IN THE
Supreme Court of the United States

BYRON LEWIS BLACK,

Petitioner,

v.

STATE OF TENNESSEE,

Respondent.

ON PETITION FOR A WRIT OF CERTIORARI TO
THE TENNESSEE SUPREME COURT

APPENDIX TO PETITION FOR WRIT OF CERTIORARI

EXECUTION SCHEDULED FOR AUGUST 5, 2025, AT 10AM.

OFFICE OF THE FEDERAL PUBLIC DEFENDER
FOR THE MIDDLE DIST. OF TENNESSEE
CAPITAL HABEAS UNIT

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FILED
07/08/2025
Clerk of the
Appellate Courts

IN THE SUPREME COURT OF TENNESSEE
AT NASHVILLE

BYRON LEWIS BLACK v. STATE OF TENNESSEE

Criminal Court for Davidson County
No. 88-S-1479

No. M2000-00641-SC-DPE-CD

ORDER

Byron Lewis Black, a death-row inmate, appeals the trial court's denial of his request for an evidentiary hearing on his petition asserting he is not competent to be executed. The trial court held that Mr. Black did not make the required threshold showing; that is, he did not offer evidence which, if deemed credible, would show he is not presently competent to be executed. *See Van Tran v. State*, 6 S.W.3d 257 (Tenn. 1999). For that reason, the trial court declined to proceed to an evidentiary hearing on competency. On appeal, Mr. Black argues the trial court should have determined his competency to be executed based on the criteria for "idiocy" used in the common law during the period in which our nation was founded. To the extent Mr. Black seeks to relitigate his claim that he is "intellectually disabled" and therefore ineligible for the death penalty, that question was fully litigated—repeatedly—in prior proceedings. Mr. Black did not prevail, those rulings and appeals became final long ago, and he cannot relitigate those adverse rulings in this competency proceeding. To the extent Mr. Black is asking this Court to reconsider the standard for competency to be executed and adopt a standard that differs from longstanding precedent from this Court and the United States Supreme Court, we decline to do so. Under this Court's long-established standard for competency to be executed, we agree with the trial court that the evidence offered by Mr. Black did not make a threshold showing sufficient to warrant an evidentiary hearing on competency.[1] Accordingly, the judgment of the trial court is affirmed.

I. Procedural Background

Over thirty-six years ago, the defendant, Byron Lewis Black, was convicted of the

[1] We conclude that this appeal does not present extraordinary circumstances that necessitate oral argument. *See Van Tran*, 6 S.W.3d at 272.

March 1988 triple murders of his girlfriend, Angela Clay, age 29, and her two daughters, Latoya, age 9, and Lakeisha, age 6. Mr. Black received consecutive life sentences for the murders of Angela Clay and Latoya Clay, and he was sentenced to death for the murder of Lakeisha Clay based on six aggravating circumstances found by the jury. On direct appeal, this Court affirmed Mr. Black's convictions and sentences. *State v. Black*, 815 S.W.2d 166 (Tenn. 1991), *reh'g denied* (Tenn. Sept. 3, 1991).

In 1992, Mr. Black sought state post-conviction relief. After a hearing, the post-conviction court denied relief. The Tennessee Court of Criminal Appeals affirmed the post-conviction court's judgment, and this court denied Mr. Black's application for permission to appeal. *Black v. State*, No. 01C01-9709-CR-00422, 1999 WL 195299 (Tenn. Crim. App. Apr. 8, 1999), *perm. app. denied* (Tenn. Sept. 13, 1999), *cert. denied*, *Black v. Tennessee*, 528 U.S. 1192 (2000).

Mr. Black's extensive efforts to establish that he was intellectually disabled at the time of the crime began in August 2000, when he filed a petition for writ of habeas corpus in the United States District Court for the Middle District of Tennessee. *See Black v. Bell*, 181 F.Supp.2d 832, 839 (M.D. Tenn. 2001). Among other claims, the petition argued that Mr. Black was "mentally retarded" (now "intellectually disabled").[2] The district court granted the State's motion for summary judgment and dismissed the petition. *Id*. at 883.

Mr. Black appealed the district court's ruling to the United States Court of Appeals for the Sixth Circuit. However, in this time frame, this Court issued its opinion in *Van Tran v. State*, 66 S.W.3d 790 (Tenn. 2001), holding as a matter of first impression that the execution of a "mentally retarded" person violates the Eighth Amendment to the United States Constitution and Article I, section 16 of the Tennessee Constitution. Significantly, *Van Tran* further held that retroactive application of this new rule was warranted for cases on collateral review. Approximately six months later, on June 20, 2002, the United States Supreme Court held that the execution of "mentally retarded" persons violates the Eighth Amendment to the United States Constitution. *Atkins v. Virginia*, 536 U.S. 304 (2002).

The Sixth Circuit held the appeal in abeyance while Mr. Black pursued a motion to reopen his state post-conviction proceedings seeking to establish his ineligibility for the death penalty based on the "mental retardation" categorical exclusion announced in *Van Tran* and *Atkins*. After an evidentiary hearing, the state post-conviction court found that Mr. Black was not "mentally retarded." The Tennessee Court of Criminal Appeals affirmed, and this Court denied Mr. Black's application for permission to appeal. *Black v.*

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[2] The statute was amended while Mr. Black was pursuing habeas relief in the federal courts. The amended statute substituted the term "intellectual disability" for the term "mental retardation." *See* Act of March 24, 2010, ch. 734, §§ 1, 7, 2010 Tenn. Pub. Acts, https://perma.cc/NY2N-MSMW (codified as amended at Tenn. Code Ann. § 39-13-203). We use the former term only to maintain consistency with the record from that time period.

State, No. M2004-01345-CCA-R3-PD, 2005 WL 2662577 (Tenn. Crim. App. Oct. 19, 2005), *perm. app. denied* (Tenn. Feb. 21, 2006), *cert. denied*, *Black v. Tennessee*, 549 U.S. 852 (2006).

The Sixth Circuit then remanded the case to the federal district court for the limited purpose of reconsidering Mr. Black's "mental retardation" claim in light of *Atkins*. In April 2008, the federal district court dismissed Mr. Black's *Atkins* claims, and the case returned to the Sixth Circuit in a consolidated appeal.

During the pendency of the Sixth Circuit appeal, this Court released its decision in *Coleman v. State*, 341 S.W.3d 221 (Tenn. 2011), which clarified Tennessee's intellectual disability statute. The Sixth Circuit affirmed the district court in part; however, the panel again remanded the case for further proceedings related to the impact of *Coleman*. *Black v. Bell*, 664 F.3d 81 (6th Cir. 2011), *reh'g denied* (6th Cir. Jan. 4, 2012). On this second remand, the federal district court concluded that Mr. Black failed to carry his burden of demonstrating intellectual disability (formerly "mental retardation") by a preponderance of the evidence. *Black v. Colson*, No. 3:00–0764, 2013 WL 230664 (M.D. Tenn. Jan. 22, 2013), *aff'd sub nom.*, *Black v. Carpenter*, 866 F.3d 734 (6th Cir. 2017), *reh'g en banc denied* (6th Cir. Oct. 27, 2017), *cert. denied sub nom.*, *Black v. Mays*, 584 U.S. 1015 (2018). The Sixth Circuit affirmed that decision, agreeing with the district court that Mr. Black had not proved by a preponderance of the evidence that he had significantly subaverage general intellectual functioning as evidence by an I.Q. score of 70 or below. *Black v. Carpenter*, 866 F.3d at 744–50. Notably, the Sixth Circuit evaluated Mr. Black's intellectual disability claim in light of this Court's decision in *Coleman* as well as the United States Supreme Court's then-recent guidance on intellectual disability determinations in *Moore v. Texas*, 581 U.S. 1 (2017), *Brumfield v. Cain*, 576 U.S. 305 (2015), *Hall v. Florida*, 572 U.S. 701 (2014).

Upon the conclusion of the standard three-tier appeals process,[3] on September 20, 2019, the State filed a motion to set an execution date for Mr. Black in accordance with Tennessee Supreme Court Rule 12(4).[4] In response to the motion, Mr. Black raised the issue of his competency to be executed and requested a hearing pursuant to *Van Tran v. State*, 6 S.W.2d 237 (Tenn. 1999). *See* Tenn. Sup. Ct. R. 12(4)(A).

On February 24, 2020, this Court granted the State's motion to set an execution date for Mr. Black and established deadlines for proceedings to consider Mr. Black's claim that he is not competent to be executed, citing *Van Tran v. State*, 6 S.W.3d at 267-68, *State v.*

[3] The standard three-tier review includes a direct appeal in state court, state post-conviction review, and federal habeas corpus review.

[4] The State originally filed a motion to set an execution date in March 2000; however, the motion was denied at that time due to the continuing habeas corpus proceedings.

Irick, 320 S.W.3d 284 (Tenn. 2010), and *Madison v. Alabama*, 586 U.S. 265 (2019). Upon the motion of Mr. Black, the Court reset the execution for April 8, 2021; however, the Court ultimately stayed the execution due to the COVID-19 pandemic.

In 2021, the Tennessee General Assembly amended Tennessee's intellectual disability statute. *See* Act of April 26, 2021, ch. 399, 2021 Tenn. Pub. Acts, https://perma.cc/CKC7-HVRD (codified at Tenn. Code Ann. § 39-13-203(g)). Relevant here, the revisions established a procedure authorizing certain death-row inmates to raise an intellectual disability claim by filing an appropriate motion with the trial court; however, the amended statute prohibited such a motion for any inmate whose intellectual disability claim had been "previously adjudicated on the merits." *See id.* at §2 (codified at Tenn. Code Ann. § 39-13-203(g)). On June 3, 2021, pursuant to the revised statute, Mr. Black filed a "Motion to Declare Defendant Intellectually Disabled," again seeking categorical exclusion from the death penalty. After reviewing the procedural history of the case, the trial court denied the motion, finding that Mr. Black's intellectual disability claim had been previously adjudicated on the merits. The Tennessee Court of Criminal Appeals affirmed. *Black v. State*, No. M2022-00423-CCA-R3-PD, 2023 WL 3843397 (Tenn. Crim. App. June 6, 2023), *no perm. app. filed.*[5]

During this time, this Court lifted the previous stay of execution and reset Mr. Black's execution for August 18, 2022. However, in April 2022, Tennessee Governor Bill Lee granted a temporary reprieve to death-row inmate, Oscar Franklin Smith, and subsequently paused all executions, including the scheduled execution of Mr. Black.

Tennessee resumed executions in 2025, adopting a revised single-drug protocol utilizing pentobarbital. By order dated March 3, 2025, this Court reset Mr. Black's execution for August 5, 2025, with corresponding deadlines for proceedings to consider Mr. Black's competency-to-be-executed claim, including (per *Van Tran*) an initial determination by the trial court of whether Mr. Black had made the requisite threshold showing to warrant a competency hearing.

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[5] Mr. Black chose not to seek review in this Court of the 2023 Tennessee Court of Criminal Appeals decision. Nonetheless, Mr. Black and the amici continue to raise issues resolved in that appeal, especially the legitimacy of the district attorney's "concession" that Mr. Black is intellectually disabled. As noted by our Court of Criminal Appeals, the district attorney did not stipulate a fact, but instead attempted to stipulate a legal conclusion, namely, whether Mr. Black is intellectually disabled under legal standards. *Black*, 2023 WL 3843397, at *9–10 (citations omitted). As the intermediate appellate court recognized, parties may not stipulate to questions of law; before accepting such a concession, courts "independently analyze[] the underlying legal issue to determine whether the concession reflects a correct interpretation of the law." *Black*, 2023 WL 3843397, at *9–10. Here, the trial court rejected the district attorney's purported concession/stipulation as an attempt to avoid the statute's procedural bar, and the Court of Criminal Appeals affirmed. *Id*. Mr. Black chose not to appeal and may not raise the issue in this proceeding.

On May 29, 2025, Mr. Black filed a petition in the Circuit Court for Davidson County, Tennessee, to be declared incompetent to be executed under common law principles prohibiting execution of the "*non compos mentis*." The petition identified three experts, whose recent reports were among the exhibits attached to the petition. The State filed a response to the petition, asserting that the allegations "raise no doubt about [Mr. Black's] present competency," and emphasizing that Mr. Black's own expert found him competent to be executed under the prevailing competency standard. The State asked the trial court to summarily dismiss the petition because Mr. Black failed to make the threshold showing required by *Van Tran*.

On June 5, 2025, the trial court entered a "Memorandum and Order" concluding that Mr. Black's petition and attachments failed to make the requisite threshold showing of a genuine disputed issue regarding Mr. Black's present competency to be executed necessary to warrant an evidentiary hearing. Mr. Black now appeals.

II. Competency to Be Executed

In this appeal, we must consider whether the trial court erred in concluding that Mr. Black failed to make the threshold showing necessary to warrant a hearing on his competency petition.[6] We review the trial court's conclusion de novo with no presumption of correctness afforded to the trial court's determination. *Irick*, 320 S.W.3d at 292; *Thompson v. State*, 134 S.W.3d 168, 177 (Tenn. 2004) (clarifying the standard of review of a trial court's threshold showing determination).

In *Van Tran*, this Court established Tennessee's procedures for litigating competency to be executed, after the United States Supreme Court held in *Ford v. Wainwright*, 477 U.S. 399 (1986), that the Eighth Amendment prohibits the execution of the insane. As indicated in *Ford*, the issue of competency to be executed is ripe for determination only when execution is imminent. *Van Tran*, 6 S.W.3d at 267. Thus, a death-row inmate challenging competency to be executed must raise the claim in response to the State's motion to set an execution date. *Id.* Once the death-row inmate raises the issue, this Court remands the question of competency to be executed to the trial court where the inmate was initially convicted and sentenced. *Id.* Per the deadline established in this Court's order, the inmate must initiate the proceedings by filing in the trial court a petition

[6] *See Van Tran*, 6 S.W.3d at 271–72 (explaining the procedure to automatically appeal the trial court's denial of a competency hearing on the ground that the prisoner failed to make a threshold showing). We note that this procedure does not contemplate the filing of a reply brief in this Court. We have considered Mr. Black's reply brief, but we remind the parties that a motion for leave to file and lodge with the Court is the proper mechanism for filing any pleading not contemplated in the *Van Tran* procedure.

alleging he or she is not competent to be executed. *Id.* at 267–68. The district attorney general must file a response to the petition. *Id.* at 268. Within four days, the trial court must decide if a competency hearing is warranted. An inmate is not entitled to an evidentiary hearing unless the trial court determines the inmate has made a threshold showing that a genuine, disputed issue exists regarding the inmate's *present* competency. *Id.* at 269 (emphasis added). The inmate carries the burden of making this threshold showing. In *Van Tran*, this Court explained:

> This burden may be met by the submission of affidavits, depositions, medical reports, or other credible evidence sufficient to demonstrate that there exists a genuine question regarding petitioner's present competency. In most circumstances, the affidavits, depositions, or medical reports attached to the prisoner's petition should be from psychiatrists, psychologists, or other mental health professionals.

Id. (citations omitted). "At least some of the evidence submitted must be the result of recent evaluations or observations of the inmate." *Id.* The threshold showing cannot be satisfied by only stale evidence related to the inmate's competency or incompetency in the distant past, or by unsupported assertions of a family member or an attorney. *Id.*

The trial court's assessment of the sufficiency of an inmate's threshold showing must be premised on the appropriate standard for competency-to-be-executed proceedings. In *Van Tran*, the Court held that under Tennessee law a prisoner is not competent to be executed "if the prisoner lacks the mental capacity to understand the fact of the impending execution and the reason for it." *Id.* at 266 (adopting the standard suggested by Justice Powell in his partial concurrence in *Ford,* 477 U.S. at 422).[7] Some years later, after the United States Supreme Court revisited the issue of the standard for competence to be executed in *Panetti v. Quarterman*, 551 U.S. 930 (2007), this Court recognized that the competency standard adopted in *Van Tran* must be construed consistently with the principles espoused in *Panetti*. *Irick*, 320 S.W.3d at 294. We explained:

> In our view, *Panetti* teaches that the test for competence to be executed requires a prisoner to have "a rational understanding of his conviction, his impending execution, and the relationship between the two." Stated differently, under *Panetti*, execution is not forbidden so long as the evidence

[7] In adopting Justice Powell's view in *Van Tran*, this Court rejected the "assistance prong" that requires a prisoner to possess the ability to assist counsel in his or her defense at the competency-to-be-executed stage. *Van Tran*, 6 S.W.3d at 265-66 (explaining that this more stringent prong is used to determine competency to stand trial or to plead guilty in Tennessee). In his trial court memorandum, Mr. Black suggests, in passing, that the Court should now add the assistance prong to our competency-to-be-executed competency standard. We decline to do so.

> shows that the prisoner does not question the reality of the crime or the reality of his punishment by the State for the crime committed.

Id. at 295 (citations omitted) (incorporating the *Panetti* competency standard into the *Van Tran* proceeding). The Court is also mindful of *Madison v. Alabama*, 586 U.S. 265 (2019), in which the United States Supreme Court noted that, regardless of the cause of the inmate's mental state, "the sole inquiry [under *Panetti*] remains whether the [inmate] can rationally understand the reasons for his death sentence." *Id.* at 277 (considering whether dementia and other health ailments precluded the inmate's execution under *Panetti*).

In view of these controlling legal principles, we conduct our de novo review of Mr. Black's petition and accompanying documents.

III. Mr. Black's Petition

Mr. Black filed a twenty-seven page "Petition to Declare Byron Black Incompetent to be Executed." Notably, the petition does not allege that Mr. Black is incompetent under the standards articulated in *Van Tran*, *Irick*, *Panetti*, or *Madison*. Instead, Mr. Black's counsel asks that Mr. Black be declared incompetent to be executed under common law standards that prohibit execution of the *non compos mentis*, including "lunatics" and "idiots."[8] The petition includes Mr. Black's interpretation of these common law principles; describes Mr. Black's past and present physical and mental health conditions; and asserts that Mr. Black cannot be executed because he is an "idiot" at common law. Attached to the petition are twenty-five exhibits, most of which relate to Mr. Black's multi-year pursuit of his intellectual disability claim. For our purposes, much of the information is stale or does not support a claim that Mr. Black is not *presently* competent to be executed under the standard that governs this *Van Tran* proceeding. *See Van Tran*, 6 S.W.3d at 269. Most relevant to our inquiry are the recent reports of three mental health professionals – Dr. Lee Ann Preston Baecht, a board-certified forensic psychologist; Dr. Daniel Martell, a board-certified forensic psychologist/neuropsychologist; and Dr. Ruben C. Gur, a professor of neuropsychology. These are outlined below.

Dr. Lee Ann Preston Baecht

In a report dated May 28, 2025, Dr. Baecht indicated Mr. Black was referred to her by his defense counsel for a mental health evaluation to assess his competency to be

[8] As highlighted by the trial court, Mr. Black incorrectly stated in his petition that this Court remanded the case to the trial court for consideration of Mr. Black's competency-to-be-executed claim under *Ford v. Wainright* and the Eighth and Fourteenth Amendments. In fact, the record reflects that the remand orders referred to competency proceedings under *Van Tran*, *Irick*, and *Madison*.

executed. Dr. Baecht interviewed Mr. Black in a private visitation room at Riverbend Maximum Security Prison on May 14 (approximately 4 hours), on May 15 (approximately 2 hours), and on May 21, 2025 (approximately 1.5 hours). The report contained the following relevant summaries of the interviews:

> [First Interview] When asked if he had been assigned an execution date, Mr. Black correctly stated, "August 5." When asked what would happen on that date, he stated, "I will be put to death." When asked how, he stated, "some kind of protocol." . . . When asked why the [S]tate intended to execute him on August 5, he stated, "Because they think I committed murder." When asked, he correctly stated he was given the death sentence for the murder of the youngest victim."
>
> . . .
>
> [Second Interview] Consistent with his statements during our first clinical interaction, during our second interview, Mr. Black correctly recalled that he is scheduled to be executed on August 5 and that he was sentenced to death for the murder of Lakeisha. When asked about the potential methods of execution, he stated, "the protocol." However, he stated he was not certain what the protocol is, adding "I just hear people talking about it." He was aware that there was debate regarding the use of the protocol, adding that he had seen pictures of the last person executed, and "He turned blue and purple. The protocol didn't kill him, He suffered a lot." When asked if there was another potential method of execution in Tennessee, he correctly stated, "the electric chair, I think." He indicated he had not thought about which option he would choose.
>
> . . .
>
> [Third Interview] During our third clinical interaction, Mr. Black again correctly recalled that he had been convicted of murdering Angela Clay and her two daughters, Latoya and Lakeisha. He also correctly stated that he was scheduled to be executed on August 5, for the murder of Lakeisha. He correctly listed the two potential methods of execution in Tennessee as the electric chair and the "protocol," which he described as being "a liquid substance" that is "injected."

Dr. Baecht opined, based on a strict interpretation of the competency standard articulated by *Van Tran v. State*, *Ford v. Wainwright*, *Panetti v. Quarterman*, and *Madison v. Alabama*, that Mr. Black likely meets this "low bar" for competency to be executed because Mr. Black understands he is scheduled to be executed on August 5, 2025; recognizes that death is permanent; and understands the State seeks to execute him for the murder of

Lakeisha Clay.

Dr. Daniel A. Martell

In a report dated May 27, 2025, Dr. Martell, who had previously evaluated Mr. Black for intellectual disability in 2020, indicated he had re-examined and re-tested Mr. Black at the request of Mr. Black's counsel on April 28, 2025, at Riverbend. Dr. Martell was not asked to evaluate or to opine on Mr. Black's present competency to be executed under the *Panetti* standard. Instead, defense counsel presented Dr. Martell with the following referral questions focused on Mr. Black's argument that the common law prohibits execution of the "*non compos mentis*":

> 1. Based upon your most recent assessment of Mr. Black, do you continue to hold your opinion that Mr. Black is intellectually disabled? Please supply the basis for your opinion.
>
> 2. Please describe any changes in Mr. Black's condition since you previously assessed him 2019 and the basis for your conclusions.
>
> 3. Please describe any deficits that Mr. Black exhibits with respect to memory, linguistic fluency, and cognitive functioning.
>
> 4. Please describe your conclusions regarding Mr. Black's ability to manage his own affairs, with a particular focus on his ability to manage financial affairs and his ability to live independently.
>
> 5. At common law, an individual was categorically exempt from execution if he or she was found to be *non compos mentis*. Does Mr. Black meet the following criteria for being non compos mentis?
>
> > a. An idiot is an individual who exhibits low intellectual functioning from nativity and who is incapable of managing his affairs.
> >
> > b. A person is *non compos mentis* if by reason of disease, accident, or other mental condition loses memory and understanding such that he is incapable of managing his own affairs.
>
> 6. Please describe the symptoms associated with profound intellectual disability. In your opinion, would such an individual be capable of planning and committing a homicide?

Dr. Martell's report concludes that Mr. Black meets the criteria for being "*non compos mentis*," and reiterates his own earlier opinion that Mr. Black is intellectually disabled.

Dr. Ruben C. Gur

In a final report dated May 28, 2025, Dr. Gur interpreted structural and functional neuroimaging data from magnetic resonance imaging (MRI) and positron emission tomography (PET) scans taken in May 2022. According to the report, the structural neuroimaging findings "show 'brain dysfunction' that may impair Mr. Black's ability to integrate information and base decisions on intact reasoning . . . ." He opined that Mr. Black "likely experiences cognitive deficits, particularly in the context of executive and memory functions . . . ." Dr. Gur observed abnormalities in brain structure with changes over the decades that may suggest a neurodegenerative process, such as Alzheimer's disease or Parkinson's disease. However, Dr. Gur did not discuss how, if at all, these findings relate to Mr. Black's present competency to be executed. Dr. Gur also did not interview Mr. Black.

Trial Court's Decision

Upon review of the petition and attachments, the trial court assessed Mr. Black's competency claim under the *Panetti* standard. In its memorandum and order, the trial court emphasized that Mr. Black's own expert, Dr. Baecht, found him competent to be executed under this competency standard. The trial court further noted that Mr. Black's petition failed to assert that any alleged mental infirmity, in isolation or in combination, renders him incompetent to be executed under this competency standard. In conclusion, the trial court found that Mr. Black failed to make the necessary threshold showing under *Van Tran* that there is a genuine, disputed issue regarding his present competence to be executed such that a competency hearing was warranted. The trial court declined to consider Mr. Black's assertion of incompetency to be executed under the common law "idiocy" principle for "want of jurisdiction."

IV. Analysis

Mr. Black does not argue that he is incompetent to be executed under the standard we set forth in *Van Tran* and refined in *Irick* to ensure consistency with *Panetti*. Instead, he argues that his execution is prohibited because he satisfies the standard for "idiocy" under the common law. We begin by evaluating Mr. Black's petition under the *Panetti* standard that governs claims of incompetency in a *Van Tran* proceeding and conclude that his evidence fails to meet the *Panetti* standard. We then explain why, to the extent Mr. Black seeks to relitigate intellectual disability or argue for a new categorical exclusion from execution, his argument regarding common law idiocy is procedurally barred. Finally, we decline Mr. Black's request that we reconsider the standard for competency to be executed.

a. *Panetti* Competency Standard

In this *Van Tran* proceeding, Mr. Black was required to make a threshold showing that a genuine, disputed issue exists regarding his present competence to be executed under the *Panetti* standard. *See Van Tran*, 6 S.W.3d at 269; *Irick*, 320 S.W.3d at 295. A prisoner is presently incompetent if he does not have "a rational understanding of his conviction, his impending execution, and the relationship between the two." *Irick*, 320 S.W.3d at 295. We agree with the trial court that Mr. Black has failed to make a threshold showing that he is presently incompetent to be executed under this standard.

The most relevant evidence provided by Mr. Black consisted of the three recent expert reports summarized above. Mr. Black's own expert, Dr. Baecht, found him likely competent to be executed under the *Panetti* standard. The other two experts, Dr. Martell and Dr. Gur, did not expressly address the *Panetti* standard in their assessments, and neither expert undermined Dr. Baecht's assessment so as to create a genuine, disputed issue regarding Mr. Black's present competency to be executed. We review the question de novo, assuming for purposes of this appeal that the evidence submitted by Mr. Black would be found credible. We conclude that Mr. Black failed to make the requisite threshold showing to warrant an evidentiary hearing on his competence under *Van Tran*. Accordingly, we affirm the trial court on that issue.

b. Common Law Idiocy Argument

Mr. Black argues that he "meets the criteria for 'idiocy' at common law and therefore 'his execution would violate the Eighth Amendment's ban on cruel and unusual punishments." He insists he is *not* arguing that he is incompetent to be executed under the *Panetti* standard, but rather that the *Panetti* standard "is insufficient to provide the protections for 'idiots' that were available under the common law at the time of the Founding."

To the extent Mr. Black's argument about the common law is an attempt to relitigate his intellectual disability claim, that argument is procedurally barred. The trial court properly understood that it was required under our specific remand order to preside over a *Van Tran* proceeding under the competency standards enumerated by this Court in *Van Tran* and *Irick*. The narrow procedure we adopted in *Van Tran* was necessary because *Ford*-based incompetency claims are "generally not considered ripe until execution is imminent" and could not be effectively adjudicated under the Post-Conviction Act. *Van Tran*, 6 S.W.3d at 264; *see also Panetti*, 551 U.S. at 943 (noting that "*Ford*-based incompetency claims, as a general matter, are not ripe until the time has run to file a first federal habeas petition"). The procedure we adopted in *Van Tran* is thus limited to adjudicating *Ford*-based claims of incompetency grounded in insanity. As explained above, Mr. Black has not made the requisite showing that he is incompetent under the *Panetti* standard. Competency is the only claim he is entitled to assert in this proceeding.

Accordingly, the trial court properly declined to consider Mr. Black's common law idiocy argument because it fell outside the scope of the order remanding the case for a *Van Tran* hearing. *See Weston v. State*, 60 S.W.3d 57, 59 (Tenn. 2001) ("Neither a trial court nor an intermediate court has the authority to expand the directive or purpose of this Court imposed on remand.").

Moreover, Mr. Black has already litigated and relitigated his claim that he is intellectually disabled and therefore categorically ineligible for the death penalty. Those many efforts were all unsuccessful. *See Black v. State*, No. M2004-01345-CCA-R3-PD, 2005 WL 2662577 (Tenn. Crim. App. Oct. 19, 2005), *perm. app. denied* (Tenn. Feb. 21, 2006), *cert. denied*, *Black v. Tennessee*, 549 U.S. 852 (2006); *Black v. Colson*, No. 3:00–0764, 2013 WL 230664 (M.D. Tenn. Jan. 22, 2013), *aff'd sub nom.*, *Black v. Carpenter*, 866 F.3d 734 (6th Cir. 2017), *reh'g en banc denied* (6th Cir. Oct. 27, 2017), *cert. denied sub nom.*, *Black v. Mays*, 584 U.S. 1015 (2018); *see also Black v. State*, No. M2022-00423-CCA-R3-PD, 2023 WL 3843397 (Tenn. Crim. App. June 6, 2023), *no perm. app. filed*. Four different courts—a state trial court, the Court of Criminal Appeals, a federal district court, and the United States Court of Appeals for the Sixth Circuit—considered Mr. Black's intellectual disability claim on the merits and held that the proof failed to establish that he is intellectually disabled. He is not permitted to relitigate that issue at this late stage by shoehorning it into a *Van Tran* proceeding.

To the extent Mr. Black is arguing for a new categorical exclusion from execution that is distinct from incompetency under the *Panetti* standard or intellectual disability under *Atkins* and its progeny, he had ample opportunities to raise that argument at an earlier stage. *See Irick*, 320 S.W.3d at 297-98 (explaining that a *Van Tran* proceeding is not the proper proceeding to seek a new categorical exclusion because the proceeding is *sui generis* and not a trial). He did not do so.

And to the extent Mr. Black is asking this Court to reconsider the standard for competency to be executed, he offers no compelling reason for us to adopt a standard that differs from longstanding precedent from this Court and the United States Supreme Court. We respectfully decline to do so.

V. Application for a Stay of Execution

On June 23, 2025, Mr. Black filed an application for a stay of his execution scheduled for August 5, 2025. Tennessee Supreme Court Rule 12(4)(E) provides that this "Court will not grant a stay or delay of an execution date pending resolution of collateral litigation in state court unless the prisoner can prove a likelihood of success on the merits in that litigation." Tenn. Sup. Ct. R. 12(4)(E). Mr. Black asserts that he is entitled to a stay if he can show "more than a mere possibility of success" in the litigation and "the balance of equities tips in his favor." (quoting respectively *Irick*, 556 S.W.3d at 689; and *Ramirez v. Collier*, 595 U.S. 411, 421 (2022)). In his motion seeking a stay, he relies only on a

contention of success in the present appeal of the Petition before us. Because this Court has found Mr. Black unsuccessful in this appeal, he cannot demonstrate a likelihood of success. Accordingly, his application for a stay of his execution is respectfully denied.

CONCLUSION

For the reasons explained above, the trial court's judgment dismissing Mr. Black's petition to be declared incompetent to be executed is affirmed. This order is not subject to rehearing under Tennessee Rule of Appellate Procedure 39, and the Clerk is directed to certify this opinion as final and to immediately issue the mandate. As provided by this Court's order of March 3, 2025, the Warden of the Riverbend Maximum Security Institution, or his designee, shall carry out the execution of Byron Lewis Black in accordance with Tennessee law on the 5th day of August, 2025, unless a stay is entered by this Court or by a federal court. Counsel for Byron Lewis Black shall provide to the Office of the Appellate Court Clerk in Nashville a copy of any order of stay. The Clerk shall expeditiously furnish a copy of any stay order to the Warden of the Riverbend Maximum Security Institution.

This order is designated for publication pursuant to Tennessee Supreme Court Rule 4.

PER CURIAM

IN THE CRIMINAL COURT FOR DAVIDSON COUNTY, TENNESSEE

BYRON BLACK,	)	
Petitioner	)	
	)	**No. 88-S-1479**
v.	)	**Capital Case**
	)	**(Competency to be Executed)**
STATE OF TENNESSEE	)	
Respondent.	)	

FILED
Davidson County
Criminal Court Clerk
JUN 05 2025
Deputy Clerk

MEMORANDUM AND ORDER

This case is before the Court pursuant to a remand order from the Supreme Court of Tennessee, dated March 3, 2025, for a determination of Byron Black's claim that he is not competent to be executed. The Supreme Court has set his execution for August 5, 2025. The trial court proceedings are to be held in accordance with the timelines and procedures established in *Van Tran v. State*, 6 S.W.3d 257, 267-71 (Tenn. 1999).

The issue to be resolved under *Van Tran*, *supra*, is rather straightforward: Has the Petitioner made a threshold showing that he is incompetent to be executed? If a criminal defendant scheduled for execution can prove that his mental illness or disorder is of such severity that he lacks a rational understanding of the state's rationale for his imminent execution, then he may not be executed. If he does rationally understand the connection between the crime and his execution, then he is competent and can be executed. The standard for the threshold showing required to proceed further is set forth below.

The remand order states:

> On February 24, 2020, this Court granted the State's motion to set an execution date for Byron Lewis Black and established deadlines for proceedings to consider Mr. Black's claim that he is not competent to be executed. *See Van Tran v. State*, 6 S.W.3d 257, 267-68 (Tenn. 1999); *State v. Irick*, 320 S.W.3d 284 (Tenn. 2010); *Madison v. Alabama*, 586 U.S. 265 (2019). Upon motion of Mr. Black, the Court reset the execution for April 8, 2021, but ultimately stayed the execution due

> to the COVID-19 pandemic. The Court lifted the stay and reset the execution for August 18, 2022; however, in April 2022, Governor Lee granted a temporary reprieve in another scheduled execution and subsequently paused all executions until a revised lethal injection protocol was announced on December 27, 2024.
>
> Pursuant to Tennessee Supreme Court Rule 12(4)(E), it is hereby ORDERED that the execution of Mr. Black is reset for August 5, 2025. Correspondingly, Mr. Black shall file his petition alleging incompetency to be executed in the trial court no sooner than May 27, 2025, and no later than May 29, 2025. As previously ordered, the competency proceedings shall be held in accordance with the timelines and procedures established in Van Tran.

The rule of competency to be executed applies in death penalty cases and to the mental state of a prisoner on the date of his execution. It is not the incompetency rule that applies during criminal trial proceedings, nor is it the same as a claim of intellectual disability (formerly called mental retardation).[1] Those claims by Mr. Black have been previously litigated in the state and federal courts and rejected. Again, the current competency claim applies only to the mental state of Mr. Black on the day of his execution. He must be able to rationally understand that he has been convicted of murder, and that is why he is being executed. If he understands that simple proposition, then he is competent to be executed. Most prisoners are able to comprehend at least the fact of their conviction and its connection to their execution, though they may be seriously mentally ill or otherwise intellectually disabled. However, if Mr. Black's mental incapacity prevents him from rationally understanding the connection between the crime and his execution, then he is incompetent to be executed, and the Eighth Amendment will not allow his execution. This Court would be obliged to grant a full evidentiary hearing if Mr. Black's petition and supporting exhibits meet a threshold showing of his inability to rationally understand the connection between the murders and his scheduled execution.

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[1] Incompetency for execution is also different from the competency standard applied in civil matters.

The legal standard of competence required for execution is whether the prisoner's "mental state is so distorted by a mental illness" that he lacks a "rational understanding" of "the State's rationale for [his] execution." *Panetti v. Quarterman*, 551 U.S. 930, 958-59 (2007); *see also id.* at 962 (describing the inquiry as whether "a subject's perception of reality [is] so distorted that he should be deemed incompetent."). "*Panetti* teaches that the test for competence to be executed requires a prisoner to have "a rational understanding of his conviction, his impending execution, and the relationship between the two." *State v. Irick*, 320 S.W.3d 284, 295 (Tenn. 2010) (quotation and citation omitted). This standard is not concerned with the cause of the prisoner's mental state, "but a consequence—to wit, the prisoner's inability to rationally understand his punishment." *Madison v. Alabama*, 586 U.S. 265, 278 (2019).

If Mr. Black establishes the threshold showing that there is a genuine issue regarding his present competence to be executed, then a hearing should be held. *Van Tran*, 6 S.W.3d at 269. That threshold showing must include the following requirements:

> The petition shall identify the proceeding in which the prisoner was convicted and sentenced and shall clearly set forth the facts alleged to support the claim that execution should be stayed due to present mental incompetence. The petition shall have attached to it affidavits, records, or other evidence supporting the factual allegations of mental incompetence. The petition shall also identify any previous proceedings in which the prisoner has challenged his or her mental competency in relation to the conviction and sentence in question.

Van Tran, 6 S.W.3d at 267.

In determining whether a hearing is required, this Court must be able to conclude that Mr. Black has made a threshold showing that he does not meet the competency standard for execution. The Tennessee Supreme Court explained in *Van Tran*:

> Therefore, we adopt a rule that places the burden on the prisoner to make a threshold showing that he or she is presently incompetent. This burden may be met by the submission of affidavits, depositions, medical reports, or other credible

> evidence sufficient to demonstrate that there exists a genuine question regarding petitioner's present competency. In most circumstances, the affidavits, depositions, or medical reports attached to the prisoner's petition should be from psychiatrists, psychologists, or other mental health professionals. *Id.* [*State v. Harris*, 789 P.2d 60, 69 (Wash. 1990)]. If the trial court is satisfied there exists a genuine disputed issue regarding the prisoner's present competency, then a hearing should be held. *Harris*, 789 P.2d at 69–70.
>
> We emphasize that the proof required to meet the threshold showing must relate to *present* incompetency. Therefore, by definition, at least some of the evidence submitted must be the result of recent mental evaluations or observations of the prisoner. The threshold can not be satisfied if the only evidence offered is stale in the sense that it relates to the prisoner's distant *past* competency or incompetency. We also note that the unsupported conclusory assertions of a family member of the prisoner or an attorney representing the prisoner will ordinarily be insufficient to satisfy the required threshold showing.

Id. at 269.

Mr. Black has exhausted all appellate remedies in state as well as federal court, and his alleged mental infirmities have been raised and considered by numerous trial courts and appellate proceedings during and since his 1990 trial for murder and imposition of the death sentence. Mr. Black was convicted of the 1988 cold-blooded triple murders of his sometime girlfriend Angela Clay, age 29, and her two daughters, Latoya, age 9, and Lakeisha, age 6. He received life sentences for the murders of Angela and Latoya Clay and was sentenced to death for the murder of Lakeisha Clay. At the time of the murders, Mr. Black was on furlough from a conviction for the malicious shooting of Ms. Clay's husband, from whom she was separated. Mr. Black was 33 years old when he was convicted of murder. He has been incarcerated for over 35 years. Before Mr. Black's incarceration in 1988, he displayed some deficits, but he was functional, and while a slow learner, he had received a regular diploma from a vocational high school. He read slowly but was literate and was never considered a remedial student. He was not considered to be "retarded" by the school system. He played high school football, worked as a courier, and was briefly married.

At the murder trial, there was an issue of Mr. Black's competency to stand trial. A hearing was held and experts testified, including one appointed by the trial judge (the undersigned judge has presided over all Mr. Black's trial proceedings). Mr. Black was found competent. He understood the charges against him, the role of counsel, the judge, and the jury, and he was able to consult with and assist counsel in preparing his defense. Testimony also established that his IQ of 76 was in the lower end of the normal range. The competency finding was affirmed on direct appeal. *See State v. Black*, 815 S.W.2d 166, 173-75 (Tenn. 1991).

The issue of Mr. Black's competency to stand trial was again addressed in his post-conviction case. It was determined that his trial counsel were not ineffective in presenting the issue. Although witnesses testified that there were questions regarding Mr. Black's competency, the issue had been properly presented to the trial court. *See Black v. State*, 1999 WL 195299, at *21 (Tenn. Crim. App. Apr. 8, 1999). It was also noted that the experts found no support for an insanity defense. *Id.* at *17.

In 2003, Mr. Black's post-conviction case was reopened to consider a claim that he was mentally retarded (now referred to as intellectually disabled). Both the United States Supreme Court and the Supreme Court of Tennessee had ruled that a mentally retarded person could not be executed. *Van Tran v. State*, 66 S.W.3d 790 (Tenn. 2001), and *Atkins v. Virginia*, 536 U.S. 304 (2002). *Atkins* held that "The clinical definition of mental retardation requires not only subaverage intellectual functioning but also significant limitations in adaptive skills such as communication, self-care and self-direction that became manifest before age 18." *Atkins*, 536 U.S. at 318.[2] A three

[2] Manifestation before the age of 18 is an important factor as mental retardation (intellectual disability) is a static condition. *Hill v. Shoop*, 11 F.4th 373, 385-86 (6th Cir. 2021).

(3) day hearing on the issue was held in 2004, and multiple experts and lay witnesses testified. Mr. Black was found to be not retarded. That finding was sustained on appeal. *Black v. State*, 2005 WL 2662577, at *17 (Tenn. Crim. App. Oct. 19, 2005) ("Because Petitioner failed to prove that he is mentally retarded by a preponderance of the evidence, he is not excluded from the sentence of death.").

Mr. Black then raised the issue of mental retardation (intellectual disability) in federal court, where it was litigated and moved between the district court and the Sixth Circuit Court of Appeals several times over issues of interpretation and changes in terms related to the determination of the issue. In 2017, the federal court finally resolved the pending case, and Mr. Black was denied relief. *See Black v. Carpenter*, 866 F.3d 734 (6th Cir. 2017) (containing a complete history of the litigation, its multiple appeals, and factual determinations).

In 2021, Mr. Black filed still another claim, asserting he could avail himself of a recently amended Tennessee statute which allowed inmates who had never been able to raise an *Atkins* claim asserting intellectual disability (formerly, mental retardation) an opportunity to do so. Because Mr. Black had previously availed himself of the statute, his claim was denied. *Black v. State*, 2023 WL 3843397 (Tenn. Crim. App. June 6, 2023).

Now, Mr. Black asserts he is incompetent for his execution, which is scheduled for August 5, 2025. In accordance with the *Van Tran* timeline, Mr. Black filed on May 29, 2025, a Petition to Declare Byron Black Incompetent to be Executed (27 pages) and an accompanying memorandum (6 pages). The State responded on June 2, 2025, by filing an Opposition to Petition to Declare Bryon Black Incompetent to be Executed (11 pages). Mr. Black filed a Reply to the State's response on June 3, 2025 (12 pages).

Mr. Black's petition does not allege his incompetence under *Irick, supra, Panetti, supra,* and *Madison, supra.* It addresses itself entirely to a request for this Court to consider traditional common law standards, which, he contends, prohibit the execution of the "non compos mentis" and "idiots," and apply to Mr. Black. The only Eighth Amendment case cited in the petition is *Ford v. Wainwright*, 477 U.S. 399 (1986), for its discussion of sparing the "insane" from execution and its passing reference from Blackstone about sparing the "idiots and lunatics" from execution. *Id.* at 406-07. What the petition fails to mention is that *Ford's* "category of defendants defined by their mental state" as incompetent to be executed has been significantly clarified and refined by the much more specific incompetency standard set out in *Panetti* and *Madison.*[3] *See Madison*, 586 U.S. at 268-29.

According to the State's 11-page response, Mr. Black's petition should be summarily dismissed because the allegations "raise no doubt about his present competency[,]" and he has not met the required threshold showing his competency to be executed is genuinely in issue (Response at 1). The State emphasizes that Mr. Black's "own expert *confirms* his competency" (*id.*). Additionally, the State argues that Mr. Black's common law "idiocy" claim "presses novel theories," (*id.* at 7), which are both procedurally barred and previously determined. The State asserts, "Preclusion aside, this competency proceeding is simply not the proper forum for litigating Black's ineligibility for execution due to intellectual disability or idiocy" (Response at 9). The State quotes the Supreme Court's initial remand order from February 2020 and argues that "[t]he sole purpose of this proceeding is for [] the Court to make 'a determination of [Black's] present

[3] These subsequent cases adopted Justice Powell's concurring opinion in *Ford* and clarified the *Ford* Court's use of the vague term "insanity." *See Panetti*, 551 U.S. at 957.

competency, including the initial determination of whether he has met the required threshold showing'" (*id.*).

An examination of Mr. Black's petition for what it alleges and does not allege is required. It states in the introduction:

> This action is brought pursuant to *Van Tran v. State*, 6 S.W.3d 257 (Tenn. 1999), the Tennessee Supreme Court's March 3, 2025, Order remanding this matter to this Court for consideration of Mr. Black's claim under *Ford v. Wainwright*, 477 U.S. 399 (1986), and the Eighth and Fourteenth Amendments to the United States Constitution. At common law, the law prohibited the execution of the non compos mentis, which included "idiots." [footnote omitted] Because any punishment that was prohibited at the Founding remains unconstitutional, the execution of Mr. Black offends the deeply ingrained common law prohibition against the execution of individuals with severely limited mental capacities. This argument proceeds in three parts. It begins by describing the applicable common law principles related to the law regarding the non compos mentis. It then describes Mr. Black's myriad of conditions that severely limit his understanding, comprehension, memory, and ability to manage his own affairs. It concludes by demonstrating that, in light of these conditions, Mr. Black is non compos mentis and cannot be executed.

The first sentence of the above quote states it is brought pursuant to "the Tennessee Supreme Court's March 3, 2025, Order remanding this matter to this Court for consideration of Mr. Black's claim under *Ford v. Wainwright*, 477 U.S. 399 (1986), and the Eighth and Fourteenth Amendments to the United States Constitution" (Petition at 2). This assertion is incorrect. The remand order does <u>not</u> mention *Ford v. Wainwright*. As can be readily seen, *supra* at pp. 1-2, the remand order references *Van Tran*, *Irick*, and *Madison*.

The petition's conclusion and prayer for relief are as follows:

> VIII. Conclusion
>
> Mr. Black would be considered a "idiot" at common law. Ample evidence exists to support this conclusion and numerous expert reports document Mr. Black's low intellectual functioning, deficits in his ability to manage his affairs, poor memory, and brain damage. This evidence would be more than sufficient at common law to support a finding of "idiocy." Because "[t]here is now little room for doubt that the Eighth Amendment's ban on cruel and unusual punishment

embraces, at a minimum, those modes or acts of punishment that had been considered cruel and unusual at the time that the Bill of Rights was adopted[,]" Mr. Black is incompetent to be executed. *Ford*, 477 U.S. at 405.

IX. Prayer for Relief

Based on the foregoing, Petitioner Black's counsel respectfully request the following relief, as applicable:

1. Declare Byron Black incompetent to be executed under traditional common law standards prohibiting the execution of individuals with significantly limited intellectual abilities.

2. In the alternative, impanel a jury to determine whether Mr. Black's execution would violate common law prohibitions.

3. Hold that the State's 2022 stipulation and the doctrine of judicial estoppel bars the State from now disputing Mr. Black's intellectual functioning.[4]

4. In the alternative, should the Court find that no jury proceeding is necessary, Counsel for Mr. Black respectfully request that the Court holds an evidentiary hearing.

The petition, as per *Van Tran*, *supra*, identifies three experts who are available to testify on behalf of Mr. Black if a hearing is ordered: Dr. Martell, Dr. Baecht, and Dr. Gur. These three experts filed supporting reports as exhibits to the petition. Dr. Martell's report is based on his examination and testing of Mr. Black on April 28, 2025 (Exhibit 1 to Petition). Dr. Baecht's report is based on interviews with Mr. Black conducted on May 14, 15, and 21, 2025, consideration of medical and other records, and a collateral interview with Mr. Black's sister on May 20, 2025 (Exhibit 4 to Petition). Dr. Gur's report is based on his interpretations of MRI images and PET scans from 2022 (Exhibit 3 to Petition). The three experts filed reports dated May 27 or 28, 2025.

[4] The State is not bound by any stipulations, concessions, or other agreements made by the local district attorney general related to a request for collateral review. Tenn. Code Ann. § 40-30-114(c)(1).

The petition wholly fails to allege that Mr. Black lacks a rational understanding of his impending execution and the reason for it. Instead, the petition presents the novel argument that the common law prohibits the execution of the "non compos mentis" and "idiots." According to counsel for the Petitioner, "any punishment that was prohibited at the Founding remains unconstitutional" and Mr. Black's execution will "offend[] the deeply ingrained common law prohibition against the execution of individuals with severely limited mental capacities" (Petition at 2). This new argument was not presented to the Tennessee Supreme Court and is outside the scope of that Court's remand order. The petition does not direct this Court to any record where the alleged common law "idiot" claim was ever presented to the state supreme court for consideration or was to be addressed as part of the remand.

Again, the argument of Mr. Black's counsel proceeds in three parts:

> It begins by describing the applicable common law principles related to the law regarding the non compos mentis. It then describes Mr. Black's myriad of conditions that severely limit his understanding, comprehension, memory, and ability to manage his own affairs. It concludes by demonstrating that, in light of these conditions, Mr. Black is non compos mentis and cannot be executed.

(Petition at 2). This common law argument is supported by the recent report of Daniel A. Martell, Ph.D., ABPP, dated May 27, 2025, which concludes that Mr. Black meets the criteria for "non compos mentis" (Exhibit 1 to Petition at 12). Dr. Martell's report also reaffirms his prior opinion that Mr. Black is intellectually disabled (*id.* at 10; *see also* Exhibit 2 to Petition, Dr. Martell's report dated 8/25/2020; Exhibit 9 to Petition, Dr. Martell's supplemental report dated 12/13/2021). Of the six questions the Petitioner's counsel submitted to Dr. Martell, not one asks him to address the relevant standard of competency for execution (Exhibit 1 to Petition at 1-2). Instead, Dr. Martell was asked the following:

> 1. Based upon your most recent assessment of Mr. Black, do you continue to hold your opinion that Mr. Black is intellectually disabled? Please supply the basis for your opinion.
>
> 2. Please describe any changes in Mr. Black's condition since you previously assessed him 2019 and the basis for your conclusions.
>
> 3. Please describe any deficits that Mr. Black exhibits with respect to memory, linguistic fluency, and cognitive functioning.
>
> 4. Please describe your conclusions regarding Mr. Black's ability to manage his own affairs, with a particular focus on his ability to manage financial affairs and his ability to live independently.
>
> 5. At common law, an individual was categorically exempt from execution if he or she was found to be non compos mentis. Does Mr. Black meet the following criteria for being non compos mentis?
> a. An idiot is an individual who exhibits low intellectual functioning from nativity and who is incapable of managing his affairs.
> b. A person is non compos mentis if by reason of disease, accident, or other mental condition loses memory and understanding such that he is incapable of managing his own affairs.
>
> 6. Please describe the symptoms associated with profound intellectual disability. In your opinion, would such an individual be capable of planning and committing a homicide?

Exhibit 1 to Petition at 1-2. As a result, Dr. Martell never opines on the *Irick* and *Madison* standard for competency to be executed, and he was never asked to do so.

In important contrast, the Petitioner's expert, Lea Ann Preston Baecht, Ph.D., ABPP, states that she was hired "for a mental health evaluation to assess his [Mr. Black's] competency to be executed" (Exhibit 4 to Petition at 1). Dr. Baecht found Mr. Black to be competent. She met with Mr. Black three separate times in May of this year for a total of 7.5 hours to evaluate his competency for execution. Several passages of her report are relevant to the issue before this Court:

> When asked if he had been assigned an execution date, Mr. Black correctly stated, "August 5." When asked what would happen on that date, he stated, "I will be put to death." When asked how, he stated, "some kind of protocol." When asked about his views on death, he shared that he has faith, adding, "I know I am a child

of God. I know that for a fact." He stated that he hoped that he would go to heaven after his death. When asked why the state intended to execute him on August 5, he stated, "Because they think I committed murder." When asked, he correctly stated he was given the death sentence for the murder of the youngest victim.

* * *

Consistent with his statements during our first clinical interaction, during our second interview, Mr. Black correctly recalled that he is scheduled to be executed on August 5 and that he was sentenced to death for the murder of Lakeisha. When asked about the potential methods of execution, he stated, "the protocol." However, he stated he was not certain what the protocol is, adding, "I just hear people talking about it." He was aware that there was debate regarding the use of the protocol, adding that he had seen pictures of the last person executed, and "He turned blue and purple. The protocol didn't kill him. He suffered a lot." When asked if there was another potential method of execution in Tennessee, he correctly stated, "the electric chair, I think." He indicated he had not thought about which option he would choose.

During our third clinical interaction, Mr. Black again correctly recalled that he had been convicted of murdering Angela Clay and her two daughters, Latoya and Lakeisha. He also correctly stated that he was scheduled to be executed on August 5, for the murder of Lakeisha. He correctly listed the two potential methods of execution in Tennessee as the electric chair and the "protocol," which he described as being "a liquid substance" that is "injected."

* * *

OPINION REGARDING COMPETENCY TO BE EXECUTED

It is my understanding that *Van Tran v. State* (1999) held that under Tennessee law, a prisoner is "not competent to be executed if the prisoner lacks the mental capacity to understand the fact of the impending execution and the reason for it." There have also been three Supreme Court opinions that address the standard for competency to be executed (*Ford v. Wainwright* (1986), *Panetti v. Quarterman* (2007), and *Madison v. Alabama* (2019)). In *Ford v. Wainwright* (1986), the Court held that at a minimum, defendants must "know the fact[s] of their impending execution and the reason for it." In *Panetti v. Quarterman* (2007), the Court noted, "A prisoner's awareness of the State's rationale for an execution is not the same as a rational understanding of it." It further held "gross delusions stemming from a severe mental disorder may put an awareness of a link between a crime and its punishment in a context so far removed from reality that the punishment can serve no proper purpose." Additionally, the Court noted that if these delusions influence "the prisoner's concept of reality [so] that he cannot reach a rational understanding of the reason for the execution," then they preclude execution. In *Madison v.*

> *Alabama* (2019), the Court held that "The Eighth Amendment may prohibit the execution of a prisoner who does not suffer from delusions if the prisoner's memory loss interacts with other mental shortfalls so that the prisoner does not have a rational understanding of why the state is exacting the death penalty." The Court further opined that it was not necessary for the prisoner to recall committing the crime, "because a person lacking such a memory may still be able to form a rational understanding of the reasons for his death sentence." The Court explained, "Memory loss still may factor into the 'rational understanding' analysis that *Panetti* demands. If that loss combines and interacts with other mental shortfalls to deprive a person of the capacity to comprehend why the State is exacting death as punishment, then the *Panetti* standard will be satisfied. That may be so when a person has difficulty preserving any memories, so that even newly gained knowledge (about, say, the crime and punishment) will be quickly forgotten. Or it may be so when cognitive deficits prevent the acquisition of such knowledge at all, so that memory gaps go forever uncompensated."
>
> With a strict interpretation of the standard set forth in the aforementioned cases, Mr. Black likely meets this low bar for competency to be executed. That is, Mr. Black understands that he is scheduled to be executed on August 5, 2025, and he recognizes that death is permanent. Mr. Black also understands that the reason the state seeks to execute him is because it is believed that he murdered Lakeisha Clay.

(Exhibit 4 to Petition at 11-12).

Dr. Baecht was correct in her understanding of the law and the "low bar for competency to be executed" (*id.* at 12). Her opinion is right on point. She is an expert witness whose report was filed by Mr. Black's counsel. Her qualifications and experience are excellent, as detailed in her report.

This Court acknowledges that Mr. Black's mental as well as physical health has deteriorated in the last several years. This Court does not ignore that fact. However, Dr. Baecht found Mr. Black is competent to be executed under the controlling standard. She found Mr. Black is not psychotic or delusional, and he is free of manic symptoms, but he suffers from confabulation (*i.e.*, memory errors he believes to be accurate). Even assuming he is intellectually disabled, as Dr.

Baecht has found, she also recognized that finding does not make him incompetent to be executed.[5] It bears repeating that, whether it is cognitive decline, moderate dementia, or other mental impairment, those conditions do not bar execution as long as Mr. Black has the ability to rationally understand why the state seeks to execute him. *See Madison*, 586 U.S. at 278-79.

The only other contemporary evidence of Mr. Black's mental state is a report from Dr. Ruben C. Gur, dated May 28, 2025. In the report, Dr. Gur interprets brain imaging and scans of Mr. Black, which were conducted in 2022. According to Dr. Gur, the imaging shows brain dysfunction that *may* impair Mr. Black's ability to reason and integrate information (Exhibit 3 to Petition at 5). Dr. Gur explains the abnormalities in Mr. Black's "brain structure encompass brain systems that are important for regulating emotion and behavior, as well as learning from past experiences and recalling complex past events" (*id.*). Dr. Gur does not connect his interpretation of the brain imaging to Mr. Black's competency nor opine on Mr. Black's ability to rationally understand his impending execution and the reason for it.

Most of the documents attached as exhibits to the petition relate to the previously determined claim that Mr. Black is intellectually disabled. As discussed, the new expert reports filed as exhibits to the petition are:

1. Exhibit 1: Daniel A. Martell, Ph.D., ABPP, report dated May 27, 2025 – finding Mr. Black meets the criteria for "non compos mentis"

2. Exhibit 3: Ruben C. Gur, Ph.D., report dated May 28, 2025 – structural neuroimaging findings show brain dysfunction that may impair Mr. Black's ability to integrate information and base decisions on intact reasoning and appreciation of situation-specific contingencies

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[5] While this Court declines to wade into the asserted common law claim of "idiocy," *see supra* at 10, and *infra* at 16, it would be hard to reconcile Dr. Baecht's detailed factual report of conversations with Mr. Black, as well as her recitation of his history, with Justice O'Connor's description of "idiocy" in *Penry v. Lynaugh*, 492 U.S. 302, 332-34 (1989).

3. Exhibit 4: Lea Ann Preston Baecht, Ph.D., ABPP, report dated May 28, 2025 – finding Mr. Black understands he is scheduled to be executed on August 5, 2025, for the murder of Lakeisha Clay

There are many additional exhibits dating back many years, most, if not all, of which contain evaluations entered as exhibits or testimony in prior court hearings where Mr. Black did not prevail. These exhibits simply reassert evidence from those previous cases. To the extent the older exhibits even address the issue of competency, they do not opine on Mr. Black's competency *for execution*. Some address Mr. Black's competency to *stand trial*, which is a different standard than competency to be executed. As discussed previously, Mr. Black's competency to stand trial was fully litigated before his trial. He was found competent, and this was affirmed on appeal. *Black*, 815 S.W.2d at 173-75.

The competency for execution standard is distinguished from competency to stand trial, intellectual disability, and even the "idiocy" alleged in the current petition. The petition does not assert that Mr. Black fails to meet the competency standard for execution. Nor does it argue that Mr. Black's alleged intellectual disability, "idiocy," or any other mental infirmity in isolation or combination, renders him incompetent for execution under the standards set out in *Irick*, *supra*, *Panetti*, *supra*, and *Madison*, *supra*.

Decision

Mr. Black's own expert witness, Dr. Baecht, reports that he is competent to be executed under *Panetti*, *supra*, and *Madison*, *supra*. The petition does not allege that Mr. Black fails to meet the relevant standard for competency to be executed. Nor does the petition argue that Mr. Black's alleged intellectual disability, "idiocy," or any other alleged mental infirmity in isolation or combination render him incompetent for execution under *Irick*, *Panetti*, and *Madison*.

For the reasons expressed above, this Court finds that the petition and the filed records fail to meet the threshold showing that he is presently incompetent to be executed. This Court finds that there is no genuine disputed issue regarding the present competency of Mr. Black under the above-cited controlling precedent. As a result, no evidentiary hearing is needed, nor will one be ordered.

Secondly, this Court declines to consider the allegation of "idiocy" under the asserted common law claim set out in the petition for want of jurisdiction. This Court's jurisdiction over this matter is governed by the remand order. This Court is of the opinion that the Supreme Court of Tennessee contemplated no such common law claim in its remand order. The Supreme Court specifically referenced *Irick* and *Madison*, and there is no indication in the record that this additional common law claim was known or would be asserted when the remand order was entered. If this Court is mistaken in its judgment as to the scope of the remand, it is prepared to proceed further, well before the execution date.

IT IS SO ORDERED, this 5th day of June 2025.

s/WALTER C. KURTZ
Walter C. Kurtz
Criminal Court Judge
By Designation of the Tennessee Supreme Court

cc: Mr. Raymond J. Lepone, Mr. G. Kirby May, Mr. Alan Groves
Office of the Tennessee Attorney General
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Perelman SCHOOL OF MEDICINE
UNIVERSITY of PENNSYLVANIA

Ruben C. Gur, PhD
Professor, Departments of Psychiatry, Radiology & Neurology
Director, Brain Behavior Laboratory & the Neuroimaging & Cognitive Core

PATIENT NAME:	BYRON BLACK
DATE OF BIRTH:	03/23/1956
DATE OF IMAGING:	MRI: 05/10/2022 PET: 05/10/2022
DATE OF REPORT:	05/28/2025
INTEGRATION BY:	Ruben C. Gur, PhD; Jack C. Lennon, MA
REFERRED BY:	Amy Harwell, Esq.

Background

Mr. Black is a 69-year-old male who was referred for quantitative analysis of structural and functional neuroimaging data, specifically structural magnetic resonance imaging (sMRI) and positron emission tomography (PET). Other medical, psychological, and legal records were not available for review and, therefore, do not inform the present evaluation.

Results of Magnetic Resonance Imaging (MRI): Volumetric Structural Analysis

MR images were analyzed using FreeSurfer (v7.4.0; https://surfer.nmr.mgh.harvard.edu/), an open-source software platform for processing and analyzing (human) brain MRI. A clinical read dated 05/11/2022 was provided by Dr. M. Erik Landman of Vanderbilt University Medical Center indicating "No acute intracranial findings. Mild presumed chronic white matter small vessel ischemic changes."

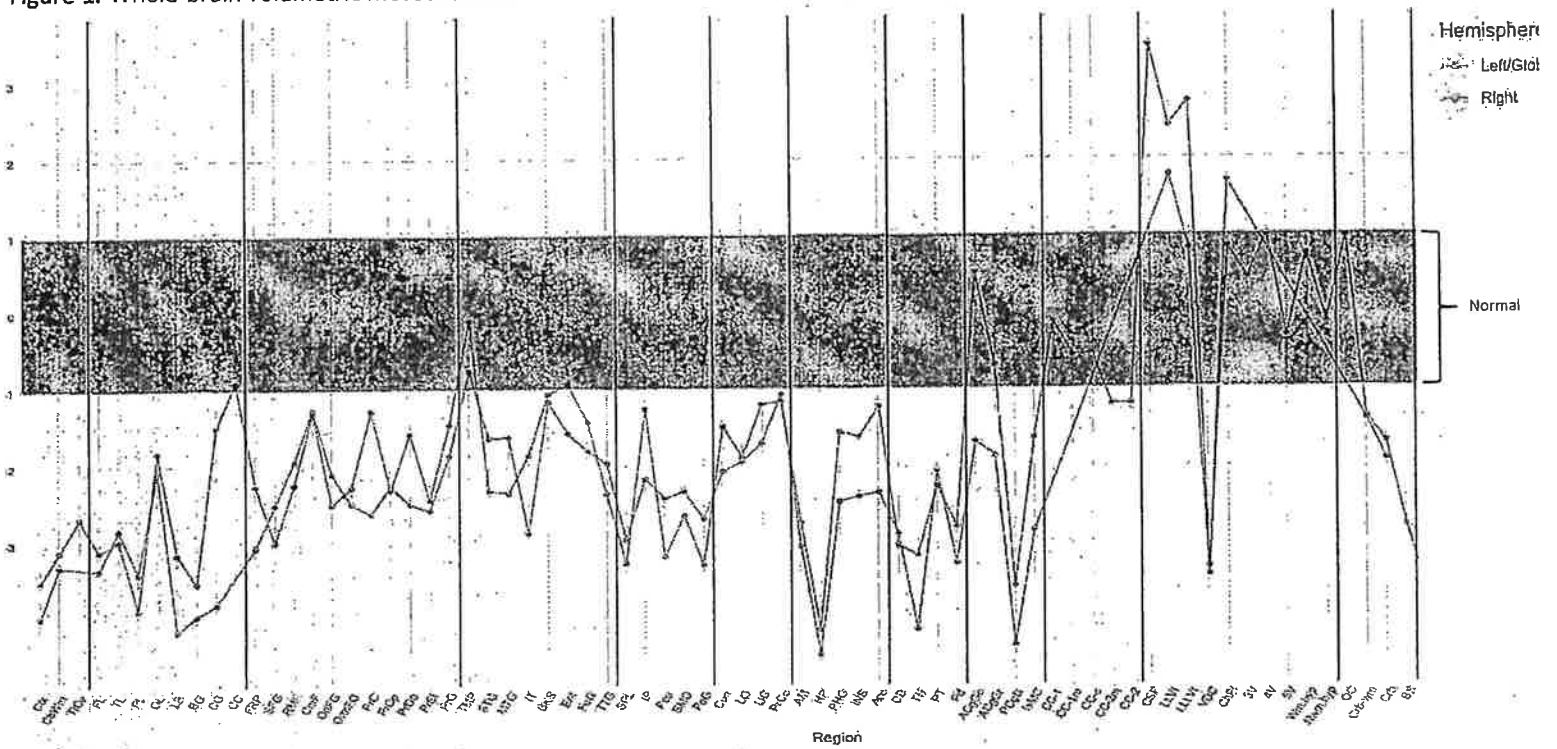
Mr. Black demonstrated total cortical volume that is 3.49 standard deviations below normal, with total gray matter volume ($z = -3.97$), subcortical gray matter ($z = -4.17$), and overall segmented brain tissue volume ($z = -4.03$) also markedly reduced. Total intracranial volume is significantly below normal ($z = -2.68$). Cortical atrophy is also present in parietal and occipital areas (e.g., precuneus $z = -3.18$ left; cuneus $z = -1.49$ left), with involvement of posterior medial structures that support visual-spatial awareness and memory retrieval. The right hemisphere generally exhibits greater atrophy, particularly in limbic and medial structures, while the left hemisphere shows a broader pattern of volume reduction across cortical regions. Volume reductions are especially severe in bilateral limbic and medial temporal regions. Specifically, bilateral hippocampal volume is profoundly reduced ($z = -4.13$ left, -4.45 right), along with the thalamus ($z = -4.14$ right), posterior cingulate cortex ($z = -4.34$ right), and several other subcortical hubs critical to cognition and emotional regulation. This pattern of widespread structural loss suggests global brain atrophy. Correspondingly, ventricular volumes are elevated, with enlargement of the inferior lateral ventricle ($z = +2.73$ left), lateral ventricles ($z = 2.42$ left, 1.77 right), and cerebrospinal fluid (CSF) volume overall ($z = 3.46$). These findings are consistent with loss of parenchymal brain tissue and potential compensatory expansion of fluid-filled spaces.

These widespread reductions in cortical and subcortical volumes are likely to impair Mr. Black's ability to regulate behavior, integrate emotional and cognitive input, and reason effectively. The extensive damage to hippocampal and thalamic structures, together with posterior cingulate hypotrophy, strongly suggests memory impairment, difficulty with orientation, and compromised ability to learn from prior experience. Parietal lobe damage, especially in precuneus, portend difficulties in the integration of multimodal information and the sense of self-agency. Deficits in these brain regions thus increase vulnerability to confusion, suggestibility, and confabulation – wherein memory gaps may be unintentionally filled with inaccurate information.

Collectively, structural MRI findings in Mr. Black indicate profound and widespread volume loss. The degree of hypotrophy observed is well beyond the expected range for healthy male controls, and functional consequences are expected across cognitive, emotional, and social domains.

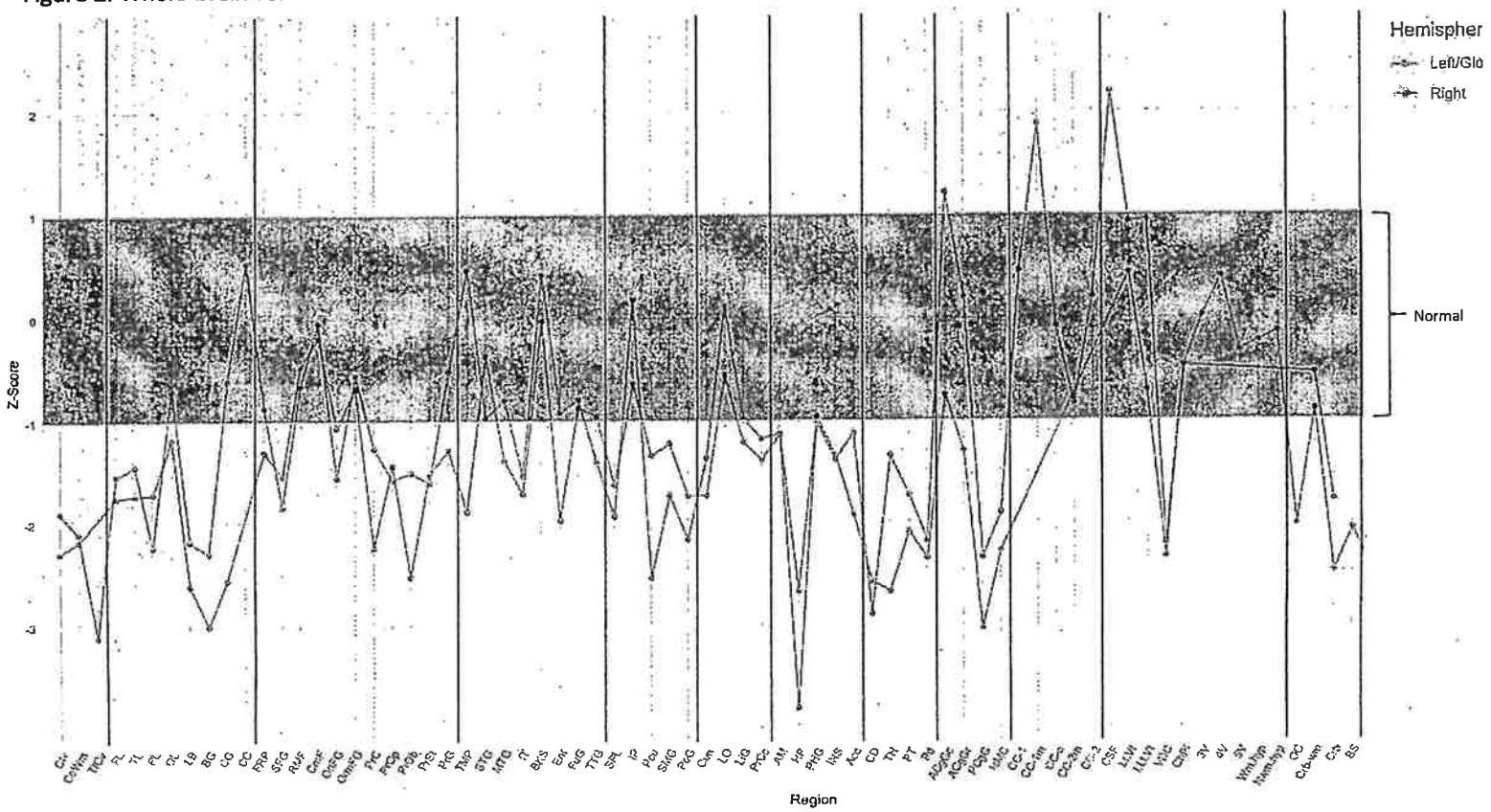
EXHIBIT 3

Figure 1. Whole-brain volumetric measurements of Mr. Black's 2022 structural MRI scan.



Results are expressed as Z-scores relative to a comparison group of healthy males over 30 years of age.
Ctx = Cortex Volume, CbWm = Cerebral White Matter Volume, TICv = Estimated Total IntraCranial Volume,
FL=Frontal Lobe, TL=Temporal Lobe, PL=Parietal Lobe, OL=Occipital Lobe, LB=Limbic Area, BG=Basal Ganglia, CG=Cingulate, CC=Corpus Callosum, FRP= Frontal Pole, SFG = Superiorfrontal,
RMF = Rostralmiddlefrontal, CmF= Caudalmiddlefrontal, OrlFG= Lateralorbitofrontal, OrmFG= Medialorbitofrontal, PrC =Paracentral, PrOp =Parsopercularis, PrOb =parsorbitalis,
PrSt = Parstriangularis, PrG = Precentral, TMP = Temporal Pole, STG = Superiortemporal, MTG = Middletemporal, IT = Inferiortemporal, BKS = Bankssts, Ent = Entorhinal,
FuG = Fusiform, TTG = Transversetemporal, SPL = Superiorparietal, IP = Inferiorparietal, Pcu = Precuneus, SMG = Supramarginal, PoG = Postcentral, Cun = Cuneus, LO = Lateraloccipital,
LiG = Lingual, PrCc = Pericalcarine, AM = Amygdala, HP = Hippocampus, PHG = Parahippocampal, INS = Insula, Acc = Accumbens Area, CD = Caudate, TH = Thalamus, PT = Putamen,
Pd = Pallidum, ACgGc = Caudalanteriorcingulate, ACgGr = Rostralanteriorcingulate, PCgG = Posteriorcingulate, IsMC = Isthmuscingulate, CC-1 = Corpus Callosum Anterior,
CC-1m = Corpus Callosum Mid Anterior, CC-c = Corpus Callosum Central, CC-2m = Corpus Callosum Mid Posterior, CC-2 = Corpus Callosum Posterior, CSF = Cerebral Spinal Fluid,
Lt.Vt = Lateral Ventricle, Lt.Lt.Vt = Inferior Lateral Ventricle, VDC = VentralDC, ChPl = Choroid Plexus, 3V = 3rd Ventricle, 4V = 4th Ventricle, 5V = 5th Ventricle,
Wm.hyp = White Matter Hypointensities, Nwm.hyp = Non White Matter Hypointensities, OC = Optic-Chiasm, Crb-wm = Cerebellum White Matter, Crb = Cerebellum Cortex, BS = Brain Stem

Figure 2. Whole-brain volumetric measurements of Mr. Black's 2001 structural MRI scan.



Comparison of Volumetric Data Across 2001 and 2022

Between 2001 and 2022, several brain regions exhibited marked volumetric changes. Notably, the volume of both cortex and white matter are now below 3 SDs lower than the normative sample, and several cortical and subcortical regions showed clear evidence of further atrophy. Correspondingly, there were substantial increases in cerebrospinal fluid-associated structures, including the optic chiasm (+135.8%), right inferior lateral ventricle (+133.5%), right choroid plexus (+113.1%), and white matter hypointensities (+93.3%), indicating ventricular expansion. In addition, the mid-anterior segment of the corpus callosum declined by −45.8%, the anterior cingulate cortex dropped by −42.5%, and the right rostral anterior cingulate shrank by −41.2%. Additional reductions were seen in the left inferior parietal lobe (−32.5%) and the frontal pole (−30.3%). These changes reflect measurable regional atrophy despite consistent comparison standards across both time points, suggesting the possibility of a neurodegenerative process or other accelerated decline not sufficiently explained by normal aging. Also evident is structural expansion in fluid-filled and periventricular regions, as when tissue dies, it is replaced by fluid.

Results of Positron Emission Tomography (PET)

The PET study from 05/10/2022 examined the regional distribution of cerebral metabolic rates for glucose (CMRgl) using 18^{F}-fluoro-d-2-deoxyglucose (FDG). Dr. Jacob Dubroff reported that "the technique described in the corresponding report appears standard of care and in line with most recent guidelines.[1]" The PET study was subjected to a quantitative analysis using a standard regions of interest (ROI) approach. Dr. Dubroff conducted this analysis with MIMneuro™ (v. 7.3.4), a proprietary software product developed and distributed by MIM Software, Inc. (https://www.mimsoftware.com/about/MIM).

Dr. Dubroff continued, "In reviewing the images, they are of acceptable quality without significant artifact. Using MIMneuro™ version 7.3.4 and the high-resolution, unenhanced T1 sequence with isotropic voxels from brain MRI obtained on 05/10/2022, studies were co-registered and analyzed.[2, 3] The images show decreased radiotracer distribution throughout the cingulate gyrus" **(Figure 3)**

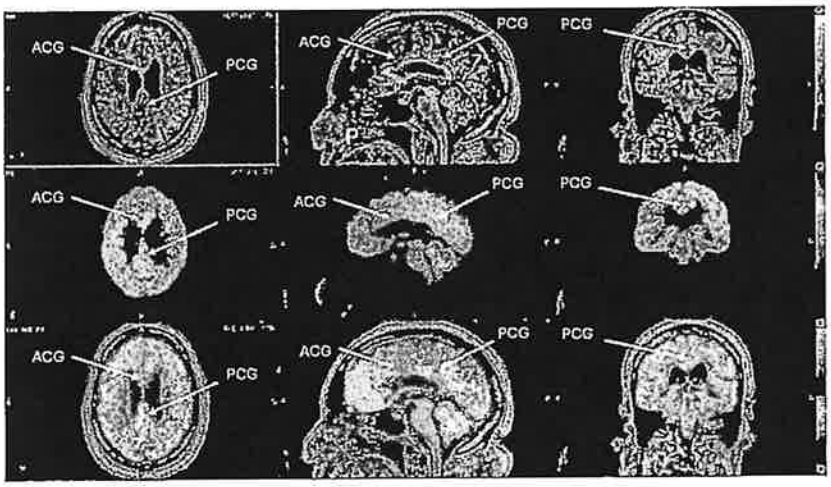


Figure 3. Figure shows decreased glucose metabolism in the cingulate gyrus including the anterior (ACG) and posterior (PCG) portions. [18F]FDG-PET brain and MRI T1 sequence were co-registered. MRI T1 sequence images (top row) and PET images (middle row) were co-registered into fused PET/MRI images (bottom row). Arrows identify the "ACG" and "PCG" in the transaxial (first column), sagittal (2nd column), and coronal (3rd column) planes. PET images are shown using a rainbow color scale. Scale bar on the right depicts relative metabolism (red=higher, violet=lower). MRI images are shown in gray scale. (Dr. Jacob Dubroff, 04/25/2025).

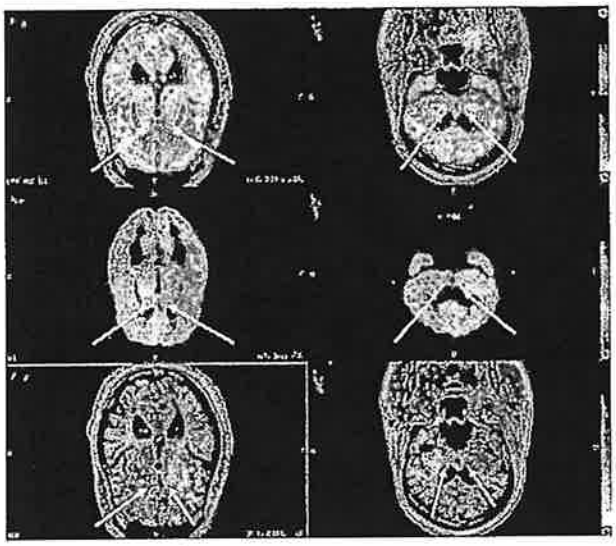


Figure 4. Figure shows location of the bilateral caudate (white arrows) which quantitative analysis demonstrated bilateral hypometabolism, decreased glucose metabolism. [18F]FDG-PET brain and MRI T1 sequence were co-registered. MRI T1 sequence images (top row) and PET images (middle row) were co-registered into fused PET/MRI images (bottom row). Arrows identify the right and left caudate in the transaxial (first column) and coronal (2nd column) planes. PET images are shown using a rainbow color scale. Scale bar on the right depicts relative metabolism (red=higher, violet=lower). MRI images are show in gray scale. (Dr. Jacob Dubroff, 04/25/2025).

In conclusion, Dr. Dubroff reported "both qualitative and quantitative examination of this [^{18}F]FDG-PET brain imaging study demonstrate abnormally depressed glucose metabolism in the cingulate gyrus. Quantitative analysis reveals hypometabolism of the bilateral caudate **(Figure 4)**. These findings are not specific for a particular condition. While cingulate hypometabolism can be observed in the setting of neurodegenerative disorders and dementia such as Alzheimer's disease [2-4], the absence of involvement of other typical locations like the temporal or parietal lobes argues against such an etiology. Cingulate gyrus hypometabolism, however, has been observed in the setting of traumatic brain injury [5-7]. More specifically, two of the references implicate diffuse axonal injury[5,6]. Diffuse axonal injury is characterized by widespread damage to axons, long projections of nerve cells that conduct signals,

throughout the brain usually caused by a rapid decelerating injury such as during automobile accidents – it was first described in boxers[8]. [^{18}F]FDG-PET brain demonstrating hypometabolism of the caudate is also an indeterminate finding; it has been observed in different movement disorders such as Parkinson's disease and multiple system atrophy (MSA) [9,10]. Animal models of traumatic brain injury measuring brain glucose metabolism with [^{18}F]FDG-PET have identified decrease in the caudate[11,12]. Lombardi et al. found those traumatic brain injury patients with more preservative responses, inappropriately repetitive despite the absence of a stimulus, to a frontal lobe behavioral task demonstrated greater caudate hypometabolism using [^{18}F]FDG-PET brain imaging[13]. No regions of qualitatively increase brain glucose metabolism were identified. Increased metabolism in the bilateral superior parietal lobule is favored to reflect a normal variant and not consistently observed during a particular brain injury or condition. Three-dimensional display of brain regions with decreased glucose metabolism can be found in **Figure 5** and results of the above analysis of CMRgl relative to whole brain are plotted in **Figure 6** for all regions sampled (Left hemisphere in red, Right hemisphere in turquoise). Graphical visualizations of statistical results for the MRI and PET studies were conducted with R (v4.4.1), a programming language for statistical computing and graphics, and RStudio Desktop (v2024.09.0+375), an integrated development environment for R.

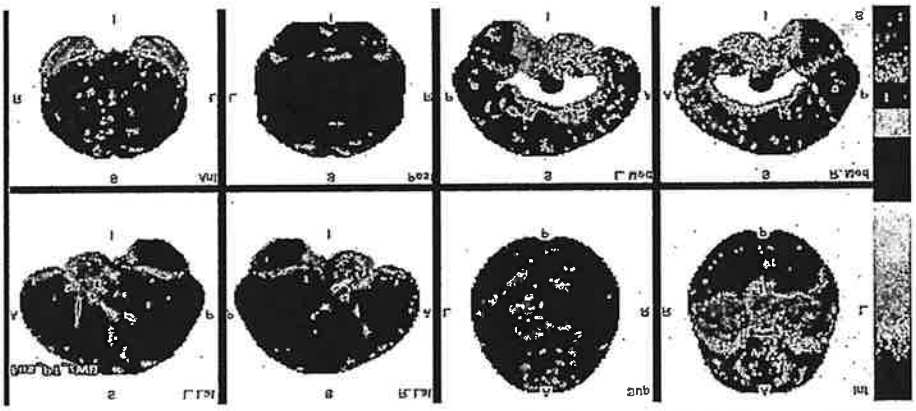
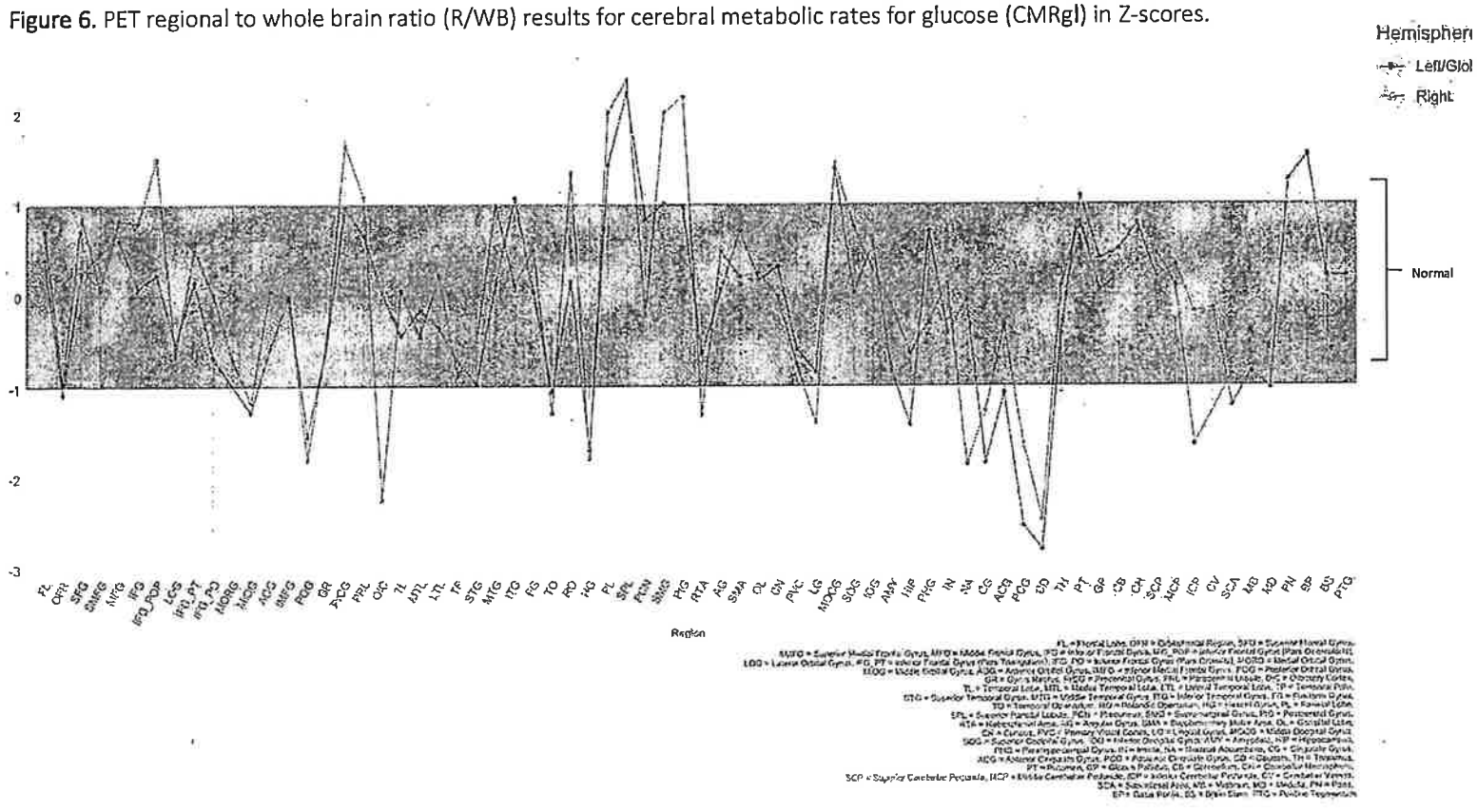


Figure 5. Figure illustrates a 3-dimensional display of brain regions with decreased glucose metabolism determined by Z-scores (color) overlaid onto the corresponding MRI T1 sequence (gray scale). The color bar (right) indicates Z-score: teal=1.5 to 2.25, navy blue=2.25 to 3, and purple > 3. (Dr. Jacob Dubroff, 04/25/2025).

As can be seen in **Figure 6**, consistent with Dr. Dubroff's report, there was bilaterally reduced metabolism in the cingulate gyrus and caudate. The evaluation also showed regions of hyper-metabolism (>2 SDs above normal) in the bilateral parietal lobe, particularly superiorly, as well as right-sided hypermetabolism within the supramarginal gyrus and postcentral gyrus.

Figure 6. PET regional to whole brain ratio (R/WB) results for cerebral metabolic rates for glucose (CMRgl) in Z-scores.



Summary and Conclusions

Results of the structural neuroimaging findings show brain dysfunction that may impair Mr. Black's ability to integrate information and base decisions on intact reasoning and appreciation of situation-specific contingencies. He likely experiences cognitive deficits, particularly in the context of executive and memory functions, multimodal integration of sensory information, as well as deficits in emotional regulation and motivation. The structural neuroimaging data show significant hypotrophy across frontal, temporal, parietal, and occipital lobes, some extend up to nearly 4SDs below the expected range. The PET findings likewise show marked variability among regions, with several key regions showing abnormal metabolic activity. Specifically, the cingulate gyrus and caudate are notable concerns, which are functionally interconnected through shared roles in emotion, cognition, motor behavior, and motivation. Notably, the PET scan was performed during a "default-mode" state, namely Mr. Black was not facing a task. Current theory is that regions hyperactivated in this state will become hypoactivated and, conversely, hypoactivated regions will become hyperactivated when the individual is challenged. By that theory, when individuals with this configuration of default mode activity are faced with a challenge, their emotional brain (hippocampus, insula, cingulate) and more primitive basal ganglia will become hyperactive while their 'thinking executive brain' (parietal cortex) will be 'shutting down.' [14-16]

These abnormalities in brain structure encompass brain systems that are important for regulating emotion and behavior, as well as learning from past experiences and recalling complex past events. Individuals with such abnormalities may face difficulties using normative means for regulating behavior and resisting impulses to act on motivations, especially situations with high perceived threat or reward. For instance, Mr. Black may behave impulsively even if such behaviors result in negative consequences, as motivation for reward may be too great to suppress by the faulty parietal cortex integration system and frontal lobe control. These behaviors could include those related to substance use, poor financial decisions, hypersexuality, overeating, or other behaviors that convert reward motivation into action. This could also be related to increased suggestibility and poor decision-making under situations of high stress.

The etiology of these abnormalities is difficult to determine and requires clinical evaluation and integration with history. However, the lower overall brain volume is likely a result of combined genetic and environmental factors and could indicate a neurodevelopmental disorder due to largely symmetrical findings. Within this background, hypotrophy of several limbic regions could suggest PTSD or other mood or trauma-related disorder. Traumatic brain injury is also consistent with several findings of structural and functional abnormalities, such as decreased metabolism in the cingulate gyrus and signs of diffuse axonal injury. Given the changes over the past two decades, several findings may also suggest a neurodegenerative process, such as Alzheimer's disease or Parkinson's disease.

Thank you for the opportunity to participate in Mr. Black's evaluation. The opinions I express with regard to the neuroimaging findings meet standards of scientific certainty. Please let me know if you have questions or need further elaboration or analysis.

Sincerely,

Ruben C. Gur, PhD

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BY ELECTRONIC MAIL

August 25, 2020

Kelley J. Henry
Supervisory Asst. Federal Public Defender
810 Broadway, Suite 200
Nashville, TN 37203

RE: Byron Black Examination

Dear Ms. Henry,

I am writing to share the findings and opinions from my examination and testing of Mr. Black, and review of the case materials you have provided pursuant to the above captioned matter.

Referral Question

You have asked that I examine and test Mr. Black in order to provide the Court with opinions regarding whether he meets the diagnostic criteria for Intellectual Disability pursuant to *Atkins v. Virginia*.

Summary of Opinions

Based on my examination, interviews, and review of the materials that I have been provided, I have reached the following opinions to a reasonable degree of psychological certainty:

(1) Mr. Black has significantly subaverage intellectual functioning based on valid, objective test scores that fall within the range of Intellectual Disability.

(2) Mr. Black exhibits significant deficits or impairments in all three domains of adaptive functioning (Conceptual, Social and Practical) at the level of "Mild" to "Moderate" severity.

(3) Mr. Black's intellectual and adaptive deficits originated in the developmental period.

(4) Mr. Black meets all of the criteria for Intellectual Disability pursuant to *Atkins v. Virginia*.

Qualifications of Examiner

I was an expert witness for the Government in *Atkins v. Virginia*, and I have since consulted on dozens of *Atkins*-related cases for both prosecutors and defense attorneys throughout the country.

I received a Bachelor's Degree in psychology with honors from Washington and Jefferson College (1980), a Master's Degree in psychology from the University of Virginia (1985), and a Ph.D. in clinical psychology from the University of Virginia (1989). I completed my clinical psychology internship specializing in forensic psychology at New York University Medical Center, Bellevue Hospital, and Kirby Forensic Psychiatric Center in New York City (1986-1987), and was awarded a Post-Doctoral Fellowship in Forensic Psychology, also at New York University Medical Center, Bellevue Hospital, and Kirby Forensic Psychiatric Center during which I specialized in forensic neuropsychology (1987-1988).

I am Board Certified in Forensic Psychology by the American Board of Forensic Psychology of the American Board of Professional Psychology, Diplomate Number 5620. I am a Fellow of the American Academy of Forensic Psychology; a Fellow and Past-President of the American Academy of Forensic Sciences; and a Fellow of the National Academy of Neuropsychology. I am licensed as a clinical psychologist by the State of California, License Number PSY15694.

I am also licensed as a clinical psychologist by the State of New York, License Number 011106.

I am currently an Assistant Clinical Professor of Psychiatry and Biobehavioral Sciences at the Semel Institute for Neuroscience and Human Behavior and the Resnick Neuropsychiatric Hospital of the David Geffen School of Medicine at UCLA. From 1992 to 1996 I was a Clinical Assistant Professor in the Department of Psychiatry at New York University School of Medicine.

I have authored over 100 publications and presentations at professional meetings, with a research emphasis on forensic issues involving forensic neuropsychological assessment, mental disorders, brain damage, intellectual disability, elder capacities, and violent criminal behavior.

I have been admitted to testify as an expert witness in more than two hundred cases, including testimony in both criminal and civil matters in federal and state courts throughout the United States. I have consulted and testified for both prosecutors and defense attorneys in criminal cases, as well as plaintiffs and defense attorneys in civil matters.

Basis for Opinions

Scope of Examination and Informed Consent

I personally examined Mr. Black December 10 and 11, 2019 in a quiet, private room at the Riverbend Correctional Institution for a total of approximately seven (7) hours. Comfort breaks were taken as needed.

He was advised that I had been retained by your office, of the limits on confidentiality in this forensic context, and of the lack of any treating relationship between us. Mr. Black was able to provide his informed consent to participate with this understanding.

Materials Reviewed

I have reviewed the following background materials provided by your office:

- Deposition of Dr. Gur 03/19/2004
- Quantitative Structural Brain Imaging Consultation Draft 03/17/2004
- Declaration of Dr. Gur 11/15/2001
- Quantitative Functional Brain Imaging Consultation Draft 02/29/2004
- Report of Dr. Pamela Auble
- Report of Dr. Patti VanEys
- Report of Dr. Gillian Blair
- Report of Dr. Kenneth Anchor

- Declaration Of Marc Tasse
- Declaration of Stephen Greenspan
- Declaration of Daniel Grant, 11/16/2001
- Affidavit of Dr. Dan Grant
- Dr. Albert Globus 11/14/2001
- Declaration of Ross Alderman
- Declaration of Connie Westfall
- Declaration of Rossi Turner
- Declaration of Freda Black Whitney
- Declaration of Melba Black Corley
- RMSI Records
- VUMC Records-Byron
- Height and Weight Chart
- VUMC Brain imaging studies

Tests and Procedures Administered

During my examination I administered a battery of intellectual and neuropsychological tests and procedures including:

- Behavioral Observations and Mental Status Examination
- Structured Neuropsychological Interview
- Rey's 15 Items
- Test of Memory Malingering
- ACS Word Choice Malingering Test
- Wechsler Adult Intelligence Scale-IV
- Wechsler Memory Scale-IV
- California Verbal Learning Test-II
- Wide Range Achievement Test-IV
- Trail Making Test, Parts A and B
- Boston Naming Test
- Tests of Verbal Fluency (F-A-S and Animal Naming Test)
- d2 Test of Attention
- Delis-Kaplan Executive Function System
  - Color-Word Interference Test
- Wisconsin Card Sort
- Halstead Categories Test
- Luria's Tests of Graphomotor Sequencing and Inhibition
- Luria's Tests of Motor Sequencing and Control
- Hooper Visual Organization Test
- Line Bi-Section Test
- Adaptive Functioning History and Clinical Interview

Background Information

Mr. Black's case, background, and family history have been extensively discussed elsewhere in the case materials, and will not be reiterated in detail here. Rather, information provided by him and others relevant to a determination of his intellectual and adaptive functioning will be presented below.

Examination Findings

Behavioral Observations and Mental Status Examination

Byron Black is a 63-year-old African American man who presented for testing dressed in a gray sweatshirt under light yellow, prison-issued scrubs. He was rolled into the examination room sitting on a small desk chair as he can only walk very short distances. He had short wavy hair that was combed back, and a mustache although he was otherwise was clean-shaven. He wore glasses.

Upon my first meeting him and throughout both days of the examination he had a very outgoing and overly-familiar way of interacting with me that was indicative of disinhibited social judgment. However, he was very cooperative and effortful throughout the examination and testing.

He was well oriented to the world around him, knowing who he was, where he was, and the approximate date and time.

His speech was produced at a normal rate and volume with clear articulation and a normal quantity of output.

His thoughts were expressed in a coherent and logical fashion, although he had a tendency randomly to go into tangential details unrelated to the topic at hand. This is a problem with self-monitoring and goal-directed thinking known as tangentiality.

Emotionally his observable affect was constricted in range and intensity and this presentation remains stable over both days of examination and testing. His underlying mood was inferred to be euthymic. His insight was fair.

He described his appetite as, "pretty good," but he said that his weight goes, "up and down," as a consequence of his diabetes. He also described his sleep as, "pretty good." He stated that he gets along with no changes in his interpersonal relationships or activities recently.

When asked how he's been doing emotionally he reported, "I guess OK." He then stated that he has health concerns that trouble him, as he has a painful broken hip that cannot be repaired due to his heart condition.

Mr. Black has a complicated history of serious medical problems, including prostate cancer surgery with complications due to accidentally cutting into his bladder, diabetes, congestive heart failure, hypertension, and a degenerative bone disease that has caused him to break his right hip.

He is unable to undergo surgery to repair his broken hip due to his fragile heart condition and 25% ejection fraction, so he is confined to a rolling desk chair and can only ambulate very short distances. He indicated that his physician has warned him that his other hip is also degenerated and also at imminent risk for fracture.

He reported that he was diagnosed with "prostrate" [sic] cancer in 2019. He had a PSA of 9.7 which, "made my heart start getting weak." He reported that during his cancer surgery they accidentally cut into his bladder and as a result he has two catheters.

He also stated that he was diagnosed with diabetes in 2017, and that he is had shortness of breath and a heart condition, "for a few years now, since 2017 I think. I only had 25% heartbeat." He reported that he had three stents placed in his heart in September of 2018, and also had a hernia operation the same year.

Neurocognitive Testing Results

Data Validity

In any high-stakes forensic examination such as this one, it is imperative to determine whether the individual being tested is putting forth their best effort, and to rule-out malingering. Therefore, a part of my examination I administered a variety of both free-standing and

embedded measures of effort and malingering to test the validity of Mr. Black's test findings.

He "passed" with a valid performance on each of these tests, including:

(1) the Rey 15 Item Malingering Test,
(2) the Test of Memory Malingering,
(3) Reliable Digit Span,
(4) the ACS Word Choice Test, and
(5) the Forced-Choice Trial of the CVLT-II.

This level of performance indicates that he was putting forth his best effort, and the test results obtained can be relied upon as valid indictors of his current level on intellectual and cognitive functioning.

Intelligence (IQ) Testing

I administered the Wechsler Adult Intelligence Scale -IV to Mr. Black, the current gold-standard for IQ testing in the United States. He obtained a Full-Scale IQ of 67, which is a significantly subaverage score, falling more than two standard-deviations below the mean in the "Extremely Low" range, and places him squarely in the range of Intellectual Disability. There was no significant "scatter" between his subtest scores, indicating that his limited cognitive abilities are evenly developed, with no areas of particular strength or relative weakness.

His WAIS-IV IQ scores are summarized in the table below:

Composite Score Summary

Scale	Sum of Scaled Scores	Composite Score		Percentile Rank	95% Confidence Interval	Qualitative Description
Verbal Comprehension	15	VCI	72	3	67-79	Borderline
Perceptual Reasoning	17	PRI	75	5	70-82	Borderline
Working Memory	9	WMI	69	2	64-78	Extremely Low
Processing Speed	9	PSI	71	3	66-82	Borderline
Full Scale	50	FSIQ	67	1	64-72	Extremely Low
General Ability	32	GAI	71	3	67-77	Borderline

Confidence Intervals are based on the Overall Average SEMs. Values reported in the SEM column are based on the examinee's age.
The GAI is an optional composite summary score that is less sensitive to the influence of working memory and processing speed. Because working memory and processing speed are vital to a comprehensive evaluation of cognitive ability, it should be noted that the GAI does not have the breadth of construct coverage as the FSIQ.

Academic Achievement Testing

Testing with the Wide Range Achievement Test-IV showed that the academic difficulties that he had during his school years have endured into adulthood. Academically, he repeated the second grade which is an early indication of his cognitive limitations, and struggled in school.

Results from my testing indicate that his academic skills fall at the bottom 2nd percentile for Math, and the bottom 4th percentile overall for Reading:

	National Percentile	Grade Equivalent
Word Reading	4	5.1
Sentence Comprehension	5	7.0
Spelling	21	8.9
Math	2	3.5
Reading Composite	4	n/a

Attention and Speed of Information Processing

Mr. Black exhibited mild impairment on a test of his visual attention and speed of information processing (Trails A). These deficits were also seen as mild-to-moderate impairments on the Symbol Search and Coding subtests of the WAIS-IV.

Memory Testing

On the Wechsler Memory Scale–IV, Mr. Black exhibited significantly impaired memory functioning, both Verbal and Visual memory, as well as Immediate and Delayed memory, placing his scores at a level commensurate with his Intellectually Disabled IQ. His subscale scores are summarized in the table below:

WMS–IV Alternate Index Score Summary

Index	Sum of Scaled Scores	Index Score	Percentile Rank	Confidence Interval	*SEM*	Qualitative Description
Immediate Memory (LMVR)	9	69	2	64-80	4.5	Extremely Low
Delayed Memory (LMVR)	10	70	2	65-79	3.67	Borderline
Auditory Memory (LM)	9	71	3	66-81	4.5	Borderline
Visual Memory (VR)	10	73	4	69-79	2.12	Borderline

WMS–IV Alternate Indexes derived using Logical Memory and Visual Reproduction (LMVR).
Confidence Intervals reported at the 95% Level of Confidence.

A similar pattern of impaired memory was seen on the California Verbal Learning Test-II, which tests his ability to learn a list of words over multiple trials, and repeat them back after a distractor list and delay periods. Here, Mr. Black was able to learn some of the list of words after multiple trials, but had difficulty recalling them after a short delay period.

Learning the original list of words also significant interfered with his ability to learn a second list, a phenomenon called "proactive interference." His score was two standard deviations below the mean and in the bottom two percent of people of his age and education.

He also had an abnormal tendency to confabulate – a pathological process of repeatedly inserting words that were not on the list into his memory, resulting in contaminated recall. His confabulation score placed him at the bottom 0.7 percentile for people of his age and education. In other words, he confabulated more that 99.3% of others of his background.

Finally, after a 20-minute delay period, he had enormous difficulty distinguishing the words he had been asked to learn from a list of unrelated words. His score here was five standard deviations below average, placing him below 1 in 10,000 others of his age and education.

Language Functioning

His language functioning is significantly impaired, with clinical evidence of expressive aphasia including severe impairment in his language functioning characterized by frank anomia (an inability to find words for things); and impaired sematic verbal fluency (e.g., the ability to name things in categories such as animals). He also exhibited clinical evidence of paraphasia, for example saying "prostrate" when he meant prostate.

His score on the Boston Naming Test, which evaluates his ability to find the words for common objects, was 5.6 standard deviations below expectation for his age, and 3.3 standard deviations below expectation for his level of education. His word-finding ability is more impaired than over 99.9% of others of his age or education.

Frontal Lobe - Executive Functioning

Testing of Mr. Black's frontal lobe or higher-level "executive" mental functions revealed multiple deficit areas involving the following cognitive abilities:

(a) divided attention,

(b) multitasking,

(c) abstract problem-solving,

(d) defective self-monitoring resulting in severe confabulation,

(e) evidence of multimodal perseveration (a pathological repetition of behavior without awareness, seen in both graphomotor and problem-solving abilities).

His performance on the Wisconsin Card Sort (a test of visual abstract problem solving) revealed a tendency to perseverate in seeking to generate problem-solving ideas. His score on the Halstead Category test, which measures abstract reasoning and the higher-order cognitive skills needed for problem solving and learning from mistakes was also impaired.

Mild grapho-motor perseveration was seen on a test where he was required to write a line of alternating m's and n's, where his ability to switch smoothly and effectively was impaired.

Finally, he demonstrated severe impairment on a test of his ability to switch effectively between competing stimuli (Trails B), again indicating difficulty with set-switching and multitasking. He repeatedly lost track of what he was supposed to be doing and needed external redirection to get back on track.

Visual Perception and Organization

Tests of Mr. Black's visual perception and organization skills (Hooper Visual Organization Test) were indicative of moderate impairment in his visual organization and processing skills. He scored lower than 91% of others of his age and education on this test.

Evidence Regarding Intellectual Disability

The DSM-5 defines Intellectual Disability (ID) as a neurodevelopmental disorder that begins in childhood and is characterized by intellectual difficulties as well as difficulties in conceptual, social, and practical areas of living. The DSM-5 diagnosis of ID requires the satisfaction of three criteria:

1. Deficits and intellectual functions, such as reasoning, problem solving, planning, abstract thinking, judgment academic learning and learning from experience, confirmed by both clinical assessment and individualized, standardized intelligence testing;

2. Deficits in adaptive functioning that result in failure to meet developmental in socio cultural standards for personal independence and social responsibility. Without ongoing support, the adaptive deficits limit functioning in one or more activities of daily life, such as communication, social participation, and independent living, across multiple environments, such as home, school, work , and community; and

3. Onset of intellectual and adaptive deficits during the developmental period.

The DSM-5 definition of ID encourages a more comprehensive view of the individual than was true under the fourth edition, DSM-IV. More importance is placed clinical judgment with regard the presence of adaptive deficits, and less emphasis is placed on bright-line IQ cutoff scores. The DSM-5 has also placed significantly more emphasis on adaptive functioning and the performance of usual life skills as the hallmark indicia of intellectual disability.

Diagnostic Criterion A:
IQ and Neuropsychological Test History

The DSM-5 includes the following discussion with regard to evaluating Criterion A:

> Criterion A refers to intellectual functions that involve reasoning, problem solving, planning, abstract thinking, judgment, learning from instruction and experience, and practical understanding. Critical components include verbal comprehension, working

memory, perceptual reasoning, quantitative reasoning, abstract thought, and cognitive efficiency. Intellectual functioning is typically measured with individually administered and psychometrically valid, comprehensive, culturally appropriate, psychometrically sound tests of intelligence. Individuals with intellectual disability have scores of approximately 2 standard deviations or more below the population mean, including a margin for measurement error (generally +5 points).

* * * *

Factors that may affect his scores include practice effects and the "Flynn effect" (overly high scores due to out-of-date test norms).

* * * *

Individual cognitive profiles based on neuropsychological testing are more useful for understanding intellectual abilities than a single IQ score. Such testing may identify areas of relative strengths and weaknesses, an assessment important for academic and vocational planning.

IQ test scores are approximations of conceptual functioning but may be insufficient to assess reasoning in real-life situations and mastery of practical tasks. For example, a person with an IQ score above 70 may have such severe adaptive behavior problems in social judgement, social understanding, and other areas of adaptive functioning that the person's actual functioning is comparable to that of individuals with a lower IQ score. Thus, clinical judgment is needed in interpreting the results of IQ tests.[1]

Mr. Black's IQ and Neurocognitive Functioning

During my examination and testing, Mr. Black achieved a Full-Scale IQ score of 67, in the "Extremely Low" range of intellectual functioning. Mr. Black thus has significantly subaverage intellectual functioning that falls in the range of Intellectual Disability.

This finding is consistent with Mr. Black's history of past IQ testing, (which is described accurately and in detail by Dr. Marc Tasse in his declaration[2]) that has repeatedly shown his IQ to be significantly

[1] DSM-5, p. 37.
[2] 2008 Declaration of Marc Tasse, Ph.D., FAAIDD, p.13.

subaverage and in the range of Intellectual Disability using individually-administered, culturally-appropriate intelligence tests dating back to 1993. Four different examiners, using several different intelligence tests,[3] all placed Mr. Black in the range of Intellectual Disability with his Flynn-adjusted Full-Scale IQ scores falling between 53 and 71. Dr. Stephen Greenspan also came to the same conclusions regarding this evidence of Intellectual Disability in his 03/13/2008 declaration.[4]

During my examination, I also did additional neurocognitive testing to look at Mr. Black's capacity for reasoning, problem-solving, planning, abstract thinking, academic learning, and learning from experience. The results of that testing revealed clinically significant and significantly subaverage functioning in the following areas:

(1) significant memory impairment at a level commensurate with his Intellectually Disabled IQ score;

(2) extreme confabulation (abnormal intrusions of extraneous, irrelevant, and incorrect information into his recall);

(3) Severe deficit in attention

(4) severe impairment in his language functioning characterized by frank anomia (an inability to find words for things) and impaired sematic verbal fluency (e.g., the ability to name things in categories such as animals);

(5) impaired visual organization processing; and

(6) deficits in his frontal lobe/executive abilities including:

- divided attention,
- multitasking,
- abstract problem-solving, and

[3] Including the Wechsler Adult Intelligence Scale – Revised in 1993 by Dr. Blair (FSIQ=69) and again in 1997 by Dr. Auble (FSIQ = 71); the Wechsler Adult Intelligence Scale – III in 1995 by Dr. van Eys (FSIQ= 67); and the Stanford-Binet 5th Edition in 1986 by Dr. Grant (FSIQ=53).

[4] Declaration of Stephen Greenspan, Ph.D., 03/13/2008, p. 13-14.

- evidence of multimodal perseveration (a pathological repetition of behavior without awareness, seen in both graphomotor and problem-solving abilities).

Dr. Daniel H. Grant, who examined and neuropsychologically tested Mr. Black in October of 2001, noted that in addition to his significantly subaverage intellectual functioning, Mr. Black had significant neuropsychological impairments in the areas of:

(1) verbal memory;

(2) listening comprehension and oral expression;

(3) receptive and expressive vocabulary; and

(4) deficits in functional academic skills including reading comprehension and arithmetic skills.[5]

Dr. Pamela Auble, who examined and neuropsychologically tested Mr. Grant in February and March of 1997 found no evidence of poor effort or malingering, and significant neurocognitive deficits involving:

(1) attention;

(2) memory;

(3) word-finding;

(4) manual dexterity; and

(5) executive abilities including abstract problem solving and multi-tasking.[6]

These findings are consistent with the structural and functional neuroimaging findings reported by Dr. Gur in 2001 (MRI scan) and 2004 (PET scan).

The findings from the neuropsychological testing provide additional evidence of neurocognitive deficits that indicate and support a finding of significantly subaverage intellectual functioning.

[5] Dr. Grant's 11/16/2001 declaration, p. 6-7.
[6] Report of Pamela Auble, Ph.D., 3/5/1997.

Conclusion Regarding Mr. Black's Intellectual Functioning

It is my opinion that Mr. Black meets Criterion A based on test scores that place him within the range for a diagnosis of intellectual disability. Mr. Black's impaired performance on the neuropsychological testing administered during this examination in conjunction with his current and prior IQ testing provides clear evidence of substantial impairment in intellectual functions that involve reasoning, problem solving, planning, abstract thinking, judgment, learning from instruction and experience, and practical understanding; as well as critical components that include verbal comprehension, working memory, perceptual reasoning, quantitative reasoning, abstract thought, and cognitive efficiency.

Diagnostic Criterion B: Significant Deficits or Impairments in Adaptive Functioning

The second major prong of the Intellectual Disability diagnosis requires evidence of impairment in Adaptive Functioning. *Global* impairment in adaptive functioning is not required for the diagnosis of Intellectual Disability. It is typical for adaptive strengths to co-exist with weaknesses in this population. However, the diagnosis itself is made based on the identification of adaptive weakness areas alone. Both the DSM-5 and American Association on Intellectual and Developmental Disabilities (AAIDD) criteria require impairment in just one broad domain of functioning (i.e., Conceptual, Practical, or Social).

THE CONCEPTUAL DOMAIN

The **conceptual domain** involves skills in language, reading, writing, math, reasoning, knowledge, memory, and self-direction.

In this domain, there is both empirical and anecdotal evidence that Mr. Black has significant impairments that cluster in three broad areas, including:

(1) functional academic skills:

(2) language skills; and

(3) concept formation and self-direction.

Examples of Mr. Black's Conceptual Domain impairments include the following:

- Academically, he repeated the second grade which is an early indication of his cognitive limitations, and struggled in school.

  > During my examination I asked Mr. Black about his school experience. He did not know why he had to repeat the 2nd grade but he did state, "I did not understand some things."

- Findings from my neurocognitive testing indicate that his academic skills fall at the bottom 2nd percentile for Math, and the bottom 4th percentile for Reading.

During my examination when I asked Mr. Black about his school experience, he reported being socially awkward. "I mostly stayed to myself. I'm a quiet person." Then out of the blue he stated, "We have communion here every Sunday."

Rossi Turner grew up with Byron Black, lived on the same street, and attended the same school. She shared the following observations regarding his abilities as a child in her declaration:

> I am two years younger than Byron Black. Byron had to repeat the 2nd grade so I was one grade behind him.
>
> [When playing] a Tisket a Tasket, ... Byron never seemed to catch on when the bag was dropped behind him. One of the other children would have to yell at him, "Byron, look behind you."
>
> When we played red light, green light ... Byron would get put out all the time. He was generally the first one out.
>
> Even in marbles, Byron wasn't good. He was not too well coordinated.[7]

Dr. Daniel H. Grant, who examined and neuropsychologically tested Mr. Black in October of 2001, noted that in addition to his significantly subaverage intellectual functioning, Mr. Black had significant neuropsychological impairments in the areas of:

---

[7] Declaration of Rossi Turner, 3/15/2008, p.1-4.

(1) verbal memory;

(2) listening comprehension and oral expression;

(3) receptive and expressive vocabulary; and

(4) deficits in functional academic skills including reading comprehension and arithmetic skills.[8]

Dr. Pamela Auble, who examined and neuropsychologically tested Mr. Grant in February and March of 1997 found no evidence of poor effort or malingering, and significant neurocognitive deficits involving:

(1) attention;

(2) memory;

(3) word-finding;

(4) manual dexterity; and

(5) executive abilities including abstract problem solving and multi-tasking.[9]

Ross Alderman, who was Mr. Black's attorney during his capital murder trial, declared as follows:

> during our interactions with Byron Black, Byron completely could not focus on the case. ... An example of just how out of touch Byron was with what was going on in the trial is when after the jury went out to deliberate on the issue of sentence, Byron asked me, "Do I get to testify now?" It was clear to me that Byron had not understood what had occurred in the proceedings. I believe that he had no clue about what had been going on for the past two weeks. He lacked the ability to process what had been occurring.[10]

Conclusion Regarding Adaptive Impairment in the Conceptual Domain

The Diagnostic and Statistical Manual of Mental Disorders-5th Edition characterizes the various severity levels for adaptive impairments seen

[8] Dr. Grant's 11/16/2001 declaration, p. 6-7.
[9] Report of Pamela Auble, Ph.D., 3/5/1997.
[10] Declaration of Ross Alderman, Esq., 11/14/2001, p.1-2.

in Intellectual Disability. Based on the evidence summarized above, Mr. Black's level of functioning is best captured by the DSM-5 description of "mild" severity in the **conceptual domain:**

> For preschool children, there may be no obvious conceptual differences. For school age children and adults, there are difficulties in learning academic skills involved in reading, writing, or arithmetic, time, or money, with support needed in one or more areas to meet age – related expectations. In adults, abstract thinking, executive function (i.e., planning, strategizing, priority setting, and cognitive flexibility), and short-term memory, as well as functional use of academic skills (e.g., reading, money management), are impaired. There is a somewhat concrete approach to problems and solutions compared with age–mates.[11]

THE SOCIAL DOMAIN

The **social domain** refers to empathy, social judgment, interpersonal communication skills, the ability to make and retain friendships, gullibility and vulnerability to manipulation, and similar capacities.

Mr. Black's record reflects deficits in his Social Domain functioning. Examples of his social domain impairments include:

- Socially, he his overly-familiar with strangers and has problems with boundaries and personal space. He is very outgoing, overly friendly, and relates in a somewhat child-like manner as if he has known you for a long time even when you first meet him, waving and expressing affection. His attorney at trial observed this as well.

- A childhood friend described him as not having many close friends. He was unable to "catch on" to the rules of simple childhood games like Tisket-a-Tasket, Red Light-Green Light, or marbles. He was described as findings things that others could do easily to be too difficult for him. He was also described as having memory problems during childhood, and difficulty keeping track of time, and needing support from others to function effectively in his daily life.

[11] DSM-V, p. 34.

- His high school football coach, Al Harris, described him as unable to learn and remember plays.

Rossi Turner grew up with Byron Black, lived on the same street, and attended the same school. She shared the following observations regarding his abilities as a child in her declaration:

> Looking back on it, Byron was different. Things that others could do so easily were difficult for him. And, Byron smiled a lot, but it looked off key. ...
>
> Although Byron had a lot of cousins and a pretty big family, he didn't have many close friends. Byron would occasionally make small talk with people, but not often.
>
> [When playing] a Tisket a Tasket, ... Byron never seemed to catch on when the bag was dropped behind him. One of the other children would have to yell at him, "Byron, look behind you."
>
> When we played red light, green light ... Byron would get put out all the time. He was generally the first one out.
>
> Even in marbles, Byron wasn't good. He was not too well coordinated.[12]

Ross Alderman, who was Mr. Black's attorney during his capital murder trial, declared as follows:

> Byron almost constantly wore a big childlike smile on his face, a smile which was often out of place, given the circumstances. ... Also, when talking, he would get close-in to my face, not in a threatening way, but in a socially inappropriate way.[13]

Conclusion Regarding Adaptive Impairment in the Social Domain

The Diagnostic and Statistical Manual of Mental Disorders - 5th Edition (DSM-5) characterizes the various severity levels for adaptive impairments seen in Intellectual Disability. Based on the evidence

[12] Declaration of Rossi Turner, 3/15/2008, p.1-4.
[13] Declaration of Ross Alderman, Esq., 11/14/2001, p.1.

summarized above, Mr. Black's level of functioning is best captured by the DSM-5 descriptions for "Mild" severity in the **social domain.**

Mild impairment in the social domain is described as follows:

> Compared with typically developing age–mates, the individual is immature and social interactions. For example, there may be difficulty in accurately perceiving peers' social cues.
>
> Communication, conversation, and language are more concrete or immature than expected for age. There may be difficulties regulating emotion and behavior in an age–appropriate fashion; these difficulties are noticed by peers in social situations. There is limited understanding of risk in social situations; social judgment is immature for their age, and the person is at risk of being manipulated by others (gullibility).[14]

THE PRACTICAL DOMAIN

The **practical domain** centers on self-management in areas such as personal care, job responsibilities, money management, recreation, and organizing school and work tasks.

The records also establish impairment in Mr. Black's Practical Domain functioning, including:

- His younger brother reported that he did not read, did not cook, and would repeat things over and over (perseveration). He is described as never living independently, and not having a checking account.
- Interviews with Lynette Childs Black who was briefly married to him, indicated that he was never able to live independently and that they lived with his mother when they got married. She described him as "childish" and reliant on his family members for support.

There has also been objective testing of his adaptive functioning that supports a finding of deficits in these domains, including:

- Dr. Grant administered the Independent Living Scales (ILS) and obtained impaired scores reflecting deficits in

[14] DSM-5, p. 35.

Mr. Black's practical adaptive skills involving money management, managing home and transportation, health, and safety.

- Dr. Greenspan administered the Street Skills Survival Questionnaire (SSSQ) and obtained similar evidence of impairment in Mr. Black's Practical functional abilities, including independent living skills.

- Dr. Greenspan also did a retrospective administration of the Vineland Adaptive Behavior Scales—Second Edition (Vineland–2) with multiple reporters which while not a standardized way of using the test, did obtain highly convergent findings across reporters indicating overall impairment in Mr. Black's functional abilities in all three diagnostic domains.

Dr. Daniel H. Grant, who examined and tested Mr. Black in October of 2001, noted in his declaration that:

> It is important to note that Mr. Black never lived in dependently. He never did the laundry, cooked, cleaned the house or participated in the care of his son. Even when married he and his wife lived with relatives who cared for Mr. Black. He did not contribute financially to his family and his wife said he never had a bank account. He never contributed financially to the cost of housing or utilities.[15]

Rossi Turner, grew up with Byron Black, lived on the same street, and attended school. She shared the following observations regarding his abilities as a child in her declaration:

> I remember his grandpa having to tell him time and time again to do his chores and how to do it the right way. Byron had to bring in kindling and coal. ... Byron wasn't lazy, he just had trouble remembering to do his chores.
>
> Because Byron couldn't remember things folks would have to repeat things to him especially if it was a direction. I remember his sisters saying over and over, "Byron, I just told you to do

[15] Declaration of Daniel H. Grant, Ed.D,12/24/2001, p. 7.

> that." He had a thing about snapping his fingers and say [sic], "yeah, I forgot that," when someone reminded him.
>
> Byron would forget and lose track of time. He would be told to get home at a certain time but he wouldn't remember and his grandpa would come and get him saying, "Byron, what did I tell you?" Byron would meekly say, "Yes, grandpa."[16]

Freda Black Whitney, who is Byron Black's younger sister by five years, shared the following observations in her declaration:

> I have noticed that Byron repeats a lot of the same things over and over.
>
> I never saw Byron read for pleasure.
>
> I've never known Byron to cook. I don't think he knows how to cook.
>
> While all of us left home and took care of ourselves and our families, Byron never did. Even when he was married he did not provide an independent residence for his family but continued to live with either our mother or father or with his wife's family. He didn't even have a checking account.[17]

Melba Black Corley, Byron Black's older sister by six years, provided the following observations in her declaration:

> I did not see him just sitting around reading for fun. Although my sisters and I would use the mobile library that went to our school, I do not remember Byron using this library. He only read what he had to for school. Byron didn't mature like he should have.[18]

Investigator Connie Westfall interviewed **Lynette Childs Black**, who was briefly married to Byron Black, in April of 1997. She prepared a declaration that includes a memo documenting that interview, which notes:

> ...as a couple Lynette and Byron never had their own place. After divorcing they went their separate ways, ... Lynette characterized Byron as being quote childish, "he wanted to stay

[16] Declaration of Rossi Turner, 3/15/2008, p.1-4.
[17] Declaration of Freda Black Whitney, 3/16/2008, p. 1-2.
[18] Declaration of Melba Black Corley, 3/15/2008, p.1-2.

up underneath his family." That was the thing that broke them up.[19]

Conclusion Regarding Adaptive Impairment in the Practical Domain

The Diagnostic and Statistical Manual of Mental Disorders - 5th Edition (DSM-5) characterizes the various severity levels for adaptive impairments seen in Intellectual Disability. Based on the evidence summarized above, Mr. Black's level of functioning is best captured by the DSM-5 descriptions of "Moderate" severity in the **practical domain**.

Moderate impairment in the practical domain is described as follows:

> The individual can care for personal needs involving eating, dressing, elimination, and hygiene as an adult, although an extended period of teaching and time is needed for the individual to become independent in these areas, and reminders may be needed. Similarly, participation in all household tasks can be achieved by adulthood, although an extended period of teaching is needed, and ongoing support will typically occur for adult level performance. Independent employment in jobs that require a limited conceptual and communication skills can be achieved, but considerable support from coworkers, supervisors, and others as needed to manage social expectations, job complexities, and ancillary responsibilities such as scheduling, transportation, health benefits, and money management. A variety of recreational skills can be developed. This typically requires additional supports and learning opportunities over an extended period of time. Maladaptive behavior is present in a significant minority and causes social problems.[20]

[19] Westfall declaration attachment, p. 1.
[20] Ibid.

Diagnostic Criterion C: Onset of Intellectual and Adaptive Deficits During the Developmental Period

Both the record and my clinical examination make a clear and unequivocal case that the onset of Mr. Black's Intellectual Disability occurred during the developmental period.

Both the record and my clinical examination indicate that the onset of Mr. Black's Intellectual Disability occurred during the developmental period, thus meeting the third prong of the diagnostic criteria.

Summary of Opinions

Based on my examination, interviews, and review of the materials that I have been provided, I have reached the following opinions to a reasonable degree of psychological certainty.

Opinion with Regard to Intellectual Functioning

As noted above, it is my opinion that Mr. Black has significantly subaverage intellectual functioning based on valid, objective test scores within the range of intellectual disability.

Opinion with Regard to Impairments in Adaptive Functioning

Mr. Black exhibits significant deficits or impairments in all three domains of adaptive functioning (Conceptual, Social and Practical), at the level of "Mild" to "Moderate" severity. His adaptive impairments are clearly related to his underlying cognitive limitations. There is substantial "convergent validity" from anecdotal, contemporaneous, and empirical data sources supporting the conclusion that Mr. Black functions adaptively in the range of Intellectual Disability, which meets the second diagnostic prong.

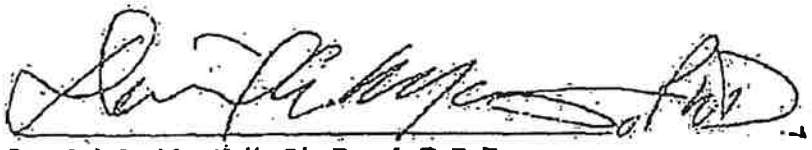
Opinion with Regard to Age of Onset

It is my opinion that Mr. Black's intellectual and adaptive deficits find their origin in the developmental period. The data discussed above clearly show that he was exhibiting impairments in conceptual, social, and practical adaptive abilities during his development prior to age 18.

Based on these findings, it is my opinion that Byron Black meets the all of the criteria for a diagnosis of Intellectual Disability pursuant to *Atkins v. Virginia*.

Thank you for the opportunity to evaluate this interesting case. If you have any questions, please feel free to contact me directly any time at (949) 230-7321.

Sincerely,



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BY ELECTRONIC MAIL

December 13, 2021

Kelley J. Henry
Supervisory Asst. Federal Public Defender
810 Broadway, Suite 200
Nashville, TN 37203

RE: Byron Black Supplemental Report

Dear Ms. Henry,

I am writing to update and elaborate on my opinions regarding Mr. Black's diagnosis of Intellectual Disability pursuant to the above captioned matter.

Supplemental Referral Questions

You have asked that I address three supplemental referral questions:

1. Is the Sixth Circuit Court of Appeals' analysis and conclusion that Mr. Black's significantly subaverage intellectual functioning did not manifest prior to age-18 consistent with the most current scientific standards, including those set-forth in the AAIDD-12, and the forthcoming DSM-V-TR?

2. Taking into consideration all of the evidence before you, including the documents you have reviewed and your independent examination of Mr. Black in 2019, and while applying the most current scientific standards including those set-forth in the AAIDD-12 and forthcoming DSM-V-TR, did Mr. Black's intellectual disability manifest prior to age 18?

3. Did the Sixth Circuit Court of Appeals in their majority opinion correctly understand the Flynn effect and its implications?

EXHIBIT
tabbies 9

Supplemental Materials Reviewed

I have previously been provided with the documents detailed in my report dated August 25, 2020 (see "Materials Reviewed" on pp. 3-4). In addition, to assist in addressing the supplemental referral questions listed above, I have been provided with the following:

1. The Sixth Circuit Court of Appeals decision in Black v. Carpenter, 866 F.3d 734 (6th Cir. 20h17).

2. Bryon Black's school records, which include the test scores referenced by the Court of Appeals.

3. The amicus brief submitted by the American Association on Intellectual and Developmental Disabilities in support of Mr. Black's petition for rehearing.

Opinions Regarding Supplemental Referral Questions

I have reached the following opinions regarding the supplemental referral questions to a reasonable degree of neuropsychological certainty:

1. Is the Sixth Circuit Court of Appeals' analysis and conclusion that Mr. Black's significantly subaverage intellectual functioning did not manifest prior to age-18 consistent with the most current scientific standards, including those set-forth in the AAIDD-12, and the forthcoming DSM-V-TR?

It is my opinion that the Sixth Circuit Court of Appeals analysis and conclusion is not consistent with the most current scientific standards for the diagnosis of Intellectual Disability.[1]

In 2017, the Sixth Circuit Court of Appeals found that Byron Black failed ailed to establish intellectual disability based on their conclusion that he could not "show that he has significantly subaverage general intellectual functioning that manifested before Black turned eighteen." *Black v. Carpenter*, 866 F.3d 734, 750 (6th Cir. 2017).

In reaching their conclusion that Mr. Black failed to prove age-of-onset of his intellectual disability, the Sixth Circuit defined the problem as follows:

[1] Determining whether a capital defendant has intellectual disability requires courts to follow clinical standards developed by disability professionals. Moore v. Texas, 137 S. Ct. 1039, 1044 (2017).

> Black's argument requires three steps: (1) reject Black's childhood "group-administered" IQ scores (83, 97, 92, 91, 83); (2) either rely exclusively on the 2001 IQ scores (69, 57), or else apply a downward adjustment to the pre-2001 adulthood IQ scores (76, 73, 76) to account for the Flynn Effect and the SEM, so as to reduce those scores to below 70; and (3) presume that the adulthood scores, in the absence of contradictory childhood IQ scores (and by disregarding evidence put on by the State to rebut Black's contention that his mother's alcohol consumption caused Black to suffer any brain damage that caused any level of mental retardation), are evidence of lifelong mental retardation that must have manifested itself before age eighteen. Each of these three steps is a necessary condition for Black to prevail on his *Atkins* claim as we see it.[2]

Unpacking the Sixth Circuit Court of Appeals analysis, they identify three areas that bear reconsideration in light of evolving standards of professional decision-making regarding the diagnosis of Intellectual Disability:

a) Whether it is professionally appropriate to consider "group-administered" intelligence scores in making a diagnosis of Intellectual Disability;
b) Whether it is professionally appropriate to consider and adjust IQ test scores for norm obsolescence (i.e., the "Flynn Effect); and
c) Whether IQ scores obtained in adulthood are valid indications that Mr. Black had impairment in IQ during the developmental period as required for a diagnosis of Intellectual Disability.

The acknowledged authorities for the professional standard of care used in the diagnosis of Intellectual Disability are found in two treatises: (1) The *Diagnostic and Statistical Manual of Mental Disorders – Fifth Edition* (DSM5); and (2) the 12th edition of *Intellectual Disability: Definition, Diagnosis, Classification, and Systems of Supports* published by the American Association on Intellectual and Developmental Disabilities (AAIDD).

Impropriety of group-administered tests. *Group-administered* tests of intelligence, as the moniker implies, are given to groups of people all at the same time, typically in a classroom setting, similar to taking the SAT test for college admissions. They permit obtaining intelligence estimates on large groups of people at once, but at the cost of poor precision because they are

[2] Id. at 748.

limited in the scope of functions they assess, and do not correlate well with standardized, individually-administered IQ tests.

Individually-administered IQ tests are given in a private, one-on-one setting with a clinical psychologist who gives the test, records and scores the responses, and observes with behavior of the individual during each of the subtests involved.

Both the DSM5 and the AAIDD standard specify that only *individually-administered* IQ tests are appropriate for use in diagnosing Intellectual Disability. The DSM5 states, "Invalid scores may result from the use of brief intelligence screening tests or group tests."[3] The AAIDD specifies the professional standards of this requirement in detail:

> In reference to determining significant limitations in intellectual functioning, a full- scale IQ score should be used. This best practice guideline: (a) is based on the general factor of intelligence (i.e., g), which was initially identified by Spearman (1927) and is at the apex of the Carol three-stratum model of human intelligence (Carol, 1993); and (b) reflects the fact that, despite differences among current test developers in terms of the abilities assessed on different intelligence tests, the consensus is that general intelligence, and by inference intellectual functioning, is most accurately assessed and represented using a current reliable, valid, individually administered, comprehensive, and standardized test that yields a full- scale IQ score. In implementing this best practice, we endorse using Floyd at al.'s (in press) guideline for selecting a comprehensive test of general intelligence. Such a test should: (a) include at least six subtests, and (b) sample at least three (preferably more) CHC broad- strata abilities.[4]

Thus, the professional requirement that IQ testing must utilize individually-administered, comprehensive testing explicitly precludes reliance on group-administered test scores. This is true for several reasons including, for example, their lack of comprehensiveness due to the limited number of cognitive domains that they assess, and the lack of reliability and validity of the IQ scores obtained from them when compared to the gold-standard

[3] DSM5, p.37.
[4] AAIDD Intellectual Disability: Definition, Diagnosis, Classification, and Systems of Supports, 12th Edition, p. 28-29.

individually-administered tests. Just as scores from group-administered tests cannot be used as a basis for diagnosing Intellectual Disability, neither can they be used to rule it out. Mr. Black's group-administered test scores are simply not professionally relevant under the current standard of care.

Adjusting IQ test scores for norm obsolescence. The professional standards set out by both the DSM5 and the AAIDD both specifically endorse adjusting IQ scores for norm obsolescence. Norm obsolesce is a statistical artifact that arises from scientific evidence that humans get incrementally more intelligent as they evolve. This has been termed the "Flynn Effect" after James Flynn who discovered this by studying populations throughout the world.

A recent meta-analysis of the Flynn Effect, based on an analysis of 285 studies dating back as far as 1951, has demonstrated conclusively: (a) that the effect is real and legitimate, (b) that the data support previous estimates of the magnitude of the Flynn effect (at 0.3 IQ points per year since the norming of the test used); and (c) that the universe of studies demonstrates its robustness across different age groups, IQ measures, clinical samples, and levels of performance.[5]

As a result, the professional standard of care has evolved to address incorporation of adjustments for norm obsolescence. For example, the DSM5 states: "Factors that may affect test scores include practice effects and the "Flynn effect" (i.e., overly high scores due to out- of- date test norms).[6] The AAIDD states:

> Interpreting previously administered intellectual functioning assessments in terms of the extent to which the assessment: (a) used a standardized and individually administered comprehensive intelligence test; (b) was the [then] most recent version of the standardized test used, including the most recent norms; (c) took into consideration the confidence interval within which the person's true score fell; and (d) was corrected for the age of the norms employed. *Current best practice guidelines recommend that in cases in which an IQ test with aged norms is used as part of a diagnosis of ID, a correction of the Full-Scale IQ score of 0.3 points per year since the*

[5] Trahan, L. H., Stuebing, K. K., Fletcher, J. M., & Hiscock, M. (2014). The Flynn effect: a meta-analysis. Psychological Bulletin, 140(5), 1332–1360.
[6] DSM5, p.37.

test e-norms were collected is warranted (Fletcher et al., 2010; Gresham and Reschly, 2011; Kaufman, 2010; Reynolds et al., 2010).[7]

Hence, adjusting Mr. Black's IQ scores for norm obsolescence is consistent with current professional standards, and the correct thing to do.

Whether IQ scores obtained in adulthood are valid indications of Mr. Black's IQ during the developmental period. Having a diagnosis of ID is not required during the developmental period. It would be a deviation from professional standards of care not to diagnose ID simply because an individual was never formally assessed during the developmental period.

The lack of a formal ID assessment can arise due to a number of factors including a lack of resources, having ID mistaken for other disorders, a desire to socially-promote students and move them along to avoid social stigma, or the diagnosis having simply been "missed." Because of these issues, neither the DSM5 nor the AAIDD requires that a diagnosis be made during the developmental period.

Thus, it is entirely reasonable and appropriate to rely on IQ and neurocognitive test scores obtained later in life to make the diagnosis, if those scores are indicative of substantial impairment in intellectual functioning. In Mr. Black's case, he has been tested by different doctors, using different tests, and at various points in time – with all the results being consistent with a finding of, "Deficits and intellectual functions, such as reasoning, problem solving, planning, abstract thinking, judgment, academic learning, and learning from experience, confirmed by both clinical assessment and individualized, standardized intelligence testing."[8]

wThis is evidence of what is known as, "convergent validity," that his intellectual functioning is significantly impaired, and hence serves as evidence that he meets diagnostic criteria for Intellectual Disability. This is further supported by evidence in the record of impairment in his cognitive functioning as a child and throughout the developmental period as reflected by: (1) his repeating the second grade, (2) being placed in an "ungraded" class in the third grade, (3) having poor academic achievement test scores

[7] AAIDD Intellectual Disability: Definition, Diagnosis, Classification, and Systems of Supports, 12th Edition, p. 42 (emphasis added).
[8] DSM 5, p. 33.

that have persisted to the present day, and (4) statements describing his cognitive deficits from witnesses who knew him well during that time.

> **2. Taking into consideration all of the evidence before you, including the documents you have reviewed and your independent examination of Mr. Black in 2019, and while applying the most current scientific standards including those set-forth in the AAIDD-12 and forthcoming DSM-V-TR, did Mr. Black's intellectual disability manifest prior to age 18?**

Yes. I base this opinion on the answers provided above as well as the following:

The AAIDD lays out professional guidelines for establishing onset during the developmental period:

> It is possible to make a retrospective diagnosis of ID after the individual attains age 22. To do so, the clinician must establish that the significant deficits in both intellectual functioning and adaptive behavior were present during the period of the individual's development. In this situation, when the person does not have a diagnosis of ID established during the developmental period, it is necessary for clinicians to assess the past functioning of the individual to determine whether a diagnosis of ID applies to person.[9]

This endeavor also requires the use of clinical judgment. The primary purpose of establishing the age of onset is one of differential diagnosis, in order to differentiate individuals with ID from those with late-acquired low intellectual functioning due to traumatic brain injuries, degenerative disorders, infectious diseases, and other causes.

Evidence of cognitive impairment. As I noted in my 08/25/2020 report, there were indications of intellectual deficits quite early in Mr. Black's life. He struggled in school, and had to repeat the second grade – the first clear indication that he was impaired intellectually and as a result struggled academically from a very young age. Even today he still functions at the early elementary school level in the bottom 2 percent for math and the bottom 4 percent for reading skills.

[9] Ibid., p. 41.

A review of his academic records reflects his struggles academically, particularly with standardized tests of cognitive skills like reading readiness and academic achievement. On the Metropolitan Reading Readiness Test administered in June of 1962 when he was 6 years old, he obtained a score of 39, placing him at risk for reading problems. Reading readiness tests generally, "measure physiological maturity, comprehension or the spoken language, ability to perceive similarities and differences, ability to follow directions, and the ability to draw simple figures."[10]

His school records indicate that he had to repeat the second grade, and that once he was promoted to the third grade he was placed in an "ungraded" class (i.e. no grades were assigned for him) prior to being promoted to the fourth grade.

By the time he was in the 7th grade, his scores on the Metropolitan Achievement Test indicated that he was two to three years behind in all subjects (i.e., functioning at the 4th or 5th grade level although he was in the 7th grade). Impaired scores in all subjects is indicative of intellectual Disability rather than a specific learning disability.

Dr. Daniel Grant stated in his 11/16/2001 declaration:

> Mr. Black's performance on the Differential Aptitude Test (DAT) administered in the ninth grade would be the best indicator of his level of functioning. This is a well normed test and is published by the publishers of the Wechsler Scales (WAIS-R and WAIS-III). His performance on the Verbal Recognition yielded a percentile of 3, stanine 1; Nonverbal yielded a percentile of 2, stanine of 1; and the VR&NA (a good predictor of intelligence and general ability) yielded a percentile of l and a stanine of 1. His performance on the DAT places Mr. Black's level of functioning within the mildly retarded range.
>
> Áfter reviewing Mr. Black's educational records and reading the interview of Jackie Thomas, Byron Black's Sixth grade teacher, and Mrs. Ford, Byron Black's fifth grade teacher, his true academic performance is suspect. Jackie Thomas stated," ... In my class what I did was I gave work that they could succeed at." Mr. Thomas further stated, "I always gave them something that they could do well. I would not allow a student to get a bad grade in my class." Mrs. Ford

[10] Arthur w. Heilman, Principles and Practices of Teaching Reading (Columbus, Ohio: E. Merrill Books, Inc., 1967), p. 28.

stated, "The black teachers were liberal in their grading." She further noted that A's and B's at that time probably would be C's and D's now.

* * * *

His mental retardation manifested during the developmental period as noted by his not developing age-appropriate independent living skills before the age of eighteen and as noted by his significantly subaverage performance on the Differential Aptitude Test that was administered when he was in the ninth grade. His performance on the VR&NA on the DAT yielded a percentile score of I which indicates 99 out of a 100 individuals scored better than Mr. Black on that test.

Evidence of impairment in adaptive functioning. I have described specific evidence of impairment in Mr. Black's adaptive functioning during the developmental period on pages 15-23 of my August 25, 2020 report, and those findings are directly relevant to establishing that he evinced deficits in his adaptive functioning prior to age 18. Siblings, neighbors, and cousins who grew up with him during his developmental period describe him as slow, challenged in school, and behind his peers in social and adaptive skills and abilities.[11]

These findings are further supported by impairments described in the March 13, 2008 declaration of Dr. Stephan Greenspan:

Outcome-based evidence, such as a child being retained in elementary school (which occurred in this case) and very low academic achievement (also true in this case) can also be used as evidence that the developmental criterion has been met.

* * * *

Individualized IQ data for Mr. Black as a child is lacking, for the simple reason that he left high school in the very same year that the federal statute (PL-94-142) that mandated special education was enacted. During the time that Mr. Black was in elementary school, the assumption was that a child would be socially promoted if he was well-behaved (which by all accounts, Mr. Black was), regardless of how little he learned (see Affidavit by Mary Craighead, an administrator at Mr. Black's elementary school). Just the same, Mr. Black was retained

[11] Cf. declarations of Freda Black Whitney (sister); Rossi Turner (neighbor he grew up with); Melba Black Corley (sister); Statements of Dr. Sallye Renee Granberry (cousin) to investigator Gaye Nease.

in the second grade, even given that tendency to overlook such learning difficulties. Undoubtedly, an individualized IQ test would have been administered had Mr. Black been born ten years later. The absence of such IQ data makes it impossible to know whether he would have qualified for a diagnosis of MR during that period. Mr. Black's relatively good report cards in elementary school are incongruent with the fact that he was retained and also with his marginal or failing grades in High School. The mystery is cleared up when reading the statements by his fifth and sixth grade teachers (noted in point #17 in the declaration by Dr. Grant). They stated that "I would never allow a student to get a bad grade" (6th grade teacher) and "teachers were liberal in their grading" and a B would be the equivalent of a D at a later time (5th grade teacher). Furthermore, administrator Mary Craighead indicated in her affidavit that the emphasis back then was on helping low-achieving African-American children to feel good about themselves and to experience success in all of their endeavors. This attitude likely also explains why Mr. Black obtained relatively high scores on group administered IQ tests, as it is very possible, indeed likely, that these tests (which even state experts testified are not appropriate for diagnosing MR) were administered in a non-standard manner that could even have involved teacher assistance. Even so, it should be noted that the IQ criterion for diagnosing MR was minus 1 SD (full-sale score of 85), during the years 1961 to 1973, and that the 85 that Mr. Black obtained on the Otis-Lennon group IQ test could, thus, have qualified him at that time.

Dr. Grant correctly noted that the best evidence that Mr. Black would have met the MR intellectual functioning criterion in the Developmental period was his very low performance (standard scores of 71 and 67) on the Differential Abilities Test (DAT). Although not specifically termed an IQ test, the DAT correlates very highly with IQ and in the absence of an IQ test can be used as a substitute. Furthermore, Mr. Black's mostly failing grades in High School (where the overprotective stance of his elementary school no loner applied) is probably a better indicator of the depth of his intellectual limitations. Those limitations carry over today into his very low achievement standard score (72) as an adult on the WRAT-III and the Nelson-Denny reading test.

* * * *

> Although he attended an elementary school considered the most disadvantaged and low-functioning in the district (as reflected in its being chosen for a special Ford Foundation program), Mr. Black was made to repeat second grade, which is a clear indication that he was considered to be very "slow" even in that much slower than average setting. There is also very clear evidence from standardized achievement scores that Mr. Black functioned intellectually at a very low level.

The findings from Dr. Greenspan provide solid evidence in support of my opinion that Mr. Black exhibited deficits in adaptive functioning specifically in the Conceptual Domain during the developmental period. Notably, although there is evidence that he was impaired in the other domains as well (i.e., Social and Practical) the diagnostic criteria only require a finding of impairment in one area in order to make the diagnosis.

3. Did the Sixth Circuit Court of Appeals in their majority opinion correctly understand the Flynn effect and its implications?

No.

The Sixth Circuit Court of Appeals statement that, "If *Atkins* had been a 1917 case, the majority of the population now living—if we were to apply downward adjustments to their IQ scores to offset the Flynn Effect from 1917 until now—would be too mentally retarded to be executed,"[12] reflects a fundamental misunderstanding of the Flynn effect and its application in this setting. As I have already discussed above, adjustments to IQ test scores due to norm obsolescence (i.e., the Flynn Effect") are the standard of care under the current professional guidelines for the diagnosis of Intellectual Disability (i.e., the DSM and the AAIDD). In the Atkins context, this is particularly true given the need for the utmost precision required in such a high-stakes context.

Like milk in the refrigerator, as the norms for the IQ test age they spoil and require adjustments in order to maintain their diagnostic accuracy. Because the mean (average) IQ score in the population has been shown to increase by approximately three (3) points per decade, so too the statistical point that falls two standard-deviations below that mean also slowly creeps up.

[12] Id. at 749.

In order to be precise in determining whether an individual's IQ is objectively substantially impaired, the period of time between when the normative data for the IQ test was collected and when the test was administered has to be taken into consideration; and adjustments based on that period of time need to be made by subtracting 0.3 IQ points per year multiplied by the number of years between when the test was normed and when the individual was tested with it. This provides the most accurate indication of how far the person being tested falls from the average IQ in the population, which is critical for establishing the first prong of the ID diagnosis. The Flynn Effect and its role in *Atkins* litigation is discussed in much greater detail a chapter by McGrew.[13]

Hence, in controversion to the Sixth Circuit Court of Appeals suggestion that Flynn Effect adjustments are timed from the date that Atkins was decided, in actuality the window of time for the adjustment is narrow and goes forward from the time that the normative data for the test was obtained to the date that an aging test was administered.

Thank you for the opportunity to evaluate this interesting case. If you have any questions, please feel free to contact me directly any time at (949) 230-7321.

Sincerely,

Daniel A. Martell, Ph.D., A.B.P.P.
Fellow, American Academy of Forensic Psychology
Fellow, National Academy of Neuropsychology
Fellow and Past President, American Academy of Forensic Sciences

[13] McGrew, KS. (2015). Norm obsolescence: the Flynn Effect. Chapter 10 in Polloway, EA (Ed.), The Death Penalty and Intellectual Disability. Washington DC: American Association on Intellectual and Developmental Disabilities.

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BY ELECTRONIC MAIL

May 27, 2025

Marshall Jenson
Asst. Federal Public Defender
810 Broadway, Suite 200
Nashville, TN 37203

RE: Byron Black Updated Examination

Dear Mr. Jensen,

I am writing to share the findings and opinions from my examination and testing of Mr. Black, and review of case materials you have provided pursuant to the above captioned matter.

Referral Questions

1. Based upon your most recent assessment of Mr. Black, do you continue to hold your opinion that Mr. Black is intellectually disabled? Please supply the basis for your opinion.

2. Please describe any changes in Mr. Black's condition since you previously assessed him 2019 and the basis for your conclusions.

3. Please describe any deficits that Mr. Black exhibits with respect to memory, linguistic fluency, and cognitive functioning.

4. Please describe your conclusions regarding Mr. Black's ability to manage his own affairs, with a particular focus on his ability to manage financial affairs and his ability to live independently.

5. At common law, an individual was categorically exempt from execution if he or she was found to be non compos mentis. Does Mr. Black meet the following criteria for being non compos mentis?

a. An idiot is an individual who exhibits low intellectual functioning from nativity and who is incapable of managing his affairs.

b. A person is non compos mentis if by reason of disease, accident, or other mental condition loses memory and understanding such that he is incapable of managing his own affairs.

6. Please describe the symptoms associated with profound intellectual disability. In your opinion, would such an individual be capable of planning and committing a homicide?

Qualifications of Examiner

I received a bachelor's degree in psychology with honors from Washington and Jefferson College (1980), a master's degree in psychology from the University of Virginia (1985), and a Ph.D. in clinical psychology from the University of Virginia (1989). I completed my clinical psychology internship specializing in forensic psychology at New York University Medical Center, Bellevue Hospital, and Kirby Forensic Psychiatric Center in New York City (1986-1987), and was awarded a Post-Doctoral Fellowship in Forensic Psychology, also at New York University Medical Center, Bellevue Hospital, and Kirby Forensic Psychiatric Center during which I specialized in forensic neuropsychology (1987-1988).

I am Board Certified in Forensic Psychology by the American Board of Forensic Psychology of the American Board of Professional Psychology, Diplomate Number 5620. I am a Fellow of the American Academy of Forensic Psychology; a Fellow and Past-President of the American Academy of Forensic Sciences; and a Fellow of the National Academy of Neuropsychology. I am licensed as a clinical psychologist by the State of California, License Number PSY15694.

I am also licensed as a clinical psychologist by the State of New York, License Number 011106.

I have recently retired as an Assistant Clinical Professor of Psychiatry and Biobehavioral Sciences at the Semel Institute for Neuroscience and Human Behavior and the Resnick Neuropsychiatric Hospital of the David Geffen School of Medicine at UCLA where I have been since

1995. From 1992 to 1996 I was a Clinical Assistant Professor in the Department of Psychiatry at New York University School of Medicine.

I have authored over 100 publications and presentations at professional meetings, with a research emphasis on forensic issues involving forensic neuropsychological assessment, mental disorders, brain damage, intellectual disability, elder capacities, and violent criminal behavior.

I have been admitted to testify as an expert witness in more than two hundred cases, including testimony in both criminal and civil matters in federal and state courts throughout the United States. I have consulted and testified for both prosecutors and defense attorneys in criminal cases, as well as plaintiffs and defense attorneys in civil matters. I was the Commonwealth's expert in *Atkins v. Virginia*, and have testified for the State of Tennessee in two prior *Ford* cases, including *State v. Paul Dennis Reid, Jr.* and *State v. Robert Glen Coe*.

Basis for Opinions

Scope of Examination and Informed Consent

I personally re-examined and re-tested Mr. Black on April 28, 2025 in a quiet, private room at the Riverbend Correctional Institution for a total of approximately five hours. Comfort breaks were taken as needed.

He was advised that I had been retained by your office, of the limits on confidentiality in this forensic context, and of the lack of any treating relationship between us. Mr. Black was able to provide his informed consent to participate with this understanding.

Tests and Procedures Administered

During my re-examination I administered a battery of intellectual and neuropsychological tests and procedures including:

- Behavioral Observations and Mental Status Examination
- Structured Neuropsychological Interview
- Advanced Clinical Systems - Word Choice/Effort test
- Dementia Rating Scale -2
- Independent Living Scales

- California Verbal Learning Test-3
- Boston Naming Test
- Trail Making Test, Parts A & B
- Delis-Kaplan Executive Function System
  - Verbal Fluency
  - Color-Word Interference

Examination Findings

Behavioral Observations and Mental Status Examination

Byron Black is now a 69-year-old African American man who presented for testing dressed in yellow, prison-issued scrubs. He arrived at the examination room in a wheelchair. He had a mustache, and his thinning black hair was slicked down and longer at the back of his head. He wore glasses. He was very friendly and outgoing, and recognized me from my previous examination. He was again cooperative and effortful throughout.

He was adequately oriented to the world around him, knowing who he was, where he was, and the approximate date and time. His speech was produced at a normal rate and volume with clear articulation and a normal quantity of output.

His thoughts were expressed in a coherent and logical fashion, although he still exhibited a tendency to go into random tangential details and tell stories unrelated to the topic at hand.

Emotionally his observable affect was stable and broad in range and intensity. His affect was appropriately related to his mood and to the content of his thoughts. His underlying mood was inferred to be euthymic. His insight was fair.

He is in extremely poor health. He described that his weight has increased, having gone from 193 to 200 pounds due to being placed on a "kidney diet." He has Stage 4 renal failure requiring periodic dialysis. He is also diabetic, and reported that he has "Stage 4 heart failure," having had a pacemaker implanted on 5/24/2024. He had surgery to replace his right hip in April of 2025, and is awaiting surgery for his left hip as well. Mr. Black also has a complicated history of other serious medical problems, including prostate cancer surgery with complications due to accidentally cutting into his bladder,

diabetes, congestive heart failure, hypertension, and a degenerative bone disease that has caused him to break his right hip. He had three stents placed in his heart in September of 2018, and also had a hernia operation the same year.

He described his sleep as, "pretty good," using the same words that he did at the time of my prior examination. He stated that his interpersonal relationships or activities are, "OK." When I asked how he has been doing emotionally he said, "pretty good."

He denied awareness of any changes in his speech, language, cognition, or memory, although the testing results contradicted this.

Test Findings

Data Validity

In every high-stakes forensic examination such as this one, it is imperative to determine whether the individual being evaluated is putting forth their best effort, and to rule out malingering. Therefore, as part of my examination I again administered both free-standing and embedded measures of effort and malingering to assess the validity of Mr. Black's test findings.

As before, he "passed" with a valid performance on both the freestanding ACS Word Choice/Effort Test and the embedded Forced-Choice Trial of the CVLT-III. These results indicate that he was putting forth his best effort, and the other tests I administered can be relied upon as valid indicators of his current level of neurocognitive functioning.

Functional Living Ability

I administered the **Independent Living Scales** (ILS) to Mr. Black during this examination. The ILS is a standardized, performance-based assessment designed to evaluate an individual's functional competence and capacity to live independently. It assesses abilities critical to everyday living, particularly in older adults or individuals with cognitive impairments, brain injuries, or psychiatric conditions. It is comprised of five subscales:

1. Memory/Orientation – Awareness of personal information, time, and place.

2. Managing Money – Ability to make financial decisions and perform monetary calculations.
3. Managing Home and Transportation – Skills in home maintenance, meal preparation, and transportation.
4. Health and Safety – Ability to respond to emergencies and manage health-related tasks.
5. Social Adjustment – Judgment in social interactions and use of community resources.

It also includes Problem-Solving and Performance–Information Discrepancy indices to assess discrepancies between knowledge and actual task performance.

Mr. Black obtained the following scores on the ILS:

Scale	Score	Interpretation
Memory/Orientation	42	**Moderate impairment** – impairment in basic orientation and memory for daily functioning.
Managing Money	26	**Extremely low** – Indicates severe difficulty with financial management; high risk/not safe to manage funds independently.
Managing Home/Transportation	35	**Extremely Low** – Major deficits in home-related tasks and safe transportation use.
Health and Safety	36	**Extremely low** – Poor judgment regarding health decisions and personal safety; limited ability to manage health needs and respond to unsafe situations.

Social Adjustment	43	**Moderate impairment** – Significant difficulties in social interactions and use of community resources
Problem Solving	28	**Extremely low** – Severe impairment in applying reasoning and decision -making skills to real-world situations. Unable to make sound, independent decisions.
Performance–Information Discrepancy Index	34	**Large discrepancy** – Indicates that Mr. Black may know what to do in theory but cannot execute tasks effectively in practice.
Full Scale Score	73	**Extremely low** – Overall, Mr. Black shows **marked global impairment** in skills essential for independent living.

Mr. Black's ILS results reflect broad and significant impairment in his adaptive functioning, especially in the areas most critical for safe and autonomous living. Of particular concern is the Managing Money score of 26, suggesting he lacks even basic financial decision-making skills and would be highly vulnerable to financial exploitation or mismanagement. His scores reflect an inconsistent ability to manage daily routines, environmental safety, and personal health needs, indicating that he would be at high risk if left unsupervised. His Problem-Solving Index score is also severely deficient, reflecting poor practical reasoning, diminished judgment, and difficulty adapting to new or unstructured challenges, a key marker of functional incompetence.

Dementia Testing

The **Dementia Rating Scale-2** (DRS-2) is a test that measures multiple cognitive functions associated with dementia including standardized tests of attention and concentration, memory, praxis and constructional ability, and executive functioning. It is normed using data collected as part of the Mayo Clinic's Older Americans Normative Studies (MOANS) and permits the comparison of Mr. Black's test performance with a national sample of 623 community-dwelling elderly participants.

Mr. Black's DRS-2 profile is consistent with a moderate dementia syndrome, with disproportionately severe impairment in executive function, relative preservation of attention and construction, and moderate deficits in memory and conceptualization. His Total Score places him in the bottom 3-5% of others his age.

His scores support the presence of cognitive deficits that affect his functional independence and decision-making capacity. Importantly, the pattern of disproportionate executive impairment could be indicative of frontal-subcortical involvement (e.g., vascular cognitive impairment, frontotemporal dementia) rather than purely Alzheimer's-type pathology.

Neuropsychological Test Score Changes

At the time of my previous testing in 2019, in addition to establishing an IQ in the range of intellectual disability (Full Scale IQ = 67), my testing showed marked impairments in Mr. Black's attention and memory, higher-order executive functioning, and language skills.[1] For the present examination, I selected a battery of neurocognitive tests looking for any changes in his brain functioning in these areas.

Results indicated a very significant neurocognitive decline. His scores over time are summarized in the table below. All test results are expressed in national percentiles, comparing Mr. Black to others of his age, sex, and education:

[1] 8/25/2020 report, p. 13.

Test	12/2019	04/2025
Boston Naming Test	<0.1%	<0.0001%
F-A-S Verbal Fluency	25%	2%
Delis-Kaplan Executive Function System Color-Word		
Color Naming	16%	1%
Word Reading	16%	2%
Inhibition	50%	50%
Switching	75%	25%
California Verbal Learning Test		
Trials 1–5 Correct	32%	5%
Delayed Recall Correct	9%	1%
Total Recall Correct	19%	3%
Trail Making Part A	2%	16%
Trail Making Part B	0.2%	18%

Attention and memory. Mr. Black's scores have fallen significantly in this area, to the point where his ability to attend to a list of items and repeat them back, even after multiple repetitions is severely impaired. After a short delay period, his memory for those same items falls to the bottom first percentile (i.e., 99 out of 100 men of his age and education can remember more of the list). His score on the Trail Making Test, Part A however, did show improvement, but still fell in the bottom 16th percentile.

Language. Mr. Black has also experienced a substantial loss in his ability to find words to express himself. He was severely impaired in this area in 2019 (less than one man in a thousand performs as badly as he did), but his expressive language in this area is now even more profoundly disabled, to the point where less that one in over 10,000 are as impaired as he is. His verbal fluency, as measured by his ability to say words beginning with different letters (F-A-S), fell from the 25th percentile to the bottom 2nd percentile nationally.

Executive functioning. His higher-order cognitive abilities required for reasoning, problem-solving, and abstract thinking have also diminished significantly. For example, he was impaired in his ability to name things one might buy in a grocery store. He had great difficulty

with dividing his attention between competing ideas, like switching between naming pieces of fruit and pieces of furniture, or naming colors, and reading words for colors, and switching between them. His score on the Trail Making Test, Part B, however, showed improvement.

Answers to Referral Questions

1. Based upon your most recent assessment of Mr. Black, do you continue to hold your opinion that Mr. Black is intellectually disabled? Please supply the basis for your opinion.

> Mr. Black met all the criteria for a diagnosis on Intellectual Disability at the time of my assessment in 2009. Since that time, he has experienced substantial physical and mental decline that have affected both his his neurocognitive capacity as well as his functional adaptation skills. He is now fully dependent on others for basic functional activities of daily living, and unable to fend for himself independently if left unassisted.
>
> He remains Intellectually Disabled.

2. Please describe any changes in Mr. Black's condition since you previously assessed him 2019 and the basis for your conclusions.

> As reported in detail above, Mr. Black's mental condition has deteriorated significantly over the past six years. He has experienced substantial neurocognitive losses in the areas of memory, language, and executive functioning that are most likely attributable to a combination of his multiple medical

conditions, most notably stage 4 renal failure,[2] and stage 4 heart failure;[3] as well as his advancing age.

3. Please describe any deficits that Mr. Black exhibits with respect to memory, linguistic fluency, and cognitive functioning.

Mr. Black has experienced additional significant declines in his memory, verbal fluency, and executive functioning with many of his current test scores placing him in the very bottom percentiles of the population in these areas. These impairments are described in detail above. His neurocognitive functioning is following a deteriorating course.

4. Please describe your conclusions regarding Mr. Black's ability to manage his own affairs, with a particular focus on his ability to manage financial affairs and his ability to live independently.

Based on his history and the present testing, Mr. Black is unable to manage his own affairs. He is unable to live independently without external sources of support, and this has been true throughout his lifetime. He is also dependent on others for managing financial affairs.

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[2] Weiner DE, Seliger SL. Cognitive and physical function in chronic kidney disease. Curr Opin Nephrol Hypertens. 2014 May;23(3):291-7.

Zammit AR, Katz MJ, Bitzer M, Lipton RB. Cognitive Impairment and Dementia in Older Adults With Chronic Kidney Disease: A Review. Alzheimer Dis Assoc Disord. 2016 Oct-Dec;30(4):357-366.

Sánchez-Román S, Ostrosky-Solís F, Morales-Buenrostro LE, Nogués-Vizcaíno MG, Alberú J, McClintock SM. Neurocognitive Profile of an Adult Sample With Chronic Kidney Disease. Journal of the International Neuropsychological Society. 2011;17(1):80-90.

[3] Goyal, P., Albert, N., et al. (2024). Cognitive Impairment in Heart Failure: A Heart Failure Society of America Scientific Statement. Journal of Cardiac Failure, Volume 30, Issue 3, 488 – 504.

Tirziu, Daniela et al. (2023). Impact and Implications of Neurocognitive Dysfunction in the Management of Ischemic Heart Failure. Journal of the Society for Cardiovascular Angiography & Interventions, Volume 2, Issue 6, 101198.

5. At common law, an individual was categorically exempt from execution if he or she was found to be non compos mentis. Does Mr. Black meet the following criteria for being non compos mentis?

a. An idiot is an individual who exhibits low intellectual functioning from nativity and who is incapable of managing his affairs.

b. A person is non compos mentis if by reason of disease, accident, or other mental condition loses memory and understanding such that he is incapable of managing his own affairs.

Yes, Mr. Black meets this definition. His intellectual deficits are documented to have been life-long, he has never been capable of managing his own affairs or living independently, and he is totally dependent on others at the present time.

6. Please describe the symptoms associated with profound intellectual disability. In your opinion, would such an individual be capable of planning and committing a homicide?

The severity of intellectual disability is graded on a scale from mild to moderate to severe to profound. A person with profound intellectual disability (ID) is extremely unlikely to be capable of committing murder in the conventional legal or psychological sense, due to the severity of their cognitive and adaptive impairments.

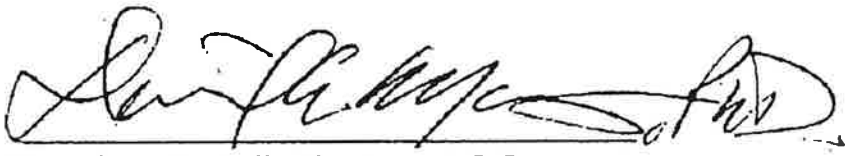
Individuals with profound ID typically have IQs below 20–25 and function at the level of an infant or toddler. They are nonverbal or minimally verbal, don't understand cause-and-effect relationships, and require 24/7 supervision for all activities, including basic self-care. They lack understanding of abstract concepts, including legal or moral ideas such as right/wrong, intent, or consequences.

As a result of these profound limitations, they would lack the capacity to form the intent to kill, as they would be incapable of planning or understanding the nature or consequences of a homicidal act. In rare cases where a person with profound ID is physically involved in an act that causes another's death, the

context is typically accidental or the result of impulsive behavior without understanding the consequences.

Thank you for the opportunity to evaluate this interesting case. If you have any questions, please feel free to contact me directly any time at (949) 230-7321.

Sincerely,



Daniel A. Martell, Ph.D., A.B.P.P.
Fellow, American Academy of Forensic Psychology
Fellow, National Academy of Neuropsychology
Fellow and Past President, American Academy of Forensic Sciences

LEA ANN PRESTON BAECHT, PH.D., ABPP
CLINICAL PSYCHOLOGIST
BOARD CERTIFIED IN FORENSIC PSYCHOLOGY

FORENSIC PSYCHOLOGICAL REPORT

OPINION REGARDING COMPETENCY TO BE EXECUTED

Name:	**Byron Black**
Date of Birth:	3/23/1956
Dates Interviewed:	5/14/2025, 5/15/2025, and 5/21/2025
Date of Report:	5/28/2025

REFERRAL INFORMATION

Mr. Black is a 69-year-old man who was referred to me by his defense counsel, Marshall Jensen, Assistant Federal Public Defender, Capital Habeas Unit, Middle District of Tennessee, for a mental health evaluation to assess his competency to be executed. He is currently housed at the Riverbend Maximum Security Institution in Nashville, Tennessee. In March 1989, Mr. Black was convicted of three counts of Murder in the First Degree, for the deaths of Angela Clay and her two daughters, Latoya and Lakeisha Clay. He was sentenced to death for the murder of Lakeisha Clay. Currently, he has an execution date of 8/5/2025.

QUALIFICATIONS AND EXPERIENCE OF EXAMINER

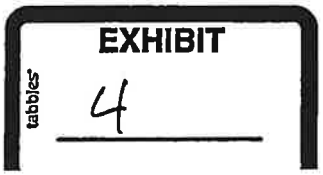
I received a Bachelor's Degree in Psychology from Western Illinois University in Macomb, Illinois, in 1991. I obtained a Master's Degree in Clinical Psychology from Southern Illinois University in Carbondale, Illinois, in 1995, and a Ph.D. in Clinical Psychology from Southern Illinois University in Carbondale, Illinois, in 1998. I completed my one-year pre-doctoral internship at the United States Medical Center for Federal Prisoners, in Springfield, Missouri in 1998. Following this, I was awarded a one-year Post-Doctoral Fellowship in Forensic Psychology at the United States Medical Center for Federal Prisoners, where I received specialized training in conducting forensic assessments under the supervision of board-certified forensic psychologists.

After completing my specialty training in forensic psychology, I was hired as a full-time forensic psychologist at the United States Medical Center for Federal Prisoners. I subsequently worked for 23 years at that facility, completing approximately 1,500 court-ordered forensic evaluations of pre-trial federal defendants. These forensic evaluations most frequently addressed issues such as competency to stand trial, mental state at the time of the offense, need for inpatient mental health treatment, and risk of future dangerousness. However, in this role, I was also involved in several cases involving *Atkins* issues, along with several cases addressing the issue of competency in capital cases (competency to stand trial, competency to assist in Habeas Appeals, competency to waive Habeas Appeals, and competency to be executed). In this role, I often worked with defendants diagnosed with severe mental illness, along with intellectual disabilities.

I retired from the Federal Bureau of Prisons in December 2021, and since that time, I have maintained a private forensic practice. In my private practice, I conduct evaluations for Social Security Disability Determinations. I also conduct pre-trial forensic evaluations addressing issues such as competency to stand trial, mental state at the time of the offense, diminished capacity, risk of future dangerousness, and competency to be executed.

In my nearly three decades as a forensic psychologist, I have testified more than 150 times and have been qualified as an expert in forensic psychology in numerous federal courts across the country, as well as state courts in Missouri and Oklahoma.

I hold licenses to practice psychology in Missouri (License Number 2018036917), New York (License Number 024722-01), and New Mexico (License Number PSY-2023-0033). I also hold credentials through PSYPACT (Psychology Interjurisdictional Compact), which allows me to practice psychology in participating PSYPACT states (which include Tennessee).



I have been Board Certified in Forensic Psychology by the American Board of Professional Psychology since 2011, and I was previously a faculty member for the Board of Forensic Psychology (2019-2024). In my role as a faculty member, I reviewed work samples and was involved in conducting oral exams of individuals seeking to obtain board certification in forensic psychology.

EVALUATION PROCEDURES

Mr. Black was interviewed in a private visitation room at the Riverbend Maximum Security Institution on 5/14/2025 (approximately 4 hours), 5/15/2025 (approximately 2 hours), and 5/21/2025 (approximately 1.5 hours). Mr. Blacks's defense counsel, Marshall Jensen, was present as an observer during these interviews.

At the outset of our first interview, I informed Mr. Black of the nature and purpose of the evaluation, as well as the limits of confidentiality of the information to be obtained. I explained that I had been asked to evaluate whether he was competent to be executed. I further explained that in forming my opinion I would use information he provided, as well as information contained in collateral records. He was informed that I would be sharing my opinion with his defense counsel, and if he requested that I do so, that I would be writing a report explaining my conclusions. I further explained that if I was asked to prepare a report then his defense counsel would share that report with the Court and other parties involved in the litigation. I explained that if that were to occur, I could also be asked to testify in Court about my findings. Mr. Black demonstrated a sufficient understanding of this information and agreed to proceed with the interview. At the beginning of each of our subsequent two interviews, this information was again briefly reviewed.

As part of the evaluation, I reviewed the following documents, which were provided to me by his defense counsel:

1. Report, authored by Daniel A. Martell, Ph.D., ABPP, dated 05/27/2025.
2. Report, authored by Ruben C. Gur, Ph.D., and Jack C. Lennon, M.A., dated 05/22/2025.
3. Supplemental Report, authored by Daniel A. Martell, Ph.D., A.B.P.P., dated 12/13/2021.
4. Motion to Declare Petitioner Intellectually Disabled Pursuant to Tennessee Code Annotated §39-13-203, dated 06/04/2021.
5. Psychological Report, authored by Daniel A. Martell, Ph.D., ABPP, dated 08/25/2020.
6. Revised Declaration of Stephen Greenspan, Ph.D., dated 07/20/2019.
7. Affidavit, Pamela Auble, dated 7/18/2009.
8. Declaration of Freda Black Whitney, dated 03/16/2008.
9. Declaration of Melba Black Corley, dated 03/15/2008.
10. Declaration of Stephen Greenspan, Ph.D., dated 03/13/2008.
11. Declaration of Marc J. Tassé, Ph.D., FAAIDD, dated 03/08/2008.
12. Declaration of Rossi Turner, dated 03/15/2008.
13. Affidavit of Dr. Daniel Grant, filed 11/23/2004.
14. Report, authored by Eric S. Engum, Ph.D., J.D., dated 7/2/2003.
15. Report, authored by Susan R. Vaught, Ph.D., dated May 2003.
16. Declaration of Ruben Gur, Ph.D., dated 11/15/2001.
17. Preliminary Neuropsychiatric Evaluation, authored by Albert Globus, M.D., dated 11/14/2001.

18. Declaration of Ross Alderman, Esq., dated 11/04/2001.
19. Psychological Evaluation Report, authored by Patti van Eys, Ph.D., dated 03/28/2001.
20. Neuropsychological Evaluation Report, authored by Pamela Auble, Ph.D. dated 3/5/1997.
21. Preliminary Psychiatric Evaluation, authored by William Bernet, M.D., dated January 20, 1997.
22. Report of Gilliam Blair, Ph.D., dated 10/7/1993.
23. State v. Black Direct Appeal, dated August 5, 1991.
24. Two letters, addressed to Pat McNeely, defense counsel, authored by Mr. Black, dated June 1989 and July 1989.
25. Transcript of Competency Hearing of Mr. Black, dated 2/16/1989 and 2/21/1989.
26. Order directing William Kenner to conduct an evaluation of Mr. Black's competency, dated 2/16/1989.
27. Psychological Evaluation Report, authored by Kenneth Anchor, Ph.D., dated 1/17/1989.
28. Records from VUMC regarding Mr. Black, to include brain imaging studies.

I also conducted a collateral interview via telephone with Mr. Black's youngest sister, Freda Black Whitney, on 5/20/2025. Given that Mr. Black has undergone psychological testing on numerous prior occasions, no additional psychological testing was administered.

BEHAVIORAL OBSERVATIONS/CURRENT MENTAL FUNCTIONING

Appearance, attitude, and behavior: As noted above, Mr. Black was interviewed on three separate occasions (5/14/2025, 5/15/2025, and 5/21/2025) at Riverbend Maximum Security Institution for a total of approximately 7.5 hours. This evaluation was conducted in a small private room, and there were no significant interruptions or distractions during the evaluation. He was in a wheelchair[1], and a peer assisted him by pushing him to the interview room.

His hygiene and grooming were good, and he was attired in clean jail-issued clothing. Throughout our three clinical interactions, Mr. Black sat calmly, and he made appropriate eye contact. On each occasion, he presented as friendly and was easily engaged in conversation. He generally demonstrated appropriate social boundaries during our interactions, though he was overly familiar at the conclusion of each our interviews (e.g., stating he loved us both, referring to me and Mr. Jensen). Overall, he presented as rather simplistic and concrete in his thinking. Notably, he appeared to minimize his history of deficits which are documented in collateral records (e.g., denying issues related to learning offensive football plays in high school, denying any deficits in social skills as a child, denying deficits in reading, math, or money management), and my impression was that he was naively attempting to paint himself in a positive light.

Thought process and content: During each of our interactions, Mr. Black was properly oriented to person, place, time, and situation. His speech was normal in rate and volume, with no signs of pressured speech (i.e., speaking quickly or more than usual with an urgent need to express thoughts without interruption) or flight of ideas (i.e., rapidly jumping from one topic to the next). Although he generally answered questions relevantly, on occasion, his responses were irrelevant to the query posed to him. On those occasions, it was suspected that he either did not understand the question or did not recall the information being asked. (Notably, it is not uncommon for individuals with low intellect to attempt to mask their lack of understanding by simply providing a response, even if it does not answer the question.)

Additionally, while Mr. Black largely expressed his thoughts in a coherent and logical fashion, he periodically digressed from the topic being discussed. Similarly, he also periodically interjected irrelevant information. Notably, while most of the information he provided regarding his social history was consistent with collateral records, he struggled with recalling accurate timelines. Relatedly, Mr. Black also periodically provided inaccurate information about his history (e.g., that he had Covid in 2018), and it was clear that on the occasions when this occurred, he did not recognize that the information he presented was not accurate. These instances appeared reflective of confabulation, which refers to a memory error where a person unintentionally recalls false or distorted memories

[1] Mr. Black reportedly recently underwent a right hip replacement and is unable to walk unassisted at this time.

and believes them to be accurate. Confabulations are often associated with intellectual disability and neurocognitive disorders.

In discussing his current legal situation, Mr. Black made some statements regarding his trial, which were not believed to be reality-based (e.g., asserting that he witnessed the mother of Angela Clay provide an envelope to the judge assigned to the case). Given his history and current presentation, it is my opinion that this assertion is an example of a confabulation as opposed to a delusion. (Both delusions and confabulations are forms of false beliefs, but they differ in etiology, with confabulations being associated with neurocognitive disorders, and delusions being associated with psychotic disorders.) Mr. Black denied a history of experiencing psychotic symptoms (hallucinations, disorganized thinking, delusions), and none were observed. When asked, he denied a history of paranoid delusional ideation (e.g., that others have attempted to harm him, plot against him, or spy on him). He also denied a history of experiencing ideas of reference (i.e., a false belief that neutral events have special, personal meaning) or being preoccupied with beliefs that others viewed as odd or inaccurate. He also denied ever believing that his thoughts could be broadcast or that thoughts could be inserted into his mind.

Mood: Mr. Black denied feeling significantly depressed during our clinical interaction, though he shared that he has lost a large number of friends and family members this past year. When asked, he rated his mood as "6" on a 10-point scale with "1" representing "very depressed." He did not report experiencing any symptoms of depression, and he denied a history of ever feeling suicidal. His affect, meaning his behavioral expression of emotion, was consistent with the content of his speech. He smiled and laughed at socially appropriate times, and he never became tearful.

Mr. Black also denied a history of ever experiencing manic symptoms. Mania refers to an extremely elevated or irritable mood. Consistent with his self-report, collateral records do not document a history of manic symptoms, and he was not observed to demonstrate any symptoms of mania.

Perception: Mr. Black denied a history of ever experiencing auditory or visual hallucinations, and he did not engage in any behavior during the current evaluation suggestive of attending to hallucinations.

SUMMARY OF RELEVANT RECORDS

Mr. Black's personal history has been detailed in prior reports submitted to the Court and will not be repeated here. The following is a brief summary of information from his background that is relevant to diagnostic considerations. In terms of his educational history, the records indicate that Mr. Black was held back in the second grade, though he was reportedly never identified as being in need of special education programming. (Relevantly, Dr. Greenspan noted in his declaration that the federal statute that mandated special education was not enacted until the year that Mr. Black left high school; thus, it is likely that many children during this era were not correctly identified as needing special education services.) Records indicate that Mr. Black was never administered an individual IQ test during his developmental years, and all IQ scores contained in his school records were obtained from group-administered tests of intelligence. (Group measures are not considered to be appropriate for ruling out the presence of intellectual disability due to issues with their reliability and validity.)

Collateral records indicate that as an adult, Mr. Black generally maintained unskilled employment. However, he reportedly never lived independently, instead living with members of his family (i.e., parents, cousin) even during his brief marriage. There is no information in the collateral records to suggest that he ever participated in mental health treatment in the community.

EVALUATIONS OF MR. BLACK'S COMPETENCY TO STAND TRIAL:

DeDe Wallace Mental Health Center: In September 1988, Mr. Black was evaluated by a three-person team at DeDe Wallace Mental Health Center (Leonard Morgan, Jr., Ph.D., Brad Diner, M.D., and Calvilyn Allmon, M.S.W.), who each separately interviewed Mr. Black and concluded that he was competent to stand trial. Dr. Diner reportedly interviewed Mr. Black for 45 minutes, Dr. Morgan interviewed him for 60 minutes, and Ms. Allmon

interviewed him for 45 minutes. Notably, no psychological testing was completed as part of this evaluation, and the assessment of Mr. Black's intellectual abilities appears to have been guided by clinical judgment only.

Notably, the field of forensic psychology has evolved considerably since the time these evaluations were completed, with improvements in training, scientific knowledge, available assessment measures, and guidelines for best practice. Indeed, it was not until 1991 that the American Psychological Association (APA) developed and published the Specialty Guidelines for Forensic Psychologists.

Of concern, the evaluations completed by the clinicians at DeDe Wallace Mental Health Center appeared to have been quite brief and cursory in nature. Indeed, Dr. Morgan testified that at the time, he was conducting four to five evaluations per week, which is an incredibly high number and suggests he and his colleagues were significantly overworked. To put this into context, the Federal Bureau of Prisons generally does not assign an evaluator more than four evaluations per *month* if possible, as they recognize that the quality of the work will decrease if more cases are assigned. Additionally, as noted above, no psychological testing was completed as part of these evaluations, and it appears likely that if testing had been completed at that time, they would have identified Mr. Black's intellectual deficits and more thoroughly assessed his competency-related abilities. Relatedly, it also appears that no assessment of Mr. Black's *decisional* capabilities (which are critical in the assessment of a defendant's ability to assist in their own defense) was completed. This issue is particularly concerning given that research has shown that deficits in decisional capabilities are often what underlie a finding of incompetency in individuals with intellectual disability. Lastly, testimony from the competency hearing in this case raised a concern for the presence of bias on the part of the evaluators, as well as the offering of unsupported opinions. For example, in his testimony, Dr. Morgan discussed assumptions that he made about Mr. Black ("that he was selling himself") and when asked how he arrived at that conclusion, he stated, "I believe it's because he looks, and talks, and reacts like so many other people like that that I've worked with daily."

Kenneth Anchor, Ph.D.: In January 1989, Mr. Black was evaluated by a defense-retained expert, Kenneth Anchor, Ph.D. Dr. Anchor administered the Shipley-Hartford Institute of Living Scale-Revised, a paper-pencil questionnaire that provides an estimated IQ score. This measure is not considered appropriate for diagnosing or ruling out a diagnosis of intellectual disability. Mr. Black's performance on this measure provided an estimated IQ score of 76. Dr. Anchor further noted Mr. Black had deficits in his knowledge of legal proceedings and concluded, "His competence to stand trial at this time was difficult to establish."

Notably, while Dr. Anchor did complete some psychological testing in this case, I also have concerns regarding the quality of Dr. Anchor's evaluation of Mr. Black's competency. Of concern, Dr. Anchor struggled to articulate the basis for his opinion during testimony, and he made some statements which were simply inaccurate (i.e., that a low score on the Lie Scale of the MMPI could provide insight into whether the defendant was being truthful about matters unrelated to the MMPI).

Dr. William Kenner: On February 16, 1989, the court appointed Dr. Kenner to complete an independent evaluation of Mr. Black's competency. It does not appear that Dr. Kenner administered any psychological testing. Dr. Kenner later testified that he believed Mr. Black "meets the minimum standard for competency."

Of concern, it appears that Dr. Kenner also spent only a brief amount of time with Mr. Black before concluding that he was competent (i.e., 1 hour and 30 minutes). In this short time frame, he asserted that he gathered a detailed history from Mr. Black, as well as completed a competency-focused interview. (In my experience, it takes much longer to conduct a thorough social history interview and a thorough competency-focused interview, particularly in high-stakes capital cases.) Like prior evaluators, there is no information to suggest that Dr. Kenner evaluated Mr. Black's decisional competence. Lastly, the content of Dr. Kenner's testimony during the competency hearing raised the concern of confirmation bias (i.e., when an individual favors information that confirms their existing beliefs, resulting in them overlooking or downplaying contradictory evidence or the possibility of contradictory evidence.) For example, when asked if it were possible that he may have changed his opinion if he had spent more time with Mr. Black, Dr. Kenner testified, "I don't feel it would change. If it were a borderline case and I had some questions about it, then I would have spent more time with him. But I felt like he was fairly open-and-shut, clearly

competent." However, on cross-examination, Dr. Kenner acknowledged there were some legal issues of particular relevance to Mr. Black's case that he did not explore to determine if Mr. Black understood those concepts (e.g., the two parts to his trial, mitigating evidence, and aggravating evidence). Recognizing that the field of forensic psychology has evolved significantly since this evaluation took place, in my opinion, this evaluation would not meet today's expected standard of forensic practice in a capital case.

POST-CONVICTION EVALUATIONS:

Following his conviction for the instant offenses, Mr. Black underwent a number of evaluations, many of which included the administration of individually administered tests of intelligence. Although many of these evaluators also administered tests of personality, the following summary will focus on Mr. Black's assessed IQ scores. Notably, in the past four decades, there have been advancements in our understanding of the proper methods to assess for the presence of intellectual disability. More specifically, current national standards for the assessment of intellectual disability (as recommended by the American Association on Intellectual and Developmental Disabilities (AAIDD) Manual) specifically recommend correcting for the "Flynn Effect[2]." Thus, Flynn-Adjusted scores will also be listed below, even when they were not originally considered by the evaluating clinician.

Gillian Blair, Ph.D.: In her Psychological Report, dated 10/7/1993, Dr. Blair noted that Mr. Black obtained the following scores on the Wechsler Adult Intelligence Scale, Revised (WAIS-R): Verbal Intelligence Quotient (VIQ) = 73, Performance Intelligence Quotient (PIQ) = 75, Full Scale Intelligence Quotient (FSIQ) = 73. Dr. Blair did not attempt to assess Mr. Black's adaptive behavior. Although Dr. Blair did not calculate a Flynn-Adjusted Score at the time of her evaluation, Mr. Black's Flynn-Adjusted FSIQ would be 69.

Pamela Auble, Ph.D., ABPP, Clinical Neuropsychologist: In her Neuropsychological Evaluation Report, dated 3/5/1997, Dr. Auble documented that she administered a large battery of tests to Mr. Black to assess personality, malingering, attention, memory, and intellectual functioning. She noted that on the WAIS-R, Mr. Black obtained the following scores: VIQ= 76, PIQ = 77, FSIQ = 76. She further noted, "There was no evidence of a systematic attempt to fake wrong answers on the cognitive testing." Dr. Auble did not administer any measures to assess Mr. Black's academic skills or adaptive behavior. Although Dr. Auble did not calculate a Flynn-Adjusted Score at the time of her evaluation, Mr. Black's Flynn-Adjusted FSIQ would be 71.

Patti van Eys, Ph.D.: In her Psychological Report, dated 3/28/2001, Dr. van Eys noted that on the WAIS-III, Mr. Black obtained a VIQ = 67, PIQ = 79, and FSIQ = 69. No additional assessment instruments were administered. Although Dr. van Eys did not calculate a Flynn-Adjusted Score at the time of her evaluation, Mr. Black's Flynn-Adjusted FSIQ would be 67.

Daniel H. Grant, Ph.D.: Dr. Grant evaluated Mr. Black on 10/15/2001 and 10/16/2001 and administered several tests to include the Stanford-Binet Intelligence Scale - Fourth Edition, the Wide Range Achievement Test 3 Edition (WRAT-3), and the Nelson-Denny Reading Comprehension Test. Mr. Black's academic skills as measured on the WRAT-3 and Nelson-Denny Reading Comprehension Test produced grade-equivalents of 4th grade for both arithmetic and reading comprehension. His performance on the Stanford-Binet Intelligence Test-Fourth Edition yielded the following scores: Verbal Reasoning = 56, Abstract Reasoning 76, Quantitative Reasoning = 61, Short-term Memory = 56, and Composite Score = 57. Although Dr. Grant did not calculate a Flynn-Adjusted Score at the time of his evaluation, Mr. Black's Flynn-Adjusted FSIQ would be 53.

Albert Globus, M.D.: On November 14, 2001, Dr. Globus wrote in a preliminary psychiatric evaluation that based upon his review of previously administered psychological testing and collateral records, he believed Mr. Black "suffers from major deficiencies in attention, memory, cognition, affect, and social judgement that are consistent

[2] The Flynn Effect refers to the robust research finding that the US population is gaining an average of three full scale IQ points per decade. Thus, as a test's norms become out of date, it contributes to the error in measurement of an individual's IQ. This error in measurement should be considered in considering an individual's IQ score.

with a diagnosis of mental retardation." Dr. Globus did not administer any psychological testing during his evaluation of Mr. Black.

Ruben Gur, Ph.D.: On 11/15/2001, Dr. Gur submitted a declaration indicating that he believed it likely that Mr. Black suffered from a brain disorder. In support of this conclusion, he cited Mr. Black's history of head injury as a high school athlete, reports that he may have been exposed to alcohol in utero, that he was likely exposed to lead as a child, that he experienced iron deficiency anemia as an infant, as well as his review of neuropsychological testing.

POST-CONVICTION REPORTS BASED ON REVIEW OF DATA

Susan R. Vaught, Ph.D.: In May 2003, Dr. Vaught reviewed Mr. Black's prior evaluations and collateral records and offered the opinion that "there is sufficient evidence to give the benefit of the doubt to Mr. Black, in that he may be currently functioning at or near the clinical and legal cut-off score of 70 on most acceptable measures, at this time in his life." However, she also concluded that there was "not sufficient evidence to diagnose adaptive deficits meeting criteria for mental retardation/developmental disability." Notably, Dr. Vaught did not administer any standardized assessment tools to assess for deficits in adaptive behavior (as recommended by the American Association on Intellectual and Developmental Disabilities (AAIDD) Manual) but rather simply relied upon her review of the available collateral records at that time. Dr. Vaught also concluded that she "could find no compelling evidence that the lower-functioning picture I see now in Mr. Black's intellectual testing emerged prior to age 18, when he still seemed to be functioning in the low average to borderline range intellectually and academically." Thus, she concluded that he did not meet the full criteria required for a diagnosis of intellectual disability (formerly referred to as mental retardation).

Eric S. Engum, Ph.D., J.D.: In a report dated 07/02/2003, Dr. Engum reviewed prior evaluations and collateral records in order to opine on whether he believed Mr. Black met the criteria for an intellectual disability. In his report, Dr. Engum asserted that the reason Mr. Black did not undergo individually administered intelligence testing as a child was likely because there was no perception by educators that Mr. Black had any intellectual deficits—an assertion that simply ignores the myriad of other potential reasons why such testing was not completed. Dr. Engum also speculated that Mr. Black may have attempted to malinger intellectual deficits when evaluated by Dr. van Eys; however, in my opinion, this assertion was not well-supported and was speculative. Dr. Engum also opined that IQ scores should not be corrected for error in measurement (i.e., Flynn-adjusted). Dr. Engum ultimately opined that "there is no indication that Mr. Black has performed in the past or is presently performing in the mentally retarded range of functioning."

Stephen Greenspan, Ph.D.: On 3/13/2008, Dr. Greenspan submitted a declaration which detailed his review of the relevant records in this case, as well as his assessment of Mr. Black's history of adaptive functioning. In this declaration, he noted that Tennessee Circuit Court Judge Walter C. Kurtz had recently opined on 5/5/2004, that Mr. Black did not meet the criteria for Intellectual Disability (formerly referred to as mental retardation) and thus would not be exempt from execution under *Atkins v. Virginia*. In order to assess Mr. Black's adaptive functioning, Dr. Greenspan conducted collateral interviews and completed a retrospective evaluation of Mr. Black's adaptive functioning at age 17.5 years using the Vineland-2 questionnaire. He also administered the SSSQ, a direct measure of adaptive behavior, to Mr. Black. Dr. Greenspan documented that Mr. Black's scores on the Vineland-2 were indicative of significant deficits in adaptive behavior. Dr. Greenspan also opined that based on his review of the data, he believed these deficits were present during the developmental period (e.g., being held back in the second grade, scores under the 70-75 ceiling on the Differential Aptitude Test given in the 9th grade and mostly failing grades in high school).

Marc J. Tasse, Ph.D.: On 3/18/2008, Dr. Tasse submitted a declaration which detailed his review of the evaluations of Mr. Black, along with his expertise with respect to the assessment and diagnosis of Intellectual Disability. In his declaration, Dr. Tasse noted that there was no reliable individualized assessment of Mr. Black's intellectual functioning completed during his developmental years. He further noted that there was evidence to suggest that Mr. Black struggled academically (e.g., "doing poorly in reading and having been retained in second grade"). He

further opined, "There appears to be compelling evidence that Mr. Black's current intellectual functioning is significantly subaverage. Most experts agree that Mr. Black meets prong 1 of the definition of mental retardation." Additionally, he noted that Dr. Greenspan's recent comprehensive evaluation of Mr. Black's adaptive behavior provided strong evidence that Mr. Black experienced significant limitations in adaptive behavior and that these deficits were manifested prior to age 18 years.

Daniel A. Martell, Ph.D., ABPP: On 12/10/2019 and 12/11/2019, Dr. Martell evaluated Mr. Black at the request of his defense team to offer an opinion as to whether Mr. Black met the diagnostic criteria for Intellectual Disability. Dr. Martell administered a large battery of psychological tests, to include tests of intelligence, memory, and effort. In his report, dated August 25, 2020, Dr. Martell noted that both free-standing and embedded measures of effort indicated that Mr. Black did not attempt to malinger intellectual or cognitive deficits. On the WAIS-IV, Mr. Black obtained the following scores: Verbal Comprehension Index=72, Perceptual Reasoning Index= 75, Working Memory Index=69, Processing Speed Index=71, and Full Scale IQ =67. Dr. Martell also found that Mr. Black's performance on the Wide Range Achievement Test-IV showed math skills at the 2nd percentile and reading skills at the 4th percentile. He also demonstrated impaired memory functioning on the Wechsler Memory Scale-IV, as well as deficits in language functioning on the Boston Naming Test. Based on the available data, Dr. Martell opined that Mr. Black has significantly subaverage intellectual functioning, significant deficits in all three domains of adaptive functioning (conceptual, social, and practical), and that these intellectual and adaptive deficits were present during the developmental period. Ultimately, he concluded, "Based on these findings, it is my opinion that Byron Black meets all of the criteria for a diagnosis of Intellectual Disability pursuant to *Atkins v. Virginia*."

Susan R. Vaught, Ph.D.: In 2022, Dr. Vaught was retained by the Office of the Federal Public Defender in Nashville, Tennessee, to reconsider her May 2003 opinion on whether Mr. Black met the criteria for intellectual disability. In her report, dated 02/28/2022, Dr. Vaught noted she was asked to "review additional documentation now available in this case, and to consider changes in Tennessee law, standards of care, and diagnostic criteria that have occurred since [she] rendered the original opinion." Relatedly, she noted in her report, "scientific knowledge, clinical practice and diagnostic standards based on that science, and terminology related to developmental and intellectual disabilities have evolved considerably in the nearly two decades since [she] last reviewed this case." More specifically, she noted that clinical studies, standard of practice and Tennessee law no longer relied upon a "bright line" IQ score as a cutoff for the diagnosis of intellectual disability. That said, she noted, "My clinical opinion in 2022, as in 2003, is that Mr. Black has consistently tested in the mild range of intellectual disability as an adult and continues to do so." Additionally, Dr. Vaught noted that since her original record review of Mr. Black in 2003, more information had become available (through reports from family, friends, and former educators) regarding Mr. Black's general functioning as a child, adolescent, and young adult. She further noted that after considering the additional information, to include the findings of Dr. Greenspan, she now believed "the preponderance of data in Mr. Black's record shows that he does meet the diagnostic criteria of developmentally-based adaptive deficits." Dr. Vaught also noted that there was now considerably more information in the record to document that Mr. Black's deficits were present during the developmental period, and she cited a number of specific examples/statements from the record which she found to be particularly relevant to support this conclusion. In her report, Dr. Vaught also thoughtfully discussed the changes in standard practice in the diagnosis of intellectual disability since her original report, explaining that while adjusting scores for the Flynn Effect was not common in 2003, the field now recognizes that "applying this correction to scores from older versions of tests, and older scores, in order to look at them through today's lens for clinical diagnosis, not only should be done, but must be done for accuracy's sake." Ultimately, she opined, "My 2022 opinion differs from my 2003 opinion in that I believe the preponderance of data in Mr. Black's record shows that based on current scientific knowledge and standards of clinical practice, Mr. Black does meet the onset criteria for the diagnosis of intellectual disability." She further noted, "Based exclusively on review of extensive available records, in my professional opinion, Byron Black does meet criteria established in the 2021 changes to § 39-13-203 for diagnosis of intellectual disability. This represents a change in my 2003 opinion, based on new information in his record, the ability to review his performance at multiple points in time across multiple practitioners, changes in scientific knowledge and standards of practice, and changes in diagnostic criteria, which I have outlined in the body of this report."

Ruben Gur, Ph.D.: On 05/10/2022, Mr. Black underwent a structural magnetic resonance imaging (sMRI) and a positron emission tomography (PET). The results from these imaging studies were then analyzed by Dr. Ruben Gur, a professor in the Department of Psychiatry, Radiology and Neurology at the University of Pennsylvania School of Medicine. In his report, dated 05/22/2025, Dr. Gur noted, "Collectively, structural MRI findings in Mr. Black indicate profound and widespread volume loss." He further noted, "functional consequences are expected across cognitive, emotional, and social domains." Dr. Gur further concluded, "Results of the structural neuroimaging findings show brain dysfunction that may impair Mr. Black's ability to integrate information and base decisions on intact reasoning and appreciation of situation-specific contingencies. He likely experiences cognitive deficits, particularly in the context of executive and memory functions, multimodal integration of sensory information, as well as deficits in emotional regulation and motivation."

Daniel A. Martell, Ph.D., ABPP: On 4/28/2025, Dr. Martell re-evaluated Mr. Black and administered a battery of neuropsychological tests. In his report, dated 5/27/2025, Dr. Martell detailed Mr. Black's performance on these neuropsychological measures, noting his scores declined significantly from his prior evaluation of him in 2020. Dr. Martel noted that Mr. Black's profile on the Dementia Rating Scale-2 was "consistent with a moderate dementia syndrome, with disproportionately severe impairment in executive function, relative preservation of attention and construction, and moderate deficits in memory and conceptualization. He further noted, "His scores support the presence of cognitive deficits that affect his functional independence and decision-making capacity." According to Dr. Martell, "Mr. Black's mental condition has deteriorated significantly over the past six years. He has experienced substantial neurocognitive losses in the areas of memory, language, and executive functioning that are most likely attributable to a combination of his multiple medical conditions, most notably stage 4 renal failure and stage 4 heart failure, as well as his advancing age." Dr. Martell ultimately opined that Mr. Black remains intellectually disabled and opined that he met the criteria for being non compos mentis.

DIAGNOSTIC IMPRESSION

Based on the available information, it is my opinion that Mr. Black meets the diagnostic criteria for the following diagnoses in accordance with the *Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition, Text Revised* (*DSM-5-TR*):

Intellectual Disability
Major Neurocognitive Disorder

Intellectual Disability: The *DSM-5-TR* defines an intellectual disability as "a disorder with onset during the developmental period that includes both intellectual and adaptive functioning deficits in conceptual, social, and practical domains." Consistent with this diagnosis, Mr. Black's Flynn-corrected IQ scores on individually administered IQ tests have been in the range of 53 to 71, scores that are all consistent with intellectual disability. Additionally, in reviewing Dr. Greenspan's assessment of his adaptive functioning, there is currently sufficient information from collateral sources to demonstrate that Mr. Black had impairment in adaptive functioning in the conceptual, social, and practical domains. Lastly, collateral sources of information also indicate that his condition was present during the developmental period.

Major Neurocognitive Disorder: As noted above, Dr. Martell concluded in his report that Mr. Black's performance on neuropsychological testing was "consistent with a moderate dementia syndrome." Notably, in the DSM-5-TR, the term "dementia" is now considered to be "subsumed under the newly named entity *Major Neurocognitive Disorder*."[3] The DSM-5-TR criteria for a Major Neurocognitive Disorder include the following:

A. Evidence of significant cognitive decline from a previous level of performance in one or more cognitive domains, based on:

[3] Page 667 of the DSM-5-TR

1. Concern of the individual, a knowledgeable informant, or the clinician that there has been a significant decline in cognitive function; and

2. A substantial impairment in cognitive performance, preferably documented by standardized neuropsychological testing, or, in its absence, another quantified clinical assessment.

B. The cognitive deficits interfere with independence in everyday activities (i.e., at a minimum, requiring assistance with complex instrumental activities of daily living such as paying bills or managing medications).

C. The cognitive deficits do not occur exclusively in the context of delirium.

D. The cognitive deficits are not better explained by another mental disorder (e.g., major depressive disorder, schizophrenia).

With respect to Criterion A, in our recent telephone interview, Mr. Black's sister shared that she has noticed a decline in Mr. Black's memory in recent years. More specifically, she reported that he frequently repeats himself, with no awareness that he is doing so. Additionally, the neuropsychological test results from Dr. Martell's recent evaluation of Mr. Black clearly indicate that he has experienced a decline in neurocognitive functioning. Thus, Criterion A appears to be met. In terms of Criterion B, while Mr. Black has fewer demands placed upon him in his current structured environment than he would have in the community, the available information suggests he requires assistance even in this structured environment. Although he accurately recalled during our first interview that he currently takes 14 different medications, he was unable to list these medications or recall when he is scheduled to take these medications. Additionally, it was clear from his statements that he would be unable to manage his medications independently without assistance. Given his recent scores on neuropsychological testing, it appears unlikely that he would be able to independently complete other complex activities of daily living if required to do so. Thus, Criterion B appears to be met. There is also no indication that Mr. Black's cognitive deficits are the result of delirium or another mental disorder. Thus, the available data supports the conclusion that Mr. Black has a Major Neurocognitive Disorder.

SUMMARY OF COMPETENCY-FOCUSED INTERVIEWS

Mr. Black was interviewed regarding his understanding of his current legal circumstances over the course of three different interviews (5/14/2025; 5/15/2025; 5/21/2025). On each of these occasions, he displayed cognitive deficits in that he periodically became confused, displayed impaired memory for the events which led to his conviction, provided irrelevant and/or incorrect information regarding his trial and the evidence in his case, and periodically digressed from the topic being discussed, requiring redirection.

Notably, during our first clinical interaction, when he was first asked what led to his current incarceration at the Riverbend Maximum Security Institution, he immediately began discussing a prior criminal case (i.e., a Malicious Shooting conviction where he was sentenced to serve two years in a workhouse). Following this, he began discussing various family members and his relationships with them in a manner that was difficult to follow. When redirected and asked about his arrest for the instant offenses, he correctly recalled that he was arrested at the workhouse. However, when asked when he learned that he was charged with three murders, he nonsensically replied, "after trial." Notably, even after I educated him on the meaning of the word "charged," he continued to state that he did not learn that he was "charged" with three murders until after his trial was complete. Relatedly, at another point during our first clinical interview, he became confused and stated that he believed that his murder trial occurred the year before the murders occurred. When questioned about his timeline, he eventually conceded that his trial likely occurred after the murders occurred. He correctly recalled that the three murder victims were Angela Clay, a woman he was dating at the time, and her two daughters (Latoya and Lakeisha).

When asked during our first clinical interaction what he recalled from his trial, he displayed a very poor recollection, and he often conflated what occurred in his murder trial with his prior conviction for Malicious Shooting. Similarly, he often confused various attorneys that he has worked with over the years, and at one point,

he incorrectly named his trial attorney. Notably, while he remembered one event from the trial (e.g., a gun being passed around to the jury), he incorrectly asserted that no one from his family testified at his trial and incorrectly asserted that the three murders occurred on a night when he was incarcerated in the workhouse.

When asked, Mr. Black stated that he did not recall being evaluated to assess whether he was competent to stand trial. He was subsequently informed that his competency was assessed by several different clinicians, but he was ultimately found to be competent to proceed. He correctly recalled that he was found guilty at the trial. However, when asked what his sentence was, Mr. Black stated, "I'm not sure. I'm not sure how they ran it." He was informed that he was sentenced to death for the murder of the youngest victim, Lakeisha.

Notably, Mr. Black subsequently made several statements which were not consistent with information contained in the records regarding the events which led to his arrest, and it appears likely that these statements reflected confabulation (i.e., filling in gaps in his memory with incorrect information). For example, he stated that he picked the victims up on the afternoon of the murders after they attended the circus. He denied picking up Angela after work on the night of the murders, insisting that she did not work on weekends or evenings. He also listed a different place of employment for Angela and insisted that she had never worked at the hospital listed in the records. As mentioned earlier in the report, at one point, he stated that he recalled witnessing Angela's mother provide a white envelope to the judge before his conviction, adding that while he did not know what was contained in the envelope, he suspected it might have been a bribe.

When asked if his case had ever been appealed, Mr. Black stated, "Not that I know of." He was subsequently given corrective education on his prior appeals and their outcomes. Mr. Black expressed trust in his current defense team. When asked, Mr. Black indicated he was unfamiliar with the term "clemency hearing." He was subsequently provided with education on this term.

When asked if he had been assigned an execution date, Mr. Black correctly stated, "August 5." When asked what would happen on that date, he stated, "I will be put to death." When asked how, he stated, "some kind of protocol." When asked about his views on death, he shared that he has faith, adding, "I know I am a child of God. I know that for a fact." He stated that he hoped that he would go to heaven after his death. When asked why the state intended to execute him on August 5, he stated, "Because they think I committed murder." When asked, he correctly stated he was given the death sentence for the murder of the youngest victim.

Given his poor recollection regarding the events that occurred at his trial, during our second clinical interview, Mr. Black was provided with information from the record on the events that led to his arrest and the evidence in his case. When asked about this information later in the interview, while he recalled much of the information correctly, he continued to display some confusion/lack of recall. For example, he continued to insist that his mother never testified at his trial, despite having been told otherwise. Thus, the information was repeated on each occasion he provided incorrect information. Notably, on several occasions, he also provided the same incorrect information regarding when and where Angela worked.

Consistent with his statements during our first clinical interaction, during our second interview, Mr. Black correctly recalled that he is scheduled to be executed on August 5 and that he was sentenced to death for the murder of Lakeisha. When asked about the potential methods of execution, he stated, "the protocol." However, he stated he was not certain what the protocol is, adding, "I just hear people talking about it." He was aware that there was debate regarding the use of the protocol, adding that he had seen pictures of the last person executed, and "He turned blue and purple. The protocol didn't kill him. He suffered a lot." When asked if there was another potential method of execution in Tennessee, he correctly stated, "the electric chair, I think." He indicated he had not thought about which option he would choose.

During our third clinical interaction, Mr. Black again correctly recalled that he had been convicted of murdering Angela Clay and her two daughters, Latoya and Lakeisha. He also correctly stated that he was scheduled to be executed on August 5, for the murder of Lakeisha. He correctly listed the two potential methods of execution in

Tennessee as the electric chair and the "protocol," which he described as being "a liquid substance" that is "injected."

Mr. Black accurately recalled some of the prior education provided to him during our second interaction (e.g., that he had been evaluated for competency prior to his trial; that he was on furlough on the night of the murders, that his mother and nephew had testified at his trial; that he had made inconsistent statements to police after his arrest, that his case had been appealed). However, when asked, he was unable to articulate what evidence likely led to his conviction. When pressed to discuss why he believed he was convicted in this case, he made the vague statement, "He said, she said." However, again, he was unable to clearly articulate why, though when asked, he conceded that his inconsistent statements to police were likely damaging. Following this, he repeated his assertion that he witnessed Angela's mother meeting with the judge privately and also mentioned that he believed the jury may have mistakenly thought his .22 pistol was the murder weapon. Later in the interview, he again repeated several statements that were not consistent with information contained in the record (e.g., that he picked up Angela and the children from a circus on the day of the murder, that Angela did not work weekends, that Angela worked at a different hospital). He also later seemed to confuse events from his prior case of Malicious Shooting with the events from his trial for murder.

OPINION REGARDING COMPETENCY TO BE EXECUTED

It is my understanding that *Van Tran v. State* (1999) held that under Tennessee law, a prisoner is "not competent to be executed if the prisoner lacks the mental capacity to understand the fact of the impending execution and the reason for it." There have also been three Supreme Court opinions that address the standard for competency to be executed (*Ford v. Wainwright* (1986), *Panetti v. Quarterman* (2007), and *Madison v. Alabama* (2019)). In *Ford v. Wainwright* (1986), the Court held that at a minimum, defendants must "know the fact[s] of their impending execution and the reason for it." In *Panetti v. Quarterman* (2007), the Court noted, "A prisoner's awareness of the State's rationale for an execution is not the same as a rational understanding of it." It further held "gross delusions stemming from a severe mental disorder may put an awareness of a link between a crime and its punishment in a context so far removed from reality that the punishment can serve no proper purpose." Additionally, the Court noted that if these delusions influence "the prisoner's concept of reality [so] that he cannot reach a rational understanding of the reason for the execution," then they preclude execution. In *Madison v. Alabama* (2019), the Court held that "The Eighth Amendment may prohibit the execution of a prisoner who does not suffer from delusions if the prisoner's memory loss interacts with other mental shortfalls so that the prisoner does not have a rational understanding of why the state is exacting the death penalty." The Court further opined that it was not necessary for the prisoner to recall committing the crime, "because a person lacking such a memory may still be able to form a rational understanding of the reasons for his death sentence." The Court explained, "Memory loss still may factor into the 'rational understanding' analysis that *Panetti* demands. If that loss combines and interacts with other mental shortfalls to deprive a person of the capacity to comprehend why the State is exacting death as punishment, then the *Panetti* standard will be satisfied. That may be so when a person has difficulty preserving any memories, so that even newly gained knowledge (about, say, the crime and punishment) will be quickly forgotten. Or it may be so when cognitive deficits prevent the acquisition of such knowledge at all, so that memory gaps go forever uncompensated."

With a strict interpretation of the standard set forth in the aforementioned cases, Mr. Black likely meets this low bar for competency to be executed. That is, Mr. Black understands that he is scheduled to be executed on August 5, 2025, and he recognizes that death is permanent. Mr. Black also understands that the reason the state seeks to execute him is because it is believed that he murdered Lakeisha Clay. That said, it is important to note that it is also my opinion that Mr. Black meets the diagnostic criteria for an Intellectual Disability[4], and he has developed increasingly impairing neurocognitive deficits in the past several years, such that he currently meets the diagnostic

[4] Although the Court understandably concluded that Mr. Black was not intellectually disabled during prior proceedings, this decision was based on the information available at that time, including the opinion of Dr. Vaught. However, in 2022, Dr. Vaught revised her 2003 opinion, and explained, "based on current scientific knowledge and standards of clinical practice, Mr. Black does meet the onset criteria for the diagnosis of intellectual disability."

criteria for a Major Neurocognitive Disorder. As detailed above, as a result of the combination of these two conditions, Mr. Black is currently unable to accurately recall the events from his trial, and he holds many mistaken beliefs (i.e., confabulations arising from his neurocognitive disorder) about the events which led to his arrest and conviction. Notably, if the Court were to hold a broader interpretation of "rational understanding" of the reason for his execution (i.e., an ability to accurately recall his trial without confabulations), then Mr. Black would not be competent to be executed. (It is my understanding that the low bar set by the current competency to be executed standard is based upon the assumption that the defendant was competent at the time of trial; however, as discussed earlier in this report, it is my opinion that the competency evaluations completed before Mr. Black's trial were unfortunately well below today's standard for best practice, particularly for a high stakes capital case.)

Lastly, it is important to note that if the standard for competency to be executed in Tennessee included a requirement that the prisoner be able to assist in their defense, I would opine that he was not competent to be executed. More specifically, Mr. Black's current neurocognitive deficits impair his decision-making abilities, his ability to recall the facts of his case and trial, and his ability to communicate with his defense counsel about his case.

Lea Ann Preston Baecht, Ph.D.

Lea Ann Preston Baecht, Ph.D., ABPP
Clinical Psychologist
Board Certified in Forensic Psychology
American Board of Professional Psychology

BYRON LEWIS BLACK, Petitioner

No. 3:00-0764

vs. Judge Campbell

RICKY BELL, Warden, Respondent

DECLARATION OF STEPHEN GREENSPAN, Ph.D.

Declarant, Dr. Stephen Greenspan, states:

Background and Focus of My Evaluation

I was retained by attorneys Kelley Henry and Michael Passino of the Office of the Federal Public Defender in Nashville to perform various tasks in order to render an opinion concerning the validity of the claim of their client, Byron Lewis Black, to have mental retardation (MR) and, thus, to be exempt from execution in light of the 2002 US Supreme Court ruling in Atkins v. Virginia. I am being compensated at the rate of $200 per hour, plus travel expenses, for my services in this case.

Byron Black is an African-American male who at the present time is within a week or two of his 52nd birthday. He is under a sentence of death for three homicides committed in 1988, when he was 32 years of age. In 2004, a hearing was held before Tennessee Circuit Court judge Walter C. Kurtz to determine whether Mr. Black was exempt from execution under Atkins as well as van Tran v. State (Tennessee, 2001). On May 5, 2004, Judge Kurtz ruled that Mr. Black did not have MR. It is my understanding that my role is to render an opinion, based on my review of documents as well as new data collected by me, concerning whether or not I believe the earlier conclusion (namely that Mr. Black does not have MR) was justified.

The main basis for Judge Kurtz's conclusion, as I understand it, was that Mr. Black did not appear to meet the third—"Developmental Criterion"—prong of the legal definition of MR. This prong requires that "significant deficits in intellectual functioning" (the first prong) and "deficits in adaptive functioning" (the second prong) need to have been present and

EXHIBIT 10

noted before the age of 18. With respect to the period before age 18, Judge Kurtz was unconvinced that Mr. Black met either the intellectual or adaptive functioning criteria. With respect to Mr. Black's status as an adult, Judge Kurtz stated that while it appeared that Mr. Black did meet the intellectual functioning prong, he was unconvinced that he met the adaptive functioning prong as an adult.

The main focus of my evaluation is on whether I believe that Mr. Black did or did not meet the intellectual and adaptive functioning criteria during the developmental period. In addition, I will render an opinion as to whether or not Mr. Black meets the adaptive functioning criterion as an adult.

My Qualifications

In the past four years, I have been qualified as an expert on MR and related cognitive disorders in four or five capital proceedings in the states of Arizona, California and Colorado. In addition, I have previously been qualified as an expert on MR in family court proceedings in New Jersey and Connecticut. I am a licensed psychologist in the state of Nebraska and was previously licensed in the state of Tennessee (current status: inactive). In addition to testifying in several so-called "Atkins" proceedings, I have been a consultant (and submitted declarations) in numerous other cases. Although my work thus far has always been at the request of attorneys representing defendants, I have found that a claim of mental retardation was unjustified in approximately half of the cases in which I actually examined a defendant (in contrast to other cases, in which my role was limited to educating the court about the nature of mental retardation and/or opined about the adequacy of reports by other experts.)

I am a Clinical Professor of Psychiatry at the University of Colorado Health Sciences Center, and Emeritus (retired) Professor of Educational Psychology at the University of Connecticut. I received a Ph.D. in Developmental Psychology from the University of Rochester, and was a Postdoctoral Fellow in Mental Retardation and Developmental Disabilities at the University of California at Los Angeles' Neuro-psychiatric Institute. Before moving to Connecticut, I held academic appointments at the University of Nebraska and at George Peabody College of Vanderbilt University.

I have been elected "Fellow" (a designation given only to the most qualified members) by the Mental Retardation division of the American Psychological Association and by the American Association on Mental Retardation. I was also elected to a term as President of the Academy on Mental Retardation, which is the most prestigious research organization in the field. I have published extensively on MR, with particular emphasis on "adaptive behavior." I am a leading scholar in the MR field, as seen in the most recent diagnostic manual of the American Association on Mental Retardation (AAMR), AM. ASS'N ON MENTAL RETARDATION, MENTAL RETARDATION: DEFINITION, CLASSIFICATION AND SYSTEMS OF SUPPORTS (10th Edition, 2002) (hereinafter "the 2002 AAMR Manual"), which cited at least twelve publications by me, more than that of any other authority. My book WHAT IS MENTAL RETARDATION, co-edited with H. Switzky (AAMR; 2003; rev. ed. 2006) has, in a short time, become one of the most-quoted reference works in the field of mental retardation and has been described by Yale professor Edward Zigler as "the best book ever written about the definition and diagnosis of mental retardation." In 2008, AAMR recognized my contributions to the field by granting me its highest honor, the Gunnar and Rosemary Dybwad Award for Humanitarianism.

Materials Examined and Activities Performed

Expert reports or declarations examined:

- Expert disclosure of Eric Engim, PhD dated July 2, 2003
- Declaration of Ruben Gur, PhD dated November 15, 2001
- Declaration of Daniel Grant, EdD, dated November 16, 2001
- Psychological Evaluation by Patti van Eys, PhD, dated March 28, 2001
- Report by Albert Globus, MD, dated November 14, 2001
- Report by Susan Vaught, PhD, dated May 2003

Affidavits and Interviews from lay witnesses examined:

- Affidavit of Arlita Black Swanson (sister), dated January 11, 2003
- Affidavit of Freda Black Whitney (sister), dated January 11, 2003
- Affidavit of Lynette Childs Black (sister), dated January 15, 2003

- **Affidavit of Finis Black (uncle),, undated copy**
- **Affidavit of Alberta Black Crawford (sister), dated January 13, 2003**
- **Affidavit of Melba Black Corley (sister), dated January 11, 2003**
- **Affidavit of Mary Craighead (Elementary School Administrator) dated May 8, 2003**
- **Notes of Interviews with most of the above**
- **Notes of interview with Julia Mai Black (mother)**
- **Notes of interview with Renee Granberry, MD (cousin)**
- **Notes of interview with Richard Corley (co-worker and supervisor)**
- **Notes of interview with Rossi Turner (childhood friend)**
- **Notes of interview with Bart Tucker (high school counselor)**
- **Notes of interview with Karen Greer (sister)**

Other Documents examined:

- **Elementary and Secondary School grade reports for Byron Black**
- **Memorandum and order by Judge Walter C. Kurtz, dated may 5, 2004**
- **Independent Living Scale manual and record form (faxed from Dr. Grant)**

Activities Performed:

- **In-person Interview with Al Harris (former high school football coach)**
- **Phone interview with Mary Black (aunt by marriage)**
- **In-person interview and Vineland adaptive behavior assessment with Rossi Turner**
- **In-person joint interview and Vineland adaptive behavior assessment with Melba Black Corley and Freda Black Whitney**
- **In-person interview and assessment of Byron Black**
- **Phone interview with Dr. Daniel Grant (regarding the Independent Living Scale)**

Criteria To Use in Diagnosing Mental Retardation

As described in my widely-cited book WHAT IS MENTAL RETARDATION? (American Association on Mental Retardation, 2006), MR is not always an easy diagnosis to make, especially with individuals in the range of mild MR, where virtually all Atkins applicants are likely to be found. In this brief discussion, I shall discuss the three prongs to be used in diagnosing MR, emphasizing both the letter and the spirit of these prongs.

Virtually all legal definitions of MR used in the US are derived from either or both of the diagnostic manuals published by the American Association on Mental Retardation (AAMR, recently renamed the American Association on Intellectual and Developmental Disabilities) and the American Psychiatric Association, through its "Diagnostic and Statistical Manual" (DSM). The AAMR diagnostic manual has gone through several revisions, with the most recent being the tenth edition (AAMR-10), published in 2002. DSM has also gone through several revisions, with the most recent being the text-revised fourth edition (DSM-4TR), published in 2000. Starting with DSM-3 (1980), the definition of MR contained in each version of DSM has been derived entirely, except for minor wording changes, from the most current AAMR manual. Thus, the definition of MR contained in the 2000 DSM-4TR is derived from the 1992 AAMR-9, while it is highly likely that the definition of MR in the forthcoming DSM-5 will be nearly identical to the definition of MR contained in the 2002 AAMR-10. Therefore any differences in the definitions of MR in DSM and AAMR manuals reflect the fact that the most recent DSM manual pre-dates the most recent AAMR manual, and does not reflect substantive or philosophical differences between the two organizations.

The definitions of MR in the AAMR and DSM manuals contain two parts: a conceptual (abstract) definition, followed by an operational (concrete) definition. While the operational definitions of MR have changed somewhat over the years, the conceptual definitions have remained essentially unchanged since they were first formulated by AAMR over 45 years ago, in the fifth edition of its manual, published in 1961.

The conceptual definition of MR, as reflected in both AAMR and DSM manuals, and in statutes and court opinions in Tennessee and most other states, has three parts: (a) deficits in intellectual functioning, (b)

concurrent deficits in adaptive functioning (also known as adaptive behavior), and (c) evidence of the disorder before the onset of adulthood. As stated above, these conceptual criteria have remained essentially unchanged in various AAMR and DSM editions.

One difference between DSM 4-TR and AAMR-10 is that DSM 4-TR emphasizes "significantly subaverage intellectual functioning" and "concurrent deficits or impairments in present adaptive functioning" while AAMR-10 emphasizes "significant limitations in intellectual functioning and in adaptive behavior".

The Tennessee statute (TCA-39-13-203) defining MR in criminal cases is aligned more closely with DSM 4-TR, in that it emphasizes "deficits" in adaptive functioning rather than "significant deficits". Specifically, the statute reads: "...Mental Retardation means significant subaverage general intellectual functioning ..., deficits in adaptive behavior ... [and it] must have been manifested during the developmental period..."

This difference between "deficits" and "significant deficits" is more than a semantic distinction, in that it has implications for the operational definition that follows. The difference is that AAMR-10 applies the same criterion (approximately two standard deviations below the mean, or the second percentile of the population) for both intelligence and adaptive behavior, while DSM 4-TR applies the two standard deviation criterion only for intellectual functioning but does not specify any statistical criterion for meeting the second prong of the definition. Thus, "significant deficit" implies a more stringent criterion (typically set at the second percentile of the population) while "deficit" or "impairment" implies a much less stringent criterion, which if it is specified (not the case with DSM 4-TR or the Tennessee statute) is typically set at approximately one standard deviation below the mean (a standard score of 85, which indicates a percentile rank of about the 16th percent of the population).

The operational criteria for diagnosing MR, and the complications involved in applying them in this particular case, are discussed briefly in the following three sub-sections and in the Findings section that follows those.

(1) The Intellectual Criterion. MR is a disorder whose core impairment is in the area of intelligence. This construct is typically measured through one's performance on an individually-administered test of intelligence which results in a full-scale IQ score that locates one's functioning in relation to the mean for the general population. IQ tests are constructed so that the population mean is set at a score of 100, with a standard deviation (an index of statistical variability) of 15. The ceiling for MR is currently established as "approximately two standard deviations below the population mean". The term "approximately" refers mainly to the fact that no test is fully reliable and one should take various factors into account when interpreting a test number. The main thing to take into account is the fact that test scores vary approximately five points around one's "true score". As two standard deviations (2 x 15) equals 30 points, the upper IQ level for meeting the intellectual criterion for MR is 75 (100 minus 30 plus 5 [the reliability index]). In addition, one should take into account factors such as practice effect (possible learning from taking a second test too soon), changes in and adequacy of test norms, and possible malingering.

One of the factors to take into consideration when interpreting IQ scores is what has been termed the "Flynn effect". This term refers to the fact that the overall population has been gaining in performance on IQ tests at a rate of 3 points per decade (0.3 points per year), and this finding is taken into account by test developers when they develop new test editions every few years, in that the norms are toughened. Because a diagnosis of MR could be affected significantly depending on when in a test's cycle a person is tested, the Flynn effect has been used to adjust Full Scale IQ scores using the following formula: (a) subtract the year of the of the test's publication (or, ideally, when the norms were compiled, which typically is two years earlier) from the year a test was administered; (b) multiply this figure by 0.3; (c) subtract this figure from the person's obtained IQ score, with the resulting number being the Flynn-adjusted score.

Thus if someone was tested in 1990 on a test normed in 1978 and received an IQ score of 78, one would multiply 12 (1990-1978) by 0.3, with the resulting number being 3.6. Subtracting 4 points (the rounded sum) from 78, one would receive an adjusted IQ score of 74. A discussion of the Flynn effect in diagnosing MR is contained in a paper by me (Stephen Greenspan, Spring 2006. Issues in the use of the Flynn Effect to adjust IQ scores when

diagnosing MR, which appeared recently in PSYCHOLOGY IN MENTAL RETARDATION AND DEVELOPMENTAL DISABILITIES, which is the official publication of the mental retardation Division of the American Psychological Association. As indicated in that paper, the Flynn effect adjustment formula when diagnosing MR has been accepted as a legitimate practice by state and Federal trial courts (e.g., Walker v. True, 399 F.3d 315, 322-32, 4th Cir. 2005). It is also beginning to be recognized in various appellate courts. As example, on February 28, 2007 the U.S. Navy-Marine Corps Court of Criminal Appeals stated: "In determining whether an offender meets this definition [of MR], standardized IQ scores scaled by the SEM and the Flynn effect will be considered" (web: NMCCA, code 07).

To summarize, the phrase "approximately two standard deviations below the population mean on a standardized test of intelligence" means that one should not rely rigidly on an IQ score number, but should take into account the adequacy of the test, the nature and meaning of the norms, the context in which the test was administered, ethnic and linguistic factors, etc. This is the main use for "clinical judgment" in diagnosing MR. As noted in the book CLINICAL JUDGMENT (AAMR, 2006) by Robert Schalock and Ruth Luckasson (two of the main authors of AAMR-10), clinical judgment in diagnosing MR is <u>not</u> a matter of relying on intuition or gut feeling (which can be misleading, especially in unqualified clinicians) but rather involves using test scores in a thoughtful and scientifically valid manner. A rigid reliance on a test score, without such thoughtfulness, can and often does result in "false positives" (wrongly concluding someone has MR when he does not) or "false negatives" (wrongly concluding someone does not have MR when he does".)

Although a clinician diagnosing MR should not rely on gut feeling (which can vary from clinician to clinician), the notion of clinical judgment (which is relied on heavily in reaching any diagnosis in the human services, not just MR) requires the clinician to interview and have some personal contact, however brief, with the person he or she is diagnosing. This is a matter of basic professional ethics and practice. In the 2004 state court MR hearing both of the two prosecution psychologists testified that they did not believe Mr. Black to have MR, in spite of their never having interviewed or even laid eyes on him. To me, such a "paper diagnosis" lacks credibility and serves to undermine the validity of their findings.

Because in the past, clinicians often relied rigidly and mindlessly on an IQ number, and particularly failed to rake into account the five-point standard error of test scores, AAMR-10 operationally defined approximately two standard deviations below the mean as "a score below 70-75". This indicates that clinicians or agencies making a determination of MR solely on whether a score is below or above 70 are not engaging in acceptable practice. Raising the ceiling from 70 into 70-75 also reflected a policy decision that past manuals, in their concern to eliminate false positives had defined the MR class too narrowly and some loosening of the criteria needed to be undertaken to avoid the now-widespread problem of false negatives.

DSM 4-TR (which preceded AAMR-10) does not use the 70-75 formula. However, it is stated quite clearly that one should take into account standard error of the test and not just rely rigidly on the obtained score. In addition, both AAMR-10 and DSM 4-TR indicate that there are circumstances where reliance on a single "full-scale" IQ score can be misleading. Specifically, it is well-known that individuals with known brain damage syndromes present a mixed pattern of intellectual competence and incompetence, and summarizing across to obtain a single score can serve to obscure the true nature and extent of an individual's impairment. In such circumstances, one must be especially careful to go beyond just full-scale IQ and look at other (sometimes more qualitative) sources of data where these are available and useful.

Finally, the emphasis in both AAMR-10 and DSM 4-TR is on use of individualized and adequately standardized measures, and not on group administered and/ or brief screening instruments. There are only a few such individualized instruments suitable for diagnosing MR, such as the Wechsler scales (WAIS-3), the Stanford-Binet (SB-5), the Woodcock Johnson cognitive battery, etc. Group measures are not acceptable for ruling MR in or out for several reasons, the two most important being: (a) their much weaker reliability and validity, and (b) lack of information about the circumstances of administration (e.g., the possibility that someone may have received help, not been paying attention, etc).

(2) The Adaptive Behavior Criterion. For over the past 45 years, it has no longer been considered adequate to rely solely on IQ scores in determining whether one has or does not have MR. This is because IQ test scores, particularly in the "mild" level of impairment, do not always translate to other settings, and a diagnosis of MR should indicate a fairly global impairment affecting many areas of functioning. Thus, to qualify for a diagnosis of MR, one should show significant deficits in both IQ and "adaptive behavior". The current conceptualization of adaptive behavior relies on a "tripartite model" of intelligence and adaptive functioning that I developed over 25 years ago, and uses my work as the basis. This model has three parts: (a) "conceptual" adaptive skills (understanding academic processes); (b) "practical" adaptive skills (understanding physical processes) and (c) "social" adaptive skills (understanding people and social processes). In determining if someone meets the Adaptive Behavior criterion, it is necessary to show significant deficits in only one of these three areas (AAMR-10). Sources of data can come, preferably, from formal test scores on rating instruments (such as the Vineland or ABAS) administered to informants, supplemented sometimes by formal test scores on individually administered measures (such as the Street Smarts Survival Questionnaire), and from qualitative information gathered from affidavits, records, and observation by an evaluator.

The 2002 AAMR manual specified that the most important source of information regarding whether an individual meets the adaptive behavior criterion is whether one falls approximately two standard deviations (i.e., a standard score below the 70-75 range) on a standardized rating measure of adaptive behavior such as the Vineland. Two pathways to meeting the AAMR's adaptive behavior criterion were offered: (a) a standard score below 70-75 on an overall (composite) score, or (b) a standard score below 70-75 on at least one of the three adaptive skill areas of conceptual adaptive skills, practical adaptive skills or social adaptive skills.

In establishing the possibility of being above 70-75 in one or even two of the three adaptive skill areas (or having good scores on particular items within sub-average adaptive skill areas), the AAMR wished to emphasize that having mild MR is not incompatible with being able to do many things, such as drive a car, hold a job, be married, have relatively normal language and (even) commit crimes that may require some degree of planning and volition.

In its Users Guide, which is a supplement to the 2002 Manual and written by the same authors, the AAMR indicates that in high stakes assessments, such as an Atkins hearing, the use of retrospective ratings of adaptive behavior is often necessary, and is justified in such cases. In such retrospective ratings, raters are asked to rate an individual not as he is today but as he was at the time when the rater knew him best, living in the community. Retrospective ratings are needed because the current setting (e.g., Death Row) does not provide opportunities to assess success or failure in more typical roles (e.g., worker) or tasks (e.g., operating appliances or dealing with neighbors). Also, MR is a disability that can best be understand as a need for supports in fulfilling such community roles and tasks. Another reason for retrospective assessment of adaptive behavior is because such assessments may not have been carried out during the Developmental period and retrospective assessment helps to establish if the individual had significant impairments during that period.

As already mentioned, one operational difference between AAMR-10 and DSM 4-TR, in terms of adaptive behavior/ functioning, is that DSM uses the words "limitations" and "deficits", implying either no statistical cutting score or, at most, a minus one SD (standard score of 85) criterion. AAMR-10, on the other hand, uses the words "significant deficits", implying minus two SDs (standard score below 870-75), although as mentioned, this can be accomplished either in terms of an overall adaptive composite (quotient) of 70-75 or less, or such a score in only one of the three domains of "social", "practical" or "conceptual" adaptive skills.

In DSM 4-TR, the criterion for adaptive functioning (the term this manual prefers, but which means the same thing as adaptive behavior) is defined as deficits in at least two out of eleven functional areas: communication, self-care, home living, social/ interpersonal skills, use of community resources, self-direction, functional academic skills, work, leisure, health and safety. This list is derived from AAMR-9 (1992), which was published eight years before DSM 4-TR. In AAMR-9, the adaptive behavior criterion was established as deficits in 2 out of 10 adaptive skill areas (health and safety were combined into one area) or deficits in overall composite adaptive quotient. In AAMR-10, these ten (11 in DSM 4-TR) skill areas were collapsed into the three adaptive behavior domains (social, practical, conceptual) mentioned above.

In the Tennessee statute (TCA-39-13-203), the adaptive behavior criterion (which is described simply as "deficits in adaptive behavior"), is stated globally and is not broken down into component skills or domains (unlike DSM 4-TR's 11 skills and AAMR-10's 3 domains). Because of that globality, and also because the standard is "deficits" rather than "significant deficits", the Tennessee definition appears to offer considerable flexibility (including the use of non-statistical data) in determining whether or not someone meets the adaptive behavior criterion.

(3) <u>The Developmental Criterion</u>. MR is a term indicating that an individual has serious intellectual impairments which first manifested during what is termed the "developmental period". The developmental period is defined as anytime between birth and 18 (some interpret this as before the end of one's 18th year). The purpose of this criterion is to rule out those who were normal in childhood but whose impairments first manifested in adulthood, such as through a motor vehicle accident. Information about whether one meets the developmental criterion can come from a variety of sources, such as medical or school records and testimony by teachers, family members and peers.

One of the controversies in interpretation of the developmental criterion involves whether or not the individual must have been eligible for a diagnosis of MR before the age of 18. This appears to have been the standard used by Judge Kurtz, but it my respectful view that he was mistaken in making that interpretation. If one takes that tack, then one can use the absence of any IQ score, or adaptive behavior score, before the age of 18 as evidence that would rule out a current diagnosis of MR. In my view, this is an incorrect, and overly rigid, interpretation of the developmental criterion.

A more appropriate, and flexible, interpretation of the developmental criterion is that when a person qualifies as having MR as an adult, one should be able to show that there were precursors or indicators that developed or were evident during the childhood or adolescent period. In other words, a diagnosis of MR would be inappropriate if a child was of average or above average intellectual and adaptive functioning prior to 18 but suddenly showed a steep decline, perhaps because of some injury that developed during adulthood. Outcome-based evidence, such as a child being retained in elementary school (which occurred in this case) and very

low academic achievement (also true in this case) can also be used as evidence that the developmental criterion has been met.

A related issue has to do with evidence of organic (i.e., biological) etiology, such as diagnosed brain damage that is most likely attributable to a developmental process that started early in life. To establish mild MR (which is the sub-category most relevant in this case), one does not have to have evidence of a known etiology, and such evidence is typically lacking. However, such evidence-when it exists—can by itself be used to satisfy the developmental criterion. A good example of this is if there is brain imaging evidence that is highly suggestive of neurological abnormalities indicative of Fetal Alcohol Spectrum Disorder (a major known cause of mild MR). Where such evidence exists (as it does in this case), this could also be used to buttress the conclusion that the third prong for a diagnosis of MR has been met.

My Findings Regarding Whether Byron Black Has MR

It is my conclusion that Byron Black qualifies for a diagnosis of mild MR. My reasons flow from my finding that he meets all three of the definitional prongs. These are discussed under each of the prongs below.

(a)Intellectual Functioning Prong. In adulthood, it is clear that Mr. Black meets the intellectual functioning prong of a diagnosis of MR. In November 2001, Dr. Daniel Grant obtained a full-scale IQ on the Stanford-Binet (SB-4) of 57. On the C-TONI, the best non-verbal IQ test which correlates highly with full-scale IQ, Dr. Grant obtained an IQ score of 64. In October 1993, Dr. Gillian Blair obtained a WAIS-R full-scale IQ score of 73, which is under the 70-75 ceiling. The WAIS-R was normed in 1979 and was, thus, 14 years obsolescent in 1993. A Flynn adjustment would reduce this IQ score by 4 points (0.3 for each year of norm obsolescence), bringing it to 69. In 1997, Dr. Pamela Auble also used the WAIS-R and obtained a full-sale IQ score of 76, which would be reduced another 6 points (for the 18 years of norm obsolescence). In March, 2001, Dr. Patti van Eys administered the more current WAIS-3 and obtained a full-scale IQ of 69, which is under the 70-75 cutting score, and very much in line with the Flynn-corrected scores for the outdated WAIS-R.

Thus, the overwhelming consensus among all of these individualized IQ administrations is that Mr. Black meets the first intellectual functioning) prong for a diagnosis of MR as an adult.

Individualized IQ data for Mr. Black as a child is lacking, for the simple reason that he left high school in the very same year that the federal statute (PL-94-142) that mandated special education was enacted. During the time that Mr. Black was in elementary school, the assumption was that a child would be socially promoted if he was well-behaved (which by all accounts, Mr. Black was), regardless of how little he learned (see Affidavit by Mary Craighead, an administrator at Mr. Black's elementary school). Just the same, Mr. Black was retained in the second grade, even given that tendency to overlook such learning difficulties. Undoubtedly, an individualized IQ test would have been administered had Mr. Black been born ten years later. The absence of such IQ data makes it impossible to know whether he would have qualified for a diagnosis of MR during that period.

Mr. Black's relatively good report cards in elementary school are incongruent with the fact that he was retained and also with his marginal or failing grades in High School. The mystery is cleared up when reading the statements by his fifth and sixth grade teachers (noted in point #17 in the declaration by Dr. Grant). They stated that "I would never allow a student to get a bad grade" (6^{th} grade teacher) and "teachers were liberal in their grading" and a B would be the equivalent of a D at a later time (5^{th} grade teacher). Furthermore, administrator Mary Craighead indicated in her affidavit that the emphasis back then was on helping low-achieving African-American children to feel good about themselves and to experience success in all of their endeavors.

This attitude likely also explains why Mr. Black obtained relatively high scores on group administered IQ tests, as it is very possible, indeed likely, that these tests (which even state experts testified are not appropriate for diagnosing MR) were administered in a non-standard manner that could even have involved teacher assistance.

Even so, it should be noted that the IQ criterion for diagnosing MR was minus 1 SD (full-sale score of 85), during the years 1961 to 1973, and that the 85 that Mr. Black obtained on the Otis-Lennon group IQ test could, thus, have qualified him at that time.

Dr. Grant correctly noted that the best evidence that Mr. Black would have met the MR intellectual functioning criterion in the Developmental period was his very low performance (standard scores of 71 and 67) on the Differential Abilities Test (DAT). Although not specifically termed an IQ test, the DAT correlates very highly with IQ and in the absence of an IQ test can be used as a substitute. Furthermore, Mr. Black's mostly failing grades in High School (where the overprotective stance of his elementary school no loner applied) is probably a better indicator of the depth of his intellectual limitations. Those limitations carry over today into his very low achievement standard score (72) as an adult on the WRAT-III and the Nelson-Denny reading test.

In short, Mr. Black gave clear evidence of intellectual limitations in the developmental period, and there is continuity rather than discontinuity linking his intellectual limitations today and his intellectual limitations as a child.

(b)Adaptive Functioning Prong. The main focus of my evaluation of Byron Black was on his level of adaptive functioning. That is because he appears, as summarized above, to meet the intellectual criterion, but questions were raised by Judge Kurtz regarding whether he met the adaptive functioning criterion either currently, or more specifically, prior to the age of 18.

Adaptive Behavior is most typically evaluated through a rating instrument, such as the ABAS-2 or the Vineland-2 (the two instruments which, along with the SIB, are most widely used in Atkins cases). Using a rating instrument to evaluate the adaptive functioning of someone who has been in prison, especially death row, for a number of years is difficult, if not impossible, for a number of reasons. These reasons include the difficulty in finding raters but more importantly, the absence of opportunities to perform many of the behaviors (such as cooking or using public transportation) that are items on such instruments. Furthermore, the whole purpose underlying the development of these instruments is to assess the supports needed to live successfully in the community, and to face the kinds of challenges and ambiguities one would find in the community. Obviously, death row is a setting that provides few such challenges and ambiguities.

A common mistake that is often made when evaluating the adaptive functioning of someone in prison is to look at his level of adjustment, such as through the presence or absence of discipline write-ups. Some experts, usually those testifying for the state, will look at a defendant who is not a discipline problem and conclude that he could not have MR. The problem with such a conclusion is that adjustment in prison is typically a matter of whether or not one has a cooperative versus hostile personality, and being a cooperative and pleasant person in no way rules out MR. In fact, it is likely the case that people with mild MR, assuming they do not also have mental illness, will tend to be more apt to go along with rules and orders, in part because such a tendency generally served them well in covering up their limitations in work, school and other settings in the community. Furthermore, there are relatively few choices one has to make on death row, and the rules are few, clear and unambiguous. So it is fair to say that people with mild MR are likely to adjust better in a highly structured setting such as death row, and such adjustment in no way can be used to infer how impaired one's adaptive functioning would be in the community.

For these reasons, to assess one's level of current adaptive functioning in prison, one would most likely have to rely on the few "direct" measures of adaptive functioning, such as the "Independent Living Scales" (ILS) used by Dr. Grant, or the "Street Survival Skills Questionnaire" (SSSQ) used by me. Both measures are direct in the sense that one presents everyday problems to a subject (such as filling out a bank deposit slip, or figuring out a paycheck) and seeing whether the subject passes such items. Both the ILS and the SSSQ are mainly measures of the "Practical Adaptive Skills" domain of adaptive functioning, and they have population norms.

Dr. Grant stated in his report that Mr. Black received a standard score in the 70-75 range on three of the five ILS sub-scales that, together, give information about the adaptive behavior domain of "Practical Adaptive Skills". These sub-scales are labeled "managing money" (standard score of 73), "managing home and transportation"(standard score of 73), and "health and safety" (standard score of 72). He was in the normal range on two other ILS sub-scales that, in my view, are unrelated to MR: memory and "social". The reasons why the social sub-scale on the ILS is not diagnostically relevant are two-fold: (a) it mainly taps happiness/ agreeableness which I have already noted is not indicative one way or the other of MR, and (b) it involves solely self-report (rather than problem-

solving) and self-report is notoriously unreliable as a source of diagnostic information in people with MR (who almost universally inflate their description of themselves in order to appear competent (this well-established phenomenon is termed "the cloak of competence". See the classic book of the same name by UCLA Professor Robert Edgerton).

As an independent validation of Dr. Grant's ILS data, I administered the SSSQ, another direct measure of adaptive behavior that mainly taps Practical Adaptive Skills. This test has over 200 items in which a subject is presented with an object or process and then picks the correct one out of four pictures that depicts the object or process. Mr. Grant obtained an overall standardized score (78) which is highly congruent with the 73, 73 and 72 standard scores obtained by Dr. Grant on three relevant sub-scales and certainly meets the "deficit" or "impairment" (minus one SD) standard implicit in DSM 4-TR and in TCA-39-13-203. Also, I found that Mr. Black was below the minus 2 SD standard on three of the nine SSSQ sub-scales and below the minus one SD standard on a fourth.

Before testing Mr. Black on the SSSQ, I administered the Dot Counting Test, which is one of the most used and respected measures of possible malingering on cognitive tasks. This test shows pictures with dots and the task is to count them correctly and in a short period of time. Mr. Black made zero mistakes, and this fact plus the very short average time per picture gave very strong indication that he approached the testing situation in a fully attentive and effortful manner. Thus, I concluded that the SSSQ scores were highly valid and lacked any indication of malingering.

Qualitative data suggesting Mr. Black met the adaptive behavior criterion in adulthood (but prior to conviction in this case) are that he never lived independently (lived with parents, even after marriage), never had a check book, never cooked, never washed his clothes, never did anything suggestive of adult status other than holding a job (which most adults with mild MR do) and driving a car (which many individuals with mild MR do, as suggested in the AAMR criterion of significant impairment in only one out of three domains). Another indication of Mr. Black's impaired adaptive status came from my interview with his high school football coach, Al Harris, who indicated that in over 30 years as a coach, Mr. Black stood out as especially slow. He indicated that although Byron had good physical skills, he could generally not be used on offense for the reason that he could

not learn the plays and was used on offense only when a highly simplified playbook was developed for his use.

Because lack of evidence of adaptive incompetence before the age of 18 appeared to be a major issue in Judge Kurtz's ruing, I conducted a retrospective assessment of Mr. Black's adaptive functioning, using the age 17 years-six months as the target age. I used the most widely-used and respected adaptive behavior rating instrument, the Vineland-2. This instrument is published by Pearson Assessment, the publisher of the most widely respected intelligence test, the Wechsler Scales, and is the publisher that adheres to the highest standards for test development.

The Vineland-2 is filled out by an examiner after each interview with one or more informants. I conducted two such interviews, one with a boyhood friend, Rossi Turner, who knew Mr. Black until he left Nashville to go to school outside the state, and a joint interview with two sisters: Melba Black Corley (older sister) and Freda Black Whitney (younger sister). In the latter interview, I asked for consensus between the two sisters before scoring each item and generally such consensus was obtained. I should note that all three informants hold responsible professional jobs and appear to be people of average or above average intelligence. All three of them indicated they knew Mr. Black very well during the age period (17-6) being rated.

The Vineland-2 labels its domains somewhat differently than does AAMR-10, but they are generally equivalent. The three domains on the Vineland-2 are: "Communication" (which taps basically what AAMR-10 calls "Practical Adaptive Skills"; "Daily Living Skills"(which taps what AAMR-10 calls "Practical Adaptive Skills") and "Socialization" (which taps what AAMR-10 calls "Social Adaptive Skills"). In addition, one sums across all of the items on the scale to obtain a Composite (overall) adaptive quotient.

The standard scores obtained on the Vineland-2 were as follows:
On Communication (Conceptual Adaptive Skills), Mr. Black received a standard score of 75 on the Vineland based on interview with the sisters, while he obtained an identical score on the Vineland based on interview with Mr. Turner.

On Daily Living (Practical Adaptive Skills), Mr. Black received a standard score of 76 on the Vineland based on interview with the sisters, while he obtained a standard score of 71on the Vineland based on interview with Mr. Turner.

On Socialization (Social Adaptive Skills) Mr. Black received a standard score of 63 on the Vineland based on interview with the sisters, while he obtained a standard score of 67 on the Vineland based on interview with Mr. Turner.

On overall Composite Adaptive Behavior, Mr. Black received a standard score of 70 on the Vineland based on interview with the sisters, while he obtained an identical standard score of 70 on the Vineland based on interview with Mr. Turner.

In short, Mr. Black met the AAMR-10 criterion of significant (minus two SD) deficit on adaptive behavior on both sets of Vineland ratings, and he also met the AAMR criterion of significant (70-75 or below) on one out of three domains. Using the somewhat less stringent standards embedded in DSM 4-TR and the Tennessee statute, his qualification is even more clear-cut.

(c)<u>Developmental Prong.</u> As indicted earlier, this prong can be interpreted as either meaning that one must show evidence that could cause a diagnosis of MR to be met prior to 18 (Judge Kurtz's apparent interpretation) or rather only evidence that adult impairments can be traced to indicators of failure, low functioning or causation evident prior to 18 (my interpretation).

Using the looser interpretation, there is no doubt in my mind that Mr. Black satisfies this prong. Although he attended an elementary school considered the most disadvantaged and low-functioning in the district (as reflected in its being chosen for a special Ford Foundation program), Mr. Black was made to repeat second grade, which is a clear indication that he was considered to be very "slow" even in that much slower than average setting. There is also very clear evidence from standardized achievement scores that Mr. Black functioned intellectually at a very low level.

Finally, very powerful evidence that Mr. Black meets the developmental criterion can be found in the very clear-cut evidence obtained by Dr. Gur of structural damage to his brain (abnormal corpus colussum, or mid-brain, seen in MRI image) suggestive of Fetal Alcohol Spectrum Disorder).

Using the more stringent approach to the Developmental criterion apparently used by Judge Kurtz, I believe Mr. Black also meets the developmental criterion, defined in TCA-39-13-203 as "the MR must have been manifested during the developmental period, or by eighteen (18) years if age". The main evidence that could be pointed to as suggesting that Mr. Black was of normal intelligence were the group IQ scores, but these are unreliable tests that cannot be substituted for individualized tests which were not routinely administered (because special education had not yet been federally mandated). Furthermore, the atmosphere at that time was one of helping children such as Byron Black to have feelings of success and it is possible, indeed likely, that he was given assistance with those tests. The Differential Aptitude Test given in 9th grade, and which showed scores under the 70-75 ceiling, along with mostly failing grades in High School are much stronger evidence of the extent of Mr. Black's limitations during the period before he turned 18.

Conclusion

It is my professional opinion, to a high degree of psychological certainty, that Byron Lewis Black meets all three criteria for a diagnosis of mild MR, whether using DSM 4-TR, AAMR-10 or TCA 39-13-203.

FURTHER DECLARANT SAITH NOT.

I declare under penalty of perjury under the laws of the United States of America that the foregoing is true and correct.

Dated: March 13, 2008

Stephen Greenspan, Ph.D.

DECLARATION OF MARC J. TASSÉ, PhD, FAAIDD

I, Marc J. Tassé, declare under penalty of perjury and the laws of the United States, the following to be true to the best of my information and belief:

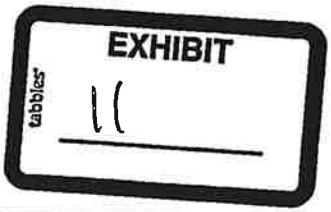
1. My name is Marc J. Tassé, Ph.D., FAAIDD and I am a licensed psychologist in North Carolina (NC #2613). I completed my Ph.D. in research-clinical psychology at the Université du Québec à Montréal. My doctoral dissertation focused on the study of adaptive behavior assessment in individuals with mental retardation. Following my Ph.D., I completed a post-doctoral fellowship in mental retardation and developmental disabilities at The Ohio State University Nisonger Center, University Center for Excellence in Developmental Disabilities Education, Research, and Service. I am also a "Fellow" of the American Association on Intellectual and Developmental Disabilities.

   I am an Associate Professor in the Department of Child and Family Studies at the University of South Florida (USF). I am also the Associate Director of the USF Florida Center for Inclusive Communities (FCIC). The USF FCIC is a federally funded University Center for Excellence in Developmental Disabilities. Our Mission is three-fold: (1) provide training to undergraduate, graduate and post-graduate students in the field of mental retardation and related developmental disabilities (MR/DD), (2) offer services and state-wide technical assistance to individuals with MR/DD across the age span and to agencies providing supports and services to these individuals, and (3) conduct research in the field of MR/DD.

   I've worked with individuals with mental retardation for the past 20 years. I have provided direct clinical services as well as supervised graduate and post-graduate psychology students in providing direct services to individuals with MR/DD. I've been involved in hundreds of psychological assessments and eligibility/diagnostic evaluations of mental retardation involving children, adolescents, and adults. I have worked extensively over the past 20 years directly with individuals with mental retardation of all ages. I have provided consultative services and technical assistance to families, service providers, and state MR/DD agencies. Over the past 10 years, I have also been involved in providing individual therapy to adolescents and adults with mental retardation and co-occurring psychiatric disorders or complex behavior problems.

   In the past (i.e., 1985 to 1993), I also worked as a behavior specialist (Douglas Hospital; Montreal, Canada), providing behavior programming and developing intervention plans for children and adults with mental retardation and co-occurring behavior problems or psychiatric disorders.

   In addition to my clinical work, I actively conduct research in the field of mental retardation. I have published over 65 book chapters, peer-reviewed journal articles, and monographs in the area of mental retardation or developmental disabilities. I have given over 100 presentations, workshops, or seminars at local, state/provincial, national, and international scientific/professional meetings in the field of mental retardation.



I am a co-author on the American Association on Intellectual and Developmental Disabilities (AAIDD; formerly known as the American Association on Mental Retardation) 2002[1] Manual that defines mental retardation and the recently published AAIDD User's Guide (Schalock et al., 2007)[2]. I have also worked on the development of standardized tests in the field of mental retardation. One such assessment instrument was the *Supports Intensity Scale* (SIS). The *SIS* is a standardized measure of individual support needs for adolescents and adults with mental retardation. I have also worked on the development and refinement of the Quebec Adaptive Behavior Scale, as well as other standardized assessment instruments in the area of measuring problem behavior and psychopathology in individuals with mental retardation. I currently Chair the American Association on Intellectual and Developmental Disabilities' *ad hoc* committee on the development of the Diagnostic Adaptive Behavior Scale (DABS). The DABS has been in development for approximately three years and should result in a standardized test of adaptive behavior that will focus on diagnosing the presence of "significant adaptive behavior deficits" for the purpose of diagnosing mental retardation. I was recently awarded the "Service" award by the American Association on Intellectual and Developmental Disabilities for my work with individuals with mental retardation and complex behavior support needs.

I am an active member of the following professional associations:

- American Association on Intellectual and Developmental Disabilities (Fellow)
- American Psychological Association [member of Divisions: 5 (Assessment), 33 (I&DD), 41 (Psychology & Law Society)]
- International Association for Behavior Analysis
- National Association for the Dually Diagnosed (MR/MI)
- North Carolina Psychology Board of Psychologists (License #2613)

I am an *ad hoc* reviewer for the following professional journals:

- American Journal on Mental Retardation
- Intellectual and Developmental Disabilities
- International Clinical Psychopharmacology
- Journal of Autism and Developmental Disorders
- Journal of Intellectual Disability Research
- Research in Developmental Disabilities
- Revue francophone de la déficience intellectuelle

2. I was asked by Attorneys Kelley Henry and Michael Passino, on behalf of their client Mr. Byron Black (D.O.B.: 3/23/1956), to do the following:

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[1] Luckasson, R., Borthwick-Duffy, S., Buntinx, W. H. E., Coulter, D. L., Craig, E. M., Reeve, A., Schalock, R. L., Snell, M. E., Spitalnik, D. M., Spreat, S., & Tassé, M. J. (2002). *Mental retardation: Definition, classification, and system of supports.* Washington, DC: American Association on Mental Retardation.

[2] Schalock, R. L., Buntinx, W. H. E., Borthwick-Duffy, S., Luckasson, R., Snell, M. E., Tassé, M. J., & Wehmeyer, M. L. (2007). *User's Guide Mental Retardation: Definition, Classification, and Systems of Supports, 10th Edition. Applications for Clinicians, Educators, Disability Program Managers, and Policy Makers.* Washington, DC: American Association on Intellectual and Developmental Disabilities.

a. Discuss the nature and common characteristics of mental retardation (MR) and the criteria and methods used in making a diagnosis of MR.

b. Review available reports by other experts in this case and evaluate their adequacy in relation to the criteria and methods discussed in (a).

c. Make recommendations to the attorneys regarding what additional assessment information might be needed to further establish the presence or absence of a diagnosis of mental retardation in this case.

d. Read the Memorandum and Order written by Judge Walter C. Kurtz of the Fifth Circuit Court for Davidson County, Tennessee on May 5th, 2004. Provide comments on aspects related to the diagnosis of mental retardation contained in this Order that might shed additional light in this case.

3. In undertaking the tasks described above, I examined the following relevant case materials relating to Mr. Byron Black:
   - Psychological/Psychiatric Evaluation/Opinion: Ms. Jaros and Drs. Anchor, Auble, Blair, van Eys, Vaught, Grant, Engum, Gur, Bernet.
   - Declaration of Dr. Globus
   - Deposition of Dr. Gur
   - Declaration of Dr. Greenspan
   - Social History and Life Time Line
   - Judge Kurtz's Memorandum and Order in the Fifth Circuit Court for Davidson County, TN (5/5/2004)
   - Post-conviction Hearing Transcripts 1989
   - Post-conviction Hearing Transcripts 2004

4. DEFINITION OF MENTAL RETARDATION

Van Tran v. State determined the mental retardation definition to be applied in Tennessee. Van Tran v. State defined mental retardation as follows: "***significantly subaverage general intellectual functioning as evidenced by a functional intelligence quotient (I.Q.) of seventy (70) or below; (2) deficits in adaptive behavior; and (3) mental retardation manifested during the developmental period or by eighteen (18) years of age.***"

The definition of mental retardation found in the Tennessee Code is consistent with the definitions endorsed by the Diagnostic and Statistical Manual of Mental Disorders (DSM-IV-TR; American Psychiatric Association, 2000)[3] and the American Association on Intellectual and Developmental Disabilities (AAIDD; Luckasson et al., 2002).

The **DSM-IV-TR** defines mental retardation as follows: (a) significantly subaverage intellectual functioning: an IQ of approximately 70 or below on an individually administered IQ test; (b) concurrent deficits or impairments in present adaptive functioning in at least two of the

[3] American Psychiatric Association (2000). *Diagnostic and Statistical Manual of Mental Disorders (4th Edition, Text Revision; DSM-IV-TR)*. Washington, DC: Author.

following areas: communication, self-care, home living, social/interpersonal skills, use of community resources, self-direction, functional academic skills, work, leisure, health, and safety; and (c) onset is before age 18 years.

The **American Association on Intellectual and Developmental Disabilities'** (AAIDD; formerly known as the American Association on Mental Retardation) defines mental retardation as: "***a disability characterized by significant limitations both in intellectual functioning and in adaptive behavior as expressed in conceptual, social, and practical adaptive skills. Mental retardation originates before age 18.***" The AAIDD operationally defined "significant limitations" to be at least two standard deviations below the population mean (i.e., typically a standard score of 70 when the mean = 100 and the standard deviation = 15). The adaptive behavior prong of this definition is met if the individual has significant limitations in (1) conceptual, practical, or social skills or (2) the overall composite (e.g., full-scale) score of adaptive behavior.

Intellectual Functioning

The assessment of intellectual functioning is a task that requires specialized professional training. For the purpose of diagnosing mental retardation, AAIDD stipulates that IQ assessment data should be obtained and interpreted by an examiner experienced with people who have mental retardation and who is qualified in terms of professional and state regulations as well as publisher's guidelines for conducting thorough and valid evaluations of intellectual functioning.

The determination that an individual's intellectual functioning is "significantly" sub-average fulfills the first requirement for being diagnosed with mental retardation. "Significant sub-average intellectual functioning" is defined as a performance that is represented by a full-scale IQ score of approximately 70 or less, while considering all sources of test error. A standard score or intelligence quotient of "70" represents a population-referenced performance that is two standard deviations below the population mean (i.e., population average score = 100, standard deviation = 15). Significant deficits in intellectual functioning are best determined using an individually administered standardized test of intelligence. The full scale or composite IQ is generally regarded as the best estimate of an individual's general intellectual functioning (Luckasson et al., 2002).

Assessment of intellectual functioning must be done using an individually administered comprehensive standardized test of intelligence. The results obtained from group administered tests of intelligence or abbreviated measures of intellectual functioning lack the sufficient reliability and psychometric robustness to be used for the purpose of making a diagnosis of mental retardation. These instruments serve a screening purpose but should not be relied upon when making or refuting a diagnosis of mental retardation.

The Wechsler Adult Intelligence Scale – Third Edition, when used in accordance to best practice, is considered by many as the gold standard for measuring an adult individual's intellectual functioning. Other well accepted individually administered full-scale measures of intellectual functioning for adults include: Stanford-Binet Intelligence Scale-Fifth Edition, Woodcock-Johnson III Test of Cognitive Abilities, and Kaufman Adolescent and Adult Intelligence Test.

Established practice in intellectual assessment informs us that there are several important factors to consider when interpreting the IQ score. The IQ score obtained on any standardized IQ test is an estimate of the individual's "true" intelligence. This estimate is not without error. In addition to the standard error of measurement of the test used, it is important to consider the Flynn effect and possible practice effect when interpreting IQ results (see AAIDD's User's Guide).

The AAIDD User's Guide proposed a number of guidelines to ensure proper assessment of intellectual functioning for the purpose of diagnosing mental retardation. Chief among these elements are the following:

- "*intellectual functioning is best understood as being composed of a general factor ('g')* [i.e., full-scale IQ score].
- *appropriate standardized measures should reflect the individual's social, linguistic, and cultural background and that proper adaptations must be made for any motor or sensory limitations.*
- *psychometric instruments that assess intelligence perform best when used with people who score within two to three standard deviations of the mean and that extreme scores are more subject to measurement error.*
- *assessment of intellectual functioning through the reliance on intelligence tests is fraught with the potential for misuse if consideration is not given to possible errors in measurement.*" (Schalock et al., 2007; page 12).

Sources of Error for the Test Administered

The AAIDD and DSM-IV-TR agree on the importance of taking into consideration all factors contributing error to the obtained IQ test results when interpreting someone's intellectual functioning for the purpose of making a diagnosis of mental retardation. The AAIDD (Luckasson et al., 2002) stipulated the following: *"Although far from perfect, intellectual functioning is still best represented by IQ scores when obtained from appropriate assessment instruments. The criterion for diagnosis is approximately two standard deviations below the mean, considering the standard error of measurement for the specific assessment instruments used and the instrument's strengths and weaknesses."* (page 14). Furthermore, according to the DSM-IV-TR (American Psychiatric Association, 2000), **the IQ prong of mental retardation is met if an individual's full-scale IQ score falls between 70 – 75 (roughly accounting for a 95% confidence interval resulting from standard error of measurement on most IQ tests) or lower (DSM-IV-TR; see pages 41 – 42).** In addition to the standard error of measurement, sources of error surrounding the obtained IQ score may include error that is attributable to the Flynn effect and/or practice effect, and thus the interpretation of the results should account for these factors (see Schalock et al., 2007).

Flynn Effect

The "Flynn effect" is a well-established scientific fact that IQ scores on standardized tests for the American population have been steadily increasing for more than 70 years. Dr. James R. Flynn is a well-respected researcher who studied this rise in IQ scores. Flynn's research uncovered that IQ scores have been increasing from one generation to the next in the United States, as well as in all other developed countries for which we have IQ data. This increase in IQ scores over time was dubbed the "Flynn effect" by Hernstein and Murray, the authors of the book *The Bell Curve*. Some have advanced plausible explanations for this increase in IQ scores that have included: improved nutrition, trend towards smaller families, better education, etc. The

only **theoretical** aspect to the Flynn effect is the "why." The causal factors driving this trend have not yet been scientifically established. Most likely, it is an interaction of multiple factors.

Flynn reported a greater increase in the Wechsler Performance IQ, which is more heavily loaded on fluid abilities, than on the Wechsler Verbal IQs. According to Flynn's research, the average gain in global IQ scores since 1932 is approximately 0.3 points per year. Because of this, IQ tests need to be renormed periodically to recalibrate the scores. In cases where a test with aging norms is used, a correction for the obsolescence of the norms is warranted (e.g., 0.3 points per year since norms were compiled). I will use the WAIS-III to illustrate this point. The population mean on the WAIS-III was set at 100 when it was originally normed in 1995 (test published in 1997). Hence, if the WAIS-III was used to assess an individual's IQ in 2005, the individual's score should be corrected downward as follows: 0.3 points x 10 = 3 points ("10" being the number of years elapsed since the norming of the WAIS-III). After taking the Flynn effect into consideration it is still necessary to account for the test's standard error of measurement when interpreting an individual's test results.

The AAIDD *User's Guide* (Schalock et al., 2007) emphasizes the importance of considering the Flynn effect when interpreting an individual's IQ score in making a diagnosis of mental retardation.

The so-called "Flynn effect" is NOT a theory. It is a well-established scientific fact that the US population is gaining an average of 3 full-scale IQ points per decade. The Flynn effect has been consistently documented over the past 60-plus years. There is NO published scientific evidence currently existing that casts any doubt over it relevance with respect to ongoing IQ gains in the American population. In fact, a recent study published in the *American Psychologist* (a top-rated peer-reviewed scientific journal published by the American Psychological Association), reported on data supporting the effects of the Flynn effect specifically on individuals with mental retardation (see Kanaya, Scullin, & Ceci, 2003[4]). The passage of time since an IQ test was normed is directly related to that test's obsolescence. More time has passed since the norming of an IQ test the greater will be the artificial inflation of the obtained IQ scores on that test. This obsolescence of the test's norms contributes to the error that surrounds the obtained IQ score and we must take this source of error into account when interpreting an individual's obtained IQ score.

National standards are crucial in any field to ensure a uniform and consistent application of best practice. National standards are based on a foundation of empirical knowledge, science, and peer-review and are meant to serve as a guide for proper practice in that respective field. Professional practice should be consistent with established national guidelines, when such standards are available. The AAIDD User's Guide published by the former American Association on Mental Retardation (Schalock et al., 2007) represents the accepted national standard on the proper diagnosis of mental retardation. These national standards clearly indicate that when trying to establish a diagnosis of mental retardation, with respect to the assessment of general intellectual functioning, it is necessary to correct any obtained IQ score for all sources of error associated with the test used. These professional guidelines specifically mention correcting for the obsolescence of a test's norms (i.e., "Flynn effect").

[4] Kanaya, T., Scullin, M. H., & Ceci, S. J. (2003). The Flynn effect and U.S. policies: The impact of rising IQ scores on American society via mental retardation diagnoses. *American Psychologist, 58,* 778 – 790.

Adaptive Behavior

Van Tran defines adaptive behavior as referring to "*how effectively individuals cope with common life demands and how well they meet the standards of personal independence expected of someone in their particular age group, socio-cultural background, and community setting.*" In the AAIDD 2002 manual, adaptive behavior is defined as an individual's conceptual, social, and practical adaptive skills (see Luckasson et al., 2002). The AAIDD recommended that significant limitations in adaptive behavior be established through the use of standardized measures that have been normed on the general population. These three adaptive skills domains are defined as follows:

Conceptual Skills: defined by communication skills, functional academics, and self-direction.

Social Skills: defined by such abilities as interpersonal skills, social responsibility, following rules, and self-esteem. Higher order social skills have also been identified to include such elements as gullibility, naiveté, and avoiding victimization.

Practical Skills: consist of basic personal care skills such as hygiene, domestic skills, health and safety as well as work skills.

The AAIDD specified: "*The examination of adaptive skills must be documented within the context of community environments typical of the individual's age peers and culture*" (page 78). Hence, assessing an individual's adaptive behavior in an institutional context is inappropriate for the purpose of determining if an individual has mental retardation. Assessing if someone is well adapted in an institutional setting (e.g., a prison) might be useful for determining if additional structure is needed or for planning interventions to facilitate integration, but has no relevance in determining how an individual's adaptive functioning compares to the general population for the purpose of establishing a diagnosis of mental retardation.

Another important aspect of adaptive behavior assessment is the measure of the individual's "typical performance" and not best or assumed ability (Luckasson et al., 2002). Thus, when assessing the individual's adaptive behavior, we assess what the person **typically does** and not what he/she can do or could do. This is a critical distinction with the assessment of intellectual functioning, where we assess best or maximal performance.

The AAIDD 2002 definition reminded us of an important understanding about mental retardation. Namely, that within an individual with mental retardation, significant impairments often co-exist with strengths. Individuals with mild mental retardation are capable of doing many things. Most of these individuals will have strengths and areas of competence that might surprise many laypersons or even professionals who have limited experience in working with individuals with mild mental retardation. In the process of diagnosing mental retardation, the finding of significant limitations in conceptual, social, or practical adaptive skills is not outweighed by the presence of some ability on the individual's part. These discrete abilities are not uncommon in individuals with mild mental retardation and should not be viewed as discounting a diagnosis of mental retardation.

Age of Onset and Etiology

With respect to the possible cause of mental retardation, more than 40% of all cases of mild mental retardation are of undetermined etiology. The cause of mental retardation is often likely related to a combination of risk factors. These might include, but are not limited to, pre-natal maternal malnutrition, in uterine insult or trauma, genetic disorders, fetal alcohol spectrum disorder, pre-natal and post-natal exposure to toxins, childhood malnutrition, neglect, abuse, and/or impoverished and under-stimulating home environment.

There are several hundreds of disorders associated with mental retardation. Genetic disorders, such as Down syndrome, which have a well known phenotype (including almond shaped eyes, short stature, round face, etc) is more often associated with moderate to profound level of mental retardation. Again, the cause for more than 40% of cases of mild mental retardation remains unknown. AAIDD has listed numerous risk factors that might explain mental retardation, these risk factors may be of prenatal origin, perinatal, and/or postnatal (see table below).

Mental Retardation is a functional diagnosis, based on evidence regarding someone's functioning in academic and real-world settings. As such, knowledge of the cause of someone's mental retardation is not necessary in order to make a diagnosis, and in the majority of cases (especially of mild MR) one cannot say for certain what caused the condition. Nevertheless, knowledge of a possible or likely cause is a valuable thing to have, especially in establishing whether someone meets the developmental criterion. In the case of mild MR, especially in individuals from impoverished and disadvantaged backgrounds, it is often the case that environmental deprivation and parental under-stimulation in infancy and early childhood are contributing risk factors. However, one can be from such a background and still have contributing biological factors such as pre-maturity, low birth weight, prenatal infection or malnutrition, mother's alcohol consumption during pregnancy, birth trauma, chromosomal syndromes, etc. The key in diagnosing individuals from disadvantaged backgrounds is to see if an individual is viewed within his own family and community as unusually impaired, even when compared to other individuals from the same background. It also helps in making a diagnosis if one can also point to biological risk factors, such as severe head injuries or maternal alcohol consumption during pregnancy, even though evidence of a known cause is not necessary to make a diagnosis of mental retardation.

Table 1. Table of Risk Factors for Mental Retardation (see Luckasson et al., 2002; page 127)

	Biomedical	Social	Behavioral	Educational
Prenatal	Chromosomal Dx Single-gene Dx Syndromes Cerebral dysgensis Maternal illnesses Parental age	Poverty Maternal malnutrition Domestic violence Lack of access to prenatal care	Parental drug use Parental alcohol use Parental smoking Parental immaturity	Parental cognitive disability without supports Lack of preparation for parenthood
Perinatal	Prematurity Birth injury Nenatal Dx	Lack of access to birth care	Parental rejection of caretaking Parental abandonment of child	Lack of medical referral for intervention services at discharge

Postnatal	Traumatic brain injury Malnutrition Meningoencephalitis Seizure Dx Degenerative Dx	Impaired child-caregiver Lack of adequate stimulation Family poverty Chronic illness in the family Institutionalization	Child abuse and neglect Domestic violence Inadequate safety measures Social deprivation Difficult child behaviors	Impaired parenting Delayed diagnosis Inadequate early intervention services Inadequate special-education services Inadequate family Support

Dx = Disorders

5. MYTHS AND MISCONCEPTIONS REGARDING MENTAL RETARDATION

For most people with mental retardation, there is not a "mentally retarded" look. There are no distinctive features or personality types to mental retardation. It is important to remember the sage words of Ruth Luckasson (1990): "*Ninety percent of persons with mental retardation don't drool, don't stumble, aren't mute. They have significantly impaired intellectual ability, but often don't have any physical stigmata that indicate mental retardation. They won't 'look' a certain way.*" It is dangerously naïve to think that one can "tell" if someone is mentally retarded, or not mentally retarded, by looking or talking to them. Less than 10% of all cases of mental retardation are attributable to a condition such as Down syndrome. The vast majority (approximately 80%) of individuals with mental retardation function in the mild range of intellectual and adaptive behavior deficits.

The DSM-IV-TR notes: "*No specific personality and behavioral features are uniquely associated with mental retardation. Some individuals with mental retardation are passive, placid, and dependent, whereas others can be aggressive and impulsive*" (see page 44 – 45). Additionally, mental retardation can co-exist with any number of other psychiatric disorders or personality traits. The DSM-IV-TR is quite explicit on page 47 when it states: "*The diagnostic criteria for mental retardation do not include an exclusion criterion; therefore, the diagnosis should be made whenever the diagnostic criteria are met, regardless of and in addition to the presence of another disorder.*" Thus, for example, an individual may have both mental retardation and conduct disorder as a child or mental retardation and antisocial personality disorder as an adult. The presence of a co-existing mental disorder should not summarily be used to deny the individual's functioning if it meets criteria for a diagnosis of mental retardation.

6. CLINICAL JUDGMENT

The American Association on Intellectual and Developmental Disabilities (Luckasson et al., 2002) has recognized the important role of the professional's experience and knowledge of mental retardation and individuals with this condition, in diagnosing mental retardation. The AAIDD has defined clinical judgment as it relates to diagnosing mental retardation as follows:

> *"Clinical judgment is a special type of judgment rooted in a high level of clinical expertise and experience; it emerges directly from extensive data. It is based on the clinician's explicit training, direct experience with people who have mental retardation, and familiarity with the person and the person's environments"* (page 95).

AAIDD further clarified clinical judgment by stating:

> "... *[clinical judgment] should be viewed as a tool of clinicians with training and expertise in mental retardation and ongoing experiences with – and observations of – people with mental retardation and their families*" (page 95).

The professional must use his or her clinical judgment throughout the diagnostic process. The experience and clinical judgment in mental retardation informs the professional to take well-established phenomena such as Flynn effect, practice effect, and cloak of competence into consideration when evaluating the data used in making a diagnosis of mental retardation (see AAIDD User's Guide; Schalock et al., 2007).

When diagnosing other mental health disorders such as schizophrenia, clinical judgment plays a central role. In such a process, the clinician weighs various bits of evidence and then judges if an individual fits the behavioral criteria for a particular disorder. In the case of MR, however, the role of clinical judgment has very little room to operate, and is used mainly to see if test scores can be depended on reliably. There are two reasons for this: (a) many psychologists and psychiatrists have little or no training or experience in this area, and their clinical judgment about MR may be untrustworthy; and (b) because people with mild MR can have areas of relatively normal functioning, and not express obvious signs of sub-normality, clinical judgment can be very misleading, especially when it is used to rule out a diagnosis of MR. Thus, while clinical judgment has a role in diagnosing MR, it does not play as prominent a role as in other disorders (in which test scores have little or no diagnostic role) and clinical judgment should not be used as an independent diagnostic criterion separate from its use in commenting on and interpreting IQ and adaptive behavior test scores.

7. REVIEW OF EXPERT REPORTS REGARDING MENTAL RETARDATION

The records indicate that Mr. Black was never administered an individual standardized test of intellectual functioning prior to his incarceration. All IQ scores reported in his school records were obtained from group administered tests of intelligence. These measures are not well normed nor possess the psychometric properties necessary to be used in diagnostic decision-making. For this reason, these results cannot be relied upon to confirm or refute prong 1 of a diagnosis of mental retardation.

Since his incarceration, Mr. Black has been evaluated on several occasions using individually administered tests of intellectual functioning. In this section I focus my comments on the psychological evaluations and reports that centered on the question of mental retardation.

Kenneth Anchor, Ph.D. Psychological Evaluation dated 1/17/1989 – Mr. Black was 32 years old.

Dr. Anchor interviewed and conducted some individual assessments with Mr. Black. Dr. Anchor administered the Shipley-Hartford Institute of Living Scale – Revised Norms and obtained an IQ score of 76. It should be noted that the Shipley-Hartford Institute of Living Scale is a short self-answered paper-pencil questionnaire that provides an abbreviated estimate of intellectual functioning and should not be relied upon for the purpose of confirming or refuting a diagnosis of mental retardation (see AAIDD; Luckasson et al., 2002).

Gillian Blair, Ph.D. Psychological Report dated 10/7/1993 – Mr. Black was 37 years old.

Dr. Blair administered the WAIS-R during an evaluation conducted at the Riverbend Maximum Security Institution. During this evaluation, Mr. Black obtained the following scores on the WAIS-R: VIQ = 73, PIQ = 75, FSIQ = 73. Dr. Blair also administered to Mr. Black a series of other tests that measured memory and personality (e.g., Rorchach, MMPI-2, PAI, Sentence completion test, WMS-R); however, she did not attempt to assess his adaptive behavior.

Pamela Auble, Ph.D. Psychological Report dated 3/5/1997 – Mr. Black was almost 41 years old.

Dr. Auble administered a battery of tests of personality, malingering, attention, memory, and intellectual functioning. Dr. Auble administered the WAIS-R (an individually administered test of intellectual functioning) to Mr. Black and obtained the following scores: VIQ = 76, PIQ = 77, FSIQ = 76. There was no assessment attempted of Mr. Black's academic skills or adaptive behavior.

Patti van Eys, Ph.D. Psychological Report dated 3/28/2001 – Mr. Black was 45 years old.

Dr. van Eys was retained to assess Mr. Black's intellectual functioning. Dr. van Eys administered the WAIS-III on which Mr. Black obtained a VIQ = 67, PIQ = 79, FSIQ = 69. No other assessment instruments were completed at this time.

Daniel H. Grant, Ph.D. Affidavit of Testing Conducted on 10/15 & 10/16/2001 – Mr. Black was 45 years old.

Dr. Grant administered a battery of assessment instruments to Mr. Black at Riverbend Maximum Security Institution. During this psychological evaluation, Dr. Grant assessed Mr. Black using the Stanford-Binet Intelligence Scale – Fourth Edition (SB-FE), Wide Range Achievement Test – 3rd Edition (WRAT-3), Nelson-Denny Reading Comprehension Test, among other tests.

Mr. Black's academic skills as measured on the WRAT-3 and Nelson-Denny Reading Comprehension Test yielded grade-equivalents of 4th grade for both arithmetic and reading comprehension. His performance on the SB-FE yielded the following scores: Verbal Reasoning = 56, Abstract Reasoning = 76, Quantitative Reasoning = 61, Short-term Memory = 56, and Composite Score = 57. The SB-FE Composite Score is comparable to the WAIS-III FSIQ. It should be noted, however, that the mean and standard deviation on the SB-FE are 100 and 16, respectively. Thus, a Composite Score = 68 would represent a score that is 2 standard deviations below the population mean.

Dr. Grant also administered the CTONI, a test of non-verbal intelligence. I will not review Mr. Black's results on this instrument since it is a narrow band test of intelligence and not as reliable as the SB:FE and should be used only when more robust and global measures cannot be used, according to AAIDD 2002 (Luckasson et al., 2002), which was not the case here.

Susan R. Vaught, Ph.D. Review of Existing Psychological Evaluation Data and Professional Opinion Regarding the Question of Mental Retardation dated May 2003 – Mr. Black was 45 years old.

Dr. Vaught was asked to conduct a file review of Mr. Black's previous psychological evaluations and extensive records. Following this review of previously administered intellectual evaluations, Dr. Vaught concluded that Mr. Black met prong 1 of the diagnostic criteria for mental retardation.

It would appear that Dr. Vaught never met with, nor interviewed, Mr. Black or anyone else who may have had knowledge about his adaptive behavior or developmental/social history. Dr. Vaught's conclusions regarding Mr. Black's adaptive behavior appear to be based entirely on a paper review. There is no evidence in Dr. Vaught's report either that she requested any specific or additional standardized testing be done to assist her in reaching her clinical opinion in this matter. It should be noted that Dr. Vaught relied on the AAIDD (Luckasson et al., 2002) Manual in making her determination of prong 2 "deficits in adaptive behavior"; however, AAIDD (2002) clearly specifies that "*for the diagnosis of mental retardation, significant limitations in adaptive behavior should be established through the use of standardized measures normed on the general population, including people with disabilities and people without disabilities. On these standardized measures, significant limitations in adaptive behavior are operationally defined as performance that is at least two standard deviations below the mean of either (a) one of the following three types of adaptive skills: conceptual, social, or practical, or (b) an overall score on a standardized measure of conceptual, social, and practical skills*" (see Luckasson et al., p. 76).

Eric S. Engum, Ph.D., J.D. Review of Existing Psychological Evaluation Data and Professional Opinion Regarding the Question of Mild Mental Retardation dated 7/2/2003 – Mr. Black was 45 years old.

Dr. Engum was asked to review the data from existing psychological evaluations and case records and opine regarding whether or not Mr. Black has mental retardation. Dr. Engum neither assessed nor interviewed Mr. Black before formulating his clinical opinion and completing his written report. Dr. Engum reviewed Dr. van Eys' psychological evaluation and asserted that Mr. Black had to be malingering during Dr. van Eys' administration of the WAIS-III because he obtained a scaled score of 4 on Digit Span and scaled score of 2 on Arithmetic. Dr. Engum's inference is solely based upon the fact that Mr. Black's scaled scores on these two subtests on the WAIS-III administration done in 2001 by Dr. van Eys were lower that Mr. Black's scores obtained on the previously administered WAIS-R in 1997 by Dr. Auble. First, one must be very cautious comparing results on different versions of an intelligence test. In 1997 Mr. Black was administered the WAIS-R and in 2001 he was administered the WAIS-III. These are entirely different versions of the WAIS and research has shown that individuals obtain consistently lower IQ scores when tested on a more recent version of the same IQ test (see above – the Flynn effect). This difference in scaled scores should not be assumed to be an indication of malingering on Mr. Black's part.

I disagree with Dr. Engum's assertion that one cannot or should not correct obtained IQ scores for error of measurement. Research over the past several decades has clearly shown that IQ scores are rising and that an individual score artificially higher on a test with aging norms than he would on a test with more recent norms (see Table 1 & Flynn effect above). This is in fact recommended by

Mr. Byron's Previous Results on IQ Testing

Flynn effect: IQ inflation = 0.3/year

TEST USED	YEAR NORMED	YEAR ADMIN.	# YEARS ELAPSED		IQ SCORES OBTAINED	IQ INFLATION	IQ SCORES CORRECTED FOR FLYNN EFFECT	TEST STANDARD ERROR OF MEAUREMENT IQ < 70 – 75 PRONG 1 MET?
WAIS-R	1979	1993	14	VIQ	73			
		Age: 37 y.o.		PIQ	75			
Dr. Blair				FSIQ	73	4.2	69	YES
WAIS-R	1979	1997	18	VIQ	76			
		Age: 41 y.o.		PIQ	77			
Dr. Auble				FSIQ	76	5.4	71	YES
WAIS-III	1995	2001	6	VIQ	67			
		Age: 45 y.o.		PIQ	79			
Dr. van Eys				FSIQ	69	1.8	67	YES
SB-FE	1986	2001	15	VR	56			
		Age: 45 y.o.		AR	76			
				QR	61			
				Mem	56			
Dr. Grant				Comp	57	4.5	53	YES

the AAIDD when interpreting IQ results for the purpose of making a diagnosis of mental retardation. It should be noted that when Mr. Black was administered the WAIS-R in 1993 by Dr. Blair, the WAIS-R had been normed almost 15 years earlier, thus resulting in an inflation of approximately 4 points on the WAIS-R Full Scale IQ. This is a significant source of discrepancy between the measured IQ (obtained on the WAIS-R) and the individual's true IQ.

I respectfully disagree with Dr. Engum's conclusion that there is no evidence indicating that Mr. Black has significant subaverage intellectual functioning. Table 1 clearly indicates that Mr. Black meets prong 1 of the definition of mental retardation.

8. After reviewing the existing psychological evaluations and reports available, I recommended to Mr. Black's attorneys that they hire a professional to conduct a thorough assessment of Mr. Black's adaptive behavior. This adaptive behavior assessment should be conducted by a professional experienced in the area of mental retardation and adaptive behavior assessment. Since Mr. Black has been incarcerated for numerous years and that a contemporary assessment of his current adaptive behavior is impossible, the best available method would be to interview relatives and other individuals who knew him well prior to his incarceration and possibly prior to age 18 years. Retrospective assessment of adaptive behavior is recommended in such cases by the AAIDD Guidelines for diagnosing mental retardation. I thought that this assessment would yield definitive information regarding prong 2 and contribute valuable clinical information regarding whether or not Mr. Black has mental retardation.

9. RECENT COMPREHENSIVE ASSESSMENT OF MR. BLACK'S ADAPTIVE BEHAVIOR

Stephen Greenspan, Ph.D., a nationally-recognized and respected expert in the field of mental retardation, conducted a comprehensive adaptive behavior assessment using multiple sources of information including: the Vineland Adaptive Behavior Scales – 2nd Edition (a comprehensive standardized assessment of adaptive behavior), a review of existing records, a review of existing affidavits from relatives and other individuals who know Mr. Black.

Dr. Greenspan followed the guidelines put forth by the AAIDD (Schalock et al., 2007) in conducting his retrospective adaptive behavior assessment. Dr. Greenspan interviewed three different individuals in order to complete the VABS-2. A retrospective assessment is sometimes the best method available of assessing the individual's adaptive behavior. Again, adaptive behavior must be assessed in relation to community living. Using a retrospective assessment of adaptive behavior is in some circumstances the only adequate means of assessing adaptive behavior since all existing diagnostic systems, including Van Tran, define adaptive behavior as: "[adaptive behavior] *refers to how effectively individuals cope with common life demands and how well they meet the standards of personal independence expected of someone in their particular age group, socio-cultural background, and community setting.*" Hence, this refers to how the individual copes and adapts to society's expectations in the community, not prison.

Dr. Greenspan also asked these individuals to recall and assess Mr. Black's adaptive behavior prior to his 18th birthday. The advantage of conducting a retrospective assessment in this manner is that it also allows a determination if the age of onset (prong 3) criterion was met.

Based on Dr. Greenspan's evaluation of Mr. Black's adaptive behavior, Mr. Black presents significant deficits in social adaptive skills as well as significant deficits in his overall adaptive behavior (VABS-2 Composite Score = 70), thus meeting AAIDD (Luckasson et al., 2002) and Tennessee Code Annotated section 39-13-203's prong 2 criterion for mental retardation.

10. COMMENTS ON JUDGE KURTZ'S CONCLUSIONS REGARDING MENTAL RETARDATION

Mental retardation is a developmental disability, with its origin during the developmental period. Again, although it originates during the developmental period, it is not always correctly identified and diagnosed during this developmental period. Mental retardation is a chronic and life-long condition from which one seldom out grows. Conversely, one does not acquire mental retardation in adulthood. Mental retardation is a functional definition, which has no pre-set cause or etiology that must be present to be diagnosed. Similarly, there are no co-existing conditions that preclude making a diagnosis of mental retardation. Hence, if an individual functions with significant impairments in intellectual and adaptive functioning and it can be reasonably assumed to have originated during the developmental period a diagnosis of mental retardation is warranted.

There was no reliable individualized assessment of Mr. Black's intellectual functioning conducted during his school years. One should not assume that because a child was not referred for testing or special education that the child in question was not struggling in school. Clearly Mr. Black struggled in school, doing poorly in reading and having been retained in second grade.

There appears to be compelling evidence that Mr. Black's current intellectual functioning is significantly subaverage. Most experts agree that Mr. Black meets prong 1 of the definition of mental retardation. Dr. Greenspan's recent comprehensive evaluation of Mr. Black's adaptive behavior provides strong evidence indicating that Mr. Black has significant limitations in adaptive behavior and that these deficits were manifested prior to age 18 years.

As per any diagnostic system as well as the Tennessee statute 39-13-203, prong 3 refers only to documenting that the onset of significant subaverage intellectual functioning and deficits in adaptive behavior were manifested prior to age 18. No diagnostic system requires that a definitive diagnosis of mental retardation be made before the individual reaches the age of 18 years. An initial diagnosis of mental retardation can be made at any age, as long as the manifestation of prongs 1 and 2 can be documented during the developmental period or in other words, before the individual turns 18 years old.

I declare under penalty of perjury and the laws of the United States that the foregoing is a true and correct statement.

Signed on this 17th day of March, 2008.

Marc J. Tassé, PhD, FAAIDD

DECLARATION OF DANIEL H. GRANT, Ed.D.

1. I am Daniel H. Grant. I am licensed as a psychologist by the State of Georgia (Georgia License Number 859) with training in psychological and neuropsychological evaluation procedures. I have an Ed.D. in school psychology from the University of Georgia, with a major in school psychology and a minor in mental retardation and reading. In addition to attaining the qualifications for licensure in psychology, I obtained both pre and post-doctorial training at the Medical College of Georgia in clinical neuropsychology. I am board certified as a clinical neuropsychologist by the American Board of Professional Neuropsychology. I am also a board certified forensic examiner and a Fellow of the American College of Forensic Examiners.

2. My professional experience includes employment as a staff psychologist at Georgia Regional Hospital in Savannah, Georgia, an assistantship with Dr. Allen Kaufman in the Department of Educational Psychology at the University of Georgia, A school psychologist with the Hall County Hall County Board of Education in Gainesville Georgia, Georgia. For almost fifteen years I was a consultant psychologist (30 hours a week) for the diagnostic unit of the Coastal Correctional Institution in Garden City, Georgia, where I assessed approximately 2500 inmates with the majority being below the IQ of 80. I made recommendations regarding housing, and assisted in assessing inmates for potential problems with adaptability and adjustment to prison life. For six years I was a contract neuropsychologist for the Out Patient Psychiatry Department at Winn Army Hospital at Fort Stewart, Georgia. For the past three years I have been a contract part-time psychologist with the Georgia Department of Juvenile Justice at the Savannah Regional Youth Detention Center in Savannah, Georgia. My responsibilities there include providing assessment and treatment, making recommendations regarding housing, and assessing residents for potential problems with adaptability and adjustment to incarceration. I have also maintained a private practice in psychology and clinical neuropsychology. A true copy of my curriculum vitae is attached to this affidavit.

3. October 15 and 16, 2001 I evaluated Mr. Black. I met with Mr. Black at the Riverbend Maximum Security Institution in Nashville Tennessee. I conducted a clinical interview and administered a series of tests and procedures to assess Mr. Black's level of intelligence, adaptive functioning, language skills and memory functioning. The tests I administered included: Stanford Binet Intelligence Scale-Fourth Edition, Comprehensive Test of Nonverbal Intelligence, Peabody Picture Vocabulary Test, Expressive Vocabulary

EXHIBIT
tabbies 12

Test, Visual Naming Test from the Multilingual Aphasia Examination, Oral and Written Language Scales, Letter and Category Fluency (F-A-S and Animals) Test, Wide Range Achievement Test-Revision Three(Arithmetic Subtest), Nelson Denny Reading Comprehension Test (Form H), Reitan Story Memory Scale, Denman Neuropsychological Memory Scale (Short Form),Visual Search and Attention Test, Benton Visual Form Discrimination Test, Benton Judgment of Line Orientation, Color Trials 1 and 2, Bender Gestalt, Independent Living Scales, Rapid Alternating Hand Task, structured clinical interview. These are the types of tests which experts in my field normally and regularly rely upon when forming and expressing expert opinions. I am trained at the administration and interpretation of these tests.

4. I have also examined a voluminous number of records, documents and testimony pertaining to Mr. Black. The reports I relied on the most are included below, the other documents are attached to the end of this declaration:

1. Interview with Finis Black by Gaye Nease
2. Interview with Mary Frances Coplan by Gaye Nease
3. Interview with Freda Whitney by Gaye Nease
4. Interview with Richard Corley by Gaye Nease
5. Interview with Melba Corley by Gaye Nease
6. Interview with Siblings of Julia Mai Black: Finis Black; Dan Black; and, Alberta Crawford on 4-22-97 by Libby Moore
7. Interview with Jackie M. Thomas by Gaye Nease
8. Interview with Teachers by Gaye Nease
9. Interview with Alberta Black Crawford by Gaye Nease
10. Interview with Lynette Childs Black by Gaye Nease
11. Interview with Johnny Moore (Supposed Father of Bryon Black) by Gaye Nease
12. Interview with Mary Coletta Harrison by Gaye Nease
13. Interview with Arleta Black Swanson (Byron's Sister)
    Interview with Karen Black Greer (Byron's Sister) by Gaye Nease
14. Trial testimony of Dr. Warren Thompson State of Tennessee v. Walter R. Kendricks, Davidson County, Tennessee,
15. Julia Black's statements to the police
16. Psychological Evaluation by Patti van Eys, Ph.D.
17. Psychological Evaluation by Pamela Auble, Ph.D.
18. Psychological Evaluation by Gillian Blair, Ph.D.
19. Byron Black's school records
20. Declaration of Ross Alderman
21. Mitigation Statute 39-13-204 page 25
22. Mental Retardation Statute 39-13-203 pages 46-47
23. Birth certificate of Byron Black
24. Hospital Records of Byron Black
    Baptist Hospital
    Meharry Hospital (formally General Hospital)
    Metro Health Records
    Riverbend Maximum Security Prison Health Records

Vanderbilt Clinic and Hospital Records
25. Incarceration Records of Byron Black
26. Transcript of Competency Hearing of Byron Black
27. Mackey V. State 537 S. W. 2nd 704 (TN1975)
28. Medical and death Information on Julia Mai Black
29. Miranda Warning Information
30 Records and Transcripts of Testimony
DeDe Wallace Center Competency Records
Calvin Y. Allmon, M.S.S.W.
Bradley Diner, M.D.
Leonard Morgan, Jr., Ph.D. Clinical Psychologist
Pat Jaros, M.A. Licensed Psychological Examiner
William Kenner, M.D. Psychiatrist

5. Mental Retardation
I understand the state of Tennessee defines mentally retarded defendants- Death sentence prohibited As used in section39-13-203 as:
1. Significantly subaverage general intellectual functioning as evidenced by a functional Intelligence Quotient (IQ) of seventy (70) or below:
2. Deficits in adaptive behavior and
3. The mental retardation must have been manifested during the developmental period, or by eighteen (18) years of age.
This Standard derives from the classification systems of the American Association on Mental Retardation (AAMR, 1983 & 1992 ed.) and the Diagnostic and Statistical Manual of Mental Disorders (DSM-III-R, 1987 & DSMIV-TR, 2000) which I have specifically considered in setting forth my opinion in this matter.

6. General intellectual functioning is defined as an intelligence quotient (IQ) obtained by assessment with one or more individually administered general intelligence tests, such as the WAIS-III or Stanford Binet or the Comprehensive Test of Nonverbal Intelligence (CTONI). Significantly subaverage general intellectual functioning is defined by the AAMR and the DSMIV-TR as an IQ of approximately 70-75 or below on a standardized, individually administered test of general intellectual functioning. Since any measure is fallible, an IQ score is generally thought to involve an error of measurement of approximately five points; hence, an IQ of 70 is considered to represent a band or zone of 65 to 75. Treating the IQ with so flexibility permits inclusion of people with IQ's somewhat higher than 70 who exhibit significant deficits in adaptive behavior.

7. Deficits in adaptive behavior (also known as "adaptive functioning "or "adaptive skills") refer to limitations in practical and social intelligence. Practical intelligence refers to the ability to maintain oneself as an independent person in managing the ordinary activities of daily living, and is important for adaptive abilities like functional academics, work, leisure, self-direction, and self-care. Social intelligence refers to the ability to understand social expectations and the behavior of other persons and to judge appropriately how to conduct oneself in social situations, and is central to such adaptive abilities like social skills, communication, work, leisure, home living, functional

academic skills and use of the community. It is a measure of an individual's ability to function effectively in society, and refers to the person's effectiveness in areas such as social skills, communication, and daily living skills, and how well the person meets the standards of personal independence and social responsibility expected of his or her age by his or her cultural group. Specific adaptive limitations often coexist with strengths in other adaptive or personal capabilities. In order to qualify for a diagnosis of Mental retardation, an individual must possess deficits in adaptive functioning in at least two of the following areas: communication, self-care, home living, social/interpersonal skills, use of community resources, self direction, functional academic skills, work, leisure, health, and safety.

8. Most mentally retarded people do not have obvious physical abnormalities. Oftentimes they appear to have nominally average language skills. Unless the disability is severe, many mentally retarded persons can perform semi-skilled and repetitive tasks with relative ease. They can drive cars. They can maintain lower level jobs with repetitive unskilled tasks. Mentally retarded people often develop coping skills in which they try to hide their disability in an attempt to appear as being "normal." One of these coping skills is the tendency to answer in the affirmative. For these reasons, many people who are thought of as simply being "slow" are in fact mentally retarded. Oftentimes there are no glaring indicators that a person may be mentally retarded.

9. A mentally retarded person does not have the mental capacity of an average person. The abilities to plan, organize and reason are often diminished, judgment is often limited, depending upon the complexity of the situation. Mentally retarded persons have limited learning abilities and poor abstract reasoning. They tend to think in concrete terms. Mentally retarded persons also tend to exhibit intellectual rigidity, which is often demonstrated by difficulty understanding and learning from mistakes and by persisting in counterproductive behaviors; for this reason, mentally retarded persons often experience difficulties in independently arriving at a behavior appropriate for a given situation. All of these limitations help explain why many mentally retarded people have difficulties understanding legal proceedings or legal defenses.

RESULTS OF THE EVALUATION OF BYRON BLACK

10. Mr. Black's performance on the Stanford Binet-Fourth Edition yielded a test composite score of 57 placing his level of intelligence within the mildly mentally retarded range of intelligence. Mr. Black's performance indicated that 99 percent of the population on which the test was normed scored better than did Mr. Black. Standard scores on the individual components of the test were: Verbal Reasoning 56, Abstract Reasoning 76, Quantitative Reasoning 61, Short-term Memory 56.

11. I also administered the Comprehensive Test of Nonverbal Intelligence (CTONI), a widely and professionally accepted test of nonverbal intellectual functioning which measures nonverbal planning, organizational skills, problem solving and spatial ability. His performance yielded a Nonverbal IQ of 64 (placing him at the 1 percentile), Pictorial Nonverbal IQ of 66 (placing him at the 1 percentile) and a Geometric Nonverbal IQ of

68 (placing him at the 2 percentile). Mr. Black's scores indicate that 98 to 99 percent of the population performed better than Mr. Black on this test. His performance on the CTONI placed Mr. Black's intellectual performance on all three intellectual measures within the mildly mentally retarded range of intelligence. Mr. Black's performance indicated the severity of his deficits in nonverbal reasoning, nonverbal planning, organizational skills and higher level complex spatial ability.

12. All of Mr. Black's scores were within the mildly mentally retarded range. It is my opinion, to a reasonable degree of psychological certainty, that Mr. Black's performance on these two measures of intelligence placed his intellectual abilities within the mildly mentally retarded range of intelligence.

13. Mr. Black was administered the WAIS-R on 10-7-93 by Gillian Blair. His performance on the WAIS-R yielded a Verbal IQ of 73, Performance IQ of 75 and a Full Scale IQ of 73. It should be noted the WAIS-R was normed in 1980. The Psychological Corporation, the publisher of the Wechsler Scales published an article in 1996 which stated individuals tend to gain approximately 3 to 5 IQ points over a 10 year period. One of the main reasons stated for revising the WAIS-R was outdated normative information. If Mr. Black's WAIS-R IQ scores are corrected for the age of the normative information his intellectual performance would be within the mildly retarded range of intelligence. His Full Scale IQ Score would be between 68 and 70. Pamela Auble, Ph.D. administered the WAIS-R to Byron on either 2-27-97or 3-5-97. He received a Verbal IQ score of 76, Performance IQ of 77 and a Full Scale IQ of 76. When these scores are corrected for the outdated normative information Mr. Black's intellectual performance on this administration of the WAIS-R should be reduced by 5 to 6 points. This would correct his Full Scale IQ by reducing it to an IQ of 70 or 71. On 3-28-01 Patti van Eys, Ph.D. administered the WAIS-III to Mr. Black. His performance on the WAIS-III yielded a Verbal IQ of 67, Performance IQ of 76 and a Full Scale IQ of 69.

14. It is important to note all of the individually administered intelligence tests administered to Mr. Black have yielded consistent results. His full Scale IQ on all of these tests place Mr. Black's level of intelligence within the mildly retarded range according to the DSMIV-TR and AAMR diagnostic criteria.

15. Mr. Black was given several group administered intelligence tests while a student. Mr. Black repeated the second grade and often group administered tests in school are scored by grade and not by age as individually administered IQ tests are. If you had repeated a grade this could inflate your IQ score significantly. Group administered tests are not as carefully normed in relation to the national census or socioeconomic data. When a test is administered in a group there can be little control of the testing situation. As Dr. Thompson said in his testimony in the State of Tennessee v. Walter Kendricks " They ....(group administered IQ tests)...predict some things, but it's not as accurate a measure of intelligence or ability as we'd like to have, but it was what we used back then." He went on to say that an 85 on an Otis-Lennon ..."did not rule out mental retardation." It is important to note the DSMIV-TR and the AAMR do not allow the use of a group administered intelligence test in the diagnosis of Mental Retardation.

16. Mr. Black's performance on the Differential Aptitude Test (DAT) administered in the ninth grade would be the best indicator of his level of functioning. This is a well normed test and is published by the publishers of the Wechsler Scales (WAIS-R and WAIS-III). His performance on the Verbal Recognition yielded a percentile of 3, stanine 1; Nonverbal yielded a percentile of 2, stanine of 1; and the VR&NA (a good predictor of intelligence and general ability) yielded a percentile of 1 and a stanine of 1. His performance on the DAT places Mr. Black's level of functioning within the mildly retarded range.

17. After reviewing Mr. Black's educational records and reading the interview of Jackie Thomas, Byron Black's Sixth grade teacher, and Mrs. Ford, Byron Black's fifth grade teacher, his true academic performance is suspect. Jackie Thomas stated, "...In my class what I did was I gave work that they could succeed at." Mr. Thomas further stated, "I always gave them something that they could do well. I would not allow a student to get a bad grade in my class." Mrs. Ford stated, "The black teachers were liberal in their grading." She further noted that A's and B's at that time probably would be C's and D's now.

18. Mr. Black's Performance on the Oral and Written Language Scale (OWLS) a test of receptive and expressive language skills, yielded a Listening Comprehension standard score of 71 (test age 10-6) and an Oral Expression standard score of 67 (test age 8-6). His performance on the OWLS indicates significant deficits with Mr. Black's Listening Comprehension and Oral Expression. Mr. Black's Performance on the Peabody Picture Vocabulary Test-Third Edition (PPVT-III), test of an individual's "hearing" or listening vocabulary, yielded a standard score of 66. Mr. Black's performance reveals a significant deficit in his listening or receptive language skills. His performance on the Expressive Vocabulary Test (EVT), a measure of expressive vocabulary, yielded a standard score of 57 indicating a significant deficit in Mr. Black's expressive vocabulary skills. To further measure his expressive language skills he was administered the Visual Naming subtest from the Multilingual Aphasia Examination. This is a test of naming pictures of familiar objects. Mr. Black's performance was severely defective and below the 2 percentile level. Mr. Black's significant deficits on the Expressive Vocabulary Test, Vocabulary Reasoning subtest of the Stanford Binet-Fourth Edition, and the Visual Naming subtest of the Multilingual Aphasia Examination probably also indicate a deficit in word retrieval and /or retrieval deficits in general. Mr. Black exhibited a strength in his verbal fluency (list all the words he can think of beginning with the letters F-A-S in one minute) on which he received a standard score of 90. His Category Fluency (list all the animals he could think of in one minute) yielded a standard score of 78. Mr. Black's lower Category Fluency standard score of 78 is most likely related to his word retrieval difficulties. t

19. Mr. Black's performance on the Arithmetic subtest of the Wide Range Achievement Test-Revision Three (WRAT-III) yielded a standard score of 72 and grade equivalent of 4.6. His performance on the Nelson-Denny Reading Comprehension Test yielded a grade equivalent of 4.7. Mr. Black's performance on these academic tests indicate significant deficits in his functional academic skills.

20. Mr. Black's performance on the Denman Neuropsychological Memory Scale (Short Form) Yielded a Verbal Memory Standard score of 65 which indicates a moderate impairment in Mr. Black's verbal memory. His performance on the Reitan Story Memory Scale yielded a learning standard score of 58 after five learning trials (story repartitions). His retention score after a four hour delay yielded a standard score of 116. This is a significant strength and indicates Mr. Black exhibits much difficulty with the acquisition and encoding of new information but once the information is acquired he is able to retain the information.

21. Mr. Black 's performance on the Visual Search and Attention Test yielded a percentile score of 19. This is a visual cancellation task and is a measure of sustained attention for one minute. Mr. Black's performance on the Color Trails 1 yielded a standard score of 88 indicated low average ability in his sustained visual attention involving perceptual tracking and simple sequencing. His performance on the Color Trails 2 which involves an alternating sequencing pattern and is a measure of visual scanning, sustained visual attention and graphomotor skills was within the lower limits of the average range. His sustained attention as measured on these tests is within the low average range. This would indicate Mr. Black's memory deficits are related to encoding difficulties and not to difficulties with sustained attention.

22. Mr. Black was administered the Benton Visual Form Discrimination Test and his performance was within the average range indicating good visual discrimination skills. His performance on the Benton Judgment of line orientation was within the low average range adequate visual orientation skills.

23. Mr. Black's performance on the Independent Living Scale placed his ability to manage money, do monetary calculations, pay bills and take precautions with money at a standard score of 73. His ability to manage the home, use public transportation and maintain a safe home was at a standard score of 73. His awareness of personal health status and ability to evaluate health problems, handle medical emergencies, and take safety precautions and use of health and safety was at a standard score of 72. His performance on the Memory and Orientation subtest was within the average range. It is a measure of his awareness of his surroundings and assesses short-term memory for brief facts rather than large chunks of semantically related information (a story) as measured by the two tests of memory described in section 20 of this declaration. Mr. Black rated his level of social adjustment as average but it is apparent this is a skewed self rating.

24. It is important to note Mr. Black never lived independently. He never did the laundry, cooked, cleaned the house or participated in the care of his son. Even when married he and his wife lived with relatives who cared for Mr. Black. He did not contribute financially to his family and his wife said he never had a bank account. He never contributed financially to the cost of housing or utilities.

25. Mr. Black is mentally retarded. His performance on the Wais-III administered by Dr. Patti van Eys yielded a Full Scale IQ of 69. His corrected Full Scale IQ on the WAIS-R

administered by Dr. Gillian Blair was 70 or less and his corrected Full Scale IQ score on the WAIS-R administered by Dr. Pamela Auble was 70 or 71. His performance on the Stanford Binet-Fourth Edition yielded a Test Composite (standard score) of 57. His performance on the Comprehensive Test of Nonverbal intelligence yielded a Nonverbal IQ of 64. All of these scores meet the criteria for significantly subaverage general intellectual functioning as evidenced by a functional intelligence quotient (IQ) of 70 or below especially when the standard error of measurement is considered.

26. Mr. Black has significant deficits in adaptive behavior. For example communication skills as measured by Oral and Written Language Scales placed his listening Comprehension skills at a standard score of 71 (test age 10-6) and Oral Expression standard score 67 (test age 8-6) are significantly impaired. His performance on the Peabody Picture Vocabulary Test-Third Revision, standard score of 66 and his standard score of 57 on the Expressive Vocabulary Test revealed Mr. Black's expressive and receptive vocabulary are also significantly impaired. Mr. Black also had significant deficits on a test of visual naming and on the Verbal Reasoning subtest of the Stanford Binet- Fourth Edition. These test results indicate Mr. Black has a significant deficit in his communication skills.

Mr. Black's performance on the Nelson-Denny Reading Comprehension test placed his reading comprehension skills at the 4.7grade level. His arithmetic skills as measured by the Arithmetic subtest on the Wide Range Achievement Test were at the 4.6 grade level. His performance on the Managing Money subtest of the Independent Living Scale placed his ability to manage money, do monetary calculations, pay bills and take precautions with money was at a standard score of 73. Mr. Black's performance on these tests indicate his functional academic skills are significantly impaired.

It is also important to add Mr. Black has never lived independently, never did the laundry, cooked, cleaned the house, cared for his son or contributed financially to his family or to the maintenance of his residence.

27. His mental retardation manifested during the developmental period as noted by his not developing age appropriate independent living skills before the age of eighteen and as noted by his significantly subaverage performance on the Differential Aptitude Test that was administered when he was in the ninth grade. His performance on the VR&NA on the DAT yielded a percentile score of 1 which indicates 99 out of a 100 individuals scored better than Mr. Black on that test.

28. The Declaration of Ross Alderman, who was trial counsel for Mr. Black, describes behaviors Mr. Black presented at trial that are consistent with an individual who has significant deficits in language skills, memory, verbal reasoning, problem solving skills and significant subaverage intelligence. It is also important to note Mr. Black's deficits and difficulties reported in my declaration would be expected to become more apparent and he more dysfunctional in a stressful situation such as court. Therefore I was not surprised at Mr. Alderman's description of Mr. Black's behavior during his trial.

29. It is important to note the waiver used to obtain permission from Mr. Black to search his premises was written at a 12.0 grade level based on the Flesh-Kincaid Readability Formula. This is a formula that is regularly relied upon by linguists and reading specialists in order to determine the readability of written passages. As I have stated above Mr. Black's reading comprehension level is at the 4.7 grade level. He has significant deficits in his listening comprehension skills and a limited receptive or listening vocabulary. Given the fact that Mr. Black possesses reading and language skills within the fourth to fifth grade level it is probable that he may not have fully comprehended and understood the consequences of giving consent for the purposes for which these forms were intended, or do to his significantly subaverage intelligence that he could rationally make such a decision. This is further supported by the difficulty Mr. Black experienced comprehending and understanding the "happenings" in the court room and the difficulty he had in assisting his counsel which was noted in Mr. Alderman's Declaration. The concept of what constitutional rights are, the meaning of hereinafter, hereby authorize, the concepts of refusal of consent and of search warrants, are abstract. It would take great explanation and questioning to ensure that Mr. Black intelligently and knowingly comprehended the intent and potential harm to him entailed by his waiver of rights as set forth in these forms.

Date 16 November 2001

Daniel H. Grant, Ed.D.

Birth Certificate of Byron Black
Hospital Birth Records of Byron Black
Educational Records of Byron Black
Medical Records of Byron Black
- Baptist Hospital
- Meharry Hospital (General Hospital formerly)
- Metro Health Records
- Riverbend Maximum Security Prison Health Records
- Vanderbilt Clinic & Hospital Records

Incarceration Records of Byron Black
Psychological Records and Transcript of Testimony
- Kenneth Anchor, Ph.D. ABPP Licensed/Board Certified and Clinical Psychologist
- Pamela Auble, Ph.D. Clinical Neuropsychologist
- William Bernet, M.D. Psychiatrist
- Gillian Blair, Ph.D. Licensed Psychologist
- DeDe Wallace Center Competency Records
  - Calvilyn Y. Allmon, M.S.S.W.
  - Bradley Diner, M.D.
  - Leonard Morgan, Jr., Ph.D. Clinical Psychologist
- Pat Jaros, M.A. Licensed Psychological Examiner
- William Kenner, M.D. Psychiatrist
- Patti van Eys, Ph.D. Licensed Clinical Psychologist

Transcript of Competency Hearing Byron Black
Mackey v. State 537 S.W.2nd 704 (TN 1975)
First Degree Murder Statute
Mental Retardation Statute 39-13-203 pages 46-47
Mitigation Statute 39-13-204 page 25
Interview by Libby Moore April 23, 1997 of Julia Mai Black, Finis Black, Dan Black and Alberta Black Crawford.
Declaration of Connie Westfall
Interview of Lynette Childs Black 04/26/97 by Connie Westfall
Declaration of Gaye Nease
Interview of Jackie M. Thomas 09/26/01 by Gaye Nease
Interview of Alberta Black Crawford 03/19/01 by Gaye Nease
Interviews of Lynette Childs Black 03/24/01 & 11/10/01 by Gaye Nease
Interview of Johnny Moore 08/15/01 by Gaye Nease
Interview of Mary Frances Coplan 11/05/01 by Gaye Nease
Interview of Finis Black 03/23/01 by Gaye Nease
Interview of Mary C. Harrison 03/15/01 by Gaye Nease
Interview of Arleta Black Swanson and Karen Black Greer 10/18/01 by Gaye Nease
Interview of Richard Corley 10/11/01 by Gaye Nease
Interviews of Melba Black Corley 03/22/01 & 10/10/01 by Gaye Nease
Interview of Freda Black Whitney 03/17/01 by Gaye Nease

Miranda Warning information
Consent to search information
Transcript of Evidence State of Tennessee v. Walter R. Kendricks, Case # 92-C-1496 pgs 73-152
Medical and Death Information on Julia Mai Black
Declaration of Ross Alderman

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November 14, 2001

Kelley Henry
Assistant Federal Public Defender
Office of the Federal Public Defender
Middle District of Tennessee
810 Broadway, Suite 200
Nashville, TN 37203

Re: Preliminary Neuropsychiatric Evaluation
Byron Black

Dear Ms. Henry:

At your request I am submitting a brief preliminary report in this case although there remains considerable medical evaluation yet to be done. The work currently foreseen consists largely of laboratory assessment of the neuro-anatomical, -physiological, -psychological, and -chemical status of Mr. Black's brain. I will describe what is yet to be done later in this letter report. Nevertheless considerable medical investigation has been completed including a careful and thorough psychiatric history, a clinical mental status examination, and neurological assessment along with an extensive review of collateral documents. These documents include multiple psychological and psychiatric examinations, a description of the facts of the case as determined by the court, statements of lay witnesses, school psychological records, and statements by defense attorneys involved in the guilt phase of his trial. The documents reviewed will be listed along with their relevant findings in the text of this letter report. Due to the nature of this brief report the inferences and the datum used to form the basis of my conclusions will be mixed together in the text. While this is regrettable, it is unavoidable. I ask the indulgence of the reader to distinguish carefully between the data base and various levels of inferential commentary. I will do my best to make a clear distinction between the former and latter in my writing.

I have found ample support for my conclusion that Byron Black suffers from substantial mental illness whose etiology is perinatal organic impairment of his brain. Obviously brain and behavior are functionally inseparable. Therefore he has a clinical picture of gross impairments in cognition, affect, and therefore social judgment that mimic to some degree two psychiatric diagnosis: Ganser Syndrome and schizophrenia. His disorder is not functional, purely psychogenic, or under his personal control or volition. His personal family history strongly supports probable damage to his brain secondary to his mother's drinking during her pregnancy. Other unknown etiological factors may have been important in his clinical picture, however currently we have no psychiatric means to elucidate them. His school records seem to indicate little or no evidence of mental retardation, however on close examination the testing is

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belied by his probable academic capability. Inconsistencies, not only in the facts he related regarding the alleged offense, but in other matters not related to guilt, support the contention that he suffers from major deficiencies in attention, memory, cognition, affect and social judgment that are consistent with a diagnosis of mental retardation. Psychological testing in the past and preliminary findings of Dr. Ruben Gur, Ph.D. as well as prison records also are consistent with this interpretation as are the findings of my mental status examination. It is my current opinion that the brain abnormality from which Mr. Black suffers will prove to involve the frontal and temporal cortices. However, such a clinical prediction at this point in his evaluation is not reliable. What is reliable is that he has a long standing brain abnormality that has lead to a variety of psychosocial signs and symptoms.

The exact diagnostic formulation awaits consideration of the neuropsychological findings of Dr. Gur's work as well as the findings of one or multiple electroencephalograms, either paper tracing or computerized; a brain nuclear magnetic resonance scan; and a brain positron emission tomography. While the fundamental effects of his organic disorder are apparent at this time, the results of these tests will allow a more meaningful description of the relationship between the locus and nature of the brain disorder and his substantial psychosocial abnormalities of his behavior. However, I must warn the court that though the findings are serious, they do not in and of themselves specifically point to a psychiatric disorder that elucidates or proves guilt. In fact, in my experience of twenty two years of forensic work, his personal history and his clinical findings to this point seem atypical of those individuals I have examined that are clearly responsible for impulsive, psychiatrically based killings.

In this case his perinatal history is of great importance to the diagnostic formulation. However, one should keep in mind that there are many causes of brain damage that are difficult or impossible to trace with the present state of our technology. Thus if the contention that alcohol ingestion by his mother during the time she was pregnant proves insupportable by future investigation, it does not negate the possibility of these other causes. That there was some such brain injury is amply demonstrated by his clinical findings outlined below. Nevertheless his mother's ingestion of alcohol during his pregnancy is strongly supported. His account indicates that his mother was a long time drinker of Crawford Liquor, a form of scotch. His mother admitted that she drank "a good bit." Her life style supports at least her use, if not her abuse of drinking. Her brother reported she drank during her pregnancy. Byron Black's father said she "wasn't doing like she should have been doing" and that she drank while carrying Byron. Her daughters said she stayed out all night, went to clubs, and "drank but not at home." Of but suggestive importance is the fact that she had no prenatal care and knew nothing of Byron's early medical and development history. In short she appeared to be alcoholic and to drink almost all the time as well as when she was pregnant with Byron. The medical literature is clear that there is a dose related toxic effect of alcohol on fetuses and, even though the classical stigmata of fetal alcohol syndrome does not always appear, developmental abnormalities in brain function are produced by even small amounts of alcohol ingestion during pregnancy.

His early life history is remarkably free of the child abuse and family dysfunction almost always found in individuals who have committed killings of this type. Nevertheless some minimal evidence of at least lack of individual attention is consistent with his personal history. However, it does not seem to be sufficient to explain his psychosocial abnormalities as an adult. In fact, largely because of the positive impact of his extended family, his early life could best be described as supportive and nurturing, but not strongly attentive to his special needs as an individual suffering from mild brain damage. He lived a stable life in a house his grandfather built. He accompanied his grandfather at work as source of many fond memories and

corroborated by the statements of relatives. His mother could not recall any of his maturational milestones or of his childhood illnesses, a fact that is atypical of maternal memories with which I am familiar. He had a loving relationship with his father (though somewhat distant), his grandfather, and his mother. His grandfather and father were good models for him. His mother and his siblings lived with his grandparents. He said of his parents' relationship: "I would not say they were a couple. He was there for all of us. I would say that he was our father and she was our mother." His father was with his mother's family for dinners and was kind to him and his siblings. He recalls his father buying popcycles for all the kids. There was no known physical, psychological, or sexual abuse. Byron Black developed long term friends. Byron recalls loving school and great academic and athletic success. While there is some doubt about his academic and athletic capabilities, he apparently did enjoy school and has good memories of this experience. There is no evidence of substantial rejection or mistreatment by peers. He was not a disciplinary problem and was described by one teacher as a "nice boy." Thus there seems to be little in his early life history that would indicate a powerfully negative impact on Byron Black's mental health.

As an adult, Byron Black worked consistently. While his jobs did not require much education or training, they did require some responsibility and reliability. He is very proud of his work records and seemed to inflate his importance. His wife supported his contention that he worked regularly.

A number of lay persons have commented on his personality and mental health. Oftentimes these type of observations are most helpful to fill in some of the gaps necessitated by the post facto examinations of clinicians. They are often acute. His former wife, Lynette Childs, described him as "childish" and "not responsible." He tried to be a good father, but did not help much financially. When they were married, they never had a place of their own. She denied that he was impulsive saying he never got angry. He did not even respond physically to her hitting him with a calculator. She never knew him to fight. She did believe he was in a "mild delusional state." She said: "He acts like his mind is gone, like he's still in high school." She described his talk as "crazy." When he is pressed emotionally, she claimed he "does not make sense." He tends to "block out things." He still believes himself to be married to her. She has never done anything to encourage this belief, nevertheless he still holds fast to this view of their relationship. "I think about him having a mental problem with delusions because of the way he thinks we are going to get back together." She made an insightful observation regarding his affective state (the relationship between what is happening and his internal emotional state). When on television after his arrest for a triple homicide, he was smiling. Flattened or inappropriately elevated affect is commonly seen in mentally retarded individuals who do not understand and in individuals who suffer from schizophrenia. Melby Corley, his sister, said she had never seen him in conflict with his friends and had not seen him show any aggressive behavior out of the ordinary. Freda Whitney, another sister, never saw him out of control. These commentaries are of interest. They point to the following inferences. His lack of responsibility is consistent with poor social judgment and defective cognition. His persistence in believing that he and Lynette are deeply in love and spiritually inseparable to this day borders on the delusional. It coincides with his firm belief that he lost a lung in high school and that he got outstanding grades in high school. He has persisted in these beliefs despite efforts to convince him otherwise. Delusions are defined as fixed false beliefs inconsistent with one's culture and education. Fixed means unchangeable despite convincing presentation of contrary facts. While these signs and symptoms are not exactly typical of delusions seen in schizophrenia or the unconscious or dissociative representations of facts in Ganser syndrome, they are consistent with mild brain damage seen in mentally retarded individuals. His lack of aggressive

behavior and passive indifference is also typical of many who suffer mild brain damage from early in life. This is especially consistent with his description that his mother gives of his early behavior. He was a very easy baby who slept a lot. Of itself this description would not be of much help in diagnosis. But it grows more significant considering his mild brain damage resulting from his mother's ingestion of alcohol.

In my opinion, the most creditable psychiatric and psychological evaluations point to sufficient brain damage to explicate much of his abnormal behavior, thought and feeling. Some of the examinations point either to the complete absence of behavioral and cognitive abnormalities or to very mild degrees of personality disturbance. These latter examinations suffer from very short interviews; insufficient analysis of school records; inadequate review of personal history, prison records, and psychological testing; lack of interviews of family members or witnesses; and inadequate reporting that does not reveal either the data base nor the logic leading to their inferences.

School records reveal little or no evidence of mental retardation. IQ scores were 83 in 1963, 97 in 1964, and 91 in 1967. The values of the IQ tests may be the result of group testing, poor administration, or incompetent scoring. Although I do not know why there was this repeated testing, a couple of hypotheses are possible. One is, of course, that it was the school systems routine. Another is that some teachers were wondering about some of his behaviors in school. What teacher commentary is available is also not particularly supportive of mild mental retardation. The grades reported are fair ranging from C's to B's. Their inconsistency with later testing and opinion of all the examiners call them into question. The possibility of an intervening medical event producing brain damage is yet another possibility, but it is not born out by the medical records I have available. However one commentary by his sixth grade teacher may be helpful. Jackie Thomas said he never saw any "mental retardation." However he readily admitted that his pedagogic practice would not yield much information about mental retardation. "I don't mind saying that he might have been, because in my class what I did was I gave work that they could succeed at." He also said that he had one female student, who was very helpful to him and who was under his close observation, and who turned out to be mentally retarded in her testing. He learned this from the school psychologist and was quite surprised. However, there seems to be no reliable answer to the discrepancy between his school testing and that of the later experts unless the reason might lie in cultural factors affecting the practices of his school such as social promotion or inadequate resources.

Dr. Kenneth Anchor, Ph.D. performed an examination in January of 1989. He did not interview anyone but Mr. Black. He reported that Byron told him he had a lung removed and that he was inordinately proud of his work record. On the Shipley Hartford Intelligence Test Byron Black scored 76. This test is not very accurate below 85 and above 110. Dr. Anchor believed he suffered from impaired cognition, was repressed and rigid, had "emotional blockage", was easily offended, and showed no personality disorders. His defense mechanisms were marginal, a finding that would suggest poor coping and impaired social judgment. His Goldberg Index indicated a psychotic disorder. His Minnesota Multiphasic Personality Disorder showed evidence of adjustment disorder, delusional disorder of paranoid type, and/or paranoid schizophrenia. He was of the opinion that his mental defects rendered him not competent to stand trial apparently for reasons of psychological defects rather than lack of gross understanding of the functions of the court. Incidentally no one, including myself, found him not able to describe the functions of the court and its functionaries although a number found him incompetent. In regard to his potential of brutal killings he commented: "This young man does not appear to be prone to irrationally or self defeatingly initiate physical abuse of others."

In February and March of 1997, Dr. Pamela Auble, Ph.D tested him. She too reported discrepancies in his personal history regarding his marriage and the number of his children, his removed lung, and his grades in school. She commented on how resistant he was to changing some of these beliefs, a characteristic of delusional beliefs as mentioned above. His self image was primitive. He suffered from defects in fine motor speed, immediate recall, attention to task, learning ability, and verbal reasoning. Further he suffered from dysnomia, word finding difficulty, "some type of confabulation", concrete thinking, difficulty in imposing structure on his thinking, perseveration, and impaired mental flexibility. She also concluded he suffered from dissociative phenomena as he met a woman, yelled at her, and a then claimed he never met her. She commented on his abnormal view of life which might be paraphrased by saying he had a extraordinarily rosy view of life. It was more optimistic than Dr. Auble deemed realistic. At the same time as he was distrustful, he claimed a special relationship with his former wife: "I love you forever, God bless you. Amen. And that if he could change his ex-wife, my life would be complete, Mr. and Mrs. Black." His defense mechanism are primitive and ineffective: repression and denial. Personality testing did not suggest malingering but was not particularly valid. The Rorschach showed some signs of a schizophrenic diagnosis and organic disorder of the brain. All of these findings are consistent with the diagnosis of mild mental retardation and show some similarity to the delusions seen in schizophrenia in a person of low intelligence. She strongly recommended a neurological evaluation.

In March of 2001, Dr. Patti van Eys, Ph.D. tested him. She described past testing as being consistent with delusional thinking, concrete thought pattern, poor insight, and impaired social judgment. An example was his request that she hunt up a niece of his at a football game to send her greetings, something Dr. Eys could not do. He worked hard at his testing but scored full scale IQ of 69, verbal of 67, and performance 79. Her verbal IQ places him below ninety eight of one hundred persons, her performance IQ below ninety five of one hundred. Verbal IQ is very important to social judgment. Such a large discrepancy between verbal and performance IQ suggest medical trauma to the brain rather than a genetic effect. It is very common in brain damaged individuals. His working memory, a measure of mental flexibility, was but 61, placing him at the lowest of one hundred and ninety nine people. Her findings are consistent with neurological impairment and mental retardation as she found poor social judgment as well as a low IQ score.

Patricia Jaros, MA, a licensed psychological examiner, reviewed the records, tested him and testified. She found his answers "difficult to follow", replete with loose associations (a finding consistent with schizophrenia), "marginally delusional", and subject to gross exaggerations of positive attributes. For instance he told her he handled millions and millions of dollars during his employment. He showed signs of paranoia and lacked sufficient insight. His defense mechanisms were primitive and included denial, projection, and repression. She described him as low average or mentally retarded. All of these findings are consistent with degraded social judgment sufficient to impair his competence.

In August and September of 1993, Dr. Gillian Blair, Ph.D. interviewed and tested him. He found loose associations, circumstantial thinking, suspiciousness bordering on delusion, a flattened affect manifested by a fixed grin, and multiple contradictions in his personal history. His Rorschach test showed elevated indices of schizophrenia, perception of others in a distorted fashion, superficial and lack of maturity, impulsivity when stressed, and disorganized and lacking capacity for cognitive control. On the Minnesota Multiphasic Personality Inventory he was defensive, fake good (made himself look healthier than he was, the opposite of what a

malingerer would show), inhibition, massive over control, and defense mechanisms of repression, denial, projection, and rationalization. These findings would suggest he may misperceive his psychosocial environment, have poor coping skills, and suffer from a defect in social judgment. These finding would suggest significant problems in regard to competency. His WAIS-R and WMS-R revealed an IQ full scale 73, verbal 73, and performance 75. The standard deviation were three and the spread in the subtests was high. His memory index was only 61. While he made no statement regarding competence, he found Byron Black's function was borderline retarded. Please keep in mind that social function tends to be more impaired than one would expect from the IQ testing alone.

In November of 1992, Dr. William Bernet, M. D., a psychiatrist, did an evaluation. He found Byron Black to misstate the facts of his life not in a fashion typical of lies and also not typical of delusions. He gave approximate statements. Often times he was paranoid, practiced psychological denial, avoided reality, and presented with a persistent smile. He could not comprehend the seriousness of his situation. He was extraordinarily positive and complimentary being grandiose and not dealing with reality. He showed evidence of perseveration. He found his intelligence lower than average. He believed he might suffer from a Ganser Syndrome. He described his findings as consistent with organicity and with not being competent to stand trial.

Particularly impressive are the mental health records from Riverbend Prison. In 1995 he "appeared paranoid" and believed his clothes were stolen by other inmates with the complicity of the staff. He was considered a security risk because of these irrational beliefs. In 1994 he showed a "happy affect" and seemed "giddy." Mention is made of possible chronic delusional material. In 1993 he complained of other inmates wearing his clothes. Staff considered him to be mildly paranoid or delusional. These observations are consistent with lay opinion and psychological testing.

Several professionals did evaluations which did not point to organicity, did suggest personality defects, and supported borderline mental retardation.

Dr. William Kenner, M. D., a psychiatrist, found him competent to stand trial on the basis of a two and one half hour interview. While he knew the functions of the court, he did not know about the nature of a divided trial. While his IQ was quoted as 76, no mention was made of the Shipley Hartford test and its proclivity for error in the lower range, not its relative inaccuracy compared to more extensive testing. Dr. Kenner did not mention his verbal IQ, a most important factor in competence and social judgment, nor did he mention the spread in the sub scores indicative of organic disorder of the brain. He did not explore his interpersonal skills. He attributed his paranoid stance and inaccuracy to a personality defect. He mentioned Byron Black trusted his attorney, a fact not in particular contention. He made no effort to evaluate him for brain damage and provided no formal report allowing study of his reasoning based on his findings or comparison to the basic data revealed by other experts.

Dr. Bradley Diner, M. D., a psychiatric resident, provided a very short report and brief testimony based on a forty five minute interview. He thought that Byron Black had "good understanding" and was competent. He found no evidence of thought disorder, religiosity, or interpersonal difficulties. On page 99 of his testimony he agreed that Byron Black was delusional, on page 100 "I do not think he's delusional." He did indicate he thought he was of borderline intellectual function, but offered no testing and no review of other testing.

In September of 1988, Dr. Leonard Morgan, Ph.D., assessed him for one hour. He described Byron Black as a salesman, an observation that apparently did not occur to the other professionals who interviewed him. He described Byron's view of the world as "simple" but observed he "did not look like he was retarded." He did no testing and did not review any testing. He emphatically asserted he was not delusional and was competent.

In September of 1988, Calvilyn Y. Allmon, MS SW did a 45 minute interview and submitted a very brief report. She offered no data in the way of information and based her opinion that he was competent on her conversation with the defendant.

Recently, Ruben Gur, Ph.D., evaluated Byron Black. In a telephone conference he told me he does not yet have a formal report. He found Byron Black to have substantial difficulty with awareness of his emotions, in fact he was "very impaired." He was impulsive, rigid, showed a defective memory, and inappropriate affect. He believes these findings stem from organic disorder in the orbital frontal and/or temporal corteces of the brain. He will participate with me in a complete neurological evaluation to be described below.

Finally two lawyers have testified in a manor to support the diagnosis of mental retardation or dissociative delusional state. Mr. Ross Alderman will submit a declaration that Byron Black asked that he testify after the jury was recessed. He testified: "He was never able to comprehend or understand the significance of the evidence we were talking about." (page 204) Byron said of the damaging evidence presented in court that God would save him and then he smiled. He could not deal with negative evidence because he believed God would protect him. He never seemed to be disturbed that the state was seeking a death penalty. Patrick McNally testified to his "religious ideation" and said: "Honestly, I'm not sure Byron understood a lot of what was going on." (page 312) Such firmly and unrealistically held religious beliefs correspond to a common finding in schizophrenia and sometimes in temporal lobe injuries, named religiosity. However, these are more commonly prodromal in nature and are presented in a different fashion. They are consistent with the poor comprehension common in mentally retarded individuals.

My mental status examination showed many abnormalities. I noticed that the circumference of his cranium seemed mildly out of proportion to the size of his head and his forehead sloped. Whether these findings are of any significance awaits magnetic scan of his brain. His self image, especially in regard to attractiveness, bordered on the delusions. He firmly believes his former wife awaits his return. He has an immensely distorted view of the world, it is simply full of flowers, love, and Godliness as are his letters. He holds these views while holding a discordant view represented by almost pathological suspiciousness and having a loner life style devoid of even the limited companionship available to him in his incarceration. He stands very close, not respecting our culturally acceptance interpersonal distance. His eye contact is intense and inappropriate socially. He wears a constant smile suggesting either a delusional state or a flattened and abnormally elevated affect. His speech is slow and soft. His anxiety level is very low given his circumstances. His affect is inappropriate, almost euphoric. He loves everybody and is simultaneously consumed by paranoid suspicions. He seems delusional about his appearance, his attractiveness, his academic abilities, his medical history, the role of the staff in regard to the loss of clothes sent by his mother, his importance and most importantly for competence about his social and legal circumstances. Immediate recall and registration is poor. His thinking is circumstantial, marked by religiosity, perpetual mourning, and concrete. His ability to abstract is poor. For example when asked what people who live in glass houses meant, he replied: "An expression like that is stay out of trouble and don't do anything wrong."

These findings are consistent with temporal lobe lesions as is his preoccupation with religious themes as demonstrated by his letters. These abound with hearts, birds, "I love you", religious platitudes, "love, love, love." For example: "My family really loves and cares about you and so do I. Keep on smiling because I am always smiling." His writing in court is repetitious, simplistic, shows frequent misuse of words, and has inappropriate comments about abuse of his constitutional rights. His defense mechanisms are immature, promote misunderstanding and rigidity, and poor social judgment. These findings are consistent with poor perception, memory defect, low intelligence in the range IQ of 70 or below, and the effects of a long standing organic disorder of the brain on his current behavior.

Given the fact that a full neurological work up is planned, a formal diagnosis at this time is inappropriate. Suffice it says Byron Black is, in my opinion, mentally retarded and disabled in regard to social judgment. His diagnosis will be organic brain syndrome, probable etiology toxic effects of alcohol ingestion by his mother during pregnancy, and rule out atypical schizophrenia or dissociative states. The electroencephalogram, computerized or paper tracing, the magnetic resonance image of the brain, and the positron emission tomography along with the comprehensive neuropsychological evaluation of Dr. Gur should provide the data base for a more detailed and specific diagnosis.

In summary, the clinical history reveals evidence of early onset brain damage secondary to alcohol ingestion by his mother. It was sufficient to produce an IQ lower than all but two or three per cent of the population. His verbal ability, learning, disability, memory defects, and poor perception of reality have induced a mental state resembling delusional. It has rendered him so defective in understanding that he can not ably and reasonably assist his attorney in his defense. In competency, verbal intelligence is paramount. An accurate memory of his life and a realistic view of his capability also play a major role. Experts in the past who have found him competent, failed to take sufficient history, performed very short interviews, did not use the collateral data base that is available, and seemed to suffer from pre-conceived view of his status. They did not examine the role of disturbed and pathological affect (relation between his thinking and his mood) so abundant in his findings. Experts finding for competence tended to perform longer interviews, saw him as retarded and socially dysfunctional, gave credence to his semi-delusional state, relied on previous examinations and testing, looked into his defect in reasoning ability, and assessed his disturbed affect.

Thank for this opportunity to be of service to you, your client, and the court and for your expression of confidence in my work by the referral of this fascinating and challenging case. Please feel free to call or write at your convenience.

Respectfully yours,

Albert Globus, M. D.

Declaration of Albert Globus, M. D.

Additions to Preliminary Neuropsychiatric Evaluation of

Byron Black

1. The purpose of this declaration is to provide a progress report on further laboratory evaluations of Byron Black. My new and supplemental findings strongly support the contention of my previous letter that Mr. Byron Black was incompetent to stand trial in 1988. I will provide a brief, but still incomplete report of recent developments in regard to the etiology and neuropsychiatric findings making it medically certain that Byron Black has suffered from a long standing organic psychosis. While these findings are still being explored, the preliminary results clearly and completely support this diagnosis. I have learned nothing from my recent work that obviates the statements made in my letter of November 14, 2001. This psychosis has substantially impaired his social judgment to the point where he was incompetent to rationally and effectively assist his attorneys in the preparation of his defense.

2. Dr. Ruben Gur has performed extensive testing. Although no formal report is yet available, the findings prove he has an inability to recognize his emotions. He is in fact more impaired than most people who suffer from schizophrenia. These findings implicate both the frontal and temporal lobes of the brain, particularly the orbital frontal cortex. Perception is also impaired as Dr. Gur's testing revealed substantial defects in memory. Likely etiological factors were drinking by his mother during pregnancy, lead poisoning, and possible concussions. While Mr. Black is able to abstract, his thinking is rigid and lacks flexibility. Dr. Gur predicts that these findings make probable positive findings in magnetic resonance images and positron emission tomography of the brain. These deficits impact social judgment, what lay people call decision making. When these capabilities are impaired, competence to stand trial is impaired, because the nature and effect of events and the cognitive manipulation of various social roles are impaired. This also impacts social judgment and thus competence.

3. Dr. Daniel H. Grant, Ph.D. evaluated Byron Black on October 15 and 16, 2001. Dr. Grant performed an extensive series of neuropsychological tests. He found Mr. Black mildly mentally retarded in intelligence tests with substantial social behavioral deficits. He questioned the value of group administered intelligence tests performed when Byron Black was young. He found current deficits in oral comprehension. He found a lack of academic skills. His review of his social history indicated Mr. Black lacks social and adaptive skills related to day to day activities. He points out that his deficits would particularly handicap him in the give and take verbal communication in court room proceedings. Of particular importance was his lack of oral and language skills. These findings would support the contention that he was not competent to stand trial. They are also consistent with an organic or physical disorder of his brain that would produce the signs and symptoms enumerated in my previous report.

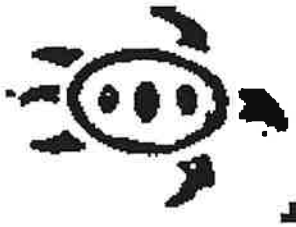
4. At this time, I have received films of the magnetic resonance images and colored photographs of the positron emission tomography of Mr. Black's brain. I have also consulted with Dr. Kessler, who performed the PET Scans. I have reviewed this material carefully myself and consulted with a nuclear radiologist and radiologist in Sacramento. The magnetic tape and the films have been submitted to Dr. Gur for quantification. I have consulted with Dr. Gur who informed me of his and his conferring radiologist's preliminary opinion of these tests. The opinion is unanimous that both methods reveal definite abnormalities. These include changes in the cerebral cortex, the brain ventricles, and the white matter indicating organic damage to the structure of the brain in the MRI. Hypometabolism of glucose in the orbito-frontal cortex, the medial and polar temporal cortex, and the caudate and/or the putamen is seen in the PET Scans. These findings are consistent with loss of cells and/or reduced function in existing cells. The cortical structures effected are the neuroanatomical substrata for executive functions and

impulse control. The extensive findings in the cerebral cortex and ventricles are seen in individuals with schizophrenia and/or brain atrophy of long duration. These findings elucidate the extensive nature of the neuropsychiatric signs and symptoms, especially neuropsychological test findings, the disturbance in affect (mood), the mild paranoid nature of his thinking. and his abnormal social behavior. When the quantification of the PET findings are available more specific statements will be possible. Nevertheless, these findings provide a non-malingerable anatomical and physiological basis for his deficits in social judgment leading to lack of competence at the time of trial. Specific representative instances such as lack of normal judgment may be found in the affidavits of Palmer Singleton, attorney at law, and the declaration of Ross Alderman, attorney at law.

5. Observable deficits in social behavior; abnormal neuropsychological testing of cognitive, memory, and affective functions; and neuro-anatomical and -chemical abnormalities in the brain all lend substantial support to the current diagnosis of organic psychosis. Historical accounts of deficits in social behavior are consistent with these findings. Early life history provides a reliable onset of his brain disorder well before the offense and a medically probable etiological explanation for these findings. Therefore, it is my opinion that Byron Black was incompetent to stand trial secondary to a lack of realistic comprehension of the relevant facts of his case and an inability to assist his attorney in the rational preparation of his defense due to a psychotic condition stemming from an organic disorder of the brain.

Date

Albert Globus, M. D.



Susan R. Vaught, Ph.D.

February 28, 2022

Kelley Henry
Supervisory APPD, Capital Habeas Unit
810 Broadway Suite 200
Nashville, TN 37203

Re: Byron Black, Intellectual Disability Determination

REASON FOR OPINION

I was retained by attorney Kelley Henry, accompanied by Coordinating Investigator Ben Leonard, from the Office of the Federal Public Defender in Nashville, to reconsider my May, 2003 opinion on the question of intellectual disability for Byron Black. Specifically, Ms. Henry asked me to review additional documentation now available in this case, and to consider changes in Tennessee law, standards of care, and diagnostic criteria that have occurred since I rendered the original opinion. As was the case in 2003, I have completed this task exclusively by review of records, and have not, at any time, personally evaluated Mr. Black. Now, as in 2003, I will not be offering a diagnosis, but instead commenting on whether or not there is sufficient evidence to suggest that Mr. Black's functioning meets the three prongs necessary to consider a diagnosis of intellectual disability.

QUALIFICATIONS

I obtained my Bachelor of Arts Degree in Psychology and English from the University of Mississippi (1985). While working my way through undergraduate school, my primary job was as a direct care staff member for North Mississippi Retardation Center, now renamed North Mississippi Regional Center. Following undergraduate school, I obtained my Master's Degree in Clinical Psychology and Intellectual and Developmental Disabilities Research (then called Mental Retardation Research) in 1989, and my Doctoral Degree in Clinical Psychology and Intellectual and Developmental Disabilities Research (then called Mental Retardation Research) from Vanderbilt University in 1991. To fund my graduate studies, I was awarded a Kennedy Center Traineeship in Intellectual and Developmental Disabilities (then called Mental Retardation).

I pursued my clinical internship at Temple University Health Sciences Center in Philadelphia, PA, where I split my time between Clinical Psychology and Neuropsychology (1991). On internship, my training in

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intellectual and developmental disabilities often came to bear, and I frequently assessed clients who were both mentally ill and developmentally disabled. I then pursued a fellowship In Clinical Neuropsychology, also at Temple (1992). Once more, I frequently assessed persons with developmental disability. I worked as a behavioral specialist for persons with developmental disability, contracted with the State of Pennsylvania 8 hours a week for nine months during this two year period, and worked 15 hours per week as-a unit psychologist for a private Intellectual and Developmental Disabilities program for seven months.

Following fellowship, I maintained a clinical practice as well as a specialty practice in neuropsychology in Tennessee (1993-2008). As a part of that specialty practice, I saw difficult to manage patients for the State of Tennessee. I assumed my current position at Western State Hospital in Kentucky in 2008. Currently, I am Director of Psychology and Director of Western Kentucky Psychology Internship Consortium. During the last 13-14 years, I have continued to assess, consult, and contract to see individuals with intellectual and developmental disabilities. I would estimate I have performed over 3000 assessments of such individuals since licensure in 1991-1992, in addition to consulting with programs who serve people with intellectual and developmental disabilities, speaking at conferences, and providing local and state level trainings in this area.

I am licensed in Kentucky and Tennessee, and in the course of my current position, I routinely testify in the State of Kentucky on matters of civil and criminal competence, with many of those cases involving persons with intellectual or developmental disabilities.

RECORDS REVIEWED

At the request of the above-noted attorney, I have reviewed the following documents:

12/13/2021	Supplemental Report (Daniel A. Martell, Ph.D., A.B.P.P.)
06/04/2021	Motion to Declare Petitioner Intellectually Disabled Pursuant to Tennessee Code Annotated §39-13-203
08/25/2020	Psychological Report (Daniel A. Martell, Ph.D., A.B.P.P.)
07/20/2019	Revised Declaration of Stephen Greenspan, Ph.D.
03/15/2008	Declaration of Melba Black Corley
03/13/2008	Declaration of Stephen Greenspan, Ph.D.
03/08/2008	Declaration of Marc J. Tassé, Ph.D., FAAIDD
03/15/2008	Declaration of Rossi Turner
11/15/2001	Declaration of Ruben Gur, Ph.D.
11/04/2001	Declaration of Ross Alderman, Esq.

Of particular note, all but two of these documents were completed five or more years after my initial review of records for Mr. Black. Additionally, scientific knowledge, clinical practice and diagnostic standards based on that science, and terminology related to developmental and intellectual disabilities

have evolved considerably in the nearly two decades since I last reviewed this case, which does have bearing on the opinion I will offer.

Using the above-referenced data, I considered the criteria necessary for diagnosis of intellectual disability, according to Tennessee's most recent 2021 iteration of § 39-13-203.

I. SIGNIFICANTLY SUBAVERAGE GENERAL INTELLECTUAL FUNCTIONING.

This aspect of the diagnosis of intellectual disability has undergone transformative change across methods of scientific consideration, clinical practice, and diagnostic criteria since 2003. Clinical studies, standard of practice, and now Tennessee state law reject the use of "bright-line" standards. It has always been established clinical practice to consider standard error of measurement, and this standard of practice has now been codified in Tennessee. Additionally, the numerical criteria have been removed from both the DSM-5 definition of intellectual disability and legal requirements for the use of the diagnosis in the State of Tennessee. DSM-5-TR, due to be released March 18, 2022, continues this practice. Taken as a whole, these changes in standard of practice and diagnosis give considerable flexibility in the clinical interpretation of IQ scores from individually-administered tests, and arbitrary "cut-offs" no longer apply.

As noted in Dr. Greenspan's revised 2019 declaration, he reviewed measures of intellectual capacity completed on Mr. Black in 1993, 1997, and 2001 (March, and November x 2), across a span of 8 years, reporting, "All of the full-scale IQ tests cluster around or below an IQ of 69." He accurately noted that the lower score of 57 on the Stanford-Binet is not an outlier, but consistent with the fact that this measure routinely produces lower scores than the Wechsler series. To this we can add Dr. Martell's 2020 findings, where Mr. Black again achieved a full-scale IQ of 67 on the WAIS-IV, with no subtest scatter. Dr. Martell also conducted a robust evaluation for malingering, and noted that results indicated that Mr. Black appeared to be putting forth his best effort, and that results could be considered to be a valid estimate of Mr. Black's intellectual and cognitive functioning. Additionally, using the multiple consistent and unchanging data points now available and spanning 19 or more years of measurement, progressive cognitive decline can be ruled out as alternative explanations for test findings.

My clinical opinion in 2022, as in 2003, is that Mr. Black has consistently tested in the Mild Range of Intellectual Disability as an adult, and continues to do so. I believe that he meets this criteria for the diagnosis of intellectual disability, and that the findings of practitioners who have directly assessed his intelligence should continue to be given considerable weight. Further, using current standards of science and practice, as well as historical standards of science and practice, if there are previous assessments in which clinicians did not appropriately consider standard error of measurement in interpretation of testing results, these should not be given weight.

II. DEFICITS IN ADAPTIVE BEHAVIOR

Just as with intellectual capacity, a diagnosis of intellectual disability no longer relies on a specific cut-off score with respect to formal measurement of adaptive capacity. Additionally, since my 2003 report, Mr. Black's adaptive capacity has been formally measured at different points in time, and in my clinical

opinion, definitively measured by Dr. Greenspan in 2008 (with reiteration of findings in 2019), in both his evaluation of Mr. Black's self-report, and his use of retrospective averaging of multiple sources to obtain a valid Vineland-2 profile. All subtest scores and the Composite score were consistent with intellectual capacity scores.

In the intervening time from 2003 record review, more information has been brought forth about his general functioning in society as a child, teen, and young adult, based on reports of family, friends, and trained educators, that reflects "real world" functioning was not adequate or age-appropriate. Additional evaluation of academic testing records has also ensued, and convincing evidence put forth that Mr. Black never developed any academic or functional living skills beyond the level of a primary or middle-school student. His job and driving skills were noted not to have exceeded those achieved by many persons with Mild Intellectual Disability, and reports indicated that his adaptive issues were more capacity-based (developmental) than choice-based (criminal behavior/personality disorder). He appeared to make genuine effort to learn and to comply, per these reports, and was not failing in these areas because he simply preferred to focus on his own needs/not meet demands of job, family, and society.

With the addition of Dr. Greenspan's findings, the changes in diagnostic and interpretive criteria (especially the move away from numerical cutoffs), the consistency of Mr. Black's scores over time, and the additional information now available about his real-world functioning, my 2022 opinion differs from my 2003 opinion in that I believe the preponderance of data in Mr. Black's record shows that he does meet the diagnostic criteria of developmentally-based adaptive deficits.

III. THIS CONDITION MANIFESTED DURING THE DEVELOPMENTAL PERIOD.

On this criteria, considerably more information was available in the record than I had in 2003. Specifically, the following data points stand out as most relevant:

Melba Corley (Sister)
"Byron didn't mature like he should have."

"His entire life, Byron never lived on his own"

Ms. Corley discussed the fact that even though Mr. Black married, he and his wife lived with either her family members or his, seemingly because they needed assistance with adult living skills.

Rossi Turner (Childhood Friend)
"He was not too well coordinated."

"Because Byron couldn't remember things, folks would have to repeat things to him especially if it was a direction."

Mr. Turner noted that Mr. Black could not grasp the basic rules and procedures for typical children's games, and gave multiple examples. His description of Mr. Black's personality and these events suggested that Mr. Black was not oppositional, but forgetful, and that he had significant difficulty learning and remembering steps and tasks. Mr. Black did not improve in these skills with practice, or with age. Additionally, Mr. Black tended to smile in a child-like fashion, even when this was not appropriate, which continues in present time.

Dr. Gur

"Byron Black was exposed to neurotoxins in utero and as a small child...Mr. Black's mother drank throughout pregnancy...high risk for lead poisoning and likely exposed to lead."

Dr. Gur noted that Mr. Black had pediatric iron deficiency anemia. This is a known risk factor for intellectual disability.

"Mr. Black has been an avid football player at varsity level and has suffered several head injuries..." When Dr. Gur completed these studies, little was in the literature about post-concussive syndromes or the toll of repeated blows to the head related to playing football, even as a child or teen/young adult. Literature now abounds on Chronic Traumatic Encephalopathy, which would be a consideration for Mr. Black, and also would have occurred in the now more flexible developmental period (prior to the age of 22 years). This more than any other specific factor may account for the "islands of preserved functioning" seen across testing, where Mr. Black performs better than expected in some areas, but significantly worse in skills associated with bilateral frontal regions.

Dr. Gur's findings also included abnormalities of the Corpus Callosum (midbrain) on MRI, suggestive of what was then called Fetal Alcohol Effects, but now based on Mr. Black's childhood presentation, would more currently be labeled alcohol-related neurodevelopmental disorder (ARND).

Dr. Greenspan

In his original report, Dr. Greenspan addressed the group intelligence testing scores after additional exploration of direct reports from teachers, family, and schoolmates, noting "...It is very possible, indeed likely, that these tests (which even state experts testified are not appropriate for diagnosing MR) were administered in a non-standard manner that could have even involved teacher assistance."

He also pointed out, "Even so, it should be noted that the IQ criterion for diagnosing MR was mins 1 SD (full-scale score of 85) during the years 1961-1973, and that the 85 that Mr. Black obtained on the Otis-Lennon group IQ test could, thus have qualified him at that time."

He further provided a concise historical summary, noting, "Mr. Black never lived independently (lived with parents, even after marriage), never had a checkbook, never cooked, never washed his clothes, never did anything suggestive of adult status other than holding a job...and driving a car...high school football coach, Al Harris, who indicated that in over 30 years as a coach, Mr. Black stood out as especially slow...generally could not be used on offense for the reason that he could not learn the plays and was used on offense only when a highly simplified playbook was developed for his use."

In his revised declaration, Dr. Greenspan revisited his initial results using updated terminology and current criteria from diagnostic manuals and standard of care guidelines for persons with intellectual disabilities, and these guidelines only reinforced and strengthened his original opinion.

Changes In Standard of Practice and Diagnostic Criteria

Adding to this additional information are changes in standard of practice and what is in common use in daily clinical care and diagnosis. In 2003, the Flynn Effect was a valid and robust research concept that was just beginning to make its way into clinical practice, and it was not yet in common usage by the preponderance of relevant practitioners. In the intervening 18-19 years, the Flynn Effect has been even more thoroughly researched and repeatedly validated, is now included in most testing manuals, and in short, in 2022, considering the changes in population intelligence is a common and well-accepted scientific and clinical practice related to the measurement of IQ. As such, applying this correction to scores from older versions of tests, and older scores, in order to look at them through today's lens for clinical diagnosis, not only should be done, but must be done for accuracy's sake. This, coupled with the removal of strict number-based criteria, changes the interpretation of Mr. Black's prior known scores, and places them squarely in the range of Mild Intellectual Disability.

Unlike many of the practitioners whose declarations are cited in this document, I am not a forensic psychologist, but a practicing clinician who works daily with individuals who have intellectual and developmental disabilities, in clinical treatment settings. My area of specialization is more clinical nuance than the crossroads between clinical and legal nuance. I routinely review cases and assist with developmental histories, and review clinical indications of age of onset of deficits for the State of Kentucky. I can say with a strong degree of clinical certainty that the information I have delineated in this section would be sufficient to meet the onset criteria of the diagnosis of intellectual disability, and it would be sufficient to qualify someone for services for person with intellectual and developmental disabilities in Kentucky. In my more recent work in the State of Tennessee on clinical cases (2019/2020), the same would be true.

In summary, then, my 2022 opinion differs from my 2003 opinion in that I believe the preponderance of data in Mr. Black's record shows that based on current scientific knowledge and standards of clinical practice, Mr. Black does meet the onset criteria for the diagnosis of intellectual disability.

GENERAL SUMMARY OF OPINION

Based exclusively on review of extensive available records, in my professional opinion, Byron Black does meet criteria established in the 2021 changes to § 39-13-203 for diagnosis of intellectual disability. This represents a change in my 2003 opinion, based on new information in his record, the ability to review his performance at multiple points in time across multiple practitioners, changes in scientific knowledge and standards of practice, and changes in diagnostic criteria, which I have outlined in the body of this report.

Due to my opinion being based on records review alone, I am not formally applying any diagnosis for Mr. Black; however, all of the very qualified experts who have directly assessed his capacity also believed he met these criteria, formally applied the diagnosis of intellectual disability, and have provided current, detailed, and valid clinical reasons for their opinions. Moreover, they have offered additional opinions that their findings remain valid under DSM-5, the upcoming DSM-4-TR, and changes in Tennessee law.

I hope this information is beneficial to you in moving forward with Mr. Black's case. Please let me know if I may be of additional assistance in this case.

Susan Redmond-Vaught, Ph.D
Licensed Clinical Psychologist/HSP

IN THE UNITED STATES DISTRICT COURT
FOR THE MIDDLE DISTRICT OF TENNESSEE
NASHVILLE DIVISION

BYRON LEWIS **BLACK**,	)	
	)	
Petitioner,	)	
	)	No. 3:00-0764
vs.	)	Judge Campbell
	)	
RICKY **BELL**, Warden,	)	
	)	
Respondent.	)	

DECLARATION OF ROSSI TURNER

Declarant, Rossi Turner, states:

1. I am an adult resident of Nashville, Tennessee. I make this declaration based on personal knowledge.

2. I am two years younger than Byron Black. Byron had to repeat the second grade so I was one grade behind him. Although we were never in the same grade at various times Byron and I attended the same school. In 1973, I received a scholarship and attended the Vermont Academy, a private preparatory school in Saxtons River, Vermont. Even while I was going to school in Vermont, I continued to see Byron during school holidays and summers. I returned to Tennessee and attended both the University of Tennessee and Tennessee State University, receiving an undergraduate degree in political science and a masters degree in health education. For some time I was the Program Director for the Tennessee Personal Assistance Project, which provided training for staff who, in turn, worked with mentally and physically challenged persons. I am currently the Education Director for the Boys and Girls Club of Middle Tennessee. My education, training and experience help me better understand Byron Black and how we, and he, grew up.

3. Byron and I grew up on the same street. I lived at 1019 Reservoir with my father and grandmother and he lived 3 or 4 doors up with his grandparents, his mother and his four sisters. Coal and wood was used for heat and to cook at both of our houses. My grandmother made soap in a big iron kettle in the back yard. I remember her grabbing a chicken and snapping the neck and then plucking it right in the back yard. The same things were going on up the street at Byron's house.

4. I remember playing with Byron almost everyday from the time I was three or four years old up until the middle of the 2nd grade when my family moved to North Nashville. When we were little, Byron and I even took baths together and were more like brothers than friends.

5. I started first grade at the same elementary school, Carter-Lawrence, that Byron attended. Even though we were not in the same class, we would be on the playground together

6. Even after I moved to North Nashville, I still spent a lot of time with Byron. My grandmother continued to live in the same neighborhood as Byron's family. She liked to have me stay with her so I was there on the weekends and during the summers.

7. In addition to both of us attending Carter-Lawrence Elementary School, Byron and I also attended Rose Park Junior High School at the same time. I was in the seventh ~~and eighth~~ grade while Byron was in the eighth ~~and ninth~~ grades.

8. Growing up, the children in the neighborhood played together a lot outside. Byron and I rode bicycles together, which is what we did when were in Junior High School. We would ride through dirt and spin the bike tires. We were always needing new tires. Byron's grandfather would have to buy new tires for Byron's bike and would fuss at Byron for causing this extra expense.

9. Particularly during the time when I was four, five and six, all of the neighborhood children played together. We played Mama the Bread is Burning, Red Light-Green Light, a Tisket a Tasket, London Bridge, and similar games where lot of children could play.

10. In a Tisket a Tasket, all of us stood in a circle except the one who was "it." The person who was "it" would walk behind the rest of us and then drop a paper bag behind someone. The objective, of course, was for the person behind whom the bag had been dropped to chase after the person who dropped it and tag them. If they tagged them then the original person who was "it" was "it" again. However, if the person whom the bag had been dropped behind did not tag the other child before that child reached the spot they had vacated, then this person was it. Byron never seemed to catch on when the bag was dropped behind him. One of the other children would have to yell at him, "Byron, look behind you."

11. When we played Red Light, Green Light one child was in the center of the circle and all the rest of us formed a circle. The person in the center called out either Red Light for stop, or Green Light for go. Byron would get put out all the time. He was generally the first one out.

12. Even in marbles, Byron wasn't good. He was not too well coordinated.

13. Looking back on it, Byron was different. Things that others could do so easily were difficult for him. And, Byron smiled a lot, but it looked off key

14. I remember his grandpa having to tell him time and time again to do his chores and how to do it the right way. Byron had to bring in kindling and coal. Byron's grandpa would put the stick on him when his chores weren't done. Byron wasn't lazy, he just had trouble remembering to do his chores.

15. Because Byron couldn't remember things folks would have to repeat things to him

especially if it was a direction. I remember his sisters saying over and over, "Byron, I just told you to do that." He had a thing about snapping his fingers and say, "Yeah, I forgot that," when someone reminded him.

16. Byron would forget and loose track of time. He would be told to get home at a certain time but he wouldn't remember and his grandpa would come and get him saying, "Byron, what did I tell you?" Byron would meekly say, "Yes, Grandpa."

17. Although Byron had a lot of cousins and a pretty big family, he didn't have many close friends. Byron would occasionally make small talk with people, but not often. He could talk about sports, but did not talk about much of anything else. I never heard Byron talk about any goals for his life.

18. Looking back on growing up with Byron, my education, experience and training tell me now that Byron was pretty impaired. And, looking back on it, as I have briefly described in this declaration everyone sort of recognized and compensated for Byron's inabilities. Byron needed his family to prop him up. Even when Byron was a teenager, he would repeatedly forget his curfew, I remember his mama saying, "I tell that boy to get back here at a certain time, but he doesn't remember."

FURTHER DECLARANT SAITH NOT.

I declare under penalty of perjury under the laws of the United States of America that the foregoing is true and correct.

Dated: March 15, 2008

ROSSI TURNER

DECLARATION OF ROSS ALDERMAN, ESQ.

1. I am Ross Alderman. I am licensed to practice law in the State of Tennessee. Along with Pat McNally, I was trial counsel at Byron Black's capital murder trial.

2. I testified during the competency hearing and in post conviction regarding my belief that Byron was incompetent to stand trial. As a lawyer, it was clear to me that Byron simply could not assist the defense team in developing a theory of defense or mitigation.

3. During our interactions with Byron Black, Byron completely could not focus on the case. For instance, we'd talk to Byron telling him that we needed him to help us, but he told us not to worry about it and it was not a problem, because God would save him. Byron was convinced that some divine presence in court would release him from the proceedings or that some divine manifestation would liberate him. As I stated during my testimony at the competency hearing, I believe that Byron was delusional about what was going on.

4. Byron almost constantly wore a big child-like smile on his face, a smile which was often out of place, given the circumstances. I don't ever recall Byron being angry. Byron's affect was unusual. Also, when talking, he would get close in to my face, not in a threatening way, but in a socially inappropriate way.

5. During the course of trial, we as counsel had little interaction with Byron concerning the substance of the proceedings, including during voir dire. I don't recall having much meaningful dialogue with Byron. Byron couldn't understand how anything in the courtroom affected him, and he didn't understand the implications of the witnesses' testimony.

6. An example of just how out of touch Bryon was with what was going on in the trial is when after the jury went out to deliberate on the issue of sentence, Byron asked me, "Do I get to testify now." It was clear to me that Byron had not understood what had occurred in the proceedings.

I believe that he had no clue about what had been going on for the past two weeks. He lacked the ability to process what had been occurring.

7. I had no tactical reason for failing to make objections to any particular jury instructions.

8. We depended upon Dr. Ken Anchor to assist us in evaluating issues relating to Byron's mental state and competency. I was not aware of any proof indicating that Byron is mentally retarded. Similarly, I was not aware of any evidence that Byron suffers brain damage.

9. Our ability to investigate the case was a function of the fast-track that we were on. Ultimately, the case was tried about a year from the homicide in question, and approximately seven months after arraignment.

DATE: 11-14-01

Ross Alderman, Esq.