VOLUME XVII OF XVII

STATE OF SOUTH CAROLINA

IN THE SUPREME COURT

Appeal from Lexington County

Honorable Eugene C. Griffith, Circuit Court Judge

THE STATE,

RESPONDENT,

V.

TIMOTHY RAY JONES, JR.,

APPELLANT.

APPELLATE CASE NO. 2019-001008

RECORD ON APPEAL

ROBERT M. DUDEK
Chief Appellate Defender

SUSAN B. HACKETT
Appellate Defender

DAVID ALEXANDER
Appellate Defender

LARA M. CAUDY
Appellate Defender

TAYLOR D. GILLIAM
Appellate Defender

South Carolina Commission on Indigent Defense
Division of Appellate Defense
PO Box 11589
Columbia, SC 29211-1589
(803) 734-1330

ATTORNEYS FOR APPELLANT

ALAN WILSON
Attorney General

DONALD J. ZELENKA
Deputy Attorney General

MELODY J. BROWN
Senior Assistant Deputy Attorney General

TOMMY EVANS, JR.
Assistant Attorney General

S. R. HUBBARD, III
Solicitor, Eleventh Judicial Circuit

Rembert Dennis Building
1000 Assembly Street, Room 519
Columbia, SC 29201
(803)734-3727

ATTORNEYS FOR RESPONDENT

PAGES 8001-8366

INDEX

VOLUME I

INDEX i

TRANSCRIPT OF TRIAL HELD APRIL 29 – JUNE 13, 2019 1

MOTION FOR FORMAL ARRAIGNMENT IN FRONT OF JURY 81

MOTION TO INSTRUCT JURORS ON NOT GUILTY BY REASON OF INSANITY PRIOR TO INDIVIDUAL VOIR DIRE 105

COURT'S RULING DENYING MOTION FOR FORMAL ARRAIGNMENT IN FRONT OF JURY AND DENYING MOTION TO INSTRUCT JURORS ON NOT GUILTY BY REASON OF INSANITY PRIOR TO INDIVIDUAL VOIR DIRE 113

MOTION FOR A CONTINUANCE, CHANGE OF VENUE, AND TO ESTABLISH PENALTY FOR VIOLATION OF GAG ORDER 115

COURT DEFERS RULING 115

DEFENDANT'S PLEA OF NOT GUILTY BY REASON OF INSANITY 121

VOIR DIRE 127

MOTION AND MEMORANDUM SUBMITTED REGARDING EMOTIONAL NATURE OF GRUESOME PHOTOGRAPHS 156

COURT DEFERS RULING 157

DISCUSSION OF JUROR FORM 159

DISCUSSION OF GAG ORDER VIOLATIONS INVOLVING AMBER KYZER 169

COURT'S RULING NOT TO ISSUE SANCTIONS WITH LEAVE TO REVISIT 178

MOTION FOR A CONTINUANCE TO REVIEW VIDEO FOOTAGE 179

COURT'S RULING DENYING MOTION 180

MOTION TO PROHIBIT "MAGIC QUESTION" REHABILITATION IN LIEU OF A CHALLENGE 183

MOTION TO RESTRICT REHABILITATION OF BIASED JURORS 184

COURT'S RULING ON BOTH MOTIONS
DETAILING VOIR DIRE PROCESS.....186

RENEWED MOTION TO DEFER DEATH PENALTY VOIR DIRE
UNTIL PENALTY PHASE IF NECESSARY.....187

COURT'S RULING DENYING MOTION 188

RENEWED MOTION TO ALLOW JURORS WITH
RELIGIOUS OBJECTION TO DEATH PENALTY.....188

COURT'S RULING DENYING MOTION 188

RENEWED MOTION TO STRIKE JURORS
AS THEY ARE QUALIFIED 188

COURT'S RULING DENYING MOTION 189

RENEWED AMENDED MOTION TO INSTRUCT JURORS ON
NOT GUILTY BY REASON OF INSANITY PRIOR TO
INDIVIDUAL VOIR DIRE.....194

COURT DEFERS RULING.....202

RENEWED MOTION TO INFORM JURY OF THE CONSEQUENCES
OF A NOT GUILTY BY REASON OF INSANITY VERDICT 210

COURT'S RULING DENYING RENEWED MOTION.....227

MOTION TO EXCLUDE EVIDENCE BASED ON LATE
DISCLOSURE AND/OR TO GRANT A CONTINUANCE.....229

COURT'S RULING DENYING MOTION
WITH LEAVE TO REVISIT 231

April 30, 2019

QUALIFYING OF JURORS INDIVIDUALLY

ROBERT CODY (JUROR #97)
Examination by the Court 263
Direct Examination by Mr. Young 282
Juror Disqualified by the Court.....283

KENNETH HALL (JUROR #174)
Examination by the Court 285
Direct Examination by Mr. Young 296
Cross-examination by Mr. Hubbard 352
Re-direct Examination by Mr. Young 359
Juror Qualified by the Court over Defense Objection 368

May 1, 2019

QUALIFYING OF JURORS INDIVIDUALLY (CONTINUED)

PAUL LONG (JUROR #256)
Examination by the Court 370
Juror Disqualified by the Court....383

GARRETT JOHNSON (JUROR #221)
Examination by the Court 383
Direct Examination by Mr. McGuire....396
Cross-examination by Mr. Hubbard 431
Juror Qualified by the Court over Defense Objection 440

RENEWED MOTION FOR A CHANGE OF VENUE 447

COURT'S RULING DENYING MOTION 448

QUALIFYING OF JURORS INDIVIDUALLY (CONTINUED)

THOMAS LANGDALE (JUROR #240)
Examination by the Court 448
Juror Disqualified by the Court....458

JACOB WHITTEN (JUROR #473)
Examination by the Court 459
Direct Examination by Mr. Young 476
Cross-examination by Mr. Hubbard 490
Re-direct Examination by Mr. Young 493
Juror Qualified by the Court 494

SARAH FUCCI (JUROR #150)
Examination by the Court 497
Juror Disqualified by the Court....500

VOLUME II

CONTINUED - TRANSCRIPT OF TRIAL HELD APRIL 29 – JUNE 13, 2019 501

QUALIFYING OF JURORS INDIVIDUALLY (CONTINUED)

JAMES PRESCOTT (JUROR #339)
Examination by the Court 501
Direct Examination by Mr. McGuire 521
Cross-examination by Ms. Mayes 533
Juror Qualified by the Court 535

MARTHA EDWARDS (JUROR #135)
Examination by the Court 549
Juror Disqualified by the Court 562

KANDY THIVIERGE (JUROR #432)
Examination by the Court 563
Juror Disqualified by the Court 574

ARTHUR CHAVIS (JUROR #91)
Examination by the Court 575
Direct Examination by Mr. Young 592
Cross-examination by Mr. Graham 602
Juror Qualified by the Court 604

SARA RUSSO (JUROR #368)
Examination by the Court 605
Juror Disqualified by the Court 617

May 2, 2019

QUALIFYING OF JURORS INDIVIDUALLY (CONTINUED)

KRISTIANA MCGILL (JUROR #24)
Examination by the Court 618
Direct Examination by Mr. Young 636
Cross-examination by Mr. Graham 653
Juror Disqualified by the Court 658

RENEWED MOTION TO INFORM JURY OF THE CONSEQUENCES
OF A NOT GUILTY BY REASON OF INSANITY VERDICT 663

COURT'S RULING DENYING MOTION 664

QUALIFYING OF JURORS INDIVIDUALLY (CONTINUED)

PAUL JENNINGS (JUROR #219)
Examination by the Court 675
Direct Examination by Mr. McGuire 689
Cross-examination by Mr. Hubbard 693
Juror Qualified by the Court 698

TAMIKA SUMMERS (JUROR #421)
Examination by the Court 708
Juror Disqualified by the Court 717

KEITH SHIREY (JUROR #393)
Examination by the Court 717
Juror Disqualified by the Court 719

RENEWED MOTION FOR A CHANGE OF VENUE 723

COURT'S RULING DENYING MOTION 723

QUALIFYING OF JURORS INDIVIDUALLY (CONTINUED)

PHILLIP SMITH (JUROR #405)
Examination by the Court 731
Juror Disqualified by the Court 733

CONRAD GORE (JUROR #166)
Examination by the Court 733
Direct Examination by Mr. Secor 742
Cross-examination by Ms. Mayes 753
Juror Qualified by the Court 754

DANIEL HALL (JUROR #172)
Examination by the Court 760
Juror Disqualified by the Court 761

LAURA NIELSON (JUROR #312)
Examination by the Court 762
Juror Disqualified by the Court 764

KELLY STONE (JUROR #416)
Examination by the Court 766
Juror Disqualified by the Court 781

SARAH MCNEAL (JUROR #283)
Examination by the Court 781
Juror Disqualified by the Court 785

TIFFANY KENT (JUROR #231)
Examination by the Court 785
Direct Examination by Mr. Young 795
Cross-examination by Mr. Graham 805
Juror Qualified by the Court 808

JESSICA MILLER (JUROR #283)
Examination by the Court 809
Direct Examination by Mr. McGuire 818
Cross-examination by Ms. Mayes 826
Juror Qualified by the Court 828

May 3, 2019

QUALIFYING OF JURORS INDIVIDUALLY (CONTINUED)

AMY GIRARDEAU (JUROR #162)
Examination by the Court 854
Direct Examination by Mr. Young 862
Cross-examination by Ms. Mayes 871
Juror Qualified by the Court over Defense Objection 875

DAVID MURPHY (JUROR #302)
Examination by the Court 876
Direct Examination by Mr. McGuire 885
Cross-examination by Mr. Graham 894
Juror Qualified by the Court over Defense Objection 907

NATHANAEL BROWN (JUROR #59)
Examination by the Court 909
Juror Disqualified by the Court 913

DAVID CONNELLY (JUROR #101)
Examination by the Court 914
Juror Disqualified by the Court 916

HOPE DERRICK (JUROR #125)
Examination by the Court 916
Juror Disqualified by the Court 918

DESIREE JORDAN (JUROR #226)
Examination by the Court 919
Direct Examination by Mr. Secor 928
Cross-examination by Mr. Hubbard 935
Juror Qualified by the Court 939

JEFFREY GRIFFITH (JUROR #169)
Examination by the Court 941
Juror Disqualified by the Court....946

SCOTT SPIGENER (JUROR #411)
Examination by the Court 952
Direct Examination by Mr. Secor 962
Cross-examination by Ms. Mayes....975
Juror Qualified by the Court 976

TONYA HARMON (JUROR #179)
Examination by the Court 977
Direct Examination by Mr. McGuire....985
Cross-examination by Mr. Hubbard 992
Juror Qualified by the Court 995

ANDREW LEWIS (JUROR #247)
Examination by the Court 997

VOLUME III

CONTINUED - TRANSCRIPT OF TRIAL HELD APRIL 29 – JUNE 13, 2019 1001

QUALIFYING OF JURORS INDIVIDUALLY (CONTINUED)

ANDREW LEWIS (JUROR #247) (CONTINUED)
Direct Examination by Mr. Secor 1005
Cross-examination by Mr. Graham....1018
Juror Qualified by the Court 1027

JOE MEDLOCK (JUROR #286)
Examination by the Court 1028
Court Disqualified by the Court....1035

CARMEN LUCAS (JUROR #260)
Examination by the Court 1036
Juror Disqualified by the Court....1038

FRANKLIN NELSON (JUROR #306)
Examination by the Court 1038
Juror Disqualified by the Court 1041

JEREMY MASON (JUROR #272)
Examination by the Court 1041
Direct Examination by Mr. Young 1049
Cross-examination by Ms. Mayes 1056
Juror Qualified by the Court 1059

May 6, 2019

QUALIFYING OF JURORS INDIVIDUALLY (CONTINUED)

KELLY TOMLINSON (JUROR #438)
Examination by the Court 1065
Juror Disqualified by the Court 1070

DINAH WASHINGTON (JUROR #457)
Examination by the Court 1070
Direct Examination by Mr. Young 1079
Cross-examination by Mr. Hubbard 1086
Juror Qualified by the Court 1094

PHILIP TURNER (JUROR #444)
Examination by the Court 1101
Direct Examination by Mr. Secor 1110
Cross-examination by Mr. Graham 1118
Juror Qualified by the Court 1120

ANH PHAM (JUROR #329)
Examination by the Court 1121
Direct Examination by Mr. Young 1130
Cross-examination by Ms. Mayes 1140
Juror Qualified by the Court 1142

CHRISTOPHER WILDE (JUROR #476)
Examination by the Court 1143
Juror Disqualified by the Court 1146

GEOFFREY SHACKLEY (JUROR #383)
Examination by the Court 1146
Juror Disqualified by the Court 1148

RYAN HATCHER (JUROR #183)
Examination by the Court 1152
Juror Disqualified by the Court 1154

CAROLYN MAYERS (JUROR #275)
Examination by the Court 1155
Juror Disqualified by the Court 1159

AVERY RENWICK (JUROR #348)
Examination by the Court 1164

KRISTIN ASHBURN (JUROR #17)
Examination by the Court 1168
Juror Disqualified by the Court 1179

AVERY RENWICK (JUROR #348) (CONTINUED)
Re-examination by the Court 1179
Juror Disqualified by the Court 1181

TRACY WEHR (JUROR #464)
Examination by the Court 1182
Direct Examination by Mr. Secor 1189
Cross-examination by Ms. Mayes 1197
Re-direct Examination by Mr. Secor 1200
Juror Qualified by the Court 1201

ELIZABETH DURHAM (JUROR #129)
Examination by the Court 1202
Juror Disqualified by the Court 1204

LAWRYN HENDERSON (JUROR #186)
Examination by the Court 1205
Juror Disqualified by the Court 1209

PETER KLEEMOFF (JUROR #237)
Examination by the Court 1210
Juror Disqualified by the Court 1212

TERRIE HANLEY (JUROR #177)
Examination by the Court 1212
Direct Examination by Mr. Madsen 1220
Cross-examination by Ms. Mayes 1231
Juror Qualified by the Court 1233

RACHNA PRASAD (JUROR #338)
Examination by the Court 1235
Direct Examination by Mr. McGuire 1244

RENEWED MOTION TO INFORM JURY OF THE CONSEQUENCES OF A NOT GUILTY BY REASON OF INSANITY VERDICT 1270

QUALIFYING OF JURORS INDIVIDUALLY (CONTINUED)

RACHNA PRASAD (JUROR #338) CONTINUED
Re-examination by the Court 1274
Juror Disqualified by the Court over Defense Objection 1274

SHARON LINDLER (JUROR #249)
Examination by the Court 1280
Direct Examination by Mr. Secor 1288
Cross-examination by Ms. Mayes 1298
Juror Qualified by the Court 1302

JEFFREY LONG (JUROR #254)
Examination by the Court 1309
Direct Examination by Mr. Young 1317
Cross-examination by Mr. Hubbard 1329
Re-direct Examination by Mr. Young 1331
Juror Qualified by the Court over Defense Objection 1334

EMILY ATKINS (JUROR #19)
Examination by the Court 1336
Direct Examination by Mr. McGuire 1346
Cross-examination by Mr. Hubbard 1348
Re-direct Examination by Mr. McGuire 1350
Juror Disqualified by the Court over Defense Objection 1357

TOSHIA ADDISON (JUROR #241)
Examination by the Court 1359
Direct Examination by Mr. Madsen 1366
Cross-examination by Mr. Graham 1379
Juror Qualified by the Court 1380

EDGARDO ALVIRA (JUROR #10)
Examination by the Court 1382
Direct Examination by Mr. Secor 1398
Direct Examination by Mr. Hubbard 1402
Cross-Examination by Mr. Secor 1408
Re-direct Examination by Mr. Hubbard 1412
Juror Qualified by the Court over State's Objection 1417

JOHNNY ROWELL (JUROR #363)
Examination by the Court 1417
Juror Disqualified by the Court....1419

GAIL MASSARO (JUROR #273)
Examination by the Court 1419
Juror Disqualified by the Court....1423

ANTONIO WRIGHT (JUROR #496)
Examination by the Court 1423
Juror Disqualified by the Court....1426

May 7, 2019

MOTION FOR STATE TO EXAMINE
JURORS FIRST ON NEXT PANEL 1433

COURT'S RULING GRANTING MOTION 1434

QUALIFYING OF JURORS INDIVIDUALLY (CONTINUED)

SYLVIA CANNON (JUROR #74)
Examination by the Court 1434
Juror Disqualified by the Court....1438

STACEY FOSTER (JUROR #146)
Examination by the Court 1439
Direct Examination by Mr. Hubbard 1451
Cross-examination by Mr. Young....1464
Juror Qualified by the Court 1477

LASHAREE MELVIN-JONES (JUROR #287)
Examination by the Court 1479
Juror Disqualified by the Court....1481

JUDY NIXON (JUROR #314)
Examination by the Court 1482
Direct Examination by Mr. Hubbard 1489
Cross-examination by Mr. Secor 1494

VOLUME IV

CONTINUED - TRANSCRIPT OF TRIAL HELD APRIL 29 – JUNE 13, 2019 1501

QUALIFYING OF JURORS INDIVIDUALLY (CONTINUED)

JUDY NIXON (JUROR #314) (CONTINUED)
Juror Qualified by the Court 1501

TONI CLARK (JUROR #96)
Examination by the Court 1503
Direct Examination by Ms. Mayes 1512
Cross-examination by Mr. Madsen 1518
Juror Qualified by the Court 1523

NATHAN CHAPMAN (JUROR #89)
Examination by the Court 1524
Direct Examination by Mr. Graham 1534
Cross-examination by Mr. McGuire 1539
Re-direct Examination by Mr. Graham 1550
Juror Disqualified by the Court....1555

DORIS TAYLOR (JUROR #426)
Examination by the Court 1565
Juror Disqualified by the Court....1567

ZACHARY GANTT (JUROR #156)
Examination by the Court 1567
Direct Examination by Mr. Hubbard 1576
Cross-examination by Mr. Young....1581
Re-direct Examination by Mr. Hubbard 1590
Juror Qualified by the Court over Defense Objection 1595

BARBARA HOWELL-STEVENSON (JUROR #199)
Examination by the Court 1602
Direct Examination by Mr. Young 1612
Juror Disqualified by the Court....1621

RICHARD GENTLE (JUROR #159)
Examination by the Court 1621
Direct Examination by Mr. Secor 1628
Cross-examination by Ms. Mayes....1636
Re-direct Examination by Mr. Secor 1640
Re-cross Examination by Ms. Mayes 1642
Juror Qualified by the Court over Defense Objection 1646

TONYA SASSER (JUROR #372)
Examination by the Court 1647
Juror Disqualified by the Court....1649

TODD BUEHRIG (JUROR #62)
Examination by the Court 1649
Direct Examination by Mr. Madsen 1659
Cross-examination by Mr. Graham 1669
Juror Qualified by the Court over Defense Objection 1674

AMY WRIGHT (JUROR #495)
Examination by the Court 1675
Direct Examination by Mr. McGuire 1682
Cross-examination by Ms. Mayes 1689
Juror Qualified by the Court 1694

ROBIN EHRLICH (JUROR #136)
Examination by the Court 1695
Direct Examination by Mr. Young 1705
Cross-examination by Mr. Graham 1712
Juror Qualified by the Court 1715

LADONNA LEE (JUROR #244)
Examination by the Court 1718
Direct Examination by Mr. Madsen 1729
Cross-examination by Mr. Graham 1741
Juror Qualified by the Court 1744

ELIZABETH BROWN (JUROR #56)
Examination by the Court 1749
Direct Examination by Ms. Kuchar 1757
Cross Examination by Ms. Mayes 1765
Juror Qualified by the Court 1766

LAURIE LONG (JUROR #255)
Examination by the Court 1773
Juror Disqualified by the Court 1777

DEBORA CARTER (JUROR #77)
Examination by the Court 1777
Juror Disqualified by the Court 1780

PATRICIA TEAL (JUROR #430)
Examination by the Court 1780
Juror Disqualified by the Court 1783

PATRICIA FOWLER (JUROR #147)
Examination by the Court 1784
Juror Disqualified by the Court 1788

TAMEKA MERRITT (JUROR #288)
Examination by the Court 1788
Juror Disqualified by the Court....1790

ANDREW KIRKWOOD (JUROR #236)
Examination by the Court 1790
Direct Examination by Mr. Young 1802
Juror Disqualified by the Court....1807

May 8, 2019

QUALIFYING OF JURORS INDIVIDUALLY (CONTINUED)

JEREMY DAVIS (JUROR #117)
Examination by the Court 1811
Juror Disqualified by the Court....1814

SHANNA NELSON (JUROR #308)
Examination by the Court 1814
Direct Examination by Mr. Young 1826
Cross-examination by Ms. Mayes....1840
Re-direct Examination by Mr. Young 1845
Juror Qualified by the Court over Defense Objection 1848

AMY SIMPSON (JUROR #396)
Examination by the Court 1853
Direct Examination by Mr. McGuire....1863
Juror Disqualified by the Court....1882

JONATHAN JACKSON (JUROR #210)
Examination by the Court 1885
Juror Disqualified by the Court....1890

SCOTT JOHNSON (JUROR #222)
Examination by the Court 1890
Direct Examination by Mr. Madsen....1898
Cross-examination by Mr. Graham....1906
Juror Qualified by the Court 1908

KAREN PEREZ (JUROR #326)
Examination by the Court 1909

RENEWED MOTION FOR A CHANGE OF VENUE 1919

COURT'S RULING DENYING MOTION 1920

QUALIFYING OF JURORS INDIVIDUALLY (CONTINUED)

KAREN PEREZ (JUROR #326) (CONTINUED)
Direct Examination by Mr. Young 1921
Juror Disqualified by the Court.....1927

JASON SMITH (JUROR #402)
Examination by the Court 1928
Direct Examination by Mr. Young 1938
Cross-examination by Ms. Mayes.....1948
Juror Qualified by the Court 1949

LASHONDA ROBERTS (JUROR #355)
Examination by the Court 1951
Juror Disqualified by the Court.....1954

KAYLA BURGESS (JUROR #65)
Examination by the Court 1955
Juror Disqualified by the Court.....1957

DONNIE BLACKMON (JUROR #39)
Examination by the Court 1962
Direct Examination by Mr. McGuire.....1971
Cross-examination by Mr. Hubbard 1983
Juror Qualified by the Court 1985

DAWN APPLEGATE (JUROR #14)
Examination by the Court 1986
Direct Examination by Mr. Madsen.....1997

VOLUME V

CONTINUED - TRANSCRIPT OF TRIAL HELD APRIL 29 – JUNE 13, 2019 2001

QUALIFYING OF JURORS INDIVIDUALLY (CONTINUED)

DAWN APPLEGATE (JUROR #14) (CONTINUED)
Cross-examination by Mr. Graham.....2006
Juror Qualified by the Court 2010

ROGER SANDY (JUROR #370)
Examination by the Court 2012
Direct Examination by Mr. Young 2021
Cross-examination by Ms. Mayes.....2029
Juror Qualified by the Court over Defense Objection 2033

REBA WILLIAMS (JUROR #41)
Examination by the Court 2035
Direct Examination by Mr. McGuire 2044
Cross-examination by Mr. Hubbard 2051
Juror Qualified by the Court 2053

AMY BOOZER (JUROR #44)
Examination by the Court 2055
Juror Disqualified by the Court 2057

TINA PENN (JUROR #325)
Examination by the Court 2057
Juror Disqualified by the Court 2059

ROBERT TATE (#425)
Examination by the Court 2059
Juror Disqualified by the Court 2061

JOSEPH STRACZEK (JUROR #417)
Examination by the Court 2062
Juror Disqualified by the Court 2065

TRAVIS ROSS (JUROR #361)
Examination by the Court 2070
Juror Disqualified by the Court 2073

WILLIAM CUNNINGHAM (JUROR #109)
Examination by the Court 2074
Direct Examination by Mr. McGuire 2085
Cross-examination by Mr. Hubbard 2095
Juror Qualified by the Court over Defense Objection 2100

RICHARD SHINN (JUROR #392)
Examination by the Court 2101
Juror Disqualified by the Court 2104

MATTHEW HASLINGER (JUROR #181)
Examination by the Court 2104
Juror Disqualified by the Court 2106

BRIAN PUGH (JUROR #343)
Examination by the Court 2107
Juror Disqualified by the Court 2109

WENDY ALLISON (JUROR #8)
Examination by the Court 2109
Direct Examination by Mr. Madsen 2120
Cross-examination by Mr. Graham 2128
Juror Disqualified by the Court 2134

LINDA SMITH (JUROR #403)
Examination by the Court 2134
Direct Examination by Mr. Young 2142
Cross-examination by Ms. Mayes 2151
Juror Qualified by the Court 2154

May 9, 2019

QUALIFYING OF JURORS INDIVIDUALLY (CONTINUED)

KIMBERLY HUGHES (JUROR #200)
Examination by the Court 2159
Juror Disqualified by the Court 2162

CHRISTOPHER ROCKER (JUROR #357)
Examination by the Court 2162
Direct Examination by Mr. Young 2171
Cross-examination by Mr. Hubbard 2181
Juror Disqualified by the Court 2186

JOSEPH NEELEY (JUROR #305)
Examination by the Court 2186
Juror Disqualified by the Court 2188

SUSAN WATSON (JUROR #461)
Examination by the Court 2188
Juror Disqualified by the Court 2191

TIMOTHY BELAY (JUROR #34)
Examination by the Court 2191
Direct Examination by Mr. Madsen 2199
Cross-examination by Mr. Hubbard 2208
Juror Qualified by the Court 2211

TODD BEDENBAUGH (JUROR #32)
Examination by the Court 2212
Direct Examination by Mr. McGuire 2222
Cross-examination by Mr. Hubbard 2232
Re-examination by the Court 2236
Re-direct Examination by Mr. McGuire 2237
Juror Qualified by the Court 2237

ROGERS CHAMBERS (JUROR #86)
Examination by the Court 2238
Juror Disqualified by the Court 2243

TERESA MACFAWN (JUROR #264)
Examination by the Court 2247
Direct Examination by Mr. Young 2257
Cross-examination by Mr. Graham 2266
Juror Qualified by the Court 2269

THOMAS LEE (JUROR #245)
Examination by the Court 2270
Direct Examination by Mr. McGuire 2280
Cross-examination by Ms. Mayes 2288
Juror Qualified by the Court over Defense Objection 2292

TAYLOR MEDLIN (JUROR #285)
Examination by the Court 2293
Direct Examination by Mr. Madsen 2302
Cross-examination by Mr. Graham 2310
Juror Qualified by the Court over Defense Objection 2316

VICTORIA SCHNEIDER (JUROR #377)
Examination by the Court 2319
Juror Disqualified by the Court 2324

ASHLEY RUSSELL (JUROR #366)
Examination by the Court 2325
Juror Disqualified by the Court 2326

CANDY WHISENANT (JUROR #469)
Examination by the Court 2326
Direct Examination by Mr. Young 2335
Cross-examination by Ms. Mayes 2344
Re-direct Examination by Mr. Young 2348
Juror Qualified by the Court 2349

LAGUADIA CAUGHMAN (JUROR #83)
Examination by the Court 2351
Juror Disqualified by the Court....2355

BRYAN FERREIRA (JUROR #143)
Examination by the Court 2355
Juror Disqualified by the Court....2358

May 13, 2019

RENEWED MOTION FOR A CHANGE OF VENUE 2363

COURT'S RULING DENYING MOTION 2363

MOTION FOR COURT TO RULE JURORS
#10 AND #226 NOT QUALIFIED 2365

MOTION FOR JUROR #444 TO BE STRUCK FOR
NOT TRUTHFULLY ANSWERING JURY QUESTIONNAIRE 2370

MOTION FOR COURT TO REVIEW RULINGS ON JUROR #174,
JUROR #221, JUROR #302, AND JUROR #411 2374

COURT'S RULING DISQUALIFYING
JUROR #10 AND JUROR #444 ONLY 2382

JURY SELECTION 2384

MOTION FOR DISQUALIFICATION
FOR CAUSE OF JUROR #156, ZACHARY GANTT 2389

COURT'S RULING DENYING MOTION 2389

JURY SELECTION CONTINUED 2389

DEFENSE BATSON CHALLENGE TO JURY SELECTION 2392

COURT'S RULING DENYING MOTION TO RESTRIKE
THE JURY BASED UPON A BATSON VIOLATION 2398

RENEWED MOTION FOR A CHANGE OF VENUE 2399

COURT'S RULING DENYING MOTION 2399

MOTION TO REQUIRE SPECIFICITY OF "OTHER BAD ACTS" EVIDENCE IN RESPONSE TO STATE'S MOTION TO ADMIT SUCH EVIDENCE 2408

DISCUSSION AND OBJECTION TO A JURY INSTRUCTION ON NOT CONSIDERING THE CONSEQUENCES OF A VERDICT AND REFUSAL TO CHARGE THE STATUTE 2419

MOTION TO SUPPRESS DEFENDANT'S STATEMENTS TO MISSISSIPPI INVESTIGATORS 2424

COURT'S RULING DENYING MOTION 2426

MOTION TO EXCLUDE DEFENDANT'S STATEMENT TO MISSISSIPPI INVESTIGATORS REFERENCING "GARBAGE" 2427

COURT'S RULING DENYING MOTION 2430

MOTION TO EXCLUDE DEFENDANT'S STATEMENTS TO MISSISSIPPI INVESTIGATORS AS AN INADMISSABLE OPINION ON A LEGAL ISSUE 2430

COURT'S RULING DENYING MOTION IN PART 2433

MOTION TO EXCLUDE STATEMENT FROM DEFENDANT'S INTERVIEW WITH MISSISSIPPI INVESTIGATORS AS AN INADMISSABLE OPINION ON THE ULTIMATE ISSUE 2434

COURT'S RULING DENYING MOTION 2435

MOTION TO EXCLUDE STATEMENT FROM DEFENDANT'S INTERVIEW WITH MISSISSIPPI INVESTIGATORS AS AN IRRELEVANT LAY OPINION 2435

COURT'S RULING DENYING MOTION 2436

MOTION TO EXCLUDE DEFENDANT'S STATEMENT TO MISSISSIPPI INVESTIGATORS REGARDING CAR ODOR 2436

COURT'S RULING DENYING MOTION 2439

STATE'S MOTION FOR A BLAIR HEARING 2452

COURT DEFERS RULING 2453

May 14, 2019

TESTIMONY VIDEOTAPED (OUT OF THE PRESENCE OF
THE JURY FOR LATER PRESENTATION TO THE JURY)

DR. TRAVIS SNYDER
Direct Examination by Mr. Young 2454
Voir Dire Examination by Mr. Graham.....2461
Continued Direct Examination by Mr. Young.....2463
Cross-examination by Mr. Graham.....2483

VOLUME VI

CONTINUED - TRANSCRIPT OF TRIAL HELD APRIL 29 – JUNE 13, 2019 2501

TESTIMONY VIDEOTAPED (OUT OF THE PRESENCE OF
THE JURY FOR LATER PRESENTATION TO THE JURY CONTINUED)

DR. TRAVIS SNYDER
Re-direct Examination by Mr. Young 2507

TESTIMONY (IN CAMERA)

DR. TRAVIS SNYDER
Examination by Mr. Young 2512

TESTIMONY (FOR LATER VIEWING ON
VIDEOTAPE IN THE PRESENCE OF THE JURY)

DR. TRAVIS SNYDER
Re-direct Examination by Mr. Young (Continued) 2514

PROFFERED TESTIMONY REGARDING THE
SUFFICIENCY OF THE SEARCH WARRANT
AFFIDAVIT FOR CELL PHONE

LT. JESSIE LAINTZ (IN CAMERA)
Direct Examination by Ms. Mayes 2519

ARGUMENT BY MR. SECOR 2526

ARGUMENT BY MS. MAYES.....2529

REPLY ARGUMENT BY MR. SECOR.....2529

COURT'S RULING THAT AFFIDAVIT IS SUFFICIENT
AND DENYING MOTION TO SUPPRESS 2542

RENEWED MOTION TO INFORM JURY OF THE CONSEQUENCES
OF A NOT GUILTY BY REASON OF INSANITY VERDICT 2547

COURT'S RULING DENYING MOTION 2547

GUILT PHASE OF TRIAL

OPENING STATEMENT BY MR. GRAHAM....2556

OPENING STATEMENT BY MR. MADSEN....2563

MOTION FOR A MISTRIAL 2573

COURT'S RULING DENYING MOTION 2573

May 15, 2019

TESTIMONY

JAN WISE
Direct Examination by Ms. Mayes 2576
Cross-examination by Mr. Madsen....2588
Re-direct Examination by Ms. Mayes 2590

JANET RICARD
Direct Examination by Ms. Mayes 2591
Cross-examination by Mr. Madsen....2603
Re-direct Examination by Ms. Mayes 2611
Re-cross Examination by Mr. Madsen....2615

JIM MCCONNELL
Direct Examination by Mr. Hubbard 2618
Cross-examination by Mr. Secor 2648
Re-direct Examination by Mr. Hubbard 2656

CHRISTINA EHLKE
Direct Examination by Ms. Mayes 2658
Cross-examination by Mr. Young....2685
Re-direct Examination by Ms. Mayes 2700
Re-cross Examination by Mr. Young 2705

LIEUTENANT JESSE LAINTZ
Direct Examination by Mr. Graham 2708
Cross-examination by Mr. Madsen.....2712
Re-direct Examination by Mr. Graham 2721
Re-cross Examination by Mr. Madsen.....2722

LINDA WATKINS
Direct Examination by Mr. Hubbard 2723

CHARLES JOHNSON
Direct Examination by Ms. Mayes 2739
Cross-examination by Mr. Madsen.....2758
Re-direct Examination by Mr. Mayes.....2760

JAMIE MCCLELLAN
Direct Examination by Mr. Graham 2761
Cross-examination by Mr. Young.....2771

MARTY PATTERSON
Direct Examination by Mr. Hubbard 2778
Cross-examination by Mr. Secor 2803
Re-direct Examination by Mr. Hubbard 2827
Re-cross Examination by Mr. Secor 2831

May 16, 2019

TESTIMONY CONTINUED

STACY JONES
Direct Examination by Mr. Graham 2835
Cross-examination by Mr. Madsen.....2888
Re-direct Examination by Mr. Graham 2914

ERIC JOHNSON
Direct Examination by Mr. Graham 2918
Cross-examination by Mr. Young.....2956

DISCUSSION OF THE AWARENESS OF
THE WITNESS OF WHETHER THE DEFENDANT
INVOKED HIS RIGHT TO COUNSEL.....2973

PROFFERED TESTIMONY

ERIC JOHNSON (IN CAMERA)
Cross-examination by Mr. Young.....2978

COURT'S RULING ALLOWING QUESTIONS FROM
THE STATE ABOUT OBTAINING A SEARCH WARRANT 2980

TESTIMONY CONTINUED (IN THE PRESENCE OF THE JURY)

ERIC JOHNSON (CONTINUED)
Cross-examination by Mr. Young (Continued) 2982
Re-direct Examination by Mr. Graham 2982

May 17, 2019

TESTIMONY CONTINUED

CHARLIE CRUMPTON
Direct Examination by Mr. Hubbard 2986

VOLUME VII

CONTINUED - TRANSCRIPT OF TRIAL HELD APRIL 29 – JUNE 13, 2019 3001

TESTIMONY CONTINUED

CHARLIE CRUMPTON (CONTINUED)
Cross-examination by Mr. Secor 3009

DISCUSSION OF THE DEFENSE'S POSITION THAT THE
STATE HAS OPENED THE DOOR TO QUESTIONING
THE VOLUNTARINESS OF THE DEFENDANT'S STATEMENTS 3010

COURT'S RULING THAT ITS PRIOR RULING CONTROLS.....3014

PROFFERED TESTIMONY

CHARLIE CRUMPTON (IN CAMERA)
Cross-examination by Mr. Secor 3017

TESTIMONY CONTINUED (IN THE PRESENCE OF THE JURY)

CHARLIE CRUMPTON (CONTINUED)
Cross-examination by Mr. Secor (Continued) 3021
Re-direct Examination by Mr. Hubbard 3031

KEITH MCMAHAN
Direct Examination by Mr. Graham 3032
Cross-examination by Mr. Madsen.....3040
Re-direct Examination by Mr. Graham 3041

STIPULATION REGARDING BLOOD SAMPLE,
STATE'S EXHIBIT #70.....3041

TESTIMONY CONTINUED (IN THE PRESENCE OF THE JURY)

DUSTIN SMITH
Direct Examination by Ms. Mayes 3042
Cross-examination by Mr. Madsen.....3054
Re-direct Examination by Ms. Mayes 3061

KENNAN FREDERICK
Direct Examination by Ms. Mayes 3065
Cross-examination by Mr. Madsen.....3078

DENISE ATKINSON
Direct Examination by Ms. Mayes 3079
Cross-examination by Mr. Madsen.....3087

MARTY LONGSHORE
Direct Examination by Ms. Mayes 3088

PROFFERED TESTIMONY

DAVID MACKEY (IN CAMERA)
Direct Examination by Mr. Young 3092

TESTIMONY CONTINUED (IN THE PRESENCE OF THE JURY)

DAVID MACKEY
Direct Examination by Mr. Hubbard 3094
Cross-examination by Mr. Young.....3131
Re-direct Examination by Mr. Hubbard 3144

BRITTANY PICKLE
Direct Examination by Mr. Graham 3146

MOTION *IN LIMINE* TO EXCLUDE
CERTAIN CRIME SCENE PHOTOGRAPHS.....3163

COURT DEFERS RULING ON MOTION *IN LIMINE*
BECAUSE OF UNCERTAINTY OF THE PHOTOGRAPHS
SOUGHT TO BE ADMITTED.....3164

MOTION *IN LIMINE* TO LIMIT TESTIMONY
REGARDING CHILDREN'S STATE OF UNDRESS 3164

COURT DEFERS RULING ON PHOTOGRAPHS 3166

TESTIMONY CONTINUED

BRITTANY PICKLE (CONTINUED)
Direct Examination by Mr. Graham (Continued) 3168

May 20, 2019

TESTIMONY CONTINUED

STEPHANIE STANLEY
Direct Examination by Mr. Graham 3175

KAREN LEONHARDT
Direct Examination by Ms. Mayes 3185
Cross-examination by Mr. Madsen 3190

PROFFERED TESTIMONY

KAREN LEONHARDT (IN CAMERA)
Re-direct Examination by Ms. Mayes 3194

TESTIMONY CONTINUED (IN THE PRESENCE OF THE JURY)

KAREN LEONHARDT (CONTINUED)
Cross-examination by Mr. Madsen (Continued) 3194
Re-direct Examination by Ms. Mayes 3195
Re-cross Examination by Mr. Madsen.....3196

RULE 403 DISCUSSION OF STATE'S EXHIBIT #177 3199

ARGUMENT BY MR. HUBBARD.....3200

ARGUMENT BY MR. YOUNG.....3201

COURT'S RULING ALLOWING EXHIBIT.....3201

RULE 403 DISCUSSION OF AUTOPSY PHOTOGRAPHS.....3202

COURT'S RULING PROHIBITING ADMISSION OF
PHOTOGRAPHIC EVIDENCE WITH LEAVE TO REVISIT 3213

TESTIMONY CONTINUED

DR. JANICE ROSS
Direct Examination by Mr. Hubbard 3218
Cross-examination by Mr. Young....3245
Re-direct Examination by Mr. Hubbard 3255
Re-cross Examination by Mr. Young 3258
Re-direct Examination by Mr. Hubbard 3259

SHELBY DERRICK
Direct Examination by Mr. Graham 3263
Cross-examination by Mr. Young....3266

MOTION TO PROHIBIT THE STATE FROM MAKING POTENTIAL PCR ISSUE ARGUMENTS 3275

COURT'S RULING DENYING MOTION 3276

TESTIMONY CONTINUED

SHELBY DERRICK (CONTINUED)
Cross-examination by Mr. Young (Continued) 3276

CANDY KYZER
Direct Examination by Mr. Graham 3279
Cross-examination by Mr. Madsen....3284

BRITT DOVE
Direct Examination by Mr. Graham 3285
Cross-examination by Mr. Madsen....3292

AMBER KYZER
Direct Examination by Ms. Mayes 3294

MOTION FOR A MISTRIAL....3334

COURT'S RULING DENYING MOTION 3337

RENEWED MOTION FOR A MISTRIAL 3342

COURT'S RULING DENYING MOTION 3342

TESTIMONY CONTINUED

AMBER KYZER (CONTINUED)
Direct Examination by Ms. Mayes (Continued) 3342
Cross-examination by Mr. Young....3344
Re-direct Examination by Ms. Mayes 3351

HEATHER CLARY
Direct Examination by Mr. Graham 3352

May 21, 2019

TESTIMONY (OUT OF THE PRESENCE OF
THE JURY FOR LATER PRESENTATION TO THE JURY)

DR. JONATHAN LIPMAN
Direct Examination by Mr. Madsen....3363
Cross-examination by Ms. Mayes....3411
Re-direct Examination by Mr. Madsen....3446
Re-cross Examination by Ms. Mayes 3450

TESTIMONY (IN THE PRESENCE OF THE JURY)

CYNTHIA BOBE
Direct Examination by Mr. Graham 3455
Cross-examination by Mr. Young....3459

VICKIE ROBERTS
Direct Examination by Mr. Graham 3461

JACKSON V. DENNO HEARING (IN CAMERA)

TESTIMONY

TRAVIS PRESSLEY
Direct Examination by Mr. Hubbard 3464
Cross-examination by Mr. Young....3470

DEFENSE TESTIMONY

BENJAMIN BOYD
Direct Examination by Mr. Madsen....3476
Cross-examination by Mr. Hubbard 3481
Re-direct Examination by Mr. Madsen....3483

ARGUMENT BY MR. HUBBARD....3484

ARGUMENT BY MR. YOUNG....3484

COURT'S RULING THAT DEFENDANT'S STATEMENTS WERE VOLUNTARY....3485

TESTIMONY CONTINUED (IN THE PRESENCE OF THE JURY)

TRAVIS PRESSLEY
Direct Examination by Mr. Hubbard....3489
Cross-examination by Mr. Young....3496

VOLUME VIII

CONTINUED - TRANSCRIPT OF TRIAL HELD APRIL 29 – JUNE 13, 2019....3501

TESTIMONY CONTINUED

BENJAMIN BOYD
Direct Examination by Mr. Hubbard....3516
Cross-examination by Mr. Madsen....3520

ARGUMENTS ABOUT REDACTIONS TO STATE'S EXHIBITS #187 AND #198....3529

TESTIMONY CONTINUED

MIKE PHIPPS
Direct Examination by Mr. Graham....3536
Cross-examination by Mr. Young....3576
Re-direct Examination by Mr. Graham....3590

May 22, 2019

DISCUSSION OF REDACTIONS TO A "PACKET" OF CELL PHONE EXTRACTION EVIDENCE....3595

TESTIMONY CONTINUED

MIKE PHIPPS (CONTINUED)
Re-direct Examination by Mr. Graham (Continued)....3600
Re-cross Examination by Mr. Young....3609

THE STATE RESTS....3612

MOTION FOR A DIRECTED VERDICT....3612

ALL PREVIOUS MOTIONS RENEWED 3612

RENEWED MOTION FOR A MISTRIAL 3613

RENEWED MOTION FOR A CHANGE IN VENUE 3613

COURT'S RULINGS DENYING ALL MOTIONS 3613

DEFENSE CASE

PRESENTATION OF PRE-RECORDED
TESTIMONY OF DR. TRAVIS SNYDER 3619

PROFFERED TESTIMONY

ADAM CREECH (IN CAMERA)
Direct Examination by Mr. Madsen.....3623

DEFENSE TESTIMONY CONTINUED (IN THE PRESENCE OF THE JURY)

ADAM CREECH
Direct Examination by Mr. Madsen.....3628
Cross-examination by Mr. Hubbard 3699

PROFFERED TESTIMONY

ADAM CREECH (IN CAMERA)
Cross-examination by Mr. Hubbard 3702

DEFENSE TESTIMONY CONTINUED (IN THE PRESENCE OF THE JURY)

ADAM CREECH (CONTINUED)
Cross-examination by Mr. Hubbard (Continued) 3716

May 23, 2019

DEFENSE TESTIMONY CONTINUED

ADAM CREECH (CONTINUED)
Cross-examination by Mr. Hubbard (Continued) 3735
Re-direct Examination by Mr. Madsen.....3757
Re-cross Examination by Mr. Hubbard 3764

DR. BHUSHAN AGHARKAR
Direct Examination by Mr. Secor 3765
Cross-examination by Ms. Mayes.....3809

ERIC BRENTON SANDREAMELI
Direct Examination by Mr. Young 3838
Cross-examination by Mr. Hubbard 3849

MICAH SUTTON
Direct Examination by Mr. Secor 3850
Cross-examination by Mr. Hubbard 3863

DR. APRIL HAMES
Direct Examination by Mr. Young 3865
Cross-examination by Mr. Graham.....3894
Re-direct Examination by Mr. Young 3914
Re-cross Examination by Mr. Graham 3918

STATE'S MOTION TO EXCLUDE VIDEOTAPED
TESTIMONY OF CYNTHIA TURNER 3920

May 24, 2019

COURT'S RULING GRANTING STATE'S MOTION
TO EXCLUDE VIDEOTAPED TESTIMONY OF CYNTHIA TURNER.....3926

DEFENSE TESTIMONY CONTINUED

DR. ERIN BIGLER
Direct Examination by Mr. Young 3932
Cross-Examination by Mr. Hubbard.....3959
Re-direct Examination by Mr. Young 3971
Re-cross Examination by Mr. Hubbard 3975

PROFFERED TESTIMONY

ROBERTA THORNSBERRY (IN CAMERA)
Direct Examination by Mr. Secor 3978

ARGUMENTS ON PROPOSED LIMITATIONS
ON DEFENSE TESTIMONY 3991

VOLUME IX

CONTINUED - TRANSCRIPT OF TRIAL HELD APRIL 29 – JUNE 13, 2019 4001

COURT'S RULING LIMITING THE
TESTIMONY OF ROBERTA THORNSBERRY 4005

DEFENSE TESTIMONY CONTINUED (IN THE PRESENCE OF THE JURY)

ROBERTA THORNSBERRY
Direct Examination by Mr. Secor 4010
Cross-examination by Mr. Graham....4037
Re-direct Examination by Mr. Secor 4052

MOTION TO LEAD WITNESS UNDER RULE 611(C)....4055

COURT'S RULING GRANTING MOTION 4055

DEFENSE TESTIMONY CONTINUED

BRIAN TRAVIS
Direct Examination by Mr. Madsen....4055
Cross-examination by Mr. Graham....4067
Voir Dire Examination by Mr. Madsen 4069
Cross-examination by Mr. Graham (Continued) 4071

May 28, 2019

DEFENSE TESTIMONY CONTINUED

PRESENTATION OF PRE-RECORDED TESTIMONY
OF DR. JONATHAN LIPMAN 4101

STATE'S MOTION TO EXCLUDE TESTIMONY OF
CHILDREN'S COUNSELOR, KIMBERLY FENDER 4101

COURT DEFERS RULING....4104

DEFENSE TESTIMONY CONTINUED

SHERRY HENRY
Direct Examination by Mr. Madsen....4105
Cross-examination by Ms. Mayes....4127
Re-direct Examination by Mr. Madsen....4141
Re-cross Examination by Ms. Mayes 4144

PROFFERED TESTIMONY

KIMBERLY FENDER (IN CAMERA)
Direct Examination by Mr. Young 4150
Cross-examination by Ms. Mayes....4157

COURT'S RULING GRANTING STATE'S MOTION TO EXCLUDE TESTIMONY OF CHILDREN'S COUNSELOR, KIMBERLY FENDER EXCEPT FOR THE FACT SHE WAS A COUNSELOR 4159

DEFENSE TESTIMONY CONTINUED (IN THE PRESENCE OF THE JURY)

KIMBERLY FENDER
Direct Examination by Mr. Young 4163
Cross-examination by Ms. Mayes....4163

BRANTLEY BROKAW
Direct Examination by Mr. Secor 4164
Cross-examination by Mr. Graham....4179

BRICE MANKOWSKI
Direct Examination by Mr. Secor 4184
Cross-examination by Ms. Mayes....4192

TODD SCHELLING
Direct Examination by Mr. Secor 4199
Cross-examination by Ms. Mayes....4214
Re-direct Examination by Mr. Secor 4221
Re-cross Examination by Ms. Mayes 4222

JAIMEET ANEJA
Direct Examination by Mr. Secor 4223
Cross-examination by Mr. Hubbard 4229

May 29, 2019

DEFENSE TESTIMONY CONTINUED

JODIE DURNEY
Direct Examination by Mr. Madsen....4234
Cross-examination by Ms. Mayes....4244

RUBY DURNEY
Direct Examination by Mr. Madsen....4246
Cross-examination by Mr. Graham....4251

CHRYSTAL BALLENTINE
Direct Examination by Mr. Young 4254
Cross-examination by Ms. Mayes....4266
Re-direct Examination by Mr. Young 4277

SANDRA BLACK
Direct Examination by Mr. Young 4278
Cross-examination by Ms. Mayes....4281

JOY LORICK
Direct Examination by Mr. Young 4287
Cross-examination by Ms. Mayes....4309
Re-direct Examination by Mr. Young 4321
Re-cross Examination by Ms. Mayes 4323

CAROLYN WILLIFORD
Direct Examination by Mr. Secor 4325

PROFFERED TESTIMONY

CAROLYN WILLIFORD (IN CAMERA)
Direct Examination by Mr. Secor 4347

COURT'S RULING ALLOWING DEFENDANT'S EXHIBIT #262, BUT DENYING ADMISSION OF DEFENDANT'S EXHIBITS #263, #264, #265, #266....4352

DEFENSE TESTIMONY CONTINUED (IN THE PRESENCE OF THE JURY)

CAROLYN WILLIFORD (CONTINUED)
Direct Examination by Mr. Secor (Continued)....4353
Cross-examination by Ms. Mayes....4357
Re-direct Examination by Mr. Secor 4362

TIMOTHY JONES, SR.
Direct Examination by Mr. Secor 4363

PROFFERED TESTIMONY

TIMOTHY JONES, SR. (IN CAMERA)
Direct Examination by Mr. Secor 4415

DEFENSE TESTIMONY CONTINUED (IN THE PRESENCE OF THE JURY)

TIMOTHY JONES, SR. (CONTINUED)
Direct Examination by Mr. Secor (Continued)....4416
Cross-examination by Mr. Hubbard 4434

PROFFERED TESTIMONY

TIMOTHY JONES, SR. (IN CAMERA)
Re-direct Examination by Mr. Secor 4477

COURT'S RULING LIMITING TESTIMONY
OF TIMOTHY JONES, SR. 4488

May 30, 2019

MOTION TO ISSUE A LIMITING INSTRUCTION
PRIOR TO DR. FRIERSON'S TESTIMONY 4490

VOLUME X

CONTINUED - TRANSCRIPT OF TRIAL HELD APRIL 29 – JUNE 13, 2019 4501

COURT'S RULING GRANTING MOTION TO ISSUE
LIMITING INSTRUCTION IN PART, BUT DEFERING
FURTHER RULING 4505

STATE'S MOTION TO EXCLUDE
TESTIMONY OF BETHANY YEISER 4505

PROFFERED TESTIMONY

BETHANY YEISER (IN CAMERA)
Direct Examination by Mr. Madsen.....4513

COURT'S RULING GRANTING STATE'S MOTION TO
EXCLUDE TESTIMONY OF BETHANY YEISER.....4538

DEFENSE TESTIMONY CONTINUED (IN THE PRESENCE OF THE JURY)

DR. RICHARD FRIERSON
Direct Examination by Mr. Young 4544

LIMITING INSTRUCTION BY COURT.....4544

DEFENSE TESTIMONY CONTINUED (IN THE PRESENCE OF THE JURY)

DR. RICHARD FRIERSON (CONTINUED)
Direct Examination by Mr. Young (Continued) 4546

PROFFERED TESTIMONY

DR. RICHARD FRIERSON (IN CAMERA)
Direct Examination by Mr. Young 4602

MOTION FOR A MISTRIAL 4604

COURT'S RULING DENYING MOTION 4605

DEFENSE TESTIMONY CONTINUED (IN THE PRESENCE OF THE JURY)

DR. RICHARD FRIERSON (CONTINUED)
Cross-examination by Mr. Graham.....4605
Re-direct Examination by Mr. Young 4705

MOTION TO RECONSIDER RULING TO
EXCLUDE THE TESTIMONY OF BETHANY YEISER.....4710

COURT'S RULING DENYING RENEWED MOTION.....4711

May 31, 2019

DEFENSE TESTIMONY CONTINUED (IN THE PRESENCE OF THE JURY)

DR. BEVERLY WOOD
Direct Examination by Mr. Young 4715
Cross-examination by Ms. Mayes.....4733
Re-direct Examination by Mr. Young 4753

DR. JULIE DORNEY
Direct Examination by Mr. Young 4755

PROFFERED TESTIMONY

DR. JULIE DORNEY (IN CAMERA)
Direct Examination by Mr. Young 4765
Cross-examination by Mr. Graham.....4766
Re-direct Examination by Mr. Young 4770

DEFENSE TESTIMONY CONTINUED (IN THE PRESENCE OF THE JURY)

DR. JULIE DORNEY (CONTINUED)
Direct Examination by Mr. Young (Continued).....4773
Cross-examination by Mr. Graham.....4809
Re-direct Examination by Mr. Young 4888

THE DEFENSE RESTS 4894

COLLOQUY WITH DEFENDANT ON HIS RIGHT TO TESTIFY 4896

MOTION FOR A MISTRIAL ON DRUG USAGE.....4899

COURT'S RULING DENYING MOTION 4899

RENEWED MOTION FOR A DIRECTED VERDICT, RENEWED MOTION FOR A MISTRIAL, RENEWED MOTION FOR A CHANGE OF VENUE, RENEWED MOTION FOR SUPPRESSION OF ALL ROADBLOCK EVIDENCE, AND ALL OTHER PREVIOUS MOTIONS 4900

COURT'S RULINGS DENYING MOTIONS.....4901

June 3, 2019

REPLY TESTIMONY

DR. KIMBERLY KRUSE
Direct Examination by Mr. Hubbard 4911
Cross-examination by Mr. Secor 4947
Re-direct Examination by Mr. Hubbard 4973
Re-cross Examination by Mr. Secor 4978

THE STATE RESTS 4980

CURATIVE INSTRUCTION ON TESTIMONY OF DR. WOOD REGARDING COCAINE 4987

RENEWED OBJECTION AND MOTION FOR A MISTRIAL 4987

COURT'S RULING DENYING MOTION 4987

CLOSING ARGUMENT BY MR. HUBBARD 4988

VOLUME XI

CONTINUED - TRANSCRIPT OF TRIAL HELD APRIL 29 – JUNE 13, 2019 5001

CLOSING ARGUMENT BY MR. YOUNG 5021

DEFENSE REQUEST FOR INSTRUCTION ON INVOLUNTARY INTOXICATION AND ON THE CONSEQUENCES OF A VERDICT OF NOT GUILTY BY REASON OF INSANITY AND THE CONSEQUENCES OF A VERDICT OF NOT GUILTY BUT MENTALLY ILL 5051

COURT'S RULING DENYING REQUEST FOR JURY INSTRUCTION 5053

JURY CHARGE 5053

RENEWED OBJECTIONS TO REFUSAL TO GIVE REQUESTED JURY INSTRUCTIONS 5073

RENEWED DENIAL OF REQUEST TO CHARGE 5073

COLLOQUY WITH THE DEFENDANT AND COUNSEL ON THE DEFENDANT'S RIGHT TO ADDRESS THE JURY 5074

COLLOQUY REGARDING BLU-RAY PLAYER 5076

COLLOQUY WITH FOREPERSON OF THE JURY REGARDING TEXT MESSAGES AND GOOGLE SEARCHES 5078

June 4, 2019

DEFENSE MOTION FOR A MISTRIAL 5083

COURT'S RULING DENYING MISTRIAL MOTION 5085

CONTINUED COLLOQUY PERTAINING TO EXHIBITS VIEWED DURING DELIBERATION 5086

RENEWED DEFENSE MOTION FOR A MISTRIAL 5095

COURT'S RULING DENYING RENEWED MISTRIAL MOTION 5095

JURY VERDICT 5097

POLLING OF THE JURY 5097

DEFENSE MOTION FOR A NEW TRIAL AND RENEWAL OF ALL PREVIOUS MOTIONS AND OBJECTIONS 5101

COURT'S RULING DENYING MOTION FOR A NEW TRIAL AND RENEWED MOTIONS AND OBJECTIONS....5101

COURT EXPLAINS TWENTY-FOUR HOUR WAITING PERIOD TO JURY....5103

June 5, 2019

MOTION BY COUNSEL BEATTIE BUTLER TO ELICIT TESTIMONY AND ADDRESS THE JURY ON BEHALF OF TIM JONES, SR., PURSUANT TO THE VICTIMS' BILL OF RIGHTS....5108

SOLICITOR'S OPPOSITION TO THE MOTION....5109

RESPONSE BY COUNSEL BUTLER....5111

COURT DEFERS RULING ON MOTION....5112

DEFENSE REQUEST FOR A LIMITING INSTRUCTION REGARDING THE TESTIMONY OF DR. FRIERSON AND DR. KRUSE....5112

COURT DEFERS RULING....5125

DEFENSE MOTION TO EXCLUDE POST-MORTEM PHOTOGRAPHS OF VICTIMS....5126

DISCUSSION PERTAINING TO PENALTY PHASE PHOTOGRAPHS....5130

COURT'S RULING ALLOWING STATE'S PENALTY PHASE PHOTOGRAPHS AND VIDEOTAPE....5146

RENEWED OBJECTION TO THE COURT'S RULING....5147

DEFENSE MOTION TO EXCLUDE AUTOPSY PHOTOGRAPHS....5148

COURT'S RULING ALLOWING AUTOPSY PHOTOGRAPHS....5156

June 6, 2019

PENALTY PHASE OF TRIAL

OPENING STATEMENT BY MS. MAYES....5162

OPENING STATEMENT BY MR. YOUNG....5167

STATE'S MOTION TO INCORPORATE GUILT PHASE
EVIDENCE INTO THE PENALTY PHASE 5175

COURT'S RULING GRANTING MOTION
TO INCORPORATE GUILT PHASE EVIDENCE 5175

RENEWED MOTION FOR A LIMITING INSTRUCTION
REGARDING THE TESTIMONY OF DR. FRIERSON 5176

COURT'S RULING DENYING MOTION
FOR A LIMITING INSTRUCTION 5176

TESTIMONY

DAVE LAWRENCE
Direct Examination by Mr. Hubbard 5178

DEFENSE MOTION FOR A MISTRIAL BASED
ON JUROR CRYING OVER PHOTOGRAPHS 5199

DISCUSSION OF JUROR'S REACTION TO PHOTOGRAPHS 5199

COURT'S RULING DENYING DEFENSE
MOTION FOR A MISTRIAL 5204

TESTIMONY CONTINUED

DAVE LAWRENCE CONTINUED
Direct Examination by Mr. Hubbard (Continued) 5206
Cross-examination by Mr. Madsen 5207

SHELBY DERRICK
Direct Examination by Mr. Graham 5213

DR. JANICE ROSS
Direct Examination by Mr. Hubbard 5222

JANET RICARD
Direct Examination by Ms. Mayes 5232

DEFENSE OBJECTION TO TESTIMONY (IN CAMERA) 5246

PROFFERED TESTIMONY

JANET RICARD (IN CAMERA)
Direct Examination by Ms. Mayes 5248

ARGUMENT PERTAINING TO PROFFERED TESTIMONY 5249

COURT'S RULING ALLOWING TESTIMONY 5251

TESTIMONY CONTINUED (IN THE PRESENCE OF THE JURY)

JANET RICARD CONTINUED
Direct Examination by Ms. Mayes (Continued) 5254
Cross-examination by Mr. Madsen 5264

JOY LORICK
Direct Examination by Ms. Mayes 5266
Cross-examination by Mr. Young 5274

JURY EXCUSED FOR THE DAY 5276

DEFENSE MOTION THAT AUTOPSY PHOTOGRAPHS
BE VIEWED IN OPEN COURT 5276

STATE'S OPPOSITION TO THE DEFENSE MOTION 5277

COURT DEFERS RULING ON MOTION 5278

June 7, 2019

COURT'S RULING DENYING DEFENSE MOTION
REGARDING VIEWING OF AUTOPSY PHOTOGRAPHS 5278

DEFENSE EXCEPTION TO THE COURT'S RULING
REGARDING VIEWING OF AUTOPSY PHOTOGRAPHS 5279

COURT'S RULING REFUSING TO RECONSIDER
DENIAL OF DEFENSE MOTION 5279

TESTIMONY CONTINUED

JACQUELYN MORAN
Direct Examination by Ms. Mayes 5281
Cross-examination by Mr. Madsen 5297

JOHNATHAN STONE
Direct Examination by Mr. Hubbard 5298

AMY SHEARER
Direct Examination by Ms. Mayes 5319

THE STATE RESTS 5336

DEFENSE MOTION FOR A DIRECTED VERDICT, RENEWED MOTION FOR A MISTRIAL, RENEWED MOTION FOR A NEW TRIAL, AND RENEWAL OF ALL PREVIOUS MOTIONS.....5336

COURT'S RULINGS DENYING MOTIONS.....5336

DEFENSE MOTION TO INCORPORATE DEFENSE GUILT PHASE EVIDENCE INTO PENALTY PHASE 5337

COURT'S RULING GRANTING MOTION 5337

STATE'S OBJECTION TO THE DEFENSE TESTIMONY OF SERGEANT BARRY SOWARDS 5337

DISCUSSION REGARDING OPPOSED TESTIMONY OF SERGEANT BARRY SOWARDS 5338

COURT'S RULING ALLOWING DEFENSE TESTIMONY OF SERGEANT BARRY SOWARDS 5342

COURT RECONSIDERS RULING ALLOWING DEFENSE TESTIMONY OF SERGEANT BARRY SOWARDS 5344

PROFFERED TESTIMONY

BARRY SOWARDS (IN CAMERA)
Direct Examination by Mr. Madsen.....5345

COURT'S RULING EXCLUDING THE TESTIMONY OF SERGEANT BARRY SOWARDS 5346

DEFENSE TESTIMONY (IN THE PRESENCE OF THE JURY)

KERRY BREEN
Direct Examination by Mr. Young 5348
Cross-examination by Mr. Hubbard 5353
Re-direct Examination by Mr. Young 5354

SERGEANT BARRY SOWARDS
Direct Examination by Mr. Madsen.....5354

RENEWED DEFENSE OBJECTION TO EXCLUSION OF TESTIMONY OF SERGEANT BARRY SOWARDS 5367

June 10, 2019

DEFENSE TESTIMONY CONTINUED

DR. DONNA MADDOX
Direct Examination by Mr. Young 5373
Cross-examination by Mr. Hubbard 5398
Re-direct Examination by Mr. Young 5427

STATE'S OBJECTION TO VIDEOTAPE OF ROBERTA THORSNBERRY, THE DEFENDANT'S GRANDMOTHER AND GREAT-GRANDMOTHER TO THE FIVE VICTIMS 5430

DISCUSSION OF ROBERTA THORNSBERRY EVIDENCE.....5431

DEFENSE TESTIMONY CONTINUED (IN THE PRESENCE OF THE JURY)

ROBERT BRANNON
Direct Examination by Mr. Madsen.....5441
Cross-examination by Mr. Graham.....5444
Re-direct Examination by Mr. Madsen.....5447

RONALD ROGERS
Direct Examination by Mr. Madsen.....5447

ROBERTA THORNSBERRY
Direct Examination by Mr. Secor 5452

PROFFERED TESTIMONY

ROBERTA THORNSBERRY (IN CAMERA)
Direct Examination by Mr. Secor 5453

ARGUMENTS PERTAINING TO LIMITATIONS ON THE TESTIMONY OF ROBERTA THORNSBERRY 5457

COURT'S RULING SUSTAINING STATE'S OBJECTIONS TO TESTIMONY OF ROBERTA THORNSBERRY 5463

OBJECTION TO THE COURT'S RULING 5463

DEFENSE TESTIMONY CONTINUED (IN THE PRESENCE OF THE JURY)

ROBERTA THORNSBERRY (CONTINUED)
Direct Examination by Mr. Secor (Continued).....5466
Cross-examination by Mr. Graham.....5474
Re-direct Examination by Mr. Secor 5480

DISCUSSION OF THE ADMISSABILITY OF
THE TESTIMONY OF DR. ADRIANA FLORES.....5483

PROFFERED TESTIMONY

TIMOTHY JONES, SR. (IN CAMERA)
Direct Examination by Mr. Secor 5493

VOLUME XII

CONTINUED - TRANSCRIPT OF TRIAL HELD APRIL 29 – JUNE 13, 2019 5501

DEFENSE TESTIMONY CONTINUED (IN THE PRESENCE OF THE JURY)

TIMOTHY JONES, SR.
Direct Examination by Mr. Secor 5505
Cross-examination by Mr. Hubbard 5524
Re-direct Examination by Mr. Secor 5532
Re-cross Examination by Mr. Hubbard 5533

DISCUSSION OF THE PROFFER OF DEBORAH GREY'S TESTIMONY,
THE PROFFER OF DR. ADRIANA FLORES' TESTIMONY, AND
THE PROFFER OF BETHANY YEISER'S TESTIMONY 5534

REQUEST TO PLAY PROFFERED TESTIMONY OF
BETHANY YEISER FOR JURY.....5536

COURT'S RULING DENYING REQUEST TO
PLAY PROFFERED TESTIMONY OF BETHANY
YEISER FOR JURY.....5539

PROFFERED TESTIMONY

DEBORAH GREY (IN CAMERA)
Direct Examination by Mr. Secor 5543

STATE'S OBJECTIONS AND DISCUSSION
REGARDING THE TESTIMONY OF DEBORAH GREY.....5594

June 11, 2019

STATE'S OBJECTION TO ALLOWING
THE TESTIMONY OF DR. ADRIANA FLORES....5598

DISCUSSION REGARDING THE
TESTIMONY OF DR. ADRIANA FLORES....5600

STATE'S MOTION TO SEAL PROFFERED
TESTIMONY OF DR. ADRIANA FLORES....5603

DEFENSE OPPOSITION TO MOTION....5604

COURT'S RULING GRANTING MOTION....5604

PROFFERED TESTIMONY

DR. ADRIANA FLORES (IN CAMERA)
Direct Examination by Mr. Young....5606
Cross-examination by Mr. Hubbard....5630

MOTION TO SEAL ALL RELATED COURT'S EXHIBITS....5639

MOTION FOR A NEW TRIAL BASED ON
AFTER-DISCOVERED EVIDENCE THAT DR. KRUSE'S
TESTIMONY WAS UNRELIABLE DURING THE GUILT PHASE....5639

COURT'S RULING DENYING MOTION....5640

ARGUMENTS ON THE ADMISSABILITY OF
DR. ADRIANA FLORES'S TESTIMONY....5640

COURT'S RULING EXCLUDING TESTIMONY
OF DR. ADRIANA FLORES....5645

COURT'S RULING LIMITING TESTIMONY
OF DEBORAH GREY....5647

DEFENSE EXCEPTION TO RULING
LIMITING SOCIAL HISTORY TESTIMONY....5651

DEFENSE TESTIMONY CONTINUED (IN THE PRESENCE OF THE JURY)

DEBORAH GREY
Direct Examination by Mr. Secor....5657

AMBER KYZER
Direct Examination by Mr. Young 5715
Cross-examination by Ms. Mayes.....5719
Re-direct Examination by Mr. Young 5734
Re-cross Examination by Ms. Mayes 5735

DEBORAH GREY (CONTINUED)
Direct Examination by Mr. Secor (Continued).....5735

June 12, 2019

DEFENSE TESTIMONY CONTINUED

DEBORAH GREY (CONTINUED)
Cross-examination by Mr. Hubbard 5789
Re-direct Examination by Mr. Secor 5807

STATE'S OBJECTION TO PUBLISHING THE VIDEOTAPED TESTIMONY OF CYNTHIA TURNER DURING THE PENALTY PHASE AND ARGUMENT REGARDING THAT TESTIMONY 5810

COURT'S RULING EXCLUDING THE TESTIMONY OF CYNTHIA TURNER 5821

DEFENSE TESTIMONY CONTINUED

JULIE JONES
Direct Examination by Mr. Secor 5824
Cross-examination by Mr. Graham.....5843

TYLER JONES
Direct Examination by Mr. Young 5850

TRAVIS JONES
Direct Examination by Mr. Secor 5859

JACKIE RANGEL
Direct Examination by Mr. Secor 5869

THE DEFENSE RESTS 5886

COLLOQUY WITH DEFENSE COUNSEL AND DEFENDANT ON HIS RIGHT TO ADDRESS THE JURY AND TO TESTIFY.....5887

DEFENSE RENEWS ALL PREVIOUS MOTIONS.....5889

COURT'S RULING DENYING MOTIONS 5890

June 13, 2019

CLOSING ARGUMENT BY MR. HUBBARD 5892

DEFENSE OBJECTION THAT STATE'S CLOSING ARGUMENT DENIED DEFENDANT'S DUE PROCESS RIGHT TO A FAIR TRIAL 5917

COURT'S RULING DENYING RELIEF 5918

STATE'S MOTION *IN LIMINE* TO PLACE LIMITATIONS ON THE DEFENSE CLOSING ARGUMENT 5919

DISCUSSION OF THOSE PROPOSED LIMITATIONS 5919

DEFENSE RENEWED MOTION THAT STATE'S USE OF AUTOPSY PHOTOGRAPHS AND INFLAMMATORY CLOSING ARGUMENT VIOLATED DEFENDANT'S DUE PROCESS RIGHT TO A FAIR TRIAL 5924

COURT'S RULING REFUSING TO RECONSIDER ITS PRIOR RULING 5926

CLOSING ARGUMENT BY MR. SECOR 5927

ARGUMENTS PERTAINING TO THE JURY INSTRUCTIONS (IN CAMERA) 5940

JURY CHARGE 5947

EXCEPTIONS TO JURY INSTRUCTION 5962

NOTE FROM THE JURY 5964

SENTENCING VERDICT 5965

POLLING OF THE JURY 5966

MOTION TO SET ASIDE VERDICT, INTER ALIA, AS BEING THE RESULT OF PASSION AND BASED ON UNCONSTITUTIONAL LIMITATIONS ON MITIGATING EVIDENCE 5969

ALL PREVIOUS MOTIONS RENEWED 5969

REQUEST FOR INDIVIDUAL RULINGS ON
EACH GROUND FOR A NEW TRIAL 5970

COURT'S RULING DENYING MOTION FOR A NEW TRIAL 5970

COURT'S RULING DENYING ALL RENEWED PREVIOUS MOTIONS 5971

COURT SENTENCES DEFENDANT TO DEATH 5971

TRANSCRIPT OF PRETRIAL HEARING HELD DECEMBER 13, 2017 5976

SCHMERBER MOTION AND MOTION FOR
COLLECTION OF SUSPECT STANDARDS 5979

TESTIMONY

ADAM CREECH
Direct Examination by Ms. Mayes 5982
Cross-examination by Mr. Madsen 5996

VOLUME XIII

TRANSCRIPT OF PRETRIAL HEARING HELD DECEMBER 13, 2017 6001

TESTIMONY CONTINUED

ADAM CREECH (CONTINUED)
Cross-examination by Mr. Young 6005
Re-direct Examination by Ms. Mayes 6008
Re-cross Examination by Mr. Madsen 6018

GAILE HEATH
Direct Examination by Ms. Mayes 6019
Cross-examination by Mr. Young 6022
Re-direct Examination by Ms. Mayes 6026
Re-cross Examination by Mr. Young 6028

ARGUMENT BY MS. MAYES 6029

ARGUMENT BY MR. MADSEN 6034

ARGUMENT AS TO MR. YOUNG
ON HANDWRITING COMPARISONS 6041

COURT DEFERS RULING 6050

DEFENSE MOTION TO REVOKE ANY
PRIOR CONSENT OR WAIVER OF FOURTH
OR FIFTH AMENDMENT RIGHTS BY DEFENDANT 6054

COURT'S RULING GRANTING MOTION IN PART 6060

DEFENSE MOTION REASSERTING DEFENDANT'S FIFTH
AND SIXTH AMENDMENT RIGHTS AND NOT CONSENTING
TO ANY QUESTIONING WITHOUT A LAWYER PRESENT 6061

COURT'S RULING GRANTING MOTION 6061

DEFENSE MOTION FOR DEFENDANT TO BE
PRESENT AT ALL HEARINGS 6064

COURT'S RULING GRANTING MOTION
OTHER THAN FOR STATUS CONFERENCES 6064

MOTION TO QUASH INDICTMENTS, PROVIDE WITNESSES
THAT HAVE ACTUAL KNOWLEDGE OF THE CASE, PROVIDE
FAVORABLE INFORMATION TO THE DEFENSE, AND TO HAVE A
COURT REPORTER PRESENT FOR THE GRAND JURY PROCEEDINGS 6065

COURT DEFERS RULING 6066

MOTION TO PROHIBIT THE DEFENDANT FROM BEING
EXHIBITED IN JAIL CLOTHING OR WHILE SHACKLED 6067

COURT'S RULING GRANTING MOTION 6068

MOTION TO PRESERVE ALL EVIDENCE AND TO
PRECLUDE ADDITIONAL TESTING DESTROYING EVIDENCE
WITHOUT NOTICE AND PRIOR COURT APPROVAL 6069

COURT'S RULING TO HAVE A MOTION
HEARING IF SPECIFIC EVIDENCE IS IDENTIFIED 6070

MOTION TO REQUIRE INVESTIGATIVE AGENCIES
TO PRESERVE NOTES OF ALL INTERVIEWS AND
INVESTIGATIVE ACTIONS 6070

COURT'S RULING FOR THE SOLICITOR TO NOTIFY
APPLICABLE AGENCIES TO PRESERVE NOTES 6072

MOTION THAT ALL HEARINGS BE ON THE
RECORD WITH A COURT REPORTER 6072

COURT'S RULING GRANTING MOTION 6073

MOTION FOR THE SOLICITOR TO RESPOND
IN WRITING TO EACH MOTION THAT IS CONTESTED 6073

COURT'S RULING GRANTING MOTION 6074

DEFENSE MOTION TO SET HEARING
DATES ON ALL PRE-TRIAL MOTIONS 6074

COURT'S RULING AGREEING TO
SET A "PREDICTABLE SCHEDULE" 6074

TRANSCRIPT OF PRETRIAL HEARING HELD JANUARY 5, 2018.....6076

MOTION FOR CONSENT ORDER
PERTAINING TO SCDC RECORDS 6078

AGREEMENT TO CONSENT ORDER.....6079

MOTION FOR AN ORDER SEALING PRISON
VISITATION LOGS TO ENSURE CONFIDENTIALITY.....6079

COURT'S RULING TO PARTIALLY SEAL
PRISON VISITATION LOGS 6089

MOTION REGARDING COLLECTION OF
BUCCAL SWABS AND HANDWRITING EXEMPLARS 6090

COURT'S RULING THAT DEFENSE COUNSEL CAN BE
PRESENT DURING THE COLLECTION OF SAMPLES.....6090

TRANSCRIPT OF PRETRIAL HEARING HELD MAY 25, 2018 6100

STATE'S MOTION FOR CLARIFICATION OF RULING
THAT IT RESPOND TO EVERY MOTION IN WRITING.....6104

COURT'S RULING THAT THE STATE
RESPONDING IN WRITING IS OPTIONAL 6106

MOTION FOR ALL EVIDENTIARY MATTERS
TO BE HEARD IN CAMERA.....6107

COURT'S RULING GRANTING MOTION 6109

MOTION TO HAVE SOLICITOR PROVIDE WRITTEN NOTICE
OF NON-STATUTORY EVIDENCE IN AGGRAVATION NO LATER
THAN THIRTY DAYS AFTER DISCOVERY OF SUCH EVIDENCE.....6109

COURT'S RULING GRANTING MOTION IN PART.....6110

MOTION FOR AN ORDER REQUIRING THE
PRODUCTION OF ALL MATTERS INVOLVING
VICTIM IMPACT EVIDENCE AND FOR A PRE-TRIAL
HEARING ON VICTIM IMPACT TRIAL PRESENTATION.....6111

COURT'S RULING FOR ALL PARTIES TO COMPLY
WITH DISCOVERY, BRADY, AND RULE 5 STANDARDS.....6116

MOTION FOR AN ORDER DIRECTING THE STATE
TO PROVIDE BIRTH DATES AND SOCIAL SECURITY
NUMBERS OF ALL STATE'S WITNESSES.....6120

COURT'S RULING THAT NON-LAW
ENFORCEMENT BIRTH DATES AND SOCIAL
SECURITY NUMBERS BE PROVIDED.....6122

MOTION FOR DISCLOSURE OF PSYCHIATRIC
HISTORY OF STATE'S WITNESSES.....6123

COURT DEFERS RULING.....6128

MOTION TO PREVENT THE STATE FROM SEEKING A
SENTENCE OF DEATH, OR IN THE ALTERNATIVE, TO
QUASH THE INDICTMENTS FOR FAILURE TO ALLEGE
STATUTORY AGGRAVATING CIRCUMSTANCES THAT
CONSTITUTE THE ELEMENTS OF A CAPITAL OFFENSE
IN THE INDICTMENTS.....6128

COURT'S RULING DENYING MOTION.....6128

MOTION FOR DISCLOSURE OF ANY IMPROPER
BIAS OR PREJUDICE ON THE PART OF THE SOLICITOR,
COURT PERSONNEL, OR OTHER STATE ACTORS.....6129

COURT'S RULING THAT ANY SUCH BIAS
OR PREJUDICE MUST BE REVEALED.....6130

MOTION FOR DISCLOSURE OF ALLEGED PRIOR
WRONGS, CRIMES, OR BAD ACTS EVIDENCE THE
STATE INTENDS TO INTRODUCE AT TRIAL.....6130

STATE CONSENTS TO MOTION 6130

MOTION FOR DISCLOSURE OF ANY POSSIBLE BIAS ON
THE PART OF THE TRIAL COURT THAT COULD BE GROUNDS
FOR A MOTION FOR RECUSAL 6131

COURT'S RULING THAT NO BIAS EXISTS
WHICH WOULD BE A GROUNDS FOR RECUSAL 6131

MOTION TO DECLARE THE DEATH PENALTY
STATUTORY SCHEME UNCONSTITUTIONAL AS
OVER BROAD AND ARBITRARY BECAUSE IT FAILS
TO NARROW THE CLASS OF ELIGIBLE CANDIDATES 6131

COURT'S RULING DENYING MOTION 6132

MOTION TO PREVENT EX PARTE COMMUNICATION
BETWEEN THE STATE AND THE COURT 6132

COURT'S RULING GRANTING MOTION 6133

SECOND MOTION TO DECLARE THE DEATH
PENALTY STATUTE UNCONSTITUTIONAL 6133

COURT'S RULING DENYING MOTION 6134

MOTION TO DECLARE DEATH PENALTY
UNCONSTITUTIONAL BASED ON LACK OF STANDARDS
AND SAFEGUARDS TO PRESENT DISPARATE AND
ARBITRARY TREATMENT 6134

COURT'S RULING DENYING MOTION 6138

MOTION FOR THE COURT REPORTER'S TAPES AND NOTES
TO BE MADE A PART OF THE RECORD 6138

COURT'S RULING GRANTING MOTION
AS FAR AS PRACTICABLE 6139

MOTION TO CHALLENGE THE
PARTICULAR EXECUTION PROCEDURE 6140

COURT'S RULING DENYING MOTION AS PREMATURE 6140

MOTION FOR A NEIL V. BIGGERS HEARING
BEFORE AN IN-COURT IDENTIFICATION 6141

COURT'S RULING GRANTING MOTION 6141

MOTION TO PREVENT LAW ENFORCEMENT,
COURT OFFICIALS, AND BAILIFFS FROM HAVING
IMPROPER INFLUENCE ON THE JURY 6142

COURT'S RULING THAT IT WILL MEET WITH
BAILIFFS AND COURT PERSONNEL ON PROPER PROCEDURES 6142

MOTION TO DECLARE THE DEATH PENALTY
STATUTORY SCHEME UNCONSTITUTIONAL IN DENYING
JURY SENTENCING FOR A DEFENDANT WHO PLEADS GUILTY 6143

COURT'S RULING DENYING MOTION 6144

MOTION TO SEQUESTER
WITNESSES PRIOR TO HEARINGS 6145

COURT'S RULING GRANTING MOTION 6147

MOTION FOR APPOINTMENT OF A NEUTRAL WITNESS
MONITOR TO ENFORCE SEQUESTRATION ORDERS 6147

COURT'S RULING DENYING MOTION 6149

MOTION FOR INSTRUCTION TO VICTIMS'
FAMILY AND OTHER SPECTATORS TO REFRAIN
FROM SHOWING EMOTIONS IN THE COURT ROOM 6149

COURT'S RULING THAT IT WILL
MANAGE ANY PROBLEMS THAT ARISE 6149

DEFENSE MOTION THAT PETIT
JURY NOT BE SEQUESTERED 6149

COURT'S DEFERS RULING 6150

MOTION TO DECLARE DEATH PENALTY STATUTORY
SCHEME UNCONSTITUTIONAL AS ARBITRARY AND
STANDARDLESS PURSUANT TO FURMAN V. GEORGIA 6150

MOTION TO PREVENT PREJUDICIAL SECURITY MEASURES 6152

COURT'S RULING AGREEING TO COORDINATE
COURTROOM SECURITY AND MANAGEMENT 6153

MOTION FOR A DAILY TRANSCRIPT OF
ALL VOIR DIRE PROCEEDINGS 6153

COURT DEFERS RULING 6155

MOTION TO PROHIBIT PROSECUTORIAL
MISCONDUCT AND TO LIMIT THE PROSECUTORS'
OPENING STATEMENT AND CLOSING ARGUMENT 6157

COURT'S RULING THAT THE STATE HAS BEEN
PUT ON NOTICE BUT A CONTEMPORANEOUS
DEFENSE OBJECTION IS REQUIRED 6157

MOTION FOR JURY TO VIEW EXECUTION PROCESS 6158

COURT'S RULING DENYING MOTION 6159

MOTION TO PROHIBIT JURY ARGUMENT ON GENERAL
DETERRENCE OR TO PERMIT THE DEFENSE TO PRESENT
EVIDENCE ON THE TOPIC 6159

COURT'S RULING DENYING MOTION 6161

MOTION TO EXCLUDE EVIDENCE OF
PRISON CONDITIONS AND PRIVILEGES 6161

COURT DEFERS RULING 6162

MOTION TO PROHIBIT COMPARATIVE
WORTH EVIDENCE AND ARGUMENT 6162

COURT'S RULING GRANTING MOTION 6162

DEFENSE NOTICE OF INTENT TO TENDER
PLEA OF NOT GUILTY BY REASON OF INSANITY 6163

COURT RECOGNIZES THE GIVING OF NOTICE 6163

TRANSCRIPT OF PRETRIAL HEARING HELD DECEMBER 19, 2018 6175

ORDER FOR DR. DORNEY TO
PRODUCE REPORT BY JANUARY 9, 2019 6186

DISCUSSION OF CONSENT ORDER REGARDING
DOCUMENTS FROM DSS AND A PENDING CIVIL CASE 6188
COUNSEL FOR DSS OPPOSES

DISCLOSURE OF DSS DOCUMENTS....6190

COURT DEFERS RULING....6203

DEFENSE REQUEST FOR COURT ORDER FOR THE DEPARTMENT OF MENTAL HEALTH TO TAPE-RECORD ANY INTERVIEWS WITH AMBER JONES....6210

COURT DEFERS RULING....6212

DEFENSE REQUEST FOR A HEARING ON THE LEGALITY OF THE MISSISSIPPI ROADBLOCK....6216

DEFENSE MOTION FOR INDEPENDENT TESTING OF EVIDENCE....6221

COURT'S RULING THAT BOTH SIDES COMPLY WITH SECURITY MEASURES DURING TESTING....6222

DISCUSSION AND ARGUMENTS ON JURY QUESTIONNAIRE....6228

COURT DEFERS RULING ON JURY QUESTIONNAIRE LEGAL ISSUES....6245

TRANSCRIPT OF PRETRIAL HEARING HELD JANUARY 11, 2019....6251

DEFENSE MOTION TO AUDIO RECORD INTERVIEW WITH AMBER JONES....6254

COURT'S RULING DENYING MOTION IN PART....6267

DISCUSSION OF JURY QUESTIONNAIRE....6269

COURT'S TENTATIVE RULING THAT JURY QUESTIONNAIRE WILL BE MORE GENERAL....6281

DISCUSSION OF DEFENSE EXPERT'S TESTIMONY ON UNCONSTITUTIONALITY OF THE SOUTH CAROLINA DEATH PENALTY STATUTE....6288

COURT'S RULING THAT THE DEFENSE CAN PROFFER EVIDENCE ON THE UNCONSTITUTIONALITY OF THE DEATH PENALTY....6306

PROFFERED TESTIMONY

DR. WANDA FOGLIA
Direct Examination by Mr. Young 6314

END OF PROFFERED TESTIMONY 6420

MOTION FOR DEFENDANT TO BE TRANSFERRED
TO LEXINGTON COUNTY DETENTION CENTER PENDING TRIAL 6421

COURT'S RULING GRANTING MOTION 6421

COURT'S RULING ON HOW IT WILL
PRODUCE A JURY QUESTIONNAIRE 6426

TRANSCRIPT OF PRETRIAL HEARING HELD JANUARY 31, 2019 6434

TESTIMONY

DR. RICHARD FRIERSON
Examination by the Court 6437

COLLOQUY REGARDING DR. FRIERSON
EVALUATING DEFENDANT 6439

TESTIMONY CONTINUED (WITHOUT DEFENDANT PRESENT)

DR. RICHARD FRIERSON (CONTINUED)
Examination by the Court (Continued) 6441
Direct Examination by Mr. Young 6444
Re-examination by the Court 6448
Cross-examination by Mr. Graham 6449
Re-direct Examination by Mr. Young 6454

COLLOQUY WITH DEFENDANT REGARDING
TESTIMONY OF DR. BRAWLEY 6458

TESTIMONY CONTINUED (WITHOUT DEFENDANT PRESENT)

DR. TORA BRAWLEY
Direct Examination by Mr. Young 6459
Cross-examination by Mr. Graham 6464

COURT'S RULING DECLINING TO
LIMIT TESTING BY DR. FRIERSON 6469

DEFENSE MOTION FOR ANY REPORT OR RESULTS
FROM THE MMPI TO BE SEALED AND PROVIDED TO
THE DEFENSE AND THE COURT FOR REVIEW PRIOR
TO DISCLOSURE TO THE STATE 6475

COURT'S RULING ON DISCLOSURE OF TESTING RESULTS 6480

STATE'S MOTION FOR A HEARING SHOULD DEFENDANT
INVOKE HIS FIFTH AMENDMENT RIGHTS 6482

COURT'S RULING GRANTING MOTION 6482

FURTHER DISCUSSION OF JURY QUESTIONNAIRE 6485

VOLUME XIV

**CONTINUED - TRANSCRIPT OF PRETRIAL HEARING
HELD JANUARY 31, 2019** 6501

MOTION FOR PERSONAL SERVICE ON
ALL RETURNED JURY QUESTIONNAIRES 6512

COURT'S AGREEMENT TO FOLLOW UP
ON RETURNED NO SERVICE QUESTIONNAIRES 6513

MOTION TO QUASH INDICTMENT AND
HAVE COURT REPORTER PRESENT DURING
GRAND JURY PROCEEDINGS 6516

COURT'S RULING DENYING MOTION 6516

MOTION FOR VICTIM IMPACT TESTIMONY TO BE
REDUCED TO WRITING FOR REVIEW BY DEFENSE 6518

COURT'S DEFERS RULING UNTIL
AND UNLESS IT BECOMES NECESSARY 6518

MOTION THAT ALTERNATE JURORS
NOT BE IDENTIFIED AS ALTERNATES 6519

COURT'S RULING GRANTING MOTION 6520

MOTION TO REQUIRE THE COURT TO ESTABLISH
THE RACE, GENDER, AND ETHNICITY OF EVERY
PROSPECTIVE JUROR FOR THE RECORD 6522

COURT DEFERS RULING 6522

MOTION TO DISCLOSE THE PAST AND PRESENT RELATIONSHIPS, ASSOCIATIONS, AND TIES BETWEEN THE SOLICITOR AND PROSPECTIVE JURORS AND TO DISCLOSE RECORDS ABOUT PROSPECTIVE JURORS IN THE PROSECUTION'S POSSESSION 6522

COURT'S RULING GRANTING MOTION 6523

MOTION TO PROHIBIT THE USE OF JUROR ORIENTATION VIDEOTAPES OR HANDBOOKS 6523

COURT'S RULING GRANTING MOTION 6523

MOTION TO DISQUALIFY FOR CAUSE TYPE ONE OR TYPE TWO JURORS WITHOUT "REHABILITATION" 6523

COURT DEFERS RULING UNTIL ACTUAL VOIR DIRE 6524

MOTION FOR COMPENSATION OF JURORS AT CURRENT WAGES 6525

COURT'S RULING DENYING MOTION 6526

MOTION FOR AN ORDER TO VIDEOTAPE VOIR DIRE PROCEEDINGS 6527

COURT'S RULING DENYING MOTION 6528

MOTION TO LIMIT CONVERSATIONS BETWEEN JURORS AND BAILIFFS 6528

COURT'S RULING GRANTING MOTION 6528

MOTION TO STRIKE JURORS AS THEY ARE QUALIFIED BY THE COURT 6529

COURT'S RULING DENYING MOTION 6530

TRANSCRIPT OF PRETRIAL HEARING HELD FEBRUARY 4, 2019 6542

DEFENSE MOTION FOR A CONTINUANCE 6545

MOTION FOR A BENCH TRIAL 6547

COLLOQUY PERTAINING TO DEFENSE MOTION....6547

COURT'S RULING DENYING MOTION FOR
A CONTINUANCE WITH LEAVE TO RESTORE....6552

TRANSCRIPT OF PRETRIAL HEARING HELD MARCH 11-14, 19, 2019....6556

March 11, 2019

MOTION TO SUPPRESS EVIDENCE SEIZED
PURSUANT TO AN ILLEGAL ROADBLOCK....6564

TESTIMONY

MOLLY MILLER
Direct Examination by Ms. Mayes....6565
Voir Dire Examination by Mr. McGuire....6571

MOTION TO SEQUESTER WITNESSES....6575

COURT'S RULING GRANTING SEQUESTRATION....6576

TESTIMONY CONTINUED

MOLLY MILLER (CONTINUED)
Direct Examination by Ms. Mayes (Continued)....6578
Cross-examination by Mr. McGuire....6583
Re-direct Examination by Ms. Mayes....6618

CHARLIE CRUMPTON
Direct Examination by Mr. Hubbard....6621
Cross-examination by Mr. McGuire....6625
Re-direct Examination by Mr. Hubbard....6640

CHARLES JOHNSON
Direct Examination by Ms. Mayes....6642
Cross-examination by Mr. McGuire....6670

MOTION TO BAR QUESTIONS REGARDING
PENDING CHARGES AGAINST STATE'S WITNESSES....6693

COURT'S RULING GRANTING MOTION....6698

TESTIMONY CONTINUED

ROBERT WAYNE THOMPSON
Direct Examination by Mr. Graham 6700
Cross-examination by Mr. McGuire 6714

MARTY PATTERSON
Direct Examination by Mr. Hubbard 6721
Cross-examination by Mr. McGuire 6731

ARGUMENT BY MS. MAYES.....6735

ARGUMENT BY MR. MCGUIRE.....6738

ARGUMENT BY MR. HUBBARD.....6743

REPLY ARGUMENT BY MR. MCGUIRE 6745

COURT DEFERS RULING ON MOTION TO SUPPRESS
EVIDENCE SEIZED PURSUANT TO AN ILLEGAL ROADBLOCK.....6751

MOTION TO SUPPRESS USE OF
DEFENDANT'S PERSONALITY TESTING 6753

COURT DEFERS RULING 6754

MOTION FOR STATE TO PROVIDE BILL OF
PARTICULARS REGARDING AGGRAVATING EVIDENCE 6754

COURT DEFERS RULING 6758

March 12, 2019

COURT'S RULING DENYING MOTION TO SUPPRESS
EVIDENCE SEIZED PURSUANT TO AN ILLEGAL ROADBLOCK.....6760

JACKSON V. DENNO HEARING.....6768

COURT'S RULING ADMITTING DEFENDANT'S
STATEMENTS REGARDING SPICE 6769

COURT'S RULING ADMITTING DEFENDANT'S
STATEMENTS REGARDING CAR ODORS 6771

TESTIMONY

JAMIE MCCLELLAN
Direct Examination by Mr. Graham 6772
Cross-examination by Mr. Young.....6778
Re-direct Examination by Mr. Graham 6791

ARGUMENT BY MR. YOUNG.....6796

ARGUMENT BY MR. HUBBARD.....6796

REPLY ARGUMENT BY MR. YOUNG.....6802

COURT DEFERS RULING ON ADMISSIBILITY
OF DEFENDANT'S STATEMENTS TO OFFICER
MCCLELLAN REGARDING CHILDREN 6803

TESTIMONY CONTINUED

MARTY PATTERSON
Direct Examination by Mr. Hubbard 6804
Cross-examination by Mr. Secor 6814
Re-direct Examination by Mr. Hubbard 6862
Re-cross Examination by Mr. Secor 6874
Re-direct Examination by Mr. Hubbard 6875

ERIC JOHNSON
Direct Examination by Mr. Graham 6880
Cross-examination by Mr. Young.....6912
Re-direct Examination by Mr. Graham 6945

THE STATE RESTS 6947

March 13, 2019

JACKSON V. DENNO HEARING CONTINUED 6948

DEFENSE TESTIMONY

TIMOTHY JONES, SR. (CALLED OUT OF ORDER)
Direct Examination by Mr. Secor 6951
Cross-examination by Mr. Hubbard 6974
Re-direct Examination by Mr. Secor 6997

RENEWED MOTION TO HAVE ALL EVIDENTIARY
MATTERS HEARD IN CAMERA.....6998

COURT'S RULING RENEWING
HIS GRANT OF THE MOTION 6999

VOLUME XV

**CONTINUED - TRANSCRIPT OF PRETRIAL HEARING
HELD MARCH 11-14, 19, 2019** 7001

DEFENSE TESTIMONY CONTINUED

TIMOTHY JONES, SR. (CONTINUED)
Re-direct Examination by Mr. Secor (Continued).....7005

ERIC JOHNSON (RECALLED)
Direct Examination by Mr. Young 7009
Cross-examination by Mr. Graham.....7013
Re-direct Examination by Mr. Young 7018

ADAM CREECH
Direct Examination by Mr. Graham 7022
Cross-examination by Mr. Madsen.....7072
Re-direct Examination by Mr. Graham 7116
Re-cross Examination by Mr. Madsen.....7137
Re-direct Examination by Mr. Graham 7144

March 14, 2019

MOTION TO CHANGE VENUE DUE TO PRETRIAL PUBLICITY 7148

COURT DEFERS RULING ON MOTION TO CHANGE VENUE.....7150

JACKSON V. DENNO HEARING CONTINUED 7151

REPLY TESTIMONY

ERIC JOHNSON (RECALLED)
Direct Examination by Mr. Graham 7152
Cross-examination by Mr. Young.....7159

DAVID MACKEY
Direct Examination by Ms. Mayes 7162
Cross-examination by Mr. Young.....7194
Re-direct Examination by Ms. Mayes 7225
Re-cross Examination by Mr. Young 7233

ADAM CREECH (RECALLED)
Direct Examination by Mr. Young 7237
Cross-examination by Mr. Graham.....7240

March 19, 2019

JACKSON V. DENNO HEARING CONTINUED 7258

ARGUMENTS ON ADMISSIBILITY OF DEFENDANT'S STATEMENTS TO OFFICER MCCLELLAN REGARDING CHILDREN 7259

COURT'S RULING ADMITTING STATEMENTS.....7274

ARGUMENTS ON ADMISSIBILITY OF DEFENDANT'S STATEMENT TO UNDER-SHERIFF PATTERSON REGARDING SUV CONTENTS 7275

COURT'S RULING ADMITTING STATEMENT 7283

ARGUMENTS ON ADMISSIBILITY OF DEFENDANT'S STATEMENT AFTER INVOCATION OF HIS RIGHT TO SILENCE 7287

COURT'S RULING ADMITTING STATEMENT 7300

ARGUMENTS ON ADMISSIBILITY OF DEFENDANT'S STATEMENTS FROM SEPTEMBER 7TH INTERROGATION 7301

COURT'S RULING ADMITTING STATEMENTS.....7326

ARGUMENTS ON ADMISSIBILITY OF DEFENDANT'S STATEMENTS FROM SEPTEMBER 8TH INTERROGATION 7326

COURT'S RULING ADMITTING STATEMENTS.....7339

ARGUMENTS ON ADMISSIBILITY OF DEFENDANT'S STATEMENT TO HIS FATHER IN THE PRESENCE OF POLICE 7340

COURT'S RULING ADMITTING STATEMENT 7345

ARGUMENTS ON ADMISSIBILITY OF DEFENDANT'S STATEMENTS FROM SEPTEMBER 9TH INTERROGATION 7347

COURT'S RULING ADMITTING STATEMENTS.....7352

ARGUMENTS ON ADMISSIBILITY OF DEFENDANT'S STATEMENTS FOLLOWING LOCATION OF BODIES.....7353

COURT'S RULING ADMITTING STATEMENTS....7355

ARGUMENTS ON ADMISSIBILITY OF DEFENDANT'S STATEMENTS FROM SEPTEMBER 11TH INTERROGATION....7357

COURT DEFERS RULING ON STATEMENTS....7361

TRANSCRIPT OF PRETRIAL HEARING HELD APRIL 11, 2019....7370

MOTION TO CHALLENGE EXECUTION PROCEDURE....7376

COURT DEFERS ARGUMENT UNTIL NECESSARY....7376

MOTION *IN LIMINE* TO SUPPRESS AUTOPSY AND BODY RECOVERY PHOTOGRAPHS....7379

COURT DEFERS RULING ON ADMISSIBILITY OF PHOTOGRAPHS....7384

MOTION TO PREVENT DEATH QUALIFICATION OF JURY....7390

COURT'S RULING DENYING MOTION....7402

MOTION TO INSTRUCT JURY ON THE MEANING OF A LIFE SENTENCE WITHOUT PAROLE....7402

COURT'S RULING GRANTING MOTION....7404

MOTION TO ENSURE MITIGATING CIRCUMSTANCES RECEIVE DUE WEIGHT AND ATTENTION FROM JURY....7405

COURT'S RULING GRANTING MOTION....7415

MOTION FOR CONSTITUTIONALLY ADEQUATE VOIR DIRE....7416

COURT'S RULING GRANTING MOTION....7422

MOTION FOR AN INSTRUCTION ON JURORS TAKING NOTES AND FOR JUROR NOTES TO BE MADE PART OF THE RECORD....7423

COURT'S RULING GRANTING MOTION IN PART AND DEFERRING IN PART....7426

MOTION TO ENSURE CHALLENGED QUESTIONS OF PERSPECTIVE JURORS COMPLY WITH A FAIR AND IMPARTIAL TRIAL....7427

COURT DEFERS RULING 7432

MOTION FOR RESTRICTION ON
REHABILITATION OF JURORS DURING VOIR DIRE 7437

COURT'S RULING GRANTING MOTION 7438

MOTION TO PRECLUDE TESTIMONY
REGARDING PRISON CONDITIONS 7439

STATE CONSENTS TO MOTION 7439

MOTION FOR JURY INSTRUCTION ON
NON-UNANIMOUS PENALTY PHASE VERDICT 7440

COURT DEFERS RULING 7445

MOTION TO QUALIFY JURORS WITH RELIGIOUS
OBJECTION TO DEATH PENALTY 7447

COURT'S RULING DENYING MOTION 7451

MOTION TO ALLOW JURORS TO SUBMIT
WRITTEN QUESTIONS TO WITNESSES 7451

COURT'S RULING DENYING MOTION 7454

MOTION TO PRECLUDE STATE FROM PURSUING
DEATH PENALTY DUE TO SEVERE MENTAL ILLNESS 7455

COURT'S RULING DENYING MOTION 7456

MOTION *IN LIMINE* TO BAR INTRODUCTION OF
DEFENDANT'S TATTOOS 7457

STATE CONSENTS TO MOTION 7458

MOTION TO EXCLUDE TESTIMONY REGARDING
POSTMORTEM RAPE KITS 7458

STATE CONSENTS TO MOTION 7458

MOTION TO EXCLUDE STATEMENTS OF MERAH JONES 7459

STATE CONSENTS TO MOTION 7459

MOTION *IN LIMINE* TO EXCLUDE TESTIMONY
REGARDING CHILDREN'S STATE OF UNDRESS 7459

COURT DEFERS RULING 7460

MOTION TO PROHIBIT TESTIMONY REGARDING
DEFENDANT'S INTERNET SEARCHES 7461
COURT'S RULING GRANTING MOTION
UNLESS DEFENSE OPENS THE DOOR 7462

MOTION TO EXCLUDE TESTIMONY REGARDING
DEFENDANT USING RACIST LANGUAGE 7462

STATE CONSENTS TO MOTION 7462

MOTION TO EXCLUDE EVIDENCE OF BUTTERFLY KNIFE.....7462

STATE CONSENTS TO MOTION 7463

DISCUSSION OF VOIR DIRE PROCESS 7464

WRITTEN EXHIBITS, MOTIONS, AND DOCUMENTS

DEFENDANT'S EXHIBIT #1 (DR. TRAVIS
SNYDER'S CURRICULUM VITAE) 7473

DEFENDANT'S EXHIBIT #2 (REPORT OF
DR. SNYDER'S MEDICAL IMAGING STUDY).....7480

DEFENDANT'S EXHIBIT #3 (MAGNETIC
RESONANCE IMAGING OF JONES' BRAIN).....7495

VOLUME XVI

DEFENDANT'S EXHIBIT #136
(DR. ERIN D. BIGLER'S CURRICULUM VITAE) 7505

DEFENDANT'S EXHIBIT #362 (GENOGRAM
OF JONES' IMMEDIATE FAMILY).....7626

DEFENDANT'S EXHIBIT #363 (GENOGRAM
OF JONES' EXTENDED FAMILY) 7627

COURT'S EXHIBIT #63 (WITNESS LIST) 7628

COURT'S EXHIBIT #64 (THREE TYPES OF JURORS).....7634

COURT'S EXHIBIT #83 (DEFENDANT'S
REQUESTED PRELIMINARY INSTRUCTIONS).....7635

COURT'S EXHIBIT #88 (DR. BHUSHAN S. AGHARKAR'S
SOURCES OF INFORMATION).....7638

COURT'S EXHIBIT #89 (REPORT ISSUED BY
DR. BHUSHAN S. AGHARKAR).....7659

COURT'S EXHIBIT #94 (DR. RICHARD FRIERSON'S
FORENSIC EVALUATION).....7668

COURT'S EXHIBIT #95 (DR. RICHARD FRIERSON'S
CURRICULUM VITAE).....7720

COURT'S EXHIBIT #99 (JONES' SOCIAL HISTORY).....7744

COURT'S EXHIBIT #100 (DR. JULIE DORNEY'S
CURRICULUM VITAE).....7877

COURT'S EXHIBIT #102 (DR. RICHARD FRIERSON'S
SOURCES OF INFORMATION FOR THE FORENSIC EVALUATION).....7884

COURT'S EXHIBIT #103 (JONES' ADVISEMENT
OF RIGHTS SENT TO DR. KIMBERLY KRUSE).....7899

COURT'S EXHIBIT #104 (TESTING CONDUCTED
BY DR. KIMBERLY KRUSE).....7901

VOLUME XVII

COURT'S EXHIBIT #106 (DEFENDANT'S
REQUESTED JURY INSTRUCTIONS).....8153

COURT'S EXHIBIT #120 (DR. DONNA MADDOX'S
FORENSIC EVALUATION).....8175

COURT'S EXHIBIT #121 (GENOGRAM OF JONES' FAMILY).....8180

COURT'S EXHIBIT #122 (DR. ADRIANA FLORES'
CURRICULUM VITAE).....8181

COURT'S EXHIBIT #123 (AFFIDAVIT OF DR. ADRIANA FLORES).....8188

COURT'S EXHIBIT #124 (CRITIQUE OF
DR. KRUSE'S TESTING BY DR. FLORES).....8199

DEFENDANT'S EXHIBIT #1 (LETTER DATED 1/16/2019, OBJECTING TO PERSONALITY TESTING) (FROM THE JANUARY 31, 2019 PRETRIAL HEARING) 8258

COURT'S EXHIBIT #13 (CHARLES JOHNSON'S AFFIDAVIT REGARDING ROADBLOCK) (FROM THE MARCH 11-14, 19, 2019 PRETRIAL HEARING) 8259

EX PARTE PETITION FOR CERTIFICATE TO PRODUCE MATERIAL WITNESS, CYNTHIA TURNER, AND DOCUMENTS FROM OUT OF STATE (DATED MARCH 28, 2019)....8261

EX PARTE CERTIFICATE REGARDING OUT OF STATE WITNESS, CYNTHIA TURNER (FILED APRIL 2, 2019) 8263

EMERGENCY PETITION FOR COURT ORDER ALLOWING VIDEOTAPED TESTIMONY OF CYNTHIA GRANADO JONES TURNER (DATED MAY 9, 2019) 8265

ORDER THAT CYNTHIA GRANADO JONES TURNER SUBMIT TO VIDEOTAPED INTERVIEW (DATED MAY 9, 2019) 8269

MOTION TO VOIR DIRE POTENTIAL JURORS REGARDING THE CONSEQUENCE OF A VERDICT OF NOT GUILTY BY REASON OF INSANITY AND GUILTY BUT MENTALLY ILL AND FOR JURORS TO BE INSTRUCTED AS TO THE CONSEQUENCE OF A VERDICT OF NOT GUILTY BY REASON OF INSANITY AND GUILTY BUT MENTALLY ILL (FILED APRIL 11, 2019)....8270

SUPPLEMENT TO MOTION TO VOIR DIRE POTENTIAL JURORS REGARDING THE CONSEQUENCE OF A VERDICT OF NOT GUILTY BY REASON OF INSANITY AND GUILTY BUT MENTALLY ILL AND FOR JURORS TO BE INSTRUCTED AS TO THE CONSEQUENCE OF A VERDICT OF NOT GUILTY BY REASON OF INSANITY AND GUILTY BUT MENTALLY ILL (FILED APRIL 24, 2019)....8284

MOTION FOR CONSTITUTIONALLY ADEQUATE VOIR DIRE (FILED APRIL 25, 2018) 8342

MOTION TO SUPPRESS EVIDENCE AND FRUITS FROM UNLAWFUL ROADBLOCK (FILED APRIL 12, 2018)....8348

NOTICE OF INTENT TO SEEK THE DEATH PENALTY AND ORDER (FILED DEC. 9, 2015)....8352

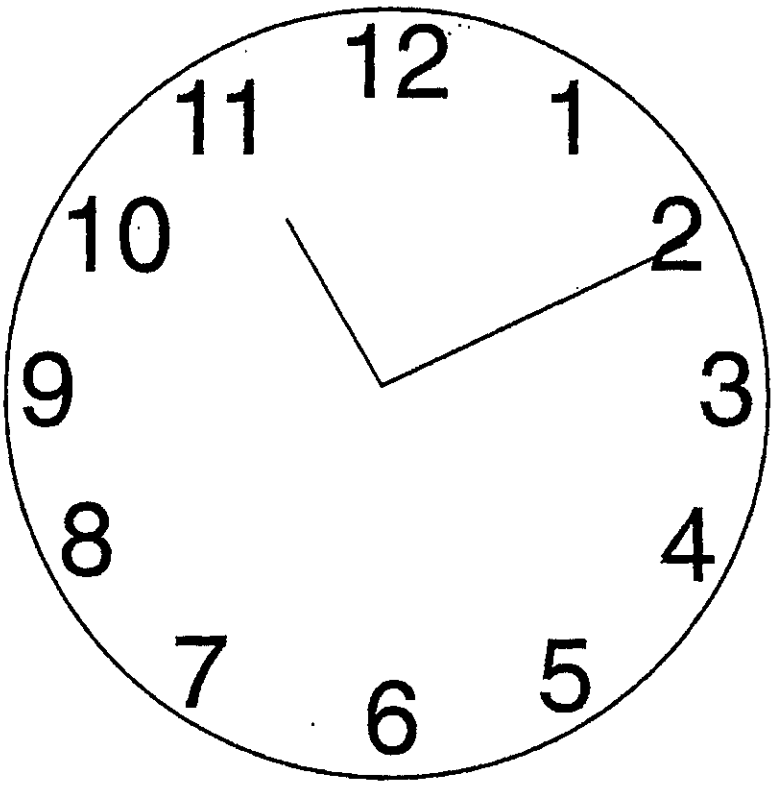
ORDER ASSIGNING THE HONORABLE
EUGENE C. GRIFFITH, JR. AS PRESIDING JUDGE
(DATED DEC. 20, 2016) 8355

INDICTMENTS 8356

CERTIFICATE OF COUNSEL 8366

THE FOLLOWING DOCUMENTS ARE ON FILE WITH THIS COURT:

STATE'S EXHIBIT #177 (PHOTO-KNEE), STATE'S EXHIBIT #206 (BODY RECOVERY VIDEO), STATE'S EXHIBIT #207 (ELIAS BODY RECOVERY PHOTOS), STATE'S EXHIBIT #207A (PHOTO-ELIAS), STATE'S EXHIBIT #207B (PHOTO-ELIAS), STATE'S EXHIBIT #208 (MERAH BODY RECOVERY PHOTO), STATE'S EXHIBIT #208A (PHOTO-MERAH), STATE'S EXHIBIT #208B (PHOTO-MERAH), STATE'S EXHIBIT #209 (GABRIEL BODY RECOVERY PHOTO), STATE'S EXHIBIT #209A (PHOTO-GABRIEL), STATE'S EXHIBIT #209B (PHOTO-GABRIEL), STATE'S EXHIBIT #209C (PHOTO-GABRIEL), STATE'S EXHIBIT #209D (PHOTO-GABRIEL), STATE'S EXHIBIT #210 (ABIGAIL BODY RECOVERY), STATE'S EXHIBIT #210A (PHOTO-ABIGAIL), STATE'S EXHIBIT #210B (PHOTO-ABIGAIL), STATE'S EXHIBIT #211 (NAHTAHN BODY RECOVERY PHOTO), STATE'S EXHIBIT #211A (PHOTO-NAHTAHN), STATE'S EXHIBIT #211B (PHOTO-NAHTAHN), STATE'S EXHIBIT #211C (PHOTO-NAHTAHN), STATE'S EXHIBIT #211D (PHOTO-NAHTAHN), STATE'S EXHIBIT #212 (AUTOPSY-ELI), STATE'S EXHIBIT #212A (PHOTO-ELI), STATE'S EXHIBIT #212B (PHOTO-ELI), STATE'S EXHIBIT #212C (PHOTO-ELI), STATE'S EXHIBIT #213 (AUTOPSY-MERAH), STATE'S EXHIBIT #213A (PHOTO-MERAH), STATE'S EXHIBIT #213B (PHOTO-MERAH), STATE'S EXHIBIT #214 (AUTOPSY-GABRIEL), STATE'S EXHIBIT #214A (PHOTO BODY-GABRIEL), STATE'S EXHIBIT #214B (PHOTO SHIRT-GABRIEL), STATE'S EXHIBIT #214C (PHOTO SLIPPER-GABRIEL), STATE'S EXHIBIT #214D (PHOTO JOURNAL-GABRIEL), STATE'S EXHIBIT #214E (PHOTO DIAPER-GABRIEL), STATE'S EXHIBIT #214G (PHOTO BODY-GABRIEL), STATE'S EXHIBIT #215 (AUTOPSY ABIGAIL), STATE'S EXHIBIT #215A (PHOTO BODY-ABIGAIL), STATE'S EXHIBIT #215B (PHOTO BODY-ABIGAIL), STATE'S EXHIBIT #216 (AUTOPSY NAHTAHN), STATE'S EXHIBIT #216A (PHOTO BODY-NAHTAHN), STATE'S EXHIBIT #216B (PHOTO BODY-NAHTAHN), STATE'S EXHIBIT #216C (PHOTO ELBOW-NAHTAHN), DEFENDANT'S EXHIBIT #135 (CD DR. BIGLER-IMAGES), DEFENDANT'S EXHIBIT #137 (POWERPOINT), COURT'S EXHIBIT #90 (VIDEO-CYNTHIA TURNER)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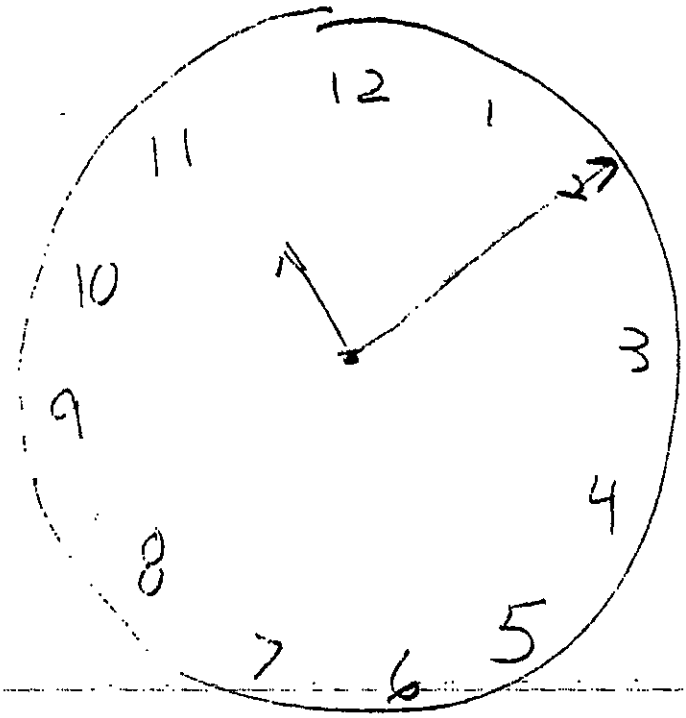
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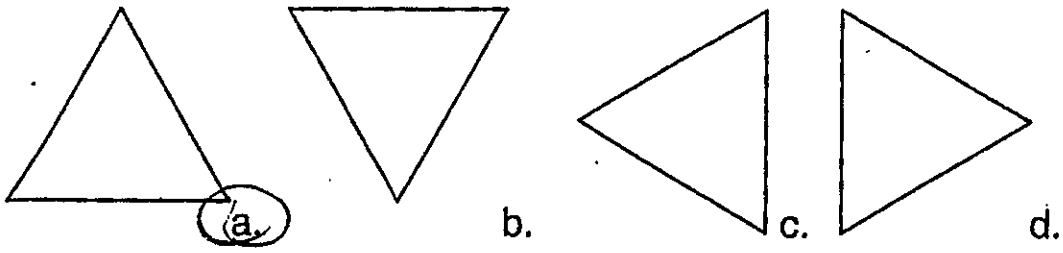

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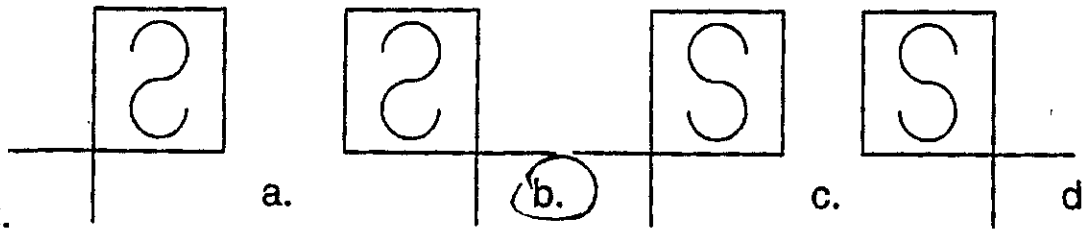

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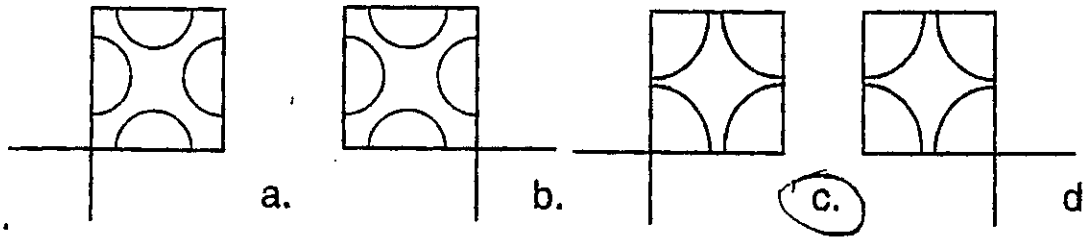

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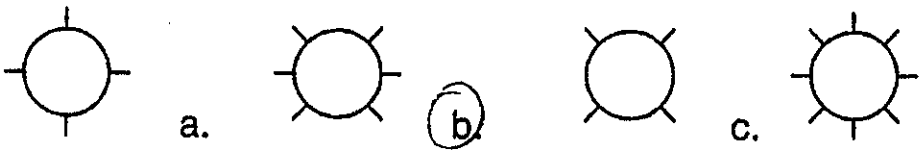

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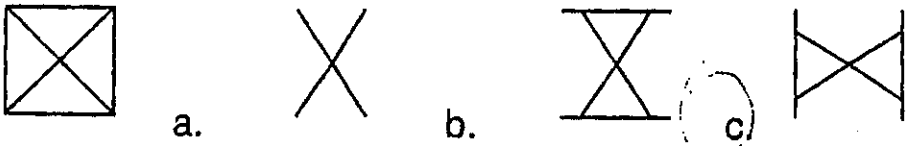

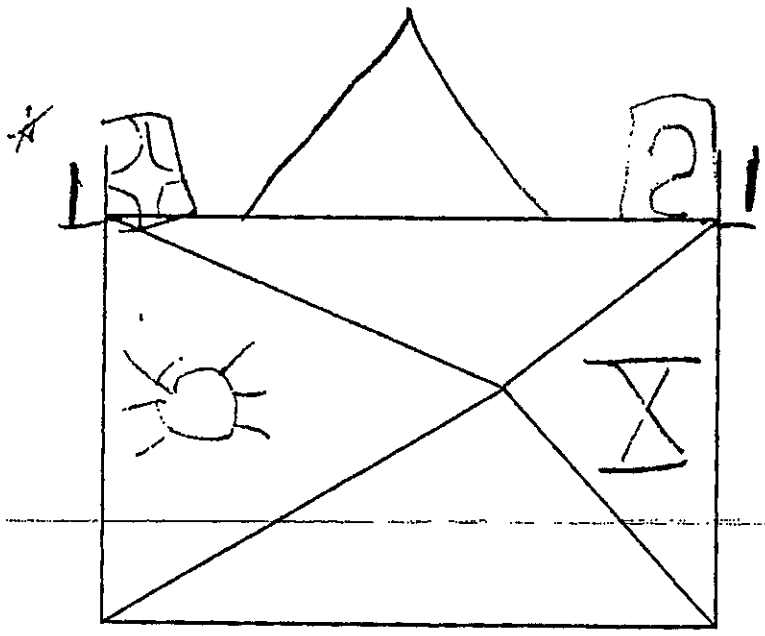

KAPLAN

KBNA™

BAYCREST NEUROCOGNITIVE ASSESSMENT™

Response Booklet

Date of Testing: 2-22-19

Examinee's Name: Timothy Jones Jr

Examiner's Name: Krcyc

PEARSON

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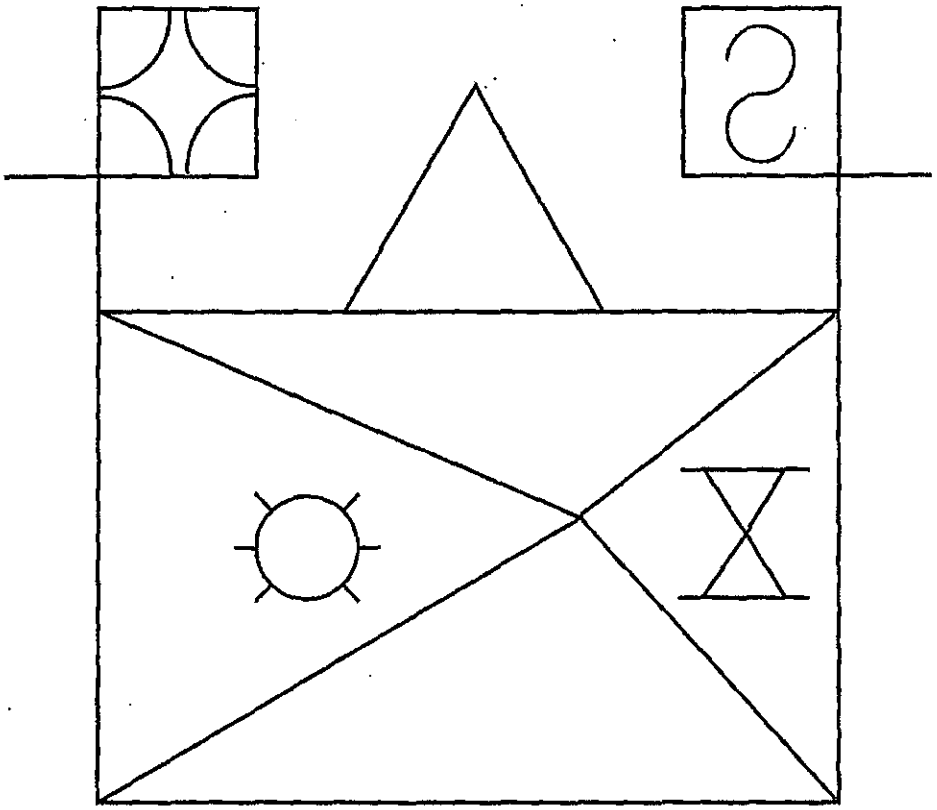
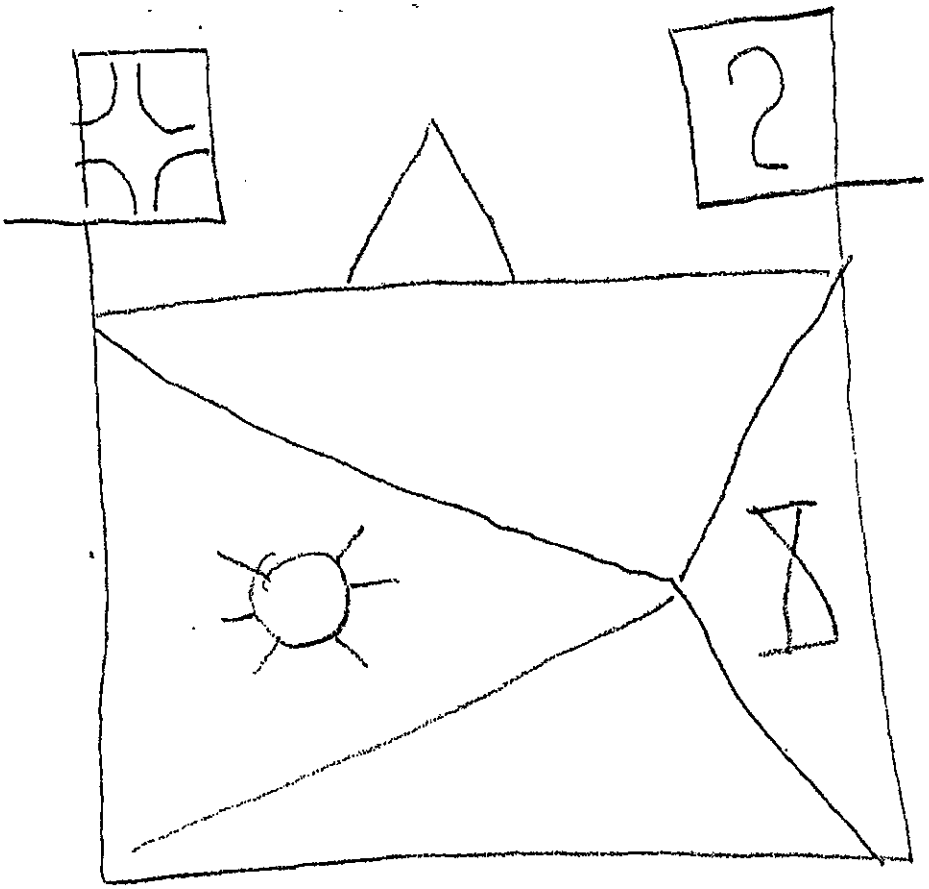
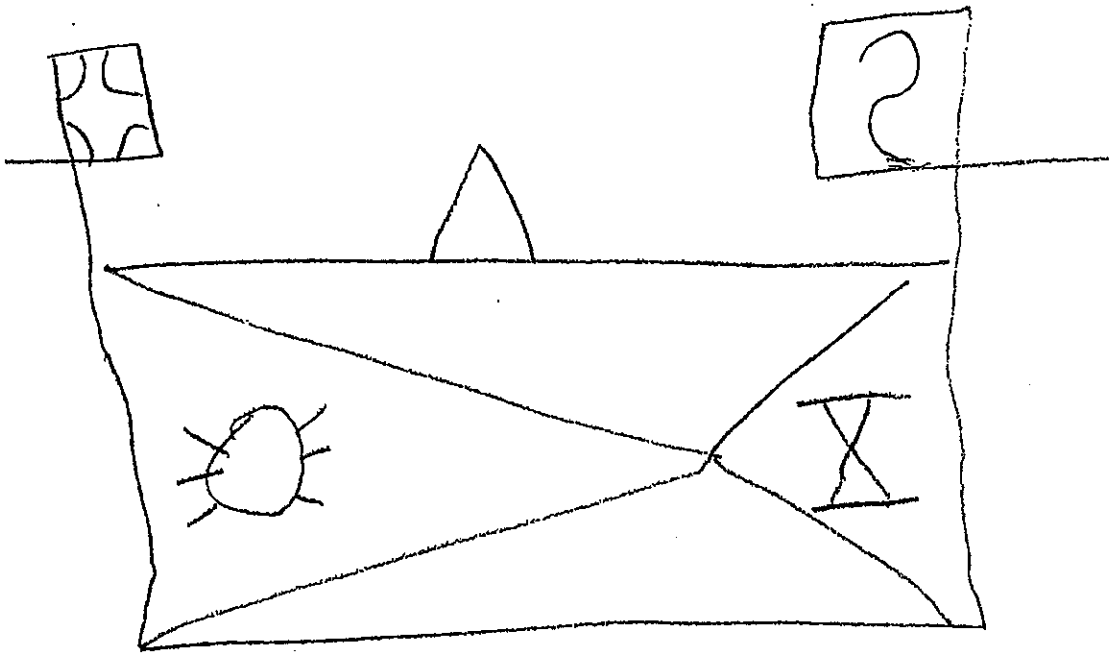
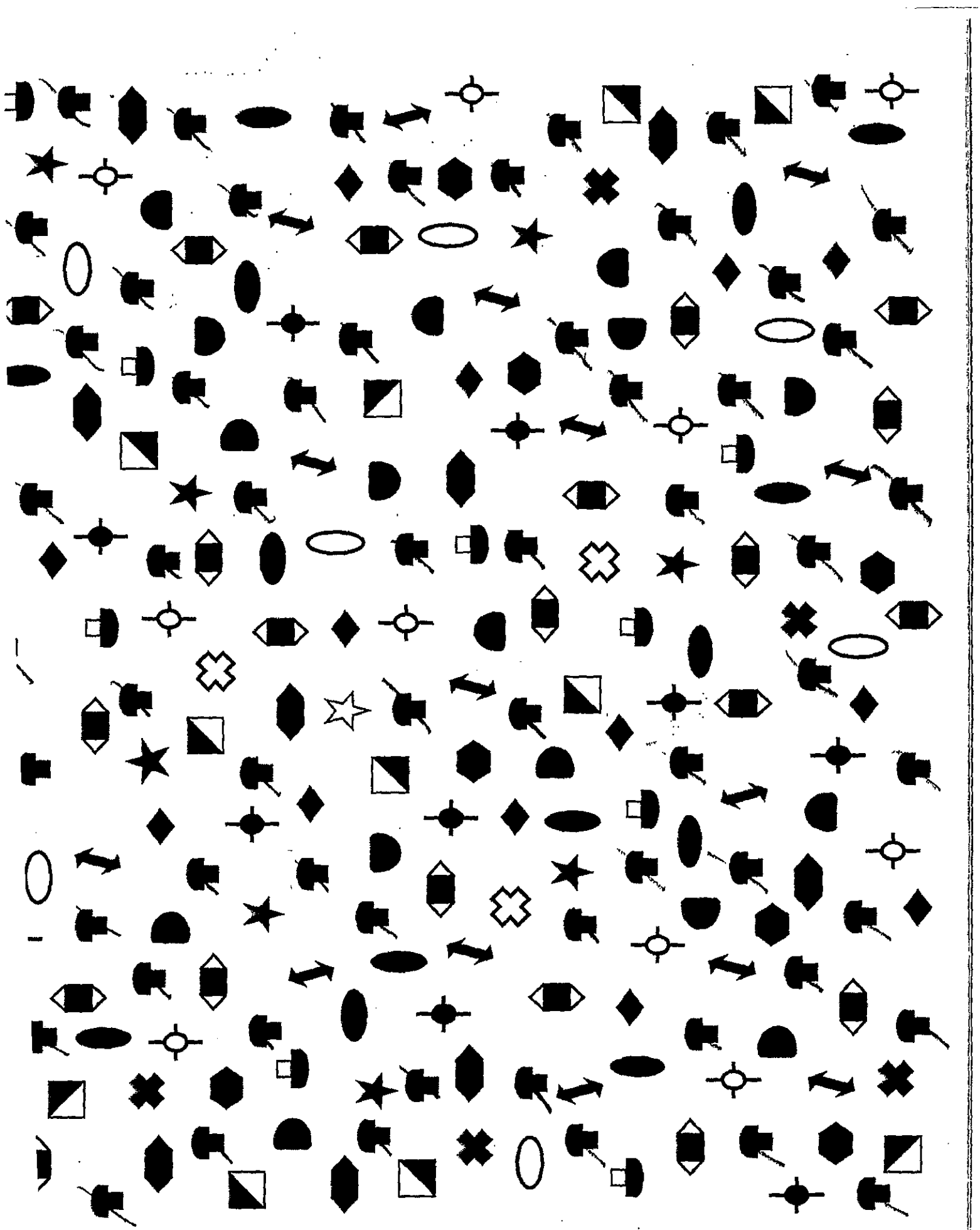
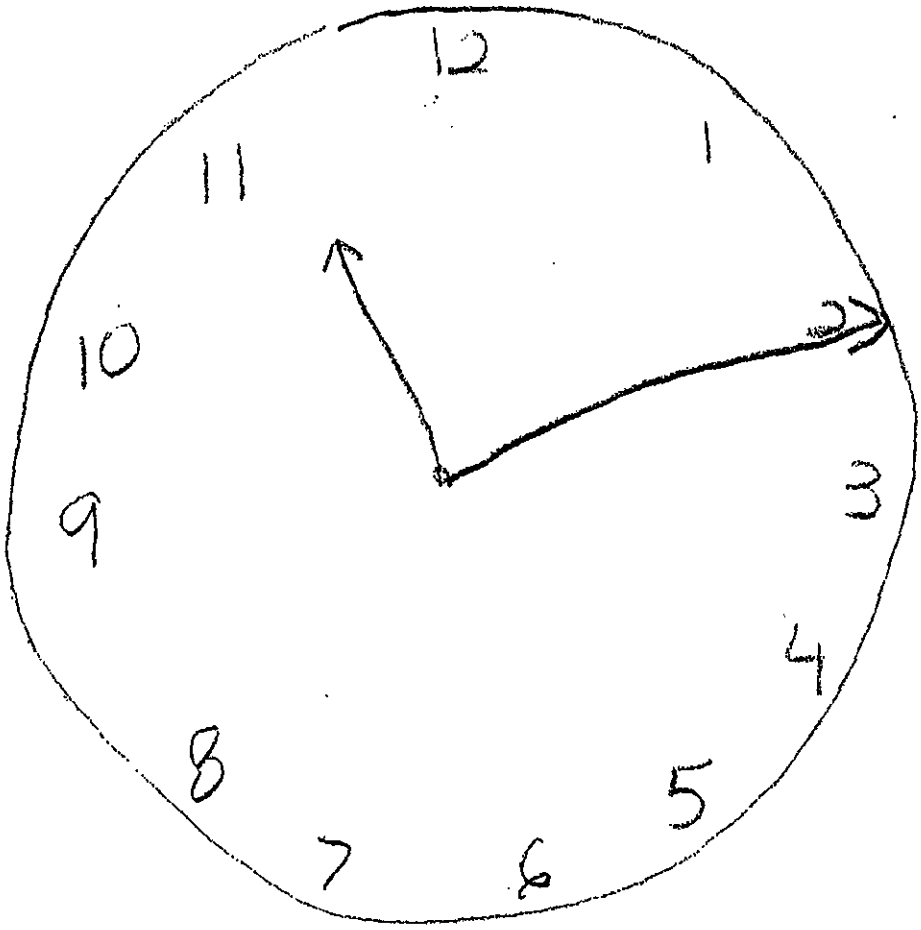
Product Number: 0154170038







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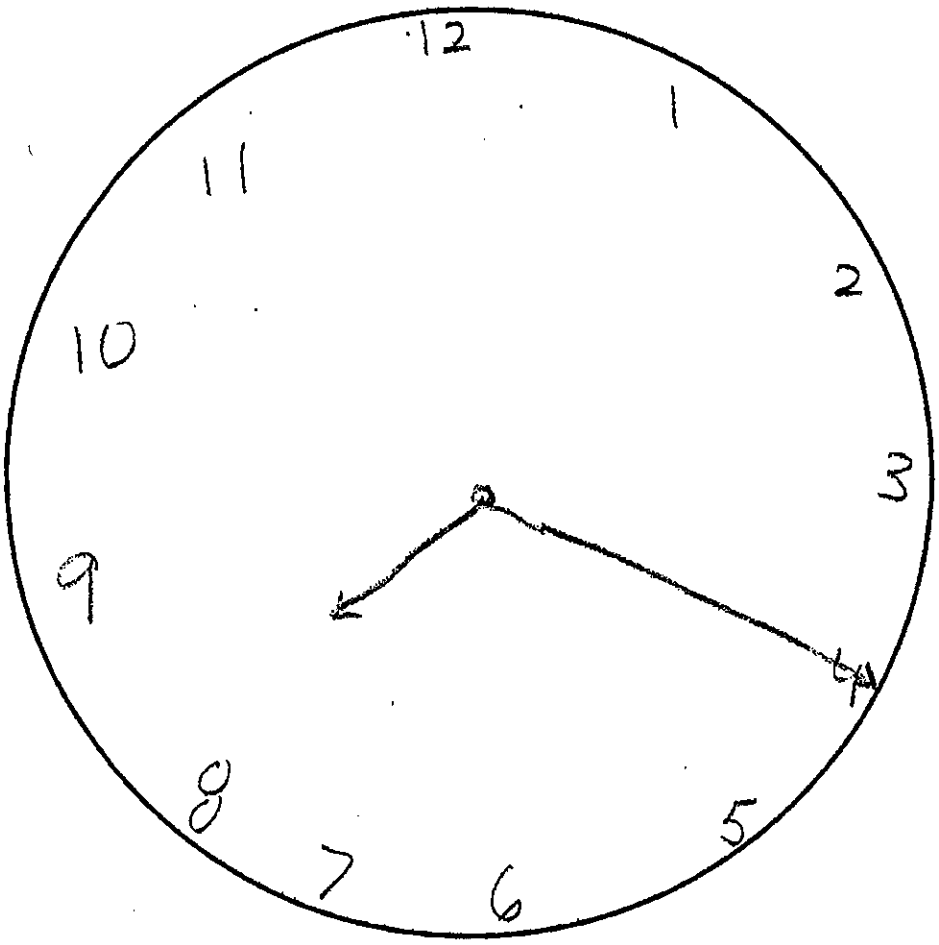

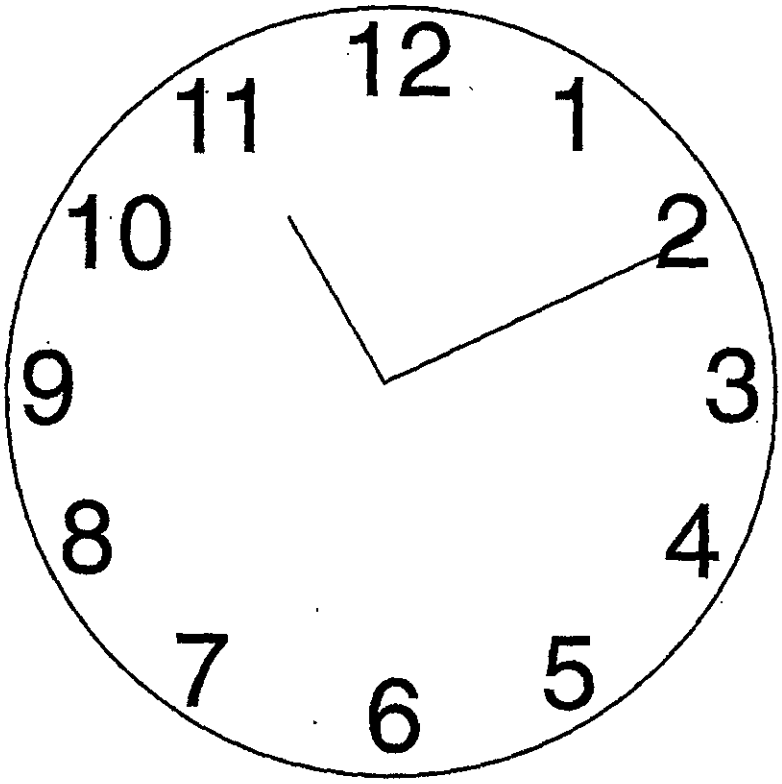
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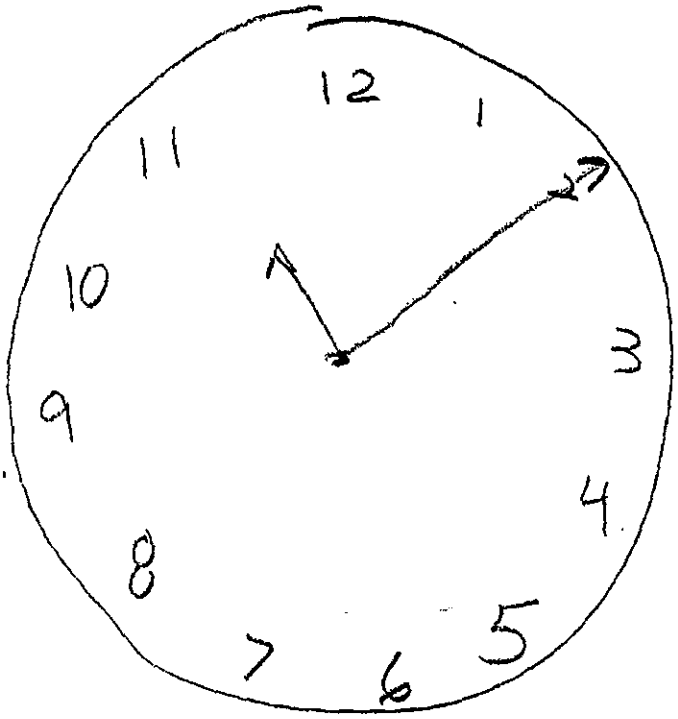
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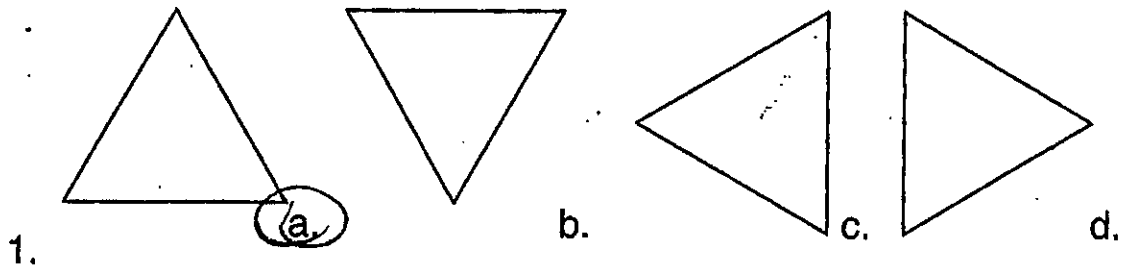
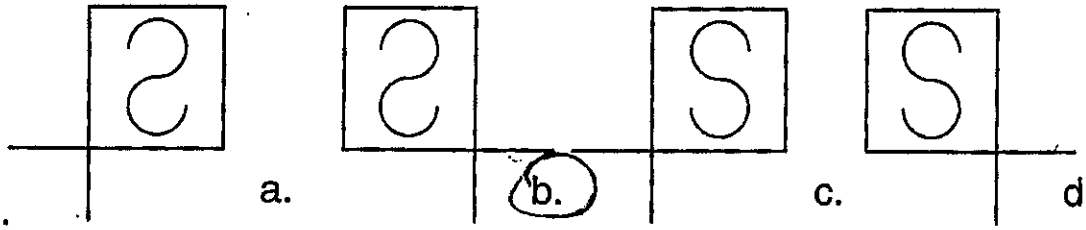
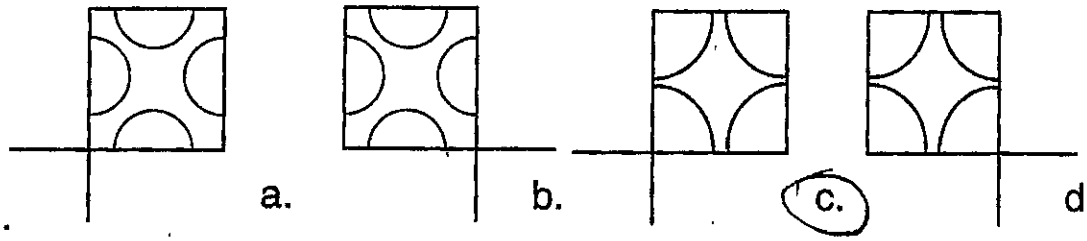


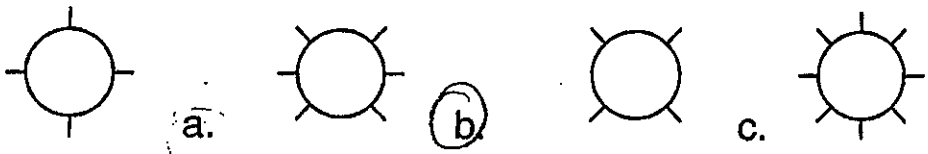
1. a. b. c. d.



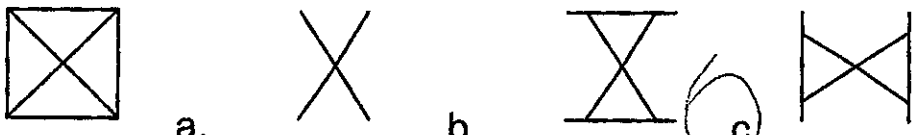
2. a. b. c. d.



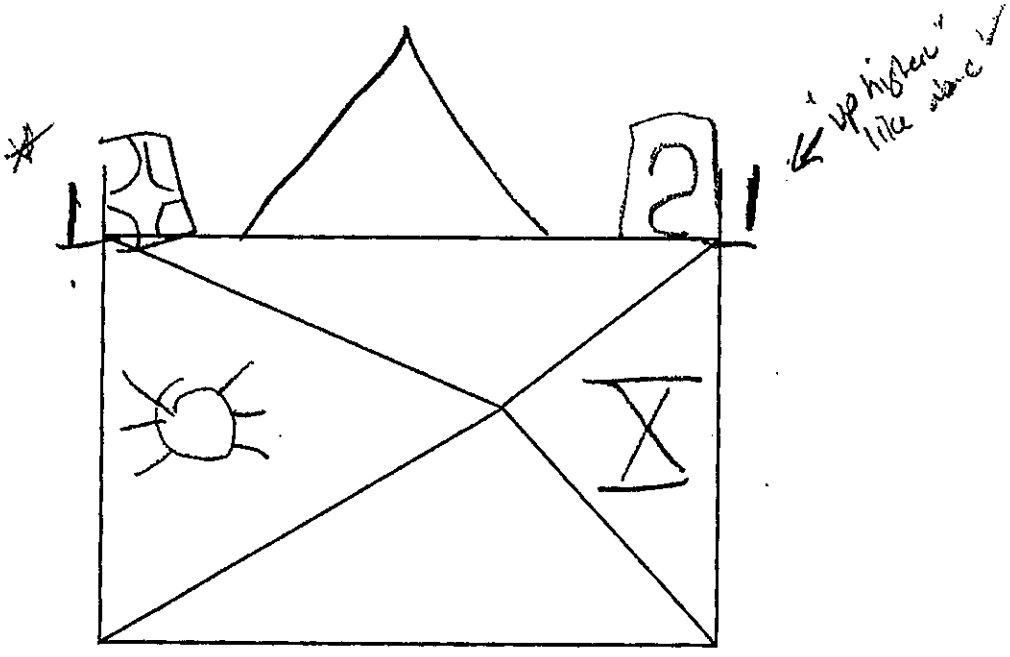
3. a. b. c. d.



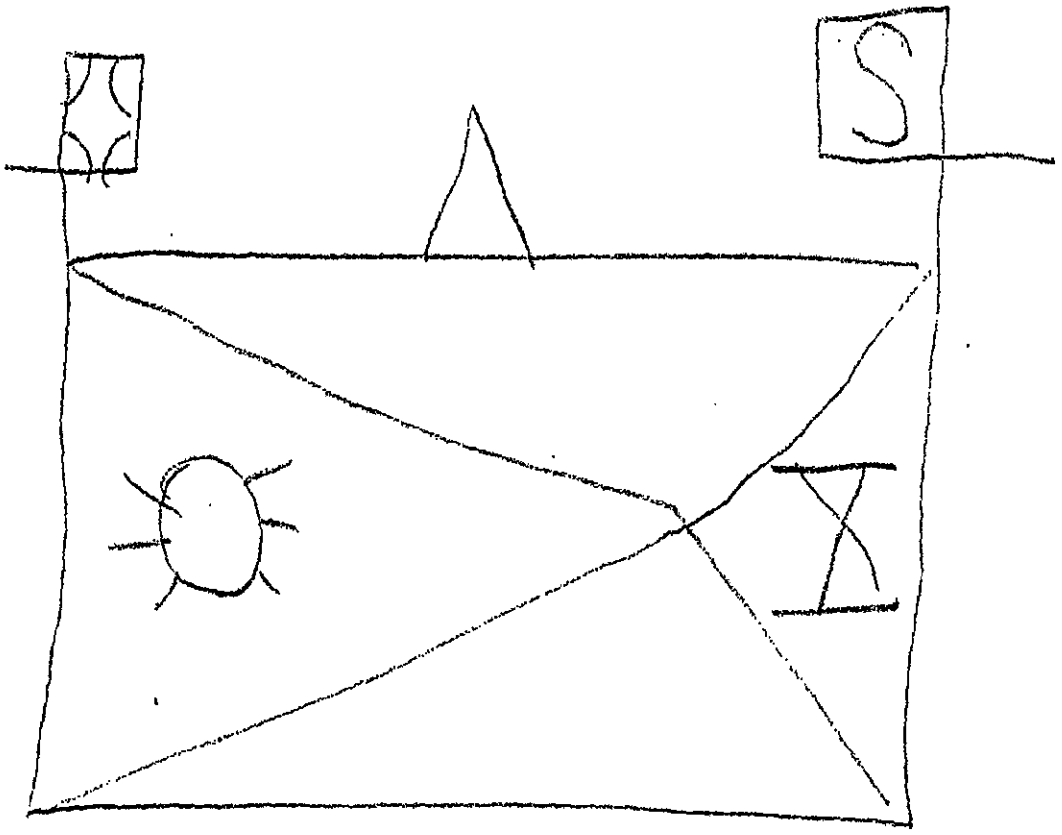
4. a. b. c. d.



5. a. b. c. d.



"upright" like above ✓


S

8012

1. Orientation

Note. Before beginning this subtest, introduce yourself to the examinee. Record responses verbatim. Award 0–1 point for each response.

Item/Response	Score (0, 1)
1. **What is today's date?** If the examinee gives correct month, day, and year, give credit for items 2–3 and skip to Item 4. Friday (2/23)	1
2. **What year is this?** 2009	1
3. **What month is this?** 2	1
4. **What day of the week is this?** F	1
5. **What season is this?** Winter	1
6. **What time is it now?** Actual Time: 1 : 40	1
7. **What is the name of this place?** If the examinee gives a general response (e.g., "hospital"), say, **Yes, but what is the name of this hospital?** C.F. / MH Bldg	1
8. **What city/town are we in now?** Wm.	1
9. **What state/province are we in now?** SC	1
10. **How old are you?** 37	1
11. **When were you born?** [redacted]	1
12. **What is my name?** Is this how you introduced yourself? ✓ Yes ___ No Dr. Kimberly Rose	1
13. **Is this the first time we have met?** Have you met the examinee before? ✓ Yes ___ No	1
Total Score	(0–13) 13

2. Sequences

For each item, record responses verbatim and completion time in seconds. Award 1 point for each correct response and sum the points to obtain the item score.

Item/Correct Response	Response	Completion Time	Item Score
1. **Months Forward** Jan Feb Mar Apr May June July Aug Sept Oct Nov Dec	✓	WNL	(0–12) 12
2. **Months Backward** Dec Nov Oct Sept Aug July June May Apr Mar Feb Jan	✓	WNL	(0–12) 12
3. **Letters Rhyming With *Key*** B C D E G P T V Z	✓	↓	(0–9) 9
4. **Curved Capital Letters** B C D G J O P Q R U	✓	↓	(0–11) 11
5. **Counting Backward by Fours** 60 56 52 48 44 40 36 32 28 24 20 16 12 8 4	✓	↓	(0–13) 13
		WNL	(0–57) 57
		Total Completion Time	**Total Score**

3. Numbers

Record responses verbatim for each oral trial. For each trial, award 1 point for each correct response. Sum the trial scores to obtain the item score.

Item	Oral Trial 1		Oral Trial 2		Written Trial		Item Score (0–3)
	Response	Score	Response	Score	Response	Score	
1. 279–57–64							
2. 591–08–32							
3. 913–863–80–95							
						Total Score	(0–9)

Trial 3

	Response Type								
	Intrusions			Clusters		Regions			Score
	S	NS	Repetition	C	S	P	M	R	(0, 1)
Asparagus	✓								
Milk	✓								
Notebooks	✓								
Coffee	✓								
Folders	✓								
Spinach	✓								
Lemonade	✓								
Celery	✓								
Envelopes	✓								
Potatoes	✓								
Scissors	✓								
Soda	✓								
Trial 3 Sums									(0–12) 10
	Combined 0								

Trial 4

Asparagus	✓								
Milk	✓								
Notebooks									
Coffee	✓								
Folders									
Spinach	✓								
Lemonade	✓								
Celery	✓								
Envelopes	✓								
Potatoes	✓								
Scissors	✓								
Soda	✓								
	Letters	✓							
Trial 4 Sums									(0–12) 12
	Combined 1								

Subtest Sums	Intrusions			Clusters		Regions			(0–48)	
	S	NS	Repetitions	C	S	P	M	R		
	X	1	—						36	Recall Total Score
	Combined									

8014

7. Auditory Signal Detection

Circle each target that is endorsed and cross through each nontarget that is endorsed. Award 1 point for each target endorsed. Sum the number of nontargets endorse

Practice Trial

L B **A** Q R **A** X **A** T C

Scoring Trial

V U **A** N M H D C T **A** J S F P Y J
Y P W X **A** G I C X B Q M F I F N
J C P **A** W U F M R B Y **A** P G I X
T E W R U X Y B L O J E **A** L U U
A X J C X **A** E G C H U P N V U F
S B **A** D M X H F Q K B F P B T U
N V **A** C D O **A** E S F R B J* I R J
F T G M Y T **A** L I O L **A** S Q G S
B H I O Q N **A** H K F P R Y **A** V G
V K Y J T P E L Q F D **A** L M H D
Q I **A** R X **A** I J U X B E Q H K R
M **A** D E R N N O X O Y X B Y **A** E
F D H **A** J N V I X X U V T J P P
L R R M **A** Q R D

Targets	
First Half	(0–11)
Second Half	(0–11)
Combined	(0–22)

Nontargets	
First Half	(0–97)
Second Half	(0–97)
Combined	(0–194)

Targets Combined		Nontargets Combined			
(0–22)	–	(0–194)	=	(0–22)	Adjusted Score

8. Symbol Cancellation

Allow the examinee up to 2 minutes to complete the page. Award 1 point for each target symbol endorsed. Sum the number of nontargets endorsed.

Targets	
Left Half	(0–30)
Right Half	(0–30)
Combined	(0–60)

Nontargets	
Combined	(0–150+)

Targets Combined		Nontargets Combined			
(0–60)	–	(0–150+)	=	(0–60)	Adjusted Score

10. Word Lists 2

Free Recall

Record responses verbatim and enter a check mark in the applicable response-type column. Award 1 point for each correct response.

Do Not Read	Response	Response Type: Intrusions S	Intrusions NS	Repetition	Clusters C	Clusters S	Score (0, 1)
Asparagus							
Milk							
Notebooks							
Coffee							
Folders							
Spinach							
Lemonade							
Celery							
Envelopes							
Potatoes							
Scissors							
Soda							
	Letters						
	Sums						(0–12)
		Combined					

Free Recall Score

Free Recall Score [ ] ÷ Word Lists 1 Trial 4 [ ] × 100 = [ ] % Percent Retention

Cued Recall

Record responses verbatim and enter a check mark in the applicable response-type column. Award 1 point for each correct response.

	Response	Response Type: Intrusions S	Intrusions NS	Repetition	Score (0, 1)
Vegetables	Asp.				
	Pots.				
	Celery				
	Spi.				
Beverages	Milk				
	Coffee				
	Soda				
	Lem.				
Office Supplies	Letters X		✓		
	Scissors				
	Notebooks				
	envelopes				
	Sums	—	—	—	(0–12)
		Combined			

Cued Recall Score

Free Recall [9] + Cued Recall [11] = [20] (0–24) Recall Total Score

8016

11. Complex Figure 2

Recall

Enter a check mark for each criterion element included in the examinee's drawing and award 0–2 points according to the criteria here and in Appendix A.

Criterion Element	Included	Score (0–2)	Scoring Criteria
Large Rectangle	✓	2	Four sides are present and resemble a rectangle, not a square. Four sides meet at right angles (i.e., >75°).
Small Squares	✓	2	Both squares are present and positioned above large rectangle and at the top of the vertical extensions; each contains four right angles (i.e., >75° and <105°); ratio of longest to shortest side is ≤1:1.2.
Semicircles	✓	2	Four semicircles are present and do not touch each other or intersect.
Backward S	✓	2/1	Shape is that of an S facing backward and does not touch any sides of the small square.
Triangle	✓	2	A triangle is present and rests on top and within 5% of center of the large rectangle. The sides are approximately equal in length, within a ratio of 1:1.2.
Oblique Lines	✓	2	Four oblique lines are present, each starting within 1/8" of each corner of the rectangle. They join within 1/8" of an imaginary horizontal bisector of the rectangle and to the right of center of the rectangle.
Sunburst	✓	2	A circle with six short lines extending outward from its perimeter is positioned in the correct sector of the rectangle. Three of the lines are on the left of the circle, and three are on the right.
X	✓	2	An X with two intersecting line segments and with top and bottom horizontal lines is positioned within the correct sector of the large rectangle.
Vertical Extensions	✓	2	Two lines extend vertically, one from the upper-left and one from the upper-right corner of the large rectangle. The ratio of each extension to the height of the rectangle ranges from 1:1.25 to 1:1.18.
Horizontal Extensions	✓	2	Two lines extend horizontally, approximately parallel to the top of the rectangle, one from each of the lower side of the small squares. Each line is between 1.5 and 1.9 of the length of the side of the squares.
		19 (0–20)	**Recall Total Score**

Recognition

For the identification task, record the letter corresponding to the examinee's response. For the placement task, enter a check mark for each correct placement. For each task, award 1 point for each correct response.

Criterion Element	Identification: Correct Response	Identification: Response	Identification: Score (0,1)	Placement: Scoring Criteria	Placement: Correct Placement	Placement: Score (0,1)
Triangle	a	a	1	Must rest on top of rectangle and within 5% of center of rectangle	✓	1
Right Square	b	b	1	Must be above and right of the rectangle, within 5% of vertical extension	✓	1
Left Square	c	c	1	Must be above and left of the rectangle, within 5% of vertical extension	✓	1
Sunburst	b	b	1	Must be in left sector of rectangle	✓	1
X	c	b ✓	1	Must be in right sector of rectangle	✓	1
					10 (0–10)	**Recognition Total Score**

13. Sentence Reading–Arithmetic

For Items 1–2, record the examinee's reading of the problems verbatim. Award 0–2 points for reading accuracy. For items 1–2 and the arithmetic problems, award 1 point for each correct response.

Item	Response	Reading Accuracy Score (0–2)	Item	Correct Response	Arithmetic Score (0–1)
1			1	$4.18	
			2	$0.82	
			4 + 8	12	
			16 + 34	50	
			453 + 926 + 187	1,566	
2			38 – 5	33	
			76 – 13	63	
			831 – 546	285	
			7 × 8	56	
			27 × 3	81	
	Reading Accuracy Score	(0–4)	615 × 16	9,840	
				Arithmetic Score	(0–11)

14. Reading Single Words

Enter a check mark for each correct pronunciation. Record incorrect responses verbatim. Award 1 point for each correct response.

Item	Response	Item Score: Regular Words	Item Score: Irregular Words	Item Score: Pseudo-words	Total Score
1. Throng					
2. Gauge					
3. Caum (cawm)					
4. Skate					
5. Thorough					
6. Scane (skayn)					
7. Armament					
8. Heir					
9. Prode (proad)					
10. Grill					
11. Basten (bas ten, bays ton)					
12. Benign					
13. Splendid					
14. Montle (mon tel, mun tel)					
15. Biscuit					
		(0–5)	(0–5)	(0–5)	(0–15)

8018

16. Verbal Fluency ✓

Record responses verbatim. Enter a check mark for each perseveration (*P*) and each intrusion (I). Award 1 point for each correct response.

C Words

1–15 Seconds Responses	Score (0,1)	P	I	16–30 Seconds Responses	Score (0,1)	P	I	31–45 Seconds Responses	Score (0,1)	P	I	46–60 Seconds Responses	Score (0,1)	P	I
Cat	1			Children	1			Carpet				Coolant			
Carry	1			Cap	1			Chill				Cornmeal			
Cold	1			Cancel	1										
Camera	1			Crispy	1										
Call	1			Cultivator	1										
Craft	1			Candy	1										
Creek	1														
Court	1														
	8				6				2				2		

C Words Score: 18

Animals

1–15 Seconds Responses	Score (0,1)	P	I	16–30 Seconds Responses	Score (0,1)	P	I	31–45 Seconds Responses	Score (0,1)	P	I	46–60 Seconds Responses	Score (0,1)	P	I
Rabbit	1			cat	1			fish	1			[illegible]	1		
lion	1			rabbit	1			[illegible]	1			[illegible]	1		
chick	1			bear	1			sea [illegible]	[illegible]			[illegible]	1		
donkey	1			dog	1							[illegible]	1		
[illegible]	1			[illegible]	1										
cat	1			pig	1										
horse	1			[illegible]	1										
cow	1			fish	1										
bull	1														
bobcat	1														
	10				8				3				4		

Animals Score: 25

First Names

1–15 Seconds Responses	Score (0,1)	P	I	16–30 Seconds Responses	Score (0,1)	P	I	31–45 Seconds Responses	Score (0,1)	P	I	46–60 Seconds Responses	Score (0,1)	P	I
Peter	1			Tim	1			Ase	1			Father	1		
Alex	1			Jonathan	1			Ambrose	1			Jen	1		
Boyd	1			Jones	1			Marcy	1			James	1		
Laura	1			Peter	1			Amos	1			Xavier	1		
Sara	1			Matt	1			Sam	1			Steven	1		
Bob	1			Paul	1			Matt				Travis	1		
Kate	1			Luther	1			[illegible]	1			Amy	1		
Carl	1			Cole	1										
Chas	1			Miamar	1										
Brad	1			Veronica	1										
	10				10				7				7		

First Names Score: 34

1–15 Seconds Score [ ] + 16–30 Seconds Score [ ] + 31–45 Seconds Score [ ] + 46–60 Seconds Score [ ] = [ ] Total Score

Total Perseverations [ ] Total Intrusions [ ]

Phonemic Fluency (*C* Words): 18

Semantic Fluency (Animals + First Names): 59

25 + 34

18. Picture Recognition

Circle *Y* or *N* for each response. For each ***Incorrect*** response, enter a check mark in the applicable Error Type column. Correct responses are printed in boldfaced italics. Award 1 point for each correct response.

Item	Response		Error Type				
			Semantic	Perceptual	Semantic/ Perceptual	Unrelated	
1. Windmill	***Y***	N					
2. Goat	Y	***N***					
3. Clothespin	***Y***	N					
4. Spinning wheel	Y	***N***					
5. Spider	Y	***N***					
6. Motorcycle	***Y***	N					
7. Rocking chair	***Y***	N					
8. Guitar	Y	***N***					
9. Well	Y	***N***					
10. Belt	Y	***N***					
11. Cow	***Y***	N					
12. Pliers	Y	***N***					
13. Piano	***Y***	N					
14. Tie	***Y***	N					
15. Switch	***Y***	N					
16. Trumpet	Y	***N***					
17. Chair	Y	***N***					
18. Iron	***Y***	N					
19. Umbrella	Y	***N***					
20. Shirt	***Y***	N					
21. Toaster	Y	***N***					
22. Nail file	Y	***N***					
23. Violin	***Y***	N					
24. Telephone	***Y***	N					
25. Dress	Y	***N***					
26. Screw	***Y***	N					
27. Roller skate	Y	***N***					
28. Helicopter	Y	***N***					
29. Owl	***Y***	N					
30. Lobster	***Y***	N					
31. Frog	***Y***	N					
32. Pumpkin	Y	***N***					
33. Lamp	Y	***N***					
34. Star	Y	***N***					
35. Kangaroo	***Y***	N					
36. Television	Y	***N***					
37. Barrel	***Y***	N					
38. Eagle	Y	***N***					
39. Envelope	***Y***	N					
40. Anchor	***Y***	N					
Total Score	(0–40)		(0–5)	(0–5)	(0–5)	(0–5)	(0–20) **Total Errors**

8020

21. Conceptual Shifting

For each part of each item, circle the numbers corresponding to the examinee's selections of designs and record the attribute descriptions verbatim. Award 1 point fc each correct response.

Item	Design Selections	Attribute Description	Correct Response	A Score (0, 1)	B Score (0, 1)
1. A	(1) (2) 3 (4)	shape	1, 2, 4: same shape	1	
B	(1) 2 (3) (4)	colored	1, 3, 4: same shading		1
2. A	(1) 2 (3) (4)	sizes	1, 3, 4: same size	1	
B	(1) 2 (3) 4	shade/colored	1, 3, 4: same shading		1
3. A	1 (2) (3) (4)	oriented same	2, 3, 4: same orientation	1	
B	(1) (2) (3) 4	Ø shad	1, 2, 3: all white or no shading		1
4. A	(1) (2) 3 (4)	shape	1, 2, 4: same shape	1	
B	(1) 2 (3) (4)	Ø color	1, 3, 4: all white or no shading		1
5. A	1 (2) (3) (4)	oriented same	2, 3, 4: same orientation	1	
B	(1) (2) (3) 4	shading	1, 2, 3: same shading		1
6. A	(1) (2) (3) 4	shape (external)	1, 2, 3: same external shape	1	
B	(1) 2 (3) (4)	circle (internal)	1, 3, 4: same internal shape		1
7. A	(1) 2 (3) (4)	oriented same	1, 3, 4: same orientation	1	
B	1 (2) (3) (4)	Δ corners	2, 3, 4: small triangle in same corner		1
8. A	(1) (2) (3) 4	open	1, 2, 3: open figure	1	
B	(1) (2) 3 (4)	line/curve	1, 2, 4: line and curve		1
9. A	(1) (2) 3 (4)	direction	1, 2, 4: point in same direction	1	
B	(1) (2) 3 (4)	# petals	1, 2, 4: same number of petals		1
10. A	(1) 2 (3) (4)	shady	1, 3, 4: same shading in square	1	
B	(1) 2 (3) (4)	Δ shading	1, 3, 4: same shading in triangle		1
				(0–10) 10	(0–10) 11

A Score	B Score	Total Score
		(0–20) 20

22. Picture Description–Oral

Record the examinee's description verbatim (you may use a cassette recorder). Assign a point rating that best corresponds to the description. Roughly estimate the average length of all phrases.

(0–4)	Content Score

≥ 6 words	2
3–5 words	1
< 3 words	0

Phrase Length Score

23. Auditory Comprehension

Circle *Y* or *N* in the appropriate column to indicate the examinee's response to the first or second reading of the question. Award 2 points for a correct response to the ***first*** reading or 1 point for a correct response to the ***second*** reading. Correct responses are printed in boldfaced italic.

Item	First Reading		Second Reading		Score (0–2)
1. Is there a chair in this room?	***Y***	N	***Y***	N	
2. Is a comb good for brushing your teeth?	Y	***N***	Y	***N***	
3. Do you buy shoes in a furniture store?	Y	***N***	Y	***N***	
4. Do you put on your shoes after your socks?	***Y***	N	***Y***	N	
5. If the bear was killed by the tiger, is the tiger dead?	Y	***N***	Y	***N***	
					(0–10) Total Score

24. Repetition

Record responses verbatim. Award 1 point for each correct response.

Item	Response	Score (0, 1)
1. Belong		
2. President		
3. Authorized signature		
4. If he comes, I will go.		
5. The prosecutor's closing argument convinced the jury.		
		(0–5) Total Score

25. Picture Description–Written

Assign a point rating that best corresponds to the description.

(0–4) Content

19. Expression of Emotion

Enter a check mark for each ***correct*** spontaneous (S) or imitated (I) expression. Award 2 points for each ***correct spontaneous*** expression and 1 point for each ***correct imitated*** expression.

Expression	Spontaneous	Score (0, 2)	Imitation	Score (0, 1)
1. Angry				
2. Happy				
3. Surprised				
4. Sad				
	Spontaneous Score	(0–8)	Imitation Score	(0–4)

20. Practical Problem Solving

Record responses verbatim. For each item, award 2 points for ***two*** acceptable responses or 1 point for ***one*** acceptable response (printed in *italics*).

Item	Acceptable Responses	Response	Score (0–2)
1. What would you do if you smelled smoke in your house or apartment?	*notify fire department; try to locate source and extinguish fire, if possible; leave the house or apartment*	- yell fire ✓ - look for source ✓	2
2. What would you do if you were told that the water to your house would be turned off for 3 days?	*collect enough water by some means to last for 3 days; purchase bottled water; arrange to stay some place else for 3 days*	- go to hotel - call a friend to stay	2
3. You were informed that you owe $2,000 in taxes. You do not have that much money available. What could you do?	*borrow money from some source or arrange for a loan; ask for an extension for payment; ask to pay by installments; sell stocks/bonds to obtain money; cash savings bonds; sell property or real estate to obtain money*	- call IRS to arrange - take loan	2
4. If someone visiting you suddenly reported feeling sick and then fainted, what would you do?	*offer immediate assistance, such as lay the person down; telephone for medical assistance; call 9–1–1*	- pulse - 9-1-1	2
5. What would you do if you saw a 2-year-old child playing in the middle of the street?	*immediately remove the child from the street; tell the child's parents; yell to the child to move*	- get child & take him up in arms - look for car or parents	2
			10 (0–10) Total Score

17. Praxis

8023

Record the examinee's dominant hand. Enter a check mark for each spontaneous (S) or imitated (I) correct movement. Award 2 points for each ***correct spontaneous*** movement and 1 point for each ***correct imitated*** movement.

Examinee's Dominant Hand	
R	L

Intransitive Movements

Dominant Hand			
Movement	S	I	Score (0–2)
1. Wave			
2. Motion "Come here"			
3. Signal "Stop"			
4. Salute			

Nondominant Hand			
Movement	S	I	Score (0–2)
1. Wave			
2. Motion "Come here"			
3. Signal "Stop"			
4. Salute			

\+ = (0–16) **Intransitive Score**

Transitive Movements

Dominant Hand			
Movement	S	I	Score (0–2)
1. Turn key			
2. Hammer			
3. Brush teeth			
4. Comb hair			

Nondominant Hand			
Movement	S	I	Score (0–2)
1. Turn key			
2. Hammer			
3. Brush teeth			
4. Comb hair			

\+ = (0–16) **Transitive Score**

Buccofacial Movements

Movement	S	I	Score (0–2)
1. Blow candle			
2. Suck straw			
3. Lick crumbs			
4. Cough			

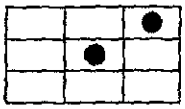
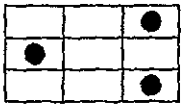
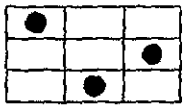
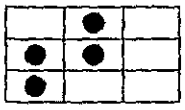
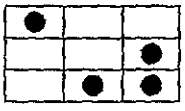
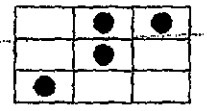
= (0–8) **Buccofacial Score**

Intransitive + Transitive + Buccofacial = (0–40) **Total Score**

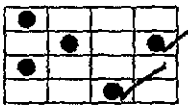
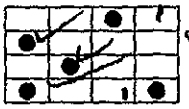
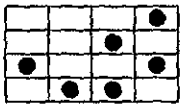
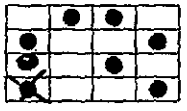
15. Spatial Location

For each item, mark an X on the grid to indicate correct and incorrect chip placements. Grids are shown from the examiner's view. Item adjusted scores are based on the following general formula: **Number of Correct Chip Placements *minus* [Total Number of Chips Placed minus Correction Factor]**. Use the formula provided with each item to obtain the item adjusted score. Sum the item adjusted scores to obtain the subtest adjusted score.

3 x 3 Grid

Item		Adjusted Score
Practice		
1		3 (Number Correct) − [3 (Total Chips) −3] = ✓
2		___ (Number Correct) − [___ (Total Chips) −3] = ✓
3		___ (Number Correct) − [___ (Total Chips) −4] = ✓
4		___ (Number Correct) − [___ (Total Chips) −4] = ✓
5		___ (Number Correct) − [___ (Total Chips) −4] = ✓

4 x 4 Grid

Item		Adjusted Score
6		5 (Number Correct) − [5 (Total Chips) −5] = 5
7		5 (Number Correct) − [5 (Total Chips) −5] = 5
8		3 (Number Correct) − [5 (Total Chips) −5] = 3
9		6 (Number Correct) − [6 (Total Chips) −6] = 6
10		6 (Number Correct) − [7 (Total Chips) −7] = 6

(0–46) 43 **Adjusted Score**

12. Picture Naming

8025

Record all responses verbatim. Record completion time and award 1 point for each ***correct, spontaneous*** response.

	Spontaneous			Semantic Cue		Phonemic Cue	
Item	Response	Score (0–1)	Time	The artist was trying to draw . . .	Response	The first sound of the word is. . .	Response
1. Cow				an animal		*c*	
2. Shirt (blouse)				an article of clothing		*sh*	
3. Telephone (phone)				a means of communication		*te*	
4. Tie (necktie, cravat)				something worn with a shirt		*t*	
5. Owl				a bird		*ow*	
6. Switch (light switch)				something to do with electricity		*sw*	
7. Iron (steam iron)				an appliance		*ir*	
8. Motorcycle (motorbike, bike)				a means of transportation		*mo*	
9. Piano (grand piano)				a musical instrument		*pi*	
10. Screw				a piece of hardware		*sc*	
11. Violin (viola, fiddle, cello)				a musical instrument		*vi*	
12. Clothespin (clothespeg)				something used to hang laundry		*cl*	
13. Rocking Chair (rocker)				a piece of furniture		*ro*	
14. Windmill				a building often found in Holland		*wi*	
15. Lobster (crayfish, crawdad)				something that lives in the ocean		*lo*	
16. Frog (toad)				something that lives in a pond		*fr*	
17. Kangaroo				an Australian animal		*ka*	
18. Barrel				something to store things in		*ba*	
19. Envelope				something used for a letter		*en*	
0. Anchor				something used by boats or ships		*an*	
	Total Score	(0–20)		Completion Time	Semantic Cues (0–20)		Phonemic Cues (0–20)

10. Word Lists 2

Recognition

Circle *Y* or *N* for each response. For each *yes* response (correct or incorrect), enter a check mark in the applicable response-type column. Correct responses are printed in boldfaced italics. Award 1 point for each correct response.

Item	Response	Hit	FPR	FPU	Score (0,1)
1. Corn	Y ***N***				
2. Milk	***Y*** N				
3. Envelopes	***Y*** N				
4. Spaghetti	Y ***N***				
5. Asparagus	***Y*** N				
6. Fish	Y ***N***				
7. Shampoo	Y ***N***				
8. Potatoes	***Y*** N				
9. Erasers	Y ***N***				
10. Folders	***Y*** N				
11. Tea	Y ***N***				
12. Soap	Y ***N***				
13. Pears	Y ***N***				
14. Lemonade	***Y*** N				
15. Paint	Y ***N***				
16. Juice	Y ***N***				
17. Mop	Y ***N***				
18. Scissors	***Y*** N				
19. Cola	Y ***N***				
20. Onions	Y ***N***				
21. Spinach	***Y*** N				
22. Soda	***Y*** N				
23. Notebooks	***Y*** N				
24. Broccoli	Y ***N***				
25. Cocoa	Y ***N***				
26. Detergent	Y ***N***				
27. Toothpaste	Y ***N***				
28. Pencils	Y ***N***				
29. Celery	***Y*** N				
30. Staples	Y ***N***	−1			
31. Blueberries	Y ***N***				
32. Coffee	***Y*** N				
33. Lamb	Y ***N***				
34. Sponge	Y ***N***				
35. Paper	Y ***N***				
36. Carrots	Y ***N***				
	Sums	(0–12) 11	(0–12) 12	(0–12) 12	(0–36) 35 Recognition Total Score
			Combined		

Hits (0–12) — False Positives Combined (0–24) = (0–12) Adjusted Score

9. Clocks

8027

Free Drawing, Predrawn, Copy

For each component, enter a check mark for each included feature. Award 0–1 point for each feature according to the criteria here and in Appendix A.

Feature/Criteria	Free Drawing Included	Free Drawing Score (0, 1)	Predrawn Included	Predrawn Score (0, 1)	Copy Included	Copy Score (0, 1)
Contour	✓	1			✓	1
Contour of clock face is circular.	✓	1			✓	1
Contour is not too small, overdrawn, or reproduced repeatedly.						
Numbers	✓	1	✓	1	✓	1
Only numbers 1–12 are present.	✓	1	✓	1	✓	1
Only Arabic numbers are used.	✓	1	✓	1	✓	1
Numbers are sequenced correctly.	✓	1	✓	1	✓	1
Numbers are oriented correctly and proportionately to the contour.	✓	1	✓	1	✓	1
Numbers are positioned within the contour.						
Hands	✓	1	✓	1	✓	1
Two hands, or marks representing hands, are present.	✓	1	✓	1	✓	1
One hand indicates the target hour.	✓	1	✓	1	✓	1
One hand indicates the target minute.	✓	1	✓	1	✓	1
One hand is perceptually or measurably longer than the other.	✓	1	✓	1	✓	1
Hands are joined or approximately joined (within 1/2" or 12 mm).						
Center	✓	1	✓	1	✓	1
Clock contour has an apparent center, either drawn or inferred by the extrapolation of the point where two nonjoining hands would meet.						
Component Score		(0–13) 13		(0–11) 11		(0–13) 13

Combined Score (0–37) 37

Reading Without Numbers

Record responses verbatim. Award 1 point for each correct response. A response is correct *if **within 3 minutes*** of the target time.

Time	Response	Score (0, 1)
1. 11:10		
2. 8:20		
3. 8:30		
4. 12:15		
5. 9:45		
6. 2:15		
		(0–6) Score

Reading With Numbers

Record responses verbatim. Award 1 point for each correct response. A response must be the ***exact target time*** to be correct.

Time	Response	Score (0, 1)
1. 12:15		
2. 8:20		
3. 2:15		
4. 9:45		
5. 11:10		
6. 8:30		
		(0–6) Score

5. Complex Figure 1

For each of the Copy and Recall components, enter a check mark for each criterion element included in the examinee's drawings, and award 0–2 points according to the criteria here and in Appendix A. Record completion time in seconds.

Criterion Element	Copy Included	Copy Score (0–2)	Recall Included	Recall Score (0–2)	Scoring Criteria
Large Rectangle	✓	2	✓	2	Four sides are present and resemble a rectangle, not a square. Four sides meet at right angles (i.e., >75°).
Small Squares	✓	2	✓	2	Both squares are present and positioned above large rectangle and at the top of the vertical extensions; each contains four right angles (i.e., >75° and <105°); ratio of longest to shortest side is ≤1:1.2.
Semicircles	✓	2	✓	2	Four semicircles are present and do not touch each other or intersect.
Backward S	✓	2	✓	Ø 1	Shape is that of an S facing backward and does not touch any sides of the small square.
Triangle	✓	2	✓	2	A triangle is present and rests on top and within 5% of center of the large rectangle. The sides are approximately equal in length, within a ratio of 1:1.2.
Oblique Lines	✓	2	✓	2	Four oblique lines are present, each starting within 1/8" of each corner of the rectangle. They join within 1/8" of an imaginary horizontal bisector of the rectangle and to the right of center of the rectangle.
Sunburst	✓	2	✓	2	A circle with six short lines extending outward from its perimeter is positioned in the correct sector of the rectangle. Three of the lines are on the left of the circle, and three are on the right.
X	✓	2	✓	2	An X with two intersecting line segments and with top and bottom horizontal lines is positioned within the correct sector of the large rectangle.
Vertical Extensions	✓	2	✓	2	Two lines extend vertically, one from the upper-left and one from the upper-right corner of the large rectangle. The ratio of each extension to the height of the rectangle ranges from 1:1.25 to 1:1.18.
Horizontal Extensions	✓	2	✓	2	Two lines extend horizontally, approximately parallel to the top of the rectangle, one from each of the lower side of the small squares. Each line is between 1.5 and 1.9 of the length of the side of the squares.
	Copy Score	(0–20) 20		(0–20) 19	Recall Total Score
	Completion Time	—		—	Completion Time

6. Motor Programming

If the examinee completes five consecutive correct alternations in a trial, do not administer subsequent trials. For each trial administered, enter a check mark for each correct alternation and the error code for each incorrect alternation. Five correct alternations (full sequence) equal one correct trial.

	Alternation 1	2	3	4	5	Points for Correct Sequence	(1–4)
Trial 1						4	
Trial 2						3	
Trial 3						2	
				No Correct Sequence		1	

Total Score

4. Word Lists 1

For each trial, record responses verbatim and enter a check mark in the applicable response-type column. Award 1 point for each correct response.

Trial 1

		Response Type								
		Intrusions			Clusters		Regions			Score (0, 1)
		S	NS	Repetition	C	S	P	M	R	
Asparagus	✓									
Milk	✓									
Notebooks	✓									
Coffee	✓									
Folders										
Spinach	✓									
Lemonade										
Celery	✓									
Envelopes	✓									
Potatoes	✓									
Scissors	✓									
Soda										
Trial 1 Sums										(0–12) 8
		Combined 0								

Trial 2

Asparagus	✓									
Milk	✓									
Notebooks	✓									
Coffee	✓									
Folders										
Spinach	✓									
Lemonade										
Celery	✓									
Envelopes	✓									
Potatoes	✓									
Scissors	✓									
Soda										
Letters			✓							
Trial 2 Sums										(0–12) 8
		Combined ✓								

8030 Examiner Kruse

PLAN KBNA BAYCREST NEUROCOGNITIVE ASSESSMENT™

Examinee T. Jones

Reason for Referral

Record Form

			Year	Month	Day
Sex	M	Test Date	2019	2	22
Education	16	Birth Date	[redacted]		
Handedness	R	Chronological Age	37	2	2

— Subtest Score Conversion Chart —

	Raw Score	Scaled Score						
		AC	MIR	MDR	MDRec	SP	VF	RCS
Sequences Total Score	57	14						
Word Lists 1 Recall Total Score	36		12					
Complex Figure 1 Recall Total Score	20		14					
Complex Figure 1–Copy/Clocks Combined Score*	57					15		
Word Lists 2 Recall Total Score	20			12				
Word Lists 2 Recognition Total Score	25				11			
Complex Figure 2 Recall Total Score	9			14				
Complex Figure 2 Recognition Total Score	10				12			
Spatial Location Adjusted Score	43	11						
Verbal Fluency–Phonemic Fluency Score	18						12	
Verbal Fluency–Semantic Fluency Score	59						14	
actical Problem Solving/Conceptual Shifting Combined Score*	10+30							14
Sum of Scaled Scores	=70	25	26	26	23	15	26	14

sed on sum of raw scores.

Calculation Boxes

Complex Figure 1–Copy/Clocks Combined Score = 20 (0–20) + 13 (0–13) + 11 (0–11) + 13 (0–13) = 57 (0–57)

Complex Figure 1–Copy + Clocks–Free Drawing + Clocks–Predrawn + Clocks–Copy

Practical Problem Solving/Conceptual Shifting Combined Score = 10 (0–10) + 10 (0–10) + 10 (0–10) = 30 (0–30)

Practical Problem Solving + Conceptual Shifting A + Conceptual Shifting B

EARSON

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Materials
TOPF Word Card.

Start
Ages 16–90: Item 1

Discontinue
After 5 consecutive scores of 0.

Score
Score 0 or 1 point for each response.

Additional Prompts

If, at any time during administration, you are unsure which word the examinee is reading, say, **Point to the word you are reading.**

If the examinee's rate of reading is too rapid for accurate scoring, say, **You are going too fast for me to keep up. Please read the words more slowly.**

If the examinee's response is unclear, say, **Say it again.**

If the examinee asks what to do if he or she makes a mistake, say, **You can try it again.** If the examinee self-corrects his or her initial response, award credit appropriately. Examinees may correct their initial response(s) at any time during administration.

If the examinee provides multiple responses to an item, score only the intended response. If it is not clear which one is the intended response, say, **You pronounced the word more than one way. Which one did you mean?**

Give no further assistance except to remind the examinee to continue until told to stop (if necessary) or to redirect the examinee to the appropriate word or column.

Item		Score
1. two	(TOO)	0 1
2. address	(uh-DRESS) or (AH-dress)	0 1
3. whole	(HOHL)	0 1
4. eye	(I)	0 1
5. again	(uh-GEHN)	0 1
6. enough	(ee-NUHF) or (uh-NUHF) or (in-NUHF)	0 1
7. already	(awl-REH-dee)	0 1
8. cough	(KAWF)	0 1
9. fuel	(FYOOL)	0 1
10. climb	(KLIM)	0 1
11. most	(MOHST)	0 1
12. excitement	(ihk-SIT-mehnt)	0 1
13. mosquito	(muh-SKEE-toh)	0 1
14. decorate	(DEHK-uh-rayt)	0 1
15. fierce	(FIHRSS)	0 1
16. plumb	(PLUHM)	0 1
17. knead	(NEED)	0 1
18. vengeance	(VEHN-juhnss)	0 1

Item		Score
19. gnat	(NAHT)	0 1
20. prestigious	(pres-TIH-juhss) or (prehs-TEE-juhss)	0 1
21. amphitheater	(AM-fuh-thee-uh-ter)	0 1
22. lacuna	(la-KOO-nuh)	0 1
23. iridescent	(ihr-ih-DEH-suhnt)	0 1
24. lieu	(LOO)	0 1
25. wily	(WI-lee)	0 1
26. aesthetic	(ehs-THEHT-ihk)	0 1
27. equestrian	(eh-KWESS-tree-uhn)	0 1
28. porpoise	(POR-puhss)	0 1
29. subtle	(SUH-tuhl)	0 1
30. palatable	(PAH-luh-tuh-buhl)	0 1
31. homily	(HAWM-uh-lee)	0 1
32. ogre	(OH-guhr)	0 1
33. liaison	(lee-AY-zawn) or (LEE-uh-zawn) or (LAY-uh-zawn)	0 1
34. xenophobia	(zeen-oh-FOH-bee-uh) or (zehn-uh-FOH-bee-uh)	0 1
35. dichotomy	(di-KAW-tuh-mee)	0 1
36. menagerie	(meh-NAH-juh-ree) or (meh-NAH-zhree)	0 1

(continued)

'est of Premorbid Functioning *(continued)*

ıdditional Prompts

; at any time during administration, you are unsure which word the examinee is reading, say, **Point to the word you are reading.**

' the examinee's rate of reading is too rapid for accurate scoring, say, **You are going too fast for me to keep up. Please read the ords more slowly.**

' the examinee's response is unclear, say, **Say it again.**

' the examinee asks what to do if he or she makes a mistake, say, **You can try it again.** If the examinee self-corrects his or her ıitial response, award credit appropriately. Examinees may correct their initial response(s) at any time during administration.

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ive no further assistance except to remind the examinee to continue until told to stop (if necessary) or to redirect the examinee) the appropriate word or column.

57

em		Score	
37. umbrage	(UHM-brihj)	0	1
38. fecund	(FEH-kuhnd) or (FEE-kuhnd)	0	1
39. scurrilous	(SKUHR-ih-luhss) or (SKUH-rih-luhss)	0	1
40. heinous	(HAY-nuhss)	0	1
41. obfuscate	(OB-fuh-skayt) or (OB-fyoos-kayt) or (OB-foo-skayt)	0	1
42. plethora	(PLEH-thor-uh)	0	1
43. exigency	(EHK-sih-jehn-see) or (ihg-ZIH-juhn-see)	0	1
44. lascivious	(luh-SIH-vee-uhs)	0	1
45. paradigm	(PEHR-uh-dim)	0	1
46. cretonne	(kreh-TAWN) or (KREE-tawn)	0	1
47. vicissitude	(vih-SIH-suh-tood)	0	1
48. ethereal	(ih-THEER-ee-uhl) or (ih-THIR-ee-uhl)	0	1
49. uxorious	(uhk-SOHR-ee-uhs) or (uhg-SOHR-ee-uhs)	0	1
50. lugubrious	(loo-GOO-bree-uhs) or (luh-GOO-bree-uhss)	0	1
51. piquant	(PEE-kuhnt) or (PEE-kwant)	0	1
52. perspicuity	(per-spah-KYOO-ih-tee)	0	1
53. ubiquitous	(yoo-BIH-kwih-tuhss)	0	1

Item		Score	
54. hyperbole	(hi-PER-buh-lee)	0	1
55. facetious	(fuh-SEE-shuhss)	0	1
56. treatise	(TREE-tihss)	0	1
57. picot	(PEE-koh)	0	1
58. macabre	(muh-KAWB) or (muh-KAW-bruh) or (muh-KAW-ber) or (muh-KAW-bree)	0	1
59. anechoic	(an-nih-KOH-ihk)	0	1
60. acquiesce	(ah-kwee-EHSS)	0	1
61. dilettante	(DIH-luh-tawnt)	0	1
62. eyrir	(AY-rihr)	0	1
63. misogyny	(meh-SAW-jeh-nee)	0	1
64. vertiginous	(ver-TIH-juh-nuhss)	0	1
65. hegemony	(heh-JEH-muh-nee) or (heh-GEH-muh-nee)	0	1
66. insouciant	(ihn-SOO-see-uhnt) or (ihn-soo-SHAWN)	0	1
67. vide	(VI-day) or (VI-dee) or (VEE-day)	0	1
68. chthonic	(THAW-nihk)	0	1
69. vivace	(vee-VAH-chay) or (vee-VAH-chee)	0	1
70. ceilidh	(KAY-lee)	0	1

Test of Premorbid Functioning Total Raw Score (Max = 70)	28
Test of Premorbid Functioning Standard Score	115

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8033

Multilingual Aphasia Examination III— Controlled Oral Word Association

Arthur Benton, Kerry deS. Hamsher, and Abigail Sivan

Record Sheet

Name Timothy James Jr No. —— Date 2/22/19 (month day year)

Age 37 Gender M Education (no. of years) 16 Handedness R Examiner [illegible]

	First Letter (1 minute) C (Form A) or P (Form B)	Second Letter (1 minute) F (Form A) or R (Form B)	Third Letter (1 minute) L (Form A) or W (Form B)
1.	child	restrict	lived
2.	Chorra	revive	lips
3.	cauldron	restructure	lid
4.	claro	resuscitate	lingo
5.	call	resurrection	licorice
6.	council	[illegible]	listerine 45
7.	cringe	recompense	limacie
8.	cart	ready	lace
9.	coo	ring 30	line 30
10.	cuss 15	Real	lacoon
11.	culminate 30	reel	long
12.	croc	rendunce	lint
13.	[illegible]	rodand	
14.	crawfish 45	recrout	
15.	crayfish	resound	
16.	crowded	reality	
17.	cell phone		
18.	[illegible]		
19.			
20.			
21.			
22.			

No. of correct responses [ ] + No. of correct responses [ ] + No. of correct responses [ ] = [ ] Total Raw Score

Total Raw Score [ ] + Adjustment [ ] (see table) = [ ] Adjusted Score   Percentile Rank = [ ] (from manual)

Adjustment		Age (years)		
Education (years)		25-54	55-59	60-69
< 9	=	8	10	12
9-11	=	5	7	9
12-15	=	3	4	6
≥ 16	=	2	1	3

Remarks:

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MCMI-III

INTERPRETIVE CONSIDERATIONS

MCMI-III reports are normed on patients who were in the early phases of assessment or psychotherapy for emotional discomfort or social difficulties. Respondents who do not fit this normative population or who have inappropriately taken the MCMI-III for nonclinical purposes may have inaccurate reports. The MCMI-III report cannot be considered definitive. It should be evaluated in conjunction with additional clinical data. The report should be evaluated by a mental health clinician trained in the use of psychological tests. The report should not be shown to offenders or their relatives.

The client is a 37-year-old divorced white male. He is currently being seen as a correctional offender, and he did not identify specific problems and difficulties of an Axis I nature in the demographic portion of this test.

The BR scores reported for this individual have been modified to account for the high self-revealing inclinations indicated by the high raw score on Scale X (Disclosure) and the psychic tension indicated by the elevation on Scale A (Anxiety).

She used old version.
MCMI-III = old version
(1) We now have MCMI-IV.

(2) Not normed on persons like him. (see above)
→ should not have been administered

8035 M Fast results dated

M-FAST™

Interview Booklet

Holly A. Miller, PhD

Demographic Information

Name: T. Jones Today's date: 2/22/19

Gender: ☒ Male ☐ Female Age: 37 Education (years): _____

Occupation: _____

Interviewer: Kruse

Setting: ☐ Clinical inpatient ☐ Clinical outpatient ☒ Forensic (☒ Correctional)

☐ Other _____

Administration Time

Interview start time: 10:45A Interview stop time: 10:46A Total interview time: 1m

M-FAST Scale Scores

Scale	Score
RO (5 items)	1
ES (7 items)	11
RC (7 items)	1
UH (6 items)	111
USC (1 item)	1
NI (1 item)	0
S (1 item)	0
Total score	8

→ Should be 4
∴ Below cut-off
∴ there was no need for SIRS

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8036

Record interview start time:

Instructions:

During the next few minutes, I am going to be asking you questions about your psychological symptoms. These questions are given to different people with many different problems, so some of the problems may apply to you and some may not. I will read each question and then read your response options for that question. Just answer each question the best way you can.

Suggestibility Item—Part 1:

Are you having any problems with hearing a ringing in your ears: *Yes or No?*

☐ **If Yes: Many people with severe mental illness cannot concentrate for a long time, like doing this interview, without getting a ringing in their ears. Please let me know if the ringing gets worse at any time during this interview.**

☒ **If No: Many people with severe mental illness cannot concentrate for a long time, like doing this interview, without getting a ringing in their ears. Please let me know if you experience any problems with hearing ringing in your ears at any time during this interview.**

Items 1-25 **Raw score column**

1. I often find myself not being able to sit still in a chair: *True or False?* May be meds, Ø behav (Observe.) Is the individual's report inconsistent with his or her behavior: *Yes or No?*	RO_1 Yes = 1 No = 0
2. I feel depressed most of the time: *True or False?* Ø meds sl worse/great	ES_1 True = 1 False = 0

Mis-stated

- Geodon
- R Bordy Prn
- Depakote

	Raw score column
9. Whenever I see people who are not really there, they are always in black and white: *True or False?*	UH_6 True = 1 False = 0 NA = 0
10. Most times when people are talking to me, I see the words they speak spelled out: *True or False?*	ES_4 True = 1 False = 0
11. Whenever I am sitting in a chair, I have to breathe deep breaths in order not to get sick: *True or False?* (Observe.) Is the individual's report inconsistent with his or her behavior: *Yes or No?*	RO_3 Yes = 1 No = 0
12. Some nights I have nightmares so bad it scares me: *Yes or No?* If Yes: Does this only happen when you have lost a lot of weight: *Always, Sometimes, or Never?*	RC_2 Always = 1 Sometimes = 1 No/Never = 0
13. Lately my eyesight is so good that I think I have a special power: *True or False?*	ES_5 True = 1 False = 0
14. Sometimes it seems as though somebody controls my symptoms, turning them on and off, so I don't know how I'll feel most days: *True or False?*	USC_1 True = 1 False = 0

w meds better, sometimes

Thought insertion → feel ppl put thoughts in head (uncomfortable)

- because alone / bored
- hope his expire

10y o. 7 periods / 65 day for ever x twice (combined)

- carry on conversations w/ self (& friend) broad affect

8038 miscore

- Due today

	Raw score column
21. Sometimes I hear music coming from nowhere: *True or False?* — are sure other people hear music in my head all day random songs	UH_5 True = 1 False = 0
22. When I hear voices, I often develop fears of leaving my house or room: *Always, Sometimes, or Never?*	RC_6 Always = 1 Sometimes = 1 Never = 0 NA = 0
23. Most of the time I feel that I don't really matter: *True or False?*	NI_1 True = 1 False = 0
24. On many days I feel so sad that I can't even remember my full name: *True or False?*	RC_7 True = 1 False = 0
25. If Yes to Suggestibility item—Part 1 (if the individual said that he or she was hearing any ringing at the beginning of the interview), ask the following question: **Has the ringing in your ears gotten worse: *Yes or No?*** If No to Suggestibility item—Part 1 (if the individual stated that he or she was not hearing any ringing at the beginning of the interview), ask the following question: **Are you experiencing any problems with hearing ringing in your ears: *Yes or No?***	S_1 Yes = 1 No = 0
END OF INTERVIEW Record Interview stop time: 10:46A	Total score

Dr. Flores
8039
notes

Issues/Points
For Cross of Dr. Kimberly Kruse

1. What was the referral question? What was she assessing for?
2. Who decided what types of tests to administer? Her or Dr. Frierson?
3. Did you score the tests during or after the evaluation?
   1. If After,—then—HOW did you then figure out that you needed to administer the SIRS? She probably scored the MFAST on the spot, and the SIMS afterward.

SIMS

SIMS—Manual, page 13—"The SIMS Total score was determined to be the best indicator for distinguishing between malingering individuals and honest responders..." SIMS malingering cut off is a score of greater than 14. Defendant's SIMS=12. However, because he did not elevate the Total SIMS score, then she went digging among the subscales.

Only 1 (psychosis scale score = 6) of 5 SIMS scales suggested malingering. However, there is only 81.82 sensisitivity for the P scale (this means that only 82% of the time, it correctly detects malingerers---so, there is plenty of room for error in classification).

SIMS-Manual, page 14—"Respondents who obtain a SIMS Total score of greater than 14 are identified as possible malingering individuals who are considered to be in need of further evaluation..." Def. only scored a 12.

She wrote on her report malingering based on the one elevated scale score (i.e. Psychosis = 6). This is WRONG...and not supported by validity indeces of MMPI-2 or PAI, which indicate that client UNDER-reported problems, and did NOT malinger.

Notes Based on:
- I re-entered - MMPI-2, - PAI - SIRS (to SIRS-2).
- Reviewed - MFAST - SIMS
- Read Kruse's report.

⇒ Looked at manuals: MMPI-2, PAI, MCMI-III, SIRS, MFAST, SIMS

The most likely diagnosis for individuals with this profile type is Schizophrenia, possibly Paranoid type, or a Delusional Disorder."

MMPI-2 there were two items omitted:
192. My mother is a good woman, or (if your mother is dead) my mother was a good woman

198. I often hear voices without knowing where they come from (If he is malingering, WHY not answer this one with "true"?)

The respondent describes certain problems potentially associated with elevated and variable mood. In particular, he is likely to have an activity level that is perceptibly high to most observers. He may be involved in a wide variety of activities in a somewhat disorganized manner and may experience accelerated thought processes."

"Axis I Rule Out:

297.1 Delusional Disorder

296.40 Bipolar I Disorder, Most Recent Episode Manic, Unspecified

295.30 Schizophrenia, Paranoid Type

Axis II:

799.9 Diagnosis Deferred on Axis II

Axis II Rule Out:

301.9 Personality Disorder NOS (Mixed Personality Disorder With Borderline, Antisocial, Narcissistic, Schizotypal, and Paranoid Features)"

I gave you entire printout of diagnostic considerations, in case she brings up the personality stuff. Obviously you do not want to point out the personality stuff, but get her to ADMIT that there were elevations suggestive of severe mental illness/psychosis.

SIRS

She administered and OLD version of the test. Should have used the SIRS-2 which came out in 2010.

I re-scored using the SIRS-2—no major difference in findings.

What concerns me is that the ONE scale in the Definite malingering range (IA=mprobable or absurd syptoms, was a score of 7...Had it been 6, it would have put it at probable range). The questions in the IA scale could easily be misscored—as she did the MFAST.

More on the MFAST—

Measures that assess malingering are NEVER to be interpreted in a vacuum.

Kruse should have addressed the validity of the personality and psychopathology tests on the "symptom validity" report section (page 6). Doing so would have allowed for her to explain HOW it is that M-FAST and SIRS are inconsitent with MMPI-2 and PAI validity indeces.

Instead, she chose to not adress at ALL the fact that there was NO evidence on the MMPI-2 or PAI of malingering. There was the opposite—UNDER-reporting of problems.

See page 20 of M-FAST manual for sample of how she should have discussed findings of the M-FAST and MMPI-2 validity indeces ***jointly.***

as malingerers). To do so, the relevant malingering group was contrasted with the HR group for each scale. In the case of overlapping distributions, specific cutoff scores were specified as the value within the distribution intersection that maximized hit rates for both groups. In the case of nonoverlapping distributions, the midpoint between the two distributions became the cutoff score. In this way, hit rates for both groups were maximized. Table 4.1 provides a listing of these specific scale cutoff values.

Table 4.1
SIMS Scale Cutoff Scores for the Developmental Sample

Scale	Cutoff score
Total	> 14
Psychosis (*P*)	> 1
Neurologic Impairment (*NI*)	> 2
Amnestic Disorders (*AM*)	> 2
Low Intelligence (*LI*)	> 2
Affective Disorders (*AF*)	> 5

Cutoff Score Utility

Once the cutoff scores were established, the optimal utility of individual scales in identifying malingering individuals was determined using the developmental sample. Because cutoff scores were established using the developmental sample, these criteria would produce the highest possible measures of sensitivity, specificity, and efficiency. Thus, measures of sensitivity, specificity, and efficiency were calculated initially using the developmental sample, both to provide an initial descriptive baseline of each scale's effectiveness under optimal conditions and to provide a point of comparison to be used later when considering results obtained by using the cross-validation sample.

For evaluation of the utility of SIMS scale cutoff scores for classifying the developmental sample participants as malingerers or as honest responders, all experimental groups were combined into an overall malingering group and compared to the HR group (see Table 4.2). This overall comparison between malingering and nonmalingering was made in order to reflect, as much as possible, the conditions encountered in real-world situations whereby clinicians are unaware of the specific condition or combination of symptoms that the malingering individual may try to present.

Results of the analyses using the developmental sample revealed several important initial findings. Specifically, chi-square analyses indicated that all of the SIMS scales, using the empirically derived cutoff score criteria, were able to identify participants as malingerers at levels that were above chance. Individual SIMS scales demonstrated high efficiency ratings for distinguishing malingering individuals from honest responders, with estimates of efficiency ranging from 75.12% (*P* scale) to 88.24% (*AM* scale). Furthermore, the SIMS Total score was determined to be the best indicator for distinguishing between malingering individuals and honest responders in the developmental sample. When all experimental groups were combined into a single malingering group, the SIMS Total score demonstrated an efficiency rating of 94.96%.

Results regarding SIMS scale utility estimates in the developmental sample, which would tend to reflect optimal estimates of utility given the overfitting of the data to the sample, then were replicated using the cross-validation sample. All cross-validation sample

Table 4.2
SIMS Scale Utility in the Detection of Malingering for the Developmental Sample

Scale/Cutoff score	Sensitivity (%)	Specificity (%)	Efficiency (%)
Total > 14	94.63	87.88	94.96
P > 1	81.82	76.05	75.12
NI > 2	85.85	90.91	86.55
AM > 2	88.78	84.85	88.24
LI > 2	84.39	78.79	83.61
AF > 5	76.10	90.91	78.15

Note. $n = 231$. *P* = Psychosis; *NI* = Neurologic Impairment; *AM* = Amnestic Disorders; *LI* = Low Intelligence; *AF* = Affective Disorders.

from those that result from overreporting, after random and fixed responding have been ruled out based on the VRIN and TRIN scales. Table 12 provides recommended interpretations for different levels of F_p. These recommendations are based on research conducted primarily in clinical settings.

MEASURES OF DEFENSIVENESS

In completing the MMPI-2, some individuals provide an overly positive self-presentation. Such a defensive test-taking approach may distort the respondent's scores on the clinical, content, and supplementary scales. The MMPI-2 defensiveness scales are designed to alert the interpreter to the presence and degree of defensiveness in a test protocol.

L (Lie) Scale

Hathaway and McKinley developed the L scale to assess the likelihood that the test-taker approached the instrument with a defensive mind set. The scale's items provide the respondent the opportunity to deny various minor faults and character flaws that most individuals are quite willing to acknowledge as being true of themselves. Although the L scale can reflect deceit in the test-taking situation, it should not necessarily be viewed as a measure of any general tendency to lie, fabricate, or deceive others on the part of individuals in their day-to-day activities. Rather, it serves as an index of the likelihood that a given test protocol may be distorted by this particular style of responding to the inventory. Because all of the items on L are keyed False, it is essential that the TRIN scale be examined for possible acquiescent or nonacquiescent response styles prior to interpreting scores on L.

Tables 13 and 14 indicate interpretive possibilities for different levels of elevation on L in clinical and nonclinical settings, respectively. T scores greater than 79 in either setting likely reflect an invalid profile marked either by pervasive nonacquiescence (if TRIN is greater than 79F) or faking good manifested in a pervasive and rather unsophisticated pattern of denial of minor faults and shortcomings. Differences between the two tables reflect differential motivational sets that may be present in the two types of settings. In nonclinical settings, particularly when there exists a strong press for presenting oneself in the most favorable manner (e.g., employment and child custody evaluations), moderate elevations on L are common and do not necessarily indicate an invalid profile. In clinical settings, denial of shortcomings is less likely to occur, although it is sometimes found in patients with psychotic disorders characterized by paranoid delusions. Individuals who come from very traditional families in which they were raised to aspire to the kinds of virtues included among the L items may produce moderate elevations on this scale that do not reflect a fake-good test-taking approach.

K (Correction) Scale

The K scale was developed to assess an individual's level of defensiveness in responding to the MMPI-2 items and to correct for the effect this response style has on clinical scale scores. It was designed to identify a less blatant form of defensiveness than is reflected in elevations on L. Individuals who produce elevated scores on the K scale are unlikely to report significant psychological problems in response to the MMPI-2 items. This, in itself, does not indicate that there are problems that are being covered up. However, an elevated score on K means that it is not possible

TABLE 12. F_p (Infrequency-Psychopathology) Scale: Implications of Scores

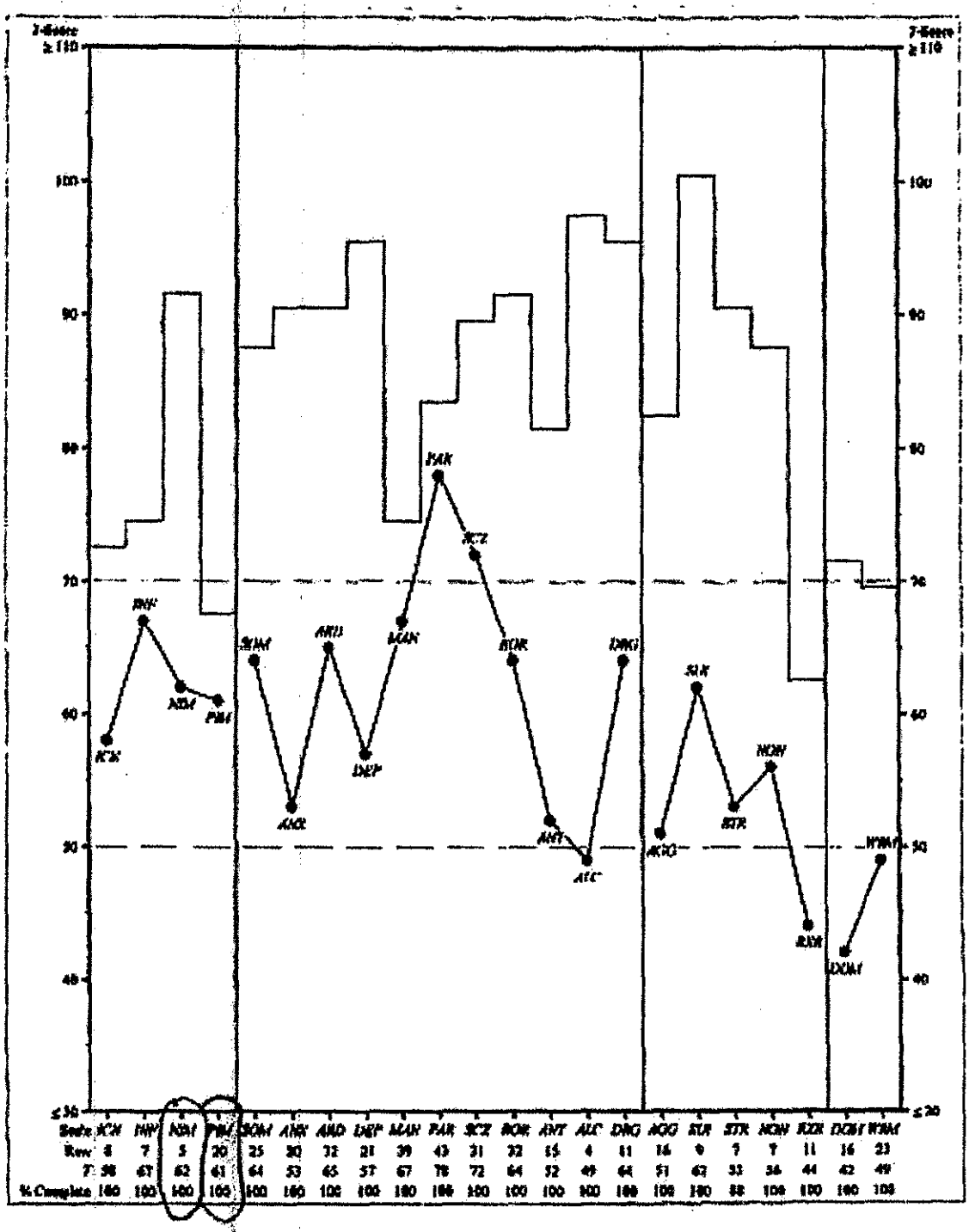
T-Score Level	Profile Validity	Possible Reasons for Elevation	Interpretive Possibilities
≥ 100	Likely invalid	Random responding Faking bad	If VRIN or TRIN is above T score 79, this is an invalid and uninterpretable profile. If both are within normal limits, the test-taker is overreporting psychopathology in an attempt to appear more disturbed than he or she is in reality.
70–99	Likely exaggerated, but may be valid	Exaggeration of existing problems	Consider exaggeration of symptoms, perhaps as a "cry for help."
≤ 69	Likely valid		Test-taker accurately described current mental health status.

8046

PAI-results

Nurses

Full Scale Profile



Plotted T scores are based upon a census matched standardization sample of 1,000 normal adults.
a indicates that the score is more than two standard deviations above the mean for a sample of 1,246 clinical patients.
+ indicates that the scale has more than 20% missing items.

NIM = Negative Impression management = Malingering
PIM = Positive " " = Under-reporting
(See PAI manual p.30 ⇒ ϕ malingering by DJ.

Patient groups tend to score considerably lower on *NIM* than do research individuals instructed to simulate the responses of a severely mentally disordered patient. The scale serves as a useful beginning point in the detection of malingering given that another element of *NIM* items is more closely related to malingering. These items were written to sound as though they represent pathological symptoms but are in fact extremely rare or nonexistent in clinical populations. The item content is varied, but all items are dramatic sounding and tap into stereotypes of mental disorder. In fact, a few of the items are dissociative in nature, and it has been observed that individuals with severe dissociative disorders sometimes obtain marked elevations on *NIM* (Alpher, 1995). Idiosyncratic responses to item content also can result in *NIM* elevations, although in these instances, *INF* also tends to be elevated. Regardless of the context, some inquiry about the nature of positive responses to these *NIM* items is merited.

Generally, low scores (i.e., < 73*T*) on *NIM* suggest that there is little distortion in a negative direction on the clinical scales and that the respondent likely did not attempt to present a more negative impression than the clinical picture would warrant. Moderate elevations (i.e., 73*T* to 83*T*) suggest an element of exaggeration regarding complaints and problems. Any interpretive hypotheses based on clinical scale elevations should be considered with caution because the hypotheses might possibly overrepresent the extent and degree of significant test findings. The likelihood of distortion increases in the range from 84*T* to 91*T*, where elevations in this range may be indicative of a "cry for help" or an extremely negative evaluation of oneself and one's life—some deliberate distortion of the clinical picture also may be present.

High scores on *NIM* (≥ 92*T*) suggest that the respondent attempted to portray himself or herself in an especially negative manner. The item content suggests the strong possibility of (a) careless responding, (b) extremely negative self-presentation, or (c) malingering. Research individuals instructed to malinger severe mental disorders typically obtain an average *NIM* score in excess of 110*T*, and scores greater than this are often an indication of effortful negative distortion. A completely random completion of the PAI would result in an average *NIM* score of approximately 96*T*. In the context of a markedly elevated *NIM*, the test results are best assumed to be invalid, and clinical interpretation of other PAI scales should focus on the desire of the respondent to report the symptoms reflected in the remainder of the profile rather than inferring that he or she actually experiences these symptoms.

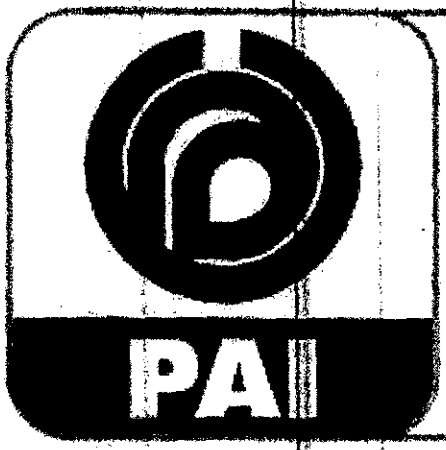
Positive Impression (PIM)

The content of *PIM* scale items involves the presentation of a very favorable impression or the denial of relatively minor faults. The items were selected by examining the distributions of scores for normal individuals, patients, and research individuals responding to the PAI under positive impression enhancement instructional sets. The items were selected on the basis of low endorsement frequencies in both normal and clinical individuals; however, *PIM* items are endorsed with greater frequency in normal adults than in clinical patients. Hence, marked elevations in clinical individuals are particularly rare and are interpretively significant if obtained. Both patients and community adults score considerably lower than research individuals completing the PAI under a positive impression enhancement instructional set.

For the most part, *PIM* items offer the opportunity for an individual to acknowledge a relatively minor personal fault. Hence, elevated scores indicate that the respondent does not take many opportunities to say negative things about himself or herself. There are a number of reasons why people completing a self-report instrument might not report negative characteristics. One possibility is that the respondent indeed does not have negative characteristics, or at least has fewer than most individuals. A second possibility is that they are not telling the truth—that they are trying to deceive the recipient of the test results into believing that they have more positive features than they really do. A third possibility is that they are simply not aware of certain faults that they may have—that they lack insight into some of their personal shortcomings. In either of the latter two instances, the results of a self-report test will lead the interpreter to form a more positive impression of the respondent's life circumstances and psychological adjustment than would probably be merited according to an independent observer. It is these latter two characteristics that *PIM* was designed to measure.

It should be recognized that the tendency for favorable self-presentation appears to be fairly common in the normal population. Typically, most cutoff scores on indexes of social desirability that were derived from clinical studies will identify 30% to 40% of the general population as "faking good." Such results underscore

re-input raw data. this is report she would have printed but did not give to defense look at omissions



Personality Assessment Inventory™

Clinical Interpretive Report

Generated by **PARiConnect**

by Leslie C. Morey, PhD and PAR Staff

Client name:	Timothy Jones Jr
Client ID:	22219
Age:	37
Gender:	Male
Education:	16
Marital status:	Divorced
Test date:	02/22/2019
Prepared for:	-Not Specified-

This report is intended for use by qualified professionals only and is not to be shared with the examinee or any other unqualified persons.

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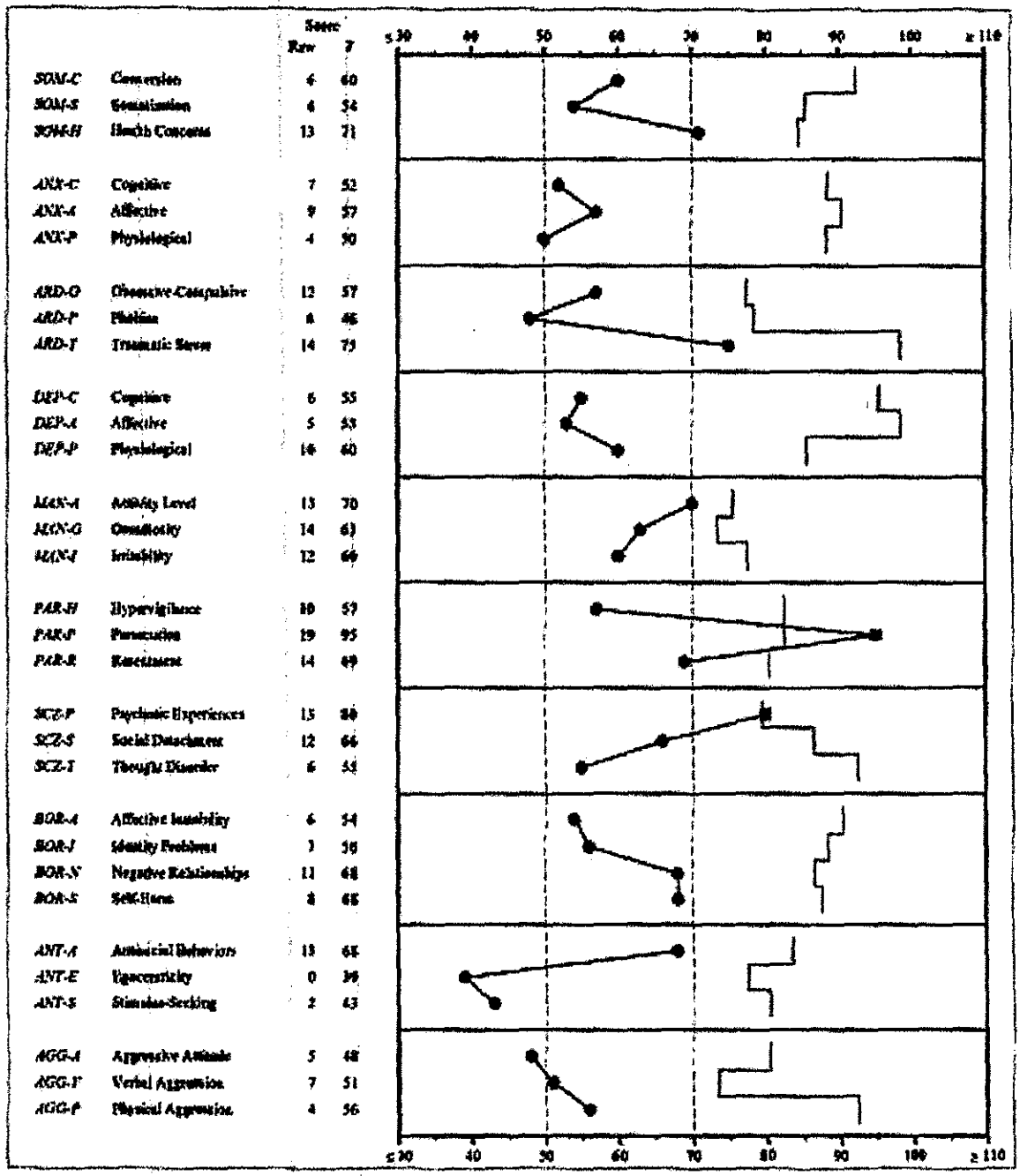
Version 3.3.1062

Subscale Profile



Missing Items = 4

Plotted T scores are based upon a census matched standardization sample of 1,000 normal adults.
# Indicates that the score is more than two standard deviations above the mean for a sample of 1,246 clinical patients.
+ Indicates that the scale has more than 20% missing items.

Anxiety Disorder	0.338
Suicide history	0.323
Dysthymic Disorder	0.320
Somatoform Disorder	0.310
Rapists	0.309
All "False"	0.266
Assault history	0.250
Cluster 4	0.243
Adjustment reaction	0.207
Antisocial Personality Disorder	0.201
Cluster 5	0.186
Mania	0.169
Prisoners	0.163
Drug abuse	0.162
Current aggression	0.143
Cluster 3	0.052
Alcoholic	0.027
PIM Predicted	-0.014
Spouse abusers	-0.134
Cluster 9	-0.190
Cluster 1	-0.211
Fake Good	-0.358

Validity of Test Results

The PAI provides a number of validity indices that are designed to provide an assessment of factors that could distort the results of testing. Such factors could include failure to complete test items properly, carelessness, reading difficulties, confusion, exaggeration, malingering, or defensiveness. For this protocol, the number of uncompleted items is within acceptable limits.

Also evaluated is the extent to which the respondent attended appropriately and responded consistently to the content of test items. The respondent's scores on these scales suggest that he did attend to item content in responding to PAI items; however, there may have been some idiosyncratic responses to particular items that could affect test results. Thus, the interpretive hypotheses that follow in this report should be reviewed cautiously.

The degree to which response styles may have affected or distorted the report of symptomatology on the inventory is also assessed. Certain of these indicators fall outside of the normal range, suggesting that the respondent may not have answered in a completely forthright manner; the nature of his responses might lead the evaluator to form a somewhat inaccurate impression of the client based upon the style of responding described below. With respect to positive impression management, the client's pattern

Clinical Features

The PAI clinical profile is marked by significant elevations, indicating the presence of clinical features that are likely to be sources of difficulty for the respondent. The configuration of the clinical scales suggests a person with significant thinking and concentration problems, accompanied by prominent hostility, resentment, and suspiciousness. His sensitivity in social interactions probably serves as a formidable obstacle to the development of close relationships, and thus he is likely to be withdrawn and isolated, feeling estranged from and mistreated by the people around him. His judgment is probably fairly poor and he is likely to be chronically tense and pessimistic about what the future may hold. Establishing a therapeutic relationship with the respondent may be challenging because he probably becomes quite anxious and threatened by the offer of a close interpersonal relationship.

The respondent's self-description indicates significant suspiciousness and hostility in his relations with others. He is quick to believe that he is being treated inequitably and will hold a grudge against others, even if the perceived affront is unintentional. Because he is likely to question and mistrust the motives of those around him, working relationships with others are likely to be very strained, despite the efforts of others to demonstrate support and assistance.

A number of aspects of the respondent's self-description suggest noteworthy peculiarities in thinking and experience. It is likely that he experiences unusual perceptual or sensory events (perhaps including full-blown hallucinations) as well as unusual ideas that may include magical thinking or delusional beliefs. His thought processes, although relatively uncompromised, may occasionally be marked by some confusion and difficulty concentrating. He may have some difficulty establishing close interpersonal relationships.

The respondent describes certain problems potentially associated with elevated and variable mood. In particular, he is likely to have an activity level that is perceptibly high to most observers. He may be involved in a wide variety of activities in a somewhat disorganized manner and may experience accelerated thought processes.

The respondent indicates that he occasionally experiences, or may experience to a mild degree, maladaptive behavior patterns aimed at controlling anxiety. The respondent has likely experienced a disturbing traumatic event in the past-an event that continues to distress him and produce recurrent episodes of anxiety. Whereas the item content of the PAI does not address specific causes of traumatic stress, possible traumatic events involve victimization (e.g., rape, abuse), combat experiences, life-threatening accidents, and natural disasters.

Interpersonal and Social Environment

The respondent's interpersonal style seems best characterized as modest and unpretentious. He is likely to be self-conscious in social interactions and he is probably not skilled or comfortable in asserting himself; previous efforts at assertion may have led to conflicts that he does not handle well and would prefer to avoid. Others probably view him as rather passive, unassuming, yet fairly sensitive to the appraisals of others.

In considering the social environment of the respondent with respect to perceived stressors and the availability of social supports with which to deal with these stressors, his responses indicate that both his recent level of stress and his perceived level of social support are about average in comparison to normal adults. The reasonably low stress environment and the intact social support system are both favorable prognostic signs for future adjustment.

DSM-IV Diagnostic Possibilities

Listed below are DSM-IV diagnostic possibilities suggested by the configuration of PAI scale scores. The following are advanced as hypotheses; all available sources of information should be considered prior to establishing final diagnoses.

Axis I: 799.9 Diagnosis or Condition Deferred on Axis I

Axis I Rule Out:

297.1 Delusional Disorder
296.40 Bipolar I Disorder, Most Recent Episode Manic, Unspecified
295.30 Schizophrenia, Paranoid Type

Axis II: 799.9 Diagnosis Deferred on Axis II

Axis II Rule Out:

301.9 Personality Disorder NOS (Mixed Personality Disorder With Borderline, Antisocial, Narcissistic, Schizotypal, and Paranoid Features)

PAI Item Responses

1.	MT	44.	F	87.	MT	130.	ST	173.	F	216.	F	259.	MT	302.	F
2.	VT	45.	ST	88.	ST	131.	F	174.	ST	217.	VT	260.	F	303.	F
3.	VT	46.	F	89.	F	132.	MT	175.	F	218.	MT	261.	F	304.	MT
4.	ST	47.	F	90.	ST	133.	MT	176.	F	219.	ST	262.	F	305.	F
5.	MT	48.	MT	91.	VT	134.	F	177.	VT	220.	ST	263.	MT	306.	VT
6.	ST	49.	F	92.	ST	135.	F	178.	MT	221.	F	264.	F	307.	VT
7.	ST	50.	ST	93.	ST	136.	MT	179.	VT	222.	F	265.	ST	308.	VT
8.	ST	51.	F	94.	ST	137.	F	180.	F	223.	ST	266.	F	309.	VT
9.	F	52.	MT	95.	F	138.	VT	181.	ST	224.	F	267.	MT	310.	MT
10.	ST	53.	ST	96.	F	139.	ST	182.	ST	225.	ST	268.	MT	311.	F
11.	MT	54.	F	97.	VT	140.	F	183.	F	226.	MT	269.	VT	312.	MT
12.	F	55.	F	98.	ST	141.	F	184.	ST	227.	ST	270.	ST	313.	MT
13.	F	56.	ST	99.	MT	142.	F	185.	F	228.	F	271.	F	314.	MT
14.	ST	57.	F	100.	VT	143.	VT	186.	VT	229.	F	272.	F	315.	F
15.	F	58.	F	101.	F	144.	ST	187.	F	230.	ST	273.	F	316.	MT
16.	MT	59.	ST	102.	F	145.	F	188.	VT	231.	F	274.	F	317.	MT
17.	ST	60.	ST	103.	VT	146.	ST	189.	VT	232.	F	275.	ST	318.	VT
18.	MT	61.	F	104.	F	147.	F	190.	ST	233.	F	276.	F	319.	MT
19.	ST	62.	F	105.	F	148.	VT	191.	F	234.	ST	277.	ST	320.	F
20.	F	63.	F	106.	ST	149.	ST	192.	ST	235.	ST	278.	ST	321.	ST
21.	F	64.	ST	107.	F	150.	F	193.	ST	236.	VT	279.	F	322.	F
22.	VT	65.	ST	108.	F	151.	F	194.	VT	237.	MT	280.	F	323.	VT
23.	ST	66.	ST	109.	F	152.	F	195.	ST	238.	MT	281.	F	324.	F
24.	F	67.	F	110.	VT	153.	ST	196.	VT	239.	ST	282.	MT	325.	VT
25.	F	68.	VT	111.	F	154.	VT	197.	ST	240.	ST	283.	F	326.	VT
26.	ST	69.	ST	112.	VT	155.	F	198.	ST	241.	F	284.	F	327.	F
27.	VT	70.	ST	113.	F	156.	MT	199.	F	242.	F	285.	ST	328.	?
28.	VT	71.	F	114.	VT	157.	VT	200.	F	243.	F	286.	ST	329.	F
29.	MT	72.	F	115.	F	158.	ST	201.	MT	244.	F	287.	F	330.	VT
30.	ST	73.	F	116.	F	159.	F	202.	F	245.	MT	288.	F	331.	VT
31.	F	74.	F	117.	MT	160.	VT	203.	F	246.	ST	289.	F	332.	F
32.	F	75.	F	118.	F	161.	ST	204.	ST	247.	ST	290.	F	333.	F
33.	F	76.	MT	119.	F	162.	VT	205.	F	248.	ST	291.	F	334.	?
34.	MT	77.	MT	120.	F	163.	F	206.	F	249.	F	292.	ST	335.	?
35.	F	78.	ST	121.	F	164.	ST	207.	VT	250.	ST	293.	VT	336.	?
36.	F	79.	F	122.	VT	165.	F	208.	F	251.	F	294.	VT	337.	VT
37.	ST	80.	ST	123.	VT	166.	F	209.	ST	252.	MT	295.	MT	338.	ST
38.	F	81.	F	124.	ST	167.	F	210.	MT	253.	MT	296.	MT	339.	F
39.	F	82.	F	125.	F	168.	ST	211.	F	254.	F	297.	ST	340.	F
40.	F	83.	F	126.	F	169.	VT	212.	VT	255.	F	298.	MT	341.	F
41.	VT	84.	F	127.	VT	170.	VT	213.	ST	256.	ST	299.	MT	342.	VT
42.	F	85.	VT	128.	ST	171.	F	214.	ST	257.	MT	300.	ST	343.	ST
43.	F	86.	F	129.	ST	172.	F	215.	F	258.	ST	301.	VT	344.	ST

re-input data from Kruse's administration this is full printout

MMPI-2
Minnesota Multiphasic Personality Inventory-2

Adult Clinical Interpretive Report

MMPI®-2
The Minnesota Report™: Adult Clinical System-Revised, 4th Edition
James N. Butcher, PhD

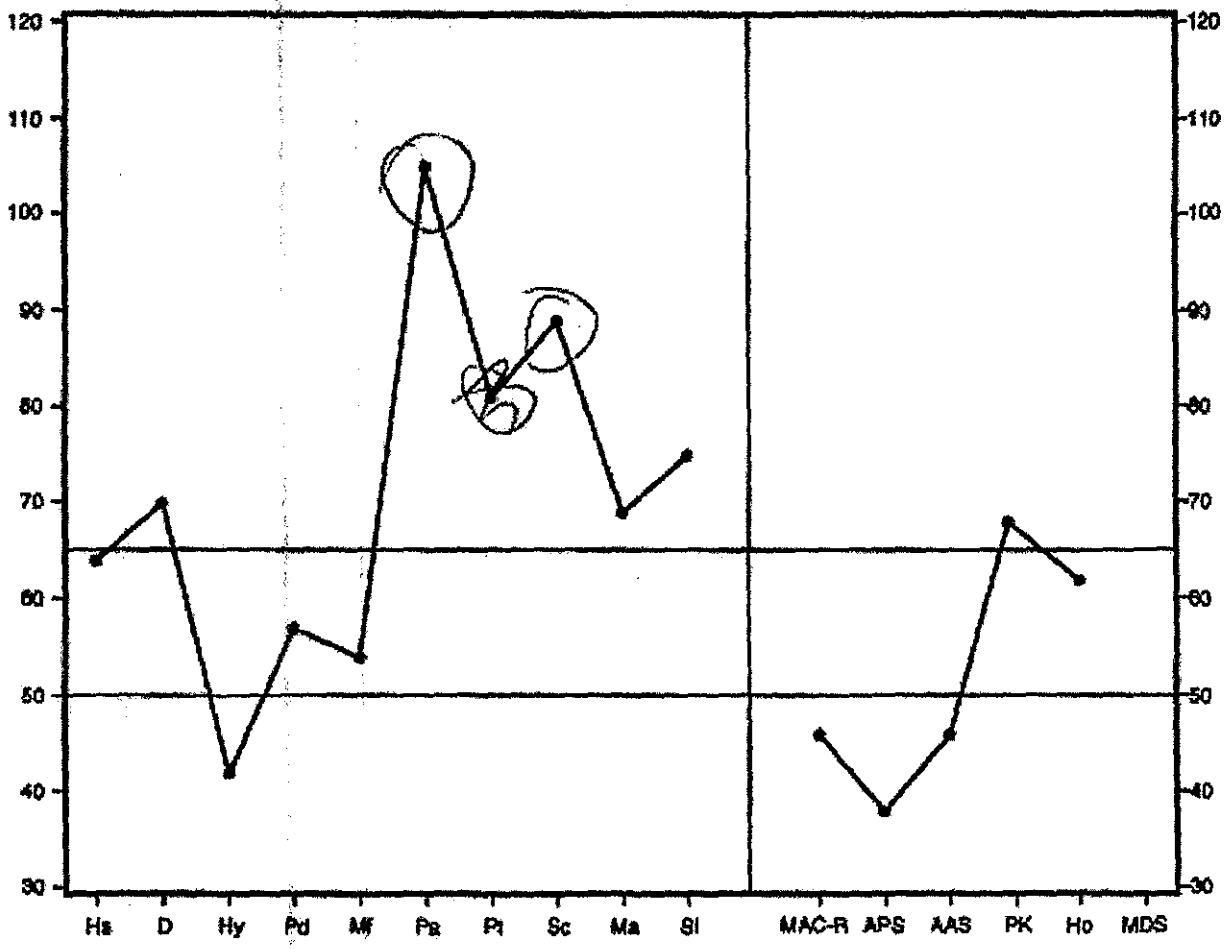
Name:	Timothy Ray Jones, Jr
Age:	37
Gender:	Male
Marital Status:	Divorced
Years of Education:	16
Date Assessed:	02/22/2019

Setting was specified as "Other."

PsychCorp

[9.7 / 1 / 03]

MMPI-2 CLINICAL AND SUPPLEMENTARY SCALES PROFILE



	Hs	D	Hy	Pd	Mf	Pa	Pt	Sc	Ma	SI	MAC-R	APS	AAS	PK	Ho	MDS
Raw Score:	10	28	17	20	28	25	26	34	24	47	19	19	2	19	28	*
K Correction:	8			6			15	15	3							
T Score:	64	70	42	57	54	105	81	89	69	75	46	38	46	68	62	*
Response %:	100	100	100	100	100	100	100	99	100	100	100	100	100	100	100	*

Welsh Code: 6***87"02'9+1-45/3: L'F+-/K:

Profile Elevation: 72.1

*MDS scores are reported only for clients who indicate that they are married or separated.

PROFILE VALIDITY

The client responded to the MMPI-2 items by claiming to be unrealistically virtuous. This test-taking attitude weakens the validity of the test and shows an unwillingness or inability on the part of the client to disclose personal information. Despite this extreme defensiveness, he responded to items reflecting some unusual symptoms or beliefs. Many reasons may be found for this pattern of uncooperativeness: conscious distortion to present himself in a favorable light, lack of psychological sophistication, or rigid neurotic adjustment.

↑ under-reporting
↓ malingering

SYMPTOMATIC PATTERNS

Scales Pa and Sc were used as the prototype to develop this report. A severe psychological disorder is reflected in this profile. The client appears to be experiencing a florid psychotic process that includes personality decompensation, social withdrawal, disordered affect, and erratic, possibly assaultive, behavior. He appears to be quite confused, withdrawn, and preoccupied with occult or abstract ideas, and he may feel that others are against him because of his beliefs. He may appear quite apathetic, tends to spend a great deal of time in fantasy, and might suffer from hallucinations, blunted or inappropriate affect, and hostile, irritable behavior. He appears confused and disoriented, and he may behave in unpredictable, highly aggressive ways. This MMPI-2 clinical profile reflects chronic maladjustment, although he may presently be experiencing an intensification of problems. Personality decompensation, disorganization, and thought disorder are likely to persist.

In addition, the following description is suggested by the client's scores on the content scales. He has difficulty managing routine affairs, and the items he endorsed suggest a poor memory, concentration problems, and an inability to make decisions. He appears to be immobilized and withdrawn and has no energy for life. He views his physical health as failing and reports numerous somatic concerns. He feels that life is no longer worthwhile and that he is losing control of his thought processes. He views the world as a threatening place, sees himself as having been unjustly blamed for others' problems, and feels that he is getting a raw deal out of life. He is rather high-strung and believes that he feels things more, or more intensely, than others do. He feels quite lonely and misunderstood at times.

He endorsed a number of extreme and bizarre thoughts, suggesting the presence of delusions and/or hallucinations. He apparently believes that he has special mystical powers or a special "mission" in life that others do not understand or accept.

An understanding of the client's underlying personality, as represented by his scores on the PSY-5 scales, can provide a clinical context in which to view the extreme psychological symptoms he is presently experiencing. He apparently holds some unusual beliefs that appear to be disconnected from reality. His high score on the PSYC (Psychoticism) scale suggests that he often feels alienated from others and might experience unusual symptoms such as delusional beliefs, circumstantial and tangential thinking, and loose associations.

TREATMENT CONSIDERATIONS

Individuals with this profile may be experiencing a great deal of personality deterioration, which may require hospitalization if they are considered dangerous to themselves or others. Psychotropic medication may reduce their thinking disturbance and mood disorder. Outpatient treatment may be complicated by their regressed or disorganized behavior. Day treatment programs or other such structured settings may be helpful in providing a stabilizing treatment environment.

Long-term adjustment is a problem. Frequent, brief "management" therapy contacts may be helpful in structuring their activities. Insight-oriented or uncovering therapies tend not to be helpful for individuals with this profile and may actually exacerbate the problems. This individual is unlikely to be able to establish a trusting working relationship with a therapist.

If psychological treatment is being considered, it may be profitable for the therapist to explore the client's treatment motivation early in therapy. His scores on the content scales indicate some feelings and attitudes that could be unproductive in psychological treatment and in implementing change.

	Raw Score	T Score	Resp %
Schizophrenia Subscales			
Social Alienation (Sc_1)	12	88	100
Emotional Alienation (Sc_2)	4	78	100
Lack of Ego Mastery, Cognitive (Sc_3)	4	66	100
Lack of Ego Mastery, Conative (Sc_4)	3	55	100
Lack of Ego Mastery, Defective Inhibition (Sc_5)	7	89	100
Bizarre Sensory Experiences (Sc_6)	7	75	100
Hypomania Subscales			
Amorality (Ma_1)	0	35	100
Psychomotor Acceleration (Ma_2)	7	58	100
Imperturbability (Ma_3)	3	47	100
Ego Inflation (Ma_4)	5	63	100
Social Introversion Subscales (Ben-Porath, Hostetler, Butcher, & Graham)			
Shyness/Self-Consciousness (Si_1)	14	77	100
Social Avoidance (Si_2)	8	71	100
Alienation--Self and Others (Si_3)	6	53	100
Content Component Scales (Ben-Porath & Sherwood)			
Fears Subscales			
Generalized Fearfulness (FRS_1)	1	53	100
Multiple Fears (FRS_2)	0	37	100
Depression Subscales			
Lack of Drive (DEP_1)	1	46	100
Dysphoria (DEP_2)	1	50	100
Self-Depreciation (DEP_3)	3	62	100
Suicidal Ideation (DEP_4)	1	62	100
Health Concerns Subscales			
Gastrointestinal Symptoms (HEA_1)	1	57	100
Neurological Symptoms (HEA_2)	3	60	100
General Health Concerns (HEA_3)	2	56	100
Bizarre Mentation Subscales			
Psychotic Symptomatology (BIZ_1)	2	64	100
Schizotypal Characteristics (BIZ_2)	7	86	100
Anger Subscales			
Explosive Behavior (ANG_1)	0	39	100
Irritability (ANG_2)	1	41	100
Cynicism Subscales			
Misanthropic Beliefs (CYN_1)	9	58	100
Interpersonal Suspiciousness (CYN_2)	6	62	100

CRITICAL ITEMS

The following critical items have been found to have possible significance in analyzing a client's problem situation. Although these items may serve as a source of hypotheses for further investigation, caution should be used in interpreting individual items because they may have been checked inadvertently.

The percentages of endorsement for each critical item are presented in brackets following the listing of the item. The percentage of the MMPI-2 normative sample of 1,138 men who endorsed the item in the scored direction is given.

Acute Anxiety State (Koss-Butcher Critical Items)

Of the 17 possible items in this section, 10 were endorsed in the scored direction:

5. I am easily awakened by noise. (True)
   [N = 41]
15. I work under a great deal of tension. (True)
   [N = 37]
28. I am bothered by an upset stomach several times a week. (True)
   [N = 8]
39. My sleep is fitful and disturbed. (True)
   [N = 11]
140. Most nights I go to sleep without thoughts or ideas bothering me. (False)
   [N = 23]
218. I have periods of such great restlessness that I cannot sit long in a chair. (True)
   [N = 30]
223. I believe I am no more nervous than most others. (False)
   [N = 16]
301. I feel anxiety about something or someone almost all the time. (True)
   [N = 15]
444. I am a high-strung person. (True)
   [N = 22]
463. Several times a week I feel as if something dreadful is about to happen. (True)
   [N = 4]

Depressed Suicidal Ideation (Koss-Butcher Critical Items)

Of the 22 possible items in this section, 5 were endorsed in the scored direction:

130. I certainly feel useless at times. (True)
   [N = 34]
146. I cry easily. (True)
   [N = 13]
273. Life is a strain for me much of the time. (True)
   [N = 16]

361. Someone has been trying to influence my mind. (True)
[N = 4]

Antisocial Attitude (Lachar-Wrobel Critical Items)

Of the 9 possible items in this section, 4 were endorsed in the scored direction:

35. Sometimes when I was young I stole things. (True)
[N = 58]
84. I was suspended from school one or more times for bad behavior. (True)
[N = 17]
254. Most people make friends because friends are likely to be useful to them. (True)
[N = 24]
266. I have never been in trouble with the law. (False)
[N = 41]

Family Conflict (Lachar-Wrobel Critical Items)

Of the 4 possible items in this section, 1 was endorsed in the scored direction:

21. At times I have very much wanted to leave home. (True)
[N = 32]

Somatic Symptoms (Lachar-Wrobel Critical Items)

Of the 23 possible items in this section, 8 were endorsed in the scored direction:

28. I am bothered by an upset stomach several times a week. (True)
[N = 8]
33. I seldom worry about my health. (False)
[N = 37]
47. I am almost never bothered by pains over my heart or in my chest. (False)
[N = 19]
57. I hardly ever feel pain in the back of my neck. (False)
[N = 27]
142. I have never had a fit or convulsion. (False)
[N = 7]
159. I have never had a fainting spell. (False)
[N = 27]
229. I have had blank spells in which my activities were interrupted and I did not know what was going on around me. (True)
[N = 8]
295. I have never been paralyzed or had any unusual weakness of any of my muscles. (False)
[N = 15]

122. At times my thoughts have raced ahead faster than I could speak them. (True)
[N = 80]
316. I have strange and peculiar thoughts. (True)
[N = 15]
319. I hear strange things when I am alone. (True)
[N = 4]

Depression and Worry (Lachar-Wrobel Critical Items)

Of the 16 possible items in this section, 6 were endorsed in the scored direction:

73. I am certainly lacking in self-confidence. (True)
[N = 17]
130. I certainly feel useless at times. (True)
[N = 34]
180. There is something wrong with my mind. (True)
[N = 5]
273. Life is a strain for me much of the time. (True)
[N = 16]
411. At times I think I am no good at all. (True)
[N = 20]
415. I worry quite a bit over possible misfortunes. (True)
[N = 27]

Deviant Beliefs (Lachar-Wrobel Critical Items)

Of the 15 possible items in this section, 10 were endorsed in the scored direction:

42. If people had not had it in for me, I would have been much more successful. (True)
[N = 4]
99. Someone has it in for me. (True)
[N = 5]
138. I believe I am being plotted against. (True)
[N = 2]
144. I believe I am being followed. (True)
[N = 1]
216. Someone has been trying to rob me. (True)
[N = 3]
259. I am sure I am being talked about. (True)
[N = 18]
314. I have no enemies who really wish to harm me. (False)
[N = 12]
333. People say insulting and vulgar things about me. (True)
[N = 6]
361. Someone has been trying to influence my mind. (True)
[N = 4]
466. Sometimes I am sure that other people can tell what I am thinking. (True)

OMITTED ITEMS

The following items were omitted by the client. It may be helpful to discuss these item omissions with this individual to determine the reason for noncompliance with the test instructions.

123. If I could get into a movie without paying and be sure I was not seen I would probably do it.
192. My mother is a good woman, or (if your mother is dead) my mother was a good woman.
198. I often hear voices without knowing where they come from.

End of Report

NOTE: This MMPI-2 interpretation can serve as a useful source of hypotheses about clients. This report is based on objectively derived scale indices and scale interpretations that have been developed in diverse groups of patients. The personality descriptions, inferences, and recommendations contained herein need to be verified by other sources of clinical information because individual clients may not fully match the prototype. The information in this report should only be used by a trained and qualified test interpreter. The report was not designed or intended to be provided directly to clients. The information contained in the report is technical and was developed to aid professional interpretation.

This and previous pages of this report contain trade secrets and are not to be released in response to requests under HIPAA (or any other data disclosure law that exempts trade secret information from release). Further, release in response to litigation discovery demands should be made only in accordance with your profession's ethical guidelines and under an appropriate protective order.

441: 2	442: 1	443: 2	444: 1	445: 2	446: 1	447: 2	448: 2	449: 1	450: 2
451: 2	452: 1	453: 1	454: 2	455: 1	456: 1	457: 2	458: 2	459: 1	460: 1
461: 2	462: 1	463: 1	464: 2	465: 1	466: 1	467: 1	468: 2	469: 2	470: 2
471: 2	472: 2	473: 1	474: 2	475: 2	476: 1	477: 2	478: 2	479: 2	480: 2
481: 2	482: 2	483: 1	484: 1	485: 1	486: 2	487: 2	488: 1	489: 2	490: 1
491: 2	492: 1	493: 2	494: 1	495: 1	496: 1	497: 2	498: 1	499: 2	500: 2
501: 2	502: 2	503: 2	504: 2	505: 2	506: 2	507: 2	508: 2	509: 2	510: 2
511: 2	512: 1	513: 2	514: 1	515: 1	516: 2	517: 2	518: 2	519: 2	520: 2
521: 2	522: 2	523: 2	524: 2	525: 2	526: 1	527: 2	528: 1	529: 1	530: 2
531: 1	532: 1	533: 2	534: 2	535: 1	536: 2	537: 2	538: 2	539: 2	540: 2
541: 1	542: 1	543: 1	544: 2	545: 1	546: 1	547: 1	548: 2	549: 1	550: 1
551: 2	552: 2	553: 2	554: 2	555: 2	556: 2	557: 1	558: 1	559: 2	560: 2
561: 1	562: 1	563: 1	564: 1	565: 2	566: 2	567: 1			

MCMI®-III

MILLON® CLINICAL
MULTIAXIAL INVENTORY-III

MCMI®-III
Millon® Clinical Multiaxial Inventory-III
Profile Report
Theodore Millon, PhD, DSc

ID Number:	[redacted]
Age:	37
Gender:	Male
Setting:	Correctional Inmate
Race:	White
Marital Status:	Divorced
Date Assessed:	02/22/2019

PsychCorp

[7.3 / 1 / 4.0.12]

INTERPRETIVE CONSIDERATIONS

MCMI-III reports are normed on patients who were in the early phases of assessment or psychotherapy for emotional discomfort or social difficulties. Respondents who do not fit this normative population or who have inappropriately taken the MCMI-III for nonclinical purposes may have inaccurate reports. The MCMI-III report cannot be considered definitive. It should be evaluated in conjunction with additional clinical data. The report should be evaluated by a mental health clinician trained in the use of psychological tests. The report should not be shown to offenders or their relatives.

The client is a 37-year-old divorced white male. He is currently being seen as a correctional offender, and he did not identify specific problems and difficulties of an Axis I nature in the demographic portion of this test.

The BR scores reported for this individual have been modified to account for the high self-revealing inclinations indicated by the high raw score on Scale X (Disclosure) and the psychic tension indicated by the elevation on Scale A (Anxiety).

MILLON CLINICAL MULTIAXIAL INVENTORY - III

CONFIDENTIAL INFORMATION FOR PROFESSIONAL USE ONLY

INVALIDITY (SCALE V) = 0 INCONSISTENCY (SCALE W) = 3
PERSONALITY CODE: 2A 8B 2B ** 3 * 1 7 8A 6B + 5 6A " 4 ' ' // S ** P C * //
SYNDROME CODE: A N ** R * // PP ** - * //
DEMOGRAPHIC CODE: [redacted]/CI/M/37/W/D/-/--/--/--/------/--/------/

CATEGORY		SCORE RAW	SCORE BR	PROFILE OF BR SCORES (0 / 60 / 75 / 85 / 115)	DIAGNOSTIC SCALES
MODIFYING INDICES	X	125	76		DISCLOSURE
	Y	7	35		DESIRABILITY
	Z	13	61		DEBASEMENT
CLINICAL PERSONALITY PATTERNS	1	11	71		SCHIZOID
	2A	21	102		AVOIDANT
	2B	17	91		DEPRESSIVE
	3	11	80		DEPENDENT
	4	2	7		HISTRIONIC
	5	11	51		NARCISSISTIC
	6A	4	47		ANTISOCIAL
	6B	7	63		SADISTIC
	7	19	65		COMPULSIVE
	8A	9	65		NEGATIVISTIC
	8B	17	95		MASOCHISTIC
SEVERE PERSONALITY PATHOLOGY	S	22	99		SCHIZOTYPAL
	C	13	76		BORDERLINE
	P	19	84		PARANOID
CLINICAL SYNDROMES	A	15	99		ANXIETY
	H	3	44		SOMATOFORM
	N	14	94		BIPOLAR: MANIC
	D	6	61		DYSTHYMIA
	B	3	59		ALCOHOL DEPENDENCE
	T	6	70		DRUG DEPENDENCE
	R	14	76		POST-TRAUMATIC STRESS
SEVERE CLINICAL SYNDROMES	SS	12	70		THOUGHT DISORDER
	CC	5	64		MAJOR DEPRESSION
	PP	14	104		DELUSIONAL DISORDER

NOTEWORTHY RESPONSES

The client answered the following statements in the direction noted in parentheses. These items suggest specific problem areas that the clinician may wish to investigate.

Health Preoccupation

74. I can't seem to sleep, and wake up just as tired as when I went to bed. (True)
149. I feel shaky and have difficulty falling asleep because painful memories of a past event keep running through my mind. (True)

Interpersonal Alienation

10. What few feelings I seem to have I rarely show to the outside world. (True)
18. I'm afraid to get really close to another person because it may end up with my being ridiculed or shamed. (True)
27. When I have a choice, I prefer to do things alone. (True)
48. A long time ago, I decided it's best to have little to do with people. (True)
63. Many people have been spying into my private life for years. (True)
69. I avoid most social situations because I expect people to criticize or reject me. (True)
99. In social groups I am almost always very self-conscious and tense. (True)
161. I seem to create situations with others in which I get hurt or feel rejected. (True)
165. Other than my family, I have no close friends. (True)
167. I take great care to keep my life a private matter so no one can take advantage of me. (True)
174. Although I'm afraid to make friendships, I wish I had more than I do. (True)

Emotional Dyscontrol

22. I'm a very erratic person, changing my mind and feelings all the time. (True)
34. Lately, I have gone all to pieces. (True)
83. My moods seem to change a great deal from one day to the next. (True)
116. I have had to be really rough with some people to keep them in line. (True)
124. When I'm alone and away from home, I often begin to feel tense and panicky. (True)
134. I sometimes feel crazy-like or unreal when things start to go badly in my life. (True)

Self-Destructive Potential

24. I began to feel like a failure some years ago. (True)
112. I have been downhearted and sad much of my life since I was quite young. (True)
151. I've never been able to shake the feeling that I'm worthless to others. (True)
154. I have tried to commit suicide. (True)

Childhood Abuse

81. I'm ashamed of some of the abuses I suffered when I was young. (True)
132. I hate to think about some of the ways I was abused as a child. (True)

Eating Disorder

No items endorsed.

End of Report

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[7.3 / 1 / 4.0.12]

MILLON CLINICAL MULTIAXIAL INVENTORY - III

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DEMOGRAPHIC CODE: [redacted]/CI/M/37/W/D/-/--/--/--/------/--/------/

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	2B	17	91		DEPRESSIVE
	3	11	80		DEPENDENT
	4	2	7		HISTRIONIC
	5	11	51		NARCISSISTIC
	6A	4	47		ANTISOCIAL
	6B	7	63		SADISTIC
	7	19	65		COMPULSIVE
	8A	9	65		NEGATIVISTIC
	8B	17	95		MASOCHISTIC
SEVERE PERSONALITY PATHOLOGY	S	22	99		SCHIZOTYPAL
	C	13	76		BORDERLINE
	P	19	84		PARANOID
CLINICAL SYNDROMES	A	15	99		ANXIETY
	H	3	44		SOMATOFORM
	N	14	94		BIPOLAR: MANIC
	D	6	61		DYSTHYMIA
	B	3	59		ALCOHOL DEPENDENCE
	T	6	70		DRUG DEPENDENCE
	R	14	76		POST-TRAUMATIC STRESS
SEVERE CLINICAL SYNDROMES	SS	12	70		THOUGHT DISORDER
	CC	5	64		MAJOR DEPRESSION
	PP	14	104		DELUSIONAL DISORDER

MMPI-2
Minnesota Multiphasic Personality Inventory-2

MMPI®-2
Minnesota Multiphasic Personality Inventory®-2
Extended Score Report

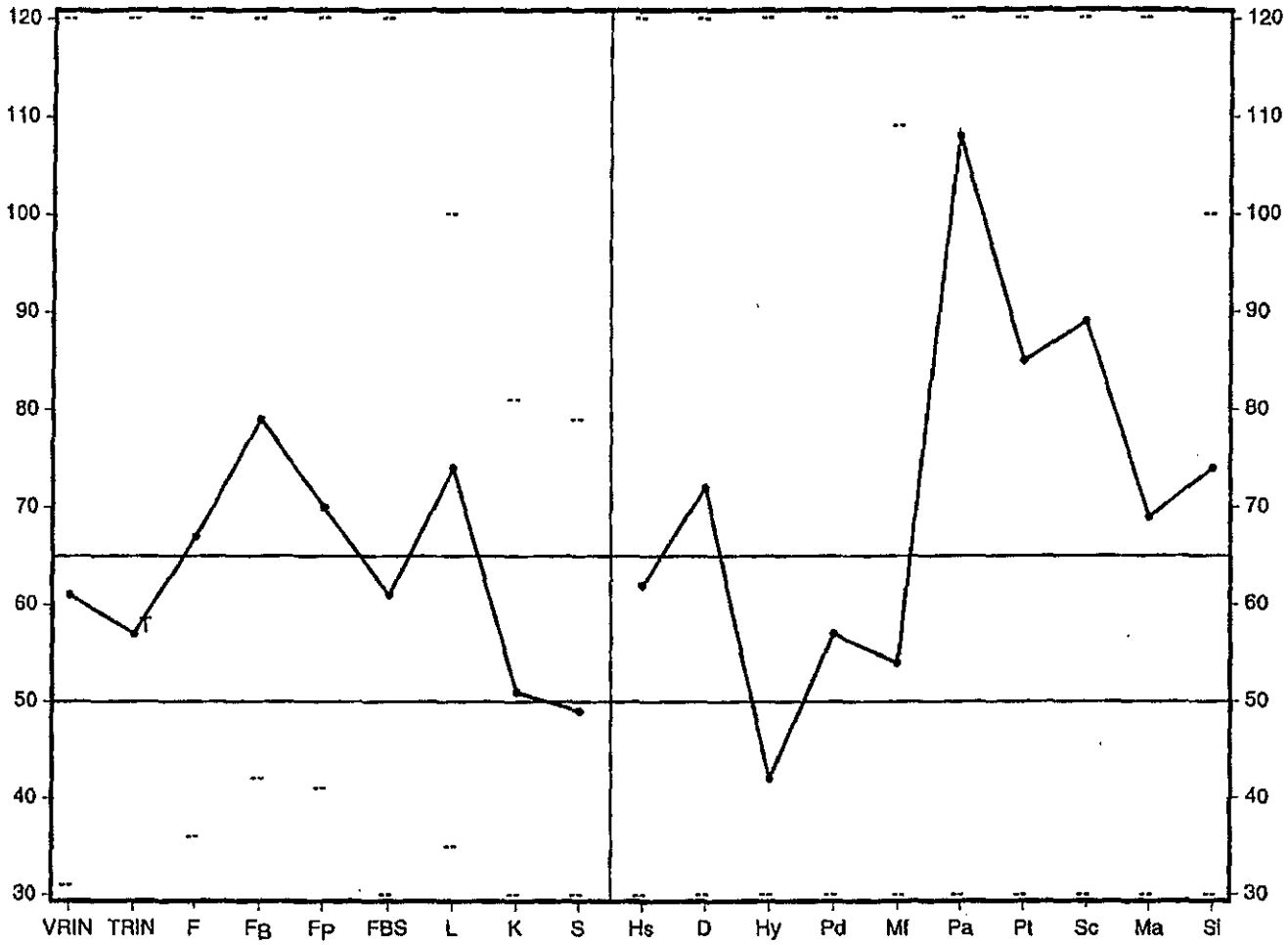
Name:	TIMOTHY JONES
ID Number:	[redacted]
Age:	37
Gender:	Male
Date Assessed:	02/22/2019

PsychCorp

[5.3 / 3 / 4.0.12]

ID: [redacted]
TIMOTHY JONES

MMPI-2 VALIDITY AND CLINICAL SCALES PROFILE



	VRIN	TRIN	F	FB	FP	FBS	L	K	S	Hs	D	Hy	Pd	Mf	Pa	Pt	Sc	Ma	Si
Raw Score:	8	10	10	9	4	16	9	16	24	9	29	17	20	28	26	27	33	24	46
K Correction:										8			6			16	16	3	
T Score (Plotted):	61	57T	67	79	70	61	74	51	49	62	72	42	57	54	108	85	89	69	74
Non-Gendered T Score:	62	58T	69	79	72	58	75	52	48	60	70	41	57		107	81	87	69	72
Response %:	100	100	97	100	96	100	100	100	100	100	100	100	100	100	100	100	99	100	100

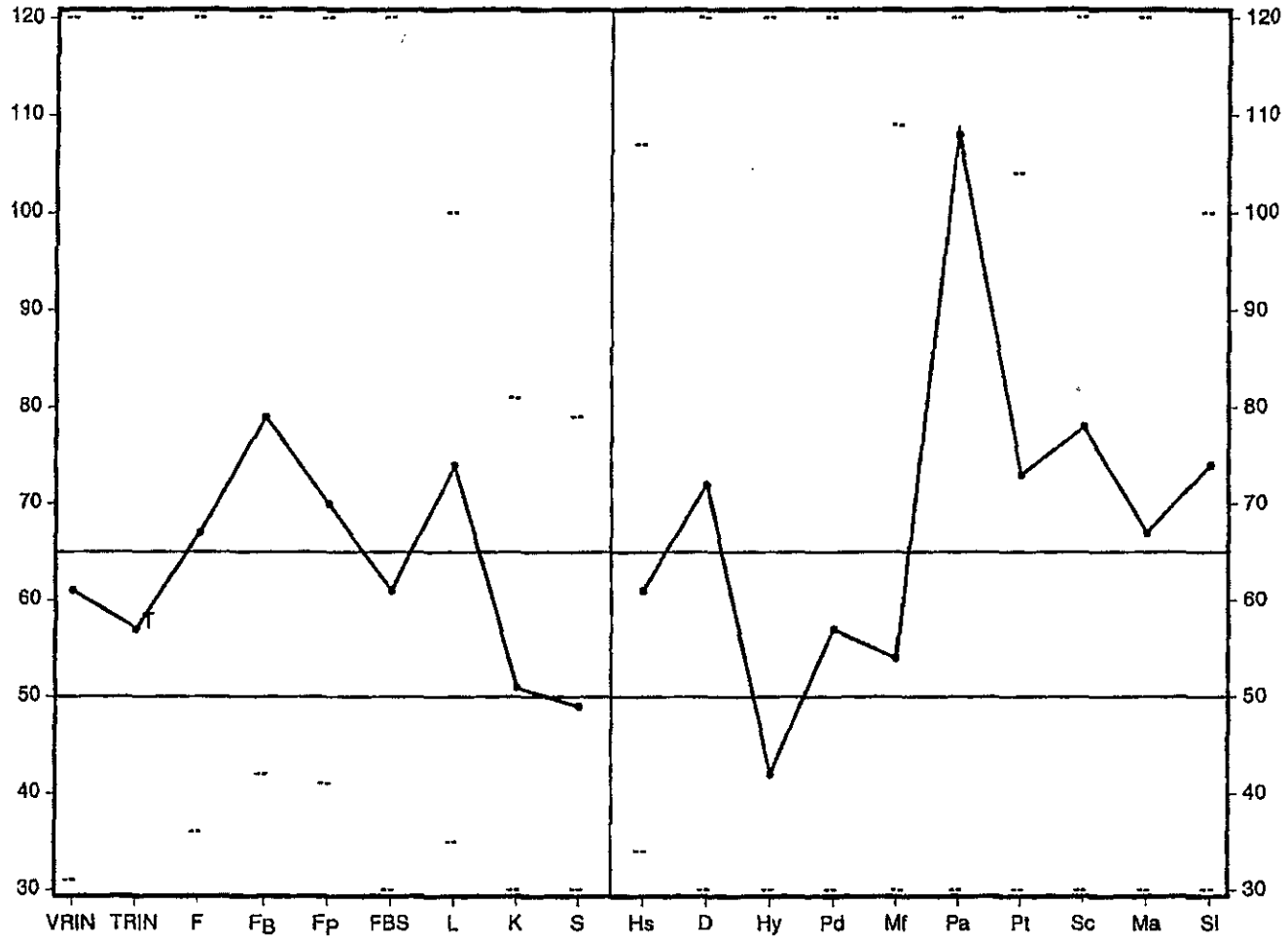
Cannot Say (Raw): 2
F-K (Raw): -6
Welsh Code: 6***87"02'9+1-45/3: L'F+-K/

Percent True: 45
Percent False: 55
Profile Elevation: 73.0

The highest and lowest T scores possible on each scale are indicated by a "--".

For Information on FBS, see Ben-Porath, Y. S., & Tellegen, A. (2006). The FBS: Current Status, a report on the Pearson web site (www.pearsonassessments.com/tests/mmpi_2.htm).

MMPI-2 **NON-K-CORRECTED** VALIDITY/CLINICAL SCALES PROFILE



	VRIN	TRIN	F	F_B	F_P	FBS	L	K	S	Hs	D	Hy	Pd	Mf	Pa	Pt	Sc	Ma	SI
Raw Score:	8	10	10	9	4	16	9	16	24	9	29	17	20	28	26	27	33	24	46
T Score (Plotted):	61	57T	67	79	70	61	74	51	49	61	72	42	57	54	108	73	78	67	74
Non-Gendered T Score:	62	58T	69	79	72	58	75	52	48	59	70	41	58		107	71	77	68	72
Response %:	100	100	97	100	96	100	100	100	100	100	100	100	100	100	100	100	99	100	100

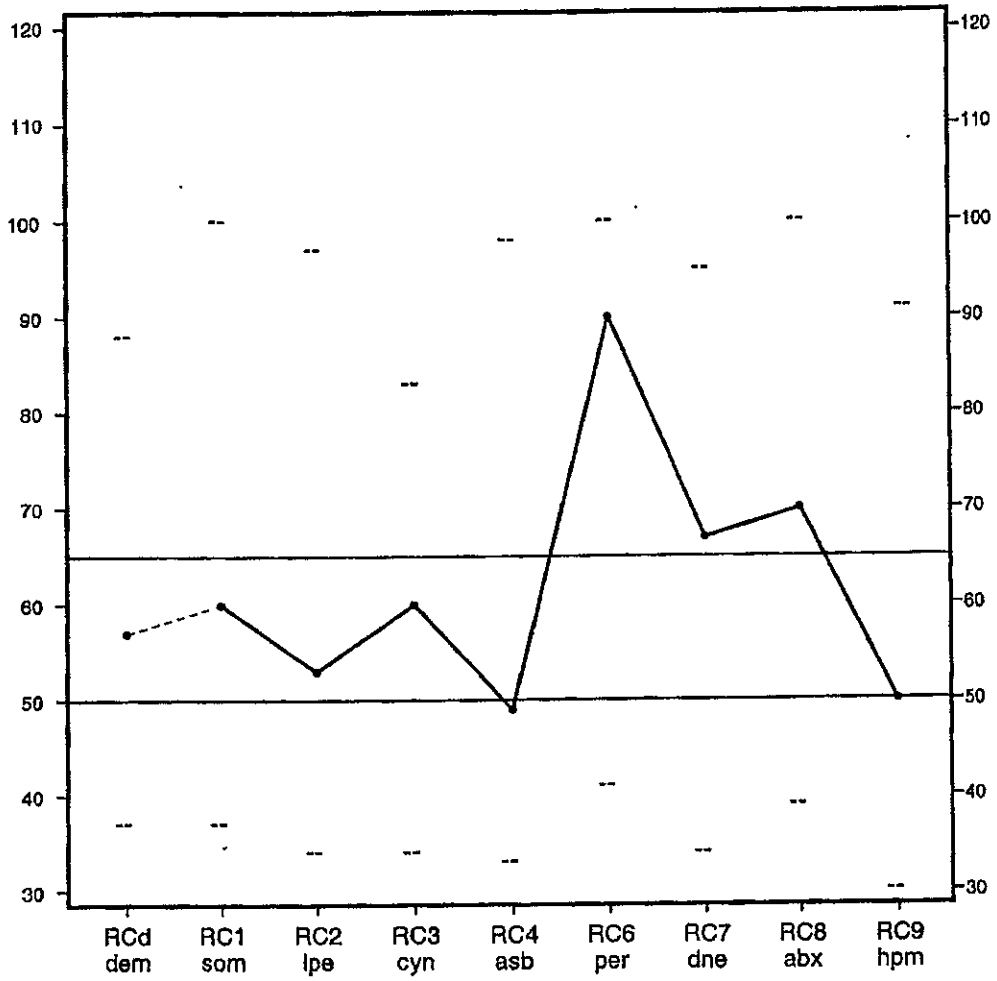
Cannot Say (Raw):	2	Percent True:	45
Profile Elevation:	69.8	Percent False:	55

The highest and lowest T scores possible on each scale are indicated by a "--".

Non-K-corrected T scores allow interpreters to examine the relative contributions of the Clinical Scale raw score and the K correction to K-corrected Clinical Scale T scores. Because all other MMPI-2 scores that aid in the interpretation of the Clinical Scales (the Harris-Lingoes subscales, Restructured Clinical Scales, Content and Content Component Scales, PSY-5 Scales, and Supplementary Scales) are not K-corrected, they can be compared most directly with non-K-corrected T scores.

For information on FBS, see Ben-Porath, Y. S., & Tellegen, A. (2006). The FBS: Current Status, a report on the Pearson web site (www.pearsonassessments.com/tests/mmpi_2.htm).

MMPI-2 RESTRUCTURED CLINICAL SCALES PROFILE



	RCd dem	RC1 som	RC2 lpe	RC3 cyn	RC4 asb	RC6 per	RC7 dne	RC8 abx	RC9 hpm
Raw Score:	7	6	5	10	5	12	13	7	13
T Score (plotted):	57	60	53	60	49	90	67	70	50
Non-Gendered T Score:	55	59	54	61	52	100	65	70	51
Response %:	100	100	100	100	100	100	100	94	100

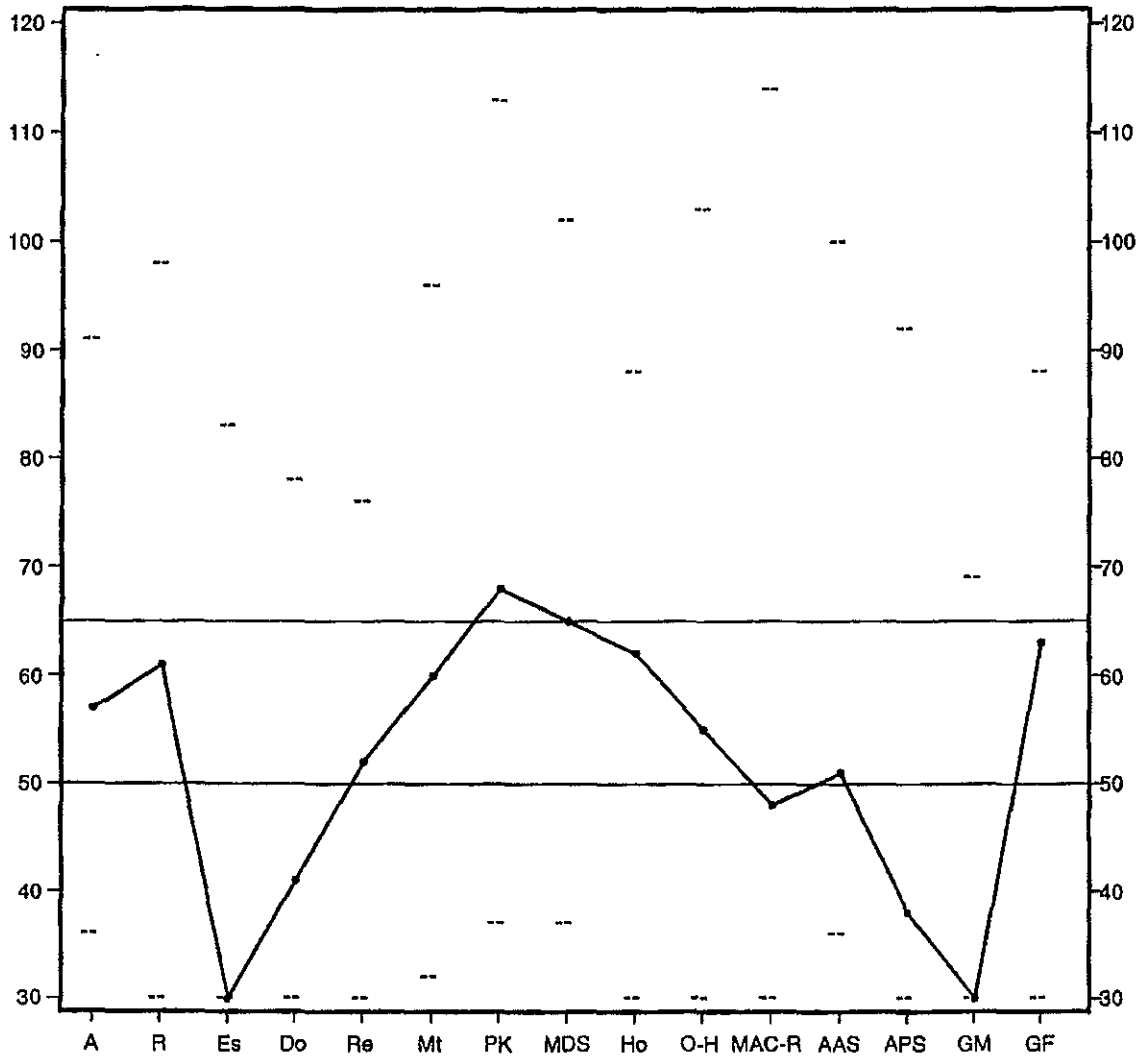
The highest and lowest T scores possible on each scale are indicated by a "--".

LEGEND

dem= Demoralization	**cyn** = Cynicism	**dne** = Dysfunctional Negative Emotions
som= Somatic Complaints	**asb** = Antisocial Behavior	**abx** = Aberrant Experiences
lpe = Low Positive Emotions	**per** = Ideas of Persecution	**hpm**= Hypomanic Activation

For information on the RC scales, see Tellegen, A., Ben-Porath, Y.S., McNulty, J.L., Arbisi, P.A., Graham, J.R., & Kaemmer, B. 2003. The MMPI-2 Restructured Clinical (RC) Scales: Development, Validation, and Interpretation. Minneapolis: University of Minnesota Press.

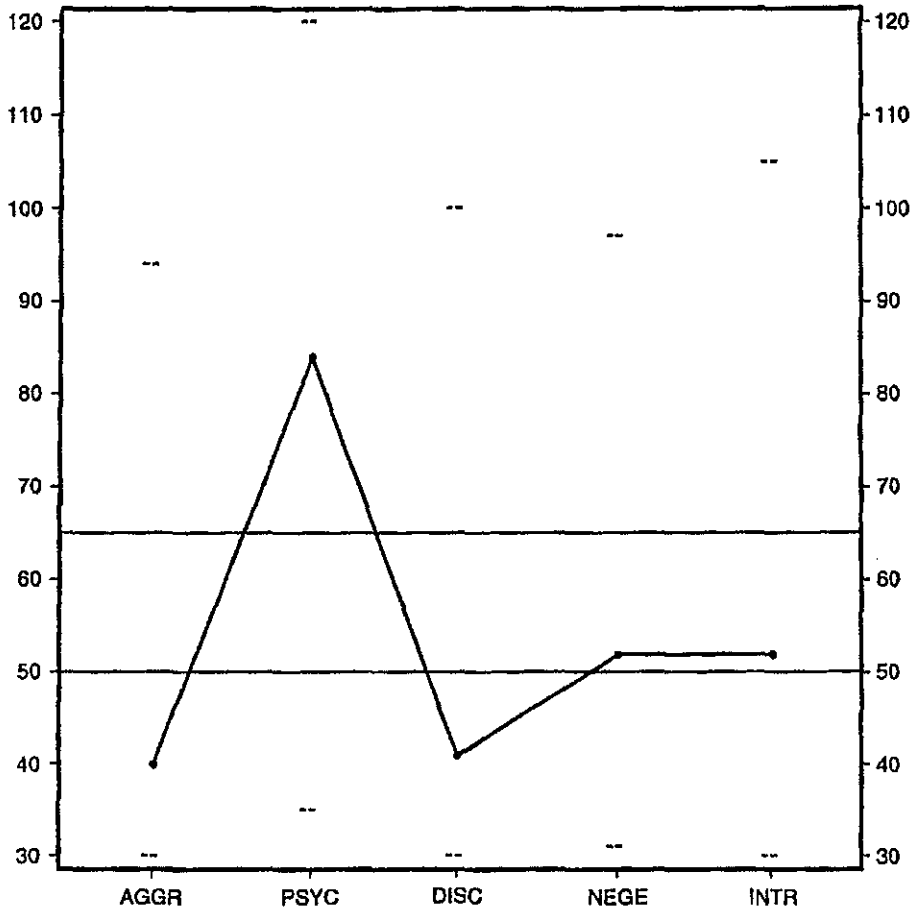
MMPI-2 SUPPLEMENTARY SCALES PROFILE



	A	R	Es	Do	Re	Mt	PK	MDS	Ho	O-H	MAC-R	AAS	APS	GM	GF
Raw Score:	15	20	27	14	21	18	19	6	28	14	20	3	19	28	34
T Score (plotted):	57	61	30	41	52	60	68	65	62	55	48	51	38	30	63
Non-Gendered T Score:	56	60	32	41	51	59	67	63	63	53	51	53	38		
Response %:	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100

The highest and lowest T scores possible on each scale are indicated by a "--".

MMPI-2 PSY-5 SCALES PROFILE



	AGGR	PSYC	DISC	NEGE	INTR
Raw Score:	5	14	10	11	12
T Score (plotted):	40	84	41	52	52
Non-Gendered T Score:	42	85	45	51	52
Response %:	100	96	100	100	100

The highest and lowest T scores possible on each scale are indicated by a "--".

ADDITIONAL SCALES
(to be used as an aid in interpreting the parent scales)

	Raw Score	T Score	Non-Gendered T Score	Resp %
Harris-Lingoes Subscales				
Depression Subscales				
Subjective Depression (D_1)	13	66	64	100
Psychomotor Retardation (D_2)	8	65	64	100
Physical Malfunctioning (D_3)	5	67	65	100
Mental Dullness (D_4)	3	53	52	100
Brooding (D_5)	4	62	60	100
Hysteria Subscales				
Denial of Social Anxiety (Hy_1)	0	30	30	100
Need for Affection (Hy_2)	3	36	35	100
Lassitude-Malaise (Hy_3)	4	57	56	100
Somatic Complaints (Hy_4)	4	57	55	100
Inhibition of Aggression (Hy_5)	6	71	70	100
Psychopathic Deviate Subscales				
Familial Discord (Pd_1)	2	51	51	100
Authority Problems (Pd_2)	2	40	43	100
Social Imperturbability (Pd_3)	0	30	30	100
Social Alienation (Pd_4)	9	77	76	100
Self-Alienation (Pd_5)	4	53	53	100
Paranoia Subscales				
Persecutory Ideas (Pa_1)	14	120	120	100
Poignancy (Pa_2)	5	68	67	100
Naivete (Pa_3)	5	51	50	100
Schizophrenia Subscales				
Social Alienation (Sc_1)	12	88	86	100
Emotional Alienation (Sc_2)	4	78	78	100
Lack of Ego Mastery, Cognitive (Sc_3)	4	66	67	100
Lack of Ego Mastery, Conative (Sc_4)	3	55	55	100
Lack of Ego Mastery, Defective Inhibition (Sc_5)	7	89	86	100
Bizarre Sensory Experiences (Sc_6)	7	75	73	100
Hypomania Subscales				
Amorality (Ma_1)	0	35	36	100
Psychomotor Acceleration (Ma_2)	7	58	59	100
Imperturbability (Ma_3)	3	47	48	100
Ego Inflation (Ma_4)	5	63	62	100
Social Introversion Subscales				
Shyness/Self-Consciousness (Si_1)	14	77	75	100
Social Avoidance (Si_2)	8	71	72	100
Alienation--Self and Others (Si_3)	5	50	50	100

	Raw Score	T Score	Non-Gendered T Score	Resp %
Content Component Scales				
Fears Subscales				
Generalized Fearfulness (FRS_1)	1	53	51	100
Multiple Fears (FRS_2)	0	37	34	100
Depression Subscales				
Lack of Drive (DEP_1)	1	46	46	100
Dysphoria (DEP_2)	1	50	48	100
Self-Depreciation (DEP_3)	3	62	62	100
Suicidal Ideation (DEP_4)	1	62	62	100
Health Concerns Subscales				
Gastrointestinal Symptoms (HEA_1)	1	57	55	100
Neurological Symptoms (HEA_2)	3	60	58	100
General Health Concerns (HEA_3)	3	64	64	100
Bizarre Mentation Subscales				
Psychotic Symptomatology (BIZ_1)	2	64	64	100
Schizotypal Characteristics (BIZ_2)	7	86	86	100
Anger Subscales				
Explosive Behavior (ANG_1)	0	39	39	100
Irritability (ANG_2)	1	41	40	100
Cynicism Subscales				
Misanthropic Beliefs (CYN_1)	8	55	56	100
Interpersonal Suspiciousness (CYN_2)	6	62	63	100
Antisocial Practices Subscales				
Antisocial Attitudes (ASP_1)	6	49	51	100
Antisocial Behavior (ASP_2)	3	59	64	100
Type A Subscales				
Impatience (TPA_1)	1	39	40	100
Competitive Drive (TPA_2)	6	66	68	100
Low Self-Esteem Subscales				
Self-Doubt (LSE_1)	5	64	64	100
Submissiveness (LSE_2)	1	48	47	100
Social Discomfort Subscales				
Introversion (SOD_1)	13	73	75	100
Shyness (SOD_2)	7	74	72	100
Family Problems Subscales				
Family Discord (FAM_1)	4	55	54	100
Familial Alienation (FAM_2)	0	40	41	100

	Raw Score	T Score	Non-Gendered T Score	Resp %
Negative Treatment Indicators Subscales				
Low Motivation (TRT_1)	2	54	53	100
Inability to Disclose (TRT_2)	4	68	68	100

Uniform T scores are used for Hs, D, Hy, Pd, Pa, Pt, Sc, Ma, the content scales, the content component scales, and the PSY-5 scales. The remaining scales and subscales use linear T scores.

OMITTED ITEMS

Those items for which there is no response or for which both true and false responses have been entered are considered "omitted." The potential for lowering the elevation of individual scales or the overall profile and rendering the administration invalid increases with the number of omitted items. Defensiveness, confusion, carelessness, and indecision are among the common reasons for omitting items. Examination of the content of the items that were omitted by the respondent may reveal specific problem areas or suggest reasons for their not responding appropriately to all items. Following are the items that were omitted:

192. My mother is a good woman, or (if your mother is dead) my mother was a good woman.
198. I often hear voices without knowing where they come from.

CRITICAL ITEMS

The MMPI-2 contains a number of items whose content may indicate the presence of psychological problems when endorsed in the deviant direction. These "critical items," developed for use in clinical settings, may provide an additional source of hypotheses about the respondent. However, caution should be used in interpreting critical items since responses to single items are very unreliable and should not be treated as scores on full-length scales -- for example, an individual could easily mismark or misunderstand a single item and not intend the answer given. The content of the items and the possibility of misinterpretation make it important to keep the test results strictly confidential. Special caution should be exercised when interpreting these items in nonclinical settings.

Acute Anxiety State (Koss-Butcher Critical Items)

5. I am easily awakened by noise. (True)
15. I work under a great deal of tension. (True)
28. I am bothered by an upset stomach several times a week. (True)
39. My sleep is fitful and disturbed. (True)
140. Most nights I go to sleep without thoughts or ideas bothering me. (False)
218. I have periods of such great restlessness that I cannot sit long in a chair. (True)
223. I believe I am no more nervous than most others. (False)
301. I feel anxiety about something or someone almost all the time. (True)
444. I am a high-strung person. (True)
463. Several times a week I feel as if something dreadful is about to happen. (True)

Depressed Suicidal Ideation (Koss-Butcher Critical Items)

130. I certainly feel useless at times. (True)
146. I cry easily. (True)
273. Life is a strain for me much of the time. (True)
411. At times I think I am no good at all. (True)
485. I often feel that I'm not as good as other people. (True)

Mental Confusion (Koss-Butcher Critical Items)

32. I have had very peculiar and strange experiences. (True)

180. There is something wrong with my mind. (True)
316. I have strange and peculiar thoughts. (True)

Persecutory Ideas (Koss-Butcher Critical Items)

17. I am sure I get a raw deal from life. (True)
42. If people had not had it in for me, I would have been much more successful. (True)
99. Someone has it in for me. (True)
124. I often wonder what hidden reason another person may have for doing something nice for me. (True)
138. I believe I am being plotted against. (True)
144. I believe I am being followed. (True)
145. I feel that I have often been punished without cause. (True)
216. Someone has been trying to rob me. (True)
241. It is safer to trust nobody. (True)
251. I have often felt that strangers were looking at me critically. (True)
259. I am sure I am being talked about. (True)
314. I have no enemies who really wish to harm me. (False)
333. People say insulting and vulgar things about me. (True)
361. Someone has been trying to influence my mind. (True)

Antisocial Attitude (Lachar-Wrobel Critical Items)

35. Sometimes when I was young I stole things. (True)
84. I was suspended from school one or more times for bad behavior. (True)
254. Most people make friends because friends are likely to be useful to them. (True)
266. I have never been in trouble with the law. (False)

Family Conflict (Lachar-Wrobel Critical Items)

21. At times I have very much wanted to leave home. (True)

Somatic Symptoms (Lachar-Wrobel Critical Items)

28. I am bothered by an upset stomach several times a week. (True)
33. I seldom worry about my health. (False)
47. I am almost never bothered by pains over my heart or in my chest. (False)
142. I have never had a fit or convulsion. (False)
159. I have never had a fainting spell. (False)
229. I have had blank spells in which my activities were interrupted and I did not know what was going on around me. (True)
295. I have never been paralyzed or had any unusual weakness of any of my muscles. (False)

Sexual Concern and Deviation (Lachar-Wrobel Critical Items)

268. I wish I were not bothered by thoughts about sex. (True)

Anxiety and Tension (Lachar-Wrobel Critical Items)

15. I work under a great deal of tension. (True)
17. I am sure I get a raw deal from life. (True)
218. I have periods of such great restlessness that I cannot sit long in a chair. (True)
223. I believe I am no more nervous than most others. (False)

261. I have very few fears compared to my friends. (False)
301. I feel anxiety about something or someone almost all the time. (True)
320. I have been afraid of things or people that I knew could not hurt me. (True)
463. Several times a week I feel as if something dreadful is about to happen. (True)

Sleep Disturbance (Lachar-Wrobel Critical Items)

5. I am easily awakened by noise. (True)
39. My sleep is fitful and disturbed. (True)
140. Most nights I go to sleep without thoughts or ideas bothering me. (False)
328. Sometimes some unimportant thought will run through my mind and bother me for days. (True)

Deviant Thinking and Experience (Lachar-Wrobel Critical Items)

32. I have had very peculiar and strange experiences. (True)
122. At times my thoughts have raced ahead faster than I could speak them. (True)
316. I have strange and peculiar thoughts. (True)
319. I hear strange things when I am alone. (True)

Depression and Worry (Lachar-Wrobel Critical Items)

73. I am certainly lacking in self-confidence. (True)
130. I certainly feel useless at times. (True)
180. There is something wrong with my mind. (True)
273. Life is a strain for me much of the time. (True)
411. At times I think I am no good at all. (True)
415. I worry quite a bit over possible misfortunes. (True)

Deviant Beliefs (Lachar-Wrobel Critical Items)

42. If people had not had it in for me, I would have been much more successful. (True)
99. Someone has it in for me. (True)
138. I believe I am being plotted against. (True)
144. I believe I am being followed. (True)
216. Someone has been trying to rob me. (True)
259. I am sure I am being talked about. (True)
314. I have no enemies who really wish to harm me. (False)
333. People say insulting and vulgar things about me. (True)
361. Someone has been trying to influence my mind. (True)
466. Sometimes I am sure that other people can tell what I am thinking. (True)

Substance Abuse (Lachar-Wrobel Critical Items)

168. I have had periods in which I carried on activities without knowing later what I had been doing. (True)
429. Except by doctor's orders I never take drugs or sleeping pills. (False)

End of Report

NOTE: This and previous pages of this report contain trade secrets and are not to be released in response to requests under HIPAA (or any other data disclosure law that exempts trade secret information from release). Further, release in response to litigation discovery demands should be made only in accordance with your profession's ethical guidelines and under an appropriate protective order.

KAPLAN

KBNA™

BAYCREST NEUROCOGNITIVE ASSESSMENT™

Response Booklet

Date of Testing: 2-22-19

Examinee's Name: Timothy Jones JR

Examiner's Name: Krcyc

PEARSON

PsychCorp™

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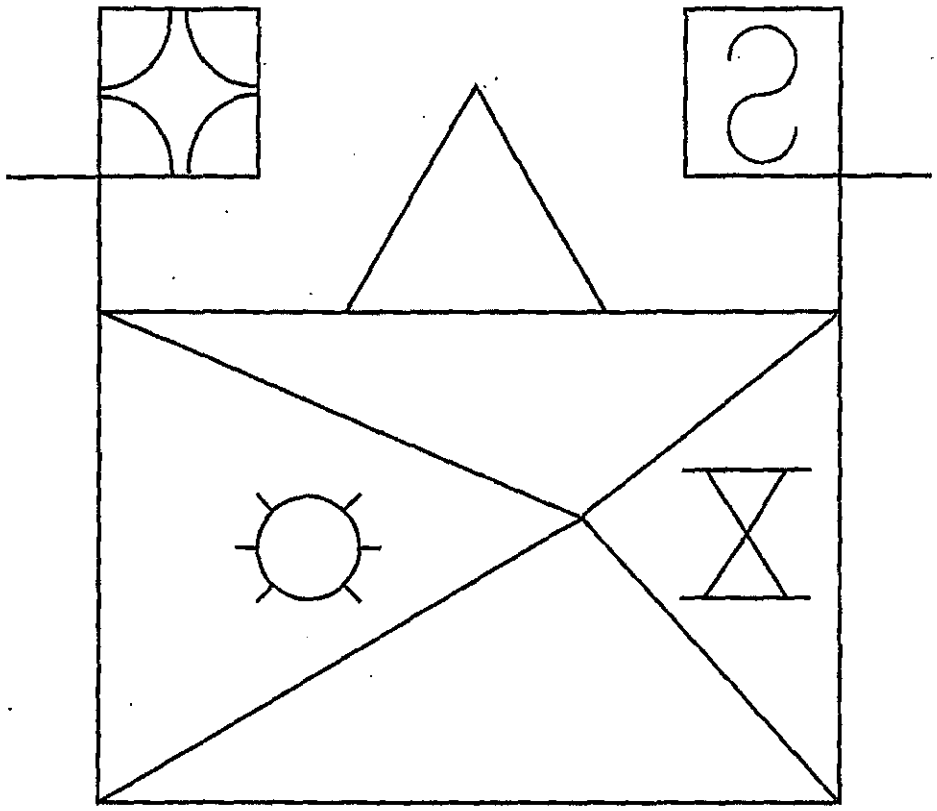
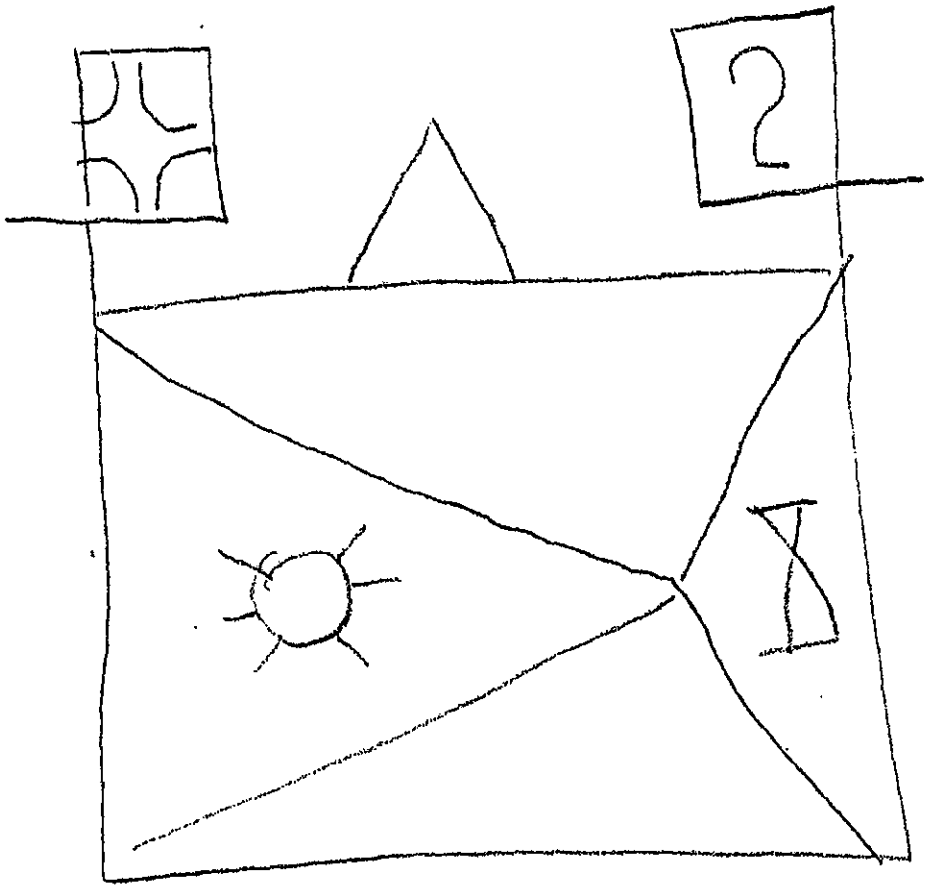
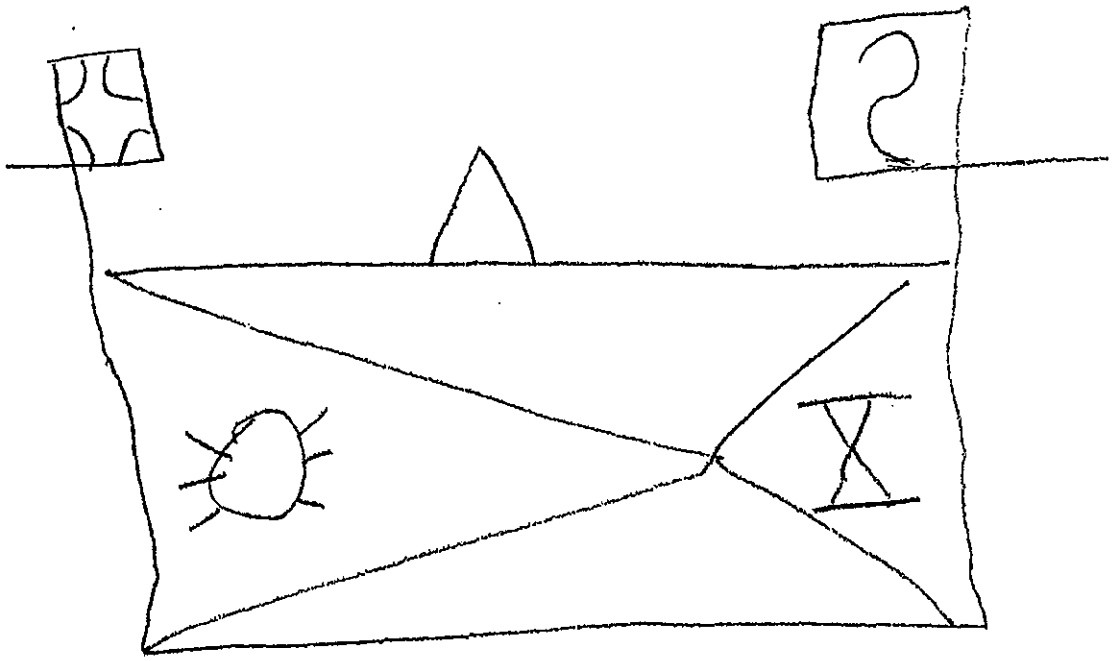
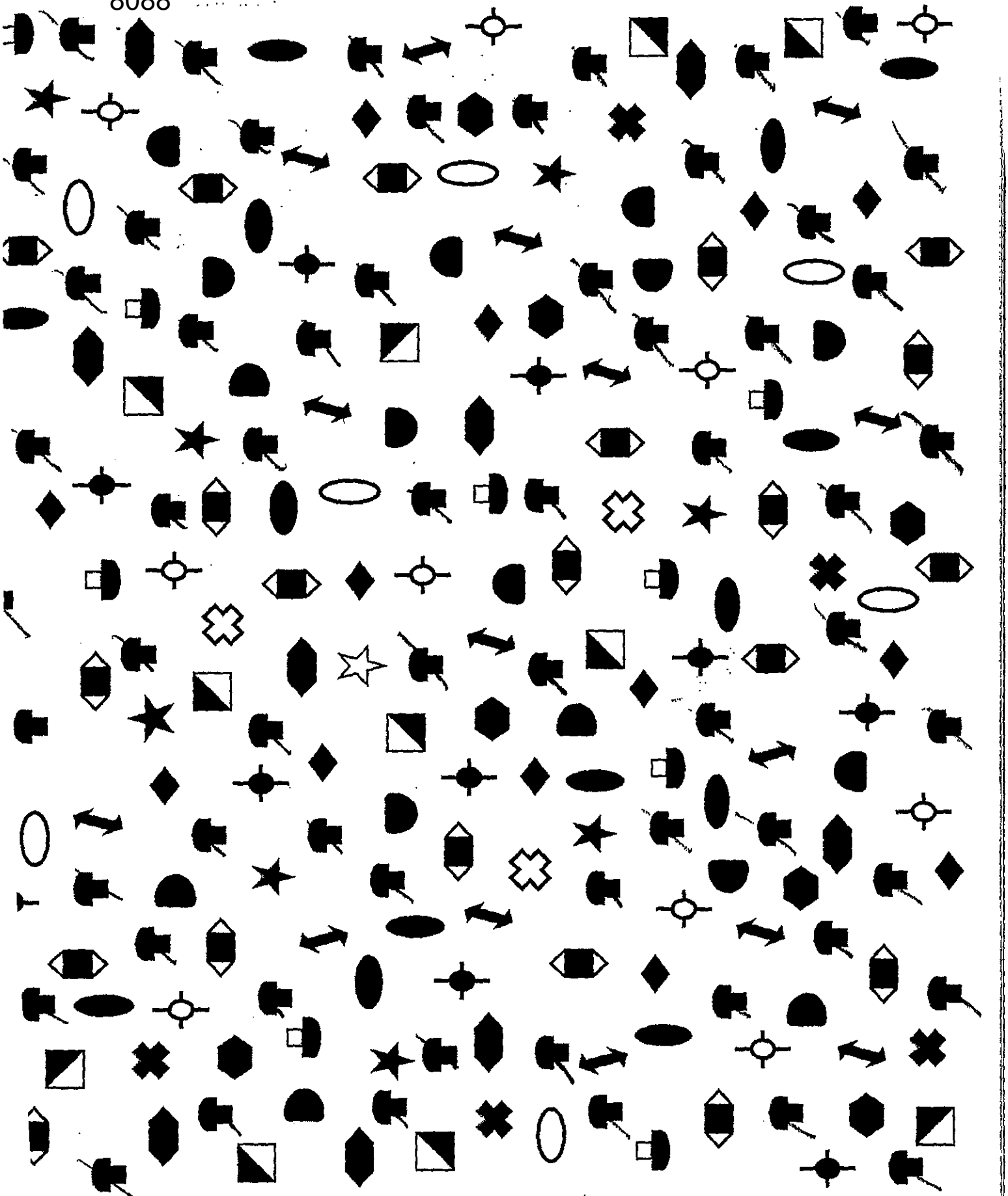
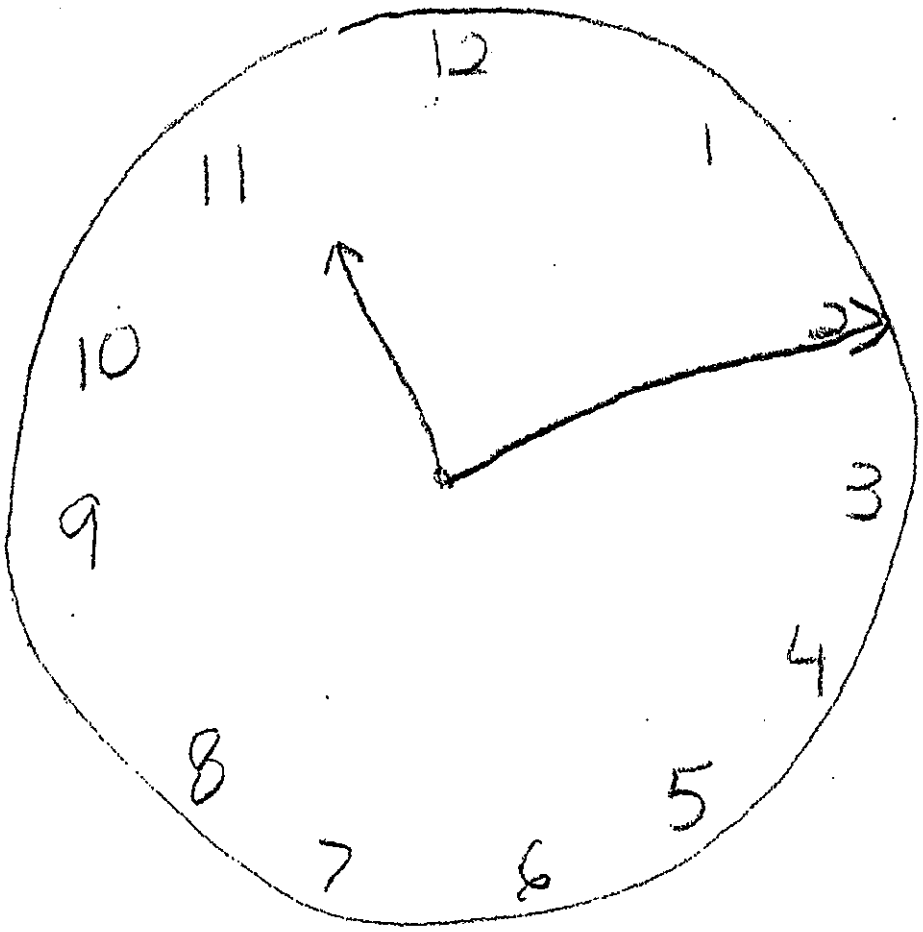
Product Number: 0154170038







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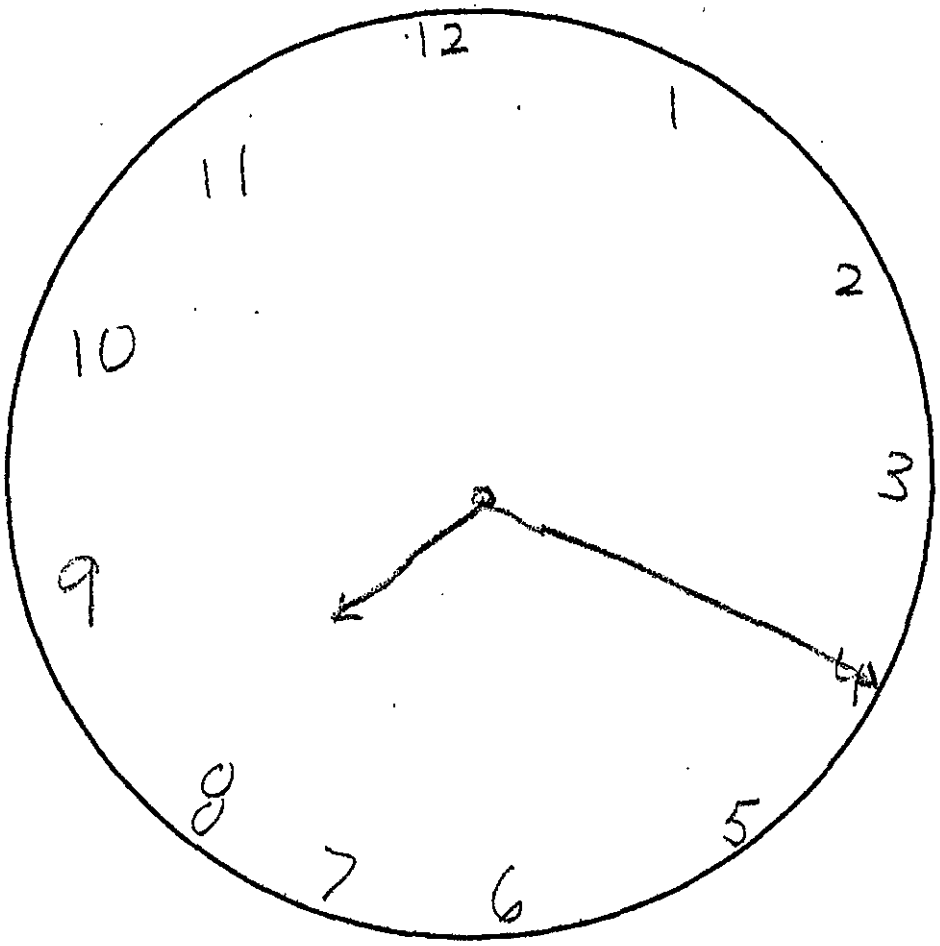

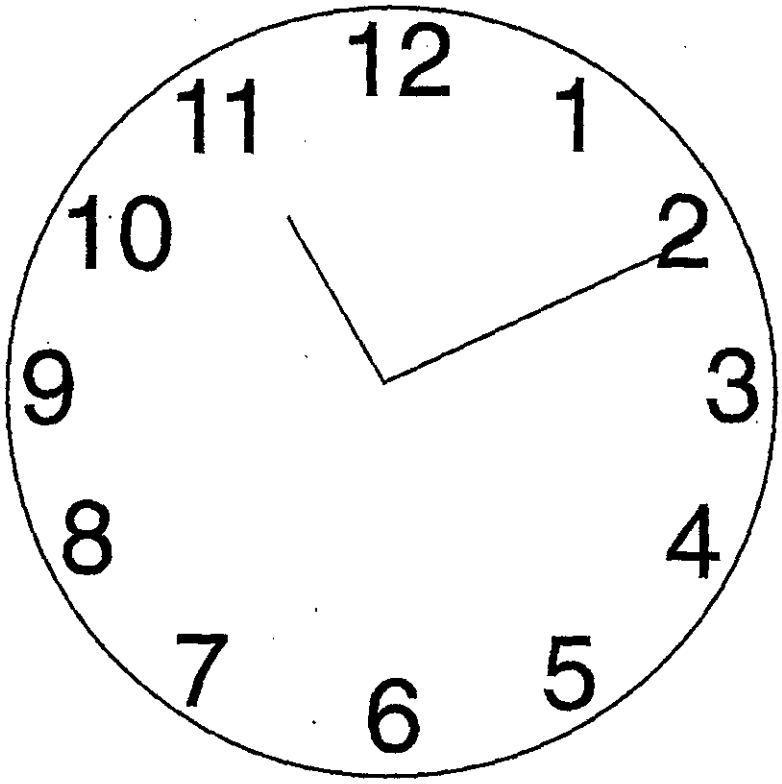
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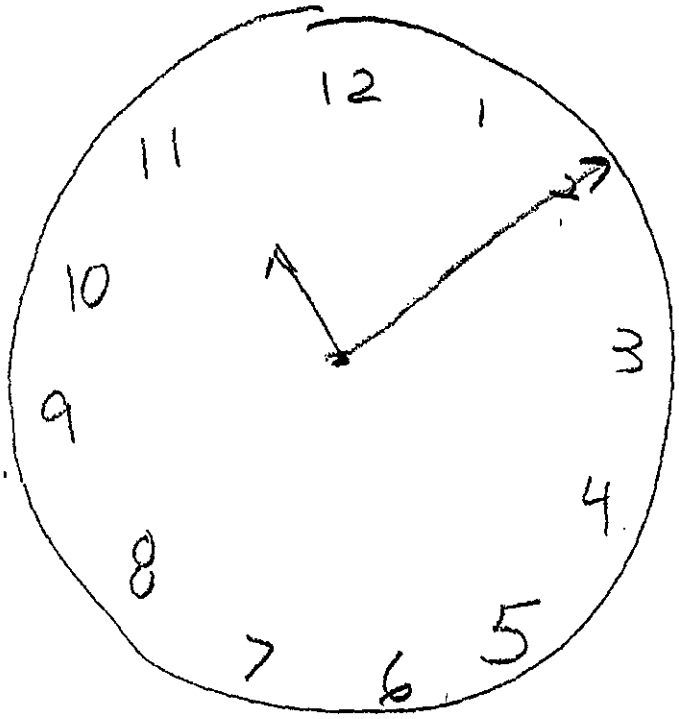
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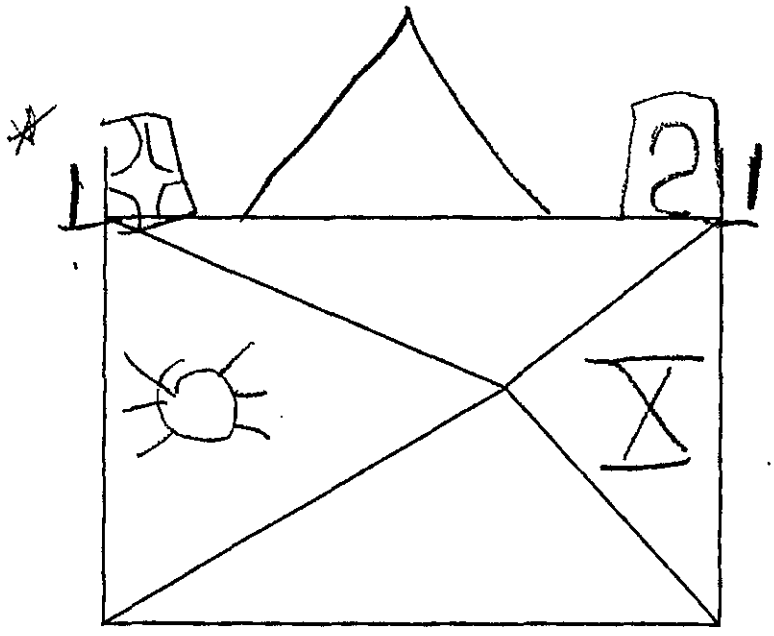
1. a. b. c. d.

2. a. b. c. d.

3. a. b. c. d.

4. a. b. c. d.

5. a. b. c. d.



4	16	453
+ 8	+ 34	926
		+ 187
38	76	831
− 5	− 13	− 546
7	27	615
x 8	x 3	x 16

8094

1. Orientation

Note. Before beginning this subtest, introduce yourself to the examinee. Record responses verbatim. Award 0–1 point for each response.

Item/Response		Score (0, 1)
1. **What is today's date?** If the examinee gives correct month, day, and year, give credit for Items 2–3 and skip to Item 4.	Friday (2/27/09)	1
2. **What year is this?**	2009	1
3. **What month is this?**	2	1
4. **What day of the week is this?**	F	1
5. **What season is this?**	Winter	1
6. **What time is it now?** Actual Time: 1 : 40	2?	1
7. **What is the name of this place?** If the examinee gives a general response (e.g., "hospital"), say, **Yes, but what is the name of this hospital?**	C.F. / MH Bldg	1
8. **What city/town are we in now?**	Wm	1
9. **What state/province are we in now?**	SC	1
10. **How old are you?**	37	1
11. **When were you born?**	[redacted]	1
12. **What is my name?** Is this how you introduced yourself? ✓ Yes ___ No	Dr. Kimberly Kose	1
13. **Is this the first time we have met?** Have you met the examinee before? ✓ Yes ___ No		1
	Total Score	(0–13) 13

2. Sequences

For each item, record responses verbatim and completion time in seconds. Award 1 point for each correct response and sum the points to obtain the item score.

Item/Correct Response	Response	Completion Time	Item Score
1. **Months Forward** Jan Feb Mar Apr May June July Aug Sept Oct Nov Dec	✓	WNL	(0–12) 12
2. **Months Backward** Dec Nov Oct Sept Aug July June May Apr Mar Feb Jan	✓	WNL	(0–12) 12
3. **Letters Rhyming With *Key*** B C D E G P T V Z	✓		(0–9) 9
4. **Curved Capital Letters** B C D G J O P Q R U	✓		(0–11) 11
5. **Counting Backward by Fours** 60 56 52 48 44 40 36 32 28 24 20 16 12 8 4	✓		(0–13) 13
		WNL	(0–57) 57
		Total Completion Time	**Total Score**

3. Numbers

Record responses verbatim for each oral trial. For each trial, award 1 point for each correct response. Sum the trial scores to obtain the item score.

Item	Oral Trial 1		Oral Trial 2		Written Trial		Item Score (0–3)
	Response	Score	Response	Score	Response	Score	
1. 279–57–64							
2. 591–08–32							
3. 913–863–80–95							
						Total Score	(0–3)

Trial 3

		Response Type								
		Intrusions			Clusters		Regions			Score
		S	NS	Repetition	C	S	P	M	R	(0, 1)
Asparagus	✓									
Milk	✓									
Notebooks	✓									
Coffee	✓									
Folders	✓									
Spinach	✓									
Lemonade	✓									
Celery	✓									
Envelopes	✓									
Potatoes	✓									
Scissors	✓									
Soda	✓									
Trial 3 Sums										(0–12) 10
		Combined 0								

Trial 4

Asparagus	✓									
Milk	✓									
Notebooks										
Coffee	✓									
Folders										
Spinach	✓									
Lemonade	✓									
Celery	✓									
Envelopes	✓									
Potatoes	✓									
Scissors	✓									
Soda	✓									
	Letters		✓							
Trial 4 Sums										(0–12) 12
		Combined 1								

	Intrusions			Clusters		Regions			(0–48)
	S	NS	Repetitions	C	S	P	M	R	
Subtest Sums	X	2	—						36 Recall Total Score
	Combined X								

4. Word Lists 1

8096

For each trial, record responses verbatim and enter a check mark in the applicable response-type column. Award 1 point for each correct response.

Trial 1

		Response Type								
		Intrusions			Clusters		Regions			Score
		S	NS	Repetition	C	S	P	M	R	(0, 1)
Asparagus	✓									
Milk	✓									
Notebooks	✓									
Coffee	✓									
Folders										
Spinach	✓									
Lemonade										
Celery	✓									
Envelopes	✓									
Potatoes	✓									
Scissors	✓									
Soda										
Trial 1 Sums										(0–12) 8
		Combined 0								

Trial 2

Asparagus	✓									
Milk	✓									
Notebooks	✓									
Coffee	✓									
Folders										
Spinach	✓									
Lemonade										
Celery	✓									
Envelopes	✓									
Potatoes	✓									
Scissors	✓									
Soda										
Letters			✓							
Trial 2 Sums										(0–12) 8
		Combined ↓								

5. Complex Figure 1

For each of the Copy and Recall components, enter a check mark for each criterion element included in the examinee's drawings, and award 0–2 points according to the criteria here and in Appendix A. Record completion time in seconds.

Criterion Element	Copy Included	Copy Score (0–2)	Recall Included	Recall Score (0–2)	Scoring Criteria
Large Rectangle	✓	2	✓	2	Four sides are present and resemble a rectangle, not a square. Four sides meet at right angles (i.e., >75°).
Small Squares	✓	2	✓	2	Both squares are present and positioned above large rectangle and at the top of the vertical extensions; each contains four right angles (i.e., >75° and <105°); ratio of longest to shortest side is ≤1:1.2.
Semicircles	✓	2	✓	2	Four semicircles are present and do not touch each other or intersect.
Backward S	✓	2	✓	Ø 1	Shape is that of an S facing backward and does not touch any sides of the small square.
Triangle	✓	2	✓	2	A triangle is present and rests on top and within 5% of center of the large rectangle. The sides are approximately equal in length, within a ratio of 1:1.2.
Oblique Lines	✓	2	✓	2	Four oblique lines are present, each starting within 1/8" of each corner of the rectangle. They join within 1/8" of an imaginary horizontal bisector of the rectangle and to the right of center of the rectangle.
Sunburst	✓	2	✓	2	A circle with six short lines extending outward from its perimeter is positioned in the correct sector of the rectangle. Three of the lines are on the left of the circle, and three are on the right.
X	✓	2	✓	2	An X with two intersecting line segments and with top and bottom horizontal lines is positioned within the correct sector of the large rectangle.
Vertical Extensions	✓	2	✓	2	Two lines extend vertically, one from the upper-left and one from the upper-right corner of the large rectangle. The ratio of each extension to the height of the rectangle ranges from 1:1.25 to 1:1.18.
Horizontal Extensions	✓	2	✓	2	Two lines extend horizontally, approximately parallel to the top of the rectangle, one from each of the lower side of the small squares. Each line is between 1.5 and 1.9 of the length of the side of the squares.
	Copy Score	(0–20) 20		(0–20) 19	Recall Total Score
	Completion Time	—		—	Completion Time

6. Motor Programming

If the examinee completes five consecutive correct alternations in a trial, do not administer subsequent trials. For each trial administered, enter a check mark for each correct alternation and the error code for each incorrect alternation. Five correct alternations (full sequence) equal one correct trial.

	Alternation 1	2	3	4	5	Points for Correct Sequence	
Trial 1						4	(1–4)
Trial 2						3	
Trial 3						2	Total Score
				No Correct Sequence		1	

8098

7. Auditory Signal Detection

Circle each target that is endorsed and cross through each nontarget that is endorsed. Award 1 point for each target endorsed. Sum the number of nontargets endors

Practice Trial

L B **A** Q R **A** X **A** T C

Scoring Trial

V U **A** N M H D C T **A** J S F P Y J
Y P W X **A** G I C X B Q M F I F N
J C P **A** W U F M R B Y **A** P G I X
T E W R U X Y B L O J E **A** L U U
A X J C X **A** E G C H U P N V U F
S B **A** D M X H F Q K B F P B T U
N V **A** C D O **A** E S F R B J* I R J
F T G M Y T **A** L I O L **A** S Q G S
B H I O Q N **A** H K F P R Y **A** V G
V K Y J T P E L Q F D **A** L M H D
Q I **A** R X **A** I J U X B E Q H K R
M **A** D E R N N O X O Y X B Y **A** E
F D H **A** J N V I X X U V T J P P
L R R M **A** Q R D

Targets	
First Half	(0–11)
Second Half	(0–11)
Combined	(0–22)

Nontargets	
First Half	(0–97)
Second Half	(0–97)
Combined	(0–194)

Targets Combined		Nontargets Combined			Adjusted Score
(0–22)	–	(0–194)	=	(0–22)	

8. Symbol Cancellation

Allow the examinee up to 2 minutes to complete the page. Award 1 point for each target symbol endorsed. Sum the number of nontargets endorsed.

Targets	
Left Half	(0–30)
Right Half	(0–30)
Combined	(0–60)

Nontargets	
Combined	(0–150+)

Targets Combined		Nontargets Combined			Adjusted Score
(0–60)	–	(0–150+)	=	(0–60)	

9. Clocks

8099

Free Drawing, Predrawn, Copy

For each component, enter a check mark for each included feature. Award 0–1 point for each feature according to the criteria here and in Appendix A.

Feature/Criteria	Free Drawing Included	Free Drawing Score (0, 1)	Predrawn Included	Predrawn Score (0, 1)	Copy Included	Copy Score (0, 1)
Contour						
Contour of clock face is circular.	✓	1			✓	1
Contour is not too small, overdrawn, or reproduced repeatedly.	✓	1			✓	1
Numbers			✓			
Only numbers 1–12 are present.	✓	1	✓	1	✓	1
Only Arabic numbers are used.	✓	1	✓	1	✓	1
Numbers are sequenced correctly.	✓	1	✓	1	✓	1
Numbers are oriented correctly and proportionately to the contour.	✓	1	✓	1	✓	1
Numbers are positioned within the contour.	✓	1	✓	1	✓	1
Hands			✓			
Two hands, or marks representing hands, are present.	✓	1	✓	1	✓	1
One hand indicates the target hour.	✓	1	✓	1	✓	1
One hand indicates the target minute.	✓	1	✓	1	✓	1
One hand is perceptually or measurably longer than the other.	✓	1	✓	1	✓	1
Hands are joined or approximately joined (within 1/2" or 12 mm).	✓	1	✓	1	✓	1
Center						
Clock contour has an apparent center, either drawn or inferred by the extrapolation of the point where two nonjoining hands would meet.	✓	1/13	✓	1/11	✓	1/13
Component Score		(0–13) 13		(0–11) 11		(0–13) 13

Combined Score (0–37) 37

Reading Without Numbers

Record responses verbatim. Award 1 point for each correct response. A response is correct if ***within 3 minutes*** of the target time.

Time	Response	Score (0, 1)
1. 11:10		
2. 8:20		
3. 8:30		
4. 12:15		
5. 9:45		
6. 2:15		
		(0–6) Score

Reading With Numbers

Record responses verbatim. Award 1 point for each correct response. A response must be the ***exact target time*** to be correct.

Time	Response	Score (0, 1)
1. 12:15		
2. 8:20		
3. 2:15		
4. 9:45		
5. 11:10		
6. 8:30		
		(0–6) Score

8100

10. Word Lists 2

Free Recall

Record responses verbatim and enter a check mark in the applicable response-type column. Award 1 point for each correct response.

Do Not Read	Response	Response Type: Intrusions S	Intrusions NS	Repetition	Clusters C	Clusters S	Score (0, 1)
Asparagus							
Milk							
Notebooks							
Coffee							
Folders							
Spinach							
Lemonade							
Celery							
Envelopes							
Potatoes							
Scissors							
Soda							
	letters						
	Sums						(0–12) 9
		Combined					

Free Recall Score

Free Recall Score [—] ÷ Word Lists 1 Trial 4 [—] × 100 = [— %] Percent Retention

Cued Recall

Record responses verbatim and enter a check mark in the applicable response-type column. Award 1 point for each correct response.

	Response	Response Type: Intrusions S	Intrusions NS	Repetition	Score (0, 1)
Vegetables	Asp.				
	Pots.				
	Celery				
	Sp.				
Beverages	Milk				
	Coffee				
	Soda				
	Lem.				
Office Supplies	Letters X		✓		
	Scissors				
	Notebooks				
	envelopes				
	Sums	—	—	—	(0–12) 11
		Combined			

Free Recall [9] + Cued Recall [11] = [(0–24) 20] Recall Total Score

10. Word Lists 2

Recognition

Circle *Y* or *N* for each response. For each *yes* response (correct or incorrect), enter a check mark in the applicable response-type column. Correct responses are printed in boldfaced italics. Award 1 point for each correct response.

Item	Response	Response Type: Hit	FPR	FPU	Score (0,1)
1. Corn	Y ***N***				
2. Milk	***Y*** N				
3. Envelopes	***Y*** N				
4. Spaghetti	Y ***N***				
5. Asparagus	***Y*** N				
6. Fish	Y ***N***				
7. Shampoo	Y ***N***				
8. Potatoes	***Y*** N				
9. Erasers	Y ***N***				
10. Folders	***Y*** N				
11. Tea	Y ***N***				
12. Soap	Y ***N***				
13. Pears	Y ***N***				
14. Lemonade	***Y*** N				
15. Paint	Y ***N***				
16. Juice	Y ***N***				
17. Mop	Y ***N***				
18. Scissors	***Y*** N				
19. Cola	Y ***N***				
20. Onions	Y ***N***				
21. Spinach	***Y*** N				
22. Soda	***Y*** N				
23. Notebooks	***Y*** N				
24. Broccoli	Y ***N***				
25. Cocoa	Y ***N***				
26. Detergent	Y ***N***				
27. Toothpaste	Y ***N***				
28. Pencils	Y ***N***				
29. Celery	***Y*** N				
30. Staples	Y ***N***	−1			
31. Blueberries	Y ***N***				
32. Coffee	***Y*** N				
33. Lamb	Y ***N***				
34. Sponge	Y ***N***				
35. Paper	Y ***N***				
36. Carrots	Y ***N***				
	Sums	(0–12) 11	(0–12) 12	(0–12) 12	(0–36) 23 Recognition Total Score
			Combined		

Hits (0–12) — False Positives Combined (0–24) = (0–12) Adjusted Score

8102

11. Complex Figure 2

Recall

Enter a check mark for each criterion element included in the examinee's drawing and award 0–2 points according to the criteria here and in Appendix A.

Criterion Element	Included	Score (0–2)	Scoring Criteria
Large Rectangle	✓	2	Four sides are present and resemble a rectangle, not a square. Four sides meet at right angles (i.e., >75°).
Small Squares	✓	2	Both squares are present and positioned above large rectangle and at the top of the vertical extensions; each contains four right angles (i.e., >75° and <105°); ratio of longest to shortest side is ≤1:1.2.
Semicircles	✓	2	Four semicircles are present and do not touch each other or intersect.
Backward S	✓	1	Shape is that of an S facing backward and does not touch any sides of the small square.
Triangle	✓	2	A triangle is present and rests on top and within 5% of center of the large rectangle. The sides are approximately equal in length, within a ratio of 1:1.2.
Oblique Lines	✓	2	Four oblique lines are present, each starting within 1/8" of each corner of the rectangle. They join within 1/8" of an imaginary horizontal bisector of the rectangle and to the right of center of the rectangle.
Sunburst	✓	2	A circle with six short lines extending outward from its perimeter is positioned in the correct sector of the rectangle. Three of the lines are on the left of the circle, and three are on the right.
X	✓	2	An X with two intersecting line segments and with top and bottom horizontal lines is positioned within the correct sector of the large rectangle.
Vertical Extensions	✓	2	Two lines extend vertically, one from the upper-left and one from the upper-right corner of the large rectangle. The ratio of each extension to the height of the rectangle ranges from 1:1.25 to 1:1.18.
Horizontal Extensions	✓	2	Two lines extend horizontally, approximately parallel to the top of the rectangle, one from each of the lower side of the small squares. Each line is between 1.5 and 1.9 of the length of the side of the squares.
		(0–20) 19	**Recall Total Score**

Recognition

For the identification task, record the letter corresponding to the examinee's response. For the placement task, enter a check mark for each correct placement. For each task, award 1 point for each correct response.

Criterion Element	Identification: Correct Response	Identification: Response	Identification: Score (0,1)	Placement: Scoring Criteria	Placement: Correct Placement	Placement: Score (0,1)
Triangle	a	a	1	Must rest on top of rectangle and within 5% of center of rectangle	✓	1
Right Square	b	b	1	Must be above and right of the rectangle, within 5% of vertical extension	✓	1
Left Square	c	c	1	Must be above and left of the rectangle, within 5% of vertical extension	✓	1
Sunburst	b	b	1	Must be in left sector of rectangle	✓	1
X	c	c	1	Must be in right sector of rectangle	✓	1
					(0–10) 10	**Recognition Total Score**

12. Picture Naming

Record all responses verbatim. Record completion time and award 1 point for each ***correct, spontaneous*** response.

	Spontaneous			Semantic Cue		Phonemic Cue	
Item	Response	Score (0–1)	Time	The artist was trying to draw . . .	Response	The first sound of the word is . . .	Response
1. Cow				an animal		*c*	
2. Shirt (blouse)				an article of clothing		*sh*	
3. Telephone (phone)				a means of communication		*te*	
4. Tie (necktie, cravat)				something worn with a shirt		*t*	
5. Owl				a bird		*ow*	
6. Switch (light switch)				something to do with electricity		*sw*	
7. Iron (steam iron)				an appliance		*ir*	
8. Motorcycle (motorbike, bike)				a means of transportation		*mo*	
9. Piano (grand piano)				a musical instrument		*pi*	
10. Screw				a piece of hardware		*sc*	
11. Violin (viola, fiddle, cello)				a musical instrument		*vi*	
12. Clothespin (clothespeg)				something used to hang laundry		*cl*	
13. Rocking Chair (rocker)				a piece of furniture		*ro*	
14. Windmill				a building often found in Holland		*wi*	
15. Lobster (crayfish, crawdad)				something that lives in the ocean		*lo*	
16. Frog (toad)				something that lives in a pond		*fr*	
17. Kangaroo				an Australian animal		*ka*	
18. Barrel				something to store things in		*ba*	
19. Envelope				something used for a letter		*en*	
20. Anchor				something used by boats or ships		*an*	
	Total Score	(0–20)		Completion Time	Semantic Cues (0–20)		Phonemic Cues (0–20)

13. Sentence Reading–Arithmetic

For Items 1–2, record the examinee's reading of the problems verbatim. Award 0–2 points for reading accuracy. For Items 1–2 and the arithmetic problems, award 1 point for each correct response.

Item	Response	Reading Accuracy Score (0–2)	Item	Correct Response	Arithmetic Score (0–1)
1			1	$4.18	
			2	$0.82	
			4 + 8	12	
			16 + 34	50	
			453 + 926 + 187	1,566	
2			38 − 5	33	
			76 − 13	63	
			831 − 546	285	
			7 × 8	56	
			27 × 3	81	
			615 × 16	9,840	
	Reading Accuracy Score	(0–4)		Arithmetic Score	(0–11)

14. Reading Single Words

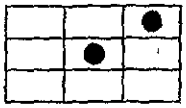
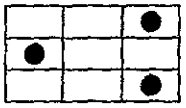
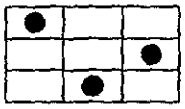
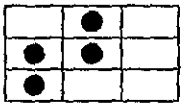
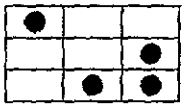
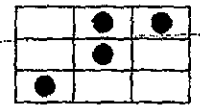
Enter a check mark for each correct pronunciation. Record incorrect responses verbatim. Award 1 point for each correct response.

Item	Response	Item Score: Regular Words	Item Score: Irregular Words	Item Score: Pseudo-words	Total Score
1. Throng					
2. Gauge					
3. Caum (cawm)					
4. Skate					
5. Thorough					
6. Scane (skayn)					
7. Armament					
8. Heir					
9. Prode (proad)					
10. Grill					
11. Basten (bas ten, bays ton)					
12. Benign					
13. Splendid					
14. Montle (mon tel, mun tel)					
15. Biscuit					
		(0–5)	(0–5)	(0–5)	(0–15)

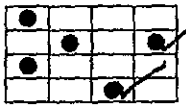
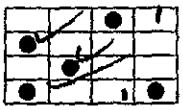
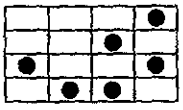
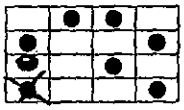
15. Spatial Location

For each item, mark an X on the grid to indicate correct and incorrect chip placements. Grids are shown from the examiner's view. Item adjusted scores are based on the following general formula: **Number of Correct Chip Placements *minus* [Total Number of Chips Placed minus Correction Factor]**. Use the formula provided with each item to obtain the item adjusted score. Sum the item adjusted scores to obtain the subtest adjusted score.

3 x 3 Grid

Item		Adjusted Score
Practice		
1		3 (Number Correct) − [3 (Total Chips) −3] = ✓
2		___ (Number Correct) − [___ (Total Chips) −3] = ✓
3		___ (Number Correct) − [___ (Total Chips) −4] = ✓
4		___ (Number Correct) − [___ (Total Chips) −4] = ✓
5		___ (Number Correct) − [___ (Total Chips) −4] = ✓

4 x 4 Grid

Item		Adjusted Score
6		5 (Number Correct) − [5 (Total Chips) −5] = 5
7		5 (Number Correct) − [5 (Total Chips) −5] = 5
8		3 (Number Correct) − [5 (Total Chips) −5] = 3
9		6 (Number Correct) − [6 (Total Chips) −6] = 6
10		6 (Number Correct) − [7 (Total Chips) −7] = 6

(0–46) 43 **Adjusted Score**

8106

16. Verbal Fluency ✓

Record responses verbatim. Enter a check mark for each perseveration (P) and each intrusion (I). Award 1 point for each correct response.

C Words

1–15 Seconds				16–30 Seconds				31–45 Seconds				46–60 Seconds			
Responses	Score (0,1)	P	I	Responses	Score (0,1)	P	I	Responses	Score (0,1)	P	I	Responses	Score (0,1)	P	I
Cat	1			Children	1			Carpet				Coolant			
Carry	1			Cat	1			Chill				Command			
Cold	1			Cancel	1										
Camera	1			Crispy	1										
Case	1			Cutthroat	1										
Work	1			Cavity	1										
Creek	1														
Count	1														
	8				6				2				2		

C Words Score: 18

Animals

1–15 Seconds				16–30 Seconds				31–45 Seconds				46–60 Seconds			
Responses	Score (0,1)	P	I	Responses	Score (0,1)	P	I	Responses	Score (0,1)	P	I	Responses	Score (0,1)	P	I
Rabbit	1			Cat	1			[illegible]	1			[illegible]	1		
Lion	1			Rabbit	1			[illegible]	1			[illegible]	1		
Devil	1			Bear	1			[illegible]	1			[illegible]	1		
Donkey	1			Doe	1										
Elk	1			Deer	1										
Cat	1			Lion	1										
Horse	1			Tiger	1										
Cow	1			Fish	1										
Bull	1														
Bullet	1														
	10				8				3				4		

Animals Score: 25

First Names

1–15 Seconds				16–30 Seconds				31–45 Seconds				46–60 Seconds			
Responses	Score (0,1)	P	I	Responses	Score (0,1)	P	I	Responses	Score (0,1)	P	I	Responses	Score (0,1)	P	I
Peter	1			Tim	1			Alex	1			Frank	1		
Alex	1			Thomas	1			Ambrose	1			Jen	1		
Boyd	1			James	1			Trevor	1			James	1		
Laura	1			Peter	1			Tanner	1			Xavier	1		
Sara	1			Mark	1			Zeus	1			Steven	1		
Bob	1			Neil	1			Mary	1			David	1		
Kate	1			Justin	1			Adam	1			Tony	1		
Carl	1			Eric	1										
Shaq	1			Miamar	1										
Brad	1			Venezia	1										
	10				10				7				7		

First Names Score: 34

1–15 Seconds Score [ ] + 16–30 Seconds Score [ ] + 31–45 Seconds Score [ ] + 46–60 Seconds Score [ ] = [ ] Total Score

Total Perseverations [ ] Total Intrusions [ ]

Phonemic Fluency (C Words): 18

Semantic Fluency (Animals + First Names): 59

25 + 34

17. Praxis

8107

Record the examinee's dominant hand. Enter a check mark for each spontaneous (S) or imitated (I) correct movement. Award 2 points for each ***correct spontaneous*** movement and 1 point for each ***correct imitated*** movement.

Examinee's Dominant Hand	
R	L

Intransitive Movements

Dominant Hand				Nondominant Hand			
Movement	S	I	Score (0–2)	Movement	S	I	Score (0–2)
1. Wave				1. Wave			
2. Motion "Come here"				2. Motion "Come here"			
3. Signal "Stop"				3. Signal "Stop"			
4. Salute				4. Salute			

\+ = (0–16) Intransitive Score

Transitive Movements

Dominant Hand				Nondominant Hand			
Movement	S	I	Score (0–2)	Movement	S	I	Score (0–2)
1. Turn key				1. Turn key			
2. Hammer				2. Hammer			
3. Brush teeth				3. Brush teeth			
4. Comb hair				4. Comb hair			

\+ = (0–16) Transitive Score

Buccofacial Movements

Movement	S	I	Score (0–2)
1. Blow candle			
2. Suck straw			
3. Lick crumbs			
4. Cough			

= (0–8) Buccofacial Score

Intransitive + Transitive + Buccofacial = (0–40) Total Score

8108

18. Picture Recognition

Circle *Y* or *N* for each response. For each ***Incorrect*** response, enter a check mark in the applicable Error Type column. Correct responses are printed in boldfaced italics. Award 1 point for each correct response.

Item	Response		Error Type				
			Semantic	Perceptual	Semantic/ Perceptual	Unrelated	
1. Windmill	***Y***	N					
2. Goat	Y	***N***					
3. Clothespin	***Y***	N					
4. Spinning wheel	Y	***N***					
5. Spider	Y	***N***					
6. Motorcycle	***Y***	N					
7. Rocking chair	***Y***	N					
8. Guitar	Y	***N***					
9. Well	Y	***N***					
10. Belt	Y	***N***					
11. Cow	***Y***	N					
12. Pliers	Y	***N***					
13. Piano	***Y***	N					
14. Tie	***Y***	N					
15. Switch	***Y***	N					
16. Trumpet	Y	***N***					
17. Chair	Y	***N***					
18. Iron	***Y***	N					
19. Umbrella	Y	***N***					
20. Shirt	***Y***	N					
21. Toaster	Y	***N***					
22. Nail file	Y	***N***					
23. Violin	***Y***	N					
24. Telephone	***Y***	N					
25. Dress	Y	***N***					
26. Screw	***Y***	N					
27. Roller skate	Y	***N***					
28. Helicopter	Y	***N***					
29. Owl	***Y***	N					
30. Lobster	***Y***	N					
31. Frog	***Y***	N					
32. Pumpkin	Y	***N***					
33. Lamp	Y	***N***					
34. Star	Y	***N***					
35. Kangaroo	***Y***	N					
36. Television	Y	***N***					
37. Barrel	***Y***	N					
38. Eagle	Y	***N***					
39. Envelope	***Y***	N					
40. Anchor	***Y***	N					
Total Score	(0–40)		(0–5)	(0–5)	(0–5)	(0–5)	(0–20) **Total Errors**

19. Expression of Emotion

Enter a check mark for each ***correct*** spontaneous (S) or imitated (I) expression. Award 2 points for each ***correct spontaneous*** expression and 1 point for each ***correct imitated*** expression.

Expression	Spontaneous	Score (0, 2)	Imitation	Score (0, 1)
1. Angry				
2. Happy				
3. Surprised				
4. Sad				
	Spontaneous Score	(0–8)	**Imitation Score**	(0–4)

20. Practical Problem Solving

Record responses verbatim. For each item, award 2 points for ***two*** acceptable responses or 1 point for ***one*** acceptable response (printed in *italics*).

Item	Acceptable Responses	Response	Score (0–2)
1. What would you do if you smelled smoke in your house or apartment?	*notify fire department; try to locate source and extinguish fire, if possible; leave the house or apartment*	- yell fire ✓ - look for source ✓	2
2. What would you do if you were told that the water to your house would be turned off for 3 days?	*collect enough water by some means to last for 3 days; purchase bottled water; arrange to stay some place else for 3 days*	- go to hotel - call a friend to stay	2
3. You were informed that you owe $2,000 in taxes. You do not have that much money available. What could you do?	*borrow money from some source or arrange for a loan; ask for an extension for payment; ask to pay by installments; sell stocks/bonds to obtain money; cash savings bonds; sell property or real estate to obtain money*	- call IRS in orange - take loan ✓	2
4. If someone visiting you suddenly reported feeling sick and then fainted, what would you do?	*offer immediate assistance, such as lay the person down; telephone for medical assistance; call 9–1–1*	- pulse - 9-1-1	2
5. What would you do if you saw a 2-year-old child playing in the middle of the street?	*immediately remove the child from the street; tell the child's parents; yell to the child to move*	- get child & take him up in arms - look for car or parents	2
			(0–10) 10 **Total Score**

8110

21. Conceptual Shifting

For each part of each item, circle the numbers corresponding to the examinee's selections of designs and record the attribute descriptions verbatim. Award 1 point for each correct response.

Item	Design Selections	Attribute Description	Correct Response	A Score (0, 1)	B Score (0, 1)
1. A	(1) (2) 3 (4)	Shape	1, 2, 4: same shape	1	
B	(1) 2 (3) (4)	Shaded	1, 3, 4: same shading		1
2. A	(1) 2 3 (4)	SIZES	1, 3, 4: same size	1	
B	(1) 2 (3) 4	Shade/Colored	1, 3, 4: same shading		1
3. A	1 (2) (3) (4)	oriented same	2, 3, 4: same orientation	1	
B	1 2 3 4	Ø Shade	1, 2, 3: all white or no shading		1
4. A	(1) (2) 3 (4)	Shape	1, 2, 4: same shape	1	
B	(1) 2 (3) 4	Ø Color	1, 3, 4: all white or no shading		1
5. A	1 (2) (3) (4)	Oriented same	2, 3, 4: same orientation	1	
B	(1) 2 3 4	Shading	1, 2, 3: same shading		1
6. A	(1) (2) (3) 4	Shape (Overall)	1, 2, 3: same external shape	1	
B	(1) 2 (3) 4	Circle (Inside)	1, 3, 4: same internal shape		1
7. A	(1) 2 (3) 4	Oriented same	1, 3, 4: same orientation	1	
B	1 (2) (3) (4)	Δ Corners	2, 3, 4: small triangle in same corner		1
8. A	(1) (2) (3) 4	open	1, 2, 3: open figure	1	
B	(1) (2) 3 4	line/curve	1, 2, 4: line and curve		1
9. A	(1) (2) 3 (4)	direction	1, 2, 4: point in same direction	1	
B	1 (2) 3 (4)	# petals	1, 2, 4: same number of petals		1
10. A	(1) 2 (3) (4)	Shady	1, 3, 4: same shading in square	1	
B	(1) 2 (3) 4	Δ Shading	1, 3, 4: same shading in triangle		1
				(0–10) 10	(0–10) 11

A Score	B Score	Total Score
		(0–20) 21

22. Picture Description–Oral

Record the examinee's description verbatim (you may use a cassette recorder). Assign a point rating that best corresponds to the description. Roughly estimate the average length of all phrases.

(0–4)	Content Score	≥ 6 words 3–5 words < 3 words	2 1 0	Phrase Length Score

23. Auditory Comprehension

Circle *Y* or *N* in the appropriate column to indicate the examinee's response to the first or second reading of the question. Award 2 points for a correct response to the ***first*** reading or 1 point for a correct response to the ***second*** reading. Correct responses are printed in boldfaced italic.

Item	First Reading		Second Reading		Score (0–2)
1. Is there a chair in this room?	***Y***	N	***Y***	N	
2. Is a comb good for brushing your teeth?	Y	***N***	Y	***N***	
3. Do you buy shoes in a furniture store?	Y	***N***	Y	***N***	
4. Do you put on your shoes after your socks?	***Y***	N	***Y***	N	
5. If the bear was killed by the tiger, is the tiger dead?	Y	***N***	Y	***N***	
					(0–10) Total Score

24. Repetition

Record responses verbatim. Award 1 point for each correct response.

Item	Response	Score (0, 1)
1. Belong		
2. President		
3. Authorized signature		
4. If he comes, I will go.		
5. The prosecutor's closing argument convinced the jury.		
		(0–5) Total Score

25. Picture Description–Written

Assign a point rating that best corresponds to the description.

(0–4) Content

8112

PLAN KBNA BAYCREST NEUROCOGNITIVE ASSESSMENT™

Record Form

Examiner Kruse

Examinee T. Jones

Reason for Referral

			Year	Month	Day
Sex	M	Test Date	2019	2	22
Education	16	Birth Date	[redacted]		
Handedness	R	Chronological Age	37	2	2

— Subtest Score Conversion Chart —

	Raw Score	Scaled Score						
		AC	MIR	MDR	MDRec	SP	VF	RCS
Sequences Total Score	57	14						
Word Lists 1 Recall Total Score	36		12					
Complex Figure 1 Recall Total Score	20		14					
Complex Figure 1–Copy/Clocks Combined Score*	57					15		
Word Lists 2 Recall Total Score	20			12				
Word Lists 2 Recognition Total Score	26				11			
Complex Figure 2 Recall Total Score	9			14				
Complex Figure 2 Recognition Total Score	10				12			
Spatial Location Adjusted Score	43	11						
Verbal Fluency–Phonemic Fluency Score	18						12	
Verbal Fluency–Semantic Fluency Score	59						14	
actical Problem Solving/Conceptual Shifting Combined Score*	10 20 =30							14
Sum of Scaled Scores		25	26	26	23	15	26	14

sed on sum of raw scores.

Calculation Boxes

Complex Figure 1–Copy/Clocks Combined Score =

0–20	0–13	0–11	0–13		0–57
20	13	11	13	=	57
Complex Figure 1–Copy	+ Clocks–Free Drawing	+ Clocks–Predrawn	+ Clocks–Copy		

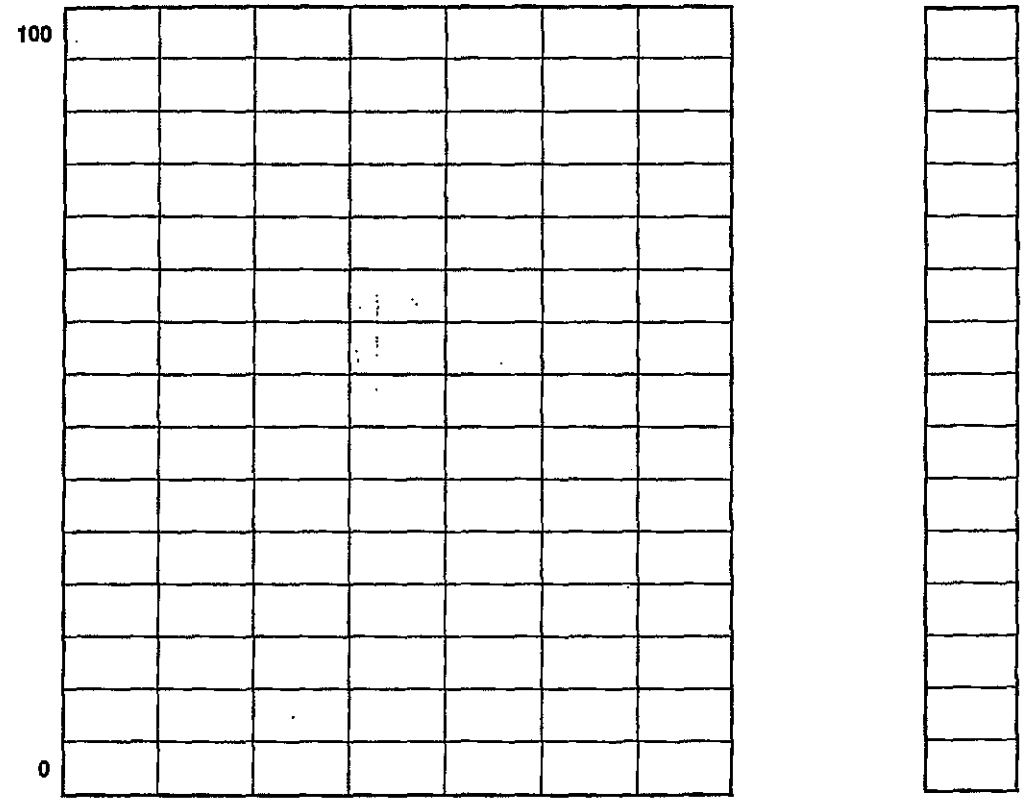
Practical Problem Solving/Conceptual Shifting Combined Score =

0–10	0–10	0–10		0–30
10	10	10	=	30
Practical Problem Solving	+ Conceptual Shifting A	+ Conceptual Shifting B		

— Index Score Conversion Chart —

	AC	MIR	MDR	MDRec	SP	VF	RCS
Sum of Scaled Scores	25	26	26	23	15	26	14
Index Score (*T* Score)	60	64	62	57	67	61	63
95 % Confidence Interval	57-85	60-68	58-67	49-62	56-70	57-66	59-67
Percentile Rank	84	92	88	76	96	86	90

Sum of Index *T* Scores	Total Index *T* Score
434	70
	69-73
	98



ehavioral Observations:

8114

Materials
TOPF Word Card.

Start
Ages 16–90: Item 1

Discontinue
After 5 consecutive scores of 0.

Score
Score 0 or 1 point for each response.

Additional Prompts

If, at any time during administration, you are unsure which word the examinee is reading, say, **Point to the word you are reading.**

If the examinee's rate of reading is too rapid for accurate scoring, say, **You are going too fast for me to keep up. Please read the words more slowly.**

If the examinee's response is unclear, say, **Say it again.**

If the examinee asks what to do if he or she makes a mistake, say, **You can try it again.** If the examinee self-corrects his or her initial response, award credit appropriately. Examinees may correct their initial response(s) at any time during administration.

If the examinee provides multiple responses to an item, score only the intended response. If it is not clear which one is the intended response, say, **You pronounced the word more than one way. Which one did you mean?**

Give no further assistance except to remind the examinee to continue until told to stop (if necessary) or to redirect the examinee to the appropriate word or column.

Item		Score
1. two	(TOO)	0 1
2. address	(uh-DRESS) or (AH-dress)	0 1
3. whole	(HOHL)	0 1
4. eye	(I)	0 1
5. again	(uh-GEHN)	0 1
6. enough	(ee-NUHF) or (uh-NUHF) or (in-NUHF)	0 1
7. already	(awl-REH-dee)	0 1
8. cough	(KAWF)	0 1
9. fuel	(FYOOL)	0 1
10. climb	(KLIM)	0 1
11. most	(MOHST)	0 1
12. excitement	(ihk-SIT-mehnt)	0 1
13. mosquito	(muh-SKEE-toh)	0 1
14. decorate	(DEHK-uh-rayt)	0 1
15. fierce	(FIHRSS)	0 1
16. plumb	(PLUHM)	0 1
17. knead	(NEED)	0 1
18. vengeance	(VEHN-juhnss)	0 1

Item		Score
19. gnar	(NAHT)	0 1
20. prestigious	(pres-TIH-juhss) or (prehs-TEE-juhss)	0 1
21. amphitheater	(AM-fuh-thee-uh-ter)	0 1
22. lacuna	(la-KOO-nuh)	0 1
23. iridescent	(ihr-ih-DEH-suhnt)	0 1
24. lieu	(LOO)	0 1
25. wily	(WI-lee)	0 1
26. aesthetic	(ehs-THEHT-ihk)	0 1
27. equestrian	(eh-KWESS-tree-uhn)	0 1
28. porpoise	(POR-puhss)	0 1
29. subtle	(SUH-tuhl)	0 1
30. palatable	(PAH-luh-tuh-buhl)	0 1
31. homily	(HAWM-uh-lee)	0 1
32. ogre	(OH-guhr)	0 1
33. liaison	(lee-AY-zawn) or (LEE-uh-zawn) or (LAY-uh-zawn)	0 1
34. xenophobia	(zeen-oh-FOH-bee-uh) or (zehn-uh-FOH-bee-uh)	0 1
35. dichotomy	(di-KAW-tuh-mee)	0 1
36. menagerie	(meh-NAH-juh-ree) or (meh-NAH-zhree)	0 1

(continued)

'est of Premorbid Functioning *(continued)*

ıdditional Prompts

; at any time during administration, you are unsure which word the examinee is reading, say, **Point to the word you are reading.**

'the examinee's rate of reading is too rapid for accurate scoring, say, **You are going too fast for me to keep up. Please read the 'ords more slowly.**

'the examinee's response is unclear, say, **Say it again.**

'the examinee asks what to do if he or she makes a mistake, say, **You can try it again.** If the examinee self-corrects his or her ıitial response, award credit appropriately. Examinees may correct their initial response(s) at any time during administration.

'the examinee provides multiple responses to an item, score only the intended response. If it is not clear which one is the ıtended response, say, **You pronounced the word more than one way. Which one did you mean?**

;ive no further assistance except to remind the examinee to continue until told to stop (if necessary) or to redirect the examinee ɔ the appropriate word or column.

57

Item		Score
37. umbrage	(UHM-brihj)	0 1
38. fecund	(FEH-kuhnd) or (FEE-kuhnd)	0 1
39. scurrilous	(SKUHR-ih-luhss) or (SKUH-rih-luhss)	0 1
40. heinous	(HAY-nuhss)	0 1
41. obfuscate	(OB-fuh-skayt) or (OB-fyoos-kayt) or (OB-foo-skayt)	0 1
42. plethora	(PLEH-thor-uh)	0 1
43. exigency	(EHK-sih-jehn-see) or (ihg-ZIH-juhn-see)	0 1
44. lascivious	(luh-SIH-vee-uhs)	0 1
45. paradigm	(PEHR-uh-dim)	0 1
46. cretonne	(kreh-TAWN) or (KREE-tawn)	0 1
47. vicissitude	(vih-SIH-suh-tood)	0 1
48. ethereal	(ih-THEER-ee-uhl) or (ih-THIR-ee-uhl)	0 1
49. uxorious	(uhk-SOHR-ee-uhs) or (uhg-SOHR-ee-uhs)	0 1
50. lugubrious	(loo-GOO-bree-uhs) or (luh-GOO-bree-uhss)	0 1
51. piquant	(PEE-kuhnt) or (PEE-kwant)	0 1
52. perspicuity	(per-speh-KYOO-ih-tee)	0 1
53. ubiquitous	(yoo-BIH-kwih-tuhss)	0 1

Item		Score
54. hyperbole	(hi-PER-buh-lee)	0 1
55. facetious	(fuh-SEE-shuhss)	0 1
56. treatise	(TREE-tihss)	0 1
57. picot	(PEE-koh)	0 1
58. macabre	(muh-KAWB) or (muh-KAW-bruh) or (muh-KAW-bar) or (muh-KAW-bree)	0 1
59. anechoic	(ah-nih-KOH-ihk)	0 1
60. acquiesce	(ah-kwee-EHSS)	0 1
61. dilettante	(DIH-luh-tawnt)	0 1
62. eyrir	(AY-rihr)	0 1
63. misogyny	(meh-SAW-juh-nee)	0 1
64. vertiginous	(ver-TIH-juh-nuhss)	0 1
65. hegemony	(heh-JEH-muh-nee) or (heh-GEH-muh-nee)	0 1
66. insouciant	(ihn-SOO-see-uhnt) or (ihn-soo-SHAWN)	0 1
67. vide	(VI-day) or (VI-dee) or (VEE-day)	0 1
68. chthonic	(THAW-nihk)	0 1
69. vivace	(vee-VAH-chay) or (vee-VAH-chee)	0 1
70. ceilidh	(KAY-lee)	0 1

Test of Premorbid Functioning Total Raw Score (Max = 70)	28
Test of Premorbid Functioning Standard Score	115

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8116

Multilingual Aphasia Examination III—Controlled Oral Word Association

Arthur Benton, Kerry deS. Hamsher, and Abigail Sivan

Record Sheet

Name Timothy James Jr No. — Date 2 22 19 (month day year)

Age 37 Gender M Education (no. of years) 16 Handedness R Examiner Rene

	First Letter (1 minute) C or P		Second Letter (1 minute) F or R		Third Letter (1 minute) L or W	
	(Form A)	(Form B)	(Form A)	(Form B)	(Form A)	(Form B)
1.	child		restrict		lived	
2.	Chorea		revive		lips	
3.	Cannon		restrictive		lied	
4.	Cho		resuscitate		limp	
5.	Coil		resurrection		liabilities	
6.	Crucial		volcano		listerine	
7.	Crime		compromise		limacie	
8.	Cat		rendition		love	
9.	Cop		King 30		live	
10.	Cuss 15		Real		locate	
11.	Culminate 20		zeal		love	
12.	Croc		reduce		link	
13.	Cosmic		reduced			
14.	Crawfish 45		recreate			
15.	Crayfish		recline			
16.	Crowded		realm			
17.	Cell phone					
18.	Cut					
19.						
20.						
21.						
22.						
	No. of correct responses 17 +		No. of correct responses 11 +		No. of correct responses 11 =	Total Raw Score

Total Raw Score 39 + Adjustment (see table) 2 = Adjusted Score 41 Percentile Rank = 71 (from manual)

Adjustment				
		Age (years)		
Education (years)		25-54	55-59	60-69
< 9	=	8	10	12
9-11	=	5	7	9
12-15	=	3	4	6
16+	=	2	1	3

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M-FAST™

Interview Booklet

Holly A. Miller, PhD

Demographic Information

Name: T. Jones Today's date: 2/22/19

Gender: ☒ Male ☐ Female Age: 37 Education (years): _____

Occupation: _____

Interviewer: Kruse

Setting: ☐ Clinical inpatient ☐ Clinical outpatient ☒ Forensic ☒ Correctional

☐ Other _____

Administration Time

Interview start time: 10:16A Interview stop time: 10:46A Total interview time: 31m

M-FAST Scale Scores

Scale	Score
RO (3 items)	1
ES (7 items)	11
RC (7 items)	1
UH (5 items)	111
USC (1 item)	1
NI (1 item)	0
S (1 item)	0
Total score	8

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Utility Rates of M-FAST Total Scores for the Nonclinical Samples

M-FAST scores	NPP	PPP	Specificity	Sensitivity
1	1.00	.66	.51	1.00
2	.99	.80	.77	.99
3	.98	.90	.90	.98
4	.94	.96	.96	.93
5	.93	.96	.97	.93
6	.94	1.00	1.00	.93
7	.86	1.00	1.00	.82
8	.81	1.00	1.00	.75
9	.86	1.00	1.00	.83
10	.84	1.00	1.00	.81
11	.82	1.00	1.00	.77
12	.77	1.00	1.00	.69
13	.73	1.00	1.00	.61
14	.68	1.00	1.00	.51
15	.63	1.00	1.00	.39
16	.61	1.00	1.00	.32
17	.59	1.00	1.00	.28
18	.56	1.00	1.00	.18
19	.56	1.00	1.00	.18
20	.54	1.00	1.00	.12
21	.53	1.00	1.00	.08
22	.52	1.00	1.00	.04
23	.52	1.00	1.00	.04
24	.52	1.00	1.00	.04
25	.51	1.00	1.00	.00

Note. $N = 210$. Base rate of simulated malingering = 51%. NPP = Negative Predictive Power; PPP = Positive Predictive Power.

Utility Rates of M-FAST Total Scores for the Clinical Samples

M-FAST scores	NPP	PPP	Specificity	Sensitivity
1	1.00	.48	.40	1.00
2	1.00	.52	.49	1.00
3	.99	.57	.60	.97
4	.96	.56	.72	.93
5	.96	.62	.78	.93
6	.97	.68	.83	.93
7	.96	.72	.86	.93
8	.91	.73	.89	.79
9	.87	.88	.95	.73
10	.84	.95	.98	.67
11	.81	1.00	1.00	.57
12	.78	1.00	1.00	.47
13	.75	1.00	1.00	.40
14	.83	1.00	1.00	.63
15	.72	1.00	1.00	.30
16	.71	1.00	1.00	.23
17	.68	1.00	1.00	.18
18	.67	1.00	1.00	.10
19	.66	1.00	1.00	.07
20	.66	1.00	1.00	.03
21	.66	1.00	1.00	.03
22	.66	1.00	1.00	.03
23	.66	1.00	1.00	.03
24	.66	1.00	1.00	.03
25	.66	1.00	1.00	.03

Note. $N = 86$. Base rate of malingering = 35%. NPP = Negative Predictive Power; PPP = Positive Predictive Power.

Record interview start time:

Instructions:

During the next few minutes, I am going to be asking you questions about your psychological symptoms. These questions are given to different people with many different problems, so some of the problems may apply to you and some may not. I will read each question and then read your response options for that question. Just answer each question the best way you can.

Suggestibility item—Part 1:

Are you having any problems with hearing a ringing in your ears: *Yes or No?*

☐ If Yes: **Many people with severe mental illness cannot concentrate for a long time, like doing this interview, without getting a ringing in their ears. Please let me know if the ringing gets worse at any time during this interview.**

☒ If No: **Many people with severe mental illness cannot concentrate for a long time, like doing this interview, without getting a ringing in their ears. Please let me know if you experience any problems with hearing ringing in your ears at any time during this interview.**

Items 1-25 **Raw score column**

1. **I often find myself not being able to sit still in a chair:** ***True or False?*** May be medinices, Ø before (Observe.) Is the individual's report inconsistent with his or her behavior: *Yes or No?*	RO_1 Yes = 1 No = 0
2. **I feel depressed most of the time:** ***True or False?*** Ø med S much great	ES_1 True = 1 False = 0

- Geodon
- R Bordy Risperdal
- Depakote

8120

	Raw score column
3. **Some days I have major mood swings, where for a while I feel great and then I feel depressed: *Yes or No?*** (Yes) If Yes: **Does this only happen when you believe that someone is after you: *Always, Sometimes, or Never?*** (Always)	RC_1 Always = 1 Sometimes = 1 No/Never = 0
4. **Do voices tell you to do things: *Yes or No?*** (Yes) Ø anymore w/ med. If Yes: **Do you always obey them: *Yes or No?*** (No) Now = yes Too scared to admit / Yes + No / as kid see why denied on it	UH_1 Yes = 1 No = 0
5. **I feel unusually happy most of the time: *True or False?*** (False)	ES_2 True = 1 False = 0
6. **I experience hallucinations that last continually for days: *True or False?*** (True) Now W/ meds better), but yes Shadows on walls/blanket free → Mg brand diff. times Dcolors. Shade off light grey	UH_2 True = 1 False = 0
7. **Whenever I am sitting down, I have to check under the chair many times to see if anything is under it: *True or False?*** (False) (Observe.) Is the individual's report inconsistent with his or her behavior: *Yes or No?* (No)	RO_2 Yes = 1 No = 0
8. **Many times during the day, I hear a loud radio playing when there is not a radio on near me: *True or False?*** (True) No - misunderstood, songs all day, like a radio	ES_3 True = 1 False = 0

Thumbs = elevated elephant Move

	Raw score column
9. **Whenever I see people who are not really there, they are always in black and white:** ***True or False?***	UH_3 True = 1 False = 0 NA = 0
10. **Most times when people are talking to me, I see the words they speak spelled out:** ***True or False?***	ES_4 True = 1 False = 0
11. **Whenever I am sitting in a chair, I have to breathe deep breaths in order not to get sick:** ***True or False?*** (Observe.) Is the individual's report inconsistent with his or her behavior: *Yes or No?*	RO_3 Yes = 1 No = 0
12. **Some nights I have nightmares so bad it scares me:** ***Yes or No?*** If Yes: **Does this only happen when you have lost a lot of weight:** ***Always, Sometimes, or Never?***	RC_2 Always = 1 Sometimes = 1 No/Never = 0
13. **Lately my eyesight is so good that I think I have a special power:** ***True or False?***	ES_5 True = 1 False = 0
14. **Sometimes it seems as though somebody controls my symptoms, turning them on and off, so I don't know how I'll feel most days:** ***True or False?***	USC_1 True = 1 False = 0

w meds better, sometimes

Thought insertion → feel ppl put thoughts in head (uncontrol)

- because alone / better
- hears his breathing

10y o. 7 periods / 6 stay for ever

X twice (command)

- Carry on conversations w/ self (& friend) or dead whos

*

	Raw score column
15. When I hear voices, I hear them from either my right or my left ear, but rarely from both at the same time: *True or False?* From inside/from w/in head/ " Never heard audible voice	ES_6 True = 1 False = 0 NA = 0
16. Sometimes I am convinced that I have more than one personality: *Yes or No?* outside my head/ that would be terrible" If Yes: At those times, do you feel dizzy or lightheaded: *Always, Sometimes, or Never?* M = DID / F = ØΨ	RC_3 Always = 1 Sometimes = 1 No/Never = 0
17. The times when you can't go to sleep, do you often smell strange odors that are not really there: *Always, Sometimes, or Never?*	RC_4 Always = 1 Sometimes = 1 Never = 0 NA = 0
18. When I hear voices, my hands begin to sweat: *True or False?*	RC_5 True = 1 False = 0 NA = 0
19. Often, I get the strange feeling that I am from another planet: *True or False?*	ES_7 True = 1 False = 0
20. On many occasions, I feel things crawling on me when there is nothing there: *True or False?*	UH_4 True = 1 False = 0

- Due to day

	Raw score column
21. **Sometimes I hear music coming from nowhere: *True or False?*** - unsure after the ear ringing - music in my head all day - random songs	UH_5 True = 1 False = 0
22. **When I hear voices, I often develop fears of leaving my house or room: *Always, Sometimes, or Never?***	RC_6 Always = 1 Sometimes = 1 Never = 0 NA = 0
23. **Most of the time I feel that I don't really matter: *True or False?***	NI_1 True = 1 False = 0
24. **On many days I feel so bad that I can't even remember my full name: *True or False?***	RC_7 True = 1 False = 0
25. If Yes to Suggestibility item—Part 1 (if the individual said that he or she was hearing any ringing at the beginning of the interview), ask the following question: **Has the ringing in your ears gotten worse: *Yes or No?*** If No to Suggestibility item—Part 1 (if the individual stated that he or she was not hearing any ringing at the beginning of the interview), ask the following question: **Are you experiencing any problems with hearing ringing in your ears: *Yes or No?***	S_1 Yes = 1 No = 0
END OF INTERVIEW Record Interview stop time: 10:46A	**Total score**

8124
Timothy Jones JR.
DOB: 12/20/1981

Exam Date:
2/22/2019

Test Results

WCST scores	Raw scores	Age & Education Demographically Corrected: Standard scores	Age & Education Demographically Corrected: *T* scores	Age & Education Demographically Corrected: %iles	U.S. Census Age-matched: Standard scores	U.S. Census Age-matched: *T* scores	U.S. Census Age-matched: %iles
Trials Administered	81						
Total Correct	68						
Total Errors	13	99	49	47%	104	53	61%
% Errors	16%	98	49	45%	103	52	58%
Perseverative Responses	7	97	48	42%	106	54	66%
% Perseverative Responses	9%	95	47	37%	104	53	61%
Perseverative Errors	7	96	47	39%	105	53	63%
% Perseverative Errors	9%	93	45	32%	103	52	58%
Nonperseverative Errors	6	100	50	50%	105	53	63%
% Nonperseverative Errors	7%	100	50	50%	106	54	66%
Conceptual Level Responses	66						
% Conceptual Level Responses	81%	98	49	45%	103	52	58%
Categories Completed	6			> 16%			> 16%
Trials to Complete 1st Category	12			> 16%			> 16%
Failure to Maintain Set	1			> 16%			> 16%
Learning to Learn	1.52			> 16%			> 16%

SIRS Structured Interview of Reported Symptoms

Interview Booklet

Richard Rogers, Ph.D.

8125

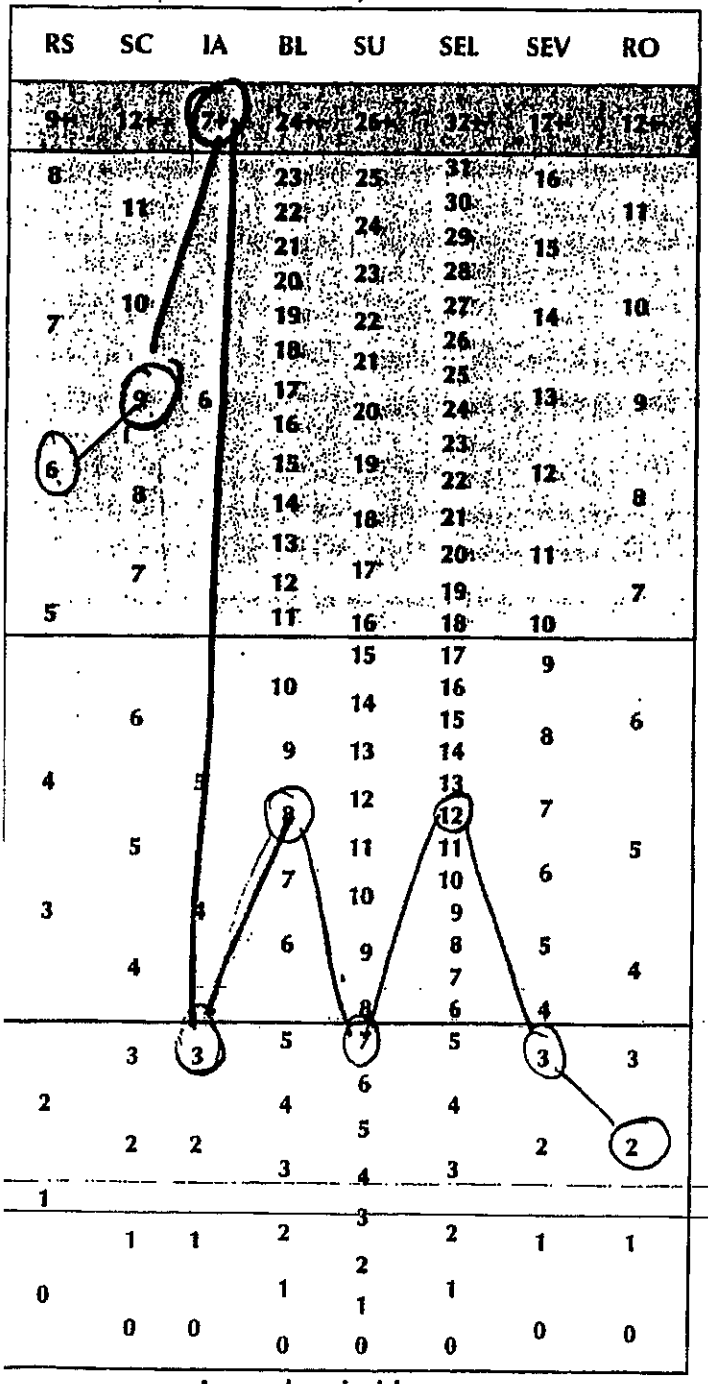
Client Name Timothy R Jones Jr. Interview Date 2-22-2019

Sex M Age 37 Education 11a yrs/BA Occupation —

Interviewer Kruse Interview Setting Inmate/Forensic

SIRS Profile

Primary Scales



Legend on inside cover

Scale Scores

Primary Scales

RS (Sum items marked with a ●)	= 6
SC (Sum items marked with a ◗)	= 9
IA (Sum items marked with a ■)	= 7
BL (Sum BL_1 from p. 3 and BL_2 from p. 9)	= 3 + 5 = 8
SU (Sum SU_1 from p. 3 and SU_2 from p. 9)	= 3 + 4 = 7
SEL (Sum SEL_1 from p. 3 and SEL_2 from p. 9)	= 5 + 7 = 12
SEV (Sum SEV_1 from p. 3 and SEV_2 from p. 9)	= 1 + 2 = 3
RO (Sum items marked with a ◪)	= 2
# of Primary Scales in definite range	1
# of Primary Scales in probable range	2

Supplementary Scales

DA (Sum items marked with a ◆)	=
DS (Sum items marked with a ◗)	=
OS (Sum items marked with a ▲)	=
SO (Sum items marked with a ◭)	=
INC (Sum INC_1 from p. 3 and INC_2 from p. 9)	=

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Detailed/Repeated Inquiries I

Detailed/Repeated Inquiries II

Enter Time Started _____

structions: You will be asked about many specific psychological problems. These are standard questions about notional difficulties that may or may not apply to you.

	DETAILED INQUIRIES I				REPEATED INQUIRIES I				Inconsistency Score
	X	No	Yes	Unbearable		X	No	Yes	Unbearable	
o you have any major problems with:										
1. ...people reading your mind?	X	0	(1)	2	71.	X	0	(1)	2	
2. ...getting motivated?	X	(0)	1	2	72.	X	(0)	1	2	
3. ...having thoughts about suicide?	X	(0)	1	2	73.	X	(0)	1	2	
4. ...expressing strong feelings?	X	0	(1)	2	74.	X	0	(1)	2	
ıe problem you mentioned with...is it unbearable?										
o you have any major difficulties with:										
5. ...feelings of self-doubt?	X	0	(1)	2	75.	X	0	(1)	2	
6. ...seeing religious visions?	X	(0)	1	2	76.	X	(0)	1	2	
7. ...being restless?	X	0	(1)	2	77.	X	0	(1)	2	
8. ...having strangers talk about you behind your back?	X	0	(1)	(2)	78.	X	0	1	(2)	
ıe difficulty you mentioned with...is it unbearable?										
o you have any major problems with:										
9. ...striving to be successful?	X	(0)	1	2	79.	X	(0)	1	2	
0. ...noticing very strange smells?	X	(0)	1	2	80.	X	(0)	1	2	
1. ...communicating with other planets?	X	(0)	1	2	81.	X	(0)	1	2	
2. ...having too much energy?	X	(0)	1	2	82.	X	(0)	1	2	
e problem you mentioned with...is it unbearable?										
o you have any major difficulties with:										
3. ...making everyday decisions?	X	(0)	1	2	83.	X	(0)	1	2	
4. ...having your body move strangely?	X	(0)	1	2	84.	X	(0)	1	2	
5. ...being organized?	X	(0)	1	2	85.	X	(0)	1	2	
6. ...fighting evil forces?	X	(0)	1	2	86.	X	(0)	1	2	
e difficulty you mentioned with...is it unbearable?										

Turn to page 4 and begin General Inquiries I.

Turn to page 9 and begin Detailed Inquiries II.

oring Worksheet

INC_1 Total (Sum Inconsistency scores in this column) (1)

(3) (Sum scores for shaded Detailed Inquiries I)

(3) (Sum scores for unshaded Detailed Inquiries I)

(5) (Count number of Detailed Inquiries I endorsed with a score of 1 or 2)

(1) (Count number of Detailed Inquiries I endorsed with a score of 2)

Young Leader ID [illegible] 8127

GENERAL INQUIRIES I

		No Answer	No	Qualified yes/ Sometimes	Definite Yes	
17.	Do you sometimes feel shy around people you don't know?	X	0	(1)	2	♦
18.	Are your thoughts sometimes broadcasted so that large numbers of people know what you are thinking? Do they know your thoughts without being told by anyone?	X	(0)	1	2	●
19.	Are there times when it is difficult for you to admit you are wrong?	X	(0)	1	2	♦
20.	Does the furniture where you live seem to change its shape and color from day to day?					
Rule-out:	Was it because you were on drugs?	X	0	1	(2)	■
21.	Do you sometimes worry that others might not like you?	X	0	1	(2)	♦
22.	Have you learned to manage any of your psychological problems?	X	0	1	(2)	
23.	Do most of your problems suddenly appear without any warning?	X	0	1	(2)	▲
24.	Do you have exactly two nightmares every evening?	X	(0)	1	2	▲
25.	At times when you feel hopeless, do you also feel lightheaded or faint?	X	(0)	1	2	●
26.	Do you have any secrets that no one else knows?	X	(0)	1	2	

		No Answer	Consistent	Inconsistent	Suddenly Worse	
27.	Are you always looking around the room so that you won't have any unpleasant surprises?	X	(0)	1	2	■

		No Answer	No	Qualified yes/ Sometimes	Definite Yes	
28.	Do you frequently have muscle spasms while drinking water?	X	(0)	1	2	
29.	Do people have a strange odor to them? Is that more than just body odor?	X	(0)	1	2	●
30.	At times when you feel upset, do you have problems concentrating?	X	0	1	(2)	♦
31.	Have you heard actual voices talking to you when there wasn't anyone there? Do these voices sing to you in a foreign language?	X	(0)	1	2	
32.	Do all of your problems seem to take care of themselves and quickly disappear?	X	(0)	1	2	

	No Answer	No	Qualified yes/ Sometimes	Definite Yes	
33. Do you sometimes have strange feelings in your body? Do these feelings only occur on Tuesday?	X	0	1	2	▲
34. Do you just not care what others might think about you? Does this include mental health professionals?	X	0	1	2	♦
35. Do you have any unusual beliefs about automobiles? Do you believe they have their own religion?	X	0	1	2	■
36. When outside, do you become afraid of things which couldn't possibly hurt you, such as grass or flowers?	X	0	1	2	
37. Do you have a strong sense of what is morally right and wrong?	X	0	1	2	♦
38. At times when you have been more physically active, did you develop fears that others might hurt you?	X	0	1	2	

	No Answer	Consistent	Inconsistent	Suddenly Worse	
39. Do you lose your train of thought when answering questions? Yes	X	0	1	2	■

	No Answer	No	Qualified yes/ Sometimes	Definite Yes	
40. Are you sometimes too critical of other people?	X	0	1	2	♦
41. Do you hear unnatural sounds or voices? Do they come from closets and nowhere else?	X	0	1	2	▲
42. In the middle of talking to people, do you sometimes begin to rhyme your words?	X	0	1	2	●
43. Do you often comb or brush your hair? Do you feel you always have to comb or brush your hair before and after every meal?	X	0	1	2	
44. Do you sometimes like to fool or mislead doctors?	X	0	1	2	♦
45. Do you sometimes feel like insulting people who have been rude to you?	X	0	1	2	♦
46. Do you hear voices that others don't seem to hear? Do these voices happen every time your appetite for food increases?	X	0	1	2	

	No Answer	Consistent	Inconsistent	Suddenly Worse	
47. Do you often repeat yourself, saying the same thing several times?	X	(0)	1	2	■

	No Answer	No	Qualified yes/ Sometimes	Definite Yes	
48. Have you been exaggerating some of your psychological problems?	X	(0)	1	2	♦
49. Do you often have upsetting sexual thoughts which bother you only on elevators?	X	(0)	1	2	
50. Do you have a need to wash your hands frequently? Is this related to any unique or special powers that you possess?	X	(0)	1	2	●
51. Do you find it difficult to say no to a friend?	X	0	1	(2)	♦

	No Answer	Consistent	Inconsistent	Suddenly Worse	
52. Do you blink your eyes more than most people?	X	(0)	1	2	■

	No Answer	No	Qualified yes/ Sometimes	Definite Yes	
53. Do you have feelings of hopelessness? Does this always happen to you when you see children?	X	(0)	1	2	
54. Do you hold back telling people everything...keep some things to yourself?	X	0	1	(2)	
55. Is the government trying to keep track of your actions? Are they using military aircraft to do this?	(X)	0	1	2	
56. When you are nervous, do you sometimes laugh at things which are not funny?	X	(0)	1	2	♦

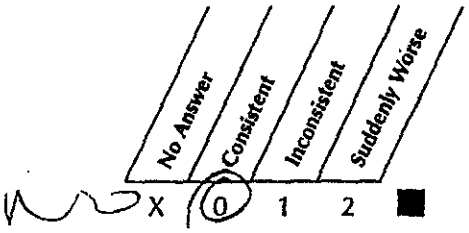
ome people with psychological problems have difficulty with concentration and memory. Please complete the following est as quickly as you can.

57. What is the opposite of:
   (a) UNDER Over ✓
   (b) BRAVE fertful ✓
   (c) TALL Short ✓
   (d) FAST Slow ✓
   (e) OPEN close ✓

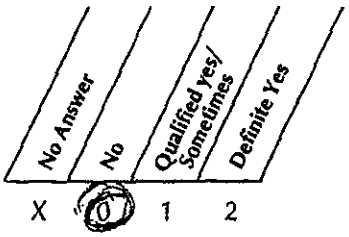
Total errors 0

58. What word rhymes with:
   (a) CRY try ✓
   (b) OLD fold ✓
   (c) STAR bar ✓
   (d) ATE date ✓
   (e) BOAT Rat/Rote ✓

Total errors 0



59. Is your breathing rapid and shallow whenever you are sitting still?



60. Do you feel elated or "too good to be true" from watching the evening news?

61. Do you have fears of growing old? X 0 1 2 ♦

62. Do you sometimes feel like you are physically outside of your own body?

le-out: Was this only because you were taking drugs or didn't get enough sleep? X 0 1 2 ●

63. Do you have severe headaches at the same time you have abnormal sexual thoughts? X 0 1 2 ●

	No Answer	Consistent	Inconsistent	Suddenly Worse	
64. Do you always gesture or move your hands when you are talking? (yes)	X	0	(1)	2	■

	No Answer	No	Qualified yes/ Sometimes	Definite Yes	
65. Do you become nervous and fidgety whenever you use the bathroom?	X	(0)	1	2	
66. Do you have any trouble remembering peoples' names that you have just met?	X	0	1	(2)	♦
67. Do you have strong religious thoughts and periods of giggling? Do these happen together?	X	0	1	(2)	●
68. Does pain ever bounce through your body going back and forth from limb to limb?	X	0	(1)	2	■
69. Does your face look strange or unfamiliar to you?	X	(0)	1	2	●
70. Do you sometimes make up psychological problems that don't really exist?	X	(0)	1	2	♦

I would like to go over several earlier questions to make sure I have the correct information.

Turn to page 3 and begin Repeated Inquiries I.

	DETAILED INQUIRIES II				REPEATED INQUIRIES II				Inconsistency Score
	X	No	Yes	Unbearable	X	No	Yes	Unbearable	
you have any major problems with:									
7. ...concentration?	X	0	1	2	157. X	0	1	2	
8. ...strange or disturbing thoughts?	X	0	1	2	158. X	0	1	2	
9. ...waking up early in the morning?	X	0	1	2	159. X	0	1	2	
0. ...hearing voices which aren't really there?	X	0	1	2	160. X	0	1	2	
e problem you mentioned with...is it unbearable?									
you have any major difficulties with:									
1. ...others plotting against you?	X	0	1	2	161. X	0	1	2	
2. ...being irritated with others?	X	0	1	2	162. X	0	1	2	
3. ...losing weight?	X	0	1	2	163. X	0	1	2	
4. ...feeling that you can control world events?	X	0	1	2	164. X	0	1	2	
ie difficulty you mentioned with...is it unbearable?									
o you have any major problems with:									
5. ...being very depressed?	X	0	1	2	165. X	0	1	2	
6. ...having others control your movements?	X	0	1	2	166. X	0	1	2	
7. ...sleeping too much?	X	0	1	2	167. X	0	1	2	
8. ...over-reacting to difficult situations?	X	0	1	2	168. X	0	1	2	
ie problem you mentioned with...is it unbearable?									
o you have any major difficulties with:									
9. ...pronouncing difficult words?	X	0	1	2	169. X	0	1	2	
0. ...maintaining your interest in activities?	X	0	1	2	170. X	0	1	2	
1. ...keeping your sexual feelings under control?	X	0	1	2	171. X	0	1	2	
2. ...having unfriendly people following you?	X	0	1	2	172. X	0	1	2	
he difficulty you mentioned with...is it unbearable?									

Turn to page 10 and begin General Inquiries II.

Enter Time Finished _____

Total Time _____

coring Worksheet

INC_2 Total (Sum Inconsistency scores in this column) _____

L_2 5 (Sum scores for shaded Detailed Inquiries II)

U_2 4 (Sum scores for unshaded Detailed Inquiries II)

EL_2 7 (Count number of Detailed Inquiries II endorsed with a score of 1 or 2)

EV_2 2 (Count number of Detailed Inquiries II endorsed with a score of 2)

GENERAL INQUIRIES II

		No Answer	No	Qualified yes/ Sometimes	Definite Yes	
103.	Do you sometimes wish you were more self-confident?	X	0	1	(2)	♦
104.	Can people put thoughts in your mind against your will? Is it that they actually put thoughts in your head without speaking to you?	X	0	1	(2)	●
105.	Do you occasionally have trouble making important decisions?	X	0	(1)	2	♦
106.	Do buildings appear to change in shape? Does their shape seem different to you at different times?					
Rule-out:	Was it only because you were on drugs?	X	0	1	(2)	■
107.	Do you sometimes wish for world peace or an end to poverty?	X	0	1	(2)	
108.	When you've had emotional problems, were you successful at helping yourself?	X	0	(1)	2	
109.	Did your emotional problems come suddenly so that one day you were completely normal and the next day you were very troubled?	X	0	1	(2)	▲
110.	Have you lost exactly 4 pounds in the last 12 months?	X	(0)	1	2	▲
111.	At times when you have felt happy, did you lose all interest in other people?	X	0	(1)	2	●
112.	Do you feel angry when others try to take advantage of you?	X	0	1	(2)	♦

		No Answer	Consistent	Inconsistent	Suddenly Worse	
113.	Do you find it difficult to sit in a chair without looking under or behind it? NO	X	(0)	1	2	■

		No Answer	No	Qualified yes/ Sometimes	Definite Yes	
114.	Do your teeth hurt only while eating breakfast?	X	(0)	1	2	▲
115.	Are you bothered by strange smells wherever you go?	X	(0)	1	2	●
116.	Do you feel nervous when speaking to a large audience?	X	0	1	(2)	♦
117.	Can cats or dogs communicate with you in some special way? Does this involve actual words from them?	X	(0)	1	2	

8134

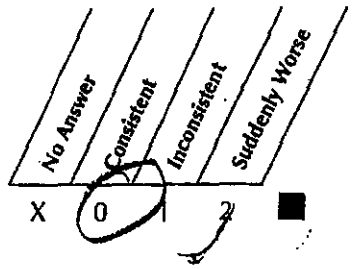
	No Answer	No	Qualified yes/ Sometimes	Definite Yes	
118. Have you ever woken up one morning and realized that all of your problems were gone...that you were feeling completely okay?	X	0	1	(2)	
119. Do people seem to criticize you more on Wednesdays than any other day?	X	(0)	1	2	▲
120. Does it matter to you what mental health professionals think about you?	X	0	1	(2)	
121. Do you believe that trees have supernatural powers?	X	(0)	1	2	
122. Do you become fearful of soft household objects for no real reason?	X	(0)	1	2	■
123. Has there ever been a period of time when you worried about the future?	X	0	1	(2)	♦
124. Have you ever felt that people were following you? Did you experience an increase in appetite during those times?	X	0	(1)	2	●

	No Answer	Consistent	Inconsistent	Suddenly Worse	
125. Do you stutter and stumble over your words when you first talk with someone?	X	(0)	1	2	■

	No Answer	No	Qualified yes/ Sometimes	Definite Yes	
126. Would you be upset if a police officer caught you speeding?	X	0	(1)	2	
127. Do you feel more confused or upset at noon time than at other times?	X	(0)	1	2	
128. Do you make up your own words and expect others to understand them?	X	(0)	1	2	
129. Do you have to cross your arms before you can cross the street?	X	(0)	1	2	■
130. Do you sometimes like to keep doctors guessing about what is really going on with you?	X	(0)	1	2	♦
131. Do you sometimes pretend to know something so you won't look stupid?	X	(0)	1	2	♦
132. Have you ever heard voices coming out of nowhere? Was this at the same time you had seizures or trouble walking?	X	0	1	(2)	●

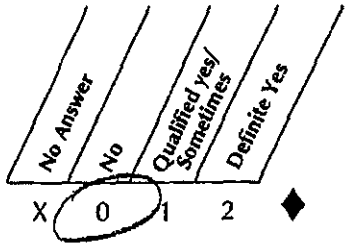
↳ Over-Stimulation
-frozen

133. When talking to others, do you whisper for no apparent reason?



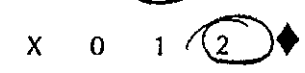
134. Do you make your symptoms seem worse than they actually are?

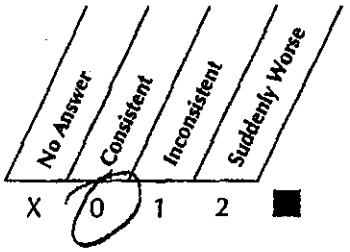
135. Do you spend much time worrying about your physical health? Would this average between 30 and 40 minutes each day?



136. Do you have thoughts about your own talents and abilities? Do these thoughts occur at times when you have an increased need for sleep?

137. Is it hard for you to forget mistakes you've made in the past?

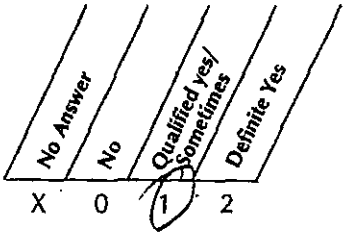


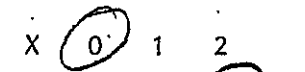


138. Do you tend to frown most of the time?

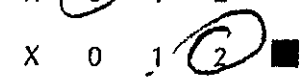
139. Do you experience feelings of terror at the sound of children's voices?

140. Do you often tell people only half the story...leave it to them to figure out the rest?

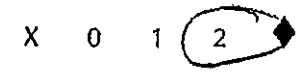




141. Can common insects be used for electronic surveillance?



142. Do you have any painful memories from your childhood?



8136

Some people with psychological problems have difficulty with concentration and memory. Please complete the following test as quickly as you can.

143. What is the opposite of:

(a) HOT COLD

(b) SAD MAD

(c) SLENDER OVERW.

(d) SLEEPY AWAKE

(e) HUNGRY FULL

Total errors 0

144. What word rhymes with:

(a) FAT CAT

(b) BOOK TOOK

(c) CAKE BAKE

(d) SLOW OW

(e) MOP HOP

Total errors 0

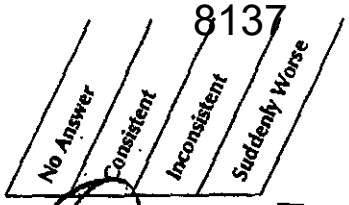
	No Answer	Consistent	Inconsistent	Suddenly Worse
145. Do you tend to sigh when talking to others?	X	(0)	1	2 ■

	No Answer	No	Qualified yes/ Sometimes	Definite Yes
146. Do you often experience feelings of energy and excitement? Do these feelings occur at unusual times, like when you hear sad news?	X	0	(1)	2 ●
147. Do you ever have thoughts about "getting even" when someone hurts your feelings?	X	(0)	1	2 ♦
148. Do you sometimes feel strange and unreal for several days in a row?	X	0	1	(2)
149. Do you sometimes have severe physical pains? Do these pains create feelings of inner happiness or peace?				
Rule-out: Was this only because of prescribed medication you were taking?	X	(0)	1	2 ●

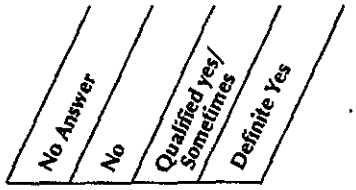
Detailed/Repeated Inquiries I

Detailed/Repeated Inquiries II

8137



150. Do you move your feet a lot when sitting in a chair? X (0) 1 2 ■



151. Do you have intense feelings of depression?
Do these only occur while watching TV? X (0) 1 2

152. Are your moods affected by the weather? X 0 (1) 2

153. Do you often feel scared?
Does this seem to happen to you when your personal hygiene is poor? X (0) (1) 2 ●

154. Do you often have physical pain?
Do you experience this pain equally throughout your body? X 0 (1) 2

155. Have there been major changes in the way your body looks to you?
Rule-out: Is it just because you have been getting older, or are physically ill? X 0 1 (2) ●

156. Have you ever made up psychological problems that didn't really exist? X (0) 1 2 ♦

I would like to go over several earlier questions to make sure I have the correct information.

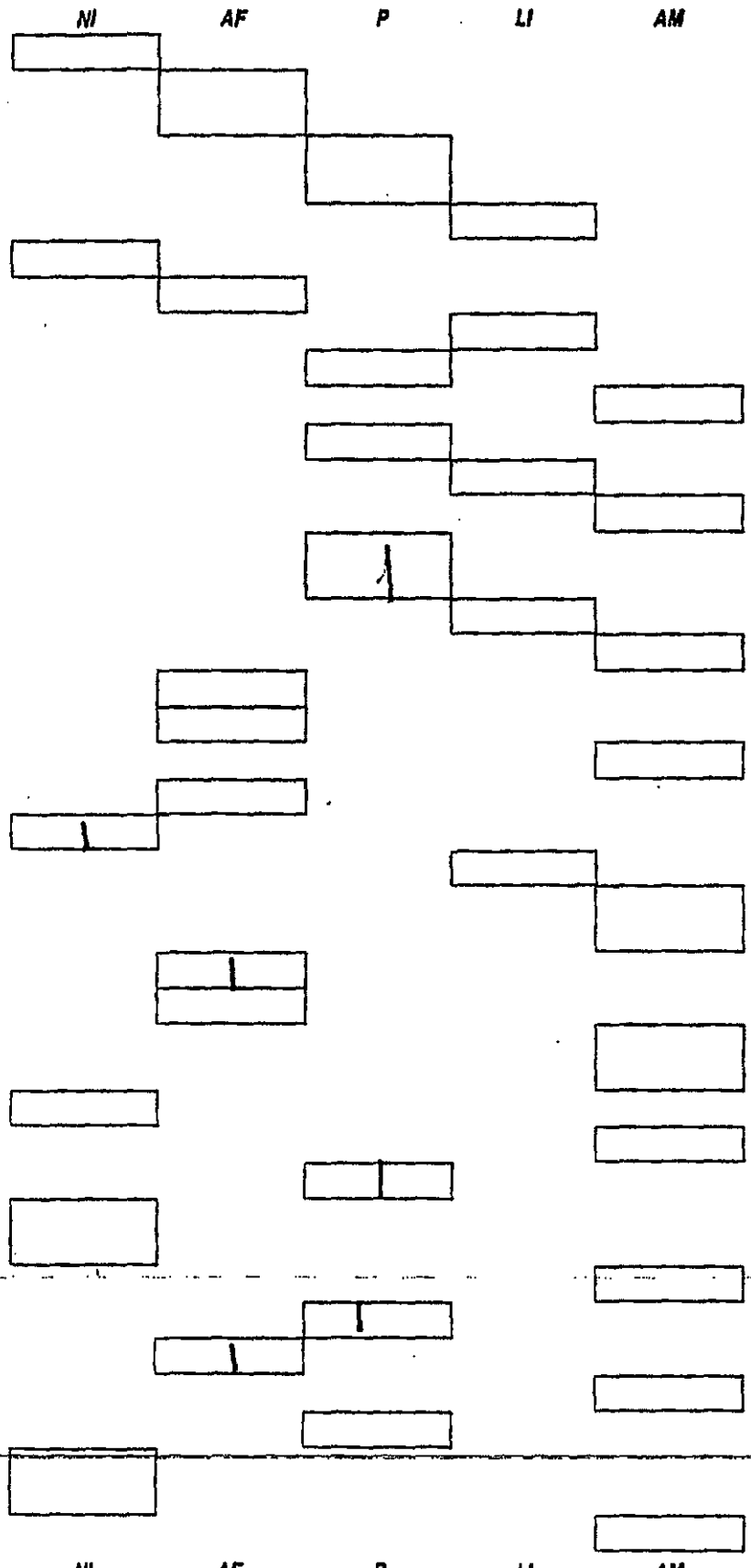
Turn to page 9 and begin Repeated Inquiries II.

8138

IMS Scoring Form

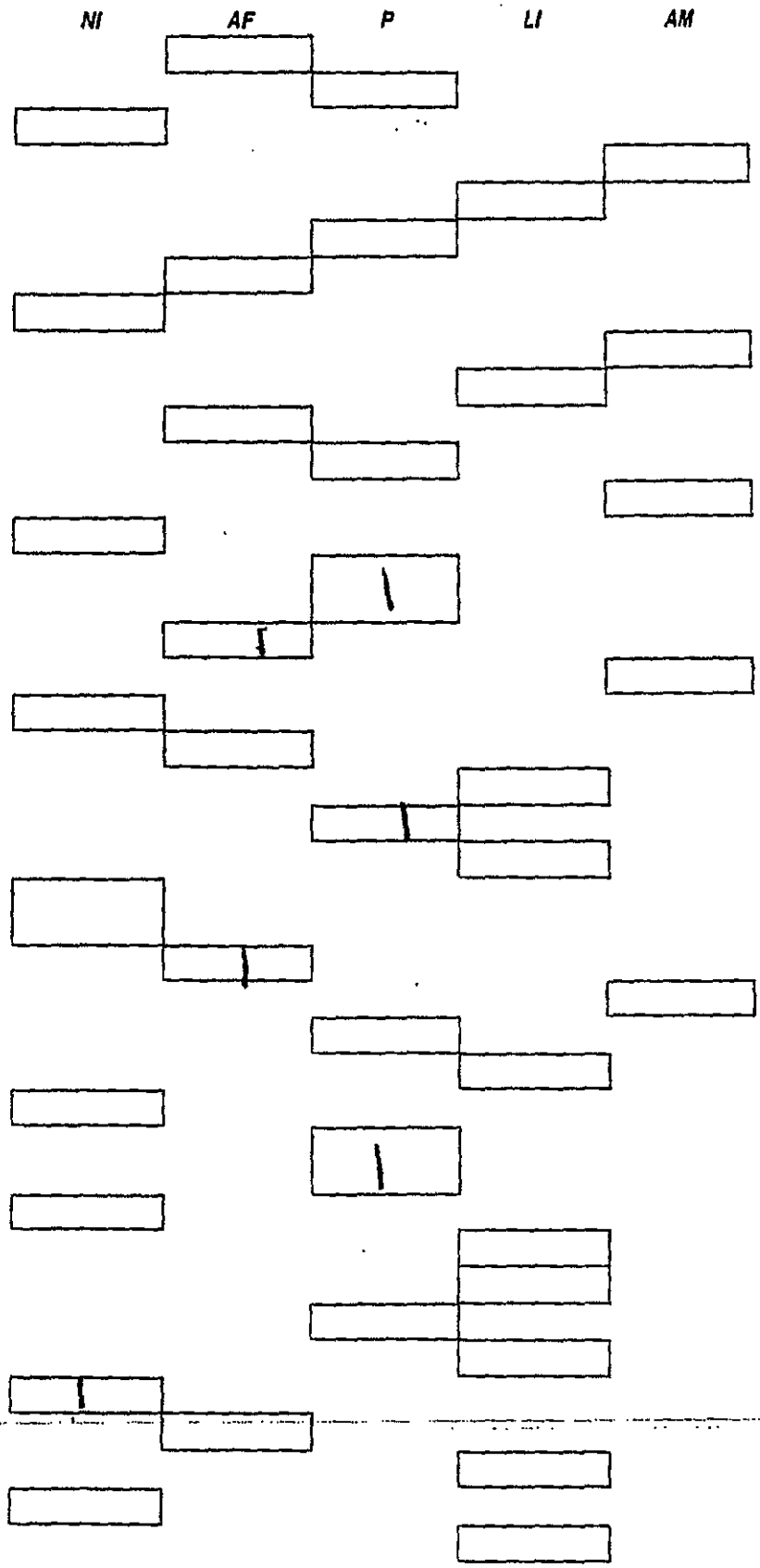
Name Timothy Jones Jr Today's Date 2/22/19

Gender Male Age 37 Date of Birth [redacted]



1.					1	(0)
2.					1	0
3.					1	(0)
4.					1	(0)
5.					1	(0)
6.					1	(0)
7.					(0)	1
8.					1	0
9.					(0)	1
10.					1	0
11.					1	(0)
12.					1	0
13.			1		(1)	0
14.					1	0
15.					1	0
16.					1	0
17.					1	(0)
18.					1	0
19.					0	(1)
20.		1			(1)	0
21.					1	0
22.					1	0
23.		1			0	(1)
24.					1	0
25.					1	0
26.					1	0
27.					1	0
28.			1		1	0
29.					1	(0)
30.					1	0
31.			1		(1)	0
32.		1			1	0
33.					1	0
34.					1	0
35.					1	0
36.					1	0

	NI	AF	P	LI	AM
Subtotal Items 1-36	1	2	3	0	0



	NI	AF	P	LI	AM		
37.						1	0
38.						1	0
39.						1	0
40.						1	0
41.						1	0
42.						1	0
43.						1	0
44.						1	0
45.						1	0
46.						0	1
47.						1	0
48.						1	0
49.						1	0
50.						1	0
51.			1			1	0
52.		1				1	0
53.						1	0
54.						0	1
55.						0	1
56.						0	1
57.			1			1	0
58.						0	1
59.						1	0
60.		1				1	0
61.						1	0
62.						1	0
63.						0	1
64.						1	0
65.			1			1	0
66.						1	0
67.						1	0
68.						1	0
69.						1	0
70.						1	0
71.	1					1	0
72.						0	1
73.						1	0
74.						1	0
75.						0	1

	NI	AF	P	LI	AM	TOTAL
Subtotal items 37-75	1	2	3	0	0	
→ Subtotal items 1-36	1	2	3	0	0	
Scale raw scores	2	4	6	0	0	12
Clinical cutoff scores	> 2	> 5	> 1	> 2	> 2	> 14

IMS Response Form 8140

ame _____ Today's Date ____/____/____

ender _____ Age _____ Date of Birth ____/____/____

T = True or usually true for you **F = False or usually untrue for you**

. Sometimes I lose all feeling in my hand so that it is as if I have a glove on.	T	(F)
. When my depression becomes too severe, I go out for long walks or do some form of exercise to reduce the tension.	T	(F)
. I believe that an individual's phone number is not randomly assigned but is God's way of determining one's salvation.	T	(F)
. If your shadow points to the southeast, the sun is in the northeast corner of the sky.	T	(F)
. Food doesn't taste the same as it has in the past.	T	(F)
. I seldom laugh.	T	(F)
. Gold and silver are alike because they're both metals.	(T)	F
. I have noticed that my shadow dances wildly even though I remain still.	T	(F)
. I can remember what I was doing one hour ago.	(T)	F
. I have noticed that my body changes shape even though my weight stays the same.	T	(F)
. The capital of Italy is Hungary.	T	(F)
2. I have difficulty remembering my address.	T	(F)
3. There is nothing that I can do, besides taking medication, that has any effect on the voices I hear.	(T)	F
4. The United States has 55 states.	T	(F)
5. The major problem I have is with my memory.	T	(F)
6. Even though I'm depressed most of the time, I feel best in the morning after a good night's sleep.	T	(F)
7. My mood is worse at night.	T	(F)
8. More than three times a day I find myself getting up to get something only to forget what it was.	T	(F)
9. At times I am so depressed I welcome going to bed early to "sleep it off."	T	(F)
0. My major problem is that my brain is injured.	(T)	F
. There are six days in a week.	T	(F)
. Recently I've noticed that my memory is getting so bad that there have been entire days that I cannot recall.	T	(F)
. I seldom cry.	T	(F)
. The more depressed I get, the more I want to eat.	T	(F)
At times I've been unable to remember the names or faces of close relatives so that they seem like complete strangers.	T	(F)
Walking is difficult for me because of my problems with balance.	T	(F)
I have difficulty remembering the day of the week.	T	(F)
I believe that the government has installed cameras in stop lights to spy on me.	(T)	F
Sometimes when writing a phone number, I notice that the numbers come out backwards even though I don't mean to do it.	T	(F)
I have difficulty remembering today's date.	T	(F)
People can put thoughts in my mind against my will.	(T)	F
I have trouble sleeping.	(T)	F
My past life and important events became a blur to me almost overnight.	T	(F)
I believe that if you think very hard it is possible to actually see the thoughts of others.	T	(F)
Sometimes my muscles go limp for no apparent reason so that my arms and legs feel as if they weigh a ton.	T	(F)
I have difficulty remembering my phone number.	T	(F)

(continued)

T = True or usually true for you F = False or usually untrue for you

37. As the day progresses my mood gets worse.	T	(F)
38. The voice(s) that I hear, which others do not hear, has (have) never stopped since it (they) began.	T	(F)
39. I have pain in my body which seems to feel like bugs crawling under the surface of my skin.	T	(F)
40. I cannot remember whether or not I have been married.	T	(F)
41. I cannot count backwards from 20 to 1 without making a mistake.	T	(F)
42. Flowers have magical powers like the ability to talk to people.	T	(F)
43. I have no trouble falling asleep but I wake up often during the night.	T	(F)
44. There is a constant ringing in my ears.	T	(F)
45. I was told of an angry meeting I had with someone, but I do not recall any of it.	T	(F)
46. Candles are made of wax.	(T)	F
47. I am depressed all the time.	T	(F)
48. The voice(s) I hear, which no one else hears, come(s) from outside my head.	T	(F)
49. While driving, I sometimes forget how to get home.	T	(F)
50. I have difficulty recognizing written and spoken words.	T	(F)
51. The fear I have of someone hurting me is so real that I know exactly how and when they would do it.	(T)	F
52. I do not seem to have the energy I used to have.	(T)	F
53. When I can't remember something, hints do not help.	T	(F)
54. There has been no change in my sense of smell.	(T)	F
55. When I'm "down," I can get a lift through my hobbies, interests, or friends.	(T)	F
56. A judge and a lawyer are alike because they are both part of the legal system.	(T)	F
57. One day, all of a sudden, I began to hear one or more voices that other people couldn't hear.	(T)	F
58. A door and a gate are alike because they are both openings.	(T)	F
59. Although I am able to move them with no difficulty, I have noticed several parts of my limbs are numb.	T	(F)
60. I can't seem to express my feelings.	(T)	F
61. I have difficulty remembering my birth date.	T	(F)
62. In my visions, I often see parts of bodies covered with blood.	T	(F)
63. Washington was our first President.	(T)	F
64. At times my leg, below the knee, goes limp and I'm unable to move it.	T	(F)
65. When I hear voices coming out of nowhere, I want to run but find I can't even walk without great difficulty.	(T)	F
66. I work slowly and produce a small amount because my activities are so limited.	T	(F)
67. If you have $1.50 and I take away fifty cents, you will have 75 cents left.	T	(F)
68. In the series — 1 12 123 — the next response would be 456.	T	(F)
69. When I hear voices, I feel as though my teeth are leaving my body.	T	(F)
70. The major problem I am having is that things are hard for me to understand.	T	(F)
71. Once a week I suddenly find myself cold even though the actual temperature is warm.	(T)	F
72. Even though things seem pretty bad, I try to remain hopeful that they'll get better.	(T)	F
73. A man had 56 apples and a neighbor gave him 37 more. He now has 83.	T	(F)
74. I find lately that I suffer from headaches and dizziness just before I forget something.	T	(F)
75. In the series — 11 22 33 — the next correct answer would be 44.	(T)	F

Wisconsin Card Sorting Test™: Computer Version 4

Research Edition

by

Robert K. Heaton, PhD, and PAR Staff

Client Information

Last Name: Jones	Test Date: 2/22/19
First Name: Timothy	Test Description: (no description)
Client ID: [redacted]	
BirthDate: [redacted]	Rapport: Good
Age: 37 years, 2 months	Cooperation: Adequate
Gender: Male	Effort: Adequate
Ethnicity: Caucasian (not of Hispanic Origin)	On Medication: Yes
Education: 16 years	Description of Medication:
Handedness: Right	
Occupation: (not specified)	

Caveats

Use of this report requires a thorough understanding of the Wisconsin Card Sorting Test (WCST; Berg, 1948; Grant & Berg, 1948), its interpretation, and clinical applications as presented in the WCST Manual (Heaton, Chelune, Talley, Kay, & Curtiss, 1993). This report is intended for use by qualified professionals.

This report reflects a computerized administration of the WCST. It is important to recognize that normative data used in this report were developed using the standard 128-card version of the WCST (Heaton et al., 1993). While research to date has demonstrated general equivalence between computerized administration and card administration of the WCST (Artiola i Fortuny & Heaton, 1996; Hellman, Green, Kern, & Christenson, 1992), no definitive equivalence data are available for the computerized administration of this version of the WCST and, as such, normative scores must be interpreted cautiously. In order to estimate the potential effects of a computerized administration on test performance, users should be familiar with the original card version.

Users should refer to the WCST Manual (Heaton et al., 1993) for the clinical interpretation of this score report. Clinical interpretation of the WCST requires professional training and expertise in clinical psychology and/or neuropsychology. The utility and validity of the WCST as a clinical measure of cognitive ability are directly related to the professional's background and knowledge and, in particular, familiarity with the information contained in the WCST Manual.

WCST results should be interpreted within the context of a larger clinical assessment battery and relevant clinical and historical information about this client. Additionally, use of WCST scores for clinical or diagnostic decisions should not be attempted without a good understanding of brain-behavior relationships and the medical and psychological factors that affect them.

PAR Psychological Assessment Resources, Inc. / 16204 North Florida Ave. / Lutz, FL 33549 / 1.800.331.8378 / www.parinc.com

Version: 1.04 (4.50.024)

Timothy Jones Jr.
DOB: 12/20/1981

Exam Date: 2/22/2019

Test Results

WCST scores	Raw scores	Age & Education Demographically Corrected: Standard scores	Age & Education Demographically Corrected: *T* scores	Age & Education Demographically Corrected: %iles	U.S. Census Age-matched: Standard scores	U.S. Census Age-matched: *T* scores	U.S. Census Age-matched: %iles
Trials Administered	81						
Total Correct	68						
Total Errors	13	99	49	47%	104	53	61%
% Errors	16%	98	49	45%	103	52	58%
Perseverative Responses	7	97	48	42%	106	54	66%
% Perseverative Responses	9%	95	47	37%	104	53	61%
Perseverative Errors	7	96	47	39%	105	53	63%
% Perseverative Errors	9%	93	45	32%	103	52	58%
Nonperseverative Errors	6	100	50	50%	105	53	63%
% Nonperseverative Errors	7%	100	50	50%	106	54	66%
Conceptual Level Responses	66						
% Conceptual Level Responses	81%	98	49	45%	103	52	58%
Categories Completed	6			> 16%			> 16%
Trials to Complete 1st Category	12			> 16%			> 16%
Failure to Maintain Set	1			> 16%			> 16%
Learning to Learn	1.52			> 16%			> 16%

Response Deck 1

Sorting Principle	Correct Seq. Number	Card Number	Column Sorted To	Categories Matched	Perseverative Principle	Perseverative Response
C	-	1.	1	FN		
	-	2.	3	F		
	1	3.	4	C	F	
	2	4.	1	CN	F	
	3	5.	2	CF	F	
	4	6.	3	CF	F	
	5	7.	4	CN	F	
	6	8.	1	C	F	
	7	9.	2	C	F	
	8	10.	3	C	F	
	9	11.	4	C	F	
	10	12.	1	CF	F	
F	-	13.	4	C	C	*p*
	-	14.	3	C	C	*p*
	1	15.	1	F	C	
	2	16.	4	CFN	C	
	3	17.	2	FN	C	
	4	18.	4	F	C	
	5	19.	1	CF	C	
	6	20.	4	F	C	
	7	21.	2	FN	C	
	8	22.	3	FN	C	
	9	23.	2	FN	C	
	10	24.	1	F	C	
N	-	25.	2	F	F	*p*
	-	26.	3	C	F	
	-	27.	4	C	F	
	1	28.	4	FN	F	
	2	29.	2	CFN	F	
	3	30.	1	CN	F	
	4	31.	4	FN	F	
	5	32.	1	CN	F	
N	*6*	33.	3	N	F	
	7	34.	4	N	F	
	8	35.	1	N	F	
	9	36.	4	N	F	
	10	37.	2	N	F	
C	*1*	38.	3	CN	N	
	-	39.	1	N	N	*p*
	1	40.	4	CN	N	
	2	41.	1	CFN	N	
	3	42.	4	C	N	
	4	43.	3	C	N	
	5	44.	2	CN	N	
	-	45.	3	N	N	*p*
	1	46.	3	CF	N	
	2	47.	4	CF	N	
	3	48.	3	CN	N	
	4	49.	2	CN	N	
	5	50.	3	C	N	
	6	51.	4	C	N	
	7	52.	2	CF	N	
	8	53.	1	C	N	
	9	54.	2	C	N	
	10	55.	4	C	N	
F	-	56.	2	C	C	*p*
	-	57.	2	N	C	
	1	58.	1	FN	C	
	2	59.	3	FN	C	
	-	60.	2	CN	C	
	1	61.	2	F	C	
	2	62.	3	CFN	C	
	3	63.	1	CF	C	
	4	64.	3	F	C	

Response Deck 2

Sorting Principle	Correct Seq. Number	Card Number	Column Sorted To	Categories Matched	Perseverative Principle	Perseverative Response
F	*5*	1.	1	FN	C	
	6	2.	3	F	C	
	7	3.	1	F	C	
	8	4.	4	F	C	
	9	5.	2	CF	C	
	10	6.	3	CF	C	
N	-	7.	1	F	F	*p*
	1	8.	3	N	F	
	2	9.	4	N	F	
	3	10.	2	N	F	
	4	11.	1	N	F	
	5	12.	3	N	F	
	6	13.	2	N	F	
	7	14.	1	N	F	
	8	15.	3	N	F	
	9	16.	4	CFN	F	
	10	17.	2	FN	F	
		18.				
		19.				
		20.				
		21.				
		22.				
		23.				
		24.				
		25.				
		26.				
		27.				
		28.				
		29.				
		30.				
		31.				
		32.				

Sorting Principle	Correct Seq. Number	Card Number	Column Sorted To	Categories Matched	Perseverative Principle	Perseverative Response
		33.				
		34.				
		35.				
		36.				
		37.				
		38.				
		39.				
		40.				
		41.				
		42.				
		43.				
		44.				
		45.				
		46.				
		47.				
		48.				
		49.				
		50.				
		51.				
		52.				
		53.				
		54.				
		55.				
		56.				
		57.				
		58.				
		59.				
		60.				
		61.				
		62.				
		63.				
		64.				

End of Report

8146

The Dot Counting Test

RECORD FORM

WPS

Kyle Boone, Ph.D.
Po Lu, Psy.D., and
David S. Herzberg, Ph.D.

Examinee Name: Timothy Jones JR

ID Number: 12-20-1981

Date of Testing: 2-22-2019 Age: 37

Gender: ☐ Female ☒ Male Years of Education Completed: 16

Race/Ethnicity: ☐ American Indian/Alaska Native ☐ Asian ☐ Black/African American ☐ Hispanic/Latino ☐ Native Hawaiian/Pacific Islander ☒ White ☐ Other

Other Background Information/Notes: Injury

Read aloud the following instructions to the examinee:

I'm going to show you cards with dots on them. I want you to count the dots as quickly as you can and then tell me your answer.

Fill in the boxes below during administration. See instructions in chapter 2 of the *Dot Counting Test Manual*.

Card	Correct Count	Examinee Count	Error?	Response Time (sec)
1	11	11	-0	5
2	19	18	-1 ✓	9
3	15	15	-0	6
4	23	22	-1 ✓	8
5	27	28	-1 ✓	20
6	7	7	-0	3
7	12	12	-0	1
8	20	20	-0	1
9	16	16	-0	5
~~10~~	~~24~~	illegible	illegible	illegible
11	28	illegible	illegible	illegible
12	8			

Scoring Instructions

1. Count the number of check marks in the *Error?* column and enter the count in the space below labeled *Total Errors*.
2. Sum the Response Times for Cards 1 through 6 and enter this total in the space below labeled Cards *1-6 Total Response Time*. Divide this total by 6. Enter the result in the space labeled *Mean UG Time*.
3. Sum the Response Times for Cards 7 through 12 and enter this total in the corresponding space below. Divide this total by 6. Enter the result in the space labeled *Mean G Time*.
4. Calculate the E-score by summing Total Errors, Mean UG Time, and Mean G Time, then rounding the result to the nearest whole number by applying the following rules:
   - If the first digit to the right of the decimal point is 4 or less, round *down* to the nearest whole number (e.g., 6.23 rounds to 6).
   - If the first digit to the right of the decimal point is 5, round to the nearest *even* whole number (e.g., 6.51 rounds to 6, but 7.51 rounds to 8).
   - If the first digit to the right of the decimal point is 6 or greater, round *up* to the nearest whole number (e.g., 6.78 rounds to 7).
5. Enter the rounded sum in the box labeled *E-score*.

101 ÷ 6 = 16.83
Cards 1-6 Total Response Time — Mean UG Time

14 ÷ 6 = 2.33
Cards 7-12 Total Response Time — Mean G Time

3 + 16.83 + 2.33 = ~~23~~ 22.163
Total Errors + Mean UG Time + Mean G Time = E-Score

The following values are filled in during interpretation. Please consult chapter 4 of the *Dot Counting Test Manual* for detailed instructions.

Comparison Group: Traumatic / Head Inj

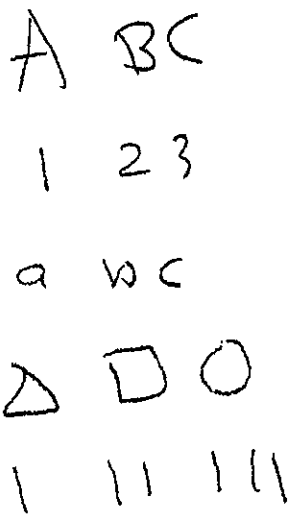
E-Score Cutoff: 20 Base Rate: 15%

Sensitivity: illegible Specificity: illegible

PPA: illegible NPA: illegible

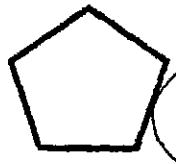
Interpretive Range: illegible

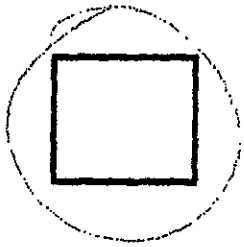
[redacted]

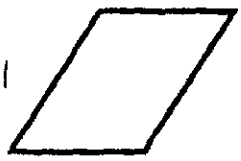
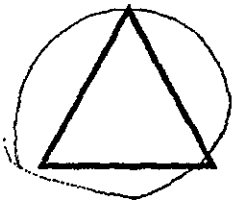


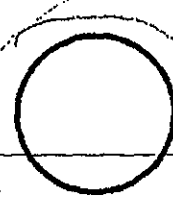
8148

d  II B 5 c

A III e  2 —

  6 1 F a

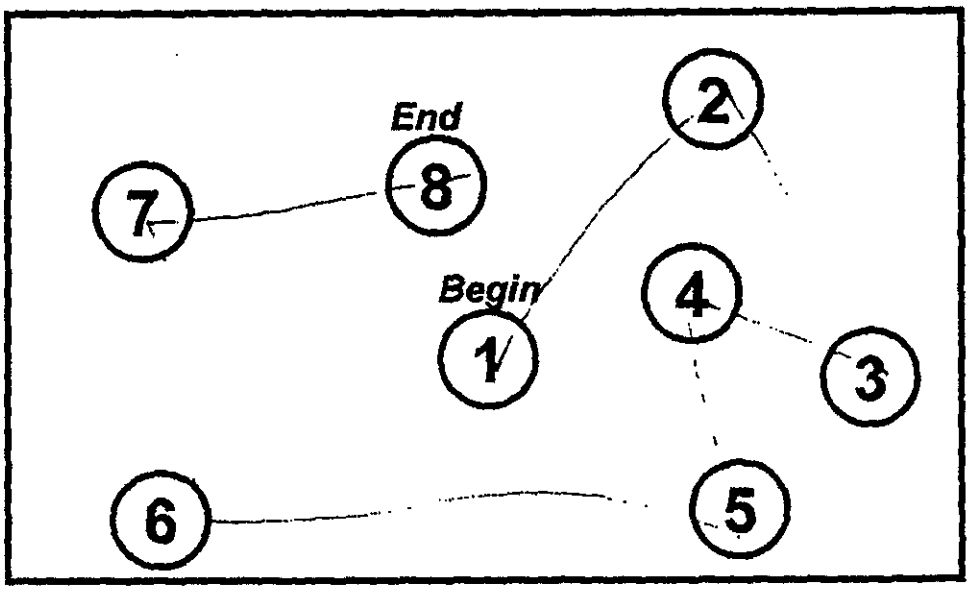
 4 C b  D

I E f =  3

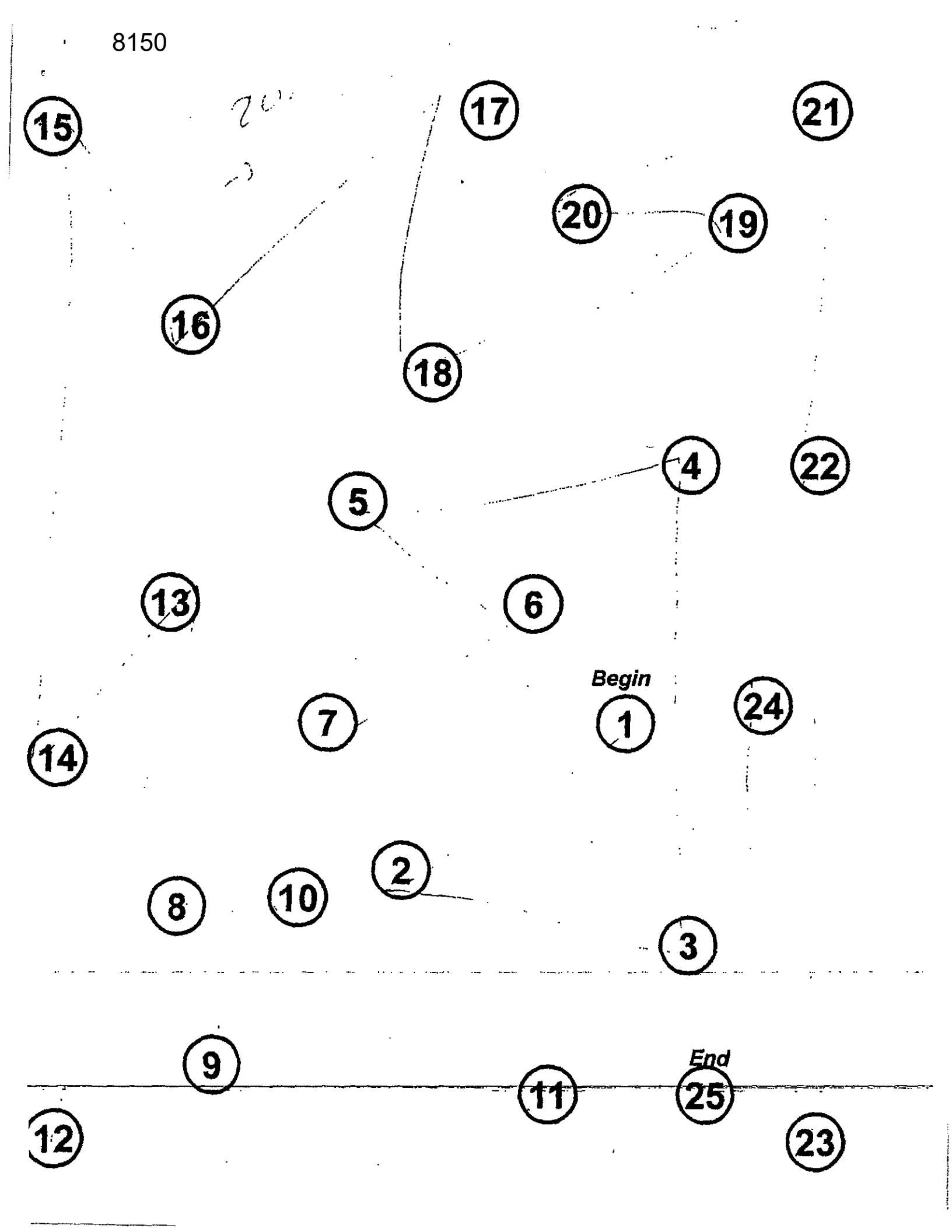
TRAIL MAKING

Part A

SAMPLE



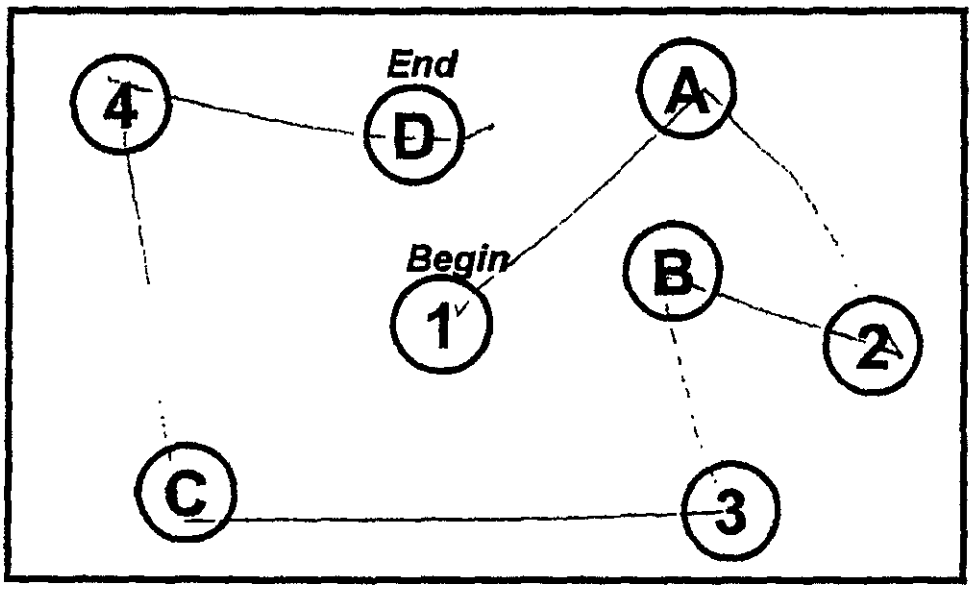
8150



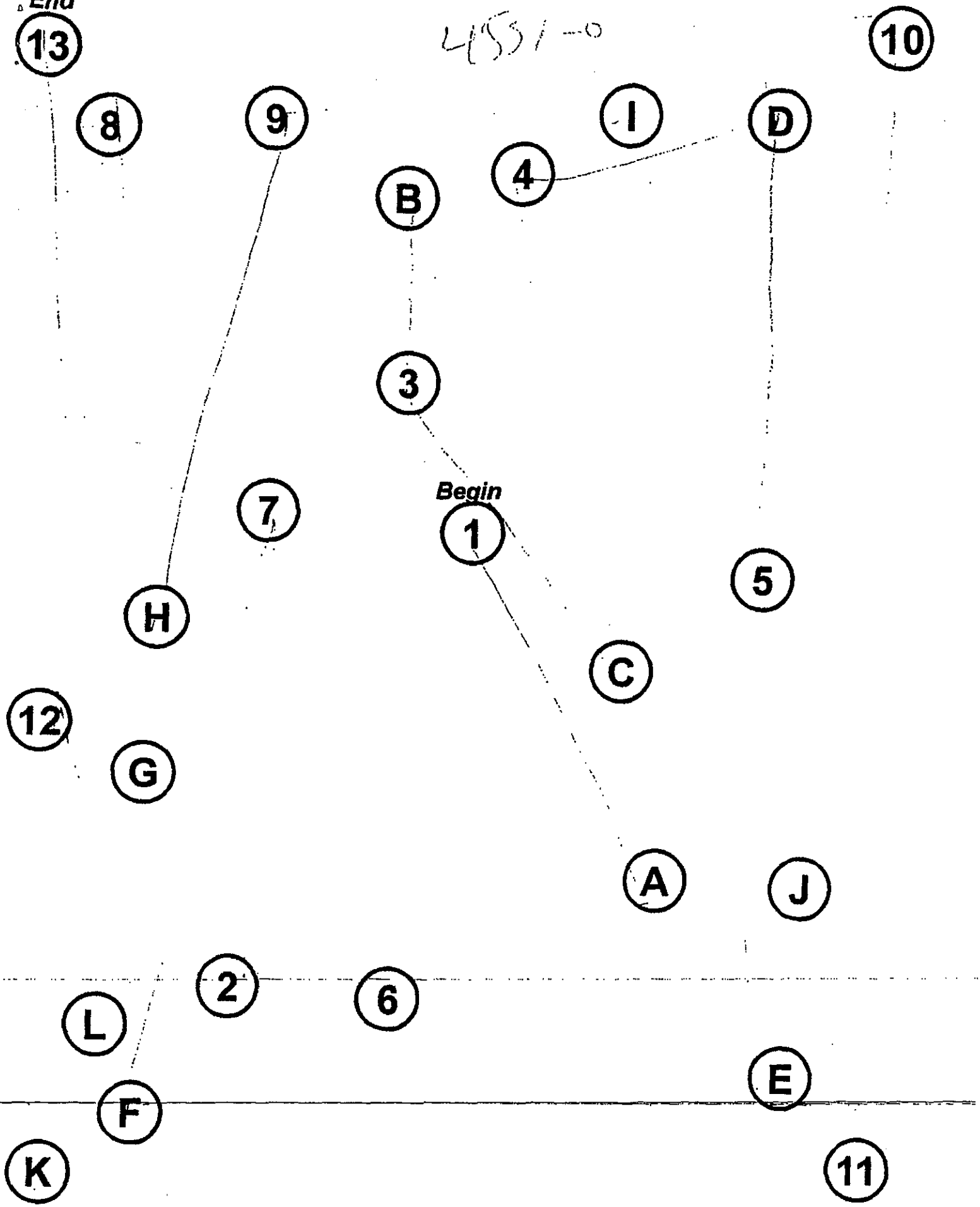
TRAIL MAKING

Part B

SAMPLE



8152



STATE OF SOUTH CAROLINA)	**IN THE COURT OF GENERAL SESSIONS**
)	
COUNTY OF LEXINGTON)	
THE STATE,)	**INSTRUCTIONS**
)	**2015-GS-32-188**
)	**2015-GS-32-189**
TIMOTHY RAY JONES, JR)	**2015-GS-32-190**
Defendant.)	**2015-GS-32-191**
)	**2015-GS-32-192**

1. Preliminary Instructions

   a. Introduction
   b. Court: Instructor of the Law
   c. Jury: Finder of the Facts/Witness Credibility
   d. Prior record of witness
   e. Weighing the Evidence
   f. Circumstantial/Direct Evidence
   g. Expert witness testimony
   h. Voluntariness of Statements
   i. Burden of Proof
   j. Reasonable Doubt
   k. Criminal Intent
   l. Copy of Jury Instructions

2. Specific Law of the Case
   a. Murder
   b. Defense-NGRI
   c. Burden of Proof
   d. Verdict forms
   e. Involuntary Intoxication
   f. Voluntary Intoxication
   g. Accident
   h. Consequences of verdict

3. Failure of Defendant to Testify – Defendant's Right to Remain Silent

4. Conclusion and verdict form

INSTRUCTIONS

MEMBERS OF THE JURY, THE STATE OF SOUTH CAROLINA CHARGES THE DEFENDANT, TIMOTHY R. JONES, JR, WITH THE CRIME OF MURDER. YOU WILL OF COURSE BEAR IN MIND THAT THE DEFENDANT HAS PLED NOT GUILTY BY REASON OF INSANITY, AND BY THAT PLEA, Mr. Jones DENIES THE CHARGEs ALLEGED IN THE INDICTMENTS. Defense would request that this language be struck.

THE DEFENDANT COMES INTO THIS COURT CLOTHED WITH A PRESUMPTION OF INNOCENCE, AND THIS PRESUMPTION OF INNOCENCE CONTINUES THROUGHOUT THE CASE AND ENTITLES THE DEFENDANT TO A VERDICT OF NOT GUILTY UNLESS AND UNTIL IT IS DISPELLED BY EVIDENCE SATISFYING YOU, THE JURY, BEYOND A REASONABLE DOUBT THAT THE DEFENDANT IS GUILTY OF THE OFFENSEs CHARGED, AND THE STATE HAS PROVED EACH AND EVERY ELEMENT OF THE ALLEGED CRIMEs BEYOND A REASONABLE DOUBT.

THE COURT: INSTRUCTOR OF THE LAW

THE SAME CONSTITUTION AND LAW WHICH MAKES YOU, THE JURY, THE FINDERS OF THE FACTS AND THE EVIDENCE AS I HAVE DISCUSSED WITH YOU, MAKES ME, AS THE JUDGE, THE SOLE AND

ONLY INSTRUCTOR OF THE LAW. YOU MUST ACCEPT AS CORRECT THE LAW WHICH I INSTRUCT AND APPLY TO IT THE EVIDENCE, AS YOU FIND IT, AND REACH A VERDICT.

IF I SHOULD MAKE AN ERROR IN THE LAW AS I INSTRUCT IT TO YOU, THERE IS ANOTHER TIME AND PLACE WHERE THAT ERROR CAN BE CONSIDERED AND, IF NECESSARY, CORRECTED. Defense believes that this statement is a violation of the rules against talking about possible appeals and shouldn't be given – see State v. Linder, 276 S.C. 304 (1981) and Caldwell v. Mississippi, 472 U.S. 320 (1985). BUT FOR THE PURPOSE OF THIS CASE TODAY, Defense would request that this language be struck as above. YOU MUST ACCEPT THE LAW AS I INSTRUCT IT. AND IN THAT REGARD, I TELL YOU THAT NEITHER YOU, NOR I, FOR THAT MATTER, SHOULD BE CONCERNED ABOUT WHAT WE BELIEVE OR THINK THE LAW OUGHT TO BE, BUT ONLY CONCERN YOURSELVES WITH WHAT I INSTRUCT YOU THE LAW TO IN FACT BE.

JURY: JUDGE OF FACTS AND CREDIBILITY OF WITNESSES

UNDER THE CONSTITUTION AND LAWS OF SOUTH CAROLINA, YOU ARE THE SOLE FINDERS OF THE FACTS IN THIS CASE. I AM NOT ALLOWED TO SUGGEST IN ANY WAY WHAT I MAY THINK

ABOUT THE GUILT OR INNOCENCE OF THE DEFENDANT.

YOU ALSO ARE THE JUDGES OF THE CREDIBILITY AND BELIEVABILITY OF THE WITNESSES WHO HAVE TESTIFIED IN THIS CASE. IN PASSING UPON THEIR CREDIBILITY YOU MAY TAKE INTO CONSIDERATION MANY THINGS, SUCH AS:

-- WHAT WAS THE MANNER AND APPEARANCE OF THE WITNESS WHO TESTIFIED? WAS HE OR SHE STRAIGHT FORWARD, OR WAS HE OR SHE HESITANT IN ANSWERING? Defense requests this language be struck. "Hesitant" in answering should not be considered in assessing credibility of a witness. "Reluctance" or "evasiveness" would be more appropriate.

-- HOW DID THE WITNESS COME TO KNOW THE FACTS THAT HE OR SHE TESTIFIED TO? OR WHAT WAS HIS OR HER ABILITY TO KNOW THESE FACTS?

-- IS THERE SOME REASON A WITNESS WOULD WANT TO GIVE TESTIMONY WHICH WOULD HELP OR HURT ONE SIDE OR THE OTHER? IN OTHER WORDS, WAS THE WITNESS BIASED OR PREJUDICED?

--AND, WAS THE TESTIMONY OF A WITNESS STRENGTHENED OR WEAKENED BY OTHER TESTIMONY OR EVIDENCE?

YOU – THE JURY – MAY BELIEVE AS MUCH OR AS LITTLE OF EACH WITNESS' TESTIMONY AS YOU THINK PROPER. YOU MAY BELIEVE THE TESTIMONY OF A SINGLE WITNESS AGAINST THAT OF MANY WITNESSES, OR JUST THE OPPOSITE.

YOU MAY BELIEVE PART OF A WITNESS'S TESTIMONY AND DISBELIEVE THE REST.

THE FACT THAT TESTIMONY IS NOT CONTROVERTED DOES NOT MEAN YOU MUST ACCEPT IT AS TRUE AND UNDISPUTED. YOU STILL MUST GAUGE THE CREDIBILITY OF THE WITNESS TO DETERMINE THE BELIEVABILITY OR TRUTH OF THE FACTS OFFERED THROUGH THE TESTIMONY.

PRIOR RECORD OF WITNESS

A PERSON WHO HAS A PAST CRIMINAL RECORD IS COMPETENT TO TESTIFY DURING A TRIAL. A PAST RECORD DOES NOT AFFECT THE ABILITY OF THAT WITNESS TO TESTIFY. THE PAST RECORD MAY ONLY BE CONSIDERED BY YOU, IF AT ALL, IN DETERMINING THE WITNESS' BELIEVABILITY.

REMEMBER, YOU ARE THE SOLE JUDGES OF THE FACTS IN THE CASE AND OF THE BELIEVABILITY OF ANY AND ALL OF THE WITNESSES.

WEIGHING THE EVIDENCE

AS THE SOLE FACT FINDERS, YOU SHOULD HAVE LISTENED CLOSELY TO THE EVIDENCE PRESENTED. WEIGHING THE EVIDENCE IS ENTIRELY A MENTAL PROCESS. YOU MUST WEIGH THE EVIDENCE USING YOUR GOOD JUDGMENT AND COMMON SENSE.

DIRECT/CIRCUMSTANTIAL EVIDENCE

THERE ARE TWO TYPES OF EVIDENCE WHICH ARE GENERALLY PRESENTED DURING A TRIAL – DIRECT AND CIRCUMSTANTIAL EVIDENCE.

DIRECT EVIDENCE IS THE TESTIMONY OF A PERSON WHO ASSERTS OR CLAIMS TO HAVE ACTUAL KNOWLEDGE OF A FACT, SUCH AS AN EYEWITNESS. CIRCUMSTANTIAL EVIDENCE IS PROOF OF A CHAIN OF FACTS AND CIRCUMSTANCES INDICATING THE EXISTENCE OF A FACT. THE LAW MAKES ABSOLUTELY NO DISTINCTION BETWEEN THE WEIGHT OR VALUE TO BE GIVEN TO EITHER DIRECT OR CIRCUMSTANTIAL EVIDENCE. Defense requests that this language be struck. The law unequivocally makes a distinction in the value of direct and circumstantial evidence. NOR IS A GREATER DEGREE OF CERTAINTY REQUIRED OF CIRCUMSTANTIAL

EVIDENCE THAN OF DIRECT EVIDENCE. YOU SHOULD WEIGH ALL THE EVIDENCE IN THE CASE.

YOU SHOULD WEIGH ALL THE EVIDENCE IN THE CASE. HOWEVER, TO THE EXTENT THE STATE RELIES UPON CIRCUMSTANTIAL EVIDENCE, ALL OF THE CIRCUMSTANCES MUST BE CONSISTENT WITH EACH OTHER, AND WHEN TAKEN TOGETHER, POINT CONCLUSIVELY TO THE GUILT OF THE ACCUSED BEYOND A REASONABLE DOUBT. IF THESE CIRCUMSTANCES MERELY PORTRAY THE DEFENDANT'S BEHAVIOR AS SUSPICIOUS, THE PROOF HAS FAILED. AFTER WEIGHING ALL THE EVIDENCE, WHETHER DIRECT EVIDENCE OR CIRCUMSTANTIAL EVIDENCE OR SOME COMBINATION OF THE TWO, IF YOU ARE NOT CONVINCED OF THE GUILT OF THE DEFENDANT BEYOND A REASONABLE DOUBT, YOU MUST FIND THE DEFENDANT NOT GUILTY or not guilty by reason of insanity.

EXPERT WITNESSES

THE RULES OF EVIDENCE ORDINARILY DO NOT PERMIT WITNESSES TO TESTIFY TO OPINIONS OR CONCLUSIONS. AN EXCEPTION TO THIS RULE EXISTS FOR WITNESSES WE CALL "EXPERT WITNESSES". A WITNESS WHO, BY EDUCATION AND

EXPERIENCE, HAS BECOME EXPERT IN SOME ART, SCIENCE, PROFESSION, OR CALLING MAY STATE AN OPINION AS TO RELEVANT AND MATERIAL MATTER, IN WHICH THE WITNESS CLAIMS TO BE AN EXPERT, AND MAY ALSO STATE THE REASONS FOR THE OPINION.

YOU SHOULD CONSIDER ANY EXPERT OPINION RECEIVED IN EVIDENCE IN THIS CASE AND, LIKE ANY OTHER EVIDENCE, GIVE IT THE WEIGHT YOU THINK IT DESERVES. IF YOU DECIDE THAT THE OPINION OF AN EXPERT WITNESS IS NOT BASED ON SUFFICIENT EDUCATION AND EXPERIENCE [The defense believes this language should be struck. The Court has qualified witnesses in this case as experts. Jurors may not determine expertise on their own, they are required to accept the Court's finding that a witness is an expert], OR IF YOU CONCLUDE THAT THE REASONS GIVEN IN SUPPORT OF THE OPINION ARE NOT SOUND, OR THAT THE OPINION IS OUTWEIGHED BY OTHER EVIDENCE, YOU MAY DISREGARD THE OPINION ENTIRELY. AN EXPERT WITNESS' TESTIMONY IS TO BE GIVEN NO GREATER WEIGHT THAN THAT OF OTHER WITNESSES SIMPLY BECAUSE THE WITNESS IS AN EXPERT. FURTHER, YOU ARE NOT REQUIRED TO ACCEPT AN EXPERT'S OPINION, EVEN THOUGH IT IS

NOT CONTRADICTED.

BURDEN OF PROOF

IN A CRIMINAL PROSECUTION, THE STATE HAS THE BURDEN OF PROOF. IN THIS STATE, ACCORDING TO OUR CONSTITUTION, THE PROSECUTION MUST PROVE THEIR CASE TO THE STANDARD OF PROOF BEYOND A REASONABLE DOUBT BEFORE A FINDING OF GUILT MAY OCCUR. IF THE STATE FAILS TO MEET THIS HIGH BURDEN, THE DEFENDANT IS ENTITLED TO A VERDICT OF NOT GUILTY or not guilty by reason of insanity. NORMALLY THE DEFENSE HAS NO BURDEN BECAUSE OF THIS PRESUMTION, Presumption of innocence? BUT IN THIS CASE Mr. Jones has entered a plea of NOT GUILTY BY REASON OF INSANITY. THE DEFENSE HAS THE BURDEN OF PROVING THIS DEFENSE. THE BURDEN OF PROOF of this defense IS BY THE GREATER WEIGHT OF THE EVIDENCE OR PREPONDERANCE OF THE EVIDENCE.

REASONABLE DOUBT

WHAT IS A REASONABLE DOUBT? IT IS SIMPLY THIS: A REASONABLE DOUBT IS THE KIND OF DOUBT THAT WOULD CAUSE A REASONABLE PERSON TO HESITATE TO ACT.

REASONABLE DOUBT MAY ARISE FROM EVIDENCE WHICH IS

IN THE CASE, OR FROM THE LACK OR ABSENCE OF EVIDENCE IN THE CASE. PROOF BEYOND A REASONABLE DOUBT IS PROOF THAT LEAVES YOU FIRMLY CONVINCED OF THE DEFENDANT'S GUILT [The defense believes this sentence should be the first sentence of the paragraph]. IT IS A DOUBT TO WHICH ONE CAN ASSIGN A REASON, IF THE ASSIGNMENT CAN BE DONE REASONABLY, FIRMLY, AND CONVINCINGLY. A REASONABLE DOUBT IS THE KIND OF DOUBT THAT WOULD MAKE A REASONABLE, CONSCIENTIOUS, and HONEST PERSON HESISTATE TO ACT IN A MATTER IMPORTANT TO HIS or her OWN AFFAIRS.

I FURTHER CHARGE YOU THAT A DEFENDANT IS ENTITLED TO EVERY REASONABLE DOUBT THAT MAY ARISE IN THE CASE. WHAT THAT MEANS IS SIMPLY THIS: IF ANY OF YOU HAVE HAD A DOUBT ABOUT ANYTHING DURING THIS TRIAL, YOU WOULD BE REQUIRED TO RESOLVE THAT DOUBT IN FAVOR OF THE DEFENDANT.

THE VERY FACT, HOWEVER, THAT THE JURY ENGAGES IN A FULL AND FREE DISCUSSION OF THE ISSUE OF GUILT OR NON-GUILT or not guilty by reason of insanity IN THIS CASE DOES NOT AUTOMATICALLY MEAN THAT REASONABLE DOUBT EXISTS IN THIS CASE. YOU MUST MAKE THE DETERMINATION OF WHETHER OR

NOT REASONABLE DOUBT EXISTS AS TO THE GUILT OF THE DEFENDANT. IF YOU FIND THAT THE STATE HAS NOT MET THE BURDEN OF PROOF BEYOND A REASONABLE DOUBT, THE DEFENDANT IS ENTITLED TO A VERDICT OF NOT GUILTY or not guilty by reason of insanity.

CRIMINAL INTENT

CRIMINAL INTENT IS A NECESSARY ELEMENT OF EACH CRIME THAT MUST BE PROVED BY THE STATE BEYOND A REASONABLE DOUBT.

CRIMINAL INTENT IS ALWAYS A MATTER THAT MUST BE DETERMINED BY THE JURY FROM THE CIRCUMSTANCES SURROUNDING THE SITUATION. THERE IS NO WAY TO PROVE INTENT TO A MATHEMATICAL CERTAINTY. THERE IS NO WAY MEDICAL SCIENCE CAN DISSECT A PERSON'S BRAIN AND DETERMINE WHAT HE OR SHE HAD IN MIND, SO THE LAW STATES CRIMINAL INTENT MAY BE INFERRED FROM THE CIRCUMSTANCES SHOW TO HAVE EXISTED, BOTH BEFORE AND AFTER THE FACT. THIS IS HOW YOU, THE JURY, MAKES A DETERMINATION OF WHETHER OR NOT THE REQUESITE INTENT WAS PRESENT.

CRIMINAL INTENT IS A STATE OF MIND THAT OPERATES

JOINTLY WITH AN ACT OR OMISSION IN THE COMMISSION OF A CRIME. CRIMINAL INTENT IS A MENTAL STATE OF CONSCIOUS WRONGDOING SO IT IS UP TO YOU, THE JURY, TO DETERMINE WHAT THE DEFENDANT INTENDED TO DO BASED ON THE CIRCUMSTANCES SHOWN TO HAVE EXISTED. I TELL YOU THAT THE STATE MUST PROVE CRIMINAL INTENT BEYOND A REASONABLE DOUBT JUST AS THE STATE MUST PROVE EVERY ELEMENT BEYOND A REASONABLE DOUBT.

COPY OF CHARGE IN THE JURY ROOM[1]

I WILL GIVE YOU A COPY OF THESE INSTRUCTIONS. DURING YOUR DELIBERATIONS, YOU MAY REFER TO THE INSTRUCTIONS TO GUIDE YOUR DECISION-MAKING. YOU MUST CONSIDER THE INSTRUCTIONS AS A WHOLE AND NOT FOLLOW SOME AND IGNORE OTHERS.

SPECIFIC LAW OF THE CASE

MURDER

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[1] Pursuant to S.C. Code Ann. § 16-3-20, a copy of the jury instructions on statutory aggravating and mitigating circumstances must be given to the jury in writing in capital cases. In non-capital cases, upon request by the jury and consent of the parties, the jury may be given written, or other form of, Defense request this language not be included in copy provided to jury. instructions

Mr. Jones IS CHARGED WITH five counts of MURDER. For each indictment THE STATE MUST PROVE BEYOND A REASONABLE DOUBT THAT Mr. Jones KILLED ANOTHER PERSON WITH MALICE AFORETHOUGHT. The state must prove all of these elements for each of the counts of murder beyond reasonable doubt. The elements are: Killing of another person with malice aforethought. MALICE IS HATRED, ILLWILL, OR HOSTILITY TOWARDS ANOTHER PERSON. IT IS THE INTENTIONAL DOING OF A WRONGFUL ACT WITHOUT JUST CAUSE OR EXCUSE AND WITH AN INTENT TO INFLICT AN INJURY OR UNDER CIRCUMSTANCES THAT THE LAW WILL INFER AN EVIL INTENT.

MALICE AFORETHOUGHT DOES NOT REQUIRE THAT MALICE EXISTS FOR ANY PARTICULAR TIME BEFORE THE ACT IS COMMITTED, BUT MALICE MUST EXIST IN THE MIND OF THE DEFENDANT JUST BEFORE AND AT THE TIME OF THE ACT IS COMMITTED. THEREFORE, THERE MUST BE A COMBINATION OF THE PREVIOUS EVIL INTENT AND THE ACT.

MALICE AFORETHOUGHT MAY BE EXPRESS OR INFERRED. THESE TERMS, "EXPRESS" AND "INFERRED" DO NOT MEAN DIFFERENT KINDS OF MALICE BUT MERELY THE MANNER IN WHICH MALICE

MAY BE SHOWN TO EXIST. THAT IS EITHER BY DIRECT EVIDENCE OR BY INFERENCE FROM THE FACTS AND CIRCUMSTANCES WHICH ARE PROVED. EXPRESS MALICE MAY BE SHOWN WHEN A PERSON SPEAKS WORDS WHICH EXPRESS HATRED OR ILL WILL FOR ANOTHER OR WHEN THE PERSON PREPARED BEFOREHAND TO DO THE ACT WHICH WAS LATER ACCOMPLISHED; FOR EXAMPLE, LYING IN WAIT FOR A PERSON OR ANY OTHER ACTS OF PREPARATION GOING TO SHOW THAT THE DEED WAS WITHIN THE DEFENDANT'S MIND WOULD [The defense requests that this word be changed to "could"] BE an example of EXPRESS MALICE.[421] MALICE MAY BE INFERRED FROM CONDUCT SHOWING A TOTAL DISREGARD FOR HUMAN LIFE.

NGRI-

THE DEFENDANT HAS RAISED THE DEFENSE OF INSANITY. CRIMINAL INTENT IS REQUIRED TO PROVE THAT THE DEFENDANT

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[41] When giving examples, be sure they do not constitute a charge on the facts of the case. State v. Hughey, 339 S.C. 439, 529 S.E.2d 721 (2000), overruled on other grounds, Rosemond v. Catoe, 383 S.C. 320, 680 S.E.2d 5 (2009).

IS GUILTY OF THE CRIME CHARGED. A PERSON WHO IS INSANE CANNOT HAVE CRIMINAL INTENT AND, THEREFORE, CANNOT BE FOUND GUILTY OF A CRIME.

IN ORDER TO BE FOUND NOT GUILTY BY REASON OF INSANITY, IT MUST BE SHOWN THAT, AT THE TIME OF THE CRIME, THE DEFENDANT HAD A MENTAL DISEASE OR DEFECT WHICH MADE HIM UNABLE TO DISTINGUISH MORAL OR LEGAL RIGHT FROM WRONG OR TO RECOGNIZE THE CRIME AS MORALLY OR LEGALLY WRONG.

BY RAISING THE DEFENSE OF INSANITY, THE DEFENDANT DOES NOT NECESSARILY ADMIT THE CRIME WAS COMMITTED. [The defense requests that the instructions state that the defendant does admit the acts were committed]. THE STATE MUST STILL PROVE BEYOND A REASONABLE DOUBT THAT THE DEFENDANT COMMITTED THE CRIME. HOWEVER, THE DEFENDANT MUST PROVE INSANITY BY A PREPONDERANCE OF THE EVIDENCE. A PREPONDERANCE OF THE EVIDENCE SIMPLY MEANS THE GREATER WEIGHT OF THE EVIDENCE, OR MORE LIKELY THAN NOT.

IF YOU FIND THERE IS EVIDENCE IN THE RECORD THAT AT THE TIME THE CRIME WAS ALLEGEDLY COMMITTED, IT IS MORE

LIKELY THAN NOT THAT, BECAUSE OF A MENTAL DISEASE OR DEFECT, THE DEFENDANT DID NOT KNOW THE ALLEGED CRIME WAS MORALLY OR LEGALLY WRONG, THE STATE MUST THEN PROVE BEYOND A REASONABLE DOUBT THAT THE DEFENDANT WAS SANE. Defense's position is that if the jury finds that the defense has shown by a preponderance of the evidence that he is NGRI then the jury must find him Not Guilty by Reason of Insanity. As discussed in the verdict forms.

IT IS FOR YOU TO DECIDE WHAT THE STATE OR CONDITION OF THE DEFENDANT'S MIND WAS AT THE TIME THE ALLEGED CRIME WAS COMMITTED.

INSANITY CAUSED BY THE USE OF DRUGS OR ALCOHOL MAY BE A DEFENSE IF THE INSANITY IS PERMANENT AND DESTROYS THE DEFENDANT'S ABILITY TO KNOW RIGHT FROM WRONG.[738] I agree that this is what that case says, however I believe that the appropriate standard is that where the voluntary intoxication causes a permanent brain defect of disease Insanity may be considered, but there is no such thing as permanent insanity, in the legal context, there may be people rendered permanently mentally ill, but not permanent insanity.

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[78] State v. Hartfield, 300 S.C. 469, 388 S.E.2d 802 (1990).

HOWEVER, WHEN VOLUNTARY INTOXICATION HAS NOT PRODUCED PERMANENT INSANITY permanent brain defect or disease, IT IS NOT A DEFENSE TO THE CRIME. A PERSON WHO VOLUNTARILY BECOMES INTOXICATED IS JUST AS RESPONSIBLE FOR THE ACTS COMMITTED WHILE INTOXICATED AS IF THE PERSON WERE NOT INTOXICATED.[749]

THERE ARE FOUR POSSIBLE VERDICTS YOU MAY RETURN IN THIS CASE.[850]

ONE: IF YOU HAVE ANY REASONABLE DOUBT AS TO THE DEFENDANT'S GUILT AFTER CONSIDERING ALL THE EVIDENCE, THEN YOU MUST FIND THE DEFENDANT NOT GUILTY.

TWO: IF YOU HAVE NO REASONABLE DOUBT THAT THE DEFENDANT COMMITTED THE CRIME, BUT YOU FIND THAT IT IS MORE LIKELY THAN NOT THAT, BECAUSE OF A MENTAL DISEASE OR DEFECT, THE DEFENDANT COULD NOT DISTINGUISH MORAL OR LEGAL RIGHT FROM WRONG OR RECOGNIZE THE CRIME AS

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[79] State v. Crocker, 272 S.C. 344, 251 S.E.2d 764 (1979); State v. Vaughn, 268 S.C. 119, 232 S.E.2d 328 (1977).

[80] If there is evidence of insanity or a mental disease or defect, the trial judge must submit not guilty by reason of insanity, guilty but mentally ill, guilty, and not guilty verdict to the jury. State v. Rimert, 315 S.C. 527, 446 S.E.2d 400 (1994); S.C. Code Ann. § 17-24-30.

MORALLY OR LEGALLY WRONG, YOU MUST FIND THE DEFENDANT NOT GUILTY BY REASON OF INSANITY.

THREE: IF YOU HAVE NO REASONABLE DOUBT THAT THE DEFENDANT COMMITTED THE CRIME, AND THAT THE DEFENDANT HAD THE MENTAL CAPACITY TO DISTINGUISH MORAL OR LEGAL RIGHT FROM WRONG OR RECOGNIZE THE CRIME AS MORALLY OR LEGALLY WRONG, BUT YOU FIND THAT IT IS MORE LIKELY THAN NOT, BECAUSE OF A MENTAL DISEASE OR DEFECT, THE DEFENDANT COULD NOT FOLLOW THE LAW, YOU MUST FIND THE DEFENDANT GUILTY BUT MENTALLY ILL.

AS WITH INSANITY, THE DEFENDANT HAS THE BURDEN OF PROVING THAT HE (SHE) IS GUILTY BUT MENTALLY ILL BY A PREPONDERANCE OF THE EVIDENCE.

FOUR: THE FINAL POSSIBLE VERDICT IN THIS CASE IS GUILTY. YOU MAY ONLY FIND THE DEFENDANT GUILTY IF THE STATE HAS PROVED BEYOND A REASONABLE DOUBT THAT THE DEFENDANT COMMITTED THE CRIME, THAT THE DEFENDANT WAS ABLE TO DISTINGUISH MORAL AND LEGAL RIGHT FROM WRONG AND TO RECOGNIZE THE CRIME AS MORALLY AND LEGALLY WRONG, AND THAT THE DEFENDANT WAS ABLE TO FOLLOW THE LAW.

STATEMENT OF DEFENDANT

A STATEMENT ALLEGED TO HAVE BEEN MADE BY THE DEFENDANT HAS BEEN ADMITTED INTO EVIDENCE IN THIS CASE. WHILE THE COURT HAS DETERMINED THAT THE STATEMENT IS ADMISSIBLE, I INSTRUCT YOU THAT YOU MAKE THE ULTIMATE DECISION OF WHETHER OR NOT THE DEFENDANT MADE THE STATEMENT. IF THE DEFENDANT DID MAKE THE STATEMENT, YOU MUST DETERMINE WHETHER THE STATEMENT WAS MADE BY THE DEFENDANT VOLUNTARILY AND OF HIS OWN FREE WILL. THIS MEANS THAT THE STATEMENT WAS NOT CAUSED BY PRESSURE, FORCE, FEAR, THREATS, COERCION, OR INTIMIDATION, OR BY HOPE OR A PROMISE OF LENIENCY OR A REWARD OF ANY KIND. IN DETERMINING WHETHER THE STATEMENT WAS VOLUNTARY, YOU SHOULD CONSIDER BOTH THE CHARACTERISTICS OF THE DEFENDANT AND THE DETAILS OF THE QUESTIONING. SOME OF THE FACTORS THAT YOU MUST CONSIDER ARE: (1) THE AGE OF THE DEFENDANT; (2) THE DEFENDANT'S EDUCATION OR LACK OF EDUCATION; (3) THE DEFENDANT'S MENTAL ABILITY OR CAPACITY; (4) THE DEFENDANT'S I.Q. OR INTELLIGENCE; (5) THE DEFENDANT'S BACKGROUND AND ENVIRONMENT; (6) THE PLACE AND LENGTH OF

DETENTION; (7) THE NATURE OF THE QUESTIONING; AND (8) THE ADVICE, OR LACK THEREOF, TO THE DEFENDANT OF HIS (HER) CONSTITUTIONAL RIGHTS INCLUDING, BUT NOT LIMITED TO, THE RIGHT TO REMAIN SILENT; THAT ANY STATEMENT COULD BE USED AGAINST HIM (HER) IN A COURT OF LAW; THE RIGHT TO HAVE A LAWYER PRESENT; THAT IF HE (SHE) COULD NOT AFFORD A LAWYER, A LAWYER WOULD BE APPOINTED TO REPRESENT HIM (HER) WITHOUT ANY COST; AND THAT HE COULD STOP MAKING A STATEMENT AT ANY TIME. YOU MUST CAREFULLY CONSIDER ALL OF THE SURROUNDING CIRCUMSTANCES BEFORE YOU GIVE ANY WEIGHT TO AN ALLEGED STATEMENT.

THE STATE HAS THE BURDEN OF PROVING BEYOND A REASONABLE DOUBT THAT THE ALLEGED STATEMENT WAS VOLUNTARY. IF YOU DETERMINE IT WAS, YOU MAY GIVE THE STATEMENT ANY FURTHER CONSIDERATION THAT YOU DEEM PROPER. YOU MUST DECIDE WHAT WEIGHT, IF ANY, SHOULD BE GIVEN TO THE ALLEGED STATEMENT. IF YOU DETERMINE THE ALLEGED STATEMENT WAS NOT THE FREE AND VOLUNTARY STATEMENT OF THE DEFENDANT, YOU SHOULD NOT CONSIDER THE STATEMENT AT ALL.[6]

INVOLUNTARY MANSLAUGHTER

Defense has requested and my recollection is that the court agreed to give and involuntary manslaughter charge as to the indictment for Murder against Nahtahn.

ACCIDENT

THE DEFENDANT HAS RAISED THE DEFENSE OF ACCIDENT. As to the indictment of Murder against Nahtahn. AN ACT MAY BE EXCUSED ON THE GROUND OF ACCIDENT IF IT IS SHOWN THAT THE ACT WAS UNINTENTIONAL, THAT THE DEFENDANT WAS ACTING LAWFULLY, AND THAT REASONABLE CARE WAS USED BY THE DEFENDANT. THE BURDEN IS ON THE STATE TO PROVE BEYOND A REASONABLE DOUBT THAT ACT WAS NOT AN ACCIDENT BUT WAS CAUSED BY THE NEGLIGENCE OR CARELESSNESS ON THE PART OF THE DEFENDANT.

VOLUNTARY INTOXICATION

INSANITY CAUSE [should be "caused"]BY THE USE OF DRUGS OR ALCOHOL MAY BE A DEFENSE IF THE INSANITY IS PERMANENT AND DESTROYS THE DEFENDANT'S ABILITY TO KNOW RIGHT FROM WRONG.[971] Same argument as above. HOWEVER, WHEN VOLUNTARY

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[6] State v. Davis, 309 S.C. 326, 422 S.E.2d 133 (1992).

INTOXICATION HAS NOT PRODUCED PERMANENT INSANITY, IT IS NOT A DEFENSE TO A CRIME. A PERSON WHO VOLUNTARILY BECOMES INTOXICATED IS JUST AS RESPONSIBLE FOR THE ACTS COMMITTED WHILE INTOXICATED AS WHEN THE PERSON IS NOT INTOXICATED.[982]

Involuntary Intoxication

There are two types of intoxication, voluntary and involuntary. Involuntary intoxication may result from innocently consuming an intoxicant, through being tricked into it by another, or being forced to take it, or perhaps through unanticipated side effects of a prescription drug taken on orders of a physician.

If you find that the defendant experienced unanticipated effects from prescribed medication, and as a result, he lost his ability to exercise independent judgement and volition while committing the crimes alleged against him, then it would be your duty to find the defendant not guilty.

PUNISHMENT OR CONSEQUENCE

IN DETERMINING THE GUILT OR INNOCENCE OF THE DEFENDANT, You should not CONSIDER ANY POSSIBLE PENALTY or consequence of the verdict. Any consequence of any of the potential verdicts SHOULD NEVER BE CONSIDERED BY YOU IN ANY WAY

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[91] State v. Hartfield, 300 S.C. 469, 388 S.E.2d 802 (1990).

[92] State v. Crocker, 272 S.C. 344, 251 S.E.2d 764 (1979); State v. Vaughn, 268 S.C. 119, 232 S.E.2d 328 (1977).

Timothy Ray Jones, Jr.
Date of Birth: [redacted]
Dates of Evaluation: 9/13/14, 6/24/15, 4/18/16, 7/7/17, 5/8/19, 5/22/19
Date of Report: 5/29/19

Identifying Information: Mr. Jones is a 37-year-old male who has been charged with five counts of Murder in Lexington County. The victims were his children. He was referred for evaluation by his attorney, Boyd Young.

Role of Examiner: The undersigned evaluated Mr. Jones soon after his apprehension. She has served as a consultant to oversee Mr. Jones' treatment while he has been confined and to render opinions about his diagnosis. She has evaluated him six times over the past five years.

Sources of Information:

1. Interview case manager Tishiro Inabinet 9/14/14
2. DMH Competency to Stand Trial Evaluation 5/31/16
3. DMH Criminal Responsibility Evaluation 5/27/19
4. Review of Medical Imaging Examination Travis Snyder DO (skull fracture, hemorrhagic shearing, intraparenchymal hemorrhage, shearing injury, contusion and cortical thickening, hippocampal atrophy, thinning and irregularity of corpus callosum)
5. Neuropsychological Evaluation 4/19/16 Tora Brawley, Ph.D.
6. Review entitled Mental Illness in Discovery
7. Discovery Summary Part I
8. Discovery Summary Part 2
9. Recorded calls from Mr. Jones' telephone 10/5/13-2/7/14
10. Review testimony Dr. Snyder 5/21/19
11. Review Edited Video Cynthia Turner 5/21/19
12. Review DMH Report Kimberly. Kruse, Psy. D. 3/7/19
13. Interview Barry Sowards 5/8/19, 5/22/19
14. Correct Care Solutions records 5/6/19
15. Report Erin Bigler Ph.D. 2/28/19
16. Neuroscience Consulting Memorandum to NCI File 12/21/16, 11/3/17 Jonathan Lipman, Ph.D.
17. Telephone consultation Dr. Beverly Wood 5/22/19
18. Telephone consultation Nurse West 5/22/19 (Lexington Detention Center)
19. Report Dr. Julie Rand Dorney 4/26/19

Evaluation #1 9/13/14 (Kirkland Correctional Institution)
Others present: Boyd Young
Prior to the evaluation, the undersigned met with Mr. Jones' case manager, Tishiro Inabinet who reported that Mr. Jones had been evaluated by Dr. Wood and diagnosed with Psychosis Not Otherwise Specified (DSM-IV-TR). Dr. Wood reported that Mr. Jones had been involved in

two motor vehicle accidents. Mr. Inabinet reported Mr. Jones status was "mattress and blanket only."

At the time of his evaluation, Mr. Jones reported symptoms of auditory hallucinations. He stated the voices were "random." He reported there was more than one. He stated there were two or three and the voices were familiar to him. He stated they are: "my children, old friends, family and some people I don't know." He reported the voices engaged in "casual conversation." He stated they are worse when he is frightened or upset or argues with someone. He stated sometimes they talk about him. He stated to keep them quiet, he "sucks" his mind up with data to "turn the power off to their conversations." He stated they do bad things when he is scared. "That night they told me: 'I'm gonna get rid of them kids." He reported the older he gets, the stronger they get. He stated the voices have been present since he was aged twelve and he has "learned to live with it."

He endorsed delusional beliefs. He reported his son (Nahtahn, 6 years old) was "rigging electrical outlets" to kill himself or me. He stated he told Nahtahn too much about how they work. He stated he (Nahtahn) blew four outlets on the wall. He stated his son was taking the divorce out on himself, Mr. Jones and Amber, his mother. He stated the other children "could see the look on his face." He stated his son was very smart and had a "beyond normal fascination with electricity."

He also discussed saving his son Eli (7 years old) and his other children from prison sentences. He stated he (Eli) threatened to cut his mother up and feed her to the dog. Mr. Jones stated he could read nonverbal cues. He stated Nahtahn outsmarted him because there were no black marks on the four outlets. "I don't know how he did it. He outsmarted me." He stated Nahtahn could have sprayed something on them. He stated Nahtahn denied rigging the outlets. "The look in his eye told me it was not an accident...I could have sent him in front of a firing squad and he wouldn't tell...I wasn't doing nothing dad." He reported earlier in the day he "cracked his (Nahtahn's) ass with a belt. My Dad cracked my ass..it did me good" He reported he made him (Nahtahn) do PT that day...squats, pushups. They did "Insanity" together. He stated when he went to check on him in bed, he was not breathing. He reported: "the other voices took over. You better get their asses. They are gonna get you too. They are gonna think you killed (sic)."

He reported a history of drug use. He denied using drugs on the day of the offenses. "I did them after...It didn't quiet the voices." He stated he did "Scooby snax" on that Wednesday. He stated: "it is spice with mushrooms." He stated it helped him "shut the voices up." He also reported long term use of alcohol since the age of 12. He reported frequent marijuana use while growing up.

On mental status examination, he was alert and oriented. He had a labile affect. One time during the interview he yelled "Fuck." He cried during the interview. He had some difficulty concentrating (four of five serial subtractions). He was able to abstract similarities between simple objects, but not difficult objects. He performed well above average on a test of verbal fluency but had one episode of perseveration (n=23). He was able to register three items and recall them correctly after five minutes using visual cues.

On screening neurological examination, he had one beat lateral nystagmus. His tandem gait was normal. His Rhomberg sign was negative. He did not have frontal release signs. He was able to perform a Luria test without perseveration. He did not have dysmetria.

Evaluation #2 6/24/15 (Kirkland Correctional Institution)
He had a noticeable improvement in his mental status examination. He reported he was prescribed Prozac®, Propanolol, Geodon®, Prazosin®, Remeron® and Zantac®. He reported his thinking had "cleared up a few months ago." He reported "it had been a while" since he heard voices.
He reported flashbacks of killing his daughter Merah. "It's like a tape recorder in my head. It plays over and over." He reported he had been self-medicating in the past with spice, K-2 and Red Bulls. He reported his present mood was calm. He discussed Nahtahn throwing water on the outlets. "He thought he would be back with Mom if dad were dead. He wanted us back together. She was not open to that." He reported he felt like part of him was gone because he no longer hears voices. "I got along with them for years." His affect was flat.

Evaluation #3 4/18/16 (Kirkland Correctional Institution)
He had prominent negative symptoms during this evaluation. He also had masked facies from his medication. He was on suicide watch because he had attempted to hang himself. He stated he used a bed sheet and did not get it "tight enough." He reported his medications were: Prozac®, Geodon®, Propanolol®, Prazosin® and that Prolixin® had been started. He denied auditory hallucinations. He reported he is "sometimes still sad." When further questioned, he reported he is sad at least twice a week for the day. He reported he wondered if the drugs made him crazy but stated: "they calmed me down." He reported he "replayed what happened a lot." He mainly has flashbacks about strangling Merah. He still endorsed the belief that Nahtahn was trying to kill him. "He is just like me. He missed his Mom growing up. I can't blame him." He stated he kept asking him (Nahtahn) the simple question: "What did you do to the outlet" He (Nahtahn) kept saying: "I didn't do anything." I kept questioning him, and he would not tell me. "I shook him. He hit the floor. He was overworked. He collapsed. I put him in bed." "I killed my son. I watched him pass away. It broke my heart."
He reported he was glad the voices are gone. "They can drug me up but they can't get rid of me." He stated the voices did tell him how to hang himself. He stated they told him: "to go back home." He stated it becomes easier to listen to them. "They hear everything I see. They make me listen to them."
On cognitive examination, he was able to perform a trails test, although he was slow. He was able to reproduce a visual design. He showed some deficits in attention. He performed poorly on a test of verbal fluency compared to the past (n=6). He scored poorly on a test of delayed memory.

Evaluation #4 7/7/17 (Lee County)
He reported he had a radio that broke today. He reported he would ask Dr. Woods for a new handle. He reported he is prescribed Perphenazine, Geodon®, Propranolol®, Vistaril® and Prozac®. He reported his sleep is good. He stated he does not have canteen or rec. He denied that anyone was threatening him. He reported he thinks of his children every day. "I miss

them." He reported he was tired of "dealing with every day." He reported he uses distraction (Dialectical behavioral skill) when he feels that way. He reported he is reading. He discussed how "everything fell apart and a depressed state" before the offense. "I think about the kids." He reported he did not want them to go through what he had to dealing with his mother. He stated he wanted to go with them. He continued to have a flat affect. He did not voice any delusions.

Evaluation #5 5/8/19 Lexington County Courthouse
He reported he has hallucinated six times in the past two months. He stated the voices are a male and female He stated they happened when he "is quiet and about to doze off." He stated they say "random things." Otherwise, his affect was bright. He denied suicidal or homicidal ideation. The officers who transport him reported he is more isolative than his baseline.

Evaluation #6 5/22/19 Lexington County Courthouse
Mr. Jones was alert and oriented. He was observed attending to trial testimony. He attempted to minimize symptoms reported by Officer Sowards. He denied suicidal ideation, although he was placed on suicide watch the evening before upon his return from court. He refused to wear the suicide garb and stated: "It is against my religious beliefs. Men aren't supposed to wear skirts. Men wear slacks and women wear skirts." He stated: "I was not up all night singing Twinkle, Twinkle Little Star. Who said that?" He did report an increase in auditory hallucination over the past weekend and last night. He stated: They are not command." He stated they interfere with the onset of his sleep. He stated he always thought his voices were "intrusive thoughts" until he spoke with Dr. Dorney recently. He stated he has heard voices six times in the past three months. He stated he heard the voices twice in one day last Saturday. He reported he has started journaling his hallucinations because he cannot remember what they say. He stated he was unable to journal yesterday because he was not allowed to have a pencil on suicide watch. He denied suicidal ideation but stated: "I am worried about my family and legal team." His affect was animated but not labile. His insight is fair. He does not recognize his own symptoms at times although he can state what they are.

Diagnoses
Schizophrenia, continuous type
Unspecified Neurocognitive Disorder (Minor Neurocognitive Impairment from head injury as evidenced by abnormal neuropsychological testing)
Alcohol Use Disorder, Mild, In a Controlled Environment
Cannabis Use Disorder, Mild, In a Controlled Environment
G6PD deficiency
Hypothyroidism

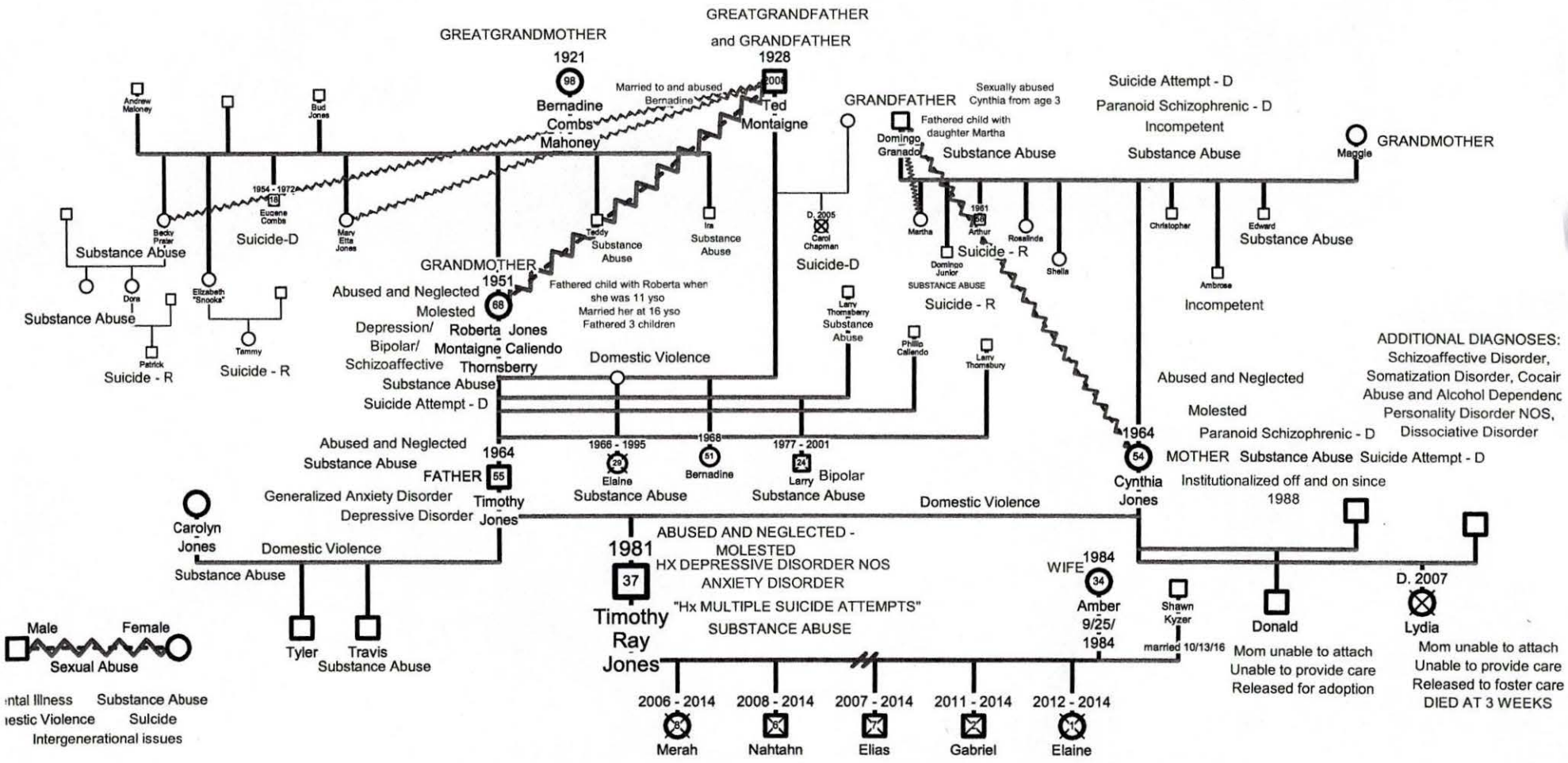
Discussion of Diagnoses:
Mr. Jones has reported hallucinations and has documented delusions for a period of time greater than six months (2014, 2015, 2016, 2017). He has had a significant deterioration in

function. (College educated, employed, full time father to present charges). His symptoms have persisted despite treatment and abstinence from any illicit substances. He has prominent negative symptoms associated with his illness as well. There have been reports of prominent depression for which he has received treatment. There have also been reports of expansive mood which may qualify him for a diagnosis of Schizoaffective Disorder. During the period of time that I have evaluated him, his psychotic symptoms and negative symptoms have predominated.

He does have a history of head injury secondary to motor vehicle accident. Neuropsychological testing revealed deficits in multiple areas of cognition. He also had neuroimaging which was interpreted to be abnormal. He was opined to have had a decline in his intellectual functioning. He had deficits in verbal learning, verbal fluency, delayed visual memory, speed of mental tracking, executive functioning, processing speed and motor functioning.

Donna S. Maddox, MD
Consulting Forensic Psychiatrist

TIM JONES FAMILY



Adriana L. Flores, Ph.D.
Licensed Psychologist
Forensic and Clinical Psychology

3520 Piedmont Road, NE, Suite 330▪ Atlanta, GA 30305 ▪ (Ph) 404-849-6022 ▪ (F) 404-351-0243
adriana@dunflo.com

SUMMARY

Forensic psychologist (bilingual in Spanish/English) providing expert testimony in the fields of forensic psychology and clinical psychology. Expertise in:

- Evaluation of competency to stand trial, testify, and waive miranda rights
- Capacity to consent to sexual contact
- Criminal responsibility
- Mitigating issues
- Assessment of malingering, psychiatric symptoms, cognitive (IQ and memory) and abilities, academic achievement, and executive functioning
- Dangerousness risk assessment

EDUCATION

Post-Doctoral Fellowship (2000-2001)
Emory University School of Medicine

Doctor of Philosophy (Ph.D.) in Clinical Psychology (2000)
Miami University

Pre-Doctoral Internship in Clinical Psychology (1999-2000)
Emory University School of Medicine

Master of Arts (M.A) in Clinical Psychology (1996)
Miami University

Bachelor of Arts (B.A.) in Psychology (1990)
University of Wisconsin-Milwaukee; Graduated with Honors in Psychology

Intensive Psychology Curriculum (1988-1989)
University of Wisconsin-Milwaukee Study Abroad Program
Nottingham University; Nottingham, England

ACADEMIC APPOINTMENT

Feb. 2012 to Present — Adjunct Assistant Professor
Department of Psychiatry & Behavioral Sciences (Psychiatry & the Law Program)
Emory University School of Medicine

Train and supervise Forensic Psychology Postdoctoral Residents and Forensic Psychiatry Fellows from Emory School of Medicine's Psychiatry and the Law Program on (1) expert witness court testimony and (2) evaluation of (a) competency to stand trial, testify, waive Miranda rights, and consent to sexual contact; (b) criminal responsibility, (c) risk of dangerousness, (d) malingering, and (e) mitigation.

CLINICAL and ADMINISTRATIVE EXPERIENCE

May 2007-Present — Forensic and Clinical Psychology Private Practice (Atlanta, GA)
Flores Forensic and Clinical Psychology, LLC (formed March 2018)

Criminal—Expert testimony experience in federal and state court on: criminal responsibility, competency (to stand trial, testify, waive miranda rights, consent to sexual contact), dangerousness risk assessment and management, suicide risk, mitigating circumstances, and malingering.

Civil—Evaluation of worker's compensation claimants; civil case plaintiffs and defendants.

Psychotherapy: Adult and adolescent

Psychological Evaluation: Adults and adolescents

January 2013 - April 2015 — Clinical Associate
Peachtree DBT (Atlanta, GA)

DBT team member providing peer supervision and feedback

Oct. 2007-Sept. 2011 — Director of Treatment Programming
Georgia Regional Hospital at Atlanta (GRH/A)
Department of Behavioral Health and Developmental Disabilities (DBHDD), State of Georgia

Psychiatric hospital executive responsible for the development and directing of hospital-wide therapeutic programming at a 300-bed state inpatient psychiatric hospital. Consumers included the following populations: adult forensics, adult mental health, and individuals with developmental disabilities.

- Responsible for ensuring that hospital-wide therapeutic programming is compliant with hospital and DBHDD policies as well as standards relating to The Joint Commission, CMS, the Department of Justice, and other regulatory organizations.
- Led the development and implementation of therapeutic programming (e.g. treatment malls)
- Established performance and outcome measures of therapeutic programming
- Member of hospital's Executive and Clinical Leadership Committees
- Co-Chairperson of GRH/A's Provision of Care Performance Improvement Function Group (Dec. 2007 to April 2009): this group ensures adherence to state, federal, and accreditation agencies' regulations in (1) care and treatment, (2) assessment, (3) continuum of care, and (4) infection control
- Co-chairperson of GRH/A's Ethics Committee (2005 to 2008)
- Board member of the Georgia Department of Human Resources Institutional Review Board (IRB)--appointed by DBHDD Commissioner (2007 to September 2011)

Aug. 2001-Sept. 2007 — Inpatient Forensic Psychologist
Georgia Regional Hospital at Atlanta (GRH/A)
Department of Behavioral Health and Developmental Disabilities (DBHDD), State of Georgia

Member of multidisciplinary team on an inpatient acute forensic psychiatry unit evaluating and treating adults adjudicated as Incompetent to Stand Trial or Not Guilty By Reason of Insanity.

- Provided expert witness court testimony in Forensic Psychology and Clinical Psychology
- Psychological evaluations for diagnostic and treatment planning purposes and, malingering
- Comprehensive Risk Assessments
- Developed individualized treatment plans
- Individual and group psychotherapy
- Coordinated Forensics Department's monthly in-service training program
- Member of multidisciplinary leadership team that develops SOPs for Forensics
- Chairperson of Employee Recognition Committee, Treatment Mall Workgroup, and Performance Improvement Project on Customer Service
- Consulted throughout hospital on: Spanish-speaking clients, risk assessment, Post Traumatic Stress Disorder, cultural-diversity, adolescents, and safety/security issues

OTHER CLINICAL EXPERIENCE

2005-2007 Licensed Psychologist
Medlin Treatment Center, Inc; Stockbridge, Georgia

Responsibilities: Adult, child, adolescent, and family psychotherapy. Focus on treatment of juvenile sex offenders and victims of abuse.

2000-2001 Psychology Postdoctoral Fellow, Hughes Spalding Children's Hospital,
Children's Hospital of Atlanta (CHOA) Atlanta, Georgia

Responsibilities: Member of multidisciplinary team treating adolescents at risk at inner-city adolescent primary care clinic. Provided individual, group, and family therapy. Evaluation of adolescents with a history of sexual assault. Led a psychotherapy group for adolescents with Acute Stress Disorder or Post Traumatic Stress Disorder associated with sexual assault.

1999-2000 Psychology Intern, Grady Health System, Atlanta, Georgia
Three, four-month rotations (forensic psychology; adult—inpatient and outpatient; and child, adolescent and family).

Responsibilities: Conducted competency to stand trial and criminal responsibility evaluations of inmates at urban, county jail. Brief and long-term outpatient psychotherapy. Member of multidisciplinary team treating adults with severe mental illness on inpatient psychiatry unit in large, inner city hospital. Conducted comprehensive psychological evaluations.

1997-1999 Therapist, Community Counseling and Crisis Center, Oxford, Ohio

Responsibilities: Adult, adolescent, child, family, and couples psychotherapy.

1995-1998 Therapist, Miami University Psychology Clinic, Oxford, Ohio

Responsibilities: Adult, adolescent, child, and family psychotherapy.

1996-1997 Child and Family Therapist, Children's Hospital Medical Center of Cincinnati, Cincinnati, Ohio

Responsibilities: Brief and long-term outpatient child and family psychotherapy. Member of inpatient child psychiatry multidisciplinary treatment team. Psychological evaluations of children with severe mental illness on inpatient psychiatry unit in large, inner city hospital. School consultation.

1995-1996 Therapist, Community Mental Health Centers of Warren County, Inc., Springboro, Ohio

Responsibilities: Adult, child, and adolescent psychotherapy.

RESEARCH EXPERIENCE

2000-2001 Researcher
Emory University School of Medicine
Department of Psychiatry and Behavioral Sciences, Atlanta, Georgia

Project: Psychological Adjustment and Risky Sexual Behavior of At-risk Adolescents

1993-2000 Doctoral Dissertation and Master's Thesis
Miami University

Projects: Effects of perceptions of interparental conflict on adolescents and young adults.

TEACHING & MENTORING

2004-Present **Emory University School of Medicine**
Postdoctoral Fellowship in Psychology Seminar Speaker
Present yearly on forensic psychology, working for the state of Georgia, and career development

2004-Present **Emory University School of Medicine**
Postdoctoral Residency Program in Psychology Mentor

2001-2007 **Georgia Regional Hospital at Atlanta**
Forensics' In-service Training Coordinator

2000- 2001 **Emory University School of Medicine**
Behavioral Mentor, Seminar of Pediatrics Residents

PUBLICATIONS

Bachanas, P. J., Morris, M. K., Lewis-Gess, J. K., Sarett-Cuasay, E. J., **Flores, A. L.**, Sirl, K. S., & Sawyer, M. K. (2002). Psychological Adjustment, Substance Use, HIV Knowledge, and Risky Sexual Behavior in At-Risk Minority Females: Developmental Differences During Adolescence. *Journal of Pediatric Psychology, 27,* 373-384.

Flores, A. & Bachanas, P.J. (2001). Psychology and primary care: An integrative model. APA

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Celano, M. & **Flores, A. L**. (2001). A review of *Family Therapy with Hispanics: Toward Appreciating Diversity,* e.d. by Maria T. Flores & Carey, G. *The Family Psychologist, 17,* 4-5.

Newton, T. L., Bane, C. M., **Flores, A.**, & Greenfield, J. (1999). Dominance, gender, and cardiovascular reactivity during social interaction. *Psychophysiology, 36,* 245-252.

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PRESENTATIONS

Shah, S, Flores, A, & Egan, G. (April 2019) Beyond Tarasoff: Federal and State Laws Psychologists Should Know. CEU Ethics Workshop at Georgia Psychological Association 2019 Annual Meeting, Atlanta, GA

Flores, A (December 2018) Mitigation Evaluations: Answering "How Did We Get Here?" Presented at Middle District of Alabama Federal Defenders, Inc, Montgomery, AL

Perdew Silas, N and Flores, A (October 2018) Ethically Representing Mentally Ill Clients. Presented at the 2018 Fall Meeting and Seminar of the National Association of Criminal Defense Lawyers (NACDL), Savannah, GA (Conference theme: "Decoding and Litigating Mental Health Issues")

Flores, A (July 2018) The Forensic Psychology Evaluation: When and Why. Training presented at Middle District of Alabama Federal Defenders, Inc, Montgomery, AL

Flores, A., Shah, S., & Egan, G. (April 2018) Ethical and Cultural Considerations in Psychological Testing as Part of Clinical and Forensic Evaluations. CEU Ethics Workshop at Georgia Psychological Association 2018 Annual Meeting, Athens, GA

Flores, A., Shah, S., & Egan. G. (March 2017) Professional Skills and Ethics Associated with Testifying in Court. CEU Ethics Workshop at Georgia Psychological Association 2017 Annual Meeting, Atlanta, GA

Flores, A (November 2016) Assessment of Substance Abuse in Hispanics: Use of CAGE-AID Clinic for Education, Treatment, and Prevention of Addiction, Inc. Atlanta, GA

Flores, A., Shah, S., & Egan. G. (November 2016) Professional Skills and Ethics Associated with Testifying in Court. Presenter in CEU Ethics Workshop, Psychology Division of the Emory University School of Medicine at Grady Health System, Atlanta, GA

Flores, A. (June 2016). Cultural Competency in Mental Health Settings. Clinic for Education, Treatment, and Prevention of Addiction, Inc., Atlanta, GA.

Flores, A., Egan, G., & Waford, R. (September 2015). The Dangerous Patient?? Competing Clinical, Risk Management, Legal, and Ethical Issues in Decision-Making. Presenter in CEU Ethics Workshop, Department of Psychology and Behavioral Sciences, Emory University School of Medicine, Atlanta, GA

Flores, A. (April 2015). Mitigation: Stories from the Trenches. Mercer University School of Law (Class), Macon, GA

Flores, A. (March 2011). Mental Health Issues Among Hispanic Female Teens. Presented at the Latin American Association, Atlanta, GA.

Flores, A. (May 2010). Public and Mental Health Challenges in the Latin American Community. Invited speaker at St. Crispin's Conference, Atlanta, GA.

Flores, A., Silas, K., & Mendelsohn, B. (October 2009). The Best Methods with Madness. Invited speaker at St. Crispin's Conference, Atlanta, GA.

Flores, A. (January 2007). Depression and Suicide Risk Among Hispanic Adolescents. Invited speaker at the meeting of the Hispanic Health Coalition of Georgia, Atlanta, GA.

Flores, A and Shore, C. (April 2002). Adolescents' Responses to Peer Conflict as a Function of Resolution and Perceptions of Interparental Conflict. Poster presented at the Ninth Biennial Meeting of the Society for Research on Adolescence, New Orleans, LA

Sarett-Cuasay, E., Flores, A., Bachanas, P.J., Morris, M., Lewis-Gess, J.,Ries, J., & Sawyer, M. (August 2001). Adolescents' perceived risk for contracting HIV: Implications for HIV prevention. Poster presented at 2001 American Psychological Association Conference, San Francisco, CA

Flores, A. L., Sarett-Cuasay, E. J., Bachanas, P. J., Morris, M. K., Lewis-Gess, J., & Sawyer, M. K. (April 2001). Psychological Adjustment, Substance Use and Risky Sexual Behavior: Intervention and Prevention Challenges in Adolescent Primary Care. Poster presented at the 8th Florida Conference on Child Health Psychology, Gainesville, FL.

Newton, T. L., Sanford, J., & Flores, A. L. (September 1996). Child Care, Housework, and Cardiovascular Responses of Men and Women in Dual-Earner Couples. Poster presented at the conference on: Research, Prevention, Treatment, and Service Delivery in Clinical and Community Settings, Washington, D.C.

Newton, T. L., Bane, C., Flores, A., & Greenfield, J. (March 1995). Dominance and Interpersonal Power Bases: Associations with Cardiovascular Reactivity During Mixed-Sex Dyadic Interactions. Poster presented at the Annual Meeting of the Society of Behavioral Medicine, San Diego, CA.

Newton, T. L., Bane, C., Flores, A., & Greenfield, J. (March 1995). Oral Contraceptives and Cardiovascular Responses to Interpersonal Stress. Poster presented at the Annual Meeting of the Society of Behavioral Medicine, San Diego, CA.

CONSULTING EDITOR
Professional Psychology: Research and Practice (peer reviewed journal)
(Jan. 2008-Present)

PROFESSIONAL ACTIVITY

July 2017-Present	Board of Directors Georgia Psychological Association Diversity Directorate Chairperson: Committee on the Psychology of Women and Girls
August 2015-Present	Board of Directors, Executive Team Member CETPA (**Clinic for Education, Treatment and Prevention of Addiction, Inc.)** **Atlanta, Georgia** Executive Member of Board of Directors of CETPA, a non-profit, community-based mental health agency providing prevention and treatment of mental health and substance abuse primarily to Latino individuals
2017, 2018, 2019	Participant (as expert witness in mock trial) Trial Techniques Program Emory University School of Law
November 2018-Present	Consultant Diversity Consultation Service Brain Health Center; Department of Psychiatry and Behavioral Sciences Emory University School of Medicine
March 2018	Organizer and Chair of Panel on Finding Resources and Solutions for Mental Health Issues, Federal Defender Program inc, CLE Spring Seminar, Atlanta, GA
May 2011	Panel member appointed by the State of Georgia Board of Psychology Examiners to revise the state of Georgia psychologist licensing exam

MEDIA

December 2018	Atlanta Journal Constitution interviewed for article: "Henry County student appeals expulsion for sexual misconduct" (Published December 17, 2018)
September 2012	TruTV-In Session (Two live appearances/discussions on the insanity defense)

PROFESSIONAL AFFILIATIONS

American Psychological Association
American Psychology-Law Society (Division 41 of APA)
Georgia Psychological Association

LICENSURE

State of Georgia License #2792

FOREIGN LANGUAGE

Spanish. Fluent in oral and written expression. Psychological evaluations and psychotherapy in Spanish.

FLORES FORENSIC & CLINICAL PSYCHOLOGY, LLC
ADRIANA L. FLORES, PH.D.
Licensed Psychologist
Forensic and Clinical Psychology

3520 Piedmont Road, NE
Suite 330
Atlanta, GA 30305

T: (404) 849-6022
F: (404) 351-0243

adriana@dunflo.com

Affidavit of Dr. Adriana L. Flores

State of Georgia)
:
Forsyth County)

Before me, a Notary Public in and for said state and county, personally appeared Adriana L. Flores, Ph.D. who is known to me, and after being duly sworn by me deposes and says as follows:

1. My name is Adriana L. Flores, Ph.D. and I am over the age of nineteen (19) years. I currently reside in Milton, Georgia.

2. I am a licensed psychologist (State of Georgia License Number 2792) specializing in forensic and clinical psychology.

3. I have been qualified in federal (Georgia, Alabama, Pennsylvania) and state court (Georgia) as an expert witness in clinical and forensic psychology approximately 90 times.

4. I have been retained as an expert witness by the prosecution and the defense.

5. I am an Adjunct Assistant Professor at Emory University School of Medicine, Department of Psychiatry and Behavioral Sciences, Psychiatry and the Law Program.

6. I have worked in the field of forensic psychology for almost 20 years.

7. I reviewed Dr. Kimberly K. Kruse's "Forensic Mental Health Evaluation" report of defendant, Timothy Ray Jones, Jr., dated March 7, 2019.

8. I reviewed Dr. Kimberly K. Kruse's entire videotaped testimony (direct and cross) in State of SC v Timothy Jones.

9. Dr. Kruse was qualified as an expert in neuropsychology, not in clinical or forensic psychology, yet she used forensic testing measures and testified to forensic issues.

10. Dr. Kruse testified on direct that she has been qualified in South Carolina "75 times in neuropsychology in civil, criminal, and probate" matters. This is misleading since she did not state how many times specifically, she has testified in with regard to criminal matters, or worked on death penalty cases.

11. I reviewed Dr. Kimberly K. Kruse's raw data for the following testing measures:

    a. Minnesota Multiphasic Personality Inventory, Second Edition (MMPI-2)

    b. Personality Assessment Inventory (PAI)

    c. Miller Forensic Assessment of Symptoms (M-FAST)

    d. Structured Interview of Reported Symptoms (SIRS)

    e. Structured Inventory of Malingered Symptomatology (SIMS)

12. I re-entered Mr. Jones' responses of the PAI and MMPI-2 onto their respective computerized scoring software systems.

13. Among the five psychological instruments I reviewed, one was outdated. Dr. Kruse should have used the SIRS-2 (published in 2010), instead of the original SIRS (which is no longer in publication).

14. I rescored Mr. Jones' SIRS responses onto the SIRS-2.

15. The SIRS-2 has a classification scale (Rare Symptom Total), that the original SIRS does not have, and is meant to reduce false positives (i.e., erroneously classifying an evaluee as malingering).

16. The Modified Total Index on the SIRS-2 replaced the SIRS Total, to better classify indeterminate responders.

17. Dr. Kruse also used an outdated version of the Millon Clinical Multiaxial Inventory. She used the MCMI-III. She should have used the MCMI-IV, published in 2015.

18. The SIMS manual (page 5), states, "A determination of malingering should be made in the context of a comprehensive evaluation only, whereby multiple sources of data (e.g., psychosocial, psychiatric, and medical history; clinical interview; comparison of subjective reports of symptoms to objective information and observations; results from malingering-specific and psychological inventories), converge to corroborate such a classification."

19. The testing results of Dr. Kruse's evaluation of Mr. Timothy Jones do not corroborate her testimony that Mr. Jones was malingering, for the following reasons:

    a. Dr. Kruse, in her aforementioned authored psychological evaluation report, noted about Mr. Jones, "He says he has been essentially symptom free since taking antipsychotic medication in prison" (Kruse report, p. 5) and "He also reports initial psychomotor

retardation and thinking, with prescription implementation. He reports this has dissipated significantly from 2016, when he was taking a higher dose of Geodon. This is also noted to be the time of evaluation by Dr. Brawley, 4/19/16" (Kruse report, p. 5) These data are *in*consistent with malingering.

b. Results of the MMPI-2 and PAI validity indices indicate that, rather than exaggerating/ malingering psychological problems, Mr. Jones was under-reporting psychological problems. He was making himself look healthier than he may be. This is contradictory to malingering.

c. Dr. Kruse should have considered the results of the validity indices of psychopathology and personality testing (MMPI-2, PAI, and MCMI-2), in conjunction with results from the malingering inventories.

d. Dr. Kruse scored the MFAST incorrectly.

20. There was no need to administer any of the malingering test measures since they are all based on *present* reports of problems. Given that Mr. Jones *denied any current symptoms*, there was no need to administer any of the malingering instruments.

21. Dr. Kruse's testimony of the results of the malingering instruments (M-FAST, SIRS, M-FAST) is misleading since she did not testify to the time-reference of the tests. Jurors could infer that the results indicate malingering of psychological problems at the time of the offense.

22. The psychopathology and personality instruments Dr. Kruse administered have imbedded validity indices which inform with regard to over-reporting (e.g., malingering) of symptoms. So, there was no need to administer malingering instruments, especially since Mr. Jones denied current symptoms during Dr. Kruse's clinical interview of him—thus making administration of the three aforementioned malingering tests inappropriate.

23. A psychological evaluation report should state the referral question/issue. Dr. Kruse's report lacks this critical information. The referral question in unclear. Was it to assess for malingering? Or was it for diagnostic clarification?

24. Dr. Kruse's testimony was misleading regarding the meaning of findings of the SIMS and M-FAST. Both tests are *only* screeners for malingering. She did not testify to this fact.

25. Mr. Jones' SIMS score of 12 was below the cutoff score of 14, and therefore not suggestive of malingering.

26. SIMS-Manual, page 14—"Respondents who obtain a SIMS Total score of greater than 14 are identified as possible malingering individuals who are considered to be in need of further evaluation..." Mr. Jones scored a SIMS Total of 12.

27. Yet, Mr. Jones only elevated one of the five SIMS scales, the Psychosis Scale score, which is not as accurate in identifying malingerers as the SIMS score above 14.

28.The SIMS manual (p. 13) states, "Furthermore, the SIMS Total Score was determined to be the best indicator for distinguishing between malingering individuals and honest responders in the developmental sample."

29.Sensitivity in test psychometrics refers to a test's ability to correctly classify an individual as having the disorder, or issue being assessed (e.g., malingering).

30.The SIMS manual (page 13) states that the Sensitivity rate using a Total score greater than 14 is 94.63, whereas for a P (Psychosis) greater than 1 is only 81.82. This indicates that the Psychosis subscale is not as accurate in identifying malingerers, as is the Total score of greater than 14. Therefore, Dr. Kruse's interpretation of Mr. Jones' elevated Psychosis Score, rather than his SIMS Total score of 12 (and thus, not elevated), as malingering is incorrect.

31.The SIMS manual (p. 14) further states, "*As such, interpretations regarding the likelihood of malingering can be made with greater confidence when the interpretation is based on the SIMS Total score than when the interpretation is based on the SIMS scale scores in isolation*"—which is what Dr. Kruse did.

32.Dr. Kruse offered misleading testimony, on direct, by quoting directly from the SIMS manual that, "Even low level of endorsement, Psychosis greater than 1 of such inconsistent, bizarre, and/or atypical symptoms is highly suggestive of malingered psychosis, given the rarity with which such symptoms are endorsed by actual psychiatric patients" (p. 15).

33.On cross examination, Dr. Kruse referred to the SIMS as "effort test." This is incorrect. The SIMS is a test of malingering.

34.On cross examination, Dr. Kruse testified that "data is consistent across the board" for malingering. This is incorrect.

35.Dr. Kruse testified on direct that his L scale score of 74 indicates that he is not a reliable historian. The L scale does not assess an individual's reliability as a historian.

36.Dr. Kruse testified on direct that his "L" in L scale indicates "Lie." This testimony is misleading since she failed to qualify her response further, suggesting that Mr. Jones is a liar. This was after she had already testified multiple times that he was malingering psychosis, and specifically, schizophrenia.

37.In fact, the MMPI-2 manual (p. 20), states, "Although the L scale can reflect deceit in the test-taking situation, it should not necessarily be viewed as a measure of any general tendency to lie, fabricate, or deceive others on the part of individuals in their day to day activities."

38.The L score of 74, was not confirmation of an invalid profile.

39.In fact, per the MMPI-2 manual (p. 21), Mr. Jones' L score of 74, combined with his within normal limits TRIN score "reflects a rather unsophisticated pattern of faking good." This means that he tried to present himself as healthier than he may be. This is *in*consistent with malingering.

40. Mr Jones L scale score of 74 actually indicates that he is attempting to make himself as having less problems than he actually may have. This is *contradictory* to malingering

41. On cross examination, Dr. Kruse testified that Mr. Jones demonstrated a "tendency of over-reporting symptoms." This is not true. Mr. Jones' F scale T score of 67 is *in*consistent with over-reporting of symptoms.

42. Mr. Jones did *not* elevate the F- scale (F scale T score = 67) that assesses malingering of psychological problems. This indicates *lack of* evidence of malingering.

43. Additionally, other MMPI-2 validity scale results further indicate that Mr. Jones was not attempting to "fake bad" (i.e. malinger).

44. In spite of under-reporting problems, there is evidence of mental illness on the MMPI-2.

45. Dr. Kruse noted in her report, "He scored high in persecutory ideas..." Given that there is no evidence of over-reporting of psychological problems, and rather, that Mr. Jones attempted to present himself as more problem-free than he may actually be, this suggests that at some point, he has experienced these problems.

46. Indeed, Dr. Kruse indicated elevation of depressive, paranoid, anxiety, bipolar/manic, and delusional disorder on the MMPI-2. Given that there was no evidence of malingering, this suggests that Mr. Jones reported experiencing true psychological problems.

47. Scales Pa and Sc were elevated on the MMPI computerized report pages that Dr. Kruse submitted. Given under-reporting, and that the F-scale (fake bad scale) was NOT elevated, this suggests that there is real, genuine psychosis that the client reported experiencing at some point in his life.

48. The MMPI-2 asks questions about past and present problems, not just present, and not just past.

49. When asked by prosecution about whether Mr. Jones gave a "hodge-podge" of responses, Dr. Kruse agreed. Yet, MMPI-2 and PAI validity scales that assess for inconsistent responding were valid, and thus MMPI-2 and PAI findings do not support Dr. Kruse's testimony regarding Mr. Jones responding with hodge-podge.

50. One of two items omitted on the MMPI-2 was item *198— I often hear voices without knowing where they come from*. Lack of an affirmative response by Mr. Jones is *in*consistent with malingering. If Mr. Jones is malingering, how does Dr. Kruse explain why he did not answer with "true"?

51. The computerized scored report of the MMPI-2 produced when I rescored Mr. Jones' protocol responses yielded the following information:

    a. "Despite this extreme defensiveness, he responded to items reflecting some unusual symptoms of beliefs...."

b. "Scales Pa and Sc were used as the prototype to develop this report. A severe psychological disorder is reflected in this profile...."

c. "He endorsed a number of extreme and bizarre thoughts, suggesting the presence of delusions and/or hallucinations. He apparently believes that he has special mystical powers or a special 'mission' in life that others do not understand or accept."

d. Under "Diagnostic Considerations," "The most likely diagnosis for individuals with this profile type is Schizophrenia, possibly Paranoid type, or a Delusional Disorder."

46. Dr. Kruse only submitted to the defense parts of the computer-scored report. The entire printout is actually 14 pages.

47. On her report, Dr. Kruse omitted reporting findings that contradict malingering.

48. Dr. Kruse testified on direct that PAI validity indices indicated "not only was over-reporting found, but underreporting." This is not true. The negative impression validity scale, which informs of over-reporting, indicated that the "*there is no evidence to suggest that the respondent was motivated to portray himself in a more negative or pathological light than the clinical picture would warrant" (based on my re-entry/re-scoring of the PAI raw data).*

49. Results of both, negative (i.e, suggestive of over-reporting, or malingering) and positive (under-reporting problems to make oneself appear in a positive light) are ALWAYS included in the validity portion of the PAI computerized report, which Dr. Kruse used. Yet, she did not submit to the defense, nor include in her report, the negative impression findings, which suggest that Mr. Jones was not malingering.

50. Dr. Kruse literally included in her report the paragraphs immediately and below the following, which she omitted— *"With respect to negative impression management, there is no evidence to suggest that the respondent was motivated to portray himself in a more negative or pathological light than the clinical picture would warrant."* (This means Mr. Jones was not malingering).

51. The print out portions of the computerized PAI report Dr. Kruse submitted to the defense do <u>not</u> include the part stating results of negative impression management (i.e., she did not give the following part to the defense—"*With respect to negative impression management, there is no evidence to suggest that the respondent was motivated to portray himself in a more negative or pathological light than the clinical picture would warrant.")*

52. Findings of the PAI Dr. Kruse did report indicate that Mr. Jones under-reported problems. This is contradictory to malingering.

53. Dr. Kruse stated in her report that Mr. Jones did not answer in a forthright manner—she is correct. This is because he tried to make himself seem healthier than he is, with less problems, not because he was being deceptive by exaggerating problems/malingering.

54. PAI findings are consistent with MMPI-2 findings—Two different tests, yet the same two clinical scales were elevated. Paranoia and Schizophrenia were elevated on both measures. In light of the fact that there was no evidence of malingering, per the validity indices of both measures, this suggests that Mr. Jones reported problems he had experienced at some point.

55. What PAI printout says that Dr. Kruse omitted from her report—

"A number of aspects of the respondent's self-description suggest noteworthy peculiarities in thinking and experience. It is likely that he experiences unusual perceptual or sensory events (perhaps including full-blown hallucinations) as well as unusual ideas that may include magical thinking or delusional beliefs. His thought processes, although relatively uncompromised, may occasionally be marked by some confusion and difficulty concentrating. He may have some difficulty establishing close interpersonal relationships.

The respondent describes certain problems potentially associated with elevated and variable mood. In particular, he is likely to have an activity level that is perceptibly high to most observers. He may be involved in a wide variety of activities in a somewhat disorganized manner and may experience accelerated thought processes."

56. On the MMPI-2 computerized report, the following possible diagnoses are listed, yet not reported by Dr. Kruse
297.1 Delusional Disorder

296.40 Bipolar I Disorder, Most Recent Episode Manic, Unspecified

295.30 Schizophrenia, Paranoid Type

57. Mr. Jones' MFAST score was = 8 (cut off for possible malingering, and therefore need for a SIRS is 6).

58. His score should have been 4—therefore below the cut off , and the SIRS should not even have been administered.

59. MFAST Item 2: I feel depressed most of the time —she circled True, yet he responded, "No, meds work great" (should have been scored "0")

60. MFAST Item 4: Do voices tell you to do things? She circled "Yes", yet he told her "not anymore with medications" (should have been scored "0") Then, she followed it up with the second part, "Do you always obey them?" She circled "yes", yet he told here "too scared to act on it."

61. MFAST Item 6: I experience hallucinations that last continually for days: she circled True, yet he told her, "Now with meds, better, but yes" (should have been scored "0")

62. MFAST Item 21: Sometimes I hear music coming from nowhere: she circled true, yet he told her "due to drugs" and "music in my head all day, random songs" (should have been scored "0")
63. MFAST Item 15, When I hear voices, I hear them from either my right or my left ear, but rarely from both at the same time: He answered False and then spontaneously made statement: "from inside/from within head. Never heard audible voice outside my head, that would be terrible" (this is *in*consistent with malingering).

64. Consistent with Mr. Jones' MFAST response to Item 15, Dr. Kruse noted on her written report that Mr. Jones "commented, 'That would be scary if I heard an audible voice in the room." Mr. Jones, therefore, reported at least twice directly to Dr. Kruse that he did not hear voices outside his head. This is *in*consistent with malingering.

65. I have concerns that Dr. Kruse may have administered/scored the the SIRS incorrectly.

66. Results of the SIRS and MFAST (which is misscored) are inconsistent with the validity indices of the MMPI-2 and PAI. If Mr. Jones really was malingering, then, results of the MMPI-2 and PAI would have been invalid due to symptom exaggeration. Yet, you have the opposite results. Those tests showed under-reporting of psychological problems by Mr. Jones in an attempt to present himself in a positive light, that is, healthier and with less problems than he may actually have experienced.

67. There was no need to administer three psychopathology and personality tests. They are duplicative.

68. There was no need to administer three malingering tests. Once Dr. Kruse gave the MFAST, only SIRS should have been given.

69. Measures that assess malingering are NEVER to be interpreted in a vacuum.

70. Dr. Kruse should have addressed the validity of the personality and psychopathology tests on the "symptom validity" report section (page 6). Doing so would have

allowed for her to explain how it is that M-FAST and SIRS results are inconsistent with MMPI-2 and PAI validity indices.

71. Dr. Kruse chose to not address at all the fact that there was no evidence on the MMPI-2 or PAI of malingering. There was the opposite—under-reporting of problems.

72. Page 20 of M-FAST manual shows a sample of how Dr. Kruse should have discussed findings of the M-FAST and MMPI-2 validity indices jointly.

73. Dr. Kruse should have reviewed Mr. Jones' medical records, in particular, his jail medical records as these likely provide data relevant to her assessment and opinions.

74. Dr. Kruse testified on direct that the purpose of her evaluation was "to gather objective information to help with differential diagnosis and to conceptualize defendant." Psychiatric diagnoses should not be made simply based on objective testing results. Diagnoses are never arrived at in a vacuum. Dr. Kruse should have interviewed Mr. Jones' jail treating psychiatrist, or at minimum, reviewed his jail medical records as these would have provided additional pertinent data.

75. Personality testing in a death penalty case is irrelevant, and could be prejudicial toward the defendant.

76. Dr. Kruse testified on direct that personality testing looks at "how people go about life, how they might be like personally, and how they might cope with problems and stressors." This does not aid in diagnostic clarification. This type of data is irrelevant in an insanity case.

77. Dr. Kruse testified on direct that Mr. Jones has a personality disorder, consisting of antisocial and borderline personality traits. This has nothing to do with assessing whether or not Mr. Jones has ever exhibited symptoms of a mental illness.

78. On direct, Dr. Kruse referred to measures of malingered symptoms as "psychotic validity testing". This is incorrect and misleading, as the jury may infer that if someone does not do well on "psychotic testing", then they are not psychotic.

    a. In fact, the SIMS, SIRS, and MFAST do not only assess for psychosis.

    b. An evaluee can be both, psychotic and malingering. These are not mutually exclusive.

79. Dr. Kruse does not state malingering on her report, yet testified that Mr. Jones was malingering.

80. On direct, Dr. Kruse testified that the malingering measures she administered only assess for malingering of psychosis. This is not true. The SIMS, for example, is also a screener for malingering of neurologic impairment, low intelligence, affective disorders, and amnestic disorders.

81. For the reasons noted above, and per the American Psychological Association's (APA) *"Ethical Principles of Psychologists and Code of Conduct" (effective January 1, 2017),* I opine that Dr. Kruse may have violated the following ethical principles that psychologists are to abide by:

    a. ***2.01 Boundaries of Competence*** *(a) Psychologists provide services, teach, and conduct research with populations and in areas only within the boundaries of their competence, based on their education, training, supervised experience, consultation, study, or professional experience.*

    b. ***2.04 Bases for Scientific and Professional Judgments*** *Psychologists' work is based upon established scientific and professional knowledge of the discipline.*

    c. ***3.04 Avoiding Harm*** *(a) Psychologists take reasonable steps to avoid harming their clients/patients, students, supervisees, research participants, organizational clients, and others with whom they work, and to minimize harm where it is foreseeable and unavoidable.*

    d. ***9.01 Bases for Assessments*** *(a) Psychologists base the opinions contained in their recommendations, reports, and diagnostic or evaluative statements, including forensic testimony, on information and techniques sufficient to substantiate their findings (see also Standard 2.04, Bases for Scientific and Professional Judgments).*

82. I am obligated (and intend to comply), per the following APA ethical guidelines, to communicate with Dr. Kimberly K. Kruse about my concerns regarding her

    a. *assessment method of Mr. Timothy Jones,*

    b. *scoring and interpretation of malingering and psychopathology/personality tests,*

c. *misleading findings reported on her psychological evaluation report,*

d. *incorrect, and misleading testimony, and*

e. *failure to submit to defense counsel all raw testing data.*

Per American Psychological Association's *"Ethical Principles of Psychologists and Code of Conduct" (effective January 1, 2017),*

1. Resolving Ethical Issues,

1.03 Informal Resolution of Ethical Violations

When psychologists believe that there may have been an ethical violation by another psychologist, they attempt to resolve the issue by bringing it to the attention of that individual, if an informal resolution appears appropriate and the intervention does not violate any confidentiality rights that may be involved.

Adriana L. Flores, PhD

ADRIANA L. FLORES, PH.D.
Affiant

Sworn to and subscribed before me on this the 10th day of June, 2019.

Notary Public

My commission expires on:
4/10/23

Notary Public
Tori Avery
Forsyth County, GA
Exp. April 10, 2023

8199
ID: 12201981

MCMI-III

[redacted]

INTERPRETIVE CONSIDERATIONS

MCMI-III reports are normed on patients who were in the early phases of assessment or psychotherapy for emotional discomfort or social difficulties. Respondents who do not fit this normative population or who have inappropriately taken the MCMI-III for nonclinical purposes may have inaccurate reports. The MCMI-III report cannot be considered definitive. It should be evaluated in conjunction with additional clinical data. The report should be evaluated by a mental health clinician trained in the use of psychological tests. The report should not be shown to offenders or their relatives.

The client is a 37-year-old divorced white male. He is currently being seen as a correctional offender, and he did not identify specific problems and difficulties of an Axis I nature in the demographic portion of this test.

The BR scores reported for this individual have been modified to account for the high self-revealing inclinations indicated by the high raw score on Scale X (Disclosure) and the psychic tension indicated by the elevation on Scale A (Anxiety).

She used old version.
MCMI-III = old version
(1) We now have MCMI-IV.

(2) Not normed on persons like him. (see above)
⇒ should not have been administered

MMPI-2

OMITTED ITEMS

Those items for which there is no response or for which both true and false responses have been entered are considered "omitted." The potential for lowering the elevation of individual scales or the overall profile and rendering the administration invalid increases with the number of omitted items. Defensiveness, confusion, carelessness, and indecision are among the common reasons for omitting items. Examination of the content of the items that were omitted by the respondent may reveal specific problem areas or suggest reasons for their not responding appropriately to all items. Following are the items that were omitted:

192. My mother is a good woman, or (if your mother is dead) my mother was a good woman.
198. I often hear voices without knowing where they come from.

CRITICAL ITEMS

The MMPI-2 contains a number of items whose content may indicate the presence of psychological problems when endorsed in the deviant direction. These "critical items," developed for use in clinical settings, may provide an additional source of hypotheses about the respondent. However, caution should be used in interpreting critical items since responses to single items are very unreliable and should not be treated as scores on full-length scales -- for example, an individual could easily mismark or misunderstand a single item and not intend the answer given. The content of the items and the possibility of misinterpretation make it important to keep the test results strictly confidential. Special caution should be exercised when interpreting these items in nonclinical settings.

Acute Anxiety State (Koss-Butcher Critical Items)

5. I am easily awakened by noise. (True)
15. I work under a great deal of tension. (True)
28. I am bothered by an upset stomach several times a week. (True)
39. My sleep is fitful and disturbed. (True)
140. Most nights I go to sleep without thoughts or ideas bothering me. (False)
218. I have periods of such great restlessness that I cannot sit long in a chair. (True)
223. I believe I am no more nervous than most others. (False)
301. I feel anxiety about something or someone almost all the time. (True)
444. I am a high-strung person. (True)
463. Several times a week I feel as if something dreadful is about to happen. (True)

Depressed Suicidal Ideation (Koss-Butcher Critical Items)

130. I certainly feel useless at times. (True)
146. I cry easily. (True)
273. Life is a strain for me much of the time. (True)
411. At times I think I am no good at all. (True)
485. I often feel that I'm not as good as other people. (True)

Mental Confusion (Koss-Butcher Critical Items)

32. I have had very peculiar and strange experiences. (True)

M-Fast Validation 8201

M-FAST™

Interview Booklet

Holly A. Miller, PhD

Demographic Information

Name: T. Jones Today's date: 2/22/19

Gender: ☒ Male ☐ Female Age: 37 Education (years): _____

Occupation: _____

Interviewer: Bruce

Setting: ☐ Clinical inpatient ☐ Clinical outpatient ☒ Forensic ☒ Correctional

☐ Other _____

Administration Time

Interview start time: 10:05A Interview stop time: 10:40A Total interview time: 35m

M-FAST Scale Scores

Scale	Score
RO (3 items)	1
ES (7 items)	11
RC (7 items)	1
UH (5 items)	111
USC (1 item)	1
NI (1 item)	0
S (1 item)	0
Total score	8

→ Should be 4
∴ Below cut-off
∴ there was no need for SIRS

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M-FAST scores	NPP	PPP	Specificity	Sensitivity
1	1.00	.66	.51	1.00
2	.99	.80	.77	.99
3	.98	.90	.90	.98
4	.94	.96	.96	.93
5	.93	.96	.97	.93
6	.94	1.00	1.00	.93
7	.86	1.00	1.00	.82
8	.81	1.00	1.00	.75
9	.86	1.00	1.00	.83
10	.84	1.00	1.00	.81
11	.82	1.00	1.00	.77
12	.77	1.00	1.00	.69
13	.73	1.00	1.00	.61
14	.68	1.00	1.00	.51
15	.63	1.00	1.00	.39
16	.61	1.00	1.00	.32
17	.59	1.00	1.00	.28
18	.56	1.00	1.00	.18
19	.56	1.00	1.00	.18
20	.54	1.00	1.00	.12
21	.53	1.00	1.00	.08
22	.52	1.00	1.00	.04
23	.52	1.00	1.00	.04
24	.52	1.00	1.00	.04
25	.51	1.00	1.00	.00

Note. $N = 210$. Base rate of simulated malingering = 51%. NPP = Negative Predictive Power; PPP = Positive Predictive Power.

M-FAST scores	NPP	PPP	Specificity	Sensitivity
1	1.00	.48	.40	1.00
2	1.00	.52	.49	1.00
3	.99	.57	.60	.97
4	.96	.56	.72	.93
5	.96	.62	.78	.93
6	.97	.66	.83	.93
7	.96	.72	.86	.93
8	.91	.75	.89	.79
9	.87	.88	.96	.73
10	.84	.96	.98	.67
11	.81	1.00	1.00	.57
12	.78	1.00	1.00	.47
13	.75	1.00	1.00	.40
14	.83	1.00	1.00	.63
15	.72	1.00	1.00	.30
16	.71	1.00	1.00	.23
17	.68	1.00	1.00	.13
18	.67	1.00	1.00	.10
19	.66	1.00	1.00	.07
20	.66	1.00	1.00	.03
21	.66	1.00	1.00	.03
22	.66	1.00	1.00	.03
23	.66	1.00	1.00	.03
24	.66	1.00	1.00	.03
25	.66	1.00	1.00	.03

Note. $N = 86$. Base rate of malingering = 35%. NPP = Negative Predictive Power; PPP = Positive Predictive Power.

Record interview start time:

Instructions:

During the next few minutes, I am going to be asking you questions about your psychological symptoms. These questions are given to different people with many different problems, so some of the problems may apply to you and some may not. I will read each question and then read your response options for that question. Just answer each question the best way you can.

Suggestibility Item—Part 1:

Are you having any problems with hearing a ringing in your ears: *Yes or No?*

☐ **If Yes: Many people with severe mental illness cannot concentrate for a long time, like doing this interview, without getting a ringing in their ears. Please let me know if the ringing gets worse at any time during this interview.**

☒ **If No: Many people with severe mental illness cannot concentrate for a long time, like doing this interview, without getting a ringing in their ears. Please let me know if you experience any problems with hearing ringing in your ears at any time during this interview.**

Items 1-25	Raw score column
1. I often find myself not being able to sit still in a chair: *True or False?* May be medicines, Ø behav. (Observe.) Is the individual's report inconsistent with his or her behavior: *Yes or No?*	RO_1 Yes = 1 No = 0
2. I feel depressed most of the time: *True or False?* Ø meds sure a great	ES_1 True = 1 False = 0

Mis-stated

- Geodon
- R Bandy
- Depakote

	Raw score column
3. Some days I have major mood swings, where for a while I feel great and then I feel depressed: *Yes or No?* If Yes: Does this only happen when you believe that someone is after you: *Always, Sometimes, or Never?*	RC_1 Always = 1 Sometimes = 1 No/Never = 0
4. Do voices tell you to do things: *Yes or No?* If Yes: Do you always obey them: *Yes or No?*	UH_1 Yes = 1 No = 0
5. I feel unusually happy most of the time: *True or False?*	ES_2 True = 1 False = 0
6. I experience hallucinations that last continually for days: *True or False?*	UH_2 True = 1 False = 0
7. Whenever I am sitting down, I have to check under the chair many times to see if anything is under it: *True or False?* (Observe.) Is the individual's report inconsistent with his or her behavior: *Yes or No?*	RO_2 Yes = 1 No = 0
8. Many times during the day, I hear a loud radio playing when there is not a radio on near me: *True or False?*	ES_3 True = 1 False = 0

	Raw score column
9. Whenever I see people who are not really there, they are always in black and white: *True or False?*	UH_3 True = 1 False = 0 NA = 0
10. Most times when people are talking to me, I see the words they speak spelled out: *True or False?*	ES_4 True = 1 False = 0
11. Whenever I am sitting in a chair, I have to breathe deep breaths in order not to get sick: *True or False?* (Observe.) Is the individual's report inconsistent with his or her behavior: *Yes or No?*	RO_3 Yes = 1 No = 0
12. Some nights I have nightmares so bad it scares me: *Yes or No?* If Yes: Does this only happen when you have lost a lot of weight: *Always, Sometimes, or Never?*	RC_2 Always = 1 Sometimes = 1 No/Never = 0
13. Lately my eyesight is so good that I think I have a special power: *True or False?*	ES_5 True = 1 False = 0
14. Sometimes it seems as though somebody controls my symptoms, turning them on and off, so I don't know how I'll feel most days: *True or False?*	USC_1 True = 1 False = 0

-because alone / hears his belief
-hears his belief

Thought insertion - feel ppl put thoughts in head (uncomfortable)

10y o. → periods / stay for ever

5

x three (command)

-carry on conversations w/ self (& friend) & dad who

8206

	Raw score column
15. When I hear voices, I hear them from either my right or my left ear, but rarely from both at the same time: *True or False?* From inside/from w/in head/ * Never heard audible voice	ES_6 True = 1 False = 0 NA = 0
16. Sometimes I am convinced that I have more than one personality: *Yes or No?* outside my head, that would be terrible" If Yes: At those times, do you feel dizzy or lightheaded: *Always, Sometimes, or Never?* (M) = DID / (F) = ØΨ	RC_3 Always = 1 Sometimes = 1 No/Never = 0
17. The times when you can't go to sleep, do you often smell strange odors that are not really there: *Always, Sometimes, or Never?*	RC_4 Always = 1 Sometimes = 1 Never = 0 NA = 0
18. When I hear voices, my hands begin to sweat: *True or False?*	RC_2 True = 1 False = 0 NA = 0
19. Often, I get the strange feeling that I am from another planet: *True or False?*	ES_7 True = 1 False = 0
20. On many occasions, I feel things crawling on me when there is nothing there: *True or False?*	UH_4 True = 1 False = 0

	Raw score column
21. Sometimes I hear music coming from somewhere: *True or False?*	UH_5 True = 1 False = 0
22. When I hear voices, I often develop fears of leaving my house or room: *Always, Sometimes, or Never?*	RC_8 Always = 1 Sometimes = 1 Never = 0 NA = 0
23. Most of the time I feel that I don't really matter: *True or False?*	NI_1 True = 1 False = 0
24. On many days I feel so sad that I can't even remember my full name: *True or False?*	RC_7 True = 1 False = 0
25. If Yes to Suggestibility item—Part 1 (if the individual said that he or she was hearing any ringing at the beginning of the interview), ask the following question: **Has the ringing in your ears gotten worse: *Yes or No?*** If No to Suggestibility item—Part 1 (if the individual stated that he or she was not hearing any ringing at the beginning of the interview), ask the following question: **Are you experiencing any problems with hearing ringing in your ears: *Yes or No?***	S_1 Yes = 1 No = 0
END OF INTERVIEW Record Interview stop time: 10:46A	**Total score**

Scoring Instructions:

1. Remove the first page using the perforated edge and add the raw scores for Items 1-25. Enter the sum in the Total raw score box at the end of the interview.
2. Add the raw scores for all items with an *identical* scale label and enter each sum in the space provided on page 1 for that scale score.
3. Add the scale scores and enter the sum in the Total score box on page 1.
4. Compare the numbers for the Total score on pages 1 and 7 for consistency.
5. Transfer the Interview start and stop times to the first page of the Interview booklet. Calculate the Total interview time and enter in the space provided on page 1.

10r - 1 cases
notes 8209

Issues/Points
For Cross of Dr. Kimberly Kruse

1. What was the referral question? What was she assessing for?
2. Who decided what types of tests to administer? Her or Dr. Frierson?
3. Did you score the tests during or after the evaluation?
   1. If After,—then—HOW did you then figure out that you needed to administer the SIRS? She probably scored the MFAST on the spot, and the SIMS afterward.

SIMS

SIMS—Manual, page 13—"The SIMS Total score was determined to be the best indicator for distinguishing between malingering individuals and honest responders..." SIMS malingering cut off is a score of greater than 14. Defendant's SIMS=12. However, because he did not elevate the Total SIMS score, then she went digging among the subscales.

Only 1 (psychosis scale score = 6) of 5 SIMS scales suggested malingering. However, there is only 81.82 sensisitivity for the P scale (this means that only 82% of the time, it correctly detects malingerers--so, there is plenty of room for error in classification).

SIMS-Manual, page 14—"Respondents who obtain a SIMS Total score of greater than 14 are identified as possible malingering individuals who are considered to be in need of further evaluation..." Def. only scored a 12.

She wrote on her report malingering based on the one elevated scale score (i.e. Psychosis = 6). This is WRONG...and not supported by validity indeces of MMPI-2 or PAI, which indicate that client UNDER-reported problems, and did NOT malinger.

Notes Based on:
- I re-entered - mmpi-2,
  - PAI
  - SIRS (to SIRS-2).
- Reviewed - MFAST
  - SIMS
- Read Kruse's report.

⇒ Looked at manuals:
- mmpi-2
- PAI
- mcmi-III
- SIRS
- MFAST
- SIMS

MMPI-2

MMPI-2
she did NOT submit full computer print out report. She handpicked what she wrote in her report. I entered the client's MMPI-2 responses and computer scored and printed out the full report. She would have done the same. However, she ONLY submitted to defense a barebones computer report. I suspect she ran two reports (the one I produced, which is comprehensive), and a more basic, profile one, which is what she submitted to defense. Either way, even the barebones report contradicts what she included in the report.

MMPI-2: Kruse stated that L Scale score "implying dishonest test taking or extreme defensiveness." The MMPI-2 report does NOT use the words "implying dishonest test taking" (that is Kruse's misleading language)

MMPI-2 findings (elevated L scale) indicate that he actually under-reported problems in an attempt to portray himself in an overly positive light.—this is CONTRADICTORY to malingering.

In spite of UNDER-reporting problems, there is evidence of clear mental illness—psychosis.

Scales Pa and Sc were elevated on the report pages she submitted—given under-reporting, and that the F-scale (fake bad scale) was NOT elevated, this suggests that there is REAL, GENUINE psychosis that the client reported. The MMPI-2 asks questions about PAST and Present problems, not just present, and not just past.

MMPI-2 handpicked statements from MMPI2 print out report.

She ommitted the following from the print out report:

P. 5 of Dr. Flores' MMPI-2 printout—
"Despite this extreme defensivenss, he responded to itemas reflecting some unusual symptoms of beliefs...."

"Scales Pa and Sc were used as the prototype to develop this report. A severe psychological disorder is reflected in this profile...."

"He endorsed a number of extreme and bizarre thoughts, suggesting the presence of delusions and/or hallucinations. He apparently believes that he has special mystyical powers or a special 'mission' in life that others do not understand or accept."

"Diagnostic Considerations

The most likely diagnosis for individuals with this profile type is Schizophrenia, possibly Paranoid type, or a Delusional Disorder."

MMPI-2 there were two items omitted:
192. My mother is a good woman, or (if your mother is dead) my mother was a good woman

198. I often hear voices without knowing where they come from (If he is malingering, WHY not answer this one with "true"?)

PAI

Big problems here too.

Again ONLY submitted to defense parts of the printed computer-scored findings. The entire printout is actually 14 pages.

Handpicked what she included in her report.

Omitted findings that contradict malingering. See below.

Did not include She literally included the paragraphs immediately and below the following, which she omitted (and is clearly helpful to defense)—

"With respect to negative impression management, there is no evidence to suggest that the respondent was motivated to portray himself in a more negative or pathological light than the clinical picture would warrant."
(THIS means he was NOT malingering).

Findings she DID report indicate that client UNDER-reported problems. (This is CONTRADICTORY to malingering).
He did not answer in a forthright manner—she is correct. This is because he tried to make himself better than he is, with less problems. NOT because he was being deceptive/malingering.

PAI findings are consistent with MMPI-2 findings—Two diffferent tests, yet the SAME two clinical scales were elevated.

Like MMPI-2, PAI results also indicate clear severe mental illness. Paranoa and Schizophrenia were elevated. This is important BECAUSE there was no evidence of malingering, and on the contrary, he was UNDER-reporting.

What PAI printout says that Kruse omitted from her report—

"A number of aspects of the respondent's self-description suggest noteworthy peculiarities in thinking and experience. It is likely that he experiences unusual perceptual or sensory events (perhaps including full-blown hallucinations) as well as unusual ideas that may include magical thinking or delusional beliefs. His thought processes, although relatively uncompromised, may occasionally be marked by some confusion and difficulty concentrating. He may have some difficulty establishing close interpersonal relationships.

The respondent describes certain problems potentially associated with elevated and variable mood. In particular, he is likely to have an activity level that is perceptibly high to most observers. He may be involved in a wide variety of activities in a somewhat disorganized manner and may experience accelerated thought processes."

"Axis I Rule Out:

297.1 Delusional Disorder

296.40 Bipolar I Disorder, Most Recent Episode Manic, Unspecified

295.30 Schizophrenia, Paranoid Type

Axis II:

799.9 Diagnosis Deferred on Axis II

Axis II Rule Out:

301.9 Personality Disorder NOS (Mixed Personality Disorder With Borderline, Antisocial, Narcissistic, Schizotypal, and Paranoid Features)"

I gave you entire printout of diagnostic considerations, in case she brings up the personality stuff. Obviously you do not want to point out the personality stuff, but get her to ADMIT that there were elevations suggestive of severe mental illness/psychosis.

MFAST

Scored incorrectly—She scored MFAST= 8 (cut off for possible malingering, and therefore need for a SIRS is 6).

His score should have been 4—therefore BELOW the cut off and the SIRS should not even have been administered.

Item 2: I feel depressed most of the time —she circled True, yet he responded, "No, meds work great" (should have been scored "0")

Item 4: Do voices tell you to do things? She circled "Yes", yet he told her "not anymore with medications" (should have been scored "0") Then, she followed it up with the second part, "Do you always obey them?" She circled "yes", yet he told here "too scared to act on it."

Item 6: I experience hallucinations that last continually for days: she circled True, yet he told her, "Now with meds, better, but yes" (shold have been scored "0")

Item 21: Sometimes I hear music coming from nowhere: she circled true, yet he told her "due to drugs" and "music in my head all day, random songs" (should have been scored "0")

On item 15, When I hear voices, I hear them from either my right or my left ear, but rarely from both at the same time: He answered False and tehn spontaneously made statement: "from inside/from within head. Never heard audible voice outside my head, that would be terrible" (this is Inconsistent with malingering).

SIRS

She administered and OLD version of the test. Should have used the SIRS-2 which came out in 2010.

I re-scored using the SIRS-2—no major difference in findings.

What concerns me is that the ONE scale in the Definite malingering range (IA=mprobable or absurd syptoms, was a score of 7...Had it been 6, it would have put it at probable range). The questions in the IA scale could easily be misscored—as she did the MFAST.

There was NO need to do THREE personality tests. In this case, the results were valid and indicative of a psychotic disorder.

There was NO need to administer THREE malingering tests. Once she gave the MFAST, only SIRS should have been given.

Results of the SIRS and MFAST (which is misscored) are INCONSISTENT with the validity indeces of the MMPI-2 and PAI. If he really was malingering, then, results of the MMPI-2 and PAI would have been invalid due to symptom exaggeration. Yet, you have the OPPOSITE. Those tests should Under-reporting in an attempt to present himself in a positive light, that is, less ill and with less problems than he has.

More on the MFAST—

Measures that assess malingering are NEVER to be interpreted in a vacuum.

Kruse should have addressed the validity of the personality and psychopathology tests on the "symptom validity" report section (page 6). Doing so would have allowed for her to explain HOW it is that M-FAST and SIRS are inconsitent with MMPI-2 and PAI validity indeces.

Instead, she chose to not adress at ALL the fact that there was NO evidence on the MMPI-2 or PAI of malingering. There was the opposite—UNDER-reporting of problems.

See page 20 of M-FAST manual for sample of how she should have discussed findings of the M-FAST and MMPI-2 validity indeces ***jointly.***

8218 **MMPI-2 Scale Scores**

L	52
F	120
K	47
TRIN	60
VRIN	55
F_B	149
F(p)	120
Hs	70
D	76
Hy	65
Pd	60
Mf	40
Pa	79
Pt	70
Sc	59
Ma	81
Si	45

Note. *L* = Lie; *F* = Infrequency; *K* = Correction; *TRIN* = True Response Inconsistency; *VRIN* = Variable Response Inconsistency; F_B = Back Infrequency; *F(p)* = Infrequency Psychopathology; *Hs* = Hypochondriasis; *D* = Depression; *Hy* = Hysteria; *Pd* = Psychopathic Deviate; *Mf* = Masculinity/Femininity; *Pa* = Paranoia; *Pt* = Psychasthenia; *Sc* = Schizophrenia; *Ma* = Hypomania; *Si* = Social Introversion.

Figure 4. (continued)

Psychopathology [*F*(p)] scales were all markedly elevated, indicating the endorsement of many severe psychiatric symptoms. Mr. N's MMPI-2 clinical scales were also markedly elevated, but were inconsistent with both behavioral observations and the examinee's description of his problems. The following interpretation was made on the basis of the interview and testing results.

Mr. N reported a sudden onset and resolution of severe psychotic symptoms that are very rare for psychiatric patients. His behavior on the unit was inconsistent with the behavior that would be expected for an individual experiencing an authentic disorder, and his symptoms appeared to worsen whenever the unit psychologist was present. This presentation was atypical and raised suspicions that the patient might be malingering to avoid criminal prosecution. M-FAST results were highly suggestive of malingered mental illness. His M-FAST Total score and three scale scores (see Figure 4) were significantly higher than scores of genuine psychiatric patients. He endorsed symptoms that are very atypical and extreme. His performance on the M-FAST also suggested that he did not appear to be aware of his behavior within the interview setting, as his self-report was markedly inconsistent with behavioral observations. Because of the M-FAST results, the MMPI-2 and SIRS were administered for diagnostic purposes.

Mr. N's MMPI-2 results were also suggestive of malingered mental illness. His performance on the MMPI-2 revealed elevations on the validity scales that suggested overreporting of psychopathology. His MMPI-2 profile had elevations on the Infrequency (F), Back Infrequency (F_B), and Infrequency Psychopathology [F(p)] scales. Although he also had marked elevations on many of the clinical scales, this test performance was inconsistent with his self-reported experiences and behavioral observations. Results from the SIRS were consistent with the M-FAST and MMPI-2 results. His performance suggested that he did not appear to be aware of his own speech characteristics or physical movements within the interview setting and has a very atypical presentation of symptoms. The elevations on eight of the SIRS primary scales were consistent with the results obtained from the M-FAST and MMPI-2. The information obtained from behavioral observations and psychological testing was consistent with the diagnosis of malingering.

↑

sample write up

* Sx should have discussed M-FAST findings in conjunction with validity indices of MMPI-2 and PAI.

as malingerers). To do so, the relevant malingering group was contrasted with the HR group for each scale. In the case of overlapping distributions, specific cutoff scores were specified as the value within the distribution intersection that maximized hit rates for both groups. In the case of nonoverlapping distributions, the midpoint between the two distributions became the cutoff score. In this way, hit rates for both groups were maximized. Table 4.1 provides a listing of these specific scale cutoff values.

Table 4.1
SIMS Scale Cutoff Scores for the Developmental Sample

Scale	Cutoff score
Total	> 14
Psychosis (*P*)	> 1
Neurologic Impairment (*NI*)	> 2
Amnestic Disorders (*AM*)	> 2
Low Intelligence (*LI*)	> 2
Affective Disorders (*AF*)	> 5

Cutoff Score Utility

Once the cutoff scores were established, the optimal utility of individual scales in identifying malingering individuals was determined using the developmental sample. Because cutoff scores were established using the developmental sample, these criteria would produce the highest possible measures of sensitivity, specificity, and efficiency. Thus, measures of sensitivity, specificity, and efficiency were calculated initially using the developmental sample, both to provide an initial descriptive baseline of each scale's effectiveness under optimal conditions and to provide a point of comparison to be used later when considering results obtained by using the cross-validation sample.

For evaluation of the utility of SIMS scale cutoff scores for classifying the developmental sample participants as malingerers or as honest responders, all experimental groups were combined into an overall malingering group and compared to the HR group (see Table 4.2). This overall comparison between malingering and nonmalingering was made in order to reflect, as much as possible, the conditions encountered in real-world situations whereby clinicians are unaware of the specific condition or combination of symptoms that the malingering individual may try to present.

Results of the analyses using the developmental sample revealed several important initial findings. Specifically, chi-square analyses indicated that all of the SIMS scales, using the empirically derived cutoff score criteria, were able to identify participants as malingerers at levels that were above chance. Individual SIMS scales demonstrated high efficiency ratings for distinguishing malingering individuals from honest responders, with estimates of efficiency ranging from 75.12% (*P* scale) to 88.24% (*AM* scale). Furthermore, the SIMS Total score was determined to be the best indicator for distinguishing between malingering individuals and honest responders in the developmental sample. When all experimental groups were combined into a single malingering group, the SIMS Total score demonstrated an efficiency rating of 94.96%.

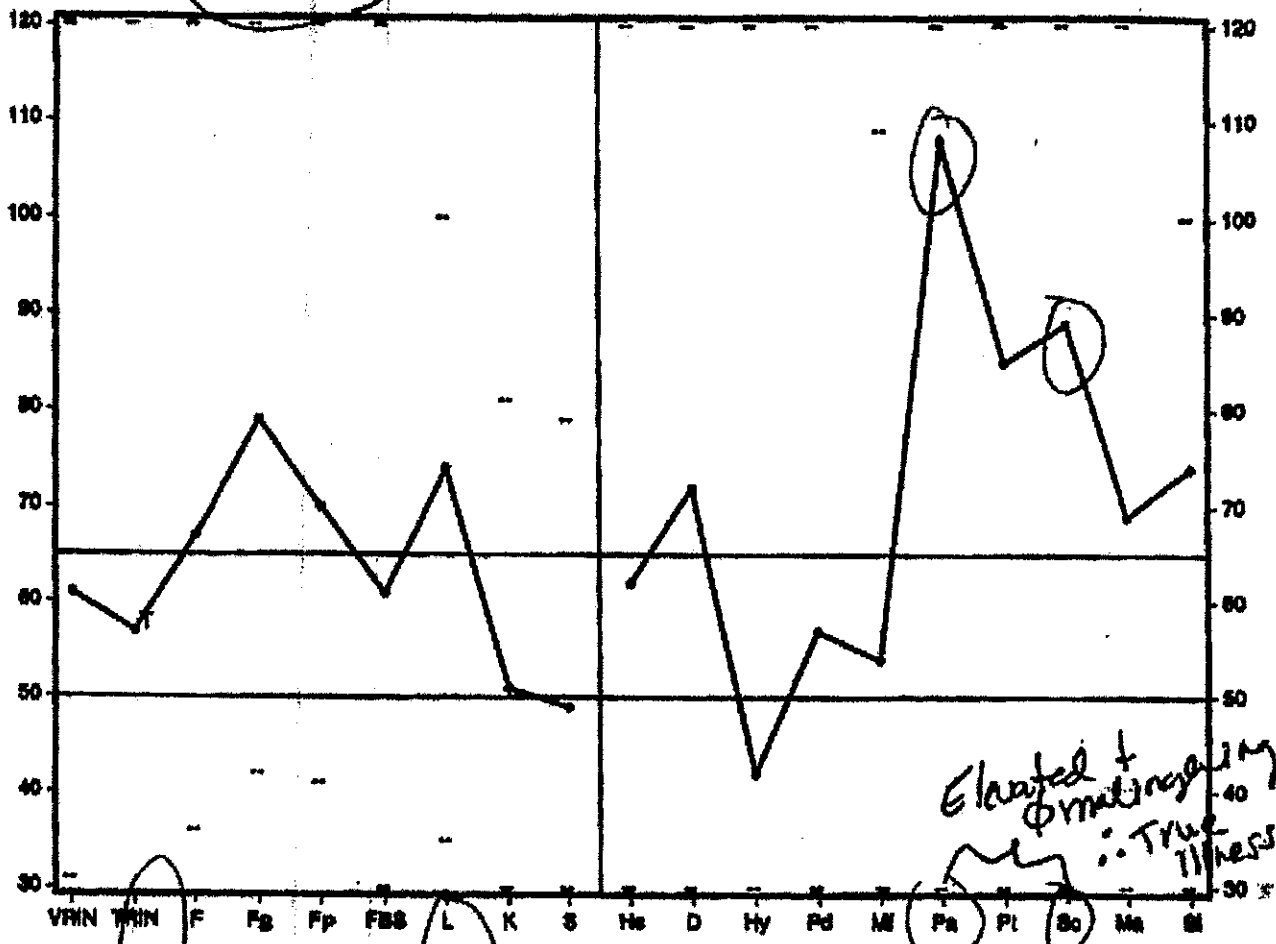
Results regarding SIMS scale utility estimates in the developmental sample, which would tend to reflect optimal estimates of utility given the overfitting of the data to the sample, then were replicated using the cross-validation sample. All cross-validation sample

Table 4.2
SIMS Scale Utility in the Detection of Malingering for the Developmental Sample

Scale/Cutoff score	Sensitivity (%)	Specificity (%)	Efficiency (%)
Total > 14	94.63	87.88	94.96
P > 1	81.82	76.05	75.12
NI > 2	85.85	90.91	86.55
AM > 2	88.78	84.85	88.24
LI > 2	84.39	78.79	83.61
AF > 5	76.10	90.91	78.15

Note. $n = 231$. *P* = Psychosis; *NI* = Neurologic Impairment; *AM* = Amnestic Disorders; *LI* = Low Intelligence; *AF* = Affective Disorders.

MMPI-2 VALIDITY AND CLINICAL SCALES PROFILE



	VRIN	TRIN	F	Fb	Fp	FBS	L	K	S	Hs	D	Hy	Pd	Mf	Pa	Pt	Sc	Ma	Si
Raw Score:	8	10	10	9	4	16	9	16	24	9	29	17	20	28	26	27	33	24	46
K Correction:										5			6			16	16	3	
T Score (Plotted):	61	157T	67	79	70	61	74	51	49	62	72	42	57	54	106	85	89	69	74
Non-Gendered T Score:	62	88T	69	79	72	58	75	52	48	60	70	41	57		107	81	87	69	72
Response %:	100	100	97	100	96	100	100	100	100	100	100	100	100	100	100	100	99	100	100

Cannot Say (Raw): 2
F-K (Raw): -6
Welsh Code: 6***87'02'9+1-45/3: L'F+-K/

Percent True: 45
Percent False: 55
Profile Elevation: 73.0

D Faking Good
- Underreporting problems
- Opposite of malingering (see MMPI-2 manual pg 2021)

The highest and lowest T scores possible on each scale are indicated by a "*".

For information on FBS, see Ben-Porath, Y. S., & Tellegen, A. (2008). The FBS: Current Status, a report on the Pearson web site (www.pearsonassessments.com/tests/mmpi_2.htm).

...from those that result from overreporting, after random and fixed responding have been ruled out based on the VRIN and TRIN scales. Table 12 provides recommended interpretations for different levels of F_p. These recommendations are based on research conducted primarily in clinical settings.

MEASURES OF DEFENSIVENESS

In completing the MMPI-2, some individuals provide an overly positive self-presentation. Such a defensive test-taking approach may distort the respondent's scores on the clinical, content, and supplementary scales. The MMPI-2 defensiveness scales are designed to alert the interpreter to the presence and degree of defensiveness in a test protocol.

L (Lie) Scale

Hathaway and McKinley developed the L scale to assess the likelihood that the test-taker approached the instrument with a defensive mind set. The scale's items provide the respondent the opportunity to deny various minor faults and character flaws that most individuals are quite willing to acknowledge as being true of themselves. Although the L scale can reflect deceit in the test-taking situation, it should not necessarily be viewed as a measure of any general tendency to lie, fabricate, or deceive others on the part of individuals in their day-to-day activities. Rather, it serves as an index of the likelihood that a given test protocol may be distorted by this particular style of responding to the inventory. Because all of the items on L are keyed False, it is essential that the TRIN scale be examined for possible acquiescent or nonacquiescent response styles prior to interpreting scores on L.

Tables 13 and 14 indicate interpretive possibilities for different levels of elevation on L in clinical and nonclinical settings, respectively. T scores greater than 79 in either setting likely reflect an invalid profile marked either by pervasive nonacquiescence (if TRIN is greater than 79F) or faking good manifested in a pervasive and rather unsophisticated pattern of denial of minor faults and shortcomings. Differences between the two tables reflect differential motivational sets that may be present in the two types of settings. In nonclinical settings, particularly when there exists a strong press for presenting oneself in the most favorable manner (e.g., employment and child custody evaluations), moderate elevations on L are common and do not necessarily indicate an invalid profile. In clinical settings, denial of shortcomings is less likely to occur, although it is sometimes found in patients with psychotic disorders characterized by paranoid delusions. Individuals who come from very traditional families in which they were raised to aspire to the kinds of virtues included among the L items may produce moderate elevations on this scale that do not reflect a fake-good test-taking approach.

K (Correction) Scale

The K scale was developed to assess an individual's level of defensiveness in responding to the MMPI-2 items and to correct for the effect this response style has on clinical scale scores. It was designed to identify a less blatant form of defensiveness than is reflected in elevations on L. Individuals who produce elevated scores on the K scale are unlikely to report significant psychological problems in response to the MMPI-2 items. This, in itself, does not indicate that there are problems that are being covered up. However, an elevated score on K means that it is not possible

TABLE 12. F_p (Infrequency-Psychopathology) Scale: Implications of Scores

T-Score Level	Profile Validity	Possible Reasons for Elevation	Interpretive Possibilities
≥ 100	Likely invalid	Random responding Faking bad	If VRIN or TRIN is above T score 79, this is an invalid and uninterpretable profile. If both are within normal limits, the test-taker is overreporting psychopathology in an attempt to appear more disturbed than he or she is in reality.
70–99	Likely exaggerated, but may be valid	Exaggeration of existing problems	Consider exaggeration of symptoms, perhaps as a "cry for help."
≤ 69	Likely valid		Test-taker accurately described current mental health status.

manual

TABLE 13. L (Lie) Scale: Implications of Scores in Clinical Settings

T-Score Level	Profile Validity	Possible Reasons for Elevation	Interpretive Possibilities
≥ 80	Likely invalid	Faking good Pervasive nonacquiescence	If TRIN is greater than 79F, the protocol is characterized by a pervasive pattern of nonacquiescence and is, therefore, invalid and uninterpretable. If TRIN is within normal limits, the high L score reflects a very strong pattern of faking good and a likely invalid test protocol.
65–79	May be invalid	Faking good Traditional background Moderate nonacquiescence	If TRIN is in the 65F–79F range, the elevation on L likely reflects a moderate pattern of nonacquiescence rather than faking bad. If TRIN is within normal limits, the elevation on L likely reflects a rather unsophisticated pattern of faking good. The higher the L score, the greater the likelihood that the MMPI-2 scales do not accurately represent existing psychopathology.
≤ 64	Likely valid		

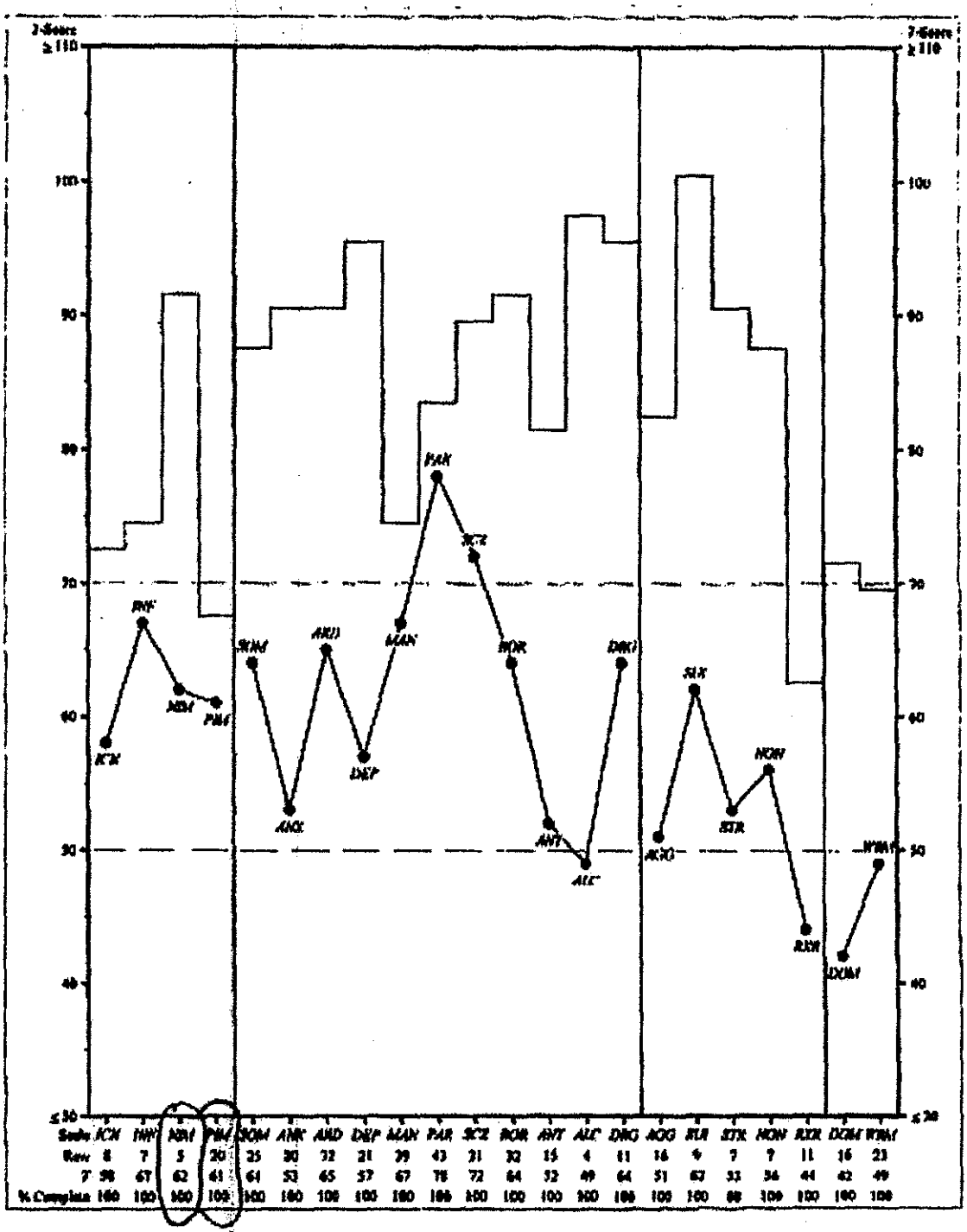
Faked in a good

TABLE 14. L (Lie) Scale: Implications of Scores in Nonclinical Settings

T-Score Level	Profile Validity	Possible Reasons for Elevation	Interpretive Possibilities
≥ 80	Likely invalid	Faking good Pervasive nonacquiescence	If TRIN is greater than 79F, the protocol is characterized by a pervasive pattern of nonacquiescence and is, therefore, invalid and uninterpretable. If TRIN is within normal limits, the high L score reflects a very strong pattern of faking good and a likely invalid test protocol.
70–79	May be invalid	Moderate faking good Moderate nonacquiescence	If TRIN is in the 65F–79F range, the elevation on L likely reflects a moderate pattern of nonacquiescence rather than faking. If TRIN is within normal limits, the elevation on L likely reflects a moderate and rather unsophisticated pattern of faking good. The higher the L score, the greater the likelihood that the MMPI-2 profile may not accurately represent existing psychopathology.
65–69	Questionably valid	Overly positive self-presentation	Respondent likely minimized psychological and behavioral difficulties. This may result in underestimation of problems.
60–64	Likely valid	Unsophisticated defensiveness	Respondent denied minor faults and shortcomings that most people acknowledge readily, perhaps owing to the belief that it is in her or his best interest to do so. Test-taker may come from a traditional background.
≤ 59	Valid		

to rule out the presence of psychological difficulties based on the MMPI-2 profile. This is particularly true for scales that are very direct in assessing psychopathology such as the MMPI-2 content scales. Because all but one of the K scale items are keyed False, it is essential that the TRIN scale be examined for possible acquiescent or nonacquiescent response styles prior to interpreting deviant scores on K. Tables 15 and 16 provide interpretive guidelines for various ranges of scores on the K scale in clinical and nonclinical settings, respectively. As is the case with L, differences between

Full Scale Profile



Scale	ICN	INF	NIM	PIM	SOM	ANX	ARD	DEP	MAN	PAR	SCZ	BOR	ANT	ALC	DRG	AGG	RIT	STR	MON	RXR	DOM	WRM
Raw	8	7	5	20	25	30	32	21	29	43	31	32	15	4	11	16	9	7	7	11	16	23
T	58	67	62	61	61	53	65	57	67	78	72	64	52	49	64	51	62	53	56	44	62	49
% Complete	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	88	100	100	100	100

Plotted T scores are based upon a census matched standardization sample of 1,000 normal adults.
a indicates that the score is more than two standard deviations above the mean for a sample of 1,246 clinical patients.
+ indicates that the scale has more than 20% missing items.

NIM = Negative Impression management = Malingering
PIM = Positive " " = Under-reporting
(See PAI manual p.30 ⇒ ϕ malingering by D.

actual content of the item, or begin to respond to items figuratively rather than literally, the results will not be interpretable in any straightforward manner. Because such respondents are not approaching the test in the way that most people do, the results of the self-report test should not be interpreted as if it was.

The distribution of *INF* is similar for both normal and clinical individuals in that both distributions are very different from that derived by simulating random responding. Generally, low scores (i.e., < 60*T*) suggest that the respondent attended appropriately to item content in responding to the PAI items.

Moderate elevations (i.e., 60*T* to 74*T*) indicate some unusual responses to *INF* items and, at the higher end of this range, one should consider potential sources such as (a) reading difficulties, (b) random responding, (c) confusion, (d) scoring errors, (e) idiosyncratic item interpretation, or (f) failure to follow the test instructions. Any interpretive hypotheses based on the PAI should be reviewed with caution if *INF* is in this range, and some inquiry about *INF* responses would be useful before clinical scale results are interpreted.

High scores on *INF* (i.e., ≥ 75*T*) suggest that the respondent did not attend appropriately to item content in responding to the PAI items. Completely random completion of the PAI results in an average *INF* score of 86*T*. There are several potential reasons for scores in this range, including (a) reading or language difficulties, (b) random responding, (c) confusion, (d) scoring errors, or (e) failure to follow the test instructions. Regardless of the cause, the test results are best assumed to be invalid and no clinical interpretation of the PAI is recommended, although an examination of specific *INF* items may yield useful information about the source of the elevations. For example, an inmate at a correctional facility might respond negatively to an *INF* item such as "Sometimes I get ads in the mail that I don't really want" because of particular aspects of an atypical setting.

Ds T-score = 62

Negative Impression (NIM)

The Negative Impression (*NIM*) scale contains items that present an exaggerated unfavorable impression or represent extremely bizarre and unlikely symptoms. The scale was designed to alert the interpreter to the possibility that the results of the test may portray a more negative impression of the individual than might otherwise be merited. To put it another way, the self-report of a high scorer on *NIM* is probably more pathological than an objective observer would report when describing the respondent. However, although *NIM* is sensitive to negative distortion, it must be emphasized that *NIM* is not a malingering scale per se.

NIM items were selected on the basis of low endorsement frequencies in both normal and clinical individuals, although *NIM* items are clearly endorsed with greater frequency in clinical patients than in normal adults. Individuals with clear-cut and severe emotional problems can and will obtain elevated scores on *NIM*, and more disturbed populations obtain higher scores than those who are less impaired. This relationship appears to result from the association between certain forms of mental disorder and characteristic perceptual and cognitive features that can lead to negative response styles. Several different types of mental disorders lead individuals to perceive themselves, other people, or situations in a manner more negatively than might be warranted in the eyes of an objective observer. For example, the depressed patient with a self-view of inadequacy may be viewed by others as able and highly effective, interpersonal relationships that appear solid to others may be suspect in the mind of the paranoid individual, and a situation that may appear to the clinician as relatively benign may be perceived as insurmountable by the borderline patient. Although these distortions clearly reflect psychopathology, the clinician must be cognizant of the influence that these perceptual styles have when interpreting the PAI profile.

The *NIM* scale includes two types of items. One type presents an exaggerated or a distorted impression of the self and current circumstances, and the other represents extremely bizarre and unlikely symptoms. Each of these tendencies can cause distortion of self-report in a negative direction. An individual who tends to exaggerate the negative aspects of his or her life can provide a self-report that appears very pathological. As noted earlier in this chapter, this response style can actually represent a prominent component of many psychopathological syndromes, but the *NIM* scale can enhance discriminant validity, revealing the degree to which the distortion may be a result of this perceptual style. At times, there may be so much distortion as to render the test results dubious in terms of interpretability. However, this does not mean that the person was malingering. Rather, the test is invalid in the sense that there are serious distortions, and extreme caution must be exercised in interpreting the test results at face value. Nonetheless, the results may accurately depict the way such a person feels about himself or herself and his or her circumstances.

Patient groups tend to score considerably lower on *NIM* than do research individuals instructed to simulate the responses of a severely mentally disordered patient. The scale serves as a useful beginning point in the detection of malingering given that another element of *NIM* items is more closely related to malingering. These items were written to sound as though they represent pathological symptoms but are in fact extremely rare or nonexistent in clinical populations. The item content is varied, but all items are dramatic sounding and tap into stereotypes of mental disorder. In fact, a few of the items are dissociative in nature, and it has been observed that individuals with severe dissociative disorders sometimes obtain marked elevations on *NIM* (Alpher, 1995). Idiosyncratic responses to item content also can result in *NIM* elevations, although in these instances, *INF* also tends to be elevated. Regardless of the context, some inquiry about the nature of positive responses to these *NIM* items is merited.

Generally, low scores (i.e., < 73*T*) on *NIM* suggest that there is little distortion in a negative direction on the clinical scales and that the respondent likely did not attempt to present a more negative impression than the clinical picture would warrant. Moderate elevations (i.e., 73*T* to 83*T*) suggest an element of exaggeration regarding complaints and problems. Any interpretive hypotheses based on clinical scale elevations should be considered with caution because the hypotheses might possibly overrepresent the extent and degree of significant test findings. The likelihood of distortion increases in the range from 84*T* to 91*T*, where elevations in this range may be indicative of a "cry for help" or an extremely negative evaluation of oneself and one's life—some deliberate distortion of the clinical picture also may be present.

High scores on *NIM* (≥ 92*T*) suggest that the respondent attempted to portray himself or herself in an especially negative manner. The item content suggests the strong possibility of (a) careless responding, (b) extremely negative self-presentation, or (c) malingering. Research individuals instructed to malinger severe mental disorders typically obtain an average *NIM* score in excess of 110*T*, and scores greater than this are often an indication of effortful negative distortion. A completely random completion of the PAI would result in an average *NIM* score of approximately 96*T*. In the context of a markedly elevated *NIM*, the test results are best assumed to be invalid, and clinical interpretation of other PAI scales should focus on the desire of the respondent to report the symptoms reflected in the remainder of the profile rather than inferring that he or she actually experiences these symptoms.

Positive Impression (PIM)

The content of *PIM* scale items involves the presentation of a very favorable impression or the denial of relatively minor faults. The items were selected by examining the distributions of scores for normal individuals, patients, and research individuals responding to the PAI under positive impression enhancement instructional sets. The items were selected on the basis of low endorsement frequencies in both normal and clinical individuals; however, *PIM* items are endorsed with greater frequency in normal adults than in clinical patients. Hence, marked elevations in clinical individuals are particularly rare and are interpretively significant if obtained. Both patients and community adults score considerably lower than research individuals completing the PAI under a positive impression enhancement instructional set.

For the most part, *PIM* items offer the opportunity for an individual to acknowledge a relatively minor personal fault. Hence, elevated scores indicate that the respondent does not take many opportunities to say negative things about himself or herself. There are a number of reasons why people completing a self-report instrument might not report negative characteristics. One possibility is that the respondent indeed does not have negative characteristics, or at least has fewer than most individuals. A second possibility is that they are not telling the truth—that they are trying to deceive the recipient of the test results into believing that they have more positive features than they really do. A third possibility is that they are simply not aware of certain faults that they may have—that they lack insight into some of their personal shortcomings. In either of the latter two instances, the results of a self-report test will lead the interpreter to form a more positive impression of the respondent's life circumstances and psychological adjustment than would probably be merited according to an independent observer. It is these latter two characteristics that *PIM* was designed to measure.

It should be recognized that the tendency for favorable self-presentation appears to be fairly common in the normal population. Typically, most cutoff scores on indexes of social desirability that were derived from clinical studies will identify 30% to 40% of the general population as "faking good." Such results underscore

the difficulty of distinguishing defensive responding from nondefensive with respect to clinical instruments. A number of instruments have used scales similar to *PIM* to correct other scales on the test for defensive responding as if such scales tapped into pure suppressor variables, but the PAI makes no such correction because attempts to eliminate social desirability from clinical scale scores tend to remove criterion-related variance and lower validity.

Low scores on *PIM* (i.e., < 44*T*) are strongly indicative of candid responding. Typically, respondents in this range are unlikely to be holding much back. Generally, scores from 44*T* to 56*T* suggest that the respondent did not attempt to present an unrealistically favorable impression in completing the test, although scores in the upper end of this range tend to be unusual in clinical settings.

Moderate elevations (i.e., 57*T* to 67*T*) suggest that the individual responded in a manner to portray himself or herself as relatively free of the common shortcomings to which most individuals will admit. This response style could be overt, but it could also involve a covert, automatic defensive process. With *PIM* in this range, the accuracy of interpretations based on the PAI clinical scales profile may be distorted, and interpretive hypotheses should be reviewed with caution. It is likely that the PAI profile will underrepresent the extent and degree of significant test findings, although the influence on the PAI scales may be scale specific. For example, a respondent may be minimizing drug problems but accurately describing problems with aggression.

High scores on *PIM* (i.e., ≥ 68*T*) suggest that the respondent attempted to portray himself or herself as exceptionally free of the common shortcomings to which most individuals will admit. When scores in this range are obtained, the validity of the PAI clinical scale profile is questionable, and extreme caution in the clinical interpretation of other PAI scales is recommended. However, such scores are usually rare, and concerns about defensiveness should be raised at even lower scores, as previously noted.

Supplemental Validity Indicators

Malingering Index (MAL)

Morey (1996) developed the Malingering Index (MAL) as a more specific indicator of malingering that would be relatively independent of psychopathology. MAL is composed of eight configural features of the PAI profile that tend to be observed much more frequently in the profiles of individuals simulating mental disorder (particularly severe mental disorders) than in actual clinical patients. Scoring of the index is described in chapter 2. The features of MAL range from basic elevations of the validity scales to particular (and peculiar) configural aspects of the clinical scales and subscales.

A MAL raw score of 3 (i.e., 84*T*) or greater, which is more than two standard deviations above the mean of the clinical standardization sample, should raise questions of malingering. Scores of 5 (i.e., 111*T*) or greater are highly unusual in clinical samples and tend to occur only when severe mental disorder is being feigned. It appears that the sensitivity of MAL will decline when milder forms of psychopathology (e.g., depression, anxiety) are being simulated, although the effects of coaching appear to be mixed. Thus, where the malingering of milder disorders is a concern, adjustments to the MAL cutoff score may be needed to optimize the utility of decisions.

Rogers Discriminant Function (RDF)

The Rogers Discriminant Function (RDF; Rogers et al., 1996) is a discriminant function that was developed to distinguish the PAI profiles of bona fide patients from those simulating psychiatric disorders (including both naïve and coached simulators). The scoring involves weighted combinations of 20 PAI scores, as described in chapter 2. The formula yields a discriminant function score that has a cutoff score of about 0, which can then be converted to a *T* score. Thus, in interpreting the results of the function, raw scores greater than 0 (i.e., 59*T*) suggest malingering, whereas scores less than 0 suggest that no effort at negative distortion was made. The function has an interesting characteristic of yielding similar results when applied to both community and patient samples. The meaning of this similarity in community and clinical groups is that scores on this function are independent of clinical status—the function does not appear to confound true psychopathology and effortful negative impression management.

Defensiveness Index (DEF)

The Defensiveness Index (DEF; Morey, 1996) involves a set of indicators developed to further supplement the tools for identifying effortful defensive responding. This index is composed of nine configural features of the PAI profile that tend to be observed with greater frequency in individuals instructed to present a

re-input raw data.
this is report she would have printed but did not give to defense look at omissions

Personality Assessment Inventory™

Clinical Interpretive Report

Generated by PARiConnect

by Leslie C. Morey, PhD and PAR Staff

Client name:	Timothy Jones Jr
Client ID:	22219
Age:	37
Gender:	Male
Education:	16
Marital status:	Divorced
Test date:	02/22/2019
Prepared for:	-Not Specified-

This report is intended for use by qualified professionals only and is not to be shared with the examinee or any other unqualified persons.

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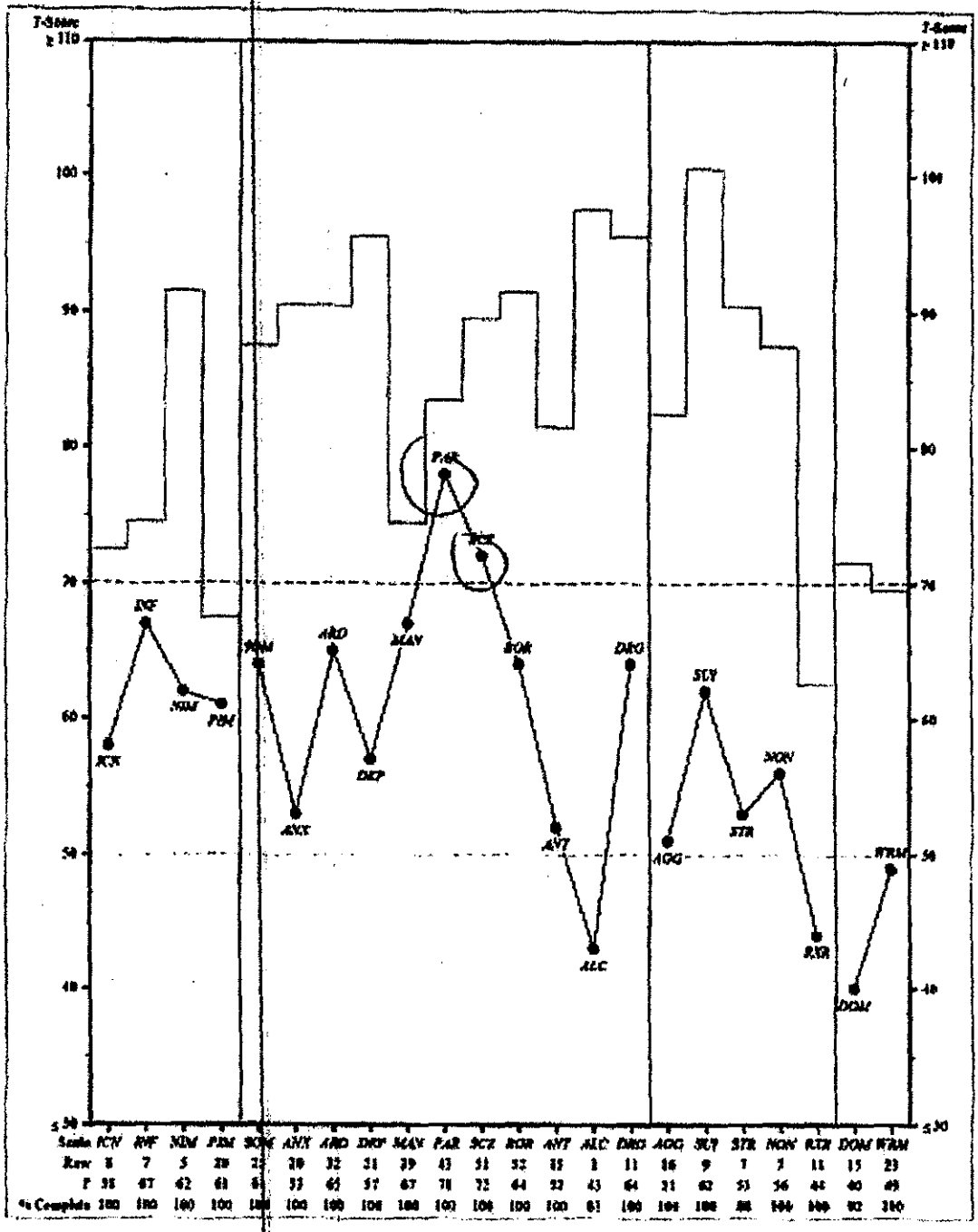
Version: 3.30.062

Full Scale Profile



Plotted T scores are based upon a census matched standardization sample of 1,000 normal adults.
= Indicates that the score is more than two standard deviations above the mean for a sample of 1,245 clinical patients.
+ Indicates that the scale has more than 20% missing items.

PAI Clinical Interpretive Report
Timothy Jones Jr (22219)
03/22/2019

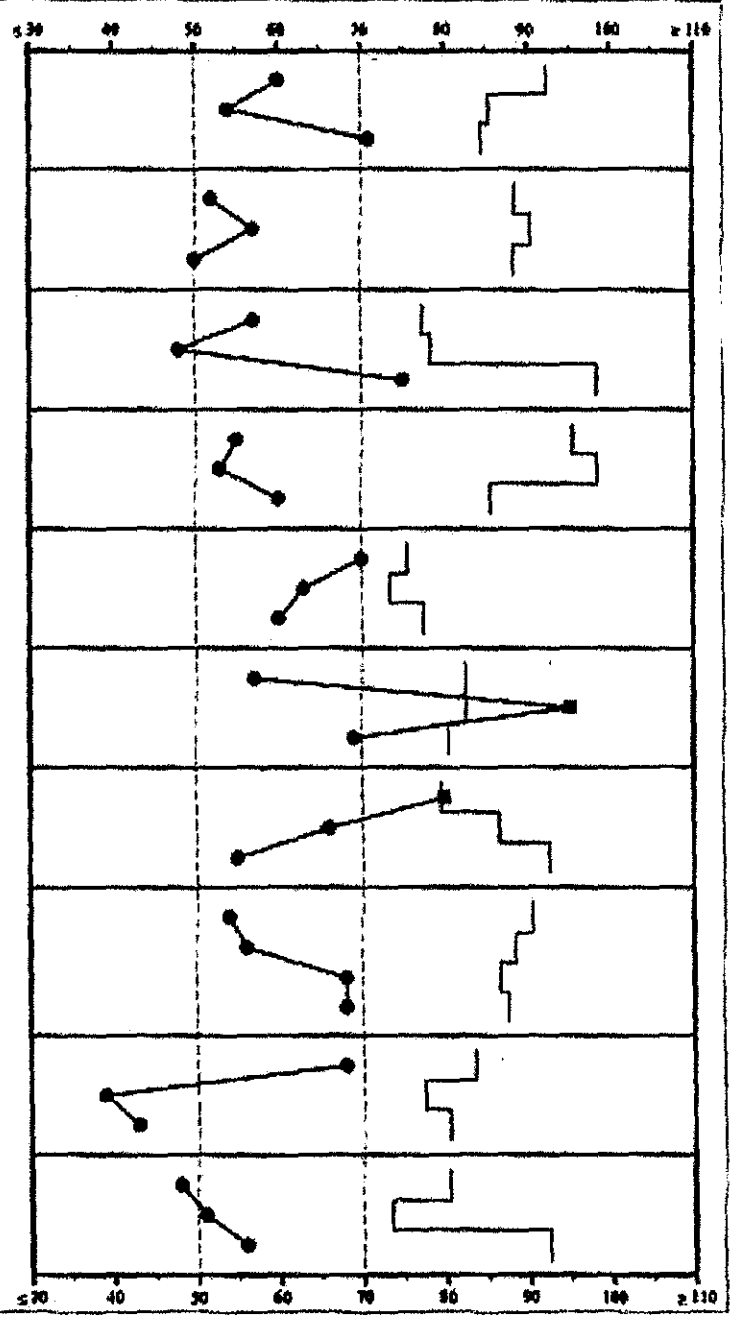
Krause

She will argue psychotic symptoms are due to cannabis abuse (per Dr. Krause)

These are the same elevated scales Krause saw. (She provided this page to defense, but neglected to address clinical elevations)

Subscale Profile

		Score Raw	T
SOM-C	Conversion	6	60
SOM-S	Somatization	6	54
SOM-H	Health Concerns	13	71
ANX-C	Cognitive	7	52
ANX-A	Affective	9	57
ANX-P	Physiological	4	50
ARD-O	Obsessive-Compulsive	12	57
ARD-P	Phobias	8	48
ARD-T	Traumatic Stress	14	75
DEP-C	Cognitive	6	55
DEP-A	Affective	5	53
DEP-P	Physiological	10	60
MAN-A	Activity Level	13	70
MAN-G	Grandiosity	14	63
MAN-I	Irritability	12	69
PAR-H	Hypervigilance	10	57
PAR-P	Persecution	19	95
PAR-R	Resentment	14	69
SCZ-P	Psychotic Experiences	13	80
SCZ-S	Social Detachment	12	66
SCZ-T	Thought Disorder	6	55
BOR-A	Affective Instability	6	54
BOR-I	Identity Problems	3	50
BOR-N	Negative Relationships	11	68
BOR-S	Self-Harm	8	65
ANT-A	Antisocial Behaviors	13	65
ANT-E	Egocentricity	0	39
ANT-S	Stimulus-Seeking	2	43
AGG-A	Aggressive Attitude	5	48
AGG-V	Verbal Aggression	7	51
AGG-P	Physical Aggression	4	56



Missing Items = 4

Plotted T scores are based upon a census matched standardization sample of 1,000 normal adults.
# indicates that the score is more than two standard deviations above the mean for a sample of 1,246 clinical patients.
+ indicates that the scale has more than 20% missing items.

Additional Profile Information

Supplemental PAI Indexes

Index	Value	T Score
Defensiveness Index	3	51
Cashel Discriminant Function	182.29	60
Malingering Index	2	71
Rogers Discriminant Function	-0.43	55
Suicide Potential Index	6	59
Violence Potential Index	5	66
Treatment Process Index	3	60
ALC Estimated Score	---	59
	(1 *T* higher than *ALC*)	
DRG Estimated Score	---	58
	(6 *T* lower than *DRG*)	
Mean Clinical Elevation	---	62

Coefficients of Fit with Profiles of Known Clinical Groups

Database Profile	Coefficient of Fit
Cluster 10	0.519
Schizophrenia	0.519
Fake Bad	0.512
All "Slightly True"	0.498
Schizoaffective Disorder	0.496
NIM Predicted	0.493
Random responding	0.488
Antipsychotic medications	0.468
Paranoid delusions	0.466
Auditory hallucinations	0.448
Cluster 6	0.448
All "Mainly True"	0.446
Self-Mutilation	0.403
Cluster 7	0.396
All "Very True"	0.385
Cluster 2	0.380

Database Profile	Coefficient of Fit
Current suicide	0.371
Posttraumatic Stress Disorder	0.369
Cluster 8	0.357
Borderline Personality Disorder	0.352
Major Depressive Disorder	0.343

Anxiety Disorder	0.338
Suicide history	0.323
Dysthymic Disorder	0.320
Somatoform Disorder	0.310
Rapists	0.309
All "False"	0.266
Assault history	0.250
Cluster 4	0.243
Adjustment reaction	0.207
Antisocial Personality Disorder	0.201
Cluster 5	0.186
Mania	0.169
Prisoners	0.163
Drug abuse	0.162
Current aggression	0.143
Cluster 3	0.052
Alcoholic	0.027
PIM Predicted	-0.014
Spouse abusers	-0.134
Cluster 9	-0.190
Cluster 1	-0.211
Fake Good	-0.358

Validity of Test Results

The PAI provides a number of validity indices that are designed to provide an assessment of factors that could distort the results of testing. Such factors could include failure to complete test items properly, carelessness, reading difficulties, confusion, exaggeration, malingering, or defensiveness. For this protocol, the number of uncompleted items is within acceptable limits.

Also evaluated is the extent to which the respondent attended appropriately and responded consistently to the content of test items. The respondent's scores on these scales suggest that he did attend to item content in responding to PAI items; however, there may have been some idiosyncratic responses to particular items that could affect test results. Thus, the interpretive hypotheses that follow in this report should be reviewed cautiously.

The degree to which response styles may have affected or distorted the report of symptomatology on the inventory is also assessed. Certain of these indicators fall outside of the normal range, suggesting that the respondent may not have answered in a completely forthright manner; the nature of his responses might lead the evaluator to form a somewhat inaccurate impression of the client based upon the style of responding described below. With respect to positive impression management, the client's pattern

of responses suggests that he tends to portray himself as being relatively free of common shortcomings to which most individuals will admit. He/She appears motivated to make a positive impression during the evaluation and is reluctant to admit to minor faults. Given this apparent defensive tendency, the interpretive hypotheses in this report should be reviewed with caution. The clinical profile may underrepresent the extent and degree of any significant findings in certain areas due to the client's efforts to minimize negative information. Particular attention should be paid to the possibility of denial of problems with drinking or drug use, as such individuals may be particularly reluctant to admit to the negative consequences associated with such problems.

Despite the level of defensiveness noted above, there are some areas where the client described problems of greater intensity than is typical of defensive respondents. These areas could indicate problems that merit further inquiry. These areas include: suspiciousness; impact of traumatic events; unusual ideas or beliefs; preoccupation with physical functioning; impulsivity; heightened activity level; failures in close relationships; history of antisocial behavior; thoughts of death or suicide; hostility and bitterness; poor interpersonal rapport; drug abuse or dependence; low frustration tolerance; poor sense of identity; physical signs of depression; unusual sensory-motor problems; poor control over anger; inflated self-esteem; tension and apprehension; moodiness; disruptions in thought process; unhappiness; distrust; and compulsiveness or rigidity.

With respect to negative impression management, there is no evidence to suggest that the respondent was motivated to portray himself in a more negative or pathological light than the clinical picture would warrant.

Clinical Features

The PAI clinical profile is marked by significant elevations, indicating the presence of clinical features that are likely to be sources of difficulty for the respondent. The configuration of the clinical scales suggests a person with significant thinking and concentration problems, accompanied by prominent hostility, resentment, and suspiciousness. His sensitivity in social interactions probably serves as a formidable obstacle to the development of close relationships, and thus he is likely to be withdrawn and isolated, feeling estranged from and mistreated by the people around him. His judgment is probably fairly poor and he is likely to be chronically tense and pessimistic about what the future may hold. Establishing a therapeutic relationship with the respondent may be challenging because he probably becomes quite anxious and threatened by the offer of a close interpersonal relationship.

The respondent's self-description indicates significant suspiciousness and hostility in his relations with others. He is quick to believe that he is being treated inequitably and will hold a grudge against others, even if the perceived affront is unintentional. Because he is likely to question and mistrust the motives of those around him, working relationships with others are likely to be very strained, despite the efforts of others to demonstrate support and assistance.

A number of aspects of the respondent's self-description suggest noteworthy peculiarities in thinking and experience. It is likely that he experiences unusual perceptual or sensory events (perhaps including full-blown hallucinations) as well as unusual ideas that may include magical thinking or delusional beliefs. His thought processes, although relatively uncompromised, may occasionally be marked by some confusion and difficulty concentrating. He may have some difficulty establishing close interpersonal relationships.

The respondent describes certain problems potentially associated with elevated and variable mood. In particular, he is likely to have an activity level that is perceptibly high to most observers. He may be involved in a wide variety of activities in a somewhat disorganized manner and may experience accelerated thought processes.

The respondent indicates that he occasionally experiences, or may experience to a mild degree, maladaptive behavior patterns aimed at controlling anxiety. The respondent has likely experienced a disturbing traumatic event in the past-an event that continues to distress him and produce recurrent episodes of anxiety. Whereas the item content of the PAI does not address specific causes of traumatic stress, possible traumatic events involve victimization (e.g., rape, abuse), combat experiences, life-threatening accidents, and natural disasters.

The respondent indicates some concerns about physical functioning and health matters in general. He reports being particularly preoccupied with his health status and physical problems. His social interactions and conversations likely often focus on his health problems, and his self-image may be largely influenced by a belief that he is handicapped by his poor health.

The respondent reports that drug use may be the source of some problems in his life. These problems may include strained interpersonal relationships, vocational and/or legal problems, and use of drugs to manage stress.

The respondent describes himself as rather moody and others may view him as overly sensitive. He may be dissatisfied with his more important relationships and uncertain about major life goals.

According to the respondent's self-report, he describes NO significant problems in the following areas: problems with empathy; unhappiness and depression; marked anxiety.

Self-Concept

The self-concept of the respondent appears to involve a self-evaluation that has both positive and negative aspects. His attitudes about himself may vary from states of pessimism and self-doubt to periods of relative self-confidence and self-satisfaction. Some fluctuation in self-esteem may be observed as a function of his current circumstances, although these fluctuations will not be extreme and are comparable to those experienced by most adults. During stressful times in particular, he is prone to be somewhat self-critical, uncertain, and indecisive.

Interpersonal and Social Environment

The respondent's interpersonal style seems best characterized as modest and unpretentious. He is likely to be self-conscious in social interactions and he is probably not skilled or comfortable in asserting himself; previous efforts at assertion may have led to conflicts that he does not handle well and would prefer to avoid. Others probably view him as rather passive, unassuming, yet fairly sensitive to the appraisals of others.

In considering the social environment of the respondent with respect to perceived stressors and the availability of social supports with which to deal with these stressors, his responses indicate that both his recent level of stress and his perceived level of social support are about average in comparison to normal adults. The reasonably low stress environment and the intact social support system are both favorable prognostic signs for future adjustment.

Treatment Considerations

Treatment considerations involve issues that can be important elements in case management and treatment planning. Interpretation is provided for three general areas relevant to treatment: behaviors that may serve as potential treatment complications, motivation for treatment, and aspects of the respondent's clinical picture that may complicate treatment efforts.

With respect to suicidal ideation, the respondent does report experiencing periodic and perhaps transient thoughts of self-harm. He is probably pessimistic and unhappy about his prospects for the future. Specific follow-up regarding the details of his suicidal thoughts and the potential for suicidal behavior is warranted.

With respect to anger management, the respondent describes his temper as within the normal range, and as fairly well-controlled without apparent difficulty.

The respondent's interest in and motivation for treatment is comparable to that of adults who are not being seen in a therapeutic setting. However, his level of treatment motivation is somewhat lower than is typical of individuals being seen in treatment settings. His responses suggest that he is satisfied with himself as he is, that he is not experiencing marked distress, and that, as a result, he sees little need for changes in his behavior. However, the respondent does report a number of strengths that are positive indications for a relatively smooth treatment process, if he were willing to make a commitment to treatment.

If treatment were to be considered for this individual, particular areas of attention or concern in the early stages of treatment could include:

He may be somewhat defensive and reluctant to discuss personal problems, and as such he may be at-risk for early termination.

He may have initial difficulty in placing trust in a treating professional as part of his more general problems in close relationships.

He may currently be too disorganized or feel too overwhelmed to be able to participate meaningfully in some forms of treatment.

Critical Item Endorsement

A total of 27 PAI items reflecting serious pathology have very low endorsement rates in normal samples. These items have been termed critical items. Endorsement of these critical items is not in itself diagnostic, but review of the content of these items with the respondent may help to clarify the presenting clinical picture. Significant items with item scores of 1, 2, or 3 are listed below.

Delusions and Hallucinations

90. *SCZ-P* Sometimes it seems that my thoughts are broadcast so that others can hear them. (ST, 1)
130. *SCZ-P* Others can read my thoughts. (ST, 1)
170. *SCZ-P* I've heard voices that no one else could hear. (VT, 3)
308. *PAR-P* I'm the target of a conspiracy. (VT, 3)

Potential for Self-Harm

100. *SUI* I've made plans about how to kill myself. (VT, 3)

Potential for Aggression

181. *AGG-P* I've threatened to hurt people. (ST, 1)

Substance Abuse, Current and Historical

23. *DRG* I've tried just about every type of drug. (ST, 1)

Traumatic Stressors

34. *ARD-T* I keep reliving something horrible that happened to me. (MT, 2)
114. *ARD-T* I've been troubled by memories of a bad experience for a long time. (VT, 3)

Potential Malingering

129. *NIM* I think I have three or four completely different personalities inside of me. (ST, 1)

True Response Set

75. *DEP-P* I have no trouble falling asleep. *(False)* (F, 3)
142. *DRG* I never use illegal drugs. *(False)* (F, 3)

Idiosyncratic Context

80. *INF* Sometimes I get ads in the mail that I don't really want. *(False)* (ST, 2)

PAI Item Responses

1.	MT	44.	F	87.	MT	130.	ST	173.	F	216.	F	259.	MT	302.	F
2.	VT	45.	ST	88.	ST	131.	F	174.	ST	217.	VT	260.	F	303.	F
3.	VT	46.	F	89.	F	132.	MT	175.	F	218.	MT	261.	F	304.	MT
4.	ST	47.	F	90.	ST	133.	MT	176.	F	219.	ST	262.	F	305.	F
5.	MT	48.	MT	91.	VT	134.	F	177.	VT	220.	ST	263.	MT	306.	VT
6.	ST	49.	F	92.	ST	135.	F	178.	MT	221.	F	264.	F	307.	VT
7.	ST	50.	ST	93.	ST	136.	MT	179.	VT	222.	F	265.	ST	308.	VT
8.	ST	51.	F	94.	ST	137.	F	180.	F	223.	ST	266.	F	309.	VT
9.	F	52.	MT	95.	F	138.	VT	181.	ST	224.	F	267.	MT	310.	MT
10.	ST	53.	ST	96.	F	139.	ST	182.	ST	225.	ST	268.	MT	311.	F
11.	MT	54.	F	97.	VT	140.	F	183.	F	226.	MT	269.	VT	312.	MT
12.	F	55.	F	98.	ST	141.	F	184.	ST	227.	ST	270.	ST	313.	MT
13.	F	56.	ST	99.	MT	142.	F	185.	F	228.	F	271.	F	314.	MT
14.	ST	57.	F	100.	VT	143.	VT	186.	VT	229.	F	272.	F	315.	F
15.	F	58.	F	101.	F	144.	ST	187.	F	230.	ST	273.	F	316.	MT
16.	MT	59.	ST	102.	F	145.	F	188.	VT	231.	F	274.	F	317.	MT
17.	ST	60.	ST	103.	VT	146.	ST	189.	VT	232.	F	275.	ST	318.	VT
18.	MT	61.	F	104.	F	147.	F	190.	ST	233.	F	276.	F	319.	MT
19.	ST	62.	F	105.	F	148.	VT	191.	F	234.	ST	277.	ST	320.	F
20.	F	63.	F	106.	ST	149.	ST	192.	ST	235.	ST	278.	ST	321.	ST
21.	F	64.	ST	107.	F	150.	F	193.	ST	236.	VT	279.	F	322.	F
22.	VT	65.	ST	108.	F	151.	F	194.	VT	237.	MT	280.	F	323.	VT
23.	ST	66.	ST	109.	F	152.	F	195.	ST	238.	MT	281.	F	324.	F
24.	F	67.	F	110.	VT	153.	ST	196.	VT	239.	ST	282.	MT	325.	VT
25.	F	68.	VT	111.	F	154.	VT	197.	ST	240.	ST	283.	F	326.	VT
26.	ST	69.	ST	112.	VT	155.	F	198.	ST	241.	F	284.	F	327.	F
27.	VT	70.	ST	113.	F	156.	MT	199.	F	242.	F	285.	ST	328.	?
28.	VT	71.	F	114.	VT	157.	VT	200.	F	243.	F	286.	ST	329.	F
29.	MT	72.	F	115.	F	158.	ST	201.	MT	244.	F	287.	F	330.	VT
30.	ST	73.	F	116.	F	159.	F	202.	F	245.	MT	288.	F	331.	VT
31.	F	74.	F	117.	MT	160.	VT	203.	F	246.	ST	289.	F	332.	F
32.	F	75.	F	118.	F	161.	ST	204.	ST	247.	ST	290.	F	333.	F
33.	F	76.	MT	119.	F	162.	VT	205.	F	248.	ST	291.	F	334.	?
34.	MT	77.	MT	120.	F	163.	F	206.	F	249.	F	292.	ST	335.	?
35.	F	78.	ST	121.	F	164.	ST	207.	VT	250.	ST	293.	VT	336.	?
36.	F	79.	F	122.	VT	165.	F	208.	F	251.	F	294.	VT	337.	VT
37.	ST	80.	ST	123.	VT	166.	F	209.	ST	252.	MT	295.	MT	338.	ST
38.	F	81.	F	124.	ST	167.	F	210.	MT	253.	MT	296.	MT	339.	F
39.	F	82.	F	125.	F	168.	ST	211.	F	254.	F	297.	ST	340.	F
40.	F	83.	F	126.	F	169.	VT	212.	VT	255.	F	298.	MT	341.	F
41.	VT	84.	F	127.	VT	170.	VT	213.	ST	256.	ST	299.	MT	342.	VT
42.	F	85.	VT	128.	ST	171.	F	214.	ST	257.	MT	300.	ST	343.	ST
43.	F	86.	F	129.	ST	172.	F	215.	F	258.	ST	301.	VT	344.	ST

Missing Items

The following items were not answered by the reepondent:

Item	Text
328.	My relationship with my spouse or partner is not going well.
334.	My drinking has never gotten me into trouble.
335.	My drinking has caused problems with my work.
336.	I don't like letting people know when I disagree with them.

***** End of Report *****

8240

re-input data from Krusel's administration this is full printout

MMPI-2
Minnesota Multiphasic Personality Inventory-2

Adult Clinical Interpretive Report

MMPI®-2
The Minnesota Report™: Adult Clinical System-Revised, 4th Edition
James N. Butcher, PhD

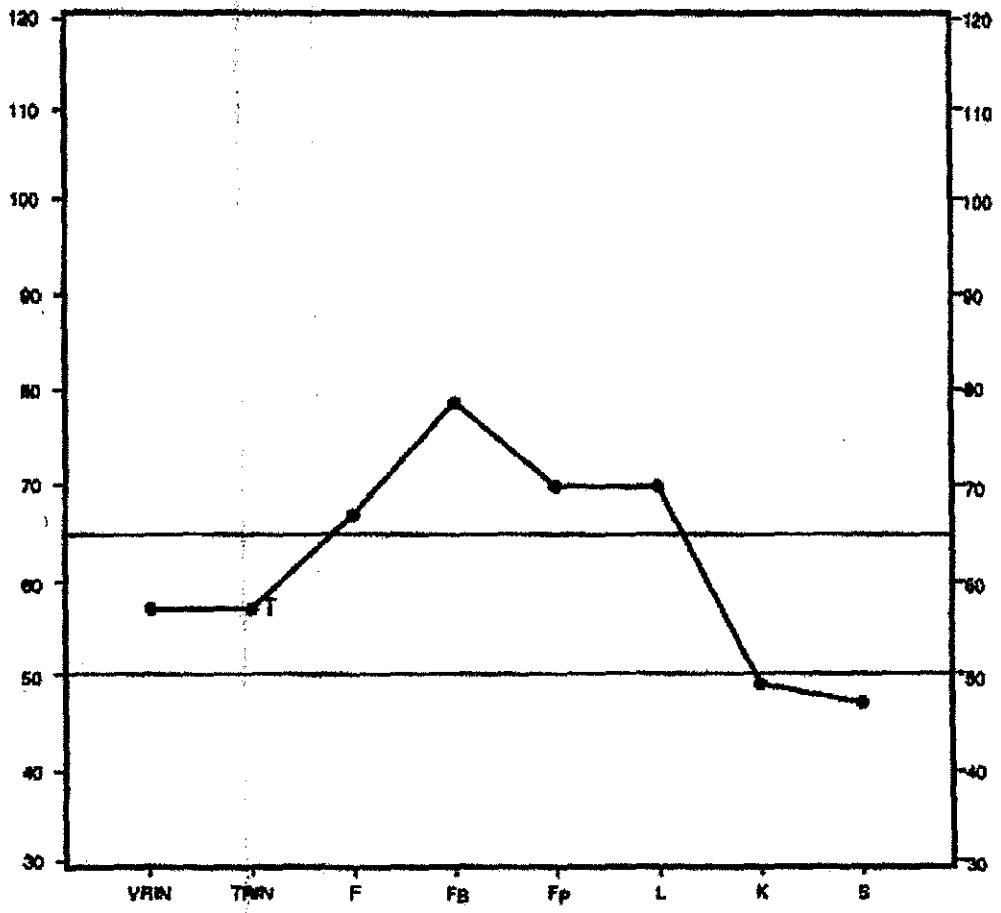
Name:	Timothy Ray Jones, Jr
Age:	37
Gender:	Male
Marital Status:	Divorced
Years of Education:	16
Date Assessed:	02/22/2019

Setting was specified as "Other."

PsychCorp

[9.7 / 1 / CG]

MMPI-2 VALIDITY PATTERN

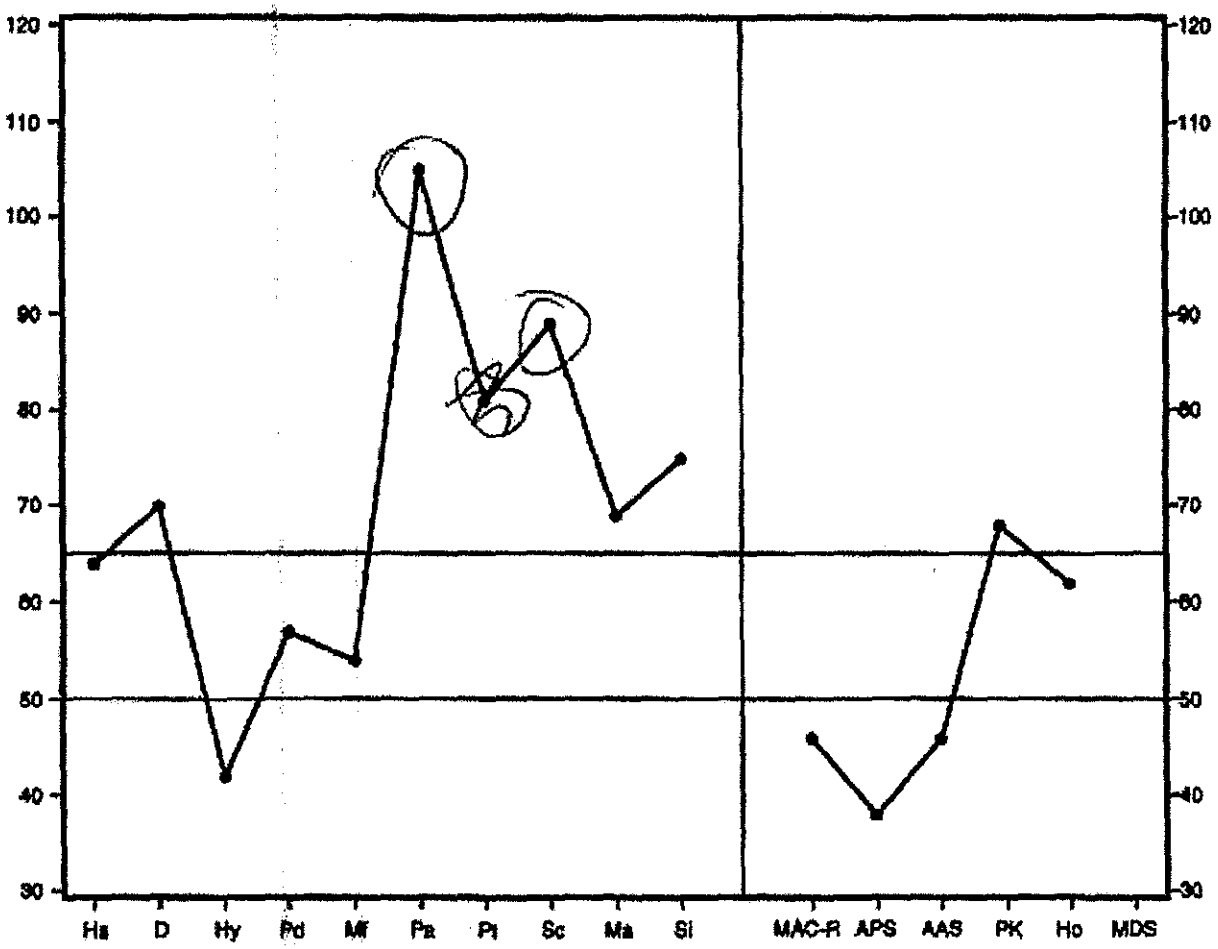


	VRIN	TRIN	F	FB	Fp	L	K	S
Raw Score:	7	10	10	9	4	8	15	22
T Score:	57	57T	67	79	70	70	49	47
Response %:	100	100	97	100	100	93	100	98

Cannot Say (Raw):	3
Percent True:	46
Percent False:	54

	Raw Score	T Score	Resp. %
S_1 - Beliefs in Human Goodness	4	41	100
S_2 - Serenity	6	50	100
S_3 - Contentment with Life	1	35	100
S_4 - Patience/Denial of Irritability	7	63	100
S_5 - Denial of Moral Flaws	4	58	80

MMPI-2 CLINICAL AND SUPPLEMENTARY SCALES PROFILE



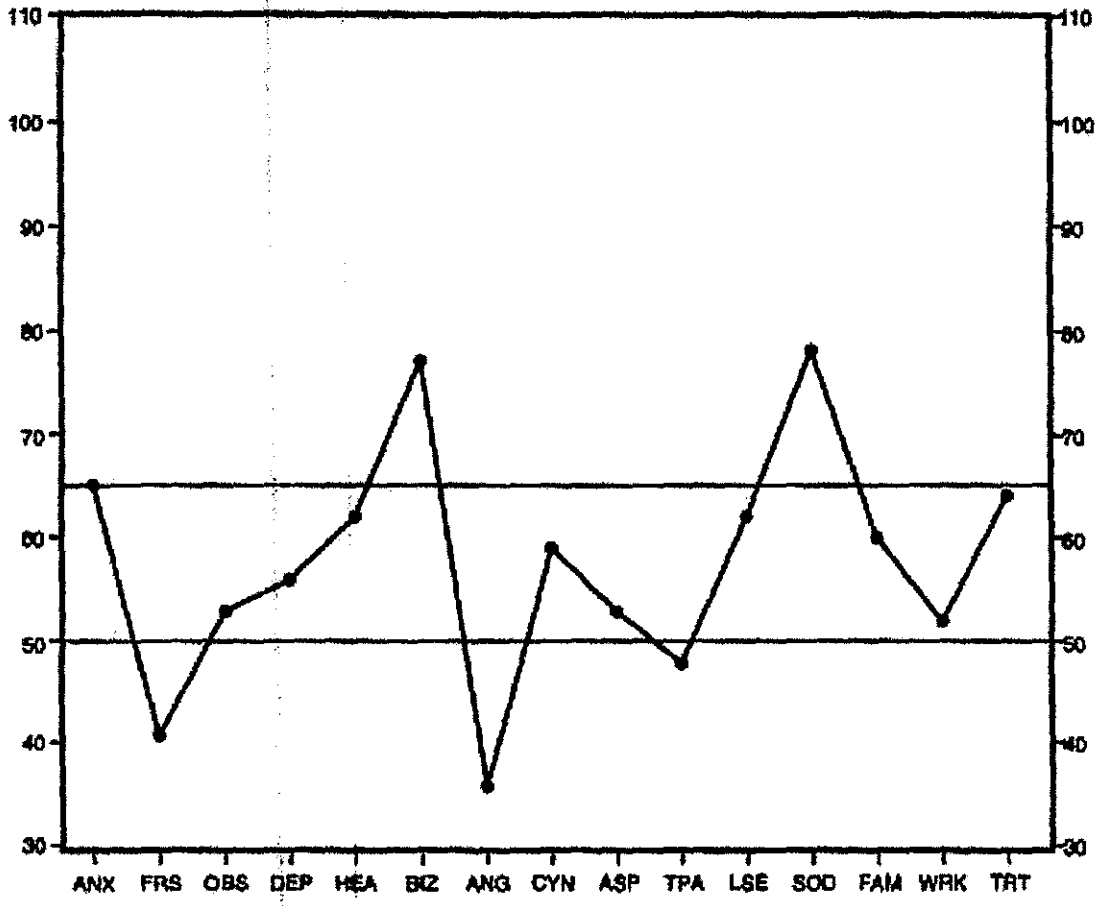
	Hs	D	Hy	Pd	Mf	Pa	Pt	Sc	Ma	Si	MAC-R	APS	AAS	PK	Ho	MDS
Raw Score:	10	28	17	20	28	25	26	34	24	47	19	19	2	19	28	*
K Correction:	8			6			15	15	3							
T Score:	64	70	42	57	54	105	81	89	69	75	46	38	46	68	62	*
Response %:	100	100	100	100	100	100	100	99	100	100	100	100	100	100	100	*

Welsh Code: 6***87"02'9+1-45/3: L'F+-/K:

Profile Elevation: 72.1

*MDS scores are reported only for clients who indicate that they are married or separated.

MMPI-2 CONTENT SCALES PROFILE



	ANX	FRS	OBS	DEP	HEA	BIZ	ANG	CYN	ASP	TPA	LSE	SOD	FAM	WRK	TRT
Raw Score:	12	1	6	7	10	10	1	15	10	8	9	20	9	8	10
T Score:	65	41	53	56	62	77	36	59	53	48	62	78	60	52	64
Response %:	100	100	100	100	100	96	100	100	95	100	100	100	100	100	100

PROFILE VALIDITY

The client responded to the MMPI-2 items by claiming to be unrealistically virtuous. This test-taking attitude weakens the validity of the test and shows an unwillingness or inability on the part of the client to disclose personal information. Despite this extreme defensiveness, he responded to items reflecting some unusual symptoms or beliefs. Many reasons may be found for this pattern of uncooperativeness: conscious distortion to present himself in a favorable light, lack of psychological sophistication, or rigid neurotic adjustment.

under-reporting & malingering

SYMPTOMATIC PATTERNS

Scales Pa and Sc were used as the prototype to develop this report. A severe psychological disorder is reflected in this profile. The client appears to be experiencing a florid psychotic process that includes personality decompensation, social withdrawal, disordered affect, and erratic, possibly assaultive, behavior. He appears to be quite confused, withdrawn, and preoccupied with occult or abstract ideas, and he may feel that others are against him because of his beliefs. He may appear quite apathetic, tends to spend a great deal of time in fantasy, and might suffer from hallucinations, blunted or inappropriate affect, and hostile, irritable behavior. He appears confused and disoriented, and he may behave in unpredictable, highly aggressive ways. This MMPI-2 clinical profile reflects chronic maladjustment, although he may presently be experiencing an intensification of problems. Personality decompensation, disorganization, and thought disorder are likely to persist.

In addition, the following description is suggested by the client's scores on the content scales. He has difficulty managing routine affairs, and the items he endorsed suggest a poor memory, concentration problems, and an inability to make decisions. He appears to be immobilized and withdrawn and has no energy for life. He views his physical health as failing and reports numerous somatic concerns. He feels that life is no longer worthwhile and that he is losing control of his thought processes. He views the world as a threatening place, sees himself as having been unjustly blamed for others' problems, and feels that he is getting a raw deal out of life. He is rather high-strung and believes that he feels things more, or more intensely, than others do. He feels quite lonely and misunderstood at times.

He endorsed a number of extreme and bizarre thoughts, suggesting the presence of delusions and/or hallucinations. He apparently believes that he has special mystical powers or a special "mission" in life that others do not understand or accept.

An understanding of the client's underlying personality, as represented by his scores on the PSY-5 scales, can provide a clinical context in which to view the extreme psychological symptoms he is presently experiencing. He apparently holds some unusual beliefs that appear to be disconnected from reality. His high score on the PSYC (Psychoticism) scale suggests that he often feels alienated from others and might experience unusual symptoms such as delusional beliefs, circumstantial and tangential thinking, and loose associations.

PROFILE FREQUENCY

Profile interpretation can be greatly facilitated by examining the relative frequency of clinical scale patterns in various settings. The client's high-point clinical scale score (Pa) occurred in 9.6% of the MMPI-2 normative sample of men. However, only 3.0% of the sample had Pa as the peak score at or above a T score of 65, and only 2.2% had well-defined Pa spikes. This elevated profile configuration (6-8/8-6) is very rare in samples of normals, occurring in less than 1% of the MMPI-2 normative sample of men. His high-point clinical scale score on Pa occurred in 9.6% of the group of military men reported by Butcher, Jeffrey, et al. (1990). In this sample, 3.4% of the men had the Pa scale at or over a T score of 65, and only 2.3% had well-defined Pa spikes at that level of elevation.

PROFILE STABILITY

The relative elevation of the highest scales in his clinical profile reflects high profile definition. If he is retested at a later date, his peak scores on Pa and Sc are likely to retain their relative salience in his retest profile.

INTERPERSONAL RELATIONS

Disturbed relationships are characteristic of individuals with this profile type. The client feels socially inadequate and has very poor social skills. He is rather introverted and is fearful and suspicious of others. He may be blatantly negative in social interactions. He tends to feel insecure in personal relationships, is hypersensitive to rejection, and may become jealous at times. He tends to need a great deal of reassurance. Individuals with this profile are quite self-absorbed and find marital relationships problematic. Marital breakup is not uncommon.

He is a very introverted person who has difficulty meeting and interacting with other people. He is shy and emotionally distant. He tends to be very uneasy, rigid, and overcontrolled in social situations. His shyness is probably symptomatic of a broader pattern of social withdrawal. Personality characteristics related to social introversion tend to be stable over time. His generally reclusive behavior, introverted lifestyle, and tendency toward interpersonal avoidance may be prominent in any future test results.

The client's scores on the content scales suggest the following additional information concerning his interpersonal relations. His social relationships are likely to be viewed by others as problematic. He may be visibly uneasy around others, sits alone in group situations, and dislikes engaging in group activities.

DIAGNOSTIC CONSIDERATIONS

The most likely diagnosis for individuals with this profile type is Schizophrenia, possibly Paranoid type, or a Delusional Disorder. His scores on the content scales suggest that his unusual thinking and bizarre ideas need to be taken into consideration in any diagnostic formulation.

TREATMENT CONSIDERATIONS

Individuals with this profile may be experiencing a great deal of personality deterioration, which may require hospitalization if they are considered dangerous to themselves or others. Psychotropic medication may reduce their thinking disturbance and mood disorder. Outpatient treatment may be complicated by their regressed or disorganized behavior. Day treatment programs or other such structured settings may be helpful in providing a stabilizing treatment environment.

Long-term adjustment is a problem. Frequent, brief "management" therapy contacts may be helpful in structuring their activities. Insight-oriented or uncovering therapies tend not to be helpful for individuals with this profile and may actually exacerbate the problems. This individual is unlikely to be able to establish a trusting working relationship with a therapist.

If psychological treatment is being considered, it may be profitable for the therapist to explore the client's treatment motivation early in therapy. His scores on the content scales indicate some feelings and attitudes that could be unproductive in psychological treatment and in implementing change.

ADDITIONAL SCALES

	Raw Score	T Score	Resp %
Personality Psychopathology Five (PSY-5) Scales			
Aggressiveness (AGGR)	5	40	100
Psychoticism (PSYC)	14	84	96
Disconstraint (DISC)	11	42	97
Negative Emotionality/Neuroticism (NEGE)	11	52	100
Introversion/Low Positive Emotionality (INTR)	12	52	100
Supplementary Scales			
Anxiety (A)	15	57	100
Repression (R)	19	58	100
Ego Strength (Es)	27	30	100
Dominance (Do)	14	41	100
Social Responsibility (Re)	21	52	100
Harris-Lingoes Subscales			
Depression Subscales			
Subjective Depression (D_1)	12	64	100
Psychomotor Retardation (D_2)	8	65	100
Physical Malfunctioning (D_3)	5	67	100
Mental Dullness (D_4)	3	53	100
Brooding (D_5)	4	62	100
Hysteria Subscales			
Denial of Social Anxiety (Hy_1)	0	30	100
Need for Affection (Hy_2)	3	36	100
Lassitude-Malaise (Hy_3)	4	57	100
Somatic Complaints (Hy_4)	4	57	100
Inhibition of Aggression (Hy_5)	6	71	100
Psychopathic Deviate Subscales			
Familial Discord (Pd_1)	2	51	100
Authority Problems (Pd_2)	2	40	100
Social Imperturbability (Pd_3)	0	30	100
Social Alienation (Pd_4)	9	77	100
Self-Alienation (Pd_5)	4	53	100
Paranoia Subscales			
Persecutory Ideas (Pa_1)	14	120	100
Poignancy (Pa_2)	5	68	100
Naivete (Pa_3)	4	46	100

	Raw Score	T Score	Resp %
Schizophrenia Subscales			
Social Alienation (Sc_1)	12	88	100
Emotional Alienation (Sc_2)	4	78	100
Lack of Ego Mastery, Cognitive (Sc_3)	4	66	100
Lack of Ego Mastery, Conative (Sc_4)	3	55	100
Lack of Ego Mastery, Defective Inhibition (Sc_5)	7	89	100
Bizarre Sensory Experiences (Sc_6)	7	75	100
Hypomania Subscales			
Amorality (Ma_1)	0	35	100
Psychomotor Acceleration (Ma_2)	7	58	100
Imperturbability (Ma_3)	3	47	100
Ego Inflation (Ma_4)	5	63	100
Social Introversion Subscales (Ben-Porath, Hostetler, Butcher, & Graham)			
Shyness/Self-Consciousness (Si_1)	14	77	100
Social Avoidance (Si_2)	8	71	100
Alienation--Self and Others (Si_3)	6	53	100
Content Component Scales (Ben-Porath & Sherwood)			
Fears Subscales			
Generalized Fearfulness (FRS_1)	1	53	100
Multiple Fears (FRS_2)	0	37	100
Depression Subscales			
Lack of Drive (DEP_1)	1	46	100
Dysphoria (DEP_2)	1	50	100
Self-Depreciation (DEP_3)	3	62	100
Suicidal Ideation (DEP_4)	1	62	100
Health Concerns Subscales			
Gastrointestinal Symptoms (HEA_1)	1	57	100
Neurological Symptoms (HEA_2)	3	60	100
General Health Concerns (HEA_3)	2	56	100
Bizarre Mentation Subscales			
Psychotic Symptomatology (BIZ_1)	2	64	100
Schizotypal Characteristics (BIZ_2)	7	86	100
Anger Subscales			
Explosive Behavior (ANG_1)	0	39	100
Irritability (ANG_2)	1	41	100
Cynicism Subscales			
Misanthropic Beliefs (CYN_1)	9	58	100
Interpersonal Suspiciousness (CYN_2)	6	62	100

	Raw Score	T Score	Resp %
Antisocial Practices Subscales			
Antisocial Attitudes (ASP_1)	7	52	94
Antisocial Behavior (ASP_2)	3	59	100
Type A Subscales			
Impatience (TPA_1)	1	39	100
Competitive Drive (TPA_2)	6	66	100
Low Self-Esteem Subscales			
Self-Doubt (LSE_1)	5	64	100
Submissiveness (LSE_2)	1	48	100
Social Discomfort Subscales			
Introversion (SOD_1)	13	73	100
Shyness (SOD_2)	7	74	100
Family Problems Subscales			
Family Discord (FAM_1)	4	55	100
Familial Alienation (FAM_2)	1	49	100
Negative Treatment Indicators Subscales			
Low Motivation (TRT_1)	2	54	100
Inability to Disclose (TRT_2)	4	68	100

Uniform T scores are used for Hs, D, Hy, Pd, Pa, Pt, Sc, Ma, the content scales, the content component scales, and the PSY-5 scales. The remaining scales and subscales use linear T scores.

CRITICAL ITEMS

The following critical items have been found to have possible significance in analyzing a client's problem situation. Although these items may serve as a source of hypotheses for further investigation, caution should be used in interpreting individual items because they may have been checked inadvertently.

The percentages of endorsement for each critical item are presented in brackets following the listing of the item. The percentage of the MMPI-2 normative sample of 1,138 men who endorsed the item in the scored direction is given.

Acute Anxiety State (Koss-Butcher Critical Items)

Of the 17 possible items in this section, 10 were endorsed in the scored direction:

5. I am easily awakened by noise. (True)
   [N = 41]
15. I work under a great deal of tension. (True)
   [N = 37]
28. I am bothered by an upset stomach several times a week. (True)
   [N = 8]
39. My sleep is fitful and disturbed. (True)
   [N = 11]
140. Most nights I go to sleep without thoughts or ideas bothering me. (False)
   [N = 23]
218. I have periods of such great restlessness that I cannot sit long in a chair. (True)
   [N = 30]
223. I believe I am no more nervous than most others. (False)
   [N = 16]
301. I feel anxiety about something or someone almost all the time. (True)
   [N = 15]
444. I am a high-strung person. (True)
   [N = 22]
463. Several times a week I feel as if something dreadful is about to happen. (True)
   [N = 4]

Depressed Suicidal Ideation (Koss-Butcher Critical Items)

Of the 22 possible items in this section, 5 were endorsed in the scored direction:

130. I certainly feel useless at times. (True)
   [N = 34]
146. I cry easily. (True)
   [N = 13]
273. Life is a strain for me much of the time. (True)
   [N = 16]

411. At times I think I am no good at all. (True)
[N = 20]
485. I often feel that I'm not as good as other people. (True)
[N = 17]

Mental Confusion (Koss-Butcher Critical Items)

Of the 11 possible items in this section, 3 were endorsed in the scored direction:

32. I have had very peculiar and strange experiences. (True)
[N = 24]
180. There is something wrong with my mind. (True)
[N = 5]
316. I have strange and peculiar thoughts. (True)
[N = 15]

Persecutory Ideas (Koss-Butcher Critical Items)

Of the 16 possible items in this section, 14 were endorsed in the scored direction:

17. I am sure I get a raw deal from life. (True)
[N = 5]
42. If people had not had it in for me, I would have been much more successful. (True)
[N = 4]
99. Someone has it in for me. (True)
[N = 5]
124. I often wonder what hidden reason another person may have for doing something nice for me. (True)
[N = 29]
138. I believe I am being plotted against. (True)
[N = 2]
144. I believe I am being followed. (True)
[N = 1]
145. I feel that I have often been punished without cause. (True)
[N = 9]
216. Someone has been trying to rob me. (True)
[N = 3]
241. It is safer to trust nobody. (True)
[N = 20]
251. I have often felt that strangers were looking at me critically. (True)
[N = 24]
259. I am sure I am being talked about. (True)
[N = 18]
314. I have no enemies who really wish to harm me. (False)
[N = 12]
333. People say insulting and vulgar things about me. (True)
[N = 6]

361. Someone has been trying to influence my mind. (True)
[N = 4]

Antisocial Attitude (Lachar-Wrobel Critical Items)

Of the 9 possible items in this section, 4 were endorsed in the scored direction:

35. Sometimes when I was young I stole things. (True)
[N = 58]
84. I was suspended from school one or more times for bad behavior. (True)
[N = 17]
254. Most people make friends because friends are likely to be useful to them. (True)
[N = 24]
266. I have never been in trouble with the law. (False)
[N = 41]

Family Conflict (Lachar-Wrobel Critical Items)

Of the 4 possible items in this section, 1 was endorsed in the scored direction:

21. At times I have very much wanted to leave home. (True)
[N = 32]

Somatic Symptoms (Lachar-Wrobel Critical Items)

Of the 23 possible items in this section, 8 were endorsed in the scored direction:

28. I am bothered by an upset stomach several times a week. (True)
[N = 8]
33. I seldom worry about my health. (False)
[N = 37]
47. I am almost never bothered by pains over my heart or in my chest. (False)
[N = 19]
57. I hardly ever feel pain in the back of my neck. (False)
[N = 27]
142. I have never had a fit or convulsion. (False)
[N = 7]
159. I have never had a fainting spell. (False)
[N = 27]
229. I have had blank spells in which my activities were interrupted and I did not know what was going on around me. (True)
[N = 8]
295. I have never been paralyzed or had any unusual weakness of any of my muscles. (False)
[N = 15]

Sexual Concern and Deviation (Lachar-Wrobel Critical Items)

Of the 6 possible items in this section, 1 was endorsed in the scored direction:

268. I wish I were not bothered by thoughts about sex. (True)
[N = 21]

Anxiety and Tension (Lachar-Wrobel Critical Items)

Of the 11 possible items in this section, 8 were endorsed in the scored direction:

15. I work under a great deal of tension. (True)
[N = 37]
17. I am sure I get a raw deal from life. (True)
[N = 5]
218. I have periods of such great restlessness that I cannot sit long in a chair. (True)
[N = 30]
223. I believe I am no more nervous than most others. (False)
[N = 16]
261. I have very few fears compared to my friends. (False)
[N = 44]
301. I feel anxiety about something or someone almost all the time. (True)
[N = 15]
320. I have been afraid of things or people that I knew could not hurt me. (True)
[N = 14]
463. Several times a week I feel as if something dreadful is about to happen. (True)
[N = 4]

Sleep Disturbance (Lachar-Wrobel Critical Items)

Of the 6 possible items in this section, 4 were endorsed in the scored direction:

5. I am easily awakened by noise. (True)
[N = 41]
39. My sleep is fitful and disturbed. (True)
[N = 11]
140. Most nights I go to sleep without thoughts or ideas bothering me. (False)
[N = 23]
328. Sometimes some unimportant thought will run through my mind and bother me for days. (True)
[N = 23]

Deviant Thinking and Experience (Lachar-Wrobel Critical Items)

Of the 10 possible items in this section, 4 were endorsed in the scored direction:

32. I have had very peculiar and strange experiences. (True)
[N = 24]

122. At times my thoughts have raced ahead faster than I could speak them. (True)
[N = 80]
316. I have strange and peculiar thoughts. (True)
[N = 15]
319. I hear strange things when I am alone. (True)
[N = 4]

Depression and Worry (Lachar-Wrobel Critical Items)

Of the 16 possible items in this section, 6 were endorsed in the scored direction:

73. I am certainly lacking in self-confidence. (True)
[N = 17]
130. I certainly feel useless at times. (True)
[N = 34]
180. There is something wrong with my mind. (True)
[N = 5]
273. Life is a strain for me much of the time. (True)
[N = 16]
411. At times I think I am no good at all. (True)
[N = 20]
415. I worry quite a bit over possible misfortunes. (True)
[N = 27]

Deviant Beliefs (Lachar-Wrobel Critical Items)

Of the 15 possible items in this section, 10 were endorsed in the scored direction:

42. If people had not had it in for me, I would have been much more successful. (True)
[N = 4]
99. Someone has it in for me. (True)
[N = 5]
138. I believe I am being plotted against. (True)
[N = 2]
144. I believe I am being followed. (True)
[N = 1]
216. Someone has been trying to rob me. (True)
[N = 3]
259. I am sure I am being talked about. (True)
[N = 18]
314. I have no enemies who really wish to harm me. (False)
[N = 12]
333. People say insulting and vulgar things about me. (True)
[N = 6]
361. Someone has been trying to influence my mind. (True)
[N = 4]
466. Sometimes I am sure that other people can tell what I am thinking. (True)

[N = 32]

Substance Abuse (Lachar-Wrobel Critical Items)

Of the 3 possible items in this section, 1 was endorsed in the scored direction:

168. I have had periods in which I carried on activities without knowing later what I had been doing.
(True)
[N = 9]

ITEM RESPONSES

1: 1	2: 1	3: 1	4: 2	5: 1	6: 1	7: 2	8: 2	9: 1	10: 1
11: 2	12: 1	13: 2	14: 2	15: 1	16: 1	17: 1	18: 2	19: 2	20: 1
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SCCID
SOUTH CAROLINA COMMISSION FOR INDIGENT DEFENSE

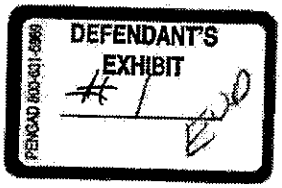
Capital Trial Division
1330 Lady Street, Suite 401
Columbia, South Carolina 29201
Telephone: 803.734.7818
Facsimile: 803.734.1668

S. Boyd Young, Chief Attorney
Bill McGuire, Deputy Attorney
Emily Kuchar, Attorney
Claedrika Mulligan-Green, Paralegal

Email: byoung@sccid.sc.gov
Email: bmcguire@sccid.sc.gov
Email: ekuchar@sccid.sc.gov
Email: cmulligangreen@sccid.sc.gov

January 16, 2019

Dr. Richard Frierson
3555 Harden Street Extension Suite 301
Columbia, SC 29203



Dr. Kimbery Kruse
11 Richland Medical Park Dr
Columbia SC, 29203

Re: Timothy Ray Jones, Jr.
Death Penalty Case

Dear Dr.s Frierson and Kruse,

Please accept this letter as notice that Timothy Ray Jones, Jr. through his counsel objects to any personality testing that may or may not be scheduled for January 25, 2019. Mr. Jones has been instructed by counsel to assert his 5th Amendment rights as it relates to any personality testing including but not limited to the MMPI or any form of Hare psychopathy checklist. It is the defense's position that any personality testing is not relevant to an assessment of criminal responsibility, is not responsive to any testing done by the defense, and would be improper. The defense would respectfully request a list of the tests scheduled for January 25 for a full review, but regardless does not consent to any personality testing. I can be reached at 803-201-4369 to discuss.

Sincerely,

S. Boyd Young

Cc: Timothy Ray Jones, Jr.

STATE OF MISSISSIPPI)
)
COUNTY OF SMITH)

AFFIDAVIT

Former Smith County Sheriff's Deputy Charles Johnson, who appeared personally before me, affirms and states the following is within his personal knowledge and belief:

1. On Saturday, September 6, 2014, I was working as a Smith County Sheriff's Deputy in the state of Mississippi. Things were quiet that night and Deputy Wayne Thompson and I decided to conduct a traffic safety checkpoint at HWY 18 East, outside of the city limits. When officers want to set up a roadblock they just seek approval from the supervisor. There are no formal authorization procedures.

2. Whenever Sheriff Crumpton is out of the office, Undersheriff Marty Patterson is in charge. Undersheriff Marty Patterson was the supervisor on the night of September 6, 2014, so we called him and he approved our checkpoint.

3. I have set up many roadblocks, usually on Friday and Saturday nights. I regularly set up outside the city limits and don't use signs or flares. We just set these roadblocks up and stop all the cars that come through.

4. These roadblocks/check points are not designed to find a certain person, nor was it in response to any specific traffic or crime problem in that area. The roadblock/checkpoint was designed to check for driver's licenses and required paperwork such as proof of insurance.

5. On September 6, 2014, Timothy R. Jones, Jr. was probably the fifth or sixth car through the checkpoint. It was approximately 7:45 p.m. As soon as Mr. Jones lowered the window of his vehicle, I detected a strong odor coming from inside, as well as the smell of burnt marijuana.

6. I asked Timothy Jones, Jr. to pull to the side for further investigation because his eyes were glassy and red, and his speech was slurred. Timothy Jones, Jr. advised me that he was tired, but complied with instructions.

7. I asked Timothy Jones, Jr. to exit the vehicle and move to the rear of the vehicle. I then asked for and received consent to search the vehicle. The roadblock was shut down after Timothy R. Jones Jr. was arrested.

8. I was not certified to conduct field sobriety tests. I was not wearing a body camera. I did not have a dash camera on my vehicle either.

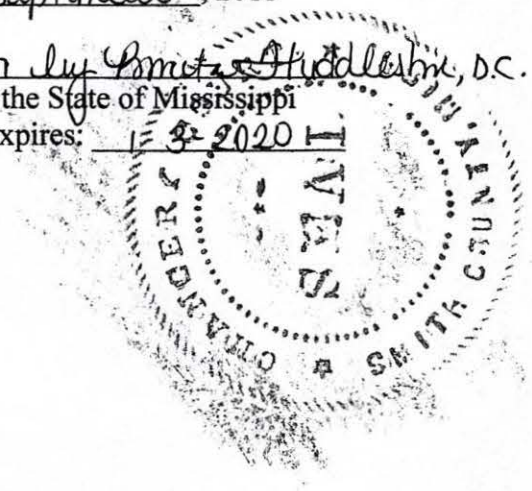
9. Timothy R. Jones, Jr. was arrested after further investigation revealed the presence of synthetic marijuana, also known as "spice," and paraphernalia used for smoking it.

Further affiant sayeth naught.

Charles Johnson
CHARLES JOHNSON

Sworn to and subscribed before me
This 24th day of September, 2018

Cindy Austin by Brittany Huddleston, D.C.
Notary Public for the State of Mississippi
My commission expires: 1-3-2020



STATE OF SOUTH CAROLINA
COUNTY OF LEXINGTON

IN THE COURT OF GENERAL SESSIONS
ELEVENTH JUDICIAL CIRCUIT

STATE OF SOUTH CAROLINA,	
Plaintiff,	**Indictment No: 2015-GS-3200-188**
	2015-GS-3200-189
v.	**2015-GS-3200-190**
	2015-GS-3200-191
TIMOTHY RAY JONES, JR.,	**2015-GS-3200-192**
Defendant.	

EX PARTE PETITION FOR CERTIFICATE TO PRODUCE MATERIAL WITNESS AND DOCUMENTS FROM OUT OF STATE

Timothy Ray Jones, Jr., through his attorneys, Stanley Boyd Young and Robert Madsen, and pursuant to the Uniform Act to Secure the Attendance of Witnesses from Without a State in Criminal Proceedings, S.C. Code §19-9-10 through §19-9-130, hereby moves this Court to issue a Certificate under the seal of this Court stating that **Cynthia Marie Granado Jones**, in the City of **Syracuse** in the State of **New York**, is a material witness pertaining to a criminal prosecution case before this Court, that **Cynthia Marie Granado Jones** is required to appear and testify for 5 weeks, and that **Cynthia Marie Granado Jones** shall be compensated, pursuant to the Uniform Act. If witness has a funding order approved by the court, witness will be reimbursed according to the order.

In support there of it is stated as follows:

1. **Cynthia Marie Granado Jones** is a material witness in this case which is scheduled to begin on the 29th day of April 2019 and last for approximately 5 weeks.
2. **Cynthia Marie Granado Jones** is an out-of-state witness and resides at Hutchings Psychiatric Center in the City of **Syracuse**, State of **New York**.
3. It is necessary for the defense of this case that **Cynthia Marie Granado Jones** be required to appear at the trial on the 29th day of April 2019.

4. The State of **New York** has adopted the Uniform Act to Secure the Attendance of Witnesses from Without a State in Criminal Proceedings. By its adoption of the Uniform Act, the State of **New York** has agreed that courts of the State of South Carolina may summon material witnesses from the State of **New York** to travel to the State of South Carolina.

WHEREFORE, the defense respectfully requests this Court to issue a Certificate under the seal of this Court stating **Cynthia Marie Granado Jones**, in the City of **Syracuse** in the State of **New York**, is a material witness pertaining to a criminal prosecution case before this Court, that **Cynthia Marie Granado Jones** is required to appear and testify for 5 weeks, and that **Cynthia Marie Granado Jones** shall be compensated, pursuant to the Uniform Act.

S. Boyd Young, Attorney
Counsel for Timothy Ray Jones, Jr.

Lexington, South Carolina
This 28 day of March, 2019

STATE OF SOUTH CAROLINA **COUNTY OF LEXINGTON**	**IN THE COURT OF GENERAL SESSIONS** **ELEVENTH JUDICIAL CIRCUIT**
STATE OF SOUTH CAROLINA, **Plaintiff,** **v.** **TIMOTHY RAY JONES, JR.,** **Defendant.**	**Indictment No: 2015-GS-3200-188** **2015-GS-3200-189** **2015-GS-3200-190** **2015-GS-3200-191** **2015-GS-3200-192**

EX PARTE CERTIFICATE REGARDING OUT OF STATE WITNESS

I, the Honorable Eugene Griffith, Assigned Circuit Court Judge for the Eleventh Judicial Circuit, Lexington County, South Carolina, a court of record, do hereby certify:

1. The trial in the above-captioned matter is scheduled to begin on April 29, 2019 and to continue for a period of 5 weeks.

2. The witness, **Cynthia Marie Granado Jones**, who resides in **Syracuse, New York**, is a necessary and material witness for the defense pursuant to the Uniform Act to Secure the Attendance of Witnesses from Without a State in Criminal Proceedings. S.C. Code §19-9-10 through §19-9-130.

3. If said witness comes into the State of South Carolina pursuant to an order directing the appearance of such witness during the above trial, the laws of the State of South Carolina give the witness protection from arrest or Service of Process, civil or criminal, in connection with matters which arose before entrance into said state pursuant to said order.

4. This Certificate is made for the purpose of being presented to a Judge in **Syracuse, State of New York** where said witness is residing, to request proceedings to compel said witness, **Cynthia Marie Granado Jones**, to attend and testify before this Court in the

State of South Carolina as a material witness at trial in the above-captioned criminal proceeding.

WITNESS the Honorable Eugene C. Griffith, Jr., Assigned Circuit Judge for the Eleventh Judicial Circuit, Lexington County, State of South Carolina, a Court of record.

The Honorable Eugene C. Griffith, Jr.
Presiding Circuit Judge

Lexington, South Carolina
This 1st day of April, 2019

County Court, Civil Branch
Onondaga County

In the Matter of the Application Of

Timothy Ray Jones, Jr., Petitioner

vs.

Index No. _____/_____

NOTICE OF EMERGENCY PETITION

Cynthia Granado Jones Turner, Respondent

PLEASE TAKE NOTICE that upon the verified petition of Timothy Ray Jones, Jr. sworn to on May 8, 2019, and the attached exhibits, petitioner will request this court, at 9:30 AM on May 9, 2019, at the Courthouse, 505 S. State Street, in the Clerks Office, Suite 110, for a judgment, pursuant to Civil Practice Law and Rules, granting the following relief to the petitioner:

ORDER allowing the videotaped testimony of material witness Cynthia Granado Jones Turner and for such other and further relief as this Court may deem just and proper.

Dated: Onondaga County, New York

8th day of May, 2019

Respectfully Submitted,

David B. Savlov
Assigned Counsel Program
109 S. Warrant St., Suite 220
Syracuse, NY 13202
dsavlov@ocbaacp.org
315-476-2921

To: Respondent

Mental Hygiene Legal Service, Kathryn A. Strodel
of counsel for Cynthia Granado Jones Turner

At I.A.S. Part ____ of the Supreme Court of the State of New York, held in and for the County of Onondaga, at the Courthouse thereof, 505 S. State Street, Syracuse, N.Y., on the 8th day of May, 2019

County Court, Civil Branch
Onondaga County

Present Hon: _____
Justice of the Supreme Court

In the Matter of the Application Of

Timothy Ray Jones, Jr., Petitioner

vs. Index No. _____/_____

Cynthia Granado Jones Turner, Respondent

EMERGENCY PETITION FOR COURT ORDER ALLOWING VIDEOTAPED TESTIMONY OF CYNTHIA GRANADO JONES TURNER

COMES NOW, Timothy Ray Jones, Jr., through undersigned counsel, and moves this Honorable Court under NY CLS CPL § 640.10(2) to order the videotaping of the testimony of Cynthia Granado Jones Turner for a capital criminal proceeding in the State of South Carolina.

As grounds, counsel states as follows:

1. Timothy Ray Jones, Jr. is currently facing capital charges in the State of South Carolina, County of Lexington. Counsel is currently in the middle of voir dire, and the trial is expected to start Monday, May 13, 2019.

2. Witness Cynthia Granado Jones Turner is a resident at an assisted living facility in Syracuse.
3. The Honorable Eugene Griffith, of the Eleventh Judicial District Court of General Sessions of South Carolina has certified that the testimony of this witness is necessary and material. Attachment A; NY CLS CPL § 640.10(2)(2019); *see People v McCartney*, 345 N.E.2d 326 (N.Y. 1976).
4. Cynthia Granado Jones Turner is unable to leave the State of New York due to disability and special needs.

Petitioner requests that this Court order Cynthia Granado Jones Turner to submit to a videotaped interview with counsel for petitioner in lieu of in-person testimony at petitioner's trial. *See, e.g.*, NY CLS CPL § 660.20(2)(b)(2019) ("An order directing examination of a witness conditionally must be based upon the ground that there is reasonable cause to believe that such witness will not be amenable or responsive to legal process or available as a witness at a time when his testimony will be sought, [] because he is Physically ill or incapacitated."); NY CLS CPL § 630.10 (2019)("Under the circumstances prescribed in this article, a person confined in an institution within this state pursuant to a court order may, upon application of a party to a criminal action or proceeding, demonstrating reasonable cause to believe that such person possesses information material thereto, be produced by court order and compelled to attend such action or proceeding as a witness.").

WHEREFORE, Petitioner respectfully requests that this Court order Cynthia Granado Jones Turner to submit to a videotaped interview with counsel for petitioner on Thursday May 9, 2019 and/or Friday, May 10, 2019 at the location of respondent's choice.

9th day of May, 2019

Counsel for Timothy Ray Jones, Jr.
David B. Savlov
Assigned Counsel Program, Inc.
109 S. Warrant St., Suite 220
Syracuse, NY 13202
dsavlov@ocbaacp.org

VERIFICATION

State of New York
County of Onondaga

David B. Savlov being duly sworn, deposes and says: That I am counsel for the petitioner in this proceeding, that I have read the foregoing petition and know the contents thereof; that the same is true to my own knowledge, except as to matters therein stated to be alleged on information and belief; and that as to those matters I believe them to be true.

Counsel for Timothy Ray Jones, Jr.

Sworn to before me on the
9th day of May, 2019

Notary Public

ROSEMARY HAGE
NOTARY PUBLIC, STATE OF NEW YORK
Registration No. 01HA6375571
Qualified in Onondaga County
Commission Expires May 29, 2022

County Court of the State of New York
County of Onondaga
505 S. State Street
Syracuse, N.Y. 13202
9th day of May, 2019

County Court
Onondaga County

Present Hon: Stephen J. Dougherty

In the Matter of the Application Of

Timothy Ray Jones, Jr., Petitioner

vs. Index No. _____/_____

Cynthia Granado Jones Turner, Respondent

ORDER

Pursuant to the Emergency Petition for Court Order Allowing Videotaped Testimony of Cynthia Granado Jones Tuner, it is hereby ordered that Respondent, Cynthia Granado Jones Turner, shall submit to a videotaped interview with counsel for Petitioner on Thursday May 9, 2019 and/or Friday, May 10, 2019 at the location of Respondent's choice.

9 day of May, 2019

The Honorable Stephen J. Dougherty
Onondaga County Court

#96

DEATH PENALTY CASE

STATE OF SOUTH CAROLINA **COUNTY OF LEXINGTON**	**IN THE COURT OF GENERAL SESSIONS** **ELEVENTH JUDICIAL CIRCUIT**
STATE OF SOUTH CAROLINA, **STATE,** **v.** **TIMOTHY RAY JONES, JR.,** **Defendant.**	**Indictment No.s: 2015-GS-32-188** **2015-GS-32-189** **2015-GS-32-190** **2015-GS-32-191** **2015-GS-32-192**

MOTION TO VOIR DIRE POTENTIAL JURORS REGARDING THE CONSEQUENCE OF A VERDICT OF NOT GUILTY BY REASON OF INSANITY AND GUILTY BUT MENTALLY ILL AND FOR JURORS TO BE INSTRUCTED AS TO THE CONSEQUENCE OF A VERDICT OF NOT GUILTY BY REASON OF INSANITY AND GUILTY BUT MENTALLY ILL

Introduction

In State v. Poindexter, 314 S.C. 490 (1993), the South Carolina Supreme Court stated:

> The function of the jury is to determine whether a defendant is guilty or not guilty, and the consequences of a conviction are of no aid in determining whether the defendant committed the offense. Therefore, *the consequences need not be brought to the jury's attention unless the jury has a statutory right to fix or recommend punishment.*

Id. at 492 (emphasis added).

The court therefore held the trial court's refusal to allow the jury to be informed of the consequences of a verdict of Not Guilty by Reason of Insanity (NGRI) and Guilty but Mentally Ill (GBMI) was not error. This holding, however, is contrary to the reasoning of the United States Supreme Court regarding the issue of information being withheld from capital jurors by South Carolina courts.

Precedent

In Simmons v. South Carolina, 512 U.S. 154 (1994), the Court considered a trial court's refusal to inform a capital jury that the defendant would not be eligible for parole if sentenced to life imprisonment. The Court reasoned that, without being informed of the defendant's parole ineligibility,

> the jury reasonably may have believed that [defendant] could be released on parole if he were not executed. To the extent this misunderstanding pervaded the jury's deliberations, it had the

> effect of creating a false choice between sentencing [defendant] to death and sentencing him to a limited period of incarceration. This grievous misperception was encouraged by the trial court's refusal to provide the jury with accurate information regarding [defendant's] parole ineligibility...

Id. at 161-62.

The Court further noted that an instruction informing the jury of defendant's parole ineligibility would have been legally accurate, and "certainly...more accurate than no instruction at all, which leave the jury to speculate whether 'life imprisonment' means life without parole or something else." Id. at 167. "It can hardly be questioned that most juries lack accurate information about the precise meaning of 'life imprisonment' as defined by the States." Id. at 169. See also, Boyde v. California, 494 U.S. 370, 380 (1990) (stating that a defendant is denied Due Process when the jury is not permitted to consider constitutionally relevant evidence).

"While juries ordinarily are presumed to follow the court's instructions, we have recognized that in some circumstances the risk that the jury will not, or cannot, follow instructions is so great, and the consequences of failure so vital to the defendant, that the practical and human limitations of the jury system cannot be ignored." Simmons at 171.

Ultimately the Court held that the "false dilemma" created by failing to inform the jury of the defendant's parole ineligibility violated his rights under the Due Process Clause of the Fourteenth Amendment. Id.

In Shafer v. South Carolina, 532 U.S. 36 (2001), the Court again addressed the issue of a South Carolina capital jury not being informed that the defendant would not be eligible for parole in the event the jury sentenced him to life imprisonment.

In its analysis, the Court stated

> When the jury determines the existence of a statutory aggravator, a tightly circumscribed factual inquiry, none of [defendant's] due process concerns arise. There are no misunderstandings to avoid, no false choices to guard against. The jury, as aggravating circumstance factfinder, exercises no sentencing discretion itself. If no aggravator is found, the judge takes over and has sole authority to impose [a sentence of between thirty years and life imprisonment].

Id. at 51.

The Court ultimately held the defendant's due process rights were violated by not informing the jury of his parole ineligibility, despite the jury being informed that "life imprisonment" meant "until the death of [defendant]." Id. at 39-40.

South Carolina Statutory Law Regarding Verdicts of Not Guilty by Reason of Insanity and Guilty but Mentally Ill

South Carolina Code Section 17-24-40(A) ("Commitment of person found not guilty by reason of insanity") reads as follows:

> In the event a verdict of "not guilty by reason of insanity" is returned, the trial judge must order the person who was the defendant committed to the South Carolina State Hospital for a period not to exceed one hundred twenty days. During that time, an examination must be made of the person to determine the need for hospitalization of the person pursuant to the standards set forth in Section 44-17-580.

Section 17-24-50 ("Length of confinement or supervision of defendant found not guilty by reason of insanity") states, "In no case shall a defendant found not guilty by reason of insanity be confined or be under supervision longer than the maximum sentence for the crime with which he was charged without full civil commitment proceedings being held."

Section 17-24-70 ("Sentencing of defendant found guilty but mentally ill") states, "If a verdict is returned of 'guilty but mentally ill' the defendant must be sentenced by the trial judge as provided by law for a defendant found guilty…".

Analysis

In a 2015 article published in the Journal of the American Academy of Psychiatry and the Law, Dr. Richard L. Frierson uncovered a troubling lack of understanding by members of the South Carolina criminal bar regarding knowledge of the legal definitions of NGRI and GBMI, as well as the dispositional outcomes of verdicts of NGRI and GBMI. See "Mental Illness and Mental Health Defenses: Perceptions of the Criminal Bar," J. Am. Acad. Psychiatry Law, 43:483-91, 2015, attached.

According to the empirical data contained in the article, Dr. Frierson found the following: 76% of respondents properly identified the legal definition of NGRI; 58% of respondents properly identified the legal definition of GBMI; 88% of respondents properly identified the dispositional outcome of an NGRI verdict; and 14% of respondents properly identified the dispositional outcome of a GBMI verdict. Perhaps most troubling of all, only 5% of judicial respondents properly identified that persons found GBMI could receive a death sentence. Id. at Table 5.

Taken as a representation of the legal profession as a whole, the data shows that at the time of the article's publication: 24% of South Carolina attorneys who practice criminal law could not properly identify the legal definition of NGRI, 42% of South Carolina attorneys who practice criminal law could not properly identify the legal definition of GBMI, 12% of South Carolina attorneys who practice criminal law could not properly identify the dispositional outcome of an NGRI verdict, and 86% of South Carolina attorneys who practice criminal law could not properly identify the dispositional outcome of a GBMI verdict. And lastly, 95% of South Carolina judges believed that defendants found GBMI could not be sentenced to death.

Dr. Frierson's data begs the following question: if a statistically significant number of legal professionals who have experience and expertise in criminal cases involving mental health defenses cannot properly define those defenses or identify the dispositional outcome of a verdict rendered in favor of those defenses, how can it be assumed that a jury will, or will be able to, follow a court's instructions regarding those defenses?

The issue in Mr. Jones' case is compounded by the fact that the State will seek to introduce evidence that Mr. Jones confessed to the killings of his five young children. Even if instructed as to the legal definition of NGRI, which many lawyers and judges fail to comprehend, a juror asked to consider a verdict

of NGRI may reasonably interpret that the consequence of such a verdict will be that Mr. Jones will not be held accountable for the killings, despite his admissions, and that he may ultimately be released from custody.

Akin to the reasoning in Simmons, a juror in Mr. Jones' case may reasonably believe that he could be released if found NGRI, creating a false choice between finding him guilty and finding him NGRI. An instruction informing Mr. Jones' jury of the consequence of an NGRI verdict would be legally accurate, and certainly more accurate than no instruction at all, which would leave the jury to speculate whether NGRI means he will not be held accountable – and may be released from custody – or something else.

In Simmons, the Court acknowledged that "most juries lack accurate information about the precise meaning of 'life imprisonment,'" 512 U.S. at 169, a phrase that – at face value – seemingly does not require explanation. In Shafer, the Court reiterated its belief that juries lack accurate information about the precise meaning of 'life imprisonment' even when instructed that it means "until the death of [the defendant]." 532 U.S. at 39-40. If it is presumed that a jury may misinterpret an instruction that 'life imprisonment' means 'until the death of the defendant,' it is at least equally possible that a jury may misinterpret the meaning of an NGRI verdict by speculating as to the consequences of such a verdict.

Furthermore, it is a legal fiction that a jury that renders a verdict of NGRI does not fix punishment. An NGRI verdict, pursuant to South Carolina Code Sections 17-24-40(A) and 17-24-50, affirmatively and unequivocally fixes punishment. A presiding judge who receives an NGRI verdict from a jury *must* order the defendant committed to the South Carolina State Hospital. There is no judicial discretion because the verdict, in and of itself, fixes the punishment.

A judge in the penalty phase of a capital trial has far more discretion, as the jury's sentence is described as a "recommendation" (S.C. Code Section 16-3-20(A)), and the judge is required – before imposing a sentence of death upon the jury's recommendation – to make a determination that the recommendation was "warranted under the evidence of the case and was not a result of prejudice, passion or any other arbitrary factor." S.C. Code Section 16-3-20(C). In the event of an NGRI verdict in the first phase of a capital trial, the judge makes no such determination because the jury's verdict fixes the punishment.

While juries are generally presumed to follow a court's instructions, the United States Supreme Court has determined that "in some circumstances the risk that the jury will not, or cannot, follow instructions is so great, and the consequences of failure so vital to the defendant, that the practical and human limitations of the jury system cannot be ignored." Simmons at 171. This is especially true in cases where there are "misunderstandings to avoid [and] false choices to guard against." Shafer at 51. In Mr. Jones' case, the potential for misunderstandings and false choices could be easily eliminated by allowing defense counsel to voir dire potential jurors regarding the consequences of NGRI and GBMI verdicts. See State v. Stanko, 376 S.C. 571, 580 (2008) (Pleicones, J., dissenting) (stating that "[a] capital defendant who will interpose a diminished capacity or insanity defense is entitled to voir dire the jurors whether they entertain any bias against such a defense. In fact, this Court has already recognized the appropriateness of such inquiry. See State v. Poindexter, 324 S.C. 490 (1993)").

The United States Supreme Court has repeatedly emphasized the principle that because of the exceptional and irrevocable nature of the death penalty, "extraordinary measures" are required by the Eight and Fourteenth Amendments to ensure the reliability of decisions regarding both guilt and punishment in a

capital trial. Eddings v. Oklahoma, 455 U.S. 104, 118 (1982) (O'Connor, J., concurring). See also, Gilmore v. Taylor, 508 U.S. 333 (1993); Gregg v. Georgia, 428 U.S. 153, 187 (1976) (stating that, in capital cases, a court must be "particularly sensitive to ensure that every safeguard is observed").

Failure to allow voir dire of potential jurors in Mr. Jones' case regarding the consequences of an NGRI and GBMI verdict would violate his rights under the Fifth, Eighth and Fourteenth Amendments to the United States Constitution, corresponding sections of the South Carolina Constitution, and South Carolina Rule of Criminal Procedure, Rule 14(c), which states, "In all cases, the trial judge shall ensure that the defendant's rights under the state and federal constitutions to a trial by jury are preserved."

Wherefore, Mr. Jones moves this Court to order that defense counsel be permitted to voir dire potential jurors regarding the consequences of an NGRI and GBMI verdict and whether potential jurors entertain any bias against rendering such verdicts in light of the legal consequences thereof. Additionally, Mr. Jones requests that the jury empaneled be instructed as to the legal consequences of verdicts of NGRI and GBMI.

Respectfully Submitted,

S. Boyd Young, Esq.
S.C. Bar #16959
Director, Capital Trial Division
South Carolina Commission on Indigent Defense
1330 Lady Street, 4th Floor
Columbia, SC 29201

Counsel for Mr. Jones, Jr.

REGULAR ARTICLE

Mental Illness and Mental Health Defenses: Perceptions of the Criminal Bar

Richard L. Frierson, MD, Mary S. Boyd, MD, and Angela Harper, MD

As the number of state mental hospital beds declines, persons with persistent mental illness are increasingly encountered by those working in the legal system. Attorneys may have little experience in working with this population. This research involved a 32-item written survey of the 492 members of the criminal bar in South Carolina. Demographic variables were surveyed, and attorneys were asked to define two common terms describing mental illnesses (delusion and psychosis) and the legal criteria for verdicts of not guilty by reason of insanity and guilty but mentally ill. They were also asked to identify the most severe mental illness (schizophrenia). Attitudes about these verdicts and about working with defendants who are mentally ill were also surveyed. Results indicate that attorneys are fairly knowledgeable about mental illness, but not verdicts involving mental illness, particularly the verdict of guilty but mentally ill. Most attorneys prefer to work with clients who do not have mental illness. However, as they become more experienced interacting with defendants who are affected by mental illness, they become more knowledgeable and are more willing to defend them. A large majority believe that their law school education about mental illness was inadequate. When comparing attorney occupations, public defenders were the most knowledgeable about mental illness and mental health defenses, followed by prosecutors and private defense attorneys. Judges were the least knowledgeable group.

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A large number of persons with severe and persistent mental illness are incarcerated in correctional facilities worldwide, and the number continues to rise in the United States.[1] The increase in the incarceration of those with mental illness is due to several factors, including a reduction in available state mental hospital beds, lack of sufficient community mental health treatment, and an overall increase in rates of imprisonment in the United States.[2] In studies in which samples have been controlled for demographic differences, rates of mental illness among incarcerated offenders have been found to be at least double the comparable rates in the general population.[3] In one systemic review of surveys, the prevalence of psychotic disorders was 3 to 7 percent, major depression 10 percent, and personality disorder 65 percent in correctional populations.[4] In the nation's largest state prison system (Texas), schizophrenia and other psychotic disorders have a prevalence rate of 3.8 percent.[5]

Before entering the correctional system, defendants are adjudicated in the criminal court. The process involves a series of hearings, including arraignment and bond setting, preliminary hearings (e.g., evidentiary and waiver hearings in juvenile court), trial, and sentencing. Defendants with mental illness have numerous special interests within the process of adjudication. For example, in some jurisdictions, they may be eligible for diversion to a mental health court. There may also be concerns about their competency to stand trial or their mental state at the time of the alleged offense. For these matters to be raised before the court, the defendant's mental illness must be recognized by someone involved in the process. The Supreme Court has held that the need for a capacity-to-stand-trial evaluation can and should be posed by any court officer (i.e., attorney, judge, or prosecutor) at any step in the legal process.[6] Little is known about how attorneys and prosecutors recognize mental illness in a defendant. Attorney training in basic mental illness recognition and mental health law may be inadequate. In addition, little is known about attorneys' attitudes toward clients with mental illness and mental health defenses, as there have

Dr. Frierson is Professor of Clinical Psychiatry, University of South Carolina School of Medicine, Columbia, SC. Dr. Boyd is Staff Psychiatrist, Dorn VA Medical Center, Columbia, SC. Dr. Harper is in private practice, Columbia Psychiatric Associates LLC, Columbia, SC. Dr. Boyd is currently in private practice, Vista Psychiatric Consultants, LLC, Columbia, SC. Address correspondence to: Richard L. Frierson, MD, University of South Carolina School of Medicine, 3555 Harden Street Extension, Suite 301, Columbia, SC 29203. E-mail: richard.frierson@uscmed.sc.edu.

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been few studies examining their feelings on the topic. Such defendants depend on their attorneys to advise them of defenses available to them and to make recommendations about whether such a defense of mental illness is in their best interest. Unfortunately, this type of legal decision may be made with little client involvement.[7] In one study of attorneys, defense lawyers were more in favor of a defense of not guilty by reason of insanity (NGRI) and expressed attitudes that supported the defense, whereas prosecuting attorneys were more opposed to it.[8] This study also demonstrated that defense attorneys may use a potential NGRI defense to negotiate a more desirable plea bargain. In regard to the verdict of guilty but mentally ill (GBMI), prosecutors tend to favor this verdict, as they believe it will reduce acquittals for reason of insanity.[9]

The purpose of this study was fourfold:

to survey the criminal bar's knowledge about psychotic mental illness and their attitudes about defending or prosecuting those with mental illness;

to explore attorney understanding and attitudes about verdicts predicated on mental illness;

to examine correlations of demographic characteristics, experience, and job position with knowledge and attitudes among different legal professions (prosecutor, public defender, private defense attorney, or judge); and

to examine attorneys' satisfaction with their training in recognizing mental illness and understanding mental health law as it applies to criminal courts.

Verdicts in South Carolina in Cases Raising a Defense of Mental Illness

South Carolina has two statutorily defined verdicts that are potentially applicable to defendants with mental illness: not guilty by reason of insanity (NGRI) and guilty but mentally ill (GBMI). Both verdicts were established in 1984 in South Carolina after the passage of the Federal Insanity Defense Reform Act (IDRA) the same year,[10] after the insanity acquittal of John Hinkley following his assassination attempt on President Ronald Reagan. To be adjudicated NGRI, the court must find that a defendant, as a result of mental disease or defect, lacked the capacity to distinguish moral or legal right from moral or legal wrong or to recognize the particular act charged as morally or legally wrong.[11] Recognizing the difficulty in proving the NGRI defense styled after the *M'Naughten* rule, the South Carolina legislature enacted another statute in 1984 that created a GBMI verdict. The definition of the GBMI verdict was adopted from the volitional prong of the American Law Institute (ALI) Model Penal Code.[12] To be adjudicated GBMI, a defendant must be found to have had the capacity to distinguish right from wrong or to recognize his act as being wrong, but because of mental disease or defect, to have lacked the capacity to conform his conduct to the requirements of the law.[13] In both verdicts the burden of proof lies with the defense by a preponderance of the evidence. Defendants adjudicated NGRI are confined to a psychiatric hospital for a minimum of 120 days, after which they can be released only by the trial court. Persons adjudicated GBMI are incarcerated in the South Carolina Department of Corrections but undergo psychiatric evaluation at the beginning of their sentence. Most are placed in the general prison population within 1 month.[14] Jurors are instructed about the definitions of these verdicts before deliberation, but are not allowed to be instructed on the dispositional outcomes. The South Carolina Supreme Court, in *State v. Rimert*,[15] ruled that instruction about dispositional outcomes does not aid the jury in its function. The U.S. Supreme Court also held that instructing a jury in federal cases on the consequences of an NGRI verdict is improper under the Insanity Defense Reform Act of 1984.[16] Other state jurisdictions vary on this question.

Inmates who are adjudicated GBMI are not exempt from a capital sentence. South Carolina is the only state to have sentenced an inmate to death who was adjudicated GBMI because he lacked volitional control over his actions at the time of his offenses.[17] In states using the ALI Model Penal Code, not only would such a person avoid the death penalty, he would be likely to be confined to a mental hospital as a result of having been found NGRI.

Method

This study was approved by the Institutional Review Board (IRB) of the University of South Carolina. A 32-item written survey (Table 1) was mailed to the members of the criminal law division of the South Carolina Bar ($N = 492$). After this first mailing, 187 responses were received (38%). Another mailing of the survey was sent 12 weeks later to nonresponders, which resulted in another 70 responses, for a total of 257 responses (52.2%). Two of the

Table 1 The Survey

Please answer the following questions. In order to preserve research validity, please do not consult with texts, statutes, or colleagues prior to completing the survey. Please circle the best answer. If you do not know the answer, please guess.

Which of the following most closely describes your occupation?

1. Prosecuting attorney
2. Public defense attorney
3. Judge
4. Private defense attorney

How long have you been a prosecutor or defense attorney?

1. 0–3 years
2. 3–5 years
3. 5–10 years
4. >10 years

How long have you been practicing law in general?

1. 0–3 years
2. 3–5 years
3. 5–10 years
4. >10 years

Where did you attend law school?

1. Southeast United States
2. Northeast United States
3. Midwest United States
4. Southwest United States
5. Western United States
6. International degree

Did you receive any instruction in law school about mental illness?

1. Yes
2. No

Did you receive any instruction in law school about mental health law?

1. Yes
2. No

Do you feel that your education about mental health issues was adequate?

1. Yes
2. No

Have any of the following suffered from a severe mental illness, such as Schizophrenia, Bipolar Disorder (Manic Depression) or Major Depression?

1. You
2. Friend
3. Family member
4. None
5. Other (neighbor, coworker, etc.)

How prevalent is mental illness among criminal defendants?

1. <5%
2. 5–15%
3. 15–25%
4. >25%

How many cases have you prosecuted or defended that have involved an individual with mental illness?

1. No cases
2. 1–5 cases
3. 6–15 cases
4. >15 cases

How many cases have you prosecuted or defended that involved a **Not Guilty by Reason of Insanity (NGRI)** defense or outcome?

1. No cases
2. 1–5 cases
3. 6—5 cases
4. >15 cases

How many cases have you prosecuted or defended that involved a **Guilty but Mentally ill (GBMI)** plea or outcome?

1. No cases
2. 1–5 cases
3. 6–15 cases
4. >15 cases

Which of the following is the correct definition of a **delusion**?

1. A false belief firmly held by the patient despite evidence to the contrary
2. A false sensory perception, such as seeing or hearing things that are not present
3. Impairment of thinking where a patient becomes disoriented to time, place, or events
4. A rapid succession of fragmentary thoughts or speech in which content changes abruptly

Which of the following is the correct definition of **psychosis**?

1. A loss of contact with reality
2. Rapidly shifting mood states
3. Repetitive behaviors such as counting or hand washing
4. A loss of contact with reality; persistent and extreme elevation in mood

Which of the following is the most severe and chronic mental illness?

1. Major depression
2. Bipolar disorder
3. Schizophrenia
4. Obsessive compulsive disorder

South Carolina has two mental illness verdicts: Not Guilty By Reason Of Insanity (NGRI) and Guilty But Mentally Ill (GBMI). Please circle the best answer to the following questions involving these verdicts.

What do you think the verdict **Not Guilty by Reason of Insanity (NGRI)** means?

1. The defendant has a severe mental illness and cannot stand trial.
2. The defendant had mental illness at the time of the crime.
3. The defendant who committed the crime had a mental illness that prevented him from understanding that what he did was wrong.
4. The defendant who committed the crime had a mental illness that prevented him from controlling his actions according to the law.

Table 1 Continued

What do you think the outcome of the **Not Guilty By Reason Of Insanity (NGRI)** verdict *is* for a serious felony such as murder, assault and battery with intent to kill, rape, etc?

1. The defendant goes home.
2. The defendant goes to prison.
3. The defendant goes to a psychiatric hospital for treatment and then is transferred to a prison when stable enough to complete his sentence.
4. The defendant goes to a psychiatric hospital for treatment and then is released to go home when determined not to be dangerous to self or others.

What do you think the outcome of the **Not Guilty by Reason of Insanity (NGRI)** verdict *should be* for a serious felony such as murder, assault and battery with intent to kill, rape, etc?

1. The defendant goes home.
2. The defendant goes to prison.
3. The defendant goes to a psychiatric hospital for treatment and is transferred to a prison when stable enough to complete the sentence.
4. The defendant goes to a psychiatric hospital for treatment and is released to go home when determined not to be a danger to self or others.

What do you think the verdict **Guilty But Mentally Ill (GBMI)** means?

1. The defendant has a severe mental illness and cannot stand trial.
2. The defendant had mental illness at the time of the crime.
3. The defendant who committed the crime had a mental illness that prevented him from understanding that what he did was wrong.
4. The defendant who committed the crime had a mental illness that prevented him from controlling his actions according to the law

What do you think the outcome of the **Guilty But Mentally Ill (GBMI)** verdict *is* for a serious felony such as murder, assault and battery with intent to kill, rape, etc?

1. The defendant goes home.
2. The defendant goes to prison.
3. The defendant goes to a psychiatric hospital for treatment and is transferred to a prison when stable enough to complete the sentence.
4. The defendant goes to a psychiatric hospital for treatment and is released to go home when he is determined not to be a danger to self or others.

What do you think the outcome of the **Guilty But Mentally Ill (GBMI)** verdict *should be* for a serious felony such as murder, assault and battery with intent to kill, rape, etc?

1. The defendant goes home.
2. The defendant goes to prison.
3. The defendant goes to a psychiatric hospital for treatment and is transferred to a prison when stable enough to complete his sentence.
4. The defendant goes to a psychiatric hospital for treatment and is released to go home when he is determined not to be a danger to themselves or others.

Which of the following crimes/offenses would influence your decision to recommend an NGRI plea?

1. Felony offense with a >10-year potential sentence
2. Felony offense with a <10-year potential sentence
3. Misdemeanor offense
4. Makes no difference
5. Would never recommend

Which of the following crimes/offenses would influence your decision to recommend a GBMI plea?

1. Felony offense with a >10-year potential sentence
2. Felony offense with a <10-year potential sentence
3. Misdemeanor offense
4. Makes no difference
5. Would never recommend

In you opinion, should jurors be told the potential outcome of a verdicts such as Not Guilty By Reason of Insanity (NGRI) or Guilty But Mentally Ill (GBMI) before they have to decide the verdict in a case?

1. Yes
2. No

Do you think that if jurors knew the outcome it would influence their decision?

1. Yes
2. No

Do you think that a defendant found GBMI can receive the death penalty?

1. Yes
2. No

Should the NGRI verdict be eliminated?

1. Strongly agree
2. Somewhat agree
3. Neutral
4. Somewhat disagree
5. Strongly disagree

Table 1 Continued

Should the GBMI verdict be eliminated?		
1. Strongly agree		4. Somewhat disagree
2. Somewhat agree		5. Strongly disagree
3. Neutral		
I would rather defend or prosecute clients who do not have mental illness		
1. Strongly agree		4. Somewhat disagree
2. Somewhat agree		5. Strongly disagree
3. Neutral		
What is your age?		
What is your sex (circle one)?	Male	Female
Are you married (circle one)?	Yes	No

returned surveys were not included for analysis because more than 10 questions remained unanswered.

Demographic variables examined included age, gender, marital status, attorney type (prosecutor, public defender, private defense attorney, or judge), experience in years practicing law and practicing in the current position, geographic area of law school, history of instruction about mental illness or mental health law, and number of cases involving defendants with mental illness and defenses predicated on mental illness. Attorneys were also asked about their personal experience with mental illness in themselves, family members, friends, or others.

Knowledge of mental illness was assessed with three multiple-choice questions asking the respondents to identify correctly the most severe and chronic mental illness ("schizophrenia") and to define the clinical terms "delusion" and "psychosis" from multiple-choice answers.

Knowledge and attitudes about verdicts in cases with a mental illness defense were assessed by asking the participants to identify the correct legal definition and dispositional outcomes of the NGRI and GBMI verdicts and to select what they believe the definition of each verdict and dispositional outcome should be. They were also asked whether defendants adjudicated GBMI could receive a death sentence in South Carolina. Finally, they were asked whether they believed the NGRI or GBMI verdicts should be eliminated and whether they would rather defend and prosecute defendants who do not have mental illness.

Survey Results

Demographic variables are summarized in Table 2. Our response sample was predominately male and predominately private defense attorneys or public defenders.

Table 3 summarizes attorney experience in working with defendants with mental illness or using, prosecuting, or adjudicating a mental illness defense. Although it appears that the prevalence of defendants with mental illness is relatively high, the rate of use of such a defense is low.

Table 2 Demographic Variables and Experience

Variable	Data
Age, years	26–73 (mean, 45.64)
Gender	
Male	80
Female	20
Marital status	
Married	76
Unmarried	24
Current occupation	
Private defense attorney	57
Public defender	23
Prosecutor	17
Judge	3
Years in current job	
≤3	10
4–5	12
6–10	20
>10	58
Mental illness instruction in law school	
Yes	26
No	74
Mental health law Instruction in law school	
Yes	17
No	83
Mental health instruction adequate	
Yes	15
No	83
Unknown	2
Personal experience with mental illness	
Self	5.6
Friend	35.8
Family	29.9
Other	8.6
None	31

Data are percentage of analyzed responses, unless stated otherwise. $N = 255$.

Table 3 Experience With Defendants with Mental Illness and Mental Health Defenses

Experience	Occurrence
Prevalence of mental illness among defendants	
<5%	9
5–15%	29
15–25%	28
>25%	31
No answer	3
Number of cases involving mental illness	
None	4
1–5 cases	20
6–15 cases	18
>15 cases	58
Number of NGRI cases	
None	44
1–5 cases	44
6–15 cases	9
>15 cases	3
Number of GBMI cases	None
None	42
1–5 cases	44
6–15 cases	10
>15 cases	4

Data are percentages of respondent groups. $N = 255$.

Responses regarding attorneys' knowledge of psychotic mental illness revealed that 71 percent correctly identified the definition of delusion, 87.5 percent correctly identified the definition of psychosis, and 72.5 percent identified schizophrenia as the most severe and chronic mental illness.

Responses to questions measuring knowledge about mental illness verdicts and outcomes are summarized by attorney type in Table 4. Attorney experience with defendants with mental illness and mental illness verdicts is outlined in Table 5 by attorney type. Finally, attitudes toward defendants with mental illness and mental illness verdicts are presented in Table 6 by attorney type.

A significant number of attorneys (27%) mistakenly believed that GBMI is defined as merely having mental illness at the time of the offense, not necessarily as lacking the capacity to conform behavior to the requirements of the law. Also a large majority (82%) mistakenly believed that persons adjudicated GBMI go to a hospital outside of prison before they are sent to prison. Almost half of the attorneys (41%) erroneously believed that a person found GBMI could not receive the death sentence.

Questions assessing attorney attitudes revealed that most attorneys believe an NGRI outcome should involve hospitalization and then release (86%) and that a GBMI outcome should involve hospitalization before prison. A majority of attorneys (81%) indicated that the severity of the crime and potential punishment are not factors that are considered when deciding whether to seek an NGRI verdict. Similarly, a majority (76%) indicated that the severity of the crime does not influence the decision to pursue a GBMI verdict. Most attorneys favor the existence of the NGRI verdict (77%). They are slightly less enthusiastic about the GBMI verdict (62% favor its existence). Also, most attorneys (57%) believe that jurors should be informed of the dispositional outcome of the NGRI and GBMI verdicts, a practice that is not currently allowed by law in South Carolina. A large majority (96%) believe that dispositional outcome should influence a juror's decision in arriving at a verdict.

Half of the attorneys surveyed would rather work with individuals who do not have mental illness, and 37 percent were neutral in their response to this question, leaving only 13 percent to indicate that they are just as happy working with defendants with mental illness as with other defendants. The public defenders, compared with other occupations, were most in favor of allowing an NGRI defense (89%) and a GBMI verdict (66%). Seventy-four percent of the attorneys have never received training in recognizing mental illness and 83 percent have never received education concerning mental health law. They also believe that their training in this area has been inadequate (85%).

Statistical Findings

When survey results were compared by gender, attorney type, attorney job experience, law school instruction about mental illness, experience working

Table 4 Experience With Defendants with Mental Illness and Mental Health Defenses by Occupation

Experience	Prosecutor ($N = 43$)	Public Defender ($N = 59$)	Private Defense Attorney ($N = 144$)	Judge ($N = 9$)	Total ($N = 255$)
More than 15 cases with defendants with mental illness	52	83	53	33	59
Has used the NGRI defense in a case	64	87	44	33	56
Has tried or pleaded a case with a GBMI verdict	64	80	51	17	59

Data are percentages of respondent groups.

Table 5 Correct Responses by Occupation, Regarding Mental Illness, Mental Illness Verdicts, and Dispositional Outcomes

Survey Item	Prosecutor (N = 43)	Public Defender (N = 59)	Private Defense Attorney (N = 144)	Judge (N = 9)	Total (N = 255)
Defined delusion	74	70	71	50	71
Defined psychosis	86	89	87	100	88
Identified schizophrenia as most severe mental illness	64	80	71	83	72
Identified legal definition of NGRI	83	74	74	99	76
Identified legal definition of GBMI	64	70	50	50	58
Identified dispositional outcome of NGRI	98	93	86	83	88
Identified dispositional outcome of GBMI	7	20	14	17	14
Identified that persons found GBMI could receive death sentence	52	78	56	5	59

Data are percentages of respondent groups.

with defendants with mental illness, and personal experience with mental illness, the following statistically significant results were found by Pearson's chi square analysis.

Gender Differences

Public defenders (p = .002) and prosecutors (p = .001) were more likely to be female than were private defense attorneys.

Women were 3.27 times more likely than men to self-report a history of mental illness (11.8%, women, 3.9%, men; p = .028) and were less likely to be married (58% women, 80% men, p = .001).

No gender differences were noted in survey responses, with the exception that men were more likely to state that they would never use an NGRI defense (p = .048).

Results According to Legal Occupation

Public defenders were 2.38 times more likely than private defense attorneys to know the definition of GBMI (p = .01).

Public defenders were 3.18 times more likely than prosecutors (p = .009) and 2.73 more likely than private defense attorneys (p = .005) to know that persons found GBMI could receive a death sentence.

Public defenders (p = .00), private defense attorneys (p = .008), and prosecutors (p = .05) were significantly more likely than judges to know that persons found GBMI could receive a death sentence.

Prosecutors were 5.1 times more likely than public defenders to have worked on fewer than six cases involving a mental health defense (p = .016). Private defense attorneys were 6.8 times more likely than public defenders to have worked on fewer than six cases involving a mental health question (p = .000).

Public defenders were 4.86 times more likely than prosecutors (p = .01) to state that NGRI acquittees should go to a hospital and then home when no longer dangerous. Private defense attorneys were also 3.12 times more likely than prosecutors (p = .006) to share this belief.

Public defenders were 3.2 times more likely than prosecutors to state that jurors should be informed of the dispositional outcome of the NGRI and GBMI verdicts before deliberations.

Prosecutors (p = .000) and judges (p = .038) were both 8 times more likely than public defenders to agree or be neutral about the elimination of the NGRI verdict.

Table 6 Attitudes About Defendants with Mental Illness and Mental Illness Verdicts

Opinion	Prosecutor (N = 43)	Public Defender (N = 59)	Private Defense Attorney (N = 144)	Judge (N = 9)	Total (N = 255)
Would rather defend, prosecute, or judge defendants who do not have mental illness	69	43	47	50	50
The NGRI verdict should be eliminated	50	11	18	50	23
The GBMI verdict should be eliminated	38	33	40	50	38

Data are percentages of respondent groups.

Attorney Experience on the Job

In all job categories, respondents with >10 years in their jobs were 3.14 times more likely to be able to define psychosis correctly ($p = .003$).

Respondents with >10 years in their jobs were 1.77 times more likely to be neutral or favor the elimination of the NGRI verdict ($p = .034$).

Law School Instruction

Law school instruction did not correlate with correct responses to questions about mental illness or mental illness verdicts.

However, those who reported adequate mental health training were 2.7 times more likely to identify schizophrenia as the most severe and chronic mental illness ($p = .046$).

Attorney Experience With Defendants Who Had Mental Illness

Attorneys with more than six cases involving defendants with mental illness were more likely to define psychosis correctly ($p = .011$), to recognize schizophrenia as the most severe and chronic mental illness ($p = .034$), to know NGRI ($p = .002$) and GBMI ($p = .03$) outcomes, and to know that defendants found GBMI could receive a death sentence ($p = .004$).

Attorneys with more than six cases involving defendants with mental illness were more likely to oppose eliminating the NGRI defense ($p = .014$) and were less opposed to working with defendants with mental illness ($p = .045$).

Personal Experience With Mental Illness

Personal experience of the participants with mental illness in themselves, family, friends, or acquaintances did not correlate significantly with any response.

Discussion

There are several limitations to this study. With a 52 percent response rate to the survey, selection bias may skew results, as attorneys more interested in or more knowledgeable about mental illness or mental health law may have disproportionately returned the survey. It is also impossible to know whether the occupational composition of the responders actually represents the current composition of the criminal bar. Given that only 17 percent of responders were prosecutors and 3 percent judges, those groups may be underrepresented in this sample. Also, this survey was brief and by no means comprehensive. Posing only three questions about psychotic mental illness was merely a screening of knowledge and is in no way a comprehensive assessment of the respondents' understanding. However, with longer surveys, response rates tend to decrease; therefore, this survey was kept as brief as possible in an attempt to obtain an adequate response rate.

Lawyers were fairly knowledgeable about the two common psychiatric terms, *psychosis* and *delusion*, and the severity of schizophrenia, most likely because the majority of them have had experience with a significant number of defendants with mental illness. Unfortunately, half of the respondents appear to prefer to represent a client who does not have mental illness. Thus, the stigma of mental illness may affect the degree of advocacy that defendants with mental illness receive from their attorneys, especially if the attorney is less experienced in working with clients with mental illness. It is clear that with increased experience in representing clients with mental illness, attorneys' attitudes toward this population become more positive. This finding has implications in the training of attorneys or law students to work with clients who have mental illness. Having practical hands-on experience in this area may be more beneficial than taking the standard didactic approach.

The respondents in this study appeared to be misinformed about the legal definition and dispositional outcome of the GBMI verdict. Unfortunately, this lack of knowledge may lead attorneys to misinform their defendants about dispositional outcome, and therefore defendants may base serious decisions about pleading on erroneous information. This possibility could partially explain results of an earlier study of the first 45 South Carolina GBMI inmates that showed that they had a considerable lack of understanding of the GBMI plea, what it meant for them, and its impact on their sentence.[14]

There is evidence that public defenders are more in favor of instructing jurors on dispositional outcomes of a verdict of mental illness than are prosecutors, perhaps because a GBMI verdict can sometimes represent a compromise when the defense is arguing NGRI (and thus hospitalization rather than prison) and the prosecution is arguing guilt.[18,19] Also, because they are not instructed on dispositional outcomes, many jurors may make decisions based on

erroneously perceived dispositional outcomes (i.e., an acquittee judged NGRI is released into the community, and a defendant with a verdict of GBMI is sent to a psychiatric hospital).[20] Finally, research has shown that jurors are confused by courts' instructions on insanity, and the addition of the GBMI option may exacerbate this problem.[21,22]

This study is limited to one state jurisdiction. However, the clear lack of knowledge about the GBMI verdict among members of the criminal bar in South Carolina may be applicable to other jurisdictions that use this verdict. Definitions of the GBMI verdict vary widely among state jurisdictions, and South Carolina is not the only state to have sentenced an individual who was found GBMI to death.[23] For example, before abolishing the death penalty in 2011, Illinois sentenced a defendant to death after a GBMI plea.[24] Attorneys in states with both a death penalty and GBMI verdict should be aware of the legal standard for GBMI as well as the possibility of a death sentence with this plea. In addition, South Carolina is a traditionally conservative state. Attitudes about defendants with mental illness and verdicts of mental illness may be more progressive in other jurisdictions.

In this study, public defenders appeared to be more knowledgeable about mental illness and mental health defenses than private attorneys, prosecutors, and judges. Their familiarity with mental illness is attributable to the likelihood that public defenders encounter the largest proportion of defendants with mental illness. The downward socioeconomic drift in major mental illness precludes most defendants with severe mental illness from being in a position to afford private legal counsel. It also appears from the data that public defenders learn by doing. As they become more experienced with defendants with mental illness, they become more knowledgeable, they view the insanity defense more favorably, and they are more willing to represent them.

From the results of this study, it appears that lawyers are unlikely to receive instruction about mental illness or mental health law during law school. They also indicated that their education in these areas was inadequate. With the large number of persons with mental illness being adjudicated in the criminal courts, law school curricula and continuing legal education providers should consider offering more training to members of the criminal bar on mental illness and mental health law. Forensic psychiatrists, by virtue of their training and experience, may be in an ideal position to assist with such training.

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Motion #100

DEATH PENALTY CASE

STATE OF SOUTH CAROLINA
COUNTY OF LEXINGTON

IN THE COURT OF GENERAL SESSIONS
ELEVENTH JUDICIAL CIRCUIT

STATE OF SOUTH CAROLINA,	
STATE,	
	Indictment No.s: 2015-GS-32-188
v.	**2015-GS-32-189**
	2015-GS-32-190
TIMOTHY RAY JONES, JR.,	**2015-GS-32-191**
	2015-GS-32-192
Defendant.	

SUPPLEMENT TO MOTION TO VOIR DIRE POTENTIAL JURORS REGARDING THE CONSEQUENCE OF A VERDICT OF NOT GUILTY BY REASON OF INSANITY AND GUILTY BUT MENTALLY ILL AND FOR JURORS TO BE INSTRUCTED AS TO THE CONSEQUENCE OF A VERDICT OF NOT GUILTY BY REASON OF INSANITY AND GUILTY BUT MENTALLY ILL

The United States Supreme Court's decisions in Hall v. Florida and Moore v. Texas illustrate that the "evolving standards of decency" concept applies to state procedures concerning a defendant's culpability based on his mental state. 134 S. Ct. 1986 (2014); 137 S. Ct. 1039 (2017). The first step in an "evolving standards of decency" analysis is an objective test. Kennedy v. Louisiana, 554 U.S. 407, 421 (2008). The "objective indicia of consensus" is determined using State practice, including examining legislative enactments, executions, and jury verdicts. Roper v. Simmons, 543 U.S. 551, 575 (2005). It is not only the number of states with a similar practice, but also the "consistency of the direction of change." *Id.* at 556; Kennedy, 554 U.S. at 431 ("Consistent change might counterbalance an otherwise weak demonstration of consensus.").

The second step in an "evolving standards of decency" analysis is a subjective test. Kennedy, 554 U.S. at 421. The United States Supreme Court will determine if a punishment is grossly disproportionate or constitutionally excessive based on its own understanding of the Eighth Amendment's "text, history, meaning, and purpose." *Id.*; Coker v. Georgia, 433 U.S. 584, 597 (1977)(plurality decision). In the context of whether a state's procedures for determining intellectual disability are adequate, the Court examines

whether the challenged procedure "creates an unacceptable risk that persons with intellectual disability will be executed." Hall, 134 S. Ct. at 1990; Moore, 137 S. Ct. at 1044,1051 (citation omitted).

South Carolina's refusal to allow a jury instruction about the consequence of a Not Guilty by Reason of Insanity (NGRI) verdict renders it an "outlier" under the "evolving standards of decency," and therefore violates Mr. Jones' Eighth Amendment rights. See Moore, 137 S. Ct. at 1052. In 1994, the United States Supreme Court found a jury instruction regarding the consequence of a NGRI verdict was not necessary under a federal statute or as a matter of federal practice in Shannon v. United States. 512 U.S. 573, 587 (1994). Now, twenty-five years later, thirty jurisdictions allow a jury instruction concerning the consequences of a NGRI verdict.[1] In addition, the "consistency of the direction of change" since the Court's decision in 1994 indicates that five additional jurisdictions now allow a jury instruction.[2] Although prior to the Court's decision in Shannon, one other jurisdiction went from prohibiting an instruction to requiring it. See Glasscock v. State, 570 S.W.2d 354, (Tenn. Crim. App. 1978) (discussing legislature responding to court's concerns by enacting statute requiring jury instruction in 1977). It is particularly relevant to understanding contemporary norms that many states have codified the requirement of a jury instruction. See Atkins, 536 U.S. at 316 ("The evidence [of a contemporary norm against executing the intellectually

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[1] See Instruction Required: **Alaska**: Alaska Stat. § 12.47.040(c)(2018); **Colorado**: *People v. Tally*, 7 P.3d 172, 184 (Colo. App. 1999); **Florida:** *Roberts v. State*, 335 So. 2d 285, 287-88 (Fla. 1976); **Georgia**: O.C.G.A. § 17-7-131(3)(A-C)(2018); **Kansas**: K.S.A. § 22-3428(6)(current through SB 9 and HB 2044); **Nevada**: *Kuk v. State*, 392 P.2d 630, 634 (Nev. 1964); **New Hampshire**: *State v. Blair*, 732 A.2d 448, 451 (N.H.1999); **New Jersey**: *State v. Krol*, 344 A.2d 289, 304-05 (N.J. 1975); **New York**: NY CLS CPL § 300.10 (3)(2019); **Pennsylvania**: *Commonwealth v. Mulgrew*, 380 A.2d 349, 351-52 (1977); **Tennessee**: Tenn. Code Ann. § 33-7-303(e)(2019); **Utah**: *State v. Shickles*, 760 P.2d 291, 298 (Utah 1988*), abrogated in part by State v. Lucero*, 328 P.3d 841 (Utah 2014). Instruction Upon Request: **California**: *People v. Kelly*, 822 P.2d 385, 408-09 (Cal. 1992) (en banc); **Hawaii**: HRS § 704-402(2)(2018); **Indiana**: *Georgopolus v. State*, 735 N.E.2d 1138, 1143 n.3 (Ind. 2000); Kentucky: Ky. Rcr. Rule 9.55 (2019); **Louisiana**: *State v. Babin*, 319 So. 2d 367, 381 (La. 1975); **Maryland**: *Erdman v. State*, 553 A.2d 244, 250 (Md. 1989); **Massachusetts**: *Commonwealth v. Mutina*, 323 N.E.2d 294, 301-02 (1975); **Missouri**: § 552.030 (6) R.S.Mo (2018); **North Carolina**: *State v. Hammonds*, 224 S.E.2d 595, 603-04 (N.C. 1976); **West Virginia**: *State v. Daggett*, 280 S.E.2d 545, 549 (W. Va.1981). Judge's Discretion: **Connecticut**: *State v. Holmquist,* 376 A.2d 1111, 1113 (1977); *State v. Wade*, 113 A. 458, 460 (Conn. 1921); **District of Columbia**: *In re Bumper*, 441 A.2d 975, 976 fn.1 (D.C. App. 1982); **Military**: *United States v. Smith*, 24 M.J. 859, 863 (A.C.M.R. 1987); **Wisconsin**: *State v. Shoffner*, 143 N.W.2d 458, 465-66 (Wis. 1966). If Jurors receive Misinformation: **Arizona**: *State v. Cornell*, 878 P.2d 1352, 1367 (Ariz. 1994); **Federal Government**: *Shannon v. United States*, 512 U.S. 573, 587 (1994); *United States v. Waagner*, 319 F.3d 962, 966 (7th Cir. 2003); **Iowa**: *State v. Becker*, 818 N.W.2d 135, 162-63 (Iowa 2012), *overruled in part on other grounds, Alcala v. Marriott Int'l, Inc.*, 880 N.W.2d 699 (Iowa 2016); **North Dakota**: *State v. Huber*, 361 N.W. 2d 236, 238 (N.D. 1985); **Wyoming**: *Haynes v. State*, 186 P.3d 1204, 1213 (Wyo. 2008).

[2] *See Roper*, 543 U.S. at 556; *Kennedy*, 554 U.S. at 434 (listing new state enactments as demonstrative of contemporary norms); *State v. Cornell*, 878 P.2d 1352, 1367 (Ariz. 1994); *Georgopolus v. State*, 735 N.E.2d 1138, 1143 n.3 (Ind. 2000); O.C.G.A. § 17-7-131(3)(A-C)(relevant section enacted in 2006); *Haynes v. State*, 186 P.3d 1204, 1213 (Wyo. 2008); *State v. Becker*, 818 N.W.2d 135, 162-63 (Iowa 2012), *overruled in part on other grounds, Alcala v. Marriott Int'l, Inc.*, 880 N.W.2d 699 (Iowa 2016).

disabled] carries even greater force when it is noted that the legislatures that have addressed the issue have voted overwhelmingly in favor of the prohibition.").

Evidence that South Carolina should allow voir dire and jury instructions regarding the consequences of NGRI and GBMI verdicts was outlined in a 2005 article by Dr. Lisa M. Sloat and Dr. Richard L. Frierson published in the Journal of the American Academy of Psychiatry and the Law. See "Juror Knowledge and Attitudes Regarding Mental Illness Verdicts," J. Am. Acad. Psychiatry Law, 33:208-13, 2005, attached. The article's findings were based on a study of qualified South Carolina jurors' understandings and attitudes about NGRI and GBMI verdicts and dispositional outcomes. Based upon the empirical data used, the study made the following findings:

- Only 4.2% of respondents correctly identified the definitions and dispositional outcomes of both NGRI and GBMI verdicts. Id. at 211.
- 13.5% of respondents who correctly identified the definition of NGRI believed the dispositional outcome of such a verdict was that the defendant would be sent home without being required to spend any time in a psychiatric hospital or prison. Id.
- 68.4% of respondents believed that a defendant found GBMI could not receive the death penalty. Id. at 212.
- 84% of respondents believed that jurors should be informed of the dispositional outcomes of NGRI and GBMI verdicts before deliberation. Id.
- 70.6% of respondents reported that knowing the dispositional outcomes of NGRI and GBMI verdicts would influence their decisions as jurors, even if the trial judge instructed the jury not to consider such outcomes in arriving at a verdict. Id.

The article concludes by stating that these results "suggest that jurors may decide verdicts partly on what they believe will be the dispositional outcome of the verdict. Because only 4.2 percent of prospective jurors in this study correctly identified the meaning and disposition of both the NGRI and GBMI verdicts, it can be hypothesized that jurors may be making decisions based on erroneous perceptions." Id. at 213. Although the article suggests that such erroneous perceptions may be cured by jury instructions regarding the dispositional outcomes of NGRI and GBMI verdicts prior to deliberations, in a capital case, a jury instruction prior to deliberations would fail to identify jurors who are unable to return a verdict according to law or who are substantially impaired in their ability to act in accordance with their oath and the judge's instructions. S.C. Code § 16-3-20(E); State v. Evins, 373 S.C. 404 (2007).

The United States Supreme Court has repeatedly emphasized the principle that because of the exceptional and irrevocable nature of the death penalty, "extraordinary measures" are required by the Eight

and Fourteenth Amendments to ensure the reliability of decisions regarding both guilt and punishment in a capital trial. Eddings v. Oklahoma, 455 U.S. 104, 118 (1982) (O'Connor, J., concurring). See also, Gilmore v. Taylor, 508 U.S. 333 (1993); Gregg v. Georgia, 428 U.S. 153, 187 (1976) (stating that, in capital cases, a court must be "particularly sensitive to ensure that every safeguard is observed"). Given the significant number of jurisdictions that allow jury instructions regarding the consequences of an NGRI verdict, it would hardly be "extraordinary" for South Carolina to do the same. Furthermore, ensuring that every safeguard is observed can be achieved by permitting voir dire of prospective jurors regarding their understanding and attitudes about NGRI and GBMI verdicts and dispositional outcomes. See, Morgan v. Illinois, 504 U.S. 719, 736 (1992) (stating that the risk that unqualified jurors could have been empaneled as a consequence of inadequate voir dire is "unacceptable in light of the ease with which that risk could have been minimized").

The defense proposes the following voir dire questions regarding NGRI and GBMI:

1). What are your feelings about the defenses of NGRI and GBMI in the context of a case involving the killings of five children under the age of eleven?

2). Understanding that a person found NGRI is committed to the State Hospital for psychiatric treatment and then may be ultimately released, could you meaningfully consider rendering a verdict of NGRI in a case involving the killings of five children under the age of eleven?

3). Would the knowledge that a defendant found NGRI could one day be released from custody affect your decision-making process when rendering a verdict?

4). Do you understand that a person found GBMI can be sentenced to death?

The defense proposes the following instruction from the Court prior to individual voir dire:

In this case you will be asked to consider four possible verdicts: Not Guilty, Not Guilty by Reason of Insanity, Guilty but Mentally Ill, and Guilty. If the jury unanimously finds the defendant Not Guilty, the trial will end. If the jury unanimously finds the defendant Not Guilty by Reason of Insanity, the trial will end and I will commit the defendant to the South Carolina State Hospital where he will remain for a period of up to one hundred and twenty days, during which time a determination will be made regarding the need for further hospitalization. The law provides that the period of further hospitalization could be the remainder of defendant's natural life. If the jury finds unanimously that the defendant is either Guilty or Guilty but Mentally Ill, the case will proceed to a penalty phase where the jury will determine whether the defendant is sentenced to life imprisonment without the possibility of parole or to death.

To deny Mr. Jones voir dire and jury instructions on the consequences of NGRI and GBMI verdicts would violate his Sixth, Eighth and Fourteenth Amendments rights, as well as his rights under the South Carolina Constitution, Art.1, §§ 3, 14, and 15.

Respectfully Submitted,

S. Boyd Young, Esq.
S.C. Bar #16959
Director, Capital Trial Division
South Carolina Commission on Indigent Defense
1330 Lady Street, 4th Floor
Columbia, SC 29201

Counsel for Mr. Jones, Jr.

REGULAR ARTICLE

Juror Knowledge and Attitudes Regarding Mental Illness Verdicts

Lisa M. Sloat, MD, and Richard L. Frierson, MD

We begin with a brief overview of the Not Guilty by Reason of Insanity (NGRI) and Guilty but Mentally Ill (GBMI) verdicts in the United States and then report on a study of qualified jurors ($n = 96$) in which we examined jurors' understanding and attitudes about mental illness verdicts and the disposition of mentally ill defendants. Results indicate that although the jury pool was highly educated, only 4.2 percent of jurors could correctly identify both the definitions and dispositions of defendants found NGRI and GBMI. Jurors with lower educational levels were less likely to identify the dispositional outcome of a GBMI verdict ($p < .05$). Eighty-four percent of respondents believed that juries should be informed of dispositional outcome before deciding a verdict. Also, 68.4 percent of jurors erroneously believed that a defendant found GBMI could not receive the death penalty. Among jurors who correctly identified the definition of GBMI, those with lower educational levels were more punitive in their attitudes toward disposition of the GBMI defendants, believing they should eventually be sent to prison ($p < .05$).

J Am Acad Psychiatry Law 33:208–13, 2005

The disposition of mentally ill offenders continues to be a controversial issue as lawmakers try to balance the public's demand for retribution and safety with the offender's civil rights and need for treatment. A large majority of states have enacted legislation that establishes an insanity defense. These statutes are based on the common law principle that the accused should not be held criminally responsible if he or she was "insane" at the time of the offense. This principle was summarized by Judge David Bazelon: "Our collective conscience does not allow punishment where it cannot impose blame" (Ref. 1, p 876). The criteria used to determine eligibility for a verdict of Not Guilty by Reason of Insanity (NGRI) vary across jurisdictions. Most states use some version of the M'Naghten rule, which requires that defendants be mentally ill to the extent that they do not know the nature and quality of their criminal acts or that their criminal acts are wrong.[2] Most of the remaining states use the American Law Institute's (ALI) standard, which holds that defendants are not criminally responsible if, as a result of mental disease or defect, they lacked substantial capacity either to appreciate the criminality of their conduct or to conform their conduct to the requirements of the law.[3] In most jurisdictions, defendants found NGRI are hospitalized for treatment in a psychiatric hospital and released when they are no longer mentally ill or dangerous.

In addition to these insanity statutes, several states have enacted legislation that includes a separate Guilty but Mentally Ill (GBMI) verdict. The first GBMI statute was enacted in Michigan in 1975 in reaction to the Michigan Supreme Court's decision in *People v. McQuillan*.[4] Before this decision, insanity acquittees were automatically committed to the Michigan Department of Mental Health for an indeterminate time. This practice was declared unconstitutional because it violates due process and denies the insanity acquittees equal protection by failing to provide them with release procedures available to individuals committed under other civil commitment statutes. As part of the *McQuillan* decision, the court ordered that all previously committed insanity acquittees be evaluated and released if they no longer met criteria for civil commitment. A total of 270 patients were evaluated and 214 were released. Within a year of their release, two of the acquittees committed heinous and highly publicized crimes.[5] The Michigan GBMI statute[6] was enacted a year later in response to public outcry. The statute stated that a defendant could be found GBMI if the trier of

Dr. Sloat is Clinical Assistant Professor of Psychiatry, University of Maryland Medical School, and Staff Psychiatrist, Clifton T. Perkins Hospital Center, Jessup, MD. Dr. Frierson is Associate Professor of Psychiatry, William S. Hall Psychiatric Institute, University of South Carolina, Columbia, SC. Address correspondence to: Richard L. Frierson, MD, University of South Carolina, William S. Hall Psychiatric Institute, PO Box 119, Columbia, SC 29203. E-mail: rlf51@dmh.state.sc.us

fact found that the defendant was guilty of the offense, was mentally ill at the time of the offense, and did not lack the substantial capacity either to appreciate the nature and quality or wrongfulness of his conduct or to conform his conduct to the requirements of the law. It further stated that the same criminal sanctions should be imposed on a person found GBMI as on a person found guilty.

At least eight additional states created GBMI statutes in response to the insanity acquittal of John Hinkley, Jr., in 1982, after his attempted assassination of President Reagan. Currently, 12 states utilize some form of GBMI verdict: Alaska, Delaware, Georgia, Illinois, Indiana, Kentucky, Michigan, New Mexico, Pennsylvania, South Carolina, South Dakota, and Utah.[7]

Mental Illness Verdicts in South Carolina

South Carolina defines insanity (NGRI) as an affirmative defense that a defendant, as a result of mental disease or defect, "lacked the capacity to distinguish moral or legal right from moral or legal wrong or to recognize the particular act charged as morally or legally wrong."[8]

The GBMI statute was enacted in South Carolina in April of 1984. The statute states that a person is GBMI[9]:

> . . .if at the time of the commission of the act constituting the offense, he had the capacity to distinguish right from wrong or to recognize his act as being wrong. . .but because of a mental disease or defect he lacked sufficient capacity to conform his conduct to the requirements of the law.

Persons adjudicated GBMI must be taken to a facility designated by the Department of Corrections for treatment and retained there until, in the opinion of the staff at the facility, such inmates can be safely moved to the general population of the Department of Corrections to serve the remainder of their sentences.

Criticisms of the GBMI Verdict

The American Psychiatric Association,[10] American Psychological Association,[11] and American Bar Association[12] have all opposed the GBMI verdict. GBMI statutes have been widely criticized for several reasons.

One criticism is that persons found GBMI are subject to the same criminal sanctions as offenders who are found guilty, including incarceration and death. Some have argued that the statute may as well be called "guilty but ignorant" or "guilty but remorseful," since GBMI does not indicate mitigated or diminished capacity.[13] In fact, studies have shown that defendants found GBMI receive longer sentences. For example, Callahan *et al.*[14] compared the sentences of those offenders who pled insanity and were subsequently found guilty with those who were found GBMI. Their results indicated that defendants found GBMI often received longer sentences than those found guilty with no mental disorder. Specifically, they found that those receiving a GBMI verdict were sent to prison 80 percent of the time (rather than receiving probation) as opposed to 62.8 percent of those found guilty without a mental illness. Also, those found GBMI received a life sentence 14 percent of the time as opposed to 5.5 percent of the time for those found guilty without mental disorder. This difference was even more significant when the charge was murder, as those found GBMI received life sentences 70.6 percent of the time, as opposed to 49.2 percent of the time for non-mentally ill defendants found guilty.

Another criticism of the GBMI verdict is that it does not always guarantee mental health treatment for the inmate. Some states make no provision for mandatory treatment. For example, the statute in Georgia specifically states that prisoners found GBMI receive treatment only as financial resources permit.[15] In addition, in *People v. Marshall*[16] the Illinois Court of Appeals ruled that failure to assure treatment for individuals found GBMI does not make the statute unconstitutional.

Another criticism is that jurors may not understand the difference between the NGRI and GBMI verdicts and may see a GBMI finding as a compromise verdict between guilty and NGRI.[5] The GBMI verdict gives jurors two verdicts (guilty and guilty but mentally ill) by which to find a defendant guilty and only one verdict (Not Guilty by Reason of Insanity) by which to find the defendant not guilty when the insanity defense is raised. In one study, prosecutors agreed that the GBMI statute makes it easier to prosecute a case when a defendant pleads insanity.[17]

The Debate About Juror Instructions

A common misperception held by the public is that defendants found NGRI are released into the community just as any other acquitted individual would be.[18] This has led some to argue that juries

should always be instructed that NGRI acquittees will be committed for treatment and will not be released until they are judged not to be a threat to society. In response, numerous courts have ruled on whether a defendant has a right to have the jury instructed as to the consequences of an NGRI verdict. A small number of states have approved the use of instructions to a jury as to the outcome of an NGRI verdict (California, Colorado, Florida, Louisiana, Massachusetts, Maryland, Pennsylvania, and Utah).[19] However, most courts have ruled that such instructions would distract a jury from its sole function as the trier of fact and that consideration of the disposition of these defendants would influence jury decision-making. These courts have held that jurors should only consider the statutory definitions of these verdicts during their deliberation.

This was the case in South Carolina, as decided in *State v. Gary Allen Rimert*.[20] In this case, the defendant was found GBMI on a charge of murder and appealed the decision, in part, on whether the jury should have been instructed as to the dispositional consequences of the GBMI and NGRI verdicts. The Supreme Court of South Carolina upheld the trial judge's decision not to instruct the jury regarding the dispositional consequences of these verdicts.

Study Hypotheses

This study was designed to test several hypotheses. Mental illness verdicts are not easily understood and are not part of common, everyday knowledge. Therefore, we hypothesized that most prospective jurors could not correctly identify the definitions and dispositional outcomes of the NGRI and GBMI verdicts. We also hypothesized that jurors would consider the consequences (i.e., perceived dispositional outcomes) of their verdicts and would let those beliefs influence their verdicts, even if instructed not to do so by the trial judge. This study was designed to measure jurors' knowledge about two subjects: the meaning of these verdicts in South Carolina and the disposition of individuals found NGRI or GBMI. In addition, we assessed juror attitudes as to what they thought the disposition should be of defendants found NGRI or GBMI.

Method

This study was approved by the Institutional Review Board of the University of South Carolina and the Chief Administrative Judge for the Fifth Judicial Circuit (Richland and Kershaw Counties). A written, multiple-choice instrument was given to volunteers from a qualified circuit court jury pool in Richland County, South Carolina, by the Clerk of Court as they were discharged from jury duty. Residents of Richland County who are called for jury duty serve for an entire week. At the end of that week, our questionnaires were handed out to discharged jurors, whether they had participated in a jury trial or not. In addition to the questionnaire, jurors were provided a stamped, self-addressed envelope to return the survey. Richland County contains the state's capital (Columbia) and has a population of approximately 325,000 persons. The high school graduation rate is 85 percent and the median income is $40,000.

The survey questioned jurors about the following demographic variables: sex, age, educational level, occupation, and the juror's relationship to the law enforcement and legal communities (juror, friend, family member, or none). Jurors were also asked if they and/or anyone they knew "suffered from a severe mental illness such as Schizophrenia, Bipolar Disorder (Manic Depression), or Major Depression," with the same choice of response (juror, friend, family member, or none).

The prospective jurors were asked to choose the correct definition of the NGRI and GBMI verdicts using the following choices: (1) the defendant has a severe mental illness and cannot stand trial; (2) the defendant was mentally ill at the time of the crime; (3) the defendant had a mental illness that prevented him or her from understanding that what he or she did was wrong (correct response for NGRI); and (4) the defendant had a mental illness that prevented him or her from controlling his or her actions according to the law (correct response for GBMI). The prospective jurors were asked to identify the dispositional outcome of the NGRI and GBMI verdicts and what the outcomes should be, using the following choices: (1) the defendant goes home; (2) the defendant goes to prison; (3) the defendant goes to a psychiatric hospital for treatment and is transferred to prison when stable enough to complete the sentence (correct response for GBMI); and (4) the defendant goes to a psychiatric hospital and is then released to go home when he or she is no longer a danger to him- or herself or others (correct response for NGRI). The prospective jurors were asked whether a defendant

Table 1 Demographic Variables

Variable	% Total Group
Sex	57.3 female
	42.7 male
Educational level*	2.1 less than high school
	12.5 high school graduate or GED
	31.3 some college
	27.1 college graduate
	27.1 postgraduate education
Relationship to law enforcement†	2.0 self
	13.5 friend
	10.3 family member
	77.1 none
Relationship to a lawyer†	4.1 self
	21.8 friend
	13.5 family member
	62.5 none
Relationship to a judge†	0.0 self
	7.3 friend
	2.1 family member
	90.6 none
Relationship to someone with a major mental illness†	6.2 self
	8.3 friend
	26.0 family member
	67.7 none

The mean age was 46 years (range, 19–69).
* Values in this category do not total 100.0% due to rounding.
† Values in these categories do not total 100.0% as answers are not mutually exclusive.

found guilty but mentally Ill could receive the death penalty.

Finally, the prospective jurors were asked if they thought that jurors should be instructed as to the dispositional outcomes of the NGRI and GBMI verdicts before deliberation. They were also asked if this knowledge would influence their verdict, even if the judge instructed them not to consider dispositional outcomes in reaching a verdict.

Results

Of the 200 surveys distributed to the qualified jury pool, 101 (50.5%) were returned. Five responders gave multiple answers to a single-answer question or failed to respond to one or more questions. Therefore, 96 of the 101 questionnaires were included in the analysis. The demographic variables are summarized in Table 1. The responding jurors were highly educated, with 97.9 percent having at least a high school education, and 54.2 percent having completed college and/or post-graduate education. Six percent of jurors admitted to having a mental illness, and 34 percent indicated that they knew someone with a major mental illness. The occupational profile of the responder group was diverse: 47 percent were nonprofessionals, 35 percent were professionals, 16 percent were unemployed, and 2 percent did not identify their occupations.

Table 2 Juror Knowledge

	% Correct	% Incorrect
Definition of NGRI	55.3	44.7
Definition of GBMI	37.2	62.8
Dispositional outcome of NGRI	62.5	37.5
Dispositional outcome of GBMI	78.1	21.9
All of above	4.2	—

Juror knowledge is summarized in Table 2. Only 4.2 percent of all respondents identified the correct meanings and outcomes of both the NGRI and GBMI verdicts. When questioned as to the legal definition of the NGRI verdict, 55.3 percent of the prospective jurors answered correctly, while 24.5 percent chose the definition of the GBMI verdict. When questioned as to the legal definition of the GBMI verdict, 37.2 percent answered correctly, while 27.7 percent chose the definition of the NGRI verdict.

Regarding the disposition of an NGRI verdict, 62.5 percent of responders identified the correct disposition; however, 27.1 percent chose the GBMI disposition (hospital, then prison), and 10.4 percent believed the defendant would go home. Among jurors who chose the correct legal definition for NGRI, 71.2 percent also chose the correct disposition, while 15.4 percent chose the disposition for GBMI, and 13.5 percent answered that they believed the defendant would go home (Table 3).

When asked about the dispositional outcome of the GBMI verdict, 78.1 percent answered correctly, and 17.7 percent chose the disposition of those found NGRI. Among jurors who chose the correct legal definition of a GBMI verdict, 88.6 percent

Table 3 Responses Regarding Dispositional Outcome of NGRI Among Those Who Knew Correct Legal Definition

	Dispositional Outcome Is, %	Dispositional Outcome Should Be, %
Psychiatric hospital, then home when no longer dangerous (correct answer)	71.2	56.9
Psychiatric hospital, then prison once stabilized	15.4	39.2
Home	13.5	2.0
Prison	0.0	2.0

Columns do not total 100.0% due to rounding.

Table 4 Responses Regarding Dispositional Outcome of GBMI Among Those Who Knew Correct Legal Definition

	Dispositional Outcome Is, %	Dispositional Outcome Should Be, %
Psychiatric hospital, then home when no longer dangerous	11.4	8.6
Psychiatric hospital, then prison once stabilized (correct answer)	88.6	80.0
Home	0.0	2.9
Prison	0.0	8.6

Columns do not total 100.0% due to rounding.

chose the correct outcome, while 11.4 percent chose the outcome for an NGRI verdict. The majority of respondents (68.4%) answered incorrectly, believing that a defendant found GBMI could not receive a death sentence (Table 4).

In assessing juror attitude about the disposition of NGRI acquittees, 56.8 percent of jurors who identified the correct legal definition of NGRI believed that defendants should go to a hospital and then home when they were no longer dangerous, while 39.2 percent thought that defendants should go to prison after being hospitalized. Jurors were more unified in their attitudes about the disposition of defendants found GBMI. Eighty percent of jurors who correctly identified the legal definition of GBMI believed that the defendant should go to a hospital and then to prison.

A large majority (84%) of respondents believed that jurors should be informed of the outcome of these verdicts before deliberation and 70.6 percent reported that knowing the outcome would influence their decisions, even if the judge instructed them not to consider the outcome in arriving at a verdict.

There was little statistical correlation among the demographic variables studied and knowledge of mental illness verdicts and their dispositional outcomes. The only statistically significant finding was that among those jurors with a post-high school education, those who did not complete a degree were less likely to identify the outcome of a GBMI verdict correctly ($p < .005$).

Finally, among jurors who knew the correct legal definition of NGRI, those with at least some college education were more likely to think that insanity acquittees should go to a hospital and then home while jurors with a high school education or less believed that insanity acquittees should go to a hospital and then prison ($p < .026$). This difference did not exist for the GBMI verdict.

Discussion

Among demographic variables, the educational level of the responders was well above the 85 percent high school graduation rate for this area. Less than 2.1 percent of the responders did not have a high school education, and 55 percent had a college degree. This probably reflects sampling bias. Because the survey involved a written instrument, those jurors who are illiterate may have been excluded. In addition, because this study was presented as a project of the University of South Carolina (located in Richland County), those associated with that institution may have been more likely to complete the study. Finally, because these surveys were distributed to jurors during the summer months, the jury pool may have been more educated, because professors, teachers, and students may defer jury duty to the summer months. Despite the high educational level of this sample, only 4.2 percent of the prospective jurors correctly identified both the legal definitions and dispositional outcomes of the NGRI and GBMI verdicts. This finding was not surprising to us, as these are difficult concepts and are not part of common, everyday knowledge or general education.

Six percent of the responders reported having a major mental illness (defined in the question as Schizophrenia, Bipolar Disorder, or Major Depressive Disorder). Thus, the point prevalence of major mental illness in this sample may be higher than in the general population and may also represent sampling bias, as mentally ill individuals may have been more interested in taking the survey.

The lack of significant correlation between demographic variables and knowledge base was consistent across age, sex, relationship to law enforcement, relationship to someone in the legal community, and relationship to someone with a major mental illness. The finding that, compared with jurors with a college or post-graduate degree, those who attended college but did not complete a degree were less likely to identify the outcome of the GBMI verdict correctly ($p < .05$) is probably true of jurors with a high school diploma or less. However, this finding was probably obscured in groups in the lower educational levels by the low response rate. Therefore, the difference did not reach statistical significance. Although knowledge about mental illness verdicts is poor across all educational levels, a higher educational level may predict better knowledge about dispositional out-

comes of the NGRI and GBMI verdicts. Among jurors who correctly identified the meaning of NGRI, juror attitude about the disposition of mentally ill defendants appears to be influenced by educational level. The less educated jurors were significantly more punitive, believing that those found NGRI should eventually go to prison after hospitalization rather than home when no longer dangerous.

In the wake of the recent U.S. Supreme Court decision barring the execution of the mentally retarded,[21] the finding that a majority of jurors did not believe that a defendant found GBMI could receive a death sentence may become an appellate issue. If jurors believe that GBMI individuals may not be executed, they may be more likely to decide a defendant is GBMI rather than NGRI in capital cases if they base their decision on perceived dispositional outcome. Because both the NGRI and GBMI verdicts require a unanimous jury finding, only one juror with such a misperception could be crucial in deciding the ultimate outcome in a capital case. The existence of GBMI inmates on death row may become the next battleground in the debate over capital punishment.

In this study, we found that a large majority (84%) of prospective jurors wanted to know the dispositional outcomes of mental illness verdicts and would consider these outcomes when reaching a verdict, even if instructed not to by the trial judge (70.6%). These results suggest that jurors may decide verdicts partly on what they believe will be the dispositional outcome of the verdict. Because only 4.2 percent of prospective jurors in this study correctly identified the meaning and disposition of both the NGRI and GBMI verdicts, it can be hypothesized that jurors may be making decisions based on erroneous perceptions. An argument can be made that jurors should be provided with accurate information regarding dispositional outcomes prior to jury deliberation.

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CORRECT CARE
RECOVERY SOLUTIONS

NCCHC

COLUMBIA REGIONAL CARE CENTER

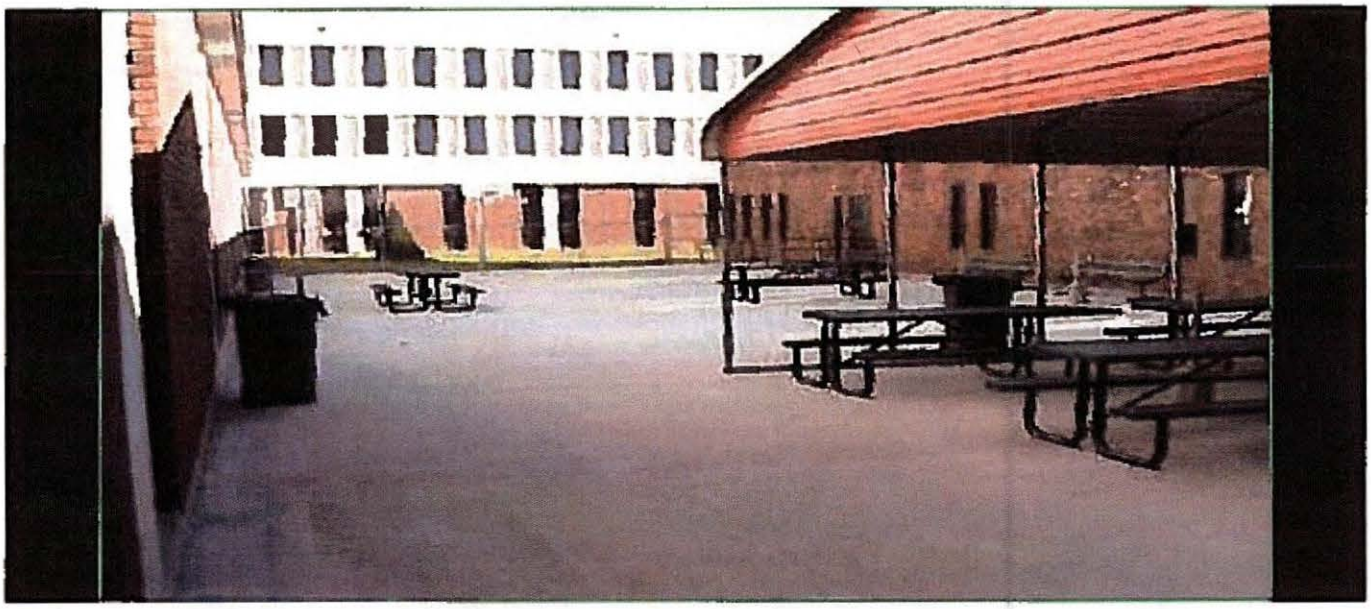
PATIENT HANDBOOK

7901 Farrow Road
Columbia, South Carolina 29203
Phone: 803.935.0505 / Fax: 803.935.4569

WELCOME

December 2014

TABLE OF CONTENTS



2 Welcome

3 About CRCC

4 Expectations and Privacy Practices

5 Risk Management & Safety / Ethics Committee

6 Intake Process

9 Sickcall

10 Your Part In Your Care & Safety / Helpful Tips About Medication

11 Pharmacy Services / Dental Care

12 Mental Health Services

15 Patient Rights and Responsibilities

16 Patient Rules

18 Personal Daily Living Needs

22 Mail

23 Visitation

24 Library and Recreation

25 Telephone

26 Pastoral Care Services

27 Patient Canteen

28 Patient Bank

29 Legal Issues

30 Patient Grievance Procedure

32 Prison Rape Elimination Act / Definitions

33 Assault/Abuse

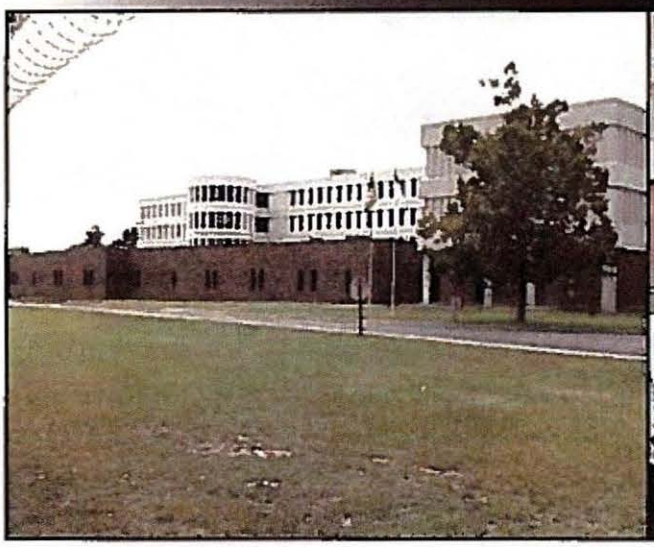
36 Security Operations / Self-Discipline

37 Formal Disciplinary Action

41 Patient Release / Special Communication Issues

42 Daily Operating Schedule

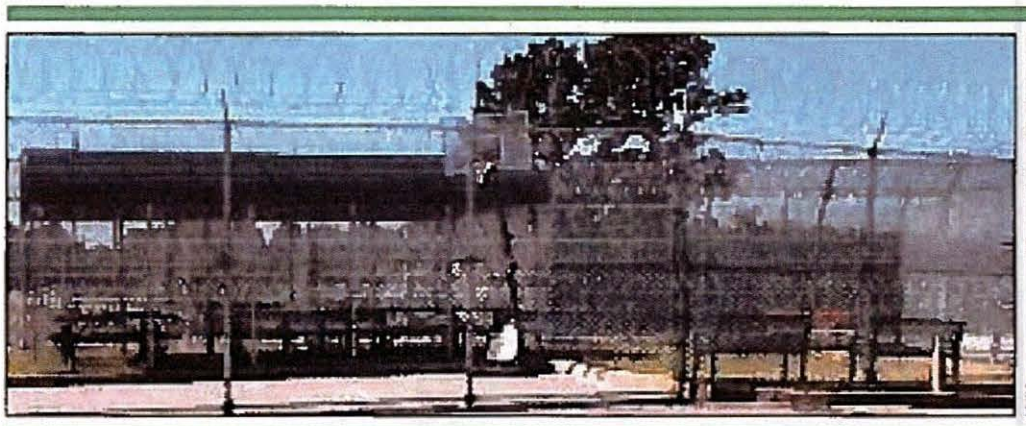
WELCOME

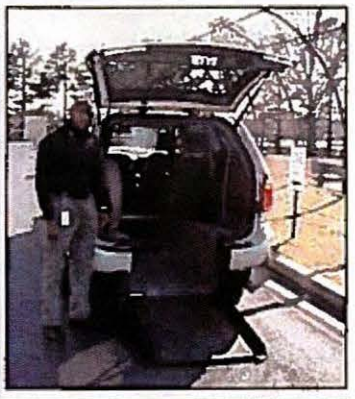


Columbia Regional Care Center (CRCC) has prepared this handbook to furnish you with facts regarding services and opportunities available at the Center. If you are aware of what is expected of you and what services exist for your benefit, you can make a better adjustment.

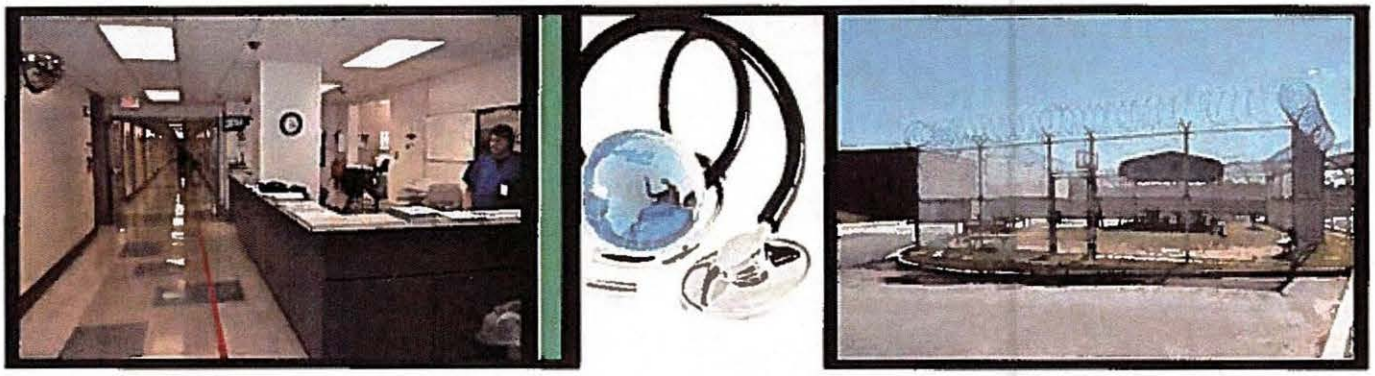
You should keep this handbook for permanent reference while at CRCC. We encourage you to take advantage of all opportunities and programs offered at the Center to improve yourself.

The information contained in this handbook is taken from CRCC's Policies and Procedures. When given a lawful command, even if not addressed by this handbook, you must comply with the instructions of the Center staff member.





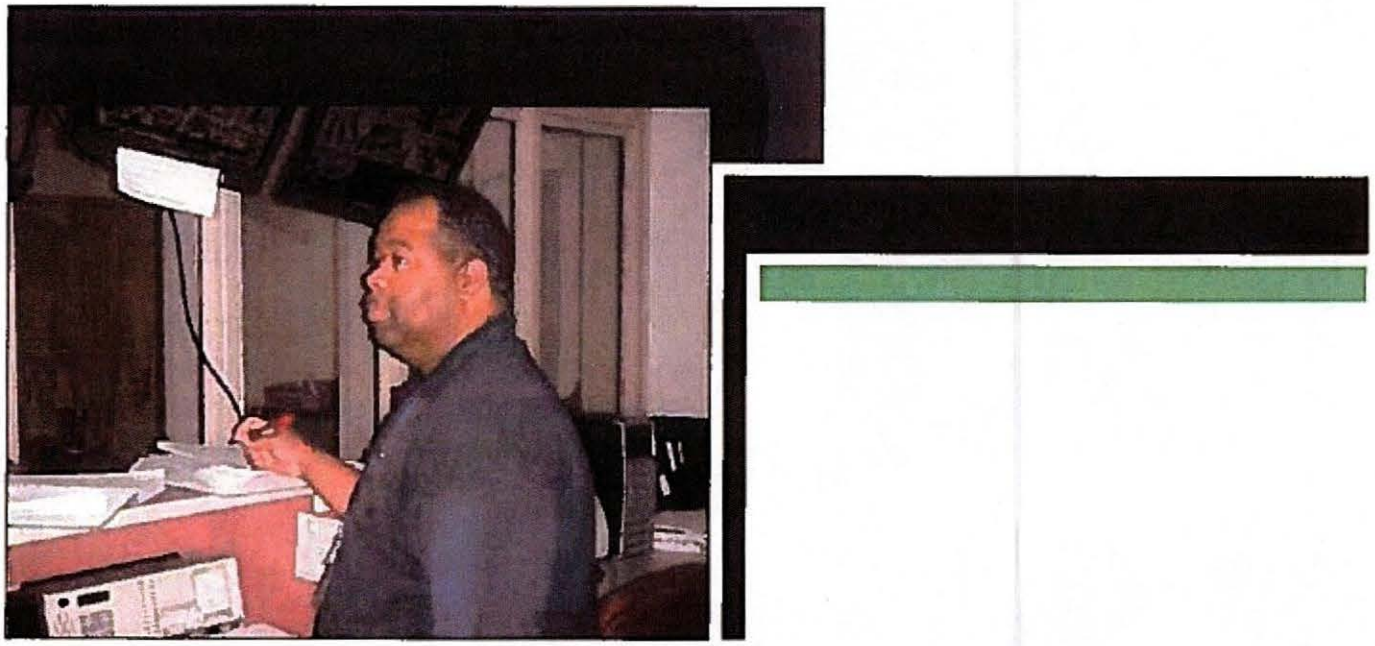
Columbia Regional Care Center



CRCC is a Correct Care, LLC facility that focuses on providing and combining secure treatment services with subacute, skilled nursing, chronic, terminal medical treatment and mental health care under a common administration by professional private sector management.

CRCC shall provide the community with quality care services for special needs patients through:

- Operating a safe, humane, and secure environment;
- Delivering services in a caring spirit; and promoting an atmosphere where the love of God and neighbors flourishes.



Expectations

CRCC has established expectations and standards of conduct to promote respect, safety, conformity and a comfortable environment for both patients and staff.

We do our best to provide for your safety while you are in the hospital. We ask that you help us with this. Patients who are more involved in their care in the hospital tend to do better and stay safer. By working with us, you can lower your risk of injury and make your hospital stay as safe as possible.

Here are some tips you can follow to help us maintain your safety:

- Identify yourself: Make sure that you wear your hospital I.D. wristband at all times.
- Please follow hospital rules. They are there for your and other patients' safety.
- Ask questions if you do not understand what is being asked of you. It is your right to know why something is being done.

Privacy Practices

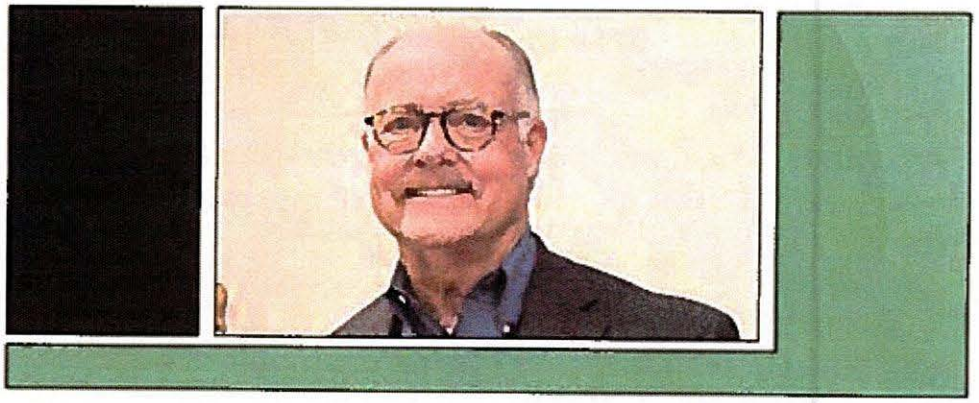
CRCC promises to protect your confidential information. Our privacy practices are described in our "Notice of Privacy Practices." This booklet explains how these procedures will be carried out by all hospital staff, security personnel, volunteers, and business associates of CRCC.

8300

Risk Management & Safety Program

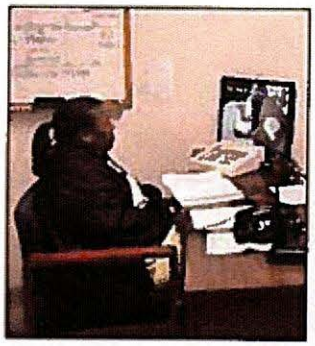
We believe all persons are entitled to care in an environment free from harm. To maintain such an environment, all events which cause or may cause harm to persons or property are reported. This information is analyzed so that corrective or preventive actions may be taken.

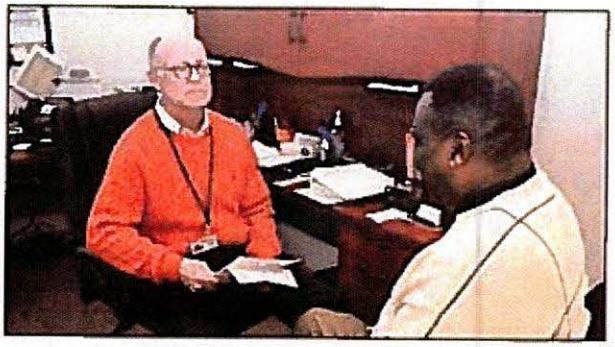
Our Risk Management and Safety programs are part of a larger Performance Improvement process to constantly improve hospital services. If you see anything at the hospital that you feel is unsafe, please notify hospital staff promptly. For your safety, certain areas of the hospital are monitored by video cameras.



Ethics Committee

In some cases, issues regarding your care may also be addressed by the hospital's Ethics Committee. Further information about this committee is available on each Care Unit. Please ask one of the treatment team staff for more information.





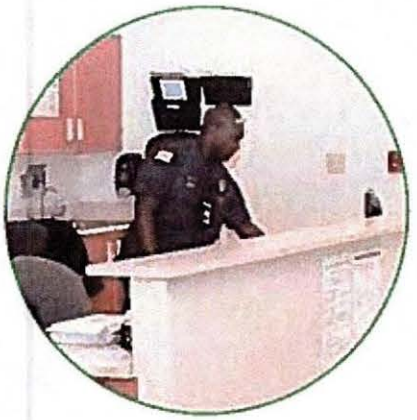
Intake Process

ID Wristband

Upon your arrival at CRCC, you will receive a photo identification wristband. Wristbands will be worn on the left wrist, unless a medical condition prohibits. It will contain your photo, name, CRCC number, and sending facility/agency.

- If it comes off, please notify staff and they will replace it. You will not be permitted to leave the unit without your I.D. wristband.
- Check the information on your hospital I.D. wristband to make sure that all of the information is correct.
- Make sure that staff members check your I.D. wristband before any test is performed or when giving you medication.

You must wear your ID wristband with the picture showing outward at all times.



Consequences For Failure To Wear Or Tampering With Your ID Wristband

1. You will **not** be able to order items from the Canteen.
2. You will **not** be able to receive visitors, make telephone calls or have library or horticulture privileges.
3. May affect your points and level (please check with your mental health clinician for details on this system).
4. A written account will be made part of your record when you return to your sending agency—and could effect your release date.

HIPAA and Rights & Responsibilities

During the Intake process you will be provided copies of and required to sign an Acknowledgement/Receipt of the following:

- Patient Rights and Responsibilities
- Notice of Privacy Practices
- Medical Treatment Consent

Intake Process

Language Translators

If English is not your primary language, you can request the services of a translator. Notify a staff member so that proper arrangements may be made to accommodate your needs.

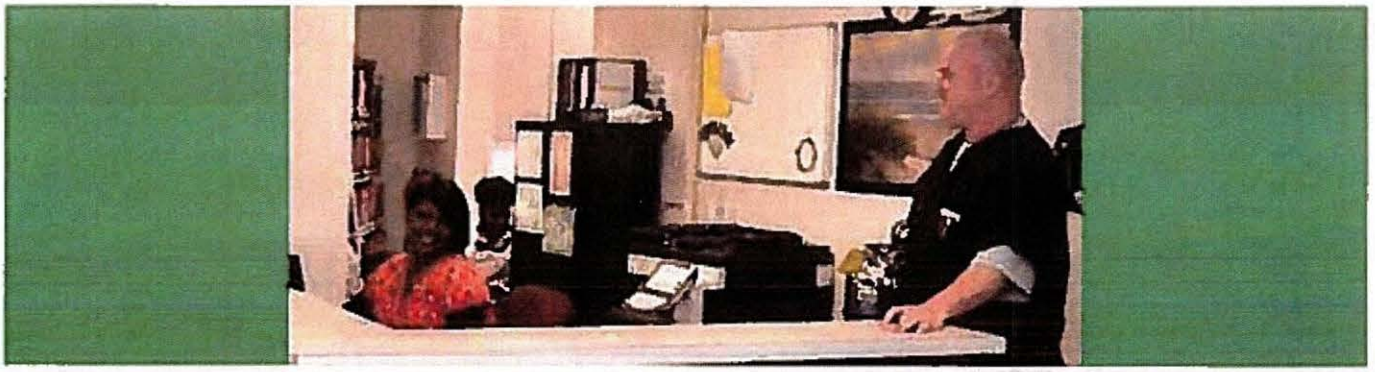
Admission Assessment

Upon admission, you will be requested to provide medical history information. Nurses will review the information with you and ask questions to clarify responses. It is very important that you answer all questions honestly and to the best of your ability. Routine procedures, such as vital signs, weight, blood, and urine specimens will be performed by the nursing staff on your assigned unit.

Inform the Healthcare Provider, Nurse or other Medical Staff of the Following:

- Any medical conditions including diabetes, high blood pressure, heart problems, kidney problems, tuberculosis, AIDS or the HIV virus.
- Any prescribed medications you are presently taking, as well as any that you or your healthcare provider recently discontinued.
- Any medication or allergies you may have.

Your failure to furnish complete and accurate information to health care providers may seriously jeopardize your health.



Intake Process

Nutritional Assessment

After admission, a physician's diet order will be written for each patient and a nutritional assessment will be completed. Any allergies and religious preferences will be taken into account. A nutritional consult can be ordered at any time by the medical provider based on your nutritional/dietary needs.

Dental Screening

You will receive a dental screening within 8 hours of your intake processing. This is a clinical observation and does not constitute a diagnosis or treatment plan. You may report the need for emergency dental treatment at any time. Emergency dental conditions include severe toothaches, abscesses, and fractures of teeth or jaw.

Hygiene Items

Every patient is issued one (1) of each personal hygiene item once they arrive to their assigned unit. Depending on the unit you are assigned to, you are responsible for securing your personal hygiene items and for using them appropriately.

Health Care

You will receive health care by a team of licensed health care providers, which includes physicians, mental health providers, nurses, technicians, and others.

You have the right to refuse health care treatment.

Participating In Your Care

- Provide accurate information about your past history and current concerns.
- Discuss your personal recovery plan with your healthcare team.
- Make sure that you understand and agree with your plan.
- Be informed about your treatment and medication.
- If you are experiencing pain, inform your nurse or health care provider. Most pain can be controlled. You and your healthcare team can work together to manage your pain.

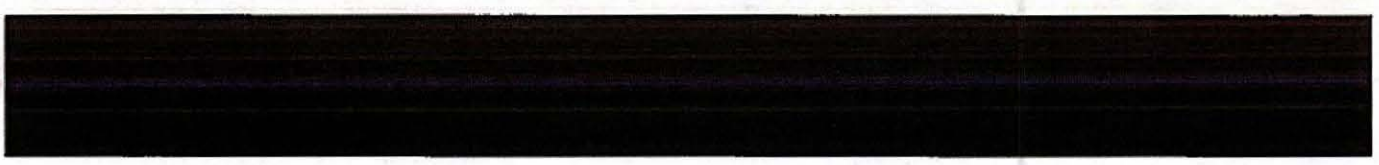
Sick Call

Procedural Guidelines

- Sick call is the system whereby a patient reports and receives individualized and appropriate health care for non-emergency illnesses or injuries. Sick call will be conducted daily by a qualified health care professional. This is done either in the patient's room for non-ambulatory patients or by taking a verbal/written request at the nurse's station.
- You may initiate the sick call process by verbalizing your specific medical complaint to any member of the CRCC staff or completing a written sick call request. Any patient complaints made to a non-healthcare staff member will be reported to the Charge Nurse for follow-up.
- The Registered Nurse will evaluate and treat the patient according to policy and procedures. A complaint dealt with by nursing protocols which occurs three (3) times in a seven (7) day period will be referred to a healthcare provider for assessment. Any complaints/requests that are not covered by the nursing protocols will be referred to the healthcare provider.
- All routine referrals to the healthcare provider will be seen on regular healthcare provider rounds.
- All emergencies will be reported immediately to the healthcare provider for evaluation and/or referral.

Nurse Call Button And Emergency Medical Needs

A Nurse Call and/or Panic Button is available in each room. It has been placed there to call for medical assistance in times of legitimate need. You should not hesitate to use to use the Call/Panic Button when you have a situation that you cannot attend to yourself and need immediate help. It should be pointed out, however, that repeated abuse of the Call/Panic Button for trivial matters, or to harass nursing personnel, will result in disciplinary action and could effect response time when there is a real problem. To call a Nurse, press the red colored button and then release. A member of the nursing staff will respond as quickly as possible. Emergency services are available twenty-four hours a day. All medical emergencies will be assessed and determined by a qualified health care provider. If the health care provider prescribes medication, a medical staff member will administer it to you at the prescribed time(s).



Your Part in Your Care & Safety / Helpful Tips About Medication

Your Part In Your Care & Safety

Everyone has a role in making your stay here at Columbia Regional Care Center safe. Your role includes speaking up if you have questions or concerns or if you do not understand your recovery plan. Participate and make decisions in your care and learn from your hospital experience. Know your medications and understand how they will help you.

If you experience any unsafe conditions or unanticipated outcomes in your treatment and/or medical care, it should be reported to your unit nurse/recovery team for review and appropriate action. **You** can play an important role in achieving the best outcome from your medication. To ensure medications are used safely and effectively, follow these tips:

- Maintain a list of all your medications and learn the names, purpose, dosage strength, and schedules of your individual medications.
- Maintain a list of medications that you cannot take (for reasons like allergic reactions) and be able to explain the reasons why.
- Don't hesitate to ask questions regarding anything you do not understand or that does not seem right.
- Verify your understanding of proper medication use and effects by repeating this information to your health care providers (for example, during your recovery team meetings).

Helpful Tips About Medication

There are four (4) main types of medication used to treat mental illness. Here is a brief summary of each type of medication. More detailed information can be given to you by your nurse or doctor.

1. Antipsychotics: Examples include: Risperdal, Seroquel, Haldol, Zyprexa, Geodon, Abiligy, Invega. These medications lessen hallucinations (voices), stabilize mood swings, aid you in concentration, lessen paranoid and bizarre thoughts, and help you to be able to care for yourself.

2. Antidepressants: Examples include: Lexapro, Prozac, Effexor, Wellbutrin, Paxil. These medications help lessen the symptoms of depression that last at least two weeks such as: being withdrawn, change in eating or sleeping habits, thoughts of harming self, and feelings of hopelessness.

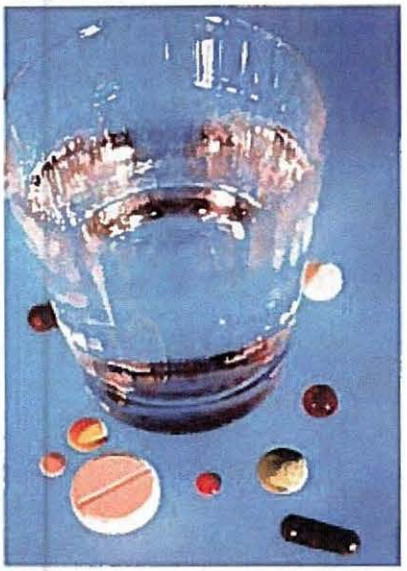
3. Mood Stabilizers: Examples include: Lithium, Depakote, Tegretol, Trileptal. These medications even out your mood, preventing the real high and low mood swings that you may experience and that your family might notice.

4. Antianxiety: Examples include: Vistaril, Klonopin, Ativan, Buspar. These medications are used to decrease severe anxiety and calm nerves. These can produce physical and psychological dependence and withdrawal symptoms. If you are addiction prone or an addict, you should be under careful observation when taking these medicines.

8306

Pharmacy Services

Examples of Medication Side Effects



Some possible side effects of medications are:

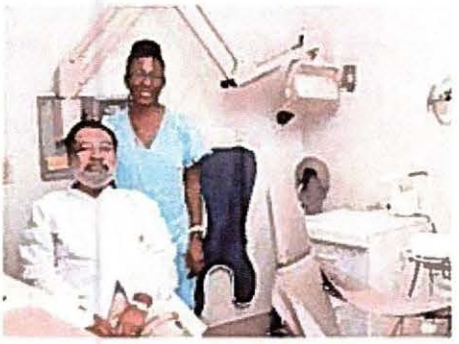
- Headaches
- Excessive thirst
- Frequency in urinating
- Constipation
- Diarrhea
- Weight gain or loss
- Rash
- Sensitivity to sun/sunburn
- Dry mouth
- Change in blood pressure
- Dizziness
- Restlessness
- Stiffness in joints/slowed movements
- Irritability

Notify A Health Care Provider About:

1. Any troublesome or distressing side effects you may experience.
2. Any over-the-counter or prescription medication prescribed by other health care providers that you are taking.
3. Any herbal products or vitamins you are taking.
4. Any questions you have about the specific medication(s).

Dental Care

Routine dental care includes treatment for cavities, bleeding gums, need for cleaning, broken or lost fillings, and broken dentures.



Routine dental treatment is available by appointment only. In order to ensure that proper attention is provided, you should briefly describe the problem to the attending healthcare provider and the Charge Nurse will submit your name on the dental list so that you will be seen. During your initial dental examination, you will be advised by the dentist of any badly broken or diseased teeth that should be removed.

You Have The Right To Refuse Dental Treatment

Poor eating habits, coupled with poor daily cleaning habits, usually result in dental disease. Daily preventive dental care is your responsibility and is extremely important. A toothbrush will be issued to you upon arrival.

Mental Health Services

At CRCC, a program exists to provide for the safety, security, and treatment of patients with mental health problems. Mental health patients with emergency or acute medical problems will be transported to a local hospital for treatment if needed.

Patients in an acute stage of mental illness will be treated at the facility. The appropriate agency will be notified should off site services be required. Diagnosis and recommendations will be noted on the psychiatric evaluation by the attending Psychiatrist.

Evaluation

1. A Psychiatric Evaluation will be completed after admission or referral and will include a brief medical history; a mental status examination including suicidality and homicidality; a history of the current illness; a description of the patient's current attitudes and behavior; an estimate of intellectual functioning, memory functioning and orientation; and an inventory of the patient's assets.
2. A Psychosocial Assessment by a licensed mental health professional or someone seeking licensure under the direct supervision of a licensed mental health professional will be completed after admission.
3. A Personal Safety Plan will be completed by a licensed clinician after admission. The Personal Safety Plan assists with the determination of the patient's personal preference for techniques of de-escalation to prevent displays of aggression.
4. When additional assessments, such as intellectual assessments, suicide assessment, etc. are needed, documentation will include findings, plan of action, and be signed and dated by the clinician.
5. Brief Medical screenings will be performed by licensed medical providers.

Mental Health Services

Treatment Program

1. A multidisciplinary treatment plan will be generated during the first treatment team meeting, but no later than seven days after admission. The treatment plan will be reviewed by the clinical treatment team and updated at a minimum of every six months. However, the team will discuss the treatment process monthly with the patient.
2. A Treatment Plan consists of a series of written statements specifying a patient's particular course of treatment and the roles of qualified health care professionals in carrying it out. The plan is individualized, multidisciplinary and based on assessment of your needs. The treatment plan is developed by a multidisciplinary team of professionals at the time the condition is identified and updated as warranted.
3. Group therapy will be provided on each unit. Groups such as Life Skills, Coping Skills, Horticulture Therapy, other educational classes, and the Work Therapy Program are available to all patients. The treatment may include group and individual counseling.
4. The use of a Behavior Step Plan or Behavior Improvement Plan is discussed by the treatment team and implemented by security, nursing, and mental health staff. An approved copy of any current behavioral management plan will be placed in the Behavioral Management section of the chart.
5. Individual counseling will be provided based on a physician approval. The assigned licensed clinician will document each session following the therapy.
6. Crisis intervention services will be provided as needed.
7. Substance abuse group therapy is provided by a licensed clinician as appointed.

Description of Level System

Unit three (3) is designed to have three (3) Areas of Treatment (AOT) that are focused on motivating patients to stabilize and restore their emotional and behavioral control:

- Red Level
- Yellow Level
- Green Level

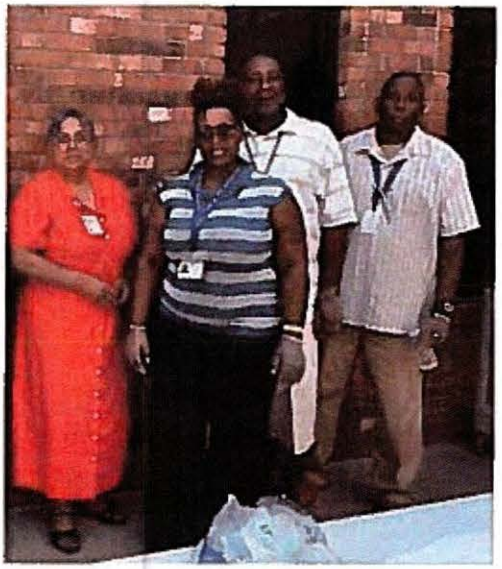
Patients can earn points by group therapy participation, behavioral improvement plans, Step Program, treatment team participation, and individual therapy sessions. Patients can "cash-in" earned points for special events.

Mental Health Services

Treatment Team Progress Reviews

In conjunction with your sending agency, you will be scheduled for a Progress Review based on a review schedule. At this Progress Review, your behavior and adjustment for the stated period will be evaluated. The report will address the entire spectrum of your facility life. It is a permanent part of your record and a copy will be sent to your parent agency. Therefore, you should assist in making sure it is as accurate and thorough as possible. During Progress Reviews, several things may be accomplished, such as your visiting list may be updated, and requests for program changes can be reviewed and discussed with you.

One of the most important aspects of the Progress Review is your behavior. The team will, at this time, answer any questions you have regarding your behavior and stay at CRCC. Any programs that you are involved in or need to become involved in will be discussed.



The basic purpose of the Progress Review is to document your progress and keep you informed of how you are doing. The Progress Review time should also be utilized in planning for the future. Come to your review prepared to ask questions and contribute to the procedure.

Keep in mind that this review is an instrument that can either help or hinder your stay at CRCC. If you received a good evaluation during the preceding review period, it will be noted on these documents. On the other hand, any bad reports will be shown as well. Your participation in the programs available at CRCC will also be listed on these documents.

8310

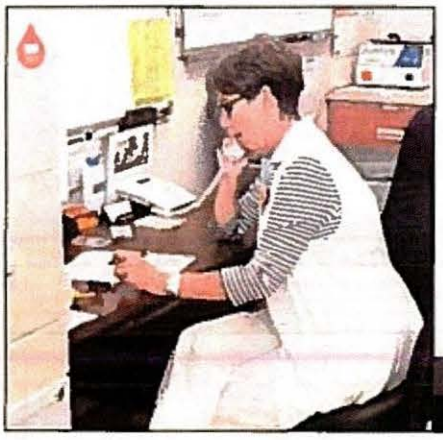
Patient Rights and Responsibilities

Patient Rights

1. Right to equal treatment regardless of race, religion, ethnicity, handicap, or sexual orientation.
2. Right to practice religious activities, including silent prayer and moments of reverence, attending organized religious gatherings, and counsel with ministers.
3. Right to safe living conditions, including hygienic accommodations and a safe and secure environment.
4. Right to protection from abuse, including physical abuse, emotional abuse, and other forms of exploitation.
5. Right to freely speak and express oneself in writing.
6. Right to health care, including necessary medical, mental health and dental treatment, and nourishing meals.
7. Right to be informed regarding facility policies, procedures, practices, and guidelines.
8. Right to receive and maintain approved personal possessions, including mail or other personal property.
9. Right to access legal counsel, including confidential conversations and correspondence, and right to electively consent and participate in recreational, educational, and psychotherapeutic activities.
10. Right to protection from retaliation.

Patient Responsibilities

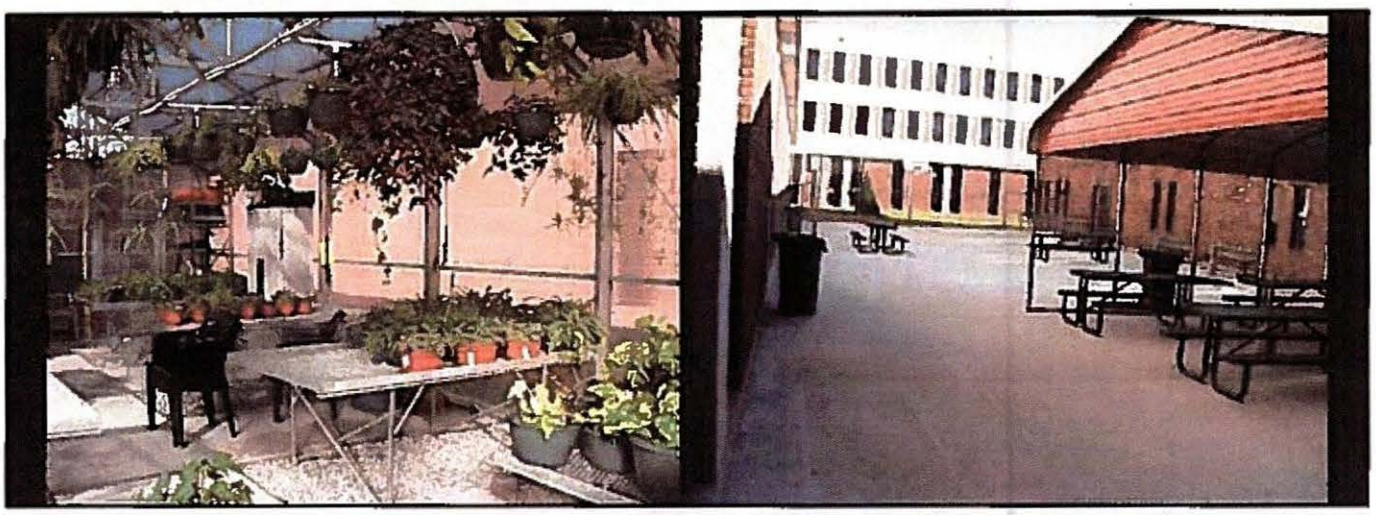
1. Responsibility to respect the natural and rightfully chosen differences between people.
2. Responsibility to be tolerant of the choices of others regarding their practices and beliefs about a higher power, and responsibility to not impose personal beliefs upon them.
3. Responsibility to ensure others' comfort and safety by exercising appropriate care and precautions when using facilities.
4. Responsibility to treat others with courtesy and respect, seeking not to take advantage of them, or manipulate them.
5. Responsibility to not be offensive and responsibility to utilize appropriate channels of communication.
6. Responsibility to communicate genuine personal needs and responsibility to respect the needs of others.
7. Responsibility to limit approved personal possessions to items that can be safely contained in authorized space.
8. Responsibility to earnestly engage counsel for representation.
9. Responsibility to sincerely and meaningfully take part in those activities for which consent is provided.
10. Responsibility to communicate with staff effectively to get individual needs met, and to use the appropriate grievance procedure in a meaningful manner.



Patient Rules

1. During counts, televisions and radios will be turned off. Patients in the dayroom will return to their room.
2. You are not permitted to enter any area of the facility other than the one to which you are assigned without specific direction and escort.
3. Under no circumstances is a patient allowed to enter another patient's room.
4. No patient is allowed in any office area without a staff member present.
5. It is your responsibility to keep the immediate area near your bed clean and sanitary at all times. If a patient is physically unable to assist in this, housekeeping will ensure that the area is clean and sanitized. Paper and debris are not to be left on the floor, under or around the beds.
6. Items are not to be laid or stored on vacant beds.
7. All items must be properly stored or they will be confiscated.
8. Shoes will be neatly stored under the bed.
9. Fire and Safety Regulations prohibit:
   - Cardboard boxes, plastic bags or milk cartons from being stored in the unit.
   - Blocking the ventilation grills and the placement of any article over the window or door windows.
10. Pictures will not be hung, taped or fastened in any way on room walls, ceilings, doors or beds.
11. Patients will not put up makeshift clotheslines.
12. Smoking is strictly prohibited.
13. Emergency situations such as fire, flooding due to plumbing failure, fellow patient in distress, etc. will be reported immediately to a staff member.
14. The volume of all televisions and recreational activities will be kept at a minimum as to not disturb others and will be monitored by the Unit Custody Officers.

Patient Rules



15. Television for authorized patients will be permitted only during the times specified below:

a. Monday – Thursday	9:00 a.m. - 11:30 p.m.
b. Friday	9:00 a.m. - 12:00 midnight
c. Saturday	8:00 a.m. - 12:00 midnight
d. Sunday	8:00 a.m. - 11:30 p.m.
e. Nights Preceding Holidays	8:00 a.m. - 12:00 midnight

16. Occasionally, special events may be approved for extending viewing hours through the entirety of a program. The Shift Supervisor has the authority to approve this extension.
17. Television is a privilege and not a right. In the event of a disagreement regarding program selection, the Custody Officer of the Unit will make the program choice to best satisfy the majority. If that does not resolve the matter, officers are well within their authority to turn the television off. The Shift Supervisor has the authority to deny this privilege in order to maintain the order and security of the Care Unit.
18. The Care Unit lights will be turned off at:

a. Sunday – Thursday	11:30 p.m.
b. Friday & Saturday	12:00 midnight
c. Nights Preceding Holidays	12:00 midnight

19. All talking and unnecessary movement shall cease after lights are turned off and during counts.
20. Patient radios must be battery operated and equipped with earphones. Radios may be taken to the recreation area, but otherwise are not permitted off the Care Unit.
21. No wire of any type will be connected to the radio as an antenna or antenna extension. Failure to comply with this guideline can result in confiscation of the radio.

Marriage of a Patient

Patients will not be allowed to marry while at CRCC.

Personal Daily Living Needs

Hygiene Items: To ensure that each and every patient is able to comply with the grooming and clothing standards set forth at CRCC, you will have access to the following items:

Grooming Kit:

- Razor—controlled as required
- One (1) toothbrush
- One (1) tube of toothpaste
- Liquid soap
- One (1) comb – controlled as required
- One (1) deodorant

Bed Linen, Towels & Wash Clothes:

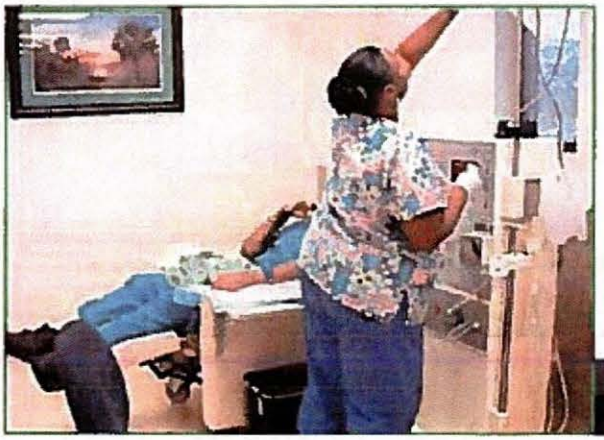
- One (1) towel
- One (1) washcloth
- Two (2) sheets
- One (1) pillowcase
- One (1) blanket
- One (1) mesh bag

Clothing:

- One (1) scrub uniform
- Three (3) pair of socks
- Three (3) pair of underwear/tee shirts
- One (1) pair of tennis shoes
- One (1) pair of shower shoes

Health and comfort items will be inspected by CRCC staff prior to distribution. These items will be distributed to every patient on an as needed or on a direct exchange basis. Some replacement clothing can be purchased from the canteen.

Patients may receive replacement items only in exchange for worn out items. The staff will ensure that you are provided with the supplies you need, but there must be strict controls placed in order to prevent waste and abuse.



8314

Personal Daily Living Needs

Laundry Services

Laundry services are provided to all patients. Your Care Unit staff will help you with questions regarding laundry schedules and clothing exchange.

- All personal items of clothing are laundered on site. Other items and linens are sent to an off-site Contractor.
- Each unit is scheduled certain days of each week to do patients personal laundry on site.
- The personal laundry is washed by the nursing staff on night shift on the assigned laundry days.
- The patients place their clothing in the provided mesh bag and the staff will collect it from each room.
- It will be returned to the appropriate patient after laundry service is completed.
- Be sure all items and mesh bag are labeled with your name to assure the appropriate items are returned to you.
- Uniforms are not washed in the facility. They are sent out to a contract laundry service. Please do not place uniforms in the mesh bags to be washed by staff.

Day	Morning shift	Evening shift
Monday	2	4
Tuesday	2	7
Wednesday	5	3
Thursday	5	7
Friday	6	4
Saturday	6	3
Sunday	1	7

Patients on the DMH Units are to be escorted to the laundry room and allowed to do their own laundry which must be completed by 10:30 p.m. on assigned days.

The only exception to this are the acute patients and patients who are physically or mentally impaired from performing this task.

Meals

All patient meals are served by our dietary/food service department. Meals are served in assigned rooms. Meal serving times will vary by unit. The meal times listed below reflect the time spans in which you may receive your meal.

Breakfast	6:00 a.m.- 7:30 a.m.
Lunch	11:00 p.m.- 12:30 p.m.
Dinner	4:00 p.m.- 5:30 p.m.

Personal Daily Living Needs

Authorized Personal Items

The following list is an example of authorized items that you may be allowed to have in your possession as determined by the health care professional and the Security Director.

Health & Comfort Items

- One (1) comb (plastic or flexible)
- One (1) pair prescription eye glasses
- One (1) set of dentures
- Artificial limbs
- Two (2) handkerchiefs (plain white)

Religious Materials

All religious material must be approved by the Chaplain and the Security Director. Religious materials may not be inflammatory or disparaging to any religious or racial group. Examples of items you may be allowed to have in your possession are:

- Holy Bible
- Book of Mormon
- Book of Buddhism
- Holy Quaran or Koran

Miscellaneous Personal Items

- Miscellaneous personal items such as pictures, letters, address books, calendar, etc. may be permitted as approved by the Security Director.
- Provisions will be made to assist indigent patients with social needs.

Personal Daily Living Needs

Proper Storage Of Personal Property

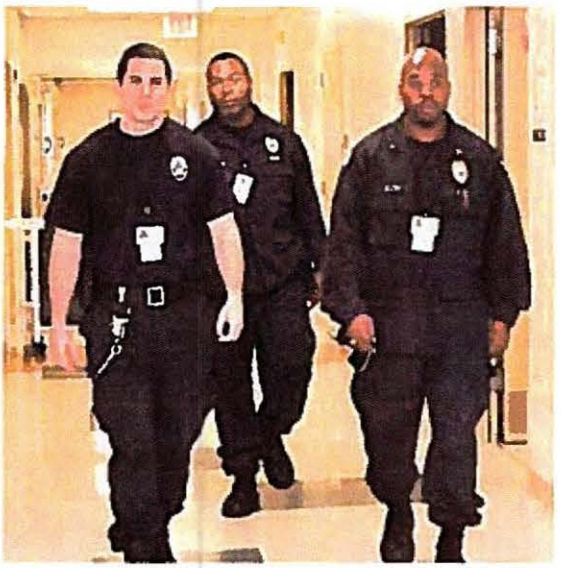
Patients will store approved personal property in approved CRCC issued containers. No property will be on the walls, heaters, windows, ceiling, sink, door, mirrors or air vents. Any violation of this regulation may result in disciplinary action and confiscation of the items.

Count Times

The security staff will make scheduled counts to ensure the presence of assigned patients. Compliance with the count procedure is of the utmost importance. No movement will be allowed within the Center once a headcount begins.

Count times are as follows

7:30 a.m.
12:00 noon
3:30 p.m.
7:00 p.m.
9:30 pm (Photo Roll Call Count)
11:30 p.m.
4:00 a.m.



Unscheduled counts will be held as situations dictate. When an unscheduled count is announced, you will be expected to comply with Security Officers' directions promptly and without discussion.

Fire

All areas of CRCC will have a primary evacuation plan posted in a conspicuous location to ensure the safety of all patients, employees, and visitors. All evacuation plans will lead directly to a hazard-free area where supervision and continued medical care will be provided. The fire evacuation rules are for your safety. Failure to follow instructions may result in disciplinary action.

Mail

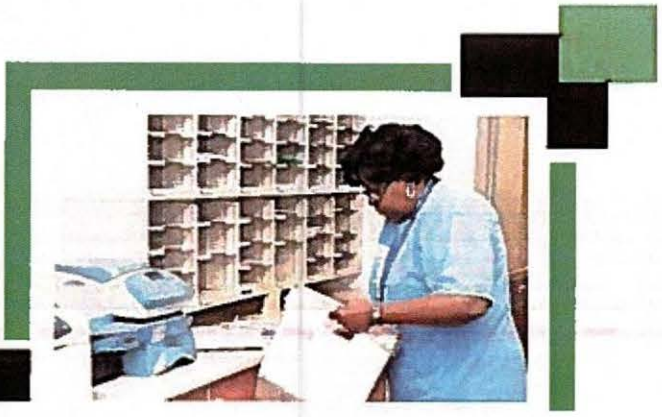
While at CRCC, you may send and receive mail subject to CRCC rules and regulations. All mail will be inspected by the Mailroom for contraband. Your mail will not be censored. Incoming legal mail between you and your attorney or the courts will be opened in your presence and checked for contraband. You may not use the mail to plan any kind of illegal activities. You may not correspond with anyone in another correctional facility without approval from the Facility Administrator or Security Director. If you desire to correspond with another family member who is incarcerated, you must first submit a Patient Communication Form through the Security Director or Facility Administrator.

CRCC provides indigent patients with postage to send one (1) free letter per week. The day designated for mailing these free letters is Wednesday of each week.

There are restrictions on what type of magazines you may receive. If you have questions as to what type of magazines you may receive, you may submit a Patient Communication Form to the Security Director for clarification/approval. All approved magazines must come directly from the publisher.

A return address for both incoming and outgoing mail must be on the envelope in order for it to be processed. The correct mailing address for CRCC is as follows:

Your Name, Hospital Number
Your Housing Unit and Bed Assignment
Columbia Regional Care Center
7901 Farrow Road
Columbia, SC 29203



Visitation

At CRCC, you are encouraged to maintain close contact with your family. We understand the importance of family support and will do everything reasonable to facilitate it.

As a matter of general practice, members of your immediate family, 12 years of age and older, will be permitted visitation. Visiting hours are on Saturday and Sunday from 8:30 am until 4:00 pm. Physical contact between you and visitors is strictly prohibited.

The approved visitation list from your sending agency will be strictly adhered to unless the agency provides other instructions or permission in writing. If we do not have an authorized list from your sending agency you will be asked to complete a Request of Authorized Visit List for up to 10 family members that will be maintained in your Security File.

Visit Request Process

- You must submit a Patient Communication Form weekly with the names of the individuals you wish to have visit and date of visit.
- The visitation request must be submitted no later than noon every Friday.
- The names you submit on the Communication Form will be verified to determine if they are on your approved visitation list. Anyone not on the approved list will be denied visitation.
- The Communication Form will then be submitted to the Security Director for final approval.
- Your name and the authorized visitors will then be placed on the Weekend Visitation List.

Special Visits

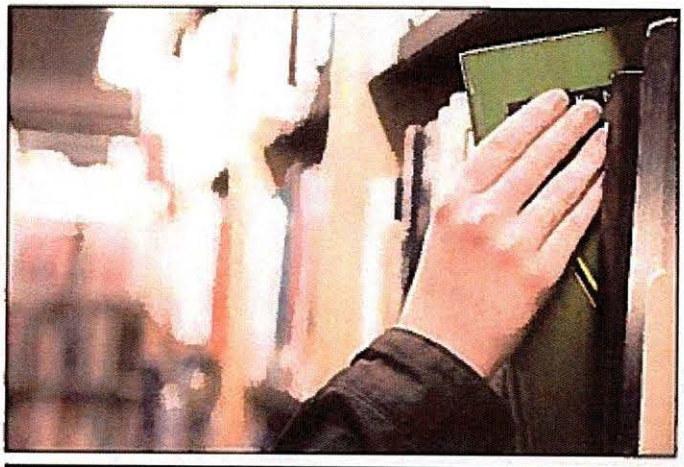
Special visits are visitations that occur outside the normal visitation schedule (Saturday, Sundays, Holidays).

- A special visit can be requested by the patient using the Communication Form or by an authorized visitor, by telephone, at least 48 hours prior to the requested visit.
- Special visits will only be approved by the Facility Administrator, Assistant Facility Administrator or Security Director.

Because CRCC is a secure treatment facility and many patients are here with serious communicable health problems, children under 12 years of age are not permitted to enter during regular visits. Visitation with children under the age of 12 (for up to 2 hours) will be scheduled the third weekend of each month unless changed or cancelled for security reasons. Exceptions for terminally ill and hospice patients can be made on a "case-by-case" basis, and only on the recommendation of the staff social worker, health care provider or chaplain.

Visitors will be allowed to have no more than $20.00 in their possession at the time of their visit in order to purchase items from the vending machine. It is your responsibility to advise your family or friends of the rules governing visitation.

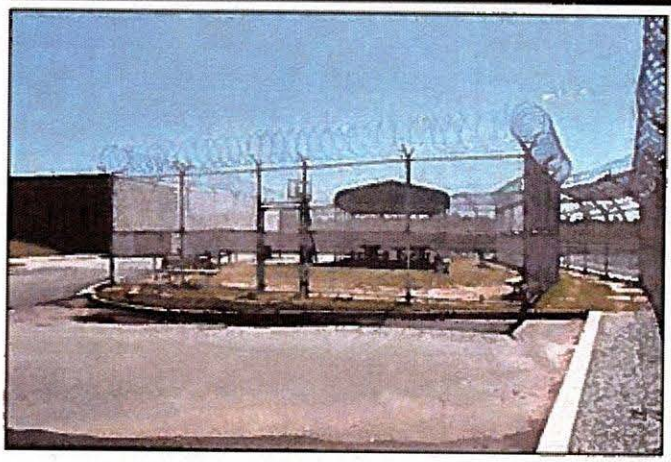
Library/Reading Material

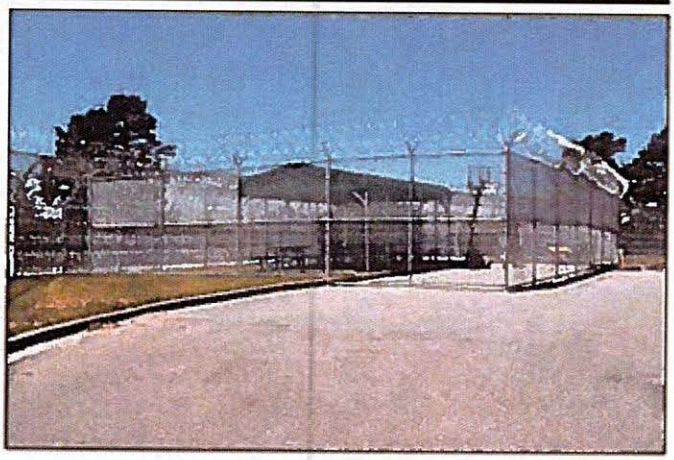


Reading material will be made available through the library. Check with your social worker for assistance in receiving reading material.

Recreation

The only area allowed for indoor recreation is the Dayroom. These areas are restricted when recreation is not in progress. Television and/or indoor games may begin at 8:30 a.m., if the unit cleanliness meets the Custody Officer's approval. The Dayrooms will close at 9:00 p.m. Outdoor recreation and exercise is available, weather and other conditions permitting, at least five (5) hours per week.





Telephone

All personal patient telephone calls are recorded. Any call placed to your attorney of record will not be recorded. In order for a call to your attorney to not be recorded you must:

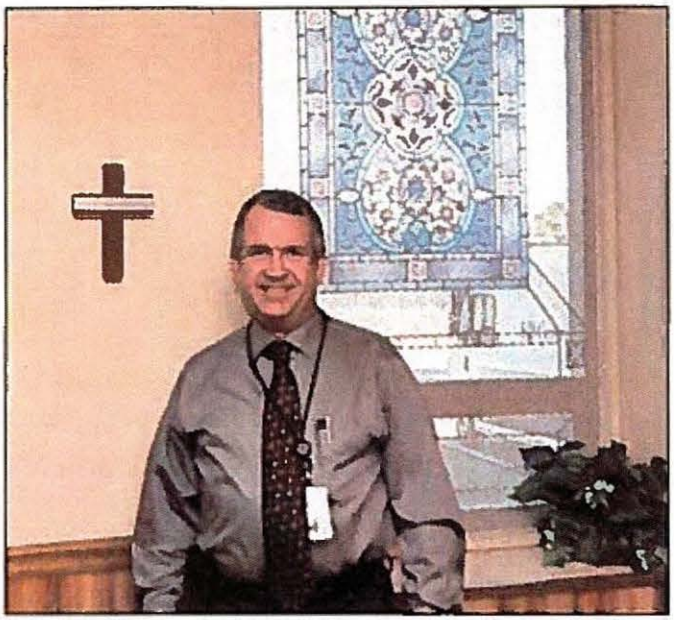
- Submit a Communication Form to the Security Director listing the name, address, and telephone number (including area code) of the attorney(s).
- After verification and receipt of an official correspondence from the attorney's office, the number will be blocked from recording.
- You should only use the number(s) you provided to speak with your attorney. All other numbers will be recorded.

Each Care Unit is equipped with telephones for patient use. The telephone system is available from 9 a.m. until 9 p.m., seven days a week. Phone minutes can be purchased through the canteen and accessed with the pin number you are provided.

Incoming emergency phone calls will be referred to the Shift Supervisor or other appropriate CRCC staff. Emergencies will be verified before being discussed with you. You will be allowed to use a telephone with approval of the Shift Supervisor or other appropriate CRCC staff in emergency situations.

All patients are expected to display proper courtesy and discipline in utilizing the Care Unit phones. The Unit Custody Officer will establish a list of those patients who wish to use the phone. This list will be adhered to in the order written. Phones on the units are programmed to limit calls to twenty (20) minutes. When the allotted time has expired, the telephone will automatically disconnect.

Pastoral Care Services



Pastoral Care Services are provided to support the religious, spiritual, moral, and ethical needs of the patient population at CRCC. Individual religious needs will be met in conjunction with available space, security, and medical requirements.

The staff chaplain is a licensed clergy member of a recognized religious denomination. The chaplain is responsible for providing religious support and pastoral care consistent with the moral and ethical well-being of the entire facility. Patients' religious freedom and personal rights are respected regardless of their religious affiliation.

Chaplains are authorized to conduct rites, sacraments, and services as required by their respective denomination. The staff chaplain is considered a teacher in the area of religious instruction. The chaplain is also responsible to the Facility Administrator for conducting and maintaining religious education programs.

The staff chaplain serves as Volunteer Coordinator for the facility. Approved volunteers will contribute to the spiritual well-being of patients and their families by:

- Developing a pastoral relationship with individual patients.
- Participating in necessary activities associated with Correct Care, LLC. and CRCC.
- Conducting programs for the moral, spiritual, and social development of patients and their families.
- Being available to all patients for pastoral activities and spiritual assistance.
- Contributing to the rehabilitation of patients through worship services, pastoral activities and by cooperating with other members of the staff, denominational boards, committees, and clergy.

Patient Canteen

The purpose of the Canteen is to provide you with items of convenience, at the lowest practical price. The purchase of items from the Canteen must be governed by the below listed rules:

- You will receive a Canteen Order Sheet every week. Order sheets will be turned in on Sunday night in the appropriate location and your orders will be filled and delivered to you on Wednesday morning. In the event of a Holiday these days may change but every effort will be made to make sure that you get your Canteen Orders filled on the day designated. You will be notified if there are any changes to the day the orders need to be turned in or when you will receive them.
- You may purchase/possess health and comfort items based on your points and level as described earlier. The amount you may spend on these items is also based on your points and level. Under no circumstances will any patient be allowed to order more than $50 per week from the canteen.
- You may not share items with or purchase items for other patients.
- The amount of items you may order from each section is listed at the top of each section. If you order more than the allowed amount for that section, items will be arbitrarily crossed off until the amount is at the allowed level.
- Large quantity purchases for the obvious purpose of bartering or resale to fellow patients is not permitted.
- If you place an order you **may not refuse it** when it is delivered.
- If there is an error in your order, or you are missing items you have been charged for, we will make sure that you are credited for those items.
- All containers/wrappings should be properly discarded after the product has been removed/consumed.

If there are items that you think would be helpful to the general patient population, you may submit a request to add those items to the Canteen Order Sheet to the Assistant Facility Administrator for review. Requests will be evaluated on the basis of need, cost, and security considerations.

Patient Bank

CRCC provides a Patient Trust Fund service. This fund is administered as follows:

1. All deposits must be received as follows:
   - Through the United States Postal Service to the attention of :

Columbia Regional Care Center
Attention: Patient Canteen Fund
PO Box 23587
Columbia, SC 29224

   - Online or by Telephone as follows: www.GovPayNow.com or call 888-277-2535
   - You will need:

Your Credit or Debit Card
Patient's name, number and location
Pay Location Code – 5500

2. The only negotiable items accepted for deposit in your account will be United States Postal Money Orders, other recognized money orders, cashier's and government checks. All other negotiable items (i.e., cash, traveler's checks or personal checks) will not be accepted and will be returned to sender. It is your responsibility to advise friends and family of these procedures.
3. If you have money in an account from your previous institution it can be requested for you. To have any funds from a previous institution requested, you must complete a Patient Communication Form stating that you want your funds requested to be sent. Once this request is received, a letter will be drafted for your signature and mailed to the appropriate facility. Any money received from your previous institution will be deposited in your Personal Trust Account as soon as it is received.
4. You will be provided with a balance on your account each time a Canteen order or purchase is made and whenever there is a deposit.
5. If you need to know the balance in your Personal Trust Account at any other time you may submit a request in writing on a Patient Communication Form and a statement of your account will be provided to you.

Legal Issues

Special Legal Problems

This is an issue that should be addressed separately from all other types of problems since it is often a source of confusion for newly assigned patients.

You may have a situation during your period of incarceration at CRCC when your sentence is reduced, increased, modified or changed in some way. In instances such as these, CRCC has no authority in these matters. It is generally a good idea to contact your attorney, the sending facility, or the courts, if you have a problem of a legal nature. Neither the employees of CRCC nor any Center official can assist you in any meaningful way, other than to help explain what changes have been ordered. You will find your attorney, the sending facility, and the courts much more knowledgeable regarding your legal options.

Legal Services

CRCC maintains a limited library of legal materials and access to LexisNexis, a legal computer program. Patients may make a request to use these items. If you are in need of assistance in these areas, arrangements should be made through your sending agency. CRCC staff members cannot be actively involved in your legal affairs other than to assist with obtaining access to the available legal material. If you need assistance:

- Send a Patient Request Form to the Education Instructor
- Attempts will be made to provide you with the requested material within ten (10) working days.

Photocopies

Patients requiring photocopying should submit a Patient Request to the mailroom. Photocopies will be made at a cost of ten (10) cents a page. A limited number of photocopies of legal documents may be made for patients who are indigent; however, the patient's account will still be charged in the event funds become available later.

Notary Service

Notary services are available upon request through a Patient Communication Form.

Patient Grievance Procedure

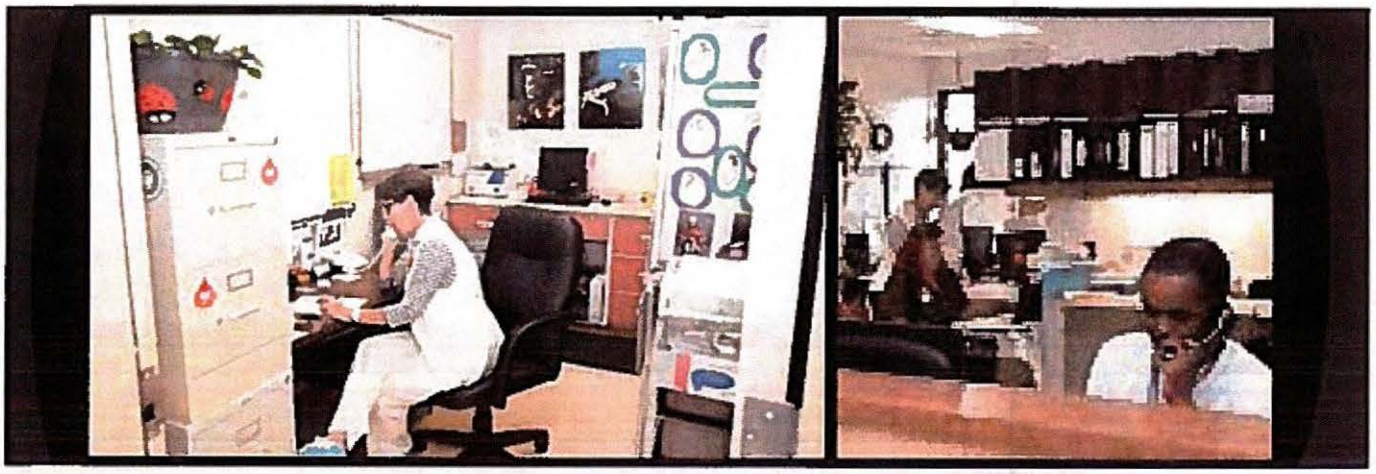
A Grievance is regarded as a formal complaint of an incident, policy or condition within CRCC. Grievances can often be resolved quickly through direct communication with the staff person(s) responsible for the affected area of the grievance. In order for the Grievance Procedure to function properly, you can be assured that no retaliation will be taken against you for filing a legitimate complaint. At the same time, you must not abuse the system by knowingly and intentionally making a false statement or repeatedly submitting frivolous claims. When filing a Grievance, complete each section, writing only in the space provided for your use. It is important to state what you expect on the form.

No patient will be subjected to reprisal, retaliation, harassment, or disciplinary action for filing a formal grievance, or participating in the resolution of a formal grievance.

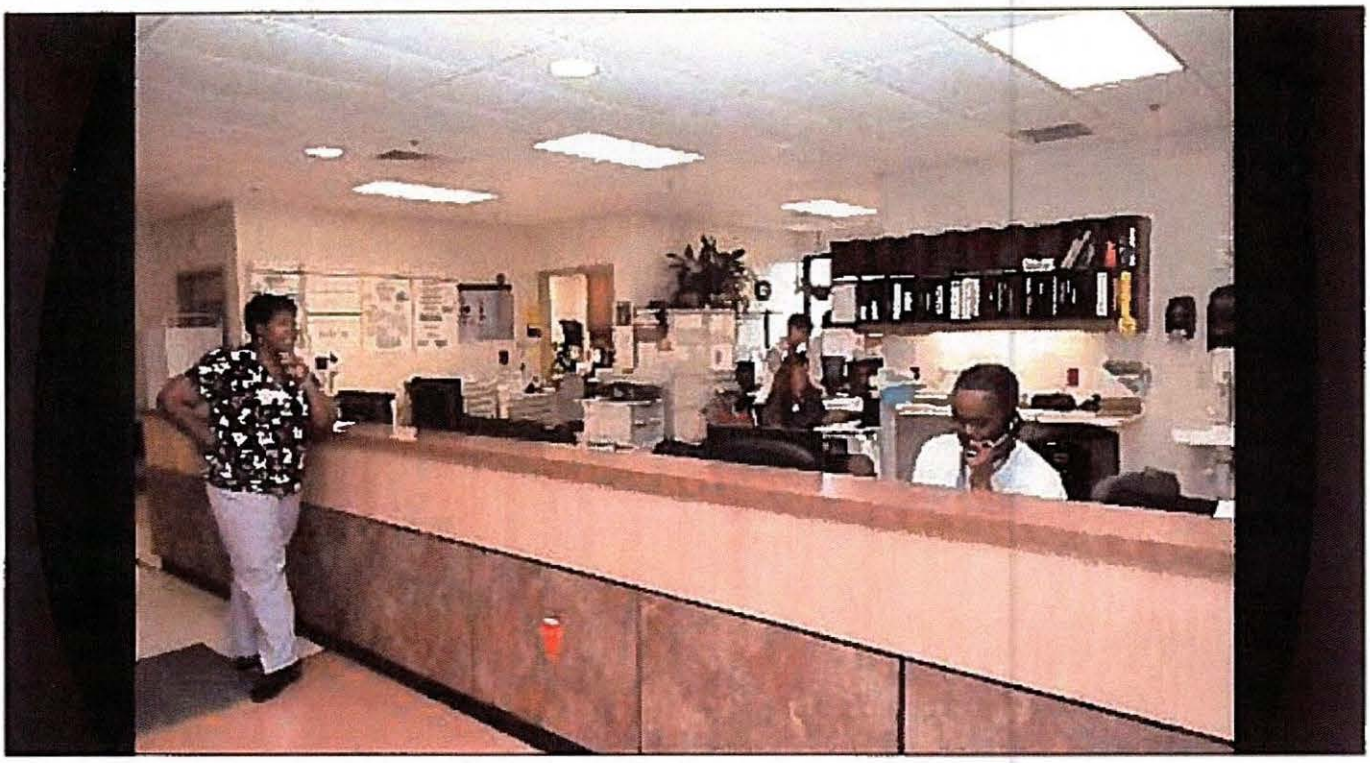
The Risk Manager / Patient Advocate will be designated as the Grievance Coordinator. The Grievance Coordinator will ensure that all CRCC patients have access to the grievance process, and the formal and informal request system.

Patients found to be misusing or abusing the patient formal grievance system will be subjected to limitation.

- Misuse or abuse of the grievance system refers to:
    1. Repetitive filing of grievances on the same matter.
    2. Filing grievances that contain vulgar, indecent, offensive or insulting language.
    3. Filing grievances to harass individuals or disrupt the operation of the facility.
    4. Filing grievances not designed to lead to any practical result.
    5. Filing grievances with knowledge that they contain false statements for the purpose of causing harm to CRCC or its personnel.
- Limitation refers to a sanction imposed on a patient found to be abusing or misusing the patient formal grievance system. Patients subjected to a limitation may still utilize the grievance system for processing other legitimate grievances that do not relate to the matter(s) for which the limitation was imposed.
- When a person misuses or abuses the formal grievance system, further grievances received on the same matter will have "GRIEVANCE NOT ACCEPTED DUE TO" stamped on them. A copy will be made for the Grievance Coordinator's file and the original will be returned to the patient.



Patient Grievance Procedure



Valid formal grievances include, but are not limited to the following:

- Discriminatroy Policies and Procedures.
- Actions of a staff member toward a patient.
- Actions of a patient toward another patient. The writer of the grievance must be one of the patients involved in the situation.
- Theft and/or destruction of patient property.
- Inappropriate disciplinary actions.

Invalid formal grievances include items such as:

- Requesting a change of Unit, room or roommate assignment.
- Grievances requesting that a specific person not be allowed to work on a specific unit or terminated.
- Grievances concerning hearsay information.
- Grievances about situations not involving the writer.
- Any issue outside of the control of CRCC such as:
  1. State and federal court decisions.
  2. Decisions made by the sending facility, including placement and discharge.
  3. State and federal laws and regulations.

In those cases where a question may arise as to whether an issue is a valid formal grievance, the Grievance Coordinator will confer with the Facility Administrator. The Grievance Coordinator will advise the patient as to the

Prison Rape Elimination Act

Sexual Assault, Abuse, and Harrassment Awareness

All patients at CRCC have a right to be safe and free from sexual harassment and sexual assault. There is a "zero tolerance" policy here at CRCC and prevention is a top priority. Standards are in place for the detection, prevention, reduction, and punishment of prison rape. Prudent efforts will be made to ensure the safety of the patient and staff.

It is a Duty to Report Abuse, Neglect or Exploitation

Definitions

A. Carnal Knowledge: Contact between the penis and vulva or the penis and the anus, including penetration of any sort, however slight.

B. Oral Sodomy: Contact between the mouth and the penis, the mouth and the vulva or the mouth and the anus.

C. Sexual Fondling: The touching of a private body part of another person for the purpose of gratification.

D. Sexual Assault with an Object: The use of any hand, finger, object or other instrument to penetrate, however slightly, the genital or anal opening of the body of another person.

E. Rape: The carnal knowledge, oral sodomy, sexual assault with an object or sexual fondling of a person forcibly or against that person's will.

Patient-on-Patient Sexual Abuse/Assault

Sexual abuse is used to describe a broad range of sexual activity including nonphysical sexual behavior. Sexual assault is used to emphasize violent sexual behavior:

A. Contact between the penis and vulva or the penis and anus, including penetration, however slight.

B. Contact between the mouth and the penis, vulva, or anus.

C. Penetration of the anal or genital opening of another person, however slight, by a hand, finger, object, or other instrument.

D. Any other intentional touching, either directly or through the clothing, of the genitalia, anus, groin, breast, inner thigh, or buttocks of any person, excluding contact incidental to a physical altercation, and

E. Coercion into sexual acts by threatening another patient with physical violence or bodily injury.

Definitions

Staff-On-Patient Sexual Abuse/Assault

Sexual abuse/assault between staff, contractors, or volunteers and patients include:

A. Contact between the penis and vulva or the penis and anus, including penetration, however slight,

B. Contact between the mouth and the penis, vulva, or anus,

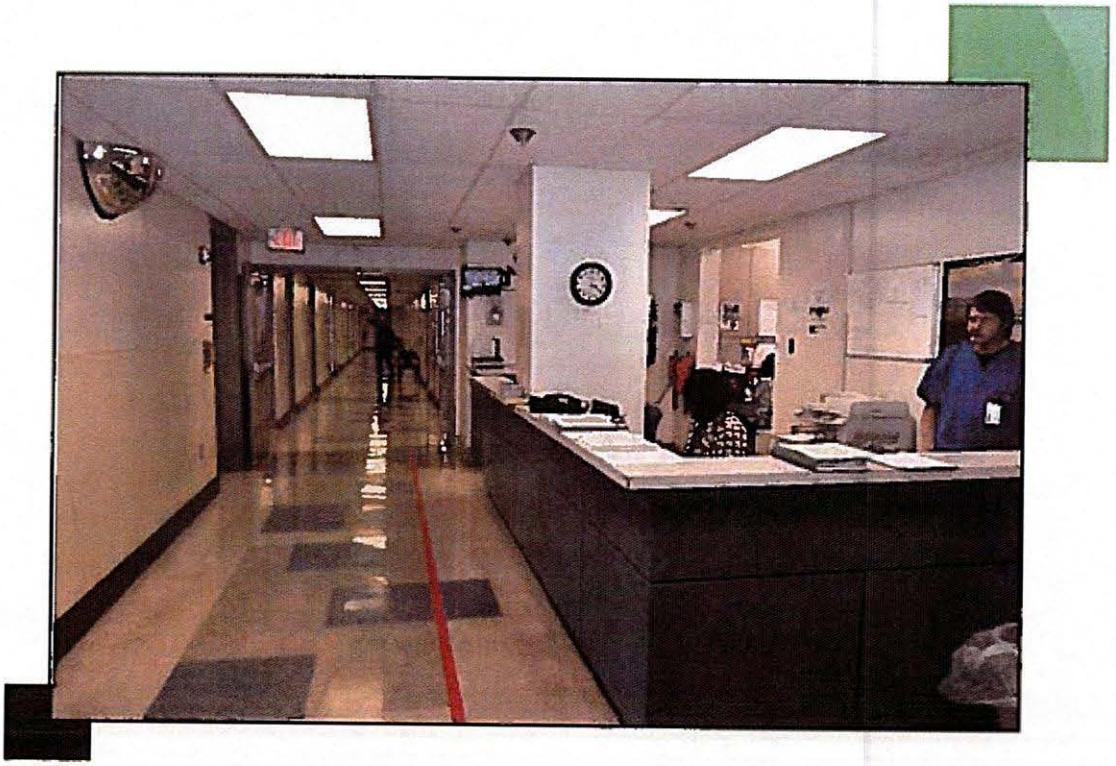
C. Penetration of the anal or genital opening of another person, however slight, by a hand, finger, object, or other instrument,

D. Any other intentional touching, either directly or through the clothing, of the genitalia, anus, groin, breast, inner thigh, or buttocks of any person, which is unrelated to official duties, or where the staff member, contractor, or volunteer has the intent to arouse, abuse, or gratify sexual desire, and

E. Any display of a staff member, contractor, or volunteer of his or her uncovered genitalia, buttocks or breasts in the presence of a patient.

Staff Sexual Misconduct

Staff sexual misconduct is characterized by behaviors between a staff member and patient which can include, but are not limited to, indecent, profane or abusive language or gestures and inappropriate visual surveillance of patients.



Assault/Abuse

Prohibited Acts

A patient, who engages in inappropriate sexual behaviors with or directs it at another, can be charged with the following Prohibited Acts under the Detainee Disciplinary Policy:

- Using Abusive or Obscene Language
- Sexual Assault
- Making a sexual proposal
- Indecent exposure
- Engaging in sexual acts

Detention As A Safe Environment

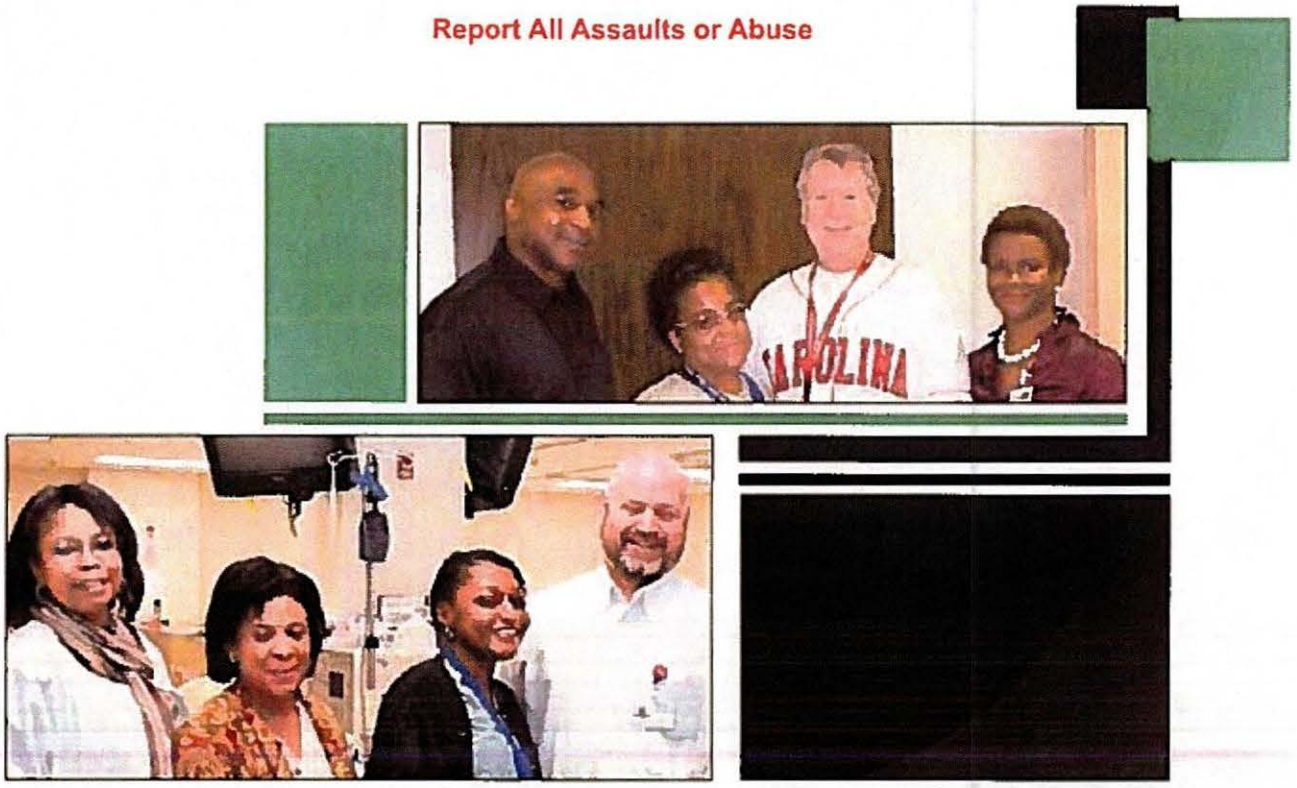
While you are detained, no one has the right to pressure you to engage in sexual acts or engage in unwanted sexual behaviors regardless of your age, size, race, or ethnicity. Regardless of your sexual orientation, you have the right to be safe from unwanted sexual advances and acts.

Remember, due to the nature of incarceration, NO sex in prison or at CRCC is considered consensual sex regardless of the nature of the act. This includes sex with other patients and/or institutional personnel. Take ALL sexual contact seriously and treat it as an assault.

Confidentiality

Information concerning the identity of a patient victim reporting a sexual assault, and the facts of the report itself, shall be limited to those who have the need to know in order to make decisions concerning the patient's welfare and for law enforcement investigative purposes.

Report All Assaults or Abuse



Assault/Abuse

Report All Assaults

Employees will accept all reports made verbally, in writing, anonymously, and from third parties and shall promptly document and verbal reports. If you become a victim of a sexual assault, you should report it immediately to any staff person you trust, to include housing officers, chaplains, medical staff, or supervisors. Staff members keep the reported information confidential and only discuss it with the appropriate officials on a need to know basis. If you are not comfortable reporting the assault to staff, you have other options:

U. S. Marshal's Patients

- Write a letter reporting the sexual misconduct to the person in charge of the United States Marshal's patients.
- To ensure confidentiality, use special (Legal) mail procedures.
- File a Detainee Grievance (DA1). If you decide your complaint is too sensitive to file with the officer in charge or unit nurse, you can file your Grievance directly with the Patient Advocate. You can get the forms from your unit officer, or a facility supervisor.
- Write to the Office of Inspector General (OIG), which investigates allegations of staff misconduct, or you may write to the Federal Bureau of Prisons. The addresses are:

U. S. Department of Justice
Office of Inspector General
P. O. Box 27606
Washington, DC 20534

OR

Central Office
Federal Bureau of Prisons
320 First Street N.W.
Washington, DC 20534

Call, at no expense to you, the Office of Inspector General.
The phone number is 1-800-869-4499.

South Carolina Department of Mental Health Patients

- You may call the South Carolina Law Enforcement Department (SLED),
- The State Long Term Care Ombudsman, or
- The Lieutenant Governor's Office at the following numbers:

866-200-6066 – SLED
803-734-9900 – Long Term Care Ombudsman
800-868-9095 – Lieutenant Governor's Office

Assault/Abuse

South Carolina Department of Corrections, Georgia Department of Corrections and All Others

- File a Detainee Grievance (DA1). If you decide your complaint is too sensitive to file with the officer in charge or unit nurse, you can file your grievance directly with the Patient Advocate. You can get the forms from your housing unit officer, or a facility supervisor.
- Write to the Office of Inspector General (OIG), which investigates allegations of staff misconduct, or you may write to the Federal Bureau of Prisons. The addresses are:

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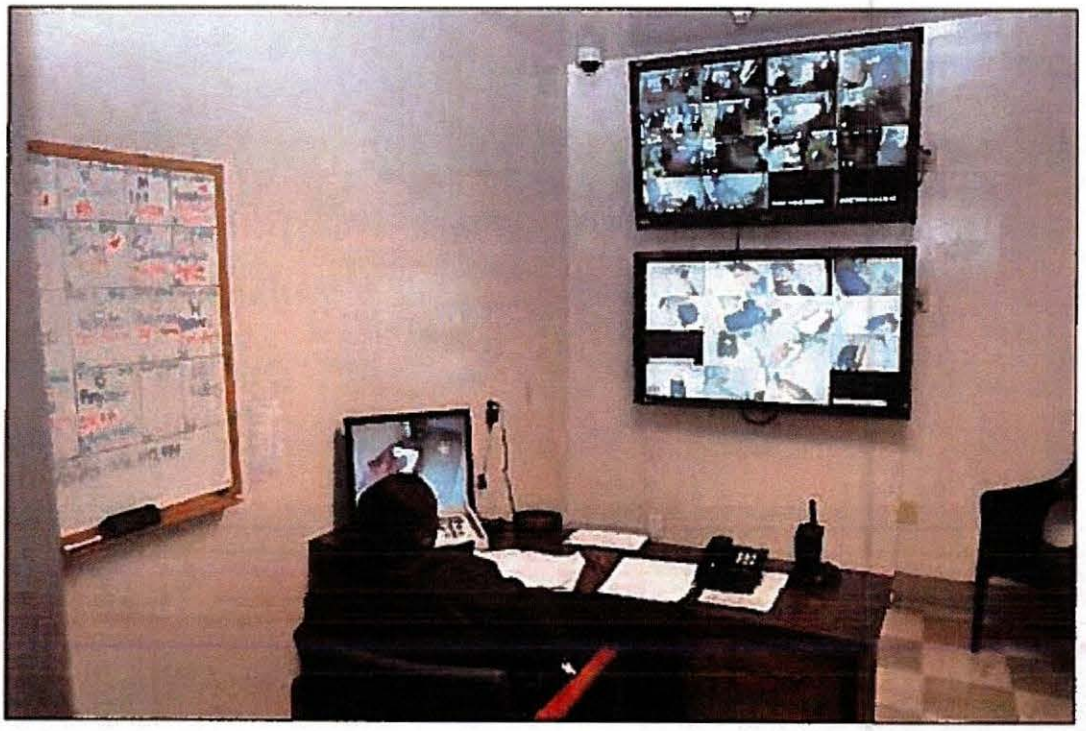


Security Operations

Security is the concern of everyone, but primarily the duty of the Custody Officers. Custody Officers have a role of providing for security, custody, and control of all patients held in CRCC. Your housing unit is supervised by Custody Officers who are trained to provide assistance. You are encouraged to try to solve your own individual problems in a responsible manner. However, problems may arise that will be beyond your control. Do not hesitate to discuss these matters with a staff member of CRCC. If they cannot assist, they will be able to refer you to someone who can.

Self Discipline, Rules & Regulations

Self-discipline is the most important part of maintaining order. This occurs when you are aware of the Rules and Regulations and, through your own self-discipline and determination, follow them. An orderly Correctional Community is necessary to maintain an effective program. You are expected to follow the rules and be respectful of others within CRCC. Good order and discipline will be maintained and you can expect corrective action for any violation of facility Rules and Regulations. The Rules and Regulations are listed in this manual for your benefit. All staff members are responsible for maintaining order and protecting your well-being by enforcing the Rules and Regulations.

Formal Disciplinary Action

A Disciplinary Report will be written by staff members observing a rule violation or having evidence that a violation of the Rules and Regulations has been committed. You will be given a copy of the charges placed against you and you will have a formal hearing before a Hearing Official. Each case is processed on an individual basis. Depending on the seriousness of the offense, a wide-range of corrective measures can be applied. Loss of privileges and disciplinary confinement are some of the disciplinary measures available. If you are found guilty, the Disciplinary Report will become a part of your Institutional Record. Disciplinary Reports may delay program considerations and suspend your privileges.

Disciplinary Severity Scale And Prohibited Acts

Code	Greatest Offense Category Prohibited Acts
100	Killing
101	Assaulting any person (including sexual assault) or an armed assault on the institution's secure perimeter (a charge for assaulting any person at this level is to be used only when serious physical injuries have been attempted or carried out by a patient)
102	Escape from an escort; escape from a secure institution (low, medium and high security level and administrative institutions)
103	Setting a fire(This category applies only when found to pose a threat to life serious bodily harm or in furtherance of a prohibited act of greatest severity, e.g. in furtherance of a riot or escape: Otherwise the charge is properly classified Code 218 or 329.)
104	Possession, manufacturing or introduction of a gun, firearm, weapon, sharpened instrument, knife, dangerous chemical, escape tool/device, explosive or ammunition
105	Rioting
106	Encouraging others to riot
107	Taking hostage(s)
108	Refusing to provide a urine sample to take part in drug-abuse testing
109	Threatening a staff member, law enforcement, security officer or public official with bodily harm
198	Interfering with a staff member in the performance of duties (conduct must be of the greatest severity)
199	Conduct that disrupts or interferes with security or the orderly operations of the facility (conduct must be of the greatest severity)

Greatest Offense Category Sanctions

A. Initiate criminal proceedings
B. Disciplinary transfer to another unit
C. Disciplinary segregation (up to 90 days)
D. Make monetary restitution (if funds are available)
E. Loss of privileges, e.g. canteen, recreation, free time, etc (in conjunction with A-D).

Formal Disciplinary Action

Code	High Offense Category Prohibited Acts
200	Escaping from unescorted community
201	Fighting, boxing, wrestling, sparring, and any other form of physical encounter, including horseplay that causes or could cause injury to another person
202	Possession or introduction of an unauthorized tool
203	Threatening another with bodily harm
204	Extortion, blackmail, protection, demanding or receiving money, canteen or any other form of payment for protection, avoiding bodily harm or threat of being informed against
205	Engaging in sexual acts
206	Making sexual proposal or threat to another
208	Wearing a disguise or mask
209	Tampering with or blocking any locking device
210	Tampering with food or drink
211	Possession, introduction, or use of narcotics, narcotic paraphernalia, or drug not prescribed for the individual by the medical staff
212	Possessing an officer's or any staff member's clothing
213	Engaging in or inciting a group demonstration
214	Encouraging others to participate in a work stoppage or to refuse to work
215	Refusing to provide a urine sample or otherwise cooperate in a drug test
216	Introducing alcohol into the facility
217	Giving or offering an official or staff member a bribe or anything of value
218	Giving money or receiving money from any person for an illegal or prohibited purpose, such as introducing/conveying contraband
219	Destroying, altering, or damaging property worth more than $100
220	Being found guilty of any combination of three high moderate or low moderate offenses within 90 days
221	Signing, preparing, circulating or soliciting support for prohibited group petitions
222	Possessing or introducing an incendiary device, e.g., matches, lighters, etc.
223	Any act that endanger person(s) and/or property
*298	Interfering with a staff member in the performance of duties (conduct must be of highest severity). This charge is to be used only when no other charge of high severity is applicable.
*299	Conduct that disrupts or interferes with the security or orderly operation of the facility (conduct must be of highest severity). This charge is to be used only when no other charge of highest severity is applicable
*	When the prohibited act is interfering with a staff member in the performance of duties (Code 198, 298, 398 or 498) of conduct that disrupts (Code 199, 299, 399 or 499), the disciplinary hearing officer should specify in its finding the severity level of the conduct, citing a comparable offense in that category. For example, we find the act of ___ to be of high severity, most comparable to Code 213, "engaging in a group demonstration."

High Offense Category Sanctions

A. Initiate criminal proceedings
B. Disciplinary transfer (recommended)
C. Disciplinary segregation (up to 30 days)
D. Make monetary restitution (if funds are available)
E. Loss of privileges, e.g. canteen, recreation, unit activities, etc.
F. Change housing unit
G. Removed from program and/or group activities
H. Loss of job
I. Impound and store patient personal property
J. Confiscate contraband
K. Room restriction
L. Warning

Formal Disciplinary Action

Code	High Moderate Offense Category Prohibited Acts
300	Indecent exposure
301	Stealing
302	Misuse of authorized medication
303	Loss, misplacement, or damage of a less restricted tool
204	Lending property or other item of value for profit/increase return
305	Possession of item(s) not authorized for receipt or retention; not issued through regular channels
306	Refusal to clean assigned living area
307	Refusing to obey the order of a staff member or officers (may be categorized and charged as a greater or lesser offense, depending on the kind of disobedience: continuing to riot is Code 105-Rioting; continuing to fight is Code 201-Fighting; refusing to provide a urine sample, Code 215
308	Insolence toward a staff member
309	Lying or providing false statement to staff
310	Counterfeiting, forging, or other unauthorized reproduction of money proceedings or other official documents or item, e.g. security document, identification cards, etc. (may be categorized as greater or lesser offense, depending on the nature and purpose of the reproduction, e.g., counterfeiting release papers to effect escape-Code 101 or 200).
311	Participating in an unauthorized meeting or gathering
312	Being in an unauthorized area
313	Failure to stand count
314	Interfering with count
315	Making, possessing, or using intoxicant(s)
316	Refusing a breathalyzer test or other test of alcohol consumption
317	Gambling
318	Preparing or conducting a gambling pool
319	Possession of gambling paraphernalia
320	Unauthorized contact with public
321	Giving money or another item of value to, or accepting money or another item of value from anyone, including another patient, without staff authorization
322	Destroying, altering, or damaging property (facility or another person's) worth more than $100
*398	Interfering with a staff member in the performance of duties (conduct must be of highest severity). This charge is to be used only when no other charge of high severity is applicable.
*399	Conduct that disrupts or interferes with the security or orderly operation of the facility (conduct must be of highest severity). This charge is to be used only when no other charge of highest severity is applicable
note	Any combination of high moderate and low moderate offenses during a 90-day period shall constitute a high offense.

High/ Moderate Offense Category Sanctions

A. Initiate criminal proceedings
B. Disciplinary transfer (recommended)
C. Disciplinary segregation (up to 72 hours)
D. Make monetary restitution
E. Loss of privileges: canteen, recreation, free time, etc.
F. Change housing
G. Remove from program and/or group activities
H. Loss of job
I. Impound and store patient's property
J. Confiscate contraband
K. Restrict to housing unit
L. Reprimand

Formal Disciplinary Action

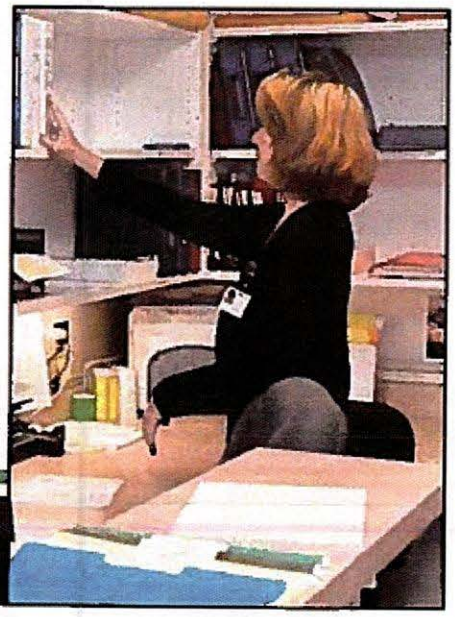
Code	Low Moderate" Offense Category Prohibited Acts
400	Possession of property belonging to another person
401	Possessing unauthorized clothing
402	Malingering, feigning illness
403	Smoking where prohibited
404	Using abusive or obscene language
405	Tattooing, body piercing, or self-mutilation
406	Unauthorized use of mail or telephone with restriction or temporary suspension of the abused privileges often the appropriate sanction
407	Conduct with a visitor in violation of rules and regulation(with restriction or temporary suspension of visiting privileges often the appropriate sanction)
408	Conduction of a business
409	Possession of money or currency, unless specifically authorized
410	Failure to follow safety or sanitation regulations
411	Unauthorized use of equipment or machinery
412	Using equipment or machinery contrary to posted safety standards

Low Moderate Offense Category Sanctions

A. Make monetary restitution
B. Loss of privileges: canteen, recreation, free time, etc.
C. Change housing
D. Remove from program and/or group activities
E. Loss of job
F. Impound and store patient's property
G. Confiscate contraband
H. Restrict to housing unit
I. Reprimand
J. Warning

Violation of State / Federal Law(s)

In cases such as participation in escape, riot, assault, or other serious violations, formal charges may be made and your case referred for prosecution. You can be prosecuted in outside court in addition to action through CRCC's disciplinary procedures.



Patient Release

Your release from CRCC will be determined by your medical condition and the laws, policies, and procedures of the committing authority (county, city, state, federal). You will be provided this information as it becomes available to CRCC.

Special Communication Issues

Problems are going to arise while you are at CRCC. Perhaps the most important step in solving a problem is to address the proper individual or department. Below is a list of anticipated problems and the correct responsible authority to contact. Though it is understood that all problems are not covered here, this can be used as a guide while you are here. If you do not have access to the person you need to contact, send a Patient Request Form to that person or department. Patient Request Forms are available on each Care Unit.

ISSUE	RESPONSIBLE AUTHORITY
Canteen Account Issues	Canteen Manager/Security
Clothing	Intake
Death of Family Member	Chaplain/Social Worker/Security
Dental	Sick Call
Diet Health	Medical Admin./Food Services
Substance Abuse	Social Worker/Medical Services
Patient Trust Account	Business Office
Grievance	Risk Manager
Legal Issues	Education
Mail	Security/Mailroom

Daily Operating Schedule

Daily Operating Schedule

4:00 a.m.	Informal Count
6:00 a.m.	Wake-up/Lights On
6:00 a.m. - 7:30 a.m.	Breakfast
7:30 a.m.	Formal Count
8:30 a.m.	Dayroom Open
11:00 a.m. – 12:30 p.m.	Lunch
12:00 p.m.	Formal Count
3:30 p.m.	Formal Count
4:00 p.m. – 5:30 p.m.	Dinner
6:00 p.m.	Activities Resume
7:00 p.m.	Formal Count
9:00 p.m.	Dayroom Close
9:30 p.m.	Photo Roll Call Count
11:30 p.m.	Informal Count
11:30 p.m.	Lights Out (Sunday - Thursday)
12:00 a.m.	Lights Out (Friday - Saturday)

Patient Handbook

Acknowledgement of Receipt

Patient Name_____CRCC#_____

Important Phone Numbers:_____

Date Received:_____

CORRECT CARE
RECOVERY SOLUTIONS

Motion #56

DEATH PENALTY CASE

STATE OF SOUTH CAROLINA **IN THE COURT OF GENERAL SESSIONS**

COUNTY OF LEXINGTON **ELEVENTH JUDICIAL CIRCUIT**

STATE OF SOUTH CAROLINA, Plaintiff, v. TIMOTHY RAY JONES, JR., Defendant.	**Indictment Nos.:** 2015-GS-3200-188 2015-GS-3200-189 2015-GS-3200-190 2015-GS-3200-191 2015-GS-3200-192

MOTION FOR CONSTITUTIONALLY ADEQUATE VOIR DIRE

COMES NOW, defense counsel for Timothy Ray Jones, Jr., who respectfully request that they be allowed to conduct constitutionally adequate voir dire. This motion is based upon the Sixth, Eighth and Fourteenth Amendments to the United States Constitution, Art. I, sec.s 3, 14, and 15 of the Constitution of South Carline, and S.C. Code 16-3-25(C)(1).

A DEFENDANT HAS THE RIGHT TO ADEQUATE VOIR DIRE SO THAT HE MAY OBTAIN A FAIR AND IMPARTIAL JURY

The right to a fair and impartial jury is guaranteed by the Sixth and Fourteenth Amendments of the United States Constitution. The right to an impartial jury and the need for a process guaranteed to ensure such an impartial jury is specifically "heightened" in capital cases. *State v. Ramseur*, 524 A.2d 188 (N.J. 1987).

The purpose of voir dire is to satisfy Timothy Ray Jones, Jr.s' right to obtain fair and impartial jury, and putting time restrictions or limiting the number of questions during voir dire may result in a denial of that right. *Williams v. State*, 424 So.2d 148 (Fla. App. 1982) (reversing

conviction due to a trial court curtailing voir dire). While it may be commendable for a court to conduct business promptly, this result must "never be attained at the risk of denying to a party on trial a substantial right." *De La Rosa v. State*, 414 S.W.2d 668, at 672 (Tex. Cr. App. 1967) (citing *Carter v. State*, 272 S.W. 477 (Tex. Cr. App. 1925).

STANDARD FOR REMOVING A JUROR FOR CAUSE

A "juror should be excused if there is *any reasonable doubt* about the potential juror's ability to render an impartial verdict." *Kessler v. Florida*, 752 So.2d 545 (Fla. 1999) (emphasis added) (quoting *Turner v. State*, 645 So.2d 444 (Fla. 1994).

ASKING JURORS IF THEY CAN "FOLLOW THE LAW" IS NOT SUFFICIENT TO CURE INADEQUATE VOIR DIRE

A trial court must not prejudicially curtail voir dire. Further, any such curtailment of voir dire is never cured by merely seeking a commitment from the juror that he or she will "follow the law" as is sometimes given by the judges. *Morgan v. Illinois*, 504 U.S. 719, 112 S.Ct. 2222 (1992); *State v. Sheppard*, 468 So.2d 594 (La. App. 1985) (reversing murder conviction due to trial court improperly limiting voir dire). Also, simply asking jurors if the nature of the crime would prevent them from being fair is ineffective voir dire as is really only invites one answer. *State v. Biegenwald*, 594 A.2d 172 (N.J. S.Ct. 1991) (reversing murder conviction for trial court's failure to allow voir dire on issue of murder victim being only three years old).

ATTORNEYS MUST BE ABLE TO VOIR DIRE AND EXPLORE POTENTIAL MISUNDERSTANDINGS OF THE LAW

Regarding issues of the law, a judge's explanation of a legal principle and the juror's promise under oath to accept and follow the law is only the one step of the inquiry. The first step

is to determine, through appropriate voir dire, if the juror truly understood the legal principle at issue. Counsel should always have the opportunity to assure that the potential juror understands the vital legal principles of the case. *State v. Gonzales*, 2 S.W.3d 600 (Tex. App. 1999) (reversing verdict due to trial court's failure to allow defense to voir dire on issue of a necessity defense); *Stringfellow v. State*, 859 S.W.2d 451 (Tex. App. 1993) (reversing trial court's decision not allowing defense to voir dire on which jurors could follow court's instruction regarding issue of parole); *Stave v. Thomas*, 680 So.2d 37 (La. App. 1996) (reversing conviction due to trial court's limitation of voir dire regarding elements of the offense, specific intent, and reasonable doubt); *State v. Sheppard*, 468 So.2d 594 (La. App. 1985) (reversing murder conviction due to trial court's improper limitation on voir dire).

A trial court's limitation of voir dire to whether the juror will accept the law as given has never been favored. *State v. Thomas,* 680 So.2d 37 (La. App. 1996). Further, given the complexity of the law, necessarily involving basic rights belonging to a defendant, curtailing voir dire regarding legal principles cannot ever be cured by a trial court procuring a commitment from the juror that he "will follow the law." *Id* at 41. It is counsel who must question the juror about the juror's experiences and attitudes and biases not otherwise disclosed. *Id.*

AEDQUATE VOIR DIRE INCLUDES THE RIGHT TO VOIR DIRE ON SUBSTANTIAL MITIGATING OR AGGRAVTING FACTS

Attorneys must be able to voir dire on facts of significance when there is a reasonable probability that those facts could prevent the juror from rendering an unbiased verdict. *State v. Longworth*, 313 S.C. 360 (S.C. 1993); *State v. Davis*, 309 S.C. 326 (S.C. 1992). A juror must be unbiased, impartial, and able to carry out the law. *State v. Green*, 301 S.C. 347 (1990). A juror should be disqualified if mitigating or aggravating evidence prevents the juror from fairly

considering both available penalties, death and life without parole. *State v. Longworth*, 313 S.C. 360 (1993) (declaring it proper to voir dire on issue of whether jurors could consider death as punishment for mildly retarded defendant).

As stated above, merely asking jurors if the nature of the crime would prevent them from being fair is ineffective voir dire as it really invites only one answer. Attorneys must be able to voir dire regarding significant and specific facts that could uncover juror bias regarding specific facts found within the case on which the juror may be seated. *State v. Biegenwald*, 594 A.2d 172 (N.J. S.Ct. 1991) (reversing murder conviction for trial court's failure to allow adequate voir dire on issue of murder victim being only three years old).

Multiple appellate courts have also held that evidence of prior murders or double murders committed by a defendant is just the type of aggravating evidence that must be addressed in voir dire. *State v. Cash*, 50 P.3d 332 (Cal. S. Ct. 332 2003) (reversing murder conviction for trial court's failure to allow voir dire on evidence of prior murder); *State v. Biegenwald*, 594 A.2d 172 (N.J. S.Ct. 1991) (reversing murder conviction due to trial court's failure to allow voir dire on evidence of prior murder); *State v. Roberston*, 630 So.2d 1278 (La. 1994) (reversing murder conviction and death sentence for trial court's failure to remove juror for cause when juror indicated bias in favor of death penalty in cases of double murder); *see also State v. Maxie*, 653 So2d. 526 (La. 1995) (reversing conviction and sentence for trial court's failure to remove juror who indicated bias in favor of death penalty in rape-murder cases).

CONCLUSION

The right to a fair and impartial jury is guaranteed by the Sixth and Fourteenth Amendments of the United States Constitution. The right to an impartial jury and the need for a

process designed to ensure such an impartial jury is specifically "heightened" in capital cases. *State v. Ramseur*, 524 A.2d 188 (N.J. 1987).

The "heightened reliability" demand is found in the Eight Amendment to the United States Constitution. *Sumner v. Shuman*, 483 U.S. 66, 71 (1987); *see also Eddings v. Oklahoma*, 455 U.S. 104, 111 (1982) (quoting *Woodson*, 428 U.S. at 304); *Barefoot v. Estelle*, 463 U.S. 880, 924 (1983) (Blackmun, J., dissenting) (noting concern for assuring heightened reliability in capital sentencing is "as firmly established as any in [the Court's] Eighth Amendment jurisprudence"); *Eddings v. Oklahoma*, 455 U.S. 104, 111 (1982) (O'Connor, J., concurring) ("[T]his Court has gone to extraordinary measures to ensure that the prisoner sentenced to be executed is afforded process that will guarantee, as much as humanly possible, that the sentence was not imposed out of whim, passion, prejudice, or mistake."); *Godfrey v. Georgia*, 446 U.S. 420, 443 (1980) (Burger, C.J., dissenting) ("[I]n capital cases we must see to it that the jury has rendered its decision with meticulous care.").

Moreover, the Fourteenth Amendment guarantees every capital defendant a fair and unbiased trial. *See Cone v. Bell*, 129 S.Ct. 1769, 1772 (2009) ("The right to a fair trial, guaranteed to state criminal defendants by the Due Process Clause of the Fourteenth Amendment, imposes on States certain duties consistent with their sovereign obligation to ensure 'that "justice shall be done" in all criminal prosecutions.'"); *United States v. Agurs*, 427 U.S. 97, 107 (1976) ("We are dealing with the defendant's right to a fair trial mandated by the Due Process Clause of the Fifth Amendment to the Constitution. Our construction of that Clause will apply equally to the comparable Clause in the Fourteenth Amendment applicable to trials in state courts.").

Finally, Title 16 of the South Carolina Code requires that no sentence of death be "imposed under the influence of passion, prejudice, or any other arbitrary factor." S.C. Code Ann. 16-3-25(C)(1).

Thus, to ensure that the requirement of S.C. Code 16-3-25 (C)(1) and the demanding constitutional standard of heightened reliability in death penalty cases is preserved throughout Timothy Ray Jones, Jr.'s capital trial, including the voir dire process, the Court should allow counsel for the state and defense to engage in adequate voir dire.

WHEREFORE, the defense respectfully requests that this Court:

(a) Allow the attorneys for the state and defense to engage in adequate voir dire; and

(b) Grant such other and further relief as the Court deems proper.

DATED this 23 day of April, 2018.

Respectfully Submitted,

S. Boyd Young, Attorney
1330 Lady Street, Suite 401
Columbia, SC 29211
(803) 734-1351

Robert Madsen, Lexington County Public Defender
206 E. Main Street
Lexington, SC 29072
(803) 785-8873

Counsel for Timothy Ray Jones, Jr.

Motion #27

STATE OF SOUTH CAROLINA
COUNTY OF LEXINGTON

IN THE COURT OF GENERAL SESSIONS
ELEVENTH JUDICIAL CIRCUIT

STATE OF SOUTH CAROLINA, Plaintiff, v. TIMOTHY RAY JONES, JR., Defendant.	**Indictment No: 2015-GS-3200-188** **2015-GS-3200-189** **2015-GS-3200-190** **2015-GS-3200-191** **2015-GS-3200-192**

Motion to Suppress Evidence and Fruits from Unlawful Roadblock

Defendant, by and through his undersigned attorney, hereby presents this Memorandum of Law in support of his Motion to Dismiss or Suppress due to the roadside checkpoint in this matter being unconstitutional. No discussion of the facts will be presented in this Memorandum because it is being prepared prior to the State presenting evidence as to the validity and constitutionality of said checkpoint. This Memorandum will be a discussion of the legal principals and applicable case law on roadside checkpoints.

LEGAL ARGUMENTS

The most recent and most complete case regarding roadside checkpoints in the State of South Carolina is State v. Groom, 378 S.C. 615, 664 SE2d 460 (2008). While this case discussed the suppression of drugs at a checkpoint, it includes discussion of and findings on

issues regarding all roadside checkpoints.

A checkpoint whose primary purpose is general crime control is unconstitutional. City of Indianapolis v. Edmond, 531 U.S. 32, 121 S.Ct.447 (2007). In determining whether a checkpoint is for the purpose of general crime control or merely a driver's license checkpoint, the Court should consider the plans, procedures and duration as well as any protocol followed by the law enforcement agency. Factors or issues to consider when determining whether the checkpoint was for general crime control or for a constitutional purpose, the Court should consider any signage, whether or not supervisory officers were aware of and approved the checkpoint, the effectiveness of the checkpoint or other checkpoints similar to this one, the location, the time of day and whether or not the officers are afforded unconstrained discretion at the checkpoint. The State should provide evidence of the protocol, including the number of motorist stopped, how it will be determined which motorist to stop and how the site and time of the roadblock was determined. City of Indianapolis v. Edmond, 531 U.S. 32, 121 S.Ct.447 (2007).

While the State may rely upon the case of Michigan Department of State Police v. Sitz, 496 U.S. 444, 110 S.Ct.2481 (1990), this case does not allow any and all highway sobriety checkpoints or driver's license checkpoints without some constraints. In the Sitz case, the Michigan State Police Department had established sobriety checkpoint programs with strict guidelines governing their operations, site selection and publicity. The Michigan State Police Department provided empirical data showing that 126 vehicles passed through the checkpoint, the average vehicle delay was 25 seconds and two (2) drivers were arrested for driving under the influence. There had also been previous hearings where extensive testimony was offered

concerning the effectiveness of such programs. Unless the Newberry City Police Department can provide the same type of empirical data showing the effectiveness and the procedures utilized, the checkpoint does not pass constitutional muster.

Another important case regarding roadside checkpoints is Brown v. Texas, 443 U.S. 47, 99 S.Ct.2637 (1979). In Brown, the United States Supreme Court found that to determine the constitutionality of a checkpoint, the Court should weigh the gravity of the public concerns served by the checkpoint, the degree to which the checkpoint advances the public interest, and the severity of the interference with individual liberty. Id. at 2640. A central concern with balancing the considerations listed above, is the "unfettered discretion of officers in the field." Id. at 2640. Furthermore, the 4th Amendment requires that checkpoints or seizures must be based on specific, objective facts indicating that society's legitimate interest require the checkpoint or seizure or that the seizure or checkpoint must be carried out pursuant to a plan embodying explicit neutral limitations on the conduct of the individual officers. Id., quoting Delaware v. Prouse at 663.

The State must clear two hurdles before any evidence derived from or flowing from a roadside checkpoint can be admissible in any trial. First, the State must show that the checkpoint was not for general crime suppression but instead that it was for a specialized interest. The State must show the plans, procedures, duration and effectiveness of the checkpoint to prove the true purpose. If the checkpoint was for generalized crime suppression or crime control, there is no further analysis needed and the checkpoint is unconstitutional, and all evidence derived therefrom should be suppressed.

If the State can clear the first hurdle and show that the checkpoint was, in fact, a driver's license checkpoint, the State must then show the gravity of the public interest, the degree to which the seizure or checkpoint serves the public interest and the severity of the interference on the individual drivers. In weighing these factors, the Court should consider empirical evidence presented and whether a detailed protocol, which limits the on-scene officer's discretion, is in place. Absent the State tipping the scales in favor of constitutionality by evidence proving there is a grave public interest that the roadside checkpoint effectively serves that public interest and that the roadside checkpoint presents a minimal interference on the freedom of the motorist, the checkpoint must be found unconstitutional and all evidence derived therefrom must be suppressed.

CONCLUSION

Defendant intends to apply the facts as presented by the State in this matter at a pretrial hearing to the law as stated in this Memorandum.

Respectfully Submitted,

Robert M. Madsen, Eleventh Circuit Public Defender
202 East Main Street
Lexington, South Carolina 29072
(803)785-8873

S. Boyd Young, Attorney
1330 Lady Street, Suite 401
Columbia, SC 29211
(803) 734-1351

Counsel for Timothy Ray Jones, Jr.

State of South Carolina
Office of the Solicitor
Eleventh Judicial Circuit

COUNTIES
EDGEFIELD / LEXINGTON
McCORMICK / SALUDA
FAXES: (803) 785-8431 or (803) 785-8255

LEXINGTON COUNTY JUDICIAL CENTER
205 E. MAIN ST. ROOM 309
LEXINGTON, SOUTH CAROLINA 29072
TELEPHONE: (803) 785-8352

DONALD V. MYERS
Solicitor

December 9, 2015

To: Timothy Ray Jones, Jr., Defendant, and his attorneys, Rob Madsen and Boyd Young

RE: STATE v. TIMOTHY RAY JONES, JR.
Indictments # 2015-GS-32-188 thru 191 & 195

Dear Mr. Jones, Mr. Madsen & Mr. Young:

Pursuant to §16-3-20, et. seq. of the South Carolina Code of Laws, as amended, this is to notify and inform you that the State will seek the death penalty in the above-entitled case if the defendant is found guilty on the charges of Murder presently pending against him. This, of course, refers to the deaths of his five children: Abigal Jones, Gabriel Jones, Nahtahn Jones, Elias Jones and Mera Gracie Jones which occurred in Lexington County on or between August 28th and 29th, 2014.

You will be notified at a later date of the aggravating circumstances upon which the State will rely in seeking the death penalty.

Very truly yours,

Donald V. Myers

2015 DEC -9 PM 12:33
BETTIA CARRIGG
CLERK OF COURT
LEXINGTON SC

A TRUE COPY
Lex. Co. C.C.P., G.S. & F.C.

STATE OF SOUTH CAROLINA)
)
COUNTY OF LEXINGTON)
)
STATE)
)
v.)
)
TIMOTHY RAY JONES, JR.,)
)
Defendant.)
_____)

IN THE COURT OF GENERAL SESSIONS

DEATH PENALTY NOTICE ORDER
Ind #2015-GS-32-188 thru 191 & 195

The above case was before the Court on Wednesday, December 9, 2015. The defendant, Timothy Ray Jones, Jr., was present and represented by Robert Madsen, Public Defender for Lexington County, and S. Boyd Young. The State was represented by Solicitor Donald V. Myers and Deputy Solicitor Shawn Graham.

The Solicitor served the defendant and his attorneys with a written Notice that the State would seek the Death Penalty in this case. The written Notice was in the form of a letter dated December 9, 2015, from the Solicitor to the defendant, Mr. Madsen and Mr. Young. This letter is incorporated herein and filed with the Lexington County Clerk of Court.

IT IS THEREFORE ORDERED that the defendant and the defense attorneys have been notified of the Solicitor's intention to seek the death penalty pursuant to § 16-3-26 (a) of the 1976 South Carolina Code of Laws, as amended.

AND IT IS SO ORDERED.

The Honorable R. Knox McMahon
11th Circuit Chief General Sessions Judge

Lexington, South Carolina
December 7th, 2015

The Supreme Court of South Carolina

State of South Carolina, Prosecutor,

v.

Timothy Ray Jones, Jr., Defendant.

Lexington County
2015-GS-32-00188 through 00191 & 00195

ORDER

IT IS ORDERED that the Honorable Eugene C. Griffith, Jr. be vested with exclusive jurisdiction to hear and dispose of the above case. Judge Griffith shall decide all matters pertaining to this case, including motions to appoint or relieve counsel, and shall retain jurisdiction over this case regardless of where he may be assigned to hold court and may schedule such hearings as may be necessary at any time without regard as to whether there is a term of court scheduled. In addition, Judge Griffith is requested to provide the Office of Court Administration with an update on the status of this case every one hundred and twenty days.

Costa M. Pleicones
Chief Justice

December 20, 2016
Columbia, South Carolina

WITNESSES
- 12/9/15 Def. arraigned by Hon. Few
Lexington County Sheriffs Department

~~T. L. Stoner~~ Adam Creech

Law Enforcement Case #: 14016136

DVM

ARREST WARRANT NUMBER

2014A3210800324

ACTION OF GRAND JURY

TRUE BILL

Foreperson of Grand Jury
Date: 1/12/15

VERDICT
Guilty

Jessica K. Miller
Foreperson of Petit Jury
Date: 6-4-19

8356

DOCKET NO. 2015GS3200188

The State of South Carolina

County of Lexington

COURT OF GENERAL SESSIONS

JANUARY TERM 2015

THE STATE
vs.

Timothy Ray Jones Jr

CDR #: 0116

Indictment for

MURDER

§ 16-03-0010

DONALD V. MYERS, SOLICITOR

A TRUE COPY
Lex. Cty. C.C.C.P., G.S. & F.C.

RECEIVED
JUN 21 2019
SC Court of Appeals

8357

JAN 13 2015

STATE OF SOUTH CAROLINA	)	INDICTMENT FOR MURDER
COUNTY OF LEXINGTON	)	§ 16-03-0010

At a Court of General Sessions, convened on JANUARY 2015, the Grand Jurors of Lexington County present upon their oath:

That **Timothy Ray Jones, Jr.** did in Lexington County on or between August 28 and 29, 2014, unlawfully, willfully, feloniously, and with malice aforethought kill the victim, **Mera Gracie Jones**, by means of strangulation and/or other violent means or instruments, and the victim died on or between August 28 and 29, 2014, in Lexington County as a proximate result thereof, in violation of Section 16-3-10 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
12/9/15 DV assigned by Hope Strick
Lexington County Sheriff's Department

~~T. L. Stoner~~ Adam Creech

Law Enforcement Case #: 14016136

DVM

ARREST WARRANT NUMBER

2014A3210800323

ACTION OF GRAND JURY

TRUE BILL

Foreperson of Grand Jury
Date: 11/12/15

VERDICT
Guilty

Jessica K. Miller
Foreperson of Petit Jury
Date: 6-4-19

DOCKET NO. 2015GS3200189

The State of South Carolina

County of Lexington

COURT OF GENERAL SESSIONS

JANUARY TERM 2015

THE STATE
vs.

Timothy Ray Jones Jr

CDR #: 0116

Indictment for

MURDER

§ 16-03-0010

DONALD V. MYERS, SOLICITOR

A TRUE COPY
Lex. Co. C.C.C.P., G.S. & F.C.

RECEIVED
JUN 21 2019
SC Court of Appeals

8358

8359

JAN 13 2015

STATE OF SOUTH CAROLINA	)	INDICTMENT FOR MURDER
COUNTY OF LEXINGTON	)	§ 16-03-0010

At a Court of General Sessions, convened on JANUARY 2015, the Grand Jurors of Lexington County present upon their oath:

That **Timothy Ray Jones, Jr.** did in Lexington County on or between August 28 and 29, 2014, unlawfully, willfully, feloniously, and with malice aforethought kill the victim, **Elias Jones**, by means of strangulation and/or other violent means or instruments, and the victim died on or between August 28 and 29, 2014, in Lexington County as a proximate result thereof, in violation of Section 16-3-10 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.

Donald V. Myers
SOLICITOR

WITNESSES 12/09/15 Def. arraigned by Hope Smith
Lexington County Sheriffs Department

~~T. L. Stoner~~ Adam Creech

Law Enforcement Case #: 14016136

DVM

ARREST WARRANT NUMBER

2014A3210800320

ACTION OF GRAND JURY

TRUE BILL

Foreperson of Grand Jury
Date: 1/12/15

VERDICT

Guilty

Jessica K. Muller
Foreperson of Petit Jury
Date: 6-4-19

8360

DOCKET NO. 2015GS3200190

The State of South Carolina

County of Lexington

COURT OF GENERAL SESSIONS

JANUARY TERM 2015

THE STATE
vs.

Timothy Ray Jones Jr

CDR #: 0116

Indictment for

MURDER

§ 16-03-0010

DONALD V. MYERS, SOLICITOR

A TRUE COPY
Lex. Co. C.C.C.P., G.S. & F.C.

SC Court of Appeals
JUN 21 2019
RECEIVED

8361

STATE OF SOUTH CAROLINA)
)
COUNTY OF LEXINGTON)
)

INDICTMENT FOR
MURDER

§ 16-03-0010

At a Court of General Sessions, convened on JANUARY 2015, the Grand Jurors of Lexington County present upon their oath:

That **Timothy Ray Jones, Jr.** did in Lexington County on or between August 28 and 29, 2014, unlawfully, willfully, feloniously, and with malice aforethought kill the victim, **Abigail Jones**, by means of strangulation and/or other violent means or instruments, and the victim died on or between August 28 and 29, 2014, in Lexington County as a proximate result thereof, in violation of Section 16-3-10 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
10/9/15 Dy. arraigned by Hope Faid
Lexington County Sheriffs Department

~~T. L. Stoner~~ Adam Creech

Law Enforcement Case #: 14016136

DVM

ARREST WARRANT NUMBER

2014A3210800321

ACTION OF GRAND JURY

TRUE BILL

Foreperson of Grand Jury
Date: 11/12/15

VERDICT
Guilty

Jessica K. Miller
Foreperson of Petit Jury
Date: 6-4-19

8362

DOCKET NO. 2015GS3200191

The State of South Carolina

County of Lexington

COURT OF GENERAL SESSIONS

JANUARY TERM 2015

THE STATE
vs.

Timothy Ray Jones Jr

CDR #: 0116

Indictment for

MURDER

§ 16-03-0010

DONALD V. MYERS, SOLICITOR

A TRUE COPY
Lex. Co. C.C.C.P., G.S. & F.C.

RECEIVED
JUN 21 2019
SC Court of Appeals

8363

JAN 13 2015

STATE OF SOUTH CAROLINA	)	INDICTMENT FOR MURDER
COUNTY OF LEXINGTON	)	§ 16-03-0010

At a Court of General Sessions, convened on JANUARY 2015, the Grand Jurors of Lexington County present upon their oath:

That **Timothy Ray Jones, Jr.** did in Lexington County on or between August 28 and 29, 2014, unlawfully, willfully, feloniously, and with malice aforethought kill the victim, **Gabriel Jones**, by means of strangulation and/or other violent means or instruments, and the victim died on or between August 28 and 29, 2014, in Lexington County as a proximate result thereof, in violation of Section 16-3-10 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 12/09/15 Arraigned by Hope Strick

Lexington County Sheriffs Department

~~T. L. Stoner~~ Adam Creech

Law Enforcement Case #: 14016136

DVM

ARREST WARRANT NUMBER

2014A3210800322

ACTION OF GRAND JURY

TRUE BILL

Foreperson of Grand Jury

Date: 11/12/15

VERDICT

Guilty

Jessica K. Miller

Foreperson of Petit Jury

Date: 6-4-19

8364

DOCKET NO. 2015GS3200195

The State of South Carolina

County of Lexington

COURT OF GENERAL SESSIONS

JANUARY TERM 2015

THE STATE
vs.

Timothy Ray Jones Jr

CDR #: 0116

Indictment for

MURDER

§ 16-03-0010

DONALD V. MYERS, SOLICITOR

A TRUE COPY
Lex. Co. C.C.C.P., G.S. & F.C.

RECEIVED
JUN 21 2019
SC Court of Appeals

8365

JAN 15 2015

STATE OF SOUTH CAROLINA	)	INDICTMENT FOR MURDER
COUNTY OF LEXINGTON	)	§ 16-03-0010

At a Court of General Sessions, convened on JANUARY 2015, the Grand Jurors of Lexington County present upon their oath:

That **Timothy Ray Jones Jr** did in Lexington County on or between August 28 and 29, 2014, unlawfully, willfully, feloniously and with malice aforethought kill the victim, **Nahtahn Jones**, by hitting or striking the victim, by causing physical exhaustion, by mortally injuring or causing injuries to the victim by means or instruments unknown, and/or by unknown means of a wanton or reckless disregard for human life, and the victim died on or between August 28 and 29, 2014, in Lexington County as a proximate result thereof, in violation of Section 16-3-10 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.

Donald V. Myers
SOLICITOR

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Jul 30 2021

S.C. SUPREME COURT

CERTIFICATE OF COUNSEL FOR APPELLANT

Counsel for appellant certifies that this Record on Appeal contains all material proposed to be included by any of the parties and not any other material and that this Record on Appeal complies to the best of my ability with the April 15, 2014 order from the South Carolina Supreme Court entitled "Revised Order Concerning Personal Identifying Information and Other Sensitive Information in Appellate Court Filings."

Respectfully Submitted,

Robert M. Dudek
Chief Appellate Defender

South Carolina Commission on Indigent Defense
Division of Appellate Defense
PO Box 11589
Columbia, SC 29211-1589

ATTORNEY FOR APPELLANT

This 30th day of July, 2021.