No. 21-6428

# In The Supreme Court of the United States

DANNY LEE HILL,

*Petitioner,*

v.

TIM SHOOP, WARDEN,

*Respondent.*

**On Petition For Writ Of Certiorari To The United States Court Of Appeals For The Sixth Circuit**

## BRIEF OF AMICI CURIAE THE NATIONAL DISABILITY RIGHTS NETWORK, DISABILITY RIGHTS OHIO, DISABILITY RIGHTS MICHIGAN, DISABILITY RIGHTS TENNESSEE, KENTUCKY PROTECTION AND ADVOCACY, AND THE ARC OF OHIO IN SUPPORT OF PETITIONER

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TABLE OF CONTENTS

TABLE OF AUTHORITIES

## INTERESTS OF AMICI[1]

The National Disability Rights Network (NDRN) is the non-profit membership organization for the federally mandated Protection and Advocacy (P&A) and Client Assistance Program (CAP) agencies for individuals with disabilities. The P&A and CAP agencies were established by the United States Congress to protect the rights of people with disabilities and their families through legal support, advocacy, referral, and education. There are P&As and CAPs in all 50 states, the District of Columbia, Puerto Rico, and the U.S. Territories (American Samoa, Guam, Northern Mariana Islands, and the US Virgin Islands), and there is a P&A and CAP affiliated with the Native American Consortium which includes the Hopi, Navajo and San Juan Southern Paiute Nations in the Four Corners region of the Southwest. Collectively, the P&A and CAP agencies are the largest provider of legally based advocacy services to people with disabilities in the United States.

Disability Rights Ohio is a not-for-profit organization designated by the Ohio Governor as the protection and advocacy system under federal law for people with disabilities in Ohio. *See* 42 U.S.C. § 15001, *et seq*.; R.C. 5123.60. Disability Rights Michigan, Disability Rights

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[1] No counsel for a party authored this brief in whole or in part, and no entity or person, other than the *amici*, their members and counsel, made a monetary contribution intended to fund the preparation or submission of this brief. Counsel of record for the parties consented to *amici*'s intent to file this brief and received notice at least 10 days prior to its due date.

Tennessee and Kentucky Protection and Advocacy are the designated protection and advocacy agencies for their respective states. These organizations bear responsibility to enforce and carry out the federal mandates under the federal protection and advocacy laws for people with mental illness and developmental disabilities. Each agency has decades of experience, and they have collectively served hundreds of thousands of people with disabilities through education, advocacy, and direct legal representation.

The Arc of Ohio is the state affiliate of The Arc of the United States with the mission to advocate for the fundamental, moral, civil, and constitutional rights of people with intellectual and developmental disabilities. The Arc of Ohio is a statewide membership association made up of people with disabilities, their families, friends, interested citizens, and professionals in the disability field. Together with their individual members and local chapters, The Arc of Ohio represents over 330,000 Ohioans and their families.

## SUMMARY OF ARGUMENT

In *State v. Lott*, 779 N.E.2d 1011 (Ohio 2002), the Ohio Supreme Court adopted substantive standards and procedural guidelines for implementing this Court's decision in *Atkins v. Virginia*, 536 U.S. 304 (2002) forbidding a death sentence for any person with

intellectual disability.[2] *Lott* instructed trial courts to adjudicate *Atkins* claims by determining whether, by a preponderance of the evidence, the petitioner met the clinical framework set forth by the American Association of Mental Retardation (AAMR)[3] and the American Psychiatric Association (APA)[4] which consisted of three prongs: (1) sub-average intellectual functioning; (2) deficits in adaptive skills; and (3) onset during the developmental period. AAMR Manual 8; DSM-IV-TR 41.

To properly apply this definition, the operable clinical guidelines stressed: (1) "the importance of *convergent validity*, or the consistency of information obtained from different sources and settings," AAMR Manual 86; (2) the appropriate exercise of clinical

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[2] The Ohio Supreme Court has since concluded that "*Lott* is outdated in requiring a finding of 'significant limitations in two or more adaptive skills.'" *State v. Ford*, 140 N.E.3d 616, 655 (Ohio 2019). Instead, Ohio now follows the current clinical guidelines, which require significant deficits in any one of three adaptive skill sets. "Moreover, *Lott*'s holding that there is a rebuttable presumption that a defendant is not intellectually disabled if his or her IQ score is above 70 is no longer valid." *Id*.

[3] The term "mental retardation" has been replaced by and has the same meaning as "intellectual disability." *See Hall v. Florida*, 572 U.S. 701, 704 (2014). This brief uses the term "intellectual disability" or "ID" except in direct quotes or descriptions of historical significance.

[4] At that time, the clinical guidelines were set forth in MENTAL RETARDATION: DEFINITION, CLASSIFICATION, AND SYSTEMS OF SUPPORT (10th ed. 2002) [hereafter, AAMR Manual], its related USER'S GUIDE [hereafter, AAMR User's Guide], and the APA's DIAGNOSTIC AND STATISTICAL MANUAL OF MENTAL DISORDERS (4th ed. text revision 2000) [hereafter, DSM-IV-TR].

judgment, which "emerges directly from extensive data," *id*. at 95 ("Thus clinicians who have not gathered extensive relevant assessment data should not claim clinical judgment."); and (3) the essential role of historical information, particularly from the development period. AAMR User's Guide 18 ("Conduct a thorough social history that includes . . . the investigation and organization of all relevant information about the person's life including status, trajectory, development, functioning, relationships, and family."). It is a fundamental aspect of the clinical guidelines—both at the time they were explicitly adopted in *Lott* and in present day—that an intellectual disability determination be based on *as much relevant information as possible*.

There was an overwhelming amount of relevant historical information available for consideration when Danny Hill's *Atkins* claim came before the Trumbull County Court of Common Pleas. As the Petition for Writ of Certiorari explains in detail, Hill was identified in kindergarten as a person with intellectual disability and spent the entirety of his school career in special education programs and institutions for children with intellectual disability. Hill was determined to be a person with intellectual disability following ten separate psychological evaluations conducted over the course of his life from ages six to nineteen. His long, documented social history demonstrates (through formal testing and direct observation by those who spent significant time with him in various settings) that he struggled and lagged behind his peers in academic achievement, social skills development, self-control,

personal hygiene, maturity, abstract reasoning, self-direction and emotional regulation, among other things. Prior to his state-court *Atkins* hearing, Hill was described as a person with intellectual disability by virtually every teacher, evaluator, psychologist, institution, and court that encountered him.

In *amici*'s extensive experience, it is unusual to encounter such a comprehensive historical record—in both its breadth and quality—that so consistently and convincingly documents an individual's intellectual disability. The Ohio courts rejected Hill's *Atkins* claim only by deviating significantly from the clinical guidelines that *Lott* instructed them to follow. Most importantly, the trial court's decision to focus on whether Hill was "presently" intellectually disabled (and the court's instruction to the evaluating experts to do the same) undermined the reliability of the entire fact-finding process and paved the way for multiple additional violations of the clinical guidelines. *Amici* submit this brief to offer a discussion of the relevant clinical guidelines and to explain how the abdication of those guidelines impacted the outcome of Hill's case.[5]

[5] This brief relies exclusively on sources of clinical guidelines that were available and well-known at the time of the State court's decision in Danny Hill's case.

## ARGUMENT

### I. The Trial Court's Decision to Focus on "Present Functioning" Violated the Clinical Guidelines and Undermined the Reliability of the State Courts' Fact-Finding Process.

Although the trial court stated its intention to follow *Lott* and apply the clinical guidelines of the AAMR and APA to adjudicate Danny Hill's *Atkins* claim, the court's first substantive ruling ensured that promise would never be fulfilled. Faced with the powerful historical record in this case, the State urged the trial court to "assess [Hill's] current and *not* past mental status for purposes of his *Atkins* claim." Supp APX 177.[6] The State filed several pleadings maintaining, with no support in the existing clinical literature or *Atkins* itself, that the only relevant issue was Hill's functioning in his "*current* environment," and claiming that to consider the historical evidence of Hill's intellectual disability would be "patently unfair" and stretch the intent of *Atkins* "to the breaking point." Supp APX 176–78, 217, 220, 222, 330, 335, 349.

Hill objected that limiting the inquiry to present functioning would "contradict[] *Atkins* and fl[y] in the face of *Lott*." Supp APX 288. He noted "the record is replete with reliable, convincing evidence that [Hill] was in fact a person with mental retardation," Supp

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[6] This brief references two portions of the underlying record. Transcripts of the *Atkins* hearing are cited here with the prefix "TR." Pleadings and documentary evidence submitted to the trial court are cited with the prefix "Supp APX."

APX 291, and the proper exercise of clinical judgment "'emerges directly from extensive data.'" *Id*. at 417 (quoting AAMR Manual 95). Most significantly, at the time of the *Atkins* hearing, Hill had been incarcerated for nearly twenty years since his arrest at age eighteen. Thus, a narrow focus on his "present" functioning would limit the evidence entirely to the prison setting, rendering it "impossible to get an accurate medical diagnosis."[7] Supp APX 293–94.

The trial court rejected clear clinical guidelines and sided with the State, concluding it would "evaluate [Hill's] *Atkins* claim based on his *current* mental status," and instructing the experts to determine "whether or not [Hill] is *presently* mentally retarded and therefore ineligible for the death penalty." Supp APX 249–50, 425. Three experts (Drs. David Hammer, for the defense; Nancy Huntsman, for the court; and Greg Olley, for the State) conducted a joint evaluation at the prison during which they administered testing directly to Hill and interviewed six prison employees. They did not conduct any collateral interviews with witnesses who knew Hill outside of the prison setting or during the developmental period. The experts unanimously agreed that prong one was satisfied. Dr. Hammer found prongs two and three were likewise satisfied, based on Hill's "rich" record of deficits in

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[7] Hill's position was undoubtedly correct. As discussed in detail throughout this brief, the clinical guidelines require a thorough review of extensive data, collected from multiple sources, to assess an individual's *typical* behavior in a *community* setting, which prison surely is not. *See infra*, pp.3-4, 11-13.

adaptive behavior prior to the age of eighteen. TR 233. Drs. Olley and Huntsman focused on whether Hill was "presently mentally retarded" and relied heavily on Hill's prison behavior and verbal abilities to conclude that he is not.[8] Supp APX 1125–26.

The trial court's requirement that the evaluation focus on "present functioning" permeated the proceedings and negatively impacted the reliability of the evaluations. Dr. Olley testified he had participated in nine previous *Atkins* hearings, but this was the first time he had been instructed by the court to examine only present functioning. TR 649. He explained that: (1) the clinical guidelines require an assessment of adaptive behavior in the *community* rather than a prison setting; TR 868 ("That's not what an assessment of adaptive behavior asks us to do. It asks us to assess the person relative to people in their typical community."); (2) the medical community cautions against reliance on self-reported adaptive behavior, TR 760 ("I would be cautious of any death row inmate reporting on his own behavior."); and (3) this evaluation was therefore "unusual" and "challenging" because it was "impossible to assess all of Mr. Hill's adaptive behavior while he is in prison." TR 869–70. Dr. Olley pointed to

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[8] Dr. Olley concluded that "[t]he available information on Mr. Hill's current functioning does not allow a diagnosis of mental retardation." Supp APX 1125. Dr. Huntsman felt that "in many respects" the most persuasive evidence was the prison officials' "consistent descriptions of [Hill] as 'average' within the death row population at Mansfield." Supp APX 1141. However, she also acknowledged that it was difficult to assess adaptive behavior in a prison setting. Supp APX 1140.

the court's limitation as the reason for the overall structure of the evaluation and for his own reliance on prison behavior and verbal behavior. TR 674 ("Judge Curran's order, as I understood it to us was to demonstrate mental retardation at the present time. And that was the focus of the evaluation conducted by the three psychologists in April of this year."); *id*. at 743 (stating he relied on Hill's verbal behavior because "Judge Curran's directions to us was to determine mental retardation currently. And this was a current piece of information."); *id*. at 862 (explaining to the court, "I think our protocol was different in the sense that in speaking among the three psychologists, we were aware of your order to look at Mr. Hill's present functioning. And that was why we conducted the evaluation at that time, and why we interviewed six people from the prison, and why we toured the prison facilities.").

Dr. Huntsman agreed with Dr. Olley that the focus of their evaluation was on present functioning:

> When the referral was made I only answered the question that was asked in the referral. And the referral asked whether he is now a mentally retarded individual. And that's the question I answered. And it's my opinion that now he is not a mentally retarded individual.

TR 1052. Dr. Huntsman admitted intellectual disability was not her specialty, TR 988, and stated she had never read the AAMR Manual. TR 1162. She did not know the AAMR and APA guidance regarding the use of anecdotal and record-based evidence for assessing

adaptive behavior. TR 988, 982–84. She did not review Hill's historical records in detail because she did not want to "contaminate" her perspective. TR 1079. When the State asked whether Dr. Huntsman would nevertheless reach the same conclusion "based on all the information," she reiterated, "I wasn't asked to address it in my report," but "my opinion is that he was probably not retarded at the time of the offense." TR 1052.

Dr. Hammer was the Director of Psychology at The Nisonger Center, a federally funded program at The Ohio State University tasked with training mental health professionals on the topic of intellectual disability. TR 142, 145–46. He estimated he had conducted 500 intellectual disability–related evaluations over the course of his career. TR 150. Unlike Drs. Olley and Huntsman, Dr. Hammer never described the referral question as limited to "now" or "present functioning" and instead engaged extensively with Hill's social history records, describing his prior professional evaluations, school records, and teacher and evaluator observations as highly relevant to an assessment of adaptive behavior. TR 206, 223–24, 227–29, 233. Dr. Hammer stated a careful review of such records was "the lifeblood" of his work, necessary for the proper exercise of clinical judgment, and "standard psychological practice." TR 196, 205, 248. He placed little emphasis on Hill's prison behavior, explaining "you need to assess adaptive skills relative to the person functioning within the community. . . . And in this case he's obviously not functioning within the community and hasn't been functioning within the community for

20 years." TR 407–08. He gave little weight to prison guards' descriptions of Hill as an "average" inmate because laypeople in this setting are not typically able to identify mild intellectual disability. TR 423.

It was unsurprising that all three experts agreed Hill met the requirements of prong one (i.e., significantly sub-average intellectual functioning) because his IQ consistently hovers in the mid-60s. In addition, the State has since conceded that Hill meets the requirements of prong three (onset during the developmental period). *Hill v. Shoop*, 11 F.4th 373, 387 (6th Cir. 2021) ("The Warden also admits that any adaptive deficits that Hill does have arose before he turned 18."). Accordingly, this brief focuses on the lower courts' treatment of prong two (i.e., deficits in adaptive skills). The trial court relied on the opinions of Olley and Huntsman to support its conclusion that Hill failed to satisfy prong two, but this decision was fundamentally flawed given its directive to the experts to focus on present functioning, an instruction that was at odds with the clinical guidelines adopted in *Lott*. It has long been established by the medical consensus that a proper assessment of adaptive behavior must be based on a thorough, rigorous collection of information. *See*, *e.g.*, AAMR User's Guide 8 (describing "the importance of clinical judgment" and stressing the thorough and systematic collection of data as a "critical part of best practices."). This careful review should be based on as many sources of data as possible and span the individual's entire life history, particularly the developmental period:

> Adaptive behavior must be examined in the context of the developmental periods of infancy and early childhood, childhood and early adolescence, late adolescence, and adulthood. A continuing theme is the importance of the developmental relevance of specific skills within these adaptive areas.

AAMR Manual 75; *see also id*. at 85 ("It is also essential that people interviewed about someone's adaptive behavior be well-acquainted with the typical behavior of the person over an extended period of time, preferably in multiple settings.").

Deficits in adaptive behavior must be documented within the context of a community environment typical of the individual's peers. AAMR Manual 13; *see also* AAMR Manual (9th ed. 1992) at 6 ("Community environments typical of the individual's age peers refers to homes, neighborhoods, schools, businesses, and other environments in which persons of the individual's age ordinarily live, learn, work and interact."). Thus, adaptive behavior cannot be assessed in any reliable fashion in a prison environment or other highly controlled setting. AAMR Manual 85 ("Observations made outside the context of community environments typical of the individual's age peers and culture warrant severely reduced weight."). The medical community (then and now) also cautions evaluators against reliance on self-reported information because people with intellectual disability are often unreliable raters who over-estimate their own abilities. *See*, *e.g.*, AAMR Manual 85; Robert B. Edgerton, THE CLOAK OF COMPETENCE:

STIGMA IN THE LIVES OF THE MENTALLY RETARDED 158–59 (1st ed. 1967). In other words,

> [A] comprehensive and correct understanding of the condition of mental retardation requires a multidimensional and ecological approach that reflects the interaction of the individual and his or her environment, and the person-referenced outcomes of that interaction related to independence, relationships, contributions, school and community participation, and personal well-being.

AAMR Manual at 48. No reasonable clinician properly applying the clinical guidelines (and free from the limitation imposed by the Ohio trial court) would ignore the rich historical record that was available in Hill's case and examine only adult behavior in an institutionalized setting. This was not a minor deviation from the clinical guidelines, but rather, a fundamental repudiation of their very essence.

Thus, the *en banc* Sixth Circuit Court of Appeals' majority subsequently missed the mark entirely by finding the state court's focus on "present functioning" was not unreasonable because "[i]f intellectual disability is not a transient condition, then the outcome should not change if the court evaluates a defendant's abilities at the time of the crime or at the time of a later *Atkins* hearing." *Hill v. Shoop*, 11 F.4th at 386. By insisting that the evaluation focus on "present functioning," the trial court discounted to legal irrelevance the vast majority of information necessary for a reliable clinical assessment of intellectual disability. There

was a large body of evidence compiled over the course of Hill's developmental history by multiple people who observed his behavior in various contexts. In addition to formal testing by qualified examiners, the historical record contains direct observations of Hill's behavior and adaptive skills by teachers, counselors, school principals, family members, and Department of Youth Services and Probation employees. This is precisely the type of information that forms the heart of a reliable medical diagnosis, and the Ohio courts' decision to discount it was in error.

## II. The Ohio Court of Appeals Unreasonably Concluded the Available Record Was "a Thin Reed."

The trial court rejected Hill's *Atkins* claim and the Ohio Court of Appeals affirmed, finding Hill failed to satisfy prong two because of his "lack of effort" on standardized measures the experts attempted to administer during their joint evaluation. *State v. Hill*, 894 N.E.2d 108, 122 (Ohio Ct. App. 2008).[9] At the joint evaluation, "Drs. Hammer, Olley, and Huntsman attempted to administer various adaptive behavior tests, including the Street Survival Skills Questionnaire, the

[9] Hill's school records contained four administrations of the Vineland Social Maturity Scales, but the experts all agreed that these results were unreliable (because Hill's mother, who also had an intellectual disability, served as the informant for some and for others the informant was not recorded) and that, regardless, it was not a particularly good test for accurately measuring adaptive behavior. *Id*. at 123–24.

Woodcock Johnson Tests of Achievement, and the Adaptive Behavior Assessment System."[10] *State v. Hill*, 894 N.E.2d at 122. No reliable results could be obtained because of "Hill's lack of effort." *Id.* During the testing process, Hill put his hands over his eyes, stated "this stuff is hard" and "my head won't work no more," and began to cry, causing the examiners to abandon their testing plans. Supp APX 1112. Hill's decision not to cooperate, the court reasoned, forced the examiners into a situation where the remaining record left only "a thin reed" insufficient for a diagnosis. This conclusion is as scientifically unsound as it is inconsistent with the record evidence.

While the use of a standardized measure of adaptive behavior is *recommended* whenever possible, it was not (and is not) required. The clinical guidelines clearly recognize there will be certain "challenging" situations in which the use of such an instrument is not an option, including cases involving older individuals and ones where reliable informants cannot be located. AAMR Manual 94. In this case, Hill had been in prison for twenty years at the time of the experts' evaluation

[10] Neither the SSSQ nor the Woodcock Johnson measure overall adaptive behavior and they are not listed as recommended instruments in the clinical literature for this purpose. *See* AAMR Manual 87–90. The SSSQ examines a narrow group of behaviors of a select segment of the population and the Woodcock Johnson is a test of academic achievement. The ABAS is an appropriate measure of adaptive behavior but is most useful and reliable when administered to a collateral witness rather than the individual being assessed. *Id*. at 85 ("assessment typically takes the form of an interview process, with the respondent being a parent, teacher, or direct-service provider").

and no appropriate informants were available for a formal adaptive behavior assessment. TR 431. All of the experts acknowledged this situation was challenging because there were no appropriate formal tests for the prison setting. TR 431, 868, 1130. When a standardized test is not possible or available, other sources of adaptive behavior information, such as social history records, prior evaluations, and behavioral observations of collateral witnesses, can and must be used. AAMR Manual 95; *see also* TR 262, 382 (Dr. Hammer explaining these same principles).

Even when a formal measure can be obtained, it should *never* be solely relied upon as providing the conclusive answer to the relevant questions regarding adaptive behavior. AAMR Manual 75 (an appropriate adaptive behavior assessment "goes beyond what can be observed in a formal testing situation"). "No existing measure of adaptive behavior completely measures all adaptive behavior domains." AAMR Manual 74. Some adaptive skills are "particularly difficult to measure using a rating scale or are not contained on any existing standardized instruments," but they "should still be considered in the overall diagnostic decision process and evaluated by other means." AAMR Manual 74–75. In addition, instruments completed by self-reported answers are unlikely to be reliable.[11] AAMR Manual 85. The only way to reliably assess adaptive behavior

[11] Thus, even if Hill had fully cooperated with the testing, it is likely that the state court would have discounted his answers as subjective, unreliable, and self-interested.

is to carefully examine all the relevant available data. By contrast,

> clinicians who have not gathered extensive relevant assessment data should not claim clinical judgment. Clinical judgment should *not* be thought of as a justification for abbreviated evaluations, a vehicle for stereotypes or prejudices, a substitute for insufficiently explored questions, an excuse for incomplete or missing data, or a way to solve political problems.

AAMR Manual 95.

Here, the experts were not forced into an evidentiary void as the appellate court concluded. There was, in fact, a large and detailed body of evidence to be mined—one that all three experts described as more extensive than they usually encountered—which the evaluation circumstances *heightened* the need for the experts to carefully review. The most critical components of that record went ignored, not because of Hill's performance during the contemporary evaluation, but because of the trial court's own instructions.

## III. Hill's Verbal Behavior, Prison Behavior and Demeanor Do Not Rule Out Intellectual Disability.

After erroneously concluding that the available record was but a mere "thin reed" of "anecdotal evidence," the Ohio Court of Appeals then purported to analyze the record but focused on clinically irrelevant

factors such as verbal behavior, prison behavior and demeanor. For example, regarding Hill's school history, the Court of Appeals observed that "Hill knew how to write" and was described by at least one teacher as "'a bright, perceptive boy with high reasoning ability.'" *State v. Hill*, 894 N.E.2d at 124. The Court of Appeals focused on the language Hill used in his interrogation and in subsequent statements to a news reporter. The opinion also focused heavily on Hill's behavior in prison and noted the trial court's observation that Hill did not appear to the trial judge to be intellectually disabled during his appearances in court. *Id*. at 124–25.

The fact that Hill "knew how to write" is irrelevant under the clinical definitions, as it is well accepted that people with intellectual disability can learn to read, write, and achieve academically up to about a sixth-grade level (although Hill never scored above a third-grade level on any standardized measure of academic achievement). DSM-IV-TR 43. The teacher who described Hill as "a bright, perceptive boy" worked with him at The Fairhaven Program for Mentally Retarded Children, and her use of this language does not, in any way, indicate that Hill is not a person with intellectual disability. The same teacher noted that Hill, at age fifteen, read only at a first-grade level and needed to work on adaptive skills such as following class rules, working without disrupting others, showering regularly and using deodorant. Supp APX 578. The record is replete with information that Hill suffers from significant deficits in functional academics and several other areas of adaptive skills. The Court of Appeals'

analysis of the school records is particularly puzzling given that all three experts agreed Hill suffered from significant deficits in academic functioning.[12] Supp APX 1117, TR 783, TR 1112.

As explained above, it is well established that reliance on behavior in an institutional setting is clinically inappropriate. AAMR Manual 83, 85, 86. In addition, none of Hill's prison behavior was inconsistent with intellectual disability, nor can his behavior in an institutionalized setting serve as a proxy for the rigorous evaluation the clinical guidelines demand.[13] In the same vein, the use of Hill's verbal

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[12] To satisfy prong two, *Lott* required significant deficits in two out of ten sub-skill areas: functional academics, communication, self-direction, social skills, leisure, self-care, home living, community use, health and safety, and work. 779 N.E.2d at 1014; *see also*, AAMR Manual 82, table 5.2.

[13] It is also worth noting that several of the Ohio court's findings about Hill's prison behavior are contradicted by the prison records, which contain multiple entries along the following lines:

- Inmate Hill "has few, if any, friends," is "socially withdrawn" and "weak, indecisive, easily led," "gives impression of ineptness, incompetence in managing everyday problems of living." Supp APX 1341.
- Inmate Hill "tries, but cannot seem to follow directions," "continually asks for help from staff," "needs constant supervision," "seems dull and unintelligent," is "impulsive, unpredictable," "passive, easily led." Supp APX 1343.
- "[D]ue to his very limited writing ability, he has been requesting assistance from other inmates in his cell block area to help him with his correspondence." Supp APX 1510.
- "[I]t was discovered that two (2) inmates of this unit are illiterate. . . . A case in point: Inmate Hill had

behavior was contrary to clinical guidelines. AAMR User's Guide 22 ("Do not use past criminal behavior or verbal behavior to infer level of adaptive behavior or about having MR/ID."). That two of the three experts felt they should focus on these factors due to the trial court's instruction does not render them clinically valid data points from which to draw a medically meaningful conclusion. Likewise, there is no support in the clinical literature for the idea that the trial judge should be able to tell by observing Hill in court whether he is or is not a person with an intellectual disability. DSM-IV-TR 44 ("No specific personality or behavioral features are uniquely associated with Mental Retardation."); *id*. at 46 ("There are no specific

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recently received a letter from the Courts through the Public Defenders' Office informing him of his indefinite stay of execution. However, Hill was not able to read or understand until I read said letter to him." Supp APX 1512.

- "Realizing that Hill is illiterate, I elected to talk to him at the gate in his range." Supp APX 1553.
- Multiple requests from Hill asking staff for assistance understanding his commissary account balance, ending with responses such as: "You did receive this money on August 3"; "Inmate interviewed this date, money checked out with cashier's office"; "his grandmother sent in $10 but he could not realize it since she sent it along with his aunt's money order to him. His current balance is $5.41"; "Cashier's office telephoned 3:51 p.m. Balance in his account this date is $0.41." Supp APX 1556-76.
- "Main problem is adjustment problem and retardation." Supp APX 1817.
- "[I]t is rather puzzling that somebody with his retardation would end up on death row." Supp APX 1820.

physical features associated with Mental Retardation."). This idea is nothing more than a common layperson's misconception, which the trial judge adopted at the State's suggestion, and the Ohio Court of Appeals incorporated into its own reasoning. Supp APX 3188 (State's Proposed Findings of Fact and Conclusions of Law). Stereotype has no place in a clinically sound evaluation of intellectual disability.

In its analysis of whether the Ohio Court of Appeals' decision was based on an unreasonable determination of the facts, the Sixth Circuit drew a series of conclusions supportive of a finding that Hill is a person with intellectual disability. For example:

- The State court relied on Hill's behavioral problems in school, but "behavioral problems . . . do not necessarily correlate with an absence of intellectual disability," *Hill v. Shoop*, 11 F.4th at 388, and "[e]ach of the three experts who testified at Hill's *Atkins* proceeding agreed that Hill's behavioral problems during childhood did not necessarily contradict a finding of significant adaptive limitations." *Id.*
- "Hill's school records suggest that he struggled academically as a child." *Id*.
- "There is also evidence that Hill needed reminders to perform basic personal hygiene and lacked self-direction." *Id*. at 389.
- There was "additional evidence [in the school records], not included in the Court of Appeals summary, [that] may be relevant to

determining whether Hill had significant limitations in two or more adaptive skills." *Id*.

- The State court relied on Hill's police interrogation, but "in looking at the evidence, it is unclear that Hill's conduct demonstrated self-direction or self-preservation." *Id*.

- The State court did not mention "the testimony of three experts—Dr. Douglas Darnall, Dr. Nancy Schmidtgoessling, and Dr. Douglas Crush—who found that Hill was intellectually disabled at the time of the 1986 trial." *Id.* at 389–90. This was particularly concerning "given *Lott*'s direction that courts should rely on professional evaluations of the defendant's mental state." *Id*. at 390.

- The State court relied heavily on Hill's prison behavior, but "[b]oth Dr. Olley and Dr. Huntsman, who later concluded that Hill was not intellectually disabled, conceded that Hill's conduct in the highly-regulated prison environment was not a good indicator of his adaptive skills." *Id*.

- Although "trial courts should not rely solely on their own perception of the defendant in court to determine whether the defendant is intellectually disabled," the Court of Appeals "still utilized the trial court's perception here because it aligned with the conclusions of two experts." *Id.* at 391.

Despite these observations, the Sixth Circuit ultimately concluded that the Ohio Court of Appeals' interpretation of the evidence was not unreasonable,

particularly because it relied on the opinions of two experts. But this conclusion is wholly inconsistent with the clinical guidelines that the State court purported to apply. The concept of *convergent validity* requires that a clinician carefully examine the totality of the evidence and draw conclusions only where they are supported by multiple data points taken from multiple sources. AAMR Manual 86, 95. The Sixth Circuit's analysis pays no heed to *Lott*'s explicit adoption of the clinical guidelines and assumes instead that as long as the Court of Appeals' decision accurately describes *some portions* of the record, its ultimate conclusions are not unreasonable.

The Ohio Court of Appeals' factual conclusions are contradicted by the overwhelming weight of the evidence *and* the clinical consensus. Its rejection of Hill's *Atkins* claim cannot be salvaged by pointing to the opinions of Olley and Huntsman because it is clear from their testimony that they, too, failed to adhere to the clinical guidelines and their opinions were fundamentally flawed due to their constricted focus on present functioning. The Sixth Circuit's opinion is therefore incorrect in its claim that "[a]ll three experts relied on a comprehensive record of Hill's history." *Hill v. Shoop*, 11 F. 4th at 391.

## CONCLUSION

The Ohio state courts claimed adherence to the medical community's clinical guidelines but proscribed the evidence to a narrow set of sources—ones that have little to no value in a proper assessment of intellectual disability—and ignored the information that was most critical and relevant to Hill's adaptive behavior. The state courts then gave great weight to improper and largely irrelevant factors such as Hill's prison behavior, verbal behavior, and appearance. The Ohio courts' reasoning departs significantly from and bears no relationship to the clinical guidelines, and this led to the rejection of a clear-cut case of intellectual disability. This Court should grant the petition and reverse the judgment below.

Respectfully submitted,

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