IN THE SUPREME COURT OF THE UNITED STATES

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RAFAEL L.BEIER,

PETITIONER,

vs.

UNITED STATES OF AMERICA,

RESPONDENT.

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ON PETITION FOR WRIT OF CERTIORARI TO
THE UNITED STATES COURT OF APPEALS
FOR THE NINTH CIRCUIT

APPENDIX

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UNITED STATES COURT OF APPEALS

FOR THE NINTH CIRCUIT

UNITED STATES OF AMERICA, Plaintiff-Appellee, v. RAFAEL BEIER, AKA Rafael L. Beier, AKA Rafael Leonhard Wolfga Beier, Defendant-Appellant.	No. 22-35485 D.C. Nos. 2:21-cv-00064-DCN 2:14-cr-00117-DCN-1 District of Idaho, Boise ORDER

Before: S.R. THOMAS and McKEOWN, Circuit Judges.

The request for a certificate of appealability (Docket Entry Nos. 8 and 9) is denied because appellant has not made a "substantial showing of the denial of a constitutional right." 28 U.S.C. § 2253(c)(2); *see also Miller-El v. Cockrell*, 537 U.S. 322, 327 (2003).

Any pending motions are denied as moot.

DENIED.

UNITED STATES DISTRICT COURT

FOR THE DISTRICT OF IDAHO

RAFAEL L. BEIER, Petitioner, v. UNITED STATES OF AMERICA, Respondent.	Case No. 2:21-cv-00064-DCN 2:14-cr-00117-DCN-1 **MEMORANDUM DECISION AND ORDER**

I. INTRODUCTION

Pending before the Court is Petitioner Rafael Leonhard Wolfgang Beier's Motion to Vacate, Set Aside, or Correct Sentence under 28 U.S.C. § 2255. Dkt. 1.[1] The Government filed a Response to Beier's Motion. Dkt. 7. Beier filed a reply. Dkt. 11.

For the reasons outlined below, the Court finds good cause to DENY the motion.

II. BACKGROUND

The factual background of this case is fully detailed in the Court's Memorandum Decision and Order from April 5, 2021. CR–117, Dkt. 247. Beier, a former medical doctor, was convicted of over sixty separate counts of distributing prescription opiates and amphetamines. CR–117, Dkt. 252, at 1. After his 2016 trial, Beier failed to appear for the Return of Verdict, was sentenced to 192 months of incarceration, and exhausted his appeals without success.

[1] In this Order, "CR–117" is used when citing to Beier's criminal case record in 2:14-cr-00117-DCN-1. All other docket citations are to the record in the instant civil case.

After his trial but before sentencing, the Court granted Beier a post-trial competency hearing, which lasted two days. CR-117, Dkt. 166. Beier claimed that he was not competent to stand trial due to a brain injury that occurred as a result from a car crash in 1996. *See* CR-117, Dkt. 164-1. The Court appointed a forensic unit psychologist, Dr. Cynthia Low, to evaluate Beier for mental competency. CR-117, Dkt. 172, at 1. At the competency hearing, the Government called Dr. Low along with Dr. Craig Panos, an expert in brain injury, and offered into evidence the findings of three other experts who examined Beier. Dkts. 3-1; 3-2. The defense called Dr. Richard Adler, a forensic psychiatrist; Dr. Andrew Newberg, a brain imaging expert; and Dr. Craig Beaver, a clinical neuropsychologist; and offered into evidence the findings of two other experts who examined Beier. *Id.* The defense also called two of Beier sons and Yanhua Gao, Beier's wife at the time, to testify about the effects of Beier's 1996 car crash and other additional head injuries that Beier sustained after 1996. Dkt. 3-1. The exhaustive evidence focused on Beier's mental state and the physical and mental effects of the car accident in 1996, and the interaction between the two. *See* Dkts. 3-1;3-2.

The competency hearing concluded on July 27, 2017. Dkt. 3, at 1. The Court deemed Beier competent to stand trial on October 26, 2017. CR-117, Dkt. 194. Thus, the Court found no reason to retry Beier or deem his criminal trial a mistrial.

On February 6, 2021, Beier filed the instant motion seeking to vacate, set aside, or correct his sentence on two grounds of ineffective assistance of counsel. Dkt. 1. First, Beier asserts his trial counsel failed to investigate mental health defenses in violation of the Sixth Amendment. *Id.* at 4. Second, he claims trial counsel failed to properly explain the

sentencing guideline ranges and failed to advise Beier to accept a plea agreement. *Id.* at 5.

III. TIMELINESS OF PETITION

Under the applicable statute of limitations, a § 2255 motion must be brought within one year after a judgment of conviction becomes final unless the motion has been statutorily tolled according to 28 U.S.C. § 2255(f)(2)–(4). A judgment of conviction becomes final when it "has been rendered, the availability of appeal exhausted, and the time for a petition for certiorari elapsed or a petition for certiorari denied." *United States v. Schwartz*, 274 F.3d 1220, 1223 (9th Cir. 2001) (cleaned up). Beier's § 2255 petition was filed on February 6, 2021—less than one year after his judgment became final on February 24, 2020—and is thus timely. *See generally* Dkt. 1; CR–117, Dkt. 258.

IV. LEGAL STANDARD

Title 28 U.S.C. § 2255 provides four grounds under which a federal court may grant relief to a federal prisoner who challenges the imposition or length of his or her incarceration: (1) "that the sentence was imposed in violation of the Constitution or laws of the United States;" (2) "that the court was without jurisdiction to impose such sentence;" (3) "that the sentence was in excess of the maximum authorized by law;" or (4) "that the sentence is otherwise subject to collateral attack[.]" § 2255(a).

Relief under § 2255 is afforded "[i]f the court finds that . . . there has been such a denial or infringement of the constitutional rights of the prisoner as to render the judgment vulnerable to collateral attack." § 2255(b). Furthermore, "a district court must grant a hearing to determine the validity of a petition brought under that section '[u]nless the motions and the files and records of the case *conclusively show* that the prisoner is entitled

to no relief.'" *United States v. Blaylock*, 20 F.3d 1458, 1465 (9th Cir. 1994) (emphasis in original) (quoting § 2255). In determining whether a § 2255 motion requires a hearing, "[t]he standard essentially is whether the movant has made specific factual allegations that, if true, state a claim on which relief could be granted." *United States v. Withers*, 638 F.3d 1055, 1062 (9th Cir. 2011).

A district court may dismiss a § 2255 motion based on a facial review of the record "only if the allegations in the motion, when viewed against the record, do not give rise to a claim for relief or are 'palpably incredible or patently frivolous.'" *Id.* at 1062–63 (quoting *United States v. Schaflander*, 743 F.2d 714, 717 (9th Cir. 1984)). Conclusory statements in a § 2255 motion are insufficient to require a hearing. *United States v. Hearst*, 638 F.2d 1190, 1194 (9th Cir. 1980); *see also James v. Borg*, 24 F.3d 20, 26 (9th Cir. 1994) ("Conclusory allegations which are not supported by a statement of specific facts do not warrant habeas relief.").

V. ANALYSIS

Beier claims ineffective assistance of counsel via § 2255 on two separate grounds: (1) counsel failed to raise a mental defect or insanity defense, and (2) counsel failed to explain or advise him to accept a plea agreement.

As the United States Supreme Court has noted, "[a] court considering a claim of ineffective assistance must apply a 'strong presumption' that counsel's representation was within the 'wide range' of reasonable professional assistance." *Harrington v. Richter*, 562

U.S. 86, 104 (2011) (quoting *Strickland v. Washington*, 466 U.S. 668, 688 (1984)).[2] Therefore, Beier must satisfy both prongs of "the two-part *Strickland v. Washington* test." *Hill v. Lockhart*, 474 U.S. 52, 56–58 (1985) (citing *Strickland*, 466 U.S. at 687–90); *see also Lee v. United States*, 137 S. Ct. 1958, 1964–67 (2017). To establish ineffective assistance under that test, Beier bears the burden of proof to show (1) that his counsel's advice was not "'within the range of competence demanded of attorneys in criminal cases,'" *Hill*, 474 U.S. at 56–59 (quoting *McMann v. Richardson*, 397 U.S. 759, 771 (1970); and (2) "that there is a reasonable probability that, but for counsel's unprofessional errors, the result of the proceeding would have been different." *Strickland*, 466 U.S. at 694.[3]

The first element "requires showing that counsel made errors so serious that counsel was not functioning as the 'counsel' guaranteed the defendant by the Sixth Amendment." *Id.* at 687. The second element "requires showing that counsel's errors were so serious as to deprive the defendant of a fair trial, a trial whose result is reliable." *Id.* If either prong of the *Strickland* test is not satisfied, "it cannot be said that the conviction or sentence resulted from a breakdown in the adversary process that renders the result unreliable." *Id.* Thus, a claim of ineffective assistance of counsel may be rejected on either the deficiency or prejudice prong, and a court need not address both. *See United States v. Thomas*, 417 F.3d

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[2] In applying that presumption, a court must make an effort "to eliminate the distorting effects of hindsight" and instead "to reconstruct the circumstances of counsel's challenged conduct" and "evaluate the conduct from counsel's perspective at the time." *Strickland*, 466 U.S. at 689.

[3] A reasonable probability is a probability sufficient to undermine confidence in the outcome. *Strickland*, 466 U.S. at 694.

1053, 1056 (9th Cir. 2005).

The *Strickland* standard is "highly demanding" and requires the petitioner to prove that his attorney's performance amounted to "gross incompetence." *Kimmelman v. Morrison*, 477 U.S. 365, 382 (1986). Because "it is all too tempting for a defendant to second-guess counsel's assistance after conviction or adverse sentence" and "all too easy for a court, examining counsel's defense after it has proved unsuccessful, to conclude that a particular act or omission of counsel was unreasonable," judicial scrutiny of counsel's performance "must be highly deferential." *Strickland*, 466 U.S. at 689. When assessing an ineffective assistance of counsel claim, "a court must indulge a strong presumption that counsel's conduct falls within the wide range of reasonable professional assistance; that is, the defendant must overcome the presumption that, under the circumstances, the challenged action 'might be considered sound trial strategy.'" *Id.* (quoting *Michel v. Louisiana*, 350 U.S. 91, 101 (1955)).

A. Ineffective Assistance of Counsel for Failing to Investigate Mental Health Defenses Prior to Trial

Beier claims that he had a mental-health defect that affected the *mens rea* element of his crimes and that counsel was ineffective for not seeking a psychological evaluation or otherwise investigating the issue. Beier asserts that there is ample record evidence of these problems but fails to consider the overwhelming evidence to the contrary, which including the testimony of both the Government's expert in psychology and the Court's own expert during Beier's competency hearing.

"Trial counsel has a duty to investigate a defendant's mental state if there is evidence

to suggest that the defendant is impaired." *Douglas v. Woodford*, 316 F.3d 1079, 1085 (9th Cir. 2003). Even if defense counsel does not ask for one, "a trial judge must conduct a competency hearing whenever the evidence before him raises a bona fide doubt about the defendant's competence to stand trial." *Odle v. Woodford*, 238 F.3d 1084, 1087 (9th Cir. 2001).

In this case, Beier alleges that trial counsel admitted that he may have made a mistake by not seeking a competency evaluation for Beier prior to trial in an interview noted by Dr. Adler. Dkt. 1, at 13. However, the Court finds this allegation unpersuasive, not only because the statement allegedly made by trial counsel is unsupported hearsay, but because the Court held a two-day competency hearing after the trial where Beier failed to show that he lacked competency to stand trial and aid in his defense.[4] Although Beier may have shown enough evidence to support the potential for a mild brain injury more than a decade before committing his crimes, that was insufficient to show incompetency to stand trial or mental defect such that he was not responsible for his actions.

Further, the Ninth Circuit has already conclusively found that a mental defect defense would not have changed the outcome of trial. *United States v. Beier*, 780 Fed. App'x 460, 462 (9th Cir. 2019) ("[B]ecause the district court found [Beier] competent and rejected his insanity and diminished capacity arguments, the evidence [of a traumatic brain

[4] In other words, any pre-trial failure by counsel to claim defendant was incompetent to stand trial was resolved when the Court held a post-trial/pre-sentencing hearing on competency. If the Court had found defendant incompetent at that time, it could have declared the trial a mistrial without sentencing him. Defendant makes no attempt to show that his competency changed between the time of trial and the time of the competency hearing.

injury], even if new, did not indicate that [Beier] would probably be acquitted in a new trial."). This alone is sufficient to deny this ineffective assistance of counsel claim for lack of prejudicial effect.

The issue of Beier's potential mental defect or insanity defense was conclusively addressed by this Court and decided after a two-day competency hearing. Beier was deemed competent with only the potential of a mild neuro cognitive disorder, but no clear diagnosis of this disorder. *See* Dkt. 3-2, at 17–18.

Beier's capacity to stand trial and evidence of sanity were attested to by both the Court's appointed expert witness, Dr. Cynthia Low, and the Government's seven other expert witnesses. Dkt. 7, at 8. Although the defense expert witnesses disagreed with both Dr. Low and the Government's expert witnesses, the Court found Dr. Low to be the most credible witness because she spent the most time with Beier in a clinical role, and her "explanation and reasoning" were more complete than the defense experts who demonstrated "result oriented bias" during the hearing. Dkt. 7-5, at 7, 9–11.

Accordingly, due to the lack of a severe mental-health defect and the lack of diminished capacity as an appropriate defense, counsel made a reasonable strategic decision in not pursuing any capacity issues further and focusing instead on other tactics. *Cf. Williams v. Woodford*, 384 F.3d 567, 612 (9th Cir. 2004). Beier has not carried his burden of proving deficient performance or prejudice, and his claim for ineffective assistance of counsel necessarily fails.

Beier insists that an evidentiary hearing is necessary under *Burrows*.[5] Significant in *Burrows*, the defendant had a history of mental health issues and had been hospitalized for such, but there was no competency evaluation or hearing to determine any mental health issues and there was little evidence in the trial court's record regarding his mental health issues.[6] In the instant case, there was an evaluation and an extensive competency hearing. *See* Dkt. 3. Thus, an evidentiary hearing would not supply new facts for the Court's determination. Therefore, the filings here are sufficient because they supply all the facts the Court needs to address Beier's claims about his competency and mental defect defenses. This satisfies the requirement of § 2255 stating that the Court does not need to have an evidentiary hearing if ". . . the motions and files and records of the case conclusively show that a prisoner is entitled to no relief." 28 U.S.C. § 2255(b).

B. Ineffective Assistance of Counsel for Failing to Explain the Sentencing Guidelines and Failing to Advise Defendant to Plea

The right to effective assistance of counsel does attach to a defendant's presentencing attempts to cooperate with the government. *United States v. Leonti*, 326 F.3d 1111, 1116–17 (9th Cir. 2003). And the defendant must have the final decision regarding acceptance or denial of a plea deal. *United States v. Blaylock*, 20 F.3d 1458, 1466 (9th Cir. 1994). However, according to the second prong of the *Strickland* test, the defendant also "must show that there is a reasonable probability that 'but for counsel's unprofessional

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[5] *United States v. Burrows*, 872 F.2d 915 (9th Cir. 1989).

[6] *Id.*, at 916-17.

errors, the result would have been different.'" *Id.* (citing *Strickland*, 466 U.S. at 694).

Here, Beier asserts that his trial counsel was ineffective for failing to explain and advise to accept a beneficial plea offer sent by the Government to settle his case on October 27, 2014. Dkt. 1, at 16. Beier admits his trial counsel emailed and faxed that plea offer to him. Dkt. 1-1, at 21. In the email and fax containing the plea offer, trial counsel also sent Beier the deadline for the decision, sentencing guidelines, and an outline of the Government's evidence. Dkt. 1, at 16–17. Beier alleges that he did not review the offer upon receipt, did not know the sentencing guidelines, and did not have an idea that this would be an advantageous offer for him, however that cannot be true considering the text of the email Beier himself used as evidence. This is the sort of conclusory allegation, which is insufficient to require a hearing or to warrant relief under § 2255. *See Hearst*, 638 F.2d at 1194; *James*, 24 F.3d 20 at 26 ("Conclusory allegations which are not supported by a statement of specific facts do not warrant habeas relief.").

The October 2014 email also discusses that Beier had rejected a prior plea offer that was even more favorable, which also led the government "to do additional investigation and interview and identify additional people," ultimately adding to Beier's charges. *Id.* The Government includes a separate email communication between Beier's trial counsel and the prosecuting attorney in its response brief, which discusses plea agreement options and Beier's "outright rejection of [the Government's] many overtures to settle the case." Dkt. 7-4. This email dated January 15, 2016, came more than a year after the plea offer Beier relies on in his motion. In the January 2016 email, trial counsel also said he "plan[ned] a long sit-down with Rafael, soon, and while [he didn't] expect things to change, it [would]

be one last chance to confirm or eliminate the chance of resolving the case short of trial." *Id.* A defendant cannot, after the fact of trial, decide that he then wants to accept a previous (and expired) plea offer because he was unsuccessful at trial—that is always a risk of going to trial.

Because trial counsel sent the October 2014 plea offer to Beier, both by email and by fax, clearly outlining the options that Beier faced, trial counsel fulfilled his burden of informing Beier of the plea agreement and his options. Beier was not left in the dark by his counsel who tried to reach him concerning the matter. Trial counsel's actions demonstrate a reasonable course of actions when trying to reach Beier, and thus there is no evidence of ineffective assistance of counsel.

Additionally, even if trial counsel had not communicated the plea deal clearly with Beier, it is not likely that, but for the miscommunication, the outcome would have been different. It is not reasonably probable that Beier would have accepted the plea deal offered on October 24, 2014. The belief from both his trial counsel and the prosecutor that offering a plea deal to Beier was a futile endeavor was reasonable because he previously rejected multiple plea offers, Beier had a difficult disposition to work with, and Beier maintained the opinion that he was in no way culpable for his actions.

In conclusion, the Court DENIES Beier's ineffective assistance of counsel claims.

V. CERTIFICATE OF APPEALABILITY

When a district court enters a final order denying a petition under § 2255, it must either issue or deny a certificate of appealability ("COA"). By statute, a COA may issue "only if the applicant has made a substantial showing of the denial of a constitutional right."

28 U.S.C. § 2253(c)(2). When a court has dismissed the petition or claim on the merits, the petitioner must show that "reasonable jurists would find the district court's assessment of the constitutional claims debatable or wrong." *Slack v. McDaniel*, 529 U.S. 473, 484 (2000). For the reasons set forth above, the Court concludes that Beier has failed to make any showing, let alone a substantial showing, of the denial of a constitutional right. Accordingly, the Court will not issue a COA.

If Beier wishes to proceed to the United States Court of Appeals for the Ninth Circuit, he must file a notice of appeal in this Court within thirty days after entry of this Order, and he must seek a COA from the United States Court of Appeals for the Ninth Circuit in accordance with Federal Rule of Appellate Procedure 22(b)(2). *Id.* ("In a habeas corpus proceeding in which the detention complained of arises from process issued by a state court, or in a 28 U.S.C. § 2255 proceeding, the applicant cannot take an appeal unless a circuit justice or a circuit or district judge issues a certificate of appealability under 28 U.S.C. § 2253(c) . . . .").

VI. CONCLUSION

For all the reasons stated above, the Court finds no reason to set aside Beier's conviction or sentence. Furthermore, the Court finds it unnecessary to conduct an evidentiary hearing on the same. Thus, the motion is DENIED.

VII. ORDER

NOW THEREFORE IT IS HEREBY ORDERED:

a. Beier's Motion to Vacate, Set Aside, or Correct Sentence under 28 U.S.C. § 2255 (Dkt.1) is DENIED.

b. The Court finds there is no need for an evidentiary hearing.

c. No certificate of appealability shall issue. Beier is advised that he still may request a certificate of appealability from the Ninth Circuit Court of Appeals, pursuant to Federal Rule of Appellate Procedure 22(b) and Local Ninth Circuit Rule 22-1. To do so, he must file a timely notice of appeal.

d. If Beier files a timely notice of appeal, and not until such time, the Clerk of the Court shall forward a copy of the notice of appeal, together with this Order, to the Ninth Circuit Court of Appeals.

DATED: May 25, 2022

David C. Nye
Chief U.S. District Court Judge

NOT FOR PUBLICATION

FILED

JUL 2 2019

MOLLY C. DWYER, CLERK
U.S. COURT OF APPEALS

UNITED STATES COURT OF APPEALS

FOR THE NINTH CIRCUIT

UNITED STATES OF AMERICA, Plaintiff-Appellee, v. RAFAEL BEIER, AKA Rafael L. Beier, AKA Rafael Leonhard Wolfgang Beier, Defendant-Appellant.	No. 17-30247 D.C. No. 2:14-cr-00117-EJL-1 MEMORANDUM*

Appeal from the United States District Court
for the District of Idaho
Edward J. Lodge, District Judge, Presiding

Argued and Submitted May 14, 2019
Seattle, Washington

Before: O'SCANNLAIN and FRIEDLAND, Circuit Judges, and EZRA,** District Judge.

Appellant, a Doctor of Osteopathic Medicine ("D.O.") was convicted after a jury trial of distributing oxycodone, Adderall, and hydrocodone outside the usual course of his professional medical practice and without a legitimate medical

* This disposition is not appropriate for publication and is not precedent except as provided by Ninth Circuit Rule 36-3.

** The Honorable David A. Ezra, United States District Judge for the District of Hawaii, sitting by designation.

purpose in violation of 21 U.S.C. §§ 841(a), 846, and 859. The remaining facts of the case are known by the parties and it is unnecessary to recite them here.

Appellant appeals his conviction, arguing: (1) the district court clearly erred when it found Appellant competent; (2) the district court abused its discretion when it denied Appellant's request for a new trial; (3) the district court abused its discretion when it refused to admit a specific defense expert's report; (4) Wharton's Rule applies, and Appellant's conspiracy conviction should be vacated; (5) the district court plainly erred in failing to give an adequate specific unanimity instruction; (6) the substantive counts of Appellant's conviction should be vacated along with his conspiracy conviction; (7) the district court abused its discretion in calculating the appropriate drug quantities at sentencing; and (8) Appellant's case should be remanded and sent to a new district judge. For the reasons that follow, we **AFFIRM** Appellant's conviction and sentence.

Competency. The district court's competency determination is a factual finding that must be affirmed unless clearly erroneous. *See* Fed. R. Civ. P. 52(a); *United States v. Gastelum-Almeida*, 298 F.3d 1167, 1171 (9th Cir. 2002). In making such a determination, the district court may consider the defendant's irrational behavior, medical evaluations, and the court's own interaction with the defendant. *Davis v. Woodford*, 384 F.3d 628, 644–45 (9th Cir. 2004); *Williams v. Woodford*, 384 F.3d 567, 604 (9th Cir. 2004). Although defense counsel's

representations are "a factor which should be considered," courts need not "accept without question" those representations. *Drope v. Missouri*, 420 U.S. 162, 177 n.13 (1975). The district court made its competency determination after a two-day hearing which included expert testimony from both sides and one neutral, court-appointed expert and fact witnesses from both sides. The district court made credibility findings as to all the witnesses and credited the neutral, court-appointed expert's testimony over that of the defense experts. There is no basis in the record for a finding that any of those credibility determinations or the ultimate competency determination was clearly erroneous.

Motion for New Trial. Appellant moved for a new trial based on the evidence presented at the competency hearing under Federal Rule of Criminal Procedure 33. A district court's denial of a motion for new trial based on an allegation of newly discovered evidence is reviewed for abuse of discretion, *United States v. Hinkson*, 585 F.3d 1247, 1259 (9th Cir. 2009) (en banc), and the court considers the *Harrington* factors in arriving at its conclusion. *United States v. Harrington*, 410 F.3d 598 (9th Cir. 2005).[1] The evidence as to competency stems from a Traumatic Brain Injury in 1996 and is thus not newly discovered. Beier

[1] The *Harrington* factors are: (1) the evidence is newly discovered; (2) the defendant was diligent in seeking the evidence; (3) the evidence is material; (4) the evidence is not (a) cumulative or (b) impeaching; and (5) the defendant would probably be acquitted in a new trial based on the evidence. 410 F.3d at 601.

could have discovered it prior to sentencing by exercising reasonable diligence, and his initial counsel's failure to order a competency evaluation is not properly challenged in a motion for a new trial. Further, because the district court found Appellant competent and rejected his insanity and diminished capacity arguments, the evidence, even if new, did not indicate that Appellant would probably be acquitted in a new trial. Accordingly, the evidence fails the second and fifth *Harrington* factors, and the district court did not abuse its discretion.

Defense Expert's Report. The district court's refusal to admit an expert's report from an unrelated case concerning a different defendant was not an abuse of discretion. *See* Fed R. Evid. 401, 403, 703. It was not "manifestly erroneous," and even if it had been in error, the error was not prejudicial, and the verdict was not affected by the result. *Boyd v. City and County of San Francisco*, 576 F.3d 938, 943 (9th Cir. 2009).

Wharton's Rule. Whether a defendant may be convicted of both conspiracy and the underlying substantive offense is a question of law, which is reviewed de novo. *United States v. Castro*, 887 F.2d 988, 996 (9th Cir. 1989). Wharton's Rule states that "an agreement by two persons to commit a particular crime cannot be prosecuted as a conspiracy when the crime is of such a nature as to necessarily require the participation of two persons for its commission." 1 R. Anderson, Wharton's Criminal Law & Procedure 191 (1957); *Castro*, 887

F.2d at 996. However, where, as here, a conspiracy count "charges the existence of an agreement . . . to possess and distribute" and the substantive counts "charge actual . . . possession[] and distribution" the substantive counts can be committed by an individual, and therefore "the Rule has no bearing." *United States v. Kearney*, 560 F.2d 1358, 1367 (9th Cir. 1977). Accordingly, Wharton's Rule does not apply to Appellant's convictions for conspiracy and the substantive counts of possession and distribution. Further, as the conspiracy count stands, we need not consider Appellant's argument regarding the vacation of the substantive counts.

Specific Unanimity Instruction. Because Appellant did not object to the district court's jury instructions at trial, any alleged error in jury instructions is reviewed for plain error. *United States v. Lapier*, 796 F.3d 1090, 1096 (9th Cir. 2015). The plain error standard requires that Appellant show: (1) error; (2) that is clear or obvious, rather than subject to reasonable dispute; (3) that affected appellant's substantial rights, which in the ordinary case means it affected the outcome of the district court proceedings; and (4) that affected the fairness, integrity, or public reputation of judicial proceedings. *Id.* The district court *sua sponte* gave a specific unanimity instruction in this case, which followed the 9th Circuit Model Criminal Jury Instruction 7.9. Because that instruction required the jury to reach its verdict on the conspiracy charge "with all of you agreeing as to the particular crime which the conspirators agreed to commit," there was not clearly a

"genuine possibility of jury confusion," *Lapier*, 796 F.3d at 1096, and any error here was not plain.

Drug Quantities at Sentencing. A district court's evaluation of the reliability of the evidence at sentencing is reviewed for abuse of discretion. *United States v. Vera*, 893 F.3d 689, 692 (9th Cir. 2018).

The district court relied on both Board of Pharmacy records and witness estimates to establish drug quantities for sentencing. The witnesses here testified in court and aspects of their testimony were corroborated by other witnesses and evidence. The district court therefore acted within its discretion in determining that their statements "possess[ed] sufficient indicia of reliability to support [their] probable accuracy." *United States v. Forrester*, 616 F.3d 929, 949 (9th Cir. 2010) (quoting *United States v. Kilby*, 443 F.3d 1135, 1141 (9th Cir. 2006)). Further, the district court relied on the most conservative estimates of drug quantities derived from those witnesses' statements, appropriately "'err[ing] on the side of caution' in approximating the drug quantity." *Kilby*, 443 F.3d at 1141 (quoting *United States v. Culps*, 300 F.3d 1069, 1076 (9th Cir. 2002)). Accordingly, the district court did not abuse its discretion in calculating drug quantity for sentencing.

New District Judge on Remand. As Appellant's conviction is affirmed on all bases, no remand is necessary. Therefore, the Court need not consider

Appellant's argument that remand to a different district judge would be appropriate.

AFFIRMED.

UNITED STATES DISTRICT COURT

FOR THE DISTRICT OF IDAHO

UNITED STATES OF AMERICA, Plaintiff, vs. RAFAEL BEIER, Defendant.	Case No. 2:14-cr-00117-EJL **AMENDED ORDER**

INTRODUCTION

Before the Court in the above-entitled matter are Defendant's Motion to Determine Competency and a second Motion for a New Trial based on newly discovered evidence. (Dkt. 150, 168.) For the reasons stated herein, the Defendant's Motions are denied.

FACTUAL AND PROCEDURAL BACKGROUND

The Defendant was charged by way of an indictment with one count of Conspiracy to Dispense a Controlled Substance, sixty-six counts of Distribution of a Controlled Substance, and four counts of Distribution of a Controlled Substance to a Person Under the Age of Twenty-One. (Dkt. 73.) A seven-day jury trial was held and on May 17, 2016 the Jury returned a verdict of guilty on all of the charges presented to it. (Dkt. 112, 116.)[1] Following the verdict, the Court allowed Defendant's trial counsel to withdraw from the case. (Dkt. 127.) Newly retained defense counsel appeared and moved to stay the sentencing proceedings so the Court could consider the defense's Motions to Determine the Defendant's Competency and second Motion for a New Trial. (Dkt. 150,

[1] The Government dismissed counts 53, and 58-61 at trial. (Dkt. 108, 116, 119.)

168.)[2] In light of those Motions, the Government requested a mental competency evaluation. (Dkt. 154.) The Court granted the stay and ordered that the Defendant undergo mental competency evaluations by both his own chosen mental health professionals as well as a psychologist from the Bureau of Prisons. (Dkt. 155.) On July 26-27, 2017, the Court then held a two-day hearing on the matter. Thereafter, the parties filed post-hearing briefing. (Dkt. 192, 193.) The matter is now ripe. Having considered the entire record in this case, the parties' briefing on the Motions, and the testimony and evidence presented at the hearing, the Court finds as follows.

DISCUSSON

1. Motion to Determine Competency

The Motion to Determine the Defendant's Competency is made pursuant to 18 U.S.C. § 4241. (Dkt. 150.) The test for competency is whether the defendant has the "sufficient present ability to consult with his lawyer with a reasonable degree of rational understanding and whether he has a rational as well as factual understanding of the proceedings against him." *Dusky v. United States*, 362 U.S. 402 (1960). "Competence is defined as the ability to understand the proceedings and to assist counsel in preparing a defense." *United States v. Dreyer*, 705 F.3d 951, 961 (9th Cir. 2013) (quoting *Miles v. Stainer*, 108 F.3d 1109, 1112 (9th Cir. 1997) (citing *Dusky supra*). The Defendant must have such a rational and factual understanding throughout the proceedings; i.e. at trial as well as at sentencing. The Court's obligation to assess competency is a continuing one that persists through the sentencing phase. *United States v. Duncan*, 643 F.3d 1242, 1248 (9th Cir. 2011) (The "competency right does not end at a conviction."). "Although the level of competency

[2] The Court previously granted in part and denied in part defense counsel's first Motion for Judgment of Acquittal and/or new Trial. (Dkt. 139, 162.) The Motion was granted only with respect to Counts 62, 63, 66, and 67 which the Government conceded were lesser-included crimes and, therefore, the convictions on those counts were vacated.

mandated by due process does not vary based on the specific stage of the criminal proceeding, the defendant's ability to participate or assist his counsel must be evaluated in light of the type of participation required." *Dreyer*, 705 F.3d at 961 (citing *Godinez v. Moran*, 509 U.S. 389, 400–01 (1993)).

"The Constitution provides criminal defendants with the right to be competent during trial." *Duncan*, 643 F.3d a 1248 (citing *Indiana v. Edwards*, 554 U.S. 164, 170 (2008); *Dusky supra*, and *Drope v. Missouri*, 420 U.S. 162 (1975)). "At all times before his conviction, a defendant must have a rational as well as factual understanding of the proceedings against him and a sufficient present ability to consult with his lawyer with a reasonable degree of rational understanding." *Id.* (internal quotation marks and emphasis omitted). "If a defendant fails to satisfy either of those requirements, then the proceedings against him may go no further." *Id.* Following a conviction, the defendant must have "the capacity to appreciate his position and make a rational choice as to whether to challenge his conviction or sentence on appeal or in post-conviction proceedings." *Id.* (citing *Miller ex rel. Jones v. Stewart*, 231 F.3d 1248, 1250 (9th Cir. 2000) (quoting *Rees v. Peyton*, 384 U.S. 312, 313 (1966))). As to sentencing, the Ninth Circuit has stated:

> Sentencing is a critical stage of the criminal process, and the defendant's allocution, is an essential element of a criminal defense. Competence at sentencing therefore requires, among other things, that the defendant be able to assist in his own defense by participating in his 'elementary right' of allocution. Although a defendant is not compelled to speak on his own behalf at sentencing, courts have long recognized the importance of affording him such an opportunity. The creation of various procedural protections has not lessened the need for the defendant, personally, to have the opportunity to present to the court his plea in mitigation. The most persuasive counsel may not be able to speak for a defendant as the defendant might, with halting eloquence, speak for himself. At sentencing, the test of competency is whether the defendant is able to understand the nature of the proceedings and participate intelligently to the extent participation is called for. The ability to allocute, in short, is an essential element of this participation.

Dreyer, 705 F.3d at 961 (citations and marks omitted)

The standard applicable to this analysis is a preponderance of the evidence. *See* 18 U.S.C. § 4241 (a defendant is not competent to stand trial if the court finds by a preponderance of the evidence that the defendant is presently suffering from a mental disease or defect rendering him mentally incompetent to the extent that he is unable to understand the nature and consequences of the proceedings against him or to assist properly in his defense.). The Government bears the burden of proving the Defendant was competent to stand trial. *See United States v. Frank*, 956 F.2d 872, 875 (9th Cir. 1991).

When determining a defendant's competency the Court may consider expert testimony as well as counsel's observations and evaluations of the defendant. *See United States v. Garza*, 751 F.3d 1130, 1137 (9th Cir. 2014) (citing *Hernandez v. Ylst*, 930 F.2d 714, 718 (9th Cir. 1991) ("While counsel's observations are not necessarily determinative, a defendant's counsel is in the best position to evaluate the client's comprehension of the proceedings.")); *Stanley v. Cullen*, 633 F.3d 852, 861 (9th Cir. 2011). A court should also evaluate its own interactions with a defendant, including whether the defendant is alert, able to testify coherently, and participating in colloquies with the court. *See Williams v. Woodford*, 384 F.3d 567, 604 (9th Cir. 2004); *United States v. Lewis*, 991 F.2d 524, 528 (9th Cir. 1993). Applying these standards to this case, the Court finds the Defendant was and is competent.

A. Whether Defendant is Suffering from a Mental Disease or Defect.

The defense asserts Dr. Beier suffers from a mental disease and defect namely, a Mild Neurocognitive Disorder Due to Traumatic Brain Injury (TBI). (Dkt. 193 at 3.) In support of its position, the defense presented the reports, materials, and testimonies of three expert witnesses: Dr. Richard Adler, M.D., Dr. Andrew Newberg, M.D., and, on rebuttal, Dr. Craig Beaver, Ph.D., ABPP-CN. The defense also provided reports, conclusions, and findings from Dr. Paul Connor,

Ph.D., and Dr. Elizabeth Ziegler, Ph.D., as well as other testing results and materials. (Dkt. 189, Exs. A-Q, S-V.)

Dr. Adler is a forensic and clinical psychiatrist who performed a clinical evaluation of the Defendant as well as a review of the testing and materials related to the Defendant's competency. Dr. Adler's report concludes the Defendant has a mental disease and mental defect making him incompetent to have formed the necessary intent to commit the crimes of which he was convicted, to have stood trial, and to be sentenced. (Dkt. 164, Att. 1, Adler Report.)[3] Dr. Adler's specific diagnosis that the Defendant suffers from a Mild Neurocognitive Disorder Due to TBI is based on a "convergence of data" when, taken as a whole, he testified, support his diagnosis and conclusions. In arriving at his diagnosis and opinions, Dr. Adler reviewed several materials listed in his report including: interviews of the Defendant by Dr. Adler and others; interviews of individuals who know the Defendant including family members and prior counsel; neuropsychological, neuroradiological, and NeuroQuant testing and analysis; other personality testing; Positron Emission Tomography; and discovery from this case. (Dkt. 164, Att. 1, Adler Report at 2.) Dr. Adler basis his diagnosis on those materials, noting in particular that the Defendant was involved in a 1996 motor vehicle accident with marked head trauma as well as other episodes resulting in additional head injuries; changes in the Defendant's cognitive functioning observed by Defendant's son; impairment of cognitive functioning demonstrated in the testing; evidence of head trauma including loss of consciousness, amnesia, and neuroimaging;

[3] At the competency hearing the parties admitted the reports of their respective experts. (Dkt. 186-189.) When citing to the expert reports in this Order, however, the Court has cited to where those reports appear in the docket for this case for ease of reference in the future. Regardless, the Court makes clear that it has considered all of the materials submitted at the competency hearing as well as the entire record contained in the docket itself in ruling on the Motions at issue in this Order.

presence of persistent symptoms of neurocognitive disorder/deficits after the injury; and the deficits are not better explained by another mental disorder. (Dkt. 164, Att. 1, Adler Report at 26.)

Dr. Newberg is a neuroscientist and researcher in the field of nuclear medical brain imaging. Dr. Newberg did not opine regarding the Defendant's competency. Instead, Dr. Newberg testified regarding his qualitative and quantitative analysis of the Defendant's PET[4] scan as one factor to be considered as part of the complete picture of the Defendant's competency. Dr. Newberg explained that his analysis of the Defendant's neuroradiological testing showed both hypometabolism and hypermetabolism activity in different areas of the Defendant's PET scan which is consistent with the existence of a TBI but does not evidence a disease which impacts the brain uniformly. Thus, Dr. Newberg concluded the Defendant's neuroradiological data showed no indication of a neurodegenerative disorder but that there is evidence of other abnormalities consistent with a TBI. Dr. Newberg's testimony and findings are based on his analysis of the data, not a clinical evaluation of the Defendant.

Dr. Beaver is a licensed psychologist and Diplomate in Clinical Neuropsychology who submitted an Affidavit agreeing with Dr. Adler's diagnosis of Mild Neurocognitive Disorder Secondary to TBI as well as his opinions that Defendant was not competent to stand trial, form the intent to commit the crimes of which he was convicted, and is not competent to be sentenced. (Dkt. 182.) Dr. Beaver's Affidavit and testimony were offered to rebut the Government's position and experts.

Having carefully reviewed the reports and materials presented by the defense as well as observing first-hand the witnesses at the hearing, the Court finds Dr. Adler and Dr. Beaver were

[4] "PET" refers to a Positron Emission Tomography scan which was performed on the Defendant's brain at the University of Washington Medical Center on November 17, 2016. Dr. Newberg made a quantitative analysis of the PET other neurological data.

suspect during their testimony. The Court's view of their testimony is circumspect and careful so as to give appropriate consideration to their expertise while recognizing their bias in favor of the Defendant that was obvious during their testimony. Additionally, while it is not unusual for an expert to assist counsel when necessary and even during the testimony of an adverse witness, the assistance and interaction in this case between counsel and these experts was noticeably different and indicative of a result oriented bias. The Court considers Dr. Newberg's testimony to be accurate and credible but of limited value as his analysis and conclusion are narrow as to the existence of evidence supporting the finding of a TBI.

The defense also offered the testimony of lay witnesses who described their interactions and observations with the Defendant. *Mitchell*, 706 F.Supp.2d at 1151 ("[T]he Court may rely on, in addition to expert testimony, lay witness testimony concerning the [defendant's] rational behavior, and cross examination of [defendant's] expert."). Specifically, the defense called the Defendant's current wife, Yanha Gao, and two of the Defendant's sons, Branden and Dresden Beier, who each testified about the changes they observed in their father's behaviors following the 1996 car accident.

Yanha Gao testified concerning the decline of the Defendant's medical practice following the 1996 car accident when Defendant was not tending to his practice. Ms. Gao also testified about other head injuries the Defendant suffered in 2010 and 2012. During cross-examination, testimony was elicited indicating that Ms. Gao and the Defendant were married in 1995 while the Defendant was still married to his first wife, Brandon and Dresden's mother.

Brandon Beier testified that since the 1996 car accident, his father has been "different" stating the Defendant pulled away from the family, would become "very focused" on one thing and nothing else would matter, and his medical practice began to suffer. Brandon described how

the Defendant's behavior during his involvement in the events leading up to the crimes in this case was a marked change. On cross-examination, Brandon Beier testified that he had not seen the trial or all of the evidence related to the charges but was generally aware of the facts.

Similarly, Dresden Beier testified that subsequent to the 1996 car accident the Defendant withdrew from the family and was more removed. Dresden also testified that his father's actions during the time of the charges in this case was 180 degrees different from the dad he knew including dressing like he was in his twenties and hanging out with younger people at the strip club. On cross-examination, Dresden also testified that he had not observed the trial in this case nor seen the evidence presented and admitted he had limited contact with the Defendant over the last few years.

The Court views the testimony of these witnesses as truthful but with caution. These witnesses' relationship with the Defendant imply an understandable bias towards the Defendant. More notably, the cross-examinations revealed that these witnesses' observations were not fully informed given they had limited contact with the Defendant in recent years, they were unaware of certain facts and circumstances that may account for the Defendant's apparent change in behavior, and they had only a general knowledge of the Defendant's conduct giving rise to the charges in this case but had not observed the trial nor seen the overwhelming evidence presented against the Defendant.

The Government, on the other hand called Dr. Craig Panos, M.D., and Dr. Cynthia Low, Ph.D., to testify at the hearing in support of its position that the Defendant is not suffering from a mental disease or defect and is competent. The Government also provided the reports from those witnesses as well as reports from Dr. Tylor Reichel, M.D., Dr. Daniel Martell, Ph.D., A.B.P.P., and Dr. Louisa Lavy, M.D., as well as other materials. (Dkt. 188, Exs. 1-21.)

Dr. Panos practices in the areas of concussion and sports medicine, family medicine, and emergency medicine at medical care facilities in north Idaho. Dr. Panos testified at the hearing concerning his experience with concussions and opined that the Defendant is not incompetent as a result of any prior head injuries; noting in particular that there have been no lasting symptoms or long-term complaints consistent with the existence of a TBI. Further, Dr. Panos noted the absence of physical evidence of a TBI on the MRI or in the Defendant's other records. The Court finds this testimony to be somewhat relevant but not as complete as that of Dr. Newberg. The Court does, however, find Dr. Panos' testimony that the presence of a TBI does not necessarily mean an individual is incompetent to be quite relevant and telling particularly since other witnesses testified similarly in this regard.

Dr. Low, a psychologist at the Bureau of Prisons, was appointed by the Court to conduct an evaluation of the Defendant. Dr. Low's report does not dispute Dr. Adler's diagnosis that the Defendant has a Mild Neurocognitive Disorder, due to TBI. Instead, Dr. Low provides an alternative/additional hypothesis for the Defendant's symptoms listed by Dr. Adler – i.e., inhibition/inability to have perspective on the basis, rationale, and/or motivation of his own and others' behavior, denial of "reality," and lack of accepting responsibility. Dr. Low's report then goes on to explain how those symptoms relied upon by Dr. Adler are "better explained by [the Defendant's] long-standing personality traits and maladaptive coping mechanisms." (Dkt. 179 at 19.) Ultimately, Dr. Low's report concludes the Defendant "is not suffering from a mental disease or defect which would substantially impair his ability to understand the proceedings of his sentencing hearing, or to participate in an allocution, if he so chooses. His denial of the facts of the case and refusal to accept responsibility for his actions are volitional and are attributed to his

personality traits and his need to view himself positively, rather than to a neurocognitive disorder." (Dkt. 179 at 20.)

Having considered all of the foregoing, the Court finds the diagnosis that the Defendant suffers from a Mild Neurocognitive Disorder Due to TBI is supported by a preponderance of the evidence. The Defendant has a history of head traumas. Although the Defendant's MRI and PET appear normal or unremarkable on their own, the quantitative analysis of the neuroradiological testing data show evidence of a mild condition in the form of variable metabolic readings on the PET and reduced volume in certain areas of the brain on the MRI. The Defendant's neuropsychological testing data contain some areas of functioning and processing that could statistically appear to show impairments. (Dkt. 153, 164.) The parties dispute the validity of the opposing experts' conclusions derived from the results of the Defendant's neuropsychological testing and data with regard to the standard deviations applied and the experts' interpretations of the Defendant's scoring on certain tests; i.e. whether the Defendant's test results and/or scores put him in the "normal" range or if he was "below normal" in certain areas. The Court has reviewed the results of the data and tests in light of the parties' arguments on those discrepancies and concludes that regardless of the particulars, the Defendant's test results often placed him on the borderline with some of the results showing him at or above normal and a few of the results being slightly below normal. That he lies on the cusp of many of the testing results is consistent with and reflected by the diagnosis of the Defendant's neurocognitive disorder as being "mild." That is to say, any mental defect the Defendant has is extremely slight and, as discussed in the following section, does not impair his ability to have a rational and factual understanding of the proceedings and assist his counsel with a reasonable degree of rational understanding.

Further evidence of the Defendant's mild mental condition was provided by the testimony of witnesses who knew or had observed the Defendant. Each of those witnesses noted similar personality traits including the Defendant's: reluctance to recognize minor faults in himself, tendency to repress undesirable characteristics, faulty perspective of himself and others, denial of reality, and refusal of responsibility. Those observations are generally consistent with the neuropsychological testing. While Dr. Low ultimately concluded differently with regard to the diagnosis of the existence of a mental disease or defect, finding instead that the Defendant's conduct was explained by his particular personality traits, Dr. Low did not specifically disagree with Dr. Adler's diagnosis. Further, the conclusions of Dr. Panos that the Defendant has not suffered from any TBI are less complete with regard to the existence of a mental defect than those of the defense experts. When viewing the totality of the evidence presented, the Court concludes the Defendant is suffering from a mild mental defect.

That being said, "[t]hat a defendant suffers from some degree of mental illness or disorder does not necessarily mean that he is incompetent to assist in his own defense." *United States v. Mitchell*, 706 F.Supp.2d 1148, 1221 (D. Utah 2010) (quoting *United States v. DeShazer*, 554 F.3d 1281, 1286 (10th Cir. 2009) and citing *United States v. Vamos*, 797 F.2d 1146, 1150 (2d Cir. 1986) ("It is well-established that some degree of mental illness cannot be equated with incompetence to stand trial.")). "A defendant lacks the requisite rational understanding if his mental condition precludes him from perceiving accurately, interpreting, and/or responding appropriately to the world around him." *Mitchell*, 706 F.Supp.2d at 1151 (citation omitted). Many of "the circuits addressing competency after *Dusky* have used a sufficient contact with reality as the touchstone for ascertaining the existence of a rational understanding." *Id.* The Court therefore considers below whether the Defendant's mental impairment renders him incompetent to proceed.

B. Does the Defendant's Mental Disease or Defect Prevent Him from Having a Rational and Factual Understanding of the Proceedings and/or Prevent him from Consulting with and Assisting his Counsel with a Reasonable Degree of Rational Understanding.

The defense argues Dr. Beier was not competent at trial and is not competent to proceed to sentencing because he was and is unable to assist his counsel or exercise his right of allocution at the sentencing hearing. (Dkt. 178, 182, 193.) The Government maintains the Defendant is competent to proceed to sentencing and was competent at the trial. (Dkt. 181, 192.)

This inquiry requires the Court to determine whether the Defendant's mental disease or defect impaired or is impairing his ability to "have a rational as well as factual understanding of the proceedings against him and a sufficient present ability to consult with his lawyer with a reasonable degree of rational understanding." *Duncan*, 643 F.3d a 1248; *see also United States v. Dreyer*, 705 F.3d at 961 ("At sentencing, the test of competency is whether the defendant is able to understand the nature of the proceedings and participate intelligently to the extent participation is called for.") (citations and marks omitted).

Having carefully considered the evidence, testimony, arguments, and the entire record in this case, the Court finds the Defendant's mental disease or defect does not prevent him from having a rational and factual understanding of the proceedings. Just the opposite, it is obvious from the record that the Defendant had and has a clear understanding of his legal position and the options available to him. During his interview with Dr. Adler, the Defendant discussed his understanding of the charges, proceedings, roles of the courtroom participants, and understanding of court procedures which, although sometimes eccentric, show the Defendant has and had a rational and factual understanding of the proceedings. (Dkt. 164, Att. 1, Adler Report at 9-14.)

This Court presided over the trial in this matter and has had numerous opportunities to engage with and observe the Defendant first hand. The Court's own observations of the Defendant

are that he fully understands the proceedings, his legal position and the options available to him such that he had and has the requisite rational and factual understanding of the proceedings. While the jury ultimately did not believe the Defendant's testimony at trial, the Court's view of his testimony was that it was coherent, rational, and clear. The evidence at trial established that the Defendant engaged in a lengthy period of criminal conduct during which he was calculated in what he was doing and took steps to avoid being caught by law enforcement. Moreover, the direct video and audio evidence of the Defendant's conduct presented at trial indisputably show the Defendant was well aware of his conduct, knew that his actions were illegal, was actively hiding from and/or attempting to avoid getting caught, and certainly understood the ramifications of his actions if he were apprehended. This is further evidenced by the fact that the Defendant failed to appear for the return of the verdict.

In addition to the evidence from the trial, other testimony and evidence in the record shows the Defendant was and is competent. The Defendant sustained a medical practice before and after the 1996 car accident. While there was testimony that the medical practice was experiencing troubles in more recent years, those troubles are undoubtedly due at least in part to the Defendant's criminal conduct. Further, Dr. Panos testified that he regularly worked with the Defendant between the years 2007 to 2012 in his capacity as an Emergency Physician and observed no issues with the Defendant's competency to practice medicine. Just the opposite, Dr. Panos testified that the Defendant had a good clinical knowledge base, critical thinking skills, and judgment, was reliable and accessible, knew his patient's history, and appropriate in his demeanor. The Court finds that testimony is compelling given it relates directly to first-hand observations of the Defendant's mental acuity at or near the time of the Defendant's criminal conduct by an unbiased individual.

The changes in the Defendant's behavior as testified to by his family do not show the Defendant's lack of rational understanding or incompetence. The Court views the testimony of the Defendant's family as truthful but lacking in a complete understanding of the Defendant's actions. Those witnesses were without the full knowledge of the Defendant's activities; both his personal and criminal conduct. The fact that the Defendant appeared to withdraw from his sons, for instance, is more readily explained by the fact that he had married Yenua Gao while still married to his first wife, the mother of Branden and Dresden Beier, than by any mental disease or defect; particularly since his second marriage occurred prior to the 1996 car crash. Likewise, his later affair with one of the women he was writing false prescriptions for is consistent with his prior behavior. The Court finds the record shows that the Defendant's choices in his personal and professional life were consistent both before and after the 1996 car accident and involved circumstances of which his family was unaware of and, understandably, could not explain.

The Court finds Dr. Low's testimony and "alternative" hypothesis is particularly credible and most accurately explains the Defendant and why he has a rational and factual understanding of the proceedings and is able to assist his counsel. Dr. Low concludes that the Defendant's actions were the result of his personality traits – i.e., the Defendant's "denial of the facts of the case and refusal to accept responsibility for his actions are volitional and are attributed to his personality traits and his need to view himself positively, rather than a neurocognitive disorder." (Dkt. 179, Att. A, Low Report at 19-20.) In reaching her conclusion, Dr. Low reviewed and considered all of the same materials as the defense experts but, importantly, she spent more time observing and interviewing Dr. Beier than any other expert. *United States v. Birdsell*, 775 F.2d 645, 651 (5th Cir. 1985) (The district court was reasonable in relying on the observations of witnesses who had long-

term daily contact with petitioner rather than conclusions based on a relatively brief period of examination.).

Moreover, the Court finds Dr. Low's testimony to be extremely credible. Dr. Low is an experienced and unbiased witness who regularly performs competency evaluations for the Bureau of Prisons and is impartial as to the outcome of this case. In contrast, the testimony of Dr. Adler and Dr. Beaver were obviously biased and result oriented whereas Dr. Low's testimony was impartial, cooperative, complete, and, above all, the most credible witness with regard to the Defendant's competency; specifically as to her explanation and reasoning of the Defendant's rational and factual understanding of the proceedings and his ability to consult with his lawyer with a reasonable degree of rational understanding. In her testimony, Dr. Low explained the Defendant's test results and the reasoning and basis for her conclusions differing from those of the defense experts. The Court finds that explanation and reasoning to be correct and adopts the same as well as Dr. Low's conclusion that the Defendant is competent. While the defense has been highly critical of Dr. Low's conclusions, the Court finds those arguments lack merit and are not supported by the record.[5]

For these reasons, the Court finds the Defendant's mental disease or defect did not and does not prevent him from understanding his legal position and the options available to him. The Court further finds the Defendant's mild disease or defect did not and is not preventing him from making a rational choice among the options available to him. The Defendant rationally understood and was/is fully aware of his legal options. Although the Defendant was a difficult client who made decisions against the advice of counsel, the Defendant is and was fully capable of making

[5] The Court also finds the testimonies of Dr. Adler and Dr. Beaver critiquing and questioning Dr. Low's testimony and report were unpersuasive, bias, inconsistent, and soundly rebutted on cross-examination.

rational choices. His decision to proceed to trial based on his belief that he was innocent and/or that he could prevail at trial is not uncommon, irrational, or caused by any mental disease or defect. Again the Court finds Dr. Low's analysis and conclusion that the Defendant's personality traits led him to his decisions is correct and supported by the evidence in the record and consistent with this Court's own first-hand observations of the Defendant. There is no doubt in this Court's mind that the Defendant completely understood the proceedings, his options, and that his decisions were rational and not impaired by any mental disease or defect.

Finally, the Court concludes the Defendant's mental disease or defect did not and is not preventing him from consulting with and assisting his attorney with a reasonable degree of rational understanding. During the trial, the Defendant was actively involved in discussions with his counsel, took notes, conferred with counsel both when Court was in-session and on breaks, and was fully engaged in the proceeding. During his testimony at trial, the Defendant was clear and articulate in his responses to questions. The Court has considered the statements by trial counsel regarding his observations and interactions with the Defendant; in particular, that it may have been a "big mistake" for him to not have examined whether the Defendant was competent. (Dkt. 164, Att. 1, Adler Report at 4.) The Court finds trial counsel's observations are consistent with Dr. Low's conclusion that the Defendant's conduct, choices, and reasoning are volitional and the result of his particular personality traits, not a mental disease or defect. In fact, trial counsel concluded similarly that the Defendant's denial of obvious facts in the case were due to his being a "stubborn and proud man" and noted that the Defendant was concerned with proving his good character. (Dkt. 164, Att. 1, Adler Report at 3, 5.) While undoubtedly a difficult client, the Court finds the Defendant was not and is not precluded from rationally and reasonably consulting with and assisting his attorney.

D. Conclusion

The Court finds the Defendant is suffering from a mild mental disease or defect but that mental disease or defect did not and is not impairing his ability to assist his counsel with a reasonable degree of rational understanding. The Court further finds the Defendant has a rational as well as factual understanding of all of the proceedings in this case including pre-trial, trial, and the upcoming sentencing hearing. In sum, the Court finds the Defendant was competent to commit the offenses of which he has been convicted, was competent to proceed to trial, and is competent to be sentenced.

2. Motion for a New Trial

The Defendant's second Motion for a New Trial is made pursuant to Federal Rule of Criminal Procedure 33(b)(1) which allows for such a motion based on new evidence to be made within three years after the verdict. (Dkt. 169.) The Defendant argues Dr. Adler's opinion that the Defendant's mental disease and defect affected his ability to form the intent to commit the crimes charged against him is new evidence not known at the time of trial which warrants granting a new trial. The Government opposes the Motion arguing the circumstances and evidence establish the Defendant's guilt, his competence to proceed to trial, and his mental capacity to have formed the necessary intent to commit the crimes. (Dkt. 179.)

Federal Rule of Criminal Procedure 33 allows a court to grant a new trial "if the interests of justice so require." Fed. R. Crim. P. 33(a). "A district court's power to grant a motion for a new trial is much broader than its power to grant a motion for judgment of acquittal." *United States v. Alston*, 974 F.2d 1206, 1211 (9th Cir. 1992). "A motion for a new trial is directed to the discretion of the district judge. It should be granted only in exceptional cases in which the evidence preponderates heavily against the verdict." *United States v. Pimentel*, 654 F.2d 538, 545 (9th Cir.

1981) (internal citations removed). The defendant has the burden to justify the need for a new trial. *United States v. Shaffer*, 789 F.2d 682, 687 (9th Cir. 1986).

As determined above, the Court finds the Defendant's mild mental disease and defect did not and do not render him incompetent to proceed to trial, to proceed to sentencing, or to form the necessary intent to commit the offenses of which he was convicted. Therefore, the Court finds the interests of justice do not warrant granting a new trial in this case. The Motion is denied.

3. Sentencing Hearing

The trial in this matter concluded on May 17, 2016 and the sentencing hearing was set for August 23, 2016. (Dkt. 112, 125.) The Court granted the defense extensions of time to file post-trial motions, retain new counsel, complete the competency evaluations, and hold the competency hearing. The Court has now ruled on all of those matters and the case is ready to proceed to sentencing. Given the length of time this matter has been pending since it was filed and since the time the verdict was returned, the Court finds it necessary for the sentencing to proceed without undue delay. The Initial Presentence Report was filed on July 18, 2016. (Dkt. 142.) Thus, all that remains is for the parties to submit any objections to the Initial Presentence Report, the filing of the final presentence report, and for the parties to provide any sentencing materials and/or motions to the Court for its consideration. The Court will set deadlines for those filings as stated below. The date for sentencing is set for November 29, 2017 at 9:00 a.m. in Coeur d'Alene, Idaho.

ORDER[6]

NOW THEREFORE IT IS HEREBY ORDERED that the Defendant is DEEMED TO BE COMPETENT in all respects as stated herein and, therefore, the Motion for New Trial (Dkt. 168) is **DENIED**. The Motion to Set Oral Argument (Dkt. 170) is **DEEMED MOOT**.

IT IS FURTHER ORDERED that the Sentencing Hearing in this matter is set for **November 29, 2017 at 9:00 a.m. in Coeur d'Alene, Idaho** as follows:

1) Objections to the Initial Presentence Report (Dkt. 142) shall be filed on or before **November 6, 2017**.

2) The Final Presentence Investigation Report shall be filed no later than **November 20, 2017**.

3) Any and all sentencing materials, letters in support, motions, and the like shall all be filed no later than **November 21, 2017**.

4) The Sentencing Hearing is set for one hour. The parties shall advise the Court no later than seven days in advance if additional time is necessary.

DATED: October 30, 2017

Honorable Edward J. Lodge
United States District Court

[6] This Order is amended only to correct typographical errors in the dates set for the sentencing deadlines.

AO 243 (Rev. 09/17)

MOTION UNDER 28 U.S.C. § 2255 TO VACATE, SET ASIDE, OR CORRECT SENTENCE BY A PERSON IN FEDERAL CUSTODY

United States District Court	District Idaho	
Name *(under which you were convicted)*: Rafael L. Beier		Docket or Case No.: 1:14-CR-00117-BLW
Place of Confinement: Lompoc FCI, Lompos, California	Prisoner No.: 16223-023	
UNITED STATES OF AMERICA V. Rafael L. Beier	Movant *(include name under which convicted)*	

MOTION

1. (a) Name and location of court which entered the judgment of conviction you are challenging:

   United States District Court for the District of Idaho

   (b) Criminal docket or case number (if you know): 2:14-cr-00117-BLW

2. (a) Date of the judgment of conviction (if you know): 11/29/2017

   (b) Date of sentencing: 11/29/2020

3. Length of sentence: 192 Months

4. Nature of crime (all counts):

   Count One - Conspiracy to Distribute a Controlled Substance, Oxycodone and Hydrocodone, in violation of 21 U.S.C. 846: Counts Two through Fifty-Two; Counts Fifty-Four through Fifty-Seven; and Count Sixty-Two through 67 - Distribution of Controlled Substance, Adderall, Hydrocodone and Oxycodone, in violation of 21 U.S.C. 841: Counts Sixty-Eight through Seventy-One - Distribution of Oxycodone to Minor, in violation of 21 U.S.C. 841 & 859.

5. (a) What was your plea? (Check one)

   (1) Not guilty ☑ (2) Guilty ☐ (3) Nolo contendere (no contest) ☐

6. (b) If you entered a guilty plea to one count or indictment, and a not guilty plea to another count or indictment, what did you plead guilty to and what did you plead not guilty to?

6. If you went to trial, what kind of trial did you have? (Check one) Jury ☑ Judge only ☐

7. Did you testify at a pretrial hearing, trial, or post-trial hearing? Yes ☑ No ☐

8. Did you appeal from the judgment of conviction? Yes ☑ No ☐

9. If you did appeal, answer the following:

(a) Name of court: United States Court of Appeals for the Ninth Circuit

(b) Docket or case number (if you know): 17-30247

(c) Result: Affirmed

(d) Date of result (if you know): 7/2/2019

(e) Citation to the case (if you know): 780 Fed. Appx' 460 (9th Cir. 2019)

(f) Grounds raised:

1. Whether the district court erred in finding the Defendant competent.
2. Whether the district court erred in denying a new trial based on newly discovered evidence.
3. Whether Wharton's Rule required reversal of the conspiracy in Count One.
4. Whether the Defendant was entitled to a specific unanimity instruction.
5. Whether the district court erred in determining the drug quantity for sentencing.

(g) Did you file a petition for certiorari in the United States Supreme Court? Yes ☑ No ☐

If "Yes," answer the following:

(1) Docket or case number (if you know): 19-7180

(2) Result: Petition for writ of certiorari denied

(3) Date of result (if you know): 2/24/2020

(4) Citation to the case (if you know): —U.S.—, 140 S. Ct. 1219 (2020)

(5) Grounds raised:

1. Does a criminal defendant's discovery of a recognized mental impairment after conviction at trial constitute newly discovered evidence under Federal Rule of Criminal Procedure 33(b)(1) even though the defendant is aware of the facts underlying the cause of the mental impairment before trial?
2. What should lower federal courts consider when determining whether newly discovered evidence "would probably result in an acquittal" on a motion for new trial under Federal Rule of Criminal Procedure 33(b)(1)?

10. Other than the direct appeals listed above, have you previously filed any other motions, petitions, or applications, concerning this judgment of conviction in any court?

Yes ☐ No ☑

11. If your answer to Question 10 was "Yes," give the following information:

(a) (1) Name of court:

(2) Docket or case number (if you know):

(3) Date of filing (if you know):

(4) Nature of the proceeding:

(5) Grounds raised:

(6) Did you receive a hearing where evidence was given on your motion, petition, or application?

Yes ☐ No ☐

(7) Result:

(8) Date of result (if you know):

(b) If you filed any second motion, petition, or application, give the same information:

(1) Name of court:

(2) Docket of case number (if you know):

(3) Date of filing (if you know):

(4) Nature of the proceeding:

(5) Grounds raised:

(6) Did you receive a hearing where evidence was given on your motion, petition, or application?

Yes ☐ No ☐

(7) Result:

(8) Date of result (if you know):

(c) Did you appeal to a federal appellate court having jurisdiction over the action taken on your motion, petition, or application?

(1) First petition: Yes ☐ No ☐

(2) Second petition: Yes ☐ No ☐

(d) If you did not appeal from the action on any motion, petition, or application, explain briefly why you did not:

12. For this motion, state every ground on which you claim that you are being held in violation of the Constitution, laws, or treaties of the United States. Attach additional pages if you have more than four grounds. State the facts supporting each ground. Any legal arguments must be submitted in a separate memorandum.

GROUND ONE: Ineffective assistance of defense counsel for failing to investigate mental defenses before trial, in violation of the Sixth Amendment right to counsel.

(a) Supporting facts (Do not argue or cite law. Just state the specific facts that support your claim.):

After Movant's conviction, and before the sentencing hearing, the district court authorized a complete forensic psychiatric evaluation. This evaluation resulted in an expert, Richard Adler, MD's, diagnosis from the Diagnostic and Statistical Manuel of Mental Disorders, Fifth Edition (DSM-5) that Defendant suffered from mild-Neurocognitive Disorder (mild-NCD) due to Traumatic Brain Injury (TBI). Dr. Adler concluded that Movant had both a mental disease and a mental defect that impaired Movants's ability to form the intent to commit each of the charged offenses, and this mental disease and defect was of such a sever degree that the Movant was unable to appreciate the nature and quality or the wrongfulness of his acts, thereby, supporting both a diminished capacity defense and an insanity defense for trial. Trial counsel possessed and observed sufficient facts that put counsel on notice before trial that Movant's mental condition was impaired. Trial counsel failed to investigate or obtain expert assistance to determine if Movant suffered from a mental disease and/or defect that provided Movant with legally valid mental defenses prior to Movant's jury trial. This failure fell below the standards of professional conduct. Trial counsel's "errors [were] so serious that counsel was not functioning as the 'counsel' guaranteed the [Movant] by the Sixth Amendment." Counsel's failure to investigate prejudiced the Movant and trial counsel's errors "were so serious as to deprive the defendant of a fair trial, a trial whose result is reliable." Movant's "conviction[s] and []sentence resulted from a breakdown in the adversary process that rendered the result unreliable." See Attached Ground One - (a) (continued) & incorporate all facts in the Memorandum in Support.

(b) **Direct Appeal of Ground One:**

(1) If you appealed from the judgment of conviction, did you raise this issue?

Yes ☐ No ☑

(2) If you did not raise this issue in your direct appeal, explain why:

Allegations of ineffective assistance of counsel are normally reserved for post-conviction motions for relief.

(c) **Post-Conviction Proceedings:**

(1) Did you raise this issue in any post-conviction motion, petition, or application?

Yes ☐ No ☑

(2) If you answer to Question (c)(1) is "Yes," state:

Type of motion or petition:

Name and location of the court where the motion or petition was filed:

Docket or case number (if you know):

Date of the court's decision:

Result (attach a copy of the court's opinion or order, if available):

(3) Did you receive a hearing on your motion, petition, or application?

Yes ☐ No ☐

(4) Did you appeal from the denial of your motion, petition, or application?

Yes ☐ No ☐

(5) If your answer to Question (c)(4) is "Yes," did you raise the issue in the appeal?

Yes ☐ No ☐

(6) If your answer to Question (c)(4) is "Yes," state:

Name and location of the court where the appeal was filed:

Docket or case number (if you know):

Date of the court's decision:

Result (attach a copy of the court's opinion or order, if available):

(7) If your answer to Question (c)(4) or Question (c)(5) is "No," explain why you did not appeal or raise this issue:

GROUND TWO: Ineffective assistance of counsel for failing to adequately explain how the United States Sentencing Guidelines applied in relation to the government's offer to settle with a 46 to 57 month guideline range, and for failure to adequately advise Movant that is was in his best interest to settle his case.

(a) Supporting facts (Do not argue or cite law. Just state the specific facts that support your claim.):

On June 17, 2014, the government charged Movant with one count of Unlawful Distribution of a Controlled Substance, as a physician registrant, outside the scope of professional practice and for no a legitimate medical reason. (Doc. 1). Trial counsel entered his appearance in this case on June, 23, 2014. (Doc. 8). On September 16, 2014, the government obtained a 61 count superseding indictment that included 1 count of conspiracy to distribute a controlled substance, 56 counts of distribution of a controlled substance, and 4 counts of distributing a controlled substance to a minor. All counts alleged Movant was a registrant acting outside the scope of his professional practice and without a legitimate medical purpose. (Doc. 21). Movant eventially proceeded to trial on a fourth superseding indictment wherein a jury returned a verdict finding him guilty of conspiracy to distribute controlled substance, 62 counts of unlawful distribution and 4 counts of unlawful distribution to a minor, all as a physician registrant as previously alleged. (Docs. 73 & 116). The district court calculated the quantity of controlled substance resulting in a base offense level of 32. The base offense level was increased 2 levels for obstruction of justice, and increased by an additional 2 levels for organizer/leader. This resulted in a 188 to 235 month sentencing range. The district court imposed a192 month (16 years) term of imprisonment. (Doc. 206). See Attached Ground Two - (a) (continued) & incorporate all facts in the Memorandum in Support.

(b) **Direct Appeal of Ground Two:**

(1) If you appealed from the judgment of conviction, did you raise this issue?

Yes ☐ No ☑

(2) If you did not raise this issue in your direct appeal, explain why:

Claims of ineffective assistance of counsel are generally raised in post-conviction proceedings.

(c) **Post-Conviction Proceedings:**

(1) Did you raise this issue in any post-conviction motion, petition, or application?

Yes ☐ No ☑

(2) If you answer to Question (c)(1) is "Yes," state:

Type of motion or petition:

Name and location of the court where the motion or petition was filed:

Docket or case number (if you know):

Date of the court's decision:

Result (attach a copy of the court's opinion or order, if available):

(3) Did you receive a hearing on your motion, petition, or application?

Yes ☐ No ☐

(4) Did you appeal from the denial of your motion, petition, or application?

Yes ☐ No ☐

(5) If your answer to Question (c)(4) is "Yes," did you raise the issue in the appeal?

Yes ☐ No ☐

(6) If your answer to Question (c)(4) is "Yes," state:

Name and location of the court where the appeal was filed:

Docket or case number (if you know):

Date of the court's decision:

Result (attach a copy of the court's opinion or order, if available):

(7) If your answer to Question (c)(4) or Question (c)(5) is "No," explain why you did not appeal or raise this issue:

GROUND THREE:

(a) Supporting facts (Do not argue or cite law. Just state the specific facts that support your claim.):

(b) **Direct Appeal of Ground Three:**

(1) If you appealed from the judgment of conviction, did you raise this issue?

Yes ☐ No ☐

(2) If you did not raise this issue in your direct appeal, explain why:

(c) **Post-Conviction Proceedings:**

(1) Did you raise this issue in any post-conviction motion, petition, or application?

Yes ☐ No ☐

(2) If you answer to Question (c)(1) is "Yes," state:

Type of motion or petition:

Name and location of the court where the motion or petition was filed:

Docket or case number (if you know):

Date of the court's decision:

Result (attach a copy of the court's opinion or order, if available):

(3) Did you receive a hearing on your motion, petition, or application?

Yes ☐ No ☐

(4) Did you appeal from the denial of your motion, petition, or application?

Yes ☐ No ☐

(5) If your answer to Question (c)(4) is "Yes," did you raise the issue in the appeal?

Yes ☐ No ☐

(6) If your answer to Question (c)(4) is "Yes," state:

Name and location of the court where the appeal was filed:

Docket or case number (if you know):

Date of the court's decision:

Result (attach a copy of the court's opinion or order, if available):

(7) If your answer to Question (c)(4) or Question (c)(5) is "No," explain why you did not appeal or raise this issue:

GROUND FOUR:

(a) Supporting facts (Do not argue or cite law. Just state the specific facts that support your claim.):

(b) **Direct Appeal of Ground Four:**

(1) If you appealed from the judgment of conviction, did you raise this issue?

Yes ☐ No ☐

(2) If you did not raise this issue in your direct appeal, explain why:

(c) **Post-Conviction Proceedings:**

(1) Did you raise this issue in any post-conviction motion, petition, or application?

Yes ☐ No ☐

(2) If you answer to Question (c)(1) is "Yes," state:

Type of motion or petition:

Name and location of the court where the motion or petition was filed:

Docket or case number (if you know):

Date of the court's decision:

Result (attach a copy of the court's opinion or order, if available):

(3) Did you receive a hearing on your motion, petition, or application?

Yes ☐ No ☐

(4) Did you appeal from the denial of your motion, petition, or application?

Yes ☐ No ☐

(5) If your answer to Question (c)(4) is "Yes," did you raise the issue in the appeal?

Yes ☐ No ☐

(6) If your answer to Question (c)(4) is "Yes," state:

Name and location of the court where the appeal was filed:

Docket or case number (if you know):

Date of the court's decision:

Result (attach a copy of the court's opinion or order, if available):

(7) If your answer to Question (c)(4) or Question (c)(5) is "No," explain why you did not appeal or raise this issue:

13. Is there any ground in this motion that you have not previously presented in some federal court? If so, which ground or grounds have not been presented, and state your reasons for not presenting them:

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14. Do you have any motion, petition, or appeal now pending (filed and not decided yet) in any court for the you are challenging? Yes ☑ No ☐

If "Yes," state the name and location of the court, the docket or case number, the type of proceeding, and the issues raised.

Motion to reduce sentence (compassionate relief) in this district court in relation to the criminal sentence, No. 2:14-CR-00117-BLW. (Doc 227)

15. Give the name and address, if known, of each attorney who represented you in the following stages of the judgment you are challenging:

(a) At the preliminary hearing:

(b) At the arraignment and plea:
Jim Seibe, Retained

(c) At the trial:
Jim Seibe, Retained

(d) At sentencing:
Stephen R. Hormel, Retained

(e) On appeal:
Stephen R. Hormel, Retained

(f) In any post-conviction proceeding:
Stephen R. Hormel, Retained, Jay McEntire, Appointed Federal Defenders of E.WA and Idaho

(g) On appeal from any ruling against you in a post-conviction proceeding:

16. Were you sentenced on more than one court of an indictment, or on more than one indictment, in the same court and at the same time? Yes ☑ No ☐

17. Do you have any future sentence to serve after you complete the sentence for the judgment that you are challenging? Yes ☐ No ☑

(a) If so, give name and location of court that imposed the other sentence you will serve in the future:

(b) Give the date the other sentence was imposed:

(c) Give the length of the other sentence:

(d) Have you filed, or do you plan to file, any motion, petition, or application that challenges the judgment or sentence to be served in the future? Yes ☐ No ☐

18. TIMELINESS OF MOTION: If your judgment of conviction became final over one year ago, you must explain why the one-year statute of limitations as contained in 28 U.S.C. § 2255 does not bar your motion.*

* The Antiterrorism and Effective Death Penalty Act of 1996 ("AEDPA") as contained in 28 U.S.C. § 2255, paragraph 6, provides in part that:

A one-year period of limitation shall apply to a motion under this section. The limitation period shall run from the latest of –

(1) the date on which the judgment of conviction became final;

(2) the date on which the impediment to making a motion created by governmental action in violation of the Constitution or laws of the United States is removed, if the movant was prevented from making such a motion by such governmental action;

(3) the date on which the right asserted was initially recognized by the Supreme Court, if that right has been newly recognized by the Supreme Court and made retroactively applicable to cases on collateral review; or

(4) the date on which the facts supporting the claim or claims presented could have been discovered through the exercise of due diligence.

Therefore, movant asks that the Court grant the following relief:

Vacate the judgment in a criminal case, grant a new trial, and/or order that offer of 46 to 57 months in prison be reinstated.

or any other relief to which movant may be entitled.

Dated this 6th day of February, 2021.

s/Stephen R. Hormel, Pro Hac Vice
Signature of Attorney (if any)

s/David Partovi
Pro Hac Vice, Designee

I declare (or certify, verify, or state) under penalty of perjury that the foregoing is true and correct and that this Motion under 28 U.S.C. § 2255 was placed in the prison mailing system on

(month, date, year)

Executed (signed) on (date)

Signature of Movant

If the person signing is not movant, state relationship to movant and explain why movant is not signing this motion.

Ground One - (a) (continued):

Furthermore, it is alleged that there is a reasonable probability that, but for counsel's deficiencies, the results of the proceedings would have been different, thus, undermining confidence in the outcome of the previous proceedings and Movant's jury trial.

In a post-trial interview with trial counsel conducted and reported by Dr. Adler, trial counsel noticed before trial that Movant "might be 'manic." Trial counsel also opined that Movant "might be taking illicit drugs." Trial counsel observed that Movant "went on verbal 'tangents'" [and] "had a habit of 'going on' about persecution of Native Americans because of their religious beliefs." Trial counsel "*felt that there had never been a 'genuine, thorough discussion' of the case with* [Movant]. (Emphasis in Expert report).

Trial counsel observed that Movant persistently 'den[ied] the obvious'" and Movant did not "accept[] logical deductions.'" Movant's "case related explanations" to trial counsel "seemed hard to believe." Trial counsel noticed "considerable dissonance between the [case] material and [Movant's] account."

Trial counsel "indicated that [Movant] blankedly: 'denied everything.'" Movant "turned down a plea agreement from the Prosecutor that would have been an outcome much more favorable than the sentencing range he faces presently." Movant basically told trial that: "I can't plead guilty if I'm not guilty." Trial counsel observed that Movant "seemed to have a 'martyr complex,' alternately calling it a 'crucifixion complex.'"

Trial counsel said that "[Movant] reminded [counsel] of another client who comported himself as if he was 'watching himself on TV' and it seemed that [Movant] had an 'inability to perceive his own behavior.'" Trial counsel observed that Movant was mentally "separated from what he was really doing.'" Trial counsel "endorsed that the prior client had Dissociative Disorder and [counsel] wondered whether [Movant] might be similarly afflicted."

Trial counsel told Dr. Adler that "[he] may have made a big mistake" by not seeking a competency evaluation. Trial counsel stated that Movant's "'status [as a physician] dissuaded [counsel] from [taking] that approach.'"

Trial counsel's observations, as detailed in his interview with Dr. Adler, put counsel on notice that Movant's mental condition may be significantly impaired. Trial counsel's failure to investigate and/or to obtain expert assistance to determine Movant's mental condition at the time Movant is alleged to have committed the offenses, fell below the standards of professional conduct. In light of Dr. Adler's finding from the DSM-5 that Movant suffered for a mental disease and defect that supported the mental defenses for trial as heretofore described, and establishes that Movant's right to a fair and reliable trial was prejudiced by counsel's errors in failing to investigate the existence of mental defenses, and these errors deprived Movant of the right to counsel as guaranteed by the Sixth Amendment.

Ground Two - (a) (continued):

On October 27, 2014, the government offered to settle Movant's case with a 46 to 57 month sentencing guideline range in an email sent to defense counsel. Attached Email. On October 29, 2014, counsel's office legal assistant forwarded the offer email to gmail address, "rafaelwolfgangbeier@gmail.com." Counsel's legal assistant wrote: "Dear Dr. Beier: Below please find an email that we received from the prosecutor in your matter. Please advise us of your decision no later than November 5, 2014 so that we can draft an appropriate response." Movant alleges that he never opened this email or reviewed this email.

On November 6, 2014 at 12:07, the same email was sent by facsimile from Seibe Law Offices to another number with an Idaho area code. Movant alleges that this number was the facsimile number for Silver Valley Medical Center, his family medical center in Pinehurst, Idaho. The email informed counsel that the offer would be withdrawn and closed after November 6, 2014. Attached at 2

Movant does not recall if he personally reviewed the facsimile copy of the offer email. However, Movant specifically alleges that counsel never met with him to discuss the contents of the email, nor did counsel consult with him about the details in the email offer. Movant alleges that counsel never explained to him how the sentencing guideline range calculations applied in his case, and never explained the how the calculations would significantly increase the prison term if Movant lost at a trial.

Richard S. Adler, MD, spoke to trial counsel during the course of conducting a complete psychiatric forensic evaluation. Trial counsel indicated that he "felt that there had never been a 'genuine, thorough discussion' of the case with [Movant]. *See*, Declaration of Richard S. Adler, MD, Re: Motion to Vacate, Set Aside or Correct Sentence Pursuant to 28 U.S.C. § 2255, Appendix 3 at 4.

Movant alleges that had he understood how the sentencing guidelines operated before his trial, and had he understood that if he lost at trial he was facing 15 or more years in prison, Movant would not have elected to go to trial. Movant alleges that he had an understanding of the federal sentencing laws, he would have accepted the 46 to 57 month guideline range offer in the October 27, 2014 email.

Beier

Siebe Law <siebelaw@gmail.com> Wed, Oct 29, 2014 at 12:28 PM
To: Rafael Beier <rafaelwolfgangbeier@gmail.com>

Dear Dr. Beier:

Below please find an email that we received from the prosecutor in your matter. Please advise us of your decision no later than November 5, 2014 so that we can draft an appropriate response.

Thank you,

Carol Morales
Legal Assistant

---------- Forwarded message ----------
From: **Whelan, Traci (USAID)** <Traci.Whelan@usdoj.gov>
Date: Mon, Oct 27, 2014 at 2:49 PM
Subject: Beier
To: "jsiebe@moscow.com" <jsiebe@moscow.com>, "Siebe Law (siebelaw@gmail.com)" <siebelaw@gmail.com>
Cc: "Jacobson, Edward I (FBI)" <Edward.Jacobson@ic.fbi.gov>

Dear Jim,
I was just doing the jury instructions for our January 6th trial on Dr. Beier. As I was going through all the counts and all the jury instructions I started adding up the pills. Based upon the oxycodone which are currently charged Dr. Beier is looking at 66.9 grams of oxycodone which equates to 442 kilograms of marijuana or a level 28. If convicted, the relevant conduct should change the amount of oxycodone distributed to well over 400 grams. That will convert to about over 2,680 kilograms of marijuana or level 32 or 34.

The sentence difference:
A level 34 is 151-188 months in prison.
A level 28 is 78-97 (with acceptance and reduction for pre sentencing guideline adjustment that range drops to 46-57 months in prison.

We previously offered Dr. Beier an opportunity to plead guilty to the original indictment-which would have resulted in an offense level of about 18 (after acceptance the prison range would have been 18-24 months). He rejected that offer. I do not believe Dr. Beier will consider any offer from the United States but as I evaluate the case, I think he is making a mistake.

Dr. Beier's rejection of the offer caused the United States to do additional investigation and interview and identify additional people who were buying pills from Dr. Beier. All of these individuals will testify at trial. In summary, the evidence against Dr. Beier includes audio and video recordings of the Shopko buy, audio of his conversation with Destiny, bill bottles found in hotel rooms where he and his co conspirator were visiting others, a pharmacist who talked to him and to whom he verified a prescription as valid even though the individual had been and was in jail at the time, pharmacists who talked to him about other invalid prescriptions but to whom the Dr. confirmed the prescriptions as valid,

numerous individuals who bought prescriptions for cash. Simply put, I wish all of my cases had such overwhelming evidence.

I am writing one last time to determine if Dr. Beier has any interest in resolving the case with a guilty plea to Count One. The United States will dismiss the remaining counts which include counts which have a one year mandatory minimum and double the possible punishment. As I said earlier, I don't believe Dr. Beier will entertain such an offer but I know you will provide it to him. Please let me know his response by November 6, 2014. The offer will be considered withdrawn and closed after that date. In the meantime, I will continue to prepare for trial.

Thank you for your consideration.

Sincerely,
Traci J. Whelan

UNITED STATES DISTRICT COURT
DISTRICT OF IDAHO

UNITED STATES OF AMERICA,	)
	) No.
Plaintiff,	) No. 2:14-CR-00117-BLW
	)
vs.	) DECLARATION OF RICHARD S.
	) ADLER, M.D., Re: MOTION TO
RAFAEL BEIER,	) VACATE, SET ASIDE OR CORRECT
	) SENTENCE PURSUANT TO
Defendant.	) 28 U.S.C. § 2255

I, Richard S. Adler, MD, am over 18 years of age and competent to testify. I declare as follows:

I conducted a complete forensic evaluation of Rafael Beier prior to his sentencing hearing in the above-entitled matter. The purpose of the evaluation was to determine Dr. Beier's mental condition at the time of the evaluation and, if able, to determine his mental condition at the time of the offenses, prior to his jury trial and during his jury trial. My resume and prior case experience as an expert are attached to this declaration. Appendix 1 (App. 1) at 1-12; and App. 2 at 1-14.

The report of my Forensic Psychiatric Examination (Report), consisting of 31 pages, is incorporated by reference to this declaration and attached to this declaration. App. 3 at 1-31. Also, incorporated by reference and attached to this declaration is the court reporter's transcript of my testimony given on July 26, 2017, before the Honorable Edward J. Lodge at a competency hearing and hearing on a motion for new trial. App. 4 at 1-87 and 118-143. Upon review of

each before executing this declaration, I certify that the substance and content of my report and testimony remain true and correct according to my complete forensic examination and analysis. This declaration is intended to supplement that information.

It was my opinion before, and remains my opinion today, that Dr. Beier suffered from, and continues to suffer from, a mental disease and defect, namely, mild Neurocognitive Disorder (mild-NCD) due to Traumatic Brain Injury (TBI), as set out in my Report. App. 1 at 3 and 29. It is my opinion that the brain damage from the TBI, caused by several serious blows to the head over years, cannot with certainty be reversed, and that the normal process of aging will exacerbate his overall cognitive status. Having said that, neuroscience is an area that is burgeoning, and accordingly, it would be imprudent to be completely pessimistic.

It was my opinion before, and remains my opinion now, that the mild-NCD due to TBI suffered by Dr. Beier represents a serious and significant impairment in Dr. Beier's mental functioning. His impairment manifests itself in delusional thinking (i.e., psychosis - the most severe level of derangement in thinking). This is consistent with those symptoms included in the DSM-5's section on neurocognitive disorders, both mild and major. App. 5 at 7.

It is entirely appropriate to characterize Dr. Beier's condition as a mental "defect" because TBI is injury to a person's brain, resulting in brain damage. The defect has left him with less ability than he had before the TBI, and less ability than the average person. Dr. Beier's condition is also described as a mental "disease" because the TBI is the result of an injury.

The reasons why I did not diagnosis a Delusional Disorder, nor diagnose a Psychotic Disorder, is because mild NCD due to TBI is the best and most accurate diagnosis (per the diagnostic schema outlined in the DSM-5) based on all the history of head trauma gathered, the neuropsychological data obtained, and the neuroimaging testing results (i.e., the brain Magnetic Resonance Imaging (MRI) and the brain Positron Emission Tomography (PET)).

My professional responsibility requires that I provide the most accurate diagnosis from the DSM-5 based on the data I obtained and reviewed. The fact that I diagnosed Dr. Beier with the "mild" form of a NCD does not and did not directly reflect upon the severity that the mental disease and defect has on the relevant medico-legal capacities.

It is important to note that the DSM-5 instructs that in the "major" form of a NCD, the cognitive deficits will "interfere with independence in everyday activities." App. 5 at 3. Thus, a person suffering from the "major" form of the disorder usually requires dependent living and assistance in day-to-day living activities. *Id.*

In the "mild" form of NCD, however, the "cognitive deficits do not interfere with capacity for independence in everyday activities." App. 5 at 6. The DSM-5 explains that in mild-NCD "complex instrumental activities of daily living such as paying bills or managing medications are preserved, but greater effort, compensatory strategies, or accommodations may be required." *Id.* Thus,

presence of the mild-NCD in a person can still severely impair a person's mental functioning to the degree I have opined was present in Dr. Beier. Thus, there is nothing in the applicable and relevant science to argue against or diminish from my stated opinion that Dr. Beier's severe delusional thinking (also referred to as psychotic thinking) was present and pertinent to a diminished capacity and/or an insanity defense. To make this absolutely explicit, there is no basis to conclude that *both* can be and were the case - (1) Dr. Beier maintained independent living during the times alleged in the indictment and throughout his trial process, and (2) he was clearly and actively delusional (i.e., psychotic). Not only are the two NOT mutually exclusive, it is generally understood that people can be delusional (i.e., psychotic) and transact typical activities of daily life.

It is my opinion that the severity of the mental disease and defect suffered by Dr. Beier impaired his ability to form the intent to commit the offenses charged against him, and rendered Dr. Beier unable to appreciate the nature and quality or wrongfulness of his acts at the time of the commission of the offenses charged against him. App. 3 at 3 and 29; and App. 2 at 13-17.

The DSM-5 explains the following about NCD:

* NCD may be accompanied by "psychotic symptoms ..." where "[p]aranoia and other delusions are common features, and often a *persecutory theme* may be a prominent aspect of delusional ideation." (emphasis added). App. 5 at 7. Also, "disorganized speech and disorganized behavior are not characteristic of psychosis in NCDs." *Id.* (Italics added for emphasis). "[D]isinibition" is an "important behavioral symptom[]" associated with a NCD. App. 5 at 8.

* "Neuropsychological testing ... [should be] part of the standard evaluation of NCDs and *is particularly critical in the evaluation of mild NCD.*" (Italics added for emphasis). Id. Mild-NCD impairments typically lie in the 1-2 standard deviation below the norm (between the 3rd and 16th percentiles). *Id.*

* NCD "may go undiagnosed in high-functioning individuals..." and "[n]orms are more challenging to interpret in individuals with high ... levels of education..." *Id.*

The forensic information I obtained supports my opinions that Dr. Beier had a diminished capacity and was insane at the time he committed the offenses resulting from mild-NCD due to TBI. That information included:

* Neuropsychological testing and assessment by Elizabeth Ziegler, Ph.D., where she "strongly suspect[ed] some degree of delusional disorder ..." and recommended that Dr. Beier have an MRI test and "undergo a more sophisticated forensic psychiatric evaluation to better evaluate his delusional thought processes..." App. 6 at 11.

* My interview with trial counsel, Mr. Jim Siebe, who observed that Beier "had an inability to perceive his own behavior" and described him as "mentally 'separated from what he was really doing.'" App. 3 at 4.

* My forensic interview with Dr. Beier's eldest son, Branden Beier, who noticed personality changes, including "chang[ing] his style of clothes ... dressing 'like a teenager ... a regression in maturity'" Branden Beier reported that Dr. Beier lacked "'the accountability factor,' and his father's reasoning was 'very odd ... he minimized things.'" App. 3 at 5-6.

* I requested additional neuropsychological consultation which was provided by Paul Connor, Ph.D. Dr. Connor's testing results revealed cognitive impairments between the 3rd and 16th percentiles in: (1) working memory - 9th percentile; (2) story recall - 12th and 13th percentiles; (3) social perception related to auditory skills, particularly the ability to detect mismatch between the literal and implied meaning of language - 9th percentile; and (4) a test of executive functioning/problem solving, - 5th percentile. App. 17-19.

* I obtained a brain MRI (i.e., neuroradiological testing) from the University of Washington Medical Center where sophisticated quantitative analysis detected defects, including those in an area associated "[o]ne of the most important functions of the brain…the "metacognitive evaluations of oneself and others." What this means "is having the perspective on the basis, rationale, and/or motivation of your own behavior and other persons' behavior [and] ... this is precisely what Dr. Beier can no longer do properly." App. 3 at 27.

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[1] Magnetic Resonance Imaging (i.e., MRI) can detect structural brain damage and Positron Emission Tomography (PET) can detect either increased or decreased "metabolic activity" in the brain. Whether increased or decreased activity is present, both are relevant abnormalities.

* I received a PET scan that was reviewed by the widely recognized expert Andrew Newberg, M.D., His quantitative analysis revealed decreased activity in areas of Defendant's brain that cause "heightened emotions such as excessive anger or impulsive behaviors, or reduced emotions such as depression" and increased activity in areas of his brain "associated with problems with concentration or executive functioning such as rapid processing of information or complex problem solving." App. 3 at 23. The data that I gathered and reviewed for the forensic assessment was considered as a whole and reflected considerable convergent validity. The data "all indicate that Dr. Beier suffered traumatic brain injury not only in 1996, but likely in a number of episodes, consistent with the history he provided." App. 3 at 26. It is my opinion that "[b]y virtue of his [mild-NCD due to TBI], Dr. Beier continues to maintain a perspective on his case that departs from the 'plain facts,' and his thinking is so separated from reality, that it warrants being described as both 'psychotic' and 'delusional.'"[2] App. 3 at 29.

It should be noted that Mr. Siebe told me that he "may have made a big mistake" in failing to evaluate Dr. Beier for competency. App. 3 at 4. Based on the interactions between Mr. Siebe and Dr. Beier, as reported to me by Mr. Siebe,

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[2] I also obtained significant data from a report from Grant Haven, M.D, a contract psychiatrist from the Bureau of Prisons. He diagnosed Dr. Beier with unspecified neurocognitive impairment, R419 using the International Classification of Disorders (ICD) nomenclature system. This condition manifests in a patient's impaired awareness. App. 7.

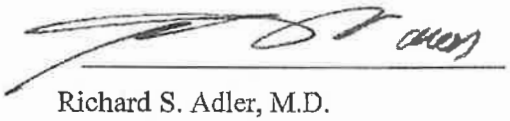
his observations and experiences with Dr. Beier during the course of representation should have alerted Mr. Siebe to the potential existence of a mental impairment that warranted investigation and evaluation prior to Dr. Beier's trial.

The impact of the mental disease and defect has on Dr. Beier meets both prongs for the insanity defense under federal law. As I explained at the hearing on July 26, 2017, "Dr. Beier ... is psychotic; his reasoning is not actually based in reality:" he "maintained ... that what he was doing was helping people ... [a]nd ... the helping of people supersedes and is not related to actually breaking the law or failing to appropriately transact his medical responsibilities: that he maintains that this was solely due to being conned or being taken unawares or undermined by the behavior of others ... which is what leads me to calling the thinking psychotic." App. 4 at 15. "[Dr. Beier] doesn't understand that ... he is doing something that is against the law. He believes that he is helping, and that helping supersedes or in some way diminishes from those other considerations." App. 4 at 15-16. "[V]ery closely associated, is the issue of wrongfulness.... So, there's some comment where he says, 'They are trying to indict me,' which [] would suggest that he understands the legal wrongfulness [,] [b]ut then there is the area of having consideration of the moral wrongfulness [,] [a]nd he believes he is doing God's work. I think he conveyed that he regards himself as being a saint. And he has all kinds of moral and religious considerations that do affect that arm of the wrongfulness, the moral wrongfulness." App. 4 at 16. Thus, it is my opinion that due to the severity of Dr. Beier's mental disease and defect, he could not appreciate the nature and quality or the wrongfulness of his conduct at the time he committed the offenses. Dr. Beier's circumstances meet the definition of an insanity defense under federal law.

After review of jury instructions submitted at Dr. Beier's trial, it is my understanding that in order to prove a conspiracy to distribute controlled substances illegally, the government had to prove that Dr. Beier willfully participated in an unlawful plan to distribute the controlled substances. He was charged as a physician licensed to prescribe controlled substances. Therefore, the government had to prove that Dr. Beier "acted with the intent to distribute the controlled substances outside the usual course of professional practice and without legitimate medical purposes" to prove the charges of distribution and to prove the conspiracy. It is my opinion, based on the severity of symptoms of his NCD due to TBI, that the severe psychotic/delusional nature of his mental disease and defect, Dr. Beier could not form the intent to distribute the prescription medications outside the usual course of his professional practice and without legitimate medical purposes as set out in the instructions.

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

Dated this 5th day of February, 2021 at Seattle, Washington.



Richard S. Adler, M.D.

CERTIFICATE OF SERVICE

I hereby certify that on February 6, 2021, I electronically filed the foregoing with the Clerk of the Court using the CM/ECF System which will send notification of such filing to the following: Traci Whelan and Michael Mitchell, Assistant United States Attorneys.

s/Stephen R. Hormel
Attorney for Beier

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FORENSIC PSYCHIATRIC EXAMINATION

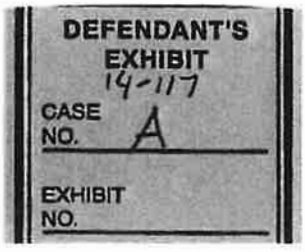
Evaluee:	Rafael Beier
Docket Number:	2:14 CR00117-001
Date of Birth:	December 10, 1953
Dates of Examination:	October 26, 2016 and November 1, 2016
Date of Report:	January 19, 2017

Rafael Beier is a sixty-three (63) year old physician who was referred to me by counsel, Mr. Stephen R. Hormel. Mr. Hormel has been the examinee's lawyer following the guilt/innocence phase of the case captioned above. Mr. Hormel learned during his representation of Dr. Beier that his client had suffered a number of episodes of traumatic brain injury (TBI).

At my request, counsel sent me a letter, dated October 31, 2016 detailing his interactions with the examince and articulating specific consultative questions.

Mr. Hormel stated: "[I]t is my belief that he is unable to assist me in his defense at sentencing. I also believe there was in issue as to whether he could have properly assisted trial counsel in his defense at trial." Counsel asked me to evaluate and render an opinion about both competencies (i.e., to be sentenced and to stand trial) and also, if applicable, whether "reduced mental capacity affected Dr. Beier's ability to form the intent to commit the crimes charged against him, or whether it affected his ability to distinguish right from wrong."

The letter continued with: 'I have observed and experienced an inability of Dr. Beier to rationally process (absorb) the real historical facts relating to the circumstances leading to his charges.... I detected an acute inability to rationalize and process facts that are obvious in his case...This concern was enhanced when I compared Dr. Beier's testimony in relation to the facts presented by the government at trial." Mr. Hormel alluded to the Government's initial offer to resolve the case – which would have resulted in an overwhelmingly favorable outcome had Dr. Beier accepted the offer. At the present state of the case, Mr. Hormel believes that Dr. Beier cannot properly discuss with him "the facts of his case and to develop what to say in exercising his right of allocution at the sentencing hearing."



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January 19, 2017

Counsel has brought to my attention the case of US v. Dreyer, 705 F.3d 951 (2013). This will be considered in relation to the evaluative data acquired, and addressed in the "Discussion" section below.

I am a Board-certified Adult, Child and Adolescent Psychiatrist. My resume is attached. All opinions are offered here are made with a reasonable degree of medical certainly.

The following were relied upon in arriving at my opinion:

1. Psychiatric interview of the evaluee, October 26, 2016 1:1 in a private room at the Federal Detention Center, SeaTac, WA,
2. Administration of the Personality Assessment Inventory (PAI), October 26, 2016,
3. Administration of the Revised Competency Assessment Instrument, October 26, 2016,
4. Psychiatric interview of the evaluee, November 1, 2016 1:1 in a private room at the Federal Detention Center, SeaTac, WA,
5. Report of forensic neuropsychologist Elizabeth Ziegler, Ph.D., dated October 3, 2016, (11 pages),
6. Phone collateral interview, Mr. David Jackson (brother of examinee), October 24, 2016, 2:00 p.m. to 2:30 p.m.,
7. Phone collateral interview, Mr. Phillip Savage (sibling of examinee), October 25, 2016, 11:00 a.m. to 11:35 a.m.,
8. Email, from Stephen R. Hormel counsel, regarding consultative questions, dated October 31, 2016,
9. Phone collateral interview, Attorney Mr. James Siebe, October 31, 2016, 5:00 p.m. to 6:00 p.m.,
10. Collateral telephonic interview, Mr. Branden Beier, (examinee's son), November 16, 2016, 8:30 a.m. to 9:10 a.m.,
11. Draft "Declaration of Re: Competency Evaluation" [sic], Mr. Brandon Beier, November 15 - 16, 2016 (5 pages),
12. Magnetic Resonance Image and Diffusion Tensor Image of the brain, University of Washington Medical Center, November 17, 2016,
13. NeuroQuant® analysis of brain Magnetic Resonance Image (MRI),
14. Analysis of November 17, 2016 Positron Emission Tomography (PET) scan by Andrew Newberg, MD, Director of Research, Myrna Brind Center of Integrative Medicine, Thomas Jefferson University and Hospitals, Philadelphia, PA, dated December 29, 2016 (6 pages),
15. Neuropsychological testing, Paul D. Connor, Ph.D. of examinee, November 30, 2016 and telephonic debriefing/email also November 30, 2017,
16. Email from Andrew Newberg, M.D., January 14, 2017,
17. Discovery, provided by counsel.

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SUMMARY:

As explained in detail in the "Opinion/Discussion," section it is my opinion with reasonable medical certainty that Dr. Beier: (1) does not possess the requisite mental capacities to meet the statutory definition of Competency to Be Sentenced, (2) did not possess the requisite mental capacities consistent with Competency to Stand Trial, and, (3) reduced mental capacity affected Dr. Beier's ability to form the intent to commit the crimes charged against him, and affected his ability to distinguish right from wrong." This incapacity exists by virtue of *both* a mental disease and a mental defect, namely: Mild Neurocognitive Disorder Due to Traumatic Brain Injury (DSM-5 Code 331.83, at page 624, ICD Code G31.84). As a direct product of this mental disease and mental defect, Dr. Beier cannot assist counsel, nor does he possess either a rational or factual understanding of the charges. It is unlikely that he can be restored.

NOTIFICATION OF RIGHTS AND LIMITS OF CONFIDENTIALITY[1]:

Prior to the start of both formal evaluation sessions, Dr. Beier was informed of the purposes of the examination, the limits upon its confidentiality, and that Counsel, the Prosecutor, and the Judge might receive a copy of a report, if one was generated. Dr. Beier was informed that the evaluation could result in recommendations for treatment. He was made aware that he was not required to answer any questions. Dr. Beier was given an opportunity to ask questions. After this, Dr. Beier was asked explicitly if he wished to proceed, and he indicated a willingness to do so.

Dr. Beier conveyed his understanding that he did not do well on testing administered by Dr. Ziegler. He himself noted that he had "problems with complicated things," saying that this was "obvious" to him.

PHONE COLLATERAL INTERVIEW, (PRIOR) ATTORNEY, JAMES SIEBE:

Mr. Siebe had represented Dr. Beier in both this matter and a prior matter that ultimately was dismissed.

Mr. Siebe indicated that he had concerns about Dr. Beier's mental status during the representation of the Defendant. He wondered in particular whether Dr. Beier might be "manic," mentioning to me that Dr. Beier with some frequency sent him electronic communications at early morning hours (e.g., 2:30 a.m.). At other times he wondered if Dr. Beier might be taking illicit drugs. Dr. Beier seemed quite concerned about what Mr. Siebe thought of him, as if Dr. Beier needed to "prove something about his [good] character." Dr. Beier frequently went on verbal "tangents." Dr. Beier had a habit of "going on" about the persecution of Native Americans because of their religious

[1] Collateral informants were similarly provided appropriate notifications before any substantive interviewing was begun.

beliefs. Overall, he characterized Dr. Beier as a "difficult client." *Counsel felt that there had never been a "genuine, thorough discussion" of the case with his client.* (Italics added for emphasis).

Additionally, Mr. Siebe described his client's persistent behavior of 'denying the obvious,' and Dr. Beier's track record of 'not accepting logical deductions.' Some of the case-related explanations Dr. Beier offered counsel seemed hard to believe. Mr. Siebe commented on the "considerable dissonance between the [case] material and his account." As an example, Mr. Siebe had gone over a transcript of evidence used in the trial. Dr. Beier insisted that: "it doesn't show what they [the US Government] says it shows," but Mr. Siebe, could not follow Dr. Beier's line of reasoning.

During the trial itself, there was also the problem of Dr. Beier, "interrupting me throughout..." Dr. Beier would frequently assert that things simply didn't say (or reflect) what they seemed to say. Dr. Beier also very frequently indicated that he was unable to understand material presented.

When Dr. Beier took the stand, his testimony was "inconsistent with what he told me [in the office] previously." He described Dr. Beier as mentally "checked out... he didn't respond to me... like he did in the office."

Finally, Mr. Siebe recounted an unusual display of behavior. He told me that Dr. Beier brought with him a larger than life-size mounted photograph of his "wife" Destiney, who is shown completely naked. Counsel thinks, that Dr. Beier provided this to show him why he was so enamored with the woman. On more than one occasion, he suggested that they use it as an exhibit at trial; which Mr. Siebe vetoed. Mr. Siebe indicated that although he did not want to hold on to the poster, Dr. Beier insisted that he hold on to it, and that it remains in his possession.

Mr. Siebe indicated that his client blankedly: "denied everything." The client turned down a plea agreement from the Prosecutor that would have been an outcome much more favorable than the sentencing range he faces presently. He basically told Mr. Siebe that: "I can't plead guilty if I'm not guilty." Mr. Siebe also commented that his client seemed to have a "martyr complex," alternately calling it a "crucifixion complex."

Mr. Siebe told me that in retrospect Dr. Beier reminded him of another client who comported himself as if he was "watching himself on TV" and it seemed that Dr. Beier had an "inability to perceive his own behavior." He said that Dr. Beier was mentally "separated from what he was really doing." Mr. Siebe endorsed that the prior client had Dissociative Disorder and he wondered whether Dr. Beier might be similarly afflicted. (Italics added for emphasis).

I asked Mr. Siebe if he had entertained whether Dr. Beier was lacking Competence to Stand Trial. He replied: "I may have made a big mistake in that respect." Noting that he has referred clients for Competency evaluations in the past, Mr. Siebe stated that Dr. Beier's "status [as a physician] dissuaded me from [taking] that approach."

Mr. Siebe wanted to stress that he chalked up Beier's denial concerning the obvious facts of the case to his being a stubborn and proud man. He wrote: "The jury obviously chose to discredit everything we submitted in the form of testimony and argument, which is not surprising."

COLLATERAL TELEPHONIC INTERVIEW AND DECLARATION, BRANDEN BEIER (SON):

Mr. Beier is the oldest of Dr. Beier's eight children. He has owned a long-term care and home health agency for 10 – 15 years. He has a Bachelor's degree is School Psychology/Social Work.

Mr. Beier spontaneously emphasized his father's "trusting nature," explaining this has been long-standing.

He told me that Dr. Beier lost his job with the Indian Health Service (IHS) after a 1996 motor vehicle accident. The truck rolled over several times. The declaration includes that according to Branden's brother, Dresden (who was present), Dr. Beier *was knocked unconscious for a period of time*. (Italics added for emphasis).

After the accident, the parents separated. Also, his father didn't follow rules, and was not willing to wear the uniform that he was provided as part of his IHS appointment. Dr. Beier would "buck against whatever they told him to do."

In a similar vein, Dr. Beier did not last at the clinic position he took in Kellogg, ID in 2000 – 2001. There, he was "disruptive, questioned the system… ordered tests that would not be reimbursed…. stood up for the underdog."

Working after this in his own clinic, Dr. Beier was not responsible, leaving the premises at times when he had patients scheduled. His practice was "falling apart" and in 2011 – 2012 he let go a lot of staff at the clinic…. Around this time, he changed his style of clothes… dressing "like a teenager… there was a regression in maturity…. He left the clinic to help Destiney [sp?]… would go and bail out a friend of hers [for example]."

Dr. Beier would act on his "overwhelming need to help people," and bought cars he did not need and could not really afford. He would take extended trips to Hawaii, take people to Hawaii at his expense, let people stay at his clinic building [against the provisions of his lease]. He gave some of his older cars away. He brought people to stay at his home. His second wife contacted Branden, asking him to reason with his father.

Dr. Beier would go on tangents and become preoccupied by different things, such as training for the Iron Man competition and running up to 20 miles a day, becoming quite gaunt.

The draft declaration included: "I would say the largest change of all was in/around 2011/2012 that occurred to the point that the discussions or times of rationalizing [with his father] seemed to be less and less effective in which it appeared that he lost a little more of real[i]ty so to speak... the thought process of what we as his family could see, he could not understand... at [the] present day... he seems to have a[n] even more diluted sight [sic] or disorientation to the ability to learn... Almost to a point of disorientation to changes[,] however... small they may be."

In addition to the mental status change after 1996, more recently there has been a noticeable decline in Dr. Beier's cognitive ability. The son said that Dr. Beier has "struggled with the phone system at SeaTac... and it happens time and time again... he has poor short term memory.

Related to the legal case (but not only in relation to the legal case) he said his father would be truthful when confronted, but he tended to have "far-fetched explanations" for things... Branden alluded to there being the absence of 'the accountability factor,' and that his father's reasoning was "very odd... he minimized things." Mr. Beier denied any knowledge that his father abused drugs.

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EVALUATION BY ELIZABETH ZIEGLER, PH.D.:

Partly at my suggestion, Dr. Beier was evaluated first by a Spokane forensic neuropsychologist. Counsel retained Elizabeth Ziegler, Ph.D. for this task. Dr. Ziegler examined Dr. Beier on September 13 and September 20, 2016. She authored an eleven-page report on October 3, 2016.

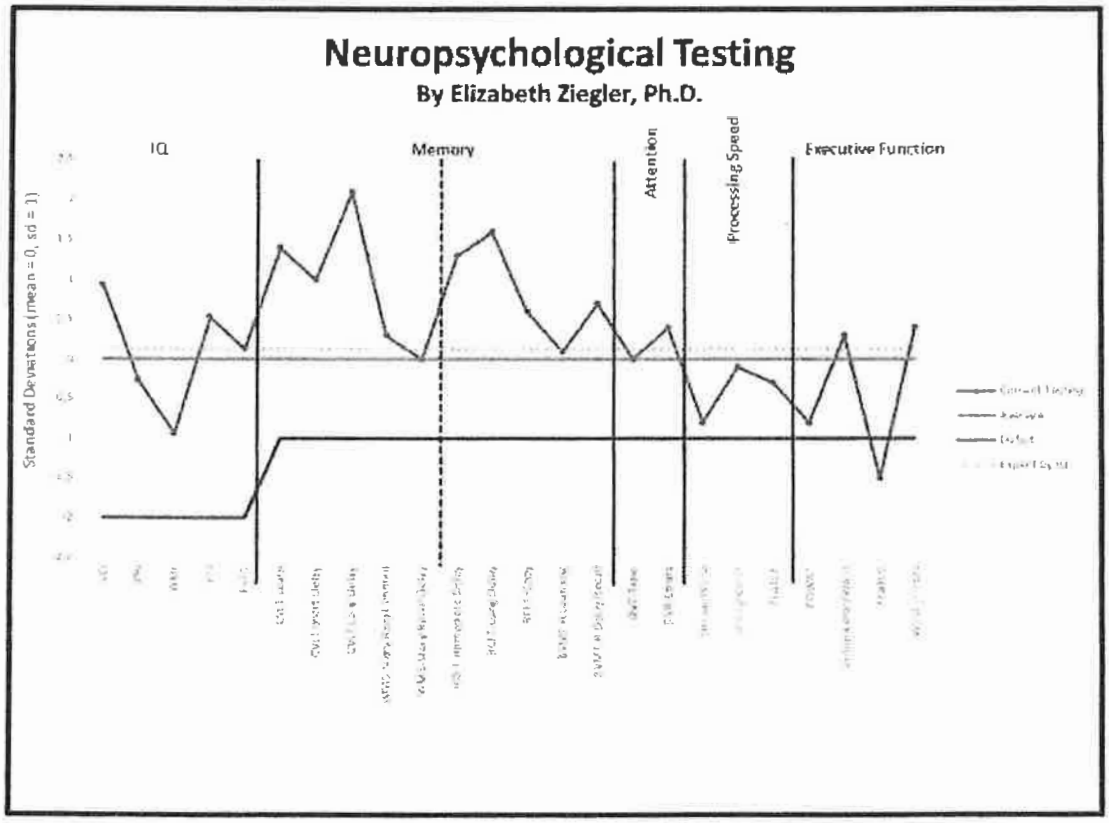

Figure 1. Neuropsychological test results obtained by E. Ziegler, Ph.D.

Dr. Paul Connor (see below) reviewed Dr. Ziegler's results, and provided a graph summarizing the findings (Figure 1).

In Figure 1, the vertical scale on the left reflects scores in terms of standard deviations. The average person would be expected to score at the "0" mark (shown in solid green), but given Dr. Beier's present tested IQ, his results would be expected to fall at the dotted line (also in green) which is slightly above it. As a convention, good performance is reflected at positive (above the green line),

and deficient performance is shown below the green line. Dr. Beier's results are variable, and reveal a "patchy" distribution of areas of poor performance.

At the left side, under "IQ" are the results of a widely-used test of intellectual functioning, the Wechsler Adult Intelligence Scale – 4th Edition (WAIS-IV). The main (aka "Index") scores have a mean and of 100 and a standard deviation of 15. Dr. Connor converted the scores to standard deviations to assist comparison with the other tests. The results include: Verbal Comprehension Index (VCI): 114 (82nd percentile) High Average range, Perceptual Reasoning Index (PRI): 96 (39th percentile) Average range, Working Memory Index (WMI): 86 (18th percentile) Low Average range, Processing Speed Index(PSI): 108 (70th percentile) Average range, Full Scale IQ (FSIQ): 102 (55th percentile) Average range, General Ability Index (GAI): 105 (63rd percentile) Average range.[2]

Dr. Ziegler pointed out the existence of an 18-point difference between VCI and PRI was statistically significant and has a cumulative percentage of 9.5% in the normative population. It is also noted that Working Memory Index who low, given the Verbal Comprehension Index. Three tests assessing Processing Speed were lower than the PSI of the WAIS-IV. There was also unevenness among the four tests shown under "Executive Function."

Dr. Ziegler interviewed Dresden Beier about the motor vehicle accident. The truck, he stated, "rolled" and the vehicle was totaled. Everybody in the truck lost consciousness, and Dresden was the first to awaken. Dr. Beier was still unconscious. Dresden was transported to a local hospital, but he does not believe his father was transported anywhere for care. Dresden believes that his father suffered a fracture of the collarbone.

Dr. Ziegler indicated a concern about neurological factors, and she recommended a brain MRI be done to explore possible structural abnormalities. She commented that Dr. Beier had a fixed, rigid and obsessive focus on details of his trial and a significant lack of insight and minimization of this psychiatric status. She was concerned about delusional thinking. She did entertain the possibility that Dr. Beier was demonstrating *early frontotemporal dementia.* (Italics added for emphasis).

DRAW A CLOCK TEST:

As a preliminary part of the examination on October 26th, I administered the Draw a Clock Test (DAC). Dr. Beier was given a sheet of paper with a circle on it, and asked to place numbers on the page as they appear on a clock. He was able to provide an appropriate response, placing the "12" first. He then placed the other numbers clockwise from 1 to 11. This suggested adequate effort and cooperation.

[2] When computing the General Ability Index (GAI), which bases overall ability on just core verbal and performance subtests without the influence of working memory or processing speed, his index score was average (63rd percentile, GAI = 105).

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PERSONALITY ASSESSMENT INVENTORY (PAI), ADMINISTERED ON OCTOBER 26, 2016:

The PAI[3] consists of 344 statements to which the examinee is asked to respond "somewhat true," "mostly true," "very true" or "false." The PAI results that are produced are compared to persons of similar age, gender and educational background.

The PAI's interpretive report cautions that the information obtained 'should be viewed as only one source of hypotheses about the individual being evaluated. No decisions should be based solely on the information contained in this report. The PAI data should be integrated with all other sources of information in reaching professional decisions about this individual.'

'The degree to which response styles may have affected or distorted the report of symptomatology on the inventory is also routinely assessed. Certain of these indicators fall outside of the normal range, suggesting that the respondent may not have answered in a completely forthright manner; the nature of his responses might lead the evaluator to form a somewhat inaccurate impression of the client based upon the style of responding described below. With respect to positive impression management, the client's pattern of responses suggests that he tends to portray himself as being relatively free of common shortcomings to which most individuals will admit, and *he appears somewhat reluctant to recognize minor faults in himself.* Given this apparent tendency to repress undesirable characteristics, the interpretive hypotheses in this report should be reviewed with caution. *Although there is no evidence to suggest an effort to intentionally distort the profile, the results may underrepresent the extent and degree of any significant findings in certain areas due to the client's tendency to avoid negative or unpleasant aspects of himself.'* (Italics added for emphasis).

EXAMINATION CONCERNING (IN)COMPETENCY TO PROCEED (ADMINISTRATION OF THE REVISED COMPETENCY ASSESSMENT INSTRUMENT (R-CAI) (RILEY JA, NELSON C, GANNON JL, 1989):

Understanding/Appreciation of the charges he faces:

Dr. Beier stated that he was facing charges for "Selling prescriptions – about sixty (60)." He spontaneously added: "Absolutely not… I was conned." He indicated that these were all felonies. He conveyed that felonies are more serious than misdemeanors. He elaborated that to commit such a such a charge the person had to "intentionally know [they were] selling prescriptions." Asked if people in general would regard him with some fear on the basis of such a charge, Dr. Beier stated: "probably not." He added: "I was found guilty in [a] 'kangaroo court'… I witnessed lying."

[3] Morey LC. Personality Assessment Inventory ™ (PAI ®) Professional Manual, 2nd Edition. Lutz, FL: Psychological Assessment Resources, 2007.

When asked about the possible sentence he might get if found guilty, he responded that he could be sentenced to "twenty [years] to life in federal prison."

When asked about the meaning of "probation," he responded that it was when they "decide not to put you in prison – see if you obey the law… follow rules."

When asked what possible conditions might apply to a disposition of probation, he replied: "anything they tell you, you have to do… I don't know… not commit crimes I guess."

He indicated that if found "not guilty," a person would then "go about [their] normal life." When asked about the outcome of being found "not guilty by reason of insanity," he stated: "They go to a mental institution, I guess, until they figure it out. If not insane [any more] they maybe they let 'em go."

I asked him what pleas a person can enter in court. He responded initially: "[to] lesser charges." He then said "Guilty or Not Guilty." I reminded him about Not Guilty by Reason of Insanity (NGRI). When asked what a plea of "not guilty" meant, he responded "I didn't commit the crime."

When asked what the plea of "guilty" meant, he responded only with: "[You are] Guilty or if you don't plead Guilty, something worse will happen to you."

When asked again about the meaning of "not guilty by reason of insanity," he stated that the person had: "no comprehension of what they were doing..."

I asked him: "How do you think you can be defended against these charges?" He replied: "[Number] one… witnesses. The stepbrother of the woman who broke in and stole [my] prescriptions, he said he paid Dr. Beier twenty thousand dollars a week [not true]. Second, [about the Oxycontin[s] 80 mg – it is not in the database. Third, each witness could have been challenged." He mentioned in particular Jordan Newkirk. Saying that he, [Dr. Beier] was a victim of "entrapment… [she] set me up…" He asserted that Ms. Newkirk "had burglarized eighteen places… [they did identify her as the] thief… she was not impuned on cross-examination."

He was asked: "Is there a way you can you explain your way out of these charges," to which he responded: "[I am] naïve. Rafael means defender/healer.[4] I was conned, scammed. There was no [trial] prep[aration] except a week or two before trial. I didn't have the money to pay him [prior counsel, Mr. Siebe]."

Asked: "on what do you think your lawyer should concentrate in order to best defend you," he replied: "track down each witness in the case, [such as] John Luke here from Coeur d'Alene… the

[4] In actuality, according to Wikipedia, its meaning is "God is Healer" or "God has healed."

girl Fawnie Bracamonte... had [also] scammed Dr. Kent Young... the feds gave her a deal... Destiney has a stepbrother. It is said that this involved $500,000 in pain pills -- $1,0000 per prescription. The credibility of the witnesses... her [sic] and her boyfriend were arrested... they gave her immunity. I wrote a prescription to Destiney's grandmother, but on one occasion the grandmother was not taken to the Emergency Room to see me. [They] broke into my clinic while I was at the Iron Man [Competition] at Hawaii... The forgers were not charged for what they did."

Appraisal of Functions of Courtroom Participants:

In response to asking Dr. Beier about the role of defense counsel he said: "Defend you against the charges."

When asked about the prosecuting attorney, he replied that it is to "prove you're Guilty... but not to ignore the truth."

As for the judge, Dr. Beier said: "to make sure all the laws are obeyed in presenting evidence."

I asked Dr. Beier about the function of the jury. He responded: "to hear the evidence... [to be] impartial."

Then I asked him to explain about the defendant in a case. He responded, "me – to give information that he can to the attorney."

As for the role of witnesses, Dr. Beier stated that it was to "tell the truth... what they know."

Understanding of Court Procedures:

Dr. Beier was asked if defendants always have to testify in their own cases. He said "no." I asked who makes the decision whether he testifies, he responded: "the defendant."

I asked Dr. Beier if he does testify, does he have to tell everything that happened. He replied: "I did testify."

I asked him if he testifies who asks him questions first. He said: "defense attorney." Asked who also later poses questions, he said: "prosecutors."

He was asked: "If the prosecutor asks you questions, what is it that he is trying to accomplish?" He responded: "get you to paint a picture they want... [that] you're guilty."
Dr. Beier was asked about the difference between a court trial and a jury trial. He responded that in a court trial it is "just the judge."

The examinee was asked about what he'd like to be the outcome of his trial. He stated that: "Every walks away, learns a lesson, no jail." He explained: "I don't believe the system helps anybody. Prisons should be hospitals... [focus on] rehab... [people being] healed."

Asked how he'd feel about an acquittal, he responded that he could accept that outcome.

When asked about his willingness to appeal an adverse verdict, he said that he could accept that also.

Dr. Beier, when asked if he would accept a plea bargain, he told me that this does not apply. He added that in his case the Prosecutor, FDA, DEA all committed crimes, were "overzealous" and had "blinders" on. He added, however, that 'it would not serve society for him to retaliate.'

Dr. Beier feels that the court in which he is to be adjudicated does have authority over him. When asked about the meaning of "evidence," he said that it was: "things they bring up to prove a point – one or another – not necessarily the truth."

Likewise, when asked: "What evidence do they have against you," he stated it was: "a recording Destiney made. It was tampered, edited... it is difficult for me to remember... it was made to be able to blackmail me."

He was asked what he thought his chances were of being found "not guilty," to which he replied: "this world is without judgment... Christ – authorities killed him. I don't trust the Goverment. The Government started Slavery, Racial Segregation... Genocide... Has stolen. The recording of the girl who brought [her] grandmother to me... [It's like the Devil [trying] to get somebody to do something wrong. The audio recording was quiet. Subscript[s were] used. Judge told the jury [certain things] without [actual] evidence." Dr. Beier went on to state very directly: "I didn't write the prescriptions." Instead, he asserted that it was "Fawnie Bracamonte [who was] blackmailing me at the clinic. I told my receptionist to call the police."

Ability to cooperate rationally with Counsel:

Dr. Beier knew that he had an attorney and knew his name. He stated that he has met with his lawyer "much more than the other [i.e., prior] attorney... a total of twelve times. Six hours in total" as an estimate.

He indicated that he has confidence in his lawyer, but stated "only a miracle from God will fix this thing." Asked in particular if he believes that his lawyer is trying to do a good job for him, he stated: "yes." He was asked if he disagrees in any way about his lawyer's handling of his case, he replied "so far... [he has been] very attentive." He did lament that in the guilt phase that he had 'let the prior attorney have his way. I was too trusting with everybody... I would voice an opinion but would not fire him."

When asked about the meaning of confidentiality between him and his lawyer, he said that it means, "things I say to him cannot be discussed with anyone without my permission."

I asked Dr. Beier who had raised the issue of his trial competency. He responded by saying that he was not actually aware of any issues raised by Dr. Ziegler and/or his attorney. He added that: 'I'm not good about things... easily deceived... too trusting... I was scammed good.' He pointed out the he has had "problems with memory" that he noted prior to the examination by Dr. Ziegler. For example, he said that for the last 4 – 5 years that he cannot remember the name of a patient without having their chart available to him. He said that at the jail he has been identified by other inmates as "vulnerable... an easy mark."

He hoped that the issues of his trial competency "doesn't get me in an institution for the rest of my life."

Dr. Beier feels that he does not remember everything that happened relevant to his case. He explained that the events occurred 3 – 4 years ago and that he saw "hundreds of patients in a month." Thus, he must rely on chart notes. He understands that he is expected to tell his lawyer everything relevant that he knows and remembers. He otherwise does not see a problem doing so [!].

As for his Capacity to Testify, he was asked about the Police Report. Instead, he commented on the Government's closing argument at trial. He emphasized that they asserted that he was "driven by greed." He was adamant that he was "trying to help people," but he was "conned." He pointed out that if he was 'driven by greed,' where in actuality "is the money?" He said that at his clinic he "never checked ID's." Some of the people he only saw once or twice. Poignantly, he said that he has avoided instituting an Electronic Health Record "because it is complicated... I don't [even] know how to email... [I use the] fax only." He restated that it is "hard to learn... remember passcodes." He did allude to "the car wreck," but said that he did not actually recall it. He indicated that he had been taken to the hospital and that the vehicle did roll over. Dr. Beier did indicate that he suffered a loss of consciousness.

Asked about the circumstances of his arrest, he recalled that he was pulled over on the road. He said that he did not make a statement or a confession. The arrest was not a surprise in that he knew "they were trying to indict" him.

Courtroom demeanor:

Dr. Beier indicated that if a witness lies about him in court that he should tell his lawyer. When asked who is likely to lie about him, he said: "Josh Taylor... because he is motivated to save his sister's hide and to avoid getting in trouble himself." Dr. Beier added that he had dismissed Mr. Taylor from his practice. He was being seen in the context of a Workman's Compensation matter. Mr. Taylor "threatened to blackmail me" he said.

Asked what he should do if he does not understand something a witness is saying, he responded: "tell my attorney." He was asked how he is expected to act in court.

He responded: "polite." When asked if he is permitted to freely speak out in court, he indicated "no." I then asked him what he thought would happen if he spoke out or moved about in court without permission. He stated: "they don't let you… they take you out of the courtroom. You are in deep trouble." I asked if he ever had problems behaving in court. He told me that he said to the Prosecutor: "You must have no conscience." This was conveyed to the Judge, who advised him to avoid such comments.

Additionally, Dr. Beier says that he has managed the stresses of the period of incarceration by virtue of his "religious beliefs." He indicated that he was taking no medications.

I asked Dr. Beier if he had ever been mentally ill. He responded: "no." Asked if he felt he was mentally ill at present, he responded: "no." Asked if he felt, in his opinion that he was trial competent, he responded: "there are competency issues here."

CLINICAL INTERVIEW:

On the second visit, I asked Dr. Beier to rate how he is doing presently overall on a scale of 1 (lowest) to 100 (best possible) – taking all aspects of life into account. He conveyed that he was "40" on the scale. He said that prior to his legal problems (i.e., two years ago) he was doing 95 on the same scale. Primarily he identified prominent negatives as "being incarcerated, a humiliating circumstance," for which he felt "righteous indignation." He added that he feels "like Christ – the whole system is out of control."

Dr. Beier emphasized that he has had long-standing problems with being "naïve, gullible."

He denied any prior history of psychiatric illness. When asked about any family history of psychiatric illness, he recounted that his sister had a "sex change."

Regarding his Past Medical History, Dr. Beier denied any chronic medical problems other than "high triglycerides." He never had any major episodes of medical illness, and never was medically hospitalized. The only surgery he ever had was for extraction of his wisdom teeth at age 19.

He reported several episodes of head trauma, however. This first of these was in 1996, related to motor vehicle accident. He reported also that police "beat me up" in 1997 – 1998, but there was no clear loss of consciousness. This was the basis for a civil law suit. In 2006, according to Dr. Beier, a "horse reared up" and hit him in the face. He needed to have stitches, but indicated that his wife "sewed him up." He was hit around the area of the left eye. He was also "beat up" in Coeur d'Alene in 2012. He was taken to the Kootenai Medical Center. Although the medical record does not convey this, Dr. Beier was "in a head lock" and does not recall the event. He did not disclose the

actual details in the Emergency Room, he told me because be was "embarrassed to tell the doctor I was beat up... [and] beat up easily." He told me that this situation followed "a girl borrowing his Avalanche [a car]."

Dr. Beier denied ever having a seizure. He is on no medications and denied having any medication, food or environmental allergies.

With regard to medical "Review of Systems," he reported recently "twisting" his back, and having intermittent ringing of his ears for about five years. He denied any history of substance abuse.

He denied having any significant family history of medical illness.

PHONE COLLATERAL INTERVIEW, PHILLIP SAVAGE:

Mr. Savage told me that there is no obvious indication of dementia-type symptoms. Per Mr. Savage, the Defendant articulates well. Dr. Beier has never had treatment for psychological problems. Mr. Savage told me that the examinee is "amazingly resilient."

Mr. Savage heard at some point that Dr. Beier was offered a plea bargain but refused – because he would have to lose his medical license. Mr. Savage said that there was "no talking sense to him... he thought he could win the case... felt that he had a good lawyer, and witnesses... could win." Supposedly, there is audio and video recorded of an interaction related to Dr. Beier being paid $1000 for a prescription he wrote.

Also, Mr. Savage recalls that on May 19, 2016 around 11:00 a.m. he got a call about his brother being "on the run." The FBI was looking for him. Mr. Savage felt "shocked," since he was not aware of the gravity of this brother's legal situation prior to that time.

PHONE COLLATERAL INTERVIEW, DAVID JACKSON:

Mr. Jackson is a stepbrother. He indicated that they grew up in a "very dysfunctional family" and as a result "everybody has something wrong with them." Mr. Jackson said that "all [the] siblings [have] been through a lot." Dr. Beier, however, "had the worst... was beat the worst. My father never laid a hand on us... took it out on him." He said that his stepbrother is a "smart guy." Rafael left home as a teenager. He graduated med school at 40. He had four kids with first wife, four kids with second wife.

Reported that mother is German, "full-blooded," and treated kids as she was raised. Rafael was her first born. She was not abusive to him, but Mr. Jackson's father, Rafael's stepfather, beat Rafael several times with a belt, and David witnessed it. David characterized Rafael as a "very supportive stepbrother."

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MENTAL STATUS EXAMINATION (NOVEMBER 1, 2016):

Dr. Beier appeared his stated age. Furthermore, he was notably thin and appeared physically fit. He wore eyeglasses and was appropriately dressed (in correctional facility garb) and groomed.

He was entirely cooperative and pleasant. Eye contact was direct. His motoric activity was within normal limits and there were no tics, twitches, stereotypies (i.e., repetitive, complex movements) nor any other abnormal involuntary movements noted.

His speech was normal in volume, tone, rate and style. His productions were spontaneous.

Dr. Beier rated his mood as 4 on a scale of 1 (lowest) to 10 (highest). His mood does not go below 4, and can elevate to a 7 when reading Scriptures. His affect was consistent with his stated mood, without any grossly bizarre or inappropriate features.

Dr. Beier's thoughts appeared coherent and goal directed. No loose associations were appreciated.

The examinee denied any suicidal ideation. Dr. Beier also denied homicidal ideation.

The examinee did not exhibit any prominent or overt delusions concerning thought insertion, thought withdrawal, religious themes, or frank grandiosity. He denied auditory and visual hallucinations.

Dr. Beier reported that he sleeps excessively (i.e. 16 hours a day) due to boredom. He reported that his appetite is normal. He described his energy as 4 on a scale of 1 (lowest) to 10 (highest). He described his memory as 4 on a scale of 1 (lowest) to 10 (highest), pointing out that he has had a real problem learning the "routines" at the Federal Detention Center. He gave as an example his needing help accessing the computer. As for concentration, he characterized it as 8 on a scale of 1 (lowest) to 10 (highest).

Dr. Beier was administered the Mini-Mental Status Examination.[5] Dr. Beier identified the day of the week (correctly) as Tuesday and indicated that it was November 1, 2016. He identified the season as "fall."

He identified his location as the Federal Detention Center, SeaTac. He stated he was in King county. He reported that he was in the State of Washington, and he described the floor of the facility as being the first.

[5] Folstein MF, Folstein SE, McHugh PR. Mini-Mental State: A Practical Method for Grading the Cognitive

When presented with three words verbally, he was able to recall three of three items immediately. After five minutes, he recalled two of the three items spontaneously. The last was recalled on cue from a list of three possibilities. He spelled WORLD backwards correctly.

Dr. Beier was able to name two common items, and he was able to repeat a simple phrase. He could carry out a simple, three-step command. He could read and follow a simple command.

When asked to write a simple sentence, he produced: "Jesus loves us all." He was asked to copy a figure of two interlocking pentagons as exactly as possible. His performance was good.

Dr. Beier correctly identified the current president and the four that preceded him. He did not know the name of the current governor of Washington, but stated that the governor of Idaho is named Otter. He indicated that five large cities in Idaho are: Coeur d'Alene, Sand Point, Boise, Lewiston and Kellogg. When asked about notable current events he replied: "Ammon Bundy [was] acquitted... a shock given Government corruption." He also mentioned the upcoming national election, and "talk regarding email and Hillary Clinton. He told me that the last major holiday was Halloween.

When asked to perform "serial sevens," (i.e., taking 7 from 100 and then repeating the subtraction of 7 from that number) he made one error, stating: 93 – 86 – 77 – 70 – 63 – 56 – 49 – 42 – 35 – 28.

When asked to provide the meaning of widely known proverbs, he indicated:

- "People in glass houses shouldn't throw stones" (familiar to him): "Similar to Christ saying "You without sin, cast the first stone"."
- "A rolling stone gathers no moss" (familiar to him): At first, he said that he was clueless, but asked to guess, he stated: "If [the stone is] moving, friction makes it gather no moss."
- "The grass is always greener on the other side" (familiar to him) – "Sometimes people have the tendency to think other situations than their own are better."

NEUROPSYCHOLOGICAL TESTING BY PAUL CONNOR, PH.D.:

Dr. Connor was asked to augment the evaluation of Dr. Ziegler. The bulk of Dr. Connor's testing was reasonably within normal limits, and fairly consistent with the Full-Scale IQ as measured by Dr. Ziegler. There were no prominent discrepancies between the testing results acquired by Dr. Connor and those acquired/the test interpretation/opinions reached by Dr. Ziegler.

However, there were some notable issues found, among them:

1. Working memory that involved distraction (of 36 seconds duration) was impaired at – 1 Standard deviation or more (a "mild impairment"), putting Dr. Beier at -1.3 standard

deviations, which is the 9th percentile. This reflects that as the multitasking load increases, Dr. Beier has significantly greater difficulties,

2. On the Gudjonsson Suggestibility Scales - 2 (GSS-2), there was a problem with story recall (mildly impaired range at 12th and 13th percentiles), and also a problem with "shift" (9th percentile) which is consistent with Dr. Beier's self-report of being gullible, easily swayed by others. Dr. Connor pointed out that Dr. Beier's performance on a different but similar test (Story Recall), when assessed by Dr. Ziegler, was within the average range. The difference between the two tests could be an issue of the load of information that the examinee is asked to take in. The Gudjonsson story has much more information to recall than did the one used by Dr. Ziegler. This suggests that troubles become more prominent when Dr. Beier is pressed and overloaded.
3. Dr. Beier on the GSS-2 also demonstrated an increase in both "fabrications" (adding content not actually in the story) and "distortions" (recalling information that was in the story, but reporting it with some inaccuracy(ies)),
4. Related to this was a "mild" impairment" (9th percentile) on a test of social perception related to auditory skills, particularly the ability to detect mismatch between the literal and implied meaning of language,
5. Dr. Beier's most significant area of impairment (within the moderately impaired range at the 5th percentile), was on an executive functioning/problem-solving test (i.e., DKEFS Tower Test), which is time-sensitive.

Dr. Connor did not feel that the findings were what would be expected in a typical cortical dementia. Neither did he feel that the findings were consistent with a "subcortical" dementing process.

Dr. Connor took special note of the recurrent episodes of traumatic brain injury (which included episodes of loss of consciousness) and felt that the neuropsychological findings suggest this is the cause that is most likely. Below is a graphic representation of the testing results with the vertical scale on the left reflecting scores in terms of standard deviations. The average person would be expected to score at the "0" mark (shown in solid green), but given Dr. Beier's present tested IQ, his results would be expected to fall at the dotted line (also in green) that is slightly above it. Consistent with the results discussed in the preceding paragraphs, Dr. Beier's results are variable, but reveal a "patchy" distribution of areas of poor performance.

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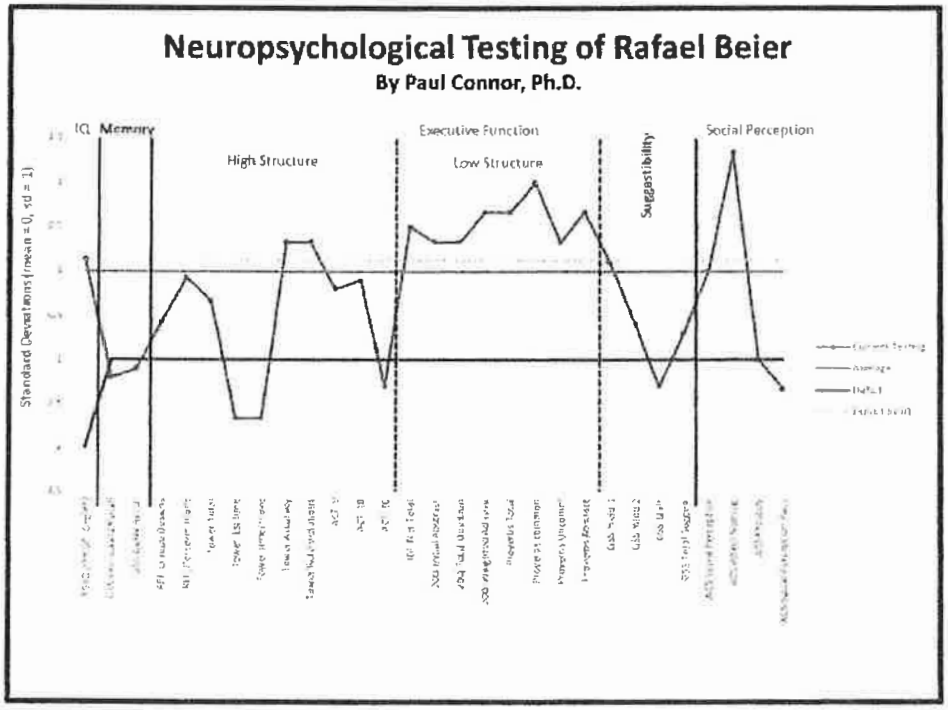

Figure 2. Neuropsychological test results obtained by Paul Connor, Ph.D.

NEURORADIOLOGICAL TESTING, UNIVERSITY OF WASHINGTON MEDICAL CENTER, NOVEMBER 16, 2016:

Given the concerns regarding Dr. Beier's history of head trauma and his abnormal neuropsychological test results, a Magnetic Resonance Image of his brain (along with a Diffusion Tensor Image - DTI) of the brain were ordered.

Such testing, particularly when quantified, can demonstrate brain damage which might assist in understanding the nature and extent of Dr. Beier's documented cognitive impairments (as described by neuropsychologists Elizabeth Ziegler, Ph.D. and Paul D. Connor, Ph.D.).
The scan, read clinically, was interpreted to generally reflect a normal study. The DTI was reported to be "grossly normal." Ventricular sizes were found to be within normal limits for age. However, the quantified volume of the hippocampus (right and left sides aggregated) was reported to be at the lowest 6th percentage for age, "at the lower limits of normal for age."

A (limited) NeuroQuant® General Morphometry Report was provided. Not mentioned in the actual report, was an Asymmetry Index (the difference between the right and left volumes divided by their mean) in excess of 10% at the: (1) Lateral Ventricle, (2) Inferior Lateral Ventricle, and (3) Hippocampus.

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NEUROQUANT® ANALYSIS OF BRAIN MAGNETIC RESONANCE IMAGE (MRI):

NeuroQuant® reports findings in terms of Z-scores.[6] A z-score can be calculated from the following formula: $z = (X - \mu) / \sigma$, where z is the z-score, X is the value of the element, μ is the population mean, and σ is the standard deviation. www.stattrek.com, accessed January 15, 2015.

The quantification method used by The University of Washington reported a combined value for the right and left side.

The NeuroQuant analysis presented below provides measurements for the both the right and left sides. A z-score of + or – 1.65 is considered clinically significant. However, in the table below, selected values are included that may not reach that same level of abnormality, but are notable and reported nonetheless.

To assist in understanding the anatomical location of the named structures, please refer to the figures below:

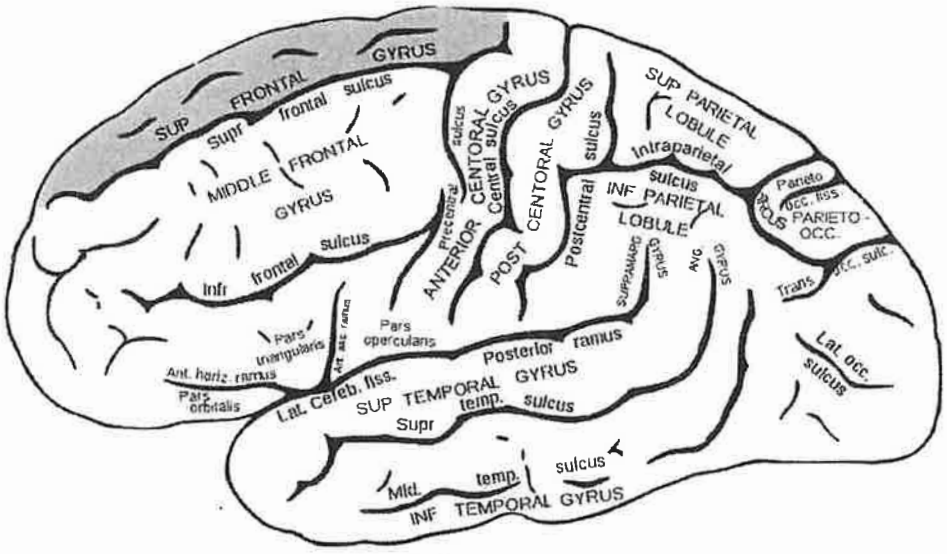

Figure 3. Lateral view of the human brain
Anterior aspect (i.e., front) is to the left
The Superior Frontal Gyrus is highlighted in Yellow

[6] A z-score can be calculated from the following formula: $z = (X - \mu) / \sigma$, where z is the z-score, X is the value of the element, μ is the population mean, and σ is the standard deviation. www.stattrek.com, accessed January 15, 2015.

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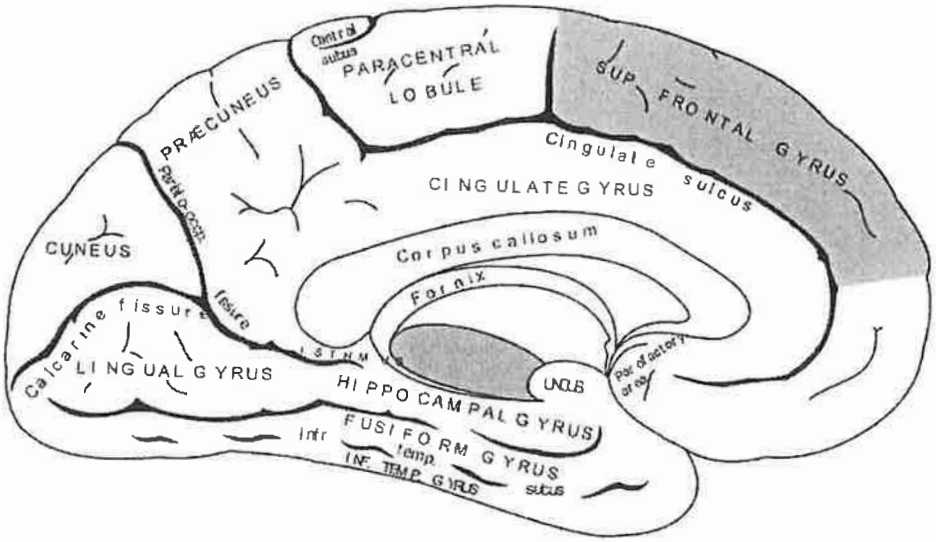

Figure 4. Medial (i.e., inside) view of the human brain
Anterior aspect (i.e., front) is to the right
The Superior Frontal Gyrus is highlighted in Yellow

Among the notable findings:

1. Total cerebral gray matter was reduced at around Z of – 1.0 bilaterally (16th percentile),
2. There is a marked difference between the statistically large right amygdala and the average left-sided amygdala,
3. This same trend is present at the anatomically adjacent structure, the hippocampus, which is above average on the right side, and decreased on the left,
4. There is a statistically prominent decrease in volume of the left superior frontal gyrus, and to a lesser extent a decrease in the volume of the right superior frontal gyrus,
5. There is a statistically prominent decrease in volume of the right anterior frontal gyrus, and to a lesser extent a decrease in the volume of the left anterior frontal gyrus,
6. There are trends related to decreased volume of the inferior parietal lobes bilaterally,
7. There is a statistical decrease in the volume of the right supramarginal parietal gyrus,
8. There is a statistical decrease in the volume of the left inferior temporal gyrus. The right side of this structure is greater than the mean,
9. A (limited) NeuroQuant® General Morphometry Report was performed by CorTechs Labs. An Asymmetry Index (the difference between the right and left volumes divided by their mean) in excess of 10% at the: (1) Inferior Lateral Ventricle, (2) Amygdala, (3) Caudate and (4) Thalamus.

AREA	LEFT	RIGHT
Total Cerebral Gray Matter	- 1.04	- 0.99
Hippocampus	- 0.74	0.44
Amygdala	- 0.03	>1.65
SUPERIOR FRONTAL GYRUS	**< - 1.65**	- 0.99
ANTERIOR MIDDLE FRONTAL GYRUS	- 1.23	**< - 1.65**
Inferior Parietal	- 0.92	- 1.18
SUPRAMARGINAL PARIETAL GYRUS	- 0.64	**- 1.64**
INFERIOR TEMPORAL GYRUS	**- 1.64**	0.47

Table 1. NeuroQuant® results
Values are show as Z-scores
Results of special note are shown bolded in red

The function of the superior frontal gyrus, and its relevance to this matter, is addressed in the "Discussion" section.

POSITRON EMISSION TOMOGRAPHY (PET):

Brain PET was conducted on November 17, 2016 at the University of Washington Medical Center. The clinical reading was unremarkable.

Dr. Newberg concluded that the PET scan was of "reasonably good quality," permitting further analysis.

Dr. Newberg stated in a summary: "Overall, the findings demonstrate several areas of increased and decreased metabolic activity. *These findings do not represent a clear diagnostic pattern (e.g. frontotemporal dementia or Alzheimer's disease) and thus may represent changes associated with traumatic brain injury, especially if there were more than one* [episode of trauma]. The reason for such a diagnosis is that each head injury can result in distinct effects on brain function and hence result in a variety of apparently unrelated metabolic findings. Areas of decreased metabolism can be associated with regions that have experienced damage or dysfunction related to the trauma either directly or by distant effects." (Italics added for emphasis).

STRUCTURE	LEFT Z-SCORE	RIGHT Z-SCORE	LEFT – RIGHT DIFFERENCE Z-SCORE
Hippocampus	-1.3	-0.30	**-1.0**
Middle Frontal Gyrus	0.30	-0.70	**1.5**
Inferior Frontal Gyrus	0.2	-0.40	**1.0**
Anterior Cingulate Gyrus	1.0	0.50	**1.2**
Inferior Temporal Gyrus	2.4	0.50	**1.3**
Fusiform Temporal Gyrus	-0.40	-2.0	**1.8**

Table 2. PET Scan results
Values are show as Z-scores
Results of special note are shown bolded in red

He explained: "Hypometabolism in the limbic regions can be associated with abnormal emotional responses or memory functions. Patients with such abnormalities can have heightened emotions such as excessive anger or impulsive behaviors, or reduced emotions such as depression. In addition, hypometabolism in the hippocampus in particular has been associated with an increased likelihood of developing Alzheimer's disease and/or *chronic traumatic encephalopathy*." (Italics added for emphasis).

Alternately, "Hypermetabolism [as is also seen here] could be associated with problems with concentration or executive functions such as rapid processing of information or complex problem solving."

As a clinician, Dr. Newberg has typically used 1 SD as meaningful, and he has done so in forensic cases as well. He pointed out that 'most research shows a natural variability of approximately 8-10% in any given region and thus, values that are more than that (i.e. more than 1SD) are considered to be significant in the literature.' In addition, he stated: "sometimes subtle changes, especially if there are a number of them, can be clinically important." He felt that using +/- 1 SD was appropriate given the overall findings in this case.

OPINION/DISCUSSION:

"A defendant is competent to stand trial and be sentenced if he has both a "sufficient present ability to consult with his lawyer with a reasonable degree of rational understanding and a rational as well as factual understanding of the proceedings against him." *United States v. Fernandez*, 388 F.3d 1199, 1251 (9th Cir.2004)."

At sentencing, "the test [of competency] is whether the defendant is able to understand the nature of the proceedings and participate intelligently to the extent participation is called for." *Chavez,* 656 F.2d at 518 (9th Cir.1981). The ability to allocute, in short, is an essential element of this participation."

As this relates to forensic psychiatric issues of the present matter, the case of *Dryer* appears very informative.

Dr. Dryer like Dr. Beier, had no significant criminal history. Dr. Dryer plead guilty to Conspiracy to Distribute Controlled Substances (i.e., Opiates). Between the Guilt and Sentencing Phases of his trial he was diagnosed with Frontotemporal Dementia, an illness that causes changes in personality and behavior, impairing social interactions, causing disinhibition and a loss of insight (i.e. self-understanding) and impulse control.

Dryer's Counsel explained to the Court that his client, would not allocate because he might "speak inappropriately," "make denials," or "not accept responsibility." Like Dr. Beier, Dr. Dryer's mental state had been a matter of concern among family members for some time (i.e., while he was practicing medicine), but had not been diagnosed. In retrospect however, the onset of Dr. Dryer's dementia was estimated to have occurred ten (10) years prior.

Dr. Dryer's situation was notably similar to the instant case here, in that Dr. Dryer had difficulty recognizing or admitting that his actions were inconsistent with professional standards of conduct.

Dr. Beier's situation differed from that of Dr. Dryer, in that Dr. Dryer was nonetheless able to avail himself of a plea agreement in which he admitted guilt to just two (2) counts of the thirty-count (30) indictment against him.

It was opined by one or more evaluators that "any distortions [i.e., misstatements] were the result of Dr. Dryer's faulty judgment, insight and recall, rather than intentional misrepresentation." Furthermore, it was opined that Dr. Dryer's "moral compass was effectively compromised by brain damage over which he had impaired control." Additionally, Dr. Dryer's dementia was said to have prevented him from accurately critiquing or monitoring his own behavior and from foreseeing its consequences.

In *Dryer*, the appellate court referred specifically to: "...the consistency between counsel's statements and the supporting expert reports..." noting that this provided the District Court "substantial evidence" regarding possible deficits in "Dreyer's ability to assist in his own defense."

In 1996, Dr. Beier suffered head trauma (i.e., traumatic brain injury), including an extended period of loss of consciousness, during a motor vehicle accident. After this, it was noted that his personality seemed different. There were additional episodes of head trauma reported, and also a greater negative impact on his mental functioning, such as cognitive inflexibility and illogicality, as time progressed.

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In 2013, the American Psychiatric Association published the fifth edition of its Diagnostic and Statistical Manual (DSM – 5), which classifies Dr. Beier's traumatic brain injuries and their sequelae as Mild Neurocognitive Disorder Due to Traumatic Brain Injury (DSM-5 Code 331.83, ICD Code G31.84 at page 624).

The diagnostic criteria for a Mild Neurocognitive Disorder are:

A. Evidence of modest cognitive decline from a previous level of performance in one or more cognitive domains (complex attention, executive function, learning and memory, language, perceptual-motor, or social cognition) (modest" cognitive decline is defined in the DSM-5 as performance on standardized cognitive tests equivalent to Z = -1 to -2 (i.e., between the 3rd-16th percentile)) based on:

1. Concern of the individual, a knowledgeable informant, or the clinician that there has been a significant decline in cognitive function; and
2. A substantial impairment in cognitive performance, preferably documented by standardized neuropsychological testing or, in its absence, another quantified clinical assessment.
3. The cognitive deficits do not interfere with independence in everyday activities (but greater effort, compensatory strategies, or accommodation may be required).
4. The cognitive deficits do not occur exclusively in the context of a delirium.
5. The cognitive deficits are not better explained by another mental disorder (e.g., major depressive disorder, schizophrenia).

More specifically, Major or Mild Neurocognitive Disorder Due to Traumatic Brain Injury (mNCD-TBI) has the following diagnostic criteria:

A. The criteria are met for major or minor neurocognitive disorder.
B. There is evidence of a traumatic brain injury – that is, an impact to the head or other mechanisms of rapid movement or displacement of the brain within the skull, with one or more of the following:
    1. Loss of consciousness.
    2. Posttraumatic amnesia.
    3. Disorientation and confusion.
    4. Neurological signs (e.g., neuroimaging demonstrating injury; a new onset of seizures; a marked worsening of a pre-existing seizure disorder; visual field cuts; anosmia; hemiparesis).
C. The neurocognitive disorder presents immediately after the occurrence of the traumatic brain injury or immediately after recovery of consciousness and persists after the post-injury period.

In Dr. Beier's case, the following quote of Sir Charles Symonds (1937) seems apt: "In order to understand the effects of head injury, we must undertake full study of the individual's constitution. In other words, it is not just the kind of injury that matters, but the kind of head that is injured."

As reflected in Dr. Beier's Personality Assessment Inventory results: "he appears somewhat reluctant to recognize minor faults in himself' and has 'an apparent tendency to repress undesirable characteristics..." Dr. Beier's brother, Mr. Phillip Savage spontaneously commented that the examinee is "amazingly resilient." Thus, it is not surprising that Dr. Beier: (1) did not present himself for medical attention after the TBI in 1996, nor did he (2) raise any issue of mental status changes or complaints prior those raised by current counsel. However, it may be the case that the impact of the repeat episodes of head trauma have been particularly deleterious due to: (1) unreported precedent psychiatric illness, (2) unreported precedent substance abuse and/or (3) the cumulative effect of head trauma affected a number of different brain areas.

As noted above, Dr. Beier fully meets the diagnostic criteria for Mild Neurocognitive Disorder Due to Traumatic Brain Injury (mNCD-TBI): (1) he suffered the 1996 motor vehicle accident which was marked by head trauma, (2) his son observed a change in Dr. Beier's cognitive functioning, (3) there is a substantial impairment in cognitive functioning demonstrated in testing done by both Dr. Ziegler and Dr. Connor, (4) the deficits are not better explained by another mental disorder, (5) there was loss of consciousness, (6) there was posttraumatic amnesia for the accident, (7) there is neuroimaging that demonstrates the injury, and, (8) the NCD presented after the injury and persists. This diagnosis of Mild Neurocognitive Disorder due to Traumatic Brain Injury (mNCD-TBI) represents *both* a mental disease and a (neurological) defect.

Cognitive impairments among persons with Neurocognitive Disorder due to Traumatic Brain Injury are most commonly found in the domains of: (1) processing speed, (2) complex attention, (3) declarative memory, (4) executive function, and (5) social cognition. In this case there is an exact match between the "textbook" mNCD-TBI identified problems and those demonstrated on Dr. Beier's neuropsychological testing.

The results of Dr. Beier's neuropsychological testing, MRI volumetric analysis and quantitative PET scan all indicate that he suffered traumatic brain injury not only in 1996, but likely a number of episodes, consistent with the history he provided. The conclusion is based in the widespread, myriad pattern of abnormalities and clinical presentation, which is discrepant from those found in other organic brain disorders, particularly Frontotemporal Dementia (from which Dr. Dryer suffered) or the more commonly known Dementia of the Alzheimer's Type.

The findings of asymmetry, both on the NeuroQuant® and PET analysis are especially compelling. Ross, Ochs, DeSmit and colleagues[7] studied an issue highly relevant to the instant case, and the failure of the clinical facility to identify the abnormalities.

NeuroQuant volumetric analyses were compared with clinical radiologists' ("naked eye") interpretations. NeuroQuant found significantly higher rates of atrophy (50.0%), abnormal asymmetry (83.3%), and progressive atrophy (70.0%) than the radiologists (12.5%, 0% and 0%, respectively). NeuroQuant was more sensitive for detecting at least one sign of atrophy, abnormal asymmetry, or progressive atrophy (95.8%) than the traditional radiologist's approach (12.5%). The results of the study showed that the large majority of the TBI patients had abnormal asymmetry of the brain, and that the radiologists failed to identify any sign of asymmetry.

The researchers noted that it is unlikely that normal aging in adults causes brain asymmetry. The primary effect of aging on brain volume is generalized atrophy, probably because the left side of the brain ages at the same rate as the right. The authors point out, soberly that: "it is true that there is no specific treatment for atrophy in patients with chronic TBI."

Among the areas of the brain shown from the NeuroQuant® to be prominently affected is the Superior Frontal Gyrus (SFG) (left side, and right side also). See Figure 3, Figure 4 and Table 1 above.

The SFG, and the adjacent Anterior Cingulate Cortex, are structures markedly important for Cognitive Emotional Control, including what is termed "error monitoring" and "cognitive flexibility."

Performance on the Trail Making Test – B (done in this evaluation), is considered a prime reflection of "cognitive flexibility." As shown in Figure 1, Dr. Beier obtained his lowest score on the Ziegler exam on "Trails – B." It was 1.5 standard deviations below the norm.

One of the important functions of the brain associated with the frontal cortex is "metacognitive evaluations of oneself and others." What this means is having perspective on the basis, rationale, and/or motivation of your own behavior and other persons' behavior. It appears that this is precisely what Dr. Beier can no longer do properly.

As for the SFG, damage to this structure produces: "inhibition deficits, [problems with] immediate memory recall and processing speed deficits, as well as lower fluid intelligence scores..." These are all demonstrated on his neuropsychological testing results. His present Full Scale IQ of 102 (essentially average) is considerably below what would be expected of a typical medical practitioner, and is a likely sad reflection of the loss in mental faculties.

[7] Ross DE, Ochs AL, DeSmit ME, et al. Man Versus Machine Part 2 Comparison of Radiologists' Interpretations and NeuroQuant Measures of Brain Asymmetry and Progressive Atrophy in Patients With Traumatic Brain Injury. J Neuropsychiatry Clin Neurosci 27:147–152, 2015.

Returning to the focal issue, Competency to Stand Trial and the necessary elements ("sufficient present ability to consult with his lawyer with a reasonable degree of rational understanding and a rational as well as factual understanding of the proceedings against him"):

1. The collateral interview of prior counsel Mr. Jim Siebe, established that counsel had concerns about Dr. Beier's mental status during the representation of the Defendant. Mr. Siebe knew something was wrong, and considered whether Dr. Beier was "manic" and/or was taking illicit drugs. Dr. Beier frequently went on verbal "tangents," to such an extent that Counsel felt that there had never been a "genuine, thorough discussion" of the case with his client.
2. I asked Mr. Siebe if he had entertained whether Dr. Beier was lacking Competence to Stand Trial. He replied: "I may have made a big mistake in that respect." Noting that he has referred clients for Competency evaluations in the past, Mr. Siebe stated that Dr. Beier's "status [as a physician] dissuaded me from [taking] that approach."
3. Mr. Siebe noted that Dr. Beier was 'denying the obvious...not accepting logical deductions.' Mr. Siebe could not follow Dr. Beier's line of reasoning. During the trial itself, Mr. Siebe said that his client was "interrupting me throughout..." and indicated that very often he was unable to understand material presented. When Dr. Beier took the stand, his testimony was "inconsistent with what he told me [in the office] previously." He described Dr. Beier as mentally "checked out... he didn't respond to me... like he did in the office."
4. Dr. Beier rejected a favorable plea agreement, insisting: "I can't plead guilty if I'm not guilty."

The above information gives compelling evidence that Dr. Beier at trial did not possess the capacities to consult with his lawyer with a reasonable degree of rational understanding and a rational as well as factual understanding of the proceedings against him. Quite clearly, he neither actually assisted counsel in a meaningful way, nor did he demonstrate either a rational or factual understanding of the proceedings against him.

Dr. Beier's underlying mental disease and defect, namely, Mild Neurocognitive Disorder due to Traumatic Brain Injury, persists. Mr. Hormel stated: "[I]t is my belief that he is unable to assist me in his defense at sentencing... I have observed and experienced an inability of Dr. Beier to rationally process (absorb) the real historical facts relating to the circumstances leading to his charges.... I detected an acute inability to rationalize and process facts that are obvious in his case...This concern was enhanced when I compared Dr. Beier's testimony in relation to the facts presented by the government at trial." At the present state of the case, Mr. Hormel believes that Dr. Beier cannot properly discuss with him "the facts of his case and to develop what to say in exercising his right of allocution at the sentencing hearing."

Mr. Hormel's observations are essentially identical to those of Mr. Siebe.

Richard S. Adler, M.D.
Forensic Psychiatric Evaluation
In re: Rafael Beier
January 19, 2017

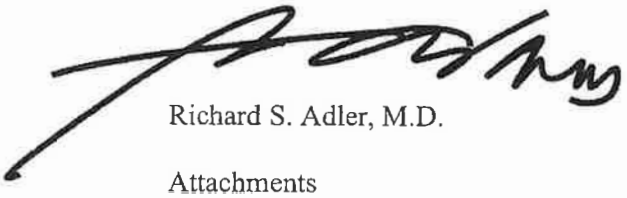
Despite Dr. Beier's meetings with counsel, and the examination by Dr. Ziegler, his present rational and factual understanding of the proceedings, (including the evidence, etc. against him), are significantly and meaningfully impaired. By virtue of his Mild Neurocognitive Disorder due to Traumatic Brain Injury, he continues to maintain a perspective on his case that departs from the "plain facts," and his thinking is so separated from reality, that it warrants being described as "psychotic" as well as "delusional." As a result, his interaction with counsel fails to meet the meaning of the words "consult" or "assist." Thus, it is my opinion with reasonable medical certainty that Dr. Beier does not have the capacities consistent with Competency to be Sentenced. In particular, the similarities to the case of Dr. Dryer are notable here. Dr. Beier, as a direct result of Mild Neurocognitive Disorder due to Traumatic Brain Injury (and delusional, psychotic thinking and poor insight) would have problems allocuting. Despite being found guilty, his rigid and non-reality based thinking have a reasonably likelihood of causing him to "speak inappropriately," "make denials," and/or "not accept responsibility."

Counsel furthermore asked me whether "reduced mental capacity affected Dr. Beier's ability to form the intent to commit the crimes charged against him, or whether it affected his ability to distinguish right from wrong." Dr. Beier has Mild Neurocognitive Disorder Due to Traumatic Brain Injury. He has demonstrated damage to the frontal cortex, a structure essential for proper perspective on the basis, rationale, and/or motivation of his own behavior and other persons' behavior. This is the exact deficit his son Branden Beier detected. The case facts reflect that this is precisely what Dr. Beier failed to do and continues to be unable to do. In the jargon of Neuropsychiatry, he cannot make metacognitive evaluations of oneself and others. More specifically, damage to the SFG likely adds inhibition deficits so that he is more likely to act on impulse. There appears to be a direct connection between these cognitive impairments and his ability to form the intent and understand right from wrong associated with the subject crimes.

With regard to the ability of Dr. Beier to be restored, it is appropriate to echo the comment of Dr. Ross et al, in that: "there is no specific treatment for atrophy in patients with chronic TBI." I do not believe that Herculean efforts to restore Dr. Beier's legal competencies outweigh the risks of compelled medication such as antipsychotics.

I hope that I have answered the medico-legal questions in a complete and readily understandable fashion. If you have questions or concerns, please do not hesitate to contact me.

Respectfully submitted,



Richard S. Adler, M.D.

Attachments

Richard S. Adler, M.D.
Forensic Psychiatric Evaluation
In re: Rafael Beier
January 19, 2017

Paul D. Connor, Ph.D. Neuropsychological Assessment Services
SUMMARY SCORES

Name:	**Rafael Beier**
Test Date:	11/30/2016
Birthdate:	12/1/1953
Age:	62
Education:	20+

WECHSLER ADULT INTELLIGENCE SCALE – FOURTH EDITION (WAIS-IV):

Full Scale IQ	102

RUFF'S FIGURAL FLUENCY: (mean=50, sd=10)

	T-Score	Percentile
Total Unique Designs	44.3	28.1
Perseverations	50.7	52.8

CONSONANT TRIGRAMS: (mean=50, sd=10)

	T-Score	Percentile
9 Second Delay Trials	48	42
18 Second Delay Trials	49	45
36 Second Delay Trials	37	9

DELIS-KAPLAN EXECUTIVE FUNCTION SYSTEM: (mean=10, sd=3)

	Standard Score	Percentile
Twenty Questions		
Initial Abstraction	11	63
Total Questions	11	63
Weighted Achievement	12	75
Tower Test		
Total Achievement	9	37
First Move Time	5	5
Time per Move	5	5
Move Accuracy	11	63
Total Rule Violations	11	63
Proverbs Test		
Total Achievement	12	75
Common Proverb Achievement	13	84

Uncommon Proverb Ach.	11	63
Accuracy Score	12	75
Abstraction Score	12	75

IOWA GAMBLING TEST: (mean=50, sd=10)

	T-	Percentil
Net Total	55	69
Net 1	43	24
Net 2	57	76
Net 3	51	54
Net 4	53	62
Net 5	56	73

ACS: SOCIAL COGNITION: (mean=10, sd=3)

	Scaled	Percentil
Social Perception	10	50
Affect Naming	14	91
Prosody	7	16
Social Perception Pairs	6	9

GUDJONSSON SUGGESTIBILITY SCALE 2: (mean=50, sd=10)

	Scaled	Percentil
Immediate Recall	38	12
Delayed Recall	39	13
Yield 1	51	53
Yield 2	44	27
Shift	37	9
Total Suggestibility	43	23

ADVANCED CLINICAL SOLUTIONS – EFFORT ASSESSMENT SCORE:

	Raw Score
Word Choice	50/50

THE DOT COUNTING TEST:

Score
E-Score 11

DIAGNOSTIC AND STATISTICAL MANUAL OF MENTAL DISORDERS

FIFTH EDITION

DSM-5™

AMERICAN PSYCHIATRIC ASSOCIATION

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Other Specified Delirium

780.09 (R41.0)

This category applies to presentations in which symptoms characteristic of delirium that cause clinically significant distress or impairment in social, occupational, or other important areas of functioning predominate but do not meet the full criteria for delirium or any of the disorders in the neurocognitive disorders diagnostic class. The other specified delirium category is used in situations in which the clinician chooses to communicate the specific reason that the presentation does not meet the criteria for delirium or any specific neurocognitive disorder. This is done by recording "other specified delirium" followed by the specific reason (e.g., "attenuated delirium syndrome").

An example of a presentation that can be specified using the "other specified" designation is the following:

Attenuated delirium syndrome: This syndrome applies in cases of delirium in which the severity of cognitive impairment falls short of that required for the diagnosis, or in which some, but not all, diagnostic criteria for delirium are met.

Unspecified Delirium

780.09 (R41.0)

This category applies to presentations in which symptoms characteristic of delirium that cause clinically significant distress or impairment in social, occupational, or other important areas of functioning predominate but do not meet the full criteria for delirium or any of the disorders in the neurocognitive disorders diagnostic class. The unspecified delirium category is used in situations in which the clinician chooses *not* to specify the reason that the criteria are not met for delirium, and includes presentations for which there is insufficient information to make a more specific diagnosis (e.g., in emergency room settings).

Major and Mild Neurocognitive Disorders

Major Neurocognitive Disorder

Diagnostic Criteria

A. Evidence of significant cognitive decline from a previous level of performance in one or more cognitive domains (complex attention, executive function, learning and memory, language, perceptual-motor, or social cognition) based on:

1. Concern of the individual, a knowledgeable informant, or the clinician that there has been a significant decline in cognitive function; and
2. A substantial impairment in cognitive performance, preferably documented by standardized neuropsychological testing or, in its absence, another quantified clinical assessment.

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

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

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

Specify whether due to:

Alzheimer's disease (pp. 611–614)
Frontotemporal lobar degeneration (pp. 614–618)
Lewy body disease (pp. 618–621)
Vascular disease (pp. 621–624)
Traumatic brain injury (pp. 624–627)
Substance/medication use (pp. 627–632)
HIV infection (pp. 632–634)
Prion disease (pp. 634–636)
Parkinson's disease (pp. 636–638)
Huntington's disease (pp. 638–641)
Another medical condition (pp. 641–642)
Multiple etiologies (pp. 642–643)
Unspecified (p. 643)

Coding note: Code based on medical or substance etiology. In some cases, there is need for an additional code for the etiological medical condition, which must immediately precede the diagnostic code for major neurocognitive disorder, as follows:

Etiological subtype	Associated etiological medical code for major neurocognitive disorder[a]	Major neurocognitive disorder code[b]	Mild neurocognitive disorder code[c]
Alzheimer's disease	Probable: 331.0 (G30.9) Possible: no additional medical code	Probable: 294.1x (F02.8x) Possible: 331.9 (G31.9)[c]	331.83 (G31.84) (Do not use additional code for Alzheimer's disease.)
Frontotemporal lobar degeneration	Probable: 331.19 (G31.09) Possible: no additional medical code	Probable: 294.1x (F02.8x) Possible: 331.9 (G31.9)[c]	331.83 (G31.84) (Do not use additional code for frontotemporal disease.)
Lewy body disease	Probable: 331.82 (G31.83) Possible: no additional medical code	Probable: 294.1x (F02.8x) Possible: 331.9 (G31.9)[c]	331.83 (G31.84) (Do not use additional code for Lewy body disease.)
Vascular disease	No additional medical code	Probable: 290.40 (F01.5x) Possible: 331.9 (G31.9)[c]	331.83 (G31.84) (Do not use additional code for the vascular disease.)
Traumatic brain injury	907.0 (S06.2X9S)	294.1x (F02.8x)	331.83 (G31.84) (Do not use additional code for the traumatic brain injury.)
Substance/ medication-Induced	No additional medical code	Code based on the type of substance causing the major neurocognitive disorder[c, d]	Code based on the type of substance causing the mild neurocognitive disorder[d]

Etiological subtype	Associated etiological medical code for major neurocognitive disorder[a]	Major neurocognitive disorder code[b]	Mild neurocognitive disorder code[c]
HIV infection	042 (B20)	294.1x (F02.8x)	331.83 (G31.84) (Do not use additional code for HIV infection.)
Prion disease	046.79 (A81.9)	294.1x (F02.8x)	331.83 (G31.84) (Do not use additional code for prion disease.)
Parkinson's disease	Probable: 332.0 (G20) Possible: No additional medical code	Probable: 294.1x (F02.8x) Possible: 331.9 (G31.9)[c]	331.83 (G31.84) (Do not use additional code for Parkinson's disease.)
Huntington's disease	333.4 (G10)	294.1x (F02.8x)	331.83 (G31.84) (Do not use additional code for Huntington's disease.)
Due to another medical condition	Code the other medical condition first (e.g., 340 [G35] multiple sclerosis)	294.1x (F02.8x)	331.83 (G31.84) (Do not use additional codes for the presumed etiological medical conditions.)
Due to multiple etiologies	Code all of the etiological medical conditions first (with the exception of vascular disease)	294.1x (F02.8x) (Plus the code for the relevant substance/medication-induced major neurocognitive disorders if substances or medications play a role in the etiology.)	331.83 (G31.84) (Plus the code for the relevant substance/medication-induced mild neurocognitive disorders if substances or medications play a role in the etiology. Do not use additional codes for the presumed etiological medical conditions.)
Unspecified neurocognitive disorder	No additional medical code	799.59 (R41.9)	799.59 (R41.9)

[a]Code first, before code for major neurocognitive disorder.
[b]Code fifth character based on symptom specifier: .x0 without behavioral disturbance; .x1 with behavioral disturbance (e.g., psychotic symptoms, mood disturbance, agitation, apathy, or other behavioral symptoms).
[c]Note: Behavioral disturbance specifier cannot be coded but should still be indicated in writing.
[d]See "Substance/Medication-Induced Major or Mild Neurocognitive Disorder."

Specify:

Without behavioral disturbance: If the cognitive disturbance is not accompanied by any clinically significant behavioral disturbance.

With behavioral disturbance *(specify disturbance):* If the cognitive disturbance is accompanied by a clinically significant behavioral disturbance (e.g., psychotic symptoms, mood disturbance, agitation, apathy, or other behavioral symptoms).

Specify current severity:

Mild: Difficulties with instrumental activities of daily living (e.g., housework, managing money).

Moderate: Difficulties with basic activities of daily living (e.g., feeding, dressing).

Severe: Fully dependent.

Mild Neurocognitive Disorder

Diagnostic Criteria

A. Evidence of modest cognitive decline from a previous level of performance in one or more cognitive domains (complex attention, executive function, learning and memory, language, perceptual motor, or social cognition) based on:
   1. Concern of the individual, a knowledgeable informant, or the clinician that there has been a mild decline in cognitive function; and
   2. A modest impairment in cognitive performance, preferably documented by standardized neuropsychological testing or, in its absence, another quantified clinical assessment.

B. The cognitive deficits do not interfere with capacity for independence in everyday activities (i.e., complex instrumental activities of daily living such as paying bills or managing medications are preserved, but greater effort, compensatory strategies, or accommodation may be required).

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

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

Specify whether due to:

Alzheimer's disease (pp. 611–614)
Frontotemporal lobar degeneration (pp. 614–618)
Lewy body disease (pp. 618–621)
Vascular disease (pp. 621–624)
Traumatic brain injury (pp. 624–627)
Substance/medication use (pp. 627–632)
HIV infection (pp. 632–634)
Prion disease (pp. 634–636)
Parkinson's disease (pp. 636–638)
Huntington's disease (pp. 638–641)
Another medical condition (pp. 641–642)
Multiple etiologies (pp. 642–643)
Unspecified (p. 643)

Coding note: For mild neurocognitive disorder due to any of the medical etiologies listed above, code **331.83 (G31.84).** Do *not* use additional codes for the presumed etiological medical conditions. For substance/medication-induced mild neurocognitive disorder, code based on type of substance; see "Substance/Medication-Induced Major or Mild Neurocognitive Disorder." For unspecified mild neurocognitive disorder, code **799.59 (R41.9).**

Specify:

Without behavioral disturbance: If the cognitive disturbance is not accompanied by any clinically significant behavioral disturbance.

With behavioral disturbance *(specify disturbance):* If the cognitive disturbance is accompanied by a clinically significant behavioral disturbance (e.g., psychotic symptoms, mood disturbance, agitation, apathy, or other behavioral symptoms).

Subtypes

Major and mild neurocognitive disorders (NCDs) are primarily subtyped according to the known or presumed etiological/pathological entity or entities underlying the cognitive decline. These subtypes are distinguished on the basis of a combination of time course, characteristic domains affected, and associated symptoms. For certain etiological subtypes, the diagnosis depends substantially on the presence of a potentially causative entity, such as Parkinson's or Huntington's disease, or a traumatic brain injury or stroke in the appropriate time period. For other etiological subtypes (generally the neurodegenerative diseases like Alzheimer's disease, frontotemporal lobar degeneration, and Lewy body disease), the diagnosis is based primarily on the cognitive, behavioral, and functional symptoms. Typically, the differentiation among these syndromes that lack an independently recognized etiological entity is clearer at the level of major NCD than at the level of mild NCD, but sometimes characteristic symptoms and associated features are present at the mild level as well.

NCDs are frequently managed by clinicians in multiple disciplines. For many subtypes, multidisciplinary international expert groups have developed specialized consensus criteria based on clinicopathological correlation with underlying brain pathology. The subtype criteria here have been harmonized with those expert criteria.

Specifiers

Evidence for distinct behavioral features in NCDs has been recognized, particularly in the areas of psychotic symptoms and depression. Psychotic features are common in many NCDs, particularly at the mild-to-moderate stage of major NCDs due to Alzheimer's disease, Lewy body disease, and frontotemporal lobar degeneration. Paranoia and other delusions are common features, and often a persecutory theme may be a prominent aspect of delusional ideation. In contrast to psychotic disorders with onset in earlier life (e.g., schizophrenia), disorganized speech and disorganized behavior are not characteristic of psychosis in NCDs. Hallucinations may occur in any modality, although visual hallucinations are more common in NCDs than in depressive, bipolar, or psychotic disorders.

Mood disturbances, including depression, anxiety, and elation, may occur. Depression is common early in the course (including at the mild NCD level) of NCD due to Alzheimer's disease and Parkinson's disease, while elation may occur more commonly in frontotemporal lobar degeneration. When a full affective syndrome meeting diagnostic criteria for a depressive or bipolar disorder is present, that diagnosis should be coded as well. Mood symptoms are increasingly recognized to be a significant feature in the earliest stages of mild NCDs such that clinical recognition and intervention may be important.

Agitation is common in a wide variety of NCDs, particularly in major NCD of moderate to severe severity, and often occurs in the setting of confusion or frustration. It may arise as combative behaviors, particularly in the context of resisting caregiving duties such as bathing and dressing. Agitation is characterized as disruptive motor or vocal activity and tends to occur with advanced stages of cognitive impairment across all of the NCDs.

Individuals with NCD can present with a wide variety of behavioral symptoms that are the focus of treatment. Sleep disturbance is a common symptom that can create a need for clinical attention and may include symptoms of insomnia, hypersomnia, and circadian rhythm disturbances.

Apathy is common in mild and mild major NCD. It is observed particularly in NCD due to Alzheimer's disease and may be a prominent feature of NCD due to frontotemporal lobar degeneration. Apathy is typically characterized by diminished motivation and reduced goal-directed behavior accompanied by decreased emotional responsiveness. Symptoms of apathy may manifest early in the course of NCDs when a loss of motivation to pursue daily activities or hobbies may be observed.

Other important behavioral symptoms include wandering, disinhibition, hyperphagia, and hoarding. Some of these symptoms are characteristic of specific disorders, as discussed in the relevant sections. When more than one behavioral disturbance is observed, each type should be noted in writing with the specifier "with behavioral symptoms."

Diagnostic Features

Major and mild NCDs exist on a spectrum of cognitive and functional impairment. Major NCD corresponds to the condition referred to in DSM-IV as *dementia*, retained as an alternative in this volume. The core feature of NCDs is acquired cognitive decline in one or more cognitive domains (Criterion A) based on both 1) a concern about cognition on the part of the individual, a knowledgeable informant, or the clinician, and 2) performance on an objective assessment that falls below the expected level or that has been observed to decline over time. Both a concern and objective evidence are required because they are complementary. When there is an exclusive focus on objective testing, a disorder may go undiagnosed in high-functioning individuals whose currently "normal" performance actually represents a substantial decline in abilities, or an illness may be incorrectly diagnosed in individuals whose currently "low" performance does not represent a change from their own baseline or is a result of extraneous factors like test conditions or a passing illness. Alternatively, excessive focus on subjective symptoms may fail to diagnose illness in individuals with poor insight, or whose informants deny or fail to notice their symptoms, or it may be overly sensitive in the so-called worried well.

A cognitive concern differs from a complaint in that it may or may not be voiced spontaneously. Rather, it may need to be elicited by careful questioning about specific symptoms that commonly occur in individuals with cognitive deficits (see Table 1 in the introduction to this chapter). For example, memory concerns include difficulty remembering a short grocery list or keeping track of the plot of a television program; executive concerns include difficulty resuming a task when interrupted, organizing tax records, or planning a holiday meal. At the mild NCD level, the individual is likely to describe these tasks as being more difficult or as requiring extra time or effort or compensatory strategies. At the major NCD level, such tasks may only be completed with assistance or may be abandoned altogether. At the mild NCD level, individuals and their families may not notice such symptoms or may view them as normal, particularly in the elderly; thus, careful history taking is of paramount importance. The difficulties must represent changes rather than lifelong patterns: the individual or informant may clarify this issue, or the clinician can infer change from prior experience with the patient or from occupational or other clues. It is also critical to determine that the difficulties are related to cognitive loss rather than to motor or sensory limitations.

Neuropsychological testing, with performance compared with norms appropriate to the patient's age, educational attainment, and cultural background, is part of the standard evaluation of NCDs and is particularly critical in the evaluation of mild NCD. For major NCD, performance is typically 2 or more standard deviations below appropriate norms (3rd percentile or below). For mild NCD, performance typically lies in the 1–2 standard deviation range (between the 3rd and 16th percentiles). However, neuropsychological testing is not available in all settings, and neuropsychological thresholds are sensitive to the specific test(s) and norms employed, as well as to test conditions, sensory limitations, and intercurrent illness. A variety of brief office-based or "bedside" assessments, as described

in Table 1, can also supply objective data in settings where such testing is unavailable or infeasible. In any case, as with cognitive concerns, objective performance must be interpreted in light of the individual's prior performance. Optimally, this information would be available from a prior administration of the same test, but often it must be inferred based on appropriate norms, along with the individual's educational history, occupation, and other factors. Norms are more challenging to interpret in individuals with very high or very low levels of education and in individuals being tested outside their own language or cultural background.

Criterion B relates to the individual's level of independence in everyday functioning. Individuals with major NCD will have impairment of sufficient severity so as to interfere with independence, such that others will have to take over tasks that the individuals were previously able to complete on their own. Individuals with mild NCD will have preserved independence, although there may be subtle interference with function or a report that tasks require more effort or take more time than previously.

The distinction between major and mild NCD is inherently arbitrary, and the disorders exist along a continuum. Precise thresholds are therefore difficult to determine. Careful history taking, observation, and integration with other findings are required, and the implications of diagnosis should be considered when an individual's clinical manifestations lie at a boundary.

Associated Features Supporting Diagnosis

Typically the associated features that support a diagnosis of major or mild NCD will be specific to the etiological subtype (e.g., neuroleptic sensitivity and visual hallucinations in NCD due to Lewy body disease). Diagnostic features specific to each of the subtypes are found in the relevant sections.

Prevalence

The prevalence of NCD varies widely by age and by etiological subtype. Overall prevalence estimates are generally only available for older populations. Among individuals older than 60 years, prevalence increases steeply with age, so prevalence estimates are more accurate for narrow age bands than for broad categories such as "over 65" (where the mean age can vary greatly with the life expectancy of the given population). For those etiological subtypes occurring across the lifespan, prevalence estimates for NCD are likely to be available, if at all, only as the fraction of individuals who develop NCD among those with the relevant condition (e.g., traumatic brain injury, HIV infection).

Overall prevalence estimates for dementia (which is largely congruent with major NCD) are approximately 1%–2% at age 65 years and as high as 30% by age 85 years. The prevalence of mild NCD is very sensitive to the definition of the disorder, particularly in community settings, where evaluations are less detailed. In addition, in contrast with clinical settings, where cognitive concern must be high to seek and locate care, there may be a less clear decline from baseline functioning. Estimates of the prevalence of mild cognitive impairment (which is substantially congruent with mild NCD) among older individuals are fairly variable, ranging from 2% to 10% at age 65 and 5% to 25% by age 85.

Development and Course

The course of NCD varies across etiological subtypes, and this variation can be useful in differential diagnosis. Some subtypes (e.g., those related to traumatic brain injury or stroke) typically begin at a specific time and (at least after initial symptoms related to inflammation or swelling subside) remain static. Others may fluctuate over time (although if this occurs, the possibility of delirium superimposed on NCD should be considered). NCDs due to neurodegenerative diseases like Alzheimer's disease or frontotemporal lobar degeneration typically are marked by insidious onset and gradual progression, and

the pattern of onset of cognitive deficits and associated features helps to distinguish among them.

NCDs with onset in childhood and adolescence may have broad repercussions for social and intellectual development, and in this setting intellectual disability (intellectual developmental disorder) and/or other neurodevelopmental disorders may also be diagnosed to capture the full diagnostic picture and ensure the provision of a broad range of services. In older individuals, NCDs often occur in the setting of medical illnesses, frailty, and sensory loss, which complicate the clinical picture for diagnosis and treatment.

When cognitive loss occurs in youth to midlife, individuals and families are likely to seek care. NCDs are typically easiest to identify at younger ages, although in some settings malingering or other factitious disorders may be a concern. Very late in life, cognitive symptoms may not cause concern or may go unnoticed. In late life, mild NCD must also be distinguished from the more modest deficits associated with "normal aging," although a substantial fraction of what has been ascribed to normal aging likely represents prodromal phases of various NCDs. In addition, it becomes harder to recognize mild NCD with age because of the increasing prevalence of medical illness and sensory deficits. It becomes harder to differentiate among subtypes with age because there are multiple potential sources of neurocognitive decline.

Risk and Prognostic Factors

Risk factors vary not only by etiological subtype but also by age at onset within etiological subtypes. Some subtypes are distributed throughout the lifespan, whereas others occur exclusively or primarily in late life. Even within the NCDs of aging, the relative prevalence varies with age: Alzheimer's disease is uncommon before age 60 years, and the prevalence increases steeply thereafter, while the overall less common frontotemporal lobar degeneration has earlier onset and represents a progressively smaller fraction of NCDs with age.

Genetic and physiological. The strongest risk factor for major and mild NCDs is age, primarily because age increases the risk of neurodegenerative and cerebrovascular disease. Female gender is associated with higher prevalence of dementia overall, and especially Alzheimer's disease, but this difference is largely, if not wholly, attributable to greater longevity in females.

Culture-Related Diagnostic Issues

Individuals' and families' level of awareness and concern about neurocognitive symptoms may vary across ethnic and occupational groups. Neurocognitive symptoms are more likely to be noticed, particularly at the mild level, in individuals who engage in complex occupational, domestic, or recreational activities. In addition, norms for neuropsychological testing tend to be available only for broad populations, and thus they may not be easily applicable to individuals with less than high school education or those being evaluated outside their primary language or culture.

Gender-Related Diagnostic Issues

Like age, culture, and occupation, gender issues may affect the level of concern and awareness of cognitive symptoms. In addition, for late-life NCDs, females are likely to be older, to have more medical comorbidity, and to live alone, which can complicate evaluation and treatment. In addition, there are gender differences in the frequency of some of the etiological subtypes.

Diagnostic Markers

In addition to a careful history, neuropsychological assessments are the key measures for diagnosis of NCDs, particularly at the mild level, where functional changes are minimal

and symptoms more subtle. Ideally, individuals will be referred for formal neuropsychological testing, which will provide a quantitative assessment of all relevant domains and thus help with diagnosis; provide guidance to the family on areas where the individual may require more support; and serve as a benchmark for further decline or response to therapies. When such testing is unavailable or not feasible, the brief assessments in Table 1 can provide insight into each domain. More global brief mental status tests may be helpful but may be insensitive, particularly to modest changes in a single domain or in those with high premorbid abilities, and may be overly sensitive in those with low premorbid abilities.

In distinguishing among etiological subtypes, additional diagnostic markers may come into play, particularly neuroimaging studies such as magnetic resonance imaging scans and positron emission tomography scans. In addition, specific markers may be involved in the assessment of specific subtypes and may become more important as additional research findings accumulate over time, as discussed in the relevant sections.

Functional Consequences of Major and Mild Neurocognitive Disorders

By definition, major and mild NCDs affect functioning, given the central role of cognition in human life. Thus, the criteria for the disorders, and the threshold for differentiating mild from major NCD, are based in part on functional assessment. Within major NCD there is a broad range of functional impairment, as implemented in the severity specifiers. In addition, the specific functions that are compromised can help identify the cognitive domains affected, particularly when neuropsychological testing is not available or is difficult to interpret.

Differential Diagnosis

Normal cognition. The differential diagnosis between normal cognition and mild NCD, as between mild and major NCD, is challenging because the boundaries are inherently arbitrary. Careful history taking and objective assessment are critical to these distinctions. A longitudinal evaluation using quantified assessments may be key in detecting mild NCD.

Delirium. Both mild and major NCD may be difficult to distinguish from a persistent delirium, which can co-occur. Careful assessment of attention and arousal will help to make the distinction.

Major depressive disorder. The distinction between mild NCD and major depressive disorder, which may co-occur with NCD, can also be challenging. Specific patterns of cognitive deficits may be helpful. For example, consistent memory and executive function deficits are typical of Alzheimer's disease, whereas nonspecific or more variable performance is seen in major depression. Alternatively, treatment of the depressive disorder with repeated observation over time may be required to make the diagnosis.

Specific learning disorder and other neurodevelopmental disorders. A careful clarification of the individual's baseline status will help distinguish an NCD from a specific learning disorder or other neurodevelopmental disorders. Additional issues may enter the differential for specific etiological subtypes, as described in the relevant sections.

Comorbidity

NCDs are common in older individuals and thus often co-occur with a wide variety of age-related diseases that may complicate diagnosis or treatment. Most notable of these is delirium, for which NCD increases the risk. In older individuals, a delirium during hospitalization is, in many cases, the first time that an NCD is noticed, although a careful history will often reveal evidence of earlier decline. Mixed NCDs are also common in older individuals, as many etiological entities increase in prevalence with age. In younger individuals, NCD often co-occurs with neurodevelopmental disorders; for example, a head in-

jury in a preschool child may also lead to significant developmental and learning issues. Additional comorbidity of NCD is often related to the etiological subtype, as discussed in the relevant sections.

Major or Mild Neurocognitive Disorder Due to Alzheimer's Disease

Diagnostic Criteria

A. The criteria are met for major or mild neurocognitive disorder.

B. There is insidious onset and gradual progression of impairment in one or more cognitive domains (for major neurocognitive disorder, at least two domains must be impaired).

C. Criteria are met for either probable or possible Alzheimer's disease as follows:

For major neurocognitive disorder:

Probable Alzheimer's disease is diagnosed if either of the following is present; otherwise, **possible Alzheimer's disease** should be diagnosed.

1. Evidence of a causative Alzheimer's disease genetic mutation from family history or genetic testing.
2. All three of the following are present:
   a. Clear evidence of decline in memory and learning and at least one other cognitive domain (based on detailed history or serial neuropsychological testing).
   b. Steadily progressive, gradual decline in cognition, without extended plateaus.
   c. No evidence of mixed etiology (i.e., absence of other neurodegenerative or cerebrovascular disease, or another neurological, mental, or systemic disease or condition likely contributing to cognitive decline).

For mild neurocognitive disorder:

Probable Alzheimer's disease is diagnosed if there is evidence of a causative Alzheimer's disease genetic mutation from either genetic testing or family history.

Possible Alzheimer's disease is diagnosed if there is no evidence of a causative Alzheimer's disease genetic mutation from either genetic testing or family history, and all three of the following are present:

1. Clear evidence of decline in memory and learning.
2. Steadily progressive, gradual decline in cognition, without extended plateaus.
3. No evidence of mixed etiology (i.e., absence of other neurodegenerative or cerebrovascular disease, or another neurological or systemic disease or condition likely contributing to cognitive decline).

D. The disturbance is not better explained by cerebrovascular disease, another neurodegenerative disease, the effects of a substance, or another mental, neurological, or systemic disorder.

Coding note: For probable major neurocognitive disorder due to Alzheimer's disease, with behavioral disturbance, code first **331.0 (G30.9)** Alzheimer's disease, followed by **294.11 (F02.81)** major neurocognitive disorder due to Alzheimer's disease. For probable neurocognitive disorder due to Alzheimer's disease, without behavioral disturbance, code first **331.0 (G30.9)** Alzheimer's disease, followed by **294.10 (F02.80)** major neurocognitive disorder due to Alzheimer's disease, without behavioral disturbance.

For possible major neurocognitive disorder due to Alzheimer's disease, code **331.9 (G31.9)** possible major neurocognitive disorder due to Alzheimer's disease. (**Note:** Do *not* use the additional code for Alzheimer's disease. Behavioral disturbance cannot be coded but should still be indicated in writing.)

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October 31, 2016

Richard S. Adler, M. D.
1700 Seventh Avenue, Suite 210
Seattle, Washington 98101

Re: United States v. Rafael Beier, 2:14-CR-117-EJL

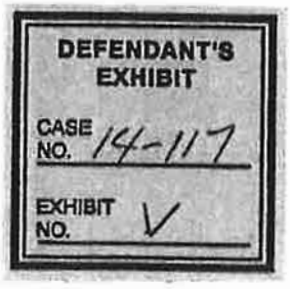
Dear Dr. Alder:

This letter is written at your request. You asked that I detail my observations during my interactions with Dr. Beier. It is my belief that he is unable to assist me in his defense at sentencing. I also believe there was an issue as to whether he could have properly assisted trial counsel in his defense at trial.

In my conversations with Dr. Beier, it is apparent that he understands he was charged and stands convicted of serious federal drug trafficking offenses involving his preparation of pain pill prescriptions. He understands that his convictions will result in imprisonment. He understands who the prosecutor is, who the law enforcement agents are, who the witnesses were, and who the judge is in the criminal proceedings. He also understands the roles of each of the participants in the criminal proceedings. He understands my position as his retained lawyer. He understands who I am and what my function is in relation to his defense.

Primarily, I have observed and experienced an inability on Dr. Beier's rationally process (absorb) the real historical facts relating to the circumstances leading to his charges. It is my opinion that Dr. Beier is mentally impaired to such a degree that it significantly interferes with his ability to assist me by making a completely informed and correct decision in his case. In my experience, I believe this is due to cognitive deficits or defects.

I have been Dr. Beier's trial lawyer since June of this year. After review of Dr. Beier's information and review of the trial transcripts, the government's evidence and discovery, I became concerned that Dr. Beier suffered from some sort of mental deficit(s) that affects his ability to process facts that are different from his own view, and much to his detriment. I detected an acute inability to rationalize and process facts that are obvious in his case, especially



those facts that are beyond dispute and that run to counter view of the case. This concern was enhanced when I compared Dr. Beier's testimony in relation to the facts presented by the government at trial.

This comparison increased my belief that Dr. Beier may suffer from cognitive impairments that interfere with his ability to assist counsel. This has been confirmed through Dr. Ziegler's report of her examination.

It is my belief that Dr. Beier's ability to make a reasoned decision about his case is extremely impaired. For example, you have been provided with documentation that shows that the government's initial offer to resolve his case would have resulted an overwhelmingly favorable outcome had he accepted the offer. He may have avoided prison time altogether, or at most, he would have faced a sentencing guideline range that is 10 percent of the range he now faces after conviction at trial.

It is my opinion, Dr. Beier was incapable of considering that avenue, even in the face of what appears to be overwhelming evidence against him. In other words, I believe he has an impaired mental condition that significantly interfered with his ability to make a rational decision, even when following counsel's advice to accept the offer was undoubtedly in his best interest. This is why I believe that Dr. Beier was likely incompetent at the time of his jury trial to properly assist in his defense.

In addition, I concur with Dr. Ziegler. I do not believe that Dr. Beier presently has the ability to properly assist in his sentencing. I do not believe the Dr. Beier's impaired mental conditions allows him to properly discuss with me the facts of his case and to develop what to say in exercising his right of allocution at the sentencing hearing. In that regard, I concur with Dr. Ziegler and this is due to a rigidity in his thought process caused by a mental impairment.

I have nearly twenty six years of criminal defense. Nineteen of those years were devoted to public defense. The last seven years, I have continued to emphasize criminal defense which accounts for over ninety percent of my private practice. In addition, I worked for sixteen years exclusively representing criminal defendants charged with serious federal offenses as a trial lawyer with the Federal Defenders of Eastern Washington and Idaho. Over seven of those years I was the Chief Trial Attorney, the first-line supervisor of all trial attorneys in the federal defender's office.

I have handled a variety of criminal cases involving mental impairments and competency issues over the years. I believe that I have developed an ability to spot mental issues that should be brought to a court's attention. In my interactions with Dr. Beier, it is my opinion that his rigidity in his thought process is due to an impaired mental condition as opposed to some criminal design. He presents himself as authentic even though his view consistently to strays from real facts.

In addition, Dr. Beier had practiced medicine for over 20 years before his arrest, including his residency. His conduct in this case runs counter to information I have received from family members, from community members and patients of Dr. Beier. This information portray him as a much different person.

For these reasons, I believe Dr. Beier does not possess the mental capacity to assist me properly in his defense. I ask that in your evaluation of Dr. Beier, you determine whether or not Dr. Beier suffers from a mental disease or defect that affects his ability to assist me at sentencing. I also ask that if you conclude Dr. Beier suffers from a mental disease or defect, that you determine whether or not you he was competent at the time of trial to assist trial counsel in his defense.

If you determine that Dr. Beier likely suffered from a mental disease or defect at the time of his trial to a degree that is ability to assist his trial counsel was impaired, I ask that you also determine whether or not Dr. Beier may have suffered from a reduced mental capacity during the course of the events charged in the indictment. If so, I ask that you determine whether or not such reduced mental capacity affected Dr. Beier's ability to form the intent to commit the crimes charged against him, or whether it affected his ability to distinguish right from wrong.

If you need any further information, please contact me, and thank you for your assistance in this matter.

Sincerely,

s/Stephen R. Hormel
Attorney at Law

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UNITED STATES DISTRICT COURT

FOR THE DISTRICT OF IDAHO

RAFAEL LEONHARD BEIER, Petitioner, vs. UNITED STATES OF AMERICA, Respondent.	Criminal No.: 2:14-cr-00117-BLW Civil No.: 2:21-cv-00064-BLW **UNITED STATES' RESPONSE OPPOSING PETITIONER'S 28 U.S.C. § 2255 MOTION**

The United States of America, by and through Rafael M. Gonzalez, Jr., Acting United States Attorney for the District of Idaho, and the undersigned Assistant United States Attorneys, respectfully submit this response and move the Court for an order denying the Petitioner's 28 U.S.C. § 2255 motion and for the denial of a certificate of appealability.

FACTUAL AND PROCEDURAL BACKGROUND

Beier was convicted after a six-day jury trial wherein the United States presented over thirty witnesses.[1] [2] (ECF 103-116.) During trial, the United States proved that Beier distributed large quantities of oxycodone, hydrocodone and Adderall, outside the scope of his professional practice and without a legitimate medical purpose, to adult dancers and others, in exchange for money and even sex. (ECF 131 pp. 161-177; ECF 132 pp. 89-92, 116, 118; ECF 133 pp. 73-78, 104-107, 195-206, 208-227; ECF 135 pp. 67-69) (trial transcripts).) During the trial, Beier testified and adamantly denied any guilt, setting his reputation against the Government's witnesses. (ECF 135 pp. 34-132, 131-32.) Beier absconded at the end of the trial, failing to appear for the jury's verdict, and the District Court issued an arrest warrant. (ECF 113; ECF 137 pp. 14-15.)

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[1] As used throughout:
DKT: Documents filed in this § 2255 proceeding, including the competency hearing transcripts submitted as documents 3-1 and 3-2;
ECF: Documents filed in the underlying criminal case, including the trial transcripts; and
PSR: Presentence Investigation Report filed as ECF 198.

[2] In depth briefing of the factual and procedural background of this case was presented to the Ninth Circuit and we cite to that briefing here for this Court's reference. (U.S.C.A. No. 17-30247, DKT 21.) We do not include the same level of detail here because the United States believes it unnecessary to resolve the issues presented in this § 2255 filing.

Following the trial and Beier's arrest, Beier filed motions for acquittal and a new trial. (ECF 120, 139-140, 145, 147.) These motions were completely briefed and denied by the Court.[3] (ECF 145, 147, 162.) Beier next filed a motion to stay sentencing and later requested a competency hearing based upon "neuropsychological" and "forensic psychiatric evaluation[s]" that had been prepared during the delay. (ECF 143 pp. 1-5; ECF 150 pp. 1-5; ECF 164.) Beier requested a new trial arguing that he should be allowed to present the testimony of his newly retained experts and argue that at the time of the offense he was insane and had diminished capacity. (ECF 168, 169, 180.) The United States opposed the new trial arguing that the evidence, including medical evaluations, did not support it. (ECF 179, 180.)

The District Court held a two-day competency hearing and received evidence and testimony from three groups of experts: defense experts, including Dr. Adler, the Government experts, including Dr. Panos, and the Court's own expert, Dr. Low. (DKT 3-1 pp. 1-238; DKT 3-2 pp. 1-164 (competency hearing transcripts).) During this competency hearing, the Court admitted twenty-one Government exhibits. (Exhibit B pp. 1-176.)

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[3] Within this briefing, the Government agreed with Beier's argument that four lesser-included charges should be vacated and the District Court vacated those counts of conviction in its order denying the motion for acquittal and new trial. (ECF 162 p. 9.)

Following the competency hearing, the District Court made detailed findings and held that Beier was competent and did not suffer diminished capacity. (Exhibit E pp. 1-19; ECF 195.) The District Court also denied Beier's request for a new trial. (Exhibit E pp. 17-19.)

Beier filed a direct appeal to the Ninth Circuit. (U.S.C.A. 17-30247.) Relevant here, Beier argued that the District Court clearly erred when it found him competent and abused its discretion when it denied his request for a new trial. (*Id.*, DKT 15.) The Government responded and following oral argument, the Ninth Circuit affirmed Beier's conviction and sentence. (*Id.*, DKT 21, 45 and 51; ECF 219.) The Ninth Circuit held that "[t]here is no basis in the record for finding that. . . the [District Court's] ultimate competency determination was erroneous." (Exhibit A p. 3 (*United States v. Rafael Beier*, 780 Fed.Appx. 460, 462 (9th Cir. 2019)).) The Ninth Circuit further held that:

> because the District Court found Appellant competent and rejected his insanity and diminished capacity arguments, the evidence, if new, did not indicate that Appellant would probably be acquitted in a new trial.

(Exhibit A p. 3 (*Beier*, 780 Fed.Appx. at 462.)) Following the Ninth Circuit denial, Beier sought *en banc* review then *certiorari*, and both were denied. (U.S.C.A. 17-30247; DKT 50, 55.)

LEGAL STANDARD FOR INEFFECTIVE ASSISTANCE

To prevail on claims of ineffective assistance of counsel, the movant must show: 1) that his counsel's conduct fell below a standard of objective reasonableness; and 2) that counsel's incompetence prejudiced him. *Williams v. Taylor,* 529 U.S. 362, 390-91 (2000); *Strickland v. Washington*, 466 U. S. 668, 687-88 (1984). In evaluating an ineffective assistance of counsel claim, the court may consider the performance and prejudice components in either order. *Strickland,* 466 U.S. at 697. The court need not consider one component if there is an insufficient showing of the other. *Id.*

A. Counsel's performance

Strickland sets a "highly demanding" standard and essentially requires the movant to prove that his attorney's performance amounted to "gross incompetence." *Kimmelman v. Morrison*, 477 U.S. 365, 382 (1986). There is a "wide range of reasonable professional assistance," and a "strong presumption" that counsel's conduct fell within that range. *Strickland*, 466 U.S. at 689. "Judicial scrutiny of counsel's performance must be highly deferential." *Id.* Moreover, the Supreme Court has cautioned against narrowing the wide range of conduct that is acceptable under the Sixth Amendment. *Nix v. Whiteside*, 475 U.S. 157, 165 (1986).

When judging counsel's conduct, the issue is not what might have been possible or even what might have been "prudent or appropriate." *Burger v.*

Kemp, 483 U.S. 776, 794 (1987). The only question is "what is constitutionally compelled." *Id.* This reflects the fact that "[t]he object of an ineffectiveness claim is not to grade counsel's performance." *United States v. Thomas,* 417 F.3d 1053, 1056 n.1 (9th Cir. 2005) (citing *Strickland,* 466 U.S. at 697). "Representation is an art, and an act or omission that is unprofessional in one case may be sound or even brilliant in another." *Strickland,* 466 U.S. at 693. Therefore, the question is not "what the best lawyers would have done," or "even what most good lawyers would have done," but simply whether "some reasonable lawyer could have acted in the circumstances, as defense counsel acted []." *Coleman v. Calderon*, 150 F.3d 1105, 1113 (9th Cir. 1998), *rev'd on other grounds*, 525 U.S. 141 (1998).

B. Actual prejudice must be shown

The burden is on the moving party to show actual prejudice from the attorney's substandard performance. *Strickland,* 466 U.S. at 694. Thus, even if his counsel had been grossly incompetent, the movant must still "show that there is a reasonable probability that, but for counsel's unprofessional errors, the result of the proceedings would have been different." *Id.* "[A]n attorney's inadequate representation does not rise to the level of a constitutional violation unless the deficiency so infected the adversarial process as to raise doubts about the reliability of the proceeding's outcome." *Howard v. Clark*, 608 F.3d 563, 568 (9th Cir. 2010) (citing *Strickland*, 466

U.S. at 687).

"Unless a defendant makes both showings" – proving gross incompetence and prejudice – "it cannot be said that the conviction [was] unreliable." *Benson v. Chappell*, 958 F.3d 801, 827 (9th Cir. 2020) (quoting *Strickland,* 466 U.S. at 687).

ARGUMENT

Beier makes two claims in the pending § 2255 motion: (1) that defense counsel rendered ineffective assistance of counsel for failing to investigate Beier's competence and mental health before trial, and (2) that defense counsel was ineffective for failing to explain one offer of settlement and the United States Sentencing Guidelines. (DKT 1 pp. 4-5.) Based upon the record before this Court, both claims should be denied.

A. Beier's ineffective assistance of counsel claim fails because Beier did not show that he suffered diminished capacity or insanity at the competency hearing. Beier also fails to prove prejudice.

Beier's claim that trial counsel was ineffective because he did not investigate Beier's "impaired" mental condition, thus depriving Beier of "valid mental defenses" for his insanity and diminished capacity fails for two reasons. (DKT 1 p. 4.) First, Beier is not insane nor does he suffer from diminished capacity, so trial counsel was not ineffective for not investigating the issue. This was determined after a two-day competency hearing. Second

– and as the Ninth Circuit noted – Beier also failed to show that his newly claimed evidence, if it was even accepted as new[4] and true, would probably result in an acquittal.

Beier's guilt, including his claims of insanity and diminished capacity, have been thoroughly litigated in District Court and on appeal. Judge Lodge convened a two-day competency hearing to decide the issue. (ECF 186-187.) Defense experts and lay witness opined that Beier had longstanding insanity and diminished capacity caused by a 1996 car wreck and was not responsible for his drug trafficking activity fifteen years later or competent for sentencing. (DKT 3-1 pp. 4-237; DKT 3-2 pp. 112-163.) This position was refuted by Government experts and the Court's appointed expert, Dr. Low. (DKT 3-2 pp. 1-111.)

Dr. Craig Panos, MD, a brain injury expert, testified that there was no evidence that Beier suffered a traumatic brain injury sufficient to cause mental incapacity, and six neurologists and radiologists (Doctors: Haynor, Morris, Matesan, Khorsand, Lavy and Reichel) interpreted Beier's PET and MRI scans as substantially normal. (DKT 3-1 p. 95; DKT 3-2 pp. 4-30;

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[4] On appeal, the Ninth Circuit affirmed the District Court's denial of Beier's motion for a new trial because his arguments involve a claimed injury that occurred over a decade earlier, in 1996, "and is thus not newly discovered." (Exhibit A p. 3 (*Beier*, 780 Fed.Appx. at 462).)

Exhibit B pp. 41-46, 50, 147-48; Exhibit C pp. 1-4.) The District Court admitted each doctors imaging or neurological report. (ECF Nos. 188-189; Exhibit B pp. 41-46, 50, 147-48; Exhibit C pp. 1-4.)

The Government's position was further supported by other evidence admitted at trial and during the competency hearing. This included documents showing that the State of Idaho appointed Beier as an expert to evaluate the competency of the elderly in guardianship proceedings, and testimony that Beier supervised a local psychology clinic during the period of his crimes and alleged mental incapacitation. (Exhibit B pp. 102-142; DKT 3-1 pp. 137-38; ECF 136 pp. 50-58 (reporting the trial testimony of a psychologist and psychosocial rehabilitative specialist who Beier supervised at the clinic).)

The District Court also received testimony from the Court's own expert, Dr. Low, who opined that Beier was neither insane nor had diminished capacity. (DKT 3-2 pp. 49-111.) Dr. Low's report was also admitted into evidence at the competency hearing. (Exhibit B pp. 8-28.)

Following the hearing and additional briefing, the District Court found that Beier had not shown that he had diminished capacity or insanity and denied his request for a new trial. (ECF 192, 193, 195 (District Court's order attached as Exhibit E).) The District Court's order explained that the Court found that its own expert, Dr. Low, was the "most credible" having spent the

most time evaluating Beier, and that her "explanation and reasoning" were more complete than defense experts who demonstrated "result oriented bias" during the hearing. (Exhibit E pp. 7, 9, 14-16.) The District Court also found that its own observations of Beier, through trial, competency proceedings and Beier's own trial testimony, were consistent with Dr. Low's conclusion and revealed no evidence of insanity or diminished capacity. (*Id.* at 12-14, 16.) The District Court noted that video and audio recordings of Beier, admitted at trial, "indisputably show [Beier] . . . knew his actions were illegal" and showed that Beier was "actively hiding" his conduct from law enforcement. (*Id.* at 13.)

The District Court's order also explained that Beier's "sustained medical practice" since 1996, and the testimony that he was a capable physician, undermined his claims of longstanding incapacity stemming from a 1996 car wreck. (*Id.* at 13-14.) The Court found that Beier's actions and character were consistent before and after the car accident. (*Id.* at 14.) For instance, when Beier claimed that his affair with his co-defendant was out of the norm for him and supported his claims of traumatic brain injury from a 1996 car wreck - the District Court noted that Beier had an affair and married another woman while married to his first wife **before** this wreck. (*Id.* at 7, 14.) The District Court found that Beier's affair was risky behavior consistent with his character and not evidence of incapacity as the defense

continues to claim. (*Id.* at 14; DKT 1-1 p. 7 (arguing, in Beier's § 2255 motion, that his affair with "a stripper" is evidence of his incapacity).)

Beier challenged the District Court's ruling and the Ninth Circuit affirmed, holding that "[t]here is no basis in the record for finding that. . . the [District Court's] ultimate competency determination was erroneous." (Exhibit A p. 3.) Notably, the Ninth Circuit also held that:

> because the district court found Appellant competent and rejected his insanity and diminished capacity arguments, the evidence, if new, did not indicate that Appellant would probably be acquitted in a new trial.

(*Id.*) This failure to show prejudice alone – that there was an error that raises doubts about the reliability of the proceeding's outcome – negates Beier's claim of ineffective assistance by his counsel. *Clark,* 608 F.3d at 568; *Strickland*, 466 U.S. at 687. However, Beier has not shown his incapacity in the first instance – something he is required to do before this Court even reaches this prejudice analysis.

B. The record shows that Beier refused all offers and insisted on going to trial. The contention that trial counsel was ineffective because he did not convey a 2014 plea offer, or explain the sentencing guidelines, is a false narrative with no support in the record.

The United States extended several plea offers to Beier, including an offer on October 27, 2014, a year and a half before trial. (DKT 1 pp. 16-17.) These offers were rejected and the United States continued to gather more

evidence for trial and ultimately sought and obtained four superseding indictments, consistent with the building evidence showing the extent of Beier's crimes. (ECF 73 (Fourth Superseding Indictment).)

In the end, Beier never accepted responsibility for his actions, and required the United States to prove his guilt, which is proper and his Constitutional right. Having made that decision, he should not be allowed to mislead this Court and claim, after his conviction, that he would have chosen to plea when the entire record demonstrates that his claim has always been actual innocence and no culpability.

There is no merit to Beier's argument that his trial counsel, Jim Siebe, failed to inform him of plea offers. Interestingly, Beier's § 2255 memorandum reports that trial counsel conveyed at least one plea offer, stating that "trial counsel told Dr. Adler that Beier denied everything" and "turned down a plea agreement from the Prosecutor that would have been an outcome more favorable than the sentencing range he faces presently." (DKT 1-1 p. 18.) Trial counsel's recollection is confirmed by an email from him, to the United States, months before trial, on January 15, 2016. There trial counsel confirmed that Beier had turned down multiple offers, stating:

> Thank you so much for your recent email. I appreciate the effort that went into preparing the potential offer, given our previous outright rejection of your many overtures to settle the case. I plan a long sit-down with Rafael, soon, and while I don't

> expect things to change, it will be one last chance to confirm or eliminate the chance of resolving the case short of trial.

(Exhibit D p. 2 (email accompanying the affidavit of AUSA Traci Whelan).)

Beier never accepted responsibility for his criminal conduct and the evidence in this case demonstrates that this is Beier's character – having a long history of "stubborn" denials when facing accusations. (Exhibit E p. 16 (District Court's competency order.) In his § 2255 motion, Beier is reported to have told trial counsel, "I cannot plead guilty if I'm not guilty" and "seemed to have a martyr complex, alternatively calling it a crucifixion complex." (DKT 1-1 p. 18.) Indeed, when meeting with a defense expert to support his claims of incapacity, Beier stated "I don't trust the Government" because the Government carried out "Slavery, Racial Segregation . . . Genocide," and referred to the proceedings as "kangaroo court," denying any culpability. (DKT 2-3 pp. 9, 12.) This is not new behavior caused by brain trauma - it is who Beier is. He has a demonstrated history of anti-government rhetoric when facing accusations.

In 1986, a decade before his claimed head injury, Beier was on probation after being convicted for possessing stolen firearms. (PSR p. 31.) While on probation, the Idaho Department of Corrections prepared a violation report stating that when probation officers went to search Beier's residence, Beier "denied that he resided at the address." (*Id.* at 32.) When

officers began their search, Beier "yelled that the officers were KGB Agent[s], fascist pigs, and gestapo mother f_ckers." (*Id.* (internal quotation marks omitted).) Beier "created such a disturbance that the probation officers were unable to complete the search." (*Id.*) During this incident, Beier physically resisted officers who later found a shotgun hidden beneath some boards in Beier's garage. (*Id.*)

In this case, Beier chose to plead not guilty and go to trial because he is aggressively antagonistic and has been that way for decades. The District Court captured it correctly when it quoted Beier's trial attorney who stated that Beier is "stubborn" and is one of those people who will deny truth in the face of "obvious facts" because he is too "proud" to ever admit fault. (Exhibit E p. 16; ECF 195 p. 16).

CONCLUSION

Respectfully, this motion should be denied because Beier has failed to show that his counsel's conduct fell below a standard of objective reasonableness. Counsel's conduct was reasonable and there is no issue with Beier's competence and he does not suffer from diminished capacity or insanity. Since Beier cannot demonstrate the first prong, this Court need not continue the analysis. However, even if Beier could meet the burden of the first prong, by proving that he was mentally incapacitated during the period of his drug dealing, he cannot show that counsel's incompetence prejudiced

him. Beier has not shown that the "result of the proceedings would have been different." *Strickland,* 466 U.S. at 694. For these reasons we urge this Court to deny Beier's petition for the reasons argued herein.

RESPECTFULLY submitted this the 9th day of April, 2021.

RAFAEL M. GONZALEZ, JR.
ACTING UNITED STATES ATTORNEY

s/ Michael W. Mitchell
MICHAEL W. MITCHELL
Assistant United States Attorney

s/ Traci J. Whelan
TRACI J. WHELAN
Assistant United States Attorney

CERTIFICATE OF SERVICE

I HEREBY CERTIFY that on 9th day of April, 2021, the foregoing **UNITED STATES' RESPONSE OPPOSING PETITIONER'S 28 U.S.C. § 2255 MOTION** was electronically filed with the Clerk of the Court using the CM/ECF system, and that a copy was served on the following parties or counsel by:

Stephen R. Hormel Hormel Law Office, LLC steve@hormellaw.com	ECF Filing

s/ Carin Crimp
Legal Assistant

FEDERAL DETENTION CENTER
SEATAC, WA
FORENSIC EVALUATION

NAME: Beier, Rafael
REGISTER NUMBER: 16223-023
DATE OF BIRTH: [redacted]1953
CASE NUMBER: 2:14-cr-00117-EJL
DATE OF REPORT: January 26, 2017

REFERRAL INFORMATION

In an order dated October 5, 2016, the Honorable Edward J. Lodge, Senior United States District Court Judge for the District of Idaho, requested an evaluation of Rafael Beier for mental competency prior to sentencing, pursuant to 18 U.S.C. Section 4241. Specifically, the order requests an examination to determine whether the defendant is suffering from a mental disease or defect rendering him mentally incompetent to the extent that he is unable to understand the nature and consequence of the proceedings against him or to assist properly in his defense. The referral questions are posed in regard to Mr. Beier's current convictions of Conspiracy to Dispense a Controlled Substance and 65 counts of Distribution of a Controlled Substance.

The defendant did not arrive at FDC SeaTac until October 19, 2016, and defense counsel Stephen Hormel requested the evaluation begin after the conclusion of his expert's evaluation, which commenced November 1, 2016. A request for the 30-day evaluation to begin after that date was made and granted by the Courts. The Courts later granted a joint motion by counsel on both sides to extend the evaluation, with the report being due no later than January 31, 2017.

IDENTIFYING INFORMATION

Rafael Leonhard Wolfgang Beier is a 63-year-old, separated, Caucasian male, who was arrested in Coeur d'Alene, Idaho, on May 28, 2014, for the instant offenses. He was released on pretrial supervision but re-arrested on May 23, 2016, after failing to appear for the jury verdict. Mr. Beier reported he had been residing in Kingston, Idaho, with his wife and children for approximately five years and operated a private practice as a "country doctor."

ASSESSMENT PROCEDURES

Prior to commencing the assessment, Mr. Beier was fully informed of its nature and purpose and gave informed assent. He was also informed that any information he provided was subject to inclusion in the evaluation report, which would be available to the Court. This evaluator explained the limits on confidentiality could include the review of all social correspondence and telephone calls. The defendant verbalized an adequate understanding of the purpose of the evaluation, and agreed to participate to the best of his ability.

The procedures utilized in the evaluation of Mr. Beier included clinical interviews; observations of his behavior at this facility; and the Personality Assessment Inventory (PAI). The PAI is an

objective test which measures personality dimensions and provides indices of psychopathology or mental disorders. Supplemental information was gathered through a review of legal documents, mental health records, and monitoring of telephone calls Mr. Beier made while at FDC SeaTac. Telephone interviews were also conducted with Mr. Beier's son and brother.

BACKGROUND INFORMATION ACCORDING TO THE DEFENDANT

Mr. Beier appeared to be reliable historian during the interviewing process. He provided extensive information about personal and family history, the instant offenses, past emotional difficulties, and substance use. His credibility was sound.

According to Mr. Beier, he was born on December 1, 1953, in Berlin, Germany, to an intact family whose parents divorced when he was two or three. He is the oldest of five children, three of whom are half-siblings. He denied the presence of any birth complications but reported he was a small baby and weighed just over five pounds. The defendant reached developmental milestones in a timely manner. He denied a history of any significant childhood accidents or injuries.

Mr. Beier was born to Barbara Martalla and Wolfgang Beier, both of whom are German. He knows very little about his father and does not know if he is alive, since he has had no contact with him since his parents divorced. The defendant indicated prior to the divorce, his father called the authorities and claimed their mother had left him and his younger sister, Cornelia, alone without supervision. As a result, both were placed in an orphanage. Relatives were able to secure the defendant's release, but Cornelia remained in the orphanage for four years before being reunited with the family.

Barbara Martalla is age 83 and resides with her third husband, Warren Martalla, in Pinehurst, Idaho. She used to be a school bus driver, and suffers from severe arthritis in her hips, necessitating the use of a walker. Mrs. Martalla was described as a kind and giving woman. However, Mr. Beier also reported German people are strict and do not "put up with nonsense." As a result, Mrs. Martalla used to be too strict with Cornelia, slapping her and being "too physical," while she yelled at the defendant and spanked him. Mr. Beier reported his maternal relatives were members of the Latter Day Saints (LDS) church, and his mother is likewise a stalwart member who always took the children to church. He related well to her during his childhood and is very close to her now; he had recent contact with her just prior to his arrival to FDC SeaTac. He indicated he appreciates her for keeping the family together. Mrs. Martalla has no mental health, substance abuse, or legal history, nor is there any on her side of the family.

Mrs. Martalla married Warren in approximately 2000. He is one or two years younger than she and used to be a dentist in the Air Force. Mr. Martalla is also an LDS member and Mr. Beier gets along well with him. He indicated Mr. Martalla currently suffers from Alzheimer's Dementia.

Mrs. Martalla was married to Andrew Frank Jackson Wallace from 1959 until his death in 1991 of unknown causes; he was in his mid-50's. This was the man who raised Mr. Beier and whom he viewed as a father. He was in the military and met Mrs. Martalla while stationed in Germany. Mr. Wallace was described as a very strict individual who was also racist; he refused to let the defendant bring African-American peers home. His employment history was unstable and he worked in factories and as a carpet installer. He converted to the LDS faith after marrying the defendant's mother but never attended church. Mr. Wallace spanked the defendant as discipline and once hit him with a plastic bat. Mr. Beier reported he always related well to his stepfather. He advised Mr. Wallace sexually abused Cornelia during her early adolescence. Their mother found out and the church intervened by providing counseling to Mr. Wallace and advising Mrs. Martalla to never leave Cornelia alone with him. Mr. Beier reported he did not know what was happening at the time, and never discussed the issue with his stepfather.

When recounting his siblings, Mr. Beier reported he has one full sibling and three maternal half-siblings. As noted above, his full sister, Cornelia, is 1 ½ years younger. She began running away from home due to the sexual abuse, was placed in a girl's home with lesbians, and became transgender. Mr. Beier indicated Cornelia's name is now Phil and he believes she underwent sex reassignment surgery. Phil resides in Seattle and is married to a woman; the defendant contacts him at least yearly but does not know how to handle the transgender issue. He also received a card from him during the current evaluation. Mr. Beier is very uncomfortable about this issue and reported he and his family continue to refer to Phil as "she" and "Cornelia" when out of his presence. He indicated Cornelia is a good person who has made bad choices, and she reportedly told their mother she regrets her decision to become a man. He believes she is "living a lie." Mr. Beier also spent some time discussing how his LDS beliefs impact his opinions about sexual issues. He views homosexuality as a mental illness, believes it is immoral for society to "feed into" transgendered issues, and believes doctors who perform sex reassignment surgeries should have their licenses revoked because they are "feeding into an illness."

Mr. Beier's half siblings, whose father is Mr. Wallace, are Jeanie, age 56, David, age 55, and Becky, age 54. Jeanie resides in Coeur d'Alene and used to work at the defendant's clinic. David resides in Spokane and used to work in maintenance. Mr. Beier reported seeing both Jeanie and David often because they lived nearby. Becky is a social worker and resides in Everett, Washington; the defendant does not typically have much contact with her. He did not believe any of his siblings have substance abuse or legal problems and claimed he was close to all of them.

Mr. Beier was initially raised in Berlin, Germany. After his parents divorced, he spent much of his time with his maternal grandparents in East Berlin, as his mother worked in West Berlin. After his mother married Mr. Wallace, the family moved to the United States in 1960 when he was six. They moved to Dallas, Texas, as Mr. Wallace was from that area. He recalled there were many African-Americans in the area and segregation was the norm at the time. The defendant only spoke German and became known as "the German kid." His transition to the new

culture was difficult. The family moved to Denver, Colorado, when he was in the fifth or sixth grade. They were poor and lived in poor neighborhoods or the projects. However, the church always assisted with food and they were able to get by. Mr. Beier reported they lived in three different places in Denver due to his stepfather's jobs and/or lob losses. Once his stepfather found steady work the family was able to purchase a house and their finances improved a bit. He recalled there were many Mexican people in West Denver and he was able to fit in, and reported most of their neighborhoods consisted of 50% minorities. He noted the times were tumultuous due to the civil rights movement and the Vietnam War. The defendant described himself as a compassionate child. He did not like the way minorities were treated and once "pulverized" a child in elementary school who was bullying an African-American boy. During his senior year of high school his family moved to Kansas City, Missouri, but Mr. Beier stayed with his paternal grandmother to finish school.

Mr. Beier asserted his religious upbringing was "totally LDS." Aside from his stepfather, the family attended church every Sunday and participated in church activities during the week. They received monthly visits from "home teachers" from the church, and his mother was active in women's groups. Although his stepfather did not participate in activities he was supportive of their beliefs. Mr. Beier believes strongly in Scripture and the Book of Mormon. He grew up understanding he is to keep himself apart from the ways of the world, and he considers the rest of the world to be "Gentiles." The defendant reported his entire outlook on life is influenced by his church and everything about his religious beliefs influence who he is as a person. He reportedly prays every morning and night, reads the scriptures daily, and quoted scriptures at times. He acknowledged some people may perceive him to be overly religious.

The defendant reported being married twice. His first marriage was to Susan, which lasted from 1976 until 1994 or 1995. He was in his early 20's and she was 23 when they married. Susan was described as a homebody who was very nice and an LDS member. She worked intermittently in secretarial positions. Susan developed diabetes and also became moodier after a hysterectomy. Mr. Beier asserted she was grouchy and became cold and frigid. They grew apart and he believes her moodiness led to the end of their marriage. Susan now lives in Boise, Idaho; the defendant has four children with her.

The defendant's children with Susan are Branden, age 39, Secia, age 37, Dresden, age 36, and Joseph, age 35. Branden resides in Lewiston, Idaho, and owns a large and successful home health agency. He has power of attorney for Mr. Beier and is paying for his attorney. Secia is a pharmacist in the Rheumatology Department of Oregon Health Sciences University in Portland; she is very busy and does not contact the family often. Dresden resides in Michigan and is a podiatrist and surgeon. He served as a medic in Iraq and suffered from Posttraumatic Stress Disorder. Joseph is a third year medical student in Florida. Mr. Beier further spontaneously named all of his various grandchildren from these older children.

Mr. Beier then married Yan Hua Gao, a Chinese woman, in either 1994 or 1995. She was previously married with a child, and has a medical degree from China. She is age 54 and is a part-time pharmacist. The defendant has four children with Yan Hua. She initially treated him "like a prince" but later told him she was tired of serving him. He reported a difficult marriage, explaining she began having an affair in 2005 or 2006 with her former medical school classmate, Dr. Shun. Mr. Beier reported Yan Hua went to China every summer with the children (he sometimes accompanied them) and not only began seeing Dr. Shun, but asked Mr. Beier for permission to continue the affair. She quoted LDS history to him of multiple wives, told him how good the sex was with Dr. Shun, and asked him to remove her IUD so she could have a baby with her paramour. Mr. Beier was very upset and had Yan Hua's brother, who resided in China, intervene on his behalf. This only succeeded in making Yan Hua angry and the defendant eventually removed her IUD. He stated her affair lasted two or three years. He hoped she would "come to her senses" and reminded her repeatedly the church would not bless the relationship. Dr. Shun was then run over by a car and suffered severe injuries, but they continued the affair. He then developed colon cancer and ended the affair with Yan Hua.

Nevertheless, a couple of years later, Yan Hua began having another affair with Roger, a man she met at the local gym. As with Dr. Shun, she claimed she was in love with Roger and wanted to have a baby with him. Mr. Beier reported his wife is still seeing Roger, and their children were aware of the affairs. He further reported people at his medical clinic were aware of the affair, as he lives in a small town. He and Yan Hua lived like roommates and have separate bedrooms; she avoided him and they have not been intimate for five years. Shortly after he was detained, Mr. Beier stated Yan Hua requested a divorce and filed divorce papers. They were not accepted by the judge for unknown reasons, but he recently received updated divorce papers while at FDC SeaTac. He indicated Yan Hua resides in Kingston, Idaho, with their minor children.

Mr. Beier's children with Yan Hua include Benjamin, age 20, Rachael, age 18, Wolfgang, age 16, and Angel, age 14. He also considers Yan Hua's daughter Chung Chung, age 27, as his daughter. She was age five or six when the defendant married Yan Hua and is currently a third year medical student at the University of Washington. Benjamin is a sophomore in the Air Force Academy in Colorado Springs and wants to be a military pilot. Rachael is a pre-med sophomore at the University of Idaho, Wolfgang is a high school junior and football star, and Angel is taking advanced classes in the ninth grade. The defendant emphasized how accomplished all of his children are and stated he is equally close to all of them. Prior to coming to FDC SeaTac, he wrote to all of them and usually spoke to his two youngest children at least weekly. He also received televideo visits at the Bonner County Jail with his three oldest sons. Mr. Beier claimed all of his children are supportive of him but blame him a bit for being "stupid" and letting others "con" him.

Mr. Beier later hesitantly disclosed another significant relationship but refused to provide the woman's name or the circumstances in which they met. He believes he was "conned" by this

woman who "chased after" him for the last two or three years. The defendant claimed she told him she had a dream in which her deceased mother told her not to pass up Dr. Beier. She stated her mother died of breast cancer and knowing Mr. Beier was very religious, she supposedly used that information because he believes God can speak to people in their dreams. (He then shared the Bible story of Joseph and his dreams.) The defendant claimed she took advantage of him emotionally, as he thought she would rescue him from his bad marriage. He alleged he was naïve and continued to see this woman after her friend advised she only wanted to marry him for his money. However, Mr. Beier reported he broke up with her after the woman's friend told him she was "evil."

Mr. Beier began school in Dallas, Texas, at an unknown age and struggled because he did not know English. He repeated the second grade as a result, but learned English well enough by the fourth grade to where he was advanced to the fifth grade, essentially placing him back on track. He guessed he received satisfactory grades. Mr. Beier defended other children who were being bullied. He spent his free time playing outdoors and catching snakes and horny toads. He attended sixth through ninth grades in Denver; due to the family's multiple moves he attended three different junior high schools. The defendant had good attendance and received mostly A's and B's. He had no difficulty with transitioning to the different schools and always related well with his peers. He then attended South High School in Denver and graduated in 1972 with an approximately 2.5 grade point average (GPA). Mr. Beier reported he began to "goof off" the last couple of years, as he was immature, bored, and did not apply himself. He continued to relate well to his peers and participated in wrestling in the tenth grade. He reported an incident his senior year when he was jailed overnight because he was with some friends who tried to outrun the police in their car. Mr. Beier did not know what his charges were but they were dismissed.

In 1974 at age 20, the defendant began a two year Mormon mission. He was initially sent to the Duck Valley Indian Reservation in Idaho, and felt it was an inspiration to be called there as he used to play the Indians in "cowboys and Indians" as a child. He laughed as he recalled fond memories of his time there, stating he became good friends with some of the Indians. He was then transferred to the Fort Hall Indian Reservation in Pocatello, Idaho, then to Boise, and on to Rigby, Idaho. His last placement was in Jackson Hole, Wyoming, where Mr. Beier met celebrities such as Robert Goulet. He reported enjoying his mission experience.

The defendant then attended Ricks College in Rexburg, Idaho, for 1 ½ years and obtained an associate degree in General Education in 1977. He reported a 3.5 GPA. Mr. Beier obtained a job for Union Pacific as a switchman and brakeman. After several years there, he was laid off due to the economy and resumed his education at Idaho State University. He attended for three years and graduated in 1986 with a bachelor degree in Zoology, and a GPA of approximately 3.7. The defendant then pursued a degree as a Doctor of Osteopathic Medicine at the University of Health Sciences in Kansas City, Missouri. He noted it was a difficult program in which he had to take 25 credits per semester. He bargained with God, saying he would never turn away poor people if he

graduated. Mr. Beier did graduate in 1991; he estimated his GPA was between 2.5 and 3.0, but he did not care as he was simply happy to graduate. He progressed to a residency at Kansas University, spending a total of five years there. He reported spending 1 ½ years in a Psychiatry rotation with the remainder in family practice, and completed his residency in 1996.

Mr. Beier's first job as a physician was for Indian Health Services as part of the Commissioned Corp of the U.S. Public Health Service (PHS). He was placed in Lapway, Idaho, on the Nez Perce Reservation. The defendant stated he was classified as a Lieutenant. He did not like wearing his uniform and clashed with a nurse practitioner over clinical decisions. He felt the Native Americans were being "screwed over" and left both the job and PHS after two years. Mr. Beier then worked for the Havasupai Tribe as a civil servant physician in the Grand Canyon. He reported he was in a very remote area and thus had to act as coroner and pharmacist. He made many house calls to the elderly but also had to provide emergency care to tourists, such as search and rescue projects. The defendant recalled having to rappel down the sides of cliffs to rescue people. He treated Native Americans who were involved in drunken accidents, and some of the Native Americans came to his home at night to address minor concerns. Mr. Beier reported he got into trouble for seeing them outside the clinic, as his supervisor believed they were taking advantage of him. However, he felt he could not turn them away. The defendant also did not relate well to the local police because he did not appreciate the way they treated the Native Americans. He was unhappy with the poor medical treatment they received and thus left this job after 2 ½ years.

Mr. Beier moved to Coeur d'Alene and worked with a physician named Dr. Haller for a year in his private practice. He did not agree with Dr. Haller's "assembly line medicine," as Dr. Haller allegedly stated they had to "run the mean (patients) through."

The defendant thus opened his own clinic in 2002 or 2003 in Pinehurst, Idaho, which mainly treated a low socioeconomic population. His wife, Yan Hua, operated the business side of the clinic. He stated every day was rewarding, as he took his time with his patients and enjoyed helping them. Mr. Beier described himself as being like an old-fashioned country doctor who set his own hours. His patients consisted of elderly individuals, miners, and Native Americans from various tribes. He did not typically query about substance use, although some patients trusted him enough to disclose their use to him. Additionally, Mr. Beier reported he did not withhold narcotics to patients who smoked marijuana although he did not condone marijuana use. He indicated one patient advised him her two sisters, who were also his patients, were "scamming" him because they sold the narcotics and Xanax he prescribed. The defendant reported being in shock at this information. He claimed he later found out about a local drug ring and "riff raff," after charges were filed against him, and stated Yan Hua always told him he was gullible about these people.

Mr. Beier denied any history of substance abuse. He first tried alcohol at age 18 or 19 and never liked the taste. He tried marijuana a few times during his senior year of high school. He has never abused any prescription medications and has never participated in substance abuse treatment.

The defendant reported a significant adult medical history consisting of various head injuries. He did not know they had a bearing on anything until his children told his lawyer about them, which led to his recent neuropsychological testing. In approximately 1996 Mr. Beier was in a motor vehicle accident in which he hit black ice while traveling 55 to 60 miles per hour. His vehicle slid and rolled, resulting in loss of consciousness. He indicated his son reportedly took him to the hospital but he could not actually recall that event. He noted having bruised ribs as a result. About a year later Mr. Beier was ordered by police to leave church, as his first wife was there and had a restraining order against him. The police attempted to arrest him; he was pepper sprayed, his head was knocked on the ground, and he lost consciousness. The defendant regained consciousness in jail and did not receive any medical care. He filed a lawsuit, arguing he did not violate the restraining order, and won. Mr. Beier added the plaintiff, the Nez Perce County, appealed to the Ninth Circuit Courts, who ruled in his favor.

In approximately 2005, Mr. Beier was hit in the head by one of his horse's hooves, resulting in loss of consciousness and a laceration on his eye. His wife, Yan Hua, stitched him. Around 2008, while training for an Ironman competition, the defendant was running at dusk. He hit an obstacle, landed on his face, and lost consciousness. He did not seek medical care. Mr. Beier later was involved in a mountain bike accident in approximately 2011 after crashing into a ditch. He was not wearing a helmet, lost consciousness, and sustained scrapes. Lastly, sometime between 2010 and 2012, Mr. Beier allowed a homeless patient with a child to borrow his car. He then discovered she was drinking in his car and found a strange man in it. After confronting him, the man put the defendant in a headlock and he woke up on the ground. His wife took him to the hospital. A CT scan of his head showed no significant findings, but he had amnesia for the event for a day or so. Mr. Beier also reported his face was swollen and he received a suture above his lip.

The defendant denied any current health problems and is not taking any medication. He believes he is fairly healthy. He reported completing six Ironman competitions from 2008 to 2012, and once placed in the Top 10 in his age group. Mr. Beier indicated he never exercised until about 2006. He was unsure if it was necessary to compete in six competitions and does not feel a need to compete again, laughing about the experience being a "torture chamber."

Mr. Beier denied having any mental health history. He has never been psychiatrically hospitalized, attempted or contemplated suicide, participated in counseling, or taken psychotropic medication. He denied a history of any significant anxiety, depression, or psychotic symptoms. He noted he simply feels sad now about his legal situation and his divorce proceedings, but finds

his religion to be a great source of support. The defendant also asserted being incarcerated has produced psychological trauma due to poor general treatment as an inmate.

The defendant spoke repeatedly about memory problems. When asked for details, he indicated he did not really notice any problems until others made him aware of it. He sometimes forgot the names of both long-term and new patients, although this is more of a difficulty with newer patients. He was unable to provide any other examples of memory deficits.

However, Mr. Beier spoke frequently about not having any "street smarts," being naïve, and being unaware of happenings in his environment. He noted even in the community, he was focused on his own life and not the events at the hospital where he worked. He stated he did not question patients when they complained of pain and had "real good stories." Mr. Beier's medical assistant told him he was naïve and fell for patients' stories about losing Xanax prescriptions, which he would refill. She also told him female patients simply needed to cry about pain pills and he would prescribe them. A pharmaceutical representative also told him he was gullible. The defendant became teary when revealing this, stating "It makes me feel like an idiot." He discussed difficulties in "tracking," but all of his examples were in a correctional setting. For example, the defendant reported he did not understand the racial politics on the unit amongst the inmates. He reportedly had difficulties remembering meal times and count times. He described an incident in which two inmates were fighting in their room; although Mr. Beier was sitting nearby, he was not aware of it while everybody else was. He reported his roommates frequently told him he was not living in the real world because he was unaware of his surroundings.

With regard to criminal history, Mr. Beier reported a couple of "false arrests," which were already discussed, i.e. the incident in high school and the arrest at his church. He vaguely reported another incident in which he was with a friend who stole something; Mr. Beier was also given an unknown charge but it was dropped. He intermittently discussed the injustices of his current conviction, stating, "The whole thing is lies." The defendant spoke in detail of how various witnesses lied about him and they received immunity for doing so. He discussed testimony about him allegedly giving large amounts of money to people (supposedly in exchange for selling drugs or prescriptions) but stated he did not have such money and still had financial burdens. He also spoke of a woman breaking into his clinic and stealing his prescription pad. Mr. Beier sounded bitter in stating none of these people were charged for anything and he claimed his trial was a "farce." He further complained of the retained attorney he had then, who did not spend very much time on his case. He advised this attorney of various witnesses to contact to testify Mr. Beier had been "scammed," but the attorney did not seek them.

INFORMATION FROM SUPPLEMENTAL SOURCES

Legal: The legal documents available for review consisted of a Presentence Investigation Report, dated July 18, 2016; a Motion to Stay Sentencing Procedures, for Forensic Psychiatric Evaluation, and for the Court to Determine Competency Pursuant to 18 U.S.C. Section 4241, dated

October 3, 2016; and email communications with defense attorney Stephen Hormel, dated December 1, 2016. Although all of the available documents were reviewed in detail, for the sake of brevity and clarity, only summary information, as it pertains to the referral questions, is provided herein.

The PSR indicated a Fourth Superseding Indictment was filed on December 15, 2015. Count 1 charged Mr. Beier with Conspiracy to Dispense a Controlled Substance. Specifically, it alleged he conspired with others to distribute Oxycodone, Hydrocodone, and Adderall beginning in at least 2012 and ending on or about May 28, 2014. Counts 2 through 67 alleged he distributed these controlled substances on various dates, and counts 68 to 71 alleged he distributed controlled substances to a person under age 21. He was found guilty by jury on May 17, 2016, of Counts 1 through 52, 54 through 57, and 62 through 71. Mr. Beier failed to appear for the jury verdict and was arrested on May 23, 2016. The PSR indicated sentencing guidelines of 235 to 293 months, while AUSA Traci Whelan advised the sentencing range was between 120 and 240 months.

The PSR was extremely lengthy, as multiple people were interviewed. It indicated Destiny Blaski, a dancer for Stateline Showgirls, reported she was engaged to the defendant. In an interview on July 24, 2013, she advised she met him six to eight years earlier as a dancer. He wrote prescriptions for her and other club employees. Ms. Blaski reported she relied on Mr. Beier financially and believed she could "stay engaged to him forever because she could get whatever she wanted from him and she knew she could make a lot of money off him." Other dancers from Stateline Showgirls were interviewed and reported receiving prescriptions from Mr. Beier. He was then arrested on May 28, 2014, after participating in a controlled buy.

Mr. Beier's criminal history was reported in the PSR. He received two years of probation in 1986 after an arrest in 1985 for Grand Theft by Possession, as he knowingly possessed stolen guns. A report of violation was filed on October 14, 1986, for refusing a lawful request when officers attempted to search his residence, refusing to get into the state probation vehicle, and possession of a firearm. Another report of violation was filed on December 17, 1986, for failure to abide to directives to make payments to restitution and cost of supervision, and moving without permission. The Courts allowed Mr. Beier to withdraw his guilty plea on June 17, 1988, and dismissed his charges. Other arrests include two charges of Grand Theft in 1986, which were dismissed, charges of Violation of Protection Order, Resisting or Obstructing Officers, and Malicious Injury to Property in 1997 (all dismissed), a Trespass charge in 1997 (dismissed), and charges in 2013 of Aggravated Assault, Burglary, and Possession or Use of a Legend Drug Without Prescription (all dismissed). With regard to the 2013 charges, records indicate officers responded to a domestic dispute between Mr. Beier and Destiny Blaski, in which he had allegedly threatened her with a gun. Ms. Blaski reported he was her fiancé and she used to sell pills for him, leading to their fight. Mr. Beier reported Ms. Blaski hit him; he acknowledged having a gun and demanding the keys to a truck Ms. Blaski had been using. The officer examined text

messages between them and concluded Ms. Blaski was meeting Mr. Beier in what was "clearly a drug deal."

Defense attorney Stephen Hormel submitted a motion to the Courts on October 3, 2016. He indicated after being retained, he sought an extension for sentencing and time for both a neuropsychological and forensic psychiatric evaluation for the purpose of developing mitigation for sentencing. Mr. Hormel indicated Dr. Ziegler, a neuropsychologist, opined Mr. Beier could not properly assist counsel with sentencing due to his mental condition. She also recommended a more specialized forensic psychiatric evaluation and an MRI. Mr. Hormel then arranged for Dr. Adler to conduct the recommended psychiatric evaluation.

Mr. Hormel, in an email to this evaluator, indicated he began to represent Mr. Beier in summer 2016 and became increasingly concerned about a diminished mental condition. He saw his client almost weekly and was concerned about his ability to assist. He thus reached out and found Dr. Ziegler to perform neuropsychological testing. She raised concerns about competency and a potential delusional disorder, and recommended a more specialized evaluation. Mr. Hormel then sought an independent competency evaluation from Dr. Adler, to include MRI and PET scans.

Medical: Medical records available for review consisted of a Neuropsychological Evaluation by Elizabeth Ziegler, Ph.D., dated October 3, 2016; a Forensic Psychiatric Examination by Richard S. Adler, M.D., dated January 19, 2017; and FDC SeaTac medical records, dated October 19 to November 9, 2016.

Neuropsychologist Elizabeth Ziegler performed a forensic neuropsychological evaluation of the defendant on September 13 and 20, 2016, as referred by defense attorney Stephen Hormel. He expressed concerns about Mr. Beier's competency and neuropsychological status. Dr. Ziegler's report was a revised report to protect attorney-client privilege. She administered numerous tests, reviewed various records including letters from relatives, and interviewed Mr. Beier's son, Dresden Beier.

Dr. Ziegler indicated Mr. Beier expressed frustration and anger regarding many perceived civil rights injustices. She described him as being fixated and obsessive about these topics and having rigid thought processes, i.e. "thought process appeared to be consistent with delusional thinking." Mr. Beier reported he relied on his faith and adopted a "Christ-like view" to help him cope. He allegedly shared his religious views with other inmates and became a mentor to them by counseling them, leading prayer circles, and reading scripture. He denied any significant mental health concerns but reported being stressed about his wife filing for divorce. Dr. Ziegler felt the defendant was not a reliable source in understanding his psychiatric history, as he lacked insight into his thoughts and his behaviors being out of touch with reality. She did not observe any mood problems. Likewise, Mr. Beier did not feel he had any cognitive impairments and only reported age related changes.

Dresden Beier advised Dr. Ziegler of significant changes after he and his father were involved in a serious motor vehicle accident in 1996 or 1997. Their truck hit black ice at highway speeds and rolled several times. Both lost consciousness with Dresden awaking first; they then crawled out of the truck. Dresden was taken to the hospital but did not believe his father was hospitalized. However, he thought his father was later seen by medical professionals. Dresden further indicated his father began to exhibit an obsessive and delusional focus on various issues, such as religion and fitness. Letters from family documented an obsessive focus on Native American culture. These obsessions waxed and waned over time. Dresden reported around 1996 or 1997, his father told him he needed to have multiple wives and sought to become a polygamist. Prior to this time, Mr. Beier had not engaged in any extreme religious activities. However, Dresden acknowledged his father had affairs and was somewhat of a womanizer. Dresden reported observing very significant changes in 2010, when his father spoke of being in love with a stripper named Destiny and appeared infatuated with her. Dresden advised him to think about what he was doing and his father began to withdraw from everyone. Dresden thus had limited contact with him after that time. He added he believed his father was taken advantage of by strippers.

Dr. Ziegler indicated Mr. Beier passed 100% of the performance validity tests, meaning his effort was credible. However, she noted symptom validity testing revealed underreporting or defensiveness. Results from intellectual testing indicated overall average intellectual functioning with stronger verbal skills. Dr. Ziegler found Mr. Beier's overall cognitive abilities were largely intact with relative weaknesses in attention, working memory, and executive functioning. His verbal learning and memory skills fell into the average to very superior ranges, while his visual learning and memory fell into the average to high average ranges. Estimates of his premorbid functioning compared to the current testing results indicated the presence of some cognitive decline. Mr. Beier's results on a personality test revealed a defensive test taking style, in which no significant elevations were found. The only thing that could be gleaned was a dislike of others and possible introversion. Dr. Ziegler believed the defendant had a "savior-like complex" and suspected a delusional disorder because his rigid and obsessive beliefs in areas of religion, fitness, relationships, and Native American culture had impacted various areas of his life. She recommended a brain MRI and considered early frontotemporal dementia due to more recent personality and behavior changes. Dr. Ziegler also recommended a more specialized forensic psychiatric evaluation to assess for delusional thought processes. She did not believe Mr. Beier was competent to assist with sentencing due to his fixed and obsessive focus on details of his trial, and a significant lack of insight and minimization of his psychiatric status.

Dr. Adler, a forensic psychiatrist, was also referred by Stephen Hormel, who had concerns about Mr. Beier's ability to assist at sentencing. Specifically, he felt his client could not properly discuss with him "the facts of his case and to develop what to say in exercising his right of allocution at the sentencing hearing." Mr. Hormel also expressed concerns about whether or not the defendant could have properly assisted trial counsel in his defense at trial. Lastly, he requested an opinion about whether reduced mental capacity affected Mr. Beier's ability to form

the intent to commit the crimes charged against him, or affected his ability to distinguish right from wrong.

Dr. Adler interviewed several sources. Mr. Beier's prior attorney, James Siebe, described the defendant as a "difficult client" who persistently engaged in "denying the obvious" and "not accepting logical deductions." Mr. Siebe was concerned of possible mania and wondered if the defendant was using illicit drugs. Mr. Beier frequently went on verbal tangents and interrupted Mr. Siebe throughout the trial. He also needed to "prove something about his [good] character," "denied everything," and appeared to have a "martyr complex." Mr. Siebe attributed this denial to being a proud and stubborn man.

Branden Beier, the defendant's son, was also interviewed by Dr. Adler. Much of the information was similar to what Branden Beier provided to this evaluator (see Collateral section). Additionally, he reported his father acted on an "overwhelming need to help people" by taking people to Hawaii at his expense, allowing people to stay in his clinic building, giving away some of his older cars, and bringing people to stay at his home. Branden reported with regard to the legal case, his father was truthful when confronted but tended to have "far-fetched explanations" for things. He noted his father minimized things and alluded to the absence of "the accountability factor."

Phillip Savage, the defendant's brother, saw no evidence of obvious dementia-type symptoms and noted the defendant articulates well. He also described Mr. Beier as "amazingly resilient." With regard to the legal case, Mr. Savage reported there was "no talking sense to him…he thought he could win the case…felt he had a good lawyer, and witnesses…could win."

Throughout his evaluation with Mr. Beier, Dr. Adler reported frequent instances of the defendant seemingly minimizing his accountability by emphasizing his naiveté and being conned by others. When asked how he could explain his way out of his charges, the defendant responded, "[I am] naïve. Rafael means defender/healer. I was conned, scammed." He also reported, "I'm not good about things…easily deceived…too trusting…I was scammed good." He noted he was "trying to help people" but was "conned." Mr. Beier reported long standing problems with being "naïve, gullible." He also advised other inmates identified him as "vulnerable…an easy mark." He did not believe he had performed well in the testing performed by Dr. Ziegler and alleged he had problems with memory prior to her evaluation. He also stated he has "problems with complicated things," indicating it was "obvious" to him.

Dr. Adler administered the Personality Assessment Inventory and quoted a portion of the computer generated test report. It indicated Mr. Beier tended to portray himself as being "relatively free of common shortcomings to which most individuals will admit, and he appears somewhat reluctant to recognize minor faults in himself." The report also indicated, "The results

may underrepresent the extent and degree of any significant findings in certain areas due to the client's tendency to avoid negative or unpleasant aspects of himself."

Dr. Adler worked with Paul Connor, Ph.D., who augmented Dr. Ziegler's evaluation with additional neuropsychological testing. No significant discrepancies were found between his results and those of Dr. Ziegler's. Dr. Connor found Mr. Beier's working memory to show more impairment as he was asked to perform more multitasking. The most significant impairment was in the area of executive functioning and problem solving. Overall, the testing results were variable and revealed a "patchy" distribution with areas of poor performance.

Dr. Adler further incorporated results from an MRI conducted at the University of Washington Medical Center on November 16, 2016, and PET scan conducted on November 17, 2016. The MRI scan reflected a normal study, but the volume of Mr. Beier's hippocampus was at "the lower limits of normal for age." Dr. Adler then presented a "NeuroQuant" analysis of the MRI, which segments and measures volumes of brain structures and compares the volumes to norms (www.cortechslabs.com/neuroquant/). Decreased volume was found in various parts of the brain, as well as brain asymmetry (please refer to Dr. Adler's report for details). Results from the PET scan were unremarkable. However, Dr. Adler quoted a Dr. Newberg, who presumably interpreted the PET scan, as saying, "Overall, the findings demonstrate several areas of increased and decreased metabolic activity." Dr. Newberg opined the results may represent changes associated with traumatic brain injury, particularly if there was more than one episode of trauma.

Incorporating all of these results, Dr. Adler diagnosed Mr. Beier with Mild Neurocognitive Disorder Due to Traumatic Brain Injury. He cited his 1996 motor vehicle accident resulting in head trauma, changes observed by his son in cognitive functioning, a substantial impairment in cognitive functioning as shown by neuropsychological testing, and neuroimaging which demonstrates the injury. Dr. Adler asserted Mr. Beier exhibited impairment with cognitive flexibility, metacognitive evaluations (having perspective on the basis, rationale, and or motivation) of his and others' behavior, inhibition deficits, immediate memory recall and processing speed deficits, and lower fluid intelligence scores. Based on this diagnosis, Dr. Adler opined Mr. Beier, at trial, did not possess the ability to consult with his lawyer with a reasonable degree of rational understanding and did not have a rational or factual understanding of the proceedings against him. He further opined the defendant does not have the capacities consistent with competency to be sentenced. Dr. Adler cited his continuation of maintaining a perspective on his case that departs from the "plain facts" and his interaction with counsel fails to meet the meaning of the words "consult" or "assist." He added Mr. Beier's rigid and non-reality based thinking have a likelihood of causing him to "speak inappropriately," "make denials," and/or "not accept responsibility."

Mr. Beier arrived to FDC SeaTac on October 19, 2016. During his health screen, he denied the presence of any medical issues or mental health problems, aside from memory difficulties as a

result of head injuries. Nothing unusual was observed with regard to his mental status. During his physical examination on October 24, 2016, Mr. Beier reported he had hyperlipidemia but was not taking any medication.

The defendant met with the contract psychiatrist on November 9, 2016. He reported a history of multiple head injuries with gradual cognitive decline and listed the same events as he did to this psychologist. The psychiatrist also contacted Mr. Beier's son, Branden, who reported the same things as he did to this psychologist (see Collateral section below). The defendant did not complain of any mood problems, trauma symptoms, or psychosis, and no such symptoms were observed. Mr. Beier complained of difficulties learning and stated he was gullible on the unit. The psychiatrist observed him to be content with constricted and bland affect, and logical thought processes. Results from a mental status examination indicated the defendant was slow in performing mental arithmetic with one error, but his recent and remote memory were intact. The psychiatrist diagnosed him with Unspecified symptoms and signs with cognitive functions and awareness, and opined psychiatric follow up and psychotropic medications were not needed.

Collateral: Branden Beier, the defendant's oldest son, was telephonically interviewed on November 29, 2016. He reported he has grown closer to his father in the past five to 10 years, although they have experienced a role reversal in which Branden became more of a parent to him. He indicated his father became more dependent on him and needy over the years; Branden's grandmother or Yan Hua also called Branden with concerns about Mr. Beier.

Branden indicated while growing up, his father always told him and his siblings to present themselves positively, i.e. to act like a doctor's children and not like hoodlums. However, Branden reported observing a "huge change" in his father's personality after a motor vehicle accident in 1996 or 1997. His parents separated and divorced in 1997, and Mr. Beier lost his job at Indian Health Services due to insubordination or behavior unbecoming of an officer. Branden guessed his father was coming to work late and was not following protocol by refusing to wear his military uniform. After his parents divorced, he did not see his father for two to three years. Branden then discovered his father had moved to Arizona and he had limited contact with Branden and his siblings.

After the motor vehicle accident, Branden described his father's personality as obsessive compulsive. He reported his father obsesses over odd things and the focus changes at times. Branden began to notice this sometime between 2001 and 2003, and noted each obsession lasts three to four years. At one point his father obsessed about Native Americans, researching the culture. He wanted to help them even if they suffered from self-inflicted problems. He failed to show up at work at Indian Health Services or was inefficient at work because his Native American friends needed him. Branden also referenced his father once videotaped himself dressed up as a Native American and dancing.

Mr. Beier then began to obsess about exercising and competing in Ironman competitions, which Branden indicated was somewhat positive. However, it affected his work in that Mr. Beier sometimes missed appointments with his patients because he was training for competitions.

In 2011 or 2012, Mr. Beier began to associate with people in their early 20's, which Branden found odd. His brother, Dresden, felt it was inappropriate. Branden believes these people gave his father a false sense of security; he advised his father to stop these associations and warned he would lose his practice. He told his father he was being scammed, as Mr. Beier gave money away to these people and to homeless people, to the point where his wife, Yan Hua, had to cut him off financially. Branden further reported his father was allowing people he barely knew to use cars he financed, which Branden then had to take possession of and sell. He believed these people were "milking him dry."

Branden recalled his father became very quiet and depressed in 2013. His marriage was falling apart, he had poor relationships with his children, he was alone, and he was being scammed. Branden explained the children were not talking to Mr. Beier because he was acting so odd; he had begun to dress like an 18-year-old and let his hair grow long. When asked about the marriage, Branden reported Yan Hua had an affair sometime between 2006 and 2008, which his father revealed to him. Branden characterized the marriage as an open one, in that both Yan Hua and his father had affairs but stayed together for the sake of their children. Yan Hua used to tell Branden about his father's girlfriend and the money he was giving her. He appeared to be involved with women in their 20's and early 30's who had children and were struggling. Branden confronted his father about this and of being "scammed," but Mr. Beier refused to believe him. Branden was unsure if his father was naïve or just needy. He added his belief of Yan Hua also scamming his father for money. He stated his father allows people to control him and believes he simply has a need to be accepted by others.

In 2013 or 2014, Mr. Beier stopped associating with most of this younger crowd and began to become more focused on church. Branden described this as an obsession with the LDS church, in that Mr. Beier advised people in the jail of the world coming to an end and encouraging them to prepare themselves. Branden explained although his father was active in the LDS church during Branden's childhood, it was to a "normal" degree and not like this.

Branden reported his father has no mental health history but he also never sought help. Branden hired his current attorney, Steve Hormel, for sentencing purposes. He reported according to Mr. Hormel, his father had difficulties focusing and argued about what happened at his trial. Regardless, Branden believes his father has accepted his conviction. Nevertheless, he has noticed significant changes in his father's mental status in the past two months. He indicated Mr. Beier has cut off contact with all family, although Branden encourages him to contact others. He noticed his father seems disoriented, needs help using the phones, and was nervous about his cellmate leaving because he was dependent on him to remind him of the rules. Branden was

unsure if this was due to depression, as his father used to call him one to three times weekly from an Idaho jail.

David Jackson, the defendant's half-brother, was telephonically interviewed on December 7, 2016. He reported he is eight years younger than Mr. Beier. He indicated his brother had a difficult upbringing, as their father used to "beat the hell" out of him with a belt. Mr. Jackson indicated he and his other siblings were not abused like this by their father because, unlike the defendant, they were his father's biological children. Mr. Jackson could not recall their mother's reaction to this abuse, but added she was also abusive and beat all the children. He asserted they were beat almost daily, and he recalled his mother slapping him for small infractions such as playing the piano incorrectly. Nevertheless, Mr. Jackson reported his mother escaped from Germany and raised them the best she could, as her mother raised her the same way.

Mr. Jackson reported he lives 70 to 80 miles away from Mr. Beier, and thus only saw him several times a year during holidays. He stated they were not very close. He described his brother's personality as easy-going, funny, and friendly; he never observed him to be angry, depressed, or anxious. Mr. Jackson indicated his mother often told him of what was happening in Mr. Beier's life. For example, he heard his brother became involved with a girl at a strip club, and was jailed a couple of times because of this girl. In fact, their mother bailed him out of jail. Mr. Jackson was also made aware that his brother and wife stayed together for years but slept in different rooms. He reported only having a couple of contacts with Mr. Beier in 2016. Although he did not observe any significant behavioral changes throughout the years, Mr. Jackson noted the defendant has been dealing with his legal issues for a couple of years and he is sure he is depressed about that.

Phone calls Mr. Beier made from FDC SeaTac were also monitored; defendants are aware their calls are monitored. Mr. Beier called his son Branden a few times. On October 20, 2016, he bitterly complained throughout of enduring "psychological trauma" in order to obtain his MRI and PET scans, claimed he was treated like "dog crap," and asserted inmates were treated abusively. However, the defendant also laughed when recounting the story of obtaining his scans, and called the U.S. Marshals "fat as hell." He reported feeling dehumanized to the point of not wanting to write or call people, and complained that the people who "scammed" him were going "scott free." Mr. Beier asserted he was unable to track anything and his memory was "goofed up." However, he was able to recall the name of this psychologist and the frequency of our meetings.

During a call to Branden on December 1, 2016, he reported participating in more psychological tests the day before and "I was just as dumb as a rock." The defendant claimed he was unaware he had so many mental defects and was "clueless" as to what was going on. Branden advised his MRI results were normal but there may have been indications of slight damage to the hippocampus area. Branden also reported the MRI ruled out Alzheimer's or dementia. Mr. Beier

continued to state, "I can't track on things, I can't remember things," and reported his cellmate advised it was obvious Mr. Beier did not know what was going on. He stated he did not know why he was unable to remember meal times after being at FDC SeaTac for over a month.

EVALUATION FINDINGS

Mental Status/Behavioral Observations: Mr. Beier presented as a taller than average, slim Caucasian male who appeared to be his stated age. He was adequately groomed with appropriate hygiene. No difficulties in gait or balance were observed. Mr. Beier exhibited good eye contact and was pleasant, polite and cooperative. He was soft spoken and exhibited normal cadence, prosody, and rate of speech. He sometimes became tangential, especially when speaking about various perceived injustices, but he was either easily redirected to the topic at hand or was able to redirect himself.

The defendant occasionally referenced scripture and various Bible stories, and acknowledged some people may view him as being "overly religious." No signs of hallucinations, delusions, or thought disorganization were observed and he denied all psychotic symptoms. However, Mr. Beier presented with a strong victim-stance, frequently emphasizing how naïve he is and how others often took advantage of him. He began to cry at one point when speaking of this, stating it "makes me feel like an idiot." He also frequently complained of memory and "tracking" problems.

The defendant was oriented to person, time, place, and circumstance, although he was off on the date by two days. He was slow in performing simple mental arithmetic but had no difficulties performing simple spelling. During a mini mental status examination, Mr. Beier's immediate memory was good but he was only able to recall one of three items after a brief delay.

Mr. Beier's mood was dysphoric. He reported feeling sad about his legal circumstances and his ongoing divorce. He indicated being incarcerated was extremely traumatic and he complained the general treatment in custody was abusive. For instance, he complained of policies requiring visual searches after visits and asserted staff should simply allow inmates to smuggle in marijuana, as he did not view that as being significant or dangerous. Mr. Beier rated his mood as a 4 on a scale of 1 to 10 (10 being best), and denied suicidal or homicidal thoughts or intentions. His affect, or emotional responsiveness, was within normal limits and appropriate to the topic being discussed. He was teary when discussing his divorce and his legal case but often laughed when sharing anecdotes of his younger years. The defendant reported good energy, adequate concentration, and good appetite. He reported sleeping too much because he was bored and due to a lack of activities. He also noted sleep was an escape because he had pleasant dreams. Mr. Beier reported spending his time frequently reading scriptures, running laps, and performing push-ups. He stated his religious beliefs get him through the day. He further noted other inmates know he is a physician and ask him for medical advice.

Intellectual Functioning: Cognitive testing was not performed, as defense counsel hired outside experts to perform comprehensive neuropsychological testing.

Personality Dimensions: Results from the PAI indicated Mr. Beier tended to answer questions in an idiosyncratic manner. Furthermore, he tended to portray himself in a positive light and appeared reluctant to recognize and acknowledge minor faults. This does not appear to be highly unusual given his religious upbringing and background. Despite his defensive response style, Mr. Beier endorsed some areas with greater intensity than expected. These include anxiety surrounding a traumatic event and suspiciousness. Please also note Mr. Beier's level of defensiveness most probably underrepresents his true psychological functioning. Indeed, no clinical elevations were noted in areas of mood disorders, thought disorders, or health concerns. The defendant may view himself negatively and may blame himself for past failures. However, this may not be apparent to others, who probably view him as being confident with leadership abilities. Mr. Beier's level of motivation to engage in treatment is significantly lower than those who are in a treatment setting. He denied being in distress and sees no need to change himself.

Diagnoses and Prognosis: On the basis of the available information, Mr. Beier's diagnoses according to the criteria in the Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition (DSM-5) are:

331.83 Mild Neurocognitive Disorder, Due to Traumatic Brain Injury (per Richard Adler, M.D.)

The reader is directed to pages 13 and 14 for a full explanation of this diagnosis, as explained by Dr. Adler. This psychologist does not dispute this diagnosis. However, I would like to provide an alternate/additional hypothesis for some of Mr. Beier's symptoms, particularly his inhibition, inability to have perspective on the basis, rationale, and or motivation of his own and others' behavior, denial of "reality," and lack of accepting responsibility. These symptoms appear to be better explained by long-standing personality traits and maladaptive coping mechanisms.

Mr. Beier is extremely defensive and unwilling to admit to minor flaws and shortcomings, as shown by personality testing conducted by myself, Dr. Ziegler, and Dr. Adler. He engages in substantial impression management and actively avoids negative aspects of himself. Some of this may be attributed to his religious background and upbringing. Mr. Beier also does not appear to possess much insight into his mental and emotional functioning, which again, may be a defense mechanism. His various statements to myself and other professionals indicate he wants to portray himself as a good physician whose intent is solely to help others, which correlates with his religious and spiritual beliefs. He emphasizes being a naïve and gullible victim in various matters, and being easily "conned" and "scammed," although collateral sources indicate he had clearly and repetitively been warned by family members and coworkers of potential scams. The defendant also chose to minimize or omit negative aspects of himself during the interview. He

incorrectly claimed he was close with all his siblings and children and did not disclose he lost a job due to insubordination, his repeated affairs (and description by one son as being somewhat of a womanizer), and legal troubles resulting from his relationship with Ms. Blaski.

It is quite noteworthy Mr. Beier's second marriage was very tumultuous, with his wife openly cheating on him, which in turn, appeared to contribute to his relationship with Ms. Blaski. Branden Beier reported his father may have had a strong need to be accepted by others, which would not be unusual due to his wife's rejection. Therefore, the lack of inhibition viewed by others may have been driven by other needs rather than from a neurocognitive disorder. I also opine the defendant's level of impression management and need to view himself in a positive light is the driving force behind his denial of reality and refusal of responsibility. However, it should also be noted his Branden reported to Dr. Adler his father was truthful when confronted about information related to his legal case.

The prognosis for Mr. Beier is guarded. Again, he possesses very little insight into his psychological functioning and exhibits little introspective skills. Personality testing indicates he does not believe he has a need to change at this time. Although he denied any significant depression, he should continue to be monitored throughout the legal process for depressive symptoms.

OPINION ON THE ISSUE OF PRESENT COMPETENCY TO PROCEED TO SENTENCING

During intermittent discussions of what occurred at his trial, Mr. Beier presented as extremely defensive and indignant. He claimed information from the PSR was inaccurate and stated all the witnesses were not credible and were lying because the case involved a drug ring. He reported the prosecution "bought" the witnesses. He alleged there was no verification of certain things, despite being read different parts of the PSR. Mr. Beier then asserted, "It's like a witch hunt," and then briefly spoke of the Salem witch trials. He also complained of the "crooked authorities," who "manipulated tons of stuff," and then mentioned Christ being crucified unnecessarily.

Mr. Beier reported his attorney has not discussed with him what to expect at the sentencing hearing. He was advised he has the right to allocate, or speak, at the hearing, if desired. He reported he did not think it would help, and would "leave it in God's hands."

In summary, Mr. Beier is not suffering from a mental disease or defect which would substantially impair his ability to understand the proceedings of his sentencing hearing, or to participate in an allocution, if he so chooses. His denial of the facts of the case and refusal to accept responsibility for his actions are volitional and are attributed to his personality traits and his need to view himself positively, rather than to a neurocognitive disorder.

NAME: Beier, Rafael
REGISTER NUMBER: 16223-023
CASE NUMBER: 2:14-cr-00117-EJL
PAGE: 21

Cynthia A. Low, Ph.D.
Forensic Unit Psychologist
WA License #PY2352

Reviewed by: Katherine Skillestad Winans, Ph.D.
Chief Psychologist
WA License #PY60170774

AFFIDAVIT

I, Traci J. Whelan, do swear and affirm the following:

1. I am an officer of the Court and have been admitted to the Idaho State Bar since 1991.
2. I am employed as an Assistant United States Attorney for the District of Idaho and have been so employed since October of 1998.
3. I am an adult over the age of 18 years old.
4. I am part of the prosecution team in the case of the United States v. Rafael Beier 14CR-117-BLW.
5. I have been involved in the case since before the first indictment was filed.
6. Once charges were filed against Dr. Beier, I had repeated contact with Dr. Beier's defense attorney, Jim Siebbe.
7. I conveyed several different offers to Mr. Siebbe which he told me he communicated to Dr. Beier.
8. Mr. Siebe told me, on several occasions, that Dr. Beier refused the offers extended by the United States.
9. Exhibit D is a true and accurate email exchange between Mr. Siebbe and myself.

Dated this 7th day of April, 2021.

Traci J. Whelan

Sworn to and signed in front of me this 7 day of April, 2021.

Crystal Staaben

My Commission Expires: 4/23/26

CRYSTAL STAABEN NOTARY PUBLIC STATE OF IDAHO

EXHIBIT D_001

Whelan, Traci (USAID)

From: Jim Siebe <jsiebe@moscow.com>
Sent: Friday, January 15, 2016 10:14 AM
To: Whelan, Traci (USAID)
Subject: Beier Trial Length

Traci:

Thank you so much for your recent email. I appreciate the effort that went into preparing the potential offer, given our previous outright rejection of your many overtures to settle the case. I plan a long sit-down with Rafael, soon, and while I don't expect things to change, it will be one last chance to confirm or eliminate the chance of resolving the case short of trial.

I wanted to follow-up concerning our conversation regarding the length of the trial. For clarification purposes, I assume your estimate of 5-8 days included my cross examination and case, correct? (Of course, not knowing exactly what my approach will be, I know you have enough trial experience to come close in your estimates). I certainly am not trying to hold you to any specific estimate. I can't imagine it taking longer, either, although I do remember your earlier estimate (before you superseded and before we discussed a number of stipulations) of three weeks.

I am preparing to commit to a number of people this weekend who will rely upon me for travel and equipment for a Grand Canyon trip we am planning following the trial (assuming there is one). This would include forwarding a substantial deposit per person to the NPS for the permit, as my friends most probably won't go if I can't be there to help furnish equipment and manage a 300 mile river trip (Lees Ferry to lake Mead).

Thank you for your attention to my request.

Jim Siebe

UNITED STATES DISTRICT COURT

DISTRICT OF IDAHO

UNITED STATES OF AMERICA, Plaintiff, vs. RAFAEL BEIER, Defendant.	CASE NO. 2:14-cr-00117-EJL **COMPETENCY HEARING DAY 2**

TRANSCRIPT OF PROCEEDINGS - VOLUME 2
BEFORE THE HONORABLE EDWARD J. LODGE
THURSDAY, JULY 27, 2017; 8:46 A.M.
COEUR D'ALENE, IDAHO

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Proceedings recorded by mechanical stenography, transcript produced by computer.

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I N D E X

JULY 27, 2017

sane at the time of the crime. Other issues of competency, such as competency to complete the sentencing, to waive *Miranda* rights, to proceed pro se.

Q. And these are specifically at a court's order; is that correct?

A. Always, yes.

Q. How many forensic psychological assessments have you conducted over the 20 years?

A. I am just estimating, several hundred.

Q. And just to dig a little deeper on that, approximately, if you know, how many do you do per year?

A. Per year, approximately 40.

Q. And you have worked there for 20 years, correct?

A. Yes. And I have been a forensic psychologist there since 2001.

Q. Okay. Sixteen years?

A. Yes.

Q. Thank you.

Now, you just talked to us a little bit about the different kinds of assessments you do: competency to stand trial, proceed pro se, whether they're competent for *Miranda* waivers, and competency to proceed to sentencing, as well as a few insanity defenses, correct?

A. Yes.

Q. What specifically were you asked to do by the Court in this

case?
A. I was asked to render an opinion about Dr. Beier's competency to proceed to sentencing.
Q. And that is the only thing you were asked to evaluate?
A. Yes.
Q. And is that the only thing you will be addressing today in your testimony?
A. Yes.
Q. Dr. Low, in the course of your work, have you ever concluded that an individual was not competent?
A. Certainly.
Q. And how often have you found somebody not competent to proceed?
A. Approximately 15 percent.
Q. In the course of your work, have you ever concluded, consequently then, that an individual was competent?
A. Yes.
Q. And how often does that happen?
A. That would be approximately 85 percent.
Q. And is that in line with the national standards?
A. I believe it is in line with the national statistics.
Q. Yes. I'm so sorry; it is statistics, not standards.
And then in the course of your work, have you ever been able to not make a determination regarding competency?
A. Yes.