Department of Health & Human Services
DHHS
Division of Behavioral Health
State of Nebraska
NEBRASKA Pete Ricketts, Governor

May 10, 2016

The Honorable Peter C. Bataillon
Douglas County District Court
1701 Farnam St.
Omaha, NE 68183-001

EXHIBIT
56
6-7-16 AS

RE: JENKINS, NIKKO
CASE NO.: CR13-2768

Your Honor:

Nikko Jenkins is a 29-year-old man, who was ordered to undergo a competency evaluation for sentencing on four counts of First Degree Murder, four counts of Use of a Deadly Weapon to Commit a Felony, and four counts of being a Felon in Possession of a Firearm, in relation to three separate incidents that occurred in a two week period in August 2013.

Given the nature of this evaluation, additional background may be pertinent as the competency to stand trial issue was addressed during earlier phases of the proceedings. He was found competent to stand trial in early 2014. Mr. Jenkins represented himself during the trial phase and pled no contest to the charges listed above. He was convicted on 04/08/2014 and was reappointed counsel to represent him during the sentencing phase. In May 2014, Mr. Jenkins' attorneys

raised the question of competence in regards to sentencing. Additional competency evaluations were completed by Drs. Bruce Gutnik, Y. Scott Moore, and Klaus Hartmann, although resulted in differing opinions. Ultimately, Mr. Jenkins was found incompetent to proceed with the sentencing phase of a death penalty case. Lincoln Regional Center (LRC) personnel engaged in competency restoration efforts from August 2014 – February 2015, at which time an opinion was offered that Mr. Jenkins was competent to proceed. Shortly thereafter, the Court issued an order finding Mr. Jenkins competent. In May 2015 and December 2015, Mr. Jenkins was re-evaluated by Dr. Gutnik, who opined that the defendant was not competent. Following Dr. Gutnik's December 2015 evaluation, the court ordered LRC personnel to conduct the current evaluation.

SOURCES OF INFORMATION

- Available Douglas County District Court records
- Available Methodist Richard Young records; dated 02/03/1995 - 02/24/1995
- Available Nebraska Department of Correctional Services (NDCS) records; dated 11/17/2003 -04/21/2016
    - o Includes notes from Premier Psychiatric Group from 04/14/2015 – 03/17/2016
- Available Douglas County Corrections (DCC) records; dated 02/13/2010 - 11/13/2013

- Competency and mental status at time of offense evaluation; Dr. Y. Scott Moore; dated 07/20/2010
- Letter from Mr. Jenkins to the 'Director of LRC,' stamped as received on 05/31/2012
- Letter from Mr. Jenkins to Rachel Johnson, Religious Coordinator at the Lincoln Regional Center, stamped as received on 06/06/2012
- Omaha Police Department audio records; dated 08/29/2013 and 09/03/2013
- Competency evaluations; Dr. Bruce Gutnik; dated 11/08/2013, 05/07/2014, 05/04/2015, 12/07/2015
- Competency evaluation; Dr. Y. Scott Moore; dated 12/22/2013
- Mental status at time of offense evaluation; Dr. Bruce Gutnik; dated 02/06/2014
- Competency evaluation; Dr. Y. Scott Moore and Dr. Klaus Hartmann; dated 06/19/2014
- Lincoln Regional Center (LRC) records; dated 08/15/2014 to 02/16/2015
    - Includes 02/11/2015 competency opinion authored by the undersigned
- Lancaster County Court filings from Mr. Jenkins; dated 04/28/2014 and 08/26/2014
- Letter from Mr. Jenkins to the Douglas County Attorney's Office; dated 10/01/2014

- Douglas County District Court motions from Mr. Jenkins; dated 01/30/2015; 10/14/2015; 11/09/2015; 11/30/2015; 12/14/2015; 12/21/2015; 04/11/2016 (no file stamp date)
- Letter from Mr. Jenkins to Omaha Police Department; stamped as received on 12/10/2015
- Letter from Mr. Jenkins to Jennifer Tinsley, Douglas County Sheriff's Department; dated 12/25/2015
- Audio recording of voice message left by Mr. Jenkins on a telephone number for the Douglas County Election Commissioner's Office (in an apparent mistaken attempt to contact the Omaha World Herald); date listed as 12/28/2015

Methods of evaluation:

- Sessions with the undersigned evaluators (01/06/2016, 03/16/2016; 04/21/2016)
- Communication with Mr. Tom Riley, Defense Attorney (02/10/2016)
- Communication with Ms. Brenda Beadle, Deputy County Attorney (12/28/2016)

LIMITS OF CONFIDENTIALITY

Mr. Jenkins was notified of the limits of confidentiality and the purpose of the evaluation. Specifically, he was informed that the Court ordered a competency evaluation for sentencing. He was informed that any

information he disclosed could be included in a written report that would be distributed to the Court, his attorney, and the County Attorney. He was informed that he could choose not to divulge information that he wanted to be kept confidential. He indicated he understood the limitations of confidentiality as he was able to articulate key concepts of the limitations in his own words.

MENTAL HEALTH HISTORY

Mr. Jenkins has interacted with mental health professionals at various facilities since the age of 8. Mental health professionals have consistently described his chaotic upbringing with exposure to family violence, history of substance abuse, and conduct problems. Records consistently describe Mr. Jenkins' exhibition of antisocial personality characteristics as an adult. However, there has been disagreement amongst mental health professionals regarding whether Mr. Jenkins has exhibited symptoms of major mood or psychotic disorders. Some mental health professionals viewed his reported symptoms as characteristic of bipolar or psychotic disorders, while other mental health professionals considered Mr. Jenkins' reported symptoms as malingered for secondary gain. These differing interpretations of Mr. Jenkins' reported symptoms were also evidenced in the multiple competency evaluations following the charges currently pending sentencing.

As a result of these different conceptualizations, efforts to conduct a thorough differential diagnosis were undertaken as part of prior competency restoration treatment in August 2014 – February 2015 to provide clarification for the Court. That detailed mental health history is detailed in the 02/11/2015 opinion authored by the undersigned, but a synopsis of the information is included in a chart attached to this report. A summary of the last year's events is also provided below to establish the basis for the current opinion.

Several patterns emerged during the August 2014 – February 2015 course of competency restoration with LRC. The details of those observations are outlined in the 02/11/2015 opinion to the court, but are briefly summarized here to offer relevant background for the current opinion. Through the duration of that course of treatment, Mr. Jenkins was predominantly focused on his placement (within a correctional facility; in segregation) and his perceptions that he was mistreated by various agencies, systems, and persons (e.g., NDCS, District Court, LRC). He repeatedly asserted he experienced mental health problems, but only offered labels for his purported difficulties and was unable to describe relevant subjective experiences or details. He claimed to engage in seemingly bizarre behaviors (e.g., snorting/drinking his semen), although he attributed these behaviors to his belief that it would enhance his masculinity and they were unrelated to the legal proceedings. Similarly, while actual self-harm was not a prominent problem during competency restoration treatment, he frequently made threats to harm himself

or others. These statements were always in the context of attempts to control others' actions or perceptions of him (e.g., move units, appear "insane," influence the findings of the competency evaluation). Although Mr. Jenkins cited a "conspiracy" against him in his legal case, his reasoning for his belief was not delusional in nature. Furthermore, he contradictorily stated his purported symptoms did not distress him, while at the same time accused others of being responsible for his "psychological and emotional deterioration." Despite his assertions of such mental deterioration, the defendant himself admitted that such deterioration had not taken place due to his efforts to maintain safety. It should be noted that the undersigned did not witness such deterioration during this competency restoration time period.

During competency restoration treatment, Mr. Jenkins refused to engage in structured assessments and interviews designed to assess his functioning, citing concerns that results of such assessments would be used against him. Over the course of time, through frequent sessions (up to 5 times/week), it became clear that Mr. Jenkins' self-report of symptoms was not validated by observational data. There was no indication his functioning was adversely affected by psychotic or major mood symptoms, as would have been expected if he were experiencing such symptoms. Despite his self-report of experiencing intrusive symptoms, the content of his thought was almost always focused on legal maneuvers, his perceived mistreatment and associated complaints, and self-aggrandizing in nature. Moreover,

his focus on obtaining certain diagnoses and prescriptions for antipsychotic medication appeared to be motivated by secondary gain, and he consistently rejected treatment when it was offered. His stance was relatively consistent throughout the course of treatment – in that he would demand something (e.g., item, placement, treatment, diagnosis) and resort to threats, manipulation, or intimidation in an effort to obtain the outcome he, desired. Eventually, Mr. Jenkins voiced a desire to be found competent.

Ultimately, Mr. Jenkins was found competent to proceed in February 2015, following the competency restoration efforts of the undersigned. In May 2015, Dr. Bruce Gutnik re-evaluated Mr. Jenkins for competency for sentencing. He opined that Mr. Jenkins remained psychotic and appeared to have deteriorated since he saw him the year prior. He described Mr. Jenkins as difficult to re-direct from talk about his purported hallucinations and delusions of demons and Apophis. He described his thinking as tangential, with loose associations and pressured speech. In regards to understanding his legal situation, Mr. Jenkins reported to Dr. Gutnik he did not understand that a plea of no contest was essentially a guilty plea, and asserted that he was not responsible for the murders. Dr. Gutnik re-evaluated Mr. Jenkins in December 2015, and again opined that he was incompetent to proceed and suffered from hypomania and severe psychotic symptoms. It is unclear from Dr. Gutnik's May and December 2015 reports if he had access to the February 2015 evaluation authored by the undersigned or was aware of

numerous professionals raising concern about malingering in the past.

According to NDCS records, from March 2015 – April 2016, Mr. Jenkins engaged in at least 18 acts of self-harming behavior, additional threats to engage in self-harm, and physical and verbal aggression towards NDCS staff. Some episodes of self-harm required sutures, although records indicate that none of the lacerations required emergent medical care and were able to be attended to on site, within the NDCS facility. NDCS records indicate that Mr. Jenkins carved numbers and words into his forehead and stomach and lacerated body parts such as his face, tongue, and penis. Notable recent events include Mr. Jenkins' use of a NDCS staffs badge to cut his penis. According to Mr. Jenkins, he obtained the badge on 01/18/2016 and kept the badge in his possession until 01/26/2016 when he cut his penis. He also cut his penis at least two additional times in February 2016. On 02/24/2016 Mr. Jenkins stole keys from staff, broke the keys, swallowed pieces of the keys, and kept a handcuff key hidden in his mouth before returning the key to staff on the evening of 02/25/2016. Although he recently abstained from self-harm behavior for over 8 weeks, Mr. Jenkins expressed his intent to self-harm during his court hearing. For example, on 03/23/2016, Mr. Jenkins told his therapist, "It will be different when I do it in front of the cameras and all the reporters and the Judge. And will show I am insane. And what you all have created by keeping me here like this. They always put this shock thing on me, but I am going to do it."

In addition to self-harming behavior (non-suicidal in nature), Mr. Jenkins has made comments about killing himself or wanting to die. NDCS records from September 2015 and December 2015 describe instances in which Mr. Jenkins tied a jumpsuit and a sweatshirt to the bars of his window, raising staff concern about a possible suicide attempt. In January 2016, Mr. Jenkins attempted to hang himself on a chain link fence at the Nebraska State Penitentiary (NSP). When describing the incident, staff indicated that Mr. Jenkins was "holding onto the chain with his hands, keeping it from completely tightening around his neck," suggesting that this was not an actual attempt to end his life. However, Mr. Jenkins stated, "I attempted to kill myself by hanging myself on this date because I am tired of being persecuted . . . Due to my own psychological, physical, and emotional deterioration I do not want to live any more, I want to die." In February 2016, NSP staff reported that Mr. Jenkins was "acting suspicious" with a waist chain around his neck and appeared to be looking for a place to hang himself.

When discussing his self-harm behaviors with NDCS staff, Mr. Jenkins endorsed hearing commands from voices of Apophis, Satan, and demons. For example, following his act of self-harm on 01/26/2016 Mr. Jenkins stated, "I hid that badge in my rectum. That is my official testimony. I had orders from gods to sacrifice my blood." NDCS mental health notes repeatedly indicate that Mr. Jenkins has never appeared to be responding to internal stimuli during his weekly therapy sessions and more frequent crisis intervention sessions, even

though he has reported hearing voices constantly. However, a July 2015 Premier Psychiatric Group note (Dr. Tayo Obatusin) states, "As at time *[sic].* The patient needs higher level of care. He is grossly psychotic, delusional and unable to care for self. He may need some Haldol dec or Abilifiy Maintenna shot." From April – August 2015, Premier Psychiatric (Dr. Obatusin) notes list a diagnosis of Schizoaffective Disorder, Bipolar Type, although those notes also indicate that Mr. Jenkins was self-harming "with the intention to get out of isolation." With the exception of the July 2015 note, generally Premier Psychiatric Group notes indicate Mr. Jenkins does not consistently endorse psychotic symptoms. One practitioner stated, "His psychotic symptoms have never been consistently reported, in some interviews they weren't mentioned at all, and at other times it was inserted as it *[sic]* was almost an afterthought" (3/17/16). In October 2015, Premier Psychiatric notes indicate Mr. Jenkins continued to report suffering from "5 psychotic breaks" in the previous month, but was not able to provide details or examples of his symptoms. Furthermore, recent Premier Psychiatric notes indicate that Mr. Jenkins' reported mood fluctuations occurred in relationship to situational stress, and he did not exhibit symptoms of depression. In October 2015, Schizoaffective Disorder was ruled out as a diagnosis, and recent notes indicate that malingering was a possibility.

At times, Mr. Jenkins suggested he receives relief from stress through self-harming behaviors. NDCS mental health records document several statements made by

Mr. Jenkins in which he suggests self-harm behaviors provide a level of stress relief such as, "Slicing myself is the best way to deal with my stress," (CMHN, 6/25/15) and "[Self-harm] helps. Really helps me, when I am feeling anxious. Or agitated. I get that rush of endorphins in my brain, and I just feel better, feel more calm, feel more in control" (CMHN, 7/31/15). After swallowing keys on 02/24/2016, Mr. Jenkins blamed his therapist indicating that he had become upset earlier that day when his therapist set therapeutic boundaries and discontinued a session. Mr. Jenkins told his therapist, "You walked out on me," and "You know I have abandonment issues." He also described experiencing feelings of sadness, depression, hopelessness, and fear prior to the incident.

While Mr. Jenkins generally indicated he hears voices all the time, NDCS records contain notable exceptions including the following statements made by Mr. Jenkins: "I am not psychotic all the time. Just some times," (Chronological Mental Health Note [CMHN], 8/14/15), [He hears voices] "when staff don't do what I want them to do, like with my mail. And if people make me mad" (CMHN, 8/14/15), and "In LCC I had no psychotic episodes. They showed concern for my well-being and no psychotic episodes occurred. If I see people care for my well-being then I have no psychotic episodes. I want you to talk to other people about this to get me moved" (CMHN, 1/13/16). Finally, NDCS records from June 2015 document Mr. Jenkins stating, "That's the reason I'm doing all this crazy shit, so I can use the insanity defense." The author of the note then writes, "At this

point, inmate Jenkins realized he was telling me this information, and then stated, 'I mean I do everything the voices in my head say, Apophis and that.' "

NDCS records detail the defendant's statements conveying that his behaviors are motivated by secondary gain. According to a Premier Psychiatric note from August 2015, when Mr. Jenkins was asked about behaving in ways to achieve secondary gain, he responded, "I do that sometimes. Last week I forced a staff to get me coffee after I threatened to cut myself with a razor blade. . . . She got me the coffee." Throughout April 2015 – December 2015, Mr. Jenkins repeatedly suggested his self-harm behavior would cease if he received something he desired or that he would engage in self-harm behavior if he did not receive something he wanted. Before self-harming with staffs badge in January 2016, Mr. Jenkins demanded more food in exchange for his return of the badge; when food was not provided, he cut his penis with the badge. In February 2016, Mr. Jenkins refused direction to leave the shower and stated that staff would need to "spray" him. Afterwards, he indicated he needed use of force documents for his court case.

In regards to aggression towards others, Mr. Jenkins hit and threw bodily fluids at staff. He made homicidal threats such as, "If I wanted to I could have dragged [a staff member] into my room, shut the door, and ate his fucking intestines," and "As soon as I get my number and they transfer me to Tecumseh I'm gonna have direct access to ya'll and I'm gonna go back to my cell and make a nice, long knife. Then I'm going to use it to kill

three to five of you all guards." Mr. Jenkins also threatened individuals involved in his case, including the major actors in the court proceedings. In an NDCS incident report (dated 2/23/16) NSP staff wrote, "[Mr. Jenkins] said 'When I get out I'm going to hunt down [individuals involved with his case] and kill them and their families. If they have grandkids or kids, I'm going to kill them right in front of them because I warned them that I am a very scary being."

Mr. Jenkins successfully followed a behavioral plan to abstain from self-harm and aggression towards others at various times over the course of the last year. In October 2015, Mr. Jenkins did not engage in any acts of self-harm and was the subject of fewer misconduct reports. However, acts of self-harm and the number of misconduct reports spiked in November 2015. According to NDCS records, throughout November, December 2015, and early January 2016, Mr. Jenkins made statements that conveyed his negative behaviors were related to his legal strategy. For example, after an instance in which Mr. Jenkins was restrained, he stated, "I accomplished what I wanted, this documentation will be essential in my case to show my incompetency. This will display that I am so insane that you had to strap me down (11/28/15)." In January 2016, he stated, "Normal people don't do that [in reference to snorting/drinking semen and urine]. And that proves I am psychotic and need meds (1/7/16)." It should be noted that while Mr. Jenkins reports engaging in these unusual behaviors, NDCS records do not indicate that staff members have observed such actions. He also

made statements such as, "I have assaulted 6 staff members during Thanksgiving weekend. I wish to have charges brought against me in the Lancaster County District Court. If I must write to the State Patrol myself, I will," and "I feel better that they are obligated to get me a new trial and charges. I will now get what I want." Notably, in late December, Mr. Jenkins confessed to additional crimes to NSP staff and to a Douglas County Sheriff Detective and media contacts, requesting to be charged for new offenses.

Although NDCS mental health records repeatedly note that Mr. Jenkins does not respond to internal stimuli, other difficulties are occasionally characterized by mental health staff. His therapist has noted "Mr. Jenkins refers to delusional material or auditory experiences to a greater degree when presenting as emotionally dysregulated. When he reports feeling calm and is less reactive, [his] reports containing delusional material or auditory experiences occur less often and with less intensity" (CMHN, 12/23/15). Additionally, his therapist has identified the possibility that Mr. Jenkins experiences increases in anxiety related to his legal situation. Mr. Jenkins reportedly experiences some sleep difficulties, such as waking frequently throughout the night. While he labels certain behaviors as "mania," mental health notes indicate he consistently is able to slow and quiet his speech when prompted, and his presentation is not reflective of a true manic episode.

At this time, his psychiatric provider (Premier Psychiatric Group) lists Mr. Jenkins' diagnoses as Rule Out

Unspecified Depressive Disorder (in relation to feelings of sadness and depression) and Antisocial, Narcissistic, and Borderline Personality Disorders. Although he demanded prescriptions for reported mood and psychotic symptoms, he generally refused to take medication. Most recently, Mr. Jenkins was prescribed an antidepressant (Prozac) to treat his reported symptoms of depression. After "cheeking" the medication, Mr. Jenkins was required to take the medication in liquid form, which he claimed hurt his throat. The medication was subsequently discontinued. He has requested Depakote (mood stabilizer), but the Premier Psychiatric Group provider did not prescribe it, noting "I tried to reinforce that the medication he is requesting is not the recommended [treatment] for his current reported mood/symptom, but he again interrupted, and said, 'I am only here to ask you for Depakote, and if you are not going to prescribe that for me, I am going to leave' (3/10/16)."

PAST PSYCHOLOGICAL TESTING

In August 2014, during the prior course of treatment to restore competency, Mr. Jenkins was administered the Structured Interview of Reported Symptoms, 2nd Edition (SIRS-2), an instrument designed to assess endorsement of a range of common and less common symptoms of mental illness. On the SIRS-2, Mr. Jenkins obtained a pattern of markedly elevated subscales that is strongly characteristic of an individual feigning a mental disorder. Out of 8 primary scales, Mr. Jenkins' scores on 4 of those scales were in the definite

feigning range (above the 98th percentile when compared to a clinical group), and an additional 3 primary scales were in the probable feigning range. This pattern is rarely observed in examinees with genuine disorders that endeavor to present themselves accurately. Specifically, Mr. Jenkins reported a high proportion of unusual symptoms on two separate scales that are typically observed in feigners, but not in genuine patients. He also obtained an elevation on a sub-scale for improbable or absurd symptoms that, by definition, are outlandish and almost never observed in clinical populations. Mr. Jenkins reported an unexpectedly high proportion of symptoms associated with a major mental disorder. This proportion is not typically characteristic of patients with only genuine disorders. Furthermore, he reported a higher-than-expected proportion of symptoms that were occurring with extreme intensity, which is consistent with individuals fabricating or exaggerating their symptom presentation.

The Minnesota Multiphasic Personality Inventory – 2 (MMPI-2), a well validated measure of psychopathology and personality functioning, was repeatedly attempted during that same time frame (August – December 2014). Administration of the Millon Clinical Multiaxial Inventory – III (MCMIIII), an inventory designed to identify emotional, behavioral, and interpersonal difficulties, was also attempted in December 2014. Mr. Jenkins refused to complete those instruments despite each of his concerns being addressed.

In early 2016, Mr. Jenkins completed the SIMS (Structured Inventory of Malingered Symptomatology) with

NDCS personnel. The results of that test also suggested feigning of psychiatric symptoms. Specifically, he had an elevation on a scale for bizarre or unusual psychotic symptoms not typically present in genuine psychotic disorders. Mr. Jenkins had an elevation on a scale for atypical depression and anxiety symptoms. He also endorsed a high number of items that are inconsistent and rarely occur in neurological disorders.

MENTAL STATUS EXAM

Mr. Jenkins was fully oriented throughout the evaluation sessions. Mr. Jenkins has visible tattoos covering most of his face and neck, as well as some on his arms and hands. Mr. Jenkins consistently presented with good hygiene. In the past, Mr. Jenkins wore eyeglasses, but he did not during the current evaluation as a result of safety concerns and his recent use of sharp items to self-harm. Nonetheless, his eye contact was appropriate, and it was clear he could see each person in the room. Mr. Jenkins' psychomotor activity was normal. Any agitation noted was related to feelings of discontent about situational factors (namely his segregation status and legal situation).

Mr. Jenkins has not displayed observable positive or negative symptoms suggestive of a psychotic disorder or symptoms. He was fully oriented with logical, goal-oriented thought processes. There was no evidence of responding to internal stimuli, disorganized thought processes, or loose associations. At times, Mr. Jenkins labeled his experiences as "hallucinations" or

"delusions" in reference to Apophis or engaging in blood sacrifice rituals (i.e., self-harm), although these remarks were infrequent and generally in the context of his arguments that he is mentally ill and needs to be removed from segregation. He consistently attended to the evaluation and demonstrated behaviors that were tied to reality-based motivators. He did not talk of these reported psychotic experiences as if they were at the forefront of his mind, but instead presented them in a manner that appeared rehearsed and in relation to other demands (e.g., removed from segregation, placed in a psychiatric facility). His concerns were solely about reality-based, situational concerns (e.g., his placement, privileges, legal situation).

Mr. Jenkins displayed a normal range of mood fluctuations (e.g., frustrated, angry, irritated, pleasant) appropriate to his circumstances, albeit sometimes with exaggerated indignation or anger about perceived slights. His affect was full and congruent with mood. Mr. Jenkins talked at length about certain topics and identified "racing, very fast, up and down, up and down, up and down" thoughts; however there was no evidence of racing thoughts. At times, he shifted the focus of the session, but this appeared to be an attempt to control the discussion. He could generally be redirected back to previous topics or questions, and while it was clear that he understood the questions. Mr. Jenkins did not display any difficulties with mood swings or significant anxious or depressed mood. Mr. Jenkins exhibited no difficulty with memory. Intellectual

functioning appeared to be in the low average to average range.

BEHAVIORAL OBSERVATIONS

The undersigned evaluators met with Mr. Jenkins at the Nebraska State Penitentiary (NSP) on three occasions in 2016: January 6, March 16, and April 21. Each evaluation was conducted in a conference room on the restrictive housing unit. During the evaluations on January 6 and March 16, Mr. Jenkins was in restraints and wore a spit sock, though he did not wear the spit sock during the April session due to improvements in his behavior. Correctional officers remained outside the conference room door throughout the duration of the evaluations.

For each session, Mr. Jenkins appeared to have an agenda he wanted to discuss and tended to return to his agenda when not specifically answering a question. He attempted to control the conversation by providing lengthy answers to the questions posed to him and demanding that evaluators write down specific statements he made. Mr. Jenkins frequently directed the conversation toward his self-mutilation, "deteriorating" mental health, perceived mistreatment, frustration with placement in segregation, and complaints about the legal system. Throughout sessions, Mr. Jenkins presented as intimidating, insulting, demanding, and arrogant.

Mr. Jenkins enumerated the various self-harming incidents he engaged in over the last year, but described

his goals and plans suggesting he is oriented to the future. He discussed lacerations to his penis, stating "I carry out orders from the immortals." He described these commands as "audio commands" from Apophis, Satan, and demons. At times, he reported that these commands revolve around topics such as self-sacrifice, while at other times he attributed his self-harm to other motivators (e.g., change in placement). Mr. Jenkins stated, "If I give up on my body they will kill me" and reported that he can "see the unseen and hear the unheard." When questioned regarding the specific nature of such commands, the defendant would often shift topics.

Mr. Jenkins threatened to self-harm in the future and made vague statements about the possibility of harming others. He made statements such as, "I'm gonna mutilate my genitals and eat them – self-cannibalism. I'm gonna do that in a few days," and raised his voice, "You know what I'm doing right? Gearing up for what's gonna happen later. I love getting myself in this manic state. [Laughed loudly] It gets bloody. Real, real bloody." He indicated that he fulfills prophecies and stated, "When I say it's gonna happen, it's gonna happen." At no point during these comments did he reference experiencing command auditory hallucinations and appeared to be attempting to shock the undersigned with the dramatic nature of his statements.

During the first session evaluators highlighted that Mr. Jenkins historically was able to abstain from self-harm for long periods of time. He responded he had access to coping mechanisms in his cell in the past, but

currently had nothing in his room that could assist him. An evaluator emphasized that Mr. Jenkins has successfully controlled his self-harm in the past even when he was in isolation, but he refused to respond to this discrepancy. As of the 04/21/2016 session, Mr. Jenkins went approximately 8 weeks without engaging in self-harm behavior. However, he continued to insist he was not "grounded in reality," experiences "animalistic rage," and that lack of self-harm does not indicate he "is stable and not living in altered psychotic reality." When asked for descriptions of his purported symptoms and experiences, Mr. Jenkins relied on labels utilizing medical and psychological terminology that did not subjectively describe his experiences.

When Mr. Jenkins was pushed to describe specifically what is problematic about his reported psychotic symptoms, he paused for a lengthy period of time before stating, "I never said it was a problem. Society says it's a problem." He described his ability to channel the commands and again stated the experience was not problematic. Although he endorsed experiencing auditory hallucinations, again Mr. Jenkins was unable to provide details about his experience. He indicated that he should not need to describe his experience of psychotic episodes because the evaluators are mental health professionals who "should know" and "shouldn't have to ask." He stated he uses terms like "psychotic episode" because mental health professionals understand such terminology.

Mr. Jenkins reported feeling "paranoid," which occurs when he is out of his cell seemingly talking with other

inmates or other people in routine fashion, while internally thinking about hurting those individuals. He described the belief that "everyone is going to kill me, stab me, arrest me," though this was clearly in the context of reality-based concerns based on prior experiences associated with a criminal and violent lifestyle. When asked if violence is synonymous with psychosis, Mr. Jenkins responded, "My violence comes under psychosis." Additionally, Mr. Jenkins referred to himself as a "man God," a "phenomenon," and a "genetic freak."

When the undersigned attempted to discuss treatment options and behavioral strategies to address his reported difficulties and complaints, Mr. Jenkins countered that the first step of treatment should be to release him from segregation. In regards to psychotic symptoms, he indicated that if he was removed from segregation, his "psychotic symptoms would go away." Mr. Jenkins expressed frustration with LRC personnel for not recognizing the "physical evidence of my deterioration." Throughout the evaluations, Mr. Jenkins expressed his desire to be transferred to the Lincoln Regional Center, although he struggled to identify what purpose hospitalization would serve since he adamantly stated he does not require or take medication for his condition despite his contradictory assertion that he has "already proven I'm better on medications." He described varied reasons for refusing psychotropic medications (i.e. distrust of medication provided by NSP as the institution has a "conspiracy against [him]," a claim he asserted is supported by "seven Senators;" the belief that medications are simply a "band

aid;" the prescription of incorrect and unhelpful medications), and asserted that "federal courts would not allow [involuntary medication]." Throughout the sessions, evaluators asked why Mr. Jenkins requests medication he refuses to take, to which he responded, "Parts of me want to do the right thing." However, he also stated other coping strategies, such as listening to music and yoga work better than medication, and attributed his religion, which he identified as Hindu, as a reason for his medication noncompliance.

Throughout the evaluation, Mr. Jenkins frequently cited case law and statutes he believed relevant to his case in terms of legal strategies for his court case and his efforts to obtain a change in placement due to his claimed mental health issues. Although he frequently misinterpreted or misapplied legal information, Mr. Jenkins demonstrated an ability to converse about his intended legal strategies in a rational and coherent manner. He acknowledged his lack of willingness to defer to legal counsel was not due to psychotic symptoms but because of a desire to do things his way to gain a desired outcome. When asked how he devises legal strategies, Mr. Jenkins identified using LexisNexis and law books. Specific to his legal situation, he described perceived violations of his 6th, 8th, and 14th amendment rights and detailed several strategies he is pursuing to either change his placement, get evidence suppressed, or have his case dismissed. For example, he expressed the belief that he could not be held in segregation because he is a "mentally ill" person and discussed his plan to raise that argument in higher

courts. Mr. Jenkins identified experts he believed would testify on his behalf about his mental state, which would assist his pursuit of various legal efforts to either be found incompetent, have his conviction overturned, or be transferred to a mental health facility. Mr. Jenkins identified a statute (28-303) as the first degree murder statute and repeatedly held up his hand to display this number tattooed on his "trigger finger," asking "That's original, isn't it?" During the April session, Mr. Jenkins indicated that he believed he will be exonerated due to DNA evidence associated with bullets found at the crime scene(s), which is the same argument he submitted in a recent handwritten motion he sent to the court. Evaluators asked him to clarify his reasoning for confessing to additional crimes if his ultimate goal was to be exonerated. He stated "You'll see, they won't charge me. Can't charge me off of just a confession," and made reference to how the confession of a mentally ill person cannot be used against them.

While Mr. Jenkins voiced varied complaints about the judge, his attorneys, and the prosecutors, the crux of these complaints was that others have acted in ways he believes are improper, unethical, or illegal. These complaints extended to the undersigned, whom he called "unethical and unprofessional," suggested they lacked intelligence and minimized his mental illness, and threatened professional reputations and licenses. At the beginning of the third session, Mr. Jenkins accused the evaluators of "derailing" and "stalling" due to fear of testifying.

DIAGNOSTIC IMPRESSIONS

Psychosis

Overall, Mr. Jenkins has been inconsistent in his report of psychotic symptoms. Records indicate that Mr. Jenkins first reported hallucinatory experiences as a child, but Richard Young providers characterized those symptoms as reactions to traumatic experiences (i.e., nightmares) or real experiences (i.e., older boys who instructed him to steal). The lack of further report of such symptoms until over a decade later provides credence to that initial conceptualization of those symptoms. As an adult, his self-report has been inconsistent over time, with the exception of a common theme of hearing the voices of Apophis and other gods/demons in recent years. Despite his reports of such symptoms, there has been no indication that he is responding to such internal stimuli during any interactions with the undersigned evaluators. Second, his report of such symptoms correlates with situations in which there is the potential for secondary gain. Mr. Jenkins calls attention to these reported symptoms, labels them as symptoms, requests treatment for them, but then habitually refuses treatments offered. Similarly, he repeatedly has made requests for antipsychotic or mood stabilizing medication to be prescribed (while noting that he would not take it if it were prescribed) and for a diagnosis of Schizoaffective Disorder to be documented, suggesting that he is more interested in how the documentation can serve his legal interests or how he could be placed in a less restrictive setting than in actually receiving treatment.

Despite his reported problems with delusions and hallucinations, Mr. Jenkins does not demonstrate a decrease in functional abilities (e.g., hygiene, self-care, communication, planning) or disorganized thinking, as would be expected in a person genuinely experiencing such intrusive symptoms. Furthermore, psychological test results demonstrated a pattern of responding that was characteristic of feigning symptoms in 2014 (SIRS-2) and as recently as February 2016 (SIMS). His current presentation and self-reported symptoms are remarkably similar to his presentation during the prior episode of competency restoration, raising the same concerns about intentional production of symptoms. While Mr. Jenkins reports significant distress, at times related to his repeated self-harm over the last year, this distress appears unrelated to psychotic symptoms, but instead related to secondary gain, personality characteristics, and his use of maladaptive coping strategies to handle situational stress.

While Mr. Jenkins may hold some overvalued ideas about idealizing gods and goddesses, these ideas do not appear delusional in nature. Furthermore, the claimed rituals related to Apophis in which he reportedly engages (e.g., consumption of body fluids, exercising, prayer), do not significantly affect his ability to function on a daily basis, and indeed have not affected his legal strategizing. On the other hand, his seemingly bizarre behaviors do result in secondary gain – some have psychological benefits, while others have legal benefits.

Mr. Jenkins talks at length about how he perceives he has been mistreated by his attorneys and others involved with the court system. Although his beliefs may be inaccurate, they are not based on delusional or pathological reasoning, but instead based on life experiences colored by his tendency to blame his problems on external factors. Furthermore, his assertions about being mistreated by legal counsel and the criminal justice system are not tied to his purported beliefs about gods, demons, or hallucinatory experiences.

Based on available records, previous psychotic diagnoses seem to be primarily as a result of Mr. Jenkins' self-report of hallucinations and delusions as opposed to objective confirmation of symptoms. In addition, malingering has been questioned for several years. There is no indication that he has a chronic psychotic disorder, and he does not appear to suffer from psychotic symptoms at this time.

Mood

Mr. Jenkins does not present with a significant mood disturbance at this time. Observations suggest that he demonstrates normal fluctuations in mood, which are largely related to situational factors. There has been no indication of manic or hypomanic symptoms during sessions for the current evaluation. Mr. Jenkins presents as grandiose, although this is a stable characteristic that has not fluctuated for many years and is indicative of a personality trait. While he has endorsed "racing thoughts" or "mania," he generally cannot

describe these symptoms. Further, there has been no objective evidence during the prior course of treatment with LRC staff (August 2014 – February 2015) or during the current evaluation to suggest he experiences a pressure to talk, flight of ideas, or thoughts that race faster than they can be expressed verbally. Although he attempts to control the direction of conversation and speaks quickly about statutes, case law, and judicial codes, it is always possible to interrupt him, redirect him, and disrupt his flow of thoughts. There has been no indication of distractibility; instead, Mr. Jenkins demonstrates a good ability to sustain attention to matters important to him. Collateral information indicates Mr. Jenkins has maintained a good appetite and adequate sleep.

Records describe mood fluctuations during his brief hospitalization at age 8, although the professionals at Richard Young ultimately conceptualized his difficulties as indicative of anxiety, maladaptive coping strategies, and personality characteristics. Records indicate Mr. Jenkins reported isolated incidents of difficulty sleeping on other occasions, although these generally coincided with situational factors that caused stress. NDCS records indicate that he discontinued several sleep studies to confirm and clarify his reports of insomnia after sleeping adequately on the first night of the studies. NDCS records indicate that he was reported to experience a disruption in sleep in January 2013, although this problem seemingly remitted within a short time without intervention. NDCS records also note that numerous individuals described

him as "hypomanic" at times, highlighting lengthy monologues, animated behavior, and rapidly shifting topics. It is possible that, in the past, he may have experienced brief mood disturbances related to situational stressors that remitted without treatment. However, personality characteristics (most likely borderline or narcissistic traits) could have mimicked, and in brief interactions easily been mistaken for, hypomanic-like episodes.

Mr. Jenkins did not exhibit symptoms of major depression during the current evaluation. He has maintained interest in activities that he values (e.g., exercise, reading, legal motions) and has described feeling as if he has adequate energy to complete tasks and pursue his priorities. He has engaged in repeated self-harm and endorsed suicidal ideation over the course of the last year. Overall, NDCS records suggest that his self-harming behaviors have been largely motivated by attempts to influence the actions of others (e.g., appear "insane," obtain food/property, be removed from segregation). It is possible that he has experienced transient depressive symptoms related to situational factors.

Antisocial Personality Traits

Mr. Jenkins presents with obvious symptoms of Antisocial Personality Disorder, demonstrating a pervasive pattern of disregard for and violating the rights of others since childhood. The detailed criteria for diagnosis of this disorder were outlined in the 02/11/2015 report previously submitted to the court by the undersigned.

No changes have occurred in regards to these criteria, and this disorder remains prevalent and relevant to his current presentation.

Narcissistic Personality Traits

Mr. Jenkins also demonstrates strong narcissistic characteristics, also unchanged since the 02/11/2015 report by the undersigned. These traits continue to remain prominent in his presentation and will continue to adversely affect his interactions with legal counsel and the court. He maintains a grandiose sense of self-importance, marked by expectations that others will recognize his superiority despite the lack of commensurate accomplishments. He frequently talks of being physically superior and "brilliant," refers to himself as a "mastermind," and consistently brags about ways in which he intends to 'one up' others (e.g., judges, homicide detectives, Corrections' personnel, LRC professionals). Mr. Jenkins exhibits a sense of entitlement, often making demands of others or trying to secure special treatment

Borderline Personality Traits

Mr. Jenkins exhibits traits associated with Borderline Personality Disorder. He has demonstrated problems in the way in which he views relationships, at times ranging between idealizing the other person, while at other times devaluing that individual. Mr. Jenkins exhibits some characteristics that may be related to identity disturbance, in that at times he talks of wanting to

be "good," although he mostly speaks with reverence about harming others. It is unclear if this behavior is related to borderline traits, as his presentation must be viewed in the light of his attempts at secondary gain. He has engaged in self-harming behaviors and endorsed suicidal ideation, which could be indicative of borderline personality traits. It is also possible that self-harming behaviors have been motivated by attempts to manipulate others (e.g., demanding moves to other units/facilities; attempting to appear mentally ill), and he has made numerous statements giving credence to that possibility. For example, historically he reported that he "mastermind[ed]" his legal situation in an attempt to have NDCS held liable for him not receiving mental health treatment and has commented several times to NDCS staff that he would act "insane." Mr. Jenkins' affect and mood changes only last for short periods of time, consistent with borderline traits as opposed to a major mood disturbance. In addition, Mr. Jenkins has presented with significant anger that is inappropriate to the situation, and at times, has experienced difficulty controlling his anger. Lastly, it is possible that as a result of borderline traits, Mr. Jenkins expresses his distress and anger in a way that may be interpreted in dramatic/bizarre fashion. Such experiences would be transient, stress-related features that fall within the realm of borderline personality disorder experience. These verbalized symptoms have been portrayed by him as psychotic symptoms in the past.

Posttraumatic Stress Disorder

Mr. Jenkins witnessed significant traumatic events as a young child, raising the question of whether his reaction to such events caused a clinical disturbance, such as Posttraumatic Stress Disorder (PTSD). As a child, records indicate that he experienced nightmares about the family violence he witnessed. However, there is no information to suggest that Mr. Jenkins experiences symptoms clearly related to PTSD at this time.

DIAGNOSIS

Other Specified Personality Disorder (e.g., Mixed Personality Features – Antisocial, Narcissistic, and Borderline)

Malingering

Polysubstance Dependence (by history)

History of Posttraumatic Stress Disorder

COMPETENCY-RELATED ABILITIES

With respect to the criteria outlined in *State v. Guatney*, Mr. Jenkins has demonstrated sufficient mental capacity to appreciate his presence in relation to time, place, and things. Mr. Jenkins is able to discuss at length the prior proceedings in his case, including his plea of no contest, motions by various parties, and associated rulings. He is aware that he is slated to begin the sentencing phase, which could include the death penalty. He understands that he is in a court of law, convicted of four counts of murder and eight other

associated felony charges, and is able to describe the details of those offenses. He realizes that there is a Judge on the bench, a prosecutor who will argue for the death penalty, and defense attorneys who will defend him. Mr. Jenkins has spoken of a "conspiracy" involving various legal actors, although upon further investigation, this does not comport with paranoia reflective of a mental illness. Instead, these beliefs are indicative of his general mistrust of others, which has been validated by his life experiences in which violence was a frequent occurrence. Mr. Jenkins understands he is expected to tell his lawyers all he knows and remembers about the events involved in the offenses, although he has been mostly critical towards legal counsel seemingly as a result of disagreement about legal strategies. Mr. Jenkins' conflicts with his attorneys are driven by his personality characteristics, as opposed to symptoms of a major mental illness. He is aware that a panel of judicial officers will be present to determine his sentence in a death penalty hearing. Mr. Jenkins understands the appellate process, should he be sentenced to death. He has demonstrated sufficient memory to relate answers to questions posed to him. Mr. Jenkins is capable of following testimony reasonably well. He is also capable of testifying on his own behalf if necessary, although it should be expected that he would attempt to dominate court proceedings or insert information that he desired to be heard, even if it peripherally related to the question at hand.

Mr. Jenkins appears capable of meeting the stresses of a trial without having a breakdown in rationality or

judgment. Over the course of the last year, Mr. Jenkins has been engaged in weekly individual therapy with NDCS personnel to target his maladaptive behaviors, including self-harm, and improve management of stress. He is able to discuss and implement appropriate strategies for a sustained period of time, indicating that he is capable of using alternatives to self-harm and other maladaptive behaviors when he chooses to do so. Mr. Jenkins' motivation to comport himself appropriately may wax and wane over time, specifically if he determines that behaving in a certain manner (e.g., dramatic behavioral displays) furthers his endeavor to: 1) appear more mentally disturbed than is the case, 2) draw attention to himself, or 3) give traction to certain legal strategies. It is the opinion of the undersigned that Mr. Jenkins is capable of maintaining appropriate behavior in court, although he may choose to engage in disruptive behaviors for one of the reasons enumerated above. Such behaviors are volitional in nature, and are not due to a major mental illness.

Mr. Jenkins has at least minimum contact with reality and does not present with disorganized thought processes or significant symptoms indicative of a major mental illness at this time. His purported delusional beliefs have no bearing on his legal strategies. The topic of gods or demons minimally emerged in sessions (both during the current evaluation and during treatment from 2014 – 2015); instead, he spoke at length about legal strategies or complaints about what he perceives to be mistreatment by various parties. He has

the minimum level of intelligence necessary to grasp the events taking place. He can confer coherently with an appreciation of the legal proceedings, as evidenced by his ability to provide detailed accounts of past hearings. The defendant denied difficulty comprehending his legal situation or symptomatic interference when consulting with legal counsel.

Mr. Jenkins repeatedly recounted ways in which he was unsatisfied with legal counsel. The crux of the disagreement centers on Mr. Jenkins' desire to pursue arguments based on certain laws and codes that his attorneys have informed him are not applicable in his criminal case (e.g., the Mental Health Commitment Act). There is no indication that his expressed dissatisfaction with legal counsel is related to a mental illness, with the exception of a personality disorder. He has not developed rapport with legal counsel, although this is related to his narcissistic view of himself, as he does not believe that anyone is smarter or savvier than he. Further, he portrays his disruptive and difficult behavior as a strategy to disrupt the proceedings against him. As such, he is capable of establishing rapport should he desire to do so, although his personality style is such that he is likely to find fault with any strategy that person(s) should undertake.

Mr. Jenkins appears capable of both giving and receiving advice from his lawyers and assisting in preparation of a rational defense if he chooses to do so. He has cited several legal standards, statutes, and rights relevant to his case and has identified specific evidence (e.g., certain mental health records, transcripts from

legislative hearings) he believes could be used to support his desired legal strategy in the future. Mr. Jenkins appears to misapply some legal concepts or misinterpret statutes; however, these errors are not due to diminished intellectual functioning or symptoms of a major mental illness, such as delusional thinking. In addition, he is capable of learning new information to correct these errors, although his personality is such that he may have difficulty receiving feedback from others (including counsel) that is contradictory to his position unless he sees it as his interest to do so. Furthermore, he is likely to find fault, place blame, and claim ineptitude on the part of others if they do not provide unconditional acceptance of his statements or agreement with his desired strategies. He is able to divulge facts and discuss the ramifications of different strategies without paranoid distress. He is capable of making simple decisions at this time. He has demonstrated a desire for justice, rather than undeserved punishment.

CONCLUSION

Diagnostically, the impression of the undersigned remains unchanged since the 02/15/2015 opinion. Significant characterological problems, namely antisocial, narcissistic, and borderline traits, remain prominent and motivate the majority of Mr. Jenkins' behavior.

Historically, there has been disagreement about whether Mr. Jenkins has a psychotic or major mood disorder, or was malingering those symptoms.

Collateral records suggest that diagnoses of psychosis were largely based on Mr. Jenkins' self-report of hallucinations and delusions. It is the opinion of the undersigned that Mr. Jenkins does not suffer from a psychotic disorder. Any such reported symptoms (e.g., auditory hallucinations) do not comport with what is known about genuine psychotic symptoms, appear to be largely contrived, and do not interfere with legal strategies or day-to-day functioning. NDCS records from the last year, as well as observations during the current evaluation, indicate that Mr. Jenkins labels his purported symptoms without being able to provide actual descriptions of such symptoms as would be expected if they were actually something he had experienced. He tends to claim hallucinations as an afterthought, and inconsistently attributes his self-harm to such symptoms, while also making other statements about being motivated by secondary gain. There has been no indication of disorganized thought processes or distraction by internal stimuli during the current evaluation or documented in NDCS records, with the exception of a July 2015 Premier Psychiatric Group note where he was referred to as "grossly psychotic." At this time, Mr. Jenkins does not present with symptoms of a major mood disturbance. There has been no indication of manic or major depressive symptoms during the current evaluation. At times, he presented as animated, agitated, or irritable, although these expressions were in response to situational factors. At times he engages in long tirades, although it is not difficult to re-direct him or stop his flow of thoughts. His commentary about seemingly bizarre behaviors (e.g.,

ingesting semen and its effect on neurotransmitters) appears largely for dramatic effect and in an effort to shock the listener. His claims about these behaviors being related to mental illness shift when providers attempt to process such activity with him. These behaviors appear volitional and related to a personality disorder, rather than a mood disturbance.

Mr. Jenkins both highlights what he labels as symptoms and demands treatment to be offered, while at the same time contradicts his assertions that he is suffering from symptoms by refusing first-line treatment for his purported problems. An individual who genuinely suffers from such symptoms, and has the insight that such experiences are symptoms, generally wants to ease their suffering. This is not true in Mr. Jenkins' case. Instead, he continually demands certain types of treatment/placement, but consistently declines to accept treatment offered, variably asserting that external factors (e.g., others' alleged mistreatment, placement) have caused his difficulties. Consistent with his explicit threats about evaluators having negative consequences if they do not provide his requested diagnosis, his presentation strongly suggests that secondary gain is motivating him to feign symptoms.

Mr. Jenkins' personality characteristics (antisocial, narcissistic, and borderline) appear to primarily account for his disruptive behaviors during court proceedings and difficulty communicating with others. This combination of personality traits, in addition to feigning of symptoms and lack of cooperation, complicated the diagnostic picture in the past. However, when

viewed in light of all the available records, a clear pattern emerges – Mr. Jenkins provides labels of symptoms he asserts he experiences in dramatic fashion, cannot offer descriptions of his experiences of such symptoms, makes demands for certain treatments, bullies or intimidates others to attempt to obtain such diagnoses/medications/placement recommendations, then refuses treatment offered. His self-harming behavior has consistently been associated with attempts to extort certain things from others (e.g., food, recommendation for placement, access to desired items) and/or anger when his demands are unmet. Although at times he offers an explanation that he is acting on commands from Apophis when he self-harms, he contradictorily notes that he would have refrained from self-harm if his demands had been met (e.g., food/property). He asserts these incidents cause him to go into a "psychotic state," which is not at all reflective of how psychosis actually manifests and seems to simply be mislabeling of angry or violent ideation. In addition, no other markers of a thought disorder, such as disorganized thinking, are present during such claimed episodes, raising further suspicion about the authenticity of his self-report. Individuals who act upon auditory hallucinations to engage in such destructive behaviors would be expected to demonstrate an associated level of distress (as such symptoms are intrusive and uncomfortable) that is not demonstrated by Mr. Jenkins, who records describe as relatively calm immediately before, during, and after such actions. While he appears to have difficulty with frustration tolerance and impulse control, many – if not all – of his self-harming

behaviors had a pre-planned quality (e.g., holding onto items with which to self-harm for many days before actually acting out). In other words, his behavior and symptoms displayed are not consistent with a pattern supportive of a psychotic disorder diagnosis, as the presentation of the claimed symptoms tend to be opportunistic in nature.

Mr. Jenkins views himself as the victim and externalizes all responsibility for his behavior and circumstances. He holds tightly to this perception and appears to spend a great amount of time ruminating about strategies to make others 'pay' for how he perceives he has been mistreated, which has generally been the impetus for his self-harming behaviors and many of his legal maneuvers (e.g., lawsuits, motions, and threats to sue). His focus on external factors, including placement, access to property/items, and requests for various treatment, has been consistent for almost 10 years, although the specific nature of his requests occasionally shift. The constant has been that he generally is dissatisfied with his treatment and placement and does not accept requested treatment when it is provided. Mr. Jenkins does not accept any personal responsibility in achieving more successful or personally desirable outcomes, which is a necessary component for any behavioral change. Psychotherapy, namely Dialectical Behavior Therapy (DBT – which he is currently receiving), could assist him in developing more adaptive skills to manage his emotional distress and achieve his espoused goals; however, so long as he maintains his focus on others being responsible for his

problems, then he is unlikely to incorporate techniques that could assist him in adaptively managing his reactions to situations.

To conclude, it is the opinion of the undersigned that Mr. Jenkins is currently competent to proceed with sentencing. The defendant has demonstrated an adequate factual understanding of the proceedings. Additionally, Mr. Jenkins has demonstrated the ability to rationally apply such knowledge to his own case. He can coherently discuss the proceedings in detail and is able to extensively describe the purpose of upcoming hearings and potential legal strategies. Lastly, if he desires to do so, he has the ability to consult with counsel with a reasonable degree of rational understanding.

Mr. Jenkins is likely to continue to act in ways that disrupt court proceedings if he perceives it as beneficial to do so. Particularly, each time he approaches sentencing, he is likely to escalate in his disruptive behaviors (e.g., self-harming, assaultive behavior, threatening harm to self and others), in an attempt to thwart the proceedings or appear mentally ill. These behaviors are largely volitional and related to personality characteristics, as opposed to a major mental illness. He has exhibited the ability to control these behaviors when he desires or is motivated to do so, as demonstrated during long stretches of time in which he abstained from self-harm.

Based on past behaviors and Mr. Jenkins' sporadic threats about self-harm and harming others (including those involved in the legal proceedings), it is strongly

recommended that safety precautions be taken in any setting he may be housed in, during transport to/from court hearings/appointments, and during court proceedings.

Respectfully submitted,

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/s/ Chaturvedi, MD 05/10/2016
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cc: Donald Kleine
Douglas County Attorney

Thomas Riley
Douglas County Public Defender

APPENDIX A

Summary of Historical Diagnoses

Defendant's Age (Date)	Provider/Facility	Behavioral Observations	Diagnosis
8 (1995)	Dr. Jane Dahlke / Richard Young	• Conduct problems / Aggression (Threats to harm others, Arson, Fighting, Killing animals, Family teaching him to fight, Carrying a gun, Theft) • Suicidal statements • Trauma-related symptoms (sleep problems, anxiety, nightmares) • Enuresis • Distractible/Impulsive	• Oppositional Defiant Disorder • ADHD • Functional Enuresis
13	Residential substance abuse treatment facility	None available	None available
17	Youth Correctional Facility	• Assaultive • Antisocial behavior • No major mental health concerns	• Conduct Disorder • Adjustment Disorder, with Depressed Mood
20 (2007)	NDCS	• Self-report: ○ Depression ○ "Criminally insane" ○ "See[ing] things" ○ Sleep problems • Refused sleep study • Later, denied mental health concerns • Threats to kill others • Angry about segregation	None
21 (2008)	NDCS	• Self-report: ○ "Rage" ○ Homicidal ideation ○ Segregation made him "very mentally ill" and likely to kill others when released from prison ○ "Paranoid schizophrenia" • Clinicians note: ○ Reported symptoms were identified as gang-related paranoia • Prescribed Depakote for 4 days for behavioral problems ○ Meds discontinued due to refusals	• Antisocial Personality Disorder • No Major Mental Illness, including psychosis or mood disturbance

22 (Jan-Mar/2009)	NDCS	• Self-report: ○ "Homicidal maniac" ○ Predicts that NDCS will be held liable when he kills others when released ○ "Schizophrenia" ○ "Multiple personalities" ○ Sleep problems • Sleep study showed no problems on the 1st night; Mr. Jenkins discontinued the study & stated he did not need medicine	• Antisocial Personality Disorder • No Major Mental Illness, including psychosis or mood disturbance
22 (May 2009)	NDCS	• Self-report: ○ 1st report of auditory hallucinations of an "Egyptian god" telling him to kill others • Clinicians note: ○ Not psychotic, but using the label of hallucinations to disown his homicidal thoughts ○ Seeking attention ○ "More manipulative and criminal than mentally ill"	• Personality Disorder • No Major Mental Illness
22 (May – Nov/2009)	1) Dr. Natalie Baker/NDCS 2) Another NDCS Mental Health Professional 08/2009 (documented name illegible)	• Self-report: ○ Hearing voice of Apophis ○ Apophis trying to control him ○ Anger ○ Nightmares & flashbacks ○ Feared being poisoned ○ Sleep problems • Sleep study showed no problems on the 1st night; Mr. Jenkins discontinued the study • Threatened to commit suicide (08/2009), but listed motivators inconsistently (command hallucinations v. wanted to move units due to peer conflict) • Prescribed Risperdal & Depakote for 3 mos., but questionable adherence (flushing meds, outright refusal)	1) Dr. Baker: • Psychosis NOS • Possible Schizoaffective Disorder • Strong Personality Disorder Traits • Polysubstance Dependence • Probable PTSD • Adjustment Disorder • Rule Out Bipolar v. Schizophrenia 2) Other MH Professional • "Manipulative"

23 (Dec 2009 – Feb 2010)	Dr. Baker/NDCS	• Self-report: ○ "Possessed" ○ "Multiple personalities" • Assaulted officers & attempted to escape while on a furlough for funeral • Requesting medicine • Dr. Baker revised diagnostic opinion – noting symptoms were "inconsistent," and that Mr. Jenkins appeared to be using symptoms and meds "for secondary gain, including to avoid legal consequences" • Meds discontinued	Dr. Baker revised: • Behavioral/ Personality Disorder • Possible Feigning
23 (Feb 2010 – July 2011)	Dr. Eugene Oliveto/Douglas County Corrections	• Self-report: ○ Auditory hallucinations of Apophis ○ "Multiple personalities" ○ Frequent complaints about perceived mistreatment • Clinicians note: ○ Generally listed as unremarkable mental status, with exception of talk about harming others due to Apophis' directions ○ Anger ○ Grief • Requesting medicine • Prescribed Risperdal & Depakote, but consistently refused	• Schizoaffective v. Bipolar Disorder • PTSD with Dissociative Episodes • Possible Dissociative Identity Disorder • "Antisocial/Impulsive/ Dangerously Obsessive"
23 (July 2010)	Dr. Y. Scott Moore	• Competency & insanity evaluations	• Antisocial Personality Disorder • Unlikely to have a Psychotic Disorder
24-26 (July 2011 – July 2013)	NDCS	• Self-report: ○ "Severe psychosis" ○ "Multiple personalities" ○ Violent ideation ○ States he drinks semen ○ Sleep problems ○ Wrote letters in sideways script, which he labeled as indicative of the "psychosis state of schizophrenia"	Mental Illness Review Team: • Narcissistic & Antisocial Personality Disorders • No major mental illness

		○ Referred to presentation of symptoms as a "skit" in conversations with mother and girlfriend	
25 (Apr – Dec 2012)	Dr. Baker/NDCS	• Self-report: ○ "Rapid deterioration" ○ "Severe psychological disability" • Self-harming behaviors (wrapped drop chain around neck, cut face) ○ Listed motivators inconsistently (would act out or "insane" until his requests were met v. commands from Apophis/rituals) • Staff observations of anger, agitation, & rapid speech	• Narcissistic & Antisocial Personality Traits • Suspected Malingering
26 (Jan – Feb 2013)	Dr. Baker/NDCS	• Self-harming behavior (cut face) ○ Listed motivators inconsistently (would stop acting out if had ear buds or paper v. commands from Apophis/rituals) • Isolated account of not sleeping & exercising naked at night (Jan 2013)	• Psychosis NOS • Antisocial & Narcissistic Personality Traits • Possible Bipolar • Possible Delusional Disorder • Possible Schizoaffective Disorder • Possible Malingering
26 (Mar 2013)	Dr. Martin Wetzel/NDCS	• Provider noted that reported psychotic symptoms were not typical of psychotic disorder • Provider identified problems with sleep, mood, and behavior	• Antisocial & Narcissistic Personality traits • Probable Bipolar NOS • Probable PTSD • Possible Malingering
26 (Apr 2013)	Dr. C.B. Jack/NDCS	• No requests for treatment • No signs of mental illness • Provider described him as "performing," and used session as a "lecture platform" • Reference to his attempt to get a psychiatric diagnosis so he "could get paid," seemingly in reference to disability benefits	• Antisocial Personality Disorder with Narcissistic Features v. • Narcissistic Personality Disorder with Antisocial Features

26 (spring 2013)	Staff observations/ NDCS	• Self-report:
		  ○ "Mentally ill"
		  ○ Threats to kill people when released
		  ○ Requests civil commitment
		• Others described as:
		  ○ Intimidating
		  ○ Narcissistic
		  ○ "Hypomanic" (pressured speech, animated, grandiose)
		  ○ No responding to internal stimuli
		  ○ No disorganized thoughts	

26 (June – July 2013)	Staff Observations/ NDCS	• Self-Report:
		  ○ No plans to harm others
		  ○ No commands from or thoughts about Apophis
		  ○ No mental health symptoms/concerns	

26 (Sept 2013 – Apr 2014)	Dr. Oliveto/Douglas County Corrections	• Self-Report:
		  ○ "Legally insane"
		  ○ Possessed
		  ○ Orders from Apophis to kill others (index offenses)
		  ○ Self-harm statements/ingested hydrocortisone cream
		  • Later reported he ingested it to get out of segregation
		• Staff Observations:
		  ○ "Somewhat paranoid," but "play[ed] up" symptoms
		  ○ Focused on moving to less restrictive placement & legal concerns
		• Prescribed Risperdal (later changed to Seroquel), Lithium, & Wellbutrin but took for 1 week, then refused
			• Paranoid Schizophrenia
			• PTSD
			• Attention Deficit Disorder
			• "Narcissistic psychopath with obsessive delusional thinking"

27 (Nov 2013)	Dr. Bruce Gutnik	• Competency evaluation	• Schizophrenia • Rule Out Schizophrenia Disorder • Rule Out Other Specified Personality Disorder (Cluster B and Obsessive/Compulsive Features)
27 (Dec 2013)	Dr. Y. Scott Moore	• Competency evaluation	• Malingering • Antisocial Personality Disorder
27 (Feb 2014)	Dr. Gutnik	• Insanity evaluation	• Schizophrenia Disorder, Bipolar Type

27
(May – July 2014)
	NDCS	• Self-report
		  ○ Psychotic during self-harm
		  ○ Threats to self-harm
		• Staff Observations:
		  ○ No indication of psychotic or major mood symptoms
		  ○ Self-harming behaviors
		  ○ Behavioral issues (e.g., broke sprinkler, barricaded self)
		• Prescribed Seroquel (at LCC), but mostly refused
			• Not available

27 (May 2014)	Dr. Gutnik	• Competency evaluation	• Schizoaffective Disorder, Bipolar Type • Rule Out Other Specified Personality Disorder (Cluster B and Obsessive/Compulsive Features)
27 (June 2014)	Drs. Moore & Klaus Hartmann	• Competency evaluation	• Malingering
27 – 28 (Aug 2014 – Feb 2015)	Drs. Rajeev Chaturvedi, Jennifer Cimpl, Mario Scalora (undersigned)/ LRC professionals/ NDCS placement	• Competency Restoration Treatment • Reports of psychotic & major mood symptoms inconsistent with observations • Frequent complaints about treatment & placement • Prescribed Zoloft & Inderal for situational stress, anxiety, & agitation, but consistently refused	• Other Specified Personality Disorder (Antisocial, Narcissistic, & Borderline Traits) • Malingering • History of PTSD

28 – 29 (May & Dec 2015)	Dr. Gutnik	• Competency evaluation	• Schizoaffective Disorder, Bipolar Type • Rule Out Other Specified Personality Disorder (Cluster B and Obsessive/Compulsive Features)
28 (Apr – Aug 2015)	Dr. Tayo Obatusin/ Premier Psychiatric Group	• Details in narrative below • Self-harming, but attributed to attempts to be removed from segregation • Prescribed antipsychotic and mood stabilizing medication, but refused	• Schizoaffective Disorder, Bipolar Type • Antisocial Personality Disorder • Narcissistic Personality Disorder • Borderline Personality Disorder
29 (Oct 2015 – Mar 2016	Randi Nielsen APRN/Kelsie Morgan PA-C/Premier Psychiatric Group	• Details in narrative below • Self-harming, but did not appear to be impulsive and more indicative of attempts at secondary gain (e.g., "paper trail," obtain access to desired items) • Prescribed antidepressant, but generally refused	• Unspecified Depressive Disorder ○ Noted as needed to be Ruled Out in March 2016 • Antisocial Personality Disorder • Narcissistic Personality Disorder • Borderline Personality Disorder • Possible Malingering (Mar 2016)