No. 18-5634

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IN THE
Supreme Court of the United States

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KIPLAND PHILLIP KINKEL,
Petitioner,

v.

GARRETT LANEY, SUPERINTENDENT,
OREGON STATE CORRECTIONAL INSTITUTION,
Respondent.

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On Writ Of Certiorari
To The Supreme Court Of Oregon

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REPLY TO BRIEF IN OPPOSITION TO PETITION FOR WRIT OF CERTIORARI

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REPLY TO BRIEF IN OPPOSITION
TO PETITION FOR WRIT OF CERTIORARI

In its Brief in Opposition to Petition for Certiorari, the State asserts that the Oregon Supreme Court correctly held that petitioner's crimes "reflected 'irreparable corruption rather than the transience of youth'" and therefore his sentence of 112 years was valid. (Resp't's Br. in Opp'n 1.) The Oregon Supreme Court's decision misunderstands this Court's prior decisions establishing that it must be rare and uncommon to sentence a juvenile to life in prison without the possibility of parole. A juvenile's sentence must provide "some meaningful opportunity to obtain release based on demonstrated maturity and rehabilitation." *Miller v. Alabama*, 567 U.S. 460, 479 (2012) (quoting *Graham v. Florida*, 560 U.S. 48, 75 (2010)). In the rare circumstance that the sentencer determines that a life without parole sentence is appropriate, it must find that the child "exhibits such irretrievable depravity that rehabilitation is impossible" and demonstrates "irreparable corruption." *Montgomery v. Louisiana*, __ U.S. __, 136 S. Ct. 718, 733-734 (2016).

The sentencing court did not find Petitioner to be irreparably corrupt. The court never determined that he was outside the bounds of rehabilitation. Rather, the court found that he suffered from a treatable mental illness that led to his commission of the crime. Based on this fact alone, the Oregon Supreme Court concluded that this Court's decisions in *Roper, Miller,* and *Graham* were irrelevant. The transiency of youth, the court held, was inconsistent with Petitioner's condition. *Kinkel v. Persson*, 417 P.3d 401, 416 (Or. 2018).

Because Petitioner was sentenced in 1999, years before this Court set the established rules for juvenile sentencing, it obviously did not consider the proper Eighth Amendment considerations in its judgment. Quite plainly, the sentencing court did not contemplate if "the juvenile offender before it is a child 'whose crimes reflect transient immaturity' or is one of 'those rare children whose crimes reflect irreparable corruption' for whom a life without parole sentence may be appropriate." *Tatum v. Arizona*, __ U.S. ___, 137 S. Ct. 11, 13 (2016) (Sotomayor, J., concurring) (mem.) (citing *Montgomery*, 136 S. Ct at 734). *Miller* and its progeny require a "sentencer" to make these factual determinations, not a reviewing court. *Id*.

The Oregon Supreme Court, in reviewing Petitioner's 1999 sentencing, did not dismiss his claim on state law grounds, nor did the court remand Petitioner's case for a resentencing in light of the profound changes to Eighth Amendment jurisprudence and considerations. *Kinkel*, 417 P.3d at 416. Rather, the court addressed the merits of whether Petitioner was irreparably corrupt under the Eighth Amendment. Finding that he was, the reviewing Oregon Supreme Court emphasized that Petitioner's psychological condition was "unrelated to his youth." *Id*. Respondent's assertion that Petitioner failed to raise the first and third questions ignores the fact that Petitioner had no opportunity to raise those issues. The Oregon Supreme Court resolved Petitioner's claim based on an interpretation of *Roper, Miller,* and *Graham* for mentally ill children. The opinion miscasts both the nature of mental illness and the prognosis for those suffering from mental illness—thereby turning a traditional *mitigating* factor into an aggravator justifying death by incarceration.

Petitioner's case presents the question of whether children who are afflicted with a treatable mental illness are—by virtue of that illness—excluded from the rules announced in *Graham* and *Miller*.

I. THIS COURT SHOULD GRANT CERTIORARI BECAUSE THE OREGON SUPREME COURT USED MENTAL ILLNESS AS A PROXY FOR "IRREPARABLE CORRUPTION," IN CONTRAVENTION OF THIS COURT'S HOLDINGS

A. Petitioner's Psychotic Disorder Was Treatable And Not Evidence Of Irretrievable Depravity Or Irreparable Corruption

Petitioner suffers from a psychotic disorder. *Kinkel*, 417 P.3d at 404; (App. 3A-5A.) Although he has since spent decades in remission, at age 15, he experienced command hallucinations, which led him to commit the crimes for which he was later sentenced. (App. 6A, 10A, 16A.) Petitioner was so young at the time of his sentencing (November of 1999) for these offenses that the psychologist who evaluated him stated that a definitive diagnosis could only be "determined over time" as his symptoms may evolve with age. (App. 4A.)[1] At Petitioner's only sentencing proceeding, which took place more than a decade before this Court's decisions in *Miller* and *Montgomery*, one psychologist explained that Petitioner would go through a variety of treatment

[1] Q: Is it common for some individuals to phase between one diagnosis and another?
A: Yes, especially at young ages. I think, again, its recognized that diagnosing adolescents is a tricky proposition. They're much harder to be definitive about, and sometimes their diagnoses merge and blend over time. Usually, it all coalesces by the time someone is about 25. (App. 4A:17-24 (excerpt from Dr. Orin Bolstad's testimony)).
Dr. William Sack also testified.
Q: Is it your experience generally that it's easy to diagnose fifteen- and sixteen-year-olds?
A: No. Fifteen- and sixteen-year-olds are in the process of—they're in a developmental process, and they are an emerging adult, and so symptom pictures can change. And they are not a fixed—that's why we avoid—we tend to avoid making personality diagnoses with adolescents because they don't yet have a formed personality. So teenagers are emerging adults, but their symptom profiles can change as they continue to develop. (App. 15A:14-23.)

programs and also concluded that a determination of Petitioner's rehabilitation would be "irresponsible" because no one "is really capable of making that kind of prediction." (App. 7A:11-19.) At the same time, the doctor concluded that there were a number of reasons to be optimistic about Petitioner's prognosis including that "the nature of his delusions is still immature." (App. 9A:17-23.) Another psychologist testified that Petitioner's illness "responds better to treatment and has a better prognosis in general than the other forms of schizophrenia," (App. 17A), and that Petitioner could be "safely returned to the community." (App. 18A.) There was no testimony presented to the sentencer that Petitioner's condition was disconnected from his still developing adolescence or that his more severe symptoms would be fixed or permanent.

Experts who testified at Petitioner's 1999 sentencing agreed that his condition was treatable, but not necessarily curable. *Kinkel*, 417 P.3d at 405. In rejecting Petitioner's Eighth Amendment claim, the Oregon Supreme Court reasoned that "there is no cure for [petitioner's] condition." *Id*. at 406 (alteration in original). This simple phraseology glosses over the research on juvenile mental illness which finds that symptoms of mental illness are hardly fixed or immutable. Rather, scientific literature reveals that the traits of mentally ill children change over time. A 1994 meta-analysis examining 100 years of schizophrenic patients concludes that 40% improve in just 5.6 years. James D. Hegarty, et al., *One Hundred Years of Schizophrenia: A Meta-Analysis of the Outcome Literature*, 151 AM. J. PSYCHIATRY 1409, 1409 (1994). *See also* PAULIINA JUOLA, OUTCOMES & THEIR PREDICTORS IN

SCHIZOPHRENIA IN THE NORTHERN FINLAND BIRTH COHORT 1966 36, 44 (2015), http://jultika.oulu.fi/files/isbn9789526207728.pdf. Another study suggests that "around 50% of people with the illness meet objective criteria for recovery for periods of time during their lives, with the periods increasing in frequency and duration once past middle age." Alan S. Bellack, *Scientific & Consumer Models of Recovery in Schizophrenia: Concordance, Contrasts, & Implications*, 32 SCHIZOPHRENIA BULL. 432, 440 (2006), *available at* https://academic.oup.com/schizophreniabulletin/article/32/3/432/1908737. In some instances, these improvements persist without medication and therefore "[t]here is increasing recognition that recovery is not only possible, but that it may even be common."[2] *Id.* at 432.

Critically, for Eighth Amendment considerations, "much of the pernicious effect of schizophrenia is manifested early in the course of illness, followed by a plateau, and then gradual improvement for many patients." *Bellack, supra*, at 437. Furthermore, research indicates that the mere experience of mental illness as a juvenile can simply delay the transition from youth to adulthood. Joann Elizabeth Leavey, *Youth Experiences of Living with Mental Health Problems: Emergency, Loss, Adaptation & Recovery (ELAR)*, 24 CANADIAN J. MENTAL HEALTH 109, 109, 122 (2005); M. DAVIS ET AL., BECOMING AN ADULT: CHALLENGES FOR THOSE WITH MENTAL

[2] "Studies vary in specific criteria, measures, samples, and time frame, but overall 20–70% of people with careful research diagnoses appear to have a good outcome, with substantial reduction of symptoms and good quality of life and role function over extended periods of time. The modal percentage with good outcomes is in the range of 50%." *Bellack, supra*, at 437.

HEALTH CONDITIONS, RESEARCH BRIEF 3 (2011). In essence, the symptoms of mental illness such as schizophrenia are transitory over time with many patients experiencing substantial improvement as they age. Rather than being divorced from adolescence, as the Oregon Supreme Court proclaimed, the symptoms of a psychotic illness are often connected to maturation and brain development.

Dr. Konkol, a pediatric neurologist, provided an optimistic prognosis for Petitioner. (App. 12A-13A.) Dr. Orin Bolstad, cited by the Majority, concluded that Petitioner, once treated, "can be pretty normal." (App. 8A:13-17.) Dr. William Saks even offered that, so long as medication and counseling conditions were met, he would be "happy to have [Petitioner] as my next-door neighbor." (App. 18A:3-10.) Uniformly, the experts who testified at Petitioner's 1999 sentencing expected that he would not be a risk to the public and would recover from the worst aspects of his illness. In other words, there was no evidence that Petitioner falls into the "rarest" of juveniles who are "permanent[ly] incorrigib[le]." *Montgomery*, 136 S. Ct. at 734.

B. The Oregon Supreme Court's Decision Vitiates This Court's Eighth Amendment Analysis In *Miller* And *Montgomery*

Approximately 50-75 percent of youth in the juvenile justice system suffer from a mental health disorder. Lee A. Underwood & Aryssa Washington, *Mental Illness & Juvenile Offenders*, INT'L J. ENVTL. RES. PUB. HEALTH, Feb. 2016 at 1, 2-3.[3] Psychotic disorders are among the most common types of mental illnesses found in young people with juvenile criminal convictions. *Id*. at 3. While one in five youth experience a severe mental illness, only a small fraction go on to experience that illness as an

[3] *Available at* https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4772248/pdf/ijerph-13-00228.pdf.

adult. *Kinkel*, 417 P.3d at 421 (Egan, J., dissenting) (citing National Institute of Health, *Transforming the understanding and treatment of mental illnesses* (November 2017), https://www.nimh.nih.gov/health/statistics/mental-illness.shtml (accessed May 3, 2018). Additionally, mental illness has long been recognized as a mitigating factor. *Rompilla v. Beard*, 545 U.S. 374, 390-91 (2005) (reversing a death penalty sentence for counsels' failure to look at defendant's prior conviction file in which "they would have found a range of mitigation leads" including test results describing defendant's mental health as "pointing to schizophrenia and other disorders" which "would have unquestionably gone further to build a mitigation case"); *Porter v. McCollum*, 558 U.S. 30, 39-40 (2009) (per curiam) (reversing a death penalty sentence for failure to "conduct a thorough investigation of the defendant's background" to assess all potential mitigating factors, including "evidence of [the defendant's] mental health or mental impairment"); *United States v. Jones*, 352 F. Supp. 2d 22, 25-26 (D. Me. 2005) (imposing a reduced sentence based on defendant's history of mental illness); *United States v. Pallowick*, 364 F. Supp. 2d 923, 928 (E.D. Wis. 2005) (determining mental illness was a mitigating factor in sentencing and finding that "courts regularly have held that depression and anxiety may cause a substantially reduced mental capacity, supporting mitigation of punishment for crime." *See United States v. Shore,* 143 F. Supp. 2d 74, 83-84 (D. Mass. 2001) (collecting cases); *see also United States v. Perry,* No. 98-4265, 1999 WL 95531, at *1 (4th Cir. Feb. 17, 1999) (per curiam); *United States v. Woodworth,* 5 F. Supp. 2d 644, 647-48 (N.D. Ind. 1998); *United States v.*

Brown, No. 96-CR-451, 1997 WL 786643, at *5 (N.D. Ill. Dec. 18, 1997); *United States v. Herbert,* 902 F. Supp. 827, 829-30 (N.D. Ill. 1995). This holds true in cases following this Court's decision in *Miller v. Alabama*. *People v. Gipson*, 34 N.E.3d 560, 582 (Ill. App. Ct. 2015); *see also People v. Horta*, 67 N.E.3d 994, 1012-1013 (Ill. App. Ct. 2016) (explaining that the *Gipson* court found "compelling factors in mitigation" to include "defendant's mental illness). Prevailing jurisprudence views the presence of a mental illness as a condition that makes someone less culpable, not more.

Simply put, a mentally ill youthful offender cannot, based solely on his mental illness, be designated " the rare [and uncommon] juvenile offender" for whom a life without parole sentence would be constitutional. *Montgomery*, 136 S. Ct. at 733-34. If that were true, then a substantial portion of juveniles could be sentenced to die in prison. *Miller* and *Montgomery* counsel otherwise. Yet, the Oregon Supreme Court's decision would turn Miller on its head—permitting a great number of juveniles to be sentenced to life without parole, while the more rare, and more culpable, mentally healthy offender would be eligible for release.

II. STATE LAW DOES NOT BAR RELIEF

Respondent further opposes *certiorari* by arguing that Oregon Revised Statute 138.550(2) bars post-conviction relief on any ground that was raised "in the direct appellate review proceeding." (Resp't's Br. in Opp'n 16-17 (citing Or. Rev. Stat. § 138.550(2))). Petitioner did indeed raise an Eighth Amendment claim on direct review. It was rejected in 2002, ten years before *Miller* was decided. The State's argument fails. First, the requirements of *Miller* were not, and could not, have been

addressed on direct appellate review, as they did not yet exist. Second, the Oregon Supreme Court addressed the merits of Petitioner's arguments, not the procedural bars that were extensively briefed by Respondent. *Kinkel*, 417 P.3d at 407. Third, the Oregon Supreme Court has already accepted another case for review addressing the very issues that Respondent would have this Court understand to be settled. *See White v. Premo,* Nos. S065188, S065223 (Or. pet. for review allowed Oct. 4, 2018), *available at* https://www.courts.oregon.gov/news/Lists/ArticleNews/Attachments/992/9023fc25635e634fa888c1763bbb745d-Oct%205%20-%20Media%20Release%20conference%20results.pdf. Plainly, Petitioner is asking this Court to review the merits of what a lower court addressed.

III. THE FIRST AND THIRD QUESTIONS ARE PROPERLY PRESENTED

Respondent contends that Petitioner did not raise the first and third questions presented to this Court. As discussed above, Petitioner was denied post-conviction relief in the circuit court and in the Court of Appeals on procedural grounds. *Kinkel,* 417 P.3d at 406-07. On review in the Oregon Supreme Court, the issues presented were whether Petitioner was procedurally barred from reaching the federal claim and, if not, whether his sentence violated the Eighth Amendment. *Id*. at 407. The Oregon Supreme Court did not address the procedural issues, but instead concluded that Petitioner's Eighth Amendment challenge "fails on the merits." *Id*. The Oregon Supreme Court's conclusion—that Petitioner's mental illness excluded him from the sentencing limitations in *Roper, Miller,* and *Graham*, *id*. at 416,—resolved the case on the merits, even though the merits were never briefed or argued by any of the

parties in those proceedings. The Oregon Supreme Court's ruling is unprecedented.[4] Petitioner has never been provided any opportunity to address that conclusion or present his *Miller* claim. This Court's rules regarding the granting of *certiorari* permit review where "a state court . . . has decided an important question of federal law that has not been, but should be, settled by this Court." SUPREME COURT RULE 10(c). Therefore, the issues are properly presented to this Court.

CONCLUSION

For the foregoing reasons, Petitioner respectfully requests that this Court grant the Petition for *Certiorari*.

Respectfully Submitted,

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November 20, 2018

[4] Respondent's argument that Petitioner has failed to show a circuit split on this issue is answered by pointing out that Petitioner is unaware of any court, state or federal, making a similar holding.

APPENDIX

Excerpts from November, 1999 Sentencing Hearing

IN THE CIRCUIT COURT OF THE STATE OF OREGON FOR LANE COUNTY

BEFORE THE HONORABLE JACK MATTISON, JUDGE

COURTROOM 201

THE STATE OF OREGON,)
Plaintiff,)
-vs-) Case No. 20-98-09574
KIPLAND PHILIP KINKEL,)
Defendant.)
)

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DAY TWO SENTENCING HEARING

WEDNESDAY, NOVEMBER 3, 1999

results, I think you can have more faith in all those results, taken together.

Q. In addition to the tests you conducted yourself, have you also reviewed the data from Dr. Johnson, the state expert's testing?

A. Yes.

Q. What tests did he conduct?

A. He also gave the MMPI, adolescent version, the same test I did, approximately six and a half months after I did mine. In addition to that, he also gave the Rorschach again, and he also gave a third test by Reynolds, which is a true-false, paper-pencil test on psychopathology somewhat similar to the MMPI.

Q. Based upon the work you've done with Mr. Kinkel, have you come to a conclusion on whether he suffers from a mental disease?

A. Yes. It's my opinion that Kip Kinkel does suffer from a mental illness.

Q. And do you have an opinion on whether he suffered from a mental illness on May 20th and May 21st of 1998?

A. Yes, that would be my opinion. I believe he did suffer from mental illness on both of those dates.

Q. And do you have a more specific diagnosis?

A. Well, I think it's clear to me that he has a

psychotic disorder. It's clear to me that he has profound paranoid symptoms. I think that he is relatively young for the onset for of schizophrenia. The usual onset age for schizophrenia is about 25, and so I think it might be a little bit presumptuous to offer a definitive diagnosis about him at this young age.

But I do find that he has a lot of features in common with schizophrenia, paranoid type. He has a lot of features in common with schizo-affective disorder, which is merely a combination of schizophrenia and depression. And he certainly has a lot of features in common with bipolar, manic disorder. And which one of those three diagnoses ends up to be a definitive diagnosis I think will be determined over time, but at this point in time I think it's a bit presumptuous to offer a very definitive diagnosis because of his age.

Q. Is it common for some individuals to phase between one diagnosis and another?

A. Yes, especially at young ages. I think, again, it's recognized that diagnosing adolescents is a tricky proposition. They're much harder to be definitive about, and sometimes their diagnoses merge and blend over time. Usually it all coalesces by the time someone is about 25.

Q. Do each of the diagnoses which you have,

which you discuss contain a psychotic feature to them, or can they?

A. Yes.

Q. Can you explain briefly what psychosis is.

A. Psychosis simply refers to a thought disorder. There are many manifestations of thought disorders. Probably the most usual ones have to do with hallucinations. Delusions are also a very common aspect of thought disorder and psychotic thinking.

And finally, there's a whole set of disorganized kinds of thinking that goes into schizophrenia. Generally we refer to that as loose associations, or associations that are not very cognitively tight. So there's a whole host of these kinds of symptoms that are associated with psychosis, but chiefly they are hallucinations, delusions, and disorganized thinking.

Q. What's the prevalence of mental illness in the general population?

A. About one percent, and that's true regardless of the country.

Q. So in our community of two hundred thousand, there are two hundred people who are mentally ill?

A. Correct.

Q. And what's the prevalence in the juvenile

parents.

In fact, I was intrigued by the note he wrote on the same evening, May 20th. After shooting his parents, the note, if I recall correctly, says words to this effect: I just killed my parents, exclamation point. I don't know why. I love my parents. They were wonderful people. I'm not getting this exactly correct, but those are the main messages. I'm sorry I did this. I don't know why I did this. I had no choice.

And I think that paragraph is a beautiful illustration of what Resnick is talking about. He thought his parents were wonderful. So why did he kill them? He doesn't know. And I think that's consistent with Resnick's argument that when you can't find a reasonable reason, then you need to look for the possibility of an irrational reason, a psychotic reason.

I noted with interest that Detective Warthen and Dr. Suckow both pursued an area of questioning with him that was audiotape recorded. And the nature of the questions they asked Kip were centered around the issue of, did you shoot them to protect them from the embarrassment of being kicked out of school? And that seemed to be the theme of Dr. Suckow's interview, as well as Dr. Warthen's. And so I found that kind of interesting that they pursued that as a rational reason.

Unfortunately, he's not been in a good environment to do a medication analysis. He's been in a jail. He's been in a setting in which he's been told he can't talk about things like the voices to the jail doctors. So it's hard for a jail doctor to know how he's doing when the jail doctor can't inquire about the voices.

I think if we had him on SITP, we could do a much better job of sorting out what is the right medication -- there are a number of different antipsychotics -- and what the right dosage would be.

Q. Doctor, can you advise this court with any certainty how dangerous or whether or not Kip will be dangerous at some remote time in the future?

A. Not really. I think that it would be irresponsible to try to make a prediction twenty-five, thirty, forty years hence about someone's behavior. I don't think I'm capable of doing that as a psychologist. I don't think anyone is really capable of making that kind of prediction.

It's important to note that you're talking about a prediction of low base rate events. Suicide and homicide -- and for that matter violent behavior -- are pretty low frequency events in society, and they're very hard to predict. And to try to predict something thirty years hence, I would say that's virtually impossible. So

I would be reluctant to even try to guess about a prediction such as that.

Q. Are you aware of some positive prognostic indicators of the potential that he may successfully rehabilitate? And I don't mean cure; I mean treat.

A. Yes. I would say that this is a positive prognostic indicator in the form that I think he's had a positive response to antipsychotic medications, and that's good. Not all patients do. And so the fact that he has benefited from it -- I think that he is likely to benefit from it more once we can fine tune it -- I think that's a positive sign.

Frankly, in my experience, people with his kind of symptomatology who benefit from medicine, they can do quite well. The delusions go away. The voices go away. And in Kip's case, when the delusions and the voices have gone away, he can be pretty normal.

And I think that's another related prognostic indicator. He's capable intellectually. I think he's capable of finishing high school. He can do that at SITP. He's capable of earning college credits. And I think if he's not troubled by his delusions or his voices, he's going to function pretty well. And I think that's a positive indicator.

I think it's also a positive indicator that

he has not been a management problem the whole time he has been in jail. As far as I know, from having reviewed the records, I don't know of any serious management problem that he's posed.

And in the work I do in SITP and at Maclaren, I can tell you that that is a very important thing. When we have inmates who present management problems, it's very hard to treat them. And that's a very poor prognostic indicator. We have youngsters who are so difficult to manage and cause so much trouble to staff that I'm very dubious about them ever getting better, and I think they have a life of trouble ahead of him.

And Kip is not characterized that way. He has never been a management problem. I find him very respectful and very polite when I talk to him, and I think that's a positive sign.

Another positive sign is that the nature of his delusions is still immature. His delusions are not well organized. They're not systematized, they're not layered, they're not convoluted. They're early-stage delusions. And I have found that antipsychotic medications help people in early stage with delusions quite a bit.

But people who have had delusions for twenty or thirty years as adults and then they are medicated,

there are many different types of schizophrenia, and each subtype requires a different type of treatment and different kind of medication. And we're refining our knowledge about the subtypes that pertain. And I think as we get clearer about exactly the precise nature of Kip's diagnosis, we will be in an even better position to know exactly how to treat him. So I think there are a number of advances on the horizon.

Q. Did a mental illness contribute to Kip's conduct on May 20th and May 21st on 1998?

A. In my opinion, it did.

Q. Is it treatable?

A. It's treatable.

MR. SABITT: Nothing further.

CROSS-EXAMINATION

BY MS. TRACY:

Q. First of all, I would like to ask a point of clarification. When you talked about hopes on the horizon and safeguards that would be in place if he would be released after a 25-year sentence, he could be on post-prison supervision for life.

You're certainly aware that that is not a life sentence; that is a flat 25-year sentence. And once he has served that 25 years, there are no sanctions that the state of Oregon can impose if he chooses not to follow

IN THE CIRCUIT COURT OF THE STATE OF OREGON FOR LANE COUNTY

BEFORE THE HONORABLE JACK MATTISON, JUDGE

COURTROOM 201

THE STATE OF OREGON,)
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KIPLAND PHILIP KINKEL,)
Defendant.)
)

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THURSDAY, NOVEMBER 4, 1999

means that the child is having or has had significant problems with the birth and getting oxygen and blood flow to the brain. It's like flipping a coin. It doesn't have any specificity.

Q. Is there some potential that may have contributed to the deficits that you find?

A. There is some, but not a high probability.

Q. I see. And the other history that you reviewed, in terms of the psychological testing Dr. Bolstad did later, on Dr. Bolstad's report, how does that overlay with your neurologic exam?

A. I think it was consistent with it, but it was -- it was different from my approach. And it was another piece of the puzzle, but not related directly to mine. But it would have fit.

Q. And what's the prognosis for someone with the deficits he has?

A. Based on my experience, with children who I've had similar to Kip -- not exactly the same, because I don't think anybody is exactly the same -- I would be hopeful. Mainly because the effects of proper management, that is, setting up a proper environment, where there is a recognition of a deficit, where there is a bypass strategy around the deficit, where there is development of positive reinforcing habits and behavior to sort of train the

mind -- this is everything a parent would do with a normal child, but you have to do this more laboriously and with smaller steps with a child with a lesion.

There is great hope that medication could help. In my experience, at least 75 percent, and depending on how hard you push and how meticulous you are, you can maybe get that up to 80, 90 percent in some groups, children, to get a positive response from medication. And then I think counseling, to deal with the broader issues that surround a neurologic dysfunction.

Q. So when you advised me to discontinue the antipsychotic and antidepressant medications that he had been taking, would one expect to see some of these ratty areas and the holes on the SPECT perhaps more complete had he been medicated?

A. Medication has an effect on the brain, and brain activity correlates with mind. There could have been an effect. I can't really say with a high degree of certainty that it would have occurred in this case, but it's been shown in the past that that can happen.

MR. SABITT: Thank you. No further questions. Oh, I would offer 119.

THE COURT: That's the SPECT scan. I assume you have no objection? Hearing none, it's received.

(DEFENSE EXHIBIT 119 RECEIVED.)

IN THE CIRCUIT COURT OF THE STATE OF OREGON FOR LANE COUNTY

BEFORE THE HONORABLE JACK MATTISON, JUDGE

COURTROOM 201

THE STATE OF OREGON,)
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DAY FOUR SENTENCING HEARING

FRIDAY, NOVEMBER 5, 1999

about the voices. It was not obviously a pleasant experience for him to be sharing this.

Q. Anything significant about those observations?

A. Well, I felt they were compatible with the diagnosis and commensurate with the fact that I was getting a valid picture of his inner life.

I might add, in addition, that the material in this area that he described to me was very consistent with what he described to Dr. Bolstad, very consistent with the videotape material that he gave to Dr. Park Deitz, which I happened to observe last week. So his story over this period of time was quite consistent.

Q. Is it your experience generally that it's easy to diagnose fifteen- and sixteen-year-olds?

A. No. Fifteen- and sixteen-year-olds are in the process of -- they're in a developmental process, and they are an emerging adult, and so symptom pictures can change. And they are not a fixed -- that's why we avoid -- we tend to avoid making personality diagnoses with adolescents because they don't yet have a formed personality. So teenagers are emerging adults, but their symptom profiles can change as they continue to develop.

Q. So as I understand it, the full extent of the pathology hasn't revealed itself and onset doesn't

was psychotic, floridly psychotic, whether he falls into one of these groups or the other.

Q. Each of those diagnoses are equally characterized or can be by psychotic episodes; is that correct?

A. Yes.

Q. Do you have an opinion as to what effect, if any, his mental disease had on his conduct on May 20th and May 21st of 1998?

A. Yes, I do.

Q. And what is that opinion?

A. I feel that his crimes and his behavior on those two days were directly the product of a psychotic process that had been building intermittently in him over a three-year period and suddenly emerged and took over control of his ego, and he became a very dangerous individual.

Q. Did you discuss with Mr. Kinkel during the course of your evaluation or at any time the events of May 20th and May 21st of 1998?

A. I did not go into great detail. I did not take him through all the events of those horrible two days. Several reasons for that. I was the third mental health professional to see him, and by the time I had seen him, Dr. Bolstad had taken him through those events in

A. Well, his illness is a treatable condition. I can't claim that it's curable, but it's certainly treatable. And I think if I can just quote our bible here, DSM-IV, which we use to make diagnoses and which guides us in our treatment plans, the DSM-IV says: Some evidence suggests that the prognosis for paranoid types of schizophrenia may be considerably better than for the other types of schizophrenia, particularly with regard to occupational functioning and capacity for independent living.

My footnote to that would be the tragedy of his illness is that, on the one hand, it allowed him to plan in a methodical way because his cognitive structures were relatively intact compared to other forms of schizophrenia.

I think our common notion of schizophrenia is a disheveled person walking down the street, talking incoherently. That is schizophrenia, but we're talking about a different kettle of fish here. This is paranoid schizophrenia. These people can look very normal.

So on the one hand, the illness had caused him to commit these tragedies. Also, it's the illness that responds better to treatment and has a better prognosis in general than the other forms of schizophrenia. That's the ironic tragedy of the whole

a potential for Mr. Kinkel to be a safe member of our community?

A. Yes, I think that if Mr. Kinkel takes medication, is consistently cared for by a psychiatrist that he trusts, in 25 or 30 years, I think he can be safely returned to the community. I would be happy to have him as my next-door neighbor if those conditions were met, that he was under good psychiatric care and that he was taking medication and his symptoms were obliterated. I don't think he would be a danger to society.

Q. And do you think there's a hopeful perspective with the proper medication to obliterate his symptoms, as you say?

A. I would like to point out to the court that the medications he's on today we did not have five years ago. And I think in the next 25 years, our psychopharmacology is going to be much improved. We're going to have new forms of medication that are much more specific to the particular diagnoses.

I think one of the things that has confused -- from what I read in the newspapers, that we have -- we use the term "schizophrenia," and it means so many different conditions, and it's hard to understand that we use one term for probably what in the next twenty-five years is going to be several different