

STATE OF SOUTH CAROLINA
IN THE SUPREME COURT

Appeal from Greenville County

G. Edward Welmaker, Circuit Court Judge

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S.C. Supreme Court

RUBEN RAMIREZ,

PETITIONER,

V.

STATE OF SOUTH CAROLINA,

RESPONDENT

Appellate Case No. 2012-208626

APPENDIX

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1 STATE OF SOUTH CAROLINA)
2 COUNTY OF GREENVILLE) COURT OF GENERAL SESSIONS
3) 2007-GS-23-3245
4) 2007-GS-23-4394
5) 2007-GS-23-4395
6) 2007-GS-23-4396
7) 2007-GS-23-4397

8 State of South Carolina) TRANSCRIPT OF RECORD
9)

10 -vs-)

11 Ruben Rameriz, Jr.)

12 ---- Ramirez ----)

13 November 03, 2008
14 Greenville, South Carolina

15 B E F O R E:

16 THE HONORABLE EDWARD MILLER, Judge.

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

18 CHERYL AARON, Esquire
19 Attorney for State

20 MONTI DESAI, Esquire
21 Attorney for Defendant

22 CAROLINE HISKELL
23 Circuit Court Reporter
24
25

COPY

I N D E X

(There were no witnesses.)

E X H I B I T S

(There were no exhibits)

State versus Ruben Rameriz

P R O C E E D I N G S

THE CLERK: Your Honor, this is case 2007-GS-23-3394, the State versus Ruben Rameriz indicted for assault and battery with intent to kill, pleading to the same; case 2007-GS-23-4395 he is indicted for kidnapping, pleading to the same; 2007-GS-23-4396 indicted for criminal sexual conduct with a minor in the first degree, pleading to the same; 2007-GS-23-4397 indicted for burglary in the first degree, pleading to the same. The last is case 2007-GS-23-3245, he is indicted for lewd act upon a child, pleading to the same.

Mr. Rameriz, would you please raise your right hand.

RUBEN RAMERIZ, having been duly sworn, testified as follows:

THE COURT: Mr. Rameriz, how old are you?

MR. RAMERIZ: I'm 18.

THE COURT: What's the highest grade you finished in school?

MR. RAMERIZ: Eighth grade.

THE COURT: Can you read and write?

MR. RAMERIZ: Yes, Your Honor.

THE COURT: Have you ever worked?

MR. RAMERIZ: No, Your Honor.

THE COURT: Are you single?

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1 MR. RAMERIZ: Yes, Your Honor.

2 THE COURT: Do you have children?

3 MR. RAMERIZ: No, Your Honor.

4 THE COURT: And how many days have you been
5 in jail?

6 MS. AARON: 468 as of today, Your Honor.

7 THE COURT: In the last 24 hours, have you
8 had any drugs, alcohol or medication?

9 MR. RAMERIZ: No, Your Honor.

10 THE COURT: Have you ever been treated for
11 the abuse of alcohol, drugs, mental illness or emotional
12 problems?

13 MR. RAMERIZ: No, Your Honor.

14 THE COURT: Are you sober today?

15 MR. RAMERIZ: Yes, Your Honor.

16 THE COURT: Do you know what's going on?

17 MR. RAMERIZ: Yes, Your Honor.

18 THE COURT: Tell me in your own words what's
19 going on.

20 MR. RAMERIZ: I'm charged with serious
21 charges and I know I'm looking up to life and these are
22 serious charges and they are nothing to play with.

23 THE COURT: I understand y'all want to enter
24 a plea guilty but mentally ill; is that right?

25 MR. DESAI: Yes, Your Honor.

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1 THE COURT: Mr. Desai, I believe the burden
2 is on you to show me that he fits in that category and the
3 law requires we hold a hearing on it.

4 MR. DESAI: As per Dr. Ghetto's (ph) reports
5 and the reports by the mental health doctor I believe.
6 Both the doctors have stated that to the best of their
7 opinion and medical certainty, Mr. Rameriz is unaware of
8 whether his actions were right or wrong, yet he was not
9 capable of conforming himself to those actions. One of
10 those actions that Dr. Ghetto has mentioned, his
11 impulsivity and he talked about Ruben just doing things on
12 impulse, but yet he talks about the fact that he
13 understands what he is doing is wrong. Based on that, I
14 would just ask that we plead guilty but mentally ill.

15 THE COURT: What's the State's position?

16 MS. AARON: Your Honor, the State is aware of
17 the most recent report which does diagnose him with a
18 mental illness. That is attached to the proposed Order
19 that we've given Your Honor. We are aware of that
20 evaluation and are aware of the findings and do not
21 contest the findings of that physician.

22 THE COURT: Officer Brackett anything you
23 want to add to that? Are you satisfied with that?

24 MS. BRACKETT: Yes, sir.

25 THE COURT: Do you want to add Dr. Ghetto's

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1 evaluation into evidence?

2 MR. DESAI: Yes, Your Honor, I do.

3 THE COURT: Any objection from the State?

4 MS. AARON: None, Your Honor. I would just
5 ask if it's going to be marked that we also attach it to
6 the Order because the wording in the Order refers to it.

7 THE COURT: I'll tell you, we'll attach it to
8 the Order and that way it will become a part of the
9 record. What was the other psychological report that you
10 referred to?

11 MS. AARON: Your Honor, he was sent to
12 Columbia for a determination of his competency to stand
13 trial. They did not comment on his mental illness as a
14 diagnosis. They did determine that he was competent to
15 stand trial and I can hand that up and have it attached as
16 well. It does not address the diagnosis.

17 (Report reviewed by the Court.)

18 THE COURT: I will find on the record that he
19 does suffer from a mental illness. He'd been diagnosed
20 with Attention Deficit Hyperactivity Disorder and a
21 Combined Type. There are reports of judgement disorder
22 with mixed emotion of disturbance and conduct, severe
23 mental retardation.

24 Mr. Rameriz, you're up here on a number of
25 different offenses and I'm going to go through each of

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1 them with you. At some point during the course of these
2 proceedings, you need to speak with your attorney or there
3 is something you don't understand, you just signal, okay?

4 MR. RAMERIZ: Yes, Your Honor.

5 THE COURT: The first Indictment before me,
6 07-3245, it alleges that you did in Greenville County,
7 January 25, '07 being over the age of 14, willfully and
8 lewdly committed or attempted a lewd and lascivious act
9 upon the body or with the parts of the child, ML, who is
10 under the age of 16 with the intent of arousing, appealing
11 to, gratifying the lust, passion or sexual desires of
12 yourself or the child and that carries 15 years in prison.
13 Do you understand that?

14 MR. RAMERIZ: Yes, Your Honor.

15 THE COURT: You are also here on Indictment
16 07-4397, alleges you did in Greenville County on or about
17 January 26, '07 willfully and unlawfully enter the
18 dwelling of BL located on North Main Street in Mauldin,
19 South Carolina without consent and with force and with the
20 intent to commit a crime of burglary first and it carries
21 from 15 years to life in prison. Do you understand that?

22 MR. RAMERIZ: Yes, Your Honor.

23 THE COURT: It is a Violent Offense which
24 means it's non-parolable, so if you've heard anything
25 about parole, just forget about it and plan on doing

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1 day-for-day whatever sentence I give you, do you
2 understand?

3 MR. RAMERIZ: Yes, Your Honor.

4 THE COURT: It's also a Most Serious Offense
5 and a Most Serious Offense is a classification required to
6 mandate if you get two or more convictions for a Most
7 Serious Offense, you are eligible for life in prison
8 without parole, do you understand that?

9 MR. RAMERIZ: Yes, Your Honor.

10 THE COURT: You are also here on 07-4396
11 alleges you did in Greenville County on or about January
12 26, '07 commit a sexual battery on BL who was less than 11
13 years of age. Criminal sexual conduct with a minor in the
14 first degree carries 30 years, do you understand that?

15 MR. RAMERIZ: Yes, Your Honor.

16 THE COURT: It is also a Violent Offense, no
17 parole. It's also a Most Serious Offense. Two or more
18 convictions for a Most Serious Offense you are eligible
19 for life in prison for life without parole, do you
20 understand that?

21 MR. RAMERIZ: Yes, Your Honor.

22 THE COURT: You are also here on Indictment
23 07-4395 alleges you did in Greenville County on or about
24 January 26, '07 unlawfully seize, abduct, confine,
25 inveigle decoy or carry away BL without the authority of

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1 law, and kidnapping carries 30 years, do you understand
2 that?

3 MR. RAMERIZ: Yes, Your Honor.

4 THE COURT: And it is a Violent Offense and a
5 Most Serious Offense. Do you understand those
6 classifications?

7 MR. RAMERIZ: Yes, Your Honor.

8 THE COURT: And finally you're here on
9 Indictment 07-4394. It alleges that you did in Greenville
10 County, January 26, '07 unlawfully and with malice
11 aforethought by express or implied committed an assault
12 and battery on BL, assault and battery with intent to kill
13 and it carries 20 years, do you understand that?

14 MR. RAMERIZ: Yes, Your Honor.

15 THE COURT: It is also a Violent and Most
16 Serious Offense, do you understand that?

17 MR. RAMERIZ: Yes, Your Honor.

18 THE COURT: Do you want me to explain those
19 classifications to you again?

20 MR. RAMERIZ: No, Your Honor.

21 THE COURT: Understanding the nature of the
22 charges against you and the maximum possible punishment,
23 how do you want to plead?

24 MR. RAMERIZ: Guilty.

25 THE COURT: Has anybody forced you in any way

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1 or coerced you or threaten you or made you any promises to
2 get you to enter this plea?

3 MR. RAMERIZ: No, Your Honor.

4 THE COURT: Are you doing this freely and
5 voluntarily?

6 MR. RAMERIZ: Yes, Your Honor.

7 THE COURT: It is your choice. Do you
8 understand that you have a right to a trial by jury?

9 MR. RAMERIZ: Yes, Your Honor.

10 THE COURT: You would be presumed innocent
11 unless and until the State could prove you guilty beyond
12 any reasonable doubt of each and every element of each
13 offense that you are charged with. You would have a right
14 to confront and cross-examine the witnesses and the
15 evidence put up against you by the State. You would have
16 the right to use the subpoena power of the State to compel
17 in court all relevant and competent evidence in your
18 defense or you can remain silent. Your silence cannot be
19 held against you. You can never be compelled to
20 incriminate yourself or make a statement that would hurt
21 your legal interests. Do you understand that?

22 MR. RAMERIZ: Yes, Your Honor.

23 THE COURT: I don't know if you made a
24 statement in this case, but if you made a statement and
25 you enter this plea and I accept it, then you give up your

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1 right to contest the Constitutional propriety of that
2 statement. Do you understand that?

3 MR. RAMERIZ: Yes, Your Honor.

4 THE COURT: The same is true of evidence. I
5 don't know what evidence has been seized in this case, but
6 if you enter this plea and I accept this plea, then you
7 give up your right to challenge the Constitutional
8 propriety of the seizure and introduction of this
9 evidence. Do you understand that?

10 MR. RAMERIZ: Yes, Your Honor.

11 THE COURT: Do you understand all of those
12 rights?

13 MR. RAMERIZ: Yes, Your Honor.

14 THE COURT: Understanding all those rights,
15 how do you want to plead?

16 MR. RAMERIZ: Guilty.

17 THE COURT: Are you guilty?

18 MR. RAMERIZ: Yes, Your Honor.

19 THE COURT: Are you totally and completely
20 satisfied with your lawyer?

21 MR. RAMERIZ: Yes, Your Honor.

22 THE COURT: Do you think he's done everything
23 that's reasonably necessary to adequately prepare your
24 defense in this case?

25 MR. RAMERIZ: Yes, Your Honor.

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1 THE COURT: Is there anything else you think
2 he should have done?

3 MR. RAMERIZ: No, Your Honor.

4 THE COURT: Is there anything that he did
5 that you think he should not have done?

6 MR. RAMERIZ: No, Your Honor.

7 THE COURT: Do you have any complaints
8 against your lawyer, against the Solicitor's Office or
9 against law enforcement with respect to your treatment?

10 MR. RAMERIZ: No, Your Honor.

11 THE COURT: And have you had enough time to
12 review the evidence the State has against you?

13 MR. RAMERIZ: Yes, Your Honor.

14 THE COURT: Listen carefully, they're going
15 to tell me their version of the facts and I'm going to
16 want to know if you agree with it or disagree with it?

17 Okay, tell me about it.

18 MS. AARON: May it please the Court, Your
19 Honor, in the early evening hours of January 26, 2007,
20 eight-year-old Minor was at her home,
21 Pleasantdale Apartments in Mauldin. There was a knock at
22 the door. She was supposed to be picked up by a family
23 friend to go skating that evening so she opened the door.
24 This defendant was on the other side of the door and asked
25 to use the bathroom. She said, no, my mom is not home,

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1 tried to shut the door, he pushed back and pushed his way
2 into the apartment. The victim states that he struck her
3 several times while in the apartment, choked her while
4 they were there and grabbed her by chain that she had
5 around her neck which held her house key.

6 She stated that he drug her out of the
7 apartment and into some woods behind the apartment near a
8 body of water. She states the defendant repeatedly called
9 her a "bitch" and beat her. She saw a lot of blood. The
10 defendant took off her underwear, rubbed his penis against
11 her vagina and felt her breasts. He put his penis into
12 her mouth and into her buttocks.

13 At some point, the victim defecated on
14 herself. Afterwards, the defendant told her to put her
15 face into the water and she refused. He then stomped her
16 very hard in the face and head and then walked away.

17 The victim states that he repeatedly
18 threatened to kill her during the altercation. After he
19 left, she states that she laid very still in the woods for
20 a long time until she could not hear him walking anymore.
21 She got up and started walking in the direction that she
22 believed was her apartment complex.

23 She came onto a road in Mauldin and was
24 immediately spotted by two ladies in an SUV that was
25 driving by. They could immediately tell that she had been

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1 assaulted and beaten due to the swelling in her face and
2 the way she was not dressed. They called 911 and the
3 police arrived to find this little eight-year-old wrapped
4 in a blanket shaking and upset. She had bruising to her
5 face and a laceration to her lip.

6 She was able to give the officers some
7 details of the incident and a brief description of the
8 defendant. Later she was shown a line-up and immediately
9 without hesitation identified this defendant.

10 When he was apprehended, he was cooperative
11 with the deputies. He stated that he knew why they were
12 there because of "what he did to that little girl." He
13 told a story very similar to her account including his
14 statement that after the sexual assault he, "tried to
15 choke her again and told her to lay down on the ground by
16 a river. He slapped her, hit her and choked her again."
17 He said, "I left her by herself and I don't know what
18 happened to her."

19 Since this incident, the child has undergone
20 several surgeries to correct her face including the
21 placement of her eyes. I've handed up a picture of the
22 child. It is in black and white so it does not show the
23 prominent bruising that was taken that night. She did
24 swell up a lot more after that incident.

25 Also, I passed up a proof sheet with two

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1 pictures marked. They show the apartment and the woods so
2 that Your Honor can get an idea of the proximity. She
3 wasn't taken very far. There were woods right behind the
4 apartment.

5 Your Honor, this victim is in continued
6 therapy for her mental state after this attack. She is to
7 the follow-up stage with her medical condition. The
8 doctor's have indicated she has recovered as much as she
9 will. She's in follow-up from now on. She remains
10 traumatized. Her mother indicates that she continues to
11 have nightmares and she has not returned to the same
12 little girl that her mother knew before this incident.

13 Your Honor, the mother of this child is here.
14 She has asked to speak. There is another incident of a
15 lewd act that occurred the day before.

16 Do you want to hear from her first or do you
17 want to hear --

18 THE COURT: However you want to present it.

19 MS. AARON: I'll go ahead and give you the
20 second set of facts. On January 25, 2007, the father of a
21 seven-year-old child who was in the same apartment complex
22 reported that this defendant who this child knows by name
23 put his hands down her shirt and touched her breast while
24 she was out playing. He then told her that he was Santa
25 Claus and had her sit on his lap. She got scarred and

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1 told him that she had chocolate in her car and she ran to
2 her car and locked herself in it, and her father then came
3 out to call her for dinner.

4 When her father came out, the defendant hid
5 around the building and the father did get a look at him.
6 He did not report the incident that evening. This was the
7 day before the incident happened with the little ^{Minor}
8 child. He indicated that he thought that he could take
9 care of it and prevent another incident on his own so he
10 did not report it. He was very remorseful when he talked
11 to the police the next day and actually found out what had
12 happened to ^{Minor}.

13 We had attempted to contact the parents of
14 this little girl for today's plea. They have moved. They
15 do not live at that apartment complex any more. We've had
16 no luck with contacting him at his job, so we have elected
17 to go forward, but I did indicate that Ms. Logan is
18 present. She is standing with our victim advocate in the
19 back. She has a statement, Your Honor, that she would
20 like to read.

21 THE COURT: Alright, yes, ma'am.

22 MS. LOGAN: "It's been almost two years but
23 it seems like yesterday. The pain that you have caused us
24 is unbearable. You took something from my daughter that
25 she could never get back. You took something from my

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1 daughter that she could never get back. You took her
2 pride, dignity, but most of all her self-control. She
3 still wakes up with nightmares and she's afraid to be
4 alone. Because of you she will never be the same.

5 She has changed so much and sometimes I find
6 it hard to even know or recognize my daughter. The sad
7 thing about it is she asks why did this happen to me and
8 the only thing I could do is cry. There is no reason in
9 this world for what you have done. You are a selfish,
10 self-centered, angry and controlling person. You had no
11 right to do damage to our lives and take her innermost
12 prized possession. You need to get on her knees and pray
13 to God to have mercy on your soul.

14 You do this to a ten-year-old beautiful and
15 joyful girl as she did not ask for it. What were you
16 thinking to treat her so badly and brutally. My daughter
17 was a thoughtful child and without a doubt you have took
18 that away from her.

19 I am a single young parent working and
20 supporting my daughter on my own. I stand here today in
21 court for my daughter seeking justice for her and hoping
22 justice to be served."

23 THE COURT: Thank you, ma'am. Is there
24 anything else you'd like to tell me.

25 Ms. Logan, if you decide there's anything

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1 else, you just let me know.

2 MS. AARON: Your Honor, he has no prior
3 record.

4 MR. DESAI: Thank you, Your Honor. Before I
5 start my presentation, I'd like to first let the Logan
6 family know and Your Honor know as well that my
7 presentation in no way shape or form is meant to make any
8 excuses for Ruben's actions nor is it made to put any
9 blame on anyone else except for Ruben.

10 Ruben was 16 years old at the time of the
11 incident. He's 18 years old now as he has informed you.
12 He was in the eighth grade. He is a citizen of the United
13 States and he was born in Florida. It was November of
14 2006 he moved here with his father.

15 Your Honor, in order to understand everything
16 that's going on here it is necessary for me to tell you
17 some background information.

18 This tragic incident was not only tragic to
19 the Logan family, but it was certainly tragic to Ruben and
20 his family as well. His two brothers who are 13 and 8
21 look up to Ruben as a roll model. And I know you're
22 thinking what a roll model to look up to, someone who goes
23 out and does things like these, but Ruben has had a very
24 very rough childhood.

25 His mother had left him early in life in his

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1 childhood. He was raised by his Aunt Maria in Florida.
2 At age 10, his mother left and took Ruben and his two
3 brothers with her. She was a known drug addict. She had
4 affairs in front of these children. She would bring
5 strange men into the house while the dad would go to work
6 and have sex in front of these children. That was
7 devastating to these children.

8 A few years later, Mr. Rameriz was finally
9 able to get custody back from the mother, but he had to
10 support these children. He had to work for a living. His
11 Aunt Maria, who is Ruben's younger sister, offered to take
12 care of the children in Florida while Ruben came to South
13 Carolina to work. He kept sending money back to Florida
14 to support these three boys.

15 Your Honor, you've had the opportunity to
16 read Dr. Ghetto's interviews with Ruben and it clearly
17 shows that he's met with Ruben on five different
18 occasions. So this was not just a interview he did on
19 only one occasion and came to these conclusions just based
20 on one meeting. He's met with Ruben on five different
21 occasions. He's had about three or four hours on each
22 occasion.

23 He talks about how Ruben's ADHD and how his
24 lack of self-confidence makes him how he is. He talks
25 about how timid he is.

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1 When he came here in South Carolina in 2006,
2 he was 16 years old and he was in the eighth grade.
3 People were making fun of him and calling him a dummy. On
4 one occasion he told me when I went to visit him in prison
5 that someone had said: You're ugly and no one is ever
6 going to love you.

7 Dr. Ghetto talks about his attitude towards
8 woman in general. His mother being the first woman that
9 he was exposed to, how she left a bad taste in his mouth;
10 how she was not an ideal female figure, and mother figure
11 for sure, and how that developed into his attitude towards
12 woman in general. I asked him what he meant when he
13 called that little girl the "B" word. And while you and I
14 may understand the severity of it, he said: I was just
15 saying that because that's what I say to all women. And
16 that's not for lack of respect for the other person, but
17 that's just how he thinks. I ask him why he left her
18 there, just to show you how shortsighted he was, he said:
19 I just wanted to make sure she would not have remembered.
20 I wanted her to forget about me. So he thought that
21 leaving her in that pond there face down, she would
22 somehow erase that part where the assault took place.

23 Again, Your Honor, I'm not making any excuses
24 for Ruben's actions. I certainly know that the Logan
25 family is not taking any excuses. He has shown remorse

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1 since day one. The first question he asked me: Can I
2 write that little girl's mother a letter and apologize to
3 her. I obviously advised him against that. I told him
4 that he should not contact the victim's family at all and
5 he'll have his day in court to apologize to whomever he
6 needs to apologize to.

7 Also, your Honor, this was never a trial.
8 This was put on the trial docket for motion hearing
9 purposes and that we were going to plead thereafter. This
10 was a plea all along. Ruben, as Ms. Aaron has told you
11 has been very cooperative. He has been nothing but
12 honest. He has told the investigators from the beginning
13 that he was guilty of these crimes. He's never made any
14 excuses and I believe they'll probably tell you.

15 Your Honor, what was missed in the
16 investigation and came out during Dr. Ghetto's interview
17 is that there were three Hispanic males living right below
18 Ruben. These guys were bringing Ruben into the house and
19 making him watch the Playboy Channel; again, not an
20 excuse. This young 16 year old kid was aroused by that.
21 A few minutes before this incident took place, these guys
22 had just brought Ruben in and was showing him the Playboy
23 Channel. As Dr. Ghetto, again, told you about his
24 impulsivity and as the basis of his plea, he just couldn't
25 control his actions. He went and did what he had to do to

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1 temporarily satisfy himself.

2 I certainly understand this is a very very
3 tragic situation for the victim's family, and certainly
4 for the RAMERIZ family. I just ask, Your Honor, that you
5 consider everything that I have presented today including
6 Dr. Ghetto's evaluation, including Ruben's upbringing or
7 lack thereof while you sentence him.

8 Your Honor, I do have Mr. Rameriz who would
9 like to address the Court at the appropriate time.

10 THE COURT: Go ahead.

11 MR. DESAI: Your Honor, we have an
12 interpreter.

13 INTERPRETER, having been duly sworn,
14 interpreted the testimony as follows:

15 THE COURT: State your name for the record.

16 INTERPRETER: (Inaudible).

17 MR. RAMERIZ: Your Honor, I ask you and the
18 family of the victim -- I never asked for this to happen.
19 I tried to teach my kids respect for other people. I
20 also, sometimes it's not the way we want it to be but I'd
21 like to tell the mother of the victim not to leave the
22 kids alone for any time and I apologize to the family.

23 THE COURT: Thank you.

24 Is there anything you want to tell me?

25 MR. RAMERIZ: I'm sorry for the victim's

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1 family and I realize when I was outside, I never listened
2 to my parents, but ever since I got locked up, I learned
3 from my mistakes. I've been studying from the bible, Your
4 Honor, and I learned from my mistakes. I hope one day
5 they can forgive me, especially for that little girl what
6 I did to her, Your Honor. And once again, Your Honor, I'm
7 sorry for the victim.

8 MR. DESAI: Just one more thing, Your Honor,
9 I'd like to note for the record. In Dr. Ghetto's report
10 on Paragraph 3, Page 5, I'll quote it real quick where he
11 says he is "clearly cognitive limited across the entire
12 range of cognitive functioning, judgement and insight
13 appear poor while impulse control appeared grossly in tact
14 during interviews." He also says on Page 4,
15 "Psychological testing, which was valid, did not suggest
16 significant conduct disorder features which suggested to
17 this interviewer that there maybe a reasonably good chance
18 for Ruben to change his life force given the optimal
19 treatment and or structure."

20 Your Honor, he's never had any kind of
21 opportunity to be treated for any of these illnesses that
22 he's had. Based on Dr. Ghetto's report, I believe that
23 Ruben will be able to rejoin society and be a productive
24 member if proper treatment is, in deed, rendered.

25 THE COURT: I'm not sure there is anyway to

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1 treat the problems that he has. I'm not being glib and
2 I'm not being derogatory. It's a question of ability.
3 Anything --

4 MS. AARON: Nothing further from the State,
5 Your Honor.

6 THE COURT: I don't know what to do. The
7 victim and the victim's family, I just give you my
8 heartfelt sympathy and I'm sorry that anyone would have to
9 go through this.

10 I certainly wouldn't want to embarrass him,
11 but his I.Q. level is as low as any I've ever seen.

12 MS. AARON: Your Honor, with the guilty but
13 mentally ill plea, the Department of Corrections will do
14 an evaluation of their own and consider, obviously,
15 treatment in whatever facility he is sent to, but I would
16 ask, Your Honor, to consider, obviously the severity of
17 the offense.

18 THE COURT: I'm going to give him 20 years on
19 everything concurrent with the exception of the lewd act
20 which is 15 years consecutive suspended with probation for
21 five years mental health counseling.

22 MS. AARON: It would go without saying no
23 victim contact.

24 THE COURT: Yes. No victim contact and -- I
25 don't know if there's restitution. I don't know how we

State versus Ruben Rameriz

1 would handle that.

2 MS. AARON: Your Honor, the Restitution
3 Silver Group has been informed. I don't know the extent
4 to which they're paying, but I don't think it's going to
5 have any likelihood of collection.

6 THE COURT: Ma'am, I wish you the very best
7 and the very best to your daughter, and thank you for
8 coming to court.

9 And good luck to you.

10 MS. AARON: Thank you, Your Honor.

11 ---END OF TRANSCRIPT RECORD---

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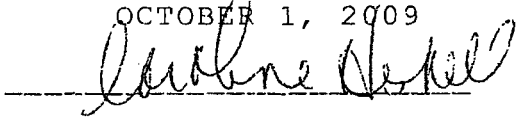
25

State versus Ruben Rameriz

1 I, the undersigned Caroline Hiskell, Official
2 Court Reporter for the Thirteenth Judicial Circuit of the
3 State of South Carolina, do hereby certify that the
4 foregoing is a true, accurate, and complete transcript of
5 record of all the proceedings had and evidence introduced
6 in the trial of the captioned case, relative to appeal, in
7 the Circuit Court of Greenville County, South Carolina on
8 the 3rd day of November, 2008.

9 I do further certify that I am neither of kin,
10 counsel, nor interest to any party hereto.

11
12 OCTOBER 1, 2009

13 
14 Caroline Hiskell
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FORM 5

STATE OF SOUTH CAROLINA)

COUNTY OF GREENVILLE)

IN THE COURT OF COMMON PLEAS

H 2 P 3:23

Ruben Ramirez Jr.)

SCDC ID NO.: 00331556)

Full name and prison number (if any) of Applicant:)

2009-CP-23-9285

v.)

APPLICATION FOR

State of South Carolina)

POST-CONVICTION RELIEF)

INSTRUCTIONS - READ CAREFULLY

In order for this application to receive consideration by the Court, it shall be in writing (legibly handwritten or typewritten), signed by the applicant and verified (notarized), and it shall set forth in concise form the answers to each applicable question. If necessary, applicant may furnish his answer to a particular question on the reverse side of the page or on an additional page. Applicant shall make clear to which question any such continued answer refers.

Since every application must be sworn under oath, any false statement of a material fact therein may serve as the basis of prosecution and conviction for perjury. Applicants should, therefore, exercise care to assure that all answers are true and correct.

If the application is taken in forma pauperis, it shall include an affidavit (attached at the back of the form) setting forth information which establishes that applicant will be unable to pay the fees and costs of the proceedings. When the application is completed, the original shall be mailed to the Clerk of Court for the County in which the applicant was convicted.

1. Place of detention Lee Correctional Institution (990 Wisacky Highway, Bishopville, SC 29010)
2. Name and location of Court which imposed sentence Court of General Sessions, Greenville County, Greenville, South Carolina
3. Name(s) of co-defendant(s) (if any) N/A
4. The indictment number or numbers (if known) upon which and the offenses for which sentence was imposed:
 - (a) 2007-GS-23-3245
 - (b) 2007-GS-23-4394
 - (c) 2007-GS-23-4395

(d) 2007-GS-23-4396

(e) 2007-GS-23-4397

5. The date upon which sentence was imposed and the terms of the sentence:
- (a) November 03, 2008
- (b) _____
- (c) _____
6. Check whether a finding of guilty was made:
- (a) after a plea of guilty X
- (b) after a plea of not guilty _____
- (c) after a plea of nolo contendere _____
7. Did you appeal from the judgment of conviction or the imposition of sentence?
No
8. If you answered "yes" to (7), list:
- (a) the name of each Court to which you appealed:
- i. _____
- ii. _____
- iii. _____
- (b) the result in each such Court to which you appealed:
- i. _____
- ii. _____
- iii. _____
- (c) the date of each such result:
- i. _____
- ii. _____
- iii. _____
- (d) if known, citations of any written opinion or orders entered pursuant to such results:
- i. _____
- ii. _____
- iii. _____
9. If you answered "no" to (7), state your reasons for not so appealing:

(a) Not advised of right to appeal by his Attorney or the presiding Judge and therefore was not aware of his right to appeal.

(b) _____

(c) _____

10. State concisely the grounds on which you base your allegation that you are being held in custody unlawfully:

(a) Not advised of right to appeal.

(b) Defendant was charged in two separate incidents and he was not advised by his Attorney or the presiding Judge of his right to two separate trials.

(c) Not offered the use of a translator until the end of the guilty plea hearing.

11. State concisely and in the same order the facts which support each of the grounds set out in (10):

(a) The Defendant appeared in court on November 3, 2008 to waive his rights and plead guilty to the above listed warrants. The Court nor his attorney properly advised the Defendant of all his constitutional rights.

(b) English is the Defendant's second language which he speaks but not fluently. The Defendant's guilty plea hearing was conducted in English without the benefit of a translator. A translator was used, however, at the very end of his hearing when the Defendant addressed the Court. Consequently, the Defendant was unable to fully understand the proceedings prior to using the translator.

(c) _____

12. Prior to this application have you filed with respect to this conviction:

(a) any petition in a State Court under South Carolina Law? No

(b) any petition in State or Federal Courts for habeas corpus or post-convictions relief? No

(c) any petition in the United States Supreme Court for certiorari other than petitions, if any, already specified in (8)? No

(d) any other petitions, motions or applications in this or any other Court? No

13. If you answered "yes" to any part of (12), list with respect to each petition, motion or application:

(a) the specific nature thereof:

- i. _____
- ii. _____
- iii. _____
- iv. _____

(b) the name and location of the Court in which each was filed:

- i. _____
- ii. _____
- iii. _____
- iv. _____

(c) the disposition thereof:

- i. _____
- ii. _____
- iii. _____
- iv. _____

(d) the date of each such disposition:

- i. _____
- ii. _____
- iii. _____
- iv. _____

(e) if known, citations of any written opinions or orders entered pursuant to each such disposition:

- i. _____
- ii. _____
- iii. _____
- iv. _____

14. Has any ground set forth in (10) been previously presented to this or any other Court, State or Federal, in any petition, motion or application which you have filed?

No

15. If you answered "yes" to (14) identify:

(a) which grounds have been presented:

- i. _____

ii. _____

iii. _____

(b) the proceedings in which each ground was raised:

i. _____

ii. _____

iii. _____

16. If any ground set forth in (10) has not previously been presented to any Court, State or Federal, set forth the ground and state concisely the reasons why such ground has not previously been presented:

(a) The Defendant was not advised of his right to appeal and this application for Post Conviction Relief is his first opportunity to litigate his complaints.

(b) _____

(c) _____

17. Were you represented by an attorney at any time during the course of:

(a) your arraignment and plea? Yes (plea only)

(b) your trial, if any? N/A

(c) your sentencing? Yes

(d) your appeal, if any, from the judgment of conviction or the imposition of sentence? N/A

(e) preparation, presentation or consideration of any petitions, motions or applications with respect to this conviction, which you filed? Yes

18. If you answered "yes" to one or more parts of (17), list:

(a) the name and address of each attorney who represented you:

i. Monte Desai, The Dick James Law Firm, 611 N. Main Street, Greenville, SC 29601. (Guilty Plea)

ii. Matthew Kappel, Law Office of Matthew J. Kappel, PC, P.O. Box 10334, Greenville, SC 29603. (Application for Post Conviction Relief)

iii. _____

(b) the proceedings at which each such attorney represented you:

i. Guilty Plea

ii. This Application for Post Conviction Relief

iii. _____

19. State clearly the relief you seek in filing this application:

Remand to Trial Court

20. Are you now under sentence from any other court that you have not challenged?

No

STATE OF SOUTH CAROLINA)

County of GREENVILLE)

VERIFICATION

I, Ruben Ramirez Jr., being duly sworn upon my oath, depose and say that I have subscribed to the foregoing application; that I know the contents thereof; that it includes every ground known to me for vacating, setting aside or correcting the conviction and sentence attacked in this application; and that the matters and allegations therein set forth are true.

Ruben Ramirez Jr

SWORN to and subscribed before me this 27th
day of OCTOBER, 2009

M. L. Kapp (L.S.)
Notary Public

My Commission Expires: May 19, 2019

APPLICATION TO PROCEED WITHOUT PAYMENT
OF COSTS AND AFFIDAVIT
IN SUPPORT THEREOF

I, Ruben Ramirez Jr., hereby apply for leave to proceed in this action without prepayment of fees or costs or security therefor. In support of my application I declare under penalty of perjury that the following facts are true:

- (1) I am the applicant in this action and I believe I am entitled to redress.
- (2) Because of my poverty I am unable to pay the costs of said proceeding or give security thereof.

Ruben Ramirez Jr.
Applicant

SWORN or affirmed to and subscribed before me this
29 day of OCTOBER, 2008.

[Signature]
Notary Public

My Commission Expires: May 19, 2019

STATE OF SOUTH CAROLINA	)	IN THE COURT OF COMMON PLEAS
	)	C.A. No. 2009-CP-23-9285
COUNTY OF GREENVILLE	)	
	)	
Ruben Ramirez,	)	
S.C.D.C. No. 331556,	)	
	)	
Applicant,	)	
	)	RETURN
v.	)	
	)	
State of South Carolina,	)	
	)	
Respondent.	)	
	)	

In response to the post-conviction relief application filed November 2, 2009, the Respondent would show this Court:

I.

The Applicant is incarcerated with the South Carolina Department of Corrections pursuant to the Greenville County Clerk of Court's orders of commitment. The Greenville County Grand Jury indicted the Applicant at the April 2007 term of General Sessions for lewd act upon a child (2007-GS-23-3245) and at the May 2007 term for assault and battery with intent to kill (ABIK) (2007-GS-23-4394), kidnapping (2007-GS-23-4395), first-degree criminal sexual conduct (CSC) with a minor (2007-GS-23-4396), and first-degree burglary (2007-GS-23-4397). Monte Desai, Esquire represented the Applicant.

On November 3, 2008, the Applicant pled guilty as indicted. The Honorable Edward W. Miller sentenced the Applicant to concurrent terms of twenty (20) years for ABIK, twenty (20) years for kidnapping, twenty (20) years for first-degree CSC with a minor, and twenty (20) years for first-degree burglary. Judge Miller levied a consecutive sentence of fifteen (15) years suspended with five (5) years probation for lewd act upon a child. The Applicant did not appeal.

Attached herewith and incorporated herein by reference are the records of the Greenville County Clerk of Court regarding the subject convictions, the Applicant's records from the South Carolina Department of Corrections, and the guilty plea transcript.

II.

In his application for post-conviction relief the Applicant alleges he is being held in custody unlawfully for the following reason:

1. Ineffective assistance of counsel:
 - a. Not advised of right to appeal.
 - b. Not advised of the right to separate trials.
 - c. Not offered the use of a translator until the end of the plea hearing.
 - d. Not advised of his constitutional rights.

III.

The Respondent asserts the Applicant's allegation that his attorney was ineffective is without merit. The Respondent asserts the Applicant's attorney rendered effective assistance well within the standard of "reasonableness within professional norms" for a criminal defense attorney.

Where ineffective assistance of counsel is alleged as a ground for relief, the Applicant must prove that "counsel's conduct so undermined the proper functioning of the adversarial process that the trial cannot be relied on as having produced a just result." Strickland v. Washington, 466 U.S. 668, 686, 104 S. Ct. 2052, 2064 (1984); Butler v. State, 286 S.C. 441, 442, 334 S.E.2d 813, 814 (1985).

The proper measure of performance is whether the attorney provided representation within the range of competence required in criminal cases. The courts presume counsel "rendered adequate assistance and made all significant decisions in the exercise of reasonable

professional judgment.” Strickland, 466 U.S. at 690, 104 S. Ct. at 2066. The Applicant must overcome this presumption in order to receive relief. See Cherry v. State, 300 S.C. 115, 118, 386 S.E.2d 624, 625 (1989).

A two-pronged test is used in evaluating allegations of ineffective assistance of counsel. First, the applicant must prove counsel’s performance was deficient. Under this prong, attorney performance is measured by its “reasonableness under prevailing professional norms.” Cherry v. State, 300 S.C. at 117, 386 S.E.2d at 625 (quoting Strickland, 466 U.S. at 688; 104 S. Ct. at 2065). Second, counsel’s deficient performance must have prejudiced the Applicant such that “there is a reasonable probability that, but for counsel’s unprofessional errors, the result of the proceeding would have been different.” Cherry, 300 S.C. at 117-18, 386 S.E.2d at 625. “A reasonable probability is a probability sufficient to undermine confidence in the outcome of trial.” Johnson v. State, 325 S.C. 182, 186, 480 S.E.2d 733, 735 (1997) (citing Strickland v. Washington, 466 U.S. 668, 104 S. Ct. 2052 (1984)).

The Respondent submits the Applicant cannot satisfy either requirement of the Strickland v. Washington test. However, the allegation of ineffective assistance of counsel probably raises questions of fact that cannot be conclusively refuted by the record. The Respondent requests an evidentiary hearing to fully resolve this issue. See Sharper v. State, 279 S.C. 264, 265, 305 S.E.2d 247, 248 (1983) (citing Norman v. State, 276 S.C. 278, 277 S.E.2d 707 (1981)).

IV.

The Respondent denies each allegation not expressly admitted, qualified or explained.

V.

WHEREFORE, having made its Return, the Respondent requests that a hearing be held

on the issues raised in the PCR application.

Respectfully submitted,

HENRY DARGAN McMASTER
Attorney General

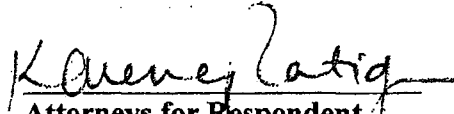
JOHN W. McINTOSH
Chief Deputy Attorney General

SALLEY W. ELLIOTT
Assistant Deputy Attorney General

KAREN C. RATIGAN
Assistant Attorney General

P.O. Box 11549
Columbia, S.C. 29211

By:


Attorneys for Respondent

April 7, 2010

STATE OF SOUTH CAROLINA)

COUNTY OF GREENVILLE)

IN THE COURT OF COMMON PLEAS

2009-CP-23-9285

RUBEN RAMIREZ, 331556)

Applicant,)

vs)

AFFIDAVIT OF SERVICE BY MAIL

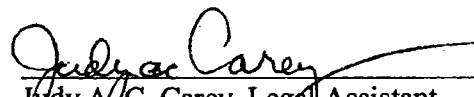
STATE OF SOUTH CAROLINA,)

Respondent.)

1. I am an employee of the Respondent in the above-captioned action.
2. Regular communication by mail exists throughout the State of South Carolina and that this is a proper circumstance of service by mail.
3. I have this day served a copy of the **Return** in the above-captioned matter on the following person by depositing same in the United States mail, postage prepaid:

Matthew J. Kappel, Esquire
Post Office Box 10334
Greenville SC 29603

DATED this 7th day of April, 2010.


 Judy A. Carey, Legal Assistant
 For Respondent

STATE OF SOUTH CAROLINA	)	COURT OF COMMON PLEAS
	)	
COUNTY OF GREENVILLE	)	Case No(s) : 2009CP2309285
	)	
Rubin Ramirez,	)	
	)	
Applicant,	)	
	)	
-VS-	)	TRANSCRIPT OF RECORD
	)	
State of South Carolina,	)	
	)	
Respondent.	)	
	)	

May 09, 2011
Greenville, South Carolina

B E F O R E:

HONORABLE G. EDWARD WELMAKER, Judge.

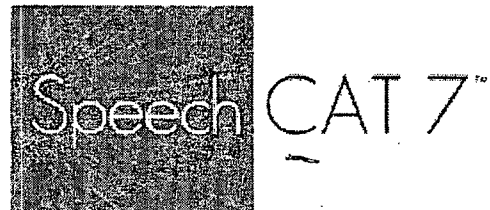
A P P E A R A N C E S:

KAREN RATIGAN, Esquire
Attorney for the State

MATT KAPPEL, Esquire
Attorney for the Applicant

Teresa B. Johnson
Certified Verbatim Reporter
P.O. Box 2812
Greenville, S.C. 29602

Records are
taken and
produced via



I N D E XDIRECT CROSS REDIRECT RECROSS**APPLICANT'S WITNESSES:**

Monte Desai

by Mr. Kappel 4

by Ms. Ratigan 29

by Mr. Kappel 33

Motions 34

Certificate of Reporter 43

EXHIBITS PAGE

<u>NO.</u>	<u>DESCRIPTION</u>	<u>ID</u>	<u>EV</u>
APPLICANT EXHIBITS			
A-1	Forensic Evaluation	8	9
A-2	Psychological Evaluation	11	11
A-3	Manual of Mental Disorders	18	22

RESPONDENT EXHIBITS

(No exhibits offered.)

COURT EXHIBITS

(No exhibits offered.)

P R O C E E D I N G S

(WHEREUPON, the proceedings begin on the 9th day of May, 2011 at approximately 2:12 p.m.)

THE COURT: All right, Ms. Ratigan.

MS. RATIGAN: May it please the Court, Your Honor. This is the case of Rubin Ramirez versus the State of South Carolina. Docket number is 2009-CP-23-9285. Mr. Ramirez was indicted for Lewd Act upon a Child, Assault and Battery with Intent to Kill, Kidnaping, First degree Criminal Sexual Conduct with a Minor and first degree Burglary.

On November 3rd, 2008, he entered a plea of guilty but mentally ill before Judge Miller. He received concurrent terms of 20 years for Assault and Battery with Intent to Kill, 20 years for Kidnaping, 20 years for first degree CSC with a Minor, 20 years for first degree Burglary. Judge Miller also levied a consecutive sentence of 15 years suspended with five years probation for Lewd Act. Did not file an appeal. The State is ready to proceed today.

I would note for the record and for Your Honor's information, you have numbers of the

1 victim's family that are here today to observe
2 the proceedings.

3 **THE COURT:** Mr. Kappel.

4 **MR. KAPPEL:** Thank you, Your Honor. May
5 it please the Court. Good afternoon. There
6 are a number of grounds that the application
7 was filed. Uh, we wish to proceed solely on
8 the psychological ground, which is actually not
9 in the application. I spoken to Ms. Ratigan
10 about this at length. She has no objection to
11 us if we need to amend that pleading going
12 ahead and doing so. That's the intent of our
13 application for post-conviction relief was
14 based on the psychological evaluations.

15 **THE COURT:** All right.

16 **MR. KAPPEL:** Thank you.

17 **THE COURT:** You may call your first
18 witness.

19 **MR. KAPPEL:** We're going to call Monte
20 Desai.

21 **THE CLERK:** Place your left hand on the
22 Bible. Please raise your right hand.

23 **MONTE DESAI**
24 having first been sworn, testifies as follows:

25 **THE CLERK:** Thank you. You may be seated.

1 **THE WITNESS:** Thank you.

2 **THE CLERK:** State your full name for the
3 record please.

4 **THE WITNESS:** Monte Dinkar Desai. Middle
5 name, D-I-N-K-A-R.

6 **DIRECT EXAMINATION**

7 **BY MR. KAPPEL:**

8 **Q** Okay. Mr. Desai, good afternoon.

9 **A** Good afternoon.

10 **Q** Uh, you were retained by the Ramirez family
11 to represent Rubin Ramirez, Junior. Is that correct?

12 **A** Uh, yes, sir. I was with the law firm at
13 the time, the Dick James Law Firm.

14 **Q** Okay. Now in -- you were very kind to
15 provide me a complete copy of your file, is that
16 correct?

17 **A** Yes, sir.

18 **Q** Okay. In the file, there was, uh, other
19 lawyers who were listed on various documents. There
20 were documents with Dick James' name. There were
21 documents with Max Singleton's name. Of course,
22 there were documents with your name. Do you recall
23 approximately what part of the process you were
24 actually the, I guess, lead counsel or the person
25 responsible for this case?

1 A Uh, just for clarification purposes, Mr.
2 Singleton was employed there prior to my arrival at
3 the Dick James Law Firm or my employment with Dick
4 James Law Firm which was July of 2007, I believe.

5 Q So you started at that firm in July of
6 2007?

7 A Uh, yes, sir.

8 Q Okay. Now, Max Singleton had already left?

9 A Yes, sir.

10 Q And had -- was Max Singleton, while he was
11 at the Dick James' Law Firm, was he the one
12 responsible for this case?

13 A That is my understanding.

14 Q Okay.

15 A I do not personally know that.

16 Q But this case was at that firm. When you
17 became employed there in 2007, you basically adopted
18 the file and took it as your own. Is that correct?

19 A Yes, sir.

20 Q All right. Now, in July 2007, uh, Rubin
21 was in the Greenville County Detention Center, is
22 that correct?

23 A That's correct.

24 Q And I believe he was there for almost 500
25 days before he pled guilty, correct?

1 **A** That sounds right, yes.

2 **Q** So he was available to you whenever you
3 needed to talk to him because he was in the detention
4 center, is that right?

5 **A** Yes, sir.

6 **Q** You ever have any trouble communicating
7 with him or did you ever have any kind of indication
8 that there was -- something wasn't right with him?

9 **A** I did. That is why we got him evaluated by
10 Dr. Gedo. At times, one of the times I met with
11 Rubin, Rubin was very naive. I don't think he quite
12 understood the gravity of the offense or the offenses
13 that he had committed. I thought he was kind of --
14 uh, I just don't think he understood everything that
15 was going on.

16 **MR. KAPPEL:** Your Honor, I'm going to ask
17 the witness to discuss a competency evaluation.
18 It was entered during the course of the plea.
19 I'm more than happy to mark it as Applicant's 1
20 for this hearing for clarification.

21 **THE COURT:** All right. You can do that.

22 **(WHEREUPON, Plaintiff's Exhibit 1 is marked for**
23 **identification.)**

24 **BY MR. KAPPEL:**

25 **Q** I would like for you to, uh, -- can you

1 identify Plaintiff's number 1?

2 **A** I believe this might be the initial
3 evaluation that was conducted by the State maybe.

4 **Q** Okay.

5 **MR. KAPPEL:** At this time, we ask that
6 this document be admitted.

7 **THE COURT:** Any objections?

8 **MS. RATIGAN:** None, Your Honor.

9 **THE COURT:** Without objection.

10 (WHEREUPON, Plaintiff's Exhibit 1 is admitted
11 into the record.)

12 **BY MR. KAPPEL:**

13 **Q** Now, I'd ask you to look at just the --
14 what's marked number 1. It's got three pages on it.
15 If you look at the last, very last paragraph on page
16 3, the very last sentence, does that look like an
17 opinion on competency to you?

18 **A** I believe so.

19 **Q** Okay. And in fact, their recommendation
20 was to return to court basically to stand trial. Is
21 that right?

22 **A** That is correct.

23 **Q** Okay. Now, this report was done June 7th,
24 2007, correct?

25 **A** Yes, sir.

1 Q So that, this report -- and it's actually
2 -- on the last page, you can tell, it was signed on
3 June 7th and June 8th. So one would assume that you
4 had this document in your file when you became
5 employed at the Dick James Law Firm. Does that sound
6 correct?

7 A Either then or soon thereafter, yes, sir.

8 Q Okay. So I would assume that when you met
9 with your client and determined that he wasn't really
10 understanding what was going on around him, that you
11 would have paid particular attention to this
12 competency evaluation, isn't that right?

13 A Yes, sir.

14 Q Now, on the first page, it's got diagnosis.
15 You see Access 1, Access 2 and Access 3. And each of
16 those diagnosis says no diagnosis. Did you attach
17 any significance to that at all when you read it?

18 A I did not, Mr. Kappel. I didn't really
19 understand it to be honest with you. That's why I
20 wanted another medical professional to take a look at
21 it.

22 Q Right. So for us, Access 1, 2 and 3 really
23 kind of just -- it's psychological terminology that
24 we just don't understand, correct?

25 A That's correct.

1 Q Okay. So you asked -- I think you
2 petitioned or you asked or you hired, I can't recall,
3 but you obtained Dr. Gedo, is that correct?

4 A That's correct.

5 Q Did you guys pay Dr. Gedo or is that a
6 court-appointed evaluation?

7 A I believe the client paid for it. Yes,
8 sir.

9 Q Okay. And, uh, can you identify that
10 document please?

11 A This is the report that Dr. Gedo provided
12 to us after evaluating, uh, Rubin on 1, 2, 3, 4 and I
13 believe 5 different occasions.

14 Q Okay. And it's entitled at the top, Report
15 of Psychological Evaluation. It's under Dr. Steven
16 M. Gedo's letterhead so to speak?

17 A Yes, sir.

18 MR. KAPPEL: Okay. At this time, we move
19 number 2 in, Judge.

20 MS. RATIGAN: No objection, Judge.

21 MR. KAPPEL: Without objection, Exhibit 2
22 is into evidence.

23 (WHEREUPON, Plaintiff's Exhibit 2 is marked for
24 identification and admitted into the record.)

25 BY MR. KAPPEL:

1 Q Now, the first thing that you look at in
2 doctor -- well, let me ask you this. Going back to
3 number, uh, -- Applicant's number 1, do you recall
4 how long a Dr. Dulal and Barbara Christenson met with
5 Rubin Ramirez? I'm not trying to make you go through
6 the whole thing. It's basically --

7 A Right off top of my head, I do not.

8 Q Okay. But if you look at number 12 on the
9 sources of information, which is at the top of page
10 2.

11 A It says 100 minutes.

12 Q Okay. So they met with him for about an
13 hour, hour and a half or so.

14 A Sure.

15 Q Then, of course, the first thing that comes
16 to mind when we look at Dr. Gedo's report is the
17 number of times that he actually met with, uh, with,
18 uh, Rubin.

19 A Sure.

20 Q Does that stand out in your mind?

21 A Yes, sir.

22 Q In fact, you pointed out to the court
23 during the plea, uh, that Dr. Gedo had met with, uh,
24 Rubin Ramirez extensively. Do you remember saying
25 that to the judge?

1 A Uh, yes, sir. Based on the evaluation, it
2 tells me that he met with him on February 5th, 12th,
3 19th, March 11th, March 27th of 2008.

4 Q Right. In fact, he told the Court that he
5 met with Rubin Ramirez on those occasions and met
6 with him for three to four hours on each occasion?

7 A That sounds correct.

8 Q So basically, Dr. Gedo met with Rubin
9 perhaps -- there's 1, 2, 3, 4, 5 interviews if we
10 just take three hours, that's no less than 15 hours.
11 Is that correct?

12 A Yes, sir.

13 Q And it was over the course of the 15 hours
14 of interviewing with Mr. Ramirez or with Rubin that
15 he came to a diagnosis?

16 A That's correct.

17 Q Do you recall the diagnosis that he
18 reached?

19 A Not without looking at this.

20 Q Please, uh, --

21 A The word "severe mental retardation" comes
22 to mind. I believe he did mention that.

23 Q Okay. If you look at page 5 -- if you look
24 at Access 5 or -- excuse me -- Access 2 and Access 5,
25 does he not diagnose Rubin with severe mental

1 retardation?

2 A Yes, sir, Access 2.

3 Q Access 5, which is basically what they call
4 the -- well, we'll get to that in a second. But
5 basically, Access 5, they gave him a level of 35?

6 A That's correct.

7 Q And the highest the past year was 35?

8 A Yes, sir.

9 Q Do you have any idea what that number of 35
10 means or what significance it has?

11 A I remember looking it up in, I believe, the
12 DST manual, if I'm not mistaken, at the time. But I
13 do not remember what that means now.

14 Q Okay. Do you recall in, uh, reading in Dr.
15 Gedo's report that he states that Rubin did not begin
16 speaking until he was seven years old?

17 A I do.

18 Q Is that something you knew prior to this
19 report?

20 A I did not.

21 Q Do you recall Dr. Gedo indicating that
22 Rubin had intellectual test results of a level, IQ
23 level of 31 to 44?

24 A I do recall that.

25 Q You recall that?

1 A I think so, yes.

2 Q Okay. Did you know that prior to the
3 study?

4 A I did not.

5 Q Okay. Basically, Dr. Gedo's establishing
6 Rubin to be having the age equivalent function from
7 four-to-seven years old, does that sound correct?

8 A Yes, sir.

9 Q Now, you are aware that there's a line of
10 cases in South Carolina that indicate that there is a
11 presumption that kids, age 7 to 14, are presumed to
12 not have the capacity to commit crimes. You aware of
13 that -- those cases?

14 A Yes.

15 Q Of course, it's a rebuttal of presumption,
16 but there is a presumption nonetheless, is that
17 correct?

18 A That's correct.

19 Q Now, I want to point you out to the bottom
20 of par -- page 4. If you will, kindly review this
21 first block paragraph, excuse me, the last block
22 paragraph on page 4.

23 A (Reading.) Yes, sir.

24 Q Okay. Now, basically, in this paragraph,
25 if you don't mind me just paraphrasing for you now

1 that you are familiar with it, it says that Rubin was
2 judged to be responsible for his behavior?

3 A Yes, sir.

4 Q That would seem to indicate that Dr. Gedo
5 is referring to the competency evaluation, does it
6 not?

7 A Yes, sir.

8 Q And but then he says, in the next
9 statement, he says, however, there is a diagnosable
10 psychological condition of significance, ADHD, which
11 does affect people in many of the ways described
12 above including intellectual impairments, poor social
13 skills. As noted, he is functioning at intellectual
14 levels of a four-to-seven-year old.

15 A Yes, sir.

16 Q Does that not sound like Dr. Gedo in his
17 evaluation?

18 A Obviously, Dr. Gedo reviewed the competency
19 exam. Does it not sound like he is -- he's not --
20 let me put it this way. The psychological evaluation
21 is not to establish competency, is that correct?

22 A I'd agree.

23 Q That is just simply to diagnose what is
24 going on with Rubin, correct?

25 A Right.

1 Q Does he not tend to be saying in that
2 paragraph that, uh, we -- I am alluding to the fact
3 that they have judged him to be competent, however, I
4 am going -- I'm giving you this warning. He's got
5 significant psychological conditions and that he acts
6 -- has the intellectual ability of a four-to-seven-
7 year old?

8 A I read that as a diagnosis and then a
9 disclaimer of a sort.

10 Q Well, what part of that paragraph is the
11 diagnosis?

12 A I -- the way we read it, and uh, I have no
13 way of proving it, but I did talk to Dr. Gedo
14 specifically about that. I also asked him if he was
15 talking about his behavior at the time of the
16 incident or was he talking about the evaluation
17 itself. He indicated to me that he was talking about
18 at the time those crimes occurred is what he was
19 referring to as to his behavior. But he kind of
20 reiterated the fact that he is still functioning at
21 the level of a four-to-seven-year old.

22 Q Right.

23 A It is rather confusing, yes.

24 Q Yeah, of course. It's all very confusing.
25 But essentially, Dr. Gedo is not offering an opinion

1 on competency.

2 A I think you are right about that.

3 Q There's nothing in the report to suggest
4 that he's competent to stand trial. That was
5 actually something that was done in June of 2007,
6 correct?

7 A Yes, sir. Sure.

8 Q Now, let me show you, uh, you alluded to it
9 just a moment ago. I don't want to through this big
10 book around. But this is a book called the DSM or
11 the diagnosed -- Diagnostic and Statistical Manual of
12 Mental Disorders. Is this what you were referring to
13 when you looked it up?

14 A Yes, sir.

15 Q Okay.

16 A I read the fourth edition that I looked up.
17 That's fifth.

18 Q I'm not sure which edition this is. This
19 is the fourth edition.

20 A Okay.

21 Q Uh, I've taken the liberty of making just
22 some photocopies so it would make it just a little
23 bit easier.

24 (WHEREUPON, Plaintiff's Exhibit 3 is marked for
25 identification purposes.)

1 **MR. KAPPEL:** Judge, I'm sorry I didn't
2 make an extra copy. I can give you the book if
3 you'd like.

4 **THE COURT:** I've got the book in my ---

5 **MR. KAPPEL:** Okay.

6 **THE COURT:** --- office. I'll check it
7 later.

8 **MR. KAPPEL:** Beg the Court's indulgence. I
9 do have a copy of it. I'm sorry.

10 **THE COURT:** All right.

11 **BY MR. KAPPEL:**

12 **Q** Now, in the DSM manual, they talk about
13 what's called a GAF or a GAF scale which is basically
14 a Global Assessment of Functioning. In Dr. Gedo's
15 report, he gives an Access 5 present level of 35.
16 Would that not be the GAF level?

17 **A** Yes, sir.

18 **Q** And if you look on page 32 of the document
19 I just handed you, uh, it talks about the global
20 assessment. I assume that this is part of the study
21 that you took when you got Dr. Gedo's report, you
22 went to the DSM. One would assume that you went
23 straight to the GAF to see what 35 actually meant,
24 correct?

25 **A** Yes, sir. I used it in a Social Security

1 case as well. Anything below 50 is considered way
2 below.

3 Q In fact, 70 -- isn't 70 actually the level
4 for mental retardation?

5 A That's my understanding. There are
6 different levels of mental retardation as well.

7 Q Okay. Well, I'd ask you just to take a
8 quick look at page 39. Let me just say that's not --
9 there aren't 39 pages in front of you. That's just
10 the page number. So ---

11 A I got it.

12 Q --- I'm just using that number for
13 simplicity.

14 A Yes, sir.

15 Q And you see the entry for mental
16 retardation?

17 A Correct.

18 Q And it shows an approximate level -- well,
19 it actually shows an IQ of approximately 70 or below.
20 Then the DSM level is -- let me find the DSM --
21 excuse me, the GAF level. The GAF level -- and
22 that's on page 34. Isn't that about 31 to 40 and,
23 uh, that shows severe mental retardation.

24 A Tell me which page you are talking about.

25 Q I'm sorry. I'm on page 34.

1 A Okay. Is there a specific line number?

2 Q Let me go about it this way because this is
3 just really confusing. But you recall in Dr. Gedo's
4 report that he's got an I -- he establishes that
5 Rubin has an IQ level of 31 to 44. You remember
6 that?

7 A I do.

8 Q That's on page 4 of his report?

9 A Yes, sir.

10 Q And that -- on page 39, they establish that
11 retardation is an IQ of 70, correct?

12 A Yes, sir.

13 Q And I would assume that you would have
14 discovered that, of course, as well comparing Dr.
15 Gedo's report with the DSM in determining that Rubin
16 is, in fact, both with his IQ and his global
17 assessment of functioning, is well below the
18 standards and, in fact, is consistent with Dr. Gedo's
19 diagnosis of severe mental retardation?

20 A Yes, sir.

21 Q Okay. Then, of course, if you look on page
22 42 where they discuss the degrees of severity of
23 mental retardation, his diagnosis was 31 -- 8.1,
24 which establishes an IQ level from 20 to 25 all the
25 way up to 35 to 40?

1 **A** That's correct.

2 **MR. KAPPEL:** Okay. Your Honor, uh, I would
3 ask that the printouts that I have just gone through
4 be admitted into evidence for a learned treatise
5 exception. These pages are a direct correlation with
6 the report from Dr. Gedo in terms of the diagnosis,
7 the Access 5 diagnosis. The global assessment
8 functioning and the IQ level are consistent with --
9 not consistent with. But the ability to fully
10 evaluate the report from Dr. Gedo, one would need
11 the DSM report or book.

12 **THE COURT:** Any objection from the State?

13 **MS. RATIGAN:** No objection, Your Honor.

14 **THE COURT:** Without objection, it is admitted
15 as Exhibit 3.

16 **MR. KAPPEL:** Thank you, Judge.

17 (WHEREUPON, Plaintiff's Exhibit 3 is marked for
18 identification and admitted into the record.)

19 **BY MR. KAPPEL:**

20 **Q** There was a, uh, -- sorry.

21 If the Court will indulge one second. (Pause.)

22 Okay. Mr. Desai, in addition, in your file,
23 you provided me with psychological reports from Florida.
24 Do you recall having those reports in your file as well?

25 **A** Very vaguely.

1 Q Okay. Let me just ask you real quick, uh,
2 there was a study that was completed in Florida.

3 A From Florida DSS maybe?

4 Q Uh, it's just the Highlands County School
5 Board ---

6 A Okay.

7 Q --- assessment. And it just basically
8 indicates that his IQ, would this sound correct, that he
9 performed better than approximately one percent of his
10 peers?

11 A That sounds right. I think that was the report
12 that I used in order to place him in an appropriate
13 class.

14 Q Okay. Do you recall the types of grades that
15 he was making while he was in school? Were they pretty
16 low, low grades?

17 A I remember them being low. I'm not --

18 Q Uh-huh. I'm not asking you for numerical
19 scores.

20 A Sure. I think that sounds right.

21 Q So here is my question. My question is, uh,
22 after you received Dr. Gedo's report where he indicates
23 that Rubin is functioning on a four-to-seven-year-old
24 level, after he offers the basically word of caution on
25 the bottom of page four about the competency, in addition

1 to the Access 1, 2, 3 and 4 and 5 diagnoses, coupled with
2 his very poor grades and the fact that he's performing
3 only better than one percent of his classmates, did you
4 ever decide to revisit the competency evaluation as being
5 accurate?

6 A I did not.

7 Q And in fact, during the plea, it was Judge
8 Miller that heard the plea, isn't that correct?

9 A That's correct.

10 Q In fact, Judge Miller states in the transcript,
11 the plea, on page 24, that Rubin's IQ is as low as he's
12 ever seen. Correct?

13 A Yes, sir.

14 Q And there wasn't really any -- in fact, there
15 wasn't -- there's only, uh, one moment where anybody
16 eluded to the competency exam, but the lion's share,
17 overwhelming majority of the hearing focused on Dr.
18 Gedo's report and not on the competency report.

19 A You're right about that.

20 Q Isn't that correct?

21 A Yes, sir.

22 Q And in fact, having looked at everything from
23 Dr. Gedo and everything that we're seeing with IQ just
24 being so far below severe mental retardation, even the
25 judge is saying the IQ is as low as he's ever seen.

1 Then, we pull up this evaluation, this competency
2 evaluation and we've got another diagnosis for Access 1,
3 no diagnosis for Access 2, no diagnosis for Access 3.
4 They spend one hour and a half with Rubin --

5 MS. RATIGAN: I'm going to object. Is there
6 a question?

7 MR. KAPPEL: It's coming.

8 THE COURT: Okay.

9 MR. KAPPEL: Thank you. It's coming. It's
10 going to take a while.

11 THE COURT: Well --

12 MR. KAPPEL: I'll try to -- I mean, I can
13 parse it out one question at a time if the Court
14 wishes, but --

15 THE COURT: Just ask him what you need to ask
16 him.

17 MR. KAPPEL: Well, I will.

18 BY MR. KAPPEL:

19 Q Do you recall in the competency evaluation
20 that, uh, there is some discussion about the therapy and
21 Rubin, about his psychological condition?

22 A Are we talking about Dr. Dulal's report or Dr.
23 Gedo's report?

24 Q Dulal's reports, yes, sir.

25 A On what page?

1 Q It's, uh, the second full paragraph on page 2.

2 A Can you ask me that question again please?

3 Q You recall reading that there was some
4 discussion as to what Rubin told them about his
5 psychological condition?

6 A Yes, sir. I do.

7 Q What did the report tell -- indicate?

8 A That he denied it. He denied history of any
9 major medical or psychological problems of the past.

10 Q Okay. In addition, does it talk about of kind
11 of his grades that they evaluated? Do you recall that in
12 this report?

13 A I do. I think it says 92 in Language Arts, 95
14 in Math, 80 in Social Studies, 93 in Science and 95 in
15 Health.

16 Q So basically, what they are doing is they are
17 establishing that there's no -- that he's denying any
18 mental illness and that he's making A's and B's in
19 school, is that correct?

20 A Yes, sir.

21 Q Now, once again, having looked at Dr. Gedo's
22 report, looking at the DSM, looking at his IQ, looking at
23 his global assessment and then revisiting the competency
24 exam, would it not seem to be prudent to have potentially
25 reevaluated his competency?

1 A I think you can say that:

2 Q The question is would you say that?

3 A Uh, probably.

4 MR. KAPPEL: Just a moment, Judge. (Pause.)

5 BY MR. KAPPEL:

6 Q Ultimately, Mr. Desai, would you not agree that
7 while Dr. Gedo's report is important to tell us about
8 Rubin and what is going on with him, would you not agree
9 that the competency study is probably the most important?

10 A I would agree with you. If I could just
11 clarify the previous question.

12 Q Sure.

13 A I think Rubin -- what this report reads is that
14 Rubin told the doctors that he usually receives C's and
15 D's, but it was the DSS studies that suggested that he
16 received those grades that I mentioned, 92, 95, 80, 93
17 and 95.

18 Q Okay.

19 A So Rubin didn't tell them that he got those
20 grades. They found that information out through an
21 independent source.

22 Q Right. I understand.

23 A I misstated that earlier. That's why I wanted
24 to clarify that.

25 MR. KAPPEL: Court's indulgence, Your Honor.

1 (Pause.)

2 BY MR. KAPPEL:

3 Q Let me ask you this question. Uh, Rubin was 16
4 when he was charged with these crimes, is that correct?

5 A Yes, sir.

6 Q Was he ever charged as a juvenile?

7 A I am not sure. As we talked about earlier, I
8 took over this case after the decision to charge -- or
9 try him as an adult was already made. I believe Cheryl
10 Aaron was the Solicitor on this case and I kind of took
11 it over after, I believe, that statute had already
12 passed.

13 Q Now, you are familiar with the statute that
14 says 16-year-old that's charged with a variety of crimes
15 can be charged as an adult at the election of the
16 Solicitor's office. Isn't that correct?

17 A Yes, sir.

18 Q Okay. Once you received Dr. Gedo's report that
19 indicated that Rubin was acting on a four-to-seven-year-
20 old intellectual scale and he was diagnosed as severe
21 mental retardation, did you ever express to her that this
22 case could and should be returned to the Family Court?

23 A I had several conversation with Ms. Aaron. The
24 State's position was very firm in that based on their
25 initial evaluation. He was competent to stand trial and

1 they were not going to reevaluate him again.

2 Q Okay. When you say -- I was just talking about
3 having him -- if you are dealing with a four-to-seven-
4 year-old, not reevaluating him, but sending him back to
5 the Family Court.

6 A Going back and seeing if he needs to be tried
7 as a juvenile.

8 Q That's correct.

9 A Yes, sir. That conversation did take place
10 with Ms. Aaron. Her position was that they were not
11 going to do that.

12 MR. KAPPEL: Okay. That's all I have, Judge.

13 THE COURT: You may cross-examine the
14 witness.

15 **CROSS-EXAMINATION**

16 **BY MS. RATIGAN:**

17 Q So at the time you had taken over the file,
18 discovery had already been filed?

19 A I believe so. Yes, ma'am.

20 Q By the time you had taken the file, the
21 competency evaluation had already been performed?

22 A Yes, ma'am. I think the date on that is June
23 7th. It was done one month prior maybe.

24 Q So after you got the case and you looked at the
25 evaluation and you met with Mr. Ramirez, at that point,

1 you thought perhaps there needs to be a further
2 evaluation?

3 A Yes, ma'am.

4 Q That was the evaluation with Dr. Gedo?

5 A That is correct.

6 Q Was Mr. Ramirez on any medication at the time?

7 A Not that I recall. That doesn't mean he wasn't
8 on any medication. I just don't remember.

9 Q I assume you had several conversations with Dr.
10 Gedo about his meetings with Mr. Ramirez and with the
11 report. Would that be fair to say?

12 A Yes, ma'am.

13 Q Did the doctor ever express to you that perhaps
14 Mr. Ramirez needed to be reevaluated for competency?

15 A He did not. He did express to me that he
16 needed additional time to evaluate him thoroughly and
17 continued to visit, I guess, on five different occasions.

18 Q After Dr. Gedo evaluated Mr. Ramirez, would you
19 say you had kind of a better understanding of how to
20 communicate with him?

21 A He really was never tough to communicate with.
22 I mean, he was -- he was -- he was -- he was a child, I
23 guess. I still saw him as a little boy. He never had
24 any -- I mean, he always accepted what he had done wrong.
25 He was very remorseful. As far as talking to him, I

1 never had any issues.

2 Q And he was a teenager himself at the time, is
3 that correct?

4 A That's correct.

5 Q Did you explain to him what you were going to
6 court to do that day to plea guilty?

7 A Yes, ma'am. I did.

8 Q Did he appear to understand what was going to
9 happen that day in the courtroom?

10 A At the time, I thought so. I do question that
11 now however.

12 Q At what point did you decide to pursue a plea
13 of guilty but mentally ill? Was it after Dr. Gedo's
14 evaluation?

15 A Yes, ma'am, and after extensive conversation
16 with the Solicitor or Assistant Solicitor Cheryl Aaron.

17 Q Was she in agreement to proceed GBMI plea?

18 A She was. We looked at several things. Uh,
19 Rubin, if I'm not mistaken gave a voluntary statement.
20 We looked at every different angle that we could to see
21 if I could suppress that statement, if there was anything
22 that was unconstitutional about that statement. After
23 exploring those possibilities and coming to a conclusion
24 that there wasn't one and, at a trial, that statement
25 would, in fact, be introduced, we kind of went into

1 mitigation mode, so to speak. At that time, we started
2 exploring other options.

3 Q I believe, the transcript, you stated this was
4 going to be a guilty plea from Day 1, is that correct?

5 A Yes. When I said Day 1, I don't mean the day I
6 picked up the file.

7 Q Right.

8 A After I -- the biggest -- the strongest piece
9 of evidence the State had was, I believe, his statement.
10 That certainly, uh, was a -- was something that we looked
11 at.

12 Q You testified that you did not decide to
13 revisit the competency issue after receiving Dr. Gedo's
14 evaluation. Can you pinpoint a reason why you did not?

15 A I don't remember.

16 Q If Dr. Gedo had advised that a further
17 competency evaluation was necessary, would you have
18 pursued one at that point?

19 A Absolutely.

20 MS. RATIGAN: Beg the Court's indulgence.

21 (Pause.)

22 BY MS. RATIGAN:

23 Q Obviously, we get into a little bit of Monday
24 morning quarter-backing when we come at cases more than
25 two years later, but at the time he pled guilty, November

1 3rd of 2008, were you comfortable with the decision to go
2 ahead and enter a GBMI plea to these charges?

3 A I was or else I would not have presented him to
4 the court.

5 MS. RATIGAN: That's all I have, Your Honor.

6 THE COURT: Redirect?

7 MR. KAPPEL: Briefly, Judge.

8 REDIRECT EXAMINATION

9 BY MR. KAPPEL:

10 Q The statement that, uh, Rubin gave, are you
11 familiar with the statement? The contents of it?

12 A Not right now, Mr. Kappel. I looked at it at
13 that time.

14 Q Okay.

15 A I can go through my file and find it if you'd
16 like. Or if you have one for me to read, I'll be glad
17 to.

18 Q Let me see if I can find one real quick. If I
19 can't, we'll just move on. (Pause.)

20 A (Reading.) Yes, sir.

21 Q Okay. Now, upon rereading the statement that
22 Rubin gave, it's pretty matter of fact. He just pretty
23 much comes right out and says exactly what he did, did he
24 not?

25 A And that was his demeanor throughout, uh, the

1 case and throughout my interactions with him.

2 Q Okay. In fact, his statement is word-for-word
3 from the actual statement from the victim?

4 A It sounds that way, yes, sir.

5 Q Okay. The transcript of the plea indicates
6 that there is a, like a pretrial motion or motion on the
7 trial calendar. Was that to suppress the statement or
8 was that for another purpose?

9 A That was to -- that was to declare him guilty
10 but mentally ill.

11 Q Okay. So that wasn't like a Jackson v. Deno
12 type hearing?

13 A No, sir.

14 MR. KAPPEL: Thank you, Judge.

15 THE COURT: All right. Thank you, sir. You
16 may step down.

17 THE WITNESS: Thank you, Your Honor.

18 THE COURT: You may call your next witness.

19 MR. KAPPEL: Judge, that's all the witnesses
20 we have.

21 THE COURT: Anything from the State?

22 MS. RATIGAN: No, Your Honor. Uh, we'd rest
23 on Mr. Desai's testimony and the record. I do not
24 have the exact cite in front of me. We would rely
25 on the Bannister versus State line of cases. I want

1 to say it's 2008. But basically, that line of cases
2 says that it is speculative to discuss potential
3 witnesses or potential reports if they are not
4 presented. We would argue there's nothing to
5 counter the finding of competency. It was his
6 burden to come in here today and prove that if Mr.
7 Desai had ordered a second competency evaluation, it
8 would have gone the other way. Since no such report
9 has been made, no expert has testified, we would
10 argue it's purely speculative to now argue that he
11 was not competent.

12 Again, there's a line of cases that decided --
13 that determined -- pardon me -- discuss both
14 witnesses, experts and reports that all follow that
15 line. And unless you provide it at the PCR hearing,
16 you can not speculate as to what may or may not have
17 happened if those reports had been requested at the
18 time of the plea.

19 **THE COURT:** Well, I --

20 **MR. KAPPEL:** Your Honor --

21 **THE COURT:** Yes, sir?

22 **MR. KAPPEL:** I'm sorry. May I?

23 **THE COURT:** Yes, sir. I'll be glad to hear
24 from you.

25 **MR. KAPPEL:** Thank you, Judge. What I'm

1 prepared to ask the Court to do is if the Court were
2 to look at the competency evaluation documents that
3 were evaluated, the Department of Juvenile Justice
4 records. What I'm prepared to ask the Court to do
5 today is to require the State to provide us the
6 Department of Juvenile Justice records so that we
7 can review them and leave the record open and order
8 that a new competency exam be undertaken.

9 Uh, my client is in the Department of
10 Corrections. The family is of meager financial
11 background. I don't think there's any problem if we
12 leave -- you know, I'm not asking the Court to rule
13 today. What I'm asking the Court to do is to leave
14 the record open, provide us these records from the
15 Department of Juvenile Justice and let's have a look
16 at those records and then see if we can ask --
17 petition the court to order a new competency
18 evaluation to be undertaken.

19 **MS. RATIGAN:** Judge, the State's position on
20 that is there is no right to discovery in PCR. That
21 should have been undertaken prior to this
22 evidentiary hearing. Furthermore, I believe it's
23 (inaudible) held that defendant -- pardon me -- an
24 applicant does not need to be competent for his
25 post-conviction relief hearing.

1 We would argue a competency evaluation at this
2 time would not be probative. And again, if seeking
3 some kind of competency evaluation to try to
4 determine his potential competency back in 2008;
5 that's something that should have been requested
6 prior to the evidentiary hearing today. We could
7 have had a motion for discovery. It's his burden of
8 proof.

9 **THE COURT:** Even if it had been done -- if it
10 was done next month or if it was done three months
11 ago, how are they going to -- I know they are very
12 capable down there, but how are they going to be
13 able to determine what his mental state was in 2008
14 or '7?

15 **MR. KAPPEL:** Well, that's a phenomenal
16 question. But what the state is arguing to the
17 Court is that it's too speculative to try to
18 determine whether or not this case needs to be
19 vacated because there isn't an expert testifying to
20 his competency and, at the same time, she's saying
21 even if we did have an expert, they couldn't do it.

22 **THE COURT:** Well, they could do it maybe
23 based on the record.

24 **MR. KAPPEL:** If I was to undertake the record
25 of a psychological evaluation or competency exam six

1 months ago, their argument would be, well, that has
2 nothing to do or no impact as to what actually
3 occurred in 2007.

4 **MS. RATIGAN:** It should have taken place six
5 months ago. This is his one evidentiary hearing.
6 It's his burden of proof to come in here and make
7 allegations. And then to want to bootstrap in these
8 additional findings of fact after the evidentiary
9 hearing is prolonging a process that he knew was
10 coming. This is discovery. There is no discovery
11 in PCR without showing good cause. We would simply
12 argue there's no good cause shown and this should
13 have been done like any other case. You have
14 discovery prior to the case. You don't have
15 discovery after the case.

16 **MR. KAPPEL:** That may be, Judge, but what I'm
17 asking the Court to do is to leave the record open,
18 allow us to get these documents by court order and
19 then let us look at it and see if petitioning the
20 court for a new competency exam would be
21 appropriate.

22 **THE COURT:** Just based on the juvenile
23 records?

24 **MR. KAPPEL:** Based upon Dr. Gedo's own report
25 that is so inconsistent with what was presented in

1 the competency exam.

2 THE COURT: But how is the juvenile records
3 going -- in other words, that could have been done
4 before today?

5 MR. KAPPEL: Yes, sir.

6 THE COURT: Cause you not relying on the
7 juvenile records.

8 MR. KAPPEL: Well, what we were concerned
9 about was if we undertook our own competency exam,
10 that they would have looked at this initial
11 competency report and wanted those records. What
12 we're suggesting to the Court is if we can get those
13 records and look at what Dr. Dulal reviewed in
14 making this study, then we can determine whether or
15 not we can either try to hire somebody or ask the
16 Court to appoint somebody to do another competency
17 exam.

18 I see no harm in simply just leaving the record
19 open to allow this process to be undertaken. As I
20 said, these competency exams are very expensive.
21 What we're asking for the court is leave to allow us
22 to try to undertake this and then come back and
23 either supplement the record or not supplement the
24 record. We're not asking for another evidentiary
25 hearing.

1 **MS. RATIGAN:** That's exactly what would
2 happen. You're going to get another expert to come
3 in here. And I'm going to have to drag Mr. Desai
4 back in here. The victim's family is going to have
5 to come back in here. And we're going to have to
6 talk about something that should have been done
7 before today. This case was filed in 2009.

8 **THE COURT:** The real issue here, based on the
9 limited matter that's before the Court is whether,
10 based on Dr. Gedo's report, a second evaluation
11 should have taken place. Isn't that ---

12 **MR. KAPPEL:** That's correct.

13 **THE COURT:** --- what we're here --

14 **MR. KAPPEL:** That's correct.

15 **THE COURT:** So is it really going to matter
16 what another evaluation shows?

17 **MR. KAPPEL:** Based on the Court's own
18 comments a few minutes ago, I don't think the Court
19 is too persuaded by a new competency evaluation no
20 matter what it says.

21 **THE COURT:** But I mean --

22 **MR. KAPPEL:** So --

23 **THE COURT:** -- I mean, we're looking back at
24 what took place right before the plea, right?

25 **MR. KAPPEL:** We're looking back at the time--

1 **THE COURT:** For the purposes of this hearing,
2 again, we're not back to where we were before.

3 **MR. KAPPEL:** That's correct.

4 **THE COURT:** So how does leaving the record
5 open really affect that?

6 **MR. KAPPEL:** Well, we were hoping to evaluate
7 those records and potentially have a new competency
8 exam and persuade the Court that was sufficient to
9 vacate the conviction.

10 **THE COURT:** Based upon the competency exam
11 that sides with Dr. Gedo?

12 **MR. KAPPEL:** Based on a competency exam that
13 gives an opinion after having evaluated the
14 diagnosis. The competency exam that was conducted
15 in 2007 says there is no diagnosis. In fact, the
16 competency exam in 2007 relies upon my own client
17 for trying to understand his mental capacity, which
18 he denied having any mental infirmities when, in
19 fact --

20 **THE COURT:** But they had the other records?

21 **MR. KAPPEL:** Well, that's just it. I don't
22 know what they had. The other records from Florida
23 indicate that his IQ and intellectual ability was
24 below 99 percent of his peers.

25 **THE COURT:** Where is the reference to the

1 Florida records?

2 MR. KAPPEL: Well, that's just it. That was
3 my reference based on my review of Mr. Desai's file.
4 It had psychological studies from the school
5 district that he attended in Florida. I don't know
6 if they reviewed those records in the competency
7 exam.

8 THE COURT: Well, my inclination is not to
9 leave the record open, but I am going to review the
10 exhibits that you have offered and the transcript.
11 I may revisit that, but I think the record is
12 sufficiently complete to make a decision on that
13 issue as to whether or not the attorney met the
14 Strickland guidelines.

15 If I see from -- a lot of information has come
16 may way today. If I see something different, then I
17 will certainly, uh, before my ruling, give you that
18 opportunity, Mr. Kappel. I will take this under
19 advisement.

20 MR. KAPPEL: All right. Thank you, Judge.

21 MS. RATIGAN: Thank you, Your Honor.

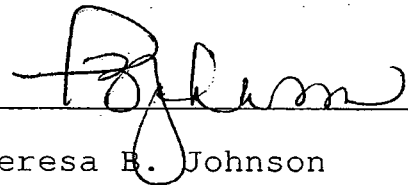
22 (WHEREUPON, the proceedings conclude at
23 approximately 3:09 p.m.)
24
25

CERTIFICATE

STATE OF SOUTH CAROLINA)
)
COUNTY OF GREENVILLE)

I, the undersigned, Teresa B. Johnson, Official Court Reporter for the Thirteenth Judicial Circuit of the State of South Carolina, do hereby certify that the foregoing is a true, accurate and complete Transcript of Record of all the proceedings had and evidence introduced in the trial of the captioned case, relative to appeal, in the Court of Common Pleas for Greenville, South Carolina, on this 21st day of April, 2012.

I do further certify that I am neither of kin, counsel nor interest to any party hereto.

A handwritten signature in dark ink, appearing to read 'T. B. Johnson', is written over a horizontal line.

Teresa B. Johnson

Circuit Court Reporter

TRANSACTION REPORT

P.01/01

83

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P.002

FORENSIC OUTPATIENT EVALUATION

DATE OF EVALUATION: June 7, 2007

PRESIDING: Mayank H. Dalal, M.D.

SECOND EXAMINER: Barbara Christensen, LMSW-CP

DIAGNOSES: AXIS I: No Diagnosis
 AXIS II: No Diagnosis
 AXIS III: No Diagnosis

COMPETENCY TO STAND TRIAL: Yes.

DISPOSITION: Ruben was seen at the Department of Juvenile Justice for a court ordered evaluation. Following evaluation, Ruben remained at the Department of Juvenile Justice awaiting disposition of his charges.

IDENTIFYING DATA: Ruben is a 16-year-old Hispanic male who was seen at the Department of Juvenile Justice, Columbia, South Carolina pursuant to a court order from Greenville County General Sessions Court. The court order requests an evaluation of his competency to stand trial. Court order specifies that Ruben is charged with Criminal Sexual Conduct with a Minor and Sex/Lewd Act, Committing or Attempting Lewd Act upon Child. Review of arrest warrant and incident report suggests that Ramirez is also charged with Burglary First Degree, Kidnapping, and Assault and Battery with Intent to Kill.

SOURCES OF INFORMATION:

1. Court order from Greenville County General Sessions Court requesting competency to stand trial.
2. Pertinent arrest warrants
3. Pertinent incident reports
4. Review of victim's statement dated January 31, 2007
5. Review of statement from James Leitke
6. Affidavit of photograph identification by Greenville County Police Department dated January 31, 2007
7. Investigative report
8. Supplementary report
9. Review of pictures of related to the injury of alleged victim



RAMIREZ, RUBEN

10. Crime scene investigative report
11. Department of Juvenile Justice records
12. Clinical forensic interview for about one hundred minutes at Department of Juvenile Justice, Columbia, South Carolina on June 7, 2007

PERTINENT STATEMENTS: Ruben is a 16-year-old Hispanic male who was born on July 25, 1990 in Florida. He reported that he was raised in Florida until October of 2006 when he came to Mauldin, South Carolina to live with his father. He reported that his biological parents left him in Florida when he was little (around age of 7). He stated that he was living with his uncle and his uncle's girlfriend in Florida. He has two younger biological brothers. He is the oldest of his siblings. He stated that he was living with his father, two brothers, a stepbrother, and stepmother in Mauldin, South Carolina before the alleged incident. He described his childhood as "so-so." He denied a history of abuse or neglect. He denied a history of running away, setting fires or cruelty to animals. He denied use of illicit drugs or alcohol. He denied getting into legal trouble before this alleged incident.

* Ruben denied a history of inpatient or outpatient psychiatric treatment. He reported that he was in eighth grade at Beck Academy in Mauldin, South Carolina. He was in regular class. He denied being expelled from school but admitted that he has been suspended eight different times for minor things. He reported that he received usually C's and D's in his grades. Review of Department of Juvenile Justice school records of educational report (May 17, 2007) suggests that Ruben has received 92 in language arts, 95 in math, 80 in social studies, 93 in science, and 95 in health. Ruben denied a history of major medical or psychological problems in the past. * Currently he is on Vistaril 150 mg p.o. q. h.s. for sleep problem. He denied disturbance in his sleep or appetite. He admitted having write-ups in DJJ for kicking doors and flooding toilets.

MENTAL STATUS EXAM: On the day of evaluation, Ruben was properly dressed and groomed. He appeared his stated age. He was concerned and cooperative. He had some speech difficulties probably related to the language barrier. He was coherent. There was no evidence of abnormal movements or bizarre behavior. His thought process was logical and goal directed. There was no evidence of delusions, hallucinations, or illusions. There was no evidence of looseness of association or flight of ideas. He was oriented for time, place, person, and situation. He described his mood as "alright." He reported that his mood today is "better, because I'm trying to stay out of getting into trouble." His fund of knowledge was average. His abstraction ability was average. His memory was within normal limits. His attention and concentration were normal. He did not appear to be a danger to himself and/or others.

CONCLUSION REGARDING COMPETENCY TO STAND TRIAL: On the day of evaluation, Ruben was able to read his rights adequately with some difficulty in reading words like *solicitor, evaluation, and competency*. He understood that the evaluation is ordered by the judge. He understood the nonconfidential nature of the evaluation and the fact that a copy of the report will be sent to his attorney, solicitor, and the judge. He elected to do this evaluation without presence of his

RAMIREZ, RUBEN

OUTPATIENT EVALUATION

attorney. Ruben was able to state alleged charges against him. He reported that his charges are "serious because that's about raping." He was able to state that murder is one of the most serious charges a person can get for which a person gets life or death penalty. He reported that if he is found guilty of his charges he can get time up to a few years in the Department of Juvenile Justice. He stated that if he has any questions related to his charges or possible penalties he can ask his attorney. Ruben was aware that he has a male attorney but could not recall the name of his attorney. When informed, he was able to retain and recall the name of his attorney during the evaluation. He stated that his attorney is in the court for him, will try to find him not guilty or try to get a shorter sentence if he is to be found guilty of his charges. He was aware that the solicitor is against him in courtroom proceedings. Ruben reported that he will not talk to solicitor alone, without presence of his attorney, because he is against me. He stated that a judge and a jury listen to both sides and try to decide the case and find somebody guilty or not guilty. He was able to state the meaning of *guilty plea*, *not guilty plea*, and *a plea bargain*. He was able to state the importance of evidence, witness, and appropriate courtroom behavior. He demonstrated no delusional or psychotic thinking regarding his charges or courtroom proceedings.

It is our opinion that Ruben has sufficient factual and rational understanding of the charges against him and that he can assist his attorney in his defense if he so chooses. Therefore, it is our opinion, with reasonable medical certainty, that Ruben is currently competent to stand trial.

RECOMMENDATIONS: Return to court.



Mayank H. Dalak, M.D.
Forensic Psychiatrist

MHD/lb

D: 06/07/07
RT/EM: 06/07/07
F/EM: 06/08.07 (mhd).

RAMIREZ, RUBEN

OUTPATIENT EVALUATION

Stephen M. Gedo, Jr., Ph.D.
P.O Box 1027
Drayton, SC 29333
(864) 591-0031

REPORT OF PSYCHOLOGICAL EVALUATION

NAME: Ramirez, Ruben

DOB: 07/25/1990

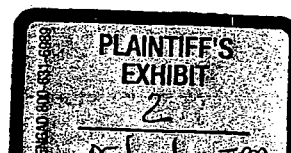
EVALUATION DATES: 02/05, 02/12, 02/19, 03/11, 03/27/2008 (these include collateral interviews).

INTRODUCTION: Ruben Ramirez is a 17-year-old Hispanic male, referred by his lawyer, Mr. Monte Desai of the Dick James Law Firm, for psychological evaluation. Ruben is currently incarcerated, and awaiting trial for five serious charges due to an incident which occurred in January 2007. Most of the historical information was obtained from the collateral sources noted below, due to Ruben's intellectual limitations.

EVALUATION PROCEDURES: Clinical Interview, Personal History Questionnaire, Personality Inventory for Youth (PIY), Hand Test, Substance Abuse Subtle Screening Inventory-A2 (SASSI-A2), Paulhaus Deception Scales (PDS), Forer Structured Sentence Completion Test (FSCT), Aggression Questionnaire (AQ), Test of Memory Malingering (TOMM), Wide Range Intelligence Test (WRIT). Also available for review were medical records supplied by Mr. Desai. In addition, collateral interviews were conducted with Ruben's father and step-mother, Julian Cabra, assistant to Mr. Desai, and by phone with Maria, Ruben's paternal aunt who raised him for a good deal of his childhood.

CHIEF COMPLAINT: "My mind is not right—I forget things after about 30 minutes, that's why punishment does not usually work with me." However, "jail is different—it is hard in jail—it is not a game—I won't do it (the assault) again now." Furthermore, "what I did was wrong—I didn't think it was wrong when I did it—people on tv enjoy it—but now I know how it was for her for me to keep her from her family—like I can't see mine now." Finally, "I liked pornography—I thought How would it feel?—that's how (why) I got the little girl."

HISTORY OF PRESENT PROBLEM: Ruben is accused of abducting an eight-year-old girl from her home, forcing her to perform oral sex, and leaving her in the woods near her home. Ruben acknowledged these acts. He stated that he first saw the girl playing on a playground "watched her for about five minutes," and thought, "she's pretty, she's a girl," and asked her if her parents were home. He reportedly followed her home, knocked on her door, forced his way into her house, and took her to some nearby woods, where he forced her to perform oral sex. He said that she was crying and he knew "she didn't want to do it," and remembers thinking "she misses her parents, she's scared." He reportedly did not take her back to her house because "I thought she would call 911, and she had seen my face—I wanted to get away."



Ruben reported that prior to the crime he was "watching the Playboy Channel on tv" with three adult male neighbors "before I saw the little girl." He reportedly first saw pornography on television in late 2006, watched the Playboy channel a total of four times, and witnessed heterosexual petting and intercourse. The sexual acts he viewed the night prior to his assault reportedly were not violent, involved women performing oral sex on men, and were sexually arousing to him. Ruben's father and stepmother reported that the neighbors in question were three adult men, here from Mexico, between 25-30 years old. Two of the men reportedly have spouses in Mexico; the men reportedly worked construction jobs, and have since left the area. Mr. Ramirez reported that "Ruben was in jail before we found out about the pornography".

Ruben reported that "if they had not caught me I might have done it again," however, "now that I have been caught I will listen to my dad and tell my brothers not to get in trouble and go to jail." He described jail as "scarey-I cry in jail, you never know if the grownups there will do something to you, beat you up, hurt you, rape you, or steal your food." He added, "I changed since jail-I want to stay out and be with my family-be a big brother to my brothers." He has apparently given some thought to his actions, as "sometimes when I'm by myself in bed I go back in time-wish I never do it-I say I'm sorry to the little girl and her family." He also said "I hope she is not sad the rest of her life-I hope she's not afraid to have a boyfriend-I hope she does not remember what happened," and "I feel sad, really, really bad." He also spoke about his younger brothers ("if someone does something like that to them I want to know-but you can't save them-you can't do nothing").

Ruben's stepmother reported that prior to the assault, Ruben had been becoming increasingly oppositional and less responsive to discipline at home for some time. For example, he "would go out the whole day after being told not to," and "would wake up at 4 am and go walking in bad neighborhood," sometimes for long distances. On Halloween 2006, he "did not want to dress up for Halloween- he said he wanted to go watch movies, and left his brothers." Ruben reported that starting at about 14 years old, he began "getting (positive) attention from other kids when I got sent to the principal's office at school-I thought getting in trouble was cool." He also reported, "I got bored in school," would interrupt others' conversations, and "would not listen to what the teachers said." There were apparently multiple school suspensions.

PAST PSYCHIATRIC HISTORY: Ruben was diagnosed with Attention Deficit-Hyperactivity Disorder (ADHD) in 1999, and treated with Strattera. It is not clear why the medication was discontinued.

FAMILY PSYCHIATRIC HISTORY: Biological mother reportedly has a history of drug addiction and psychiatric problems.

PAST MEDICAL HISTORY: Non-contributory.

PSYCHOSOCIAL/DEVELOPMENTAL HISTORY: Ruben is the oldest of three boys born to a family broken by his parents' divorce when he was 10-11 years old. Ruben was born, and primarily raised, in Florida, although the family did apparently move at least once to South Carolina while still together. Ruben's mother left the family in 1999, to be with "an uncle" of Ruben's, with who she had been having an affair. The boys apparently lived briefly with their mother and/or her mother. However, Ruben's mother was described as "like a child herself--unable to care for herself much less kids." She was/is perhaps cognitively impaired, but medical attention was never obtained. Members of family reportedly "used drugs," and were "not normal," and provided very little support. The children apparently were not cared for properly when young, "their mother didn't wash them, they ran naked on the street, had no supervision -- they did whatever they wanted to do." Reportedly, all three of the boys stopped speaking for a time after their mother left.

Eventually, the boys stayed with a paternal aunt, Maria, who along with her husband raised them for several years. Per the phone conversation with Maria, they got consistent attention, care, and discipline during that period. Mr. Ramirez, unable to find work in Florida, was in South Carolina during that time, apparently sending money to help with the care of his children. Ruben and his brothers moved to be with their father (and stepmother) in 2006.

Ruben was reportedly mentally retarded from birth. He reportedly did not begin speaking until age seven, and had consistent problems in school, being placed in special education classes, and passed along even though he failed grades. He reportedly had no sexual experience prior to the assault. He had "dated" one girl for 2-3 months at age 15-16, without sexual activity, including kissing, before "she liked somebody else."

MENTAL STATUS EXAMINATION: Ruben presented as an average to small-framed Hispanic male, who was accompanied by two uniformed police officers. He wore an orange jumpsuit, and both arms and legs were shackled. His manner was somewhat timid, and he was generally quiet and respectful. Affect and mood appeared congruent, and were grossly appropriate to the topic being discussed. Thought patterns were concrete, simplistic, and often vague. He appeared to become confused easily, and his attention did appear to wander at times. However, there was no evidence of psychotic thought processes, and he denied any history of hallucinations, delusions, or suicidal/homicidal ideation. He was clearly cognitively limited across the entire range of cognitive functioning. Judgement and insight appeared poor, while impulse control appeared grossly intact during the interview.

Ruben appeared to have no difficulty comprehending English, or responding appropriately to verbal or written questions. He did have difficulty understanding some words, such as "conscience," "intercourse," and "ideal," but readily asked for explanations.

PSYCHOLOGICAL TESTING: Test results were valid, and response patterns generally suggested an accurate attempt at self-portrayal. Personality test results indicate that the most problematic areas are in areas related to intellectual functioning. Those who respond similarly

often have cognitive limitations and difficulty with achievement, with interventions which may include retention in grade, and/or placement in special education courses. Inadequate language skills, and limited reading comprehension are suggested. L

Intellectual test results correspond to a general IQ level of 31-44, at the 95% confidence level. This range falls within the DSM-IV-TR category of Severe Mental Retardation. Ruben's age-equivalent functioning ranges from <4 to 7-years-old, across various intellectual abilities. Particularly impairments in his general ability level, use of verbal skills to solve visual tasks, attention to visual details, visual acuity, spatial abilities, and non-verbal reasoning, flexibility in novel problem solving, and regulation of impulsivity and/or attention are suggested.

Ruben may have a tendency toward restlessness, disorganization, and poorly modulated expression of angry feelings. Even more pronounced appears to be significant social discomfort; Ruben is likely to be quiet, shy, and easily embarrassed. He may be quite anxious, or even fearful when meeting strangers, and may prefer not to talk to people with whom he is unfamiliar. He may be typically quite interpersonally isolated, with a paucity of experiences related to positive interactions or friendships with peers. Those who respond similarly have often been subject to criticism, ridicule, and/or rejection by peers. Ruben may find interactions with adults more emotionally safe than with those of his own age.

Other suggested themes include repeated experiences of failure, easy discouragement, and a positive relationship with his father and brothers. Test responses suggested more mixed and ambivalent feelings about prior experiences with females in his life. On the one hand such contacts appear to be valued, but anger/disrespect appear to be present as well. Ruben may also tend to experience some of his emotions somatically, and may be mildly preoccupied with concerns about physical illness or problems.

There were no suggestions of a paraphilia, extremely unusual or bizarre thoughts or experiences, paranoia or exaggerated suspiciousness or hostility, severe moodiness, depression, or generalized anxiety, suicidal or homicidal thoughts or behavior, or drug/alcohol abuse.

COMMENTS AND DIAGNOSTIC CONSIDERATIONS: The impression was of an adolescent with an early history of neglect and deprivation, who has been intellectually impaired, and developmentally delayed throughout most, if not all, of his life. Per the given history, behaviors characteristic of conduct disorder began at approximately age 14. However, psychological testing, which was valid, did not suggest significant conduct-disordered features, which suggests to this interviewer that there may be a reasonably good chance for Ruben to change his life course given the optimal treatment and/or structure.

There was no evidence of psychosis, and Ruben was judged to be responsible for his behavior. However, there is a diagnosable psychological condition of significance, ADHD, which does affect people in many of the ways described above, particularly when combined with intellectual impairments and poor social skills. As noted, he is functioning at intellectual levels of a 4-7-

year-old. Ruben is likely to be highly malleable; that is, to be strongly influenced by those around him, and treatment which addresses the ADHD pharmacologically, as well as teaches coping/social skills would be important in assisting him to adapt effectively to societal standards, and to have better interactions with peers. He was not judged to have a paraphilia (sexual disorder); however, his attitudes towards females may be quite ambivalent, and he will need basic coaching/counseling in order to learn appropriate ways of interacting with female peers. Ruben will likely need help and coaching with each important developmental task in life. Diagnostic impressions are:

AXIS I: Attention-Deficit/Hyperactivity Disorder, Combined Type.

R/O Adjustment Disorder with Mixed Disturbance of Emotions & Conduct.

AXIS II: Severe Mental Retardation.

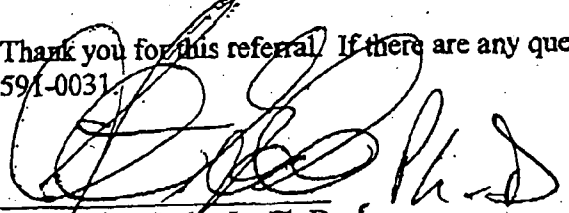
AXIS III: None known.

AXIS IV: Problems related to social environment; educational problems, problems with access to health care services.

AXIS V: Present Level: 35

Highest in Past Year: 35

Thank you for this referral. If there are any questions, please feel free to contact me at (864) 591-0031.


Stephen M. Gedo, Jr., Ph.D.

DIAGNOSTIC AND STATISTICAL MANUAL OF MENTAL DISORDERS

FOURTH EDITION
TEXT REVISION

—DSM-IV-TR—

AMERICAN PSYCHIATRIC ASSOCIATION



Multiaxial System

- Axis I Clinical Disorders
Other Conditions That May Be a
Focus of Clinical Attention
- Axis II Personality Disorders
Mental Retardation
- Axis III General Medical Conditions
- Axis IV Psychosocial and
Environmental Problems
- Axis V Global Assessment of
Functioning

Multiaxial Assessment

A multiaxial system involves an assessment on several axes, each of which refers to a different domain of information that may help the clinician plan treatment and predict outcome. There are five axes included in the DSM-IV multiaxial classification:

- Axis I Clinical Disorders
Other Conditions That May Be a Focus of Clinical Attention
- Axis II Personality Disorders
Mental Retardation
- Axis III General Medical Conditions
- Axis IV Psychosocial and Environmental Problems
- Axis V Global Assessment of Functioning

The use of the multiaxial system facilitates comprehensive and systematic evaluation with attention to the various mental disorders and general medical conditions, psychosocial and environmental problems, and level of functioning that might be overlooked if the focus were on assessing a single presenting problem. A multiaxial system provides a convenient format for organizing and communicating clinical information, for capturing the complexity of clinical situations, and for describing the heterogeneity of individuals presenting with the same diagnosis. In addition, the multiaxial system promotes the application of the biopsychosocial model in clinical, educational, and research settings.

The rest of this section provides a description of each of the DSM-IV axes. In some settings or situations, clinicians may prefer not to use the multiaxial system. For this reason, guidelines for reporting the results of a DSM-IV assessment without applying the formal multiaxial system are provided at the end of this section.

Axis I: Clinical Disorders

Other Conditions That May Be a Focus of Clinical Attention

Axis I is for reporting all the various disorders or conditions in the Classification except for the Personality Disorders and Mental Retardation (which are reported on Axis II). The major groups of disorders to be reported on Axis I are listed in the box below. Also reported on Axis I are Other Conditions That May Be a Focus of Clinical Attention.

When an individual has more than one Axis I disorder, all of these should be reported (for examples, see p. 35). If more than one Axis I disorder is present, the principal diagnosis or the reason for visit (see p. 3) should be indicated by listing it first. When an individual has both an Axis I and an Axis II disorder, the principal diagnosis or the

reason for visit will be assumed to be on Axis I unless the Axis II diagnosis is followed by the qualifying phrase "(Principal Diagnosis)" or "(Reason for Visit)." If no Axis I disorder is present, this should be coded as V71.09. If an Axis I diagnosis is deferred, pending the gathering of additional information, this should be coded as 799.9.

Axis I

Clinical Disorders

Other Conditions That May Be a Focus of Clinical Attention

Disorders Usually First Diagnosed in Infancy, Childhood, or Adolescence

(excluding Mental Retardation, which is diagnosed on Axis II)

Delirium, Dementia, and Amnesic and Other Cognitive Disorders

Mental Disorders Due to a General Medical Condition

Substance-Related Disorders

Schizophrenia and Other Psychotic Disorders

Mood Disorders

Anxiety Disorders

Somatoform Disorders

Factitious Disorders

Dissociative Disorders

Sexual and Gender Identity Disorders

Eating Disorders

Sleep Disorders

Impulse-Control Disorders Not Elsewhere Classified

Adjustment Disorders

Other Conditions That May Be a Focus of Clinical Attention

Axis II: Personality Disorders

Mental Retardation

Axis II is for reporting Personality Disorders and Mental Retardation. It may also be used for noting prominent maladaptive personality features and defense mechanisms. The listing of Personality Disorders and Mental Retardation on a separate axis ensures that consideration will be given to the possible presence of Personality Disorders and Mental Retardation that might otherwise be overlooked when attention is directed to the usually more florid Axis I disorders. The coding of Personality Disorders on Axis II should not be taken to imply that their pathogenesis or range of appropriate treatment is fundamentally different from that for the disorders coded on Axis I. The disorders to be reported on Axis II are listed in the box below.

In the common situation in which an individual has more than one Axis II diagnosis, all should be reported (for examples, see p. 35). When an individual has both an Axis I and an Axis II diagnosis and the Axis II diagnosis is the principal diagnosis or the reason for visit, this should be indicated by adding the qualifying phrase "(Principal Diagnosis)" or "(Reason for Visit)" after the Axis II diagnosis. If no Axis II dis-

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s V71.09. If an Axis I diagnosis is deferred,
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Classified

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the Axis II diagnosis. If no Axis II dis-

order is present, this should be coded as V71.09. If an Axis II diagnosis is deferred,
pending the gathering of additional information, this should be coded as 799.9.

Axis II may also be used to indicate prominent maladaptive personality features
that do not meet the threshold for a Personality Disorder (in such instances, no code
number should be used—see Example 3 on p. 37). The habitual use of maladaptive
defense mechanisms may also be indicated on Axis II (see Appendix B, p. 811, for def-
initions and Example 1 on p. 37).

Axis II

Personality Disorders

Mental Retardation

Paranoid Personality Disorder	Narcissistic Personality Disorder
Schizoid Personality Disorder	Avoidant Personality Disorder
Schizotypal Personality Disorder	Dependent Personality Disorder
Antisocial Personality Disorder	Obsessive-Compulsive Personality Disorder
Borderline Personality Disorder	Personality Disorder Not Otherwise Specified
Histrionic Personality Disorder	Mental Retardation

Axis III: General Medical Conditions

Axis III is for reporting current general medical conditions that are potentially rele-
vant to the understanding or management of the individual's mental disorder. These
conditions are classified outside the "Mental Disorders" chapter of ICD-9-CM (and
outside Chapter V of ICD-10). A listing of the broad categories of general medical
conditions is given in the box below. (For a more detailed listing including the specific
ICD-9-CM codes, refer to Appendix G.)

As discussed in the "Introduction," the multiaxial distinction among Axis I, Axis II,
and Axis III disorders does not imply that there are fundamental differences in their
conceptualization, that mental disorders are unrelated to physical or biological fac-
tors or processes, or that general medical conditions are unrelated to behavioral or
psychosocial factors or processes. The purpose of distinguishing general medical con-
ditions is to encourage thoroughness in evaluation and to enhance communication
among health care providers.

General medical conditions can be related to mental disorders in a variety of ways.
In some cases it is clear that the general medical condition is directly etiological to the
development or worsening of mental symptoms and that the mechanism for this ef-
fect is physiological. When a mental disorder is judged to be a direct physiological
consequence of the general medical condition, a Mental Disorder Due to a General
Medical Condition should be diagnosed on Axis I and the general medical condition
should be recorded on both Axis I and Axis III. For example, when hypothyroidism
is a direct cause of depressive symptoms, the designation on Axis I is 293.83 Mood
Disorder Due to Hypothyroidism, With Depressive Features, and the hypothyroid-
ism is listed again and coded on Axis III as 244.9 (see Example 3, p. 37). For a further
discussion, see p. 181.

In those instances in which the etiological relationship between the general medical condition and the mental symptoms is insufficiently clear to warrant an Axis I diagnosis of Mental Disorder Due to a General Medical Condition, the appropriate mental disorder (e.g., Major Depressive Disorder) should be listed and coded on Axis I; the general medical condition should only be coded on Axis III.

There are other situations in which general medical conditions are recorded on Axis III because of their importance to the overall understanding or treatment of the individual with the mental disorder. An Axis I disorder may be a psychological reaction to an Axis III general medical condition (e.g., the development of 309.0 Adjustment Disorder With Depressed Mood as a reaction to the diagnosis of carcinoma of the breast). Some general medical conditions may not be directly related to the mental disorder but nonetheless have important prognostic or treatment implications (e.g., when the diagnosis on Axis I is 296.30 Major Depressive Disorder, Recurrent, and on Axis III is 427.9 arrhythmia, the choice of pharmacotherapy is influenced by the general medical condition; or when a person with diabetes mellitus is admitted to the hospital for an exacerbation of Schizophrenia and insulin management must be monitored).

When an individual has more than one clinically relevant Axis III diagnosis, all should be reported. For examples, see p. 35. If no Axis III disorder is present, this should be indicated by the notation "Axis III: None." If an Axis III diagnosis is deferred, pending the gathering of additional information, this should be indicated by the notation "Axis III: Deferred."

Axis III

General Medical Conditions (with ICD-9-CM codes)

- Infectious and Parasitic Diseases (001-139)
- Neoplasms (140-239)
- Endocrine, Nutritional, and Metabolic Diseases and Immunity Disorders (240-279)
- Diseases of the Blood and Blood-Forming Organs (280-289)
- Diseases of the Nervous System and Sense Organs (320-389)
- Diseases of the Circulatory System (390-459)
- Diseases of the Respiratory System (460-519)
- Diseases of the Digestive System (520-579)
- Diseases of the Genitourinary System (580-629)
- Complications of Pregnancy, Childbirth, and the Puerperium (630-676)
- Diseases of the Skin and Subcutaneous Tissue (680-709)
- Diseases of the Musculoskeletal System and Connective Tissue (710-739)
- Congenital Anomalies (740-759)
- Certain Conditions Originating in the Perinatal Period (760-779)
- Symptoms, Signs, and Ill-Defined Conditions (780-799)
- Injury and Poisoning (800-999)

Axis I

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relationship between the general medical condition and the Axis I diagnosis. If the medical condition is clearly related to the Axis I diagnosis, the appropriate code should be listed and coded on Axis I; if not, it should be coded on Axis III.

Medical conditions are recorded on Axis I if they affect the understanding or treatment of the disorder. For example, a psychological reaction to the diagnosis of carcinoma of the breast would not be directly related to the mental disorder and would not have treatment implications (e.g., a depressive disorder, recurrent, and on which psychotherapy is influenced by the general diabetes mellitus is admitted to the treatment of insulin management must be monitored).

For a medically relevant Axis III diagnosis, all Axis I disorders are present, this is the case. If an Axis III diagnosis is determined, this should be indicated by

with ICD-9-CM codes)

and Immunity Disorders

Disorders (280-289)

Disorders (320-389)

9)

the Puerperium (630-676)
(680-709)

Connective Tissue (710-739)

al Period (760-779)
(780-799)

Axis IV: Psychosocial and Environmental Problems

Axis IV is for reporting psychosocial and environmental problems that may affect the diagnosis, treatment, and prognosis of mental disorders (Axes I and II). A psychosocial or environmental problem may be a negative life event, an environmental difficulty or deficiency, a familial or other interpersonal stress, an inadequacy of social support or personal resources, or other problem relating to the context in which a person's difficulties have developed. So-called positive stressors, such as job promotion, should be listed only if they constitute or lead to a problem, as when a person has difficulty adapting to the new situation. In addition to playing a role in the initiation or exacerbation of a mental disorder, psychosocial problems may also develop as a consequence of a person's psychopathology or may constitute problems that should be considered in the overall management plan.

When an individual has multiple psychosocial or environmental problems, the clinician may note as many as are judged to be relevant. In general, the clinician should note only those psychosocial and environmental problems that have been present during the year preceding the current evaluation. However, the clinician may choose to note psychosocial and environmental problems occurring prior to the previous year if these clearly contribute to the mental disorder or have become a focus of treatment—for example, previous combat experiences leading to Posttraumatic Stress Disorder.

In practice, most psychosocial and environmental problems will be indicated on Axis IV. However, when a psychosocial or environmental problem is the primary focus of clinical attention, it should also be recorded on Axis I, with a code derived from the section "Other Conditions That May Be a Focus of Clinical Attention" (see p. 731).

For convenience, the problems are grouped together in the following categories:

- **Problems with primary support group**—e.g., death of a family member; health problems in family; disruption of family by separation, divorce, or estrangement; removal from the home; remarriage of parent; sexual or physical abuse; parental overprotection; neglect of child; inadequate discipline; discord with siblings; birth of a sibling
- **Problems related to the social environment**—e.g., death or loss of friend; inadequate social support; living alone; difficulty with acculturation; discrimination; adjustment to life-cycle transition (such as retirement)
- **Educational problems**—e.g., illiteracy; academic problems; discord with teachers or classmates; inadequate school environment
- **Occupational problems**—e.g., unemployment; threat of job loss; stressful work schedule; difficult work conditions; job dissatisfaction; job change; discord with boss or co-workers
- **Housing problems**—e.g., homelessness; inadequate housing; unsafe neighborhood; discord with neighbors or landlord
- **Economic problems**—e.g., extreme poverty; inadequate finances; insufficient welfare support
- **Problems with access to health care services**—e.g., inadequate health care services; transportation to health care facilities unavailable; inadequate health insurance

- Problems related to interaction with the legal system/crime—e.g., arrest; incarceration; litigation; victim of crime
- Other psychosocial and environmental problems—e.g., exposure to disasters, war, other hostilities; discord with nonfamily caregivers such as counselor, social worker, or physician; unavailability of social service agencies

When using the Multiaxial Evaluation Report Form (see p. 36), the clinician should identify the relevant categories of psychosocial and environmental problems and indicate the specific factors involved. If a recording form with a checklist of problem categories is not used, the clinician may simply list the specific problems on Axis IV. (See examples on p. 35.)

Axis IV

Psychosocial and Environmental Problems

Problems with primary support group
 Problems related to the social environment
 Educational problems
 Occupational problems
 Housing problems
 Economic problems
 Problems with access to health care services
 Problems related to interaction with the legal system/crime
 Other psychosocial and environmental problems

Axis V: Global Assessment of Functioning

Axis V is for reporting the clinician's judgment of the individual's overall level of functioning. This information is useful in planning treatment and measuring its impact, and in predicting outcome.

The reporting of overall functioning on Axis V can be done using the Global Assessment of Functioning (GAF) Scale. The GAF Scale may be particularly useful in tracking the clinical progress of individuals in global terms, using a single measure. The GAF Scale is to be rated with respect only to psychological, social, and occupational functioning. The instructions specify, "Do not include impairment in functioning due to physical (or environmental) limitations."

The GAF scale is divided into 10 ranges of functioning. Making a GAF rating involves picking a single value that best reflects the individual's overall level of functioning. The description of each 10-point range in the GAF scale has two components: the first part covers symptom severity, and the second part covers functioning. The GAF rating is within a particular decile if either the symptom severity or the level of functioning falls within the range. For example, the first part of the range 41–50 describes "serious symptoms (e.g., suicidal ideation, severe obsessional rituals, frequent shoplifting)" and the second part includes "any serious impairment in social, occupational, or school functioning (e.g., no friends, unable to keep a job)." It should be noted

il system/crime—e.g., arrest; incar-

blems—e.g., exposure to disasters, caregivers such as counselor, social service agencies

orm (see p. 36), the clinician should id environmental problems and in- g form with a checklist of problem at the specific problems on Axis IV.

ental Problems

ystem/crime
s

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of the individual's overall level of g treatment and measuring its im-

can be done using the Global As- scale may be particularly useful in al terms, using a single measure. psychological, social, and occupa- it include impairment in function-

tioning. Making a GAF rating in- individual's overall level of func- e GAF scale has two components: ond part covers functioning. The e symptom severity or the level of e first part of the range 41-50 de- vere obsessional rituals, frequent ous impairment in social, occupa- to keep a job)." It should be noted

that in situations where the individual's symptom severity and level of functioning are discordant, the final GAF rating always reflects the worse of the two. For example, the GAF rating for an individual who is a significant danger to self but is otherwise functioning well would be below 20. Similarly, the GAF rating for an individual with minimal psychological symptomatology but significant impairment in functioning (e.g., an individual whose excessive preoccupation with substance use has resulted in loss of job and friends but no other psychopathology) would be 40 or lower.

In most instances, ratings on the GAF Scale should be for the current period (i.e., the level of functioning at the time of the evaluation) because ratings of current functioning will generally reflect the need for treatment or care. In order to account for day-to-day variability in functioning, the GAF rating for the "current period" is sometimes operationalized as the lowest level of functioning for the past week. In some settings, it may be useful to note the GAF Scale rating both at time of admission and at time of discharge. The GAF Scale may also be rated for other time periods (e.g., the highest level of functioning for at least a few months during the past year). The GAF Scale is reported on Axis V as follows: "GAF = ," followed by the GAF rating from 0 to 100, followed by the time period reflected by the rating in parentheses—for example, "(current)," "(highest level in past year)," "(at discharge)." (See examples on p. 35.)

In order to ensure that no elements of the GAF scale are overlooked when a GAF rating is being made, the following method for determining a GAF rating may be applied:

STEP 1: Starting at the top level, evaluate each range by asking "is either the individual's symptom severity OR level of functioning worse than what is indicated in the range description?"

STEP 2: Keep moving down the scale until the range that best matches the individual's symptom severity OR the level of functioning is reached, whichever is worse.

STEP 3: Look at the next lower range as a double-check against having stopped prematurely. This range should be too severe on both symptom severity and level of functioning. If it is, the appropriate range has been reached (continue with step 4). If not, go back to step 2 and continue moving down the scale.

STEP 4: To determine the specific GAF rating within the selected 10-point range, consider whether the individual is functioning at the higher or lower end of the 10-point range. For example, consider an individual who hears voices that do not influence his behavior (e.g., someone with long-standing Schizophrenia who accepts his hallucinations as part of his illness). If the voices occur relatively infrequently (once a week or less), a rating of 39 or 40 might be most appropriate. In contrast, if the individual hears voices almost continuously, a rating of 31 or 32 would be more appropriate.

In some settings, it may be useful to assess social and occupational disability and to track progress in rehabilitation independent of the severity of the psychological symptoms. For this purpose, a proposed Social and Occupational Functioning Assessment Scale (SOFAS) (see p. 817) is included in Appendix B. Two additional proposed scales that may be useful in some settings—the Global Assessment of Relational Functioning (GARF) Scale (see p. 814) and the Defensive Functioning Scale (see p. 807)—are also included in Appendix B.

Global Assessment of Functioning (GAF) Scale

Consider psychological, social, and occupational functioning on a hypothetical continuum of mental health-illness. Do not include impairment in functioning due to physical (or environmental) limitations.

Code (Note: Use intermediate codes when appropriate, e.g., 45, 68, 72.)

- 100 Superior functioning in a wide range of activities, life's problems never seem to
| get out of hand, is sought out by others because of his or her many positive qual-
91 ities. No symptoms.
- 90 Absent or minimal symptoms (e.g., mild anxiety before an exam), good functioning
| in all areas, interested and involved in a wide range of activities, socially effec-
81 tive, generally satisfied with life, no more than everyday problems or concerns
(e.g., an occasional argument with family members).
- 80 If symptoms are present, they are transient and expectable reactions to psycho-
| social stressors (e.g., difficulty concentrating after family argument); no more than
71 slight impairment in social, occupational, or school functioning (e.g., temporarily
falling behind in schoolwork).
- 70 Some mild symptoms (e.g., depressed mood and mild insomnia) OR some difficulty in
| social, occupational, or school functioning (e.g., occasional truancy, or theft within the
61 household), but generally functioning pretty well, has some meaningful interper-
sonal relationships.
- 60 Moderate symptoms (e.g., flat affect and circumstantial speech, occasional panic attacks)
| OR moderate difficulty in social, occupational, or school functioning (e.g., few
51 friends, conflicts with peers or co-workers).
- 50 Serious symptoms (e.g., suicidal ideation, severe obsessional rituals, frequent shoplifting)
| OR any serious impairment in social, occupational, or school functioning (e.g., no
41 friends, unable to keep a job).
- 40 Some impairment in reality testing or communication (e.g., speech is at times illogi-
| cal, obscure, or irrelevant) OR major impairment in several areas, such as work or
31 school, family relations, judgment, thinking, or mood (e.g., depressed man avoids
friends, neglects family, and is unable to work; child frequently beats up younger children,
is defiant at home, and is failing at school).
- 30 Behavior is considerably influenced by delusions or hallucinations OR serious
| impairment in communication or judgment (e.g., sometimes incoherent, acts grossly
21 inappropriately, suicidal preoccupation) OR inability to function in almost all areas
(e.g., stays in bed all day; no job, home, or friends).
- 20 Some danger of hurting self or others (e.g., suicide attempts without clear expectation
| of death; frequently violent; manic excitement) OR occasionally fails to maintain min-
11 imal personal hygiene (e.g., smears feces) OR gross impairment in communication
(e.g., largely incoherent or mute).
- 10 Persistent danger of severely hurting self or others (e.g., recurrent violence) OR per-
| sistent inability to maintain minimal personal hygiene OR serious suicidal act
1 with clear expectation of death.
- 0 Inadequate information.

The rating of overall psychological functioning on a scale of 0-100 was operationalized by Luborsky in the Health-Sickness Rating Scale (Luborsky L: "Clinicians' Judgments of Mental Health." *Archives of General Psychiatry* 7:407-417, 1962). Spitzer and colleagues developed a revision of the Health-Sickness Rating Scale called the Global Assessment Scale (GAS) (Endicott J, Spitzer RL, Fleiss JL, Cohen J: "The Global Assessment Scale: A Procedure for Measuring Overall Severity of Psychiatric Disturbance." *Archives of General Psychiatry* 33:766-771, 1976). A modified version of the GAS was included in DSM-III-R as the Global Assessment of Functioning (GAF) Scale.

Functioning (GAF) Scale

... functioning on a hypothetical continuum of mental and physical impairment in functioning due to

... appropriate, e.g., 45, 68, 72.)

... activities, life's problems never seem to be caused by his or her many positive qual-

... (anxiety before an exam), good functioning in a wide range of activities, socially effective in dealing with everyday problems or concerns (e.g., problems).

... it and expectable reactions to psychosocial stressors (e.g., after family argument); no more than minor impairment in school functioning (e.g., temporarily

... and mild insomnia) OR some difficulty in functioning (e.g., occasional truancy, or theft within the last 12 months) OR some impairment in social or school functioning (e.g., few

... substantial speech, occasional panic attacks) OR some impairment in social or school functioning (e.g., few

... obsessive compulsive rituals, frequent shoplifting) OR some impairment in social or school functioning (e.g., no

... communication (e.g., speech is at times illogical, or incoherent, or socially inappropriate) OR some impairment in social or school functioning (e.g., few friends) OR some impairment in social or school functioning (e.g., few

... delusions or hallucinations OR serious impairment in social or school functioning (e.g., sometimes incoherent, acts grossly inappropriately, or has suicidal ideation) OR some impairment in social or school functioning (e.g., few

... suicide attempts without clear expectation of help OR some impairment in social or school functioning (e.g., few friends) OR some impairment in social or school functioning (e.g., few

... or others (e.g., recurrent violence) OR some impairment in social or school functioning (e.g., few friends) OR some impairment in social or school functioning (e.g., few

... of 0-100 was operationalized by Luborsky and his colleagues' "Judgments of Mental Health." Archives of General Psychiatry developed a revision of the Health and Social Adjustment Scale (HAS) (Endicott J, Spitzer RL, Fleiss JL, Cohen D). The HAS is a modified version of the GAS was included in the DSM-IV GAF Scale.

Examples of How to Record Results of a DSM-IV Multiaxial Evaluation

Example 1:

Axis I	296.23	Major Depressive Disorder, Single Episode, Severe Without Psychotic Features
	305.00	Alcohol Abuse
Axis II	301.6	Dependent Personality Disorder
		Frequent use of denial
Axis III		None
Axis IV		Threat of job loss
Axis V	GAF = 35	(current)

Example 2:

Axis I	300.4	Dysthymic Disorder
	315.00	Reading Disorder
Axis II	V71.09	No diagnosis
Axis III	382.9	Otitis media, recurrent
Axis IV		Victim of child neglect
Axis V	GAF = 53	(current)

Example 3:

Axis I	293.83	Mood Disorder Due to Hypothyroidism, With Depressive Features
Axis II	V71.09	No diagnosis, histrionic personality features
Axis III	244.9	Hypothyroidism
	365.23	Chronic angle-closure glaucoma
Axis IV		None
Axis V	GAF = 45	(on admission)
	GAF = 65	(at discharge)

Example 4:

Axis I	V61.10	Partner Relational Problem
Axis II	V71.09	No diagnosis
Axis III		None
Axis IV		Unemployment
Axis V	GAF = 83	(highest level past year)

Multiaxial Evaluation Report Form

The following form is offered as one possibility for reporting multiaxial evaluations. In some settings, this form may be used exactly as is; in other settings, the form may be adapted to satisfy special needs.

AXIS I: Clinical Disorders Other Conditions That May Be a Focus of Clinical Attention

Diagnostic code DSM-IV name

_____	_____
_____	_____
_____	_____

AXIS II: Personality Disorders Mental Retardation

Diagnostic code DSM-IV name

_____	_____
_____	_____

AXIS III: General Medical Conditions

ICD-9-CM code ICD-9-CM name

_____	_____
_____	_____
_____	_____

AXIS IV: Psychosocial and Environmental Problems

Check:

- ☐ Problems with primary support group Specify: _____
- ☐ Problems related to the social environment Specify: _____
- ☐ Educational problems Specify: _____
- ☐ Occupational problems Specify: _____
- ☐ Housing problems Specify: _____
- ☐ Economic problems Specify: _____
- ☐ Problems with access to health care services Specify: _____
- ☐ Problems related to interaction with the legal system/crime Specify: _____
- ☐ Other psychosocial and environmental problems Specify: _____

AXIS V: Global Assessment of Functioning Scale

Score: _____

Time frame: _____

ion Report Form

lity for reporting multiaxial evaluations.
ctly as is; in other settings, the form may

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ital Problems

fy: _____

Specify: _____

Specify: _____

I system/crime Specify: _____

ms Specify: _____

ing Scale

Score: _____

Time frame: _____

Nonaxial Format

Clinicians who do not wish to use the multiaxial format may simply list the appropriate diagnoses. Those choosing this option should follow the general rule of recording as many coexisting mental disorders, general medical conditions, and other factors as are relevant to the care and treatment of the individual. The Principal Diagnosis or the Reason for Visit should be listed first.

The examples below illustrate the reporting of diagnoses in a format that does not use the multiaxial system.

Example 1:

296.23 Major Depressive Disorder, Single Episode, Severe Without Psychotic Features

305.00 Alcohol Abuse

301.6 Dependent Personality Disorder; Frequent use of denial

Example 2:

300.4 Dysthymic Disorder

315.00 Reading Disorder

382.9 Otitis media, recurrent

Example 3:

293.83 Mood Disorder Due to Hypothyroidism, With Depressive Features

244.9 Hypothyroidism

365.23 Chronic angle-closure glaucoma
Histrionic personality features

Example 4:

V61.10 Partner Relational Problem

Disorders Usually First Diagnosed in Infancy, Childhood, or Adolescence

The provision of a separate section for disorders that are usually first diagnosed in infancy, childhood, or adolescence is for convenience only and is not meant to suggest that there is any clear distinction between "childhood" and "adult" disorders. Although most individuals with these disorders present for clinical attention during childhood or adolescence, the disorders sometimes are not diagnosed until adulthood. Moreover, many disorders included in other sections of the manual often have an onset during childhood or adolescence. In evaluating an infant, child, or adolescent, the clinician should consider the diagnoses included in this section but also should refer to the disorders described elsewhere in this manual. Adults may also be diagnosed with disorders included in this section for Disorders Usually First Diagnosed in Infancy, Childhood, or Adolescence if their clinical presentation meets relevant diagnostic criteria (e.g., Stuttering, Pica). Moreover, if an adult had symptoms as a child that met full criteria for a disorder, but now presents with an attenuated or residual form, the In Partial Remission specifier may be indicated (e.g., Attention-Deficit/Hyperactivity Disorder, Combined Type, In Partial Remission). For most (but not all) DSM-IV disorders, a single criteria set is provided that applies to children, adolescents, and adults (e.g., if a child or adolescent has symptoms that meet the criteria for Major Depressive Disorder, this diagnosis should be given, regardless of the individual's age). The variations in the presentation of a disorder that are attributable to an individual's developmental stage are described in a section in the text titled "Specific Culture, Age, and Gender Features." Specific issues related to the diagnosis of Personality Disorders in children or adolescents are discussed on p. 687.

The following disorders are included in this section:

Mental Retardation. This disorder is characterized by significantly subaverage intellectual functioning (an IQ of approximately 70 or below) with onset before age 18 years and concurrent deficits or impairments in adaptive functioning. Separate codes are provided for Mild, Moderate, Severe, and Profound Mental Retardation and for Mental Retardation, Severity Unspecified.

Learning Disorders. These disorders are characterized by academic functioning that is substantially below that expected given the person's chronological age, measured intelligence, and age-appropriate education. The specific disorders included in this section are Reading Disorder, Mathematics Disorder, Disorder of Written Expression, and Learning Disorder Not Otherwise Specified.

Motor Skills Disorder. This includes **Developmental Coordination Disorder**, which is characterized by motor coordination that is substantially below that expected given the person's chronological age and measured intelligence.

Communication Disorders. These disorders are characterized by difficulties in speech or language and include **Expressive Language Disorder**, **Mixed Receptive-Expressive Language Disorder**, **Phonological Disorder**, **Stuttering**, and **Communication Disorder Not Otherwise Specified**.

Pervasive Developmental Disorders. These disorders are characterized by severe deficits and pervasive impairment in multiple areas of development. These include impairment in reciprocal social interaction, impairment in communication, and the presence of stereotyped behavior, interests, and activities. The specific disorders included in this section are **Autistic Disorder**, **Rett's Disorder**, **Childhood Disintegrative Disorder**, **Asperger's Disorder**, and **Pervasive Developmental Disorder Not Otherwise Specified**.

Attention-Deficit and Disruptive Behavior Disorders. This section includes **Attention-Deficit/Hyperactivity Disorder**, which is characterized by prominent symptoms of inattention and/or hyperactivity-impulsivity. Subtypes are provided for specifying the predominant symptom presentation: **Predominantly Inattentive Type**, **Predominantly Hyperactive-Impulsive Type**, and **Combined Type**. Also included in this section are the **Disruptive Behavior Disorders**: **Conduct Disorder** is characterized by a pattern of behavior that violates the basic rights of others or major age-appropriate societal norms or rules; **Oppositional Defiant Disorder** is characterized by a pattern of negativistic, hostile, and defiant behavior. This section also includes two **Not Otherwise Specified** categories: **Attention-Deficit/Hyperactivity Disorder Not Otherwise Specified** and **Disruptive Behavior Disorder Not Otherwise Specified**.

Feeding and Eating Disorders of Infancy or Early Childhood. These disorders are characterized by persistent disturbances in feeding and eating. The specific disorders included are **Pica**, **Rumination Disorder**, and **Feeding Disorder of Infancy or Early Childhood**. Note that **Anorexia Nervosa** and **Bulimia Nervosa** are included in the "Eating Disorders" section presented later in the manual (see p. 583).

Tic Disorders. These disorders are characterized by vocal and/or motor tics. The specific disorders included are **Tourette's Disorder**, **Chronic Motor or Vocal Tic Disorder**, **Transient Tic Disorder**, and **Tic Disorder Not Otherwise Specified**.

Elimination Disorders. This grouping includes **Encopresis**, the repeated passage of feces into inappropriate places, and **Enuresis**, the repeated voiding of urine into inappropriate places.

Other Disorders of Infancy, Childhood, or Adolescence. This grouping is for disorders that are not covered in the sections listed above. **Separation Anxiety Disorder** is characterized by developmentally inappropriate and excessive anxiety concerning

Mental Retardation

separation from home is characterized by a speaking in other situations. **Childhood** is characterized by social relatedness that is atypical for the person's age. **Adolescence** is characterized by social relatedness that is atypical for the person's age. **Adolescence Not Otherwise Specified** is characterized by social relatedness that is atypical for the person's age with onset in infancy, childhood, or adolescence. **Specific disorder in the Classification**

Children or adolescents that are not defined as retarded. **Abuse or Neglect, Problem, Child or Adolescent** at the end of the manual. **Clinical Attention**" (see **DSM-III-R** included **Overanxious Disorder** because of similarities in

Diagnostic Feature:

The essential feature of intellectual functioning (Criterial functioning in at least one of the following areas: home living, social/interpersonal, functional academic skills) must occur before age 18. Etiologies and may be associated with other mental disorders that affect the functioning.

General intellectual functioning (equivalent) obtained by a standardized intelligence test (3rd Edition; Stanford-Binet) significantly below average (approximately 2 standard deviations below the mean). There is a measurement error of approximately 15 points, which may vary from instrument to instrument. A range of 60-70 points is considered

Usually First Diagnosed in Infancy,
Childhood, or Adolescence

Motor Coordination Disorder. It is substantially below that expected for the child's chronological age and measured intelligence.

are characterized by difficulties in language **Disorder, Mixed Receptive-Expressive Disorder, Stuttering, and Communication Disorder Not Otherwise Specified.**

Disorders are characterized by severe delays in areas of development. These include delays in communication, and the child's activities. The specific disorders include **Autism, Childhood Disintegrative Disorder, and Asperger's Disorder.**

Disorders. This section includes disorders which are characterized by prominent impulsivity. Subtypes are provided for **Attention-Deficit/Hyperactivity Disorder, Predominantly Inattentive Type, and Combined Type.** Also included are **Conduct Disorder** which violates the basic rights of others or major social norms, and **Oppositional Defiant Disorder** which is characterized by defiant behavior. This section also includes **Attention-Deficit/Hyperactivity Disorder, Conduct Disorder, and Oppositional Defiant Disorder Not Otherwise Specified.**

Early Childhood. These disorders are characterized by feeding and eating problems. The specific disorders include **Feeding Disorder of Infancy or Early Childhood, Bulimia Nervosa, and Anorexia Nervosa.** These are included in the manual (see p. 583).

are characterized by vocal and/or motor tics. The disorders include **Chronic Motor or Vocal Tic Disorder, and Tic Disorder Not Otherwise Specified.**

includes **Encopresis**, the repeated passage of feces into the rectum, and **Enuresis**, the repeated voiding of urine into the bladder.

Adolescence. This grouping is for disorders first diagnosed above. **Separation Anxiety Disorder** is characterized by excessive anxiety concerning separation from home or from those to whom the child is attached.

Mental Retardation

Separation Anxiety Disorder is characterized by a consistent failure to speak in specific social situations despite speaking in other situations. **Reactive Attachment Disorder of Infancy or Early Childhood** is characterized by markedly disturbed and developmentally inappropriate social relatedness that occurs in most contexts and is associated with grossly pathogenic care. **Stereotypic Movement Disorder** is characterized by repetitive, seemingly driven, and nonfunctional motor behavior that markedly interferes with normal activities and at times may result in bodily injury. **Disorder of Infancy, Childhood, or Adolescence Not Otherwise Specified** is a residual category for coding disorders with onset in infancy, childhood, or adolescence that do not meet criteria for any specific disorder in the Classification.

Children or adolescents may present with problems requiring clinical attention that are not defined as mental disorders (e.g., Relational Problems, Problems Related to Abuse or Neglect, Bereavement, Borderline Intellectual Functioning, Academic Problem, Child or Adolescent Antisocial Behavior, Identity Problem). These are listed at the end of the manual in the section "Other Conditions That May Be a Focus of Clinical Attention" (see p. 731).

DSM-III-R included two anxiety disorders specific to children and adolescents, **Overanxious Disorder of Childhood** and **Avoidant Disorder of Childhood**, that have been subsumed under **Generalized Anxiety Disorder** and **Social Phobia**, respectively, because of similarities in essential features.

Mental Retardation

Diagnostic Features

The essential feature of Mental Retardation is significantly subaverage general intellectual functioning (Criterion A) that is accompanied by significant limitations in adaptive functioning in at least two of the following skill areas: communication, self-care, home living, social/interpersonal skills, use of community resources, self-direction, functional academic skills, work, leisure, health, and safety (Criterion B). The onset must occur before age 18 years (Criterion C). Mental Retardation has many different etiologies and may be seen as a final common pathway of various pathological processes that affect the functioning of the central nervous system.

General intellectual functioning is defined by the intelligence quotient (IQ or IQ-equivalent) obtained by assessment with one or more of the standardized, individually administered intelligence tests (e.g., Wechsler Intelligence Scales for Children, 3rd Edition; Stanford-Binet, 4th Edition; Kaufman Assessment Battery for Children). Significantly subaverage intellectual functioning is defined as an IQ of about 70 or below (approximately 2 standard deviations below the mean). It should be noted that there is a measurement error of approximately 5 points in assessing IQ, although this may vary from instrument to instrument (e.g., a Wechsler IQ of 70 is considered to represent a range of 65-75). Thus, it is possible to diagnose Mental Retardation in

individuals with IQs between 70 and 75 who exhibit significant deficits in adaptive behavior. Conversely, Mental Retardation would not be diagnosed in an individual with an IQ lower than 70 if there are no significant deficits or impairments in adaptive functioning. The choice of testing instruments and interpretation of results should take into account factors that may limit test performance (e.g., the individual's sociocultural background, native language, and associated communicative, motor, and sensory handicaps). When there is significant scatter in the subtest scores, the profile of strengths and weaknesses, rather than the mathematically derived full-scale IQ, will more accurately reflect the person's learning abilities. When there is a marked discrepancy across verbal and performance scores, averaging to obtain a full-scale IQ score can be misleading.

Impairments in adaptive functioning, rather than a low IQ, are usually the presenting symptoms in individuals with Mental Retardation. *Adaptive functioning* refers to how effectively individuals cope with common life demands and how well they meet the standards of personal independence expected of someone in their particular age group, sociocultural background, and community setting. Adaptive functioning may be influenced by various factors, including education, motivation, personality characteristics, social and vocational opportunities, and the mental disorders and general medical conditions that may coexist with Mental Retardation. Problems in adaptation are more likely to improve with remedial efforts than is the cognitive IQ, which tends to remain a more stable attribute.

It is useful to gather evidence for deficits in adaptive functioning from one or more reliable independent sources (e.g., teacher evaluation and educational, developmental, and medical history). Several scales have also been designed to measure adaptive functioning or behavior (e.g., the Vineland Adaptive Behavior Scales and the American Association on Mental Retardation Adaptive Behavior Scale). These scales generally provide a clinical cutoff score that is a composite of performance in a number of adaptive skill domains. It should be noted that scores for certain individual domains are not included in some of these instruments and that individual domain scores may vary considerably in reliability. As in the assessment of intellectual functioning, consideration should be given to the suitability of the instrument to the person's sociocultural background, education, associated handicaps, motivation, and cooperation. For instance, the presence of significant handicaps invalidates many adaptive scale norms. In addition, behaviors that would normally be considered maladaptive (e.g., dependency, passivity) may be evidence of good adaptation in the context of a particular individual's life (e.g., in some institutional settings).

Degrees of Severity of Mental Retardation

Four degrees of severity can be specified, reflecting the level of intellectual impairment: Mild, Moderate, Severe, and Profound.

317	Mild Mental Retardation:	IQ level 50-55 to approximately 70
318.0	Moderate Retardation:	IQ level 35-40 to 50-55
318.1	Severe Mental Retardation:	IQ level 20-25 to 35-40
318.2	Profound Mental Retardation:	IQ level below 20 or 25

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- IQ level 35–40 to 50–55
- IQ level 20–25 to 35–40
- IQ level below 20 or 25

319 Mental Retardation, Severity Unspecified, can be used when there is a strong presumption of Mental Retardation but the person's intelligence is untestable by standard tests (e.g., with individuals too impaired or uncooperative, or with infants).

317 Mild Mental Retardation

Mild Mental Retardation is roughly equivalent to what used to be referred to as the educational category of "educable." This group constitutes the largest segment (about 85%) of those with the disorder. As a group, people with this level of Mental Retardation typically develop social and communication skills during the preschool years (ages 0–5 years), have minimal impairment in sensorimotor areas, and often are not distinguishable from children without Mental Retardation until a later age. By their late teens, they can acquire academic skills up to approximately the sixth-grade level. During their adult years, they usually achieve social and vocational skills adequate for minimum self-support, but may need supervision, guidance, and assistance, especially when under unusual social or economic stress. With appropriate supports, individuals with Mild Mental Retardation can usually live successfully in the community, either independently or in supervised settings.

318.0 Moderate Mental Retardation

Moderate Mental Retardation is roughly equivalent to what used to be referred to as the educational category of "trainable." This outdated term should not be used because it wrongly implies that people with Moderate Mental Retardation cannot benefit from educational programs. This group constitutes about 10% of the entire population of people with Mental Retardation. Most of the individuals with this level of Mental Retardation acquire communication skills during early childhood years. They profit from vocational training and, with moderate supervision, can attend to their personal care. They can also benefit from training in social and occupational skills but are unlikely to progress beyond the second-grade level in academic subjects. They may learn to travel independently in familiar places. During adolescence, their difficulties in recognizing social conventions may interfere with peer relationships. In their adult years, the majority are able to perform unskilled or semiskilled work under supervision in sheltered workshops or in the general workforce. They adapt well to life in the community, usually in supervised settings.

318.1 Severe Mental Retardation

The group with Severe Mental Retardation constitutes 3%–4% of individuals with Mental Retardation. During the early childhood years, they acquire little or no communicative speech. During the school-age period, they may learn to talk and can be trained in elementary self-care skills. They profit to only a limited extent from instruction in pre-academic subjects, such as familiarity with the alphabet and simple counting, but can master skills such as learning sight reading of some "survival" words. In their adult years, they may be able to perform simple tasks in closely supervised set-

tings. Most adapt well to life in the community, in group homes or with their families, unless they have an associated handicap that requires specialized nursing or other care.

318.2 Profound Mental Retardation

The group with Profound Mental Retardation constitutes approximately 1%–2% of people with Mental Retardation. Most individuals with this diagnosis have an identified neurological condition that accounts for their Mental Retardation. During the early childhood years, they display considerable impairments in sensorimotor functioning. Optimal development may occur in a highly structured environment with constant aid and supervision and an individualized relationship with a caregiver. Motor development and self-care and communication skills may improve if appropriate training is provided. Some can perform simple tasks in closely supervised and sheltered settings.

319 Mental Retardation, Severity Unspecified

The diagnosis of Mental Retardation, Severity Unspecified, should be used when there is a strong presumption of Mental Retardation but the person cannot be successfully tested by standardized intelligence tests. This may be the case when children, adolescents, or adults are too impaired or uncooperative to be tested or, with infants, when there is a clinical judgment of significantly subaverage intellectual functioning, but the available tests (e.g., the Bayley Scales of Infant Development, Cattell Infant Intelligence Scales, and others) do not yield IQ values. In general, the younger the age, the more difficult it is to assess for the presence of Mental Retardation except in those with profound impairment.

Recording Procedures

The specific diagnostic code for Mental Retardation is selected based on the level of severity as indicated above and is coded on Axis II. If Mental Retardation is associated with another mental disorder (e.g., Autistic Disorder), the additional mental disorder is coded on Axis I. If Mental Retardation is associated with a general medical condition (e.g., Down syndrome), the general medical condition is coded on Axis III.

Associated Features and Disorders

Associated descriptive features and mental disorders. No specific personality and behavioral features are uniquely associated with Mental Retardation. Some individuals with Mental Retardation are passive, placid, and dependent, whereas others can be aggressive and impulsive. Lack of communication skills may predispose to disruptive and aggressive behaviors that substitute for communicative language. Some general medical conditions associated with Mental Retardation are characterized by certain behavioral symptoms (e.g., the intractable self-injurious behavior associated with Lesch-Nyhan syndrome). Individuals with Mental Retardation may be

319 Mental Retardation, Severity Unspecified

vulnerable to exploitation by others, being denied rights and opportunities. Individuals with Mental Retardation that is estimated to be three to four times the associated mental disorder (e.g., in Personality Change Due to Head Injury and there is no evidence that the individuals who have Mental Retardation are, however, often complicated by the fact that the severity of the Mental Retardation and skills may result in an inability to perform major Depressive Disorder in a nonverbal manner on manifestations such as depression, are observed by others). More often, however, it may be difficult to choose a category. Not Otherwise Specified category (e.g., Specified). The most common associated disorders are Activity Disorder, Mood Disorders, Movement Disorder, and Mental Dementia Due to Head Trauma). Individuals with Mental Retardation may be at higher risk for Pathological changes in the brain at a time these individuals are in their early years and are not evident until later.

Associations have been reported between comorbid symptoms and mental disorders to increase the risk for Attention-Deficit/Hyperactivity Disorder in individuals with Prader-Willi syndrome and those with William's syndrome and Attention-Deficit/Hyperactivity Disorder.

Predisposing factors. Etiologic factors, psychosocial, or some combination of these factors seen in clinical settings, no clear pattern has been identified in individuals with Mental Retardation. Predisposing factors include:

Heredity: These factors include chromosomal abnormalities (e.g., Down syndrome, phenylketonuria, and Tay-Sachs disease), autosomal recessive metabolic abnormalities (e.g., Tay-Sachs disease, phenylketonuria, and Tay-Sachs disease), and chromosomal abnormalities (e.g., Down syndrome, phenylketonuria, and Tay-Sachs disease). Advances in genetic testing have identified forms of Mental Retardation.

Early alterations of embryonic development: Early alterations of embryonic development (e.g., Down syndrome, phenylketonuria, and Tay-Sachs disease) (e.g., maternal alcohol consumption, maternal drug use, and maternal infections).

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requires specialized nursing or other

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vulnerable to exploitation by others (e.g., being physically and sexually abused) or
being denied rights and opportunities.

Individuals with Mental Retardation have a prevalence of comorbid mental disorders
that is estimated to be three to four times greater than in the general population. In some
cases, this may result from a shared etiology that is common to Mental Retardation and
the associated mental disorder (e.g., head trauma may result in Mental Retardation and
in Personality Change Due to Head Trauma). All types of mental disorders may be seen,
and there is no evidence that the nature of a given mental disorder is different in individ-
uals who have Mental Retardation. The diagnosis of comorbid mental disorders is, how-
ever, often complicated by the fact that the clinical presentation may be modified by the
severity of the Mental Retardation and associated handicaps. Deficits in communication
skills may result in an inability to provide an adequate history (e.g., the diagnosis of Ma-
jor Depressive Disorder in a nonverbal adult with Mental Retardation is often based pri-
marily on manifestations such as depressed mood, irritability, anorexia, or insomnia that
are observed by others). More often than is the case in individuals without Mental Retar-
dation, it may be difficult to choose a specific diagnosis and in such cases the appropriate
Not Otherwise Specified category can be used (e.g., Depressive Disorder Not Otherwise
Specified). The most common associated mental disorders are Attention-Deficit/Hyper-
activity Disorder, Mood Disorders, Pervasive Developmental Disorders, Stereotypic
Movement Disorder, and Mental Disorders Due to a General Medical Condition (e.g., De-
mentia Due to Head Trauma). Individuals who have Mental Retardation due to Down
syndrome may be at higher risk for developing Dementia of the Alzheimer's Type.
Pathological changes in the brain associated with this disorder usually develop by the
time these individuals are in their early 40s, although the clinical symptoms of dementia
are not evident until later.

Associations have been reported between specific etiological factors and certain
comorbid symptoms and mental disorders. For example, fragile X syndrome appears
to increase the risk for Attention-Deficit/Hyperactivity Disorder and Social Phobia;
individuals with Prader-Willi syndrome may exhibit hyperphagia and compulsivity,
and those with William's syndrome may have an increased risk of Anxiety Disorders
and Attention-Deficit/Hyperactivity Disorder.

Predisposing factors. Etiological factors may be primarily biological or primarily
psychosocial, or some combination of both. In approximately 30%–40% of individu-
als seen in clinical settings, no clear etiology for the Mental Retardation can be deter-
mined despite extensive evaluation efforts. Specific etiologies are more likely to be
identified in individuals with Severe or Profound Mental Retardation. The major pre-
disposing factors include:

Heredity: These factors include inborn errors of metabolism inherited mostly
through autosomal recessive mechanisms (e.g., Tay-Sachs disease), other single-gene
abnormalities with Mendelian inheritance and variable expression (e.g., tuberous
sclerosis), and chromosomal aberrations (e.g., translocation Down syndrome, fragile
X syndrome). Advances in genetics will likely increase the identification of heritable
forms of Mental Retardation.

Early alterations of embryonic development: These factors include chromosomal
changes (e.g., Down syndrome due to trisomy) or prenatal damage due to toxins
(e.g., maternal alcohol consumption, infections).

Environmental influences: These factors include deprivation of nurturance and of social, linguistic, and other stimulation.

Mental disorders: These factors include Autistic Disorder and other Pervasive Developmental Disorders.

Pregnancy and perinatal problems: These factors include fetal malnutrition, prematurity, hypoxia, viral and other infections, and trauma.

General medical conditions acquired in infancy or childhood: These factors include infections, traumas, and poisoning (e.g., due to lead).

Associated laboratory findings. Other than the results of psychological and adaptive behavior tests that are necessary for the diagnosis of Mental Retardation, there are no laboratory findings that are uniquely associated with Mental Retardation. Diagnostic laboratory findings may be associated with a specific accompanying general medical condition (e.g., chromosomal findings in various genetic conditions, high blood phenylalanine in phenylketonuria, or abnormalities on central nervous system imaging).

Associated physical examination findings and general medical conditions. There are no specific physical features associated with Mental Retardation. When Mental Retardation is part of a specific syndrome, the clinical features of that syndrome will be present (e.g., the physical features of Down syndrome). The more severe the Mental Retardation (especially if it is severe or profound), the greater the likelihood of neurological (e.g., seizures), neuromuscular, visual, auditory, cardiovascular, and other conditions.

Specific Culture, Age, and Gender Features

Care should be taken to ensure that intellectual testing procedures reflect adequate attention to the individual's ethnic, cultural, or linguistic background. This is usually accomplished by using tests in which the individual's relevant characteristics are represented in the standardization sample of the test or by employing an examiner who is familiar with aspects of the individual's ethnic or cultural background. Individualized testing is always required to make the diagnosis of Mental Retardation. The prevalence of Mental Retardation due to known biological factors is similar among children of upper and lower socioeconomic classes, except that certain etiological factors are linked to lower socioeconomic status (e.g., lead poisoning and premature births). In cases in which no specific biological causation can be identified, the Mental Retardation is usually milder (although all degrees of severity are represented) and individuals from lower socioeconomic classes are overrepresented. Developmental considerations should be taken into account in evaluating impairment in adaptive skills because certain of the skill areas are less relevant at different ages (e.g., use of community resources or employment in school-age children). Mental Retardation is more common among males, with a male-to-female ratio of approximately 1.5:1.

Prevalence

The prevalence rate of Mental Retardation has been estimated at approximately 1%. However, different studies have reported different rates depending on definitions used, methods of ascertainment, and population studied.

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Course

The diagnosis of Mental Retardation requires that the onset of the disorder be before age 18 years. The age and mode of onset depend on the etiology and severity of the Mental Retardation. More severe retardation, especially when associated with a syndrome with a characteristic phenotype, tends to be recognized early (e.g., Down syndrome is usually diagnosed at birth). In contrast, Mild Retardation of unknown origin is generally noticed later. In more severe retardation resulting from an acquired cause, the intellectual impairment will develop more abruptly (e.g., retardation following an encephalitis). The course of Mental Retardation is influenced by the course of underlying general medical conditions and by environmental factors (e.g., educational and other opportunities, environmental stimulation, and appropriateness of management). If an underlying general medical condition is static, the course is more likely to be variable and to depend on environmental factors. Mental Retardation is not necessarily a lifelong disorder. Individuals who had Mild Mental Retardation earlier in their lives manifested by failure in academic learning tasks may, with appropriate training and opportunities, develop good adaptive skills in other domains and may no longer have the level of impairment required for a diagnosis of Mental Retardation.

Familial Pattern

Because of its heterogeneous etiology, no familial pattern is applicable to Mental Retardation as a general category. The heritability of Mental Retardation is discussed under "Predisposing Factors" (see p. 45).

Differential Diagnosis

The diagnostic criteria for Mental Retardation do not include an exclusion criterion; therefore, the diagnosis should be made whenever the diagnostic criteria are met, regardless of and in addition to the presence of another disorder. In **Learning Disorders** or **Communication Disorders** (unassociated with Mental Retardation), the development in a specific area (e.g., reading, expressive language) is impaired but there is no generalized impairment in intellectual development and adaptive functioning. A Learning Disorder or Communication Disorder can be diagnosed in an individual with Mental Retardation if the specific deficit is out of proportion to the severity of the Mental Retardation. In **Pervasive Developmental Disorders**, there is qualitative impairment in the development of reciprocal social interaction and in the development of verbal and nonverbal social communication skills. Mental Retardation often accompanies Pervasive Developmental Disorders.

Some cases of Mental Retardation have their onset after a period of normal functioning and may qualify for the additional diagnosis of **dementia**. A diagnosis of dementia requires that the memory impairment and other cognitive deficits represent a significant decline from a previously higher level of functioning. Because it may be difficult to determine the previous level of functioning in very young children, the diagnosis of dementia may not be appropriate until the child is between ages 4 and 6 years. In general, for individuals under age 18 years, the diagnosis of dementia is

made only when the condition is not characterized satisfactorily by the diagnosis of Mental Retardation alone.

Borderline Intellectual Functioning (see p. 740) describes an IQ range that is higher than that for Mental Retardation (generally 71-84). As discussed earlier, an IQ score may involve a measurement error of approximately 5 points, depending on the testing instrument. Thus, it is possible to diagnose Mental Retardation in individuals with IQ scores between 71 and 75 if they have significant deficits in adaptive behavior that meet the criteria for Mental Retardation. Differentiating Mild Mental Retardation from Borderline Intellectual Functioning requires careful consideration of all available information.

Relationship to Other Classifications of Mental Retardation

The classification system of the American Association on Mental Retardation (AAMR) includes the same three criteria (i.e., significantly subaverage intellectual functioning, limitations in adaptive skills, and onset prior to age 18 years). In the AAMR classification, the criterion of significantly subaverage intellectual functioning refers to a standard score of approximately 70-75 or below (which takes into account the potential measurement error of plus or minus 5 points in IQ testing). Furthermore, DSM-IV specifies levels of severity, whereas the AAMR 1992 classification system specifies "Patterns and Intensity of Supports Needed" (i.e., "Intermittent, Limited, Extensive, and Pervasive"), which are not directly comparable with the degrees of severity in DSM-IV. The definition of developmental disabilities in Public Law 95-602 (1978) is not limited to Mental Retardation and is based on functional criteria. This law defines *developmental disability* as a disability attributable to a mental or physical impairment, manifested before age 22 years, likely to continue indefinitely, resulting in substantial limitation in three or more specified areas of functioning, and requiring specific and lifelong or extended care.

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22 years, likely to continue indefinite-
more specified areas of functioning,
care.

Diagnostic criteria for Mental Retardation

- A. Significantly subaverage intellectual functioning: an IQ of approximately 70 or below on an individually administered IQ test (for infants, a clinical judgment of significantly subaverage intellectual functioning).
- B. Concurrent deficits or impairments in present adaptive functioning (i.e., the person's effectiveness in meeting the standards expected for his or her age by his or her cultural group) in at least two of the following areas: communication, self-care, home living, social/interpersonal skills, use of community resources, self-direction, functional academic skills, work, leisure, health, and safety.
- C. The onset is before age 18 years.

Code based on degree of severity reflecting level of intellectual impairment:

- 317 Mild Mental Retardation:** IQ level 50–55 to approximately 70
- 318.0 Moderate Mental Retardation:** IQ level 35–40 to 50–55
- 318.1 Severe Mental Retardation:** IQ level 20–25 to 35–40
- 318.2 Profound Mental Retardation:** IQ level below 20 or 25
- 319 Mental Retardation, Severity Unspecified:** when there is strong presumption of Mental Retardation but the person's intelligence is untestable by standard tests

Learning Disorders (formerly Academic Skills Disorders)

The section on Learning Disorders includes Reading Disorder, Mathematics Disorder, Disorder of Written Expression, and Learning Disorder Not Otherwise Specified.

Diagnostic Features

Learning Disorders are diagnosed when the individual's achievement on individually administered, standardized tests in reading, mathematics, or written expression is substantially below that expected for age, schooling, and level of intelligence. The learning problems significantly interfere with academic achievement or activities of daily living that require reading, mathematical, or writing skills. A variety of statistical approaches can be used to establish that a discrepancy is significant. *Substantially below* is usually defined as a discrepancy of more than 2 standard deviations between achievement and IQ. A smaller discrepancy between achievement and IQ (i.e., between 1 and 2 standard deviations) is sometimes used, especially in cases where an individual's performance on an IQ test may have been compromised by an associated disorder in cognitive processing, a comorbid mental disorder or general medical condition, or the individual's ethnic or cultural background. If a sensory deficit is

STATE OF SOUTH CAROLINA)
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 COUNTY OF GREENVILLE)
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 Ruben Ramirez,)
 S.C.D.C. No. 331556,)
)
 Applicant,)
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 v.)
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 State of South Carolina,)
)
 Respondent.)

IN THE COURT OF COMMON PLEAS
 C.A. No. 2009-CP-23-9285

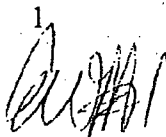
ORDER OF DISMISSAL

2011 AUG - 1 P 2:48

This matter comes before the Court by way of an application for post-conviction relief (PCR) filed November 2, 2009. The Respondent made its return on April 7, 2010. An evidentiary hearing into the matter was convened on May 9, 2011 at the Greenville County Courthouse. The Applicant was present at the hearing and represented by Matthew J. Kappel, Esquire. Karen C. Ratigan, Esquire of the South Carolina Office of the Attorney General represented the Respondent.

The Applicant's plea counsel, Monte Desai, Esquire, testified at the PCR hearing. The Court had before it the transcript of the guilty plea hearing, the records of the Greenville County Clerk of Court, the Applicant's records from the South Carolina Department of Corrections, the application for post-conviction relief, and the Respondent's return.¹

¹ On May 23, 2011 (two weeks after the conclusion of the PCR hearing and this Court's decision to take the matter under advisement), the Applicant's counsel filed a Motion to Hold the Record Open and Allow Submission of a New Competency Evaluation. This matter is discussed *infra* on page 7 of this Order of Dismissal.

1


PROCEDURAL HISTORY

The Applicant is presently confined in the South Carolina Department of Corrections pursuant to orders of commitment from the Greenville County Clerk of Court. The Applicant was indicted at the April 2007 term of the Greenville County Grand Jury for lewd act upon a child (2007-GS-23-3245) and at the May 2007 term for assault and battery with intent to kill (ABIK) (2007-GS-23-4394), kidnapping (2007-GS-23-4395), first-degree criminal sexual conduct (CSC) with a minor (2007-GS-23-4396), and first-degree burglary (2007-GS-23-4397). He was represented by Monte Desai, Esquire.

On November 3, 2008, the Applicant entered a plea to these charges of guilty but mentally ill. The Honorable Edward W. Miller sentenced the Applicant to concurrent terms of twenty (20) years for ABIK, twenty (20) years for kidnapping, twenty (20) years for first-degree CSC with a minor, and twenty (20) years for first-degree burglary. Judge Miller levied a consecutive sentence of fifteen (15) years suspended with five (5) years probation for lewd act upon a child. The Applicant did not appeal.

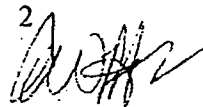
ALLEGATIONS

In his PCR application, the Applicant alleges he is being held in custody unlawfully for the following reasons:

1. Ineffective assistance of counsel:
 - a. Not advised of right to appeal.
 - b. Not advised of the right to separate trials.
 - c. Not offered the use of a translator until the end of the plea hearing.
 - d. Not advised of his constitutional rights.

FINDINGS OF FACT AND CONCLUSIONS OF LAW

This Court has had the opportunity to review the record in its entirety and has heard the testimony and arguments presented at the PCR hearing. This Court has further had the

2


opportunity to observe each witness who testified at the hearing, and to closely pass upon their credibility. This Court has weighed the testimony accordingly.

Set forth below are the relevant findings of fact and conclusions of law as required by S.C. Code Ann. § 17-27-80 (2003).

Post-Conviction Relief Issues

The Applicant alleges he received ineffective assistance of counsel. In a PCR action, “[t]he burden of proof is on the applicant to prove his allegations by a preponderance of the evidence.” Frasier v. State, 351 S.C. 385, 389, 570 S.E.2d 172, 174 (2002).

For an applicant to be granted PCR as a result of ineffective assistance of counsel, he must show both: (1) that his counsel failed to render reasonably effective assistance under prevailing professional norms, and (2) that he was prejudiced by his counsel’s ineffective performance. See Strickland v. Washington, 466 U.S. 668, 104 S. Ct. 2052 (1984); Porter v. State, 368 S.C. 378, 383, 629 S.E.2d 353, 356 (2006). When there has been a guilty plea, the applicant must prove that counsel’s representation was below the standard of reasonableness and that, but for counsel’s unprofessional errors, there is a reasonable probability that he would not have pled guilty and would have insisted on going to trial. Hill v. Lockhart, 474 U.S. 52, 58-59, 106 S. Ct. 366, 370 (1985); Roscoe v. State, 345 S.C. 16, 20, 546 S.E.2d 417, 419 (2001).

Plea counsel testified his employer was initially retained to represent the Applicant but that he assumed representation when he began working at that law firm in July 2007. Plea counsel testified that – prior to his assuming representation – the State had already completed a competency evaluation of the Applicant.² Plea counsel testified this evaluation (performed by Dr. Dalal) found the Applicant was competent to stand trial. Plea counsel testified, however, that

² Applicant’s Exhibit 1.

the Applicant was very naïve and did not understand the gravity of the charges, so he obtained a psychological evaluation.³ Plea counsel testified Dr. Gedo performed this evaluation in 2008. Plea counsel testified that, while Dr. Gedo's psychological evaluation found the Applicant was severely mentally retarded,⁴ it did not make a determination of competency. Plea counsel testified he had several conversations with Dr. Gedo about the results of the psychological evaluation and that Dr. Gedo never recommended the Applicant undergo another competency evaluation. Plea counsel testified that, if Dr. Gedo had suggested this, he would have pursued a second competency evaluation. Plea counsel testified this case was always going to result in a guilty plea⁵ and that he believed a plea of guilty but mentally ill was appropriate after he received Dr. Gedo's report. Plea counsel testified the Applicant was easy to communicate with and understood his explanation of the court process and what would happen at the plea hearing.

Regarding the Applicant's claim of ineffective assistance of counsel, this Court finds the Applicant has failed to meet his burden of proof. This Court finds plea counsel provided credible testimony about his decision-making process in preparing the Applicant's case. This Court further finds plea counsel adequately conferred with the Applicant, conducted a proper investigation, and was thoroughly competent in his representation. This Court notes the Applicant admitted to the plea judge that he was guilty. (Plea transcript, p.11). The Applicant also told the plea judge that he understood the trial rights he was waiving in pleading guilty, was satisfied with counsel, and had not been coerced in any way. (Plea transcript, pp.9-12).

Specifically, this Court finds the Applicant failed to meet his burden of proving plea

³ Applicant's Exhibit 2.

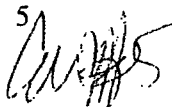
⁴ Plea counsel testified he referred to the Diagnostic and Statistical Manual (DSM) of Mental Disorders several times in reading Dr. Gedo's report. A portion of the DSM was admitted as Applicant's Exhibit 3.

⁵ Plea counsel testified a main reason the case was headed towards a guilty plea was because there was no legal basis to suppress the Applicant's confession to police.



counsel should have obtained a second competency evaluation of the Applicant. This Court notes that, in order to prevail on a claim that plea counsel was ineffective in failing to request a second competency evaluation (which is tantamount to the error claimed of not requesting a third evaluation in this case), the Applicant must show a “reasonable probability” that he was either insane at the time the crime was committed or incompetent at the time of the plea. See Matthews v. State, 358 S.C. 456, 596 S.E.2d 49 (2004). Based upon the court-ordered competency evaluation, the independent psychological evaluation’s description of the Applicant’s understand of the events leading up to his charges, and plea counsel’s testimony regarding the Applicant’s ability to communicate and understand the proceedings, this Court finds the Applicant has failed to meet the reasonable probability standard.

As with any claim of ineffective assistance of counsel, a claim that counsel failed to request an additional competency evaluation must be evaluated under the Strickland standard. This Court finds plea counsel’s actions were objectively reasonable and within prevailing professional norms. Plea counsel sought an independent psychological evaluation, did not have trouble communicating with his client, and made the strategic choice to pursue a plea of guilty but mentally ill when – in addition to Dr. Gedo’s report – plea counsel determined there was no basis to suppress the Applicant’s statement to the police. Seeking an independent evaluation in and of itself surpasses what has previously been deemed effective assistance. See Jeter v. State, 308 S.C. 230, 417 S.E.2d 594 (1992). While plea counsel may have wavered in his appraisal of the Applicant’s understanding in hindsight, Strickland cautioned that “every effort be made to eliminate the distorting effects of hindsight.” Strickland, 466 U.S. at 689, 104 S. Ct. at 2055; see also Whitehead v. State, 308 S.C. 119, 122, 417 S.E.2d 529, 531 (1992) (“Courts must be wary of second-guessing counsel’s trial tactics. . . .”). This Court also notes that, as neither expert

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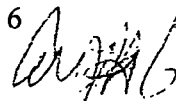
testimony nor a second competency evaluation were presented at the PCR hearing, any discussion about the potential impact of such an evaluation is purely speculative. See Dempsey v. State, 363 S.C. 365, 370, 610 S.E.2d 812, 815 (2005) (finding that, as the applicant failed to have an expert testify at the evidentiary hearing, “any finding of prejudice is merely speculative”); see also Bannister v. State, 333 S.C. 298, 303, 509 S.E.2d 807, 809 (1998) (the South Carolina Supreme Court “has repeatedly held a PCR applicant must produce the testimony of a favorable witness or otherwise offer the testimony in accordance with the rules of evidence at the PCR hearing in order to establish prejudice from the witness’ failure to testify at trial.”) (emphasis in original). As the Applicant failed to prove by a preponderance of the evidence that he was not competent to plead guilty, plea counsel’s performance cannot be deemed deficient.

Accordingly, this Court finds the Applicant has failed to prove the first prong of the Strickland test – that plea counsel failed to render reasonably effective assistance under prevailing professional norms. The Applicant failed to present specific and compelling evidence that plea counsel committed either errors or omissions in his representation of the Applicant. This Court also finds the Applicant has failed to prove the second prong of Strickland – that he was prejudiced by plea counsel’s performance.

This Court concludes the Applicant has not met his burden of proving counsel failed to render reasonably effective assistance. See Frasier v. State, 351 S.C. at 389, 570 S.E.2d at 174.

All Other Post-Conviction Relief Allegations

As to any and all allegations that were raised in the application or at the hearing in this matter and not specifically addressed in this Order, this Court finds the Applicant failed to present any evidence regarding such allegations. Accordingly, this Court finds the Applicant waived such allegations and failed to meet his burden of proof regarding them. Therefore, they

6


are hereby denied and dismissed.

**Motion to Hold the Record Open and Allow
Submission of a New Competency Evaluation**

Two (2) weeks after the PCR hearing in this case (and while the matter was still under advisement), counsel for the Applicant filed a Motion to Hold the Record Open and Allow Submission of a New Competency Evaluation. That Motion is denied. A full PCR hearing was held on any and all issues the Applicant wished to litigate. The Applicant was notified of the date of the PCR hearing approximately one (1) month in advance and was on notice to present any and all pertinent evidence to this Court during this hearing. Given that the PCR hearing took place eighteen (18) months after the PCR application was filed, there was ample time for evidence to be obtained for submission at that hearing. As such, allowing the record to remain open for the submission of a competency evaluation – especially since this issue was known to the Applicant and was, in fact, the sole issue argued at the hearing – would give the Applicant a second opportunity to marshal facts and evidence to support his position. This Court finds this would be a second “bite at the apple” and contrary to the position expressed by the South Carolina Supreme Court. See, e.g., Odom v. State, 337 S.C. 256, 261, 523 S.E.2d 753, 755 (1999) (“[A]n applicant is entitled to a full adjudication on the merits of the original petition, or ‘one bite at the apple.’”).

CONCLUSION

Based on all the foregoing, this Court finds and concludes the Applicant has not established any constitutional violations or deprivations before or during his guilty plea and sentencing proceedings. Counsel was not deficient in any manner and the Applicant was not prejudiced by counsel’s representation. Therefore, this PCR application must be denied and

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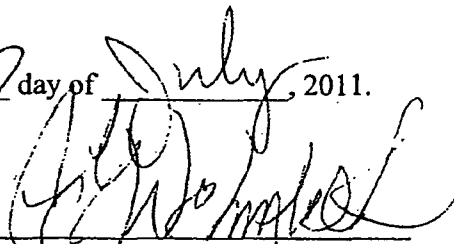
dismissed with prejudice.

This Court advises the Applicant that he must file a notice of intent to appeal within thirty (30) days from the receipt of this Order if he wants to secure appropriate appellate review. His attention is also directed to Rules 203, 206, and 243 of the South Carolina Appellate Court Rules for the appropriate procedures to follow after notice of intent to appeal has been timely filed.

IT IS THEREFORE ORDERED:

1. That the application for post-conviction relief be denied and dismissed with prejudice; and
2. That the Applicant be remanded to the custody of the Respondent.

AND IT IS SO ORDERED this 27 day of July, 2011.


G. Edward Welmaker
Resident Judge
Thirteenth Judicial Circuit

Greenville, South Carolina.

STATE OF SOUTH CAROLINA)
)
 COUNTY OF GREENVILLE)
)
 Ruben Ramirez, Jr.,)
)
 PLAINTIFF,)
)
 vs.)
)
 State of South Carolina,)
)
 DEFENDANT.)
 _____)

IN THE COURT OF COMMON PLEAS
 C.A. NO: 2009-CP-23-9285

MOTION TO RECONSIDER,
 OPEN, ALTER OR AMEND
 SCRCP 59(a), 59(e)

SEP 11 PM 4:22

COMES NOW, the Plaintiff by and through his attorney, who pursuant to Rule 59(a) and 59(e) of the South Carolina Rules of Civil Procedure and South Carolina common law moves this court to reconsider the court's Order denying Petitioner's request to hold the record open, consider Plaintiff's forensic psychiatric evaluation performed by Dr. Thomas Martin, and the court's denial of Petitioner's application for post conviction relief.

In support of this motion, counsel presents the following:

1) The Plaintiff pleaded guilty but mentally ill to Assault and Battery with Intent to Kill, Kidnapping, Criminal Sexual Conduct with a Minor in the 1st Degree, Buglary 1st and Lewd Act Upon a Child on November 3, 2008 before Circuit Judge Edward Miller. The Plaintiff was sentenced to twenty years in the Department of Corrections and fifteen years consecutive suspended upon five years of probation.

2) Prior to Plaintiff's guilty plea, the State had the Plaintiff evaluated by Dr. Mayank H. Dalal for competency on June 7, 2007. In Plaintiff's competency evaluation, Dr. Dalal relied upon the Plaintiff for the history of his mental condition. Specifically, Dr. Dalal stated that Plaintiff "denied a history of inpatient or outpatient psychiatric treatment" and a "history of major medical or psychological problems in the past." Dr. Dalal did not cite any

additional studies or information that he reviewed regarding Plaintiff's mental condition for completing the competency evaluation. Following a review of the Plaintiff for 100 minutes, Dr. Dalal concluded the Plaintiff to be competent.

3) Prior to Plaintiff's guilty plea, the Plaintiff was also evaluated on behalf of the defense, by Dr. Stephen M. Gedo, Jr. PhD who evaluated the him on five occasions for up to three to four hours for each session, the last session held on March 27, 2008. Dr. Gedo concluded that the Plaintiff suffered from Severe Mental Retardation with an IQ level of 31-44 and an age equivalent function of 4-7 years old (Plaintiff was 17 years of age when Dr. Gedo evaluated him). Severe mental retardation as described in the Diagnostic and Statistical Manual of Mental Disorders (hereinafter "DSM") is characterized by "significantly subaverage intellectual functioning ." In addition, Dr. Gedo stated Petitioner's AXIS V or Global Assessment of Functioning within the DSM assessment to be 35 which indicates "[s]ome impairment in reality testing or communication . . . [or] major impairment in several areas, such as work or school, family relations, judgment thinking or mood" Despite having Dr. Gedo's report indicating the Plaintiff's severe mental retardation, Defense counsel failed to obtain an additional opinion on Plaintiff's competency to stand trial.

4) Plaintiff's ground for post conviction relief was based upon trial counsel's failure to object to Dr. Dalal's competency evaluation. An evidentiary hearing was held on the Post Conviction Relief on May 9, 2011. Prior to the end of the evidentiary hearing, Plaintiff's counsel requested the court to allow the record to be held open and permit the submission of an additional psychiatric evaluation. The court took the case under advisement.

5) Subsequent to the evidentiary hearing and while the case was under advisement, Plaintiff's counsel again moved the court to "hold the record open" on May 23,

2011 and informed the court that Dr. Thomas Martin, MD would be conducting an psychiatric evaluation on the Plaintiff on Tuesday, May 31, 2011, only eight days later.

6) Dr. Martin issued his report on June 10, 2011 and concluded that the Plaintiff is not competent to stand trial today and would not have been competent to stand trial on November 3, 2008. In essence, the Dr. Martin stated that the Plaintiff suffers from "severe mental retardation with coexistent maladaptive social and language skills." These disabilities would have been equally present in the Plaintiff at the time of the incident as well as Plaintiff's court date in 2008 because there is "no medical or psychiatric treatment for severe mental retardation." Dr. Martin further concluded that "in light of [Ruben's] history and current presentation, it remains unclear . . . how [he] was ever found 'competent to stand trial.'"

7) Plaintiff's counsel initially filed an additional motion requesting relief on June 20, 2011 repeating the motion to hold open the record and to review Dr. Martin's psychiatric evaluation and take Dr. Martin's testimony.

(8) The court executed an Order on August 1, 2011 denying the Plaintiff's motions and Plaintiff's application for Post Conviction Relief. In support of denying Plaintiff's motion to hold the record open, the court relied upon Odom v. State, 337 S.C. 256, 261, 253 S.E.2d753,755 which stated "[A]n applicant is entitled to a full adjudication on the merits of the original petition, 'one bite at the apple.'" The court's reliance on Odom, respectfully however, is misplaced. In Odom, the Petitioner had previously filed an application for post conviction relief which was dismissed. Odom subsequently filed a second application nearly two years later. In Odom, it was the petitioner's second application filed nearly two years after his first one that was at issue. "All applicants are entitled to a full and fair opportunity to present claims in one PCR application. Successive PCR applications and appeals are generally disfavored

because they allow an applicant to receive more than ‘one bite at the apple as it were’” (emphasis added). Here in this case, Petitioner is asking for relief that is within the bounds of time and procedure for the court to examine the evidence. Motions timely filed before the court has ruled on the application or timely filed under Rule 59 of the South Carolina Rules of Civil Procedure are within the “one bite at the apple” as outlined in Odom. The relief requested by Petitioner is still within his first PCR and granting a hearing to hear from Dr. Martin will not prejudice the state. Refusing to weigh Dr. Martin’s testimony, rather, would be an injustice.

9) Finally, Dr. Martin has executed an affidavit in support of his findings and Plaintiff has attached his affidavit and psychiatric report hereto.

10) Trial counsel failed to challenge the finding of competency when he had a clear basis for doing so.

PRAYER: Based upon the forensic psychiatric study performed by Dr. Martin and the findings of Dr. Gedo, Rule 59(a), 59(e) of the SCRCP, Common Law of South Carolina, and in the interests of justice, Counsel prays for the following relief:

(a) The court reopen the case and consider Dr. Martin’s psychiatric evaluation and his testimony;

(b) Reconsider Petitioner’s Application for Post Conviction Relief;

(c) For such other and further relief as the Court may deem just and proper.

Respectfully submitted,



Matthew J. Kappel
Attorney for the Plaintiff
PO Box 10334
Greenville, SC 29603
864-467-9595 (voice)
864-467-1945 (fax)

August 11, 2011
Greenville, South Carolina

STATE OF SOUTH CAROLINA)
)
 COUNTY OF GREENVILLE)
)
 Ruben Ramirez, Jr.,)
)
 PLAINTIFF,)
)
 vs.)
)
 State of South Carolina,)
)
 DEFENDANT.)
 _____)

IN THE COURT OF COMMON PLEAS
 C.A. NO: 2009-CP-23-9285

CERTIFICATE OF SERVICE

2011 AUG 11 PM 4:23

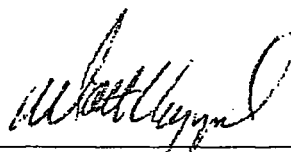
The undersigned hereby certifies that he did serve one copy of Plaintiff's Motion To Reconsider, Alter or Amend, affidavit of Dr. Thomas V. Martin and Psychiatric Evaluation of Dr. Martin in the U.S. Mail postage prepaid and by electronic mail to the following address:

Karen Ratigan
 Asst. Attorney General
 1000 Assembly Street
 Columbia, SC 29201

and

kratigan@scag.gov.

Respectfully submitted,



Matthew J. Kappel
 Attorney for the Plaintiff
 PO Box 10334
 Greenville, SC 29603
 864-467-9595 (voice)
 864-467-1945 (fax)

August 11, 2011
 Greenville, South Carolina

STATE OF SOUTH CAROLINA)
COUNTY OF GREENVILLE)
Ruben Ramirez,)
S.C.D.C. No. 331556,)
Applicant,)
v.)
State of South Carolina,)
Respondent.)

IN THE COURT OF COMMON PLEAS
C.A. No. 2009-CP-23-9285

**RETURN TO MOTION TO HOLD THE
RECORD OPEN AND ALLOW SUBMISSION
OF A NEW COMPETENCY EVALUATION**

TO: MATTHEW J. KAPPEL, ESQUIRE, ATTORNEY FOR THE APPLICANT

Respondent, by and through undersigned counsel, making Return to Applicant's Motion to Hold the Record Open and Allow Submission of a New Competency Evaluation, would respectfully show unto this Court:

1. The matter is before the Court by way of post-conviction relief action filed November 2, 2009.
2. An evidentiary hearing was convened on May 9, 2011 at the Greenville County Courthouse.
3. Applicant was present at this bench trial and was represented by Matthew J. Kappel, Esquire. Applicant testified in his own behalf. Also testifying was Applicant's plea attorney, Monty D. Desai, Esquire.
4. After both parties rested their respective cases and the matter was concluded, Applicant's counsel requested the case be held open in order to both obtain Applicant's juvenile records and have Applicant undergo another competency evaluation (one was performed by Dr. Dalal prior to the guilty plea hearing). This Court took the entire matter under advisement.

5. Applicant's counsel filed a Motion to Hold the Record Open and Allow Submission of a New Competency Evaluation on May 23, 2011 (which was received by Respondent on May 25, 2011). Applicant moves this Court to hold the record open in order to have Applicant submit to a second competency evaluation.

6. Respondent submits Applicant's Motion should be denied.

7. Respondent submits Applicant's Motion is both misplaced and premature. In general, post-trial motions in civil cases are filed after the entry of an order of judgment. See, e.g., Rules 59 and 60, SCRCP. This Court has neither issued its final decision nor filed a final order in the matter. As such, Applicant's Motion must be denied.

8. Respondent submits Applicant's Motion is an attempt to conduct discovery after the bench trial in this case has already occurred. The bench trial in this case was conducted eighteen (18) months after the PCR application was filed. Applicant had the burden of proof in this case. See Frasier v. State, 351 S.C. 385, 389, 570 S.E.2d 172, 174 (2002) ("The burden of proof is on the applicant to prove his allegations by a preponderance of the evidence."). As such, Applicant was on notice that he would have to present a second competency evaluation at trial in order to sustain his claim that Mr. Desai should have requested such an evaluation before Applicant pled guilty. See, e.g., Dempsey v. State, 363 S.C. 365, 370, 610 S.E.2d 812, 815 (2005) (finding that, as the applicant failed to have an expert testify at the evidentiary hearing, "any finding of prejudice is merely speculative"); Palacio v. State, 333 S.C. 506, 513, 511 S.E.2d 62, 66 (1999) (holding that, since the contents of challenged documents were not presented at the PCR hearing, the Applicant could not demonstrate how the failure of counsel to obtain these documents prejudiced the defense). A PCR applicant is given "one bite at the apple" in the PCR setting, and the PCR evidentiary hearing is the venue for all evidence and arguments to be made

to the court. See Odom v. State, 337 S.C. 256, 261, 523 S.E.2d 753, 755 (1999) (“[A]n applicant is entitled to a full adjudication on the merits of the original petition, or ‘one bite at the apple.’”). Petitioner was given adequate time to investigate his claims and present them to the PCR court. There must be finality to the litigation process. As such, Applicant’s Motion must be denied.

9. Respondent submits the post-conviction relief court fully reviewed and properly ruled upon all issues and that the Motion to Hold the Record Open and Allow Submission of a New Competency Evaluation should be denied. In the event, however, that this Court grants Applicant’s Motion, Respondent submits a second hearing will be required in order to allow cross-examination of the expert who is purported to be conducting this second competency evaluation.

Respectfully submitted,

ALAN WILSON
Attorney General

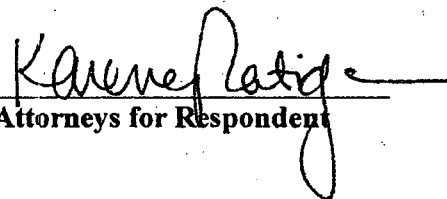
JOHN W. McINTOSH
Chief Deputy Attorney General

SALLEY W. ELLIOTT
Assistant Deputy Attorney General

KAREN C. RATIGAN
Assistant Attorney General

P.O. Box 11549
Columbia, S.C. 29211

By:


Attorneys for Respondent

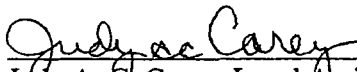
May 27, 2011

STATE OF SOUTH CAROLINA	)	
	)	IN THE COURT OF COMMON PLEAS
COUNTY OF GREENVILLE	)	
	)	2009-CP-23-9285
	)	
RUBEN RAMIREZ, JR., 331556	)	
	)	
Applicant,	)	
	)	
vs	)	AFFIDAVIT OF SERVICE BY MAIL
	)	
STATE OF SOUTH CAROLINA,	)	
	)	
Respondent.	)	
	)	

1. I am an employee of the Respondent in the above-captioned action.
2. Regular communication by mail exists throughout the State of South Carolina and that this is a proper circumstance of service by mail.
3. I have this day served a copy of the **Return to Motion to Hold the Record Open and Allow Submission of a New Competency Evaluation** in the above-captioned matter on the following person by depositing same in the United States mail, postage prepaid:

Matthew J. Kappel, Esquire
Post Office Box 10334
Greenville SC 29603

DATED this 27th day of May, 2011.


 Judy A. E. Carey, Legal Assistant
 For Respondent

STATE OF SOUTH CAROLINA)
)
 COUNTY OF GREENVILLE)
)
 Ruben Ramirez,)
 S.C.D.C. No. 331556,)
)
 Applicant,)
)
 v.)
)
 State of South Carolina,)
)
 Respondent.)

IN THE COURT OF COMMON PLEAS
 C.A. No. 2009-CP-23-9285

ORDER

FILED
 2011 JUL 23 AM 9:31
 CLERK OF COURT

The above-captioned case is a post-conviction relief matter arising from an application filed November 2, 2009. An evidentiary hearing was convened on May 9, 2011 and the final order of dismissal was signed by this Court on July 27, 2011 and filed August 1, 2011.

This matter is back before the Court by way of Applicant's "Motion to Reconsider, Open, Alter or Amend SCRCP 59(a), 59(e)" filed August 11, 2011. Respondent received the motion on August 17, 2011 and made its return on August 25, 2011.

This Court has carefully reconsidered all of the evidence in this case, as well as Applicant's motion and supporting memorandum. This Court will not amend its final order of dismissal to consider the psychiatric evaluation of Applicant performed by Dr. Thomas V. Martin that was submitted with Applicant's post-trial motion. This Court has decided, however, that a belated appeal from Applicant's guilty plea is warranted.

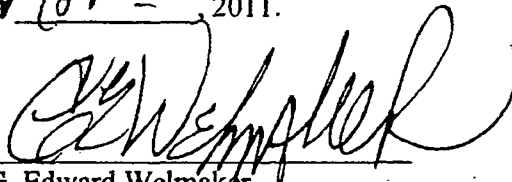
IT IS THEREFORE ORDERED:

1. That within thirty (30) days of service of this Order, counsel for Applicant must file a Notice of Appeal to secure the appropriate review of Applicant's convictions. Counsel and Applicant are directed to Davis v. State, 288 S.C. 290, 342 S.E.2d 60 (1986) and Rule 243(i), SCACR for the appropriate procedure for securing belated appellate review.

[Handwritten signature]

2. That there are no further alterations or amendments to the final order of dismissal in this case.

AND IT IS SO ORDERED this 22 day of Nov - 2011.


G. Edward Welmaker
Presiding Judge
Thirteenth Judicial Circuit

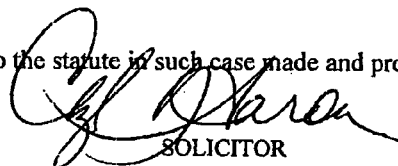
STATE OF SOUTH CAROLINA)
)
COUNTY OF GREENVILLE)

INDICTMENT FOR
BURGLARY FIRST DEGREE

At a Court of General Sessions, convened on May 30, 2007 the Grand Jurors of Greenville
County present upon their oath:

That RUBEN RAMIREZ JR did in Greenville County, on or about the 26th day of January 2007, willfully and
unlawfully enter the dwelling of B.L. located at Mauldin, South Carolina,
without consent and with force and with the intent to commit a crime. This is in violation of §16-11-311 of the
South Carolina Code of Laws (1976) as amended.

Against the peace and dignity of the State, and contrary to the statute in such case made and provided.


SOLICITOR

WITNESSES

DOCKET NO. 2007-GS-23-

CGA

004397

The State of South Carolina

County of Greenville

Inv Mahlstadt /5

Mauldin Police Department

1/29/2007

COURT OF GENERAL SESSIONS

MAY TERM 2007

11-3-08

THE STATE

vs.

PLEAD GUILTY

RUBEN RAMIREZ JR

ARREST WARRANT NUMBER

1560828

ACTION OF GRAND JURY

TRUE BILL.

Buty Murphy

FOREMAN GRAND JURY

Foreperson of Grand Jury

VERDICT

Indictment for

0079

BURGLARY FIRST DEGREE

VIOLATION § 16-11-0311

Foreperson of Petit Jury

Date:

218

STATE OF SOUTH CAROLINA)
)
COUNTY OF GREENVILLE)

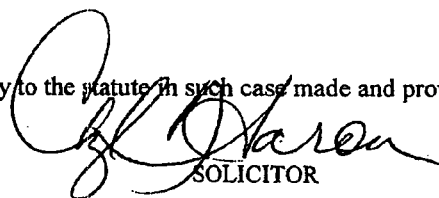
INDICTMENT FOR
CRIMINAL SEXUAL CONDUCT WITH A MINOR FIRST DEGREE

At a Court of General Sessions, convened on May 30, 2007 the Grand Jurors of Greenville

County present upon their oath:

That RUBEN RAMIREZ JR did in Greenville County, on or about the 26th day of January 2007, commit a sexual battery on B.L., who was less than eleven years of age. This is in violation of §16-3-655(A)(1)[formerly 16-3-655(1) of the South Carolina Code of Laws (1976) as amended

Against the ~~peace~~ and dignity of the State, and contrary to the statute in such case made and provided.


SOLICITOR

WITNESSES

Inv Mahlstedt /5

Mauldin Police Department

1/29/2007

DOCKET NO. 2007-GS-23-

CGA

004396

The State of South Carolina

County of Greenville

COURT OF GENERAL SESSIONS

MAY TERM 2007

11-3-08

THE STATE

vs.

PLEAD GUILTY

RUBEN RAMIREZ JR

ARREST WARRANT NUMBER

I560827

ACTION OF GRAND JURY

TRUE BILL*Betty Murphy*

FOREMAN GRAND JURY

Foreperson of Grand Jury

VERDICT

Indictment for

0385

CRIMINAL SEXUAL CONDUCT WITH A MINOR
FIRST DEGREE

VIOLATION § 16-03-0655(A)(1)

Foreperson of Petit Jury

Date:

217

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STATE OF SOUTH CAROLINA)
)
COUNTY OF GREENVILLE)

INDICTMENT FOR
KIDNAPPING

At a Court of General Sessions, convened on

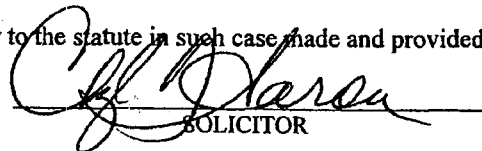
May 30, 2007

the Grand Jurors of Greenville

County present upon their oath:

That RUBEN RAMIREZ JR did in Greenville County, on or about the 26th day of January 2007, unlawfully seize, abduct, confine, inveigle, decoy or carry away B.L., without the authority of law. This is in violation of §16-3-910 of the South Carolina Code of Laws (1976) as amended.

Against the peace and dignity of the State, and contrary to the statute in such case made and provided.


SOLICITOR

WITNESSES

Inv Mahlstedt /5

Mauldin Police Department

1/29/2007

ARREST WARRANT NUMBER

1560829

ACTION OF GRAND JURY

TRUE BILL

FOREMAN GRAND JURY

Foreperson of Grand Jury

VERDICT

Foreperson of Petit Jury

Date:

DOCKET NO. 2007-GS-23-

CGA

The State of South Carolina 004395

County of Greenville

COURT OF GENERAL SESSIONS

MAY TERM 2007

11-3-08

THE STATE

PLEAD GUILTY

vs.

RUBEN RAMIREZ JR

Indictment for

0095

KIDNAPPING

VIOLATION § 16-03-0910

ENTERED
ACCT.

216

STATE OF SOUTH CAROLINA)
)
COUNTY OF GREENVILLE)

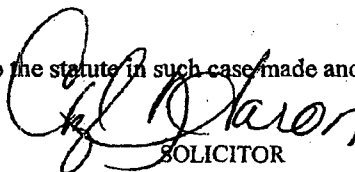
INDICTMENT FOR
ASSAULT AND BATTERY WITH INTENT TO KILL

At a Court of General Sessions, convened on May 30, 2007 the Grand Jurors of Greenville

County present upon their oath:

That RUBEN RAMIREZ JR did in Greenville County, on or about the 26th day of January 2007, willfully, unlawfully and with malice aforethought, either express or implied, commit an assault and battery upon B.L. This is in violation of §16-3-620 of the South Carolina Code of Laws (1976) as amended.

Against the peace and dignity of the State, and contrary to the statute in such case made and provided.


SOLICITOR

WITNESSES

Inv Mahlstedt / 3

Mauldin Police Department

1/29/2007

DOCKET NO. 2007-GS-23-

CGA

The State of South Carolina

004394

County of Greenville

COURT OF GENERAL SESSIONS

MAY TERM 2007

11-3-08

THE STATE

vs.

PLEAD GUILTY

RUBEN RAMIREZ JR

ARREST WARRANT NUMBER

1560831

ACTION OF GRAND JURY

TRUE BILL*Betty Murphy*

FOREMAN GRAND JURY

Foreperson of Grand Jury

VERDICT

Indictment for

0014

ASSAULT AND BATTERY WITH INTENT TO
KILL

VIOLATION § 16-03-0620

Foreperson of Petit Jury

Date:

215

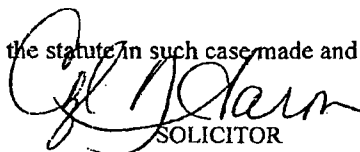
STATE OF SOUTH CAROLINA)
)
COUNTY OF GREENVILLE)

INDICTMENT FOR
LEWD ACT UPON A CHILD

At a Court of General Sessions, convened on April 17, 2007 the Grand Jurors of Greenville
County present upon their oath:

That RUBAN RAMIREZ JR did in Greenville County, on or about the 25th day of January 2007, being over the
age of fourteen years, willfully and lewdly commit or attempt a lewd and lascivious act upon or with the body, or
its parts, of M.L., a child under the age of sixteen years, with the intent of arousing, appealing to, or gratifying the
lust, passions, or sexual desires of herself or such child. This is in violation of §16-15-140 of the South Carolina
Code of Laws (1976) as amended.

Against the peace and dignity of the State, and contrary to the statute in such case made and provided.


SOLICITOR

WITNESSES

Ty Bracken

/Brown/S

Greenville County Sheriffs Office

2/1/2007

DOCKET NO. 2007-GS-23-
CGA 003245

The State of South Carolina

County of Greenville

COURT OF GENERAL SESSIONS

APRIL TERM 2007

11-3-08

THE STATE

PLEAD GUILTY

vs.

RUBAN RAMIREZ, JR.

ARREST WARRANT NUMBER

1472161

ACTION OF GRAND JURY

TRUE BILL*Betty Murphy*

FOREMAN GRAND JURY

Foreperson of Grand Jury

VERDICT

Indictment for

2468

LEWD ACT UPON A CHILD

VIOLATION § 16-15-0140

Foreperson of Petit Jury

Date:

413