

STATE OF SOUTH CAROLINA

IN THE SUPREME COURT

Appeal from Lexington County

Honorable Robert E. Hood, Circuit Court Judge

Appellate Case Number: 2025-001760

RECEIVED

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S.C. SUPREME COURT

GARY DUBOSE TERRY, #5053,

PETITIONER,

V.

STATE OF SOUTH CAROLINA,

RESPONDENT.

PETITION FOR A WRIT OF CERTIORARI

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QUESTIONS PRESENTED

I.

Whether the PCR court erred in finding that Applicant is not a person with intellectual disability by relying on DDSN evaluators whose opinions deviated from accepted clinical standards, despite evidence presented at the PCR hearing of IQ scores in the intellectual disability range and adaptive deficits manifesting during the developmental period.

II.

Whether the PCR court failed in its duty to “make specific findings of fact, and state expressly its conclusions of law, relating to each issue presented,” S.C. Code § 17-27-80, by signing verbatim an order drafted by the State.

III.

Whether the PCR court erred in denying Applicant’s motion to reconstruct the record where extensive portions of the PCR hearing were recorded as “indiscernible,” including substantive expert testimony and portions of the PCR court’s ruling on the qualifications of an expert whom the court later found to be incredible, and where the hearing transcript was not sufficient to allow the PCR court to fully consider the issues raised or this Court to meaningfully evaluate the PCR court’s conclusions.

STATEMENT OF THE CASE

Petitioner, Gary Dubose Terry, was convicted and sentenced to death in 1997. This Court affirmed his convictions and sentence on direct appeal. *State v. Terry*, 339 S.C. 352, 529 S.E.2d 274 (2000), *cert. denied*, 531 U.S. 882 (2000). Terry subsequently sought post-conviction relief (“PCR”) which was denied by the PCR court in 2009, and this Court affirmed. *Terry v. State*, 394 S.C. 62, 714 S.E.2d 326 (2011). Certiorari was denied by the United States Supreme Court. *Terry v. South Carolina*, 565 U.S. 1206 (2012). Neither trial counsel nor initial PCR counsel investigated or raised an intellectual disability claim under *Atkins v. Virginia*, 536 U.S. 304 (2002).

In federal habeas proceedings, newly appointed counsel identified the unraised *Atkins* claim after discovering evidence that Terry was likely a person with intellectual disability. On March 21, 2022, after federal courts denied habeas relief, Terry filed a successive PCR application raising a single ground: that he has intellectual disability and is therefore categorically ineligible for the death penalty under *Atkins* and *Franklin v. Maynard*, 356 S.C. 276, 588 S.E.2d 604 (2003). An evidentiary hearing was held before the Honorable Robert E. Hood on July 17–18, 2024, in a digital courtroom without a live court reporter, relying on a recording system that experienced technical difficulties immediately.¹ App. 5–7, 461.

Terry presented evidence on all three statutory criteria for intellectual disability. *See* S.C. Code § 16-3-20(c)(b)(10) (requiring (1) significantly subaverage intellectual functioning; (2) deficits in adaptive functioning; and (3) onset during the developmental period). Dr. Greenspan, an expert in psychology specializing in diagnosing intellectual disability, appeared remotely via

¹ The first portion of hearing took place with one of the microphones producing feedback described as “blown out,” and another set at a very low volume. App. 461. Neither Terry’s counsel, Respondent’s counsel, nor the PCR court were aware of the microphone issues and problems with recording in-person testimony at the time of the hearing.

Webex² and testified regarding his evaluation of Terry, explaining that his review of Terry’s educational and medical records, history of traumatic brain injuries, expert reports, interviews with Terry and his ex-wife, Louanne, employment history, and IQ testing revealed numerous indicators of abnormal cognitive functioning, App. 163, including adult IQ scores of 77, App. 76. Dr. Greenspan opined that Terry is a person with intellectual disability, App. 84, 369, explaining that the two childhood IQ scores of 92 were the only evidence of normal cognitive functioning, App. 163, and that Terry’s progression from a learning disability—assuming that diagnosis was accurate—to intellectual disability resulted from traumatic brain injuries sustained after those tests but still within the developmental period, App. 184–85. Dr. Scott Decker, an expert in neuropsychology and IQ testing, testified that he administered the Woodcock-Johnson IV to Terry, who scored 74, also within the range of intellectual disability. App. 214, 400.

The State offered the testimony of Drs. Alicia Hall and Jessica Davis, both psychologists with the South Carolina Department of Disabilities and Special Needs. Dr. Hall testified about her evaluation of Terry and opined that he was not a person with intellectual disability. App. 274, 433. Dr. Davis testified that she administered the WAIS-IV to Terry, with Dr. Hall observing during the testing. App. 233. The PCR court accepted post-hearing briefs from both parties. App. 349–50, 864–924.

On November 14, 2025, counsel received the hearing transcript from stenographer Bobbi Fisher, who transcribed the recording obtained by the CRP system. App. 461. Ms. Fisher reported “several technical issues” that “made hearing the audio quite a challenge”, resulting “in numerous

² A week before the evidentiary hearing, counsel for Terry notified the State and the court that Dr. Greenspan would need to appear remotely via Webex. App. 857. At the hearing, the Webex connection “cut in and out and/or was hard to understand at times,” App. 841, and participants reported difficulty hearing portions of his testimony, App. 96, 126.

indiscernible marks throughout the transcript.” App. 461. Despite efforts to fill gaps in Dr. Greenspan’s testimony using the Webex recording, 201 indiscernible notations remained in 354 pages, including missing testimony, arguments, and court rulings. App. 461, 826–37. On January 15, 2025, Terry submitted a formal transcript challenge, proposing corrections where possible. App. 826–37. Ms. Fisher made her best efforts to address the gaps, providing a partially corrected transcript and a spreadsheet reflecting the corrections, but 163 “indiscernible” notations remained. App. 840–42, 845–53.

Terry filed a Motion to Reconstruct the Record on February 18, 2025, which the PCR court denied on March 20, 2025, finding that the gaps in the transcript do not affect “any pivotal testimony” and could be “easily discerned from the context.” App. 1040. The PCR court set deadlines for post-hearing briefs and proposed orders. Terry filed his post-hearing brief on April 7, 2025; Respondent filed a brief on April 18, 2025; and Terry replied on May 2, 2025. Both parties submitted proposed orders on June 2, 2025. The PCR court signed the State’s proposed order denying relief, App. 925–56, on June 27, 2025. App. 957–88. This appeal follows.

ARGUMENT

REASONS THE WRIT SHOULD BE GRANTED

I. The PCR Court Erred in Finding that Applicant is Not a Person with Intellectual Disability.

a. Legal and Clinical Standards for Intellectual Disability

Individuals with intellectual disability are categorically ineligible for the death penalty. *Atkins v. Virginia*, 536 U.S. 304 (2002); *Franklin v. Maynard*, 356 S.C. 276, 588 S.E.2d 604 (2003). This categorical exemption recognizes that, as a class, persons with intellectual disability are less morally culpable and therefore less deserving of the death penalty. The United States Supreme Court held in *Atkins*, and has reaffirmed in a series of decisions since creating the categorical bar

in 2002, that executing individuals with intellectual disability “contravenes the Eighth Amendment, for to impose the harshest of punishments on [these defendants] violates his or her inherent dignity as a human being” because people with intellectual disability are less able to make “calculated judgments,” to “control impulses,” and “to abstract from mistakes and learn from experience.” *Atkins*, 536 U.S. at 316–20; *Hall v. Florida*, 572 U.S. 701, 708–09 (2014). While states retain “the task of developing appropriate ways to enforce the restriction on executing the intellectually disabled,” that discretion is “not unfettered” and “must be informed by the medical community’s diagnostic framework.” *Moore v. Texas*, 581 U.S. 1, 12–13 (2017) (quoting *Hall*, 572 U.S. at 719). When assessing intellectual disability, states and courts cannot disregard current medical standards in favor of outdated clinical standards or lay stereotypes. *Id.* at 13, 18–20; App. 72–74 (stereotypes about intellectual disability frequently result in mistakes in diagnosis), 180–82 (noting common stereotypes of people with intellectual disability).

South Carolina has defined intellectual disability as “significantly subaverage general intellectual functioning existing concurrently with deficits in adaptive behavior and manifested during the developmental period.” S.C. Code Ann. § 16-3-20(c)(b)(10) (2018). This definition comports with the medical community’s generally accepted definition of intellectual disability, which identifies three required diagnostic criteria: (1) significantly subaverage intellectual functioning; (2) deficits in adaptive functioning; and (3) onset of these deficits during the developmental period.³ *Hall*, 572 U.S. at 710; *Atkins*, 536 U.S. at 308, n. 3; *Moore*, 581 U.S. at 1;

³ Dr. Stephen Greenspan testified at the PCR hearing about the definition of intellectual disability and the clinical standard for assessing intellectual disability. Dr. Greenspan is a psychologist, with a PhD in psychology with an emphasis on developmental psychology and developmental disabilities. App. 12, 355. Dr. Greenspan is a lifetime fellow of the American Association of Intellectual and Developmental Disabilities, App. 355, a former president of the Academy on Mental Retardation, *id.*, and the most cited authority on intellectual disability in the DSM-5, the DSM-5-TR, and the 11th edition of the AAIDD manual. App. 14, 17. This Court qualified Dr.

State v. Blackwell, 420 S.C. 127, 139 801 S.E.2d 713 (2017); *Franklin v. Maynard*, 356 S.C. 276, 588 S.E.2d 604 (2003); Am. Psychiatric Ass’n, Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition Text Revision 38 (2022) [“DSM-5-TR”]; Am. Ass’n on Intellectual & Developmental Disabilities, *Intellectual Disability: Definition, Diagnosis, Classification, and Systems of Supports*, 1, 13 (12th ed. 2021) (“AAIDD-12”). Intellectual disability must be proven by a preponderance of the evidence at a hearing. *Franklin*, 356 S.C. at 279, 588 S.E.2d at 606 (citations omitted). A preponderance means “‘proof which leads the [trier of fact] to find that the existence of the contested fact is more probable than its nonexistence.’” *State v. Grooms*, 343 S.C. 248, 254 n. 5, 540 S.E.2d 99, 102 n.5 (2000) (quoting 2 McCormick on Evidence § 339, 5th ed. 1999 (alteration in original)).

b. Terry’s Background

Terry exhibited impaired intellectual and adaptive functioning beginning in early childhood. App. 373–75. His cognitive deficits were evident early on from his consistent and “dramatic school failure.” App. 106. Terry was repeatedly assessed for and placed in special education and “noted by his teachers for his slowness and inability to learn.” App. 376. Terry struggled throughout his school years, repeated the fifth grade, and remained in special education from fifth through ninth grade, when he dropped out. App. 100, 424. On standardized testing, Terry was “very impaired across the board intellectually or academically.” App. 100; *see also* App. 373. For example, Terry’s performance on the McGraw-Hill Comprehensive Test of Basic Skills

Greenspan as an expert in psychology with a specialization in diagnosing intellectual disability. App. 19, 47.

Terry also offered testimony from Dr. Scott Decker, a neuropsychologist with a PhD in school psychology and neuropsychology, App. 379, and the State offered testimony from Drs. Alicia Hall and Jessica Davis, both psychologists with DDSN.

(CTBS), which he was administered in grades two through five, was “consistently below grade in all of his subjects.” App. 423. Consequently, Terry repeated the fifth grade and was enrolled in special education classes. App. 100, 157, 423. When Terry’s school attempted to return him to general education classes, “Mr. Terry’s transition to the general education setting was unsuccessful” so he remained in the special education program. App. 424. Terry’s learning difficulties extended beyond the classroom. As Dr. Hall noted, he was frequently singled out for abuse by his father “more than his brothers because it took him longer to catch on when his father was teaching him to do something.”⁴ App. 423; *see also* App. 323.

Terry also exhibited impaired adaptive functioning from an early age, persisting into adulthood, which was illustrated by his “incredibly bad judgment in all areas of his life in the social domain.” App. 107. Specifically, Terry demonstrated gullibility and social vulnerability, two hallmarks of deficits in the social domain, as both a child and an adult. App. 108, 151. Terry’s mother, Patsy, recalled that Terry was overly influenced by friends and got into trouble as a result. App. 108–09, 330, 375. Dr. Hall noted that, according to Patsy, Terry’s childhood friends often scapegoated him and he did not recognize when others were using him. App. 330–31. Terry was also socially isolated as a child and as an adult: Terry’s mother noted that he did not have many friends in his youth, App. 120; Terry’s fifth-grade teacher, in referring Terry for evaluation, noted that Terry was “withdrawn from the rest of the class,” App. 424; and Terry’s ex-wife, Louanne, reported that he “had few genuine friends,” App. 432.

Terry was rated in school on the Vineland Social Maturity Scale, a measure of adaptive deficits, when he was 11 years old and in the 5th grade. App. 111–12, 375. Terry was scored in the

⁴ As Dr. Hall noted, Terry has a history of severe and extensive childhood abuse by his father and siblings, which, according to the AAIDD, is a risk factor for intellectual disability. App. 320; AAIDD-11 at 66.

ID range as functioning about three grades below his age, indicating severely impaired adaptive functioning. App. 111–12, 375. As Terry’s teachers began to recognize his deficits, Terry was referred for further testing: He was twice administered the WISC-R in childhood, at age 11 and age 14, and despite his adaptive deficits and poor school performance, Terry received an IQ score of 92 on both tests.⁵ App. 104, 205, 427. However, after that testing, Terry suffered several neurological injuries prior to age 22 that exacerbated his cognitive and adaptive deficits, including regularly sniffing glue as a child and adolescent, a head injury from a fall from a tree at age 17, and a motorcycle accident at age 19, all of which likely caused brain damage. App. 144, 157, 169–70, 185, 209.

As a result of these neurological injuries, Terry—who was already “anything but normal” during childhood, App. 376—became more impaired as he emerged into adolescence and adulthood. *Id.*; App. 184 (Dr. Greenspan: “The head injuries . . . are the critical factor that caused him to go from learning disabled, assuming that was a correct diagnosis, to intellectually disabled as they occurred before the end of the developmental period, before the age of 22”). The cumulative impact of Terry’s head injuries was evident even in his teenage years. In 1982, at age 14, Terry was administered the Bender-Gestalt, a visual-motor measure that indicates the presence of brain damage. Terry scored on a “very impaired level” that is “strongly indicative of brain damage,” consistent with other evidence of impaired intellectual functioning that Dr. Greenspan reviewed. App. 102, 373. Further, Terry’s performance on neuropsychological testing by Dr. Robert Deysach in 1997 was “strongly indicative of brain damage.” App. 103. Dr. Hall also

⁵ As discussed further below, the WISC-R has several flaws that make it unreliable, particularly for children with intellectual disability.

acknowledged that Terry’s history of head injuries and substance use may have affected his cognitive functioning. App. 301, 434.

Terry’s cognitive and adaptive impairments persisted into adulthood. Terry was never able to live independently, relying on family or romantic partners to support him and help him function in the community, like many people with intellectual disability. App. 109–10, 257–58, 328. His ex-wife, Louanne Smith, was responsible for all the household chores and for taking care of their children, and was the primary breadwinner. App. 109, 259, 328, 425. Louanne could not trust Terry to take care of their children, even for something as simple as remembering to feed them or testing the temperature of a bottle of formula. App. 329. Louanne not only handled the family’s living arrangements and finances, App. 257, 259, 332, 425, but was also responsible for scheduling Terry’s medical appointments—if Terry needed to go to the doctor, he relied on Louanne to make an appointment for him, App. 329. Similarly, when Terry lived with his older brother, Billy, Terry did not handle the finances and instead turned any money he made over to Billy to pay the rent and utilities. App. 332, 433.

Terry’s employment history also reflected deficits in adaptive functioning. A history of employment does not preclude a diagnosis of ID.⁶ App. 366. All of Terry’s jobs involved menial labor and ended in failure, and he struggled to maintain any one job for long, all of which is consistent with intellectual disability. App. 183, 366, 425. As Dr. Greenspan explained, Terry had “a very spotty and sporadic work history,” which is “very typical of people with mild intellectual

⁶ Dr. Hall pointed to Terry’s attempts to address his needs in the prison system as evidence that Terry did not have deficits in adaptive functioning. App. 323, 434. However, both the DSM-5 and *Moore v. Texas* state that reliance on adaptive strengths developed in prison is improper because prison is a structured, controlled environment. *Moore v. Texas*, 581 U.S. 1, 16 (2017); DSM-5 at 38; AAIDD-11 User’s Guide 20 (counseling against reliance on “behavior in jail or prison”).

disability.” App. 183. Dr. Hall noted he worked “sporadically” and needed Louanne’s help to secure any jobs that he did have. App. 326–27.

While Terry reported having a car repossessing business, App. 326, 425, Louanne handled all the paperwork and finances, while Terry’s role was limited to the straightforward task of picking up the car he was told to repossess. App. 109, 110, 262, 326, 425. As Dr. Greenspan explained, Terry would complete that work at night, “when he didn’t really have to interact with people,” App. 182, and Terry admitted in his interview with Dr. Hall and Dr. Davis that the business “would have been a big mess if I tried to do . . . the taxes,” App. 262. Even with Louanne’s help, the business ended in failure when Terry made the mistake of trusting his cousin to run the business and his cousin stole from him—another indicator of intellectual disability. App. 155, 183, 425.

c. The PCR Court erred in rejecting the clinical guidelines of the medical community.

The PCR court mischaracterized the role that clinical standards must play in the Court’s *Atkins* determination. App. 966 (“[T]he [United States Supreme] Court has been equally clear that clinical opinions neither dominate nor control the decision to be made under the Eighth Amendment.” (citing *Hall v. Florida*, 572 U.S. 701, 721 (2014)), 11, 12 n.5. This ignores the Court’s explicit directive that a court’s discretion to enforce the ban on executing people with intellectual disability is “not unfettered” and “must be informed by the medical community’s diagnostic framework.” *Moore*, 581 U.S. at 12–13 (quoting *Hall*, 572 U.S. at 719).

Further, the court’s reliance on the dissent in *Ex parte Segundo* (by a lone judge, from a *per curiam* opinion granting *Atkins* relief) is misplaced. App. 968 n.5 (quoting *Ex parte Segundo*, 663 S.W.3d 705, 712–13 (Tex. Crim. App. 2022) (Newell, J., dissenting)). This dissent, which the PCR court cited to support the proposition that “[a]t most, *Atkins* may be said to have prohibited the death penalty for those who were ‘mentally retarded’ based upon a national consensus about

what society believed that meant *in 2002*,” *id.*, is neither a binding nor an accurate statement of the law of *Atkins* and its progeny. To the contrary, the Supreme Court has consistently established that the *Atkins* inquiry must be informed by medical guidelines and consensus, including the change and evolution of that consensus over time, and courts may not disregard current medical standards in favor of older clinical standards or lay stereotypes about intellectually disabled people. *Moore*, 581 U.S. at 13, 18–20; App. 72–74 (stereotypes about intellectual disability frequently result in mistakes in diagnosis), 180–82 (noting common stereotypes of people with intellectual disability).

d. Prong 1: Subaverage Intellectual Functioning

A person meets the significantly subaverage intellectual functioning prong if his intellectual functioning, as measured by a comprehensive standardized IQ test, is two standard deviations below the population mean, including a margin for measurement error. DSM-5-TR at 39. This means a full-scale IQ score of approximately 75 or below when assessed on a comprehensive standardized IQ test that is individually administered according to the proper protocols. *Id.*; *Atkins*, 536 U.S. at 309 n.5 (“It is estimated that between 1 and 3 percent of the population has an IQ between 70 and 75 or lower, which is typically considered the cutoff IQ score for the intellectual functioning prong of the mental retardation definition.”). When a petitioner presents evidence that the “individual’s IQ score, adjusted for the test’s standard error, falls within the clinically established range for intellectual functioning deficits,” reviewing courts must “continue the inquiry and consider other evidence of intellectual disability.” *Moore*, 581 U.S. at 15.

Prong 1 is assessed in light of the totality of the evidence. Because “intellectual disability is a condition, not a number,” *Hall*, 572 U.S. at 722–23; App. 32, 66, a diagnosis of intellectual

disability does not turn solely on a defendant's strict IQ score.⁷ *Moore*, 581 U.S. at 15; App. 66. Rather, courts must “continue the inquiry and consider other evidence of intellectual disability where an individual's IQ score, adjusted for the test's standard error, falls within the clinically established range for intellectual-functioning deficits.” *Moore*, 581 U.S. at 15; App. 66. Thus, when assessing whether a defendant meets the subaverage intellectual functioning prong, courts should consider the nature of the test, the method by which the test was administered, and other factors that may affect the validity of the IQ scores.⁸ App. 66 (“there are all kinds of possible explanations” for score variations, including “possible corruption on the part of an evaluator or incompetence”), 202 (explaining the importance of adhering to “strict, standardized” rules of test administration to ensure that scores are valid).

In determining whether Prong 1 is satisfied, both the standard error of measurement and the Flynn Effect must be considered. The standard error of measurement is considered to be up to five points on either side of the IQ score. Am. Ass'n on Intellectual & Developmental Disabilities, *Intellectual Disability: Definition, Classification, and Systems of Supports* (11th ed. 2010) at 36

⁷ Courts have found that an individual was a person with intellectual disability despite having IQ test scores in the 80s, or even up to 93. *See, e.g., Pruitt v. Neal*, 788 F.3d 248, 253–54, 270 (7th Cir. 2015) (finding the defendant had intellectual disability with IQ scores of 52, 76 and 93); *United States v. Wilson*, 170 F. Supp. 3d 347, 363, 392 (E.D.N.Y. 2016) (finding the defendant had intellectual disability with reported IQ scores of 84, 78, 78, 70, 80, 84, 76 and 80); *Branch v. Epps*, 844 F. Supp. 2d 762, 772–73 (N.D. Miss. 2011) (finding the defendant had intellectual disability with reported IQ scores of 68, 84, 68 and 60); *People v. Superior Court (Vidal)*, 155 P.3d 259, 261, 267–69 (Cal. 2007) (finding the defendant had intellectual disability with reported IQ scores of 81, 92, 78 and 77); *Commonwealth v. Gibson*, 925 A.2d 167, 170–71 (Pa. 2007) (finding the defendant had intellectual disability with reported IQ scores of 67, 81 and 74).

⁸ Dr. Scott Decker testified at the PCR hearing about the importance of adhering to strict and standardized guidelines in IQ test administration, as well as to his administration of the Woodcock-Johnson IV to Terry. Dr. Decker is a neuropsychologist, with a PhD in school psychology and neuropsychology. App. 379. He has developed multiple intelligence assessments, including the Woodcock-Johnson, Stanford-Binet, and Bender-Gestalt. App. 195. This Court qualified Dr. Decker as an expert in neuropsychology and IQ test administration. App. 200.

(“AAIDD-11”); Simon Whitaker, *Error in the Estimation of Intellectual Ability in the Low Range Using the WISC-IV and WAIS-III*, 48 *Personality and Individual Differences* 517, 517 (2010). This error means that the true IQ score of an individual who obtains a score of 70 on a test can lie anywhere between the range of 65 to 75. AAIDD-12 at 35–36; Am. Psychiatric Ass’n, *Diagnostic and Statistical Manual of Mental Disorders* (5th ed. 2013) at 37 (“DSM-5”). As the United States Supreme Court explained, the standard error of measurement is “a statistical fact, a reflection of the inherent imprecision of the test itself.” *Moore*, 581 U.S. at 13; *Hall*, 572 U.S. at 713.

The Flynn Effect is the widely recognized phenomenon that IQ scores increase roughly 0.33 points per year as IQ tests age and test norms become obsolete. AAIDD-11 at 37; AAIDD-11 User’s Guide at 23; DSM-5 at 37; *see also United States v. Hardy*, 762 F. Supp. 2d 849, 858 (E.D. La. 2010). There is a consensus among practitioners that IQ scores obtained with older tests must be corrected for norm obsolescence. AAIDD-12 at 123; AAIDD-11 at 37 (“[B]est practices require recognition of a potential Flynn Effect when older editions of an intelligence test (with corresponding older norms) are used in the assessment or interpretation of an IQ score.”); Randy G. Floyd et al., *Theories and Measurement of Intelligence*, in *APA Handbook of Intellectual and Developmental Disabilities: Foundations* (L. M. Glidden et al. eds., 2021). Flynn correction requires that IQ scores be adjusted downward approximately 0.33 points for every year after a test has been normed.⁹ AAIDD-12 at 42.

⁹ For example, if a person obtains a score of 70 in 2020 on an IQ test that was normed in 2010, the score should be corrected to 66.7 ($0.33 \times 10 \text{ years} = 3.3$; $70 - 3.3 = 66.7$). AAIDD-12 at 42.

The purpose of correcting for the Flynn Effect “is not to correct for possible changes in actual intelligence in an individual or subgroup but rather to ensure that all individuals (regardless of their demographics) are measured by the same yardstick when being compared to an arbitrary (70 or 75) general population diagnostic criterion.” *Hardy*, 762 F. Supp. 2d at 858 (quoting Stephen Greenspan, *Flynn-Adjustment is a Matter of Basic Fairness: Response to Roger B. Moore, Jr.*, *Psychol. Mental Retardation & Dev’l Disabilities*, Vol. 32, No. 3 at 8 (2007) (S-29)). Clinicians

There are a variety of other factors regarding the administration of an IQ test—including when the test was normed and released for use, whether the appropriate testing instrument was used, and whether the test was properly administered and scored—which must be evaluated by an experienced expert using appropriate clinical judgment. *See Hall*, 572 U.S. at 722–23 (courts “must afford these test scores the same studied skepticism that those who design and use the tests do, and understand that an IQ test score represents a range rather than a fixed number.”). The WISC-R is especially problematic in terms of score reliability. *See* Stephen D. Truscott et al., *WISC-R Subtest Reliability Over Time: Implications for Practice and Research*, 74 Psychol. Rep. 147, 154 (1994) (“[A]lthough some stability exists for some of the subtest scores over time, stability is not sufficient for diagnosis, program planning, or decision making,” particularly for children with intellectual disability).

Terry presented evidence, including IQ testing and other testing results, at the PCR hearing that he meets the criteria for Prong 1. In 2022, Dr. Scott Decker administered the Woodcock-Johnson IV, one of three gold-standard IQ tests, to Terry. App. 204, 396-400; David Freedman, *Cognitive and Functional Assessment: A Practitioner’s Guide to Testing*, Federal Death Penalty Resource Counsel 54 (Mar. 2019) (describing WJ-IV as one of the three dominant, comprehensive, and nationally normed IQ tests which meet the current psychometric criteria for reliability and validity). Terry’s obtained IQ score was adjusted per the requisite Flynn effect, resulting in a full-

have recognized the elevated importance of the Flynn Effect in cases involving a possible intellectual disability diagnosis because people with intellectual disability may be particularly susceptible to the Flynn Effect. *Hardy*, 762 F. Supp. 2d at 859 (citing Caroline Everington & J. Gregory Olley, *Implications of Issues in Atkins v. Virginia, Defining and Diagnosing Mental Retardation*, 8 J. Forensic Psychol. Practice 1, 7 (2008), and Tomoe Kanaya et al., *The Flynn Effect and U.S. Policies: The Impact of Rising IQ Scores on American Society Via Mental Retardation Diagnoses*, 58 AM. PSYCHOL. 778, 787 (2003)); *see also* Tomoe Kanaya et al., *The Rise and Fall of IQ in Special Ed: Historical Trends and Their Implications*, J. School Psychol. 41, 453-65 (2003).

scale IQ score of 74, with a 95% confidence interval of 69 to 79. App. 204, 400. Terry’s score on this test “includes the range of scores that extend two standard deviations below the mean, which is typically considered as a diagnostic threshold for intellectual disability.” App. 400. “Based on behavioral observations during testing and consistency in test performance,” Dr. Decker concluded that Terry put forth good effort and that his score was a valid measure of intellectual ability, App. 205, 396. Dr. Hall also treated the score as valid in her analysis. App. 317.

The PCR court gave “no weight” to Dr. Decker’s score because Terry reported having previously had shingles during Dr. Decker’s administration of the Woodcock-Johnson IV. App. 983. However, Dr. Decker testified that he was aware that Mr. Terry had shingles, but, in his professional opinion, Terry was not debilitated by illness during the administration of the Woodcock-Johnson, App. 217, and Terry’s score was a reliable measure of his intellectual ability, App. 214, 223. Dr. Hall similarly did not dispute Dr. Decker’s conclusion that the score was valid. App. 317. All told, there is nothing in the record to support a finding that Terry’s Woodcock-Johnson score is not a valid estimate of his intellectual ability.

Dr. Stephen Greenspan testified that Terry’s performance on other academic achievement testing was also “very supportive of a diagnosis of ID” with respect to Prong 1.¹⁰ App. 99–100. Terry’s performance on standardized testing during his school years was consistently below grade level and indicative of intellectual impairment. App. 100, 102; *see also* App. 373. Neuropsychological testing in adulthood indicated brain damage, exacerbating his deficits. App. 103, 374. Traumatic brain injuries are likely to cause deficits in cognitive processing speed—the measures on which Terry scored lowest on the Woodcock-Johnson and the WAIS-IV. App. 211,

¹⁰ It is not necessary for a clinician to personally administer an IQ test to conclude that a person meets the criteria for Prong 1 of an intellectual disability diagnosis. App. 79.

247, 396, 429. The DSM-5-TR recognizes traumatic brain injury as a risk factor for intellectual disability. DSM-5-TR at 44; App. 336.

The State presented the testimony of Dr. Alicia Hall, who relied on unreliable and problematic IQ testing to conclude Terry does not meet Prong 1. App. 433. Specifically, Dr. Hall relied most heavily on the two WISC-R tests administered at age 11 and age 14, on which Terry received a score of 92. App. 104, 205, 427. Dr. Hall also cited the WAIS-IV administered in April 2024 by Dr. Jessica Davis, with Dr. Hall observing, on which Terry received a Flynn-adjusted score of 76 (with a 95% confidence interval of 71 to 81).¹¹ App. 234–35, 241, 317–18, 419, 431. These scores are less reliable indicators of Terry’s intellectual functioning than Dr. Decker’s Woodcock-Johnson test for multiple reasons.

First, WISC-R scores for children with intellectual disabilities, particularly subtests, do not meet accepted reliability standards. Stephen D. Truscott et al., *WISC-R Subtest Reliability Over Time: Implications for Practice and Research*, 74 Psychol. Rep. 147, 153 (1994); App. 206 (the WISC-R had “measurement issues” and was unreliable because it was not clear that the test measured what it purported to measure). “[A]lthough some stability exists for some of the subtest scores over time, stability is not sufficient for diagnosis, program planning, or decision making,” *id.* at 154, and “[t]ransitory shifts” in WISC-R scores make the risk of error too high reliable interpretation, *id.* at 154–55. The WISC-R is especially unreliable for children with brain injuries, like Terry, because it cannot accurately measure intelligence affected by traumatic brain injury, meaning that Terry’s childhood scores were not reliable. App. 206.

¹¹ As Dr. Hall acknowledged on cross-examination, she did not apply the Flynn Effect correctly in her report. She applied the Flynn Effect from the date of publication of the WAIS-IV (2008), rather than the year of norming (2007). Consequently, Terry’s corrected score on the WAIS-IV would be a 76. App. 118, 319.

Moreover, Dr. Greenspan testified that Terry's WISC-R scores could not rule out intellectual disability, partly because brain injuries occurring after testing likely affected his cognitive functioning. App. 104. Dr. Greenspan explained that, even taking the scores at face value, despite a number of medically sound reasons not to do so, the scores would not rule out a diagnosis of intellectual disability because of Terry's brain injuries, which occurred after the testing but during the developmental period, and qualifying Woodcock-Johnson score. App. 104. Despite these problems, the circuit court failed to account for the effects of Terry's brain injuries on his intellectual functioning and assumed with no evidence that Terry's childhood IQ scores were valid and reliable measurements of his abilities. App. 979.

Finally, Terry's WAIS-IV score is less reliable than the Woodcock-Johnson score because Dr. Davis administered it with Dr. Hall present as a third-party observer. App. 234–35, 241, 317, 419. The American Psychological Association (APA) strongly discourages the presence of third-party observers, even clinical observers, during IQ tests because tests are not normed in situations involving observers and the presence of an observer can affect the examinee's performance. App. 119, 253–55. The APA particularly advises against using third-party observers when an IQ test is being administered for legal purposes. App. 254.

Further, the PCR court's analysis of Terry's childhood IQ scores is flawed, and it fails to account for the effects of Terry's brain injuries on his intellectual functioning. The PCR court assumed with no evidence that Terry's childhood IQ scores are valid and reliable measurements of his intellectual abilities. App. 979 (“[N]o evidence demonstrates that [the childhood] tests were not properly given or that the scores are not valid.”). As Dr. Greenspan explained, without any further information regarding how the WISC-Rs were administered, it is impossible to assume

anything about whether the test was administered or scored correctly, and thus whether the results are reliable. App. 140–41.

Even assuming that Terry’s childhood IQ scores are valid and reliable, Terry presented evidence of intervening brain injuries during the developmental period that would have caused and accounted for the decline in his cognitive functioning, which the PCR court failed to address. App. 184, 301, 376, 434. In order to demonstrate intellectual disability, an individual is not required to show that the condition originated at birth—only that it was present during the developmental period. AAIDD-11 at 27 (“[E]specially when the etiology of the disability indicates progressive damage (such as malnutrition) or damage related to an acquired disease or injury (such as infection or **traumatic brain injury**), the condition may originate later [than birth].” (emphasis added)). The PCR court found Dr. Greenspan unreliable on this point because Terry’s childhood IQ scores were not included in Dr. Greenspan’s report, App. 979–80, but ignored Dr. Greenspan’s testimony that he considered those scores and determined that, even if the scores were accurate, Mr. Terry’s brain injuries in the developmental period would explain his decline in intellectual functioning. App. 184; *see also* App. 301, 376, 434.

e. Prong 2: Deficits in Adaptive Functioning

The second element of a diagnosis of intellectual disability is deficits in adaptive behavior. Adaptive behavior refers to typical activities of everyday living in a community setting and considers a person’s typical behavior in the community without support. *See* App. 62 (adaptive behavior refers to how a person “function[s] in the community or in their family or in their peer group”); AAIDD-11 at 45 (defining adaptive behavior as “the collection of conceptual, social, and practical skills that have been learned and are performed by people in their everyday lives”). To show deficits in adaptive behavior, an individual must demonstrate significant deficits in only one

of three skill areas of adaptive behavior: conceptual, social, or practical. *Moore*, 581 U.S. at 15; AAIDD-11 at 41–42; DSM-5 at 33; App. 63, 64, 105, 107, 319; AAIDD-12 at 31; DSM-5-TR at 37. Conceptual skills involve, among other things, “competence in memory, language, reading, writing, math reasoning, acquisition of practical knowledge, problem solving, and judgment in novel situations.” DSM-5-TR at 42; *see also* App. 63. The social domain involves “awareness of others’ thoughts, feelings, and experiences; empathy; interpersonal communication skills; friendship abilities; and social judgment.” DSM-5-TR at 42; *see also* App. 63. Lastly, the practical domain involves “learning and self-management across life settings, including personal care, job responsibilities, money management, recreation, self-management of behavior, and school and work task organization.” DSM-5-TR at 42; *see also* App. 63. Adaptive deficits exist when at least one domain “is sufficiently impaired that ongoing support is needed for the person to perform adequately across multiple environments, such as home, school, work, and community.” DSM-5-TR at 42.

In addition to a careful review of all available data, the clinical guidelines strongly recommend that, whenever possible, adaptive behavior be assessed with standardized scales. Such tests provide an objective, norm-referenced method for evaluating an individual’s functioning. AAIDD-12 at 38–39, 47; DSM-5-TR at 42. The availability of a standardized instrument to measure adaptive behavior can greatly improve the reliability of an intellectual disability assessment.¹²

Standardized adaptive behavior scales are administered to someone who knows the subject well and who has had an opportunity to observe their behavior closely. The informant is asked to

¹² Marc J. Tassé, *Adaptive Behavior Assessment and the Diagnosis of Mental Retardation in Capital Cases*, 16 *Applied Neuropsychology* 117–18 (2009).

describe typical behavior across various domains and the scores are then compared to a normed set of data, in much the same way that IQ tests examine an individual's performance compared to the general population. The AAIDD recommends the use of several such tests, including the Vineland Scale, which is a well-established instrument that meets "contemporary standards for standardization, reliability, and validity."¹³

Terry demonstrated deficits in all three areas of adaptive functioning, beginning in the developmental period. With respect to the practical domain, Terry was never able to live fully on his own, and his romantic partners were responsible for managing the household, handling finances, and taking care of their children. App. 109, 257–59, 328–29. He struggled to maintain employment, all his jobs involved menial labor, and all ended in failure. App. 183, 367, 425. In the conceptual domain, Terry struggled throughout his school years, was placed in special education, and was unable to complete his GED even after his incarceration. Finally, in the social domain, Dr. Greenspan testified that Terry was "severely, if not profoundly, impaired," and Dr. Hall similarly recognized Terry's social deficits. App. 107, 319–20, 432. Terry was gullible and easily influenced as both a child and an adult, and "had few genuine friends." App. 107–09, 151, 432. Finally, Terry was rated on the Vineland Social Maturity Scale, a gold-standard test to measure adaptive functioning, in elementary school and scored in the range of intellectual disability. App. 111, 112, 375.

The PCR court erred in relying on the testimony of Dr. Hall to conclude that Terry did not satisfy Prong 2 because Dr. Hall's testimony, and consequently the court's conclusions, are replete with errors. Dr. Hall recognized that Terry has deficits in at least two of the three areas of adaptive

¹³ J. Gregory Olley, *Adaptive Behavior Instruments*, in *The Death Penalty and Intellectual Disability* 189 (Edward A. Polloway ed., 2015); *see also* AAIDD-12 at 31.

behavior—conceptual and social—and that those deficits were present during the developmental period. App. 320, 432 (noting the results of the Vineland indicated Terry “was having deficits in his social skills as a youngster”), 16 (“Mr. Terry demonstrated deficits in conceptual skills as a youngster”). Nonetheless, Dr. Hall concluded that Terry did not meet the criteria for Prong 2 of an intellectual disability diagnosis. App. 434. *Contra Moore*, 581 U.S. at 15; AAIDD-11 at 41–42; DSM-5 at 33; App. 63, 64, 105, 107, 319; AAIDD-12 at 31; DSM-5-TR at 37 (all recognizing that an individual must demonstrate deficits in **only one** of the three areas of adaptive behavior to satisfy Prong 2).

i. Dr. Hall failed to account for the “cloak of competence” and relied too heavily on Terry’s self-report of his adaptive behavior.

As Dr. Hall acknowledged, individuals with intellectual disability often attempt to compensate for their limitations by masking their disability, which is a pattern of behavior known as the “cloak of competence.” Robert B. Edgerton, *The Cloak of Competence: Stigma in the Lives of the Mentally Retarded* 158–59 (1st ed. 1967); App. 109–10, 292–93 (Dr. Hall: “The cloak of competence is this idea that individuals who are mild ID develop mannerisms that, in order to mask their deficits from other neurotypical folks, that they don’t want to stand out or seem dumb. So they’ll do things to kind of mask that, to present themselves as higher functioning than they actually are.”). Often, individuals will “mask their deficits and attempt to look more able and typical than they actually are.” *Hardy*, 762 F. Supp. 2d at 854–55. “It has long been recognized in the field that one of the most commonly encountered characteristics of individuals who have intellectual disability is their intense motivation to mask their limitations.” James W. Ellis et al., *Evaluating Intellectual Disability: Clinical Assessments in Atkins Cases*, 46 Hofstra L. Rev. 1305, 1367 (2018); *see also* AAIDD-11 at 51–52 (“[P]ersons with higher IQ scores are more likely to mask their deficits and attempt to look more able and typical than they actually are.”). Quite

simply, there is such an intense stigmatization of individuals who are labeled as having an intellectual disability that they will go to tremendous lengths to hide their intellectual and functional deficits and present themselves as functioning normally, which may make intellectual disability difficult to detect. *Id.* at 1367–68; AAIDD-11 at 52 (“‘[M]ental retardation’ has been a particularly stigmatizing and pejorative label that leads most individuals with this label to fight hard not to be identified as ‘MR.’”). Higher-IQ individuals with intellectual disability “frequently present a mixed competence profile. They typically have a history of academic failure and marginal social and vocational skills.” *Hardy*, 762 F. Supp. 2d at 854–55 (quoting Robert L. Schalock et al., *User’s Guide: Mental Retardation Definition, Classification and Systems of Supports—10th Edition* 18 (AAIDD 2007)). Moreover, people with intellectual disabilities “typically have a strong acquiescence bias or a bias to please that might lead to erroneous patterns of responding.” *Id.* Thus, it is important not to rely on a person’s self-report of what he can or cannot do to assess adaptive functioning where intellectual disability is suspected. *See* App. 110, 293, 322.

With respect to adaptive behavior in particular, Dr. Hall relied on her view that Terry “described his adult life in terms that generally indicated average levels of adaptive functioning.” App. 432; *see also* App. 322. Yet she simultaneously acknowledged the dangers of relying on the self-report of someone suspected of having an intellectual disability, because such individuals often attempt to mask their deficits through the cloak of competence, including by overstating their abilities or claiming to be capable of tasks they cannot actually perform. App. 322.

The PCR court noted that “Dr. Hall questioned Applicant for examples and did not leave the information at surface or face value.” App. 986-87. However, the record demonstrates that Dr. Hall credited much of what Mr. Terry told her without confirmation, and sometimes even credited Mr. Terry’s self-report over statements from Louanne and Patsy that contradicted it. *See, e.g.,* App.

326–29. While the PCR court faulted Dr. Greenspan because he “admitted never speaking with Applicant’s teachers, childhood friends, or any of his previous doctors,” App. 979, the court ignored the fact that Dr. Hall did not speak to any of these people either, and offered no explanation for why that fact should render Dr. Greenspan’s testimony incredible but have no bearing on Dr. Hall’s.

ii. Dr. Hall and the PCR court relied on stereotypes of what people with intellectual disability can or cannot do.

Stereotypes of what individuals with an intellectual disability should look or act like “should spark skepticism.” *Moore*, 581 U.S. at 18 (rejecting the Texas appellate court’s reliance upon lay stereotypical perceptions of Moore’s intellectual functioning including education in normal classrooms, his father’s reaction to his academic challenges, and his sister’s perceptions of his intellectual disabilities); App. 72–74, 180–82. In *Moore*, the Supreme Court cautioned courts against relying on “incorrect stereotypes”—such as that persons with intellectual disability can “never have friends, jobs, spouses, or children”—and common misimpressions to exclude individuals from a diagnosis of intellectual disability. 581 U.S. at 17–18; AAIDD-11 at 26, 151; App. 72–73 (noting that intellectual disability is not visually apparent and that people with intellectual disability are frequently not globally impaired), 180–82 (noting that, contrary to popular misconceptions, people with intellectual disability are often able to perform routine tasks, work, or maintain relationships). Incorrect—but widely held—stereotypes about people with intellectual disability include that they (1) “look and talk differently from persons from the general population”; (2) “are completely incompetent and dangerous”; (3) “cannot do complex tasks”; (4) “cannot get driver’s licenses, buy cars, or drive cars”; (5) “do not and cannot support their families”; (6) “cannot romantically love or be romantically involved”; (7) “cannot acquire vocational and social skills necessary for independent living”; and (8) “are characterized only by

limitations and do not have strengths that occur concomitantly with the limitations.” *Id.*; *United States v. Roland*, 281 F. Supp. 3d 470, 480 (D.N.J. 2017); *see also* App. 72–73, 180–82.

The PCR court found that “Dr. Hall’s testimony showed that she was not influenced by stereotypes either for or against intellectual disability.” App. 984–85. The record clearly demonstrates that this is not accurate. The record shows that Dr. Hall relied on a number of stereotypes of people with intellectual disability in reaching her conclusions. Specifically, Dr. Hall concluded that Terry could not have deficits in adaptive behavior because he engaged in romantic relationships, was sporadically employed, could clean, cook, and do laundry “on occasion,” performed yard work, and completed household chores as a child. App. 291–92, 309, 310, 433–34. None of these behaviors exclude Terry from a diagnosis of intellectual disability.¹⁴ *See* App. 884–85.

In relying on Dr. Hall’s conclusions, the PCR court similarly erred in relying on inaccurate stereotypes. First, the court noted, as support for its conclusion that Terry is not intellectually disabled, that “once Applicant had more resource classes his grades improved.” App. 981. This assertion relies on a stereotype of people with intellectual disability—that they can never improve academically. To the contrary, people with intellectual disability will show academic or adaptive

¹⁴ Dr. Hall also improperly relied on Terry’s attempts to address his needs in the prison system as evidence that Terry lacked deficits in adaptive functioning. App. 323, 434. However, the DSM-5, the AAIDD, and the Supreme Court all recognize that reliance on adaptive strengths developed in a structured, controlled environment, such as a prison, is improper. *Moore*, 581 U.S. at 16 (cautioning against reliance on adaptive strengths developed in prison); AAIDD-11 at 47 (“[T]his is a critical distinction between the assessment of adaptive behavior and the assessment of intellectual functioning, where best or maximal performance is assessed.”); App. 323. Clinicians widely agree that adaptive functioning should not be analyzed based on prison behavior. *Moore*, 581 U.S. at 16; DSM-5 at 38 (“Adaptive functioning may be difficult to assess in a controlled setting (e.g. prisons, detention centers); if possible, corroborative information reflecting functioning outside those settings should be obtained.”); AAIDD-11 at 20 (warning against reliance on “behavior in jail or prison”).

improvement when given proper support; in fact, the AAIDD recommends additional classroom support as a means to improve academic performance in children with intellectual disability. AAIDD-11 at 194–99 (explaining the utility of accommodated educational practices to “strengthen the likelihood for success in learning” in children with intellectual disability).

Further, the PCR court found that the fact that Terry was married means that he “was good at manipulating others.” App. 981. In addition to the fact that this is simply an unreasonable conclusion to draw from a marriage, it is a classic example of the improper reliance on the stereotype that people with intellectual disability can never get married. *Contra* AAIDD-11 at 151 (criticizing the stereotype that people with intellectual disability cannot have spouses). The Order further asserts that Terry cannot be intellectually disabled because he “could do his work as a child with no assistance, and was able to fix things,” and briefly worked repossessing cars before his cousin stole from him, relying on the incorrect stereotypes that people with intellectual disability cannot work or learn skills. App. 981–82. The court also ignored the record evidence that Terry was unable to maintain that business by himself: Louanne was the one who in fact took care of all the paperwork and financial work for the business, while Terry’s role was limited to the straightforward task of picking up the cars he was told to repossess. App. 109, 110, 262, 326, 425. As Dr. Greenspan explained, Terry would complete that work at night, “when he didn’t really have to interact with people,” App. 182, and Terry admitted in his interview with Dr. Hall and Dr. Davis that the business “would have been a big mess if I tried to do . . . the taxes,” App. 262. Even with Louanne’s help, the repossessing business ended in failure when Mr. Terry made the mistake of trusting his cousin to run the business and his cousin stole from him—demonstrating gullibility, another indicator of intellectual disability. App. 155, 183, 425; AAIDD-12 at 30.

Lastly, the PCR court dismissed Terry’s history of working “menial jobs,” including “at two grocery stores, at a gas station as a mechanic and for a tree service,” as solely a product of his low education level¹⁵ rather than a sign of intellectual disability. App. 982. The court’s finding, however, misses the forest for the trees: The reason Terry had only a ninth-grade education, and therefore could only obtain jobs at that education level, is that he was too intellectually impaired to progress further—a sign of intellectual disability. Contrary to the Supreme Court’s directives, the PCR court emphasized Terry’s adaptive strengths over his adaptive deficits. *Contra Moore I*, 581 U.S. at 10, 16 (noting requirements from the AAIDD and DSM that the intellectual disability “inquiry should focus on deficits in adaptive functioning” (internal quotation marks omitted)); AAIDD-11 at 47; DSM-5 at 33, 38.

iii. Dr. Hall and the PCR court conflated signs of intellectual disability with other mental disorders and dismissed Terry’s history of risk factors for intellectual disability.

Dr. Hall erroneously attempted to explain away Terry’s symptoms of ID as indicators of other disorders that are not mutually exclusive of, and can co-occur with, intellectual disability. First, Dr. Hall attributed behavior indicative of adaptive deficits, such as Terry’s difficulties maintaining romantic relationships, to a 1994 diagnosis of antisocial personality disorder. App. 432. Even assuming that diagnosis was correct, the existence of another mental or personality disorder does not preclude a diagnosis of intellectual disability. *Moore*, 581 U.S. at 17; *Brumfield v. Cain*, 576 U.S. 305, 319 (2015) (noting “antisocial personality disorder is not inconsistent with...intellectual disability” and that the diagnostic criteria for intellectual disability has no “exclusion criterion; therefore, the diagnosis should be made . . . regardless of and in addition to

¹⁵ The PCR court asserted that Terry had a tenth-grade education. App. 982. Terry in fact dropped out of school before completing the ninth grade, when he was sixteen years old. App. 293, 294, 423.

the presence of another disorder”); App. 332–33. Mental health professionals recognize that intellectual disability frequently co-occurs with other mental or physical impairments (referred to as co-morbid). *Moore*, 581 U.S. at 17; App. 333; DSM-5-TR at 45 (“Co-occurring mental, neurodevelopmental, medical and other physical conditions are frequent in intellectual developmental disorder, with rates of some conditions (e.g. mental disorders, cerebral palsy, and epilepsy) three to four times higher than in the general population”); *see also* AAIDD-12 at 103; AAIDD-11 at 58–63.

Similarly, Dr. Hall disregarded the impact of Terry’s trauma history, academic failure, family poverty, impaired parenting, and childhood abuse. These factors are considered by the medical community to be “risk factors” for intellectual disability, not reasons to eliminate a diagnosis. App. 71, 320, 336; *Moore*, 581 U.S. at 11 (rejecting reliance on “alternative causes” such as abuse, academic failure, and undiagnosed learning disorders to negate intellectual disability), 16–17 (“Clinicians rely on such factors as cause to explore the prospect of intellectual disability further, not to counter the case for a disability determination.”); DSM-5 at 39; AAIDD-11 at 59–60 (“[A]t least one or more of the risk factors [described in the manual] will be found in every case of” intellectual disability), 66 (identifying postnatal risk factors for intellectual disability); *see also* App. 71, 320, 336 (identifying glue sniffing, abuse, and head injuries as risk factors for intellectual disability).

While Dr. Hall recognized that Terry suffered severe and extensive childhood abuse by his father and siblings, and that Terry was singled out for abuse by his father “because it took him longer to catch on when his father was teaching him to do something,” App. 423; *see also* App. 320, 323, she disregarded the impact of that history on Terry’s intellectual functioning. App. 306–07. Such history is both a risk factor for and indicator of intellectual disability, not a reason to

exclude a diagnosis. App. 320, AAIDD-11 at 66. Dr. Hall similarly recognized that Terry’s head injuries and substance use during the developmental period may have affected his cognitive functioning. App. 301, 434. A diagnosis of intellectual disability is proper where a traumatic brain injury suffered during the developmental period sufficiently impairs a person’s cognitive functioning. App. 377.

Finally, Dr. Hall attempted to explain Terry’s poor school performance, an indication of deficits in both intellectual functioning and the conceptual domain of adaptive functioning, by attributing it to a learning disability, exclusive of intellectual disability. App. 310, 433. The existence of a learning disability does not exclude a diagnosis of intellectual disability because, while often confused, the two disorders are fundamentally different: intellectual disability is a neurodevelopmental disorder that profoundly affects actual intelligence and overall intellectual functioning, while a learning disability interferes with academic achievement. DSM-5 at 31, 32; App. 186–87, 244, 294. Learning disabilities frequently co-occur with intellectual disability¹⁶, DSM-5 at 40, and individuals with intellectual disability are often misdiagnosed with learning disabilities in school, in part because the latter is viewed as a more “socially acceptable” diagnosis. App. 183.

The PCR court, relying on Dr. Hall’s testimony, erred in finding that Terry’s childhood abuse and lack of family support “has nothing to do with intellectual functioning.” App. 986. To the contrary, AAIDD and the DSM recognize that childhood abuse and a lack of parental support are risk factors for intellectual disability, and thus bear heavily on both intellectual and adaptive functioning. DSM-5 at 39; AAIDD-11 at 60 (identifying “child abuse and neglect,” “impaired

¹⁶ In particular, attention deficit hyperactivity disorder (ADHD) is one of the disorders that co-occurs most frequently in individuals with intellectual disability. DSM-5 at 40.

parenting,” and “inadequate family support,” among others, as risk factors for intellectual disability). Similarly, the Supreme Court has recognized that such factors are “cause to explore the prospect of intellectual disability further, not to counter the case for a disability determination.” *Moore I*, 581 U.S. at 16–17.

f. Prong 3: Onset in the Developmental Period

The final prong of the intellectual disability diagnosis is onset during the developmental period, defined as before age 22. App. 53, 55, 65, 333. “The developmental onset criterion requires there be a ‘continuity of concern’ about the individual extending back into the developmental period. It does not require that the individual had been labeled as having ID (or having qualifying scores) during that period[.]” App. 376.

Terry presented evidence of a continuity of concern surrounding his intellectual and adaptive functioning beginning in early childhood. App. 376. Terry was repeatedly assessed for impairment in school, placed in special education, App. 101, and “noted by his teachers for his slowness and inability to learn,” App. 376, indicating that educators perceived him as impaired during the developmental period. As Dr. Greenspan explained, because IQ testing is a “very expensive, time-consuming process,” “[i]t’s only done for one reason”—to assess the possibility of intellectual disability when an individual is performing poorly. App. 138. Further, intellectual disability cannot be ruled out by failure to diagnose it during the developmental period, even if testing is administered. App. 333–34, 376.

Terry’s adaptive functioning deficits also originated in the developmental period, as evidenced by his history of academic failure, lack of friendships in childhood, App. 120, and history of being singled out for abuse by his father “because it took him longer to catch on” when learning how to do something, App. 423; *see also* App. 323.

Finally, as discussed in Section II, Terry’s preexisting cognitive and adaptive deficits were exacerbated by brain injuries sustained during the developmental period. App. 184, 301, 376, 434. A diagnosis of intellectual disability is proper when a traumatic brain injury during the developmental period sufficiently impairs cognitive functioning. App. 377.

Despite recognizing that Terry’s deficits were present during the developmental period and that his adolescent brain injuries likely impacted his functioning, Dr. Hall concluded that Terry does not meet Prong 3—onset in the developmental period. App. 434. Dr. Hall relied on Terry’s adolescent WISC-R scores to opine that he did not satisfy Prong 3 while simultaneously noting that he demonstrated adaptive deficits “as a youngster.” *Id.* Contrary to Dr. Hall’s opinion, the age of onset prong also does not require deficient IQ scores—or any IQ scores—before age 22. *See* App. 333–34; *Roland*, 281 F. Supp. 3d at 478; *Nicholson v. Branker*, 739 F. Supp. 2d 839, 857 (E.D.N.C. 2010); *State v. Covington*, No. 71914, 2019 Nev. Unpub. LEXIS 88, at *8 (Nev. Jan. 22, 2019).

The PCR Court erred by incorrectly applying the requirements of Prong 3, relying on the fact that Terry was not diagnosed with intellectual disability while in school. App. 980. Clinical consensus holds that intellectual “disability does not necessarily have to have been formally identified [during the developmental period] but must have originated during the developmental period,” meaning the signs of intellectual disability need only have *manifested* before age 22. AAIDD-11 at 27; App. 333–34; *see also Blackwell*, 420 S.C. at 172, 801 S.E.2d at 737; *Oats v. State*, 181 So. 3d 457, 469 (Fla. 2015). In fact, as Dr. Greenspan testified, at the time that Terry was growing up, schools were loathe to diagnose a student with intellectual disability because of the stigma associated with the diagnosis. *See* App. 183. Instead, students with intellectual disability were diagnosed with learning disabilities, as Terry was. *Id.* (explaining that a learning disability is

considered a more “socially acceptable” diagnosis). Finally, while the Court recognizes that Terry “was given a maturity scale test in fifth grade,” App. 980, the Order ignores that Terry scored in the intellectually disabled range on that test, the Vineland Social Maturity Scale. App. 112, 321.

The PCR court erred in finding that Terry did not satisfy any of the three diagnostic prongs and that Terry is not a person with intellectual disability, and this Court should reverse.

II. The PCR Court Erred in Signing the State’s Proposed Order Verbatim.

At the conclusion of the evidentiary hearing, both parties submitted proposed orders, and the PCR court signed Respondent’s proposed order verbatim. *Compare* App. 957–88 (Order of Dismissal) *with* App. 925–56 (Respondent’s Proposed Order). This verbatim adoption of Respondent’s proposed order violates S.C. Code § 17-27-160 and contravenes this Court’s directives governing capital PCR orders, warranting relief.

In capital PCR cases, S.C. Code § 17-27-160(D) requires that “the hearing judge in writing shall make specific findings of fact and state expressly the judge’s conclusions of law relating to each issue.” S.C. Code § 17-27-80 similarly requires a PCR court to “make specific findings of fact, and state expressly its conclusions of law, relating to each issue presented.” *See also* Rule 52(a), SCRCP (“[T]he court shall find the facts specially and state separately its conclusions of law thereon.”). Although prevailing parties to draft proposed orders in non-capital cases,¹⁷ this Court has expressly disapproved of this practice in capital cases and has “strongly encourage[d]” judges to “draft their own findings of fact and conclusions of law.” *Hall v. Catoe*, 360 S.C. 353, 365, 601 S.E.2d 335, 341 (2004). This requirement reflects South Carolina law’s mandate that

¹⁷ *See Fishburne v. State*, 427 S.C. 505, 516, 832 S.E.2d 584, 589 (2019) (outlining the procedure for collaborative “preparation and finalization of a [non-capital] PCR order”).

courts—not parties—independently assess the evidence and law, and render even-handed conclusions based on sound, impartial judgment.¹⁸ See S.C. Code §17-27-160(D).

Since *Hall*, this Court has remanded three capital cases for failure to comply with §§ 17-27-80 and 17-27-160. *Inman v. State*, 439 S.C. 97, 100, 886 S.E.2d 204, 206 (2023) (“the PCR court erred in failing to address Inman’s remaining PCR claims as required by S.C. Code Ann. § 17-27-80”); *Simmons v. State*, 416 S.C. 584, 592-93, 788 S.E.2d 220, 225 (2016) (holding the PCR court erred in failing to make specific findings of fact and rulings of law on each issue raised); *Lindsey v. State*, No. 2012-206087 (S.C. Sept. 30, 2014) (vacating State-drafted order due to “the frequency and severity of the drafting errors” and reiterating the “Court’s admonishments to PCR judges in *Pruitt* [*v. State*, 310 S.C. 254, 423 S.E.2d 127 (1992)]”). Thus, this Court should require the PCR court to draft its own order addressing Terry’s claim for relief rather than relying on a party to draft proposed findings of fact and/or conclusions of law.

South Carolina courts permit adoption of proposed orders only when the judge has meaningfully reviewed the order and ensured it reflects the judge’s actual reasoning. In *Hall*, this Court declined reversal only because the PCR judge provided explicit assurances of meaningful review, stating on the record that he would “carefully review the proposed order” and ensure it reflected “as I find them to be.” 360 S.C. at 364, 601 S.E.2d at 341. In *Lindsey v. State*, the Court upheld adoption of the State’s order only because the judge explained, in detail, that he had

¹⁸ This Court’s disapproval of this practice is consistent with a nationwide consensus. Adoption of a party’s proposed findings is widely condemned because it represents “an abandonment of the duty and the trust that has been placed in the judge,” *United States v. El Paso Natural Gas Co.*, 376 U.S. 651, 657 n.4 (1964) (quoting Judge J. Skelly Wright in *Seminars for Newly Appointed United States District Judges* 166 (1963)), and leads instead to judgments that are self-evidently “not the original product of a disinterested mind.” *Flowers v. Crouch-Walker Corp.*, 552 F.2d 1277, 1284 (7th Cir. 1977); see also, e.g., *Shaw v. Martin*, 733 F.2d 304, 309 n.7 (4th Cir. 1984) (“The adoption of one party’s proposed findings and conclusions is a practice with which we have expressed disapproval on a number of occasions.”).

reviewed the proposed order and that it reflected his own view of the case. 2025 WL 3085693, at *12 (S.C. Nov. 5, 2025).

Here, the PCR court made no statements suggesting independent review, and the order contains glaring errors that any independent review would have identified. Most notably, there is no evidence in the record to support the order’s finding that Dr. Decker’s Woodcock-Johnson score was entitled to “no weight” despite Dr. Decker’s testimony that the score was a valid measure of Terry’s intellectual ability, App. 205, 397, and the fact that Dr. Hall, the State’s own expert, treated the score as valid in her analysis, App. 317. Courts treat such inaccuracies in party-drafted orders as “internal evidence” of non-review. *Jefferson v. Upton*, 560 U.S. 284, 292–94 (2010) (expressing “serious doubts” about verbatim adoption where the party-drafted order’s findings contained “internal evidence suggesting that the judge may not have read them,” including misstatements about nonexistent witnesses); *see also, e.g., Anderson v. City of Bessemer City*, 470 U.S. 564, 571–73 (1985) (warning that findings drafted by the prevailing party often contain “overreaching and exaggeration”).

III. The PCR Court Erred in Denying Applicant’s Request to Reconstruct the Record.

There is a “heightened need for reliability and rationality in the determination of whether an individual should be sentenced to death” under the Eighth Amendment. *California v. Ramos*, 463 U.S. 992, 1021 (1983) (citing *Woodson v. North Carolina*, 428 U.S. 289, 395 (1976) (plurality opinion)); *Lockett v. Ohio*, 483 U.S. 586, 604 (1978) (recognizing the “qualitative difference between death and other penalties calls for a greater degree of reliability when the death sentence is imposed”); *Gardner v. Florida*, 430 U.S. 349, 359 (1977)). That requirement applies with particular force in an *Atkins* proceeding, where the question is whether the applicant is categorically ineligible for execution. *Atkins v. Virginia*, 536 U.S. 304 (2002).

To ensure meaningful appellate review, South Carolina law permits a circuit court to reconstruct the record when a transcript is incomplete. *State v. Ladson*, 373 S.C. 320, 324, 644 S.E.2d 271, 273 (Ct. App. 2007); *see also China v. Parrott*, 251 S.C. 329, 162 S.E.2d 276 (1968); *Dolive v. J.E.E. Developers, Inc.*, 308 S.C. 380, 383, 418 S.E.2d 319, 321 (Ct. App. 1992). Reconstruction is necessary when “the incomplete nature of the transcript prevents the appellate court from conducting a ‘meaningful appellate review’,” prejudicing the defendant. *Ladson*, 373 S.C. at 325–26, 644 S.E.2d at 274. Where reconstruction is possible, this Court may remand for a reconstruction hearing; if the record cannot be reconstructed with the “completeness and reliability necessary for this [C]ourt to engage in meaningful appellate review,” this Court may reverse and remand for a new trial. *Id.* at 326–28, 644 S.E.2d at 274–75.

Here, the PCR erred by refusing to reconstruct the transcript of the two-day *Atkins* evidentiary hearing, resulting in materially defective 354-page transcript containing 163 “indiscernible” notations. App. 1–354. These omissions include expert testimony, objections, legal argument, and court rulings, despite the PCR court’s assertion that the gaps did not affect pivotal testimony. *See* App. 863. The resulting record is inadequate to permit meaningful appellate review of the denial of *Atkins* relief.

This deficiency is particularly prejudicial because the PCR court’s ruling rested almost entirely on credibility determinations. The PCR court expressly refused to “afford any significant weight to Applicant’s experts based on specific errors, bias, and lack of accurate and/or meaningful support” while crediting Dr. Hall and Dr. Davis as giving “credible and supported” testimony. App. 987. The transcript’s pervasive gaps preclude this Court from reviewing the basis for those credibility determinations. In particular, the PCR court rejected Dr. Greenspan’s opinion as being “entitled to such little weight” because of the “overall lack of precision and omissions” that

allegedly undermined his credibility. App. 983. This Court cannot meaningfully review that determination because his voir dire and testimony are littered with omissions due to technical difficulties, App. 6–7, 19, 23, and “indiscernible” notations, *see, e.g.*, App. 13, 25–30, 33, 35, 38, 34, 59, 61, 69, 75–78, 82, 93, 99–100, 103–04, 106–07, 112, 114, 118, 120, 132–33, 147, 151, 159, 161, 167, 169, 176.

Moreover, the PCR court faulted Dr. Greenspan’s methodology, including his alleged reliance on an “imprecise and self-created questionnaire”, App. 983, and a purported “lack of supporting and/or persuasive data” regarding adaptive functioning, App. 980. Both issues were addressed and extensively argued before the Court determined that Dr. Greenspan’s testimony was admissible. App. 39–47. Yet, these seven pages contain some of the most significant transcript deficiencies, with thirty-four “indiscernible” notations during the State’s argument, App. 39–42, 44–45; twenty-eight during the defense’s response, App. 42–45; and three during the court’s ruling, App. 45–47. Without reconstruction, this Court cannot determine whether the PCR court’s later factual findings are supported by the evidence and arguments presented.

Given the magnitude of the missing portions, the centrality of those portions to the *Atkins* determination, and the heightened reliability required in capital proceedings, the PCR court erred by refusing to reconstruct the record. The only remedy that preserves Mr. Terry’s right to meaningful appellate review is for this Court to remand with instructions to reconstruct the record or, if reconstruction is impossible, to order a new evidentiary hearing.

CONCLUSION

For the reasons stated above, the record of the circuit court proceedings was insufficient to provide a basis for meaningful appellate review, and the PCR court’s conclusions and order

denying relief are governed by errors of law and unsupported by record evidence. Therefore, this Court should grant certiorari to correct those errors.

Respectfully submitted,

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