No. _____

IN THE

Supreme Court of the United States

MICHAEL DUANE ZACK,

Petitioner,

v.

RON DESANTIS, ET AL.,

Respondents.

On Petition for a Writ of Certiorari to the United States Court of Appeals for the Eleventh Circuit

APPENDIX TO PETITION FOR A WRIT OF CERTIORARI

THIS IS A CAPITAL CASE WITH AN EXECUTION SCHEDULED FOR TUESDAY, OCTOBER 3, 2023, AT 6:00 P.M.

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CERTIFICATE OF SERVICE

I HEREBY CERTIFY that a true copy of the foregoing has been furnished by United States Mail, first-class postage prepaid, to Jason W. Rodriguez, Assistant Attorney General, Office of the Attorney General, PL-01, The Capitol, Tallahassee, FL 32399, on this 28th day of September, 2023.

Respectfully submitted,

/s/ LINDA McDERMOTT
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INDEX TO APPENDIX

ATTACHMENT A

Zack v. Governor of Fla.

United States Court of Appeals for the Eleventh Circuit

September 26, 2023, Filed

No. 23-13021 Non-Argument Calendar

Reporter
2023 U.S. App. LEXIS 25432 *

MICHAEL DUANE ZACK, III, Plaintiff-Appellant, versus GOVERNOR OF THE STATE OF FLORIDA, CHIEF FINANCIAL OFFICER, ATTORNEY GENERAL, STATE OF FLORIDA, COMMISSIONER OF AGRICULTURE, CHAIRWOMAN FLORIDA COMMISSION ON OFFENDER REVIEW, COORDINATOR, OFFICE OF EXECUTIVE CLEMENCY, DIRECTOR, OFFICE OF CLEMENCY INVESTIGATIONS, USCA11

Core Terms

clemency, updated, candidacy, notice, member of the board, death-row, interview, district court, membership, merits, stay of execution

Opinion

[*1] 2 Order of the Court 23-13021

Defendants-Appellees.

Appeal from the United States District Court for the Northern District of Florida D.C. Docket No. 4:23-cv-00392-RH

Before WILLIAM PRYOR, Chief Judge, and ROSENBAUM and JILL

PRYOR, Circuit Judges.

PER CURIAM:

Michael Duane Zack is a Florida death-row prisoner who is scheduled to be executed on October 3, 2023, at 6:00 p.m.

Zack brings this action under *42 U.S.C. § 1983*, arguing that Governor Ron DeSantis and several other state officials violated his constitutional right to due process because they allegedly have not adequately considered his request for executive clemency. Along-side his complaint, he moved for an emergency stay of execution. The district court denied Zack's motion for a stay.

Zack now moves in this Court for a stay of execution pend-ing his appeal of the district court's decision. After reviewing the record and the governing legal standards, we agree with the district court, and we too deny Zack's request for a stay.

USCA11 Case: 23-13021 Document: 10-1 Date Filed: 09/26/2023 Page: 3 of 16

23-13021 Order of the Court 3

I. BACKGROUND

Zack is a Florida death-row prisoner who was

sentenced to death in 1997 **[*2]** following his conviction for the sexual assault, rob-bery, and murder of Ravonne Kennedy Smith. His execution is scheduled for October 3, 2023, at 6:00 p.m. The facts concerning Zack's crimes were set forth in the Florida Supreme Court's deci-sion affirming his convictions and sentence. *Zack v. State, 753 So. 2d 9, 13-14 (Fla. 2000)* (per curiam). Because they do not bear on the issues presented here, we do not discuss them further. Instead, we focus on Florida's clemency procedures-the subject of Zack's current challenge.

A. Clemency in Florida

Under Florida law, the executive branch has the authority to commute punishments. *Fla. Const. art. IV, § 8(a)*; *Fla. Stat. § 940.01(1)*. Florida law does not impose any limitations on state officials' exercise of their discretion. *Barwick v. Governor of Florida, 66 F.4th 896, 898 (11th Cir. 2023)*; *Bowles v. DeSantis, 934 F.3d 1230, 1235-36 (11th Cir. 2019)*. "[T]he people of the State of Florida have vested 'sole, unrestricted, unlimited discretion exclusively in the executive in exercising this act of grace.'" *Carroll v. State, 114 So. 3d 883, 888 (Fla. 2013)* (quoting *Sullivan v. Askew, 348 So. 2d 312, 315 (Fla. 1977)*).

Clemency decisions are made by the Clemency Board, which includes the Governor and the Cabinet-the Chief Financial Officer, the Attorney General, and the Commissioner of

USCA11 Case: 23-13021 Document: 10-1 Date Filed: 09/26/2023 Page: 4 of 16

4 Order of the Court 23-13021

Agriculture. *Fla. Stat. § 940.01(1)*; *Barwick, 66 F.4th at 898*. To gov-ern clemency procedures, the Board has adopted the **[*3]** *Florida Rules of Executive Clemency. Parole Comm'n v. Lockett, 620 So. 2d 153, 155 (Fla. 1993)*. The clemency procedures for capital prisoners are largely dictated by Rule 15, which is titled "Commutation of Death Sentences." Fla. R. Exec. Clemency 15.

Under Rule 15, the Florida Commission on Offender Re-view ("Commission")-which is distinct from the Clemency Board-"may conduct a thorough and detailed investigation into all factors relevant to the issue of clemency and provide a final re-port to the Clemency Board." *Id.* at 15(B). The investigation begins either "at such time as designated by the Governor" or, in the ab-sence of any action by the Governor, "immediately after the de-fendant's initial [federal] petition for writ of habeas corpus … has been denied by the Eleventh Circuit Court of Appeals …." *Id.* at 15(C). And "[c]ases investigated under previous administrations may be reinvestigated at the Governor's discretion." *Id.*

After an investigation, the Commission prepares and issues a final report to the Board with its findings and conclusions. *Id. at 15(D)*. Florida law requires that report to include "the circum-stances, the criminal records, and the social, physical, mental, and psychiatric conditions and histories of persons under consideration by the board for pardon, commutation of sentence, or remission of fine, **[*4]** penalty, or forfeiture." *Fla. Stat. § 947.13(1)(e)*. The final re-port "shall be forwarded to all members of the Clemency Board within 120 days of the commencement of the investigation, unless

USCA11 Case: 23-13021 Document: 10-1 Date Filed: 09/26/2023 Page: 5 of 16

23-13021 Order of the Court 5

the time period is extended by the Governor." Fla. R. Exec. Clem-ency 15(D).

Once the final report has been submitted to the Clemency Board, any member of the Board has twenty days to request a hear-ing. *Id. at 15(E)*. That time restriction does not apply to the Gov-ernor, who may set a hearing at any time. *Id.* at 15(F). The Rules do not provide any other restrictions or limitations on the timing of the Clemency Board's ultimate decision on a death-row pris-oner's clemency candidacy. Nor do the Rules otherwise discuss special procedures for clemency proceedings that were initiated during a previous gubernatorial administration.

The Rules are also silent regarding whether clemency candi-dates may submit additional materials to the Board after the initial investigation, interview, and report. Put differently, the Rules nei-ther authorize nor preclude supplemental submissions of any infor-mation a clemency candidate believes the Board should consider.

The clemency **[*5]** process must be concluded before the Gover-nor may issue a warrant for execution. *Fla. Stat. § 922.052(2)(b)*; *Abdool v. Bondi, 141 So. 3d 529, 545 (Fla. 2014)* ("[T]he statute spe-cifically provides that no capital defendant will be executed unless executive clemency proceedings have concluded.").

B. Zack's Clemency Proceeding

Zack's clemency proceeding began in May 2013. He was represented by counsel from the Office of the Public Defender for the Tenth Judicial Circuit. Zack's clemency interview took place

USCA11 Case: 23-13021 Document: 10-1 Date Filed: 09/26/2023 Page: 6 of 16

6 Order of the Court 23-13021

on April 24, 2014. And his memorandum in support of his candi-dacy was submitted on May 23, 2014.

Following the submission of his memorandum, neither Zack nor his counsel received any contact or communication from the Commission or the Board. That silence continued until August 17, 2023, when the Commission sent a letter to Zack's counsel to notify them that the Governor denied Zack's request for clemency and simultaneously issued a death warrant.

In between the time when Zack's clemency materials were submitted in 2014 and when Zack's clemency request was denied in 2023, the entire membership of the Clemency Board turned over. And the Supreme Court of the **[*6]** United States decided two cases during this period finding defects in Florida's capital-punish-ment scheme. *See Hall v. Florida, 572 U.S. 701 (2014)*; *Hurst v. Flor-ida, 577 U.S. 92 (2016)*. Zack also alleges that, during this time, there have also been significant developments in research about Fetal Alcohol Syndrome ("FAS"), a condition from which he suf-fers.

C. Procedural History

On September 5, 2023, Zack initiated this action in federal district court, alleging that the Governor and the other members of the Clemency Board violated his federal constitutional right to due process by inadequately considering his candidacy for clem-ency. He also moved for an emergency stay of execution.

USCA11 Case: 23-13021 Document: 10-1 Date Filed: 09/26/2023 Page: 7 of 16

23-13021 Order of the Court 7

The thrust of Zack's argument is that he was effectively de-nied access to the clemency process because neither he nor his counsel were notified that the Governor was actively

considering his candidacy. He believes it was significant that (1) the full com-position of the Clemency Board changed since his clemency mate-rials were submitted, and (2) there have been developments in FAS research, so the Board could not have considered all the relevant factors. Zack essentially argues **[*7]** that he has a right to be heard by the current members of the Clemency Board regarding develop-ments that occurred after his first clemency interview.

The state officials ("State") moved to dismiss his complaint or for judgment on the pleadings, and they opposed his request for a stay of execution. The State argues that the procedures provided during Zack's clemency proceeding satisfy the minimum standards imposed by the Due Process Clause. In the State's view, the new membership of the Clemency Board does not entitle Zack to a new clemency interview, and because clemency is an ongoing process Zack can still submit any written materials to the Board for full consideration.

The district court denied Zack's motion for a stay of execu-tion. It observed that Zack had a clemency hearing and made a written submission to the Board, and it concluded that his clem-ency process satisfied the Due Process Clause. The district court noted that the State's clemency procedures did not prevent Zack from submitting additional materials about FAS if he believed they would support his clemency application. And it concluded that the

Due Process Clause "does **[*8]** not require the clemency process to start and finish between elections or before the Clemency Board's mem-bership changes."

Zack moved in this Court for an emergency stay of execu-tion pending appeal.

II. STANDARD OF REVIEW

"We may grant a stay of execution only if the prisoner 'es-tablishes that (1) he has a substantial likelihood of success on the merits, (2) he will suffer irreparable injury unless the injunction is-sues, (3) the injunction would not substantially harm the other liti-gant, and (4) if issued, the injunction would not be adverse to the public interest.'" *Barwick, 66 F.4th at 900* (quoting *Bowles, 934 F.3d at 1238*). "To obtain a stay, the prisoner 'must satisfy all of the re-quirements for a stay, including a showing of a significant possibil-ity of success on the merits.'" *Id.* (quoting *Hill v. McDonough, 547 U.S. 573, 584 (2006)*).

The prisoner's likelihood of success on the merits is "[t]he 'first and most important question'" before us. *Id. at 902* (quoting

Jones v. Comm'r, Ga. Dep't of Corr., 811 F.3d 1288, 1292 (11th Cir. 2016)). If he cannot meet that requirement, we need not consider the remaining factors. *See id.*

III. DISCUSSION

We begin with Zack's likelihood of success on the merits.

There is no debate that death-row prisoners have a **[*9]** limited cognizable due-process interest in their state clemency proceed-ings. *Ohio Adult Parole Auth. v. Woodard, 523 U.S. 272, 289 (1998)* (O'Connor, J., concurring in part and concurring in the judgment). Justice O'Connor's concurring opinion "provides the

holding in

Woodard." *Barwick, 66 F.4th at 902*. *See also Wellons v. Comm'r, Ga. Dep't of Corr., 754 F.3d 1268, 1269 n.2 (11th Cir. 2014)* (acknowledg-ing that Justice O'Connor's concurrence "set binding precedent"). Her concurrence establishes that the Due Process Clause requires "some *minimal* procedural safeguards" in clemency proceedings to protect a death-row prisoner's life interest. *Woodard, 523 U.S. at 289* (O'Connor, J., concurring in part and concurring in the judg-ment) (emphasis in original).

Justice O'Connor provided a few examples in which judicial intervention might be warranted in the clemency process. *Id.* Those examples contemplated "a scheme whereby a state official flipped a coin to determine whether to grant clemency," or a case in which "the State arbitrarily denied a prisoner any access to its clemency process." *Id.* After suggesting that there may be in-stances in which a clemency process violated the Due Process Clause, she concluded that the clemency process at issue in *Woodard* itself-which provided the prisoner with three days' no-tice of his clemency interview, ten days' notice of his hearing, ex-cluded his counsel from the interview, and prohibited **[*10]** evidence at the hearing-did not violate the Due Process Clause. *Id. at 289-90*.

USCA11 Case: 23-13021 Document: 10-1 Date Filed: 09/26/2023 Page: 10 of 16

10 Order of the Court 23-13021

Since *Woodard*, we have said "'the key word' in Justice O'Connor's opinion 'is minimal.'" *Barwick, 66 F.4th at 903* (quot-ing *Gissendaner v. Comm'r, Ga. Dep't of Corr., 794 F.3d 1327, 1331 (11th Cir. 2015)* (alteration and internal quotation marks omitted)). Outside the "'extreme situations'" suggested in her opinion, "the federal Due Process Clause does not justify judicial intervention into state clemency proceedings." *Gissendaner, 794 F.3d at 1331* (quoting *Faulder v. Tex. Bd. of Pardons & Paroles, 178 F.3d 343, 344 (5th Cir. 1999)*). The Florida Constitution "vests the clemency power solely in the executive branch, and the exercise of the power is discretionary." *Valle v. Sec'y, Fla. Dep't of Corr., 654 F.3d 1266, 1268 (11th Cir. 2011)*. Clemency is "granted as 'a matter of grace.'" *Id.* (quoting *Woodard, 523 U.S. at 280-81* (plurality opinion)).

In this case, Zack contends that his state clemency proceed-ing violated the Due Process Clause because the full composition of the Clemency Board has changed since he submitted his clem-ency materials in 2014. He also argues that the current Board could not have considered all the relevant factors because he was de-prived of notice that the Governor was actively considering his clemency application and he has not had an opportunity to submit updated materials regarding scientific developments in the study of FAS. But we cannot agree that **[*11]** any purported deficiency rises to the level required to sustain a constitutional violation.

First, the change in Clemency Board membership does not yield a due-process violation. The Board members who made the final determination to deny Zack clemency had access to all the

USCA11 Case: 23-13021 Document: 10-1 Date Filed: 09/26/2023 Page: 11 of 16

23-13021 Order of the Court 11

same materials as the Board members who may have reviewed his candidacy when it was first submitted in 2014. For example, the current Board members could review the same final report the Commission submitted in 2014

and they could then use that report to inform their determination about whether clemency is war-ranted. So the change in membership itself does not suggest that the clemency procedures here were arbitrary or otherwise imper-missible.

Our precedent suggests that a change in the composition of the Board membership does not entitle a death-row prisoner to any additional procedural safeguards in the clemency process. In *Mannv. Palmer*, a death-row prisoner argued that Florida's clemency pro-cedures violated the Due Process Clause because, after the prisoner received a full clemency hearing with counsel present in 1985, he and **[*12]** his counsel were denied access to an updated clemency inves-tigation that the Governor conducted in 2013. *713 F.3d 1306, 1316 (11th Cir. 2013)*. Despite the significant passage of time, we held that Florida's procedures were consistent with the Due Process Clause. *Id.* The prisoner received a full hearing, with the assistance of counsel, and state law did not entitle him to any other proce-dures. *Id.*

Zack claims that *Mann* is not on point because Zack can point to several issues that the Board has not yet considered-such as the updated research about FAS-whereas, in *Mann*, the Board considered all the relevant information. But while there was a sec-ond hearing there, we explained that "Florida law did not obligate

USCA11 Case: 23-13021 Document: 10-1 Date Filed: 09/26/2023 Page: 12 of 16

12 Order of the Court 23-13021

the Governor to grant [the prisoner] a second clemency hearing" despite the significant passage in time and the different composi-tion of the Board when clemency was denied. *Id.* And when con-sidering Zack's clemency candidacy, the Board has wide latitude to choose which information it considers.

We have also previously held that every clemency board member need not attend every clemency hearing. In *Gilreath v.State Board of Pardons* **[*13]** *and Paroles*, we reviewed a situation in which one clemency board member was absent from a clemency board meeting at which people spoke in favor of the prisoner's clemency candidacy. *273 F.3d 932, 934 (11th Cir. 2001)* (per curiam). We concluded that the board member's absence from the oral presen-tations did not amount to a due-process violation. *Id.* The record in that case showed that the absent board member reviewed the comprehensive written files in the matter and discussed the oral presentations that he missed with a clemency-board lawyer. *Id.*

Zack believes that the turnover among the Clemency Board members creates a constitutional defect because, under the Clem-ency Rules, the current Board members could not have requested a hearing about Zack's candidacy. But even if the current Board members could not unilaterally decide to schedule a hearing, the Clemency Rules permit the Governor to set a hearing at any time. Fla. R. Exec. Clemency 15(F). And clemency cannot be granted without the Governor's approval. *Fla. Stat. § 940.01(1)*. So if the necessary members of the Clemency Board believed a hearing was warranted, the Rules provided a mechanism for such a hearing.

USCA11 Case: 23-13021 Document: 10-1 Date Filed: 09/26/2023 Page: 13 of 16

23-13021 Order of the Court **[*14]** 13

Second, the record and governing legal standards do not support Zack's argument that he has been deprived of notice or that the State has prevented him from submitting

additional mate-rials regarding FAS or its effect on his development and upbringing. On notice, Zack does not dispute that he had notice of and partici-pated in the clemency interview that took place in 2014. And we are unaware of any authority to support Zack's argument that he is constitutionally entitled to additional notice that the Governor is reviewing his clemency application. Once the clemency materials are properly before the Board, the Board may render its decision at any time. *See* Fla. R. Exec. Clemency 4 (explaining that the Gover-nor has the "unfettered discretion" to deny, and the Governor and Board have the "unfettered discretion" to grant, clemency "at any time, for any reason"); *see also* *Gissendaner, 794 F.3d at 1331* (hold-ing that notice of clemency hearing and opportunity to present oral testimony and written statements supporting clemency application satisfied Due Process Clause).

As for the additional submissions to the Board about FAS, there is no provision in the Clemency Rules that prevented Zack from providing supplemental materials if he believed they would bolster **[*15]** his clemency application. Indeed, the State represents that he still may do so. According to the State, the Clemency Board would consider any new materials, even if clemency had previ-ously been denied, because clemency in Florida is an ongoing pro-cess.

USCA11 Case: 23-13021 Document: 10-1 Date Filed: 09/26/2023 Page: 14 of 16

14 Order of the Court 23-13021

Zack suggests we should not take the State's representations at face value because the Commission sent a letter to Zack's coun-sel indicating that the signed death warrant "concludes the clem-ency process." But despite that letter, the State has said that any materials Zack submits will receive full consideration. In essence, the State says it will provide Zack with the same relief he seeks from us-the Clemency Board's full consideration of his updated FAS materials. And we have no reason to believe that the Board's review would be different whether we order it to conduct that re-view or whether it does so on its own volition. In either scenario, the Board will ultimately decide whether Zack's updated FAS ma-terials warrant clemency based on whatever criteria the Board chooses to consider.

While Zack is correct that there is no Clemency **[*16]** Rule affirm-atively authorizing supplemental submissions, there is also no Rule precluding them. And the State says that any materials that Zack submitted about the research on FAS would have been considered as part of his clemency application. So based on the record, we cannot conclude that there was no opportunity for Zack's counsel to submit updated materials.

Zack believes that he should have an opportunity to submit his supplemental information without the threat of an active death warrant because, in his view, any post-warrant submissions "cer-tainly will encounter a greater burden of review as to the standard for granting clemency than one would pre-warrant." But because the Board has significant discretion to dictate the clemency

USCA11 Case: 23-13021 Document: 10-1 Date Filed: 09/26/2023 Page: 15 of 16

23-13021 Order of the Court 15

standards, we have no way to evaluate the correctness of Zack's claim. And even if we could, we have explained that "the Clem-ency Board retains wide latitude to render its decisions, and judicial review of those decisions is quite limited." *Barwick, 66 F.4th at 905*.

Finally, Zack argues that the State's assertion about the on-going nature of clemency overlooks the fact that **[*17]** there are no addi-tional financial resources available to Zack's clemency counsel and that Zack's state-court counsel is prohibited from assisting with his clemency application. *See* Fla. Stat. § 27.711(11). Zack is correct that the divided nature of his representation creates challenges as-sociated with submitting updated materials to the Clemency Board after clemency counsel exhausts its state funding. *See* Fla. Stat. § 940.031(2) (limiting clemency counsel's compensation to $10,000). But since there is no constitutional right to clemency counsel, Bowles, 934 F.3d at 1242 n.8, we cannot conclude that the challenges associated with Zack's divided representation violate the Due Process Clause. The remedy for these problems must come from state law. *See* id. at 1246.

* * *

Because the Clemency Rules do not prevent Zack from sub-mitting the updated FAS materials, we cannot conclude that the Board's purported failure to consider them violated Zack's right to due process. No matter what we say in this decision, Zack retains the opportunity to submit these materials to the Board for its con-sideration. And any opinion we offered about whether the updated evidence is compelling could not affect the ultimate decision about

USCA11 Case: 23-13021 Document: 10-1 Date Filed: 09/26/2023 Page: 16 of **[*18]** 16

16 Order of the Court 23-13021

Zack's clemency application. That decision lies exclusively with the Governor and the Clemency Board. Bowles, 934 F.3d at 1242 (explaining that "the federal judiciary exercises very little, if any, oversight" over the state executive officials' exercise of their discre-tion in the clemency process).1

IV.CONCLUSION

Zack's due-process claim does not have a substantial likeli-hood of success on the merits. We must therefore deny his motion for a stay of execution pending appeal.

MOTION FOR A STAY OF EXECUTION PENDING APPEAL DENIED.

1 Because we conclude Zack's challenge to Florida's clemency procedures is unlikely to succeed on the merits, we do not consider the remaining stay fac-tors.

End of Document

ATTACHMENT B

DECLARATION OF NATALIE NOVICK BROWN, PhD, SOTP
PURSUANT TO 28 U.S.C. SEC. 1746 AND SEC. 92.525 OF TITLE VII, FLORIDA STATUTES

1. I am a clinical and forensic psychologist with specialized postdoctoral training in Fetal Alcohol Spectrum Disorders (FASDs) at the University of Washington, which was followed by 27 years of forensic and clinical experience in that field. Since my formal training in the mid-1990s, I have maintained my expertise in FASD in several ways: ongoing review of relevant literature, research on the developmental and behavioral manifestations of prenatal alcohol exposure, authoring over 40 publications on FASD in the peer-reviewed literature, and evaluating hundreds of individuals with FASD in legal jurisdictions around the United States. My resume is appended to this declaration.

2. In my capacity as a forensic expert on FASD, I was retained by current defense counsel for Michael Duane Zack, an individual with a longstanding Fetal Alcohol Syndrome (FAS) diagnosis. Mr. Zack's FAS was diagnosed prior to, and presented in mitigation at, his 1997 trial. Subsequently, previous and current counsel have raised the issue that Mr. Zack is intellectually disabled. I was informed of and have reviewed documents reflecting a 2015 neuropsychological finding that Mr. Zack meets diagnostic criteria for intellectual disability (ID). I also am aware that the Florida courts ruled he was not intellectually disabled because his IQ scores were considered to be disqualifying.

3. Mr. Zack's current attorneys asked me to provide information regarding: (a) the evolution of medical and scientific knowledge regarding FASD, (b) how FASD relates to ID, and (c) the concept of "intellectual disability equivalence" as it relates to a diagnosis of FASD (specifically FAS). This declaration provides my findings, to a reasonable degree of professional certainty.

The evolution of medical and scientific understanding related to FASD

4. This year marks the 50th anniversary of the first peer-reviewed publication in the United States on FASD.

5. The first documentation of what we know as Fetal Alcohol Syndrome occurred in a French peer-reviewed journal in 1968. That medical publication did not include diagnostic criteria, nor did it lead to recognition of FAS in France or anywhere else in the world. Five years later in 1973, two United States physicians, including Kenneth Lyon Jones, noted a pattern of birth defects (facial anomalies, growth deficiency, and central nervous system abnormality) in 11 infants with unrelated backgrounds. The mothers of all these children were alcoholics. The disorder was called Fetal Alcohol Syndrome.

6. By the end of the 1970s, animal studies had established that alcohol was a teratogen – a substance that easily crossed the placenta to produce physical damage in a developing embryo or fetus. Autopsy studies on infants with FAS confirmed the

vulnerability of the fetal brain to alcohol exposure. It was soon discovered that such exposure was the most frequent cause of mental deficiency.

7. In 1980, the Research Society on Alcoholism issued the first diagnostic guidelines for FAS, which involved three criteria in the context of prenatal alcohol exposure: (1) a characteristic pattern of facial abnormalities, (2) pre- or postnatal deficiency in height and/or weight, and (3) central nervous system (CNS) damage.

8. In 1981, the U.S. Surgeon General issued a national health advisory warning pregnant women about the dangers of alcohol to their unborn children, including brain damage. [This health advisory would be updated by the Surgeon General in 2005.] In 1988, the Director of the Office of Scientific Affairs of the National Institute on Alcohol Abuse and Alcoholism warned that brain damage in FAS was permanent and that cognitive deficits associated with that brain damage appeared to worsen with age and persist into adulthood. This led Congress to pass the Alcoholic Beverage Labeling Act (PL 100-690), which required every alcoholic beverage container sold in the United States to carry a label warning women against drinking during pregnancy.

9. Throughout the 1970s and 1980s, most of the early research on FASD focused on infants and young children with either FAS or what was then termed Fetal Alcohol Effects (FAE), a condition involving the same brain damage as in FAS but without the outward physical manifestations (i.e., facial dysmorphia and growth deficiency). These early government-funded studies investigated some of the more obvious anomalies associated with prenatal alcohol exposure such as stillbirth and premature birth as well as cognitive deficits and neurobehavioral effects. Chronological in design, this research initially followed the developmental trajectories of young children with FASD for seven years. Later, additional grants would extend this longitudinal perspective throughout childhood to the adult years.

10. By the end of the 1980s, studies in Europe as well as the United States had found that even if prenatal alcohol exposure did not result in outright intellectual disability as quantified then by an IQ cutoff score, it could cause significant impairment in executive functioning, with direct, severe, and far-reaching effects on adaptive behavior and developmental outcomes. Eventually, the neurodevelopmental and behavioral impairments in FASD were found to be produced at lower exposure levels than seen in FAS.

11. By the early 1990s, it was becoming apparent in the scientific field that the cognitive and adaptive impairments in FASD were the key diagnostic element because they involved thinking and behavior and as such were far more devastating than the growth deficiency and facial abnormalities seen in FAS. However, it would take approximately two more decades for the mental health literature to formally acknowledge the central importance of the cognitive and adaptive dysfunction in FASD.

12. By the mid-1990s, the longitudinal research was beginning to find convergent evidence that executive dysfunction was universal in FASD, as was significantly

disturbed social behavior and maladaptive coping, including social incompetence. In the context of childhood adversity, social incompetence manifested as a negative developmental trajectory characterized by coping failures in many functional domains.

13. Our relevant professional community now understands that ID is less a disorder of rote learning and more a disorder of thinking and ability to adjust schemas to adapt to changing situations. Deficits in that regard constitute adaptive dysfunction, of which one of the most important and overlooked impairments is poor social judgment. More than simple "niceness" or social popularity, social judgment involves executive decision-making and anticipating likely outcomes from particular courses of action while recognizing and avoiding risk. In fact, impaired social judgment is a core defining feature of the adaptive dysfunction in FASD.

14. Despite these advances, little was known about how prenatal alcohol exposure could affect adult behavior, particularly its nexus to criminal offending. Early efforts by lawyers to raise FASD during criminal (and especially capital) trials motivated some research scientists to investigate the lifelong functional implications of FASD, which led to Center for Disease Control (CDC) funding for a large study of children, adolescents, and adults with FASD. The study looked at maladaptive coping patterns, characterizing the developmental consequences of impaired coping as "secondary disabilities." When the study was published in 1996, results were (and still are) considered groundbreaking.

15. The secondary disabilities study identified eight adverse developmental outcomes associated with FASD: mental health problems, school disruption, substance abuse, trouble with the law, confinement, sexually inappropriate behavior, dependent living, and employment problems. Risk and protective factors also were identified in the study. Among the most important protective factors were early FAS diagnosis by age six, developmental disabilities services throughout the school years, and stable, protective, nurturing caregiving. Risk factors were abuse and neglect, exposure to domestic violence, an IQ greater than 70, and an FASD diagnosis other than FAS (i.e., FAE at the time). Regarding the latter, it was understood that because of its physical manifestations, FAS was more "visible" to caregivers and professionals and therefore easier to identify than FAE.

16. Notably, the secondary disabilities study found that a high percentage of youths and adults with FASD had been arrested or convicted at least once in their life. For males with FASD between the ages of 12 and 51, 68% were found to have experienced trouble with the law. But despite that discovery, the scientific community still did not know the specific cognitive and adaptive difficulties in FASD that interacted with environmental factors to cause criminal conduct.

17. Throughout the 1990s, additional medical discoveries occurred that shed light on the nexus between FASD and the legal system. In particular, a 1991 study found IQ did not predict cognitive and adaptive functioning in FASD, making IQ somewhat irrelevant to diagnosis.

18. In 1996, the Institute of Medicine (IOM) published a set of medical diagnostic criteria that specified five conditions under the FASD umbrella: FAS with confirmation of prenatal alcohol exposure, FAS without that confirmation, partial FAS (pFAS), Alcohol Related Neurodevelopmental Disorder (ARND), and Alcohol Related Birth Defects (ARBD). The diagnosis ARND replaced the previous diagnosis FAE. Of the five IOM diagnoses, only FAS had the entirety of visible physical features (facial abnormalities and growth deficiency) as well as the brain damage. Partial FAS had some of the physical features, and ARND had none. However, criteria for all FASD conditions except ARBD (a diagnosis for skeletal and organ abnormalities) required CNS abnormality, which was defined generally as structural or functional anomalies. Thus, IOM's emphasis in the 1996 criteria remained on the outward physical manifestations of prenatal alcohol exposure.

19. In 2001, the FASD Legal Issues Resource Center was established at the University of Washington's Fetal Alcohol and Drug Unit. This was a first-of-its-kind program to promote flow of information about FASD between the scientific and legal communities. Lawyers would provide transcripts and other records from cases involving clients who suffered from FASD, and the organization would use that information to educate legal professionals about the conditions. For example, the Center provided information highly relevant to the legal field, such as individuals with FASD could be eager to please, vulnerable to suggestion, easily led by others, susceptible to manipulation, unaware of easily predictable consequences, and impulsive to the point of engaging in catastrophic behaviors that seemed inexplicable. One of the earliest instances where the FASD Legal Issues Resource Center collaborated was Mr. Zack's case.

20. Following Mr. Zack's trial in 1997, several diagnostic systems were published in the United States that clarified, specified, and refined the IOM diagnostic criteria: the 4-Digit Code, CDC's guidelines for FAS, and two revisions of the IOM protocol. These updates went far beyond the 1996 guidelines to specify how the functional criteria in the CNS abnormality were to be defined and quantified. However, while these newer systems maintained the basic four-pronged diagnostic schema (prenatal alcohol exposure, facial dysmorphia, growth deficiency, and CNS abnormality), varying definitions of the functional CNS criteria created confusion. Also of concern, emphasis in the new diagnostic systems remained on the physical (medical) criteria rather than the functional (mental health) symptoms. Because both medical and mental health criteria were involved, diagnosing FASD required a multidisciplinary team.

21. Consistent with the historic emphasis on the physical features in FASD, the fourth editions of the Diagnostic and Statistical Manual (DSM-IV and DSM-IV-TR) diagnosed the mental health sequelae of FASD very generally as *cognitive disorder not otherwise specified*, providing no specific functional criteria. In fact, it was not until 2013 that this situation changed markedly with publication of DSM-5, which included specific diagnostic criteria for the CNS dysfunction in FASD. The diagnosis was called *Neurobehavioral Disorder Associated with Prenatal Alcohol Exposure* (ND-PAE), and its purpose was to address the brain damage from exposure in functional terms.

Importantly, the committee developing these criteria was composed of many of the most prominent North American researchers in the field of FASD. Thus, the ND-PAE guidelines represented the current science at the time.

22. Within the NS-PAE guidelines, DSM-5 codified three "super domains" of impaired functioning: neurocognitive, self-regulation, and adaptive functioning. The focus was solely on functioning in the context of prenatal alcohol exposure, and diagnosis could be made with or without the presence of physical anomalies (i.e., the physical features were irrelevant). Essentially, ND-PAE clarified the neurodevelopmental and behavioral health symptoms associated with FASD, emphasizing three important aspects of the functional impairment in the disorder: (a) neurocognitive impairment included executive dysfunction; (b) executive dysfunction involved mental control (self-regulation) of attention, emotion, behavior, and impulses; and (c) adaptive dysfunction (e.g., inability to manage appropriate social and personal behavior) was paramount. Later research in 2006 and 2012 would find that executive dysfunction in FASD actually *predicted* adaptive impairment, a direct causal link unique to ID as well as FASD.

23. Until DSM-5, understanding the legal relevance of FASD in defendants such as Mr. Zack was beyond the reach of diagnostic schemes emphasizing the physical anomalies in FASD. Although FASD was diagnosed in the forensic context by medical professionals in the 1990s and early 2000s, until DSM-5 there were no clear criteria for evaluating the brain *dysfunction* and understanding its direct nexus to criminal behavior. Thus, publication of DSM-5 showed that at the time of Mr. Zack's trial, the science regarding the impact of FASD on functioning was inexact.

24. Emphasis in ND-PAE on the functional deficits in FASD mirrored DSM-5's emphasis on executive/adaptive functioning and de-emphasis of an IQ number in ID. In fact, as delineated by DSM-5, ND-PAE is essentially identical to ID except for precise IQ score in the latter and confirmation of prenatal exposure to alcohol in the former. In DSM-5, both ND-PAE and ID involve deficits in "intellectual functions," which are defined almost entirely in terms of *executive* rather than intellectual skills (i.e., deficits in general mental abilities, such as reasoning, problem solving, planning, abstract thinking, judgment, academic learning, and learning from experience). Both conditions involve adaptive dysfunction, which is defined in DSM-5 as "fail(ure) to meet standards of personal independence and social responsibility in one or more aspects of daily life, including communication, social participation, academic or occupational functioning, and personal independence at home or in community settings." As in ID, cognitive and adaptive impairments in FASD manifested during the developmental period.

25. In the years immediately following DSM-5's release, full scientific consensus regarding the brain dysfunction in FASD, especially as it pertained to ID-equivalence, had not yet been reached. This delay was reflected by the fact that DSM-5's proposed diagnostic criteria for ND-PAE were not included in the manual's core section of Diagnostic Criteria and Codes (which contains officially recognized diagnoses available for clinical usage) but rather in a section called "Conditions for Further

Study," which described proposed criteria for which future research was encouraged. However, by that point, the research underlying ND-PAE had a 40-year history of convergent findings – a distinction far exceeding the diagnostic criteria for nearly all other conditions in the DSM-5, including ID.

26. As clinicians began using DSM-5's clear diagnostic criteria, the process of "general" acceptance in the research, clinical, and forensic fields took several years, beginning with the Doyle et al. publication in 2015, *Neurobehavioral Disorder Associated with Prenatal Alcohol Exposure (ND-PAE): Review of Evidence and Guidelines for Assessment* (attached). In 2016, researchers began proposing that ND-PAE criteria be used in the clinical context and published articles to that effect in the peer-reviewed literature (respectively, Kabel et al., *Neurobehavioral Disorder Associated with Prenatal Alcohol Exposure (ND-PAE): Proposed DSM-5 Diagnosis*; and Hagan et al., *Neurobehavioral Disorder Associated with Prenatal Alcohol Exposure*; both attached). That same year (2016), the American Academy of Pediatrics (AAP) endorsed the use of ND-PAE and its criteria to diagnose FASD in children, at which point ND-PAE began to be routinely accepted in the clinical field for adults as well as children.

27. Meanwhile, during the years leading up to DSM-5's publication, I had assembled an informal team of mental health professionals to provide attorneys with expert advice, testing, and diagnostic assessment in criminal cases involving individuals with FASD. In a 2010 paper published in the peer-reviewed literature, our group made suggestions related to assessing and diagnosing FASD in the forensic context. The recommendations were based upon the IOM criteria and subsequent clinical protocols.

28. Around the same time, epidemiological research was making important discoveries about the prevalence of FASD in the forensic context. For example, in 2011 a study showed that youths with FASD were 19 times more likely to be incarcerated than those without FASD. Adult studies in correctional institutions found similar rates, namely that approximately 15 to 25 percent of individuals involved in the legal system had FASD. These findings were striking because FASD, like ID but unlike other conditions such as substance use disorders, occurred in individuals through no action of their own and caused lifelong brain damage totally beyond their control.

29. Immediately after the 2016 publications and AAP's endorsement, I and others began publishing articles in the peer-reviewed literature suggesting the use of ND-PAE as the official mental health diagnosis for FASD conditions and standard of practice in the forensic context (i.e., Greenspan et al., *FASD and the Concept of "Intellectual Disability Equivalence*, 2016; Brown et al., *Fetal Alcohol Spectrum Disorders [FASD] and Competency to Stand Trial [CST],* 2017); *Suggestions for a 'Best Practices' Approach to Forensic Evaluation*, 2017; all three attached). By 2018/2019, ND-PAE criteria had become widely accepted by FASD professionals in the forensic as well as research and clinical fields. In my own practice, ND-PAE had been accepted – without exception – in many capital murder cases around the country, ultimately figuring prominently in rulings of life without parole instead of the death penalty.

30. In 2021, Springer – a highly regarded multinational publisher of scientific books – published my first-of-its-kind textbook entitled *Evaluating Fetal Alcohol Spectrum Disorders in the Forensic Context: A Manual for Mental Health Practice*. In addition to my own chapters on cognitive and adaptive functioning, the treatise contained contributions from many of the most esteemed FASD scholars and practitioners in the world. Recognizing FASD as a crisis situation in the criminal and disability fields, the textbook established FASD's equivalence to ID in the legal context as well as in the medical and mental health fields.

31. The evolving understanding of FASD and its functional equivalence to ID has been of great import in the legal system, particularly in capital cases. For example, I helped author an American Bar Association resolution that called for United States courts to identify FASD and respond effectively to the disability. The resolution was adopted in 2012. In 2015, Timothy Flowers, who had been sentenced to death in 2002, was resentenced to life due to a judge's finding that brain damage from his FASD impaired his ability to exercise judgment, make independent decisions, and process information in stressful circumstances. In 2021, Leroy Johnson, a California capital defendant convicted of murdering a couple in a botched burglary, received a unanimous life jury verdict due to testimony from three FASD experts about the functional impact of his brain-based disability. And last year, Nikolas Cruz, a Florida capital defendant convicted of murdering 17 people in a high school shooting, was sentenced to life following compelling testimony from two FASD experts about the functional impact of his disability. In all three cases, the defendant's form of FASD (i.e., ARND) did not rise to the level of FAS, which many still recognize as the most severe form of FASD.

32. As Kenneth Lyons Jones, one of the two physicians who discovered FAS in the 1970s and one of the two experts who testified for defense in the Cruz case, wrote in a forward to my textbook, the scientific and medical community has finally come to a consensual tipping point establishing FASD as a condition requiring special protections in the legal system.

FAS is a severe form of FASD, which is a uniquely ID-equivalent condition[1]

33. The medical and scientific community now recognizes that reliance on full-scale IQ scores is an outmoded concept for determining ID. This view is reflected in the most recent diagnostic manuals published by the American Psychiatric Association (DSM-5-TR, 2022) and American Association on Intellectual and Developmental Disabilities

[1] Because the scientific and medical communities recognize that the full continuum of FASD is ID-equivalent, this section will discuss FASD generally. However, it is important to note that Mr. Zack's specific condition is FAS, which is considered the most severe form of FASD because it involves all four of the diagnostic criteria. It also is important to note that FAS represents a very small minority of individuals diagnosed with an FASD. In fact, of the several hundred forensic evaluations I have participated in around the country, FAS was diagnosed in only a handful of cases.

(AAIDD, 2021). While recognizing IQ scores as relevant considerations when evaluating ID, these guidelines deemphasized the importance of numerical scores and instead stressed *clinical presentation* of significantly subaverage intellectual functioning (defined primarily as executive deficits) and adaptive dysfunction, with onset during the developmental period.

34. Despite this progress, certain societal systems have lagged behind. To address this problem, I and pre-eminent professionals in the field of developmental disorders developed the term "Intellectual Disability (ID) Equivalence" to refer to accommodations made by legal and other governmental entities to provide services, supports, and protections to individuals who, due to cognitive impairment and significant adaptive deficits, were clearly operating within the functional equivalence of ID but had not received that particular diagnosis. Examples of conditions that likely would warrant such protections notwithstanding IQ score include Down Syndrome and Fragile X Syndrome.

35. FAS is an ID-equivalent condition for multiple reasons: (a) it stems directly from brain impairment at birth; (b) people with FAS have adaptive deficits and support needs not only similar to but *identical* to those seen in ID; (c) the deficits are quantifiable and, like IQ, can be measured in terms of standard deviations from the mean; and (d) intellectual and adaptive functioning of individuals with FAS is *lower* than in individuals with similar IQ scores who do not have FAS, which means that even if an individual with FAS has an IQ over the range typically seen in ID, they nonetheless function at an intellectually-disabled level.

36. Like ID, FASD in all of its diagnostic manifestations (i.e., FAS, pFAS, ARND) is considered a severe neurodevelopmental disability because of its substantial impact on adaptive behavior. Both disorders manifest during the developmental period. FASD always is congenital; ID usually is congenital. Both conditions are lifelong.

37. Increasingly over the past decade, less weight is being placed on an IQ number and more on adaptive behavior. The process of learning adaptive skills during the developmental period is central to FASD's ID-equivalence, because FASD is devastating to adaptive development. Even when individuals with FASD have IQs in the average or higher range (which Mr. Zack does not), they still function adaptively at a level consistent with ID.

38. Because IQ scores of individuals with FASD reflect performance in highly-structured test settings with considerable examiner guidance, such scores do not reflect how brain damage in affected persons manifests in everyday behavior in the unstructured real world. For instance, a person with FASD whose IQ falls in the 70s typically functions adaptively as if their IQ is much lower (i.e., in the 50s or 60s) due directly to executive dysfunction. Consequently, the adaptive deficits in FASD are worse than in individuals with ID alone, where adaptive functioning is roughly on par with IQ. DSM-5 and DSM-5-TR recognize ND-PAE's severity by requiring at least two deficient

adaptive domains whereas ID requires only one or more. Thus, based on the DSM, ND-PAE is at least as severe as ID.

39. The learning and adaptive behavior impairments in FASD are directly attributable to executive dysfunction, which is scientifically known to directly cause impairments in foresight, judgment, attention, memory, impulse control, ability to control inappropriate reactions, rule-following ability, efficiency, ability to strategize, abstract reasoning, planning ahead, predicting outcomes, self-regulating, interpreting social cues, communicating, employing practical skills, and navigating the community appropriately and independently. In addition, because of adaptive impairments in social skills, issues with attention-seeking behaviors, suggestibility, gullibility, and immaturity are often present.

40. Adaptive deficits in individuals with FASD grow more pronounced with age, which is worse than in ID where deficits in executive and adaptive functioning tend to remain relatively stable throughout the lifespan and far worse than in attention-deficit hyperactivity disorder (ADHD), where impairments in attention and self-regulation tend to improve by adulthood. For instance, socialization deficits in FASD worsen with age to the point of stagnation. Due to the wide-ranging executive/adaptive dysfunction in FASD, affected individuals tend to function many years below their actual age (i.e., arrested development), which gradually leads by adulthood to adverse outcomes in important developmental domains (i.e., the “secondary disabilities” described earlier). The ongoing erosion in adaptive functioning over the developmental years that is unique to FASD appears to stem from delays in postnatal brain maturation.

41. Infants born with FASD are at high risk for further abusive and traumatic exposures. For example, a disproportionate number of children with FASD experience physical and/or sexual abuse, domestic violence, neglect, and disrupted attachment following removal from biological parents. When children with executive and adaptive dysfunction experience such adversity, their risk of secondary disabilities increases significantly due in large part to dysfunctional coping capacity. For example, most individuals with FASD have one or more comorbid mental health conditions that may include other neurodevelopmental disorders such as ID or ADHD as well as substance abuse, depression, and suicidality.

42. As in ID, although protective factors in FASD may improve developmental outcomes somewhat, such factors do not actually “treat” or “cure” the condition.

43. Although FAS, unlike ARND, carries visible physical markers of disability (especially in early childhood), the cognitive, intellectual, emotional, and behavioral harm typically is invisible. As with ID, one cannot rule out FASD because someone “looks” normal, “seems” articulate, or got a driver’s license. An important vulnerability in FASD as well as ID is that people with both conditions often present with a complicated mixture of abilities and impairments (coexisting strengths and deficits). Children with both conditions also learn how to superficially mask their disabilities in an attempt to “fit in” with normally-developing peers. This may lead to inaccurate perceptions that their

maladaptive behaviors are the result of intention or psychiatric dysfunction rather than cognitive/adaptive deficiency.

44. Another common misconception about FASD, especially in the case of individuals with FAS whose facial features may become less dysmorphic as they age, is that the condition is a temporary state that can be overcome. Another misconception is that individuals with adaptive deficiency much worse than their IQ scores might suggest are malingering disability. A frequent misconception in the forensic context is that conduct disorder or a personality disorder explain offense conduct. While such labels are easy to apply to most capital offenders, they explain nothing and ignore the brain-based biological dysfunction underlying the criminal acts of people with FASD.

45. Systemic ignorance of FASD's ID-equivalence compounds the untreated progression of disabilities inherent in the disorder and causes discriminatory treatment in the legal context of affected individuals who, like those with ID, lack accountability beyond their cognitive capacity.

46. By definition in DSM-5 and DSM-5-TR, all people with FASD are deficient in executive as well as adaptive functioning, as are all individuals with ID. Moreover, as noted in Paragraph 36, executive dysfunction has a more severe impact on adaptive behavior in FASD than in ID.

47. It is because people with FASD have more serious limitations than might be inferred from their often "borderline" IQ scores that knowledgeable scholars and professionals argue for a more inclusive approach. As a result, a growing consensus has emerged in the fields of both ID and FASD that it is executive function capacity and not IQ that directly affects everyday adaptive functioning in persons with these neurodevelopmental disorders. Whether in ID or in FASD, IQ simply reflects a person's ideal intellectual capacity under highly structured situations that bear no resemblance to real-world conditions. To reiterate, in the medical and scientific community, denying services and protections solely based upon a full-scale IQ score slightly above a 70-75 cutoff is an outmoded concept. From a clinical and medical perspective, it is frankly absurd that an individual with an IQ of 79 and established cognitive/adaptive deficits related to FAS/FASD would be denied the supports and protections given to an individual without FASD whose IQ is a few points lower.

48. In other words, the brain pathology that makes an individual's disability just that, a disability, manifests in complex and variegated ways that cannot be captured by a test score with limited context validity. This pathology occurs in equal manner and force in individuals with FASD whose functioning in the world cannot be meaningfully distinguished from ID. And, the presence of FASD alone negatively impacts the validity of an IQ test score, because individuals with FASD function—both intellectually and adaptively—at a significantly lower level than their IQ-matched peers.

49. Some jurisdictions have already codified their understanding of FAS as ID-equivalent. For instance, Alaska provides protections and services for "developmentally disabled"

individuals, which the state defines as "having an identifiable physical, mental, sensory, or psychosocial condition that has a probability of resulting in developmental delay even though a developmental delay may not be exhibited at the time the condition is identified" (Title 47, chapter 20, Alaska Stat. § 47.20.290). Listed among such conditions are Down Syndrome, Fragile X Syndrome, and Fetal Alcohol Syndrome.

50. Although an individual with FASD need not have FAS specifically to function at the level of ID, the severity and strict diagnostic criteria for a diagnosis of FAS warrant its inclusion as an ID-equivalent condition.

Mr. Zack's lifelong functioning cannot be differentiated from intellectual disability

51. Numerous and varied sources corroborate Mr. Zack's FAS/FASD diagnosis. For brevity, and because Mr. Zack's FAS diagnosis is well-established, I will not duplicate his extensive and troubled life history here but rather incorporate by reference the following corroborative sources: (a) testimony that Mr. Zack's biological mother drank 6-10 beers at least twice per week throughout her pregnancy, which significantly exceeds the 13 or more alcoholic beverages per month associated with an ND-PAE diagnosis in DSM-5 and DSM-5-TR[2]; (b) birth records consistent with microcephaly, a physical feature present in FAS wherein the head and brain are deficient in size; (c) childhood speech, language, and motor delays; (d) chronic academic achievement deficits; (e) neurological assessments in adulthood that show low IQ scores, verbal deficits, impaired executive functioning, and a significant "split" between verbal and performance scores, which alone makes full-scale IQ unreliable; (f) numerous accounts from Mr. Zack's family, friends, and medical/mental health providers depicting a lifelong history of intellectual and adaptive impairments; (g) similar accounts illustrating a profoundly abusive environment throughout Mr. Zack's childhood and adolescence, which exposed him to risk factors known to exacerbate cognitive/adaptive dysfunction and associated developmental disabilities; (h) similar accounts detailing an utter absence of protective factors such as early intervention and attentive nurturing; (i) having had a FAS diagnosis since at least 1997, which was rendered by qualified medical and neuropsychological practitioners; (j) a 2014 diagnosis of ID rendered by a qualified neuropsychologist, which was consistent with FASD being the leading known cause of ID; and (k) multiple adverse life outcomes consistent with the FASD secondary disabilities research.

52. Although Mr. Zack has had many factors in his life that have contributed to or worsened his deficits in intellectual and adaptive functioning, there is no explanation other than FAS that adequately explains his *lifelong* impairment. For example, although he nearly died at the age of three after ingesting 10 ounces of cherry vodka,

[2] It should be noted that, contrary to the scientific belief at the time of Mr. Zack's trial that barbiturates had the most toxic effects on a developing fetus, it is now known that alcohol has the single most devastating teratogenic impact on the fetal brain of all substances of abuse.

he had severe speech and motor delays prior to that event as well as atypical hyperactive behavior from infancy on, such as incessant rocking. In other words, his disability was observable from the time he left the womb.

53. The secondary disabilities in Mr. Zack's history, which include instances of criminal behavior, reflect how his cognitive dysfunction and associated adaptive impairments produced many of the negative life course outcomes predicted by the FASD research (i.e., a cause-and-effect process). Of the eight secondary disabilities identified in the CDC study, Mr. Zack's history contains every single one. Of the most prominent risk factors for secondary disabilities resulting from FASD, Mr. Zack's life history contains each one. Of the most prominent protective factors, his life history contains none. In other words, a convergence of factors Mr. Zack had no control over predisposed him to catastrophic outcomes, including what would appear to be inexplicable criminal behavior in the absence of an understanding of his FASD and its ID-equivalence.

54. Because of his brain dysfunction, Mr. Zack was unable to cope effectively with life experiences and function effectively without external structure and consistent supports. The only two periods of time in his life when he functioned relatively adequately occurred (a) during his year-long psychiatric hospitalization at age 11-12, and (b) during his incarceration subsequent to his conviction and death sentence. This is reflective of medical and scientific knowledge that structured settings with consistent routines are one of the most effective supports for individuals with FASD and ID.

55. I note and have no reason to dispute Mr. Zack's 2014 diagnosis of ID. However, it is my professional opinion, consistent with the present consensus in the medical and scientific community, that there is no meaningful distinction between the cognitive, neurodevelopmental, behavioral, and adaptive functioning of an individual with FASD who does not have a precise ID diagnosis and an individual without FASD who has an ID diagnosis. Indeed, due to the severity of adaptive dysfunction in FASD and the progressive severity of those impairments across the developmental years, FASD can be more catastrophic than ID to daily functioning and capacity as they relate to the legal system. In light of Mr. Zack's FAS diagnosis and the extensive background information documenting severe cognitive and adaptive impairments at all stages of his life, I have no doubt he always has functioned as an intellectually disabled individual, regardless of his IQ score or diagnosis.

I hereby certify that the facts set forth are true and correct to the best of my personal knowledge, information, and belief, pursuant to 28 U.S.C. Sec. 1746 and Sec. 92.525 of Title VII, Florida Statutes.

August 27, 2023

Natalie Novick Brown, PhD — Date

ATTACHMENT C

DECLARATION OF JULIAN DAVIES, MD

PURSUANT TO 28 U.S.C. SEC. 1746 AND SEC. 92.525 OF TITLE VII, FLORIDA STATUTES

Qualifications

1. I am a Clinical Professor of Pediatrics at the University of Washington. For 20 years, I have evaluated children and adults at the longest-running Fetal Alcohol Spectrum Disorder (FASD) diagnostic clinic in the United States. I have trained FASD diagnostic teams from around the world, and am published in the peer-reviewed literature on prenatal alcohol and drug exposures. My CV is appended to this declaration. In preparing this declaration I have reviewed excerpts from trial testimony, mental health evaluations, and lay witness declarations.

The evolution of scientific/medical understanding of FAS and FASD

2. Since the identification of Fetal Alcohol Syndrome (FAS) in 1973, scientific advancements have refined our understanding of the physical and behavioral signs and symptoms of this brain-based disorder, as well as the consequences throughout the lifespan of those afflicted by FASD.

3. FASD, and FAS in particular, is a multisystem condition that involves the entire body. Although FAS causes visible physical anomalies in children including growth retardation, microcephaly, and facial dysmorphia, its most significant impairments relate to structural and functional brain damage. FASD is the leading preventable cause of intellectual disability in the developed world.

4. Terminology related to FASD has shifted as the medical community has learned more about the disorder. The term "FASD" is an umbrella term for several disorders. Although all conditions under the FASD umbrella have devastating consequences, Mr. Zack's diagnosis from testifying experts at trial, FAS, is generally considered to be the most severe manifestation of FASD. Based on (a) the time period in which the diagnosis was rendered, (b) the requirements for a diagnosis of FAS at that time, and (c) how little was known about the condition then, his 1997 diagnosis of FAS would correspond with what is now labeled in the World Health Organization's International Classification of Diseases (ICD-10) as "Fetal alcohol syndrome, dysmorphic" (Q86.0).

5. Animal models show that prenatal alcohol exposure has lifelong adverse effects on neuroendocrine function, particularly the hypothalamic-pituitary-adrenal axis, which plays a key role in the response to stressors. In other words, individuals with FASD may be permanently hyperreactive to stress, increasing their vulnerability to childhood trauma and neglect.

6. Prenatal alcohol exposure can also lead to microcephaly and structural abnormalities in various brain regions, including the frontal lobes, corpus callosum, basal ganglia, hippocampus, amygdala, and cerebellum. FASD brain deficits also include abnormal connectivity between brain regions, as well as abnormal patterns of maturation during the developmental period. This means that the brain damage in FASD is widespread and

governs areas of the brain with different practical responsibilities, setting the afflicted individual up for failure in multiple realms, which often manifest as increasing adaptive gaps over time relative to unaffected peers.

7. In terms of forensic relevance, the scientific community has learned that FASD creates attention deficit symptoms (impaired attention, impulsivity, hyperactivity) in approximately over 50% of afflicted individuals, and trouble with law enforcement for approximately 60%. FASD is associated with symptoms that would otherwise be attributed to a conduct or personality disorder, but which have vastly different contexts of origin and motivation. This is one reason why, from a medical perspective, individuals with FASD need additional protections—their symptom presentation is highly likely to be misinterpreted as moral culpability that they are not capable of possessing on account of their lifelong deficits.

A Brief History of ID and ID-equivalence

8. Prior to the early 20th century, individuals with intellectual disability (ID) were identified by how they functioned in the everyday world, or what has come to be termed "adaptive behavior." Specifically, people with ID were differentiated from the general population by the perception that they lacked the capacity for independent living.

9. Reliance on the IQ metric was popularized by eugenicists and white supremacists in the early to mid-twentieth century. Rather than being used for meaningful diagnosis and implementation of supports, the metric was used to support claims of Northern European racial superiority, suppress immigration, and to place individuals with below-average IQ into gender-segregated institutions and/or involuntarily sterilize them. In other words, IQ measures were not used for the clinical, educational, and social purposes for which we now expect them to serve; rather, they were used to prevent procreation of individuals with low IQs under the guise of "protecting the superiority of the white race," regardless of whether those individuals had any actual problems functioning.

10. The clinical concept of using IQ ceilings to divide individuals into "impaired" and "normal" classes was popularized approximately 60 years ago when the organization now known as the American Association on Intellectual and Developmental Disability (AAIDD) published their first diagnostic manual. This marked the origin of intellectual disability as a three-pronged diagnosis. At that time, the intellectual impairment prong was measured by an IQ score falling at least one standard deviation below the mean (approximately 85). This threshold was overinclusive, because many individuals with IQs in that range were not functioning at an intellectually disabled level, due to an absence of adaptive deficits.

11. Rather than refine criteria related to adaptive deficits, the organization simply changed the benchmark for IQ score to two standard deviations below the mean. This was an overcorrection, which became known to create an excessive number of "false negatives" where individuals who were clearly intellectually disabled were wrongly denied a diagnosis based on an IQ score falling above 70. This is now considered outmoded.

12. Most proposed reforms related to ID diagnostics in the past several decades (such as adjustments for standard error of measurements in tests; raising the ceiling of a qualifying score to 75 instead of 70; inserting the word "approximately" before the number 70 or

the words "minus two standard deviations below the mean"; and correcting for norm obsolescence, or the "Flynn effect") have been motivated by a need to rectify the problem of false negatives caused by setting a qualifying IQ score too low. These measures have not been sufficient, but they demonstrate a consistent recognition by the scientific and medical communities that there is a need to allow for a diagnosis of ID in equivalent disorders, notwithstanding an IQ score that is slightly too high to qualify under a prior definition. This is the position underlying the ID section of the DSM-5, which states that neuropsychological tests, particularly of executive functioning, are more diagnostically useful than an IQ score.

13. This is seen in DSM-5-TR's Criterion A, which now requires: "Deficits in intellectual functions, such as reasoning, problem solving, planning, abstract thinking, judgment, academic learning, and learning from experience, confirmed by both clinical assessment and individualized, standardized intelligence testing." Furthermore, this testing should be broader than a single IQ score, and incorporate clinical judgment rather than an arbitrary single-score cutoff:

> Individual cognitive profiles based on neuropsychological testing as well as cross-battery intellectual assessment (using multiple IQ or other cognitive tests to create a profile) are more useful for understanding intellectual abilities than a single IQ score (Flanagan and McGrew 1997; Greenspan 2017).
>
> Such testing may identify areas of relative strengths and weaknesses, an assessment important for academic and vocational planning. IQ test scores are approximations of conceptual functioning but may be insufficient to assess reasoning in real-life situations and mastery of practical tasks (Bertelli et al. 2018; Flanagan and McGrew 1997; Harris 2006; Harris and Greenspan 2016; Schalock 2011; Yalon- Chamovitz and Greenspan 2005). For example, a person with deficits in intellectual functioning whose IQ score is somewhat above 65–75 may nevertheless have such substantial adaptive behavior problems in social judgment or other areas of adaptive functioning that the person's actual functioning is clinically comparable to that of individuals with a lower IQ score. Thus, clinical judgment is important in interpreting the results of IQ tests, and using them as the sole criteria for the diagnosis of an intellectual developmental disorder is insufficient.

14. Another proposed reform by experts in the field, which actually addresses the problem it was meant to solve, is the ID-equivalence model. This model simply identifies conditions which, by their very nature, are meaningfully indistinguishable from ID in presentation, type, and severity. Examples of these conditions are Down Syndrome, Fragile X Syndrome, and FAS. Under this model, equivalent conditions are eligible for the same supports and protections as ID.

15. This model reflects the medical and scientific community's belief that direct real-world functioning is more important than indirect performance on an imperfect measure (e.g., IQ scores) that inaccurately predicts real-world functioning. In the context of FASD, this would not require any sort of retraction from reliance on cognition as the central feature of ID and ID-equivalence. Deficits in thinking, learning, and overall intelligence are central to understanding ID and FASD. But intelligence is not interchangeable with an IQ, which is a measure that is much better at predicting academic performance than it is real-world functioning. There are multiple forms of intelligence not measured by IQ tests.

16. In the fields of ID and FASD, the cognitive impairment that most contributes to everyday impairments is *executive functioning*. This term refers to skills controlled primarily by the prefrontal cortex, including supervisory attention and control processes in the brain that are involved in the selection, planning, initiation, execution, monitoring, and troubleshooting of goal-directed behavior in non-routine situations. Executive function is particularly important in situations that require error detection and correction, such as in dangerous, manipulative, pressured, and technically difficult situations.

17. This harkens back to the originalist notion of ID as pertaining to individuals who are not able to live independently due to impaired adaptive functioning. Because poor judgment in approaching novel problems places an individual at physical or social risk, and because individuals with ID and FASD demonstrate these deficits, these conditions require extra protections to buffer against their failure to appreciate various dangers and learn how to avoid them. These dangers include malnutrition, loss of housing, loss of employment, medical complications, victimization, exploitation, and imprisonment.

18. The import of recent refinements to diagnostic criteria for ID and FASD over the past several years are instructive. For instance, the DSM-5 now places ID under the umbrella category of Neurodevelopmental Disorders", and has added a parenthetical second name: "Intellectual Disability (Intellectual Developmental Disorder)". This reflects a paradigm shift from a "disability" approach, which emphasizes arbitrary psychometric (i.e., IQ) cutoffs, to a more clinical and qualitative "disorder" approach, which emphasizes the medical and neurodevelopmental nature of the condition.

19. Put simply, while IQ and other test scores function as a window into a person's cognitive functioning, they should not be used rigidly as make-or-break bases for ruling ID in or out. This is because IQ is viewed as a reflection of underlying brain pathology, which is complex and cannot be captured by the myopic lens of a single test score.

20. This is vitally important to the recognition of FASD as an ID-equivalent condition. Like those with ID, individuals with FASD are at increased risk for maladaptive behaviors that may lead to criminal activity and victimization. They also have secondary disabilities, such as mental health problems, social ineptness, substance use disorders, school and employment difficulties, and an inability to manage the necessities of daily life. These factors make individuals with FASD dramatically more vulnerable to legal troubles.

21. Critically, having an IQ score above the arbitrary 70-75 cutoff often used by the legal system does not protect individuals with FASD from the secondary disabilities and negative consequences mentioned above. Indeed, individuals with FASD who have IQs above 70 are actually *more* likely to have trouble with the law than those with an IQ below 70.

22. For several years, preeminent FASD clinicians have posited that FASD is an ID-equivalent condition. In *Evaluating Fetal Alcohol Spectrum Disorders in the Forensic Context: A Manual for Mental Health Practice* (Springer, 2021; corrected, 2022), a publication that I and several other FASD experts contributed to, Kenneth Lyons Jones, MD, noted that we are "at a tipping point relative to this disorder." *Id.* at viii. This observation is of significant import, as Dr. Jones was one of two physicians who first described FAS in 1973 and is uniquely situated to know the history of medical and scientific viewpoints relative to this disorder.

23. The consensus regarding FASD as an ID-equivalent disorder is not limited to experts in the field of FASD; medical and scientific professionals whose primary specialization is ID join in the consensus that these are equivalent disorders. One noteworthy professional is Stephen Greenspan, PhD, who is a leading authority on intellectual disability, the most-cited researcher in the ID section of the DSM-5, and the co-author (along with Natalie Novick Brown, PhD) of "FASD and the Concept of ID-equivalence" in *Fetal Alcohol Spectrum Disorders in Adults* (Springer, 2016).

As a result of FASD, Mr. Zack functions at the level of intellectual disability

24. Mr. Zack has confirmed prenatal alcohol exposure, based on his biological father's trial testimony that Mr. Zack's biological mother drank 6-10 beers in one sitting, twice a week (although there are indications that at times it was three times per week), throughout her pregnancy. This is a "high-risk" pattern of prenatal alcohol exposure.

25. Mr. Zack's deficits have been apparent for the entirety of his lifespan. His birth records indicate physical measurements consistent with microcephaly and low birth weight relative to length. We now know that microcephaly in a child prenatally exposed to alcohol is associated with a high risk of severe brain functional impairments.

26. He also had neurobehavioral manifestations that preceded later risk factors such as toxic ingestions, physical abuse, head trauma, mental health disorders, and substance use. Accounts from family members demonstrate that he started crawling late. He did not walk until he was 18 months old. He had communication delays as a toddler. He had nearly nightly enuresis (bed-wetting) into his teenage years. He constantly rocked back and forth. His siblings described him as "very slow".

27. He had a documented history of academic underachievement at least as far back as third grade, and even his childhood IQ testing showed a split in verbal and performance IQ scores. Records note that Mr. Zack was disruptive to the class, in part due to behaviors that are consistent with attention deficits. His siblings noted that Mr. Zack had great difficulty learning, reading, writing, memorizing numbers, and coloring. They tried to help him with his homework, but he struggled so much he would wind up in tears and his sisters did his homework with him.

28. Around the household, Mr. Zack was unable to complete simple chores and routine tasks. When he tried to wash dishes, someone else had to rewash them. He could not color coordinate his clothes, fold his clothes, or choose appropriate clothes for the weather. He struggled to match socks. He could not make his bed. He constantly got into trouble for forgetting to bring pajamas to change into after nightly bath time. When Mr. Zack was 12 years old, he was functioning at a lower level than his six-year-old sister. When he and his siblings underwent a residential move, he could not understand that he needed to take clothes with him. He couldn't understand the rules to games the other siblings played.

29. Mr. Zack was gullible and a follower. His siblings noted that he could be convinced to do anything, including riding a bicycle on a bridge rail (which resulted in him falling and coughing up blood for days). He became a scapegoat, taking blame for things the other children did. This continued into adulthood. He was overly trusting.

30. An Army medical report from his stepfather's enlistment period noted that Mr. Zack, by the age of 11, had multiple and severe behavioral difficulties in the home and school.

Difficulties referenced in the report included impulsivity, irresponsibility, outbursts and disruptive behavior, depression and withdrawal, low self-esteem, and giving over money or material things to attempt to gain others' favor.

31. This is all consistent with the presentation of FASD in a child of that age. That report also notes that prior health records in the Army's possession showed "serious problems" identified by a physician's assistant 3 years prior, but that his parents failed to make follow-up appointments. He was referred to a child psychology department, but again, he was not taken there. Other justifications by Mr. Zack's mother for failing to seek follow-up care when recommended included her own personality conflict with a physician.

32. Around this time, there is a documented suicide attempt for Mr. Zack, and he was institutionalized for approximately a year. It appears that, apart from his time incarcerated on death row, the year Mr. Zack spent institutionalized was the best he ever functioned. This is consistent with what is known about individuals with FASD and ID—routine and structure are of paramount importance.

33. As an adult, the mother of his child noted that although Mr. Zack had the best of intentions, he was incapable of basic adult responsibilities. He could not read or write. He did not have a bank account, and would reportedly not have been able to balance a checkbook if he did. He had no driver's license, could not read a map or navigate, could not read or write well enough to fill out a simple job application, and could not maintain even menial jobs. He lived with his former paramours, who stated that he would not have been able to safely live alone. His only responsibilities in the home were to help get diapers and formula for his daughter, but he couldn't even do that very well. He was not capable of safely supervising a child due to his impaired attention. He did not know how to make any foods that required measurement or directions. He had poor personal hygiene, not understanding basics like how to properly wipe after using the toilet, comb hair, brush teeth, wash his clothes, and only bathed when specifically instructed. His former partner noted in retrospect that the adult Mr. Zack functioned at approximately the same level as a disabled child.

34. Mr. Zack had impaired concentration, constantly losing focus and needing specific, repeated instructions and supervision for the simplest of tasks. He could not plan ahead. He did not think of consequences. He could not be trusted to know how to pick up pizza from the store or buy groceries. He tried several times to complete a GED but kept failing. He got fired from jobs because he was unable to show up on time or complete required tasks. One noteworthy example was as a janitor, when he could not measure and mix cleaning chemicals.

35. Mr. Zack's siblings also describe his concrete thinking, such as nailing a cabinet door back on after it fell, and thinking it was fixed because the door was on, even though it no longer opened. His current wife notes that he struggles to understand things and is slow to respond to questions. In communications, he needs the person speaking to him to use basic vocabulary and make a single statement at a time, allowing him to process it before moving on to another statement or question. If this is not done, Mr. Zack gets overwhelmed. He stutters and does not use words correctly.

36. A friend of Mr. Zack's family, who was a retired prison guard and deputy sheriff and with whom Mr. Zack resided as a teenager, stated that Mr. Zack was one of the lowest functioning individuals he has ever encountered.

37. In conclusion, Mr. Zack's developmental and life trajectory is very consistent with our clinical and research experience with severe FASD.

What do we know now that we didn't at trial?

38. Since the 1990s, the FASD clinical and research community has dramatically increased our knowledge of the brain structural and functional impairments caused by alcohol, and the risk of "secondary disabilities."

39. It is notable that many of the adverse life outcomes (disrupted school experience, trouble with the law, confinement, drug/alcohol problems, mental health concerns) in Mr. Zack's case fit a classic pattern of fetal alcohol secondary disabilities. These result from having the primary disabilities (brain damage that you're born with) of FASD but none of the identified protective factors such as early diagnosis of FASD and a stable, sober, and supportive childhood home.

40. A landmark FAS study published in 2004 described risk factors that influence these adverse FASD outcomes. What is remarkable about Mr. Zack's history is that in addition to a high-risk pattern of prenatal alcohol exposure and FASD diagnosis, his formative years were marked by all of the risk factors shown in this study to increase the risk of adverse outcomes: no early diagnosis of FASD, lack of stable/nurturing caregiving, multiple home placements, FSIQ test result over 70, domestic violence and abuse, poor quality home environment in middle childhood, caregivers who abused alcohol, many life basic needs not met, and male gender. These risk factors increased the odds of his adverse outcomes 2- to 4-fold.

41. For example, if we look at "trouble with the law," about 60% of adolescents and young adults with FASD will have this outcome, but if we look more specifically at those like Mr. Zack with additional risk factors (male gender, disrupted school experience), the rates climb to 83% having been in trouble with the law and, among these, 69% have been incarcerated in jail or prison. Working from the other direction, researchers using active case ascertainment found FASD in at least 17% (as high as 31%) in a North American correctional population.

42. We also now know that prenatal alcohol exposure is the most harmful prenatal substance exposure, not barbiturates as was claimed at trial. There was also discussion at trial that perhaps his brain outcomes were primarily the result of trauma and neglect. Since then, we have studied the relative contributions of prenatal alcohol exposure (PAE) compared to other prenatal (e.g. exposure to tobacco and other illicit drugs, poor prenatal care) and postnatal risk factors (e.g. multiple home placements, physical/sexual abuse, low socio-economic status), and found that in 2020 that "individuals with PAE present with a multitude of other prenatal and postnatal risk factors. The prevalence of these risk factors is often 3 to 7-fold higher than in the general population. PAE was the dominant risk factor explaining the largest proportion of variance in brain structural and functional outcomes in this study." Since Mr. Zack's trial we have learned that yes, the developing brain is vulnerable to many risk factors (which in fact cluster together with prenatal

alcohol exposure), but alcohol has been shown to be a dominant risk factor and should be weighted accordingly.

43. Another way of thinking about this is that the brain in FASD is an *adversity magnet*, and is more vulnerable to being impacted by those comorbid risks. The neurobehavioral impacts of FASD that they are born with make those affected more likely to experience harsh or abusive parenting, more likely to sustain toxic exposures (such as Mr. Zack's unusual alcohol overdose as a toddler) and head injuries, more likely to be led astray by peers, more likely to drop out of school, and more likely to turn to drugs and alcohol. Those adversities add insult to brain injury.

44. Finally, we now understand that in FASD, an IQ score is a very poor predictor of overall functioning. The majority of individuals with severe FASD have a full-scale IQ over 70-75, but their adaptive functioning is well below that expected for their level of IQ. This gap is mediated by deficits in executive functioning. Many of our FASD clinic patients have had severe deficits missed by school psychologists who, with limited resources, often only test IQ and academic achievement. To illustrate this, in our clinic's FASD population, only 24% have impairments on cognitive testing like IQ, with 35% having academic achievement deficits, but 46% show executive skills impairments, and 60% have adaptive deficits.

45. It is only through comprehensive neuropsychometric testing that the full extent and pattern of disability is revealed in FASD, and we are always careful to acknowledge that test scores from a skilled evaluator in a calm, 1:1 environment will often dramatically over-represent real-world performance.

46. This modern understanding of FASD and the limitations of IQ scores has led to changes in disability policy and the law. For example, in Washington State where I practice, **House Bill 2008—Eliminating the use of intelligence quotient scores in determining eligibility for programs and services for individuals with developmental disabilities** was passed last year with strong support from FASD experts, with the following statutory language:

> Further, the legislature finds that intelligence quotient testing does not accurately indicate whether a person needs support to be personally and socially productive, which is the goal of the developmental disabilities administration outlined in RCW 71A.10.015. Therefore, the legislature finds that requiring intelligence quotient testing in assessing whether a person has an intellectual or developmental disability is not an appropriate diagnostic tool and eliminating the use of intelligence quotient scores has been a goal of the legislature for more than 40 years.

47. FASD is a quintessential example of variability in performance predicting low adaptive functioning. One of my psychology colleagues from FASD clinic wrote the following in support of HB 2008:

> One of the greatest challenges I experience in advocating for individuals with … FASDs is in helping people understand how disabling the differences between the strengths and weaknesses within an individual's neurocognitive profile can be.
>
> I have interacted with many people who recognize, comprehend, and appreciate without difficulty the needs of individuals who experience more global delays or differences (from expected levels) across all neurocognitive areas (including IQ), and how this results in

adaptive functioning that is equally low. There is little resistance to the idea that individuals with this type of profile need and deserve supports of the sort available through DDA.

What can be much harder to help people understand (not just those making DDA eligibility determinations, but also teachers, physicians, etc.) is the very different profile of so many of our neurodiverse clients —those who have very low adaptive skills (represented by valid scores) but much higher scores in some of the cognitive measures. These are individuals about whom I hear caregivers and educators say things like, "how can someone so 'smart' be so bad at [insert skill related to ADLs]?" The vulnerability of some of these individuals is far greater because of the difference between their apparently intact cognitive functioning (especially when represented by IQ) and their true adaptive skills.

It is my understanding that DDA resources are intended to support the needs of individuals who are not able to independently succeed at activities of daily living (adaptive skills); unfortunately, the IQ criteria leave vulnerable a great many individuals who need this support.

Those of us providing clinical, behavioral, and educational intervention and support services to individuals with neurodevelopmental diagnoses devote much of our effort to helping others to understand the differences between competence and compliance. Inherent in the current system is the potential for a risky assumption that if the intellectual skills (as represented by IQ scores) are intact, adaptive skills (as represented by scores) that are impaired are due to noncompliance rather than noncompetence. This assumption is dangerous and harmful and leaves many of our most vulnerable without needed supports. IQ does not equal competence.

For those without neurodevelopmental disorders (other than intellectual disability), IQ (biases notwithstanding) often does serve as a reasonable predictor of the general range of other neurocognitive skills. For individuals with FASDs …, this is not the case (and why comprehensive neuropsych evaluations can be so important). When we conduct our evaluations, we are often doing work that illustrates that the tremendous variability within an individual's profile is what is responsible for the challenges they experience in daily functioning—that, for example, an individual can have an IQ score of 88 and executive functioning scores in the 60s, social communication skills in the 70s, vocabulary in the 90s, math in the 50s, and reading in the 80s….and adaptive skills in the 60s.

48. I hope that this declaration has been helpful in outlining the considerable evolution in FASD knowledge since the time of Mr. Zack's trial, and illustrating how misleading a single IQ summary score can be in determining disability status.

I hereby certify that the facts set forth are true and correct to the best of my personal knowledge, information, and belief, pursuant to 28 U.S.C. Sec. 1746 and Sec. 92.525 of Title VII, Florida Statutes.

Julian Davies, MD

27th of August, 2023

Date

ATTACHMENT D

NEUROPSYCHOLOGICAL ASSOCIATES

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BOARD CERTIFIED DIPLOMATE IN NEUROPSYCHOLOGY

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PATIENT'S NAME:	Michael Duane Zack
DATE OF BIRTH:	December 14, 1968
CHRONOLOGICAL AGE:	46 years
CASE NUMBER:	1996-CF-2517A
DEFENSE ATTORNEY:	Dawn Macready, Esquire
DATES OF EVALUATION:	March 10, April 15, 2015
DATE OF REPORT:	May 26, 2015

NEUROPSYCHOLOGICAL EVALUATION

REASON FOR REFERRAL:

Mr. Michael Zack was referred for a neuropsychological evaluation by his attorney. The purpose of the evaluation was to gain a greater understanding of his past and present psychological and neuropsychological functioning.

Mr. Zack was advised of the purpose for the evaluation during the interview. He was told that information he chose to provide during interviews, any of his statements or actions, and any other information obtained about him, would not be confidential. Mr. Zack indicated that he understood the lack of confidentiality and agreed to proceed with the evaluation.

INFORMATION SOURCES:

Mr. Zack was evaluated at Union Correctional Institute in Raiford, Florida. He was interviewed and administered the following tests:

- Category Test
- Expressive Vocabulary Test – 2
- Peabody Picture Vocabulary Test – 4th Edition
- Projective Drawings
- Stroop Color and Word Test
- Tactual Performance Test
- Test of Memory Malingering
- Test of Variables of Attention
- Trail Making Test Part A & B
- Wechsler Adult Intelligence Scale – 4th Edition
- Wechsler Memory Scale – 4th #Edition

Wisconsin Card Sorting Test

Other information came from these sources:

Telephone Interview with Ms. Ziva Knight, sister of Michael Zack
Telephone Interview with Mr. Frederick Anglemyer, Foster parents of Mr. Zack.
Telephone Interview with Mrs. Phyllis Anglemyer, Foster parents of Mr. Zack

Medical/Psychological Records
Southeast Louisiana Hospital, 1980 – 1981.
Brentwood Hospital, 1981.
Comanchee County Memorial Hospital, Ziva Midkiff, 1989.
Central Louisiana State Hospital, Theresa McEwing, 1981 – 1984.
U.S. Army Hospital, Ft. Campbell, KY, 1968.
U.S. Army Hospital, Wildflecken, 1972.
U.S. Army Hospital, Ft. Polk, LA, 1980.
Jim Taliaferro Community Mental Health Center, 1991.

Presentence Investigation
Sentencing Order, 1997.
U.S. Court of Appeals, 2013.
Clemency Council:
- Declarations
- Letters of Support
- Interview of Michael Duane Zack, 2014.
- Statement of Michael Duane Zack

BACKGROUND INFORMATION:

Family History:

Mr. Michael Zack was born to Mrs. Mary Helen Cardwell Zack and Mr. Michael Duane Zack. He was the second child of his mother, with one older sister, Theresa McEwing, four years older, and two younger sisters, Melissa Midkiff and Ziva Midkiff. His parents separated shortly after his birth.

Mrs. Zack was a passenger in a car that was hit by a truck during her eighth month of pregnancy. She was reportedly thrown from the vehicle and subsequently went into labor. Michael was born one month premature. ["Premature rupture of membrane," U.S. Army Hospital, Ft. Campbell, KY.]

Mrs. Mary Helen Zack remarried Mr. Anthony Midkiff when Michael was nine months of age. Mr. Midkiff physically abused Michael. He was punched and beaten in the head, thrown

against the wall, and kicked with boots that had spurs on them. Mr. Midkiff knocked Michael unconscious several times. Mr. Midkiff ran Michael over with a car, he attempted to poison him and to drown him. Michael was given drugs and alcohol, which would cause him to pass out, and he was injected with drugs. Mr. Midkiff did not seek medical attention for Michael and closed wounds himself using a staple gun.

Michael Zack had enuresis up to age 12. Mr. Midkiff used an electric blanket to shock Michael when he urinated in bed. He placed a spoon on Michael's penis after Michael urinated in bed. Mr. Midkiff sexually abused Michael.

Mr. Michael Zack has two children, from two separate relationships. His daughter, Beth, is 27 years old and disabled. His son, Jeremy, is 24, and he has not had any contact with him.

Mr. Michael Zack has been married to Ms. Ann-Kristin Soerenmo from Norway, for the past nine years.

Educational History:

Mr. Michael Zack attended kindergarten through first grade in Fort Riley, Kansas. Some behavioral difficulties were reported by the school. After the family moved to Germany Michael attended second grade and part of third grade in Germany. Behavioral problems were reported by the school in Germany. When his problems escalated, he was taken to a mental health center, but the suggested treatment was not obtained. His parents decided instead to send him to live with his Godparents in Texas in the winter of 1977. Michael completed the third and part of the fourth grade in Texas. He remained in Texas until December 1979, when his parents moved to Fort Polk, Louisiana. He was sent back to his parents and completed the fourth and part of the fifth grade at Polk Elementary in Louisiana. At this point Michael was said to be one year behind his age appropriate placement. It is unclear how much further he went in school. No school records were available for review.

Employment History:

Mr. Michael Zack did not have any regular full time employment. He worked as a day laborer in construction on and off.

Medical/Psychiatric History:

Mr. Michael Zack was born one month premature after his mother was in an accident.

Mr. Michael Zack was hospitalized on 2/8/72 (3 years old), where he remained for two days, after he drank 10 ounces of cherry flavored vodka. . ["Ingestion of Vodka." "Child drank approx. 10 oz of cherry flavored vodka." Jeffrey Lindenbaum MAJ, MC., Attending Physician, USAHC Wildflecken]

Michael fell out of a tree and broke his leg in 1978, age 10. It is possible that he suffered a head injury along with this fall. Michael fell out of a tree and broke his arm in May 1980, age 11.5. It is possible that he suffered a head injury at the time of this fall.
Michael Zack was hit in the head with a pool ball at age 18 or 19. He suffered a loss of consciousness.

In the fall of 1979, age 10.5, Michael was slipped LSD by a stranger. He was treated at Ft. Polk Louisiana Army Hospital.

On 11/27/80, Michael was taken to the Emergency Room and admitted to the U.S. Army Hospital in Fort Polk, Louisiana, where he remained for three days. There were varying accounts in the records, but he was acting bizarre after ingesting an "unknown liquid." He was described as either being homicidal or suicidal.

Michael Zack was admitted to Southeast Louisiana Hospital on 12/1/80, subsequent to his hospitalization at U.S. Army Hospital in Fort Polk, Louisiana. He spent one year in the Psychiatric unit of the hospital. Michael received individual and group therapy. On March 1981, while hospitalized, Michael's mother was murdered by his older sister. There were allegations that Mr. Midkiff was involved in her murder.

Michael Zack was the victim of a car accident at age 19. He was "knocked out, car wrecked, head split frontal." Michael was the victim of a car accident at age 21. It was a "roll over, lost consciousness."

Michael Zack fell into a manhole at age 20 or 21. He suffered a back injury and possible head injury. Michael was the victim of a car accident at age 23. "My head was busted open."

Adaptive Functioning:

Michael Zack was unable to perform many activities of daily living when he was a child and youth. He needed assistance with bathing, choosing clothing, and preparing food. He would get lost easily.

It is reported that Michael attended a school for the "mentally retarded." No records were available for review.

Michael Zack has never had a savings or checking account in the bank.

Michael Zack has never had a driver's license. He reported failing the driving test 12 times.

BEHAVIORAL OBSERVATIONS:

Mr. Michael Zack presented as a 5 foot 10 inch, 175 pound, Caucasian married male. He was oriented to person, place, and time. He denied auditory or visual hallucinations and suicidal ideation. His thought processes appeared lucid and rational but extremely disorganized. Speech articulation was slow with significant stuttering. Answers to most questions were long winded and often veered off the point.

Mr. Zack appeared depressed, but he did not readily admit to these feelings. His affect throughout the evaluation was appropriate to the content. Eye contact was maintained.

Mr. Zack was comfortable in the testing situation, he completed the assigned tasks appropriately. His level of motivation was good throughout the evaluation and he appeared to put forth genuine effort. Rapport was established with the examiner. As a result of his motivation and effort, the results are considered to be a valid indication of his present cognitive functioning.

VALIDITY TESTING:

The Test of Memory Malingering (TOMM), a test of visual recognition memory of everyday objects, which is helpful in assessing validity was administered. On the first trial, Mr. Zack correctly pointed out 47 of the 50 pictures. ON the second trial, he correctly pointed out all 50 of the pictures. After a delay with interference, Mr. Zack identified all 50 pictures. These scores indicate sincere effort on his part and rule against malingering.

On the Test of Variables of Attention (T.O.V.A.), a continuous performance test measuring attention, there is a Symptom Exaggeration Index (SEI), to see whether there is exaggeration of symptoms by the subject for secondary gain. Results of the SEI for Mr. Zack indicated that "Based on the subject's pattern of performance, there is no evidence of symptom exaggeration."

TEST RESULTS:

General Intellectual Status:

On the Wechsler Adult Intelligence Scale – 4th Edition, administered on 3/10/15, Mr. Zack obtained the following scores:

Scale	Composite Score		Percentile Rank	95% Confidence Interval	Qualitative Description
Verbal Comprehension	VCI	74	4	69 – 81	Borderline
Perceptual Reasoning	PRI	105	63	99 – 111	Average
Working Memory	WMI	77	6	72 - 85	Borderline
Processing Speed	PSI	74	4	68 – 85	Borderline
Full Scale	FSIQ	80	9	76 – 84	Low Average

Mr. Michael Zack's Full Scale I.Q. score, generally considered to be an estimate of his current level of cognitive ability, was in the Low Average range of intellectual functioning and at the 9th percentile among his peers. Since there is a significant difference between index scores, and the Full Scale I.Q. is a composite of the index scores, it is not the best indicator of true intellectual functioning.

His Verbal Comprehension I.Q. score was in the Borderline range and significantly lower, 31 points, than his Perceptual Reasoning score. This is indicative of significantly weaker verbal skills across the board.

Working Memory, or the skills such as ability to sustain attention, short term auditory memory, and numerical ability, was equivalent to his Processing Speed ability. Both Working Memory and Processing Speed were in the Borderline range and significantly lower than Perceptual Reasoning. Working Memory was 28 points lower and Processing Speed was 31 points lower than Perceptual Reasoning.

Verbal Comprehension Subtests Summary

Subtest	Scaled Score	Percentile
Similarities	5	5
Vocabulary	6	9
Information	5	5

Within the Verbal Comprehension domain, Mr. Zack's scores were in the Borderline range.

Perceptual Reasoning Subtests Summary

Subtest	Scaled Score	Percentile
Block Design	11	63
Matrix Reasoning	11	63
Visual Puzzles	11	63

Within the Perceptual Reasoning domain, Mr. Zack's scores were in the Average range.

Working Memory Subtests Summary

Subtest	Scaled Score	Percentile
Digit Span	6	9
Arithmetic	6	9

Within the Working Memory domain, Mr. Zack's scores were in the Low Average range.

Processing Speed Subtests Summary

Subtest	Scaled Score	Percentile
Symbol Search	4	2
Coding	6	9

Within the Processing Speed domain, Mr. Zack's performed in the Low Average to Borderline range.

The following is a table of I.Q. tests administered to Mr. Michael Zack over the years. There is a clear pattern of consistently low Verbal I.Q. scores, mostly in the Borderline range of functioning.

	Verbal I.Q.	Performance I.Q.	Full Scale I.Q.	Split - Verbal Performance
WISC-R Age 11 – 1980	84	104	92	22 points
WAIS-R Age 29 – 1997	79	95	84	16 points
WAIS-R Age 29 – 1997	78	104	86	26 points
WAIS-III Age 34 – 2002	76	86	79	10 points
WAIS-4 Age 46 – 2015	74	105	80	31 points

Mr. Michael Zack has an Auditory Processing Disorder. There is a clear breakdown in his ability to receive, remember, understand, and use information received in an auditory manner.

Executive Function:

On the Tactual Performance Task, a measure of tactile form recognition, memory for shapes and spatial location, as well as psychomotor problem solving ability while blindfolded, Mr. Zack's total time was equal to 13 minutes 35 seconds, average range. First, with use of only his dominant right hand, he was able to complete the assignment in 6 minutes 31 seconds, average range. On the second trial using his non-dominant left hand, he was able to complete the assignment in 4 minutes 42 seconds, average range. On the third trial using both hands, he completed the assignment in 2 minutes 22 seconds, average range.

After the task was complete, Mr. Zack was asked to draw the various shapes and place them in their correct locations. He remembered 5 out of the 10 shapes, mildly impaired range, and was not able to localize any of the shapes in their correct positions, severely impaired range, and considered to be pathognomonic for brain damage.

On the Category Test, a measure of nonverbal reasoning and problem solving skills using error correcting feedback, Mr. Zack committed 41 errors, which placed him in the average range of functioning.

On the Wisconsin Card Sorting Test, a measure which assesses the ability to form abstract concepts, to maintain and to shift set, and to utilize feedback, Mr. Zack completed 6 categories, average range, and committed 19 perseverative errors, moderately impaired range of functioning.

Attention/Concentration:

On the Trail Making Test, a test of speed for attention, sequencing, mental flexibility, visual search and motor function, Mr. Zack obtained the following scores. On Trails A, he required 36 seconds to complete the task, average range. On Trails B, a more complex task requiring the alternation of numbers and letters, he required 1 minutes 37 seconds, moderately impaired range.

On the Test of Variables of Attention, a continuous performance task that measures attentional abilities, Mr. Zack showed no evidence of symptom exaggeration. His overall performance was not within normal limits. Inconsistency, impulsivity, and inattention measures were abnormal. The Attention Performance Index of -3.41 is in the range of individuals independently diagnosed with ADHD.

Learning/Memory:

Learning and memory functioning, as measured by the Wechsler Memory Scale – 4th Edition, revealed the following Index scores:

Index	Index Score		Percentile	Description
Auditory Memory	AMI	81	10	Low Average
Visual Memory	VMI	100	50	Average
Visual Working Memory	VWMI	94	34	Average
Immediate Memory	IMI	86	18	Low Average
Delayed Memory	DMI	92	30	Average

Mr. Zack's index scores ranged from Average to Low Average range of memory functioning. His highest scores were in Visual Memory, a measure of his ability to remember information presented in a visual manner. It is important to note that the 19 point difference between his higher Visual Memory and lower Auditory Memory is akin to the Performance and Verbal I.Q. differences.

Language:

On the Peabody Picture Vocabulary Test – 4th Edition, a measure of receptive language using pictures, Mr. Zack obtained a standard score of 88, percentile of 21, age equivalent of 17.11 years. This score is in the low average range of receptive language functioning.

On the Expressive Vocabulary Test – 2nd Edition, a measure of word knowledge and expressive language, Mr. Zack obtained a standard score of 79, percentile of 8, grade equivalent of 6.8. This score is in the borderline range of expressive language functioning and significantly lower than his receptive language skills.

The Stroop Color and Word Test, a test measuring the ease with which a person can shift his or her perceptual set to conform to changing demands, was administered. Mr. Zack obtained the following scores: T = 31 for Word; T = 27 for Color; T = 36 for Word-Color. These scores are indicative of slow reading speed and inability to shift cognitive sets.

Personality:

Mr. Michael Zack is depressed at the present time. He is introspective and sincerely remorseful for his past actions. He is respectful and has not gotten into fights – 3 DR's in over 20 years. His behavior over the past twenty years does not conform to a diagnoses of Anti-Social Personality Disorder.

> "A Personality Disorder is an enduring pattern of inner experience and behavior that deviates markedly from the expectations of the individual's culture, is pervasive and inflexible, has an

onset in adolescence or early adulthood, is stable over time, and leads to distress or impairment." Diagnostic and Statistical Manual or Mental Disorders Fifth Edition, page 645.

Mr. Zack's history, symptoms, and behaviors, are more akin to a history of head injury, than to a personality disorder. Head injury, especially multiple head injuries, often result in marked personality change, which has been the case with Mr. Michael Zack.

CONCLUSIONS

Mr. Michael Zack meets the criterial for intellectual disability. His verbal language base skills have always been in the significantly impaired range. Most probably, the etiology is based on numerous head injuries sustained over his life span. In all likelihood, Mr. Zack will demonstrate left hemisphere brain abnormalities.

Adaptive functioning skills have been compromised since childhood. He functions well in a highly structured environment, such as the prison system, where little independent planning and functioning is required.

Onset of Mr. Michael Zack's disabilities was prior to the age of 18 and continues at the present time.

RECOMMENDATIONS

Administration of the Stanford-Binet – 4, an I.Q. measure more sensitive to the lower end of the population.

Further evaluation of current adaptive functioning using different psychometric measures.

Brain scanning with the PET scan to further delineate brain pathology.

Hyman H. Eisenstein, Ph.D., A.B.N.

ATTACHMENT E

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PSYCHOLOGICAL EVALUATION

Name: Mr. Michael Duane Zack
Date of Birth: December 14, 1968
Gender: Male
Age: 54 years
Dates of Examination: 8/23/2023 and 8/24/2023
Date of Report: August 27, 2023

Referral Question:

Mr. Michael Duane Zack is a 54-year-old, married, cis-gender, heterosexual, White, Christian male who was placed under death warrant in the State of Florida on August 17, 2023. Mr. Zack has been housed at the Florida State Prison (FSP) since that date.

Mr. Zack was referred for a psychological evaluation by his legal team at the Office of the Federal Defender for the Northern District of Florida. Specifically, this examiner was retained for the purpose of conducting a trauma-informed psychological assessment of Mr. Zack and asked to render opinions related to his present psychological functioning. This report serves to memorialize those opinions, to a reasonable degree of psychological certainty.

Case Summary:

Mr. Zack learned of his execution date when several correctional officers arrived at his cell at Union Correctional Institution (UCI) in the late afternoon of August 17, 2023. It is my understanding that he, like others on death row, had no notice of the Governor's consideration of his execution warrant or that his execution would be scheduled. In fact, Mr. Zack had a clemency interview in 2014, and indicated that, because so much time had passed since then without any hint of a warrant, he was not expecting a warrant to be issued for him. Mr. Zack expressed how overwhelming it was for him to learn that his execution had been scheduled.

Immediately upon the reading of his execution warrant, Mr. Zack was removed from his cell at UCI, which had been his "home" for the past two decades, and was transported to FSP, where he was placed on death watch. For an individual with the type of extensive history that

Mr. Zack experienced during his formative years, this abrupt and unexpected change in his circumstances has served to further retraumatize him.

Conditions of Evaluation:

At the beginning of our first meeting on August 23, 2023, and during our subsequent encounter on August 24, 2023, I identified myself to Mr. Zack and then confirmed his name and date of birth. During each of these meetings I discussed the limits of confidentiality of our meetings. I advised Mr. Zack that I would share my findings with his legal team and submit a written report to be used at their discretion. On each of these occasions, Mr. Zack agreed to the condition that I approach this evaluation with no particular result in mind and that I would exercise independent professional judgment in all aspects of this evaluation. Mr. Zack understood the limits of confidentiality and consented.

Sources of Information:

Data for this report were gathered during two detailed clinical interviews with Mr. Zack (each lasting approximately 4 and 3.5 hours), including an extensive mental status exam, and a battery of psychological measures. This information was supplemented by a review of relevant background materials including life history, documents from several collateral sources throughout Mr. Zack's lifespan; portions of testimony from Mr. Zack's 1997 trial; an overview of the facts of the offenses for which Mr. Zack was convicted and sentenced; previous psychological reports; transcripts from Mr. Zack's 2014 clemency interview; and Department of Corrections records.

Each of these sources of information were considered in the writing of this report.

Behavioral Observations and Mental Status

Each session was conducted in a private room at FSP in Raiford, Florida. Mr. Zack was brought to each session wearing his institutional issued clothing and white sneakers. His hands were shackled together and to his waist and his feet were shackled together. On the second day of our interviews, his hands were shackled using "side cuffing" and his feet remained shackled together. He was of average height and presented as an alert, casually-groomed, healthy, White male who had a crew cut and a greying moustache and beard.

Mr. Zack was tearful at the start of our first meeting and appeared highly anxious throughout the rest of our time together. Notwithstanding his obvious distress, he was pleasant, engaged, and cooperative. Socially, Mr. Zack was able to engage in reciprocal social interactions and reciprocal conversation with the examiner. He appeared to be able to adequately see and hear all test stimuli presented to him. He wore his glasses periodically to read or look at materials presented to him. Mr. Zack reportedly is not prescribed a hearing aid or hearing assistance device.

As he reported his predominant language to be English, all tasks were administered to him in English. Mr. Zack's expressive speech was comprehensible, with a slightly notable disturbance of articulation or pronunciation. His verbal fluency was intact. Receptively, Mr. Zack appeared to comprehend all directions and instructions presented to him, although he frequently required repetition of a question or direction. Regarding fine motor functions, Mr. Zack was right-hand dominant. He displayed a generally good pencil grasp, with generally good fine motor control. Gross motor functions, while not formally assessed, appeared within normal limits. With regard to attention, he generally sustained his attention and concentration on tasks, notwithstanding his need for repetition. There was no noticeable disturbance of activity levels. Overall, Mr. Zack impressed as performing at the best of his abilities.

Throughout his time with this examiner, Mr. Zack's speech was normal in rhythm and rate, clear, coherent, and logical. As our discussions continued, Mr. Zack would become tense at times, but he remained cooperative throughout. For the better part, Mr. Zack's mental status was consistent across both our interviews, however there were points as he recalled his early childhood and adolescent experiences that he would shake his head sadly and look into the distance. As his level of comfort grew, he became reflective and offered spontaneous, detailed information about his life experiences. During each of our sessions, Mr. Zack was cooperative, complied with all requests made of him, and was extremely polite. His judgment and insight were good and his remote and recent memory appeared to be intact. At this point in time, the most distressing event for Mr. Zack has been receiving his execution notification and the subsequent loss of access to social supports and familiar routines. Despite this distress, overall, Mr. Zack was able to remain on task during each of our meetings.

No impairments in reality contact were evident at any time. Mr. Zack denied experiencing any auditory hallucinations (such as hearing voices when nobody is present), paranoia, bizarre thoughts, or other psychotic symptoms. No delusional beliefs (false views that persist even in the face of contrary evidence) were elicited. Overall, Mr. Zack's mood was sad and his affect was constricted, both appropriate to the content of our discussion. Mr. Zack denied any current aggressive impulses, including suicidal and homicidal ideation. Mr. Zack repeatedly referred to his wife and "his people" (his family and friends) as both protective and motivational factors in his life. Mr. Zack adamantly denies any current substance use.

Mr. Zack's responses to questions asked of him appeared to be free of any deliberate attempts to present a distorted picture. In all our meetings, he provided his personal history and current experiences in an unrehearsed fashion with sufficient detail, consistency, logic and attention.

Findings Related to Clinical Interview

This change, particularly in light of Mr. Zack's cognitive and adaptive deficits, has been profoundly destabilizing. As an individual with a developmental disability, consistent structure and dependable supports are critical to Mr. Zack's functioning within a given environment. These ameliorative factors are not present on death watch at FSP. For instance, Mr. Zack's experience on death watch at FSP is significantly more isolated than his experience at UCI. He

is the only individual on death watch, so instead of having a community of peers to socialize with as he did in the UCI dayroom or during recreation on the yard, Mr. Zack is primarily confined to his cell with no peers to talk to.

Additionally, he is further cut off from friend and family supports. One example of this is that although Mr. Zack was supposed to receive a personal phone call immediately after being notified of his warrant, at the time of my last meeting with him on August 24 - a full week later—he had still not received a personal phone call. Another is that access to his tablet, which he used to email his wife and other supportive individuals, has been entirely removed. Although Mr. Zack may receive printouts of emails sent to him, he must handwrite and mail responses—often overseas. Because of this, Mr. Zack is deprived of any sort of "back and forth" conversation, as Mr. Zack is unable to provide contemporaneous responses.

Deprivation of Mr. Zack's tablet has also caused him to lose access to numerous photos of his loved ones. As an individual with clear deficits related to higher level cognitive processing (i.e., Mr. Zack has concrete thinking, as opposed to abstract reasoning), photos have been an effective way for Mr. Zack to cope with physical separation from his friends and family. He described looking at the pictures as a way to "go to a happy place" and self-soothe when he is overwhelmed. The removal of these visual reminders has been extremely distressing to Mr. Zack.

Indeed, death watch has removed most of Mr. Zack's coping mechanisms. He does not have access to his artistic supplies, which he had previously used as a means of healthy expression. He does not have access to outdoor space and fresh air. He has restricted access to a shower, so he is unable to partake in his typical hygiene routine. Although he has access to books, his intellectual and developmental deficits have always made reading difficult for him. With the stress and distraction of his imminent execution, Mr. Zack is unable to sustain the level of concentration necessary to read.

Coexisting with a lack of access to his established coping mechanisms, Mr. Zack is being subjected to constant reminders that he is about to be killed. Since his placement on death watch, he has been exposed to recent news coverage about other capital cases in which individuals who have been on death row with him are now—in contrast to Mr. Zack's situation—receiving life sentences. He will be subjected to numerous questions focused on the logistics of his execution. He will be asked what his last meal will be. He will be asked who will be present at his execution. He will be measured for a burial suit. He will be asked how his remains will be disposed of. This functions as a constant reminder that he, himself, is about to be killed.

Based upon the extensive background information I have received regarding Mr. Zack, and based on his clinical presentation during my evaluation, his mental state has been destabilized by the combined impact of profoundly increased stress and profoundly decreased support. Mr. Zack communicated his confusion about the warrant-setting and death watch processes, and he became tearful and emotional during our interview. Mr. Zack indicated that it was through the institutional setting and community of death row that he evolved and grew as a

person. He made lasting relationships built on mutual respect and kindness. Other prisoners helped him to learn how to read and write, and assisted him in learning to live without self-medicating with drugs and alcohol. Mr. Zack repeatedly emphasized that he is not the same person that he was at the time of the crime.

Psychological Findings

A wide variety of symptoms are associated with childhood and adult interpersonal victimization (including mood disturbances[1], somatization[2], identity disturbance[3], difficulties in emotional regulation[4], insecure attachment[5], chronic interpersonal difficulties[6], dissociation[7], substance abuse[8], suicidal thoughts and behaviors[9], and tension reduction or externalizing activities[10]). Thus, in addition to multiple clinical interviews, the following instruments were used to provide an independent assessment of Mr. Zack's history and current functioning.

i) The Saint Louis University Mental Status (*SLUMS*[11]), an 11-question screening questionnaire that tests orientation, memory, attention, and executive function;
ii) The Montreal Cognitive Assessment (MoCA[12]), a 30-question screening instrument for mild cognitive dysfunction. It assesses different cognitive domains:

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[1] Dworkin, E. R., Menon, S. V., Bystrynski, J., & Allen, N. E. (2017). Sexual assault victimization and psychopathology: A review and meta-analysis. *Clinical psychology review*, *56*, 65-81.

[2] Dietrich, A. (2003). Characteristics of child maltreatment, psychological dissociation, and somatoform dissociation of Canadian inmates. *Journal of Trauma & Dissociation*, *4*(1), 81-100.

[3] Briere, J., & Rickards, S. (2007). Self-awareness, affect regulation, and relatedness: Differential sequels of childhood versus adult victimization experiences. *The Journal of nervous and mental disease*, *195*(6), 497-503.

[4] Van der Kolk, B. A., Pelcovitz, D., Roth, S., & Mandel, F. S. (1996). Dissociation, somatization, and affect dysregulation: The Complexity of adaption to trauma. *The American journal of psychiatry*.

[5] Cloitre, M., Stovall-McClough, C., Zorbas, P., & Charuvastra, A. (2008). Attachment organization, emotion regulation, and expectations of support in a clinical sample of women with childhood abuse histories. Journal of Traumatic Stress: Official Publication of The International Society for Traumatic Stress Studies, 21(3), 282-289.

[6] Pietrzak, R. H., Goldstein, M. B., Malley, J. C., Zack, D. C., & Southwick, S. M. (2009). Subsyndromal posttraumatic stress disorder is associated with health and psychosocial difficulties in veterans of Operations Enduring Freedom and Iraqi Freedom. *Depression and anxiety*, *26*(8), 739-744.

[7] Briere, J., Scott, C., & Weathers, F. (2005). Peritraumatic and persistent dissociation in the presumed etiology of PTSD. *American Journal of Psychiatry*, *162*(12), 2295-2301.

[8] Ouimette, P. E., & Brown, P. J. (2003). *Trauma and substance abuse: Causes, consequences, and treatment of comorbid disorders*. American Psychological Association.

[9] Panagioti, M., Gooding, P. A., & Tarrier, N. (2012). A meta-analysis of the association between posttraumatic stress disorder and suicidality: the role of comorbid depression. *Comprehensive Psychiatry*, *53*(7), 915-930.

[10] Briere, J., & Gil, E. (1998). Self-mutilation in clinical and general population samples: Prevalence, correlates, and functions. *American journal of Orthopsychiatry*, *68*(4), 609-620.

[11] Tariq, S. H., Tumosa, N., Chibnall, J. T., Perry III, H. M., & Morley, J. E. (2006). The Saint Louis University Mental Status (SLUMS) Examination for detecting mild cognitive impairment and dementia is more sensitive than the Mini-Mental Status Examination (MMSE)-A pilot study. *American Journal of Geriatric Psychiatry*, *14*(11), 900-910

[12] Nasreddine, Z. S., Phillips, N. A., Bédirian, V., Charbonneau, S., Whitehead, V., Collin, I., ... & Chertkow, H. (2005). The Montreal Cognitive Assessment, MoCA: a brief screening tool for mild cognitive impairment. *Journal of the American Geriatrics Society*, *53*(4), 695-699.

attention and concentration, executive functions, memory, language, visuoconstructional skills, conceptual thinking, calculations, and orientation;

iii) The Adverse Childhood Experiences (ACE[13]), a 10-item instrument used to identify childhood experiences of abuse and neglect;

iv) Somatic Symptom Scale-8 (SSS-8[14]). The eight item SSS is a brief, patient-reported outcome measure of somatic symptom burden. These symptoms were originally chosen to reflect common symptoms in primary care but they are relevant for a large number of diseases and mental disorders.

v) The Physician's Health Questionniaire-9 (PHQ-9[15]), a 9-item instrument for screening, diagnosing, monitoring and measuring the severity of depression;

vi) The Hopkins Symptom Checklist-25 (HSCL-25[16]), a 25-item instrument that consists of two subscales measuring depression and anxiety;

vii) The Life Events Checklist for *DSM-5* (LEC-5[17]), an instrument which assesses exposure to 16 events known to potentially result in PTSD or distress; and

viii) The Trauma Symptom Inventory-2 (TSI-2[18]), a 136-item adult self-report measure of posttraumatic stress and other psychological sequelae of traumatic and stressful events;

All these instruments have been used to assess mental health domains that are important across psychiatric diagnoses. In Mr. Zack's case, they are used to enhance clinician decision-making and along with a comprehensive mental status assessment, to assist with clinical diagnosis and assess for malingering. These measures have been used widely in research and clinical settings to screen for and assess symptoms, and to make provisional diagnosis in a variety of populations. All have been shown to have strong psychometric properties and are culturally appropriate. Mr. Zack was given the option to complete the self-report measures on his own or have this examiner read them to him. Although he chose to have them read to him, there were several moments when the questions had to be repeated and/or rephrased. Mr. Zack willingly responded to each item of each questionnaire in a reasonable amount of time.

To assess his cognitive functioning, Mr. Zack was administered the Montreal Cognitive Assessment (MoCA) during our first meeting. The MoCA is a 30-question screening instrument for mild cognitive dysfunction. It assesses different cognitive domains: attention and concentration, executive functions, memory, language, visuoconstructional skills, conceptual

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[13] Foege, W. H. (1998). Adverse childhood experiences. *A public health perspective. Am J Prev Med*, *14*(4), 354-55.

[14] Gierk, B., Kohlmann, S., Kroenke, K., Spangenberg, L., Zenger, M., Brähler, E., & Löwe, B. (2014). The somatic symptom scale–8 (SSS-8): a brief measure of somatic symptom burden. *JAMA internal medicine*, *174*(3), 399-407.

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[17] Weathers, F. W., Blake, D. D., Schnurr, P. P., Kaloupek, D. G., Marx, B. P., & Keane, T. M. (2013). *The life events checklist for DSM-5 (LEC-5).* Instrument available from the National Center for PTSD at www. ptsd. va. gov.

[18] Briere, J. (2011). Trauma Symptom Inventory-2 (TSI-2). Odessa, Florida: Psychological Assessment Resources

thinking, calculations, and orientation. On the MoCA, he scored a 21 out of 30. As a follow up, during our second meeting, Mr. Zack was administered the Saint Louis University Mental Status (SLUMS), an 11-question screening questionnaire that tests orientation, memory, attention, and executive function during our first meeting. Here, he earned a 24 out of 30. His scores on both of these measures place Mr. Zack within the range of limited neurocognitive functioning, findings consistent with his previous Neuropsychological Evaluations. All highlighting his limited cognitive abilities.

The Adverse Childhood Experiences (ACE) instrument measures 10 types of childhood trauma. Five are personal (physical abuse, verbal abuse, sexual abuse, physical neglect, and emotional neglect) and five are related to other family members (a parent who is an alcoholic, a mother who is a victim of domestic violence, a family member in jail, a family member diagnosed with a mental illness, and the disappearance of a parent through divorce, death or abandonment). Each type of trauma counts as one. An ACE of 4 or more is of concern[19, 20]. As has been documented throughout the psychological literature, the higher the individual's ACE score, the higher the risk for health and social and emotional problems. On the ACE, Mr. Zack scored a "9" out of 10, indicating childhood exposure to all but one of the ten categories used to identify childhood incidents of abuse and neglect (this finding indicates multiple traumatic experiences prior to age 18 and supports his description of early traumatic events).

While the ACE scale is among the gold standard instruments for assessing adverse childhood experiences, it does have some shortcomings. One limitation is a narrow range of childhood adversities covered, such as the exclusion of bullying. Another example is restricting witnessing domestic violence to mothers and stepmothers, and excluding witnessing such behavior towards siblings. Another limitation is the low number of items, only 10, making it easier to apply in many circumstances but does not capture other critical ones. Finally, the ACE does not include information on timing and duration of exposure or of how exposure levels change across development. Given Mr. Zack's remarkably elevated ACE score, to get a detailed sense of his experiences, the MACE was also administered. Mr. Zack's responses on this measure provided not only further evidence of the toxic environment he grew up in during his childhood and his adolescent years, but also highlighted the types of adverse experiences he repeatedly endured (e.g., witnessing abuse towards his siblings, physical abuse, sexual assault).

Mr. Zack reported having experienced many of the 10 different types of maltreatment captured by the MACE (Emotional Neglect, Non-Verbal Emotional Abuse, Parental Physical Maltreatment, Parental Verbal Abuse, Sexual Abuse, Witnessing Violence to Siblings[21]). Throughout the times we met, he was willing to discuss his experiences. He earned an overall score of 45 out of 75. These findings are a testimony of not only what Mr. Zack experienced and witnessed, but also his feelings of terror and helplessness during his formative years.

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[19] www.AcesTooHigh.com
[20] www.acestudy.org
[21] Teicher MH, Parigger A (2015) The 'Maltreatment and Abuse Chronology of Exposure' (MACE) Scale for the Retrospective Assessment of Abuse and Neglect During Development. PLoS ONE 10(2): e0117423. https://doi.org/10.1371/journal.pone.0117423

Since somatic symptoms are the core features of many medical diseases, and are used to evaluate the severity and course of illness, the Somatic Symptom Scale-8 (SSS-8) was administered to Mr. Zack. Here he earned a 6, placing him in the "Low" range of somatic symptoms. Following the SSS-8, Mr. Zack completed the Physician's Health Questionniaire-9 (PHQ-9). On the PHQ-9, a 9-item instrument for screening, diagnosing, monitoring and measuring the severity of depression; Mr. Zack scored a 13 out of 27, a score which is consistent with "Mild" depressive symptoms. Here, Mr. Zack endorsed multiple depressive symptoms including anhedonia, hopelessness, and difficulties with concentration. Remarkably, on the Hopkins Symptom Checklist-25 (HSCL-25, a 25-item instrument that consists of two subscales measuring anxiety and depression; where a score above 1.75 is significant), Mr. Zack earned 2.7 on the scale measuring anxiety (e.g., feeling tense and keyed up, nervousness), and a 2.47 on the scale measuring depression (e.g., an acute sense of self-blame, sadness, loneliness, excessive worry, and feelings of worthlessness). He earned an overall score of 2.46 on both scales. Taken together, these findings are indicative of significant depressive symptoms.

Mr. Zack's responses on the PTSD Checklist–Civilian for *DSM-5* (PCL-C-5), a 20-item measure evaluating the 20 DSM-5 symptoms of PTSD underscore the extent of his terror during that time and how much past events have reemerged to haunt him today. On this measure of PTSD that seeks to understand how much the individual has been bothered by this incident "in the past month," Mr. Zack earned a score of 43 out of 80, far above the recommended PCL-5 cutoff point of 31-33, and consistent with a finding of PTSD. Typically, when an individual earns a significant score on the LEC-5, the Clinician-Administered PTSD-5 (CAPS-5[22]), a structured interview designed to make a categorical PTSD diagnosis, as well as to provide a measure of PTSD symptom severity is administered. To be clear, Mr. Zack has a pre-existing diagnosis of PTSD related to his prior traumatic experiences. In addition, the specific recent, devastating news of his impending execution, *standing alone*, meets criterion for an Acute Stress Disorder (ASD). Acute Stress Disorder contains all criteria of PTSD, but deals with symptoms that have been present for less than one month. As Mr. Zack learned of his imminent execution approximately one week prior to our interview, that specific stressor has caused ASD. If these traumatic symptoms related to news of his pending execution persist after one month, he would meet the criteria for PTSD related to that trauma.

Mr. Zack's scores on various scales of The Trauma Symptom Inventory-2 (TSI-2) a 136-item adult self-report measure of posttraumatic stress and other psychological sequelae of traumatic and stressful events, were consistent with a history of severe child abuse and neglect. All of these findings are consistent with Mr. Zack's extensive trauma history.

Mr. Zack's performance on all the objective measures of validity fell within the normal range. As such, these results appear to be a valid representation of Mr. Zack's current functioning. In my professional opinion, informed by data gathered from the earlier mentioned sources and from my clinical interview of Mr. Zack, he meets the following diagnostic criteria

[22] Weathers, F. W., Bovin, M. J., Lee, D. J., Sloan, D. M., Schnurr, P. P., Kaloupek, D. G., ... & Marx, B. P. (2018). The Clinician-Administered PTSD Scale for DSM–5 (CAPS-5): Development and initial psychometric evaluation in military veterans. *Psychological assessment*, *30*(3), 383.

according to the *DSM-5-TR*:

Diagnostic Impression *(DSM-5-TR):*

308.3 (F43.0)	Acute Stress Disorder
309.81 (F43.10)	Posttraumatic Stress Disorder, Chronic (by history) (ICD-11 Complex Posttraumatic Stress Disorder)
296.32 (F33.1)	Major Depressive Disorder, Recurrent, Moderately Severe
294. 9	Cognitive Disorder NOS (by history)
314.01	Attention Deficit-Hyperactive Disorder, Combined Type (by history)
304.80	Polysubstance Dependence, In Remission In Controlled Environment (by history)
312.30	Impulse Control Disorder NOS (by history)
V62.89	Borderline Intellectual Functioning (by history)
V15.41 (Z62.810)	Personal History of physical abuse in childhood (by history)
V15.41 (Z62.810)	Personal History of sexual abuse in childhood (by history)
V15.49 (Z91.49)	Other Personal History of Psychological Trauma (by history)
V62.5 (Z65.1)	Imprisonment and other incarceration

Conclusions

Prior to his incarceration on death row, Mr. Zack suffered from numerous traumas and disadvantages which—coupled with a lack of support systems—led him down a destructive path. Over the past twenty-five years, he has utilized the supports available to him on death row, such as: structure and routine; coping mechanisms such as grounding exercises and healthy forms of self-expression, such as through art; development of positive peer influences and role models; and sobriety.

Based upon my review of Mr. Zack's prison records and in discussing them with him, it is clear that he has been a model prisoner with only a few minor disciplinary infractions in the past twenty-five years and none within the past twenty years. Indeed, it is my opinion that Mr. Zack's few disciplinary infractions are consistent with his cognitive impairments and difficulty adapting to new and changing environments. For example, one of these few incidents was due to Mr. Zack's failure to wear a shirt of the correct color during a prison event. This is reminiscent of his sister's account that, as a child, Mr. Zack frequently got into trouble during his bedtime routine because he kept forgetting pajamas to change into after bathing.

Additionally, in the decades since Mr. Zack's incarceration on death row, he has forged a sense of community and support that was not present prior to his incarceration. He has developed long-term, close relationships with his wife, Ann-Kristin; numerous pen pals; and other individuals on death row. He has maintained these relationships by keeping in regular contact with his loved ones via written letters, phone calls, in-person visits, and emails on his tablet.

Mr. Zack has a history of profound traumatic experiences that are prolifically documented in his legal and psychological records.

Recommendations

The recommendations put forward here are based on the observations made of Mr. Zack during this evaluation. Despite his past and his current struggles, Mr. Zack has demonstrated a number of critical strengths, including the capacity to develop deep emotional connections with other people, a deep and abiding respect for others, and the ability to grow and learn, and the desire to make positive contributions to the larger society.

In the conclusions of the Neuropsychological Evaluation of May 26, 2015, conducted by Dr. Hyman H. Eisenstein in which Mr. Zack was found to meet the criteria for intellectual disability, Dr. Eisenstein noted that Mr. Zack's "Adaptive functioning skills have been compromised since childhood. He functions well in a highly structured environment, such as the prison system, where little independent planning and functioning is required" (p. 11). As is observed throughout this report, Mr. Zack has thrived in this environment, he has developed skills (e.g., his art), learned basic reading and writing skills, and developed solid and respectful relationships both with peers and individuals within and outside the prison walls. For an individual like Mr. Zack who has a history of such extensive trauma, his new and unexpected circumstances are bewildering and have created a sense of unremitting, uncontrollable and unpredictable stress, serving to destabilize his psychoemotional wellbeing.

In order to help Mr. Zack, I recommend, to the extent possible, reintroduction of his support systems to stabilize his mental health and provide coping mechanisms at this highly stressful time. Specifically, I recommend:

- Reducing Mr. Zack's isolation by providing him daily opportunities to speak to his family and friends, whether in person or by phone. In Mr. Zack's case, it is likely that he would need opportunities to use the phone due to his loved ones' proximity to FSP.
- Allowing him daily time to use his tablet. Mr. Zack's tablet serves as a way to communicate and connect with his family and friends. In addition, the photos and previous e-mails provide a proven coping strategy for him and allows him to go to his "happy place" with positive memories.
- Providing him outdoor time so that he can see the sky, feel the sun, walk in yard, exercise, and get fresh air to stimulate his senses and calm his anxieties.
- Giving him time to use his art supplies.
- Offering him showers each day.

It was truly a pleasure to meet with Mr. Zack. Please feel free to contact me with any additional questions.

Adeyinka M. Akinsulure-Smith, Ph.D., ABPP
Psychologist, New York State License #013405

ATTACHMENT F

DECLARATION OF PETER N. MILLS

PURSUANT TO 28 U.S.C. 1746

1. My name is Peter N. Mills. I am a lawyer licensed by the Florida Bar and employed by the Office of the Public Defender for the Tenth Judicial Circuit (PD-10).

2. On July 1, 2013, PD-10 was appointed to represent Michael Duane Zack in his clemency proceedings. Along with Mr. Zack's case, PD-10 was appointed as clemency counsel in five other cases.

3. Because the office was appointed to six capital clemency cases, a schedule was established staggering the clemency interviews and submissions with the agency now known as the Florida Commission on Offender Review (FCOR). Former Assistant Public Defender Austin Maslanik was assigned to represent Mr. Zack. Mr. Zack's clemency interview was conducted on April 24, 2014; his memorandum in support was submitted on May 23, 2014. Mr. Maslanik ultimately retired from PD-10. Upon Mr. Maslanik's retirement, I was assigned to oversee any capital clemency related matters on behalf of PD-10.

4. However, since the submission of Mr. Zack's memorandum, no one from FCOR or the Clemency Board contacted PD-10 in any form until Public Defender Howard "Rex" Dimming, II, received a letter, dated August 17, 2023, stating that the Governor denied clemency for Mr. Zack and his death warrant had been signed. Though it had been over nine years since Mr. Zack's clemency interview and

submission of his memorandum, FCOR did not offer Mr. Zack an opportunity to update his submission.

5. I learned that extensive litigation has occurred in Mr. Zack's case since his interview and the submission of his memorandum in support of clemency. For example, following the United States Supreme Court's decision in *Hall v. Florida*, 572 U.S. 701 (2014), Mr. Zack litigated the issue of his intellectual disability. At the time his clemency submission was made, the controlling law in Florida precluded consideration of his intellectual disability claim because he did not have a qualifying IQ score of 70 or below. However, in *Hall*, the Supreme Court invalidated Florida's strict 70 cutoff because "intellectual disability is a condition, not a number." 572 U.S. at 723. Following *Hall*, Dr. Hymen Eisenstein authored a report indicating that "Mr. Michael Zack meets the criteria for intellectual disability." The Florida courts again summarily rejected Mr. Zack's claim based upon his IQ scores not meeting a threshold number without allowing any opportunity for evidence as to how he could still meet the requirements for intellectual disability making him ineligible for a death sentence. Due to the timing of the clemency proceeding, relevant information was not provided to FCOR, the Governor, or the Clemency Board. If provided with the opportunity, I would have offered Dr. Eisenstein's May 26, 2015, report and explained its importance in the clemency determination.

6. In addition, in 2016, the United States Supreme Court held that the sentencing statute under which Mr. Zack was sentenced to death was unconstitutional. *Hurst*

v. Florida, 577 U.S. 92 (2016). Though Mr. Zack timely litigated the issue, the Florida Supreme Court, held that the retroactivity of *Hurst* applied only to some individuals on death row based upon the date that their sentence became final. The retroactivity analysis was unprecedented and worked to Mr. Zack's detriment. Due to the timing of the clemency proceeding, relevant information about the constitutionality of Mr. Zack's death sentence was not provided to FCOR, the Governor, or the Clemency Board. If provided with the opportunity, I would have offered information about Mr. Zack's non-unanimous jury recommendation and the arbitrariness of the Florida Supreme Court's retroactivity determination to his case.

7. Most importantly, if provided with the opportunity, I would have offered FCOR, the Governor and the Clemency Board information about Fetal Alcohol Syndrome (FAS), a condition that Mr. Zack suffers. Specifically, the information contained in the declarations of Dr. Natalie Novick Brown, Ph.D. and Dr. Julian Davies, M.D., that outlines the recent understanding and consensus about FAS and its functional equivalence to intellectual disability, strongly compel clemency. The critical impact of Mr. Zack's lifelong condition—one that preexisted his birth—explains why he does not squarely meet Florida's statutory definition of intellectual disability requirements but demonstrates how individuals like Mr. Zack must be exempt from the death penalty.

8. My experience in representing capital defendants at trial has provided me insight as to how the clinical understanding of FAS, if adequately presented and explained,

often causes jurors to recommend life. Unfortunately, some courts have not caught up with the science and as Mr. Zack's case demonstrates, FAS is often misunderstood. Clemency is meant to be the fail-safe of the criminal justice system. But, the fact that the recent consensus and understanding of FAS was not presented to FCOR, the Governor, and the Clemency Board means that there was no opportunity for the fail-safe to work

I hereby certify that the facts set forth are true and correct to the best of my knowledge, information, and belief, subject to the penalty of perjury, pursuant to 28 U.S.C. 1746.

Peter N. Mills

September 1, 2023

ATTACHMENT G

STATE OF FLORIDA
OFFICE OF EXECUTIVE CLEMENCY

RON D. DeSANTIS, GOVERNOR, CHAIRMAN
ASHLEY B. MOODY, ATTORNEY GENERAL
JIMMY T. PATRONIS JR, CHIEF FINANCIAL OFFICER
WILTON SIMPSON, COMMISSIONER OF AGRICULTURE
and CONSUMER SERVICES

S. MICHELLE WHITWORTH, COORDINATOR

4070 Esplanade Way, Tallahassee, Florida 32399-2450
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Toll Free: 1-800-435-8286

August 17, 2023

Mr. Howard "Rex" Dimmig II
Public Defender
Tenth Judicial Circuit
PO Box 9000 Drawer PD
Bartow, Florida 33831

RE: Zack, Michael Duane, III
DC #124439
EC #D200315

Dear Mr. Dimmig,

After a review of the clemency investigation material provided by the Florida Commission on Offender Review in accordance with the Rules of Executive Clemency, the Governor has denied clemency for your client, Michael Duane Zack III.

A death warrant signed on August 17, 2023, concludes the clemency process.

Sincerely,

S. Michelle Whitworth
Coordinator

cc: Governor Ron DeSantis
Ms. C. Suzanne Bechard, Associate Deputy Attorney General
Ms. Brandy Fortune, Florida Commission on Offender Review
Mr. Robert Friedman, Capital Collateral Regional Counsel
Ms. Dawn Macready, Capital Collateral Regional Counsel
Ms. Linda McDermott, Office of the Federal Public Defender
Inmate, Michael Duane Zack III DC #124439

ATTACHMENT H

IN THE UNITED STATES DISTRICT COURT FOR THE NORTHERN DISTRICT OF FLORIDA TALLAHASSEE DIVISION

MICHAEL DUANE ZACK,

Plaintiff,

v. CASE NO. 4:23cv392-RH

RON DESANTIS et al.,

Defendants.

_____/

ORDER DENYING THE MOTION FOR A STAY OF EXECUTION

A Florida jury convicted Michael Duane Zack in 1996 of murder and other offenses. The judge sentenced him to death. The conviction and sentence were upheld on direct appeal and in state and federal collateral attacks.

On August 17, 2023, clemency was denied, and Mr. Zack's execution was scheduled for October 3, 2023. Mr. Zack promptly filed this action under 42 U.S.C. § 1983 challenging the constitutionality of the clemency proceeding. He has moved for a stay of execution. This order denies the motion.

Another collateral attack is pending in state court. But this § 1983 action does not challenge the conviction or sentence. The only issue here is whether Mr. Zack was denied due process in the clemency proceeding.

The clemency proceeding began in 2013. Represented by counsel, Mr. Zack appeared for a clemency interview and submitted a memorandum in support of clemency in 2014. The clemency proceeding remained pending, with no formal action, until August 17, 2023. On that date the Governor notified Mr. Zack that clemency was denied.

Mr. Zack filed this § 1983 action less than three weeks later, on September 5, 2023. The defendants are state officials involved in the clemency process, including the Governor and the three other members of the Clemency Board. It is now settled that a due-process claim of this kind can properly be brought under § 1983 rather than by a habeas petition under 28 U.S.C. § 2254. *See Barwick v. Gov. of Fla.*, 66 F.4th 896, 901–02 (11th Cir. 2023).

One ground on which Mr. Zack asserts a due-process violation is the delay and change in personnel between 2014, when the clemency issue was submitted, and 2023, when the clemency issue was decided. The Governor and other members of the Clemency Board all changed during that period.

On the underlying merits of the clemency issue, Mr. Zack asserts he suffers from fetal alcohol syndrome, a mitigating factor whose consequences are much

better understood in the medical profession today than they were in 2014. Indeed, Mr. Zack says this renders him intellectually disabled and thus not properly subject to the death penalty. Mr. Zack says he has been denied an opportunity to present his clemency claim to the current Clemency Board and, more importantly, that he has been denied an opportunity to argue for clemency based on the current state of medical knowledge about fetal alcohol syndrome.

The defendants say Mr. Zack could have presented any information he wished at any time prior to the recent denial of clemency and indeed could still present the information today. The notice provided to Mr. Zack on August 17, 2023 said the death warrant "concludes the clemency process," but the defendants assert the Governor retains the ability to grant clemency at any time prior to the actual execution. If the Governor chose to grant clemency now, surely Mr. Zack would not object.

It is clear that a death-sentenced person has a right to due process in connection with a state-authorized clemency application. *See Ohio Adult Parole Auth. v. Woodard*, 523 U.S. 272, 289 (1998) (O'Conner, J., concurring) (stating that "some *minimal* procedural safeguards apply to clemency proceedings") (emphasis in original); *Wellons v. Comm'r, Ga. Dep't of Corr.*, 754 F.3d 1268, 1269 n.2 (11th Cir. 2014) (treating Justice O'Conner's *Woodard* concurrence as controlling). The defendants do not assert the contrary. They assert, instead, that

the procedures afforded Mr. Zack provided whatever minimal level of process was due.

The defendants are correct. Mr. Zack was represented by counsel in the clemency proceeding. Mr. Zack was allowed to make a written submission and to appear in person with his counsel for an interview. In this § 1983 action, Mr. Zack has not alleged he was denied the opportunity to present in 2014 any information he wished to present. Had clemency been promptly denied at that time, Mr. Zack would have no ground to assert he was denied due process. *See, e.g.*, *Barwick*, 66 F.4th at 904–05 (rejecting a due-process challenge to Florida's clemency procedures).

The state officials involved in the clemency process, including the Governor and other members of the Clemency Board, were not obligated to somehow anticipate—without being notified by Mr. Zack—that he might have new information he wished to present. That he did not raise the issue is understandable; if the file was being ignored, any execution was being delayed. But understandable or not, it was Mr. Zack, not clemency officials, who possessed any new information and asserted there were new grounds for clemency. Nothing prevented him from presenting the information.

Nor was the state obligated to start the process anew when the members of the Clemency Board changed. The members of the Clemency Board are the

Governor and members of the cabinet, all elected statewide every four years. It thus is commonplace for the members to change. Due process does not require the clemency process to start and finish between elections or before the Clemency Board's membership changes. *See, e.g.*, *Mann v. Palmer*, 713 F.3d 1306, 1316–17 (11th Cir. 2013) (rejecting a due-process challenge to the 2013 denial of clemency because due process was provided in clemency proceedings conducted in 1985); *see also Gilreath v. State Bd. of Pardons & Paroles*, 273 F.3d 932, 934 (11th Cir. 2001) (holding clemency board member's absence from clemency meeting did not violate due process).

This order would reach the same result anyway, but it bears noting that Mr. Zack seems not to believe his own suggestion that the updated fetal-alcohol-syndrome information might affect the clemency outcome. In response to Mr. Zack's motion for a stay of execution, the defendants have asserted Mr. Zack can present the new information now, and that, if warranted, clemency can still be granted based on that information. One might reasonably expect that, if Mr. Zack really believes that the new information might produce a different clemency outcome, he would accept the defendants' invitation and submit the information to the Governor and Clemency Board now, together with a renewed request for clemency. Mr. Zack apparently has not done so, instead doubling down on the due-process claim.

In any event, Mr. Zack is unlikely to prevail on the merits of his due-process challenge to the clemency procedure followed in his case. He is not entitled to a stay of execution on this basis. *See, e.g.*, *Barwick*, 66 F.4th at 900 (setting out the prerequisites to a stay of execution, including a substantial likelihood of success on the merits).

IT IS ORDERED:

The motion for a stay of execution, ECF No. 3, is denied.

SO ORDERED on September 15, 2023.

s/Robert L. Hinkle
United States District Judge