APPENDIX C TO STEPHEN WEST'S RESPONSE TO STATE'S MOTION TO SET EXECUTION DATE

REPORT OF PABLO STEWART , M.D. DATED 12/13/02

AFFIDAVIT OF PABLO STEWART, M.D.

I, Pablo Stewart, M.D., declare as follows:

1. I am a physician licensed to practice in California, with a specialty in clinical and forensic psychiatry. I have extensive clinical, research, and academic experience in the diagnosis, treatment, and prevention of substance abuse and related disorders, including the management of patients with dual diagnoses and the use of psychotropic medication and diagnostic, treatment, and community care programs for persons with Posttraumatic Stress Disorder. I have written and published numerous articles in peer review journals on topics that include dual diagnoses, psychopharmacology and the treatment of psychotic disorders and substance abuse. I have designed and taught courses on protocols for identifying and treating psychiatric patients with substance abuse histories and have supervised psychiatric residents in teaching hospitals. I have worked closely with local and state governmental bodies in designing and presenting educational programs about psychiatry, substance abuse, and preventative medicine.

2. I received my Bachelor of Science from the United States Naval Academy, Annapolis, Maryland, in 1973, with a major in chemistry. I received my Doctor of Medicine Degree from the University of California, San Francisco, School of Medicine in 1982.

3. I have served as Medical Director of the Comprehensive Homeless Center, Department of Veterans Affairs Medical Center in San Francisco where I had overall responsibility for the medical and psychiatric services at the Homeless Center; Chief of the Intensive Psychiatric Community Care Program, Department of Veterans Affairs Medical Center in San Francisco, a community based case management program that is social work managed; Chief of the Substance Abuse Inpatient Unit, Department of Veterans Affairs Medical Center in San Francisco, where I

had overall clinical and administrative responsibilities for the unit; and Psychiatrist, Substance Abuse Inpatient Unit, where I provided consultation to the Medical/Surgical Units regarding patients with substance abuse issues. I am currently the Chief of Psychiatric Services at Haight Ashbury Free Clinic, a position I have held since 1991. I served as a Physician Specialist to the Westside Crisis Center, San Francisco from 1984 to 1987 and the Mission Mental Health Crisis Center from 1983 to 1984.

4. In addition to my clinical and teaching responsibilities, I have experience in forensic psychiatry. From 1988 to 1989, I was Director, Forensic Psychiatric Services for the City and County of San Francisco where I had administrative and clinical responsibilities for psychiatric services provided to the inmate population of San Francisco. My duties included direct clinical and administrative responsibility for the Jail Psychiatric Services and the Forensic Unit at San Francisco General Hospital. From 1986 to 1990, I was Senior Attending Psychiatrist, Forensic Unit, University of California, San Francisco General Hospital, where I was responsible for a 12-bed maximum-security psychiatric ward. One of my duties was advising the San Francisco City Attorney on issues pertaining to forensic psychiatry.

5. I am also serving as medical and psychiatric consultant to the monitors of the agreement between the United States and Georgia to improve the quality of juvenile justice facilities, critical mental health, medical and educational services, and treatment programs. The monitor is the Institute of Crime, Justice and Corrections at George Washington University. I have qualified and testified as a Psychiatric Expert witness in federal court cases regarding the implementation of constitutionally mandated psychiatric care to California's inmate population at different maximum security and psychiatric care facilities. I serve as a Technical Assistance

Consultant to the Center for Substance Abuse Treatment, Substance Abuse and Mental Health Services Administration, Department of Health and Human Services; and Psychiatric Consultant to the San Francisco Drug Court.

6. In 1985, I received the Mead-Johnson American Psychiatric Association Fellowship for demonstrated commitment to public sector psychiatry and was selected as the Outstanding Psychiatric Resident by the graduating class of the University of California, San Francisco, School of Medicine. In 1985 - 1986, I was the Chief Resident, Department of Psychiatry, University of California San Francisco General Hospital and had direct clinical supervision of seven psychiatric residents and three to six medical students.

7. I have served as an Examiner for the American Board of Psychiatry and Neurology and am a Diplomate of the same Board. I am active in several professional associations and have served as the President, Secretary-Treasurer and Councilor-at-large of the Alumni-Faculty Association, University of California, San Francisco, School of Medicine; Vice President of the Northern California Area, Alumni-Faculty Association, University of California, San Francisco; and Associate Clinical Member of the American Group Psychotherapy Association.

8. I have held academic appointments as Associate Clinical Professor, Assistant Clinical Professor, and Clinical Instructor in the Department of Psychiatry, University of California, San Francisco, School of Medicine, since 1989. I received the Henry J. Kaiser Award for Excellence in Teaching in 1987 and was selected by the graduating class of the University of California, San Francisco, School of Medicine as one of the top ten faculty members for the academic year 1994 - 1995, 1990 - 1992, and 1988 - 1989. I designed, planned and taught "Drug Alcohol Abuse" and "Alcoholism," one unit courses covering major aspects of drug and alcohol abuse;

supervised fourth year medical students in the care of dual diagnostic patients at the Psychiatric Continuity Clinic, Haight Ashbury Free Clinic; facilitated a weekly psychiatric intern seminar on "Psychiatric Aspects of Medicine;" and lectured on addictionology and substance abuse to the School of Pharmacy, UCSF.

Referral Questions

9. At the request of counsel for Stephen West[1], I conducted a psychiatric assessment of Mr. West to determine what factors contributed to his actions surrounding the offenses for which he has been sentenced to death, the presence and effect of any mental disease from which he may suffer, and the role of alcohol and substance abuse in his and his family's life.

Materials Reviewed

10. In order to answer the questions asked of me, I conducted a clinical interview of Mr. West and reviewed extensive material relating to the legal proceedings against him and his social and medical history, including birth records, academic records, military records, affidavits and testimony of family members, prison medical and psychiatric records, Stephen's statements to law enforcement and testimony, his codefendant's statements to law enforcement, and excerpts of legal proceedings. I also reviewed the exhaustive reports of Richard Dudley, M.D., and Claudia R. Coleman, Ph.D., and consulted with them by telephone conference. These are the kinds of materials routinely relied upon by members of my profession in providing expert opinions.

Social and Medical History

[1] In the interest of clarity, Mr. West and his family members will be referred to by their first names.

11. Mr. West was born September 16, 1962, while his mother was a patient in a psychiatric hospital in Anderson, Indiana. Stephen was the youngest of five children born to Wanda West, a mentally ill woman who was ill equipped to parent any of her children. The child's grandmother reared her first child, Debra, born when Wanda was only a teenager. Wanda's second child died in infancy, apparently from complications of hemolytic disease, which developed when Wanda's Rh-negative blood was incompatible with the infant's Rh-positive blood. Wanda and her husband, Vestor West, reared her last three children (Patty, Teddy, and Stephen) as a family, although Vestor denied paternity of Stephen. Stephen's biological father, according to family reports, was Vestor's brother, Vaughn. By all accounts Vestor shared Wanda's limited abilities to parent. An alcoholic who could not read or write, Vestor worked in menial jobs. Wanda worked occasionally as a house cleaner in a hotel. The family was impoverished and lived in public housing.

12. Stephen's family has a significant history of major mental illness that significantly interfered with the family's functioning and derailed Stephen's developmental trajectory. His mother, Wanda demonstrated psychotic symptoms that included auditory hallucinations, delusions, and paranoia. She believed that others plotted against her and talked about her and that a little man in her head spoke to her. When she was pregnant with Stephen, she attempted suicide by gas inhalation. Her symptoms were severe enough that she required psychiatric hospitalization and treatment with medication and electroconvulsive therapy (ECT). Stephen's older sister, his niece, and two of his maternal aunts have Bipolar Disorder, a major psychiatric disease recognized to have a strong genetic component. His biological daughter is taking medication for Attention Deficit Hyperactivity Disorder (ADHD).

13. Stephen survived prolonged, life threatening maltreatment at the hands of his mother and her husband. The abuse began in early childhood and continued until Stephen left home to join the military in an attempt to find safety from the relentless abuse he survived. His mother and stepfather physically assaulted Stephen without provocation or fear of reprisals. They beat, kicked, punched, and threw him, causing injuries that left him deformed and disabled. His mother beat him with belts, shoes and her hands, often pinching him until he bled. She grabbed him by his feet and slung him into a wall. During one episode of being slung into a wall Stephen was knocked "cross eyed. Stephen had multiple surgeries to correct his vision. At another point, she broke Stephen's ankles. The physical assaults caused bruising, bleeding, and scarring. Stephen's alcoholic stepfather, described as having a temper and being unpredictable as well as retarded, regularly beat Stephen and his siblings. Stephen's stepfather hit him with a belt, the buckle of the belt, a cord, sticks, a broom handle and his fists on all part of his body.

14. Extreme acts of cruelty accompanied the constant battering Stephen survived. The acts of cruelty formed an effective strategy of coercive control by both parents that included public humiliation, degradation, threats to maim, control over basic bodily functions, captivity, and isolation. In an act of humiliation and degradation, Wanda forced Stephen to sit outside on the porch clad only in his underwear while the neighborhood children ridiculed him. .Wanda exiled Stephen as a child to an unheated, cold room where he had to sleep on a urine soaked mattress. She withheld food from him as a form of punishment. Wanda singled Stephen out for the harshest punishment while favoring her other son, Teddy, whom she did not physically abuse. Wanda offered words of encouragement for Stephen's siblings, but withheld support for

Stephen. His stepfather cursed Stephen, calling him a bastard because Stephen's biological father was the stepfather's brother.

15. Stephen developed a characteristic set of responses to surviving chronic and severe abuse. He became so fearful of his mother that he tensed when she came near him. An aunt described him as "shivering up" when she approached him. If his mother raised her arm toward him in any manner, he became immobilized and cried. Stephen became a fearful, timid, shy child who did not act out. He was passive and not aggressive, accepting the blows without fighting back. Stephen was undernourished as a child. His sister Patricia Depew, described a picture of neglect and abuse:

> I always picture Steve with long, blond, curly hair, never combed, a diaper dragging down to his knees, always needing changed, bruises, very, very, very thin. You could always see his ribs; all of his bones always. . . .[M]ost of the time he was crying.

His academic records show that, like other abused children, his responses to chronic danger at the hands of his caretakers interfered with his academic performance. He began drinking alcohol and smoking marijuana in junior high school in an effort to quell the overwhelming emotions he experienced. Although he was promoted from one grade to the next, his academic marks fell far below his potential. He withdrew from school in the eleventh grade and joined the army, where he served three years before being discharged under honorable conditions in 1982.

16. Stephen developed clear symptoms of psychiatric disease as he matured that prevented him from functioning in the community in the manner he desired. After discharge from the military, Stephen moved to Cleveland, Ohio, where he spent several years growing up, and

worked on maintenance crews and in construction. It was in Ohio where he met and married his wife Karen, with whom he has three daughters: Krystal Marie, Stephanie Michelle and Tiffany Kay. He deeply wanted his marriage to be successful and wanted to meet his responsibilities as a father. In an effort to be a responsible husband and father, he reduced his drinking greatly, but he continued to experience symptoms of anxiety and depression that interfered with his ability to maintain employment. He and Karen returned to Tennessee and he took a job at McDonald's in Lake City, Tennessee, where he met his codefendant.

17. Prior psychiatric evaluations and psychological assessments provide a uniform picture of the distressing symptoms that affected Stephen over the course of his life. He experienced social anxiety, chronic apprehension, restlessness, sleep disturbance, fatigue, and poor concentration. He showed signs of obvious physical agitation and felt "wired up" all the time. He moved and fidgeted constantly. He walked for miles to "burn some of that energy off" so he could sleep. He described forgetfulness, racing thoughts, blackouts, dizziness, blurred vision, and insomnia. He demonstrated sudden autonomic changes commonly seen in survivors of life threatening trauma, including increased pulse rate, tremors and shaking, and sweating. He reported losing his vision, having spots in his vision, and episodes of syncope as often as three or four times a week. He self medicated by using marijuana and drinking alcohol. His symptoms and the course of his illness are consistent with Posttraumatic Stress Disorder as a result of childhood abuse and exposure to the murder for which he has been convicted, Polysubstance Abuse/Dependence (alcohol and marijuana), Attention Deficit Hyperactivity Disorder, and Mood Disorder with Psychotic Features (resolved).

Clinical Interview

18. I interviewed Stephen West on August 26, 2002, at the Riverbend Maximum Security Institute, where he is a death-sentenced prisoner. Stephen is a Caucasian male who appears his stated age. He was somewhat tense and mildly anxious but was cooperative throughout the interview. He is euthymic. He was alert and oriented. He described past episodes of severe depression with psychotic features of hearing whispers.

19. At the time of the interview with me, Stephen was medicated with Effexor 75 mg BID, an antidepressant; Haldol, an antipsychotic; and trazodone, an antidepressant. Psychiatric staff at the prison started Stephen on these medications for chronic depression characterized by anhedonia, mood lability, and sadness. Paxil and Elavil were not effective for Stephen's condition. Paxil made him very drowsy and he slept too much. Paxil had similar effects on Stephen's intense anxiety as marijuana and drinking, but was even stronger. Paxil addressed Stephen's symptoms of anxiety but his depression was not responsive. Elavil did not have any positive effects but caused him difficulty urinating. Stephen reported that the medications are effective and that he feels the "best I've felt in my life. I feel like a human." It is unclear what the exact effects of his medication regimen are because Haldol was begun at the time same time he started Effexor. Of note, the Effexor dealt with symptoms of depression but Stephen remained anxious (i.e., foot twitching, racing thoughts, tapping his feet). It was due to these symptoms that Trazodone 100 mg was started. After the trazodone was started, all of these symptoms subsided. Haldol was begun while he was still depressed and the Paxil and Elavil were not addressing these symptoms. Stephen admitted to hearing whispers while he was severely depressed. The Haldol did address this symptom. Of note, he had ADHD-like symptoms for a while after starting Effexor and Haldol.

20. Since being medicated, Stephen was able to recognize that he has suffered a life-long depressive syndrome. His "style" of depression was the "withdrawn" variety. This is consistent with prior mental health evaluations and lay witness reports describing him as passive and complacent. Due to his depression being treated effectively, he was able to be friendly and enjoy activities with others. He was relieved to be getting along with people. He felt that the custody staff would report how well he has been doing since he began receiving proper medication. He described himself at the time of the interview as being happy.

21. Stephen had significant memory impairments, most likely associated with the acute trauma he experienced during his formative years. His recall memory began when he was 17 or 18 years of age and corresponded to his joining the U.S. Army where he was stationed in the U.S. and in West Germany as a combat engineer. He has a few non-specific memories before the age of 13. He has no direct memories of the well-documented abuse inflicted upon him and appears to be sincere in this denial. He does not have much of a memory for events since age 17. He described his memory as being "fragmented." For example, he could not recall the previous mental health expert who evaluated him. The relative immediacy of the offense made it easier for him to access traumatic memories of the offense at the time he was questioned by law enforcement and testified. This coupled with his being under the extremely stressful situation of police interrogation increased his vulnerability to reexperiencing the actual trauma and relating its details. This unfortunate situation was also recreated in the courtroom where he appeared detached and cold in telling the details of the crime, when in fact, he was displaying classic symptoms of posttraumatic stress disorder.

22. Stephen is unclear about the exact onset of his drinking, but believes it began when he was young and in junior high school. He consumed up to a case of beer and a pint of liquor or more daily. By the time he was 17, he drank daily until he passed out each night. When he awakened, he was unable to remember how he got home. He described his teen years as ones spent in an alcohol-drug induced stupor. He continued drinking until a few weeks before the offense, secondary to his wife's pregnancy. In an effort to prepare for parenting and to keep his marriage intact, Steve had greatly reduced his drinking. As he reduced his drinking, he confirmed the fact of increased ADHD-like symptoms as his drinking decreased.

23. Stephen began using marijuana at the same time he began drinking in junior high school. Marijuana "calmed him down." He smoked up to 20 marijuana cigarettes a day. He smoked hashish while in the military. By the time of his arrest, his drinking and use of marijuana had substantially decreased to a few beers now and then and an occasional marijuana cigarette.

Mental Status at the Time of the Offense

24. Stephen reported that on the day of the offense he and his codefendant left work and purchased two six packs of beer and stopped at his house for three more beers. Stephen and the codefendant drove around drinking until early morning hours. By the time they arrived at the house where the offenses occurred, Stephen was drowsy and drunk. According to Stephen, his codefendant did not make known his plans to harm the two women in the house until after they entered the house. Instead, the codefendant told Stephen he wanted to go into the house to borrow money from one of the occupants who was a friend of his. After they entered the house, the codefendant revealed he was armed with a gun and knives, sexually assaulted both women, and forced Stephen to participate in sexual acts with one of the women. Stephen was passive

throughout the offenses and followed orders to move from one room to the next or to have one of the victims perform sexual acts on him. Stephen, however, refused to participate in stabbing either victim, both of whom were stabbed to death by the codefendant. The codefendant threatened to have Stephen's family killed if Stephen went to the police. At the time of the offenses, Stephen believed he was helpless to take any action against his codefendant and was overwhelmed and frozen by the sheer terror at his codefendant's actions. He did not plan or intend for his codefendant to harm anyone and he was repulsed and horrified by the codefendant's actions.

Conclusions

25. A constellation of psychiatric symptoms and disorders affected Stephen West's behavior at the time of the offenses. The kind of prolonged abuse that Stephen survived constitutes extreme duress and breaks the bonds that children need to develop into healthy adults. It caused Stephen to relinquish his autonomy, moral principles and relationships with others for the sake of his survival. He developed an insidious progressive form of posttraumatic stress disorder that controlled and constricted his entire life. Stephen, like other chronically traumatized people, became hypervigilant and lived in a state of constant arousal, acutely tuned to following the coercive demands of others in positions of perceived power. His severe memory loss is avoidance of memories of abuse and inability to tolerate re-experiencing acts of abuse that he survived. He displays classic physiological responses to abuse such as increased heart and pulse rate, trembling, sweating, and dizziness. This disorder is long-standing and chronic.

26. The long term consequence of surviving terror at the hands of his father and mother resulted in numerous alterations in Stephen's behavior and functioning that are recognized in psychiatry as the sequellae to trauma, but he also has been plagued with other major mental disorders, including Major Depressive Disorder with Psychotic Features, Attention Deficit Hyperactivity Disorder, and Polysubstance Abuse/Dependence. He has experienced persistent depression and chronic anxiety, auditory hallucinations, sleeplessness, hopelessness, and agitation. As a child and young adult, he ingested copious amounts of alcohol to suppress the terror and anxiety associated with the abuse. Prolonged ingestion of alcoholism, especially during critical developmental periods, can result in deleterious changes to brain structure and function, as well as other body organs. Brain changes associated with alcoholism include lower white-matter volume, enlarged ventricles and sulci, and lower brain weight. It can also cause abnormalities in brain function including lowered brain metabolism, impaired memory and other cognitive deficits.

27. It is my professional opinion, which I hold to a reasonable degree of medical certainty, that Stephen West was under unusual and substantial duress when he participated in the events that led to the deaths of Wanda and Sheila Romines. His capacity to conform his conduct to the requirements of the law at the time of his offense and to appreciate the wrongfulness of his conduct was substantially impaired. The extreme duress he experienced is the direct result of the psychiatric disease from which he suffers. Stephen had a present, imminent and pending fear of death or serious bodily harm at the hands of his co defendant and a reasonable belief that he could not escape his codefendant's control. The codefendant was described as a bizarre, belligerent, and dominant person, while Stephen was uniformly described as passive and

submissive. Stephen's history of subjection to totalitarian control, combined with the codefendant's threats to kill Stephen's family, deprived him of the sense of autonomy that allows independent action and the ability to choose a course of action . The events of the crime shattered Stephen's already fragile mental state to the point that he responded to the violent and threatening situation with complete submission and dissociation resulting in loss of contact with reality. At the time of the killings, Stephen responded to his codefendant's commands without plan, thought, or recognition of the consequences of his actions. He harbored no intent to kill or malice for the victims, and his actions were taken without premeditation or understanding, knowledge about the difference between right and wrong, or awareness of the risks to others of his behavior.

28. I have been asked to offer my opinion about Stephen's intoxication at the time of the offense. Stephen was intoxicated at the time of the offense, secondary to the chronic symptoms of posttraumatic stress disorder, depression, and ADHD he experienced. Because Stephen had greatly decreased his alcoholic intake for months prior to the evening of the offense, he was especially susceptible to the effects of alcohol and its exacerbating effects on Stephen's underlying mental impairments. Alcohol causes impaired judgment, reasoning, and insight. In sufficient quantities, such as the amount Stephen consumed over a relatively short period of time, it causes mental confusion and altered states of consciousness. It is my professional opinion, which I hold to a reasonable degree of medical certainty, that Stephen's intoxication at the time of the offense exacerbated Stephen's underlying mental impairments and further eroded his ability to understand and conform his conduct to that required by the law.

I declare under penalty of perjury under the laws of the State of California and the United States that the foregoing is true and correct. Executed on December 13, 2002.

PABLO STEWART, M.D.