence before the triers of fact in a manner that willbeofassistanceinreachingadecisionaboutwhethertheoffenderiscapableofa speciúc psycholegal ability or required capacity (e.g. include a full history, observations,andtesting includingdescriptions orobservationsoftheoffenderandperhaps extensively quoting the offender's responses).

CURRENT PRACTICES IN THE ASSESSMENT

OF COMPETENCY FOR EXECUTION

To evaluate current practices in the evaluation of competency for execution and identify assessment issues that are considered to be important by professionals who conduct this type of evaluation, we interviewed seven mental health professionals who have been involved in evaluating competency to be executed. We asked these professionals about (i) their past experiences with speciúc cases in an attempt to determine how they conceptualize the nature of this type of competency and the pertinentissuesinconductingthistypeofevaluationand(ii)speciúcchecklistareas thatmayormaynotbeusefuland/ornecessarytoincludeinaninterviewevaluation checklist for competency to be executed.

All seven of the mental health professionals that were interviewed held a Ph.D. degree;onealsoheldaJ.D.andoneheldanM.S.Ed.degreeinadditiontothePh.D. Two individuals had conducted (or were presently involved in) competency for execution evaluations during the current year (in Arkansas and Tennessee), three others had conducted their last evaluation of this type in the 1990s (in Alabama, Missouri,andTexas),andtwooftheprofessionalslastconductedaCFEevaluation in 1989 (in Utah and Arkansas).

When asked about current practices in the evaluation of competency for execution,theprofessionalsidentiúedanumberofcomponentsthattheybelievemakeup the structure of a thorough CFE evaluation. Identiúed components included reviewing case materials, prison records, medical records, trial transcripts, and psychiatricrecords(includingthoseduringandpriortotheoffender'sincarceration on death row); examining statutes or relevant court decisions to determine the applicable criteria for a given jurisdiction; consulting with the retaining attorney; interviewing and conducting psychological or other relevant testing with the offender; interviewing family members of the offender, prison oúcials and correctional oúcers, and other offenders who have had contact with the offender; and observing the offender in his cell on death row.

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4 Videooraudiorecordingisusefulinthattheevaluatorisabletoreviewtheevaluationaswellaspresent thetapetocomplementhisorhertestimony;however,recordingtheevaluationisalsosubjecttolegal– strategic decisions by the attorney and, therefore, should be discussed with the retaining attorney beforehand.

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The CFE evaluators reported using a number of different psychological tests during CFE evaluations including the MMPI (or MMPI-2), MCMI (or MCMI-II), PAI, SADS, or PSE to assess psychopathology and test-taking style; the SIRS, VIP, or Rey 15 to assess malingering (when indicated); the WAIS-R[5], Shipley, TONI, or KFAST to assess intellectual functioning or to diagnose mental retardation; the PPVT-R to assess language functioning; the BEERY or BNT to assess dementia; the PCL-R to assess psychopathy (when indicated); the IFI to assess reasoning ability; and the Halstead-Reitan to assess neuropsychological functioning (when indicated). There was some disagreement about whether or not to use projective techniques for this type of evaluation, with one professional indicating that he would use the Rorschach 'when indicated,' and another stating that he would 'never' use the Rorschach or any other projective technique for this type of evaluation. None of the other CFE evaluators mentioned projective techniques.

In response to inquiries about the assessment of the speciûc criteria for incompetency, all of the evaluators indicated that they asked the offenders speciûcally about each of the relevant criteria (for their respective jurisdictions). One evaluator indicated that he also used an unpublished checklist of items (Ackerson, unpublished doctoral dissertation) and another evaluator indicated that he used a forensic assessment instrument that was developed to assess an offender's reasoning abilities (the Interdisciplinary Fitness Interview). In addition, all of the evaluators reported that they focused speciûcally on the offender's understanding of death and the reasons for it. Three of the evaluators indicated that they made an attempt to assess the offenders' reasoning abilities, in addition to simple factual understanding, with respect to death.

When asked about the most challenging aspects of the evaluation of an offender's competency for execution, three global issues were identiûed: (i) the nature of the inquiry itself and the gravity of the consequences, (ii) the difûculty the evaluator may experience in trying to remain objective, and (iii) the evaluator's own personal difûculties with the death penalty.

With regard to the gravity issue, the CFE evaluators reported feeling that the magnitude and the immediacy of the consequences for the offender had an impact upon their evaluation in terms of the amount of time and energy they put into ensuring that they conducted a thorough and comprehensive evaluation. With regard to objectivity, one professional, speaking candidly, indicated that he found it difûcult to maintain objectivity for three reasons: (i) you become sharply aware of your own personal beliefs about the death penalty, (ii) you get to know the offender and may not see anything to prevent the offender from being executed, and (iii) it is difûcult to resist the pull to afûliate with the attorneys who retained you as the case is always presented to you from their point of view. Finally, with regard to the personal difûculties, several CFE evaluators reported feeling that this type of evaluation can be emotionally difûcult for the evaluator because the task forces the evaluator to deal with his or her own feelings and beliefs about capital punishment. When asked whether they would consider conducting another CFE evaluation in the future, six of the seven evaluators indicated that they would. Each of these evaluators felt that they were prepared to do these evaluations with what they perceived as the necessary amount of comprehensiveness and scrutiny. In addition, they felt that they would be leaving this task to someone who might not do as thorough a job if they declined. It appears that these evaluators were alluding to the distinction we made earlier in this paper. That is, that some evaluators might conduct evaluations that meet only the minimum standards rather than professional standards. The one evaluator who indicated that he would not conduct another CFE evaluation stated that he has had a change of heart with respect to capital punishment and no longer feels that the death penalty is an acceptable form of punishment. This evaluator felt that individuals who conduct this type of evaluation have to be in favor of the death

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The reader is reminded that the majority of these evaluations were conducted a number of years ago and, therefore, some of the instruments reported, while perhaps out of date now, were not out of date at the time of the evaluation.

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penalty. We do not agree with this assertion but did not poll other evaluators about their opinions on this matter.

Speciûc problems that were encountered by these professionals in conducting CFE evaluations included difûculty in accessing medical records from other facilities, difûculty in ûnding a proper setting for this type of evaluation, difûculty in gaining access to the offender at times (e.g. being required to interview from behind glass at some facilities), difûculty in establishing or maintaining rapport with embittered offenders or those who refused to cooperate, and insufûcient allocation of resources by the court (i.e. in terms of time required to obtain all the relevant records as well as compensation).

When asked to give their opinions about their respective jurisdiction's criteria for incompetency for execution, most of the evaluators indicated that they believed the criteria to be very minimal standards that were patterned after Ford, which has avery low threshold for competence. Several evaluators felt that the courts interpret the Ford criteria as factual understanding, whereas they believe that the courts should consider the higher standard of rational understanding when making CFE determinations. Similarly, when asked about the most difûcult aspect of the CFE criteria to assess, a number of evaluators felt that it was difûcult to distinguish between a factual and rational understanding of death. One evaluator indicated that this was especially so since there is no 'gold standard' for understanding death. When asked how they might change the CFE criteria if they could, a number of CFE evaluators stated that they would further deûne the required level of understanding.

In addition to questions about current practices in the evaluation of CFE, the CFE evaluators were also asked to give their opinions about items we had included in a preliminary version of our CFE interview checklist. We now turn to the subject of this last part of the inquiry: a checklist for CFE evaluations.

CHECKLIST FOR EVALUATIONS OF COMPETENCY FOR EXECUTION

Prior to conducting the interviews with the CFE evaluators, we compiled a list of content areas that we felt were important or useful to include in a checklist for evaluations of CFE. We then asked the CFE evaluators about the importance and utility of each of the checklist topics. Their responses were then used to revise and edit the checklist topic areas. The revised version of the checklist is presented in the Appendix.[6]

The checklist is divided into four sections: understanding the reasons for punishment, understanding the punishment, appreciation and reasoning (in addition to simple factual understanding), and ability to assist attorney. These four sections are representative of the legal criteria for CFE that have been set out by various states (see Acker & Lanier, 1997; Harding, 1994).

Most states model their statutes after the criteria set out in Ford and, therefore, consider only the prisoner's ability to understand the punishment that is being imposed and the reasons why it is being imposed. The ûrst two sections of the checklist parallel these two Ford criteria. The ûrst section targets the offender's understanding of the reasonsfor punishment: that is, his or her understanding of the crime and other conviction-related information. Speciûc topic areas include the offenders' understanding of the reasons why they are in prison; their place of residence within the prison; the crime for which they were convicted, including an explanation of the criminal act and victim identifying information; the perceived justice of the conviction; reasons why other people are punished for the same offense; and any self-identiûed, unique, understandings of the offense and trial that the offenders may have. These areas were identiûed as relevant content areas to determine the extent of the offender's factual understanding regarding punishment.

The second section targets the offender's understanding of the punishment: that is, that the punishment he or

[6] A user-friendly version of the checklist (i.e. with space for the offender's responses and the evaluator's comments) is available from the authors.

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she is facing is death. Speciûc topic areas include the offender'sunderstandingofthesentence;themeaningofasentenceofdeath;whatit means for a person to be dead; speciûc understandings about death from execution; and the reasons for execution. The evaluators surveyed indicated that it was important to ask questions about death from a number of different angles (e.g. meaning of death, speciûc understandings about death from execution) so as to facilitate a thorough evaluation of any irrational beliefs or ideas the offender may hold regarding death.

The literature on other types of competence (e.g. competence to consent to treatment) documents that there is often a relationship between the severity of the consequences (to the individual being assessed) and the stringency of the standard used to evaluate competence (see, e.g., see Roth, Meisel, & Lidz, 1977). This, coupled withthegravityoftheconsequencesintheparticularinstanceofCFE,leads us to believe that it is important to assess the offender's appreciation and reasoning abilities (in addition to simple factual understanding). Therefore, the third section of the checklist lists topic areas speciûc to the assessment of an offender's appreciation and reasoning abilities with respect to death and execution. Speciûc content areas in this section include the offender's appreciation of the personal importance of the punishment and the personal meaning of death; the offender's rationality or reasoning about the physical, mental, and personal changes that occur during and after execution; beliefs regarding invulnerability; inappropriate affect; acceptance or eagerness for execution; and beliefs against execution. Although the Ford criteria are often interpreted as the offender's factual understanding, we believe that mental health professionals involved in CFE evaluations should also assess the offender's appreciation and reasoning and leave it to the court to determine how to interpret the Ford (or other relevant) criteria in each speciûc case.

Finally, the last section of the checklist identiûes issues related to the offender's ability to assist his or her attorney. This section will be especially relevant in jurisdictions that rely upon criteria that are broader in nature than those outlined in Ford, such as the capacity to comprehend the reasons that might make the capital sentenceunjustand to communicate these reasonseffectively. Speciûctopic areas in this section include the identity of the offender's attorney and the amount of time that the attorney has been working for the offender; the offender's trust in the attorney; awareness of execution date; status of appeals; what the attorney is attempting to accomplish through the appeals; how the appeals will be processed and assessed; the actual substance of the appeals; important content that the offender may have withheld from the attorney; and any pathological reasons for not planning or discussing appeals.

Using the Checklist

Several issues need to be emphasized regarding the use of this checklist. We have intended this checklist to serve as an aide memoire to assist professionals in conducting the interview portion of CFE evaluations.[7]While we have sought to be comprehensive, the evaluator needs to be mindful that important issues might arise in a particular case that have not been included in this checklist. Although the purpose of this checklist is to guide the evaluator through relevant issues pertaining to competence for execution, simply going through this checklist is not enough to assess every individual adequately with respect to competence for execution. We think of this checklist as an organizing structure to be used to guide the evaluator through relevant topic areas in the assessment of competency for execution.

Speciûc areas of inquiry follow each of the topics included on the checklist. Speciûc questions were deliberately not listed in order to encourage evaluators to develop their own style of questioning for each of the content areas. On a related note, it is important for evaluators to phrase questions in such a way so as not to

[7]Theevaluatoriscautionedthattheinterviewisonlyonecomponentofacomprehensivecompetencyfor execution evaluation.

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lead the offender to exaggerated or malingered pathological responses. This precaution is, of course, part of all forensic interviewing in which evaluees may be motivated to exaggerate or present false impressions of psychopathological disorders.

The available research on death row offenders indicates that they are disproportionately intellectually limited and academically deúcient (Cunningham & Vigen, 1999, manuscript under review). Therefore, it is important for evaluators to use language that is straightforward and understandable when evaluating a particular offender. If a particular offender holds a known delusional system, it would be important for an evaluator to assess this delusional system directly with respect to the execution process, the reasons why this individual is to be executed, and what it means to be executed, as well as the offender's beliefs about the perceived role that his or her attorney plays in this process.

CONCLUSION

In conclusion, we would like to make a few general points about the evaluation of competency for execution. First, we encourage professionals who perform CFE evaluations to think of them as being an area of specialization within their work. Although CFE evaluations would probably not be an exclusive area of practice for most practitioners (considering the low base rate of this type of evaluation), it is important to treat it as a specialization and to devote concentrated and attentive study, feedback, consultation, and continuing education to this task.

Second, we view CFE evaluations as an area of evolving practice. Although the Ford criteria, speciúcally, have evolved little, the consideration and understanding of what the Ford criteria mean to CFE evaluators appears to be evolving. In addition, the practice of psychological evaluations in this arena continues to develop. We view our work in this area as contributing to the dialogue and elaboration of issues that is designed to move this evolution along to the next stages. We encourage other professionals to do so as well in the interests of a fuller understanding of these important issues.

Finally, this checklist represents a úrst step that will need to go through a process that includes úeld-testing, standardization, and the development of norms. For this to happen it will be important to receive feedback from professionals who use this checklist in their practice.

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APPENDIX: INTERVIEW CHECKLIST FOR EVALUATIONS OF COMPETENCY FOR EXECUTION

This checklist was developed for use in evaluations of competency for execution. The evaluator is encouraged to ask additional and follow-up questions to ensure a thorough understanding of the offender's abilities in each area. Speciûc areas of inquiry are included for each topic in the checklist.

MCMLXXXVIII. Understanding of the reasons for punishment
i. Reason why in prison
a. How offender came to be in prison b. What offender did to get there
c. Initial charges and how they led to actual conviction
d. Sequence of events from offense to arrest, trial, sentence, and then to imprisonment
ii. Place of residence within the prison
c. Where offender currently resides within the prison, including number of cell or dorm, name of cell block, and the area of the prison (e.g. protective custody, segregation, death row, general population)
d. Prior places of residence within the prison, including hospital, segregation, holding cells, or other units iii. Conviction information
IIIIIIIIIIIIIII. Crime for which offender was convicted b. When offender was convicted
c. In what city or county, state, and court the trial was held d. How long offender has been in prison iv. Explanation of criminal act
c. Name of the criminal act offender committed
d. Similarities and differences between this and the actual behaviors involved in the offense
e. What (insert charge for which offender was convicted) involves/entails v. Victim identifying information
c. Name of the victim b. Age of the victim
c. Whether the victim was a male or female
d. Ways in which the victim is described and understood by offender vi. Perceived justice of conviction
c. What offender believes was just about his/her conviction
b. What offender believes was unjust about his/her conviction
c. Fairness, accuracy, and what was and would be right are explored
vii. Reasons other people are punished for same offense
b. What offender believes about why other people convicted of (same offense) are punished
c. What offender believes about the type of punishment that anyone convicted of (same offense) receives
d. Reasons for different degrees of punishment
viii. Self-identiûed unique understandings of offense and trial
b. Any special understandings of his/her offense that makes sense only to the offender

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c. Special understandings ofhis/hertrial thatmakessenseonlytotheoffender c. Aspects of this charge or crime that most people would not understand unless the offender told them

II. Understanding of the punishment

iii. Sentence for the crime—speciúcally

b. Sentence that offender received for his/her conviction ii. Meaning of a sentence of death

b. Beliefs about what it actually means to receive a sentence of death iii. Meaning when a person is dead

b. Beliefs about what it means for any person to be dead

c. Beliefs about what it would mean for him/her to be dead c. How he/she would know that someone was dead iv. Speciúc understanding about death from execution

b. Explanation of the procedures for execution that he/she will undergo: what happens, how it works

c. Explanation of what will be done with his/her property after execution c. Explanation of what will be done with his/her remains after execution v. Reasons for execution

b. Reasons and beliefs about why s/he should be executed

c. Reasons and beliefs about why s/he should not be executed

d. Societal reasons, religious ideas, legal issues, involvement of other persons, personalized reasons

III. Ability to appreciate and reason in addition to simple factual understanding

The following items address the issues of appreciation and reasoning. Although the criteria for competency to be executed from Ford v. Wainwright do not speciúcally use the terms appreciation or reasoning, it may be important to establish the offender's appreciation of the personal importance of these proceedings and reasoning or ability to rationally manipulate information regarding the proceedings.[8]

ii. Appreciation of the personal importance of this punishment

c. What it would mean to be executed

d. Issues of triviality, irrelevance, involvement, salience

ii. Appreciation of the personal meaning of death

c. What it will mean personally to be dead: events, activity, consequences, changes

d. Ways in which the offender will be otherwise affected

e. Ways in which others (important to the offender) will be affected

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With respect to the criteria for competence to stand trial, many jurisdictions require the defendant to havetheabilitytoappreciateandreasoninadditiontosimpleunderstanding.Inaddition,theliteraturein the area of competence to consent to treatment indicates that there is often a relationship between the severity of the consequences and the stringency of the standard used to evaluate competence. Given the serious nature of the consequences in the case of competence for execution and the fact that more than the simple ability to factually understand is usually required for competence to stand trial, it would therefore, make sense for a stricter standard than simply the ability to factually understand be used for competence for execution. This standard could include understanding as well as appreciation, and rationality or reasoning.

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iii. Rationality/reasoning regarding the physical changes during and after execution
c. Explanation about whether s/he will be physically different after s/he is executed (than s/he is now)
d. Explanation about exactly what happens physically when anyone is executed (and when the offender him or herself is executed)
iv. Rationality/reasoning regarding the mental changes during and after execution
c. Explanation about what will happen mentally when s/he is executed
d. Beliefs about whether and how s/he will be any different mentally after execution than s/he is right now
v. Rationality/reasoning regarding other personal changes during and after execution
c. Beliefs about transformations or changes that will happen to him/her after execution
vi. Rationality/reasoning regarding beliefs in invulnerability
c. Reasons or beliefs why s/he will not or may not die when executed
d. Whether anything different would happen personally upon execution than to anyone else who is executed
vii. Inappropriate affect about execution with associated rationality/reasoning
c. Current feelings when s/he thinks about being executed
d. How the offender imagines s/he will feel just prior to being executed c. Unexpected or peculiar affect
viii. Rationality/reasoning regarding acceptance or eagerness for execution
c. Reasons why the offender might be looking forward to being executed b. Reasons why the offender may have accepted his/her execution

ix. Rationality/reasoning regarding factors associated with beliefs that person should not be executed
c. Reasons why s/he should not be executed b. Reasons why s/he might not be executed
IV. Ability to Assist Attorney
ix. Identity of attorney
c. Name of the offender's attorney b. Where located
c. Address or phone number d. What attorney looks like ii.
Time with current attorney
i. How long since this attorney has been retained by the offender b. Last time that the offender saw or spoke to attorney c. Frequency of correspondence with attorney
d. Frequency with which the offender has seen attorney (over some length of time)
iii. Trust of attorney
d. Trust in attorney's skills and competence
e. Trust in attorney's caring and investment in case
f. What the attorney has speciúcally done to show that he or she is trustworthy
g. Indications that attorney can or cannot be trusted
h. Beliefs regarding for whom attorney works
iv. Awareness of execution date (if any) or likely date
d. Knows if execution date has been set
e. If a date has been set, what that date is
f. If a date has or has not been set, ideas about when he/she might be executed
v. Status of appeals
d. Knowledge if whether attorney is currently working on an appeal, and, if so, what it is
e. Knowledge of úlings of any previous appeals on his/her behalf
f. What (if any) appeals are still available

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vi. What attorney seeks to accomplish through appeals
  d. Understanding of issues and goals in appeals
  e. What could happen as a result of the appeals
vii. How appeals will be processed and assessed
  d. Understanding of what happens as appeals are processed and assessed
  e. Knowledge of who is responsible for hearing and making a decision about appeals
viii. Actual substance of appeals
  d. Whether the offender has read any of the information prepared for the appeals
  e. Offender's understanding about what issues the appeals are based on
ix. Important content withheld from attorney
  d. Whether attorney has been told everything needed in order to úle appeals on the offender's behalf
  e. Anything that the offender has deliberately withheld from his/her lawyer
  f. Any information that the offender would never tell his/her lawyer
x. Pathological reasons for not planning or discussing appeals
  d. Any personal reasons that other people might not understand for why offender might not plan an appeal
  e. Any special reasons why the offender might not discuss an appeal
  f. Anything happening that keeps the offender from believing attorney or speaking freely with attorney

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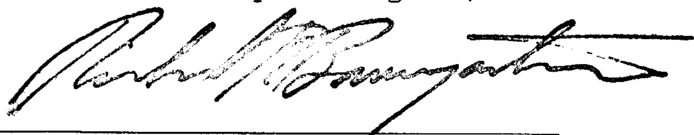
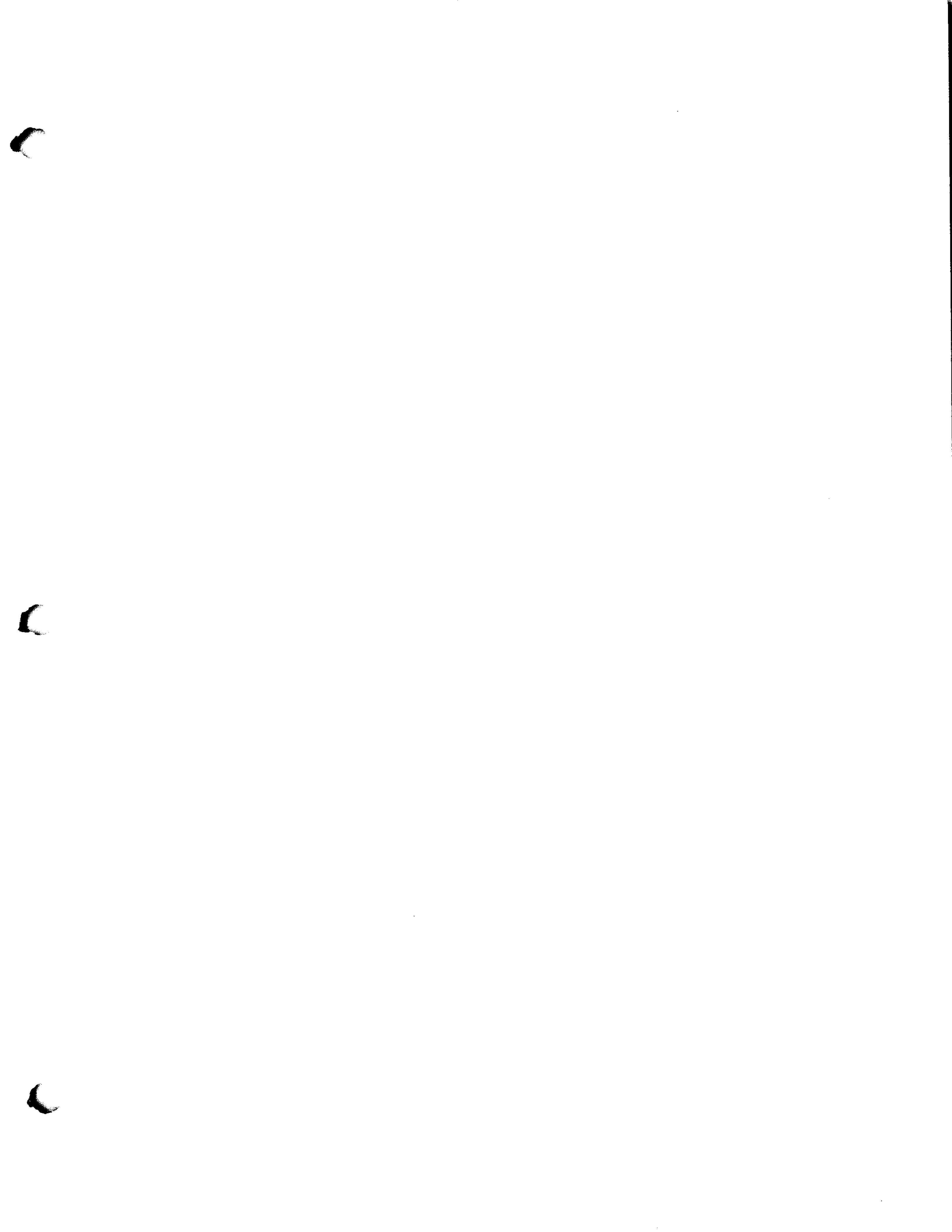
(Article - Assessment of Competency for Execution: Professional Guidelines and an Evaluation Checklist)

Exhibit No. 4

Identified and made a part of the record this 27th day of August, 2010.



Judge Richard R. Baumgartner



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STATE OF TENNESSEE VS. Billy Ray Irick
CASE NO. 24527 EXHIBIT NO. 5
DATE 8-17-10 ID ___ EVD ✓

Kathy Ann Jeffers
4-16-85
Det. Don Wiser

DW: This is an interview with Kathy Ann Jeffers. The date is the 16th of April, 1985, the time is 2:05 p.m. And you reside where, Mrs. Jeffers?

KJ: 1205 Exeter.

DW: Okay, in the city of Knoxville?

KJ: Yes sir.

DW: County of Knox?

KJ: Yes.

DW: State of Tennessee?

KJ: Yes.

DW: And you're employed by....

KJ: Hagaman's Truck Stop.

DW: And you were born at... what city?

KJ: Knoxville.

DW: On....

KJ: July 29th, 1954.

DW: Okay. And you understand this interview is being taped?

KJ: Yes sir.

DW: And you understand that this is Det. Ashburn?

KJ: Yes sir.

DW: And my name is Det. Wiser. And we've identified ourself as Police Officers to you?

KJ: Yes sir.

DW: Alright. And who do you reside with on Exeter?

KJ: Had been just me and my kids. My husband and I've been separated.

DW: Okay. And would you name your kids?

KJ: My two stepsons, Kenny - little Kenny - and James.

DW: Okay, this is your husband's children? Alright. But you were keeping them?

KJ: Uh huh.

DW: And who else?

KJ: My daughter Paula.

DW: Paula who?

KJ: Paula Dyer.

DW: Alright, and who else?

KJ: My two sons, Chuckie and Jason.

DW: Chuckie and Jason. And do you know a person by the name of Billy Ray Irick?

KJ: Yes sir.

DW: How did you come to know Mr. Irick?

KJ: Through my husband.

DW: And this was when you were living in Clinton?

KJ: Yes sir.

DW: And Mr. Irick stayed with you and babysitted for you and your husband?

KJ: Yes sir.

DW: And your house burnt down in Clinton, is that correct?

KJ: Yes sir.

DW: And you all moved to Knoxville?

KJ: Yes sir.

DW: And you and your husband had some marital problems?

KJ: Yes sir.

DW: Did you ever have an affair with Mr. Irick?

KJ: No.

DW: Were you ever accused of it?

KJ: Yes.

DW: And did your husband accused you of it?

KJ: Yes.

DW: Has, were, there another girl living with you all in Clinton?

KJ: Uh, a friend of mine stayed for a couple of weeks. She wasn't really living there, she....

DW: I'm talking about another child of your husband's.

KJ: Uh, Linda. Stoddard.

DW: Okay. And where is she at?

KJ: She's with her mother.

DW: What's her mother's name?

KJ: Pamela Taylor.

DW: And where does Miss Taylor live at?

KJ: It's on Woodland Avenue. I think it's 105, but I'm not, I'm not positive of that.

DW: In the city of Knoxville.

KJ: Um hm.

DW: And how old's this child?

KJ: She's 7 also.

DW: And where does she go to school at?

KJ: Um, it's not Brownlow, it's not Oakwood -

DW: Was Mr. Irick ever accused of abusing this child?

KJ: He was questioned, but nothing ever came of it.

DW: What was he questioned about?

KJ: Uh, as far as the way of punishing her, you know, whipping her too hard, you know, stuff like that.

DW: Did he whip these other children?

KJ: He uh, whipped one of the boys on occasion.

DW: Did he ever whip Paula?

KJ: Not that I can remember.

DW: Yeah. And Paula was a sweet child, wasn't she? And everyone.....

KJ: She liked everybody and everybody liked her....

DW: Yeah. And on the 15th of April, 1985, were you at your home?

KJ: Yes sir.

DW: And was Mr. Irick there?

KJ: My husband brought him over there?

DW: About what time?

KJ: Well, they were there before I got there.

DW: And you were at your grandmother's and then come down?

KJ: Yes sir.

DW: And you laid down and went to sleep?

KJ: Yes sir.

DW: Because you work the night shift at Hagaman's?

KJ: Uh huh.

DW: And did any of the children lay down with you and go to sleep?

KJ: Yes sir they did.

DW: Which children?

KJ: Paul, Chuckie, and then I got up about 9 o'clock and uh, I got the baby, Jason, you know, and took him in and laid him down next to Paula and laid back down until I could get him to sleep.

DW: Okay, and where was your husband at?

KJ: He left, said he was going to pick Margaret, his sister, up or something at Krispy Kreme.

DW: Yeah. And where was Mr. Irick at?

KJ: He was outside, out back.

DW: Yeah. Was he going to babysit for you that night?

KJ: I didn't want him to. I asked my husband to.

DW: Yeah, but your husband wanted to go down to the truck stop? So, you went on to work at what time?

KJ: I left a few minutes before 10. I'm not sure exactly...

DW: And where was Paula at when you left?

KJ: She was in bed asleep, in the front bedroom, her brothers were in the other bed.

DW: What did Paula have on, when you left?

KJ: She had on her, she calls it her Valentine sweater, white with red hearts and everything on it....

DW: Yeah, and what else?

KJ: And a pair of blue jeans, had a leather patch - not a patch but a...tag... in the back....

DW: Yeah.

KJ: said "Smacks"(?)....

DW: Yeah, and what else?

KJ: A white pair of uh, like terry cloth underwear.

DW: Alright. And did you find these.....

KJ: Yes sir, I did.

DW: When?

KJ: When I left the hospital (?)....

DW: Last night or this morning....and where were they at?

KJ: At the foot of my bed....

DW: And your bed is where?

KJ: The living room is between the kids room and my bedroom.

DW: The room where that you left Paula at.....And so, you went to work at Hagaman's, and then the next time you saw your husband, where was that at?

KJ: He came in, I was getting ready to go to the phone. The girl I work with, Donna, was there with me. I was going to call and see if he was at the

KJ: other truck stop and tell him to go home, that Bill was drunk and talking crazy....

DW: Bill called you?

KJ: No, I went down early for a reason, to find Kenny and ask him to go home and stay with the kids. But he walked in the door of Hagaman's....

JA: Bill was drunk when you left home?

KJ: I had to find somebody to stay with the kids.

DW: Yeah, but Bill was intoxicated when you left?

KJ: He wasn't drunk drunk, but he was well on his way.

DW: Yeah. And so you told your husband when he come in - what did he tell you when he come in the truck stop?

KJ: He came in with a box of donuts from Krispy Kreme.

DW: Yeah.

KJ: And he started talking about Margaret (?), and I interrupted him, and I asked him to please go to the house and stay with the kids, that Bill was drinking and talking crazy.

DW: And what'd he say?

KJ: He shrugged it off, said "Aw, kids'll be alright."

JA: What time was that?

KJ: A few minutes after 10.

DW: And then when was the next time you saw your husband?

KJ: He came in, I guess it was, had already clocked in - well, he said he would go, and he said he had to, something to do and then he would go on to the house. And uh, I clocked in and I started work. At, a little before 11:30 I think, when he came in.

DW: And what did he say then?

KJ: He came in and said that Billy'd called him at TA, and that Paula was hurt bad.

DW: TA's Truck Stops of America , right?

KJ: Yeah.

DW: And did you give him anything?

KJ: I gave him a quarter for the pay phone.

DW: Yeah, and then what?

KJ: And he called back, I guess about 15 minutes later, 15-20 minutes later. Said he was already at Children's Hospital and to hurry up and get there.

DW: And then what did you do?

KJ: I left work.

DW: And where did you go?

KJ: Across the street and put gas in my car because it was on empty.

DW: Yeah...

KJ: And I turned the emergency flashers on and went straight to the hospital.

DW: Anything you need to add here, Mr. Ashburn?

KJ: I wouldn't have left, but I's sure he go back.

DW: Anything you need to add to this tape, Kathy?

JA: Have you ever had any feelings that maybe Bill might be abusing one of the kids?

KJ: No. He loved, he loved the kids. He took up for them, all of them. If anybody said anything to them, he was one of the first ones there .... He was one of the first ones there to defend them.

DW: Has Bill ever made any sexual advances towards any women that you know of?

KJ: Well, he's had some girlfriends, but....

DW: Well, I mean, do you know of him in any sexual affairs with any other girls?

KJ: Well, he had a girlfriend Tammy, you know, but that's.....

DW: Tammy?

KJ: She was a minor.

DW: Yeah. Where was she at?

KJ: She lived in Clinton. She's not there now, her....she's back with her father. It's not even in Tennessee, I'm not sure exactly where it's at.

DW: Yeah. Has....

KJ: Her aunt and uncle stopped that.

DW: Yeah. Did, you never saw any, any, Bill do anything, abuse or sexually or physically or mentally towards any of the children?

KJ: No. He'd holler at them sometimes, you know, but....

DW: Anything you'd want to add to this?

KJ: Not that I can think of right now.

DW: Anything you need to add? This concludes the interview with Kathy Ann Jeffers, 7-29-54 date of birth. The time is 2:20, the location of this interview was the Conference Room, Safety Building, the third floor./////

(Statement - Kathy Ann Jeffers)

Exhibit No. 5

Identified and made a part of the

record this 27th day of August, 2010.

Judge Richard R. Baumgartner

Bruce G. Seidner, Ph.D.

Clinical &Forensic Psychology
Family Mediation

865.584.0171
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The Northshore Group
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Knoxville, TN 37919-4054

Vita

Education:

Williamsville South High School Williamsville, NY	Graduated: June, 1972
Canisus College Buffalo, NY	Biology Major Sept., 1972 - June, 1974
Antioch College Yellow Springs, OH	BA in Psychology Sept., 1974 - June, 1977
Menninger School of Psychiatry Topeka, KS	Antioch/Menninger Intern Dec., 1977 - April, 1979
University of Tennessee Knoxville, TN	Clinical Psychology – APA approved Sept., 1979 - March, 1987

University Departmental Awards:

1979 - 1981 Graduate Assistantship in Clinical Psychology

Licensure:

1983 - 1987 Psychological Examiner's License - Clinical, State Licensing Board for the Healing Arts (Tennessee)

1987 to Present Licensed Clinical Psychologist - Clinical, State Licensing Board for the Healing Arts (Tennessee)
Tennessee License Number: P001196

1998 to 2003 Supreme Court of Tennessee Alternative Dispute Resolution Commission
Rule 31 Mediator in the field of Family Mediation
Certificate Number: 0534

Malpractice Insurance:

Kirke-Van Orsdel, Incorporated
1776 West Lakes Parkway
West Des Moines, IA 50398

STATE OF TENNESSEE VS. Billy Ray Irick
CASE NO. 24527 EXHIBIT NO. 6
DATE 8-17-10 ID ____ EVD ✓

Clinical Experience:

Camarillo State Hospital
Camarillo, CA.
January, 1975 - April, 1975
Title: Antioch Intern
Supervisor: S. Hart, Ph.D.

Dayton Free Clinic & Counseling Center
Dayton, Ohio
January, 1975 - December, 1976
Title: Staff Member
Supervisor: Bruce G. Steele, MA

The Menninger Foundation
Topeka, KS.

a. January, 1977 - June, 1977
Title: Antioch Intern
Supervisors:
Cecil B. Chamberline, M.D.
Rudy Serrano, MA
Stephen Lerner, Ph.D.

b. July, 1977 - April, 1979
Title: Child-Care Worker
Supervisors:
Cecil B. Chamberline, M.D.
Rudy Serrano, MA

University of Tennessee Psychological Clinic
Knoxville, TN
June, 1980 - September, 1980
Title: Clinical Psychology Trainee
Supervisors: Clinical Faculty

Daniel Arthur Rehabilitation Center
Oak Ridge, Tennessee
September, 1980 - June, 1981
Title: Clinical Psychology Trainee
Supervisor: R. Jeff Slavin, Ph.D.

Overlook Mental Health Center
Blount County Clinic
Maryville, TN

a. September, 1981 - June, 1982

Title: Clinical Psychology Trainee
Supervisors:
Robert E. Levey, Ph.D.
John B. Judd, Ph.D.

b. June, 1982 - April, 1983

Title: Clinical Associate
Supervisor:
Robert E. Levey, Ph.D.

Overlook Mental Health Center
The Maryville Family Guidance Clinic
Maryville, Tennessee
April, 1983 - May, 1984
Title: Psychological Examiner
Supervisor: Robert E. Levey, Ph.D.

Roane County School System
Kingston, TN

September, 1983 - May, 1984
Title: Psychological Examiner
Supervisor: David W. Stewart, Ph.D.
Nassau County Medical Center
East Meadow, New York
June 1984 - June 1985
Title: Clinical Psychological Intern
Supervisor: Aaron Balasney, Ph.D.

Cherokee Mental Health Center
Morristown, Tennessee
August, 1985 - February, 1987
Title: Psychological Examiner
Supervisor: Peter Watrous, Ph.D.

Peninsula Hospital
Louisville, TN
December, 1986 to October, 1989
Title: Clinical Psychologist
Supervisor: William B. Berez, Ph.D.

Child and Adult Clinical Associates
Knoxville, TN
October, 1989 to April, 1993
Title: Clinical Psychologist

The Northshore Group
Knoxville, TN
April, 1993 to Present
Title: Clinical Psychologist

Academic Experience:

University of Tennessee
Knoxville, TN
January, 1995 to Present
Title: Clinical Assistant Professor
University Studies and Graduate Program in Clinical Psychology

Professional Affiliations:

American Psychological Association – Member
American Psychology-Law Society – Member
American Psychological Association - Division of Psychoanalysis-Member
Tennessee Psychological Association – Member
Knoxville Area Psychological Association – Member
Society for Personality Assessment – Member
Appalachian Psychoanalytic Society - Past President
Association of Family and Conciliation Courts – Life Member
Tennessee Valley Mediation Association - Past President
Tennessee Supreme Court, Lawyer's Assistance Program Ram Team-Clinician Member

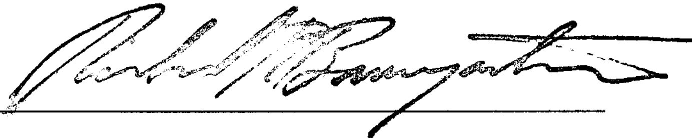
Curriculum Vitae Accurate as of 1/5/09

(CV - Dr. Seidner)

Exhibit No. 6

Identified and made a part of the

record this 27th day of August, 2010.



Judge Richard R. Baumgartner

STATE OF TENNESSEE VS. Billy Ray Irick
CASE NO. 24527 EXHIBIT NO. 7
DATE 8-17-10 ID ____ EVD ✓

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Competency Evaluation
State of Tennessee v. Billy Ray Irick
In the Criminal Court for Knox County, Tennessee, Division I

BACKGROUND

This evaluation is submitted in response to an Order signed by Judge R. Baumgartner on the 6th day of August 2010, in which I was appointed to evaluate the issue of Mr. Irick's competency to be executed.

History

Mr. Irick has been incarcerated since 1985 after being convicted for the first-degree murder and aggravated rape of a 7-year old female in the home where he was then residing. There is extensive documentation and objective evaluations that Mr. Irick has long suffered major psychiatric illness and substance dependence. From his first psychological evaluation in 1965 at age 7 and his subsequent hospitalization in Eastern State Psychiatric Hospital in 1966 and lasting 10 months, through his adolescence and young adulthood, there is no evidence that his illness abated and significant evidence that his use of drugs and alcohol served to exacerbate the impulsivity, poor judgment, and lack of conventional achievement that would evidence any change in his condition. From the current perspective of Mr. Irick himself, he was prone to feeling deep rage and would become reactive to frustrations in dealing with people and could become violent. He relates that he is capable of great loyalty and attachment but does better when he is relatively solitary and unfettered with obligations. He was reticent to discuss his psychiatric history in detail but described periods of time for which he has no memory, the predicates of which are intense affect states, alone or augmented with mood altering drugs. He denies a

history of hallucinations or psychosis that is discrepant from his documented evaluation history. Because the focus of our work was related to his current functional competence to be executed, and not a historical tracking and diagnostic differential evaluation, I did not press Mr. Irick for information he was clearly resistant to exploring in more detail unless it related to his thinking and affect relative to his execution.

Method

I met with Mr. Irick in the Knox County Detention Facility on 8/14/10 for 8 hours and on 8/15/10 for 4.5 hours in a well-lit comfortable and private room. Mr. Irick completed a WAIS-IV (Wechsler Adult Intelligence Test-IV) and an MMPI-2 (Minnesota Mutltiphasic Personality Test-2) in addition to our extensive discussions of my role in this litigation and issues directly related to his competence to be executed. Mr. Irick was entirely cooperative and demonstrated a detailed understanding of his situation. He had no hesitation consenting to the evaluation and evidenced appropriate mood and thinking throughout our time together. He summarized our work as follows, "You're here to find out what I think and sent by the DA or the Judge. They want to know enough about me to know if I am competent to be executed." He viewed this, however, as a formality because all of his legal efforts to be exonerated and found not guilty of this crime have failed. He is, nonetheless, "going to fight this to the end" which he believes will ultimately be his execution on December 7, 2010.

Mental Status

Mr. Irick was easy to engage, largely good humored, and decidedly kind throughout the interview. He described no animus toward the examiner who he viewed as "just doing his job." His only requirement was that I be objective and truthful about my findings. When he became resistant to further discussion at times relative to historical events or confronted with discrepant information he would close his eyes and stop talking. These were brief moments to regain composure and did not have any odd appearance as he appropriately excused himself. He described how he has learned as an adult to control his emotion by

either walking away or taking a deep breath. He acknowledges that he has not always had this capacity. He became briefly emotional when naming the victim, but here too, he paused and described what he characterized as his deep hurt and anger that anyone could imagine him harming someone that he cared for. In all other regards he demonstrated a full range of affect including appropriate frustration with some of the Wechsler tasks, outrage at the hypocrisy of specific individuals, curiosity, enjoyment of relating life anecdotes relative to entertaining events and the important relationships he has experienced in his life. He was entirely appropriate in his expression of anger, sarcasm, and cynicism. He was articulate, logical, and passionately critical of the corrections system, legislative dynamics, and the death penalty as practiced. He evidenced some difficulty remembering names and needed to correct some time lines but this was minimal and he related that his memory has declined at this point in his life. All narrative was coherent and there was no evidence of thought blocking, tangential thinking, or any other disorder of thinking or of affect. However, this did require, as noted, that he take brief and infrequent moments to re-group when emotionally aroused, but there was no failure to do so in the 12.5 hours of face to face time we shared. He denied feeling depressed or being subject to anxiety historically in our interview. Anger is the predominant affect that he has been troubled by. He describes periods of time where he "checks out" and for which he has no memory. These lost periods of time are not especially troubling to him, but they are significant relative to his mental health history. He admits to having sleep disturbance and night terrors at intervals but denies hallucinations and there was no indication of delusory thinking in general. He asserts that he is innocent of his charges and details "public facts" related to lost evidence in his matter and what he posits as political pressures that have deprived him of any further legal options at this time. While these "facts" can be argued, there is no delusory content or magical thinking that was apparent in the interview. He has led an alternative lifestyle of short-term employments, travel without definite destination, extreme substance dependence, and adoption of Native American spiritual perspectives. His hair is shoulder length and his long beard give him an unconventional appearance, but I could not find any functional defect in his current mental status or in his current medical or prison records.

Test Results

When considered globally, in terms of Composite Scores, the current IQ testing is entirely consistent with the testing performed in November 2009. Mr. Irick is currently functioning with an Average Full Scale IQ of SS 97(42nd Percentile).

Composite Score Summary

Scale	Sum of Scaled Scores	Composite Score	Percentile Rank	95% Confidence Interval	Qualitative Description
Verbal Comprehension	35	VCI 108	70	102-113	Average
Perceptual Reasoning	34	PRI 107	68	100-113	Average
Working Memory	14	WMI 83	13	77-91	Low Average
Processing Speed	13	PSI 81	10	75-91	Low Average
Full Scale	96	FSIQ 97	42	93-101	Average
General Ability	69	GAI 108	70	103-113	Average

This is an individual who clearly demonstrates significant cognitive strengths and weaknesses, but there is no obvious or systematic intellectual deficit which would question or, more importantly, impairs his functional capacity relative to his adjudicative competence or competence to be executed.

The MMPI-2 results demonstrate the clear and consistent intention of Mr. Irick to express the upset and struggle that he has experienced during his lifetime of objective psychiatric illness and substance dependence. The subsequent results of the clinical scales are open to a range of inferences but are not reliably interpretable because of the extreme responding on scales that express infrequent and pathological experience. Additionally, scales that reflect optimism, resilience, and personal virtue are spuriously low relative to even a psychiatric population. Taken together, these scales are described as the respondent's test taking orientation and are a check on the reliability and validity of the MMPI-2 clinical results. With an F Scale T Score of 120 and both the K Scale and the S Scale at a T Score of 30, I am hard pressed to make use of the subsequent results of this instrument.

Evaluation

Is the subject aware of the punishment he is about to receive and the reason he is to receive it?

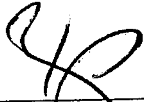
While Mr. Irick is currently stable and does not demonstrate any cognitive or affective defects that impair his functional abilities or competence, his history of conduct problems and mental illness is well documented. The stability and consistency of prison life has allowed him to develop control over the affect storms, dissociative experience, and psychiatric disorders that clearly drove the majority of his pre-incarceration living.

Mr. Irick describes himself as having been adopted into the Lakota Native American spiritual tradition before his incarceration. He appears knowledgeable of this tradition and respectfully described his sense of place and purpose relative to his life and circumstances as someone with this perspective. It is his view that everything has a purpose and reason relative to the plans and intentions of the Creator. During his incarceration he has developed himself as an artist who paints and is gratified by being able to create and share his paintings as gifts. He describes his life at this point, like all other lives, as constrained by circumstances. He describes his intention to strive to make the most of his circumstances until he is dead. It is his perspective that we are all born with a death sentence and we make the most of our lives within the constraints and opportunities that originated from the Creator. People who have the conceit that there is life after death bemuse him. It is his view that will become "worm food" after he is executed. Though, he admits to teasing those who hold the view of a heaven and hell, reminding them that they too will have to face judgment for their actions in life and for their actions toward him.

He is critical of the performance of his first appointed attorneys but reasons that due to the "high profile" nature of the crime, and his poor luck that it had political capital for those building early careers, it was the best he could do. He describes being very close to his attorneys of some 25 years and feels confident that they have worked closely with him in his subsequent appeals and his attempts to retry his matter in light of a number of what he alleges are failures of the legal system to protect his rights or have a fair trial. I clearly can have no opinion on the factual basis of whether evidence was lost or suppressed, but I can comment on his knowledge of the course of his litigation, the issues of what he views as inconsistent outcomes and penalties, his legal options over the years, and his sense that he has run out of options. He does not accept the legitimacy of his death penalty but states that he has no option but to accept it if he fails in his fight to overturn it. He argues that there is no deterrence effect that has ever been established for the death penalty and he is aghast at the inconsistency of its application. Why some death eligible crimes are punished with life without parole while others are punished with execution is, in his view, capricious and/or deliberate political machination. He asserts that executions have become a "circus" when they should be a private matter between the families of the victim and perpetrator who need a sense that this loss of life has been answered with a life in return. He respects that for some an execution represents the opportunity to deal with a loss and create a sense of closure. Mr. Irick does not oppose the death penalty itself and feels that "a life for a life" is justified. But he is very critical of how this is applied. He feels that the media and public have no standing to be present at an execution but that it might be important for the families of the victim if they chose to be present and to include the presence of the perpetrators family if it were acceptable to the victims family.

At this point in time Mr. Irick continues to resist his execution and expresses confidence that his lawyers are doing everything they can to protect and defend him. But, he describes being realistic and is contemplating his choice of death by lethal injection or electrocution. He appears knowledgeable of the objective facts related to both methods and has full knowledge that this will likely be his last major life

decision. He feels it is wrong but he fully appreciates, understands and accepts that he will likely be put to death on the 7h of December 2010.



Bruce G. Seidner, Ph.D.
Clinical Psychologist
License TN P001196

DOCUMENTS REVIEWED

Document	Date
1. Affidavit of Dr. William F. Blackerby	09/14/1999
2. Affidavit of Dr. Kenneth S. Nickerson	09/17/1999
3. Affidavit of Ramsey Jeffers	11/03/1999
4. Affidavit of Linda Jeffers	11/03/1999
5. Affidavit of Cathy Jeffers	11/03/1999
6. Affidavit of Kathy Jeffers	11/12/1999
7. Affidavit of Juanita Porter	09/12/1999
8. Interview, Kathy Jeffers by Detective Don Wiser	04/16/1985
9. Statement, Kenneth Darryl Jeffers to Detective Don Wiser	04/16/1985
10. Statement, James Lee Jeffers to Detective Don Wiser	04/16/1985
11. Handwritten Notes, Unknown Author	10/10/1986
12. Letter, U.S. Department of Justice to Randall S. Nichols with attachments	10/04/1999
13. Order, Irick v. Bell	02/29/2000
14. Petitioner's Second Motion to Expand Record	02/24/2000
15. Discharge Summary, Billy Ray Irick from unnamed hospital	03/23/1973
16. Order, Irick v. Bell	03/03/2000
17. Affidavit of Inez M. Prigmore	05/20/1999
18. Initial Classification Psychological Summary, Billy Ray Irick	12/12/1986
19. Affidavit of James H. Varner	03/15/2010
20. Affidavit of Kenneth A. Miller	03/08/2010
21. Affidavit of Douglas A. Trant	03/08/2010
22. Affidavit, Clifton R. Tennison, Jr. , M.D.	02/25/2010
23. Psychiatric Evaluation of Billy Ray Irick by Peter I. Brown, M.D., FRCPC	04/30/2010
24. Birth Certificate, Billy Ray Irick	08/25/1958
25. Untitled Psychiatric Report re: Billy Ray Irick by Dr. Robert J. Desnick, MA	03/03/1965
26. Intake of Billy Ray Irick by Nina Braswell, ACSW	03/31/1965
27. Report re: Billy Ray Irick by Kenneth B. Carpenter, M.D., Psychiatrist-Director	04/28/1965
28. Psychological Test Report re: Billy Ray Irick by John A. Edwards	05/19/1965
29. Second Intake Staff Note, author unnamed, re: Billy Ray Irick	06/17/1965
30. Letter to Paul Duncan from Nina Lunn, ACSW re: Billy Ray Irick	11/14/1966
31. Letter to Paul Duncan from Nina Lunn, ACSW re: Billy Ray Irick	03/07/1967
32. Report of Hospital School Teacher to Regular School Teacher re: Billy Ray Irick	06/02/1967
33. Letter to Dr. Kenneth Carpenter from Susan H. Tellerson & Mary B. Wilson re: Billy Ray Irick	09/01/1967
34. Letter to Admitting Officer of Eastern State Psychiatric Hospital from Kenneth B. Carpenter, M.D. re: Billy Ray Irick	10/24/1966
35. Letter to Bennie M. Fleming from Nina Lunn re. Billy Ray Irick	10/25/1966
36. Memorandum from Peggy A. Gilmore re: State of Tennessee Department of Mental Health Record of Billy Ray Irick	10/26/1967
37. Release for Medical Records of Billy Ray Irick by Kenneth A. Miller	08/16/1985
38. Release for Medical Records of Billy Ray Irick by Kenneth A. Miller	09/03/1985
39. Letter from Kenneth B. Carpenter, M.D. to Kenneth A. Miller re: Medical Records of Billy Ray Irick	09/16/1985
40. Eastern State Psychiatric Hospital Social Records of Billy Ray Irick	10/24/1966
41. Medical Record, Billy Ray Irick by Knoxville Orthopedic Clinic	08/05/1977
42. Indictment, Billy Ray Irick for Murder and Aggravated Rape	06/18/1985
43. Medical Records, Billy Ray Irick by The Helen Ross McNabb Center	05/08/1975
44. Transcript of the Evidence, State of Tennessee v. Irick	
45. Various Records re: Billy Ray Irick from the Church of God Home for Children	11/18/1985
46. United States Army Records, Billly Ray Irick	11/12/1975
47. Order, State of Tennessee v. Billy Ray Irick	04/01/1996
48. Presentence Report, Billy Ray Irick	11/26/1986

49. Competency Evaluation, Billy Ray Irick by Pamela Auble, Ph.D.	02/02/1989
50. Riverbend Maximum Security Prison Records, Billy Ray Irick	08/03/2010
51. Phone List, RMSI Warden's Office re: Billy Ray Irick	08/13/2010
52. Nueropsychological Consultation, Dr. Malcom Spica re: Billy Ray Irick	12/04/2009

(Report from Dr. Seidner)

Exhibit No. 7

Identified and made a part of the

record this 27th day of August, 2010.

Judge Richard R. Baumgartner

C E R T I F I C A T E

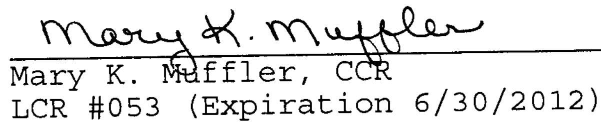
STATE OF TENNESSEE:

COUNTY OF KNOX:

I, Mary K. Muffler, Official Court Reporter for the Sixth Judicial District of the State of Tennessee and State of Tennessee Notary Public, do hereby certify that I reported in machine shorthand the above proceedings and that the foregoing pages constitute a true and accurate record of the proceedings had and evidence introduced in the captioned cause in the Criminal Court for Knox County, Tennessee, Division I, on the 16th and 17th days of August, 2010.

I further certify that I am not an attorney or counsel for any of the parties, nor a relative or employee of any attorney or counsel connected with the action, nor financially interested in the action.

Witness my hand and seal this 27th day of August, 2010.



Mary K. Muffler, CCR
LCR #053 (Expiration 6/30/2012)

My commission expires: July 8, 2014

CERTIFICATE OF THE COURT

This was all the evidence introduced and proceedings had relevant to questions raised on appeal of this cause which is signed, approved, and ordered to be made a part of the record by the Court.

August 27, 2010

Judge Richard R. Baumgartner