

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

Jan 05 2026

S.C. SUPREME COURT

GARY DUBOSE TERRY, #5054,

PETITIONER,

V.

STATE OF SOUTH CAROLINA,

RESPONDENT.

APPENDIX
VOLUME 1 OF 3

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1 STATE OF SOUTH CAROLINA * COURT OF COMMON PLEAS
 2 COUNTY OF LEXINGTON * TRANSCRIPT OF RECORD
 3 -----X
 4 GARY DUBOSE TERRY, *
 5 Applicant, *
 6 vs. * Case No. 2022-CP-32-00924
 7 STATE OF SOUTH CAROLINA, *
 8 Respondent. *
 -----X

Hearing Dates:
 July 17-18, 2024

REVISED/CORRECTED

ATKINS HEARING - VOLUME I
 July 17, 2024

B E F O R E:

The Honorable Robert E. Hood, Presiding Judge

A P P E A R A N C E S:

E. Charles Grose, Jr., Esq.
 Allison Franz, Esq.
 Attorneys for the Applicant

Tommy Evans, Jr. Esq.
 Melody J. Brown, Esq.
 Assistant General Attorneys for the Respondent

Recorded by: DCRP Court Monitor Roderick Fitzgerald
 Partial (Webex) for Dr. Greenspan's testimony

Transcribed by: Bobbi Fisher, RPR
 SC Official Court Reporter III

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E X H I B I T S

(Exhibits on file in Clerk of Court's Office.)

Applicant's Exhibit

No.	Description	ID.	REC'D
1	Dr. Greenspan's C.V.	18	
2	Dr. Greenspan's 7/25/24 Report	122	124
3	Dr. Greenspan's 7/10/24 Report	122	124
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No.	Description	ID.	REC'D
1	Dr. Hall's Report	228	
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COURT REPORTER LEGEND

Dash (--) Indicates an interruption in speech

Ellipses (...) Indicates trailing off in speech

(ph) Indicates phonetic word

[Verbatim] Indicates the word is said as written

(Indiscernible)[Transcription] Indicates word(s) is
not known due to audio recording
quality

P R O C E E D I N G S

[Digital recording technical difficulties.]

THE COURT: All right, Rod. You good?

COURT MONITOR: [Indiscernible.]

THE COURT: All right. We're on the record in Gary Terry versus the State of South Carolina, 2022-CP-32-924. Mr. Terry is present, represented by Ms. Franz and Mr. Grose. The State's present, represented by Ms. Brown and Mr. Evans.

Anything we need to take up before we get started, Mr. Grose?

MR. GROSE: I don't believe so, from my perspective anyway.

THE COURT: All right. Ms. Brown?

MS. BROWN: Yes, Your Honor. We had filed a pre-trial exhibit. And I have two copies; one for Your Honor one for your law clerk. And we will also have this morning a motion to exclude testimony from Dr. Greenspan. We have prepared a memorandum in support of that. We'd ask [indiscernible] hand that up at this time. [Indiscernible] to opposing counsel might be the simplest way to approach this.

May I approach, Your Honor?

THE COURT: You may.

MS. BROWN: To be brief, Dr. Greenspan will give testimony [indiscernible] and of course, as an expert, we would be entitled to voir dire. Some of that, I believe, will

1 bring out testimony that is important for our motion to
2 exclude the testimony. So, Your Honor, [indiscernible] are
3 the motions.

4 [Digital recording technical difficulties.]

5 THE COURT: Okay. And he's testifying virtually?

6 MS. FRANZ: Yes, sir.

7 THE COURT: When was someone going to tell me that?

8 MR. GROSE: [Indiscernible] told me that last week
9 [indiscernible]. The clerk asked us this morning
10 [indiscernible] witnesses going to be testifying virtually
11 [indiscernible].

12 THE COURT: I don't even know how to set all that up over
13 here.

14 Rod, how are you able to record that?

15 COURT MONITOR: [Indiscernible].

16 THE COURT: Rod, how are you going to record that?

17 COURT MONITOR: [Indiscernible].

18 THE COURT: Zoom is not the same system as the Webex
19 system.

20 MR. GROSE: I understand.

21 THE COURT: The issue is you're in a digital courtroom.
22 You're not with a live court reporter so it's a different
23 setup.

24 MR. GROSE: With all the time we have [indiscernible].

25 THE COURT: And they have no court reporter

1 [indiscernible]. It's just a system recording itself.

2 MR. GROSE: I've also -- when I've done trials
3 [indiscernible].

4 THE COURT: I'm not disputing that any of that's
5 happened, but we're in a digital courtroom. It's a different
6 setup. There's microphones in the courtroom that are
7 recording. How is he going to [indiscernible]?

8 That's what I'm asking Rod.

9 Is there a [indiscernible] to record it?

10 [Digital recording technical difficulties.]

11 THE COURT: [Indiscernible] pipe in his speaker through
12 one of these microphones and everybody in here leaves their
13 microphones on, do you think that will work?

14 [Digital recording technical difficulties.]

15 THE COURT: All right. Dr. Greenspan, can you go ahead
16 and turn on your video?

17 Yeah, I can't hear him at all.

18 Rod, are you back on?

19 COURT MONITOR: Yes.

20 THE COURT: Okay. All right. Dr. Greenspan, what we're
21 doing at this point in the system is we're testing the system.
22 I'm going to have you speak here in just a moment to see the
23 court reporter's ability to record what's going on.

24 Mr. Grose, can you-all turn on your videos?

25 Are you logging back in, Rod?

1 COURT MONITOR: I'm sorry?

2 THE COURT: Are you logging back in?

3 (Pause in the proceedings.)

4 THE COURT: Can y'all turn on your videos?

5 MR. GROSE: My video is on. It's showing on my screen.

6 THE COURT: Dr. Greenspan, quote "Mary Had a Little Lamb"
7 or something like that. We're trying to test the audio. Just
8 anything. It doesn't matter. It doesn't have to do with the
9 case. I'm just trying to figure out the audio.

10 (Pause in the proceedings.)

11 THE COURT: Where is this guy?

12 UNIDENTIFIED SPEAKER: [Indiscernible].

13 THE COURT: And why isn't he here?

14 UNIDENTIFIED SPEAKER: We went before the
15 [indiscernible].

16 THE COURT: If I re-read through this pretrial brief and
17 it doesn't say anything about a virtual hearing, I'm not going
18 to be happy.

19 MR. GROSE: It's in the cover email that went with it,
20 Your Honor.

21 THE COURT: Okay. So here's what we're going to have to
22 do.

23 Rod, you're going to have to not record the thing. We're
24 going to have to make the virtual recording of it part of the
25 record. Okay? All right. So, Rod, go ahead and turn -- go

1 ahead and log out.

2 Okay. Dr. Greenspan, can you hear me?

3 THE WITNESS: Yes, sir.

4 THE COURT: Okay. And Mr. Evans, can you try talking?

5 MR. EVANS: Dr. Greenspan, can you hear me?

6 THE WITNESS: Yes, sir, I can very well.

7 THE COURT: Okay. Ms. Franz, go ahead and try.

8 MS. FRANZ: Dr. Greenspan, can you hear me?

9 THE WITNESS: [Indiscernible].

10 THE COURT: Go ahead, Ms. Franz. Keep talking. He needs
11 to be able to hear you.

12 MS. FRANZ: I'm sorry. I can't -- he can't hear me?

13 THE COURT: No.

14 THE WITNESS: I can hear you; it's just [indiscernible].

15 MS. FRANZ: That might be it. Can you hear me now?

16 THE COURT: Don't record it on the digital machine. I'm
17 just going to record it. Do you see what I mean? Then, that
18 way, we don't have to deal with a bunch of feedback.

19 MR. GROSE: I logged out because I couldn't see all the
20 people on the screen. I think I need to be let back in the
21 courtroom. I still can't see.

22 Dr. Greenspan, can you hear me?

23 THE WITNESS: [Indiscernible].

24 THE COURT: Y'all just need to set the computer up in
25 between the two of you so it can see all three of you. Just

1 turn yours off, Mr. Grose, and use Ms. Franz's.

2 Okay. So is he the first issue that we need to take up
3 this morning?

4 MS. BROWN: Yes, sir, Your Honor. We would move to
5 exclude during voir dire.

6 THE COURT: Okay. All right. So here's what we do:
7 No. 1, we're making a virtual recording of Dr. Greenspan's
8 testimony, voir dire, whatever you want to call it that we're
9 recording through the Webex system. Okay? For that, the
10 lawyers and I will stay muted unless you are asking questions
11 or making an objection; otherwise, we're going to have so much
12 feedback that no one can understand what's going on. So if
13 you need to hop in, you know, unmute yourself. But, until
14 then, if you'll keep yourself muted, that will help control
15 the feedback.

16 Do y'all understand what we're doing?

17 MR. GROSE: Yes, sir.

18 THE COURT: Do you understand what we're doing?

19 MR. EVANS: Yes, sir, Your Honor.

20 THE COURT: All right. So y'all mute yourselves and then
21 I'm going to talk to Dr. Greenspan.

22 MS. BROWN: Your Honor, the only problem that we have is
23 we can't hear. Is there a way to control volume otherwise?

24 THE COURT: No. That's why this whole thing doesn't
25 work. That's why you're supposed to be in the privacy of your

1 office with a set of headphones on so you can hear. So you're
2 going to --

3 Ms. Doyle, can you go over there and make sure...

4 You're going to be able to hear the questioning and me.
5 It's going to be him that you can't hear. It's still going to
6 be a bunch of feedback, but it won't record that way.

7 This isn't the way it's supposed to be done, so....

8 Okay. All right. Dr. Greenspan, can you hear me?

9 THE WITNESS: Yes, sir.

10 THE COURT: Okay. And I'm going to need you to speak up
11 or get closer to the microphone. Okay?

12 THE WITNESS: Yes, I was.

13 THE COURT: Yeah, like, do you have a microphone or
14 anything like that that's available to you?

15 THE WITNESS: Afraid not. I need to buy one, but at the
16 moment, I don't have one.

17 THE COURT: Okay. You're going to need to speak up
18 significantly.

19 THE WITNESS: Okay. I'll try to do that.

20 THE COURT: Okay. All right. So good morning,
21 Dr. Greenspan. Thank you for your patience with us. We're
22 here on 2022-CP-32 -924, Terry versus the State of South
23 Carolina. The State has a pretrial motion concerning
24 qualifications so we'll let Mr. Terry start with
25 Dr. Greenspan's voir dire.

1 DR. STEPHEN GREENSPAN,
2 was examined and testified to as follows:

3 VOIR DIRE EXAMINATION

4 BY MR. GROSE:

5 Q Dr. Greenspan, can you hear me?

6 A Yes. Good morning, Mr. Grose.

7 MR. GROSE: I can't -- I could hear a minute ago, but I
8 can't now.

9 BY MR. GROSE:

10 Q Dr. Greenspan, can you state your full name for the
11 record.

12 A Stephen Greenspan. S-t-e-p-h-e-n G-r-e-e-n-s-p-a-n.

13 Q All right. And what is your profession?

14 A I'm a psychologist.

15 Q And, if you would, would you please summarize your
16 professional employment -- I mean, your educational
17 experiences? I'm sorry.

18 A Yes. A bachelor's from Johns Hopkins, a master's from
19 Northwestern, a Ph.D. from the University of Rochester, and
20 post-doctoral certificate from UCLA.

21 Q All right. And after you completed your post-doctorate,
22 what did you do as far as employment?

23 A I was an assistant professor and research scientist at
24 George Peabody College of Vanderbilt University. And then I
25 went to Nebraska where I was [indiscernible; technical

1 difficulties] ---

2 THE COURT: And now he's gone.

3 A --- in Colorado where I was affiliated with University of
4 Colorado Medical School. And now [indiscernible].

5 THE COURT: I think we need to go back to Nebraska
6 forward.

7 BY MR. GROSE:

8 Q Dr. Greenspan, we lost you on this end. Can you go back
9 to the University of Nebraska and go forward?

10 A Yes. In Nebraska, I was affiliated with the University
11 of Nebraska and also worked at Boys Town at a research center
12 where I headed up a program, a research on intellectual
13 disability. And then I moved to Connecticut where I
14 eventually became a full professor of educational psychology.
15 I retired from there and then moved to Colorado where I was
16 affiliated with the University of Colorado and developed a
17 consulting practice, including forensic cases. And now I live
18 in northern California.

19 Q And so for how many years have you practiced as a
20 psychologist?

21 A Probably half a century, I would say.

22 Q And do you have any certifications and licenses?

23 A Yes. I have a psychology license from the State of
24 Nebraska, which I allowed to become dormant, and I still have
25 a psychology license from the State of Nebraska.

1 Q And during your career, have you focused on intellectual
2 disabilities?

3 A Yes. That's been my main focus. For example, I'm the
4 most cited authority in the section on intellectual disability
5 in the DSM-5. And I testify in forensic cases, typically in
6 Atkins proceedings such as this one.

7 Q Okay. And have you conducted evaluations regarding
8 intellectual disability?

9 A Yes, I have on many occasions, both criminal and civil
10 cases.

11 Q And can you estimate the number of evaluations you have
12 conducted?

13 A Well, in criminal cases, at least 40, I would say. And
14 for --

15 Q And -- I'm sorry, go ahead.

16 A Sorry. And for service eligibility, maybe another 20 or
17 so.

18 Q And why do you mean by "service eligibility"?

19 A Well, for example, let's say someone with apparent
20 developmental disability applies for services from whatever
21 state they live in and there's some question about their
22 eligibility, and I'm sometimes hired to come in and determine
23 if that's an appropriate decision.

24 Q And you mentioned Atkins evaluations. Can you explain
25 what an Atkins evaluation is?

1 A Well, in November of 2002, the U.S. Supreme Court in the
2 case of Atkins v. Virginia ruled that people with what was
3 then called mental retardation could not be executed. And I
4 had started -- I started getting calls from attorneys or
5 sometimes public defender offices asking if I would be willing
6 to testify. Because I was no longer teaching at that point, I
7 was more available than I would have been otherwise, and so I
8 often am asked to consult and asked to consult both in terms
9 of helping a Court to understand what intellectual disability
10 is and what's the appropriate method to use in making that
11 determination and also getting involved in testifying about a
12 particular individual and whether or not they qualify, in my
13 opinion, as intellectually disabled.

14 Q And are you or have you been a member of different
15 professional organizations?

16 A Yes. I'm a member of the American Psychological
17 Association and was elected a fellow, which is the highest
18 level of membership. And that's within the Division 33, which
19 is the division on mental retardation and autism now.

20 American Psychological Society, same thing; I'm a fellow.
21 I was elected a fellow of the American Association on
22 Intellectual and Developmental Disabilities, which is the main
23 professional organization in the intellectual disability
24 field.

25 And I may be -- I was, at one time, the president of the

1 Academy on Mental Retardation. And I'm probably leaving out
2 one or two.

3 Q And probably what?

4 A Probably leaving out one or two other organizations that
5 I have been involved in.

6 Q So is it fair to say you have been involved in a number
7 of professional organizations involving psychology and
8 intellectual disabilities?

9 A Yes. For example, in DSM-5, on the section on
10 intellectual disability, in the online version, which is the
11 one only which has citations, I'm the most cited person in the
12 field of intellectual disability within that chapter.

13 Q And in addition to your involvement with the DSM-5, have
14 you -- do you have any publications?

15 A Well, I was also a member for awhile of the
16 classification committee or AAIDD, the American Association of
17 Intellectual and Developmental Disability. And I was the main
18 consultant to the committee writing the DSM-5 chapter on
19 intellectual disability. So I'm very familiar with the
20 diagnostic criteria and the manuals that define intellectual
21 disability and what's involved in drafting those -- those
22 documents.

23 Q All right. When you say the DSM-5, can you explain what
24 you mean by that?

25 A Yes. It's called the Diagnostic and Statistical Manual

1 of Mental Disorders, DSM. It's gone through several
2 revisions. So the most recent one is the fifth edition.
3 That's why they call it DSM-5. And then, recently, there was
4 another revision, which they called text revision, so it's --
5 the most current one is DSM-5-TR for text revision. And I
6 believe I continue to be the most cited person in that current
7 document because it really is just basically the same as the
8 former one with one minor change.

9 Q And you also mentioned the AAIDD. What is that?

10 A Yes. DSM is a psychiatric organization which covers many
11 dozens, if not hundreds, of disorders. AAIDD just has one
12 focus, and that's intellectual disability. And they also have
13 a manual, which is now in its 12th -- 12th revision or 12th
14 edition, so I would call that AAIDD-12. They're very closely
15 assigned in their definition of intellectual disability in
16 part because, as membership -- cross-membership across the two
17 groups in terms of their committees that wrote these manuals.
18 At one time, I was a member of the committee that wrote the
19 AAIDD manual.

20 In the AAIDD 11th edition, I was the most cited authority
21 just as I am in the DSM-5 and 5-TR.

22 Q And the AAIDD manual, is that the intellectual disability
23 definition, diagnosis, clarification, and systems of support?

24 A Yes, I believe that's the name of it.

25 Q All right. And in addition to your involvement in the

1 AAIDD manual and the DSM-5 with regard to intellectual
2 disabilities, have you published in any scientific journals?

3 A Yes. I probably have 50 or 60 refer- -- articles and --
4 which include various chapters in books. It's probably close
5 to a hundred. And I have also published five or six books of
6 my own, including one that's about to come out from Springer
7 Publishing titled, "The Parkland School Shooter and Fetal
8 Alcohol Syndrome."

9 Q And have -- are your publications listed on your C.V.?

10 A Yes, they are.

11 Q And we had sent you a folder of exhibits. Did you have a
12 chance to look at those?

13 A Yes.

14 (Applicant's Exhibit No. 1, Dr. Greenspan's C.V. was
15 premarked for identification.)

16 BY MR. GROSE:

17 Q And Applicant's Exhibit 1, do you recognize that as a
18 copy of your C.V.? It's ten pages long.

19 A Yes. I don't have that called up on my screen. Is that
20 in the box or folder you sent me?

21 Q Yes, sir.

22 A I have it on a separate laptop. Here we go. I thought
23 might be it dead. Yeah, I have to plug it in. It's about to
24 die. I apologize. I thought it was up and running, but the
25 battery died.

1 To try to save the Court some time, is it possible for
2 you to put it up for me to look at it or can I just say that
3 I'm sure it is my C.V.?

4 MS. FRANZ: Can you see that, Dr. Greenspan?

5 BY MR. GROSE:

6 Q Can you see that, Dr. Greenspan?

7 A What's that? Oh, yes. I wasn't looking.

8 Q And we have marked it as Applicant's Exhibit 1. It looks
9 like your April 2024 C.V. that has ten pages.

10 A Yes. I may have a couple more publications since then
11 but that is definitely my C.V.

12 MR. GROSE: Okay. At this time, I would offer
13 Dr. Greenspan's C.V. into evidence as Applicant's Exhibit 1.

14 MR. EVANS: Your Honor, we would hold any objections for
15 approval of the C.V. into evidence since we are going to
16 object with him being allowed an expert in this field, Your
17 Honor.

18 MR. GROSE: Then I would proffer Applicant's Exhibit
19 No. 1 at this time and a copy for the court reporter, a copy
20 for the Court and your law clerk [indiscernible].

21 THE COURT: Thank you.

22 MR. GROSE: At this time, I would offer Dr. Greenspan as
23 an expert in psychology with a specialization in diagnosing
24 intellectual disability.

25 [Digital recording technical difficulties.]

1 THE COURT: [Indiscernible] exhibit [indiscernible]?

2 MR. GROSE: I have provided them with a copy.

3 THE COURT: I mean on the screen.

4 MR. EVANS: Oh, I don't know.

5 THE COURT: Okay. Y'all just pull that off the screen
6 for me, please.

7 All right. And Mr. Evans, are you doing it?

8 MR. EVANS: [Indiscernible], Your Honor.

9 THE COURT: All right, Mr. Evans. If you will unmute
10 yourself. And, Ms. Franz, if you will mute. There you go.

11 MR. EVANS: Thank you, Your Honor. May it please the
12 Court?

13 VOIR DIRE CROSS-EXAMINATION

14 BY MR. EVANS:

15 Q Dr. Greenspan, do you remember speaking to me at a
16 deposition last week, last Thursday?

17 A Yes, sir.

18 Q Okay. And I asked you questions about your report. You
19 filed a report -- well, you sent a report that was dated on
20 July 5th of this year; isn't that correct?

21 A Yes.

22 Q Okay. And in this report, you list activities you
23 performed but you never listed any dates that you performed
24 any of these activities; isn't that correct?

25 A I believe that's true, yes.

1 Q Okay. And you also listed documents that you received
2 and, I guess, reviewed -- numerous documents, but there is no
3 listing of the actual documents and where they're from listed
4 or when you listed them -- when you reviewed them; isn't that
5 correct?

6 A I think that's probably true, yes, sir.

7 Q Okay. And I remember asking you about notes, and you
8 said that -- and during the deposition, that you have terrible
9 handwriting and you can barely read the notes yourself; isn't
10 that correct?

11 A Yes.

12 Q Okay. So you are prepared to testify strictly from your
13 memory and not reviewing any notes or anything of that nature?

14 MR. GROSE: Your Honor, at this time, I have to interpose
15 an objection. We have provided the Attorney General with the
16 notes that he had available.

17 We sent those to you this week. So for you to suggest
18 that is a misrepresentation.

19 MR. EVANS: Your Honor, they provided notes of two
20 witnesses. Nothing else. And I'm talking about notes from
21 discussions with the defendant and also any notes that he
22 received or wrote down from any of the records he reviewed.
23 We never received any of those things. That's the notes he's
24 talking about, and he's going to testify or prepared to
25 testify about documents he reviewed [indiscernible] I don't

1 even know [indiscernible] from something he reviewed we don't
2 know when because it's not listed when he reviewed it, those
3 notes, in his actual reports, Your Honor.

4 MR. GROSE: First of all, none of this goes to his
5 qualifications or the reliability. We --

6 MR. EVANS: Oh, yes, it does. I mean, if he's testifying
7 from memory, then it's not reliable.

8 MR. GROSE: May I finish?

9 THE COURT: You may?

10 MR. GROSE: I assume they're not going to offer any
11 witnesses here [indiscernible]. We provided them with the
12 notes of one of the collateral interviews that was done and
13 notes that he took when he was providing or using a structured
14 interview with Mr. Terry here. And so for him to suggest that
15 there's no notes that's been provided, it's not true.

16 Secondly, he had an opportunity -- he only -- the
17 deposition is only about an hour, but he had an opportunity in
18 that deposition to ask about records and go into details and,
19 you know, it's -- and he has an opportunity to be
20 cross-examined.

21 Again, none of this goes to qualification.

22 MR. EVANS: Your Honor, [indiscernible].

23 THE COURT: All right. Any -- the objection made. It's
24 overruled. We're in the middle of voir dire as to
25 qualifications. You may continue to question the witness.

1 [Digital recording technical difficulties.]

2 BY MR. EVANS:

3 Q Now, Dr. Greenspan, according to the DSM-5, in order to
4 make a determination of --

5 THE COURT: All right. I don't think the system's
6 pulling you up.

7 (Pause in the proceedings.)

8 THE COURT: Hang on just a second, Dr. Greenspan.

9 This is what happens when we do virtual hearings.

10 (Pause in the proceedings.)

11 THE COURT: All right, Dr. Greenspan. I think we fixed
12 the technological issues. Mr. Evans is questioning you.

13 And I don't know that I swore you in before you started,
14 but do you swear or affirm all the information you're going to
15 give today, either previously or in the future, to be the
16 truth, the whole truth, and nothing but the truth so help you
17 God?

18 THE WITNESS: I do.

19 (Dr. Stephen Greenspan was duly sworn.)

20 THE COURT: Thank you, Dr. Greenspan.

21 Okay. You may continue, Mr. Evans.

22 MR. EVANS: Yes, Your Honor.

23 BY MR. EVANS:

24 Q Now, Dr. Greenspan, according to the DSM-5, in order to
25 make a determination of intellectual disability, you must meet

1 deficits in intellectual functioning, deficits in adaptive
2 functioning, and it all must occur during the developmental
3 period; isn't that correct?

4 A That's correct.

5 Q And in order to find deficits in adaptive functioning,
6 you did a common sense questionnaire; isn't that correct?

7 A Yes, but that was not the whole basis for my
8 determination.

9 Q Okay. And in this questionnaire, you have done it with
10 Mr. Terry, and he made answers to this questionnaire; isn't
11 that correct?

12 A Which I believe you have. I sent it to Mr. Grose, yes.

13 Q Yes. Okay. And, basically, this questionnaire is
14 scenarios to determine his common sense; isn't that correct?

15 A Yes. By common sense, I mean risk awareness -- social
16 risk awareness.

17 Q Okay. And the only person that's going to make the
18 determination of social risk awareness is you; isn't that
19 correct?

20 A Could you repeat that, please?

21 Q The only person that's going to make this determination
22 is you; isn't that correct?

23 A That's true of any clinician, yes.

24 Q Okay. So this -- and this questionnaire was created by
25 yourself; isn't that true?

1 A Yes.

2 Q And nobody else in the psychological community uses this
3 questionnaire; isn't that correct?

4 A For the most part, that's true.

5 Q Okay. And this questionnaire is not recognized in the
6 psychological community; isn't that true?

7 A Well, my work is very recognized and it has been --
8 people have expressed an interest in this. But, at this
9 point, I wouldn't call it a test. It's a framework for asking
10 questions to try to get at someone's risk awareness, which is
11 certainly part but not all of adaptive behavior.

12 But you're right; it's, at this point, being used mainly
13 by me as a structured framework for interviewing someone.

14 Q Okay. This is not a standardized instrument used by
15 psychologists; isn't that correct?

16 A It's not a test, sir.

17 Q So it's also not a standardized --

18 A It's an interview framework, which is what psychiatrists
19 use when they interview people.

20 Q So this is not something that is used by psychologists
21 normally. It's only used by you; isn't that correct?

22 A Well, I would [indiscernible] fairness [indiscernible].

23 THE COURT: And he's frozen.

24 Maybe you can ask him the question over again.

25 BY MR. EVANS:

1 Q Dr. Greenspan, you froze for a second there. I'm going
2 to re-ask the question.

3 This is nothing that's used by psychologists normally;
4 isn't that correct? It's only used by you; isn't that true?

5 A [Indiscernible].

6 Q Dr. Greenspan, did you hear my question?

7 A Yes. I said yes.

8 Q Okay. You froze again.

9 And there is no scientific reasoning to this
10 questionnaire? No scoring or anything like that that's done
11 from this questionnaire; isn't that correct?

12 A No, it's qualitatively evaluative.

13 Q Okay. By yourself and no one else?

14 A Yes.

15 Q Okay. It's not peer-reviewed or anything like that;
16 isn't that correct?

17 A It's not a test. It's an interview framework.

18 Q Okay. And in your report, you reviewed the report of
19 Dr. Scott Decker; correct?

20 A Yes, reporting on the testing he had done, particularly
21 the Woodcock-Johnson cognitive instrument.

22 Q And you also, I think during your deposition, testified
23 that you read the results of a CAT scan done by Dr. Daysach,
24 who was a person that testified in the original trial; isn't
25 that correct?

1 A Well, he's a neuropsychologist so I reviewed his
2 testimony about the testing that he did, and he referred to a
3 CAT scan. But I don't believe he did the CAT scan. As a
4 neuropsychologist, he would not be the person to administer or
5 interpret the CAT scan, which is a medical procedure.

6 Q Now, during the deposition, you stated that had you
7 testified in about 30 cases, all for the defense; isn't that
8 correct?

9 A Yes.

10 Q And you gave us a listing of some of the cases you did
11 testify into; isn't that true?

12 A [Indiscernible].

13 THE COURT: And he's out again.

14 All right. He seems back with us. I think you can
15 re-ask the question.

16 BY MR. EVANS:

17 Q Dr. Greenspan, you gave us a list of cases you testified
18 in; isn't that correct?

19 A I gave a list of recent cases. [Indiscernible] testify
20 in all of them.

21 Q Could you repeat that, please?

22 A I gave a listing of some recent cases. I did not testify
23 in every one of those. I didn't realize that's all you
24 wanted.

25 Q Okay. All right. But there are some cases that we found

1 that you have testified in. Do you remember testifying in the
2 Commonwealth v. Flor case in Pennsylvania?

3 A Which case was that?

4 Q Commonwealth v. Flor?

5 A I testified in Pennsylvania, but I didn't catch the name
6 of the person I testified about. Could you repeat that or
7 spell it?

8 Q F-l-o-r. Flor. Robert Anthony Flor.

9 A Yes. It's been a long time. I don't remember much -- I
10 don't remember much about that, but I do remember the name.

11 Q Okay. So you didn't remember when the Supreme Court of
12 Pennsylvania decided that, when it stated in their opinion,
13 "His critical acceptance," talking about yourself, "of the
14 opinions of the appellant's other expert notwithstanding those
15 best practices were not adhered to, led to -- led it to
16 discount the credibility of his opinion evidence." You don't
17 remember reading that in the opinion in this case?

18 A No. This is the first time I have heard that.

19 Q Okay. Do you remember testifying in the case of Blue v.
20 Thaler in the U.S. District Court in Houston?

21 A Again, could you repeat the name of the person I
22 testified about?

23 Q Blue v. Thaler, T-h-a-l-e-r.

24 A [Indiscernible].

25 Q Okay. So I guess you don't remember when Judge Keith

1 Hoyt, U.S. District Court judge, wrote in his decision that,
2 "Dr. Greenspan urges this Court to grant the habeas writ
3 because Blue's scores are close that are required for a
4 diagnosis of retardation, which should be enough in the
5 capital context. Dr. Greenspan lessens the credibility of his
6 expert opinion when he dilutes the psychological principles
7 because this is a death penalty case. Science operates
8 independent from the process of law. Blue's IQ scores should
9 qualify him for a diagnosis of mental retardation based on
10 objective facts -- factors, not an expert witness' perspective
11 on capital punishment."

12 MR. EVANS: I don't think he even heard that.

13 BY MR. EVANS:

14 Q Dr. Greenspan?

15 A I don't recall. I have no recollection [indiscernible].
16 [Indiscernible] my opinion and often I do agree. I could
17 provide you with many, many ---

18 Q Dr. Greenspan, you have to repeat everything you just
19 said because I didn't get a word of it. Could you please
20 repeat what you just said?

21 A Completely [indiscernible], sir.

22 Q Okay. Do you remember the Candelario Santana case from
23 Puerto Rico, testifying in that case?

24 A Yes, I do.

25 Q You do remember testifying in that case?

1 A Yes.

2 Q Okay. I guess you don't remember when District Court
3 Judge José Antonio Fusté wrote, "We note this mismatch between
4 Dr. Greenspan's credentials and his performance here as a
5 warning to other courts who may yet hear his testimony in the
6 future. Dr. Greenspan serves as an expert in cases of this
7 sort across the country and such service demands impeccable
8 professional reputation. Carelessness and evasiveness have no
9 place in any courtroom; yet, Dr. Greenspan demonstrated those
10 characteristics amply here and may do so again elsewhere."

11 Have you ever read that opinion or remember this being
12 said about you, Dr. Greenspan?

13 A [Indiscernible]. Yes. I said yes.

14 Q Yes, you do. Okay.

15 MR. EVANS: Beg the Court's indulgence.

16 Nothing further, Your Honor.

17 THE COURT: Any follow-up, Mr. Grose?

18 MR. GROSE: Yes, sir.

19 VOIR DIRE REDIRECT EXAMINATION

20 BY MR. GROSE:

21 Q Dr. Greenspan, can you hear me?

22 A Yes, I can, sir.

23 Q Let me pick up where they left off on the Candelario
24 Santana case. Do you know if that judge was eventually
25 sanctioned and removed from the bench?

1 A He was. He was also disbarred by the Puerto Rican Bar
2 Association.

3 Q The State has picked a handful of cases that criticized
4 your opinion. Have courts relied on your opinion?

5 A Many times.

6 Q When you say "many times," have courts relied on your
7 opinion regarding your diagnosis of intellectual disability of
8 a particular person?

9 A Yes. I don't have a score card, but I would say more
10 often than not they do agree with me, and I have many cases I
11 could cite where the judge said very positive things about me
12 and my testimony.

13 Q Mr. Evans asked you about the list of cases that you
14 provided. And as I recall the question came up in your
15 deposition, did you have a complete list of cases, and you
16 said you did not; is that correct?

17 A No. I had some computer disasters in recent years, and
18 it would be very difficult for me to come up with a complete
19 list at this point.

20 Q And what you agreed to provide Mr. Evans was a list of
21 those recent cases that you had worked on.

22 A Yes, going back a couple of years. I may have left one
23 or two out.

24 Q All right. And that's, in fact, what you did do; is that
25 correct?

1 A Yes, sir.

2 Q Okay. And these cases that Mr. Evans asked you about
3 today, he had an opportunity to ask you about those in your
4 deposition and he didn't do it, did he?

5 A No, he didn't ask me about them.

6 Q Okay. Mr. Evans started off asking you questions about
7 the diagnostic criteria contained in the DSM-5; do you recall
8 that question?

9 A Yes, sir.

10 Q Is intellectual disability a number?

11 A No. In fact, in the Hall v. Florida case, the judge --
12 the Supreme Court justice who wrote that opinion -- I'm
13 blocking out his name. I think it was Stevens -- Justice
14 Stevens -- wrote, quote, "Intellectual disability" -- he might
15 have used the term "mental retardation" -- "is a condition,
16 not a number," unquote.

17 Q And what does -- that statement, "a condition, not a
18 number," is that something that you're familiar with in the
19 scientific community as well?

20 MR. EVANS: Your Honor, I object to that question. I
21 think it's going beyond the scope of my cross-examination.

22 THE COURT: I'll allow it.

23 MR. GROSE: Continue? All right.

24

25

1 BY MR. GROSE:

2 Q I don't know if you could hear that ---

3 A Yes, I did.

4 Q --- Dr. Greenspan. The judge overruled the objection.

5 Can you explain what the "condition, not a number" means
6 in the scientific community regarding intellectual disability.

7 MR. EVANS: Your Honor, I renew my objection. This is
8 voir dire. I think he's lapsing into an opinion
9 [indiscernible] testimony, if you allow the testimony.

10 THE COURT: [Indiscernible] qualifications
11 [indiscernible].

12 MR. GROSE: Well, that was my objection earlier, and they
13 went far beyond his qualifications.

14 THE COURT: No, they went directly to reliability factors
15 that counsel just said he had to go through so if you have
16 something to ask him about his qualifications or the testimony
17 to -- as to his being reliable, then ask it.

18 BY MR. GROSE:

19 Q Dr. Greenspan, they asked you about the common sense
20 questionnaire. Can you explain what the common sense
21 questionnaire is?

22 A Yes. Common sense can be defined in various ways. I
23 define it as awareness of obvious risk, whether it's social
24 risk, such as getting arrested, or physical risk, such as
25 getting run over. It's a very important aspect of adaptive

1 behavior, also known as adaptive functioning. In fact, DSM-5
2 mentions risk awareness, I believe.

3 And so the common sense questionnaire is basically a
4 social problem-solving interview in which I present scenarios.
5 The typical way to approach a social problem-solving is to
6 present a problem and ask somebody how they should solve it.
7 I think the more important approach in terms of surviving in
8 the world is to present a problem, present a solution, and
9 then see if the individual understands why it might be a bad
10 solution in terms of the possible disastrous consequences that
11 would accrue from that behavior -- portrayed behavior.

12 And so the common sense questionnaire basically presents
13 24 or 25 scenarios in which someone is portrayed
14 [indiscernible] but coming up with a solution.

15 Q Now, is the common sense questionnaire, is it intended to
16 be a psychological test?

17 THE COURT: I don't think he heard your question.

18 MR. EVANS: I lost him on my screen.

19 BY MR. GROSE:

20 Q Dr. Greenspan, can you hear me now?

21 A Yes, sir.

22 Q We lost you for a second here. My last question was: Is
23 the common sense questionnaire intended to be a psychological
24 test?

25 A [Indiscernible] score [indiscernible] neurological test.

1 Q Okay. The term "structured interview" was used earlier.
2 What -- is the common sense questionnaire a structured
3 interview?

4 A Yes. That's a basic method used by psychiatrists who are
5 not qualified to administer tests, and it's also a method used
6 by any mental health expert interviewing someone. I just
7 present it in terms of a method of getting at someone's
8 reasoning about social situations.

9 Q So is it fair --

10 A But structured --

11 Q I apologize; please continue.

12 A No, structured interview is a very, very common method
13 used in forensic -- in forensic evaluations, and this is my
14 attempt to get at it -- around this. So the risk awareness,
15 which I see is critical and, to my knowledge, there is no
16 other test or method for getting at a risk awareness.

17 Q When you say that a structured interview is a common
18 technique used by psychiatrists and psychologists, can you
19 explain what you mean by that? Try and give some examples?

20 A [Indiscernible].

21 Q We lost you for a second. Can you start over your
22 answer, please?

23 A Structured [indiscernible] and I'm structuring around an
24 ability or an issue that's generally not evaluated because
25 there are no other ways of getting at it. Even though the DSM

1 says that risk awareness is very important, this is my attempt
2 to develop a way -- excuse me -- of getting a handle on
3 someone's risk awareness.

4 Q Okay.

5 A Every psychiatrist who evaluates someone uses a
6 structured interview approach. So it's a very commonly used
7 method in forensic evaluations.

8 Q And is it used in evaluations for competency to stand
9 trial, for example?

10 A Yes. I mean, most people who do competency evaluations
11 don't do formal testing. And there is -- there are one or two
12 tests that are used in competency evaluations but they're
13 generally not used. Rather, the method used is a structured
14 interview.

15 Q All right. And does -- does the common sense
16 questionnaire assist you in exercising your clinical judgment?

17 A Yes, it helps me see if someone has an ability to
18 recognize and understand risk. In that sense, it's important.

19 Q And does the DSM-5 and the AAIDD manual endorse the use
20 of clinical judgment in diagnosing intellectual disability?

21 A And they both do. In fact, AAIDD has their own book on
22 this subject for -- involving clinical judgment, particularly
23 in terms of diagnostic -- diagnosing intellectual disability.
24 It's a very critical part of any mental health expert doing an
25 evaluation. Otherwise, what do you need a clinician for? You

1 might as well just use a number.

2 Q Okay. And the common sense questionnaire assists you on
3 what you -- what's considered Prong 2 sometimes, the deficits
4 and adaptive behaviors; is that correct?

5 A Very much so, yes. But it's not the whole thing, by any
6 means.

7 Q And I wanted to follow up on that. I think you said
8 earlier, when Mr. Evans was questioning you, that the common
9 sense questionnaire was not the sole basis for your diagnosis
10 in this case. Can you explain that?

11 A Well, I looked at a lot of documents, many of them
12 pertain to Mr. Terry's adaptive functioning, his adaptive --
13 and I use the terms "adaptive functioning" and "adaptive
14 behavior" as equivalent because DSM uses "functioning" and
15 AAIDD uses "behavior" in many documents pertaining to
16 Mr. Terry's adaptive functioning or lack thereof.

17 And there is also the test of his adaptive functioning
18 called a Vineland Social Maturity Scale that I refer to.
19 There's a chart that I have access to that lists a lot of his
20 adaptive behavior deficits. So it's definitely not the case
21 that I relied solely on the common sense questionnaire. That
22 was useful mainly as it gave me a focus of my interview with
23 him -- my remote interview with him.

24 Q All right. And they asked you some questions about the
25 neuropsychologist, Dr. Deysach.

1 A Yes.

2 Q And is relying on the opinions in examinations of
3 neuropsychologists, is that something that's endorsed by the
4 DSM-5 and/or the AAIDD manual?

5 A Yes. Neuropsychological testimony and assessment is very
6 critical. It should be part of any Atkins case. DSM-5 --
7 excuse me -- goes even so far as to say that
8 neuropsychological data is often more important than IQ, not
9 only at getting at Prong 2 but also getting at Prong 1, which
10 is intellectual functioning.

11 And, in fact, Dr. Deysach talks about something that he
12 called adaptive intelligence, quote/unquote, which is a term
13 that's also used in DSM-5 where they indicate that adaptive --
14 deficits in adaptive intelligence, and they specifically
15 mention risk unawareness as an example of that. It's very
16 important to diagnose the intellectual disability in both
17 Prong 1 and Prong 2.

18 And by adaptive [indiscernible] are referring to how
19 someone views various stressful and potentially dangerous
20 situations.

21 MR. GROSE: Your Honor, that's all the questions I have
22 at this time. I would renew offering -- I would renew
23 offering Dr. Greenspan as an expert in psychology and
24 diagnosing intellectual disability.

25 THE COURT: And is he your first witness?

1 MR. GROSE: Yes, sir.

2 THE COURT: Okay.

3 Dr. Greenspan, just stay with us for a few minutes.

4 Okay? Don't go anywhere but I'm just going to mute you while
5 we do some things here on the record. Okay?

6 THE WITNESS: Very good, sir.

7 THE COURT: Thank you.

8 Rod, are we up? Rod? We're up?

9 All right. So the applicant has proffered Dr. Greenspan
10 as the expert in the area of psychology and diagnosing
11 intellectual disability as a specialty; is that correct?

12 MR. GROSE: Yes, sir.

13 THE COURT: All right. Let me hear your argument as to
14 qualifications and admissibility under -- well, the test for
15 determining the admissibility of scientific evidence under
16 [indiscernible].

17 MR. EVANS: Your Honor, [indiscernible] mentioned Jones
18 earlier, and the Court ruled [indiscernible] Jones and State
19 v. Council. The indications -- well, I'd just ask you to
20 consider whether or not, to find somebody reliable, those
21 publications and peer-reviewed [indiscernible] by application
22 of the method, the type of evidence involved in the case,
23 quality control procedures to ensure reliability and
24 consistency of the method recognized scientific
25 [indiscernible] procedures.

1 Our basic argument is, first of all, [indiscernible]
2 nobody else used it [indiscernible] actual results are totally
3 determined are totally determined by an opinion of the doctor.
4 And he [indiscernible] with the knowledge of whether or not
5 something is common sense.

6 Common sense to him is different than common sense to me.
7 Common sense to him is definitely probably different than
8 common sense [indiscernible] in this case. But
9 [indiscernible] determine [indiscernible]. We don't see that
10 in that [indiscernible].

11 THE COURT: So as far as the -- the way my brain kind of
12 processes through this [indiscernible], just so you understand
13 the framework that [indiscernible], it's kind of step number
14 one is we have [indiscernible], per Council, we have to go
15 through will the evidence assist the trier of fact if he's
16 qualified, and is the underlying facts reliable.

17 You're really focusing in on Factor 3, which then
18 triggers into the Jones factors of qualification, peer review,
19 is this what they're normally doing, is this the practice in
20 the field. And that's where you're focusing in on to try and
21 exclude him as an expert witness.

22 There's no doubt that he has the requisite education to
23 be a psychologist or that he's licensed to be a psychologist
24 or has been in the past or has training in psychology or any
25 of that kind of stuff; right?

1 MR. GROSE: Yes, sir.

2 MR. EVANS: But, Your Honor, the thing about it is, the
3 second prong [indiscernible] DSM-5. Adaptive functioning must
4 be shown that [indiscernible] to do that, according to DSM-5,
5 only by questioning an individual but also speaking to
6 [indiscernible] that know him, like his parents or anybody
7 that's raised him, his wife. Also counselors and also
8 teachers and also other medical providers. [Indiscernible]
9 did not do that, to force his wife -- he was forcing -- his
10 ex-wife was forced by [indiscernible] Mr. Terry, but also
11 never spoke to his mother. You know, Dr. Hall did speak with
12 his mother and got valuable information out of him. That was
13 not done by this doctor. He said in the deposition that she
14 couldn't talk to me [indiscernible]. However, Dr. Hall did.

15 Also, Your Honor, he relied on that questionnaire
16 substantially.

17 THE COURT: [Indiscernible] questionnaire?

18 MR. EVANS: Yes, sir, Your Honor. And our opinion is
19 that that's not reliable. Nobody else is using it. It was
20 [indiscernible] reliable [indiscernible] somebody else would
21 be using it in the country. Nobody else is using that
22 questionnaire. It is only him that is using it; therefore, we
23 question his reliability. We question that reliability and
24 for it to be used to show deficits of adaptive functioning, we
25 feel that it is wrong. It should not be reliable in this

1 court under testimony of this doctor because that is a major
2 factor in determining whether somebody [indiscernible].

3 Also, Your Honor, if I can read to the Court regarding
4 what's measured by DSM-5, on page 37, it says, "Standardized
5 measures are used for knowledgeable informants, parent or
6 other family members, teacher, counselor, provider." And it's
7 not true -- there's no source or information [indiscernible]
8 from a medical and mental health evaluations or some
9 standardized measures and interview sources must be
10 interpreted to use the clinical judgment.

11 Our opinion is that has not been done in this case in
12 order to make a determination on [indiscernible] functioning;
13 therefore, our argument is that he should not be allowed to
14 testify, especially [indiscernible] because the methods he
15 used are not reliable and should not be followed by this Court
16 in making a determination of whether or not Mr. Terry is
17 intellectually disabled.

18 THE COURT: Okay. Thank you, Mr. Evans.

19 Mr. Grose?

20 MR. GROSE: Yes, Judge Hood. I think under the
21 [indiscernible] cite [indiscernible] vs. [Indiscernible]. And
22 I think we don't have any issue on the first prong,
23 [indiscernible]. The issue on the third prong
24 [indiscernible]. And I wanted to go a little more into the
25 DSM in interpreting scores because, as Mr. Evans just argued,

1 there's a [indiscernible] judgment now [indiscernible]
2 instruments to determine.

3 However, first let me say it's just broad. It's not
4 [indiscernible]. Dr. Greenspan did talk to Mr. Terry's mother
5 and Mr. Terry's ex-wife, so [indiscernible].

6 Dr. Greenspan will testify about his review of school
7 records, which was [indiscernible] developmental period
8 [indiscernible] his diagnosis as to Prong 1 and Prong 2.
9 Though they're in the report, we didn't get in to all of that.

10 I will also note that, you know, if they're trying to
11 make a common sense questionnaire [indiscernible].
12 Dr. Greenspan is not [indiscernible] something that is not a
13 structured interview where he needs this [indiscernible]
14 assessment. He testified that it's something that the
15 psychiatrist and psychologists generally do, and I would just
16 note [indiscernible], that [indiscernible] call Dr. Hall from
17 DDSN, and [indiscernible] of SCDDSN competency to stand trial
18 instrument that she used.

19 We've also been provided with a Patton Informal Adaptive
20 Behavior Inventory, Adaptive Behavior [indiscernible]
21 questionnaires as [indiscernible] version . Those are also --
22 I would be [indiscernible] say those are instruments that are
23 structured interviews, particularly the competency to stand
24 trial [indiscernible] that's ever been published in the
25 scientific literature [indiscernible].

1 So most of what, if not all -- if not all of those
2 [indiscernible] goes to the weight of the evidence and not the
3 admissibility of [indiscernible].

4 THE COURT: Okay. All right. Anything as to that issue,
5 Mr. Evans?

6 MR. EVANS: One thing, Your Honor. In reading
7 Dr. Greenspan's deposition, he specifically stated, "I did not
8 get much out of the interview with the mother. She was very
9 shaky. I concluded that the ex-wife was a much better
10 informant." That's why I said before, he's tried to talk to
11 the mother and he couldn't get much out of her but Dr. Hall
12 did, Your Honor.

13 And, also, I think that the Court needs to focus on the
14 Moore decision. In the Moore decision, the Supreme Court
15 state that you must assess not only, one, whether the expert's
16 method is reliable, but also, two, whether the substance of
17 the expert's testimony is reliable.

18 The actual measures used by DDSN -- that's a state
19 agency, Your Honor -- [indiscernible]. That's something that
20 you as the other individual can decide to [indiscernible]
21 questionnaire [indiscernible] and totally determination about
22 the common sense from this questionnaire [indiscernible]
23 Dr. Greenspan and no one else. As I said before, that is
24 something that we all differ when we make that determination.
25 Your common sense may be different than mine. The defendant's

1 common sense may be different [indiscernible], so how can he
2 make that kind of determination [indiscernible]?

3 MR. GROSE: Your Honor, two things quickly: Just for
4 clarification, [indiscernible].

5 MR. EVANS: In the memo, page 10.

6 MR. GROSE: Well, I had reviewed [indiscernible] -- the
7 only reason that I bring that up is they keep referring to a
8 Supreme Court [indiscernible] Court of Appeals, so I just
9 wanted the record to be clear on that.

10 With regard to the adaptive behavior on Prong 2, going to
11 the AAIDD manual, there was testimony there's no requirement
12 that any adaptability behavior scale be [indiscernible] as
13 Dr. Greenspan testified to in regards to [indiscernible] DSM-5
14 and AAIDD manual.

15 THE COURT: All right. So the standard before the Court,
16 as found in Council and Jones -- Council is, of course, a 1999
17 Supreme Court case on the admissibility of scientific
18 evidence; Jones is a back-in-1979 case, but they're all quoted
19 throughout the common-day case law that we use all the way and
20 until Watson v. [Indiscernible]. I cited cases recently on
21 these types of issues, so let's just kind of walk through them
22 one by one.

23 No. 1: Will the evidence assist the trier of fact?
24 Well, the Court is the trier of fact in this circumstance, so
25 the Court will answer that question in the affirmative, yes.

1 Is the expert witness qualified? And, clearly,
2 Dr. Greenspan is qualified. He's a psychologist. He's also
3 qualified to give diagnoses in the area of intellectual
4 disability. He has an undergraduate degree, a master's
5 degree, a doctorate degree. He's a professor and some form of
6 a consulting practice. He's written chapters in books. He's
7 written articles. He's cited in some form in the DSM-5.
8 Clearly, he's qualified as an expert in the area.

9 Prong C is the underlying science is reliable. And then
10 when you determine and go through your reliability, that's
11 when Jones kind of kicks in and talks about accommodations and
12 peer review, prior application on the internal procedures, and
13 consistency of the method.

14 And so I think the -- you know, where the State is really
15 of focusing in on is this common sense questionnaire. And I
16 don't know that that, in and of itself, automatically kicks
17 out Dr. Greenspan's opinion. I think that's an issue that
18 he's using the common sense questionnaire that no one else
19 uses, I don't think that's the only basis of his opinion.
20 He's told me that he's reviewed other documents, other
21 reports, other doctors' reports. He clearly spoke with the
22 ex-wife and clearly had some conversation with the mother. He
23 clearly has, you know, interviewed and spoke with Mr. Terry.

24 So I don't know that this common sense questionnaire is
25 this, you know, smoking gun or magic bullet that is the sole

1 basis of his opinion. I do -- you know, I think that the
2 common sense questionnaire is fair game for cross-examination
3 on the fact that no one else uses it, that it's not
4 peer-reviewed, that it's not -- this isn't something that
5 they're teaching for people to do. There's no quality control
6 procedures.

7 Like Mr. Evans said, you know, common sense is kind of a,
8 you know, thing that, you know, you're -- when I think that
9 you've demonstrated common sense in asking about the
10 [indiscernible]. I have a 15-year-old child and I see that
11 every single day; he clearly thinks he's exercising common
12 sense and he's clearly not, in my opinion.

13 So I think the common sense questionnaire is a -- what I
14 would call a tool in the toolbox; that it's not -- you know,
15 it's not the magic -- it's not the magic bullet as to
16 Dr. Greenspan's opinion. His use of the common sense
17 questionnaire can be fully explored on cross-examination and
18 totally attacked on cross-examination as to all the different
19 issues, but I don't know that that's the only thing
20 [indiscernible] in his opinion. I think there are other
21 things that are going into his opinion or I expect him to
22 testify that there are other things going into his opinion
23 besides that one thing, and, therefore, I will allow him to
24 testify under 702 and Council and Jones.

25 And so we'll be ready to start with that next?

1 MR. GROSE: Yes, sir. Can we have a --

2 THE COURT: Yeah, we're going to take a break. I just
3 want to map it out, what we're doing.

4 MR. GROSE: Before I move past this, there was an
5 objection to admitting Exhibit 1 as the C.V. --

6 THE COURT: Yeah, we're going to admit that
7 [indiscernible].

8 And then anything else from the State before we take a
9 break and come back to Dr. Greenspan?

10 MR. EVANS: No, Your Honor.

11 THE COURT: Okay. All right. So I'm going to go back on
12 here just to tell him what we're doing. Okay? Just give me
13 just a second.

14 All right. Dr. Greenspan, can you hear me okay, sir?

15 THE WITNESS: Yes, Your Honor. I can.

16 THE COURT: Okay. Wonderful. Thank you very much.

17 So it's about 11:15, give or take a couple of minutes.

18 We're going to take about a ten-minute break because everyone
19 here needs to go to the restroom and get a drink of water and
20 things like that. You're welcome to take that break. If you
21 could just be back -- I'm going to leave the Webex up and
22 running, so if you could just leave yours running, and we'll
23 be back in about 15 minutes, and then we'll start with your
24 testimony. Okay?

25 And I lost him.

1 Let me make sure he can hear me.

2 All right. We'll be in a ten-minute break. Thank you.

3 (A brief recess was taken from 11:14 a.m. to 11:25 a.m.)

4 MR. GROSE: Before we start, I do have a -- I don't know
5 if it's logistical --

6 THE COURT: Okay.

7 MR. GROSE: One logistical matter. Obviously, Mr. Terry
8 is here, and under the security that he's been in the cuffs
9 and that black box all morning ---

10 THE COURT: Okay.

11 MR. GROSE: --- he tells me that his hands are getting
12 numb.

13 THE COURT: Okay.

14 MR. GROSE: And I think his preference would actually be
15 to go back, that he would waive his appearance for this
16 hearing, if the Court would allow it.

17 THE COURT: Okay. And can we not just take his handcuffs
18 off? Who is charge of that? The SCDC people?

19 Hello. Tell me your name.

20 SGT. JONES: Sergeant Jones.

21 THE COURT: Hey, Sergeant Jones. How are you?

22 SGT. JONES: I'm good. How are you?

23 THE COURT: Can we uncuff Mr. Terry?

24 SGT. JONES: You want us to take everything off?

25 THE COURT: No, just his handcuffs.

1 SGT. JONES: Just this black box?

2 THE COURT: Yeah.

3 (Pause in the proceedings.)

4 THE COURT: Starting to get a little feeling?

5 THE APPLICANT: Yes, sir.

6 THE COURT: Okay. Yeah, maybe get him in that chair
7 without arms. That may be a little easier for him to
8 maneuver.

9 Is that better?

10 THE APPLICANT: Thanks, Your Honor.

11 THE COURT: Okay. You're welcome.

12 So Mr. Terry is still with us. We've taken off what they
13 call this black box. Just so the record is clear, Mr. -- I
14 have been now in numerous hearings with Mr. Terry, more than I
15 can remember. His behavior has always been exemplary. He's
16 never been a problem or had an issue or caused any behavioral
17 issues for the Court, so I have no problem doing that.

18 And I can see the marks on his hands where they were
19 digging into him. Somebody should have told me sooner; I
20 would have --

21 MR. GROSE: That's on me.

22 THE COURT: That's okay. I would have been happy to do
23 so.

24 I apologize, Mr. Terry. I didn't -- I didn't know about
25 it, but I have no problem with you being -- with the black box

1 off due to your exemplary behavior throughout all of our
2 hearings. He's never been anything but polite and respectful
3 to the Court, so I appreciate that.

4 And -- okay, we're going to try to make this -- anything
5 else we need to take up before we get into Dr. Greenspan?

6 Mr. Grose?

7 MR. GROSE: No, sir.

8 THE COURT: Okay. Anything else from the State?

9 MR. EVANS: No, Your Honor.

10 THE COURT: Okay. Let's see if we can get this going in
11 the right direction.

12 Dr. Greenspan is still not on your screen. Is he on
13 yours?

14 MR. EVANS: Yes, sir.

15 THE COURT: Okay.

16 MR. GROSE: He's not on mine yet.

17 THE COURT: I don't know that that matters as long as
18 he's on mine and you can see him.

19 All right. Dr. Greenspan, can you hear me?

20 THE WITNESS: Yes, sir, I can.

21 THE COURT: Okay. Great. And make sure you speak up.
22 Okay?

23 THE WITNESS: Doing my best, sir.

24 THE COURT: Okay. And why don't you let him use the --
25 is he on yours, Ms. Franz?

1 MS. FRANZ: Yeah, [indiscernible].

2 Dr. Greenspan, can you hear us?

3 THE COURT: I can't hear him.

4 MR. GROSE: I don't know why mine's not.

5 THE COURT: It's because there's not enough internet in
6 these buildings to run six and seven computers on a video
7 system.

8 (Pause in the proceedings.)

9 THE COURT: Hang on just for a minute, Dr. Greenspan.
10 We're trying to set something up different.

11 (Pause in the proceedings.)

12 THE COURT: All right. Dr. Greenspan, can you hear me?

13 THE WITNESS: Yes, sir.

14 THE COURT: Okay. You're going to need to speak up. You
15 have got to keep your voice up.

16 THE WITNESS: Okay.

17 THE COURT: Louder.

18 THE WITNESS: I'll do my best.

19 THE COURT: That's the level you need to be at. Thank
20 you.

21 THE WITNESS: Basically shouting. I need to get a
22 microphone.

23 THE COURT: Ready?

24 MR. GROSE: Yes, sir.

25 DIRECT EXAMINATION

1 BY MR. GROSE:

2 Q All right. Dr. Greenspan, can you hear me?

3 A I don't hear Mr. Grose.

4 THE COURT: You're muted.

5 MR. GROSE: Oh.

6 BY MR. GROSE:

7 Q Can you hear me now?

8 A Yes, sir.

9 Q All right. The judge has qualified you as an expert. So
10 what I want to do is turn to the substance of your testimony.
11 And could you explain what is meant by the term "intellectual
12 disability"?

13 A Yes, it's a condition which has been called various other
14 names over the years. Previously, before that, mental
15 deficiency. Before that, idiocy and other terms that today
16 are no longer acceptable.

17 Around 1960, the organization now known as AAIDD
18 published a manual which defined it as a condition
19 characterized by deficiencies in intellectual functioning,
20 adaptive functioning, and with onset in the so-called
21 developmental period.

22 Q Okay. And are there various tools or resources that are
23 used as guides for diagnosing intellectual disability?

24 A Well, there are these three prongs that I just mentioned,
25 and within each prong, there are methods that are used to try

1 to get at whether a person qualifies on that prong. But
2 there's not really a standardized method. I have been
3 involved in cases where a Court made a determination of
4 intellectual disability without any formal instrument.

5 And of course there are different levels of severity and
6 in the cases of the most severe impairment, you don't even
7 really need an instrument; it's pretty obvious.

8 Q All right. Well, before we get into certain instruments,
9 there was some discussion earlier about the DSM-5-TR. Does
10 the DSM-5-TR provide diagnostic criteria for ID?

11 A Yes. It's the same three criteria that I just mentioned
12 and that are also mentioned in the South Carolina criminal
13 code.

14 Q Okay. So you have had an opportunity to compare the
15 definition in the South Carolina Penal Code with the DSM-5-TR
16 definition?

17 A Yes. It's basically the same, except they use the word
18 "adaptive behavior" as opposed to "adaptive functioning,"
19 which suggests to me that they derived it more from AAIDD
20 because that's the term they use. But the three
21 definitions -- AAIDD, DSM-5, and the South Carolina Code --
22 are essentially identical.

23 Q And so, as I understand it, there's three prongs: The
24 subaverage intelligent functioning, deficits, and adaptive
25 behavior and onset in the developmental period; is that

1 correct?

2 A Yes, sir.

3 Q All right. Can you define for the Court what the
4 developmental period is?

5 A I'm sorry; I lost you there.

6 Q Can you please define for Judge Hood what the
7 developmental period is?

8 A Childhood or adolescence? DSM doesn't really define it.
9 They use the term "developmental onset" or "developmental
10 period." AAIDD, at one time, defined it as "before the age of
11 16" then they changed it to "before the age of 18," and now
12 it's defined as "before the age of 22."

13 But we're basically talking about onset while the person
14 is still developing in terms of their brain capacity. If the
15 onset occurred in a 30-year-old, they might be diagnosed with
16 dementia or mental disability rather than -- they would be
17 diagnosed with dementia, which is now called something else.
18 I can't remember what. But they would not be eligible for
19 diagnosis. Intellectual disability has to occur before the
20 age of 22.

21 Q All right. I want to focus on Prong 1, the subaverage
22 intellectual functioning. Can you tell the Court what that
23 means?

24 A Thinking, problem-solving, abstract reasoning. Very
25 close to academic potential in that the most common way of

1 getting at it is an IQ test, and the IQ test is basically
2 derived from academic achievement instruments. And academic
3 achievement is also very closely related to this prong.

4 Q And can you explain a little bit more about what an IQ
5 test is?

6 A I'm sorry; is there a question?

7 Q I'm sorry. Can you explain a little bit more about what
8 an IQ test is?

9 A Yes. IQ refers to intellectual quotient. It was
10 invented around the beginning of the 20th century, around
11 1905.

12 MR. EVANS: Your Honor, I would raise an objection. It
13 looks like he's reading something and not testifying. So I
14 would like to know what he's reading and why he's not actually
15 testifying from his knowledge. I mean, that's what it looks
16 like to me. Looks like he's not looking at the camera but
17 looking at a page.

18 THE COURT: You can ask him about that on
19 cross-examination.

20 MR. GROSE: Thank you, Judge Hood.

21 BY MR. GROSE:

22 Q Dr. Greenspan, the judge has overruled the objection so
23 if you could continue explaining what an IQ test is.

24 A Yeah. It's short for intellectual quotient. The first
25 IQ test was developed in France by Binet and Simon -- Simon --

1 and, basically, they took items from the educational
2 curriculum at a time when universal public schooling was first
3 coming about, and that -- and then they administer these items
4 to people of different ages or grade levels. And then they
5 came up with what they called mental age, which later was used
6 statistically to convert it into quotient, which basically
7 indicates where someone falls in the continuum in terms of
8 percentile rank.

9 And in the United States, a professor at Stanford
10 University took the Binet and standardized it and translated
11 it, and that became the Stanford-Binet, which was the first
12 American instrument. And that's still around. But then David
13 Wechsler, W-e-c-h-s-l-e-r, in New York came up with his own
14 version.

15 And those are the two most widely used instruments: The
16 Wechsler scales, which is one for children called the WISC --
17 Wechsler Intelligent Scale for Children -- and the WAIS,
18 W-A-I-S -- Wechsler Adult Intelligence Scale, and then the
19 Stanford-Binet. And then a third widely used instrument today
20 is the Woodcock-Johnson Cognitive Battery. Those are the
21 three-most widely used measures of intelligence today.

22 So that's what IQ is. IQ basically measures the ability
23 to reason abstractly. One criticism that I have made over the
24 years is their aspects of intelligence, particularly social
25 intelligence, that are not really tapped by IQ. And that's

1 why we came up with the second prong, adaptive behavior.

2 Q Well, sticking with the first prong for a moment, what is
3 the role of IQ testing in Prong 1?

4 A Well, as I said, there are three tests that are widely
5 used. The Wechsler, W-e-c-h-s-l-e-r, Scales with child and
6 adult versions; the Stanford-Binet, which was not used in this
7 case; and the Woodcock-Johnson, which was used in this case.

8 Q And how are tasks like the Wechsler scales and the
9 Woodcock-Johnson used in diagnosing ID?

10 A Well, as a general rule, agencies for the courts or
11 Social Security or adult service agencies use a cutting score
12 of 75; until recently, it was 70. That's a standard score
13 derived from testing of a large standardization sample. And a
14 score of 75 puts someone at the 5th percentile, which means
15 95 percent of the population does better on that test.

16 So a standard score of 75 on either of the Wechsler
17 scales or the Stanford -- or, in this case, the
18 Woodcock-Johnson would be a qualifying score, but then it's
19 important to make corrections for possible unreliability of
20 the score, the most common such correction is called the Flynn
21 Effect -- F-l-y-n-n -- which looks at the fact that norms
22 become obsolete. In order to be able to compare scores across
23 different years or tests, it's important to make such
24 corrections.

25 Q Okay. And the word "Flynn," is that -- Flynn, is that

1 the name of the person who did the research?

2 A Yes, the main person, but others have also. In England,
3 they call it the Lynn Effect, L-y-n-n, or the Lynn-Flynn
4 Effect.

5 He is an American who moved to New Zealand and was very
6 interested in -- and discovered the fact that test publishers
7 update their norms every time they come up with a new edition,
8 and he was able to come up with a correction factor for making
9 scores across different versions, put them on the same
10 metrics, so it's fair to compare people.

11 Q All right. And is the Flynn Effect scientifically
12 recognized?

13 A Yes. There have been at least a hundred studies of the
14 Flynn Effect. With maybe one or two exceptions, everyone
15 accepts it as valid and important.

16 Q And is it accepted by the DSM-5-TR and the AAIDD manual?

17 A Yes, both mention it and say that Flynn [indiscernible]
18 should always be made in any case when diagnosing intellectual
19 disability.

20 Q And the term "norm obsolescence" is often used with the
21 Flynn Effect. Can you explain what that means?

22 A Yeah. I want to try to keep it from becoming too
23 complicated. Basically, when they come up with a new version
24 of a test, I'd say the WAIS-4 or as opposed to the WAIS-3,
25 which is the third edition, the previous edition, they'll take

1 a sample of let's say 100 or so subjects in the
2 standardization sample, and they'll give them both the old
3 version and the new version, and they'll counterbalance the
4 order and also allow a few months to elapse because it's
5 similar and is likely to occur because there's quite a few
6 items that are the same.

7 And what they find over and over again is that scores go
8 down on the new -- on the new test because, paradoxically,
9 performance goes up. So the test publisher has to adjust the
10 norms in order for everybody in the population to have a mean
11 score of 100, which puts you at the 50th percentile.

12 So that's how it's calculated.

13 Q I want to switch gears a little bit. What is meant by
14 "standard error of measurement"?

15 A Well, it's highly unlikely that someone will perform
16 exactly the same every time they take a test or every time
17 they do any activity, whether it's swinging at a baseball or
18 anything else for that matter.

19 So standard error is a statistical concept that refers to
20 the likelihood that a score is valid; that is, it will fall
21 within a range. It's say the 90th percentile. You can be 90
22 percent confident that this is a true score.

23 So the standard error for IQ tests is generally about
24 five points, which means that the obtained score falls in a
25 range plus or minus five of where that person's true

1 intelligence is likely to fall.

2 Q And what is meant by the practice effect?

3 A Well, the practice effect refers to the learning that
4 occurs when you take a test. So if you administer the same
5 test to someone, let's say a week or a month apart, they're
6 almost always likely to do better the second time because
7 they're more familiar with the items. And this is especially
8 likely to occur with items that are, you know, what's called
9 practical or performance intelligence because these are
10 unique. They're puzzles. They're things that you wouldn't
11 necessarily learn in school, whereas the verbal intelligence
12 items are, in fact, things that are fairly commonplace within
13 school settings.

14 So in order to correct for the possibility that there's
15 some learning [indiscernible], the recommendation made in the
16 manuals, DSM and AAIDD, is to wait at least six months before
17 administering the same test.

18 So let's say you have two psychologists coming in to
19 evaluate the same person at around the same time; they should
20 not use the same tests. If one uses the WAIS, the other
21 should use the Woodcock-Johnson or the Stanford-Binet.

22 But even there, there's likely to be some cross-learning
23 because some of the items are very similar.

24 Q All right. I want to switch gears and talk about Prong
25 2, the deficits in adaptive behavior. Can you explain what

1 Prong 2 is all about?

2 A Yes. In the old days before IQ tests -- and I'm talking
3 about 19th century or early 20th century, before we had IQ
4 tests, if we were to say someone has intellectual disability
5 or whatever, the term was used back then probably "idiocy" or
6 "imbicility", it would be based on their behavior, the fact
7 that everyone saw them as impaired, unable to live
8 independently or to do -- or to deal with various problems
9 suggests being overly influenced by other people.

10 But with the development of the IQ test, that tended to
11 be all that was used. But it became obvious that that was too
12 limiting. For example, when IQ tests was very popular through
13 the first half of the 20th century and on into the second
14 half, around the same time that classes in special education
15 became developed, too many kids were put in special classes
16 solely on the basis of IQ, even though they could function
17 fine in society or even in the social world or the school.
18 And the minority of the individuals or poor individuals were
19 particularly likely to be overrepresented with the ID label.

20 So as a corrective against that tenancy, the concept of
21 adaptive behavior or adaptive functioning was developed, and
22 that refers to less to how somehow functions in the classroom
23 and more to how they function in the community or in their
24 family or in their peer group.

25 Q Are there different domains for assessing adaptive

1 functioning?

2 A Yes. And this is why I became heavily cited, because,
3 initially, there was no real definition of adaptive behavior.
4 It wasn't really differentiated very much in terms of
5 different domains.

6 So around 1980 or so, I proposed that there are three
7 components of adaptive behavior: Conceptual adaptive
8 behavior, social adaptive behavior, and practical adaptive
9 behavior. Those are the domains that are still used and cited
10 and why I'm so heavily cited.

11 According to the manuals, AAIDD and DSM, one has to be
12 impaired in only one of these three domains, not all three.
13 And that refers to the fact that people with ID, particularly
14 what's called mild ID or high-functioning have differentiating
15 profiles. They could be relatively normal in some areas but
16 definitely impaired in one or more areas.

17 Q Can you explain what's meant by the conceptual domain?

18 A Yeah, things like counting, telling time, keeping track
19 of money, use of language, able to communicate, that sort of
20 thing.

21 Q And can you explain what's meant by the social domain?

22 A Understanding people, understanding social situations,
23 ability to come up with effective problem-solving, knowing
24 what to do if you find somebody's wallet in the street, for
25 example.

1 Q And can you explain what's meant by the practical domain?

2 A Ability to deal with objects, mechanical objects or
3 processes. Getting around using public transportation or
4 other modes of transportation.

5 Q And I believe you already touched on this but does
6 somebody have to have deficits in all three domains or not?

7 A No. As I mentioned, you only need -- at least according
8 to the manuals, one has to be significantly impaired in only
9 one of these three domains. At least that's the way the
10 manual approaches it.

11 Q And of course the manuals are accepted by the scientific
12 community.

13 A Yes. And by the legal community.

14 Q All right. Can somebody with an intellectual disability,
15 particularly a mild intellectual disability, have
16 relatively --

17 A You're kind of fading in and out, Mr. Grose.

18 Q I'm sorry. Can somebody with an intellectual disability,
19 particularly a mild intellectual disability, have relative
20 strengths?

21 A Yes. The term "mild" is a misnomer. It implies it's
22 insubstantial. In fact, until recently, people with mild
23 disabilities -- intellectual disability weren't
24 institutionalized and they still are eligible for various
25 government benefits and voc rehab, that sort of thing.

1 But one of the findings of the research community in
2 recent years is that people with intellectual disability can
3 do many things, contrary to the common stereotype that they're
4 globally impaired. I mean, there was some research by the
5 U.S. Department of Education following up people with
6 intellectual disability and as the -- as well as other
7 impairments, and what they found is that, five years later,
8 ten years later, people with intellectual disability or
9 labeled with intellectual disability can do all kinds of
10 things. They can get married, hold a job. Most people with
11 intellectual disability are employed in one way or another and
12 often have -- they have more skills than we gave them credit
13 for in the past.

14 Q And the third prong of intellectual disability is onset
15 during the developmental period. And of course you have
16 already talked about what that means, but how does the onset
17 and developmental period relate to Prong 1 and Prong 2?

18 A Because the continuity of concern. It doesn't mean that
19 they were labeled in the developmental period because a lot of
20 factors, such as School Board policy or competence of
21 evaluators or family attitudes. It means that there's always
22 been a continuity of concerned people wondering about whether
23 the person could achieve -- for example, being held back at
24 school, retained, which happened in this case. That's a
25 concern about the person's ability to learn.

1 And the other thing to understand about the developmental
2 period is that we're not necessarily talking about onset in
3 early childhood or in utero or in the childhood, period.
4 Since the developmental period is defined up to age 22, you
5 could have someone functioning okay and have some accident or
6 other event happens -- illness -- at age 18 or 19 and becomes
7 seriously impaired or more impaired. That's qualifying
8 because it happened during the developmental period. It
9 doesn't have to happen early on, although typically it does.

10 Q With regard to Prong 1, is it possible to rule out an
11 intellectual disability based on an I-score or other score
12 over a certain level?

13 A No. In fact, that was the key issue in Hall v. Florida,
14 I believe, because they decided because his score -- he had
15 one or two high scores, there's no point even evaluating Prong
16 2. And the Court ruled that's not proper; they should have
17 evaluated Prong 2. And that's where the quote I mentioned
18 before, "It's a condition, not a number." You should always
19 evaluate for both Prong 1 and Prong 2, even if the scores on
20 Prong 1 fall above this very arbitrary 75 plus or minus
21 number.

22 So -- and, also -- and I have written about this subject.
23 It speaks to the reliability issue. There's always going to
24 be some variation in scores. You might have some qualifying
25 scores and some high scores, and there are all kinds of

1 possible explanations, including possible corruption on the
2 part of an evaluator or incompetence. And one should not
3 assume that only the high score is valid.

4 Q With regard to Prong 2, is it possible to rule out an
5 intellectual disability based on a particular adaptive
6 behavior, skill, or accomplishment?

7 A No. And this is probably the major misconception in
8 Atkins cases. The manuals basically state that ID is ruled in
9 by incompetence but is not ruled out by competence. Because
10 there's quite a bit of variability, including the fact that
11 you only need to be deficient in one out of three areas of
12 adaptive behavior, there are always going to be some -- except
13 in the most, most severely impaired people -- globally
14 impaired, you're always going to find the pattern of skills
15 and deficits. And this, in part, reflects the -- what's
16 called the modularity of brain damage and basically would --
17 when we're talking about ID, we're talking about the outward
18 manifestation of brain damage, since the brain is the --
19 effects or determines intelligence.

20 Some forms of brain damage will affect certain areas of
21 skill more than others. So it's a mistake to do what's called
22 cherry-picking, for two reasons. One, because it's always
23 going to be some variability, and two, because we don't always
24 know the context -- like, for example, I have been involved in
25 cases where someone was described as a roofer. If you

1 actually looked at their job performance, they were never
2 allowed on the roof because it was considered dangerous for
3 them or the people down below where they would throw material.

4 So the fact that someone has some areas of skill, that's
5 part of the disorder. That's part of being human and should
6 never be used to rule out ID.

7 On the other hand, if someone has clear deficiencies,
8 that could be indicative of ID. But the fact they have some
9 areas of competence should never be used to rule out ID.

10 Q Earlier, I asked you a question about intellectual
11 disability being a condition and not a number. Can you
12 explain what that means in your profession?

13 A Yes. And this is especially important at DSM as opposed
14 to AAIDD. AAIDD is an organization made of mainly people
15 who -- bureaucrats who work either for state agencies or local
16 service agencies or disability determination agencies. For
17 the most part, the people making these determinations don't
18 have the -- either the skills or the opportunity to look at
19 the individual.

20 They also have a large complement of psychologists who
21 tend to worship numbers, especially if they come from an IQ
22 test.

23 And so their -- they tend to have more of an emphasis on
24 numbers -- DSM, which is published by the American Psychiatric
25 Association, which is a medical organization.

1 And I should also point out that, when the Supreme Court
2 cites authorities because they have never come up with their
3 own definition of intellectual disability, they leave it
4 pretty much up to States to do that. They always -- the
5 Supreme Court always refers to DSM and the American
6 Psychiatric Association. There's much less discussion, if
7 any, on AAIDD.

8 In the medical profession, to my knowledge, is not a
9 single medical condition -- psychiatric condition. It's
10 diagnosed based on a number on a test. There may be tests
11 which suggest the possible disability or disorder, but the
12 disorder is always diagnosed qualitatively by a clinician
13 using clinical judgment and looking at various sources of
14 information.

15 And so you can have a low number on a particular medical
16 test and still have somebody who is impaired. And vice versa.
17 And that's kind of how they approach intellectual disability
18 as well. It's a more wholistic approach, looking at the
19 person and not just relying solely on a test number.

20 Test numbers can be useful, but you have to go beyond
21 them. And that's pretty much [indiscernible] see the
22 disorder.

23 Q In order to diagnose intellectual disability, is it
24 necessary to determine what the causation is?

25 A No. Typically, we don't know. I mean, there are well

1 over a hundred possible causes of intellectual disability. In
2 the majority of cases, we don't know the cause and we don't
3 need to know the cause.

4 Now, if we know the cause, that's usually helpful and
5 important, but ID is what's called a functional diagnosis.
6 You either meet the criteria or you don't. It doesn't matter
7 what the cause might be.

8 Q While it's not necessary to determine the cause, can you
9 give the Court some examples of what could cause an
10 intellectual disability?

11 A It could be an infection such as meningitis or
12 encephalitis, which typically occurs when the individual is a
13 child. It could be the cutoff of oxygen during the birth
14 process, a cord wrapped around the neck, let's say. And that
15 would be anoxia or hypoxia. Anoxia is the total cut-off of
16 oxygen; hypoxia is a partial cut-off.

17 It could be a traumatic brain injury. It could be a
18 genetic condition such as Down syndrome, which effects brain
19 development.

20 Q How could a traumatic brain injury --

21 A Could be malnutrition. Any number of causes.

22 Q How could a traumatic brain injury play a role in causing
23 ID?

24 A Yes. Traumatic brain injury is one of the major known
25 causes. My brother, for example, was dropped on his head by a

1 baby nurse when he was three days old, and he has intellectual
2 disability. As a result of that, in fact, the first lecture I
3 went to when I was being trained in intellectual disability at
4 UCLA was by a famous British psychiatrist named Michael
5 Rutter, R-u-t-t-e-r, and it was all about the role of
6 traumatic brain injury in causing both autism and intellectual
7 disability. And my brother has autism in addition to
8 intellectual disability.

9 Now, a subvariant of traumatic brain injury is fetal
10 alcohol spectrum disorder or fetal alcohol syndrome where
11 maternal drinking during pregnancy damages the brain and
12 basically causes a traumatic brain injury but it's caused
13 internally rather than being hit on the head. And that's
14 become a major interest of mine in recent years.

15 Q For traumatic brain injury to play a role in causation of
16 ID, does it have to occur prenatal or during infancy?

17 A No. It can occur at any time during the developmental
18 period. And I should also point out that these causes are not
19 necessarily mutually exclusive. For example, you could have
20 someone who was impaired, whether or not it reached the level
21 of intellectual disability, in childhood as a result of
22 sniffing glue or maternal consumption of alcohol or drugs or
23 other things such as birth anoxia and then complicated -- as
24 complicated by head injuries or a major head injury when
25 they're either an adolescent or before the age of 22. And

1 that can kind of push him over the edge because causes, risk
2 factors tend to multiply -- have a multiplier effect. And if
3 you have multiple causes, you're likely to have a more severe
4 impairment.

5 And, of course, social factors such as family and
6 education play into that as well. For example ---

7 Q Do you need a break to get a drink of water?

8 A --- from maternal anoxia. The major study in Hawaii
9 where they looked at kids who suffered birth anoxia, cord
10 wrapped around the neck, cut-off of oxygen. The ones who were
11 from upper-class families or upper/middle-class families, for
12 the most part, recovered. The ones from more impaired
13 families or marginally functioning families, that made it
14 worse. They did not recover because they weren't stimulated
15 enough.

16 Q Are there various stereotypes regarding intellectual
17 disability or people with intellectual disabilities?

18 A Yeah, there are many stereotypes.

19 Q Can you give us an example of some of those?

20 A That it's obvious that you can look at somebody. Sorry.
21 I was on the board of an ARC, A-R-C, Association for Retarded
22 Citizens, and one of the board members turned out to be a
23 person with intellectual disability who was served by the
24 agency, and it took me six months to figure that out because
25 they had good superficial social skills, I would have called

1 them, cocktail party skills, "How are you?" sort of thing.
2 But after a while, it became obvious because they had a
3 limited repertoire; they'd keep repeating it.

4 So, for the most part, people with intellectual
5 disability look normal and have relatively normal social
6 skills. So you can't really tell from looking at somebody.
7 That's a major stereotype. And of course the other major
8 stereotype I have mentioned is that their adaptive functioning
9 limitations are global. It affects every area. That's
10 probably the biggest because, in fact, people with
11 high-functioning intellectual disability always have areas of
12 relative functioning, things like having girlfriends or
13 holding jobs or things of that sort.

14 I can't tell you the number of cases I have been involved
15 in where a relatively normal woman, educated, sometimes
16 professional, falls in love with and marries a guy with an
17 intellectual disability because they're nice to them or
18 they're good providers, if they happened to belong to a gang,
19 let's say.

20 So whatever the role is, you're going to find some people
21 with intellectual disability playing it, whether it's driving
22 a car or any of that sort of thing.

23 Q Can stereotypes regarding intellectual disability result
24 in mistakes in diagnosis?

25 A Can you repeat that? Sorry.

1 Q I'm sorry. Can the stereotypes that you have mentioned
2 regarding intellectual disability, can they result in mistakes
3 in making a diagnosis?

4 A Yes. It's a very common problem. I see it all the time
5 both in civil and criminal cases.

6 Q In diagnosing an intellectual disability, what role does
7 clinical judgment play?

8 A Well, it's very important. We don't want to have the
9 diagnosis made by a computer, and there's not one other
10 condition in the DSM-5 -- as I said, there's several
11 hundred -- where clinical judgment doesn't play a role. And
12 that's true of ID as well. But it's important to know what we
13 mean by clinical judgment.

14 Q Can you explain that? Can you explain what's meant by
15 clinical judgment?

16 A Yes. I mean, for one thing, you need to have a clinician
17 with experience. Particularly in this case, people with
18 relatively high-functioning ID because, in criminal cases,
19 that's really what we're talking about. If the person were
20 more severely impaired, most likely, they would have been
21 diverted and not tried. And often you'll have an expert who
22 has worked in institutional settings where the reference group
23 that he's familiar with is much more globally and severally
24 impaired or they may have had training many years ago when the
25 stereotypes were more widely accepted.

1 But part of the clinical judgment is being able to
2 context of the testing and know when test results are to be
3 taken less seriously than other occasions. And people put it
4 all together. And very often you have [indiscernible] of
5 cases. They may be very competent clinicians generally,
6 particularly around mental health issues, but they often have
7 little or no training or familiarity with the literature on
8 intellectual disability.

9 So, basically, their opinion is that of a layperson,
10 essentially, with all the stereotypes that lay people have
11 about intellectual disability.

12 Q How has the scientific community's understanding of
13 intellectual disability changed over the years?

14 A Well, in several ways. One, we no longer use highly
15 pejorative terms, like "mental deficiency" or "mental
16 subnormality" or even "mental retardation." We try to be more
17 respectful in the terminology that we use.

18 But -- and, actually, some other countries -- in Europe,
19 in particular -- where the fight to change the terminology to
20 "intellectual disability" -- initially, it was resisted in
21 this country, but -- AAIDD, for example, used to be AAMR, and
22 the first vote to change it to AAIDD was turned down. The
23 professionals eventually got on board with it.

24 But probably the major change has been, like, accepting
25 the -- and this is based on a lot of empirical evidence. It's

1 not a globally disabling condition, at least at the upper
2 levels of it; that people, in fact, do have competencies, and
3 that's a major change.

4 And then, of course, more acceptance of -- at one time,
5 even after the definition of -- the three-part definition was
6 developed in the 1970s or 1980s. For at least ten years
7 nobody used Prong 2. Now, it would be considered
8 unprofessional not to look at Prong 2.

9 Q And then, earlier, you talked sort of about the
10 development of Prong 2 over the years as far as the scientific
11 community's understanding.

12 A Yes. Well, I mean, the first instrument to get at Prong
13 2 was developed at an institution in Iowa, and the focus was
14 on very low-level behavior -- [indiscernible] bathroom by
15 himself or dress himself. And that was a time when not only
16 were the institutions made of primarily with people with
17 severe disorders ; today, we don't even have very many
18 institutions anymore. They have been closing down. The
19 service model used today is mostly group homes or people
20 living independently with supports. Institutions are becoming
21 a dying breed, so to speak.

22 But as people moved into the community, it became obvious
23 that Prong 2 -- more meaningful approach to Prong 2 is not
24 whether the person can feed themselves or go to the bathroom by
25 themselves but, rather, can they cope with the temptations that

1 exist when they're on their own in the community and likely to
2 be exploited in one way or another. And that's why the
3 importance of social awareness has kind of [indiscernible]
4 much more than in the past.

5 Q When we were going through your qualifications as an
6 expert, the term "adaptive intelligence" came up. Can you
7 remind us what that means?

8 A Yeah, that's a term that was actually used in the DSM-5
9 when the committee and the chairperson, James Harris --
10 Dr. James Harris, a psychiatrist -- no longer alive -- was
11 writing the text for DSM-5 and DSM-5-TR in the section,
12 "Intellectual Disability." He used that term to make the
13 point that the most critical aspect of adaptive behavior or
14 adaptive functioning, which is what DSM calls it, is things
15 like risk awareness, the application of intelligence to
16 real-world situations.

17 And one reason I'm cited a lot is because that's been my
18 emphasis over the years.

19 Q Has the scientific community's understanding of change
20 and understanding of intellectual disability also included
21 neuropsychological testing?

22 A Yes. When I started out quite a few years ago, you'd see
23 an IQ test and that would be -- or maybe educational
24 achievement, that would be -- you would never see any testing
25 or testimony by a neuropsychologist [indiscernible] specialty

1 within clinical psychology. Today, it would be an exception
2 to not see that. It's almost always the case that a
3 neuropsychologist and neuro[indiscernible] are used.

4 And as I said before, the DSM-5, it even states that, in
5 cases where there's a belief, based on Prong 2, that the
6 person has ID but IQ scores are too high, then you should look
7 at neuropsych testing as, in some ways, a better indicator of
8 Prong 1 than IQ.

9 Neuropsych testing kind of falls at the interface between
10 Prongs 1 and 2, and, for that reason, it's very important.

11 Q Now, earlier, you said that a person can have the
12 condition called intellectual disability even though that was
13 not diagnosed during the developmental period; is that right?

14 A Yes. All kinds of reasons for that, some of them having
15 to do with changes in the climate of what's acceptable. For
16 example, the incidents of diagnosed ID in schools has gone
17 down at the same time that the incidents of diagnosed autism
18 has gone way up. And the reason for that is that parents --
19 nobody wants their kid to be labeled ID. It implies
20 hopelessness. Autism is more acceptable, including people who
21 are kind of at the normal end of the spectrum, and it's a more
22 socially acceptable diagnosis, so it's just not diagnosed as
23 much in schools. That doesn't mean the kids don't have it.
24 And where it becomes evident is that they have it later when
25 they leave school and they have trouble coping, or they might

1 cope very well.

2 But, as an adult, that's where you -- parents will
3 sometimes have a change of heart when they realize that their
4 son or daughter is always going to need support, and a more
5 optimistic label, such as learning disability or ADHD or
6 autism, doesn't provide them what they need.

7 Q So is it possible to diagnose an adult or somebody who is
8 outside of the developmental period as having an intellectual
9 disability?

10 A Yes. Sorry; my shoulder is locking up here.

11 It's very common. I see it all the time in Atkins
12 proceedings where the person was not labeled as ID earlier for
13 various reasons. Some irrelevant, extraneous, so to speak.
14 And then they're appropriately diagnosed by experts as adults.

15 So it's not only a possible; it's very common in my
16 experience.

17 Q So in order to go about diagnosing somebody -- in this
18 case, in an Atkins context -- how do you go about doing that?
19 What procedures do you follow?

20 A Well, the first step is to look at what's available. I
21 mean, if somebody has had multiple measures of cognition and
22 IQ or other indicators, my job is not to give another IQ test,
23 although that's not necessarily something I do anymore, but,
24 rather, to make sense of what's there. And the same is true
25 of all the other evidence. In these cases, there's usually a

1 plethora of evidence and reports, and what's needed is
2 somebody knowledgeable about ID to make sense out of it and
3 pull it together. So that's the starting point.

4 Now, there may be occasions where I take a more active
5 role, particularly around Prong 2, and interview people
6 sometimes using a formal instrument, not always. And I have
7 seen many cases where an ID determination was made by the
8 Court where there was no formal instrument.

9 In this case, there is one, but it was done early on.

10 Q And we'll come back to that. Go ahead, I'm sorry.

11 A So it depends on the case, but it's -- the role of the
12 clinician, such as myself, is to use clinical judgment and
13 experience to indicate whether the evidence seems to support
14 ID or not, and often, this involves looking at reports by
15 other experts and indicating which ones I consider valid and
16 which I consider questionable.

17 And then I would not typically make a formal diagnosis if
18 I haven't met the person. Rather, I would indicate whether
19 the evidence is congruent or not. If I have met the person,
20 then I would feel more confident ethically to say whether I
21 thought they had ID.

22 Q As part of doing an assessment in an Atkins case, what
23 role does reviewing records play?

24 A It's a starting point. I see it as very critical. I can
25 often get everything that I need from the records.

1 Q And what do you mean by that?

2 A Well, if people expressed concern about the individual's
3 functioning, if there's a lot of evidence that he or she --
4 usually he -- was failing in school or was unable to keep a
5 job, was unable to do various things that you would expect
6 somebody for their age to be able to do, that's all important.
7 That's a lot more important than anything I could get out of
8 meeting the person for an hour or two in a prison setting.

9 Q And you mentioned testing a minute ago, and you said you
10 could review what's available. Is there any requirement that
11 you actually administer a test yourself?

12 A No. Well, I mean, obviously my role differs according to
13 the case and what I'm asked to do. But I think my most
14 valuable contribution in these cases is usually as a teaching
15 expert, whether I diagnose it or not, because courts -- and
16 lawyers too, for that matter -- typically don't have
17 professional training in ID and they may not understand the
18 literature on it.

19 Q You mentioned clinical interviews. What's the role of
20 clinical interviews in diagnosing intellectual disability in
21 the Atkins context?

22 A Well, the interview has to be structured in some way. I
23 can't just go in there and shoot the breeze with the person,
24 although that could be interesting.

25 So every interview in this kind of setting is clinical.

1 It's for the purpose of drawing conclusions about the person.

2 Q All right. And then that would include interviewing the
3 person to be diagnosed or not diagnosed with an intellectual
4 disability?

5 A Yes, as well as percipient witnesses, so people in the
6 family, teachers, people who know him well, because they have
7 information that I could never develop, whether I use a test
8 or not.

9 Q And speaking of tests, with regard to Prong 1, is an IQ
10 test the only way to assess intellectual functioning?

11 A No. As I mentioned before, IQ and educational
12 achievement, they're very closely related in part because the
13 first IQ test we developed from achievement tests or
14 achievement curricula, and, to a large extent, that remains
15 the case today. [Indiscernible] educational achievements,
16 such as the Wide Range Achievement Test, which is commonly
17 given, as it was in this case, is important. Grades -- if a
18 person is failing, although there can be various reasons why
19 someone is failing. If a person is retained in school, held
20 back. A lot of different indices, including test indices,
21 such as neuropsych data, as I mentioned. Neuropsych data can
22 be more useful than IQ data.

23 You would like it to be congruent, all of it, more or
24 less the same, but quite often, you find some discrepancies.
25 And then clinical judgment comes in to play in determining

1 what's important.

2 Q And as far as Prong 2, you mentioned earlier that there's
3 some instruments to help diagnose the deficits in adaptive
4 functioning. Is an instrument like that required?

5 A No. I have been involved in many number of cases where
6 there was no such formal instrument.

7 Q And then that gets back to the clinical judgment as one
8 of the ways of doing it; is that right?

9 A I missed the first few words there.

10 Q And then that gets back to clinical judgment?

11 A Yes. I mean, sometimes we're talking about quite a few
12 years have passed before the person was in the family or in
13 the school. People may have died off. People's memories
14 might have faded. It may be hard to find appropriate
15 witnesses, and these instruments require some degree of
16 certainty by the person filling it out. A very limited number
17 of guesses are allowed.

18 Q All right. I want to --

19 A That's just one way of -- there's just one way of getting
20 at it. It's not the only way or necessarily the best way.

21 Q All right. I want to switch gears and talk about Gary
22 Terry now. Were you asked to do an evaluation of Gary Terry?

23 A Yes. Yes, I was.

24 Q And did that include a clinical interview of Mr. Terry?

25 A Yeah, done remotely at the jail or prison.

1 Q And did that include interviewing collateral witnesses?

2 A Yes.

3 Q And did that include interviewing [sic] records -- both
4 social history records and reports from other -- other
5 evaluators?

6 A Yes. I think you misspoke; you used the word
7 "interview." I reviewed all that stuff.

8 Q Okay. And did you form an opinion as to whether or not
9 Gary Terry is a person with an intellectual disability?

10 A Yes, I did form an opinion.

11 Q And what is that opinion?

12 A Mr. Terry qualifies under South Carolina statute and the
13 major manuals -- diagnostic manuals as someone with an
14 intellectual disability.

15 Q And that's the DSM-5-TR and the AAIDD manuals?

16 A Yes.

17 Q Now, as part of your review in this case, the records
18 that you reviewed, did you review a number of records?

19 A I'm sorry; you faded there.

20 Q I'm sorry; I moved away from the screen.

21 As part of your evaluation, did you review records
22 regarding Gary Terry?

23 A They're all mentioned in my report. It's quite a few
24 records.

25 Q Okay. And I want to ask you specifically about certain

1 records, whether you reviewed them. Do you have access to
2 that Dropbox file we sent?

3 A I have another screen here and it's right in front of me.
4 Go ahead.

5 (Applicant's Exhibit No. 5, School Records, was premarked
6 for identification.)

7 BY MR. GROSE:

8 Q All right. One of the documents that we sent you was
9 premarked as Applicant's Exhibit No. 5, which is school
10 records -- it's about 140 or '42 pages. Did you review that?

11 A Yes, I did.

12 Q And we also sent you Applicant's Exhibit No. 6, which is
13 one page from the South Carolina Department of Corrections
14 records. Did you review that?

15 A Yes.

16 (Applicant's Exhibit No. 7, Richland Memorial Hospital
17 Records, was premarked for identification.)

18 BY MR. GROSE:

19 Q One of the records that we sent you was Applicant's
20 Exhibit No. 7, which is records from Richland Memorial
21 Hospital. Did you review that?

22 A Yeah. But I missed the number. You kind of pulled away
23 there. What is it?

24 Q Applicant's Exhibit No. 7.

25 A Yes.

1 Q We also sent you Applicant's Exhibit No. 8, which is also
2 more records from the Richland Memorial Hospital. Did you
3 review those?

4 A Yes, I believe so.

5 (Applicant's Exhibit No. 9, Emergency Room Records, was
6 premarked for identification.)

7 BY MR. GROSE:

8 Q Applicant's Exhibit No. 9 is emergency room records. Did
9 you review those records?

10 A Yes.

11 (Applicant's Exhibit No. 10, MUSC Neurology Record, was
12 premarked for identification.)

13 BY MR. GROSE:

14 Q Applicant's Exhibit No. 12 is records from the Department
15 of Corrections -- I'm sorry, Applicant's Exhibit No. 10, one
16 page. Did you review that?

17 A MUSC Neurology, yes.

18 Q I'm sorry. I'm sorry. I misread that. Thank you for
19 that correction.

20 (Applicant's Exhibit No. 11, Richland County Detention
21 Center Record, was premarked for identification.)

22 BY MR. GROSE:

23 Q Applicant's Exhibit No. 11 is a one-page document from
24 the detention center in Richland County. Did you review
25 those?

1 A Yes.

2 (Applicant's Exhibit No. 12, Dr. Hazleton Records, was
3 premarked for identification.)

4 BY MR. GROSE:

5 Q And Applicant's Exhibit No. 12 is records from
6 Dr. Hazleton. Did you review those?

7 A Yes, I did.

8 Q And so these records that I just reviewed with you in
9 Applicant's Exhibit No. 5 through 12, did these assist you in
10 forming your opinion regarding Gary Terry?

11 A I'm sorry; I lost most of that.

12 Q I'm sorry. Applicant's Exhibits No. 6 [sic] through 12,
13 these records that you reviewed, did that assist you in
14 forming your opinion regarding Gary Terry?

15 A Yes, they did.

16 Q And are these the type of records that are reasonably
17 relied upon in your profession in conducting an Atkins
18 assessment of intellectual disability?

19 A Yes. They're very commonly relied on.

20 MR. GROSE: And, at this time, Your Honor, I would offer
21 Applicant's Exhibit 6 through 12 into evidence -- I'm sorry, 5
22 through 12 into evidence.

23 MS. BROWN: Your Honor, the State objects. Certainly an
24 expert can use hearsay in forming an opinion. No problem with
25 that. But the admissibility is something total different.

1 Our Court in State v. Jennings and in the Allegra case
2 talked about the report itself. The report itself cannot come
3 in because that is a reflection of just hearsay statement
4 after hearsay. An expert is not a conduit for hearsay.

5 Now, that does not in any way mean that there's a
6 limitation for him using that in forming his opinion, but
7 there is no basis for admissibility that has been offered for
8 these documents.

9 And I have copies of those cases, if I may hand those up
10 to the Court.

11 THE COURT: You may.

12 MS. BROWN: Your Honor, the ager (ph) review on that one
13 in State v. Jennings, if you look at the bottom of the Westlaw
14 page that's printed, around pages 4 and 5, the Court talks
15 about the hearsay that comes in with that report. Well, this
16 is the same thing if you introduce the report that has
17 excerpts from these documents. That is hearsay. Our Court
18 has found that that is improper. And that's a 2011 case from
19 our state's Supreme Court.

20 Allegra is a Court of Appeals case that was reversed on
21 different grounds. But, again, if we look at the Westlaw page
22 11, we talk about the admissibility of a report. The Court of
23 Appeals also found that it's hearsay in the report. There's
24 no basis for it to be offered. There's no admissibility
25 ruling that could be made. There's nothing that says it's

1 anything other than hearsay; therefore, the report and any
2 kind of indication within the report of a quotation or
3 statement or the like is simply hearsay and not admissible.
4 Therefore, we object, Your Honor.

5 MR. GROSE: Your Honor, what I'm hearing from them is one
6 case didn't even address this issue as far as the whole thing
7 was concerned. And the other case has do with the report of
8 the person who was testifying.

9 None of these records, Applicant's Exhibits 5 through 12,
10 are Dr. Greenspan's report. These are records that he relied
11 on insofar as making his diagnosis. In particular, when we
12 get to it, many of these records have to do with why he
13 believes that intellectual disability diagnosis had an onset
14 during the developmental period. So we believe that these are
15 admissible.

16 MS. BROWN: Your Honor, if I may. Two things. One is,
17 the only rule I heard that is being relied on for
18 admissibility would be 703. And there's nothing in 703 itself
19 that says that these documents that are reviewed by an expert
20 can be admitted into evidence. Now, if there's another rule
21 that's a hearsay objection, I have not quite heard it yet.

22 And as I believe we have said before, we're not asking
23 this Court to go through and make its own determination on the
24 individual rulings. This Court is accepting expert opinions
25 so the expert can understand where he's going -- or, excuse

1 me, where the Court can understand where the expert is going
2 and why he's relied upon. But you're not making your own
3 determination based on those records.

4 Now, if there's a particular record that needs to be
5 introduced for, say, for instance, impeachment purposes,
6 that's different. But, so far, there hasn't been a rule of
7 evidence that has been offered to Your Honor to form a basis
8 to allow admissibility.

9 Thank you, sir.

10 MR. GROSE: Well, their objection, I don't think, was
11 originally based on hearsay. These are not necessarily being
12 offered for the truth but as to what Dr. Greenspan relied upon
13 in forming his opinion, and certainly the information that an
14 expert relies on is relevant and can be of assistance to the
15 Court and --

16 THE COURT: And the issue isn't is it relevant. The
17 issue is, is it admissible?

18 MR. GROSE: Relevant evidence is admissible under Rule
19 401 and 402.

20 THE COURT: Not automatically, no. That's a blanket
21 statement of the law. That's completely inaccurate,
22 Mr. Grose. Relevant evidence is not admitted in trials every
23 day in South Carolina.

24 MR. GROSE: We believe --

25 THE COURT: So tell me how school records, medical

1 records, hospital records, and SCDC records are not all
2 hearsay, and therefore, not admissible as far as admitting it
3 into evidence?

4 MR. GROSE: Your Honor, at this time, I would just
5 proffer Exhibit 5 through 12 for the record. Those would be
6 my proffers at this time, and we can come back to this issue
7 after we develop a foundation a little bit more.

8 THE COURT: Okay. He's certainly allowed to testify as
9 to what he read, how he used the information, how it
10 formulated his opinion, how it formulated his basis for the
11 opinion, how it went into how he came up to the conclusion
12 that he did or what report from what medical record or what
13 hospital record or what school record or what SCDC record and
14 how that -- he's allowed to testify to all that. He's allowed
15 to testify that -- to the information that helped formulate
16 his opinion, but that doesn't make school records, which I
17 assume are from the late 1970s, automatically admissible as
18 evidence, as exhibits. He can use all that information to
19 give his opinion.

20 And you may continue. You've got about eight minutes,
21 and then we're going to need to break for lunch in eight
22 minutes.

23 MR. GROSE: Okay.

24 BY MR. GROSE:

25 Q Dr. Greenspan, do you have your report of July 5th, 2024,

1 handy?

2 A Yes. I need to call it up on my computer. Hold on a
3 second.

4 Q Sure.

5 A Yes. Go ahead.

6 Q All right. If you could turn to page 2 and 3 of that
7 report. Is that where you identified the records that you
8 reviewed?

9 A Yes, it is.

10 Q All right. And could you list off those records for the
11 Court, please.

12 A Okay. I'm referring to a not-quite-final draft, so I
13 think I later supplemented it with a few more, but I have head
14 injuries, CAT scan, previous scans, successor final stamped.
15 I'm not quite sure what that is. Adaptive functioning chart,
16 psychological and medical records, medical chronology, 1994
17 Charter Rivers records, 1986 motorcycle accident records,
18 Deysach testimony -- D-e-y-s-a-c-h -- MUSC Neurology, some
19 more Charter Rivers medical records, defense penalty
20 presentation, SPECT report -- that's S-P-E-C-T, school
21 records, Woodcock-Johnson 2022 report, IQ and adaptive
22 functioning scores table.

23 As I mentioned, there were a few more that were in the
24 final version, but I'd have to do a little searching to find
25 that.

1 Q And, of course, you interviewed [sic] the records that we
2 talked about a minute ago; is that correct?

3 A Yes, I did.

4 Q In addition to reviewing records, you said that you
5 interviewed Gary Terry. How did that interview take place?

6 A Could you repeat that? I lost the first part.

7 Q That you had interviewed Gary Terry. How did that
8 interview take place?

9 A Remotely.

10 Q And how long did you interview him?

11 A A couple of hours.

12 Q All right. And did you also do some collateral
13 interviews?

14 A Yes. Mother, Patsy, and former wife, Louanne.

15 Q Okay. And how did those interviews take place?

16 A Also remotely.

17 Q And did the interview of Mr. Terry, his mother, and
18 former wife --

19 A I'm sorry; I can't hear you.

20 Q I'm sorry. Did the interview of Mr. Terry, his mother,
21 and his former wife assist you in forming your diagnosis?

22 A Yeah. The mother and the former wife of Mr. Terry were
23 important. [Indiscernible] the mother had a bad day or not,
24 but I found that rather unhelpful and terminated it fairly
25 soon, as there were just too many "I don't know" responses. I

1 was interested to see that Dr. Hall's report had a much more
2 helpful picture of the mother, and I found that very useful
3 also. So I didn't just rely on my assessment; I relied on
4 some of the information collected by Dr. Hall.

5 Q Thank you, Dr. Greenspan.

6 MR. GROSE: Judge, I'm not sure where we are on the eight
7 minutes, but I think that this would be a natural breaking
8 point.

9 THE COURT: All right. Dr. Greenspan, we're going to
10 take a lunch break. I have another hearing I have to do in a
11 couple of minutes. Let's start back at 1:45 Eastern Time. I
12 assume you're in California. So if you'll do that calculation
13 for me and we'll start back in an hour and 45 minutes. If
14 you'll be back in this virtual courtroom at that time, I would
15 appreciate it.

16 THE WITNESS: I will. Thank you.

17 THE COURT: Thank you, Dr. Greenspan.

18 Okay. Anything from the State before we break for lunch?

19 MR. EVANS: No, Your Honor.

20 THE COURT: From the Applicant?

21 MR. GROSE: Not at this time.

22 THE COURT: Okay. All right. I'm going to jump on a
23 virtual roster meeting, so y'all are welcome to get out of
24 this. We'll start back at 1:45.

25 MR. GROSE: Did you say 1:45?

1 THE COURT: Please.

2 MR. GROSE: Well, you said we were taking an
3 hour-and-45-minute break a minute ago.

4 THE COURT: Oh, 2:45. I thought it was noon. Can y'all
5 tell Dr. Greenspan that? Sorry. I thought it was noon. My
6 bad. 2:45. 2:45. My bad.

7 (A lunch recess was taken from 12:58 p.m. to 2:48 p.m.)

8 THE COURT: Dr. Greenspan, are you still with us? There
9 he is.

10 Can everybody go ahead and turn on their cameras for me?
11 His restraint's okay, Mr. Grose?

12 MR. GROSE: Sorry?

13 THE COURT: Mr. Terry's -- your hands okay?

14 THE DEFENDANT: Yes, sir.

15 THE COURT: Okay. Okay.

16 All right. Dr. Greenspan, can you hear me okay, sir?
17 You are muted. Let me unmute you. Can you hear me now,
18 Dr. Greenspan?

19 Mr. Grose, why don't you see if you can get...

20 MR. GROSE: Dr. Greenspan, can you hear me?

21 Dr. Greenspan? Dr. Greenspan, you might be on mute.

22 THE COURT: No, he's not on mute. I think he may just
23 have his volume down.

24 MR. GROSE: Oh, okay.

25 THE COURT: That's my guess.

1 MR. GROSE: Dr. Greenspan? Dr. Greenspan, can you hear
2 me?

3 THE COURT: Dr. Greenspan, if you're talking, we cannot
4 hear you.

5 Want to try to call him?

6 (Pause in the proceedings.)

7 THE COURT: I'm not sure what he's looking at. Looks
8 like his mouth is moving but...

9 Can anybody else hear him? Okay. I can't either.

10 He may have some kind of mute on his computer. I guess
11 he could be talking to somebody else.

12 MR. GROSE: Dr. Greenspan?

13 THE COURT: He's holding up the phone. Do you want to
14 try calling him again on his phone?

15 (Pause in the proceedings.)

16 THE COURT: All right. Dr. Greenspan, can you hear me
17 okay?

18 THE WITNESS: Yes, sir.

19 THE COURT: And we're going to continue now in your
20 continue now in your direct examination by Mr. Grose and
21 you're still under oath. Do you understand that?

22 THE WITNESS: I do.

23 THE COURT: Okay. And can everybody hear? Everybody
24 okay? Okay. All right. Let's continue as we were, please,
25 before.

1 Mr. Grose?

2 THE WITNESS: Sorry; the picture went away.

3 MR. GROSE: All right. Well, we can see you. Can you
4 hear me all right?

5 THE WITNESS: I can hear you. I don't know. I must have
6 touched my screen and it did something. So I joined the
7 meeting again. Well, I guess we'll just have to do it
8 without -- wait a minute. Here we go.

9 MR. GROSE: Are you ready?

10 THE WITNESS: Yeah. I can't see you but that's fine. As
11 long as you can hear me.

12 MR. GROSE: Yes, sir.

13 BY MR. GROSE:

14 Q Before we broke for lunch, we had begun talking about
15 your diagnosis of Gary Terry as a person with an intellectual
16 disability. I want to start with Prong 1, the sub-average
17 intellectual functioning, and ask: Did you review
18 Dr. Decker's Woodcock-Johnson Cognitive Test, Fourth Edition,
19 results?

20 A Yes, I did.

21 Q And what did you find significant about those results?

22 A Well, they seem to support a diagnosis of ID. That's
23 what I found significant.

24 Q Okay. And why is that?

25 A Well, it was something like 76. They don't call it a

1 full scale but that's basically what it is. And he had taken
2 into account reliability issues plus Flynn Effect issues. It
3 clearly indicates someone functioning at the five -- the 5th
4 percentile, which is in the ID range. And it's also congruent
5 with other information.

6 Q I'm going to come back in a minute, but if I told you
7 that score --

8 A I'm sorry?

9 Q I'm going to come back to the other information in a
10 minute, but if I told you the score was a 77, is that still
11 your opinion?

12 A Yes.

13 Q All right. And when you say "adjusted for Flynn Effect,"
14 would that reduce the score?

15 A Yes, significantly.

16 Q All right. And do you consider the Flynn Effect to be a
17 controversial concept or one that's accepted in the scientific
18 community?

19 A It's widely accepted in the scientific community, and
20 it's universally accepted within the Court -- forensic
21 community.

22 Q All right. In your report, you state, "In my opinion,
23 this is a qualifying score for ID even without being corrected
24 for norm obsolescence." What do you mean by that?

25 A Well, I would never rule out ID based on one of two

1 points, for one thing. And it's close enough, in my opinion.

2 Q Okay. And certainly with the Flynn adjustment, it's in
3 range?

4 A Yes, sir.

5 Q All right. Now, in your experience and in your opinion,
6 how does the Woodcock-Johnson compare to the WAIS-IV as a test
7 of measuring intelligence?

8 A Well, I think it's equally [indiscernible] valid as a
9 measure of intelligence. It has certain advantages over the
10 Wechsler scales.

11 Q And now what are those advantages?

12 A Well, it's based on a theory of intelligence whereas the
13 Wechsler scales have no theory.

14 Q So when you say the Woodcock-Johnson is based on a theory
15 of intelligence, what is that theory? What do you mean by
16 that?

17 A Well, it's a theory called the Horn-Carroll theory of
18 intelligence, and it's considered the state-of-the-art theory
19 of intelligence today. And the main developer of that test is
20 someone I know very well and I have a lot of respect for. I
21 believe it reflects current thinking about what intelligence
22 is. And part of the problem with IQ tests, for the most part,
23 [indiscernible] based on any real definition of what
24 intelligence is, whereas the Woodcock-Johnson is.

25 Q And in addition to the Woodcock-Johnson test, did you

1 review any of the historical information on Gary Terry?

2 A Yes, I reviewed achievement scores, including, I believe,
3 the [indiscernible] who gave the Woodcock-Johnson also gave
4 the Woodcock-Johnson. And, if anything, his achievement
5 scores, including the WRAT, W-R-A-T, scores -- there were
6 three administrations in school.

7 Q Okay.

8 A They're all -- all very supportive of a diagnosis of ID.

9 Q Okay. So you referred to it, the WRAT, W-R-A-T. Is that
10 the Wide Range Achievement Test?

11 A Yes, it is.

12 Q And was Gary administered the Wide Range Achievement Test
13 in the fifth, sixth, and ninth grades?

14 A Yes, he was.

15 Q And what did you find significant about the
16 administration of that examination on those three occasions?

17 A He was very impaired in all three areas that were
18 covered, less so on the third administration. He was still
19 impaired in some areas. On the other two, he was very
20 impaired across the board intellectually or academically.

21 Q All right. And was Gary ever recommended for special
22 education?

23 A I believe he was. And I know he was also held back at
24 least once.

25 Q All right. And what is the significance --

1 A Let me amend that. He was not only recommended for
2 special education, he was enrolled in special education.

3 Q And what is the significance of that?

4 A Well, it nails down the Prong 3, for one thing.

5 Q I'm sorry? It nails down the what?

6 A I'm sorry?

7 Q You said it nails down what?

8 A The third prong, developmental onset.

9 Q Okay. And why is that?

10 A Well, you only hold someone back if they're failing to
11 learn or if there's reason to believe that there's some
12 cognitive impairment, and he -- that was obvious from test
13 scores, from grades, from educational records. He was seen as
14 someone impaired, and I believe, at one time, he was -- the
15 term "mental retardation" was even used in schools.

16 Q All right. In your report, you reference reviewing the
17 results of the Bender-Gestalt -- I may not be pronouncing that
18 right -- Measure. What is that?

19 A I think you're pronouncing it right. Bender-Gestalt. I
20 did see it.

21 Q Earlier in your testimony, you talked about the
22 neuropsychological testing that Dr. Deysach did. Did you find
23 any significance of Dr. Deysach's examinations and testing
24 with regard to Prong 1?

25 A Well, he found brain damage -- strong indications of

1 brain damage, and certainly that's something that the
2 Bender-Gestalt does. I can't recall exactly what he did in
3 terms of Prong 1.

4 Q Okay. Can I refer you to your report on this regard?

5 A Yes, you can.

6 Q If I could refer you to your response to Question 1 on
7 the third bullet point.

8 A I'm sorry; I kind of lost you there.

9 Q I'm sorry. Your response to Question 1, the third bullet
10 point under Prong 1.

11 A With regard to the Bender-Gestalt?

12 Q Yes, sir.

13 A Well, he scored a very impaired level.

14 Q Okay. And what's the significance of that?

15 A I'm sorry; I can't hear anything.

16 Q Oh, I'm sorry. What was the significance of him being --
17 Gary being very impaired on the Bender-Gestalt?

18 A Well, it's strongly indicative of brain damage, of which
19 we have other evidence for. I would not -- I would not use
20 that specifically to get at Prong 1, however.

21 Q But it's consistent with other evidence that you have
22 reviewed?

23 A Yes.

24 Q Okay. And in the final three bullet points in that
25 section, you talk about Dr. Deysach's neuropsychological

1 testing. What was significant about his testing with regards
2 to Prong 1?

3 Dr. Greenspan?

4 A [Indiscernible] and brain damage also, but it's a
5 cognitive measure, and he did extremely poorly on the Halstead
6 Category Test.

7 Q Okay. And we lost you for a second. But was the -- did
8 Dr. Deysach find evidence of brain impairment that could be
9 related to the head injuries?

10 A Yes, very much so.

11 Q All right. And with regard to visual memory, Dr. Deysach
12 found impairment there. What is the significance of that?

13 A Well, it's an aspect of intelligence as well as an aspect
14 of a brain intactness or impairment. An intellectual
15 instability is very much a brain disorder.

16 Q And the Halstead Category Test, what did -- what was the
17 significance about Dr. Deysach's administration of that?

18 A Strongly indicative of brain damage and it's a cognitive
19 instrument that he did poorly on. As I said earlier, there
20 are many cognitive [indiscernible] of Prong 1 besides IQ.

21 Q Now, as part of those school records, were you aware of
22 some IQ scores that were administered or IQ examinations that
23 were administered to Mr. Terry?

24 A Yes.

25 Q And was that in 1979 and 1982?

1 A Yes.

2 Q And I believe that those were reported -- both were
3 reported as a full-scale IQ of 92. Does the existence of
4 those test scores change your opinion with regard to Prong 1?

5 A No. I say they're anomalous in the sense that
6 [indiscernible] with other cognitive evidence. Obviously, it
7 does create some ambiguity, but, overall, given all the other
8 indicators of Prong 1, I would not rule it out based on those
9 scores. Also keeping in mind that there are other indices of
10 brain damage that occurred long after that, that are reflected
11 in the later Woodcock-Johnson scores that are much lower.

12 Q And so if Mr. Terry's brain was damaged and that affected
13 his intelligence and that occurred after the 1979 and 1982 IQ
14 exams but in the developmental period, would Mr. Terry still
15 qualify for a diagnosis of ID?

16 A Yes, he would because his cognitive performance is
17 qualifying but still -- at the later date but still within the
18 ID range. Now, I have never said that just -- you know, that
19 he's perfectly normal -- was perfectly normal at the earlier
20 age because he was failing in school, was held back, was in
21 special education, did very poorly in terms of academic
22 achievement.

23 The only evidence from the school years that might be
24 used to dispute [indiscernible].

25 Q Okay. And going back to something that you said earlier,

1 it's not required that the causation of ID be determined, is
2 it?

3 A That's true, and it usually isn't.

4 Q And I think you also mentioned that, earlier in your
5 testimony, that an accumulation of factors or insults to the
6 brain over a period of time but occurring in the developmental
7 period can cumulatively result in IQ -- or in diagnosis of ID;
8 is that right?

9 A Yes. Sorry. I mean, a second or third head injury would
10 definitely be a kind of additional, if not multiplier, of the
11 earlier impairments. And certainly there's significant
12 evidence of later brain injury.

13 Q And we'll talk about that later, but you do see that
14 pattern in Mr. Terry's history?

15 A Yes, I do.

16 Q I want to turn to Prong 2, the deficits in adaptive
17 functioning. Do you believe that Gary Terry meets the
18 diagnostic criteria under Prong 2?

19 A I do, yes.

20 Q All right. And why is that?

21 A Well, as I testified earlier, there are three domains.
22 That's actually based on my research and writing. Social,
23 conceptual, and practical. And you only need significant
24 impairment in one of those three. I believe there's
25 significant impairment in two of them, conceptual and social.

1 The only one where it's not clear that he qualifies is
2 practical.

3 Q Let's start with the practical then. Why do you say it's
4 not clear whether he qualifies in that domain?

5 A Hold on a second; my battery is dying. I need to change
6 the plug here. I have got two laptops and only one battery
7 charger.

8 Well, in all the descriptions of him and in his
9 employment history, it seems that he had some practical
10 skills.

11 Q And would that be an area --

12 A Around motors, cars, that sort of thing.

13 Q And would that be an area of relative strengths for
14 Mr. Terry?

15 A For sure it would be.

16 Q Okay. The conceptual domain, what was your conclusion
17 about Mr. Terry and this conceptual domain?

18 A Very impaired.

19 Q And when you say "very impaired," what leads you to that
20 conclusion?

21 A Dramatic school failure, for one thing.

22 Q Okay.

23 A And Prong 1 is related to conceptual. In fact, in some
24 of my writing, I suggested that we're [indiscernible] the
25 conceptual really should be a Prong 1 issue. Or it's an area

1 that cuts across two areas -- two of the three -- two of the
2 prongs.

3 But, you know, clearly -- clearly, in terms of conceptual
4 intelligence or conceptual adaptive functioning, if it's an
5 area of great deficiency as reflected in being held back and
6 just generally failing [indiscernible].

7 Q And with regard to the social domain, what is your
8 opinion of Mr. Terry in the social domain?

9 A Severely, if not profoundly, impaired.

10 Q And why do you say that, Dr. Greenspan?

11 A Yeah, I mean, I could list a whole bunch of behaviors
12 which, for some reason, never fully made it into my report,
13 but -- such as telling somebody to shoot him in the leg to get
14 out of paying child support. Can you imagine anything dumber
15 than that? Just incredibly bad judgment in all areas of his
16 life in the social domain.

17 Q So then it is your opinion that Gary Terry has
18 significant deficits in the social and practical domains that
19 qualify him for a diagnosis of intellectual disability?

20 A Social and conceptual. You said practical.

21 Q Oh, I'm sorry. Social and conceptual. My mistake.
22 Thank you for correcting me.

23 A Yes. He's impaired in two of the three. He's more
24 normal in the practical. But according to the manuals, you
25 only need to be impaired in one of the three, and he meets

1 that.

2 Q Now, you said earlier that you would never make a
3 diagnosis of intellectual disability without interviewing the
4 person. What was significant in your interview of Gary Terry
5 with regard to Prong 2, the adaptive functioning?

6 A Well, I also said earlier that it's really impossible
7 because ID is a somewhat hidden disorder. It's really
8 impossible in a short encounter with someone to make a
9 diagnosis one way or the other. Rather, we look for evidence
10 that might rule it out. And I don't see -- I didn't see
11 anything in my interaction with Mr. Terry that in any way is
12 inconsistent or incongruent with a diagnosis of ID.

13 Q I believe you testified earlier that you conducted an
14 interview with Patricia Terry, who is Gary Terry's mother?

15 A Yes. I didn't get much out of that, I'm afraid.

16 Q All right. But you also mentioned earlier that you
17 looked at the information that Dr. Hall reported in her report
18 regarding her interview of Ms. Terry. Did you find anything
19 significant in what Dr. Hall reported?

20 A Yes. The mother, Patricia Terry, told all kinds of
21 stories to Dr. Hall that are indicative of deficits in
22 adaptive functioning.

23 Q Can you give some examples?

24 A Well, she mentioned -- I believe she mentioned
25 gullibility and social vulnerability. I mean, that's been my

1 hallmark in my career over the last 20 years. I wrote the
2 first book on gullibility and persuaded both AAIDD and DSM to
3 consider gullibility an indicator of ID. And she talked about
4 his being overly influenced by his friends and getting in
5 trouble as a result.

6 Q And you mentioned that you interviewed Louanne Terry,
7 Mr. Terry -- Gary Terry's ex-wife; is that correct?

8 A Yes.

9 Q And what did you find significant from interviewing
10 Louanne?

11 A Well, it was just one story after another about how she
12 propped him up. You need to look at context when you look at
13 what people do. And every time he's been in the community, he
14 depended on someone -- typically a woman -- to prop him up.

15 And she filled out various paperwork he had to do for his
16 business, which ended up failing, and, you know, he did one
17 thing after another that was foolish, in her opinion, such as
18 driving very recklessly. But she always supported him.

19 To me, that's an almost universal finding when I see a
20 person with ID living in the community. A very common pattern
21 is to have someone like Louanne helping him to function,
22 trying to get him all kinds of help. Often, he would reject
23 that help.

24 Q And I think you already answered this, but is it typical
25 for people with ID that are living in the community to have

1 benefactors or support structures around them?

2 A Yes. I mean, there's a lot of research on that. There's
3 a term called the cloak of competence based on a book by an
4 anthropologist. And Robert Edgerton, he called it the cloak
5 of competence. He looked at people who had been
6 institutionalized in California. Back then, they were all
7 pretty much mildly -- the term was retarded. And, in every
8 case, they had a benefactor who, to some extent, enabled them
9 to cover up the extent of their limitations.

10 And that's sort of the universal tendency for people with
11 ID, to cover up their limitations and to portray themselves as
12 more competent than they really are. That's one reason why
13 you should always rely on others to tell you about -- what
14 someone can do in terms of adaptive behavior. One should
15 never get that information solely from the person himself.

16 And that was one of my criticisms of Dr. Hall's report
17 because she relied very heavily on Gary Terry to talk about
18 all the things he could -- claimed to be able to do.

19 Q And one of the things that you mentioned a minute or two
20 ago was Gary setting up a business. In context, does that
21 rule out or support your diagnosis of intellectual disability?

22 A No, even if he could do it, it wouldn't rule it out, but
23 the fact is, based on what I have learned, if not for
24 Louanne's contribution, he would never have been able to set
25 up or operate that business. And as it is, he -- it ended up

1 failing.

2 Q All right. Now, in your report, you mentioned a 1977
3 Vineland Social Maturity Scales, which was administered to
4 Gary. He was 11 years old in the 5th grade at the time. Can
5 you tell us what the Vineland Social Maturity Scale is?

6 A Yes. It was -- it's an early version of what later
7 became known as the Vineland Adaptive Behavior Scale, which is
8 currently still in use. The early one was developed by Edward
9 Hall -- no, I'm sorry -- Doll, D-o-l-l. He was one of the
10 early leaders in the intellectual -- in the field of
11 intellectual disability. He defined ID primarily in terms of
12 social incompetence rather than IQ. That was a hallmark.

13 So the Vineland was a third-party rating scale filled out
14 by a teacher, a parent, or someone else who knew the
15 individual. And that's the case today with the Vineland
16 Adaptive Behavior Scale, which grew out of the Vineland Social
17 Maturity Scale.

18 In my experience, there's only one reason to administer a
19 third-party adaptive behavior scale, such as the Vineland, and
20 that's if professionals -- in this case, educators -- believed
21 that ID is something that needs to be ruled out or ruled in.

22 So aside from the performance, the fact that he was rated
23 on the ID indicates that ID was a concern and is supportive of
24 Prong 2, and obviously, Prong 3 as well.

25 Q Why do you say "obviously Prong 3 as well"?

1 A Because Prong 3 is based on continuity of concern. And
2 here we had a concern expressed in grade -- what grade did you
3 say? I'm sorry; I don't have the report in front of me.

4 Q Fifth grade, age 11, 1979.

5 A So at age 11, I believe he repeated the fifth grade. He
6 was failing in the fifth grade. There was concern both
7 because he repeated it and also because he was given the
8 Vineland, which, as I said, is a measure that's only given if
9 you think the person might have what then was called mental
10 retardation.

11 And he did very poorly on it. He certainly scored in the
12 ID range on the Vineland, which, in itself, is very supportive
13 of Prong 2, at a point before the later head injuries.

14 Q And then, of course, the head injuries potentially add to
15 that; correct?

16 A I would say they definitely added to it.

17 Q And in your report, you make reference to descriptions
18 that teachers made at the time. What was significant about
19 that?

20 A Sorry; I have a cold here.

21 Well, one of the teachers, according to Patricia, the
22 mom -- and this is in Dr. Hall's report -- [indiscernible]
23 mildly retarded. Now, Patricia disputed it, but, you know,
24 she's hardly qualified as a diagnostician, and most parents
25 don't feel good about having a child called retarded.

1 But, you know, he was seen as quite impaired back then.

2 Q And in your report, with regard to Prong 2, you
3 referenced Dr. Deysach's report again and the use of the term
4 "adaptive intelligence." What did you find significant with
5 regard to that as far as your diagnosis on Prong 2?

6 A Well, adaptive intelligence, as used by Dr. Deysach --
7 and actually as mentioned in the DSM-5 and in my own research,
8 which DSM-5 cited, the most important aspect of Prong 2 for
9 diagnosing ID is how you understand and deal with complicated
10 and emotionally challenging situations, often the kinds of
11 things that get people in serious legal difficulty and
12 certainly as seen in Mr. Terry's very dumb behaviors,
13 impulsive behaviors.

14 So adaptive intelligence is very informative both in
15 terms of why Mr. Terry does poorly in the community and was
16 always in trouble, but it's also very supportive of someone
17 with brain damage and intellectual disability.

18 Q Now, I think you've already touched on this, but with
19 regard to Prong 3 -- well, actually, before I move on to Prong
20 3, there were some questions earlier during your
21 qualifications about the common sense questionnaire. Can you
22 explain again what that is?

23 A It's a social problem-solving measure, but -- or
24 interviews -- structured interview. But unlike most social
25 problem-solving interviews which ask people to generate good

1 solutions to problems, the common sense questionnaire asked
2 them to see if they can recognize bad solutions, which I think
3 is more meaningful because, if you can't identify a bad
4 situation or a bad course of action, very often, they're
5 attributed by other people who take advantage of someone's
6 gull -- naive-tility (ph) then you're likely to get in
7 trouble. And, in fact, criminal behavior of people with ID as
8 reflected in the original Atkins ruling by Justice Stephens
9 talks about gullibility. I don't think the word was used.
10 But that's one reason used by the Supreme Court for taking
11 death penalty off the table because almost always -- not
12 always but very often when a person with ID gets in trouble,
13 including commits a homicide or participates in a homicide,
14 very often they're in cahoots with a more competent
15 confederate who may have [indiscernible] but is more likely to
16 understand the consequences both to the victim but also
17 legally to themselves, not to mention that are able to make a
18 deal with the prosecution.

19 So -- sorry; I kind of lost the thread here. What was
20 the question again?

21 Q Well, that's all right. I was going to move on and ask
22 you about social risk awareness. That's something that you
23 mentioned that the common sense questionnaire measures. What
24 is meant by social risk awareness?

25 A The fact that a particular course of action -- in the

1 case of the common sense questionnaire, portrayed action --
2 could get you arrested, it could get you killed, it could
3 bring about an undesirable outcome. And it's something that
4 all of us have to do regardless of our level of intelligence.
5 We're always faced with temptation with inducements to do
6 things that are not in our interest, and survival in the world
7 physically, as well as in terms of staying out of prison,
8 requires the ability to recognize behaviors that should not be
9 engaged in. And they're affected by both judgment and as well
10 as impulsivity. And impulsivity is the usual outcome of brain
11 damage as is poor judgment.

12 Q Was the common sense questionnaire the only tool that you
13 relied on for your diagnosis on Prong 2?

14 A No. I relied on other records, some of it reflected in
15 my report, other things as I mentioned that I have got from
16 other -- subsequently. So I looked at everything that I had
17 access to. I didn't just rely on the common sense. In fact,
18 I doubt I would come to a different conclusion even if I
19 hadn't done the common sense questionnaire.

20 Q And why is that?

21 A Because there's much evidence to support deficits in
22 Prong 2 that have nothing to do with anything I got from the
23 common sense questionnaire.

24 Q I think you have touched on this already, but I want to
25 turn to the developmental onset. And with Prong 1, what's

1 your opinion about the --

2 A I'm sorry; I'm losing you there.

3 Q I'm sorry. With regard to Prong 1, what is your opinion
4 with regard to onset in the developmental period?

5 A Well, I believe it qualifies, in terms of ID. Certainly
6 in terms of the later assessment, but on the Woodcock-Johnson
7 more recent assessments. But even with regard to the earlier,
8 except for the two IQ scores, it was a lot of suggestion that
9 Prong 1 was impaired.

10 Q And are you aware of the test that was administered this
11 year by the Department of Disabilities and Special Needs, the
12 WAIS-IV examination?

13 A Yes.

14 Q And you were aware of the full scale that was reported of
15 an 82?

16 A Yes.

17 Q Does that test change your opinion with regard to
18 Prong 1 -- not only Prong 1 but also the onset of Prong 1
19 during the developmental period?

20 A Does it change my opinion? No.

21 Q And why is that?

22 A Well, for one thing, if you correct for the Flynn Effect,
23 you have a qualifying score because it's an old test. And
24 it's also a possible practice effect because he was given that
25 same test once before. Or I may be mistaken about that.

1 And, also, I don't think the Woodcock-Johnson is a better
2 indicator of his cognitive -- level of cognitive impairment.

3 Q Let's unpack a couple of things there. You already
4 mentioned the Woodcock-Johnson. Why do you believe that
5 that's a better indicator?

6 A Yeah, again, you sort of faded a little bit.

7 Q I'm sorry. I wanted to unpack that last answer a little
8 bit. The Woodcock-Johnson, why do you believe that that's a
9 better indicator than the WAIS-IV?

10 A Well, I believe it's a more valid test. The one thing
11 that's interesting, there's no current research that I'm aware
12 of with regard to the congruence or discongruence in results
13 from either the WAIS -- from both the WAIS and the
14 Woodcock-Johnson. There was some research early on but not
15 recently. I know that because it came up in a case in Nevada
16 that I participated in recently, and I actually called the
17 main scientist, Kevin McGrew, for the Woodcock-Johnson
18 cognitive test. I know him because he was kind of a student
19 of mine, although he was at the University of Minnesota. I
20 was kind of an outside member of his doctoral committee, and
21 the topic of his dissertation actually cited me in the title.
22 It was a test of the validity of Greenspan's theory of
23 adaptive behavior, which is interesting because Kevin McGrew
24 started out stating adaptive behavior and then moved over into
25 Prong 1.

1 And what he told me was there's no -- not only is there
2 no current research on -- I mean, what we know is they're
3 correlated. That's what people do. And correlated means that
4 someone who does high on one test will do high on the other,
5 and someone who does poorly on one test will do poorly on the
6 other. But in and of itself, you could have a high
7 correlation between two tests, but they may come up with a
8 different answer -- a different [indiscernible].

9 His position is that it's not an important question. I
10 think it is an important question because decisions are made
11 based on the result of a test and it would be useful to know
12 if they consistently differ. And I believe they do
13 consistently differ. Now, that doesn't mean that the
14 Woodcock-Johnson is an inferior test. It's very likely, in my
15 opinion and that of others, it's a better test. But...

16 Q All right. You mentioned the Flynn Effect. In
17 Dr. Hall's report, was the Flynn Effect for the 2024 WAIS-IV,
18 was that correctly applied?

19 A No. She used the date of publication in determining --
20 in determining obsolescence, which is the number of years that
21 have expired since the norms were collected. She used the
22 date of publication.

23 Q And what date is the appropriate date to use?

24 A The date of norming (ph). And it takes a long time to
25 develop these tests before they're published. And the date of

1 norming is usually, on average, about two years prior to the
2 date of publication. So she should have used the date of
3 norming, which would have caused her score to come down by at
4 least one point. And I believe there was one other issue.

5 Q The --

6 A I'm sorry?

7 Q Beg your indulgence for just a moment.

8 A I can't hear you; sorry.

9 Q Are you aware as to whether or not there was an observer
10 present while the WAIS-IV was administered?

11 A Yes. The WAIS-IV was administered by another
12 psychologist, whose name escapes me at the moment. And
13 Dr. Hall was in there as a supervisor to observe. More
14 typically when you do a supervisor kind of relationship, it's
15 done through a one-way mirror. In this case, she was in the
16 same room as the person administering it.

17 Q And what kind of concerns arise when there's an observer
18 in the room when the test is administered?

19 A Well, it's definitely not recommended practice.

20 Q And why is that?

21 A It could make the person nervous or in some way affect
22 them.

23 Q And with regard to your opinion on Prong 2, did the
24 deficits of adaptive function, did they onset during the
25 developmental period?

1 A Yes, for sure.

2 Q And why do you say "for sure"?

3 A Well, there's a lot of evidence for poor judgment and
4 deficiencies in both conceptual and social, adaptive
5 functioning that occurred both in the period between 18 and
6 22, which is the current AAIDD ceiling, but even before 18, as
7 reflected, for example, in the history of academic failure.
8 And also things like not having friends.

9 It was noted by, I believe, the mother that -- and also
10 Louanne -- that he didn't have very many friends, which is one
11 reason why, when people with intellectual disability don't
12 have friends, one reason why they're so gullible, aside from
13 their cognitive limitations, is because they're
14 [indiscernible] to maintain the friendship by doing whatever
15 they're asked to do.

16 Q Earlier in your testimony and in your report, you refer
17 to ID as a functional diagnosis. What do you mean by
18 "functional diagnosis"?

19 A It's not an etiological -- e-t-i-o-l-o-g-i-c-a-l --
20 diagnosis. That is, we don't usually know the case -- the
21 cause, and we don't need to know the cause. What we need to
22 know is whether they meet the criteria, which are essentially
23 behavioral criteria. How do they behave in school? How do
24 they behave in the job? That sort of thing.

25 So, in that sense, it's functional in that we don't need

1 to know if there's a cause or what the cause might be.

2 Q And in your report and in your testimony today, you have
3 talked about the significance of the traumatic brain injuries
4 that Gary suffered. Can you explain the role of that in
5 reaching your opinion with regard to onset of both Prong 1 and
6 2 during the developmental period?

7 A Well, those traumatic brain injuries, by all accounts,
8 were very severe and significant, and certainly it would
9 account for why his intelligence went down. And it might
10 account for his, obviously, deficient social judgment,
11 including in his criminal history.

12 Q All right. Prior to those injuries, would you consider
13 Gary Terry to have been somebody who was normal functioning?

14 A No. I would consider him very sub-average functioning
15 but not necessarily ID functioning.

16 Q But then after the traumatic brain injuries, would you
17 consider him ID functioning?

18 A Yes.

19 Q And why is that?

20 A Well, for one thing, cognitively, he's doing very poorly,
21 and in terms of his adaptive intelligence or adaptive
22 behavior, many of the incredibly stupid things that he did,
23 such as asking somebody to shoot him in the leg to get out of
24 paying child support, happened after the head injuries, I
25 believe.

1 Q And are your opinions here today to a reasonable degree
2 of scientific certainty?

3 A Yes.

4 Q And to a reasonable degree of scientific certainty, what
5 is your opinion as to whether or not Gary Terry is a person
6 with an intellectual disability?

7 A I believe all the evidence that I looked at, including my
8 meeting with him, supports a diagnosis of intellectual
9 disability as defined by the two manuals and also by the South
10 Carolina criminal statute.

11 Q And you prepared reports on July 25th, 2024, and a
12 supplemental report on July 10th, 2024, that have been marked
13 as Exhibits 2 and 3.

14 (Applicant's Exhibit No. 2, Dr. Greenspan's 7/25/24
15 Report, was premarked for identification.)

16 (Applicant's Exhibit No. 3, Dr. Greenspan's 7/10/24
17 Report, was premarked for identification.)

18 MR. GROSE: At this time, Your Honor, I would move
19 Exhibits 2 and 3 into evidence.

20 MR. EVANS: Your Honor, we object to these reports being
21 placed into evidence, piggy-backing the objection earlier for
22 the records to be placed into evidence. Also, we feel that
23 this is cumulative. He already testified about what was in
24 the reports. There's no need for these reports to be entered
25 into evidence. The best evidence is the testimony, Your

1 Honor.

2 THE WITNESS: I'm sorry. I don't hear anything anymore.
3 I don't know if you're talking to me or not.

4 MR. EVANS: No, I'm talking to the judge.

5 THE COURT: He can't hear you.

6 MR. GROSE: Dr. Greenspan, they're making an objection to
7 your reports.

8 THE WITNESS: Okay.

9 MR. EVANS: Basically, the best evidence is testimony.
10 He already testified to the things that are actually in the
11 reports. This evidence is cumulative. It doesn't need to be
12 entered into evidence. We would go with his testimony, and
13 therefore, we object to his reports being entered into
14 evidence. And, also, this is also considered hearsay, as was
15 argued previously before this Court regarding the records
16 being placed into evidence, Your Honor.

17 MR. GROSE: Well, Your Honor, both of these reports --
18 and you have not seen them -- but both of them are designated
19 declarations where Dr. Greenspan states that "My opinions in
20 this declaration are made with a reasonable degree of
21 scientific certainty, and I'm willing to testify regarding
22 these opinions under penalty of perjury."

23 A declaration is, in a lot of ways, equivalent to an
24 affidavit, and the PCR statute expressly authorizes accepting
25 affidavits. Obviously, they are relevant, and that would be

1 our argument.

2 MR. EVANS: Your Honor, an affidavit is only acceptable
3 when the witness cannot be in court to testify.

4 This witness is in court to testify, was under the
5 penalty of perjury under oath testifying today, Your Honor.

6 THE COURT: Do they say anything different?

7 MR. GROSE: No, sir.

8 MR. EVANS: And, Your Honor --

9 THE COURT: What's the point of it? is what I don't
10 understand.

11 MR. GROSE: Well, that's what I don't understand either.
12 I think that dilatates in favor of admitting them, but...

13 MR. EVANS: Yeah, what's the point of putting them into
14 evidence when he testified what was in the record. And it's
15 also unnecessary bolstering, Your Honor. He already testified
16 to this.

17 THE COURT: They're admitted. He's already testified to
18 it. It's fine.

19 MR. GROSE: Okay. Thank you, Your Honor. Beg the
20 Court's indulgence for a moment.

21 (Applicant's Exhibit Nos. 2 and 3 were received into
22 evidence.)

23 MR. GROSE: Dr. Greenspan, that's all the questions I
24 have of you at this time. I believe that Mr. Evans or
25 somebody from the Attorney General's Office is going to ask

1 you some questions, and there may be a brief pause while we
2 switch out the computers here at the podium.

3 THE COURT: He can just -- you can stay right there.

4 THE WITNESS: Okay. Thank you.

5 THE COURT: Yeah, just turn on -- just unmute yourself
6 right there. And then let's see if we can hear everybody.

7 MR. GROSE: All right. I've muted this, and I've turned
8 down the volume here, but I can turn it back up.

9 THE COURT: Well, let's play with it. Try talking,
10 Mr. Evans.

11 MR. EVANS: Dr. Greenspan, can you hear me?

12 THE WITNESS: Yes, Mr. Evans, I can.

13 MR. EVANS: Okay. Your Honor, can you hear?

14 THE WITNESS: I can hear, but I can't see anything.

15 THE COURT: Why don't y'all pull that computer down to
16 the table.

17 All right. Try talking again, Mr. Evans.

18 MR. EVANS: Dr. Greenspan, can you hear me?

19 THE WITNESS: Yes, I can hear you loud and clear,

20 Mr. Evans.

21 MR. EVANS: Okay. MR. EVANS: Okay.

22 CROSS-EXAMINATION

23 BY MR. EVANS:

24 Q Now, in your report, you say you were initially contacted
25 by Mr. Terry's counsel back in 2023; isn't that correct?

1 A Yes. I believe there might have been some change in
2 the --

3 THE COURT: Ms. Franz, can y'all hear?

4 MR. GROSE: I cannot hear.

5 MR. EVANS: Hold on, Mr. Greenspan -- Dr. Greenspan.

6 A I was initially contacted by counsel, but --

7 MR. EVANS: Dr. Greenspan, could you hold on a minute?

8 THE WITNESS: Yeah.

9 THE COURT: Do y'all have your computer up?

10 MS. FRANZ: I'm sorry, Your Honor. I'm having some
11 computer difficulties. I'll have it back up in a minute.

12 MR. GROSE: I unplugged it and it cut off. My apologies.

13 (Pause in the proceedings.)

14 THE COURT: Dr. Greenspan, just hold right there. We're
15 trying to get something set up. Okay?

16 THE WITNESS: Thank you.

17 THE COURT: Thank you, Dr. Greenspan. And thank you for
18 your patience.

19 THE WITNESS: No problem.

20 (Pause in the proceedings.)

21 MR. EVANS: Dr. Greenspan, can you hear me?

22 THE WITNESS: Yes, I can.

23 BY MR. EVANS:

24 Q Now, as I said earlier, in your report, you were
25 initially contacted by Mr. Terry's counsel in 2023; isn't that

1 correct?

2 A Yes, but the person who contacted me I don't believe is
3 on that team anymore.

4 Q Okay. And you were asked to evaluate and make an
5 assessment regarding if Mr. Terry was intellectually disabled;
6 correct?

7 A Well, it may have evolved somewhat, but that's generally
8 accurate, yes.

9 Q Okay. And at that time, you knew Mr. Terry was given the
10 death penalty and is currently sitting on death row?

11 A Yes, I did.

12 Q And during the deposition, you admitted that you are
13 against the death penalty?

14 A Well, it's evolved. I started out being pretty neutral,
15 and as I learned more about the death penalty and as I got
16 involved in these various cases, I do have some concerns about
17 it, the way it's administered or inconsistency as to how it's
18 applied.

19 Q So you are opposed to the death penalty: Yes or no?

20 A Yes.

21 Q Okay. Now, you're currently living in Berkeley,
22 California; isn't that correct?

23 A Yes.

24 Q I'm sure there are a lot of experts between Lexington,
25 South Carolina, and Berkeley, California; isn't that correct?

1 A I'm assuming you're -- that's true, yes.

2 Q But they decided that, of all the psychological experts
3 in this country they could have contacted, they decided to
4 contact you; wasn't that true?

5 A I'd like to believe it's because they thought no one else
6 was as good as me.

7 Q Okay. Maybe so.

8 Now, during your deposition, you testified that you
9 testified in 30 Atkins hearings; isn't that correct?

10 A Approximately and maybe more.

11 Q Okay. And you never once testified for the prosecution;
12 isn't that true?

13 A I have never been asked. I used to hand out my card to
14 prosecutors. None of them ever called me.

15 Q So your answer is yes, you never testified for the
16 prosecutor, only for the defense; correct?

17 A In death cases, I have testified -- I have gotten
18 involved in -- as a consulting expert by prosecution, yes, but
19 not in death cases.

20 Q Not in death cases.

21 So in all your Atkins cases that you testified in, it was
22 only for the defense?

23 A Well, I testify as to the truth as I see it. I don't see
24 myself as a member of the team, so to speak.

25 Q Okay. So that's a yes? You only testified for the

1 prosecutor -- I mean, for the defense, never for the
2 prosecution?

3 A Correct.

4 Q Now, during your deposition, you said, right now, you are
5 actively involved in researching and publishing. You're not
6 teaching anymore, are you?

7 A No, except when I give lectures, which I do from time to
8 time.

9 Q Okay. And you also said you have a small forensic
10 practice and you consult and testify in criminal cases, most
11 of that being in death penalty cases; isn't that true?

12 A And I sometimes get involved in service eligibility
13 cases, which are civil.

14 Q All right. But criminal cases, for the most part, are
15 death penalty cases; correct?

16 A Yeah. I mean, I have had a few non-death cases and
17 hopefully more in the future, but that's been the bulk of my
18 testimony, yes.

19 Q And of course you're being compensated for your work in
20 this case; isn't that correct?

21 A If I remember to bill, which is, for me, a problem. But,
22 yes, I am being compensated.

23 Q Okay. So your livelihood depends on your opinion in this
24 case; isn't that true?

25 A I wouldn't say I'm independently wealthy, but I can

1 assure you, I don't depend on what I get from these cases.
2 Between my investments and my pension, I do pretty well
3 without it.

4 Q Now, during the deposition, you say you spoke to
5 Mr. Terry for one to two hours?

6 A Yes.

7 Q And most of that time was primarily to fill out that
8 common sense questionnaire; isn't that true?

9 A Probably half, yeah.

10 Q Did you speak to him about anything else during that
11 session?

12 A I asked about how he was doing. Things of that sort. I
13 generally try to stay away from the crime facts because that's
14 not my area of responsibility.

15 Q Okay. And you also spoke to his ex-wife, Louanne?

16 A I did, yes.

17 Q And also you said you attempted to speak with his mother.

18 A That didn't go very well, unfortunately.

19 Q But Dr. Hall was able to speak with her and get valuable
20 information from her; isn't that correct?

21 A Which I relied on to some extent, yes.

22 Q Oh. You relied on Dr. Hall's assessment to come to your
23 final assessment on your original -- your first report?

24 A No, because I think I got it later.

25 Q Okay. So you did not rely on what Dr. Hall got from his

1 mother for your first assessment on your report?

2 A Well, I relied on it to some extent in preparing to
3 testify today because I found it very interesting, and I'm
4 impressed that she was able to have a good interview with
5 Patricia Terry. Unfortunately, I did not have that
6 experience.

7 Q All right. Now, in your report, you stated you reviewed
8 medical records, prison records, and psychological records.
9 Where were these records from?

10 A Well, a lot of the records were school based from his
11 experience in school. There was a -- he was hospitalized a
12 couple of times because of alcohol dependency, primarily
13 through the efforts of his wife Louanne. I have to look at
14 the name of that facility, but there was some good stuff in
15 there. There was the report from Dr. Deysach. There was the
16 Woodcock-Johnson report from -- excuse me while I look up his
17 name.

18 Q And, Dr. Greenspan, what are you reading while you're
19 testifying right there?

20 A Well, I'm trying to look up the name of -- of the
21 psychologist who administered the Woodcock-Johnson. I have
22 another laptop with my report on it, and I thought I might
23 find it on there.

24 Q That's Dr. Decker; isn't it? Isn't that correct?

25 A Dr. Decker. Scott Decker, who I believe is a professor

1 at the University of South Carolina. I relied on his report.
2 The Charter Rivers, there was quite a bit of stuff from that.

3 Q Okay. And you said you read the transcript of the
4 testimony of Dr. Deysach?

5 A No, I wouldn't call it a transcript. It was a report but
6 it was an unusual format, kind of question and answer that I
7 assume he came up with.

8 Q Okay. So --

9 A It was not a standard report.

10 Q Okay. So his testimony in the original case was not
11 provided to you?

12 A Not in terms of a [indiscernible], no.

13 Q And you never spoke to any of Mr. Terry's teachers?

14 A No, I did not.

15 Q You never speak to any of his friends?

16 A I'm sorry; I lost you there.

17 Q You never spoke to any of his friends?

18 A Generally, I don't.

19 Q Generally, you don't speak to any friends of the
20 individual you're examining?

21 A Occasionally I do, but I did not in this case.

22 Q And you never spoke to any of his doctors?

23 A No.

24 Q Now, you wrote a supplemental report assessing the report
25 made by Dr. Hall; isn't that correct?

1 A I'm not sure I would say I assessed it. I commented on
2 it.

3 Q Well, I would say you critiqued it; didn't you? There
4 were certain things about it you disagree with?

5 A Yes.

6 Q Okay. And that report was done on July 10th of this
7 year?

8 A Yeah. I -- I received her report right after I
9 [indiscernible] report and that's why it's a later date.

10 Q Okay. Now, in this report on page 1, you stated that,
11 "Dr. Hall states the diagnostic criteria for ID correctly,
12 according to DSM-5, but she does not cite the AAIDD manual";
13 isn't that correct?

14 A No, I said she cited DSM's definition but did not cite
15 the AAIDD definition.

16 Q Okay. I just said that.

17 Now, you do realize this is a court proceeding and not a
18 scientific or medical proceeding; isn't that correct?

19 A I missed part of that. Could you repeat it?

20 Q You understand this is a court proceeding and not a
21 scientific or medical proceeding?

22 A Yes, of course.

23 Q Okay. So Dr. Hall, yourself, and this Court has to apply
24 the definition of intellectual disability that's found under
25 South Carolina law; isn't that correct?

1 A Yes.

2 Q Okay. Now, Section 16-3-20(C)(b) of the South Carolina
3 Code of Laws define intellectual disability as "significantly
4 subaverage generally intellectual functioning existing
5 concurrently with deficits and adaptive behavior and
6 manifested during the developmental period."

7 You are aware of this definition; isn't that correct?

8 A Very -- very much so.

9 Q All right. Now, the DSM-5 defines intellectual
10 disability as "There must be three criteria that must be met:
11 Deficits in intellectual functioning, deficits in adaptive
12 functioning, and onset intellectual and adaptive deficits
13 during the developmental period." That is very familiar to
14 the current statute in South Carolina law; isn't that correct?

15 A It's basically the same thing except they call it
16 adaptive functioning rather than adaptive behavior.

17 Q Okay. And that was the criteria that Dr. Hall followed;
18 isn't that correct?

19 A Yes. That was the framework she said she used.

20 Q Okay. Now, the DSM-5 is the book that psychologists use
21 in order -- for the determination of diagnosis; isn't that
22 correct?

23 A Not just psychiatrists -- not just psychologists but
24 psychiatrists or social workers. Anyone in the mental health
25 profession who is making a diagnosis that relates to a mental

1 condition.

2 Q Okay. And in the preface of the DSM-5 it states, "The
3 American Psychiatric Association's Diagnostic and Statistical
4 Manual of mental disorders is a clarification of mental
5 disorders with associated criteria designed to facilitate more
6 reliable diagnosis of these disorders." So the DSM was
7 created in order for the uniform diagnosis of psychologists or
8 psychiatrists or social workers all over the country; isn't
9 that correct?

10 A Yes, I would say that's true.

11 Q All right. Now, in your report -- your supplemental
12 report, you stated that Dr. Hall cites the letter of the DSM-5
13 but does not appear to the application of the spirit. Do you
14 remember writing that in your report?

15 A Well, I said she applies the letter but not necessarily
16 the spirit.

17 Q Okay. And it was your opinion that she relayed on
18 scoring and not the wholistic approach to make an actual
19 diagnosis of intellectual disability?

20 A I believe that's what I said, yes.

21 Q Okay. But the DSM-5 states under "Deficits of
22 intellectual disability" that "deficits must be confirmed by
23 both clinical assessments and individualized, standardized
24 intelligent testing so test scores are important to assess
25 intellectual functioning"; isn't that correct?

1 A I believe that's true, yes.

2 Q Okay. And the only score that you mentioned in your
3 report is the 77 IQ score given by Dr. Decker; correct?

4 A Yeah, that was probably an oversight. I wrote that
5 report very quickly. I didn't have a lot of time to do it.

6 Q Okay. And that IQ test was done on 2022, two years ago,
7 well beyond the developmental period of Mr. Terry; correct?

8 A That's true.

9 Q Okay. Now, did you ever consider the 92 IQ score that he
10 got at age 11 or the 92 score he got at age 14, both within
11 the developmental period?

12 A I'm sorry? Do I what?

13 Q Did you ever consider the IQ score of 92 that he got at
14 age 11 and the 92 score he got at age 14, both tests done
15 during the developmental period?

16 A So what's the question?

17 Q Did you consider those tests in making your diagnosis?

18 A I said before that that's certainly complicating factors.

19 Q Okay. But they're not at all mentioned in your report.

20 A No, that's true.

21 Q Okay. Now, it's true Dr. Hall considered these tests in
22 her report; isn't that correct?

23 A I would say so, yes.

24 Q Okay. Also in your report, you failed to mention that,
25 during the testing of Dr. Decker, Mr. Terry has shingles,

1 which is a painful debilitating virus that causes a painful
2 rash that cause debilitating eyesight of Mr. Terry during that
3 test; isn't that true, that he has shingles at the time he did
4 that test?

5 A I have had shingles. I know how -- I know what it is.

6 Q And he had shingles while he took Dr. Decker's test;
7 isn't that correct?

8 A I didn't know that.

9 Q Well, did you read Dr. Decker's report? Because it's
10 mentioned in his report.

11 A Yeah, he did talk about eyesight. I don't remember
12 specifically whether he linked it to shingles.

13 Q Excuse me?

14 A Yeah, I do remember his reference to the eyesight issue.

15 Q Okay. But that's not referenced in your report
16 whatsoever, is it?

17 A No, it's not in my report.

18 Q Would you agree that having a debilitating rash,
19 especially curtailing some of your eyesight, could affect your
20 scoring and the IQ test?

21 A Well, the scoring is something performed by the
22 psychologists. It could affect the score, yes.

23 Q Okay. Looking at your reports --

24 A I'm sorry; I lost you there.

25 Q Okay. Hold on one second.

1 Looking over on your report on page 8, you mentioned, I
2 think on like the fourth paragraph -- in your report,
3 Dr. Greenspan, on page 8 --

4 A Yes.

5 Q Hold on a second.

6 Okay. In earlier reports -- did you change your report
7 before you came to court today?

8 A No, I haven't. I barely looked at it, let alone changed
9 it, no.

10 Q Because the earlier report, it stated -- and you
11 mentioned, "The mere fact that he was given multiple
12 individually administered IQ tests independent of the results
13 is enough to satisfy the developmental criterion." Do you
14 remember writing that?

15 A Yes, I wrote it, and I believe it.

16 Q Okay. So independent of the scores, just because he had
17 been administered many tests, that shows he's intellectually
18 disabled?

19 A No, I didn't say.

20 Q Okay. What did you mean by that?

21 A Well, giving an individual IQ test such as the WAIS or
22 the WISC or the Woodcock-Johnson is a very expensive,
23 time-consuming process. It's only done for one reason, and
24 that's because someone's being considered for a diagnosis that
25 would suggest the possibility of intellectual disability or

1 try to get a handle on why they're doing poorly in school, for
2 example.

3 Q So why did you seek independent results?

4 A Well, because I was talking specifically, sir, about
5 Prong 3. I was not saying that the test itself supports
6 Prong 1. I said it supports Prong 3, because it suggests
7 concern. And I defined -- or I described Prong 3 as a
8 continuity of concern. We only give individual IQ tests if
9 there's a concern.

10 Q Okay. Of course you give the tests when there's concern,
11 but wouldn't the results of those tests be important?

12 A Well, obviously, they could be important.

13 Q Okay. And Mr. Terry, during those years in elementary
14 and middle school or high school, he tested at a 92; isn't
15 that correct?

16 A Yeah, assuming those were valid administrations; I have
17 no reason to think they aren't. But I would have like to have
18 seen the actual reports by the psychologists, and that was
19 not -- I was not able to do that. I'd be more confident in
20 them if I knew how they were administered and who administered
21 them or what their qualifications were. I have seen many
22 cases where, once I have that information, I had reason to
23 question whether it was valid administration.

24 Q Well, I mean, school psychologists administer those
25 tests; right?

1 A Well, I don't know that. I didn't see a report from any
2 school psychologist. I chaired the school psychology program
3 at the University of Connecticut. I'm very familiar with
4 school psychologists. I know that some of them are good and
5 some of them are not so good.

6 Q Okay. So --

7 A It's always important to have that kind of information.

8 Q Okay. So you said you read the school records and you
9 didn't remember seeing the school psychologist's scoring in
10 those records?

11 A I believe that's true.

12 Q You don't remember seeing it or you saw it?

13 A I don't remember seeing it. I may be mistaken.

14 Q Okay. So the 92 score, where did that come from, if it
15 wasn't from the school psychologist's records?

16 A Well, I'm assuming it was done by a school psychologist
17 because that's the function of a school psychologist is to
18 administer IQ tests. It's not something that anyone else
19 could do.

20 Q Right. Of course.

21 A But some of them have master's degrees. Some of them
22 have what's called a six-year degree -- diploma which is sort
23 of halfway between a master's and a doctorate. Some have
24 doctorates. I have even seen school psychology reports that
25 were done by totally unqualified people.

1 Q But you have no proof these people were unqualified, do
2 you?

3 A I don't, no. But that's why you should never put all
4 your emphasis on one test result.

5 Q Okay. Well, I'm going to move on.

6 Now, in your report, you mentioned the low levels of
7 learning that Mr. Terry had.

8 A Yes.

9 Q Okay. But no one in school diagnosed him as being
10 intellectually disabled; isn't that correct?

11 A That's true.

12 Q Okay. They basically defined him as being learning
13 disabled; correct?

14 A That was the label given to him, yes.

15 Q Okay. And learning disabled is different than
16 intellectual disability; isn't that correct?

17 A Learning disabled is, in theory, different, but it's not
18 always properly -- it's not a label that's properly -- always
19 properly given. It's often improperly given.

20 Q Okay. Well, this is a lot of guesses you're making,
21 Dr. Greenspan. You have no idea or no record showing that it
22 was improperly given, do you?

23 A Well, it requires normal adaptive functioning, for one
24 thing. And we don't have that here.

25 Q Well --

1 A Even in the school years. In that sense, I would
2 question its validity. At any rate, it doesn't mean anything.
3 The question is, does he have intellectual disability during
4 the developmental period, not whether it was properly or
5 improperly diagnosed in school.

6 Q Okay. So you're saying that he had adaptive functioning
7 problems in elementary school. Did you talk to any of his
8 teachers?

9 A No, I did not. I relied ---

10 Q Okay. Thank you.

11 A --- for one thing on the Vineland.

12 Q And you didn't talk to his mother either, did you?

13 A Briefly, yes.

14 Q Did you get anything out from her? You didn't, did you?

15 A No, I didn't find that useful.

16 Q And you never talked to any of his friends that he grew
17 up with during that time?

18 A That's true.

19 Q So you really don't know what kind of adaptive
20 functioning he had back then, do you? He made bad grades
21 pretty much. That's all.

22 A That's largely true, yes.

23 Q Okay. And people with learning disabilities usually make
24 bad grades in school. That's why they're put in special
25 education programs; isn't that correct?

1 A Yes.

2 Q Okay. And that's what they have diagnosed was Mr. Terry
3 of being, learning disabled. And you can be learning disabled
4 and not be intellectually disabled?

5 A That's true.

6 Q Okay. And you are aware he was put in resource classes
7 while he was in school?

8 A Yes, I'm aware.

9 Q Okay. And he was also put in special education classes
10 for only English and math?

11 A Repeat that, please.

12 Q He was only placed in special education classes for
13 English and math?

14 A Yes, I believe so.

15 Q Okay. And the resource class is basically classes at the
16 end of the day to help him with the school work; correct?

17 A I'm not 100 percent sure about that.

18 Q All right. Now, in your report, you said, at the age of
19 14, he stayed at the same level academically, so this reveals
20 brain damage; correct?

21 A No, in and of itself, it doesn't indicate brain damage.
22 It indicates a failure to learn.

23 Q Okay. So it could be possible he didn't have brain
24 damage. He just didn't try.

25 A Well, part of giving a test such as the WRAT is assessing

1 whether the person is making an effort. There's no indication
2 that he did not make an effort.

3 Q Okay. I'm not talking about --

4 A So, in that sense, I would say that, at least in terms of
5 those tests, that he tried.

6 Q I'm not talking about testing. I'm talking about school
7 work. He didn't rise academically.

8 A Well, I mean, people give up in school because failure is
9 painful.

10 Q Excuse me?

11 A Yes. Effort obviously enters into it. It could -- it
12 could explain why he did poorly. But there's a lot of
13 evidence here that his deficits were not a function of effort.

14 Q Okay. And you came through from this without speaking to
15 anybody that knew him at that time?

16 A That's true. Well, other than -- well, the wife.

17 Q Well, the wife didn't know him in elementary school and
18 middle school, did she?

19 A I'm sorry?

20 Q The wife didn't know him in elementary school or middle
21 school, did she?

22 A Correct.

23 Q Okay. Now, the first CT scan of Mr. Terry's head was in
24 1994 at the age of 27, well beyond the developmental period;
25 correct?

1 A That's true.

2 Q And when he was younger, I think between the ages of 10
3 and 14, he was sniffing glue with his brother; is that true?

4 A Very dangerous thing developmentally for someone to do.

5 Q Okay. But his score was never reduced during that period
6 between age 11 and age 14, did they?

7 A I'm sorry? What didn't, sir?

8 Q His scores never went down between the age of 11 and age
9 14?

10 A I think that's true, yes.

11 Q Okay. Now, in your report, you stated that Mr. Terry was
12 given the Vineland Social Maturity Scale. And, according to
13 you, this is only given when a student is suspected to have
14 ID; isn't that correct?

15 A Well, it's not given to the student. It's given to a
16 rater.

17 Q Given to a what? Could you repeat that?

18 A To rate him on it. It's a third-party rating scale.

19 Q Okay. And the Vineland Social Maturity Scale is used to
20 measure social maturation in eight areas: Communication,
21 general self-help ability, locomotion, occupation,
22 self-direction, self-eating, self-dressing, and socialization;
23 isn't that true?

24 A Yes. Those are the sub-scales on it, I believe.

25 Q Okay. And he was given this test in fifth grade; isn't

1 that true?

2 A No. He was rated on it. It wasn't given to him.

3 Q Okay. He was rated on it in fifth grade.

4 A Yes.

5 Q My mistake. Okay.

6 But after this test was given, he was still not diagnosed
7 as intellectually disabled; correct?

8 A Why do you say that? Certainly the results are
9 supportive of it.

10 Q But he was not diagnosed by anybody in that school; isn't
11 that correct?

12 A That's true.

13 Q Okay. Now, during your deposition -- and I think on
14 direct you say you couldn't really get anything out of
15 Mr. Terry's mother; isn't that true?

16 A I got too many "don't knows" and it was my clinical
17 judgment that I couldn't rely on her information. That may
18 have been an incorrect and premature conclusion.

19 Q Okay. You describe her as being shaky, during your
20 deposition?

21 A Oh, I don't know. I don't know -- or guessing. To me,
22 that's shaky.

23 Q Okay. And you said that part of your testimony here, you
24 relied on the report given by Dr. Hall; isn't that correct?

25 A I found a lot of really useful stuff in there,

1 particularly around [indiscernible].

2 Q Okay. And during your direct, you said something about
3 something mentioned Mr. -- somebody mentioned that Mr. Terry
4 was borderline retarded in school and that was in Dr. Hall's
5 report?

6 A I believe it was, yeah. And I have also seen it
7 elsewhere, but I can't tell you where I saw it.

8 Q Because the only mentioning that I remember seeing
9 regarding retardation is on page 6 where it talks about the
10 school psychologist, Tommy Wicker, recommended that Mr. Terry
11 be -- remain in regular education classes with two periods and
12 a resource room daily. And that's what was given to him;
13 isn't that correct?

14 A Yes, that's true.

15 Q Okay. And instead of being placed in a special education
16 resource program, it appears from the record that Mr. Terry
17 was retained in fifth grade. I remember you testified to
18 that, that he got retained in fifth grade; isn't that true?

19 A Yes.

20 Q Okay. And it says here, "This seems to confirm
21 Ms. Terry's recollection of her son's evaluation for special
22 education. She recalled a teacher named Fitzgerald, and she
23 was adamant that Gary was a slow learner but was not retarded.
24 She and Ms. Fitzgerald believed that Mr. Terry needed to get
25 more individual attention in class. He appeared to benefit

1 from this attention, and his grades improved, his test scores
2 improved, and he was promoted to the sixth grade the following
3 year."

4 That is also true? He got promoted the next year to the
5 sixth grade? He was retained the fifth and then, the next
6 year, he got retained -- moved up to the sixth grade; isn't
7 that correct?

8 A I believe so.

9 Q Okay. Now, Dr. Hall's report also mentioned that, as a
10 young boy, Mr. Terry did chores.

11 A Terry what? I'm sorry?

12 Q Mr. Terry did chores. He had chores as a young boy.
13 Remember reading that in her report?

14 A I didn't catch the last word. What did he have?

15 Q Chores. Chores. I'm a country boy. It's work in the
16 house when you're little. I'm a country boy. That's what we
17 call work.

18 Mr. Terry had responsibilities as a child for working in
19 the house. Did you remember reading that in Dr. Hall's report
20 from his mother?

21 A Yes, I believe I did. But I'm not a country boy, so I
22 might call it something else.

23 Q Okay. And now his mother didn't tell you that Mr. Terry,
24 as a boy, was responsible for washing dishes, sweeping the
25 floor, and he also helped his father with carpentry and

1 mechanics, and he completed these chores independently.

2 Now, that goes to adaptive functioning, doesn't it?

3 A That goes with practical adaptive functioning, which I
4 have already testified is the area of great strength for him.

5 Q Okay. And I don't know if you read this, but Louanne
6 also said that Mr. Terry once repaired the victim's washing
7 machine at one time?

8 A Again, that shows good, practical adaptive functioning.

9 Q So intelligence also?

10 A It shows good practical skills. It's an aspect of
11 intelligence. That's not tapped by IQ tests. But I have
12 already testified that he has areas of skill, as do most
13 people with intellectual disability. And practical adaptive
14 functioning is an area of particular competence and skill.

15 Q Okay. So the fact that he could do his chores, he could
16 do his work as a child during the developmental period, that
17 shows some personal independence, which must be looked at when
18 you determine adaptive functioning; isn't that correct?

19 A Well, that doesn't really indicate independence.
20 Independence would be -- would not be a mother or someone else
21 telling you what to do.

22 Q Well, independence would be -- Dr. Greenspan, do you have
23 children?

24 A Yes, I do. And grandchildren.

25 Q You have children and grandchildren. Okay.

1 So you would know how hard it is to get your children to
2 do their chores, to do their work. If they do it
3 independently, then you don't have to make them do it; isn't
4 that correct?

5 A That's obviously very important. Yes, that's important.

6 Q And that shows some adaptive functioning when you are
7 able to do things on your own without being asked; isn't that
8 correct?

9 A Of course.

10 Q And according to his mother, Mr. Terry, as a child, was
11 able to do that; correct?

12 A Yes. He had practical skills and that's an aspect of
13 that. Now, I don't know all the context, what the demands
14 were, how difficult those chores were, but certainly that's a
15 positive indication of practicable skill and motivation. And
16 people with intellectual disability often hold jobs, as I have
17 testified and written. They often like doing what I might
18 consider or you might consider menial jobs. It gives them a
19 sense of accomplishment.

20 Q Okay. Now, in the report, you mentioned something like
21 his mother reported that she was told by a third grade teacher
22 that Gary is borderline retarded.

23 A Yes.

24 Q And she didn't tell you this herself, did she?

25 A No.

1 Q Okay. As a matter of fact, this information came from
2 notes made by the social worker in his original case. Do you
3 remember reading that?

4 A Yes. Thanks for clarifying that.

5 Q Okay. So it wasn't in the school reports, and it wasn't
6 given to you verbally by Mrs. Terry; isn't that correct?

7 A Yes.

8 Q Okay. And no -- this third grade teacher, you never got
9 in contact or even know her name; isn't that true?

10 A No, I don't.

11 Q Okay. And no school psychologist ever diagnosed
12 Mr. Terry as being intellectually disabled; isn't that
13 correct?

14 A Not to my knowledge, no.

15 Q Now, isn't a person that is intellectually disabled
16 easily manipulated?

17 A That's been a major emphasis in my own writing over the
18 years. And gullibility.

19 Q All right. Now, you spoke to Mr. Terry's ex-wife
20 Louanne?

21 A I did [indiscernible] at length.

22 Q You broke up for a little while, Dr. Greenspan. Could
23 you repeat that, please? Could you repeat?

24 A At length, I talked to [indiscernible].

25 Q You spoke to her at length? Is that what you are saying?

1 A Can you hear me?

2 Q Yes. You said you spoke to her at length? Is that what
3 you said?

4 A I did talk to Louanne, yeah. I talked to her for a
5 while.

6 Q Okay. And she told you that she first met Mr. Terry at a
7 bar in Columbia; correct?

8 A Yeah, you kind of broke up there, Mr. Evans. She told me
9 it was a dance. She met him at a dance.

10 Q No, I think she said she met him at a bar, and he asked
11 her to dance.

12 A Well, I may have misunderstood her.

13 Q Do you remember that?

14 A No, that's not what I remember.

15 Q Okay. And at the time, she was a college student and he
16 was a tenth-grade dropout; correct?

17 A Well, she didn't know that. She thought he was much
18 older.

19 Q Exactly. He lied to her and told her he was nearly 26
20 years old but he was only 19; correct?

21 A Yeah. She fell for it.

22 Q And she fell for it. So he easily manipulated her. She
23 didn't manipulate him; isn't that true?

24 A Well, they're not mutually exclusive. You can manipulate
25 people and still be manipulated.

1 Q Okay.

2 A But it's true that he did not tell her the truth.

3 Q Right. And he also wooed her and convinced her to fall
4 in love with him; isn't that correct?

5 A Well, she entered into a romantic relationship with him.

6 Q As a matter of fact --

7 A Whether she fell in love with him, I really can't say.

8 Q Well, okay. Now, I remember reading -- and you might
9 have read this also in Dr. Hall's reports -- that Louanne
10 stated that Terry would sweet-talk her to get his way or bring
11 her flowers when he messed up; isn't that correct?

12 A Yes. She found him charming and amusing.

13 Q And that's very manipulative behavior also; isn't that
14 true?

15 A People with intellectual disability can manipulate. And
16 she describes herself as very naive back then.

17 Q Okay. Mr. Terry also convinced the woman, while he's on
18 death row, to marry him; isn't that true?

19 A Yeah, which created some real problems for her with her
20 parents.

21 Q Okay. So it sounds like Mr. Terry does a good job at
22 manipulating women; isn't that correct? They don't manipulate
23 him. He manipulates them; isn't that true?

24 A Well, he's had a lot of girlfriends, so I assume he has
25 some skill in that department.

1 Q Okay. He also, while serving his YOA sentence, he
2 attempted to bribe a correctional officer to get back a radio
3 for another inmate. Do you remember reading that in his SCDC
4 file?

5 A Well, yeah, but not very effectively. Rather ineptly,
6 actually. So that's more supportive of ID than contrary to
7 it.

8 Q Okay. Now, you talked about the business Mr. Terry owned
9 at one time; isn't that true?

10 A The repo, yeah.

11 Q The repo business.

12 Now, isn't it true that Mr. Terry started that business
13 and gave flyers to different car companies in Columbia in
14 order to get business repossessing cars?

15 A I'm assuming that Louanne wrote up the flyers and told
16 him what to do. But I don't know that for --

17 Q You're assuming that, but Mr. Terry is the one that
18 handed out the flyers, so you have absolutely no proof of who
19 created those flyers. It could have been Mr. Terry; isn't
20 that true?

21 A It could be true, yes.

22 Q Okay. And beyond that, he's the one that distributed the
23 flyers and got the business. Louanne did not do that, did
24 she?

25 A Well, I don't know if she knew how to do it, but she told

1 me that he had success with one company, but he failed to get
2 other companies.

3 Q Okay.

4 A And then, at some point, that company dropped him, and
5 that was the end of the business.

6 Q Well, I'm going to -- well, we're going to how he lost
7 his business in a minute.

8 Now, Louanne helped him with the paperwork and helped him
9 with the books; isn't that true?

10 A Yes, I believe that's true.

11 Q And that's because she's a college graduate and he only
12 had a tenth-grade education; isn't that true?

13 A Well, she had -- obviously had significant academic
14 skills that he lacked.

15 Q Okay. But he did the work regarding the repo business;
16 isn't that true?

17 A Apparently, yes.

18 Q Okay. And the business failed not because of what
19 Mr. Terry did, but Mr. Terry got injured and he allowed his
20 cousin to run the business and his cousin stole from him;
21 isn't that true?

22 A I believe something like that happened, yes.

23 Q Okay. So it wasn't that Mr. Terry was just so
24 intellectually disabled that he wasn't able to run the
25 business. He had a misfortune and trusted the wrong person.

1 That's why he lost the business; isn't that true?

2 A Well, trusting the wrong person is certainly supportive
3 of an ID diagnosis. But --

4 Q Oh, really? So everyone, I guess, has intellectual
5 disability because we all have trusted the wrong person at one
6 time or another.

7 MR. GROSE: Objection. Argumentative.

8 MR. EVANS: I'm asking a question.

9 THE COURT: Overruled.

10 A Many people have, including myself.

11 BY MR. EVANS:

12 Q Okay. So -- and you -- of course you're not
13 intellectually disabled, are you, Dr. Greenspan?

14 A I'd like to think I'm not.

15 Q Okay. So just because Mr. Terry trusted a family
16 member -- his cousin -- does not prove he's intellectually
17 disabled, does it?

18 A Of course not. I think you're putting words in my mouth.

19 Q No, I don't think I am. But I'm going to move on?

20 MR. GROSE: Objection. That's argumentative.

21 MR. EVANS: Withdrawn.

22 MR. GROSE: Move to strike.

23 MR. EVANS: Withdrawn.

24 THE COURT: Move on.

25 BY MR. EVANS:

1 Q Now, in your supplemental report, you discussed that
2 Dr. Hall mentioned the job that Terry had; however, she failed
3 to mention the menial nature of these jobs and how they ended
4 in failure; isn't that correct?

5 A I said that, yes.

6 Q Okay. Now, Mr. Terry dropped out in the tenth grade;
7 correct?

8 A I'm sorry? What?

9 Q Mr. Terry dropped out in the tenth grade?

10 A Yes, after being retained.

11 Q Okay. You're not going to get any higher-level jobs with
12 only a tenth grade education, would you?

13 A Usually not, no.

14 Q Okay. So the menial labor is the only labor you can get
15 with a tenth-grade education; isn't that correct?

16 A Not necessarily, but certainly for people with ID, that's
17 typically the kind of jobs they do.

18 Q Okay. So you're going to get a high-level, high-paying
19 job with no high school diplomas nowadays in this country; is
20 that what you're saying?

21 A Repeat the question, please. Could you repeat that
22 question?

23 Q So a high-level, high-paying job with no high school
24 diploma in this country; is that what you're saying?

25 A It's not impossible, but it's unlikely, yes.

1 Q It's unlikely. Okay.

2 So usually people with only a tenth-grade education,
3 regardless of their mental status, would get a menial labor
4 job; that those are the only jobs available to people with
5 high school educations -- with no high school education.

6 Isn't that correct, Dr. Greenspan?

7 A As a general rule, that's probably true, yes.

8 Q All right. Now, according to SCDC records, Mr. Terry
9 first worked with Piggly Wiggly and he got fired for an
10 argument. Did you ever remember seeing that in his SCDC
11 records?

12 A Yes. I know he didn't hold jobs very long, except for
13 one with a friend, I believe.

14 Q Okay. And he worked for Suncliff Amaco as a mechanic.
15 And that was -- you'd have to have some intellect to be able
16 to fix cars, wouldn't you?

17 A I'm missing some of your words. But, again, practical
18 intelligence is his area of strength, and part of that
19 involves working on cars.

20 Q Okay. And he also worked at Giant Food World but he quit
21 and moved to Florida; isn't that true?

22 A What did he do?

23 Q Worked at Giant Food World. It's a grocery store.

24 A Yes.

25 Q As a stocker. And then he quit and moved to Florida.

1 And then he was working for a tree ---

2 A Okay.

3 Q --- service, and that's when he got injured, at the tree
4 service.

5 A Oh, yes.

6 Q Okay. Now, you're saying earlier that his menial labor
7 jobs revealed -- and that he cannot keep them -- revealed his
8 intellectual disability? That is your belief?

9 A I would never say that and I didn't say it.

10 Q Okay. So you're saying now that it's a possibility that
11 he was not intellectually disabled because he did have menial
12 labor jobs?

13 A No. Again, I think you're misstating what I said.

14 Q So what did I --

15 A People with ID have trouble holding jobs, and that's --
16 if you look at the history of Mr. Terry's employment history,
17 that's -- I think that's a fair characterization. He never --
18 he never held a job very long. And that was certainly
19 Louanne's impression.

20 Q Okay. So you ---

21 A [Indiscernible] any one particular instance to say that
22 that's the basis for diagnosing it. It's just congruent.
23 That's all.

24 Q Okay. Now, do you remember reading his mother writing in
25 her diary that Mr. Terry cannot keep a job and he needs to

1 grow up?

2 A Yes, I believe she did say that.

3 Q Now, isn't it possible he couldn't keep a job because
4 he's just lazy?

5 A Because he was lazy?

6 Q Yes?

7 A Well, I suppose that's possible, yes.

8 Q Okay. Now, you also wrote in your supplemental report
9 regarding a disagreement with Dr. Hall when Dr. Hall said that
10 her pregnancy on Terry's birth was nonproblematic. Do you
11 remember writing that?

12 A Yes, I do remember writing that.

13 Q Okay. And you wrote about -- in your report about
14 Ms. Terry having a kidney disease while pregnant and was
15 likely taking teratogenic medications. Could you pronounce
16 that for me, please?

17 A "Te-rat-oh-gen-ic."

18 Q Teratogenic medication. Okay.

19 A It's a chemical that causes brain -- birth defects.

20 Q Okay. Now, you did not see any medical records during
21 Mrs. Terry's pregnancy, did you?

22 A No, that was from testimony by her, I believe.

23 Q I think this kidney disease came from the same
24 questionnaire about the borderline mental retarded from her
25 social worker; isn't that true?

1 A Possibly, yes.

2 Q Okay. So you have absolutely no proof of this kidney
3 disease that his mother had while she was pregnant with
4 Mr. Terry?

5 A Other than that, no, I don't.

6 Q And during the deposition, I thought teratogenic was only
7 one drug, but it's several drugs that can cause birth defects;
8 isn't that true?

9 A Well, any drug that causes birth defects is teratogenic.

10 Q Okay. So that means several drugs can cause this, not
11 just one drug; correct?

12 A Yeah. Alcohol is probably the main one.

13 Q Well, [indiscernible] alcohol is considered teratogenic
14 drugs also; isn't that true?

15 A It's probably the main one.

16 Q Okay. And you have no proof that Ms. Terry took alcohol
17 or drugs during her pregnancy?

18 A No. And I'm not saying she did. I'm just saying there
19 are very many different ways of causing [indiscernible] in a
20 fetus, including taking of medication.

21 Q Okay. And teratogenic drugs also included some
22 cancer-fighting medications, some antibiotics. But you have
23 absolutely no idea what drugs Ms. Terry was taking during her
24 pregnancy?

25 A That's true.

1 Q Okay. And you are not a medical doctor; isn't that
2 correct?

3 A That's true.

4 Q Okay. But I'm sure Ms. Terry's medical doctor would know
5 what drugs could cause birth defects; correct?

6 A Not necessarily. I mean, information about teratogenic
7 effects has improved, and that was a while -- quite a while
8 ago. Back then, they didn't know that much about it.

9 Q But this statement regarding these drugs is totally a
10 guess by you; isn't it?

11 A Well, I was taking it at face value, the fact that she
12 had kidney disease and that it was a real problem in the
13 pregnancy and that's why I said that Dr. Hall saying it was a
14 perfectly normal pregnancy may be untrue. It may be an
15 overgeneralization.

16 Q Okay. Well, Mr. Terry was carried to term, wasn't he,
17 according to his mother?

18 A I'm sorry. Again, I missed --

19 Q He wasn't born premature, was he?

20 A No, he wasn't.

21 Q Okay. And there was no knowledge of any type of birth
22 defects that he had after his birth, is there?

23 A No. And brain damage is typically something that shows
24 up later.

25 Q It shows up later when he's in school, isn't it?

1 A When he's in school, which it did.

2 Q Okay. Well, he had an IQ of 92 while he was in school,
3 didn't he?

4 A Yeah, he did. That's the only indication of normal
5 cognitive functioning. There are many indications of abnormal
6 cognitive functioning.

7 Q Well, not making good grades and being learning disabled,
8 that's abnormal also, isn't it?

9 A Absolutely. And many -- many people with LD or labeled
10 LD have brain damage.

11 Q And many people who are labeled LD just have a learning
12 disability and no brain damage or any type of intellectual
13 disability?

14 A Well, I would dispute that. I mean, if you look at the
15 history of learning disabilities, which I'm very familiar
16 with, it was always considered a form of minimal brain damage.
17 In fact, that was the term used.

18 Q Okay. All right. Let's go to the common sense
19 questionnaire. You measured -- part of your measuring of
20 adaptive functioning was the common sense questionnaire that
21 you gave Mr. Terry?

22 A Yes.

23 Q And these are, what, 23 scenarios that you told him to
24 see if Mr. Terry knew right and wrong in a particular
25 situation; isn't that true?

1 A Well, right and wrong implies moral judgment. I'm
2 really -- I think a more accurate way of -- is dumb versus
3 smart.

4 Q An accurate way of dumb versus smart? Is that what you
5 said?

6 A Yeah. In terms of understanding possible consequences
7 such as getting arrested or losing a job or developing some
8 kind of problem or other.

9 Q And this questionnaire is not done by anybody else in the
10 psychological community; isn't that correct?

11 A That's largely true, yes.

12 Q You're the only one that actually does this questionnaire
13 on patients; isn't that correct?

14 A I think others have used it.

15 Q Others have used it? Your questionnaire?

16 A Yes.

17 I'm sorry; I don't hear anything.

18 Q I'm looking for something.

19 A I can't see you, so I have no way of knowing what you're
20 doing.

21 Q Okay. During your deposition, I asked you, "Is this
22 something used by psychologists in the ordinary course of
23 business or just something that you use in your evaluations?"

24 And your answer was, "There are some people that know
25 about it, but for the most part, it's mostly me."

1 A Yes, that's true.

2 Q Okay. So people know about it but you're the only one
3 that usually uses it; correct?

4 A Yes.

5 Q Okay. And only you would get to decide what's right and
6 what's wrong with the person's answer; isn't that true?

7 A No. I didn't really give you a manual that describes how
8 it was developed, but I think a consensus of -- I did run it
9 by judges, is the term used.

10 Q You ran the questionnaire by --

11 A I didn't -- I'm not the only one who came up with a way
12 of saying this is a good answer and this is a bad answer. I
13 think the average competent adult would pretty much get
14 100 percent of these correct in terms of knowing whether a
15 particular portrayed course of behavior is good -- is
16 effective or not and understanding why it might be
17 ineffective.

18 Q Okay. And in your questionnaires, the answer is pretty
19 much black and white. There's no gray in these answers, is
20 there? And your opinion, either it's right or wrong; isn't
21 that true?

22 A Well, there are two ways of answering. The first one
23 is -- is this okay or not okay. And the second, which is
24 actually probably more important, is why it's not okay, both
25 in terms of if they say it's not okay, why. If they say it's

1 okay, I then follow up and I say, "Well, some people might say
2 it's not okay; why would they say that?"

3 So I'm not just interested in whether they can give the
4 right or wrong answer but whether they would understand why a
5 course of behavior might be ineffective or dangerous.

6 Q Okay. Because one of the questions I'm seeing in the
7 questionnaire, you mention that the scenario was, "Sarah is a
8 parent whose one-year-old child had a bad cold and does not
9 own a vaporizer, so Sarah took her child to the shower to
10 clear up congestion, but the child slipped out of her grasp,
11 hit her head on the edge of the bathtub, and the child seemed
12 pretty injured. Sarah took the child to the emergency room.
13 The doctor said, 'Sarah, how did the child hit her head?'
14 Sarah was afraid that she would be accused for child abuse so
15 she decided to make up a story and told the doctor that her
16 child hit her head against the table while running in the
17 house."

18 Now, you asked, "What do you think -- what did you think
19 of what Sarah decided to do?"

20 That's a pretty gray area, isn't it, Dr. Greenspan?
21 Because many parents would lie also; isn't that true?

22 A Well, a lot of these scenarios are based on real-life
23 cases. In fact, that's based on a case in which -- it was
24 actually a father and then a mother ended up going to jail
25 because it was pretty obvious that -- what had happened.

1 So I don't think it's a gray area at all.

2 Q But I'll repeat though: Just because you tell a lie to
3 this woman, because you're afraid you would lose your
4 children, doesn't mean --

5 A In terms of [indiscernible], that's an ineffective -- I
6 mean, some of these items are better than others. That may be
7 one of the few gray area --

8 Q You're trying to evade my question. I asked: Just
9 because a parent would lie to a nurse because they are afraid
10 they would lose their children does not mean you were
11 intellectually disabled; isn't that true?

12 A Well, I'm not evading you and I don't appreciate being
13 accused of that.

14 Q Well, answer the question, please.

15 A No, you're right.

16 Q Okay. And in this --

17 A [Indiscernible] -- competent people would answer that
18 differently.

19 Q It's some gray area in that because you have parents that
20 may be afraid to lose their children so they may lie, which is
21 wrong, but there's a reason for that; isn't that correct?

22 A Well, there's a principle in the development of tests as
23 well as interviews. It's called a Minimax [Indiscernible]
24 Theory of Reliability, and that principle basically is because
25 any one item may be unreliable. That's why I have a lot of

1 items. I have 23 items precisely because I have never draw an
2 inference from only one of them.

3 Q Okay.

4 A On the other hand, in the real world, it only takes one
5 really stupid behavior to end up in jail.

6 Q Okay. Let's talk about stupid behaviors to end up in
7 jail. Is it smart to point a gun at somebody and take their
8 money? Is that smart?

9 A Is it smart what?

10 Q To point a gun at somebody and take their money. Is that
11 a smart thing to do?

12 A Given the risks involved, no, I would say it's not smart.

13 Q Okay. Is it smart to break in somebody's house and take
14 items?

15 A No.

16 Q Okay.

17 A I don't think so, but that's my value.

18 Q Okay. So wouldn't you think that 99 percent of the
19 people who are incarcerated right now is because they did
20 something dumb and stupid?

21 A And a very large percentage of them have some kind of
22 developmental disability that's never been diagnosed.

23 Q But not all of them, do they?

24 A No, I mean, as a rule, people who end up in jail are not
25 the brightest bulbs.

1 Q Okay. But that doesn't mean they're intellectually
2 disabled. They're just not smart people; isn't that correct?

3 A Well, there's a continuum, but that's true.

4 Q Now, when Mr. Terry met you and you talked to him and you
5 gave him these scenarios, did you ever have questions about
6 his intellect?

7 A About his what?

8 Q Intellect. Did you question -- have questions to try to
9 find out his intellect, how smart he is?

10 A Well, obviously, I had questions about it because
11 [indiscernible] question. And that was one way to getting
12 answers is by giving him these scenarios.

13 Q Okay. Like Dr. Hall asked Mr. Terry about who the
14 current president is and name the presidents in order, to
15 spell the words -- to try to recall three words, to spell the
16 word block backwards. Did you ask any of these type of
17 questions?

18 A No.

19 Q Now, traumatic brain injury, you point to that as a
20 possible reason for intellectual disability; correct?

21 A It's one of the major known causes, yes.

22 Q Okay. And you mentioned the numerous head injuries that
23 Mr. Terry had during his life?

24 A Yes.

25 Q And these included the glue sniffing in 1981 when he was

1 18 -- 14, excuse me, where he almost killed himself; correct?
2 That happened?

3 A When he tried to kill himself?

4 Q No, not when he tried to kill himself. When he almost
5 killed himself at 14 from sniffing glue.

6 A Yes, I'd say that's a major factor for intellectual
7 disability, yes.

8 Q Okay. And you talked about the head injury when he fell
9 out of a tree at work in 1985?

10 A Yes.

11 Q The motorcycle accident he had in 1986; correct? That
12 happened also?

13 A Yes.

14 Q And the bar fight in 1992 when he got hit in the head
15 with a board?

16 A I believe there were two bar fights that resulted in head
17 injuries, yes.

18 Q Okay. Now, except for falling out of the tree, all of
19 these events was caused by Mr. Terry's own actions; isn't that
20 true?

21 A Caused by his own actions?

22 Q Yes.

23 A Poor judgment, I would say.

24 Q But his own actions. He did it to himself.

25 A Yes. In terms of risk unawareness, there's a hallmark of

1 people with intellectual disability. I couldn't agree more.

2 Q Okay. There's a hallmark of people just not being very
3 bright either, and it doesn't mean you're intellectually
4 disabled because you made bad decisions; isn't that correct?

5 A No. I mean, there's a continuum, and a lot of people
6 make bad decisions who are not intellectually disabled but
7 people with intellectual disabilities almost always make bad
8 decisions.

9 Q Now, you said earlier that you read the reports and the
10 testimony of Dr. Edward Deysach.

11 A Yes, I did.

12 Q And Dr. Deysach was the neuropsychologist who testified
13 in Mr. Terry's original trial.

14 A Is that a question?

15 Q Yes. He's the original -- he's the neuropsychologist
16 that testified in the original trial, isn't he?

17 A Yes.

18 Q Okay. And Dr. Deysach testified that he reviewed the
19 Charter Rivers records where Mr. Terry had a CAT scan done at
20 that time. Remember reading that?

21 A Yes.

22 Q Okay. And Dr. Deysach also said that he did a battery of
23 tests to determine if he's retarded -- was the term they used
24 back in 1996 during his trial. Did you read that part of his
25 testimony?

1 A I believe I did, yes.

2 Q Okay. And on page 2006 of the original record, his
3 lawyer asked was Gary Terry retarded, and his answer was, "No.
4 His performance fell in the low to average range but not
5 retarded." Do you remember reading that?

6 A Yes.

7 Q So Dr. Deysach, a man who was called by the defense to
8 testify on Mr. Terry's behalf and did testing on Mr. Terry to
9 make a determination of intellectual disability, said he
10 wasn't intellectually disabled; isn't that true?

11 A Yes. Presumably he was relying heavily on the IQ data.

12 Q But you don't know that for a fact. You say he did
13 testing. It could be a battery of tests he'd done. As a
14 matter of fact, he said, "I gave him a battery of tests in
15 which I wanted to make a determination of whether or not I was
16 dealing with somebody whose behavior fell in the retarded
17 range." He said that.

18 So a battery of tests presumably is a group of tests, not
19 just one; isn't that correct?

20 A Well, he didn't give that many tests, to be honest with
21 you.

22 Q Were you in the courtroom when he testified?

23 A I looked at his report.

24 Q You were looking at his report. Okay.

25 Dr. Deysach [sic], do you know about the book, "The Death

1 Penalty and Intellectual Disability" edited by Edward
2 Followay?

3 A Yeah, it's an edited book published by AAIDD, and I am
4 the most prolific contributor to that book with four chapters
5 that I either wrote solely or was first author on.

6 Q You wrote four chapters. Did you write the first four
7 chapters?

8 A No, I didn't say the first four. There were four
9 chapters in that book that I either wrote jointly, where I was
10 first author, or solely where I was the only author.

11 Q Okay.

12 A They related to all three prongs.

13 Q Okay. Now, on page 80 of this book, it states, "It
14 should be noted, however, that identification of brain
15 pathology, typically from neuropsychological test results, is
16 not in itself sufficient to establish the diagnosis of ID."
17 Would you agree with that?

18 A Who wrote that chapter you're quoting?

19 Q I don't know. It's a chapter in the book.

20 A Yeah, obviously, I would agree with that.

21 Q Okay. And your final diagnosis is that Mr. Terry is
22 intellectually disabled; correct?

23 A Yes, that's correct.

24 Q Okay. Now, he was evaluated and tested by numerous
25 school psychologists; correct?

1 A I don't know how many times. I'm sure it was more than
2 one.

3 Q Okay. And Dr. Deysach tested him also; correct?

4 A Yes.

5 Q He was examined at Charter Rivers after he went in for
6 possible -- possible addiction; isn't that correct?

7 A Yes.

8 Q Okay. And he was examined by Dr. Hall, who is a
9 psychologist at DDSN; isn't that correct?

10 A Who is that? I didn't catch the name.

11 Q Dr. Hall.

12 A Yes.

13 Q Okay. And he was also examined by Dr. Decker?

14 A Yes.

15 Q None of those doctors diagnose him as being
16 intellectually disabled. You're the only one that diagnosed
17 him as intellectually disabled; isn't that true?

18 A That's true.

19 Q Okay. One last thing. You were saying earlier that the
20 Woodcock-Johnson test was more reliable than the WAIS test;
21 isn't that true? Didn't you say that earlier in direct
22 examination?

23 A I didn't use the word "reliable." I think I -- if I used
24 any word, it would be "valid."

25 Q More valid. Okay.

1 A I mean "reliability" is a term of art that refers to
2 things like whether you come up with the same result each time
3 you administer it. Validity refers to whether it's actually
4 measuring what it claims to be measuring.

5 Q Okay. Now, earlier in your direct, you said that if
6 you're going to give a person a second IQ test, it has to be
7 done past six months; isn't that correct?

8 A Well, it's not my opinion. That's what's stated in the
9 manual. In fact, many qualified authorities would say it
10 should be more like a year.

11 Q Okay. And Dr. Hall gave Mr. Terry an IQ test two years
12 after the Woodcock-Johnson test was administered; correct?

13 A I believe someone else administered it, but she reported
14 on it.

15 Q Okay. Whoever administered the test at the Department of
16 Disability and Special Needs did it two years after his
17 previous test; correct?

18 A It was a different test.

19 Q I was about to ask you that. Didn't you say on direct
20 that you cannot give the same test twice, that you would have
21 to give a different test?

22 A Yeah, if she had given -- you know, she had given the
23 WAIS -- I mean, if she had given the Woodcock-Johnson, it
24 might have been a problem.

25 Q Okay. So she couldn't give the Woodcock-Johnson test.

1 She had to give a different test, and so she decided to use
2 the WAIS test; isn't that correct?

3 A Which is the most widely used, yes.

4 Q Okay. And so since it was done more than two years after
5 the original test and she did a different test, she pretty
6 much followed procedure, didn't she?

7 A Yes. But my criticism was not with how many years had
8 expired. And I wouldn't really call it criticism; it was an
9 observation, because I generally have a lot of respect for
10 her.

11 Q Okay.

12 A It was not -- it was a -- it was a different test, and
13 different tests measure different things, and the construct
14 we're trying to measure here is intelligence. In my opinion,
15 the Woodcock-Johnson does a better job of measuring -- a more
16 valid job of measuring intelligence.

17 Q And the test that Dr. Deysach gave, he gave this test.
18 It came up with the same score as the WAIS test, didn't it?
19 They both scored a 77.

20 A Yeah. What I saw [indiscernible] again, it was a report.
21 I didn't see his testimony. But he never gave a score. He
22 just said it was -- he just said it was a low average or
23 something like that. I never -- which is unusual. Normally,
24 you give a score.

25 Q I'm not talking about -- I'm talking about Dr. Decker.

1 Dr. Decker gave a score of 77; isn't that correct?

2 A I thought you said Deysach.

3 Q If I did, I apologize. I mean, all these D's, maybe
4 confused.

5 Dr. Decker gave a score of 77; isn't that correct?

6 A On the Woodcock-Johnson, yes.

7 Q And that was the same score that DDSN came up with? A
8 77; isn't that true?

9 A Yes. And then when you correct for Flynn Effect, they're
10 both qualifying scores for ID.

11 Q All right. Well, let's talk about the Flynn Effect. The
12 Flynn Effect, you normally multiply by .3; isn't that correct?

13 A Well, there's some dispute as to which number to use.
14 Today, the more likely number is 0.3. Dr. Hall used 0.33 but
15 that would not make much difference.

16 Q That wouldn't make much difference. Okay.

17 A I mean, at one time, it was .33 and now it's more likely
18 to be .3.

19 Q Okay.

20 A Applied to the date of norming when she used the date of
21 publication, which is two years later.

22 Q Okay. But the scores he made during the developmental
23 period, even with the Flynn Effect, scores him at a 90. And a
24 90 is above the threshold to determine intellectual
25 disability; isn't that correct?

1 A That's true.

2 Q Okay.

3 MR. EVANS: Nothing further, Your Honor.

4 One second. One second.

5 BY MR. EVANS:

6 Q A few more questions, Dr. Greenspan. Now, when did you
7 come to your final opinion? Do you remember what date?

8 A The same date I wrote my report, I believe.

9 Q So you came to your final conclusion on July 5th?

10 A Yes.

11 Q Okay. When did you complete your review of the records?

12 A Within the two weeks prior to that.

13 Q Okay. And why did you do a supplemental report?

14 A Because at the time I wrote my report, I did not have
15 access to Dr. Hall's report. If I had, I would have included
16 that as a part of our report.

17 Q Okay. But a lot of the information and interview done
18 with her mother is not in your supplemental report, is there?

19 A No. If anything, reading Dr. Hall's report, it
20 strengthened my opinion.

21 Q It strengthened your opinion.

22 A Yes, because she had a lot of really good stuff in there,
23 particularly about Prong 2, adaptive behavior.

24 Q But you didn't write about the interview she did with her
25 mother in your supplemental report, did you?

1 A No, I don't think I did. I probably should have.

2 Q Okay.

3 THE COURT: Dr. Greenspan, hold tight for just one
4 second.

5 THE WITNESS: I'm sorry? Could you repeat that?

6 THE COURT: Hold on for just one second.

7 Ballpark for me how long do you think you're going to be.

8 MR. GROSE: About five, ten minutes.

9 THE COURT: Okay. All right. Let's go ahead and push
10 through.

11 REDIRECT EXAMINATION

12 BY MR. GROSE:

13 Q Dr. Greenspan, can you hear me all right?

14 A Yes, I can.

15 Q I think Mr. Evans characterized your supplemental report
16 as a critique of Dr. Hall's report. Do you recall that?

17 A Yeah. I'd prefer not to call it a critique. It was just
18 a commentary.

19 Q Well -- and you actually -- I mean, and your supplemental
20 report indicated that there was a lot of things in Dr. Hall's
21 report that you agreed with; is that right?

22 A I was very thorough. I find her to be a very competent
23 person.

24 Q And is it fair to say that that part of the thoroughness
25 was the information that she included about her interview with

1 Gary's mother?

2 A Yes.

3 Q Okay.

4 A I found that very useful.

5 Q All right. Now, they asked you some questions about the
6 work that Gary did around the house when he was a child. Do
7 you recall those questions?

8 A I believe the word that Mr. Evans used was "chores."

9 Q Correct.

10 And the part of Dr. Hall's report that I think he was
11 referring to says that she reported Mr. Terry was responsible
12 for washing dishes, sweeping the floor, making his bed, help
13 his father with carpentry and mechanics, and doing his
14 laundry.

15 Are people with a mild intellectual disability capable of
16 washing dishes?

17 A Yes. In fact, that's a common form of employment that
18 they end up doing.

19 Q Okay. And to suggest that somebody with a mild
20 intellectual disability couldn't do that, that would be a
21 stereotype, wouldn't it?

22 A Definitely.

23 Q And sweeping floors, is somebody with a mild intellectual
24 disability able to sweep floors?

25 A Yes. It's, again, a very common behavior.

1 Q And to suggest that that means a person does not have an
2 intellectual disability, that would be a stereotype; correct?

3 A Yes, it would.

4 Q Making a bed, are people with a mild intellectual
5 disability able to make a bed?

6 A Yeah. I did a study of why people are fired, and one of
7 them involved a woman who was successful -- people with --
8 someone with an intellectual disability who was successful as
9 a chamber maid in a hotel who could make the bed. What got
10 her fired was, if somebody stayed in past the check-out time,
11 she would become very anxious, and she would knock on the door
12 and say things like, "Get your ass out of bed." So it was the
13 social intelligence or social adaptive functioning deficit
14 that got her in trouble, not the fact that she couldn't make
15 the bed.

16 Q And so to suggest that somebody with a mild intellectual
17 disability is not able to obtain and hold a job of this type
18 of nature, that would, again, be stereotyping, wouldn't it?

19 A Yes. People who, with an intellectual disability, who
20 are fired, it's usually because of social incompetence, not
21 because they can't do the menial job that they end up doing.

22 Q All right. And in that sentence, there was also
23 reference to helping his father with carpentry and mechanics,
24 and I believe that you testified that Gary has strengths in
25 the practical domain?

1 A Yes. Now, I know the father was rather cruel and
2 aggressive towards him every time he messed up, but I don't
3 doubt that he could do a lot of things in the practical
4 domain.

5 Q All right. And there was a lot of questions about the
6 various relationships that Gary had with women. I believe, on
7 direct, we talked about the fact that one of the stereotypes
8 is that people with a mild intellectual disability are not
9 capable of having romantic relationships. Do you recall that?

10 A Yes. People with intellectual disabilities often have --
11 are married or have girlfriends or boyfriends and often are
12 parents and not necessarily effective or competent parents,
13 but it's certainly a role they can play.

14 Q And the fact that people with an intellectual disability
15 enter into relationships with people who can assist them,
16 that's consistent with the cloak of competency that you talked
17 about earlier; is that fair to say?

18 A It's a very common phenomenon, yes.

19 Q As far as Mr. Terry having a business, did you look at
20 that -- the repo business. Did you look at that in the
21 context?

22 A I'm sorry? What context are you talking about?

23 Q Well, the context of what he was actually doing.

24 A I didn't get deep into it, but I understand that,
25 according to Louanne, he would do it at night when he didn't

1 really have to interact with people.

2 Q And did you understand that he had assistance with
3 filling out the paperwork for that business?

4 A Yes. And I don't doubt that he was probably trained by
5 his -- by the people he worked for as to how to go about doing
6 it properly.

7 Q All right. The fact that Mr. Terry -- well, was he very
8 successful in that business?

9 A He had some jobs, according to Louanne, but only with one
10 car dealership, and that went away and the business folded. I
11 understand from Mr. Evans that there were other reasons for
12 that. But the fact is, it was not a successful business.

13 Q All right. And is Mr. Terry's work history consistent
14 with somebody who has a mild intellectual disability?

15 A Yes, a very spotty and sporadic work history. That's
16 very typical of people with mild intellectual disability.

17 Q And Mr. Evans asked you some questions about Mr. Terry
18 being considered to have a learning disability when he was in
19 school. Do you recall those questions?

20 A Yes, I do.

21 Q And are people with a mild intellectual disability
22 oftentimes misdiagnosed with a learning disability?

23 A Very often, yes.

24 Q And why is that? What can you tell us about that?

25 A Well, it's a more socially acceptable diagnosis. Part

1 of -- one of the factors that enters into the diagnosis is how
2 parents feel about it. Parents are generally more accepting
3 of a diagnosis like that because intellectual disability
4 implies a form of hopelessness or seriousness. And then part
5 of it is a lack of understanding or sophistication by the
6 people doing the diagnosis.

7 Q And are parents -- the ordinary parents, are they
8 typically in a position to understand and diagnose
9 intellectual disability?

10 A Absolutely not.

11 Q And would Gary Terry's mother possess the ability to make
12 that diagnosis?

13 A I would doubt it very seriously, unless she has a degree
14 in special education or school psychology.

15 Q One of the things that you commented on about Dr. Hall's
16 report had to do with the head injuries and the significance
17 that she attached to them. Could you remind us of the
18 significance of the head injuries in this case?

19 A Well, the head injuries, in my opinion, are the critical
20 factor that caused him to go from learning disabled, assuming
21 that was a correct diagnosis, to intellectually disabled as
22 they occurred before the end of the developmental period,
23 before the age of 22, and that appeared to result in some
24 decline in his cognitive ability.

25 Q And that decline in his cognitive ability, is that

1 supported by the records that you reviewed?

2 A Yes.

3 Q All right. And, again, it's significant that these
4 traumatic injuries occurred after the two childhood IQ tests
5 that were administered; is that correct?

6 A Yes.

7 Q And the type of head injuries we're talking about, what
8 type of head injuries did Gary have?

9 A Fell out of a tree on his head and was in a serious car
10 injury and was hit over the head in a bar fight.

11 Q So these were fairly substantial injuries?

12 A Yes, I believe so. That showed up later in things like
13 CAT scans and SPECT scans, not to mention performance under
14 psych assessments.

15 Q And one of the things that you talked about in your
16 original report in regards to the traumatic brain injuries is
17 diagnostic overshadowing. What does that mean?

18 A Well, if there's something salient going on, we tend to
19 focus on that. I mean, a common example of that would be
20 someone with a brain injury such as autism spectrum disorder
21 but also has emotional disturbance because almost everybody
22 with that condition has emotional issues or attentional
23 issues. And because those things are so salient and because
24 the brain injury is somewhat hidden, the diagnosis tends to
25 be -- to focus on the thing that's salient, in this case, of

1 the emotionally disturbed behavior.

2 Q And so would it be a mistake to discount the brain
3 injuries that Terry suffered during the developmental period?

4 A I think it would be a big mistake.

5 Q Thank you, Dr. Greenspan. That's all I have.

6 MR. GROSE: I hope I came close to the ten minutes,
7 Judge.

8 MR. EVANS: Your Honor, if I may, three questions.
9 That's all I have.

10 RE CROSS-EXAMINATION

11 BY MR. EVANS:

12 Q Dr. Greenspan, I mentioned the work that Mr. Terry did
13 not because he can do it but he did it independently; isn't
14 that correct?

15 A You said he was dependable? Is that the word that you
16 used?

17 Q That he did them independently.

18 A Yes.

19 Q Okay.

20 A Well, we don't know that for sure. Everybody gets
21 training. Everybody gets supervision. Everybody gets some
22 degree of support.

23 Q Okay. Now, wouldn't it be a stereotype to call someone
24 learning disabled, intellectually disabled? Wouldn't that
25 also be a stereotype?

1 A I don't understand the question.

2 Q Would it be a stereotype, if a person is learning
3 disabled, to consider him intellectually disabled? Wouldn't
4 that also be a stereotype?

5 A Well, it would be an incorrect -- there are two different
6 categories or classifications, but they're made by school
7 psychologists or special educators who may not fully
8 understand the difference.

9 Q Okay. And when I asked you about his relationships, I
10 asked you about the manipulation he did with women, not the
11 fact he was in relationships; isn't that true?

12 A You asked his ability to manipulate people ---

13 Q Yes.

14 A --- or his tendency to manipulate people?

15 Q His ability to manipulate women. That's why I asked you
16 about his relationships. Not the fact that he was in them but
17 his ability to manipulate women. I asked you that.

18 A Or his tendency to.

19 Q Right.

20 And you even say he was good at it; isn't that correct?

21 A Well, he was good at getting girlfriends.

22 Q Okay.

23 A And getting into marriages, yes.

24 Q All right.

25 MR. EVANS: That's all, Your Honor.

1 MR. GROSE: Nothing further.

2 THE COURT: All right, Dr. Greenspan. Can you hear me
3 okay, sir?

4 THE WITNESS: Yes, Judge, I can.

5 THE COURT: Okay. I want to say thank you, number one,
6 for your patience with us today and for being ready to go. I
7 apologize for the technological issues that we had, but I
8 appreciate your testimony. I know you got on very early on
9 California time and I appreciate that, and you have been on
10 the witness stand almost all day with virtually little to no
11 breaks, so I appreciate that as well and I want to say thank
12 you very much for appearing, and I appreciate your testimony
13 that you have given, sir.

14 THE WITNESS: Thank you, Your Honor. I appreciate that I
15 don't have to get up at 4 a.m. again.

16 THE COURT: Okay. All right. Good. Thank you very
17 much. And I'm going to turn off the Webex. Okay,
18 Dr. Greenspan?

19 THE WITNESS: Thank you, sir.

20 THE COURT: Thank you.

21 Okay. All right. What's the plan for tomorrow?

22 MR. GROSE: We have Dr. Decker as a witness. I think
23 he'll be fairly short.

24 THE COURT: What is "fairly short"? I'm not holding you
25 to it. I'm just trying to get a ballpark.

1 MR. GROSE: Half an hour to an hour.

2 THE COURT: Okay. Do you think about the -- is that
3 about right?

4 MS. BROWN: I think so.

5 THE COURT: Okay.

6 MS. BROWN: I think it's a very focused witness.

7 We have a witness from DDSN who has informed me that
8 she'll only be available in the morning, so I just wanted to
9 bring that to everybody's attention.

10 THE COURT: Okay.

11 MS. BROWN: So hopefully we can get to her in the morning
12 or not have to reschedule. I actually -- Dr. Hall has
13 graciously said that she could be here tomorrow as well.

14 THE COURT: All right. And do you have anybody -- is
15 Decker your last witness?

16 MR. GROSE: Yes, sir.

17 THE COURT: Okay. All right. Good. All right. So
18 let's plan on that. We'll start at 9:30.

19 (The above hearing adjourned at 5:31 p.m. until July 18,
20 2024 at 9:30 a.m.)

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23

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25

1 STATE OF SOUTH CAROLINA * COURT OF COMMON PLEAS
 2 COUNTY OF LEXINGTON * TRANSCRIPT OF RECORD
 3 -----X
 4 GARY DUBOSE TERRY, *
 5 Applicant, *
 6 vs. * Case No. 2022-CP-32-00924
 7 STATE OF SOUTH CAROLINA, *
 8 Respondent. *
 -----X

Hearing Dates:
 July 17-18, 2024

ATKINS HEARING - VOLUME II
 July 18, 2024

12 B E F O R E:

13 The Honorable Robert E. Hood, Presiding Judge

14 A P P E A R A N C E S:

15 E. Charles Grose, Jr., Esq.
 16 Allison Franz, Esq.
 Attorneys for the Applicant

17 Tommy Evans, Jr. Esq.
 18 Melody J. Brown, Esq.
 Assistant General Attorneys for the Respondent

23 Recorded by: DCRP Court Monitor Roderick Fitzgerald
 24 Partial (Webex) for Dr. Greenspan's testimony

25 Transcribed by: Bobbi Fisher, RPR
 SC Official Court Reporter III

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E X H I B I T S

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Applicant's Exhibit

No.	Description	ID.	REC'D
1	Dr. Greenspan's C.V.	19	
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No.	Description	ID.	REC'D
1	Dr. Hall's Report	228	
2	Dr. Decker's C.V.	232	232
3	Dr. Hall's C.V.	265	272

P R O C E E D I N G S

(The proceedings recommenced at 9:37 a.m.)

THE COURT: Thank you. Take your seats.

All right. Good morning, everyone. We're on the record in the State of South Carolina. The State is present.

Mr. Terry is present. His counsel is present.

Anything we need to take up from the State before we get started?

MR. EVANS: Not at this time, Your Honor.

THE COURT: Okay. From the Applicant?

MR. GROSE: We would just ask that the black box be taken off again.

THE COURT: Oh, yeah. Okay. We can go ahead and take off that black box. That's fine with me. I would appreciate that.

MR. GROSE: Thank you, Judge.

THE COURT: Sure. Thank you for letting me know.

(Pause in the proceedings.)

THE COURT: All right. Okay. Anything else at this time from the Applicant before we get started?

MR. GROSE: No, sir.

THE COURT: Okay. Are y'all ready to call your next witness?

MS. FRANZ: Yes, sir. Dr. Scott Decker.

THE COURT: All right, Dr. Decker. Come on up, please.

1 And would you swear him, please, Ms. Doyle.

2 THE CLERK: Hey, how are you?

3 THE WITNESS: Good. How are you?

4 THE CLERK: All right. Raise your right hand and put
5 your left hand on the Bible.

6 DR. SCOTT DECKER

7 after having been duly sworn, was examined and
8 testified to as follows:

9 THE CLERK: All right. Take a seat over there. State
10 your full name and spelling of your last name for the record.

11 THE WITNESS: Scott Decker. D-e-c-k-e-r.

12 Good morning.

13 THE COURT: Good morning.

14 DIRECT EXAMINATION

15 BY MS. FRANZ:

16 Q Good morning, Dr. Decker.

17 A Good morning.

18 Q Where are you currently employed?

19 A The University of South Carolina Department of
20 Psychology.

21 Q And what's your current occupation?

22 A Excuse me?

23 Q What's your current occupation?

24 A Full professor of psychology.

25 Q And can you describe for the Court the education that you

1 have?

2 A I got a doctorate degree in psychology, Ball State
3 University. There, I studied with Raymond Dean, who was a
4 distinguished neuropsychologist. My training included courses
5 in neuropsychology, practicum in neuropsychology, internships
6 in neuropsychology, a post-doc at UIC.

7 After graduate school -- well, that's the education part,
8 I guess.

9 Q I'm sorry?

10 A That's the education part. I was going to tell you about
11 employment as well.

12 So I taught at -- part of my research -- part of my
13 training was in also neuropsych research where my mentor, Ray
14 Dean, collaborated with Richard Woodcock.

15 I worked -- after grad school, I actually worked in
16 test -- as a neuropsych test developer to help create the
17 Woodcock-Johnson. I also helped develop the Stanford Binet
18 test and co-authored the Bender-Gestalt test.

19 And I taught at Roosevelt University, where I taught
20 neuropsychology and research methodology. I taught at Georgia
21 State University in neuropsychology and also biological basis
22 of behavior, and now I teach assessment, cognitive and
23 academic at the University of South Carolina as well as
24 cognitive neuroscience and other neuroscience courses.

25 THE COURT: Is there a way to turn this mic up,

1 Ms. Doyle?

2 THE WITNESS: Yeah, it doesn't sound like it's working.

3 THE COURT: Is there a way to turn his mic up a little
4 bit?

5 THE WITNESS: Want me to push a button?

6 THE COURT: Is it green?

7 THE WITNESS: I don't know what these buttons do.

8 (Pause in the proceedings.)

9 THE WITNESS: I can speak louder, I guess.

10 THE COURT: Well, you're close to the microphone and I
11 appreciate that. You're already close -- maybe ask
12 [indiscernible] come up here and turn up the volume. All
13 right. Let's keep going.

14 Ms. Franz, I need you to speak up as well, please.

15 You're fine. You're close enough to the -- some people
16 never get close; they sit way back here, relaxing. And I can
17 hear you, but I want to make sure that the system is ---

18 THE WITNESS: I gotcha.

19 THE COURT: --- is picking you up.

20 So you're a full professor at U.S.C. You have been a
21 professor at multiple other colleges. You have studied under
22 neuropsychology. You helped in test development. I think
23 that's where you were in your testimony.

24 THE WITNESS: Yep. Yeah.

25 THE COURT: Okay.

1 BY MS. FRANZ:

2 Q So you would describe yourself as a neuropsychologist?

3 A Yes.

4 Q Can you explain a bit about what a neuropsychologist is?

5 A So a neuropsychologist is a psychologist with special
6 training in the brain behavior relationships with a primary
7 emphasis on clinical applications and understanding how the
8 brain, in different clinical conditions, influence behavior.

9 Q And you discussed a bit about your employment. Can you
10 explain a bit more about your role in developing the
11 Woodcock-Johnson?

12 A Sure. So through -- you know, I did research with
13 Raymond Dean as part of neuropsych projects. They were
14 developing a test called the Dean-Woodcock Neuropsych Test. I
15 was doing research on it. They liked what I was doing so they
16 asked me to come and help develop the test at Riverside
17 Publishing, which was a business. And so I was employed there
18 out of grad school specifically to help develop neuropsych
19 tests and cognitive tests. My primary role was to ensure that
20 the tests were reliable and valid.

21 Q Can you explain a bit more also about what was -- what
22 was involved with developing the Bender-Gestalt?

23 A On that, I helped supervise kind of the whole project.
24 That involved help coordinating data collection all over the
25 country. That's a national standardization data set. It was

1 co-normed with the Stanford Binet intelligence test. So
2 that's how I got involved with the Stanford Binet intelligence
3 test.

4 Most of the time, I just worked closely with the
5 Woodcock-Johnson authors, who, at the time, was Richard
6 Woodcock, Kevin McGrew, and Nancy Mather. We would oftentimes
7 have meetings to discuss research and how to implement
8 research into the tests that we were developing.

9 Q And are those tests that are typically used by
10 neuropsychologists?

11 A Yes.

12 Q And do you do any work currently involving intelligence
13 testing?

14 A I teach intelligence testing for classes. I'm developing
15 a computerized intelligence test. I do research in
16 intelligence. I do research in looking at brain monitoring to
17 predict intelligence. So yeah.

18 Q And are you a member of any professional societies or
19 organizations?

20 A Yes.

21 Q Which ones?

22 A American Psychological Association, which I should add,
23 the main accrediting bodies in applied psychology are APA --
24 American Psychological Association -- and National Association
25 of School Psychologists. My graduate program was accredited

1 by both.

2 Our current program is accredited by both, so I'm also a
3 member of National Association of School Psychology and, I
4 don't know, maybe ten others, multiple ones. Division 40 APA
5 Neuropsychology. Division 16 School Psychology. Previously
6 AERA; that's educational measurement. Neurofeedback Society.
7 Child Neuropsychology and others.

8 Q And have you had any prior experience in administering IQ
9 tests?

10 A Yes.

11 Q Approximately how many times would you say you have
12 administered an IQ test?

13 A Well, if IQ means cognitive test in clinical settings,
14 over -- hundreds. If it also involves cognitive testing or
15 intelligence testing of research cases, thousands.

16 Q And you teach administration as well?

17 A I do.

18 MS. FRANZ: May I approach the witness, Your Honor?

19 THE COURT: Yes, ma'am.

20 (Applicant's Exhibit No. 13, Dr. Decker's C.V., was
21 premarked for identification.)

22 BY MS. FRANZ:

23 Q I'm going to show you what's been marked as the
24 Applicant's Exhibit 13. Do you recognize that?

25 A My vitae.

1 Q Your vitae?

2 A Yes.

3 Q And does that summarize your training, education, and
4 professional experiences?

5 A Probably be updated, but overall, yeah.

6 MS. FRANZ: Your Honor, at this time, I would move
7 Applicant's Exhibit 13 into evidence, and I'd move to qualify
8 Dr. Decker as an expert in neuropsychology and IQ test
9 administration.

10 THE COURT: All right. Any voir dire?

11 MR. EVANS: No voir dire and no objections, Your Honor.

12 THE COURT: Okay.

13 MR. EVANS: To either motion.

14 THE COURT: All right. Very good.

15 (Applicant Exhibit No. 13 was received into evidence.)

16 BY MS. FRANZ:

17 Q Dr. Decker, what were you asked to do in this case?

18 A I was asked to assess Gary Terry's intelligence using the
19 Woodcock-Johnson test.

20 Q And were you asked to determine whether Mr. Terry is a
21 person with intellectual disability?

22 A No.

23 Q And did you administer an IQ test to Mr. Terry?

24 A I did.

25 Q Which test?

1 A Woodcock-Johnson.

2 Q And when did you administer that test?

3 A 2022. Exact date's on the report.

4 Q And if you remember, approximately how long did you meet
5 with Mr. Terry?

6 A Around three hours.

7 Q And did you also review records related to Mr. Terry,
8 including social history, medical, and school records?

9 A I did. And my primary focus was on any historic data
10 that I could relate to intellectual functioning.

11 Q So I'd like to start a bit with your work administering
12 the Woodcock-Johnson. And that's one of the tests that you
13 assisted in developing?

14 A Correct.

15 Q Are there standardized test administration rules for the
16 Woodcock-Johnson?

17 A Yes. So the administration of standardized tests,
18 everything has a protocol, so all the questions you ask,
19 everything is very laid out and you follow very specific
20 administration directions for each of the tests. You have to
21 establish what's called basal and ceilings. Basals are the
22 lower level and ceilings are the higher level to understand
23 where to start and discontinue a test.

24 There are questions -- you have got to know where to stop
25 if it's by page rules. And -- or if it's by performance or by

1 time. And it requires a lot of practice and kind of
2 memorizing rules, and it has to be done in a very strict,
3 standardized way.

4 Q Can you explain a bit about why it has to be done in such
5 a strict, standardized way?

6 A Well, the tests have -- the essential validity of the
7 tests is having the normative sample so that once you do --
8 once you assess someone's performance, you relate it to how
9 other individuals, either in the same age or grade bracket,
10 would do. And if you don't have strict rules of test
11 administration, it's -- you can get variation in performance
12 and a number of what's called error variance and reliability.
13 But then you can't compare the equivalency of norms.

14 For instance, like when I worked in test development,
15 we'd collect data of people in every state at every age
16 bracket, and you'd want to be able to have apples-to-apples
17 comparison when you're assessing different people's
18 intelligence so it becomes a standardized measure.

19 Q And can you explain what the standardized test
20 administration rules for the Woodcock-Johnson are?

21 A Well, it depends on the test. So each test has different
22 rules. So each test has a different basal and ceiling rule.
23 That is, it has -- each specific test has different starting
24 and stopping points.

25 So, just to clarify, when we're talking about, like, IQ

1 or overall ability, it's not one test. It is an assortment of
2 multiple subtests, and the IQ is derived from those
3 performance across multiple subtests.

4 So because there are different subtests, there are
5 different rules for test administration depending on the test.

6 Q What do you mean by "each test has different rules"? You
7 mean each subset within the Woodcock-Johnson?

8 A Yes. So, for example, if you have things that you're
9 showing the person, you would say, "I'm going to show you
10 stuff," versus there's other tests that are purely auditory,
11 so you wouldn't say, "I'm going to show you stuff" if you're
12 only hearing things.

13 So you have to make sure -- there's standardized
14 procedures to ensure the person understands the directions.
15 Usually, there are practice items so that they understand what
16 they're supposed to do. And then there are rules for, then,
17 how to proceed through the rest of the test.

18 Tests, unlike modern tests, unlike older tests, are
19 scaled, which means the items are statistically calibrated to
20 provide equal interval measurement. One way of
21 conceptualizing this is all of the data we collect in test
22 development essentially calibrates the item difficulty, so we
23 know statistically exactly how difficult the item is and where
24 it falls on the developmental continuum.

25 You can think of this as, like, little hurdles. So each

1 item is like a hurdle, so you don't put a big hurdle next to a
2 small hurdle when people are jumping over it. So you wouldn't
3 put a math item that says 2 plus 2 and then ask a person to do
4 calculus. That's like putting a small hurdle next to a big
5 hurdle.

6 So what we call scaling is we get statistical estimates
7 of item difficulty so that we can finally measure different
8 dimensions of ability and a higher amount of precision, I
9 think, than previous tests do.

10 Q Okay. And did you follow those administration rules in
11 the test that you administered?

12 A I did.

13 Q And what's the score that Mr. Terry received on the test
14 you administered?

15 A The General Intellectual Ability, I believe, was 77.

16 Q And did you apply the Flynn Effect in Mr. Terry's case?

17 A I did.

18 Q And what was Mr. Terry's Flynn Effect?

19 A I believe it was 74.

20 Q And is that score within the range typically considered
21 for intellectual disability?

22 A Yes.

23 Q So, in your professional opinion, is the score that
24 Mr. Terry obtained on the Woodcock-Johnson that you
25 administered a reliable estimate of his intellectual

1 functioning?

2 A Yes.

3 Q And, yesterday, Dr. Greenspan mentioned two IQ tests that
4 were administered to Mr. Terry in childhood. Did you review
5 records of those tests?

6 A I saw the scores that were reported. I didn't review the
7 actual test record. I believe the overall score was 92. And
8 it was at age 11 and age 14.

9 Q And you reviewed those results in Mr. Terry's school
10 records?

11 A I did.

12 Q And you said that Gary got a 92 on those?

13 A I believe that's what it was, yeah.

14 Q What observations, if any, did you make about those IQ
15 test results compared to the Woodcock-Johnson?

16 A Well, there's a couple of things. One is I looked at
17 those scores but I also looked at multiple scores across his
18 life history, including the academic test that he had even as
19 an early child, all the way until I believe he dropped out of
20 school at age 16.

21 It's inconclusive of how to relate the current
22 Woodcock-Johnson test to the results of the test of -- the
23 test then, which was the WISC-R. The WISC-R was based on
24 David Wechsler's work in 1974. So it's kind of like comparing
25 4K high definition televisions to black and white.

1 What was known about the WISC-R at that time is it had
2 measurement issues. They weren't sure what it measured. It
3 wasn't theory based. So the best you could do is give
4 probably the overall IQ. The overall IQ had a reliability of
5 about .79 versus Woodcock-Johnson measurements today have .97.
6 So it's quite a bit of difference in reliability.

7 The construct validity where there's multiple studies
8 looking at -- they do what's called factor analysis to try to
9 figure out the dimensions that are being tested -- were
10 inconclusive on the WISC-R. Many of the tests that were
11 included on the WISC-R were dropped in subsequent editions due
12 to measurement problems on the test.

13 It was insensitive to neurological injuries, so the best
14 evidence I could find was a study by Donders looking at
15 children with traumatic brain injury on the WISC-R. And
16 because of its imprecision, what you get is a kind of blunt
17 instrument where just the overall score is lower and the best
18 guess is, if you had a traumatic brain injury, your overall
19 score would be around 91 or 92, and that was actually
20 consistent with what Gary received.

21 The reason it's also inconclusive is because it didn't
22 measure a broad range of abilities, so how the history of
23 intelligence has kind of worked is we had these kind of crude
24 instruments, WISC-R included. And then as statistical and
25 measurement instruments became more precise, we were able to

1 measure abilities with more precision, and the history of
2 intelligence testing has gone from, "Well, we just think we're
3 measuring one thing" into "Well, we're measuring specific
4 dimensions of intelligence," which is essentially what today
5 we call the CHC theory, which is the basis of the
6 Woodcock-Johnson.

7 Q Could you explain a bit more about the aspects of
8 cognitive functioning that you mentioned the WISC-R has
9 measurement issues with?

10 A Well, numerous studies were inconclusive of what it was
11 measuring, so we got started thinking it was measuring
12 something that was called freedom from distractability, and
13 then it turned out it wasn't. It was really -- the primary
14 basis is Wechsler just kind of put a bunch of tests together
15 with a variety of questions, and it was developed -- as I
16 explained earlier, we kind of statistically calibrate to put
17 hurdles as test items in an order of difficulty.

18 At that time, these items were just kind of like, "Well,
19 this seems like a good item. We'll throw this one in. We'll
20 throw this test in." There wasn't a real basis for doing it
21 other than, "Well, maybe it was used by -- in a research
22 study. Maybe it was something Wechsler liked." But that made
23 it difficult to understand exactly what you're measuring other
24 than overall IQ. The overall IQ seemed to be the most
25 reliable part of the test, but it couldn't precisely measure

1 specific abilities.

2 They did have VIQ/PIQ. Even the way I was trained was,
3 originally, if you had 20 points between VIQ/PIQ, it was an
4 indicator of brain injury. And then it turned out they found
5 out about 40 percent of typical developing kids also had a
6 split -- 20-point split.

7 So there was just a number of measurement validity and
8 reliability issues with the test. So when I look at these
9 test scores historically going back, it's kind of like looking
10 through something through a foggy mirror of, like, I'm not
11 sure. So I would have issues with the test and, to me, it's
12 inconclusive.

13 I don't think you should just solely look at one IQ
14 score, which I think has been said. So I also looked at
15 historic education records. If you look at the continuum of
16 data over time, what would be anomalous is if you see test
17 scores in education that are above the 50th percentile across
18 the life history. If you get an IQ score of let's say even
19 105 or 110, like all -- any of this could have been
20 information that could have suggested, okay, there's no way
21 there's intellectual impairment. But those records didn't
22 exist. It was a consistent, very low scores. Many of the
23 educational scores were in the lower 10th percentile across
24 the board.

25 So my review was mainly to, "Well, if I look at my

1 results, I want to make sure my results are consistent with
2 some of the historic stuff." So if I got an IQ score of 74
3 but then I found IQ scores and educational scores in the 80th
4 percentile across his -- that would be very anomalous, but I
5 didn't see that in the record.

6 Q And you mentioned that the WISC-R did not pick up certain
7 aspects of functioning that are sensitive to traumatic brain
8 injuries. Did you review records of brain injuries that
9 happened to Mr. Terry?

10 A I reviewed events that suggested blunt force trauma to
11 the head on multiple occasions. There were some brain scan
12 records, which I didn't review in detail. Most of my work is
13 in quantitative electroencephalography, and I don't recall one
14 of those being used.

15 But there was evidence that he had had trauma multiple
16 times, including, I believe, glue-sniffing that was -- could
17 have led to hypoxia or lack of oxygen to the brain. In any of
18 those cases, the most likely deficits -- like, so, if you talk
19 about CHC theory, there's a construct called GS, which is
20 processing speed, which is the most sensitive to general
21 intellectual -- or general brain insult. The Wechsler scores
22 was VIQ/PIQ, so there's not a clear GS on that test.

23 Another problem would be with the specific looking at the
24 comparing of the neurological insults with the historic
25 records. In addition to the lack of the construct processing

1 speed, GS specific constructs is -- the WISC-R was criticized
2 for having a large loading of cultural vocabulary. Those are
3 abilities that are oftentimes referred in neuropsych as hold
4 abilities, meaning that they maintain despite head injuries
5 versus other abilities of don't hold, which are more like
6 abstract reasoning, concept formation, analysis synthesis, or
7 what's called NCHC, fluid reasoning.

8 So those could have had an impact. So he had a history
9 of a number of head injuries, and it could have had an impact
10 on test scores, but if the tests aren't specifically
11 sensitive -- and his score was in line with best guess of what
12 traumatic brain injury in children would be, then it's the
13 best you can say.

14 Q I think you may have just discussed this a little bit,
15 but could you explain a bit more about, in general, what we
16 know those types of head injuries can do to a person's
17 cognitive functioning?

18 A Well, you know, with head injury -- if you're -- you
19 know, it's a difficult process to connect a specific type of
20 neurological insult to specific behavioral outcomes when
21 you're looking at historic records. Right?

22 What the research knows -- and this is also research I do
23 at the university -- is that, usually, traumatic brain injury
24 first result in cognitive processing speed deficits. The most
25 likely reason why is, when you get blunt force trauma to the

1 head, you have what's called white matter structure. These
2 are heavily myelinated subcortical structures in your brain
3 that facilitate information transmission.

4 When you get a blunt force trauma, the myelin sheathes of
5 these neurons are injured, and information processing slows
6 down. So, oftentimes, one of the first indicators of any type
7 of head injury is something like reduced processing speed.

8 Q I am going to --

9 MS. FRANZ: May I approach the witness, Your Honor?

10 THE COURT: Yes, ma'am.

11 (Applicant's Exhibit No. 14, Dr. Decker's Report, was
12 marked for identification.)

13 BY MS. FRANZ:

14 Q I'm going to show you what's been marked as Applicant's
15 Exhibit 14. Do you recognize that?

16 A Results of the evaluation I did.

17 Q Is that a copy of the report that you did in this case?

18 A Yes, with all the references I included for Flynn Effect
19 calculations. I was going to say it's a little thicker than
20 my report, but it has the references with Flynn Effects and
21 score calculations with it.

22 Q Does that accurately summarize the --

23 A It does.

24 MS. FRANZ: Your Honor, at this time, I would move into
25 evidence what's marked as Applicant's Exhibit 14, Dr. Decker's

1 report.

2 MR. EVANS: Same objection as yesterday. Hearsay and
3 corroboration of his testimony.

4 THE COURT: And what did I do yesterday? I can't
5 remember.

6 MR. EVANS: I think --

7 MS. BROWN: I believe that you let in one report but you
8 kept out other documents.

9 THE COURT: All the underlying stuff.

10 MS. BROWN: So underlying documents.

11 THE COURT: All right. I'll allow this -- and this is
12 your report ---

13 THE WITNESS: Yes, sir. Yeah, it's my report.

14 THE COURT: --- in this case, the basis of your testimony
15 today; correct?

16 THE WITNESS: Yes, as I just spilled water all over it,
17 but...

18 THE COURT: Okay. We can get another copy of it. That's
19 okay.

20 THE WITNESS: No, it's fine. I know it by heart.

21 THE COURT: Are you okay? Do you need anything else?

22 THE WITNESS: No, I'm good.

23 THE COURT: All right.

24 (Applicant's Exhibit No. 14 was received into evidence.)

25 BY MS. FRANZ:

1 Q Just, I think, one more question, Dr. Decker.

2 A Yeah.

3 Q You mentioned that the Woodcock-Johnson is theory based?

4 A Correct.

5 Q Can you explain a bit more about that what means in its
6 relation to the [indiscernible] as well?

7 A Yeah. So, again, historically, it took time for
8 researchers to understand the measurement of intelligence.
9 The history of intelligence is looking at more differentiated
10 constructs. The number of constructs that have been able to
11 be differentiated in cognitive ability measurements has
12 increased over time.

13 Originally, with Spearman's research over a century ago,
14 it was proposed that there's general intelligence, which is
15 just one general construct of intelligence, and Cattell said
16 actually verbal abilities are different than performance
17 abilities or visual-motor types of abilities so that got
18 differentiated.

19 And then there has been more research showing more
20 differentiations of constructs over time. What we call the
21 Cattell-Horn-Carroll theory is the most differentiated
22 abilities that have been reliably discovered and replicated in
23 multiple research studies that's become the consensus of what
24 intelligence assessment constructs should include in clinical
25 assessments.

1 MS. FRANZ: Court's indulgence, Your Honor.

2 BY MS. FRANZ:

3 Q Thank you, Dr. Decker. Please answer any questions the
4 State has.

5 CROSS-EXAMINATION

6 BY MR. EVANS:

7 Q Dr. Decker, good morning.

8 A Good morning.

9 Q Now, Dr. Decker, you first met Mr. Terry on January 20th
10 of 2022?

11 A Yes.

12 Q Okay. And, at that time, you tested him with this
13 Woodcock-Johnson test?

14 A Correct.

15 Q And, at that time, he was suffering from shingles, wasn't
16 he?

17 A He reported having shingles.

18 Q Okay. And of course you know shingles is a debilitating
19 virus that causes a rash and it's painful?

20 A It's painful.

21 Q Okay. And, also, he had it in his eye -- in his right
22 eye so it obstructed his vision?

23 A I don't recall at the time, but as part of my assessment,
24 I always do an initial mental status exam and also just to try
25 to identify any factors that might mediate performance and

1 that was one, that he reported having shingles and pain.

2 Q In your report on page 1, under "Brief Observation," you
3 stated, "He also complained of right eye facial pain due to
4 shingles and stated it occasionally obstruct -- obscured
5 visitation in his right eye." That's in your report, isn't
6 it?

7 A Yes.

8 Q Okay. Now, the Woodcock-Johnson test is a test that you
9 relied on in making the evaluation of his IQ; isn't that
10 correct?

11 A Correct.

12 Q That's not the only test that psychologists use?

13 A Correct.

14 Q They also use the WAIS test also?

15 A They do.

16 Q Okay. As a matter of fact, do you remember talking to
17 Dr. Hill, who was the doctor -- Dr. Hall, excuse me -- the
18 doctor at the Department of Disabilities and Special Needs?

19 A I don't.

20 Q You don't remember talking to her?

21 A Uh-uh. About the results?

22 Q About your testing -- the original testing.

23 A Vaguely, yeah. Yeah, yeah.

24 Q All right. But she tested -- now, you did this test in
25 2022. She tested him in 2024 using the WAIS test.

1 A Yeah.

2 Q And that's a legitimate test, isn't it?

3 A Yes.

4 Q Okay. And, as a matter of fact, under protocol, you
5 cannot give the same test twice. You have to give a different
6 type of test; isn't that correct?

7 A No.

8 Q That's not correct?

9 A No.

10 Q Okay. So she could have given the Woodcock-Johnson test
11 again?

12 A She could have, yeah. The professional consensus is six
13 months. So this was two years later.

14 Q But she decided to give the WAIS test, which is a
15 legitimate test also; isn't that correct?

16 A I -- yes.

17 Q Now, looking at your report, on page 2, it seemed like
18 every category, he has low average to low except one, that of
19 pattern matching; isn't that correct?

20 A Yep. Yes.

21 Q And your final score at that time was 77?

22 A Yes.

23 Q Okay. And in your report, you stated, "His lowest
24 performance was on a measure of visual processing speed."

25 A Mm-hmm.

1 Q That's true? Okay.

2 THE COURT: Is that a yes?

3 THE WITNESS: Yes. Sorry.

4 THE COURT: That's okay.

5 BY MR. EVANS:

6 Q And, also, on page 3, you stated -- on the visual motor
7 measure, you stated in your report, "He was able to copy
8 simple geometric figures but expressed frustration while
9 attempting more complex figures."

10 A Yes.

11 Q Okay. So this was a drawing of figures on a sheet of
12 paper or something like that?

13 A Yes. This is the Bender-Gestalt test.

14 Q Okay. And he was, at the time, debilitated because of
15 shingles, wasn't he?

16 A I don't believe he was debilitated.

17 Q Okay. Well, he had problems seeing out of his right eye;
18 isn't that correct?

19 A He said he had pain in his face, and that's what I
20 recall, and that there was -- but if he was debilitated in
21 that, he wouldn't be able to even do simple geometric designs.

22 Q Okay.

23 A My interpretation of it is, as the geometric designs got
24 more cognitively complex, he had problems with it.

25 Q Okay.

1 A But the simple visual stuff, he could do. Does that make
2 sense?

3 Q Yes, it does.

4 A Okay.

5 Q Now, in your report, you also stated that other sub-test
6 scores were low average, "He demonstrated a specific weakness
7 in visual processing speed test. Although his performance on
8 this test could be considered the context of right-sided
9 facial pain with possible visual difficulties in his right eye
10 due to the shingles virus," you stated that in your report?

11 A Yes.

12 Q Okay. So the shingles could have affected his scoring?

13 A Well, that's why I documented it.

14 Q Okay. Now, did you read the report of Dr. Hall?

15 A I did not.

16 Q Well, Dr. Hall -- well, somebody in her office tested him
17 with a WAIS test of 82. Are you aware of that?

18 A I am now.

19 Q Okay. And could it be possible if he was -- and he was
20 completely healthy when he took that test with Dr. Hall.
21 Could it be possible that he could have scored an 82 if he was
22 completely healthy with you on your test?

23 A If he was completely healthy, could he score an 82? I
24 don't know.

25 Q Okay. You don't know. But it's possible?

1 A It's possible. I mean, any score could be possible.

2 Q So you're not denying it's impossible. You say it's
3 possible. But you don't know if it's possible or not. That's
4 your answer?

5 A Well, if there were other tests -- so letter pattern
6 matching, which involves visual stimuli, there's also number
7 series which you show a visual -- a page with visual items.
8 He got an 89 on it.

9 And on visualization, he got a 79, which is higher than
10 the 68. So that also involves visual information processing,
11 but he scored higher on them.

12 Q Okay. But the lowest portion that he scored on also
13 required visual processing?

14 A It required quick mental processing with visual stimuli.

15 Q Okay. And you specifically said in your report the low
16 score could have been as a result of the shingles virus?

17 A I think it's something that I wanted to document so that
18 people -- you're aware of it.

19 Q Now, you said that you did a calculation of Flynn Effect
20 on this case?

21 A I did.

22 Q When did you do that?

23 A Within days after the report. After the testing. I'm
24 sorry.

25 Q Okay. Because it looks to me, on your report, it was

1 concluded on page 3, but this -- this was added later. I
2 don't know if it was or not, because you said it was done
3 after you had done the testing.

4 A Yeah. You have to get the test scores first and then do
5 the Flynn Effect. So you have to look at the normative -- the
6 obsolescence of the norms, take what test score you have, and
7 then do the calculation. So you can't do it ahead of time.

8 Q Okay. Well, I'm not saying do it ahead of time, but it
9 wasn't a major portion -- the Flynn Effect was not a major
10 portion of your original report?

11 A I just wanted to report the facts.

12 Q Okay. All right. And you were not asked to make a
13 determination on intellectual disability?

14 A Correct.

15 Q And that's because IQ scores -- there's more to an IQ
16 score to make that determination; isn't that true?

17 A Correct.

18 Q Okay. And you said you read the school records. Did you
19 read any other records, like the medical records at Charter
20 Rivers or --

21 A Not in detail. I primarily looked through educational
22 and historic records related to any IQ test scores, any -- I
23 primarily looked at anything that could -- I could say is
24 standardized in any possibly way -- data -- that has any known
25 scientific relation with IQ scores.

1 Q Okay. And no other doctor, other than Dr. Greenspan,
2 ever diagnosed Terry has intellectual disability?

3 A I do not see a diagnosis of intellectual disability in
4 any educational records.

5 Q And in his educational records, do you recall him being
6 diagnosed as being learning disabled?

7 A I saw that in educational records.

8 Q Did you read the records or testimony of a Dr. Deysach,
9 who is this neuropsychologist?

10 A I did not. I did not have access to that information.

11 Q Okay. So you were never given this information to read
12 his report or his findings?

13 A I have not -- no.

14 Q Okay.

15 MR. EVANS: Beg the Court's indulgence.

16 I have nothing further, Your Honor.

17 MS. FRANZ: Just a few, Your Honor.

18 REDIRECT EXAMINATION

19 BY MS. FRANZ:

20 Q Dr. Decker -- and, I'm sorry, I'm going to ask you to do
21 a little math. The State mentioned ---

22 A I haven't had coffee yet.

23 Q The State mentioned the score of 82 that Mr. Terry
24 received on the WAIS score.

25 A Yeah.

1 Q Can you explain the application of the Flynn Effect on
2 the WAIS score?

3 A Yeah. So there is a -- it is widely used by -- for adult
4 intellectual assessment; however, its normative base is -- it
5 was published in 2008, so its norm base is probably 2006-2007.
6 So, I don't know -- you do the math; you got a calculator?
7 That's -- was it 11?

8 THE COURT: Would you like me to give you one?

9 THE WITNESS: Yeah, well -- okay.

10 A So you would take the number of years from, let's say,
11 2007 to the current time period. Again, there are slightly
12 different ways of doing Flynn Effect calculation. It's
13 usually multiply that number by .3. What would it be? Like
14 five?

15 BY MS. FRANZ:

16 Q I think that's roughly right.

17 A So it would be about five score correction. So that
18 would put you at 77, which is exactly what I have.

19 Q And your score -- what did your score [indiscernible] to?

20 A 74.

21 Q And were you aware of -- that Mr. Terry reported having
22 shingles at the time of your test?

23 A Well, I mean, I do an assessment, and I try to identify
24 any factors that might compromise the results. This includes
25 looking at settings, so I made sure we were in a quiet room

1 where we couldn't be distracted. I also noticed he was in
2 shackles so I thought -- you know, I'm thinking through
3 anything that could possibly impact test scores in any way.

4 He also -- this is where he first reported, when he was
5 having some trouble concentrating, that he had been hit in the
6 head with a metal object when he was a kid, I think multiple
7 times. And he did report that he had some right-side pain.
8 He, I assume, told me shingles, so I documented all of this in
9 the report, yeah.

10 I think -- if it were something that was debilitating,
11 his performance or having a high -- any cognitive impact that
12 would question the results, I would have stopped the testing
13 and I wouldn't have included. I think it is an accurate
14 description of his intelligence.

15 Q So even in light of Mr. Terry reporting that at that
16 time, your testimony was that -- is your testimony still that
17 that score is a reliable estimate of his intellectual
18 functioning?

19 A Yes. And it's also consistent with the Flynn Effect
20 adjustment of what was recently done, as you just had me
21 calculate on the stand. It's in line with it, yeah.

22 MS. FRANZ: Court's indulgence, Your Honor.

23 Nothing further, Your Honor.

24 MR. EVANS: A few questions on recross.

25

1 RE CROSS-EXAMINATION

2 BY MR. EVANS:

3 Q Dr. Decker, you just said that the Flynn Effect would
4 reduce the score to 77; isn't that correct?5 A I did the calculations here on the stand, so I -- I don't
6 want to be under trial, but, like, it should be about five
7 points. There might be decimals behind it, but something like
8 that.9 Q And so the score given by Dr. Hall was a 77. Isn't it
10 true the Flynn Effect reduced it to 77; therefore, that means
11 they did the calculations correctly? Wouldn't you say so?12 A I can't verify. I have not seen the report. I do not
13 know how they did the calculations. I have not seen this
14 information.15 Q Okay. But you just said, out your head, you calculated
16 five-point deduction.

17 A Yeah.

18 Q 72 minus 5 is 77 [sic]?

19 A Yeah.

20 Q Okay. So --

21 A I don't know if that's what they had.

22 Q That's what they had. I'm telling you that's what they
23 had.

24 A Okay.

25 Q So the computation was correct; wasn't it?

1 THE COURT: He's saying assuming that that's what they
2 had.

3 A It's in range with what I could just do on the stand,
4 yeah. It's right -- it seems approximately correct.

5 BY MR. EVANS:

6 Q Okay. And that's what your original assessment was under
7 the Woodcock-Johnson, that he scored a 77; correct?

8 A The General Intellectual Ability estimate was 77. Flynn
9 corrected it to 74, yeah.

10 MR. EVANS: Nothing further.

11 THE WITNESS: Thank you.

12 THE COURT: I appreciate you doing math on the witness
13 stand.

14 THE WITNESS: Yeah. Of all things I prepped for, that
15 wasn't it.

16 MR. EVANS: Yeah, we're lawyers. We're not good with
17 math.

18 THE COURT: I know I appreciate having everybody look at
19 you while you're trying to do math. So I --

20 Any -- is Dr. Decker excused from his subpoena? From the
21 State?

22 MR. EVANS: No objections, Your Honor.

23 THE COURT: From the Applicant?

24 MS. FRANZ: No.

25 THE COURT: No? He's good to go?

1 Okay. Thank you, Dr. Decker.

2 THE WITNESS: Thank you.

3 THE COURT: Have a nice day, sir.

4 All right. Any further witnesses from the Applicant?

5 MR. GROSE: No, sir.

6 THE COURT: All right. And who do y'all want to call
7 first?

8 MS. BROWN: May I have one moment to speak to the
9 witnesses?

10 THE COURT: Yeah, sure. Yeah.

11 Even kind of stand up, stretch, twist, turn while they
12 talk.

13 (Pause in the proceedings.)

14 THE COURT: Are you good to go?

15 MS. BROWN: One question, if I may.

16 THE COURT: Okay.

17 MS. BROWN: I'm going to ask during Dr. Hall's
18 examination -- I want to call Dr. Davis first, but I was going
19 to ask, during Dr. Hall's examination, if you would accept the
20 report from the DDSN and the email to your chambers as a Court
21 exhibit, because I know you have received the report, but we
22 don't have it in the written record, and I would like to put
23 both of those in. And if there is no objection, maybe I could
24 do that first so you can see that, and then, that way, we can
25 refer to it.

1 THE COURT: Okay.

2 MR. GROSE: We have no objection to them being a State
3 exhibit.

4 THE COURT: Okay.

5 MR. GROSE: It should be State exhibits since they're
6 offering it.

7 MS. BROWN: And this would be Court Exhibit 1.

8 MR. GROSE: I thought we were marking it as a State
9 exhibit.

10 MS. BROWN: I'm sorry. Court Exhibit 1?

11 THE COURT: Just make it a State exhibit.

12 MS. BROWN: Okay. I have got two copies if you want
13 those.

14 THE COURT: That's fine. Is that Dr. Hall's report?

15 MS. BROWN: Yes.

16 THE COURT: I have it. I have it with me. Let's mark it
17 as a State exhibit. I have Dr. Hall's report right here.

18 MS. BROWN: Okay. And I have got the cover letter with
19 it.

20 THE COURT: I have that too.

21 MS. BROWN: But not the email. Okay.

22 THE COURT: I don't know. Let me see your cover letter.

23 MS. BROWN: June 12th. Well, I think the email is June
24 12th too.

25 THE COURT: Yep, what's that I got.

1 MS. BROWN: Okay. All right. We're good.

2 THE COURT: Okay.

3 (State's/Respondent's Exhibit No. 1, Dr. Hall's Report,
4 was marked for identification.)

5 THE COURT: Okay. Who's next?

6 MS. BROWN: Your Honor, the State would call Dr. Jessica
7 Davis, please.

8 THE COURT: All right, Dr. Davis. Come on up and be
9 sworn in, please.

10 THE CLERK: All right. Raise your right hand. Place
11 your left hand on the Bible.

12 DR. JESSICA DAVIS

13 after having been duly sworn, was examined and
14 testified to as follows:

15 THE CLERK: All right. Please have a seat. State your
16 first name and the spelling of your last name for the record.

17 THE WITNESS: Jessica Davis. D-a-v-i-s.

18 DIRECT EXAMINATION

19 BY MS. BROWN:

20 Q Good morning, Doctor.

21 A Good morning.

22 Q Would you please tell us where you're currently employed
23 and your position.

24 A I am a Psychologist II at the Department of Disabilities
25 and Special Needs.

1 Q Okay. And what are your duties within that position that
2 you have?

3 A I am a forensic psychologist, so I do court-ordered
4 psychological evaluations; typically pre-trial competency
5 evaluations on folks that are suspected of having an
6 intellectual disability, related disability, or autism
7 disorder.

8 Q Do you hold any professional licenses for your work?

9 A I do. I'm licensed with the State of South Carolina as a
10 licensed psychologist.

11 Q And what kind of continuing education requirements do you
12 obtain for your work?

13 A Every two years, we require -- I think it's 24 credit
14 hours; I usually go way over that. So I attend conferences
15 and continuing education for cognitive disabilities and
16 forensic work.

17 Q Would you please review for us your educational
18 background since college.

19 A Since college? Okay. So I have two bachelor degrees
20 awarded from Coker University: one in psychology, one in
21 criminology. I went straight from undergrad into my clinical
22 doctoral program, which is an APA-accredited university.
23 During my time there, I got a masters in route, and then I
24 graduated with a degree in clinical psychology in 2018.

25 Q And what exactly is clinical psychology?

1 A Sure. So clinical psychology is a clinical practice
2 informed by science. So I'm trained not only as a researcher
3 but also as someone who assesses, diagnoses, and treats
4 individuals with any diagnosis that's found in the DSM-5.

5 Q Okay. How about giving us a brief summary of your
6 professional employment.

7 A Sure. So after I graduated with my doctorate degree, I
8 did a residency at a forensic hospital in St. Louis. After
9 that, I went to doing community psychological evaluations.
10 And I was administering IQ tests probably three times a week
11 during that period where I worked there.

12 Then I was hired at DDSN in 2020, where I have been since
13 there. And then during my graduate training as well, I worked
14 under a neuropsychologist and a neurologist, administering
15 memory batteries, which included IQ tests as well.

16 Q Okay. And are you a member of any professional
17 organizations specific to psychology?

18 A I am. I'm a member of APA.

19 Q And APA is what, for the record?

20 A The American Psychological Association.

21 Q And do they have guidelines that you adhere to?

22 A Yes. Yes.

23 Q And specialty training. Did you have any specialty
24 training to intellectual disability or IQ testing?

25 A I did during -- really during my practicums and during my

1 employments. So my specialty training is in forensic
2 evaluations, so I took ten additional classes during my
3 graduate program, but I essentially created a sub-specialty
4 within that field because they didn't offer it at my program.
5 So that is why I worked under the neuropsychologist and the
6 neurologist for two years during my graduate training, so
7 under their supervision, that's where I got a lot of my
8 consultation and supervision on administering, interpreting,
9 and writing reports relating to intellectual disability.

10 Q And do you have training on specific tests -- IQ tests
11 that you'll be using?

12 A I do, yes. We have to take those. Anybody that attends
13 an APA-accredited university has to take those.

14 Q And the IQ tests that you use have manuals that come with
15 them; is that correct?

16 A They do.

17 Q And do you routinely use those manuals as well?

18 A Yes. You actually have to use the manual to administer
19 the assessment as well.

20 Q And how many tests have you administered to assess IQ?

21 A Upwards of 400 probably.

22 Q Have you ever been qualified as an expert in any court
23 before?

24 A I have, yes.

25 Q And what discipline were you qualified to testify in?

1 A Forensic evaluations relating to intellectual disability
2 or any related disability.

3 Q And do you have a current C.V.?

4 A I do.

5 MS. BROWN: Your Honor, may I approach the witness?

6 THE COURT: You may.

7 MS. BROWN: Beg the Court's indulgence just a moment,
8 please.

9 (State's/Respondent's Exhibit No. 2, Dr. Davis's C.V.,
10 was marked for identification.)

11 BY MS. BROWN:

12 Q Dr. Davis, I'm handing you what's been marked as State's
13 Exhibit 2. Would you tell us what that appears to be to you?

14 A This is my C.V.

15 Q Does that appear to be current?

16 A It does.

17 Q Okay.

18 MS. BROWN: Your Honor, we'd move to have the Court
19 accept State's 2, the C.V. for Dr. Jessica Davis.

20 MR. GROSE: No objection.

21 THE COURT: State's 2 admitted.

22 (State's/Respondent's Exhibit No. 2 was received into
23 evidence.)

24 MS. BROWN: Your Honor, based on the testimony that you
25 have heard, we would ask -- and the C.V. and documents listed

1 too for her background -- we'd ask for you to find Dr. Davis
2 qualified as an expert in psychology and in administering IQ
3 tests.

4 MR. GROSE: No objection.

5 THE COURT: Any voir dire?

6 MR. GROSE: No, sir. No objection.

7 THE COURT: Okay. All right. Very well. She's
8 qualified. You may move forward.

9 MS. BROWN: Thank you, Your Honor.

10 BY MS. BROWN:

11 Q Dr. Davis, how did you become involve in this particular
12 case?

13 A Sure. So I am what's considered an early career
14 psychologist. While I have been practicing independently four
15 or five years as a licensed psychologist, I have never done an
16 Atkins case. So as part of my training at DDSN, Dr. Hall was
17 assigned to this case, and she brought me on to essentially
18 observe it so that I can one day do one on my own and she can
19 supervise me on it.

20 So she was sharing some information with me, and then we
21 kind of discussed the need for additional testing, and she
22 asked if I would do the testing in the case.

23 Q And so that sort of explains why Dr. Hall was with you at
24 certain steps in the testing; is that correct?

25 A She didn't have to be there to witness it. She was there

1 because this is her case, and the stakes are pretty high for
2 this type of evaluation.

3 Q Okay. And just generally, why do you administer an IQ
4 test? What are you looking for and how are you going to use
5 it?

6 A So are you asking why any psychologist would administer
7 an IQ test?

8 Q What's the general background of it?

9 A In my practice, I have administered IQ tests for many
10 different reasons. One of the reasons is to rule out or rule
11 in an intellectual disability. Other reasons might be because
12 a student is performing well in their classes and their
13 parents want to get them in the gifted program. Other reasons
14 might be because we are looking for a neurocognitive disorder,
15 or dementia, and one of the things that you have to administer
16 with those batteries is an IQ test because you want to rule
17 out whether the deficits we're seeing is intellectual in
18 nature as opposed to neurological in nature.

19 We also administer IQ tests generally whenever we want to
20 look for ADHD as well, Attention Deficit Hyperactivity
21 Disorder. We want to make sure that, again, what we're
22 dealing with is not intellectual -- any deficits that we're
23 seeing is not intellectual but, again, it's due to another
24 diagnosis.

25 So there's really a whole host of reasons why we would

1 administer it.

2 Q And so is it safe to say, Doctor, that people rely on the
3 results for a host of different decisions?

4 A Absolutely.

5 Q And we have in the report from DDSN -- the report that
6 Dr. Hall authored -- several IQ tests. And I wanted to ask
7 you the differences between the Wechsler for children test and
8 now the present Woodcock-Johnson, or Wechsler for adults test.
9 Can you tell us a little bit about the differences?

10 A There really isn't any difference. They're both actually
11 based on the same theory as -- I think it was Dr. Decker was
12 mentioning, they're both based on CHT theory, especially the
13 most recent ones where we are looking at different areas of
14 intelligence that make up the broad umbrella of intelligence.
15 So we are looking at processing speed, working memory, verbal
16 IQ, and performance IQ, so we do look at all of those between
17 the Wechsler and the Woodcock-Johnson.

18 They are highly correlated, which means they are testing
19 pretty much the exact same things. The individual questions
20 may be different, but overall, the research does suggest that
21 there is good validity in the sense that we are testing what
22 we think we are testing, which is intelligence.

23 Q Okay. And do you remember reading any reports about
24 different IQ tests with Mr. Terry before you administered your
25 IQ test for Mr. Terry?

1 A I did review them. Not in depth, though, because it was
2 not my case. But I do believe that the inconsistencies in the
3 scores and his past scores is what led us to believing that
4 additional testing was necessary.

5 Q Okay. Do you happen to recall that he was given the
6 Wechsler ---

7 Am I saying that correctly?

8 A Wechsler, mm-hmm.

9 Q --- for children test at age 11 and 14? Do you remember
10 that?

11 A (No audible response.)

12 Q So that's a different test than Wechsler for adults; is
13 that correct?

14 A It is correct, yes, but they are typically based on the
15 same theories, the same indices that we're looking for. So,
16 again, what I said earlier, the verbal intelligence, the
17 perceptual intelligence, processing speed, and working memory.
18 We're looking at the same indices, are they measuring
19 essentially the same things.

20 Q And there's a different children's test to make it easier
21 to administer for children, more reliable for that result; is
22 that correct?

23 A That is correct. So what Dr. Decker was saying earlier
24 about the basal and the ceilings, the children's test have
25 easier questions because we are administering them to

1 six-year-olds opposed to 18-year-olds.

2 Q And we have heard a different term in the courtroom about
3 IQ tests. We also heard WAIS. What do you mean if you say
4 WAIS?

5 A Sure. So that's the Wechsler Adult Intelligence Scale.
6 So that's the difference between the WISC, which is the
7 Wechsler Intelligence Scale for Children, and the WAIS is the
8 adult version.

9 Q And in your opinion, Doctor, is one better or more
10 reliable than the other?

11 A No.

12 Q Are there differences?

13 A There are differences.

14 Q Okay. In reporting scores, for instance, one uses the
15 global scale. I believe that's the Woodcock-Johnson that we
16 have heard about today.

17 What, if anything, can the Court take away from reporting
18 a global score compared to a full-scale IQ?

19 A They're essentially the same thing. They're using all of
20 the sub-tests, as Dr. Decker was describing, to calculate the
21 full scale or the global scale. They're essentially the same
22 thing. They weight the exact same indices that I was
23 mentioning earlier.

24 Q Let me ask you: Did you have any materials to rescore or
25 recheck Dr. Decker's 2022 testing on the Woodcock-Johnson?

1 A No. I believe that he did not have any of the raw data
2 or the protocols that he used.

3 Q And, believe me, I'm not criticizing anybody's math
4 skills, but there can be simple math scoring errors that
5 affect conclusions; can there not?

6 A Absolutely, mm-hmm.

7 Q But you couldn't rescore anything. You didn't have any
8 materials at all?

9 A No.

10 Q Okay. Was there any evidence of physical limitation or
11 illness at the time that you gave the test to Mr. Terry?

12 A Not that I can recall. I do know that he has a medical
13 condition that does cause some discomfort every now and again,
14 and we wanted him to make sure -- I believe it was the second
15 time we met with him when we couldn't get his -- the black box
16 off, so to speak, that he indicated that he had not had his
17 pain medicine that day. But I do believe he indicated he had
18 his pain medicine the day that we did the testing.

19 Q You noted there's no visual problems, however?

20 A No, and none were reported.

21 Q Now, would you please tell the Court how you selected the
22 test to administer to Mr. Terry?

23 A Sure. I'm a big fan of the Wechsler assessments. They
24 are my preference. That is what was really emphasized in my
25 APA accredited university training here recently. So that I

1 feel most comfortable administering and scoring that
2 assessment over the other ones, although I am trained and I
3 have used the other ones before.

4 And we also wanted to see how the same test makers --
5 because the same test makers made the WISC when he was
6 younger. It's good to kind of get the same caliber of testing
7 to kind of compare those scores.

8 Q Okay. And when you give a test and you score different
9 areas and you get different scores that tell you about
10 different aspects of intelligence or ability. So when you
11 were looking at the breakdown of the individual reporting
12 areas, what, if anything, were you able to detect about
13 Mr. Terry's intellectual function and his testing?

14 A Sure. So whenever we're looking at the different index
15 scores -- so the verbal intelligence, perceptual intelligence,
16 the working memory, and the processing speed intelligence
17 scores -- we're looking for trends. So, usually, what we see
18 in adults is that IQ scores generally fall within the same
19 areas. So if somebody is scoring 90s, they're generally
20 scoring 90s. So whenever we see deviations from that, we have
21 to look at that.

22 For Mr. Terry, his verbal intelligence was a strength for
23 him. That was the score of the 90s. His other two scores --
24 so his perceptual reasoning and the working memory fell -- I
25 believe those were in the 80s.

1 And then he has a significant weakness in processing
2 speed, and that was -- or relative weakness, I apologize, in
3 processing speed, which is the only score that he fell in the
4 70s on.

5 Q Okay. And I want to go back a little bit to your report,
6 and I don't know if you remember reading this, but there is a
7 sentence that reads, "The full scale IQ -- the FSIQ is usually
8 considered to be a most representative measure of global
9 intellectual functioning." And that's on page 11 of the
10 report.

11 Now, we just discussed a few minutes ago about reporting
12 a global score compared to a full scale. Do you agree with
13 that sentence?

14 A With caveats. Whenever there are significant variances
15 within somebody's score, whenever we look at their profile --
16 so if somebody scores a 70 on their perceptual reasoning score
17 but 100 on their verbal score, the full scale IQ is not going
18 to be the most representative of their true functioning.

19 Conversely, if somebody has attention problems or they
20 have processing speed problems, which is typically associated
21 with attention, we see that pop up in their processing speed
22 scores or their working memory scores. And so sometimes we
23 will actually drop those scores out so that we can see what
24 their functioning is like without that, because there is a
25 whole host of DSM diagnoses that can impact those other two

1 index scores, so the processing speed and the working memory.

2 Q So when we say "usually," that's the caveat, because you
3 have got to look at the individual; correct?

4 A Correct.

5 Q Okay. And you don't have a full scale in
6 Woodcock-Johnson, but you use that global as a full scale in
7 comparison; is that correct?

8 A That's correct.

9 Q Okay. And on your test, the full scale was 82; correct?

10 A I believe that was correct, yes.

11 Q And is that low average?

12 A Yes.

13 Q And can you tell us what that means? What's low average
14 mean in context of a range of IQ scores?

15 A Sure. So a score of 100 is considered average. And if
16 we think about this, the vast majority of the population --
17 upwards of 50 percent of people -- are going to score around
18 the 100 range. But whenever we are looking at the standard
19 scores, we need to look at statistical significance. And
20 whenever we are looking at diagnoses, the statistically
21 significant score for a diagnosis of an intellectual
22 disability usually falls at two standard deviations below the
23 mean. So that is a 70 or below.

24 When we get a score in the 80s, that means that, compared
25 to the vast majority of folks, there are some deficits, but

1 it's not -- it's still in the population and it happens pretty
2 frequently, if that makes sense.

3 Q Okay. And your testing also reflected what's called a 95
4 percent confidence range. So can you explain that for the
5 Court? What's that 95 percent confidence range and why do you
6 report it?

7 A Sure. So we report it because there are situational
8 factors that's going to impact everyone on how we test. If
9 we're administered the same test two years from now, three
10 years of now, we may not get the exact same score. So the 95
11 percent confidence interval is telling you that we are 95
12 percent confident that, if we were to retest an individual,
13 they would fall within this range of scores.

14 Q Okay. And the range that you reported was 78 to 86;
15 right?

16 A That's correct.

17 Q And 86 is higher than the 82 full scale and closer to
18 average?

19 A Sure. There are instances where people do better by a
20 couple of points, mm-hmm.

21 Q And you also reported what you termed a general abilities
22 score, an 86 with a confidence interval of 81 to 91. So what
23 is that score and why is it different?

24 A Sure. So the GAI, the General Ability Index score is
25 reported -- well, so the GAI is calculated based on the verbal

1 intelligence and the performance intelligence. So as I said
2 earlier, there's a lot of situational factors -- pain,
3 fatigue, effort. There's a lot of things that can impact how
4 we perform on a test. ADHD is one as well.

5 So when we see that somebody has deficits in processing
6 speed or working memory and it's statistically significant,
7 what we can do is we can drop those scores out and only
8 calculate the functioning score based on the verbal IQ and the
9 perceptual reasoning IQ.

10 Q Okay. And what do the manuals or literature tell you
11 about use of the general abilities score as you just explained
12 it to us?

13 A Sure. So it's appropriate for use whenever we notice
14 that there's a discrepancy between the two main indices that
15 we look at, so the verbal and the perceptual reasoning ones,
16 and whenever we see that there's deficits in working memory or
17 processing speed.

18 Q Is it appropriate or inappropriate to look at both the
19 full scale and the general abilities score together for a
20 range?

21 A When you say "for a range," can you explain what you
22 mean?

23 Q Your full scale score is 82. The general abilities
24 score, 86. Is it appropriate to say somewhere in there it may
25 be a good range as well of actual intellectual functioning?

1 A I wouldn't use it as a range, but it does tell us some
2 information. When the GAI is higher than the full scale IQ,
3 it tells us that, one, an individual will likely need pen and
4 paper to do work or they may need additional time; they don't
5 do well on timed tasks. But it suggests that they have the
6 ability to get there if they're provided additional time and
7 that there's less distractions than when they're performing at
8 the best that they can, if that makes sense.

9 Q And if, hypothetically, someone we know has a learning
10 disability and it has been identified that that individual
11 needs additional time to do his work, would that not, in fact,
12 support more reliability on what you have described, the
13 general ability score of 86, when that person has more time to
14 accommodate a learning disability?

15 A I wouldn't say that. A learning disability is getting at
16 really specifically academic skills. And while -- while
17 giving additional time may improve their scores on academic
18 skills, they are really truly two totally different -- totally
19 different diagnoses and totally different skills.

20 So the processing speed is really neurological. It's how
21 fast our brain is understanding information and how fast our
22 brain is responding to information, which can impact our
23 academic performance but it's not mutually exclusive with our
24 academic performance.

25 Q You make an excellent point; they are two different

1 things.

2 But if you had a note that it was observed someone does
3 better when he has more time as part of his learning
4 disability, as part of his school records, that supports what
5 you found that, with more time --

6 MR. GROSE: Objection --

7 BY MS. BROWN:

8 Q --- an individual can do better; correct?

9 MR. GROSE: Objection to the leading question, Your
10 Honor. This is direct examination.

11 THE COURT: Sustained as to leading.

12 You can rephrase your question.

13 BY MS. BROWN:

14 Q As a hypothetical, if you had a note that someone needed
15 more time because he was treated as a learning disabled
16 student but did better when he had more time to process, would
17 that be consistent with a higher score -- general abilities
18 score when you know someone needs more time to process?

19 A I think all of that information would be consistent. We
20 see, with the GAI, it is a couple points higher, and we know
21 that that is because of his relative weakness -- or because of
22 a relative weakness in the processing speed and the contextual
23 information that, during academic performances, if they got
24 more time, they performed well, that would be consistent with
25 our findings.

1 Q Thank you.

2 And to go back -- and I want to make clear because I
3 asked a question that was sort of convoluted. Learning
4 disability isn't necessarily intellectual dysfunction; you
5 have to look at both things?

6 MR. GROSE: Objection to leading.

7 BY MS. BROWN:

8 Q Is that correct?

9 THE COURT: Sustained as to leading.

10 You can answer the question.

11 A Yes. They are very different. One applies only to the
12 academic setting. While an individual who has an intellectual
13 disability will perform poorly in an academic setting, they're
14 going to perform poorly across the board in their -- in their,
15 you know, employment settings, in their relationships, they're
16 going to need support throughout their life. That's not going
17 to be the same case for somebody who has a learning
18 disability. They're not going to need the same outside
19 support.

20 When I normally give feedback to folks who do have a
21 learning disability, what I typically say is, "You can learn;
22 it's just we have to teach you in the way that you need to
23 learn" whereas, with an intellectual disability, the ability
24 to learn is not the same as what a typically functioning adult
25 or child would be.

1 Q Okay. Were you aware that Mr. Terry had a fall from a
2 tree and some head trauma in his 20s and later a stroke?

3 A I do believe he reported that during our interviews.

4 Q And those things perhaps can affect intellectual
5 function; correct?

6 A They definitely can, and, specifically, I will agree with
7 Dr. Decker; they can impact processing speed.

8 Q And even with the fall, the head trauma, and a stroke
9 later on -- and some medical difficulties as you noted earlier
10 he had reported to you -- your test showed a full scale IQ of
11 82.

12 A That's correct.

13 Q And Mr. Terry tested twice at a level of 92. And would
14 you agree that's average range?

15 A I would.

16 Q Okay. And that's when he was very young; right? 11 and
17 14?

18 A Yes.

19 Q Okay. So, in your professional opinion, how likely is it
20 for an individual to twice score, over a three-year testing
21 period, higher than his capabilities would normally reflect?

22 A That would be extremely rare, and I have never seen it.
23 It is easier for individuals to get lower scores because,
24 again, effort, fatigue. There's a lot of reasons why we might
25 get lower scores, but it's really hard to fake a higher

1 intelligence, if that makes sense.

2 Q Okay. Doctor, in your opinion to a reasonable degree of
3 psychological certainty, what is Mr. Terry's current level of
4 IQ function as reflected in the IQ score?

5 A So he scored in the low average range. As it pertains to
6 his intellectual functioning, I don't think I can give an
7 opinion to that because I didn't do the full evaluation that
8 Dr. Hall did -- reviewing the records, going through the
9 collateral interviews. I can speak to the scores that he
10 obtained.

11 Q And those are just the numbers given by the test?

12 A That's correct.

13 Q That you extract from the responses from the test. Okay.
14 Nothing to really modify -- nothing to use clinical
15 judgment on in scoring.

16 A Yes, that's correct.

17 Q And, also, Dr. Hall noted in her report an application of
18 the Flynn Effect, and she has some numbers reflected in those
19 reports -- in that report on the different tests. Was that a
20 calculation that came from you?

21 A It was not. I have never actually used the Flynn Effect.
22 It's typical to use the Flynn Effect in Atkins cases only.

23 Q Okay. And are you familiar with the AAIDD and the DSM-5?

24 A Yes.

25 Q What, if anything, do those sources advise you when using

1 the Flynn Effect or considering to use the Flynn Effect?

2 A Sure. So I have actually had to look at this on other
3 case recently. The AAID [sic] has -- it's only on one page,
4 per my memory, where they're discussing the Flynn Effect.
5 There's really no guidelines on when to use it.

6 And the DSM essentially allows clinical judgment. You
7 don't have to recalculate IQ scores to diagnose an
8 intellectual disability. And it's not typical to do that in
9 day-to-day clinical work. That's only applied in Atkins cases
10 because of the strict legal definition of an intellectual
11 disability. So the DSM really doesn't give any guidelines on
12 it either because it's just not typical.

13 Q So when you return reports for somebody trying to seek
14 services, supports, placement in school, or what have you, you
15 don't apply the Flynn Effect?

16 A I do not apply the Flynn Effect.

17 Q And Dr. Hall also reported that you gave a Montreal
18 Cognitive Test; is that correct?

19 A That's correct.

20 Q Okay. What can you tell us about your conclusions as to
21 that cognitive test?

22 A Sure. So that is a screener, but it is a pretty thorough
23 screener that's highly correlated with our large memory
24 batteries that we administer and score for neurocognitive
25 disorders, such as a TBI.

1 And Mr. Terry did exhibit some deficits, specifically in
2 attention, which is pretty consistent with our IQ score. So
3 if somebody is exhibiting deficits in attention, they're going
4 to exhibit deficits in processing speed as well typically.

5 He also exhibited some deficits in language, specially
6 language fluency. And per the testimony yesterday, I think
7 that's pretty consistent with what another neuropsychologist
8 said.

9 And then he also exhibited some deficits in memory.

10 Q Okay. And since you're here to talk about your test and
11 to explain what the Court can take away from it, is there
12 something else that you would like to explain about the report
13 to this Court that would help the Court in making a
14 determination of where that IQ level is?

15 A I don't think so.

16 Q Okay. No further questions. Would you please answer any
17 questions that Mr. Terry's counsel has?

18 A Sure.

19 THE COURT: What time do you have to leave?

20 THE WITNESS: At 11:00.

21 THE COURT: All right.

22 Go ahead, Mr. Grose.

23 CROSS-EXAMINATION

24 BY MR. GROSE:

25 Q I believe that you testified that Dr. Hall was present

1 when you administered the IQ test?

2 A Yes, that's correct.

3 Q And you're aware that the ADA -- I mean, the APA has a
4 statement against having third-party observers during an IQ
5 test?

6 A I'm actually not familiar with that. Part of my training
7 is -- we have done those things together.

8 Q Okay. So you're not aware of that?

9 A I'm not. Now, if there's a statement, I would be happy
10 to read it. I do know that, like, Dr. Greenspan yesterday
11 mentioned, that it could impact testing, but the only way it
12 would impact testing is if it actually deflated our scores
13 instead of inflated them.

14 Q But you indicated that you're a member of the APA;
15 correct?

16 A Yeah.

17 Q And that you are bound to follow their procedures?

18 A Yes.

19 Q Okay. They asked you some questions about the GAI;
20 correct?

21 A Correct.

22 Q All right. There's nothing in Dr. Hall's report where
23 she contends using the GAI is appropriate in this case; is
24 that correct?

25 A I don't believe so. I think she reported both and

1 considered both.

2 Q All right. But the WAIS 4 administrative manual doesn't
3 mention using GAI to diagnose intellectual disability, does
4 it?

5 A Well, so the DSM actually states that it has to be -- to
6 diagnose an intellectual disability, there has to be deficits
7 in intellectual functioning that is confirmed by standardized
8 assessments. So we don't use IQ tests, period, to diagnose.

9 Q Okay. But the manual -- I was asking about the WAIS 4
10 manual. The WAIS 4 manual -- and we're just talking about
11 getting a score -- that doesn't mention using the GAI; it
12 mentions using the full scale.

13 A To diagnose?

14 Q Well, as part of interpreting the results on the IQ test.

15 A Are you saying that the manual is indicating that we
16 should not interpret the GAI?

17 Q I'm saying that, when you're reporting somebody's IQ, the
18 GAI is just part of it. When you're doing the GAI, you're
19 excluding parts of the person's intelligence; is that correct?

20 A That is correct.

21 Q Okay. All right. And the same with regard to the
22 technical manual; it doesn't mention relying solely on the
23 GAI, does it?

24 A No, but as clinicians, we shouldn't rely solely on any
25 score.

1 Q Repeat that. You said, as clinicians, you should not
2 rely solely on any score?

3 A Mm-hmm, that's correct.

4 Q Okay. Are you familiar with the study which examined the
5 implications of using the full scale IQ versus the GAI
6 determination of intellectual disability using the WISC 4
7 conducted -- or concluded that the GAI should not be used to
8 diagnose ID?

9 A There's a lot of studies. I would have to look at it and
10 I would have to look at the methodology of the study to
11 determine whether those results can be applied in clinical
12 decision-making.

13 Q Would you take a look at that.

14 A Mm-hmm.

15 Q And just for the record, that's a statement on
16 third-party observers in psychological tests and assessment of
17 framework for decision-making.

18 A (Reviewing document.) Okay. So this study is about not
19 clinical observers. This is about third-party observers. I'm
20 not considered a third-party observer. I'm considered a
21 clinical observer, and it is part of our practice.

22 So, in addition, it states that "This statement does not
23 constitute an official policy of the American Psychological
24 Association nor does it purport to dispense legal advice and
25 it is not intended to establish standards of guidelines."

1 So this is not intended to -- this statement is not
2 intended to guide clinical practice, nor is it applicable to a
3 training situation.

4 Q And this was a training situation, wasn't it?

5 A Where -- where Dr. Hall was present and my involvement in
6 the case?

7 Q Where it says, "Hints," can you read that?

8 A It says, "Hints: The observer may be a psychologist or
9 trainee. In such cases, all the same issues and concerns
10 apply."

11 But, again, this is about --

12 Q I just asked you to read that.

13 A Okay.

14 Q And that's what it says?

15 MS. BROWN: Objection, Your Honor. I think she should be
16 able to explain her answer.

17 THE COURT: She can.

18 You may explain your answer, ma'am.

19 A Okay. Again, that is about how it's going to impact
20 legal situations. It's not about whether or not it's going to
21 impact the clinical performance of an individual.

22 BY MR. GROSE:

23 Q Well, this is an examination that's being used in the
24 legal context; is that correct?

25 A That's correct.

1 Q All right. And you have never participated in an Atkins
2 assessment before now; is that correct?

3 A That's correct.

4 Q All right. And this guideline suggests that it should
5 not be done that way; is that correct?

6 A It does not. It explicitly states that it is not a
7 guideline that should guide clinical practice. That's in
8 the --

9 Q But this statement is contrary to the practice that you
10 employed in this case; is that correct?

11 A The practice that was employed in this case is what's
12 taught in every APA-accredited university.

13 Q And APA-accredited universities -- the statement is that
14 there should not be third-party observers; is that correct?

15 A That's what that statement says.

16 Q Okay. And you testified earlier that this is an Atkins
17 situation and the stakes are very high.

18 A That's correct.

19 Q Okay.

20 A Mm-hmm.

21 Q All right. Now, I want to -- you were the -- an observer
22 during the clinical interview that Dr. Hall did; is that
23 correct?

24 A That's correct.

25 Q Do you have your notes from that with you up there?

1 A I don't.

2 Q Okay. I'm going to ask you some questions about those
3 notes. Does this appear to be your notes?

4 A Yes.

5 Q Okay. And on page 2 of your notes, Dr. Hall asked if
6 Gary Terry ever had a place of his own. And the response was,
7 no, that he always moved in with them.

8 And so this was -- what they were talking about was going
9 to independent living; correct?

10 A That's correct.

11 Q All right. And when it says "them," that he always moved
12 in with the girlfriends; is that right?

13 A I would have to look back over my notes, but I believe
14 that that's accurate.

15 Q The notes are right here. Do you have your copy with you
16 here today?

17 A I don't.

18 Q Okay.

19 MS. BROWN: Your Honor, for clarity, I do have copies of
20 notes that both Dr. Hall and Dr. Davis sent to opposing
21 counsel and to the State.

22 MR. GROSE: And that's what we're --

23 MS. BROWN: And I'm happy to hand them up.

24 MR. GROSE: And that's what we're looking at.

25 THE COURT: All right. You can give her her notes.

1 A Yes. In the context of that interaction, we were talking
2 about his ability to live independently with his partners.

3 Thank you.

4 BY MR. GROSE:

5 Q Well, why don't you turn to page 2 of your notes.

6 A Okay.

7 Q All right. And look at the same paragraph that I'm
8 looking at.

9 A Mm-hmm.

10 Q Can you please read that paragraph into the record?

11 A Yes. So, "Ever had your own place?"

12 "No. I always moved with them."

13 "Find place together or were they always established?"

14 "They were pretty much established. I would be staying
15 somewhere and they would come there. My name was never on
16 anything."

17 "Move into a bigger place after started having children?"

18 That was a question.

19 "Yes, we did."

20 "Did she find the place or did you help her?"

21 "She would find the place. We went to look at a few
22 things."

23 "It was her decision?" That was a question.

24 And it says, "Yeah. She would do all the paperwork. As
25 long as I had a bed and yard and kitchen, I didn't care."

1 Q And if you could go over to the top of page 4 of your
2 notes.

3 A Mm-hmm.

4 Q There was a question about "How old were you when you
5 first moved out of the parents' home into your own place"; is
6 that right?

7 A That's correct.

8 Q And the answer that he gave was, "I think 18. Moved in
9 with Billy. He was already out of the house. I was staying
10 with Laney and Wesley and all those, helping a friend lay
11 carpet." Is that right?

12 A That's correct.

13 Q So he moved directly from his parents' house into his
14 brother's house?

15 A That's what was reported.

16 Q Okay. And then going down that page a little further,
17 there was some questions about the marriage -- Gary's marriage
18 with Louanne -- to Louanne; is that right?

19 A That's correct.

20 Q And the question --

21 MS. BROWN: Your Honor, I'd like to object because this
22 is supposed to be to intellectual testing. These are
23 notes ---

24 MR. GROSE: This is cross --

25 MS. BROWN: --- that have to do with second prong. So we

1 are outside the expertise of this particular witness and
2 outside anything that could affect her testimony. It's not
3 relevant.

4 MR. GROSE: This is cross-examination, and she was privy
5 to relevant information, and I think it's admissible.

6 THE COURT: Okay.

7 BY MR. GROSE:

8 Q All right. The question was, "Who was responsible for
9 the household?"

10 A Let me find my place here. "Who was responsible for the
11 household?"

12 "Louanne."

13 Q All right. And Gary just gave her the money; correct?

14 A That's correct.

15 Q All right. And with regard to whether he was involved
16 inside household, he told you that he was not. He just did
17 yard work?

18 A Yes. He said, "Yes, wasn't involved inside household."

19 Q And he also said, "I started the business, and I would
20 just hand her money"?

21 A Yep, that's correct.

22 Q Okay. And he reported -- I'm looking at page 5 -- that,
23 on two occasions, he tried to get a GED --

24 MS. BROWN: Your Honor, I'm going to object again because
25 there's nothing impeaching, there's nothing establishing bias,

1 and there's nothing going to IQ testing, and that's purpose of
2 this witness.

3 MR. GROSE: But this witness was also --

4 THE COURT: But aren't you going to ask all the same
5 questions of Dr. Hall? So I don't understand where you're
6 going ---

7 MR. GROSE: Well, some of these -- some of these --

8 THE COURT: I don't understand where you're going with
9 that line of questioning. She's not here to give an opinion
10 as to whether or not he's intellectually disabled.

11 MR. GROSE: Well, some of this is inconsistent with
12 what's in Dr. Hall's report, which has already been marked as
13 an exhibit, No. 1 --

14 THE COURT: So why can't you ask Dr. Hall that?

15 MR. GROSE: Because I don't know what Dr. Hall is going
16 to say. She's on the witness stand, and she witnessed
17 statements that were inconsistent.

18 MS. BROWN: Well, that's -- leans towards pitting, Your
19 Honor, which wouldn't be --

20 MR. GROSE: That's not leaning towards pitting. I'm
21 not -- I haven't asking her a question about Dr. Hall's
22 report ---

23 THE COURT: Okay. Let's just go somewhere.

24 MS. BROWN: Your Honor, may I add one more basis?

25 THE COURT: No, ma'am.

1 MS. BROWN: Thank you.

2 BY MR. GROSE:

3 Q All right. Anyway, he indicated both times he gave up
4 because the information that the other inmates were trying to
5 teach him just wouldn't stick; is that correct?

6 A Where are you reading that?

7 Q I'm in that same spot.

8 A Okay. "Tried twice to get a GED while locked up and both
9 of them gave up on me." Yes, so he was trying to get help
10 from other inmates.

11 Q He also told you that most of his classes were special
12 ed?

13 A Yes, that's correct.

14 MS. BROWN: Your Honor, that's hearsay as well. I
15 just -- I just want to renew my objection because we still
16 haven't gotten to any impeachment, bias, or anything that
17 would go to --

18 THE COURT: You haven't even established how it
19 potentially is impeachment.

20 MR. GROSE: Then I would ask that this witness remain
21 until after Dr. Hall testifies. We were trying to accommodate
22 her, and it would be impeachment then.

23 THE COURT: All that stuff is in Dr. Hall's report, is it
24 not?

25 MR. GROSE: Some of this is contradictory. What I'm

1 going through is contradictory to what's in Dr. Hall's report.

2 THE COURT: It better be. Keep going.

3 MS. BROWN: Your Honor, impeachment of Dr. Hall would not
4 be necessary unless Dr. Hall is given the opportunity to see
5 what was written and ---

6 THE COURT: She's going to -- she's going to --

7 MS. BROWN: --- she admits or denies.

8 THE COURT: She's going to be given that opportunity.

9 BY MR. GROSE:

10 Q On page 7, there were some questions about Gary Terry's
11 business; is that right?

12 A It's helpful to see your highlights so I know where to
13 go. Yes.

14 Q And Gary indicated that he had people who would pay the
15 bills for him; is that right?

16 A Yes.

17 Q And that Louanne would pay the taxes?

18 A Thank you.

19 Yes, he said Louanne, I think, was paying taxes.

20 Q And that he needed help to operate the business; is that
21 correct?

22 A There was context to that in the sense that he said, "It
23 would have been a big mess if I tried to do it, the taxes."

24 So the question was, "You needed that help to operate the
25 business?"

1 MR. GROSE: Beg the Court's indulgence for a moment.
2 That's all I have, Your Honor. Thank you.

3 THE COURT: Redirect?

4 MS. BROWN: Yes, sir, Your Honor.

5 REDIRECT EXAMINATION

6 BY MS. BROWN:

7 Q Again, your -- your involvement in this case was limited
8 to the IQ test; correct?

9 A That's correct.

10 Q You were asked about conversations and notes from
11 conversations of an interview that Dr. Hall conducted with
12 Mr. Terry; correct?

13 A That's correct.

14 Q And you were asked about select portions; correct?

15 A That's correct.

16 Q How many pages are the notes that you were shown and
17 referenced in your responses in cross-examination?

18 A I have 20 pages.

19 Q So what you said on cross-examination is not the fullness
20 of the notes that are before you; correct?

21 A I would agree with that.

22 Q And some of those show, for instance, around page 3,
23 Mr. Terry saying that he learned to weld at age 11. Showed
24 one time and he knew how to do it after that. Also, that he
25 took the blame for something for another sibling so, if we

1 went to jail for it, he was younger, he wouldn't get in quite
2 as much trouble, showing reasoning. Do you see that in your
3 notes as well?

4 A There's a lot of text on this page, but I do recall that.

5 Q Thank you. Thank you.

6 He said that he was stronger than his brother and tried
7 to take care of him at one time. He was afraid his brother,
8 if he went to prison, was going to kill himself, so he was
9 trying to protect the brother. Do you recall that?

10 A I do recall that.

11 Q Okay. And in the marriage, he didn't want to be involved
12 in the household stuff.

13 A I do believe that's correct.

14 Q Child-rearing, he would actually, quote, "Throw up,"
15 start gagging if he tried to change a diaper. But didn't he
16 also say that he would change a diaper if it was just, in his
17 words, "Number one instead of number two"?

18 A That's correct.

19 Q Okay. And that he stayed at a camper at the lake with a
20 friend who was paralyzed from the waist down to help her, not
21 romantically involved, he just helped. She fell out of the
22 chair; he would go to her.

23 A Yeah, that's correct.

24 Q Okay. He never lived with his first wife? He says, "Me
25 and Tammy never lived together." And that's a quote on

1 page -- around page 4.

2 A That's correct. And I think that was my own notes in
3 there about whether that was his first wife. Because, again,
4 I didn't do all of the same.

5 Q Thank you.

6 A Mm-hmm.

7 Q And I won't go through all of it, but I just wanted to
8 establish that there was a lot of information that had to be
9 considered, synthesized, fleshed out. One or two bits of
10 information is not what either of you relied on in making
11 those notes; correct?

12 A That's correct.

13 MS. BROWN: No further questions, Your Honor.

14 THE COURT: Follow-up?

15 MR. GROSE: Nothing further at this time, Your Honor.

16 THE COURT: Okay. Thank you.

17 THE WITNESS: Thank you.

18 THE COURT: All right. Let's take our morning break.
19 We'll take about a ten-minute break and start back at 11:35.
20 Thank you very much.

21 MS. BROWN: Your Honor, may I ask the witness to be
22 excused from the subpoena?

23 THE COURT: Yes, ma'am.

24 THE WITNESS: Thank you.

25 (A recess was taken from 11:23 a.m. to 11:38 a.m.)

1 (State's/Respondent's Exhibit No. 3, Dr. Hall's C.V., was
2 marked for identification.)

3 THE COURT: Okay. Who's next?

4 MS. BROWN: Thank you, Your Honor. The State calls
5 Dr. Alicia Hall, please.

6 DR. ALICIA HALL

7 after having been duly sworn, was examined and
8 testified to as follows:

9 THE CLERK: All right. Have a seat, state your name and
10 spelling of your last name for the record.

11 THE WITNESS: Alicia, A-l-i-c-i-a, Hall, H-a-l-l.

12 DIRECT EXAMINATION

13 BY MS. BROWN:

14 Q Dr. Hall, please tell us where you're currently employed
15 and your position.

16 A The Department of Disabilities and Special Needs, and I
17 am the spike (ph) II clinical supervisor.

18 Q Okay. And what are your duties within that position?

19 A As clinical supervisor, it's my job to oversee and
20 supervise the forensic department. So I oversee the
21 clinicians we have: Dr. Davis as well as our part-time
22 psychology and our admin staff. But I also complete
23 court-ordered evaluations for competency to stand trial as it
24 relates to individuals who possibly have intellectual
25 disability or some sort of related disability.

1 Q Okay. Do you hold any special licenses where you work?

2 A Yes. I'm a licensed psychologist in the State of South
3 Carolina.

4 Q And, briefly, what qualifications do you have to meet to
5 be licensed in South Carolina?

6 A You have to have graduated from an APA-approved doctoral
7 program, which I got my doctoral degree in 2003 from the
8 University of South Florida in clinical psychology with a
9 concentration in forensics and child psychology.

10 You have to have completed a minimum of a 2000-hour
11 internship. And then post-internship, you have to have at
12 least 2000 hours of supervised clinical practice. And then
13 you have to pass the written exam as well as the oral exam.

14 Q Okay. And is that license renewable or permanent?

15 A You renew it.

16 Q And they're continuing education requirements for your
17 role?

18 A Yes. Every two years, we're required to have accumulated
19 at least 24 hours of continuing education.

20 Q Would you please review for us your educational
21 background since college.

22 A My college is Lafayette College in eastern Pennsylvania
23 where my degree was in psychology. I then went to the
24 University -- or, excuse me, Indiana State University in an
25 experimental psychology program. I transferred from there to

1 the University of South Florida, where I got my doctorate in
2 clinical psychology.

3 Q And is the end of that training in forensics?

4 A Yes, in -- like I said before, I had a concentration in
5 forensics at the University of South Florida as part of my
6 doctoral training. I trained under Randy Borum and Norman
7 Poythress both of whom are kind of well-known in the field of
8 forensic psychology.

9 And then, as part of my internship, I did my internship
10 at William S. Hall in conjunction with U.S.C. School of
11 Medicine, and so I was forensically trained at William S.
12 Hall, both child and adult forensics.

13 Q Okay. So when you say concentration, that is a track.
14 That's an actual program, almost like a minor; is that
15 correct?

16 A Yes, that would be akin to a minor.

17 Q And please explain to us a little bit about forensic
18 psychology practice compared to just psychology practice.

19 A The major difference is, when you're doing clinical work,
20 you are working for your -- or the identified patient is the
21 person you're working with. That's who you're working for.

22 In forensics, the identified patient isn't the person
23 that I'm evaluating or the identified client isn't the person
24 I'm evaluating. I'm writing about them, not necessarily for
25 them. So the person -- because all of mine are court-ordered

1 evaluations, the Court is actually the person that I'm writing
2 for, even though I'm writing about the person who has the
3 charges.

4 Q And if you would, please give us a brief summary of your
5 professional employment.

6 A I started off at -- a teacher at the -- well, a research
7 assistant -- research assistant professor at the University of
8 South Carolina School of Medicine in the Department of
9 Neuropsychiatry and Behavior Disorders where, for five years,
10 I was the chief psychologist in the genetic study looking for
11 the genes that contribute to autism spectrum disorders.

12 Then I moved over to the Department of Mental Health
13 where I was the chief psychologist in the Developmental
14 Disorders Clinic. At that time, I also began to do the
15 juvenile forensics for DMH. And then, in 2010 -- and I did
16 that from about 2006 to about 2010. I began to do adult work
17 in 2008 as well for DMH. And then, in 2010, I moved to the
18 Department of Disabilities and Special Needs.

19 Q Are you a member of any professional organizations
20 specific to psychology?

21 A Yes, the APA, the American Psychological Association.
22 I'm a member of Division 41, which is the forensic division
23 APLS. I'm also a member of AAIDD. I'm also a member of
24 INSAR, which is the International Society of Autism
25 Researchers.

1 Q And when you receive court-ordered evaluations, what are
2 the courts generally asking you to evaluate these days? Do
3 you do more competency or intellectual disability evaluations?

4 A Well, the question that DDSN is charged with per state
5 statute is to answer the question of whether or not the person
6 is competent to stand trial and whether or not the person has
7 intellectual disability or related disability that may affect
8 their level of competency. So those are the -- primarily what
9 we see most.

10 We also do other PCR evaluations. So if someone is
11 appealing where they felt like competency should have been an
12 issue that was not -- and it was not raised, we have asked to
13 participate in those. And then, of course, we do Atkins
14 challenges when they arise.

15 Q How many intellectual disability evaluations have you
16 conducted? And this is not necessarily Atkins but just the
17 totality of intellectual disability evaluations.

18 A Probably over a thousand.

19 Q And do you teach, Dr. Hall?

20 A I do.

21 Q And what do you teach and where?

22 A I teach at the University of South Carolina in the
23 Psychology Department. I'm an instructor. So, currently, I
24 rotate between two classes. In the fall, I teach forensic
25 psychology. In the spring, I typically teach child behavior

1 and mental disorders.

2 Q Have you been qualified as an expert in any court before?

3 A Yes.

4 Q In what discipline have you qualified?

5 A Clinical and forensic psychology.

6 Q Have you been qualified as an expert in intellectual
7 disability assessment before?

8 A Yes.

9 Q How many times and which courts?

10 A Here in South Carolina, across the state. I have
11 probably done about eight Atkins cases.

12 Q In your current role with DDSN, are the majority of your
13 evaluations intellectual disability evaluations during the
14 developmental period or post-developmental?

15 A We see juveniles and adults, so it's across the life
16 span.

17 Q And outside of Atkins, just how many post-developmental
18 period evaluations do you think you have done over the last
19 few years?

20 A It would be hundreds.

21 Q And how many Atkins evaluations did you say you have
22 done?

23 A Approximately eight.

24 Q About eight?

25 A Yeah. I believe five -- five or six on my own and then

1 three under supervision of our previous director.

2 Q And you have a current C.V.?

3 A I do.

4 Q I would like to show you --

5 MS. BROWN: May I approach the witness, Your Honor?

6 BY MS. BROWN:

7 Q I would like to show you what's marked State's Exhibit 3
8 and see if that looks familiar to you, please.

9 A Yes. This is my C.V.

10 Q Does that look to be your current C.V.?

11 A Yes.

12 MS. BROWN: Your Honor, we would move State's Exhibit 3
13 into the record.

14 MS. FRANZ: No objection.

15 THE COURT: All right. State's Exhibit No. 3 is
16 admitted.

17 (State's/Respondent's Exhibit No. 3 was received into
18 evidence.)

19 MS. BROWN: If I may approach, Your Honor, I have got
20 copies for you and your clerk.

21 THE COURT: Oh, thank you. Yes, you may.

22 BY MS. BROWN:

23 Q Dr. Hall, on pages 2 and 3, it appears that you have
24 indicated working on evaluations for juvenile and adults, as
25 you had mentioned earlier, and also the traumatic brain

1 injury. So is that correct that you have that experience?

2 A Yes.

3 Q Okay. And on page 3, you reference using the "Vin-land"
4 or "Vine-land" test; you'll have to tell me which way that I'm
5 supposed to pronounce that.

6 A "Vine-land."

7 Q "Vine-land."

8 And what is that?

9 A That is a measure of adaptive functioning.

10 Q Okay. So when were you first introduced to that concept
11 of adaptive functioning and testing with a standardized
12 instrument?

13 A In graduate school.

14 Q And you have used standard instruments since?

15 A Yes, ma'am.

16 Q Okay. And on page 4, it looks like you have given
17 lectures at the medical university on advanced forensic
18 psychology?

19 A Yes.

20 Q Okay. And what do you mean by "advanced forensic
21 psychology"?

22 A Annually, I give lectures to the forensic fellows at both
23 University of South Carolina School of Medicine and the
24 Medical University of South Carolina where we talk about the
25 impact of developmental disabilities on forensics and things

1 that they should be looking for when they conduct their
2 evaluations.

3 MS. BROWN: Your Honor, based on the testimony and the
4 information cataloged in Dr. Hall's C.V., we would ask the
5 Court to find Dr. Hall qualified as an expert in forensic
6 psychology and in intellectual disability assessment both
7 before and after the developmental period.

8 THE COURT: Voir dire?

9 MS. FRANZ: No, no objection.

10 THE COURT: Okay. So qualified.

11 MS. BROWN: Thank you, Your Honor.

12 BY MS. BROWN:

13 Q Dr. Hall, can you tell us how you became involved in this
14 case initially?

15 A We received -- we received an order from this Court.

16 Q And that's the ordinary way you receive a case these days
17 in your current practice; right?

18 A Yes.

19 Q All right. And you were not retained by the Applicant?

20 A No.

21 Q You were not retained by the Attorney General's Office?

22 A No.

23 Q You came in as a neutral examiner?

24 A Yes.

25 Q And post-developmental period assessments, how do you

1 begin that backward-looking assessment?

2 A We need as many records as we can possibly get. So we
3 like to look at medical records; school records; if the person
4 has applied for Social Security, those records; speaking with
5 individuals who knew the Applicant when they were younger. So
6 any informants we can get -- so we like to get as much
7 information as we can.

8 Q And in this case, who did you receive information from?

9 A Well, received a wealth of information from Mr. Terry's
10 team. They sent over a lot of records, probably over 10,000
11 pages probably of information. I also was able to interview
12 Ms. Louanne Smith, Mr. Terry's second ex-wife, and his mother,
13 Mrs. Patsy Terry.

14 Q And did you receive some things from the Attorney
15 General's Office and trial records or that sort of thing?

16 A Yes. We received his SCDC jacket and as well as the
17 transcript from the trial and the previous appeals.

18 Q Did you receive anything in the SCDC records that related
19 to Mr. Terry's use of a tablet?

20 A Yes.

21 Q And you never placed a time limit on when people can give
22 you information; correct?

23 A No.

24 Q And you want as much information as possible?

25 A As much as possible.

1 Q From either party; is that --

2 A Either -- doesn't matter where it comes from.

3 Q And you created a report for the Court?

4 A I did.

5 Q And did you previously provide that report dated June
6 12th, 2024, to Judge Hood?

7 A I did.

8 MS. BROWN: Okay. That report has previously been
9 marked, Your Honor, as State's 1. May I hand that report to
10 the witness?

11 THE COURT: Yes, ma'am.

12 BY MS. BROWN:

13 Q Dr. Hall, State's 1, does that appear to be a copy of
14 your report that you just referenced?

15 A Yes. Yes, it does.

16 Q Now, on the first page of your report, you set out your
17 evaluation purpose, and you got "to determine intellectual
18 disability," and the standard being Section 16-3-20(C)(b)(10)
19 of the South Carolina Code.

20 A Yes.

21 Q Is that correct?

22 My question, Dr. Hall: Why not the AAID D definition or
23 DSM-5?

24 A Well, in this instance, the order specifically said that
25 that was the basis for the order. So that was the qual- --

1 what's the word I'm looking for? That was the criteria that
2 the Court asked us -- the standards -- is the word I'm looking
3 for -- that is the standard the Court asked us to assess
4 Mr. Terry on.

5 Q And so going back a little bit in your forensic work, you
6 know you got a little bit of the law that you look at and a
7 little bit of clinical practice that you applied?

8 A Yes.

9 Q When you look at the law, you look at what has been
10 considered controlling law; is that fair?

11 A Yes.

12 Q Okay. And is it your opinion that, in South Carolina,
13 that you should be looking at Section 16-3-20 as your kind of
14 start point -- the question you have to answer is in 16-3-20;
15 is that fair?

16 A Yes.

17 Q Okay. What I want to ask you about, the AAIDD -- and
18 you're a member; right?

19 A Yes.

20 Q That definition and the definition in DSM-5 is almost the
21 same; is it not?

22 A Yeah. As Dr. Greenspan testified yesterday, they're
23 nearly identical. I would say the only other difference that
24 he didn't bring out is that the AAID [sic] specifies an IQ
25 score. It says, I believe, anything 75 and below where the

1 DSM does not specify an IQ score when talking about Prong 1.

2 Q Okay. Well, I want to skip ahead in your report a little
3 bit. On pages 10 to 11, you reference the DSM-5 as setting
4 criteria for intellectual disability, but then you're still
5 using the DSM-5 in context of the question for 16-3-20? Is
6 that a fair statement?

7 A Yes.

8 Q Okay. So, basically, all roads lead to the same basic
9 determination that you're going to have to have for a
10 diagnosis of intellectual disability?

11 A Yes.

12 Q Okay. First is the inquiry into the intellectual
13 functioning.

14 A Yes.

15 Q The second is adaptive behavior limitations; right?

16 A Yes.

17 Q And all of that has to be within the developmental
18 periods. Those things -- universally, that's what you're
19 looking at?

20 A Yes.

21 Q Okay. And you sat out in the report the purposes of this
22 litigation -- as I said, that 16 through 20 -- but I want to
23 look at that. Is that correct that it doesn't just say
24 "intellectual functioning" or "lower intellectual
25 functioning"? Does it not say "significantly subaverage

1 general intellectual functioning"?

2 A That is what the State statute says, yes.

3 Q Okay. Can you conceptualize that for us? What are you
4 looking at for significantly subaverage?

5 A Usually, that would be -- considered to be two standard
6 deviations below the mean, would be significant subaverage
7 intellectual functioning.

8 Q And are there other diagnoses with a significant
9 subaverage general intellectual function component?

10 A Yes. There are people who could have significant impact
11 to their intellectual functioning. So someone has a traumatic
12 brain injury, someone has a stroke, things like epilepsy can
13 affect a person's intellectual functioning.

14 Q And are there other diagnoses with adaptive behavior
15 limitations as part of that?

16 A Yes. ADHD, autism spectrum disorder, schizophrenia,
17 depression. Lots of things that we find in the DSM-5-TR can
18 have impact on a person's adaptive functioning.

19 Q But this specific condition was intellectual disability
20 requires both and that they both have occurred or been present
21 during the developmental period; right?

22 A Yes.

23 Q Now, do you interpret the phrase "the developmental
24 period" in a certain way?

25 A Yes. Prior to the age of 22.

1 Q And so when you evaluated Mr. Terry, you didn't disregard
2 anything after age 18; is that right?

3 A No.

4 Q What, if any, opinion do you have on injury occurring in
5 the developmental period that decreases intellectual function
6 in a diagnosis of intellectual disability?

7 A I'm not sure I understand your question.

8 Q Let me try that again. I even lost myself in it. Okay.
9 Is it not true that there is -- that some people disagree
10 when that developmental period ends?

11 A Yes, that is true.

12 Q And, historically, it's gone from 16 to 18, some now say
13 22?

14 A That is true.

15 Q Okay. But is there an accepted guideline or practice by
16 either the American Psychological Association or the DSM-5
17 that sets a certain age and says you must look at this?

18 A I mean, the guideline generally now is accepted to be the
19 age of 22. So anything prior to the age of 22.

20 Q So you're going by the guidelines ---

21 A Yes.

22 Q --- looking at it from 22. Even though Atkins says 18,
23 or maybe some other case law would say 18, you go by 22?

24 A Yes.

25 Q Professional norms.

1 Now, a subset of that question: If something physical
2 happens before the age of 22 -- as in a head injury, as in a
3 car accident and that sort of thing -- and there is a decrease
4 in function, is there a specific accepted guideline or
5 practice that you have to call that intellectual disability?

6 A No, you don't have to call that intellectual disability.
7 It really would depend on the level of functioning loss for
8 someone to then say that that would be -- that would qualify
9 as intellectual disability.

10 Excuse me; I have a bit of a cold.

11 THE COURT: Want some water?

12 THE WITNESS: I'm good. I brought plenty of things.

13 THE COURT: Okay. If you need some water, just -- we can
14 get you some. Just let us know. Okay?

15 THE WITNESS: Thank you.

16 THE COURT: Thank you.

17 A So you are really looking at the amount of functioning
18 loss. So if someone is -- let's say they're 16, they were a
19 neurotypically functioning child or adolescent and they had a
20 head injury and their functioning decreased but they were
21 still functioning in the low average range or what we would
22 call the borderline range, we wouldn't give them a diagnosis
23 of intellectual disability. They would have to be functioning
24 similarly to individuals who have intellectual disability for
25 them to get that diagnosis.

1 So the diagnosis that they would get instead would be a
2 neurocognitive disorder, and it would probably be
3 characterized as mild neurocognitive disorder, and that
4 would -- due to a traumatic brain injury, and that would be
5 the appropriate diagnosis.

6 Q Dr. Hall, in your report, you set out the sources of
7 information, and it appears to me it spanned about two pages,
8 single-spaced? Does that sound about right?

9 A Yes.

10 Q Okay. Do you delegate review or do you review all the
11 documents that you have listed?

12 A No. I review them all.

13 Q And I notice that you have the record from the trial
14 listed and affidavits from 2012.

15 A Yes.

16 Q Those would be things that you would have looked at as
17 well; correct?

18 A That's correct.

19 Q And you also interviewed the ex-wife, Ms. Louanne Terry
20 -- I believe you mentioned that earlier -- and Applicant's
21 mother, Patricia Terry?

22 A Yes.

23 Q But you also spoke to Mr. Terry; right?

24 A Yes.

25 Q And it looked to me like you had two dates down there.

1 Can you tell us how you interviewed Mr. Terry? The dates, the
2 times that you spent with him, just general information on
3 that?

4 A Yes. I met with Mr. Terry initially on February 28th.
5 Dr. Davis and I met with Mr. Terry where I conducted the
6 clinical interview. We met -- after having that interview
7 with him, we wanted to meet with him again to do some
8 cognitive testing. We were -- we did meet and we spoke to him
9 briefly but we were unable to do some cognitive testing
10 because there was some miscommunication about him being --
11 having the shackles removed for the testing. So we resolved
12 that issue, and then we met with him again later in April for
13 the testing. I believe that's correct.

14 Q And how long did you talk to him?

15 A I think, in total, like three hours in terms of
16 interview, not including the testing.

17 Q What, if anything, do the forensic psychology guidelines
18 set out about verification of information?

19 A Well, I mean, that's one of the things that we are
20 charged to do as best as we can is to check and verify
21 information. So that's why you want to have those sources --
22 as many sources as you possibly can so that you can verify
23 information from your informant and also from the person that
24 you are interviewing.

25 Q Now, are you aware of Guideline 902 as requesting that

1 sentiment, corroboration and data?

2 A Yes.

3 Q Let me ask you: You don't have references to all the
4 information that you read in your report; correct?

5 A When you say "references," what do you mean?

6 Q For instance, you don't discuss what happened at the
7 trial?

8 A Oh, no, I don't.

9 Q You don't discuss what the social worker found in the
10 2012 affidavit that you read?

11 A No.

12 Q How do you come about incorporating the information that
13 you do incorporate in the formal opinion, the report that you
14 do? How do you go about incorporating it?

15 A Yeah. In Atkins cases, the things that are related to
16 the crime, I avoid, because those are not going to speak to
17 the issue that I have been charged to deal with. And so I
18 don't -- so what I looked for in the transcript was other
19 mental health professionals who testified. And so I did read
20 the transcript from Dr. Deysach, the neuropsychologist who
21 testified.

22 And other than that -- because you don't want anything --
23 to look at anything that may bias my opinion. And so, as the
24 neutral arbiter, I don't want to look at anything -- so I
25 don't know any facts about Mr. Terry's case, his criminal

1 case. I don't know anything about that.

2 So I only look at information that's going to help me
3 answer the question that I have been charged to answer, and
4 that's if Mr. Terry has an intellectual disability or not.

5 Q And is some of that selection based on your efforts to
6 corroborate?

7 A Yes.

8 Q So if something -- and let me back up. Would you please
9 explain to the Court what we're talking about with
10 corroboration compared to credibility? Are you assessing
11 credibility or are you just looking at points of data that
12 converged?

13 A Well, you do both. So I'm looking to make sure -- I
14 mean, corroboration also lends to credibility so that when I'm
15 interviewing Mr. Terry, I'm looking at how he's answering the
16 questions. Does he seem forthcoming? Is he avoiding
17 answering questions? Is he offering detail in a way that --
18 that seems genuine, like he's not pushing an agenda. Is what
19 he's telling me similar to what his mom told me and what his
20 ex-wife told me? Is it similar to the contemporaneous
21 records? I mean, of course, you know, memories fade because
22 we're talking about, you know, 40-odd years ago in terms of
23 the developmental period, but in general, do those things
24 corroborate each other, so yes.

25 Q And do you find it helpful for that face-to-face

1 communication and interviews?

2 A Yes.

3 Q And why is that? What is so persuasive about it that you
4 would rather have face-to-face interviews than over the phone
5 or tele-interviews? What cues do you pick up?

6 A So much of our communication is non-verbal. So you're
7 looking at facial expressions. You're looking at gestures.
8 You're listening to tone of voice. You're -- so there's so
9 much information that we read in communication that comes with
10 more than just what the person is saying. So oftentime,
11 messages also, in the non-verbals, in that interaction -- so,
12 if at all possible, I do prefer to do interviews face-to-face.

13 Q And, Dr. Hall, I'm sure you have heard that clinicians
14 and anyone looking at intellectual disability really should
15 avoid stereotypes?

16 A Yes.

17 Q And you agree with that?

18 A Yes.

19 Q Okay. And stereotypes -- misused stereotypes, that's --
20 that rests on assumptions; right?

21 A Yes.

22 Q Okay. And the DSM and the APA direct not to rely on
23 those assumptions either; right?

24 A Yes.

25 Q However, if after consideration of details that you

1 gleaned from interviews, other investigation -- whether it's a
2 point of work or a manipulation of others or going to college,
3 whatever that point may be -- it's not an assumption at that
4 point; it's data. Correct?

5 A It becomes part of the diagnostic picture, yes.

6 Q So, hypothetically, a person who works, like, at an
7 entry-level job could fall anywhere on the intellectual range;
8 right?

9 A Yes.

10 Q Could be yes, could be no as intellectual disability. We
11 don't know enough.

12 A That's true.

13 Q Okay. But if you interview several people and they say,
14 "Oh, that guy, yeah, he's great. You know, I'm his manager.
15 He comes in. He fills out my reports for me so I don't have
16 to do it, but he wants no responsibility." It's a data point;
17 right?

18 A Yes.

19 Q But the fact that he has that job and he holds that job
20 and he helps his manager, tends to say, "Hey, he's got some
21 ability to function more so than a menial job might show."

22 A Yes.

23 Q Hypothetically?

24 A Hypothetically, yes.

25 Q Okay. Same thing with being married. Just being married

1 doesn't tell you whether somebody is intellectually disabled
2 or not.

3 A That's true.

4 Q But the information, what he does and why he does it,
5 could be a data point; right?

6 A Could be.

7 Q Okay. Driving a car, kind of the same thing?

8 A Yes.

9 Q All right. Okay. So it's essentially a zero sum result
10 when you reference a data point without any information?

11 A Yes.

12 Q Do you agree that the AAIDD and the DSM-5 have
13 recommendations for a consideration of standardized tests?

14 A Yes.

15 Q Okay. And evaluators should base diagnoses on both
16 clinical assessment and a standardized test; right?

17 A Yes.

18 Q And what are some of the standardized instruments that
19 you use for interviewing or gathering your information?

20 A The standardized tests we use were the WAIS-R -- excuse
21 me, the WAIS 4, the MoCA, and then we do the test of effort as
22 well. So those are the standardized tests.

23 And then clinical interviews, the interview that I used
24 for years now in getting background information and clinical
25 interview.

1 Q And where did you have that -- the kind of clinical
2 testing questions for interviews?

3 A DDSN, when I started, had a policy that we all use the
4 same interview because we do have a lot of repeat visitors.
5 And so it would be easier to have a standardized interview
6 form so that you could look from the previous year or two
7 years, how they answered the exact same questions. Because
8 there's no guarantee the same examiner was going to get that
9 case again. And so that's where that -- so it was initially,
10 I believe, developed by a previous head of DDSN Forensics or
11 Clinical Services. And then we have just modified it over the
12 years.

13 Q And do you have recommended questions from another
14 standardized testing instrument?

15 A I attended a workshop on Atkins evaluations. I think
16 that was maybe four years ago. I just did one this year. I
17 think that one was four years ago. And that was just an
18 example of some of the questions that could be asked for
19 assessing a person's adaptive functioning.

20 Q And you said that was a medical or --

21 A It was a continuing education program.

22 Q And do you know who recommended using that within that
23 organization?

24 A It was whoever -- I don't remember who led -- I think it
25 was whoever --

1 Q And did you know if anybody else used that as well?

2 A It's not standardized in the way that the Vineland is
3 standardized. This was just a recommendation. I tried it in
4 this case.

5 Q Was it good for you with getting the results that you
6 should have?

7 A Would I use it again? With some modifications, yes.

8 Q Okay. Now, on page 4 of your report, you set out
9 relevant history and you note that Mr. Terry appeared to be a
10 good historian. Could you corroborate some of what he said?

11 A Yes.

12 Q And, next, you noted his mother could confirm that he
13 reached his developmental milestones on time. Why is that
14 important, Dr. Hall?

15 A Well, we look at that because one of the things that we
16 notice with individuals who have intellectual disability is
17 that they start off developing slower than neurotypical peers.
18 So, typically, what you will see is that the gap between a
19 neurotypical child and a child with intellectual disability is
20 significant, but it could be small. But as they continue to
21 grow and develop, the gap widens.

22 And so individuals with intellectual disability also
23 continue to grow and develop, but they grow and develop at a
24 different pace to their neurotypical peers such that the
25 difference between functioning levels is significant as the

1 age continues.

2 And so we're looking at early development to see were
3 there any concerns, any delays in early development. If there
4 were, did they get access to treatment that could assist in
5 that. Because there are lots of reasons why kids could get
6 off their typical developmental trajectory. And so, did they
7 get access to -- like, here in South Carolina, we have First
8 Steps or BabyNet, whatever they're called now, but it's the
9 same in every state. Under the age of 3, the State will cover
10 things to help kids get back on their developmental
11 trajectory, so speech therapy, behavioral therapy,
12 occupational therapy, physical therapy, because some kids just
13 need that little extra push and then they get right back on
14 track.

15 And so we're looking at those things. Did he respond --
16 was that available to them? Did they respond to those things?
17 Were there early indications that the person was also
18 developmentally delayed?

19 Q And you had no indication of that?

20 A No. That was -- according to the school records and
21 Mrs. Terry, there were no concerns early on.

22 Q All right. And you also noted that his mother shared
23 with you that Mr. Terry could, in fact, do chores around the
24 house. And why is that important to you?

25 A Again, I was looking at things that would be expected in

1 their family culture in terms of adaptive functioning. And so
2 when we're looking at -- the piece I was looking at would be
3 considered to be practical or daily living skills. So was he
4 contributing to the household? Did he -- was he learning
5 skills that would help facilitate his independent living when
6 he became an adult and moved out of the home?

7 And so I was asking about, you know, those kind of --
8 those basic skills that we all need so that we can live on our
9 own one day.

10 Q And you mentioned family culture. What did you learn
11 from your interviews about division of work in the household
12 as part of Mr. Terry's own family culture?

13 A Mom did most of the work. The dad didn't really
14 contribute that much to the in-house upkeep; that was on Mom
15 and the kids, that she delegated services to. So they really
16 had what would be described as a traditional kind of family in
17 terms of gender role assignment.

18 Q Dr. Hall, have you heard of the term "cloak of
19 competence"?

20 A Yes.

21 Q And would you explain that to us, please.

22 A So cloak of competence is this idea that individuals who
23 are mild ID develop mannerisms that, in order to mask their
24 deficits from other neurotypical folks, that they don't want
25 to stand out or seem dumb. So they'll do things to kind of

1 mask that, to present themselves as higher functioning than
2 they actually are.

3 So that could be things like always carrying a book with
4 them. So they may have a book on, you know, neurophysics and
5 you're like -- you know, carrying that with them. Or they may
6 answer questions superficially well but -- and in a general
7 social sense, that helps them get along, but if you scratch
8 the surface, you see that they really do have deficits. They
9 don't quite understand what they're talking about. They get
10 really good at mimicking what they have heard from other
11 people using colloquialisms in the appropriate way, seemingly,
12 but if you ask them, you know, "What does that mean? Can you
13 explain it?" they're unable to explain it.

14 So it's just a way that they navigate the world in order
15 to not appear as effected as they are.

16 Q And that's the reason why you do the follow-up questions
17 is to see if you need to remove that cloak, so to speak?

18 A Yes.

19 Q Okay. And the investigation, the interviewing, all of
20 the detail -- digging in -- allows you not to stereotype, too;
21 right?

22 A Yes.

23 Q And on page 5, you set out educational history, and I
24 believe he dropped out of school around the ninth grade. Why
25 is that important to you?

1 A Well, we wanted to look at how much exposure he had and
2 ability to be educated. There are some folks who are
3 undereducated, and so that's going to affect their functioning
4 in society if they didn't have a good basic education.

5 Q And you also note that Mr. Terry did poorly in early
6 education?

7 A Yes.

8 Q As we go further, on page 6, you specifically discuss
9 learning disability. Would you describe learning disability
10 to the Court and explain how that differs from intellectual
11 disability?

12 A So learning disability is also a disability in how people
13 learn. So, typically, individuals who have a learning
14 disability have an IQ -- well, let me just say: The
15 assessment for a learning disability is looking at their
16 academic functioning. So that could be looking at classroom
17 work. But we also require a standardized test. It would be a
18 standardized test of achievement. And also an IQ test, so a
19 test of intellectual functioning.

20 So a learning disability is diagnosed when an
21 individual's academic achievement is not commensurate with
22 their intellectual functioning, meaning that their academic
23 achievement is one and a half or two standard deviations below
24 their intellectual functioning. So, typically, individuals
25 who have a learning disorder have an intellectual functioning

1 somewhere in the average range, but their academic
2 achievement, it could be in one area or multiple areas. It's
3 significantly lower. So they're not able to use that
4 intellectual functioning in terms of their learning style, so
5 they need some accommodations in order for them to be able to
6 fully use their intellectual functioning to learn material.

7 Q Okay. And I see in your report that you have highlighted
8 a definition or italicized a definition. Where does that come
9 from?

10 A Oh, this -- that definition is the definition or the
11 criteria that is used by the school system to determine
12 what -- where they're talking about a learning disorder,
13 that's what they're talking about. That's what they're
14 describing.

15 Q So does that actually come from the Department of
16 Education?

17 A From the Department of Education.

18 Q And I think you also noted that Mr. Terry benefitted from
19 classes after he was identified as learning impaired. Why did
20 you think that was important?

21 A Well, he was -- he remained in -- some classes were
22 general education, and he was in a resource model. So then
23 what they decided was that, instead of putting him in what we
24 would call a self-contained program, which means all of his
25 classes would have been in special education or performed by

1 special education teachers, they felt that he could do the
2 general education work. What he needed was assistance in that
3 and that the resource model would be a better model for him.

4 So I think he actually had a mixed model. He had some,
5 if I'm remembering correctly, special education classes and a
6 resource class that would give him the extra support he would
7 need in order to complete his classwork and meet the goals of
8 his IEP. And he benefitted from that.

9 And so kids who have intellectual disability, are
10 typically not mainstreamed. They may be mainstreamed in what
11 we would call specials or electives, so things like art, gym,
12 home economics, but all their core courses would be in the
13 special education setting.

14 And so Mr. Terry was maintained primarily in the regular
15 education setting with accommodations and modifications based
16 on his needs and he benefitted from those things.

17 Q Is it fair to say that, based on your summary and based
18 on the records that you read, that the school system was
19 trying to help Mr. Terry?

20 A Yes.

21 Q They were looking at him, testing him, and trying to get
22 him the supports he needed?

23 A Yes.

24 Q And when he accepted those supports, he did better?

25 A Yes.

1 Q Okay. Now, the psychiatric history that you put on page
2 8, I believe -- starting on page 8 -- [indiscernible] by
3 admission to Charter Hospital for substance abuse. But
4 there's also some things in there about reported
5 hallucinations and delusions, things like that.

6 When you interviewed him, did you ask him about that,
7 whether he was experiencing --

8 A Yes.

9 Q Okay. What did he tell you?

10 A No, he denied ever having experienced those things.

11 Q But when he was admitted into Charter Hospital, wasn't
12 that around the time that he was about to be tried for his
13 crimes?

14 A Yes.

15 Q And you noted that the Charter medical notes indicate
16 good intellectual capacity?

17 A Yes.

18 Q Dr. Hall, why is that important to you?

19 A Well, it's just another data point that suggested that
20 Mr. Terry had interacted with a mental health professional and
21 that mental health professional was not concerned about the
22 presence of an intellectual disability.

23 Q And within that same area of the report, you also noted
24 another medical note from Charter: "Cognitive functions were
25 determined to be intact." What does that mean?

1 A They were looking at him neurologically and so they were
2 not noticing any neurological deficits from their interview
3 and interactions with him.

4 Q And that would have been around the time of his crimes?

5 A Yes.

6 Q So past the developmental period, no matter which age
7 group?

8 A Yes.

9 Q You also noted he wanted out of Charter Rivers in about a
10 week after being there, I believe. And his reason was that he
11 was there for secondary gain. Can you tell us what that means
12 and why that's important?

13 A Well, that was the doctor's interpretation, is that
14 Mr. Terry was there because he thought that it would benefit
15 him with the judgment that he had gone in for substance abuse
16 treatment.

17 Q And can you tell whether he was released after about a
18 week?

19 A They released him. He went there voluntarily, so he
20 wasn't court ordered, so he could leave when he wanted to, but
21 they just noted that it was, you know, against medical advice.
22 They felt that he still required treatment.

23 Q And he admitted to you a history of drug use and cocaine.
24 Why is that important to you, Dr. Hall?

25 A Again, it's just as much information as you can get about

1 a person's history. Significant drug use can affect a
2 person's cognitive functioning, depending on, you know, what
3 type of drugs they use, how long they use those drugs, if they
4 were poly drug users. All those things could be important in
5 determining the impact on cognitive functioning.

6 Q And, in your report, you go over the previous
7 psychological evaluations. And starting off -- and this is on
8 page 9, Dr. Hall. Starting off with test at age 11. And
9 that's the Wechsler Intelligence Scale for Children. His
10 reported IQ -- full scale IQ is 92.

11 Is that a test that you have heard of before?

12 A Yes.

13 Q Have you relied on that test before?

14 A Yes.

15 Q And then three years later, when he's 14, same test: 92.

16 A Yes.

17 Q What, if anything, does that consistency tell you?

18 A That the tests -- that Mr. Terry, at that time, was
19 testing in the average range and it was consistent from Time 1
20 to Time 2.

21 Q And it appears from your report the next test was in 2022
22 for this action. Mr. Terry was 54, and he had suffered
23 strokes and was then suffering from shingles that affected his
24 vision, and his score was 77. What, if anything, did that 77
25 tell you?

1 A That his score was significantly lower than when he was
2 tested during the developmental period, and that lowering of
3 the score could have been due to some of the brain injuries
4 that he's had. It could have been also resulting from
5 shingles, the pain that he was in because of the shingles. It
6 could be due to motivation. So there are lots of reasons why
7 his score could be less. But I, more than likely, felt that
8 it was commensurate with the type of brain injury he had as an
9 adult.

10 Q And isn't it true that you attempted to get some
11 information? Did you ever receive any information from
12 Dr. Decker so you could kind of get in there and look at the
13 different portions and even rescore it?

14 A No. I requested the protocol for everything -- the
15 protocols for everything that Dr. Decker administered, and he
16 informed us that he did not have them available; that they
17 were part of his research files and the files as he was, I
18 believe, moving offices. It may have been inadvertently
19 thrown away or something so he didn't have access to them
20 anymore.

21 Q But you did request an IQ test be administered for
22 Mr. Terry; right?

23 A Yes.

24 Q And Dr. Davis administered that test?

25 A Yes.

1 Q And do you remember the score that came back on that one?

2 A A full scale of 82.

3 Q Okay. So now you have four scores. And when you look at
4 them, what does that tell you, big picture?

5 A That Mr. Terry's functioning has decreased subsequent to
6 the head injuries that he incurred in the post-developmental
7 period and -- which is why we also wanted to do that
8 screener -- the cognitive screener for the MoCA because
9 Mr. Terry does have some real and genuine deficits, and those
10 are evidenced by the cognitive testing that we did, the MoCA,
11 and the cognitive testing that was performed by Dr. Decker.

12 Q So there's no doubt that he has some disability now.

13 A Yeah, he definitely has some cognitive deficits.

14 Q But the records, as you saw them, did not support that he
15 had the limited -- substantial limitations --

16 A During the developmental period, that's correct.

17 Q And can you explain a little bit how you differentiate
18 between cognitive assessment and intellectual functioning
19 assessment?

20 A When we're talking about intellectual disability, we're
21 looking at, again, that IQ, that global measure that talks
22 about -- and Dr. Greenspan is correct that the IQ measures
23 that we're really talking about lends to more functioning in
24 terms of academic or occupational functioning, if we're taking
25 it outside of school.

1 When we're talking about cognitive assessment, we're
2 looking at a much broader range of brain functioning. So
3 we're looking at high order cognitive abilities, things that
4 do executive functioning. We're looking at the relationship
5 between how the -- it was brain communication of the
6 [indiscernible] ability. We're looking at how quickly a
7 person thinks, how quickly they can access information in
8 terms of memory, how quickly they can learn a piece of
9 information, do a calculation, and come up with a result.

10 And so all of that is not going to be assessed in an IQ
11 test by itself.

12 Q Let me ask you, too, in reporting the IQ test the way
13 that you reported it, even with the Flynn Effect applied to
14 some of those scores, the first two are right around 90;
15 correct?

16 A Yes.

17 Q Okay. And that's still around the average mark.

18 A Yes.

19 Q Okay. And having reviewed the information from all of
20 these different sources, you still have a pretty -- pretty
21 much a leaning toward either average or low average if you're
22 looking at everything; correct?

23 A Yes.

24 Q 50 percent of the population is around the 90 to 109
25 mark; right?

1 A Yes.

2 MS. BROWN: And, Your Honor, I have a demonstrative aid
3 that I'd like to hand up to Dr. Hall, if that would be okay.
4 And I shared it earlier with opposing counsel.

5 A I have it.

6 BY MS. BROWN:

7 Q You're ready for me. I appreciate that.

8 MS. BROWN: And I have a copy for the Court if I could
9 hand that up. It's just a demonstrative aid.

10 THE COURT: Okay. Thanks.

11 BY MS. BROWN:

12 Q Dr. Hall, can you tell us a little bit about this chart
13 that's labeled, "Distribution of IQ Scoring"?

14 A Right. So the way that IQ score or IQ tests are normed,
15 they're normed so that the scores create a normal distribution
16 so that the highest score -- so that the mean, the median, and
17 the mode are all exactly the same. And so, in terms of an IQ
18 test, that would be 100.

19 And so if we look at the space up under the curve, that
20 lets you know the percentage of the population -- where the
21 percentage of the population falls.

22 And so, for IQ tests, the normal range is considered to
23 be 90 to approximately 109, 110, and so that most folks are
24 going to fall under that level, so about half of the
25 population. So most folks are going to fall -- that's why

1 that's the highest point of the curve because most people are
2 going to fall in that range.

3 Q So the first scores at age 11, age 14, at 92, no
4 adjustment, fall within the average range?

5 A Yes.

6 Q And at the option of applying a Flynn Effect with
7 adjustment, at 11 years old, it's 90.68, according to your
8 calculations?

9 A Yes.

10 Q That's still average range; correct?

11 A Yes.

12 Q And at 14, with your Flynn Effect adjustment, it's 89.36,
13 which leans heavily, again, towards average; does it not?
14 Right at the cusp?

15 A It's right in the cusp for the beginning of low average,
16 yes.

17 Q And so his score in his 50s -- we're talking about the
18 first one administered in 2022, yes ---

19 A Yes.

20 Q --- that's going to show some downward trend right there?

21 A Yes.

22 Q Even today, he does not, in any test, go to that
23 extremely low period; correct?

24 A Yes.

25 Q Is it correct, Dr. Hall, that the DSM-5 reports

1 prevalence of intellectual disability -- true intellectual
2 disability diagnosed cases could be diagnosed as occurring in
3 approximately 1 percent of the population?

4 A Yes.

5 Q So it's a rare occurrence?

6 A It's a small number in a population.

7 Q And you also had conclusions about adaptive functioning
8 in your report. One developmental period test was given. You
9 noted that he was behind two years from the chronological age?

10 A Yes.

11 Q What does that show you? Why is that important?

12 A So the -- the school was trying to figure out why
13 Mr. Terry was not performing well in the classes. Right? And
14 this is where, I guess, I disagree with Dr. Greenspan, is that
15 the school was asking, "What is going on with this kid?" And
16 so they're looking at everything that could possibly impact
17 their academic functioning.

18 So just because they gave the social maturity scale
19 doesn't mean that they were trying specifically to see if he
20 had intellectual disability. They were really trying to get a
21 good understanding of how he was functioning across the board
22 and how that functioning could impact his academic
23 performance.

24 And so is it that the social maturity scale at the time,
25 if that's delayed, does he need academic -- did it impact his

1 academic functioning such that he would need support so they
2 could offer social/emotional classes, give him counseling,
3 support him in that way so that they could see an increase in
4 his academic performance.

5 And so that's why those measures are given because the
6 way the law is written, they have to look at the whole child,
7 because, for special education, there are about 13 different
8 disabilities that are recognized for kids to get access to
9 special education services. So it's not just strictly they're
10 looking at intellectual disability or not; they have a lot of
11 things that they have to cover, which is why they also look at
12 hearing, they look at vision, they look at social/emotional
13 functioning, they look at intellectual functioning, they look
14 at academic functioning. They're really trying to get a whole
15 picture of the child to see where the deficits fall so that
16 the school can augment services to them to augment their
17 education.

18 Q And without any judgment on this, I believe that the
19 background information that you were given shows that
20 Mr. Terry had a difficult childhood; correct?

21 A Yes.

22 Q Would you consider any allegation of physical abuse, any
23 emotional abuse, any lack of support in homework -- doing
24 homework or anything like that, are those all things in the
25 environment that can affect the ability of a child to

1 successfully go through school?

2 A Yes.

3 Q But that's not anything to do with intellectual
4 functioning, is it?

5 A No.

6 Q And at one point, you said that Mr. Terry married early,
7 and you noted he was ill-equipped to step into the role of a
8 husband.

9 A Yes.

10 Q Can that also show immaturity?

11 A Yes.

12 Q Can it show a lack of wanting to participate?

13 A I'm not sure I understand the question.

14 Q The role of the husband could be interpreted as doing
15 things around the house, and he may not want to; is that
16 correct?

17 A Yes, he may not want to.

18 Q Also, he may not want to or think he should?

19 A Yes.

20 Q But you didn't just ask him, "Do you do things around the
21 house to help out in the marriage and help your wife maintain
22 the home" or anything like that. You asked him for examples.

23 A Yes.

24 Q Okay. And in discussing, did you think -- did you at all
25 ask him about the division of labor at the house?

1 A Yeah, we talked about that.

2 Q Tell us a little bit about that, please.

3 A He really left that up to Louanne. Like, that was her
4 domain. He said that he handled the -- you know, the stuff on
5 the outside of the house. So it really mirrored what his mom
6 said about their family growing up and how their family
7 dynamic was and so that he was really modeling what the family
8 dynamic that he grew up in. And so he felt like it was his
9 role to do, like, the manly stuff, like the yard work. I
10 mean, he didn't say "manly." That's my word so let me take
11 that back.

12 You know, he did the yard work. You know, he brought
13 money into the home and then he gave the money to Louanne so
14 that she could, you know, go grocery shopping, you know, do
15 the -- you know, he said occasionally he would prepare a meal
16 or something, but, primarily, he left those responsibilities
17 up to her.

18 Q What did he tell you about his ability to do laundry?

19 A I mean, he can do laundry. He knows how to do laundry.
20 It's not a preferred activity but he can do it.

21 Q [Indiscernible] more into the "inside the home" category,
22 so....

23 A Yeah.

24 Q It wasn't something culturally he really thought he
25 should be doing.

1 A Right. And Mom said, you know, that he -- she recalled
2 that he had a favorite pair of jeans that he liked to wear,
3 and he always made sure that those were clean and ready for
4 him to wear. So when he wanted, you know, to wear his
5 favorite jeans, he would take care of them and make sure that
6 they were presentable.

7 Q And Mr. Terry also spoke to you a little bit about
8 leaving South Carolina and going down to Florida?

9 A Yes.

10 Q And he didn't take his wife with him at that point; is
11 that correct?

12 A No, no, that's correct.

13 Q And he had a job down there?

14 A Yes.

15 Q What about his comments to you, as you have incorporated
16 in your report, about taking care of his brother?

17 A He felt a responsibility to take care of his brother. He
18 felt like, in some ways, he was -- I guess emotionally
19 stronger than his brother, able to deal with some things more
20 than his brother could, so he felt like it was his
21 responsibility to step up and take care of his brother in
22 those ways.

23 Q And, Dr. Hall, you have noted that Mr. Terry does have
24 some cognitive limitations?

25 A He does.

1 Q Even today with those issues, including having suffered a
2 stroke, if you take away the third prong, would he meet the
3 first two prongs for intellectual disability?

4 A No.

5 Q But he does have a learning disability?

6 A Yes.

7 Q And he continues to have a learning disability, from what
8 you can tell?

9 A Yeah, that doesn't go away, no.

10 Q And some deficits ---

11 A Yes.

12 Q --- have increased because of different things that have
13 happened after the developmental period?

14 A Yes.

15 Q Okay. But looking at all the evidence that you have from
16 the developmental period, all the evidence that you gathered
17 through interviews, he was not intellectually disabled?

18 A Yes.

19 Q Is that an opinion that you hold with a reasonable degree
20 of psychological certainty in line with the practice of
21 forensic psychology?

22 A Yes.

23 Q On page 19 of your report, you also said that you -- you
24 have done a lot more, it appears, than what's appeared in
25 the -- what comes into the report itself.

1 A I only have 16 pages.

2 Q On page 19, you ask questions of Mr. Terry about abstract
3 reasoning.

4 A Oh, you're talking about the interview?

5 Q Yes.

6 A I thought you were talking about the report.

7 Q Well, if I said "report," I was mistaken. I'm sorry
8 about that.

9 You had said that you had -- let me back up. I will put
10 it in better context. Let's start again, shall we?

11 A Thank you.

12 Q When you did your interview and you were going through
13 different things that you were going to ask, you mentioned the
14 guideline.

15 A Yes.

16 Q And you were taking notes on the guides that you had.

17 A Yeah.

18 Q And around page 19 of the notes, you said that you had
19 asked several questions under abstract reasoning.

20 A Yes.

21 Q And I wanted to ask you, why would you ask questions
22 under abstract reasoning?

23 A It's just -- well, in terms of our -- looking at the
24 person's cognitive functioning, and so we ask questions to try
25 to get at either reasoning ability -- because it also goes

1 into their judgment, you know, are they able to -- also can be
2 used to look at their understanding of social convention, you
3 know, social standards, appropriate social behaviors. And so
4 those are the things that we kind of get at when we're looking
5 at those questions.

6 Q And then you asked some other questions about
7 [indiscernible]. You asked some questions -- follow-up
8 questions during the interview. All of those details are not
9 in your report; correct?

10 A That's correct.

11 Q But you put in what you thought were salient points, or
12 how did you determine that again?

13 A Yes. I mean, you could write 50 pages if you include
14 everything, and so I try to put in the things that most speak
15 to the question that needs to be answered and in a way that is
16 useful to the Court.

17 Q Okay. One of the phrases that you had asked to explain
18 is "what goes around, comes around." Do you recall what that
19 response was?

20 A I don't recall. I would have to look at my notes to be
21 able to recall directly.

22 Q Would it sound correct to say what you put out there, you
23 get back?

24 A Yes, that sounds about right.

25 Q Does that sound familiar to you?

1 A Yes.

2 Q That itself supports to some extent that he understands
3 consequences; correct?

4 A Well, it supports that he understands what that term of
5 phrase means. He understands when people are talking about
6 karma, essentially, you know, what that is.

7 Q And did you understand from him at all that he understood
8 where he is, what's happening, all of that? You're not
9 worried about that at all?

10 A No. He was oriented, he was alert, and he was present.
11 We didn't have any concerns that there was any type of
12 psychotic process or anything that would make it seem like he
13 wasn't in reality.

14 Q And he was cooperative?

15 A Yes, very.

16 Q And you got as much information as you could from the
17 parties? And you accepted everything?

18 A Yes.

19 Q Do you have anything else that you wish to add to your
20 report?

21 A No.

22 Q Thank you, Dr. Hall. Would you answer any questions that
23 Mr. Terry's counsel may have.

24 A Yes.

25 THE COURT: Let's take a break. Let's go ahead and break

1 for lunch. This is a good time. It's about ten to 1:00, and
2 we'll start back at 2:00.

3 MS. BROWN: 2:00?

4 THE COURT: 2:00.

5 MS. BROWN: Yes, sir.

6 THE COURT: Dr. Hall, you're not allowed to discuss your
7 testimony with anybody in any way, shape or form during the
8 break. You are allowed to enjoy your lunch break. Go to
9 lunch with whoever you want to but don't talk about your
10 testimony.

11 THE WITNESS: Yes, sir.

12 THE COURT: Okay. Thank you, Dr. Hall.

13 All right. We'll be down until 2:00. Down until 2:00.
14 Thank you.

15 (A lunch recess was taken from 12:49 p.m. to 2:00 p.m.)

16 THE COURT: -- is present. Applicant is present.

17 Dr. Hall, you're still under oath. Do you understand
18 that?

19 THE WITNESS: Yes, sir.

20 THE COURT: All right. Thank you, Dr. Hall.

21 And we're on her cross-examination; is that right?

22 MS. FRANZ: Yes.

23 THE COURT: All right. Ms. Franz, whenever you're ready,
24 ma'am.

25 CROSS-EXAMINATION

1 BY MS. FRANZ:

2 Q Good afternoon, Dr. Hall.

3 A Good afternoon.

4 Q Dr. Hall, are you familiar with the key cases on
5 intellectual disability from the U.S. Supreme Court, Atkins v.
6 Virginia, Hall v. Florida, and Moore v. Texas?

7 A Yes.

8 Q And, in this C.V., it appears that you attended two
9 trainings on intellectual disability in capital cases, and one
10 was about ten years ago in 2014 and one last year in 2023; is
11 that right?

12 A Yes.

13 Q Have you ever attended any other trainings on Atkins
14 cases?

15 A Other than the supervision that I got from my
16 predecessor, no.

17 Q Have you ever published an article on intellectual
18 disability?

19 A No.

20 Q And would it be fair to say, based on your C.V., that the
21 majority of your research has been on autism spectrum
22 disorders?

23 A Yes.

24 Q Okay. And your task in this case was -- and I'll quote
25 the first page of your report -- "to evaluate Mr. Terry to

1 determine whether he has an intellectual disability"?

2 A Yes.

3 Q And you completed that report on June 12th?

4 A Yes.

5 Q Okay. I'd like to just kind of briefly walk through each
6 prong here. So I'll start with Prong 1, and that is
7 significantly subaverage intellectual functioning; right?

8 A Yes.

9 Q And isn't it true that a score of approximately 75 or
10 below falls within the intellectual disability range?

11 A Yes.

12 Q And you agree that the standard error of measurement
13 needs to be considered in this case?

14 A Yes.

15 Q Which is plus or minus five?

16 A Yes.

17 Q And Mr. Terry has had a score of 75 or below on an IQ
18 test; is that right?

19 A I think the lowest was 77, but if you applied the Flynn
20 to that, then, yes, it would fall.

21 Q And you agree that it's proper to apply the Flynn Effect?

22 A Yes.

23 Q And that score falls below 75 when you apply the Flynn
24 Effect?

25 A On that one test, yes.

1 Q Now, on that test, I did not see anything in your report
2 offering any reasons that that score might not be valid. So
3 is it fair to say that your opinion is that that score is
4 valid?

5 A I mean, even at the time Dr. Decker wrote in the report
6 that there was some issues, but he felt that it was a valid
7 score. So that score is just a snapshot of his functioning on
8 that day, and we have several snapshots across the life span.

9 Q Okay. And it's true that that score would fall into the
10 range for intellectual disability; right?

11 A Yes.

12 Q You discussed in your report some additional IQ scores
13 that Mr. Terry received in childhood; is that right?

14 A Yes.

15 Q And those are both WISC-Rs?

16 A Yes.

17 Q And you assumed those scores were accurate and reliable?

18 A Yes.

19 Q Did you review any of the raw data for those scores?

20 A No. That was unavailable.

21 Q And your report says that the WAIS score was administered
22 to Mr. Terry by DDSN?

23 A Yes.

24 Q And you did not administer that test result?

25 A No, I did not.

1 Q Dr. Jessica Davis administered it?

2 A Yes.

3 Q And were you supervising Dr. Davis's administration of
4 the test?

5 A I trust her to administer the test but I was present.

6 Q I'd like to talk just briefly about the results of the
7 testing. So the uncorrected score that Mr. Terry obtained on
8 the WAIS score that Dr. Davis administered was an 82; is that
9 right?

10 A Yes.

11 Q And, again, you agree that it's appropriate to apply the
12 Flynn Effect in this context?

13 A Yes.

14 Q And you measured the Flynn Effect from the year of
15 publication of the WAIS score; is that right?

16 A Yes.

17 Q And that year was 2008?

18 A Yes.

19 Q And you applied a Flynn Effect correction of 0.33 points
20 per year?

21 A Yes.

22 Q Okay. Thank you.

23 And correct me if my math is wrong, but you calculated
24 2024 minus 2008, 16 years from the date of publication. 16
25 times .33 is 5.28. So the Flynn adjusted score is 76.72; is

1 that right?

2 A Yes.

3 Q Are you familiar with the AAIDD "Definition, Diagnosis,
4 Classification, and Systems of Supports Manual"?

5 A Yes.

6 Q Doesn't that manual say that Flynn correction should be
7 measured from the date the test was normed?

8 A Yes, I will concede that I should have added, at minimum,
9 a year or, at maximum, two years to this calculation.

10 Q So that would take an additional roughly .66 --

11 A .66, yeah.

12 Q All right. I would like to move on to Prong 2. And
13 Prong 2 is deficits in adaptive behavior; right?

14 A Yes.

15 Q And the three main areas of adaptive behavior under the
16 DSM-5 are social, conceptual, and practical?

17 A Right.

18 Q And I should have asked this but I believe you might have
19 answered it already: Are you familiar with the DSM-5-TR?

20 A Yes.

21 Q Thank you.

22 And under the DSM-5-TR, you only have to prove adaptive
23 deficits in one of those three areas to meet Prong 2; is that
24 right?

25 A That's correct.

1 Q And your report says that Mr. Terry had deficits in
2 social skills in his youth; isn't that right?

3 A Yes.

4 Q And the report also says that he has deficits in
5 conceptual skills, specifically with school in his youth?

6 A Yes.

7 Q Okay. And those are two different areas of adaptive
8 behavior; right?

9 A Yes.

10 Q And your report also says on page 15 that, quote, "The
11 social deficits Mr. Terry exhibited are likely due to his
12 history of significant child abuse"; is that right?

13 A Yes.

14 Q Isn't it true that the AAIDD manual states the history of
15 child abuse is actually a risk factor for intellectual
16 disability?

17 A Yes.

18 Q Now, for -- in consideration of adaptive behavior, you
19 interviewed Mr. Terry's mother, Patsy, and his ex-wife Louanne
20 Smith; is that right?

21 A That's correct.

22 Q Did you interview any of Mr. Terry's teachers?

23 A No.

24 Q How about any of his friends?

25 A No.

1 Q Any of his co-workers?

2 A No.

3 Q And your report says that Mr. Terry was rated by his
4 teacher on the Vineland Social Maturity Scale when he was a
5 child?

6 A Yes.

7 Q Is the Vineland Scale a standardized measure of adaptive
8 behavior?

9 A Yes.

10 Q And your report says that the results of that test
11 indicated that he had a social age of 9.1 years old?

12 A Yes.

13 Q And Mr. Terry was 11 years old at the time he took that
14 test; right?

15 A At the time she rated him, yes, he was 11.

16 Q And your report says that this score suggests, quote,
17 "That he was having deficits in his social skills as a
18 youngster"; is that right?

19 A Yes.

20 Q And deficits in adaptive functioning are not -- or
21 measuring deficits in adaptive functioning are not part of the
22 diagnostic criteria for a learning disability; is that right?

23 A No, they're not part of the diagnostic criteria, no.

24 Q Now, you spoke directly to Mr. Terry about his own
25 functioning; right?

1 A Yes.

2 Q And you noted in your report that, quote, "Mr. Terry
3 reported he described his adult life in terms that generally
4 indicated average levels of adaptive functioning"?

5 A Yes.

6 Q And you said you're familiar with the term "cloak of
7 competence"?

8 A Yes.

9 Q And that's the idea that people with intellectual
10 disability will hide their deficits or exaggerate their
11 strengths to make it seem as though they're less impaired than
12 they actually are?

13 A Yes.

14 Q And could that include people with intellectual
15 disability not wanting to share or tell someone about their
16 deficits; is that right?

17 A That could include that, yes.

18 Q And could it also include exaggerating their strengths or
19 telling someone that they were capable of doing things that,
20 in reality, they couldn't do; is that right?

21 A That is correct. But that's why you ask more questions.
22 You try to get beyond the cloak.

23 Q Well, you also noted on page 5 of your report that
24 Mr. Terry's ex-wife, Louanne Smith, stated that Mr. Terry had
25 a need to impress other people?

1 A Yes.

2 Q Quote, "He would say he would do things and brag and then
3 have to get bailed out"; is that right?

4 A Yes.

5 Q You also say on page 16 of your report, quote, "Since his
6 incarceration, he has demonstrated he has the adaptive
7 function skills to navigate the system to address his needs";
8 is that right?

9 A Yes.

10 Q Are you familiar with the DSM-5 counseling against
11 reliance on adaptive behavior while in prison?

12 A Yes.

13 Q Are you also familiar with the Supreme Court's decision
14 in Moore v. Texas also cautioning against reliance on adaptive
15 strengths developed in a controlled setting such as prison?

16 A Yes, because people learn how to navigate that system
17 successfully.

18 Q Now, you note on page 5 of your report that Mr. Terry's
19 mother, Patsy, told you Mr. Terry's father was abusive, and
20 Gary was singled out for abuse, quote, "more than his brothers
21 because it took him longer to catch on when his father was
22 teaching him to do something"; is that right?

23 A Yes.

24 Q And on direct, you were also asked about meeting
25 developmental milestones. Isn't it true that Mrs. Terry told

1 you Mr. Terry was slow at talking?

2 A Yes. And I asked her about what -- like, what she meant
3 by that. But the age range that she gave me when he started
4 using words actually falls within the typical range, but I
5 wouldn't expect her to know that.

6 Q But she did say -- she said Mr. Terry was slow at
7 talking. And your notes from that interview say it's slow at
8 both. I would think both means walking and talking; would
9 that be right?

10 A That's what she said. But, again, the time frame that
11 she gave me, they're actually within the typical time frame.

12 Q So that's what she told you?

13 A That's what she told me, yes.

14 Q And I'd like to talk a little bit about Mr. Terry's
15 academic performance. Your report says that Mr. Terry's
16 elementary score performance on the McGraw Hill comprehensive
17 test of basic skills was, quote, "Consistently below grade
18 level in all of his subjects"; is that right?

19 A Yes.

20 Q And on page 5, you noted that Gary struggled with many
21 subjects in school and was in special education in some
22 classes; is that right?

23 A Yes.

24 Q And he was placed in special education to address
25 deficits in reading, math, and spelling; is that right?

1 A Yes.

2 Q Do you agree with that?

3 A That's what the records suggested, yes.

4 Q And you also noted that Gary was strong in mechanical
5 subjects; is that right?

6 A Yes.

7 Q And people with intellectual disability have strength and
8 weaknesses; right?

9 A Yes.

10 Q So your report also says that Mr. Terry's teacher allowed
11 him to earn extra credit by working on his car?

12 A That's what Mr. Terry told me, yes.

13 Q So Mr. Terry used his strength and ability to do
14 mechanical work to help him deal with the deficits that he had
15 in academic skills; is that right?

16 A I guess he more bartered for assistance for his academic
17 skills.

18 Q So he's using a strength that he had in one area to make
19 up for a weakness that he has in another area?

20 A Well, to get support in another area.

21 Q And your report also says that, "At several points
22 throughout Mr. Terry's school history, he improved when he had
23 special education support but he failed when that support was
24 taken away"; is that right?

25 A Yes.

1 Q You also stated on page 5, "Mr. Terry was attempting to
2 complete the GED but was unable to do so"; is that right?

3 A Yes.

4 Q And Mr. Terry dropped out of school in the ninth grade?

5 A Yes.

6 Q And he was 16 years old at that time; right?

7 A Yes.

8 Q Now, is it right that you state on page 16, quote,
9 "Mr. Terry has not met the second prong of the intellectual
10 disability diagnosis"?

11 A Yes.

12 Q And one of the reasons that you state to support that
13 conclusion is that Mr. Terry started a business; right?

14 A Yes.

15 Q Isn't it true that you also state on page 7 that, quote,
16 "His then-wife Louanne completed the paperwork to run the
17 business"?

18 A Yes.

19 Q And another of the reasons you state to support that
20 conclusion is that Mr. Terry, quote, "maintained gainful
21 employment"?

22 A Yes.

23 Q Isn't it true that Ms. Smith, Mr. Terry's ex-wife, told
24 you that she helped Mr. Terry get jobs and that he found them
25 through word of mouth?

1 A Yeah, he didn't apply for jobs. He would hear about a
2 job or she would hear about a job, and then they would go
3 apply for it. He wasn't, like, looking in a newspaper for
4 jobs. But that's how a lot of people get jobs. They hear
5 about places having an opening and then go apply.

6 Q And isn't it also true that Ms. Smith told you that
7 Mr. Terry only worked sporadically?

8 A She said that he worked a lot of jobs. I don't remember
9 her saying the word "sporadically," but it could be that she
10 said "sporadically."

11 MS. FRANZ: May I approach the witness, Your Honor?

12 THE COURT: Yes, ma'am.

13 BY MS. FRANZ:

14 Q I'd like to show you, if I can, a copy of your notes from
15 your interview with Louanne.

16 A Yes.

17 Q I'd just direct you to the first page, the bottom of the
18 first paragraph. I believe there's a typo there. It looks
19 like it should --

20 A I have a -- I can't spell, so...

21 Q That's okay.

22 A That's probably a typo.

23 Q It looks like it should say, "She was the primary
24 breadwinner and he worked sporadically"; is that right?

25 A Yeah, let's say that's what that says.

1 Q Okay. And your report says on page 16 that one of the
2 reasons for your opinion that Mr. Terry does not meet Prong 2
3 is that he lived independently; is that right?

4 A Yes.

5 Q Isn't it true that Mr. Terry actually told you, when he
6 moved out of his parents' house, he moved right in with his
7 brother Billy?

8 A Yes, he moved in with his brother.

9 Q And isn't it also true that he then moved in with Louanne
10 when they got married?

11 A He moved in with Louanne, right.

12 Q And Mr. Terry also told you that where they lived was
13 Louanne's decision and his name was never on any paperwork for
14 housing?

15 A Yes, it wasn't important to him. He left those decisions
16 to her because she was the wife.

17 Q So isn't it true that Mr. Terry has never actually lived
18 anywhere independently by himself?

19 A Well, independently doesn't necessarily mean alone, but
20 it's talking about having your own domicile. That could be
21 with a roommate, with a married partner, whatever, but just
22 not being totally and completely -- it doesn't mean you have
23 to do everything on your own. You can do it in partnership
24 with other people.

25 Q And you also -- your report states on page 14 that

1 Mr. Terry, quote, "Very rarely contributed to the child care,
2 finances, and household chores"; is that right?

3 A Yes.

4 Q And isn't it true that Ms. Smith also told you that, if
5 she was sick, she couldn't leave the kids with Mr. Terry; she
6 had to call her parents to take care of the kids? And that
7 was because she didn't think Mr. Terry could recognize that he
8 had to feed the kids unless he himself was hungry?

9 A Yes.

10 Q And isn't it also true that Ms. Smith told you that
11 Mr. Terry could not mix his children's baby formula and needed
12 to ask Ms. Smith to test it to make sure it was the right
13 temperature?

14 A She -- I remember her saying that, if he did make the
15 baby formula, he would bring it to her to test to make sure it
16 wasn't too hot or too cold.

17 Q And isn't it also true that Ms. Smith told you Mr. Terry
18 did not make or take himself to doctor's appointments? If an
19 appointment was made, Louanne or Mr. Terry's mother would make
20 that appointment and take Mr. Terry to the appointment; is
21 that right?

22 A She said that she would make doctor's appointments, but
23 if he felt like it was anything wrong, he would have had an
24 uncle, who was a doctor, and he would just go see him. But if
25 it required an appointment, then, yes, she would make the

1 appointments.

2 Q Okay. Now, doesn't the AAIDD manual say that part of
3 adaptive functioning deficits that are often seen in people
4 with intellectual disability is being gullible, naive, and
5 easily taken advantage of by others?

6 A Yes.

7 Q And that could include being scapegoated or blamed for
8 things that others do; right?

9 A Yes.

10 Q Isn't it true that Mr. Terry's mother, Patsy, told you
11 that Gary was a follower and that he was naive and easily
12 manipulated?

13 A Yes.

14 Q And Patsy also told you that Mr. Terry had a friend who
15 would blame Mr. Terry for things that the friend did?

16 A Yes.

17 Q And Mrs. Terry also told you that Mr. Terry didn't
18 understand when people were using him; is that right?

19 A Yes.

20 Q And none of that information is discussed in your report;
21 is that right?

22 A No.

23 Q And it's also true that Ms. Smith also told you that Gary
24 was easily manipulated by his brother Billy and his cousin
25 Doug?

1 A Yes. She said that they would -- she felt like they took
2 advantage sometimes.

3 Q And Louanne also said that Mr. Terry didn't know that
4 Billy and Doug were manipulating him at those times?

5 A No. If I remember correctly, she would try to discuss
6 that with him, but he didn't want to hear it.

7 Q And he wasn't able to recognize it at that time; is that
8 right? That's consistent with what she told you?

9 A I guess you could put it that way, yeah.

10 Q And that information is also not relayed in your report;
11 is that right?

12 A No, I think I put -- put it in there that she mentioned
13 that he -- under -- when talking about his social deficits.

14 Q I believe on page 5, your report states, "His need to
15 impress led to a lot of times when he would do things and brag
16 and then have to get bailed out." Is that what you were
17 referring to?

18 A No. I thought -- that's part of it, but I did -- I
19 thought I had included -- I can't find it.

20 Q Okay. And didn't Ms. Smith also tell you that Gary's
21 cousin Doug would egg Gary on and convince him to do risky or
22 dangerous things that Gary would do because he wanted to
23 impress Doug?

24 A Yes.

25 Q Now, your report states that Ms. Smith was responsible

1 for paying all the bills when she and Mr. Terry were together;
2 right?

3 A Yes.

4 Q And that, when he lived with his brother Billy, he also
5 just gave money to Billy to pay the bills?

6 A Yes.

7 Q And in your interview with Ms. Smith, you administered a
8 questionnaire; is that right?

9 A I just asked questions. It's not a formal questionnaire.

10 Q I have in your notes from that interview are marked as
11 the Patton Informal Adaptive Behavior Inventory; is that
12 right?

13 A Yes. But this is not like a standardized questionnaire.
14 So I just consider it a list of questions. It's not --

15 Q Okay. So it's not standardized?

16 A No.

17 Q And it's not published?

18 A No.

19 Q And it's not peer-reviewed?

20 A No.

21 Q And you had said you had never used it before? You just
22 tried it out for this case?

23 A Yes.

24 Q And your report says, on page 14, in discussing
25 Mr. Terry's adaptive deficits, that, quote, "Mr. Terry's

1 behaviors are commensurate with his diagnosis of antisocial
2 personality disorder." Now, that diagnosis does not exclude
3 Mr. Terry from a diagnosis of intellectual disability;
4 correct?

5 A That's correct.

6 Q And doesn't the DSM-5-TR recognize that, quote,
7 "Co-occurring neurodevelopmental and other medical and mental
8 conditions are frequent in intellectual developmental
9 disorder"?

10 A Yes.

11 Q Okay. Now, I'd like to move on to Prong 3. Is it
12 correct to say that Prong 3 is onset in the developmental
13 period?

14 A Yes.

15 Q And the developmental period is defined as prior to age
16 22?

17 A Yes.

18 Q And that is in the AAIDD manual; is that right?

19 A AAID [sic], DSM-5-TR, yes.

20 Q And you conclude in your report that Mr. Terry does not
21 meet the criteria for Prong 3?

22 A Yes.

23 Q And your report says that he didn't receive a formal
24 diagnosis during the developmental period?

25 A No, he didn't.

1 Q Is it your testimony that a formal diagnosis in the
2 developmental period is required to meet Prong 3?

3 A It's not required, no. But he was tested during that
4 time period and that diagnosis was not offered at that time.

5 Q And the AAIDD manual says that, quote, "Disability does
6 not necessarily have to have been formally identified but must
7 have originated during the developmental period" is that
8 right?

9 A Right. There should be some evidence that it was
10 present, even if it wasn't diagnosed.

11 Q And isn't it true that you found that individuals in
12 other Atkins cases have met the diagnostic criteria for
13 intellectual disability even though there was no diagnosis of
14 intellectual disability during the developmental period?

15 A Yes.

16 Q Now, you mentioned traumatic brain injuries. Are you
17 aware of an incident when Mr. Terry was around 14 years old
18 where he rolled himself in a rug with a tube of glue and
19 passed out?

20 A I have heard talk of that, yes.

21 Q Okay. And are you aware of an incident when he was 17 in
22 which he fell out of a tree and landed on his head?

23 A I thought that happened when he was older. I'm not aware
24 of it happening at 17.

25 Q Okay. So you're not aware of that?

1 A No.

2 Q And are you aware of an incident when he was 19 when he
3 was in a motorcycle accident and reported headaches afterward?

4 A Yes.

5 Q Now, Dr. Davis administered a Montreal Cognitive
6 Assessment to Mr. Terry; is that right?

7 A Yes.

8 Q And you pronounce that acronym "moe-cah"?

9 A "Moe-cah," mm-hmm.

10 Q And the MoCA measures cognitive impairment?

11 A Yes.

12 Q And Mr. Terry scored a 19 out of 30 on that test?

13 A Yes.

14 Q Which you reported was indicative of mild cognitive
15 impairment?

16 A Yes.

17 Q And cognitive impairment is part of what we're looking at
18 when we say sub-average intellectual functioning; right?

19 A It's more than just IQ in terms of that cognitive
20 impairment. That's more looking at deficits in particular
21 cognitive abilities. Attention, memory, those kinds of
22 things, so not just word fluency. So it's measuring something
23 different from IQ.

24 Q And on page 16 of your report, you attribute those
25 cognitive deficits to, quote, "multiple etiologies, including

1 head injuries and physical abuse"?

2 A Yes.

3 Q And isn't it true that the AAIDD manual says that head
4 injuries and physical abuse are also risk factors for
5 intellectual disability?

6 A Yeah, they can be contributors.

7 Q And isn't it true that the DSM-5-TR also lists traumatic
8 brain injury as a risk factor for intellectual disability?

9 A Yes.

10 Q And in your conclusion, you point out the Preventive
11 Procedures Inoculations Form, noting that he was a normal male
12 child in good physical condition; is that right?

13 A Yes.

14 Q And that's a vaccination form; right?

15 A Yes. That was in his school record.

16 Q And it just lists the shots that a kid gets before he
17 goes to school; right?

18 A Yes.

19 Q So you're not claiming that that means someone assessed
20 him for intellectual disability and ruled it out based on
21 that?

22 A No.

23 MS. FRANZ: Court's indulgence.

24 BY MS. FRANZ:

25 Q Dr. Hall, I'd like to show you what's been proffered as

1 Exhibit 9. Can you take a quick look at that and let me know
2 if you recognize it?

3 A Yeah, it looks like a medical record talking about
4 migraine headaches.

5 Q I'd like to direct you to page 4 of that record. And it
6 says on the third line of that record, "HAS since '85.
7 Migraines since back injury"; is that right?

8 A Let me make sure we're on the right page. Okay, yes.

9 Q And HAS stands for headaches; is that right?

10 A Yes.

11 MS. FRANZ: Nothing further, Your Honor.

12 THE COURT: Redirect?

13 MS. BROWN: Thank you, Your Honor.

14 REDIRECT EXAMINATION

15 BY MS. BROWN:

16 Q Doctor, I know you were asked initially about the IQ
17 scores, the IQ testing.

18 A Yes.

19 Q And the question was, "Is it appropriate to apply the
20 Flynn adjustment?" And you said it was.

21 A Mm-hmm.

22 Q You agree with that; right?

23 A Yes.

24 Q But there's no manual that says it's mandatory, is there?

25 A No.

1 Q And the social deficits, you were asked about that, and
2 child abuse. And child abuse is a risk factor?

3 A It is.

4 Q And it's a risk factor for a lot of things that happen to
5 children. That's a risk factor to a child; correct?

6 A It's a risk factor for a lot of mental health and
7 developmental issues, yes.

8 Q It's not causation in any way, shape or form for ID?

9 A Depends.

10 Q Well, actually, that's exactly what I'm getting at. It's
11 not "if then, then ID"?

12 A Is it a one-to-one? No.

13 Q And you were asked did you interview any friends or
14 co-workers or teachers. Were you provided any information
15 from Mr. Terry's team of a co-worker or friend or teacher that
16 you could interview?

17 A No.

18 Q And Mr. Terry reported to you -- and I think you said
19 perhaps his wife also reported -- he liked to impress people.
20 He didn't like for people to look down on him?

21 A Yes.

22 Q Correct?

23 But that doesn't mean that he's intellectually disabled,
24 does it?

25 A No.

1 Q Okay. Most people don't like to be looked down upon.

2 A Right.

3 Q Okay. And there was some discussion, I think, about your
4 questionnaire, the guide that you had, and you said that it
5 wasn't standardized, it wasn't accepted. But it's used by
6 professionals; correct?

7 A Yes.

8 Q And you received that from a professional conference;
9 correct?

10 A Yes.

11 Q That was not something you came up on your own with;
12 right?

13 A No.

14 Q Okay. And the prison behavior that you mentioned, I want
15 to go back and kind of finesse that a little bit because you
16 were saying that you were aware of more and you were aware of
17 different manuals that say prison behavior, you know, should
18 not normally be accepted.

19 But isn't it a little bit more narrow than that? You
20 want to make sure that it's his decision, his writing, not a
21 command to go take a shower or that some other inmate wrote a
22 note.

23 MS. FRANZ: Objection to leading.

24 BY MS. BROWN:

25 Q Is that correct?

1 THE COURT: Sustained as to leading. Rephrase your
2 question.

3 MS. BROWN: Sure.

4 BY MS. BROWN:

5 Q Is that what you mean? What can you tell us about how
6 you look at prison behavior?

7 A The reason why you want to -- if you look at information
8 from prison is that you don't know for sure if someone
9 assisted the individual with crafting a letter or an email or
10 those kinds of things. So you want to make sure that what
11 you're reading is actually representative of the Applicant's
12 or the defendant's level of functioning.

13 And I got a wealth of information that was indicative of
14 Mr. Terry's, you know, verbal communication through emails,
15 emails with many family members, with his, I believe, deceased
16 wife. So there was a wealth of information along with his
17 communication to members in the prison about, you know, things
18 that happened that he was disputing or requests that he had.
19 So there was a lot of information.

20 And typically, what you would find when you have somebody
21 who has assistance doing that, handwriting is different, tone
22 of voice within the -- the communication is different. And so
23 you get a sense that this is not all authored by the same
24 person, and I didn't get that sense.

25 Q Okay. And you were also asked about your observation

1 that he lived independently. And I believe that you told us
2 that just means -- it doesn't have to be necessarily alone.

3 A Right.

4 Q That you have to have your own residence kind of thing?

5 A Right.

6 Q And I heard you talk about Billy and I heard you talk
7 about Louanne. I did not hear you talk about Florida. What
8 happened to that trip to Florida? Can you tell us? Does that
9 factor into your consideration about living independently?

10 A Yeah. I mean, he went there for employment.
11 Unfortunately, he had a major accident and was significantly
12 injured. So that didn't particularly pan out well for him so
13 he wasn't in Florida that long because he got injured, if I'm
14 remembering correctly, shortly -- within a couple of months of
15 having been down there.

16 Q And that was a work injury?

17 A Work-related injury, yes. And he did not go with -- you
18 know, his wife stayed back. If I remember correctly, I
19 believe the plan was for him to get established, and then she
20 would follow.

21 Q And you were asked about performance in the sixth grade,
22 that he struggled. And that was part of the struggle that
23 administrators were referencing in all of his school records?
24 Or is that another struggle?

25 A No, he consistently struggled, which led to the question

1 of what's going on with him, why is he not achieving in the
2 way we think he should be, which is why they then did the
3 evaluation to determine if he needed special education
4 services. And, like I said, initially, they were like, "Yes,
5 he has a learning disability." And the record is not clear
6 about why they decided to hold him back instead of just
7 promoting him and putting him in special education. But they
8 held him back and gave him some assistance, some resources in
9 the classroom, and he benefitted from those things.

10 And so being able to demonstrate that a person has those
11 academic struggles but making benefits where he gained, I
12 believe, like a year plus in terms of the measures that they
13 used, in terms of grade level, and that's not something you
14 would see with someone with intellectual disability. That's
15 something you would typically see with a kid who has a
16 learning disability and benefitted from the special education
17 services that were provided for him.

18 Q Yes, ma'am. Okay.

19 You were also asked about the reports from Mr. Terry's
20 mother that he was easily led. What age are we talking about
21 where she was reporting that he was easily led? What age was
22 Mr. Terry?

23 A Teen years.

24 Q So a child?

25 A Yeah, a teenager.

1 Q And didn't you have in your report something about -- or
2 your notes -- something about he would take the blame to
3 protect others ---

4 A Yes.

5 Q --- later on in life?

6 A Yes.

7 Q Is that change of any significance to you?

8 A I mean, this is something that he willfully and on his
9 own -- at least that's what he suggested -- that he wanted to
10 do, but he felt he was more equipped to take the punishment as
11 opposed to the other person.

12 Q And I didn't hear any questions about the fact that
13 Mr. Terry told you that he had a disabled friend that he
14 helped.

15 A Yes.

16 Q And was there anything in that report that indicated to
17 you that that person was actually a support for him or helped
18 him?

19 A No, he didn't say anything about that.

20 Q He was helping ---

21 A Yes.

22 Q --- the handicapped individual?

23 A Yes.

24 Q Okay. And I want to talk to you a little bit because you
25 were asked to look at just a few little things in your report

1 and in your notes talking about deficits are risk factors or
2 potential areas to explore, but having a risk factor or
3 potential area to explore or even a weakness itself isn't
4 dispositive. Don't you also have to look at the strengths?

5 A Yeah, it's not dispositive to have those weaknesses. I
6 think the weaknesses that you would see are things that you
7 would see in kids who have learning disabilities. You would
8 see the weaknesses in social skills in kids who have been
9 abused. So just to say that those are, excuse me, proof
10 positive of ID is not the case because they can be applied to
11 lots of things that kids could experience that could lead to
12 those deficits.

13 Q And you were also asked about Exhibit 9, which I believe
14 you might still have in front of you.

15 A Yes.

16 Q Is there anything there about intellectual disability?

17 A No.

18 Q Okay. And in your report, on page 5, you also -- you put
19 in there about your interview with Ms. Terry. Ms. Terry said,
20 "Gary would be slow to get it, but once he got it, he got it."

21 A Yes.

22 Q What significance does that hold for you?

23 A She was demonstrating that Mr. Terry did have a learning
24 disability and that it did take him more time to learn a new
25 skill, but once he learned it, he learned it completely. In

1 fact, she was proud that oftentimes he wouldn't want help. He
2 would want to sit down and figure it out for himself. And she
3 said that he would just go off and figure it out and then come
4 back and say, "I did it. See? I figured it out." And that
5 was a source of pride in himself and to her.

6 Q In fact, she said at one point her son would always
7 figure it out?

8 A Yes.

9 Q So that was a consistency.

10 Dr. Hall, with everything that you have heard today and
11 the discussions that we have had, is it still your opinion
12 that Mr. Terry is not intellectually disabled?

13 A Yes. I think he has cognitive deficits, but I don't
14 believe that they rise to the level that is commensurate with
15 an individual who'd have intellectual disability.

16 Q Thank you, Dr. Hall.

17 MS. BROWN: No further questions, Your Honor.

18 THE COURT: Ms. Franz?

19 MS. FRANZ: Briefly, Your Honor.

20 RE CROSS-EXAMINATION

21 BY MS. FRANZ:

22 Q Dr. Hall, you did apply the Flynn Effect in this case;
23 right?

24 A I did.

25 Q And you're not required to prove causation to make a

1 diagnosis of ID; is that right?

2 A That is correct.

3 Q And the State mentions some prison communications that
4 Mr. Terry had made that you reviewed.

5 A Yes.

6 Q You don't know whether he wrote those communications or
7 somebody did it for him; right?

8 A Can I say 100 percent? No.

9 Q And you don't know whether he wrote the grievances
10 either; right?

11 A Can I say 100 percent? No.

12 Q And you don't know whether any of the emails were written
13 with spell check assistance; right?

14 A Well, spell check assistance is part of the package, so
15 yes, I'm assuming that.

16 Q So you would say, yes, they were written with spell
17 check?

18 A Yeah.

19 Q But, regardless, the fact remains that the both the DSM
20 and Moore v. Texas say not to rely on adaptive behavior in
21 prison; right?

22 A Right. Not openly rely on them, yes.

23 (Applicant's Exhibit No. 8, Document Regarding Fall out
24 of Tree, was marked for identification.)

25 BY MS. FRANZ:

1 Q And I'm going to ask you to look at one more exhibit,
2 Dr. Hall, which was proffered as State's Exhibit 8. I'm
3 sorry; Applicant's Exhibit 8.

4 Dr. Hall -- and I would just direct you to the second
5 line of that record. First, do you recognize that record as
6 one that you reviewed?

7 A Yes.

8 Q And on the second line of that record, does it say,
9 "Patient for historian very indifferent. Wife supplied most
10 of history. States have fallen in '85 from tree"; is that
11 right?

12 A Yes.

13 MS. FRANZ: Court's indulgence.

14 At this time, I would move what's been marked --
15 proffered as Applicant's Exhibit 8 into evidence.

16 MS. BROWN: Objection on hearsay, and it has not been
17 fully interpreted. I mean, it looks like a 23 -- he was 23 at
18 the -- I'm not really sure exactly what it is. It's hearsay
19 and difficult to read on top of that.

20 THE COURT: Sustained.

21 MS. BROWN: And there was no reliance on it, so it
22 shouldn't come in under the expert cross-examination.

23 MS. FRANZ: Can be admitted for impeachment, Your Honor.

24 THE COURT: I don't know what you're impeaching her on.
25 She said she wasn't sure at what age he fell out of the tree.

1 I mean, does the report say 1985?

2 MS. FRANZ: Yes, sir.

3 THE COURT: Okay.

4 MS. BROWN: Actually, the report says that somebody said
5 '85. It's hearsay on hearsay.

6 THE COURT: It's not even a medical report.

7 MS. BROWN: No, sir.

8 THE COURT: It's not a doctor --

9 MS. FRANZ: For purposes of review, would you like to...

10 THE COURT: Yeah, I mean, it's not some doctor's report
11 where he went to the hospital after he fell out of a tree;
12 right?

13 MS. FRANZ: No, sir.

14 MS. BROWN: Not for diagnostic purposes.

15 THE COURT: Do you know what his date of birth is?

16 MS. FRANZ: 12/1/67.

17 THE WITNESS: '67.

18 THE COURT: Yeah, that's not admitted.

19 MS. FRANZ: Nothing further, Your Honor.

20 THE COURT: Okay. Thank you, Dr. Hall. You can step
21 down.

22 MS. BROWN: May I ask that Dr. Hall be excused from her
23 subpoena?

24 THE COURT: Yes, ma'am.

25 MS. BROWN: Thank you.

1 THE COURT: Thank you, Dr. Hall. I appreciate you.

2 THE WITNESS: Thank you.

3 THE COURT: And does the State wish to call any further
4 witnesses?

5 MS. BROWN: We have no further witnesses, Your Honor.

6 THE COURT: Okay. And does the Applicant wish to call
7 any in reply?

8 MR. GROSE: No, sir. I think we would just like to talk
9 with you about next steps.

10 THE COURT: Okay.

11 MR. GROSE: What we typically do in a lot of these cases
12 is we order the transcripts, and once we get the transcripts,
13 I'll supply the Court with a post-hearing briefing, and we'd
14 [indiscernible] to do that.

15 THE COURT: Okay. And what's the State's thought on
16 that?

17 MS. BROWN: I think that that would work, Your Honor. We
18 do generally prefer not to have simultaneous briefing so we
19 can respond to their brief maybe 30 days after they file.

20 THE COURT: You mean their order?

21 MS. BROWN: I'm sorry?

22 THE COURT: You mean the order?

23 MS. BROWN: If we're doing post-hearing briefs, if Your
24 Honor would like post-hearing briefs --

25 THE COURT: Oh, post-hearing briefs.

1 MS. BROWN: When we get the transcript, if perhaps you
2 could consider Applicant's brief being due in 30 days from
3 transcript and then ours 30 days from theirs, that may be a
4 full briefing for you.

5 MR. GROSE: We would agree with that with the caveat
6 that, whenever the transcript comes in, there may be a lot of
7 stuff going on in the 30 days and we might need to --

8 THE COURT: You just need to communicate with me.

9 MR. GROSE: Yes, sir. Okay.

10 THE COURT: All right. So let's -- Ms. Brown, would you
11 write up, like, a Form 4 that says we conducted a hearing
12 yesterday and today and that y'all are going to order the
13 transcripts. And then 30 days after receipt of that, the
14 Applicant's briefing is due and then 30 days after receipt of
15 that, the State's or Respondent's briefing is due.

16 You can put a caveat in there, if that comes and you're
17 in the middle of three trials, you know, or that if comes and
18 something is going on -- and that's for either side, because I
19 know you're all busy -- you just need to let me know. I'm
20 happy to work with you on time frames. It's when lawyers just
21 stop communicating with me that the law clerk starts to have a
22 panic. So if something happens and it doesn't look like
23 that's going to work, just let me know. I'm happy to work
24 with you and come up with a reasonable alternative to that.
25 Does that make sense?

1 MR. GROSE: Yes, sir. Thank you.

2 THE COURT: All right. And I'm going to put one thing on
3 the record about yesterday, just so that we're --

4 We're on the record; right, Rod? Rod?

5 Okay. So yesterday when we did Dr. Greenspan, which we
6 basically did Dr. Greenspan all day yesterday, we opened up my
7 virtual -- so this is for whoever is writing the transcripts.
8 Okay?

9 So they're going to have to get the virtual hearing from
10 my virtual courtroom for all day yesterday and what the court
11 reporter Rod has from -- Rod Fitzgerald -- Roderick Fitzgerald
12 has from the digital court reporting system here in Lexington
13 to be able to create a transcript of what Dr. Green [sic] said
14 yesterday.

15 So for -- you know, nothing was -- today is Thursday the
16 18th. Nothing was done virtual for today. So, for today, to
17 type up the transcript, they're just going to need the digital
18 court reporting systems from the live courtroom in Lexington
19 to create that transcript. But for Dr. Greenspan yesterday,
20 we're going to need to make sure that they have both. Okay?

21 Anything else from the State?

22 MS. BROWN: Nothing from the State, Your Honor.

23 THE COURT: Anything else from the Applicant?

24 MR. GROSE: No, sir, thank you.

25 THE COURT: Okay. I do want to say to all the attorneys

1 and to their witnesses -- the witnesses have probably left
2 because they were probably ready to get out of here -- but I
3 know you-all did a lot of work and a lot of crunch-time work,
4 especially over the past few weeks, to be ready to go today
5 and to process through that, and I much appreciate that extra
6 work, and I appreciate everybody being respectful and
7 professional with each other and prepared to go. That is --
8 the more and more -- the older I get, the less and less I see
9 of that, so it is much appreciated to have professional,
10 competent, and courteous lawyers in front of me. So I
11 appreciate that and all of you doing that so thank you very
12 much.

13 Just let me -- give me -- why don't you just communicate
14 with us when they get a time frame of when the transcript will
15 be due just so -- we're going to send a note to the Supreme
16 Court that says we have conducted this hearing, we're waiting
17 on transcripts and briefings, and then we'll -- and then there
18 will be a final order just so they know what's going on.

19 MR. GROSE: Well, what usually happens is -- and we can
20 get the request out, if not today, tomorrow, but what usually
21 happens is is they have 60 days to produce the transcript.

22 THE COURT: Right.

23 MR. GROSE: And sometimes that can be extended. So what
24 I would propose -- and this is what we do on appeals -- is
25 we'll let you know when it's ordered, and if there's any

1 extension on the transcript ---

2 THE COURT: Just let me know.

3 MR. GROSE: -- we'll let you know.

4 THE COURT: Perfect.

5 MR. GROSE: And when it's received, we'll give you the
6 information. And, that way, you'll be able to track this.

7 THE COURT: Awesome. Great. And just an email is
8 sufficient just to kind of keep me in the loop, so...

9 Is all that good, Ms. Brown?

10 MS. BROWN: Yes, sir.

11 THE COURT: Ms. Franz? Mr. Evans?

12 MR. EVANS: Yes, sir.

13 THE COURT: Okay. Thank you-all very much. Appreciate
14 your hard work.

15 MR. GROSE: Thank you.

16 (The proceedings concluded at 2:48 p.m.)

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1 CERTIFICATE OF TRANSCRIBER

2 CASE NAME/NUMBER: Gary Terry v. State

3 2022-CP-32-00924A

4 DATE OF HEARING: 07-17-24/07-18-24

5 COURT REPORTER/MONITOR: DCRP Roderick Fitzgerald

6 *****

7 I, Bobbi Fisher, do hereby certify that the foregoing
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9 proceedings; that said proceedings were transcribed to the
10 best of my ability from the audio recording and supporting
11 information, and that I am neither counsel for, related to,
12 nor employed by any of the parties to this case, and I have no
13 interest, financial or otherwise, in its outcome.

14
15 16
17 /s/ Bobbi Fisher_____

18 Bobbi Fisher, RPR and Certified Transcriber

19 Date Submitted: 11/3/24 REVISED: 1/30/25

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(April, 2024)

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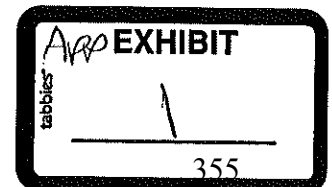
Education: Bronx H.S. of Science
Johns Hopkins University, BA (Liberal Arts)
Northwestern University, MA (History)
Univ. of Rochester, MA, PhD (Developmental Psychology)
UCLA, Post-Doc (Developmental Disabilities)

Employment:
Assistant Professor of Psychology, George Peabody College
for Teachers of Vanderbilt University, 1977-1979.
Scientist, Boys Town Center for the Study of Youth
Development, Omaha, NE, 1979-1985.
University of Connecticut, Department of Educ. Psychology.
Assoc. Prof., 1985-1994. Tenure-1989. Professor, 1995-. Emeritus 1998-.

Professional Affiliations:
American Psychological Association (Fellow)
American Psychological Society (Fellow)
Amer. Assn. on Mental Retardation, now AAIDD (Fellow)
Academy on Mental Retardation, Board Member ('90-'99) President (95-97)

Certifications:
Licensed psychologist, State of Nebraska (#100295, exp. Jan. 2025).
(special license, practice limited to ID and related disorders).
Licensed Psychologist, State of Tennessee, inactive status.

Major Consultancies/ Volunteer Activities
Member of Advisory Committee, for 1995 Int'l Spec. Olympics Games
Member, Connecticut Developmental Disabilities Planning Council, 94-98
Chair, Connecticut Office of Protection and Advocacy
for Persons with Disabilities (Governor's Appointment) 1997-1998.
Board member, Berkeley Center for Independent Living, 2023-present.
Expert forensic consultant in criminal and civil cases.
President and lay leader, Beth Ami-Colorado Congregation for
Humanistic Judaism, Denver and Boulder, Colorado, 2000-2005.



Service to Own Institution

Member, Graduate Faculty Council, University of Connecticut, 1988-1993.
Member, Executive Committee of the Graduate School, University of Connecticut, 1989-1993.
Chair, Committee on Faculty Standards, University of Connecticut Graduate Faculty Council, 1989-1993.
Chair, Blue Ribbon Panel on the Future of Doctoral Studies, University of Connecticut School of Education, 1989-1990.
Member, University Senate, University of Connecticut, 1990-1991

Theoretical Contributions

Comprehensive model of personal competence and adaptive behavior (incorporating the tripartite model of intelligence)
Model of parenting competence (9-principle model of caregiver discipline)
Action model of gullibility, foolishness, common sense and wisdom
Disability Theory/ Disability Studies

Bi-Monthly Blog Column

<https://www.psychologytoday.com/us/blog/incompetence>

Honors

Elected Fellow, American Psychological Association
Elected Fellow, American Psychological Society
Elected Fellow, American Assn. on Intell. and Develop Disability
Willowbrook Memorial Lecturer, CUNY-Staten Island
Dybwad Award for Humanitarianism, Amer. Assn. on Int. and Dev. Disability
Jacobson Award for Contributions to Int. Disability, Am. Psychological Assn.
Most-cited author, 2002 and 2010 AAIDD manuals, DSM5 section on ID
Hastdorf Lecture, Mt. Holyoke College, November 2012
Featured speaker, consensus conference on FASD and Law, Edmonton, 2013
Ann Streissguth Award for Contributions to FASD and the Law, 2016
Tom and Linda Daschle FASD Hall of Fame, awarded June 2017

Books

Karan, O. & Greenspan, S. (Eds.) (1995). *Community rehabilitation services for persons with disabilities*. Boston: Butterworth-Heinemann Publishers.

Switzky, H.N. & Greenspan, S. (Eds.) (2006). *What is Mental Retardation?: Ideas for an evolving disability in the 21st century*. (Rev. ed.) Washington: AAIDD.

Greenspan, S. (2009). *Annals of gullibility: Why people are duped and how they can avoid it.* Westport, CT: Praeger/ Greenwood.

Greenspan, S. (2012). *Elements of discipline. Nine principles for teachers and parents*. Philadelphia: Temple University Press.

Greenspan, S. (2019). *Anatomy of foolishness: The problem of risk-unawareness*. Lanham, MD: Hamilton Books / Rowman & Littlefield.

Brown, N.N., Greenspan, S. & Steele, K. (under contract). *The Parkland School Shooter: Fetal Alcohol Spectrum Disorder and Rampage Killing*. (expected pub. 2024).

Greenspan, S. (under contract). *Naïve offenders: Criminality and Incapacity*. Springer (expected pub. 2025)

Brown N.N. & Greenspan, S. (in preparation). *Severity in Human Services: Rethinking levels of impairment and disability*.

Greenspan, S. (under development). *Gullibility Politics: Understanding Trump and Trumpism*.

Greenspan, S. (under development). *Incompetence: Why People and Organizations Fail*.

Chapters in Books

Greenspan, S. (1978). Parent discipline as a conservation experiment. In R. Weizman, R. Brown, P.J. Levinson and P.A. Taylor (Eds.), *Piagetian Theory and the Helping Professions*. Los Angeles: University of Southern California.

Greenspan, S. (1979). Social intelligence in the retarded. In N.R. Ellis (Ed.), *Handbook of mental deficiency: Psychological theory and research*. Second edition. Hillsdale, N.J.: Erlbaum.

Greenspan, S. (1981). Defining childhood social competence: A proposed working model. In B.K. Keogh (Ed.), *Advances in Special Education*. Volume 3. Greenwich, CT: JAI Press.

Greenspan, S. (1981). Social competence and handicapped individuals: Practical implications of a proposed model. In B.K. Keogh (Ed.), *Advances in Special Education*. Vol. 3. Greenwich, CT: JAI.

Greenspan, S. and Budd, K.S. (1986). Research on mentally retarded parents. In J.J. Gallagher & P. Vietze (Eds.), *Families of handicapped persons: Current research, treatment and policy issues*. Baltimore: Paul Brookes & Co.

Greenspan, S. (1995). Elements for a code of everyday ethics in disability services. In O. Karan & S. Greenspan, (Eds.), *Community Rehabilitation services for persons with disabilities*. Newton, MA: Heinemann.

Greenspan, S. & Love, P. (1995). Ethical challenges in supporting persons with disabilities. In O. Karan & S. Greenspan, (Eds.), *Community Rehabilitation services for persons with disabilities*. Newton, MA: Heinemann.

Greenspan, S. (1995). There is more to intelligence than IQ. In D.C. Connery (Ed.), *Convicting the innocent*. Brookline Books.

Greenspan, S., Switzky, H & Granfield, J. (1996). Everyday intelligence and adaptive behavior: A theoretical framework. In J. Jacobson & J. Mulick (Eds.), *Manual on diagnosis & professional practice in mental retardation*. American Psychological Association.

Greenspan, S. & Love, P. F. (1997). Social intelligence and developmental disorder: Mental retardation, learning disabilities and autism. In W.F. MacLean, Jr. (Ed.) *Ellis' handbook of mental deficiency*, 3rd ed. Mahwah, NJ: Erlbaum.

Greenspan, S. & Driscoll, J. (1997). The role of intelligence in a broad model of personal competence. In D.P. Flanagan, J. Genshaft & P. Harrison (Eds.), *Contemporary intellectual assessment: Theories, tests and issues*. New York: Guilford.

Greenspan, S. (1998). A contextualist perspective on adaptive behavior. In R. Schalock (Ed.), *Measuring adaptive behavior*. DC: AAMR.

Greenspan, S., Loughlin, G. & Black, R. (2001). Credulity and gullibility in persons with mental retardation. In L.M. Glidden (Ed.), *International Review of Research in Mental Retardation*, (Vol. 24, pp. 101-135). New York: Academic.

Greenspan, S. (2004). Why Pinocchio Was Victimized: Factors Contributing to Social Failure in People with Mental Retardation. In H. N. Switzky (Ed.), *Personality and motivational systems in mental retardation*, Vol. 28, pp. 121-144). Elsevier Academic Press.

Greenspan, S. (2005). Credulity and gullibility among service providers: An attempt to understand why snake oil sells. In J.W. Jacobson, R.M. Foxx & J. Mulick (Eds.), *Controversial therapies in developmental disabilities: Fad, fashion and science in professional practice*. Erlbaum.

Greenspan, S. & Switzky, H.N. (2006; rev. ed.). Lessons from the Atkins decision for the next AAMR manual. In H.N. Switzky & S. Greenspan (Eds.), *What is Mental Retardation?: Ideas for an evolving disability*. (pp. 281-300). DC: AAMR.

Greenspan, S. & Switzky, H.N. (2006; rev. ed.). Forty-four years of AAMR manuals. In H.N. Switzky & S. Greenspan (Eds.), *What is Mental Retardation?: Ideas for an evolving disability*. (pp. 2-28). Washington, DC: AAMR.

Greenspan, S. (2009). Foolish action in adults with Intellectual Disabilities: The forgotten problem of risk-unawareness. In L. M. Glidden (Ed.), *International Review of Research in Mental Retardation*. New York: Elsevier.

Greenspan, S., Woods, G.W. & Switzky, H.N. (2015). Age of onset and the developmental period criterion. In E. Polloway (Ed.), *Death penalty and intellectual disability*. Washington, DC: AAIDD.

Greenspan, S. & Olley, G. (2015). Variability of IQ scores. In E. Polloway (Ed.), *The death penalty and intellectual disability: A guide*. Washington, DC: AAIDD.

Greenspan, S. (2015). Evolving conceptions of adaptive behavior. In E. Polloway (Ed.), *The death penalty and intellectual disability: A guide*. Washington: AIDD.

Greenspan, S. (2015). The Briseno factors. In E. Polloway (Ed.), *The death penalty and intellectual disability: A guide*. Washington, DC: AAIDD.

Greenspan, S. (2015). Explaining Gullibility of Service Providers Toward Treatment Fads. In R.M. Foxx & J. Mulick (Eds.), *Controversial therapies for autism and intellectual disabilities: Fad, fashion, and science in professional practice*. 2nd edition. Routledge.

Greenspan, S., Brown, N. N. & Edwards, W. (2015). FASD and the concept of "intellectual disability equivalence." In M. Nelson & M. Trussler (Eds.), *Law and Ethics in Fetal Alcohol Spectrum Disorder*. Amsterdam: Springer.

Greenspan, S. (2015). Broadening guardianship and lowering barriers to service eligibility. In I Binnie, & E. Jonsson (Ed), *Legal issues of FAS: Proceedings from a consensus conference*. Edmonton: Institute of Health Economics..

Greenspan, S. & Driscoll, J.M. (2015). Why people with FASD fall for manipulative ploys: Ethical limits of interrogators' use of lies. In M. Nelson & M. Trussler (Eds.), *Law and Ethics in FASD and the law*. Amsterdam: Springer.

Harris, J.C. & Greenspan, S. (2016). Nature and definition of intellectual and developmental disabilities. In N.N. Singh (Ed.), *Clinical handbook of evidence-based practices for individuals with IDD* (pp. 11-39). New York: Springer.

Greenspan, S. & Woods, G. (2016). Personal and situational factors in financial crime victimization. In M. Dion & D. Weisstub (Eds.), *Financial Crimes: Technology, Psychology, and Ethics*. Amsterdam: Springer.

- Greenspan, S. (2016). Discriminatory killing and execution of people with ID. In J.R. Lutzker, K. Guastafarro, & M. Graham (Eds.), *Maltreatment of People with Intellectual and Developmental Disabilities*. Washington, DC: AAIDD.
- Greenspan (2016). Explaining gullibility of service providers towards treatment fads. In J. Mulick & R. Foxx (Eds.), *Controversial Therapies for Autism and Intellectual Disabilities*. Erlbaum.
- Greenspan, S. & Woods, G. (2018). Social Incompetence of FASD Offenders: Risk-Awareness as a Factor in Criminal Culpability. In E. Jonsson & S. Clarren (Eds.), *Brain disorders and the law* (pp. 127-143). Amsterdam: Springer.
- Woods, G W. & Greenspan, S. (2019). Race-based discrimination in expert witness testimony. In B. Bowser & C. Devadutt, (Eds.) *Racial inequality in New York City: Looking backward and forward*. Albany: SUNY Press.
- Greenspan, S. (2020). Incompetence of defendants with ASD. In E. Kelly (Ed.), *Representing people with Autism Spectrum Disorder: A practical guide for criminal defense lawyers*. Chicago: American Bar Association.
- Greenspan, S. & Driscoll, J. M. (in press). Violence and intellectual disability. In J.M. Fabian (Ed.), *Neuroscience and violence risk in criminal offender populations*. Portsmouth, UK: Wiley & Sons
- Greenspan, S., Driscoll, J.H. & Rogers, G. L. (in press). Intellectual Disability in Childhood. In L.A. Theodore, M.A. Bray & B.A. Bracken (Eds.) *Oxford School Psychology Desk Reference*. Oxford, UK: Oxford University Press.
- Greenspan, S. (2021). Common Sense in people with Intellectual Disabilities: The challenge of deciding to say “no” to social manipulation. In I. Khemka & L. Hickson (Eds.), *Decision Making by Individuals with Intellectual and Developmental Disabilities: Research and practice*. Springer
- Greenspan, S., Brown, N.N. & Edwards, W. (2021). Determining Disability Severity Level for FASD: Assessing Extent of Impairment of Individuals and Conditions. In N.N. Brown (Ed.) *FASD: A Guide for Forensic Mental Health Assessment*. Springer. .
- Greenspan, S. (in preparation) "Therapies that are abusive: When helpers become maltreaters." In I. Khemka (Ed.), *Handbook on Maltreatment and its Prevention in Individuals with Intellectual and Developmental Disabilities*. Springer.

Articles in Refereed Journals

Chandler, M. & Greenspan, S. (1972). Ersatz egocentrism: A reply to H. Borke. *Developmental Psychology*, 7 (2), 104-106.

Chandler, M.J., Greenspan, S. & Barenboim, C. (1973). Judgments of intentionality in response to videotaped and verbally presented moral dilemmas: The medium is the message. *Child Development*, 1973, 315-320.

Chandler, M.J., Greenspan, S. & Barenboim, C. (1974). Assessment and training of role-taking and referential communication in institutionalized emotionally disturbed children. *Developmental Psychology*, 10 (4), 546-

Greenspan, S., Burka, A. & Zlotlow, S. (1975). A manual of referential communication games. *Academic Therapy*, 11 (1), 97-106.

Greenspan, S. & Barenboim, C. (1976). Empathy and pseudo-empathy: The affective judgments of first- and third-graders. *The Journal of Genetic Psychology*, 129 (1), 77-88.

Greenspan, S. (1978). Maternal affect-allowance and limit-setting appropriateness as predictors of child adjustment. *Genetic Psychology Monographs*, 98, 83-111. (based on 1976 doctoral dissertation from the University of Rochester).

Greenspan, S. & Simeonson, R.J. (1978). Influence of adult prohibition style on moral judgments of children. *Developmental Psychology*, 14 (4), 431-

Monson, L. B., Greenspan, S. & Simeonsson, R.J. (1979). Correlates of social competence in retarded children. *American Journal of Mental Deficiency*,

Greenspan, S. (1980). Is social competence synonymous with school performance? *American Psychologist*, 35 (10), 938-

Greenspan, S. and Shoultz, B. (1981). Why mentally retarded adults lose their jobs: Social competence as a factor in work adjustment. *Applied Research in Mental Retardation*, 2, 23-38.

Javel, M.E. & Greenspan, S. (1983). Influence of personal competence profiles on mainstreaming recommendations of school psychologists. *Psychology in the Schools*, 20 (4), 459-465.

Greenspan, S. and Delaney, K. (1983). Personal competence of institutionalized adult males with or without Down syndrome. *American Journal of Mental Deficiency*, 88, 218-220.

Greenspan, S. (1983). A unifying framework for educating caregivers about discipline. *Child Care Quarterly*, 12, 5-27.

- Brown, G.M. & Greenspan, S. (1984). Effect of social foresight training on the school adjustment of high-risk youth. *Child Study Journal*.
- Johnson, R.R. & Greenspan, S. (1984). Children's ability to recognize and improve upon socially inept communications. *The Journal of Genetic Psychology*, 144 (2), 255-264.
- Greenspan, S. (1985). An integrative model of caregiver discipline. *Child Care Quarterly*, 14, 30-47.
- Flood, M.F., Greenspan, S. & Mundorf, N.K. (1985). School-based services for pregnant and parenting adolescents. *Special Services in the Schools*, 2 (1), 27-44.
- Greenspan, S. & Cerreto, M. (1989) Normalization, deinstitutionalization, and the limits of research. *American Psychologist*, 44 (2), 448-449.
- Greenspan, S. & Granfield, J.M. (1992). Reconsidering the construct of mental retardation: Implications of a model of social competence. *AJMR*, 96, 442-453.
- Greenspan, S. & Negron, E. (1994). Ethical obligations of special services personnel. *Special Services in the Schools*, 8 (2), 185-219.
- Greenspan, S. & McGrew, K.S. (1996). Response to Mathias and Nettelbeck on the structure of competence: Need for theory-based methods to test theory-based questions. *Research in Developmental Disabilities*, 19 (2), 142-152.
- Greenspan, S. (1997). Dead manual walking? Why the AAMR definition needs redoing. *Education and Training in MR & DD*, 32, 179-190.
- Greenspan, S. (1998). Dandy-Walker syndrome. In L. Phelps (Ed.), *Health-related disorders in children and adolescents: A guidebook for understanding and educating* (pp. 219-223). Washington: American Psychological Association.
- Greenspan, S. (1999). What is meant by mental retardation? *International Review of Psychiatry*, 11 (1), 6-18.
- Greenspan, S. (2002). A sex police for adults with mental Retardation? Comment on Spiecker and Steutel. *Journal of Moral Education*, 31, 171-179.
- Greenspan, S. & Switzky, H.N. (2003). Execution exemption should be based on actual vulnerability, not disability label. *Ethics and Behavior*, 13 (1), 19-26.
- Greenspan, S. (2006). Gullibility in persons with high-functioning autism. *Autism Spectrum Quarterly*, 8, 14-16

- Greenspan, S. (2006). Functional concepts in mental retardation: Finding the natural essence of an artificial category. *Exceptionality*, 14 (4), 205-224.
- Greenspan, S. (2006) Rethinking “harmonious parenting,” using a three-factor discipline model. *Child Care in Practice*, 12 (1), 5-12.
- Greenspan, S. (2009). Introduction and overview of the special “Atkins” issue. *Applied Neuropsychology*.
- Edwards, W.J. & Greenspan, S. (2010). Adaptive behavior, alcohol spectrum and Fetal Disorders, *Journal of Psychiatry and Law*.
- Greenspan, S., Switzky, H.N. & Woods, GW (2011) Intelligence involves risk-awareness and intellectual disability involves risk-unawareness: Implications of a theory of common sense. *J. of Intell. and Devel. Disabilities*, 36 (4), 242-253.
- Greenspan, S. (2011). Intellectually disabled homicide defendants: Issues in diagnosis in capital cases. *Exceptionality* (Fall issue).
- Woods, G.W., Greenspan, S. & Agharkar, B. (2011). Ethnic and cultural factors in identifying FASD. *Journal of Psychiatry and Law*, 39. 9-37.
- Greenspan, S. (2011). Execution of Joe Arridy: Comments of a forensic expert. *Intellectual & Developmental Disabilities*, 49 (3), 197-202.
- Woods, G.W., Freedman, D. & Greenspan, S. (2012). Neurobehavioral assessment in forensic practice *International J. of Law & Psychiatry*, 35, 432-439.
- Greenspan, S. & Woods, G.W. (2014). Intellectual Disability as a disorder of reasoning and judgment: The gradual move away from IQ ceilings. *Current Opinion in Psychiatry*.
- Haydt, N., Greenspan, S. & Agharkar, B.S. (2014). Advantages of DSM-5 in the diagnosis of ID: Reduced reliance on IQ ceilings in Atkins. *UMKC Law Review*.
- Greenspan, S., Harris, J.C & Woods, G.W. (2015). Intellectual Disability is “a condition, not a number”: Ethics of IQ cut-offs in psychiatry, human services and law. *Ethics, Medicine and Public Health: A Multidisciplinary Journal*.
- Greenspan, S. (2016). Capturing the cognitive essence of IDD: Explaining the “relatedness” clause in DSM-5. *Psychology in Intellectual Disability and Autism*. 42 (2), 23-26.
- Greenspan, S. (2017). Borderline intellectual functioning: An update. *Current Opinion in Psychiatry*. 30 (2), 113-122.

Greenspan, S. (2018). The arbitrariness of age ceilings in developmental services. *Global J. of Intellectual and Developmental Disabilities*, 5 (4), 1-2.

Greenspan, S. (2020). Cruel and unusual punishment in the USA. *Public Integrity* (a journal of the American Society for Public Administration), 22 (5).

Brown, N.N. & Greenspan, S. (2021). Fetal Alcohol Spectrum Disorder (FASD) and diminished culpability. *Behavioral Science and the Law*.

Greenspan, S. & Brown, N.N. (2021). Establishing Eligibility for ID in People with FASD: A Function of Which Diagnostic Manual Is Used? *Behavioral Science and the Law*.

Greenspan, S. & Black, P.S. (in process). Fetal Alcohol Spectrum Disorder as a Syndromic Subtype of Autism: Broadening ASD to Incorporate a Non-Genetic Organic Condition.

Greenspan, S. (under preparation). Disability versus disorder conceptions of IDD: Science, Scientism and the Organizational Context of Category Definition

Greenspan, S., Edwards, W. & Black, P.S. (under preparation). Factors Contributing to Wrong Eligibility Decisions by California's Regional Centers.

Greenspan, S. (under development). Fuzzy human services categories: A case for noncategorical classification of developmental disorders.

Greenspan, S. (under development). Mental Age as a More Useful Concept than IQ in Forensic Testimony.

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SUPPLEMENTAL DECLARATION ABOUT GARY TERRY

Purpose of this Declaration

After submitting a Declaration in which I concluded that South Carolina condemned prisoner Gary Terry qualifies for a diagnosis of Intellectual Disability, I received from Mr. Terry's attorneys a report by Dr. Alicia Hall, a psychologist with the South Carolina Department of Disability and Special Needs. In her report, Dr. Hall reached an opposite diagnostic conclusion from mine. My purpose in this brief Supplemental Declaration is to comment on Dr. Hall's report and indicate what I agree or disagree with in Dr. Hall's report.

Aspects of Dr. Hall's Report That I Agree With

- Dr. Hall's report is extremely detailed, and I find her diligence and thoroughness to be quite admirable.
- She appears to understand that Gary Terry presents a complex picture, in that while he scored as "low average" in some areas (such as WISC and WAIS) he scored in the "Mild Disability" (another term for ID) range on other measures, such as the Montreal Cognitive Scale, the Vineland Scale, and several tests of academic achievement
- She correctly comments on Mr. Terry's cooperativeness and lack of evidence of malingering.
- She states the diagnostic criteria for ID correctly, by quoting from DSM-5 (but she does not cite the AAIDD manual).

Aspects of Dr. Hall's Report That I Disagree With

- Dr. Hall appropriately makes note of the Flynn effect but makes two incorrect statements about it: (a) she states that this is applied to years elapsed from a test's publication, while the correct date to use is year of norming (which on average is two years prior to publication date), and (b) she states that making of Flynn corrections is controversial, something that might still be true in school psychology circles, but is definitely not true in forensic circles, as I have seen almost no Atkins cases where it is not applied by experts (on both sides), where it is clearly recommended by both diagnostic manuals, and where it is almost always accepted by courts.
- Dr. Hall makes much of Mr. Terry's relatively good performance on the WAIS-IV but has almost nothing to say about his ID-qualifying performance on the Woodcock-Johnson Cognitive Battery, a test that many psychologists (including me) consider to be superior to the WAIS-IV.
- In her section on the second diagnostic prong (adaptive behavior) Dr. Hall relies heavily on the self-report by Mr. Terry. There is substantial discussion in the ID manuals and literature about why this is inappropriate (in that people with ID always exaggerate their accomplishments and attempt to conceal their limitations). As example, Dr. Hall mentions the various jobs Mr. Terry reports that he has held but does not really delve into the menial nature of his jobs, how they all ended in failure, and how there is nothing in the ID research literature that would rule out ID because of a history of employment (in fact the vast majority of people with high-functioning ID work).
- Dr. Hall talks about the "developmental period" but never defines it, either in terms of age 18 (former ceiling) or age 22 (current ceiling). This is a critical oversight, given that there appears to have been significant regression in Mr. Terry's functional abilities due to a severe head injury during the pre-age 22 period.
- Dr. Hall states that in the school psychology evaluation (page 15 of her report) Mr. Terry was labeled LD, was never diagnosed with ID, was never given ID as a rule-out diagnosis, and then concludes that none of his providers were concerned about his possibly having ID. She should know that: (a) rule-out diagnoses, while common in psychiatric reports, are almost never stated in special education reports, (b) the mere fact that he was assessed intellectually always has as an implicit purpose of ruling out ID, and (c) there is only one reason for giving the Vineland Social Maturity Scale (on which Gary Terry scored very low), namely, to rule ID in or out; (d) Learning Disability is very commonly an incorrect diagnosis by special education personnel and one cannot conclude from that whether or not ID might today be considered to have been a more appropriate diagnosis; and (e) most importantly, Dr. Hall appears to have an incorrect understanding of the third prong, in that the diagnostic manuals make clear that ID cannot be ruled out by failure to be diagnosed as ID during the developmental period.

Furthermore, Dr. Hall's assertion that nobody considered the possibility of ID thus seems to me to be unjustified, in that she never provides any direct evidence to support that inference.

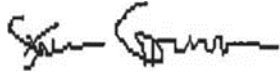
- Dr. Hall states as evidence of good adaptive behavior the fact that he started a business without noting that his wife played a critical role in establishing it or keeping it going. In a similar vein, Dr. Hall based her finding of adequate adaptive behavior on the fact that he had numerous romantic relationships, but she does not acknowledge that this is a very common characteristic of people with ID, that all of the women in his life played a role in allowing him to function in the community, and furthermore that the relationships all ended in failure. In my opinion, Dr. Hall committed the common mistake of using signs of accomplishment to rule out ID, without acknowledging that ID can be ruled in by failure but can never be ruled out by indicators of success. This rule is stated very clearly in the manuals and in the ID literature, for two reasons: (a) people with high-functioning ID always have things they can do and our understanding of ID has become more nuanced than in the past, and (b) when you look carefully at the context, what appears to be a success often turns out to look more like a failure.
- As example, Dr. Hall correctly states that Mr. Terry flunked the GED twice, but does not emphasize that while getting a GED would not rule out ID (for one thing, states and contexts such as prison make that sometimes relatively easy to accomplish), the fact that he was unable to attain a GED despite being very motivated to obtain one is very supportive of ID.
- Dr. Hall describes the birth and gestation of Gary Terry as non-problematic, without making note of the fact that his mother had kidney disease and was likely taking teratogenic medications. Her pregnancy, in my opinion, was anything but normal or problem-free.
- Dr. Hall barely mentions Mr. Terry's head injuries and certainly does not attach much weight to them. For example, while acknowledging that Mr. Terry scored very low on the MoCA (Montreal cognitive test), she minimizes the importance of it while saying it could have multiple possible causes, with head injury being one of them. However, the fact that a head injury could cause poor cognitive performance is hardly something that should be used to discount the reality or importance of the cognitive impairment. Furthermore, Dr. Hall concludes that Mr. Terry's deficits "do not rise to the level one would expect of an individual with an intellectual disability" (page 16) without explaining why she believes that to be the case.
- In my experience, there is one very likely reason why Dr. Hall reaches such a conclusion and that is his Wechsler (WISC and WAIS) scores above the usual 70-75 cut-score. But except for that, I believe the evidence supporting a diagnosis of ID is substantial.

- This leads me to my main problem with Dr. Hall’s report, which is that she cites the letter of the DSM-5 criteria but does not appear to show an appreciation of its spirit. In a recent article (Greenspan, S. & Brown, N.N. (2021), “Establishing Eligibility for ID in People with FASD: A Function of Which Diagnostic Manual Is Used?” *Behavioral Science and the Law*) my co-author and I showed how DSM-5, as the product of a medical organization (the American Psychiatric Association, attaches little importance to test scores (in fact one will not find any disability category in DSM-5 where test scores are emphasized). What counts, in contrast, is the overall clinical picture, and that picture, in my opinion, is that of someone with ID.

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My opinions in this Declaration are made with a reasonable degree of scientific certainty, and I am willing to testify regarding these opinions under penalty of perjury.

Signed in Berkeley, California on July 10, 2024



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DECLARATION ABOUT GARY TERRY

Summary of My Findings

- Gary Terry qualifies for a diagnosis of Intellectual Disability (ID) under the standards spelled out in the two major diagnostic manuals (the American Association on Intellectual and Developmental Disabilities Manual—12th Edition (AAIDD) and the Diagnostic and Statistical Manual of Mental Disorders (DSM-5-TR)), as he appears to meet all three diagnostic prongs: intellectual functioning deficits, adaptive functioning deficits, and onset in the developmental period.
- Mr. Terry suffered multiple head injuries during the developmental period, which the 12th edition of the AAIDD manual defined as from birth to age 22. As his head injuries and the onset of symptoms of intellectual disability undisputedly occurred before age 22, Gary Terry clearly qualifies for a diagnosis of ID under official diagnostic standards.
- But it is a mistake to assume that Mr. Terry was cognitively normal up until the time of the head injury. For example, he was in special education and struggled throughout his school years and was significantly delayed academically. Around the third grade his mother was told that her son was “borderline retarded”. Furthermore, his adaptive deficits were significantly impaired both in middle childhood as well as late adolescence.
- Gary Terry is an example of the role Traumatic Brain Injury (TBI), as well as pregnancy complications, play in causing ID and of the difficulty some forensic experts and special education professionals have in diagnosing ID when TBI is involved.

Background of My Involvement

In 2023, I was asked to be a forensic expert by the legal team representing Gary Terry, who is a condemned prisoner currently residing on death row in the Broad River Correctional Institution in Columbia, South Carolina. The focus of my consultation is on the possibility that Mr. Terry might have Intellectual Disability (ID, formerly Mental Retardation), and thus is ineligible for execution under the *Atkins v. Virginia* standard.

Referral Questions

Question One: Does the evidence pertaining to Gary Terry's functioning indicate if he has the condition known as Intellectual Disability (ID, formerly known as Mental Retardation)?

Question Two: Why is Traumatic Brain Injury (TBI) a major cause of ID and why is its role so often discounted?

Question Three: Even aside from the Atkins Issue, how can Gary Terry's impairments serve as mitigators of Criminal Culpability?

Background of the Case

Gary Dubose Terry is a condemned prisoner residing in South Carolina's Lieber Correctional Institution. In September 1997, Mr. Terry was convicted of murder, first degree burglary, first degree criminal sexual conduct and malicious injury to a telephone system. The crimes occurred in May 1994 when Mr. Terry broke into the home of 47-year-old Urai Jackson and beat her to death in the course of raping her. He was sentenced to death for the murder, thirty years each for burglary and the sexual offense and ten years for "malicious injury to a telephone system". In 2000, consolidating Mr. Terry's direct appeal with the mandatory review provisions of the South Carolina criminal code, the South Carolina Supreme Court affirmed the sentences. In 2009, the petitioner unsuccessfully sought post-conviction relief on five grounds. To my knowledge, the claim that the petitioner might have Intellectual Disability has not previously been adjudicated.

Activities Performed by Me

- Consulted with legal team
- Reviewed case documents
- Interviewed defendant's mother and ex-wife
- Interviewed the defendant remotely
- Drafted this report

Documents Reviewed

- Medical records on head injuries
- Previous brain scan reports
- Successor PCR petition
- Adaptive functioning chart
- Psychological medical records

- Medical chronology
- 1994 Charter Rivers records
- 1986 motorcycle accident records
- Deysach testimony
- MUSC neurology records
- Defense penalty presentation
- SPECT report
- School records
- Woodcock Johnson 2022 report
- South Carolina Supreme Court direct appeal opinion, *State v. Terry*
- Statement of the case from Fourth Circuit briefing
- Exhibits to habeas petition
- Diane Gibson Smith testimony and notes
- Employment information
- Terry family tree
- Life history chronology
- Notes on Patsy's (mother) diaries
- 2022 DNA testing
- Richland Memorial medical records
- Baptist Hospital medical records
- Fairfield County medical records
- Richland County Detention Center medical records
- Lexington Medical Center records
- Lexington County Detention Center medical records
- SCDC records
- GTL messages
- Grievance forms and applications
- Birth certificates
- Marriage and divorce records
- SCDOT records
- Criminal history records
- Various family records, including medical, school, and social history records of various family members, including Mr. Terry's parents, siblings, and children

My Qualifications

- I have a PhD in psychology from the University of Rochester and I have a postdoctoral certificate in Intellectual and Developmental Disability from UCLA Medical School. I have had a psychology license in Nebraska for many years. My psychology practice is consultative, devoted solely to developmental disorders.

- I am the most-cited authority in the DSM-5 section on Intellectual-Developmental Disability, as was also the case with the 11th edition of the AAIDD diagnostic and classification manual.
- I have many publications on adaptive behavior / adaptive functioning, dating back to 1979. In fact, I am generally credited with proposing the tripartite model of adaptive behavior (conceptual, practical, social) that is most commonly used in existing definitions of ID and Developmental Disability (DD).
- I am considered a leading authority on Fetal Alcohol Spectrum Disorder (FASD), which is the leading known cause of ID and have several publications pertaining to the condition. I received the highest award from the National Organization for Fetal Alcohol Syndrome, something I have also received from the ID and Autism Division of the American Psychological Association.
- In the edited book “The Death Penalty and Intellectual Disability” published by AAIDD, I am the first or sole author of four chapters, more than any of the other leading forensic contributors to the book.
- I formerly headed a Developmental Disability Center at the University of Connecticut and was a Gubernatorial appointee to several disability-oriented agencies and advisory boards. I have been involved in the development of cutting-edge service programs for people with cognitive disabilities.
- I am the older brother of a man with DD and benefit greatly from a lifetime of close regular contact with someone with major cognitive and adaptive limitations.
- I have authored many scientific papers that address definitional issues pertaining to ID and related disorders. Here is a partial list (a fuller list in in my CV, which is attached):

Greenspan, S. & Switzky, H.N. (2006; rev. ed.). Lessons from the Atkins decision for the next AAMR manual. In H.N. Switzky & S. Greenspan (Eds.), *What is Mental Retardation?: Ideas for an evolving disability*. (pp. 281–300). Washington, DC: AAMR.

Greenspan, S. & Switzky, H.N. (2006; rev. ed.). Forty-four years of AAMR manuals. In H.N. Switzky & S. Greenspan (Eds.), *What is Mental Retardation?: Ideas for an evolving disability*. (pp. 2–28). Washington, DC: AAMR.

Harris, J.C. & Greenspan, S. (2016). Nature and definition of intellectual and developmental disabilities. In N.N. Singh (Ed.), *Clinical handbook of evidence-based practices for individuals with IDD* (pp. 11–39). New York: Springer.

Greenspan, S., Driscoll, J.H. & Rogers, G. L. (in press). Intellectual Disability in Childhood. In L.A. Theodore, M.A. Bray & B.A. Bracken (Eds.) *Oxford School Psychology Desk Reference*. Oxford, UK: Oxford University Press.

Greenspan, S. & Granfield, J.M. (1992). Reconsidering the construct of mental retardation: Implications of a model of social competence. *AJMR*, 96, 442–453.

Greenspan, S. (1999). What is meant by mental retardation? *International Review of Psychiatry*, 11 (1), 6–18.

Greenspan, S. (2006). Functional concepts in mental retardation: Finding the natural essence of an artificial category. *Exceptionality*, 14 (4), 205–224.

Greenspan, S. (2011). Intellectually disabled homicide defendants: Issues in diagnosis in capital cases. *Exceptionality* (Fall issue).

Haydt, N., Greenspan, S. & Agharkar, B.S. (2014). Advantages of DSM-5 in the diagnosis of ID: Reduced reliance on IQ ceilings in Atkins. *UMKC Law Review*.

Greenspan, S. & Brown, N.N. (in press). Establishing Eligibility for ID in People with FASD: A Function of Which Diagnostic Manual Is Used? *Behavioral Science and Law*.

Greenspan, S., Woods, G.W. & Switzky, H.N. (2015). Age of onset and the developmental period criterion. In E. Polloway (Ed.), *Death penalty and intellectual disability*. Washington, DC: AAIDD.

Greenspan, S. (2018). The arbitrariness of age ceilings in developmental services. *Global J. of Intellectual and Developmental Disabilities*, 5 (4), 1–2.

RESPONSE TO QUESTION ONE:

Does the evidence pertaining to Gary Terry’s functioning support a diagnosis of Intellectual Disability?

There are two diagnostic manuals (DSM-5 TR and AAIDD Terminology and Classification) which define ID. Their definitional statements are largely the same. Furthermore, the legal definitions in South Carolina and other states are based almost entirely on one or both of these manuals. These documents define ID as a condition manifesting during the “developmental period” (today set at before age 22) and characterized by significant deficits in intellectual (academic) and adaptive (everyday) functioning. In my professional opinion, and based on a surfeit of evidence, Gary Terry meets all three of these criteria (intellectual, adaptive and developmental onset) and thus qualifies for a diagnosis of ID. These are spelled out further here:

Gary Terry Meets Criterion One: Impaired Intellectual Functioning

There is substantial evidence that Gary Terry is significantly impaired in his level of intellectual functioning. This evidence is summarized in the following bullet points:

- On the Woodcock-Johnson Cognitive Test, 4th edition (WJ-4), which is one of the IQ tests recognized by AAIDD for diagnosing prong one for a diagnosis of ID, Mr. Terry received a score of 77 when tested by Dr. Scott Decker in January 2022. In my opinion this is a qualifying score for ID, even without being corrected for norm obsolescence (the so-called “Flynn effect”).
- As might be expected from this score, Mr. Terry is very impaired academically, as seen in the Woodcock-Johnson achievement battery. He scored in the ID range in both reading and mathematics calculation.
- On a visual motor measure (the Bender-Gestalt), Mr. Terry scored on a very impaired level that is suggestive of brain damage.
- In grade 5, when the defendant was 11 years old, he was extremely impaired across the board on the Wide Range Achievement Test (WRAT; the handwritten notes make it difficult to link the low numbers up with specific sub-tests).
- In the 6th grade, Gary was again very academically impaired. For example, his scores on the Wide Range Achievement Test (WRAT) were as follows: reading 5.4, spelling 3.6, math 4.3. Spelling and math were especially delayed.
- In grade 9, again on the WRAT, Gary scored at the same level in reading (6.3) and math (4.6), advancing only in spelling (5.4), but even that was extremely delayed for a ninth grader. Basically, he was not learning in school, and showed the achievement pattern of someone with ID. He received special education services in reading, math, and language arts. Although he was labelled LD (Learning Disabled), his pattern of global delay would have justified a diagnosis of ID, especially as his adaptive functioning was also impaired.
- In 1982, at age 14, Gary was recommended for staying in special education with an LD designation, and to receive special services in math (rather than before in three areas), where he was functioning at grade 4.6. He has essentially stayed at the same level in math (the academic skill most affected by brain damage, in my experience) for several years.
- Neuropsychologist Dr. Deysach found evidence in adolescence of multiple head injuries (falling out of a tree) plus use of inhalants, continuing into adulthood (motorcycle accident, bar fights). CAT scan found evidence of damage in the area of the right basal ganglia. An MRI could not be conducted because of the presence of a metal implant in his skull.
- On neuropsychological tests, Dr. Deysach found the defendant especially impaired on measures of visual memory.

- On the Halstead Category test, which is sensitive to frontal lobe functioning (involving judgment and impulse control), a score of 50 errors (out of 208 items) is indicative of brain damage. Mr. Terry made 81 errors, which Dr. Deysach said “is indicative of neuropsychological impairment.”

Gary Terry Meets Criterion Two: Impaired Adaptive Behavior

Prong Two—adaptive behavior (also known as adaptive functioning)—can be established in four ways: (a) through a third-party rating instrument such as the Vineland or ABAS producing a score translatable to a percentile ranking, (b) through a third-party interview that produces qualitative evidence without such a number; (c) through documentary evidence, and (d) through direct testing. Any one of these methods can answer the question definitively, although the best approach involves (c) in combination with one or more of the other three methods. In reaching a diagnostic conclusion about Gary Terry, I have relied on all four of these methods. Together, they provide a convincing picture of someone whose adaptive functioning was significantly impaired.

- (a) In 1979, age 11, 5th grade, Gary Terry was rated in the school on the Vineland Social Maturity Scale (VMS), which was the precursor of the current Vineland Adaptive Behavior Scale. Based on my experience and historical knowledge of the field, the VMS would be used only if a student was suspected of having ID (then known as MR). This is in line with how Gary was seen by teachers, as reflected in his mother Patsy reporting that she was told by a third grade teacher that Gary was “borderline retarded.” Although the VMS did not produce standard scores, Gary scored in the MR/ ID range as he was severely impaired in his adaptive functioning, scoring about three grades below his age.
 - (b) I conducted adaptive functioning information-gathering interviews with two informants: Mr. Terry’s first wife, Louanne, and his mother, Patsy. Louanne in particular gave many answers suggestive of ID, and her answers to me seemed very thoughtful and believable.
 - (c) Documentary evidence is strongly suggestive of ID. He was described by teachers as being socially isolated (a near-universal experience of children or youth with ID) and he was described by his mother as easily socially influenced and at risk of getting in trouble as a result. (This is a characteristic of individuals with ID, as I have stated in my several heavily cited works on gullibility as a core aspect of id adaptive deficits).
 - (d) Direct testing is typically not performed in an Atkins assessment for prong 2, as there really are few such tests that are available. Nevertheless, here are two bits of evidence from direct testing that support my opinion that prong two is satisfied.
- From his neuropsychological testing, Dr. Deysach used the term “adaptive intelligence” to describe the kinds of functional impairments characterizing Mr. Terry. That is a term used in DSM-5, where it is stated that this is the most important and meaningful aspect of adaptive behavior. Such a linkage between prongs one and two has been a topic that I have addressed in several publications.

- I have developed a structured interview that I term the “Common Sense Questionnaire” (CSQ). The CSQ assesses someone’s social risk-awareness, a construct which DSM-5 TR states is highly diagnostic of ID. It was administered to Mr. Terry by me remotely.

Gary Terry Meets Criterion Three: Developmental Onset

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, as that depends on so many irrelevant factors including the knowledge and competence of clinicians, school district policies, politics and finances, attitudes and resources of parents, etc. Furthermore, brain-affecting conditions (infections, accidents, chemical ingestion, etc.) can continue throughout the childhood and adolescent period, and individuals can function more normally at an early stage (without being eligible for the ID label) and then cease to function normally at a later stage (and be eligible for the ID label) due to some intervening event, such as suffering a severe TBI or sniffing glue and becoming unconscious in early or middle adolescence. (Both of these happened to Gary Terry.)

What makes Gary Terry somewhat interesting (and challenging) from a diagnostic standpoint is that he was anything but normal (even if not ID) during the childhood period, but then clearly became more intellectually impaired during adolescence as a result of head injuries. Thus, he qualifies as ID based in large part on the TBIs during a later (but still qualifying) stage of the developmental period, but he quite certainly was developmentally impaired throughout middle childhood. That is reflected in his being assessed for special services by school psychologists (the mere fact that he was given multiple individually administered IQ tests, independent of the results, is enough to satisfy the developmental criterion). He was noted by his teachers for his slowness and inability to learn (and described by a teacher as “borderline retarded”). Furthermore, it should be understood that the TBIs were not entirely independent of Gary’s earlier adaptive deficiencies, as it was noted (as in various clinical assessments) that he lacked the judgment and self-control to avoid putting himself in physically or socially (e.g., assaultive) risky situations.

ID is what is known as a “functional diagnosis,” meaning that knowledge of a cause is not required and often is unobtainable. But it is always helpful to have some idea as to what might have caused an individual to become developmentally disabled. In the case of Gary Terry, I believe there are two sets of biological factors that explain his intellectual and adaptive limitations. With respect to his ultimate qualification as having ID, the biological explanation is that the brain injuries that he clearly experienced caused his earlier intellectual and adaptive (such as criminal conduct) limitations to become even greater when he entered adulthood. With respect to the underlying (somewhat less severe, although still substantial) intellectual and adaptive limitations that he experienced as a child, I believe the biological explanation lies in the difficult pregnancy experienced by his mother, where her left kidney shut down and she was given medication that very likely was teratogenic (a chemical taken during pregnancy that causes brain and other physical abnormalities in a developing fetus).

EVIDENCE AND OPINION PERTAINING TO QUESTION TWO:

Why is Traumatic Brain Injury (TBI) a major cause of ID and why is its role so often discounted?

There are several hundred known possible causes of ID. Traumatic Brain Injury (TBI) is one of the five or six most common causes. A history of experiencing a TBI is often found in incarcerated juveniles and adults because of their lack of judgment when confronting physically or socially risky situations. A TBI is an acquired condition caused by a forceful blow to the head, and it could be a penetrating injury (such as by a bullet or knife) that pierces the skull and enters the brain, or (most commonly) a non-penetrating closed head injury, such as from a motor vehicle accident or being deliberately struck over the head with a hard object. In some cases (such as from a wartime bomb blast), the TBI could be both penetrating (from shrapnel) and non-penetrating (from the blast). Penetrating TBIs typically do localized damage, while closed head injuries, because of the violent moving of the brain back and forth (sometimes with twisting) inside the skull, typically have more widespread effects. Not all blows to the head qualify as a TBI, as a concussion with unconsciousness and at least short-term cognitive and physical symptoms (e.g., headache) is a diagnostic requirement.

In cases where the resulting cognitive deficits are substantial enough, the person could be designated as having either a neurodevelopmental disability (ID) or a neurocognitive disability (dementia) depending on whether the accident or assault happened before or after the person's 22nd birthday. The consequences of a TBI can usually be seen immediately but sometimes they develop and worsen over time. One factor to keep in mind, especially in a case such as this one, is that the consequences of a TBI are usually worse in someone with already challenging cognitive and environmental deficiencies than it is in someone without those challenges. Certainly, such a description applies to Mr. Terry, as he was academically challenged as a child, long before he suffered the head injury in question.

The discounting of the diagnostic importance of TBI by educators and mental health experts is part of a general tendency to give short shrift to biological factors in diagnosing and treating cognitive and behavior disorders. The most dramatic example of this can be found in the case of Fetal Alcohol Spectrum Disorder (FASD), a variant of a TBI condition that is caused when a woman binge drinks alcohol while pregnant. The effect of this binge drinking is considerable structural and functional damage to the developing brain. FASD is present in a very large percentage of criminal defendants, yet it is rarely diagnosed.

Aside from insufficient training of mental health professionals in discerning brain-based conditions, the main explanation for why TBI is often discounted is what has been termed "diagnostic overshadowing." This phenomenon reflects the human tendency to focus on a very salient fact about a person and fail to "conserve" (give weight to) less salient factors that have equal, if not greater, explanatory power. The most powerful form of diagnostic overshadowing has been termed "psychiatric overshadowing," and refers to the fact that people with brain conditions typically have emotional and behavior problems, and these tend to receive all the diagnostic attention. Another common example is racial/ cultural overshadowing, where limitations of disadvantaged people are attributed entirely to culture or poverty. Another reason

why the importance of TBI is often discounted is the misconception, based on the fact that head injuries are often overcome, that TBI is not a severe condition. This misconception about TBI and related brain-based conditions, will be addressed in: Brown, N.N. & Greenspan, S. (forthcoming, 2025) *Severity and Disability*. Springer Publishing.

EVIDENCE AND OPINION PERTAINING TO QUESTION THREE:

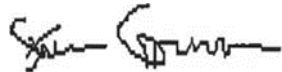
Even Aside from the Atkins Issue How Can Gary Terry's Impairments Serve as Mitigators of Criminal Culpability?

In 2001, I co-authored an article in the journal *Behavioral Science and the Law* about brain injury (specifically fetal alcohol spectrum disorder, which can be considered a special case of TBI) and diminished culpability. There, my co-author (Dr. Natalie Novick Brown) and I argued that Executive Functioning (planning, consequential thinking, impulse control), which is virtually always impaired in people with brain impairment, explains why someone like Gary Terry has lessened culpability. That is because someone who lacks Executive Functioning ability, especially if they are in an impaired state (such as intoxication), does not possess the judgment to understand fully the consequences of their actions and lacks the self-control to handle complex situations reasonably. For this reason, I believe that someone with severe TBI and associated impairments should not be treated with the same degree of moral condemnation as would be the case if they had been a normally functioning adult in a normal state.

CONCLUDING OPINION

I assert, to a reasonable degree of scientific certainty, that Gary Dubose Terry has Intellectual Disability, as this condition is defined under South Carolina law and in the professional literature. I am willing to testify regarding this opinion under penalty of perjury.

Signed in Berkeley, California on July 5, 2024



Stephen Greenspan, PhD
Psychological Consultant

Attachment: CV

SCOTT L. DECKER

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EDUCATION

Ball State University, Graduate School, Muncie, IN
Doctor of Philosophy, School Psychology/Neuropsychology, May 2002

Ball State University, Graduate School, Muncie, IN
Master of Arts, Educational Psychology, May 1998

Ball State University, Muncie, IN
Bachelor of Science, *magna cum laude* in Psychology, May 1997
Certificates (Minors): Computer Science and Philosophy
Significant Awards: Psychology Honors

ADMINISTRATIVE, ACADEMIC, AND PROFESSIONAL POSITIONS

University of South Carolina – Department of Psychology, Columbia, SC
Associate Professor, August 2015 – Present, Assistant Professor, August 2009 – 2015

University of South Carolina – Department of Psychology, Columbia, SC
Program Director, School Psychology, August 2016 - 2019

Georgia State University – Department of Counseling and Psychological Services, Atlanta, GA
Assistant Professor, August 2004 – 2009
Courses Taught: Cognitive and Academic Assessment, Biopsychology & Medication, and Psychobehavioral Diagnosis

Roosevelt University – Department of Psychology, Chicago, IL
Visiting Professor, August 2003 – July 2004
Courses Taught: Advanced Research Methods, Research Methods, Theories of Personality, and Neuropsychological Assessment

Riverside Publishing Company, Itasca, IL
Project Director, Neuropsychological Test Developer, April 2002 – August 2003
Involved in the test development of multiple neuropsychological tests including Bender-Gestalt Second Edition (Co-author), Woodcock-Johnson III Tests of Cognitive Abilities and Tests of Achievement, Woodcock-Johnson III Diagnostic Supplement, Dean Woodcock Neuropsychological Battery, and Woodcock-Johnson III for Reading First

Ball State University – Department of Educational Psychology, Muncie, IN
Instructor, August 2000 – May 2001
Courses Taught: Educational Psychology

Ball State University – Department of Educational Psychology, Muncie, IN
Supplemental Instructor, August 1998 – May 2000
Courses Taught: Psychology and Statistics

INSTRUCTION

Courses Taught
UofSC Department of Psychology: Cognitive Neuroscience, Academic Interventions, Data-Based Decision Making, Psychological Assessment I and II.

Georgia State University: Biopsychology & Medication, Psychobehavioral Diagnosis, Data-Based Decision Making, Assessment Intelligence, Assessment Achievement, Cognitive and Academic Assessment, Internship (School Psychology)

Roosevelt University – Department of Psychology: Advanced Research Methods, Research Methods, Theories of Personality, and Neuropsychological Assessment

Ball State University – Department of Educational Psychology: Educational Psychology, Psychology, and Statistics

Thesis & Dissertation Committees

Masters – Member of Committees (School Psychology, Clinical-Community Psychology)

PhD – Member of Committees (School Psychology, Clinical-Community Psychology)

CLINICAL POSITIONS

University of Illinois at Chicago Neuropsychiatric Institute, Chicago, IL

Post-doctoral Fellow, August 2003 – June 2004

Pediatric neuropsychologist.

Riverside Publishing Company, Itasca, IL

Neuropsychological Test Developer, January 2002 – August 2003

Ball State University, Muncie, IN

Neuropsychological Laboratory Intern, August 2001 – May 2002

Ball State University, Muncie, IN

BSU Clinic Intern (Pediatric/Adolescent), August 2000 – May 2001

Ball State University, Muncie, IN

Practicum Student, August 1998 – May 2000

Engaged in clinical assessment and interaction for multiple courses including Neuropsychology Child Practicum, Neuropsychology Adult Practicum, Practicum School Psychology, Pre-Practicum School Psychology, and School Consultation

RESEARCH POSITIONS

University of South Carolina

Director - Applied Cognitive Neuropsychology Laboratory, 2008-current

Affiliate –Institute for Mind and Brain, 2010 - current

Ball State University, Muncie, IN

Research Director – Neuropsychological Laboratory, August 2001 – April 2002

GRANT RECEIVED AND PENDING

Principal Investigator, Addressing Learning and Emotional Disparities due to COVID-19 in Children with SLD with Integrated Tiered Testing and Interventions, Institute of Education Sciences (IES). \$3,000,000 (in review)

Principal Investigator, Woodcock Foundation

Co-Investigator, Impact of complex metal exposure on epigenetic and intellectual/social outcomes in children. P.I. McDermott, S., National Institute of Health, \$801,407 (in review).

Principal Investigator, Predicting at-risk reading outcomes in multi-tiered models using diagnostic cognitive and neuro-cognitive tests, **\$15,000**, Woodcock Institute (2020-2021) (awarded)

Co-Investigator, Aging brain cohort at the University of South Carolina (ABC@USC), Excellence Initiative, (2019-), (awarded)

Principal Investigator, South Carolina Learning Disabilities Research Project. Office of Special Education Programs: South Carolina, **\$738,000** (2017-2021) (awarded)

Principal Investigator, Interdisciplinary Collaboration for Improving Dyslexia Identification and Reading Outcomes in South Carolina Schools: Development and validation of the **Carolina Automated Reading Assessment**. Principle Investigator. Office of Vice President of Research. Aspire II, **\$99,500** (2017) (awarded)

Principal Investigator, Predicting cognitive profiles of children with TBI using cognitive and electrophysiological measures, **\$10,000**, Woodcock Institute (2018) (awarded)

Co-Principal Investigator. Promoting engaged parents in special education (PEPSE). Aspire-II, X (2014) (awarded)

Principal Investigator, Advancing treatment and identification of children with dyscalculia. Aspire-I, X (2014) (awarded)

Principal Investigator, Improving identification of children at-risk for learning and attention problem using quantitative encephalography, USC. Office of Provost: Social Science, **\$19,953**, (Year) (awarded)

Co-Investigator, Mild traumatic brain injury and neurocognitive functioning associated with intimate partner violence, USC. Office of the Provost; Social Science, **\$15,000**, (Year) (awarded)

Data Collection of TBI patients (2010). Riverside Publishing. (\$4,125 for completion of 25 cases).

Dean-Woodcock Test Grant (2005, 2007). Woodcock-Munoz Foundation award of \$4,125 toward the purchase of new tests for the PSC.

Co-Investigator, Renewal, Research Program Enhancement Grant, **\$52,000 per year** (2009-2011) (awarded)

Co-Investigator, Research Program Enhancement Grant, **\$52,000 per year** (2005-2008) (awarded)

Play Therapy Award (2007) Private Donor (\$12,000)

Woodcock-Johnson Software Grant Award (2007). Woodcock-Munoz Foundation. \$8,000

Woodcock-Munoz (2008). Data Access Grant.

Archived Data Collection Grant (2004). Woodcock-Munoz Foundation. Total award \$3,000.

Archived Data Collection Grant (2004). Woodcock-Munoz Foundation. Total award \$5,000.

UNFUNDED

Decker (PI) & Green, J. (Co-I). Advancing treatment and identification of children with dyscalculia. R21HD081167-01 National Institute of Child Health and Human Development. (\$277,691).

Decker, S. L. (P.I.), Flory, K., Habing, B., Weist, M., & Vidal, J. (2013). Institute of Education Sciences. Refinement and validation of a theoretically based, online working memory measure for early identification of children with ADHD. (\$997,322).

Decker, S. L. (P.I.), Weist, M., & Vidal, J. (2013). Integrating assessment and intervention Models in special education. Institute of Education Sciences. (\$900,000).

Decker, S. L. (P.I.), Habing, B. & Weist, M. (2012). Institute of Education Sciences. Integrating measurement models in multi-tiered educational systems. (\$750,000).

Decker, S. L. (USC, Social Science). Can electrophysiological measures of brain activity predict neuropsychological performance in children with traumatic brain injuries? (\$20,000).

Decker, S. L. (USC, PIRA). Dyslexia Identification using multi-tiered educational measurements. (\$20,000).

Decker, S. L. (USC, PIRA) Integrating measurement models in multi-tiered educational systems. (\$20,000).

MENTORED STUDENT GRANTS and AWARDS

SPARC Support to Promote Advancement of Research and Creativity, University of South Carolina, 2020-2021 \$5K award to fund dissertation research. (Rachel Bridges)

SURF Science Undergraduate Research Fellowships Program, University of South Carolina, 2019-2020 \$4K award to fund undergraduate research (Iris Sakamota)

Magellan Scholar Award, University of South Carolina, 2016-2017
\$3K award to fund undergraduate research (Michael Eason)

Support to Promote Advancement of Research and Creativity, University of South Carolina, 2014-2015
\$5K award to fund dissertation research. (Alycia Roberts)

Magellan Scholar Award, University of South Carolina, 2014-2015
\$3K award to fund undergraduate research (Ashleigh Williams)

ISNR Research Foundation Mini-grant, International Society for Neurofeedback and Research, Research Foundation, 2012-2014
\$2K award, to fund dissertation research: Effects of Neurofeedback on Cognitive Profiles of College Students with ADHD. (Alycia Roberts)

LORETA Z-Score Student Scholarship, Applied Neuroscience, Inc., 2011-2014
Renewable single user license for Neuroguide software with unlimited software usage for the duration of the study. (Valued at approximately \$10,000). (Alycia Roberts)

Presidential Fellowship, University of South Carolina, 2010-2014
\$8K/year award, renewable for 4 years. (Alycia Roberts)

American Psychological Foundation (APF) Elizabeth Munsterberg Koppitz Graduate Scholarship (2013)
\$5,000 research award/ scholarship for research proposal to refine and validate an original online measure of working memory. (Julia Englund)

Society for the Study of School Psychology (SSSP) Dissertation Grant Award (2012)
\$5,000 research award for dissertation proposal to develop and validate an original online measure of working memory. (Julia Englund)

RESEARCH SCHOLARSHIP

Authored Psychological Tests

Brannigan, G. G., & Decker, S. L. (2003). Bender Visual-Motor Gestalt Test, Second Edition. Itasca, IL: Riverside Publishing. (Currently used throughout the U.S., South America, Mexico, Australia, and Englund).

Books

Schrank, F., Decker, S. L., & Garuto, J. (2016). Essentials of the Woodcock-Johnson 4th Edition: Tests of Cognitive Ability. Wiley Publishing.

Edited Special Issues of Journals

Decker, S. L. (approved for spring 2021). Contemporary issues in diagnostic identification of children with learning disabilities. *Journal of Psychoeducation Evaluation*.

Decker, S. L. (2008). Applications of neuropsychology in the schools: Special Issue. *Psychology in the Schools*, 45(9): 779-780.

Refereed Journal Articles

In Review

Decker, S. L., (re-submitted). Dyslexia and the school psychology challenge. *Communique*.

In Press/Published

Compton-Lilly, C, Spence, L. K., Thomas, P. L., & Decker, S. L. (2024). Stories grounded in decades of research: What we truly know about the Teaching of Reading. *The Reading Teacher*, 77(3), 392-400.

Compton-Lilly, C, Spence, L. K., Thomas, P. L., & Decker, S. L. (2024). A response to our critics: Agreements, clarifications, and Children. *The Reading Teacher*, 7(5), 751-755.

McGrew, K., Syneider, J. Decker, S. L., & Bulut, O. (2023). A network analysis of CHC intelligence measures: Implications for research, theory and interpretation of broad CHC scores “Beyond g.” *Journal of Intelligence*, 11 (19), p. 1-33.

Anzalone, C, Luedke, J.C., & Decker, S. L. (2022) Translating research practices in the cognitive assessment of mild traumatic brain injury into applied practice: A systematic review and theoretical guide. *Translational Issues in Psychological Science*.

Decker, S.L. & Luedke, J.C., (2021) Evidence-based use of cognitive testing for academic interventions: A critical appraisal of meta-analytic methodologies. *Frontiers in Education*,(6). doi: 10.3389/feduc.2021.637676

Anzalone, C., Bridges, R. M., Luedke, J. C., & Decker, S. L. (2021). Neurocognitive correlates of persisting concussion symptoms in youth. *Applied Neuropsychology: Child*, 1-10.

Hoskins, W. H., Hobbs, W. I., Eason, M. J., Decker, S., & Tang, J. (2021). The design and implementation of the Carolina Automated Reading Evaluation for reading deficit screening. *Computers in Human Behavior Reports*, 100123.

Decker, S. L. (2021). Don't Use a Bifactor Model Unless You Believe the True Structure Is Bifactor. *Journal of Psychoeducational Assessment*, 39(1), 39-49.

Decker, S. L. (2020). My QEEG and neurofeedback story: in pursuit of the neuro-cognitive origins of learning disabilities. In *Neurofeedback* (pp. 107-112). Academic Press.

Anzalone, C., Luedke, J. C., Green, J. J., & Decker, S. L. (2020). QEEG coherence patterns related to mathematics ability in children. *Applied Neuropsychology: Child*, 1-11.

Decker, S. L., Bridges, R. M., Luedke, J. C., & Eason, M. J. (2020). Dimensional evaluation of cognitive measures: Methodological confounds and theoretical concerns. *Journal of Psychoeducational Assessment*, 0734282920940879.

Bridges, R. M., & Decker, S. L. (2020). ADHD in University Settings: Predictive Validity of qEEG Coherence. *Journal of Clinical Neurophysiology: Official Publication of the American Electroencephalographic Society*.

- Decker, S. L. (2020). QEEG and neurofeedback: In pursuit of the neuro-cognitive origins of learning disabilities. In *Neurofeedback* (pp. 107-112). Academic Press.
- Ferraracci, J., Anzalone, C., Bridges, R. M., Moore, R. D., & Decker, S. L. (2019). QEEG correlates of cognitive processing speed in children and adolescents with traumatic brain injuries. *Applied Neuropsychology: Child*, 1-11.
- Moore, R. D., Sicard, V., Pindus, D., Raine, L. B., Drollett, E. S., Scudder, M. R., Decker, S. L., Ellember, D., Hillman, C. H. (2019). A targeted neuropsychological examination of children with a history of sport-related concussion. *Brain Injury*, DOI:10.1080/02699052.2018.1546408
- Strait, J., Wright, E. K., & Decker, S. L. (2019). Bender-Gestalt II Differential Item Functioning across Caucasian and African American Examinees. *Psychology in the Schools*, p.1-11.
- Decker, S. L., Strait, J. E., Roberts, A. M., & Wright, E. K. (2018). Cognitive mediators of reading comprehension in early development. *Contemporary School Psychology*, 22(3), 249-257.
- Roberts, K., Englund, J., & Decker, S. L. (2018) Developmental trajectories of verbal, static visual-spatial, and dynamic visual-spatial working memory. *Contemporary School Psychology*, 22(4): 458-467.
- Decker, S. L., Strait, J. E., Roberts, A. M., & Wright, E. K. (2017) Contributions of cognitive mediators in reading comprehension in early development. *Contemporary School Psychology*. DOI: 10.1007/s40688-017-0127-0.
- Decker, S. L., Fillmore, P. T., & Roberts, A. M. (2017). Coherence: The measurement and application of brain connectivity. *NeuroRegulation*, 4(1): 3-13.
- Decker, S. L., Ezerine, G., Ferraracci, J. T. (2016). Latent Dimensions of Executive Functions in Early Childhood. *Journal of Pediatric Neuropsychology*, 2(3-4): 89-98.
- Roberts, A., Fillmore, P., & Decker, S. L. (2016). Test-retest reliability of QEEG for Clinical Applications. *NeuroRegulation*, 3(1): 7-22.
- Van Dam, W., Decker, S. L., Durbin, J., Vendemia, J., Desai, R. (2015). Resting state signatures of domain and demand-specific working memory performance. *Neuroimage*, 118: 174-82.
- Decker, S. L., & Roberts, A., (2015) Specific cognitive predictors of math problem-solving. *Psychology in the Schools*, 52(5), 477-488.
- Coben, R., Wright, E. K., Decker, S. L., & Morgan, R. (2015). The impact of coherence neurofeedback on reading delays in learning disabled children: A randomized controlled study. *Neuroregulation*, 2(4): 168-178.
- Davis, A. S., Moore, B., Rice, V. & Decker, S. (2015). Motor deficits following pediatric mild traumatic brain injury: Implications for School Psychologists. *School Psychology Forum: Research in Practice*, 9(3): 214- 229.
- Decker, S. L., Roberts, A. M., Roberts, K. L., Stafford, A. L., & Eckert, M. A. (2015). Cognitive components of developmental writing skill. *Psychology in the Schools*, 53(6):617-625.
- Englund, J. A., Decker, S. L., Allen, R. A., & Roberts, A. M. (2014). Common cognitive deficits in children with Attention-Deficit/Hyperactivity Disorder and Autism: Working memory and visual-motor integration. *Journal of Psychoeducational Assessment*, 32(2): 95-106.
- Englund, J. A., Decker, S. L., Woodlief, D. T., & Distefano, C. (2014). Development and evaluation of an online multi-component working memory battery. *Assessment*, 21(5): 543-561.

- Decker, S. L., Roberts, A. M., & Englund, J. A. (2013). Cognitive predictors of rapid picture naming. *Learning and Individual Differences*, 25: 141-149.
- Decker, S. L., Hale, B., & Flanagan, D. (2013). Professional practice issues in the assessment of intellectual development in children for educational applications. *Psychology in the Schools*, 50(3), 300-313.
- Merino, C., Allen, R., & Decker, S. L. (2012). Bender Visual-Motor Gestalt Test Second Edition. Avaliacao Psicológica, 12. (South America).
- Decker, S. L., Englund, J. A., & Roberts, A. M. (2012). Higher-order factor structures for the WISC-IV: Implications for neuropsychological test interpretation. *Applied Neuropsychology: Child*, 3(2): 135-144.
- Beran, M., Decker, S. L., & Schwartz, A., & Smith, D. J. (2012). Uncertainty monitoring by young children in a computerized task. *Scientifica*, 2012: 1-6.
- Decker, S. L., Schneider, J. W., & Hale, J. B. (2012). Estimating base rates of impairment in neuropsychological test batteries: A comparison of quantitative methods. *Archives of Clinical Neuropsychology*, 27(1): 69-84.
- Decker, S. L. (2012). Dimensional integration of assessment outcomes with intervention services for children with specific-learning disabilities. *Applied School Psychology*, 28(2): 175-199.
- Decker, S. L., Englund, J. A., & Albritton, K. (2012). Multi-tiered measurement models: Integrating intervention methodology with norm-referenced measures. *Psychology in the Schools*, 49(4): 368-384.
- Decker, S. L., Englund, J. A., Carboni, J. A., & Brooks, J. H. (2011). Cognitive and developmental influences in visual-motor integration skills in young children. *Psychological Assessment*, 23(4): 1010-1016.
- Beran, M. J., Decker, S. L., Schwartz, A., & Schultz, N. (2011). Monkeys (Macaca Mulatta and Cebus Apella) and adults and children (Homo Sapiens) compare subtests of moving stimuli based on numerosity. *Frontiers in Psychology*, 2(61): 1-7.
- Multi-authored position paper. (2010). The Learning Disabilities Association of American's White Paper on evaluation, identification, and eligibility criteria for students with specific learning disabilities. *Learning Disabilities: A Multidisciplinary Journal*, p.1-14.
- Decker, S. L. (2010). Tactile measures in the structure of intelligence. *Canadian Journal of Experimental Psychology* 64(1): 53-59.
- Hale, J. B., Reddy, L. A., Decker, S. L., Thompson, R., Henzel, J., Teodori, A., Forrest, E., Eusebio, E., Denckla, M. B. (2008). Development and validation of a 15-minute executive function and behavior rating screening battery for children with ADHD. *Journal of Clinical and Experimental Neuropsychology*, 31(8): 897-912.
- Allen, R. & Decker, S. L. (2008). Utility of the Bender Visual-Motor Gestalt Test-Second Edition (BG-II) in the assessment of Attention-Deficit/Hyperactivity Disorder (ADHD). *Perceptual and Motor Skills*, 107(3): 663-675.
- Schmitt, A. & Decker, S. L. (2009). Tests of Memory and Learning Second Edition (TOMAL-2). *Journal of Psychoeducational Assessment*, 27(2): 157-166.
- Brenneman, M., Decker, S. L., Meyers, J., & Johnson, K. (2008). Does a continuous measure of handedness predict reading processes and reading related skills across the lifespan? *Laterality*, 13(6): 481-503.
- Allen, R., Robins, D., & Decker, S. L. (2008). Autism spectrum disorders: Neurobiology and current assessment practice. *Psychology in the Schools*, 45(10): 905-917.
- Decker, S. L. (2008). Intervention psychometrics: Using norm-referenced methods for treatment planning and monitoring. *Assessment of Effective Interventions*, 38(1): 52-61.

Decker, S.L. (2008). Introduction to special issue: Applications of neuropsychology in the schools. *Psychology in the Schools*, 45(9): 779-780.

Decker, S. L. (2008). School neuropsychology consultation in neurodevelopmental disorders. *Psychology in the Schools*, 45(9): 799-811.

Decker, S. L., Hill, S. K. & Dean, R. S. (2007). Evidence of construct similarity in Executive Functions and Fluid Reasoning abilities. *International Journal of Neuroscience*, 117(6): 735-748.

Decker, S. L. (2007). Measuring growth and decline in visual-motor processes using the Bender-Gestalt II. *Psychoeducational Assessment*, 26(1): 3-15.

Hays, D. G., Chang, C. Y., & Decker, S. L. (2007). Initial development and psychometric data for the Privilege and Oppression Inventory. *Measurement and Evaluation in Counseling and Development*, 40(2): 66-79. (ACA Research Award 2008 & MECD/Patricia Elmore Research Award 2008).

Decker, S. Allan, R., & Choca, J (2006). Construct validity of the Bender-Gestalt II with the WISC-III. *Perceptual and Motor Skills*, 102(1): 133-141.

Decker, S. L., Franklin, R. & Rohling, M. (2005). Evidence based methods of interpretation. *Clinical Neuropsychologist* (Abstract), 19(3/4): 529.

Brannigan, G. G. & Decker, S. L. (2005). The Bender-Gestalt II. *American Journal of Orthopsychiatric Association*, 76(1): 10-12.

Decker, S. L. (2004). Incremental validity in tactile measures in predicting letter-word identification skills. *Archives of Clinical Neuropsychology* (Abstract), 19(7): 907-908.

Decker, S.L., McIntosh, D., Kelly, A., Nichols, S., Titus, J., & Dean, R. S. (2001). Comorbidity Among Individuals Classified with Attention Disorders. *International Journal of Neuroscience*, 110(1/2): 43-54.

Hill, S. K., Dean, R. S., & Decker, S. L. (2001). Integration of Neuropsychological and Cognitive Theory in Rehabilitation. *International Journal of Neuroscience*, 111(3/4): 195-210.

Hill, S. K., Decker, S., Dean, R. S., & Woodcock, R. W. (1999). Defining underlying functions of the Category Test, TMT, and WCST with Woodcock-Johnson fluid reasoning. (Abstract) *Archives of Clinical Neuropsychology*, 14(1): 79.

McCoy, K. D., Hill, S. K., Dean R. S., & Decker, S. (1998). Reliability and construct validation of a neuropsychological symptom inventory. *International Journal of Neuroscience*, 96(1/2): 127-139.

Non-Refereed Journals

Decker, S. L., Davis, A., Eason, M., & Bridges, R. (2017). Executive function demands on the WJ-IV. Assessment Service Bulletin. Houghton Mifflin Publishing.

Brannigan, G. G., Decker, S. L., & Madsen, D. H. (2004). Innovative features of the Bender-Gestalt II and expanded guidelines for the use of the Global Scoring System. Assessment Service Bulletin. Itasca, IL: Riverside Publishing.

Schrank, F. A., Becker, K. A, & Decker, S.L. (2001). Calculating ability/achievement discrepancies between the Wechsler Intelligence Scale for Children –Third Edition and the Woodcock-Johnson Tests of Achievement. (Assessment Service Bulletin #4). Itasca, IL: Riverside Publishing.

Decker, S. L. & Knowles, K. (2002). Response to Krupp's article. Wisconsin School Psychologists Association, Inc, 2(1): 20-22.

Decker, S. L. (2002). Confirmatory models of sensory-motor and cognitive constructs. Dissertation Abstracts. Ball State University. Muncie, IN

Book Chapters

Decker, S.L, Anzalone, C., & Luedke, J.C. (2021) Neuropsychology Driven Evidence-Based Interventions in School Psychology. In E. Power & R.C. D'Amato (Eds.) *Understanding Our Biological Basis of Behavior: Developing Evidence-Based Interventions for Clinical, Counseling, and School Psychologists* (pp. 387-408). Springer, Cham.

Decker, S. L., Strait, J. E., Roberts, A. M., & Ferraracci, J. (2018). Intellectual and neuropsychological assessment of individuals with sensory and physical disabilities and traumatic brain injury. In D. P. Flanagan & P.L. Harrison (Eds.) *Contemporary Intellectual Assessment* (4th ed.).

Decker, S. L., Wright, E.K., & Vetter, T. (2015). Scoring the WJ-IV. In Flanagan, D. (Eds), *WJ IV Clinical Use and Interpretation*. Elsevier.

Decker, S. L. & Roberts, A., Green, J.J. (2014). sLORETA neurofeedback in a college aged ADHD. In Thatcher, R. (Ed). *LORETA Neurofeedback*. Publication in 2014.

Decker, S. L., (2013). Testing: the measurement and assessment link. In C. R. Reynolds (Ed), *The Oxford Handbook of Psychological Assessment of Children and Adolescents*. New York: Oxford University Press, 2010. [invited]

Decker, S. L., Englund, J. A., & Roberts, A. M. (2011). Intellectual and neuropsychological assessment of individuals with physical and sensory disabilities and traumatic brain injury. In Flanagan, D. P., & Harrison, P. L. (Eds.) *Contemporary Intellectual Assessment* (3rd ed.). New York: Guilford.

Decker, S. L., (2010). Best Practices in Assessing and Intervening with Children with Sensory-Motor Impairments. In D. Miller (Ed.). *Best Practices in School Neuropsychology*. July 2009 [invited].

Decker, S. L., Carboni, J. A., & Englund, J. A. (2010). Assessing visual-spatial and construction skills in a pediatric population. In Davis, A. S. (Ed.) *The Handbook of Pediatric Neuropsychology*. New York: Springer Publishing.

Decker, S.L. (2010). Stanford-Binet Fifth Edition. In Davis, A. S. (Ed.) *The Handbook of Pediatric Neuropsychology*. Springer Publishing. New York: Spring Publishing.

Fiorello, C. Hale, J. & Decker, S.L. (2009). Neuropsychology in School Psychology. *Handbook of Education, Training and Supervision of School Psychologists in School and Community*. Vol. 1. New York: Routledge [invited].

Decker, S. L., & McIntosh, D. (2009). Academic achievement measures in rehabilitation. In E. Mpofu, & T. Oakland (Eds.) *Assessment in Rehabilitation and Health*, (p. 290-294). Upper Saddle River, NJ. [invited].

McIntosh, D. & Decker, S.L. (2008). Contemporary issues in school psychology. *Oxford Handbook of School Psychology*. [invited].

Decker, S. L., Carboni, J., & Oliver, K. (2008). Perspectives on RTI from neuropsychology. In Fletcher-Janzen, E. & Reynolds, C. R. *Neuropsychological perspectives on learning disabilities in the era of RTI: Recommendations for diagnosis and intervention* (p. 192-199). John Wiley & Sons, Inc [invited].

McIntosh, D. & Decker, S. L. (2005). Neuropsychology and Special Education Law. In D'Amato, Fletcher-Janzen & Reynolds (Eds.). *Handbook of School-Neuropsychology* (p. 365-382). Wiley Publishing.

Brinkman, J., Dean, R. S., & Decker, S. L. (2005). Neuropsychology of intelligence. In D'Amato, Fletcher-Janzen & Reynolds (Eds.). *Handbook of School-Neuropsychology* (p. 303-326). Wiley Publishing.

Dean, R. S., Woodcock, R. W., Decker, S. L., & Schrank (2003). A Cognitive Neuropsychology Assessment Model. In Schrank, F. A., & Flanagan, D. *WJ III Clinical Use and Interpretation: Scientist-Practitioner Perspective* (pp. 345-377). San Diego, CA: Academic Press.

Gridley, B., Rizza, M., & Decker, S. L. (2003). Assessment of gifted children with the Woodcock-Johnson III. In Schrank, F. A., & Flanagan, D. *WJ III Clinical Use and Interpretation: Scientist-Practitioner Perspective* (p. 286-319). San Diego, CA: Academic Press.

Invited Book Reviews

Decker, S. L. & Wright, E. (invited). Psychopathology in children and adolescents. By Andrew Davis. *Applied Neuropsychology: Child*.

Decker, S. L., Roberts, A. M., & Wright, E. K. (2014). Neurofeedback: Past, Present, and Future. *PsycCRITIQUES*, 59(44).

Decker, S. L. (2009). Diagnosis of Learning Disabilities: A Neuropsychological Perspective By Bruce Pennington. *Archives of Clinical Neuropsychology*, 24(2): 197-198.

Encyclopedia Entries

Decker, S. (2011). Auditory Processing. In J. S. Kreutzer, J. DeLuca, and B. Caplan (Eds.). *The Encyclopedia of Clinical Neuropsychology*. [invited].

Decker, S. (2011). Bender Visual Motor Gestalt Test II. In J. S. Kreutzer, J. DeLuca, and B. Caplan (Eds.). *The Encyclopedia of Clinical Neuropsychology*. 2009.

Decker, S. (2011). Dean-Woodcock Neuropsychological Assessment System. In J. S. Kreutzer, J. DeLuca, and B. Caplan (Eds.). *The Encyclopedia of Clinical Neuropsychology*. [invited].

Decker, S. (2011). Emotionality. In J. S. Kreutzer, J. DeLuca, and B. Caplan (Eds.). *The Encyclopedia of Clinical Neuropsychology*. [invited].

Decker, S. (2011). Rapid Automatic Naming. In J. S. Kreutzer, J. DeLuca, and B. Caplan (Eds.). *The Encyclopedia of Clinical Neuropsychology*. [invited].

Decker, S. (2011). Reality Orientation. In J. S. Kreutzer, J. DeLuca, and B. Caplan (Eds.). *The Encyclopedia of Clinical Neuropsychology*. [invited].

Decker, S. L., Oliver, K., & Carboni, J. (2010). Intelligence. In the American Counseling Association (Ed.), *The American Counseling Association Encyclopedia of Counseling*. Alexandria, VA: American Counseling Association. [invited].

External Review of Work

Bender Visual-Motor Gestalt Test Second Edition. **Reviewed In:** Spies, R. A., & Plake, B. S. (Eds.). (2005). *The sixteenth mental measurements yearbook*. Lincoln, NE: Buros Institute of Mental Measurements.

PROFESSIONAL PRESENTATIONS

Invited Lectures

Decker, S. L. (2021). Critical assumptions of SLD models in IDEIA 2004. Learning Disabilities Association of America: Science to Practice. Invited talk.

Decker, S.L., McQuillin, S.D., Bridges, R., & Anzalone, C. (2019, Aug) Symposium: State-Wide Census on SLD and Dyslexia Identification and Policy Practices. Chicago, IL. American Psychological Association

- Decker, S. L. (2018, Feb). Neurofeedback: What school psychologists need to know. Chicago, IL. National Association of School Psychology.
- Decker, S. L. (invited). Neuropsychological approaches to writing assessment. Fordham University, New York, NY).
- Decker, S. L. (2013, Feb). Cognitive assessment: WJ-III. Richland 2 School District, Columbia, SC.
- Decker, S. L. (2011, June). Neuropsychological assessment in schools. Rock Hill, SC.
- Decker, S. L. (2010, May). Applications of neuropsychological assessment in a multi-tiered services delivery system. Fordham University Assessment Conference, New York, NY.
- Decker, S. L. (2010, Oct). Neuropsychological assessment and RTI. South Carolina Association of School Psychologists. Columbia, SC.
- Decker, S. L. (2010, June). Assessment and intervention of sensory-motor impairments. Fifth National School Neuropsychology Conference. Dallas, TX.
- Decker, S. L. (2010, May). Neuropsychological applications in multi-tiered models. Second Annual Assessment Conference at Fordham University. New York, NY.
- Decker, S. L. (2010). Neuropsychological applications in multi-tiered models of service delivery. Georgia Association of School Psychology. Savannah, GA.
- Decker, S. L. (2010) Neuropsychological applications in multi-tiered models. South Carolina Association of School Psychologists. Columbia, SC.
- Decker, S. L. (2008, Oct). Neuropsychological applications in school-based practice. Portland, OR. Oregon Association of School Psychologists.
- Decker, S. L. (2008, March). Integrating neuropsychological methodology with RTI. Georgia Association of School Psychologists. Savannah, GA.
- Decker, S. L. (2007, January). Neuropsychological Applications of the WJ-III and Dean-Woodcock Sensory-Motor Battery in School Settings. Invited presentation for Coalition of Clinical Practitioners in Neuropsychology. Orlando, FL
- Decker, S. L. (2004, September). The Bender-Gestalt II for Detroit Public School Psychologists. Detroit.
- Decker, S. L. (2004, September). Training on the Dean-Woodcock Neuropsychological Assessment Battery. University of British Columbia. Vancouver, Canada.
- Decker, S. L. (2004, August). Visual-motor Assessment. Fulton County School Psychologists. Atlanta, GA.
- International Presentations**
- Decker, S. L. (2016). Applications of neuropsychology. Henan Summer Institute: Promoting Positive Outcomes for Children and Adolescents, Henan University, China.
- Decker, S. L. (2010). Neuropsychological applications of sensory and motor tests. Neuropsychological Institute of the Inter American University of Puerto Rico. San German, PR. (Invited)
- Carboni, J., & Decker, S. (2007, May). Differences in visual-motor ability between Hispanic and Caucasian children as measured by the Bender-Gestalt II. Poster session presented at the U.S. Studies Conference, Xalapa, Veracruz, Mexico.

Decker, S. L., Carboni, J. & Ezerine, G. (2006, August). Applications of neuropsychology in the schools. Paper presented at the annual meeting of the American Psychological Association. Toronto, Canada.

Decker, S. L. (2003, March). Using the Woodcock-Johnson III in Neuropsychological Assessment. Paper presented at the National Association of School Psychology Annual Convention, Toronto, Canada.

Decker, S. L. (2003, March). The Bender-Gestalt Second Edition. Mini-Skills presentation at the National Association of School Psychology Annual Convention, Toronto, Canada.

Decker, S. L. (2003, March). Assessment of Traumatic Brain Injury with the Woodcock-Johnson III. Symposium participant at the National Association of School Psychology Annual Convention, Toronto, Canada.

Decker, S. L., & Dean, R. S. (2002). Neuropsychological Utility of the Woodcock-Johnson III. Workshop presented at International Conference of Pediatric Neuropsychology. Puerto Rico.

National Presentations

Decker, S. L. (August, 2021). Critical Assumptions of SLD identification in federal regulations. LDA Science to Practice Conference. Learning Disabilities Association of America. Virtual. (Invited)

Decker, S. L. (August, 2021). Critical Assumptions of SLD identification in federal regulations. Fall conference for Learning Disabilities Association of America. Virtual. (Requested to repeat invited talk from August)

Roberts, A. M., Decker, S. L., Wright, K. K. C., Scherr, J. F., Schiele, B., & Englund, J. A. (February, 2014). *Working Memory Assessment: Implications for School Psychologists*. Symposium accepted for presentation at the National Association of School Psychologists Annual Conference, Washington, DC.

Wright, E. K. C., Decker, S. L., Englund, J. A. (February, 2014). Cultural invariance of Bender-Gestalt-II performance: An initial exploratory analysis for individuals ages 4 to 7. Poster presented at the National Association of School Psychologists Annual Conference, Washington, DC.

Roberts, K. L., Roberts, A. M., Wright, E. K. C., & Decker, S. L. (2014, February). *Cognitive predictors of academic writing skills across early grade levels*. Poster presented at the National Association of School Psychologists Annual Convention, Washington, D.C.

Stafford, A. L., Roberts, A. M., Wright, E. K. C., & Decker, S. L. (2014, February). *Cognitive predictors of reading comprehension across development*. Poster presented at the National Association of School Psychologists Annual Convention, Washington, D.C.

Hanchon, T., Allen, R., Decker, S. L., Morrison, J., Poncy, B., & Sansosti, F. (2013). *Preparing the next generation of school psychologists: Challenges and opportunities*. Symposium presented at the National Association of School Psychologists Annual Convention, Seattle, WA.

Englund, J. A. (Chair), Decker, S. L., & Roberts, A. M. (2013). *Research-based Alternative Models of SLD Identification*. Symposium presented at the National Association of School Psychologists Annual Convention, Seattle, WA.

Englund, J. A. (2013). *Development of an online, theoretically guided working memory measure*. Poster presented at the National Association of School Psychologists Annual Convention, Seattle, WA.

Roberts, A. M., & Decker, S. L. (2013). *Cognitive predictors of rapid naming*. Poster presented at the National Association of School Psychologists Annual Convention, Seattle, WA.

Wright, E. K., Decker, S. L., Englund, J. A., & Roberts, A. M. (2013). *Higher-order factor structure of the WISC-IV: A re-analysis*. Poster presented at the National Association of School Psychologists Annual Convention, Seattle, WA.

- Englund, J. A., & Decker, S. L. (February, 2012). *Sensitivity of Bender-Gestalt-II performance to atypical development in neurodevelopmental disorders*. Poster presented at the National Association of School Psychologists Annual Convention, Philadelphia, PA.
- Decker, S. L. (Chair), Englund, J. A., Roberts, A. M., & Scherr, J. (2012). *What can brain waves tell us about executive function: Q-EEG and standardized measures of working memory, executive functions, and anxiety*. Symposium presented at the National Association of School Psychologists Annual Convention, Philadelphia, PA.
- Roberts, A. M., & Decker, S. L. (February, 2012). *Crystallized intelligence and its importance for academic success*. Poster presented at the National Association of School Psychologists Annual Conference, Philadelphia, PA.
- Englund, J. A., & Decker, S. L. (February, 2011). *Cognitive and developmental influences in visual-motor integration skills*. Poster presented at the National Association of School Psychologists Annual Convention, San Francisco, CA.
- Albritton, K. Johnson, D., Leonard, A., & Decker, S. L. (2010). Linking universal reading screeners and norm-referenced measures. Poster session presented at the annual meeting of the National Association of School Psychologist, Chicago, Illinois.
- Allen, R. & Decker, S. L. (2009, March). Autism spectrum disorders: Neurobiology and current assessment practices. Presentation delivered at the National Association of School Psychologists, March 2009.
- Carboni, J., Ezrine, G., Decker, S. L., Cadenhead, C. (2008, August). Effects of culture and language proficiency on Bender-Gestalt II performance. Poster session presented at the annual meeting of the American Psychological Association, Boston, MA.
- Carboni, J., Ezrine, G., Oliver, K., & Decker, S. (2008), February). A cross-cultural study of visual-motor ability. Poster session presented at the annual meeting of the National Association of School Psychologists, New Orleans, LA.
- Ezrine, G., Carboni, J., Shepps, A., & Decker, S. (2008, February). Prevention-focused preschool assessment: Measuring developmental trajectories toward school readiness. Poster session presented at the annual meeting of the National Association of School Psychologists, New Orleans, LA.
- Carboni, J., Marx, H. & Decker, S. L. (2007, February). Demographic influences of visual-motor ability. Poster presentation at the National Association of School Psychology. New York, NY.
- Decker, S., & Carboni, J. (2007, August). Assessment and intervention methods for perceptual-motor integration deficits. Poster session presented at the annual meeting of the American Psychological Association, San Francisco, CA.
- Decker, S., Carboni, J., & Marx, H. (2006, March). Evidence-based decision making and hypothesis testing methodology in school psychology. Presented at the annual meeting of the National Association of School Psychologists, Anaheim, CA.
- Decker, S. L. (chair), Franklin, R., & Rohling, (2005, April). Evidence based methods of interpretation. APA symposium.
- Allen, R. & Decker, S. (2005, January). Construct Validity of the Bender Gestalt II with The WISC-III. Annual conference of the Southeastern Psychological Association. Nashville, TN.
- Dean, R. S., & Decker, S. L. (2005, February). Neuropsychological screening using the Dean-Woodcock Neuropsychological Assessment System. NASP Mini-Skills.

Decker, S. L. (2004, April). Incremental validity of tactile measures in predicting letter-word identification skills. Poster presented at National Academy of Neuropsychology.

Decker, S., & Becker, K. A. (2002, August). Developmental Patterns of Visual-Motor Ability. Paper presented at the American Psychological Association Annual Convention, Chicago, IL.

Decker, S., & Becker, K. A. (2002, February). Bender Gestalt Test-Revised: Test Development and Clinical Validity. Paper presented at the National Association of School Psychologists Annual Convention, Chicago, IL.

Decker, S. (2001, April). Neuropsychological utility of the WJ-III. Poster presented at National Academy of Neuropsychology.

McIntosh, D., Decker, S., Kelly, A., Nichols, S. Dean, R. (2000, February). Comorbidity among individuals with attention disorders. Poster presented at American Psychological Association.

Decker, S., Dean, R., Kirkwood, A. (1999). Student's attitudes toward using internet supplemental instruction. Poster presented at 2nd Annual Teaching and Technology Conference.

Regional Presentations

Decker, S (October, 2021). Critical assumptions of SLD identification in IDEIA 2004. South Carolina Association of School Psychologists Fall Conference, Columbia, SC. (Invited).

Englund, J. A., & Decker, S. L. (October, 2011). The South Carolina Early Evaluation Net (SCREEN): A brief online working memory assessment. Poster presented at the South Carolina Association of School Psychologists Fall Conference, Columbia, SC.

Englund, J. A., Roberts, A. M., Hodes, D., & Decker, S. L. (October, 2010). *Cognitive influences on visual-motor integration*. Poster presented at the South Carolina Association of School Psychologists Fall Conference, Columbia, SC.

Roberts, A. M., Englund, J. A., Hodes, D., Hinojosa, S., & Decker, S. L. (October, 2010). *Variability in RTI measurement models*. Poster presented at the South Carolina Association of School Psychologists Fall Conference, Columbia, SC.

Becker, K. A., & Decker, S. (2001, October). The benefits of item bias in clinical diagnosis. Paper presented at the International Objective Measurement Conference: Focus on Health Care, Chicago, IL.

Becker, K. A., & Decker, S. (2001, June). The development of an objective scoring criteria for the Bender-Gestalt Test. Paper presented at the Midwest Objective Measurement Seminar, Chicago, IL.

Decker, S., Hunton, D., Biner, P. (1997). Symbolic self-completion and task interruption: Committed student's reactions. Butler University 9th Annual Undergraduate Research Conference.

PROFESSIONAL SERVICE

Editorial Responsibilities

Editorial Board, *Journal of School Psychology*, 2011-present

Editorial Board, *Applied Neuropsychology*, 2010 - present

Editorial Board, *Journal of Applied School Psychology*, 2009-present

Editorial Board, *Psychology in the Schools*, 2007-2012

Editorial Board, *NeuroRegulation*, 2018 - present

Editorial Board. *School Psychology Quarterly*, 2009-present

Ad Hoc Reviewer

Individual Psychology, 2007, 2009

Archives of Clinical Neuropsychology, 2010, 2014

European Journal of Psychological Assessment, 2014
American Journal on Intellectual and Developmental Disabilities, 2013

Reviewer

Sage Publication, 2007, 2013, 2014.

UNIVERSITY SERVICE

University Senate Sub-Committee on the Freedom of Expression, 2021-
Program Director: School Psychology Program, 2016-2020
University Senate: Department of Psychology Representative, 2015-present
Interim Program Director: School Psychology Program, 2014-2015
Chair APA Accreditation School Psychology Program (Accreditation renewal 7 years), 2014-2015
Executive Committee, Dept. of Psychology, University of South Carolina, 2012-present
Psychology Chair Search Committee, Dept. of Psychology, University of South Carolina, 2014-present
Quantitative Search Committee, Dept. of Psychology, University of South Carolina, 2013-present
Handbook Committee, School Psychology Program, University of South Carolina, 2012-2013
Coordinator Written Comprehensive Finals, School Psych Program, University of South Carolina, 2012-2013
APA Accreditation Committee, School Psych Program, University of South Carolina, 2013-present
Undergraduate Curriculum Committee, Dept. Psychology, University of South Carolina, 2011-2013
Faculty Affairs Committee *Secretary*. College of Education. Georgia State University, 2006 – 2008
Chair's Advisory Committee. College of Education, Georgia State University, 2007-2008

CERTIFICATION AND LICENSURE

Certified School Psychologists (IN), 2000-2008
Certified School Psychologists (GA), 2008-expired

PROFESSIONAL MEMBERSHIPS

International Neuropsychological Society
American Psychological Association
 Division 40 Clinical Neuropsychology
 Division 16 School Psychology
National Academy of Neuropsychology
International Pediatric Neuropsychology
National Association of School Psychology
Institute for Objective Measurement

HONORS AND PROFESSIONAL RECOGNITION

Outstanding Contribution to School Psychology by the South Carolina Association for School Psychologists (2019)
Mortar Board Excellence in Teaching 2011-2012. USC Mortar Board. University of South Carolina.
Early Career Scholar in School Psychology by the Society for the Study of School Psychology (2007).
American Counseling Association Research Award (2008, March). Honolulu, Hawaii.
Measurement and Evaluation in Counseling and Development/Patricia Elmore Research Award. (2008, March). Honolulu, Hawaii.
Invitation for Guest Editor Special Issue (2008). *Applications of Neuropsychology* for the journal *Psychology in the Schools*. October, 2008.

COMMUNITY ENGAGEMENT

National Recognition for Biopsychology: Using DNA sampling to teach about genetic ancestry.

- Included in National Geographic Newsletter with circulation of over 41,000
- Included in GSU newsletter
- Upcoming story in GSU alumni magazine

Parent Assessment Consultation: Assessed children from the committee to consult with parents and teach students assessment and intervention practice. Four-children in total with different developmental conditions including Autism, Non-verbal Learning Disability, and Learning Disabilities have participated in the program. Parent feedback of involvement can be found in supplemental documents.

Cross-department research activity to assist students in different programs

Decker Behavioral Analytics
46 Peyton Rd
Columbia, SC 29209
(404) 797-3007



PSYCHOEDUCATIONAL EVALUATION REPORT

-CONFIDENTIAL-

Name: Gary Terry
DoB: 12/1/1967
Sex: Male
Chronological Age: 54

Date of Report: 1/22/2022

Examiners:
Dr. Scott L. Decker

Evaluation Procedures:

Brief Interview
Woodcock-Johnson IV Test of Cognitive Abilities
Woodcock-Johnson IV Tests of Achievement
Bender-Gestalt Second Edition

Dates Administered:

1/20/22
1/20/22
1/20/22
1/20/22

REASON FOR REFERRAL

Mr. Terry is 54 year-old white male who is being tested to estimate his current level of intellectual ability. The tests used in the current assessment provided an estimate of general intellectual functioning using a variety of cognitive tests. Additionally, supplemental tests were included to provide an indicator of performance and effort validity. Results are interpreted based on age-corrected performance standards in accordance with standardized procedures documented in the technical manuals of each test.

BRIEF INTERVIEW

General

Mr. Terry is currently an inmate on death row in Columbia, South Carolina. A brief review of select educational files suggest Mr. Terry had difficulty in school as a child. Mr. Terry's performance on standardized achievement tests in the 2nd, 3rd, and 4th grade were generally below the 10th percentile. Legal reports indicate a traumatic history of abuse; however, a complete developmental history was not conducted in the current evaluation.

BRIEF OBSERVATION

Mr. Terry was tested on 1/20/2022 at 10 a.m. to approximately 1:10 p.m. Testing occurred in a small, well-lit room located near his prison cell. Mr. Terry was cooperative and talkative during testing. He stated he was left-handed and predominately responded to tasks using his left-hand. A mild tremor was noted in the left-hand which he claimed was first noticed 4 to 5 years earlier and of unknown origin. He also complained of right-side facial pain due to shingles and stated it occasionally obscured vision in his right eye. Mr. Terry pointed out several scars on his head due to blunt force trauma sustained as a child

from his father. When asked, he did not recall if he lost consciousness during any of the injuries. Mr. Terry frequently referenced having thinking problems that he described as “My mind just gets scrambled.” Throughout testing, Mr. Terry responded with high effort and often diligently used paper and pencil to figure out problems. Effort was sustained at a constant rate from the start to finish of testing with no fatigue evident. Based on behavioral observations during testing and consistency in test performance, results are considered a valid indicator of Mr. Terry’s intellectual ability.

Cognitive Assessment

Woodcock-Johnson Fourth Edition, Test of Cognitive Abilities

Mr. Terry’s intellectual ability was assessed using the *Woodcock-Johnson Fourth Edition Test of Cognitive Ability*. The standard battery of seven test representing each of the seven broad abilities were administered. When combined, the seven tests provide an estimate of General Intellectual Ability (Tests 1-7). Standard scores (SS) on the measure range from 40 to 160; 100 is exactly average and scores between 90 and 109 constitute the average range. One standard deviation equals 15 points. Scores are based on a comparison between Mr. Terry’s performance and same age peers.

(Standard score mean = 100, standard deviation = 15)

Index/Composite	SS	AE	CI	Classification
General Intellectual Ability	77	9-6	72-82	Low
Subtests				
Oral Vocabulary	87	14-2	79-95	Low Average
Number Series	89	10-4	81-97	Low Average
Verbal Attention	86	10-10	76-96	Low Average
Letter-Pattern Matching	68	8-1	54-81	Very Low
Phonological Processing	78	7-6	71-85	Low
Story Recall	76	7-6	63-88	Low
Visualization	79	7-11	68-89	Low

SS = Standard Score; AE = Age Equivalent; CI = Confidence Interval

Mr. Terry’s General Intellectual Ability was estimated to be in the Low range (SS=77; CI=72-82). Mr. Terry performed in the Low Average range on tests measuring language, number inference, and attention. His lowest performance was on a measure of visual processing speed (Letter-Pattern Matching), which was statistically lower than scores on other measures.

Academic Assessment

Mr. Terry was administered two brief measures of academic skill from the Woodcock-Johnson Fourth Edition, Tests of Achievement. In addition to obtaining a brief estimate of basic reading and math skill, the achievement tests were administered to evaluate score consistency with intellectual ability, which provides another indicator of performance validity. It measures an individual’s academic achievement in

several specified areas. A standard score between 85 and 115 falls in the Average range of achievement. Firstname's academic achievement scores on the *WIAT-III* are found in the table below:

Achievement Subtest	Standard Score (95% CI)	AE	Qualitative Description
Calculation	67 (60-75)	8-7	Very Low
Reading Fluency	74 (64-84)	9-1	Low

Mr. Terry performance suggests that his academic abilities are in the Very Low range for math calculation skills and in the Low range for reading fluency.

VISUAL MOTOR MEASURE

The Bender-Gestalt Second Edition (BG-2) is a measure of visual-motor integration capabilities, appropriate for individuals between 4 and 90+ years of age. Overall, visual-motor integration is the degree to which visual perception and finger-hand movement are well coordinated. The BG-2 comprises a range of tasks based on copying geometric figures followed by a memory recall procedure. A standard score between 90-110 range is average. Overall, Mr. Terry's performance on the BG-2 test was consistent with his intellectual ability. His copy phase was below average. He was able to copy simple geometric figures but expressed frustration while attempting more complex figures. Additionally, his drawings included collisions and rotations which indicate some perceptual organization problems. His ability to recall drawings was well-below average. He was able to recall a few basic items but was unable to recall many other figures. While attempting to remember, he claimed his mind is "scrambled" and he cannot remember other figures.

EVALUATIVE SUMMARY

Mr. Terry is a 54 year-old male who was assessed to determine his general intellectual ability. His intellectual functioning was estimated to be in the Low range. Although all subtest scores were below average, he demonstrated a specific weakness on a visual processing speed test. However, his performance on this test should be considered in the context of right-side facial pain with possible visual difficulties in his right eye due to the shingles virus. His scores on basic academic and visual-motor tests were consistent with his general intellectual ability, which provide confidence on the validity of test scores obtained during this assessment.

Thank you for the opportunity to conduct the assessment with Mr. Terry. If you have any questions regarding the assessment results, do not hesitate to contact me directly.

Examiner:

Scott L. Decker, PhD.
Neuropsychologist
Department of Psychology
University of South Carolina

TABLE OF SCORES

Woodcock-Johnson IV Tests of Cognitive Abilities (Norms based on age 54-2)

<u>CLUSTER/Test</u>	<u>W</u>	<u>AE</u>	<u>RPI</u>	<u>SS (95% Band)</u>
GEN INTELLECTUAL ABIL	495	9-6	47/90	77 (72-82)
BRIEF INTELLECTUAL ABIL	504	11-4	63/90	85 (79-91)
Oral Vocabulary	513	14-2	67/90	87 (79-95)
Number Series	498	10-4	62/90	89 (81-97)
Verbal Attention	501	10-10	61/90	86 (76-96)
Letter-Pattern Matching	485	8-1	2/90	68 (54-81)
Phonological Processing	488	7-6	41/90	78 (71-85)
Story Recall	486	7-6	62/90	76 (63-88)
Visualization	488	7-11	59/90	79 (68-89)

Woodcock-Johnson IV Tests of Achievement Form A and Extended (Norms based on age 54-2)

<u>CLUSTER/Test</u>	<u>W</u>	<u>AE</u>	<u>RPI</u>	<u>SS (95% Band)</u>
Calculation	476	8-7	4/90	67 (60-75)
Sentence Reading Fluency	480	9-1	1/90	74 (64-84)

	STANDARD SCORES			DISCREPANCY		Interpretation at
<u>VARIATIONS</u>	<u>Actual</u>	<u>Predicted</u>	<u>Difference</u>	<u>PR</u>	<u>SD</u>	<u>+ or - 1.50 SD (SEE)</u>
<i>Intra-Cognitive [Extended] Variations</i>						
Oral Vocabulary	87	79	8	80	+0.83	--
Number Series	89	78	11	83	+0.97	--
Verbal Attention	86	83	3	59	+0.23	--
Letter-Pattern Matching	68	88	-20	6	-1.59	Weakness
Phonological Processing	78	81	-3	39	-0.27	--
Story Recall	76	86	-10	20	-0.84	--
Visualization	79	85	-6	29	-0.54	--

Score Report

Name: , Gary
 Date of Birth: 12/01/1967
 Age: 54 years, 2 months
 Sex: Male
 Date of Testing: 01/20/2022

School:
 Teacher:
 Grade:
 ID:
 Examiners:

TESTS ADMINISTERED

Woodcock-Johnson IV Tests of Cognitive Abilities (Norms based on age 54-2)

Woodcock-Johnson IV Tests of Achievement Form A and Extended (Norms based on age 54-2)

TABLE OF SCORES

Woodcock-Johnson IV Tests of Cognitive Abilities (Norms based on age 54-2)

CLUSTER/Test	W	AE	RPI	SS (95% Band)
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Woodcock-Johnson IV Tests of Achievement Form A and Extended (Norms based on age 54-2)

CLUSTER/Test	W	AE	RPI	SS (95% Band)
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Sentence Reading Fluency	480	9-1	1/90	74 (64-84)

VARIATIONS	STANDARD SCORES			DISCREPANCY		Interpretation at + or - 1.50 SD (SEE)
	Actual	Predicted	Difference	PR	SD	
<i>Intra-Cognitive [Extended] Variations</i>						
Oral Vocabulary	87	79	8	80	+0.83	--
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Story Recall	76	86	-10	20	-0.84	--
Visualization	79	85	-6	29	-0.54	--

Woodcock-Johnson IV Tests of Achievement Form A and Extended Qualitative Observations

Calculation: Solved initial problems quickly with no observed difficulties but demonstrated less automaticity with the latter items (typical)

Rationale for Flynn Effect correction of WJ-4 scores

1. There is a professional and scientific consensus that obtained IQ scores must also be corrected for norm obsolescence when present (aka., the Flynn effect; AAIDD; 2010, 2021; APA: DSM-5, 2013; Floyd et al., McGrew, 2021,; McGrew, 2015b; Schalock et al., 2012; Tassé & Blume's, 2018; Watson, 2015). (See attached reference list for a more definitive review).
2. Empirical estimates for norm obsolescence are not published specifically for the WJ-4th edition tests. Therefore, norm obsolescence for the WJ-4 should be based on standard estimates for score correction generally used for all intellectual tests.
3. Standard practice for correcting scores for norm obsolescence use an estimate of .30 change in standard scores multiplied by the number of years since the normative sample was corrected. The correction is applied based on the date in which the normative sample was collected and not the date in which the test was published. (Flynn Adjustment = (Date of testing – date of normative sample) * 0.3). Scores with decimals are rounded.
4. According to Watson (2015), the date for the WJ-4 normative samples is 2010/2011. Using the year of 2011, the WJ-4 norms were collected 11 years prior to the date of 1/22/2022.
5. Using previous information, the correction for norm obsolescence on the WJ-4 is estimated as 3.3 based on the following calculation: $(11 * .3 = 3.3)$

Summary Opinion for Mr. Gary Terry

It is my expert opinion that when standard procedures are applied to correct for norm obsolescence, Mr. Gary Terry's General Intellectual Ability (GIA) would be estimated as a standard score of 74 with 95% confidence intervals of 69 to 79. As such, the standard error of measurement for Mr. Gary Terry's general intellectual ability includes the range of scores that extend two standard deviations below the mean, which is typically considered as a diagnostic threshold for intellectual disability.

Flynn effect and related references 06-20-21

Red font designates new references added since last posting.

1. Acosta, G., Smith, E., & Kreinovich, V. (2019). *Why IQ test scores are slightly decreasing: possible system-based explanation for the reversed Flynn effect*. Technical Report: UTEP-CS-19-61. https://scholarworks.utep.edu/cs_techrep/1342/
2. Al-Shahomee, A. A., Abdalla, S. E. G., & Lynn, R. (2018). An increase of intelligence in Libya from 2008 to 2017. *Personality and Individual Differences*, 130, 147-149.
3. American Association on Intellectual and Developmental Disabilities. (2010). *Intellectual disability: Definition, classification, and systems of supports—11th Edition*. Washington, DC: Author.
4. American Association on Intellectual and Developmental Disabilities. (2021). *Intellectual disability: Definition, classification, and systems of supports—12th Edition*. Washington, DC: Author.
5. Al-Shahomee, A. A., Abdalla, S. E. G., & Lynn, R. (2017). An Increase of Intelligence in Libya from 2006 to 2017. *Mankind Quarterly*, 58(2), 290-296.
6. Ang, S. A., Rodgers, J. L., Wanstrom, L. (2010). The Flynn Effect within subgroups in the U.S: Gender, race, income, education, and urbanization differences in NLSY-Children data. *Intelligence*, 38, 367-384.
7. Armstrong, E. L., Woodley, M. A., & Lynn, R. (2014). Cognitive abilities amongst the Sami population. *Intelligence*, 46, 35-39.
8. Armstrong, E. L. & Woodley, M. A. (2014). The rule-dependence model explains the commonalities between the Flynn effect and IQ gains via retesting. *Learning and Individual Differences*, 29, 41-49.
9. Armstrong, E. L., te Nijenhuis, J., Woodley, M. A., Fernandes, H. B., Must, O., & Must, A. (2016). A NIT-picking analysis: Abstractness dependence of subtests correlated to their Flynn effect magnitudes. *Intelligence*, 57, 1-6.
10. Ashton, M. (2008). Review of What is intelligence? Beyond the Flynn effect. *Personality and Individual Differences*, 44(5), 1289-1291.
11. Baker, D. P., Eslinger, P. J., Benavides, M., Peters, E., Dieckmann, N. F., & Leon, J. (2015). The cognitive impact of the education revolution: A possible cause of the Flynn Effect on population IQ. *Intelligence*, 49, 144-158.
12. Barakat, S. M. R., & Lynn, R. (2014). A Flynn effect among deaf boys in Saudi Arabia. *Intelligence*, 44, 75-77.

13. Barclay, K. J. (2015). A within-family analysis of birth order and intelligence using population conscription data on Swedish men. *Intelligence*, 49, 134-143.
14. Batterjee, A. A., & Ashria, I. (2015). Intelligence and education: The Sudan case. *Mankind Quarterly*, 56(2), 136.
15. Batterjee, A. A., Khaleefa, O., Ali, K., & Lynn, R. (2013). An increase in intelligence in Saudi Arabia, 1977- 2010. *Intelligence*, 41(2), 91-93.
16. Baxendale, S. (2010). The Flynn effect and memory function. *Journal of Clinical and Experimental Neuropsychology*, 32(7), 699-703.
17. Beaujean, A. A., & Osterlind, S. J. (2008). Using item response theory to assess the Flynn Effect in the National Longitudinal Study of Youth 79 Children and Young Adults Data. *Intelligence*, 36(5), 455-463.
18. Beaujean, A. A., & Sheng, Y. Y. (2010). Examining the Flynn Effect in the General Social Survey Vocabulary test using item response theory. *Personality and Individual Differences*, 48(3), 294-298.
19. Beaujean, A., & Sheng, Y. (2014). Assessing the Flynn effect in the Wechsler scales. *Journal of Individual Differences*, 35, 63-78.
20. Benson, N., Beaujean, A. A., & Taub, G. E. (2015). Using score equating and measurement invariance to examine the Flynn effect in the Wechsler adult intelligence scale. *Multivariate behavioral research*, 50(4), 398-415.
21. Black, S. C. (2017). High stakes IQ testing: The Flynn Effect and its clinical implications. *Journal of the Australian & New Zealand Student Services Association*, 49, 3-14.
22. Blair, C. (2006). How similar are fluid cognition and general intelligence? A developmental neuroscience perspective on fluid cognition as an aspect of human cognitive ability. *Behavioral and Brain Sciences*, 29(2), 109+.
23. Blair, C., Gamson, D., Thorne, S., & Baker, D. (2005). Rising mean IQ: Cognitive demand of mathematics education for young children, population exposure to formal schooling, and the neurobiology of the prefrontal cortex. *Intelligence*, 33(1), 93-106.
24. Bocerean, C., Fischer, J. P., & Flieller, A. (2003). Long-term comparison (1921- 2001) of numerical knowledge in three to five- and-a-half year- old children. *European Journal of Psychology of Education*, 18(4), 405-424.
25. Bordone, V., Scherbov, S., & Steiber, N. (2014). *Is population ageing decelerating in terms of cognition?*. IIASA Interim Report. IIASA, Laxenburg, Austria: IR-14-015
26. Bordone, V., Scherbov, S., & Steiber, N. (2015). Smarter every day: The deceleration of population ageing in terms of cognition. *Intelligence*, 52, 90-96.
27. Bradmetz, J., & Mathy, F. (2006). An estimate of the Flynn Effect: Changes in IQ and subtest gains of 10-yr-old French children between 1965 and 1988. *Psychological Reports*, 99(3), 743-746.
28. Bratsberg, B., & Rogeberg, O. (2018). Flynn effect and its reversal are both environmentally caused. *Proceedings of the National Academy of Sciences*, 201718793.
29. Breslau, N., Dickens, W. T., Flynn, J. R., Peterson, E. L., & Lucia, V. C. (2006). Low birth weight and social disadvantage: Tracking their relationship with children's IQ during the period of school attendance. *Intelligence*, 34(4), 351-362.
30. Brouwers, S. A., VandeVijver, F. J. R., & VanHemert, D. A. (2009). Variation in Raven's Progressive Matrices scores across time and place. *Learning and Individual Differences*, 19(3), 330-338.
31. Carl, N. (2016). IQ and socioeconomic development across Regions of the UK. *Journal of biosocial science*, 48(3), 406-417.

32. Cassarino, M., O'Sullivan, Kenny R. A., & Setti, A. (2016). Environment and cognitive aging: A cross-sectional study of place of residence and cognitive performance in the Irish longitudinal study on aging. *Neuropsychology* 30(5), 543-557.
33. Ceci, S. J., & Kanaya, T. (2010). "Apples and Oranges Are Both Round": Furthering the Discussion on the Flynn Effect. *Journal of Psychoeducational Assessment*, 28(5), 441- 447.
34. Ceci, S.J., Scullin, M., & Kanaya, T. (2003). The difficulty of basing death penalty eligibility on IQ cutoff scores for Mental Retardation. *Ethics & Behavior*, 13(1), 11- 17.
35. Ceci, S. J., & Williams, W. M. (2016). A qualitative synthesis of the Flynn Effect. *Measurement: Interdisciplinary Research and Perspectives*, 14(2), 56-63.
36. Clark, C. M., Lawlor-Savage, L., & Goghari, V. M. (2016). The Flynn effect: A quantitative commentary on modernity and human intelligence. *Measurement: Interdisciplinary Research and Perspectives*, 14(2), 39-53.
37. Clarke, R. P. (2015). Rising-falling mercury pollution causing the rising-falling IQ of the Lynn-Flynn effect, as predicted by the antiinnatia theory of autism and IQ. *Personality and Individual Differences*, 82, 46-51.
38. Cockcroft, K., Alloway, T., Copello, E., & Milligan, R. (2015). A cross-cultural comparison between South African and British students on the Wechsler Adult Intelligence Scales Third Edition (WAIS-III). *Frontiers in psychology*, 6, doi: 10.3389/fpsyg.2015.00297.
39. Cocodia, E. A., Kim, J. S., Shin, H. S., Kim, J. W., Ee, J., Wee, M. S. W., & Howard, R. W. (2003). Evidence that rising population intelligence is impacting in formal education. *Personality and Individual Differences*, 35(4), 797- 810.
40. Colom, R., Juan-Espinoso, M., & Garcia, L. F. (2001). The secular increase in test scores is a "Jensen effect". *Personality and Individual Differences*, 30(4), 553-559.
41. Colom, R., Lluís-Font, J., & Andres-Pueyo, A (2005). The generational intelligence gains are caused by decreasing variance in the lower half of the distribution: Supporting evidence for the nutrition hypothesis. *Intelligence*, 33 (1), 83-91.
42. Cunningham, M. D., & Tasse, M. J. (2010). Looking to science rather than convention in adjusting IQ Scores when death is at issue. *Professional Psychology: Research and Practice*, 41(5), 413-419.
43. Daley, T. C., Whaley, S. E., Sigman, M. D., Espinosa, M., & Neumann, C. (2003). IQ on the rise: The Flynn Effect in rural Kenyan children. *Psychological Science*, 14(3), 215-219.
44. de Kort, J., Dolan, C. V., Kan, K.-J., van Beijsterveldt, C., Bartels, M., & Boomsma, D. I. (2014). Can GE-covariance originating in phenotype to environment transmission account of the Flynn Effect? *Journal of Intelligence*, 2, 82-105.
45. Dickens, W. T., & Flynn, J. R. (2001). Heritability estimates versus large environmental effects: The IQ paradox resolved. *Psychological Review*, 108(2), 346-369.
46. Dickens, W. T., & Flynn, J. R. (2006a). Black Americans reduce the racial IQ gap: Evidence from standardization samples. *Psychological Science*, 17(10), 913-920.
47. Dickens, W. T., & Flynn, J. R. (2006b). Common ground and differences. *Psychological Science*, 17(10), 923-924.
48. Dickinson, M. D., & Hiscock, M. (2010). Age-related IQ decline is reduced markedly after adjustment for the Flynn effect. *Journal of Clinical and Experimental Neuropsychology*, 32(8), 865-870.
49. Dickinson, M. D., & Hiscock, M. (2011). The Flynn Effect in neuropsychological assessment. *Applied Neuropsychology*, 18, 136-142.

50. Dorius, S. F., Alwin, D. F., & Pacheco, J. (2016). Twentieth century intercohort trends in verbal ability in the United States. *Sociological Science*, 3, 383-412.
51. Dutton, E., Bakhiet, S. F. A., Alhossein, A. H., & Essa, Y. A. S. (2019). A Flynn Effect in Kuwait, 1985–1998. *Personality and Individual Differences*, 138, 355-357.
52. Dutton, E., Bakhiet, S. F., Essa, Y. A. S., Blahmar, T. A. M., & Hakami, S. M. A. (2017). A negative Flynn Effect in Kuwait: The same effect as in Europe but with seemingly different causes. *Personality and Individual Differences*, 114, 69-72.
53. Dutton, E., Bakhiet, S. F., Ziada, K. E., Essa, Y. A. S., & Blahmar, T. A. M. (2017). A negative Flynn Effect in Khartoum, the Sudanese capital. *Intelligence*, 63, 51-55.
54. Dutton, E., Bakhiet, S. F. A., Osman, H. A., Becker, D., Essa, Y. A. S., Blahmar, T. A. M., & Hakami, S. M. (2018). A Flynn Effect in Khartoum, the Sudanese capital, 2004–2016. *Intelligence*, 68, 82-86.
55. Dutton, E., & Lynn, R. (2013). A negative Flynn effect in Finland, 1997–2009. *Intelligence*, 41(6), 817-820.
56. Dutton, E., & Lynn, R. (2015). A negative Flynn effect in France, 1999 to 2008–9. *Intelligence*, 51, 67-70.
57. Dutton, E., van der Linden, D., & Lynn, R. (2016). The negative Flynn Effect: A systematic literature review. *Intelligence*, 59, 163-169.
58. Ehrenstein, V., Münster, A. M. B., Milstein, A., Adler, N. E., & Sørensen, H. T. (2015). Body mass index and cognitive function: Birth cohort effects in young men. *Obesity*, 23(5), 931-934.
59. Everington, C. (2014). Challenges of conveying intellectual disabilities to judge and jury. *Wm. & Mary Bill Rts. J.*, 23, 467.
60. Fitzgerald, S., Gray, N. S., & Snowden, R. J. (2007). A comparison of WAIS-R and WAIS- III in the lower IQ range: Implications for learning disability diagnosis. *Journal of Applied Research in Intellectual Disabilities*, 20, 323-330.
61. Fletcher, J. M., Stuebing, K. K., & Hughes, L. C. (2010). IQ scores should be corrected for the Flynn Effect in high-stakes decisions. *Journal of Psychoeducational Assessment*, 28(5), 469-473.
62. Flieller, A. (1999). Comparison of the development of formal thought in adolescent cohorts aged 10 to 15 years (1967-1996 and 1972-1993). *Developmental Psychology*, 35(4), 1048-1058.
63. Floyd, R. G., Farmer, R. L., Schneider, W. J., & McGrew, K. S. (2021). Theories and measurement of intelligence. In L. M. Glidden (Ed.), *APA handbook of intellectual and developmental disabilities, Volume 1* (pp. 385-424). Washington, DC: American Psychological Association.
64. Flynn, J. R. (1984a). IQ gains and the Binet decrements. *Journal of Educational Measurement*, 21, 283-290.
65. Flynn, J. R. (1984b). The mean IQ of Americans: Massive gains 1932 to 1978. *Psychological Bulletin*, 95, 29-51.
66. Flynn, J. R. (1985). Wechsler Intelligence Tests: Do we really have a criterion of mental retardation? *American Journal of Mental Deficiency*, 90(3), 236- 244.
67. Flynn, J. R. (1987). Massive IQ gains in 14 nations: What IQ tests really measure. *Psychological Bulletin*, 101, 171-191.
68. Flynn, J. R. (1998a). IQ gains over time: Toward finding the cause. In U. Neisser (Ed.), *The rising curve: Long- term gains in IQ and related measures* (pp. 25-66). Washington, DC: American Psychological Association.

69. Flynn, J. R. (1998b). Israeli military IQ tests: Gender differences small; IQ gains large. *Journal of Biosocial Science*, 30, 541-553.
70. Flynn, J. R. (1998c). WAIS-III and WISC-III: IQ gains in the United States from 1972 to 1995; how to compensate for obsolete norms. *Perceptual and Motor Skills*, 86, 1231-1239.
71. Flynn, J. R. (1999). Searching for justice: The discovery of IQ gains over time. *American Psychologist*, 54(1), 5-20.
72. Flynn, J. R. (2000). The hidden history of IQ and special education-Can the problems be solved? *Psychology Public Policy and Law*, 6(1), 191-198.
73. Flynn, J. R. (2003). Movies about intelligence: The limitations of *g*. *Current Directions in Psychological Science*, 12(3), 95-99.
74. Flynn, J. R. (2006a). Tethering the elephant: Capital cases, IQ, and the Flynn effect. *Psychology, Public Policy, and Law*, 12, 170-189.
75. Flynn, J. R. (2006b). Towards a theory of intelligence beyond *g*. *Behavioral and Brain Sciences*, 29(2), 132+.
76. Flynn, J. R. (2007a). *What is intelligence? Beyond the Flynn Effect*. New York: Cambridge University Press.
77. Flynn, J. R. (2007b). Capital offenders and the death sentence: A scandal that must be addressed. *Psychology in Mental Retardation and Developmental Disabilities*, 32(3), 3-7.
78. Flynn, J. R. (2009). The WAIS-III and WAIS-IV: Daubert motions favor the certainly false over the approximately true. *Applied Neuropsychology*, 16, 98-104.
79. Flynn, J. R. (2010a). The spectacles through which I see race and IQ debate. *Intelligence*, 38, 363-366.
80. Flynn, J. R. (2010b). Problems with IQ gains: The huge Vocabulary gap. *Journal of Psychoeducational Assessment*, 28(5), 412-433.
81. Flynn, J. R. (2013). The "Flynn Effect" and Flynn's paradox. *Intelligence*, 41(6), 851-857.
82. Flynn, J. R. "The march of reason: What was hidden in our genes." In *Handbook of Intelligence*, pp. 471-485. Springer New York, 2015.
83. Flynn, J. R., & Rossi-Casé, L. (2012). IQ gains in Argentina between 1964 and 1998. *Intelligence*, 40, 145-150.
84. Flynn, J. R., & Shaughnessy, M. F. (2017). An interview with James Flynn: Does your family make you smarter? *North American Journal of Psychology*, 19(1).
85. Flynn, J. R., & Shayer, M. (2018). IQ decline and Piaget: Does the rot start at the top? *Intelligence*, 66, 112-121.
86. Flynn, J. R., te Nijenhuis, J., & Metzen, D. (2014). The *g* beyond Spearman's *g*: Flynn's paradoxes resolved using four exploratory meta-analyses. *Intelligence*, 44, 1-10.
87. Flynn, J. R., & Weiss, L. (2007). American IQ gains from 1932 to 2002: The WISC subtests and educational progress. *International Journal of Testing*, 7(2), 209-224.
88. Flynn, J. R., & Widaman, K. F. (2008). The Flynn effect and the shadow of the past: Mental retardation and the indefensible and indispensable role of IQ. In L. M. Glidden (Ed.), *International Review of Mental Retardation* (Vol. 35, pp. 121-149). Boston: Elsevier.
89. Fox, M. C., & Mitchum, A. L. (2013). A knowledge-based theory of rising scores on "culture-free" tests. *Journal of Experimental Psychology: General*, 142(3), 979-1000.
90. Fox, M. C., & Mitchum, A. L. (2014). Confirming the cognition of rising scores: Fox and Mitchum (2013) predicts violations of measurement invariance in series completion between age-matched cohorts. *PloS one*, 9(5), e95780.
91. Frumkin, B. (2006). Challenging expert testimony on intelligence and mental retardation. *The Journal of Psychiatry and Law*, 34, 51-71.

92. Gauvain, M., & Munroe, R. L. (2009). Contributions of societal modernity to cognitive development: A comparison of four cultures. *Child Development*, 80(6), 1628–1642.
93. Genovese, J. E. (2018). Evidence of a Flynn Effect in Children's Human Figure Drawings (1902–1968). *The Journal of Genetic Psychology*, 1-7.
94. Gerstorff, D., Hüllcr, G., Drewelies, J., Eibich, P., Duezel, S., Demuth, I., & Lindenberger, U. (2015). Secular changes in late-life cognition and well-being: towards a long bright future with a short brisk ending? *Psychology and aging*, 30(2), 301.
95. Gignac, G. E. (2015). The magical numbers 7 and 4 are resistant to the Flynn effect: No evidence for increases in forward or backward recall across 85 years of data. *Intelligence*, 48, 85-95.
96. Giuliani, C., Meillon, C., Gonzalez-Colaço Harmand, M., Dartigues, J. F., & Amieva, H. (2015). Normative scores for standard neuropsychological tests in the oldest old from the French population-based PAQUID study. *Archives of Clinical Neuropsychology*, 31(1), 58-65.
97. Gobet, F., Campitelli, G., & Waters, A. J. (2002). Rise of human intelligence: Comments on Howard (1999). *Intelligence*, 30(4), 303-311.
98. Gonthier, C., Grégoire, J., & Besançon, M. (2021). No negative Flynn effect in France: Why variations of intelligence should not be assessed using tests based on cultural knowledge. *Intelligence*, 84, 101512.
99. Greenspan, S. (2006). Issues in the use of the "Flynn effect" to adjust IQ scores when diagnosing MR. *Psychology in Mental Retardation and Developmental Disabilities*, 31(3), 3-7.
100. Greenspan, S. (2007). Flynn-adjustment is a matter of basic fairness: Response to Roger B. Moore, Jr. *Psychology in Mental Retardation and Developmental Disabilities*, 32(3), 7-8.
101. Grégoire, J., Daniel, M., Llorente, A. M., & Weiss, L. G. (2015). *The Flynn effect and its clinical implications*. In L. G. Weiss, D. H. Saklofsek, J. A. Hodnack & A. Prifitera (Eds.), *WISC-IV assessment and interpretation. Scientist-practitioner perspectives* (pp. 187-212). Academic Press, 2015.
102. Gresham, F. (2009). Interpretation of Intelligence Test Scores in Atkins Cases: Conceptual and Psychometric Issues. *Applied Neuropsychology*, 16, 91–97.
103. Gresham, F., & Reschly, D. J. (2011). Standard of practice and Flynn effect testimony in death penalty cases. *Intellectual and Developmental Disabilities*, 49(3), 131-140.
104. Grigoriev, A., & Lynn, R. (2014). A study of the intelligence of Kazakhs, Russians and Uzbeks in Kazakhstan. *Intelligence*, 46, 40-46.
105. Habets, P., Jeandarme, I., Uzieblo, K., Oei, K., & Bogaerts, S. (2015). Intelligence is in the eye of the beholder: Investigating repeated IQ measurements in forensic psychiatry. *Journal of Applied Research in Intellectual Disabilities*, 28(3), 182-192.
106. Hagan, J. (2007). The label mental retardation involves more than an IQ score: A commentary on Kanaya and Ceci (2007). *Child Development Perspectives*, 1(1), 60-61.
107. Hagan, L. D., Drogin, E. Y., & Guilmette, T. J. (2008). Adjusting IQ scores for the Flynn effect: Consistent with the standard of practice? *Professional Psychology: Research and Practice*, 39, 619-625.
108. Hagan, L. D., Drogin, E. Y., & Guilmette, T. J. (2010a). IQ scores should not be adjusted for the Flynn Effect in capital punishment cases. *Journal of Psychoeducational Assessment*, 28(5), 474-476.
109. Hagan, L. D., Drogin, E. Y., & Guilmette, T. J. (2010b). Science rather than advocacy when reporting IQ scores. *Professional Psychology: Research and Practice*, 41(5), 420-423.

110. Hagan, L. D. & Guilmette, T. J. (2017). The death penalty and intellectual disability: Not so simple. *Criminal Justice*, 32, 21-27.
111. Hagmann-von Arx, P., Meyer, C. S., & Grob, A. (2008). Assessing intellectual giftedness with the WISC-IV and the IDS. *Zeitschrift für Psychologie/Journal of Psychology*, 216(3), 172-179.
112. Hartshorne, J. K., & Germine, L. T. (2015). When does cognitive functioning peak? The asynchronous rise and fall of different cognitive abilities across the life span. *Psychological science*, 26(4), 433-443.
113. Hegelund, E. R., Okholm, G. T., & Teasdale, T. W. (2021). The secular trend of intelligence test scores in the present century: The Danish experience. *Intelligence*, 85, 101525.
114. Hein, S., Reich, J., Thuma, P. E., & Grigorenko, E. L. (2014). Physical growth and nonverbal intelligence: Associations in Zambia. *The Journal of Pediatrics*, 165(5), 1017-1023.
115. Hills, T. T., & Adelman, J. S. (2015). Recent evolution of learnability in American English from 1800 to 2000. *Cognition*, 143, 87-92.
116. Hiscock, M. (2007). The Flynn effect and its relevance to neuropsychology. *Journal of Clinical and Experimental Neuropsychology*, 29(5), 514-529.
117. Holmes, B. (2014). Stalled. *New Scientist*, 223(2983), 30-33.
118. Howard, R. W. (1999). Preliminary real-world evidence that average human intelligence really is rising. *Intelligence*, 27(3), 235-250.
119. Howard, R. W. (2001). Searching the real world for signs of rising population intelligence. *Personality and Individual Differences*, 30 (6), 1039-1058.
120. Howlin, P., Savage, S., Moss, P., Tempier, A., & Rutter, M. (2014). Cognitive and language skills in adults with autism: A 40-year follow-up. *Journal of Child Psychology and Psychiatry*, 55(1), 49-58.
121. Jokela, M., Pekkarinen, T., Sarvimäki, M., Terviö, M., & Uusitalo, R. (2017). Secular rise in economically valuable personality traits. *Proceedings of the National Academy of Sciences*, 201609994.
122. Jones, G., & Potrafke, N. (2014). Human capital and national institutional quality: Are TIMSS, PISA, and national average IQ robust predictors? *Intelligence*, 46, 148-155.
123. Juan-Espinosa, M., Cuevas, L., Escorial, S., & Garcia, L. F. (2006). The differentiation hypothesis and the Flynn effect. *Psicothema*, 18(2), 284- 287.
124. Kanaya, T., Ceci, S. J. (2007a). Are all IQ scores created equal? The differential costs of IQ cutoff scores for at- risk children. *Child Development Perspectives*, 1(1), 52-56.
125. Kanaya, T., Ceci, S. J. (2007b). Mental retardation diagnosis and the Flynn Effect: General intelligence, adaptive behavior, and context. *Child Development Perspectives*, 1(1), 62-63
126. Kanaya, T., Ceci, S. J. (2011). The Flynn Effect in the WISC subtests among school children tested for special education services. *Journal of Psychoeducational Assessment*, 29(2), 125-136.
127. Kanaya, T., & Ceci, S. J. (2012). The impact of the Flynn Effect on LD diagnoses in special education. *Journal of Learning Disabilities*, 45(4), 319-326.
128. Kanaya, T., Ceci, S. J., & Scullin, M. H. (2003). The rise and fall of IQ in special ed: Historical trends and their implications. *Journal of School Psychology*, 41(6), 453-465.
129. Kanaya, T., Ceci, S., & Scullin, M. H. (2005). Age differences within secular IQ trends: An individual growth modeling approach. *Intelligence*, 33, 613-621.

130. Kanaya, T., Scullin, M. H., & Ceci, S. J. (2003). The Flynn effect and US policies: The impact of rising IQ scores on American Society via mental retardation diagnoses. *American Psychologist*, 58(10), 778-790.
131. Kane, H. D. (2000). A secular decline in Spearman's g: evidence from the WAIS, WAIS-R and WAIS-III. *Personality and Individual Differences*, 29(3), 561-566.
132. Kane, H., & Oakland, T. D. (2000). Secular declines in Spearman's g: Some evidence from the United States. *Journal of Genetic Psychology*, 161(3), 337-345.
133. Karlsson, P., Thorvaldsson, V., Skoog, I., Gudmundsson, P., & Johansson, B. (2015). Birth cohort differences in fluid cognition in old age: Comparisons of trends in levels and change trajectories over 30 years in three population-based samples. *Psychology and Aging*, 30(1), 83.
134. Kaufman, A. S. (2010a). "In what way are apples and oranges alike?" A critique of Flynn's interpretation of the Flynn Effect. *Journal of Psychoeducational Assessment*, 28(5), 382-398.
135. Kaufman, A. S. (2010b). Looking through Flynn's rose-colored scientific spectacles. *Journal of Psychoeducational Assessment*, 28(5), 494-505.
136. Kaufman, A. S., Dillon, T., & Kirsch, J. W. (2013). "A beautiful theory, killed by a nasty, ugly little fact". *PsycCRITIQUES*.
137. Kaufman, K., & Weiss, L. (2010). Guest editors introduction to the special issue of JPA on the Flynn Effect. *Journal of Psychoeducational Assessment*, 28(5), 379-381.
138. Khaleefa, O., Abdelwahid, S. B., Abdulradi, F., & Lynn, R. (2008). The increase of intelligence in Sudan 1964- 2006. *Personality and Individual Differences*, 45(5), 412-413.
139. Khaleefa, O., Sulman, A., & Lynn, R. J. (2009). An increase in intelligence in Sudan, 1987-2007. *Journal of Biosocial Science*, 41(2), 279- 283.
140. Kirkegaard, E. O. (2014). The personal Jensen coefficient does not predict grades beyond its association with g. *Open Differential Psychology*.
141. Kirton, J. W., Soble, J. R., Marceaux, J. C., Messerly, J., Bain, K. M., Webber, T. A., ... & McCoy, K. J. (2020). Comparison of models of premorbid IQ estimation using the TOPF, OPIE-3, and Barona equation, with corrections for the Flynn effect. *Neuropsychology*, 34(1), 1-10.
142. Laciga, J., & Cígler, H. (2017). The Flynn effect in the Czech Republic. *Intelligence*, 61, 7-10.
143. Lanfranchi, S., & Carretti, B. (2012). The increase in Colored Progressive Matrices test performance in individuals with Down Syndrome: A qualitative and quantitative review. *Journal of Cognitive Education and Psychology*, 11(2), 143-158.
144. León, F. R., & León, A. B. (2014). Why complex cognitive ability increases with absolute latitude. *Intelligence*, 46, 291-299.
145. Light, M. L., & Chambers, W. R. (1958). A comparison of the Wechsler Adult Intelligence Scale and Wechsler-Bellevue II with mental defectives. *American Journal of Mental Deficiency*, 62, 878-881.
146. Liu, J., Yang, H., Tunong, C., & Lynn, R. (2012). An increase of intelligence measured by the WPPSI in China, 1984-2006. *Intelligence*, 40, 139-144.
147. Loehlin, J. C. (1997). Dysgenesis and IQ: What evidence is relevant? *American Psychologist*, 52(11), 1236-1239.
148. Lynn, R. (1977). Selective emigration and the decline of intelligence in Scotland. *Biodemography and Social Biology*, 24(3), 173-182.
149. Lynn, R. (1983). IQ in Japan and the United States shows a growing disparity. *Nature*, 306, 291-292.

150. Lynn, R. (1987). Japan: Land of the Rising IQ: A reply to Flynn. *Bulletin of the British Psychological Society*, 40, 464- 468.
151. Lynn, R. (1989). A nutrition theory of the secular increase in intelligence: Positive correlations between height, head size, and IQ. *British Journal of Educational Psychology*, 59, 372-377.
152. Lynn, R. (1990). The role of nutrition in secular increases in intelligence. *Personality and Individual Differences*, 11, 273- 285.
153. Lynn, R. (1992). Does Spearman's g decline at high IQ levels? *Journal of Genetic Psychology*, 153(2), 229-230.
154. Lynn, R. (1998). In support of the nutrition theory. In Ulric Neisser (Ed.), *The rising curve: Long-term gains in IQ and related measures* (pp. 207-218). Washington DC: American Psychological Association.
155. Lynn, R. (2009a). What has caused the Flynn effect? Secular increases in the Development Quotients of infants. *Intelligence*, 37(1), 16-24
156. Lynn, R. (2009b). Fluid intelligence but not vocabulary has increased in Britain, 1979–2008. *Intelligence*, 37(3), 249- 255.
157. Lynn, R. (2013). Who discovered the Flynn effect? A review of early studies of the secular increase of intelligence. *Intelligence*, 41(6), 765-769.
158. Lynn, R. (2015). Selective Intelligence, Roman Catholicism and the Decline of Intelligence in the Republic of Ireland. *Mankind Quarterly*, 55(3), 242.
159. Lynn, R., & Cooper, C. (1993). A secular decline in Spearman's g in France. *Learning and Individual Differences*, 5(1), 43-48.
160. Lynn, R., & Cooper, C. (1994). A secular decline in Spearman's g in Japan. *Current Psychology*, 13(1), 3-9.
161. Lynn, R., & Hampson, S. (1986). The rise of national intelligence: Evidence from Britain, Japan and the U.S.A. *Personality and Individual Differences*, 7, 23-32.
162. Lynn, R., & Harvey, J. (2008). The decline of the world's IQ. *Intelligence*, 36(2), 112-120.
163. Lynn, R., & Meisenberg, G. (2010). The average IQ of sub-Saharan Africans: Comments on Wicherts, Dolan, and van der Maas. *Intelligence*, 38, 21–29.
164. Lynn, R., & Pagliari, C. (1994). The intelligence of American children is still rising. *Journal of Biosocial Science*, 26(1), 65-67.
165. Madison, G., & Sanger, J. (2016). Secular slowing of auditory simple reaction time in Sweden (1959–1985). *Frontiers in human neuroscience*, 10, <https://doi.org/10.3389/fnhum.2016.00407>.
166. Matthews, L. J., & Turkheimer, E. (2017, in press). Flynn, the Age-Table Method, and a metatheory of intelligence. *Studies in History and Philosophy of Biological and Biomedical Sciences*.
167. McGrew, K. S. (2010). The Flynn Effect and its critics: Rusty linchpins and "lookin' for g and Gf in some of the wrong places". *Journal of Psychoeducational Assessment*, 28(5), 448-468.
168. McGrew, K. (2015). Norm obsolescence: The Flynn Effect. In Polloway, E. (Ed.), *The death penalty and intellectual disability* (pp.155-169). Washington, DC: American Association on Intellectual and Developmental Disabilities.
169. McKenzie, K., Milton, M., Smith, G., & Ouellette-Kuntz, H. (2016). Systematic review of the prevalence and incidence of intellectual disabilities: Current trends and issues. *Current Developmental Disorders Reports*, 3(2), 104-115.
170. McVaugh, G. S., & Cunningham, M. D. (2009). Atkins v. Virginia: Implications and recommendations for forensic practice. *The Journal of Psychiatry and Law*, 37, 131-187.

171. Meisenberg, G. (2014). What are the causes of cognitive evolution? A critique and extension of psychogenetic theory. *Mankind Quarterly*, 54(3/4), 326.
172. Meisenberg, G. (2015). Historical variability in heritable general intelligence: Its evolutionary origins and socio-cultural consequences. *Mankind Quarterly*, 55(4), 386.
173. Meisenberg, G., & Woodley, M. A. (2013). Are cognitive differences between countries diminishing? Evidence from TIMSS and PISA. *Intelligence*, 41(6), 808-816.
174. Millones, D. M., Flores-Mendoza, C., & Rivalles, R. M. (2015). Intelligence in Peru: Students' results in Raven and its relationship to SES. *Intelligence*, 51, 71-78.
175. Mingroni, M. A. (2004). The secular rise in IQ: Giving heterosis a closer look. *Intelligence*, 32, 65-83.
176. Mingroni, M. A. (2007). Resolving the IQ paradox: Heterosis as a cause of the Flynn effect and other trends. *Psychological Review*, 114(3), 806-829. [Correction]
177. Mingroni, M. A. (2014). Future efforts in Flynn Effect research: Balancing reductionism with holism. *Journal of Intelligence*, 2, 122-155.
178. Moore, R. B. (2006). Letter to the Editor: Modification of individual's IQ scores is not acceptable professional practice. *Psychology in Mental Retardation and Developmental Disabilities*, 32(3), 11-12.
179. Morgan, G. B. & Beaujean, A. A (2014). An investigation of growth mixture models for studying the Flynn Effect. *Journal of Intelligence*, 2, 156-179.
180. Must, O., & Must, A. (2013). Changes in test-taking patterns over time. *Intelligence*, 41(6), 780-790.
181. Must, O., & Must, A. (2018). Speed and the Flynn Effect. *Intelligence*, 68, 37-47.
182. Must, O., te Nijenhuis, J., Must, A., & A. van Vianen (2009). Comparability of IQ scores over time. *Intelligence*, 37, 25-33.
183. Must, O., & Must, A. (2018). Speed and the Flynn Effect. *Intelligence*, 68, 37-47.
184. Must, O., Must, A., & Mikk, J. (2016). Predicting the Flynn Effect through word abstractness: Results from the National Intelligence Tests support Flynn's explanation. *Intelligence*, 57, 7-14.
185. Must, O., Must, A., & Raudik, V. (2003). The secular rise in IQs: In Estonia, the Flynn effect is not a Jensen effect. *Intelligence*, 31(5), 461-471.
186. Nettelbeck, T., & Wilson, C. (2004). The Flynn effect: Smarter not faster. *Intelligence*, 32(1), 85-93.
187. Nettelbeck, T. (2014). Smarter but slower? A comment on Woodley, te Nijenhuis & Murphy (2013). *Intelligence*, 42, 1-4.
188. Neisser, U. (1998). *The rising curve: Long-term gains in IQ and related measures*. Washington, DC: American Psychological Association.
189. Neisser, U., Boodoo, G., Bouchard, T. J. Jr., Boykin, A. W., Brody, N., Ceci, S. J., Halpern, D. F., Loehlin, J. C., Perloff, R., Sternberg, R. J., & Urbina, S. (1996). Intelligence: Knowns and unknowns. *American Psychologist*, 51(2), 77-101.
190. Nijman, E. E., Scheirs, J. G. M., Prinsen, M. J. H., Abbink, C. D., & Blok, J. B. (2010). Exploring the Flynn effect in mentally retarded adults by using a nonverbal intelligence test for children. *Research in Developmental Disabilities*, 31(6), 1404-1411.
191. Norton, K., Watt, S., Gow, B., & Crowe, S. F. (2016). Are tests of premorbid functioning subject to the Flynn Effect? *Australian Psychologist*, 51(5), 374-379.
192. Nugent, S. (2016). *Forensic aspects of intellectual disabilities and autism spectrum disorders* (Doctoral dissertation, University of Nottingham).

193. Oesterdiekhoff, G. W. (2012). Was pre-modern man a child? The quintessence of the psychometric and developmental approaches, *Intelligence*, 40, 470-478.
194. Oi, K. (2017). Inter-connected trends in cognitive aging and depression: Evidence from the health and retirement study. *Intelligence*, 63, 56-65.
195. O'Keefe, P. & Rodgers, J. L. (2017). Double decomposition of level-1 variables in multilevel models: An analysis of the Flynn effect in the NSLY data. *Multivariate Behavioral Research*, <https://doi.org/10.1080/00273171.1354758>.
196. O'Keefe, P., & Rodgers, J. L. (2020). The Flynn effect can become embedded in tests: How cross-sectional age norms can corrupt longitudinal research. *Intelligence*, 82, 101481.
197. Passig, D. (2015). Revisiting the Flynn effect through 3D immersive virtual reality (IVR). *Computers & Education*, 88, 327-342.
198. Pietschnig, J. (2016). The Flynn Effect: Technology may be part of it, but is most certainly not all of it. *Measurement: Interdisciplinary Research and Perspectives*, 14(2), 70-73.
199. Pietschnig, J., Deimann, P., Hirschmann, N., & Kastner-Koller, U. (2021). The Flynn effect in Germanophone preschoolers (1996–2018): Small effects, erratic directions, and questionable interpretations. *Intelligence*, 86, 101544.
200. Pietschnig, J., & Gittler, G. (2015). A reversal of the Flynn effect for spatial perception in German-speaking countries: Evidence from a cross-temporal IRT-based meta-analysis (1977–2014). *Intelligence*, 53, 145-153.
201. Pietschnig, J., & Gittler, G. (2017). Is ability-based emotional intelligence impervious to the Flynn effect? A cross-temporal meta-analysis (2001–2015). *Intelligence*, 61, 37-45.
202. Pietschnig, J., Tran, U. S., & Voracek, M. (2013). Item-response theory modeling of IQ gains (the Flynn effect) on crystallized intelligence: Rodgers' hypothesis yes, Brand's hypothesis perhaps. *Intelligence*, 41(6), 791-801.
203. Pietschnig, J., & Voracek, M. (2015). One century of global IQ gains A formal meta-analysis of the Flynn Effect (1909–2013). *Perspectives on Psychological Science*, 10(3), 282-306.
204. Pietschnig, J., Voracek, M., & Formann, A. K. (2010). Pervasiveness of the IQ rise: A cross-temporal meta-analysis. *PloS One*, 5 (12).
205. Pietschnig, J., Voracek, M., & Formann, A. K. (2011). Female Flynn effects: No sex differences in generational IQ gains. *Personality and Individual Differences*, 50, 759-762.
206. Platt, J. M., Keyes, K. M., McLaughlin, K. A., & Kaufman, A. S. (2019). The Flynn effect for fluid IQ may not generalize to all ages or ability levels: A population-based study of 10,000 US adolescents. *Intelligence*, 77, 101385.
207. Pullmann, H., Allik, J., & Lynn, R. (2004). The growth of IQ among Estonian school children from ages 7 to 19. *Journal of Biosocial Science*, 36(6), 735-740.
208. Resing, W. C., & Tunteler, E. (2007). Children becoming more intelligent: Can the Flynn effect be generalized to other child intelligence tests? *International Journal of Testing*, 7(2), 191-208.
209. Reynolds, C. R., Niland, J., Wright, J. E., & Rosenn, M. (2010). Failure to Apply the Flynn Correction in Death Penalty Litigation: Standard Practice of Today Maybe, but Certainly Malpractice of Tomorrow. *Journal of Psychoeducational Assessment*, 28(5), 477-481.
210. Rindermann, H., & Becker, D. (2018). Flynn-effect and economic growth: Do national increases in intelligence lead to increases in GDP?. *Intelligence*, 69, 87-93.

211. Rindermann, H., Becker, D., & Coyle, T. R. (2017). Survey of expert opinion on intelligence: The Flynn effect and the future of intelligence. *Personality and Individual Differences*, 106, 242-247.
212. Rindermann, H., & Pichelmann, S. (2015). Future cognitive ability: US IQ prediction until 2060 based on NAEP. *PloS one*, 10(10), e0138412.
213. Rindermann, H., & Thompson, J. (2013). Ability rise in NAEP and narrowing ethnic gaps? *Intelligence*, 41(6), 821-831.
214. Rindermann, Schott, & Baumeister (2013). Flynn effect in Turkey: A comment on Kagitcibasi and Biricik (2011), *Intelligence*, 41, 178-180.
215. Rindermann, H., & te Nijenhuis, J. (2012). Intelligence in Bali—A case study on estimating mean IQ for a population using various corrections based on theory and empirical findings. *Intelligence*, 40, 395-400.
216. Rindermann, H., & Thompson, J. (2016). The cognitive competences of immigrant and native students across the world: An analysis of gaps, possible causes and impact. *Journal of biosocial science*, 48(1), 66-93.
217. Rodgers, J. L. (1999). A critique of the Flynn Effect: Massive IQ gains, methodological artifacts, or both? *Intelligence*, 26(4), 337-356.
218. Rodgers, J. L. (2014). Are birth order effects on intelligence really Flynn Effects? Reinterpreting Belmont and Marolla 40 years later. *Intelligence*, 42, 128-133.
219. Rodgers, J. L. (2015). Methodological issues associated with studying the Flynn Effect: Exploratory and confirmatory efforts in the past, present, and future. *Journal of Intelligence*, 3(4), 111-120.
220. Rodgers, J. L., & Wanstrom, L. (2007). Identification of a Flynn effect in the NLSY: Moving from the center to the boundaries. *Intelligence*, 35(2), 187-196.
221. Roivainen, E. (2012). Economic, educational, and IQ gains in eastern Germany 1990–2006. *Intelligence*, 40, 571–575.
222. Roivainen, E. (2014). Changes in word usage frequency may hamper intergenerational comparisons of vocabulary skills: An Ngram analysis of Wordsum, WAIS, and WISC test items. *Journal of Psychoeducational Assessment*, 32(1), 83–87
223. Rönnlund, M., Carlstedt, B., Blomstedt, Y., Nilsson, L.G. and Weinehall, L. (2013). Secular trends in cognitive test performance: Swedish conscript data 1970–1993. *Intelligence*, 41(1), 19-24.
224. Rönnlund, M., & Nilsson, L. G. (2008). The magnitude, generality, and determinants of Flynn effects on forms of declarative memory and visuospatial ability: Time-sequential analyses of data from a Swedish cohort study. *Intelligence*, 36(3), 192-209.
225. Rönnlund, M., & Nilsson, L. G. (2009). Flynn effects on sub-factors of episodic and semantic memory: Parallel gains over time and the same set of determining factors. *Neuropsychologia*, 47(11), 2174-2180.
226. Rowe, D. C., & Rodgers, J. L. (2002). Expanding variance and the case of historical changes in IQ means: A critique of Dickens and Flynn (2001). *Psychological Review*, 109(4), 759–763.
227. Rushton, J. P., & Jensen, A. R. (2006). The totality of available evidence shows the race IQ gap still remains. *Psychological Science*, 17(10), 921-922.
228. Rushton, J. P., & Jensen, A. R. (2010). The rise and fall of the Flynn Effect as a reason to expect a narrowing of the Black–White IQ gap? *Intelligence*, 38(2), 213- 219.
229. Russell, E. (2007). Commentary: The Flynn effect revisited. *Applied Neuropsychology*, 14(4), 262-266

230. Russell, E. (2010). Commentary: The "obsolescence" of assessment procedures. *Applied Neuropsychology*, 17, 60-67
231. Sanborn, K. J., Truscott, S. D., Phelps, L., & McDougal, J. L. (2003). Does the Flynn Effect differ by IQ level in samples of students classified as learning disabled? *Journal of Psychoeducational Assessment*, 21(2), 145-159.
232. Salthouse, T. A. (2015). Implications of the Flynn effect for age-cognition relations. *Intelligence*, 48, 51-57.
233. Scullin, M. H. (2006). Large state-level fluctuations in mental retardation classifications related to introduction of renormed intelligence test. *American Journal of Mental Retardation*, 111, 322-335.
234. Senechal, C., Larivee, S., Audy, P., & Engelbert, R. (2007). The Flynn effect and mental retardation. *Canadian Psychology/Psychologie Canadienne*, 48(4), 256-270.
235. Shaughnessy, M. F. (2012). An interview with Jim Flynn about the Flynn Effect. *North American Journal of Psychology*, 14(1), 25-38.
236. Shayer, M. (2008). Intelligence for education: As described by Piaget and measured by psychometrics. *British Journal of Educational Psychology*, 78, 1-29.
237. Shayer, M., & Ginsburg, D. (2009). Thirty years on-a large anti-Flynn effect? (II): 13- and 14-year-olds. Piagetian tests of formal operations norms 1976- 2006/7. *British Journal of Educational Psychology*, 79, 409-418.
238. Shayer, M., Ginsburg, D., & Coe, R. (2007). Thirty years on-a large anti-Flynn effect? The Piagetian test Volume & Heaviness norms 1975-2003. *British Journal of Educational Psychology*, 77, 25-41.
239. Shenk, D. (2017). What is the Flynn Effect, and how does it change our understanding of IQ?. *Wiley Interdisciplinary Reviews: Cognitive Science*, 8:e1366. doi: 10.1002/wocs.1366.
240. Shiu, W., Beaujean, A. A., Must, O., te Nijenhuis, J., & Must, A. (2013). An item-level examination of the Flynn effect on the National Intelligence Test in Estonia. *Intelligence*, 41(6), 770-779.
241. Silverstein, M. L., & Nelson, L. D. (2000). Clinical and research implications of revising psychological tests. *Psychological Assessment*, 12(3), 298-303.
242. Simon, C. L., & Clopton, J. R. (1984). Comparison of WAIS and WAIS-R scores of mildly and moderately mentally retarded adults. *American Journal of Mental Deficiency*, 89, 301-303.
243. Skirbekk, V., Stonawski, Bonsang, E., Staudinger, U. M. (2013). The Flynn effect and population aging. *Intelligence*, 41(3), 169-177.
244. Slater, L., & Daniel, M. (2019). A-79 Flynn Effect Correction: Accuracy Base Rate for IQ/Ability Level. *Archives of Clinical Neuropsychology*, 34(6), 939-939.
245. Smirnov, I. (2017, September). The Digital Flynn Effect: Complexity of Posts on Social Media Increases over Time. In *International Conference on Social Informatics* (pp. 24-30). Springer, Cham.
246. Spitz, H. H. (1983). Intratest and intertest reliability and stability of the WISC, WISC-R, and WAIS Full Scale IQs in a mentally retarded population. *The Journal of Special Education*, 17, 69-80.
247. Spitz, H. H. (1986). Disparities in mentally retarded persons' IQs derived from different intelligence tests. *American Journal of Mental Deficiency*, 90, 588-591.
248. Spitz, H. H. (1989). Variations in Wechsler interscale IQ disparities at different levels of IQ. *Intelligence*, 13, 157-167.
249. Spruill, J., & Beck, B. L. (1988). Comparison of the WAIS and WAIS-R: Different results for different IQ groups. *Professional Psychology: Research and Practice*, 19, 31-34

250. Staff, R. T., Hogan, M. J., & Whalley, L. J. (2014). Aging trajectories of fluid intelligence in late life: The influence of age, practice and childhood IQ on Raven's Progressive Matrices. *Intelligence*, 47, 194-201.
251. Staudinger, U. M. (2015). Images of aging: Outside and inside perspectives. *Annual Review of Gerontology and Geriatrics*, 35(1), 187-209.
252. Steiber, N. (2015). Population aging at cross-roads: Diverging secular trends in average cognitive functioning and physical health in the older population of Germany. *PloS one*, 10(8), e0136583.
253. Sternberg, R. J. (2010). The Flynn Effect: So what? *Journal of Psychoeducational Assessment*, 28(5), 434-440.
254. Sundet, J. M. (2014). The Flynn Effect in families: Studies of register data on Norwegian military conscripts and their families. *Journal of Intelligence*, 2, 106-118.
255. Sundet, J. M., Barlaug, D. G., & Torjussen, T. M. (2004). The end of the Flynn effect? A study of secular trends in mean intelligence test scores of Norwegian conscripts during half a century. *Intelligence*, 32, 349-362.
256. Sundet, J. M., Borren, I., & Tambs, K. (2008). The Flynn effect is partly caused by changing fertility patterns. *Intelligence*, 36(3), 183-191.
257. Sundet, J. M., Eriksen, W., Borren, I., & Tambs, K. (2010). The Flynn effect in sibships: Investigating the role of age differences between siblings. *Intelligence*, 38, 38-44.
258. Tampubolon, G. (2015). Cognitive ageing in Great Britain in the new century: Cohort differences in episodic memory. *PloS one*, 10(12), e0144907.
259. te Nijenhuis, J. T. (2013). The Flynn Effect, group differences, and g loadings. *Personality and Individual Differences*, 55, 224-228.
260. te Nijenhuis, J., Bakhtiet, S.F., van den Hoek, M., Repko, J., Allik, J., Žebec, M.S., Sukhanovskiy, V. and Abduljabbar, A.S. (2016). Spearman's hypothesis tested comparing Sudanese children and adolescents with various other groups of children and adolescents on the items of the Standard Progressive Matrices. *Intelligence*, 56, 46-57.
261. te Nijenhuis, J., Batterjee, A. A., Van Den Hoek, M., Allik, J., & Sukhanovskiy, V. (2017). Spearman's hypothesis tested comparing Saudi Arabian children and adolescents with various other groups of children and adolescents on the items of the Standard Progressive Matrices. *Journal of Biosocial Science*, 49(5), 634-647.
262. te Nijenhuis, J. T., Cho, S. H., Murphy, R., Lee, K. H. (2012). The Flynn effect in Korea: Large gains. *Personality and Individual Differences*, 53(2), 147-151.
263. te Nijenhuis, J., Jongeneel-Grimen, B., & Kirkegaard, E. O. (2014). Are Headstart gains on the g factor? A meta-analysis. *Intelligence*, 46, 209-215.
264. te Nijenhuis, J. T., Murphy, R., & van Eeden, R. (2011). The Flynn effect in South Africa. *Intelligence*, 39(6), 456- 467.
265. te Nijenhuis, J. T., & van der Flier, H. (2007). The secular rise in IQs in the Netherlands: Is the Flynn effect on g? *Personality and Individual Differences*, 43(5), 1259-1265.
266. te Nijenhuis, J. T., & van der Flier, H. (2013). Is the Flynn effect on g? A meta analysis. *Intelligence*, 41, 802- 807.
267. Teasdale, T. W. (2009). The Danish Draft Board's intelligence test, Børge Priens Prøve: Properties and research applications through 50 years. *Scandinavian Journal of Psychology*, 50(6), 633-638.
268. Teasdale, T. W., & Owen, D. R. (2000). Forty-year secular trends in cognitive abilities. *Intelligence*, 28 (2), 115-120.

269. Teasdale, T. W., & Owen, D. R. (2005). A long-term rise and recent decline in intelligence test performance: The Flynn Effect in reverse. *Personality and Individual Differences*, 39(4), 837-843.
270. Teasdale, T. W., & Owen, D. R. (2008). Secular declines in cognitive test scores: A reversal of the Flynn Effect. *Intelligence*, 36(2), 121-126.
271. Thomas, D. (2016). Racial IQ differences among transracial adoptees: Fact or artifact? *Journal of Intelligence*, 5(1), 1.
272. Trahan, L. H., Stuebing, K. K., Fletcher, J. M., & Hiscock, M. (2014). The Flynn Effect: A Meta-analysis. *Psychological Bulletin*, 140(5), 1332-1360.
273. Truscott, S. D., & Frank, A. J. (2001). Does the Flynn effect affect IQ scores of students classified as LD? *Journal of School Psychology*, 39(4), 319-334.
274. Tuddenham, R. D. (1948). Soldier intelligence in World Wars I and II. *American Psychologist*, 3, 54-56.
275. Twenge, J. M., Campbell, W. K., & Sherman, R. A. (2019). Declines in vocabulary among American adults within levels of educational attainment, 1974–2016. *Intelligence*, 76, 101377.
276. van der Maas, H. L., & Kan, K. J. (2016). Comment on "Residual group-level factor associations: Possibly negative implications for the mutualism theory of general intelligence" by Gilles E. Gignac (2016). *Intelligence*, 57, 81-83.
277. Vaivre-Douret, L. (2011). Developmental and cognitive characteristics of "high-level potentialities" (highly gifted) children. *International journal of pediatrics*, 2011.
278. Voracek, M. (2006). Phlogiston, fluid intelligence, and the Lynn-Flynn effect. *Behavioral and Brain Sciences*, 29(2), 142+.
279. Wai, J., & Putallaz, M. (2011). The Flynn effect puzzle: A 30-year examination from the right tail of the ability distribution provides some missing pieces. *Intelligence*, 39(6), 443-455.
280. Watt, S., Gow, B., Norton, K., & Crowe, S. F. (2016). Investigating discrepancies between predicted and observed Wechsler Adult Intelligence Scale-Version IV Full-Scale intelligence quotient scores in a non-clinical sample. *Australian Psychologist*, 51(5), 380-388.
281. Weber, D., Dekhtyar, S., & Herlitz, A. (2017). The Flynn effect in Europe—Effects of sex and region. *Intelligence*, 60, 39-45.
282. Weiss, L. G. (2007). Response to Flynn. *WAIS-III Technical Report*. San Antonio: Harcourt Assessments.
283. Weiss, L. G. (2010). Considerations on the Flynn Effect. *Journal of Psychoeducational Assessment*, 28(5), 482-493.
284. Weiss, L. G., Gregoire, J., & Zhu, J. (2016). Flaws in Flynn Effect research with the Wechsler scales. *Journal of Psychoeducational Assessment*, 34(5), 411-420.
285. Wicherts, J. M. (2008). Review of What is intelligence? Beyond the Flynn effect. *Netherlands Journal of Psychology*, 64(1), 41-43.
286. Wicherts, J. M. (2016). The importance of measurement invariance in neurocognitive ability testing. *The Clinical Neuropsychologist*, 30(7), 1006-1016.
287. Wicherts, J. M., Borsboom, D., & Dolan, C. V. (2010a). Why national IQs do not support evolutionary theories of intelligence. *Personality and Individual Differences*, 48(2), 91-96.
288. Wicherts, J. M., Borsboom, D., & Dolan, C. V. (2010b). Evolution, brain size, and the national IQ of peoples around 3000 years B.C. *Personality and Individual Differences*, 48(2), 104-106.

289. Wicherts, J. M., Dolan, C. V., Carlson, J. S., & van der Maas, H. L. J. (2010). Raven's test performance of sub-Saharan Africans; mean level, psychometric properties, and the Flynn Effect. *Learning and Individual Differences*, 20 (3), 135-151.
290. Wicherts, J. M., Dolan, C. V., Hessen, D. J., Oosterveld, P., vanBaal, G. C. M., Boomsma, D. I., & Span, M. M. (2004). Are intelligence tests measurement invariant over time? Investigating the nature of the Flynn effect. *Intelligence*, 32(5), 509-537.
291. Wicherts, J. M., Dolan, C. V., & van der Maas, H. L. J. (2010a). A systematic literature review of the average IQ of sub-Saharan Africans. *Intelligence*, 38, 1-20.
292. Wicherts, J. M., Dolan, C. V., & van der Maas, H. L. J. (2010b). The dangers of unsystematic selection methods and the representativeness of 46 samples of African test-takers [rejoinder to Lynn, & Meisenberg, 2010]. *Intelligence*, 38, 30-37.
293. Widaman, K. (2007). Stalking the roving IQ score cutoff: A commentary on Kanaya and Ceci (2007). *Child Development Perspectives*, 1(1), 57-59.
294. Williams, R. L. (2013). Overview of the Flynn effect. *Intelligence*, 41(6), 753-764.
295. Williams, W. M., & Ceci, S. J. (1997). Are Americans becoming more or less alike? Trends in race, class, and ability differences in intelligence. *American Psychologist*, 52(11), 1226-1235.
296. Wongupparaj, P., Kumari, V., & Morris, R. G. (2015). A cross-temporal meta-analysis of Raven's Progressive Matrices: Age groups and developing versus developed countries. *Intelligence*, 49, 1-9.
297. Wongupparaj, P., Kumari, V., & Morris, R. G. (2020). IQ score gains over 65 years worldwide: Cross-temporal meta-analysis datasets. *Data in Brief*, 28, 104884.
298. Woodley, M. A. (2011). Heterosis doesn't cause the Flynn Effect: A critical examination of Mingroni (2007). *Psychological Review*, 118(4), 689-693.
299. Woodley, M. A. (2012a). A life history model of the Lynn-Flynn effect. *Personality and Individual Differences*, 53(2), 152-156.
300. Woodley, M. A. (2012b). The social and scientific temporal correlates of genotypic intelligence and the Flynn effect. *Intelligence*, 40(2), 189-204.
301. Woodley, M. A. (2015). How fragile is our intellect? Estimating losses in general intelligence due to both selection and mutation accumulation. *Personality and Individual Differences*, 75, 80-84.
302. Woodley, M. A. (2016). Consideration of cognitive variance components potentially solves Beauchamp's paradox. *Proceedings of the National Academy of Sciences*, 113(40), E5780-E5781.
303. Woodley, M. A., & Figueredo, A. J. (2014). The biosocial model of the rise of Western civilization: a counter-point to Oosterdiekhoff (2013). *Mankind Quarterly*, 54(3/4), 342.
304. Woodley, M. A., & Fernandes, H. B. (2015). Do opposing secular trends on backwards and forwards digit span evidence the co-occurrence model? A comment on Gignac (2015). *Intelligence*, 50, 125-130.
305. Woodley, M. A., Fernandes, H. B., Figueredo, A. J., & Meisenberg, G. (2015). By their words ye shall know them: Evidence of genetic selection against general intelligence and concurrent environmental enrichment in vocabulary usage since the mid 19th century. *Frontiers in Psychology*, 6.
306. Woodley, M. A., & Meisenberg, G. (2013). In the Netherlands the anti-Flynn effect is a Jensen effect. *Personality and Individual Differences*, 54(8), 871-876.
307. Woodley, M. A., te Nijenhuis, J., & Murphy, R. (2013). Were the Victorians cleverer than us? The decline in general intelligence estimated from a meta-analysis of the slowing of simple reaction time. *Intelligence*, 41(6), 843-850.

308. Woodley, M. A., te Nijenhuis, J., & Murphy, R. (2014). Is there a dysgenic secular trend towards slowing simple reaction time? Responding to a quartet of critical commentaries. *Intelligence*, 46, 131-147.
309. Woodley, M. A., te Nijenhuis, J., Must, O., & Must, A. (2014). Controlling for increased guessing enhances the independence of the Flynn effect from g: The return of the Brand effect. *Intelligence*, 43, 27-34.
310. Woodley, M. A. W., Peñaherrera, M. A., Fernandes, H. B., Becker, D., & Flynn, J. R. (2016). It's getting bigger all the time: Estimating the Flynn effect from secular brain mass increases in Britain and Germany. *Learning and Individual Differences*, 45, 95-100.
311. Woodley M. A.; Peñaherrera-Aguirre, M. Fernandes, H. B. F.; Figueredo, A-J. (2017). What Causes the Anti-Flynn Effect? A Data Synthesis and Analysis of Predictors. *Evolutionary Behavioral Sciences*. <http://dx.doi.org.ezp2.lib.umn.edu/10.1037/ebs0000106>.
312. Worrell, F. C., & Erwin, J. O. (2011). Best practices in identifying students for gifted and talented education programs. *Journal of Applied School Psychology*, 27(4), 319-340.
313. Young, G. W. (2012). A more intelligent and just *Atkins*: Adjusting for the Flynn effect in capital determinations of mental retardation or intellectual disability. *Vanderbilt Law Review*, 65, 615-755.
314. Young, B., Boccaccini, M. T., Conroy, M. A., & Lawson, K. (2007). Four practical and conceptual assessment issues that evaluators should address in capital case mental retardation evaluations. *Professional Psychology: Research and Practice*, 38, 169-178.
315. Zajonc, R. B., & Mullally, P. R. (1997). Birth order: Reconciling conflicting effects. *American Psychologist*, 52(7), 685-699.
316. Zhou, X. B., Zhu, J. J., & Weiss, L. G. (2010). Peeking inside the "black box" of the Flynn Effect: Evidence from three Wechsler instruments. *Journal of Psychoeducational Assessment*, 28(5), 399-411.
317. Zysberg, L. (2019). The Reversal of the Flynn Effect and Its Reflection in the Educational Arena: Data Comparison and Possible Directions for Future Research and Action. *Roczniki Pedagogiczne*, 11(3), 147-157.

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June 12, 2024

Ms. Tiffany Scott
Law Clerk to
Honorable Robert E. Hood
Fifth Judicial Circuit
Richland County Judicial Center

RE: Gary Dubose Terry
2022-CP-32-00924

Enclosed for filing, please find the Atkins Evaluation Report as required by Judge Hood's Order dated April 24, 2023. By copy of this letter, we will also provide Counsel with a copy of the Atkins Evaluation Report.

If you have any questions please feel free to contact me at (803) 898-9694 (ahall@ddsn.sc.gov) or Carolyn Benzon, DDSN General Counsel, at (803) 898-9284 (carolyn.benzon@ddsn.sc.gov).

Sincerely,

Alicia V. Hall, PhD
Psychologist II
Office of Clinical Services
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cc: Ali Franz, Esq., Justice 360
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EVALUATION FOR THE PRESENCE OF MENTAL RETARDATION/INTELLECTUAL DISABILITY PURSUANT TO ATKINS v. VIRGINIA

Name	Gary Dubose Terry	Gender	Male
Dates of Evaluation	2/28/2024, 3/21/2024 & 4/25/2024	Race	Caucasian
Place of Evaluation	SCDDSN Midlands Center	Date of Birth	12/1/1967
		Age	56 years

Examiner: Alicia V. Hall, Ph.D.
Licensed Clinical Psychologist

PURPOSE OF EVALUATION

This evaluation was conducted pursuant to the United States Supreme Court's decision in *Atkins v. Virginia*, 536 US 304 (2002). As such, the South Carolina Department of Disabilities and Special Needs (DDSN) was required to evaluate Mr. Terry to determine whether he has an Intellectual Disability. The evaluation was necessary because the Applicant Gary Dubose Terry, "is proceeding in a successive post-conviction relief (PCR) action to determine whether he is intellectually disabled. If Applicant is intellectually disabled, the Eighth Amendment prohibits his execution." See *Atkins; Franklin v Maynard*, 356 S.C. 276, 588 S.E.2d 604 (2003). The standard to be used in this evaluation is established in the *Franklin* ruling as the definition provided in S.C. Code Ann. § 16-3-20 (C)(b)(10) (2003) for mental retardation which is "significant subaverage general intellectual functioning existing concurrently with deficits in adaptive behavior and manifested during the developmental period."

LIMITS OF CONFIDENTIALITY

Before the interview started, Mr. Terry was advised of the purpose of the evaluation, and that the results and content of the evaluation would be communicated to his attorney(s), the SC Attorney General's Office, and the judge. In addition, he was informed of the possibility that the examiner might be called to testify regarding the content and results of the evaluation.

EVALUATION PROCEDURES

Mr. Terry was interviewed for approximately three hours on 2/28/2024 & 3/21/2024, by the undersigned. The Wechsler Adult Intelligence Scale - Fourth Edition (WAIS-IV) and the Montreal Cognitive Assessment were administered on 4/25/2024 by Jessica Davis, PsyD, requiring approximately three hours in total.

SOURCES OF INFORMATION

Order for Intellectual Disability Evaluation Pursuant to Applicant's Atkins v. Virginia Claim dated 4/24/2023

Records from South Carolina Department of Corrections, dated 1998-2012

Social History Questionnaire

SC State Supreme Court Appeal Terry v. South Carolina

Record on Appeal

South Carolina Supreme Court's Opinion Filed March 13, 2000

Filed Order of Dismissal

South Carolina Supreme Court's Opinion Filed August 29, 2011

Report and Recommendation Filed January 31, 2019

Order and Opinion of the United States District Court Filed September 26, 2019

Unpublished Opinion of the United States Court of Appeals Filed May 5, 2021

Affidavits

Jan Vogelsang CSW dated 6/25/2012

Patricia Terry (mother) dated 5/22/2012

Faye Terry Servoss (sibling) dated 5/24/2012

Charles Binson Register (maternal uncle) dated 5/15/2012

Donna Schwartz Watts, MD dated 6/28/2012

Birth Certificate of Gary D. Terry

Medical Records

Richland Memorial Hospital

Charter Three Rivers 8/21/1994-8/30/1994

USC Neurology Consultation note dated 2/23/2021**

Baylor Genetics WGS testing results

Letter from Christopher Cunniff, MD dated 10/18/2022

Lexington Medical Center

Trident Regional Medical Center

Tri-County Radiology North Charleston

The Cancer Center at South Carolina Oncology Associates

Richland Hospital

Employment Records

Employment Summary undated

Letter from Giant Food World dated 8/13/1997

Fax from Davey Tree Company

SC Department of Motor Vehicles records

Gary D. Terry's National Crime Information Center criminal history record

SCDC Records

Medical Records 1988-1990, 1998-2023

Inmate Infraction Records

Inmate Grievance Forms

Inmate Grievance Applications

Warden's Jacket

Central Records

Inmate Messaging System Messages 4/4/2019-4/11/2023 & 5/23/2024-6/8/2023

Divorce Decree (Terry v. Griffin) dated 2/27/1987

Marriage License (Terry & Smith) dated 6/6/1988

Interviews

LouAnne Terry ex-wife on 1/15/2024

Patricia Terry, mother, dated 1/16/2024

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School Records including

Application for admission dates 8/21/1974
Elementary School Record Richland County School District dates 1974-1980
South Carolina Cumulative School Health Record
Preventive Procedures-Inoculations and Special Test form
Middle School Record Richland County School District 1980-1983
High School Record Richland County School District 1983-1984
Handwritten Note from Ep. Elise Harris dated 8/3/1984
Information Change Form dated 1/06/1984
Information Change Form dated 5/29/1984
Information Change Form dated 11/1/1983
Information Change Form dated 11/8/1982
Handwritten Note from Ep. Harris dated 11/1/1982
Handwritten Letter from Mrs. Terry to Barbara Bradford dated 10/19/1983
Handwritten Letter from Mrs. Terry to Elsie Harris dated 10/25/1982
Handwritten note form CT undated
Richland County School District IEP Form 1 dated 11/8/1983
Richland County School District IEP Form 2 dated 12/5/1983
Review Committee Report dated 11/1/1983
Letter from Richland County School District One to Mrs. Terry dates 11/2/1983
Letter from Richland County School District One to Mrs. Terry dates 11/2/1983
Richland County School District IEP Form 1 undated
Richland County School District IEP Form 2 dated 9/1983 -5/1984
Richland County School District IEP Form 1 4/1982
Richland County School District IEP Form 2 dated 8/1982 -5/1983
Handwritten Letter from Mrs. Terry to Elise Harris dated 10/25/1982
Richland County School District IEP Form 2 dated 9/1981 -5/1982*
Richland County School District IEP Form 1 5/1980
Richland County School District IEP Form 2 dated 9/1980 -5/1981
Richland County School District IEP Form 2 dated 8/1979 -5/1980*
Notification of Re-Evaluation Results dated 4/23/1982
Psychological Report Re-Evaluation 4/23/1982
Placement Form dated 4/28/1982
Placement Form dated 5/09/1979
Richland County School District One Referral For Special Services dated 11/13/1978
Columbia Public Schools Psychological Report dated 3/20/1979
Richland County School District One Notice of Evaluation Results dated
Richland County School District One Permission for Placement date 5/9/1979
Parent Conference Information & Request of Psychological Services dated 3/6/1979
Education History & Parent Conference Information Forms dated 11/6/1978
Richland County School District One Vision/Hearing Screening dated 9/13/1978
Richland County School District One Speech Therapy Screening dated 11/9/1978

Mr. Terry's Family records

Family Tree
Psychoeducational Records for Ashley Hobbs (daughter)
Psychoeducational Records for Jeffery Dubose Griffin (son)
School Records for Morgan Terry (son)
School Records for Billy Ray Terry Jr (sibling)
School Records for Patricia Faye Terry (sibling)

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School Records for John David Terry (sibling)
School Records for Elaine Jane Terry (sibling)
Medical Records for Patricia Register (mother)
Richland County School District One Official Transcript for Patricia Baker Terry (mother)
Richland County School District One Official Transcript for Bill Ray Terry Sr. (father)
Employment History for Bill Ray Terry Sr. (father)
Patricia Terry's Diaries dated 1980-1996

*Record was illegible due to smoke and water damage from a fire.

**Record was incomplete only the front page was provided

TESTS ADMINISTERED

Wechsler Adult Intelligence Scale - Fourth Edition (WAIS-IV)
Montreal Cognitive Assessment

RELEVANT HISTORY

History in this section is as provided by Mr. Terry in the interview on 2/28/2024 and 3/21/2024 and supplemented by available records. He appeared to be a good historian. Mr. Terry is currently incarcerated on death row at Kirkland Correctional Institution in Columbia, Richland County, South Carolina. He is serving his sentence after being convicted of Murder, Burglary First Degree, Criminal Sexual Conduct First Degree and Malicious Injury to telephone system.

SOCIAL HISTORY

Mr. Terry is a 56-year-old Caucasian male. He was born and raised in Columbia, SC. He reported he was raised in a two-parent home, by his biological parents Bill Ray Sr. and Patricia Terry. His father is deceased. Both parents worked outside of the home to support the family until Mr. Terry Sr. got injured on the job and began collecting Social Security Disability Insurance. Mrs. Terry continued to work, while her husband continued to contribute by doing odd jobs, like selling scrap metal. Mr. Terry reported he has two brothers and two sisters. He stated he is the youngest child of five siblings. In a Parent Conference Information form (11/6/1978), the applicant's mother reported he was born without complications and reached his early developmental milestones in a timely manner. He described his relationship with his mother and Faye as close. He reported a "pretty close" relationship with his brother Billy Jr. and an "off and on relationship" with his brother Johnny. Mr. Terry reported he experienced physical and sexual abuse while growing up in the family household. He stated his father was often physically violent with him and his siblings. His report was confirmed by his mother in her interview with the undersigned as well as the affidavits from his sister and maternal uncle. He reported he experienced sexual abuse by his older brother. He could not recall how long the sexual abuse occurred, but related it ended "when I was nine or ten years old." The abuse stopped because Mr. Terry's father witnessed the abuse.

Mr. Terry reported he moved out of the family home when he was approximately 18 years old. He stated he moved in with his brother Billy. He stated he has lived independently with his second wife, LouAnne Smith, and a female friend Gloria. He related he assisted Gloria around the house because she was in a wheelchair. However, Mr. Terry has been incarcerated for most of his adult life. Currently, he is housed in a death row facility at the Kirkland Correctional Institution in Columbia, Richland County, South Carolina.

Mrs. Patricia Terry stated her son was born on time. She reported he reached his developmental milestones on time. She recalled her son refused to dress himself until he was 9 years old. But was responsible for various chores in the house as a child. She reported Mr. Terry was responsible for washing dishes, sweeping the floor, making his bed, helping his father with carpentry and mechanics, and doing his laundry. She related he was able to complete his assigned chores independently. She reported he got his first job at a local gas station when he was 16 years old. She stated he was hired when he asked the owner if he could work there. Mrs. Terry reported

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she and her son had a close relationship. She described his relationship with his father as difficult. In her estimation, her husband was very hard on their sons, especially Gary. She stated she believed Gary was singled out more than his brothers because it took him longer to catch on when his father was teaching him to do something. Mrs. Terry said, "Gary would be slow to get it but once he got it, he got it." She also reported the dad was abusive. She said, "if the boys didn't do what her husband wanted, he would beat them." She related this behavior continued even into their teens when her husband would hit them with his fist.

Regarding social relationships, Mrs. Terry reported her son tended to stay to himself. He enjoyed tinkering with stuff and building things. She stated he liked to work on things until he figured it out. She recalled, if given enough time, her son would always figure it out. Ms. LouAnne Smith, Mr. Terry's ex-wife, agreed he didn't have a lot of friends. She recalled he mentioned people he said he hung out with, but she never met those people. She recalled Mr. Terry spent time hanging out with his sister Faye and his brother Billy. She reported he would try to hang out with his father, but it would not last long because his father would criticize him. She described her ex-husband as "sensitive to criticism." She stated he was quick to anger if he was called stupid. She went on to say that Mr. Terry wanted to impress people. She stated his need to impress led to "a lot of times, when he would say he would do things and brag and then have to get bailed out."

EDUCATIONAL HISTORY

Mr. Terry reported he did not graduate from high school. He recalled he dropped out in the 9th grade. He stated he dropped out because "Tammy was pregnant." School records confirm he dropped out of high school during his 9th grade year. He stated he was a special education student. He reported he was in special education "for some of my classes." He related he struggled with many subjects in school but excelled at more "mechanical" subjects like Auto Shop. He believes he would have failed if his teacher didn't allow him to earn extra credit by working on his car. He denied he exhibited behavioral problems in school. He reported since being incarcerated, he tried to continue his education by earning his GED. Mr. Terry stated he attempted twice to complete the GED course. He reported he asked another inmate to tutor him on the material, but to no avail. Mr. Terry said, "Both guys [tutors] tried but gave up on me after a while."

The available school records show Mr. Terry's academic performance in the 1st through 5th grades was varied. He was required to repeat the 5th grade because his effort in his core subjects (except Language Arts) was marked "Unsatisfactory," and his progress "Needs Improvement." Starting in the 2nd grade, Mr. Terry was administered the McGraw-Hill Comprehensive Tests of Basic Skills (CTBS). The CTBS is a nationally standardized achievement test administered to all students in school. The scores were incomplete in the 2nd and 3rd grades. It appears Mr. Terry completed the entire test in the 4th and 5th grades. The results indicated that performance was consistently below grade in all of his subjects. When compared to other 4th and 5th graders, Mr. Terry's Language NP score was amongst his lowest scores. (*The National Percentile score ranks raw scores from highest to lowest and shows where an individual's raw score falls in comparison. The lowest score that is reported is 1; the highest is 99.*) The results of the CTBS are presented in the table below:

Grade	4 th (1978)			5 th (1979)			5 th (1980)		
Subject	SS	GE	NP	SS	GE	NP	SS	GE	NP
Reading	335	-	14	324	2.6	06	388	3.9	20
Language	285	-	02	311	2.1	02	333	2.4	04
Mathematics	281	-	03	349	3.4	11	396	4.7	28
Total Battery	250	-	03	303	2.8	05	350	3.6	26

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It appears that Mr. Terry was referred by his teacher for "possible special education class placement" in 1979, the end of his first attempt to pass the 5th grade. A psycho-educational report dated 3/20/1979 indicated the applicant's teacher requested the evaluation because she "noted some academic difficulties" and "he is withdrawn from rest of the class." The results of the evaluation showed that "Gary placed within the average range of intellectual ability. Discrepancies in achievement which meet the district guidelines for inclusion in the learning disability." Thus, Mr. Gary was classified as a student with a Learning Disability (LD). (*LD is a disorder in one or more of the basic psychological processes involved in understanding or in using language, spoken, or written, that may manifest itself in the imperfect ability to listen, think, speak, read, write, spell, or to do mathematical calculations, including conditions such as perceptual disabilities, brain injury, minimal brain dysfunction, dyslexia, and developmental aphasia...Learning Disability does not include learning problems that are primarily the result of: ...intellectual disability...*). The school psychologist, Tommie Wicker, MA, recommended Mr. Terry remain in regular education class with two periods in the resource room daily. Instead of being placed in the special education resource program, it appears from the record that Mr. Terry was retained in the 5th grade. This seems to confirm Mrs. Terry recollection of her son's evaluation for special education. She recalled a teacher named Fitzgerald and she was adamant that "Gary was a slow learner but was not retarded." She and Ms. Fitzgerald believed Mr. Terry needed to get more individual attention in the class. He appeared to benefit from the attention. His grades improved and test scores improved. He was promoted to the 6th grade the following year.

Mr. Terry's middle school records show he continued to struggle in English class in the 6th grade. He earned an "F" in all four marking periods in his English class. He was re-evaluated in the 7th grade. The results continued to show Mr. Terry met criteria for special education services as a student with a Learning Disability. According to his Individualized Education Program (IEP), he was placed in the general education program for most of his academic day. The remaining 2 class periods were spent in a resource class (*i.e. a remedial classroom where students with educational disabilities, such as specific learning disabilities, are given direct, specialized instruction, academic remediation, assistance with homework and related assignments individually or in groups*) to address his deficits in reading, math, and spelling. It appears Mr. Terry benefited from the resource services he received. According to the Richland County School District IEP Form 1 (4/1982), his standardized academic testing improved from his previous years. His grade equivalent scores on the CTBS were Reading=8.1, Spelling=3.3, and Math=5.6. He was also administered the Peabody Individual Achievement Test. The scores are also reported as grade equivalents. Mr. Terry Reading Recognition= 5.5, Reading Comprehension=8.8, Spelling=4.2 and Math=9.6. His special education teacher noted, Mr. Terry's strength was his "ability to handle abstract ideas," whereas, his "short attention span" was a weakness. He was doing well so he was mainstreamed to regular education setting. Mr. Terry's transition to the general education setting was unsuccessful. His attendance and academic performance suffered, so much so, that on 10/25/1982, Mrs. Terry wrote to Mrs. Harris requesting Mr. Terry be returned to the resource program. Mrs. Terry wrote, "Gary's whole attitude has changed, he has come to me and stated that he was failing... Gary just seems to be at loose ends, his schoolwork, and his belief in himself is fast doing downhill. So [sic], I'm asking you to please put him back in the resource classes before things get worse than they are now." He was returned to the resource program.

Mr. Terry was assigned to attend Eau Claire High School. The record indicates that he was absent 20 of the first 72 days of the school year, resulting in his failing most of his classes. His performance was very concerning to his mother. She wrote to Mrs. Barabra Bradford, Director of Special Education, to request her son be transferred to C.A. Johnson High School. According to the records, the resource program at C.A. Johnson High School did not have room for him. The transfer was approved by the district on 11/1/1983. He was transferred to Columbia High School. Unfortunately, the change in school did not increase Mr. Terry's attendance or academic performance. As a result, he was withdrawn from Columbia High School on 5/29/1984.

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EMPLOYMENT HISTORY

Mr. Terry reported a history of being gainfully employed. He reported he has worked in a variety of blue-collar jobs including, auto mechanic, stocker/bag boy at the Piggly Wiggly, and a junk yard. He reported he started his Repo business at the age of 25. He stated he sent fliers out to car dealerships to introduce his services. Mr. Terry stated he was very successful in the repo business because he was good at "getting people to pay their bill." He related the dealerships like to use his services because they would rather have the money than the car. He stated he ran the day-to-day operations, but his then wife LouAnne completed the paperwork required to run the business. She worked full time as a schoolteacher and kept his books at night. LouAnne Smith Terry confirmed his report during her interview with the undersigned. Mr. Terry said he ran the business until he was shot. As he recovered, he allowed his cousin to repo the cars for him, but his cousin stole the money instead which caused his business to lose his contracts with the dealerships. Mr. Terry stated he was going to start a construction company in Tennessee with a friend, but he was arrested before he could move there.

LouAnne Smith Terry reported her ex-husband was employed during their marriage, but she recalled he would not remain employed for long. She stated he would typically earn a couple of pay checks, then he would be fired for not showing up for work or getting angry at someone at work. She recalled the longest employment was four or five months at an engine shop. She reported when he was not working, he would watch tv, sleep, and run the streets. She said he would frequently take her car and be gone for hours, sometimes leaving her without transportation to get to work.

RELATIONSHIP HISTORY

Mr. Terry reported he is currently single. He has been married three times. His first marriage occurred when he was 17. He married Tammy Griffin on 5/31/1985. Mr. Terry reported they were married in secret. He never lived with his first wife. He and Ms. Griffin had one child, Jeffery Dubose Griffin. According to the divorce decree, the marriage was dissolved on 2/27/1987. A short time later Mr. Terry married his second wife, LouAnne Smith, in 1988. He and Ms. Smith had four children, Gary Jr., Morgan, Tiffiani, and Tyler (deceased). Mr. Terry had one child, Ashley, out of wedlock with Rhonda Hobbs (deceased). Ashley died in 2015. Mr. Terry reported he married his third wife, Rose, while incarcerated. They met as pen pals. Rose died from a pulmonary embolism shortly after they were married.

In the interview conducted on 1/15/2024, LouAnne Smith described the relationship as love at first sight. They met in Five Points in Columbia when she was a senior at the University of South Carolina (USC). She recalled he lied to her about his age at the time. He told her he was 26 when he was 19 years old. They dated for about a year before they were married. Over the course of their courting, she related Mr. Terry pursued her. He took the initiative to ask her out on their dates. She stated they had known each other for "two or three weeks" when she met his mother. Shortly after she married Mr. Terry, he was sentenced to 22 months in jail. When he was released, he returned to live in his family home. They didn't live together until LouAnne Smith Terry graduated from USC. They have four children together.

The former Mrs. Terry reported her ex-husband was romantic on occasion. He would use "sweet talk" and bring her flowers "when he wanted something or when he did something he wasn't supposed to do." She related the marriage was marred by infidelity by Mr. Terry. When asked who was responsible for the household duties, childcare, and finances. LouAnne Terry reported she was the primary bread winner and caretaker in the home. She recalled him getting out of changing the kids' diapers because he said it made him nauseous. When asked if the Applicant could not contribute to household duties and childcare because he lacked the skill or did not do it because he did not want to, she reported he did not like to do anything that challenged him. When asked to clarify, she stated she was not sure how much of his presentation was due to his family of origin, because "with Gary's parents, his mom works, and dad stayed home. His mom was the primary caregiver of home and kids." Thus, she was not sure if he expected his wife to take care of the home and kids in the same way his mother did.

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MEDICAL HISTORY

When asked about his health, Mr. Terry reported "My health is bad." He elaborated that "I take chemo pills every morning. I have had a couple of strokes." He related he has been diagnosed with "Charot tooth disease. It is hitting my muscles, so I use a cane." Mr. Terry reported he has experienced multiple head injuries. The worst resulting from a work injury. He was working in Florida and fell approximately 20 feet. He related he was hospitalized but does not recall a lot from that time. Mr. Terry reported he has residual weakness from his stroke in his face. He reported he is in chronic pain, that he manages with medication. He stated he has been prescribed Hydroxyurea (can treat leukemia and head and neck cancer), Buspar, Percocet, and Remeron.

Records from the South Carolina Department of Corrections indicate Mr. Terry requested and received medical care. He has been diagnosed with Essential (hemorrhagic) Thrombocythemia (*a condition where the body makes too many platelets in the blood*). Thrombocythemia can cause increased risk of stroke, blood clots, and can cause fatigue, lightheadedness, headaches, and vision changes. The medical record suggests Mr. Terry has possibly had two strokes as an adult. He also has been diagnosed with Charcot-Marie-Tooth disease, which is an inherited, genetic condition. It occurs when there are mutations in the genes that affect the nerves in your feet, legs, hands, and arms. He also has gastroesophageal reflux disease (GERD). His current medication regimen includes oxcarbazepine (treatment of partial seizures), duloxetine HCl (medication is used to treat certain mental/mood disorders), fenofibrate (treats high cholesterol and triglycerides), oxycodone HCl/acetaminophen (treats severe pain), levothyroxine sodium (treats hypothyroidism), triamcinolone acetonide (used to treat a variety of skin conditions), famotidine (an antacid (for GERD), aspirin, celecoxib (NSAID used to treat mild to moderate pain and help relieve symptoms of arthritis), folic acid, sennosides/docusate sodium (stool softener), and amitriptyline HCl (tricyclic antidepressant).

PSYCHIATRIC HISTORY

Mr. Terry reported he has a history of psychiatric hospitalization. He stated he was admitted to Charter Hospital to treat his substance abuse. He denied a history of outpatient treatment. He reported one suicide attempt while he was detained at the local detention center. He indicated he tried to hang himself but was found by another inmate in time. He reported he is currently prescribed Buspar (an Anxiolytic, used to treat anxiety) and Remeron (an antidepressant also prescribed to aid sleep) to help with his anxiety and sleep disturbance. He denied a history of visual (e.g. seeing objects not present) and/or auditory hallucinations (e.g. hearing voices), and delusions.

According to the Charter Rivers Hospital records (8/24/1994 & 8/30/1994), Mr. Terry was transported from the jail to the hospital citing a desire to get help from his depression, stating that he had been having difficulties with depression for six years. While the applicant reported symptoms of depression, "no overt [symptoms of] depression was noted." Mr. Terry's affect was "friendly and cooperative" and stated that he maintained good eye contact and a good appetite. His thoughts were "logical, coherent, and goal directed." There were no signs of psychosis, and his short and long-term memory appeared intact. Mr. Terry's cognitive functions were determined to be intact, and he was described as having "good intellectual capacity." His overall intellect categorized as "average." Mr. Terry was admitted for treatment related to alcohol dependence. His treatment plan included detoxification to be followed by individual and group psychotherapy, didactic lectures, along with introduction to the 12-step program. However, after he was detoxed "he wanted immediate discharge." In addition, he tended to "attempt to deflect his drug use" frequently. There were two instances in which Mr. Terry exhibited "truly inappropriate and explosive degrees of anger." Medication was required to aid Mr. Terry regain his self-control. As a result, Stephen Merlin, MD diagnosed Mr. Terry with Organic Explosive Disorder. He was prescribed Tegretol (an anticonvulsant, used to treat seizures, nerve pain, and bipolar disorder). It was reported Mr. Terry responded to the medication with "rapid resolution of his unstable mood." It was noted that Mr. Terry's reasoning for being at the hospital was for a secondary gain because "I told the judge I would come here and get help." After about a week in the hospital Mr. Terry wanted to be discharged. He was discharged with

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instructions to continue 12-step program and follow up with his primary care provider for medication management. His discharge diagnoses were Organic Explosive Disorder, Antisocial Personality Disorder, Alcohol Dependency, and Cocaine Abuse.

The Lexington Medical Center record indicates Mr. Terry was admitted to the emergency room after attempting to commit suicide by hanging himself at Lexington Detention Center. He was found hanging for a short period of time. The examination by the ER staff determined Mr. Terry had some respiratory distress and difficulty swallowing as well as a faint red mark around the middle portion of his neck. He did not have cognitive deficits relating to the incident.

SUBSTANCE ABUSE

Mr. Terry reported a history of drug abuse. He stated he has regularly used or experimented with cannabis, cocaine, huffing gas and glue as a youngster, pills including “some kind of speed,” and acid. Mr. Terry reported he did not believe his drug use was a problem, except cocaine. He endorsed symptoms of dependence (cravings, increased tolerance, withdrawal, inability to quit using, and increased risky behaviors). He reported he received substance abuse treatment at the Charter Three Rivers. He stated he was in the 30-day program. He reported as soon as he was discharged from the program, he began using cocaine again. Mr. Terry reported he has not used illicit substances in years.

DDSN HISTORY

Mr. Terry has not previously been evaluated by DDSN. He has never been referred to DDSN for an evaluation of eligibility for services, nor has he been evaluated regarding competency to stand trial by DDSN.

PREVIOUS PSYCHOLOGICAL EVALUATIONS

Mr. Terry has been evaluated on several occasions throughout his lifespan.

(Columbia Public Schools, age 11)

3/20/1979	Wechsler Intelligence Scale for Children-Revised	Full Scale IQ	92
		Verbal IQ	94
		Performance IQ	92
	Vineland Social Maturity Scale	Total Score	75

(Richland County School District One, age 14)

4/22/1982	Wechsler Intelligence Scale for Children-Revised	Full Scale IQ	92
		Verbal IQ	91
		Performance IQ	95
	Peabody Picture Vocabulary Test	IQ	92

Scott L. Decker, PhD evaluated Mr. Terry on 1/20/2022 (age 54). He administered a number of cognitive and academic tests, including the Woodcock-Johnson IV Test of Cognitive Abilities. The results of his evaluation are summarized below:

Woodcock-Johnson Fourth Edition, Test of Cognitive Abilities

The standard battery of seven test representing each of the seven broad abilities were administered. When combined, the seven tests provide an estimate of General Intellectual Ability (Tests 1-7). Standard scores (SS) on the measure range from 40 to 160; 100 is exactly average and scores between 90 and 109 constitute the average

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range. One standard deviation equals 15 points. Scores are based on a comparison between Mr. Terry's performance and same age peers. The results of the WJ-4 are as follows:

Index/Composite	Score	95% CI	Percentile	Descriptive Category
Subtest				
Oral Vocabulary	87	79-95	19	Low Average
Number Series	89	81-97	23	Low Average
Verbal Attention	86	76-96	18	Low Average
Letter-Pattern Matching	68	54-81	02	Very Low
Phonological Processing	78	71-85	07	Low
Story Recall	76	63-88	05	Low
Visualization	79	68-89	08	Low
Composite				
General Intellectual Ability	77	72-82	06	Low

Mr. Terry's General Intellectual Ability was estimated to be in the Low range (SS=77; CI=72-82). Mr. Terry performed in the Low Average range on tests measuring language, number inference, and attention. His lowest performance was on a measure of visual processing speed (Letter-Pattern Matching), which was statistically lower than scores on other measures.

BEHAVIORAL OBSERVATIONS/MENTAL STATUS EXAMINATION

Mr. Terry was interviewed on 4/13/2023 at the SCDDSN Midlands Center in Columbia, SC. Mr. Terry was cooperative during the interview. He appeared to be a good historian. Mr. Terry was appropriately attired in the standard institutional uniform. Grooming and hygiene were adequate. Sensory systems appeared intact. Eye contact was good. He was alert and oriented in all spheres. Speech was normal in rate and volume and articulation was clear. Attention and concentration skills appeared to be adequate in the interview. There was no indication of psychomotor agitation or slowing, and no unusual mannerisms were noted. Affect was congruent with the topic of conversation. Mood appeared to be normal; he described his current mood as "calm" and his usual mood as "calm." Mr. Terry reported no suicidal or homicidal ideation or intent. He denied experiencing visual (e.g. seeing objects not present) and auditory hallucinations (e.g. hearing voices), and none were evident in interview. No delusional (i. e., false fixed beliefs) material was elicited. His thought process was logical and coherent. Insight and judgment were adequate. Mr. Terry described sleep as variable, saying that he requires medication to sleep. He denied difficulties with his appetite, saying that he eats regular meals.

Mr. Terry was able to register and immediately recall three words. After a delay with intervening tasks, he was unable to recall the three words without cueing, indicating deficits in short term memory. He was able to spell the word *block* forward and backward indicating adequate concentration. He correctly named the current president of the United States "Biden." He was able to correctly name previous presidents of the USA "Trump, Obama, Bush, and Clinton." He also knew the first president of the United States was "Washington." The previously listed tasks were an attempt to determine Mr. Terry's fund of general knowledge. His abstract reasoning and his ability to identify similarities among objects were good. Judgment to hypothetical situations was good.

DEFINITION OF INTELLECTUAL DISABILITY

Intellectual Disability is defined by the Diagnostic and Statistical Manual, Fifth Edition, (DSM-5), using three criteria. Criterion A is "Deficits in intellectual functions, such as reasoning, problem solving, planning, abstract thinking, judgment, academic learning, and learning from experience, confirmed by both clinical assessment and individualized, standardized intelligence testing." Criterion B states "Deficits in adaptive functioning that result in failure to meet developmental and sociocultural standards for personal independence and social

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responsibility. Without ongoing support, the adaptive deficits limit functioning in one or more activities of daily life, such as communication, social participation, and independent living, across multiple environments, such as home, school, work, and community. The final Criterion C requires "Onset of intellectual and adaptive deficits during the developmental period."

PSYCHOLOGICAL TEST RESULTS

Intellectual Functioning

General intellectual functioning is defined by the Intelligence Quotient (IQ) which is obtained by assessment with a standardized, individually administered intelligence test. Significantly subaverage intelligence is defined as an IQ of about 70 or below, which is approximately two standard deviations below the mean. [Intelligence Tests have a mean of 100 with a standard deviation of 15].

Wechsler Adult Intelligence Scale - Fourth Edition (WAIS-IV)

The WAIS-IV is an individually administered battery of tests for assessing the intellectual abilities and cognitive strengths and weaknesses of adolescents and adults between the ages of 16 and 69 years. This test yields five composite scores Verbal Comprehension Index (VCI), the Perceptual Reasoning Index (PRI), the Working Memory Index (WMI), and the Processing Speed Index (PSI). For each of the composite scales, the distribution of sum of scaled scores is converted to a scale of standard scores with a mean of 100 and a standard deviation of 15. Therefore, a score of 100 on any of these five composites is equivalent to the average performance of an adult at that particular age on each composite. The VCI and the PRI consists of three core subtests. The PSI and the WMI consists of two core subtests. The scaled scores for each subtest range from 1-19, with a mean score of 10 and a standard deviation of 3. The Full Scale IQ (FSIQ) is usually considered to be the most representative measure of global intellectual functioning. It is the aggregate of the Verbal Comprehension Index (VCI), the Perceptual Reasoning Index (PRI), the Working Memory Index (WMI), and the Processing Speed Index (PSI). Mr. Terry was administered the WAIS-IV on 04/25/2024 by Jessica Davis, PsyD. He earned a FSIQ of 82 which ranks his overall ability in the Low Average range of intellectual functioning. His overall thinking and reasoning abilities exceed those of approximately 12% of adults his age. He performed much better on verbal than on nonverbal reasoning tasks. Such differences in performance, however, are not especially unusual among his peers in general. The validity of these scores will be addressed later in this report. The results of the WAIS-IV are as follows:

Index/Subtest	Score	95% CI	Percentile	Descriptive Category
Verbal Comprehension (VCI)	93	88-99	32	Low Average to Average
Similarities	10			
Vocabulary	07			
Information	09			
Perceptual Reasoning (PRI)	82	77-89	12	Borderline to Low Average
Block Design	08			
Matrix Reasoning	05			
Visual Puzzles	08			
Working Memory (WMI)	86	80-94	18	Low Average to Average
Digit Span	09			
Arithmetic	06			
Processing Speed (PSI)	79	73-89	08	Borderline to Low Average
Symbol Search	07			
Coding	05			
Full Scale (FSIQ)	82	78-86	12	Borderline to Low Average
General Ability (GAI)	86	81-91	18	Low Average to Average

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Verbal Comprehension

Mr. Terry's verbal reasoning abilities as measured by the Verbal Comprehension Index (VCI) are in the **Average** range and above those of approximately 32% of his peers (VCI = 93; 95% confidence interval = 88-99). The VCI a measure of Crystallized Intelligence, represents Mr. Terry's ability to reason with previously learned information. A person's Crystallized Intelligence is largely a function of formal and informal educational opportunities and experiences and is highly dependent upon exposure to mainstream United States culture. Mr. Terry's performance on the verbal subtests contributing to the VCI is somewhat variable although it is not particularly unusual. Examination of Mr. Terry's performance on individual subtests provides additional information regarding his specific verbal abilities.

Mr. Terry achieved his best performance among the verbal reasoning tasks on the Similarities subtest and his lowest performance on the Vocabulary subtest. His performance across these areas differs significantly and suggests that these are the areas of most pronounced strength and weakness, respectively, in Mr. Terry's profile of verbal reasoning abilities. His weak performance on the Vocabulary subtest was below that of most individuals his age.

On the Similarities subtest Mr. Terry was required to respond orally to a series of word pairs by explaining how the words of each pair are alike. This subtest examines his ability to abstract meaningful concepts and relationships from verbally presented material (Similarities scaled score = 10).

The Vocabulary subtest required Mr. Terry to explain the meaning of words presented in isolation. As a direct assessment of word knowledge, the subtest is one indication of his overall verbal comprehension. Performance on this subtest also requires abilities to verbalize meaningful concepts as well as to retrieve information from long-term memory (Vocabulary scaled score = 7).

Perceptual Reasoning

Mr. Terry's nonverbal reasoning abilities as measured by the Perceptual Reasoning Index (PRI). The PRI is designed to measure fluid reasoning in the perceptual domain with tasks that assess nonverbal concept formation, visual perception and organization, visual-motor coordination, learning, and the ability to separate figure and ground in visual stimuli. Mr. Terry obtained a PRI score in the **Low Average** range and above those of only 12% of his peers (PRI = 82; 95% confidence interval = 77-89). Mr. Terry's performance on the perceptual reasoning subtests contributing to the PRI is somewhat variable, although the magnitude of this difference in performance is not unusual among individuals his age. Examination of Mr. Terry's performance on individual subtests provides additional information regarding his specific nonverbal abilities.

Mr. Terry achieved his best performance among the nonverbal reasoning tasks on the Block Design and Visual Puzzles subtests and lowest score on the Matrix Reasoning subtest. His performances across these areas differ significantly and suggest that these are the areas of most pronounced strength and weakness, respectively, in Mr. Terry's profile of perceptual reasoning abilities. His weak performance on the Matrix Reasoning subtest was below that of most individuals his age.

Working Memory

The WMI, a measure of Short-term memory, represents Mr. Terry's ability to temporarily retain information in memory, perform some operation or manipulation on it, and produce a result. The WMI was assessed by tasks that required the examinee to repeat a series of numbers in the same order as presented and in reverse order, and to complete math problems in his head. Mr. Terry obtained a WMI in the **Low Average** range. He performed better than approximately 18% of his peers in this area (Working Memory Index [WMI] = 86; 95% confidence interval 80-94).

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Processing Speed

The PSI, a measure of Processing Speed, represents Mr. Terry's ability to perform cognitive tasks fluently and automatically, especially when under pressure to maintain attention and concentration. The PSI was assessed by tasks that required Mr. Terry to quickly and correctly scan, sequence, or discriminate simple visual information. His PSI is in the **Borderline** range when compared to his peers. He performed better than approximately 8% of his peers on the processing speed tasks (Processing Speed Index [PSI] = 79; 95% confidence interval 73-89).

The Flynn Effect Adjustment

The Flynn Effect is an error that is related to the use of outdated norms for scoring and interpreting IQ scores (see for example, Flynn, 1984, 1987, 1999, 2000). James Flynn, a New Zealand political scientist, has studied the gradual rise in measured IQ scores for decades, and his research has found that with each passing year there is an average increase in IQ of 0.33 points, ultimately resulting in an increase of approximately 3 points per decade. The American Psychological Association Dictionary of Psychology (2006) defines the Flynn Effect as:

"the gradual rise of IQ level that has been observed since the time when records of IQs first were kept. Although the average IQ remains 100, due to periodic re-norming of IQ tests, raw scores have been rising. These increases have been roughly 9 points per generation (i.e., 30 years). The gains have been unequally distributed across the different abilities, with fluid abilities show substantially greater gains than crystallized abilities." (p.382)

A controversial issue is whether IQ scores should be adjusted in accordance with the calculated rise in scores. The method for correction is quite simple and is as follows: First count the years from publication to testing, multiply this number by .33 and subtract this number from the obtained IQ. For example, if a person obtained a score of 76 in 2011 on a test published in 2005, the resulting score would be 74 ($0.33 \times 6 = 1.98$; $76 - 1.98 = 74.02$). At the time of writing, adjusting for the Flynn Effect is not done by all practicing clinicians, but it is recommended by many scholars and supported by the AAIDD (see AAIDD, 2010, pg. 37).

It appears Mr. Terry was administered a standardized individual intelligence test on two occasions during the developmental period. The first time was in 1979 as a part of an educational evaluation. At that time, he was 11 years old. He was administered the Wechsler Intelligence Scale for Children-Revised, (WISC-R). The WISC-R was published in 1974. Mr. Terry earned a full-scale IQ (FSIQ) score of 92. Mr. Terry's FSIQ was measured as 92, with the Flynn Effect Adjustment ($0.33 \times 4 = 1.32$; $92 - 1.32 = 90.68$) his FSIQ is 90.68. He was tested again in 1982, by the school psychologist using the WISC-R (1974). The results showed Mr. Terry's FSIQ score was 92. Mr. Terry's FSIQ with the Flynn Effect Adjustment ($0.33 \times 8 = 2.64$; $92 - 2.64 = 89.36$) is 89.36. Scores obtained in 1979, and 1982 did not differ significantly and fall in the Average range.

It appears that next time Mr. Terry was administered a standardized individual intelligence test was as a part of the current legal proceedings, when he was 54 years old. In 2022, Mr. Terry was administered the Woodcock-Johnson Fourth Edition, Test of Cognitive Abilities (2011). While Mr. Terry earned a GIA of 77. Mr. Terry's GIA with the Flynn Effect Adjustment ($0.33 \times 11 = 3.63$; $77 - 3.63 = 73.37$) is 73.37.

Dr. Davis administered the Wechsler Adult Intelligence Scale, Fourth Edition (2008) in 2024. Mr. Terry's FSIQ was measured as 82, with the Flynn Effect Adjustment ($0.33 \times 16 = 5.28$; $82 - 5.28 = 76.72$) his FSIQ is 76.72. Mr. Terry's GIA was measured as 86, with the Flynn Effect Adjustment ($0.33 \times 16 = 5.28$; $86 - 5.28 = 80.72$) his GIA is 80.72. The scores obtained in 2022 and 2024 were not significantly different and fall in the Borderline range.

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Montreal Cognitive Assessment (MoCA)

The Montreal Cognitive Assessment (MoCA) is a screening instrument designed for detection of mild cognitive dysfunction. It assesses different cognitive domains: attention and concentration, executive functions, memory, language, visuospatial skills, conceptual thinking, calculations, and orientation. The MoCA was administered to Mr. Terry by Jessica Davis, PsyD. He scored 19 out of 30 total, below the cut-off of 26 which suggests mild impairment. Mr. Terry displayed strengths in attention and naming, but difficulties in language, abstraction, visuospatial skills, and memory. Specifically, he had issues with clock drawing, phonemic fluency, and delayed recall. The MoCA results indicate Mr. Terry likely has mild cognitive impairment.

Adaptive Functioning

The second criterion for a diagnosis of Intellectual Disability is concurrent deficits in adaptive functioning. Adaptive functioning is defined by DSM-5 as "how effectively individuals cope with common life demands and how well they meet standards of personal independence expected of someone in their particular age group, sociocultural background, and community setting." This is further defined as requiring deficits in present adaptive functioning in at least two of the following areas: communication, social participation, and independent living, across multiple environments, such as home, school, work, and community.

The AAIDD, alternatively, defines adaptive behavior as "the collection of conceptual, social, and practical skills that have been learned and are performed by people in their everyday lives." On appropriate standardized measures of adaptive behavior, "significant limitations in adaptive behavior are operationally defined as performance that is approximately two standard deviations below the mean of either (a) one of the following three types of adaptive behavior: conceptual, social, or practical or (b) an overall score on a standardized measure of conceptual, social, and practical skills." [Quotes are from Intellectual Disability: Definition, Classification, and Systems of Supports, the eleventh edition of the AAIDD Definition Manual, 2010, page 43].

Adaptive functioning is much more difficult to quantify than intelligence. In Mr. Terry's case, there was one record of a formal assessment of his level of adaptive functioning. The assessment for special educational services included a measure of adaptive functioning. Mr. Terry was rated by his teacher on the Vineland Social Maturity Scale (VSMS), an assessment of social competence in the 5th grade. It is designed to measure social maturation in eight social areas: Communication, General self-help ability, Locomotion, Occupation, Self-direction, Self-help eating, Self-help dressing, and Socialization. The VSMS provides a Social Age (SA) and a Social Quotient (SQ). The results indicated Mr. Terry's SQ=75 and his SA=9.1 years old, two years below his chronological age at the time. This suggests he was having deficits in his social skills as a youngster. It appears from the records and collateral interview with Ms. LouAnne Smith, that Mr. Terry's social deficits/immaturity continued into adulthood. She stated he had few genuine friends. She related his social/emotional limitations interfered with his employment. She described him as able to gain employment but having a hard time maintaining it because of his temper. His social immaturity also was a problem in their marriage. He very rarely contributed to the childcare, finances, and household chores. She reported she was responsible for paying the bills and the family budget. Also, Mr. Terry was inconsiderate of Ms. Smith's needs in the relationship. He appeared supportive and loving when he wanted something from his then wife. He appeared to prefer "running the streets" as Ms. Smith related. It is important to note, the applicant was about 20 years when he married, which resulted in his being ill-equipped to step into the role of a husband. In addition, his behaviors are commensurate with his diagnosis of Antisocial Personality Disorder.

During the interview, Mr. Terry reported he described his adult life in terms that generally indicated average levels of adaptive functioning. He reported he worked regularly. He stated he enjoyed working, but ultimately started his own business so he would not be beholden to supervisors. He would get himself to work independently. He was able to keep up with his work schedule. Mr. Terry acknowledged he was not responsible for paying the rent and utilities. But he would just turn the money over to his brother Billy Jr., when they lived

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together. He related he continued that practice in his second marriage to Ms. Smith. Also, he related he contributed to maintaining the household by cleaning, cooking, and doing the laundry on occasion. He acknowledged that his wife completed most of the household chores. In addition, his mother recalled Mr. Terry was able to complete household chores as a child/teen independently.

Age of Onset

The third prong of the diagnosis of Intellectual Disability is age of onset, which must be established within the developmental period. Mr. Terry did not receive a formal diagnosis of intellectual disability during the developmental period. He was evaluated by his local school district on multiple occasions as a child and adolescent. He was diagnosed with a learning disability. However, Mr. Terry was never diagnosed with Intellectual Disability (ID). ID was never even given as a rule-out diagnosis. This indicated none of his providers were concerned ID was possibly an appropriate diagnosis for Mr. Terry.

Malingering

According to DSM-5 malingering is as the intentional production of false or grossly exaggerated physical or psychological problems, motivated by external incentives such as avoiding military duty, avoiding work, obtaining financial compensation, evading criminal prosecution, or obtaining drugs. There was no indication of Mr. Terry malingering during the interview portion of the evaluation. Formal effort testing was administered by Dr. Davis. Mr. Terry's performance was within normal limits indicating he made no attempt to feign or exaggerate cognitive impairment. In addition, there are embedded validity indicators in the WAIS-IV. The psychological literature has noted the tasks that make up the PSI Index (Coding and Symbol Search) as embedded validity indicators. A PSI score ≤ 79 , Coding scale score ≤ 5 , Symbol Search scaled score ≤ 6 , and the Coding-Symbol Search scaled score difference ≥ 5 are indicators of poor effort. Mr. Terry's PSI score was 79, Symbol Search score was 7, Coding score was 5, and the Coding-Symbol Search difference score was 2. All the four indicators suggest Mr. Terry gave good effort on the IQ test. This suggests the results obtained by Dr. Davis are likely a valid estimate of Mr. Terry's true intellectual functioning.

DIAGNOSTIC SUMMARY AND CONCLUSIONS

A diagnosis of Intellectual Disability must meet all three specific criteria. It requires concurrent significant deficits in intellectual and adaptive functioning, with an age of onset during the developmental period. Mr. Terry does not have significant deficits in intellectual functioning. His intellectual functioning measured in the low average range which is higher than would be expected of someone who truly has Intellectual Disability. Mr. Terry did demonstrate difficulties in school that appear to have impacted his academic performance; so much so, he was supported with the resource class setting in middle and high school. He was classified as a student with a Learning Disability not Intellectual Disability. Even with the Flynn effect adjustment, Mr. Terry's IQ scores produced during the developmental period are in the average range. Thus Mr. Terry does not meet criteria on the first prong of the Intellectual Disability diagnosis.

Regarding the second prong of the Intellectual Disability diagnosis, concurrent significant deficits in adaptive functioning in one or more activities of daily life and across multiple environments, such as home, school, work, and community. Mr. Terry exhibited problems in school. His grades and his performance on educational standardized tests indicated he was academically behind his peers. However, his poor performance in school appears to be related to his learning disability and variable school attendance. Mr. Terry appears to have a history of social deficits. He was rated by his teacher as having deficits in social skills in the 5th grade. Ms. Smith reported challenges in her marriage to Mr. Terry, infidelity, and lack of support. It is important to note, the applicant was about 20 years when he married, which resulted in his being ill-equipped to step into the role of a husband. In addition, his behaviors are commensurate with his diagnosis of Antisocial Personality Disorder. There is no evidence to suggest he has significant adaptive functioning deficits such that without support his functioning would be limited across multiple environments. Prior to his incarceration, Mr. Terry reported he had

AAH

several romantic relationships, lived independently, and was responsible for getting himself to work, maintained gainful employment, and started a business. His mother reported his adaptive skills were appropriate for his age. Finally, since his incarceration, he has demonstrated he has the adaptive function skills to navigate the system to address his needs. Therefore, the preponderance of the evidence suggests, Mr. Terry has not met the second prong of the Intellectual Disability diagnosis.

The final prong of the Intellectual Disability diagnosis is the onset of deficits in the developmental period. School records indicate Mr. Terry's intellectual functioning during this period was in the average range. On the Preventive Procedures-Inoculations Form (1979) described the applicant as "a normal male child in good physical condition, with no evidence of physical, mental or emotional problems." Mr. Terry demonstrated deficits in conceptual skills as a youngster. In middle school he struggled with basic mathematics, writing, and reading skills. These deficits are typical of an individual who has a Specific Learning Disability. Moreover, this diagnosis is only given in the absence of sensory deficits, subnormal intelligence, or poverty. Meaning the deficits are not attributable to hearing or vision problems, low IQ, or one's family being poor. The social deficits Mr. Terry exhibited are likely due to his history of significant child abuse. Hence, he does not meet the final prong of the Intellectual Disability diagnosis.

It is important to note, Mr. Terry's current cognitive deficits as evidenced by the MoCA and may be due to multiple etiologies (i.e. learning disability, substance use, history of head injuries (some with episodes of unconsciousness), stroke, and physical abuse). However, these do not rise to the level one would expect of an individual with an Intellectual Disability.

Based on the totality of the data, it is the opinion of this examiner that Mr. Gary Dubose Terry **does not** meet the diagnostic criteria for Intellectual Disability as defined in the South Carolina Code of Laws.



Alicia V. Hall, Ph.D.
Psychologist II
Licensed Clinical Psychologist
SC License # 1068
SCDDSN Central Office

Date signed: _____



Curriculum Vitae

Jessica Davis
 228 River Bluff Blvd,
 Columbia SC 29210
 Phone: 314-303-1148
 Jessica.Davis@ddsn.sc.gov

LICENSURE

2020 **Licensed Psychologist**
 South Carolina License #1638

EDUCATION

2013 -2018 **Psy.D., Clinical Psychology:**
 Nova Southeastern University, Fort Lauderdale, FL, American Psychological Association, accredited clinical psychology program
Concentration: Forensic Evaluations

Directed Study Title: Bridging the gap between psychology and law: Assessment Guidelines for Asylum Seekers. Supervisor: David Shapiro, Ph.D., ABPP

2013 – 2015 **M.S., Clinical Psychology**
 Nova Southeastern University, Fort Lauderdale, FL, American Psychological Association, accredited clinical psychology program.

2009 - 2013 **B.A., Psychology; B.A., Criminology (Cum Laude)**
 Coker College, Hartsville, SC

EMPLOYMENT:

Clinical Forensic Psychologist 2 **May 1, 2020 - Present**

South Carolina Department of Disabilities and Special Needs

Responsibilities: Conduct forensic evaluations for individuals suspected of intellectual disabilities or related disabilities. Consult with the Department of Mental Health regarding the presence of serious mental illnesses. Review of prior medical records, court order, as well as conduct diagnostic interviews and psychometric evaluations related to intelligence. Determine the presence of feigned or malingered intellectual deficits and determine how symptoms negatively impact individuals' competency to stand trial. Testify regarding findings from evaluations. Supervisor: Alicia Hall, Ph.D.

Adjunct Psychology Professor
Coker University

August 2022 – December 2023

Responsibilities: Create lesson plans, presentations, assignments, and tests on psychological research classes, clinical psychology classes, and criminology classes. Oversee research projects.

Classes taught include scope and methods to research in the social sciences, introduction to research methods, advance research in psychological sciences, introduction to psychology, and psychological assessment.

Supervisor: Andrea Coldwell, Ph.D.

Staff Psychologist

January 2019 – April 2020

**Center for Behavioral Health,
University of Missouri, St. Louis**

Responsibilities: Conduct collateral and diagnostic interviews, psychometric assessments, and behavioral observations for diagnostic clarification for community-based population. Services were primarily offered to children, adolescents, and young adults presenting with various symptoms. Commonly diagnosed intellectual disabilities, autism spectrum disorder, learning disorders, as well as affective diagnoses including depression and anxiety. Personality disorders as well as serious mental illness diagnoses were also diagnosed. Reports were authored offering findings, diagnostic formulation, differential diagnoses, and treatment recommendations.

Supervisors: Amy Wilson, PsyD and Mike Laveque, PsyD

**Psychology Residency, Provisionally Licensed
Metropolitan St. Louis Psychiatric Center**

August 2018 – February 2019

Forensic Pretrial Program

Responsibilities: Conduct court ordered evaluations, review records, and complete reports to be submitted to the court regarding the following: competency to stand trial, criminal responsibility, diminished capacity. In addition, conduct evaluations to determine if respondents meet the statutory definition of a sexually violent predatory and to evaluate their risk of reoffending. Depending on the defendant's presentation, cognitive, memory, and personality assessments may be included in the evaluations. These cases range from misdemeanor charges to capital offenses. The possibility to be involved in depositions and trial testimony are present.

Supervisor: Rachael Springman, PhD ABPP

Neuropsychology Psychometrician

August 2015 - May 2017

Eileen Messing & Associates, Delray Beach, Florida

Responsibilities: Conduct relevant historical intakes with patients; conduct comprehensive neuropsychological memory testing for individuals suffering from neurocognitive disease(s), traumatic brain injuries, addiction, and adolescents referred for suspected learning disabilities; score the batteries of assessments and create a written draft of the findings for neurological treatment planning.

Supervisor: Eileen Messing, PsyD

Psychometrician

September 2015 - April 2016

Dynamic Behavioral Counseling, Ft. Lauderdale, Florida

Responsibility: Conducted mental status examinations for adults, adolescents, and children seeking disability benefits. Intelligence, academic, and neurocognitive assessments were conducted to determine intellectual disabilities, learning disabilities, and neurocognitive disorders. A report was drafted and cosigned by the supervisor.

Supervisor: Royce Jalazo, Psy.D.

INTERNSHIP EXPERIENCE:

Psychology Internship

August 2017- August 2018

Fulton State Hospital

Fulton, MO

Recovery and Self-Motivation Rotation

February 2018- August 2018

Responsibilities: Provide individual and group therapy to adults in a maximum-security forensic hospital who suffer from high functioning psychosis and personality disorders (primarily Antisocial Personality Disorder). Conduct case management among the aforementioned population and participate in multidisciplinary treatment team meetings. The primarily interventions being utilized are behavioral therapy, dialectical behavioral therapy, and motivational interviewing while modeling appropriate social boundaries.

Supervisor: Jonathan Rhodes, PsyD

Forensic Rotation

August 2017 – February 2018

Responsibilities: Conduct court ordered evaluations and complete reports to be submitted to the court regarding the following: competency to stand trial, criminal responsibility, diminished capacity, and risk. Participate in annual reviews of sexually violent predators, and sexually violent predator commitment evaluations. Primarily evaluations concerning competency to stand trial are conducted (approximately 80% of evaluations). These cases range from misdemeanor charges to capital offenses. The possibility to be involved in depositions and trial testimony are present. Conducted group and individual competency restoration.

Supervisor: Jeff Kline, Ph.D., Certified Forensic Examiner

Assessment Minor Rotation

August 2017 – August 2018

Responsibilities: Conduct six psychological testing reports throughout the duration of the internship year. Two psychological testing reports must consist of a battery of assessments (two or more). These referrals come from treatment teams requesting information relevant to diagnostic clarification, treatment considerations, and gathering a baseline for cognitive functioning. The forensic intern has the opportunity to conduct testing for individuals found incompetent to stand trial. These referrals concern neurocognitive functioning, intellectual functioning, personality functioning, and the presence of feigning or malingering psychiatric symptoms.

Supervisor: Randy Telander, Ph.D., Certified Forensic Examiner

Program Evaluation Minor Rotation

August 2017 – August 2018

Responsibilities: Identifying programmatic needs, and selection of evaluation of needs, and recommendations on integrating the results to program development. Design a research design appropriate to the selected topic and apply to the institutional review board. Collect and analyze data and present findings and recommendations to treatment teams.

Title: An analysis of medication compliance among sell order inpatient maximum-security pretrial defendants and competency to stand trial outcome.

Supervisor: Niels Beck, Ph.D.

CLINICAL PRACTICA:**Practicum Student****August 2015 – August 2016****NSU Counseling Center for Older Adults**

Psychological Services Center, Nova Southeastern University, Fort Lauderdale, Florida

Responsibilities: Provide comprehensive intake, administer population specific assessments to gather baseline treatment data, provide evidence-based treatment for presenting problems, and monitor symptom reduction and progress over the course of treatment. Majority of presenting problems are closely related to interpersonal distress due to communication deficits, assertiveness deficits, and personality traits.

Supervisors: Dr. Michelle Gagnon-Blodgett, Ph.D., and Dr. Ashley Stripling, Ph. D.

Practicum Student**August 2014 – August 2015****Forensic Psychology Practicum**

Center for Psychological Studies, Nova Southeastern University, Fort Lauderdale, Florida

Responsibilities: Provide assessment, evaluation, and intervention to individuals and groups in forensic settings described below. Attend weekly group supervision. Score and interpret psychological assessments and write forensic reports for Legal Aid/Guardian Ad Litem for Family Court and Competency reports for Immigration Court.

- Palm Beach County Jail: Conduct structured interviews, mental status exams, and suicide assessments with inmates in both general population and mental health units at a maximum-security facility. Attend multidisciplinary treatment team meetings.
- Paul Rein Detention Facility: Conduct weekly Survivor Therapy Empowerment Program (STEP) group sessions with incarcerated men and women. Groups ran on mental health units.
- North Broward Detention Center: Lead weekly Survivor Therapy Empowerment Program (STEP) group sessions with incarcerated men and women. Groups ran on mental health units.
- Juvenile Detention Center: Run weekly psycho-educational group session with male and female juveniles. Topics include the criminal justice system, emotional regulation, assertiveness training, sexual education, eating disorders, and raising children.
- Legal Aid/ChildNet: Conduct court ordered custody evaluations with parents and juveniles. Administer cognitive, personality, trauma, objective and projective measures. Complete evaluation reports, communicate with caseworkers, and collect collateral information in order to provide recommendations.
- Krome Detention Center: Conduct court competency evaluations for individuals being detained and assessed for deportation.
- Atlantic Shores Hospital: Conduct weekly Survivor Therapy Empowerment Program (STEP) for Male Batterers with inpatients in the New Beginnings program.

Supervisors: Lenore Walker, Ed.D., ABPP; David Shapiro, Ph.D., ABPP; Michael Simonds, Psy.D.

TEACHING AND TRAINING EXPERIENCE:**Graduate Teaching Assistant****January 2016 - April 2016**

Nova Southeastern University, Center for Psychological Studies. Fort Lauderdale, FL

Course: PSY 1610 Adult Intervention I

Responsibilities: Aid the lead professors by evaluating first year graduate school student's implementation of different modalities of treatment. Maintained blackboard and provided any necessary academic support to students regarding the course. Graded role-play implementation of intervention and provided supplemental information about interventions.

Supervisors: Ashley Stripling, Ph.D.

RESEARCH EXPERIENCE:

Jail Coordinator, Battered Women Syndrome Questionnaire April 2014 – July 2016

Forensic Psychology Practicum, Center for Psychological Studies, Nova Southeastern University, Fort Lauderdale, Florida

Responsibilities: Communicating with Broward County Sheriff's Office for students to gain clearance to administer the Battered Women Questionnaire within the Paul Rein Detention Center.

Battered Woman Syndrome Questionnaire (BWSQ)

October 2015 – July 2016

Nova Southeastern University, Fort Lauderdale, Florida

Graduate Research Assistant

Responsibilities: Administer Battered Woman Syndrome Validation Questionnaire to female inmates at Paul Rein Detention Facility. Responsible for quality checking of completed battery packets and entering collected data into SPSS.

Research Supervisor: Lenore Walker, Ed.D.

Death Penalty Research

October 2013 – April 2016

Nova Southeastern University, Fort Lauderdale, Florida

Graduate Research Assistant

Responsibilities: Conduct an in depth case review to determine trauma histories in capitally sentenced and charged defendants. Expand on previous death penalty research regarding diagnosis, sentencing, and trauma. Examine cases that involve ineffective assistance of counsel related to mental health factors.

Research Supervisor: David Shapiro, Ph.D.

Expert Witness Research

August 2013-May 2014

Nova Southeastern University, Fort Lauderdale, Florida

Graduate Research Assistant

Responsibilities: Reviewed and coded cases where expert witnesses were either allowed or banned from court proceedings.

SYMPOSIA:

Davis, J. & Howell, T. (August 2015). Conflicting Expert Opinions. In D. Shapiro (Chair), *Why Mental Health Mitigation Fails in Capital Cases*. Symposia conducted at the 123rd American Psychological Association Annual Convention, ON.

Davis, J. & Calderin, D. (August 2016) Assessment Guidelines for Psychologists to aid in Asylum Claims^[SEP]. In D. Shapiro (Chair), *Bridging the Gap for Psychology and Law in Competency and Asylum Issues in Immigration Court*. Symposia conducted at the 124th American Psychological Association Annual Convention, CO.

Davis, J., Phillpot, A., Gibson, C., Calderin, D., & Masias-Baron, E. (August 2016) An Evaluation of the Role of Psychological Evaluations and Legal Outcomes for Asylum Cases. In D. Shapiro (Chair), *Bridging the Gap for Psychology and Law in Competency and Asylum Issues in Immigration Court*. Symposia conducted at the 124th American Psychological Association Annual Convention, CO.

Phillpot, A., Masias-Baron, E., Gibson, C., Calderin, D., & Davis, J. The Presence of Trauma in a Forensic Competency Immigration Evaluations. . In D. Shapiro (Chair), *Bridging the Gap for Psychology and Law in Competency and Asylum Issues in Immigration Court*. Symposia conducted at the 124th American Psychological Association Annual Convention, CO.

PAPER PRESENTATIONS:

Davis, J. & Calderin, D. (March 2016). *Bridging the Gap Between Psychology and Law for Asylum Seekers: Assessment guidelines for psychologists*. Paper to be conducted at the American Psychological Law Society Annual Convention, Atlanta, GA.

Davis, J., Phillpot, A., & Gibson, C. (March 2016). *Improving Collaboration Between Attorneys and Psychologists: An evaluation of psychology and law on denied asylum cases*. Paper to be conducted at the American Psychological Law Society Annual Convention, Atlanta, GA.

Phillpot, A., Davis, J. & Calderin, D. (March 2016). *The Presence of Trauma in a Forensic Immigration Sample*. Paper to be conducted at the American Psychological Law Society Annual Convention, Atlanta, GA.

POSTER PRESENTATIONS:

Schumacher, L., Phillpot A., Howell T., Caezza, J., Davis J., Calderin D., Miner M., Hylton T., Astor H., Groth C., & Shapiro, D (August 2015). Women and the Death Penalty: Sentencing Outcomes and Trauma History. Poster presented at the 123rd American Psychological Association Annual Convention, Toronto, ON.

Schumacher, L., Davis J., Howell T., Phillpot A., Calderin, D., Caezza J., Miner M., Astor H., Hylton T., Groth C., & Shapiro D. (May 2015). Prevalence of Abuse and Trauma within Capital Defendants. Poster presented at the 27th Association for Psychological Science Annual Convention, New York, NY.

Jackson, M., Shook, J., Calderin, D., Boltinghouse, J., Hanzman, J., Wentowski, H., Schumacher, L., Caezza, J., Davis, J., Phillpot, A., & Grabner, S. (May, 2014). Impact of Commonly Used Psychological Instruments on the Admissibility of Expert Witness Testimony. Poster presented at the 26th Association for Psychological Science Annual Convention, San Francisco, CA.

Jackson, M., Shook, J., Calderin, D., Boltinghouse, J., Hanzman, J., Wentowski, H., Schumacher, L., Caezza, J., Davis, J., Phillpot, A., & Grabner, S. (August, 2014). Impact of Commonly Used Psychological Instruments on the Admissibility of Expert Witness Testimony. Poster presented at the Annual American Psychological Convention, Washington, D.C.

Alicia V. Hall, PhD

OFFICE ADDRESS

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Columbia, SC 29240
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EDUCATION

WILLIAM S. HALL PSYCHIATRIC INSTITUTE

Columbia, SC. APA Approved Clinical Internship in Clinical Psychology (a partnership between the South Carolina Department of Mental Health and the University of South Carolina, School of Medicine); Completed: September, 2002. Director: William Gore, Ph.D.
2001-2002

UNIVERSITY OF SOUTH FLORIDA

Tampa, FL. Doctor of Philosophy, Ph.D. in Clinical Psychology with a minor in Forensics. Dissertation Title: "Body Image as a Function of Colorism: Testing a Theoretical Model"
Completed: April 30, 2003. Graduation: August 8, 2003
Major Professor: James Epps, Ph.D.
1994-2003

INDIANA STATE UNIVERSITY

Terre Haute, IN. Master of Arts, MA in Experimental Psychology. Thesis Title: "The influence of skin color and facial features on perceptions of Black female attractiveness" Major Professor: Veanne Anderson, Ph.D.
1992-1994

LAFAYETTE COLLEGE

Easton, PA. Bachelor of Arts, AB in Psychology with a minor in Black Studies.
Advisor: Dr. Karen Bassow, Ph.D.
1988-1992

EMPLOYMENT HISTORY

Psychologist II/Clinical Supervisor: South Carolina Department of Disabilities and Special Needs.

Responsibilities are best described as follows:

1. Serves as an Administrative Liaison and provides chief examiner duties as Clinical Supervisor/Chief Examiner.
2. Ensures and reviews CST reports submitted by direct reports are completed and provides feedback to examiners regarding clinical issues and opinions while ensuring there is not a conflict regarding agency policies/directives.
3. Acts as liaison between Clinical Services Forensics and the Judicial system.
4. Serves as liaison between DDSN Clinical Services-Forensics and SCDMH Forensic Evaluation Service and (MUSC) Medical University of South Carolina Forensics.
5. Provides supervision (administrative and clinical) to the second lead forensic examiner position for DDSN and provides on-going consultation and oversight to psychology staff and contractors who serve as primary and secondary examiners.
6. Complete evaluations in capital murder/death penalty cases related to the Atkins vs. Virginia decision.
7. Provide expert testimony as necessary to the court
8. Administrative duties as required.

Supervisor: Janet Priest, Associate State Director of Operations 4/17/2024 to present

Chief Examiner: South Carolina Department of Disabilities and Special Needs.

Responsibilities are best described as follows:

1. Provide competency evaluations statewide for juveniles and adults with developmental disabilities or traumatic brain injury being adjudicated in family and general sessions courts.
2. Write the report and submit the evaluation to the court with in ten days of completing the evaluation.
3. Work jointly with examiners from the South Carolina Department of Mental Health on cases related to competency for defendants suspected of having a dual diagnosis of mental retardation and mental illness.
4. Complete evaluations in capital murder/death penalty cases related to the Atkins vs. Virginia decision.
5. Provide expert testimony as necessary to the court.
6. Supervises lead examiner position for DDSN at Central Office and provides on-going consultation and oversight to psychology staff and contractors who serve as primary and secondary examiners.
7. Provides ongoing consultation and assistance for psychology staff who serve as secondary examiners.
8. Administrative duties as required.

Supervisor: Janet Priest, Associate State Director of Operations 2/1/2014 to present

Forensic Psychologist: South Carolina Department of Disabilities and Special Needs.

Responsibilities are best described as follows:

1. Provide competency evaluations for juveniles and adults with developmental disabilities or traumatic brain injury being adjudicated in family and general sessions courts.
2. Write the report and submit the evaluation to the court with in ten days of completing the evaluation.
3. Provide expert testimony as necessary to the court.

Supervisor: Gordon E. Brown, PhD 05/2010 to 2/1/2014

Lead Consultant: Autism Treatment Network. University of South Carolina School of Medicine, Department of Neuropsychiatry. A joint effort between the University of South Carolina School of Medicine and Greenville Hospital System funded by the Fullerton Foundation. Responsibilities are best described as follows:

1. Provides consultations for physicians via telepsychiatry throughout the Midlands and Upstate of South Carolina.
2. Educate and train pediatricians on ASDs and the importance of early screening and interventions.

Supervisor: Harry H. Wright, MD, MBA, and Ruth Abramson, PhD 08/07- 8/17

Chief Psychologist: The Developmental Specialties Clinic. Columbia Area Mental Health, SC Department of Mental Health.

Responsibilities are best described as follows:

1. Participates in a multidisciplinary specialty outpatient evaluation clinic that provided diagnostic clarification, treatment recommendations and referral sources.
2. Supervises first year Child Psychiatry Residents and Social Work Interns.
3. Provide individual, group and family therapy for children and adolescents with ASD.
4. Provide comprehensive diagnostic evaluations using the ADI-R and ADOS.

Supervisor: Monica McConnell, PhD 07/06- 7/14

Chief Psychologist: Forensic Evaluation Service, South Carolina Department of Mental Health

Responsibilities are best described as follows:

1. Provide competency evaluations for juveniles and adults with developmental disabilities or traumatic brain injury being adjudicated in family and general sessions courts.
2. Write the report and submit the evaluation to the court with in ten days of completing the evaluation.
3. Provide expert testimony as necessary to the court.

Supervisor: Jeffery Musick, PhD 07/07 to 05/10

Assistant Research Professor; The Autism and Asperger's Research Project. University of South Carolina School of Medicine, Department of Neuropsychiatry. A joint effort between Duke University and the University of South Carolina, School of Medicine. Responsibilities are best described as follows:

1. Provided comprehensive psychological evaluations for Asperger's and Autistic research participants
2. Conducted clinical interviews with enrolled families using the ADI-R, ADOS and the Vineland.
3. Designs and assists staff in research activities especially statistical analysis.

Supervisors: Ruth Abramson, Ph.D.; Harry Wright, M.D. 11/02- 12/06

Assistant Research Professor; (Co-Investigator) Biomarkers in Autism of Aripiprazole and Risperidone Treatment (BAART). University of South Carolina School of Medicine, Department of Neuropsychiatry. A joint effort between Medical University of South Carolina, and the University of South Carolina, School of Medicine. Responsibilities are best described as follows:

1. Provided comprehensive psychological evaluations for Asperger's and Autistic research participants using the ADI-R, ADOS, Vineland and SB 5.

Supervisor: Ruth Abramson, Ph.D. 08/10- present

Clinical Psychology Intern; William S. Hall Psychiatric Institute (APA Approved). A joint effort between the South Carolina Department of Mental Health and the University of South Carolina, School of Medicine.

Responsibilities are best described as follows:

First Six Month Rotation: Child and Adolescent

1. Provided individual and group therapy to children and adolescents in inpatient and outpatient settings.
2. Participates in a variety of multidisciplinary specialty outpatient evaluation clinics (Developmental Disorders Clinic, Infant Evaluation Clinic and General Child and Adolescent Clinic) that provided diagnostic clarification, treatment recommendations and referral sources.
3. Provided individual and group therapy to children in school settings.
4. Provided individual and family therapy to children in Children's Day Treatment Program.
5. Provided comprehensive evaluations to help with diagnostic clarification in inpatient and outpatient settings
6. Conducted forensic evaluations of alleged victims of child abuse.

Supervisors: Jerome H. Hanley, Ph.D.; Angela Forand, Ph.D.; George R. Holmes, Ph.D.; George Rekers, Ph.D.; Monica McConnell, Ph.D., and Allison DeFelice, Ph.D.

Second Six Month Rotation: Adult

1. Provided individual and group therapy to adults in outpatient settings.
2. Provided comprehensive psychological evaluations of adults in inpatient and outpatient settings to assist with forensic issues such as determination of competence, criminal responsibility and malingering.
3. Conducted disability evaluations for the Social Security Administration.
4. Conducted evaluations of possible learning disabilities in outpatient adults.
5. Conducted forensic evaluations of alleged victims of child abuse.

Supervisors: George Rekers, Ph.D., Allison DeFelice, Ph.D and William Gore, Ph.D. 9/01-9/02

AV Hall, PhD

Updated April 20, 2024

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Teaching Experience

Affiliate Assistant Professor; Department of Neuropsychiatry and Behavioral Science, University of South Carolina School of Medicine. Responsibilities are best described as follows:

1. Prepared and gave class lecture to medical students, residents, and fellows

Supervisor: Meera Narasimhan, MD, Chair Department of Neuropsychiatry and Behavioral Science.

4/22-present

Instructor; Human Development, Abnormal Psychology, Human Sexuality, Abnormal Child Behavior and Advanced Forensic Psychology, Department of Psychology, University of South Carolina.

Responsibilities are best described as follows:

1. Prepared and gave class lectures
2. Assigned and graded research papers and projects, homework and exams.

Supervisor: Alexandria Reynolds, Ph.D. 8/05- present

Adjunct Professor; General Psychology, Department of Social and Behavioral Sciences, Midlands Technical College. Responsibilities are best described as follows:

1. Prepared and gave class lectures
2. Assigned and graded research papers and projects, homework and exams. Supervisor: Paul Livingston, Ph.D. 8/03- 5/05

SPECIALTY TRAINING

Atkins Evaluations: Procedures, Psychometrics, and Recommendations

American Academy of Forensic Psychology, Palo Alto university

Friday, December 8, 2023

Neuropsychology and Forensic Mental Health Evaluations: Foundations, Practical Applications and Ethical Considerations

American Psychology-Law Society Conference

Wednesday, March 9th, 2016

ADOS Research Training

Weill Cornell Medical College, Center for Autism and the Developing Brain

April 9-11, 2015

ADOS Clinical Training

Vanderbilt Kennedy Center, Treatment & Research Institute for Autism Spectrum Disorders

January 8 & 9 2015

Evaluation of Intellectual Disability in Capital Cases: Twelve Years Post Atkins

American Psychology-Law Society Conference

Wednesday, March 5th, 2014

PCIT of the Carolinas Learning Collaborative

Duke University

August, 2010 –October, 2011

AV Hall, PhD

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STAT-MD Training
Medical University of South Carolina
June 17-18, 2011

ADI-R Clinical and Research Training By Latha Soorya
Medical University of South Carolina
2010

ADOS Clinical and Research Training
University of Michigan Autism &
Communication Disorders Center (UMACC)
June 2005

ADI-R Clinical and Research Training
Duke University Center for Human Genetics
December 2002

PROFESSIONAL MEMBERSHIPS

Registrant #52349, National Registrar of Health Service Providers in Psychology
APA Division 41: American Psychology-Law Society
South Carolina Autism Society
Autism Society of America
South Carolina Psychological Association
International Society of Autism Researchers
South Carolina Association of Black Psychologist
Association of Black Psychologist- National
American Association on Intellectual and Developmental Disabilities

PROFESSIONAL ACTIVITIES

Abstract Reviewer

AP-LS Annual Conference 2015 San Diego
APA Division 41: American Psychology-Law Society

Awards Committee Member

International Society of Autism Researchers
2011 to 2018

Board Member

Institutional Review Board (IRB) for the South Carolina Department of Mental Health, Specialty Area: Special Interest of Children 2009 to present

COLLOQUIUM/WORKSHOPS CONDUCTED (Limited)

Hall, A.V. Autism & Asperger's Disorder: Making the Diagnosis and Understanding the Differentials. USC Counseling Center, In service training for psychologist. Feb, 16, 2011.

AV Hall, PhD
Updated April 20, 2024

Hall, A.V. Mental Health & the Child with Special Needs. Family Connection Hopes and Dreams Conference 2013. March, 08, 2013.

Hall, A.V. Mental Health & the Child with Special Needs. Family Connection Hopes and Dreams Conference 2014. Feb, 08, 2014.

Hall, A.V. Managing Sexual Behavior. Family Connection Hopes and Dreams Conference 2014. Feb, 08, 2014.

Hall, A.V. Managing Disruptive Behavior. Family Connection Hopes and Dreams Conference 2015. Feb, 06, 2015.

Hall, A.V. Sexuality & Individuals with Developmental Disabilities. Advocacy-Links Webinar. May 18, 2018.

Hall, A.V. Care and Support of Adolescents/Adults with Autism Spectrum Disorder. The Staff Development Committee of Columbia Area Mental Health Center, Webinar. July 20, 2022.

PAPERS PRESENTED (limited)

Hall, A. V.; Abramson, R. K.; Wilkinson, E. E.; Kinsman, A.; Kelly, D. P.; and Wright H. H. *South Carolina Autism Treatment Network: Using Telepsychiatry to Increase Early Identification and Screening In Pediatric Practices*. Presented at International Meeting For Autism Research, Poster Session 116 Services I, May 13, 2011

Hall, A. V.; Abramson, R. K. and Wright H. H. South Carolina Autism Treatment Network: *Building Bridges of Collaboration and Support to Increase Early Identification and Autism Spectrum Disorder Screening in Pediatric Practices*. Presented at the 59th Annual Meeting of The American Academy of Child and Adolescent Psychiatry, New Research Poster Presentation 1.19, October 24, 2012

Abramson, R. K.; **Hall, A. V.;** Boccanfuso, L.; Scarborough, S. A *Methodological View of Robot-Assisted Autism Therapy*. Presented at the Lowcountry Autism Consortium Autism Forum, Paper Presentation Augmentative & Alternative Communication, September 07, 2013

Boccanfuso, L.; Scarborough, S.; Abramson, R. K.; **Hall, A. V.;** Wright H. H.; and O’Kane, J. A *New Robot Prototype for Promoting Spontaneous Speech & Joint Attention in Children With ASD*. Presented at American Speech-Language-Hearing Association, Paper Presentation 5673, November 22, 2014

Abramson, R. K.; **Hall A. V.;** Stuck, S.; Ravan S.; Charles, J; Williams J.; and DeVane L. *Changes in Sleep Habits during Drug Treatment of ASD*. Presented at International Meeting For Autism Research, Poster Session 162.111 Interventions - Pharmacologic, May 12, 2017

PUBLICATIONS (limited)

Hall. A.V., Godwin, M., Wright, H.H., &. Abramson, R.K. (2007) Criminal Justice Issues and Autistic Disorder. In R. Gabriels & D. Hill (Ed.), *Growing up with autism: Beyond Early Intervention*. New York: Gilford Press, 272-292.

Cuturic, M., Abramson, R. K., Moran, R. R., Hardin, J. W., **Hall, A. V.**; (2011) Clinical correlates of low serum carnitine levels in hospitalized psychiatric patients. *World J Biol Psychiatry*. Feb.

Boccanfuso, L., Scarborough, S., Abramson, R.K, **Hall, A. V.**, Wright, H.H & O’Kane, J.M.; (2016) A low-cost socially assistive robot and robot-assisted intervention for children with autism spectrum disorder: field trials and lessons learned. *Autonomous Robots*, doi:10.1007/s10514-016-9554-4

De Vane C.L., Charles J.M., Abramson R.K., Williams J.E., Carpenter L.A., Ravan S., Gwynette F., Stuck C.A., Geesey M.E., Bradley C., Donovan J.L., **Hall A.V.**, Sherk S.T., Powers N.R., Spratt E., Kinsman A., Kruesi M.J., Bragg J.E. Jr.; (2019). Pharmacotherapy of Autism Spectrum Disorder: Results from the Randomized BAART Clinical Trial. *Pharmacotherapy*, doi: 10.1002/phar.2271. [Epub ahead of print]

THE STATE OF SOUTH CAROLINA)
)
COUNTY OF LEXINGTON)
)
Gary Dubose Terry, SCDC#5054,)
)
Applicant,)
)
v.)
)
State of South Carolina,)
)
Respondent.)

IN THE COURT OF COMMON IN THE
COURT OF COMMON PLEAS
FOR THE ELEVENTH CIRCUIT

2022 CP 32 00 924
Case No. _____

Application for Post-Conviction Relief

1. Place of Detention: Broad River Correctional Institution, Columbia, South Carolina.
2. Sentencing Court: Lexington County Circuit Court in Lexington, South Carolina.
3. Not applicable.
4. The indictment number or numbers upon which the offense or offenses for which sentence was imposed:

Indictment number 1995-GS-3291670 charged murder, first degree burglary, first degree criminal sexual conduct, and malicious injury to a telephone system.

5. The dates upon which the sentence was imposed and the terms of the sentence:

A death sentence was imposed on September 21, 1997, for the crime of murder. Applicant was sentenced to life imprisonment for burglary in the first degree; thirty-five years' imprisonment for criminal sexual conduct in the first degree; and ten years' imprisonment for malicious injury to a telephone system.

6. A finding of guilty was made after a plea of not guilty.
7. The applicant did appeal from judgement of conviction and sentence.
8. Applicant appealed to:

The Supreme Court of South Carolina, which affirmed, *State v. Terry*, 339 S.C. 352, 529 S.E.2d 274 (S.C. Mar. 13, 2000);

The Supreme Court of the United States, which denied petition for writ of certiorari to the Supreme Court of South Carolina, *Terry v. South Carolina*, 531 U.S. 882 (U.S., Oct. 2, 2000);

The South Carolina Court of Common Pleas, which dismissed the application for post-conviction relief with prejudice, *Terry v. State*, No. 2000-CP-32-3470 (S.C. Ct. Common Pleas, Feb. 16, 2009);

The Supreme Court of South Carolina, which affirmed the dismissal of the application for post-conviction relief, *Terry v. State*, 394 S.C. 62, 714 S.E.2d 326 (S.C. Aug. 29, 2011);

The United States District Court for the District of South Carolina, Florence Division, which adopted a magistrate's report and recommendation denying habeas corpus, *Terry v. Sterling*, No. 4:12-1798-RMG, 2019 WL 4723354 (D.S.C. Sept. 26, 2019);

The United States Court of Appeals for the Fourth Circuit, which affirmed the denial of habeas corpus, 854 Fed. App'x 475 (4th Cir. May 5, 2021), *petition for rehearing and rehearing en banc denied* (4th Cir. June 2, 2021); and

The Supreme Court of the United States, which denied petition for writ of certiorari to the United States Court of Appeals for the Fourth Circuit. *Terry v. Stirling*, 142 S.Ct. 745 (U.S. Jan. 10, 2022).

9. Not applicable.

10 & 11. GROUNDS FOR RELIEF WITH SUPPORTING FACTS

10(a). Applicant's death sentence violates the Eighth Amendment to the United States Constitution and the corresponding provisions of the South Carolina Constitution because he is a person with intellectual disability. South Carolina law defines 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); *see also Franklin v. Maynard*, 356 S.C. 276, 588 S.E.2d 604 (2003); *Moore v. Texas*, 137 S.Ct. 1039 (2017), *Hall v. Florida*, 572 U.S. 701 (2014), *Atkins v. Virginia*, 536 U.S. 306 (2002). Applicant has significantly subaverage intellectual functioning and deficits in adaptive functioning, both of which manifested before he was eighteen years old. He is therefore ineligible for capital punishment.

11(a). Applicant has significantly subaverage intellectual functioning. The American Psychiatric Association (APA) defines significantly subaverage intellectual functioning as "deficits in "general mental abilities...that involve reasoning, problem-solving, planning, abstract thinking, judgment, learning from instruction and experience, and practical understanding." APA, *Diagnostic and Statistical Manual of Mental Disorders* 37 (5th ed. 2013) (hereinafter *DSM-5*); *see also* American Association on Intellectual & Developmental Disabilities (AAIDD), *Intellectual Disability: Definition, Classification, and Systems of Supports* 29 (12th ed. 2021) (hereinafter *AAIDD Manual*). This criterion may be established by an IQ score that is approximately two standards of deviation below the mean, or a score of approximately 70. IQ tests, however, are inherently imprecise, and

courts must therefore consider the standard error of measurement, “one of the most important concepts in measurement theory,” which converts a fixed IQ score into the 10-point range that confidently contains and best reflects a person’s true IQ score. *Hall*, 134 S.Ct. at 1995. There is also a professional and scientific consensus that obtained IQ scores are not accurate unless they are corrected for a phenomenon known as norm obsolescence, in which IQ scores artificially increase over time and warrant adjustment from aged norms when tested. This observation is known as the “Flynn Effect.” AAIDD Manual at 42, 123; DSM-5 at 37; *see also* Kevin S. McGrew, *Norm Obsolescence: The Flynn Effect* 161 in *THE DEATH PENALTY AND INTELLECTUAL DISABILITY* (Edward A. Polloway, ed. 2015) (“Not only is there a scientific consensus that the Flynn effect is a valid and real phenomenon, there is also a consensus that individually obtained IQ scores derived from tests with outdated norms must be adjusted to account for the Flynn effect, particularly in *Atkins* cases.”). Because the Flynn Effect is an “established” component of the scientific and medical “community’s diagnostic framework,” *Hall*, 134 S.Ct. at 1995, 2000, legal assessments of intellectual disability must also incorporate it. *See Walker v. Kelly*, 593 F.3d 319, 337 (4th Cir. 2010).

On a recent administration of the Woodcock-Johnson IV Test of Cognitive Abilities (hereinafter WJ-IV), one of three gold-standard IQ tests, Mr. Terry’s obtained IQ score was adjusted per the requisite Flynn effect, resulting in a full-scale IQ score of 74, with a 95% confidence interval of 69 to 79. 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 currently in use). Dr. Scott Decker, neuropsychologist, administered a measure of malingering and concluded that the testing scores were valid and that Mr. Terry put forth good effort. Mr. Terry’s IQ includes a range that extends more than two standard deviations below the mean.

- 11(b). Applicant Gary Terry also has significant deficits in adaptive functioning. Adaptive deficits are the “inability to learn basic skills and adjust behavior to changing circumstances.” *Hall*, 572 U.S. at 710. Adaptive deficits must be assessed using both “clinical evaluation and individualized . . . measures.” *Moore*, 137 S.Ct. at 1048-50. Clinicians look to whether an individual’s adaptive performance falls two or more standard deviations below the mean in any of three adaptive skill sets—conceptual, social, and practical—in determining the significance of adaptive deficits. *Id.* at 1046 (citing AAIDD, *Intellectual Disability: Definition, Classification, and Systems of Supports* 43 (11th ed. 2010)).

Mr. Terry has a documented history of special developmental needs and learning disabilities that indicate significant conceptual deficits. Throughout elementary school, Mr. Terry consistently received low marks in his progress across all subjects. Mr. Terry’s fourth grade teacher, for example, reported that in Reading, Language, and Spelling, Mr. Terry received the lowest possible mark for progress, despite receiving the highest possible mark for effort. Mr. Terry was forced to repeat fifth grade. When Mr. Terry was in fifth grade the first time, his teacher recommended that he be evaluated for special educational services. As part of the evaluation, school officials administered the Vineland Social

Maturity Scale, a standardized measure of adaptive behavior. See Donald J. Raggio & Twila W. Massingale, *Comparability of the Vineland Social Maturity Scale and Vineland Adaptive Behavior Scale—Survey Form with Infants Evaluated for Developmental Delay*, 71 Perceptual and Motor Skills 415 (1990) (noting that the Vineland Social Maturity Scale has a “long and venerable history in the assessment of adaptive behavior, particularly in the area of mental retardation”). Mr. Terry’s Vineland scores were “below the level” expected for his age, “suggested immaturity in social skills,” and fell approximately two standard deviations below the mean—the diagnostic cut-off for intellectual disability. See *Moore*, 137 S.Ct. at 1046. The school then placed Mr. Terry in a resource program for learning disabled students in language arts and math classes and developed an individualized education plan for him. Nevertheless, Mr. Terry continued to receive failing grades. His school records reflect difficulty with completing work on time, using time wisely, and thinking and working independently. Mr. Terry was repeatedly reevaluated throughout middle and high school and remained in resource courses until he dropped out of high school in ninth grade.

Mr. Terry also has a history of significant social and practical deficits. Mr. Terry’s third, fourth, and fifth grade teachers all indicated that Mr. Terry’s ability to work well independently and develop effective work habits was “unsatisfactory,” the lowest possible category. Mr. Terry’s fifth grade teacher noted that Mr. Terry “tires easily” and had “frequent inattention.” Records from his seventh grade year indicate that Mr. Terry’s weaknesses included “[e]veryday coping behavior.” Mr. Terry also repeatedly received scores of “unsatisfactory” in different categories regarding “Personal Traits,” including completing work on time, using time to advantage, thinking and working independently, and contributing to class. Mr. Terry received “unsatisfactory” in all Personal Trait categories in the 1980-81 school year. In high school, Mr. Terry also received instruction and progress assessments in independent living skills, including writing and depositing checks, recognizing and knowing the difference between various coins and bills, computing the cost of grocery items, and understanding the difference between shopping “wants” and “needs.” Mr. Terry’s mother described him as “different” and “very shy” and reported that he often “played by himself” and liked to “be by himself.” She also noted that he did not participate in sports or other activities like Boy Scouts because he did not have the attention span to sit still for prolonged periods of time. As an older teenager, Mr. Terry continued to display significant deficits. He never lived alone and could not maintain consistent employment. The jobs he did hold—a bouncer at a night club, a tree trimmer, other forms of manual labor—involved primarily physical labor.

- 11(c). Applicant Gary Terry’s significantly subaverage intellectual functioning and deficits in adaptive functioning manifested before he was eighteen years old. Mr. Terry struggled academically, and at age eleven, he was placed in special education resource classes where he remained until dropping out. Interviews with family members also confirm that Mr. Terry displayed low intellectual functioning and deficits in adaptive functioning during the developmental period.
12. Applications filed with respect to this conviction:

Applicant filed petition in a State Court under South Carolina Law, petition in Federal Court for habeas corpus and post-conviction relief, petition in the United States Supreme Court for certiorari, and other petitions, motions, or applications in this court and others.

13. With respect to each petition, motion, or application of part (12):

Applicant filed an application for post-conviction relief in the Supreme Court of South Carolina on November 30, 2000, based on allegations that trial counsel were ineffective for failing to object to the exclusion of Applicant's statement and for failing to adjust defense strategy. Applicant was denied relief on all claims and the petition was dismissed. *Terry v. State*, 714 S.E.2d 326 (S.C. 2011).

Applicant filed petition in the United States Supreme Court for certiorari, which was denied. *Terry v. State*, 531 U.S. 882 (2000).

Applicant filed second application for post-conviction relief on June 29, 2012, which was dismissed as successive on June 19, 2018.

Applicant filed for habeas corpus in Federal Court on June 29, 2012, claiming ineffective assistance of counsel for trial counsel's (1) failure to object on the basis of prosecutorial misconduct; (2) failure to disclose an actual conflict of interest; (3) failure to conduct adequate and appropriate *voir dire*; (4) failure to develop evidence supporting a defense of guilty but mentally ill; and (5) failure to object to or impeach aggravating testimony. The petition was denied on September 26, 2019.

Applicant filed a motion to alter or amend judgment pursuant to Federal Rule of Civil P. 59(e) focusing solely on the first four grounds of habeas corpus petition. The motion was denied on December 10, 2019.

14. The grounds set forth above have not been previously presented to this or any other court.
15. Not Applicable.
16. Applicant did not previously raise this claim at trial or in an initial PCR proceeding because he was represented by ineffective counsel who failed to raise it.
17. Applicant was previously represented by counsel.
18. The names and addresses of each attorney who represented applicant at each proceeding:

During trial Applicant was represented by Elizabeth Fullwood, the Lexington County Public Defender, and I. McDuffie Stone, a lawyer in private practice, who also served as a part-time prosecutor in another state judicial circuit.

Assistant Appellate Defender Robert M. Dudek, of the S.C. Office of Appellate Defense, of Columbia, represented Applicant during appeal.

H. Wayne Floyd, an attorney in private practice in West Columbia, and Melissa Armstrong (previously Kimbrough), an attorney previously in private practice in Columbia, were appointed to represent Applicant in state post-conviction proceedings.

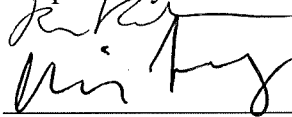
In federal habeas corpus, Applicant was represented by various attorneys: Derek J. Enderlin of Ross & Enderlin in Greenville; Elizabeth Anne Franklin-Best of Elizabeth Franklin-Best, PC, in Columbia; Laura Wood Young, previously of Blume, Franklin-Best & Young, LLC, in Columbia; and Teresa L. Norris, previously of Blume Weyble and Norris, of Columbia.

After Applicant's counsel moved for a stay in federal habeas corpus pursuant to *Rhines v. Webster*, 544 U.S. 269 (2005), he was represented in a second application for post-conviction relief by Teresa L. Norris, Elizabeth Franklin-Best, and Derek J. Enderlin.

Applicant was represented on appeal from denial of his petition for habeas corpus by Elizabeth Franklin-Best and Hannah Lyon Freedman of Justice 360, in Columbia.

19. Applicant seeks relief from his death sentence.
20. Applicant is not under sentence from any other court.

Respectfully submitted,



Hannah Freedman, S.C. Bar No. 103373

Brendan Van Winkle, S.C. Bar No. 104768

Allison Franz, S.C. Bar No. 105189

JUSTICE 360

900 Elmwood Ave., Ste. 200

Columbia, SC 29201

hannah@justice360sc.org

brendan@justice360sc.org

March 21, 2022

COPY

THE STATE OF SOUTH CAROLINA)

COUNTY OF LEXINGTON)

Gary Dubose Terry, SCDC#5054,)

Applicant,)

v.)

State of South Carolina,)

Respondent.)

IN THE COURT OF COMMON IN THE
COURT OF COMMON PLEAS
FOR THE ELEVENTH CIRCUIT

2022 CP 3200924
Case No.

CERTIFICATE OF SERVICE

The undersigned hereby certifies that a copy of Appellant's Application for Post-Conviction Relief was served by first class mail, postage prepaid, this 21st day of March, 2022, upon the following:

William Edgar Salter, III
South Carolina Attorney General's Office
P.O. Box 11549
Columbia, SC 29211



FILED
2022 MAR 21 PM 12:47
CLERK OF COURT
ELEVENTH CIRCUIT
COLUMBIA, SC

STATE OF SOUTH CAROLINA)
COUNTY OF LEXINGTON)
Gary Dubose Terry,)
Applicant,)
Vs.)
State of South Carolina,)
Respondent.)

IN THE COURT OF COMMON PLEAS
FOR THE ELEVENTH JUDICIAL CIRCUIT

Case No. 2022-CP-3200924

**MOTION TO RECONSTRUCT
THE RECORD**

Applicant, Gary Dubose Terry, by and through undersigned counsel, hereby submits the following motion to reconstruct the record of his post-conviction relief (PCR) hearing held July 17-18, 2024. In support of this motion, Applicant would show the following.

1. The PCR evidentiary hearing in this matter was held before this Court on July 17-18, 2024.

2. The hearing was recorded using the Digital Courtroom Recording Package (DCRP) in the courtroom. While a court monitor was present in the courtroom, the court monitor was not responsible for transcribing the evidentiary hearing or verifying the accuracy of the information being recorded. No court reporter was present on either day of the hearing.

3. On November 14, 2024, counsel received the transcript of the evidentiary hearing from a stenographer, Bobbi Fisher, who transcribed the hearing based on the recording obtained by the DCRP system. Ms. Fisher advised both parties of multiple issues with the hearing recording: (1) “[t]he Webex connection with Dr. Greenspan cut in and out and/or was hard to understand at times”; and (2) one of the microphones in the courtroom was “blown out” with severe feedback, and the other microphones were “turned down extremely low.” Exhibit 1. The problems with the microphones were not resolved until after the 11:14 AM break on the first day of the hearing. *Id.*

4. Ms. Fisher advised both parties that she used both the Webex and DCRP recordings to compile the hearing transcript. However, the transcript contained 201 “indiscernible” notations in 354 pages, where testimony, arguments by counsel, or court rulings were missing. Exhibit 2.

5. On December 30, 2024, undersigned counsel requested a copy of the hearing recording so that it would be possible to request and propose accurate corrections for a transcript challenge. Exhibit 3. On the same day, Court Administration advised that a copy of the recording would not be provided and instructed counsel to file a formal challenge. Exhibit 4.

6. On January 15, 2025, counsel submitted a formal transcript challenge to Ms. Fisher and Court Administration, detailing each of the 201 “indiscernible” notations, in addition to other transcription errors, and proposing corrections where possible. Exhibit 5.

7. In response to the transcript challenge, Ms. Fisher worked extensively to address the “indiscernible” notations and fill in gaps wherever possible. Exhibit 6. On January 29, 2025, Ms. Fisher provided counsel with a corrected transcript and a spreadsheet detailing the corrections that she had made. Exhibit 6; Exhibit 7. Even after Ms. Fisher’s extensive work, 163 “indiscernible” notations remain in the corrected version of the transcript. Exhibit 8.

8. There are multiple instances in the transcript in which questioning of other witnesses and argument by counsel, along with rulings by the Court, are “indiscernible,” evidently due to the difficulties with the microphones inside the courtroom. *See* Exhibit 8. In addition, one of the witnesses, Dr. Stephen Greenspan, testified virtually via Webex, and some of the “indiscernible” notations arose from problems with the Webex connection.¹

9. The extent of the missing testimony, argument, and rulings by the Court in the corrected transcript will hamper not only this Court’s ability to review this case, but also the ability

¹ Counsel for Applicant informed the Court that Dr. Greenspan would need to testify virtually on July 10, 2024. Exhibit 9.

of the South Carolina Supreme Court to review this Court's ruling on appeal. Further, it is extremely difficult, if not impossible, to prepare meaningful post-hearing briefing on the basis of an incomplete transcript that will allow this Court to meaningfully evaluate the questions raised in this PCR application and the evidence presented at the hearing.

10. Given that this case is a capital post-conviction proceeding raising a claim of categorical ineligibility for the death penalty, it is crucial that the record of the PCR hearing be as accurate as possible. The United States Supreme Court has repeatedly recognized the heightened "need for reliability" that the Eighth Amendment requires "in the determination that death is the appropriate punishment in a specific case" under the Eighth Amendment. *Caldwell v. Mississippi*, 472 U.S. 320, 323 (1985) (quoting *Woodson v. North Carolina*, 428 U.S. 280, 305 (1976) (plurality opinion)); *Zant v. Stephens*, 462 U.S. 862, 884 (1983); *Lockett v. Ohio*, 438 U.S. 586, 604 (1978) (noting that the "qualitative difference between death and other penalties calls for a greater degree of reliability when the death sentence is imposed").

CONCLUSION

For the foregoing reasons, counsel requests that the Court schedule a hearing in this matter to discuss steps that can be taken to reconstruct missing portions of the record and create a record of the case that allows for meaningful review, both by this Court and on appeal.

[signature block appears on following page]

Respectfully submitted,

/s/ E. Charles Grose, Jr.

E. Charles Grose, Jr.

The Grose Law Firm

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Greenwood, SC 29646

(864) 538-4466

charles@groselawfirm.com

/s/ Allison Franz

Allison Franz

Justice 360

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Columbia, SC 29201

(803) 765-1044

allison@justice360sc.org

February 18, 2025.

Exhibit 1



Allison Franz <allison@deathpenaltyresource.org>

Fw: TRANSCRIPT: (7/17-18/2024) Gary Terry v State

Charles Grose <charles@groselawfirm.com>
To: Ali Franz <allison@justice360sc.org>

Sun, Nov 3, 2024 at 1:31 PM

Best,
Charles

E. Charles Grose, Jr.
The Grose Law Firm, LLC
305 Main Street
Greenwood, SC 29646
Phone: 864-538-4466
Fax: 864-538-4405
Web: GroseLawFirm.com
Email: charles@groselawfirm.com

From: Fisher, Bobbi <bfisher@sccourts.org>
Sent: Sunday, November 3, 2024 10:02:51 AM
To: Charles Grose <charles@groselawfirm.com>
Cc: Transcripts <transcripts@sccourts.org>
Subject: TRANSCRIPT: (7/17-18/2024) Gary Terry v State

Attached, please find the requested transcript (see below for case details). I have also attached my invoice. If you could please forward my invoice along for processing, I'd appreciate it.

NOTE: There were several technical issues with this recording that I wanted to advise you about, which resulted in **numerous** indiscernible marks throughout the transcript:

1. The Webex connection with Dr. Greenspan cut in and out and/or was hard to understand at times.
2. While on Webex, the DCRP was also recording to capture the in-courtroom audio (objections, motions); however MIC A2 was "blown out"/severe feedback and the other mics were turned down extremely low. This made hearing audio quite a challenge. The court monitor realized this at some point in the morning, and at the 11:14 a.m. break, the court monitor resolved the issue with the MIC A2.
3. Unfortunately, DCRP does not run a backup recording so we only have the one audio file. In this case, I did use the Webex recording and went back through it again with the DCRP audio to fill in spots on Dr. Greenspan's testimony.

Also, this is one transcript file covering both days of the hearing. Day 2 does have its own title/index pages so that, if you need to print them, you can bind them separately if you need to.

[DCRP]

Gary Terry v. State
2022-CP-32-00924
July 17-28, 2024
Lexington CP- Judge Hood

Kind Regards,

Bobbi Fisher, RPR

*Ms. Bobbi Fisher, Stenographer
South Carolina Official Court Reporter III (Horry County)
NCRA Registered Professional Reporter (RPR)
DCRP Transcription Team*

~~~ CONFIDENTIALITY NOTICE ~~~ This message is intended only for the addressee and may contain information that is confidential. If you are not the intended recipient, do not read, copy, retain, or disseminate this message or any attachment. If you have received this message in error, please contact the sender immediately and delete all copies of the message and any attachments.

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**2 attachments**



**Invoice 2746 - Gary Terry v State.pdf**  
81K



**07-17-24 Terry, Gary v State.pdf**  
1751K

# Exhibit 2

1 STATE OF SOUTH CAROLINA \* COURT OF COMMON PLEAS  
2 COUNTY OF LEXINGTON \* TRANSCRIPT OF RECORD  
3 -----X  
4 GARY DUBOSE TERRY, \*  
5 Applicant, \*  
6 vs. \* Case No. 2022-CP-32-00924  
7 STATE OF SOUTH CAROLINA, \*  
8 Respondent. \*  
9 -----X

Hearing Dates:  
July 17-18, 2024

ATKINS HEARING - VOLUME I  
July 17, 2024

B E F O R E:

The Honorable Robert E. Hood, Presiding Judge

A P P E A R A N C E S:

E. Charles Grose, Jr., Esq.  
Allison Franz, Esq.  
Attorneys for the Applicant

Tommy Evans, Jr. Esq.  
Melody J. Brown, Esq.  
Assistant General Attorneys for the Respondent

Recorded by: DCRP Court Monitor Roderick Fitzgerald  
Partial (Webex) for Dr. Greenspan's testimony

Transcribed by: Bobbi Fisher, RPR  
SC Official Court Reporter III

M A S T E R   I N D E X

| <u>WITNESS/DESCRIPTION</u>                  | <u>PAGE</u> |
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| Voir Dire Cross-Examination By Mr. Evans    | 20          |
| Voir Dire Redirect Examination By Mr. Grose | 30          |
| Direct Examination By Mr. Grose             | 52          |
| Cross-Examination By Mr. Evans              | 125         |
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| Recross-Examination By Mr. Evans            | 186         |
| DR. SCOTT DECKER                            |             |
| Direct Examination By Ms. Franz             | 194         |
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| DR. JESSICA DAVIS                           |             |
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| Redirect Examination By Ms. Brown           | 263         |
| DR. ALICIA HALL                             |             |
| Direct Examination By Ms. Brown             | 266         |
| Cross-Examination By Ms. Franz              | 314         |
| Recross-Examination By Ms. Franz            | 345         |



## E X H I B I T S

(Exhibits on file in Clerk of Court's Office.)

## Applicant's Exhibit

| No. | Description                         | ID. | REC'D |
|-----|-------------------------------------|-----|-------|
| 1   | Dr. Greenspan's C.V.                | 18  |       |
| 2   | Dr. Greenspan's 7/25/24 Report      | 122 | 124   |
| 3   | Dr. Greenspan's 7/10/24 Report      | 122 | 124   |
| 5   | School Records                      | 85  |       |
| 7   | Richland Memorial Hospital Records  | 85  |       |
| 8   | Document Regarding Fall out of Tree | 346 |       |
| 9   | Emergency Room Records              | 86  |       |
| 10  | MUSC Neurology Record               | 86  |       |
| 11  | Richland County Detention Center    | 86  |       |
|     | Record                              |     |       |
| 12  | Dr. Hazelton Records                | 86  |       |
| 13  | Dr. Decker's C.V.                   | 199 | 200   |
| 14  | Dr. Decker's Report                 | 211 | 212   |

## State's/Respondent's Exhibit

| No. | Description       | ID. | REC'D |
|-----|-------------------|-----|-------|
| 1   | Dr. Hall's Report | 228 |       |
| 2   | Dr. Decker's C.V. | 232 | 232   |
| 3   | Dr. Hall's C.V.   | 265 | 272   |

## COURT REPORTER LEGEND

Dash (--) Indicates an interruption in speech

Ellipses (...) Indicates trailing off in speech

(ph) Indicates phonetic word

[Verbatim] Indicates the word is said as written

(Indiscernible)[Transcription] Indicates word(s) is  
not known due to audio recording  
quality

## P R O C E E D I N G S

[Digital recording technical difficulties.]

THE COURT: All right, Rod. You good?

COURT MONITOR: [Indiscernible.]

THE COURT: All right. We're on the record in Gary Terry versus the State of South Carolina, 2022-CP-32-924. Mr. Terry is present, represented by Mr. Franz and Mr. Grose. The State's present, represented by Ms. Brown and Mr. Evans.

Anything we need to take up before we get started, Mr. Grose?

MR. GROSE: [Indiscernible].

THE COURT: All right. Ms. Brown?

MS. BROWN: Yes, Your Honor. [Indiscernible] pre-trial exhibits. And I have two copies; one for [indiscernible] one for your law clerk. And we will also have this morning a motion to exclude [indiscernible] Dr. Greenspan. We have prepared a memorandum in support of that. We'd ask [indiscernible] hand that up at this time. [Indiscernible] to opposing counsel might be the simplest way to approach this.

May I approach, Your Honor?

THE COURT: You may.

MS. BROWN: To be brief, Dr. Greenspan will give testimony [indiscernible] and of course, as an expert, we would be entitled to voir dire. Some of that, I believe, will bring out testimony that is important for our motion to

1 exclude the testimony. So, Your Honor, [indiscernible] are  
2 the motions.

3 [Digital recording technical difficulties.]

4 THE COURT: Okay. And he's testifying virtually?

5 MS. BROWN: Yes, sir.

6 THE COURT: When was someone going to tell me that?

7 MR. GROSE: [Indiscernible] told me that last week  
8 [indiscernible]. The clerk asked us this morning  
9 [indiscernible] witnesses going to be testifying virtually  
10 [indiscernible].

11 THE COURT: I don't even know how to set all that up over  
12 here.

13 Rod, how are you able to record that?

14 COURT MONITOR: [Indiscernible].

15 THE COURT: Rod, how are you going to record that?

16 COURT MONITOR: [Indiscernible].

17 THE COURT: Zoom is not the same system as the Webex  
18 system.

19 MR. GROSE: I understand.

20 THE COURT: The issue is you're in a digital courtroom.  
21 You're not with a live court reporter so it's a different  
22 setup.

23 MR. GROSE: With all the time we have [indiscernible].

24 THE COURT: And they have no court reporter  
25 [indiscernible]. It's just a system recording itself.

1 MR. GROSE: [Indiscernible].

2 THE COURT: I'm not disputing that any of that's  
3 happened, but we're in a digital courtroom. It's a different  
4 setup. There's microphones in the courtroom that are  
5 recording. How is he going to [indiscernible]?

6 That's what I'm asking Rod.

7 Is there a [indiscernible] to record it?

8 [Digital recording technical difficulties.]

9 THE COURT: [Indiscernible] pipe in his speaker through  
10 one of these microphones and everybody in here leaves their  
11 microphones on, do you think that will work?

12 [Digital recording technical difficulties.]

13 THE COURT: All right. Dr. Greenspan, can you go ahead  
14 and turn on your video?

15 Yeah, I can't hear him at all.

16 Rod, are you back on?

17 COURT MONITOR: Yes.

18 THE COURT: Okay. All right. Dr. Greenspan, what we're  
19 doing at this point in the system is we're testing the system.  
20 I'm going to have you speak here in just a moment to see the  
21 court reporter's ability to record what's going on.

22 Mr. Grose, can you-all turn on your videos?

23 Are you logging back in, Rod?

24 COURT MONITOR: I'm sorry?

25 THE COURT: Are you logging back in?

1 (Pause in the proceedings.)

2 THE COURT: Can y'all turn on your videos?

3 MR. GROSE: My video is on. It's showing on my screen.

4 THE COURT: Dr. Greenspan, quote "Mary Had a Little Lamb"  
5 or something like that. We're trying to test the audio. Just  
6 anything. It doesn't matter. It doesn't have to do with the  
7 case. I'm just trying to figure out the audio.

8 (Pause in the proceedings.)

9 THE COURT: Where is this guy?

10 UNIDENTIFIED SPEAKER: [Indiscernible].

11 THE COURT: And why isn't he here?

12 UNIDENTIFIED SPEAKER: We went before the  
13 [indiscernible].

14 THE COURT: If I re-read through this pretrial brief and  
15 it doesn't say anything about a virtual hearing, I'm not going  
16 to be happy.

17 MR. GROSE: It's in the cover email that went with it,  
18 Your Honor.

19 THE COURT: Okay. So here's what we're going to have to  
20 do.

21 Rod, you're going to have to not record the thing. We're  
22 going to have to make the virtual recording of it part of the  
23 record. Okay? All right. So, Rod, go ahead and turn -- go  
24 ahead and log out.

25 Okay. Dr. Greenspan, can you hear me?

1 THE WITNESS: Yes, sir.

2 THE COURT: Okay. And Mr. Evans, can you try talking?

3 MR. EVANS: Dr. Greenspan, can you hear me?

4 THE WITNESS: Yes, sir, I can very well.

5 THE COURT: Okay. Ms. Franz, go ahead and try.

6 MS. FRANZ: Dr. Greenspan, can you hear me?

7 THE WITNESS: [Indiscernible].

8 THE COURT: Go ahead, Ms. Franz. Keep talking. He needs  
9 to be able to hear you.

10 MS. FRANZ: I'm sorry. I can't -- he can't hear me?

11 THE COURT: No.

12 THE WITNESS: I can hear you; it's just [indiscernible].

13 MS. FRANZ: That might be it. Can you hear me now?

14 THE COURT: Don't record it on the digital machine. I'm  
15 just going to record it. Do you see what I mean? Then, that  
16 way, we don't have to deal with a bunch of feedback.

17 MR. GROSE: I logged out because I couldn't see all the  
18 people on the screen. I think I need to be let back in the  
19 courtroom. I still can't see.

20 Dr. Greenspan, can you hear me?

21 THE WITNESS: [Indiscernible].

22 THE COURT: Y'all just need to set the computer up in  
23 between the two of you so it can see all three of you. Just  
24 turn yours off, Mr. Grose, and use Ms. Franz's.

25 Okay. So is he the first issue that we need to take up

1 this morning?

2 MS. FRANZ: Yes, sir, Your Honor. We would move to  
3 exclude during voir dire.

4 THE COURT: Okay. All right. So here's what we do:  
5 No. 1, we're making a virtual recording of Dr. Greenspan's  
6 testimony, voir dire, whatever you want to call it that we're  
7 recording through the Webex system. Okay? For that, the  
8 lawyers and I will stay muted unless you are asking questions  
9 or making an objection; otherwise, we're going to have so much  
10 feedback that no one can understand what's going on. So if  
11 you need to hop in, you know, unmute yourself. But, until  
12 then, if you'll keep yourself muted, that will help control  
13 the feedback.

14 Do y'all understand what we're doing?

15 MR. GROSE: Yes, sir.

16 THE COURT: Do you understand what we're doing?

17 MR. EVANS: Yes, sir, Your Honor.

18 THE COURT: All right. So y'all mute yourselves and then  
19 I'm going to talk to Dr. Greenspan.

20 MS. FRANZ: Your Honor, the only problem that we have is  
21 we can't hear. Is there a way to control volume otherwise?

22 THE COURT: No. That's why this whole thing doesn't  
23 work. That's why you're supposed to be in the privacy of your  
24 office with a set of headphones on so you can hear. So you're  
25 going to --



1 Ms. Doyle, can you go over there and make sure...

2 You're going to be able to hear the questioning and me.

3 It's going to be him that you can't hear. It's still going to  
4 be a bunch of feedback, but it won't record that way.

5 This isn't the way it's supposed to be done, so....

6 Okay. All right. Dr. Greenspan, can you hear me?

7 THE WITNESS: Yes, sir.

8 THE COURT: Okay. And I'm going to need you to speak up  
9 or get closer to the microphone. Okay?

10 THE WITNESS: Yes, I was.

11 THE COURT: Yeah, like, do you have a microphone or  
12 anything like that that's available to you?

13 THE WITNESS: Afraid not. I need to buy one, but at the  
14 moment, I don't have one.

15 THE COURT: Okay. You're going to need to speak up  
16 significantly.

17 THE WITNESS: Okay. I'll try to do that.

18 THE COURT: Okay. All right. So good morning,  
19 Dr. Greenspan. Thank you for your patience with us. We're  
20 here on 2022-CP-32-924, Terry versus the State of South  
21 Carolina. The State has a pretrial motion concerning  
22 qualifications so we'll let Mr. Terry start with  
23 Dr. Greenspan's voir dire.

24 DR. STEPHEN GREENSPAN,  
25 was examined and testified to as follows:

VOIR DIRE EXAMINATION

BY MR. GROSE:

Q Dr. Greenspan, can you hear me?

A Yes. Good morning, Mr. Grose.

MR. GROSE: I can't -- I could hear a minute ago, but I can't now.

BY MR. GROSE:

Q Dr. Greenspan, can you state your full name for the record.

A Stephen Greenspan. S-t-e-p-h-e-n G-r-e-e-n-s-p-a-n.

Q All right. And what is your profession?

A I'm a psychologist.

Q And, if you would, would you please summarize your professional employment -- I mean, your educational experiences? I'm sorry.

A Yes. A bachelor's from Johns Hopkins, a master's from Northwestern, a Ph.D. from the University of Rochester, and post-doctoral certificate from UCLA.

Q All right. And after you completed your post-doctorate, what do you do as far as employment?

A I was an assistant professor and research scientist at George Peabody College of Vanderbilt University. And then I went to Nebraska where I was [indiscernible; technical difficulties] ---

THE COURT: And now he's gone.

1 A --- in Colorado where I was affiliated with University of  
2 Colorado Medical School. And now [indiscernible].

3 THE COURT: I think we need to go back to Nebraska  
4 forward.

5 BY MR. GROSE:

6 Q Dr. Greenspan, we lost you on this end. Can you go back  
7 to the University of Nebraska and go forward?

8 A Yes. In Nebraska, I was affiliated with the University  
9 of Nebraska and also worked at Boycetown (ph) at a research  
10 center where I headed up a program, a research on intellectual  
11 disability. And then I moved to Connecticut where I  
12 eventually became a full professor of educational psychology.  
13 I retired from there and then moved to Colorado where I was  
14 affiliated with the University of Colorado and developed a  
15 consulting practice, including forensic cases. And now I live  
16 in northern California.

17 Q And so for how many years have you practiced as a  
18 psychologist?

19 A Probably half a century, I would say.

20 Q And do you have any certifications and licenses?

21 A Yes. I have a psychology license from the State of  
22 Nebraska, which I allowed to become dormant, and I still have  
23 a psychology license from the State of Nebraska.

24 Q And during your career, have you focused on intellectual  
25 disabilities?

1 A Yes. That's been my main focus. For example, I'm the  
2 most cited authority in the section on intellectual disability  
3 in the DSM-5. And I testify in forensic cases, typically in  
4 Atkins proceedings such as this one.

5 Q Okay. And have you conducted evaluations regarding  
6 intellectual disability?

7 A Yes, I have on many occasions, both criminal and civil  
8 cases.

9 Q And can you estimate the number of evaluations you have  
10 conducted?

11 A Well, in criminal cases, at least 40, I would say. And  
12 for --

13 Q And -- I'm sorry, go ahead.

14 A Sorry. And for service eligibility, maybe another 20 or  
15 so.

16 Q And why do you mean by "service eligibility"?

17 A Well, for example, let's say someone with apparent  
18 developmental disability applies for services from whatever  
19 state they live in and there's some question about their  
20 eligibility, and I'm sometimes hired to come in and determine  
21 if that's an appropriate decision.

22 Q And you mentioned Atkins evaluations. Can you explain  
23 what an Atkins evaluation is?

24 A Well, in November of 2002, the U.S. Supreme Court in the  
25 case of Atkins v. Virginia ruled that people with what was

1 then called mental retardation could not be executed. And I  
2 had started -- I started getting calls from attorneys or  
3 sometimes public defender offices asking if I would be willing  
4 to testify. Because I was no longer teaching at that point, I  
5 was more available than I would have been otherwise, and so I  
6 often [indiscernible] and asked to consult both in terms of  
7 helping a Court to understand what intellectual disability is  
8 and what's the appropriate method to use in making that  
9 determination and also getting involved in testifying about a  
10 particular individual and whether or not they qualify, in my  
11 opinion, as intellectually disabled.

12 Q And are you or have you been a member of different  
13 professional organizations?

14 A Yes. I'm a member of the American Psychological  
15 Association and was elected a fellow, which is the highest  
16 level of membership. And that's within the Division 33, which  
17 is the division on mental retardation and autism now.

18 American Psychological Society, same thing; I'm a fellow.  
19 I was elected a fellow of the American Association on  
20 Intellectual and Developmental Disabilities, which is the main  
21 professional organization in the intellectual disability  
22 field.

23 And I may be -- I was, at one time, the president of the  
24 Academy on Mental Retardation. And I'm probably leaving out  
25 one or two.

1 Q And probably what?

2 A Probably leaving out one or two other organizations that  
3 I have been involved in.

4 Q So is it fair to say you have been involved in a number  
5 of professional organizations involving psychology and  
6 intellectual disabilities?

7 A Yes. For example, in DSM-5, on the section on  
8 intellectual disability, in the online version, which is the  
9 one only which has citations, I'm the most cited person in the  
10 field of intellectual disability within that chapter.

11 Q And in addition to your involvement with the DSM-5, have  
12 you -- do you have any publications?

13 A Well, I was also a member for awhile of the  
14 classification committee or AAIDD, the American Association of  
15 Intellectual and Developmental Disability. And I was the main  
16 consultant to the committee writing the DSM-5 chapter on  
17 intellectual disability. So I'm very familiar with the  
18 diagnostic criteria and the manuals that define intellectual  
19 disability and what's involved in drafting those -- those  
20 documents.

21 Q All right. When you say the DSM-5, can you explain what  
22 you mean by that?

23 A Yes. It's called the Diagnostic and Statistical Manual  
24 of Mental Disorders, DSM. It's gone through several  
25 revisions. So the most recent one is the fifth edition.

1 That's why they call it DSM-5. And then, recently, there was  
2 another revision, which they called text revision, so it's --  
3 the most current one is DSM-5-TR for text revision. And I  
4 believe I continue to be the most cited person in that current  
5 document because it really is just basically the same as the  
6 former one with one minor change.

7 Q And you also mentioned the AAIDD. What is that?

8 A Yes. DSM is a psychiatric organization which covers many  
9 dozens, if not hundreds, of disorders. AAIDD just has one  
10 focus, and that's intellectual disability. And they also have  
11 a manual, which is now in its 12th -- 12th revision or 12th  
12 edition, so I would call that AAIDD-12. They're very closely  
13 assigned in their definition of intellectual disability in  
14 part because, as membership -- cross-membership across the two  
15 groups in terms of their committees that wrote these manuals.  
16 At one time, I was a member of the committee that wrote the  
17 AAIDD manual.

18 In the AAIDD 11th edition, I was the most cited authority  
19 just as I am in the DSM-5 and 5-TR.

20 Q And the AAIDD manual, is that the intellectual disability  
21 definition, diagnosis, clarification, and systems of support?

22 A Yes, I believe that's the name of it.

23 Q All right. And in addition to your involvement in the  
24 AAIDD manual and the DSM-5 with regard to intellectual  
25 disabilities, have you published in any scientific journals?

1 A Yes. I probably have 50 or 60 refer- -- articles and --  
2 which include various chapters in books. It's probably close  
3 to a hundred. And I have also published five or six books of  
4 my own, including one that's about to come out from Springer  
5 Publishing titled, "The Parkland School Shooter and Fetal  
6 Alcohol Syndrome."

7 Q And have -- are your publications listed on your C.V.?

8 A Yes, they are.

9 Q And we had sent you a folder of exhibits. Did you have a  
10 chance to look at those?

11 A Yes.

12 (Applicant's Exhibit No. 1, Dr. Greenspan's C.V. was  
13 premarked for identification.)

14 BY MR. GROSE:

15 Q And Applicant's Exhibit 1, do you recognize that as a  
16 copy of your C.V.? It's ten pages long.

17 A Yes. I don't have that called up on my screen. Is that  
18 in the box or folder you sent me?

19 Q Yes, sir.

20 A I have it on a separate laptop. Here we go. I thought  
21 might be it dead. Yeah, I have to plug it in. It's about to  
22 die. I apologize. I thought it was up and running, but the  
23 battery died.

24 To try to save the Court some time, is it possible for  
25 you to put it up for me to look at it or can I just say that



1 I'm sure it is my C.V.?

2 MS. FRANZ: Can you see that, Dr. Greenspan?

3 BY MR. GROSE:

4 Q Can you see that, Dr. Greenspan?

5 A What's that? Oh, yes. I wasn't looking.

6 Q And we have marked it as Applicant's Exhibit 1. It looks  
7 like your April 2024 C.V. that has ten pages.

8 A Yes. I may have a couple more publications since then  
9 but that is definitely my C.V.

10 MR. GROSE: Okay. At this time, I would offer  
11 Dr. Greenspan's C.V. into evidence as Applicant's Exhibit 1.

12 MR. EVANS: Your Honor, we would hold any objections for  
13 approval of the C.V. into evidence since we are going to  
14 object with him being allowed an expert in this field, Your  
15 Honor.

16 MR. GROSE: Then I would proffer Applicant's Exhibit  
17 No. 1 at this time and a copy for the court reporter, a copy  
18 for the Court and your law clerk [indiscernible].

19 THE COURT: Thank you.

20 MR. GROSE: At this time, I would offer Dr. Greenspan as  
21 an expert in psychology with a specialization in diagnosing  
22 intellectual disability.

23 [Digital recording technical difficulties.]

24 THE COURT: [Indiscernible] exhibit [indiscernible]?

25 MR. GROSE: I have provided them with a copy.

1 THE COURT: I mean on the screen.

2 MR. EVANS: Oh, I don't know.

3 THE COURT: Okay. Y'all just pull that off the screen  
4 for me, please.

5 All right. And Mr. Evans, [indiscernible].

6 MR. EVANS: [Indiscernible], Your Honor.

7 THE COURT: All right, Mr. Evans. If you will unmute  
8 yourself. And, Ms. Franz, if you will mute. There you go.

9 MR. EVANS: Thank you, Your Honor. May it please the  
10 Court?

11 VOIR DIRE CROSS-EXAMINATION

12 BY MR. EVANS:

13 Q Dr. Greenspan, do you remember speaking to me at a  
14 deposition last week, last Thursday?

15 A Yes, sir.

16 Q Okay. And I asked you questions about your report. You  
17 filed a report -- well, you sent a report that was dated on  
18 July 5th of this year; isn't that correct?

19 A Yes.

20 Q Okay. And in this report, you list activities you  
21 performed but you never listed any dates that you performed  
22 any of these activities; isn't that correct?

23 A I believe that's true, yes.

24 Q Okay. And you also listed documents that you received  
25 and, I guess, reviewed -- numerous documents, but there is no

1 listing of the actual documents and where they're from listed  
2 or when you listed them -- when you reviewed them; isn't that  
3 correct?

4 A I think that's probably true, yes, sir.

5 Q Okay. And I remember asking you about notes, and you  
6 said that -- and during the deposition, that you have terrible  
7 handwriting and you can barely read the notes yourself; isn't  
8 that correct?

9 A Yes.

10 Q Okay. So you are prepared to testify strictly from your  
11 memory and not reviewing any notes or anything of that nature?

12 MR. GROSE: Your Honor, at this time, I have to interpose  
13 an objection. We have provided the Attorney General with the  
14 notes that he had available.

15 We sent those to you this week. So for you to suggest  
16 that is a misrepresentation.

17 MR. EVANS: Your Honor, they provided notes of two  
18 witnesses. Nothing else. And I'm talking about notes from  
19 discussions with the defendant and also any notes that he  
20 received or wrote down from any of the records he reviewed.  
21 We never received any of those things. That's the notes he's  
22 talking about, and he's going to testify or prepared to  
23 testify about documents he reviewed [indiscernible] I don't  
24 even know [indiscernible] from something he reviewed we don't  
25 know when because it's not listed when he reviewed it, those

1 notes, in his actual reports, Your Honor.

2 MR. GROSE: First of all, none of this goes to his  
3 qualifications or the reliability. We --

4 MR. EVANS: Oh, yes, it does. I mean, if he's testifying  
5 from memory, then it's not reliable.

6 MR. GROSE: May I finish?

7 THE COURT: You may?

8 MR. GROSE: I assume they're not going to offer any  
9 witnesses here [indiscernible]. We provided them with the  
10 notes of one of the collateral interviews that was done and  
11 notes that he took when he was providing or using a structured  
12 interview with Mr. Terry here. And so for him to suggest that  
13 there's no notice that's been provided, it's not true.

14 Secondly, he had an opportunity -- he only -- the  
15 deposition is only about an hour, but he had an opportunity in  
16 that deposition to ask about records and go into details and,  
17 you know, it's -- and he has an opportunity to be  
18 cross-examined.

19 Again, none of this goes to qualification.

20 MR. EVANS: Your Honor, [indiscernible].

21 THE COURT: All right. Any -- the objection made. It's  
22 overruled. We're in the middle of voir dire as to  
23 qualifications. You may continue to question the witness.

24 [Digital recording technical difficulties.]  
25

1 BY MR. EVANS:

2 Q Now, Dr. Greenspan, according to the DSM-5, in order to  
3 make a determination of --

4 THE COURT: All right. I don't think the system's  
5 pulling you up.

6 (Pause in the proceedings.)

7 THE COURT: Hang on just a second, Dr. Greenspan.

8 This is what happens when we do virtual hearings.

9 (Pause in the proceedings.)

10 THE COURT: All right, Dr. Greenspan. I think we fixed  
11 the technological issues. Mr. Evans is questioning you.

12 And I don't know that I swore you in before you started,  
13 but do you swear or affirm all the information you're going to  
14 give today, either previously or in the future, to be the  
15 truth, the whole truth, and nothing but the truth so help you  
16 God?

17 THE WITNESS: I do.

18 (Dr. Stephen Greenspan was duly sworn.)

19 THE COURT: Thank you, Dr. Greenspan.

20 Okay. You may continue, Mr. Evans.

21 MR. EVANS: Yes, Your Honor.

22 BY MR. EVANS:

23 Q Now, Dr. Greenspan, according to the DSM-5, in order to  
24 make a determination of intellectual disability, you must meet  
25 deficits in intellectual functioning, deficits in adaptive

1 functioning, and it all must occur during the developmental  
2 period; isn't that correct?

3 A That's correct.

4 Q And in order to find deficits in adaptive functioning,  
5 you did a common sense questionnaire; isn't that correct?

6 A Yes, but that was not the whole basis for my  
7 determination.

8 Q Okay. And in this questionnaire, you have done it with  
9 Mr. Terry, and he made answers to this questionnaire; isn't  
10 that correct?

11 A Which I believe you have. I sent it to Mr. Grose, yes.

12 Q Yes. Okay. And, basically, this questionnaire is  
13 scenarios to determine his common sense; isn't that correct?

14 A Yes. By common sense, I mean risk awareness -- social  
15 risk awareness.

16 Q Okay. And the only person that's going to make the  
17 determination of social risk awareness is you; isn't that  
18 correct?

19 A Could you repeat that, please?

20 Q The only person that's going to make this determination  
21 is you; isn't that correct?

22 A That's true of any clinician, yes.

23 Q Okay. So this -- and this questionnaire was created by  
24 yourself; isn't that true?

25 A Yes.

1 Q And nobody else in the psychological community uses this  
2 questionnaire; isn't that correct?

3 A For the most part, that's true.

4 Q Okay. And this questionnaire is not recognized in the  
5 psychological community; isn't that true?

6 A Well, my work is very recognized and it has been --  
7 people have expressed an interest in this. But, at this  
8 point, I wouldn't call it a test. It's a framework for asking  
9 questions to try to get at someone's risk awareness, which is  
10 certainly part but not all of adaptive behavior.

11 But you're right; it's, at this point, being used mainly  
12 by me as a structured framework for interviewing someone.

13 Q Okay. This is not a standardized instrument used by  
14 psychologists; isn't that correct?

15 A It's not a test, sir.

16 Q So it's also not a standardized --

17 A It's an interview framework, which is what psychiatrists  
18 use when they interview people.

19 Q So this is not something that is used by psychologists  
20 normally. It's only used by you; isn't that correct?

21 A Well, I would [indiscernible] fairness [indiscernible].

22 THE COURT: And he's frozen.

23 Maybe you can ask him the question over again.

24 BY MR. EVANS:

25 Q Dr. Greenspan, you froze for a second there. I'm going

1 to re-ask the question.

2 This is nothing that's used by psychologists normally;  
3 isn't that correct? It's only used by you; isn't that true?

4 A [Indiscernible].

5 Q Dr. Greenspan, did you hear my question?

6 A Yes. I said yes.

7 Q Okay. You froze again.

8 And there is no scientific reasoning to this  
9 questionnaire? No scoring or anything like that that's done  
10 from this questionnaire; isn't that correct?

11 A No, it's qualitatively evaluative.

12 Q Okay. By yourself and no one else?

13 A Yes.

14 Q Okay. It's not peer-reviewed or anything like that;  
15 isn't that correct?

16 A It's not a test. It's an interview framework.

17 Q Okay. And in your report, you reviewed the report of  
18 Dr. Scott Decker; correct?

19 A Yes, reporting on the testing he had done, particularly  
20 the Woodcock-Johnson cognitive instrument.

21 Q And you also, I think during your deposition, testified  
22 that you read the results of a CAT scan done by Dr. Daysach,  
23 who was a person that testified in the original trial; isn't  
24 that correct?

25 A Well, he's a neuropsychologist so I reviewed his



1 testimony about the testing that he did, and he referred to a  
2 CAT scan. But I don't believe he did the CAT scan. As a  
3 neuropsychologist, he would not be the person to administer or  
4 interpret the CAT scan, which is a medical procedure.

5 Q Now, during the deposition, you stated that had you  
6 testified in about 30 cases, all for the defense; isn't that  
7 correct?

8 A Yes.

9 Q And you gave us a listing of some of the cases you did  
10 testify into; isn't that true?

11 A [Indiscernible].

12 THE COURT: And he's out again.

13 All right. He seems back with us. I think you can  
14 re-ask the question.

15 BY MR. EVANS:

16 Q Dr. Greenspan, you gave us a list of cases you testified  
17 in; isn't that correct?

18 A I gave a list of recent cases. [Indiscernible] testify  
19 in all of them.

20 Q Could you repeat that, please?

21 A I gave a listing of some recent cases. I did not testify  
22 in every one of those. I didn't realize that's all you  
23 wanted.

24 Q Okay. All right. But there are some cases that we found  
25 that you have testified in. Do you remember testifying in the

1 Commonwealth v. Flor case in Pennsylvania?

2 A Which case was that?

3 Q Commonwealth v. Flor?

4 A I testified in Pennsylvania, but I didn't catch the name  
5 of the person I testified about. Could you repeat that or  
6 spell it?

7 Q F-l-o-r. Flor. Robert Anthony Flor.

8 A Yes. It's been a long time. I don't remember much -- I  
9 don't remember much about that, but I do remember the name.

10 Q Okay. So you didn't remember when the Supreme Court of  
11 Pennsylvania decided that, when it stated in their opinion,  
12 "His critical acceptance," talking about yourself, "of the  
13 opinions of the appellant's other expert notwithstanding those  
14 best practices were not adhered to, led to -- led it to  
15 discount the credibility of his opinion evidence." You don't  
16 remember reading that in the opinion in this case?

17 A No. This is the first time I have heard that.

18 Q Okay. Do you remember testifying in the case of Blue v.  
19 Thaler in the U.S. District Court in Houston?

20 A Again, could you repeat the name of the person I  
21 testified about?

22 Q Blue v. Thaler, T-h-a-l-e-r.

23 A [Indiscernible].

24 Q Okay. So I guess you don't remember when Judge Keith  
25 Hoyt, U.S. District Court judge, wrote in his decision that,

1 "Dr. Greenspan urges this Court to grant the habeas writ  
2 because Blue's scores are close that are required for a  
3 diagnosis of retardation, which should be enough in the  
4 capital context. Dr. Greenspan lessens the credibility of his  
5 expert opinion when he dilutes the psychological principles  
6 because this is a death penalty case. Science operates  
7 independent from the process of law. Blue's IQ scores should  
8 qualify him for a diagnosis of mental retardation based on  
9 objective facts -- factors, not an expert witness' perspective  
10 on capital punishment."

11 MR. EVANS: I don't think he even heard that.

12 BY MR. EVANS:

13 Q Dr. Greenspan?

14 A I don't recall. I have no recollection [indiscernible].  
15 [Indiscernible] my opinion and often I do agree. I could  
16 provide you with many, many ---

17 Q Dr. Greenspan, you have to repeat everything you just  
18 said because I didn't get a word of it. Could you please  
19 repeat what you just said?

20 A Completely [indiscernible], sir.

21 Q Okay. Do you remember the Candelario Santana case from  
22 Puerto Rico, testifying in that case?

23 A Yes, I do.

24 Q You do remember testifying in that case?

25 A Yes.

1 Q Okay. I guess you don't remember when District Court  
2 Judge José Antonio Fusté wrote, "We note this mismatch between  
3 Dr. Greenspan's credentials and his performance here as a  
4 warning to other courts who may yet hear his testimony in the  
5 future. Dr. Greenspan serves as an expert in cases of this  
6 sort across the country and [indiscernible] the man's  
7 impeccable professional reputation. Carelessness and  
8 evasiveness have no place in any courtroom; yet, Dr. Greenspan  
9 demonstrated those characteristics amply here and may do so  
10 again elsewhere."

11 Have you ever read that opinion or remember this being  
12 said about you, Dr. Greenspan?

13 A [Indiscernible]. Yes. I said yes.

14 Q Yes, you do. Okay.

15 MR. EVANS: Beg the Court's indulgence.

16 Nothing further, Your Honor.

17 THE COURT: Any follow-up, Mr. Grouse?

18 MR. GROSE: Yes, sir.

19 VOIR DIRE REDIRECT EXAMINATION

20 BY MR. GROSE:

21 Q Dr. Greenspan, can you hear me?

22 A Yes, I can, sir.

23 Q Let me pick up where they left off on the Candelario  
24 Santana case. Do you know if that judge was eventually  
25 sanctioned and removed from the bench?

1 A He was. He was also disbarred by the Puerto Rican Bar  
2 Association.

3 Q The State has picked a handful of cases that criticized  
4 your opinion. Have courts relied on your opinion?

5 A Many times.

6 Q When you say "many times," have courts relied on your  
7 opinion regarding your diagnosis of intellectual disability of  
8 a particular person?

9 A Yes. I don't have a score card, but I would say more  
10 often than not they do agree with me, and I have many cases I  
11 could cite where the judge said very positive things about me  
12 and my testimony.

13 Q Mr. Evans asked you about the list of cases that you  
14 provided. And as I recall the question came up in your  
15 deposition, did you have a complete list of cases, and you  
16 said you did not; is that correct?

17 A No. I had some computer disasters in recent years, and  
18 it would be very difficult for me to come up with a complete  
19 list at this point.

20 Q And what you agreed to provide Mr. Evans was a list of  
21 those recent cases that you had worked on.

22 A Yes, going back a couple of years. I may have left one  
23 or two out.

24 Q All right. And that's, in fact, what you did do; is that  
25 correct?

1 A Yes, sir.

2 Q Okay. And these cases that Mr. Evans asked you about  
3 today, he had an opportunity to ask you about those in your  
4 deposition and he didn't do it, did he?

5 A No, he didn't ask me about them.

6 Q Okay. Mr. Evans started off asking you questions about  
7 the diagnostic criteria contained in the DSM-5; do you recall  
8 that question?

9 A Yes, sir.

10 Q Is intellectual disability a number?

11 A No. In fact, in the Hall v. Florida case, the judge --  
12 the Supreme Court justice who wrote that opinion -- I'm  
13 blocking out his name. I think it was Stevens -- Justice  
14 Stevens -- wrote, quote, "Intellectual disability" -- he might  
15 have used the term "mental retardation" -- "is a condition,  
16 not a number," unquote.

17 Q And what does -- that statement, "a condition, not a  
18 number," is that something that you're familiar with in the  
19 scientific community as well?

20 MR. EVANS: Your Honor, I object to that question. I  
21 think it's going beyond the scope of my cross-examination.

22 THE COURT: I'll allow it.

23 MR. GROSE: Continue? All right.  
24  
25

1 BY MR. GROSE:

2 Q I don't know if you could hear that ---

3 A Yes, I did.

4 Q --- Dr. Greenspan. The judge overruled the objection.

5 Can you explain what the "condition, not a number" means  
6 in the scientific community regarding intellectual disability.

7 MR. EVANS: Your Honor, I renew my objection. This is  
8 voir dire. I think he's lapsing into an opinion  
9 [indiscernible] testimony, if you allow the testimony.

10 THE COURT: [Indiscernible] qualifications  
11 [indiscernible].

12 MR. GROSE: Well, that was my objection earlier, and they  
13 went far beyond his qualifications.

14 THE COURT: No, they went directly to reliability factors  
15 that counsel just said he had to go through so if you have  
16 something to ask him about his qualifications or the testimony  
17 [indiscernible].

18 BY MR. GROSE:

19 Q Dr. Greenspan, they asked you about the common sense  
20 questionnaire. Can you explain what the common sense  
21 questionnaire is?

22 A Yes. Common sense can be defined in various ways. I  
23 define it as awareness of obvious risk, whether it's social  
24 risk, such as getting arrested, or physical risk, such as  
25 getting run over. It's a very important aspect of adaptive

1 behavior, also known as adaptive functioning. In fact, DSM-5  
2 mentions risk awareness, I believe.

3 And so the common sense questionnaire is basically a  
4 social problem-solving interview in which I present scenarios.  
5 The typical way to approach a social problem-solving is to  
6 present a problem and ask somebody how they should solve it.  
7 I think the more important approach in terms of surviving in  
8 the world is to present a problem, present a solution, and  
9 then see if the individual understands why it might be a bad  
10 solution in terms of the possible disastrous consequences that  
11 would accrue from that behavior -- portrayed behavior.

12 And so the common sense questionnaire basically presents  
13 24 or 25 scenarios in which someone is portrayed  
14 [indiscernible] but coming up with a solution.

15 Q Now, is the common sense questionnaire, is it intended to  
16 be a psychological test?

17 MR. GROSE: I don't think he heard your question.

18 MR. EVANS: I lost him on my screen.

19 BY MR. GROSE:

20 Q Dr. Greenspan, can you hear me now?

21 A Yes, sir.

22 Q We lost you for a second here. My last question was: Is  
23 the common sense questionnaire intended to be a psychological  
24 test?

25 A [Indiscernible] score [indiscernible] neurological test.



1 Q Okay. The term "structured interview" was used earlier.  
2 What -- is the common sense questionnaire a structured  
3 interview?

4 A Yes. That's a basic method used by psychiatrists who are  
5 not qualified to administer tests, and it's also a method used  
6 by any mental health expert interviewing someone. I just  
7 present it in terms of a method of getting at someone's  
8 reasoning about social situations.

9 Q So is it fair --

10 A But structured --

11 Q I apologize; please continue.

12 A No, structured interview is a very, very common method  
13 used in forensic -- in forensic evaluations, and this is my  
14 attempt to get at it -- around this. So the risk awareness,  
15 which I see is critical and, to my knowledge, there is no  
16 other test or method for getting at a risk awareness.

17 Q When you say that a structured interview is a common  
18 technique used by psychiatrists and psychologists, can you  
19 explain what you mean by that? Try and give some examples?

20 A [Indiscernible].

21 Q We lost you for a second. Can you start over your  
22 answer, please?

23 A Structured [indiscernible] and I'm structuring around an  
24 ability or an issue that's generally not evaluated because  
25 there are no other ways of getting at it. Even though the DSM

1 says that risk awareness is very important, this is my attempt  
2 to develop a way -- excuse me -- of getting a handle on  
3 someone's risk awareness.

4 Q Okay.

5 A Every psychiatrist who evaluates someone uses a  
6 structured interview approach. So it's a very commonly used  
7 method in forensic evaluations.

8 Q And is it used in evaluations for competency to stand  
9 trial, for example?

10 A Yes. I mean, most people who do competency evaluations  
11 don't do formal testing. And there is -- there are one or two  
12 tests that are used in competency evaluations but they're  
13 generally not used. Rather, the method used is a structured  
14 interview.

15 Q All right. And does -- does the common sense  
16 questionnaire assist you in exercising your clinical judgment?

17 A Yes, it helps me see if someone has an ability to  
18 recognize and understand risk. In that sense, it's important.

19 Q And does the DSM-5 and the AAIDD manual endorse the use  
20 of clinical judgment in diagnosing intellectual disability?

21 A And they both do. In fact, AAIDD has their own book on  
22 this subject for -- involving clinical judgment, particularly  
23 in terms of diagnostic -- diagnosing intellectual disability.  
24 It's a very critical part of any mental health expert doing an  
25 evaluation. Otherwise, what do you need a clinician for? You

1 might as well just use a number.

2 Q Okay. And the common sense questionnaire assists you on  
3 what you -- what's considered Prong 2 sometimes, the deficits  
4 and adaptive behaviors; is that correct?

5 A Very much so, yes. But it's not the whole thing, by any  
6 means.

7 Q And I wanted to follow up on that. I think you said  
8 earlier, when Mr. Evans was questioning you, that the common  
9 sense questionnaire was not the sole basis for your diagnosis  
10 in this case. Can you explain that?

11 A Well, I looked at a lot of documents, many of them  
12 pertain to Mr. Terry's adaptive functioning, his adaptive --  
13 and I use the terms "adaptive functioning" and "adaptive  
14 behavior" as equivalent because DSM uses "functioning" and  
15 AAIDD uses "behavior" in many documents pertaining to  
16 Mr. Terry's adaptive functioning or lack thereof.

17 And there is also the test of his adaptive functioning  
18 called a Vineland Social Maturity Scale that I refer to.  
19 There's a chart that I have access to that lists a lot of his  
20 adaptive behavior deficits. So it's definitely not the case  
21 that I relied solely on the common sense questionnaire. That  
22 was useful mainly as it gave me a focus of my interview with  
23 him -- my remote interview with him.

24 Q All right. And they asked you some questions about the  
25 neuropsychologist, Dr. Deysach.