IN THE DISTRICT COURT OF PITTSBURG COUNTY
STATE OF OKLAHOMA

IN RE: BENJAMIN R. COLE	)	
	)	**Case No.** CJ-22-140
Inmate No.: 489814	)	
	)	**Execution set for October 20, 2022**

PETITION FOR WRIT OF MANDAMUS,
BRIEF IN SUPPORT OF PETITION FOR WRIT OF MANDAMUS,
PETITIONER'S MOTION FOR EVIDENTIARY HEARING,
-and-
PETITIONER'S MOTION FOR ORDER FACILITATING PROPER EVALUATION OF PETITIONER BY EXPERTS AND BRIEF IN SUPPORT

APPENDIX OF EXHIBITS

FILED AND FILED
IN DISTRICT COURT
PITTSBURG COUNTY, OKLA
2022 AUG 15 PM 1:36
PAM SMITH
BY
DEPUTY

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COUNSEL FOR BENJAMIN COLE

IN THE DISTRICT COURT OF PITTSBURG COUNTY
STATE OF OKLAHOMA

IN RE: BENJAMIN R. COLE)
)
Inmate No.: 489814)
)

Case No. _____

Execution set for October 20, 2022

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APPENDIX OF EXHIBITS
INDEX

Exh. No.	Title of Exhibit
1	05/20/2022 Letter to Warden Farris
2	05/25/2022 Letter to Warden Farris
3	08/01/2022 Letter to Warden Farris
4	08/02/2022 Letter from Warden Farris
5	07/14/2022 Report of Scott Orth, Psy.D.
6	10/13/2016 Competency to Be Executed Evaluation by George Hough, Ph.D.
7	01/14/2018 Competency to Be Executed Evaluation Addendum by George Hough, Ph.D.
8	05/04/2022 Affidavit of George Hough, Ph.D. regarding 04/25/2022 attempted visit and observations of Cole
9	05/04/2022 Affidavit of George Hough, Ph.D. regarding 04/25/2022 attempted visit and interactions with prison staff
10	07/29/2022 Declaration of David Hough, Ph.D. regarding Orth report with sample of 2014 DOC records attached

11	01/16/2015 Affidavit of Anne Hayman, MD
12	05/11/2022 Declaration of Travis Snyder, DO
13	05/25/2022 2nd Declaration of Travis Snyder, DO
14	04/04/2009 Independent Psychiatric Consultation by Raphael Morris, MD
15	01/21/2015 Updated Independent Psychiatric Consultation by Raphael Morris, MD
16	Curriculum Vitae of David Hough, Ph.D.

FEDERAL PUBLIC DEFENDER
WESTERN DISTRICT OF OKLAHOMA

SUSAN M. OTTO
FEDERAL PUBLIC DEFENDER

DEATH PENALTY FEDERAL
HABEAS CORPUS DIVISION:
REPLY TO: __X__
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SUITE 707 OLD POST OFFICE BUILDING
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BRANCH OFFICE:
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FEDERAL TRANSFER CENTER
P.O. BOX 898802-8802
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(405) 680-4047
FAX: (405) 680-4082

May 20, 2022

VIA EMAIL AND REGULAR U.S. MAIL

Mr. Jim Farris, Warden
Oklahoma State Penitentiary
P.O. Box 97
McAlester, Oklahoma 74502-0097

Re: Benjamin Cole, DOC #489814

Dear Warden Farris:

We believe our client, Benjamin Cole, DOC #489814, is incompetent to be executed. *See* Order, *Benjamin Cole v. Jim Farris*, 15-CV-0049-GKF-CDL (N.D. Okla. Feb. 17, 2022) (finding Mr. Cole's execution date no longer indefinite and reopening action asserting Cole is incompetent to be executed pursuant to *Ford v. Wainwright,* 477 U.S. 399 (1986)). In addition to what's been presented previously in litigation, we provide the following support for our position:

1. Declaration and attached CV of neuroradiologist Travis Snyder, D.O., dated May 11, 2022;
2. Affidavit of David George Hough, Ph.D., ABPP, dated May 4, 2022;
3. Second affidavit of David George Hough, Ph.D., ABPP, dated May 4, 2022;
4. Competency to Be Executed Evaluation: Addendum of David George Hough, dated January 16, 2018;
5. Competency to Be Executed Evaluation of David George Hough, dated October 13, 2016; and
6. CV of David George Hough, PhD., ABPP.

Oklahoma Statutes, Title 22 O.S. § 1005 states:

> If, after his delivery to the warden for execution, there is good reason to believe that a defendant under judgment of death has become insane, the warden must call such fact to the attention of the district attorney of the county in which the prison is situated, whose duty is to immediately file in the district or superior court of such county a petition stating the conviction and judgment and the fact that the defendant

> is believed to be insane and asking that the question of his sanity be inquired into. Thereupon, the court must at once cause to be summoned and impaneled from the regular jury list a jury of twelve persons to hear such inquiry.

Oklahoma law also provides a definition of "insane" for these purposes which, as you will see, might be more precisely termed "incompetent to be executed."' The definition asks whether the inmate has:

> . . . sufficient intelligence to understand the nature of the proceedings against him, what he was tried for, the purpose of his punishment, the impending fate which awaits him, and a sufficient understanding to know any fact which might exist which would make his punishment unjust or unlawful, and the intelligence requisite to convey such information to his attorneys or the court. If he has, then he is sane; otherwise he is insane, and should not be executed.

Bingham v. State, 169 P.2d 311, 312 (Okla. Crim. App. 1946). We submit Mr. Cole is incompetent to be executed in all respects under this definition. It is perhaps worth making a special note that the attached materials, particularly Dr. Hough's affidavits and reports, make clear Mr. Cole does not have "sufficient understanding" and "intelligence" to convey *any* information to his attorneys or the court.

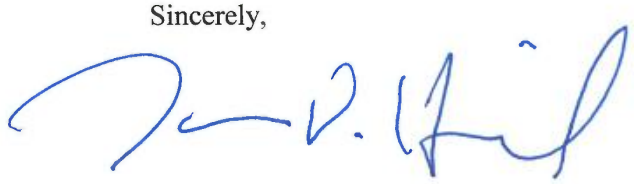
Of special import, *Panetti v. Quarterman*, 551 U.S. 930, 956-59 (2007) provides that the individual must have a *rational* understanding of his impending fate. Moreover, "[a] prisoner's awareness of the State's rationale for an execution is not the same as a rational understanding of it." *Id.* at 959. In a more recent case, the Supreme Court broadened the concept of insanity and held that dementia, too, "can cause such disorientation and cognitive decline as to prevent a person from sustaining a rational understanding of why the state wants to execute him" *Madison v. Alabama*, 139 S. Ct. 718, 729 (2019). Copies of the cases cited in this letter (*Ford, Panetti, Bingham,* and *Madison*) are attached for your convenience.

As detailed in Dr. Hough's and Dr. Snyder's materials, Mr. Cole does not have a rational understanding of his impending fate due to his significant mental illness and brain lesion. Mr. Cole's mental illness is a longstanding one, with severe symptoms that have been documented by multiple sources, including the prison's own medical providers over the years. Should you desire copies of previous reports documenting Mr. Cole's mental illness and corresponding incompetence, we will gladly provide the same.

We respectfully submit Dr. Hough's and Dr. Snyder's opinions standing alone provide "good reason" under 22 O.S. § 1005 to refer this matter for competency proceedings in the district court and ask that you notify the District Attorney of Pittsburg county of the same.

We respectfully request that you respond as soon as practicable to this letter outlining your plans going forward. Thank you for your attention to this matter.

Sincerely,



Thomas D. Hird

FEDERAL PUBLIC DEFENDER
WESTERN DISTRICT OF OKLAHOMA

SUSAN M. OTTO
FEDERAL PUBLIC DEFENDER

DEATH PENALTY FEDERAL
HABEAS CORPUS DIVISION:
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May 25, 2022

VIA EMAIL AND FEDEX

Mr. Jim Farris, Warden
Oklahoma State Penitentiary
P.O. Box 97
McAlester, Oklahoma 74502-0097

Re: Benjamin Cole, DOC #489814

Dear Warden Farris:

On Friday, I wrote to ask you to initiate competency proceedings on behalf of Benjamin Cole because he is incompetent to be executed. Among the attachments was a recent declaration/report from Dr. Travis Snyder, wherein he found Mr. Cole's recent brain MRI "markedly abnormal" and demonstrative of multiple pathologies. He further noted that more sensitive volumetric analysis and diffusion tensor imaging had not yet been capable of analysis, and reserved the right to supplement his report when they became available.

Yesterday he informed us he was able to get the volumetric analysis and diffusion tensor imaging uploaded. Attached is a second declaration/report by Dr. Snyder detailing new findings from the volumetric analysis and diffusion tensor imaging. The markedly abnormal results "are concordant with other MRI sequences and upgrade the damage identified." *See* attached declaration/report at ¶6. I believe this declaration/report, along with the other information you have been made aware of, may assist you in your decision to initiate competency proceedings for Mr. Cole.

Thank you for your attention in this matter.

Sincerely,

Thomas D. Hird

FEDERAL PUBLIC DEFENDER
WESTERN DISTRICT OF OKLAHOMA

SUSAN M. OTTO
FEDERAL PUBLIC DEFENDER

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August 1, 2022

VIA EMAIL AND OVERNIGHT POSTAL MAIL

Mr. Jim Farris, Warden
Oklahoma State Penitentiary
P.O. Box 97
McAlester, Oklahoma 74502-0097

Re: Benjamin Cole, DOC #489814

Dear Warden Farris:

On May 20, 2022, I wrote to ask you to initiate competency proceedings on behalf of Benjamin Cole, because he is incompetent to be executed, and on May 25, 2022, I wrote you to supplement that submission. I write again to supplement our submission with a new declaration from David George Hough, Ph.D., ABPP. The declaration was written in response to the report of Scott Orth, Psy.D., dated July 14, 2022. Once again, thank you for your attention to this matter.

Sincerely,

Thomas D. Hird

J. Kevin Stitt
Governor

OKLAHOMA Corrections

Scott Crow
Director

August 2, 2022

Thomas D. Hird
Assistant Federal Public Defender
Capital Habeas Unit
Federal Public Defender-Western District of Oklahoma
215 Dean A. McGee, Suite 707
Oklahoma City, OK 73102

Re: 22 O.S. § 1005 Notification - Benjamin Cole (489814)

Dear Mr. Hird,

Inmate Benjamin Cole is currently incarcerated with the Oklahoma Department of Corrections and housed at the Oklahoma State Penitentiary upon a sentence of death. Mr. Cole is set to be executed on October 20, 2022. During my tenure as Warden of this facility, I have carefully considered all information and material submitted by Mr. Cole's attorneys regarding his mental health and conditions of confinement. Additionally, pursuant to an "Order for Mental Health Evaluation" entered upon agreement of the parties in the case of *Benjamin Cole v. Jim Farris*, Case No. CIV-15-0049-GKF-CDL (United States District Court for the Northern District of Oklahoma), Mr. Cole was transported to the Oklahoma Forensic Center in Vinita, Oklahoma on July 5, 2022 and evaluated for the purpose of determining whether Mr. Cole has a rational understanding: (1) of the reasons he is being executed, and (2) that he is to be executed imminently. The evaluation was filed under seal in the referenced action at Doc. 59 and includes the following finding:

> ...Mr. Cole does not currently evidence any substantial, overt signs of mental illness, intellectual impairment, and/or neurocognitive impairment that would preclude his competency related abilities regarding his pending execution...Mr. Cole appears to evidence that he can

sufficiently and rationally discuss his understanding of the reason he is being executed, and that he is to be executed and that said execution is imminent.

As the Warden of the Oklahoma State Penitentiary, and in accordance with 22 O.S. § 1005, it is my duty to inform the Pittsburg County District Attorney if I have good reason to believe that Mr. Cole has become insane after his delivery to this prison for execution. Upon careful consideration of the material submitted by legal counsel for Mr. Cole and the above-referenced evaluation, which was obtained by agreement of all parties, it is my determination that Mr. Cole has not become insane since his delivery to the Oklahoma State Penitentiary for execution. As such, I am declining your request to initiate competency proceedings on behalf of Mr. Cole.

Sincerely,

Jim Farris
Warden, Oklahoma State Penitentiary

cc: Ashley Willis
Tessa Henry
Jennifer Crabb

OKLAHOMA DEPARTMENT OF MENTAL HEALTH
AND SUBSTANCE ABUSE SERVICES
OKLAHOMA FORENSIC CENTER

July 14, 2022

The Honorable Judge Gregory Frizzell
Judge of the United States District Court
Northern District of Oklahoma
333 West Fourth St., Rm. 411
Tulsa, Oklahoma 74103

RE: COLE, BEJAMIN ROBERT, SR. (DOB: 04/08/1965)
15-CV-0049-GFK-CDL

Dear Judge Frizzell:

In response to your Order dated 06/13/2022, I evaluated Mr. Cole on an outpatient basis at the Oklahoma Forensic Center for a mental health evaluation pertaining to his pending execution and have reached the following conclusions.

PROCEDURES OF EVALUATION:

1. Clinical interview and competency evaluation of Mr. Cole, conducted by Scott Orth, Psy.D. at the Oklahoma Forensic Center (OFC) on 07/05/2022, totaling approximately 150 minutes.
2. Review of the Order for Mental Health Evaluation for 15-CF-0049-GFK-CDL from the United States District Court for the Northern District of Oklahoma, dated 06/13/2022.
3. Review of the Petitioner's Motion for Order Facilitating Mental Health Evaluation and Brief In Support for 15-CV-049-GFK-CDL from the United States District Court for the Northern District of Oklahoma, filed 05/23/2022.
4. Review of the Court of Criminal Appeals of Oklahoma opinion for 2015 OK CR 13, dated 10/02/2015.
5. Review of the Transcript(s) of Proceedings for CV-2015-58 from the District Court of Pittsburg County, dated 08/25/2015 and 08/28/2015.
6. Review of the Transcript of Jury Trial on Competency Proceedings for CF-2002-597 from the District Court of Rogers County, held on 09/13/2004 through 09/14/2004.
7. Review of the Affidavit(s) by Ashley Barrett and Randy Lumley, regarding Mr. Cole, both sworn on 06/15/2022.
8. Review of Oklahoma Department of Corrections (ODOC) records for Mr. Cole, including medical records (dated 12/27/2004 through 03/29/2022); "Mental Health" records (Mental Health or Mental Status Review; Mental Health Assessment; Periodic Physical Examination (Non-Chronic Clinic); Wellness Check) (dated 04/15/2010 through 06/17/2022); Text Order(s) 03/10/2014 through 03/29/2022); All Problems Report (01/26/2015); All Procedures Report (07/17/2015); All Vital Signs Report (12/27/2004 through 03/29/2022); Scheduled Events (04/16/2014 through "09/03/2028"); and Medication (07/03/2017).
9. Review of records from Travis Snyder, DO, specifically Declaration (05/11/2022); 2nd Declaration (05/25/2022), and Dr. Synder's Curriculum Vitae (10/08/2021).
10. Review of records from George Hough, Ph.D., ABPP, specifically Affidavit(s) (05/04/2022); Competency to be Executed Evaluation (10/13/2016) and Addendum (01/16/2018); and Dr. Hough's Curriculum Vitae (undated).
11. Review of records from Raphael Morris, MD, specifically Independent Psychiatric Consultation (04/04/2009) and Updated Independent Psychiatric Consultation (01/21/2015).

24800 S. 4420 Rd., P.O. Box 69, Vinita, Oklahoma 74301-0069 • (918) 256-7841 Voice • (918) 256-4491 FAX

12. Review of letters to Judge Steidley by Samina R. Christopher, Ph.D., dated 07/24/2003 and 08/18/2004, regarding prior evaluations of Mr. Cole's adjudicative competence for CF-2002-597 (Rogers County).
13. Review of a letter to John Dalton, Oklahoma Indigent Defense System, by Michael R. Basso, Ph.D., regarding Mr. Cole, dated 06/15/2004.
14. Review of a Social History – Risk Assessment of Mr. Cole by Jeanne Russell, Ed.D., dated 05/27/2004.
15. Review of Round Valley Unified School District school records for Mr. Cole.
16. Review of Department of the Air Force records for Mr. Cole.
17. Collateral phone contact by OFC administrative staff with Oklahoma State Penitentiary staff on 07/13/2022, regarding Mr. Cole.
18. Records check with the medical records departments at the Oklahoma Forensic Center, Tulsa Center for Behavioral Health, Oklahoma County Crisis Intervention Center, Griffin Memorial Hospital, Central Oklahoma Community Mental Health Center, Oklahoma Crisis Recovery Unit, Jim Taliaferro Community Mental Health Center, Northwest Center for Behavioral Health, Rose Rock Recovery Center, Children's Recovery Center, and Carl Albert Community Mental Health Center for Mr. Cole.
19. Review of www.oscn.net and doc.ok.gov records for Mr. Cole, retrieved electronically on 07/05/2022.

CRIMINAL INFORMATION AND REASON FOR REFERRAL:

According to available legal documents for CF-2002-597, on 12/20/2002 Mr. Cole "grabbed [B.V.C.'s, D.O.B. 3/27/2002] feet while she was lying on her stomach and did pull her feet towards her head quickly and hard, causing her body to bend backward fracturing the spine which ruptured the aorta, causing her to bleed to death," was charged with Murder – First Degree (Child Abuse), convicted and found Guilty by a jury in Rogers County, Oklahoma on 10/21/2004, and sentenced to death on 12/09/2004.

Prior to Mr. Cole's jury trial for CF-2002-597, he was evaluated for his adjudicative competence by various experts, and was subsequently found competent to proceed following a competency jury trial in Rogers County that took placed between 09/13/2004 and 09/14/2004. The interested reader is referred to evaluations by Dr. Christopher (07/24/2003 & 08/18/2004), Dr. Russell (05/27/2004), and Dr. Basso (06/15/2004).

Following Mr. Cole's conviction for CF-2002-597, he has been subsequently evaluated by a number of additional experts, including Dr. Randall Price, Dr. Morris, and most recently by Dr. Hough. (The interested reader is referred to Dr. Hough's Competency to be Executed Evaluation, dated 10/13/2016 for a thorough review of Mr. Cole's evaluation history from 2003 through 2016). Proceedings for CV-2015-58 from the District Court of Pittsburg County, were held on 08/25/2015 and 08/28/2015 regarding Mr. Cole's competency to be executed, but the District Court subsequently found that "Petitioner had not met the burden of proof and had not shown Respondent had refused to carry out a clear legal duty" (2015 OK CR 13, 10/02/2015). Since the issuance of the Court of Criminal Appeals of Oklahoma's decision for 2015 OK CR 13, and according to the Petitioner's Motion for Order Facilitating Mental Health Evaluation and Brief In Support for 15-CV-049-GFK-CDL from the United States District Court for the Northern District of Oklahoma,

filed 05/23/2022, Mr. Cole, by his counsel, requested the Court for "an order facilitating a mental-health evaluation." Mr. Cole's counsel, Thomas D. Hird and Katrina Conrad-Legler, noted numerous concerns regarding Mr. Cole, citing Affidavits of attempted evaluations of him by Dr. Morris back in 2014, as well as more recent evaluations and/or Affidavits by Drs'. Hough and Snyder. According to the Order for Mental Health Evaluation for 15-CF-0049-GFK-CDL from the United States District Court for the Northern District of Oklahoma, dated 06/13/2022, Judge Frizzell ordered the current Mental Health Evaluation of Mr. Cole, to "determine whether Petitioner has a 'rational understanding': 1) 'of the reason [Petitioner] is being executed'; and 2) [t]hat [Petitioner] is to be executed and that execution is imminent."

NOTIFICATION OF LIMITS OF CONFIDENTIALITY:

Mr. Cole was informed (in simple language) during the interview of the nature and purpose of the evaluation and the limitations of confidentiality. After first querying his spontaneous understanding of the nature and purpose of the evaluation, I informed him the was a court-ordered evaluation for his rational understanding about the reason the State of Oklahoma is seeking to execute him, and about his rational understanding about the imminence of his pending execution. I also informed him that the usual doctor-patient relationship did not exist, and that a report would be prepared and submitted to the referring court and both his (Petitioner) and Respondent attorneys, and could be used in legal proceedings. At the outset of sitting down and querying Mr. Cole's understanding of the reason for the current evaluation, he spontaneously states "well, I guess to see if I'm competent and mentally fit to be executed," adding "they [the court] wanted to take me to get a competency evaluation and see if I'm mentally fit for court and competent here to see if I can go ahead and I guess be executed." He then spontaneously notes "as I understand it, the first new execution is August 25th, then the next one is September 23rd, and I'm third on the list, so sometime in later October, I believe, possibly the 20th" and that "they want to make sure I'm competent, and that I realize first that I killed my daughter and I went through a trial for taking my daughter's life and a jury found me guilty; they found me guilty of murder and I was given the death penalty for that, and I accept responsibility for that." In my opinion, Mr. Cole is able to indicate an appropriate understanding of the limits of confidentiality and his responses indicate he understands the information conveyed to him regarding the evaluation.

COLLATERAL INFORMATION:

As noted above, Mr. Cole's history of psychological, psychiatric, neurological, and neuropsychological evaluations has been thoroughly documented in previous letters to the court; therefore, it will not be reiterated in this letter. The interested reader is referred to the above noted evaluations (again, particularly Dr. Hough's evaluation, dated 10/13/2016) for Mr. Cole's documented history through 2016.

Oklahoma State Penitentiary records: Mr. Cole's OSP records through 2014 have been previously documented and/or litigated through various evaluations and/or hearings regarding his competency for execution, and will not be reiterated in this letter. The interested reader is referred primarily to the transcript for the Proceedings for CV-2015-58 from the District Court of Pittsburg County, dated 08/25/2015 and 08/28/2015, as well as Dr. Hough's evaluation (10/13/2016).

Since 2015, almost all of Mr. Cole's ODOC mental health records ("Mental Health" records (Mental Health or Mental Status Review; Mental Health Assessment; Periodic Physical Examination (Non-Chronic Clinic); Wellness Check), dated 04/15/2010 through 06/17/2022) note him to evidence no apparent and/or overt signs of mental illness. Notably, the majority of these records indicate he routinely does not engage with staff, with staff framing these interactions (or lack thereof) as "refusals."

Records indicate that during his interaction with detention staff shortly following his hearing on 08/28/2015, he was noted to be "sp[eaking] clearly and openly about himself and his feelings about his future death....he was alert and oriented with no evidence of thought disorder or neurological impairment...showed no delusions [firm false beliefs despite clear evidence to the contrary] in his thought process" (Mental Health Progress Note – SOAP, 09/01/2015). During an interaction with staff on 01/19/2016, Mr. Cole was noted to have "showed mild signs of Depression, from his appearance and behavior, but was able to make decisions for himself and ask for assistance from others when he has needs. He answered questions quickly and firmly when it was a subject that mattered to him" (Mental Health Progress Note – SOAP, 01/19/2016). Records did note that on 05/16/2016 Mr. Cole was "brought to medical for an evaluation. i/m [inmate] was uncooperative and required to be pepper sprayed. i/m was able to ambulate to his cell, but has been uncooperative when asked to stand on scales to be weighed. i/m [*sic*] voiced n complaints of pain except for the burning sensation of the pepper spray," (Progress Note, 05/16/2016). Mental health staff noted that on 05/16/2016, Mr. Cole "was removed from his cell for evaluation, he refused to place his arms out to be cuff [*sic*] and OC [oleoresin capsicum] spray was used. He was cuff [*sic*] and taken to Medical room on H Unit. He was uncooperative, but did ask to his Case Manage" (Mental Health Progress Note – Evaluation/uncooperative, 05/16/2016).

On 10/05/2016, Mr. Cole was noted to be "disheveled, tense, with a flat affect [absence or near absence of emotional expression]," although his thought process was noted to be "organized" (Mental Health Progress Note – SOAP, 10/05/2016). On 10/14/2016, Mr. Cole was noted to "mumble...gibberish" but was also described as being "ambulatory during mealtime and when alone in his cell, but when medical personnel...are visible he states he is unable to walk due to weakness and too confused to answer questions" (Wellness Check, 10/14/2016). On 04/05/2017, Mr. Cole was noted to have a "20 minute conversation this clinician. He recalled meeting with this clinician during and following his last 35 day notification of execution, and noted that although the execution was temporarily stayed that he didn't 'have much time left, time is growing short.'...He noted some of the other inmates in the infirmary, and that he was praying for their health. He also mentioned the death of his case manager, and his sadness upon learning of the news...Inmate spoke for such a length of time that this clinician had to break away from the conversation. Inmate thanked this clinician for checking on him, and reconfirmed with primary QMHP [qualified mental health professional] that he would see her on rounds" (Mental Health Progress Note – SOAP, 04/05/2017). During an interaction with staff, on 09/27/2017 Mr. Cole was described as evidencing "selective-mutism," and that he "chose to talk about having property removed because he had too much, but refused to exchange on queries by the staff" (Mental Health Progress Note – SOAP, 09/27/2017). On a note dated 08/16/2018, Mr. Cole was noted to have "denied any mental health concerns and did not exhibit any symptoms. When asked if he needed anything from mental health, inmate responded 'I just need Jesus.' No concerns noted by staff at this time" (Mental Health or

Mental Status Review, 08/15/2018). Staff note that on 01/17/2019, Mr. Cole "declined need for mental health services. He appeared to struggle when talking. He sat in a wheelchair holding up his legs with his hands. His clothes were in poor condition, his hair is long and unkempt but he did not smell" (Mental Health Progress Note – SOAP, 01/17/2019). His provider noted that on 04/26/2019 he was "very dirty…Inmate made short statements like 'no help' when asked if he need anything from mental health. Inmates presentation [*sic*] was bizarre as he hunched over holding his legs up in the wheel chair with his arms even though this action was unnecessary…Inmate continues to refuse to engage when meeting with medical and mental health. Although inmate has been seen by multiple staff members standing, walking and speaking on his own without much effort" (Mental Health Progress Note – SOAP, 04/19/2019).

Records indicate that on 09/10/2019, Mr. Cole was noted to "answer…questions of how he was and how he was doing. Inmate just answered with one word answers, 'yes.'…No concerns noted by staff at this time" (Mental Health or Mental Status Review, 09/10/2019). On 10/23/2019, staff noted he stated "I'm resting and I have no issues.' He denied having any mental health concerns to discuss at this time. No concerns noted by staff" (Mental Health or Mental Status Review, 10/23/2019). His provider noted that on 03/19/2020 Mr. Cole "was mumbling that he was fine. Inmate was difficult to understand and he had to repeat himself several times" (Mental Health or Mental Status Review, 03/19/2020). On 11/12/2020, Mr. Cole was noted that he "did not report or exhibit symptoms of mental illness or behavioral issues. He was friendly and cooperative. He denied having any concerns at this time" (Mental Health or Mental Status Review, 11/12/2020). Nursing staff noted that on 12/31/2020 Mr. Cole was "very talkative today. Answers all questions appropriately. Reports that he will not be able to weigh because he can't balance on the scale. I/M reports that he has been eating well and taking in an adequate amount of fluids. I'M shows no s/s [signs and/or symptoms] of dehydration…Denies needs or requests at this time" (Wellness Check, 12/31/2020). On 01/21/2021, Mr. Cole apparently had a "failure to obey" offense, although no specific information is listed in the available record regarding this incident (Mental Health Recommendations Regarding Offender Discipline, 01/25/2021). Most recently, staff note that Mr. Cole "continues to ignore QMHP when QMHP is at his door. He will cover his head or look the other way like he doesn't see QMHP" (Mental Health or Mental Status Review, 06/09/2022) and that he "would not acknowledge QMHP" (Mental Health or Mental Status Review, 06/17/2022). A number of the records reference Mr. Cole refusing various providers and tasks such as "wellness checks," but no further description is noted in the records, other than to say "[i]nmate refused to be seen" ("Mental Health" records (Mental Health or Mental Status Review; Mental Health Assessment; Periodic Physical Examination (Non-Chronic Clinic); Wellness Check), dated 04/15/2010 through 06/17/2022). Lastly, in addition to ODOC records indicating Mr. Cole does not appear to have ever been prescribed psychotropic medication since his incarceration, he has also only ever carried the "DSM IV [Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition]" diagnostic code "799.9" – Diagnosis Deferred.

Reports by Travis Snyder, D.O.: According to two Declarations from Dr. Snyder, dated 05/11/2022 and 05/25/2022, he noted he reviewed MRI (magnetic resonance images) scans of Mr. Cole's brain, and provided various interpretations of said MRIs. Dr. Snyder noted that the "clinical record is highly concordant with the imaging findings described," and that "[m]ultiple providers have stated that Benjamin Cole is not competent to understand legal proceedings and have recommended a

follow-up MRI to the 2004 MRI. Given the high concordance of the imaging with the clinical record, the imaging reviewed is supportive of their opinions" (05/11/2022). There is no indication in Dr. Snyder's Declarations, however, that he himself has ever physically observed and/or interacted in any manner with Mr. Cole.

Evaluations/Affidavits by George Hough, Ph.D., ABPP: Dr. Hough first completed a Competency to Be Executed Evaluation of Mr. Cole on 10/13/2016. At that time. Dr. Hough noted he conducted "Mental Status Interviews and Clinical Observations," and reviewed numerous reports and records pertinent to Mr. Cole and his case. Dr. Hough noted that during his interviews with Mr. Cole, he "appeared very psychologically regressed and vegetative," and that he "rarely made a verbal statement and when he did his speech was barely audible" or otherwise refused to meet with him. Dr. Hough noted that "[d]espite the breadth of these materials reviewed, it is acknowledged that this report also contains limited direct interview data from Mr. Cole himself." Dr. Hough notes, however, that "Mr. Cole's past and current attorneys have repeatedly noted that before, and especially after his capital sentence, that Mr. Cole has not been able to confer with them in a rational and coherent [understandable] manner that has been of assistance with the case. Essentially, legal defense teams have had to work on his defense without his input. Each defense team after the death sentence have encountered the same set of issues: namely, his persistent religious delusions and preoccupation with the end of the world, all of which has made it impossible to hold rational conversations with him about his case." There is no indication in his evaluation that Dr. Hough himself had elicited any type of delusional statements from Mr. Cole during his interactions with him, and that he made "clinical inferences" about him "from a review of [cited within his Evaluation] these voluminous materials." Dr. Hough indicated that based upon the totality of his evaluation of Mr. Cole, he diagnosed him with "295.90 Schizophrenia, Paranoid Type, Continuous, with chronically religiously themed delusions, (along with severe level negative symptoms); 293.89 Catatonic Features Associated with Schizophrenia: stupor, mutism and negativism; [and] 799.59 Unspecified Neurocognitive Disorder (with etiology not yet determined-11 mm brain lesion in the deep white matter of the frontal-parietal region of left hemisphere). Dr. Hough opined that Mr. Cole "is not competent to be executed. There was no affirmative evidence from this evaluation that Mr. Cole does understand and appreciate that he may again be scheduled for execution or the reasons why the execution would take place." He also recommended that Mr. Cole would "require... treatments be initiated" in order to be restored to execution competence, and that "[w]ithout attempting these treatments Mr. Cole's competency for execution will not be restored."

Dr. Hough subsequently generated a Competency to Be Executed Evaluation: Addendum, dated 01/16/2018. Dr. Hough noted that "[g]iven the extended length of time since the last report was provided it was considered necessary to provide an updated opinion upon Mr. Cole's mental status." Dr. Hough noted this was based upon him "review[ing] available documentation provided by Mr. Cole's legal defense team" but that "[u]pdated records from the professional staff employed at the McAlester Prison have not yet been forthcoming for review." Dr. Hough noted that upon his review of the information provided to him, the "amalgamation of the data from these records fully support that he is continuing to experience schizophrenic illness and that the course of his illness is chronic, unremitting, and continuing to deepen. In sum, there is no evidence from the records that Mr. Cole's mental status has improved; it has not." He acknowledges that "these records do not constitute a formal psychiatric evaluation of [his competency to be executed] issue nor was their intended

purpose to answering that question for the court. To fully assess that particular issue a comprehensive psychiatric evaluation would be required." Dr. Hough maintains his prior diagnoses for Mr. Cole, and continued to opine that Mr. Cole "is not competent to be executed."

Most recently, Dr. Hough indicated he attempted to meet again with Mr. Cole, along with his legal team, at OSP on 04/25/2022 and 04/26/2022 (Affidavit(s), 05/04/2022). Dr. Hough noted that Mr. Cole did not engage in meeting with him or his legal team during these attempted visits. He noted that his "current observations are consistent with my previous observations and with reports reflected in the medical records. Mr. Cole's overall behavior remains very regressed, and primitive, and refractory to efforts to communicate with him by others. I did not observe any behavior by Mr. Cole that I would consider rational or coherent, and his cognitive capacity is currently assessed as extremely impaired," adding that he "discern[s] no clinical improvement whatsoever since my last face-to-face encounter; it has most likely worsened" (Affidavit(s), 05/04/2022).

Affidavit(s) by Ashley Barrett and Randy Lumley: According to Affidavits by Randy Lumley and Ashley Barrett, both of whom indicate they work at OSP, they provided numerous observations about Mr. Cole's behavior, alleging that "Inmate Cole is not at all what he seems" and that he is "very troublesome and intentionally creates issues for staff." Other than being on an observational basis, it is unclear from these Affidavits how these staff members determined the "intentional" nature of Mr. Cole's behavior.

Oklahoma State Penitentiary: In a documented phone conversation by OFC administrative staff with Oklahoma State Penitentiary staff (07/13/2022), consistent with available records, staff report that Mr. Cole is not currently prescribed any psychotropic medication. Saff further indicated that Mr. Cole has not engaged in any behavioral incidents for at least approximately the last 30 days, and that he is currently housed in a "single cell" on "death row."

Records check for Mr. Cole: According to the medical records departments at the Oklahoma Forensic Center, aside from his evaluations for adjudicative competence for CF-2002-597 back in 2003 and 2004, Mr. Cole does not have any documented history of having previously received services at this facility. Additionally, according to the medical records departments at the Tulsa Center for Behavioral Health, Oklahoma County Crisis Intervention Center, Griffin Memorial Hospital, Oklahoma Crisis Recovery Unit, Central Oklahoma Community Mental Health Center, Northwest Center for Behavioral Health, Carl Albert Community Mental Health Center, Jim Taliaferro Community Mental Health Center, Children's Recovery Center, and Rose Rock Recovery Center, Mr. Cole does not have any documented history of having previously received mental health services at those facilities.

CURRENT MENTAL STATUS:
Mr. Cole is a 57-year-old White male who appears somewhat older his stated age, but is groomed within community standards. Notably, his clothing appears clear, his hair appears washed and pulled back in a ponytail, his nails appear trimmed and clean, and there is no discernable body odor from him. He presents in a wheelchair, and while he is initially is handcuffed, transport staff agree to remove them at my request and he remains uncuffed throughout the remainder of the interview. During the evaluation he displays neither increased nor decreased psychomotor activity. At times he

gestures with his hands and arms when speaking to make a point, but his gestures are all consistent with his statements. His eye contact at first is limited, in that for much of the initial part of the evaluation, he appears to be squinting; however, throughout the interview he makes comments about my behavior, and requests I resume writing when I stop at times to listen to his statements. As the evaluation progresses, he opens his eyes further, to the point that he and I are able to have more routine eye contact, all of which at that point is within cultural norms. Mr. Cole actively participates in the interview, spontaneously engaging with me, is cordial and polite, and is cooperative with me throughout the interview. Mr. Cole, does, however, routinely interject statements reflective of his own agenda, particularly regarding his views about religion. He inquires about my religious beliefs, and often requests that I write down specific responses of his, particularly when he cites scripture from the Bible. Mr. Cole routinely states that he "prefers to talk in parables," and references that he feels when he speaks he is "giving testimony," but when I specifically ask him to provide a response absent religious interjection, he is does so without difficulty. In fact, when I attempt to redirect Mr. Cole, at times he bargains for "just give me 20 more seconds to finish, and then I will answer your question," at which time he then does. I find him to be easily interruptible, and additionally at no point does he become irritated or frustrated with my attempts to redirect him. He appears to relish discussing his religious beliefs and worldview, but again when I redirect him back to the evaluation, he easily changes the topic to my question and provides a goal-directed response to it. Additionally, his subsequent responses are always relevant.

Mr. Cole describes his current emotional state as "its good, like Jesus in the Bible." Regarding his sleep, he states "I sleep all the time, but I pray a lot, too." He indicates his energy level is "about zero," but attributes this to "I'm getting old and I feel like I'm falling apart some, and I don't really remember things as well as I used to." He describes his appetite as "it's good." When I ask him, Mr. Cole does not report or endorse any current suicidal and/or homicidal ideation, intent, or plans. He also reports he has never previously attempted suicide. In fact, when I ask Mr. Cole about being suicidal, he states "I would never do something like that; for me, that would be like jumping in the Lake of Fire." His mood (sustained emotion) is euthymic (normal), and his affect (immediately expressed or observed emotion) is appropriate to his expressed thoughts and neither significantly increases or decreases in range or intensity. His attention, concentration, and focus are sufficient for the purposes of this evaluation, and appear in my opinion sufficient for execution competency. His memory also appears sufficient for execution competency, based upon his ability to spontaneously recall case specific information consistent with available records without assistance from me. Consistent with prior psychological testing of his intellectual functioning ("overall intelligence was average (FSIQ [Full Scale Intelligence Quotient] =99);" see Dr. Basso's report, 06/15/2004), Mr. Cole's intellectual functioning currently is grossly clinically estimated to be within the average range, as assessed by his general fund of information, syntax, vocabulary, and reasoning ability.

Currently, Mr. Cole's expressed thoughts are coherent (understandable), logical, and goal-directed. He does not evidence any loose associations (little or no connection between ideas in a sequence, i.e., expressed thoughts shift from one topic to another in an unrelated manner), thought blocking (train of expressed thought that suddenly stops, often in mid-sentence), or flight of ideas (expressed thoughts rapidly jump from one topic to another while remaining obviously connected). When I query him about experiencing either auditory and/or visual hallucinations (sensory perception in the absence of external stimuli), Mr. Cole states "it's just when the Lord speaks to me," noting he hears

"spiritual communications," and notes he is not having such experiences while meeting with me. He does not otherwise endorse currently experiencing or ever having had a history of experiencing, any other sort of auditory hallucination-type experience. When I ask specifically about visual hallucinations, Mr. Cole states "are you asking if I see little green men running around on the floor that beam up in a spaceship to Venus and look for the purple monsters? [laughs briefly] no, I do not see things, I never have." Further, during my meeting with Mr. Cole, he does not ever evidence any substantial overt signs of perceptual disturbances (i.e., hallucinations), substantial overt signs of mental illness, intellectual impairment, neurocognitive impairment, or memory impairment that would impair his competency related abilities.

Lastly, in my opinion, at no point does Mr. Cole spontaneously espouse any delusions (firm false beliefs despite clear evidence to the contrary). He does not ever attribute to himself, either spontaneously or when I directly query him, as having any sort of supernatural, otherworldly, mystical, and/or divine abilities and/or purpose. He does not ever reference, either spontaneously or when I directly query him, about his instant case or subsequent punishment as fulfilling any sort of prophecy, or that (presuming, for the purposes of this evaluation) when his execution is carried out, that any sort of supernatural, otherworldly, mystical, and/or divine, or prophetic event will transpire. Instead, following his execution he indicates his corporeal form will cease to exist on the plane of existence he agrees everyone considers being "alive," noting "my bones will return to dust," but that his "spirit" will "hopefully" (as he expresses it) return "to my Father in Heaven." Mr. Cole does spontaneously express the "hope" that following (again, presuming, for the purposes of this evaluation) his execution, that "ideally Governor Stitt might have a change of heart about seeking capital punishment and focusing on death for inmates, and instead focus more on life and rehabilitation," although again, at no point does he express that said event would be divine or supernatural in nature and instead states "it's just something I hope he considers and take to heart. I'll pray for him and the people of Oklahoma that it happens." Mr. Cole does reference his belief that there is "little time left in the world," and repeatedly asserts his belief that due a perception of the limited time left for humanity, that "therefore, people need to get right with Jesus." He maintains he does not have any specific directive or special and/or specific knowledge, either mystically or divinely obtained, or from any sort of otherworldly, or celestial, or divine being as having any bearing or weight on his beliefs or statements. In fact, when I press him on his beliefs, he laughs and then states, "Dr. Orth, I'm just a super-duper hyperbolic Jesus freak." He does not ever indicate, either spontaneously or when I directly query him, that his beliefs cause him any sort of distress, or that if he does not discuss them that some sort of negative and/or catastrophic event will occur. Finally, Mr. Cole's responses are not indicative of any delusions when asked about specific beliefs such as being able to read others' minds, being followed, etc.

RELEVANT HISTORY FROM DEFENDANT:

Mr. Cole self-reports he has never previously received mental health services and that he has never been prescribed psychotropic medication. Educationally, he reports he graduated high school, describing his grades while in school as "well, I'm a bit slow, but once I learn something, I get it. I had to really make myself work hard to get like a C, but I'm a determined person." He indicates he "flunked Kindergarten," but states "I don't know" when I ask the reason for it. He indicates he was never placed in any special education classes or identified as having any learning and/or intellectual disabilities. He reports a prior formal work history, including enlistment in the United States Air

Force, and notes he had never previously received Social Security benefits prior to his conviction for CF-2002-597. With regard to his physical health, Mr. Cole states "I feel like I have some impairments; basically, like I'm just falling apart," which attributes to "I can't really live the sort of holistic lifestyle I would like to while in prison." When I ask about what he considers a "holistic lifestyle," he states "like getting to eat organic food and a diet that's consistent with what's in the Bible." When I specifically ask him, he does not report having any current chronic health and/or medical conditions. With regard to history of head injuries and/or periods of losing consciousness, Mr. Cole initially states "that's all been explained in prior reports of mine," but then spontaneously adds "there was a guy with a hammer that struck me in the head back in 1985 or 1986. I went to the hospital with a concussion and had five stitches. I've also had one concussion from playing a football game back when I was 17 [years of age]." I do not know of any medical health history that would interfere with Mr. Cole's competency related abilities. Lastly, while Mr. Cole currently self-reports he had never been placed in special education classes, various reports reference he in fact had been placed in such classes, particularly due to him "functioning below his grade level at the time" (Dr. Russell's Social History – Risk Assessment, 05/27/2004). I do not otherwise have access to any additional records, other than those cited above in the Procedures of Evaluation, to either substantiate or refute any other aspects of Mr. Cole's self-reported psychosocial history.

RESPONSES TO COURT ORDERED ITEMS:
In line with the Court's order, the following are offered:

1. Whether the Petitioner has a rational understanding of the reason (Petitioner) is being executed?

YES. Mr. Cole does not currently evidence any substantial, overt signs of mental illness, intellectual impairment, and/or neurocognitive impairment that would preclude his ability to rationally understand the reason he is being executed. Throughout my evaluation with Mr. Cole, from the outset and throughout the entirety of it, he expresses both a factual ("see if I'm mentally fit for court and competent here to see if I can go ahead and I guess be executed") and rational ("the State of Oklahoma is executing me for killing my daughter") understanding of the reason he is being executed. As noted earlier, at no point does Mr. Cole ever attribute to himself, either spontaneously or when I directly query him, as having any sort of supernatural, otherworldly, mystical, and/or divine abilities and/or purpose. He does not ever reference, either spontaneously or when I directly query him, about his instant case or subsequent punishment as fulfilling any sort of prophecy, or that (presuming, for the purposes of this evaluation) when his execution is carried out, that any sort of supernatural, otherworldly, mystical, and/or divine, or prophetic event will transpire. He rationally expresses an understanding that following (presuming, for the purposes of this evaluation) his execution, that his corporeal form will cease to exist on the plane of existence he agrees everyone considers being "alive," but notes that his "spirit" will "hopefully (as he expresses)" return "to my Father in Heaven." He rationally discusses his desires for what he hopes happens with his remains, specifically noting that "if it were up to me, I would be buried in a small, modest wooden box in a Jewish cemetery somewhere in Tulsa," adding "I just would prefer they [ODOC officials] not cremate my remains." Mr. Cole does not ever assert, either spontaneously or when I directly query him, that his (presuming, for the purposes of this evaluation) pending execution by the State of Oklahoma is for any other reason other than his instant offense for CF-2002-597. Again, as noted earlier, Mr. Cole spontaneously states to me, at the very outset of our

meeting, that "they want to make sure I'm competent, and that I realize first that I killed my daughter and I went through a trial for taking my daughter's life and a jury found me guilty; they found me guilty of murder and I was given the death penalty for that, and I accept responsibility for that." Given the totality of the available data to me, it is my opinion that Mr. Cole has a rational understanding of the reason he is being executed by the State of Oklahoma.

2. Whether the Petitioner has rational understanding that (Petitioner) is to be executed and that his execution is imminent?

YES. Mr. Cole does not currently evidence any substantial, overt signs of mental illness, intellectual impairment, and/or neurocognitive impairment that would preclude his ability to rationally understand that he is to be executed and that his execution is imminent. As noted earlier, at the outset of my meeting with Mr. Cole, he spontaneously states to me that, "as I understand it, the first new execution is August 25th, then the next one is September 23rd, and I'm third on the list, so sometime in later October, I believe, possibly the 20th." At no point throughout my meeting with him does Mr. Cole express any sort of irrational, delusional, or in general psychotic or distorted belief about the (presumed, for the purposes of this evaluation) imminence of his execution. While Mr. Cole does not spontaneously discuss his understanding of the procedures of the execution process, he spontaneously and rationally acknowledges the State of Oklahoma will execute him via a lethal injection. He expresses rational awareness that this will take place in the "execution chamber" at OSP. He acknowledges that he will have a "last meal," and that he will have to make plans about what to do with his property following his execution. Again, he rationally expresses an understanding that following (presuming, for the purposes of this evaluation) his execution, that his corporeal form will cease to exist on the plane of existence he agrees everyone considers being "alive," but notes that his "spirit" will "hopefully (as he expresses)" return "to my Father in Heaven." He rationally discusses his desires for what he hopes happens with his remains, specifically noting that "if it were up to me, I would be buried in a small, modest wooden box in a Jewish cemetery somewhere in Tulsa," adding "I just would prefer they [ODOC officials] not cremate my remains." Given the totality of the available data to me, it is my opinion that Mr. Cole has a rational understanding that he is to be executed by the State of Oklahoma, and that his execution is currently imminent.

REPORT SUMMARY

Mr. Cole is a 57-year-old White male who was evaluated on an outpatient basis at the Oklahoma Forensic Center for a Mental Health Evaluation to "determine whether Petitioner has a 'rational understanding': 1) 'of the reason [Petitioner] is being executed'; and 2) [t]hat [Petitioner] is to be executed and that execution is imminent." Mr. Cole is able to communicate in a coherent, logical, and goal-directed manner regarding his pending execution. He is able to sufficiently and rationally discuss his understanding of the reason he is being executed, and that he is to be executed and that said execution is imminent. In my opinion, Mr. Cole does not currently evidence any substantial, overt signs of mental illness, intellectual impairment, and/or neurocognitive impairment that would preclude his competency related abilities regarding his pending execution. In fact, in my opinion, Mr. Cole's presentation with me during this evaluation appears largely (if not entirely) consistent with his presentation during prior evaluations of his adjudicative competence for CF-2002-597, dating back almost 20 years. Consistent with those prior opinions of his adjudicative competence, I

believe that Mr. Cole's presentation, particularly his discussion of religion and religious-themed topics, is solely the discussion of an overvalued belief system, and one that is frankly largely consistent with a religious belief system of millions of individuals who share said beliefs, and is not the product of a statutory-defined mental illness.

Again, at no point during his interview with me does Mr. Cole in his discussions about his religious belief system, ever attribute to himself any sort of supernatural, divine, mystical, or prophetic standing, meaning, or significance, and he routinely refers to himself as an earthly being whom simply enjoys (frankly relishes) discussing his religious belief system. He himself references that he likes and/or wants to discuss his religion and beliefs, and doing so is enjoyable for him. He does not express that his beliefs have any sort of obsessive quality to them (i.e., that he finds these beliefs distressing, and that if he does not discuss them that some sort of negative and/or catastrophic event will occur). Throughout the interview, despite his expressed desire to discuss his religious beliefs, I am always able to redirect him, with little difficulty, and he is able to manage said redirection without becoming distressed, frustrated, and/or irritable or agitated. At no point during my interview with Mr. Cole does he appear to ever lack any sort of capacity to engage in a discussion about his understanding of his pending execution. Overall, in my opinion, Mr. Cole appears to evidence that he can sufficiently and rationally discuss his understanding of the reason he is being executed, and that he is to be executed and that said execution is imminent.

Respectfully submitted,

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Competency to Be Executed Evaluation

Client:	Benjamin Cole
Dates of Evaluation:	February 16-17, 2016; May 10, 2016
Location of Evaluations:	Oklahoma State Penitentiary, McAlester, Oklahoma
Referral Source:	Michael Lieberman, JD. Oklahoma City, OK.
Date of Report:	October 13, 2016

REASON FOR REFERRAL:

Mr. Cole was referred for a psychological evaluation to document his current emotional and cognitive status, and to render a professional opinion as to whether he is currently competent to be executed by the State of Oklahoma.

PROCEDURES ADMINISTERED:

Mental Status Interviews and Clinical Observations; Review of Mr. Cole's collection of personal documents (16 standard boxes); Review of Accompanying Background Clinical Records & Evidence (see Appendix A)

I: Summary of Background Records:

Background

In brief, Mr. Cole was born into a family system where both parents were heavy users of drugs and alcohol before he was born, and his mother continued to drink heavily while pregnant with him. In this family Mr. Cole began using substances early, and was drinking alcohol by age 6. From there he went on to become a polysubstance user, which included huffing gasoline fumes and other toxic chemical

products. Mr. Cole's step-brother, Leonard O'Neil, reported that as a child Mr. Cole huffed gasoline for 1-2 years at a frequency of daily or sometimes once a week (Vol. I, #3, p. 314, Transcribed Interview).Throughout Mr. Cole's childhood he was severely abused physically and emotionally. Incest ran rampant in the family, as elaborated upon by Mr. Cole's step-sister Cherry Peirce (Vol. I, Affidavit, p. 374). Academically Mr. Cole was required to repeat kindergarten and he was placed in a Special Education curriculum for problems with his low reading and auditory comprehension skills. He was held back once again in 5th grade. In 6th grade his intelligence level was measured as showing a wide split between his verbal and nonverbal intelligence (Verbal IQ= 86; Performance IQ=113; Mean = 100 and Standard Deviation = 15). Discrepancies in measured IQ scores this large are not uncommon among individuals with organic brain problems. Such discrepancies indicate, as well, lateralization of brain functioning such that in Mr. Cole's case his language skills (predominantly left hemisphere) are far weaker than his rather high levels of skills related to visual-spatial-motor skills (predominantly right hemisphere). By the 8th grade he was also assessed as registering below average compared to his same-aged peers on standardized achievement measures.

By age 18 Mr. Cole drank heavily and was becoming increasingly isolated and withdrawn. After high school he experienced long periods of unemployment and worked menial jobs. At age 20 he sustained a serious closed head injury (hit in head with hammer while drinking with friends). He joined the U.S. Air Force but continued to demonstrate alcohol and impulse control problems, and he was afraid of being promoted from the rank of Airman E-2 to Airman E-3 (despite the fact that military promotion would provide extra pay and privileges, more opportunity for advancement and a greater degree of respect). His biological mother, as well as his brother, Robert, both described that Ben "snapped" while in the Air Force (Vol. I., #8, p. 11). During phone calls with him in 1993/94, for example, his communications were sounding increasingly bizarre as he told them the rock band "Slayer" was sending him subliminal messages to do things he did not want to do. He was ultimately discharged from the military after he received a two-year prison sentence in California for abusing his first son, Ben Cole, Jr.

After release from prison, Mr. Cole continued to show evidence of continued and progressive mental decline. By age 33 he was essentially homeless and adrift, and was living under bridges or in a tent by a river. He then lived in a common-law relationship with Ms. Susan Young. During that relationship they lost custody of her young son from a previous relationship, and they were both cited by child protection services for neglect. Mr. Cole's condition continued to deteriorate to the point he could not hold steady employment and he still drank heavily. In the brief union with Ms. Young the couple had a child, Brianna Victoria Cole (DOB: 3/27/2002). As reflected in the case files, Mr. Cole was subsequently convicted for first degree murder of Brianna Cole as an infant in the District Court of Rogers County, Oklahoma. Though originally offered a sentence of life without parole to avoid the death penalty, Mr. Cole rejected this plea offer and went to jury trial. Mr. Cole was found guilty at trial and was sentenced to death. He is currently on the H Unit at Oklahoma State Penitentiary ("OSP") in McAlester, Oklahoma. At the time of this evaluation, Mr. Cole is currently under a Stay of Execution in the State of Oklahoma pending the outcome of present investigations into the status of the death penalty in Oklahoma.

Prior Psychiatric Evaluations

There have been multiple psychiatric evaluations conducted of Mr. Cole over the past 13 years, beginning with early evaluations to assess his competency for trial. In parallel to these competency evaluations there have been several neuropsychological evaluations. These have provided the data required to request more sophisticated neuroimaging studies that confirmed the presence of organic brain lesions of the left hemisphere of Mr. Cole's brain.

Mr. Cole was initially evaluated at the Rogers County Jail by Dr. Kathy LaFortune, who worked for the Oklahoma Indigent Defense System ("OIDS"), on 2/13/03, to determine whether his attorney should hire

an expert witness to address his psychological disturbance at trial (Vol. I., #2, p. 198). At that time Mr. Cole was considered by Dr. LaFortune to be competent to proceed to trial though his attorneys, Silas Lyman and John Dalton (who also worked for OIDS) reported that he was unable to assist them in his defense.

Dr. Bill Sharp conducted a psychological evaluation at the behest of Mr. Cole's attorneys on 10/25/03 at the Rogers County Jail (Vol. I., #2, p. 208). During the evaluation Mr. Cole was reported to be paranoid and neuropsychological testing was recommended based upon the results obtained from neuropsychological screening measures.

Dr. Jeanne Russell was asked by Mr. Cole's attorneys to provide an in-depth assessment of Mr. Cole's social history and risk assessment (Vol. I., #2, p. 217). In her report of 5/27/04, she noted that 80% of the time he focused on religious topics and that he gets depressed on certain days of the month that remind him of his daughter's death and burial. At that point his religious discourse, though pervasive, was not yet considered of delusional proportions; rather, it was considered consistent with the fundamentalist church he had previously attended.

Based upon Dr. Sharp's recommendations, a comprehensive neuropsychological evaluation was conducted by Dr. Michael Basso on 6/15/04 (Vol. I., #9 p. 125). Dr. Basso further noted in his report Mr. Cole's prior history of head injury on the right forehead with a hammer. Dr. Basso concluded that he found a pattern of mild to moderate abnormalities in Mr. Cole's brain functioning, which included the following areas of impairment: impaired abstract visual reasoning, impaired simultaneous conceptual sequencing, impaired figural fluency, impaired verbal concept formation and impaired right tactile sensation. Overall, Dr. Basso concluded the presence of impaired brain functioning, which was maximally present in the left temporal-parietal region of the brain. He recommended further evaluation with a neurologist, as well as a magnetic resonance imagining study (MRI) and an electroencephalography (EEG).

Along with the above noted neuropsychological findings from both Dr. Sharp's screening assessment, and further quantified by Dr. Basso's full neuropsychological assessment, Mr. Cole's attorneys continued to struggle with whether he was competent to assist them in a meaningful and productive manner. They sought yet another competency evaluation. In a letter written to Judge Dwayne Steidley 8/18/04 (Vol. I., #2, p. 241), Dr. Samina Christopher reported upon her findings that Mr. Cole met the statutory requirements to stand trial and to assist counsel if he chose to do so. As with other competency reports in these earlier years, neuropsychological issues were not addressed.

The question of competency to assist counsel was again raised by Mr. Cole's attorneys, when Dr. Paula Monroe evaluated Mr. Cole on 8/30/04. On referral from attorney James Bowen, Dr. Monroe was asked to assess Mr. Cole's ability to understand the charges against him and to rationally assist counsel in his defense (Vol. I., #2, p.236). Mr. Bowen had been concerned about Mr. Cole's religious preoccupations as interfering with his ability to assist counsel. In this evaluation, Dr. Monroe found Mr. Cole competent to proceed to court.

Approximately three years later, Dr. Randall Price conducted a Competency to Stand Trial evaluation on 11/19/07 (Vol. I., p. 171, & p. 252), which included direct observations of the client –attorney interactions. Throughout the evaluation Mr. Cole spoke of little else but scripture, and told Dr. Price that he could not be interviewed about his past history since any discussion about it would be "like putting Jesus on the cross again and again, which is like doubting my own forgiveness." Throughout the evaluation he was likewise rambling in speech, grandiose and delusional. Noting the significant impairments in reality testing, as well as with communication and delusional thinking, Dr. Price opined

that while Mr. Cole did understand the factual basis of his case, he was unable to competently assist his attorney due to his perseverative focus on religiously themed delusions.

Dr. Raphael Morris provided a comprehensive psychiatric evaluation (dated 4/4/09) and found Mr. Cole to be incompetent to assist counsel. Mr. Cole was diagnosed as suffering from schizophrenia, paranoid type, with grandiose delusions manifested as hyper-religiosity (Vol. I., #2, p. 261). In this report Dr. Morris had to rely heavily upon collateral sources since Mr. Cole was too delusional to make rational sense.

Six years later, on 1/21/15, Dr. Morris evaluated Mr. Cole again and updated his previous evaluation of 4/4/009. In the update he noted that he first met Mr. Cole in 2008, and that in 2009 he opined the diagnosis of schizophrenia, paranoid type. He elaborated that Mr. Cole had demonstrated mental illness even before 2003, which had persisted to the present. He opined that Mr. Cole lacked the capacity to participate in habeas proceedings and recommended further mental health evaluations. In this affidavit Dr. Morris further noted that because Mr. Cole had not received any treatment for the schizophrenia over the six years since he had evaluated him, that he has deteriorated even further, as demonstrated by his prolonged periods of refusing to come out of his cell, refusal to meet with evaluators or his legal team, and that he has stopped bathing resulting in extremely poor hygiene. Dr. Morris also attempted to conduct an evaluation to determine Mr. Cole's competence to be executed and noted that he was not allowed to meet with the defendant in his cell to observe him there. Dr. Morris concluded that there was even more objective evidence of paranoid schizophrenia than he had observed in the 2009 evaluation. Dr. Morris also concluded, as well, that there was more evidence that Mr. Cole suffers from a neurochemical illness, a conclusion that has been supported by prior neuro-imaging studies. Dr. Morris also recommended that follow-up PET Scan and MRI studies be obtained. Finally, as Mr. Cole's execution date loomed near, Dr. Morris indicated that given all of these clinical considerations, that Mr. Cole's competency to be executed must be questioned.

Prior Neuroimaging Studies

Indicated below are the results from a series of neuroimaging studies that were conducted following on prior recommendations for advanced neuroimaging studies to clarify the pathognomonic findings obtained from the neuropsychological testing.

Dr. John Hastings, M.D. of Neurologic Medicine reviewed the results from Mr. Cole's MRI taken on 9/22/04. Dr. Hastings reported finding an 11 mm lesion of the left hemisphere, located deep in the white matter near the internal capsule (Vol. I., #2, p. 249). The lesion was non-specific but had a configuration that might be seen in a multiple sclerosis tumor or small abscess. No atrophy or shrinkage was observed as might be seen with chronic alcohol or a degenerative disease process. Further studies were recommended to determine if the lesion is static or progressive (2/13/07).

This same MRI of 9/22/04 was reviewed by Dr. Matthew Powers, M.D. of Powers Radiology, P.C. on 2/3/07. Dr. Powers provided an essential recapitulation of the report provided by Dr. Hastings (Vol. I., #2, p.251). Dr. Powers confirmed the radiological finding of an 11 mm lesion within the deep white matter of the brain. This was considered a large lesion. Findings further noted that disruption of these white matter fiber tracts in the brain tissue can result in significant behavioral dysfunction due to the interruption of electrochemical signal transmission across brain regions, resulting in impairments in information processing and a break down in the regulation of complex behavioral functioning. The cause of these defects in the frontal-temporal region were considered unknown. In this report follow up recommendations were offered: (1) a second MRI was recommended because the 11 mm lesion could be a tumor and a new MRI would help determine if the lesion is static or is continuing to grow; (2) An EEG was also recommended since the obtained results were also considered consistent with a potential seizure

disorder; (3) a PET (Positron Emission Tomography) Scan, which is the most accurate and useful form of brain scanning; (4) and finally, a fludeoxyglucose study (FDG) of local glucose metabolism.

In her affidavit of 1/16/15, Dr. Anne Hayman, a Board Certified Radiology Specialist, observed of the findings obtained with Mr. Cole's MRI images: "His brain renders him unable to respond in a normal way to his environment. The lesion and symptoms are worsening." She elaborated that the lesion could be "progressive structural and biochemical abnormalities that severely impair his ability to interact appropriately with his surroundings" (Vol. I., #2, p.300). She also noted that the lesions was detected over 10 years ago and has progressed, and that Mr. Cole's symptoms have worsened. Dr. Hayman recommended an MRI and PET scan. (1/16/15)

In the Declaration of Dr. Ruben Gur, Professor at the University of Pennsylvania School of Medicine and Senior National Institute of Health Researcher (NIH), he reviewed the raw data from the neuropsychological evaluation conducted by Dr. Basso. Dr. Gur applied these data to the Behavioral Imaging Algorithm, a computer program which helps to localize brain damage based upon various neuropsychological data (Vol. I., p. 292). Dr. Gur concluded that these findings indicated that Mr. Cole's neuropsychological test performance was well below average, with pronounced deficits identified in the frontal region of the brain, and with greater impairment in the left hemisphere. Significant damage to the left frontal-parietal lobe was identified. This pattern of neuropsychological findings was also noted to be consistent with findings of schizophrenia. Dr. Gur's final diagnosis: organic brain damage of moderate to severe levels resulting in neuropsychiatric illness. (5/11/09) It is also noted, parenthetically, that Mr. Cole's attorneys now inform that Mr. Cole is beginning to drop things frequently, a behavior often indicative of possible deterioration in gross motor control.

At Clemency Hearing on May 14, 2015 testimony was provided by evaluating psychiatrist Dr. Morris and neuroradiologist Dr. Anne Hayman. Dr. Morris noted progressive structural and biochemical abnormalities with Mr. Cole's brain that impair his ability to interact appropriately with his environment. There are structural lesions of the left globus pallidus, along with his chronic paranoid schizophrenia and left basal ganglia, and a prominence of "negative symptoms" of schizophrenia- are all related to abnormalities in the left global pallidus. Dr. Morris further opined at the Clemency Hearing that Mr. Cole would have been incompetent at his trial and that at that time he was suffering from schizophrenia, paranoid type, and that his delusions and paranoia would have prevented him from having coherent and rational discussions with his defense attorneys.

Previous Attorneys & Legal Staff

Mr. Cole's past and current attorneys have repeatedly noted that before, and especially after his capital sentence, that Mr. Cole has not been able to confer with them in a rational and coherent manner that has been of assistance with the case. Essentially, legal defense teams have had to work on his defense without his input. Each defense team after the death sentence have encountered the same set of issues: namely, his persistent religious delusions and preoccupation with the end of the world, all of which has made it impossible to hold rational conversations with him about his case. His litany of irrational decisions and months of non-communication with his attorneys, as well as his complete detachment from the legal process about his case, have been noted repeatedly across the years by his various legal teams as well as their investigators. Marked deterioration in Mr. Cole's functioning is observed particularly after 2008/2009.

Ranada Gentry had been employed as an investigator for the Office of the Public Defender and met with Mr. Cole (Vol. I., Affidavit, p. 380. (10/14/08). She described that on a visit to Mr. Cole in prison that he asked her about a book entitled, "*Strong's Concordance.*" She described that he was so excited about this book that he was behaving "similar to a 4 year old in a candy store" amidst his rapid breathing and

shaking. She elaborated that while she had had clients with similar religious preoccupations, she had never seen one as extreme as Mr. Cole.

Former defense attorney Gordon Lynn Burch III (Vol. I., Affidavit, p. 159) (1/13/15) described how when he had worked on Mr. Cole's case he had been concerned about Mr. Cole's ability to understand legal issues when the legal team tried to explain them to him. At that time he thought it was in Mr. Cole's best interest to plead guilty to avoid the death penalty and he had repeatedly tried to explain these sentencing options to him. However, Mr. Cole would not talk of anything but religion. He described that throughout his trial he never considered Mr. Cole competent to go to trial. He recalled that throughout his trial Mr. Cole's expression never changed and he remained completely detached from the court proceedings as they unfolded.

Attorney James Bowen (Vol. I., Affidavit, p. 162, p. 352) (1/13/15), who was Deputy Division Chief for the Tulsa Capital Division of the Oklahoma Indigent Defense System, described that competency issues at trial were apparent for some time because Mr. Cole could not assist in his defense due to his religious preoccupations. He described that during Mr. Cole's trial his only body movement was to blink his eyes. When the jury's verdict was read aloud he did not move.

Vicki Werneke, who had been the Chief of the Capital Post Conviction Division (CPC) of the Oklahoma Indigent Defense System (Vol. I., Affidavit, p. 165) (1/15/15) described similar experiences as described by the other referenced professionals as lead counsel. She noted that the only conversations she had with Mr. Cole were on religion. In these conversations she could not follow his thinking. She noted that she has had clients with severe mental illness issues before; yet, in her experience, Mr. Cole withdrew deeper into himself than the others with severe mental illness. Other inmates had told her about how Mr. Cole never came out of his cell and kept his cell dark inside all the time.

Anastasia Cesario had served as a Research Assistant for the Capital Post Conviction Division of the Oklahoma Indigent Defense System and had been on the defense team with attorney Vicki Werneke (1/25/07). She had interviewed Judge Steidley regarding Mr. Cole's behavior in court (Vol. I., Affidavit, p. 167) (2/26/07). On a scale of 1-10 (with 10 as worst) she reported that the judge placed his observations of Mr. Cole's dissociated behaviors at an 8-10 compared to others he had observed before the court. Judge Steidley told her he ranked Mr. Cole as demonstrating the highest level of disturbance he had seen in his court.

Timothy Wantland, JD had sat in on two days of the trial proceedings, and described that Mr. Cole had seemed distant and disinterested in them. It appeared to Mr. Wantland that Mr. Cole had impaired mental capacity (Vol. I., Affidavit, p. 170)2(/21/07).

Assistant Federal Public Defender T. Kenneth Lee represented Mr. Cole from 11/7/08 until he left the Federal Public Defender's Office on 8/8/14. (Vol. I., Affidavit, p. 180). As with other legal counsel, Mr. Lee's efforts to communicate with Mr. Cole were met with religious outpourings that were not productive, and which provided his legal team with no assistance. By the end of 12/08 and through 2009, Mr. Cole started refusing to meet with his legal team altogether. In 2009 Mr. Cole showed a distinct pattern, wherein if he came out of his cell to meet with counsel he only stayed a few minutes or would refuse to meet altogether. Most meetings were brief, lasting less than five minutes. Mr. Lee wrote an email to Mr. Cole's case worker at the prison who in responding acknowledged to Mr. Lee that Mr. Cole had not left his cell for over 2 ½ years. During his five years of representing Mr. Cole, Mr. Lee reported that he never had a substantive conversation with him that had not been eclipsed by his religiosity. Mr. Cole was never engaged in the case, and was never able to assist counsel in legal proceedings. He described how Mr. Cole's condition had regressed over time such that Mr. Cole's letters deteriorated from writing in complete sentences to producing mere fragments of thoughts written on scraps of paper. Mr.

Lee noted that Mr. Cole did not think he would be executed, as he made statements of the like that, "God would open the doors of the courthouse after his trial and he would be set free". Mr. Lee is not confident Mr. Cole understands the significance of being executed.

Anna Wright (Vol. I., Affidavit, p. 189) (1/13/15) has been employed with the Federal Public Defender's Office Habeas Corpus Unit since 11/08, and has reviewed the records collected on the Cole case. She described that Mr. Cole has been increasingly withdrawn since when she initially met him in 2008. He never made calls to their office unlike many clients. Over the past three years she has observed that he has sent small fragments of paper with only partial and incomplete sentences that never contained any reference to his case or court proceedings. She noted that "none of Mr. Cole's most recent notes indicate he is aware he is scheduled for execution." His most recent notes are nearly identical in content: "he asks for spare change for "important projects."

As Mr. Cole's execution date moved closer Ms. Wright described how on 1/18/15, for example, that his attorneys explained to him that he will have two more chances to get his religious message out; yet, nothing his attorneys said to him about his pending execution provoked any response or bodily movement. As she put it: "[e]ven in the face of our direct statements and queries to Mr. Cole, he never gave the slightest indication that he had any understanding, rational or irrational, of his pending execution or the reason for it." She elaborated that Mr. Cole's religious preoccupations interfered with all efforts at providing him with the basic information about his execution at the 35 days mark prior to the execution date. When discussing with Mr. Cole the basic provisions for his execution, such as what would be the content of his last meal, who he wanted to be on his visitor's list at his execution, who he wanted to assume the custody of his belongings after his death, and with other such final details as well, he would respond: "that's not really been decided [by God] yet", or "that's not really decided either." Ms. Wright further elaborated upon the frustration of getting Mr. Cole to realize that these lengthy discussions with him about his execution were not made in the abstract but pertained specifically to him personally: "I left the visits feeling like Mr. Cole did not appreciate the situation he was in regarding his upcoming execution and the process/arrangements surrounding this. Anything from Mr. Cole that may have initially appeared to reflect understanding was quickly diminished because of his underlying beliefs, which he could not explain." (1/29/15 Affidavit)

Prison Staff

Available records from the Oklahoma State Penitentiary at McAlester (OSP) were also reviewed. Mr. Cole's years of very poor hygiene and unwillingness to leave his cell are behaviors thoroughly documented by prison staff. Most of these clinical notes, however, reflect little more than casual observations of Mr. Cole's daily behavior in passing during the routine course of administering the prison's daily tasks. As Mr. Cole typically spent his entire day in his cell, and interacted with virtually no one, and since he did not create a behavioral disturbance that required staff attention or special intervention, his days went largely unnoticed and sparsely documented.

By 2014 Mr. Cole's prolonged isolation, abhorrent hygiene and deeply regressed and vegetative behavior could no longer be ignored by the prison clinical staff. Patti Stem, Clinical Coordinator with the Oklahoma Department of Corrections (Vol. I., # 10, p. 129), reported in the Mental Health Status Review (8/29/14) that Mr. Cole was presenting a low level of active psychotic symptoms, and that while he had previously refused meals (for self-reported religious reasons) he was now eating. Ms. Stem also noted that beginning in January 2014, Mr. Cole was showing behavior that evidenced clinical decompensation. Among other observations, she noted that at the current time of writing her clinical note that Mr. Cole had refused to engage with her. Other officers noted that Mr. Cole rarely spoke and would communicate with a simple "Yes' or "No" throughout daily routines.

The Department of Corrections Log (Vol. I., #11, dated 7/30/14; p. 401) documented numerous instances from March 2014, and thereafter, wherein Mr. Cole either refused to be seen by a staff member, remained mute when spoken to, refused to be weighed or accept medical care, and demonstrated increasingly poor eye contact and social withdrawal. In light of these staff observations reflected in the DOC Log, which had been entered by multiple observers on the H Unit, Dr. Kirby noted on 3/11/14 (Vol. I., p. 143) that "schizophrenia is a possible diagnosis" for Mr. Cole. Dr. Kirby went on to document his rationale for that inference by citing specific symptoms that are consistent with the diagnosis of schizophrenia. In his charted clinical notes, Dr. Kirby further exposed a clinical contradiction in the prison records. He indicated that the current mental health classification level as "zero" for Mr. Cole appeared incorrect; noting that if Mr. Cole had been designated as having a mental health level of "B" (implicating a higher level of severity) at age 39, then at age 49, his current mental health classification level could not now logically be at zero (Vol. I., p. 144-145). In other words, Mr. Cole's mental condition had not significantly improved over the last decade as would be implied by the classification rating in the records. Rather, it had declined.

As with other observers on 7/28/14 Dr. Patst also noted: "increasing mental health concerns" (Vol. I., p. 438).

As Mr. Cole's planned execution drew near, on 1/26/15 (Vol. I., p. 640) Patti Stem, Clinical Coordinator, accompanied the Prison Warden to meet with Mr. Cole. Ms. Stem documented the transaction following Mr. Cole's refusal to participate in the 35 Day Notification Hearing. Mr. Cole is described as explaining to both Ms. Stem and the warden that he did not come to the previous hearing because he was not prepared to make decisions pertaining to visitation, his last meal, and other details associated with his execution. He also told the warden he had to have a full body burial.

On 2/11/15 Patti Stem, Clinical Coordinator, again accompanied the Warden to CHSA to meet with Mr. Cole again and documented the transaction (Vol. I., p. 635). This note carefully documents how the warden had asked whether Mr. Cole knew that when an execution date was set that he would be executed by lethal injection; and he said "yeah." When asked if he knew why he was being executed he answered, "Yes."

A shift in the availability of Mr. Cole's records occurred in April 2015, effectively closing off any opportunity for his legal team to review them. On 4/6/15 (Vol. I., p. 5220) the Oklahoma Department of Corrections provided a Release of Protected Information document that authorized the release of medical records which reads as follows: "Entire medical record except mental health." A Mental Health Progress Note of 4/16/15 (Vol. I., p. 629), for example, further indicates that Mr. Cole agrees "to have his physical medical records [released], but apparently not his mental health." And that "he said that he had no needs from mental health or medical at this time, that he had seen enough doctors for a lifetime."

Despite Mr. Cole's reported unwillingness to have his mental health records released some were, nevertheless, released:

Beginning on 7/23/15 the Clinical Coordinator, Patti Stem documented the Warden's visit to Mr. Cole's cell and noted that he OK'd the execution date that had been set. In this detailed note, Mr. Cole is described as having many questions, and recalling numerous details from previous discussions when an execution date had been set. He is reported to have asked detailed questions, such as whether he would have to be cremated. He is reported to then correct himself by adding that, "I understand that isn't possible." He also asked whether he could have a Messianic Rabbi conduct his funeral. When asked if he knew why he was going to be executed, he responded, "my crime;" when asked what his crime was he responded "murder." He acknowledged he would cooperate with the 35 Day Notification Hearing (Vol. I., p. 723).

On 9/1/15 Clinical Coordinator, Patti Stem, again wrote very detailed observations of Mr. Cole's behavior during his 35 Day Notification Hearing and thereafter (Vol. I., p. 616). Ms. Stem reported that during this hearing Mr. Cole discussed details about the execution as well as wanting Kosher food for his last meal. At the 35 Day Notification Hearing she described Mr. Cole as clear and rational and able to talk about his spiritual advisor, his desired witnesses to the execution, as well as the details of the disposal of his body. He signed his name on the document as opposed to an "X" as on previous occasions. She elaborated that he gave no evidence of a thought disorder, was not attending to internal stimuli nor was he experiencing auditory or visual hallucinations. He acknowledged anxiety about the execution process and was provided with information about the availability of a mild anti-anxiety medication if he wanted it. Mr. Cole stated he used prayer and scripture to combat anxiety. The 35 Day Hearing and following assessment were noted as taking two hours to complete, during which Mr. Cole was described as actively engaged in the discussion.

The Oklahoma State Penitentiary (OSP) Execution Log provides a running observational assessment of an inmate's behavioral status every 15 minutes during the 35-day period immediately prior to the scheduled execution date. Mr. Cole's Execution Log began on 9/2/15 and stopped at 11:38 on 10/2/15 when an Indefinite Stay of Execution was implemented. Throughout this observational period during the countdown to his execution Mr. Cole primarily slept, sometimes did not eat, and he refused attorney visits.

On 9/15/15, while Mr. Cole would have been under the 35 day countdown to execution, it was noted on a Mental Health Assessment Form that he *crawled* [italics not original] to the cell door as he was provided with photos of the Holy Land and was appreciative of them. (Vol. I., p. 603). Such crawling behavior was reported again on a Mental Health or Mental Status Review, dated 9/24/15 (Vol. I., p. 594) which noted "Offender Cole got out of bed and crawled to the door to give this QMHP a piece of paper with updated phone information on it for his son." The writer of this clinical note, nevertheless, indicated that Mr. Cole is "feeling really good" this morning.

Prison Cellmates

There are several affidavits from Mr. Cole's former cellmates on H Unit at OSP. Each of these former cellmates found Mr. Cole's behavior to be bizarre and his hygiene highly offensive.

Former cellmate, Carlos Cuesta Rodriguez, noted in his affidavit (Vol. I., p. 148, 1/21/15) that not once in his entire year with Mr. Cole did he observe him attend to his hygiene by taking a shower or brushing his teeth. Throughout this year Mr. Cole talked to no one, kept to himself, and always had the TV on to a religious channel. He received stacks of mail from religious people throughout the world that Mr. Cole piled up in stacks within the cell. He would sometimes read his bible or write on the pages. As inmate Rodriguez succinctly put it: "Cole was not in his head."

Inmate Michael Edward Hooper had been Mr. Cole's cellmate for seven months, from 3/05 to 10/05. (Vol. I., Affidavit, #3, p. 354). Inmate Hooper variously described Mr. Cole as "repulsive", "anti-social, stayed to himself", "kinda [sic] nutty", "very moody" or "off in another world." Inmate Hooper described that he related to Mr. Cole in the same manner as he would to someone with Alzheimer's disease in a nursing home. Mr. Cole's hygiene was poor and inmate Hooper tried to show Mr. Cole how to wash himself. He described that Mr. Cole would go into what appeared to be "trance-like states" quite often. Mr. Cole preferred to keep the lights off and live in the dark. When watching television he felt that Mr. Cole couldn't follow the story being shown on the screen, that he was simply watching the visual movements without understanding anything else about the plot or characters. Mr. Cole would go on fasts, which ranged from one to 20 days in duration. Inmate Hooper said that Mr. Cole swore: "God put him in

prison and didn't seem to acknowledge the real reason he's here. He thinks God is going to release him from prison and says God took his family away." In October of 2005 he described how Mr. Cole attacked him, which led to Inmate Hooper being transferred to a different cell away from Mr. Cole. He described Mr. Cole's assault: "it wasn't him coming at me swinging, it was him coming at me with claws and he didn't know what to do." He noted that "I really don't think Mr. Cole understands the seriousness of the situation. He lives in his own little world and thinks everyone needs to take care of him."

Review of Transcript of Proceedings on 8/28/15 before Judge James Bland. (Begins on p. 849).

This is a very long and complex transcript. Provided here are but a few of the poignant exchanges with Mr. Cole in the courtroom that serve to illustrate aspects of his thinking as it pertains to the complex litigation about his future execution.

During questioning by attorney Michael Lieberman, one of Mr. Cole's defense attorneys, Mr. Lieberman pulled up his chair next to him in order to ask questions and to hear Mr. Cole's barely audible and frequently mute responses. Astonishingly, Mr. Cole said to the court that Jesus was coming back *today* [italics not original] (Vol. II., p. 868). Judge Bland asked Mr. Cole if he was aware that an execution date had been set, to which Mr. Cole replied: "October 7." "Go home. To be with Jesus. (Vol. II., p. 872)." Judge Bland asked him if he understood why he was sentenced to death; and Mr. Cole replied "death of daughter" (Vol. II., p. 873). On the one hand, it would be simple to assert that based upon Mr. Cole's succinct answers to Judge Bland's questions about execution that he does, in fact, know he is to be executed and why. Yet, if Mr. Cole believed that Jesus was returning "today," upon that very day in which he sat in the courtroom, then it cannot logically follow that he accepts that he would, in fact, actually be executed on the future date of October 7th. By Mr. Cole's logic he cannot be executed- he would have been taken by Jesus well before the execution.

Federal Public Defender Investigator Julie Gardner testified that throughout the case investigation Mr. Cole has not been able to assist his attorneys, and that he will talk exclusively about his ministry and religion (Vol. II., p. 878). She further elaborated upon the thousands of pages of Mr. Cole's religious materials, which includes 35 Bibles and two Concordances, he has collected since incarceration (Vol. II., p. 879). She has had to coordinate with prison officials to periodically collect these materials from Mr. Cole's cell since they tend to accumulate in large stacks in the cell. She admitted Mr. Cole has remained focused upon getting his spiritual message out, but she has not been able to understand from him what that message is. He has named his ministry "Seed Faith Ministries Highways and Byways Ezekiel Shepherture (sic)." The content of his messages focus on the "end times" for the world, and he has discussed other issues such as the "Bakersfield Prophesy" (Vol. II., p. 889). Specifically, the Bakersfield Prophesy refers to when Mr. Cole had become "born again" in Bakersfield, California in 1988/89. He had been at a revival meeting and someone a few pews ahead of him had told him: "the world will know you." When this statement was made to him a second time he became excited because he thought he was going to bring glory to God's name (Vol. II., p.893).Ms. Gardner further testified that Mr. Cole thought that his crime and execution, along with all the media coverage of both, was partial fulfillment of this prophesy, and he felt that God had made him do it [the homicide against his child] because he had backslidden twice from God.

Ms. Gardner further elaborated that Mr. Cole had thought he was "going home [to God]" today, in reference to Mr. Cole's above referenced assertion that Jesus was returning on this very day in time (Vol. II., p. 899). She described that the defense team had tried to see if Mr. Cole really understood that October 7th was his scheduled execution date. She described how when confronted with this specific information, "He was quiet for a while, did some sort of weird giggle, and then said 'you just have to wait, the Lord likes to show up sometimes at the very last second,' is what he said. Then he cited Luke 21:36 (Vol. II., p.

905)." The legal team then went through the biblical verse with him but still had no clear idea if Mr. Cole truly understood that he was going to be executed on October 7th.

The court denied the petitioner's request for the court to order the Department of Corrections to have the defendant sedated and transported for medical tests. The court also found no evidence the Warden had abused her discretion in the case with her determination that Mr. Cole was competent to be executed. Yet the court also acknowledged that it found some evidence that supports the position that the defendant is not competent or sane (Vol. II, 1097).

II: Evidence Review of Ben Cole's Personal Documents (consisting of 16 standard storage boxes of religious-themed materials (various bibles, books, pamphlets, tracts, post cards, essays, and hand written notes signed either by Mr. Cole or written by others to him)

The following clinical inferences are drawn from a review of these voluminous materials:

1. Mr. Cole is deeply obsessed with religious materials and he maintains his belief that he has a religious ministry. The nature of his religious preoccupations is consistent with the hyper religious delusions of grandeur that have been integral to his paranoid schizophrenic condition, and which has been in evidence for many years. These religious ideas are fantastical, apocalyptic, and on the extreme fringe far outside the mainstream of religious beliefs. These ideas are amplified and reinforced by his belief that God speaks directly to him. He also made numerous and detailed notes about prison canteen prices which became more intricate over time, often crowding many figures, symbols and lists of items onto a small slip of paper.

2. There has been superficial correspondence between Mr. Cole and various evangelical ministries throughout the United States, and with other writers internationally, who have reached out to him through various religious missions to provide him with their emotional support and pen-pal type correspondence. It is noted that in the early years of this correspondence, Mr. Cole's letters were written in a manner that was relatively clear, cogent and logical. In that correspondence he would often request money for stamps or stationary to support his continued efforts to correspond with various ministries. In late years, of course, his correspondence lacked the clarity and rationality of earlier years.

3. Mr. Cole demonstrates a very idiosyncratic method of making notations and cataloging all of his incoming correspondence regardless of the source. Over time this notation system showed less stylized cursive, and became increasingly complex and decipherable only to him. It is noted that a reversion to the use of increasingly cryptic and secret codes, or symbols, is a common symptom manifestation among chronic paranoid schizophrenics who can go on to develop a language system that consists of autistic logic and symbolism understood only by themselves and without shared social consensus.

4. Mr. Cole received from a wide variety of sources a large volume of religious books, pamphlets and tracts over the years. However, he seemed to have actually read very few of these materials. There was an absence of any kind of markings in most of the materials, or indications of turned or creased pages, or any other indications the materials had been handled and read. Mostly these materials were collected, cataloged, and stored in his cell but did not appear to have been read.

5. Those materials that were apparently read were very short religious tracts with less than 10 pages of content, or were animated cartoon type strips that convey a biblical theme. Given his documented educational history of reading problems, and low average verbal intelligence, it is

not surprising that this elementary level of reading material would be what he actually tried to read.

6. It appears that Mr. Cole kept all of the materials he received and threw nothing away. This hoarding behavior resulted in the prison facility needing to periodically request that Mr. Cole's attorneys come and take all of the materials out of his cell as the materials exceeded the amount inmates are allowed to keep pursuant to Department of Corrections regulations. Materials taken out of Mr. Cole's cell included empty plastic food wrappings pressed among his belongings, along with some of the books wrapped in cut-out paper bags.

7. Mr. Cole's penchant to collect everything and discard nothing from his cell is also consistent with classic hoarding behaviors observed among the obsessive compulsive conditions. The hoarder typically assumes they cannot part with anything since it may be needed later.

8. In his early years of incarceration Mr. Cole's penmanship can be described as generally neat, crisp and precise. In later years his writing shows crowding tendencies, indicative of increasingly impaired abilities with planning, organizing and sequencing written materials. Increasingly more information will become crowded onto a single page, or small corner of a page, comparable to micrographia (sometimes observed in neuropsychiatric conditions).

9. When Mr. Cole reviewed written materials/publications from earlier years (2005, 2006, 2007) his basic cognitive information processing abilities appeared relatively intact, as evidenced by his ability to underline biblical references on the pages, circle meaningful words, or make coherent notes in the margins. His cognitive processing skills became more impaired over time after those early years.

10. The themes and orientation of the religious literature Mr. Cole had requested from various ministries to send him were principally devoted to prophesy and apocalyptic themes, and other variations on the "end times." Over time, the content of the materials he requested were increasing divergent from mainstream religious themes, and moved more to the quasi-psychotic fringe of religious ideas. Among the fringe documents included numerous tracts of pseudo-science speculation, combined with apocalyptic themes of world destruction, which involve futuristic technologies that read like cartoons or elementary school-level pulp-fiction. These materials would appeal to an unsophisticated mind.

11. Mr. Cole requested numerous documents that pertain to popularized urban myths, and conspiracy theories. In an article in the New York Times (8/9/06) regarding universal health coverage, for example, Mr. Cole wrote comments in the margins about how this could be the forerunner of the biblical "Mark of the Beast" and made other apocalyptic notations about this topic.

12. There were few documents that contained biographical notations in the margins. Those that exist demonstrate copious notes indicating that the material he was reading had strong emotional resonation for him. In one document, for example, titled *"Dealing with Hindering Spirits"*, Mr. Cole underscored passages that pertain to demonic attacks. Such notations were not found in other texts. Though highly suggestive, firm conclusions cannot be drawn from this single text regarding whether Mr. Cole has ever felt personally attacked by demonic forces; though such biographical notations such as this one would certainly raise such questions.

13. There is a strong suggestion that at times Mr. Cole has tried to find existential meaning in his suffering while in prison. He would underline passages that describe how God guides us and

exposes us to suffering to wake us up spiritually, or how sinners can be forgiven and those who suffer from their guilt "will be given gladness of heart."

III: Mental Status Interview and Clinical Observations:

2/16/16. 1st Visit. 1.0 hour total time; Attempted Clinical Interview with Mr. Benjamin Cole- accompanied by Attorney Michael Lieberman and Investigator Julie Gardner:

At the H Unit at OSP, Supervising Officer J. Whala reported that Mr. Cole would not meet with us. Mr. Lieberman discussed with Officer Whala the manner in which Mr. Cole had been asked about whether he would agree to the visit. Officer Whala reported that he told Mr. Cole that his attorney and a doctor were here to meet with him. Officer Whala agreed to Mr. Lieberman's request to ask Mr. Cole for a second time if he would meet. Officer Whala returned with the same answer that Mr. Cole would not meet with us as requested. Officer Whala was informed that we would return tomorrow for another attempt to interview Mr. Cole and Officer Whala agreed to convey this information to Mr. Cole.

2/17/16. 2nd Visit. –2.0 hours total time. Clinical Interview with Mr. Benjamin Cole- accompanied by Attorney Michael Lieberman and Investigator Julie Gardner:

Mr. Cole was interviewed in H Unit's interview room, which was equipped with a table, four chairs and several stools situated behind the chairs. The walls were of an asbestos type material that completely insulates the walls. There was a large viewing window that looks outwards to an interior hallway within H Unit.

Clinical Observations of 2/17/16 Interview:

Mr. Cole was wheeled into the interview room in a wheel chair by one of the H Unit guards. He was in shackles on his feet and his hands. He was dressed in roughhewn clothing that appeared to be comparable to sweat clothing. He appeared very unkempt and had a long scraggly beard. His hair was very long and unwashed in a thick mat with what appeared to be a partial pony tail. He appeared very psychologically regressed and vegetative. He did not appear oriented in any sphere (time, place, person or situation). It was difficult to tell if Mr. Cole was actually asleep or not as he kept his eyes closed throughout the contact. It was not possible to tell if he was responding to internal stimuli, though there was no evidence of grimacing, mumbling to himself, or any other mannerisms typically correlated with this phenomenon. In the wheelchair he sat slumped over, leaning to the left, though still maintaining a very rigid posture. Such behaviors are commonly observed in the catatonic states, or other forms of neuropsychological compromise. His fingers were curled partially inward toward the palms, not unlike individuals with cerebral palsy. His head hung low and rested against his chest. Mr. Cole rarely made a verbal statement and when he did his speech was barely audible. He made vocal grunts when he was answering in the affirmative to a question. He never made eye contact with anyone. Most often he remained silent and non-responsive to any question posed to him. His lips did not move after he answered the first two questions (described below). After that he made no speech sounds whatsoever. These are the two questions posed to Mr. Cole that he did answer:

Question #1. Ms. Gardner opened the interview by asking Mr. Cole if he was in pain or upset? Mr. Cole replied: "just sleeping."

Question #2. Mr. Lieberman asked Mr. Cole if he recalled that he had been told that we were here yesterday? Mr. Cole replied: "not really."

Interactional Sequence following the above two questions that Mr. Cole answered:

Mr. Lieberman then proceeded to introduce this examiner and offered a general overview of why he was here. Mr. Lieberman further elaborated to Mr. Cole that they have been worried about him, and they brought Dr. Hough along to help them figure out some issues about him- specifically, whether there is a mental health issue with Mr. Cole, or whether he is so devoted to God it is hard to communicate with him. Mr. Lieberman further elaborated that they have also asked Dr. Hough to help them investigate the question of whether he is competent to be executed. Mr. Lieberman then asked Mr. Cole if he understood what had just been said to him. Mr. Cole did not respond verbally or physically to any of these questions or comments directed to him. It is, therefore, unknown if Mr. Cole understood what, if any, portion of Mr. Lieberman's comments directed to him.

After Mr. Lieberman had finished speaking to Mr. Cole, this examiner introduced himself to Mr. Cole, and offered a brief summary of his background and the purpose for today's interview. He went on to explain more fully that he has been asked to address the issue of whether he is currently psychologically competent to be executed. Mr. Cole was informed that the evaluation would consist of interviews, psychological testing if applicable, and a review of all available case evidence. This examiner then informed Mr. Cole that he had also brought an Informed Consent Document which he would like Mr. Cole to review with him, and after having all of his concerns and issues addressed, to please sign the document. He was further informed that the informed consent process is an ongoing process which he can revoke at any time, and that he should always feel that it is appropriate to raise any questions or concerns he may have about the evaluation and informed consent going forward. Thereafter, there ensued a long silence and Mr. Cole did not respond to this.

Mr. Lieberman then attempted to recruit Mr. Cole's attention by reading some scriptures from a bible he had brought with him. Mr. Lieberman read aloud from one of Mr. Cole's favorite biblical passages: Isaiah 53:5. Mr. Cole did not respond. Mr. Lieberman then read from Romans 8:28. Again, Mr. Cole did not respond. Mr. Lieberman asked him if he could help him understand the passages? Again, Mr. Cole did not move or respond.

Ms. Gardner asked if he has been eating better since he looked like he had been putting on some weight? Mr. Cole did not respond.

Mr. Lieberman asked where he wants his Bible's to be sent? To his mother? Ben Jr.? Mr. Cole did not respond.

Mr. Lieberman asked if he has met the new warden yet? Mr. Cole did not respond.

After a very long silence this examiner tried to return to the competency issue again. In an attempt to elicit his factual understanding regarding the specific issue of competency to be executed, the following questions were asked:

(1) "Ben, why does the state intend to execute you?" Mr. Cole did not respond.

(2) "What did you do that the state intends to execute you for?" Mr. Cole did not respond.

At that juncture this examiner decided to back up and try to elicit a more basic understanding of Mr. Cole's mental status orientation. He was asked the following questions: "Where are you located right now?" "What is the current date and time?" "What is the year?" "What is the name of this building you are in?" "Why are you in this building?" "What is your understanding of the situation and purpose of this meeting with us?" Mr. Cole was non-responsive to all questions.

Ms. Gardner commented about how Mr. Cole is a man of faith and the difficulty he has had in getting kosher meals. Mr. Cole did not respond to this comment.

Ms. Gardner asked Mr. Cole if he recalls when he was fasting in order to get his kosher meals? Mr. Cole did not respond to this question.

Ms. Gardner again asked if she can help him as he looked like he is in pain; and then asked whether it hurts to move? Mr. Cole did not respond to either of these questions.

This examiner then returned to the competency to be executed questions: "When you were talking to the warden and she asked you if you knew why the State was going to give you a lethal injection- do you recall what you said?" To this question Mr. Cole appeared to raise his head ever so slightly but did not answer.

It is noted that Ms. Gardner observed aloud that Mr. Cole has a hernia but he will not allow medical intervention for this condition. She further noted that the hernia is probably painful. Again, Mr. Cole was non-responsive to this comment as well.

After yet another period of prolonged silence, while Mr. Cole remained inert and non-responsive in his wheelchair, this examiner finally concluded that the current interview was not likely going to be any more verbally productive than it had been thus far and that it was time to conclude the interview. This examiner thanked Mr. Cole for his time, and told him that he planned to come back to see him again and that today had been a good start.

Clinical Impressions from 2nd visit:

Mr. Cole presents as a classic example of a severely regressed chronic schizophrenic patient (with catatonic features), whose condition is likely further compromised by the previously detected brain disorder captured by neuroimaging studies. His presentation is consistent with chronic and persistent mental illness (SPMI). His deeply regressed state is further compounded by years of chronic institutionalization (with very low levels of sensory stimulation and minimal social contact), and now with his chronological advance into his middle years. Current clinical observations are consistent with prior records and clinical observations reported by multiple observers over time. He is very non-responsive to external stimuli or to the vicissitudes of social interaction. There is no affirmative evidence from this interview that he is currently oriented to time, place, person or situation. There also is no affirmative evidence from this interview that he understands that he has been sentenced to be executed or that he understands the reason for the execution. There is no evidence to suspect that any of Mr. Cole's presentation today is a product of malingering.

3rd visit. 5/10/16. 1.0 hour total. Attempted Clinical Interview with Mr. Benjamin Cole- accompanied by Attorney Michael Lieberman and Investigator Julie Gardner:

At H Unit Mr. Lieberman, along with Ms. Gardner and this examiner, were greeted by Officer J. Whala, who waved his hand at us as we entered to signify that Mr. Cole would not meet with us today as scheduled. Officer Whala explained that he waved his hand at us in the same manner that Mr. Cole had waved to him when he told him his visitors had arrived. At Mr. Lieberman's request Officer Whala agreed to try one more time to ask Mr. Cole if he would come out of his cell to meet with us. Officer Whala returned with Mr. Cole's answer: "He said, nope, not seeing." Officer Whala also provided a

small hand written note that he reported was printed by Mr. Cole, which read: "not ready." The note was signed Benjamin Cole.

IV: Discussion and Integration:

This report is based upon three primary sources of data: first, a review of prior records and clinical evaluations that have accumulated over the years; second, a comprehensive review of written materials sent to Mr. Cole or generated by him. This review consisted of examining16 standard boxes full of materials; third, direct clinical interview and attempted interviews and observations of Mr. Cole on H Unit of OSP where Mr. Cole has resided now for well over 13 years. The combination of these three divergent sources of information complement and inform one another; yet each source of data is also unique and provides information somewhat different than the other sources. Analyses of these three divergent sources of data combine to provide convergent validity to this analysis, and the conclusions and opinions that follow are strengthened as no one single strand of data or source of data is considered fully controlling but is reliant upon cross-validation from all three sources.

Beginning with the brief synopsis of Mr. Cole's background reflected in the records review, it is evident that from its inception this has been a deeply troubled life course that had a most inauspicious start and which has assumed a progressively downward arc from the early years. Mr. Cole showed signs of mental disturbance from a young age, which was compounded and reinforced by an abusive and boundary-violating (incest) environment, and through his own use of toxic poly-substances from an early age (alcohol, gasoline fumes). Mr. Cole's academic difficulties, with several repeated grades and documented deficits in reading and auditory comprehension, are well noted. Compared to others his age, Mr. Cole's achievement scores were low. His later closed head injury from a hammer blow to the head may well have become an acquired organic brain deficit superimposed upon his limited native cognitive abilities. His emotional withdrawal and isolation was prominent by his late adolescence. Around this time, as well, he was showing overt signs of paranoia and believing rock bands were sending him messages through their music. Both his mother and brother described how he "snapped" by the time he was in the Air Force. Following his early incarceration for the physical abuse of his son, Mr. Cole became increasingly socially adrift, living as a homeless person in tents and under bridges. Unable to handle steady employment his progressive downward drift carried all the hallmarks of a slow prodromal decline into chronic schizophrenia. His alcohol use continued, which by this point in his 30's may have been a form of self-medication against the emerging psychosis. Mr. Cole sought refuge and understanding in fundamentalist religion and it was at a prayer meeting that he obtained his "Bakersfield Prophesy." His relationship with Susan Young produced a baby girl, Brianna Victoria Cole, whose life Mr. Cole tragically extinguished.

While Mr. Cole was evidently showing indications of emergent schizophrenia prior to arrest and incarceration, his psychological symptoms of growing paranoia and religiously themed delusions did not receive clinical attention until after his arrest and as he was moving forward to trial. In this context his legal counsel repeatedly questioned his ability to competently assist them in preparation of his defense. From the very beginning of his legal journey there are accounts of his emergent religiously themed delusions that continually interfered with rational communication with his attorneys. Early competency evaluations noted his religious preoccupations but would ultimately find that, nevertheless, he retained sufficient capacity to assist counsel in his defense.

Neuropsychological evaluations ultimately extended clinical understanding of Mr. Cole's behavior beyond the strictly psychological realm, and into the realm of brain based disorders. Beginning with Dr. Sharp's neuropsychological screening (10/25/03) and then on to Dr. Basso's full neuropsychological assessment (4/22/04), the obtained test data from these specialized evaluations strongly suggested underlying neuropsychological deficits. Follow up MRI studies (9/04) subsequently identified an 11 mm lesion located deep within the while matter of the frontal area of the left hemisphere. Subsequent analysis

of these findings by a range of experts confirmed the MRI finding, and all of these experts recommended that further follow up studies were necessary to determine if this lesion was continuing to grow. If the lesion continued to grow, such as might be the case if it were a tumor, then the lesion's encroachment upon other areas of the brain would subsequently impact brain functioning and have direct impact upon Mr. Cole's mental capabilities. That none of these recommended follow up studies have been conducted over the past 12 years is surprising. A review of whether medical standard of care is being met would be useful. Mr. Cole's attorneys have been prohibited from conducting the recommended evaluations on Mr. Cole's brain condition.

In the absence of this kind of medically indicated follow up evaluations, and without further information about the current status of this brain lesion, it is not possible to discern how much of Mr. Cole's current very regressed and deteriorated condition is due to the lesion and how much of his condition can be attributed to his schizophrenia. Without this follow up information it is also not possible to know what Mr. Cole's clinical response will be to any of the treatments that are provided for each of these conditions (paranoid schizophrenia and brain lesion) separately or if treated in tandem.

Since incarceration multiple legal teams have dealt with the frustration of not being able to adequately communicate with Mr. Cole. Their observations and complaints have invariably revolved around the same core issue: that his perseveration upon religiously-themed stifles all efforts to engage with him in rational discourse, to further the course of investigations on his behalf, to help him make rational and informed decisions about his legal case, and more. Attorney T. Kenneth Lee, to cite but one example, noted that in his over five years working with Mr. Cole, that at no time was he ever able to have a coherent discussion with Mr. Cole. Mr. Cole's legal teams over the years have learned to essentially live without his help or input since it has never been forthcoming due to his ongoing and persistent mental problems. These problems also appear to have assumed larger proportions after approximately 2008. Thereafter, Mr. Cole's refusal to come out of his cell to meet with his attorneys and to remain incommunicado with them became routine. Meetings with attorneys, when they did occur, were often less than five minutes then Mr. Cole would want to return to his cell. This pulling away from his attorneys is mirrored by his lifestyle in the prison, wherein he has become increasingly isolative, non-communicative, increasingly preoccupied with delusional religious ideas and oblivious to his personal hygiene.

Prison officials and several ex-cellmates have also offered narratives of Mr. Cole's behavior over time. These observations from within the prison itself essentially mirror and reinforce those observations provided by his past and current attorneys. In the prison system, Mr. Cole has become increasingly reclusive, and isolated, and his hygiene has deteriorated to the point of being intolerable to others. He has gone for long stretches of time of never leaving his cell, up to a reported period of 2 ½ years, all the while living secluded in his cell with the lights low or completely off. He has become completely immersed into his inner world of religiously themed delusions and surrounded by his mounds of books and papers, most of which have been cataloged and stored but never read.

Mr. Cole's voluminous collections of books, articles, pamphlets and various micrographic scribblings were reviewed and a conservative list of inferences were derived from this voluminous mass of materials. The magnitude of Mr. Cole's religious preoccupations is clearly evident as there is simply an absence of any material within these 16 boxes that pertained to any topic outside of the religious. Over time the content of these materials has moved increasingly to the fringe of religious ideas and into the realms of the fantastical and the delusional. That Mr. Cole perhaps derived some modicum of social support from his array of corresponders and well –wishers is quite likely. Still, Mr. Cole considered all of these materials part of his ministry. It is not clear from these materials what his ministry purported to accomplish aside from his requests for money to buy stamps and stationary. Mr. Cole has told his attorneys that all of his books and materials are part of his religious ministry and that the mother of his deceased child can do her ministry as well. Yet he does not attempt to provide ministry to others in his

local environment or otherwise reach out to spread his ministry. Mr. Cole wrote a letter, in July of 2015, to his mother and only recently did she open the letter. On the back of the letter he attached a strand of his hair and four of his teeth (personal communication from Julie Gardner, Investigator on Cole case).The content of these multiple stacks of materials, which ranged from the conventional to the outer edge of the religious fringe, also dilated particularly upon the apocalypse and end of the world. Curiously, Mr. Cole appears to have actually read very little of these materials and those he looked at are written like children's comic books. A steep decline in Mr. Cole's mental functioning was also inferred over time from these materials, as his writing became increasingly symbolic and cryptic, depicting a thought process decipherable only by him.

Despite the breadth of these materials reviewed, it is acknowledged that this report also contains limited direct interview data from Mr. Cole himself. This is despite the multiple attempts by this evaluator to interview him. The one interview available (2/17/16), albeit of limited duration and scope (as Mr. Cole remained inert and non-responsive to all attempts to engage with him), nevertheless provided a window into Mr. Cole's current mental status. My findings from these interview attempts and behavioral observations are consistent with multiple observations of prison staff (with the exception of Ms. Stem when accompanied by the warden; see below), with Mr. Cole's attorneys repeated efforts to engage with him over time, and with the more recent evaluation attempts by Dr. Morris in 2015. It is also noted that this examiner was denied the opportunity to attempt to interview Mr. Cole in his cell. On two of the three attempts to interview Mr. Cole he would not leave his cell. It is unknown as to whether an interview with him in the cell would have been more productive since it is his natural habitat. It is conceivable that he might have been more responsive since he would not have had to endure a painful move to the interview room.

The actual attempts to interview Mr. Cole, though invariably yielding a poverty of verbal statements (he answered a total two questions), were nevertheless quite informative in terms of the opportunity to observe Mr. Cole's behavior within a social context. Mr. Cole classically presents as afflicted with chronic and persistent mental illness that is severe and which is consistent with the previously offered diagnoses of chronic paranoid schizophrenia with delusions of grandeur and negative symptoms. The contribution of the above noted brain lesion is not currently known but must be understood to be factored in to the analysis. Such presentations, as observed with Mr. Cole, are typically observed among the back ward units of long term state hospitals where patients are no longer considered treatable and are merely provided custodial care. Mr. Cole appears to be receiving only custodial care in his current prison environment as well. Mr. Cole's presentation in his wheel chair, wherein he remained slumped over and non-responsive with eyes closed, is entirely consistent with prior evaluations (see Dr. Morris's several excellent evaluations in 2009 and again in 2015 for further amplification).

As noted previously, the original Clemency Application for Mr. Cole was submitted on 1/23/15 (Vol. I., p. 194). Since then concerns about Mr. Cole's declining mental and physical condition have increased significantly as well as the ability to independently assess his decline.

Finally, there are several miscellaneous topics that should be addressed. The first is that the issue of malingering has been raised by medical practitioners at OSP. Malingering is an affirmative psychiatric diagnosis and it must be established by a comprehensive psychological evaluation to assess this concern. There is no evidence from the records that this sort of psychological evaluation has been conducted; malingering is not a psychological diagnosis that is gratuitously established based merely upon casual observation during a routine physical examination.

The second observation concerns clinical documentation of Mr. Cole's condition within the prison system. Patti Stem, Clinical Coordinator (professional credentials not indicated in the records) wrote very detailed notes about the 35 Day Notification Hearing and thereafter. These notes are dense with

information and nuanced detail about Mr. Cole's mental functioning and the detailed questions about his execution he asked during these encounters. What is striking in these notes are their remarkable depiction of Mr. Cole as fully oriented and engaged with the interview process; these notes are in marked contrast to the sparsity of other clinical notes written by other prison staff over the years. They are also in contrast to the typical notes from other observers at the OSP and his attorneys over the years who portray Mr. Cole as rarely saying anything and as generally non-responsive to efforts to engage with him. Despite the years of such conversations his attorneys and professional evaluators have had with Mr. Cole, in none of those encounters was Mr. Cole able to so clearly and distinctly articulate his understanding of his pending execution as in these notes written by Ms. Stem. In these notes documenting conversations with the warden, Mr. Cole is remarkably depicted as fully competent to be executed as he understands in great detail why he is to be executed, when he will be executed, and the reason for his execution. Ms. Stem's notes do not explain or attempt to reconcile the large discrepancy between Mr. Cole's very high level of cognitive tracking and logical engagement as depicted during these several interviews with the warden, and the many years and multiple attempts during which others have tried and failed to achieve these same results.

If OSP staff has Mr. Cole's previous mental health records, which would include all of the evaluations and neuropsychological evaluations, as well as the expert opinions from the neuroimaging experts, there is no indication that these records have been clinically integrated into their formulations regarding his clinical presentation and clinical course. With the exception of Ms. Stem's notes (see above), the remainder of the clinical observations from the prison staff of Mr. Cole's daily behavior are sparse and consistent with custodial care. The exception to this practice was Dr. Kirby (3/11/14) alert to the contradiction in the prison records which documented that age 49 Mr. Cole's current level of mental functioning and concern was rated as "zero", while noting that at age 39 he had been classified at level "B." Mr. Cole's psychological condition has continued to deteriorate not improve.

A third observation is that schizophrenia is a severely debilitating mental disease. It is chronic in nature, though its course can be effectively managed with treatment when introduced in the early stages of the illness. There is no known cure for schizophrenia and the course is often progressive, especially if untreated. Mr. Cole's schizophrenia has not been treated in years. In his untreated state his condition will continue to become progressively worse. It will not spontaneously remit, or reverse course and improve. He demonstrates chronic and persistent mental illness (SPMI).

The currently observed negative symptoms of Mr. Cole's schizophrenia are different than the active symptoms of the illness. Active symptoms are demonstrated by the presence of auditory and visual hallucinations, active delusions, and often bizarre verbalizations and behavior. Active symptoms draw social attention and in prisons often require active staff management. Mr. Cole's stage of the schizophrenic illness has gone beyond this active and observable phase. The course of his illness has moved to the stage referred to in the common parlance as being a "burnt out schizophrenic." Such individuals remain socially avoidant, typically have intolerable hygiene, and appear mentally vacuous and empty, as though literally devoid of thought. Such individuals present as mere shells of their former selves, with an absence of identifiable personality features; in a word, they are no longer who they once were. Mr. Cole demonstrates the negative symptoms of schizophrenia, which is a manifestation of: having reached a chronic stage of the illness wherein he has lived with the illness now for many years; that the illness has not being treated for many years, if ever; that he has lived in a very low stimulation environment that is devoid of novelty and change and opportunities for meaningful human interactions. The end result of these various factors leads to an individual who lives almost exclusively in their own mental universe apart from the rest of humanity. That Mr. Cole's current condition has not required aggressive staff management and intervention by no means indicates that he is now no longer psychotic. To assume otherwise is to misread his psychopathology by examining only one side of the coin. Negative symptoms are a manifestation of the schizophrenic psychopathology and are considered part of the

psychosis, albeit at a different stage. An absence of overt behavioral problems that require staff management and intervention (such as use of isolation or special management) also does not equate to competence to be executed.

Summary of Clinical Condition:

1. Mr. Cole is diagnosed with chronic and persistent schizophrenia that is extreme in severity. Schizophrenia is a severe mental illness that typically takes a progressively deteriorating course. There is no known cure for schizophrenia though symptoms can be managed with currently available treatments.

2. In the absence of clinical treatment being provided to address Mr. Cole's schizophrenia, then further decline in his clinical course will continue.

3. Mr. Cole has a documented brain lesion located in the deep white matter of the frontal-parietal region of the left hemisphere of his brain that was discovered by neuroimaging studies in September 2004. Follow up studies of this lesion have not been completed as recommended by neuroimaging experts. The influence of this brain-based defect on Mr. Cole's current mental state, in combination with his schizophrenic illness is thus unknown. If the lesion is progressive then there will be greater impact than if it is static.

V: Current Diagnosis: DSM V (1)

295.90 Schizophrenia, Paranoid Type, Continuous, with chronic religiously themed delusions, (along with severe level negative symptoms)

293.89 Catatonic Features Associated with Schizophrenia: stupor, mutism and negativism

799.59 Unspecified Neurocognitive Disorder (with etiology not yet determined-11 mm brain lesion in the deep white matter of the frontal-parietal region of left hemisphere)

VI: Opinions:

1. Based strictly upon a review of the records and Mr. Cole's voluminous personal books and records, and from his behavior during evaluation, it is my professional opinion that at present Mr. Cole is not competent to be executed. There was no affirmative evidence from this evaluation that Mr. Cole does understand and appreciate that he may again be scheduled for execution or the reasons why that execution would take place.

2. If any future information should become available about Mr. Cole's response to a treatment(s) introduced for his schizophrenia, or about the follow up evaluation and any subsequent response to treatment that may be recommended for Mr. Cole's brain lesion- then all of these new sources of clinical information will be duly considered and my opinion at that time will be formulated based upon the availability and results of this new clinical information.

3. This opinion is offered within a reasonable degree of psychological certainty.

VII: Restoration of Competency:

The remedies to potentially restore Mr. Cole's capacity for competency will require that the following treatments be initiated:

1. Mr. Cole's chronic and untreated schizophrenia must be treated.

2. Mr. Cole's brain lesion must be re-evaluated and treated.

3. Mr. Cole's possible clinical responses to such treatments for these conditions are at present unknown.

4. Without attempting these treatments Mr. Cole's competency for execution will not be restored.

References:

(1) American Psychiatric Association: Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition. Arlington, VA. American Psychiatric Association, 2013.

VII: Documents Reviewed (Appendix A):

Clemency Information:

1. Pictures of Benjamin Cole
2. Federal Public Defender Clemency Packet
3. Federal Public Defender Supplemental Clemency Packet

Expert Reports:

4. Dr. LaFortune Evaluation 2/28/2003
5. Dr. Christopher Evaluation 7/24/03
6. Dr. Sharp Evaluation 2/17/04
7. Russell Risk Assessment 5/24/04
8. Dr. Basso Evaluation 6/15/04
9. Dr. Monroe Evaluation 8/30/04
10. Dr. Christopher Competency Evaluation 8/18/04
11. Dr. Hastings/Powers Radiology Report 2/3/07
12. Dr. Price Competency Evaluation 12/13/07
13. Dr. Morris Report 4/4/09
14. Declaration of Dr. Gur
15. Affidavit of Dr. Hayman 1/16/15
16. Dr. Morris Report 1/21/15

Affidavits:

17. Transcribed Interview of Leonard O'Neal 5/5/04
18. Affidavit of James C. Bowen 1/31/07
19. Affidavit of Timothy Wantland 2/21/07
20. Affidavit of Michael Hooper 2/23/07
21. Affidavit of Anastasia Cesario 2/26/07
22. Affidavit of Barbara Johnson 10/14/08
23. Affidavit of Cherry Peirce 10/17/08
24. Affidavit of Dawn Bettencourt 10/17/08

25. Affidavit of Ranada Gentry 11/3/08
26. Affidavit of Suzanne Nelson 5/1/09
27. Affidavit of G. Lynn Burch III 1/13/15
28. Affidavit of Anna Wright 1/13/15
29. Affidavit of Vicki Werneke 1/15/15
30. Affidavit of T. Kenneth Lee 1/16/15
31. Affidavit of Anna Wright 1/29/15

Prison Records:

32. 2004 to 2014 Mental Health excerpts
33. DOC Field Jacket Highlights
34. DOC Medical Records from 5/14 to 9/15
35. DOC Mental Health Records from 6/14 to 9/15
36. OSP Execution Log

Samples of Benjamin Cole's Writings:

37. Letter to Vicki Werneke 2007
38. Letter to Sandra Collette 2007
39. Letter to Candy 2008
40. Letter from Benjamin Cole 6/7/11
41. Letter to Letter to Anna Wright & Sarah Jernigan 9/20/11
42. Letter to Patti Ghezzi 6/12/13
43. Letter to Ken Lee 6/5/13
44. Letter to Tom Hird 4/4/14
45. Letter to Tom Hird 4/14/14
46. Letter to Michael Lieberman 2015

Miscellaneous Items:

47. Mandamus Transcript 8/28/15
48. Box Content 2011
49. ESH records on competency
50. Ford Petition
51. Hobbs Memo on Psych 2006
52. Religious Index
53. 16 standard storage boxes of religious-themed materials (various bibles, books, pamphlets, tracts, post cards, essays, written notes either by Mr. Cole or written by others to him

VIII: Professional Resources Consulted:

1. Zaph, P., (Boccaccini, M.T., Brodsky, S.L. (2003). Assessment of Competency for Execution: Professional Guidelines and an Evaluation Checklist. *Behavioral Sciences and the Law*. 21; 103-120. Published online 2 July 2002 in Wiley Interscience (www.inyerscience.wiley.com). DOI: 10.1002/bsi.491

2. Gilfoyle, N.F.P., Hornberg, R.S., Ogden, D.W., Taranto, R.G. (2007). *In the Supreme Court of the United States. Panetti v. Quarterman Writ of Certiorari to the U.S. Court of Appeals for 5th Circuit.* Brief for Amici Curiae American Psychological Association; American Psychiatric Association and National Alliance in Support of Petitioner. No. 06-6407

3. Melton, G.B., Petrila, J., and Poythress, N.G. (1997). *Psychological Evaluations for the Courts. A Handbook for Mental Health Professionals and Lawyers*. 2nd Edition. The Guilford Press. New York.

4. Seeds, Christopher W. "The Afterlife of Ford and Panetti: Execution Competence and the Capacity to Assist Council". (2009). *Cornell Law Faculty Publications.* Paper 74. http://scholarship.law.cornell.eu/facpub/74

5. Small, Mark A. *"Performing "Competency to be Executed Evaluations: A Psychological Analysis for Preventing the Execution of the Insane".* Mark Small. Nebraska Law Review. (1988). Available at: http://digitalcommons.unl.edu/nlr/vol67/iss3/8

6. Mello, M. (2007). Execution of the Mentally Ill: When is Someone Sane Enough to Die? *Criminal Justice,* Volume 22 (3). Fall. Published by American Bar Association.

7. Blanks, R. and Pinals, D. (2007).Competence to be Executed. *Legal Digest.* Volume 35 (3), 381-384.

8. *American Psychological Association.* (2016). Panetti v. Quarterman. http://www.apa.org/about/offices/ogc/amicus/panetti.aspx

9. Zonana, H. (2003). Analysis and Commentary. Competency to be Executed and Forced Medication: Singleton v. Norris. *The American Academy of Psychiatry and the Law.*31:372-376.

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Competency to Be Executed Evaluation: Addendum

Client: Benjamin Cole
Date of Addendum Records Review: January 14, 2018
Current Location of Client Incarceration: Oklahoma State Penitentiary, McAlester, Oklahoma
Referral Source: Michael Lieberman, JD., Assistant Federal Public Defender Oklahoma City, OK.
Date of Report: January 16, 2018

I: REASON FOR REFERRAL:

Mr. Cole was previously referred for a psychological evaluation with this psychologist to document his current emotional and cognitive status, and to render a professional opinion as to whether he was currently competent to be executed by the State of Oklahoma. In brief, in that earlier report Mr. Cole was diagnosed with ongoing and severe paranoid schizophrenia, as well as catatonic features associated with schizophrenia and unspecific neurocognitive disorder. My opinion in that report was that Mr. Cole was not competent to be executed. See the previous report of October 13, 2016.

Given the extended length of time since that last report was provided it was considered necessary to provide an updated opinion upon Mr. Cole's mental status. To do so I reviewed available documentation provided by Mr. Cole's legal defense team regarding their ongoing observations of Mr. Cole's behavior and mental status. Updated records from the professional staff employed at the McAlester Prison have not yet been forthcoming for review.

II: PROCEDURES:

Review of Accompanying Background Clinical Records & Evidence: 2016-2017 Benjamin Cole Chronology of Interactions (Excerpted) - total of 43 pages

The Background of Clinical Records & Evidence: 2016-2017 is a 43 page document which provides a condensed description of the various observations of Mr. Cole provided by his legal defense team. These descriptions include direct observations on his behavior in person while visiting him at McAlester prison; notes from phone calls from Mr. Cole; notes from reported observations of Mr. Cole's behavior by others [other inmates, as well as prison officials], encompassing approximately 20 months. These reported observations provide a multi-dimensional and richly textured description of Mr. Cole's behaviors that overlap with and extend beyond this clinician's last encounter with Mr. Cole on May 10, 2016.

The Background of Clinical Records & Evidence:2016-2017 consists of the following forms of contact with Mr. Cole: 41 phone calls between his defense team & Mr. Cole; 8 contact visits with Mr. Cole at the Oklahoma State Penitentiary; 13 unsuccessful contacts with Mr. Cole at the Oklahoma State Penitentiary- [in these instances Mr. Cole refused contact with the visiting team members]; 9 phone conversations with other inmates at Oklahoma State Penitentiary who offered their own independent observations about Mr. Cole's behavior; 4 phone calls or reported observations with the Oklahoma State Penitentiary staff or Unit Manager; and 5 phone calls and/or observations by various members of Mr. Cole's defense team who were at the facility and were visiting other inmates at the Oklahoma State Penitentiary.

III: Discussion and Integration

(a). Consistent with the clinical data previously summarized in the earlier submitted report of October 13, 2016, throughout these current observations (phone calls, face-to-face-visits at the McAlester prison, as well as observations reported by other inmates and various prison officials), Mr. Cole continues to display strong evidence for the continuation of his severe psychosis. This observation in itself is not surprising, and is consistent with the clinically predictable nature and course of his ongoing and by now very chronic schizophrenic illness. All observers' report that Mr. Cole continues to frequently articulate his religiously-themed delusional ideas, and that these ideas invariably intrude into his discourse and over-ride his train of thought, and that they infuse all elements of his thinking. Consistent with his observed psychotic thought process in evidence for years now, the structure and coherence of his thinking is typically incomprehensible to the listener. Put differently, people usually do not know what he is talking about. Often he loses his train of thought, displays neologisms and confabulatory thinking [e.g. "hard markers" of psychotic process thinking], and will become discursive upon bizarre ideas that have no basis in reality. He continues to be preoccupied with such esoteric topics as the Mayan Calendar's prediction of our economic collapse, the World Trade Center, an evil Hindu Goddess Kali, and that Roman Catholics are evil but to name a few. Observers frequently comment upon how they cannot follow all these disjointed fragments of his thoughts nor piece them together in a rational, coherent manner. The intended meaning of Mr. Cole's thought processes can be understood only by Mr. Cole alone.

Mr. Cole's hygiene also continues to be poor and invariably he is observed as disheveled and unclean. His awareness of his surroundings and the individuals who are central to his prison environment remains minimal [e.g., he was not aware Warden Trammel or Director Patton were gone [1/6/16].

As previously noted, Mr. Cole frequently refused to come out of his cell to meet with his legal team. These refusals to meet with his attorneys occurred in a random, sporadic manner. There is no identified pattern as to when he would meet or not meet with representatives of his legal team. More often than not, he refused the professional visits [out of 21 visits, he refused 13 times]. The erratic pattern of his contact refusals and the frequency with which they occurred continue to suggest that his working-relationship with his legal team is tenuous, erratic, and subject to Mr. Cole's psychotic thought processes. Typically his requests of his team members revolve around obtaining simple items such as his pictures, chick tracts, envelopes or mailing materials, or with wanting staff members to start communicating with him in a secret code. Moreover, he acknowledged that he thought the legal team members were involved in his life to help him, not as part of a legal process, but as working with him on his ministry as his personal assistants. The amalgamation of the data from these records fully support that he is continuing to experience schizophrenic illness and that the course of this illness is chronic, unremitting, and continuing to deepen. In sum, there is no evidence from the records that Mr. Cole's mental status has improved; it has not.

(b). As to the issue of whether Mr. Cole is now competent to be executed, it is noted that these records do not constitute a formal psychiatric evaluation of that issue nor was their intended purpose to accomplish answering that question for the court. To fully assess that particular issue a comprehensive psychiatric evaluation would be required.

There is no way can any isolated comment by Mr. Cole can be extracted from the record, pars pro toto, as constituting affirmative proof that Mr. Cole has now been psychiatrically restored to full competence to be executed. Any attempt to extrapolate an isolated word or fragment of thought from the morass of Mr. Cole's ongoing psychosis would be illogical and professionally unethical. Moreover, from these records there is no evidence that any psychiatric interventions have been introduced since this evaluator last saw Mr. Cole that might offer the potential to effect this restoration. To my knowledge Mr. Cole has not been provided with psychotropic medications for his schizophrenia nor has he been re-evaluated by outside medical specialists to assess and treat his brain lesion. Given that the known course of untreated and chronic schizophrenic is for the patient to become progressively worse over time, there is no reason to assume that Mr. Cole's mental status has improved; nor is there reason to assert that his competence to be executed has been restored.

IV: Updated Current Diagnosis: DSM V (1) [There is no evidence to warrant changing these diagnoses].

295.90 Schizophrenia, Paranoid Type, Continuous, with delusions of grandeur related to religiosity (along with severe level negative symptoms)

293.89 Catatonic Features Associated with Schizophrenia: stupor, mutism and negativism

799.59 Unspecified Neurocognitive Disorder (with etiology not yet determined-11 mm brain lesion in the deep white matter of the frontal-parietal region of left hemisphere)

V: Updated Opinions: [There is no evidence to warrant changing these opinions]

1. Mr. Cole is diagnosed with chronic and persistent schizophrenia that is extreme in severity. Schizophrenia is a severe mental illness that typically takes a progressively deteriorating course. There is no known cure for schizophrenia though symptoms can be managed with currently available treatments.

2. In the absence of clinical treatment being provided to address Mr. Cole's schizophrenia, then further decline in his clinical course will continue.

3. Mr. Cole has a documented brain lesion located in the deep white matter of the frontal-parietal region of the left hemisphere of his brain that was discovered by neuroimaging studies in September 2004. Follow up studies of this lesion have not been completed as recommended by neuroimaging experts. The influence of this brain-based defect on Mr. Cole's current mental state, in combination with his schizophrenic illness, is thus unknown. If the lesion is progressive then there will be greater impact than if it is static.

4. Based upon currently available data at present, Mr. Cole is not competent to be executed. **[Nor is there any presented evidence that any efforts have been undertaken to restore competency to be executed].**This opinion is qualified by the recognition that there are two knowledge vectors that remain unanswered: (1) Mr. Cole's schizophrenia remains untreated and his potential for positive response, however modest, to currently available treatment cannot be known without a trial of such treatment; (2) the magnitude of impact that Mr. Cole's brain lesion may be having upon his current mental functioning (whether singularly or in combination with the schizophrenia) also remains unknown. Any potential treatments for the brain lesion, if any, as well as Mr. Cole's possible clinical responses to such treatments, are also at this point unknown.

5. If any future information should become available about Mr. Cole's response to a treatment(s) introduced for his schizophrenia, or about the follow up evaluation and any subsequent response to treatment that may be recommended for Mr. Cole's brain lesion-then all of these new sources of clinical information will be duly considered and my opinion at that time will be formulated based upon the availability of this new clinical information.

6. These opinions are offered within a reasonable degree of psychological certainty.

VI: Updated Recommendations: [There is no evidence to warrant changing these recommendations]

1. Mr. Cole should be evaluated by medical staff at McAlester Prison for a possible trial of treatment to address his schizophrenic condition. Mr. Cole's response to any treatments provided should be carefully documented.

2. Mr. Cole should be provided with a full complement of follow up brain imaging studies to evaluate the current status of his brain lesion. All prior neuroimaging experts in their reports have uniformly recommended follow-up studies. These studies can determine if the previously identified 11 mm lesion of the left hemisphere is static or progressive, and whether there are any possible treatments available for his condition. Mr. Cole's response to any treatments provided for this condition should be carefully documented.

3. Obtaining knowledge of Mr. Cole's mental status following the introduction of both of these treatment approaches would answer whether there is any future potential for restoration of his competency for execution (whether this treatment is obtained voluntarily or involuntarily).

4. Mr. Cole's mental status and capacity for execution is a process that, clinically and ethically, will require repeated evaluations if an execution date is re-imposed as mental status and competency may fluctuate (albeit within a relatively narrow band).

5. In any future clinical evaluations with Mr. Cole this evaluator should be permitted to evaluate Mr. Cole in his cell if he will not come out to be clinically interviewed in the interview room. If Mr. Cole cannot give consent to enter the cell, then guards should be authorized to let me in to his cell.

6. All available mental health records from McAlester prison to date should be made available to Mr. Cole's legal team. This would include all mental health records produced after April 2015.

7. In light of an absence of follow-up for the brain lesion as recommended, a review of whether medical standard of care is being met should be considered.

References:

(1) American Psychiatric Association: Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition. Arlington, VA. American Psychiatric Association, 2013.

George Hough, Ph.D., ABPP

George Hough, Ph.D., ABPP

AFFIDAVIT OF DAVID GEORGE HOUGH, PH.D., ABPP

I, Dr. David G. Hough, having the legal capacity to make this affidavit, hereby state under oath as follows:

1) I am currently employed as a clinical psychologist with the Base Operational Support Team (BOST) with the United States Air Force at Keesler Air Force Base, Biloxi, Mississippi. I have been in this position since July 2021. I have been accepted for a clinical psychologist position with the Fairview Oregon Veterans Administration Community Out-patient Clinic, in Fairview, Oregon. This later position will begin on 06 June 2022. I have a Ph.D. in Clinical Psychology and am Board Certified in Clinical Psychology by the American Board of Clinical Psychology;

2) Prior to this position at Keesler Air Force Base, I was employed as a clinical psychologist by the U.S. Air Force Europe at Royal Air Force (RAF) Lakenheath, the United Kingdom from June 2016 to July 2021. I was assigned to the Aerospace Medical & Flight Operations Clinic, where I diagnosed and treated active-duty members. Prior to my position at RAF Lakenheath, I worked as a clinical psychologist in the Embedded Mental Health Clinic at Ft. Riley Kansas and was employed by the Center for Deployment Psychology (CDP); before transferring to Ft. Riley, I worked as a clinical psychologist in the Family Health Clinic at Langley Air Force Base, Langley, Virginia;

3) Prior to my employment with the military (2013 to present), I was self-employed in the private practice of clinical and forensic psychology since 1990. In this capacity I diagnosed and treated patients of all ages and diagnoses, provided individual therapy, couples and family therapy, as well as psychoanalysis. In my forensic work I have consulted with both defense and prosecuting attorneys throughout the United States on primarily criminal cases. I have conducted extensive psychological evaluations and psychological testing on criminal defendants in all manner of facilities, from city jails to federal facilities and international venues. I have provided expert witness testimony in county, state, and federal courts and at the ICTY at The Hague, Netherlands on a war crimes case. I have consulted with the U.S. Department of Justice on domestic terrorism cases and a GITMO case. I have consulted with the U.S. Drug Enforcement Administration (DEA) as their Psychological Consultant for the Central United States.

4) I have conducted psychological evaluations and provided expert witness testimony on death penalty cases since 1995 in Kansas, Missouri, and Oklahoma. I have worked with attorneys on death cases throughout their representation of their clients. I am familiar with the procedures on death row at the Oklahoma State Penitentiary (OSP),

the housing issues specific to death row at OSP, and with the unique stressors unique to prisoners who are sentenced to death;

5) I am currently working with the defense team on Benjamin Cole's case and have done so since 2016. I have reviewed all available records on the case provided by current and previous counsel, and I am familiar with records collected by his counsel during the post-conviction process and direct appeal. I have also reviewed boxes of written materials sent to Mr. Cole and provided a qualitative analysis of the main themes contained within these materials as well as the written materials generated by Mr. Cole. I have also attempted to interview Mr. Cole on several occasions, though typically he has refused to leave his cell to speak;

6) My most recent attempt to interview Mr. Cole was on April 25th and 26th, 2022. On Monday, 25 April, Mr. Cole's attorney Mr. Tom Hird, and I made our first attempt to visit Mr. Cole on this trip to the H Unit at OSP. Standing outside Mr. Cole's cell door on the H Unit, Mr. Hird initially attempted to communicate with Mr. Cole by getting down on his hands and knees and speaking through the opened metal door through which Mr. Cole's meals are delivered (aka the "bean hole"). As Mr. Hird was attempting to communicate with Mr. Cole a guard shined a flashlight into the cell through the cell window. The cell was completely dark. I could see Mr. Cole huddled in the corner in his cell. He was wearing a rough-hewn prison outfit that appeared beige in color and was tattered and in poor repair. Mr. Cole appeared very unkempt with poor hygiene. His hair is tied in thick knotted braids and his beard is shaggy and extends to his chest. This is how I have perceived Mr. Cole in the past and the attendant correctional officers confirmed that Mr. Cole does not shower or attend to his personal hygiene. There were numerous scraps of paper and odd bits of trash that have collected outside of Mr. Cole's cell, which the correctional officers confirmed were dropped by Mr. Cole.

7) Mr. Hird continued to yell through the bean-hole to Mr. Cole, asking him to come out so we could talk with him. Mr. Cole slowly attempted to make his transfer on to his wheelchair, which was positioned between the two concrete slabs which serve as beds. The back of the wheelchair was facing toward us as we peered into the cell. Mr. Cole moved very slowly into the wheelchair. At no time did I observe Mr. Cole standing erect without grasping on to something for support. After several minutes transferring to his wheelchair, Mr. Cole began to peddle his wheelchair slowly back by pushing with his feet against the concrete floor. When he was within one to two feet from the cell door where we were located, he stopped peddling his wheelchair. At that point Mr. Hird said that he could hear Mr. Cole softly whisper, "No" twice. Mr. Cole's verbalizations were spontaneous and not prompted by any questions at that point. From my position at that point, I could see Mr. Cole but did not hear him speak. Mr. Hird again attempted to communicate with Mr. Cole as he was ambulating in his wheelchair back to his bed area. Mr. Hird said to Mr. Cole that if he

needed to go to the bathroom first to empty his bladder that would be OK, that we were patient and would wait for him.

8) A this point the Unit Manager, Ms. Terri Apala, told Mr. Hird and me that we could go into the interview room which was near Mr. Cole's cell where we could wait to see if Mr. Cole would change his mind and agree to meet with us. After we were seated in the interview room the Unit Manager advised that she give Mr. Cole 15 to 20 minutes to use the bathroom in his cell and to decide if he was willing to meet with us.

9) After approximately 15-20 minutes the Unit Manager returned to the interview room where Mr. Hird and I were waiting. The Unit Manager said that Mr. Cole would not come out.

10) On the following day, 26 April, Mr. Hird and I again attempted to visit with Mr. Cole on the H Unit at OSP. We were escorted by the Case Manager, Ms. Elizabeth Schlueter, to Mr. Cole's cell door. Upon arrival at Mr. Cole's cell door, Case Manager Schlueter, who escorted us, said that she did not have a key to the bean-hole. Case Manager Schlueter told us we could yell to Mr. Cole through a narrow crack located between the cell door and the adjacent concrete wall on both sides of the cell door. Mr. Hird and I alternately took turns yelling to Mr. Cole through this crack to come out to talk with us. Mr. Hird and I each emphasized to Mr. Cole that it was very important that he allow us to speak with him directly, and that we needed to hear his perspective on how he is doing.

11) Officer Brown then arrived, and she said she did have a key to the bean- hole, which she then opened for us to attempt to communicate with Mr. Cole. Mr. Hird got down on his hands and knees to speak through the bean-hole opening and yelled to Mr. Cole that it was very important to hear from him, that timing was of the essence in his legal case. Mr. Hird and I took turns getting on our hands and knees to yell to Mr. Cole through the bean- hole. Mr. Cole was lying in his bed and was non-responsive to our efforts to communicate with him.

12) The Case Manager, Ms. Schlueter, rapped vigorously on the plexiglass covering Mr. Cole's cell door, and yelled: "Cole, some people here to see you." Mr. Cole responded to this noise and then began to slowly rouse from his bed. I observed with the aid of Officer Brown's flashlight, that Mr. Cole was wearing a thick towel or turban-like article of clothing wrapped around his forehead which covered his eyes. Mr. Hird, while till on his hands and knees in front of the bean-hole, said "Ben, if you need to use the bathroom, that's alright". Mr. Cole then very slowly transferred himself from his bed to his wheelchair, which was located between the two concrete beds in the cell. This process of transferring himself took an exceptionally long time, as Mr. Cole's movements were very slow, and deliberate. After situating himself in his wheelchair, Mr. Cole the slowly transferred himself to the toilet seat which was

located within the same general living space between the two concrete beds. The Case Manager's flashlight batteries grew progressively weaker; nevertheless, I was able to observe Mr. Cole sitting on his toilet with his head slumped to the left side while his right hand remained resting against the right side of his head.

13) As we were leaving the waiting room, after being advised by the Unit Manager that Mr. Cole was a "refusal", Mr. Hird said that he needed to see for himself what Mr. Cole would say or gesture he would make. Mr. Hird then peered into Mr. Cole's cell and promptly declared that Mr. Cole did make the same gesture across his throat as described by the Unit Manager, Ms. Apala.

14) My current observations are consistent with my previous observations and with reports reflected in the medical records. Mr. Cole's overall behavior remains very regressed, and primitive, and refractory to efforts to communicate with him by others. I did not observe any behavior by Mr. Cole that I would consider rational or coherent, and his cognitive capacity is currently assessed as extremely impaired, and is consistent with my previous face-to-face observations of him on 16 February 2016. Mr. Cole's current clinical presentation is consistent with his diagnosis of severe and chronic schizophrenia with catatonia, as well as MRI-documented organic brain damage. He continues to meet criterion for severe and persistent mental illness (SPMI).I discern no clinical improvement whatsoever since my last face-to-face encounter; it has most likely worsened.

Further affiant sayeth not.

David G. Hough, Ph.D. ABPP

DAVID G. HOUGH, PH.D., ABPP

Subscribed and sworn to me on this 4th day of May, 2022.

STATE OF MISSISSIPPI NOTARY PUBLIC ID # 63439 GREGORY LEWIS Commission Expires July 11, 2025 HARRISON COUNTY

NOTARY PUBLIC

My commission number is: #63439

My commission expires: 07/11/2025

AFFIDAVIT OF DAVID GEORGE HOUGH, PH.D., ABPP

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1) I am currently employed as a clinical psychologist with the Base Operational Support Team (BOST) with the United States Air Force at Keesler Air Force Base, Biloxi, Mississippi. I have been in this position since July 2021. I have been accepted for a clinical psychologist position with the Fairview Oregon Veterans Administration Community Out-patient Clinic, in Fairview, Oregon. This later position will begin on 06 June 2022. I have a Ph.D. in Clinical Psychology and am Board Certified in Clinical Psychology by the American Board of Clinical Psychology;

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5) I am currently working with the defense team on Benjamin Cole's case and have done so since 2016. I have reviewed all available records on the case provided by current and previous counsel, and I am familiar with records collected by his counsel during the post-conviction process and direct appeal. I have also reviewed boxes of written materials sent to Mr. Cole and provided a qualitative analysis of the main themes contained within these materials as well as the written materials generated by Mr. Cole. I have also attempted to interview Mr. Cole on several occasions, though typically he has refused to leave his cell to speak;

6) My most recent attempt to interview Mr. Cole was on April 25th and 26th, 2022. On Monday, 25 April, Mr. Cole's attorney Mr. Tom Hird, and I made our first attempt to visit Mr. Cole on this trip to the H Unit at OSP. Standing outside Mr. Cole's cell door on the H Unit, Mr. Hird initially attempted to communicate with Mr. Cole by getting down on his hands and knees and speaking through the opened metal door through which Mr. Cole's meals are delivered (aka the "bean hole"). As Mr. Hird was attempting to communicate with Mr. Cole a correctional officer shined a flashlight into the cell through the cell window. The attendant correctional officers confirmed that Mr. Cole does not shower or attend to his personal hygiene. There were numerous scraps of paper and odd bits of trash that have collected outside of Mr. Cole's cell, which the correctional officers confirmed were dropped by Mr. Cole.

7) After a few minutes of attempting to communicate with Mr. Cole, the Unit Manager, Ms. Terri Apala, told Mr. Hird and me that we could go into the interview room which was near Mr. Cole's cell where we could wait to see if Mr. Cole would change his mind and agree to meet with us. After we were seated in the interview room the Unit Manager advised that she would give Mr. Cole 15 to 20 minutes to use the bathroom in his cell and to decide if he was willing to meet with us.

8) After approximately 15-20 minutes the Unit Manager returned to the interview room where Mr. Hird and I were waiting. The Unit Manager said that Mr. Cole would not come out. Mr. Hird again explained the importance of seeing Mr. Cole. The Unit manager, Ms. Apala, repeated that Mr. Cole would not respond to her efforts to call him out of his cell when she yelled to him through the bean-hole. She said that Mr. Cole's non-response is equivalent to a "refusal", and that her orders for now are that if Mr. Cole does not want to voluntarily come out of his cell for a contact visit, then the staff are not going to force him to come out.

9) Mr. Hird and I left the H Unit and went to the OSP Administrative Building in an attempt to speak with the warden about access to Mr. Cole. In the front waiting area, we were met by Ms. Nancy Battles (Assistant to the Warden). We explained our situation with Mr. Cole and she agreed to make some phone calls on our behalf. When Ms. Battles returned, she explained that she had made a few calls (unspecified

to whom) and that for now, the prison is not going to compel or force Mr. Cole to come out of his cell if he does not want to.

10) On the following day, 26 April, Mr. Hird and I again attempted to visit with Mr. Cole on the H Unit at OSP. We were escorted by the Case Manager, Ms. Elizabeth Schlueter, to Mr. Cole's cell door. On the way to Mr. Cole's cell, the Case Manager said that Mr. Cole had not spoken to her in approximately three months and that he rarely speaks with anyone. Upon arrival at Mr. Cole's cell door, Case Manager Schlueter, who escorted us, said that she did not have a key to the bean-hole. Case Manager Schlueter told us we could yell to Mr. Cole through a narrow crack located between the cell door and the adjacent concrete wall on both sides of the cell door. Officer Brown then arrived, and she said she did have a key to the bean- hole, which she then opened for us to attempt to communicate with Mr. Cole.

11) The Case Manager, Ms. Schlueter, rapped on the plexiglass window covering Mr. Cole's cell door, and yelled: "Cole, some people are here to see you."

12) While standing at the door I asked Officer Brown and the Case Manager how difficult it would be to simply open the door to retrieve Mr. Cole for us. They acknowledged that it could easily be done, as they would simply assist Mr. Cole into his wheelchair and wheel him out to the interview room. They both acknowledged that in the case of Mr. Cole, being in his chronic and debilitated condition, they did not anticipate any sort of struggle with Mr. Cole and that it would not be difficult to bring him out.

13) Lieutenant Lumley then arrived and advised Mr. Hird and me that Mr. Cole is "not what he seems"; Lt. Lumley did not explain what he meant and I cannot draw any strong inferences from his statement. Lt. Lumley advised Mr. Hird and me that we could not be down on the floor peeking our heads into the bean- hole to talk since it is a safety hazard to do so. We were advised that we should attempt to communicate through the crack in the wall as we had done previously.

14) Ms. Apala, the Unit Manager, then arrived and said that we should wait in a waiting room, located to our immediate left, and she would give Mr. Cole a few minutes to decide whether he would come out of his cell to visit with us. The Unit Manager then returned in a few minutes and said that Mr. Cole would not come out and she made a gesture of sawing her hand across her throat to indicate that Mr. Cole had made this gesture to indicate that he refused to come out of his cell to meet with us.

15) As we were leaving the waiting room, Mr. Hird said that he needed to see for himself what Mr. Cole would say or what gesture he would make. Mr. Hird then peered into Mr. Cole's cell and promptly declared that Mr. Cole did make the same gesture across his throat with his hand as described by the Unit Manager, Ms. Apala. We

were then escorted back to the front processing area where we retrieved our licenses, returned the knife vests, and departed the H Unit.

Further affiant sayeth not.

David G. Hough, Ph.D. ABPP

DAVID G. HOUGH, PH.D., ABPP

Subscribed and sworn to me on this 4th day of May, 2022.

STATE OF MISSISSIPPI NOTARY PUBLIC ID # 63439 GREGORY LEWIS Commission Expires July 11, 2025 HARRISON COUNTY

NOTARY PUBLIC

My commission number is: #63439

My commission expires: 07/11/2025

DECLARATION OF DAVID G. HOUGH., PH. D., ABPP
Diplomate of the American Board of Professional Psychology

I, Dr. David G. Hough, having the legal capacity to make this declaration, hereby state under oath as follows:

1. I am currently employed as a clinical psychologist with the Fairview Oregon Veterans Administration Community Out-Patient Clinic in Fairview, Oregon. In this position I diagnose and treat military veterans with evidence-based psychotherapies, addressing post-traumatic stress disorder (PTSD) in particular. I have a Ph.D. in Clinical Psychology and am Board Certified in Clinical Psychology by the American Board of Professional Psychology (ABPP).

2. Prior to this position, I was employed as a clinical psychologist with the Base Operational Support Team at Keesler US Air Force Base in Biloxi, Mississippi, from July 2021 to June 2022. Prior to this position at Keesler US Air Force Base, I was employed as a Clinical Psychologist with the US Air Force Europe (USAFE) at Royal Air Force (RAF) Lakenheath, in the United Kingdom from June 2016 to July 2021. I was assigned to the Aerospace Medical and Flight Operations Clinic, where I diagnosed and treated active-duty members.

3. Prior to my position at RAF Lakenheath, I worked as a clinical psychologist in the Embedded Mental Health Clinic at Ft. Riley, Kansas, and was employed by the Center for Deployment Psychology (CDP); before transferring to Ft. Riley, I worked as a clinical psychologist in the Family Health Clinic at Langley Air Force Base, Langley, Virginia.

4. Prior to my employment with the military and V.A. from 2013 to the present, I was self-employed in the private practice of clinical and forensic psychology since 1990. In this capacity, I diagnosed and treated patients of all ages and diagnoses, provided individual therapy, couples and family therapy, as well as psychoanalysis. In my forensic work, I have consulted with both defense and prosecution teams throughout the United States on primarily criminal cases. I have conducted extensive psychological evaluations and psychological testing on criminal defendants in all manner of facilities, from city jails to federal facilities and international venues. I have provided expert witness testimony in county, state, and federal courts and at the International Criminal Tribunal - Yugoslavia at The Hague, Netherlands, on a war crimes case. I have consulted with the U.S. Department of Justice on domestic terrorism cases within the United States and on a GITMO case. I have consulted with the U.S. Drug Enforcement Administration (DEA) and served as their Psychological Consultant for the Central United States.

5. I have conducted psychological evaluations and provided expert witness testimony on death penalty cases since 1995 in Kansas, Missouri, and Oklahoma. I have worked with attorneys on death penalty cases throughout their representation of their clients. I am familiar with the procedures on death row at the Oklahoma State Penitentiary (OSP), the housing issues specific to death row at OSP, and with the unique stressors experienced by prisoners who are sentenced to death.

6. I am currently working with the defense team on Benjamin Cole's case and have done so since 2016. I have reviewed all available records on the case provided by his current and previous counsel during the post-conviction process and direct appeal. I have also reviewed boxes of written material sent to Mr. Cole and have provided a qualitative content analysis of the main themes contained within these materials, as well as the written materials generated by Mr. Cole.

I have also attempted to interview Mr. Cole on multiple occasions, wherein he has refused to leave his cell to speak to me. Typically, the prison has not assisted with Mr. Cole leaving his cell to speak to me.

7. I am in receipt of a clinical report generated by Dr. Scott Orth, Psy.D., current Director of Forensic Psychology at the Oklahoma Forensic Center, Vinita, Oklahoma. The report is dated 14 July 2022 and is addressed to The Honorable Judge Gregory Frizzell, Judge of the United States District Court, Northern District of Oklahoma. I have reviewed this report generated by Dr. Orth and will hereafter respond with my observations of this report.

8. Dr. Orth's report made no reference to physically documenting his interactions with Mr. Cole, utilizing audio, or visual aids that would provide an independent record of the encounter for third-party independent analysis. If such exists, it has not been made available at this point. The reader is left to rely solely on Dr. Orth's description. The apparent absence of an independent record forecloses on the opportunity to verify Dr. Orth's report. Moreover, an evaluation with such high stakes, as in this case, ethically warrants a thorough, independent and fully transparent evaluation and record of the clinical encounter. As I have reviewed the professional literature, I am aware that an independent and fully transparent clinical evaluation is indicated for death penalty competency evaluations and concur with research which supports this assertion(See, e.g., Radelet ML, and Barnard GW: Ethics and the psychiatric determination of competency to be executed. Bull Am Acad Psychiatry Law 14:46-47, 1986).

10. Dr. Orth's describes Mr. Cole as being able to interact spontaneously, answer questions in complete sentences, track and comprehend the flow of the conversation logically and coherently. This clinical description of Mr. Cole is in radically sharp contrast to Mr. Cole's relational style, not only with this writer, but also with his current legal team, with Dr. Morris (evaluating psychiatrist), with current OSP observers (i.e., current Case Manager), and with the litany of legal teams before his current team. In contrast to this description by Dr. Orth, the typical experience of other observers and clinical evaluators over the course of years is one wherein Mr. Cole refuses to come out of his cell to talk and sits in his wheelchair, poorly groomed, head hung to the side, staring off and being non-responsive to verbal stimuli directed toward him. Any verbalizations he might offer are rare and heavily laden with religiosity and convey no meaning to the listener relevant to the matters being discussed. His focus upon religiously themed material cannot productively be redirected. The writer has discussed this with past and present legal team members, and it has consistently held true.

11. Dr. Orth describes Mr. Cole as essentially well groomed. Moreover, Dr. Orth describes that he was able to foster a high degree of positive rapport rather quickly with Mr. Cole. These descriptions present a discontinuity with the historical records among where there are many descriptions of Mr. Cole as presenting with poor hygiene and with a well-known and chronic history of non-relatedness.

During the interview Mr. Cole seems to interrupt Dr. Orth's explanation of limitations on confidentiality in a forensic context by spontaneously answering the two central competency questions required by the referring judge and the law (See p. 3, 2nd paragraph, under section Notification of Limits of Confidentiality). Specifically, Dr. Orth reports that when he asked Mr. Cole about his understanding of the reason for the current evaluation, that Mr. Cole responded as such: "he spontaneously state[d] '...to see if I'm competent and mentally fit to be executed... for court and competent here to see if I can go ahead and I guess be executed." Mr. Cole is then described as spontaneously going on about the pending order of executions coming up, why he is being executed for his daughter's death, and that he accepts responsibility for his actions. This type of spontaneous, verbally loquacious, and erudite verbalizations by Mr. Cole have rarely been observed, and have not been observed in recent times . No effort is made to reconcile how Dr. Orth was able to accomplish in quick order what other clinicians, despite repeated attempts, have not, and in particular how he was been able to affect such verbal spontaneity and (superficially) direct answers so quickly to the two questions that constitute the heart of the competency to be executed evaluation. Dr. Orth's assertions in this regard are likewise noted, especially since Mr. Cole was transported to meet with a complete stranger, in a strange and unfamiliar environment to him. It is obvious to this writer that Mr. Cole was prepped physically and verbally for this evaluation, yet Dr. Orth makes no reference to this. As noted under paragraph 8 above, there is no corroborating record available to provide objective evidence of this reported discussion between Mr. Cole and Dr. Orth.

12. In reviewing the records from OSP (4/15/2010 through 6/17/2022), Dr. Orth selectively cites records that would ostensibly support his overall assertion that Mr. Cole does not show signs of mental illness. In fact, there are numerous OSP records indicating serious mental health issues. Some examples are attached to this declaration. For example, but to cite a few:
03/11/14 Dave Kerby, Ph.D. noted that "Schizophrenia is a possible diagnosis. Disorganized behavior is suggested by his refusal to eat. Disorganized speech was not apparent today, but a mild looseness of association was noted in January when he was willing to speak ";

on the same day, 03/11/14, Dr. Kerby also reported that" The mental health level of zero appears to be incorrect. He had a mental health level of B at age 39, so his mental health level at age 48 should not be zero. His mild symptoms of January 2014 suggest a diagnosis of psychotic disorder. He was not floridly psychotic today; however, his refusal to speak and his oppositional behavior are consistent with the possibility of paranoid thinking; his conduct could also indicate the social isolation that is typical of schizophrenia.";

on 03/20/14 Dr. Kerby reports that" while offender could have been slow with sleepiness, the lack of eye contact and refusal to speak could suggest mental health problems.... Offender

currently has no mental health diagnosis, and records are lacking a history of mental illness. However, his recent change in behavior raises the possibility of a disorder....A psychiatry referral at this time seems appropriate."

On 08/29/14 Clinical Coordinator, Patti Stem, notes that "Beginning in January Mr. Cole has evidenced behavior indicating decompensation. Notes indicate he started out with conversation laced with religious themes and decreasing communication and eye contact with clinicians. In March when the meal refusals were reported he initially refused to allow vital signs to be taken , or to see the QMHP."

I am not aware of Mr. Cole ever having been referred for a formal psychiatry evaluation as was suggested by the writers of these records.

13. Absent from these records Dr. Orth selected is any mention of the negative symptoms of psychosis.

Negative clinical symptoms refer to the peculiar affect, social disconnectedness and other symptoms that are not as dramatic as flagrant hallucinations known as positive clinical symptoms of schizophrenia. Mr. Cole's negative symptoms, described in both the historical and current records, include lengthy periods of voluntary social isolation and withdrawal, choosing to live completely in the dark for years, extremely poor hygiene, very flattened affect, and non-communication with staff members for months at a time. Such behaviors, as here mentioned, exist in the historical records but are afforded no weight by Dr. Orth. Such negative symptoms are behaviors that are observable, measurable, and in the aggregate, indicative of serious mental illness (i.e., most typically observed among the regressed and chronic schizophrenic population or among those with chronic and severe major depression). Affidavits from former cellmates, for example, have described how Mr. Cole stayed in the dark for an entire year, incommunicado, and stared blankly at the TV screen without appearing to track the storyline.

Dr. Orth does not address the fact that there is no record of Mr. Cole ever being provided with a comprehensive psychiatric evaluation by the Department of Corrections to diagnose his condition. The notes cited by Dr. Orth, especially those describing "non-cooperation" as indications of an attitude problem (and thereby inferring not mental illness), and he does not reconcile his assessment of no mental illness with the longitudinal record from other mental health professionals both within and without the prison system that Mr. Cole has a severe mental illness.

14. Dr. Orth reports that while in prison, Mr. Cole's official psychiatric diagnosis according to the Fourth Edition Diagnostic and Statistical Manual of the American Psychiatry Association (DSM-IV) has always been "799.9 No Diagnosis." This statement regarding no diagnosis is factually incorrect. The DSM-IV diagnosis of 799.9 is entitled "Diagnosis Deferred". If Mr. Cole had been given no diagnosis, the DSM-IV code should have been V71.09 entitled "No diagnosis or condition on Axis I". Arguably the 799.9 Diagnosis Deferred implies Mr. Cole clinically exhibited some aspect of mental illness yet to be fully

evaluated. As noted above, there is no record of Mr. Cole ever being provided with a comprehensive psychiatric evaluation by the Department of Corrections to diagnose his condition.

It should be noted that the DSM-IV is an obsolete and out-of-date diagnostic source that is no longer a valid source of diagnostic nomenclature and not material to the current evaluation. The DSM-IV (published in 1994) has been surpassed by three further revisions. (DSM-IV-TR published in 2000; DSM-V, published in May 2013; and DSM-V-TR, published in May 2022). Each revision incorporates updated psychiatric research and advances to standard clinical practice. Up to date clinical assessment mandates using the Diagnostic and Statistical Manual V-Text Revision, referred to as the DSM-V5-TR, published by the American Psychiatric Association in Washington, DC.

It is important to note that the 799.9 diagnostic code was dropped with the 2013 publication of the DSM V. It has not been considered a valid diagnostic code since 2013, yet the prison medical records were not updated with an appropriate diagnosis. Dr. Orth does not address the use of an obsolete diagnostic code which has been incorrectly used in the historic records to denote no diagnosis rather than the correct diagnosis deferred. Dr. Orth does not provide a current diagnosis as would be reasonably expected for a competency evaluation of this nature.

15. It is standard practice for the forensic examiner to supplement their records review and direct face-to-face interviews with objective, statistically normed, psychological testing. Psychological testing is usually administered as a comprehensive battery of tests. The purpose of the testing is to provide evidence-based assessment of the patient's emotional, cognitive, and relational functioning. Psychological testing can typically elucidate personality features not discerned by interview or records review alone. In this regard, it is understood that psychological testing constitutes a recognized standard of practice for forensic evaluation. The data obtained from the testing is used to augment and reinforce conclusions and opinions derived from ancillary sources of date (e.g., records review, collateral interviews, and direct clinical interviews and mental status observations). It is well acknowledged with forensic evaluations that the psychometric data is more accurate than interview impressions. To conduct an evaluation without psychological testing is sub-substandard evaluation practice.

If Mr. Cole had been as conversational as described, then follow-up with objective, clinically normed psychological testing would have been indicated. Mr. Cole was not presented with any psychological testing in this evaluation.

16. Dr. Orth does not opine anywhere in his report the limitations of his clinical findings. As with any forensic psychological report, it is expected that the evaluator will acknowledge any limitations, circumstances, or missing data that could alter or change the reported outcome and conclusions of the report. For example, Dr. Orth does not acknowledge the limitations inherent in evaluating Mr. Cole on only one occasion versus, say, a series of interviews which would strengthen or potentially even refute his conclusions derived from a single evaluation. Dr. Orth

does not address any limitations of his report; every forensic evaluation, by definition, will contain some limitations. Some of them are crucial to assisting the Court to weigh the credibility of the report.

18. In summary, I have reviewed the work product of Dr. Orth's evaluation with Mr. Cole and find it flawed on numerous methodological grounds, as here detailed in this declaration. Such methodological deficits undermine the foundation upon which Dr. Orth's conclusions are derived. Dr. Orth does not opine as to what degree of psychological certainty he maintains that the conclusions embedded in his report can be relied upon by the reader. With Dr. Orth's report, confidence in these presented conclusions is considered by this writer as significantly low and should be relied upon, if at all, with a high degree of caution.

Executed on this 29thy day of July 2022 at

9254 SW Chopin Lane
Portland, Oregon 97225
(228) 239-7744
Georgehough4@gmail.com
Kansas License #708

David G. Hough, Ph.D., ABPP

Oklahoma Department of Corrections

COLE, BENJAMIN
OK DoC Offender ID **489814**
4/8/1965 (49) M Caucasian
Oklahoma State Penitentiary

Mental Health Progress Note SOAP - 10/15/14 15:57

Subjective Data:

Reason for this visit: Follow-up;
Referral source: Follow-up;
Current signs or symptoms and/or responses to treatment:
Offender said that he was doing good and was waiting for his new Bible. Thanks that it was a great Bible and he will be lossing sleep, with it ariving, he will enjoy it. He talk about passages in the Bible and what they mean. He talk about Vitamin's and Omega 3 what what it will do for you and how the different ones effect diderant parts of the body and mind.
Comments on Subjective Findings:
Offender was in a good mood and talk freely for about 40 minutes. Offender showed no signs of loose thought process. Offender remains alert and fully oriented with no evidence of thought disorde or neurological impairment. No auditory, visual, tactile, or olfactory hallucinations, with no suicide or homicidal ideation. He had working thoughts and able to express them well.

Objective Data:

Appearance: Appropriate;
Offender observed to have poor or declining health? No;
Behavior: Cooperative;
Mood: Normal;
Affect: Within Normal Limits;
Speech: Normal;
Perception: No Abnormalities;
Thought Process: Organized;
Thought content: Within normal limits;
Suicidal thoughts or behavior: No;
Homicidal thoughts or behavior: No;
Self injury thoughts or behavior: No;
Oriented to person, place, time: Yes;
Concentration intact: Yes;
Memory intact: Yes;
Abstract thinking intact: Yes;
Insight and judgement intact: Yes;
Reliable history and information from Record: Yes;
Reliable history and information from Offender: Yes;

Assessment:

Plan:

Plan:
Offender will contenue to be monitorred and evaluated for changes in behavior.
Follow-up:
as needed
Return Visit: 1 month;

Signed Electronically by Bruce White, Psychological Clinician on 10/15/14 16:14
Cosigned Electronically by Patti Stem, Clinical Coordinator on 10/15/14 16:51 (requested by Bruce White, Psychological Clinician on 10/15/14 16:14)

The contents of this document are confidential and restricted to authorized personnel of the Oklahoma Department of Corrections.

Oklahoma Department of Corrections

COLE, BENJAMIN
OK DoC Offender ID **489814**
4/8/1965 (49) M Caucasian
Oklahoma State Penitentiary

Mental Health Progress Note SOAP - 10/03/14 12:25

Subjective Data:

Reason for this visit: Initial;
Referral source: Medical staff;
Current signs or symptoms and/or responses to treatment:
Offender was seen at his cell door, he had just woken and would not talk, but the Unit Officer help get him talking. He talk of the bible and the songs from the bible. He told us of the different versis and how they came about. He requested a new Gient Print Kings James Bible because he can't read the other one.
Comments on Subjective Findings:
Offender and this QMHP, with the Unit Officer talk for about 30 minutes. His speech was organized, information was correct, with no sign of a loose thought process. His hair and face hair is not keep, but his property and cell is very clean. Staff stated that he doesn't talk to everyone, but people he chooses to, he has trouble comunicating with or voicing himself or his needs. He was very calm and talk frendly and respectfully. A bible will be found if posible. There was no observation that would indicate evedence of severe mental illness, he was alert and oriented to person, place, time, and situation.

Objective Data:

Appearance: Appropriate;
Offender observed to have poor or declining health? No;
Behavior: Calm; Cooperative;
Mood: Normal;
Affect: Within Normal Limits;
Speech: Normal; Soft;
Perception: No Abnormalities;
Thought Process: Organized;
Thought content: Within normal limits;
Suicidal thoughts or behavior: No;
Homicidal thoughts or behavior: No;
Self injury thoughts or behavior: No;
Oriented to person, place, time: Yes;
Concentration intact: Yes;
Memory intact: Yes;
Abstract thinking intact: Yes;
Insight and judgement intact: Yes;
Reliable history and information from Record: Yes;
Reliable history and information from Offender: Yes;

Assessment:

Plan:

Plan:
Offender will contenue to be monitored and evaluated for changes in behavior.
Follow-up:
as needed
Return Visit: 1 month;

Signed Electronically by Bruce White, Psychological Clinician on 10/03/14 12:47
Cosigned Electronically by Janna Morgan, Chief Mental Health Officer, PhD on 10/03/14 14:47 (requested by Patti Stem, Clinical Coordinator on 10/03/14 14:40)
Cosigned Electronically by Patti Stem, Clinical Coordinator on 10/03/14 14:39 (requested by Bruce White, Psychological Clinician on 10/03/14 12:47)

The contents of this document are confidential and restricted to authorized personnel of the Oklahoma Department of Corrections.

Oklahoma Department of Corrections

COLE, BENJAMIN
OK DoC Offender ID 489814
4/8/1965 (49) M Caucasian
Oklahoma State Penitentiary

Mental Health or Mental Status Review (Late Entry) - 08/29/14 12:07

Assessment:

Purpose of Review: Death row;
Offender cell, clothing, or body unkempt or unclean: NA;
Offender incoherent, bizarre, or unusually disorganized in speech or behavior: NA;
Offender disoriented to time, place or person: NA;
Offender demonstrate deficits in memory: NA;
Offender present any psychotic features: Low;
Offender appears sad or depressed: NA;
Offender displays symptoms of anxiety: NA;
Offender angry, hostile or threatening: Low;
Offender voice displays violent tendencies: NA;
Offender shows signs of euphoric or expansive mood: NA;
Offender reports or observation of suicidal ideation or behavior: No;
Offender observed in poor or declining health: No;
Comments: Offender Cole has been on the medical concern list since March, 2014 when it was reported he was refusing meals (according to him for religious reasons). (That is no longer the case. No recent incident reports of refused meals have been received). Prior to the first of this year the EHR lists no MH concerns either reported or observed. Beginning in January Mr. Cole has evidenced behavior indicating decompensation. Notes indicate he started out with conversations laced with religious themes, and decreasing communication and eye contact with clinicians. In March when the meal refusals were reported he initially refused to allow vital signs to be taken, or to see QMHP. He later was weighed, and placed on double portions. He is on the concern list, meaning he is observed each shift by a lieutenant daily and a report sent to this writer each time. His vitals are checked bi-weekly and he is seen by MH monthly. At the current time he refused to engage with this clinician. It was difficult to determine whether he was asleep or feigning sleep. Officers note that he rarely speaks, but will communicate with them with yes or no answers throughout the daily routines of feeding, showers, etc. He has refused to see the psychiatrist on two occasions. He also refused to see the psychologist sent on 7/30/14 through his attorney to do an independent evaluation; in spite of encouraging from this writer and the warden to come out. He will continue to be closely monitored.

Signed Electronically by Patti Stem, Clinical Coordinator on 09/18/14 13:06

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Oklahoma Department of Corrections

COLE, BENJAMIN
OK DoC Offender ID 489814
4/8/1965 (49) M Caucasian
Oklahoma State Penitentiary

Mental Health or Mental Status Review - 07/30/14 09:15

Assessment:

Purpose of Review: Death row;
Offender cell, clothing, or body unkempt or unclean: NA;
Offender incoherent, bizarre, or unusually disorganized in speech or behavior: NA;
Offender disoriented to time, place or person: NA;
Offender demonstrate deficits in memory: NA;
Offender present any psychotic features: NA;
Offender appears sad or depressed: NA;
Offender displays symptoms of anxiety: Moderate;
Offender angry, hostile or threatening: NA;
Offender voice displays violent tendencies: NA;
Offender shows signs of euphoric or expansive mood: NA;
Offender reports or observation of suicidal ideation or behavior: No;
Offender observed in poor or declining health: No;
Comments: Went to cell door accompanied by Warden Trammell to inform Mr. Cole about upcoming evaluation by outside psychologist. Mr. Cole initially did not respond, but came to the door when the Warden made her presence known. He removed head covering when asked. When he was being informed about the evaluation he abruptly turned, waved this clinician away, and lay down on his bunk, turned his head away and refused to acknowledge or respond to any further questions or requests. This has been his typical response of late to any mental health contact. Of note, in spite of 3 documented tries, Mr. Cole did refuse to come out to speak to the outside psychologist. Will return Mr. Cole to the offender concern list for daily observation by security staff, and MH will continue to follow up per policy

Signed Electronically by Patti Stem, Clinical Coordinator on 08/05/14 14:21

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OKLAHOMA DEPARTMENT OF CORRECTIONS
WAIVER OF TREATMENT/EVALUATION

Facility OSP Date 5-9-14 Time 0208

I certify that I am refusing to submit to treatment at my own insistence and against the advice of the health care provider.

1. I have been advised that it is necessary for me to undergo the following treatment/evaluation: weight

2. Treatment/evaluation being refused was to be provided to me by: Kanza
(Facility Name and/or Provider)

3. I have been informed by a qualified healthcare professional of the risks attendant to my refusal. These include: weight loss pain Kidney

4. I assume full responsibility for any results caused by my decision and I hereby release the institution, its employees, officers, and the provider from all legal responsibility and liability.

5. I certify that I am of sound mind and have read, or had read to me, and fully understand the above information concerning my refusal to accept treatment/evaluation and have had an opportunity to ask questions before I affix my signature.

Benjamin Cole	5-9-14		5-9-14
Offender Signature	Date	Witness (Health Care Staff)	Date
		BB	5-9-14
		Witness	Date

If the offender refuses to sign such a statement, he/she cannot be forced to do so legally nor may release be withheld until the offender signs. If this occurs, the form should be filled out, witnessed by two facility personnel and the statement documented on the form, "SIGNATURE REFUSED."

Offender's Name	DOC NO.
Benjamin Cole	489814

DOC 140117D (R 1/10)

Oklahoma Department of Corrections

COLE, BENJAMIN
OK DoC Offender ID **489814**
4/8/1965 (49) M Caucasian
Oklahoma State Penitentiary

Mental Health Progress Note NARRATIVE - 05/06/14 12:20

Progress Note:

Note:
REFUSED TO SEE ME

Signed Electronically by James Howard, MD on 05/06/14 12:21

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Oklahoma Department of Corrections

COLE, BENJAMIN
OK DoC Offender ID **489814**
4/8/1965 (49) M Caucasian
Oklahoma State Penitentiary

Mental Health Progress Note NARRATIVE - 05/01/14 20:32

Progress Note:

Note:
REFUSED TO SEE ME

Signed Electronically by James Howard, MD on 05/01/14 20:33

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Oklahoma Department of Corrections

COLE, BENJAMIN
OK DoC Offender ID **489814**
4/8/1965 (49) M Caucasian
Oklahoma State Penitentiary

Mental Health or Mental Status Review - 04/22/14 13:30

Assessment:

Purpose of Review:
Re-evaluation

Offender cell, clothing, or body unkempt or unclean:
NA

Offender reports or observation of suicidal ideation or behavior:
No

Comments:
(Late entry). Offender refused to come to door to speak on rounds today. He turned his back, peed in the toilet, and flushed.

Signed Electronically by Dave Kerby, PhD on 04/22/14 15:50

The contents of this document are confidential and restricted to authorized personnel of the Oklahoma Department of Corrections.

OKLAHOMA DEPARTMENT OF CORRECTIONS
WAIVER OF TREATMENT/EVALUATION

Facility OKLAHOMA STATE PENITENTIARY Date 4-22-14 Time 1315

I certify that I am refusing to submit to treatment at my own insistence and against the advice of the health care provider.

1. I have been advised that it is necessary for me to undergo the following treatment/evaluation: weight evaluation

2. Treatment/evaluation being refused was to be provided to me by: OKLAHOMA STATE PENITENTIARY DENTAL (Facility Name and/or Provider)

3. I have been informed by a qualified healthcare professional of the risks attendant to my refusal. These include: PAIN, INFECTION or DEATH, worsening of condition

4. I assume full responsibility for any results caused by my decision and I hereby release the institution, its employees, officers, and the provider from all legal responsibility and liability.

5. I certify that I am of sound mind and have read, or had read to me, and fully understand the above information concerning my refusal to accept treatment/evaluation and have had an opportunity to ask questions before I affix my signature.

Benjamin Cole 4-22-14
Offender Signature Date

Witness (Health Care Staff) 4-22-14
Date

Witness 4-22-14
Date

If the offender refuses to sign such a statement, he/she cannot be forced to do so legally nor may release be withheld until the offender signs. If this occurs, the form should be filled out, witnessed by two facility personnel and the statement documented on the form, "SIGNATURE REFUSED."

Offender's Name	DOC NO.
Benjamin Cole	489814

DOC 140117D (R 1/10)

Oklahoma Department of Corrections

COLE, BENJAMIN
OK DoC Offender ID **489814**
4/8/1965 (49) M Caucasian
Oklahoma State Penitentiary

refused visit - 04/22/14 13:54

Subjective Data:

Chief Complaint:
refused visit, waiver signed.

Objective Data:

Assessment:

Plan:

Co-Payment Assignment (Select procedures - office clinic visit and/or medication(s) for co-payment)

Encounter: Medical Progress Note- SOAP
Date/Time of Service: 04/22/14 13:54
Location of Service: Oklahoma State Penitentiary
Provider: John Marlar, DO Authorizing Provider: John Marlar, DO

Signed Electronically by John Marlar, DO on **04/22/14 13:55**

The contents of this document are confidential and restricted to authorized personnel of the Oklahoma Department of Corrections.

Oklahoma Department of Corrections

COLE, BENJAMIN
OK DoC Offender ID **489814**
4/8/1965 (49) M Caucasian
Oklahoma State Penitentiary

Mental Health or Mental Status Review: Medical Observation List - 04/18/14 19:45

Assessment:

Purpose of Review:
Other Medical Observation List

Offender cell, clothing, or body unkempt or unclean:
NA

Offender reports or observation of suicidal ideation or behavior:
No

Comments:
Offender would not respond to this clinician. Officers report that he seldom talks to anyone, but he does speak to some officers to the extent of answering yes-no questions, such as "Do you want a tray?"

Signed Electronically by Dave Kerby, PhD on 04/18/14 20:02

The contents of this document are confidential and restricted to authorized personnel of the Oklahoma Department of Corrections.

Oklahoma Department of Corrections

COLE, BENJAMIN
OK DoC Offender ID **489814**
4/8/1965 (49) M Caucasian
Oklahoma State Penitentiary

Mental Health or Mental Status Review - 04/03/14 09:00

Assessment:

Purpose of Review:
Re-evaluation

Offender cell, clothing, or body unkempt or unclean:
NA

Offender appears sad or depressed:
NA

Offender voice displays violent tendencies:
NA

Offender shows signs of euphoric or expansive mood:
NA

Offender reports or observation of suicidal ideation or behavior:
No

Comments:
Offender was seen at his cell on the unit. While this clinician knocked at the door and repeatedly asked him to speak, the offender arranged neatly stacked papers, turned his back and peed, flushed the toilet, and arranged papers again. All this time he never even glanced or gestured an acknowledgement of this clinician's presence.

Signed Electronically by Dave Kerby, PhD on 04/03/14 09:50
Cosigned Electronically by Patti Stem, Clinical Coordinator on 04/03/14 15:32 (requested by Dave Kerby, PhD on 04/03/14 09:51)

The contents of this document are confidential and restricted to authorized personnel of the Oklahoma Department of Corrections.

Oklahoma Department of Corrections

COLE, BENJAMIN
OK DoC Offender ID **489814**
4/8/1965 (49) M Caucasian
Oklahoma State Penitentiary

Mental Health Progress Note NARRATIVE - 04/03/14 20:05

Progress Note:

Note:
REFUSED TO SEE ME.

Signed Electronically by James Howard, MD on 04/03/14 20:05

The contents of this document are confidential and restricted to authorized personnel of the Oklahoma Department of Corrections.

OKLAHOMA DEPARTMENT OF CORRECTIONS
WAIVER OF TREATMENT/EVALUATION

Facility BJP Date 3/22/14 Time 3- 10:15

I certify that I am refusing to submit to treatment at my own insistence and against the advice of the health care provider.

1. I have been advised that it is necessary for me to undergo the following treatment/evaluation: EVAL c SOAP

2. Treatment/evaluation being refused was to be provided to me by: [illegible] (Facility Name and/or Provider)

3. I have been informed by a qualified healthcare professional of the risks attendant to my refusal. These include: weight loss eyes

4. I assume full responsibility for any results caused by my decision and I hereby release the institution, its employees, officers, and the provider from all legal responsibility and liability.

5. I certify that I am of sound mind and have read, or had read to me, and fully understand the above information concerning my refusal to accept treatment/evaluation and have had an opportunity to ask questions before I affix my signature.

Benjamin Cole 3-27-14
Offender Signature Date

[illegible]
Witness (Health Care Staff) Date

[illegible] 3-27-14
Witness Date

If the offender refuses to sign such a statement, he/she cannot be forced to do so legally nor may release be withheld until the offender signs. If this occurs, the form should be filled out, witnessed by two facility personnel and the statement documented on the form, **"SIGNATURE REFUSED."**

Offender's Name	DOC NO.
Benjamin Cole	489814

DOC 140117D (R 1/10)

Oklahoma Department of Corrections

COLE, BENJAMIN
OK DoC Offender ID **489814**
4/8/1965 (49) M Caucasian
Oklahoma State Penitentiary

Mental Health NARRATIVE: Referral to Psychiatrist - 03/20/14 16:26

Progress Note:

Note:
Offender Cole has shown increasingly poor eye contact, social withdrawal, refusal to cooperate with medical staff, and refusal to eat. A psychiatry referral at this time seems appropriate.

Signed Electronically by Dave Kerby, PhD on 03/20/14 16:29
Cosigned Electronically by Rose Gwin, LPN, LPN on 03/25/14 10:42 (requested by Dave Kerby, PhD on 03/20/14 16:29)
Cosigned Electronically by Patti Stem, Clinical Coordinator on 03/20/14 17:10 (requested by Dave Kerby, PhD on 03/20/14 16:29)

The contents of this document are confidential and restricted to authorized personnel of the Oklahoma Department of Corrections.

Oklahoma Department of Corrections

COLE, BENJAMIN
OK DoC Offender ID 489814
4/8/1965 (49) M Caucasian
Oklahoma State Penitentiary

Mental Health Progress Note SOAP - 03/20/14 15:38

Subjective Data:

Reason for this visit: Follow-up;
Referral source: Medical staff;
Chief Complaint:
Other:
Offender refuses to be weighed.

Current signs or symptoms and/or responses to treatment:
Offender was approach at his cell door on the unit. He did not respond from his bed when this clinician knocked at the door. When a guard came by doing checks and shone a light in the cell, offender rose from the bed and walked to the door.

His gait was stiff, and his steps small. His head was down, and his eyes were never raised for eye contact. He stood mutely at the door for about fifteen to twenty seconds, while this clinician spoke to him. He never replied, but turned slowly away. With the same stiff gait he went to the toilet and urinated, flushed, then he heavily lay down to bed again.

Comments on Subjective Findings:
While offender could have been slow with sleepiness, the lack of eye contact and the refusal to speak could suggest mental health problems. This clinician saw the offender on 3/11/14, and though he was socially withdrawn, he did not show motor retardation then, and he also spoke.

Objective Data:

Appearance: Bizarre;
Behavior: Other; Distant, withdrawn
Speech: Other; Mute
Perception: Other; Cannot be check due to no speech
Thought Process: Other; Cannot be checked due to no speech
Thought content: Other; Cannot be checked due to no speech
Suicidal thoughts or behavior: No;
Homicidal thoughts or behavior: No;
Self injury thoughts or behavior: No;

Assessment:

Comments on Diagnosis:
Offender currently has no mental health diagnosis, and records are lacking a history of mental illness. However, his recent change in behavior raises the possibility of a disorder.

Plan:

Plan:
Continue to attempt to assess.

Signed Electronically by Dave Kerby, PhD on 03/20/14 15:53
Cosigned Electronically by Pat Sorrels, CHSA on 03/21/14 10:23 (requested by Patti Stem, Clinical Coordinator on 03/20/14 15:59)
Cosigned Electronically by Chris Kampas, RN on 03/22/14 13:09 (requested by Patti Stem, Clinical Coordinator on 03/20/14 15:59)
Cosigned Electronically by John Marlar, DO on 03/27/14 15:20 (requested by Patti Stem, Clinical Coordinator on 03/20/14 15:59)
Cosigned Electronically by Patti Stem, Clinical Coordinator on 03/20/14 15:58 (requested by Dave Kerby, PhD on 03/20/14 15:53)

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Oklahoma Department of Corrections

COLE, BENJAMIN
OK DoC Offender ID **489814**
4/8/1965 (49) M Caucasian
Oklahoma State Penitentiary

Mental Health SOAP: Addendum - 03/11/14 15:46 [Addendum]

Subjective Data:

Objective Data:

Suicidal thoughts or behavior: No;
Homicidal thoughts or behavior: No;
Self injury thoughts or behavior: No;

Assessment:

Comments on Diagnosis:
Offender has been a mental health level zero and has had no mental health diagnosis. While the level zero appears to have been an error, reliable records do not exist regarding past mental illness.

Schizophrenia is a possible diagnosis. Disorganized behavior is suggested by his refusal to eat. Disorganized speech was not apparent today, but a mild looseness of association was noted in January when he was willing to speak. While no clear evidence of delusions are present, he may have some unexpressed beliefs that have led him to refuse food and to refuse to interact with staff. There was a clear absence of negative symptoms and of abnormal motor movements.

Plan:

Plan:
Offender will be monitored during rounds for symptoms to clarify the diagnostic picture, as he has been willing in the past to talk during rounds on the unit. He also needs to be monitored regarding his food intake.

Signed Electronically by Dave Kerby, PhD on 03/11/14 16:18
Cosigned Electronically by Patti Stem, Clinical Coordinator on 03/11/14 18:47 (requested by Dave Kerby, PhD on 03/11/14 16:18)

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Oklahoma Department of Corrections

COLE, BENJAMIN
OK DoC Offender ID **489814**
4/8/1965 (49) M Caucasian
Oklahoma State Penitentiary

Mental Health SOAP: Mental health level B - 03/11/14 10:15

Subjective Data:

Reason for this visit: Follow-up;
Chief Complaint:
Other:
Assess mental status and physical status

Current signs or symptoms and/or responses to treatment:
Offender is a 48-yr-old white male with a mental health level of zero. Desipite this mental health level, offender during rounds in Jan 2014 showed minor symptoms of mental illness: poor eye contact, mild looseness of association in his speech, and some unusual religious content. In addition, a document dated 27 Dec 2004 when the offender was 39 years old and scanned into the EHR on 12 Sep 2011 contains information about mental health level. The document was signed by Ann Boyd, PhD, who gave the offender a mental health level of B.

Offender was seen today with Dr. Marlar in the medical room on H unit. When offender came to the door, he shook his head and said "I refuse." He repeatedly refused to participate, and steadily walked toward the door. He would not step on the scales to be weighed. He finally consented to sign a document that he refused all treatment.

His affect was not angry or irritable. Despite his oppositional conduct, his mood was in the normal range; indeed, he seemed in a good mood. His speech was too limited to obtain much impression. He mostly said simple phrases such as "I refuse" and "I'm not talking to you guys." His one statement of more than a few words referred to the meals here as "pig food", and he said that he should be receiving kosher food.

He signed a medical refusal form, showing no problems with muscle control. His gait appeared normal. There was no evidence of breathing difficulties, and his skin tone was in the normal range. Orientation and memory could not be fully gauged, due to lack of cooperation, but he showed no obvious deficits.

Comments on Subjective Findings:
The mental health level of zero appears to be incorrect. He had a mental health level of B at age 39, so his mental health level at age 48 should not be zero. His mild symptoms of January 2014 suggest a diagnosis of a psychotic disorder. He was not floridly psychotic today; however, his refusal to speak and his oppositional behavior are consistent with the possibility of paranoid thinking; his conduct could also indicate the social isolation that is typical of schizophrenia. He was not obviously psychotic today, but his mental status should continue to be monitored.

Objective Data:

Behavior: Other; uncooperative
Mood: Normal;
Affect: Within Normal Limits;
Speech: Other; Limited speech due to refusal to cooperate
Perception: No Abnormalities;
Thought Process: Other; Difficult to assess due to lack of cooperation
Thought content: Other; Lack of cooperation could suggest the possibility of paranoid thinking
Suicidal thoughts or behavior: No;
Homicidal thoughts or behavior: No;
Self injury thoughts or behavior: No;

Assessment:

Plan:

Signed Electronically by Dave Kerby, PhD on 03/11/14 11:14
Cosigned Electronically by Janna Morgan, Chief Mental Health Officer, PhD on 03/11/14 15:29 (requested by Patti Stem, Clinical Coordinator on 03/11/14 11:22)
Cosigned Electronically by Pat Sorrels, CHSA on 03/21/14 10:23 (requested by Patti Stem, Clinical Coordinator on 03/20/14 16:14)
Cosigned Electronically by Patti Stem, Clinical Coordinator on 03/11/14 11:21 (requested by Dave Kerby, PhD on 03/11/14 11:14)

The contents of this document are confidential and restricted to authorized personnel of the Oklahoma Department of Corrections.

Oklahoma Department of Corrections

COLE, BENJAMIN
OK DoC Offender ID **489814**
4/8/1965 (49) M Caucasian
Oklahoma State Penitentiary

Mental Health or Mental Status Review - 01/29/14 11:00

Assessment:

Purpose of Review:
Re-evaluation

Offender cell, clothing, or body unkempt or unclean:
NA

Offender incoherent, bizarre, or unusually disorganized in speech or behavior:
NA

Offender disoriented to time, place or person:
NA

Offender demonstrate deficits in memory:
NA

Offender present any psychotic features:
NA

Offender appears sad or depressed:
NA

Offender displays symptoms of anxiety:
NA

Offender angry, hostile or threatening:
NA

Offender voice displays violent tendencies:
NA

Offender shows signs of euphoric or expansive mood:
NA

Offender reports or observation of suicidal ideation or behavior:
No

Comments:
Mental health level zero. Offender came to the cell door and spoke at some length. His eye contact was poor, as he had his face up to the door and never looked at this clinician. His speech was coherent, though there was a suggestion of a slight looseness of association. He mentioned some religious themes: for example, "The day of the Lord is at hand."

He had noticable bad breath, and he seemed aware of it. He asked for an indigent sack, so that he could have a toothbrush and toothpaste for oral hygiene. He mentioned several times his desire for better oral hygiene. (Follow-up with case manager indicates that he is not on the indigent list).

Signed Electronically by Dave Kerby, PhD on 01/29/14 14:38

The contents of this document are confidential and restricted to authorized personnel of the Oklahoma Department of Corrections.

OKLAHOMA DEPARTMENT OF CORRECTIONS
WAIVER OF TREATMENT/EVALUATION

Facility OSP Date 11-27-13 Time 12:05

I certify that I am refusing to submit to treatment at my own insistence and against the advice of the health care provider.

1. I have been advised that it is necessary for me to undergo the following treatment/evaluation: General Health

2. Treatment/evaluation being refused was to be provided to me by: Marla
(Facility Name and/or Provider)

3. I have been informed by a qualified healthcare professional of the risks attendant to my refusal. These include: Worsening of condition, decline of health

4. I assume full responsibility for any results caused by my decision and I hereby release the institution, its employees, officers, and the provider from all legal responsibility and liability.

5. I certify that I am of sound mind and have read, or had read to me, and fully understand the above information concerning my refusal to accept treatment/evaluation and have had an opportunity to ask questions before I affix my signature.

Refused to sign 11-27-13 — Offender Signature / Date

[signature] 11-27-13 — Witness (Health Care Staff) / Date

[signature] 11-27-13 — Witness / Date

... offender refused to be seen by Medical. Has Refused to sign Waiver.

If the offender refuses to sign such a statement, he/she cannot be forced to do so legally nor may release be withheld until the offender signs. If this occurs, the form should be filled out, witnessed by two facility personnel and the statement documented on the form, "SIGNATURE REFUSED."

Offender's Name	DOC NO.
Cole	489814

DOC 140117D (R 1/10)

Oklahoma Department of Corrections

COLE, BENJAMIN
OK DoC Offender ID 489814
4/8/1965 (49) M Caucasian
Oklahoma State Penitentiary

wellness check - 11/26/13 22:30

Progress Note:

Progress Note:
officer K Hughes asked for offender to be evaluated during med pass. offender refused to come to cell door for evaluation. . officer hughes stated earlier in the day offender had been helped to shower and offender appeared to be very thin and weak. offender has not stated a hunger strike but appears to not be eating an adequate amount of food at this time. Dr. Marlar will be notified.

Encounter:	SIMPLE Narrative Note
Date/Time of Service:	11/26/13 22:30
Location of Service:	Oklahoma State Penitentiary
Provider:	Bill Savage, RN Authorizing Provider: Bill Savage, RN

Signed Electronically by Bill Savage, RN on 11/26/13 22:37
Cosigned Electronically by John Marlar, DO on 11/27/13 11:04 (requested by Bill Savage, RN on 11/26/13 22:37)

The contents of this document are confidential and restricted to authorized personnel of the Oklahoma Department of Corrections.

AFFIDAVIT OF LINDA ANNE HAYMAN, M.D.

STATE OF TEXAS)
) ss.
COUNTY OF HARRIS)

I, Linda Anne Hayman, M.D., state as follows:

1. I am a Board certified Radiology specialist with additional years of subspecialty training in Neuroradiology. I have been licensed to practice in the State of Texas since 1973.

2. I am currently the medical director of Anatom-e which makes software for analysis of the brain anatomy and function. This company is headquartered at 7505 Fannin, Suite 426, Houston Texas 77030. A copy of my resume is attached hereto.

3. All of my experience and practice has specifically involved the review and analysis of radiological scans of the brain/spine and assessment of neurological damage and injury to the brain/spine. My experience in assessing neurological brain damage is inclusive of determining the physiological and behavioral effects of damage to the various regions of the brain. From 1996-2003 I held the position of a joint tenured professorship in the Departments of Radiology and Psychiatry and Behavioral Sciences at Baylor College of Medicine in Houston, Texas. I taught brain function at the Medical School during those years. In addition I am the author of "Clinical Brain Imaging; Normal Structure and Functional Anatomy," which is a 449 page authoritative textbook on brain imaging and function. In 2002, my imaging laboratory published the lead article in the preeminent international journal, *Radiology*. The article described the imaging correlates of brain damage to the frontal lobe.

4. At the request of the Office of the Federal Public Defender for the Western District of Oklahoma, I have conducted a review of the following materials and records pertaining to death row inmate Benjamin Cole:

a) MRI of brain 9-22-04;
b) Report of Matthew Powers, M.D., radiologist;
c) Report of John D. Hastings, Neurologist;
d) Declaration of Ruben C. Gur, Ph.D., neuropsychologist;
e) Report/Consultation of Raphael Morris, M.D., psychiatrist;
f) Affidavit of Cherry Peirce;
g) Samples of correspondence written by from January, 2006 and December, 2014;
h) Oklahoma Department of Corrections medical records 2014; and,

l) Memorandum and affidavit memorializing the defense team's effort to communicate with Mr. Cole January 8, 2015.

5. Based on my review of the enumerated records and my analysis of the images of Mr. Cole's brain, it is my professional opinion that in all medical probability Mr. Cole has progressive structural and biochemical abnormalities that severely impair his ability to interact appropriately with his surroundings. My training and expertise applies to the structural lesion which is seen Mr. Cole's MR images in his left globus pallidus. This structure is part of the basal ganglia which is a relay station in the pathway connecting the left frontal lobe with the anterior thalamus. Disruption of this pathway could produce the frontal lobe symptoms described by Dr. Gur. The schizophrenia which is also present in Mr. Cole's medical history is a biochemical imbalance which has associations with inherited defects and chaotic family conditions. All of these predisposing conditions are present in Mr. Cole's medical records.

6. The synergistic effects of Mr. Cole's schizophrenia and the left basal ganglia lesion are supported by the predominance of his "negative symptoms," which have been related specifically to abnormalities in the left globus pallidus. [Proc. Natl. Acad. Sci. USA Vol. 84, pp. 561-563, January 1987 Medical Sciences]. The term "negative symptoms" refers to an absence of behaviors or feelings that are usually present. Negative symptoms may be noted as inexpressive faces, blank looks, monotone and monosyllabic speech, few gestures, a seeming lack of interest in the world and other people, and an inability to feel pleasure or act spontaneously. The two medical conditions associated with negative symptoms are *Alogia* and *Avolition.* Alogia is a condition affecting thought and speech. A person experiencing alogia will have difficulty thinking clearly. The person's speech will be reduced because the person will have difficulty speaking with others. Sometimes, the person's speech will be reduced to short answers. Avolition is when a person doesn't feel like doing anything at all. A person may sit for long periods of time, showing little interest in participating in work or everyday activities, like bathing or getting dressed. Alogia and avolition are increasingly present in Mr. Cole.

7. The lesion detected 10 years ago has likely progressed. I hold this opinion because Mr. Cole's clinical symptoms have progressed. A new MRI and PET are strongly recommended. Indeed, it is my opinion that new brain imaging is essential to both medical evaluation and legal representation of Mr. Cole..

8. In conclusion, it is my expert opinion that Mr. Cole has observable brain damage. His brain lesion renders him unable to respond in a normal way to his environment. The lesion and symptoms are worsening.

FURTHER AFFIANT SAYETH NOT.

Anne Hayman, M.D.

Subscribed and sworn to before me this 16 day of January, 2015.

NOTARY PUBLIC

My commission number is: 4-2-2015

My commission expires: 01121500.8

DECLARATION OF TRAVIS SNYDER, DO

I, Travis Snyder, DO, declare:

1. I am a physician who is board-certified in Radiology with additional board certification and added qualifications in Neuroradiology. I completed residency at Michigan State in 2014 and a fellowship in Neuroradiology at the University of Miami in 2015. I am over 18 years old.

2. I am Adjunct Professor of Radiology at Michigan State University, Adjunct Assistant Professor of Neuroradiology and Radiology at Touro University Nevada, Touro University California, and University of Nevada Reno School of Medicine and a clinical professor of Radiology at the UNLV School of Medicine. I am program director of the HCA sunrise consortium NV radiology residency. I am in clinical practice specializing in Neuroradiology. I have given and authored over 50 presentations, abstracts and articles in the field of Radiology and Neuroradiology. I have attached a copy of my Curriculum Vitae.

3. I have reviewed the MRI on Benjamin Cole (DOB 4/8/65) performed at Oklahoma State University on 3/30/22. This is a markedly abnormal MRI which demonstrates multiple pathologic findings as follows:

- 11 x 11 x 15 mm (AP, T, CC) prominent left basal ganglia lesion centered in the left globus pallidus which involves the putamen and left genu and posterior limb of the internal capsule, portions of the lentiform nucleus and the most superior anterior aspect of the midbrain. There is a small amount of central decreased SWI signal consistent with associated hemosiderin (old hemorrhage) or calcification. There is no abnormal enhancement. While this lesion was present on the 11/22/04 MRI, it likely has mildly increased in size by comparison of available key images and radiologist measurement at the time (11 mm). This is highly consistent with toxic exposure to chemicals substances, including carbon monoxide. This lesion impacts multiple regions with predominant motor function. Parkinsonism, including delayed onset) has been well described as occurring in 9.5% of patients with Carbon Monoxide (CO) and is likely much more prevalent in CO patients

with globus pallidus lesions, as only 20% of patients with CO poisoning have globus pallidus lesions (Jeon, Sohn et al. 2018) (Choi 2002). Some degree of left sided motor dysfunction would be expected given the extent of the lesion in this location and Parkinsonism would be highly consistent with this lesion. The globus pallidus also acts as a relay system connecting the frontal lobes and thalamus. There is research indicating the globus pallidus is involved in pathways affected by schizophrenia (Williams 2017) with cognitive associations well described (Li, Zhao et al. 2021). Motor, cognitive and memory symptoms have been well described in patients with strokes to these regions (Giroud, Lemesle et al. 1997).

- There is large diffuse increased FLAIR/T2 signal consistent with gliosis (scarring) involving the bilateral posterior corona radiata, the posterior centrum semiovale and posterior periatrial trigones measuring 5.3 cm on the left and 3 cm on the right in maximal dimension. This finding is also consistent with a chemical type insult, as this is one of the most common locations affected in toxic insults including carbon monoxide poisoning. Delayed neurological sequela, a demyelinating inflammatory condition occurring in approximately 24.1% of patients following a toxic exposure is associated with these imaging findings (Chang, Han et al. 1992, Pepe, Castelli et al. 2011). The corona radiata has been described as *"pivotal hubs for the neural circuitry in charge of voluntary emotional expression and cognition processing. Damage to the corona radiata disconnects the functional circuitry between the frontal cortex and brain stem, disturbing voluntary emotional expression."* (Jiang, Yi et al. 2019) Given the size of this diffuse increased bilateral signal, symptoms are highly likely. It is possible this is a new finding, as it is not mentioned in the 11/22/04 MRI report by the interpreting radiologist Dr. Powers or a subsequent review by a neurologist Dr. Hastings or neurordiologist Dr. Hayman, however it is most likely this finding was present previously, just better visualized due to superior resolution of the current study. The 2004 images are not available directly for comparison.

- There is limitation in the current viewable 3/30/22 imaging, more sensitive volumetric analysis and diffusion tensor imaging has not yet been able to be analyzed. 3D reformats of various sequences are not yet possible and would be of benefit to asses some regions in the anterior right frontal lobe. I reserve the right to supplement this report when these analyses are available.

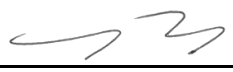
4. The clinical record is highly concordant with the imaging findings described. Dr. Gur's 2009 neuropsychiatric evaluation analysis demonstrated frontal lobe deficits, greater on the left, highly concordant with the imaging findings (Dr. Gur page 3). Ben Cole has been diagnosed with chronic and persistent severe schizophrenia (Dr. Hough page 20). The effect of the left globus pallidus centered lesion may be exacerbating this condition in addition to inherent symptoms from the damage. Mr. Cole is reported to be in a wheelchair, without reported medical cause, which may relate to the motor function of the described left globus pallidus centered lesion and possible Parkinsonism (Dr. Hough page 13).

5. Multiple providers have stated that Benjamin Cole is not competent to understand legal proceedings and have recommended a follow-up MRI to the 2004 MRI. Given the high concordance of the imaging with the clinical record, the imaging reviewed is supportive of their opinions.

6. Key images and references below.

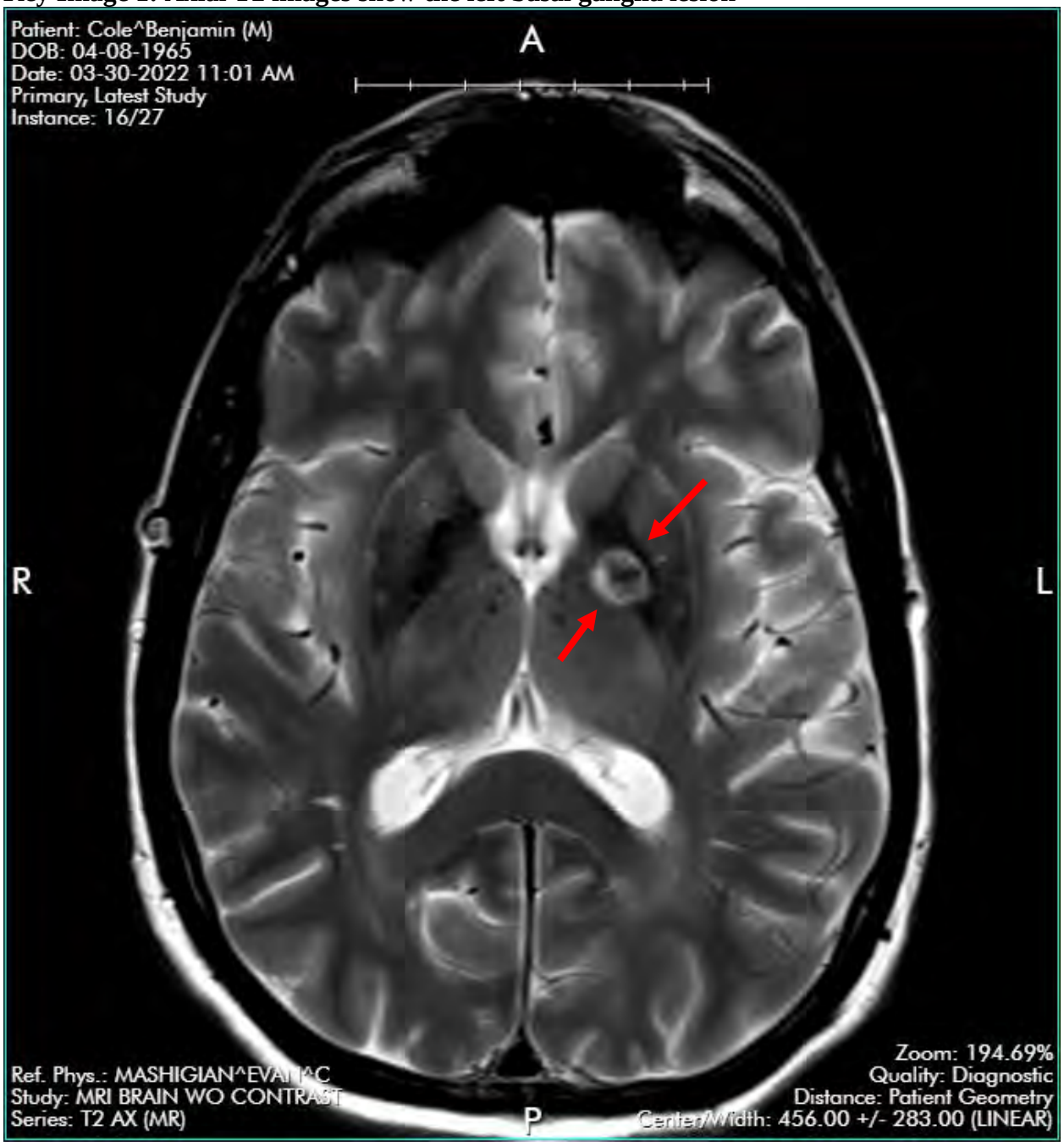
I declare under penalty of perjury under the laws of the Oklahoma that the foregoing is true and correct.

Executed on May 11th, 2022, at Las Vegas, Nevada.

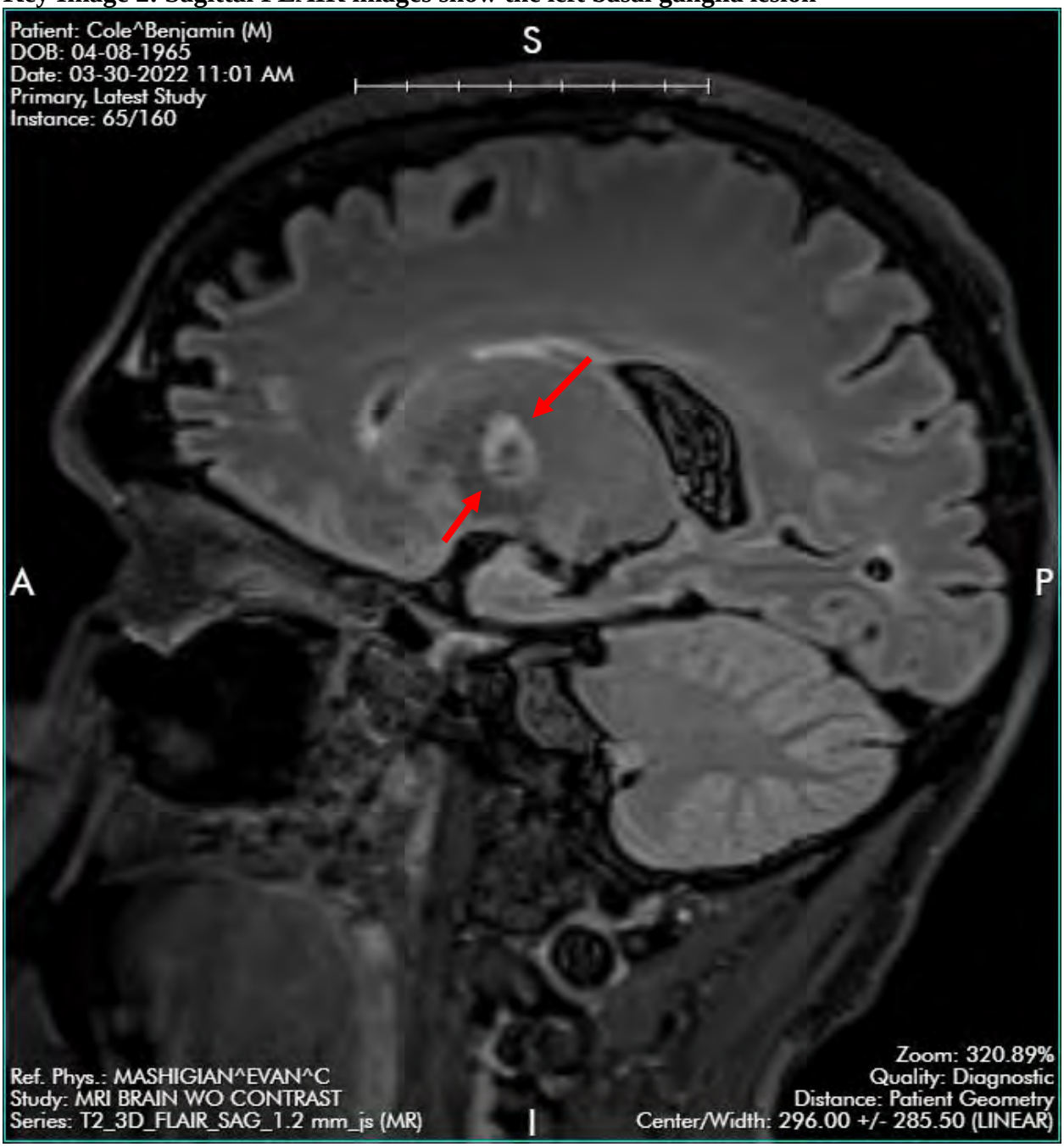


Travis Snyder, DO

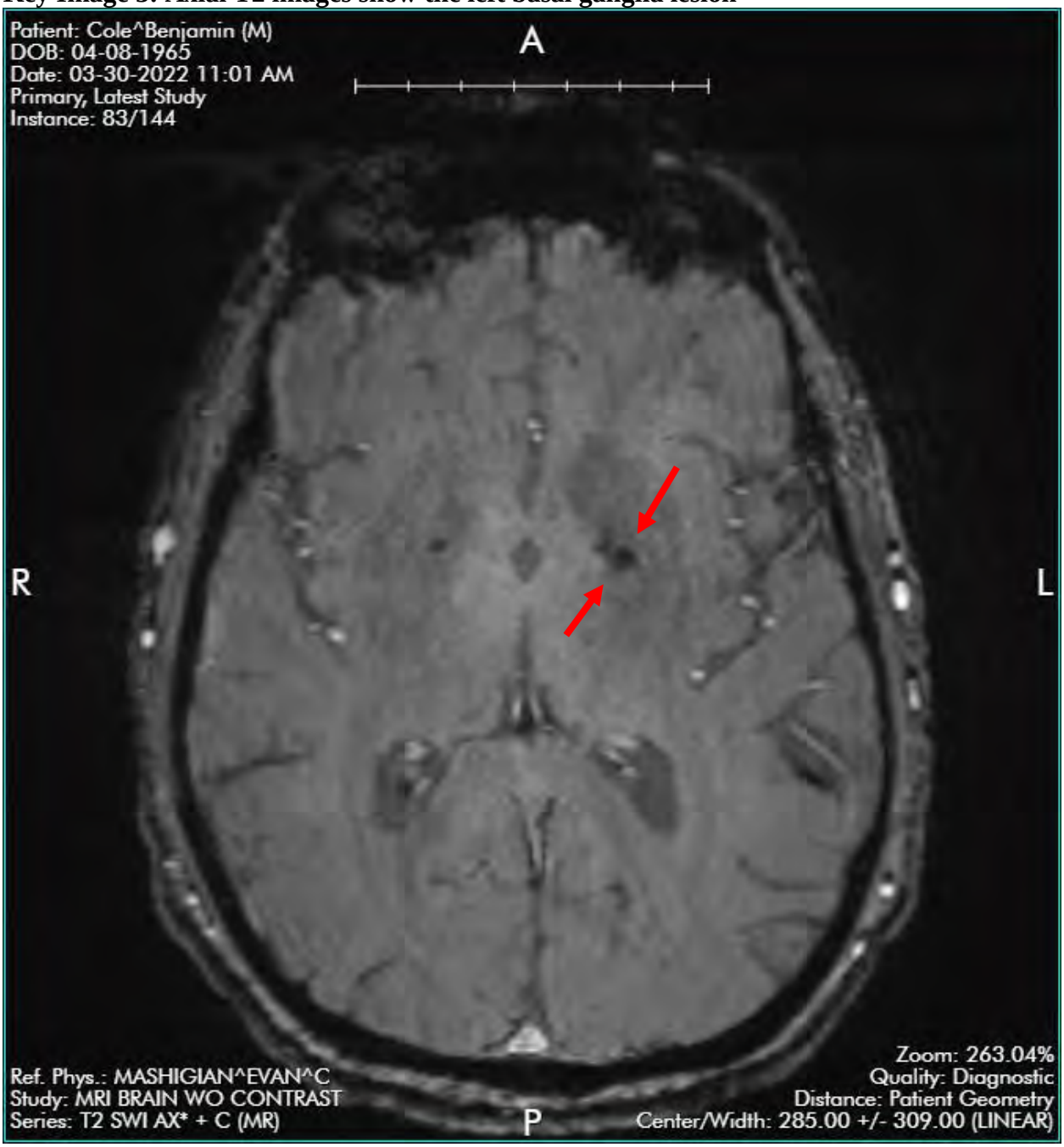
Key Image 1: Axial T2 images show the left basal ganglia lesion



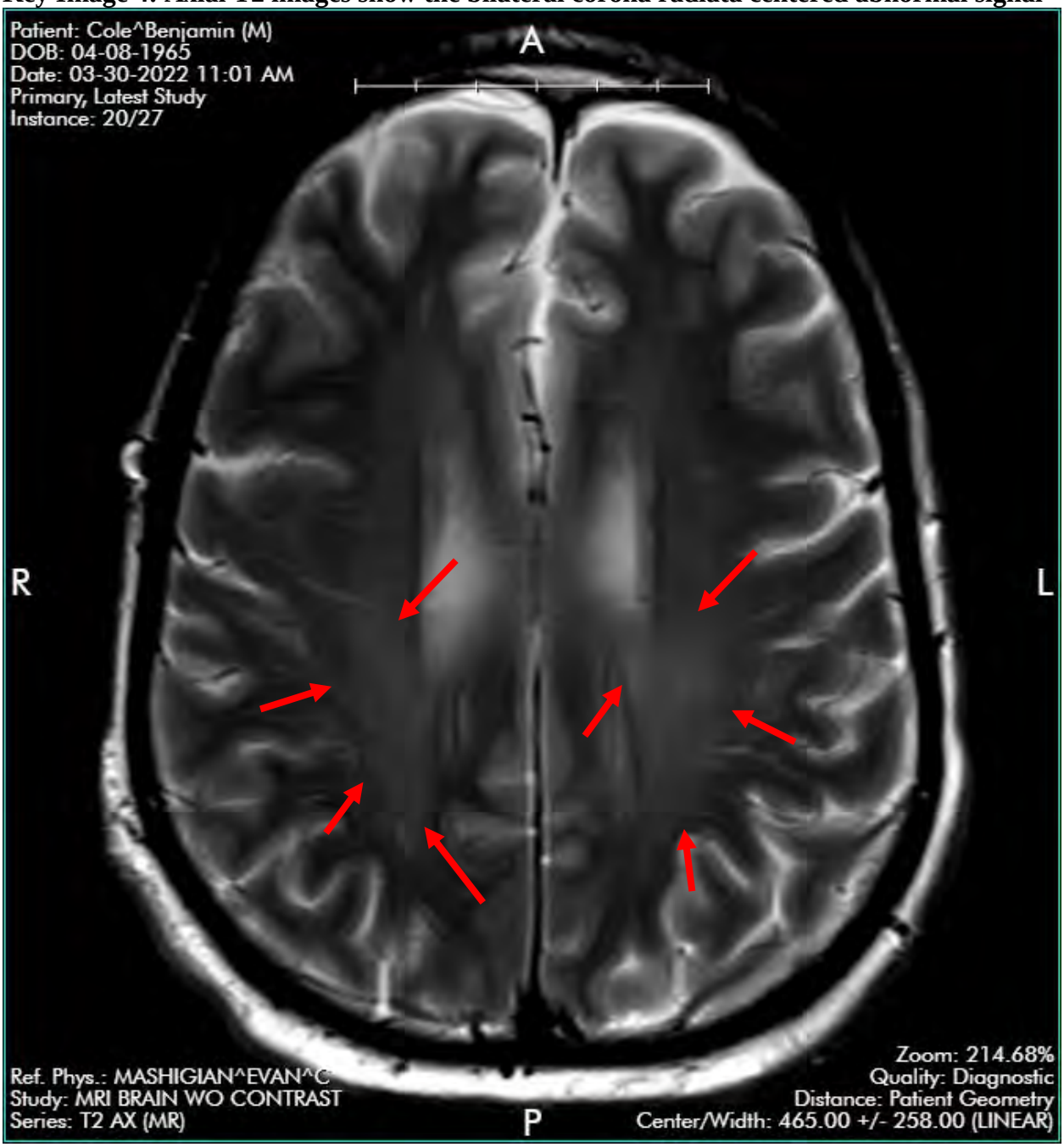
Key Image 2: Sagittal FLAIR images show the left basal ganglia lesion



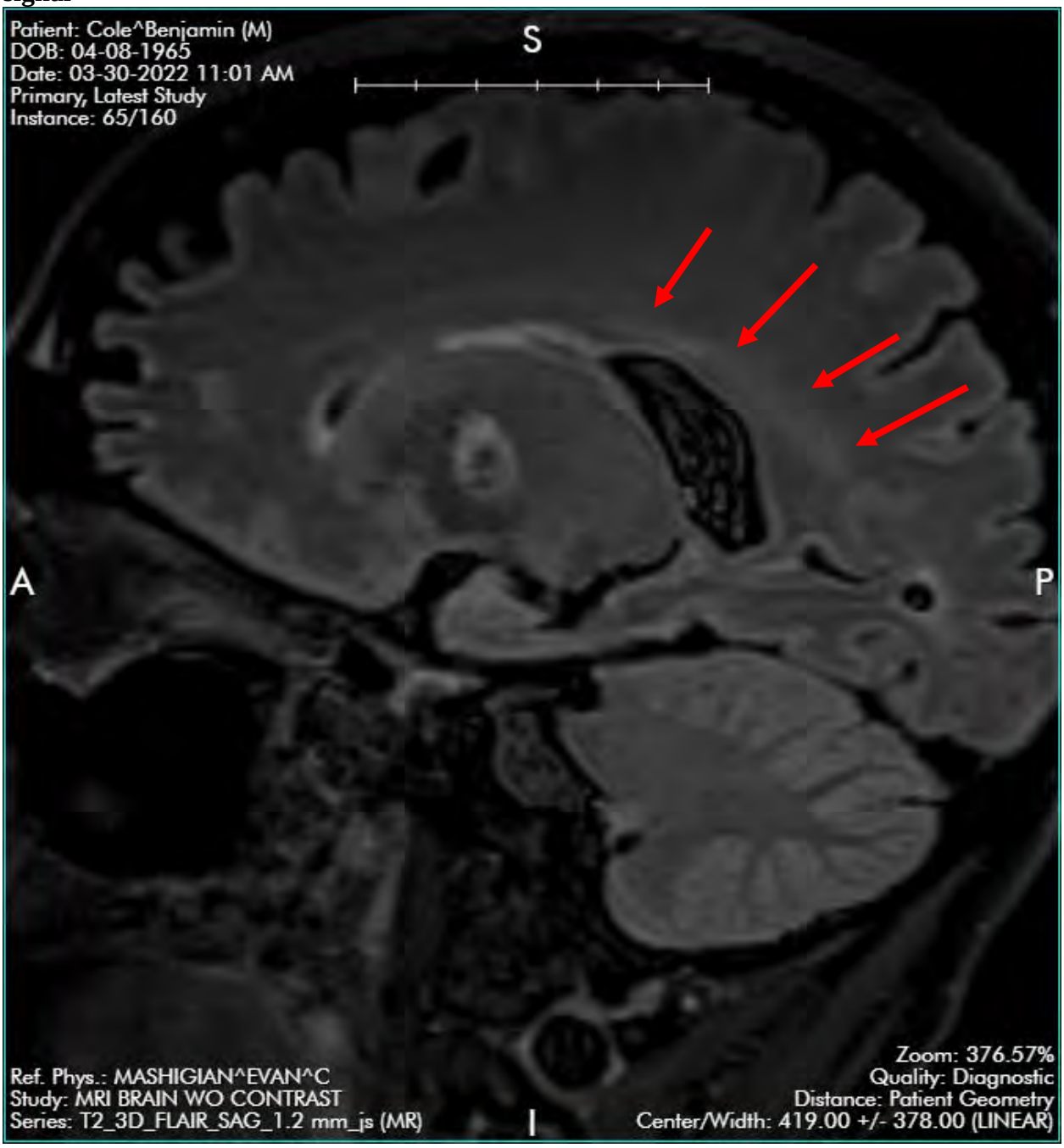
Key Image 3: Axial T2 images show the left basal ganglia lesion



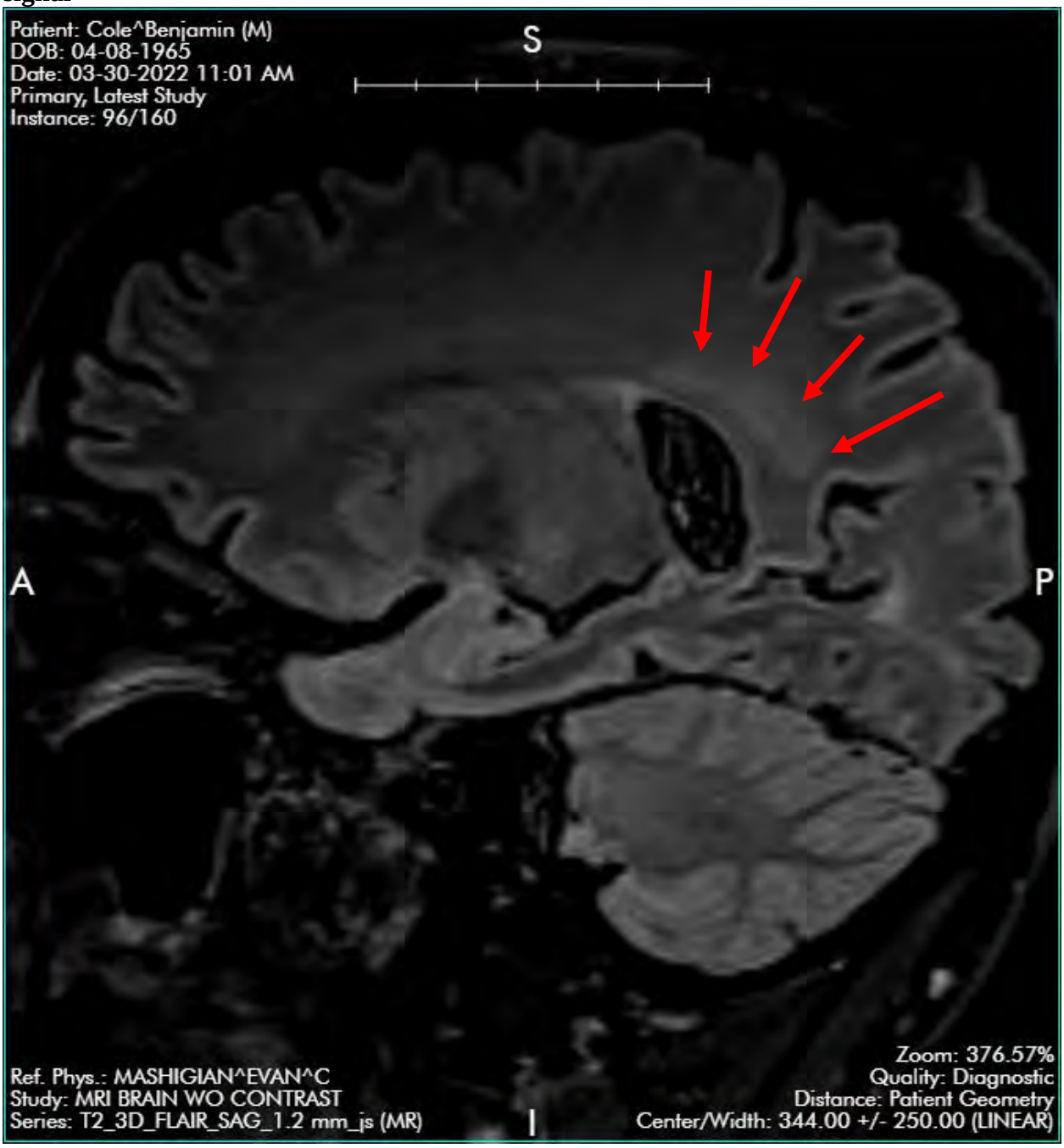
Key Image 4: Axial T2 images show the bilateral corona radiata centered abnormal signal



Key Image 5: Sagittal FLAIR images show the right corona radiata centered abnormal signal



Key Image 6: Sagittal FLAIR images show the left corona radiata centered abnormal signal



References

Chang, K. H., M. H. Han, H. S. Kim, B. A. Wie and M. C. Han (1992). "Delayed encephalopathy after acute carbon monoxide intoxication: MR imaging features and distribution of cerebral white matter lesions." Radiology **184**(1): 117-122.

Choi, I. S. (2002). "Parkinsonism after carbon monoxide poisoning." Eur Neurol **48**(1): 30-33.

Giroud, M., M. Lemesle, G. Madinier, T. Billiar and R. Dumas (1997). "Unilateral lenticular infarcts: radiological and clinical syndromes, aetiology, and prognosis." J Neurol Neurosurg Psychiatry **63**(5): 611-615.

Jeon, S. B., C. H. Sohn, D. W. Seo, B. J. Oh, K. S. Lim, D. W. Kang and W. Y. Kim (2018). "Acute Brain Lesions on Magnetic Resonance Imaging and Delayed Neurological Sequelae in Carbon Monoxide Poisoning." JAMA Neurol **75**(4): 436-443.

Jiang, C., L. Yi, S. Cai and L. Zhang (2019). "Ischemic Stroke in Pontine and Corona Radiata: Location Specific Impairment of Neural Network Investigated With Resting State fMRI." Front Neurol **10**: 575.

Li, P., S. W. Zhao, X. S. Wu, Y. J. Zhang, L. Song, L. Wu, X. F. Liu, Y. F. Fu, D. Wu, W. J. Wu, Y. H. Zhang, H. Yin, L. B. Cui and F. Guo (2021). "The Association Between Lentiform Nucleus Function and Cognitive Impairments in Schizophrenia." Front Hum Neurosci **15**: 777043.

Pepe, G., M. Castelli, P. Nazerian, S. Vanni, M. Del Panta, F. Gambassi, P. Botti, A. Missanelli and S. Grifoni (2011). "Delayed neuropsychological sequelae after carbon monoxide poisoning: predictive risk factors in the Emergency Department. A retrospective study." Scand J Trauma Resusc Emerg Med **19**: 16.

Williams, M. (2017). "An introduction to the Globus Pallidus in schizophrenia." CNS 2017: 3:(2).

2ND DECLARATION OF TRAVIS SNYDER, DO

I, Travis Snyder, DO, declare:

1. I am a physician who is board-certified in Radiology with additional board certification and added qualifications in Neuroradiology. I completed residency at Michigan State in 2014 and a fellowship in Neuroradiology at the University of Miami in 2015. I am over 18 years old.

2. I am Adjunct Professor of Radiology at Michigan State University, Adjunct Assistant Professor of Neuroradiology and Radiology at Touro University Nevada, Touro University California, and University of Nevada Reno School of Medicine and a clinical professor of Radiology at the UNLV School of Medicine. I am program director of the HCA sunrise consortium NV radiology residency. I am in clinical practice specializing in Neuroradiology. I have given and authored over 50 presentations, abstracts and articles in the field of Radiology and Neuroradiology. Please see previously disclosed Curriculum Vitae.

3. The Diffusion Tensor Imaging (DTI) and NeuroQuant volumetric analysis performed as part of the 3/30/22 Oklahoma State University MRI brain exam on Benjamin Cole (DOB 4/8/65) is now available for interpretation. These analyses are markedly abnormal and concordant with the previously described abnormal MRI findings, demonstrating multiple pathologic findings as follows:

4. Diffusion Tensor Imaging analysis of the corpus callosum:

- DTI analyzes how water flow along tiny axons. The corpus callosum is the largest fiber tract in the brain and the only significant fiber tract connecting the right and left brain. The corpus callous is the most researched and validated fiber tract in the brain for DTI and the easiest for technologists to analyze. FA (Fractional Anisotropy) is a numerical value given to how water is flowing and the values obtained relate to the overall health of the fiber tract and axons. 5 regions of the corpus callosum were analyzed.
- In Benjamin Cole FA values for the anterior inferior fiber tracts were

0.431, the anterior fiber tracts were 0.459, the midbody fiber tracts was 0.523, the posterior fiber tracts were 0.512 and the posterior inferior fiber tracts were 0.550 and the total fiber tracts were 0.516. These values are abnormal and indicate damage to the corpus callosum and are concordant with the additional findings previously described. Cognitive associations have been well described in patients with decreased FA corpus callosal values using the same protocol performed in Benjamin Cole (Asturias 2021, Hanks 2018).

- 3D reconstructions of the fiber tracts demonstrate corpus callosal axonal gaps and thinning which correspond to the decreased FA values and also match the corona radiate damage previously described.

5. Volumetric Analysis using NeuroQuant (NQ)
    - Thin T1 imaging is used to identify 48 volumetric regions of the brain and, after accounting for head size, is compared to normative age and sex matched controls.
    - In Benjamin Cole, there is diffuse cortical thinning/atrophy; the whole brain cortex is in the 5th percentile as compared to age and sex matched controls, which is two standard deviations below the mean. This means that only 5 of 100 normal patients would have cortical volumes as low as Benjamin Cole. The cortex is the thin grey matter which lines the outside of the brain and contains neurons where electrical signals are generated. This finding is concordant with the additional imaging findings previously described.
    - The right globus pallidus is in the 1st percentile as compared to age and sex matched controls. This means only 1 of 100 normal subjects would have a globus pallidus this small. This finding has been well described following toxic exposures and is consistent with the additional findings described and is consistent with injury secondary to the same process

which caused the previously described left basal ganglia and left globus pallidus lesion (Pulsipher 2006).

- Segmentation color schemes were reviewed and there is only mild discongruity indicating overall accuracy of the exam and analysis.

6. The clinical record remains highly consistent with the imaging findings as previously described. DTI and NQ are concordant with other MRI sequences and upgrade the damage identified.

7. Multiple providers have stated that Benjamin Cole is not competent to understand legal proceedings, the imaging reviewed remains supportive of their opinions.

8. Key images and references below.

I declare under penalty of perjury under the laws of the Oklahoma that the foregoing is true and correct.

Executed on May 25th, 2022, at Las Vegas, Nevada.

Travis Snyder, DO

References:

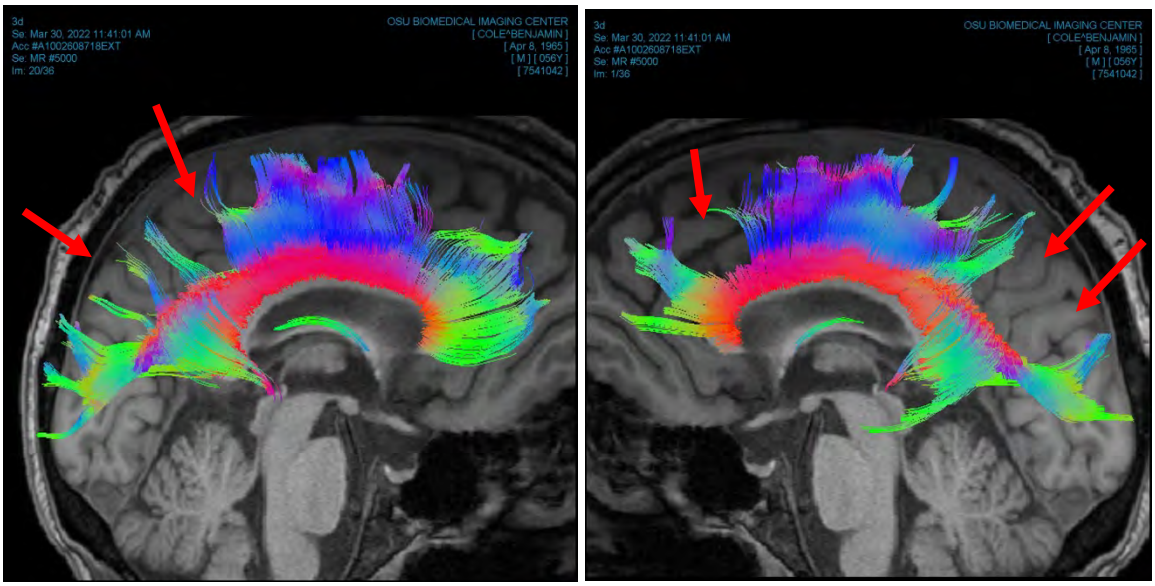
1. Asturias, A., Vanier, C., Rodriguez, A., Le Tohic, C., Barrett, B., Eisenberg, M., Gibbert, R., Zimmerman, L., Knoblauch, T., Parikh, S. Germin, L. Fazzini, E., Snyder, T. H. (2021). Association of Corpus Collosum Diffusion Imaging Data and Clinical Outcomes in Mild Traumatic Brain Injury, RSNA 2021, Oral presentation

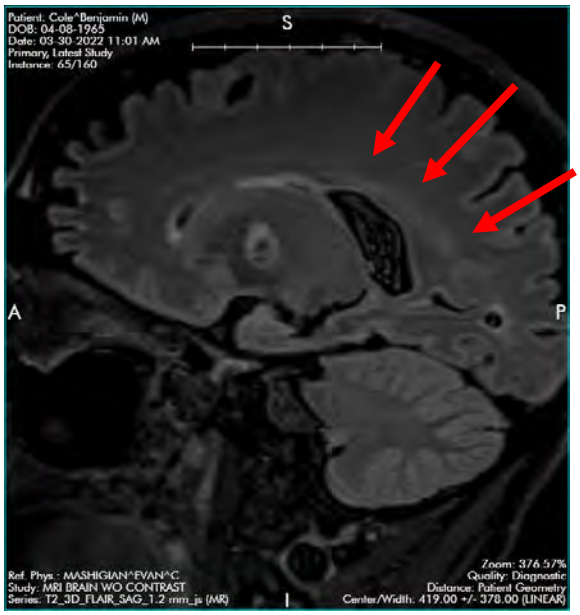
2. Robin Hanks, Scott Millis, Selena Scott, Ramtilak Gattu, Nolan B. O'Hara, Mark Haacke & Zhifeng Kou
   The relation between cognitive dysfunction and diffusion tensor imaging parameters in traumatic brain injury
   Brain Injury, 33:3, 355-363, Dec, 2018

3. Pulsipher DT, Hopkins RO, Weaver LK.
   Basal ganglia volumes following CO poisoning: A prospective longitudinal study.
   Undersea Hyperb Med. 2006 Jul-Aug;33(4):245-56.

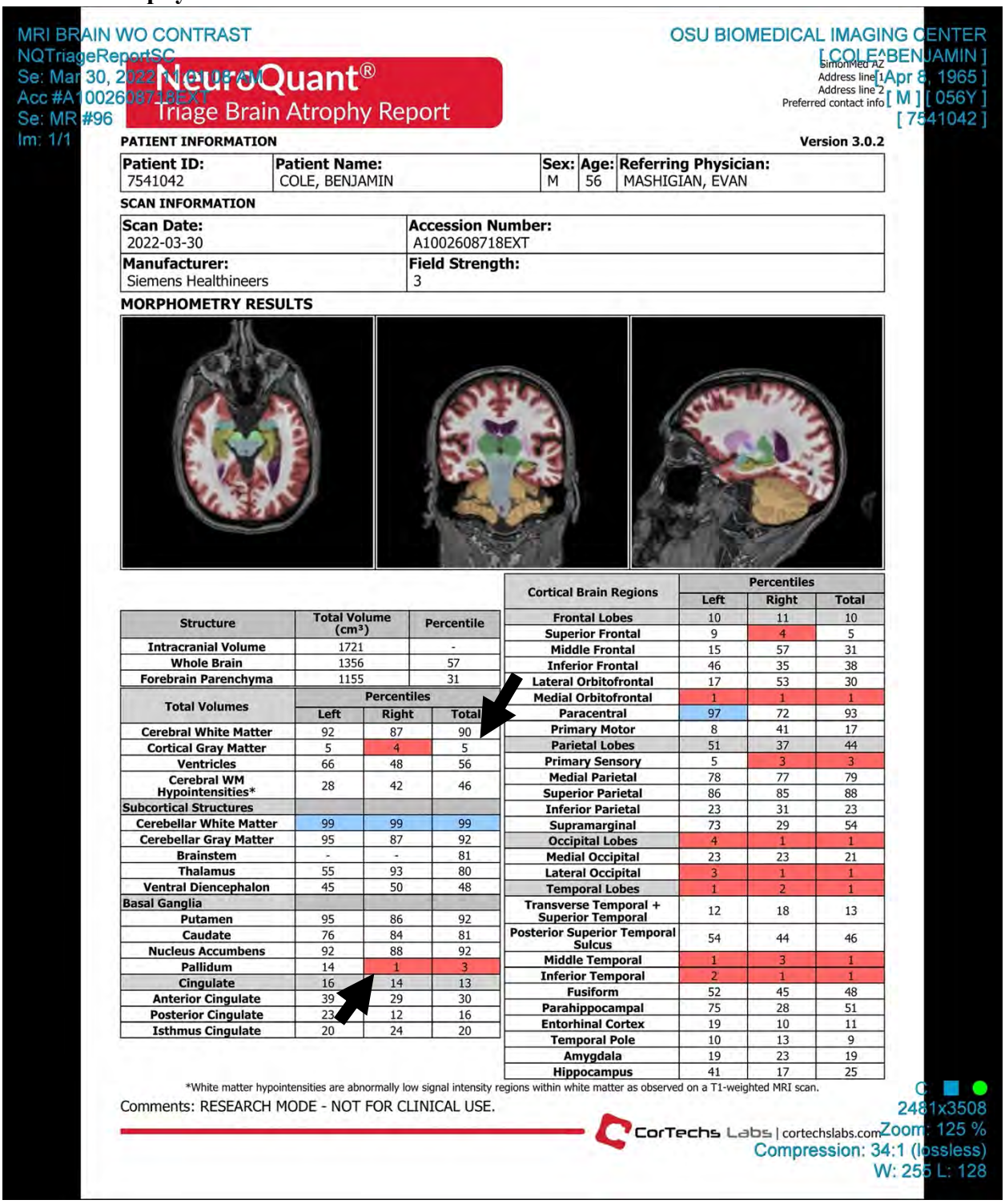
Key Image 1: Segmentation of the Corpus Callosum with calculated FA values

Key Image 2: 3D reconstructions of the Corpus Callosum DTI fiber tracts show axonal gaps and thinning which correspond to the FA values and the posterior corona radiata white matter abnormalities (bottom right image).





Key Image 3: NeuroQuant Volumetric Analysis Demonstrating Cortical and Globus Pallidus Atrophy:



MRI BRAIN WO CONTRAST
NQTriageReportSC
Se: Mar 30, 2022 [illegible] AM
Acc #A1002608718EXT
Se: MR #96
Im: 1/1

OSU BIOMEDICAL IMAGING CENTER
[COLE^BENJAMIN]
SimonMed AZ
Address line 1
Address line 2
Preferred contact info
[Apr 8, 1965]
[M] [056Y]
[7541042]

NeuroQuant®
Triage Brain Atrophy Report

PATIENT INFORMATION — **Version 3.0.2**

Patient ID:	Patient Name:	Sex:	Age:	Referring Physician:
7541042	COLE, BENJAMIN	M	56	MASHIGIAN, EVAN

SCAN INFORMATION

Scan Date:	Accession Number:
2022-03-30	A1002608718EXT
Manufacturer:	**Field Strength:**
Siemens Healthineers	3

MORPHOMETRY RESULTS

Structure	Total Volume (cm³)	Percentile
Intracranial Volume	1721	-
Whole Brain	1356	57
Forebrain Parenchyma	1155	31

Total Volumes	Percentiles		
	Left	Right	Total
Cerebral White Matter	92	87	90
Cortical Gray Matter	5	4	5
Ventricles	66	48	56
Cerebral WM Hypointensities*	28	42	46
Subcortical Structures			
Cerebellar White Matter	99	99	99
Cerebellar Gray Matter	95	87	92
Brainstem	-	-	81
Thalamus	55	93	80
Ventral Diencephalon	45	50	48
Basal Ganglia			
Putamen	95	86	92
Caudate	76	84	81
Nucleus Accumbens	92	88	92
Pallidum	14	1	3
Cingulate	16	14	13
Anterior Cingulate	39	29	30
Posterior Cingulate	23	12	16
Isthmus Cingulate	20	24	20

Cortical Brain Regions	Percentiles		
	Left	Right	Total
Frontal Lobes	10	11	10
Superior Frontal	9	4	5
Middle Frontal	15	57	31
Inferior Frontal	46	35	38
Lateral Orbitofrontal	17	53	30
Medial Orbitofrontal	1	1	1
Paracentral	97	72	93
Primary Motor	8	41	17
Parietal Lobes	51	37	44
Primary Sensory	5	3	3
Medial Parietal	78	77	79
Superior Parietal	86	85	88
Inferior Parietal	23	31	23
Supramarginal	73	29	54
Occipital Lobes	4	1	1
Medial Occipital	23	23	21
Lateral Occipital	3	1	1
Temporal Lobes	1	2	1
Transverse Temporal + Superior Temporal	12	18	13
Posterior Superior Temporal Sulcus	54	44	46
Middle Temporal	1	3	1
Inferior Temporal	2	1	1
Fusiform	52	45	48
Parahippocampal	75	28	51
Entorhinal Cortex	19	10	11
Temporal Pole	10	13	9
Amygdala	19	23	19
Hippocampus	41	17	25

*White matter hypointensities are abnormally low signal intensity regions within white matter as observed on a T1-weighted MRI scan.

Comments: RESEARCH MODE - NOT FOR CLINICAL USE.

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Zoom: 125 %
Compression: 34:1 (lossless)
W: 255 L: 128

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INDEPENDENT PSYCHIATRIC CONSULTATION

Date:
April 4, 2009

RE:
Benjamin Cole v. Marty Sirmons, Warden, Northern District of Oklahoma Case No. 08-CV-0328-CVE-PJC

Age of Defendant:
43

Date of Birth:
April 8, 1965

Address where evaluation was conducted:
Oklahoma State Penitentiary
McAlester, OK. 74502

Referred by:
T. Kenneth Lee
Assistant Public Defender, Federal Public Defender Office
Western District of Oklahoma
215 Dean A. McGee, Suite 707
Oklahoma City, Oklahoma 73102

Circumstances of the Assessment:
Federal Habeas Corpus Proceedings - evaluation requested by defense attorney

I. SUMMARY OF FINDINGS

Based on my review of the records and information provided to me by the Office of the Federal Public Defender, my interviews with members of Mr. Cole's family, and my interviews with past members of Mr. Cole's legal teams; it is my expert opinion, which is based on a reasonable degree of medical certainty, that Mr. Cole is currently and was incompetent during his state court proceedings to assist his attorneys. Mr. Cole's inability to assist his attorneys stems from Mr. Cole's schizophrenia, paranoid type, with grandiose delusions, which have manifested as Mr. Cole's hyper-religiosity. In this context, his inability to assist is not under his control and his behavior towards his legal team is not based on rational thought. In his current mental state, there is no logical incentive for giving up his grandiose delusions or the comfort of being saved by Jesus in order to assist his attorneys in saving his life. It is these primitive coping mechanisms that allow Mr. Cole to avoid having to struggle with the trauma and loss associated with his past behaviors. Unfortunately, for Mr. Cole these symptoms leave him in a stalemate with his legal team and result in his refusal to assist his attorneys in any manner.

II. INTRODUCTION:

Mr. Cole stands convicted of Murder in the First Degree and has been sentenced to death. The charges arose out of allegations that he caused the death of his nine month old daughter on or about 12/20/02. Although there was physical evidence that implicated him and he confessed to the charges in a videotaped confession, he decided to plead Not Guilty and move forward with a trial even after he was offered a plea that would have guaranteed him life in prison. He was and has continued to be uncooperative with a variety of leads that his legal teams have attempted to follow up on, which would have supported the presence of mitigating factors including: (1) his own history of being a victim of physical and sexual abuse, (2) his family history of mental illness, and (3) his own psychiatric symptoms as previously noted by mental health evaluators. The Federal Public Defender's Office contacted me to reassess his mental status in the context of his refusing visits with members of his past legal teams, evidence of worsening social withdrawal, odd idiosyncratic behaviors, expressed paranoia and grandiose statements regarding his ability to teach scripture and spread religious teachings, and most importantly because he continues to actually interfere with efforts made on his behalf in his legal case.

The following psychiatric legal issues were presented to me for consideration:

1. Does Mr. Cole suffer from a diagnosable mental disorder?

2. Does Mr. Cole have the capacity to assist in his current habeas proceedings?

3. Are Mr. Cole's actions, which obstruct his legal team's efforts on his behalf, a reasoned decision or driven by underlying delusional thought content?

4. Did Mr. Cole suffer from symptoms of his mental disorder at the time of the instant offense?

5. Did Mr. Cole lack capacity to assist in his defense at the time of his original trial and throughout his appeals process?

6. Does the fact that Mr. Cole does not have an extensive documented history of psychiatric treatment negate the presence of mental illness?

7. How does the defendant's substance abuse history factor into an understanding of the trajectory of the defendant's life and illness?

For this evaluation, I interviewed Mr. Cole both alone and with his attorney over a two day period in December, 2008. I reviewed the available mental health records, investigation reports, prior mental health evaluations, and witness affidavits. I interviewed multiple relatives and members of his past legal teams, and reviewed letters he has written. Because he was mostly uncooperative with direct questioning and insisted on spending the majority of the interview time discussing scripture and hoping to convince me of my ignorance, I was forced to utilize the collateral data made available to me to review his past personal history including his education, his employment, his misuse of alcohol, his relationships, and his reaction to the deaths of three of his siblings. I evaluated his current mental state, observing his appearance, his behavior, and his attitude. I noted what he said and the way in which he said it. I assessed his intelligence, and whether he was

oriented to all spheres. I assessed his insight into the presence of illness. Finally, I assessed his judgment and the extent of his ability to control his impulses.

My qualifications to conduct this evaluation include my faculty appointment at New York University School of Medicine, my three years as the Director of Forensic Services at Bellevue Hospital Center in New York City, my two years as the Chairman of the Hospital Forensic Committee at Kirby Forensic Psychiatric Center in New York, and my board certification in forensic psychiatry. At Bellevue Hospital Center, I conducted and supervised psychiatrists and trainees in court-ordered evaluations for the New York Criminal and Supreme Courts. At Kirby Forensic Psychiatric Center, I conducted over 100 court ordered evaluations. I have experience evaluating and treating inmates from my work on the Bellevue Hospital Prison Wards, working at Sing Sing Correctional Facility, and my work at Lincoln Correctional Facility in New York. I was a principal faculty member for New York University's forensic psychiatry residency training program and was the site supervisor for visiting medical students and residents on the prison wards. I have authored a chapter on teaching forensic psychiatry to medical students and have lectured to both medical and legal audiences on problems related to restoring competency and maintaining competency in correctional settings and forensic hospitals. My qualifications are further detailed in my curriculum vitae.

III. SUMMARY OF OPINIONS:

1. Does Mr. Cole suffer from a diagnosable mental disorder?

Yes, Mr. Cole suffers from Schizophrenia, Paranoid Type (DSM IV TR 295.30). Schizophrenia is a disorder characterized by disturbances of thought, behavior, judgment, and cognition and leads to impairments in social and occupational functioning. Mr. Cole's prominent symptoms are persecutory and grandiose delusions. In addition, one must also consider the possibility of Posttraumatic Stress Disorder and Alcohol Abuse. Posttraumatic Stress Disorder is a syndrome that develops as a result of a trauma or series of repeated trauma, with accompanying withdrawal, and heightened arousal states. It is marked by avoidance of reminders of a trauma and an exaggerated startle response that can occur with or without reminders of the traumatic events. Alcohol Abuse involves a maladaptive pattern of alcohol use that can harm relationships, cause one to miss work, and individuals may continue to drink even when they know that it is causing problems.

2. Does Mr. Cole have the capacity to assist in his current habeas proceedings?

No, Mr. Cole's paranoia towards his legal team and towards this evaluator, his grandiose delusions of his connection to Jesus, and of his own importance continue to interfere with his capacity to assist counsel. His delusions lead to rigid thinking that keeps him from discussing any past traumas or even discussing the events leading up to the instant offense and leaves him with significant cognitive distortions about his legal situation as basic as insisting that he was never offered a plea bargain in the case. His paranoia keeps him from visiting with his legal team and from currently signing releases because of his fear that this evaluator would be given the information. Mr. Cole's paranoia, coupled with his delusions, prevents him from disseminating relevant and important information to his attorneys that would illuminate the circumstances surrounding the instant offense and those problems which interfered with his life's trajectory. Given that he spent over 90% of our interview time quoting scripture and attempting to educate me and could not be redirected by me or by his attorney, his current legal team is unable to have coherent discussions with him regarding the preparation of habeas corpus proceedings.

3. Are Mr. Cole's actions which obstruct his legal team's efforts on his behalf a reasoned decision or driven by underlying delusional thought content and fears?

It is Mr. Cole's rigid delusional thinking that causes him to obstruct the efforts of his legal team. This is not in his control and it is driven by his untreated mental illness. Religious fervor and spirituality cannot alone explain his longstanding resistance to discussing any and all topics that could help explain the instant offense or provide mitigating evidence.

4. Did Mr. Cole suffer from symptoms of his mental disorder at the time of the instant offense?

Given evidence of paranoia and unstable moods and bizarre behaviors during adolescence and that the age of onset for this illness is generally during adolescence, it is clear that he suffered from his mental disorder long before the instant offense.

5. Did Mr. Cole lack capacity to assist in his defense at the time of his original trial and throughout his appeals process?

Based on my interview of his past attorneys and affidavits from his past legal teams, it is clear that his incapacity dates back as far as his original trial. Even the strategy of moving forward with trial after being offered a life sentence places his mental status in question as the following was already established: he confessed, there was extensive physical evidence, and he had previously been incarcerated for child abuse.

6. Does the fact that Mr. Cole does not have an extensive documented history of psychiatric treatment negate the presence of mental illness?

No, despite longstanding psychotic symptoms along with deficits in social and occupational functioning, Mr. Cole's total lack of insight into his illness, while preferring to maintain grandiose delusional thinking, and the limits of the correctional mental health system with respect to comprehensive psychiatric evaluation have interfered with access to treatment during his incarcerations and in the community.[1] [2] [3] Mr. Cole was also raised in such an abusive unsupportive environment that there was no chance that he could have been encouraged to consider mental health treatment on his own. The absence of treatment is also consistent with President Bush's 2004 Freedom Commission on Mental Health Report which states,

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[1] More than half of all prison and jail inmates have a mental health problem compared with 11 percent of the general population, yet only one in three prison inmates and one in six jail inmates receive any form of mental health treatment. James DJ, Glaze LE: Mental health problems of prison and jail inmates. Washington, DC: Department of Justice, Bureau of Justice Statistics Special Report, September, 2006.

[2] There are, however, many offenders with current or past psychiatric illnesses who do not have dramatically apparent symptoms. Nevertheless, such psychiatric illnesses may place the newly incarcerated offender at increased risk of clinical deterioration, disciplinary concerns, or suicide attempts. Trestman RL et al. Current and Lifetime Psychiatric Illness Among Inmates Not Identified as Acutely Mentally Ill at Intake in Connecticut Jails. Journal of the American Academy of Psychiatry and the Law, 2007; 35:490-500.

[3] Many jails now screen for mental illness, but most do so based on non-standardized protocols, that may fail to detect serious mental health problems. Trestman RL et al. Current and Lifetime Psychiatric Illness Among Inmates Not Identified as Acutely Mentally Ill at Intake in Connecticut Jails. Journal of the American Academy of Psychiatry and the Law, 2007; 35:490-500.

"Stigma frequently surrounds mental illness, prompting many people to hide their symptoms and avoid treatment. Sadly, only 1 out of 2 people with a serious form of mental Illness seeks help for the disorder."

7. How does the defendant's substance abuse history factor into an understanding of the trajectory of the defendant's life and illness?

Mr. Cole's substance abuse is consistent with what one would expect in untreated patients with psychotic disorders. His substance abuse has directly and indirectly exacerbated his mental illness in two ways. First, it distracted him from seeking treatment for underlying anxiety and paranoia as alcohol often helps minimize acute paranoia, sleep problems, and anxiety in the short term. Second, his alcohol abuse and poor impulse control alienated him from his family, other potential support people - like any of his wives, left him more unable to maintain stable living arrangements, pursue appropriate entitlements, or be motivated for treatment.[4]

IV. SOURCES OF INFORMATION:

In arriving at my opinions, I relied in part on the following sources of information:

1. Nine hours of contact visit: interviews of Mr. Cole between 12/14/08 and 12/15/08 by Raphael Morris, M.D., including observing the interaction between Mr. Cole and Ken Lee, one of his current federal habeas attorneys.
2. Telephone interview of Vicki Werneke, who represented Mr. Cole in state post-conviction proceedings, conducted on 2/19/09.
3. Telephone interview of Sandra Tussey, Mr. Cole's first wife, on 2/22/09.
4. Videotaped confession of Mr. Cole on 12/21/02.
5. Telephone interview of Vickie O'Neil, Mr. Cole's biological mother, conducted by Dr. Morris on 3/8/09.
6. Telephone interview of Barbara Johnson, Mr. Cole's step-mother, conducted by Dr. Morris on 3/8/09.

[4] The 1-year prevalence rate for schizophrenia in the United States is 1.5%, and approximately 50% of these individuals have a comorbid alcohol, cocaine, or marijuana use disorder. Reiger, DA et al. Comorbidity of mental disorders with alcohol and other drug abuse: results from the Epidemiologic Catchment Area Study. JAMA, 1990; 264:2511-2518.

7. Autopsy Report of for Brianna Cole.
8. Incident Reports regarding Brianna Cole's death.
9. Videotaped interview of Vickie O'Neil (Mr. Cole's mother); Benjamin Cole, Jr. (first son, and victim of the child abuse case that sent Mr. Cole to prison in California); and Robbie Cole (Mr. Cole's brother).
10. Competency Evaluation prepared by Dr. Price, dated 12/13/07.
11. Psychological Evaluation prepared by Dr. Basso, dated 6/15/04.
12. Psychological Evaluation prepared by Dr. Sharp, dated 10/23/03.
13. Psychological Evaluation prepared by Lisa Sneden and Kathy LaFortune, dated 7/23/03.
14. Psychological Evaluation prepared by Dr. Christopher, dated 8/18/04.
15. Memorandums concerning Ms. Gardner's interviews of Philip Hancock and Maximo Salazar, both former cellmates of Mr. Cole in prison, conducted 12/10/08 and 12/12/08 respectively.
16. Memorandums from Anna Wright and Julie Gardner, investigators/mitigation specialists with the Federal Public Defender's Office.
17. Application for Post Conviction Relief prepared by Vicki Werneke.
18. Index of Mr. Cole's religious materials, which he had kept in his cell at Oklahoma State Penitentiary.
19. Affidavit of Steve Leedy, Mr. Cole's trial investigator.
20. Affidavit of Dawn Bettencourt, daughter of Barbara Johnson and Mr. Cole's step-sister.
21. Affidavit of Cherry Pierce, daughter of Barbara Johnson and Mr. Cole's step-sister.
22. Affidavit of Barbara Johnson, Mr. Cole's step-mother
23. Affidavit of Ranada Gentry, investigator with the Federal Public Defender's Office.
24. Affidavit of Susan Young, Mr. Cole's common law wife, and the mother of Brianna Cole.
25. Statement of Susan Enea, paternal first cousin.
26. Statement of Benjamin Carl Cole, Mr. Cole's biological father.
27. School Records.
28. Military Records.
29. Defendant's letters.
30. Plea Offer and Response to Termination of Attorneys.
31. Oklahoma State Penitentiary Medical Records.
32. Trial Transcripts.
33. Fenton, W. Heterogeneity, Subtypes, and Longitudinal Course in Schizophrenia. Psychiatric Annals, 2000; 30:10.

34. Daniel, AE Care of the Mentally Ill in Prisons: Challenges and Solutions. The Journal of the American Academy of Psychiatry and the Law, 2007, 35(4): 406-410.
35. Trestman RL et al. Current and Lifetime Psychiatric Illness Among Inmates Not Identified as Acutely Mentally Ill at Intake in Connecticut's Jails. The Journal of the American Academy of Psychiatry and the Law, 2007, 35(4): 490-500.
36. Duzyurek S and Wiener J. Early Recognition in Schizophrenia: The Prodromal Stages. Journal of Practical Psychiatry and Behavioral Health, 1999, 5(4): 187-196.
37. Herz M. Early Intervention in Different Phases of Schizophrenia. Journal of Practical Psychiatry and Behavioral Health, 1999, 5(4): 197-208.
38. Ziedonis D and Stern R. Dual Recovery Therapy for Schizophrenia and Substance Abuse. Psychiatric Annals, 2001, 31(4): 255-264.
39. Ziedonis D et al. Management of Substance Abuse in Schizophrenia. Psychiatric Annals, 2000, 30(1): 67-75.
40. Practice Guideline for the treatment of patients with Substance Use Disorders, Second Edition. Supplement to the American Journal of Psychiatry, 2006, 163:8.
41. Montoya ID. Treatment Noncompliance in Patients With Co-Occuring Mental Illness and Substance Abuse. Psychiatric Times, January, 2006, 23-24.
42. President Bush's 2004 Freedom Commission Mental Health Report.
43. Beck AT et al. A New Instrument for Measuring Insight: the Beck Cognitive Insight Scale. Schizophrenia Research, 2004; 68: 319-329.
44. Dackis, C. The Neurobiology of Cocaine Dependence and Its Clinical Implications. Psychiatric Times, March 2007: 62-67.
45. The DSM IV-TR (American Psychiatric Association, 2000).
46. Marder SR et al. Schizophrenia, IX: Cognition in Schizophrenia-The MATRICS Initiative. American Journal of Psychiatry, 2004: 161:25.
47. Vries PJ et al. Demetia as a complication of schizophrenia. Journal of Neurology, Neurosurgery, and Psychiatry, 2001; 70:588-596.
48. Herbener ES et al. The Influence of Depression on the Course, Functioning, and Treatment of Patients With Schizophrenia. Psychiatric Annals, 2000; 30(10): 653-658.
49. Loebel AD et al. Duration of psychosis and outcome in first-episode schizophrenia. American Journal of Psychiatry, 1992; 149:1183-1188.
50. Melle I et al. Reducing the Duration of Untreated First-Episode Psychosis. Archives of General Psychiatry. 2004; 61:143-150.

51. Hawkins KA. Memory Deficits in Schizophrenia: inadequate assimilation or true amnesia? Findings from the Wechsler Memory Scale-revised. Journal of Psychiatry and Neuroscience, 1997, 22(3):169-179.
52. Levin S et al. Contributions of Neuropsychology to the Study of Schizophrenia. Journal of Abnormal Psychology, 1989, 98(4):341-356.
53. Reiger DA et al. Comorbidity of mental disorders with alcohol and other drugs abuse. JAMA, 1990;264:2511-2518.
54. Dixon L et al. Acute effects of drug abuse in schizophrenic patients: clinical observation and patient's self reports. Schizophrenia Bulletin, 1990; 16:69-79.
55. Dixon L et al. Drug abuse in schizophrenia patients: clinical correlates and reasons for use. American Journal of Psychiatry, 1991;148:224-230.
56. Wilkins JN. Pharmacotherapy of schizophrenia patients with comorbid substance abuse. Schizophrenia Bulletin. 1997; 23:215-228.
57. Buckley PF. Novel antipsychotic medications and the treatment of comorbid substance abuse in schizophrenia. Journal of Substance Abuse Treatment. 1998;15:113-116.
58. Hellerstein DJ et al. A prospective study of integrated outpatient treatment for substance abusing schizophrenia patients. American Journal of Addictions.1995;4:33-42.
59. Ziedonis DM and Fisher W. Motivation based assessment and treatment of comorbid substance abuse in patients with schizophrenia. Directions in Psychiatry. 1996;16:1-8.
60. Morgan, C et al: Fear Potentiated Startle in Posttraumatic Stress Disorder: Biological Psychiatry: 1995; 38: 378-385.
61. Grady, D et al: Dimensions of War Zone Stress. An Empirical Analysis: Journal of Nervous and Mental Disease: 1989; 177:6 347-350.
62. Simon, R. Posttraumatic Stress Disorder in Litigation. Washington, DC, American Psychiatric Press, Inc., 1995.

V. CONFIDENTIALITY:

Mr. Cole never fully cooperated with answering the general disclaimer statements made at the start of most forensic psychiatric interviews as he almost immediately wanted to delve into his religious themes and his frustration with his current legal team's inability to meet his needs for finding a religious guide to visit with him in the prison and being unable to help Ken Lee, one of his current habeas attorneys, be "saved by Jesus." I was however able to assess that he appreciated that I was conducting a psychiatric evaluation for this Court at the request of his attorney as

he referenced the many prior evaluation meetings he had undergone and repeatedly referred me to their reports to learn about his relevant past history.

VI. RELEVANT PAST SOCIAL, FAMILY, PSYCHIATRIC AND SUBSTANCE ABUSE HISTORY:

Of note, is the fact that Mr. Cole had become estranged from his family years ago and has had virtually no contact with his family for years. He has only spoken to his mother every few years and has been completely cut off from his father for over 20 years. His father has even indicated that he does not care if he dies or not.

Mr. Cole was one of five children born to Benjamin and Vickie Cole. Mr. Cole's parents both abused methamphetamine, and his father also abused alcohol and did not want to be involved in his life. At the age of seven, his parents divorced when Mr. Cole's mother became physically and romantically involved with Mr. Cole's father's close friend Mike O'Neil. From the time of their divorce until late adolescence, he had limited contact with his biological father and was raised primarily by his mother and her new husband, Mike O'Neil. According to his mother, Mr. Cole has always blamed her for the divorce; but at around 18, he became more hostile towards her over the divorce.

According to his mother and some of his other relatives, he was well liked and appropriate in school and motivated to complete his school work and socialize. He graduated from Geyserville High School in California. However, Dawn Bettencourt, Mr. Cole's step-sister, described him as "introverted, depressed, and ... not having a lot of friends." According to his other step-sister, Cherry Pierce, Mr. Cole "lacked any desire to actually do anything."

In 2004, Mr. Cole revealed to Jeanne Russell, clinical psychologist, that his step-father was a strict disciplinarian and that the attention had to be divided among the 6 children in the family, with at least one of the children being mentally retarded. It was only around the age of 18 that he became more isolative and withdrawn and subsequently destroyed all of his mother's canning supplies in a fit of rage. Neither his mother nor his step-father had any explanation for the change or what forces were driving that behavior. Following a confiscation of some of his things after that event, he went to stay with his father.

Although, Mr. Cole was primarily raised by his mother and his step-father, Mike O'Neil, he did stay for a short period with his father and his step-mother Barbara

Johnson. According to Barbara, Mr. Cole appeared not to have any future plans and was unmotivated to work. In fact, Barbara described Mr. Cole as "lazy and worthless." Barbara also mentioned that she was particularly disturbed by the fact that despite his being a guest, he was unwilling to follow basic rules related to the conservation of water in their home which were in place to protect the septic system and avoid financial ruin from damages to the home. He seemed totally unrelated to their concerns and also frustrated them with his unwillingness to find employment and his lack of ambition. According to Barbara, she was not concerned that Mr. Cole was a danger to her children.

Most notable in the review of the social history in this case is the rampant incest, sexual and physical abuse, and inappropriate relationships that occurred throughout all of the families that were in contact with Mr. Cole. According to Barbara and her daughters, the defendant's father molested both of his step-daughters and later physically abused his 4 year-old step granddaughter. Cherry Pierce added that Mr. Cole's father would give her "meth and dope" from age 13 to 22 and that she also had sexual relations with the defendant on one occasion when they were around 14 years old. It was also reported that Mr. Cole was molested by a cousin when he was 8 years old. Further, Leonard O'Neil, Mr. Cole's step-brother, reported that Tom Wright, one of Mike O'Neil's close friends, molested the children in the family. It is also notable that Cole family is rife with other inappropriate relationships: for example – the first husband of Barbara Johnson (Mr. Cole's step-mother) was Kenneth Dearmore who is Mr. Cole's father's uncle by marriage; Mr. Cole's step-brother Leonard O'Neil's ex-wife married Tom Wright, the man who was molesting the Cole children; and Mr. Cole's biological mother left her husband to be with Mike O'Neil, her husband's close friend. Despite corroboration of these boundary problems, Mr. Cole refused to address his thoughts on any of these relationships.

According to affidavits, Mr. Cole's father and step-father were physically and verbally abusive towards him. For example, Mr. Cole's father would yell vulgarities at him on a regular basis and his step-father Mike O'Neil would beat him with a bull whip.

Leonard O'Neil described one occasion where both he and the defendant suffered from loss of consciousness after being knocked off a motorcycle. In addition, Leonard stated that he sniffed gas with Mr. Cole when they were teenagers until they began to hallucinate and stopped doing it. Other collateral sources support that Mr. Cole was a binge drinker and according to Susan Young, Mr. Cole's common law wife, he was a heavy drinker during their relationship. According to

Sandra Tussey, his first wife, and Candy Lewis Cole, his second wife, alcohol use was problematic as well.

As mentioned earlier, Mr. Cole's mother did not consider him to have behavioral disturbances until he was 18 years old. She maintained only limited telephone contact with him over the years. Consistent with Mr. Cole's withdrawal and changes, his step-brother Leonard never met any of Mr. Cole's wives and at the time of his affidavit did not even know of Mr. Cole's first incarceration. Further, at the time of Mr. Cole's trial he had not seen his brother Robert for 20 years in part due to his new religious preoccupations. During our telephone interview, Vickie O'Neil could not explain why they had become estranged and why he had changed around age 18.

Mr. Cole's employment history is significant because it shows long periods of unemployment and short-term positions. His brief military career was complicated by difficulties tolerating his assignments and his refusal to be promoted from an E2 to an E3 Airman. It was around this time that he was experiencing difficulties in the Air Force and with his first wife, Sandra Tussey, that he abused his first son, Benjamin Cole, Jr., and was sent to prison. It is at this time that Mr. Cole demonstrated a severe deterioration in his functioning and emotional state.

To determine the extent of Mr. Cole severe deterioration in his functioning and emotional state, I conducted a telephone interview with Sandra Tussey, reviewed her affidavit, and reviewed military records that reveal there were altercations between Mr. Cole and Sandra in November, 1986. By January, 1987, Mr. Cole was noted to have engaged in the Child Abuse of his first son while he was supposedly supervising the child. When his wife returned and found the baby, she took the child to the hospital over his objections. He was convicted and sentenced to 2 years in the California DOC, starting 4/16/87. During his incarceration, they were divorced. By 9/9/88, Mr. Cole was discharged from the United States Air Force under other than honorable reasons. He was paroled from DOC on 2/24/88.

A review of his schooling indicates that he had intermittent poor grades and although there is no evidence that he was expelled or suspended, some reports indicate that he needed improvement in his conduct and work habits.

In 1988, Mr. Cole attended some classes at Bakersfield College and later worked as a welder for the Cotterman Company. By 1989, he is arrested for public drunkenness. By 1990, he is romantically involved with Candy Lewis, with whom he has 2 children. Once again, Mr. Cole experiences a severe deterioration in his

functioning and emotional state. According to Candy his attitude changed, he was no longer the man she married, and was abusing alcohol and was unemployed while living with her.

By 1998, Mr. Cole has taken up with Susan Young while she is pregnant with someone else's child. Given his past conviction, Susan's parents and Department of Human Services (DHS) expressed concerns regarding the safety of this child. Susan's parents were particularly concerned given that they were aware that prior to moving in with Susan, Mr. Cole had been living under a bridge or in a tent by the river.

On 10/26/98, Taylor Young, a neighbor of Susan Young, reported that Mr. Cole had refused to help Susan when she was in pain. By 10/27/98, DHS notes that Mr. Cole is being evicted for being unable to pay rent and that he had lived down by the river before.

By 12/9/98, a treatment plan was created for Mr. Cole to go to the Bill Willis Health Facility for assessment and treatment but there is no evidence that he followed through with this plan.

By 7/2/99, it was noted that Susan Young was unable to care for her son and the child was given to relatives. By 8/31/99, a notification concerning findings of child neglect had been filed against Mr. Cole and Ms. Young.

From 1998 through 1999, his work history included short lived jobs as a welder, laborer, bottle maker, and putting in rolling racks.

In 2002, Mr. Cole and Ms. Young had Briana, the decedent in this case. By 7/18/02, there are already signs of possible abuse, with bruising under Brianna's arms. Child Protective Services (CPS) came and started to evaluate the situation. At that point no other interventions were recommended. Ms. Young reported that Mr. Cole remained unemployed and was drinking heavily. By 12/20/02, Briana was dead.

On top of the incest, traumas, and two siblings who were mentally impaired Mr. Cole has suffered further tragedy with the death of three of his siblings: two by drowning, and one being killed in a hit and run.

RELEVANT DATA THAT SUPPORTS THE PRESENCE OF MENTAL ILLNESS INDEPENDENT OF THE EVALUATIONS OF MENTAL HEALTH PROFESSIONALS:

- In any psychiatric assessment, the role of genetic factors and genetic loading for mental illness should be assessed. Although Mr. Cole's father was physically and sexually abusive and had chemical dependency problems, he was not officially diagnosed with mental illness. Two of Mr. Cole's paternal cousins were diagnosed as having schizophrenia, and two of Mr. Cole's siblings were mentally impaired.

- As for the relatives who were formally diagnosed, Susan and Joseph Enea were both diagnosed with schizophrenia. Joseph told the family that Jehovah told him to stab himself and he subsequently stabbed himself in the stomach with a knife. Susan Enea reports that she had been hospitalized for schizophrenia and has to take medication for it.

- There is an extensive history of Mr. Cole being isolative, disconnected and having severely impaired judgment. According to Sandra Tussey, his first wife, he was not motivated to get a drivers license. He repeatedly demonstrated poor judgment when it came to coordinating travel plans around Sandra's pregnancy. She was also shocked by his poor judgment when he suggested that they could reconcile after his incarceration given how he had behaved towards their child. In addition, Mr. Cole's isolationism is so severe that he does not keep in contact with his family. Of note, his step-brother Leonard never met any of Mr. Cole's wives and at the time of Leonard's affidavit, Leonard did not even know of Mr. Cole's first incarceration. Mr. Cole also has not seen or talked to his brother Robert or his father for at least 20 years. The only exception is his mother who he called intermittently every couple of years. Further, Mr. Cole has not had contact with his family since his trial and subsequent conviction for the death of Brianna.

- Candy Cole Lewis, his second wife, recalls major fluctuations in his mood, stating that she saw him staying up all night, cleaning the house.

- Susan Young, his common law wife and the mother of Brianna, commented on Mr. Cole's relationship with Kathy Morgan, the DHS caseworker,

stating, "Ben thought Kathy was out to get him and he didn't want her around."

- Mr. Cole's taped confession suggests some psychopathology as he appears sad but is not able to explain what led to the instant offense.

- His mother described that Mr. Cole went into a depression following her divorce from his father and that later on his behavior became increasingly odd leading to very limited contact over the past 18 years. His brother Robert noted that Mr. Cole deteriorated towards the end of high school and started using alcohol.

- During the 2004 Competency Trial, John Dalton, his attorney, said,

> *"Well, I was concerned, as his attorney, that he wasn't very engaged or he wasn't very involved in preparation, in trial preparation. He was distant and he was very obsessed with religious, grandiose ideas that the end of the world was approaching. And he believed that - - well, basically, he wasn't giving me information to help defend him. He couldn't answer basic - - or he couldn't make decisions or he wouldn't make decisions that were related to defense strategy. When I advised him about the law that was involved in the case, everything that he should be aware of and he should be participating in preparation for his defense, he was removed from it."*

- Regarding whether Mr. Cole would testify, Attorney Dalton added,

> *"The most recent time - - I discussed that with him on numerous occasions, but the most recent time that I asked him how he felt about testifying and advised him what his rights were with regard to testifying and not testifying at his trial, his response was that he didn't know. He couldn't make that decision. And we talked about it some more and he finally stated that he wanted to testify. And when I asked him, you know, what - - because at this point in time I still didn't have enough information from him to build a defense and I wanted to know what he would be testifying to at his jury trial. He stated that he would give a five-minute speech on the word of God."*
>
> *"I explained to him that this criminal trial was really about the*

evidence that he was up against and defending him in court, whatever defense that was to present. He still remained focused on preaching the word of God at his trial. And that would be the only thing that he would have to say at his trial."

"Something to the effect that he doesn't understand the law, that God's law is what matters and that's the law that's going to govern his trial. And it's going to govern all of us, God's law will."

- Evidence of grandiose thinking and deficits in reality testing which I noted at the time of my evaluation in 2008 are suggested when Attorney Dalton states,

  "I think on one occasion he stated that [his trial] would touch the hearts of everyone that was involved in this case and that he may be set free because of it."

  "He can quote scripture for hours at a time and that's what he did when I would try to confront him with witness statements."

- The dangers to Mr. Cole that he experienced related to working with his legal team were noted even back in 2004 when Attorney Dalton explains what happened when he attempted to get Mr. Cole to focus on the witnesses in the case.

  "That he wouldn't hear it or that he couldn't hear it. I think he said both, that he wouldn't hear it and he couldn't hear it. And when I asked him what he meant, he said he couldn't understand it. And when I asked him why he couldn't understand it, I'm reading it to him, he indicated to me that - - either that God wouldn't let him because that would cause him to be less Christ centered or that he just couldn't mentally understand it because he would be less centered on Christ."

- In response to Attorney Dalton's efforts to encourage Mr. Cole to shave for his trial, he encountered resistance from Mr. Cole who commented that he would eventually cut his hair but that it would be a sacrifice to God.

- In a letter to James Bowan, his former trial attorney, Mr. Cole expressed his paranoia towards the chaplain, his lack of awareness of how others perceive

him, his lack of awareness of his son's needs, his lack of understanding of his attorney's role, and his relief that he has been saved by Jesus.

> *"... I have a funny suspicion that we are going to have a shakedown soon and I have accumulated my share and more of studies-paperwork. Do you know of a Christian and maybe backup?* ***I don't trust the chaplain here****, just as much as I can throw him by his tail and the churches seem to be scared to death of us! A spiritual dad would be perfect or as the Lord leads. I'm hoping in the end that Ben Jr. would be able receive all that is sent to him. If he can afford it. In your last letter to me sounds pretty good! I give God all the thanks and praises for everything.* ***Jesus saved me from the grasps of hell eternity in the lake of fire.****"*

- As recently as his October 5, 2008 letter to Candy Cole Lewis, he expressed that he will not be accepting any further visitors outside of him seeking a trustworthy friend to discuss religion. Throughout the letter he referenced multiple biblical passages some of which I will include sections of to provide some insight into the intensity of his thoughts. He apparently attempted to make the point that his harming others had a positive aspect to it since he has been able to give the Lord his undivided attention. Most of the passages he references speak of evil and spirits and hearts of stone.

Matthew 12:45

Then it goes and brings with it seven other spirits more evil than itself, and they enter and dwell there, and the last state of that person is worse than the first. So also will it be with this evil generation.

Matthew 13:22

As for what was sown among thorns, this is the one who hears the word, but the cares of the world and the deceitfulness of riches choke the word, and it proves unfruitful.

He mentions to Candy Lewis in his letter that he prayed Ezekial 38:26 for her and the young family.

And I will give you a new heart, and a new spirit I will put within you. And I will remove the heart of stone from your flesh and give you a heart of flesh.

Mark 11:23 (English Standard Version)

Truly, I say to you, whoever says to this mountain, 'Be taken up and thrown into the sea,' and does not doubt in his heart, but believes that what he says will come to pass, it will be done for him.

- According to Maximo Salazar, a former cellmate of Mr. Cole's at the Oklahoma State Penitentiary, Mr. Cole exhibited the following symptoms and behaviors in prison:
    - He never left his cell to take a shower
    - He did not sleep much
    - He never went to the yard
    - He seemed afraid to leave his cell
    - He told him that demons will try to make you do things you shouldn't
    - He asked him to read a book about demons controlling peoples minds

- Mr. Cole has also expressed grandiose delusions regarding his ability to change things in Iraq. According to Mr. Cole, the army should issue him fatigues, and arm him with a bible so that he would be able to spread the word of God. Once he began to spread the word of God, peace would be restored to the region.

- Following my evaluation of Mr. Cole in December, 2008, he developed paranoia towards me, refusing to sign releases, and stating to his legal team that he did not want me to have access to the data. In addition, he expressed the delusion that God had sent me a message to save the Jewish people and that I did not want to hear that message. He then requested that his team find him a Pentecostal psychiatrist.

- Since 2008, Mr. Cole has repeatedly referred to himself as Benjamin from the Benjamite Tribe when speaking with Attorney Lee.

VII. SUMMARY OF RELEVANT DATA FROM PRIOR MENTAL HEALTH ASSESSMENTS SINCE INCARCERATION:

- By 2/28/03, Dr. LaFortune noted clinically significant impairment on his ability to distinguish between facts which are more legally relevant or less legally relevant.

- By 7/11/03, his legal team suspected psychiatric illness and requested a competency evaluation after he waived his preliminary hearing and appeared depressed, shutting down and not following the recommendations of counsel.

- During the hearing on July 16, 2003 before the Honorable Judge L. Joe Smith regarding an application for a competency hearing, Attorney Lyman, stated,

> *"Your Honor, we've had several occasions, numerous occasions, over the period of time since we were appointed to represent Mr. Cole, to confer with him, to discuss his case, to advise him of matters in the case, and it has progressively gotten worse, as far as, in our opinion, his ability to assist us and to understand what we're talking about.*

- During Dr. Christopher's 105 minute interview on July 23, 2003, she noted,

> *Mr. Cole states that he trusts his attorneys and has confidence in their abilities to represent him, noting, 'I believe they are good at what they do.' It should be noted that when questioned as to how he might help his attorneys, Mr. Cole replies, 'I don't know how I can.' He elaborates, 'I don't see any point to an attorney. Just let me judged ...God appointed people to judge, so let them judge.' He explains that he wants to bypass a preliminary hearing because, 'I already know what evidence there is' and elaborates 'I'll do whatever they feel, whatever needs to be done.' When questioned if he lacked motivation to defend himself Mr. Cole replied, whatever will be done, will be done. It is turned over to God. Whatever judgment comes down I'll accept from our Heavenly Father. It is not a lack of anything, it is just trust in him.' Mr. Cole explains, 'I put it in the Lord's hands."*

- Dr. Sharp elicited the following symptoms upon screening during his 10/25/03 examination:

  a. Feeling that you are watched or talked about by others
  b. Feeling fearful
  c. Feeling that most people cannot be trusted
  d. Trouble concentrating
  e. Feeling uneasy when people are watching or talking about you

- On 5/24/04, Jeanne Russell, Ed.D. conducted an evaluation to better understand the impact of both psychological and sociological factors on the instant offense. She noted that he stayed focused about 80% of the time on his religious beliefs. She also ruled out the presence of psychopathy, writing,

> *Mr. Coles's overall score of "10" on the PCL-R falls at the 9.4 percentile rank with 90.6% of male offenders scoring equal to or higher than the defendant. In summary, Mr. Cole fails to meet the criteria associated with psychopathy.*

- Dr. Russell noted that Mr. Cole scored low on both the HCR20 and the VRAG, violence risk assessment tools that help predict risk for future dangerousness, citing alcohol and romantic relationships as factors increasing risk.

- In Dr. Basso's 6/15/04 report he noted,

> *"Overall, his pattern of neuropsychological performance and clinical history suggest the presence of impaired brain function. Severity of this dysfunction may be characterized as mild, and maximally present in the left temporal-parietal region."*

- Dr. Basso went on to mention,

> *"Owing to apparent difficulties involving executive function, he may require some assistance in implementing or maintaining the use of such devices. Additionally, he seems prone to difficulties when confronted with novel, unfamiliar, or complex problems."*

- Dr. Basso also did not think that Mr. Cole was a malingerer, stating,

> *"Regarding symptom validity, there were no indications that Mr. Cole exaggerated symptoms of mental illness during this evaluation. The SIRS includes several scales that are specifically designed to detect such response biases. In no case did his responses suggest these biases."*

- During the 2004 Competency Trial, Dr. Monroe's testimony touched on why he wanted a trial when he stated,

> *"I do recall that he said that people's hearts would be touched at his trial, by God."*

- Dr. Monroe also spoke to Mr. Cole's judgment when he stated,

> *"...he did have the idea that it was possible that a miracle could happen, that God could conduct some kind of miracle in this case."*

- By 9/24/07, Dr. LaFortune noted that he was consumed by religiosity to the exclusion of all other discussions of his case. She noted that Mr. Cole told her, "God wanted to catch my attention." She noted his speech to be tangential and that he asserted that the right reason to be in prison is to learn about Jesus Christ.

- On 11/19/07, Dr. Price opined that Mr. Cole was incompetent to assist his attorneys.

- In her 11/19/07 report, Dr. Price stated,

> *"Very little relevant information was obtained during this interview due to Mr. Cole's impaired mental status. He spoke of little else other that scripture and his need for religious materials from the free world. He denied any mental or emotional dysfunction. He essentially refused to relate any information about his life during this interview. He said that to talk about his past was 'like putting Jesus on the cross again and again which is like doubting his own forgiveness.' At another time in the interview, he said 'that wearing your heart on your sleeve is dragging it through the mud and hanging Jesus on the cross again.' He maintained that his only responsibility in his appeal is to pray...not to bring things back up from his past."*

- Dr. Price went on to mention,

> *"... he rambled on and on in a grandiose manner about his religious purpose in life. He stated that he needs someone in the free world to receive copies of his religious writings and preserve them for the*

future in an archival fashion. His answers to questions mostly consisted of a scripture that might be vaguely related to the questions, but often it was unrelated in any discernable fashion. Along with his hyper-religiosity, Mr. Cole revealed delusional thinking. He reported, 'I see myself as David in Psalms 51.' During this interview, Mr. Cole spoke only of scripture, and when this examiner attempted to engage him in discussions of the Bible, he resisted, preferring to be the only one who could speak and attempting to ridicule this examiner's lack of awareness of certain scriptures or of Christian television personalities."

- In her 11/19/07 report, Dr. Price notes that Mr. Cole does not leave his cell and does not use the showers. In her mental status exam, she identified a somewhat suspicious attitude, pressured speech, poor insight and judgment, euphoric mood, illogical and tangential thought process, and delusional thought content.

- Also in her 11/19/07 report, Dr. Price diagnoses Mr. Cole with Delusional Disorder, Grandiose Type DSM IV TR 297.1, Obsessive Compulsive Disorder 300.3, Alcohol Dependence 303.90, and Caffeine Intoxication. In giving him a Global Assessment of Functioning (GAF) score of 30-40 she commented on his impairment in reality testing, communication, and delusional thinking.

- Dr. Price mentions,

"The defendant reported that he cannot discuss his life history or the events surrounding the death of his daughter with attorneys, investigators, or psychologists. He related that to do so is the same as trying to crucify Jesus again. He maintained that his only responsibility in his legal situation is stay 'as close to prayer and God as possible.'"

VIII. MENTAL STATUS EXAM:

Mr. Cole presented dripping wet with a slender build with a long thick beard, and with long slicked back hair on both days of interviewing. He was oriented to person place and time. He was somewhat intrusive, delving right into scripture before we had even had the opportunity to sit and he could not allow me to complete the usually confidentiality disclaimers. He described his mood as good

and his affect was expansive in range. His speech was pressured, over-inclusive and filled with biblical references and references to passages from the Bible and could not be redirected for the most part. He was completely guarded regarding his family of origin, his trauma background and any and all past psychiatric symptoms or family history. He was guarded regarding any discussion of the instant offense and of his past crime that led to incarceration. He denied current suicidal ideation or homicidal ideation. He denied the presence of hallucinations. He was coherent but ruminative over being saved by Jesus and wanting me and his lawyer to be saved. He was tangential as he could not answer most direct questions and would move back towards religious themes regardless of the topic of the question. He expressed grandiose delusions regarding his ability to change things in Iraq were he there now, recommending that the army should issue him fatigues and arm him with a bible so that he would be able to spread the word of God. He was preoccupied with being unable to obtain a host of nutritional supplements. He was uncooperative with attempts to more closely assess his cognitive status. His judgment was poor based on him insisting that I could get all the data I wanted from his past reports, and given that he spent the majority of our 2 days together talking about scripture. His insight into the existence of a mental illness was poor. It could not be determined what his insight was into the driving forces behind the instant offense.

IX. PSYCHIATRIC FORMULATION:

I am of the opinion with a reasonable degree of medical certainty that Mr. Cole suffers from Schizophrenia, Paranoid Type according to the DSM-IV-TR (2000). This untreated mental illness has resulted in a deterioration of his mental state over the course of the past 20 years. The overall course of his illness has been a downward one and even prior to the instant offense, he had been living a marginal existence, rarely holding jobs, at times being homeless, and estranged from most of his family, even from those members of his family who were not abusive.

In the context of the isolation of death row and the self imposed isolation that he initiated by refusing to leave his cell for the most part; he has deteriorated even further over the past 3 years. There is now no contact with his family or children in part because of his paranoia with the associated self imposed isolative behaviors and in part because his letters were so foreign to them that they were alienating. In addition, for some time he has been preoccupied with finding a spiritual advisor and has been dissatisfied and unrealistic regarding the available resources. His current schizophrenic paranoia and grandiose thinking and social impairments and

impaired judgment and distortions far exceed what could reasonably be attributed to accepted religious concepts or attitudes.

In 2004, he was still able to allow for superficial evaluations by mental health evaluators, but the intensity of his untreated paranoia has escalated to the point that he cannot even participate in an evaluation superficially. Given that his delusions provide him some comfort given his current life situation, he has become attached to these thoughts despite the fact that they are at times getting in the way of assisting his legal team. It has come to the point that he no longer cooperates with evaluations, will not provide any information to his legal team, or discusses legal strategy. This was certainly evident during Dr. Price's assessment in 2007 and was even worse by the time I evaluated him in 2008. At this point his evaluators are being pulled into his systematized delusional systems, believing that I was mocking him or that I was rejecting God's direct message to me to save the Jewish people.

The essential features of schizophrenia are a mixture of characteristic signs and symptoms that have been present for a significant portion of time and these signs and symptoms are associated with marked social or occupational dysfunction. These symptoms affect behavior, perception, and judgment. The onset of illness is usually between early adolescence and the late twenties. Generally there is a marked deterioration in interpersonal functioning. Mr. Cole has suffered from both positive symptoms (delusions) and passive or negative symptoms, which are more subtle and can be misinterpreted as laziness or depression, or that the person is being actively and purposefully uncooperative. For individuals with schizophrenia, it is often difficult to maintain relationships and people often turn away from them out of fear or discomfort. Families often have trouble coping with the deterioration seen and often tend to get angry and frustrated, with high levels of expressed emotion hoping to motivate the afflicted family member. It is generally difficult for patients to form alliances especially in stressful environments such as correctional settings. Although Dr. Basso did not diagnose schizophrenia, he did note significant problems in executive functioning which is consistent with the diagnosis. Although there is mental health literature regarding the challenges of parenting with mental illness, in the context of his symptoms, lack of insight, and lack of family supports, adequate services were not mobilized to identify his mental illness or provide the support necessary when a mentally ill person has parenting responsibilities. In this case it is notable that DHS was involved but failed to implement adequate services despite his felony conviction history and lack of motivation for treatment.

In Mr. Cole's case, locating the precise onset of specific psychiatric symptoms is somewhat complicated by his trauma background and his own substance abuse. Despite these factors, by all accounts there was a significant change in his personality at the age of 18: from someone who was friendly, according to his mother, to paranoia and intense hostility for no clear reason. It was around this age, he started to destroy supplies in his mother's home.

His current symptoms include paranoid delusions towards the requests of his legal team and their motives which have spread to the belief that I refused an assignment from Jesus. There are delusions regarding his capacity to affect the war in Iraq and delusional thinking with respect to clear cut well documented decisions made in his legal case. In addition to delusional thinking there is a long history of autistic-like behaviors consistent with schizophrenia. Some of the autistic-like symptoms have included the way in which he has related to his legal teams, his family, his wives, his children, and the examiners. He has been consistently poorly related, a symptom commonly seen in patients with schizophrenia, and has displayed no interest in connecting with his lawyers or his examiners. He has been hypersensitive to sounds including the crying of his babies. We know that the crying of his babies has been a precipitating stressor in both of his felony cases; however, at this point, more data relevant to Mr. Cole's trauma background would be necessary in order to determine if in fact symptoms associated with Posttraumatic Stress Disorder (PTSD) were driving forces in the commission of the instant offense, i.e. exaggerated startle or flashbacks. Patients with PTSD have been known to react violently on occasion and if you add exaggerated startle to a person already suffering with the paranoia and poor judgment associated with schizophrenia it would be even more difficult to cope with a crying infant. Despite having children with 3 different women, he never demonstrated any interest in connecting with the needs of these women or the children, whether it be in terms of helping with childcare or even with ensuring family safety. It is notable that his history was the primary factor in Susan Young losing custody of her son. In our meetings, these negative symptoms and autistic like symptoms were noted in the restricted range of topics he would discuss, which were limited to the following: scripture, what religious material he could be provided from his legal team, and how to get access to more nutritional supplements. He was unmotivated to discuss why he had lost touch with family or why so many of his relatives have lost interest in him. He has demonstrated idiosyncratic behaviors including bathing in the sink and saving food that tends to go bad in his cell.

His current psychiatric symptoms are likely exacerbated by his current legal stressor, the traumas of his youth, the genetic loading for illness, his lack of

insight, and the lack of family supports that made prior psychiatric treatment impossible. In addition, his only models for childrearing were disturbed ones and left him void of any positive parenting instincts. Although alcohol is generally a violence risk factor, it is likely that alcohol was acting as his only "psychiatric medication" for many years. Paranoid individuals are generally anxious and alcohol can in the short run help reduce anxiety and help with sleep disturbances. In addition to some genetic loading in his family for psychosis, there is genetic loading for his alcohol abuse as well.

In the community, he never maintained friends, and for years he never bothered to get a drivers license. Despite appearing legitimately saddened following Brianna's death during his taped confession in 2002, he has apparently never been able to process how he could have been involved in these tragedies.

It is my opinion, to a reasonable degree of medical certainty, that Mr. Cole's refusals to meet with his legal teams, sign release forms, or cooperate with this evaluator is involuntary and without a knowing appreciation of its consequences. His rigidity and lack of cooperation with his legal team has been complicated by his death row status, his perception of limited cooperation from the prison, his lack of family contacts in part due to his disappointment in their "lack of interest in scripture" and the turnover of his legal teams over the years, necessitating that some issues be repeated and explored over and over.

Although Mr. Cole is not overtly hostile towards Mr. Lee, his attorney, I observed for several hours how Mr. Cole made it impossible for Attorney Lee to engage him in any meaningful discussion about his case. In fact, Mr. Cole's only agenda, when talking to Attorney Lee, is focused on religion, the scripture and how familiar Attorney Lee is with passages in the Bible, trying to save Attorney Lee's soul, and complaining about how his legal team has failed in not finding him a spiritual advisor to write and visit him in prison. Any attempt by Attorney Lee to get Mr. Cole to discuss Mr. Cole's life history, or legal strategy was met with silence. Mr. Cole refused to speak about any issues outside of his religious agenda; stating something along the lines that God had said in the scriptures that one must not look back when sowing the field, because if one does that, then the lines in the field would not be straight.

In spite of my best efforts to engage him, which included listening to his religious preaching for hours, and my accepting that he would not cooperate with the majority of my questions, I learned subsequently that he was particularly frustrated with the evaluation, and demanded that his legal team find him a Pentecostal

forensic psychiatrist. He was apparently fearful of my diagnosis and refused to sign releases to obtain his prior neuro-imaging studies for fear that I would be given access to them. It is my opinion, to a reasonable degree of medical certainty, that Mr. Cole is convinced that any cooperation or acceptance of a psychiatric diagnosis, discussion of past trauma or substance abuse, discussion of past risk behaviors, or discussion of legal strategies would undermine his faith in Jesus and undermine his current "saved" status.

When conducting mental health evaluations for the court, one must always consider the possibility that a defendant is malingering psychiatric symptoms for the purpose of supporting a legal defense. In this case, no evidence of malingering was detected. In fact, Mr. Cole does not attempt to report any psychiatric symptoms and is unwilling to discuss any and all past traumatic events including his own victimization, corroborated by multiple witnesses, and the instant offense itself, or the abuse that led to his first incarceration. In addition, Dr. Basso assessed for malingering and ruled it out based on psychological testing criteria.

The assessment of Competency to Stand Trial is generally focused on present competency. The evaluator first attempts to determine if the defendant appreciates their legal predicament, the charges, and the roles of courtroom personnel. The evaluator attempts to determine if the defendant has both a factual and rational appreciation of these issues. Next, the evaluation focuses on the defendant's capacity to assist legal counsel. An assessment of any psychiatric symptoms that could interfere with the ability to make use of counsel is made. In simple cases, this can often be done by reviewing the case with the defendant and discussing hypothetical legal scenarios to assess the flexibility of the defendant's thinking and to assess whether the defendant's legal strategies are reasonable.

When a defendant has a documented psychiatric history or speaks in a disorganized fashion, the evaluator usually explores the history further and may not simply accept statement from the defendant at face value. In fact, there are many scenarios where it is crucial that an assessment of the interaction between defendant and attorney be witnessed by the evaluator so the evaluator can actually see how actual strategies in the case are processed and agreed upon. In Mr. Cole's case, crucial information was missed by past evaluators because they did not include the attorney in the consultation with the defendant and did not watch how they interacted.

Here, the inconsistencies in Mr. Cole's statements including trusting his attorneys and then stating that he did not understand the purpose of one in his case and that

he wanted to bypass hearings, were never addressed by evaluators. A greater focus on Mr. Cole's actual strategies and how in contrast they were to his legal team's goals and even some rationale for why he wanted a trial despite his confession and all the physical evidence would have likely led to discovering that he in fact has been suffering from symptoms of his schizophrenia throughout his legal process.

Although some earlier mental health evaluators missed the presence of major mental illness, Dr. Price noted delusional thinking in the 2007 evaluation. I can speculate that there are multiple reasons for why an evaluator could miss the delusions. First, Dr. Christopher only had 105 minutes with Mr. Cole and did not observe him with his attorneys. Second, she was asking generic questions about legal strategy and may not have understood where the conflicts between Mr. Cole and his legal team lay. Had Dr. Christopher observed Mr. Cole's interaction with his legal team, it might have opened up more areas of exploration that would have demonstrated his psychopathology more clearly. In my evaluation, I had the opportunity to meet with Mr. Cole for 9 hours and was able to see the conflicts that arise with defense counsel in person. Third, delusions are not always accessible early in an interview. Psychotic patients can refrain from revealing them for periods of time unlike other psychotic symptoms which are generally recognizable early on in the interview including disorganized speech or being distracted by auditory hallucinations. Fourth, the intensity of delusions can fluctuate over time and by the time I evaluated Mr. Cole, he had suffered through 5 more years of untreated schizophrenia. Fifth, Mr. Cole was not being treated in the jail and there was no known mental health treatment history that would usually raise the index of suspicion that the defendant may suffer from a major mental illness. Sixth, in the context of updates in psychiatric training which insures that psychiatrists are culturally and religiously sensitive, one is cautious before labeling any evidence of hyper-religiosity as delusional; however, in this case, even his chaplain is unable to follow his religious ideas, and he is unable to make use of the prison chaplain out of paranoia. Incorporating his forensic psychiatrist into his delusional system indicates more than simply being devout or religiously committed.

There is no evidence from Dr. Sharp's report that he attempted to explore any of the significant symptoms that he in fact elicited during his screening or evidence that there was an attempt to better understand the factors that led to Mr. Cole's estrangement from his family or the driving factors involved in the instant offense. Even the defendant's denial of being a victim of abuse is taken at face value without inquiring about why so many other family members have claimed abuse. Although the objective testing revealed suspiciousness and referential thinking, there is no evidence from the written report that these symptoms were explored.

Had these areas been explored by Dr. Sharp, it would have revealed how pervasive Mr. Cole's delusional thinking is.

In Dr. Christopher's report, none of Mr. Cole's odd statements are challenged or even questioned and Dr. Christopher accepts that he will cooperate with counsel at his word despite counsel's concerns. The report does not indicate that competency needed to be addressed. This is significant given that all of the lawyers who worked with Mr. Cole have struggled, a pattern which I witnessed first hand during my interviews with him in 2008. Dr. Christopher never asks Mr. Cole why he would go forward with a trial given his confession, all the physical evidence, and his past child abuse charges. In this case, it was necessary to observe the interaction between Mr. Cole and his attorneys to adequately assess his capacity to assist at the various stages of his case. Dr. Christopher's report suggests that he does in fact possess a superficial appreciation of the roles of courtroom personnel; however, this is not the significant factor that makes him currently incompetent or previously incompetent. The problem in this case, has always been Mr. Cole's inability to assist his attorneys and his constant interference with his attorney's ability to defend him against these charges. Although Dr. Christopher's report does delve into whether Mr. Cole appreciates or realizes his precarious situation and how unlikely he is to prevail at trial given the evidence; there is no commentary to suggest that there may be some problems in reality testing. This is especially important because of Mr. Cole's belief that he will get parole, and in counting the days until his release. In the report, Dr. Christopher seems to minimize the extent of his psychopathology suggesting that his biggest problem is the effects of alcohol, and that she would recommend that his future interactions with children be monitored. In addition, there is no evidence that the family history is taken into consideration in ruling out psychiatric disorders.

Dr. Russell's report serves to rule out the presence of psychopathy, which was apparently the sentiment at the time of trial given the nature of the criminal charges and that he received a death sentence. Unfortunately, Dr. Russell did not elicit the delusional thinking that was elicited by Dr. Price and myself, which in my opinion is the logical explanation for Mr. Cole's life trajectory and his current approach to his dealings with his legal teams.

In summary, Mr. Cole was born into a substance abusing, incestuous, non-supportive, and violent family atmosphere. By adolescence Mr. Cole was showing signs of a prodromal psychotic disorder, namely schizophrenia. His illness worsened without treatment over the years and unfortunately did not come to the attention of the mental health system even after he was first incarcerated for child

abuse. By the time he was making babies with his 3rd wife, when he was in his thirties, he was abusing alcohol and unable to function as a parent or at a job. He was isolated from all family and was mostly estranged from his many children, having been abused himself before either being incarcerated or forced to leave. It was in this context that the horrible tragedy of the death of a 9 month old Brianna occurred. It is particularly tragic in that DHS was monitoring this couple and should have made earlier interventions given the existing risk factors. Had Mr. Cole been forced to go for psychiatric treatment, his chronic illness might have been detected in time to have prevented the death of his daughter.

It is my opinion, to a reasonable degree of medical certainty, that at this point in Mr. Cole's life, based on his background and illnesses, he is unable to establish an alliance with anyone on his legal team. In addition, a more comprehensive understanding of his mental status at the time of his past offenses is compromised by his rigid delusional thinking and autistic like behaviors. Also, in his current mental state, there is no logical incentive for giving up his grandiose delusions or the comfort of hoping to be saved by Jesus. In fact these primitive coping mechanisms for Mr. Cole are somewhat adaptive for him as they actually help him avoid having to struggle with the trauma and loss associated with his past behaviors. Unfortunately, these same symptoms leave him in a stalemate with his legal team which can not assist him until his psychosis has resolved. Reaching a state of competency would require some treatment with anti-psychotic medications. Currently, he is unmotivated to follow any of the recommendations of his legal team and given his refusals to sign releases and his statements regarding mental illness, it is clear that he is unable to accept the presence of illness which interferes with any attempts by his legal team to discuss the role mental illness has played in his legal case to date, the role it played in the commission of the instant offense, or even in any discussion of mitigating factors.

Respectfully submitted,

Raphael Morris, M.D.

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UPDATED INDEPENDENT PSYCHIATRIC CONSULTATION

Date:
January 21, 2015

RE:
Benjamin Cole Competency To Be Executed

Age of Defendant:
49

Date of Birth:
April 8, 1965

Location of Defendant:
Oklahoma State Penitentiary
McAlester, Oklahoma

Referred by:
Tom Hird
Assistant Federal Public Defender
Capital Habeas Unit
Federal Public Defender-Western District of Oklahoma
215 Dean A. McGee, Suite 707
Oklahoma City, Oklahoma 73102

Circumstances of the Assessment:
Post sentence, pending execution

I. INTRODUCTION:

Mr. Benjamin Cole stands convicted of Murder in the First Degree and has been sentenced to death. The charges arose out of allegations that he caused the death of his 9 month old daughter on or about 12/20/02. Although there was physical evidence that implicated him and he confessed to the charges in a videotaped confession, he decided to plead Not Guilty and move forward with a trial even after he was offered a plea that would have guaranteed him life in prison.

When I first met Mr. Cole in December 2008, I had been asked to evaluate his mental state in the context of his having been uncooperative with a variety of leads that his legal team attempted to follow up which would have supported the presence of mitigating factors including his own history of being a victim of physical abuse, his family history of mental illness, and his own psychiatric symptoms, previously noted by mental health evaluators.

Although the records indicated that he had been previously diagnosed with mental illness, the Federal Public Defender's Office asked me to evaluate him in 2008 in the context of his refusing visits, evidence of worsening social withdrawal, odd idiosyncratic behaviors, expressed paranoia and grandiose statements regarding his ability to teach scripture and spread religious teachings, and because he was actually interfering with efforts made on his behalf in his legal case.

In my 2009 report, I opined that Mr. Cole was suffering from Schizophrenia, Paranoid Type, that he lacked the capacity to participate in his habeas proceedings, that delusional rigid thinking was the driving force behind him sabotaging his legal team; and that the symptoms of his schizophrenia dated back to before the instant offense and were present and active throughout his trials. In that report, I summarized mental health evaluations that detected mental illness and demonstrated that mental illness was evident even before 2003 and has persisted to the present. I pointed out why he had not sought treatment and hypothesized based on my experience working in correctional and forensic facilities why his schizophrenia was not more proactively treated.

It is my understanding that Mr. Cole has not received any treatment for his schizophrenia in the more than 6 years since I met with him. By all accounts he has deteriorated even further, refusing to come out of his cell to meet with evaluators or his legal team. He almost never leaves his cell and stopped bathing.

In 2014, I was asked to evaluate Mr. Cole's competency to be executed. I was informed that the warden did not agree that he has schizophrenia and despite traveling all the way to the prison from San Diego, I was not allowed to meet with the defendant even after requesting to observe him at his cell.

In preparing this supplemental report, I reviewed multiple affidavits of clinicians and other individuals who have had contact with him over the past 6 years, reviewed the neurological evidence (his MRI of the brain) that supports his brain disorder, and reviewed the medical literature that describes his disorder and the reasons his untreated symptoms have undermined his legal defense and have caused even further deterioration in his condition and his capacities to make reasoned decisions and appreciate his situation rationally.

My qualifications to conduct this evaluation include my faculty appointment at New York University School of Medicine, my three years as the Director of Forensic Services at Bellevue Hospital Center in New York City, and my two years as the Chairman of the Hospital Forensic Committee at Kirby Forensic Psychiatric Center in New York. At Bellevue Hospital Center, I conducted and supervised psychiatrists and trainees in court-ordered evaluations for the New York Criminal and Supreme Courts. At Kirby Forensic Psychiatric Center, I conducted over 100 court ordered evaluations. I have experience evaluating and treating inmates from my work on the Bellevue Hospital Prison Wards, working at Sing Sing Correctional Facility, and my work at Lincoln Correctional Facility in New York. I was a principal faculty member for New York University's forensic psychiatry residency training program and was the site supervisor for visiting medical students and residents on the prison wards. I have authored a chapter on teaching forensic psychiatry to medical students and have lectured to both medical and legal audiences on problems related to restoring competency and maintaining competency in correctional settings and forensic hospitals. My qualifications are further detailed in my curriculum vitae.

II. SOURCES OF INFORMATION:

In arriving at my opinion, I relied in part on the following sources of information:

1. Psychiatric Consultation Report prepared by Raphael Morris, M.D., dated 4/4/09 which was based in part on the 9 hours of interviewing Mr. Cole between 12/14/08 and 12/15/08.
2. Brain MRI, dated 9/22/04.
3. Conversation with the Warden on 8/30/2014 informing me that I would not be authorized to meet with Mr. Cole and could not be escorted to his cell and was told that the warden did not think r. Cole was suffering from schizophrenia.
4. Affidavit summarizing the legal team's effort to discuss his case on 1/8/15.
5. Affidavit of Linda Anne Hayman, M.D. (Radiologist) from 2015.
6. Affidavit of Anna Wright, dated January 13, 2015.
7. Declaration of Robert C. Gur, Ph.D., (Neuropsychologist)
8. Report of Matthew Powers, M.D.
9. Report of John D. Hastings, M.D.
10. List of attempted visits by the legal team from 2010 through 2014.
11. Competency Evaluation prepared by Dr. Price, dated 12/13/07.
12. Psychological Evaluation prepared by Dr. Basso, dated 6/15/04.
13. Psychological Evaluation prepared by Dr. Sharp, dated 10/23/03.
14. Psychological Evaluation prepared by Lisa Sneden and Kathy LaFortune, dated 7/23/03.
15. Psychological Evaluation prepared by Dr. Christopher, dated 8/18/04
16. Defendant's letters
17. Plea Offer and Response to Termination of Attorneys
18. Oklahoma State Penitentiary Medical Records through 2014.
19. Trial Transcripts
20. Millan, Mark et al. Negative symptoms of schizophrenia: Clinical characteristics, pathophysiological substrates, experimental models and prospects for improved treatment. European Neuropharmacology (2014) 24, 645-692.

21. Galeno Roxana et al. Severity of Negative Symptoms in Schizophrenia Correlated to Hyperactivity of the Left Globus Pallidus and the Right Claustrum. A PET Study. Original Investigation/Summary of Original Research.
22. Hokama Hirito et al. Caudate, putamen, and globus pallidus volume in schizophrenia: A quantitative MRI study. Psychiatry ResearchL Neuroimaging 61 (1995) 209-229.
23. Heckers, Stephan. Neuopathology of Schizophrenia: Cortex, Thalamus, Basal Ganglia, and Neurotransmitter-Specific Projection Systems. Schizophrenia Bulletin, Vol. 23, No. 3., 1997 403-421
24. Fenton, W. Heterogeneity, Subtypes, and Longitudinal Course in Schizophrenia. Psychiatric Annals, 2000; 30:10.
25. Daniel, AE Care of the Mentally Ill in Prisons: Challenges and Solutions. The Journal of the American Academy of Psychiatry and the Law, 2007, 35(4): 406-410.
26. Trestman RL et al. Current and Lifetime Psychiatric Illness Among Inmates Not Identified as Acutely Mentally Ill at Intake in Connecticut's Jails. The Journal of the American Academy of Psychiatry and the Law, 2007, 35(4): 490-500.
27. Duzyurek S and Wiener J. Early Recognition in Schizophrenia: The Prodromal Stages. Journal of Practical Psychiatry and Behavioral Health, 1999, 5(4): 187-196.
28. Herz M. Early Intervention in Different Phases of Schizophrenia. Journal of Practical Psychiatry and Behavioral Health, 1999, 5(4): 197-208.
29. Ziedonis D and Stern R. Dual Recovery Therapy for Schizophrenia and Substance Abuse. Psychiatric Annals, 2001, 31(4): 255-264.
30. Montoya ID. Treatment Noncompliance in Patients With Co-Occuring Mental Illness and Substance Abuse. Psychiatric Times, January, 2006, 23-24.
31. President Bush's 2004 Freedom Commission Mental Health Report.
32. Beck AT et al. A New Instrument for Measuring Insight: the Beck Cognitive Insight Scale. Schizophrenia Research, 2004; 68: 319-329.
33. The DSM IV-TR (American Psychiatric Association, 2000)
34. Marder SR et al. Schizophrenia, IX: Cognition in Schizophrenia-The MATRICS Initiative. American Journal of Psychiatry, 2004: 161:25.

35. Vries PJ et al. Dementia as a complication of schizophrenia. Journal of Neurology, Neurosurgery, and Psychiatry, 2001; 70:588-596.
36. Herbener ES et al. The Influence of Depression on the Course, Functioning, and Treatment of Patients With Schizophrenia. Psychiatric Annals, 2000; 30(10): 653-658.
37. Loebel AD et al. Duration of psychosis and outcome in first-episode schizophrenia. American Journal of Psychiatry, 1992; 149:1183-1188.
38. Melle I et al. Reducing the Duration of Untreated First-Episode Psychosis. Archives of General Psychiatry. 2004; 61:143-150.
39. Hawkins KA. Memory Deficits in Schizophrenia: inadequate assimilation or true amnesia? Findings from the Wechsler Memory Scale-revised. Journal of Psychiatry and Neuroscience, 1997, 22(3):169-179.
40. Levin S et al. Contributions of Neuropsychology to the Study of Schizophrenia. Journal of Abnormal Psychology, 1989, 98(4):341-356.
41. Reiger DA et al. Comorbidity of mental disorders with alcohol and other drugs abuse. JAMA, 1990;264:2511-2518.
42. Dixon L et al. Acute effects of drug abuse in schizophrenic patients: clinical observation and patient's self reports. Schizophrenia Bulletin, 1990; 16:69-79.
43. Dixon L et al. Drug abuse in schizophrenia patients: clinical correlates and reasons for use. American Journal of Psychiatry, 1991;148:224-230.
44. Wilkins JN. Pharmacotherapy of schizophrenia patients with comorbid substance abuse. Schizophrenia Bulletin. 1997; 23:215-228.
45. Hellerstein DJ et al. A prospective study of integrated outpatient treatment for substance abusing schizophrenia patients. American Journal of Addictions.1995;4:33-42.
46. Morgan, C et al: Fear Potentiated Startle in Posttraumatic Stress Disorder: Biological Psychiatry: 1995; 38: 378-385.
47. Grady, D et al: Dimensions of War Zone Stress. An Empirical Analysis: Journal of Nervous and Mental Disease: 1989; 177:6 347-350.
48. Simon, R. Posttraumatic Stress Disorder in Litigation. Washington, DC, American Psychiatric Press, Inc., 1995.

III. Review of my 2009 Report:

In my description of his mental status examination, I reported that he was somewhat intrusive, delving right into scripture before we had even had the opportunity to sit and he could not allow me to complete the usual confidentiality disclaimers. His affect was expansive in range. His speech was pressured, over-inclusive, and filled with references to passages from the Bible. He could not be redirected for the most part. He was completely guarded regarding his family of origin, his trauma background and any and all past psychiatric symptoms or family history. He was guarded regarding any discussion of the instant offense and of his past crime that led to incarceration. He was ruminative over being saved by Jesus and wanting me and his lawyer to be saved. He was tangential as he could not answer most direct questions and would move back towards religious themes regardless of the topic of the question. He expressed grandiose delusions regarding his ability to change things in Iraq were he there now, recommending that the army should issue him fatigues and arm him with a bible so that he would be able to spread the word of God. He was preoccupied with being unable to obtain a host of nutritional supplements. He was uncooperative with attempts to more closely assess his cognitive status. His insight into the existence of mental illness was poor.

I opined that Mr. Ben Cole suffered from Schizophrenia, Paranoid Type and that by the time of the evaluation in 2008, his untreated mental illness had resulted in a deterioration of his mental state over the course of 20 years. The overall course of his illness has been a downward one and even prior to the instant offense, he had been living a marginal existence, rarely holding jobs, at times being homeless, and estranged from most of his family, even from those members of his family who were not abusive. I noted that in the 3 years leading up to our 2008 interview, he had deteriorated even further, refusing to leave his cell for the most part with no contact with family. I noted that his delusions and distortions surrounding religion far exceeded what could reasonably be attributed to accepted religious concepts or attitudes. I noted that back in 2004, he had still been able to participate in superficial mental health evaluation. I noted that by 2008, those who attempted to evaluate him were being pulled into his systematized delusional

systems, believing that I was mocking him or that I was rejecting God's direct message to me to save the Jewish people.

I noted that Mr. Cole has suffered from both positive symptoms (delusions) and passive or negative symptoms, which are more subtle and can be misinterpreted as laziness or depression, or that the person is being actively and purposefully uncooperative. I noted that he had paranoid delusions towards the requests of his legal team and their motives which have spread to the belief that I refused an assignment from Jesus. He was delusional at that time regarding his capacity to affect the military in Iraq and had delusional thinking with respect to clear-cut, well documented decisions made in his legal case. I noted a long history of autistic-like behaviors consistent with schizophrenia. He has been consistently poorly related, a symptom commonly seen in patients with schizophrenia. I noted multiple idiosyncratic behaviors including bathing in the sink and saving food that tends to go bad in his cell.

I noted how for several hours Ken Lee, his attorney at the time, was unable to engage him in any meaningful discussion about his case. He refused to speak about any issues outside of his religious agenda. I reviewed how, in spite of my best efforts to engage him, which included listening to his religious preaching for hours, and my accepting that he would not cooperate with the majority of my questions, I learned subsequently that he was particularly frustrated with the evaluation, and demanded that his legal team find him a Pentecostal forensic psychiatrist. He was apparently fearful of my diagnosis and refused to sign releases to obtain his prior neuro-imaging studies for fear that I would be given access to them. I later learned from his legal team that he expressed to them the delusion that God had sent me a message to save the Jewish people and that I did not want to hear that message.

I was able to rule out any malingering in his case and noted that in no way did Mr. Cole attempt to report any psychiatric symptoms.

I opined that he was incompetent to assist in his habeas proceedings.

I concluded that for him to have any chance of becoming competent, he would have needed treatment with anti-psychotic medications. In 2008, he was unmotivated to follow any of the recommendations of his legal team. Given his refusals to sign releases and his statements regarding mental

illness, I opined that he was unable to accept the presence of illness which interfered with any attempts by his legal team to discuss the role mental illness has played in his legal case to date, the role it played in the commission of the instant offense, or even in any discussion of mitigating factors.

I reviewed the neuropsychological evidence presented to me from Dr. Basso who wrote in 2004:

> *"Overall, his pattern of neuropsychological performance and clinical history suggest the presence of impaired brain function. Severity of this dysfunction may be characterized as mild, and maximally present in the left temporal-parietal region."*

IV. REVIEW OF UPDATED RECORDS:

Dr. Hayman reviewed Mr. Cole's Brain MRI and referred to his behaviors and symptoms in her affidavit:

She noted the lesion in the left basal ganglia in his case and correlated it with the medical literature that supports the presence of negative symptoms of schizophrenia with this finding. These negative symptoms would include his blank looks, his lack of motivation, his mutism, his lack of interest in the outside world. These are all symptoms that have interfered with his legal defense team's efforts and with his capacity to review his legal situation and consider the reasons for his punishment in a coherent and logical manner. Dr. Hayman recommended a follow up MRI and PET scan given that his neurologic symptoms have progressed.

The affidavit of Anna Wright notes that she found him increasingly withdrawn since first meeting him in 2008. She reported how her office contacted the prison in the context of his weight loss and him indicating that he not going to eat anything. He refused to meet with his legal team during the summer of 2014. She noted that in July, 2014, he refused to meet with Dr. Morris, the forensic psychiatrist who came from San Diego to reevaluate him. During the 55 minutes that the team sat with him in a 2015 meeting, he kept his eyes closed and was mostly silent, providing no evidence to his legal team that he understood that he was being executed or why.

Prison records from 2014 note that he refused to leave the cell.

V. CONCLUSIONS:

I continue to opine that Mr. Ben Cole suffers from Schizophrenia, Paranoid Type. Although I was confident that he suffered from this diagnosis over 6 years ago, there is even more evidence available at this time. Schizophrenia is a neurochemical disorder which damages the brain causing both positive symptoms of delusions in his case and prominent negative symptoms of avolition, anhedonia, autistic behaviors, alogia and social withdrawal in his case. Serial clinical interviews and psychological testing in the past have been consistent with his schizophrenia. At the time I assessed him in 2008, I relied on the clinical history, his mental status examination which included expressed delusions, disorganization, and his prominent negative symptoms. I had access to multiple evaluations of the mental health professionals who had noted signs and symptoms of his mental illness not to mention the difficulties all of his attorneys have experienced in trying to have rational discussions with him.

My review of the available medical records at this point finds even more objective evidence that he in fact suffers from a neuro-chemical illness with actual neuroimaging findings that in fact provide even more objective evidence to explain the severity of his symptoms. The lesion in his basal ganglia found in 2004 is consistent with many of his clinical findings as supported by the schizophrenia literature and clinical research which I cite in the sources of information section of this report.

The medical literature explains how individuals with schizophrenia deteriorate even more without treatment. This is consistent with his worsening social withdrawal and his unwillingness to communicate.

I note that the fact that he has not become violent with prison staff , has not been threatening suicide, and remains in his cell does not in any way suggest that he is not ill from schizophrenia. His social withdrawal and not outwardly expressing delusions out loud is likely to be the main reason the prison has not elected to medicate him on their own. The prison appeared to appreciate that he needed his own cell and for an extended period of time he has not been forced to share a cell.

The neurologic consultation has recommended that his brain be re-scanned. I agree with this recommendation particularly given his diagnosis and what is obvious deterioration over the last 9 years. His active symptoms of paranoia, rigidity and withdrawal interfere with any meaningful medical or psychiatric workups and have undermined his mental health and his legal situation for many years.

Another important thing to note is that it is highly likely that it will be difficult to extract him from his cell for his execution in the context of his paranoia.

He was incompetent to participate in habeas proceedings when I met with him in 2008, he has not had any treatment since then, and there is evidence of further deterioration in his Schizophrenia with respect to negative symptoms and cognitive decline, consistent with what we understand about this neuro-chemical disease.

I can find absolutely no objective evidence to suggest any improvement in his condition during the interim time period.

Although I was not allowed to evaluate Mr. Cole in person in 2014 to assess his competency to be executed, his competency to be executed must be questioned under these circumstances given all the evidence of a deteriorating course of schizophrenia.

Respectfully submitted,

Raphael Morris, M.D.

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Date of Birth: December 13, 1951. Benton Harbor, Michigan.

EDUCATION:

2003-2010	Graduate Studies in Global & International Studies-University of Kansas, Lawrence, KS.
1991-2000	Graduate of Adult Psychoanalysis Program-Topeka Institute for Psychoanalysis, Topeka, KS
1987-1989	Postdoctoral Fellowship in Clinical Psychology Menninger Clinic, Topeka KS
1982-1987	Ph.D. in Clinical Psychology California School of Professional University of Alliant International University-San Francisco, CA. (formerly California School of Professional Psychology-Berkeley, CA)
1980-1981	San Francisco State University, San Francisco, CA
1973-1978	University of Michigan-Flint, MI B.A. in General Studies, with Honors

MILITARY SERVICE:

1970-1973	United States Army Special Forces Radio Communications Specialist. 46th Special Forces Company. Thailand

PROFESSIONAL WORK AND TRAINING EXPERIENCE:

Base Operational Support Team (BOST) Psychologist-Keesler Air Force Base, Biloxi, MS. (7/21-present). Full Time 40 hours Weekly. Clinical Psychologist for Keesler AFB BOST Team.
Currently serve as the team psychologist for a four-member Base Operational Support Team (BOST) that physically embeds within designated units identified as at high risk at Keesler AFB (embedment's are typically 3-5 months duration). Embedment is informed by a wide array of gathered analytic measures &interventions are tailored to meet the specific mission & training requirements of the designated unit's unique program or unit. During embedment spend extended observation periods to build relationships, conduct evaluations and consultations to enhance unit morale and cohesion, as well as devise interventions to address individual member's human performance challenges and bolster resilience. Provide limited scope counselling to address trauma or vicarious or secondary traumatization when indicated. Provide psychological health surveillance of potential problems to keep leadership aware of unit morale as well as provide primary and secondary preventative counter-

measures before psychological health concerns impact readiness. Conduct regular command consultations with unit and wing commanders on how to leverage their skill set effectively, in line with applicable medical requirements with guidance. Develop and maintain multiple relationships, preserving positive rapport with supported unit/personnel while maintaining appropriate professional ethics and boundaries. Educate, coach, and counsel individuals regarding sub-clinical problems, such as stress, substance misuse, and family situations. Attend and participate in Mental Health Clinic Treatment Team Meetings, High Interest and Multi-disciplinary Clinical Case Staffing's regarding unit members. Provide support for personnel preparing for or returning from deployment. Unit level crisis interventions. Also concurrently assigned to the Keesler AFB's Aerospace Medical Squadron to provide periodic mental health assessments (MHA"s) and coordinate care with Military Treatment Facility (MTF) primary care providers and clinic support staff regarding service members in need of additional clinical care.

Behavioral Health Optimization Specialist-RAF Lakenheath, United Kingdom. (6/16-7/21). Full Time 40 hours Weekly. Clinical Psychologist-Behavioral Health Optimization Specialist for 48th Medical Group at RAF Lakenheath Hospital's Family Health Clinic (covering Internal Medicine & Pediatrics Clinics). Provide evidence-based short-term & solution-focused behavioral interventions and behavioral health analysis for active-duty military as well as dependents (adults, adolescents and children as well as families and couples) and retirees. Provide immediate on-site diagnostic and behavioral analysis feedback and consultations to referring primary care physicians and nursing staff, emergency room personnel, behavioral health clinicians (other psychologists, psychiatrists, social workers, substance abuse counselors and Family Advocacy Services) , and flight commanders regarding patient care and treatment recommendations. Provide crisis interventions and stabilization services, differential diagnosis, & deployment-related evaluations. Maintain basic working clinical knowledge of psychopharmacological issues, which include recognition of and interventions for substance/ prescription abuse and dependence. Liaison with hospital referral services regarding patient referrals for specialty services within the British National Health Service (NHS). Attend flight command meetings, high-interest patient meetings, participate in and delivered presentations on relevant behavioral health topics, and other duties as assigned. Initiated ongoing process improvement projects with statistical analysis to obtain ongoing analysis of behavioral health needs. Maintain BHOP Provider Certification from U.S. Air Force.

Clinical Psychologist- Champion Consultants Program with the Center for Deployment Psychology. Henry M. Jackson Foundation. Irwin Army Community Hospital (IACH). Ft. Riley Kansas (10/14-6/16). Full Time 40 hours Weekly. Provide individual and group-format clinical consultation and program evaluation for IACH clinicians to promote facility-wide use of DoD approved Evidence- Based Psychotherapies (EBP's to address issues within military population. Serve as resident subject matter expert on clinical and theoretical aspects of EBP's and conduct literature reviews of treatment efficacy for various EBP applications. Conducted comprehensive analysis and statistical plan for all clinical outcome measures to be used with a newly developed Intensive Out-Patient Program (IOP). Consult with command staff and behavioral health clinicians, as well as primary care providers about EBP's, and augment clinical implementation of EBP's throughout the facility. Provide clinical workshops and development of "tool-kit" learning modules about EBP's. Conduct clinical Program Evaluations and Needs Assessments regarding clinical utilization of services. Attend medical command meetings at IACH Main Hospital and the Embedded /Aviation Clinics throughout the facility. Provide statistical analysis of electronic records using Behavioral Health Data Portal (BHDP) to create trauma symptom reports and treatment efficacy analysis reports with traumatized populations. Complete Psycho-educational Toolkit Projects and present Grand Rounds presentations as assigned for continued education for IACH providers and clinic leadership.

Clinical Psychologist-Irwin Army Community Hospital (IACH). Ft. Riley Kansas (1/14-10/14). Full Time 40 hours Weekly. Clinical Psychologist for Outpatient Behavioral Health Unit at IACH. Provide short-term behavioral interventions and behavioral health analysis as an embedded clinician for active- duty military. Provide individual and group psychotherapy, psychological testing and psycho-diagnostic evaluations, crisis interventions and stabilization, differential diagnosis, & deployment-related evaluations for patients with developmental, emotional and behavioral disorders as well as deployment-related and combat stress conditions. Consult to military commanders regarding troop disposition, Psychological Profiles (temporary and permanent), Disciplinary Chapter Proceedings, suitability for various military schools (e.g., Sniper, Drill Instructor, Recruiter, Special Forces and Ranger) and necessity for referral to and presentations to Fitness for Duty (FFD) Panels, and Medical Evaluation Boards (MEB) to determine suitability for continued military service. Attend medical command meetings, provide after-hours on-call emergency services on scheduled rotation.

Behavioral Health Optimization Specialist-Joint Base Langley-Eustis (3/13-12/13). Full Time 40 hours Weekly. Clinical Psychologist-Behavioral Health Optimization Specialist for 633rd Air Wing Medical Group at Langley AFB Hospital's Family Health Clinic (covering Internal Medicine, Family Health, Women's Health, and Labor and Delivery, Pediatrics & Flight Medicine). Provided evidence-based short-term & solution-focused behavioral interventions and behavioral health analysis for active duty military as well as dependents (adults, adolescents and children as well as families and couples) and retirees using the U.S. Air Force's Behavioral Health Consultant Model. Provide immediate on-site diagnostic and behavioral analysis feedback and consultations (verbal and written) to referring DoD and civilian primary care physicians and nursing staff, emergency room personnel, behavioral health clinicians (other psychologists, psychiatrists, social workers, substance abuse counselors and Family Advocacy Services) , and flight commanders regarding patient care and psycho-legal implications of treatment recommendations as well as capacity to return to duty or referral for Medical Evaluation Boards (MEB's). Provide crisis interventions and stabilization services, differential diagnosis, & deployment-related evaluations. Provided short-term group psychotherapy for depressed active- duty members. Maintained basic working clinical knowledge of psychopharmacological issues, which included recognition of and interventions for substance/ prescription abuse and dependence. Provided after hours on-call services (telephonic and face-to-face consultation) with emergency room personnel and command staff as part of routine clinic rotation. Liaison with community providers and treatment programs regarding patient referrals for specialty services. Attend flight command meetings, high-interest patient meetings, participated in and delivered presentations on relevant behavioral health topics, and other duties as assigned. Obtained BHOP Provider Certification from U.S. Air Force.

Clinical Psychologist. Psychology Private Practice - Topeka, KS **(1/91-3/13). Full Time 40+ hours Weekly.** Psychological testing, psychotherapy (psychodynamic and cognitive-behavioral approaches) & psychoanalysis with children, adolescents, and adults with full spectrum of diagnoses. Couples, family therapy and group therapy. Crisis management and liaison with community providers and emergency services. Corporate management evaluations, forensic & independent psychological consultations. Psycho-legal evaluations (interviews, psychological testing, neuropsychological screenings, drug- treatment evaluations & psycho-legal research to address specific psycho-legal issues) and provide expert witness testimony. Provide comprehensive forensic evaluations (with court-testimony). Provide behavioral health care research with international NGO's regarding psychological assessment and research of best practices with psychological testing & interview approaches to assist with the documentation of allegations of torture, political and religious discrimination, and violations of human rights.

Hospital Psychologist - The Menninger Clinic (.5 FTE, 20 hours weekly), Topeka, KS (4/97- 8/98). Staff Psychologist on Professionals in Crisis and Addictions Recovery Program.

Director of Pre-Doctoral Psychology Internship Training -Topeka State Hospital, Topeka, KS (9/90- 9/92). Full Time 40 hours Weekly.

Crisis Worker - Shawnee County Community Mental Health Center, Topeka, KS (4/89-10/90) Part-Time 10 hours Weekly.

Post-Doctoral Fellowship in Clinical Psychology -The Menninger Clinic, Topeka, KS (9/87-9/89). Full Time 40 hours Weekly.

Mental Health Worker - Comprehensive Child Psychiatric Crisis Service, Children's Hospital, San Francisco, CA (10/86-7/87). Part Time-5 hours Weekly.

Adolescent Counselor - La Chaim Residential Adolescent Treatment Program, Berkeley, CA (9/86-7/87). Full Time 40 hours Weekly.

Milieu Counselor - Westside Lodge Residential Treatment Program, San Francisco, CA (9/86-5/87). Part-Time 10-15 hours Weekly.

APA-Approved Pre-Doctoral Internship in Clinical Psychology - Langley Porter Psychiatric Institute, Adolescent and Young Adult In-Patient Unit, University of California, San Francisco, CA. (9/85-7/86). University of California, San Francisco (9/83-9/84).

Psychology Internship - Oakland Community Counseling. Oakland, CA (9/84-7/85). Part Time 20 hours Weekly.

Psychology Internship- San Francisco General Hospital. Methadone Maintenance Program. Department of Psychiatry, University of California, San Francisco (9/83-9/84). Part Time 20 hours Weekly.

CONSULTATION EXPERIENCE:

American Civil Liberties Union (ACLU) of Kansas and Western Missouri

American Psychological Association. APA Member-Initiated *Task Force to Reconcile Policies Related to Psychologists' Involvement in National Security Settings.* Washington, DC.

Bosnian Initiatives for Local Development (BILD), Bosnia

Chubb Group of Insurance Companies, Chicago, IL.

City of Topeka Police Department, Topeka, KS

CyBar, Inc., Minneapolis, MN.

Death Penalty Defense Unit, State of Kansas, Topeka, KS

Federal Office of the Prosecutor, Topeka, KS.

Federal Probation Office, Topeka, KS.

Federal Probation Office, Wichita, KS.

Federal Public Defenders Office, Topeka, KS.

Federal Public Defenders Office, Kansas City, KS.

Federal Public Defenders Office, Madison, WI.

Federal Public Defenders Office, Salt Lake City, Utah

Federal Public Defenders Office, Wichita, KS.

International Criminal Tribunal for the Former Yugoslavia (ICTY)
At The Hague, The Netherlands

Heartland Works, Topeka, KS.

Kansas Advocacy and Protective Services-Topeka, KS.

Kansas City Police Department-Kansas City, MO.

Kansas National Education Association (KNEA) - Topeka Chapter, Topeka, KS.

Lyon County District Attorney's Office. Emporia, KS.

Menninger Leadership Center, Menninger Clinic, Topeka, KS.

Missouri Supreme Court. Board of Examiners. Jefferson City, MO.

National Football League (NFL) at Menninger Clinic, Topeka, KS.

NE Kansas Conflicts Office-State of Kansas, Topeka, KS.

National Rehabilitation Center, Abu Dhabi, United Arab Emirates

Northwestern Mutual Insurance Co.

Office of the United States Attorney, District of Kansas. Topeka, KS.

Office of the Public Defender- Capital Defense Division, Western Division, Kansas City, MO.

Office of the Public Defender-Western Appellate/PCR Division A-Area 52, Kansas City, MO.

Office of the Public Defender-Western District of Oklahoma. Capital Habeas Unit. Oklahoma City, OK.

Physicians for Human Rights Asylum Network, Cambridge, MA.

Professional Renewal Center, Lawrence, KS.

Psychological Resources (subcontract with U.S. Drug Enforcement Administration), Los Angeles, CA.

Shawnee County Court Services, Topeka, KS.

Shawnee County District Attorney's Office, Topeka, KS.

Shawnee County Public Defender, Topeka, KS.

Shawnee County Regional Prevention & Recovery Services, Topeka, KS.

Southwestern Bell Telephone Company, Topeka, KS.

State of Iowa Office of Disability Determination & Referral Services, Des Moines, KS.

State of Kansas Board of Indigent Defense Services, Topeka, KS.

State of Kansas Office of Disciplinary Administrator, Topeka, KS

State of Kansas Juvenile Justice Authority, Topeka, KS.

State of Kansas Mental Health & Developmental Disabilities Forensic Services, Topeka, KS.

State of Kansas Office of Disability Determination & Referral Services, Topeka, KS.

State of Kansas Office of SRS-Legal Department, Topeka, KS

State of Kansas Office of Vocational & Rehabilitation Services, Topeka, KS.

State of Kansas Supreme Court, Topeka, KS.

State of Missouri Office of Disability Determination & Referral Services, Kansas City, MO.

United Arab Emirates University, Al Ain, UAE

University of Kansas School of Law- Paul E. Wilson Public Defender Project

University of Nebraska, Department of Athletics (Football), Lincoln, NE.

Unum Provident Corporation

U.S. Department of Justice, Division of National Security, Washington, D.C.

U.S. Department of Justice, Immigration Court Competency Mental Health Referral Project, Washington, D.C. (under Project Leadership of Judge Jack Weil, Alexandria, VA.)

U.S. Drug Enforcement Administration-Psychological Consultant, Central U.S. (Chicago, Dallas, Denver, Detroit, Houston, Kansas City, Miami, St. Louis)

Wyandotte County District Attorney's Office, Kansas City, KS.

Wyandotte County Public Defender's Office, Kansas City, KS.

RESEARCH EXPERIENCE:

Project Co-Investigator - "Family Support for Astronaut Families During Exploration Class Missions to Mars." Co-investigator with research team (4 researchers) tasked to provide an initial comprehensive literature review and structured interviews (with astronauts, astronaut family members and key members of NASA Family Support Office) to address best ways to provide family support to families when an astronaut family member is deployed on Mars expeditions and assess how personal relations and interactions (family, friends and colleagues) affect astronauts' behavioral health and performance during pre-mission stage of exploration class missions (Mars Missions). This project is identified as addressing Knowledge Gap No. Eight (8) with the Human Research Program, Behavioral Health & Performance Element. (Behavioral Medicine Risks. Risk of Adverse Cognitive or

Behavioral and Psychiatric Disorders). Research Contract awarded to Center for Deployment Psychology in coordination with National Aeronautics and Space Administration (NASA). Johnson Space Center, Houston, TX. (5/15-6/16).

Project Assistant- Provided comprehensive review of psychological interviewing, psychological testing approaches, psychological testing instruments, psychological standards of care, and psychological best practices for the evaluations of torture victims. This research was used in the compilation of the book: *A Clinician's Guide to Physical and Psychological Evaluations of Torture and Ill Treatment.* (2012). Physicians for Human Rights (PHR).

Co-Investigator – "Changing Borderline Mothers' Representations of their Child's Internal Worlds" - Menninger Clinic Child & Family Center, Topeka, KS (8/96-9/97).

Research Assistant – "The California Verbal Learning Test (CVLT) Norming Project for Children", San Francisco, CA (4/85 -7/86).

Research Assistant – "The Joint Custody Project" of Jewish Family Services, San Francisco, CA (3/84-11/84).

Research Assistant – "The Brief Therapy Project" of the Mount Zion Psychotherapy Research Group, San Francisco, CA (8/83-5/86).

Project Assistant - N.I.D.A. funded research project "Community Network Approach to Drug Abuse Treatment." Department of Psychiatry, University of California, San Francisco General Hospital. (9/8-9/84).

TEACHING EXPERIENCE:

Instructor - Federal Emergency Management Agency (FEMA) Community Emergency Response Team -CERT Instructor (4/01- 1/1/09). Teach Principles of Disaster Psychology.

Instructor - Heritage Mental Health Clinic (9/02-5/05). Teach Antisocial Personality and Psychopathy Module to pre-doctoral interns.

Teaching Faculty - Kansas City Institute for Psychoanalysis (10/97 to 3/06). Co-teach various courses in psychoanalytic theory and technique

Teaching Faculty - Topeka Institute for Psychoanalysis (6/96 – 6/2000). Co-taught various courses in psychoanalytic theory and technique.

Adjunct Assistant Professor - Washburn University, Topeka, KS (1/92-5/94). Taught semester course in "Abnormal Psychology" to undergraduates.

Faculty Instructor & Director - Topeka State Hospital Pre-Doctoral Internship Program in Clinical Psychology, Topeka State Hospital, Topeka, KS (9/89-9/92).

Instructor - Karl Menninger School of Psychiatry, Menninger Clinic, (6/88-4/89). Taught principles of psychological testing to post-baccalaureate practicum students

PUBLICATIONS: Articles

Hough, G. (2017). Impact on Military Children When a Parent Deploys While Living Overseas: A brief Scope of the literature. Psychology and Behavioral Science International Journal 7(5): 55722. DOI: 10.19080/PBSIJ.2017.07.555722

Hough, G. & Twemlow, S. (2016). War Criminals and Other "Ordinary Men": A Case Report. International Journal of Applied Psychoanalytic Studies. Volume 14 (1): 35-53.

The Centre for Deployment Psychology. (2015*) Lessons Learned Manual: A Framework for Addressing Barriers to Evidence-based Psychotherapy Utilization in the Defence Department.* Contributors(Riggs, D; Cook, J; French, L.; Mann; J.; Adkins,J.; Baima, G.; Cho-Stutler, L; Fearing, T.; Frick, A.; Hough, G.; Kleoppel. E; McDermott, J.; Ordway, K.; towel, K.; Williams, S.)

Hough, G. (2012).Psychologists obtain training on human rights law and evaluation of torture survivors. Psychology International Newsletter: The American Psychological Association. June 2012, Volume 3, (2), 9-10.

Hough, G. (2008). Sojourn to Night: Srebrenica. International Journal of AppliedPsychoanalytic Studies 5 (1):16-22

Twemlow, S. & Hough, G. (2008). The Cult Leader as an Agent of a Psychotic Fantasy of Masochistic Group Death in the "Revolutionary Suicide" in Jonestown. Psychoanalysis and Psychotherapy, Vol. 24, (4), Winter, 222-239.

Hough, G. (2006). American Terrorism and the Christian Identity Movement: A Proliferation Threat From Non-State Actors. International Journal of Applied Psychoanalytic Studies, Vol. 3 (1), 79-100.

Hough, G. (2004).) Does Psychoanalysis Have Anything to Offer an Understanding of Terrorism? Journal of the American Psychoanalytic Association, 52 (3), 813-828.

Twemlow, S., Sacco, F. & Hough, G. (2003). A Socio-Psychoanalytic Perspective on Group Dynamics, Cults and Terrorism Part 1: The Context of Terrorism. Socio-Analysis The Journal of the Australian Institute of Socio-Analysis, 5, 57-78.

Twemlow, S., Sacco, F. & Hough, G. (2003). A Socio-Psychoanalytic Perspective on Group Dynamics, Cults and Terrorism Part 2: A Note on Possible Antidotes. Socio-Analysis The Journal of the Australian Institute of Socio-Analysis, 5, 79-87.

Holigrocki, R.J., Frieswyk, S.H., Kaminski, P.L., & Hough, G. (1999). FCIA: Parent-Child Interaction Assessment Technical Report NO. 099-1046. The Menninger Clinic, Family and Children Center. Topeka, KS.

Wilkinson, S. & Hough, G. (1996). Lies as Narrative Truth in Abused Adopted Adolescents. Psychoanalytic Study of the Child (51), 580-596.

Hough, G. (1995) A Clinician with a Schizophrenic Family Member: A Case Report. Bulletin of the Menninger Clinic, 59 (3), 345-356.

Hough, G. (1995) Transactions of the Topeka Psychoanalytic Society: Paper by Dr. Theodore J. Jacobs entitled "Analysis, Mutual Analysis, and Self-Analysis: On the Interplay of Minds in the Analytic Process". Bulletin of the Menninger Clinic, 59, (3), 395-397.

Hough, G. (1991) When confidentiality mandates a secret be kept: A case report. International Journal of Group Psychotherapy, 42 (1), 105-115.

Hough, G. (1987) "The Emergence of Creativity in Painters after Age Fifty: An Exploratory Study." Unpublished Dissertation.

PUBLICATIONS: Book Chapters

Hough, G. (2020). A Child's First Rose. In G. Eick & C. Poage (Eds.), "The Death Project: An Anthology of These Times" (pp. 63-69). Wichita, Kansas. Blue Cedar Press.

Hough, G. (1996). A Clinician with a Schizophrenic Family Member: A Case Report. In J.G. Allen & D.T. Collins (Eds.), Contemporary treatment of psychosis healing relationships in the "Decade of the Brain" (pp. 61-72). Northvale, New Jersey: Aronson.

PUBLICATIONS: Book Reviews

Hough, G. (2002) Book review: Dangerous Sex Offenders: A task force report of the American Psychiatric Association. Bulletin of the Menninger Clinic, 66 (1), 86-87.

Hough, G. (2002) Book review: Dispatches from the Freud Wars. By John Forrester. Bulletin of the Menninger Clinic, 64 (1), 125-127.

Hough, G. (2002) Book review: The psychology of stalking. Clinical and forensic perspectives. By Reid R. Meloy (Ed.). Bulletin of the Menninger Clinic, 65 (2), 277-278.

Hough, G. (1998). Book review. The Clinical exchange: techniques derived from self and Motivational systems. By J.D. Lichtenberg & F.M. Lachmann. Bulletin of the Menninger Clinic, 62, (2), 270-271.

Hough, G. (1997) Book review. The many faces of deceit: Omissions, lies, and disguise in psychotherapy. By H.K. Gedimann & J.S. Lieberman. Bulletin of the Menninger Clinic, 62 (2), 113-115.

Hough, G. (1997) Book review: A Meeting of Minds: Mutuality in Psychoanalysis by Lewis Aron. Bulletin of the Menninger Clinic, 61 (3), 15-16.

Hough, G. (1996) Book review: The Psychoanalyses and the Psychotherapies: The Talking Cures. By Robert Wallerstein. Bulletin of the Menninger Clinic, 60 (4), 552-554.

Hough, G. (1996) Book review: Posttraumatic stress disorder in litigation: Guidelines for forensic assessment. Edited by Robert I. Simon. Bulletin of the Menninger Clinic, 60 (1), 126-128.

Hough, G. (1995) Book Review: Surviving mental illness, stress, coping, and adaptation. By Agnes B. Hatfield & Harriet P. Lefley. Bulletin of the Menninger Clinic, 59 (1), 122-124.

Hough, G. (1993) Book Review: The personal myth in psychoanalytic theory. Edited by Peter Hartocollis & Ian David Graham. Bulletin of the Menninger Clinic, 57 (2), 268-270.

Hough, G. (1990) Book Review: Systematic treatment selection: Toward targeted therapeutic interventions, by Larry E. Butler & John F. Clarkin. Bulletin of the Menninger Clinic, 55 (3), 408-409.

Hough, G. (1990) Book Review: Creative aspects in psychotherapy, by Albert Rothenberg. Bulletin of the Menninger Clinic, 54 (2), 276-278.

Hough, G. (1990) Book Review: Self-mutilation: Theory, research & treatment, by Barent W. Walsh & Paul M. Rosen. Bulletin of the Menninger Clinic, 54 (4), 559-560.

PRESENTATIONS: (to large audiences)

Hough, G. (7/19/19). "Re-Thinking the 'Ordinary Man' Paradigm of the War Crimes Perpetrator." Paper presented at 14th Annual International Association of Genocide Scholars "The Missing Picture": Rethinking Genocide Studies & Prevention American University of Phnom Penh. Rutgers Center for the Study of Genocide and Human Rights. Phnom Penh, Cambodia.

Hough, G. & Cook, J. (2/26/16). Moral Injury Among Military Veterans. Presented to Psychology Department at Irwin Army Community Hospital at Ft. Riley, KS.

Brim, W., Weinstock, M. and Hough, G. (2/8/16). Family Support for Long Duration and Exploration Missions (#7041). NASA 2016 Human Research Program Investigator's Workshop. Frontiers in Human Space Exploration Research. Galveston Island Convention Center. Galveston, TX.

Hough, G. (8/27/15). Resilience and Burnout. Move to Health Conference: Changing the Conversation in Army Medicine. Sponsored by U.S. Office of the Surgeon General at Riley Conference Center. Ft. Riley, KS.

Hough, G. (8/27/15). Mindful Awareness & Power of the Mind. Move to Health Conference: Changing the Conversation in Army Medicine. Sponsored by U.S. Office of the Surgeon General at Riley Conference Center. Ft. Riley, KS.

Hough, G., Cook, J. & Parish, R. (4/24/15). Outcome Measures in Evidence Based Psychotherapies. Presented at Clinical Grand Rounds to Irwin Army Community Hospital at Ft. Riley, KS.

Hough, G & Alarid, J. (8/11/14) Symposium: Human Rights-Armed Conflict-Criminal Law: Transnational Crime. *Understanding the Mind of the Modern War Criminal: Pre and Post-Conviction Evaluations.* Presented at American Society of International Law. Northwestern University School of Law. Chicago, Il..

Hough, G. & Alarid, J. (8/10/14). Symposium: Psychological Evaluation of an ICTY War Criminal at The Hague. Presented at 2014 American Psychological Association's Annual Convention. Symposium 4157. Washington, DC.

Hough, G. & Kivlahan, C. (9/23/12). Learning To Do Combined Physical and Psychological Evaluations. Workshop: Advanced Forensic Training for Experienced Volunteers: Techniques for Increased Effectiveness of Evaluations and Testimony. Physicians for Human Rights. Held at American Association for the Advancement of Science (AAAS). Washington D.C.

O'Brian, S. & Hough, G. (7/21/12). Trauma Issues in Death Penalty Cases. Panel Discussion at Workshop: Capital Punishment/Death Penalty Defense. Held at Washburn University School of Law. Topeka, KS.

Hough, G. Forensic Issues in the Substance Abuse Rehabilitation Setting. (6/6-7/12). Two Day Workshop Presented to National Rehabilitation Center Clinical Staff & Invited Guests. Abu Dhabi, United Arab Emirates.

Hough, G.; Maag, J.; Irogonegaray, P.; Beale, D.; Maxfield, A. (2/26/12)).Radical Religion in Our Times. Panel Discussion. First Congregational Church, Topeka, KS.

Hough, G.; Albott, W.; Maag, J.; Kerns, K.; & Rudy, M. (11/9/11). American Terrorism and Radical Religion. Panel Discussion. Friends University. Wichita, KS.

Harder, R.; Holcombe, T.; McCollough, J.; Schlingensiepen, T.; Schlingensiepen, F.; Shaw, A. & Hough, G. (11/8/11). "Bonhoeffer in New York. Faith and Politics." Panel Discussion. First Congregational Church. Topeka, KS.

Hough, G. (10/4/11). Physicians for Human Rights and Case Discussion of an Afghan Asylum Case. Kansas University School of Medicine. Kansas City, KS.

Hough, G. & Blakeley, D. (10/19/2010). Genocide and Ordinary Men: Analysis of a Convicted War Criminal. Presented to The Greater Kansas City Psychoanalytic Society, Kansas City, MO.

Hough, G., Beale, D., Blakeley, D, Kerns, K. & Maag, J. (4/17/2010). The Psychology of War Criminals: Case Presentation of a Convicted War Criminal Evaluated at the ICTY. Case Presentation and Panel Discussion Presented to Psychiatry Grand Rounds, Stormont-Vail West Hospital, Topeka, KS.

Hough, G. (2/8/10). The Community Reinforcement and Social Networking Approach to Post-Incarceration Substance Abusers: Treatment Value and Lessons Learned. Presented at The National Rehabilitation Center Conference on Treatment in Criminal Justice Systems. Abu Dhabi, United Arab Emirates.

Hough, G., Beale, D., Benalcazar, B., Butler-Smith, A. (5/20/08). Moderator for Panel Discussion of The Political Brain: The Role of Emotion in Deciding the Fate of the Nation-authored by Drew Weston, Ph.D. Presented to The Greater Kansas City Psychoanalytic Society, Kansas City, MO.

Hough, G. (6/26/05). Panel Discussant of Topeka Civic Theatre's stage performance of *"How I Learned to Drive".* Topeka, KS.

Hough, G. & Albott, W. (06/6-7/05). Introduction to Consultation with Mental Health Professionals. State of Kansas Board of Indigents' Defense Services. Criminal Defense June CLE. Topeka, KS. & Wichita, KS.

Hough, G. & Evans, Ron (5/20/05). Using Mental Health Experts in Death Penalty Cases. Kansas Medical Education Foundation. Psychiatry Grand Rounds at Stormont-Vail Hospital. Topeka, KS.

Wilkinson, S. & Hough, G. (5/4/2005). When and How to Refer to Mental Health Professionals. Counseling Arabia 2005 Conference. Al-Ain, United Arab Emirates.

Hough, G., Miller, R., Miller, D., Benalquasar, B and Irogonegaray, P. (3/30/05). "A Civil and/or Religious Right: A Forum on the Proposed April 5th Amendment." Panel Discussion Participant at Washburn University, Topeka, KS.

Hough, G. & Albott, W. (10/29/04). Psychological Testing and Sex Offenders. Kansas Association of Trial Lawyers CLE Program Topeka, KS. .

Hough, G. (3/2/04). American Terrorism and the Christian Identity Movement: A Proliferation Threat from Non-State Actors. Greater Kansas City Psychoanalytic Institute. Kansas City, MO.

Hough, G. & Sookram, J. (7/22/03). Adolescent Development and Mental Health. Fourth Annual Governor's Conference on Juvenile Justice. Topeka, KS.

Hough, G. & Albott, W. (06/9-10/03). Introduction to Consultation with Mental Health Professionals. State of Kansas Board of Indigents' Defense Services. Criminal Defense June CLE. Topeka, KS. & Wichita, KS.

STATE LICENSES:

Kansas	License No. 708
Missouri	License No. 2001027153 (currently placed on voluntary inactive status).

HONORS:

Topeka Institute for Psychoanalysis Candidate's Writing Award for Outstanding Professional Publication (1/96).

PROFESSIONAL BOARDS:

Genocide Watch Board of Advisors (9/13-9/16)

Valeo Behavioral Health Care, Community Residence Program (CRP) Topeka, KS. (4/08 to 3/13)

Valeo Behavioral Health Care, Topeka, KS. (10/06 to 3/13)

Region II Representative. Kansas Psychological Association Board of Governors. (1/95-1/98-three-year term). Topeka, KS.

Psychoanalytic Society of Topeka- Vice President (former). Topeka, KS. (9/95-9/96).

Board of Directors Membership. Community Youth Homes, Inc. Topeka, KS. (10/90-10/91).

EDITORIAL BOARDS:

Psychiatric Services (Formerly Hospital and Community Psychiatry) - Reviewer

Journal of Applied Psychoanalytic Studies- Reviewer

American Journal of Psychotherapy-Reviewer

PROFESSIONAL CERTIFICATIONS:

American Board of Professional Psychology-Diplomate in Clinical Psychology (ABPP)

Certification as Internal Behavioral Health Consultant in Primary Care (IBHOP) with United States Air Force

PROFESSIONAL AFFILIATIONS:

American Board of Professional Psychology-Member

Fellow of the American Academy of Clinical Psychology

Physicians for Human Rights-Asylum Network

International Association of Genocide Scholars