

THE STATE OF SOUTH CAROLINA

In The Supreme Court

APPEAL FROM GREENVILLE COUNTY
Court of Common Pleas

G. Edward Welmaker, Circuit Court Judge

Appellate Case No. 2013-001945

Charles Christopher Williams,

Petitioner,

v.

The State of South Carolina,

Respondent.

BRIEF OF PETITIONER

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QUESTION PRESENTED

Did the PCR judge commit error by finding trial counsel made a strategic decision not to present evidence of fetal alcohol syndrome (FAS), when trial counsel testified they simply failed to realize and investigate the evidence of fetal alcohol syndrome and would have liked to have had such evidence before the jury?

STATEMENT OF THE CASE

On February 15, 2005, Petitioner was convicted of murder and kidnapping; he was sentenced to death by the same jury on February 19, 2005. On direct appeal, his conviction was affirmed by this Court. *State v. Williams*, 386 S.C. 503, 690 S.E.2d 62 (2010). The United States Supreme Court denied certiorari on October 4, 2010. Petitioner filed his first application for post-conviction relief on November 30, 2010, and amended applications on September 30, 2011 and November 20, 2012. He also incorporated his pre-trial brief into his application which was filed on January 16, 2013. He alleged trial counsel or appellate counsel was deficient in several aspects during the trial and appeal in violation of state and federal constitution.

The dismissal order was filed on July 24, 2013 and received on July 26, 2013 by the Petitioner's attorney. A motion for reconsideration was served on August 5, 2013. It was denied in an order filed August 9, 2013, and received by Petitioner's attorneys on August 14, 2013. Notice of appeal was served on September 12, 2013. The Petition was granted as to Question 1 on August 20, 2015.

STATEMENT OF FACTS

Around 10:00 a.m. on September 3, 2003, Petitioner entered a Bi-Lo grocery store in Greenville where his former girlfriend, Maranda Williams (Victim), worked. Petitioner accosted Victim and forced her into an office in the bakery/deli. Victim called 911 from her cell phone. During the ninety-minute phone call, hostage negotiators tried to convince Petitioner to release Victim. When Victim attempted to escape Petitioner chased, shot, and killed her. Hearing the shots, law enforcement entered the store and apprehended Petitioner. Shortly after his arrest, Petitioner gave a statement in which he confessed to the crimes for which he was later charged.

Petitioner was tried and found guilty of murder, kidnapping, and possession of a firearm during the commission of a violent crime. The State withdrew a public place aggravator before sentencing, and the jury found the remaining statutory aggravating circumstance, kidnapping. S.C. Code Ann. § 16-3-20(C)(a)(1)(b), (C)(a)(3) (2003 & Supp. 2007). *State v. Williams*, 386 S.C. 503, 690 S.E.2d 62 (2010).

The trial team presented Dr. Robert Richards and Dr. Seymour Halleck as expert psychiatrists. Dr. Richards testified that he was not a forensic psychiatrist and that Williams was a complicated case: "I'd say that his primary diagnosis is bipolar disorder, type one or type two. I'd lean towards type one, probably with rapid cycling mixed features." App. p. 1965. He also diagnosed him with obsessive compulsive disorder (OCD). App. p. 1967. On cross-examination, he testified that he was not sure about the legal standard for competence at trial, nor the mental standard to stand trial in South Carolina. App. p. 1991 - 1992. He did not know whether Williams could conform his actions to the requirements of the law or whether he was competent to assist his

attorneys. App. p. 1992. Dr. Halleck testified that Williams had a major depressive episode and was OCD. App. p. 2309. He testified that Williams capacity to conform his behavior was somewhat impaired. App. p. 2319.

At trial, the solicitor emphasized the fact that the defense's theories were inconsistent and did not provide an explanation worthy to save the Petitioner's life.

Solicitor Arial specifically told the jury that,

"The defense presented to you evidence of mental disorders through the testimony of a couple of psychiatrists. By the way, the psychiatrists didn't agree on the diagnosis. One talked about bipolarity. Other didn't say he had bipolar. Had different opinions from the two psychiatrists; but they argued to you why he did it.

App. p. 2374.

"His mental issues may have existed at the same time as this killing, but they're not the why. They just existed concurrently with it. Because he knew right from wrong. And he could conform his behavior to the requirements of the law. No one has said the mental issues caused him to kill Mandy. The reason they haven't said they caused him to kill Mandy is because they didn't. They may have affected the way he thought about things. But didn't cause him to kill Mandy, because he knew what was right, he knew what was wrong, and he knew how to conform his behavior."

App. p. 2375.

The defense also hired Jim Evans, a neuropsychologist who performed cognitive testing on the Petitioner that indicated almost the exact deficits the PCR expert found.

App. p. 3553. Dr. Evans did not testify, but notes of his interview indicate that information did not appear to crossover from one side of Williams' brain to the other, "as tho[sic] no corpus callosum". Plaintiff's Exhibit 12, App. p. 4278.¹ The week before trial,

¹ As will be seen *infra*, the corpus callosum is the area of the brain most commonly damaged by FAS.

the attorneys hired a neurologist, Dr. David Griessemar, who reported on the results of an MRI days before trial and signed an affidavit for the PCR that he was not given adequate history or testing by trial counsel. He also specifically requested the same type of testing that had already been completed by Dr. Evans, but he never saw that information. He noted specifically that if he had seen Dr. Evan's testing or if he had been informed that the mother drank during pregnancy, he would have advised the team to consider fetal alcohol syndrome (FAS). Plaintiff's Exhibit 24, App. p. 4851.

TRIAL ATTORNEYS' TESTIMONY

The PCR judge found, trial counsel "made a strategic decision to not present to the jury evidence of brain damage or a diagnosis of Fetal Alcohol Syndrome (though trial counsel was unable to articulate the reasons for that strategic decision)." App. p. 4210. In contrast, the trial attorneys testified that they never discussed FAS, they never considered it, they never ruled it in or ruled it out, they had no explanation why they did not consider it, and they would have liked to have had it before the jury. The PCR judge failed to discuss any of this testimony.

Attorney Nettles testified they never discussed FAS.² App. p. 3269. That they made no correlation between the mother's drinking and FAS. App. p. 3269. That he had no memory of the issue being raised and rejected. App. p. 3270. That they never discussed FAS in relation to the checklist they used. App. p. 3270. That they never ruled it in or ruled out. App. p. 3271. Nettles acknowledged he had no idea what the corpus callosum meant. He acknowledged they had indications there may have been brain

² It was no secret Petitioner's mother was an alcoholic before and after Petitioner was born and the trial transcript is replete with references to the mother's drinking. App. pp. 1877, 1978, 2179, 2180, 2182, 2214, 2236, 2237, 2252, 2262, 2331, 2336. The mother admitted heavy drinking during pregnancy at the PCR. App. p. 3412.

damage and he knew that drinking by a birth mother could cause brain damage, but connecting those dots never happened. App. pp. 3272-3. And: “Question: Okay. So I think we’ve beat this horse enough. It was just never, ever brought up, to your knowledge, of FAS?” Answer: “Right. It wasn’t ever brought up. It wasn’t discussed. It wasn’t ruled in, it wasn’t ruled out.” App. p. 3274. He was also clear on cross-examination that FAS never came up in discussion. App. p. 3293. There was never a meeting where they questioned whether they wanted to “chase down” FAS; he didn’t recall FAS ever being mentioned. App. p. 3294. That whether the mother’s drinking would lead to FAS was never discussed and he would dispute that it was discussed. App. p. 3294.

Nettles also testified on re-direct that they would have liked to have had such evidence: “Question: If you’d had a diagnosis of guilty but mentally ill, you would have wanted that in [the trial] phase; wouldn’t you?” Answer: “Oh, yeah.” Question: “Wouldn’t you?” Answer: “Oh, yeah.” App. p. 3310. Mr. Nettles was honest about the fact that they struggled with what was wrong with Williams, and he acknowledged that he felt there was just something about Williams “that I just couldn’t get my hand around.” App. 3311.

Mr. Mauldin was even more forthcoming that drinking during pregnancy is a red flag for fetal alcohol syndrome, “and I honestly cannot say why it wasn’t a red flag for me eight years ago. I cannot explain that.” App. 3331-2. He testified that after being shown PCR evidence and exhibits he was “dumbfounded” as to why a certain course of action did not occur – that a natural course would be to bring in a neurologist and tell him they had evidentiary information to suspect FAS and they needed whatever testing

needed to be done to determine whether it existed. App. pp. 3367-8. That he was aware the circumference of the head at birth had a correlation with FAS and one expert was requesting those records and therefore suggesting the expert suspected some symptoms or review of FAS, but Attorney Mauldin did not connect that; he didn't "have an explanation for why [he] was missing those kinds of indicators. But apparently - - looking back, [he] was." App. pp. 3359-60. He would have wanted guilty but mentally ill diagnosis. App. p. 3333. He would certainly want evidence that the defendant suffers from brain damage before the jury. App. p. 3362. If FAS had been discussed it would have been noted on the checklist. App. p. 3347. That he had no explanation why he did not follow up with experts about the fact that the mother drank during pregnancy. App. p. 3348. That he acknowledged an MRI was not done until a week before trial. App. pp. 3343-4. That he had no explanation why it was not done before then considering he was on notice the mother drank during pregnancy. App. p. 3368. And when asked if he ever went to any experts about the problem of the mother drinking, he responded, "And what could possibly have lead me to not conduct some sort of follow-up is just beyond my - I don't have an explanation for it. I just don't know. ... I surely didn't do it intentionally. I will assure you, I did not do that intentionally. I think that would be horrible. App. p. 3381. "And why in the world I didn't, with these memos being provided me, why didn't I further take the course of action that I described to Mr. Zelenka about a neurological evaluation as to that specific issue, I just - I don't know. I can't explain that." App. p. 3382. The Dismissal Order fails to address any of this testimony.

EVIDENCE OF FETAL ALCOHOL SYNDROME

The PCR judge also found, “we are just beginning to understand the role that Fetal Alcohol Syndrome (FAS) plays in human behavior in general and criminal activity in particular.” App. p. 4203. The PCR judge was given a 317 page Appendix before trial with articles discussing the numerous scientific and medical studies regarding FAS and human behavior and criminal activity. This appendix was introduced at trial as Plaintiff’s Exhibit 23, App. p. 4531. Before trial, the PCR judge was also given the 200 page manual or text book, Fetal Alcohol Syndrome: Diagnosis, Epidemiology, Prevention, and Treatment. Stratton K, Howe C, Battaglia F (editors). National Academy Press. (1996). A copy of this manual was introduced as Plaintiff’s Exhibit 31(a duplicate copy has been mailed to this Court and the referenced pages are at App. p. 4898). All of the publications (Except the article on morphometrics, App. p. 4816) note FAS causes poor impulse control and puts the individual at heightened risk for criminal activity.³

It would be impossible to adequately condense the above material and the massive amounts of research and publications done on this subject; modern investigation into the effects of Fetal Alcohol Syndrome (FAS) began in the 1970s. Plaintiff’s Exhibit 23, App. p. 4534. The United States Congress mandated that the Institute of Medicine (IOM) of the National Academy of Sciences conduct a study of FAS and related birth defects in Section 705 of Public Law 102-321, the ADAMHA Reorganization Act. Fetal Alcohol Syndrome: Diagnosis, Epidemiology, Prevention, and Treatment. Stratton K, Howe C,

³ App. pp. 4538, 4542, 4568-4570, 4607, 4614-4615, 4621, 4642-4643, 4648-4652, 4674-4677, 4686-4689, 4717, 4745-4746, 4781-4790, 4792-4793, 4841-4851.

Battaglia F (editors). Page 1. National Academy Press. (1996). (Plaintiffs Exhibit 31, App. p. 4900, cited as NAP).

While society often uses the term Fetal Alcohol Syndrome (FAS) to encompass any *in utero* damage due to alcohol, it would be more correct in using the term, fetal alcohol spectrum disorder (FASD) to encompass all of the diagnoses possible due to maternal ingestion of alcohol. South Carolina Fetal Alcohol Spectrum Disorders Strategic Plan, State Fiscal Years 2011-2013. Plaintiff's Exhibit 23, App. p. 4606. Confusing this even more is the fact that numerous authors and studies initially used the term Fetal Alcohol Effects to describe conditions that met all FAS diagnostic criteria except for the full array of facial abnormalities. NAP, p. 63, App. p. 4901. Indeed, the IOM publication consistently references simply FAS. To be precise, the IOM set forth criteria for five diagnoses: Fetal Alcohol Syndrome confirmed with maternal alcohol exposure, Fetal Alcohol Syndrome without confirmed maternal alcohol exposure, Partial Fetal Alcohol Syndrome with maternal alcohol exposure, Alcohol Related Birth Defects, and Alcohol Related Neurodevelopmental Disorder. NAP, p. 76, App. p. 4904.

One reason FAS is often used to describe all FASD diagnoses is the fact that they all have the same signs and symptoms except for the face, which develops during a very small window of time in early pregnancy and may not be as affected as the brain, which develops throughout the pregnancy. NAP, p. 78, App. p. 4906. The IOM committee also had concerns about the other labels being seen as somehow less serious than an FAS diagnosis, and specifically the IOM had reservations about the term Partial Fetal Alcohol Syndrome because, "'Partial' denotes, to some people, that the condition might not be as severe, which the committee did not wish to imply." NAP, p. 78, App. p. 4906. "This

diagnosis could be particularly useful, for example, for some patients who present for diagnosis as an adult. The natural history of FAS is such that some of the ‘hallmark’ indicators used in infancy or childhood are not maintained into adolescence or adulthood.” NAP, p. 75, App. p. 4903. In other words, while we typically think of people with Fetal Alcohol Syndrome as displaying facial features that make it apparent something is wrong with the individual, the vast majority of people suffering from some type of Fetal Alcohol Spectrum Disorder, especially adults, do not look dramatically different than the rest of us.

While Petitioner has been diagnosed with Partial Fetal Alcohol Syndrome (PFAS), (App. p. 3718) the terms FAS and FASD are used as well to describe his condition as well as to describe all of the conditions related to problems resulting from maternal ingestion of alcohol during pregnancy. Furthermore, it is important to realize that PFAS does not suggest the Petitioner’s condition is less severe than FAS; in fact, in some circumstances, PFAS can put an individual at much higher risk for adverse life course outcomes (e.g. criminal conduct) due to his condition not being recognized and his ability to mask his cognitive deficits. App. p. 3707.

After Congress mandated that the IOM establish official FASD diagnostic categories, Congress continued to appropriate resources for research and assistance; in 2002, they mandated that the Centers for Disease Control and Prevention (CDC), acting through the National Center on Birth Defects and Developmental Disabilities Fetal Alcohol Syndrome Prevention Team and in coordination with the National Task Force on Fetal Alcohol Syndrome and Fetal Alcohol Effect, develop guidelines for the diagnosis of FAS and other negative birth outcomes from prenatal exposure to alcohol. App. p. 4550.

The CDC published *Fetal Alcohol Syndrome: Guidelines for Referral and Diagnosis* (CDC) in July of 2004. App. p. 4548. While the CDC did not complete the congressional mandate to define all FASD disorders, it more specifically defined the criteria and symptoms the IOM relied on in its diagnostic criteria for all FASD conditions. Petitioner actually meets all the criteria of the CDC diagnosis described in the CDC publication, except small palpebral features, which is only one of the three facial dysmorphia noted. App. pp. 3638-43, 4573. Furthermore, these dysmorphia are formed in a narrow window of 6-8 weeks during the gestational period and are known to disappear into adulthood. NAP, p. 75, App. p. 4903.

Regardless of the specific diagnosis, organizations and agencies have been clear that prenatal exposure to alcohol creates a destructive condition that puts children and adults into a high risk category of not being able to conform to society's norms due to significant cognitive deficits that impair executive and adaptive functioning; the South Carolina Fetal Alcohol Spectrum Disorders Strategic Plan for State Fiscal Years 2011-2013, describes the problems associated with individuals with FASD: "Resulting impairments may include, but are not limited to, intellectual disability; learning disabilities; attention deficits; hyperactivity; and problems with impulse control, language, memory and social skills." App. p. 4606. They also note it is the leading cause of intellectual disability and,

"Individuals (especially youth) with FASD are at high risk of engaging in criminal activity. They face many challenges that make them vulnerable, such as being easily influenced by peer pressure; lacking impulse control; not understanding cause and effect; not learning from mistakes; making poor decisions; having memory problems; and having difficulty understanding future consequences. Researchers at the University of Washington estimate that 35% of

individuals with an FASD have been in jail or prison, and more than half of the individuals diagnosed with an FASD have been in trouble with the law.”

Id. The PCR Judge failed to mention any of the medical materials that encompassed over 500 pages, or any of the medical criteria of FAS, or the recognized complications FAS causes, or the ABA standards regarding FAS; instead, he made the brief statement “that we are just beginning to understand the role” that FAS plays in human behavior and criminal activity without any explanation or finding of fact in that regard.

PCR EXPERTS’ TESTIMONY

Petitioner presented his evidence through three experts who all have expertise in Fetal Alcohol Spectrum Disorders. Paul Connor, A neuropsychologist who conducted testing on the Petitioner and determined he was deficient in 8 out of the 11 cognitive ability domains tested. Richard Adler, a forensic psychiatrist, who diagnosed the Petitioner with partial fetal alcohol syndrome (PFAS), and Natalie Novick Brown, a forensic psychologist who reviewed Petitioner’s entire life history, as well as the other experts’ investigations and conclusions, and determined the Petitioner’s PFAS impaired his ability to such an extent that he could not conform his conduct to the requirements of the law.

Dr. Connor did extensive testing on the Petitioner that showed the abysmal adaptive functioning of the Petitioner. He testified that these are the same cognitive deficits that would make the Petitioner mentally retarded. App. p. 3446. Dr. Connor spent his early FASD work in research, and was actually part of the study cited in the quote from the South Carolina publication cited on the preceding page. App. p. 3450. He also worked with the CDC on the diagnostic criteria. App. p. 3454.

Dr. Connor gave detailed testimony regarding alcohol's effect on the fetus. App. p. 3457. He noted that despite popular belief, alcohol is more harmful to the fetus than crack cocaine, heroin, marijuana and a host of other substances. App. pp. 3483-4. It is a poison that kills brain cells, causes some brain cells to move to wrong places, and affects all parts of the brain and all the synapses. App. p. 3485. He compared it to Alzheimers in its ability to affect the entire brain and discussed how people with Alzheimers can become disinhibited and sexually inappropriate; they also can remember certain things but not others. App. pp. 3486-7. As compared to a stroke which only affects a localized part of the brain, FAS is affecting every part, every synapse. App. p. 3494.

Dr. Connor testified that FASD affects executive functioning most commonly associated with the frontal lobe but it also affects connections with the frontal lobe to all parts of the brain, bringing in all the different areas and putting it together and making appropriate decisions. App. p. 3494. He testified that his testing validates the cognitive deficits, App. p. 3498, and noted that his group of tests are standard tests that neurologists around the world would recognize as sensitive to the impacts of prenatal alcohol exposure. App. pp. 3499-3501. He also had a slide showing black/dead cell damage in the frontal area of the brain, and noted that this was where the facial features and frontal lobe would be formed. App. p. 3464. He also re-iterated that facial features are formed in a very short window in the gestation period, specifically in weeks 6-8. App. p. 3464-7.

Just as was mentioned in the literature above, this is partially why someone with PFAS can have worse than expected outcomes, because the facial features are formed in such a tight window, they are not really an accurate indicator of the amount of damage done to the brain. App. p. 3468. He testified, "that there's really no difference between

FAS, PFAS and ARND when it comes to the cognitive impacts.” App. p. 3454. He also described why these cognitive impacts were far more important than IQ - that IQ is a structured test on paper; that it is not a good indication of how people can perform in the unstructured world of everyday life. App. p. 3471. The IQ test tends to overestimate their abilities; just because someone is a good speller, it does not mean they you have good impulse control. App. p. 3472.

With FASD you see people that perform poorly despite their IQ. App. p. 3473. In fact he rarely expects to see an IQ below 70, and in PFAS cases it happens only 10% of the time; what he does see is exactly what he found in Williams: large splits in the IQ scores along with the social and adaptive deficits. App. p. 3504. With FASD, IQ scores are not a reliable measure. App. p. 3509. Williams has the IQ, but he can’t use it. App. p. 3511. For example, he reads a lot but he can’t understand what he reads. App. p. 3516. Dr. Connor also confirmed that Williams was not malingering based on a test he gave measuring level of effort. App. p. 3505-6.

Dr. Connor also noted he uses the CDC criteria regarding deficits because they are much more restrictive than the IOM. App. pp. 3482-3. The CDC requires 3 cognitive deficits out of 10; Williams had 8 out of 11. App. pp. 3517, 3703. He’s particularly bad about processing information and figuring out what to do about it. App. p. 3520. He did fairly well in language tests, but that is part of the problem; that is why his deficits are not realized and he is expected to function normally. App. p. 3521. He talks a good game so people don’t recognize his deficits; Dr. Connor described it as masking. App. p. 3522. Dr. Connor also discussed motor coordination tests and how they revealed that the two sides of Williams’ brain were not communicating. App. p. 3523. The two parts of the brain are

connected by the corpus colossum. App. p. 3524. He described executive functioning - planning, problem solving, putting it all together. App. p. 3524. He then gave very detailed information about his testing. App. pp. 3527-39.

Dr. Connor also evaluates people for mental retardation with these same tests. App. p. 3538. Williams has similar deficits consistent with people that have mental retardation; he cannot understand social cues or behave appropriately. App. p. 3539. Dr. Connor explained that people with FASD have consistently poor adaptive functioning. Williams shows abilities to perform in high structured environments, but with less structure in our normal day to day activities, he cannot perform. App. pp. 3542-4.

Dr. Connor noted that people with FASD do much worse than you would expect from their IQ: "They're essentially functioning at a level of somebody who's mentally retarded, even though their IQ is in the average range. Their day to day functioning is so impaired." App. p. 3474. Their ability to manage day to day life, hold a job, being able to interact with people and interpret social cues, being able to cope with things if something happens to them and work around it is impaired. App. p. 3474. They cannot learn from mistakes and 95% of people with FAS have mental health problems. App. p. 3478.

Dr. Connor also testified that his testing was completely consistent with the QEEG, Plaintiff's 36, App. p. 4972, which Dr. Adler would testify about. App. pp. 3547-50. And completely consistent with Dr. Evan's testing done for the trial team in 2004. App. p. 3553. Dr. Connor overlapped his test results with Dr. Evan's on a chart showing deficits in adaptive functioning, and there was almost a complete overlay. App. p. 3553.

Dr. Connor is just one part of this multi-disciplinary team. The actual diagnosis was performed by a medical doctor, which was performed by Dr. Richard Adler, whose

role as part of the multi-disciplinary team is to diagnose the Petitioner. App. pp. 3606, 3613-4. Dr. Adler testified that he had some initial exposure to FASD as a fellow at Harvard with Dr. Biederman, a known expert on attention deficit disorder, which is commonly associated with FASD. App. p. 3608. Dr. Adler does criminal and civil forensic work. App. p. 3605. He has spent a large part of his practice in child psychiatry and maintains an active clinical practice. App. p. 3604.

As the literature noted, Dr. Adler explained that PFAS is a medical diagnosis based on the IOM manual. NAP at 75-77, App. pp. 4903-5. The CDC and the IOM were mandated by congress to develop criteria for all aspects of FASD. The IOM has criteria for FAS, PFAS, and ARND, but the CDC has only published complete criteria for FAS. Because the CDC used more stringent measurements, the team uses the CDC whenever possible. App. p. 3615.

An outline of the CDC criteria for the diagnosis of FAS is printed in the CDC manual. App. p. 4573. Williams meets all the criteria, except small palpebral features. App. p. 3638-43; however, the CDC did not complete their mandate to define all FASDs. Therefore, one must look to the IOM for the criteria of PFAS: In order for an individual to be diagnosed with PFAS, he must have A. Confirmed exposure to alcohol. B. Two of the three facial feature deformities (small palpebral features, thin vermillion, or smooth philtrum). In addition, the individual must have one of the following: C. Growth Retardation; D. Central Nervous System (CNS) Abnormalities; or E. Cognitive Abnormalities. NAP p. 76-77, App. pp. 4903-5. In Petitioner's case, Dr. Adler testified Petitioner had A, B, C, D and E; although he only needed three of the criteria, Dr. Adler opined he had every one and the most criteria he had ever found in a case. App. p. 3632.

Dr. Adler also testified Williams had certain additional signs that were consistent with FASD or neurological impairments, including nystagmus, birth defects, and consistent QEEG readings. App. pp. 3668-70, 3704.

A. CONFIRMED EXPOSURE TO ALCOHOL

Dr. Adler testified that the general consensus is that 14 drinks a week will produce a child with FASD. App. p. 3620. He noted that the strongest examples were mothers that confirmed they drank every night and had multiple binges during the month which was apparently what happened in Williams' case. App. p. 3621-3. He considered the amount of alcohol that Williams' mother drank significant (4-5 drinks a night and more on weekends. App. p. 3412), App. p. 3618, and he considered this confirmation. App. p. 3624.

B. AT LEAST TWO FACIAL FEATURES

Dr. Adler next explained that as far back as 1973, there were known facial features associated with FASD: small palpebral fissures – distance between the eyelids; smooth philtrum – the valley between the nose and middle of the mouth; and thin vermilion border – thin upper lip. App. p. 3629. These are the same as printed in the CDC publication under “Facial Dysmorphia”. App. p. 4573. He explained that the CDC developed more stringent criteria than the IOM and that these standards are based on computer models where the examiner inputs the data. App. pp. 3629-30. He also explained that the facial features had almost nothing to do with the negative trajectory or bad impact of FASD on the person's life, but it is helpful to explain how you know this is what caused his problems. App. p. 3631. Exhibit 33, App. p. 4969, was introduced that

was a computer printout of the facial feature report, indicating Williams had a thin vermilion and smooth philtrum even in adulthood. App. p. 3634-9.

C. GROWTH RETARDATION

Dr. Adler explained that Williams' disproportion between height and weight would meet the criteria for growth retardation. He referenced a growth chart similar to all growth charts parents look at when they visit the pediatrician. Plaintiff's Exhibit 5, App. p. 4261. The growth chart was from when Williams was 10 months old, where Williams was between 75 and 90th percentile in height but just above the 10th percentile in weight. This would fit the criteria under disproportional low weight to height found in the IOM manual, NAP p. 76, App. p. 4904. See also CDC publication – Growth Problems. App. p. 4970.

D. CNS ABNORMALITIES

Dr. Adler explained that Part of the direct evidence of CNS abnormalities that is referenced by the IOM and CDC is "reduction in size, or change in shape of the corpus callosum, cerebellum, or basal ganglia". App. p. 4567. Dr. Adler presented a normal MRI of a corpus callosum. App. pp. 5028, 3648. He also presented the MRI of Petitioner's corpus callosum. Plaintiff's Exhibit 35, App. p. 4971.

Dr. Adler testified that not only is Williams' corpus callosum abnormal, his cingulated gyrus directly above the corpus callosum is also abnormal. App. p. 3656. He also indicated he reviewed this information with Dr. Wendy Cohen, their neuroradiologic consultant at the University of Washington, who opined the corpus callosum had moderate thinning. App. p. 3660. Furthermore, the abnormality above the corpus callosum was a developmental abnormality, described also by Dr. Connor as migration,

where the tissue is somewhere it is not supposed to be. App. p. 3666. Dr. Cohen described it as medium or kiwi sized, as opposed to small or pea size, or severe or grapefruit size. App. p. 3667. While the 2011 MRI report noted the corpus callosum had “mild” thinning, Dr. Adler testified that Dr. Harrington at MUSC later agreed it was more than mild thinning and Dr. Cohen did not believe it was mild thinning. App. pp. 3787-94.

He also noted that the measurements he received from MUSC noted the corpus callosum thinned by more than 50%. App. p. 3660. He also noted that the trial investigator’s interview notes with the trial team’s expert, Dr. Jim Evans, noted that information did not appear to crossover from one side of Williams’ brain to the other, “as tho[sic] no corpus callosum”. Plaintiff’s Exhibit 12, App. p. 4278. And Dr. Adler actually spoke to Dr. Evans about his tests and conclusions and noted it was a huge red flag. App. p. 3653-4. When shown the notes, the trial attorneys did not know what the corpus callosum meant and had no explanation about the corpus callosum and brain damage references by Dr. Evans. App. p. 3215-6, 3272, 3337.

Dr. Adler noted the additional slides the attorney general introduced, Slide 12 and 14,(Defense Exhibits 1,3,5; App. pp. 5030, 5032, 5034) actually showed the corpus callosum as thinner than slide 13(Plaintiff Exhibit 35 and Defense Exhibit 4, App. 4971, 5033). App. pp. 3756-7. And while the original 2005 MRI indicated “Normal MRI”, the physician normally indicates what they are looking for in the MRI, and in 2005 they indicated they were looking for Autism Spectrum Disorder, App. p. 3791, which has nothing to do with FASD or the corpus callosum. App. p. 3796. In 2011 when they were told they were testing for FASD, the radiologists did notice the thinning of the corpus callosum. App. p. 3787-94.

Dr. Adler also noted that the average neuroradiologist is looking for profound abnormalities, such as a tumor or stroke and doesn't focus on the corpus callosum, App. p. 3787-98, and that one study found the vast majority of neuroradiologists will not discern significant thinning in these cases, so the fact that this neuroradiologist called it mild thinning was meaningful. App. p. 3790. And regardless, due to the IOM criteria, even if there was no evidence of corpus callosum damage, because all the other criteria was met, he still fits the diagnosis of PFAS. App. p. 3798. (It should be noted here, that the CDC places MRI abnormalities and cognitive deficit abnormalities under the same category of "CNS Abnormalities", so like the IOM, you do not have to show all of the deficits listed on page 20 of the CDC – for example the summation on page 20, "Criteria for FAS Diagnosis", requires Dysmorphia, Growth Deficits and CNS Abnormality.) App. p. 4573.

Before we had MRIs, the main way to determine whether an individual had brain damage was by exam. That is why doctors (and police officers) examine nystagmus; it is a red flag showing something is not working right in the brain. App. p. 3667. Dr. Adler also noted Dr. Griesemer found nystagmus years before, and that others found mirror movement and Romberg sign; these are "soft signs" showing something is wrong with the brain. App. p. 3668. He also explained that their expectations were validated by the QEEG. The QEEG is similar to an EKG that simply registers inappropriate electrical activity. App. p. 3671. The QEEG was simply verifying problems where they believed they would find them; he explained that the brain should be working like a symphony, but when the QEEG registers "hot spots" it is like an instrument blaring out louder than the rest. App. p. 3684.

Dr. Brown later noted that they now suggest getting a QEEG first, because if it does not show problems, there is little likelihood the patient will have FASD. App. p. 3817. In this case, the QEEG verified Dr. Connor's and Dr. Evan's testing, that the frontal lobe was "essentially untethered, intermittently doing its own thing." App. p. 3692. He also noted there were consistent birth defects, misshapen fingers and an abnormal "hockey stick" crease on the Petitioner's palm. App. p. 3704. Dr. Adler testified that it was an "embarrassment of riches in the field of medicine. This is all additional, confirmatory, illuminating material that is not even really centrally necessary to make the diagnosis." App. p. 3693.

E. COGNITIVE ABNORMALITIES

The cognitive abnormalities are shown by Dr. Connor's and Dr. Evan's testing; you need three, Connor found eight out of eleven and Evans found five. App. pp. 3517, 3703. Dr. Evans did not administer as many tests as Dr. Connor. App. p. 3553. Dr. Adler classified these cognitive disorders or neuropsychological abnormalities as severe. App. p. 3707. He also explained that the impacts of Partial Fetal Alcohol Syndrome are more serious than Fetal Alcohol Syndrome because as a general rule, people that have the full abnormal face and lower IQs get more help and more services. App. p. 3707.

Because Petitioner is able to mask his disability he appears good on the surface and his problems are not identified. App. p. 3708. Therefore, even though he has an average IQ and talks a good game, he could not interpret simple proverbs like a rolling stone gathers no moss. App. p. 3709. Dr. Adler cited a journal article (App. p. 4781) that speaks to the very negative life impacts of having PFAS. App. p. 3709. He noted that these individuals are totally different from normal individuals, having statistically

significant differences in school achievement, intellectual ability, development, depression, family problems, delinquency, withdrawal, anxiety, and psychosis. App. p. 3710. They have psychosis and attention problems at a much higher rate. App. p. 3711.

He then described the alarming rate that these individuals have depression and are psychotic, and notes that Williams was given an antipsychotic shortly after he was arrested, indicating the doctors did not know what was wrong, but they were concerned enough to give him that. App. p. 3713. He also noted it was common, just as in Petitioner's case, that doctors will misdiagnose FASD, and that the State used that to its advantage in closing argument, when Solicitor Arial argued the defense experts could not even agree on a diagnosis. App. pp. 3714-5. Mental Illness is simply a manifestation of FASD. App. p. 3716. FASD is a far more serious and the impairments are markedly greater than either expert's diagnosis of bipolar disorder or OCD. FASD implicates a host of different areas in life functioning and eclipses the others. App. p. 3717.

Dr. Adler confirmed what Dr. Connor said, that the trial attorneys had the cognitive deficit information through Dr. Evans. App. p. 3693. Unfortunately, the trial team's neurologist, Dr. David Griesemmer, indicated he was never given this information or any history of the patient and that he requested further neuropsychiatric evaluation, which had in part, unknown to him, already been done by Dr. Jim Evans. His affidavit is clear that if he had seen Dr. Evan's testing or had history of the mother drinking alcohol while pregnant, he would have informed the team to investigate FAS or rule out fetal alcohol effects. Plaintiff's Exhibit 24, App. p. 4851.

Dr. Adler finished his testimony by reiterating his role in the multi-disciplinary team as simply to give the diagnosis, PFAS, but he has been involved in cases where that information has resulted in a life sentence.

Dr. Natalie Novick-Brown is the culmination of the multi-disciplinary team. She began work in the field with Dr. Streissguth, the Godmother of FAS, in 1995. App. p. 3801. She has testified for the government as well as the defense and has fifteen peer reviewed articles mostly dealing with FAS. App. p. 3803. Dr. Brown reviews all the work of the other team members, all of the Petitioner's medical, school and other records, the trial transcript, and anything else in order to determine the exact impact the FASD has on the Petitioner and its relevance to the crime. App. p. 3817-8. She explained how FASD effects executive functioning – self regulation, behavior control, thought and emotion control and how the frontal lobe takes in and controls information from all over the brain faster than a computer, using all our memories and senses to make decisions, reduce urges, and reduce the intensity of emotion; and when those executive functions are impaired you see real problematic behavioral difficulties. App. p. 3818.

We have urges all the time and we rely on executive functioning to hit the brakes all the time. App. p. 3819. Mr. Williams' executive functioning is significantly impaired – learning from experience, linking cause and effect and being able to understand and foresee consequences and take those into account when planning; all people with FASD plan, but their plans are impaired by the brain damage. They have real difficulty organizing thoughts and it showed in Williams as early as the first grade. App. p. 3820. They have a goal in mind but blinders on to everything else; they particularly cannot see

the consequences of their plan, and she has seen that in virtually every clinical patient she has evaluated; it is like having no warning system. App. p. 3825.

People with FASD have trouble self-monitoring and being aware of the impact of their actions; virtually everyone with FASD has impulse control problems - difficulty controlling strong feelings which overwhelm their ability to resist urges. App. p. 3821. This explains why Williams had the incessant reiteration with his journal - this war within his brain going back and forth, trying to control himself, but the stronger the emotion the harder it is. App. p. 3822. Williams' damaged brain doesn't play out what might happen; it does not have the capacity to determine what is the worst thing that can happen and use that to resist his urges. App. p. 3823. Their executive functioning is damaged so that they cannot understand the significance of their behavior on others and ultimately control their behavior. App. p. 3824. Stress only exacerbates that problem. App. p. 3824. This is all backed up by Williams' school records where you always see the word impulsive. App. p. 3826. These executive function deficits create the adaptive deficits that are noted in Dr. Connor's testing. App. p. 3825.

Dr. Brown has also performed *Atkins* evaluations before, and there is no doubt these were obviously life-long problems for Chris, and the adaptive functions would fit the criteria for that prong of *Atkins*; in fact, Dr. Brown testified that a number of experts and mental health professionals now believe the adaptive functions are more important than his IQ - an IQ is measured in a structured environment, but the adaptive functioning is the real indication of how the individual is able to perform in the community on a day to day basis. App. p. 3828. His school history is a good example - he has an IQ that

should be sufficient, but he is in special education early on, fails eighth grade, and eventually drops out of ninth. App. p. 3850.

In fact, Dr. Brown testified she had never seen a child repeat kindergarten and first grade and his disability was entirely consistent with FASD. App. p. 3865. He cannot use his intellect, his IQ. App. p. 3851. The adaptive deficits interfere with his ability to use the IQ, the intellect, in the real world. He can read well for example, or perform well in a routine environment without distractions. App. p. 3829. So for example, he could perform well at his work at Blockbuster if he was doing a routine repetitive task that he was familiar with, but if you mix it up and add new people, new environment or stress, there is deterioration in his performance. App. pp. 3830, 3849.

For example, there are people with mental retardation that can pass the driver's test, but they have to take it multiple times; Williams also had to take it 5 or 6 times. App. p. 3832. There are a lot of similarities between mental retardation and FASD; in the terms of their adaptive functioning and performance there is not a lot of difference. App. p. 3832. People with FASD might have better verbal skills so there is an appearance of normalcy, so by the time mentally retarded people get to adulthood, they are not very adept at disguising their mental retardation; people with FASD are better at masking. App. p. 3833. But in reality, people with FASD have child-like coping skills; they are socially children, emotionally children, and there is research going back 30 years that their adaptive functioning is equivalent to children in elementary school. App. p. 3836. In fact, Dr. Brown testified that the standardized testing placed Williams at the skill level of a nine year old. App. p. 3837-8.

Dr. Brown also testified about secondary disabilities and explained that almost 100% of people with FASD have mental health problems. The bipolar diagnosis is just a symptom of the much larger problem caused by his brain damage. App. p. 3844. The research is clear that people with FASD have life-long impacts because their impairments get worse as they reach adulthood and as they are expected to mature; their childlike ability to self regulate and cope simply cannot manage adulthood. App. p. 3847. Dr. Brown would never have expected Williams to be able to live independently. App. p. 3849. He cannot function at school by getting to class on time; he cannot function at work. Dr. Connor's testing is important because it shows Williams cannot function in these unstructured environments. App. p. 3852. Prison is structured and Williams has no problem there, but our day to day life is not structured and that is where he had problems. App. p. 3853.

Dr. Brown verified what the other experts had said, that FASD impacts the entire brain and being able to comprehend what is around you. Williams had these plans but could not follow them and in this unstructured environment; he is unable to quickly comprehend and respond appropriately. App. p. 3858-9. This behavior is consistent with Dr. Connor's testing and Williams' school performance, specifically the history from his first grade teacher. App. p. 3867. Impulsivity is not normal in non-brain damaged children. App. p. 3868. The first grade teacher's comments are entirely consistent: impulsivity, physically aggressive, easily frustrated, blames others for mistakes. App. p. 3871.

Dr. Brown explained how these child-like behaviors led to his inability to handle the break up with the victim and his suicide attempt. App. pp. 3876-7. The child-like

thinking that somehow this plan was going to work and the victim was going to admit her mistakes and they would get back together. App. pp. 3879-80. The lack of sophistication in his plan, such as “get cigarettes” or running out of gas in front of the store which caused him to believe he could not leave even though he wanted to leave. App. pp. 3882-3. There was never an indication that Williams ever considered trying to plan a way to do this in such a manner so he would not get caught. App. p. 3884.

He walks around the store and bends down with the victim behind her. He has never contemplated the one thing that happened – that there would be a struggle. App. p. 3885. While he writes in his journal he wants to kill her, he indicates to negotiators he just wants her attention and wants to talk to her. App. p. 3886. He never contemplates a struggle and when it happens, he reverts to fight or flight reaction and because of his brain damage he reacts aggressively. App. p. 3888. He cannot deal with it appropriately, and then he runs away and hides, despite knowing the SWAT team is right outside. App. p. 3889. Dr. Brown continued to describe the childlike planning, inability to see contingencies or consequences and link cause and effect. App. p. 3891.

She also explained why Dr. Crawford’s interview was so damaging. Dr. Crawford was very skilled at questioning Williams to lead him away from what he originally said to the other police investigators and in the end to take complete responsibility for planning the entire episode. App. p. 3887. Dr. Brown explained that research shows FASD people are particularly open to suggestion. In fact, there is a known and validated test for suggestibility known as the Gudjonsson Test. App. p. 3892. The testing revealed that Williams was very suggestible. App. p. 3896. Dr. Crawford’s interview was very manipulative. App. p. 3892. Dr. Brown showed through her powerpoint slides the

multiple statements that Williams made during the immediate interview with police officers and specifically how he was unsure about what he was going to do when he went to the store, and how those statements changed with skilled questioning by Dr. Crawford; and while Williams continued to vacillate, Dr. Crawford manipulated him into agreeing he premeditated the murder. App. p. 3897-8.

Dr. Brown testified that the situation overwhelmed his capacity to come out with the right behavior. App. p. 3899. She said PFAS explains why he did this unthinkable act and if he would have been born with a normal brain, she would not have expected this result. App. p. 3900. Dr. Brown ultimately opined that Williams met the definition of Guilty But Mentally Ill in that he lacked sufficient capacity to conform his conduct to the requirements of the law. App. p. 3901.

ARGUMENT

THE PCR JUDGE COMMITTED ERROR BY FAILING TO ADDRESS THE OVERWHELMING EVIDENCE AND THE CLEAR ADMISSIONS FROM TRIAL ATTORNEYS THAT THEY NOT ONLY FAILED TO CONSIDER FETAL ALCOHOL SYNDROME, BUT THAT THEY WOULD HAVE LIKED TO HAVE HAD SUCH EVIDENCE BEFORE THE JURY. HE FURTHER COMMITTED ERROR BY USING INAPPROPRIATE STANDARDS AND ANALYSIS TO DETERMINE WHETHER SAID ERROR WAS PREJUDICIAL.

SUMMARY OF ARGUMENT

The crux of this case is that trial attorneys candidly admitted they failed to discuss or investigate Fetal Alcohol Syndrome (FAS), but despite that, the PCR judge failed to even mention the trial attorneys' testimony regarding FAS. Instead he found, without explanation, that they made a strategic decision not to put forward FAS, despite their multiple and adamant admissions to the contrary. Furthermore, while inadequate investigation should call into question the trial attorneys' mitigation theory, the PCR judge ignored this lack of investigation into FAS, he failed to address Petitioner's severe cognitive deficits similar to mental retardation, and he failed to address testimony that Petitioner has the mentality of a nine year old and that because of his mental defects he could not conform his actions to the requirements of the law. Instead the PCR judge cited instances where other juries had found for the death penalty despite FAS.

This is not the analysis the United States Supreme Court said PCR judges must do; instead, the judge must make probing and specific findings of fact and weigh the totality of mitigation available versus the evidence in aggravation. *Sears v. Upton*, 130 S.Ct. 3259 (2010). A probing review of the evidence of Petitioner's organic brain damage makes it clear that it is the type of evidence this Court and the United States Supreme Court have held could have swayed one juror to fail to vote for death.

THE *STRICKLAND* STANDARD

Ineffective assistance of counsel claims are reviewed under the familiar two-prong test established by *Strickland v. Washington*, 466 U.S. 668, 687 (1984), which requires a Petitioner to show that: (1) trial counsel's performance was deficient; and, (2) the deficiency resulted in prejudice. *See also, Porter v. McCollum*, 130 S.Ct. 447, 452 (2009); *Wiggins v. Smith*, 539 U.S. 510, 521 (2003). Whether an attorney's performance was deficient is determined by a standard of "reasonableness under prevailing professional norms." *Strickland*, 466 U.S. at 688. In capital cases, the professional norms require counsel to conduct a thorough investigation into "*all reasonably available mitigating evidence.*" *Wiggins*, 539 U.S. at 524 (emphasis in original). It is well-established that trial counsel should be particularly diligent to investigate evidence of mental impairments, such as organic brain damage, because of its powerful mitigating effect. *See, e.g., Sears v. Upton*, 130 S.Ct. 3259, 3261 (2010) (holding evidence of brain damage was "significant mitigating evidence a constitutionally adequate investigation would have uncovered"); *Porter*, 130 S.Ct. at 454 (finding evidence of brain damage and cognitive deficits in reading, writing and memory were part of "the kind of troubled history we have declared relevant to assessing a defendant's moral culpability.") (quoting *Wiggins*, 539 U.S. at 535); *Rompilla v. Beard*, 545 U.S. 374, 392 (2005) (holding trial counsel was ineffective for failing to discover and present evidence of organic brain damage caused by fetal alcohol syndrome); *Tennard v. Dretke*, 542 U.S. 274, 287 (2004) (holding evidence of impaired intellectual functioning is inherently mitigating in the penalty phase of a capital case); *Wiggins*, 539 U.S. at 535 (stating that a

competent attorney, aware of the defendant's history of diminished mental capacities, among other things, would have introduced it in the capital sentencing proceeding).⁴

THE PCR JUDGE'S FINDINGS

As an initial matter, in the State's Return to the Petition, it notes "The Order of Dismissal was completed without input from either party." (State's Return p. 5, FN 4). As can be seen by emails between counsel and the PCR judge, the PCR judge granted certain extensions to complete post-trial memorandums and indicated that the extension ending on June 10, 2013 would likely be the last one. Petitioners' counsel delivered its post-trial brief to the PCR judge on that day. The State requested additional extensions which the judge did not acknowledge. Instead, in an email dated July 17, 2013 the judge's law clerk attached a draft order and indicated he did "not expect the judge to be amenable to any extensions" for post-trial motions. App. p. 5073-5078. The Petitioner filed his post-trial motion in a timely manner. The State never provided the judge with a post-trial brief or post-trial motion and should not be allowed to put forward theories it had ample opportunity to present to the Court. *Marlar v. State*, 375 S.C. 407, 653 S.E.2d 266 (2007).

4 Numerous lower courts have likewise recognized that brain damage is uniquely mitigating. See, e.g., *Hooks v. Workman*, 689 F.3d 1148, 1205 (10th Cir. 2012) ("the involuntary physical alteration of brain structures, with its attendant effects on behavior, tends to diminish moral culpability, altering the causal relationship between impulse and action."); *Wilson v. Sirmons*, 536 F.3d 1064, 1094 (10th Cir. 2008) (stating mental conditions "associated with abnormalities of the brain" are "likely to [be] regarded by a jury as more mitigating than generalized personality disorders."); *Blystone v. Horn*, 664 F.3d 397 (3rd Cir. 2011) (trial counsel's deficient performance was prejudicial where counsel failed to investigate and present evidence that Petitioner suffers from "untreated brain damage and psychiatric disorders, all of which were aggravated by a history of poly-substance abuse."); *Haliym v. Mitchell*, 492 F.3d 680, 718 (6th Cir. 2007) (prejudice found where trial counsel failed to present evidence that, among other things, Petitioner suffered a serious brain injury and functional brain impairment, which caused problems with impulsivity, judgment and problem solving); *Caro v. Woodford*, 280 F.3d 1247, 1258 (9th Cir. 2002) ("By explaining that [defendant's] behavior was physically compelled, not premeditated, or even due to a lack of emotional control, his moral culpability would have been reduced.").

For example, on page 69 and 70 of the State's Return, the State alleges the PCR judge found the mitigation investigator credible, presumably over trial counsel. The State had ample opportunity to make this argument to the judge or to clarify the judge's order in a Rule 59(e) motion, that that was indeed the PCR judge's findings. The State failed to do so. More importantly, this is simply not what the PCR judge's order says. It makes no mention of trial attorneys' testimony and the only finding is they somehow made this strategic decision without any explanation. Trial counsel cannot, as a matter of law, make an informed strategic decision about whether to present certain information when they do not know what that information is. *See, e.g., Sears v. Upton*, --- U.S. ---, 130 S.Ct. 3259, 3265 (2010); *Porter v. McCollum*, --- U.S. ---, 130 S.Ct. 447, 453 (2009).

Petitioner did argue in his post-trial motion, "The order fails to acknowledge trial counsels' failure to investigate FAS and instead finds trial counsel made a strategic decision not to present FAS. This contradicts both attorneys' testimony. PCR at 92-100, 104, 119-121, 136-137, 155 – 160, 169 – 170, 174, 180 – 182, 186 – 194, 207 – 208." App. 4225. The PCR judge dismissed Petitioner's Rule 59 motion two days after it was filed, in an order that was slightly over a page, saying he adequately addressed the issues and, "Fortunately, our judicial system provides appellate courts, which are waiting to review this decision and will have the opportunity, with a deeper insight from an impassive record of trial, to provide wise analysis for this case." App. 4229 - 4230.

The State also makes multiple references to Williams' mother denying drinking and questions whether the MRI showed thinning of the corpus collosum or only mild thinning. Again, if the State wanted to argue Williams does not suffer from FAS, it had ample opportunity to do so in the lower court, although, considering it failed to put

forward their own experts to contradict this, it is hard to understand how the PCR judge could have made that finding. More importantly, the order never disputes the fact that Petitioner has FAS.

The order also clearly ignores the undisputed PCR testimony that the Petitioner could not conform his actions to the law. The State has posited that this was not true because the expert testified the Petitioner did not have an irresistible impulse at 10:00 AM, even though the murder occurred at noon, and because the Petitioner was capable of conforming to traffic rules on the way to the murder. The expert went into great detail that Petitioner's executive functioning was severely impaired regarding the entire situation, but he could handle routine tasks somewhat regularly. More importantly, during the struggle and ensuing murder, he was impaired. App. 3859-3891.

The order also ignores the testimony that Petitioner had the mental capacity of a nine year old child. It also fails to acknowledge the fact that the solicitor used the fact that not only did the trial experts disagree, but they testified Williams could conform his conduct to the requirements of the law. The order also failed to address the Gudjohnson test that rated Williams as highly suggestible, which could have explained the damaging evidence of Dr. Crawford, who this Court described as the state's primary witness. *Williams* at 64. The State could have asked the PCR judge to clarify all of these matters; Petitioner did. But what the State cannot do is assume the PCR judge made findings to the contrary where there is no indication that is what the PCR judge did.

The State and the PCR judge also repeatedly state that the trial attorneys' experts had the evidence that Williams' mother drank during pregnancy. App. 4209, 4210. This completely fails to acknowledge that the neurologist did not have this evidence and he

would have advised the team to investigate FAS if he had known that fact. The State's Return acknowledges one time, on page 12, Dr. Griesemer (the neurologist) did not have this information. The order also fails to acknowledge or address Attorney Mauldin's testimony that if he would have suspected FAS he would have hired a neurologist and told him to do whatever testing needed to be done to determine whether it existed. App. 3367-3368. The PCR order also fails to address the fact that the trial team's neurologist was hired on the eve of trial, not given an adequate history, not only about Williams' mother drinking during pregnancy but also Dr. Evan's testing, and that the neurologist said upon seeing this evidence, that Petitioner's brain damage was far more serious than the neurologist's two hour exam indicated. (App. p. 4851)

If we are to read the PCR judge's order as the State suggests – that the PCR judge found the mitigation investigator credible, it would seem to imply that the trial attorneys were perjuring themselves. Regardless, if the investigator did discuss FAS with the trial attorneys, and somehow the trial attorneys made a decision not to present FAS without discussing FAS or even the mother's drinking with any of their experts, and particularly the neurologist, that is clear evidence the trial attorneys failed to investigate as well. This is not, as the State suggests, failure to micro-manage the mental health and medical testing performed by the experts. Return p. 11. This is a clear failure to do exactly what the ABA Guidelines demand, which is to investigate FAS and to provide their experts the information they needed to conduct their evaluations. The evidence is also in contrast to the State's position "Nor was the expert team appointed too late to provide meaningful benefit to the case." *Id.* In reality, the one expert Attorney Mauldin suggested he would ask about FAS was the neurologist, who was hired on the eve of trial and not given this

information. More importantly, the PCR judge did not address any of this or make these findings.

The PCR judge also failed to address the significant disabilities FAS causes, and instead believed that the scientific community was just beginning to understand the role FAS plays in human behavior and criminal activity. App. p. 4203. As evidenced by the massive amount of literature entered into evidence encompassing over 500 pages, this is simply not true. The damaging effects of FAS have been known for decades. Even the ABA Guidelines for Death Penalty defense specifically mention FAS in two different places. App. pp. 4340, 4390. The PCR judge also seemed to be concerned that this condition was inevitable or possibly that he believed it was still not common knowledge that drinking during pregnancy was harmful, because there were still pregnant women drinking despite the literature. App. pp. 4005-6. These beliefs make it clear the PCR judge failed to give appropriate consideration to this condition.

The PCR judge also found that each expert acknowledged that the state of the art for FASD forensic assessment was “hit or miss” prior to 2007. App. p. 4203. While the experts testified this was a slide on a power point presentation they gave at a FAS conference in 2009, they all testified there were qualified experts making this diagnosis and testifying in 2005. App. pp. 3570-1, 3723-4, 3727, 3805-3816. In fact, Dr. Novick-Brown was available to testify in 2004. App. p. 3808.⁵ Furthermore, the diagnostic criteria for FAS have been widely accepted since the 1970s, the standard four criteria were codified by the Institute of Medicine in 1996, and evidence of FAS has long been

⁵ All of the experts essentially agreed that the point of the slide and their presentation was that it was important to put together a multi-disciplinary approach as the diagnostic criteria suggested. Dr. Adler testified teams were often put together more like pick-up basketball and when they created their ensemble, they created a more protocolized approach. App. 3723-4.

recognized as mitigating in capital cases. *See, e.g., Wiggins and Rompilla*. There are undoubtedly still many individuals in many fields claiming to be experts that might give an improper diagnosis, but that does not mean one can ignore the fact that there were qualified experts available to give an appropriate opinion in 2005.

More importantly, the PCR judge's notation about the experts' testimony is the only mention in his entire order about their testimony, the medical evidence, the implications of FAS, the trial attorneys' candid admissions that they absolutely failed to consider FAS, or whether Williams even suffers from FAS. Such a complete failure to make adequate findings of facts makes it clear the PCR judge could not and did not appropriately evaluate Petitioner's condition and how powerful that evidence could have been to the jury.

The State's prejudice analysis in their Return is a recital of factual arguments that the PCR judge never ruled upon and that the State failed to ask him to clarify in a Rule 59 motion. They consist of arguments that FAS is a double-edged sword, FAS may have been hard to prove, and that the Petitioner could conform his actions to the law. (Return p. 73-80). Even if this Court considers these arguments, this Court cannot assume it knows what the PCR judge found. *Sears v. Upton*, 130 S.Ct. 3259 (2010). It must evaluate the PCR judge's order to determine whether he made sufficient findings of facts adequate for appellate review. Without determining whether Williams had FAS or how bad his cognitive deficits were due to FAS, it is impossible for this Court to determine whether the PCR judge adequately weighed that evidence to determine whether there was prejudice. The PCR judge's findings are "insufficient for appellate review." *McCray v. State*, 305 S.C. 329, 330, 408 S.E.2d 241, 241 (1991).

PREJUDICE

To establish prejudice, a PCR applicant “‘must show that there is a reasonable probability that, but for counsel’s unprofessional errors, the result of the proceeding would have been different.’” *Porter*, 130 S.Ct. at 453 (quoting *Strickland*, 466 U.S. at 694). The test is not whether a capital defendant would have received a life sentence absent trial counsel’s deficient performance. As the United States Supreme Court recently reiterated in *Porter*:

[w]e do not require a defendant to show ‘that counsel’s deficient conduct more likely than not altered the outcome’ of his penalty proceeding, but rather that he establish ‘a probability sufficient to undermine confidence in [that] outcome.

130 S.Ct. at 455-56 (quoting *Strickland*, 466 U.S. at 693-94). The question is whether “‘the undiscovered mitigating evidence, taken as a whole, might well have influenced the jury’s appraisal of [a defendant’s] culpability.’” *Rompilla*, 545 U.S. at 393. Prejudice is established if “‘there is a reasonable probability that at least one juror would have struck a different balance.’” *Wiggins*, 539 U.S. at 537.

This history of FASD and its effects on Petitioner’s life would have made a powerful mitigation story – far different from two experts that could not agree on a diagnosis and did not testify that the Petitioner could not control his actions in compliance with the law. The mitigation evidence established in PCR would have undermined the State’s case in aggravation and offered a far more sympathetic explanation for Petitioner’s actions. It would have directly challenged the solicitor’s argument that Petitioner could control his actions. Altogether, this case in mitigation

could have convinced at least one juror that death was not an appropriate sentence. *See Wiggins*, 539 U.S. at 536.

The PCR judge relied on *Jones v. State*, 332 S.C. 329, 504 S.E.2d 822 (1998). *Jones* is different in that Jones' PCR counsel introduced more of the same evidence: "The 'new' evidence is the same as the 'old' evidence." Here there is new and different evidence trial counsel failed to find and admitted they wanted. The PCR judge also relied on *Simpson v. Moore*, 367 S.C. 587, 627 S.E.2d 701 (2006). Similarly, in *Simpson* there was additional mitigation information, but not a new diagnosis. In Williams' case, the defense simply missed all the evidence of organic brain damage and presented instead, two differing diagnosis regarding mental illness. More importantly, the new experts gave uncontradicted opinions that Petitioner had severe cognitive deficits, impulse control problems and could not conform his actions to the law.

The United States Supreme Court has consistently found trial counsel ineffective for failing to investigate and present similar evidence. For example, in *Wiggins*, the Supreme Court held that defense counsel's performance was unreasonable where, much like here, trial counsel failed to offer expert testimony on the significance of Wiggins' likely FASD and instead relied on evidence of Wiggins' mental illness even though trial counsel knew that "[Wiggin's] mother was a chronic alcoholic". *Wiggins*, 539 U.S. at 524–25. Similarly, in *Rompilla v. Beard*, the Supreme Court found that counsel's assistance was ineffective when counsel failed to present evidence that the defendant suffered from organic brain damage as a result of fetal alcohol exposure, because it was an impairment that by definition existed since childhood and thus likely impaired the defendant's ability to appreciate the criminality of his conduct at the time of the offense.

545 U.S. 374, 392–393 (2005); *see also*, *Porter*, 130 S.Ct. at 451 (holding trial counsel was ineffective for failing to present evidence of brain damage that could manifest in impulsive behavior); *Sears*, 130 S.Ct. at 3262 (holding trial counsel was ineffective for failing to present evidence that the defendant had “problems with planning, sequencing and impulse control”).

Several state supreme courts have also found that failure to present evidence of FASD amounts to ineffective assistance. In *Hurst v. State*, 18 So. 3d 975, 1010–1011 (Fla. 2009), the Florida Supreme Court held that trial counsel’s failure to present evidence of FASD was not consistent with any reasonable trial strategy. The court emphasized that counsel’s performance was unreasonable in light of his knowledge that Hurst’s mother drank heavily during her pregnancy, and because Hurst’s family presented counsel with information that Hurst had borderline intellectual functioning and was emotionally immature. *Id.* The Washington Supreme Court also found counsel ineffective for failing to present evidence of FASD when, despite knowing that the defendant likely suffered from FASD, counsel retained a psychologist who was not an expert in FASD, could not make an individualized diagnosis of the defendant’s FASD, and provided erroneous testimony about FASD’s effects. *In re Brett*, 16 P.3d 601, 604–607 (Wash. 2001); *see also*, *Bond v. Beard*, 539 F.3d 256, 283 and 288 (3rd Cir. 2008) (finding trial counsel was ineffective for failing to present evidence of fetal alcohol, among other things, and noting that trial counsel did not obtain readily available school or medical records or “conduct a meaningful inquiry into [the defendant’s] family life.”);

Silva v. Woodford, 279 F.3d 825, 847 n.17 (9th Cir. 2002) (holding trial counsel was ineffective for failing to present evidence that the defendant “may suffer” from FASD).⁶

Perhaps the most compelling part of this evidence is the expert’s analysis that Williams is emotionally on the level of a nine year old. The massive amounts of research combined with Dr. Connor’s extensive testing make it clear that Williams was clearly impaired on the days and weeks leading up to the murder. While it is true the Petitioner has an average IQ, the experts were clear that his cognitive deficits, just like those of the mentally retarded, made it impossible for him to use this IQ appropriately. They were also clear, that just because an individual is good at spelling or standardized testing, it has no bearing on how he can conform his actions in real world situations. Just as the United States Supreme Court noted in *Hall v. Florida*, ___ U.S. ___, No. 12-10882 (May 27, 2014): “‘IQ test scores are approximations of conceptual functioning but may be insufficient to assess reasoning in real-life situations and mastery of practical tasks.’” DSM–5, at 37.” And, “It is not sound to view a single factor as dispositive of a conjunctive and interrelated assessment. See DSM–5, at 37 (‘[A] person with an IQ score

⁶ On page 45 of the PCR judge’s order, he relies on decisions in other states for the proposition that the trial attorneys were not deficient. Review of these cases finds them easily distinguished from this case, and some of them are not relevant at all. *Johnson v. State*, 333 S.W.3d 459 (Mo. 2011). In that case the trial experts testified defendant met conditions of FAS and went into detail of where he fell on the spectrum and how his behavior was characteristic of the syndrome. The trial attorneys clearly made a decision to focus on mental retardation in that case but did investigate and present evidence of FAS as well. Similarly in *Burgess v. State*, 962 So.2d 272 (2005), PCR counsel did not call trial attorneys and there was no evidence that they failed to investigate FAS. Furthermore, the jury voted 8 to 4 for Life and PCR experts did not find Burgess had a serious mental disease or defect. Also in *In re Andrews*, 28 Cal.4th 1234, 1259, 52 P.3d 656 (Cal. 2002): There was one brief reference that defendant “might” have suffered from FAS, but majority of the opinion is based on fact that trial attorneys gave strategic reasons for conducting the trial in the way they did. In *State v. Murphy*, 91 Ohio St. 3d 516, 542, 747 N.E.2d 765, 797 (2001) PCR counsel did not show trial counsel failed to investigate FAS. In *State v. Cooper*, 410 N.J. Super. 43, 979 A.2d 792 (N.J. Super. Ct. App. Div. 2009), New Jersey had abolished the death penalty by the time this case was reconsidered; furthermore, trial counsel had presented evidence, and the jury had found, that the mother’s prenatal ingestion of alcohol had damaged the defendant physically and developmentally.

above 70 may have such severe adaptive behavior problems . . . that the person's actual functioning is comparable to that of individuals with a lower IQ score'). *Id.*

Petitioner's cognitive deficits are exactly the same evidence that protects the mentally retarded from execution:

[B]y definition, they have diminished capacities to understand and process information, to communicate, to abstract from mistakes and learn from experience, to engage in logical reasoning, to control impulses, and to understand others' reactions. Their deficiencies do not warrant an exemption from criminal sanctions, but diminish their personal culpability.

Hall v. Florida, quoting *Atkins v. Virginia*, 536 U.S. 304 (2002).

Considering the fact that the PCR judge failed to acknowledge the vast amount of evidence regarding the severe circumstances of FAS, combined with the mistaken belief that the trial attorneys somehow decided to strategically not present FAS to the jury, it was impossible for the PCR judge to adequately weigh this evidence. Furthermore, as countless courts have held, organic brain damage is powerful evidence before a jury, and the lack of this evidence establishes a probability sufficient to undermine confidence in the outcome. This is especially true considering the divided jury, 8 - 4, and the extended deliberations. *State v. Williams*, 386 S.C. 503, 690 S.E.2d 62 (2010).

CONCLUSION

For the reasons stated, Petitioner asks this Court to vacate the conviction, or in the alternative, to remand for a new sentencing.

Respectfully submitted,

A handwritten signature in black ink, appearing to read 'D. Enderlin', written over a horizontal line.

October 20, 2015

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THE STATE OF SOUTH CAROLINA

In The Supreme Court

APPEAL FROM GREENVILLE COUNTY
Court of Common Pleas

G. Edward Welmaker, Circuit Court Judge

Appellate Case No. 2013-001945

Charles Christopher Williams,

Appellant,

v.

The State of South Carolina,

Respondent.

PROOF OF SERVICE

I certify that I have served a copy of the Brief of Petitioner on the State of South Carolina, by hand-delivered courier, delivering a copy of it to his attorney of record, Donald J. Zelenka, at the Attorney General's Office at 1000 Assembly Street, Columbia, SC 29201, on October 21, 2015.

October 21, 2015



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